<table>
<thead>
<tr>
<th>Editorial</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migration and Mental Health</td>
<td>84</td>
</tr>
<tr>
<td>Sandeep Grover, Natasha Kate</td>
<td></td>
</tr>
<tr>
<td>Balint Award</td>
<td>87</td>
</tr>
<tr>
<td>A Girl who saw friends unseen by others: What did we do?</td>
<td></td>
</tr>
<tr>
<td>Mamta Sood</td>
<td></td>
</tr>
<tr>
<td>G. C. Boral Award I 2011</td>
<td>94</td>
</tr>
<tr>
<td>Development of 12-item Disability Screening Tool (DST) in a community setting:</td>
<td></td>
</tr>
<tr>
<td>A Preliminary Analysis</td>
<td></td>
</tr>
<tr>
<td>Rachna Bhargava, BS Chavan, Tanuja Kaushal, Nitin Gupta</td>
<td></td>
</tr>
<tr>
<td>G. C. Boral Award II 2011</td>
<td>106</td>
</tr>
<tr>
<td>Study of Psychiatric Morbidity and Absenteeism in Children Enrolled in non formal community school under Sarva-Shiksha Abhiyan</td>
<td></td>
</tr>
<tr>
<td>Sweta Shah, Alka Pawar</td>
<td></td>
</tr>
<tr>
<td>Research Articles</td>
<td>113</td>
</tr>
<tr>
<td>Family Burden and Family Distress in Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>Ismail Shihabuddeen T.M., Mohan Chandran, Moosabba</td>
<td></td>
</tr>
<tr>
<td>Validation of hindi version of Perceived Stigma of Substance Abuse Scale</td>
<td>117</td>
</tr>
<tr>
<td>Surendra K. Mattoo, Siddharth Sarkar</td>
<td></td>
</tr>
<tr>
<td>Stigma and Discrimination: How do persons with Psychiatric Disorders and Substance Dependence view themselves?</td>
<td>121</td>
</tr>
<tr>
<td>Rohit Garg, B.S. Chavan, Priti Arun</td>
<td></td>
</tr>
<tr>
<td>Book Review</td>
<td>131</td>
</tr>
<tr>
<td>Disaster Psychiatry: Readiness, Evaluation and Treatment (F.J.Stoddard, A.Pandya, C.L.Katz)</td>
<td></td>
</tr>
<tr>
<td>R. Srinivasa Murthy</td>
<td></td>
</tr>
</tbody>
</table>

©2012 Indian Association for Social Psychiatry
# ABSTRACTS OF XIX NATIONAL CONFERENCE OF IASP, CHANDIGARH,
## 23-25 NOVEMBER 2012

## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presidential Address, Orations, Invited Lectures, Debate</td>
<td>A1</td>
</tr>
<tr>
<td>Award Papers</td>
<td>A6</td>
</tr>
<tr>
<td>Symposia</td>
<td>A12</td>
</tr>
<tr>
<td>Workshops</td>
<td>A24</td>
</tr>
<tr>
<td>Free Papers (Oral)</td>
<td>A28</td>
</tr>
<tr>
<td>Free Papers (Poster)</td>
<td>A37</td>
</tr>
</tbody>
</table>

©2012 Indian Association for Social Psychiatry
Humans initially are believed to have been nomadic. With the advent of farming practices, humans began to settle down, but the search for greener pastures, better land and hence a dream of better living has always driven man to move beyond his domicile. Migration as a concept and as an event has been ubiquitous in human history. Yet, there is no universally accepted definition of migration and migration is largely understood as the process of going from one country, region or place of residence to settle in another (Bhugra et al, 2011). While early humans migrated due to many factors such as changing climate and landscape and inadequate food supply, the rate of migration increased about 200 years because of labor migration, refugee migrations and urbanization. Most of the contemporary migration is predominantly economically motivated because of wide disparities in the incomes that can be earned for same kind of work in different countries and regions of the world. However, emigration is relation to wars, political conflicts and natural disasters also contributes to the worldwide statistics on migration. Migration, as a process, may occur for a short or long duration. Further, it may be temporary, semi-permanent or permanent. Depending on the number of people moving from one place to the other, the process of migration may involve an individual, family or a group of people. Depending on the place of migration, it may be local or distant, i.e. national or inter-national (Bhugra, 2004; Bhugra et al, 2011).

From mental health perspective, migration is understood as a process which can be broadly understood in three stages, i.e., pre-migration, migration and post-migration. The pre-migration phase involves decision and preparation to move; the actual migration involves physical relocation of individuals from one location to another and the post-migration phase is understood as absorption of the immigrant within the social and cultural framework of the new society and involves learning of new social and cultural rules and roles (Bhugra et al, 2011).

Migration, as an event, has a huge impact on the emotional state of the individual. To leave behind one's belongings, friends, families, value systems, social support and the like is not easy. Following this, in the new land, a migrant is often viewed as the outsider, discriminated against as he/she is different, treated as a usurper of resources, singled out and blamed and persecuted for minor matters and hence lives in a state of constant emotional turmoil. Migrants are often poor, and this, coupled with the absence of acceptance in the new land, often leads to both physical and psychological problems. Hence, migration as a process is very stressful, because it is not just a single event but is a series of events, being influenced by number of intrinsic and extrinsic factors over a period of time, sometimes for very prolonged duration. It may involve a period of loneliness, long distance relationships, lack of emotional support, adaptation to new environment and people etc. Adaptation to different kind of stresses is influenced by factors like personality of an individual, type of migration (forced versus voluntary), migration as a persecution or by choice, cultural differences between the native country and country of migration, cultural shock (difference in expectation and achievement) to name a few.

Considering the psychological impact, studying various psychiatric aspects of migrant population has always fascinated the researchers and they have therefore tried to examine and evaluate the psychiatric morbidity in various migrant populations.

In general, studies suggest that compared to later stages, there are lower rates of mental illness in the initial period involving migration (Bhugra, 2011). With regard to the relation of migration with various psychiatric disorders, data suggests important link between migration and schizophrenia. A recent meta-analysis showed that the mean weighted relative risk for developing schizophrenia among first-generation migrants was 2.7 and that for second-generation migrants was 4.5. Further, the data suggests significantly greater effect sizes for migrants from developing versus developed countries (relative risk=3.3) and for migrants from areas where the majority of the population is black (relative risk=4.8) versus white and neither black nor white (Cantor-Graae & Selten, 2005). There is no consensus with regard to the prevalence of common mental disorders among migrants, with some studies suggesting higher rates.
among the members of the new culture, but others show either no difference or lower rates. Findings also suggest elevated rates of suicide (Bhugra et al, 2011). Regarding affective disorders, a recent meta-analysis suggests that the mean relative risk of developing bipolar affective disorder among migrants was 2.47 and the mean relative risk of mood disorders of unspecified polarity was 1.25 and that of any mood disorder was 1.38 (Swinnen & Selten, 2007). High rates of post-traumatic stress disorder and depression have been reported in post-conflict population and refugees (Bhugra et al, 2011).

Considering the fact that an increasing number of people are migrating for a variety of reasons, it is important to understand to various aspects of assessment and management of psychological morbidity among immigrants. Basically, the evaluation should cover important factors in the pre-migration, migration and post-migration phase. Special attention must be paid to persons in the extremes of ages (children and elderly) as the reasons of distress in them may be different from adults and for them migration may be more frequently forced than by choice. Further, some of the elderly, having lived their entire life at one place may have considerable difficulty in adjustment and experience significant degrees of cultural shock.

It is also important for the clinicians to remember that the immigrants may have different cultural values and hence should consider this in their management of the patient. Clinicians may themselves come from communities that are at odds with the patient and hence need to take special care that they should deal with the patient without any prejudice. While using various pharmacological agents, the clinicians should remember that people from various ethnic backgrounds have difference in the pharmacokinetics and pharmacodynamics of various drugs which may manifest as sensitivity to side effects and the dose required for improvement in symptoms. The cultural values and beliefs may also influence attitude towards psychotropic medications, treatment adherence and expectation from treatment. Further, other cultural factors like dietary habits, smoking and alcohol intake pattern, use of complementary medicines etc may influence the effectiveness of various psychotropic medications. With regards to psychotherapy, lack of understanding of a person's cultural background may lead to poor therapeutic relationship.

For the service provider it is important to remember that to serve the immigrants in a better way, the services must be organized in a culturally sensitive way. The clinicians must have cultural competence to deal with people from different cultural background. Clinicians must attempt to provide culturally appropriate services related to language and other needs of migrants, refugees and asylum seekers.

As with globalization, migration within a country and outside the country is increasing rapidly and is now accepted and recognised as an important mediator of social change. Migrants do contribute positively to the new cultures and hence it is important that their mental health needs are recognised and handled in a culturally appropriate way. Clinicians, policy makers and service providers must be aware of specific needs of migrants and try to fulfil the same. From research perspective, to further our understanding about the effect of migration on mental health, there is a need to compare the mental health of migrants to what their mental health would have been had they stayed in their home country.

Historically, India has overall been more accepting towards refugees and migrants, but recent events have made us reconsider if this is only a veil of gentility. The partition of India resulted in the migration of more than a million individuals and the carnage and persecution associated with it put the non-violent independence movement to shame. Today, even within the country, migrants continue to get the raw end of the deal. The enmasse back migration of North-Eastern Indian from places as diverse and distant as Bangaluru and Delhi following the Bodo-Muslim riots in Assam showed the nation how insecure its own citizens are in different parts of the country. In Maharashtra, and especially Mumbai, the average 'UP bhaiyas' and 'Biharis', who form a large part of the work force are frequent and easy targets for censure and violence by politicians looking to enhance their vote banks. Across the nation are scattered Kashmiri Pandits, a large number of whom migrated out of the Kashmir valley following the rise of militancy, and an entire generation of these individuals has left behind centuries of tradition and culture, in fear of religious persecution.

Also it is important to note that Indians have migrated to all the corners of the globe especially those from Punjab, Gujarat and Kerala in search of economic opportunities. While they have established their places in the foreign land yet in today's world they are often ridiculed and labeled due to their appearance, targeted

©2012 Indian Association for Social Psychiatry
by religious or racial terrorists and at times not given adequate rights compared to the native population. The recent economic recession in the United States of America and the European Union has resulted in a number of Indians employed abroad losing their jobs. On return back to India, these individuals once again have difficulty readjusting to their way of life, often leading to mental health problems.

The theme of the 19th National Conference of Indian Association of Social Psychiatry – “Migration and Mental Health” - is therefore very apt. The theme symposium on this occasion would address some of the important issues related to migration and would give lead to the clinicians to improve their day to day practice in dealing with immigrants.

REFERENCES


Sandeep Grover, M.D., Associate Editor, Indian Journal of Social Psychiatry; Assistant Professor, Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh 160012. Email: drsandeepg2002@yahoo.com

Natasha Kate, M.D., Senior Resident, Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh 160012.
A GIRL WHO SAW FRIENDS UNSEEN BY OTHERS: WHAT DID WE DO?
Mamta Sood

The case

P., 18 years old unmarried girl, student of 1st year BA from Hindu nuclear family belonging to middle income urban background presented with complaints of “There are 'friends' who are not seen by others”, for 2½ years, and hearing voices and fearfulness for 2-3 months.

History revealed that 2½ years back when she was in 10th standard, she met a girl called Durga (studying in 11th standard science stream in the same school) during school recess break while she was eating lunch alone and became friends with her. At that time, in the school, she was having difficulty with mathematics and science; she had arguments with her father at home regarding her disinterest in these subjects. About a month after she had befriended Durga, one of her classmate friends asked her why she was talking in the air. The patient was perplexed at this question as she was talking to Durga whom she could see and hear as clearly as her other friend. She told her that she was talking to her new friend Durga. Her other friend replied that she could see no one. P. became embarrassed at this and asked her friend not to tell about this incident to anyone. However, from that day onwards, she asked Durga not to meet her in presence of others and told her that she would meet her after the classes or at home before her mother came back from work. If she came when others were present, P. would listen to what she said but would not reply back. She also met an old uncle (asked for water from her) and Rohit, an engineering student (saw him playing drums) over next few months. She started liking Durga as she comforted her, gave her advice (about her classmates and math) and would hold her hands (she would feel the touch as of her mother) whenever she would be stressed. She sometimes came to her home to help with math problems. Old uncle gave advice and would at times slap her (would feel pain on cheeks) if she did not follow his advice about her friends or practicing maths. There was no set time, frequency and location of their meeting her. She also denied that these people were product of her imagination or she had willful control over their appearance and disappearance. There was no history of lowering of her consciousness, or any change of her identity when she met these people. At the same time, she also acknowledged that these people were visible only to her, not to others. Also, she did not tell about these friends to her family or friends till Aug 2010. When she was asked details of their meetings she reported “I don't remember”. Her family members reported that they never noticed her talking, laughing or crying to herself during this period. She also complained of headache with no fixed quality, location, intensity or frequency, mostly when she studied math and were unrelated to visits by her “friends”. She was shown to neurologist but did not perceive any relief with medicines. The headache would get relieved after sleeping. During this period, she continued to go to school regularly; her personal care was intact, biological and socio-occupational functioning was normal. She took Psychology as subject in 11th standard, started liking the subject and decided to become a psychologist. She passed 10th and 12th standard with 68% and 83% marks respectively. During her 11th-12th class, headache and visits by “friends” continued, albeit in reduced frequency. She wanted to take admission in a renowned college in Delhi but could not clear its entrance test. She secured admission to another college away from her home, but came back within a week as she had started seeing a young male in her hostel room which she shared with girls. She felt intimidated and knew it was unreal because other girls did not behave as if a male was in their room. She did not report about this to her parents who attributed her coming back to homesickness. After coming back, as admission to most of the colleges was closed, she took admission in B.Sc. 1st year (Computer Science) in August 2010. Her headache and frequency of meeting Durga and old uncle increased; she started seeing an old age aunty in addition. She told about them to her close friend who advised her to disclose this to her family and seek professional help which she refused to do. However, in September 2010, while in the class, she started shouting as she saw old uncle (at that time, he did not speak to her) approaching her teacher with a knife. Her mother was called who took her to home. She told her mother about these people. Her family took her to psychiatrist who started on her medications (tab olanzapine 10 mg and tab escitalopram 15 mg). As per
stopped. Routine investigations were within normal
limits. Psychometric report suggested that there was no
psychosis and identified multiple stressors. The day
after hospitalization she reported that voices advised
her to take discharge and had stopped completely.
In the ward, she was cooperative, followed ward routine,
took care of herself, slept and ate regularly, did not
exhibit any demonstrative/manipulative behavior, did
not seek attention of the doctor and participated in day
care activities. Various differential diagnoses were
considered: Factitious Disorder (F 68.1), Dissociative
Disorder (unspecified) (F 44.9), Personality Disorder
(unspecified) (F 60.9) and Psychosis (Not otherwise
specified) (F 29). Her hospitalization was kept short and
it was decided that management will be done on
outpatient basis.

Exposition
She came for follow up as advised but questioned the
need for coming regularly as voices had stopped. She
also resented that since the time she had started seeing
a psychiatrist, Durga and old uncle had stopped visiting
her. She missed them as they were kind to her, she
wanted to have them back.

It was offered that she could come every week and talk
about various issues important to her or bothering her
for about 45 minutes - 1 hour. It was mutually decided
that initially she will come for 15 such visits, which could
be extended if there was any further need. However,
she expressed her reservations about usefulness of
“talk therapy” but she agreed to give it a try.

At this time, she was not going to college and spent
most of her time in her room lying down or surfing
internet. She interacted minimally with her parents and
friends and was irritable. She also had headache.

The purpose of these sessions was to provide her with a
platform where she could express, explore and
understand her behavior, thinking, feelings and
problems part by part and thus facilitating her
understanding (make sense of) of herself. She was
asked to report any incident (both important and
unimportant) and her associated feelings as they
happened and as she experienced them. Also she was
couraged to talk about her current problems and
how she wished to tackle them. The goal of initial few
sessions was to engage with her, make and maintain a
therapeutic alliance as during the ward stay, one to one
contact with her was minimal.

During first few sessions, she reported that as a child,
she was very attached to her mother, hiding behind her
whenever she felt shy. She was particularly fond of her mother's smell and would wait for her letters and coming back from abroad. At home, she was looked after by her relatives (paternal aunt, sometimes maternal aunt) and her father. She described her father as less expressive. When she was a child, he would take her on his bike wherever he went. He would get her small gifts. However, nowadays, she felt distant from her parents as her mother would spend considerable time in kitchen and doing household chores after coming back from work, and complained of tiredness whenever she wanted to go out. She also felt alienated from her father as he wanted her to pursue nursing career because of its assured returns and was critical of her choice of becoming a painter or psychologist and he trivialized her paintings. An effort was also made to engage with her mother (who accompanied her). Her mother expressed concerns about her daughter's health and future. With P.'s permission, this fact was brought to attention of her mother. Later, she reported that her parents were spending more time with her. She had started going out with her mother but she felt irritated by her father's efforts to interact with her as he still did not respect his idea of becoming a painter. She had made plans to start some course in psychology or arts.

She came regularly for first three sessions. She talked about various issues concerning her. But after 3rd session, she suddenly became very angry and informed that she will never come back as there was no use in discussing her life with a stranger. During that session, she had narrated various incidents and had felt varied range of emotions about her sister, maternal aunt, her friends and not feeling good about herself. Her decision was accepted without any questions. No efforts were made to confront or reassure or cajole her back to therapy. However, she was told that her decision not to come was her own and was respected and if she wished to come anytime in future, doctor would be available at same time in same room.

She came back after 3 weeks, reported return of terrible headaches and apprehension. She told that she had felt overwhelmed by the fact that she had never talked about herself with anyone and could not see its use. She came back because she had felt better when she was coming. Also she understood that what she spoke was considered relevant and was not trivialized or wished away. After this she did not miss her appointments without prior information. She was mostly cooperative and cordial.

She reported that due to her shyness, she followed her sister everywhere who was vivacious, jolly, and confident and would make P. do whatever she willed. Her sister would always end up having best of the gifts brought by her mother. She was never scolded for not scoring good marks and could play all day long. She resented this and did not know the reason for her being pampered. She did not understand why her sister had died. She experienced guilt feelings about her death. She felt that she should have died instead of her sister as she was better of the two. After her death, there were her photographs all over the house and she felt alone. She had started talking to God and started writing a diary addressed to Him, kept doing so for many years.

In the school, she described whenever she had to speak in the class; she would feel anxious, her heart would beat fast and would feel as if walls would collapse on her. Therefore, she never answered or asked any questions in the class. She felt lost in the school after her sister's death, she would not go to toilet even. Few of her teachers encouraged her to socialize with others. She started playing cricket and was selected to bowl for the school team. As she wrote well in English, her teacher encouraged her to participate in a speech competition. She was in 7th standard at that time. She felt very happy to be chosen but when she went to the stage, she felt very anxious and almost “peed in her pants” but managed to finish her speech. Also she had chosen to learn sitar as she was one of a few in the school who could play it. She used to play sitar in the school band. She felt that participating in these activities had made her famous in the school, prior to joining these activities she was nobody and she stood out among other girls. Now girls wanted to be friends with her despite her poor academic scores.

In 10th standard, P. had to deal with multiple issues. She left basketball because girls better than her in basketball had joined her school and she was demoted to being 11th player. She had also stopped going for debate competitions due to school policy to restrict participation of students in 10th and 12th so as to facilitate studies. Academically also, she was not doing very well. She was also not clear what subjects/careers to pursue in future.
While in 10th standard, she had made friends with Mohini when she was made to sit with her in pairs of an intelligent (Mohini) and weak (herself) student. She liked Mohini because she expressed genuine interest in her, liked her poems and told her not to think too much about dying (her poems were pessimistic and themes were related to death). Also, Mohini would side with her on many issues in the class. P. considered her to be her best friend and would dream of staying together with Mohini in a house when they grew up. She would feel frustrated when Mohini would spend less time with her, would not respond to her text messages, phone calls and would meet her only once in 2-3 days; Mohini stayed near her home. She felt resentment towards her as she would give more importance to her studies, other friends as compared to their friendship. She called her a practical person. Although she considered Mohini to be her true friend, Mohini never responded like one. Her idea of a true friend was that he/she should be available 24x7 and had to respond to friend’s call at any cost there and then. She was angry with her because she had joined another school to study science. However, most of these feelings and ideas for Mohini, she kept to herself. During this period, she also claimed that she would send text messages about dying to her friends without her knowledge of the act. She would realize about these when she would get enquiries from her friends about her problems. She says that as Mohini was first on her phone contact list (because of frequency with which the messages were sent to her), invariably these messages would go to her. Contradictions of her ideas about friendship were pointed out to her.

She had started liking arts because her teacher felt that she was good in that. In 11th, her focus shifted to arts and teacher. She would spend her time and energy on learning, surfing the Net regarding ideas for her art projects and executing them. She mentioned about an incident where a girl who had copied project from internet had got appreciation from teacher; she had felt very angry and had complained to the teacher. After this, friends of that girl were very nasty to her and had spread rumours about her. She talked about her other friends to whom she did not feel as close but nevertheless she would hang around with them. By the end of 11th standard, her skills in the subject had improved considerably and she was sent for interschool painting competitions. All her friends and acquaintances knew that she wanted admission to a particular college and getting admission had become very important for her.

When she saw that her name was not in the list of successful candidates who had cleared the entrance examination, she felt that her respect among her friends had gone down. She decided immediately to go to the other college and prepared for the trip hurriedly. There she started wearing kurta, carried a side bag and was marked out by her seniors as fresher with kurta. She started seeing a young boy in her dormitory (whom no one else saw) and she felt afraid. She did not like food, shabby bathrooms and dormitories, poorly painted walls and forlorn look of the town. She returned to Delhi in a week. She did not want to return to the college because of loss of face due to her shouting and also she found it boring and finally dropped the idea of studying arts.

It was clear that on both occasions, seeing these people (whom no one else saw) had become “the reason” for her exit from undesirable situations, whereas actual reason was her discomfort and dislike.

She herself brought the topic of “Durga and uncle”. She gave detailed description of physical appearance of Durga. She came across as “holding hands type”, wise, intelligent, understanding, selfless and helpful from her description. When asked how she was different from her sister. She smiled and went on to elaborate the differences. Uncle was an old man who would encouraged her to commit suicide (he was okay/approved her unconventional impulses) whenever, she failed to achieve what she wanted to, whenever she was in distress due to some issues with friends. When asked why she did not question him when he gave such ideas. She was surprised and reported that she would have never questioned them as they might have stopped visiting her and she did not visit them. Old uncle was completely different from her father. She expressed hostility for her father and was encouraged to talk about her father. She did not talk much about Rohit, had seen him only on a few occasions and had neutral stance towards her. A neutral attitude with nonconfrontational approach was adopted towards these people.

Frequently she would bring topic of dying, death wishes and suicidal ideas. Many a times in between or while leaving after the session, she would exclaim “you may not see me next time I am trying to find out least painful way of committing suicide”. She visualized death in horrific details and dark colours. These wishes would
generally arise when she felt stressed and frustrated. It was when she would think about her admission to college, about her painting techniques which were still not good or when her friends would not do what she expected from them.

She was started on antidepressants during her 5th visit as she had mild anxiety and depressive symptoms.

She had started going regularly to the diploma institute and had made few friends there. She was practicing on sitar for a concert. She had also started taking driving lessons. She did not complain of headache. She expressed dissatisfaction with the style and pace of teaching at the institute.

During one of the sessions, she came and exclaimed to have been kissed by a smartly dressed girl (a stranger) on the lips as she was going to a market and liked it. She talked about sexuality and sex. She was not sure about whether she was a lesbian as she had liked to be kissed by a girl.

Old uncle had stopped visiting her after the incident at college. Durga kept accompanying her to my office on a few occasions but largely she had stopped seeing them. However, now she complained of seeing another set of people, each time different, they gave her fierce looks and followed her with intent to harm her wherever she went. She felt very apprehensive and sometimes she would have to stop to let them pass. She would see fast moving two dimensional frames of people, animals and scenes as if crowd was always with her. She also heard sounds of footsteps and door knocking in the night. She felt very anxious. She claimed she had no control over these. During one of her visits, she described a man standing near the window behind the doctor's back. When asked to draw him she refused as he had indicated not to draw him. She told that she had to do what he was saying otherwise some kind of harm will come to her. She also was not sleeping well. She was advised to follow sleep hygiene. She had become very anxious. As there was no change in her condition, tab risperidone 0.5 mg HS was started. Her sleep and anxiety gradually improved and she stopped seeing these people.

During this period, she was very worried about her lack of preparation for entrance exams. She did not want to pursue diploma as she felt it was wastage of time. Her family members were worried because she was not sticking to any course (had joined three courses in 6 months and had left them). She felt that her sketching of human beings was not good enough and needed more practice. She had started going to public places to sketch. She would bring her sketches and paintings along and discuss about what she had drawn. She would wait for comments. I would pick up some aspects of sketch or painting and give some genuine comment. She talked about renowned painters. She wanted to be famous, known as renowned painter and wanted to have many pages on Google devoted to her.

She announced during one of the sessions that she had quit smoking as she wanted to concentrate on her sketching. She had started smoking while in 10th and was occasional smoker. Uncle had encouraged her to smoke. She had learnt driving and got her driving license. She took decision to start private coaching for arts classes. She searched for teachers and found one. She felt hurt when one of them rejected her because she told him about her problems.

It was apparent that she was making efforts to prepare for entrance exams.

During one of the last sessions, she asked suddenly “were Durga, uncle and others simply products of my imagination?” I asked her what she thought. She answered “I will think about it”. It was mutually decided that due to her preparation for entrance exams, she would not be able to come regularly so regular sessions were suspended. She would come occasionally just to tell how she was doing. I also went on vacations.

She came after 2½ months. She had got selected in the college of her choice finally.

We planned to resume the sessions.

Reflection

Since childhood, P. would verbally express less about herself due to shyness and anxiety. She had developed strong fantasy life, talking even to God (as if he was real) in imagination. She did not talk to Mohini about what she felt but would carry out conversation with her in her mind when alone. As she grew up, her strong need for appreciation, achievement and companionship asserted itself and she joined many activities in which she aimed to excel so as to fulfill her need for power. In 10th standard (she was sixteen years old), she had to face multiple stresses which resulted in creation of a fantasy world inhabited by people having attributes she desired to associate with them; one had all the attributes she desired from an ideal friend and another one approved her nonconventional ideas like smoking, homosexuality, suicidal wishes. She expressed all or none kind of thinking, had strong sense of right and
One day, she came and exclaimed “Doc you are so famous”. She had googled about me. My answers to her questions were informative and honest. However her curiosity did not disturb me as much as her constant suicidal wishes which she expressed explicitly. Each time she would perceive any problem with her friends or would fail to make a piece of art, she would talk about ending her life and I would be worried till her next visit.

I also asked myself: was she special to me? I felt protective and indulgent towards her, as I have always believed that adolescents, specially students are on the verge of launching into their careers and lives and need to be helped in whatever way they could be helped. There was another reason, I also have children her age and I am witness to their daily struggles.

She never asked for my contact number and never tried to visit me in my room. However, after about 3 months, at 9 PM, there was a call on my residential phone number. She told me that she pretended to be one of the junior doctors who needed to talk urgently to me and asked the phone operator to connect to my residence. “Doc, my mother is not at home and I am planning to die as my life is not worth living”, she started with this. That scared me. I asked her to come to AIIMS casualty to which she refused. She kept on talking about dying and enquiring about details of my personal life. Her mother came and I asked her to give phone to her mother to whom I explained the situation and asked her to bring her to AIIMS casualty and to keep an eye on her.

Soon after, it was followed by an email from her in my mail box where she had just greeted me. Next day her mail talked about finding about a psychiatric drug which when taken in excess leads to death and she talked about getting it by including it in my prescription.

I have been talking periodically, about how I was proceeding with her to my senior colleague; he had also seen her during the hospitalization. Now I felt the need for discussing it with him. I discussed whether information in the mail signified that she was planning to commit suicide and whether I needed to take preventive action. Also I wanted to acknowledge that I had become uncomfortable by this intrusion into my personal space (over the years of practicing psychiatry, I have learnt to keep my personal and professional spaces separate). He reassured me and told that though she had suicidal wish, the content of the letter did not reveal any immediate intent or plan, so I need not reply back. He also advised me to block her mail. He asked me to take printout and show her and tell her clearly not to write such letters. However, this was not
needed as I never received her mails as I had blocked her email address. Also I did not receive any phone calls after that.

**Progression**

The management of this case highlights the role of psychotherapy; pharmacotherapy was used as an adjunct. No particular type of psychotherapy was followed and an eclectic mix of various techniques was used. In India, there is paucity of specialist psychotherapy training and services and psychotherapy is a useful tool available to psychiatrist. Although psychotherapy forms essential part of postgraduate training in psychiatry, there is a need to strengthen this training; one such step could be to make evaluation of psychotherapy case study method essential part of examination process. Also, teaching of basic tenets of psychotherapy to undergraduates and other postgraduates will enable future doctors to form good relationship with patients and caregivers in order to gather, evaluate and impart information across complex clinical situations.

**Mamta Sood, MD, Associate Professor, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi 110029. Email: soodmamta@gmail.com**
DEVELOPMENT OF 12-ITEM DISABILITY SCREENING TOOL (DST) IN A COMMUNITY SETTING:
A PRELIMINARY ANALYSIS
Rachna Bhargava, BS Chavan, Tanuja Kaushal, Nitin Gupta

Abstract
Aim: To develop an objective and ‘easy to administer’ Disability Screening Tool to facilitate the certification process for Persons with Disabilities Act (PWD Act) in a community setting. Methodology: A sample of 541 individuals was derived from an ongoing house to house survey in Chandigarh. The subjects were administered socio-demographic sheet and the 12-item Disability Screening Tool (DST) which identified potential cases of physical and mental disabilities listed in PWD Act & National Trust Act (NTA). The presence of disability (≥40%) as per PWD Act was confirmed by the members of Disability Board in specially organized disability camps. Kappa and Positive Predictive Value (PPV) was computed to assess agreement between DST and specialists’ certification. Results: The DST had a high positive predictive value (0.75). There was ‘almost perfect’ agreement on locomotor and hearing disabilities, ‘substantial’ for mental illness and visual disabilities, ‘moderate’ for mental retardation but poor agreement for ‘multiple disabilities.’ Significantly fewer children (age ≤ 14 years), women, less educated, housewives/unemployed and people from rural background received a positive certification (i.e. disability ≥ 40%) by specialists. This was reflected in lower kappa values for all disabilities in women and rural population and for disabilities due to mental retardation and mental illness in the younger age group. Conclusions: The DST is a useful screening community-based tool that has potential to identify disabilities for certification according to PWD Act and NTA. The findings also suggest a need to reflect upon the exposure and clinical training of specialists involved in disability certification.

KEY WORDS: Disability, assessment, screening

INTRODUCTION
The commitment to ensure disabled people their human rights and equal access to social and economic opportunities at international and national levels can be met only if the most vulnerable groups (people with disabilities) are the beneficiaries of all the developments and advancements. According to Metts (2000), policy makers (international, regional, national) attempting to design and implement more inclusive disability policies, are doing this on a background of meager information, inadequate data and hardly any coordination of activities. “At present, information and data on disability are scarce, unreliable and scattered among organisations and institutions around the world, making it extremely difficult to conduct research necessary to fully understand the status of people with disabilities, develop cost-effective disability policies and strategies, or evaluate the cost-effectiveness of competing approaches” (Metts, 2000, p 55).

Research in the field of disability is problematic for several reasons. Firstly, there appears a lack of consensus on acceptable tests for disability certification according to national legislations. Secondly, there are issues related to the approach used in gathering information. In most low income or developing countries, various sources/methods employed are- overview research articles, census data, ‘key informant’ approach, and household surveys. Lastly, is the major problem related to the choice of instrument used to measure disability. In other words- what question(s) should one ask in order to capture the proportion and/or degree of disability in a population! Most existing instruments are poorly standardized, produce non-comparable estimates, and are unlikely to be cross-culturally valid in developing countries (Durkin, 2001).

A low-cost, rapid and cross-culturally valid method of identifying disabilities in children has been tested in epidemiologic surveys involving screening (using the Ten Questions) and clinical assessments of more than 22,000 children, ages 2-9 years, in Bangladesh (Zaman et al, 1990), Jamaica (Thorburn et al, 1992), and Pakistan (Durkin et al, 1998). However, it had the limitations of - not being sufficient as a single-phase survey tool (Durkin et al, 1995)), not sensitive for vision and hearing unless previously identified (Durkin et al, 1994), and not sensitive for mild conditions (Durkin et al, 1994).

India is a developing country with a large number of population suffering with disability; the estimated prevalence of disabilities is said to be around 4-8% (The
World Bank, 2007). However, India has probably one of the more developed policy frameworks for disability (PWD ACT) amongst developing nations (The World Bank, 2007). The Disability Report prepared by the World Bank (2007, page 24) highlights the need for improved identification of disability, and recommends simpler procedures for disability identification and certification.

From India, attempts have been made to develop methods and instruments that can help in identification of people with disabilities. Kuruvilla & Joseph (1999) have attempted to do so by using both methods of 'survey' and 'rapid rural appraisal' (RRA). They concluded that no one method can comprehensively identify all patients with disability, and a combination of approaches would be the most effective approach. However, they have not alluded, in detail, to the questionnaire used.

In principle, any screening instrument should be simple to understand, easy to administer, requiring a short time for evaluation, should not be difficult in terms of interpreting results, and as broad-based as possible. In our literature search, we were unable to identify any such 'psychometrically appropriate' screening instrument from India. This was surprising keeping in mind the relevance and importance of the issue of 'disability' and the commitment of the Government of India (GOI) towards implementation of the Persons with Disability Act (PWD Act).

Context of the Study

Ever since the PWD Act (1995) and United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2007) came into force, various policies were initiated for their effective implementation. Establishment of State Resource Centres for Persons with Disabilities (SRCs) in different parts of country under the National Program of Rehabilitation for Persons with Disabilities was one of them. The Department of Psychiatry, Government Medical College & Hospital, Chandigarh was designated as a Nodal Centre in May 2006. To fulfil its objectives, some of the activities included- recruitment of Community Based Rehabilitation Workers (CBRWs), training, reaching out to disabled in the community through camps, facilitating provision of benefits, aids and appliances, and ensuring free aids for the disabled who are below poverty line (BPL). In 2006, the Department of Psychiatry, under the aegis of SRC, initiated a camp-based approach towards identification and assessment of disability.

In each Camp, specialists from various disciplines: ENT, Ophthalmology, Orthopaedics, Psychiatry, Special Educator along with the disability board members (for physically disabled, mental illness and mental retardation) as per GOI guidelines examine and evaluate the degree of disability. Attempt is made to complete all the required formalities along with assessment, documentation of degree of disability, collection of application for identity-card, pension, railway concession etc. at the site of the camp. For this purpose, a notary and personnel from Social Welfare Department also participate in the camp to facilitate the procedure of preparation of Disability Cards. People who already possess a disability identity card are guided in terms of availing various benefits provided by the government. Prior to each camp, public awareness is made by contacting area leaders, teachers, Sarpanch, and also through distributing pamphlets. People who have difficulty in reaching the venue of camp are provided the required conveyance to enable them to come to the camp and undergo a comprehensive evaluation.

These camps were being held at an average frequency of once every 6 months. However, as part of an internal audit in 2009, it was observed that there was non-uniform attendance by people with disabilities in these camps. Additionally, there was a wide variation in the total number of attendees for each camp. It was also observed that on many occasions, people with disabilities would form only a minor percentage of the total attendees in a given camp. Due to these trends, the SRC re-visited the overall process of conducting the camps and looked into additional methods of increasing awareness and ensuring certification coverage for people with disabilities. In order to meet the above objectives, a house-to-house survey was planned and a screening tool to identify disabilities was developed. In this paper, the authors present the process of development of the tool for screening disability.

AIM
Development of a Screening Tool for Identification of Disabilities in the Community Setting.

OBJECTIVES
[1] To confirm (or disconfirm) the presence of various disabilities identified by the 'Disability Screening Tool (DST)'.
[2] To determine the positive predictive value of the
To assess the predictive validity of DST.

To evaluate the degree of concordance between the disability assessed by using DST and structured clinical examination.

To determine any factors influencing/pertinent to the administration and interpretation of DST in the community sample.

The population of Chandigarh formed the universe of the study based on an ongoing house to house survey being carried out since July 2009 to examine the prevalence and related rehabilitative issues of people with disability.

The sample comprised of 541 cases of disability screened from 10 rural villages and 8 urban sectors of Chandigarh, during the period of May 2010 to February 2011.

Disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).

PWD Act (1995): A person is defined to have disability if the disability score is ≥40%. Hence people diagnosed to have <40% disability were taken as 'no disability'. This is the concept followed in, and utilized for, certification of disability in the camps conducted by SRC.

Design

The study involved a three-step approach.

[A] Familiarization with DST: A team comprising of Community Based Research Workers (CBRWs) and Special Educators (SEs) was familiarized in the use of screening tool using the lecture-based and hands on administration approach. Subsequently an experienced social worker and psychologist accompanied them in the field to demonstrate interviewing skills and reduce the possibility of uncooperativeness. Supervision was provided on a regular ongoing basis thereafter.

[B] House-to-House Survey: A pair of team workers comprising of a CBRW and SE visited their allocated area. An attempt was made to ensure that the allocation of area for CBRW/SE was made on the basis of his/her residence and familiarity with the area as it was felt that this would facilitate the survey (as the CBRW/SE would be known to people and also his/her pre-existing knowledge of disabled people would add to accuracy in identification). 3-4 pairs of CBRW+SE covered a particular urban sector or a rural area. Each house was marked for identification so as to not to cover the same house again or leave any house uncovered. Both tools were administered on all members of the household. When assessing very young children (who were unable to comprehend) or adults who were unable to respond, their parents/guardians/carers responded to the

METHODOLOGY

Universe

The population of Chandigarh formed the universe of the study based on an ongoing house to house survey being carried out since July 2009 to examine the prevalence and related rehabilitative issues of people with disability.

Sample

The sample comprised of 541 cases of disability screened from 10 rural villages and 8 urban sectors of Chandigarh, during the period of May 2010 to February 2011.

Definitions

WHO (2001): Disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).

Tools

Socio-demographic Sheet:

A demographic sheet was administered to elicit information regarding the relevant demographic variables.

Disability Screening Tool (DST):

The items of the DST were constructed so as to identify various disabilities listed in the PWD Act (1995) (visual, hearing, locomotor/orthopaedic, mental retardation, mental illness, and leprosy-cured) and the National Trust Act (1999) (autism, cerebral palsy and multiple disability). As the purpose of the DST was to design a screening instrument that is simple and easy to administer, each item was constructed in simple language (so as to facilitate easy understanding for the respondent; even if illiterate). Additionally, care was taken that each item embraced the concept of disability as defined by WHO's Classification of Functioning, Disability and Health: ICF-The Model of Functioning (http://www.who.int/en) i.e. the item reflected a 'loss of functional abilities'. This was deemed necessary in order to ensure that any degree of disability was identified in the respondent community sample. Care was also taken to develop items that focused on assessing the basic activities and functional status and ability; and not necessarily the cause or medical condition (Loeb et al, 2008). The items were related to impairment and/or activity limitation with a focus on the individual-environment interaction (Grut & Ingstad, 2005). Hence, some of the items were suggestive of more than one disability e.g., one item could mean either hearing deficit or visual deficit or both. Lastly, the responses were kept in a dichotomous 'yes/no' format. Therefore, a 12-item questionnaire was developed accordingly in the local language (Hindi).

©2012 Indian Association for Social Psychiatry
questions. Attempt was made to interview all family members directly as far as possible, and to avoid data collection by proxy.

[C] Camp: People who were identified through the DST were advised to come to the camp for detailed evaluation and confirmation of disability. The details of such a Camp have been outlined in the Introduction earlier. These camps were conducted after the completion of screening of a particular area, with a frequency of at least one camp per month.

Statistical Analysis
The data so generated were analyzed using the SPSS 13.0 version. Descriptive and inferential statistics (using chi-square and t-test analysis) were applied. An Inter-Rater Reliability analysis using 'Kappa' statistics was performed to determine consistency/agreement between the DST-determined disability and disability based on the doctor's assessment. Kappa values of 0.6 or more were taken to indicate an agreement level of greater than 'moderate' i.e. 'substantial' or 'almost perfect' (Landis & Koch, 1977). Any value below 0.6 indicated poor agreement/consistency between the DST-based assessment and the camp-based diagnostic clinical assessment.

Ethical Considerations
Informed Consent was obtained from the respondents. Where the respondent was unable to give informed consent, 'consent by proxy' was taken from their identified caregiver.

RESULTS

Socio-Demographic Profile of the Sample
The mean age of sample was 29.48±17.12 years with 19.8% being in pediatric age group (≤14 years), 10.1% in adolescent age group (15-18 years), and 70.1% adults. Nearly 63% were males. Nearly 43% were illiterate or educated to primary level, with approximately 29% with at least 12 educational years. Students and unemployed/housewives accounted for approximately 30% and 41% of sample respectively. There was a predominance of people from rural background (55%), single/unmarried (58%), and from nuclear family set-up (73%).

Pattern of Disabilities identified on DST
The commonest disability identified was locomotor/orthopedic/cerebral palsy (henceforth referred to as locomotor) (n= 311). The other disabilities so identified were- mental retardation (n=75), hearing (n=45), visual (n=31), multiple disability (n=71), and mental illness (n=8). No cases of autism or leprosy were identified.

Table 1 shows that the highest PPV was obtained for locomotor disability and lowest for 'multiple disability'. Highest PPVs were obtained for physical disabilities as compared to mental disabilities.

Positive Predictive Value (PPV)
A total of 463 cases out of 541 screen positives were certified to have a disability (≥40%) according to the board of specialists (crude PPV: 0.86). However, of these only 407/541 cases were identified accurately i.e. they received the same diagnosis as per DST and clinical assessment. This generated an overall PPV of 0.75 (Table 1).

Cases that were identified with a particular disability using the DST were redistributed in another type of disability (on assessment), because of which there appears to be difference in the number of cases identified in a specific disability on screening with DST as compared to cases confirmed in that category. No cases of autism or leprosy-cured were identified.

Table 2 additionally shows that there was 'almost perfect' agreement for locomotor (orthopedic) and hearing disabilities, and 'substantial' for mental illness and visual disabilities. Agreement was 'moderate' for mental retardation and 'slight' for multiple disabilities.

Table 3 shows positive response on each item (under rows) in relation to confirmed disability after medical assessment. All items, in principle, were identifying the particular disability that they were meant to screen for, except that two items (nos. 4 & 10) were less accurate and two items (nos. 11 & 12) identified disability other than what they were supposed to measure.

Based on the dichotomy of the cut-off percentage score (≥40%) for degree of disability, the sample was divided into two groups. A comparison of their socio-demographic profile was carried out (Table 4).

Both groups were comparable regarding their mean age (Group A = 29.56±16.37 years vs. Group B = 29.03±21.14 years; t=0.25; NS), marital status, and type of family.

There was significant overrepresentation of children (aged ≤ 14 years), females, less educated (illiterate or primary education), unemployed/housewives (occupation), and people from a rural background in Group B (screen positive but not confirmed to have 40% disability).
Table 1: Accuracy in Positive Predictive Value of the DST

<table>
<thead>
<tr>
<th>Type of Disability on DST</th>
<th>Identified on DST (n=541)</th>
<th>Same Disability identified/present (after verification) (n=407)</th>
<th>Disability absent i.e. Disability &lt;40% (after verification) (n=134)</th>
<th>PPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>31</td>
<td>21</td>
<td>10</td>
<td>0.68</td>
</tr>
<tr>
<td>Hearing</td>
<td>45</td>
<td>37</td>
<td>8</td>
<td>0.82</td>
</tr>
<tr>
<td>Locomotor</td>
<td>311</td>
<td>281</td>
<td>30</td>
<td>0.90</td>
</tr>
<tr>
<td>Mental Retardation</td>
<td>75</td>
<td>54</td>
<td>21</td>
<td>0.72</td>
</tr>
<tr>
<td>Mental illness</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>0.63</td>
</tr>
<tr>
<td>Multiple Disability</td>
<td>71</td>
<td>9</td>
<td>62</td>
<td>0.13</td>
</tr>
</tbody>
</table>

Table 2: Correspondence between disabilities identified based on DST and Medical Assessment

<table>
<thead>
<tr>
<th>Type of Disability on DST</th>
<th>Doctors' evaluation</th>
<th>Visual</th>
<th>Hearing</th>
<th>Locomotor</th>
<th>Mental Retardation</th>
<th>Mental Illness</th>
<th>Multiple Disability</th>
<th>Disability &lt;40% (No Disability present)</th>
<th>Kappa#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual (N=31)</td>
<td></td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
<td>0.72</td>
</tr>
<tr>
<td>Hearing (N=45)</td>
<td></td>
<td>37</td>
<td>1</td>
<td></td>
<td>1</td>
<td>6</td>
<td></td>
<td></td>
<td>0.86</td>
</tr>
<tr>
<td>Locomotor (N=311)</td>
<td></td>
<td></td>
<td></td>
<td>281</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.85</td>
</tr>
<tr>
<td>Mental Retardation (N=75)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>54</td>
<td>21</td>
<td></td>
<td></td>
<td>0.59</td>
</tr>
<tr>
<td>Mental illness (N=8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.77</td>
</tr>
<tr>
<td>Multiple Disability (N=71)</td>
<td></td>
<td>5</td>
<td>3</td>
<td>10</td>
<td>36</td>
<td>9</td>
<td>8</td>
<td></td>
<td>0.19</td>
</tr>
<tr>
<td>Total Cases</td>
<td></td>
<td>26</td>
<td>40</td>
<td>292</td>
<td>90</td>
<td>5</td>
<td>10</td>
<td>78</td>
<td></td>
</tr>
</tbody>
</table>

# Agreement between identification on screen (with DST) and presence of verified disability (with medical assessment)

Table 3: Positive Response on Individual DST items w.r.t. Confirmed Disability

<table>
<thead>
<tr>
<th>Item Number (disability being evaluated)</th>
<th>Type of Disability confirmed</th>
<th>Visual</th>
<th>Hearing</th>
<th>Locomotor</th>
<th>Mental Retardation</th>
<th>Mental Illness</th>
<th>Multiple Disability</th>
<th>Autism</th>
<th>Leprosy cured</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Locomotor)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>2 (visual)</td>
<td></td>
<td></td>
<td></td>
<td>290</td>
<td>14</td>
<td>7</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>3 (hearing)</td>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>4 (hearing/visual)</td>
<td></td>
<td>1</td>
<td>39</td>
<td>2</td>
<td>29</td>
<td>6</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>5 (hearing/mental retardation/autism)</td>
<td></td>
<td>2</td>
<td>10</td>
<td>1</td>
<td>22</td>
<td>4</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>6 (mental retardation)</td>
<td></td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>88</td>
<td>7</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>7 (mental retardation)</td>
<td></td>
<td>1</td>
<td>1</td>
<td>80</td>
<td>5</td>
<td>6</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>8 (mental retardation/locomotor)</td>
<td></td>
<td>2</td>
<td>21</td>
<td>64</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>9 (mental retardation)</td>
<td></td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>84</td>
<td>7</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>10A-10J (mental illness)</td>
<td></td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>11 (autism)</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 (leprosy-cured)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

©2012 Indian Association for Social Psychiatry
Table 4: Demographic profile of identified cases of disability through screening checklist (N=541)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Group A: Cases having ≥ 40 % disability (n=463)</th>
<th>Group B: Cases having &lt; 40 % disability (n=78)</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentages</td>
<td>Frequency</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;14 years</td>
<td>82</td>
<td>17.7</td>
<td>25</td>
</tr>
<tr>
<td>15-18 years</td>
<td>47</td>
<td>10.2</td>
<td>9</td>
</tr>
<tr>
<td>&gt; 18 years</td>
<td>334</td>
<td>72.1</td>
<td>44</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>301</td>
<td>65</td>
<td>38</td>
</tr>
<tr>
<td>Females</td>
<td>162</td>
<td>35</td>
<td>40</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>76</td>
<td>16.4</td>
<td>14</td>
</tr>
<tr>
<td>Primary</td>
<td>109</td>
<td>23.5</td>
<td>33</td>
</tr>
<tr>
<td>Middle</td>
<td>56</td>
<td>12.1</td>
<td>11</td>
</tr>
<tr>
<td>Matric</td>
<td>73</td>
<td>15.8</td>
<td>10</td>
</tr>
<tr>
<td>Higher Secondary</td>
<td>78</td>
<td>16.8</td>
<td>6</td>
</tr>
<tr>
<td>Graduation &amp; above</td>
<td>71</td>
<td>15.3</td>
<td>4</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>132</td>
<td>28.5</td>
<td>29</td>
</tr>
<tr>
<td>Un- &amp; semiskilled</td>
<td>81</td>
<td>17.5</td>
<td>5</td>
</tr>
<tr>
<td>Skilled &amp; above</td>
<td>70</td>
<td>15.1</td>
<td>4</td>
</tr>
<tr>
<td>Unemployed/Housewife</td>
<td>180</td>
<td>38.9</td>
<td>40</td>
</tr>
<tr>
<td>Locality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>233</td>
<td>50.3</td>
<td>10</td>
</tr>
<tr>
<td>Rural</td>
<td>230</td>
<td>49.7</td>
<td>68</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>269</td>
<td>58.1</td>
<td>45</td>
</tr>
<tr>
<td>Ever Married</td>
<td>194</td>
<td>41.9</td>
<td>33</td>
</tr>
<tr>
<td>Type of family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear</td>
<td>339</td>
<td>73.2</td>
<td>57</td>
</tr>
<tr>
<td>Joint</td>
<td>124</td>
<td>26.8</td>
<td>21</td>
</tr>
</tbody>
</table>

** p<0.01  *** p<0.001  NS=Non significant

Table 5: Accuracy in Identification of Disability based on Age

<table>
<thead>
<tr>
<th>Type of Disability</th>
<th>Age (&lt;18 years)</th>
<th>Age (&gt;18 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Identified on DST</td>
<td>Verified disability Present</td>
</tr>
<tr>
<td>Visual</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Hearing</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Locomotor</td>
<td>52</td>
<td>10</td>
</tr>
<tr>
<td>Mental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retardation</td>
<td>45</td>
<td>15</td>
</tr>
<tr>
<td>Mental illness</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Multiple disability</td>
<td>33</td>
<td>3</td>
</tr>
<tr>
<td>Total cases</td>
<td>151</td>
<td>33</td>
</tr>
</tbody>
</table>

# could not be calculated
Kappa values dropped by more than 0.2 points for disability related to mental illness in the under-18 age group.

Kappa values dropped by more than 0.2 points for mental illness and approximately 0.2 points for mental retardation in females compared to males.

Kappa values dropped by more than 0.2 points for visual disability, mental retardation and multiple disabilities and approximately 0.2 for locomotor disability and disability related to mental illness in rural population with respect to urban population.

Cases that were identified on screen tool with a particular disability were redistributed in another type of disability because of which there appeared to be less cases identified in a specific disability on screen as compared to cases confirmed in that category (Tables 5-7).

**DISCUSSION**

The PWD Act 1995 and recent National Policy for Persons with Disability are significant initiatives by the Ministry of Social Justice & Empowerment, Government of India, to fulfill national & international commitments (e.g. the UNCRPD, 2007) to protect the rights of, provide equal opportunities to and empower persons with disability. However, the implementation of PWD Act has been impeded by various constraints (technical, human and financial resources). In evolving
efforts to improve coverage of persons with disabilities, the Government of India created State Resource Centres for Persons with Disabilities and Disability Boards. However, the complex/cumbersome procedure of certification and the institutional-centered approach for certification have limited community coverage.

We, in Chandigarh, under the aegis of State Resource Centre attempted to reach them at their door steps through camps. However, it was felt that merely propaganda and simplification of procedures were not enough as the people who had contacted through camps or in the hospital were far too small as compared to census figures. Hence House-to-House Survey was initiated for which a tool was required to be used by nonprofessionals. For the purpose of construction of tool, the concept of disability, its presence or absence was derived from PWD Act. The data in this paper is part of the ongoing survey which is being analysed to assess the utility of the tool visa-viz., DST.

Objective 1: Determine presence of various disabilities

The sample for this study had representation across the broad categories of children, adolescents, and adults. Males were over-represented with 2/5ths of the sample being barely educated. Housewives, unemployed and students were the main occupations identified, probably a reflection of the substantial number of females (approximately 37%), illiterate/primary educated (approximately 43%) and under 18s (approximately 30%). The sample was mainly rural, with single marital status, and living in a nuclear family set-up which could be a reflection of the mixed urban-rural population that was surveyed for this study.

The commonest disability identified was orthopedic, which is in keeping with the findings from another study in South India (Kuruvilla & Joseph, 1999). Mental Retardation being second commonest in this study was reported to have a lower prevalence in the study from South (Kuruvilla & Joseph, 1999). Kuruvilla & Joseph (1999) had reported higher presence of hearing and visual related disabilities; not too dissimilar from our study. However, we were unable to identify any person with autism and leprosy; leprosy however being reported by Kuruvilla & Joseph (1999).

Hence, overall, one may argue that the pattern of identified disability across different parts of India is not dissimilar. This bears relevance from the fact that a different but more intensive approach of combined survey and RRA had been adopted by Kuruvilla & Joseph (1999) which has implications related to pertinent issues of time, money and manpower. However, the absence of any identified individual with either autism or leprosy is curious. We, are unsure if this is a product of the less intensive training to the workers who used the DST, or the screening questions not being fully appropriate, or if the autistic cases were subsumed under mental retardation because of the high prevalence of mental retardation in autism. In addition, since the prevalence of leprosy in Indian states is quite low (2.7 to 5.1 per 100000) as per National Leprosy Eradication Programme (National Institute of Health & Family Welfare, 2009), it is possible that the sample was inadequate to identify leprosy cases.

Objectives 2-4: Validity and Concordance

The discussion related to objectives 2-4 is being presented here together due to a certain degree of overlap and linkage in the results so obtained. At the outset, we would like to draw the attention of the reader to the disability definitions listed under 'Methodology', as they are critical to the understanding of the discussion that follows.

In order to assess the usefulness of the DST, PPV was calculated. There were 463 cases with potential disability (on DST) that were identified as having ≥40% disability on camp-based structured assessment (CBA). A PPV of 0.86 implies that 8-9 out of 10 patients with a DST-identified disability will be found to have a disability on CBA. However, it is important to point out that this PPV value is probably not a true reflection of the underlying concept of PPV in general. PPV is conceptualized as a critical measure of a diagnostic method in diagnosing correctly. Although, we were able to pick up disability correctly at a level of 0.86, yet caution needs to be exercised with the fact that 463/541 confirmed CBA cases included cases in which the disability so diagnosed on CBA was different from the DST-identified disability. It was probably just that the degree of disability being ≥40% in 463 DST-identified cases, that they were reconfirmed on CBA. PPV has been said to be directly proportional to the prevalence of the condition under test (Gunnarsson & Lanke, 2002); hence, the PPV so derived may be spuriously high. Also, by this, we were unable to determine if the PPV for DST was indicative of the actual specified disability under question (Gunnarsson & Lanke, 2002).

In order to clarify this issue, we analysed the 463 CBA positive cases and found that there were 56 cases who,
though suffering with ≥40% disability, had been given a separate diagnosis from what was given by DST. Hence, these 46 cases were excluded and the re-calculated PPV was 0.75. A PPV of 0.75 implies that 3 out of 4 patients with a DST-identified disability will be found to have an identical disability as diagnosed on the CBA. Though the PPV value gets lowered, yet it is reasonably high to indicate that the DST is able to pick up specific disability under condition. This makes DST a useful screening tool with reasonable diagnostic accuracy.

To further confirm our assertion, a disability-specific analysis was carried out wherein the degree of agreement between the DST-identified individual disability and the CBA-based individual disability was examined (Table 1). High degree of agreement was present for four disabilities i.e. 'almost perfect' agreement for locomotor and hearing disabilities, and 'substantial' for mental illness and visual disabilities. Acceptable level (moderate) of agreement was seen for mental retardation. However, the degree of agreement was unacceptable ('slight') for multiple disabilities. As there were no identified cases of autism and leprosy, such analysis was not possible for these two disabilities.

Hence, it may be a fair comment that, in principle, the DST appears good at identifying nearly all of the specific disabilities in question. Poor agreement regarding 'multiple disabilities' could be due to the fact that the screen items were designed to optimize reporting by users/caregivers and often suggested the presence of two disabilities even if one item was ticked.

Table 2 shows our attempt to further understand the pattern of concordance/agreement between the DST-identified disability and the CBA-diagnosed disability. 78 cases were deemed not to suffer with any disability; though seen for every DST-identified disability, but maximally from orthopedic and mental retardation groups. Redistribution of cases occurred maximally with 'multiple disability'; an aspect already highlighted and discussed in the preceding paragraph. Apart from this disability, redistribution to a minor degree was seen with DST-identified 'hearing' disability. Hence, one can conclude with reasonable confidence that the DST-identified disability often led to a correct diagnosis.

However, it is important to highlight a related and essential conceptual issue. The CBA assessments tend to be driven by the PWD Act in which a legal definition of disability of at least 40% or more is required to give such a diagnosis (of disability), and correspondingly the concerned disability certificate. This legal definition is linked with entitlements (The World Bank, 2007). Critics have highlighted that a blanket method of collapsing everything in to one factor/figure of 40% is not easy and not appropriate in certain situations (Mont, 2007). The ICF concept needs to be kept in perspective that disability is a product of an interaction between the individual and his/her environment in which the key issue is the limitation/hindrance due to bodily/mentally/intellectually reduced functions (Grut & Ingstad, 2005). Hence, any person below the legal limit for disability (i.e. with less than 40% disability) is not necessarily 'not disabled', and may warrant healthcare intervention to overcome/reduce this impairment of functioning. The DST-identified individuals who do not meet the legal standards of disability can still and should be managed and provided with appropriate interventions from the healthcare system; both from a moral and ethical viewpoint.

The above discussion demonstrates that DST has good convergent (concurrent) validity. As the 12 items of the DST were carefully constructed using specific disabilities in mind, it can be presumed that the DST shall have face validity and content validity. However, to evaluate this, each item was carefully examined in order to determine as to whether it was measuring what it was supposed to measure, and how correctly it was measuring that construct (Table 3). Face validity was deemed to be present as each item was being scored for any given type of disability. Additionally, it was seen that there were two items (4,10) which were identifying patients with another disability more frequently than the disability they were meant to identify. Two additional items (nos. 11, 12) identified disability other than what they were supposed to measure. These items were related to 'autism' and 'leprosy'. Coupled with the fact that there were no identified CBA-based cases of these two disabilities in our sample, it maybe speculated that this is a product of the less intensive training to the workers who used the DST. Nevertheless, rest of the 8 items showed that they were practically identifying that particular disability they had been designed for reflecting high content validity. Overall, it can be concluded that we were able to demonstrate good face and content validity for the DST, though the caveats so mentioned need to be kept in perspective.

Objective 5: Factors related to administration and interpretation of DST
Various authors have mentioned about the need for understanding the various concepts related to disability from a cultural context (Altman, 2001; Loeb & Eide, 2006; Whyte & Ingstad, 1995), and not to underestimate the role of the environment and social parameters in which people with disability live (Loeb et al, 2008). Additionally, it has been seen that prevalence of disability varies across various socio-demographic variables (Kuruvilla & Joseph, 2007). Difficulties around administration of a disability assessment tool have been discussed by various authors (Durkin, 2001; Kuruvilla & Joseph, 2007; World Bank, 2007).

Hence, we thought it pertinent to explore if there were any socio-environmental factors influencing the use (administration and interpretation) of the DST. For this exercise, we examined the 2 groups of persons with (Group A) and without (Group B) CBA-diagnosed disability on various socio-demographic variables (Table 4).

It was seen that Group B had significantly higher presence of people aged ≤ 14 years, females, people who were illiterate or primary educated, being either unemployed/housewife by occupation, and from a rural background.

Further analysis was carried out using an agreement analysis to establish about the accuracy of identification and diagnosis of disability across these socio-demographic parameters. Significant results were obtained related to the parameters of- age, gender, locality (Tables 5-7).

**Age:** Poor levels of agreement were seen in the under-18 age-group for psychological disabilities (mental illness and mental retardation) reflecting that establishing a diagnosis in these conditions is probably more difficult in the pediatric and adolescent age-group. This could be arising out of either the assessor being more comfortable with adult population, or due to lack of appropriate age-specific training and expertise in assessing childhood related conditions.

**Gender:** Interestingly, levels of agreement were lower for all disabilities in females as compared to males. This was more prominent for the psychological disabilities (mental illness, mental retardation). Keeping in mind that a reasonable percentage of females were housewives, it maybe possible that an accurate measure and understanding of the degree of disability may be compromised due to the fact that these females are not working in a more objective, external environment. This would be understandable in our local socio-cultural context where females, especially from a rural background, tend to manage household aspects substantially or completely.

**Locality:** Levels of agreement were consistently lower across all disabilities in people from rural background. However, on head-to-head comparison, the urban-rural divide was apparently much more than the male-female divide. Lower levels of agreement could be a reflection of the fact that the instruments used were more in keeping with an 'urban' perspective. One can only speculate about this 'urban' perspective in relation to the skills for the clinical assessments thus conducted.

Another consistent finding evident in all the three groups in terms of agreement was that kappa remained relatively stable for more objective (physical) disabilities in comparison to mental retardation and mental illness where the drop was more than 0.2 points.

Notwithstanding the lack of any particular reason underlying the above findings, it does reflect the need for exploring and ensuring that the skill base of assessing by professionals needs regular updating through training and hands-on teaching of various core skills considered mandatory for disability assessment. This aspect is probably something that needs to explored further in disability research for the future.

**Limitations**

No study can be without limitations and our study had a few prominent ones. **Firstly,** the DST had not been subjected to a full and rigorous psychometric assessment (including reliability testing). **Secondly,** there were approximately 16% of the DST items that had serious issues around face and content validity. **Thirdly,** the sample was not large and representative enough of the population of the city, and this may restrict generalizability of results. **Lastly,** the DST requires some degree of training and supervision, before non-mental health professionals can put it to use.

**CONCLUSIONS AND FUTURE DIRECTIONS**

The above mentioned limitations need to be viewed in perspective of this study being a preliminary and exploratory in nature. Ours is probably the first such concerted attempt to develop a screening instrument based upon ongoing, long-standing clinical experience in the field of disability. The principal and second authors have been involved in the initial development and further ongoing expansion of the disability services being provided through their SRC. Our findings suggest
that the DST is a simple, user-friendly, non time-consuming and easy to interpret instrument i.e. it serves the broad purpose of being a potentially good screening instrument. Additionally we have been able to demonstrate that the DST has a high PPV, which may make it as a potential substitute for clinical-based diagnostic (not degree/severity of disability) assessments.

We are continuing with data collection under the House to House survey and hope to address the limitations outlined earlier. We are also in the process of testing the English version of the DST. However, it is important to test the replicability of DST across different geographical regions and local cultures i.e. to determine how 'culture-free' it is. It may be pertinent for professionals working in the field of disability to understand and address the issue of training and supervision on an ongoing basis. This shall help in providing quality assurance to the process of assessment and management of disability.

REFERENCES


INTRODUCTION

Emerging from bondages of subservience to British Empire, India has moved forward by a tremendous pace as a formidable economy. However, with rapid industrialisation there has been large scale migration to cities. While there migrants found jobs mostly as labour force. It came along with dense housing, poor infrastructure and hygiene. Thus their children have been exposed to physical, social and emotional adversities. Over 18 million children are at risk of learning disability, juvenile delinquency, developmental disorders, cognitive dysfunction, drug misuse, poor scholastic performance and school dropout [Thara & Padmavati – 2004]. School dropout thus becomes a norm rather than exception where 14.20% primary and 23.40% upper primary children from such backgrounds are seen dropout of school as per DISE Maharashtra 2006-07 [District Information System for Education]. Government of India took the challenge to bring all such children to schools through Sarva Shiksha Abhiyan, the goal of which is universalisation of elementary education for 6-14 years children. Education department of Pune Municipal Corporation under Sarva Shiksha Abhiyan started Vastishala – under which are run “Door Step” schools within the communities of migrant workers and low socio economic strata to ensure that children remained in school.

AIMS AND OBJECTIVES

To study the prevalence of psychiatric morbidity and reasons for absenteeism in non formal school children and factors affecting them.

MATERIALS AND METHODS

A representative sample of 50 children enrolled in Sarva Shiksha Abhiyan run “Door Step” schools was selected. These schools were non formal and located at construction sites in Pashan, Baner and Bibwewadi area of Pune. Children in age group of 10-12 years were selected after application on inclusion and exclusion criteria.

Inclusion Criteria:

a) Students whose parents or guardians gave consent for study;

b) Students with a single parent;

c) Students with mild mental retardation were included as most special schools were located at a distance.

STUDY OF PSYCHIATRIC MORBIDITY AND ABSENTEEISM IN CHILDREN ENROLLED IN NON FORMAL COMMUNITY SCHOOL UNDER SARVA-SHIKSHA ABHIYAN

Sweta Shah, Alka Pawar

Abstract

Background: There has been no study on prevalence of psychiatric morbidity and absenteeism in children attending non formal schools under Sarva Shiksha Abhiyan in India who belong to a peculiar socio-economic and cultural stratum of our society. Aim: To study the prevalence of psychiatric morbidity and reasons for absenteeism in non formal school children and factors affecting them. Materials and Methods: A sample of 50 children enrolled in Vastishala - door step schools of Sarva Shiksha Abhiyan in Pashan, Baner construction site were selected. Socio-demographic and history details were taken from parents. CBCL – Teacher Report Form was used to assess child’s behaviour as observed in class. Psychiatric diagnosis was made as per ICD-10 criteria. Reasons for absenteeism were assessed. Psychiatric morbidity and absenteeism were co-related with various socio-demographic, parent and child related variables. Chi square test was used for statistical analysis.

Results: 18% of children had a psychiatric disorder as per ICD-10 diagnostic criteria. 26% children had school absenteeism. Psychiatric morbidity was found to be significantly related to history of difficult temperament in the child and absenteeism was related to poor socio-economic status, temperamental traits and working children. Conclusion: Children facing adverse life circumstances may suffer from similar prevalence of psychiatric morbidity but mental health care facilities are not accessible to this stratum of society, hence making early intervention difficult. Psychiatric morbidity, work and migration were important reasons for absenteeism and not just lack of interest or physical illness. Larger issues like population explosion, illiteracy and poverty have been sensitized by this study.

The parent institute has been conducting training programme for teachers of Pune Municipal Corporation schools to assess children with emotional, behavioural and scholastic problems so that early recognition and intervention is made possible. As we believe that quality of childhood one has lived will shape the future not only of the child but of society and nation as a whole.
Exclusion Criteria

a) Students whose parents or guardians refused to give consent for the study; b) Students who were orphans and had no adult guardian.

Procedure

Written and informed consent was taken from the competent school authority, coordinator of Sarva Shiksha Abhiyan and parent/guardian to include their child in the study. The socio-demographic data and detailed history was obtained from parents. CBCL – Teacher Report Form developed by Achenbach (1991) was used as a screening tool to assess behavioural disturbances in children. Teachers were trained to evaluate children using Teacher Repost form of CBCL. Child was assessed clinically and specific diagnosis, where present was given, using ICD-10 diagnostic criteria for mental disorders, mental handicap and learning disabilities. Difficulties in reading/writing were noted clinically from actual class work of the child. Due to the difficult and changing locations in which this field study was conducted, formal testing using standardised tools were not a part of the study protocol. Socio-demographic, parental and child related variables affecting psychiatric morbidity and school absenteeism were studied. Statistical analysis was done using Chi square test of significance.

RESULTS

Socio-Demographic Variables:

The socio-demographic variables studied included gender, religion, type of family, monthly family income and mother tongue.

Of 50 students, 31 (62%) were females and 19 (38%) males. 46 out of 50 study subjects which is 92% were Hindu, reflective of the general population distribution. 96%, which is 48 of 50 were coming from nuclear families. Most of the students came from low socioeconomic class. There were 56%, which is 28 of 50 subjects with mother tongue Marathi and rest 44% Non – Marathi which included – Hindi, Telegu, Tamil, Kannada. (Table – 1)

Parental Factors:

Parental Education: In 70% of children, both mother and father were uneducated. 30% of parents had attended school upto primary education. None of the parents of any subject had achieved secondary education. (Table – 1)

Children Related Factors:

1. Working status – 29/50 children (58%), did household work (like looking after their siblings, cleaning the home, cooking, fetching water and buying grocery). 1 student worked regularly at a construction site after school (Table – 1)

2. Temperament – This was studied using domains as described by Thomas and Chess Classification (1977).

58% (29) had easy temperament, 30% (15) had slow to warm temperament and 12% (6) had difficult temperament. (Table – 1)

3. Siblings care in school – 80% (40) took along their siblings to school. Some of these siblings would attend Anganwadi in the school premise and those still younger were put in mobile crèches. 20% (10) children who did not bring siblings included those who were single child or had elder siblings (Table – 1)

CBCL – Teacher Report Form Score:

Significant “T” score was found in 20% (10). 8% (4) students had high score on attention problems, 8% (4) students on delinquent behaviour, 6% (3) students on aggressive behaviour, 2% (1) student on withdrawn behaviour and 2% (1) student on anxious/depressed behaviour. 16% (8) students had a significant score on externalising problems compared to 4% (2) students on internalising problems (Table – 2)

ICD – 10 Diagnosis:

18% (9) students fulfilled ICD – 10 diagnostic criteria (4 boys and 5 girls). Of the total population studied (50), 6% (3) had diagnosis of oppositional defiant and conduct disorder. 4% (2) had mild mental retardation, 2% (1) had hyperkinetic disorder, 2% (1) had anxiety...
## TABLE 1: CORRELATION OF VARIABLES WITH PSYCHIATRIC MORBIDITY AND ABSENTEEISM

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>NUMBER [N=50]</th>
<th>PSYCHIATRIC MORBIDITY</th>
<th>ABSENTEEISM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOCIODEMOGRAPHIC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>19 (38%)</td>
<td>4 (21.05%)</td>
<td>3 (15.79%)</td>
</tr>
<tr>
<td>Female</td>
<td>31 (62%)</td>
<td>5 (16.13%)</td>
<td>10 (32.26%)</td>
</tr>
<tr>
<td>Chi Sq = 0.19</td>
<td>Chi Sq = 0.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = 0.95 NS</td>
<td>P = 0.33 NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odds ratio = 1.39</td>
<td>Odds ratio = 0.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Monthly family income In Rs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1000-2999</td>
<td>14 (28%)</td>
<td>3 (21.43%)</td>
<td>10 (71.43%)</td>
</tr>
<tr>
<td>&gt;2999</td>
<td>36 (72%)</td>
<td>6 (16.67%)</td>
<td>3 (8.33%)</td>
</tr>
<tr>
<td>Chi Sq = 0.15</td>
<td>Chi Sq = 17.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = 0.986 NS</td>
<td>P = 0.00002 SIGNI.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odds ratio = 1.36</td>
<td>Odds ratio = 27.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PARENTAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Educational status*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Father - Uneducated</td>
<td>35 (70%)</td>
<td>8 (22.86%)</td>
<td>9 (25.71%)</td>
</tr>
<tr>
<td>Primary education</td>
<td>15 (30%)</td>
<td>1 (6.67%)</td>
<td>4 (26.67%)</td>
</tr>
<tr>
<td>Chi Sq = 0.93</td>
<td>Chi Sq = 0.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = 0.335 NS</td>
<td>P = 0.778 NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odds ratio = 4.15</td>
<td>Odds ratio = 0.95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Mother - Uneducated</td>
<td>35 (70%)</td>
<td>7 (20%)</td>
<td>10 (28.57%)</td>
</tr>
<tr>
<td>Primary education</td>
<td>15 (30%)</td>
<td>2 (13.33%)</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Chi Sq = 0.03</td>
<td>Chi Sq = 0.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = 0.872 NS</td>
<td>P = 0.778 NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odds ratio = 1.63</td>
<td>Odds ratio = 1.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Substance Use in**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I) FATHER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) ALCOHOL</td>
<td>27 (71.05%)</td>
<td>6 (22.22%)</td>
<td>9 (33.33%)</td>
</tr>
<tr>
<td>2) TOBACCO</td>
<td>23 (60.53%)</td>
<td>3 (13.04%)</td>
<td>3 (13.04%)</td>
</tr>
<tr>
<td>Chi Sq = 0.22</td>
<td>Chi Sq = 1.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = 0.636 NS</td>
<td>P = 0.179</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odds ratio = 1.90</td>
<td>Odds ratio = 3.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II) MOTHER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) TOBACCO</td>
<td>16 (100%)</td>
<td>4 (25%)</td>
<td>4 (25%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHILD RELATED</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Working students***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household work/other</td>
<td>29 (58%)</td>
<td>5 (17.24%)</td>
<td>11 (37.93%)</td>
</tr>
<tr>
<td>Not working</td>
<td>21 (42%)</td>
<td>4 (19.05%)</td>
<td>2 (9.52%)</td>
</tr>
<tr>
<td>Chi Sq = 0.04</td>
<td>Chi Sq = 3.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = 0.834 NS</td>
<td>P = 0.053 NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odds ratio = 1.13</td>
<td>Odds ratio = 0.17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**2) Temperament**

<table>
<thead>
<tr>
<th>Difficult</th>
<th>6 (12%)</th>
<th>5 (83.33%)</th>
<th>4 (66.67%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow to warm</td>
<td>15 (30%)</td>
<td>2 (13.33%)</td>
<td>6 (40%)</td>
</tr>
<tr>
<td>Easy</td>
<td>29 (58%)</td>
<td>2 (6.89%)</td>
<td>3 (10.34%)</td>
</tr>
</tbody>
</table>

Chi Square = 20  
P = 0.000046 SIGNI.  
Df = 2

**3) Siblings Care In school****

<table>
<thead>
<tr>
<th>Yes</th>
<th>40 (80%)</th>
<th>6 (15%)</th>
<th>12 (30%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>10 (20%)</td>
<td>3 (30%)</td>
<td>1 (10%)</td>
</tr>
</tbody>
</table>

Chi Sq = 0.41  
P = 0.52 NS  
Odds ratio = 0.41

Chi Sq = 0.79  
P = 0.375 NS  
Odds ratio = 3.86

* No parent was educated beyond primary school level
** Both parents with substance use – 32 (16 mothers and sixteen fathers)
*** Work in these children included – household work, looking after younger siblings, cooking, fetching water, construction site work.
**** These children were responsible for care of their younger siblings, hence attended school with them.

NS : Not statistically significant; SIGNI : Statistically significant

**TABLE 2: STUDENTS WITH SIGNIFICANT “T” SCORE ON CBCL – TEACHERS REPORT FORM, ICD-10**

<table>
<thead>
<tr>
<th>CBCL SIGNIFICANT ‘T’</th>
<th>NUMBER OF CHILDREN [N= 10]</th>
<th>PERCENTAGE [%]</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Withdrawn</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>II – Somatic complaints</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>III- Anxious/ Depressed</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>IV – Social Problem</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>V- Thought Problem</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VI – Attention Problem</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>VII – Delinquent Behaviour</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>VIII – Aggressive Behaviour</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Internalizing Score</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Externalizing Score</td>
<td>8</td>
<td>16</td>
</tr>
</tbody>
</table>

Of the total 50 children studies, 10 children had significant “T” score on CBCL.

<table>
<thead>
<tr>
<th>ICD –10 DISORDER</th>
<th>NUMBER [ N= 50]</th>
<th>PERCENTAGE [%]</th>
</tr>
</thead>
<tbody>
<tr>
<td>ODD &amp; CD</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>HYPERKINETIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DISORDER</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>SLEEP DISORDER</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>STUTTERING &amp; STAMMERING</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ANXIETY DISORDER</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>NOCTURNAL ENURESIS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MILD M.R.</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>MILD DEPRESSION</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>MIXEDEMOTIONAL &amp; CONDUCT DISORDER</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>WITHOUT DIAGNOSIS</td>
<td>41</td>
<td>82</td>
</tr>
</tbody>
</table>

Not including learning disorder. ODD – Oppositional defiant disorder; CD – Conduct disorder; MR – mental retardation

©2012 Indian Association for Social Psychiatry
disorder, 2% (1) had mild depression and 2% (1) had mixed emotional1 and conduct disorder (Table -2). Of the 9 students with ICD-10 diagnosis, 55.55% had absenteeism and of the 41 students without ICD-10 diagnosis, 19.51% had absenteeism (Table – 4).

**Absenteeism:**

13/50 students (26%) were absent from school for 2 or more days per week. School absenteeism is not defined per say, but absent number of days taken into consideration is varying with different studies (Table – 2). Of the 13 absentee students, 5 had diagnosable psychiatric morbidity (38.46%). 8 students (61.54%) were absent for work related issues. 11/13 absentee students (84.61%) had household work to be done of which 3 had diagnosable psychiatric morbidity (Table - 4)

**DISCUSSION**

**Socio-Demographic Variables:**

In this study, more boys (21.05%) than girls (15.13%) had psychiatric morbidity. Male: female was 0.61. This gender difference was not statistically significant. However, more boys had psychiatric morbidity than girls. This is similar to a study done by Bhargava et al (1988) who observed that more boys (40.3%) had behavioural problems than girls (36.3%). Deivasigamani (1990) too observed that more boys (43.44%) than girls (35.29%) had psychiatric morbidity, however gender difference was not found to be statistically significant. Absenteeism was higher amongst girls (32.26%) than boys (15.79%). (Table – 1) All students in the current study were from lower socioeconomic class. 28% who had income less than Rs. 2999, 3 (21.43%) had psychiatric morbidity. Lesser income was not found to be statistically significant to psychiatric morbidity. 71.43% had absenteeism and in those with income more than Rs. 2,999, 8.33% has absenteeism. Statistically significant correlation was found between lesser income and absenteeism (p=0.00002) (Table -1) Students from families with lesser income had higher burden of work and hence showed higher absenteeism. This is in keeping with the study done by Berg and Butler et al, Bradford, where poor school attendees came from materially disadvantaged homes. Other socio-demographic variables like religion, type of family and mother tongue were not found to be statistically significant when compared for psychiatric morbidity or absenteeism in the study group. Similarly in a study done by Gupta et al (2001), no statistically significant correlation of psychiatric morbidity was found with age, sex, religion and type of family.

**Parental Factors:**

**PARENTAL EDUCATION:** No statistically significant correlation of parental education was found with either

---

**TABLE 3: COMPARISON OF SIGNIFICANT 'T' SCORE ON CBCL – WITH ICD-10 DIAGNOSTIC CRITERIA**

<table>
<thead>
<tr>
<th>CBCL 'T' SCORE</th>
<th>PRESENT</th>
<th>ABSENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGNIFICANT</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>NOT SIGNIFICANT</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9</td>
<td>41</td>
</tr>
</tbody>
</table>

Sensitivity = 100%; Specificity = 97.56%; Positive Predictive value = 90%

**TABLE 4: CHILDREN WITH ICD – 10 DIAGNOSIS AND HAVING ABSENTEEISM**

<table>
<thead>
<tr>
<th>ICD – 10 DIAGNOSIS</th>
<th>NUMBER [N=50]</th>
<th>ABSENTEEISM</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESENT</td>
<td>9 (18%)</td>
<td>5 (55.55%)</td>
</tr>
<tr>
<td>ABSENT</td>
<td>41 (82%)</td>
<td>8 (19.51%)</td>
</tr>
</tbody>
</table>

Chi Square= 3.29; P = 0.0698 = NS ; Odds ratio = 5.16 ; Df = 1
psychiatric morbidity, (father – p=0.335; mother – p=0.872), or absenteeism (father – p=0.778; mother – p=0.778). This is unlike a study done by Richard et el (1999) who found a significant relationship between lesser parental education and higher psychopathology in children. (Table-1)

**WORKING MOTHER:** No statistical significance of working mothers was found with either psychiatric morbidity (p=0.765) or absenteeism (p=0.521) in this study. However, Narang et al (1991) found higher psychiatric morbidity in children having working mothers.

**PARENTAL LOSS:** No statistical significance of parental loss was found with psychiatric morbidity (p=0.792) and absenteeism (p=0.973). This was similar to the study done by Richard et el, 2000. However, Devaisigamani (1990) found higher psychiatric morbidity in children with parental loss.

**PARENTAL SUBSTANCE USE:** No statistical significance of parental substance use was found with psychiatric morbidity (p=0.636) and absenteeism (p=0.179). On the contrary, Eapen et al (2003) in his study on 6-18 year old children and Reich and Earls et al (1983) found a significant association between alcohol intake in parents and psychiatric morbidity in children. (Table –1)

**Child Related Factors:**

**WORKING STATUS:** No statistically significant correlation was found between working status of the student and psychiatric morbidity (p=0.834). Although not statistically significant, (p=0.053), there was a high tendency for remaining absent amongst working students (37.93%) as compared to those not working (9.25%) (Table –1). Of the 13 absentee students, 84.61% (11) worked in some form or other. One student had to go to construction site for work regularly which was the reason for his regular absenteeism. Almost 60% children attending these schools had household work, (looking after siblings, assisting parents in labour work) as major reasons for absenteeism. There were two children among the absentee students who put forth migration as a reason for absenteeism. In the NDES 2004 collected information, study on secondary school children in the year 2002-03, it was revealed that 13% missed school to do some type of work (domestic, on the family farm or business, or for an employer). 6% were absent to do domestic work, 6% to do family farm or family business, 6% to care for sick relative, and less than 1% to do work for an employer. Again in rural area, students were nearly three times as likely as those in urban areas to miss school to do any work (19% : 7%).

**TEMPERAMENT:** 83.33% of children with difficult temperament had psychiatric morbidity like conduct disorder, delinquent behaviour and hyperkinetic disorder, indicating that difficult temperament may be a predictor of externalising problems in future. Statistically significant correlation (p=0.000046) was found between psychiatric morbidity and temperamental characteristic, similar to the findings of Malhotra et al (1989).10.34% with easy temperament, 40% with slow to warm temperament and 66.67% with difficult temperament had absenteeism from school. This was found to be statistically significant (p=0.0005). (Table – 1)

**SIBLINGS CARE IN SCHOOL:** Was not found to be significantly correlated with psychiatric morbidity (p=0.52) or absenteeism (0.375) (Table – 1)

**Score on CBCL - TRF:**

CBCL – TRF was found to have sensitivity of 100% and specificity of 97.56% (Table – 3). 90% of students with significant score on CBCL – TRF had diagnosable psychiatric disorder. More students had externalising problems. It is likely that teachers may not realize or focus on internalising problems as compared to the externalising problems. This could be due to large number of students in classroom and internalising problems may be missed by teachers as compared to externalising problems, which lead to more disturbances in the class. Our findings are in keeping with a study done by Shenoy et al (1996). They also found CBCL – TRF as a useful tool for screening children with psychiatric morbidity in Indian school setting.

**Correlation between Psychiatric Morbidity and Absenteeism:**

Of the 13 absentee students, 5 (38.46%) had psychiatric morbidity. No statistically significant correlation was found (p=0.0698) (Table – 4). The psychiatric morbidity in these 5 students included oppositional defiant disorder and conduct disorder in 2 students, mild mental retardation in 1, hyperkinetic disorder in 1 and mixed emotional and conduct disorder in 1. This reflects that reasons for being absent from school are different in this study children unlike in some other studies where psychiatric morbidity has been a significant reason for absenteeism. Studies done by Bools et al (1990) and Berg et al (1993) found that most of the children with
severe school attendance problem suffered from psychiatric morbidity. Of the 9 students with ICD-10 diagnosis, 55.55% had absenteeism and of the 41 students without ICD-10 diagnosis, 19.51% had absenteeism.

CONCLUSION

These findings underline the need for adequate mental health services in the non formal community schools. But unfortunately, until our study, there has been no study regarding health related issues conducted on these children. Teachers’ as useful manpower for early detection of psychiatric morbidity is confirmed in our study. So, if trained properly, they can contribute to early detection, early intervention and prevention of future severe morbidity. Children belonging to economically backward conditions had more absenteeism than others. This study was conducted with the zeal to evaluate the psychological problems of these “out of school” children and the reasons that hold them from attending school, who are struggling for knowledge and upliftment inspite of various adversities. There were genuine daily life issues which prevented children from attending school. Recommendations regarding same were made to the concerned authority of Sarva Shiksha Abhiyan so that children could be sustained in main stream schooling.

REFERENCES


Sweta Shah (Corresponding author), Alka Pawar. Department of Psychiatry, B.J. Medical College and Sassoon Hospital, Pune, Maharashtra.

©2012 Indian Association for Social Psychiatry
/introduction

Families constitute the client's main social support system in India. Families are often the only ones who make life productive for those with schizophrenia. They usually perform their roles without special training and with little reward. The concept of burden shares characteristics with that of social performance, for one person's poor social performance is another person's burden. According to Platt (1985), family burden refers to the presence of problems, difficulties, or adverse events, which affect the life of the psychiatric patient's significant others. Although the entire family experiences the burden of illness, a major part of the responsibility is often shouldered by one "primary caregiver" who experiences physical and emotional burden. The existence of burden indicates the breakdown of the reciprocal arrangements that people maintain in their relationships, such that one person is doing more than their 'fair share'. This may merely result in them taking on a greater proportion or number of shared tasks but it may also restrict their activities outside their relationship. This change in pattern can be assessed against approximate norms.

Method

The study aimed to assess the family burden and family distress among the key relatives of persons with schizophrenia and to correlate both variables. One hundred key relatives or primary caregivers of individuals diagnosed to have schizophrenia as per DSM IV or ICD-10 criteria were taken up for the study with their consent to participate after the intake screening. The data collected were primary, by interviewing and administering validated Indian research instruments such as Schedule for the Assessment of Family Burden (SAFB) and Schedule for the Assessment of Family Distress (SAFD) to the treatment users. Among the participants, 53% had severe family burden and 43% had moderate burden, while 4% did not have any objective burden. Subjectively, 54% had severe family burden, 19% moderate burden, and 27% had no burden perceived. 46% had minimal distress, while 28%, 22% had moderate and marked distress, respectively. Karl Pearson Correlation coefficient r value is 0.846 and p value is 0.000 which is statistically significant.

Conclusion

There is a need for family interventions to reduce family burden and distress among the treatment users with schizophrenia for better treatment outcome.

Keywords: Schizophrenia, Family burden, Family distress.
study with their consent to participate after the intake screening. The data collected were primary; by interviewing & administering validated Indian research instruments such as Schedule for the assessment of family burden (SAFB) and Schedule for the assessment of family distress (SAFD) to the client and the significant key relatives or caregiver. Individuals having any co-morbid condition and the relatives having any chronic debilitating illness were excluded from the study.

Research Instruments


The SAFB covers six categories of objective burden, namely; Financial burden (6 items), Effect on family activities (5 items), Effect on family leisure (4 items), Effect on family interaction (5 items), Effect on physical health of other family members (2 items), Effect on mental health of family members (2 items). The scale also provides for the measurement of subjective burden by asking respondents, how much they feel negatively owing to their wards’ illness. Each item is scored on a three point scale, recorded as absent (score zero) Moderate (score-1) Severe (score-2). The scores on each category are summed and a total of three scores is indicative of the degree of objective burden. The subjective burden is also rated on three point scale.

Scale for the Assessment of Family Distress (SAFD) - Gopinath and Chaturvedi (1986)

The severity of distress is rated on a 5 point scale i.e., 0= no distress, 1=minimal distress, 2=moderate distress, 3=marked distress, 4=intense or very severe distress. Severity can also be assessed by asking the individuals to describe the distress in terms of percent distress (from 0-100). This is easier especially for rural and uneducated clients. When the relatives' rate distress by percentage method the severity can be categorized for analysis as No distress=0, Minimal distress=1-24, Moderate distress=25-49, Marked distress= 50-74, Intense distress=75-100. The distressful symptoms can be classified by two methods, depending on the nature of symptoms: Activity related (4 items), Self care related (6 items), Aggression related (5 items), Depression related (7 items). Karl Pearson Correlation coefficient, Fishers exact test and other appropriate statistical methods were carried out to do the analysis of data.

RESULTS & DISCUSSION

The caregivers belong to the age group ranging from 24 to 65 participated in this study with mean age of 50.10 and standard deviation 11.614. About 78% had education level from non-literate up to high school category among the key relatives and only 22% were from higher secondary to graduation category. 47% were House wives/ House executives where as only 5% had highly skilled job among the care givers and the rest were among the category unskilled job (10%), semi skilled (14%) and skilled (24%) job. Among the treatment users, majority (54%) had poor adherence to treatment regime where as the remaining were belonging to the category good adherence (13%), non-adherence (3%) and forced adherence (30%) respectively. Adherence to prescribed treatment plan of their ward must be given first priority while preparing the key relative for the rest of the psychosocial interventions. The Schizophrenia caused more disability compared to any other disorder for the individual despite of having good family support system unlike in higher income countries where secondary paid carers were more common. 65% of participants with Schizophrenia had more than 40% disability and 35% had less than 40% disability in this study. This supported by the study conducted by Shihabuddeen et al (2011). They found more disability in Schizophrenia than Bipolar mood disorder. 86% were singles among the treatment users and majority (69%) belong to rural domicile and 71% were having lower socio-economic status. Domicile may also influence care giving process as we got majority belonging to urban domicile had experienced more burden and distress. This is against the study conducted by Mubarak Ali & Bhatti (1988). They found that families in both urban and rural areas perceived equal burden and received equal support system. Majority of the participants (96%) i.e. key relatives or the care givers of the treatment users had moderate to severe burden objectively, however only 73 % perceived to have family burden level to be moderate to severe burden with a mean score of 1.27±0.863 and median being 2.00. About 7.6% of the families reported some form of burden due to the patients such as disruption in the family daily routine, financial stress and poor health in some members. Among the participants 46 percent had minimal distress and 50 percent had moderate to marked distress with mean score of 5.22 ± 3.265 and the median score is 4.50 (Table 1). Karl Pearson Correlation coefficient r value is 0.846 and p value is <0.001. Strength of association is shown by Spearman rho = 0.731 (Table 2).

Family psycho education is not alone enough to
improve the coping skills and quality of life of the individuals and their care givers. Burden experienced and perceived can be different due to various psychological factors of the care giver which cannot be generalized, hence require individually tailored interventions to reduce family burden for each treatment user. Systematic assessment of psychological and social factors such as family burden, family distress is required along with disability assessment of the individual for providing structured, comprehensive psychosocial interventions for better outcome of biopsychosocial treatment modality. It is not that a particular variable is increasing the burden or distress among the carers; rather, multifactorial reasons need to be compared and correlated with larger number of participants from different geographical areas to generalize any findings. As we see here, majority of the care givers experienced burden and distress unlikely to the level of disability. This means coping skills of the carers can influence treatment outcome hence providing family interventions to all the treatment users to reduce burden and distress is mandatory despite of disability level or other socio-demographic variables. Eclectic approach might help us in dealing with individually tailored and socio-culturally appropriate intervention plans while considering variety of factors that can have an impact on the treatment users for rehabilitation.

**CONCLUSION**

The importance of structured psychosocial interventions along with pharmacological/somatic treatment has been stressed in the mental health care programs. However such attempts are very few in Indian scenarios, especially in General Hospital Psychiatry Units (Shihabudden et al, 2008). An understanding of the psychosocial aspects of the clients will help in deciding the suitable interventions and also in changing negative expressed emotions of the care givers towards their ill member. It is only when Mental Health Professionals fully understand the array and types of burden and distress and its impact on the families that effective mental health care services can be delivered to them. The participation of care taking to reduce disability of their ill relative may be more effective when coping skills of the care givers are enhanced by reducing their burden and distress.

---

**Table 1: Objective & Subjective family burden and family distress**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>S.D.</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective Family Burden</td>
<td>100</td>
<td>0</td>
<td>11</td>
<td>5.65</td>
<td>3.397</td>
<td>7.00</td>
</tr>
<tr>
<td>Subjective Family Burden</td>
<td>100</td>
<td>0</td>
<td>11</td>
<td>5.22</td>
<td>3.265</td>
<td>4.50</td>
</tr>
<tr>
<td>Family Distress</td>
<td>100</td>
<td>0</td>
<td>11</td>
<td>5.22</td>
<td>3.265</td>
<td>4.50</td>
</tr>
</tbody>
</table>

Karl Pearson correlation coefficient $r = 0.846$, $p < 0.001$.

**Table 2: Correlation of family burden and family distress**

<table>
<thead>
<tr>
<th>Burden</th>
<th>No Distress</th>
<th>Minimal Distress</th>
<th>Distress</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Distress</td>
<td>Minimal Distress</td>
<td>Moderate Distress</td>
<td>Marked Distress</td>
</tr>
<tr>
<td>No Burden</td>
<td>1</td>
<td>3</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>25.0%</td>
<td>75.0%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Moderate Burden</td>
<td>3</td>
<td>36</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>7.0%</td>
<td>83.7%</td>
<td>4.7%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Severe Burden</td>
<td>0</td>
<td>7</td>
<td>26</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>.0%</td>
<td>13.2%</td>
<td>49.1%</td>
<td>37.7%</td>
</tr>
<tr>
<td></td>
<td>.0%</td>
<td>15.2%</td>
<td>92.9%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>46</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>4.0%</td>
<td>46.0%</td>
<td>28.0%</td>
<td>22.0%</td>
</tr>
</tbody>
</table>

Fishers exact test $p < 0.001$. Strength of association tested by Spearman rho $= 0.731$. 

©2012 Indian Association for Social Psychiatry
REFERENCE


Shihabuddeen Ismail, Gopinath, P.S (2003) Possible

Psycho social Interventions in a GHPU in India. Indian Journal of Psychological Medicine, 26 (2), 11-14.


Ismail Shihabuddeen T.M., (Corresponding author), Assistant Professor of Psychiatric Rehabilitation, Department of Psychiatry, Yenepoya University, Deralakatte, Mangalore-575018. E mail: izmyl.shiabudin@gmail.com

Mohan Chandran, Professor & Head, Dept.of Psychiatry, Yenepoya University, Deralakatte, Mangalore-575018.

Moosabba, Medical Superintendent, Yenepoya Medical College Hospital, Deralakatte, Mangalore.
INTRODUCTION
Substance abuse is associated with social problems like poverty and criminality, high risk behaviors and other stigmatized illnesses. Since, substance use initiation and continuation is often considered under the control of the person, substance abusers are more likely to be blamed for their condition. Thus, substance abuse is associated with significant stigma. Substance use disorders being the commonest psychiatric disorders worldwide, there is a need for studies on stigma among the substance abusers so that the barriers arising out of stigma in treatment and rehabilitation can be addressed.

Jason Luoma et al developed and validated a scale for assessment of perceived stigma towards substance abuse – the Perceived Stigma of Substance Abuse Scale (PSAS). The scale is easy to administer and shows good face and construct validity, and acceptable internal consistency.

Though India has a large population of substance abusers, studies on stigma towards substance abusers have been lacking. One reason for this could be the absence of Indian language standardized instruments to assess stigma. Such an instrument can aid in expanding research in stigma towards substance abusers, and assess the correlates of such stigma.

The present research was planned to validate PSAS in Hindi, the most common language spoken in India, so as to facilitate research into stigma perceived by substance abusers.

METHODOLOGY
The Hindi validation of the PSAS was done at the Drug Dependence Treatment Centre (DDTC) of Post Graduate Institute of Medical Education and Research (PGIMER), a post graduate teaching hospital in north India. The centre caters to a wide variety of substance abusers who are often accompanied by their relatives and acquaintances. The centre has both outpatient and inpatient facilities. The study was commenced after ethical clearance from the ethics committee of PGIMER.

PSAS is an 8 item self rated scale looking at stigma towards the substance users. All items are marked on a Likert type scale with four options ('totally disagree' to 'totally agree'). Six of the eight items are reverse scored. The scale total score ranges from 8 to 32, a higher score indicating greater perceived stigma. The scale, validated in 252 treatment seekers at addiction programs in the United States, showed good face validity, construct validity, and acceptable internal consistency. A factor analysis of the scale concluded for a single factor solution, explaining 36 percent of variance. Though validated in treatment seekers, the items are not based on personal experience of a substance abuser. Rather, they enquire about general perception towards substance abusers and hence can be responded to by non substance users as well.

The translation of the scale to Hindi required three iterations of forward and back translations, till the final scale was reached. The translations were done by resident doctors and nursing students who were not aware about the scale beforehand. Each item was analyzed for understandability, and changes in wording were made when deemed required.

The translated scale was pretested on a sample of Hindi knowing respondents (substance abusers, N=4 and

©2012 Indian Association for Social Psychiatry  117
their relatives, \( N=5 \), who were asked about any word or expression that they found ununderstandable, offensive or unacceptable. These interviews were conducted by the author SS. One of the items 'most people would be willing to date someone who has been treated for substance use' required modification with respect to cultural nuances, since a suitable translational equivalent word for 'date' could not be found.

The English and the Hindi versions of the scale were then applied in a random order and at an interval of two weeks, on a subset of patients with substance dependence who knew both the languages. Lastly, the Hindi version of the scale was applied on a larger sample of substance dependent subjects and their relatives.

**RESULTS**

The validation of the translation, carried in a subset of substance using patients \((n = 15)\) who were conversant with both Hindi and English language, showed a fair degree of correlation (Spearman's rho = 0.780, \( p = 0.001 \)) between the original English version and the Hindi translation version.

The scale was then administered to 160 subjects including 86 substance dependent subjects and 74 non-users. Of the 160 subjects, 114 (71.3%) were males, 127 (79.4 percent) were employed, and 99 (61.9 percent) were educated for >10 years. Also, 66 respondents (41.3 percent) belonged to a nuclear family, 111 (69.4 percent) were from urban background, and 100 (62.5 percent) were Hindus. Of the 86 substance dependent subjects, 44 were dependent on opioids and 42 were dependent on alcohol.

The item wise responses are shown in Table 1. Items 1, 2, 3, 4, 6 and 8 were reverse coded to generate PSAS score. The mean PSAS score of the sample was 18.97 (Standard deviation 3.65) with a range of 8 to 27. The median score on the scale was 19. The Cronbach alpha of the scale with a sample of 160 respondents was 0.641, which seems satisfactory for a short scale. The mean inter item correlation was 0.181.

A factor analysis of the scale using principal component extraction with Eigen value 1 and varimax rotation was done. The factor loadings are given in Table 2. The analysis gave a two factor solution, explaining 50.9 percent of the variance. However, using scree plot as done by Luoma et al., one factor solution emerged most optimal with Eigenvalue of 2.52 and explaining 31.8 percent of variance.

**DISCUSSION**

The Hindi version of PSAS demonstrates a fair degree of correlation with the English version. The scales were applied at an interval of two weeks. Shorter interval can produce spillover from the previous responses due to recollection from memory. Longer durations may reflect a change in actual attitudes (and stigma) over the course of time. The optimum duration between the application however, can always be debated.

The study shows that the Hindi version of PSAS has satisfactory Cronbach alpha, and gives a one factor solution with an Eigen value similar to that reported by Luoma et al. All the items have factor loadings higher than 0.400.

This study reports a reliable and valid scale for measuring stigma towards substance abusers among Hindi knowing subjects. The scale is short and self administered, and can be utilized in clinical and research settings to discern stigma towards substance abusers. It can be administered to substance abusers as well as non-users. PSAS can aid in furthering research in stigma towards substance users, looking at the correlates of such stigma, and finding interventions to surpass this stigma.

**Acknowledgement:**

We thank Drs. Sunil Gupta, Preeti Parakh and Nikita Rajpal, and nursing student Mrs Rozy Khera who helped with the forward and back translation. We thank Dr Jason Luoma for his encouragement for conducting the study. We also thank all the participants for the study.

**REFERENCES**


Table 1: Main scores.

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. Most people would willingly accept someone who has been treated for substance use as a close friend</td>
<td>2.91 (0.95)</td>
</tr>
<tr>
<td>Q2. Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen.</td>
<td>2.85 (0.85)</td>
</tr>
<tr>
<td>Q3. Most people would accept someone who has been treated for substance use as a teacher of young children in a public school.</td>
<td>2.6 (0.89)</td>
</tr>
<tr>
<td>Q4. Most people would hire someone who has been treated for substance use to take care of their children</td>
<td>2.37 (0.89)</td>
</tr>
<tr>
<td>Q5. Most people think less of a person who has been in treatment for substance use.</td>
<td>2.72 (0.83)</td>
</tr>
<tr>
<td>Q6. Most employers will hire someone who has been treated for substance use if he or she is qualified for the job</td>
<td>2.97 (0.77)</td>
</tr>
<tr>
<td>Q7. Most employers will pass over the application of someone who has been treated for substance use in favor of another applicant</td>
<td>2.55 (0.84)</td>
</tr>
<tr>
<td>Q8. Most people would be willing to date someone who has been treated for substance use.</td>
<td>2.6 (0.85)</td>
</tr>
</tbody>
</table>

On four items scale graded 1 to 4 “totally disagree” to “totally agree”

Table 2: Factor analysis of questions – factor loadings

<table>
<thead>
<tr>
<th>Question</th>
<th>Factor Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. Most people would willingly accept someone who has been treated for substance use as a close friend</td>
<td>0.521</td>
</tr>
<tr>
<td>Q2. Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen.</td>
<td>0.403</td>
</tr>
<tr>
<td>Q3. Most people would accept someone who has been treated for substance use as a teacher of young children in a public school.</td>
<td>0.447</td>
</tr>
<tr>
<td>Q4. Most people would hire someone who has been treated for substance use to take care of their children</td>
<td>0.496</td>
</tr>
<tr>
<td>Q5. Most people think less of a person who has been in treatment for substance use.</td>
<td>0.678</td>
</tr>
<tr>
<td>Q6. Most employers will hire someone who has been treated for substance use if he or she is qualified for the job</td>
<td>0.444</td>
</tr>
<tr>
<td>Q7. Most employers will pass over the application of someone who has been treated for substance use in favor of another applicant</td>
<td>0.711</td>
</tr>
<tr>
<td>Q8. Most people would be willing to date someone who has been treated for substance use.</td>
<td>0.372</td>
</tr>
</tbody>
</table>
Luoma, J.B. et al., 2010. The development and psychometric properties of a new measure of perceived stigma toward substance users. Substance Use & Misuse, 45(1-2), pp.47-57.

Surendra K. Mattoo, MD, Professor; Siddharth Sarkar, MD, Senior Resident (Corresponding author); Drug De-addiction & Treatment Centre, Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh 160012. Email: sidsarkar22@gmail.com
INTRODUCTION

The stigma, myths and misconceptions surrounding mental disorders have been identified as the major reason for a large number of patients not seeking treatment (Kohn et al., 2004). Stigma contributes to much of the discrimination and human rights violations experienced by people with mental disorders (Ngu et al., 2010). Goffman defined stigma as "an attribute that is deeply discrediting," where a person is diminished "from a whole and usual person to a tainted, discounted one" (Goffman, 1963). Stigma has been divided into public and self. Public stigma is the reaction that the general population expresses towards persons with mental disorders. Self-stigma is the prejudice which people with mental disorders turn against themselves. Both public and self-stigma may be understood in terms of three components: stereotypes, prejudice, and discrimination (Corrigan & Watson, 2002).

It is important to study stigma across different social and cultural regions. Research carried out in western countries cannot be applied to India due to its sociocultural diversity. Most of the Indian research on stigma focuses on the attitudes of the general public towards mentally ill. Assessment of stigma perceived by persons with mental illness is equally relevant. The present study was aimed to measure and compare stigma and its correlates among persons with psychiatric disorders and substance dependence. Methods: 218 patients having different psychiatric illnesses and substance dependence were assessed cross sectionally using the felt stigma scale, the insight scale, sociodemographic and clinical proforma and the scales relevant for the type of psychiatric illness to measure severity. Appropriate tests were applied for statistical analysis. Results: Stigma scores were significantly higher in the younger age group patients (p = .008), males (p = .003), patients with a continuous illness (p = .040) and symptomatic patients (p = .002). Substance dependence patients had significantly higher stigma than patients with psychiatric illnesses (p < .001). Among persons with depression, stigma was positively correlated with severity of illness (p = .001). Conclusions: The feelings of stigma and discrimination against mental illness are internalized by patients as well as public. Interventions to reduce stigma and discrimination should be as part of psychosocial management.

Key words: Stigma, discrimination, substance dependence, psychiatric illness

STIGMA AND DISCRIMINATION: HOW DO PERSONS WITH PSYCHIATRIC DISORDERS AND SUBSTANCE DEPENDENCE VIEW THEMSELVES?
Rohit Garg, B.S. Chavan, Priti Arun

Abstract

Background: Most research on stigma focuses on the attitudes of the general public towards mentally ill. Assessment of stigma perceived by persons with mental illness is equally relevant. The present study was aimed to measure and compare stigma and its correlates among persons with psychiatric disorders and substance dependence. Methods: 218 patients having different psychiatric illnesses and substance dependence were assessed cross sectionally using the felt stigma scale, the insight scale, sociodemographic and clinical proforma and the scales relevant for the type of psychiatric illness to measure severity. Appropriate tests were applied for statistical analysis. Results: Stigma scores were significantly higher in the younger age group patients (p = .008), males (p = .003), patients with a continuous illness (p = .040) and symptomatic patients (p = .002). Substance dependence patients had significantly higher stigma than patients with psychiatric illnesses (p < .001). Among persons with depression, stigma was positively correlated with severity of illness (p = .001). Conclusions: The feelings of stigma and discrimination against mental illness are internalized by patients as well as public. Interventions to reduce stigma and discrimination should be as part of psychosocial management.

Key words: Stigma, discrimination, substance dependence, psychiatric illness

©2012 Indian Association for Social Psychiatry 121
failure and weakness and as being addicted to drugs (Brown et al., 2010). Patients believe that other people consider them as being responsible for their illness, a threat to others, unpredictable, dangerous and repellant (Barney et al. 2009). Thus, stigma and feelings of unpredictability are largely shared even by patients. Better cognitive insight and attribution of personal responsibility to the illness are associated with higher levels of self stigma. These feelings negatively influence patient's social participation and achievement of goals in life (Magliano et al. 2008).

The present study was planned to measure and compare stigma and its correlates in persons with psychiatric disorders and substance dependence using a structured scale. The scale was translated into Hindi and adapted so that it can be easily understood by our patients.

MATERIALS AND METHODS

The study was conducted at the OPD of a General Hospital Psychiatry Unit of North India from January 1, 2011 to May 31, 2011. The sample consisted of 218 consecutive male and female patients with ICD 10 (WHO, 1992) diagnosis of schizophrenia and other psychotic disorders, depression, obsessive compulsive disorder (OCD) and mental and behavioral disorders due to psychoactive substance use; who were more than 16 years of age; could read and understand Hindi and gave informed consent to participate in the study. Exclusion criteria were: patients having any other medical illness or other illnesses that were stigmatizing like HIV, TB, leprosy, epilepsy, vitiligo; patients who had family h/o mental illness and were intellectually deficient. The ethics committee of the institution approved the study. It was a cross sectional study where the assessments were carried out by a qualified psychiatrists during a single visit. The diagnosis was made as per ICD 10 (WHO, 1992).

Tools:

1. Sociodemographic proforma: a semi structured proforma was developed for the study which included age, gender, education, occupation, marital status, locality, family type and monthly family income.

2. Illness related variables were recorded using a Clinical proforma: clinical parameters noted were diagnosis, total duration of illness, insight, course of illness (episodic or continuous), months of illness during the illness period and current status of the patient (in remission or not).

3. Stigma Scale for Measuring Self Stigma: For the purpose of this study, the Stigma Scale developed by King et al. (King et al., 2007) was translated to Hindi. The scale consists of 28 items, divided into 3 domains namely discrimination (13 items), disclosure (10 items) and positive aspects (5 items). We observed that most of the items on this scale are relevant to what the patients actually experience in their lives and they were relevant to Indian context also. The scales developed in the other languages like English cannot be applied as such on Indian patients. Each item in the original scale was rated on a 5 point likert scale from strongly agree, agree, neither agree nor disagree, disagree to strongly disagree. However, when the feasibility of administration was tested on Indian patients, our patients encountered difficulty in choosing appropriate responses. Hence, only 3 response options were retained: agree, neither agree nor disagree and disagree. Higher scores on total scale and 3 subscales means higher stigma. The stigma scale has been tested on a total of 218 patients having different psychiatric disorders and substance dependence (Garg et al., unpublished work). It was found to have good reliability (Cronbach's alpha = 0.840). The domains named discrimination (Cronbach's alpha = 0.811) and disclosure (Cronbach's alpha = 0.841) were also found to be reliable independently. However, the domain on positive aspects was not found to be reliable (Cronbach's alpha = 0.465). All the three domains had higher correlation with the total scale than with each other, thus indicating that the 3 domains measured separate aspects of stigma.

4. The insight scale (McIntyre et al., 2009).

5. Yale Brown Obsessive Compulsive Scale for measuring the severity of OCD (Goodman et al., 1989).

6. Hamilton rating scale for depression for measuring the severity of depression (Hamilton, 1960).

**Statistical analysis**

The statistical analysis was carried out using Statistical Package for Social Sciences (SPSS Inc., Chicago, IL, version 15.0 for Windows). All quantitative variables were estimated using measures of central location (mean, median) and measures of dispersion (standard deviation and standard error). Normality of data was checked by measures of skewness and Kolmogorov Smirnov tests of normality. For skewed data or scores, Mann-Whitney test was applied for two groups. For more than two groups Krusal Wallis test was applied. Qualitative or categorical variables were described as frequencies and proportions. Proportions were compared using Chi square or Fisher’s exact test whichever was applicable. To see the relationship between two variables Pearson Correlation coefficient or Spearman correlation was calculated. All statistical tests were two-sided and performed at a significance level of α = .05.

**RESULTS**

**Socio-demographic data:**

A total of 218 patients were included in the study. Table 1 shows the sociodemographic data of the participants and the correlation of stigma scale scores with the sociodemographic data. Majority of patients were males (55.04%) and had less than 12 years of formal education (56.88%). Out of the females (44.96%), majority were housewives (28.91%). A large number of patients were married (65.60%), had a total monthly family income of more than 10000 rupees (73.39%) and belonged to a nuclear family (61.93%). Most of them belonged to an urban locality (81.19%).

As can be seen from table 1, the scores on the discrimination and disclosure subscales were significantly different for the three age groups, being more in the younger patients than the older patients. Also, male patients (mean 12.03, ± 6.137) had significantly higher scores than female patients (mean 9.53, ± 6.029) on the disclosure subscale. (p = 0.003). The scores on any of the subscales or the total score were not significantly affected by other sociodemographic variables.

**Correlation with clinical parameters including diagnostic categories:**

Table 2 shows the correlation of stigma scale scores with the illness related variables of the participants. Out of the 218 patients, majority had depression (89, 40.83%), 47 (21.55%) had psychotic disorders other than schizophrenia, 26 (11.93%) had schizophrenia, 27 (12.39%) had OCD and 29 (13.30%) had substance dependence disorders (Alcohol dependence = 14; Opioid dependence = 15). The scores on all the three subscales differed significantly across different diagnostic groups, being maximum in patients with substance dependence and minimum in patients with depression. The results showed that the patients with substance dependence had a significantly higher score on discrimination (mean 13.07, ± 5.934) than patients with OCD (mean 8.63, ± 5.123; p = .007), and depression (mean 8.22, ± 5.152; p = .000). Also, on disclosure subscale, these patients had significantly higher score (mean 14.62, ± 5.010) as compared to patients with depression (mean 8.72 ± 6.491; p = .000), psychosis other than schizophrenia (mean 11.43 ± 5.174; p = .007) and schizophrenia (mean 10.81 ± 5.367; p = .007). The total score on stigma scale was also more in patients with substance dependence (mean 34.79, ± 8.870) as compared to those with OCD (mean 28.78, ± 9.225; p = .023), depression (mean 22.87, ± 11.230; p = .000), psychotic disorders other than schizophrenia (mean 27.83, ± 10.192; p = .008) and schizophrenia (mean 26.15, ± 9.469; p = .002). Patients with substance dependence also had a significantly lesser score on positive aspects than patients with schizophrenia (p = .004). Patients with schizophrenia had a significantly lesser score on positive aspects subscale as compared to patients with OCD (p = .024). Patients with OCD (mean 13.33 ± 6.158) had a significantly higher score than patients with depression on the disclosure subscale (p = .001) and the total score (p = .017). Discrimination was felt significantly more by patients having continuous illness than by those having episodic illness (p = 0.040) and by those patients who were not in remission (p = 0.036) at the time of assessments. Patients who were not in remission also had a significantly higher score on the disclosure subscale (mean 12.18 ± 5.734 VS mean 9.89 ± 6.396; p = 0.009). Patients who were in remission for a longer period had significantly lesser score on the positive aspects subscale.

**Correlation with duration of symptomatic period:**

An attempt was made to find correlation between stigma scores and duration of symptomatic illness. It was found that as the duration of symptomatic period increased, there was a significant increase in the total score of the stigma scale (Correlation coefficient 0.170; p = 0.012) and the subscales of discrimination (correlation coefficient 0.187; p = 0.006) and disclosure...
Table 1: Sociodemographic data of the patients and correlation with stigma scale scores

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category (N, %)</th>
<th>Discrimination Mean (± sd)</th>
<th>P value</th>
<th>Disclosure mean (± sd)</th>
<th>P value</th>
<th>Positive aspects mean (± sd)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>&lt; 30 (81, 37.16)</td>
<td>10.59 (6.364)</td>
<td>0.008*</td>
<td>12.06 (5.600)</td>
<td>0.043*</td>
<td>6.33 (2.761)</td>
<td>0.585</td>
</tr>
<tr>
<td></td>
<td>30 – 45 (81, 37.16)</td>
<td>10.09 (5.659)</td>
<td></td>
<td>10.95 (6.158)</td>
<td></td>
<td>5.94 (2.580)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; 45 (56, 25.69)</td>
<td>7.63 (5.489)</td>
<td></td>
<td>9.18 (6.780)</td>
<td></td>
<td>5.98 (2.653)</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male (120, 25.69)</td>
<td>9.77 (6.449)</td>
<td>0.892</td>
<td>12.03 (6.137)</td>
<td>0.003*</td>
<td>6.14 (2.736)</td>
<td>0.696</td>
</tr>
<tr>
<td></td>
<td>Female (98, 44.96)</td>
<td>9.49 (5.394)</td>
<td></td>
<td>9.53 (6.029)</td>
<td></td>
<td>6.04 (2.580)</td>
<td></td>
</tr>
<tr>
<td>Education (years of formal education)</td>
<td>&lt; 12 (124, 56.88)</td>
<td>9.82 (6.096)</td>
<td>0.671</td>
<td>10.42 (5.911)</td>
<td>0.142</td>
<td>5.94 (2.724)</td>
<td>0.394</td>
</tr>
<tr>
<td></td>
<td>&gt; 12 (94, 43.12)</td>
<td>9.40 (5.863)</td>
<td></td>
<td>11.55 (6.541)</td>
<td></td>
<td>6.30 (2.577)</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td>Office job (43, 19.72)</td>
<td>9.70 (6.091)</td>
<td>0.772</td>
<td>10.96 (6.400)</td>
<td>0.364</td>
<td>5.84 (2.621)</td>
<td>0.631</td>
</tr>
<tr>
<td></td>
<td>Others (69, 31.65)</td>
<td>9.00 (5.619)</td>
<td></td>
<td>11.93 (6.438)</td>
<td></td>
<td>6.49 (2.548)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Housewife (63, 28.91)</td>
<td>9.57 (5.333)</td>
<td></td>
<td>9.92 (5.955)</td>
<td></td>
<td>6.17 (2.751)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unemployed (43, 19.72)</td>
<td>10.30 (7.116)</td>
<td></td>
<td>11.26 (5.996)</td>
<td></td>
<td>6.00 (2.743)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>Single (75, 34.40)</td>
<td>10.28 (6.661)</td>
<td>0.322</td>
<td>11.65 (5.894)</td>
<td>0.217</td>
<td>5.88 (2.866)</td>
<td>0.429</td>
</tr>
<tr>
<td></td>
<td>Married (143, 65.60)</td>
<td>9.31 (5.596)</td>
<td></td>
<td>10.52 (6.342)</td>
<td></td>
<td>6.21 (2.550)</td>
<td></td>
</tr>
<tr>
<td>Monthly family income (Rs.)</td>
<td>&lt; 10000 (58, 26.61)</td>
<td>8.83 (6.275)</td>
<td>0.243</td>
<td>9.57 (6.435)</td>
<td>0.065</td>
<td>5.78 (2.829)</td>
<td>0.387</td>
</tr>
<tr>
<td></td>
<td>&gt; 10000 (160, 73.39)</td>
<td>9.94 (5.870)</td>
<td></td>
<td>11.39 (6.063)</td>
<td></td>
<td>6.21 (2.598)</td>
<td></td>
</tr>
<tr>
<td>Family type</td>
<td>Nuclear (135, 61.93)</td>
<td>9.56 (6.165)</td>
<td>0.714</td>
<td>10.79 (6.130)</td>
<td>0.649</td>
<td>6.23 (2.557)</td>
<td>0.522</td>
</tr>
<tr>
<td></td>
<td>Joint (83, 38.07)</td>
<td>9.77 (5.718)</td>
<td></td>
<td>11.11 (6.350)</td>
<td></td>
<td>5.88 (2.826)</td>
<td></td>
</tr>
<tr>
<td>Locality</td>
<td>Rural (41, 18.81)</td>
<td>8.63 (5.638)</td>
<td>0.264</td>
<td>10.12 (6.270)</td>
<td>0.382</td>
<td>5.93 (3.028)</td>
<td>0.799</td>
</tr>
<tr>
<td></td>
<td>Urban (177, 81.19)</td>
<td>9.88 (6.055)</td>
<td></td>
<td>11.09 (6.190)</td>
<td></td>
<td>6.14 (2.577)</td>
<td></td>
</tr>
</tbody>
</table>
Table 2: Correlation of patient’s illness related variables with scale scores

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category (n, %)</th>
<th>Discrimination Mean (sd)</th>
<th>P value</th>
<th>Disclosure Mean (sd)</th>
<th>P value</th>
<th>Positive aspects Mean (sd)</th>
<th>P value</th>
<th>Total score (sd)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OCD (27, 12.39)</td>
<td>8.63 (5.123)</td>
<td>0.006*</td>
<td>13.33 (6.158)</td>
<td>0.000*</td>
<td>6.81 (2.512)</td>
<td>0.048*</td>
<td>28.78 (9.225)</td>
<td>.000*</td>
</tr>
<tr>
<td></td>
<td>Substance (29, 13.30)</td>
<td>13.07 (5.934)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depression (89, 40.83)</td>
<td>8.22 (5.152)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychosis (47, 21.55)</td>
<td>10.45 (7.070)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Schizophrenia (26, 11.93)</td>
<td>10.27 (5.950)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total duration of illness</td>
<td>&lt; 1 year (36, 16.52)</td>
<td>8.22 (6.142)</td>
<td>0.219</td>
<td>9.56 (6.340)</td>
<td>0.377</td>
<td>6.72 (2.514)</td>
<td>0.163</td>
<td>24.50 (11.513)</td>
<td>.401</td>
</tr>
<tr>
<td></td>
<td>1 – 5 years (76, 34.86)</td>
<td>9.20 (6.119)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 – 10 years (54, 24.77)</td>
<td>10.63 (5.242)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; 10 years (52, 23.85)</td>
<td>10.25 (6.312)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of illness</td>
<td>Episodic (47, 21.56)</td>
<td>8.02 (5.632)</td>
<td>0.040*</td>
<td>9.91 (6.450)</td>
<td>0.228</td>
<td>5.91 (2.827)</td>
<td>0.648</td>
<td>23.85 (11.090)</td>
<td>.072</td>
</tr>
<tr>
<td></td>
<td>Continuous (171, 78.44)</td>
<td>10.09 (6.019)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current status</td>
<td>In remission (121, 55.50)</td>
<td>8.92 (5.748)</td>
<td>0.036*</td>
<td>9.89 (6.396)</td>
<td>0.009*</td>
<td>5.85 (2.756)</td>
<td>0.185</td>
<td>24.66 (10.703)</td>
<td>.002*</td>
</tr>
<tr>
<td></td>
<td>Not in remission (97, 44.50)</td>
<td>10.55 (6.181)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever admitted or not</td>
<td>Yes (46, 21.10)</td>
<td>9.72 (7.029)</td>
<td>0.815</td>
<td>11.61 (6.050)</td>
<td>0.391</td>
<td>6.07 (2.939)</td>
<td>0.991</td>
<td>27.39 (12.132)</td>
<td>.686</td>
</tr>
<tr>
<td></td>
<td>No (172, 78.90)</td>
<td>9.62 (5.698)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insight</td>
<td>1 – 3 present (26, 11.93)</td>
<td>9.35 (6.523)</td>
<td>0.770</td>
<td>11.04 (5.956)</td>
<td>0.962</td>
<td>6.15 (2.894)</td>
<td>0.785</td>
<td>26.54 (12.021)</td>
<td>.959</td>
</tr>
<tr>
<td></td>
<td>4 – 6 absent (192, 88.07)</td>
<td>9.68 (5.927)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
There is very little attempt to understand the logics
where the focus is on personal strength and weaknesses. This may make them more prone to both perceived and actual stigma. At a later age, patients are usually settled into their occupations and family life and have increased social support in terms of a marital life, which may neutralize some of the factors related to stigma.

Correlation with severity of illness:
Correlation between the stigma scores and the severity of illness among different diagnostic subgroups was studied. It was observed that among patients having depression, severity of illness was positively correlated with the discrimination subscale (correlation coefficient = 0.039) and the total score (correlation coefficient = -0.145, p = 0.025) decreased significantly among persons with substance dependence.

Correlation with severity of illness:
Correlation between the stigma scores and the severity of illness among different diagnostic subgroups was studied. It was observed that among patients having depression, severity of illness was positively correlated with the discrimination subscale (correlation coefficient = 0.039) and the total score (correlation coefficient = -0.145, p = 0.025) decreased significantly among persons with substance dependence.

DISCUSSION
In the present study, self stigma was assessed in patients with psychotic disorders (including schizophrenia), depression, OCD and substance dependence. The younger patients had significantly higher scores on the discrimination (.008) and disclosure (.003) subscales than the older patients in the present study. Further, in the present study, males had significantly higher scores than female patients on the disclosure subscale (.003). The total stigma scores or the scores on any of the subscales were not significantly affected by other sociodemographic variables. The previous studies correlating stigma scores with sociodemographic variables have found contrasting results. In these studies, higher stigma was associated with younger age of the patients (Sirey et al., 2001), older patients had higher stigma (Roeloffs et al., 2003), or age had no significant effect on stigma (Mak & Wu, 2006, Yen et al., 2005, Mann & Himelein, 2004, Ward et al., 2009; Link et al., 2001). The conflicting results from these studies might be the result of methodological differences. The reason for higher stigma in males could be because there is a certain way males are expected to think, act and behave i.e., “be tough” “do not cry” “do not show much emotions except anger”. The stigma associated with any male who does not abide by these traditional characteristics of masculinity can cause men to perceive mental health problems as personal weaknesses and failures. Also, in our culture, most females are supposed to take care of the household and men are the main bread earners of the family. So, mental illness affecting a man might result in more disruption and stigma. Hence, the finding of higher stigma related to disclosure among men.

A 20 years old male patient after recovering from a depressive episode narrated his worries about disclosing his illness “I remain so worried about my future. What if my future employers get to know of my depression? They will never give me job. If it happens after joining I might lose it.” Another 18 year old girl with depression reported “though I am the topper of my class but still my parents keep telling me that I am a mental patient whenever I have an argument with them. They keep reminding me of my problems. My brother often tells me that I will always remain mentally weak and will not be able to study well and do a job like other people. Is it true doctor?”

Investigating the association of gender with stigma, previous studies have reported contrasting results (Alonso et al., 2008; Hinton et al., 2006; Roeloffs et al., 2003; Mak and Wu, 2006; Yen et al., 2005; Mann & Himelein, 2004; Ward et al., 2009; Link et al., 2001). The possible reasons for higher stigma in younger patients in our study could be due to the fact that at a younger age, there are more social interactions focusing on self attributes and understanding about their friends. The young people are also more guided by prevalent cultural and social practices and attitudes in the society. There is very little attempt to understand the logics behind the commonly practiced rituals. They also encounter situations like career, marriage, job and
In two previous studies, it was reported that patients with lesser education experienced more stigma than those with higher education (Yen et al., 2005; Alonso et al., 2008). No such association was found in our study and many other studies (Mak and Wu, 2006; Link et al., 2001). Low levels of education are related to lower of socio economic status and poverty. Poverty itself is related to stigma. Persons with low socioeconomic status usually are dependent on others for their employment as many of them work as manual laborers and are placed at the bottom in the social hierarchy. These persons are at higher risk of facing overt stigma and discrimination at their workplace and have the fear of losing their jobs easily. They are also less likely to protest against the stigma and discrimination because of their social status. This may lead to internalization of feelings of stigma and a greater degree of social isolation and rejection. On the other hand, patients with higher education have more knowledge about the consequences of illness disclosure on their lives, careers, relationships etc. and are fearful about losing their social status if their illness is disclosed to other people. So, education can act as a double edged sword for persons with mental illness.

Although in our study there was no significant difference in stigma scores between rural and urban populations, a previous Indian study reported that rural sample had higher stigma scores than urban sample (Jadhav et al., 2007). Another Indian study reported that urban respondents felt the need to hide their illnesses and avoided illness histories in job application whereas rural respondents experienced more ridicule, shame and discrimination (Loganathan & Murthy, 2008). The reason for no differences found in our study with respect to locality could be because of the methodological differences. We had less numbers of patients from the rural background and also the rural respondents coming to our clinic usually come from areas adjoining the tricity that are almost merged into the city. So, they might not be representative of actual rural Indian population.

It is expected that patients with insight into their illness will have more stigma but no such association was seen in our study. This is in contrast to two previous studies that found that patients with greater cognitive insight had higher levels of self stigma (Mak and Wu, 2006; Mishra et al., 2009). Insight is a multidimensional phenomenon. We rated insight only as present or absent, whereas insight covers many more areas that can be addressed using more structured scales for insight. Also, the number of patients in the groups with present insight and absent insight was highly variable. This could be the reason for the difference in our results. A more comparable number in the two groups could have yielded more significant results.

The results of our study showed that patients with substance dependence had higher stigma scores than patients with schizophrenia, psychotic illnesses other than schizophrenia, OCD and depression. The presence of high levels of stigma among persons with substance dependence has been found in previous studies also (Dinos et al., 2004; Schomerus et al., 2011; Link et al., 1997). As compared to patients with mental illnesses, persons with substance dependence are less frequently regarded as mentally ill, are held much more responsible for their condition, are held more in control of their behavior, provoke more social rejection and more negative emotional reactions and are particularly at risk for discrimination (Schomerus et al., 2011). It is believed that individuals with substance dependence do not actually want to control their dependence for want of pleasure and they willingly indulge in substance seeking behavior. The biological basis behind the craving and substance seeking behavior is frequently overlooked while making views about these persons.

A 45 years old alcohol dependent person narrated “I started morning drinking 6 months ago. Earlier the non drinking people in my locality used to call me addict and avoid me but now the friends who drink only in the evening have also started avoiding me. They tell me my drinking is totally out of control”. Another 50 years old alcohol dependence patient stated “I have been trying to quit but my mind and body are used to it. My family and relatives blame me for not controlling. They say I do not want to improve and am like this only. They do not try to understand how troubled I am internally because of alcohol.”

We also found that persons with OCD have higher stigma on disclosure than persons with depression. OCD is associated with obsessions and compulsions which are considered by most people as odd and strange and can result in isolation, shame and ridicule whereas depressive symptoms are mostly not overtly visible to others and more accepted in the society even if they are visible. The only previous study measuring stigma in persons with OCD has reported that most patients conceal their illness for fear of rejection in
interpersonal interactions like job, love, marriage etc. (Stengler Wenzke et al., 2004).

A 25 years old OCD patient expressed his concerns as “I feel so ashamed about these repetitive actions. What if my friends and neighbors see me doing this? They will call me mad like my parents used to call me when they did not know it was an illness. I avoid going to other people’s place because they will get to know of my problem.”

With regard to severity of illness, it was noticed that among patients with depression, stigma scores increased significantly as the severity of illness increased. This finding has been reported by two previous studies which also found that the patients having more severe depression had a significantly higher levels of self stigma (Yen et al., 2005, Mak and Wu, 2006, Raguram et al., 1996). The reasons for higher stigma in patients with more severe depression could be attributed to the cognitive distortions leading to self blame, personalization and generalizations as well as to social withdrawal and isolation. We also observed that stigma was higher among persons with continuous illness, persons who were not in remission and those who were ill for a longer period during their illness. Thus, persons who are ill for a shorter duration and recover early have lesser stigma. All these factors would be expected to increase the severity of illness and the number of symptoms. This would clearly be expected to increase the persons expected stigma and the actual stigmatizing responses of others leading to discrimination. This finding is of great importance. Stigma has been identified as the most important barrier to obtaining health care. Higher stigma in more severely ill patients means that those who are most in need of treatment may not get it, or may get it late. So, the association of perceived stigma and severity may result in a vicious cycle resulting in untreated illness and more psychosocial impairment.

A 45 years old female patient after recovering from her 3rd episode of acute psychosis explained “we shifted to this house 1 year ago. The landlords have been forcing us to vacate the house ever since I developed the episode and became aggressive. They do not want to keep a mentally ill person at their house. They do not believe I can be symptom free even after taking treatment.” A 40 years old female with schizophrenia narrated her experiences “my husband often calls me mad even when I am ok. I have noticed that my brother who lives in the same city never comes to visit my place whenever I have symptoms, though he does visit me when I am fine.” Another schizophrenic patient after recovering told us “Since I have developed this problem, even my best friend who has been with me through thick and thin has started avoiding me. We used to meet daily but now he always tells me he is busy when I tell him to go out.”

This study has a few limitations like the number of patients was variable across different diagnostic groups and relatively small among obsessive compulsive disorder and substance dependence.

CONCLUSIONS

Many people with serious mental illness are challenged doubly. On one hand, they struggle with the symptoms and disabilities that result from the disease. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people. These feelings of stigma and discrimination are endorsed and internalized by the patients also. Our study shows that stigma is higher among younger patients and male patients. Also, stigma is higher among persons who are more severely ill and ill for a longer period. Patients who have less severe illness and improve or recover have lesser stigma. Thus, early and effective treatment of mental illness is expected to reduce felt stigma as well as the actual overt discrimination. Also, mental health professionals should look to deal with the stigma of mental illnesses along with dealing with the core signs and symptoms of mental illness.

REFERENCES


Garg, R., Arun, P., Chavan, B.S. Reliability of felt stigma scale in Indian setting. (Unpublished work)


Schomerus, G., Lucht, M., Holzinger, A., et al. (2011) The stigma of alcohol dependence compared with other
mental disorders: a review of population studies. Alcohol and Alcoholism, 46 (2), 105 - 112.


Thara, R. (2003) People with schizophrenia believe they are stigmatized at work and in the community. Evidence Based Mental Health, 6, 96.


Rohit Garg, M.D., Senior Research Associate
(Corresponding author);
Email id: drrohitgarg@hotmail.com

B.S. Chavan, M.D., Professor and Head;
Priti Arun, M.D., Professor;
Department of Psychiatry, Govt. Medical College & Hospital, Chandigarh 160030.
Reviewed by: R. Srinivasa Murthy

This is an important book useful to all psychiatrists. As the authors note, ‘this publication is the fruition of the aims of two organizations to produce a clinical manual of disaster psychiatry for those interested in responding to the broad need for disaster mental health services’. (page xv).

The book is totally addressed to the needs of the psychiatrists, which is its strength and its limitation. Book has four sections, namely, readiness, evaluation, intervention and emerging and other topics with 21 chapters. The book is chiefly based on the experiences of Americas, mostly 9/11 WTC disaster, Hurricane Katrina and the Haiti earthquake.

Readiness section (4 chapters) presents the need assessment and the available international guidelines (IASC) and the international tools (WHO-AIMS). There is a very good section of ‘self-care’ which can be useful even to psychiatrists working in other settings. Evaluation (7 chapters) covers psychiatric evaluation, special populations, serious mental illness, substance abuse, personality issues, grief and resilience. The special feature is the inclusion of the relevant tools for assessment (for example the AUDIT for screening of alcohol abuse). Interventions (7 chapters) cover psychological first aid, group and family interventions, psychotherapies, the psychopharmacology of acute and post acute phases, child and adolescent psychiatry interventions and geriatric psychiatric interventions. This is a very comprehensive and critical presentation of the data, along with case examples from different disasters.

I found the figure in Page 267 giving a schematic approach to intervention very useful. In this the changes in individual are seen at many levels and interventions are juxtaposed to meet the need. For example, neurobiological processes (pharmacological); conditioned responses (behaviour therapy); networks of meaning (psychotherapy); existential/social (group therapy). A very useful way to approach the evaluation of a sick individual and choose the interventions.

The Emerging and other topics (3 chapters) cover psychiatrist as ambassadors, legal and ethical issues, and telepsychiatry. Each chapter ends with teaching points, which are very good summarisation of the chapter and review questions. There is an appendix of key readings and resources, in addition to a very good references for each chapter.

In India, mental health professionals have been actively involved in working with a large number of disasters. The first one in which a community based psychotherapeutic method was used was the Bangalore circus tragedy in 1981 by Dr. H.S. Narayana. This was followed by mental health research and interventions following the Bhopal disaster, Prof. B.B. Sethi, Dr. R. Srinivasa Murthy and Dr. Mohan K Isaac. This was a turning point for mental health research in disaster populations. It also saw the publication of the first manual of mental health for mental health care of disasters by medical officers. These efforts were followed by the study of Marathwada Earthquake (1993) led by Prof. Mohan K. Agashe, the Orissa (now called Odisha) supercyclone (1999) by NIMHANS, Bangalore team when the first full set of intervention manuals were prepared for the survivors and the community level workers, the Gujarat earthquake (2001), the riots in Gujarat (2002) and the more recent tsunami (2004). In the country there is a progression of development of mental health interventions during the last three decades. A reflection is the publication of the ‘Psycho-Social Support and Mental Health Services in Disasters’ by the National Disaster Management Agency in December 2009. There have been two books on disaster mental health and a large number of educational materials easily available for practitioners like the Tsunami intervention material from the NIMHANS, website and that of WHO, SEARO and WHO-India websites. The national developments have been covered comprehensively recently (Kar, 2012).

I have enjoyed reading the book and found the book a very useful one for psychiatrists. I strongly recommend that it is in the shelves of the libraries of all departments of psychiatry.

Reference:


R. Srinivasa Murthy, Professor of Psychiatry (Retired), The Association for the Mentally Challenged, Near Kidwai Hospital, Dharmaram College P.O. Bangalore - 560029. Email: smurthy030@gmail.com
ABSTRACTS OF XIX NATIONAL CONFERENCE OF INDIAN ASSOCIATION FOR SOCIAL PSYCHIATRY, CHANDIGARH, 23-25 NOVEMBER 2012
Challenges for Social Psychiatry in the Contemporary Indian Society

R.K. Chadda
President, Indian Association for Social Psychiatry;
Professor of Psychiatry, All India Institute of Medical Sciences, New Delhi

The contemporary world is inflicted by a number of serious social problems like poverty, diseases, famines, population increase, drug trafficking, wars and terrorism, racism, crime, human rights violations, child abuse especially in the third world, religious conflicts, and so on. In this background, role of social psychiatry has become more vital despite dramatic advances in the field of biological psychiatry. Mental disorders have been recognized as leading contributors to the disease related global burden and disability, which is estimated to increase further in the coming years. According to WHO, depression, which is currently the third leading cause of the global burden of disease, is expected to lead the list by year 2030. In the background of increasing burden of the mental disorders, lie a number of social issues, which are likely to be responsible to this phenomenon.

In the recent years, India has been a witness to many important social issues which have a potential of affecting mental health and are an indicator of increasing societal stress. Increasing suicide rates especially in the adolescents and young adults, incidents of farmers' suicides, domestic violence, aging population with poor social support, breaking joint family system, increasing social disparities, migration, unemployment, disaster proneness of vast geographical areas and urbanisation are some of important social issues in India affecting mental health. The complex relationship between these social issues and mental health poses a strong challenge to social psychiatry.

This presentation will discuss the above mentioned issues in the light of their influence on mental health and associated burden, and the role which a psychiatrist can play. The presenter also seeks solutions, what social psychiatry has to offer.

The Future of Social Psychiatry in India

Mohan Isaac
Professor of Psychiatry (Population Mental Health),
School of Psychiatry and Clinical Neurosciences, The University of Western Australia, Perth, Australia;
Consultant Psychiatrist, Fremantle Hospital and Health Services, Fremantle, Australia; Visiting Professor of Psychiatry, National Institute of Mental Health and Neurosciences, NIMHANS, Bangalore.

“Why is social psychiatry still alive?” was the provocative title of an Editorial in a leading international review journal in psychiatry, not quite so long ago. Although ‘social psychiatry’ has a long tradition of over 100 years, it has had varied meanings at different points in time and a wide range of definitions. During the course of the past century, it has seen heydays as well as lean periods. With major advances in the fields of genetics, neurosciences and neuroimaging during the past two decades, the field was considered to be in steady decline and obituaries of ‘social psychiatry’ were beginning to be written.

But then, the larger discipline of ‘psychiatry’ itself seems to be going through an “identity crisis”. It is also under attack from various directions. At least one leading researcher has argued that psychiatry must undergo a process of “creative destruction” to reinvent its future as a premier medical speciality anchored in “evidence based behavioural neurosciences”. Many advanced countries in the world, notably UK and USA are groping with the crisis of ongoing decline in recruitment of medical graduates into psychiatry. So what is the future for psychiatry and social psychiatry, in particular? The late Leon Eisenberg famously noted in 2004, “social psychiatry is not only alive and well, but it has a bright future precisely because of genomics”. The oration will delve into the past, present and future of psychiatry with special reference to the future of social psychiatry in India.
Reviewing the above four needs for good mental health care, the following can be conclusions can be drawn.

The need for mental health services in the community is well documented. However, the utilisation of the available allopathic services is not satisfactory. Population adopts a pluralistic approach to help seeking and this often results in delays in seeking treatment, irregular use of services, and chronicity at the time of first contact with allopathic psychiatric services. There have been limited very good mental health education initiatives like the 'Maan Ki Baath', 'Manochintana' but the mental health profession has not done enough to address the mental health education of the population.

The efforts to take services to the population, (e.g. integration of mental health with primary health care), locate the services in the community (e.g. alternative care facilities in community) and use of community resources of mental health care (e.g. non-professionals in suicide prevention, child mental health, disaster mental health, geriatric care) have been a very important contribution of India to world mental health. However, each of these efforts have had the following limitations: limited coverage, limited crystallisation of the service models, limited or no evaluation, lack of continuous evolution of the programme.

One striking aspect of mental health developments in India is the way mental health professionals have taken up the leadership towards mental health services, more than any other medical professional group. Recently, Prof. Wig referred to this as an important contribution of our profession group. However, the individual initiatives have not resulted in systematisation of the efforts. Even today, there is active debate and discussion whether psychiatrists should confine their work only to 'treating defined mental disorders' or reach towards 'larger social issues and social actions'. One other major limitation is the lack of 'rigour' in evaluating the many initiatives. There is a tendency to do 'something' rather than develop a system to reach services.

The administrative support has been an area of mixed blessings. In the first decade of NMHP, there was no support in funding and a lot of professional initiatives. During the second decade there was good support and during the third decade there was surfeit of funding support. However, funds were spent in 'big' spending initiatives rather than reaching of services to the people. Further, in spite of the NMHP funding, judicial initiatives, specific state level initiatives in Karnataka,
Gujarat, Tamil Nadu, to name a few, there are no administrative mental health units either at the Ministry of Health or the state departments of mental health.

The most important limitation of the three decade journey has been the inadequate technical developments to support the NMHP by the mental health professionals. Thus, at present, the progress of NMHP is patchy and problems many. Last but not least, a universal trend is urbanization and its corollary, higher prevalence of mental disorders. The reasons for that must be studied by mental health workers: poverty, substance abuse, violence, anomie, malnutrition, among others. Response to such psychopathological challenges must also be psychosocial.

I've got you under my skin: interpersonal stress and the medically unexplained symptom

Tom Craig
President-Elect, WASP; Institute of Psychiatry, London, United Kingdom

Medically unexplained bodily symptoms that have no apparent basis in known organic disease and which are thought to have a psychological origin are ubiquitous in medical practice. Stressful experiences and the denial of emotional response are held to be important in the aetiology. In this lecture I will review some of the recent evidence in support of this causal theory showing how abnormal health beliefs may originate in childhood and be shaped by later experiences. This will draw upon studies of the interactions of somatising mothers and their children, the associations of illness with experience of particular kinds of life experience and investigations of the neural pathways that may be involved in motor conversion disorder.

DEBATE

The concept of Global Mental Health is relevant and applicable to India

Against the motion:
McDonaldization of mental health care: How relevant and applicable is the concept of “Global Mental Health’ to India in 2012?

Mohan Isaac
Professor of Psychiatry (Population Mental Health), School of Psychiatry and Clinical Neurosciences, The University of Western Australia, Perth, Australia; Consultant Psychiatrist, Fremantle Hospital and Health Services, Fremantle, Australia; Visiting Professor of Psychiatry, National Institute of Mental Health and Neurosciences, NIMHANS, Bangalore.

India was one of the first among the low and middle income countries (LAMICs) to formulate and adopt a visionary, forward looking and reformist National Mental health Programme (NMHP) as early as 1982. During the past 15 years – 9th, 10th and 11th Five Year Plans, the Government of India has sanctioned...
substantial funds for NMHP and major developments have occurred in the implementation of the programme in the country.

“Global Mental Health” (GMH) these days is being popularized as a new discipline in the field of health. The prestigious Lancet published, not one, but two series on GMH, an initial “call for action” to scale up the coverage of services for people with mental disorders in 2007 and more recently in 2011, a “renewed call for action”. The Lancet series also gave us a new slogan “No health without mental health”. (Remember: the famous Alma Ata slogan “Health for All by 2000”, by universal provision of “primary health care” where mental health is a part and parcel of primary health care). There are now Centres for GMH in cities such as London and Melbourne. The World Health Organization (WHO) has a flagship programme on mental health, famously called the mhGAP – the Mental Health Gap Action Programme, currently being evaluated in four countries, Ethiopia, Jordan, Nigeria and Panama. (Remember: WHO’s five countries project on “Strategies for extending mental health services in developing countries”). WHO recently also passed a resolution on GMH. Now there is even a call for a UN Summit (General Assembly Special Session) for GMH.

“Grand challenges” in GMH have been identified. There is also a “Movement” for GMH – an international coalition of individuals (professionals as well as public) and institutions who are committed to GMH. A new Masters programme (MSc) in GMH to train people to implement GMH programmes and carry out research on GMH is now on offer from the King’s College London and the London School of Hygiene and tropical Medicine.

But, what in fact, is GMH? The Harvard Review of Psychiatry recently brought out a special; issue on GMH as also the journal Transcultural Psychiatry. So, is GMH indeed a new discipline or old wine in new bottle? A well known Western Professor of Cultural and international Psychiatry recently described GMH as “a fashion trend” and compared it to “new pop music”. He observed that “it is nothing entirely new, but there are a lot of new components, a lot of new evidence”. The main purpose of the Movement for GMH is to focus on the huge unmet needs in mental health care, especially in LMICs, to improve access to mental health care and achieve equity in mental health care to all worldwide, reduce/close resource and treatment gap, protect and promote human rights of people affected by mental illnesses all over the world and draw policy makers and administrators attention to mental health policy, funding and personnel issues.

During the past decade and a half, due to variety of reasons which include public interest litigations (PILs), intervention by the Courts as well as the National Human Rights Commission, the Erwadi tragedy, advocacy by small groups of professionals and community mental health project experiences such as the Bellary district programme, there has been steadily increasing political and administrative will to provide adequate financial resources and expand the mental health programme in India. The problems that India faces in the field of mental health currently is not lack of political and bureaucratic will or inadequacy of finances but a lack of professional will and leadership and an effective methodology for expanding the care.

For the Motion:

R. Srinivasa Murthy
Professor of Psychiatry (Retd), The Association for the Mentally Challenged, Hosur Road, Dharmaram College, P.O. Bangalore.

‘Global Mental Health Movement’ is a recent development that addresses a number of initiatives to improve the inequalities in the mental health services across the countries, with a special focus on low and middle income (LAMI)countries. Though the specific name and the group advancing the movement is relatively new, the initiatives in this area are nearly 40 years old. The ‘Global Mental Health Movement’ can be traced to the Sixteenth Expert Committee Report of the World Health Organisation, 1975, titled ‘Organisation of mental health services in developing countries’. This was followed by the 1995, Harvard Medical School initiative, the W.H.O. World Health Report in 2001, the Institute of Medicine Report in 2001, and the most recent W.H.O., ‘mhGAP’ initiatives.

During the last four decades, the movement has been important at two levels. Firstly, it has brought focus on public mental health and community mental health care in LAMI countries (eg. Brazil, Chile, Egypt, India, Iran, Pakistan, South Africa, Sri Lanka, Uganda etc); and secondly, it has generated a large number of innovations in the care in the community and by the community in a number of LAMI countries. The fact that a number of LAMI countries have made progress in developing national programmes of mental health, revised the mental health legislation, a wide variety of innovations at the level of individuals, patients,
families, paraprofessionals, community members and a wide range of disciplines is testimony to the value of this global initiative.

I have been witness to the development of the non-institutional approaches to mental health care in India since 1972. The WHO, 1975, report was a strong stimulus for integrating mental health with general health care, which resulted in the formulation of the NMHP, in 1982, and the NMHP today forms the foundation for the mental health programme in the country. Similarly, the most recent international convention on the rights of the persons with disabilities has spurred the revision of the mental health act to be more rights based legislation. There are a number of other initiatives of global mental health initiatives influencing Indian actions (eg. Richmond fellowship leadership in rehabilitation, international collaborative research in genetics, schizophrenia etc). India has nor dependent on the 'Global Mental Health Movement' but benefitted from the same. In a number of situations it has provided leadership (e.g. nosology, yoga, family movement, CMH etc).

The criticism of the 'Global Mental Health Movement' comes of critics who consider it as 'medicalisation of suffering'; 'vagueness of psychiatric diagnosis'; 'focus on pharmacological interventions'; 'doubtful outcomes of psychiatric interventions'; 'not being sensitive to local customs and practices' ;'loss of personal context in mental health care' and a form of modern 'imperialism'. The other right criticism is the limited progress in developing mental health interventions in countries in conflict like Afghanistan, Iraq, Sudan, Somalia.

Some of the criticisms like the classification system, the limitations of the effectiveness of interventions are reflections of the state of psychiatry as a science. The wide range of initiatives in mental health the care in India (eg. family involvement, integration of mental health in general care, the community approach to detoxification, suicide prevention, disaster mental health care, empowerment of consumers and families etc ) reflect the rootedness of the movement in the socio-cultural context of the country.

The 'Global Mental Health Movement' is important for India, as it has provided the impetus for the public mental health initiatives. However, the movement needs to be further strengthened by (i) greater involvement of professionals for technical innovation; (ii) wider use of the socio-cultural aspects of communities; (iii) better evaluation methods (iv) increased national level research to support the movement and (v) adequate funding. Though mental health programmes have to be 'local' they will benefit from 'global' initiatives.
AWARD PAPERS

BALINT AWARD

Therapist Issues When Working With a Survivor of Child Sexual Abuse

KS Shubrata, Consultant Psychiatrist, Shimoga, Karnataka

Sexual abuse of children has been established across different cultures and countries. When a survivor of a child sexual abuse with multiple psychiatric problems comes to you, a pharmacological approach has a limited role. Working with sexually abused children or adult survivors of childhood sexual abuse is very frustrating, draining and at the same time rewarding. While the horror and aftermath of abusive experiences during childhood are difficult to verbalize for the patient, listening to the narratives of survivors can be harrowing and touching for the therapist. The author here describes a therapist patient relationship in a case of survivor of child sexual abuse. This is the experience with a client Ms S, a 24 yr old lady with past history of child sexual abuse by her sibling, with current diagnosis of dissociative disorder with moderate depression. The doctor here describes her difficulties in dealing with this case while she had just begun her training as a postgraduate student in psychiatry. The presentation would emphasize on how knowledge, experience and pressure play an important role in determining the therapist response within a session and the need for recognition of the same. The author would also stress on the role of supervision during training period which would help in developing a self-reflective stance. The narration would conclude with a discussion on how these facts would help in changing the author’s approach as well as how this would benefit individual clinician in general.

Pain as a Constant Companion: Therapy of a Lady with Constant Unexplained Pain

Mona Srivastava, Assistant Professor, Department of Psychiatry, Institute of Medical Sciences, BHU, Varanasi

Background and History: Ms. N is a 28 year old young mother having a four year old child. She presented for treatment after multiple consultations. The chief complaints were pain throughout the body which was pressing type, persistent with exacerbations during the times when she was upset and thought about day to day problems. The family history revealed that Ms. N had lost her mother when she was in 11th Std The past history revealed that Ms. N had been diagnosed as case of tuberculoma when she was in 9th Std. and was put of ATT which was continued for one year. Progress: The subject was constantly in pain even after pharmacotherapy, biofeedback, and relaxation therapy; hence she was taken up for psychotherapeutic intervention. From a dynamic approach a more directive and open ended approach was gradually taken. Exposition: Gradually the subject was shifted from a dynamic approach to that of a directive open ended one. The therapy revealed the importance of an honest and open communication between a sensitive client and therapist. Lessons from the Therapy: This case also highlights the importance of a holistic method of treatment; if a patient is not responding by usual means then a change of perspective is needed.

Management of a Couple Presenting with Marital and Psychosexual Problems: a Therapist’s Insight

Karuna Singh, Play Therapist, Department of Psychiatry, Government Medical College & Hospital-32, Chandigarh

Today we are living in an era of rapidly progressive science and all medical practices including psychopharmacology and psychotherapeutics are evolving rapidly and one has to keep pace with these developments. In the field of psychiatry, especially psychotherapeutics, core and very important issue is the therapist – patient relationship. This has always held an eminent position in the practice of psychotherapy and this holds true even today. However, the field of psychotherapy poses new challenges, creates new insight and teaches new lessons because of rapidly changing social values. Here, I am sharing a case which tested all my faculties of patience, training skills and execution but, finally improved. The case is about Ms and Mr. R, a newly married couple who initially presented with sexual dysfunction. We initially treated it as a case of ED but, treatment outcome was poor. The poor response prompted us to re-evaluate the couple for understanding the other factors which might have
been overlooked during initial assessment. We were surprised to unearth multiple personal, social and environmental factors which might have caused the sexual dysfunction and thus poor response. The couple, during first assessment had denied these factors. Though, the couple finally improved but it taught me so much that I will always remain indebted to them for introspection of my own errors and inadequacies and the art of overcoming them. The issues of counter-transference, judgmental in my reflections, sympathetic and identification with one of the partner influence of personal upbringing of therapist and ethical issues emerged during the therapy and their handling made me more confident and more professional.

**GC BORAL AWARD I**

**A study of profile of disability certificate seeking patients with schizophrenia over a five year period**

Yatan Pal Singh Balhara¹, Rohit Verma²

¹Assistant Professor of Psychiatry, National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), New Delhi, INDIA; ²Senior Resident, PGIMER and Dr RML Hospital, New Delhi, INDIA

**Introduction**: Schizophrenia has been identified as one of the most disabling condition known to mankind. Till recently there was no published literature on disability certification seeking behaviour of patients diagnosed with schizophrenia. The current study aimed at understanding the profile of patients diagnosed with schizophrenia seeking disability certification for a tertiary level multispecialty hospital in India. **Materials and Methods**: The study was carried out at the Psychiatry department for a tertiary care hospital in India. The evaluation of the subjects was carried out in presence of a primary care giver. First, the diagnosis was established using ICD-10 (International Statistical Classification of Diseases and Related Health Conditions). Subsequently, the disability was assessed using IDEAS. Data were analysed using SPSS (Statistical Package for Social Sciences) software version 17.

**Results**: A total of 169 subjects seeking disability certification over the study period of five years were diagnosed with schizophrenia. Out of 169 subjects 132 (78.1%) were male and 37 (21.9%) were female. There was a statistically significant difference in the marital status of the male and female study subjects. Family history of psychiatric illness was positive in 9.8% of male subjects and 10.8% of female subjects. There was no significant difference between male and female subjects for duration of illness and duration of being on treatment. Male and female subjects did not differ significantly on the IDEAS global score, personal care, interpersonal interaction, and understanding & communication domains of IDEAS. The two groups differed significantly on the work domain. **Conclusions**: Majority of patients with schizophrenia seeking disability certificate continue to be male. However, male and female subjects tend to differ very little on various socio-demographic and illness related variables. The levels of disability are also comparable among males and females. However, the work related disability is relatively higher among males and females continue to be financially dependent on the family members.

**Intimate partner violence (IPV) amongst female psychiatric out-patients – A study from India**

Sandeep Grover, Assistant Professor; Abhishek Ghosh, Senior Resident; Ajit Avasthi, Professor Natasha Kate, Senior Resident; Sunil Sharma, Social Scientist; Parmanand Kulhara, Ex-Professor

Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh

**Background**: Intimate partner violence (IPV), a subset of domestic violence (DV) is expected to be a universal and a cross cultural phenomenon. Although studies from India have evaluated IPV in women in general population, there is no data with regards IPV in women with mental disorders. Studies from West suggest the prevalence rate of IPV to be as high as 63% in women with mental disorders. **Aim**: To evaluate the prevalence and type of IPV in women with mental illness attending psychiatry outpatient clinic of a tertiary care centre. **Materials and Methods**: A self administered intimate partner violence questionnaire was completed by 1995 women suffering from various mental disorders. **Results**: The prevalence rate of IPV was 18%. Amongst the different types of violence, findings of the present study suggest that controlling behaviors were more frequent than other type of violence. The frequency of different controlling behaviors varied from 5.5 to 16%. The frequency of different behaviours amounting to physical violence varied from 1 to 5% and that of different threatening behaviours varied from 2.7 to 9.8%. No significant difference was observed amongst
A different group of psychiatric disorders in relation to the prevalence of violence across most of the items of the questionnaire. **Conclusion:** The prevalence of IPV in women with mental illness is similar to the prevalence rate of IPV in the general population of our catchment area.

**GCBORAL AWARD II**

**Relationship of caregiver burden with coping strategies, social support, psychological morbidity, and quality of life in the caregivers of schizophrenia**

Natasha Kate, Sandeep Grover, Parmanand Kulhara, Ritu Nehra

Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh

**Background:** Although many studies from India have evaluated caregiver burden associated with schizophrenia, data is lacking with respect to the relationship of caregiver burden with coping and quality of life of caregivers. **Aim:** To evaluate the relationship of caregiver burden as assessed by using Hindi Involvement Evaluation Questionnaire (IEQ) with coping strategies, social support, psychological morbidity, quality of life and socio-demographic profile of caregivers in caregivers of patients with schizophrenia. **Methodology:** This study included 100 patients with schizophrenia and their primary caregivers recruited by purposive random sampling. Additionally relationship of caregiver-burden with socio-demographic variables, clinical variables including severity of psychopathology and level of functioning of patients was studied. **Results:** Among the 4 domains of IEQ, highest number of correlations emerged with tension domain. Tension domain had positive correlation with the caregiver being single, time spent in care-giving per day, and use of avoidance, collusion, coercion as coping strategies. Additionally, tension domain was associated with poor quality of life in all the domains of WHO-QOL Bref and higher psychological morbidity. Worrying-urging I domain of IEQ correlated with frequency of visits, problem focused coping and poor physical health as per the WHOQOL Bref. Worrying urging-II domain of IEQ had positive correlation with higher level of positive symptoms, lower level of functioning of the patient, younger age of caregiver, caregiver being unmarried, and problem focused and seeking social support as coping strategies. Supervision domain of IEQ correlated positively with lower income, in being an unmarried caregiver, from urban locality and non-nuclear family. Supervision domain was associated with poor physical health as assessed by WHO-QOL Bref. **Conclusion:** Care-giving burden, especially tension is associated with use of maladaptive coping strategies and poor quality of life and higher level of psychological morbidity in caregivers.

**“Pathway of Care” in Patients of Neurotic, Stress Related and Somatoform Disorders: Study from Tertiary Centre of North India**

Anurag Agrawal, J.K. Trivedi, Adarsh Tripathi

1Senior Resident, 2Professor, 3Assistant Professor

Department of Psychiatry, C.S.M. Medical University, Lucknow.

**Background:** Patients with different mental disorders often do not seek professional help in the early part of their illness. An understanding of the ways by which people seek care for mental disorders, is important for planning mental health services, organization of training and referrals to psychiatrists from other sources of health and social care. The focus of pathway studies has long been only on psychotic disorders. However the need of the hour is to shift this focus to common mental disorders which are also associated with significant disability across multiples domains. **Aim:** To study the sequence and frequency of contacts with different types of care provider and the type of care provided in the pathway of care in the patients of “Neurotic, Stress-Related and Somatoform Disorders (ICD F40-F48)” attending the adult psychiatry OPD of a tertiary psychiatric centre of north India for the first time. **Methodology:** The present study was a cross-sectional study of 156 patients who were assessed on ICD-10, Classification of Mental and Behavioural Disorders-Diagnostic criteria for research, Semi Structured Proforma for Socio-Demographic and Clinical Details, Schedules for Clinical Assessment in Neuropsychiatry and Global Assessment of Functioning Scale. Patients were divided into aware and unaware groups based on their knowledge and information of psychiatric disorders. Pathways to psychiatric care prior to reaching study centre were studied. **Results:** Majority of the study sample (71.79%) were found unaware regarding psychiatric disorders. Traditional faith healers and local practitioners constituted the major portion of the total care providers. Average visits per patient before coming to the study centre were 5.27 (±3.689) for ‘aware’ group and 7.46 (±4.401) for ‘unaware’ group. General Medical Practitioners made 42.17% of referrals, local practitioners 19.80% of referrals and psychiatrist made
14.92% referrals. Faith healers referred only 02.63% of patients. **Conclusions:** The findings explain the indigenous role of our cultural beliefs about causes and explanations of mental illnesses, which continue from generation to generation. Awareness about psychiatric disorders in community plays vital role in early engagement with specialist services, significantly reduces myths/beliefs like supernatural causation, concern related to stigma; and promotes desirable help seeking behaviour and shortens the pathway of care hence possibly improving outcome of these psychiatric disorders.

“To tell or not to tell” – Disclosure of serostatus, stigma and discrimination faced by People Living with HIV/AIDS (PLHA) in India

Koushik Sinha Deb, Senior Research Associate; Anju Dhawan, Associate Professor; BM Tripathi, Professor; Y P S Balhara, Assistant Professor; Department of Psychiatry and NDDTC, All India Institute of Medical Sciences, New Delhi

**Introduction:** Majority of the psychological morbidity of HIV/ AIDS is believed to be linked to stigma and discrimination resulting in late diagnosis and improper medical care. Stigma and discrimination are also important as they affect self-disclosure, which in turn affects high risk behaviour. This study aims to understand the stigma & discrimination faced by HIV positive subjects and explores their disclosure pattern.

**Methodology:** A cross-sectional study with composite quantitative - qualitative design model was used. Fifty male subjects fulfilling the inclusion and exclusion criteria coming for regular treatment at the HIV clinic at AIIMS, New Delhi, India were considered for sample.

**Results:** All subjects thought their diagnosis to be stigmatizing. The most common perceived consequences were neglect by family (58%), discrimination by employers (64%), estrangement by peers (40%), breakage of marriage (38%) and loss of sexual relations (30%). Community & Religious leaders / Doctors / Hospitals were not seen as perpetrators of stigma but as a place for support. Disclosure rates varied with most disclosure to spouse. **Conclusion:** Stigma & discrimination are present in India. Actual stigma faced by patients is lesser than the stigma perceived. Disclosure is a dimensional phenomenon, with patients disclosing to some but not all persons.

**Clinicians’ versus caregivers’ ratings of burden in patients with schizophrenia and bipolar disorder**

Deepak Ghormode, Senior Resident; Sandeep Grover, Assistant Professor; Subho Chakrabarti, Professor; Alakananda Dutta, Ex-Senior Resident; Natasha Kate, Senior Resident; Parmanand Kulhara, Ex-Professor; Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh.

**Background:** Few studies have evaluated the similarities and difference in the clinician and caregivers rating of caregiver’s burden. **Aim:** To compare the clinician-rated and caregiver-rated burden in a

**BB SETHI AWARD**

Explanatory models in patients with Obsessive Compulsive Disorder: An Exploratory study

Bichitra Nanda Patra, Sandeep Grover, Munish Aggarwal, Ajit Avasthi, Subho Chakrabarti, Savita Malhotra

Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh.

**Background:** People of diverse cultural backgrounds make different attributions of illness, symptoms and treatment which in turn affect the help seeking behaviour. Aim was to explore the explanatory models of patients with obsessive compulsive disorder attending a tertiary care hospital located in North India.

**Methodology:** Eighty-nine consecutive patients with diagnosis of Obsessive compulsive disorder (according to the International Classification of Diseases-10th Revision (ICD-10) and ≥ 15 years of age were evaluated for their explanatory models using the causal models section of Explanatory Model Interview Catalogue.

**Results:** The most common explanations given were categorized into Karma-deed-heredity category (70.7%), followed by psychological explanations (62.2%), weakness (20.2%) and social causes (17.9%). Among the specific causes, commonly reported explanations were: fate/chance (42.7%), will of god (37.1%), bad deeds (27%), sorcery (24.7%), evil eye weakness of nerves (37.8%), general weakness (34.7%), bad deeds (26.2%), evil eye (24.4%) and family problems (21.9%). The explanatory models held by the patients were not associated with socio-demographic and clinical variables to a large extent. **Conclusion:** Patients with Obsessive compulsive disorder have multiple explanatory models for their symptoms and understanding the same can have important treatment implications.
population of patients with either schizophrenia or bipolar disorder, using 2 different scales to measure caregiver burden. **Methodology:** Caregivers of patients with schizophrenia or bipolar disorder completed the Hindi-version of Involvement experience questionnaire (Hindi-IEQ) and based on semi-structured interview with the caregivers the clinicians rated the burden on family burden scale. **Results:** The study included 122 patients, 65 with schizophrenia and 57 patients with bipolar affective disorder. There were widespread agreements between clinicians' and caregivers' ratings of burden. Both total objective and subjective burden on FBI as assessed by the clinician had significant positive correlation with total Hindi IEQ scores. More or less all areas of burden on the FBI correlated positively with the tension subscale, worry urging II subscale, and the total Hindi-IEQ scores. Worry-urging I and supervision sub scales of Hindi IEQ did not correlate much with FBI ratings. The caregiver-burden between schizophrenia and bipolar disorder group did not differ significantly on most of the aspects as per the clinicians rating and various subscales of Hindi-IEQ. Caregivers of patients with schizophrenia experienced significantly more burden in the domains of effect on mental health and significantly higher percentage of caregivers of patients with schizophrenia experienced moderate to severe subjective burden. However, the total Hindi-IEQ score was significantly higher for bipolar disorder. **Conclusion:** There is significant concordance between the clinician-rated and caregiver-rated burden in a population of patients with either schizophrenia or bipolar disorder.

**Knowledge, Attitude and Practice related to tobacco use and its cessation among young medical professionals**

*Shalini Singh*

Department of Psychiatry, Lady Hardinge Medical College, New Delhi

**Background:** Medical professionals play a key role in tobacco use prevention because they are often considered as role model by health care users. As such the right attitude, knowledge and practices of these professionals with respect to tobacco use and its prevention forms an important component in tobacco control activity. The aim of the study was to assess the tobacco use among young medical professionals in Delhi, their knowledge about harmful effects of tobacco and their proficiency and clinical practice in dealing with tobacco using health care users. **Methods:** A cross-sectional study was carried out using an anonymous self administered questionnaire based upon Global Health Professional Student Survey questionnaire in young medical professionals in Delhi. The questionnaire was distributed to 226 young health professionals (medical doctors, interns and final year medical students) below the age of 33 years. Descriptive statistics were used to compile and present results. **Results:** The overall response rate was 95%. The sample comprised 215 medical professionals (54% females; mean age was 23.2 years: 52% were medical students, 48% medical doctors). Tobacco use prevalence was 14.6% among doctors and 17.9% among students. All tobacco users were smokers with none reporting chewing tobacco in their lifetime. Among responders, 83.3% considered medical professionals as a role model for their patients (tobacco users 68.75% vs non –tobacco user 86.1%), 79% reported not having any formal training in tobacco cessation and 84.65% did not feel themselves to be proficient in delivering tobacco cessation services. Even though 94.8% do claim to provide evidence based tobacco cessation services. **Conclusions:** The prevalence of tobacco use among young medical professionals is less than that observed in the general population. Surprisingly, none of the study participant reported chewing tobacco which in contrast to the higher prevalence of tobacco chewing among the general population as compared to smoking. The study points towards the requirement of formal training of medical professionals in tobacco cessation practices to make them more proficient. The training in tobacco cessation should be included and made mandatory in the medical curriculum. This will go a long way in developing human resource infrastructure for tobacco cessation services across the country.

**Sexual Dysfunction in Alcohol Dependent Men taking Disulfiram and Baclofen Pharmaco-prophylaxis: A Preliminary Estimate**

*Siddharth Sarkar*

Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh

**Background:** Research looking at the sexual functioning of patients on medication for treatment of alcohol use disorders has been sparse. **Methods:** A case control activity. The aim of the study was to assess the tobacco use among young medical professionals in Delhi, their knowledge about harmful effects of tobacco and their proficiency and clinical practice in dealing with tobacco using health care users. **Methods:** A cross-sectional study was carried out using an anonymous self administered questionnaire based upon Global Health Professional Student Survey questionnaire in young medical professionals in Delhi. The questionnaire was distributed to 226 young health professionals (medical doctors, interns and final year medical students) below the age of 33 years. Descriptive statistics were used to compile and present results. **Results:** The overall response rate was 95%. The sample comprised 215 medical professionals (54% females; mean age was 23.2 years: 52% were medical students, 48% medical doctors). Tobacco use prevalence was 14.6% among doctors and 17.9% among students. All tobacco users were smokers with none reporting chewing tobacco in their lifetime. Among responders, 83.3% considered medical professionals as a role model for their patients (tobacco users 68.75% vs non –tobacco user 86.1%), 79% reported not having any formal training in tobacco cessation and 84.65% did not feel themselves to be proficient in delivering tobacco cessation services. Even though 94.8% do claim to provide evidence based tobacco cessation services. **Conclusions:** The prevalence of tobacco use among young medical professionals is less than that observed in the general population. Surprisingly, none of the study participant reported chewing tobacco which in contrast to the higher prevalence of tobacco chewing among the general population as compared to smoking. The study points towards the requirement of formal training of medical professionals in tobacco cessation practices to make them more proficient. The training in tobacco cessation should be included and made mandatory in the medical curriculum. This will go a long way in developing human resource infrastructure for tobacco cessation services across the country.

©2012 Indian Association for Social Psychiatry
Profile of Patients and Referral Pattern in a General Hospital Psychiatry Unit v/s a Psychiatric Disease Hospital: Which is the Preferred Treatment Setting?

Abhishek Chowhan, BS Chavan, Mushtaq A Margoob*

Department of Psychiatry, Government Medical College, Chandigarh & *Government Psychiatric Diseases Hospital, Srinagar

Background: In India Mental health services are dispensed by way of psychiatric hospitals as well as general hospital psychiatric unit. However there is no study comparing the service delivery in these two settings in Indian or in World literature. The present study compares the socio demographic characteristics, diagnosis and the referral pattern in patients attending these two services. Method: This was a prospective study conducted at Srinagar city of the state of Jammu and Kashmir in India at two centers i.e., Psychiatric Diseases Hospital and psychiatric outpatient unit in the general hospital of the Government Medical College. All the consecutive new cases seeking treatment from the two facilities over one month period were included. The assessment parameters included socio-demographical and clinical which was based on detailed history and physical and mental status examination. The final diagnosis was made according to International Classification of Diseases, 10th edition (ICD-10).

Results: A total of 2340 new patients were evaluated; 1411 (60.30%) from psychiatric hospital and 929 (39.70%) from psychiatric outpatient unit of government medical college. Some patients had more than one diagnosis and hence around 1488 diagnosis were observed in the psychiatric hospital group and 982 in government medical college group with co-morbidities seen in 69 and 42 patients respectively. Major depressive disorder (20.9%), Bipolar affective disorder (25.81%) and psychotic disorders (25.05%) were the main diagnosis observed in the Psychiatric hospital setting whereas Major Depressive Disorder (27.9%), Anxiety Disorders (13.34%) and Parasuicide (9.06%) were the commonest diagnosis in government medical college setting. 50.92% of patients who attended medical college OPD were referred, almost all of them by health professionals from other departments as compared to only 13.76% of patients in psychiatric hospital.

Conclusions: Both the treatment settings have an important role for the service delivery in mental health. Whereas general hospital psychiatric units have an important role in de-stigmatisation and demystification of psychiatry along with the strengthening of consultation liaison psychiatry, psychiatric hospitals are preferred destination for psychotic and chronic psychiatrically ill patients.

Quality of life and its correlates among substance dependent in eastern India: A preliminary study

Om Prakash Giri, Ph.D. Scholar; Mona Srivastava, Assistant Professor; Ravi Shankar, Assistant Professor*

Department of Psychiatry and Community Medicine*, Institute of Medical Sciences, Banaras Hindu University, Varanasi

Background: Substance Abuse is a worldwide problem that causes various problems, which severely affect physical and mental health, social and daily life. Quality of Life (QOL) is increasingly recognized as an important outcome measure in treatment studies and service evaluation. This study assessed the QOL in Alcohol Dependent (AD) and Opioids dependent (OD) and compare the same. It was further aimed to study the relationship between QOL and specified socio-demographic characteristics and social support.

Methods: Cross-sectional assessment of the three groups of subjects was made. AD and OD subjects not in active withdrawal or intoxication were included. QOL assessment was made with the World Health Organization-QOL-Bref Hindi version.

Results: The comparison of the various domains in QOL is depicted on the basis of ANOVA test. All the domains of well-being on the basis of WHOQOL score are showing significant difference. To assess the effect of socioeconomic variables on the quality of life we apply multiple linear regression analysis. Which are not shows the significant result. Conclusions: The study indicates that opioid dependence subjects experience a lower QOL when compared with the other groups studied. Social Support score too had no significant effect on any domains of WHOQOL.

©2012 Indian Association for Social Psychiatry A11
THEME SYMPOSIUM:
MIGRATION AND MENTAL HEALTH

Migration: Boon or Curse

Pradeep Arya, Consultant Psychiatrist, Surrey and Borders Partnership NHS Foundation Trust, UK

Movement and resettlement of people from one place to another and its consequences to health has been the subject of scientific enquiry since 1880 (Ravenstein, 1880). Over the years, psychiatric literature has noted increased rates of certain mental illnesses in specific migrant groups in different parts of the world.

At the time of writing this abstract, the most powerful world leader, a second generation immigrant, is contesting neck to neck in the most anxiously watched democratic election. More than a third of Britain's London 2012 Olympic medal winners were born abroad or had a foreign parent or grandparent (British Future). Over 40,000 doctors in the NHS are originally from India alone and over 28% of medical student intake is from second generation immigrants (BAPIO statistics). Indians are the second richest community in the USA and the richest resident of the UK carries an Indian passport.

Is it an overgeneralization to say that migration is bad for physical and mental health? The International Organisation for Migration reports almost 200 million migrants worldwide have provided young people with a sound body and mind to the global economy, paying nearly $100 billion in taxes alone to the US treasury whilst taking only $5 billion a year in public services!

And is Migration a curse? Mathematician Ramanujan originally refused to come to England as forbidden by Hindu scriptures. Stress and scarcity in England hastened his death at the young age of 32 contributed to by severe vitamin deficiency!

Research on migration has clearly associated it with detrimental effects on both physical (Gleize et al 2000) and mental (Gavin et al 2001) health. UK data (source Royal College of Psychiatrists) shows: Higher rates of suicidal thoughts and DSH in Pakistani, Irish and Caribbeans (Nazroo, 1997); 6 times more incidence of Schizophrenia in Afro Caribbeans (Harrison, 1990) and higher incidence of Anorexia & Bulimia amongst Egyptians and Asians. Various hypothesis including those based on cultural congruity, ethnic density, ethno and ego centricity versus socio centricity, Individualism versus Collectivism (Bhugra and Arya , 2005) have given strong arguments and explanations for how migration becomes an aetiological factor for mental illness. However none has been comprehensive enough to explain complex findings such as why Norwegians have 30-50 % higher psychiatric morbidity in the USA (Ödegaard 1932 hypothesis revisited by Jean-Paul Selten 2002). The latest on the bandwagon is Ethnic Minorities Psychiatric Illness Rates in the Community survey (BJPsych 2012) concluding the buffering effects of Ethnic Density on the risk of psychosis.

Migration is an enigma when it comes to mental illness. It remains a complex phenomenon between cause and effect in the personal histories of the physically and mentally ill people. Their move may have been due to ecological push, higher aspirations or social momentum. They may have been pulled or pushed! It may lead to success or failure! It may be a boon or a bane!!

Manifestation and assessment of mental health issues in migratory population

Savita Malhotra, Sannidhya Varma, Dept. of Psychiatry and Drug De addiction and Treatment Centre, Postgraduate Institute of Medical Education and Research, Chandigarh

Human beings have been migrating from one place to another, whether from rural to urban areas or from one country to another since time immemorial. The reasons behind such movements may range from better educational or economic opportunities, to strife in their country of origin. The life events of these people which led up to their migration, as well as the stresses that they endured during the process of migration and also while living in the new community have a profound impact on the mental health of these individuals. The mental health problems that migrants usually suffer from are diverse, including psychosis, depression, anxiety, substance use disorders, crime, delinquency and alienation. In spite of being a vulnerable population, migrants usually do not get the adequate amount of professional help for their mental health.

©2012 Indian Association for Social Psychiatry
issues for various reasons, which may vary from poor knowledge of the disorders to poor accessibility of the mental health services. It is imperative that once such individuals come in contact with the mental health system, they should undergo a comprehensive evaluation of not just their present symptoms, but also the circumstances of their migration, their present living conditions as well as their customary ways of dealing with stress.

Positive Effects of Migration? - Really!
Sudhir K Khandelwal, Professor, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi

When one thinks of migration, one usually thinks of transnational migration. However, migration can be rural-urban, which is most often the case in India. At the time India’s independence, only 30% of our population was living in the urban areas, while 70% lived in the villages. However, for gaining access to better education facilities, job opportunities, better services and living conditions, a large scale migration of rural population is perpetually taking place, which is likely to see in not too distant future, urban and rural population equalling each other. This kind of migration will have its own share of stress, but in an attempt towards upward mobility and improve their own living conditions, such migrants would willingly face and manage any stress arising thereof, and may not suffer any ill-effects or bad consequences on any short-term or long-term basis. They may accept any hardship as part of the bargain, would not let it interfere their goal of better life down the line. Such migrants continue to maintain a robust link with their families and support systems back home.

The transnational migration could be involuntary or voluntary. Instances of involuntary migration could be the one that took place during the partition of India, when a large population migrated on either side of the border; also the migration that happened during the independence struggle of Bangladesh, one large number of people migrated to India for safety and shelter. However, in time of peace, transnational migration is voluntary and is willing undertaken for reasons of better job prospects and employment, higher education, or experiencing a liberal cultural and social milieu.

A large body of literature is available that has discussed the negative social and psychological challenges and outcomes associated with immigration and settlement in unfamiliar environments. Although the process of migration-adaptation is a challenging experience, it can also mean hope for a better future, safety, and security for many individuals and groups. Groups may not always respond in negative ways and instead may adapt social and support systems based on the home culture to the new culture. The adaptation of these social and support systems are central to the settlement process and provides the context for the experience of belonging and identification.

There is a wealth of research that documents the social and psychological implications of cross-cultural transition and adaptation. Intercultural contact often requires migrants to negotiate group boundaries and identities and make adaptations to meet the demands and challenges of the new contexts. In these contexts migrant groups often find themselves in minority positions and this has implications for the way in which they adapt and negotiate their ethnic and cultural identities.

Berry’s (1997) model of acculturation and migrant adaptation contains four common responses to intercultural contact, including integration, assimilation, separation, and marginalisation. These responses are characterized by shifts in attitudes and behavior toward one's own and other communities. The different responses are also characterized by different mental health outcomes with integration being the most favorable and marginalisation the least. There is general agreement among these models that those who are rooted in their home culture report better social and psychological wellbeing compared to those who are not (Lafromboise, Coleman, & Gerton, 1993). For example, McCubbin, Futrell, Thompson, and Thompson (1998) discuss research showing that participation in ethnic community activities and strength of ethnic identification has positive links with self-esteem and wellbeing. Ghaffarian (1998) found support for the bicultural hypothesis that those who hold onto their home culture while adopting the host culture report better health outcomes.

The details of such hypotheses will be discussed during the conference.

Effects of migration in special population: Children, women and geriatric population
JK Trivedi, Professor & Shashwant Saxena, Junior Resident, Department of Psychiatry, K.G. Medical University, Lucknow.

“Migration” is used when a person or a group of people
move from one place to another, with the intention of staying in the new place for a considerable period of time. It causes considerable distress in life leading to stress resulting in varying psychiatric disorders. Children, women and elderly appear especially prone to migration associated stress.

Children may have difficulty getting admission in schools in new society. Those who get admission generally have difficulty in adjusting with new peer group and teachers. Bullying is not uncommon with those who have just migrated as already existing peer groups do not identify migrated children with themselves. Language and communication is another area where migrated child may find himself secluded.

Women have difficulty adjusting with cultural norms of new society. There is marked variation in which different societies give rights to women and behave with them, what might be just “openness” in one society may be considered as indecency and threat to existing culture in other society. There is also a high possibility of “role reversal” in family area, as she may have to share burden of earning bread with other male members of family. Abuse is also a real threat to newly migrated women.

Elderly are compromised then other age groups in learning new information and exploring things. They may not be having same respect and friend group as it existed in host society. Job and recreational problems of elderly in new society cannot be overlooked.

Above mentioned factors interact with factors like reason for migration, socioeconomic class in which migration has taken place, extent of difference between host and previous society, coping styles of migrating people, acceptance & resources of the host society, duration & extent of migration to effect mental health of migrating people of special population.

SYMPOSIUM

RECENT INITIATIVES IN COMMUNITY MENTAL HEALTH IN INDIA

Development and Implementation of Integrated Community Mental Health Model for Urban Population

BS Chavan, Professor & Subhash Das, Assistant Professor

Government Medical College & Hospital-32, Chandigarh

Goal: To set up community based comprehensive mental health services for reduction in mental health treatment gap in Chandigarh through easy accessibility of mental health facilities, integration of mental health into general health services and developing need based linkages. Objectives: 1. Integration and linkage of proposed mental health services into the general health care at PHC, district hospital and tertiary hospital by training the community based rehabilitation workers (CBRWs), members of local community mental health committee (LCMHC), ayurvedic practitioners, GPs, faith healers and ASHA workers; 2. To ensure seamless delivery and accessibility of services for people with mental illness by developing manpower at the community level which will include a team of mental health professional (MHP) and medical officer at the dispensary/PHC level; 3. To ensure availability of mental health services round the clock for dealing with mental health related crisis and disasters; 4. To promote positive mental health by conducting community meetings and activities related to mental health care. 5. To establish community mental health drop-in-centre that will contribute to capacity building and empowerment of consumers and caregivers along with provision of social and vocational skill training. Activities: 1. At the grass root level, the ASHA workers/CBRWs/caregivers and other members of LCMHC will be trained to identify cases of common mental disorders (CMD). These cases will be motivated and assisted to seek treatment from the nearest PHC. At the level of PHC/ civil dispensary, in addition to the medical officer, a MHP (clinical psychologist, Psychiatric Social Worker / Nurse trained in Psychiatry) will be engaged to facilitate liaison between the community and PHC where medical officer (MO) will be in-charge of mental health services. 3. At the level of CHC, a Counselor will be appointed who will coordinate with the medical officer and MHP at the PHC and the medical officer in-charge of CHC. The Counselor will also co-ordinate with psychiatrists at the District hospital level. 4. District hospital will have a psychiatrist to address all issues related to mental illness, including treatment provisions at outdoor and indoor. The patients requiring short admission will be admitted at the district hospital where 10 beds will be earmarked for emergency mental health problems. 5. DH will be linked to Apex Institute (COE/MHI/Medical College) which will provide [a] Effective clinical care across all streams [b] Development of mental health education material [c] Monitoring of the Community Mental Health Program[d] Training and Education [e] Research and
The two Community Mental Health Drop in Centre will have one vocational instructor, counselor and one psychiatry social worker for each centre. These will be involved in: 1. Counseling for milder mental health issues; 2. Crisis Intervention during mental health emergencies; 3. Home based care; 4. Linkages with other services; 5. Social and vocational training; 6. Screening for health problems and 7. Job placement.

**Outcome variables:** 1. The number of patients referred by the LCMHC to PHC; 2. The number of patients dropped out after discharged from hospital and brought into treatment by the LCMHC and CBRW; 3. The number of patients referred by GPs, AYUSHs and Faith Healers to PHC; 4. The number of community visits made by the core community mental health team; 5. The perceived satisfaction level of patients from the community services; 6. The number of drop-outs from community mental health services; 7. The number of patients attempting suicide; 8. Number of cases brought into treatment; 9. Number of cases received help during crisis; 10. Number of cases received legal help; 11. Number of cases underwent short vocational training; 12. Number of cases provided placement; 13. Number of cases attended day care facility and 14. Number of cases provided home based care.

**Community based model of mental health care in Rural area of Godhara District, Gujarat, India**

Ajay Chauhan, Superintendent, Hospital for Mental Health, Ahmedabad, Gujarat.

Community mental health program envisions mental health care to the doorsteps of everyone. Effective and safe drug treatments have improved quality of life for many mentally ill. Many experiments have proved that primary care doctors can be effectively trained in identifying and treating common mental disorders at PHC levels. The prevalence rate of common and severe mental disorders in Gujarat is approximately 5.55% of the population. Also, the District of Panchmahal consists of large tribal population. The Civil Hospital of Godhra has psychiatric department, the post of psychiatrist has been vacant since last 4-5 months, with 2 psychiatrists practicing in private sector. To overcome this gap of treatment there is an urgent need to establish psychiatric services at PHC & CHC levels.

The goals of the project are to- Increase access to basic community mental health care and decrease the community mental health treatment gap by 40% in district of Godhra (Panchmahal) through- Integrating community mental health care in District health system, Developing training manual and IEC material, Early identification and treatment, Promotion of mental health literacy, Fostering involvement and community participation, and Availability of medicines and supportive infrastructure. Additional objectives, principles, methods and approaches to be adopted, along with key output targets shall be discussed as part of the presentation.

**Extended Outreach Model for Community Psychiatry - Ramanathapuram, Tamil Nadu**

C Ramasubramanium, KK Nagar, Chennai.

Increasing number of people suffering with mental illness and behaviour disorders are neglected and they wander in the streets with no care. The reason is that the family members and the society have myths and misconception about mental illness and lack awareness about the disease and the availability of its treatment. For anything related to mind and behaviour disorders they go to religious persons, native healers and spiritual guides to get counselling and guidance. They don’t want to accept that it is an illness and needs medical treatment.

On the other hand, the existing medical treatment facility is inadequate to treat mental illness and have no mechanism to respond to emergency situations. The medical doctors are not adequately trained to treat the mental illness cases at the Primary Health Care level. The treatment facility is available only at very long distances which people cannot afford to utilize.

This new proposal has taken into consideration the factors that impede the care, treatment and rehabilitation of persons with mental illness and carefully planned the strategies to treat and rehabilitate the persons with mental illness.

This proposal tries to create awareness in the people and to provide treatment at various levels in the community. The mobile camps at village level and treatment at all PHCs in the two blocks chosen from the district would raise the confidence in the people to come forth to treat persons with mental illness. It also tries to mobilize peoples support and involvement in implementation of this unique experimentation in evolving models for the treatment and rehabilitation of the persons with mental illness. The specific objectives are- to create awareness among public, to train the medical doctors and paramedical workers, to provide treatment to the mentally-ill persons, to provide
sustained treatment, care and rehabilitation, to Mobilize the Community Support groups, to create Rehabilitation training centre and vocational training. It is planned to use the following Activities and Approaches for the effective implementation of the project, such as: Establishing Local Working Committee, Building Awareness, Training of Medical Personnel, Creating Treatment facility at the PHC level, Administrative Arrangements, Build up community support and participation, Establishing Rehabilitation training centres, Establishing “Group Homes “as residential long term care for the deserted and orphaned mentally disabled, and Networking with Other Departments and Converging Resources. The author will elaborate explain the salient features of the proposal at the symposium.

Community Psychiatric Care: Tribal Model (Gumla, Jharkhand)

Amool Ranjan Singh, Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Kanke, Ranchi

RINPAS is a nodal institute for implementation of National Mental Health Programme and District Mental Health Programme for the State of Jharkhand. The DMHP at Gumla is operational since June 2009. The Present Project primarily aims to empower the capacity of tribal community and health workforce to recognize, and understand the mental illness, establish an appropriate referral system, and to develop a proper social network on different levels. The goal is to deliver proper treatment, follow-up and socio-vocational rehabilitation that will benefit tribal people affected with mental illness and their caregivers. The project will cover two blocks in order to reach the goal through the delivery of appropriate treatment, follow-up and socio-vocational rehabilitation. This project will be run by RINPAs in collaboration with DMHP Gumla, NGOs and community persons. District Gumla comprises of about 10.25 lacs population with more than 75% belonging to tribal community. The goal of the project is to deliver appropriate treatment, follow-up and socio-vocational rehabilitation that will benefit tribal people with mental illness and their caregivers. Within a holistic framework, this will improve the emotional and social well being of the tribal community and decrease their social disadvantage. Specific objectives, principles, methods and approaches to be adopted, along with key output targets shall be discussed as part of the presentation.

WASP SYMPOSIUM: 'THERAPEUTIC ALLIANCE' AND 'THERAPEUTIC RELATIONSHIP' RE-VISITED.

Therapeutic Alliance and Therapeutic Relationship Revisited: Cross-cultural concepts related to Therapeutic Alliance and Therapeutic Relationship

Roy Abraham Kallivayalil
President, Indian Psychiatric Society; Secretary General, World Association for Social Psychiatry; Vice-Principal, Professor & Head, Dept of Psychiatry, Pushpagiri Institute of Medical Sciences, Tiruvalla, Kerala.

This paper discusses the Indian concepts on Therapeutic Alliance and Therapeutic Relationship and its cross-cultural implications. Charaka Samhita (1\textsuperscript{st} century AD) is an ancient Indian book which emphasizes, “Relieve suffering with compassion even at the cost of discomfort or risk to oneself”. This is one of the cornerstones of treatment in the ancient Indian setting. The therapeutic alliance was one of Guru-Chela (Teacher- Disciple) relationship between the patient and the physician. Physician, Patient, Medicines and Attendants were considered as the four important pillars. The Physician's role was central and he guides, regulates and instructs the other three. Patient was more often considered as passive recipient of benefits. Physician was like a cook and the other three like utensils, fuel and fire. Without the cook, others have no role (Venkoba Rao 1987).

In modern India, especially under the British rule, things have changed and western influences have crept in. But the ancient Indian cultural values and thinking still have a profound influence in determining therapeutic relationships. Hippocratic tradition is still very much respected in the country. The physician was often seen as a demi-god and the benevolent authoritarianism of the physician was visible. Paternalistic tradition was dominant. But in the last two decades, the waves of globalization and commercialization are sweeping India as well leading to breakdown in physician-patient trust.

How therapeutic alliance and therapeutic relationship has influenced the model of early intervention in psychosis.

Tom KJ Craig
Institute of Psychiatry, London, United Kingdom

There is a wide consensus that better outcomes in first episode psychosis are obtained by ensuring minimal delays in starting treatment and by sustaining treatment beyond an initial remission in order to minimise relapses. However it is also widely
acknowledged that as symptoms remit, young people often resist continuing treatment and play down the significance of an initial episode resulting in a tussle between health professionals who want to maintain treatment and the young person who denies the significance of the episode and who wishes to break away from what is seen as intrusive monitoring and interference in their lives. Data are presented from the Lambeth Early Onset (LEO) randomised controlled trial to show the steps taken to promote strong therapeutic alliances that were effective in promoting treatment uptake and adherence across an 18 month period.

The role of family in patient-professional 'Therapeutic Relationship'

Michaela Amering

Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria

Context - The call for inclusion of service users and their families and friends as equal partners in delivery and planning of mental health care is an exciting challenge worldwide.

Objectives – Consequences and challenges of changes in settings and culture of therapeutic contacts with empowerment and recovery-orientation promoting new roles and responsibilities for patients, for family carers and for mental health professionals, will be presented and discussed.

Key messages - New rules, e.g. user and family involvement and recovery-orientation, as well as new tools, e.g. shared decision making and crisis planning, have emerged. A focus on collaborative models of care and individual choice confront all parties concerned with an area of conflict between the concepts of empowerment and self-determination, evidence-based medicine, and mental health legislation. Developments to meet these challenges successfully must use the expertise of service users and family carers as well as clinicians.

Collaborations between service users, family carers and mental health professionals have the potential to move beyond a deficit model of mental illness towards a focus on the promotion of health, recovery and resilience, and a broadening of treatment goals beyond symptom reduction and stabilization. Recovery and resilience are concepts as well as research and practice fields that hold special promise for sharing interest and experiences.

The Trialogue experience – an exercise in communication between service users, families and friends and mental health workers on equal footing – is indicative of our capacity for gaining from serious discussions of adverse issues, such as family trauma and coercion in psychiatry, as well as the great possibilities of cooperative efforts and coordinated action towards better mental health for all.

Conclusions - Cooperative and coordinated efforts including service users, family carers, their spokespersons and public health advocates offer formidable chances to reduce stigma, discrimination and social exclusion, currently seriously limiting clinical and other efforts towards recovery.

'Therapeutic Relationship': A psychotherapeutic perspective

Vijoy Varma

Clinical Professor of Psychiatry. Indiana University School of Medicine, USA.

As the famous American trial lawyer said, "Words of comfort, skillfully administered, are the oldest therapy known to man." Doctor-patient relationship is one of the oldest professional relationships known to man. In view of its potential for both good and harm, it is no wonder that it is rigorously controlled by the society. It is even more so for the psychotherapeutic relationship, between the patient and healer.

Psychotherapy can be viewed as a contractual relationship, to attempt a therapeutic change. In the transcultural context, the relationship between the patient and the therapist can be said to vary across cultures. The doctor-patient relationship in West is a purely professional relationship; contractual, formalized, confiding and confidential; addressed to identified specific needs, based on clearer defined boundaries around individuals with individual rights and prerogatives.

As opposed to West, in the traditional societies of Asia and Africa, all relationships are multi-dimensional, subserving a myriad of functions. The same applies to a doctor-patient relationship. Doctor-patient relationship more closely approaches primary group, filial relationship, with patient's dependency needs playing a greater role, demanding a more assertive, caring and empathic role for the doctor. The doctor has been and remains a friend, philosopher and guide, a wise person, a village elder, and a benevolent senior, as also a family member. His objective is to help in all possible ways, to total growth, development and
actualization, and not just in the narrow confines of the illness.

There is a clear need to take cognizance of cross-cultural differences in doctor-patient relationship, so that various cultures can benefit from each other’s model and experience.

**SYMPOSIUM**

**COMMUNITY RESPONSE TO SUBSTANCE ABUSE IN NORTH INDIA**

**Emerging Trends in Substance Abuse**

*Debasish Basu*, Professor of Psychiatry, PGIMER, Chandigarh

Substance abuse cuts across time and space; it spans through societies, cultures, classes and epochs. However, patterns of substance are far from static. Across time and across socio-cultural milieu, newer substances emerge as trends. In India, the traditional substances of abuse have always been alcohol, opium, cannabis and tobacco – all ‘natural’ products, and often socially sanctioned to a certain extent or at least tolerated modestly. Since the 1970s and especially the 1980s, semi-synthetics and synthetics started entering the market on a large scale. If 1970s emerging trend was amphetamines, methaqualone and barbiturates, then 1980s were dominated by heroin and other opioids. 1990s continued this trend, with ever expanding opioid products such as buprenorphine, dextropropoxyphene, codeine-containing cough syrups, diphenoxylate (as in Lomotil) etc. But since mid-2000s or for the last decade, further newer trends are emerging regarding non-opioid drugs. These are: (a) the so-called club drugs, rave drugs, or designer drugs; (b) cocaine, (c) Ayurvedic or Unani drugs containing opium, and (d) inhalants. The most alarming trends are the easy accessibility of many of these prescription drugs and other products, and the attitudinal change in today’s youth to “try new things”. Along with political will and effective supply control, a concerted community response will be required to deal with the situation and to bring about demand control at the community level.

**Community Response to Changing Patterns of Substance Abuse**

*Ravindra Rao*, Assistant Professor, National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi

Substance use disorder has gained significant attention in recent years in India, largely due to changes in the pattern of substance use and its attendant complications. Specifically, substance using populations such as people who inject drugs (PWID), female drug users and adolescents using substances has gained increased attention. As compared to traditional models of service provision through hospitals, responses from community groups and those based in community settings have a number of advantages. Community based settings are able to easily reach out to the most vulnerable population, and have the ability to cover large number of affected population. These responses are also readily accepted among the local population, and demand less resources.

Recent mapping and Sentinel surveillance carried out by National AIDS Control Organisation (NACO) shows Injecting Drug Use (IDU) to be present in almost all the states of India, and consequently the prevalence of HIV is very high in this population. With advocacy efforts from community groups as well as with increased focus on HIV from all quarters, HIV prevention interventions for PWID have increased to more than three-fold in last five years. Additionally, Opioid Substitution Therapy (OST), which is an evidence-based long-term treatment and an effective HIV prevention strategy for PWID, is being scaled up in India by NACO using collaborative GO-NGO model. A number of interventions focused on female drug users based in North-east have been initiated. The issue of inhalant use among adolescent population has been gaining prominence, and pilot projects carried out in community based settings show that it is possible to reach out to this group.

Due to their proximity to affected population, community based responses are also sensitive to the changing patterns of substance use, and are able to respond faster. The community based models serve as ‘ready-reckoner’ for the Government to plan and scale up interventions.

**Community response to substance abuse in Northern India: Government Initiatives and Policies**

*AK Kala*, Clinical Director, The Mind Plus, 95-A, Model Gram, Ludhiana

In view of the fact that historically, voluntary sector in North India has never been very active in the field of mental health and substance abuse, as compared to South India, one would have expected the state governments in the North to come forward and fill the gap. What has happened, particularly in the area of substance abuse is actually the opposite. The
governments have allowed the whole landscape to be dotted with shady 'centres' for treatment of substance abuse disorders which are regulated by lax rules, rendered useless by a laxer implementation. The definition of mental illness in the Mental Health Act-1987 not clearly including Substance Abuse Disorders and a turf dispute over whether the area should be administered by the ministry of health or the social justice actually provided rationalization to the cash strapped ministries of health to abdicate the responsibility, beyond the recent initiatives aimed at harm reduction, which are driven by the HIV rather than the mental health agenda. It is argued that the way forward for the government is to integrate the treatment of substance abuse disorders within the District Mental Health Programme, which the government is planning to expand to cover, in a staggered manner, all the districts of the country in the 12th five year plan.

**Efficacy of psychosocial interventions in substance use**

Sonali Jhanjee, Associate Professor, National Drug Dependence Treatment Centre, All India Institute of Medical Sciences

In the last 30 years, there has been significant progress in the development and validation of psychosocial treatments for substance abuse and dependence. For many harmful forms of substance use, psychological interventions are the most proven forms of effective treatment. This is true for substances such as cannabis, stimulants and cocaine. For other drugs such as heroin, they are more often combined with pharmacological treatment. Psychosocial interventions with the strongest evidence and expert consensus for treating problematic drug and alcohol use are Assessment and Brief Intervention, Motivational Interviewing, Relapse prevention, Contingency Management and Cognitive Behaviour Therapy. Psychosocial interventions also include self-help groups such as Alcoholic Anonymous (AA), Therapeutic Communities (TCs) and various kinds of family interventions. Brief Interventions are particularly effective in the context of opportunistic screening and in medical settings for people not seeking alcohol and tobacco treatment thereby filling the gap between primary prevention efforts and more intensive treatment. Methadone and buprenorphine are commonly prescribed to help treat opiate dependence. Psychosocial approaches in conjunction with these drugs for opioid dependence are successful in helping keep users in their treatment programme and result in better treatment outcomes than methadone and buprenorphine alone. Contingency Management relies on rewarding positive behaviours and monetary and nonmonetary rewards typically have been made contingent on negative toxicology screens, indicating abstinence from drug use. The approaches have shown consistent success, with drug use disorders ranging from opiate and cocaine dependence to nicotine dependence. Functional analyses and strategies for changing higher-risk situations for drug use in either relapse prevention or other cognitive behavioral formats have become established treatment.

Overall psychosocial interventions help in better retention of patients on long-term pharmacotherapy, address the individual psychosocial needs of the patient, help in community reintegration and are among the available treatment options for persons using substances such as cannabis, stimulants and cocaine. However, it is not clear which treatment modalities will benefit the individual patient the most. There is also a need for research on psychological interventions in polydrug misuse, in people with psychiatric comorbidity and in people with more severe addiction problems. Future research on psychological interventions needs to identify the key 'active ingredients' which lead to a successful treatment outcome for particular groups of substance misuser, as well as treatment 'matching' effects in more typical treatment settings.

**CME SYMPOSIUM**

REHABILITATION OF PSYCHIATRIC PATIENTS

Rehabilitation of Patients with Psychoses

Debasish Basu, Professor of Psychiatry, PGIMER, Chandigarh

Psychiatric rehabilitation is the systematic application of psychosocial interventions designed to improve the symptomatic and functional course of a major psychiatric disorder. The primary treatment goal for patients with psychoses is symptom remission and an improved quality of life. Psychiatric rehabilitation has been shown to be effective in improving symptomatic and functional outcomes by teaching relapse prevention skills to patients and their caregivers. Relapse prevention interventions are most effective when they are provided in the context of a therapeutic relationship that is aimed at helping patients achieve personally valued goals. The patient's motivation to
achieve the set goals can be harnessed to reduce vulnerability to relapses. In addition to interventions that directly target relapse prevention, psychiatric rehabilitation approaches can indirectly reduce vulnerability to relapses by improving areas of functioning such as interpersonal relationships, long-term competitive employment, burden of psychotic symptoms, and cognitive functioning. A wide range of psychiatric rehabilitation methods have been shown to be effective for severe mental illnesses. The three broad domains of such methods are: vocational, social and cognitive rehabilitation. Many psychiatric rehabilitation methods focus on improving the person’s skills or competence, providing environmental supports, or using a combination of both. For example, learning illness self-management or social skills methods improve patient competence, family psychoeducation provides a more knowledgeable and supportive family milieu, and supported employment combines improved patient skills with environmental supports to facilitate work in the community.

Rehabilitating Wandered Away From Home and Abandoned People with Psychiatric Illness

Bansi M Suwalka
Ex-Associate Professor & Head, Department of Psychiatry, Govt. Medical College, Jamnagar.

If THE MENTAL HEALTH CARE BILL, 2011, posted on the ministry website, is presented and passed in winter session of Parliament, then this law is not in keeping with our culture and circumstances! It is rather more relevant to America or Europe. It is true, in USA and Italy, people were deinstitutionalised. But it is equally true that these countries have robust social service for people sent out of institutions. In India, not only institutions, run by Govt. or otherwise, have been inadequate in number but many of Government’s have been closed. Non-government’s are negligible. No BANYAN has yet been replicated. The bill talks more of procedures than feasible solutions. Discussion about “Advance Directive” occurs in excessively great length. This phenomenon is alien to us. The placement of abandoned people with psychiatric illness is mentioned in a perfunctory manner. The solution suggested is in a grandiose manner: "If one is homeless, then, that does not mean the individual would not be taken care of! Such people would be provided group homes in the community. And, lo and behold, the problem, once for all, is over! We will discuss these issues and see whether - powers that be - can still be influenced. This is last opportunity to assert our opinion. First time it was 75 years. This time it has been 25 years. (It may sound harsh, but I believe, the main achievement of this bill has been to convert rough terminology into decent one - improvements are there but not to desirable level).

Cognitive Remediation Therapy in Schizophrenia

Indira Sharma, Professor & Head, Chandrama Chaudhury, Resident, Department of Psychiatry, Institute of Medical sciences, Banaras Hindu University, Varanasi

Cognitive impairments in schizophrenia are major impediments to rehabilitation. Cognitive Remediation Therapy (CRT) addresses the problem of cognitive dysfunction in schizophrenia. The paper presents the evidence accumulated in recent years on CRTs in Schizophrenia. Apart from anecdotal reports, there are 8 randomised controlled trials (RCTs) and 3 meta-analyses. Cognitive domains targeted were working memory, planning, cognitive flexibility, attention, speed of processing, verbal learning, visual learning, memory, and executive functioning. Computer-based and non-computer-based packages have been employed. These have given usually in laboratory based settings; sometimes with home assignments. The study population was schizophrenia. Improvements in working memory occurred and were durable. Cognitive flexibility also improved on follow up. Effect size for visual learning and memory was not significant. Planning scores did not change appreciably in a few studies. Better planning scores were noted in patients with clozapine pretreatment. Cognitive benefits continued in follow up; the effect size being moderate. Cognitive performance was independent of length and method of training, but functional outcome was dependent on the type of programme availed. The combination of drill practice and strategic coaching (as in NEAR) was better than anyone alone. Signs, symptoms and self esteem also improved post-treatment. Conclusion: Overall, CRT was beneficial on the cognitive outcome of schizophrenia and is durable.

Rehabilitation of Married Women with severe mental illness

Mamta Sood, Associate Professor of Psychiatry, AIIMS, New Delhi.

©2012 Indian Association for Social Psychiatry A20
Severe mental illness like schizophrenia and bipolar disorders are difficult to manage due to chronicity, poor response to treatment and associated significant disability. Amotivation, negative symptoms, depression, poor drug compliance are some of the illness related variables related to poor rehabilitation. In married women, these difficulties are compounded by various psychosocial factors like the multiple roles assigned to them like child-bearing and child-rearing, running the home, fulfilling several other social responsibilities and also in some cases, earning income for the family. In addition, they are less likely to receive appropriate health care when sick. In most cases, their own families have to take on the responsibility for care if they become ill in contrast to married men where wife remains primary caregiver. They also experience stigma related to marriage, pregnancy and childbirth. The research suggests that women with schizophrenia experience better course and outcome. However, due to the above mentioned factors, the experience of severe mental illness in married women affects their life in a negative way. The rehabilitation needs of married women should be addressed taking into account these psychosocial issue

**SYMPOSIUM**

**URBANIZATION AND MENTAL HEALTH**

**Urbanization: Its effect on socio cultural aspects and psychological functioning of city dwellers**

*B S Chavan*, Professor & Head, Government Medical College & Hospital-32, Chandigarh

There is rapid urbanization all over the world. Urbanization has led to industrial and economic development. Thus, it has brought many advantages for the individuals who have shifted to the urban settings. The added benefit of urbanization might include better educational, health, and recreational facilities. However, in addition to the advantages, it has brought with it a set of disadvantages also. There is strong evidence that urban people are much more likely to report mental illness and depressive symptoms than non-urban population. The high incidence of psychological problems among urban population might be mostly because of higher stressful life events, poor socialization, reduced social support, pollution and congested accommodation. Mental health problems in urban context, such as depression, aggression and violence, crime, anxiety, sadness, substance abuse, and personality disorders, may be caused by poverty, fear of crime, ethnicity, and race. Behavioral problems also occur more frequently among people in urban areas and these might include sex related offences, gambling, and corruption behavior. These mental and behavioral problems of urbanization affect the entire population in the cities, especially the vulnerable section: elderly, children, and women. In addition to self suffering, the rapid urbanization has crumbled the health care and other life saving facilities in the cities. These facilities and infrastructure was planned for the people living in the cities and the rapid growth in the urban population due to migration was not taken into account at the time of planning. The movement has left behind elderly, women and children to look after themselves in the rural areas.

**Urban-Rural differences in Psychiatric morbidity: Is Urbanization responsible?**

*Mamta Sood, R K Chadda*, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi

Over last few decades, urbanization has occurred at a fast pace; this has posed significant challenge to the individual and society at large. Rapid urbanization has also resulted in gross mismatch between available mental health resources and needs. The urban living has been associated with increased prevalence of psychiatric illnesses such as major depression, schizophrenia, and anxiety and mood disorders. Prevalence of mental disorders in urban population has generally been reported higher as compared to the rural population, though the extent of difference has been variable across different studies. The mechanism by which urbanization contributes to psychiatric morbidity is not clear. The relationship between urbanization and psychiatric morbidity is reciprocal. Some of the factors associated with urbanization like greater life stress, difficult living conditions, lack of social support and social isolation contribute to mental ill health. It has also been proposed that urban environment might influence mental health in early life e.g. prenatal exposure to viral infections and poor nutrition. Mental illness itself can lead to loss of productivity and isolation. However, urban residence has its advantages also like availability of better mental health services and facilities. In the present paper, the role of factors associated with urbanization in relation to psychiatric morbidity will be discussed.

**Urbanization and Mental health: Influence of urbanization on mental health in vulnerable populations: Children, Women & Elderly**

*Roy Abraham Kallivayalil*
Urbanization has profound influence on mental health. As people migrate from villages to the cities in search of employment or better opportunities, the infrastructure in cities get strained, unable to accommodate the rising number of people. Risk of poverty and risk of environmental adversities increase. Decreased social support and breaking down of joint families, consequent to urbanization will have more adverse effects on vulnerable populations like children, women and elderly. In general, poor people experience environmental and psychological adversity that increases their vulnerability to mental disorders (Patel, 2001). Mental disorders associated with urbanization include depression, substance abuse, alcoholism, crime, family disintegration, and alienation. These will have more deleterious effects on children and women. And with increasing life expectancy, dementia will become a major problem, especially in the cities. Anxiety and depression are more prevalent among urban women than men and, are believed to be more prevalent in poor than in non-poor urban neighborhoods (Naomar Almeida-Filho et al. 2004). The metaanalysis by Reddy and Chandrashekhar (1998) revealed higher prevalence of mental disorders in urban area i.e., 80.6%, whereas it was 48.9% in rural area. With urbanization and increase of nuclear families, there has been increasing incidence of domestic violence against women. Thus urbanization poses a big challenge to vulnerable populations like women, children and elderly.

A Synthetic Perspective (of Urbanization): Can Good and Bad be Balanced? Viewpoint of a Social Scientist

J.K.Trivedi, Professor, & Saranya Dhanasekaran, Junior Resident, Department of Psychiatry, K.G. Medical University, Lucknow.

Urbanization is inevitable due to industrialization and an increasing population. Between 2011 and 2050, the world population is expected to increase by 2.3 billion with the population living in urban areas projected to gain 2.6 billion (United Nations, 2011). Thus, the urban areas of the world are expected to absorb all the population growth expected over the next four decades while at the same time drawing in some of the rural population.

Most of the population growth expected in urban areas will be concentrated in the cities and towns of the less developed regions. Developing countries thus face a double burden. They will face high levels of infectious diseases and the risk of death during pregnancy and childbirth and simultaneously confront new challenges from chronic diseases.

Urbanization can thus be viewed as a coin with two sides. On one side, urbanization offers myriad benefits like access to better educational and medical services, increased literacy and greater earning potential. People of different religions, ethnic backgrounds, social classes and races reside in the same area leading to better social integration in urbanized areas.

On the other hand, it leads to negative impacts on social, economic, and psychological characteristics of people living in cities. While urbanization brings industrial and economic development, its downside can be stress, worse living conditions, alienation, unstable employment and changed behaviours, and these have been shown to have a negative influence on mental health. Mood and anxiety disorders are more prevalent in city dwellers and the incidence of schizophrenia is strongly increased in people born and raised in cities. Urbanization may have a synergistic effect with genetic vulnerability in increasing the incidence of mental illnesses. Recent studies have also shown that city living and urban upbringing affect neural social stress processing in humans.

Thus judicious use of resources, balanced approach to development, and sound government policies are advocated for appropriate growth of advancing economies of South-Asian region. The study of the determinants, extent and outcome of the association between urbanization and mental health is the need of the hour and requires multi-disciplinary research by social scientists, social psychiatrists and public health professionals.

Adarsh Tripathi

SYMPOSIUM
STIGMA OF MENTAL ILLNESS

Speakers

Rajiv Gupta, Senior Professor, Department of
Psychiatry, PGIMS, Rohtak

Arunima Gupta, Associate Professor, Department of Psychology, MDU, Rohtak

Adarsh Kohli, Professor, Department of Psychiatry, PGIMER, Chandigarh

Naresh Nebhinani, Assistant Professor, Department of Psychiatry, PGIMS, Rohtak

Sub-topics

1. Introduction: What is stigma, stigma in psychiatry, its impact?
2. Stigmatization of Psychiatry & Psychiatrists
3. Interventions to combat the stigmatization of psychiatry.

Summary

Despite an increase in available treatment options, expanding health care facilities and high recovery rates from mental illness, stigma towards psychiatry continues to prevail. It is not only the general public that views psychiatry and psychiatrists negatively but also the medical students, health professionals other than psychiatrists and mental health professionals, families of patients as well as the media. These negative attitudes cause delay in seeking professional help for the patients, discriminate against patients and their families, and hinder in the desired social support, optimum health care and other facilities. These negative attitudes further adversely affect the outcome of psychiatric disorders. This symposium addresses the concept of stigma, attributing factors as well as measures to manage and prevent stigmatization of psychiatry as a subject and psychiatrists as professionals.
WORKSHOPS

Qualitative Research: From Definition to Design

FACILITATORS: Louise Taylor (UK), Paul Kingston (UK), Sharmi Bhattacharya (UK)

BACKGROUND & NEED:
This workshop will explore the qualitative research paradigm and its relevance to practice. Working interactively throughout the workshop we will locate qualitative research within the wider context of investigation and in so doing help you to gain an appreciation of the various approaches/methods which may be utilised. We aim to help you to develop your understanding of writing research questions which have a qualitative focus, explore some of the fundamental differences of gathering qualitative research data and finally develop an appreciation of how this type of data may be analysed.

IDENTIFIED OBJECTIVES:
1. Define qualitative research
2. Identify and evaluate different methods of qualitative research
3. Accurately write research questions which have a qualitative focus
4. Identify and evaluate how qualitative methods may be implemented in practice
5. Demonstrate an appreciation of the methods of data analysis

Rehabilitation in Schizophrenia: Case-based Skills Training Workshop

FACILITATORS: BS Chavan, Subhash Das, Nitin Gupta, Paramleen Kaur, Ajeet Sidana

BACKGROUND & NEED: Schizophrenia and related psychotic illnesses are probably the most debilitating and devastating of all mental illnesses; both for the individual and his/her family. However, with the advent of atypical antipsychotics and updated-cum-comprehensive management guidelines, there has been an improvement in the control/removal of symptomatology. But, evidence suggests that this advancement is skewed towards the attenuation of positive symptoms rather than negative symptoms.

There are considerable number of patients with schizophrenia who experience, on an ongoing basis, the 'negative' symptoms and/or 'persistent positive' symptoms. For such individuals, sole/predominant use of antipsychotics does not seem to provide answers. They need an integral component of 'non-pharmacological techniques', which can be of different types and implemented at different levels and stages of the illness.

Additionally, over recent years, the emphasis has shifted from 'treatment of symptoms' to 're-integration into the society'. In keeping with this paradigm shift, there is an increasing emphasis on implementing the model of 'rehabilitation' for patients with schizophrenia. This workshop shall focus on the concepts related to rehabilitation and attempt to provide an understanding of how to assess and manage an individual using a 'rehabilitation' paradigm.

IDENTIFIED OBJECTIVES:
1. To understand the various concepts linked with rehabilitation in schizophrenia.
2. To understand the various parameters/components which contribute towards determining the process of Rehabilitation?
3. To be able to evaluate the patient with schizophrenia for possible Rehabilitation.
4. To be able to determine the pathway of care for rehabilitation of a particular individual.
5. To be able to determine the most appropriate management strategy (or strategies) as regards rehabilitation of a particular individual.

Micro Skills of Therapeutic Listening in Psychotherapy

FACILITATOR: V Sayee Kumar

BACKGROUND & NEED: Unlike any other practice, psychotherapy is unique in addressing the most personal concerns of people in close quarters. While good listening is a basic requirement to become a Therapist, but it is equally important to refine and develop. Due to limited facilities for systematic
Psychotherapy Training in India, our graduates in mental health come out either untrained or under-trained in psychotherapy. Especially in mastering specialized skills like active listening, advance empathy etc. But the demand for such services in India is growing. So it is proposed to conduct this exercise with a format which includes a combination of brief presentations, lecture, discussion, interaction, demonstration, role play, evaluation and exercises. A care is taken to make the content and process relevant for Indian setting. At the end there will be a feedback and reflection from the participants. It is an attempt to share the knowledge and build a competency in therapeutic listening of the participants. In a fast developing country like India, it is very important to ensure required human resource development in the mental health. The fast expanding urban India expects effective non-pharmacological therapeutic interventions for their personal conflict resolutions. But we do not have adequate trained and skilled man power to offer specialised services like psychotherapy. So the best alternative is to offer short term and focused competency building exercise in psychotherapy skills in professional meets. This workshop is best suited for residents, in-terns and budding professionals in mental health disciplines who will find it useful. Mid and senior level practitioners may find it interesting to update themselves.

IDENTIFIED OBJECTIVES:

1. To sensitise the participants of the therapist's verbal and non-verbal behaviours during psychotherapy.
2. To give a training opportunity to our mental health professionals for some experiential learning.
3. To explore various nuances of therapist – patient communication.
4. To develop skills in observing verbal and non-verbal aspects of therapeutic Listening.

Developing Integrated Mental Health Services in Acute Hospital Care

FACILITATORS: George Tadros (UK), Paul Kingston (UK)

BACKGROUND & NEED:
This workshop describes a service evaluation project carried out conjointly by members of the Rapid Assessment Interface and Discharge liaison team (part of Birmingham and Solihull Mental Health NHS Foundation Trust) and members of Staffordshire University. The Mental Health Rapid Assessment, Interface and Discharge (RAID) Team provides a unique mental health service. It delivers a comprehensive range of mental health specialties within one team so that all patients over the age of sixteen can be assessed and treated, signposted or referred on to another service appropriately. The team has a dual function combining direct assessment and treatment with the provision of high quality education, training, clinical support and supervision in mental health interventions. This is designed for general hospital professionals, patients and carers within the hospital.

It consists of a service evaluation and extension of the current RAID service at Birmingham City Hospital, in the area of old age psychiatry. The aim was to screen all older adults aged 65 and over, admitted to the Medical Assessment Unit, utilising four standard screening tools. An evaluation of the effects of early detection of psychiatric illness and intervention by the RAID team facilitated in this way was carried out.

This report provides a summary of all the findings obtained through the research, with a description of the methodology used and a discussion of the findings in conjunction with their implications.

Many countries, including the UK, are experiencing an ageing of their population, with estimates that the percentage of people aged 65 and over in the UK will increase by 59% between 2000 and 2031. This has considerable implications for the health-care system. Recent figures suggest that even now, two-thirds of hospital beds of general hospitals are occupied by older people (Royal College of Psychiatrists, 2005). Moreover, elderly medical inpatients have higher rates of psychiatric disorders than are found in the general elderly population. According to a systematic review carried out by the Royal College of Psychiatrists (2005), the psychiatric co-morbidity rate of older people in general hospitals is as high as 60%, with the three most common psychiatric disorders in that population - Dementia, Depression and Delirium - accounting for 80% of the psychiatric diagnoses.

IDENTIFIED OBJECTIVES:

1. Understand the challenges related to Dementia Delirium and Depression
2. Have an awareness of the importance of Dignity

©2012 Indian Association for Social Psychiatry
3. Appreciate the impact of Dementia, Delirium, Depression and Dignity in an acute hospital setting
4. Have an understanding of the Rapid Assessment Interface and Discharge (RAID) service (an age-inclusive, drugs/alcohol inclusive, consultant-led service that is fully integrated into the structure and function of an acute hospital)
5. Know how to evaluate and research the challenges faced by psychiatric services in an acute hospital setting
6. Design an appropriate intervention service in Mental Health
7. Evaluate the impact of RAID

The Global Mental Health Assessment Tool-GMHAT/PC

FACILITATORS: Vimal Kumar Sharma (UK), Gagandeep Singh (UK)

BACKGROUND & NEED: Sharma and Copeland developed computer assisted clinical interview, the Global Mental Health Assessment Tool GMHAT/PC to assist general practitioners and front line health professionals to make a quick, convenient, and comprehensive, standardised mental health assessment. A health professional by using GMHAT/PC, in about fifteen minutes, covers worries; anxiety and panic attacks; concentration; depressed mood, including suicidal risk; sleep; appetite; eating disorders; hypochondriasis; obsessions and compulsions; phobia; mania/hypomania; psychotic symptoms; disorientation; memory impairment; alcohol misuse; drug misuse; personality problems and stressors. It gives computer assisted diagnosis, symptom ratings a summary letter as well as treatment guidelines. Its use by health professionals will help in detecting and managing mental disorders in primary care and general health settings more effectively. So far, this has been translated in to Spanish, Netherlands, German, Chinese, Arabic and Hindi. The results of cross cultural studies are very encouraging. The GMHAT/PC has also been used in the general health setting including in elderly population, cardiac patients (UK), respiratory and epilepsy patients (India) with promising findings.

IDENTIFIED OBJECTIVES:

1. To train the trainers so that they can support and train health professionals for the GMHAT/PC's routine use in their clinical practice.
2. To provide a practical demonstration of the use of GMHAT.

Knowing What is Not: Clinical Approach to Rapidly Progressive Dementias

FACILITATOR: Kavita Das (UK)

BACKGROUND & NEED: Rapidly progressive dementias (RPD) are a unique set of disorders resulting in cognitive, behavioral and motor decline in twenty four months. A variety of etiology may contribute to RPD. This session would consist of presentation of three unique cases of RPD, focusing on an interactive discussion on the clinical aspects and diagnostic workup of RPD. A standardized approach to assessment, diagnosis and management of RPD is pertinent as presentation invariably pose a clinical conundrum for Health Practitioners.

IDENTIFIED OBJECTIVES:

1. To provide insight into the differential diagnosis, clinical approach, and potential treatment options for RPD.
2. How to differentiate RPD from the more typical dementias.
3. Adopting an approach that would enable clinician to identify a reversible RPD and distinguish these conditions from RPDs that carry graver prognosis.
4. Increasing awareness of the RPDs should foster more efficient diagnostic and management strategies for this complex set of disorders.

Writing Grant Proposals for Funding

FACILITATORS: Suman Sinha, Pratap Sharan

BACKGROUND & NEED: The number of grant makers and grant seekers is increasing continuously. The grant process is getting competitive day by day and the process of grant writing has become standardized over time. For any project funding is a key resource for its feasibility and implementation. The quality of proposals received for funding under National Mental Health Programme and other central sponsored schemes is very poor and leads to their rejection. At the same time increasing number of corporate donors in India and abroad require...
that mental health professionals be equipped with basic grant writing skills so as to stand better chance in winning grant for their projects and are able to turn their dream projects in reality. While there are numerous professional grant training courses in the developed world there is hardly any training resource for grant writing in India. Neither such training is part of any medical curriculum. The present workshop is an effort to introduce and familiarise the participants to the contemporary grant writing process and strategic planning of proposals so that they are equipped with skills to write better grant proposals in future.

IDENTIFIED OBJECTIVES:

1. To introduce and familiarise the participants to the contemporary grant writing process and strategic planning of proposals
2. To equip participants with skills to write better grant proposals in future.

Psychotherapy for the Indian Setting: The process of Assessment and Conduct of Individual Dynamic Psychotherapy

FACILITATORS: VK Varma (USA), Nitin Gupta

BACKGROUND & NEED: “It is inevitable that cross-cultural differences ... must be taken into account in ascertaining suitability of and in adapting psychotherapy for a particular culture (Varma, 1985)”. Traditional cultures, like those of South Asia, revolve around primary support groups, like the family. As opposed to West, in the traditional societies of South Asia, all relationships are multi-dimensional, serving a myriad of functions. The same applies to the healer-patient relationship, the healer being a friend, philosopher and guide, a wise person, a village elder, and a benevolent senior, as also a family member. His objective is to help in all possible ways, to total growth, development and actualization, and not just in the narrow confines of the illness.

Adapting psychotherapy for the traditional societies, such as that of India requires taking into account differences in the socio-cultural and religious variables, such as, dependence versus autonomy, psychological sophistication, the introspective and verbal ability, the need for confidentiality, the nature of dyadic relationship, the personal responsibility in decision-making, the nature of guilt and shame, and the social distance between the patient and the healer. Psychotherapy may accordingly be made more active, open and direct, briefer, crisis-oriented, supportive and flexible, with greater activity on the part of the healer, and with the involvement of the larger family and social matrix. It also needs to be tuned to and blend itself to the religious belief system. Furthermore, on account of trained manpower constraints, expertise of professionals of various backgrounds may be utilized.

However, there is no model available for the practice of psychotherapy in India. The facilitators have identified various factors and processes that seem to be the key and extremely helpful in the conduct of psychotherapy in the Indian setting, and would like to share the same with the participants.

IDENTIFIED OBJECTIVES:

1. To train mental health professionals in the practice of individual psychodynamically oriented psychotherapy
2. To discuss the rationale for adapting Western-model psychotherapy for traditional societies, taking into account socio-cultural variables
3. To discuss the methodology of selection of cases and assessment for psychotherapy
4. To discuss the process of psychotherapy; from symptoms to conflicts to defense mechanisms to interpretation to working through
5. To illustrate the conduct of psychotherapy, giving case vignettes and using role-play involving the participants
Self-concept, Stigma and Quality of Life in Chronic Schizophrenia and Chronic Skin disease: A Comparative Study

Atul Kumar Rai, CRJ Khess, Dipanjan Bhattacharjee, S Akhtar

Central Institute of Psychiatry, Ranchi

Introduction: Often course and outcome of schizophrenia and various forms of chronic skin diseases are influenced by psychosocial factors. Factor like psychosocial stress has often been seen to exacerbate the illness. Chronic schizophrenia and chronic skin diseases generally have a major impact on patient's daily activities, emotional state and social relationships. Factors like one's own assessment or evaluation about his/her self especially his/her self efficacy or esteem, self-image or abilities. Aim and Objectives: To assess the self-concept, stigma and quality of life in patients with chronic schizophrenia as compared to chronic skin disease patients. Methods: This study was a cross-sectional hospital based study and it was carried out at the Central Institute of Psychiatry, Ranchi, Jharkhand. For the purpose of study 30 patients having the diagnosis of schizophrenia and 30 patients of chronic skin diseases were selected purposively. For data collection Socio-Demographic and Clinical Data Sheet, Self-Concept-Questionnaire (Saraswat & Gaur, 1981), Stigma Interview Schedule (Wahl, 1999) and WHO-QOL-100 (WHO, 1998) were used. Results and Conclusion: Significant differences were seen between the patients of chronic schizophrenia and chronic skin disease in the 'social', 'moral' domains of Self Concept Questionnaire, perceived stigma as well as two domains of quality of life measuring instrument (WHOQOL-100), e.g. 'psychological' and 'independence'. The details related to findings of the study will be shared at the time of presentation. Schizophrenia patients were found to have lower level of self-concept, and quality of life as well as higher level of stigma than the patients with chronic skin diseases.

Social-demographic Profile and Psychological problems in Afghan Refugees in New Delhi

Anuj Mittal *, Medhavi Sood**, Nishtha Khunger**

** Department of Psychology, Delhi University, New Delhi.

Aim and Objectives: 1. To study the Social demographic profile and Psychological problems in Afghan Refugee in New Delhi. 2. To study stressful life events in Afghan refugees in New Delhi. Methods: 50 Afghan Refugees who attended Psychiatry O.P. D at DDU hospital, New Delhi for any psychological Problem were included in the study using following tools (a) Semi-structure Performa (which includes Social demographic profile, General physical examination, detailed Psychiatry examination including Mental state examination and diagnosis according to ICD-10 (b) General Health Questionnaire (GHQ) (c) Presumptive stressful life event scale (PSLE) and (d) Brief psychiatric rating scale (BPRS). Results and Conclusions: It was found that 92% were female of which 38% were widows, 66% were Sikh by religion, 62% were literate and 66% had monthly income less than 10,000 rupees. Among them 42% had PTSD, 32% were diagnosed with depression, 16% with Generalised anxiety disorder (GAD) and 10% with Somatisation. GHQ showed major problems in concentration, financial problems and lack of wellbeing. Leading Stressful Life events were family conflicts, financial losses, death of a family member and change of residence.

Psychiatry Movie Club: An innovative way to teach Psychiatry

Nitasha Sharma, Sunita Sharma, Sandhya Ghai

N.I.N.E., Postgraduate Institute of Medical Education and Research, Chandigarh

Introduction: The media and the movie industry has always shown a keen interest in portraying the mental illness as main themes in their movies: Be that the movies of 80's like 'Khamoshi' or the super hits of current times like 'Ghajini'. Many of these movies have been so successful that the general public and for that matter the students studying psychiatry tend to identify psychiatry through such movies. And hence these movies can actually be utilized as a supplementary media to teach psychiatry along with the conventional methods of teaching. Aim and Objectives: The current
study was planned operationalizing the same fact. The main aim of the study was to use cinema-education in teaching Psychiatry. The study also investigated the acceptability and perceptions of students towards cinema-education. **Methods:** The investigator showed four movies related to specific topics in Psychiatry. After each movie, the actual topic was also taught using the lecture method to facilitate effective learning. A total of 37 students were involved in this movie club. At the end the student’s acceptability and perceptions towards cinema-education were assessed using a rating scale developed by researcher. **Results and Conclusion:** The results showed that majority of students had positive attitude towards cinema-education and more than 80% subjects reported that such method should be incorporated into mainstream psychiatry curriculum.

**A Feasibility Study of ASSIST Linked Alcohol Screening and Brief Interventions for Harmful Drinkers in the Workplace Settings of Class C Workers, PGIMER, Chandigarh**

Jaison Joseph, Karobi Das, Sunita Sharma, Debasish Basu*

*National Institute of Nursing Education & *Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh.

**Introduction:** The World Health Organization (WHO) developed Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) as a simple scale for rapid screening of substance users to stratify them into three levels of risk severity (mild, moderate and severe). The moderate and high risk substance users can be provided an ASSIST-linked Brief Intervention package (ASSIST-BI), again developed by WHO, aimed at reducing the risk level of substance use. **Aim and Objectives:** In this study, we evaluated the feasibility of applying the ASSIST-BI in the workplace setting for harmful drinking among class C employees of PGIMER, Chandigarh. **Methods:** A sample of thirty nine such workers with moderate or high risk level of substance use was identified by randomly screening 125 employees. These 39 moderate-high risk users have been administered ASSIST-BI. Their co-morbid substance use pattern and health consequences of substance use have also been documented. **Results and Conclusion:** This work shows that it is feasible to use ASSIST for workplace screening to identify moderate-risk level substance users and to use ASSIST-BI for their brief intervention at workplace itself.

**Burden and Coping Strategies in Caregivers of Patients of Substance Use Disorders**

Pratibha, Poonam, Priti Singh, Rajiv Gupta  

*Department of Psychiatry, Postgraduate Institute of Medical Sciences, Rohtak*

**Introduction:** Substance use disorders result in adverse impact on the caregivers. Due to psychopathology ad course of illness, the burden on their families is perceived to be heavy. Studying the family burden and coping strategies adopted by the caregivers may play an important role in long-term psychosocial management of these patients. **Aim and Objectives:** To assess family burden and coping strategies adopted by caregivers of patients of Substance use disorders. **Methodology:** 50 consecutive key relatives of patients of Substance use disorder attending De-addiction OPD at Pt BD Sharma PGIMS, Rohtak comprised the study sample. The family burden was assessed on the Interview Schedule developed by Pai and Kapur and coping strategies were assessed using Family Coping Questionnaire (FCQ). **Results and Conclusion:** The data collected was statistically analyzed and discussed in the presentation.

**Attitude towards suicide among MBBS students**

Savita Chahal, Amit Jagtiani, Naresh Nebhinani, Rajiv Gupta  

*Department of Psychiatry, Postgraduate Institute of Medical Sciences, Rohtak*

**Aims and Objectives:** To study the attitude of MBBS final year students towards suicide. **Methods:** 205 MBBS final year students studying in PGIMS, Rohtak were recruited through total enumeration method in August 2012 and ‘Suicide opinion questionnaire’ was administered to assess their attitudes towards suicide. **Results and Conclusion:** All were singles and nearly half were male and from urban locality, with the mean age of 21.9 years (range 19-26 years). Only minority had previous exposure of managing any suicidal patient and attending suicide prevention programs. Majority agreed for suicide attempters being lonely and depressed. Nearly half of the students reported small family, disturbed family and marital life, weak personality, self punishment approach, cultural inhibitions in emotional expression, national instability and disbelief in after life, as major push to attempt suicide. Two-third students were reluctant in setting up suicide clinics. Compared to boys, girls reported greater contribution of weak personality and self-destructive behaviors and lesser contribution of family disturbances and religious convictions as suicide.
triggers. Depression, loneliness, disturbed family and marital life, weak personality were commonly thought triggers for suicide. Weak personality, self-destructive behaviors, family disturbances and religious conviction scored differently as suicide triggers among in both sexes.

Developing Psychiatric Social Work at PGIMS, Rohtak: a comprehensive plan
Sushma Kumari, Vikash Ranjan Sharma, Rajiv Gupta

Department of Psychiatry, Postgraduate Institute of Medical Sciences, Rohtak

Introduction: The scope of Psychiatric Social Work (PSW) intervention encompasses the entire gamut of mental health and neurosciences. At present, services of PSW unit of PGIMS, Rohtak, are confined to inpatient/out-patient level for psychiatric patients and their distressed family members. Here the psychiatric social workers use their expertise to restore the mental health of psychologically ill & enable them to use their fullest potential to reintegrate into the society as productive & self-reliant individuals. PSW dept has so far registered 1200 patients. A special Geriatric service provides active assistance to old patients while consultation. Aim and Objectives: We present a comprehensive plan of action prepared to extend our services for special groups e.g. child and adolescents, Geriatric and substance abuse patients in addition to liaising with various governmental and NGOs. Manpower generation and utilization is another thrust area. We have started M.Phil. course in PSW. Results and Conclusion: The presentation covers an update of our services in psychiatric social work and future plans.

Group Art Work: Promoting mental health amongst the inmates of the special observation home for juveniles in conflict with law
Bhavneet Bharti, Prahbhjot Malhi

Advanced Pediatrics Center, Postgraduate Institute of Medical Education and Research, Chandigarh

Introduction: Art based interventions are influential in promoting well being and positive emotion. There is increasing acceptance that health, well being and quality of life ride on the confluence of physical, psychological and social functioning trends. Juvenile offenders are invariably insular, struggle with intimacy and are overly restrained as well as reticent. They lack consciousness of their potential as well as larger social role. Aim and Objectives: In this backdrop, a prospective group art work based intervention was carried out in the inmates of juvenile home who are in conflict with law, with an aim of improving relationships and opening the lines of communication. Methods: Our study comprised of a purposive sample of willing inmates who were in conflict with law and expressed their interest in doing some art work. A total of seventeen inmates were exposed to group art work while they stayed at the special observation home. At least half of them were migrants from the states of Bihar, Uttar Pradesh, Jharkhand and Delhi. They were provided with art material including sketch books, sketch pens, water paints, color pencils, crayons and marker pens. Besides this, some art books were kept in the observation home for their ready reference. The group art work was once a week activity. The inmates carried out art work for the rest of 6 days and were re-assessed once a week. Individual juvenile inmates and staff were interviewed using semi-structured schedules after minimum 4 weeks of intervention. Group interviews were chosen instead of focus groups, as the latter consists of juveniles from different positions in society. The interviews lasted between 30 and 90 minutes. Triangulating data from multiple methodologies improved analytical and interpretative accuracy. Results and Conclusion: Our data suggests that three main themes emerged with the Group Arts work at the JJ Home. The first theme is that the group art work is core non-threatening programs for extremely vulnerable inmates with various mental health problems such as conduct disorders, anti-social personality disorder, depression etc. The second theme is that Group Art work functions in three distinct ways: as activities, as spaces, and as communication and skill-builders. The third theme is that therapeutic gains have been achieved in the high arts participation group. One of the violent juvenile offenders has been completely rehabilitated following his stay in the JJ Home and is presently pursuing art and painting as his lifetime profession. A word of caution, there was increased demand of black permanent marker during the initial sessions, which was soon discovered to be linked to intentional inhalation to produce “high” by some of the inmates who had known history of substance abuse. Group Art Work is a promising aspect of service delivery and provides a window into the artistic lives of juveniles in conflict with law at the special observation homes. It is an acceptable, feasible and effective approach to ease stress of imprisonment and facilitate their smooth transition to society. It provided a significant platform for helping inmates to generate expressive capabilities,
develop social skills and improve their self esteem. Finally, relative to staffing and other costs, the costs resulting from operating flexible, high quality group art work provides 'enhanced nurturance,' which is a very prudent investment when the expanded benefits of Group Art work is acknowledged.

Gender, migration and mental health and among internal migrants in Bangalore

Ila Lyngkisar Rynjah, Anisha Shah

National Institute of Mental Health and Neuro Sciences, Bangalore

Aim and Objectives: To qualitatively explore gender, migration experience and mental health among internal migrants in Bangalore. Methods: A semi structured interview was carried out on 6 internal migrants to explore the migration experience (pre migration, migration and post migration history), stressors & coping, and gendered experiences. A "cultural" genogram according to principles outlined by McGoldrick, Giordano & Garcia-Preto (2005) was also carried out with the participants. Data was analysed using content analysis. Results and Conclusion: Mental health aspects identified by the participants were stresses related to adaptation to new situations, anxieties related to the same, as well as discrimination. However, there were growth opportunities too. Broadening of horizons and independence were identified as important aspects of moving, facilitating the process of individuation. With regard to the migration experience, prior migration experiences and preparedness helped in making the process easier. Safety is mentioned as the most significant difference between the genders in the process of migration. Family factors that affected migration were identified through the genogram, which also revealed gender differences in expectations. Understanding the process of internal migration in India is needed, looking at the positive and negative facets of the move; keeping gender as an important variable. This has implications for therapeutic work with this significantly growing population.

To see the expectations of children from their parents, executive functions according to their general intelligence

Rama Malhotra*, Sukeerti Saini**

*Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh

**Government Home Science College, Chandigarh

Aim and Objectives: The purpose of study is to see the expectations of children from their parents, executive functions according to their general intelligence. Methods: Survey was done and collected information from 250 consented children (both boys and girls). 50 items, self-reported questionnaire was administered for assessing the expectations of the children from their mother and father. Five Point Scale was used for executive functions. Colored progressive matrices were used for analyzing intelligence. Data was subjected to appropriate statistical i.e. Parameter and non-parameter by using SPSS-10. Results and Conclusion: It was seen that the younger children were more consistent as compared to older children. There was no relationship of the executive functions with age and intelligence. This study will provide normative information while assessing child.

Causes of domestic violence in married women with mental illness: Preliminary study

Jyoti Srivastava, Indira Sharma

Department of Psychiatry, Institute of Medical Sciences, Banaras Hindu University, Varanasi

Introduction: Domestic violence as any act of “gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.” Aim and Objectives: 1. To assess the magnitude and pattern of domestic violence in woman with mental illness. 2. To find out the causes of domestic violence. Methods: The sample of study comprised of 30 women, 16-40 years of age living with husband, with Axis one psychiatric Disorder diagnosed according to DSM IV-TR, who were selected from the Psychiatry OPD of the S.S. Hospital, BHU. The patients were assessed on the a structured questionnaire on Domestic Violence, Positive and negative syndrome scale rating form, IDEAS and Cruelty Rating Scale and Deficiency in Maintenance scale. Results and Conclusion: Domestic violence was significantly higher amongst the group of less educated and house maker women. The study found out the overall prevalence of physical violence against married women 53.3%, Economic violence 46%, emotional/verbal violence 43%, Sexual abuse 33.3%, and Stri Dhan related Harassment 10%. The main etiological factors of domestic violence were 60% of participants unable to perform domestic chores so they were becoming the victim of domestic violence. 33.3% reported that Dowry was one of the causes which
created violence in the family. It is concluded that physical, economic, emotional/verbal violence and sexual abuse among married women is quite high and a serious problem.

**Problematic use of social networking sites among urban school going teenagers**

Pankaj Kumar Mittal, Parth Singh Meena, Ram Kumar Solanki

*Department of Psychiatry, S.M.S. Medical College & Psychiatric Center, Jaipur*

**Introduction:** The problematic use of internet and social network in particular is increasingly being recognized as psychological disorders all over the world. Young adults, particularly teenagers tend to spend too much time on social networking sites. It might have deleterious effect on their academic performance, health and social interaction in real world. **Aim & Objectives:** To determine the magnitude of problematic use of social networking websites among urban school going teenagers. **Methodology:** The study included 200 students (115 boys and 85 girls) studying in class XI & XII in schools in urban localities who were using internet either at home or at other places like cyber cafés. Problematic use of social networking sites was assessed by young’s internet addiction test modified for problematic social networking use. Appropriate statistical tools and methods were employed to calculate and compile data. **Results and Conclusion:** 24.74% of the subjects were having occasional to frequent problems due to excessive use of social networking sites while 2% of the subjects were having significant problem and they needed to address their problematic use of social networking sites urgently. Significantly more boys were having problems due to excessive internet use than girls. A significant number of urban school going teenagers are having problems related to excessive use of social networking site.

**Development of Nursing Evaluation Tool: A methodological study for evaluating the functional recovery in subjects with substance dependence**

Renu Bala, Karobi Das, SK Mattoo*, Avinash Rana

*National Institute of Nursing Education & Department of Psychiatry*, *Postgraduate Institute of Medical Education & Research, Chandigarh.*

**Introduction:** Nursing Evaluation Tool (NET) is a combined total measure to check the recovery in patients during disease process. Evaluation has become a powerful, specialized discipline in recent decades, with its own sophisticated conceptual and technical apparatus. Evaluation of nursing has benefited strongly from these developments, as examples of cogent, recent evaluations demonstrate. Evaluation is already proving an indispensable practical tool for raising the quality of health care, and for advancing professional nursing standards. **Aim and Objectives:** 1. To review the literature. 2. To select and pool items to measure functional recovery. 3. To construct a “Nursing Evaluation Tool” to assess the functional recovery from substance dependence. 4. To check the validity of newly devised “Nursing Evaluation Tool.” 5. To monitor the feasibility of newly devised “Nursing Evaluation Tool.” 6. To assess the reliability of newly devised “Nursing Evaluation Tool.” 7. To present the “Nursing Evaluation Tool” with scoring key and guidelines to use. **Methods:** A methodological study was undertaken to develop Nursing Evaluation Tool for assessing the recovery in subjects admitted in drug-deaddiction centre. Delphi technique was used to develop NET along with a scoring key and the guidelines to use the tool with 8 experts. After four Delphi rounds the tool was tried on 30 subjects admitted in Drug-Deaddiction & Treatment Centre. **Results and Conclusion:** Internal consistency (reliability) and construct validity were checked by Cronbach’s alpha (unstandardised) and factor analysis respectively. The Cronbach’s alpha coefficient of present NET was 0.91, showing the reliability of the tool. It also revealed that all the items were uniformly contributing for the reliability of the tool. In the present study inter-item correlation was checked by Spearman’s correlation (bivariate). There were a total of 90 items in the original tool and out of that 33 items were deleted as Correlation-Coefficient was <0.2 and then factor analysis was done on 57 items. A total of 13 components was generated through Principal component (Varimax rotation). And all 57 items were retained in the 13 components so generated which accounted for the 89% of the variance. But overall Cronbach’s alpha coefficient of 90 items was 0.91 which indicates internal consistency of the tool. When the Cronbach’s alpha if item deleted was applied then none of the items has shown increase in the value of Cronbach’s alpha coefficient. It indicates all the items are retained through Cronbach’s alpha coefficient. Experts also felt that other 33 items are also important and could be used to assess the functional recovery in the subject. The present study resulted in the development of a valid and reliable Nursing Evaluation Tool.
Tool along with scoring key and guidelines to use the tool for subjects with substance dependence. The scale has 12 domains. It covers all the domains of functional recovery in the subjects with substance dependence i.e. Health Perception and Health Management, Nutrition and Metabolism, Elimination, Activity and Exercise, Cognition and Perception, Sleep and Rest, Self-Perception and Self-Concept, Roles and Relationships, Sexuality and Reproduction, Coping and Stress Tolerance, Values and Belief, Behaviour. The average time taken in assessing the functional recovery of a substance dependent subject is 15 minutes. The developed Nursing Evaluation Tool being valid and reliable, it is recommended to use this tool to assess functional recovery in the subjects with substance dependence. The feasibility of tool in other Drug-De addiction centres can also be checked.

A Cross-sectional Study of Characteristics of Violence among Females with Mental Illness

Anuradha, Indira Sharma

Department of Psychiatry, Institute of Medical Sciences, Banaras Hindu University, Varanasi

Introduction: Domestic violence, also known as domestic abuse, spousal abuse, battering, family violence, and intimate partner violence (IPV), is defined as a pattern of abusive behaviors by one partner against another in an intimate relationship such as marriage, dating, family, or cohabitation. Domestic violence, so defined, has many forms, including physical aggression or assault (hitting, kicking, biting, shoving, restraining, slapping, throwing objects), or threats thereof; sexual abuse; emotional abuse; controlling or domineering; intimidation; stalking; passive/covert abuse (e.g., neglect); and economic deprivation. Aim and Objectives: Violence against women is a serious problem in India. In this study we assess the prevalence and frequency of different forms of physical sexual emotional and economical violence against women. Methods: The study sample comprised of 50 women in the age group of 16 to 40 year with Axis 1 disorder as per DSMN 4-TR. The sample was selected from the Department of psychiatry OPD of SS Hospital, BHU. In this study we use four types of questionnaire i.e. Domestic Violence questionnaire-1, Violence questionnaire-2, Cruelty rating scale and, Deficiency in maintenance rating scale. The questionnaire was used for identifying the various characteristics of domestic violence among females with mental illness. Results and Conclusion: The finding of study Domestic Violence was observed in 50% of sample. In the subjects all categories of domestic violence like verbal violence 48%, physical violence 46%, economical violence 18%, sexual violence 14% dowry 8% and stridhan related violence 4% were present. The implications and conclusion will be discussed.

Follow Up Pattern of Psychiatry Patients at Christian Medical College, Ludhiana

Mamta Singla, Sandeep Kumar Goyal, Arun Sood, Arjin Philips, Sharad Philips
Department of Psychiatry, Christian Medical College & Hospital, Ludhiana

Aims and Objective: 1. To study the socio-demographic profile of patients attending the Psychiatry OPD of Christian Medical College & Hospital, Ludhiana. 2. To study follow up patterns of psychiatric patients and find its correlates if any. Methods: This study was a retrospective data analysis. Socio-demographic data of the Psychiatry patients was taken from computer database of the hospital. Other data regarding diagnostic break-up & follow-up was collected from Psychiatry files of the patients attending psychiatry OPD from April 2010 to March 2012. Total sample consisted of 1505 patients. Results and Conclusion: Sample comprised of 58.5% males and 41.5 % females. Mean age of the sample was 38 yrs. 53.4% patients were Hindu, 41.1 % Sikh, 3.3 % Christian and 2.2 % were muslim.72.3% of the patients were married, 23.3 % were unmarried and 4.5 % were divorced/widow/widower. 56.9% patients belonged to Ludhiana district, 35.7 % patients were from other parts of Punjab and 7.4% were from other states. Most common diagnosis was Depressive Disorders(31.4%) , followed by Anxiety Disorders(13.4%), Bipolar Disorders(12.2%) ,Schizophrenia and other Psychotic Disorders(9.4%), Substance Use Disorders(8.2%)and Adjustment Disorders (6.2%). In 5.1% patients diagnosis was deferred.53.1% patients had no follow up, 29.4% patients had 1-3 follow up ,14.9 % had 4-10 follow ups and 2.6% had more than 10 follow ups. Various correlates of follow-up will be discussed.

Attitude towards Psychotropic Medications in patients with obsessive compulsive disorder (OCD)

Bichitra Nanda Patra, Sandeep Grover, Munish
Aggarwal, Ajit Avasthi, Subho Chakrabarti, Savita Malhotra

Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh

Aim & Objectives: To study the attitude towards psychotropic medications in patients with obsessive compulsive disorder (OCD). Methods: Attitude towards psychotropic medication of 89 consecutive patients with OCD, coming to a tertiary care hospital was assessed using “Attitude towards psychotropic medications”, Hindi version. Results and Conclusion: Around two-third of the patients considered allopathic medicines as the most effective way of treating OCD (65.2%). More than three fourth of patients disagreed that one should use less than prescribed dose (76.4%) and nearly 70% disagreed with only reason for a mentally ill patient not working responsibly is the use of allopathic medicines (70.8%). Nearly half of the patients considered that psychotropic medications do not lead to cure but cause significant improvement (51.7%), lead to side effects but these side effects can be easily controlled (48.3%) and their long-term use can prevent recurrence of psychiatric illnesses (56.2%). However significant number of patients considered that psychotropic medications are dependence producing and patients cannot live without them (36.0%), psychotropic medications only calm down the patient (43.8%) and they make the body unusually hot, cold and dry (46.5%) and are very costly (42.7%). The present study shows patients with OCD hold both positive and negative attitude towards psychotropic medications. Hence, it is important to identify and address the negative attitude towards psychotropic medications to improve treatment adherence.

Rag-picker: Their Quality of Life and General Mental Health in Tri-city of North India; a Scene.


*Poor Patients Assistance Cell, Postgraduate Institute of Medical Education and Research, Chandigarh.
**Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh.
***G.S.C. of Nursing, Patiala.

Introduction: Indian urbanization is attractive differently. The Tricity in North India consists of Chandigarh (UT), Panchkula (Haryana), SAS Nagar (Pb.). Internal Human migration reflects human endeavour in the most testing conditions; rag-pickers are one of them who pick up waste from every corner of tricity, dumping grounds, bins. Mental Health is not just the absence of mental disorder. Aim and Objectives: In the present study an attempt was made to explore the Quality of Life and General Mental Health of rag-pickers, based on socio-demographic aspects. Methods: The study followed an exploratory research design where 150 subjects 50 each from tricity with mean age = 30 years (male & female), were interviewed with prior informed consent availed. Semi-structured interview schedule and standardized tool WHOQOL BREF, General Mental Health Questionnaire were administered to gather the data. Results and Conclusion: Total quality of life, General Mental Health was found to be moderate as per their qualification, awareness and satisfaction. As concluded the exploratory study reveals that Quality of Life and General Mental Health of rag-pickers is a matter of attention for government concerned and mental health professionals because it is not up to mark. The detail results will be discussed at the venue.

Phenomenology of Volatile Solvent Abuse: an exploratory study

Ajeet Sidana, Jasmin Kaur, BS Chavan, Sukhtej Sahni

Department of Psychiatry, Government Medical College and Hospital, Chandigarh

Introduction: There is inadequate research about the phenomenology of inhalant intoxication and withdrawal in literature. Also, the influence of type of inhalant abused, frequency of intake, mode of inhalation and total duration of inhalant use on the phenomenology has been unclear. Aim and objectives: To study the phenomenology of inhalant intoxication and inhalant withdrawal and to find out its correlation with type, frequency, mode of inhalation and duration of exposure. Methods: Patients of current volatile solvent dependence or harmful users as per ICD-10 criteria were recruited from the community clinics being run by the Department of Psychiatry, Government Medical College and Hospital, Chandigarh. A total of 34 male adolescents could be included. Phenomenology of inhalant intoxication and withdrawal was assessed cross-sectionally through the subjective experiences reported by the patients on a semi structured performa prepared for study. Results and Conclusion: The mean age of patients was 14.3 years and their mean duration of inhalant abuse was 34.2 months. There were 28 (82.3%) patients who abused adhesive fluid to fix punctures alone and 6 (17.6%) patients abused both adhesive and whitener fluid. Phenomenology of inhalant intoxication was
assessed in hedonic and aversive group of symptoms. Under hedonic experiences, all subjects reported feeling of relaxation (100%), followed by euphoria (88.2%), dissociation (67.6%), increased talkativeness (50%), hallucinations (26.5%) and grandiosity (14.2%). Under aversive experiences, 55.8% subjects reported aggressiveness, blurred vision and burning in eyes and throat, followed by rapid heartbeat (47.0%), irritability (44.1%), vertigo and chest pain (41.1%), confusion (35.3%), amnesia (20.6%), dysphoric mood (17.6%), fatigue (11.7%) and suicidal ideation (5.8%). Under the phenomenology of inhalant withdrawal, all subjects (100%) reported high levels of craving during withdrawal state of inhalants. Dysphoric mood was reported by 91.1%, followed by irritability and body ache in 88.2%, inattentiveness in 85.2%, insomnia in 76.4%, restlessness in 70.5%, anxiety in 61.7%, headache in 50%, fast heart beat in 44.1%, runny eyes/nose in 35.2%, tingling in 23.5%, nausea in 20.5%, hallucination in 5.8% and vomiting in 2.9% subjects. More severe intoxication and withdrawal phenomenology was found in patients who inhaled more than one type of inhalant, those with higher frequency of lifetime inhalant use, those who inhaled for longer duration and patients who used huffing for mode of inhalation. Current study not only provides insight about the various signs and symptoms of inhalant intoxication and withdrawal, but also the impact of type, mode, frequency and duration of inhalant use on phenomenology experienced by patients is provided.

A study to assess the effect of structured teaching module for caretakers of patients with schizophrenia and related disorders

Angel Philip, Deepika C Khakha, Mamta Sood

College of Nursing & Dept of Psychiatry, All India Institute of Medical Sciences, New Delhi

Aim: To assess the effect of a structured teaching module on the knowledge among caretakers of patients with Schizophrenia and related disorders. Materials and methods: A pre experimental study was done on a sample of 30 caretakers selected according to the inclusion criteria by convenience sampling. Based on the learning needs identified by focus group discussion and review of literature a structured teaching module was prepared in Hindi and English. The caretakers were called in groups. Informed written consent was taken. The demographic profile of patient and caretaker along with the information related to clinical profile, care of the patient and previous exposure to information on Schizophrenia and related disorders were collected. A knowledge questionnaire prepared by the researcher was used to assess the knowledge of the caretakers. The pre-test was done before the intervention. The teaching module was administered after a short discussion on the contents of the module. Next day (day 1) after a discussion to clear the doubts, the feedback was taken about acceptability of the teaching module using an acceptability performa. Post-tests were done on day 1 and day 15. Data were analyzed using paired t-test, Wilcoxon Sign rank test, independent t-test, Mann Whitney U test and ANOVA. Results: The results showed that there was a significant improvement in the knowledge of the caretakers from pre-test to post-test knowledge scores (p <0.001). There was a significant reduction from immediate post-test to post-test done after 15 days. But it was still higher than the scores before intervention showing a gain in the knowledge (5.53+ 2.79, p<0.001). Caretakers who were males and with higher educational qualification (graduation and above) were found to have a higher pre and post-tests scores. Caretakers with a previous exposure to information on Schizophrenia and related disorders were found to have significantly higher pre test knowledge scores. The duration of treatment of the patient was found to have a positive correlation between pre-test knowledge scores (p<0.05). The caretakers spending less than 12 hours in caring the patient was having a higher knowledge scores in the post-tests (p <0.05). Conclusions: The structured teaching module was found to significantly improve the knowledge of the caretakers. The caretakers perceived the teaching module as useful and implementable. However there was a reduction in the knowledge after 15 days still there was a gain in knowledge from pre-test. Gender, previous exposure to information, educational qualification, duration of care and duration of treatment were found to have a correlation with the knowledge scores.

A Study on Parents & Teachers perspective in understanding the need of Self Determination Skill Training for Persons with Intellectual Disability

*Hemant Singh Keshwal, *BS Chavan

*Regional Institute for Mentally Handicapped,
Introduction: Self-determination is a concept reflecting the belief that individuals have the right to direct their own lives. Students with mental retardation who have self-determination skills have stronger chances of being successful in making the transition to adulthood including employment and independence (Wehmeyer & Schawartz, 1997). A self-determined person sets goals, makes decisions, sees options, solves problems, speaks up for himself, understand what supports are needed for success and knows how to evaluated outcomes (Martin &Marshel, 1996). This study is an effort to understand the need of various components/domains constituting self determination from the Special educators/Vocational Instructors and parents of persons with intellectual disability. **Aim and Objectives:** The objective of the study is to understand the parents and special educators/vocational instructors view for training students with mild intellectual disability in self determination skills. As the concept of self determination for these people is new in India hence this study will help in understanding the need of training in self determination which would further help in independent living of persons with intellectual disability. **Methods:** The study was conducted on a sample size of 100 which included 50 parents and 50 special Educators/Vocational Instructors by administering a 30 item questionnaire. Special Educators working with persons with children with intellectual disability above 16 yrs and similarly parents having children/adults with mild intellectual disability who are above 16 yrs of age. This study signifies the role of Special Educators/Vocational Instructors and parents in understanding the need of training them in skills like Personal Management, Community Participation, Recreational & Leisure time, Choice Making and Problem Solving skills which constitutes Self determination. On comparing the responses of the two groups, high correlation observed. **Results and Conclusion:** The results reflects the need of training in self determination skills and importance of training which could lead to successful independent living in community as well as employment.

Impact of patient exposure and training on nursing student’s attitude towards mental illness

VS Sreeraj, S Mohanthy, S Kumar
Behaviour Therapy in Writer’s Cramp
Jaspreet Kaur, *Adarsh Kohli, Mandeep S Dhillon

Department of Physical and Rehabilitation Medicine, Postgraduate Institute of Medical Education and Research, Chandigarh & *Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh

Introduction: Writer’s Cramp is one of a considerable group of so-called occupational neuroses occurring with more or less frequency among persons whose living depends upon their ability to use their hands rapidly and continuously for many hours a day. The chief symptom is inability to use the hand, or difficulty in using it, for writing or other occupational purposes. Behavioural treatment approaches have been shown to improve handwriting performance. Aim and Objectives: To examine the effects of behaviour therapy in two patients with writer’s cramp. Methods: In the current study two cases of writer’s cramp were treated with multiple model. The main principal used was gradual approximation and desensitization after training the patients in muscle relaxation. Handwriting performance was examined before and after treatment. Results and Conclusion: Steps of therapy and stages of improvement will be discussed. In both the cases, the response to treatment was good and the improvement was maintained at 6 months follow up. The patient could write comfortably and legibly without hand muscle tension after undergoing the intense therapy. Behavior therapy is immensely useful in patients with writer’s cramp.

Impact of Working Conditions on Job Stress and Job Satisfaction among Tertiary Care Hospital Nurses
Ravinder Yadav, *Raman Sharma, **Pallvi Aggarwal, Varinder Saini, *Vipin Koushal

Department of Medical Records, Govt Medical College and Hospital-32, Chandigarh, *Department of Hospital Administration, Government Medical College and Hospital, Chandigarh,**Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh

Introduction: Stress usually originates from unmanageable external demands. Nursing profession is full of multiple demands that might become unmanageable for nurses working in stringent working conditions. Aim and Objectives: The aim of the present research investigation was to explore the impact of different working conditions on job stress and job satisfaction in tertiary care hospitals. Methods: For this purpose 100 staff nurses working in Emergency, ICU, OT, Wards were selected. Job stress was assessed by using Occupational Stress Index (Srivastava & Singh, 1981) and Job Satisfaction Scale (Singh and Sharma, 1984) was used to assess the job satisfaction of the nurses. Results and Conclusion: One way analysis of variance was rapidly and continuously for many hours a day. The chief applied to analyze the obtained data. Findings revealed that role overload and role ambiguity factors of job stress differed significantly in different working conditions of hospital nurses, F (role overload) = 3.72, p<0.05, F (role ambiguity) = 8.21, p<0.01 and OT nurses scored highest followed by wards, ICU, and emergency nurses. Role conflict, under participation, and low status (F = 3.76, 3.43, 3.03 respectively, p<0.05) were found statistically significant. Mean values indicated that OT nurses scored highest followed by wards, ICU, and emergency nurses. Job satisfaction also differed significantly F = 4.51, p<0.01. It was found that ward nurses were experiencing highest job satisfaction followed by nurses in emergency, ICU, & OT. Discussion of the present research investigation generates important implications that could be beneficial for dealing with stress in nursing profession.

MBBS Student’s Attitude Towards Suicide Prevention
Amit Jagtiani, Savita Chahal, Naresh Nebhinani, Rajiv Gupta

Department of Psychiatry, Postgraduate Institute of Medical Sciences, Rohtak

Aim and Objectives: To study the attitude of MBBS final year students towards suicide prevention. Methods: 205 MBBS final year students studying in PGIMS, Rohtak were recruited through total enumeration method in August 2012 and ‘Attitude towards suicide prevention scale’ was administered to assess their attitudes towards suicide prevention. Results and Conclusion: All were singles and nearly half were male and from
urban locality, with the mean age of 21.9 years (range 19-26 years). Only minority had previous exposure of managing any suicidal patient and attending suicide prevention programs. Nearly half were agreed that most of the suicidal people won't reveal their suicidal plans to others and one-third considered unemployment and poverty as a main cause of suicide and were quite hopeless about it. More than half of the students agreed for their responsibility for suicide prevention. Nearly half of the students considered it rewarding in working with suicidal patients while other half were not comfortable in assessing suicidal patients (girls> boys). Only minority of students were resented, defensive about suicide prevention and considered suicide management efforts as waste of resources and time. Merely half of the students had positive attitude towards working with suicidal patients. Hence there is strong need to organize more educational and training programmes on suicide prevention so that these budding health professionals could be more equipped and trained to manage these suicidal patients.

**Yoga as a Therapeutic Tool for Children with Intellectual Disability**

Ankita Malik, Manisha Sharma, BS Chavan*

**Regional Institute for Mentally Handicapped, Chandigarh & *Government Medical College and Hospital-32, Chandigarh and Regional Institute for Mentally Handicapped, Chandigarh**

**Introduction:** Yoga is one of the six schools of ancient Indian Philosophy. It is believed that yoga is the practice that enables one to achieve higher levels of performance, bringing out the hidden potentials from within. Yoga therapy is fast advancing as an effective therapeutic tool in many physical, psychological and psychosomatic disorders. There are also reports of its benefits in persons with disability including mental retardation.

**Aim & Objectives:** To study the effects of Yoga on learning and behavioural problems among children with intellectual disability.

**Methods:** In the present study 60 children of mild to moderate degree of mental retardation (IQ 35-70) who fulfilled inclusion and exclusion criteria were randomly selected from Regional Institute for Mentally Handicapped (RIMH). The consent was obtained from their parents. Subjects were assessed on intelligence through Binet Kamath Test of Intelligence. Vineland Adaptive Behavior Scale was used to measure the adaptive behaviour of the subjects, cognitive abilities were assessed through Woodcock Johnson Cognitive Abilities scale and Wechsler Memory Scale was used to assess memory. Children were randomly divided in two equal groups i.e. Experimental Group (Yogic training group) and control group. Experimental Group underwent yogic training for 3 months that comprises of 60 hours (5hours every week) with an integrated set of yogic practices, including sithilikarana vyayama (loosening exercises), yogasanas, suryanamaskar, breathing exercises, pranayama and shatrikiya. The subjects in the control group received standard care at RIMH without yoga. After 3 months of integrated yoga training, all the assessments were repeated for the experimental group as well as control group. The two subjects are compared on pre and post assessments on attributes like intelligence, adaptive behaviour, cognitive abilities and memory.

**Results and Conclusion:** It has been observed that yogic training group has shown improvement in intelligence, adaptive behavior and memory with t ratio of 1.44, 1.53 and 4.22 respectively which is not statistically significant but no enhancement has been observed in cognitive abilities of the subjects. On the other hand no significant improvement has been observed in the control group. Benefit of yoga as a therapeutic tool for children with intellectual disability will be discussed along with its implications in the development and rehabilitation of these children.

**Pathways of care in psychiatric disorders: studies done from a tertiary centre of North India**

Anurag Agrawal, JK Trivedi, Adarsh Tripathi, PK Sinha.

**Department of Psychiatry, K.G. Medical University, Lucknow.**

**Introduction:** The study of the pathway of care provides the relevant information regarding the individual's health seeking and illness behavior. Active learning from the experiences of people requiring treatment for the first time may assist service providers and policy makers to purposefully plan for more effective gateways or pathways to mental health services.

**Aim and Objectives:** To discuss and compare the results from studies done for assessment of pathway of care in patients of first episode non affective psychosis and patients of neurotic, stress related and somatoform disorders done in a tertiary psychiatric centre of northern India.

**Methods:** Two single point cross-sectional studies which involved the administration of diagnostic and assessment tools were undertaken at different time intervals.
Affective psychosis and patients of neurotic, stress related and somatoform disorders, presenting for the first time on specified days in the Adult Psychiatry OPD of a tertiary psychiatric centre of northern India constituted the study sample. Various Assessment tools were applied. The study sample was divided in Aware and Unaware group on the basis of their awareness about psychiatric disorder at the time of onset/initial stages of illness and results were compared. Results and Conclusion: The most common first care providers were faith-healers followed by Local practitioner in both the studies. Duration of untreated psychosis was about 2 and half year. Patients made average of 7.2 consultations with different type of care providers in psychotic group and 6.84 in neurotic group. Both the studies indicated low level of awareness for psychiatric disorders. Significant differences were found between aware and unaware groups in various parameters in both the studies. The present study reported a poor referral system. Awareness about psychiatric disorders in community promotes desirable help seeking behavior and shortens the pathway of care. The findings explain the indigenous role of our cultural beliefs in creating various myths/beliefs, which continue from generation to generation. More research is required in developing countries regarding pathway of care.

Schizophrenia with Petrol dependence
Aparna Goyal, Amit Jagtiani, Purushottam, Sujata Sethi, Naresh Nebhinani
Department of Psychiatry, Postgraduate Institute of Medical Sciences, Rohtak

Introduction: Adolescent glue sniffing first noted during 1940s, with reports of petrol sniffing subsequently appearing during the following decade suggested that experimentation with volatile substances (inhalants) is common during early adolescence. However, preventing and treating affected youth is difficult due to complex psychosocial issues. Today, the inhalation of volatile substances is practiced worldwide with variability in type and pattern of substances abuse. Despite that neuropharmacological research has been comparatively sparse until recently, with limited data available on effective treatment approaches. Aim & Objectives: To present a case with Schizophrenia and Petrol dependence and reviewing the available literature. Methods: We are presenting a case of}

©2012 Indian Association for Social Psychiatry A39
indicated by frequently performing illegal acts and past three visits to the juvenile home. Second, he had history of deceiving and manipulating others for selfish reasons in order to obtain money, sex or drugs. Third, he engages in repeated fights or assaults as a consequence of irritability and aggressiveness along with reckless disregard for safety of self or others. There is a consistent pattern of irresponsible behavior, including failure to stick to any school. He reported 5 changes in the school, the first one being when he was failed in class 2nd. Finally he shows no evidence of sadness, regret or remorse for actions that have hurt others. There had been no intervention by school counselor, psychiatrist, psychologist or pediatrician during his past problems. His problems worsened with his expulsion from the school in class VIII. His past encounters with police too had been punitive with no consistent efforts for rehabilitation following his release from the juvenile home. He never got support for sports in the school because of his behavioral problems. This case clearly illustrates that early recognition of mental health problems in children should be an essential part of training of the school counselors and pediatricians who are primarily responsible of child health during the early years to prevent the progression to major psychiatric disorders. Besides the members of the Juvenile Justice Board, juvenile homes should further improve their support post release to promote mental health in children.

Common Unidentified Psychological and Learning Problems in School Children

Chhaya S Prasad, *BS Chavan, Ankita Malik, Hemant,** Karuna,** Jasmine Kaur

Regional Institute for Mentally Handicapped, Chandigarh, *Department of Psychiatry, Government Medical College and Hospital, Chandigarh and Regional Institute for Mentally Handicapped, Chandigarh, ** Department of Psychiatry, Government Medical College and Hospital, Chandigarh

Introduction: School personnel, teachers in particular, have a crucial role in terms of identifying developmental and other types of issues and taking necessary precautions to prevent students from developing psychological problems. Aim and objectives: Present study was carried out to find out the common psychological causes which interfere in learning in normal class room setting. Methods: This research is a 'descriptive' study with quantitative data aiming at identifying children with low intellectual ability, attention deficit & hyperactivity, conduct disorder, emotional problems and learning problems. In the present research teachers identified 232 children out of 1000 on a semi structured screening Performa prepared by professionals. Out of 232 identified children, 135 children were assessed by a team of professionals consisting of Psychiatrist, Clinical Psychologist and Special Educator. Psychiatrist, on the basis of brief history from child's parents and teachers, and clinical examination made the diagnosis of emotional disorders, conduct disorders, and hyperkinetic disorders were made according to ICD-10 criteria. Clinical Psychologist assessed the children for intelligence on standardised psychological tools. The diagnosis of learning disability was made on the basis of examination of child's notebooks, and report from teachers for specific problems in reading and writing. The suspected children were briefly screened on NIMHANS SLD Battery by the Clinical Psychologist. Results and Conclusion: Out of 135 children, 23 children were identified to have below average intelligence with mean I.Q. of 77. Nine children were diagnosed to have attention deficit and hyperactivity disorder (ADHD), 40 children had conduct disorder, emotional problems were diagnosed in 52 children, and LD in 29 children. 97 children did not come for assessments. For further management and intervention, children having various psychological or learning problems were referred to health professionals. The implication of the study will be discussed.

Impact of Office Environment on Employees’ Productivity

Gurkirpal Singh, *Manreet Kaur; **S S Soch

Institute of Engineering and Technology, Bhaddal, *Department of Psychiatry, Government Medical College and Hospital-32, Chandigarh &** Centre for Energy Studies, PAU, Ludhiana

Introduction: Most people spend fifty percent of their lives within indoor environments, which greatly influence their mental status, actions, abilities and performance. Better outcomes and increased productivity is assumed to be the result of better workplace environment. Office environment can be described in terms of physical and behavioral components. Better environment of office will boost the employees and ultimately improve their
productivity. **Aim and Objectives:** The main objective of this research is to investigate the effects of office environment on its occupant's perceived productivity. **Methods:** A total of 75 employees (40 males and 35 females) from various offices were recruited as sample. Age range was between 25-42 yrs and minimum education qualification was graduation. Primary data was collected through a structured questionnaire. Observation was also used to collect information about the office environment. Various indicators of office design such as office layout, comfort level, level of interaction and level of distraction were considered for study. **Results and Conclusion:** Analysis of the collected data revealed that office environment has a substantial impact on the employees' productivity. The overall response, according to gender, showed differences amongst the responses for different elements in the workplace. There is a direct relationship between office environment and productivity. Most of the organizations do not give importance to office environment; this study will give them ample reasons to consider office environment as an important factor in increasing their employees' productivity.

**Wisconsin Card Sorting Test-64: Preliminary Normative data on Indian Population**

Manreet Kaur, Nitin Gupta, Archana Sharma, Karuna Singh

*Department of Psychiatry, Government Medical College and Hospital-32, Chandigarh*

**Introduction:** Wisconsin Card Sorting Test-64 is an abbreviated form of standard 128 card version of WCST. This shortened version of the WCST was developed in response to concerns for patient comfort, managed care restrictions, and tighter research budgets. It uses only the first 64 WCST cards, thereby reducing administration time while retaining the task requirements of the standard version. WCST is a widely used neuropsychological test for assessing executive functions. However, the lack of culture-specific norms has often limited clinical interpretation of performance on the WCST. **Aim and Objectives:** The aim of this study is to establish adult norms for the WCST 64 in Indian population. **Methods:** A total of 50 healthy participants (21 males, 29 females; Age range = 21 to 50 years) were recruited. Absence of physical and psychological morbidity was determined by clinical interview and GH scores of zero (using GHQ-12) respectively. After informed consent, all the participants successfully completed the study protocol. All of the participants completed the WCST, and 10 indices of WCST were calculated. **Results and Conclusion:** Various indices of WCST-64 were calculated and compared with western norms. We shall discuss the cultural issues related to WCST-64; its appropriateness and utility.

**Cost of illness of patients with Bipolar disorder**

* Mansi Somaiya, Sandeep Grover, Subho Chakrabarti, Ajit Avasthi

*LTMMC Hospital, Mumbai & Postgraduate Institute of Medical Education & Research, Chandigarh.*

**Aim and Objectives:** The study aimed at assessing the cost of care of patients with bipolar disorder. **Methods:** A prospective follow up study was followed. Seventy five patients with bipolar disorder were assessed at baseline, 3 and 6 months using the Cost assessment questionnaire. **Results and Conclusion:** Total annual cost of treatment of bipolar disorder was rupees 32,880. Among the various types of cost, indirect cost was the major contributor forming about two-third of the total cost (rupees 20,976; 63.8%). Direct cost of treatment was rupees 10,592 and the providers cost was rupees 1311 (3.96%). Indirect costs were higher for males. Lower level of functioning as indicated higher indirect and total cost. Total number of visits correlated positively with indirect cost, provider’s cost and total cost of illness. Presence of alcohol dependence was associated with higher indirect cost and total cost. Most of the cost is borne by the patients and their families and total cost borne by the family accounts for about 20% of their total income. Bipolar disorder is as costly illness to treat.

**Clinical Characteristics of Patients of Dissociative Disorders Presenting at Tertiary Care Hospital**

B S Chavan, Manreet Kaur, Navneet Kaur

*Department of Psychiatry, Government Medical College and Hospital-32, Chandigarh*

**Introduction:** Dissociative disorders can be defined as conditions that involve disruptions or breakdowns of memory, awareness, identity and/or perception. People with dissociative disorders use dissociation, a defense mechanism, pathologically and involuntarily. Dissociative disorder may be dramatic in presentation causing significant socio-economical and emotional difficulties to patients and care-givers yet very few Indian studies have explored its socio-demographic and clinical characteristics. **Aim and Objective:** The aim of
this study was to determine the prevalence and clinical features of dissociative disorder in the psychiatry department of Government Medical College & Hospital, Sec-32, Chandigarh. **Methods:** A retrospective and descriptive study was carried out over eight months, from January 2012 to August 2012, of all the patients who attended psychiatric OPD during this period. The data was extracted from the file record of patients. After identification of patients of dissociative disorder as per ICD 10, the information on socio-demographic characteristics, life events, type of presentation was collected on a semi-structured performa. **Results and Conclusion:** During a period of 8 months, 4063 patients were registered in Psychiatry OPD and out of them 53 had the diagnosis of dissociative disorder (1.3%). However, the case records of three patients could not be traced and thus the data of 50 patients was included in the present study. Mean age of the sample was 27.92 years (SD=11.98) with female preponderance (78%). Majority of the patients were single (60%) and belonged to urban population (56%). Fifty percent of the patients were housewives living in joint families. A striking biographic event was found in the majority of the cases; essentially family and interpersonal conflict (68%). Among the patients of dissociative disorder, forty eight percent had dissociative convulsion and another 28 percent were diagnosed as mixed dissociative disorder. Onset of symptoms was abrupt in 48% of the patients and duration of illness ranged from less than one month to more than ten years. Twenty-eight percent of the patients were also diagnosed with comorbid depression. When compared with other psychiatric patients both groups differ significantly on gender, occupation and income. The present study suggested that dissociative disorder predominantly affected females, mostly housewives, belonging to lower socio economic status. Dissociative disorders are less frequent in our hospital; we must overcome the difficulties due to the complexity of the diagnosis and the cultural resistances to modern health care to determine the real prevalence of these disorders in tertiary care hospital.

**An exploratory study assessing reasons behind initiation, continuation, or stoppage of alcohol after first use.**

Chavan BS, Kaushal T, Gupta N, Arora S

**Department of Psychiatry, Government Medical College & Hospital-32, Chandigarh**

**Introduction:** Few studies have investigated the reasons of alcohol initiation and continuation. **Aim and Objectives:** The present study examined reasons for trying alcohol for first time and its subsequent use. Also, the study attempted to discover the difference between drinkers and non drinkers and possible predictors that make an individual vulnerable to alcohol use. **Methods:** 280 first year college students from 6 different colleges were approached. Using the method of equal probability, every 3rd subject from each class was selected. All the selected subjects were interviewed and administered semi-structured questionnaire for gathering information regarding their experience with alcohol. **Results and Conclusion:** In our study, experimentation and peer pressure were found to be the main reasons for both alcohol use and re use. The 3 groups under study (first time drinkers, subsequent drinkers and non drinkers) were observed to differ significantly in terms of gender and stream of study. Additionally, first time drinkers vs. subsequent drinkers differed in terms of educational background, reasons for first use of alcohol, use of additional substance, and family history of alcohol use. First year of college is a unique transitional period wherein students may be especially at high risk to begin or escalate heavy drinking. Studying the nature of alcohol initiation may not only be helpful in planning awareness programmes but also in preventing Underage Drinking and Alcohol Abuse.

**Efficacy of Zolpidem as sedative in elderly male population in India**

Pankaj Sureka

Central Jail Hospital, Hari Nagar, New Delhi.

**Introduction:** Zolpidem is a non-benzodiazepine hypnotic which several studies have found to be effective for sleep onset, but has not consistently been shown to improve sleep maintenance. **Aim and Objectives:** 1. To assess efficacy of Zolpidem as sedative in elderly male population in India. 2. Prevalence of need to escalate dose of Zolpidem over 6 months of use. **Methods:** The study was longitudinal in nature carried out over a period of 6 months. 52 primary insomniacs, without psychiatric disorders or drug and alcohol abuse, more than 65 yrs old were included in the study. Patients fulfilling study criteria were included in the study after obtaining a oral informed consent for the
same. The physical examination and MMSE of the patients was done to make the necessary exclusion. The assessment tools were applied in the order starting from the Performa to assess the socio-demographic characteristics, DSM Checklist, Pittsburgh Sleep Quality Index. Participants completed a sleep diary using items from the PSQI to rate how they slept the previous night before interview. Participants also completed a medication side effect questionnaire derived from the medication package insert for Zolpidem. Confidentiality and privacy were maintained during the assessment. Data analysis was completed using SPSS (Version 12), and α was set at 0.05 for all tests of significance. Results and Conclusion: To be presented later.

A Follow up study of addiction severity and motivation in a 10 day community de-addiction camp
Abhishek Chowhan, BS Chavan, Ajeeet Sidana, Prabhjot Kaur
Department of Psychiatry, Government Medical College & Hospital-32, Chandigarh

Introduction: Substance use has been a topic of interest to many health professionals, particularly mental health. But, drug and alcohol dependence is one such area where patients do not prefer hospitals for various reasons. In India, camp approach for the treatment of substance use has been found very effective. Aim and Objective: The present study was designed to find out the effectiveness of community de-addiction camps in terms of abstinence rate in those admitted for de-addiction after a 3 month follow up. Socio-demographic profiles, addiction severity and motivation of abstinent and relapsed patients were also compared. Methods: The camp (and the study) was planned as a three rung event which consisted of Preparation for the Camp; Implementation of the Camp; Follow up Services. Results and Conclusion: A total of 25 patients were admitted in the camp. Of these 25 patients 3 patients were discharged for disciplinary reasons and 1 left the camp against medical advice, thus a total of 21 patients completed the de-addiction treatment. After 3 month follow-up, it was found that 76% remained abstinent out of which 81% were married. Majority of them belonged to joint families (75%) and the age group of 41-60 (68%). Among those who relapsed, 80% were unemployed, belonged to nuclear families and had family income less than 10,000. Addiction severity was low and motivation was high in abstinent group as compared to relapsed group. After 3 months, there was reduction in addiction severity and increase in motivation level among those who relapsed.

Initiation of Psychiatric Care for the Persons with Mental Illness languishing in the Chamatkarkar Hanuman Temple of Chindwara District of M. P - an outcome of three years’ relentless persuasion
Tapas Kumar Ray, Arnab Banerjee, Prativa Sengupta
SEVAC Mental Health & Human Rights Resource Centre, Kolkata

Introduction and Aim: In the last two years we tried to highlight the unspeakable deplorability of the living condition of the persons with mental illness languishing in the Chamatkarkar Hanuman Temple of Sausar in the Chindwara District of Madhya Pradesh from this platform. Methodology: It is noteworthy that we filed a PIL in the Hon'ble Supreme Court to bring succour to these unfortunate ailing folks on 12th January, 2010. Results and Discussion: But till date our case was heard only once for five minutes. We also brought this matter to the knowledge of the NHRC (National Human Rights Commission). NHRC asked us to undertake a pilot project and submit our report to them. NHRC also asked the Government of India to do the needful in this direction. Following the intervention of the Government of India the M.P Government made lofty promises. But nothing happened. Now with the support of the European Union SEVAC has set a psychiatric clinic into operation for extending psychiatric treatment to them. Through this presentation we intend to show how our humble approach has been bringing a change in the deplorable scenario of the temple.

Quality of Life and Coping among caregivers of patients suffering with anxiety, depression and somatoform disorders
BS Chavan, *Rachna Bhargava, Prerna Sharma, Nitin Gupta
Department of Psychiatry, Government Medical College & Hospital-32, Chandigarh & *Department of Psychology, Delhi University, Delhi

Aim and Objectives: The study was planned to examine the coping and quality of life of caregivers of people suffering with mental illness in the community setting. Methods: The sample was drawn from a general population cohort residing in Chandigarh, in whom CIDI was used as an epidemiological assessment tool. Individuals who were diagnosed to have Anxiety
disorder, Depression and Somatoform disorder on CIDI (n=77) comprised the sample and were administered WHOQOL-BREF. Their caregivers (n=58) were also assessed for their coping styles and quality of life by using Coping Checklist and WHOQOL-BREF respectively. Group comparisons and correlational analyses were conducted. **Results and Conclusion:** No significant differences were obtained on demographic features, coping and quality of life between the three caregivers’ groups. Quality of life among patient groups with psychiatric morbidity also did not differ significantly. Quality of life and coping styles was significantly correlated in the caregivers.

**Marriage of Psychiatrically ill patients: A Professional dilemma**

Priti Singh, Sudha, Rajiv Gupta  
*Department of Psychology, Delhi University, Delhi*

**Aim and Objectives:** An epidemiological study was conducted in the city of Chandigarh in order to enumerate mental disorders in the general population.  

**Methods:** The WHO 30-cluster technique was used for obtaining a representative sample. In each cluster, approximately 110 individuals were selected. 2855 individuals were administered a socio-demographic sheet and GHQ-12. Individuals scoring above the cut off on GHQ were administered CIDI for confirming the psychiatric diagnosis. **Results and Conclusion:** Out of 2855 cases, 79 cases were diagnosed to have psychiatric illness yielding a point-prevalence of 2.8%. The age ranged between 18-98 years with average being 39.66±16.19 years. Majority (69%) of the sample was married. The prevalence was lower than that reported in previous studies. The findings so obtained will be discussed in relation to the methodology used in the process of overall assessment.

**Raising Awareness of services for BME Elders' Mental Health in the UK**

Sarmishtha Bhattacharyya, Susan Mary Benbow  
*Centre for Ageing and Mental Health, Staffordshire University, UK*

**Aim and Objectives:** To review relevant literature and share experiences of working in this area. **Methods:** A workshop on this topic was held at the Faculty of Old Age Psychiatry residential conference in 2012 in Cardiff, UK. Psychiatrists attending were asked their views on big issues in working with BME populations. They wanted more confidence in working with BME elders and to share/ explore ways of engaging local communities. research and instruments to assess cognitive decline in BME elders. Themes included: accessibility of talking therapies and social interventions/ supports; the heterogeneity of the BME population; referral barriers; concepts of mental illness; education; and late presentation. Action points from the workshop included the following: learning a few words in the language and recording them in the case-file; implementing quality standards for interpreters; medicalising dementia illnesses; establishing links with communities/ religious institutions to destigmatise mental illness; using technology for communication, for example apps for iPads. Many professionals use...
innovative methods/ ideas to deliver person-centred care to BME elders. The outstanding challenge is to share information which might guide service development.

Relation of disability with spirituality/religiousness as a component of QOL in patients with residual schizophrenia

Ruchita Shah, Parmanand Kulhara, Sandeep Grover, Suresh Kumar, Rama Malhotra, Shikha Tyagi

Department of Psychiatry, Post-Graduate Institute of Medical Education and Research, Chandigarh

Introduction: Schizophrenia is a chronic mental disorder that entails significant disability in the sufferers. Disability has been shown to be associated with psycho-social Quality of Life (QOL). However, its relation with spiritual QOL has been under-studied. **Aim and Objectives:** To study the relation of disability with spirituality/religiousness as a component of QOL in patients with residual schizophrenia. Methods: The study had a cross-sectional design. One hundred and three persons with residual schizophrenia were assessed on Indian Disability Evaluation and Assessment Scale (IDEAS) for disability and on Spirituality Religiousness and Personal Beliefs domain of WHOQOL SRPB. Positive and Negative Syndrome Scale (PANSS) was used to assess psychopathology. Pearson’s correlation was computed to study the relation between IDEAS and SRPB scores. **Results and Conclusion:** The total disability score (p < 0.001) and disability score in the area of communication (<0.05) had significant negative correlation with the SRPB domain of WHOQOL SRPB. In persons with schizophrenia, better spiritual QOL is associated with lower disability. However, no causal inferences can be drawn from this cross-sectional study.

Consultation Liaison Psychiatry: Referral Pattern in Christian Medical College, Ludhiana

Sandeep Kumar Goyal, Mamta Singla, Arun Sood, Sharad Philip, Arjin Philip

Christian Medical College and Hospital, Ludhiana

**Aims and Objectives:** To study the referral pattern of Consultation Liaison Psychiatry, at Christian Medical College and Hospital, Ludhiana. **Methods:** All the consults seen by Consultant Psychiatrist from June 2010 to May 2011 were included in the study and necessary data collected. **Results and Conclusion:** Most of the consults were from medicine department (40.42%), followed by surgery (14.17%), neurology (9.79%) and nephrology (8.75%). Most common reason of referral was assessment of psychiatric symptoms (52.3%) followed by substance abuse/dependence (25.625%). Depression (26.88%) was the most common diagnosis followed by substance abuse/dependence (25.63%). Opioids were the most common substance of abuse/dependence followed by alcohol. Further details will be discussed in presentation.

Prevalence of Stigma in People Living With HIV-AIDS (PLHA)

Sannidhya Varma, Natasha Kate, Sandeep Grover, Ajit Avasthi, Sunil Sharma, Subhash Varma

Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh

Introduction: Numerous studies from around the world have shown that stigma is common in people living with HIV-AIDS (PLHA). Stigma has a profoundly deleterious effects on the combating the HIV-AIDS epidemic. It hinders PLHA from seeking help from the health care providers and in the society. Most of the studies in India are from the southern part of the country and data from the north India is lacking. **Aim and Objectives:** To study the extent of stigma experienced by PLHA. **Methods:** 200 consenting adult patients of HIV-AIDS undergoing treatment in the Antiretroviral therapy centre in PGIMER, Chandigarh, India, were asked to fill the Hindi translated version of Berger Stigma Scale for HIV. **Results and Conclusion:** Fifty eight percent of the subjects were males and the mean age of the sample was 35.5 (SD- 7.86) years. The mean score of the subjects on the Berger Stigma Scale was 104.55 (SD-26.26) out of a maximum score of 160. The mean scores of the subjects on the four subscales of HIV stigma scale were: personalized stigma subscale- 48.04(SD-13.37)(Maximum score- 72); disclosure subscale- 25.93(SD-6.36) (Maximum score- 40); negative self-image subscale- 33.64(SD-9.18)(Maximum score-52); public attitudes subscale- 52.77 (SD-14.05)(Maximum score- 80). There was no significant difference in the stigma perceived by patients of either gender. Those from rural background perceived significantly higher overall stigma, had significantly higher disclosure concerns, had significantly more negative self-image, and significantly more concern with public attitudes toward people with HIV. Age of the patient and level of education had no relationship with perceived stigma.
PLHA from rural background perceive more stigma. There is no difference in the stigma perceived by males and females and the stigma is not influenced by age and education level of the patient.

**Mental Health of Asian elders in UK- big issues in service provision**

Sarmistha Bhattacharyya, Susan Mary Benbow  
*Centre for Ageing and Mental Health, Staffordshire University, United Kingdom*

**Aims and objectives**: To highlight service issues in the care of older people with mental health problems from Asian communities in the UK. **Methods**: Four case studies are offered by the authors to illustrate relevant care issues. These are then related to a modified version of Aday and Anderson’s Framework for access to services, in order to highlight gaps/is issues in care provision for Asian elders in the UK. **Results and Conclusion**: The four illustrative case studies highlight themes which include the stigma of mental illness in such communities; cultural and language issues; and the risks and benefits of using interpreters in making diagnoses in elders from such communities. We conclude that all of the above issues can affect the services and care offered to Asian elders with mental health problems living in the UK. Several Government policies and documents in UK highlight gaps in service provision for the BME (Black and Minority Ethnic) elderly group, however despite this it can be difficult to offer person centred care to these people. It is therefore important for mental health professionals working in the UK to be aware of issues which impact on they how they organise and provide care for this group.

**Psychosocial experiences of the patients with colostomy / ileostomy: A qualitative study**

Shaffy*, Sukhpal Kaur**, Karobi Das**, Rajesh Gupta***  
*DAV Institute of Nursing, Jallandhar; **National Institute of Nursing Education, Postgraduate Institute of Medical Education & Research, Chandigarh; ***Department of General Surgery, Postgraduate Institute of Medical Education & Research, Chandigarh*

**Introduction**: Colostomy/ileostomy affects a person’s life causing a lot of suffering and social isolation. **Aim and Objectives**: To explore the psychosocial experiences of the patients with colostomy/ileostomy. **Methods**: The study was carried out at surgical OPD of a tertiary care hospital. Using purposive sampling technique, 40 patients with colostomy / ileostomy were enrolled in the study. A phenomenological research design was employed to unmask the feelings of the patients. In depth interviews were conducted and recorded using a semi-structured interview schedule exploring the psychosocial domains of the patients under study. Colaizzi’s procedural steps were adopted to analyze the data. **Results and conclusion**: Mean age of the subjects was 33.6±13.1, with the range of 16-66 yrs. 67.5% were males. Some of the subthemes which emerged were embarrassment with the ostomy care of older people with mental health problems from such communities; cultural and language issues; and the risks and benefits of using interpreters in making diagnoses in elders from such communities. We conclude that all of the above issues can affect the services and care offered to Asian elders with mental health problems living in the UK. Several Government policies and documents in UK highlight gaps in service provision for the BME (Black and Minority Ethnic) elderly group, however despite this it can be difficult to offer person centred care to these people. It is therefore important for mental health professionals working in the UK to be aware of issues which impact on they how they organise and provide care for this group.

**Disability and quality of life of patients suffering of migraine**

Shikha Tyagi, Vinod K.Sinha  
*Central Institute of Psychiatry, Ranchi*

**Introduction**: A measure of disability and quality of life will help clinicians to know about the practical difficulties, which patients face in their day-to-day life and also help them, take treatment decisions. **Aim and Objectives**: The study aimed to see the relationship between quality of life of migraine patients and the disabilities experienced by them in relation to duration, frequency and severity of illness. **Methods**: The study was a cross-sectional, hospital based study, which used purposive sampling technique. The cases which gave informed consent, the socio-demographic & clinical data sheet, migraine disability assessment questionnaire (MIDAS) and Quality de vie et migraine (QVM) questionnaire were applied. **Results and Conclusion**: The sample consisted of 95 patients. The mean age of the cases was 33.00±10.89 and the mean education of the sample was 8.84±6.07. Duration of each attack had positive correlation with intensity of each attack (p<.01). Frequency (p<.01) and intensity of each attack (p<.05) of migraine episodes was positively correlated with disability. Quality of life was positively correlated with duration of each attack (p<.01) and disability (p<.001). Quality of life positively correlated with frequency (p<.01) and intensity of each attack (p<.001). Both frequency of migraine attacks and intensity of each migraine attacks were associated with...
increased disability perceived and poorer quality of life. Also more severe migraine episode and poorer quality of life were determinants of disability whereas more frequent attacks and more disability were determinants of poorer quality of life.

The effect of brief psychosocial intervention on the burden of care in the key relatives of schizophrenia


* Department of Psychiatry, IHBAS, Delhi; ** Department of Psychiatry, Dr. RML Hospital, New Delhi; *** Department of Psychiatry, KG Medical University, UP, Lucknow

Introduction: Schizophrenia is a chronic disabling psychiatric illness, which lead to severe impairment of social and occupational functioning of the individual. At the same time it also increases the burden of care of the care givers. Aim and objectives: To assess the burden of care of the key relatives of patients suffering from schizophrenia & to see the effectiveness of brief psychosocial intervention in decreasing the burden of care of key relatives of patients suffering from schizophrenia. Methods: A total of sixty six patients suffering from schizophrenia and their key relatives were enrolled in two different groups of 33 each. One group received brief psychosocial intervention and the other group received non specific intervention. Burden of care of both groups were assessed and compared applying statistical tests. Results and Conclusion: The groups of key relatives receiving brief psychosocial intervention have significantly less burden of care in comparison to those who received non specific intervention. Brief psychosocial intervention is superior to non specific intervention in reducing the burden of care of key relatives of patients suffering from schizophrenia.

Journey of a community from denial to activism: an instance of community active intervention

BS Chavan, Suravi Patra, Nitin Gupta
Department of Psychiatry, Government Medical College & Hospital, Chandigarh

Introduction: Substance abuse is determined by a multitude of factors like socio-cultural and political factors in addition to the biological predisposition and immediate environment of the individual. Society and culture determine drug using behaviour. Who takes which drugs and when are determined by the social, cultural and religious forces working in the community. Aim and Objectives: The present study is an ethnographic account of a community in Chandigarh, which is currently struggling with the problem of drug abuse and to identify and understand the process of change, if any. Methods: Key informant interviewing was carried out at a community outreach clinic of Dept. of Psychiatry, Government Medical College and Hospital, Chandigarh to evaluate the community perception about substance abuse and its readiness to change. Results and Conclusion: Based on key informant interviews the magnitude and extent of drug abuse was gradually brought into awareness of community members. The results are discussed in terms of four stages of community motivation to change: i) early hiccups, ii) denial to acceptance, iii) acceptance to action and iv) implementation. Using an ethnographic approach, a thorough understanding of the socio-cultural and political ethos of the community helped in chalking out and implementing an action plan in which the village leaders were given key responsibilities with the goal of having a drug free community.

Ideal mentoring and effect of mentoring on psychosocial behavior, lifestyle, sexual behaviour and health condition of professional students.

Vishal Jindal, Ajeet Sidana, Dinesh Kumar Walia, Sorab Gupta
Government Medical College and Hospital, Chandigarh, India.

Aim and Objectives: 1.To study the Socio-demographic analysis with regard to mentoring 2.To study the impact of mentoring on Psychosocial and health condition of today's youth 3.Ideal mentoring. Methods: Community-based cross-sectional study. “Unmarried” individuals attending various professional courses in and around Chandigarh who were willing to participate in study and capable of giving answer themselves. 271 study subjects selected by stratified multi-stage random sampling. age, educational status, religion, caste, occupation, perceptions attitude towards mentoring, perceived psycho social benefits of mentoring etc. normal test of proportion, Chi square test, Student's t test, Mann Whitney 'U' test. Also, risk analysis was done by bi-variate analysis and variate multi logistic regression analysis. Odds ratios along with 95% confidence interval were calculated. Results and Conclusion: shows mentor’s corresponding to different

©2012 Indian Association for Social Psychiatry
category showing highest percentage of mentor for OBC (66.7%) followed by ST(55.6%) and SC(50%). The mentor’s were found least in the general category (37.1%). Highest percentage of respondents having a mentor were found in one having laborer as their father 80%. Maximum respondents having a mentor were found in low (45.7%) and middle (44.8%) socio economic status. Individuals without a mentor fight more often on a daily and monthly basis. The mentor had a positive health wise influence on their protégé was witnessed as 56.6% people who had a mentor were engaged in daily physical activity. Contradictory to the common notion respondents with mentor were less aware about the availability of contraceptives, measures to detect pregnancy, consequences of teenage pregnancy, knowledge of emergency contraceptives. Mentor had positive influence on improving the lifestyle on all aspects of their protégé. Individuals with a mentor smoke less, drink less, do less drug use, chew less, have gambled less, have done less of fighting. One quality which most individuals were looking for in their mentor is friendly behavior and helping nature. Mentor concept is still prevalent according to the traditional Indian concept with more educated and high socio-economic class still refraining from this concept. Mentoring had a positive influence on the health condition of individuals in terms of exercise and body mass index. It also improved the general lifestyle of adolescents and decreased their substance abuse rate. So mentoring is an important tool in improving the conditions of adults in all aspects.

Prevalence and pattern of tobacco use among patients with mental disorders attending outpatient services in a Tertiary Care Hospital.

Archna Sharma*, BS Chavan*, Jaspreet Kaur**

*Department of Psychiatry, GMCH, Chandigarh; **Department of Physical and Rehabilitation Medicine Postgraduate Institute of Medical Education & Research, Chandigarh

Introduction: Tobacco use is a leading preventable cause of high morbidity and mortality globally. The association between smoking and mental illness has been known and studied for many years, but the focus of much of the work in this field has been on people with severe mental illness. Recent findings from a national probability sample indicate that people with a mental illness are twice as likely as non-psychiatric controls to smoke. Aim and Objectives: To study the prevalence and pattern of tobacco use among patients with mental disorders attending outpatient services in a Tertiary Care Hospital. Methods: All the new cases attending the outpatient services at Department of Psychiatry, GMCH, from August to September, were included. Patients with ICD-10 diagnosis of psychiatry disorders who gave history of smoking or chewing tobacco were included in the study. Socio demographic profile of the study subjects was recorded. Subjects were asked about the details of consumption of tobacco products (smoked as well as smokeless) including age of initiating smoking, current smoking frequency, average number of uses per day, types of tobacco smoked on a semi structure questionnaire. Patients were administered Fagerstrom Test for Nicotine Dependence for assessing the severity of tobacco dependence. Patients using chewable tobacco were assessed on Fagerstrom Test for Nicotine Dependence (smokeless). Appropriate descriptive analysis will be done. Results and Conclusion: Will be discussed later.

Neuropsychological Profile of Children with Learning Disability

Priti Arun, Archna Sharma, Sweety Sharma, Manreet Kaur

Department of Psychiatry, Government Medical College and Hospital, Chandigarh

Introduction: Dyslexia is a Neurological Condition that is characterized by difficulties that mainly affect the ability of a child to read, write and spell. Categorized as a learning disability it usually manifests as a problem in listening, thinking, speaking, reading, writing, or spelling or in a person's ability to do math. Learning disabilities (LD) vary from person to person. It has been reported that10-15% of school children in India have learning disabilities. Aim and Objectives: The aim of the study was to assess the neuropsychological profile of children presenting with learning disability to the child guidance clinic of a tertiary care hospital. Methods: The sample comprised of thirty children in the age range of 8-15 years (both boys and girls) who presented to the Child Guidance Clinic of Government Medical College and hospital, Sector-32, Chandigarh. All the children were assessed for deficits in language and writing skills and impairments in executive functions and perceptuo-motor tasks using the National Institute of Mental Health and Neurosciences SLD index, the Bender visuo-motor gestalt test, Raven's progressive Matrices and Malin's intelligence scale for Indian children. Results
and Conclusion: The mean age of children was 11.3 years (S.D.=2.45). Majority (70%) of them were boys ranging from class 3 to 9. Majority (76.67%) of them was from joint family and all of them presented with complaints of academic decline. The profile of deficits was assessed and analyzed using appropriate statistics. Further implications of the study will be discussed later.

**Effectiveness of Behavioral Intervention in reducing pain, anxiety and distress during venipuncture among children**

Rajni Sharma

**Introduction:** There is no question that children dislike needles; there are very little data available on the occurrence of high levels of distress experienced by children undergoing routine venipunctures. Children continue to find venipuncture one of the most frightening aspects of coming to hospital. Although modern pediatric practice has broadened in scope to include health supervision and counseling, many children are so preoccupied with the possibility of an injection that this worry dominates the entire visit and limits the opportunity for other interventions. **Aim and Objectives:** To see the effectiveness of behavioral intervention in reducing pain, anxiety and distress during venipuncture among children. **Methods:** 100 children were exposed to an intervention including use of different techniques of systematic desensitisation. Distraction techniques, relaxation training, positive reinforcement, graded exposure etc. have been used to reduce the anxiety, pain and distress associated with venipuncture among children. Children were counseled before the venipuncture procedure by using these strategies and distress was assessed before, during and after the procedure. Facial expressions were rated on key to Princess Margaret Pain Assessment tool (PMHPAT). Positive reinforcement was provided for cooperation. Relaxation training involves teaching the child how to gain control over the symptoms of physiological arousal by breathing slowly and deeply and releasing muscle tension. **Results and Conclusion:** Behavioral intervention found to be positive intervention procedure to reduce distress and anxiety associated with venipuncture. Children with a history of negative medical experiences show higher levels of anxiety prior to the procedure and to be more distressed and less cooperative during the procedure than children with previous positive or neutral experiences. Future research needs to focus on practical screening tools to identify which children may be at risk of experiencing venepuncture related distress, which strategies work for whom, group work and peer support.

**Do Blood Donors Suffer from Psychological Distress? A study from North India**

Nishi Jaswal, *Nitin Gupta, ML Kaushal, Sandeep Malhotra

Department of IH&BT, IGMC, Shimla & *Govt Medical College Hospital-32, Chandigarh

**Background:** There are very few studies that have assessed psychological stress and psycho-behavioural aspects in donors. NACO guidelines advise for screening to ensure that the potential donor is in a healthy state of mind and body i.e. ‘psychologically’ and ‘physically’ healthy. From India, there is no available study assessing psychological distress in healthy donors. **Aim:** To assess psychological morbidity in healthy blood donors. **Material and Methods:** Cross-sectional study carried out in the Department of Immunohaematology and Blood Transfusion, Indira Gandhi Medical College, Shimla. The donors were recruited through voluntary blood donation camps and replacement donors attending the department were also included in the study. 311 participants were assessed using consecutive sampling method as per NACO guidelines (for screening for physically healthy donors). All were given General Health Questionnaire-12 (GHQ-12) for assessing psychological distress, wherein GHQ score ≥1 was deemed as being positive. These were completed with the help of a counsellor, wherever deemed necessary. **Results:** The total sample comprised 311 donors. The mean age was 27.50 (Range=18-58) years. Of the total donors, 262 (84%) were males and 49 (16%) were females. 245 (78%) were voluntary donors and 66 (22%) being replacement donors. 140/311 (45%) had a GHQ-12 score of ≥1 (i.e. GHQ Positive). Positive GHQ scores were seen more frequently in ‘replacement donors’ (34/66; 52%) compared to ‘voluntary donors’ (106/245; 43%). The GHQ items most frequently scored as positive by the sample were- presence of sleep disturbances (42/140; 30%), feeling tense (53/140; 38%), difficulty in handling problems (40/140; 29%), not...
being able to enjoy daily life (42/140; 30%), and not feeling as happy as before (39/140; 25%), and losing one's self-confidence (56/140; 40%). **Conclusions:** There is a very high potential psychological morbidity in blood donors of either type. The main symptoms reported were indicative of general stress-related and depressive problems. There is a need to incorporate appropriate screening for potential psychological distress for donors in order to fully adhere with NACO guidance. The preliminary results point towards a need for more in-depth studies into psychological aspects of donors. We recommend a need for specialist psychiatric training for department counsellors in order to screen and assess for psychological distress and appropriate management by counselling or triaging onto psychologist/psychiatrists.

### Quality of Life of Multi Drug Resistant Tuberculosis patients: A study of North India

Raman Sharma, Ravinder Yadav, Varinder Saini, Vipin Koushal

*Government Medical College and Hospital, Sector-32, Chandigarh*

**Background and objectives:** Tuberculosis is still one of the leading causes of mortality and morbidity. Besides clinical impact, the disease affects the Quality Of Life (QOL) too. With the rise of 21st century, Multi-Drug-Resistant TB (MDR TB) has risen as a significant public health problem due to emergence of resistance to ATT drugs. **Methodology:** This study was planned to analyze the impact of MDRTB on QOL. It was a six month analysis, with a sample size of 60 cases each of MDRTB and PTB. It was based on a pre-designed, pre-tested questionnaire using WHOQOL BREF scale. **Results and Conclusion:** Out of each group, 38 (63.33%) and 36 (60.0%) were in the 21-40 years of age groups, more than 60% married and were residing in the urban/urban slums. It was found that QoL of MDRTB patients was worse than PTB counterparts. The psychological and environmental domains (MDRTB vs. PTB 17.46 vs. 15.23 and 22.00 vs. 18.91) were more affected as compared to physical and social domains (19.03 vs. 20.05 and 7.88 vs. 9.61) in MDRTB and PTB. Financially, MDRTB patients were worst suffers as compared to PTB as former were not being covered under any program, while both groups are affected socially due to social stigma attached with disease. Thus, there is a need to design an applicable, reliable measure to better address the quality issues methodologically. This would further enable the health care professionals and management to devise relevant interventions to improve the quality of the patients as well as the programme.

### Risk factors for Suicidal ideations in patients of Schizophrenia

Umamaheswari V, Ajit Avasthi, Sandeep Grover

*Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh*

**Aim and Objectives:** To identify the risk factors for suicidal ideation in subjects with Schizophrenia. **Methods:** The study sample included 34 patients diagnosed with schizophrenia (as per MINI), aged between 18 to 60 years. On the basis of the score obtained on Beck Depression Inventory (score of 1 or more than 1 on suicidal thoughts and wishes) the study sample was divided into those with and without suicidal ideation. All the subjects in both the groups were assessed on Brief psychiatric rating scale (BPRS), Beck depression inventory (BDI), Barrat's impulsivity scale version-11 (BIS-11), irritability, anxiety and depression (IDA) scale for irritability, anxiety and depression and Buss-Durke Hostile Inventory (BHI). **Results and Conclusion:** Twenty one patients (67.74%) had suicidal ideation. Compared to those without suicidal ideations, those with suicidal ideation had significantly more number of prior hospitalization, more severe depressive symptoms, higher severity of psychotic symptoms, higher level of anxiety and externally directed irritability and had significantly higher score on the attention domain of Barratt Impulsivity Scale. There was no difference between those with and without suicidal ideations with regards to socio demographic variables and other risk factors studied. Those with suicidal ideation more frequently attempted suicide in the current episode. Repeated hospitalization, severe depressive and psychotic symptoms, presence of anxiety and external irritability and impulsiveness are risk factors for development of suicidal ideation in patients with Schizophrenia.

### Socio-demographic and clinical correlates of Quality of life in patients with BPAD

Nidhi Malhotra, Parmanand Kulhara, Subho Chakrabarti, Sandeep Grover

*Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh*

©2012 Indian Association for Social Psychiatry
Aim and objectives: The aim of this study was to assess the quality of life of patients with bipolar disorder (BPAD) in euthymic phase and to study its sociodemographic and clinical correlates. Methods: Seventy euthymic BPAD patients were assessed on WHO-QOL Bref Hindi version. Residual psychopathology was assessed using Young Mania Rating Scale (YMRS) and Hamilton Depression Rating Scale (HDRS). Results and Conclusion: The total sample was 68 (comprising 39 patients and 29 key informants”). PatSat scores obtained were high for both sub-samples of patients and key informants’, reflecting high degree of satisfaction. Amongst patients, 21 had contact with Consultant Psychiatrist and 18 with Senior Resident; and amongst ’key informants’, 15 had contact with Consultant Psychiatrist and 14 with Senior Resident. There were significantly more PatSat items that were statistically different in the ’key informant’ group than the ’patient’ group when both were compared across the consultation process with Consultant Psychiatrist and Senior Resident. PatSat is not a culture-free instrument. There is a need for adaptation of PatSat to make it applicable for use in the Indian context. Implications of these findings shall be discussed with reference to cross-cultural studies in this regard.

Does an outpatient consultation with a Consultant Psychiatrist enhance satisfaction? A pragmatic exploratory study from a tertiary care hospital set-up

Nitin Gupta, Ankita Jain, Diksha Sachdeva

Department of Psychiatry, Government Medical College & Hospital-32, Chandigarh

Objective: To assess the patient's experience of the clinician during their first outpatient consultation. Methods: Patients having contact with psychiatry outpatient services were recruited by convenience sampling and written informed consent was obtained. Following contact was either with a Consultant Psychiatrist or Senior Resident-I/C (outpatient services). After their consultation, patients were immediately recruited and administered the following scales viz. Patient Satisfaction Scale (PatSat), Socio-demographic profile sheet, Clinical Profile sheet. Data was analyzed using descriptive and inferential statistics.
statistics. **Results and Conclusions:** 29 patient-caregiver pairs were recruited. PatSat scores obtained were generally high and showed high degree of concordance between patient and caregiver; irrespective of the clinician. Implications of these findings shall be discussed with reference to their applicability in the Indian clinical setting.

**Home based neuropsychological rehabilitation in traumatic brain injury: a case report**

Manju Mohanty, S K Gupta

*Department of Neurosurgery, PGIMER, Chandigarh*

**Introduction:** Traumatic brain injury is the most common cause of death and disability in young people. Advances in critical care, imaging and trauma system organizations have led to a decrease in mortality from head injury but survivors often suffer from cognitive deficits and emotional problems. Neuropsychological rehabilitation has been found to be useful in improving the cognitive function and day to day functioning. Due to severe paucity of trained manpower and rehabilitative services, these cause a significant burden on the care givers. Thus there is a need to look for alternatives. **Aim and Objectives:** The aim of this study is to explore the efficacy of home-based neuropsychological rehabilitation in traumatic brain injury. **Methodology:** A 23-year old female was referred for post head injury neuropsychological assessment and rehabilitation. A detailed neuropsychological assessment was carried out pre and post intervention. **Results and Discussion:** The findings revealed significant impairment in her attention, verbal memory, visual memory, working memory, information processing speed, verbal fluency, social and occupational functioning. She was given a home based neuropsychological intervention package. The father was trained to impart the training. Her performance on neuropsychological assessment and dysfunction were compared pre and post intervention. The results indicated improvement in her cognitive functions, social and occupational functioning.

**Profile of adolescents who drop out after first visit**

Priti Arun, Chandrabala, Preeti Jhamb

*Department of Psychiatry, Govt. Medical College & Hospital-32, Chandigarh*

**Introduction:** A large number of patients who visit psychiatry OPD drop out after first visit. **Methodology:** Study was conducted in psychiatry OPD of Government Medical College and Hospital. A retrospective review of walk-in Performa of patients in the age group of 11 to 18 years who dropped out after first visit during four years period (2008-2011) was done. Socio-demographic data and clinical variables were noted. **Results and Discussion:** During this period a total of 2007 patients (1233 boys and 774 girls) in 11 to 18 years age group were seen. Out of these 985 (49%) dropped out. Out of boys who attended OPD 46.6% dropped out and out of girls 53% dropped out. Deliberate self harm was present in 0.8% cases. Stress due to various reasons was present in 6%, out of these 2.8% had academic or exam related stress, death of a loved one in 1% and romantic affair in 0.6%, other causes of stress were present in 1.6% of cases. Dissociative disorder was diagnosed in 3.4% cases, depressive disorder in 2.9%, borderline intelligence in 2.3%, mental retardation in 3%, anxiety in 2% and seizure disorder was present in 1.7% cases. Further implications will be presented.

**Knowledge, Attitude and Practice concerning physical health among inpatients with severe mental illness (SMI): Preliminary findings.**

Nitin Gupta, Suravi Patra, Priyanka Kalra

*Department of Psychiatry, Government Medical College & Hospital, Sector 32, Chandigarh*

**Aim and Objectives:** Patients with severe end enduring mental illness (SMI) have a higher prevalence of obesity, metabolic syndrome and diabetes mellitus than general population. Literature suggests inadequate recognition, monitoring, and management of SMI patients for these problems. Inadequate research is available for patient-related factors, especially related to their knowledge, attitudes and behaviour. No such study is available from India. This study had the following objectives viz. to assess the knowledge, attitude and practice (KAP) of physical health among patients with SMI; and to identify any relevant socio-clinical correlates with KAP. **Methodology:** Prospective inpatient cross sectional study carried out in the inpatient wing of Department of Psychiatry, GMCH-32, Chandigarh. Patients aged 18-60 years, and diagnosed with SMI (ICD-10 codes: F20-29, F30, F31) were recruited. Those with dementia, mental retardation, personality disorders were excluded. Patients were assessed just prior to discharge and were clinically stable and cooperative for atleast 48 hours. They were assessed on a specially developed Knowledge, Attitude,
Practice- Physical Health Questionnaire for SMI patients, Global Assessment of Functioning Scale (GAF), Brief Psychiatric Rating Scale (BPRS), Socio-demographic sheet, Clinical Profile sheet. Written informed consent was obtained prior to intake. Analysis was carried out using descriptive and inferential statistics. Results and Conclusions: A total of 16 patients suffering with SMI were assessed. 63% were males. Eight patients had a diagnosis of Bipolar Disorder-current episode mania, seven suffered with schizophrenia and one had persistent delusional disorder. The mean age of the patients was 32.38 years. The mean GAF score was 52.875. Variable results were obtained on KAP by the SMI patients; these will be highlighted in the presentation. Preliminary results indicate a need for enhancing knowledge, and modifying attitudes and behaviour of patients with SMI towards their physical health. Implications and strategies will be discussed.

Aetiological Models and Help Seeking Behaviour in patients with Bipolar disorder

Natasha Kate, Sandeep Grover, Parmanand Kulhara

Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh

Aim and Objective: Aim of this study was to assess the personal beliefs, aetiological models and help seeking behaviour of patients with bipolar disorder using a self-rated questionnaire. Method: Thirty eight (N=38) euthymic patients with bipolar disorder completed Supernatural Attitude questionnaire. Results and Conclusion: The mean age of the patients was 37.4 (SD-12.6) years and mean duration of education was 11.76 (SD-3.6) years. Most of the patients were males (63.2%; N=24), married (76.3%; N=29), employed (44.7%; N=17), Hindu (71.1%; N=27), came from urban (60.5%; N=23) and nuclear families (63.2%; N=24). More than one third of the patients (39.5%) believed that illness was caused due to family or work related stress. One third (31.6%) believed that the illness was due to biochemical changes in the brain. Another one-third (34.2%) of the subjects with bipolar disorder believed that mental illness can occur either due to sorcery, ghosts/evil spirit, spirit intrusion, divine wrath, planetary/astrological influences, dissatisfied or evil spirits and bad deeds of the past. One fourth (26.3%) of the patients attributed mental disorders to more than one of these beliefs. Very few patients believed that only performance of prayers (21.3%) or performance of magico-religious rituals (13.2%) was sufficient to improve their mental status. About one-fifth (21.1%) admitted that during the recent episode either they or their caregivers performed magico-religious rituals in the hope of improvement in their mental illness. About one-third (34.2%) admitted that they performed prayers or other religious rituals during the most recent episode. Patients with bipolar disorder have varied etiological models about their illness. Clinicians should provide adequate information to these patients with a focus on current level of understanding about bipolar disorder to improve the treatment outcome.

Delusion of Dhat: Diagnostic Dilemma, Case Report of an Adolescent Boy Presenting with Somatic Delusions

Suravi Patra, Ajeet Sidana, Nitin Gupta, Neeraj Jain

Department of Psychiatry, Government Medical College & Hospital, Chandigarh

Introduction: Dhat syndrome (semen loss-related psychological distress) is a culture bound syndrome seen in natives of Indian subcontinent. This syndrome is based on a shared cultural belief that semen is a precious body fluid and its loss leads to weakness in body and mind. Syndrome involve vague and multiple somatic and psychological complaints such as fatigue, listlessness, loss of appetite, lack of physical strength, poor concentration, forgetfulness and other vague somatic troubles. It commonly affects young male from average or low socioeconomic status of rural areas belonging to families with conservative attitudes toward sex. It is commonly described as neurotic sex disorder. Aim and Objectives: To present a case report of an adolescent boy presenting with somatic delusions. Methods: Here the authors have reported a case of dhat syndrome with associated somatic delusion. The patient attributes his weakness and bodily pain to the semen loss. This delusion has led to abnormal behaviour of posturing in upside down position lasting for hours and pinching at different parts of the body. He would also resort to strenuous exercise to undo the weakness caused due to loss of semen. The patient also did not allow erection and, if erection occurred, he would hit the penis with comb/scale. Results and Conclusion: The detailed psychopathology and management will be discussed at the time of presentation.

Attitude towards suicide and suicide attempters of people from rural India

Abhijit Rozatkar

Assistant Professor, Department of Psychiatry,
Introduction: Suicide is among the top five preventable causes of early mortality. Suicide rate in India is about 10.3/100,000 general population. The stigma related to suicide and suicide attempters is complex issue that arises from various factors like religion, the law or misunderstandings about the causes of suicide. Due to these and other misunderstandings about suicide, some people attempt to distance themselves from people and topics associated with suicide. Those who survive a suicide attempt often experience severe stigmatization specially related to vocation and may simply be called as “attention seekers”. Suicide survivors (loved ones of those who completed suicide), more often their family members, have reported greater perceived rejection, shame, and stigma. Social distance is akin to stigmatization, and refers to the intimacy, indifference, or hostility one displays towards particular people or groups. Thus, the stigma associated with suicide is widespread, affecting suicide attempters, the loved ones of the deceased, and even those experiencing suicidal ideation or desire. Although suicide stigmatization is a far-reaching and widespread problem, it has never been systematically studies in India. Methods: Nursing students currently undergoing training at Dr R.P. Govt. Medical College in Himachal Pradesh were asked to fill the Stigma of Suicide Scale (SOSS)-Short form, the Stigma of Suicide Attempt (STOSA) scale and the Stigma of Suicide and Suicide Survivor (STOSASS) scale. Results: The study is currently ongoing with 33 completed assessments. Further data is still being collected and shall be presented at the conference.