

**INDIAN JOURNAL OF SOCIAL PSYCHIATRY**  
**Vol. 29 (3-4), 2013**  
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**Commentary and Reflections on The First Editorial [Reprinted from IJSP 2008, 28 (1-2), 8-9]**

**RELEVANCE OF SOCIAL PSYCHIATRY IN INDIA – A REAPPRAISAL**

**J.K. Trivedi, Kailash S.**

It is a matter of great honour and privilege to offer a commentary on the Editorial of the Inaugural issue of Indian Journal of Social Psychiatry (IJSP), 1985 by Prof. B.B. Sethi on the topic "Relevance of Social Psychiatry in India". Viewed from the prism of the 27 year old editorial, Social Psychiatry appears to be all the more important and significant in present day India. Social and cultural factors play an important role in mental health promotion, causation, management and prevention of illnesses. This section will aim at a current assessment and a refocus on the topic at hand and would eventually review the progress and important milestones of the Indian Association of Social Psychiatry (IASP) and the Social Psychiatry movement in India.

The veritable boom of biological psychiatry has been a feast for the etiology-starved psychiatric minds. Bio-medicalization of psychiatry has been influenced to a greater extent by the pharmaceutical industries. Every physician is trained to view 'disorders' as being caused by predominantly biological factors right from the period of undergraduate training. The realisation that disorders can also occur because of psychological and socio-cultural factors and learning their modes of intervention, can happen only with extensive individual training and expert supervision, which is far from adequate in every field of medicine. As the contribution of psychological and socio-cultural factors is more in the field of psychiatry, the above mentioned deficit in training becomes more apparent in this field.

In India, the role of socio-cultural factors in mental health is indispensable. Rapid urbanization and growing technology has cut across national boundaries and is continuously testing the ability of people to adapt to this modernisation. Disappearance of the joint family and the support system that comes along with it, is resulting in the depletion of one of India's most valued resources. Stigma, problems of the deprived and socio-cultural issues specific to women are areas of interest not only in the developing countries like India but also in developed countries. Family care and burden, disability, suicide including farmers suicide, religion, spirituality, help-seeking behaviour, pathway of care and preventive psychiatry are areas of specific interest in India and a great deal of work still needs to be done in these areas.

Many reasons can be thought of for biological factors gaining greater attention than social factors. Biological factors can be easily assessed, are less time consuming, treated by medications and because of the complexity involved, psychiatrists are more interested in possessing it. Mental health professionals tend to follow the biological model and rely on medications for their treatment so that they are more likely to get respect from their fellow colleagues of other disciplines. On the other hand, social and cultural factors are difficult to assess, more time consuming, needs expertise to intervene and also the fact that it is easily understandable by many makes it less attractive for a psychiatrist to possess and practice it. There is also a perception that social and cultural factors are not that easily modifiable. Cutting a clear cut balance among these factors is the need of the hour for better care of the patients.

As aptly said by the first editor of IASP, most biological factors need significant social and environmental factors for their expression. Treating a disease which originates due to social factors, with biological means like medications and ignoring the social factors, would do no good for the patients. Socio-cultural factors not only play an important role in mental illnesses but also contribute significantly in most physical illnesses. Training the budding psychiatrists in assessing the socio-cultural aspects of mental health and disease and also in the modes of intervention would be of paramount importance in making Social Psychiatry reach the people in need.

A review of important milestones in the development of IASP and social psychiatry movement in India would give us an idea of the meticulous efforts that have been taken so far in this area. From the gestation of IASP in the Transcultural Psychiatric meet in Madurai, 1981 to its birth in Ranchi, 1984, the felt need for giving increased attention to socio-cultural factors in mental health and the need for an independent organisation for the same have been met to a certain extent by the IASP. The IASP today has more than 700 members from various disciplines related to mental health, aiming at furthering the vision of its founding fathers. Attempts at keeping up the commitment made by the association to

study the influence of culture on mental health and to share this knowledge in the practice of Social Psychiatry with other fields have been done by regular National conferences of IASP (NCIASP) and by the IJSP. From the first NCIASP in Kodaikanal to the last NCIASP in Patna, every conference has dealt with important social issues relevant to mental health. Three new awards have been added in the National conferences to encourage research in the field of Social Psychiatry. Keeping in pace with the growing technology, the official website of IASP has come into being from 2008, with all issues of IJSP from 2006 being accessible online.

Many memorable milestones aimed at International collaboration of IASP surely deserve a mention. The IASP organised the Regional Symposium of World Association of Social psychiatry (WASP) in New Delhi, 1989. It hosted the 13th Congress of WASP in New Delhi, 1992. IASP got formally affiliated with World Psychiatric Association (WPA) in 1993. IASP hosted the Regional Symposium of Transcultural Psychiatric Section of WPA in Chandigarh, 1995. Prestigious posts like the President and Secretary General of WASP, Regional representative from South Asia Zone to WPA, Co-Chairperson of Preventive Psychiatry section, WPA and the Secretary General of WASP have been held by esteemed members of IASP. IASP has also become a voting member of World Federation of Mental Health (WFMH). Recent NCIASP and specific symposia have been co-sponsored by WAP and WASP. All the above milestones signify better International collaboration and the ever increasing say of IASP in the global platform.

In spite of all the above mentioned efforts, the extent of the influence of Social Psychiatry movement in India on the day-to-day clinical practice and attitude of

psychiatrist and policy makers remains questionable. Focus on training young mental health professionals would go a long way in furthering the cause of the association. On the other hand national policies aimed at resolving important socio-cultural problems like unemployment will improve the mental health of the population as a whole.

**There is an urgent need to curtail the transition of the George Engel's Bio-psycho-social model of disease to Bio-bio-bio model of contemporary psychiatry in order to retain the person-centered holistic approach in the field. The Silver Jubilee conference of IASP held at Lucknow had aptly chosen "Mental Health: Prioritizing Social Psychiatry" as the theme for the conference, clearly throwing light on the path which the Social Psychiatry movement in India should adapt in the forthcoming years. With the 20th century predominantly being one of biological treatments and psychotherapy of mental disorders, let us hope that the 21st century would be one of Social Psychiatry.**

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In Memoriam...

**PROFESSOR J.K. TRIVEDI (1952-2013): A MEMORIAM**

**Vijoy Varma**

In mid-1970s, I was much involved with the Department of Psychiatry, King George's Medical College, Lucknow. I was periodically invited there as an external examiner for their M.D. degree. It was on such an occasion that I met Professor Trivedi who completed his M.D. degree there in 1977. Although he was a student and an examinee and I was an examiner, we struck a pleasant relationship, which blossomed over the years.

With his easy manners, Professor Trivedi immediately attracted me. Being junior to me in years as also in professional stature, he was deferential; however, without being subservient. He would also stay above the petty local politics of the institution. 1990s witnessed more of a turmoil in Lucknow with a criminal case being prosecuted against Professor Sethi, the HOD of Psychiatry.

As it is, I was very close to Professor Sethi, considering (and still regarding) him as my elder brother. He was almost family to me. Although he was controversial in many ways, that did not concern me or my relationship with Professor Trivedi.

In 2007, I was invited to Lucknow for the Founder's Day of the Department. Although he was not the HOD at that time, he was kind enough to host me in many ways. There was a very pleasurable dinner at his place. I remember that he kindly explained to me that, in Sanskrit, 'tr' is a separate letter, as in his name, something that I did not know.

Professor Trivedi was very much active in professional activities in psychiatry and mental health. He distinguished himself in both national and international activities and achieved accolades and recognition, perhaps as much, if not more than most of his colleagues in India. He was also very active in national and international conferences and activities in mental health. Not only that he attended these meetings, he acted as a catalyst for others, particularly other Indian colleagues.

In 2009, I was presenting a programme at the annual meeting of the American Psychiatric Association, along with my junior colleague, Dr. Nitin Gupta. At the conference itself, Professor Trivedi gave us a suggestion to present a workshop on psychotherapy at the next

conference of the Indian association for Social Psychiatry. We followed up on it resulting in the Workshop presented at the next IASP conference in Lucknow in November 2009. This has been followed by the Workshop being presented in 2010, 2011 and 2012, to the point that it has become a regular fixture of IASP. With my own personal involvement with the IASP, I consider this as his invaluable contribution to IASP and to social psychiatry and psychotherapy.

Professor Trivedi was also closely involved with the professional activities in India. He served as the Editor of the Indian Journal of Psychiatry with great distinction and took it to new heights. He served as the President of the Indian Psychiatric Society in 2004-05. He contributed a very good chapter for our book "Culture, Personality and Mental Illness" published in 2009. As usual, his chapter indicated his high marks. He was very cooperative in this task.

Professor Trivedi had very high personal qualities. He combined the unusual qualities of scholarship and rigorous research. He was friendly and conciliatory. At the same time, he held his ground.

In 2007, we went together to a conference in Sri Lanka. When we were checking-in in Colombo for the return flight, he said to me, "Sir, I have got a new grandson; I would like you to bless him." I did that and, being at the airport, bought for him a bunch of duty-free chocolates. This illustrates his humanity and humility.

Professor Trivedi was a first-rate psychiatrist and mental health professional and a thorough gentleman. In his premature demise, the profession in India – as also globally – has lost a great psychiatrist. He was always active in the profession and his ready presence will be sorely missed all over.

May his soul rest in Peace!

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Professor Vijoy K. Varma, M.B., B.S., M.D., M.Sc., D.P.M., Dip. Am. Bd. Psychiatry, FAMS, FRCPsych; Past President, Indian Association for Social Psychiatry; Professor of Psychiatry (Retired), Postgraduate Medical Institute, Chandigarh (E-mail: vijoyv@frontier.com).

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**In Memoriam...**

**'JKT' ..... A WONDERFUL HUMAN BEING WHOM THE WORLD WILL MISS**

**P. Joseph Varghese**

The sad demise of Prof. J.K. Trivedi President Elect of Indian Association for Social Psychiatry is a great loss not only for the Indian Association for Social Psychiatry but for the psychiatric community of the whole world. It is only appropriate that Prof. Debasish Basu, Editor of the Indian Journal of Social Psychiatry, has decided to bring out a special edition of the journal in his memoriam. My association with Prof. J.K. Trivedi spans for more than two decades. I was acquainted with him while attending national conferences of Indian Psychiatric Society. Slowly my relationship with JKT (as we fondly call him) blossomed into a close and deep friendship. He was one of the most loyal and dependable friends. He was always a gentleman to the core and sober and mature in his reactions. He had a deep understanding of people and didn't have malice towards anybody. He was always meticulous, punctual and serene. He always had a sense of justice and fair play in all his decisions. I had the opportunity to work closely with him while he was the Editor of Indian

Journal of Psychiatry, President of Indian Psychiatric Society and Zonal representative of World Psychiatric Association. The silver jubilee conference of Indian Association for Social Psychiatry organized by him at Lucknow in 2009 was a testimony to his organizational skill. I also knew his family, his wife and two sons who were great sources of strength to him. I have fond memories of him staying with me while he was in Kerala to attend a social function. He has been a wonderful human being whom the world will miss.

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In Memoriam...

**DR JITENDRA TRIVEDI - AS I REMEMBER HIM**

**A.K. Agarwal**

Jitendra Trivedi worked hard to achieve his goals. I had known him for nearly forty years as a student, a trainee and as a colleague in the profession. My last meeting with him was few months before he breathed his last. I went to visit him after his father's death. He already had a total renal failure and was undergoing regular dialysis. I went to his home in the evening and was expecting that he must be resting. He was busy examining a patient, once he was told that I had come to see him, he asked his wife Upama to look after me and he joined us few minutes later. We talked about his father and his illness, and he did not show any apprehension and was looking forward to his work and life in future. We discussed Yoga and its effects on health and illness. Here was a man who had lost his father few days back and had a severe physical illness personally and was focused on profession and future.

He joined the Department of psychiatry as post graduate student in 1974. He was eager to learn and was very conscientious in clinical work. He was interested in research from the beginning and got involved in various research projects with the then head of the department professor B.B.Sethi. He was involved in various ICMR projects and worked hard. He later joined the department as faculty and progressed to become professor. We used to have interactions during clinical case conferences. Whenever there was a disagreement on diagnosis or management he always wanted to express his views without any fear or favor.

When I was the head of the department he wanted to go abroad for training to Australia and he was selected for the same. But after the selection he thought that going abroad at this time may not be good for his family. He therefore declined the offer. He could make a balance between career and family.

He was a very good speaker and he was one of the presenters in most of the presentations that were held at Lucknow. He worked as assistant editor with me and professor Sethi. He could be totally relied upon doing his job effectively. He later worked as editor of the Indian Journal of psychiatry for nearly six years. He could not accept deviations from his path and that helped him to stay focused on his chosen path. He would get along with some and may not get along with others at all. He had strong likes and dislikes.

He was a good teacher and most of his students liked him. The destiny has snatched him away from his chosen path. It is said that God calls them back early whom he loves the most. May God give peace to his soul and courage to his family to bear this loss.

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**In Memoriam...**

**REMEMBERING JITENJI (PROF.J.K.TRIVEDI).....  
R.Srinivasa Murthy, S.K.Tandon, S.B.Mangalwedhe**

It is with a sense of shock and personal and professional loss we heard about the untimely demise of Prof.J.K.Trivedi. I (RSM) would refer to him as 'Jitenji', as that is how I would like to remember him. The untimely demise of Jitenji is a big loss to the family and the psychiatric profession. He has been a fine person, and his psychiatric contributions have been monumental. In the following section, three aspects of his life are focussed, namely, as a professional (RSM), as a colleague (SKT) and as a teacher (SBM) by three of us who have known him for periods ranging from 30 years to three years.

**As a professional (RSM):**

I want to recall and share one area of his very important contribution, with which I was actively associated with, I am referring to the 'Long term mental health epidemiological survey of survivors of Bhopal Tragedy'. In December 1984, when the Bhopal disaster occurred there were no psychiatrists in the city of Bhopal. Thousands needed urgent mental health care. Prof. B.B. Sethi, Professor of Psychiatry, K.G.Medical College (KGMC), Lucknow and myself were invited by the Indian Council of Medical research, New Delhi in the first week of February 1985 (two months from the time of the disaster) to assess the mental health impact of the disaster on the survivors. This was a unique opportunity for me to join hands with a senior colleague. We studied the situation, over a week, and coined the phrases 'Wounded Minds' to go with the well recognised 'Wounded bodies' of the Bhopal Population. The challenge was to address the vast mental health needs of the population. It is at this time, under the leadership of Prof. Sethi, a remarkable visionary, that a team of residents moved from Lucknow to Bhopal in batches to provide essential mental health care. Jitenji was lecturer of psychiatry at KGMC, and he was the leader of the Lucknow team. I was part of the NIMHANS team along with Dr. Mohan Isaac, and we focussed on training of medical officers on essentials of mental health care.

The Lucknow team provided yeoman service by providing essential mental health care. Jitenji and residents, in rotation, moved from Lucknow to Bhopal, in small batches and became the foundation for mental

health care in the city (see more details of this period as recalled by Dr. Tandon). In addition to providing mental health care, the team surveyed general medical clinics for mental health problems, in 1985, and established the high rate of prevalence. This study paved the way for setting up of Departments of psychiatry in each of the medical colleges and mental health care in the Bhopal city.

From 1985 to 1994, the Lucknow team carried out the annual general population epidemiological survey of the severally affected, mildly affected and control populations. This is a milestone in psychiatric epidemiology, in general and disaster mental health in particular in the country. There were many challenges of collecting data, disaster mental health was new, the new diagnostic group of post-traumatic stress disorder had been introduced into the DSM-III. I continued to be associated as part of project advisory committee and the larger scientific advisory committee. Every year we met to understand the results and plan interventions. One technical issue came as the survey progressed. The tool that was used for data collection was the interview schedule that asked the head of the household for symptoms in the family members. As the survey progressed we realised this is not sensitive to the experiences and distress of the individuals. It was decided to use a tool for individual distress, namely, self reporting questionnaire in the fifth year. The result of this survey was very different. Jitenji was hesitant to change the methodology nearly at the end of the survey, but saw the relevance of the issue and agreed to the same.

Last year (2012) Jitenji and myself re-established the Bhopal contact, in preparing a manual of mental health care for medical officers. Jitenji gave his best for this effort. It was always a pleasure to work with Jitenji. I will miss him, as a friend and valued professional colleague, very much.

**Recalling him as a teacher and colleague (SKT)**

I know Professor J.K. Trivedi since I joined the Department of Psychiatry, KGMC, Lucknow as postgraduate student in 1981. I had an opportunity to work under him as postgraduate student, as research

associate and as well as senior research officer. He was very sincere, hardworking and dedicated to his work. He was equally involved in teaching, research and patient care. He used to keep engaged all the postgraduate students in all these activities with good guidance and support. Professor Trivedi was so caring to us that often he used to say "Baccha, Sab Theek Hai" (son, everything is alright?), "Koi Pareshani to Nahi" (is there any problem?). I have carried out several research works under his guidance out of which two of them are worth mentioning here. One was platelet MAO activity in chronic schizophrenia for which Professor Trivedi was awarded Poona Psychiatrists' Association Award in 1989.

His contribution in clinic based and community based mental health survey along with psychiatric care to affected population at Bhopal after the Bhopal Gas Disaster in 1984. I remember the day when we went to start the psychiatric clinic in gas affected area of Bhopal on first day. We had only few chairs and a table under a temporary roof. He saw all the patients with keen interest and taught us how to treat these patients with our limited resources. He was very soft and supportive while seeing the patients. He had very good organising skill. Throughout our stay at Bhopal the whole team worked sincerely under his guidance and we never felt that we are away from home.

There is a lot to say about Professor Trivedi, but in brief indeed he was sincere, hardworking with excellent organising skill and full of dedication. He had full concern for everything and very much helping in nature.

#### **A Resident's experience (SBM)**

I was a resident in the Department of Psychiatry, from 2009-2012, and would like to share my experience of being taught and supported in my growth as a psychiatrist. One of the most important aspects of Prof. Trivedi was his discipline. He would be always in the department from 9 a.m. to 4 p.m. Often, when he travelled, he would come straight from the airport to the department and work for the remaining day. He Unit was known to all of us the most demanding unit to work. Lot was expected of us and the three months used to be the most demanding period of the three year course. However, at the end of the three months, there was a happy feeling for the tremendous learning that occurred during that period. One important aspect of Prof. Trivedi was the individual attention he gave to each of the resident. He assessed our strengths and weaknesses and worked at a one to one level to improve

our clinical and personal skills. In spite of his busy schedule, he made time for each of us. Another aspect of Prof. Trivedi was the involvement of the resident in the various national and international presentations and publications. He used this as a way of training us and giving confidence in our ability to reach these forums. In preparing presentations, he worked with residents, made corrections, brought greater depth to the subject with his wisdom. It was indeed a pleasure to be so associated with such a senior teacher in so intimate a manner. As a teacher, he prepared meticulously for the classes and had the great humility to ask, after the lecture, for any suggestions or missing points in his lecture. This was a rare characteristic of him. Personally, though, my thesis was under another faculty member, he went out of the way to help me complete the same. Prof. Trivedi was easily approachable to his students and very helpful in their personal problems apart from professional ones. Lastly, none of us realised that he was not in perfect health, till recently, as he never compromised his responsibility to his patients, students and the larger psychiatric profession. I cherish the memory of my association and look forward to make my professional work modelled on his work.

#### **Epilogue (RSM):**

Jitenji has contributed and changed many areas of psychiatry in general and social psychiatry in particular both in India and the developing countries. Our prayers for peace to the departed soul.

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**CORRESPONDENCE:** Prof. R. Srinivasa Murthy

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In Memoriam...

**REMEMBERING "JKT"**

**Ajit Avasthi**

In the sad and untimely demise of Prof. J.K. Trivedi, I have lost a very dear friend. Although I had heard about him and even read many of his articles that appeared in the Indian Journal of Psychiatry and elsewhere, I happened to meet him personally first time at a scientific meeting in the summer of 1988. He struck me as a knowledgeable, amiable person but a bit over confident. He would laugh loudly and appeared somewhat boisterous. We started running into each other in one or the other conference. His stock was soaring and he looked set to go places in Indian Psychiatry. He was now more popularly known as "JKT" and I too started addressing him with the same informality. Soon he was the Editor of Indian Journal of Psychiatry and that is the time when we came closer to each other. We happened to be together once at Singapore. He was in the company of his associates from KGMC and Lucknow and I was the only one from Chandigarh. That is when I discovered a new facet of his personality full of friendliness, caring, an interesting company and a superb conversationalist. We were there with our spouses and that helped to develop our relationship beyond professional and personal spheres to family level. He was now "Bhai Sahib" for me.

Prof. Trivedi occupied the august office of President of Indian Psychiatric Society. He initiated clinical practice guidelines for psychiatrists in India. He started trusting me and I was his favourite choice as the Convener of the Task Force set up for this purpose. This was around the time when we planned to hold ANCIPS at Chandigarh. What a support I got from him as President of the Society! Many people complimented us for holding an exemplary Conference. I only knew that much of the credit for it rested with JKT. He had taken upon himself a role to mentor me and he was the first one who almost implored with me to first contest for the office of Editor

of Indian Journal of Psychiatry and when I refused, he did not lose the opportunity to push me to contest for the highest office of Indian Psychiatric Society. Our relationship strengthened further when he faced an unfortunate situation in the Indian Psychiatric Society and he found in me a friend and a brother with whom he could share his anguish.

JKT was a workaholic. He could never sit idle. His desire to contribute more and more to the profession did not diminish even when he learnt that his health was not on his side. I would tell him to go slow, give due importance to his health but he would not head to my advice. He asked me to contribute a chapter to a book that he wished to bring out, he made me a part of REAP study for which he was the National Coordinator, and just a few weeks before he passed away I received a mail from him requesting me to be a part of the symposium that he planned for the forthcoming SAARC Meeting at Mysore. I would get angry, would immediately ring him up and sometimes scold him, at other times plead with him to leave all this. He would just laugh, though not so loudly now! And then I was told that he was gone. Ajit Avasthi had lost a friend, a brother but Indian Psychiatry had lost a leader, a fine researcher, an inspiring teacher, an avid clinician and an able ambassador of Indian Psychiatry at International arena. Psychiatry lost a good student!

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**Ajit Avasthi**, MD, Former President, Indian Psychiatric Society, and Professor, Department of Psychiatry, PGIMER, Chandigarh

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In Memoriam...

**A TRIBUTE TO JK TRIVEDI**  
**Roy Abraham Kallivayalil**

We are aggrieved by the sad and untimely demise of Prof JK Trivedi on Sept 16, 2013 (1952-2013).

At the time of his demise, he was President-Elect of Indian Association for Social Psychiatry, member of EC of Preventive Psychiatry Section of WPA and Chairman, Preventive Psychiatry Section of World Association of Social Psychiatry. He was also Fellow of the Royal College of Psychiatrists UK and Fellow of the American Psychiatric Association. He was one of the foremost researchers in Psychiatry from India with more than 300 publications in reputed national and international Journals.

The formation of SAARC Psychiatric Federation on September 19, 2004 at Lahore bears testimony to his leadership skills. He was the President of the Indian Psychiatric Society and myself the General Secretary of IPS at that time. His name was proposed as the President of the new organization. But he politely declined and proposed the name of Prof Abdul Malik of Pakistan as President and myself as Secretary General. We rarely see such sacrifices in public life.

I had the rare opportunity to work with him closely for nearly three decades. For many of us, he was a friend, philosopher and guide. To me, he was my dearest friend as well. We had travelled together and stayed in the same hotel room (to cut expenses) in many parts of the world. He would be carrying vegetarian food items, which we used to eat together. He had extremely polite manners. He will be waiting at the breakfast table till you have arrived.

He was very much attached to Social Psychiatry. Although he was one of the founder members, he had forgotten to renew his membership. When he was elected as a Fellow of IASP, I had the pleasure to propose his name. Later when I was President of the IASP, when I suggested that he should organize our Silver Jubilee Conference at Lucknow in 2009, he readily agreed and successfully organized one of the best conferences ever. In September 2010 we had travelled together to Marrakech for the World Congress of Social Psychiatry. It was he who had proposed my name for the post of

Secretary General of WASP. Before the actual election there were lengthy deliberations in which JKT took very active part and gave wise counsel.

**Condolences from all over the world**

We have received hundreds of messages from all over the world, only a few of which could be included here below due to paucity of space:

**Julio Arboleda-Florez** (Past President, World Association for Social Psychiatry): "I am extremely shocked by the sad news. Professor Trivedi, a towering figure in Psychiatry in India and internationally, was highly respected and, personally, I always appreciated his reasonable advice about many diverse issues in our associations. Please, accept and convey to his family and to all the colleagues in India my deep condolences for such a loss".

**Edgard Belfort** (Secretary for Education, WPA): "Dr. Trivedi's death is a truly big loss for not only Asian Psychiatry but also to the World of Mental Health. He was a guide, always willing to convey his wisdom and knowledge, the number of publications prove it, in addition to be a friendly man".

**Guiseppe R Brera** (Rector, Ambrosiana University, Italy): "I'm close to you in this sad moment and I ask you to extend my and University Ambrosiana condolences to his family and colleagues. May we remember him for his noble presence in life, his love, and the relief of many patients' and the important contributions to science, humanity and teaching. God is embracing him in the eternal life. I want to dedicate to him, his family and his friends these words that he has today inspired:

Death is

A sudden or expected

Undesirable friend of life

An infinite breathing

Of suffering

Toward an universe

Of love,

Mystery and reality  
Of our birth  
God's conception  
Of his Person  
Of our Persons....  
Here  
We meet our destiny  
All phantoms  
Of a true being,  
Shadows of the Light  
Or nights  
Of hope, truth, mercy  
For the eternal world  
For an eternal world....."

His sudden and untimely demise is a big loss to the world community of mental health professionals. We deeply mourn his sudden demise. Prof Trivedi is survived by his wife Dr Upma Trivedi (gynaecologist) and two sons Dr Mohit Trivedi (psychiatrist) and Shobit Trivedi (software engineer). Representing all of you, I had visited his home at Lucknow and joined the prayer meeting on Sept 24, 2013 and had conveyed our grief to the family.

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**Research Article**

**“PATHWAY OF CARE” IN PATIENTS WITH NEUROTIC, STRESS RELATED AND SOMATOFORM DISORDERS:  
STUDY FROM A TERTIARY CENTRE OF NORTH INDIA**

**Anurag Agrawal, Adarsh Tripathi, P.K. Sinha, J.K. Trivedi\***

**Abstract**

**BACKGROUND:** 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. **AIMS:** To study the sequence and frequency of contacts with different types of care provider and the source of referral to the study centre in the pathway of care in the patients with “**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. **METHOD:** 156 patients were assessed on ICD-10 DCR, 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:** 71.79% of patients were found unaware regarding psychiatric disorders. Traditional faith healers and unqualified health providers and Practitioners of alternative medicine constituted the majority of the care providers. Average visits per patient were 5.27 ( $\pm 3.689$ ) for 'aware' group and 7.46 ( $\pm 4.401$ ) for 'unaware' group. Faith healers referred least number of patients to the study centre. **CONCLUSIONS:** Faith healers, unqualified health providers and Practitioners of alternative medicine were the first care providers for majority of the patients. Study indicates a poor referral system. Awareness about psychiatric disorders in community plays vital role in early engagement with specialized services and promotes desirable help seeking behaviour and shortens the pathway of care.

**KEY WORDS:** Pathway of care, Awareness.

**INTRODUCTION**

Patients with mental disorders often do not seek early professional help. Crucial factors include the patient's or family's knowledge and recognition of the mental disorder and the accessibility and availability of mental health services in the community. Moreover, both socioeconomic and psychosocial factors, such as the financial situation of the family, and social stigma are also important. There is also important role of care providers along the pathway, the first care provider being the most important, who gives a direction to the pathway of care to seek further help (Lincoln et al, 1998).

In India, there is small number of qualified psychiatrists, mostly concentrated in the metropolitan and the urban areas to deal with this huge problem, further compounding the issue. It is observed in India that a majority of patients with mental disorder never seek professional help; and most of them utilize the help of unqualified medical practitioners, faith healers, and so

on. The non-availability of mental health services, penury, stigma, and superstitions associated with mental disorders, coupled with the unwillingness or inability of families to care for their mentally ill relatives, appear to be the main contributory factors for this state of affairs (Rogler et al, 1993). The widely prevalent magico-religious beliefs associated with mental illness and lower literacy, especially in rural areas, poses significant social obstacles in seeking appropriate health care for psychiatric patients. During this process, a lot of crucial time is lost which could jeopardise prognosis, as early recognition and management are of utmost importance in psychiatry (WHO, 2001).

Goldberg & Huxley (1980), proposed a 5 levels model of the pathway to psychiatric care, which assumed that people with psychiatric problems start seeking care by consulting their general practitioner, who may refer them to psychiatric facilities. However, descriptive studies regarding this issue demonstrated that people with psychiatric problems follow a variety of pathways before they reach mental health professionals, and that

their pathways are influenced by various factors including conventions governing referral, relationships between mental health professionals and other sources of help, and the availability of and accessibility to mental health facilities and other helping agencies (Gater et al, 1991, 2005). This may also be dependent on socioeconomic status, sociocultural beliefs and literacy level of people.

An understanding of the way in which people seek care for mental disorders is important for planning mental health services, for the organization of training and for the organization of referrals to psychiatrists from other sources of health and social care. It also helps in assessing people's attitude towards psychiatric patients and provides relevant information regarding belief system prevalent in the community. Pathways to care are structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem. It is defined as the sequence of contacts with individuals and organizations initiated by the distressed person's efforts and those of his or her significant others, to seek appropriate help (Rogler et al, 1993).

The studies of the 'pathway of care' provide the relevant information regarding the individual's health seeking and illness behaviour, and promote organized and efficient patient care based on the evidence based practice (Kessler et al, 2001).

Research related to help seeking behavior and attitude toward mental illnesses and services which primarily determine the pathway of care has been carried out mainly in developed nations. There is, however, deficiency of information from the developing countries (Pradhan et al, 2001).

Till now the focus has been on the pathways of care for patients of first episode of psychosis, as delay in the treatment is associated with poor outcome (Altamura et al, 2001; Black et al, 2001). Unfortunately studies are lacking for pathway of care in neurotic, stress related and somatoform disorders in both developed and developing nations. Thus the need of the hour is that mental health care priorities should be shifted from psychotic disorders to common mental disorders like depression, anxiety disorders, somatoform disorder, etc., which are also associated with high disability across multiple domains (Patel et al, 1997). This study was carried out with the aim of studying the sequence and frequency of contacts with different types of care provider and the source of referral to the study centre in

the pathway of care in the patients of "Neurotic, Stress-Related and Somatoform (N.S.S.) 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 single point cross-sectional study. Written informed consent was taken from all the patients after giving them given a full description of the study and study was approved by the IEC. Sample of the study was patients of age group 17-60 years presenting for the first time in the Adult Psychiatry OPD of Department of Psychiatry at K.G. Medical University, UP, Lucknow during August 2010 to August 2011. Schedules for Clinical Assessment in Neuropsychiatry (SCAN) was applied to exclude Subjects with any other Axis I disorders. Neurotic disorder co-morbid with severe physical illness requiring active interventions and patients with substance abuse (except nicotine) and subjects with underlying organic pathology were excluded.

A semi-structured proforma was used to collect information about the socio-demographic profile of the patients and help seeking behavior. In preparation of this proforma basic idea has been taken from the encounter form developed for the WHO by Gater et al. (1991) and from the study by Chiang et al. (2005). Semi structured proforma included in detail the myths/beliefs regarding causation of symptoms, reasons to seek help, number of contacts made with different type of care provider and duration of treatment taken from them before reaching to study centre, source of referral to study centre, the reasons for delay, if any and what finally led them to come to the study centre etc.

The study sample was divided in two groups on the basis of knowledge about psychiatric disorder at the time of onset/initial stage of illness. The subjects/family members were asked about general concept regarding psychiatric disorders and whether they knew at the time of onset/initial stage of illness that symptoms present in their patient could also be due to psychiatric disorders. If yes then whether they knew that treatment was available for these disorders?

Those who answered in affirmative to both the questions were put into the "Aware" group. Those who gave negative answer to any of the two or both the questions were put in the "Unaware" group. Appropriate statistical tests were applied for data analysis.

## RESULTS

Out of 207 patients screened during the study, 51 patients (24.64%) were excluded. Presence of other Axis 1 disorders was the most common reason (8.21%) for exclusion. Other reasons for exclusion were subjects with substance abuse other than tobacco (n=11, 5.31%), subjects not fulfilling age criteria (n=08, 3.86%), subjects who not turned up for follow up visit (n=07, 3.38%), subjects who did not gave consent (n=06, 2.90%) and subjects with underlying organic cause (n=02, 0.97%). 156 (75.36%) patients were included in the study.

The total sample was sub grouped into 'aware' and 'unaware' groups based on information obtained from semi structured proforma regarding knowledge about psychiatric disorders. Only 44 patients (28.21%) were found to have awareness regarding psychiatric disorders and constituted 'aware' group. Remaining 112 patients (71.79%) were kept in the 'unaware' group.

The 'aware' group consisted mainly by OCD (43.18%) followed by GAD and panic disorder (31.82%) and dissociative disorder (25.00%). Dissociative disorder was the most common diagnosis in 'unaware' group (48.21%) followed by OCD (20.54%), somatoform disorder (16.96%) and GAD and panic disorder (14.29%).

In this study, faith healer (FH) was a type of care provider who used to treat/cure illness or disability by recourse to divine power, without the use of medicines. Local Practitioner (LP) was a type of care provider who was either qualified in other discipline of medical sciences like Ayurvedic, Homeopathic or Unani medicine or nonqualified village/local health care providers/quacks. General Medical Practitioner (GMP) was a type of care provider who was a qualified allopathic medical practitioner. They were either having MBBS degree or having post graduate in any field of allopathic medicine except psychiatry. Psychiatrist was the type of care provider who was having postgraduate (MD/Diploma) in discipline of psychiatry. They were termed as mental health professional (MHP).

Faith healers were the most common care providers in both aware as well as unaware group. However significant statistical difference was found between them in making first contact to the faith healers (p=0.0251). [Table 1]

**Table 1: Type of first Care Provider**

Type Of First Care Provider	Total Number of Patients (N=156)		Chi Square Test
	"Aware" Group (N=44)	"Unaware" Group (N=112)	
'Faith Healer'	9 (20.45%)	46 (41.07%)	p=0.0251
'Local Practitioner'	15 (34.10%)	33 (29.46%)	p=0.7109
'General Medical Practitioner'	11 (25.00%)	20 (17.86%)	p=0.4335
'Psychiatrist'	9 (20.45%)	13 (11.61%)	p=0.2407

Table 2 shows that statistically significant difference was also present in aware and unaware group regarding number of average visits per patient (p=0.0088).

Type Of Care Provider		"Aware" Group (N=44)	"Unaware" Group (N=112)
Psychiatrist		35 (15.09%)	62 (07.43%)
Non Psychiatrist		197 (84.91%)	773 (92.57%)
Non-	FH 84	(36.21%)	441 (52.81%)
Psychiatrist	LP 61	(26.29%)	191 (22.87%)
	GMP 52	(22.41%)	141 (16.89%)
Total		232	835
Average visits per patient		5.27 (±3.689)	7.46 (±4.401)
Unpaired 't' test		p value= 0.0088	

Analysis was done regarding frequency distribution of contacts made by patients with different type of care providers during pathway of care, and it was found that patients of 'unaware' group made significantly higher frequency of contacts as compared to 'aware' group (p=0.0217). On further exploring the complex interaction between patients and different type of care providers during pathway of care, it was observed that majority (73.08%) of patients with 'N.S.S. Disorders' had at least once contacted a 'FH' while 65.74% patients had visited to a 'LP' at least once at some or other point during pathway of care; 53.21% patients made visit to a 'GMP' least once; and 42.95% patients to a psychiatrist. This observation shows that majority of patients did visit to 'FH' and 'LP' at some or other point of time during pathway of care, while more than half of patients never visited to psychiatrist at any point of time during pathway of care.

Majority (43.58%) of patients with 'N.S.S. Disorders' were referred to the study centre by previous care providers, followed by a group of peoples, denoted in this study as 'Social Worker/Paramedical Staff/Other Person Knowing This Institution' (23.07%). The other sources of referral were through 'family members of patient with psychiatric disorder in neighbourhood' (17.31%) and 'self referral', (16.03%). Significant difference between the two groups for the source of referrals was present ( $p= 0.0376$ ). We also found that Faith healers referred least number of patients although they were the most common care providers [Table 3].

**Table 3: Referral of the patients to the study Centre**

Source Of Referral	Number
A. 'Care Providers	'FH 03 (1.92%)
	LP 20 (12.82%)
	GMP 35 (22.43%)
	MHP 10 (6.41%)
	Total 68 (43.58%)
B. Other person knowing this institution(OP)/ social worker(SW)/ Paramedical staff(PS)	OP 10 (6.41%)
	SW 14 (8.97%)
	PS 12 (7.69%)
	Total 36 (23.07%)
C. Family member of patient with psychiatric disorder in neighborhood	27 (17.31%)
D. Self-referral	25 (16.03%)

## DISCUSSION

As per a report of WHO, half of the estimated 450 million people affected by mental illness globally live in Asia pacific regions (WHO, 2008) but because of multiple factors acting as barriers in the pathway of care, many are left untreated, many partially treated and only a small fraction get access to appropriate place of treatment. These factors may be cultural belief regarding mental illness, stigma, and lack of knowledge regarding psychiatric disorders and appropriate place of treatment, poor availability of psychiatric services. Culture can effect epidemiology, phenomenology as well as treatment outcome of psychiatric illness especially anxiety disorders (Trivedi et al, 2010). To the best of author's knowledge, no studies have been conducted to assess the pathway of care in 'N.S.S.

Disorders' in India and other developing countries.

In the present study majority (71.79%) of the patients were found to be "Unaware" regarding psychiatric disorders while 28.21% of the sample belonged to "Aware" group. This finding is in line with the finding of other studies which had also shown that mental health literacy is low, regardless of the population considered (Chen et al, 2000; Scott et al, 2002). Therefore, more emphasis should be laid on educational and campaign programs to raise awareness in community, especially in developing countries.

Overall the most common first care providers were 'FH' (35.26%) followed by 'LP' (30.77%) and 'GMP' (19.87%) while first contact with Psychiatrist was made by 14.10% of patients [Table-1]. Pradhan et al. (2001) had observed that only one-third of the subjects had contacted a psychiatrist as their first care provider in their study. Lahariya et al. (2010) had also found that only 9.2% patients consulted a psychiatrist as the first helping agency. This is a cause for concern as the Contacts with nonpsychiatric care providers might aggravate the sufferings of the patients by prolonging the pathway and also increase the burden of care on family members.

Together all the patients made 1067 contacts with different type of care providers during the 'pathway of care'. Majority (91.91%) of contacts was made with non psychiatrists and only 09.09% contacts were with psychiatrists [Table-2]. Bebbington et al. (2000) had also indicated in their study that most people with neurotic disorders do not make contact with mental health professionals.

On comparison between "Aware" and "Unaware" group; it was observed that nonpsychiatric care providers, especially 'FH', formed the major portion of the total care providers in both the groups. This explains that despite presence of awareness about psychiatric disorder; due to strongly held social and religious beliefs prevalent in our society, people do visit faith healers. Also due to cultural and social beliefs regarding psychiatric disorders, and also due to scarcity of mental health professionals in developing countries; large number of population consult unqualified medical practitioners especially in rural and peripheral areas; as evidenced by finding of WHO (2011), according to which, the number of psychiatrists varies from 0.05 per 100,000 population in African countries and 0.23 in South-East Asian region to 8.59 per 100,000 in European countries.

Our study had also revealed that patients in 'unaware' group had made more number of contacts with care providers than those who were aware. This explains that making frequent contacts with different type of care providers, especially with 'FH' and 'LP' delays the pathway of care. While exploring various sources of referral of patients with 'N.S.S. disorders' to study centre; It was also observed that though, patients made an average of "6.86" contacts with different type of care providers during pathway of care, only 43.58% of patients were referred by them to this centre.

The above findings illustrate lack of collaboration between different types of care providers. The other reason can be that different type of care providers; majority of whom are 'FH', generally do not get in touch with other type of care providers, especially 'GMP' and psychiatrists. Also the 'FH' being unskilled in understanding of psychiatric disorders did not give suitable advice and/or make referral of patients to a place of appropriate treatment. Gater et al. (1991) had noted that there was a longer delay on pathways of psychiatric patients involving native healers. Gureje et al. (1995) in a study from India had found that the psychiatric patients who first consulted traditional healers, tended to arrive at a psychiatric service much later than those who consulted other caregivers. Also the majority of sample of present study belong to rural areas dominated by many types of unqualified care providers and faith healers, with whom, seeking help is an easy and not a costlier job (Trivedi et al, 1979) than seeking help from elsewhere. Similarly the Local Practitioners might have been unable to understand that the symptoms of patients can be due to a psychiatric disorder and thus did not refer patients to appropriate centre.

On the basis of above observation, it could be assumed that the maximum duration of crucial time is lost in taking help from non psychiatrist care providers especially 'FH' and 'LP', despite being unskilled in taking care of patients with psychiatric disorder and making less referral to place of appropriate treatment.

Psychiatrist making comparatively smaller number of referrals in comparison to other type of care provider was expected; as they are skilled qualified mental health professionals and it is expected that usually they will not refer the patients to study centre and manage the patients by them as far as possible.

It was also found that about half of the patients seen by 'GMP' were referred to study centre for psychiatric help.

Choo et al. (1997) observed in their study done in Singapore that the medical sector was the most common source of referral.

But the worrying finding was that 'FH' made only 01.92% of referrals to the study centre. This finding suggests need to raise awareness so that people may not go to 'FH' and/or provisions to identify 'FH' in community and providing them basic knowledge and training so that they can refer seriously ill psychiatric patients to a place of appropriate care. This also emphasize the advocacy to involve these faith healer/spiritual healers in care of mental illness as they are usually the first and also the predominant care providers to mentally ill in rural areas. As they hold a pivotal position in every culture and community, and are easily accessible at low cost and because of their reputed position and cultural belief, general people are motivated to seek help from them (Trivedi et al, 1979). However feasibility and appropriateness of such strategy is to be empirically tested before making such recommendations.

Attention should be paid to raise awareness among different type of care providers specially 'LP', so that they may be able to recognize sign and symptoms of common mental disorders including 'N.S.S. Disorders', as a 'type of mental illness' so that they may refer the patients to seek help from available psychiatric services. Despite having knowledge in others discipline of medicine as Ayurvedic, Unani or Homeopathic, most of the 'LP' practice in light of modern allopathic medicine, so there is high possibility that they will be more receptive in receiving knowledge of psychiatric disorder and hence could be ready to make early referral to available psychiatric services.

The findings of our study also suggest that the common people in community and social workers also played role in referral of patients to seek treatment from study centre. This finding highlights that if provisions would be made to raise basic information about psychiatric disorder in community by educational intervention, a better outcome could be expected in terms of an early referral by community members to mental health services.

Compared with prior pathway studies, our study is unique because for the first time pathway of care in 'N.S.S. disorders' has been studied separately. While comparing these findings with studies done on pathway of care in psychotic disorders, it was seen that an area of particular concern in those studies was the duration of



untreated psychosis (DUP). Longer DUP in first-episode psychosis is associated with worse short- and long-term prognosis (Marshall et al, 2005), an increased risk of suicidal behaviour (Altamura et al, 2003) and possibly serious violence (Verma et al, 2005). However in case of 'N.S.S. Disorders', no work has been done till now on effect of delay in treatment over prognosis and could be an area of further research.

There are some limitations of this study. Recall bias is possible as retrospective information was taken. There was no structured tool to assess awareness for psychiatric disorders in the patients and family members. The severity of the disorders was not assessed which could have affected the patients'/family members' help seeking behaviour and thus pathway.

## CONCLUSION

Faith healers, unqualified health providers and Practitioners of alternative medicine were the first care providers for majority of the patients. Study indicated a poor referral system and direct access to psychiatric services after the onset of illness was not a prominent pathway. Magico-religious model of causation of psychiatric disorders was found deeply rooted in the society. Awareness about psychiatric disorders in community is poor although it played a vital role in early engagement with specialist services. There is need to increase the awareness, improve knowledge and change attitude about 'psychiatric disorders and treatment services' for better help seeking behaviour, favorable pathways of care and ultimately better outcome. Also further research is required to delineate psychiatric pathways of care and their determinants in the developing countries.

## REFERENCES

- Altamura AC, Bassetti R, Bignotti S, Pioli R, Mundo E (2003) Clinical variables related to suicide attempts in schizophrenic patients: a retrospective study. *Schizophrenia Research*, 60, 47-55.
- Altamura AC, Bassetti R, Bignotti S, et al. (2001) Duration of untreated psychosis as a predictor of outcome in first episode schizophrenia: a retrospective study. *Schizophrenia Research*, 52 29-36.
- Bebbington PE, Burgha TS, Meltzer H, et al. (2000) Neurotic disorders and the receipt of psychiatric treatment. *Psychological Medicine* 30, 6, 1369-1376.
- Black, K., Peters, L., Rui, Q, et al. (2001) Duration of untreated psychosis predicts treatment outcome in an early psychosis program. *Schizophrenia Research*, 47, 215–222.
- Chen H, Parker G, Kua J, Jorm A, Loh J (2000) Mental health literacy in Singapore: a comparative survey of psychiatrists and primary health professionals. *Annals of the Academy of Medicine Singapore*, 29, 467-473.
- Chiang JCS, Chow ASY, Chan RCK, Law CW, Eric YHC (2005) Pathway to care for patients with First-Episode Psychosis in Hong Kong. *Hong Kong Journal of Psychiatry*, 15(01), 18-22+34.
- Choo CH, et al. (1997) Profile of patients seeking psychiatric treatment from the adult public mental health services in Singapore. *Annals of the Academy of Medicine Singapore*, 26, 443–8.
- Gater R & Goldberg D (1991) Pathways to psychiatric care in South Manchester. *The British Journal of Psychiatry*, 159, 90-96.
- Gater R, Sousa B, Barrientos G, et al. (1991) The pathways to psychiatric care: a cross-cultural study. *Psychological Medicine*, 21, 761-774.
- Gater R, Jordanova V, Maric N, et al. (2005) Pathways to psychiatric care in Eastern Europe. *The British Journal of Psychiatry*, 186, 529-35.
- Goldberg D & Huxley D (1980) *Mental illness in the community: The pathways to psychiatric care*. London: Tavistock Publications
- Gureje D, Acha RA, Odejide DA (1995) Pathways to psychiatric care in Ibadan, Nigeria. *Tropical Geographic Medicine*, 47, 125-129.
- ICD-10, Clinical Descriptions And Diagnostic Guidelines, Classification Of Mental And Behavioral Disorders, WHO, Geneva.
- Kessler RC, McGonagle KA, Zhao S, et al. (1994) Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Archives of General Psychiatry*, 51, 8-19.
- Lahariya C, Singhal S, Gupta S, Mishra A (2010) Pathway of care among psychiatric patients attending a mental health institution in central India. *Indian Journal of Psychiatry*, 52(4), 333–338.
- Lincoln C, Harrigan S, McGorry PD (1998) Understanding the topography of the early psychosis pathways: An opportunity to reduce delays in

treatment. *The British Journal of Psychiatry*, 172 (supplement 33), 21–25.

Marshall M, Lewis S, Lockwood A, Drake R, Jones P, Croudace T (2005) Association between duration of untreated psychosis and outcome in cohorts of first-episode patients: a systematic review. *Archives of General Psychiatry*, 62, 975–83.

Patel, V., Simunyu, E, Gwanzura, F (1997) The pathways to primary mental health care in high-density suburbs in Harare, Zimbabwe. *Social Psychiatry and Psychiatric Epidemiology*, 32, 97-103.

Pradhan SC, Singh MM, Singh RA, et al. (2001) First care givers of mentally ill patients: A multicenter study. *Indian Journal of Medical Sciences*, 55, 203-8.

Rogler L H, Cortes D E (1993) Help-Seeking Pathways: A Unifying Concept in Mental Health Care. *American Journal of Psychiatry*, 150 (4), 554–61.

Scott TL, Gazmararian JA, Williams MV, Baker DW (2002) Health literacy and preventive health care use among Medicare enrollees in a managed care organization. *Med Care*, 40(5), 395-404.

Trivedi JK, Gupta PK (2010) An overview of Indian research in anxiety disorders. *Indian Journal of Psychiatry*, 52, 210-8

Trivedi JK, Sethi BB (1979) A psychiatric study of traditional healers in Lucknow city. *Indian Journal of Psychiatry*, 21, 133-137.

Verma S, Poon LY, Subramaniam M, Chong SA (2005) Aggression in Asian patients with first episode psychosis. *International Journal of Social Psychiatry*, 51, 365-71.

World Health Organization. (2011) *Mental Health Atlas*. Geneva: World Health Organization.

World Health Organization. (2008) *The Bare Facts*. Geneva: World Health Organization.

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## THE USE OF ASSESSMENT AND TREATMENT SCALE FOR RADICALIZATION (ATSR) AS A MEASURE FOR ASSESSING EXTREMIST VIEWS IN INDIA

Adarsh Kohli, Aditi Sharma, Wagdy Loza, Manju Mohanty

### Abstract

**Background:** Extremist ideologies are believed to be the root cause of all forms of terrorism. It is argued that shared ideological commitment and group solidarity are more important determinants of terrorist behavior than individual characteristics. **Aim: (1)** To analyze the utility of the Assessment and Treatment Scale for Radicalization (ATSR) among the Indian population. **(2)** To study the belief systems existing among the four major religious groups in India i.e. Hindus, Muslims, Christians and Sikhs. **Material and Methods:** The current study is designed to assess the prevalence of extremism amongst the people belonging to four major religious communities in Indian settings using the ATSR- Indian Adaptation. The scale was originally developed for Middle Eastern population. It is an 80 item, 6 sub scale instrument designed to quantitatively measure the religious attitudes, beliefs and ideologies of different religious communities on risk areas that are reported in the literature. The six subscales as measured by ATSR are attitude towards women, attitude towards western culture, attitude towards Israel, religiosity and fighting and political views. A total of 93 subjects (Mean age=32.43 years; SD=12.65 years) have been recruited from the four major religious communities in India namely: Hindus, Muslims, Sikhs and Christians. 20 subjects each were recruited from the religious groups namely Hindus, Muslims and Christians and 33 subjects in the Sikh group. **Results:** The ratings of the four groups on different subscales of ATSR and their significant differences on extremist ideologies have been discussed.

**Keywords:** Extremism, Radicalization, Religion

### INTRODUCTION

Extremist ideologies have been believed to be the root cause of all forms of terrorism existing all over the world. Such extremist ideologies are preached from generation to generation and hence they become an integral part of the religious beliefs. In fact, extremism and violent acts are motivated by religious beliefs. This is a common feature of all the existing religions, with some being more staunch about it and some a little liberal, yet it seems to be a part and parcel of all the religions. Such extremist ideologies pose a threat to the human race in terms of its outcome and violent acts attached to it which further perpetuate themselves to take the form of terrorism.

Ideology plays a crucial role in promoting extremism. The term "ideology" often carries a negative connotation. In reality, it is functionally neutral and broadly conceived, applied to many. However, when understood in terms of religion, it is seen that many religions either embrace or sustain an ideology. Conceptualizing extremism as a shared commitment, Crenshaw (2001) argues that "shared ideological commitment and group solidarity are much more important determinants of terrorist behavior than

individual characteristics". It can either be for promoting a cause, which is inwardly focused driven by creation and attainment of a desired goal, or for destruction of those who oppose it, which is characterized by outward focus i.e. towards the enemy or the "other" driven by annihilation of non believers and those who oppose its interests and values (Borum, 2004).

With regards to ideology, one needs to understand the role of culture in affecting such ideologies. Brannan et al. (2001) viewed the immaterial or social dimensions of culture as a unique collection of social roles, institutions, values, ideas and symbols operative in every group, radically conditioning the way in which members see the world and respond to its challenges.

Cultural values provide a moral justification for violence. Such violent extremists are often driven in part by culture based and culture specific perceptions of what is fair and what is unfair as they are moved by implicit understandings of when deprivations constitute an integral part of their lives. Such perceptions do not develop in vacuum and are strongly influenced by the prevailing cultural and ideological setting in which they emerge and this setting in turn is

shaped by the longstanding traditions and norms and also by the today's global culture. In some cases violence in the name of radicalization can be attributed to be used as a weapon to safeguard and protect the honor, duty of comrades or ancestors, the obligation to uphold the moral integrity of one's community or the importance of defending ones community or culture in the face of the perceived assaults against it.

Generally, what brings violent extremists together is their shared dedication to a particular vision of how society ought to be organized or their strong questioning of the foundations upon which their societies are presently organized. That is true of many Salafi jihadist (SJ) groups today, just as it was true – in radically different contexts, and on the basis of entirely different worldviews – of the left-wing radical groups of the 1970s in West Germany (the Red Army Faction or Baader-Meinhoff Gang), Italy (the Red Brigades) and Japan (the Japanese Red Army). The propensity of the people who continue to fight – despite the realization that they will not live to see the realization of the objectives for which they are ready to sacrifice their existence – is greatly enhanced by adherence to transcendental values that trump self-interest, Realpolitik, or cost-benefit calculations.

Juergensmeyer (2008) assessed the contributions of religious convictions in violent extremism and reported that when a conflict takes on religious connotations it tends to escalate and what initially could have been primarily a world struggle takes a new aura of a “Sacred Conflict” and this creates a whole set of new problems. He further reported that conciliation in such cases is difficult because the actors view themselves as “God's soldiers” and may believe that a divine intervention may ultimately help them to prevail which probably leads to the sustenance of the extremist ideologies. Juergensmeyer also puts forth that the timeline of such a sacred struggle is considered to be vast and perhaps even eternal.

The historical legacies and narratives of victimization have also been the factors that have profoundly shaped the outlook of extremist movements. Such legacies have a powerful impact on public attitudes and provide a primary prism through which individuals assess current events particularly when those developments may easily be interpreted as mere manifestations of the older patterns.(Evans and Philips,2007). Across the Islamic world, for e.g. there is a widely shared perception that Muslims have been consistent victims of sustained Western attacks, to the extent that wars in

Afghanistan and Iraq are perceived as manifestations of such legacies of victimization.

Juergensmeyer (2008), further gave a detailed exploration of the “cultures of violence” and he identified in a broad variety of Christian, Jewish, Muslim and Sikh contexts. He asserted that a core characteristic of these cultures is “the perception that (these communities involved) are already under attack, are being violated and that their acts are simply responses to the violence that they have suffered as cultural groups (El Sarraj,2002).

In India too, in the backdrop of the various religions it was a research question whether people with extremist views exist in Hinduism, Islam, Christianity and Sikhism.

### **AIM**

To analyze the utility of Assessment and Treatment Scale for Radicalization among the Indian population and to study the belief systems in the four major religious communities of India namely: Hindus, Muslims, Christians and Sikhs.

### **METHODOLOGY**

#### **SAMPLE**

The sample comprised of 93 subjects with 20 each belonging to either gender of three religious communities namely Hindus, Muslims, Christians and 33 subjects of Sikh community. This sample of convenience comprised of subjects of all ages, diverse educational backgrounds and occupations. The unequal numbers were recruited because more numbers were available in Sikh group.

#### **TOOLS**

The Assessment and Treatment Scale for Radicalization (Loza, 2007)

The original scale is an 80 item instrument, with six subscales; each subscale designed to tap into a prominent ideological theme. The scale was originally developed for Middle Eastern population. The six subscales in the original scale were Attitude towards Israel, Political Views, Attitude towards Women, Attitude towards Western Culture, Religiosity and Fighting. The author reduced the 80 items to 33 items and collapsed the 4 point Likert scale by merging the first two options and last two options. The author reports the scale to be reliable and valid.

The scale was firstly translated into Hindi by experts from psychology and psychiatry. After the translations were done a committee of all the experts critically

analyzed the translations by all the experts and the simple spoken Hindi version was finalized keeping in mind the Indian political scenario. It was then tried out as a pilot study on 10 subjects. The scale in Hindi was then given for back translation into English. Some of the items on Kashmir and Khalistan were added suiting the Indian political set up. Few examples of the items paraphrased in Hindi are as follows

- 1 पश्चिमी देश हमेशा दूसरी सभ्यताओं को नष्ट करने की कोशिश करते हैं।
- 2 जो देश अपने धर्म से परे/दूर हो जाते हैं वो आमतौर पर बर्बाद हो जाते हैं।
- 3 पश्चिमी सभ्यता बाकी सारी सभ्यताओं से नैतिक रूप से ज्यादा भ्रष्ट है।
- 4 जो लोग कश्मीर, खालिस्तान और अयोध्या के मुद्दों पर लड़ रहे हैं वे उग्रवादी नहीं बल्कि स्वतंत्रता सैलानी हैं।
- 5 जो लोग मेरे धर्म को नहीं मानते वो नरक में जायेंगे।
- 6 मैं नास्तिक लोगों के विरोध के हक में हूँ।
- 7 आतंकवादी असलियत में इस दुनिया में भगवान् की मर्जी को कायम करने के लिये लड़ते हैं।

## PROCEDURE

All the participants were approached individually. Consent was sought from all of them and those who gave consent were administered the scale. About 10 to 15 % of Muslims and Christians did not give their consent.

All the subjects were told that their data will be kept confidential. Their identity was not disclosed and only their age and occupation were noted. It took about 20 to 30 minutes to complete the test.

## STATISTICAL ANALYSIS

Descriptive statistics including Means and Standard Deviations were computed for all the four religious groups and ANOVA was calculated.

## RESULTS

**Table 1: Demographic profile.**

Religion (n=93)	Males	Females
Hindus(n=20)	15(75%)	5(25%)
Christians(n=20)	5(25%)	15(75%)
Muslims(n=20)	10(50%)	10(50%)
Sikhs(n=33)	6(18%)	27(82%)

Table 1 shows the demographic profile of the subjects. Table 2 shows the ATSR scores among different religious groups. It consists of the Means and Standard deviations of the different communities on five of the six subscales of ATSR. The sixth subscale being excluded since it was "Attitude towards Israel" and was not relevant in the Indian set up and also because all the items could not be substituted appropriately. The ANOVA showed that there were significant intergroup differences ( $F = 9.99$ ;  $p < 0.001$ ). Individual pair-wise differences are shown in Table 3.

**Table 3: t ratios between the four groups on the total ATSR scores**

RELIGIOUS GROUPS	t-ratio
Islam-Sikhs	1.22
Islam-Christians	4.65
Islam-Hindus	8.55**
Sikhs-Christians	3.43
Sikhs-Hindus	7.33**
Christians-Hindus	3.90
Hindus-Christians	3.90

Significant at  $p < *0.05$  level;  $p < **0.01$  level

**Table 2: Means and Standard deviations of the different communities on five of the six subscales of ATSR.**

Subscales→	Political views	Attitude towards women	Attitude towards western culture	Religiosity	Fighting
Religious groups ↓	M(SD)	M(SD)	M(SD)	M(SD)	M(SD)
Hindus	1.15(1.08)	0.90(0.85)	2.40(1.66)	2.25(1.29)	2.55(1.53)
Muslims	2.50(1.67)	2.70(1.52)	3.10(1.58)	4.15(2.25)	5.10(2.29)
Sikhs	3.03(1.18)	1.27(1.15)	2.45(1.27)	4.72(1.23)	5.15(1.87)
Christians	2.55(1.53)	1.25(0.91)	2.10(1.61)	3.50(1.82)	3.80(2.06)

Significant highlights of the results are as follows:

- 1) There were a total of 57 females out of the total sample of 93. Majority were students i.e. 41.
- 2) Sikhs as a community scored high on Political Views, Religiosity and the view of fighting for one's Religion.
- 3) Muslims as a community scored high on Attitude towards Women and a negative attitude towards Western culture
- 4) Hindus have been observed to score lowest on all the domains assessed. Christians were next in order.
- 5) Significant differences have been found between Hindus and Muslims ; Hindus and Sikhs on total ATSR scores.

## DISCUSSION

“Radical beliefs are a proxy or atleast a necessary precursor for terrorism. Radicalizing by adopting or developing extremist beliefs that justify violence is one possible pathway into terrorism involvement, but it is certainly not the only one” (Borum, 2011). Extremism refers to an ideology that advocates use of violence against the will of society at large or to use violence to enforce the will of the social body, such as a government or majority constituency (Borum, 2004). The literature is replete with extremism being most potent in radicalizing such extremist ideas which are heavily loaded with a shared ideological commitment into terrorist acts.

With this in mind the current study endeavors to see the prevalence of extremist ideas in the Indian setting using ATSR. India being a culturally diverse country with plenty of communities based on their religious preferences and practices.

Significant differences have been found with regard to the extremist ideologies between Hindus and Muslims and also between Hindus and Sikhs in India. Even though India being a secular republic and its constitution protects the rights of citizens to worship and propagate any religion or faith. The Indian population though majorly comprising of the Hindu community also exhibits a unity in diversity with all the religious communities living together in harmony. Yet there are several instances of communal conflicts among them which stems from the competing ideologies of various religious groups.

At a glance the link between religious extremism and terrorism seems obvious. Religious extremists are

willing to even murder because they embrace theologies that sanction violence in the service of “God”. They have no sympathy for their victims because they view those victims as enemies of God and they readily sacrifice their own lives because they expect huge and immediate afterlife rewards in return i.e. “martyrdom” (Becker, 1976). Fritsch (2001) noted in Islamic culture that the near collapse of public education and the corresponding rise in influence of the “madrashahs” is an important contributor to legacy of radical Islam. A gross misuse of the concept of “Jihad” is evident in Islamic terrorism. Jihad is a struggle often used for the acts of terrorism which are aimed at achieving varying political and religious supremacy implying a militant theology. Islamic terrorist organizations have been known to engage in these activities in the Middle East, Africa Europe, United States, and South Asia. The results in the current study further endorse the above mentioned studies.

There has been trouble between the Hindus and the Muslims since India became independent in 1947. The few examples are the massacre during partition and the 1992 Bombay Riots. In the recent years India also has witnessed communal violence between Hindus and Sikhs following 'Operation Blue Star' and 'Assassination of Indira Gandhi' in 1984. Many believe that communal strife in India is a result of petty political maneuvering but there is no doubt that there are resentments under the surface that politicians are able to exploit.

Similarly with regard to political views Sikhs emerged to be the most staunch as compared to other religions, followed by Christians, Muslims and Hindus respectively. Both in religiosity and attitude towards fighting, the Sikhs and Muslims were the most staunch group as compared to Hindus and Christians. Zahid, 2010 found the infusion of radical Islamic ideology into the civil and military institutions as a major constraint on the fight against extremist militancy. On similar lines, Rohan and Khurram, 2011 reported that ideological extremism along with its vicious by product terrorism is the primary national security threat facing most countries. The association between religion and extremism expansion can be traced to an evidence as presented by Jeffrey, 2006 who put forth that in 1990's the network and capabilities of Al Qaeda expanded that led to a percolation through the religious groups developing close links. The literature also shows that “warfare is not only a part of Sikhism history but also a central feature of its iconography. The last guru of the Sikh lineage

considered martyrdom to be the supreme honor bestowed upon those who live for a cause"(Jurgensmeyer,2008).

Thus, the religiosity and fighting spirit of the Sikhs could be well explained as they are known to be the born warriors and as the Sikh gurus frequently came into direct confrontation with some of the Mughal rulers in order to protect the oppressed Hindus from forced conversions at the hands of Muslim rulers.

With regard to the attitude towards Women, Muslims were found to be the most staunch group. Though The Qur'an states that both men and women are equal but it also states that "Men are the protectors and maintainers of women". There are abundant examples of atrocities towards women in the Muslim community. The practice of forced marriages at younger age, polygamy, purdah system is common. In a recent report by a news paper it was stated that even in the heart of Delhi Maulvis are warning Muslim girls not to wear bindis, go to co-educational schools or work. Muslim women are put under cultural and moral scrutiny (Yaseen,Times of India, 19 February, 2012).

Regarding the attitude towards western culture Muslims were found to be more opposed to it as compared to other religious groups. A plausible reason for such a kind of thought pattern could be that Muslims consider western society and culture to be anti-Islamic. Fuller(2003) tried to understand the reasons for such kind of Muslim alienation from the Western ways could be attributed to the fact that the cultural and institutional success of the Islamic civilization created an intense resistance to an alternative civilizational order such as Western civilization.. In their opinion western culture is Christianity. Muslims opine that alcohol consumption, pornography, popular films, music, a liberal life style and a lack of public religious practice are definite signs of the degradation of western countries. Islamic fundamentalists have termed western society as 'satanic'.

## CONCLUSION

Extremist ideologies seem to be quite prevalent amongst the Indian religious communities. When seen in terms of total ATSR scores there are significant differences between Hindus and Muslims and Sikhs and Hindus with no other differences amongst the other groups. Such kind of results as obtained in the current

study fall in sync with the Indian set up of religious diversity in terms of different domains as measured by ATSR and also to the various permutations and combinations of the historical background.

Indian adaptation of ATSR yields itself to be a useful tool in the Indian setup for tapping the extremist ideologies amongst the four major Indian religious communities. The tool is easy to administer and is time saving.

A major limitation of the current study is its small sample and the scale needs for validation on a larger sample.

## REFERENCES

- Becker, G.S.(1976).The Economic Approach to Human Behavior . University of Chicago Press:Chicago.
- Borum, R. (2004).Counterterrorism training post-9/11.In R.Gunaratana (ed.) The Changing Face of Terrorism, Singapore: Eastern Universities Press, 62-73.
- Borum, R.(2011). Radicalization into Violent Extremism I : A Review of Social Science Theories.Journal of Strategic Security,4(4),7-36.
- Brannan, D.W., Esler, P.F., & Strindberg, N.T.A. (2001).Talking to "terrorists": Towards an independent analytical framework for the study of violent substate activism. Studies in Conflict and Terrorism, 24(1), 3-24.
- Crenshaw, M. (2001). The psychology of terrorism: An agenda for the 21st century. Political Psychology, 21(2)405-42.
- El Sarraj & Eyad.(2002). Suicide Bombers: Dignity, Despair and Need for Hope. Journal of Palestine Studies,31(4),71-76.
- Fritsch , P.(2001). Religious Schools in Pakistan Fill Void-and Spawn Warriors, Wall Street Journal. A1,A24.
- Fuller,G.E.(2003).The Future of Political Islam. New York:Palgrave Macmillan
- Hussain,Z. (2010). The Scorpion's Tail: the relentless rise of Islamic Militants in Pakistan and how it threatens America. New York: Free Press.
- Jeffrey,H. (2006) The Politics of Religion-A Survey. United Kingdom: Routledge Chapman and Hall.
- Juergensmeyer,M.(2008).Global Rebellion: Religious challenges to the Secular State ,from Christian Militias to Al Qaeda.Berkeley and Los Angeles: University of California Press.

Loza, W. (2007). The Belief Diversity Scale. Unpublished Manuscript.

Martin, E. & Phillips J. (2007). Algeria: Anger of the Dispossessed. New Haven and London: Yale University Press.

Rohan, G. & Khurram, I. (2011). Pakistan: Terrorism Ground Zero. London: Reaktion Books.

Yaseen S. No Lip-stick in Seelampur. Times of India 2012 Feb 19; Sunday Times of India: Special Report.

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**Brief Communication**

**KNOWLEDGE AND ATTITUDE ABOUT SUBSTANCE USE IN SCHOOL STUDENTS**

**Naresh Nebhinani, Mamta, Arun Kumar Misra, Manpreet Kaur**

**Abstract**

Adolescence is a phase when the mind is naturally motivated to explore the world thus awareness about substance related harm is of prime importance in this population. This study was aimed to assess the drug related knowledge and attitude among school students. Students of 8th - 9th and 11th -12th standards were recruited through a drug awareness program from two high schools in Chandigarh. The Knowledge and Attitude Addiction Questionnaire for Adolescents, a self-reported questionnaire was employed in this cross-sectional study. Most of the students appeared to have adequate knowledge about addictive substances and their harmful effects to body but not about the treatment aspects in both groups. Significantly more number of students in 11th-12th standard group considered it as physical/ medical illness, discusses about drugs with their friends very frequently and would like to maintain contact with a friend who has recently entangled into drug addiction, compared to students of 8th-9th standard. Majority of students had adequate knowledge about addictive substances with limited treatment related knowledge and substantial social stigma. This highlights the need for spreading more awareness about substance related harms and available treatment options.

**Key words:** drugs, substance dependence, knowledge, attitude, adolescents

**INTRODUCTION**

Adolescence is a phase when the mind is naturally motivated to explore the world. Reproductive and Child Health Program mentions adolescents as being between 10-19 years of age (UN system in India, 2003). Currently world has 1.2 billion adolescent population and nearly 20% of Indian population is adolescent (UNICEF's report, 2011). Majority of drug abusers start substance use in adolescence, mostly as tobacco preparations and inhalants and gradually progress to other harder substances like alcohol and opioid preparations. Encouragement from the peer group, deep desire to be popular, poor parental control and easy availability of the substances make an adolescent to go for drug abuse (Chatterjee et al, 2011).

Drug abuse has increased all over the world and the age of initiation of abuse is progressively falling. Earlier initiation of drug use is found to have more impairment, crime, and difficult to quit and is usually associated with a poor prognosis and a lifelong pattern of deceit and irresponsible behavior. The prevalence rate of drug use/ substance abuse among the adolescents studying in schools ranges from 12.5% to as high as 84% across the globe (Singh et al, 1991 & Tsering 2010). Substantial knowledge about substance related harm was reported in different populations of students (Schwarz, 1997; Gassman et al, 2001; Giannetti et al, 2002; Prakash et al,

2009; Tsering et al 2010), school educators (Moreira et al, 2009), general public (Bryan et al, 2000) and health professionals (Coles et al, 1992; Happell et al, 2002). Several studies in adolescent population have reported positive association between knowledge about substance abuse and their attitudes toward substances (Schwarz, 1997; Gassman et al, 2001; Giannetti et al, 2002). Most of the studies are from west (Tsering et al, 2010; Schwarz, 1997; Gassman et al, 2001; Giannetti et al, 2002; Moreira et al, 2009; Bryan et al, 2000; Coles et al, 1992; Happell et al, 2002) and data from India (Prakash et al, 2009 & Nebhinani et al, 2012) is limited. This research was aimed to study the knowledge and attitude about substance use in school students from north India. We firstly assessed drug related knowledge and attitude in 8th-9th standard students before and after the awareness lecture (Nebhinani et al, 2012). Subsequently we extended our work in 11th-12th standard students to assess the differences and similarities in their knowledge and attitude about substance abuse compared to the earlier group.

**METHODOLOGY**

Students of 8th - 9th and 11th -12th standards were recruited in February and October, 2011 through drug awareness programs from two High Schools in Chandigarh. The Knowledge and Attitude Addiction Questionnaire for Adolescents (KAAQA) (Prakash et al,

2009), a self-reported questionnaire was employed in this cross-sectional study. It is an eleven item semi-structured questionnaire developed after a series of de-addiction awareness programs meant for school children and used in several studies from the same centre (Prakash et al, 2009 & Nebhinani et al, 2012). Verbal consent was taken from the school authorities and subjects. KAAQA was administered prior to awareness lecture on 'Problems of drug addiction and its impact on Adolescents' by NN, in his presentation he has elaborated about commonly abused substances, magnitude of problem, myths related to substances, their complications and treatment.

### STATISTICAL ANALYSIS

Analysis was done by SPSS version 14 for Windows (Chicago, Illinois, USA). Frequencies with percentages were calculated for categorical variables and mean and standard deviation were calculated for continuous variables. The data from the two groups were compared using chi-square test for categorical variables and t test for continuous variables.

### RESULTS

The sample consisted of total 365 students studying in two different schools of Chandigarh. Of these, 210 students were enrolled from 8th-9th standard of a Private school and 155 students were enrolled from 11th- 12th standards of a Government School, Chandigarh. The students ranged in age from 13-19 years with the mean ages of 13.9 year in 8th-9th standard and 16.61 years in 11th & 12th standards and understandably the age was significantly different in both groups (t value 30.02,  $p < 0.001$ ). Males were overrepresented in both groups. Relative proportion for urban students was significantly higher in 8th-9th standard group than 11th-12th standard group (100% Vs 86%,  $\chi^2$  value 30.18,  $p < 0.001$ ). Proportion of students coming from nuclear families was significantly higher in 11th-12th standard group than the other group (82% Vs 66%,  $\chi^2$  value 11.18,  $p < 0.01$ ).

Details of data on drug related knowledge and attitude are shown in **Table 1**. Both the groups appeared to have adequate and comparable knowledge about addictive substances, their harmful effects to body, treatment and management of drug abuse. In both the groups' media remained main source of information. Significantly more number of students in 11th-12th standard group considered it as physical/ medical illness, and would like to maintain contact with a friend who has recently entangled into drug addiction. Almost

double strength of students in the 11th-12th standard group discuss about drugs with their friends very frequently. Significantly higher number of students in junior classes would like to collect more and more knowledge in case of risk of developing substance abuse. More number of students studying in 11th-12th class reported substance abuse as social evil as compare to their junior counterparts. As per the prevention and treatment part was concerned both the groups appeared to have comparable knowledge and attitude. Knowledge and attitude towards addiction remained comparable for boys and girls, urban and rural locality respectively in both the groups.

### DISCUSSION

Adolescence is a transitional stage of physical and mental human development with substantial risk for initiating substance use. Substance use disorders are quite prevalent (1.8% - 57.4%) in Indian adolescents (Thacore, 1972; Mohan et al, 1976 & 1977; Verma et al, 1977; Sethi et al, 1978; Khan & Unnithan, 1979; Kushwaha et al, 1992; Panicker, 1998; Tripathi & Lal, 1999; Saluja et al, 2007).

In our study most of the students appeared to have adequate knowledge about addictive substances, their harmful effects to body and the treatment part of drug abuse. Similar to earlier studies (Prakash et al, 2009; Tsering et al, 2010; Linda et al, 2010; Nebhinani et al, 2012) media such as radio or television remained the major source of information among our subjects. As the education increases the knowledge and attitudes also changes and the same is replicated in our study.

Increased knowledge leads to more positive approach toward drug abuse as majority of students of 11th-12th standard were having free discussion with peers about addiction. They were also interested to maintain contact with any friend with drug dependence. Similar to earlier study (Linda et al, 2010) majority of our students perceived substance abuse as a problem although the older group was more aware about it and considered it as a physical/ medical disease. Interestingly younger students were more cautious in gathering more knowledge about substances in case of the risk of developing substance abuse.

In an earlier study (Nebhinani et al, 2012) we highlighted the importance of drug awareness lectures in increasing the knowledge about addiction and reducing social stigma as students were more knowledgeable and lesser students were considering it as a social evil after the awareness lecture. Most of the

**Table-1: Drug Related Knowledge and Attitude Questionnaire**

SN	Question	Responses	8th-9th class (N=210) N1 (%)	11th-12th class (N=155) N1 (%)	X <sup>2</sup> value
1	Have you heard or read about addiction and addictive substances/ drugs?	Yes No	202 (96.0) 8 (4.0)	151 (97.4) 4 (2.6)	0.424
2	Did you know about addiction and addictive substances from the mass media	Yes No	193 (92.0) 17 (8.0)	148 (95.4) 7 (4.3)	1.86
3	Addiction is a physical/ medical illness	True False	148 (70.4) 62 (29.6)	131 (84.5) 24 (15.6)	9.76**
4	Addiction is a social evil, not a disease	True False	154 (73.0) 56 (27.0)	126 (81.3) 29 (18.7)	3.16
5	Using addictive substance is harmful to body	True False	209 (99.5) 1 (0.5)	154 (99.3) 1 (0.7)	0.047
6	If I would tell you that you are at high risk for addiction, what's your reaction?	Much concerned Not concerned	199 (95.0) 11 (5.0)	142 (92.0) 13 (8.0)	1.44
		Afraid Not afraid	166 (79.0) 44 (21.0)	128 (83.0) 27 (17.0)	0.71
		Take precautions Not taking Precautions	205 (98.0) 5 (2.0)	149 (96.0) 6 (4.0)	0.67
		Gathering knowledge Not gathering knowledge	205 (98.0) 5 (2.0)	144 (93.0) 11 (7.0)	4.73*
7	How openly do you discuss about addiction with your friends/ others?	Never Occasionally Often Very frequently	42 (20.0) 100 (48.0) 31 (15.0) 37 (17.0)	11 (7.0) 79 (52.0) 10 (6.0) 55 (35.0)	27.2***
8	Would you like to maintain contact with a friend who has recently entangled into drug addiction?	Yes No	50 (24.0) 160 (76.0)	53 (34.0) 102 (66.0)	4.74*
9	There are medicines for addiction	True False	160 (76.0) 50 (24.0)	123 (79.0) 32 (21.0)	5.13
10	Do you consider that addiction is preventable?	Yes No	195 (93.0) 15 (7.0)	141 (91.0) 14 (9.0)	0.43
11	Once addiction has developed, do you consider it to be treatable?	Yes No	180 (86.0) 30 (14.0)	137 (88.0) 18 (12.0)	0.55

\* Significant at p value&lt;0.05, \*\* Significant at p value&lt;0.01, \*\*\* Significant at p value&lt;0.001

students appeared to have adequate knowledge about addictive substances and their harmful effects to body. Their attitude and knowledge towards addiction appeared to be comparable in terms of treatment and prevention among both the group.

Majority of students had adequate knowledge about addictive substances with limited treatment related knowledge and substantial social stigma. This highlights the need for spreading more awareness about treatment of substance abuse via school lectures, media and campaign at larger level.

The main limitations of our study remained the instrument used to assess knowledge and attitude towards drug dependence (KAAQA) was not standardized, and information was not collected about the personal and family history of substance use. Assessment of drug related knowledge, attitude and practices among adolescents are important as it guides to formulate effective preventive programs for the students. As demand reduction for substance can only be achieved by spreading awareness about substance abuse along with primordial and primary prevention.

#### REFERENCES:

- Adolescents in India: a profile. UNFPA for UN system in India [online]. 2003 [cited 2011 Nov 10]. Available from: [http://whoindia.org/LinkFiles/Adolescent\\_Health\\_and\\_Development](http://whoindia.org/LinkFiles/Adolescent_Health_and_Development).
- Bryan, A., Moran, R., Farrell, E., & O'Brien, M. (2000) Drug-Related Knowledge, Attitudes and Beliefs in Ireland: Report of a Nation-Wide Survey. Dublin: The Health Research Board.
- Chatterjee, S., Tempalski, B., Pouget, E.R., Cooper, H.L., Cleland, C.M., Friedman, S.R. (2011) Changes in the Prevalence of Injection Drug Use Among Adolescents and Young Adults in Large U.S. Metropolitan Areas. *AIDS and Behavior*, 15, 1570-1578.
- Coles, C.D., Good, L., Strickland, K. (1992) Knowledge and attitudes of public, addicts in treatment, and health care professionals about substance abuse in pregnancy. Atlanta: Georgia Mental Health Institute (unpublished).
- Demographic trends for adolescents: Ten key facts. UNICEF report 2011. [online] [cited 2011 November 10]; Available from: <http://www.unicef.org/sowc2011/pdfs/Demographic-Trends.pdf>.
- Gassman, R.A., Demone, H.W., Albilal, R. (2001) Alcohol and other drug content in core courses: Encouraging substance abuse assessment. *Journal of Social Work Education*, 37, 137-145.
- Giannetti, V.J., Sieppert, J.D., Holosko, M.J. (2002) Attitudes and knowledge concerning alcohol abuse: Curriculum implications. *Journal of Health and Social Policy*, 15, 45-58.
- Happell, B., Carta, B., Pinikahana, J. (2002) Nurses' knowledge, attitudes and beliefs regarding substance use: A questionnaire survey. *Nursing and Health Sciences*, 4, 193-200.
- Khan, M.Z., Unnithan, N.P. (1979) Association of socio-economic factors with drug use among college students in an Indian town. *Bulletin on Narcotics* (United Nations publication), 31, 61-69.
- Kushwaha, K.P., Singh, Y.D., Rathi, A.K., Singh, K.P., Rastogi, C.K. (1992) Prevalence and Abuse of Psychoactive Substances in Children and Adolescents. *Indian J Pediatrics*, 59, 261-268.
- Linda, H., Ali, S., Mary, U., Sukaina, A.Z. (2010) Knowledge of substance abuse among high school students in Jordan. *Journal of Transcultural Nursing*, 21, 143-150.
- Mohan, D., Arora, A. (1976) Prevalence and pattern of drug abuse among Delhi University students. *Indian J Medical Association*, 66, 28-31.
- Mohan, D., Thomas, M.G., Prabhu, G.G. (1977) Prevalence of drug abuse in high school population. *Indian J Psychiatry*, 33, 20-24.
- Moreira, F.G., Silveira, D.X., Andreoli, SB. (2009) Knowledge and attitudes related to drug abuse and prevention displayed by public school educators. *Rev Bras Psiquiatr*, 31, 95-100.
- Nebhinani, N., Misra, A.K., Kaur, M., Kulhara, P. (2012) Drug Related Knowledge and Attitude among Adolescents: A School Based Survey. *Indian J Social Psychiatry*, 28, 67-70.
- Panicker, R. (1998) Street children and drug abuse in India. In: *Drug Demand Reduction Report*. New Delhi; UNDCP Regional Office for South Asia, 34-36.
- Prakash, O., Giri, O.P., Mishra, A.K., Kumar, S., Kulhara, P. (2009) Knowledge and attitude of Indian adolescents towards addiction: finding from an exploratory survey. *J Mental Health & Human Behavior*, 14, 74-79.
- Saluja, B.S., Grover, S., Irpati, A.S., Mattoo, S.K., Basu, D. (2007) Drug Dependence in Adolescents 1978-2003: A clinic based observation from North India. *Indian J Pediatrics*, 74, 455-458.

Sethi, B.B., Manchanda, R. (1978) Pattern of drug abuse among male students. Indian J Psychiatry, 20, 166-173.

Schwarz, C.J. (1997) Knowledge and attitude of undergraduate and graduate social work students towards addiction and those who use illegal drugs. Unpublished master's thesis, California State University, Long Beach.

Thacore, V.R. (1972) Drug abuse in India with special reference to Lucknow. Indian J Psychiatry, 14, 257-61.

Tripathi, B.M., Lal, R. (1999) Substance Abuse in children and Adolescents. Indian J Pediatrics, 66, 569-575.

Tsering, D., Pal, R., Dasgupta, A. (2010) Substance use among adolescent high school students in India: a survey of knowledge, attitude and opinion. J Pharmacy and Bioallied Sciences, 2, 137-40.

Varma, V.K., Ghosh, A., Singh, S., Sig, N.N. (1977) Drug abuse among college students in India. Indian J Psychiatry, 19, 1-10.

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**ABSTRACTS OF  
XX NATIONAL CONFERENCE OF  
INDIAN ASSOCIATION FOR  
SOCIAL PSYCHIATRY,  
KOLKATA,  
8-10 NOVEMBER 2013**



## PRESIDENTIAL ADDRESS, ORATIONS AND INVITED LECTURES

### PRESIDENTIAL ADDRESS

#### What Social Psychiatry has to offer in Contemporary Psychiatric Practice?

*RK Chadda*

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Social psychiatry has often been ignored in psychiatry over almost half a century, the period when the advances in psychopharmacology, brain imaging and biological basis of mental disorders have taken place. However, the importance of social psychiatry can't be ignored. Infact, it is a branch of psychiatry, which can be said to be emerging with full vigour in the last two decades out of the forced hibernation. Social psychiatry may not look as glamorous as biological psychiatry, but it has lot to offer. The biological research into mental disorders in the last few decades despite having the advances in brain imaging and huge monetary and manpower investments has not been able to provide a breakthrough discovery. The new molecules introduced for treatment in the last two decades have been found to not much better than the first generation medications.

In recent years, increasing burden and disability due to mental disorders, delay in seeking treatment, poor adherence to treatment, stigma to mental disorders and increasing suicide rates and violence, and substance abuse have been of major concern for the mental health professionals and need interventions on the part of social psychiatrists. Understanding of the role of social factors in etiology of mental disorders and identifying the causative influences in the individual patient is of paramount importance, so as to develop suitable intervention strategies. Social psychiatry is the centre to understanding the genesis and management of psychiatric illnesses. Its role in preventive as well as therapeutic psychiatry is crucial and it is the need of the hour.

### Dr N.N. DE ORATION

#### Bridging The Mental Health Gap

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India is a vast country with huge number of patients requiring and seeking mental health care from mental health professionals. The resources to deal with this gigantic problem of mental ill health are limited. There is appreciable imbalance between residence of people and location of mental health facilities-the rural urban divide and disproportionate distribution of mental health professionals. Most of our general hospital psychiatry units and mental hospitals are inadequately staffed; the scene of private psychiatry is no different. Undergraduate medical education in relation to psychiatry is perfunctory, postgraduate psychiatric training is fragmented. National Mental Health Programme and District Mental Health Programme have positively impacted mental health delivery services. The MhGAP initiative of the World Health Organization is a welcome step in the right direction. Mental Health legislation, interventions by the Supreme Court of India and the National Human Rights Commission have energized funding of mental health programme. Much more needs to be done to make mental health services affordable and accessible so that those who need these service the most.



## INVITED LECTURES

### Cinema and Psychiatry

*Indira Ramasubba Reddy*

*Director – VIMHANS, Vijayawada*

Cinemas are the world's most popular and powerful art form. Some argue that portrayal in the movies reflects the happenings in the society and it is not true that movies have an impact on the mental health of the people. Many movie-makers argue that cinema is only for entertainment and not to be taken seriously. However, strong scientific evidence exists that there is a definite influence of movies in shaping the beliefs, attitudes and behavior of the people.

Movies act as a 'double edged sword' but the sword is sharp in portraying the negative image of mental illness and mental health professionals, which have fuelled further the misconceptions about mental illness. Violence committed by the mentally ill characters is the norm in movie portrayal, where as the reverse is true. The distorted portrayal about the mentally ill instils fears among the public and increases the stigma. The fast music, pub culture, dating, premarital and liberal sex, crime and violence among youth can be largely attributed to the western movie and media impact on the Indian conservative youth, which is definitely an indication of 'Cultural Attack' by the west.

In the Indian movies, Psychiatrists are depicted as comedians, aggressive, exploitive and as villains, which would do a lot of harm to people who are already hesitant to seek psychiatric treatment. Electroconvulsive Therapy is shown as frightful, painful and as a punishment to the rivals and also to the patients. The impact of movies is much more on the emotionally disturbed individuals than on the average or normal people. The impact of movies and their popularity has made many cine stars as MPs, MLAs, Ministers and even as Chief Ministers. The strong cinema charisma has a definite impact in changing the 'Political Psyche' of the masses.

The impact of horror and violent films and sex crimes due to erotic scenes in movies and glorification of suicides in cinemas and other media will also be discussed. A Lot of research is done on the impact of cinemas on brain functioning.

Cinema remains one of the cheapest and most easily accessible forms of entertainment. Movies appeal to an individual's unconscious desires and means of self-identification and wish fulfilment. To many, films offer a release from the day's frustrations and compensate for the deficiencies of real life. In the course of watching a film, the spectator for a while not only loses higher self-consciousness but also identifies with a character—down trodden or middle class. Psychological effects of films include influencing fashion, dress, jewellery, hair styles, personal mannerisms and speech, but the immediate response may be fear and jealousy, love and hero worship. Films no doubt influence the conduct of individuals and the influence depends upon a number of factors including social experience and personal idiosyncrasies. A common platform for moviemakers and Psychiatrists should be periodically organized at different places for mutual exchange of ideas.

### Girindrasekhar Bose and vernacularization of psychiatry in Bengal

*Amitranjan Basu*

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Dr. Girindrasekhar Bose was the first psychoanalyst in the non-western world. After his medical graduation he completed his post-graduation in psychology and subsequently a D. Sc. from the newly formed psychology department at University of Calcutta in early twentieth century, which also makes him the first Indian psychiatrist.

In the last two decades Girindrasekhar attracted scholarly attention for his views on psychoanalysis, which was not always in resonance to Freud and he tried to develop a concept that did not exclude vernacular texts as a potential resource.

In this paper, I have tried to read Girindrasekhar's views on mind and its functions and dysfunctions through his Bengali writings. For this I have selected his texts from the Bengali periodicals and two books. Close readings reveal the cultural critique to the western knowledge. I have tried to argue in this paper that, vernacularization has actually opened up the epistemic politics and the hybrid knowledge produced is not an 'impure' science but a creative discourse that attempts to revise the western science through culture.

## AWARD PAPAERS

### BALINT AWARD

#### BEYOND INVISIBLE WALLS: HOW DIFFICULT IS TO HEAL DEEPER WOUNDS

*Naresh Nebhinani*

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How do we make treatment decisions about our most complex clients? Where trauma has shattered the individual's life and substantially affected one's affective, cognitive, psychomotor domains, and persisted for an extended period of time. Such individual's often present with a wide range of psychological difficulties, like emotional distress, interpersonal problems, and behavioural dysregulation. Post traumatic stress disorder (PTSD) is a whole-body tragedy, a complex event of enormous proportions with massive repercussions for entire life. Sorting out how to proceed clinically poses a number of dilemmas and serial questions at our clinical acumen.

### GC BORAL AWARD I

#### ADOLESCENTS' MENTAL HEALTH ISSUES: KNOWLEDGE AND ATTITUDE OF ADOLESCENT GIRLS FROM RURAL BENGAL

*Prasenjit Ray, RMO cum Clinical Tutor; Amrita Chakraborti, MD Resident, Amit Kumar Bhattacharyya, Associate Professor, Paramita Ray, Assistant Professor Burdwan Medical College*

Background: The aims of this current study were to prepare and validate a Bengali questionnaire to assess knowledge and attitude of adolescents about the various mental health issues related to them, and to conduct a pilot study with this questionnaire. Method: It was a cross sectional study conducted on adolescent school girls (N=107, 12 to 18 years age) from rural background of West Bengal. A 13 item Bengali questionnaire was constructed, validated and administered on the subjects. Statistical analysis was done using SPSS (16th version). Results: Most of the items had good test re-test reliability. Mean age of the population was 13.09 years. Three knowledge based questions had more correct responses (50.5%, 52.3%, 50.5%) and one had 72% incorrect responses. Majority of the subjects recognised problem behaviours,

expressed an helping attitude, tended to seek help from parents, and thought sharing worries with others and spending time with friends could make them happy. Conclusions: This questionnaire appears reliable to assess knowledge and attitude of adolescent girls. There is need to inform adolescents about various mental health issues. Attitude to help and a sense of cohesion was conspicuous in this population. A larger and more inclusive study needed to generalize the findings.

#### SEXUAL DISORDERS AMONG ELDERLY: AN EPIDEMIOLOGICAL STUDY IN SOUTH INDIAN RURAL POPULATION.

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CONTEXT: The study on assessment of sexual functioning in the elderly was taken up as a part of major ICMR sponsored epidemiological study for the assessment of psychiatric morbidity in the rural population. It involved door to door survey of the entire population residing at Suttur village which is about 25 kilometres from Mysore city in South India. It has a population of approximately 4100 with predominance of Hindu community. There are about 1000 families in the village. There is a Primary Health Centre run by the Government of Karnataka in collaboration with JSS Medical College and Hospital. The study was designed to interview the entire population of the village with age above 60 years, so that our findings can reflect the prevalence of psychiatric and sexual disorders in South Indian Villages. OBJECTIVES: Assessment of prevalence of Sexual disorders among individuals above 60 years. METHODOLOGY: Type of study: Descriptive and exploratory, door – to – door epidemiological study. Type of sampling: Purposive Sampling. Sample Size: N=259 males and females above 60 years residing in the rural area who constituted 8.5% of the total population studied. House by House interview was done to find out individuals above 60 years. Inclusion Criteria: Above the age of 60 years of age. Exclusion Criteria: 1. Less than 60 years of age. 2. Above the age of 60 years but with psychotic symptoms, dementia or mental retardation.

**Tools Used:** Sociodemographic data proforma: Socioeconomic status assessment based on Modified B. G. Prasad's Classification; Evaluation of sexual disorders: a. International Index of Erectile function (IIEF) for males, b. Premature ejaculation diagnostic tool (PEDT) for males, c. Female sexual function questionnaire, d. Structured Interview Schedule for diagnosing other sexual disorders based on DSM IV and ICD-10 criteria. **Statistical Analysis:** Both descriptive and inferential statistics were employed in the present study. Contingency coefficient tests were applied to study the association using SPSS for windows (version 16.0). **RESULTS:** Showed majority in the age range of 66 to 75 years, Hindus, living with spouses and more than half being males (55.2%). 27.4% of the subjects were sexually active and it progressively dropped as age advanced and none sexually active after 75 years. Various myths and misconceptions were present for being not active. Among those sexually active 43.5% of the male subjects were diagnosed to have male erectile dysfunction, male premature ejaculation was found to be prevalent in 10.9%, male hypoactive sexual desire disorder was found in 0.77% and male anorgasmia in 0.38% of the subjects. Among females the prevalence of female arousal dysfunction was found to be 28%, female hypoactive sexual desire disorder 16%, female anorgasmia 20% and female dyspareunia in 8% of the female subjects. **CONCLUSION:** The geriatric sexuality one of the neglected areas and significant prevalence of sexual dysfunctions. The data would be presented in the context of psychosocial variables, biological factors and co-morbidities. It is suggested further comprehensive studies concerning older individuals and need for sex education for the improvement of quality of life.

#### **PSYCHOLOGICAL HEALTH OF CARE GIVERS OF INDIVIDUALS WITH TYPE II DIABETES MELLITUS: A CROSS SECTIONAL COMPARATIVE STUDY**

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**Introduction:** The quality of life in individuals with diabetes is also dependent upon the quality of family relationships and general well-being of caregivers because the patient depends on them to uphold in the community. Only limited studies have assessed the psychological health of caregivers to individuals with diabetes. **Aim and Objective:** The current study aims at

comparison of depression and anxiety levels among patients with diabetes and their caregivers. **Methodology:** Fifty consecutive patients-care giver dyads of subjects having type II diabetes were recruited at an out-patient clinic of Medicine at a tertiary care centre. The dyads were assessed using a semi-structured proforma for the socio-demographic details and for anxiety and depression levels using the Hospital Anxiety and Depression Scale (HADS). The data were analyzed using SPSS version 17.0. Correlation analysis was performed for multiple variables including blood glucose profile. **Results:** The mean duration of illness ( $4.93 \pm 3.53$  years) and blood glucose parameters were not found to be associated to depressive or anxiety symptoms. Depressive and anxiety disorder was observed in 24% and 44% of patients and 10% and 18% of caregivers respectively. Patients had significantly more HADS anxiety scale scores than caregivers but not for HADS depression scale. Female patients were found to be having more HADS-D scores than male patients ( $p=0.02$ ) but were not significantly different from caregivers. HADS-A scores were comparable among male and female gender in intragroup as well as intergroup comparison for patient and caregiver groups. **Conclusion:** Diabetes mellitus affects the psychological health of not only the patients but as well as the family caregivers and patients tend to be more anxious than the caregivers. Also, it was seen that women with diabetes had higher rates of depression than their male counterparts.

#### **BREAKING THE BARRIERS - A QUALITATIVE STUDY OF CARERS' EXPERIENCE OF FIRST EPISODE PSYCHOSIS.**

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**Background:** Long duration of untreated psychosis (DUP) is associated with poor outcomes and low quality of life at first contact with mental health services. However, long DUP is common. We investigated carers' experiences of the onset of psychosis and help-seeking in a hospital based sample of patients in Shimoga a city in southern state of Karnataka. **Method:** In-depth interviews were conducted with carers from a psychiatric hospital in Shimoga. Interviews covered respondents' understanding of and reaction to the onset of psychosis, their help-seeking attempts and the reactions of social networks and health services. **Thematic analysis** of interview transcripts was conducted. **Results:** Multiple barriers to prompt

treatment included not attributing problems to psychosis, difficulty in understanding symptoms, worries about the stigma of mental illness and contacting the mental health services, not knowing where to get help, relying on religious methods for cure and unhelpful responses from health professionals. Help was often not sought until crisis point, despite considerable prior distress. The person experiencing symptoms was often the last to recognize them as mental illness. The health professionals and workers were frequently willing to assist help-seeking but often lacked skills, time or knowledge to do so. Conclusion: Even modest periods of untreated psychosis cause distress and disruption to individuals and their families. In India we need to prioritize early detection. Initiatives aimed at reducing DUP may succeed not by promoting swift service response alone, but also by targeting delays in initial help-seeking. Our study suggests that strategies for doing this may include addressing the stigma associated with psychosis and community education regarding symptoms and services, targeting not only people developing illness but also a range of people in their social networks.

#### GC BORAL AWARD II

##### ASSIST-LINKED ALCOHOL SCREENING AND BRIEF INTERVENTION IN INDIAN WORKPLACE SETTING: RESULT OF A 4-MONTH FOLLOW UP

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**Introduction:** World Health Organization (WHO) attributes 2.5 million deaths every year as a result of harmful alcohol use. WHO developed an Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)-linked Brief Intervention package (ASSIST-BI) to reduce the risk level of alcohol use. Evidence of the efficacy of brief interventions in primary health care and hospital settings for harmful use of alcohol is relatively more as compared to workplace settings. Aim and objectives: To study the effectiveness of ASSIST-BI

in reducing harmful drinking in the workplace setting of class C employees after a 4-month period. Methods: A sample of 39 workers with moderate and high risk level of alcohol use was identified by randomly screening 162 employees with ASSIST. Employees who were identified as moderate and high risk drinkers by the ASSIST were given brief intervention as per ASSIST-BI. The final sample size after 4 months was 31. The individual outcomes were compared on the basis of pre and post ASSIST score and statistical methods. Results The average ASSIST scores decreased significantly at 4 months after the intervention relative to pre test ( $p = 0.001$ ). There was a significant change in ASSIST variables, drinking pattern of the subjects, moderate and high risk use of alcohol ( $p = 0.001$ ). Moreover majority of the subjects (77 %) had reduced ASSIST scores at the 4-month follow up. Conclusion: Brief intervention resulted in a statistically significant reduction in harmful drinking pattern of the study subjects ( $p < 0.01$ ) in this workplace setting.

##### ERECTILE DYSFUNCTION IN PATIENTS WITH DIABETES MELLITUS: ITS MAGNITUDE, PREDICTORS AND THEIR BIO-PSYCHO-SOCIAL INTERACTION

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Background: Persons suffering from diabetes mellitus (DM) are at higher risk of developing erectile dysfunction (ED). Several factors contribute to ED in patients of DM. Only few studies have attempted to explore physical, psychological and social factors in a single study. The aim of the index study was to measure the prevalence of ED in patients of DM and to determine the contributory role of various socio-demographic, physical, and psychological variables. Methods: One hundred and thirteen ( $N=113$ ) consenting consecutive male diabetic patients were assessed on International Index of Erectile Function Questionnaire (IIEFQ-5), Dyadic Adjustment Scale (DAS) and Beck's Depression Inventory (BDI) to measure erectile performance, quality of marriage and

depressive symptoms respectively. Pretested Bengali versions of these scales were used in the index study. Results: Prevalence of ED was 38.94%. Current age, family type, BMI, type of treatment, presence of comorbid physical illnesses, presence of micro/macrovacular complications, history of current tobacco use, quality of marriage, and depressive symptoms were significantly correlated with severity of ED. In linear regression analysis age, BMI, quality of marriage and depressive symptoms had significant predictive role ( $p < 0.05$ , adjusted R Square 0.629) on erectile performance. Conclusions: Prevalence of ED among diabetic patients is quite high and many of them were even reluctant to discuss about their sexual function with physicians. Both physical and psychosocial factors predict the occurrence of ED in this group. So, both physicians and psychiatrists should remain aware about the multi-faceted causative role of ED in DM.

#### **AN EVALUATION OF PSYCHOLOGICAL WELL BEING IN PRIMARY SURVIVORS OF UTTARAKHAND DISASTER**

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Introduction: After the 2004 Tsunami, India faced the worst natural disaster in Uttarakhand causing devastating floods and landslides. Besides the material harm, disaster also has massive impact on individual's mental health and the impact is perceived more in developing countries due to being densely populated with limited resources. Objective: The current study is an attempt to evaluate the psychological impact and its risk factors in Uttarakhand disaster. Methodology: This cross sectional study was conducted after 1 month of disaster in the primary survivors. All the included subjects were administered the semi-structured proforma for assessing socio-demographic profile and the assessment instruments: Impact of events scale-revised (IES-R), Depression Anxiety Stress Scales (DASS) and Life Orientation Test – Revised (LOT-R). Data was imputed and analysed using SPSS ver 17.0. Result: About 58% subjects had post traumatic stress disorder (PTSD) and significantly severe levels of depression,

anxiety and stress were noted in 45.3%, 57%, and 44.2% subjects respectively. A physical illness was present in 36% subjects. Loss of at least one family member was reported by 12.8% subjects. LOT-R scores were negatively correlated to IES-R. Conclusion: Psychological morbidity in the immediate post disaster period is high. Increasing age has higher levels of depression, anxiety and stress with development of negative outlook regarding their future. Increasing age, lower educational levels, physical illness, loss of a family member, and pessimistic expectations were associated with adverse psychological sequelae.

#### **HARNESSING THE POWER OF THE FAMILY: USE OF FAMILY-CAGE TO DETECT SUBSTANCE DEPENDENCE IN FAMILY MEMBERS**

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Background: CAGE questionnaire has proved to be useful in the screening of alcohol use disorders. But the validity of Family CAGE questionnaire for the diagnosis of substance dependence is still under researched. Aim: To assess the validity of Family CAGE questionnaire for various substance users in both treatment seekers and non treatment seekers. Methodology: Two hundred ten subjects were recruited from two different treatment settings. For the representation of treatment seeking population a convenient sample was collected from de-addiction centre and non-treatment seekers were obtained from the psychiatry outpatient. CAGE and Family CAGE questionnaire were applied in a self administered format. ICD 10 criteria and subsequent detailed clinical interview by a trained psychiatrist were used for the final diagnosis of substance dependence. Results: Majority of the subjects were alcohol (60%) users followed by opioid (35.2%) and cannabis (3%). The scores of CAGE ( $r^2 = 0.51$ ) and Family CAGE ( $r^2 = 0.57$ ) questionnaire were highly correlated with the ICD 10 symptom score. In the Psychiatry outpatient group, there has been a substantial inter rater agreement between the Family CAGE and the CAGE questionnaire (Cohen's kappa = 0.79). Though the inter-rater reliability of the Family CAGE and the ICD 10 diagnosis of substance dependence was moderate (Cohen's kappa = 0.61). In both the subgroups, a cut off score of 2 of Family CAGE was found to be 100% sensitive for the diagnosis of substance dependence. But with same cut off score, the specificity of diagnosis obtained from the

psychiatry outpatient was 33.3%. On the contrary in the same subgroup, cutoff of 3 was 95.8% sensitive and 100% specific. Conclusions: Self administered Family-CAGE questionnaire is a valid instrument for the diagnosis of substance dependence. The sensitivity and specificity of a cutoff score of 3 of the family CAGE questionnaire for the diagnosis of dependence are reasonably acceptable. This simple questionnaire can be used for screening purpose especially in the epidemiological studies.

#### **BB SETHI AWARD**

##### **NURSING STUDENTS' ATTITUDES TOWARDS PATIENTS WHO SELF HARM: AN EXPLORATORY STUDY**

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Background: Majority of health professionals have unfavorable attitudes towards patients presenting with self-harm, which further compromises their willingness and outcome of care. This study was aimed to assess the nursing students' attitudes toward patients who self harm. Methodology: By employing cross-sectional design, 308 nursing students were recruited through total enumeration method from May-June 2012. 'Suicide opinion questionnaire' was administered to assess their attitudes towards patients who self harm. Descriptive statistics was employed with SPSS version 14.0 for Windows. Results: Majority were single females, from urban locality, with the mean age of 20 years. Only minority had previous exposure to suicide prevention programmes and management of such cases. Majority of students agreed for mental illness, disturbed family life, and depression as major push to attempt suicide. They held favorable attitude for half of the attitudinal statement, but they were uncertain for rest half of the statements. Conclusions: They generally had favorable attitude towards suicide attempters. Their uncertain response highlights the need for enhancing educational exposure of nursing students and new staff at the earliest opportunity, to carve their favorable attitude towards patients presenting with self-harm.

##### **LONG TERM OUTCOME OF SUBSTANCE ABUSE TREATMENT THROUGH INTEGRATED CAMP APPROACH**

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Introduction: Substance dependence is a chronic, relapsing disorder and requires long term care and treatment. Community based treatment is cost effective, closer to the community, community participation is more, it is less stigmatizing and patient can stay with his family during the treatment. Objectives: To see the outcome of patients of alcohol and drug abuse admitted in community de-addiction. Method: The patients of community de-addiction camps who were admitted from 1999-2010 were followed up in June, 2012 for the purpose of outcome. Results: Out of 172 patients, 147 patients could be contacted (85.46%). More than 52% of patients of alcohol and drug abuse could maintain abstinence for more than 10 years and more than 42% of patients could maintain abstinence between 2-10 years. Conclusion: Community based de-addiction camps is cost effective interventional strategy even for long term care of patients of alcohol and drug abuse.

##### **NURSING PERSONNEL ATTITUDE TOWARDS SUICIDE PREVENTION INITIATIVES**

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Background: Preventing suicide depends upon the different health professionals' knowledge about suicide, attitude towards suicide attempters, skills to assess and manage suicidal risk. This study was aimed to assess the attitude of nursing students toward suicide prevention. Methods: By employing cross-sectional design, 308 nursing students were recruited from the two institutions through total enumeration method. 'Attitude towards suicide prevention scale' was administered. Results: Majority were single females, from urban locality, who were pursuing B.Sc Nursing with the mean age of 20 years. Only minority had previous exposure to suicide prevention programmes/workshops. About 47% of the sample showed positive attitude towards working with suicidal patients whereas 49% agreed that most of the suicidal people won't reveal their suicidal plans to others. More than 50% consider unemployment and poverty as main causes of suicide and were quite hopeless about it. Attitude towards suicide prevention was significantly different for 5 out of 14 statements among students from two different nursing colleges. Conclusions: 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.

### **DO THE VARIOUS CATEGORIES OF SOMATOFORM DISORDERS DIFFER FROM EACH OTHER IN SYMPTOM PROFILE AND PSYCHOLOGICAL CORRELATES**

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**Background:** Somatic symptoms are common presentations in primary care and specialty clinics worldwide and many of these patients are diagnosed to have somatoform disorders. However, in routine clinical practice, the sub-categories of various somatoform disorders are used rarely and there is lack of data to suggest the difference in the clinical manifestations of these sub-categories. **Aim:** To examine the prevalence of various somatic symptoms, anxiety and depression in patients diagnosed with various subtypes of somatoform disorders and to compare the symptom profile of patients with persistent somatoform pain disorder with other subtypes of somatoform disorder. **Method:** One hundred nineteen (119) patients diagnosed with somatoform disorders according to the International Classification of Diseases- 10th revision (ICD-10) were evaluated for prevalence of somatic symptoms, anxiety, depression, alexithymia, hypochondriacal worry and somatoform sensory amplification. Patients with persistent somatoform pain disorder were compared with those with other subtypes of somatoform disorders on all the parameters. **Results:** The most commonly reported symptoms were headache, excessive tiredness on mild exertion, pain in limbs, bloating and backache. Persistent somatoform disorder was the most common diagnosis given to more than half of study participants. No significant differences were found in the prevalence of various somatic complaints between those with persistent somatoform pain disorder group and those diagnosed with other somatoform disorders. Comorbid anxiety and depression were seen in two-third of the patients, but again there was no difference in the prevalence of the same between the two groups. Similarly, no significant differences were found on the alexithymia, hypochondriasis and somato-sensory amplification scales between the persistent somatoform pain disorder group and other

somatoform disorders. A significant positive correlation was found between total number of somatic symptoms and severity of depression, anxiety and level of somatosensory amplification in both the groups. **Conclusion:** There are no significant differences between the various sub-categories of somatoform disorders of ICD-10 with regard to the prevalence of somatic symptoms, anxiety or depression and clinical correlates of alexithymia, hypochondriasis and somatosensory amplification.

### **EFFECT OF ANXIETY AND DEPRESSION ON LONG TERM OUTCOME OF MYOCARDIAL INFARCTION**

*Siddharth Sarkar<sup>1</sup>, Rakesh Chadda<sup>2</sup>, Rajiv Narang<sup>3</sup>, Nand Kumar<sup>2</sup>*

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**Objective:** Anxiety and depressive symptoms are common following myocardial infarction (MI). The present study was conducted to assess the effect of anxiety and depression on clinical outcome at 18 months in patients with a recent MI. **Methods:** Patients with a recent MI attending the cardiology outpatient of a tertiary care center formed the sample of the study. Demographic and clinical data was recorded. Anxiety and depressive symptoms were assessed at the baseline using standardized instruments. The patients were contacted telephonically at 18 months to ascertain the outcome. **Results:** Out of original sample of 103, 66 patients could be contacted at 18 months. Out of the patients who could be followed up, about one third had a poor outcome at 18 months in the form of adverse cardiac event or death. Anxiety and depressive symptoms or having a psychiatric illness at the baseline did not influence outcome in this particular cohort. **Conclusions:** Anxiety or depression by itself may not be a poor prognostic factor in patients with MI.

## SYMPOSIA

### **S1 - THEME SYMPOSIUM: MENTAL HEALTH IN CHANGING SOCIAL MILIEU**

#### **Changing social milieu in contemporary society:**

*SK Khandelwal*

#### **Effects of changing social milieu on mental health:**

*Amool Ranjan*

#### **Social milieu and mental health: role of a mental health professional**

*TSS Rao*

#### **Social milieu and mental health: Perspectives of a social scientist**

Manju Mohan Mukherjee

The broader concept of health now accords greater prominence than ever to the mental and social determinants of health. Most significantly, this new understanding of health dwells less on individual attributes, but more on the nature of their interaction with the wider environment. The "environment" in its broadest sense includes not only our physical surroundings, but also the social, cultural, regulatory and economic conditions. Thus, with definition, mental health moves into the realm of the relationship between the individual, the group and the environment. Mental health is no longer conceived of as an individual trait, such as physical fitness; rather it is regarded as a resource consisting of the energy, strengths and abilities of the individual interacting effectively with those of the group and with opportunities and influences in the environment. This conceptualization leads to certain conclusions about the factors that can enhance or weaken mental health. For example factors like poverty, prejudice, discrimination, disadvantage and marginality are a threat or barrier to mental health. Although in the recent years biological understanding of mental disorders, has improved significantly, however the stress originating from the environment is still perceived as a significant factor causing psychological disturbance. There is strong link between stress and mental illness, but large number of people remain healthy even in life threatening situations. The factors which help in maintenance of homeostasis include social support, coping etc. There are numerous studies

now which show that people who have family, friends and relatives who provide emotional and material support are in better health. The social support can have buffering effect from stress. The environment is undergoing rapid change and thus it is expected that it will affect our mental health. The social psychiatrists have a larger responsibility to keep a constant vigil on these factors and provide better strategy to deal with these changing factors.

### **S2 - MENTAL HEALTH PROGRAMME, POLICY AND LEGISLATION: A CASE FOR COHERENCE**

#### **Mental Health Programme-**

*Roy Abraham Kallivayalil*

#### **Mental Health Policy-**

*BS Chavan*

#### **Mental Health Care Bill-**

*(Late) JK Trivedi & Adarsh Tripathi*

#### **Situation Appraisal and future directions. -**

*Rakesh Chadda*

India has a large burden of mental and behavioural disorders. There is a huge treatment gap due to scarcity of available mental health resources, inequities in their distribution, and inefficiencies in their use. To improve the mental health of our population, it is essential for all the stock (stake) holders' namely mental health professionals, their organizations, policy and law makers, health care providers, advocacy groups and Non Governmental Organizations to commit to a systematic and proactive strategy. Advocacy efforts by international organizations, national opinion makers and users are necessary to generate sufficient political will to prioritize mental health services. We should have a mental health policy, and a dedicated mental health budget. A mental health programme to integrate mental health care with primary health care and provision of universal, accessible, affordable mental health care at community level is being implemented to improve the situation. However, its functioning at ground level remains far from satisfactory. Till this time, there doesn't appear to be uniformity in national mental health programme and mental health legislation of the India. The new Mental Health Care Bill has been cleared by the Union Cabinet on June 14,



2013, and once approved by the Parliament, will repeal the Mental Health Act 1987. The Mental Health Care Bill 2012 makes significant strides over the Mental Health Act 1987 and proposes to bring about protection and empowerment of persons with mental illness. The Ministry of Health and Family Welfare, Government of India has appointed a Policy Group to prepare a National Mental Health Policy and Plan. This is the right time for pointing towards having greater coherence in all these efforts so that focused attempts to improve mental health care scenario of the nation could be made.

### **S3 - HOME BASED TREATMENT: A COMMUNITY OUTREACH SERVICE FOR ENGAGING THE NON-ENGAGERS.**

**The conceptual 'Hows' and 'Whys' behind Home Based Treatment:** *BS Chavan*

**The logistics related to implementation of Home Based Treatment:** *Shikha Tyagi*

**Sharing of the initial experience using an evidence-based approach:** *Nitin Gupta*

**SUMMARY:** In view of huge treatment gap, engaging the patients is one of the objective for mental health services. In India, the most common treatment set-up available for patients with mental illnesses is hospital based facilities, which necessitates them having to come there for seeking treatment. This approach, however, faces difficulties for patients who are unwilling to come to the hospital due to a myriad of reasons. Engaging with these non-engagers (or 'difficult to engage') patients as a model is widely practiced in the west. However, it has been implemented to a very limited extent in the Indian setting. The Department of Psychiatry, GMCH-32, Chandigarh has been gradually expanding its Community Outreach Services, under which the Home-Based Treatment (HBT) Program has been launched. We shall discuss about the processes and logistics related to the concepts and implementation of HBT, and share our experiences related to the running of the HBT over a period of 6 months. **Introduction:** The treatment facilities for the psychiatric patients are available in Chandigarh in both public and private sector. However, the major difficulty faced by the families/caregivers arises when the patient despite psychiatric illness refuses to seek treatment and come to the hospital. Many a times the caregivers would approach the Psychiatrist for prescribing medicines to their relative without even having seen the patient once. Considering this problem faced by the

caregivers the Psychiatric Department, Govt. Medical College & Education, Sect-32, Chandigarh started Home Base Treatment Services. Home Base Treatment Services means provision of treatment facilities to the psychiatric patients in their home setting. Why was it conceived: To Provide an alternative to hospital admission, To decrease the stigma attached to hospital admission, To provide service that is accessible, available, affordable and responsive which is in agreement with the objectives of national mental health programme, Effective treatment package in the setting of home and family, To lessen the burden of family members, Reaching the unreached, Facilitate early discharge from hospital. How it was planned: In order to provide the treatment at home, Home Base Treatment Team was constituted comprising of Psychiatric Social worker and nursing staff. Two Performa were developed to serve the purpose of HBT the first was application cum consent form where the family/friend/relative writes an application to the HOD asking for interested in availing the services. Along with the application, he/she signs the consent form. The second performa is the HBT assessment performa to be used by the PSW. The Performa was tested on around 10 patients in the OPD to see whether it will be able to serve the purpose. It was also decided that SOFAS will be administered at the first visit and then after an interval of three months to evaluate the improvement in the patient. Criteria (how we fixed) and satisfaction scale (yet to decide) needs to be added. The HBT service has been proposed for the following category of patients: Patients with gross personal neglect due to mental illness, however patient is unwilling to come for treatment; Patients with major mental illness who are staying alone and there is no one to bring them for treatment; Elderly patients with mental illness who are bed ridden and are unable to come to the hospital for treatment; Non compliant patients with a history of multiple relapses and in need of regular medication to prevent relapse and hospitalization.

### **S4 - CURRENT PERSPECTIVES ON TOBACCO USE**

**Putting tobacco harm reduction in perspective: Is there any evidence?:** *Sonali Jhanjee*

**Pharmacological and psychosocial approaches tobacco use cessation: "Thus far and the road ahead":** *Prabhu Dayal*

**Tobacco use in psychiatric disorders: A story of Inveterate Smokers?:** *Yatan Pal Balhara*

Tobacco use is a global pandemic. Tobacco dependence

is a chronic relapsing condition, requires repeated interventions and multiple attempts to quit. Strategies for assisting smoking cessation include behavioural counseling and pharmacotherapy. Three drugs are currently used as first-line pharmacotherapy: nicotine replacement therapy (NRT), bupropion and varenicline. Compared to placebo, the drug effect varies from RR = 2.27 for varenicline, to 1.69 for bupropion, and 1.60 for any form of NRT. Second-line pharmacotherapies include nortriptyline and clonidine. A Cochrane systematic review in 2013 for the first time establishes the efficacy of psychosocial support over and above pharmacotherapy. Conventional tobacco cessation policies and programs generally present tobacco users with only abstinence oriented treatment measures. However, the currently available treatment of nicotine addiction has limited efficacy. Many tobacco users are unable to achieve cessation with the current approaches and experience the very real and obvious adverse health consequences. A third approach to tobacco use cessation, tobacco harm reduction, involves the use of alternative sources of nicotine, including medicinal nicotine, modern smokeless tobacco products (swedish snus), modified conventional cigarettes and e cigarettes to reduce the harm caused by tobacco. The evidence base of effectiveness of these approaches has possible public health implications. However Tobacco harm reduction (THR) is a controversial issue with socio-political overtones and opponents of THR argue that some aspects of harm reduction interfere with cessation and abstinence of tobacco and might increase initiation of tobacco products.

Further, people with mental health and addictive disorders (MHADs) have higher rates of cigarette smoking, and less success in quitting tobacco use compared with the general population giving rise to increased tobacco-related medical illness in this MHAD population. Discussion regarding scope of this comorbidity, and addressing treatment of tobacco dependence in people with MHAD is important to reduce the morbidity and mortality in this population.

## **S5 – MARRIAGE AND PSYCHOTIC ILLNESS**

**Introduction to Marriage and Mental Health – Prakash B Behere**

**Effect of marriage in female schizophrenia patient: A Pilot study – Akshata Mulmule**

**Effect of marriage on male patients with schizophrenia – Manik Bhise**

**Effect of marriage on family functioning and clinical outcome in persons with Bipolar Affective Disorder: A case control study – Nikhil Goel**

**Legal perspectives of marriage and mental health in Indian context – Sonia Parial**

This symposium covers one of the proposed thrust areas of research i.e. mental health of special groups such as women who got married after recovery from psychoses. This symposium will further cover course and outcome of psychoses following marriage. Thus we don't have any readymade answer available, whether marriage helps in improvement or otherwise. These studies will be able to answer all pertinent questions related to the field. Rationale: It is a popular belief in general public that marriage is a cure for different forms of mental disorders from hysteria to psychosis, but, contrary to public opinion, professionals feel that marriage can be detrimental to the continue wellbeing of certain types of mental illness. By these studies we will be able to outline the role of marriage in preexisting psychosis. Present knowledge and relevant bibliography: Fish concluded precipitation of major mental illness by marriage is a largely culture bound phenomenon. Behere and Tiwari concluded it is not only the type of illness which is affected by marriage but it is also important at which stage of illness the person got married. Outcomes & Benefits of the study: The study will provide answer whether marriage is a cure for psychoses or otherwise and concerning outcome regarding their family functioning.

## **ABSTRACT**

**Title:** Effect of marriage in female schizophrenia patient: A pilot study.

**Name of Authors:** Prakash B Behere, Akshata N Mulmule.

**Speaker:** Manik Bhise

**Aims and Objectives:** 1. To study the effect of marriage on schizophrenic females in terms of demographic variables & clinical outcome, family function in both groups and marital adjustment in married patients.

**Study design:** It is an Analytical cross sectional study with comparison group in department of psychiatry AVBRH. Cases & comparison: 25 married & single female schizophrenia patients who fulfilled the selection criteria as led down in the study over 6 month period (Jan 2013 to June 2013).

Written informed consents & Clearance from institutional Ethical committee was taken.

**Scales:** A semi-structured proforma to record demographic, clinical variables; Brief psychiatric rating scale for severity of illness, Family functioning by family assessment device, Family interaction pattern scale and marital adjustment rating scale.

**Results and conclusion:**

Socio demographic variables of both groups were comparable other than occupation. 40% patients were staying with husband, 24% cases informed their spouses regarding illness prior marriage, more than 60% got married on their parent's advice & had poor adjustment. Most patients and relatives were of opinion marriage can cure mental illness. Cases with children had less separation rates. Mental illness was relatively severe in cases than comparison group; family functioning was similar in both groups. with increasing severity of illness marital adjustment deteriorates with antagonistic interaction among members.

#### **ABSTRACT**

**Title:** Effect of Marriage on male patients with schizophrenia.

**Name of Speaker:** *Manik C. Bhise*

**Introduction:** Schizophrenia affects males and females equally. Being a disabling illness with chronic course it affects all spheres of life of person. Marriage being major life time decision studying its impact on illness is of paramount importance.

**Issues under consideration:** Being a disease of young age, patients often have to make choice about marriage after onset of illness. Whether they should get married or not is first issue. Family's expectations from marriage that illness may improve as responsibility comes etc need to be seen. Social skills deficits, occupational impairment, avolition etc are some of the issues which may impair male patients in performing their duties as husband. Another consideration is sexual impairment associated with disease or its treatment. Stability of marriage is another issue. These issues assume importance in male patients as our society has different expectations from males and females, whether or not one has schizophrenia.

**Discussion:** Available literature can help us on some of the issues mentioned above. Studies have constantly revealed deficits in social and occupations functioning of patients with schizophrenia. They have less income,

are more likely to be less educated, less skilled and more likely to lose their jobs. This may affect their choices regarding marriage. Some studies show that stable marriage is a good prognosis factor for schizophrenia. Male patients are less likely to be left alone / divorced by their partners than female patients. Other studies contradict to this by showing marriage as stressful life event that may lead to more relapse. Treatment discontinuation after marriage is less common in males than females, probably because they stay in same family after marriage. In current symposium we will be reviewing literature on these issues.

#### **ABSTRACT**

**Title:** Effect of marriage on family functioning and clinical outcome in persons with Bipolar affective disorder: A Case control study.

**Name of Authors:** Prakash B Behere, Nikhil Goel

**Aims and objectives:** To study the effect of marriage in Bipolar affective disorder patients in terms of clinical outcome, family functioning and quality of life.

**Methodology:** A case control study was conducted in the Department of Psychiatry at AVBR Hospital. 55 patients each of study and control group were taken. Controls were Bipolar affective disorder patients who were never married. Brief Psychiatric Rating Scale (BPRS), Family Assessment Device (FAD) and PGI Quality of Life (QOL) scale was administered.

**Results and Conclusion:** 76% of controls had upto 5 years of duration of illness while 52% cases were having illness of more than 5 years. 72.7% controls suffered from maximum episodes of mania while only 47% cases had mania as their maximum episodes. Mean BPRS scores in control and case group was 36.72 and 39.78 respectively, which is suggestive of mild to moderately ill (Leucht et al, 2005). However the difference is not significant. Similarly mean scores of FAD & QOL in case group and in control group was different, however the difference was not significant. With this we can come to a Conclusion that marriage does not influence outcome of illness, quality of life and family functioning in persons with bipolar affective disorder.

#### **ABSTRACT**

**Speaker:** Sonia Parial

**Title:** Legal perspectives of marriage and mental health in Indian context.

Marriage is a 'contractual agreement' which formalizes and stabilizes the social relationship that comprises the

family. The contract of marriage needs both physical and mental element. It is considered to be a stress for some vulnerable people, which may lead to development or exacerbation of mental illness. Conditions prevailing in the course of marital life determine the continuation of the relationship between partners. Desertion, cruelty, adultery, and mental illness may interfere with the marital life, and it may not be possible for the relationship to continue (Nambi, 2005).

There are different laws governing marriage in different religions. According to Hindu Marriage Act(1955) grounds for judicial separation are that the respondent has been incurably of unsound mind or has been suffering continuously or intermittently from mental disorder of such a kind and such a extent that the petitioner cannot reasonably expected to leave with the respondent. Muslim Marriage Act (1939) states that a person of unsound mind cannot contract a marriage and such a marriage if contracted is void. However, if the guardian of the person of unsound mind considers such marriage to be in his interest and in the interest of society and is willing to take up all the monetary obligations of the marriage, then such a marriage can be performed. Marriage can be dissolved by divorce by the parties without recourse to court and on certain grounds by recourse to court. A Muslim husband of sound mind may divorce his wife without assigning any cause by pronouncing "TALAQ". A Muslim woman can seek divorce on the ground that her husband has been insane for a period of two years. According to Parsi Marriage law (1936) any married person may seek divorce if the defendant was a unsound mind at the time of marriage and has been habitually so up to the date of the suit: provided that the divorce shall not be granted on this ground, unless the plaintiff. Unsoundness of mind is not a ground for annulment. These acts have not been revised since years. Recent research data and consensus holds that there may be serious violation of rights of persons with mental illness in some cases where these acts are applied.

#### **S6 - REHABILITATION THROUGH THE DISABILITY ASSESSMENT REHABILITATION TRIAGE (DART) SERVICE: THE WAY FORWARD!**

*BS Chavan, Subhash Das, Shikha Tyagi, Rushi*

Despite advancement in pharmacological treatment, a large number of patients with chronic psychiatric disorders (like schizophrenia, bipolar affective disorder, recurrent depression) and organic brain disorders (e.g.

dementia) continue to exhibit deficits in cognitive, social and vocational areas which interfere in their long term outcome and rehabilitation into the society. Many such individuals thus require a comprehensive mental health service package wherein some effective non-pharmacological modalities of treatment can be provided so as to have a net positive outcome in the life of the patients as well as their caregivers. Also, many times medicines are helpful only in the acute phase of the illness and not very much effective thereafter; this being specially so in patients suffering with schizophrenia. Also, rehabilitation services for people disabled due to mental illness has, unfortunately, received less focus in the country in comparison to those with physical disabilities or mental retardation. People with mental illnesses require rehabilitation in the domains of cognitive, social as well as vocational skills. The culmination of all these factors together resulted in the commencement of the "Disability Assessment, Rehabilitation and Triage (DART)" services by the Department of Psychiatry, Government Medical College and Hospital-32, Chandigarh. Under DART services, the following units have been set-up and operationalized viz. Neuropsychological Rehabilitation Unit, Social Skills Training Unit, Vocational Skills Training and Rehabilitation Unit, and Day Care Centre. The symposium shall outline the vision behind DART, its position statement, objectives and intent, and detail the repertoire of services. The presenters will aim to highlight the scope and role of rehabilitation in modern day psychiatry and make a case for rehabilitation being given credence in management of mental illnesses, and a need for an appropriate shift of focus from biological psychiatry onto social psychiatry.

#### **S7 - RESEARCH ASSOCIATED PRIORITY INNOVATION & DEVELOPMENT (RAPID) PROGRAM OF THE IASP**

**Setting research priorities for IASP:** *Pratap Sharan*

**The schematics and pragmatics of setting up the research database:** *Ashwani Mishra*

**Research Proposal: IASP Multi-centric study on stigma related to psychosis:** *Nitin Gupta*

**Stigma related to psychosis and its correlates: Preliminary data:** *Pravin Khairkar*

Following the last year's National Conference of The Indian Association of Social Psychiatry (IASP) in Chandigarh, the Association undertook a new research initiative. The mission statement was to promote research of importance to the evolution of social

psychiatry in India through development of research collaboration. Accordingly objectives were identified, and the Executive Committee appointed an IASP Research Taskforce. In this symposium, we shall outline the remit of the Taskforce and the research vision of the IASP for its membership along with a brief discussion on the logistic requirements and support systems entailed in such an initiative. Progress on the initial work by the Taskforce and the identified short-term objectives shall be presented.

#### **S8 - MENTAL HEALTH ISSUES IN MEDICAL STUDENTS**

*Manju Mehta, Rajesh Sagar, Rachna Bhargava*

The mental health of residents in training is a topic of considerable concern. Recent attention to the issue of patient safety has led to examination of the relationship between residents' stress and compromised clinical performance. In addition, studies suggest that the mental distress experienced by medical students could potentially have adverse consequences on academic performance, competency, professionalism and health. The symposium aims to address different issues related to mental health among medical residents and share the experience of dealing with them at AIIMS.

##### **Assessment of Medical residents**

Though there is considerable research on morbidity however, review on Indian research shows that despite increase in mortality and morbidity rates, there is dearth of systematic assessment of stress and associated factors. At AIIMS, efforts have been made to screen students who are at high risk. A comprehensive assessment at different levels over the years has helped to identify vulnerable group. We intend to discuss various issues related to assessment.

##### **Psychiatric Morbidity**

Studies have revealed a high prevalence of psychological distress in medical students, ranging from 21.6% to 56%. Studies have reported an association of prolonged psychological distress with lowered medical students' self-esteem, anxiety and depression, difficulties in solving interpersonal conflicts, sleeping disorders, increased alcohol and drug consumption, cynicism, decreased attention. Prolonged psychological distress has also been linked with medical student suicide. The psychological issues identified among the students at AIIMS would be discussed.

##### **Intervention Strategies**

Few mental health programs dedicated to residents and

formally structured to meet their specific needs have been reported in the literature. The presentation aims to discuss the factors related to lack of initiatives towards innovative programs and why more residents don't take advantage of services that do exist. Further, efforts aimed towards helping residents at AIIMS would be discussed.

#### **S9 (CME Symposium) - SUICIDE IN THE NEW MILLENNIUM**

**Epidemiology of Suicide: Changing Scenario:** *Debjani Bandopadhyaya*

**Preventing Suicide in School and College Children:** *Rajesh Sagar*

**Determinants of suicide in women with mental illness and their management:** *Abhishek Pathak, Indira Sharma*

**Suicide in Elderly: Causes and Management:** *Pankaj Verma*

#### **S10 - GENDER AND MENTAL HEALTH**

**Gender Issues and Mental Health: Current Perspective** – *Rajiv Gupta*

**Is Gender Important for Psychoeducation or Psychotherapy** – *Satabdi Chakraborty*

**Gender and Help Seeking Behaviour** – *Bhupendra Singh*

**Gender and Stigma** – *Sudha Chaudhury*

In 2002, World Health Organisation passed its first Gender Policy, acknowledging the gender issue as important on its own. Unfortunately, "gender" is increasingly used inappropriately as a substitute for "sex", particularly in biomedical literature, a tendency which has created confusion. Sex denotes biologically determined characteristics, while gender indicates culturally- and socially-shaped variations between men and women. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organized, and not because of our biological differences. Health services for women have a tendency to focus on their reproductive functions, neglecting the issues related to mental health. A lack of female medical personnel is sometimes a barrier for women to utilize healthcare services. Poor women find themselves without access to healthcare more often than men from the same social group, even in rich countries like the United States. In many developing countries including India, women complain about lack of privacy, confidentiality

and information about options and services available. Gender differences in the prevalence of psychiatric disorders are well known fact. But whether this difference is also affect the outcome of psycho-education or psychotherapy? Stigma is another common factor related to psychiatric illness but to what extant this variable is related to gender differences. The aim of this symposium is to discuss why gender matters in mental health, to explain the relationship of gender and health-seeking behavior and to elucidate gender issues in relation to therapy and stigma, to examine the gender differences in common mental health problems, and to discuss current Indian perspective.

### **S11 - PSYCHO-ONCOLOGY: ROLE OF MENTAL HEALTH PROFESSIONALS IN CANCER CARE – WHERE DO WE STAND?**

**Over view of Psycho-oncology: What can mental health professionals offer?:** *Soumitra S Datta*

**Correlates of well-being in women with breast cancer in India: Associations with emotional health, cancer and treatment related variables :** *Lopamudra Tripathi*

**Suicide in medically patients – A focus on patients with cancer:** *OP Singh*

Background: Being diagnosed to have cancer can be a emotionally difficult time. Right from the beginning when its doctors break the news of diagnosis to through the various stages of cancer care there is role of mental health professionals. During the treatment phase it could be more to do with procedural anxieties, body image problems, depression etc. Following cure people often live in the shadow of fear of recurrence. In the unfortunate circumstances of the cancer progressing to terminal stages, patients benefit from support and helping them to this extremely difficult phase of facing death imminently. It's obvious in today's cancer care, that patients benefit from a combination of psychological and pharmacological interventions alongside chemotherapy, radiotherapy and surgery.

### **S12 - COMPLEXITIES IN THE MANAGEMENT OF PATIENTS WITH 'DIFFICULT TO TREAT' SERIOUS MENTAL ILLNESSES**

**The interplay of Medication Monitoring with Treatment Non-adherence:** *Sivakumar T*

**Physical Health Comorbidity and its Monitoring:** *Nitin Gupta*

**Psychiatric Comorbidity: Evaluation and Management:** *Nand Kumar*

**Cognitive Functioning: A double-edged sword?:** *Shivanand K*

**Formulating a Comprehensive Management Plan:** *Mamta Sood*

Management of patients with serious mental illnesses (defined as having nonorganic psychosis with severe dysfunction and on treatment for 2 or more years) poses a significant challenge to the clinicians. In the recent years, it has been increasingly recognized that the approach to management of these patients needs a paradigm shift from emphasis on removal of symptoms to improving overall functioning and quality of life. Amongst this population there is a subgroup of patients who are difficult to treat and continue to have persistent psychopathology and dysfunction despite receiving adequate treatment for sufficient duration. The failure to improve may be due to various factors related to the patient, family or health care systems. Medication non-adherence, unrecognized negative and cognitive symptoms, under-diagnosed physical and psychiatric co-morbidities are some of the important reasons for poor response to treatment. The management of these patients needs comprehensive evaluation and formulation of a feasible and sustainable treatment plan tailored for individual patients utilizing available evidence based knowledge. In the seminar, complexities in the management of patients with difficult to treat serious mental illnesses will be discussed.

### **S13 - SUBSTANCE USE DISORDERS: CURRENT SCENARIO AND CHALLENGES IN THE CHANGING SOCIAL MILIEU**

**Introduction and overview:** *Rajiv Gupta*

**Epidemiology – focus on changing pattern of drug use:** *Aniruddha Basu*

**Principles of management: acute and chronic treatment:** *Madhurima Ghosh*

**Principles and practice of Psychosocial management:** *Sunila Rathee, Vinay*

The importance of substance use disorders (SUD) are ingrained in the theme of the conference and no discussion of 'mental health in changing social milieu' can be complete without reference to substance use. India traditionally is a country where different forms of substance producing plantations like tobacco, cannabis and opium have been cultivated and consumed with some religious and social sanction. However, currently India is in a very vulnerable geo-political situation due

to its close proximity to the golden triangle and golden crescent. Along with this, rapid social, economic, cultural changes in the country compounded with short sighted policies, weak enforcement agencies and weak legal provisions have made substance use disorders (SUDs) one of the most burdensome medical conditions. Some comprehensive, standardised epidemiological surveys done recently have been focusing on the changing pattern of drug use in the current society and highlighting the threat of prescription drugs use and injection drug use leading to the HIV epidemic. One way to effectively deal with this huge problem is to make adequate provision for treatment. A comprehensive assessment with medical and psycho-social needs is key for successful management. Every patient who is posing problem to self, family or society due to substance use needs to be advised to quit followed by proper detoxification, pharmacological treatment and chronic management thereafter. A principle of harm reduction is to be followed wherever complete abstinence is not possible and psychosocial interventions like motivation enhancement, relapse prevention are to be practised. Along with this, rehabilitative measures are to be undertaken to help the substance users to return to the mainstream. Special treatment provisions are required for at risk groups like adolescents, females, prisoners and patients with psychiatric illnesses. If proper treatment provisions are made and patients incorporated in standardised treatment protocols then outcome is good and even comparable to other chronic medical conditions. The symposium aims to highlight the contemporary challenges and the concerted efforts required on the part of the mental health professionals including psychologist, social workers with equal participation by administration, religious leaders, and social service organization to control this scourge of modern society.

#### **S14 - THE "BRAVE NEW WORLD": MODERN ADDICTIONS IN MODERN SOCIETY**

**Alakananda Dutt: Old wine in new bottle: the 'alcopop' culture in India.**

**Kaustav Chakraborty: Erasing the mind with 'Eraz-ex'.**

**Rajarshi Neogi: Revving up the rave: club drugs in India.**

**Debasish Basu: The Unsocial Network - 'addiction' to social networking.**

Substance use and addiction patterns are not static but vary with time, culture, and societal trends. Addiction is

not simply a biological change in the brain but a biopsychosocial phenomenon. Hence it is important to understand the emergence of newer substances, newer products of older substances, and newer addictions in the rapidly changing modern Indian society today. The four talks in this symposium will try to capture these trends in the sociocultural context among various social strata. The first speaker will discuss the rise of the 'alcopop' culture in modern Indian society. The second speaker will talk about a silent epidemic of inhalant abuse as the 'poor man's cocaine'. The third speaker will highlight the emerging menace of 'club drugs' in the affluent party circles in modern India. The final speaker will elucidate the 'unsocial network': how modern society alienates people and paradoxically draws them together in a virtual world.

#### **S15 – ADOLESCENT RESILIENCE**

**Introduction to the concept of Resilience: Karobi Das**

**Pathways and Trajectories of Adolescent Development: Harpreet Kanwal**

**Models of Adolescent Resilience: Sunita Sharma**

**Bolstering Adolescence Resilience: Pathways for Future: Jaison Joseph**

With the changing milieu, the stress & adversity has emerged has one of the intrusive phenomenon percolating into the life of youth today. However, some of the youth tend to shatter during adversity, while others take adversity as a challenge and produce highly positive adaptational outcomes. In fact, it appears that some individuals who are challenged by adversity emerge stronger, with greater capacities that they may not have otherwise. This capacity to bounce back in spite of stress and adversity is labeled as 'Resilience' in psychological taxonomy. It also refers to the process of overcoming the negative effects of risk exposure, coping successfully and avoiding the negative trajectories. Resilience has been a major research theme for developmental theorists for years. Initially, resilience was studied focusing on the within person factors, however in years, the eco-systemic perspective was also considered in resilience research. Looking at the social changes happening at fast pace in Indian society there is strong need to enhance the resilience skills of adolescents to prepare them for a progressive future. The biggest challenge is to provide the preventive interventions designed to bolster the resilience. With such background the current symposium shall focus upon the understanding of psychological resilience, the pathways and trajectories of adolescent development and directions for future in implementing resilience theory into practice.

## WORKSHOPS

### W1-ADVOCACY FOR MENTALLY CHALLENGED

**FACILITATORS:** RK Brahma, Divya Gopal Mukharjee, Arabinda Brahma

Advocacy for Mentally Challenged: Advocacy means speaking / pleading for or supporting individuals or their cause. In effect I feel very strongly that both of this meanings of advocacy is a dire necessity or should be considered as a right for the mentally challenged. We are aware of the acts covering the rights of disabled people who are physically handicapped. However, mental disability are not as visible or audible because they suffer in silence- within themselves, they are often unable to articulate their suffering or needs, in an appealing manner – often disjointed and difficult to decipher. This leads to people dismissing them as “fjNm RjNm”- or in other words “mad” – not worth listening to or denigrated into subhuman category. We as psychiatrists are expected to be their advocates- fight for them against injustices, ignominy, misunderstandings, neglect and even down right oppression, not just by other fellow - citizens but institutionalized discrimination by legislation, corporates and even the state. Where is the humanity, if we cannot standup for the weak, disempowered and meek – can't be their standard bearer!!!

Stigma in urban society: Even amongst well educated and middle to higher socioeconomic group of individual's misconception and misapprehension related to mental illness is quite prevalent. This leads to their negative, avoiding and sometimes actively antagonistic behavior towards mentally ill individuals and their families. They object to their presence in their midst citing reasons like disturbance to their daily routine and affecting their children and adversely!

Stigma and Myths at Primary Care Level: Stigma, or the feeling of being negatively differentiated because of being affected by a particular condition or state, is related to negative stereotyping and prejudicial attitudes. These in turn, lead to discriminatory practices that deprive the stigmatized person from legally recognized entitlements. In developing countries like India, beliefs about the nature of mental conditions often enmeshed with religious beliefs and cultural determinants, tend to delay needed treatment by

penalizing not only the patients, but also their families. Various researches have shown that the stigma of mental illness affects the requirements for care of good quality in mental health especially at the primary care level. Time has come to break the cycle of disadvantage resulting from stigma to make a priority. An enlightened public working in unison with professional associations can leverage national governments and health care organizations to provide equitable access to treatment and to develop legislation against discrimination. These efforts may dispel the indelible mark, the stigma caused by mental illness.

### W2- DISABILITY ASSESSMENT: FIRST STEP TOWARDS PSYCHOSOCIAL REHABILITATION

**FACILITATOR:** Kamlesh Kumar Sahu

Substantial proportions of person with mental illness continue to have residual deficits despite best treatment. Majority of persons with long standing mental illness continue to manifest symptoms, impairments or disabilities. Since mental disorders manifest in social context, disability due to them is generally termed as “social disability” (Taly & Murali, 2001). Social Disability can manifest in several roles that a person is expected to perform in the society e.g. self care, interpersonal relationship, family, social and occupational. Rehabilitation can be defined as the combined and coordinated use of medical, social, educational and vocational measures for training and retraining the individual to the highest possible level of functional ability. It includes all measures aimed at reducing the impact of disabling and handicapping conditions and enabling the disabled and handicapped to achieve social integration (WHO). Rehabilitation of disability due to mental illness needs specific modes since social disability has its unique features. It can be managed well in the community with proper medical treatment and psychosocial rehabilitation. But always there is a hitch in assessment of this kind of disability since it has very unique features: It is not visible like physical disabilities (e.g. lack of motivation), experienced subjectively (e.g. hearing voices when alone), fluctuates (e.g. disability differs with duration and nature of symptoms), recurrent (e.g. disability reoccurs with fresh episode of illness) etc. So, there is a



need to have skills of assessment for this area of disability because with proper and adequate knowledge the nature of disability any intervention of rehabilitation will not be effective. Now social worker is an integral part in multidisciplinary team in treatment and rehabilitation of persons with mental illness. Hence it is very much necessary for them to acquire these skills particularly for new professionals and trainees. This workshop may be interesting for those courageous young professional social workers who want to work in this field. The entire workshop will be enriched with practical demonstration of various tools for assessment, case illustrations and usage of multimedia.

### **W3- ASSESSMENT AND MANAGEMENT OF LEARNING DISABILITIES**

**FACILITATORS:** Adarsh Kohli, Manju Mohanty

Learning disorders are characterized by deficits in acquiring expected skills in reading, writing, spellings and arithmetic, compared with other children of same age and criteria for intellectual capacity. Prevalence of learning disabilities range from 2-10% in school age children. Usually learning disabled are not easily differentiated from normal population. Learning disabilities if left undetected, result in poor academic performance, class detention or dropping out of school. They also often lead to these children losing their self-esteem, withdrawn or aggressive behavior, anxiety, depression and at times even anti-social behaviors. Thus identification, assessment and management of these children is a challenging task. The aim of this course is to impart skills, which would enable the mental health professionals, parents and teachers to be able to identify learning disabled children and planning appropriate remedial strategies. The course content will deal with the issues of methods of identification at pre-school, primary school and secondary school level. The different methods of academic and behavioral assessments will be discussed. The focus of management will be on the methods of enhancing reading, comprehension, writing, spelling and arithmetic skills. Besides the issues pertaining to associated psychosocial problems will also be taken up.

### **W4- CASE FORMULATION IN PSYCHIATRY: A HOLISTIC APPROACH**

**FACILITATOR:** Anindya Banerjee

Case formulation is a core skill in clinical psychiatry, which helps in understanding the presenting problem and guiding individualized treatment. It is a provisional

explanation or hypothesis of how an individual comes to present with a certain disorder or circumstances at a particular point in time that includes biological, psychological, social, cultural and systemic factors. It is a key element in psychiatric evaluations, discharge summary and prior authorizations for treatment. The presentation proposes to explore techniques of formulating psychiatric cases in an interactive manner.

### **W5- ASSESSMENT AND MANAGEMENT STRATEGIES FOR REHABILITATION IN MENTAL ILLNESS USING THE DART MODEL**

**FACILITATORS:** BS Chavan, Subhash Das, Nitin Gupta, Ajeet Sidana

The Department of Psychiatry, Government Medical College and Hospital-32, Chandigarh has been running the "Disability Assessment, Rehabilitation and Triage (DART)" services since December 2012 with the purpose of comprehensive rehabilitation of patients with mental illnesses. Under DART services, the following units have been set-up and operationalized viz. Neuropsychological Rehabilitation Unit, Social Skills Training Unit, Vocational Skills Training and Rehabilitation Unit, and Day Care Centre. The workshop shall focus on how to assess the suitability of patients for the purpose of rehabilitation, how to undertake a detailed assessment, how to formulate a comprehensive management plan using case vignettes and group-work.

#### **IDENTIFIED OBJECTIVES:**

1. To understand the various concepts linked with rehabilitation in mental illness.
2. To understand the various parameters/ components which contribute towards determining the process of Rehabilitation
3. To be able to evaluate the patient 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.

### **W6- COPING WITH DOMESTIC VIOLENCE**

**FACILITATORS:** Indira Sharma, Abhishek Pathak

Introduction of the topic followed by case vignettes of cases. Participants will be divided into groups. Each group will be allotted one case vignette. The group will

be discussing possible coping methods for preventing domestic violence. The prospects and consequences of each method will be discussed. Finally one or more coping method will be chosen. The group will make their presentation. There will be discussion with the participants.

#### **W7-'HOW'S AND 'WHY'S' FOR FORMULATING A COMPREHENSIVE PLAN FOR EVALUATION AND MANAGEMENT OF PATIENTS WITH SEVERE MENTAL ILLNESS**

**FACILITATORS:** Mamta Sood, Nitin Gupta

In psychiatry practice, about one third to half of the patients present with severe mental illnesses (SMIs) depending upon the setting, notwithstanding the general population prevalence rate of SMIs being 1-2%. Therefore, it is imperative to understand how to formulate a comprehensive plan for evaluation and management of patients with SMIs in routine clinical practice. The basic premise is that it should be done in accordance with available cost-effective, evidence-based treatments focusing on the patient as a whole. The diagnosis of SMI can be made based on assessment of psychopathology but for holistic evaluation, the patient needs to be assessed in the context of his/her familial (environmental) and socio-cultural milieu. The impact of psychopathology on functioning of the patient, disability suffered and physical and psychiatric co-morbidities should also be evaluated. In a similar way, although the treatment with antipsychotics remain the backbone of management of patients with SMIs, the comprehensive management plan should also address the environmental and socio-cultural issues (arising out of evaluation) keeping in perspective the short term goals of improved psychopathology and treatment of co-morbidities and long term goals of improved functioning and reduced disability. In this workshop, the focus will be on identifying the pragmatics of the 'how' and 'why' related to making a comprehensive plan for evaluation and management of patients with SMIs.

#### **W8- SECURING THE FUTURE- UNDERSTANDING THE IMPACT OF SOCIAL ENVIRONMENTAL CHANGES ON CHILDREN'S MENTAL HEALTH**

**FACILITATORS:** Sanyogita Nadkarni, Soumitra Dutta

The last decade has seen a worldwide increase in the prevalence of childhood problems. In India too, there has been a significant increase in childhood disorders. Moreover, childhood disorders are not limited to

developmental spectrum alone. New disorders are being added to the current spectrum and it is seen that childhood is no longer immune to even significant mental disorders like depression, psychosis, anxiety and PTSD. The changing nature of social fabric has definitely made a huge contribution to the current pattern of childhood disorders. In this workshop we aim to elucidate the significant social contributors and also discuss the possible pathways of prevention and treatment. We have divided the theme under the following subheadings: [1] Childhood Depression and Social Environment- we discuss the probable predisposing factors like parental discord, peer pressure, overstimulation, easy access to alcohol and drugs etc. We outline the possible macro and micro-environmental ways to manipulate the social milieu and highlight the necessary strategies for prevention and treatment including early help-seeking behaviour. [2] Juvenile Delinquency- crime has been steadily increasing in the 15-18 year age group. Although a minor by legal definition it is imperative that these young criminals are vigorously treated to prevent recidivism. We discuss the current juvenile delinquency act, the limitations and ways in which the young criminals can be helped to lead a more normal life. The workshop/symposium aims to bring the current research in front of the audience. International service delivery models will be highlighted to identify the gaps and create innovative pathways for local service models.

#### **W9- 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, sub-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

## FREE PAPERS (ORAL)

### THE ROLE OF A PSYCHIATRIC NURSE IN MANAGING PHYSICAL HEALTH OF PATIENTS WITH SEVERE AND ENDURING MENTAL ILLNESS: THE CHANDIGARH EXPERIENCE

Virtu Chongtham, BS Chavan

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

In comparison to the general population, patients diagnosed with severe and enduring mental illnesses (SMI) have heightened risk for physical health comorbidities (especially cardiovascular & metabolic disorders) & malignancies with reduced life expectancy. This is further compounded by the high prevalence of metabolic side effects due to the use of psychotropic medications (especially antipsychotics) as part of their treatment. Literature points to the under/lack of diagnosis and lack of management thereof thereby further contributing to high rates of morbidity and mortality in this disadvantaged population of patients with SMI. In the west, psychiatric nurses have taken on roles and work collaboratively in order to deliver multidisciplinary-based comprehensive care. One of such roles has been to ensure physical health monitoring and/or enabling patients with SMI to access appropriate care for their physical health. Such initiatives and roles are still not clearly defined or outlined in the Indian set-up where psychiatric nursing is still developing across various fronts, and is gradually becoming part of the multi-disciplinary set-up. The Department of Psychiatry, GMCH-32 has been running a community based outreach program for 12 patients with SMI undergoing respite care. For last 9 months, a psychiatric nurse has been involved in the care with adoption of a comprehensive multidisciplinary approach. The presenter will share her experiences and her integral role as a psychiatric nurse in the delivery of care with special emphasis on the role of a psychiatric nurse in the education, management and monitoring of physical health issues for patients with SMI.

### SOCIAL SUPPORT AND MENTAL HEALTH PROFILE IN CANCER PATIENTS: PROSPECTIVE ROLE OF SOME FACTORS ON TREATMENT MAINTENANCE

Kedar Ranjan Banerjee, Tanmoy Mitra, Jayanti Bhattacharya, Akash Mahato, Madhumita Das,

Debabani Bhattacharya.

*National Institute of Behavioural Sciences, P7 CIT Road, Kolkata*

**Background:** National Institute of Behavioural Sciences (NIBS) has been working on for more than two years on the psychological profile of cancer patients - which is barely systematically studied before in this part of our country. Our study reveals that Indian society is different than some of the western countries in dealing with cancer patients with possible devastating outcome. Though Indian family and socio-cultural structure are unique to provide support to the ailing members of the family, feeling of helplessness also is evident leading to psychiatric vulnerability. As the united or joint families still persist in areas, the caregivers are more in numbers and can usually take turns. On the contrary, the community or welfare services are mostly scanty and unorganized in India.

**Aim:** The aim of the present study is to understand how the cancer patients in India identify and acknowledge the family support as well as community support system. **Materials & Methods:** Total 148 patients (Age 18-60) having cancer diagnosed within the last one year had been studied. Patients were divided in two age groups (<30 yrs & >30 yrs) and gender wise also. The test batteries used were Duke Health Profile, Locus of Control, Socio-economic Status Scale, Perceived Support Inventory, Bells Adjustment Inventory and Parental Sensitization Index. **Results:** Subjects who scored better significantly in social health and self-esteem areas in Duke Health Profile reflected more satisfactory treatment outcome. Better parental sensitization indicated better mental health but social welfare was not perceived as an important factor for treatment availability. Better home and social adjustments were reflected in treatment outcome. Locus of control was not related to treatment outcome in general. Lower age group indicated different perceived support and outcome and females reflected better social support and adjustment. **Conclusion:** Studies indicate that both family and community and welfare support are very much needed for oncology patients in western countries. On the contrary, present study indicates that in a developing country like India, though family support is highly anticipated by cancer

patients, social welfare is not regarded as indispensable mainly due to either unavailability or inaccessibility.

### **DISCRIMINATION AND STIGMA AGAINST PATIENTS OF MENTAL HEALTH AND RELATED PSYCHOSOCIAL DILEMMAS**

Kedar Ranjan Banerjee, Jayanti Bhattacharya, Tanmoy Mitra, Akash Mahato, Madhumita Das, Debabani Bhattacharya

*National Institute of Behavioural Sciences, P7 CIT Road, Kolkata*

There has been a significant change in last decade in the area of mental health treatment. But the much needed approach in awareness of understanding the mental health problems is yet to be determined. **Aim:** To identify lacunae in our socio-legal infrastructure that creates a risk for individual with mental disorder and associated others. **Method:** Case study. **Observation:** Tania, a 17 year old suffered a manic episode with psychotic symptoms following the rigours of her board exams. She was sexually disinhibited and claimed to be pregnant. Her family believed that she had tainted the family's honor and physically chastised her. They believed her male tutor to be the culprit and seriously assaulted him despite his pleas of innocence. The family even contemplated suicide en-masse to escape a life of shame. They eventually consulted a psychiatrist and Tania recovered with treatment. She denied any sexual liaisons with her tutor. She recalled that she had seen images of nude males on her maternal uncle's laptop which had probably influenced her disinhibited sexualized behavior. The family relocated to a different city to escape scrutiny. Tania's maternal uncle denied possession of porn images and insisted that he was determined to lead a celibate life. The uncle's insisted that the tutor had several porn films on the latter's laptop. The uncle himself sought psychiatric help for anxiety disorder. **Discussion:** Who is to blame? For the stress that caused a 17 years old to become psychotic? For the atrocities meted out to a psychotic girl and an innocent man by the people ignorant of mental health problems? For the near suicidal decision of a family? For a suspected closet homosexual's reluctance to come to terms with his own personality? And tendency to displace blame onto an innocent other? How may we remedy this? The relevant points will be discussed.

### **A STUDY ON INTERNET ADDICTION, DEPRESSION, ANXIETY AND STRESS AMONG HIGH SCHOOL STUDENTS**

Arif Ali

*Department of Psychiatric Social Work, LGB Regional Institute of Mental Health, Tezpur Assam*

**Background:** There have been growing concerns worldwide for what has been labeled as "internet addiction." Research on internet addiction demonstrated that the greater use of the internet is associated with some social and psychological variables such as, declines in the size of social circle, depression, loneliness, low self-esteem and life satisfaction and low family functioning. **Aim of the study:** The present study will investigate the extent of internet addiction in High school students and to examine the relationships between internet addiction, depression, anxiety, and stress. **Methodology:** The present study will be a cross sectional survey using stratified random sampling technique. The participant will be randomly selected from high school of Tezpur, Assam and in Ranchi, Jharkhand. A total of two hundred (Hundred high school students each from Tezpur and Ranchi) sample will be randomly selected in the age range of 16-18 years for the present study. Socio demographic sheet, the online cognition scale (OCS) and the depression anxiety stress scale (DASS) will be administered. Results will be discuss in floor.

### **HOME BASED PSYCHOSOCIAL REHABILITATION SERVICES TO IMPROVE SOCIO-OCCUPATIONAL FUNCTIONS AND DISABILITY IN PERSONS WITH MENTAL ILLNESS**

Kamlesh Kumar Sahu

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**Aim:** To improve socio-occupational functions and disability in persons with major mental illness (PWMI). **Methods:** 70 samples were taken from ongoing psychosocial services in Department of Psychiatric Social Work, Institute of Psychiatry, Kolkata. PWMI diagnosed with any major mental illness of either sex between 18 – 50 years of age without any comorbidity were enrolled with their consent. For psychosocial rehabilitation (PSR) were tailored to meet individuals' needs; components from case management and assertive community treatment were adopted along with social case work techniques. The intervention

plans were executed through partnership with family members of PWMI. Pre and post assessments were done using Socio Occupational Functioning Scale and Indian Disability and Assessment Scale and analyzed to compare the level of socio-occupational functions and disability. Qualitative measures such as feed back from the service users and their family members and in depth interviews and observation were also considered to supplement the quantitative one in order to know the clear picture of the outcome. **Results:** Preliminary findings were quite exciting when majority of PWMI shown improvement in their socio-occupational functioning and disability. **Conclusions:** It is eminently feasible to start a wide spectrum of home based psychosocial rehabilitation service programmes particularly in rural areas. Feasible and sustainable could be ensured to evolve families as a partner of care.

### **SUICIDAL IDEATION IN UNDER GRADUATE COLLEGE STUDENTS IN KOLKATA: SOME PSYCHOLOGICAL CORRELATES**

Soma Sahu<sup>1\*</sup>, Sadhan Dasgupta<sup>2</sup>, Kamlesh Kumar Sahu<sup>3</sup>

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**Aim & Objectives:** To study the nature and extent of suicidal ideation and its relationship with personality traits, emotional intelligence and level of depression among college students in Kolkata and to assess the predictability of afore said variables for suicidal ideation. **Methodology:** Undergraduate students from 10 colleges from Kolkata having age of 18 years or more were selected for the present study with their written consent. Students with any major mental /physical illness and history of major hospitalization in last two years were excluded. Students who already attempted suicide, having family history of suicide attempt or suicide were also excluded from the study. 400 (equal from both sexes) criteria based sampling method was used and assessed cross-sectionally using: Socio-demographic and Clinical Datasheet, Eysenck Personality Questionnaire (Eysenck and Eysenck, 1975), Emotional Intelligence Test (Chadha and Singh, 2001), Adult Suicidal Ideation Questionnaire (Reynolds, 1987) and Beck Depression Inventory - II (Beck et al, 1996). **Result & Conclusion:** Results indicate that students have either psychoticism or neurotic personality traits having more suicidal ideation. Students having more

depression or less emotional intelligence expressed more suicidal ideation. There were no significant difference in suicidal ideation among male and female. Result also indicates that depression, emotional intelligence, neurotic and psychotic personality predisposition contribute significantly to suicidal ideations and predicted 30.5% of the variance.

### **WHY PSYCHOTHERAPY NEVER PICKED UP IN INDIA? PSYCHOSOCIAL CAUSES**

Devashish Konar

*Consultant Psychiatrist, Mental Health Care Centre, Burdwan, West Bengal*

India as a nation has always been interested in matters of mind. In fact volumes of ancient Indian writings are dedicated to the understanding of human mind. Why then psychotherapy, which is a healing art through talking, never gained popularity in India. Psychiatry that we practice in India, is completely an imposed western model based discipline. Whatever is medicine and technology based is easy to match. But talk therapy which is completely culture specific cannot be simply copied from other culture. Indian mind is different as is mind of any other culture. First let us forget all western models of talk therapy and build up a model which is typically Indian. Because we train people in alien models, we do not develop into good therapists barring few who can adapt. And then you need formal training of psychologists in more number who can take up talk therapy as their career. In India Psychiatrists are so few in number that they will never have so much time for separates talk therapy sessions. On the other hand whole lot of people who study psychology till universities go wasted serving in some administrative or clerical job, who could have been jolly well trained into clinical psychologists serving society as talk therapists. Equally important is to have proper licensing authority who will decide who all can practice talk therapy.

### **ASSESSMENT OF SOMATIC SYMPTOMS AMONG SCHOOL GOING CHILDREN: A STUDY FROM NORTH EAST INDIA**

Suman Borah, Arif Ali

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**Introduction:** Somatic symptoms are commonly reported among young children. The burden of such symptoms on both young children and health services is substantial. Research indicates that somatic symptoms could impose limitations on social function and

participation in school life. Aim: To assess somatic symptoms among school going children. Methodology: The study will be conducted in three English medium high schools under Tezpur Municipal area. The study will be a descriptive study using random sampling technique. The sample included 300 students of class 7 to 10th of Tezpur, Assam. Socio demographic sheet and Children's Somatization Inventory (CSI) and The Duke Health Profile (DUKE) will be administered to the subject's. Results will be discuss on floor

### **ROLE OF FAMILY FACTORS IN SUBSTANCE USE AMONG ADOLESCENTS ACROSS SEVEN COUNTRIES**

Yatan Pal Singh Balhara<sup>1</sup>, Olayinka Atilola<sup>2,3</sup>, Dejan Stevanovic<sup>4</sup>, Mohamad Avicenna<sup>5</sup>, Hasan Kandemir<sup>6</sup>, Rajna Knez<sup>7</sup>, Petar Petrov<sup>8</sup>, Panos Vostanis<sup>9</sup>

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**Aims and Objectives:** To assess role of family related risk factors for alcohol/substance use and abuse among a cohort of school-going adolescents from seven countries (India, Indonesia, Nigeria, Serbia, Turkey, Bulgaria and Croatia). **Methodology:** The study was conducted under the auspices of the International Child Mental Health Study Group (ICMH-SG), a non-profit research-oriented organization of child and adolescent's psychiatrists, psychologists, and other mental health practitioners from undeveloped and developing countries. The group was formed at the occasion of the Excellence in Child Mental Health conference held in Istanbul Turkey in November 2011. Participants were sampled from town/cities in the seven countries based on the convenience of the researchers. Alcohol and substance use, including problematic/hazardous use (abuse), was measured using the CRAFFT instrument. Aspects of mental health were measured using the Strength and Difficulty

Questionnaire. Independent correlates were determined using logistic regression models. The level of statistical significance was kept at  $p < .05$  for all the tests. **Results:** A total of 2454 adolescents completed the study. About 40.9% reported use of any substance during the past 12 months, mostly alcohol. Family factors like single-parent households and parental alcohol/substance use were all independently associated with substance use. Factors that showed significant independent association with any substance use are family factors like living with a single parent/non-parent caregiver; having fewer numbers of siblings, lower maternal education and unemployment, and parental alcohol or substance use. Adolescents of mothers who drink alcohol were independently associated with problematic pattern of alcohol/substance use. **Conclusions:** The modifiable family related risk factors need to be explored and followed by appropriate intervention strategies.

### **COMPARISON OF CAUSES OF DOMESTIC VIOLENCE IN MARRIED WOMEN WITH MENTAL ILLNESS & PHYSICAL ILLNESS**

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**Background:** Domestic violence against women is the most pervasive human rights violation in the world today. Violation not only causes physical injury, it also undermines the social, economic, psychological, spiritual and emotional well being of the victim, the perpetrator and the society as a whole. However, there is limited data on its cause especially in developing countries. **Objective:** To assess the magnitude and pattern of domestic violence in woman. To compare the causes of domestic violence with mental illness & physical illness. **Material & Methods:** The sample of study comprised of 30 women with mental illness and 30 women with physical illness. Mental illness patient diagnosed according to with Axis one psychiatric Disorder DSM IV-TR, who were selected from the Psychiatry OPD of the S.S. Hospital, BHU and physical illness patient suffering from mild to moderate physical illness as per ICD 10 (WHO), were be selected from the Obstetrics and Gynecology Department of S.S Hospital. The patients were assessed on the structured questionnaire on Domestic Violence. **Results:** Domestic

violence was significantly higher amongst the mental & physical illness women of educated up to graduation/post graduation and house maker women. The study found out the overall domestic violence in mental & physical illness group was 83.3% & 50%. The prevalence of verbal violence was 21% in mental illness and 8% in physical illness, economical violence was 17% & 6%, physical violence was 21% and 3% and sexual violence was 10% in mental illness. The main etiological factors of domestic violence in mental illness were 66.7% of participants unable to perform domestic chores and 33.3% husband has low frustration tolerance by nature in physical illness which is causing violence so they were becoming the victim of domestic violence. It was observed that domestic violence was greater in mental illness as compared to physical illness.

#### **EXPLORING AWARENESS ABOUT LEGAL STATUS ON SUICIDE ATTEMPT IN INDIA AMONG SUICIDE ATTEMPTERS**

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**Aim and Objectives:** To assess for presence of awareness about legal status on suicide attempt in India and collect views on its effect on suicide attempt among suicide attempters seen in a general hospital setting.

**Methodology:** Medically stabilized suicide attempters attending Crisis Intervention Clinic of JIPMER (January-December 2012), were interviewed about their suicide attempt from legal perspective on four aspects: Whether they knew about existing legal status of suicide attempt before this current suicide attempt? If not, whether knowing the legal status would have prevented this current suicide attempt? And after informing about the legal status to those who were not aware, were asked further two questions: Will knowledge about legal status prevent them from future suicide attempt? Will knowledge about legal status if made wide spread to everyone, prevent everyone from attempting suicide? **Results:** There were total 129 subjects. Mean age was 27 years, 45 % were females, 78.5 % were from rural area, years spent in education ranged from 0-15, majority belonged to nuclear families and 55.8 % were employed. Nearly half of the subjects were not aware of the legal status of suicide attempt. 72.1 % felt that this knowledge would prevent others from attempting suicide. However 55.8 % thought that

this knowledge would prevent them from attempting suicide in future. **Conclusions:** Most suicide attempters are not aware of the legal status of suicide attempt in India and majority felt that it may act as a deterrent.

#### **NURSING STUDENTS' ATTITUDE TOWARDS SUICIDE ATTEMPTERS: A STUDY FROM RURAL PART OF NORTHERN INDIA**

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**Aims and objectives:** Majority of health professionals have unfavorable attitudes towards patients presenting with self-harm, which further compromises their willingness and outcome of care. This study was aimed to assess the nursing students' attitudes toward suicide attempters. **Methodology:** Cross-sectional study was conducted in two nursing colleges of North India. 308 nursing students were recruited through total enumeration method from May-June 2012. 'Suicide opinion questionnaire' was administered to assess their attitudes towards suicide attempters. Descriptive statistics was employed with SPSS version 14.0 for Windows. **Results:** Majority were single females, from urban locality, with the mean age of 20 years. Only minority had previous exposure to suicide prevention programmes and management of such cases. Majority of students agreed for mental illness, disturbed family life, and depression as major push to attempt suicide. They held favorable attitude for half of the attitudinal statement, but they were uncertain for rest half of the statements. **Conclusions:** They generally had favorable attitude towards suicide attempters. Their uncertain response highlights the need for enhancing educational exposure of nursing students and new staff at the earliest opportunity, to carve their favorable attitude towards patients presenting with self-harm.

#### **EFFICACY OF ATTENTION TRAINING FOR CHILDREN WITH ADHD**

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Attention Deficit Hyperactivity Disorder (ADHD) is one of the most common neurobehavioral disorders of childhood. Children with ADHD have problems with



attention span and tend to be very easily distracted. They specifically have difficulty in paying, and maintaining attention over prolonged periods of time, along with difficulty in focusing and screening the stimulus presented in their surrounding environment. Consequently, their behavior is inattentive, impulsive and hyperactive. Effective intervention may improve their attention span over time, which lead them to be more productive in school and at home. **Aim & objective:** The present study aims to find out the efficacy of a 12- week attention training program for children with ADHD, aged 6- 10 years, to improve attention span of these children. **Methodology:** Total 5 children, 3 males, 2 females were selected for the study following purposive sampling technique, from Clinics in Kolkata. Before training program, parents completed ADHD – SC4 Checklist to assess severity of the problem. There was no marked difference in baseline assessment. After diagnostic and baseline assessment including the cognitive functions; training was delivered in individual session. Training program included training on sustained, selective, alternative, and divided attention. Participants completed an outcome evaluation after 12 weeks of training program. **Results & Conclusion:** Results show there was improvement in attention and reduction in scores of severity in attention scale in post assessment. Present study shows evidence for the efficacy of attention training for children with ADHD to improve attention span.

#### **BARRIERS IN REINTEGRATING PERSONS WITH MENTAL ILLNESS, AVAILING REHABILITATION TRAINING AT STATE RUN REHABILITATION HOME**

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**Introduction:** Nearly 70 percent of the Mentally Ill Citizens of this community live in their family. The affected persons are rendered Homeless when their primary caregivers are no longer alive. So the physical absence of a home coincides with the physical phenomenon are taken into the street. Other circumstances which also renders the persons homeless when the primary caregiver starts ageing and their physical energy, to take care of the mentally ill, deteriorates and sheer physical incapacity to provide care often leads these persons continue to live in the street with virtually no social support or sense of self care or protection and so they deteriorate further into

vegetative existence. Homeless persons and families are an increasing but marginalized part of societies; they have diverse and complex needs that have often not been addressed by the available services. In order to give, proper care, protection to persons with mental illness and provide them rehabilitation services, the state Commissioner for the differently abled has come out with a novel initiative to establish rehabilitation homes for the persons with mental illness in various Districts in Tamil Nadu with the support of NGOs and assistance by the Govt. of Tamil Nadu. **Aim:** To study and understand the various barriers towards reintegrating the persons with mental illness, after availing psychosocial rehabilitations training programmes. **Method:** Persons with Mental illness got admitted through rescue and rehabilitation scheme since Nov.2010 were taken as the universe for this study. A total of 30 persons with mental illness (both sex) were selected through simple random sampling method. They were assessed for their level of symptoms before and after by administering a tool on Global Assessment of Functioning (GAF) (Endicott, Fleiss & Cohen, 1976). The data was analyzed by using the appropriate statistical tests. **Findings:** Various rehabilitation interventions given to the persons with mental illness have shown in reduction of symptoms. An attempt has been made to list the barriers faced by the persons concerned, family members and others while reintegrating the Persons with Mental Illness in the society. Further the authors have suggested the remedial measures to overcome the barriers at length in the paper.

#### **SELF STIGMA AND SELF ESTEEM AMONG PERSON WITH SCHIZOPHRENIA ATTENDING PSYCHIATRIC REHABILITATION CENTRE**

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**Aim:** The study aims to assess and examine self stigma and self esteem among person with schizophrenia attending rehabilitation centre. **Methodology:** The present study is a cross sectional study. The sample will be drawn using purposive sampling from Centre of Rehabilitation Science, LGB Regional Institute of Mental Health (LGBRIMH), Tezpur, Assam. Sixty persons with diagnosis of schizophrenia (30 person with schizophrenia attending rehabilitation centre and 30 person with schizophrenia those who are not attending rehabilitation centre) will be included in the study

.Socio demographic data sheet ,Internalized stigma of mental illness scale ,self esteem inventory and Brief Psychiatry Rating scale (BPRS )will be applied to all participants. **Results:** The results will be discussed on the floor of house.

### **STUDY OF PSYCHIATRIC COMORBIDITY AND PSYCHOSOCIAL STRESS FACTORS IN PATIENTS ATTEMPTING SUICIDE**

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**Aims and Objectives:** [1] To study prevalence of psychiatric comorbidity in patients attempting suicide. [2] To assess psychosocial stress factors in those patients. **Materials and Methods:** 100 consecutive patients with alleged history of attempting suicide being referred in the Psychiatric Department of a tertiary care Hospital were selected during March –December 2012. Critically ill patients and patients without any reliable relatives were exempted from the study.

Assessment was based on a semi-structural Performa including DSM IV –TR, Beck's suicide intent scale, presumptive stressful life events' scale. **Results and discussion:** Majority were found female 66%, single mostly from upper lower socio economic class .According to the DSM IV Criteria- 32% were diagnosed with substance consumption followed by adjustment disorder (17%), depression (16%) , personality disorder (16%) and schizophrenia (7%).Mean value of total suicide intent was 20.75.Commonly used methods of self-harm were self-poisoning followed by self-cutting. Mean value of stressful life events in last 1 yr was 2.02 and 6.39 in life time. **Conclusion:** Parasuicide was found among low age group population ( below 30 yrs ) with low suicide intent where substance dependence and personality disorder prevails compare to medium to high suicide intent with more severe psychiatric comorbidity in elder subjects.

### **AN EXPLORATORY STUDY TO ASSESS THE EFFECT OF SUBSTANCE DEPENDENCE ON THE QUALITY OF LIFE OF PATIENTS IN DDTC, PGIMER, CHANDIGARH, 2012-2013**

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This exploratory study was conducted to assess the

effect of substance dependence on the Quality of life of substance dependence subjects in DDTC , PGIMER, Chandigarh. A standardized tool “WHO QOL BREF” was used to collect data. We had taken subjects from DDTC WARD and OPD. The sample size consisted of 50 subjects. The results of the study revealed that most of the subjects 24(48%) were rating their quality of life as neither poor nor good, 19(38%) were neither satisfied nor dissatisfied with their general health, experienced a lot of pain 23(46%) that effected their daily work, felt the need of medical treatment 20(40%) for doing their daily living activities, had adequate/sufficient energy for daily life, were satisfied with their sleep 18(36%),19 (38%) were satisfied with their ability to perform their daily work, 20(40%) were satisfied with their work capacity. The psychological health of substance dependent subjects was as follows most of the subjects 16(32%) were enjoying their life in moderate amount, 24(48%) were rating their life to be very meaningful, 15(30%) had moderate amount of ability to concentrate on their work,15 (30%) were very accepting of their bodily appearance, 20 (40%) were neither satisfied nor dissatisfied with their abilities, 22(44%) rarely had negative feelings. Regarding social health of substance dependent subjects it was seen that 24(48%) were satisfied with their personal relationships, 15 (30%) were satisfied with their sex life, 14 (28%) were very dissatisfied with support from their friends. The environmental health of substance dependent subjects it was observed that most of the subjects 22(44%) felt very much safe in their daily life, 27(54%) felt their physical environment was very much healthy, 14(28%) had moderate amount of money for fulfilment of needs, 15(30%) had sufficient availability of information which they had need in their daily life, 16(32%) had complete opportunity for leisure activity, 25(50%) were satisfied with their living condition and 23(46%) were satisfied with access to health services.

### **SHAME & STIGMA OF MENTAL ILLNESS**

Nitasha Sharma

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**Background:** The mental illness is a major cause of disability. The suffering of a person with mental illness is enormous. However, the shame, stigma and discrimination towards mentally ill further add on to this suffering. This stigma is prevalent in all sections of society including the mental health professionals. **Aim:** The current study aimed to investigate the attitudes of nursing students towards mental illness & associated

shame and stigma. **Methodology:** The cross sectional approach was used in current study. A total of 87 nursing students enrolled in Bachelors of Nursing Science degree currently in 3rd year of their course were included as study participants using the purposive sampling technique. The assessment measures were the socio-demographic profile sheet and a 35 item standardized scale given by Gilbert to assess attitudes towards mental illness. **Results:** The findings of the study revealed the attitudes towards mental illness on following subscales: Attitude towards mental illness in general, the external shame, the internal shame & the reflected shame, with community as well as family as frame of reference. The highest mean scores were obtained in subscale of reflected shame with respect to family followed by external shame with respect to community, with the mean scores of 7.6 & 6.6 respectively. **Conclusion:** The mental health professionals are themselves prejudiced and unconsciously harboring the stigma and discrimination towards mentally ill, hence, it is recommended to reorient the education system in such a way that while learning core psychiatry, the issues like shame and stigma are also effectively dealt with.

#### **A STUDY OF IMPACT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) AND ITS COMORBIDITIES ON FAMILY**

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Children with attention deficit hyperactivity disorder (ADHD) experience difficulties and impairments in various domains of life including academic difficulties, social skills problems, strained family relationships and functioning. **Aim:** To study the impact of ADHD and its comorbidities on family in the patients attending the outpatient clinic. **Methodology:** The study sample consisted of old and newly registered subjects between the age group of 06 to 16 years who fulfilled the DSM-IV-TR criteria for ADHD. The study subjects were subjected to a detailed evaluation on the Kiddie-Schedule for Affective Disorders and Schizophrenia-Present and Lifetime version (K-SADS-PL) for ADHD and comorbid psychiatric disorders. A questionnaire for assessing the impact of ADHD was administered and results evaluated. **Results:** Problems at school was most reported by 92.54 %, worry for the future of the child was reported by 89.55%, problems in interaction with relatives in 83.58% and problems in society due to

behavior of the child in 80.59 %. Impulsive behavior was considered to have a significant impact by parents i.e., in 79.10%, relationships among the parents was affected in 77.61 %, increased fatigue due to care was in 77.61%, infrequent injuries were reported to have an impact on families 62.68%. **Conclusions:** There is a huge need for more research into ADHD especially on its impact on the patient and their families and effective treatment strategies to manage the same in order to improve the overall quality of life of these families.

#### **A CASE CONTROL STUDY ON THE QUALITY OF LIFE OF SUBJECTS WITH ALCOHOL AND OPIOID DEPENDENCE SEEKING TREATMENT**

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**Aims and Objectives:** To assess the quality of life in opioid and alcohol dependent subjects attending a tertiary care de-addiction centre in India.

**Methodology:** Patients were recruited from the outpatient clinic of Drug De-addiction and Treatment Center, Department of Psychiatry, PGIMER, Chandigarh. Controls were healthy volunteers. The severity of substance dependence was calculated by using Drug Abuse Screening Test, Severity of Alcohol Dependence Questionnaire. The quality of life (QOL) assessment was done with World Health Organization-QOL – Bref, Hindi version (WHO-QOL-Bref). **Results:** There were significant differences in age, employment status and marital status between the alcohol dependent, opioid dependent and control group. There was significant difference in duration of substance dependence between alcohol and opioid dependent group. There were significant differences in total quality of life score and in the domain of physical health, psychological health, environment score between the study and the control group. **Conclusion:** There is poorer quality of life in subjects with alcohol and opioid dependence than the healthy control groups. Therefore, the aim of treatment of substance use disorder should also focus on the improvement in quality of life of the subjects seeking treatment.

## A STUDY ON TEMPERAMENTAL TRAITS OF CHILDREN OF COMMERCIAL SEX WORKER'S

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**Background:** The 1989 United Nations Charter guarantees every child the right of survival, protection, development and participation. But to whom and how will the children of commercial sex workers (CSWs) demand this? Their isolation from society, ignorance and lack of awareness are often the cause of their predicaments. The situation of underprivileged children in India as depicted by Child Rights and You (CRY) is disappointing. Children of CSWs constitute 5.3 million in number and between 5 and 18 years of age. They form 40% of the total population of CSWs in India. About 80% are found in the five metros, 71% of them are illiterate and 500,000 are forced to enter this trade every year. This study is an effort to explore the needs of the children of CSWs on the basis of their temperamental traits and psychosocial status. **Method and Materials:** A community based crossed sectional study was conducted at Sonagachi red light area. Aim of the study was to assess the psychological wellbeing and behaviour of the children of commercial sex worker. Semi structured interview schedule was developed to collect socio demographic details and special focus was given to explore to psychosocial behaviour, and Child Behaviour Checklist (CBCL- Youth Self Report) was used to assess temperamental traits. **Result** will be discussed during presentation.

## ANXIETY, DEPRESSION AND PSYCHOSOCIAL ISSUES OF CHILDREN OF COMMERCIAL SEX WORKERS

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**Background:** Every child has the right to a healthy and happy childhood and to become a complete person. Unfortunately an evil spirit of the West Bengal society invites women to live in a "hell hole" where they are generally looked as hapless victims and labeled commercial sex workers. Children of the commercial sex workers (CSWs) are at the receiving end of this scenario and society forces them to inherit the stigma that is attached to the profession of their mother (Pardeshi G et al. 2006). The situation of

underprivileged children in India as depicted by Child Rights and You (CRY) is disappointing. Although there are many activities focusing on the CSWs, but there are not many for their children's. The children need formal and non-formal health and life skill education (Pal et al. 2011). It is a need of the hour to draw attention to them with care and concern. This study is an effort to explore the needs of the children of CSWs on the basis of their present health and psychosocial status. **Method and Materials:** A community based crossed sectional study was conducted at Sonagachi red light area in the month of August and September 2012. Aim of the study was to assess the anxiety, depression and psychosocial issues faced by the children of commercial sex worker. Semi structured interview schedule was developed to collect socio demographic details and special focus was given to explore to psychosocial issues. Depression and Anxiety in Youth Scale (DAYS) was used to assess depression and anxiety symptom. **Result** will be discussed during presentation.

## THE COMPARATIVE STUDY BETWEEN THE COGNITIVE DEVELOPMENT IN THE PRE SCHOOL IN ANGANWARI OF RAJASTHAN VS MAORI PRE SCHOOL STUDENT OF WANGANUI NEW ZEALAND

Soumen Acharya

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The study was conducted in the anganwari in rajasthan where the tribal children were taken in the age group 3-6 years male and female The children of Wanganui Maori of New Zealand were taken in the age group 3-6 years; both male and females. The children were given CLCT test. Six areas were tested. They were- conceptual skills, information, comprehension, visual perception memory and object vocabulary. The result shown in these test in Rajasthan boys and Maori boys showed difference and same was the case with the girls. The full results will be presented

## TRANQUILIZING STIGMA: IDENTIFYING INDIVIDUAL INTERVENTIONS FOR EMPOWERING PEOPLE WITH SCHIZOPHRENIA

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**Aims and Objectives:** Stigma associated with mental illness is as old as civilization itself and continues to plague the lives of those suffering from mental illness. The stigma experiences are universal, but need to be

understood within the socio-cultural context. Specific interventions targeting the individuals to deal or address the stigmatizing experiences are negligible in India. This study was undertaken in order to understand the subjective experiences and possible implications for anti-stigma interventions for empowering individuals experiencing stigma. **Methodology:** We conducted a qualitative study using semi-structured interviews among 200 patients attending urban and rural psychiatry clinics. By using thematic content analysis we identified themes that could possibly have implications for anti-stigma interventions targeting individuals with

stigma experiences. **Results:** PWS (People with schizophrenia) described being teased, ridiculed and being labeled for life. Experiences of status loss, discrimination, anticipated discrimination and the dilemma of whether to conceal ones illness or to reveal it were also common. Suffering from the label more than the illness with distressing emotional responses was common. Many more unanswered questions that left individuals clueless were also observed. **Conclusion:** It is thus the need of the hour to conceive and develop an integrated, individualized, tailor-made therapy/therapies for PWS.

## FREE PAPERS (POSTERS)

### **REDUCING STRESS OF THE CAREGIVERS WITH 'PSYCHOLOGICAL INTERVENTION'**

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"In times of stress, the best thing we can do for each other is to listen with our ears and our hearts and to be assured that our questions are just as important as our answers." Keeping this in mind a quasi experimental study was conducted on patients' caregivers who were admitted in selected ICU's of Nehru Hospital, PGIMER, Chandigarh during the year 2013-14. The objective of the study was to assess the effect of the Psychological intervention on the stress level of the caregivers. The Modified caregiver strain index and Life event scale (Holmes and Rahe, 1967) was used to measure stress of the caregivers. 30 subjects were taken under each group from selected ICU's. Post test was taken after implementing psychological intervention using Modified caregiver strain index. Psychological intervention which was planned for four consecutive days, and conducted within 24 hours of admission of the patient in selected ICU's. The psychological intervention includes the aspects which will help the caregivers to understand the feelings associated with event and explore the coping methods to reduce stress. Also various alternatives were also discussed with the caregivers.

### **'BIBLIOTHERAPY WITH COUNSELLING' – AN INTERVENTION TO CHANGE ATTITUDE & WELL-BEING OF CARE GIVERS OF ALCOHOL DEPENDENT PATIENTS**

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Although the consumption of alcoholic beverages are commonly seen in both man's leisure and business hours, however, evidence suggests that public attitudes toward the alcoholic still remain ambivalent and fractured. The attitude of care-givers is of particular importance because they deal directly with the alcoholic, which significantly affect their health as well as of alcoholic. The aim of the present study was to assess the effect of 'Bibliotherapy with Counseling' on

change of attitude and its impact on the wellbeing of caregivers of alcohol-dependent patients. Bibliotherapy comprised of the literature related to knowledge about alcoholism and information about usual behaviour elicited by the care-givers of alcohol-dependent patients. Counselling aimed at addressing the care-giver issues influencing their attitude towards alcoholism and clarifying queries if any, using dialectical approach. This study was a one group Pretest- Posttest Study. A sample of 50 alcohol dependent patients was selected using Purposive Sampling technique from Drug De-Addiction & Treatment Centre, PGIMER, Chandigarh. Conceptual framework of the study was based on I-change Model/ Integrated Model by De Veres (2008). 'Socio-demographic sheet', 'Scale for Attitude towards Drinking and Alcoholism' and 'WHO's Subjective Well-being Inventory' were employed to ascertain the objectives of study. A five days intervention was given to the study sample in the form of 'Bibliotherapy with Counseling', consisted of three sessions of 45 min. each on 3 alternate days (i.e. Day 1, 3 & 5). The results of the study, to reveal whether the intervention was effective or not will be discussed.

### **PERCEPTIONS ABOUT ANXIETY, DEPRESSION AND SOMATIZATION IN GENERAL MEDICAL SETTINGS: A QUALITATIVE STUDY**

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**Background:** The recognition rates of anxiety and depression in general medical settings, despite the significant prevalence of such presentations, are low. Psychiatrists argue that the recognition and management of these conditions by physicians is less than optimal in primary care and general practice. We did this study to gain insights into physicians' perspectives on anxiety, depression and somatization, the conceptual models they employ and the practical problems they face in managing such patients in general medical settings. **Methods:** Focus group discussions (FGDs) were conducted with family and primary care physicians. The FGDs for physicians were tape recorded and transcribed, verbatim. The views of psychiatrists working in liaison clinics were also

ascertained. **Results:** Family and primary physicians admitted to a high prevalence of patients who present with medically unexplained symptoms. They noted the co-occurrence of psychosocial stress. All physicians working in general medical settings admitted to difficulty in separating anxiety, depression and somatic presentations because of milder, less distinct syndromes and overlapping symptoms. They argued that it was difficult to use the current three-category division and that a more complex classification would be time-consuming and impractical in primary care. **Conclusion:** Psychiatric classifications for use in primary care should consider the different context and employ physicians' perspectives rather than push specialist concepts and criteria.

### **SOCIO-DEMOGRAPHIC PROFILE OF SUICIDAL ATTEMPTERS ADMITTED TO A RURAL MEDICAL COLLEGE HOSPITAL OF CENTRAL INDIA**

Dipayan Sarkar, KK Mishra, Praveen Khairkar, Neha Gupta

*Department of Psychiatry, MGIMS, Sevagram*

**Objectives:** Vidharbha region of Maharashtra has remained in the forefront in the past due to numbers of farmers' suicide reported from this region. At point of time it reached to an epidemic like proportions. It has been stabilized over the year due to intervention by various Govt. and Non-Govt. organizations. In spite of that several cases of attempted suicide has been still admitted in this region. Quite a no of them are non-farming related. Keeping that in view we evaluated two cases who were admitted in our hospital during a short period of three months. **Methodology:** We evaluated the socio- demographic profile, economical condition, and reason for suicidal attempt for all the cases who were admitted to our medical college hospital during a short period of 3 months. (June to August 2013) . All the case details were recorded in a structured Performa. The collected data was analyzed using suitable statistical tests. **Result:** Total 21 numbers of cases were admitted during this period. Majority of patients were from male gender and in the age group of 20-29 years. Details of method of attempt used and reason for attempt will be discussed during the presentation. **Conclusion:** As it has been portrayed farming related suicide is not the main cause of suicide in this region, there are several other etiological factors which play a major role amongst the suicide attempters of this region as seen in other parts of the country.

### **NEEDS OF PATIENTS WITH SCHIZOPHRENIA ATTENDING A TERTIARY CARE HOSPITAL**

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**Background:** Patients with major mental illness especially schizophrenia have a mixture of needs in different domains. While some of their needs, mostly clinical are attended to by the treating team their social and individual needs are usually not addressed . There is a dearth on this information from resource poor countries. **Method:** Patients (N=85) with ICD 10 diagnosis of Schizophrenia of more than two years and on regular outpatient follow up were evaluated using CANSAS-P for their needs. Sociodemographic and clinical details also were collected. Met and unmet needs and gender difference in these domains were analyzed. **Results:** Average number of met needs among 22 domains assessed using CANSAS-P were in 7 domains and unmet needs were in 4 domains with no significant gender difference in both met and unmet needs. Most frequently expressed unmet need was about handling psychological distress due to mental illness, which was reported by 54% of patients. Domains like food (100%) and accomadation (96%) were rated as met need by most patients. **Conclusion:** Nearly hundred percent of this group of patients with a diagnosis of Schizophrenia had reported that all their basic needs like food and accommodation were met. Domains of unmet needs and possible causes and interventions are discussed.

### **OPTIC NEUROPATHY ASSOCIATED WITH GLUE SNIFFING: A CASE REPORT**

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*National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi*

**Objective:** The present report aims to illustrate a case of inhalant dependence with associated optic neuropathy. **Methodology:** A 14-year old boy belonging to low socioeconomic status, was seen in the out-patient clinic of National Drug Dependence Centre, AIIMS, New Delhi and was diagnosed with inhalant dependence (glue sniffing) for 2 years and nicotine dependence for 5 years according to ICD-10. Cannabis intermittent use for 4 years was reported. Patient also had a history of single episode GTCS of unknown etiology, prior to the onset of substance use (other than nicotine). A multidisciplinary

team conducted detailed in-patient clinical evaluation. On physical examination, he was found to have constricted visual field bilaterally even though there were no subjective complaints regarding vision. Upon further investigation, bilateral optic disc pallor was found. Humphrey visual field testing revealed bilaterally reduced visual fields. Malin's Intelligence Scale for Children was administered to assess intellectual functioning. **Results & Discussion:** A diagnosis of toxic optic neuropathy was made. No other causes of visual field defects could be found. Patient was found to have borderline intelligence. Consumption of substances was in a same aged peer group, none of whom were attending schools or pursuing occupations. Patient was a school dropout prior to inhalant use due to lack of interest in studies. Symptomatic management & nutrient supplementation was done. Psychoeducation regarding impact of inhalant abuse specifically on physical health and relapse prevention sessions were held. Occupational rehabilitation was planned. At 3 month follow-up, patient is maintaining abstinence and has started learning hair cutting skills. **Conclusion:** Literature which is primarily based on adult population is divided on the reversibility of inhalant associated optic neuropathy. Follow up of this particular case might provide further insight into the factors associated with the persistence or reversibility of this impairment.

#### **EFFECT OF PSYCHO-EDUCATION OF THE PRIMARY CAREGIVERS OF PATIENTS WITH SCHIZOPHRENIA AND BIPOLAR AFFECTIVE DISORDER**

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**Background:** Due to deinstitutionalization, the role of the family member has become an important factor for the treatment and outcome of the illness like schizophrenia and bipolar affective disorder. Living with a severely mentally ill relative means that the family has to cope with the unpredictable nature of psychotic symptoms, as well as the social stigma associated with the disease. The care giver's personality, quality of family relationships and degree of social support are considered as the mediating factors which determine his/her coping strategy. Coping is defined as any behavioral or cognitive response made by any family member contingent on a life event. Therefore, coping is both what a person does and also what that person thinks in response to an event or situation. Psycho-education can directly address a wide range of issues

like medication compliance, relapse and hospitalization, patient functionality, and coping style of the family members. **Aim:** To measure the coping skills of the care givers of patients with schizophrenia and bipolar affective disorder and to explore the effectiveness of a psycho-education on coping styles. **Methodology:** This study was carried out at the Psychiatry department of PGIMS Rohtak. Sample size: 30 healthy care givers of the schizophrenia and 20 healthy care givers of Bipolar Affective Disorder. All the caregivers were screened on GHQ-12 and were excluded if GHQ score was more than two. Four sessions (over three months) of intervention were provided to healthy care givers. They were assessed on Coping Checklist (CCL) at base line and after completion of intervention. **Result:** Result has shown that improvement was greater in bipolar affective disorder as compared to schizophrenia. Three subscales of CCL: problem solving, acceptance and denial improved significantly in both groups but distraction positive improved only in caregivers of patients with bipolar affective disorder.

#### **ROLE OF FAMILY ENVIRONMENT IN DEVELOPMENT AND MANAGEMENT OF PSYCHOPATHOLOGY: A CASE STUDY**

Poonam Gupta

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Family is a unit in which parents and children live together (Bhatia & Chada, 1993). Family is a dynamic, self regulatory system comprised of interdependent parts & interact one another in a somewhat predictable manner. Family has undoubtedly the most fundamental influence and have been referred as the "bed rock of child development" (Brenfenbrenner, 1976, 1986). Research has consistently demonstrated that problems within family system are associated with a variety of psychological and behavioral problems in children and adolescents (Forehand, 1993; Garmenzy, 1993). The quality of parent child attachment, the degree to which parents offer their children age-appropriate intellectual stimulation and the way in which control and warmth are combined & have highly significant effect on children's later psychological adjustment (Darling and Steinberg, 1993). Children of depressed, anxious and disturbed individuals are significantly more maladjusted, depressed and anxious (Billing and Moss, 1985). Adolescents are more likely to benefit from treatment if they and their families accept that there is the problem and are committed to resolve it. With the



aim to study the effect the role of family environment in development and management of psychopathology, a case study of a young boy of 18 years, who was brought by his parents with chief complaints of school refusal, decreased interest in studies with sadness of mood, irritability & withdrawal behaviour along with disturbed sleep and self care from one year for treatment is presented. For management of present case few psychological test and Family Environment Scale (Moos and Moos, 1974) were administered. After assessment it came to light that family environment is very stressful where conflicts, achievement orientation and control is high and cohesion, organization, intellectual, cultural and recreational orientation is very low. So, to manage the present case a total of 16 sessions were held with the young boy and his family members. The patient and family member had gained significant improvement in patient's problems and family conflicts and communication patterns from the therapy sessions. Details will be presented during presentation.

#### **FAMILY PATHOLOGY AND SOCIAL SUPPORT IN MAJOR MENTAL ILLNESSES**

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**Background:** Family is the most important primary unit where every individual finds their self identity. Current researches on psychiatric illness have indicated that family contributes significantly to the development of mental disorders. The importance of the role of the family as a causative factor in the development of mental disorders is getting more and more established, particularly over the past few decades. On the other hand family is key element from where a person gets his/her social support. From family, an individual gets emotional, financial, mental support and is able to cope with his/her problems. **Aims:** The aim of this study is to assess the family pathology and social support in the patients diagnosed with schizophrenia and bipolar affective disorder. **Method:** Total number of patients recruited for this study were sixty. 30 patients were diagnosed with schizophrenia and 30 were diagnosed with bipolar affected disorder. Sample was collected from the dept. of psychiatry, PGIMS, Rohtak. Socio-demographic datasheet, social support questionnaire were administered on patient and family pathology scale was administered on parents. **Result:** Family pathology is high in the families of patients diagnosed with schizophrenia in comparison to bipolar affective disorder. Social support was found to be poor in the

families of patients with schizophrenia in comparison to bipolar affective disorder.

#### **ATTRIBUTION OF LOCUS OF CONTROL AND TRAUMATIC LIFE EVENTS IN DEPRESSIVE PATIENTS: AN INVESTIGATION IN HOSPITAL PATIENTS**

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**Introduction:** Negative life events are noted to have a major impact in depressive patients. In fact, it has been noted that more than 75% patients with major depression report negative life events prior to depression (Jenaway & Paykel, 1997). Locus of control is a personality construct that has been observed to be associated with features of depression and anxiety. The relative risk of depression after exposure to negative life events varies from 3 to 10. It can be conceived that depression onset is more strongly related to dependent to independent life events. Life events can also be predecessor of anxiety disorder. Personality traits can be linked to life-event exposure and attribution. The locus of control may play a role in appraisal of life events which in turn affect the cognitive and behavioural approaches of the individuals. **Aim:** The present study investigate the link between locus of control, life events and negative affectivity in depressive patients. **Methods:** Total 100 (n=100) patients (age group 20-50) were selected from the Salt Lake Government hospital out door with symptoms of major depression. The test batteries used were BDI, MADRS, Life events Schedule, Locus of control, and Personality Questionnaire. They were given the tests after one week of first visit at the hospital outdoor. A group of same number of healthy subjects was used as control. **Results:** Previous history of depression, gender and type of negative events were found significant ( $p=0.05$ ) related with negative affectivity. External locus of control was also observed to be significantly ( $p=0.05$ ) related to the above construct. The controls indicated no significant relations among measures. The appraisal of stressful events remains obligatory for elevated level of negative affectivity. **Conclusion:** It can be assumed that personality style and attribution as locus of control has a major role in evaluation of traumatic life experiences. This in turn can make a subject vulnerable for the occurrence of depression. Personality trait and constitution can be a link between distressing life

events and resultant depression. The feeling of having no control over situations or events cause worries which in turn incite helplessness leading to depression. Although it is established that negative life events can precipitate depression, the association is a complex one and probably operates in both directions. Improper appraisal of negative events thus probably form a vulnerability construct for onset of depression.

### **STRESSFUL LIFE EVENTS AND THEIR ROLE IN OBSESSIVE COMPULSIVE DISORDER**

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**Background:** Etiology of Obsessive Compulsive Disorder (OCD) points to neurobiological causes along with psychological factors. While stressful life events increase a person's vulnerability to develop illness, all people having stressful life events necessarily do not develop OCD. **Objective:** To investigate the presence and impact of stressful and traumatic life events in OCD patients and compare that with OCD patients without such events. **Methodology:** Patients from National Institute of Behavioural Sciences and Apollo Gleneagles Hospital, Kolkata were recruited for this study (duration August 2011 till June 2013). A total of 42 patients diagnosed with OCD (ICD 10, DCR criteria) were divided into two groups on the basis of presence of stressful and traumatic life events preceding the onset of obsessive compulsive symptoms. A profile of the life events was made and the groups were compared upon their symptom pattern and severity. Standard evaluation procedure included assessment on the Yale Brown Obsessive Compulsive Scale, Medico Psychological Questionnaire, Life events Scale and the Beck Depression Inventory. **Results and Conclusion:** Significant number of OCD patients reported having stressful life event preceding the development of obsessive Compulsive symptoms. Further details of the results will be provided during presentation.

### **GROUP WORK PRACTICE OF SOCIAL WORK EFFECTIVE IN CHANGING THE INTEGRATED CHILD DEVELOPMENT PROGRAMES IN INDIA.**

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The ICDS is a preventive as well developmental effort; it takes a holistic approach to the child by providing a package of services which includes periodic health-check-ups, referral and medical services, monitoring of growth, immunization, supplementary feeding, non-

formal preschool education and nutrition and health education for mothers. The services are provided at the Anganwadi (literally, courtyard play centre). An anganwadi centre usually covers a population of 1000 in rural and urban area and 700 in tribal area. The specific objective of ICDS is, to: Improve the nutritional and health status of children in the age group of 0-6 years; Provide environmental condition needs for physical; social and psychological development of children; Reduce the incidence of low birth weight and severe malnutrition among children; Enhance capabilities of mother to provide proper child care; and Achieve effective coordination at the policy and implementation levels among government departments to promote child development. ICDS services through a network of anganwardis. All the services including preschool education, supplementary nutrition and health check-ups are delivered at the anganwadi by the Anganwadi Worker with the assistance of a helper. Supportive supervision and guidance, aimed at continuous improvement in the skills, is provided by the supervisor. Measures, helps us to understand the overall development of the child. These things depend upon these factors and group work can set these things. The whole community will be benefitted.

Physical set up of the anganwadi/play center:

- 1) Play centre /anganwari situated in clean and hygienic surroundings.
  - 2) Availability of safe drinking water source/and storage system.
  - 3) Availability of adequate indoor space (adequate = floor space for 30-40 children to sit comfortably, 1 square mats./child)
  - 4) Availability of adequate outdoor space (adequate = play area for 10-15 children to play at a time, 2 square mats./child).
  - 5) Utilization of the available space.
  - 6) Availability of place for storage for rations.
  - 7) Availability of kitchen for cooking
  - 8) Availability of toilets in the centre.
- B) Functionaries
- 1) Age, marital status.
  - 2) Educational background.
  - 3) Experience.
  - 4) Kind of training.

- 5) Adult/child ratio at the centre.
- 6) Motivational level of the functionary (measured through perception indicators and observation)

#### C) Services

Frequency of contacting beneficiaries

Regularity and frequency of the services provided.

##### 1) Preschool

- A) Frequency of conducting stories, hymns, outdoor games, creative activities.
- B) Variety in programmed planning.
- C) Availability and utilization of teaching aids/ play materials. Skills of the worker
- A) Planning and conducting pre school education.  
(Evaluated through observation by trained enumerators)

Health and Nutrition Education.

- a) Number of formal health and nutrition education sessions conducted.
- b) Specific message covered.
- c) Methods and techniques used. group work  
Community participation.
- A) Existence of coordination committees at anganwadis workers level.  
Agnais workers skill in eliciting community participation.
- c) Frequency of holding meeting of coordinating committee.
- d) Active involvement of self help group in the area.
- E) Administrative support.
- A) Frequency of the visit of the supervisory staff.
- B) Kind of help or assistance provided.
- c) Efficiency of introducing corrective action.
- d) Functionaries perception of the support received.
- E) Frequency of holding training sessions and demonstration

The above mentioned information will be reported as quantitative indicators, some of these will have to be, however, measures of central tendency along with dispersion could be worked out. Rates and ratios may also be required to depict the flow. The disintegration by nature of project, caste group and beneficiary

category wise and the Final discussion will be presented at the time of conference.

#### **CAUSAL ATTRIBUTION OF SYMPTOMS AMONG PRIMARY CAREGIVERS OF PATIENTS WITH DELIRIUM**

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**Background:** Unlike the West, in India, family is the key resource in the care of patients with mental illness. Family not only fulfills the need of the patients but also plays a major role in treatment seeking and compliance. Hence their perception about the causality of the disease affects help seeking. Though the same has been studied for other mental disorders, in delirium this is still unexplored. **Aim:** To study the caregivers' belief about the causes of delirium. **Methodology:** Three hundred thirty one consenting primary caregivers staying with the patients during the acute episode of delirium were evaluated for their beliefs about the plausible etiologies of symptoms of delirium. Diagnosis of delirium was based on Diagnostic and statistical manual- fourth text revision (DSM-IV-TR) criteria for delirium. Illness attribution was assessed by spontaneous reporting and probing with a checklist covering physical, stress induced, hygiene related and supernatural causes. **Results:** On spontaneous reporting, 50.5% of caregivers attributed delirium to physical illnesses as a direct cause of delirium. Other attributions included: substance abuse especially alcohol (13%), supernatural causes (13.6%), stress (3%) and 1.6% of caregivers attributed the symptoms to poor hygiene. The mean number of etiologies reported spontaneously were 1.3 (SD=0.8). On probing, 49.5% attributed symptoms to one or more supernatural causes. The mean number of etiologies reported on probing were 1.5 (SD=1.6). **Conclusions:** A significant proportion of caregivers attribute the symptoms of delirium to supernatural and other non-organic causes. This may adversely influence further treatment seeking and subsequent prognosis.

#### **HELP SEEKING BEHAVIOR AND LIFE SATISFACTION AMONG THE SPOUSES OF PERSON WITH BIPOLAR DISORDER**

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Bipolar disorder is a pathological disturbance of mood, typically characterized by oscillating manic and depressive states (DSM-IV, American Psychiatric

Association, 1994). Bipolar disorder is characterized by recurrent episodes of mania and depression, interspersed with periods of recovery during which mood would be more or less euthymic; however, such recovery is usually not complete as there remains a high incidence of occupational, psychological and social difficulties during their lifetimes (Marneros and Goodwin 2005). Due to the chronic nature of the illness the patient adds the substantial burden on care giver's which affect their quality of life. However, India is a country known for the several mixtures of cultures, which may influence the causative beliefs, and consequently, the help-seeking behaviors of the psychiatric patients as well as the caregivers. Therefore, there is a need to explore of many overt and covert factors acting as hindrance in the help seeking behaviour of the spouses of bipolar disorder. **Aim:**-To study the relationship between help seeking behavior and life satisfaction among the spouses of person with bipolar disorder. **Methods and Materials:**-This study was a hospital based cross sectional study, carried out at central institute of psychiatry, Ranchi. Total 40 spouses of person with bipolar disorder was recruited for this study. General help-seeking questionnaire and life satisfaction scale was applied on spouses. **Result:**-Result will be discussed at the time of presentation.

#### SUSCEPTIBILITY TO SMOKING AMONG ADOLESCENTS

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India is the world's second highest tobacco growing and tobacco consuming country. In the 2006 Global Youth Tobacco Survey, it was found that smoking had increased among boys and girls in India. Although the health outcomes of smoking are well known, little research has been carried out to examine adolescent smoking susceptibility in the Indian context. The aim of the present study was to examine smoking susceptibility among a sample of 1000 college students in Bangalore. The sample consisted of 488 boys and 512 girls with a mean age of 17.66 years. The students were selected from 14 English and Kannada medium colleges. Data were obtained through a Sociodemographic Data Sheet and Susceptibility to Smoking Scale (SSS; Pierce, et al, 1998). Written informed consent was obtained from all the participants and assessment was carried out in the college premises. Results revealed that 27% of boys and 10% of girls had initiated cigarette smoking. 15% of boys

and 6% of girls, who were currently non-users of cigarettes, expressed intention to smoke in the future. 54% of the subjects had family members who smoked. Susceptibility to smoking was higher among boys who had smokers in the family. The findings from the study have implications for prevention programs for smoking among adolescents in general and college students in particular.

#### THE COMPARATIVE STUDY OF PSYCHOLOGICAL FUNCTION OF CHILDREN WITH NORMAL AND ABNORMAL CHILDREN WITH HEART SURGERY

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**Background & Methods:** The children in age group 0-6 years coming for heart surgery is a great event. It is necessary with Children who had normal hemoglobin and weight and height, and compare with low weight and haemoglobin. The samples comprise of normal and underweight were taken. The children were matched for age and screened for intellectual functioning. Psychological functioning was observed by Teddy bears picnic and children play therapy. Personal construct were assessed prior to play session; the third play session was chosen for comparison of behaviours. **Results:** Children in heart surgery group as compared to low weight had greater negative personal constructs. Difference in play behaviours were seen in type of play, affective, cognitive, narrative aspect of play, and defense utilized. **Conclusion:** Psychological functioning of children with low weight and heart surgery is not disordered, they should be need for better care in the children with heart diseases.

#### MANIA FOLLOWING ORGANOPHOSPHATE POISONING: A RARE CASE REPORT

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Organophosphate (OP) poisoning is the commonest poisoning in India with nearly half of the admissions to the 'emergency' with poisoning being due to these compounds. The central nervous system effects of organophosphate intoxication have received less attention in the medical literature than peripheral effects. Certain patients displayed vague mental changes such as irritability, memory disturbances and dream abnormalities for several months after their apparent recovery from organophosphate poisoning. There are also reported cases where there is

development of schizophrenic or depressive symptoms after exposure to organophosphate insecticides. **Aim and Objectives:** To present a case where the patient developed manic episode 15 days after accidental ingestion of organophosphate poison and to review the available literature. **Methods:** We are presenting a case of 33-year-old female presented with manic episode for last 10 days. On evaluation there was past history of accidental ingestion of organophosphate insecticide 15 days before the onset of psychiatric symptoms. In the interval period between ingestion of poison and onset of manic episode the patient was asymptomatic. There was no history of any substance use. There was no

contributory family history or past history. The patient was treated with tablet olanzapine 10mg per day and the patient improved significantly within 10 days. **Conclusion:** The mechanism of mood changes and other psychiatric symptoms is as yet unclear. It may be the excess acetylcholine merely upsets the balance of transmitter systems active in cortical area or it suppresses dopaminergic activity, and resulting hypersensitivity of postsynaptic dopaminergic neurons may cause psychiatric symptoms. Although the acute muscarinic and nicotinic side-effects are well known and easily recognized, very few cases of psychiatric changes are reported.