Chapter-I

Introduction
In today's world, life challenges are more psychological as compared to the physical. Alienation at the individual and community level has emerged with the day to day problems such as fears, pressures and uncertainties of today. There is also a realization that problems can be solved by ourselves and it is the individual alone who has to cope with the worries faced in this demanding socio-psychological environment. This has urged psychologists to explore those psychological aspects of man which can act as a protective systems in his struggle. According to humanistic psychologists that it is within the individual’s own thought process, actions and perspectives that answers to his dilemmas lie.

The investigator has come across only a single study conducted in India, in relation to the kith and kin of cancer patients (Husain and Kureshi, 1985). The patient suffers but his suffering also effects his kith and kin. It is deemed still meaningful to study the behavior of the kith and kin of patients suffering from cancer, coronary heart disease, diabetes, hypertension, tuberculosis, asthma. Personality disposition seem to be a major factor in producing and sustaining feeling of worry and alienation among members of family attending the patient, both these will influence the mental health or general well-being of the kith and kin of patients.

As far as worry is concerned kith and kin are worried because of seriousness of disease, uncertainty in life, hospital conditions, worry about the expenses on treatment, problems arouse in the family due to
the condition of the patient. As far as 'Alienation' is concerned kith and kin become alienated because of observing deterioration in the health of their patients. The source of alienation may vary widely. The alienation result from economic deprivation, dependence or severity of the illness. Still in other cases, the roots of a young person's alienation is due to the family violence, parent-child relationship or other adverse developmental experiences, that is likely to produce psychological disturbance and a sense of alienation.

Considering the importance of the independent variables, namely, worry and alienation and dependent variable, mental health; it is expected that the variables worry and alienation would influence on the mental health of the kith and kin of the patients. Furthermore, the mental health of the kith and kin of patients would also be influenced by the socio-demographic variables such as their age, gender, dependency level, socio-economic status and the level of relationship.

MENTAL HEALTH : NATURE AND VIEPWOINTS

The emergence of mental health is closely related to the growth of the mental hygiene in the U.S.A. and to the development of psychotherapeutic practice and personality research.

As an explanatory construct "mental health" that gained its first adherents at the beginning of the twentieth century. The subject of Mental Hygiene concerns with the origin or causes of mental problems or disorders with a view to find ways and means of preventing them and if they occur, to find ways and means to effect, as much cure as possible, by
proper diagnosis. But mental hygiene is also concerned with the maintenance and enhancement of mental health, just as medicine and physical hygiene look after the physical side of human beings for keeping the body free from illness and to effect cure when some illness does occur to restore the vigour, Zest and Zeal for living. In the 1920's interest shifted to promoting "mental hygiene and establishing child-guidance clinics.

The term "mental health" began to replace "mental hygiene" in the 1930's and by the late 1940's is assumed an independent status with a growing and enthusiastic social movement operating in its name.

This shift in terms signified the beginning of the era of concern with the prevention of mental disorders rather than merely care and treatment and the broadening of focus to include all forms of social and psychological maladjustment rather than just the severely emotionally disturbed or psychotic. The movement began to promote "positive" mental health as a goal distinct from the elimination of mental illness. There are a number of characteristics associated with a mentally healthy person who is like a spinning top at once, stable and active and keeping going without losing the balance of mind. He is dynamic, flexible and amenable to change with rational control. He is adjusted to himself, to the members of his family and the relatives, friends and colleagues. He has wider contacts and interests. He is able to be submissive or aggressive, cooperative or resistant, a spectator or a performer according to the requirements of the situation.
The concept of mental health has been explained in different perspectives. Psychoanalytic viewpoint is that mental health is a property of individuals and a function of intrapsychic development and dynamics is still dominant. It maintains that an individual acquires good mental health as a consequence of fortunate early socialization; psychoanalysis or some other form of psychotherapy is a corrective for unfortunate early development. Thus, the individual remains the unit of analysis, and psychological health is seen as a function of the individual's unique, private intrapsychic development and life history. Subsequently, the unit of analysis was extended to include the patterning of an individual's interpersonal relations.

Recently, another view of mental health was put forward by the proponents of social psychiatry. Psychologists like Fromm (1955) and Frank (1948), take a comprehensive view of mental health as a function of the total society - its norms, values and general style of life.

Mental health is very ambiguous term because it is difficult to agree on its general application in a single context. It may be used in many different ways. It is not a very precise term, it is striving for scientific status while also serving as an ideological label.

The term 'mental' usually implies something which is purely related to the cerebral functioning of a person, and it also stands for his emotional affective states, the relationships he establishes with others, and a quite general quality that might be called his equilibrium in his/her socio-culture context. The term 'health' refers to more than physical
health, it also connotes the individual's intrapsychic balance, the fit of his psychic structure with the external environment, and his social functioning.

There is no unanimously accepted definition for health. The WHO definition states that health is a state of complete physical, mental, social well-being and not merely the absence of disease or infirmity (WHO, 1948).

Psychological distress consists of negative emotions and related conditions: depression, anxiety and worry; minor physical symptoms such as headaches, sleeplessness and exhaustion, feelings of personal inadequacy or of impending nervous breakdown. There is extensive evidence that such feelings are found in the same individuals and that this forms a 'general factor' of personality. 'The General Household Survey' finds that about 1 person in 3 reports some kind of psychological distress - severe headaches, exhaustion, sleeplessness, anxiety or depression. Evidently, symptoms of psychological distress are very widespread like coughs and colds in the sphere of physical health.

Health is an indispensable quality in human being. It has been described as soil from which the finest flowers grow. Health indicates psychosomatic well-being. To Bhatia (1982) "Health is a state of being hale, sound or whole in body and mind". The preamble of WHO charter defined health as a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity (Monopolis et al., 1977).
Today, mental health has been mentioned as the ability of person to balance one's desires and 'aspirations', to cope life stresses and to make psycho-social adjustments. A mentally healthy person is a productive and unalienated person, a person who relates himself to the world lovingly, and who uses his reason to grasp reality objectively; who experiences himself as unique individual entity, and at the same time identifies with his fellow man, who is not subject to irrational authority and accepts willingly the rational authority of conscience and reason; who is in the process of being born as long as he is alive, and considers the gift of the life the most precious chance he has.

Laddell has reported mental health as the ability to make adequate adjustments to the environment, on the plane of reality.

A mentally healthy person is also characterized by proper insight and understanding of himself through self-knowledge and self-evaluation. He accepts himself according to his/her own motives, emotions, capacities and intellectual peculiarities, handicaps and failure. A mentally healthy person is consistent in his thinking, feeling and willing and has adjustment of his desires and impulses in harmony with approved social goals. He accepts his relationships in the group by recognising the variability and flexibility of his status. A mentally healthy person is characterized by social adaptability to get along with people and to attain and maintain harmonious relationships in family, community, school workshop or office.
Menninger (1945) define mental health as the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness..... It is the ability to maintain, even temper, an alert intelligence, socially considerate behaviour and a happy disposition.

Jutras, Stylvie and Lavoie, (1995) studied about the living with an impaired elderly person: The informal caregiver's physical and mental health. Two groups of caregivers were taken comparing the health indicators of 292 adult co-residents of elderly people (aged 55+ yrs) with physical or cognitive impairments (POCIS) with those of adults living or not living with a non-impaired person (aged 55+ yrs.). Physical health were observed between co-residents of elderly people with POCIS and subject's in the comparison groups, co-residents of elderly with POCI's systematically presented poorer psychological health indicators.

A mentally healthy person has all aspects of his being, physical, mental, social or superindividulistic well coordinated into a balanced and harmonious whole in relationship with the total environment. A healthy person has a state of mind that enables him to experience the greatest amount of happiness and to attain the maximum efficiency with the minimum amount of strain or conflict. He, however, does not have the anxiety to live or clinging attitude that every thing must happen as suits his design. He is not grabbing and hoarding to have so many mouthfuls of pleasure himself but gives away more than taking and shares with others his time, energy, wealth and whatever he has.
Bhatia (1982) considers mental health as the ability to balance feelings, desires, ambitions and ideals in one's daily living. It means the ability to face and accept the realities of life.

Several psychologists and psychiatrists have presented different criteria of positive/good mental health. Maslow and Mittelmann (1951) have suggested the following criteria for normal psychological health:

(i) Adequate feeling of security.
(ii) Adequate self-evaluation.
(iii) Adequate spontaneity and emotionality.
(iv) Efficient contact with reality.
(v) Adequate bodily desires and the ability to gratify them.
(vi) Adequate self-knowledge.
(vii) Integration and consistency of personality.
(viii) Adequate life goals.
(ix) Ability to learn from experience.
(x) Ability to satisfy the requirements of the group.
(xi) Adequate emancipation from the group or culture.

Jahoda (1958) has noted following six aspects of positive mental health:

(i) Attitudes of an individual toward his own self: the accessibility of the self to consciousness, the correctness of the self-concept, and its relation to the sense of identity and the acceptance by the individual of his own self.
(ii) Growth, development, or self-actualization.

(iii) Integration

(iv) Autonomy

(v) Perception of reality

(vi) Environmental mastery

Schultz (1977) has presented following seven criteria of the healthy personality:

(i) Extension of the sense of self.

(ii) Warm relation of self to others.

(iii) Emotional security

(iv) Realistic perception

(v) Skills and assignments

(vi) Self-objectification

(vii) Unifying philosophy of life

MODELS OF MENTAL HEALTH

"Mental health" has been defined variously. Psychologists generally emphasize its negative aspect, that is, absence of pathological symptoms such as tension, anxiety, depression, emotional imbalance, anti-social habits, drug addiction. A person who does not display these symptoms is regarded as mentally healthy. This operational definition of mental health seems to be quite adequate, since it is tied up with normality. It is assumed that a normal person is well adjusted so he must be mentally healthy. However, a difficulty arises about the normality itself. It does not have an independent existence. It can be conceived...
only with reference to a specific culture. There is no common standard of normality. This argument leads us to the conclusion that a universally accepted definition of mental health is a mere myth.

Like the negative characteristics of mental health, some psychologists have prepared a list of the positive qualities of mental health. Such positive qualities like sociability, emotional maturity, effectiveness of human relationships, etc. In modern psychology several more or less independent systems have emerged and each one seeks to explain human nature. Each system tries to solve problems arising out of the complexity of the human nature. Most of these problems are concerned with mental health. These different systems can be grouped into three models viz., the mechanical, the dynamic and the humanistic.

The Mechanical Model: This model looks upon man as a reactive being and considers him as merely one more creature of nature whose behaviour can be understood, predicted and controlled through such processes as conditioning, reinforcement, generalization etc. This model uses S-R formula with its several modifications as the guiding principle in the study of various human problems including mental health. Most of the experiments which are based on this model, are upon animals not on human beings. This methodology is no doubt scientific but its primary postulate that man is simply a reactive organism is not scientific. It also fails to provide any effective solution of the problems to mental health.
2. The Dynamic Model: This model is presented by the analytical school of psychology founded by Sigmund Freud. According to this model, behind the benign exterior of man, there lurk those wishes, urges and impulses which man himself is ashamed to recognize. Since man's nature is essentially animal, he has to repress such impulses for the sake of social and cultural adjustment. Such adjustments become possible only by resorting to a number of defense mechanisms. Of great importance are the influences of childhood experiences, especially sexual in nature, at different stages of development, each stage being dominated by a special mode of achieving maximum pleasure. The secret of mental health is not to repress the animal desires so that mental conflict is avoided.

3) The Humanistic Model: This model, which looks upon man as a being in the process of becoming, lays special emphasis on his natural tendencies toward self-direction and self-fulfilment. The significant factor which affects the individual is not reality as such but rather his interpretation of reality. This means that the reality for any individual is basically the private world of his perceptions. The consistent and organized self is developed through his experiments gained as a result of interaction with others. Unimportant experiences are ignored and those which are acceptable are incorporated in self-structure. The unacceptable experiences later prove a threat to the self which requires that it should be protected from such threats. The self becomes more rigid as more protection is needed. A person becomes maladjusted when he perceives
himself at odds with his important experiences. Tension makes the situation even worse and as a result he loses his mental health.

All these models give due attention to the problem of mental health, but fail to give any effective solution to the problem of maintaining or regaining mental health.

In all advanced countries, especially in the U.S.A., where different types of psychotherapies have been developed and used, the number of maladjusted and mentally disturbed people is increasing every year. This shows that these current models have not been able to go very far in solving the mental health problems both at the individual and at the national levels. The inadequacy of these models is obviously due to the fact that they are not based on a true premise of human nature. They have completely ignored the spiritual aspect of human personality, an aspect without which one cannot hope to understand man's true nature. Hence there is need for another model which could explain human nature from a different angle.

The model that gives a true picture of human nature and explains the problems of mental health, giving due attention to the spiritual aspect, is the Islamic model as given in the Holy Qur'an.

**Qur'ānic concept of Mental Health**: Islam, as we all know, is not a religion in the ordinary sense, but is a dīn i.e. a way of living in accordance with the true nature of man. In the Qurān one reads: "the dīn, according to Allah, is Islam". Islam means complete submission to the Will of Allah and thus enjoying peace. The Qurān clearly states:
And to Allah submits all that is in the heavens and the earth, willingly or unwillingly. (13:15)

In other words, every creature on earth is bound to obey the laws of nature by following the path of diñ al-fitrah. Deviation from this path results in maladjustment.

In order to understand the nature of the Islamic model the following points are worth noting since these are its basic principles:

1) Man is not a reactive being or a slave of his urges; instead he has been created in the best mould: "Surely we created man in the best mould" (95:4)

Indeed man is the vicegerent of God on earth. As such he portrays Godly qualities. Human nature cannot be explained without referring to this spiritual aspect. Indeed that is the vital aspect of man that makes him the vicegerent of Allah on earth.

2. Man has been created with a purpose. The Qur'ān says about man:

Did you think that We had created you without purpose and that you would not be brought back to us? (for accounting) (23:115)

The real purpose of man's creation is to seek God's pleasure.

3) Man, contrary to the assumptions of the mechanical model, is not a machine. He has been given the gift of freedom to act in any way he likes. He is, however, warned that all his actions, whether right or wrong, will be judged in the next life and he will be rewarded/published accordingly.
In the light of these principles, the nature of mental health can now be explained in a more effective manner.

Since the entire creation obeys the laws of Allah, the whole universe in a way follows the true dīn which consists of obedience and complete submission to Allah, the Lord of the universe. This also implies that even in the human world the laws of nature are quite manifest. All the organs of man's body including his heart and brain follow the path of Islam. This means that they follow the course that has been ordained for them. However, man has a different position as well. On the one hand he is regulated by the Cosmic or Divine law and such he is a born Muslim; on the other hand he has been given the freedom of thought, choice and action and as such he can chalk out his own course of behaviour.

Both these aspects co-exist in man's life. If he consciously decides to submit himself to the will of Allah in the domain in which he has been given freedom of choice, he experiences no conflict in his personality. He is a Muslim voluntarily and involuntarily. Such a person belongs to ummah wasatā i.e. those who have well balanced personality. These people are muflihun, those who prosper in their lives. They neither worry nor suffer from grief:

Behold! verily on the friends of Allah there is no fear, nor shall they grieve (10:62)

On the other hand, those who, in spite of being Muslims in their involuntary life, do not exercise their higher mental functions for
recognizing their creator and misuse their freedom of choice by denying Him and not submitting to His Will, are in a state of mental conflict. This inevitable consequence of this conflict is a failure in the ultimate ideals of life. Their personality becomes disintegrated and their mental health is shattered. They then join the group of losers viz.; the Khāsirūn.

Islam does not consider mental health as merely the absence of pathology, but also emphasizes the positive aspects by which mental health can be maintained and improved. The following points explain the positive aspects.

1) The mental health programme does not recommend the suppression of human urges but insists on keeping a balance among them.

   This concept is best illustrated in the Qur'ān by using the term sawā' al-sāḥil by which is meant the path of itidāl and tawassut. This means that no urge is given undue importance at the cost of other urges. This results in a fully functioning personality, a personality which is able to deal with all personal and social problems adequately. Man is thus spared from many crisis producing situations.

2) One of the major precipitating causes of mental ill health is the feeling of frustration and despair due to envy and jealousy.

   As a result of these negative emotions man's life is shadowed by such unhealthy psychic states as anxiety and depression. He is directed not to compare himself with others.
The Qur'ān says:

And covet not those things in which Allah has bestowed his gifts more freely on some of you than on others, but ask Allah for His bounty (4:32).

In order to attain such a state of mind the muṣliḥūn inculcate certain values like sabr (patience) and shukr (gratitude). We read in the Qur'ān:

Lo! man is in a state of loss, save those who believe and do good works and exhort one another to truth, and exhort one another to endurance (103: 2-3)

In utter grief and despair the phrase: Innā li Allah wa innā illayh rājiʿūn ("To Allah we belong and to Him is our return") works like a miracle.

3) In the dynamic model, the concept of guilt plays an important role in repression, a mechanism that is the root cause of many psychic problems. Islam, on the contrary, has introduced the concept tawbah or repentance. In the Qur'ān one reads:

Your Lord hath prescribed for Himself mercy. Verily if any of you doeth evil in ignorance and repenteth afterward thereof and death rights, (for him).

Allah is forgiving and merciful (6:54)

And at another place the Holy Qur'ān approvingly mentions the believers saying:

And those who when they do something to be ashamed of, or who wronged their own souls, earnestly bring Allah to mind, and ask for forgiveness for their sins - and who can forgive sins except Allah (3:135).
4) Islam encourages certain spiritual values like rida, tawakkul, etc. The importance of these values in promoting mental health cannot be over-emphasized.

5) Some emotions like rage are responsible for certain psychosomatic illnesses. The Muslims are directed to control their emotions.

Those who restrain their anger and are forgiving toward mankind, Allah loves those who do good. (3:134)

6) It is the obligation of every man to keep normal relations with other human beings, specially those who are closely related to him by relations of blood or neighbourhood.

The secret of mental health lies in observing certain rights and obligations. These include rights of other people against him. A healthy person is one who fulfils his personal as well as social duties to the best of his ability. The following beautiful verse is his code of conduct.

Allah commands justice, and the doing of good (i.e. kindness) to kith and kin, and He forbids shameful deeds and injustice and rebellion. He instructs you that you may receive admonition(16:96)

By regarding this verse again and again one will realize that a person whose behaviour is motivated by these two goals viz., development of some positive acts and avoidance of certain deeds remains free from worries and anxieties. Psychologists agree on this point that a well adjusted person is one whose social life is well regulated.

7) Islam gives due importance to the spiritual aspect of life. Whenever
a Muslim is in trouble, he is asked to turn to Allah. Allah says:

... those who believe and whose hearts have rest in the remembrance of Allah. Verily in the remembrance of Allah do hearts find rest. (13:28)

WORRY

Worry is an individual's tendency to experience anxiety characterised by a low threshold. Worry is normally elevated in neuropsychic and severe somatic diseases, and also in healthy people experiencing the aftermath of a psychic trauma, and in many groups of individuals with deviant behaviour. Generally speaking, worry is a subjective manifestation of some personal misfortune. Contemporary studies of worry are designed to distinguish situational worry, connected with a concrete external situation, from personal worry, which is a stable property in a given individual, they are also intended to develop methods for analysing worry is the result of individual environment interactions.

It is assumed that worries have two facets, namely; the object of worry (e.g. self, close others, society, the world) and the domain of worry (the field of life with which it is concerned). The object of worry is presumed to be more important than its domain in determining the impact of worries on mental health. Only worries concerned with self and close others (micro worries) are expected to be related to poor mental health, whereas worries about society or the entire world (macro worries) are expected to be positively related to mental health. Micro worries are strongly related to poor mental health, whereas macro worries are unrelated to mental health or relate marginally to positive well-being.
A view of worry as pathological pervades the clinical literature. Traditionally, worry was treated as a subconstruct of anxiety (Spillberger, Gonzalez, Taylor, Anton, Algaze, Ross and Westberry, 1980). For example, Borkovec, Robinson, Pruzinsky and Depree (1983) defined worry as "the uncontrollable negative cognitive activity associated with anxiety". In a similar vein, DSM-III-R specified prolonged unrealistic and excessive worry as a defining feature of the General Anxiety Disorder (American Psychiatric Association, 1987). Indeed, worry scales are sometimes treated as interchangeable with anxiety measures (e.g. Wisocki, Handen, and Morse, 1986). Numerous instruments have been developed to measure worry as a form of anxiety or as a state closely related to it. In support of this conception, scores on these worry instruments are substantially correlated with various indexes of anxiety, depression, and psychosomatic symptoms. Worrying is seen as a general personality characteristic. Most instrument assume, however, that worries can be discriminated according to the topic or domain of life to which they refer. For example, Wisocki and Handen (1983) sampled items to represent three life domains, finances, health and social relationships. Tallis, Eysenck and Matthews (1992) sampled items to represent six life domains: and other have suggested from four (Barlow, 1988) to ten (Eysenck and Van Berkum, 1992) life domains of worries. In these approaches worrying is seen as potentially domain-specific. Although there is no consensus regarding the number of domains of worries or their content, it seems clear that the domain of life to which worry refers is a facet that should be included in any
conceptual definition of worries. A second facet of worries that should be included in a definition is suggested by an examination of the nonclinical literature. Work in sociology (e.g., Mufune, Osei-Hwedie, and Mwansa, 1991), developmental psychology (e.g., Gillies, 1989), psychopathology of adolescence (e.g., Kaufman, Brown, Graves, Henderson & Revolinski, 1993), and social psychology (e.g. Breakwell, Fife-Shaw, and Devereux, 1988) suggests that worries are not necessarily pathological or dysfunctional.

Boehnke, Macpherson, Meador and Petri (1989) were among the first to argue explicitly that certain types of worries might be related to positive mental health. They found that worries about problems close to self (e.g., my getting cancer, bad grades, or looking ugly) correlated with poor mental health among adolescents, as reported by their parents. In contrast, worries about wider socio-political problems (e.g., pollution, hunger in world) correlated with positive mental health. Others, too, have reported that worries about problems external to the self or to one's interpersonal relations are either positively related to well-being (Boehnke et al., 1994; Doctor, Goldenring & Powell 1987; Griffin and Prior, 1990) or unrelated to indexes of mental health (Boehnke, 1996).

How might the types of worries that correlate positively with mental health differ from those that correlate negatively with mental health? We postulate that the crucial distinction between these types of worries is not the life domain. Rather, as suggested by the studies
is threatened. What we call "micro" worries have as their object the self or those with whom the person closely identifies (the in-group or extensions of self). On the one hand, micro worries may cause poor mental health. The more people worry about possible threats to self, the more anxious or depressed they get. Intense micro worry is likely to interfere with or undermine the actions and capacities needed to cope with threat, leading to poorer outcomes for the person, an escalation of negative affect, the problems of adaptation (Brown, Moras, Zinbarg, and Barlow, 1993, Molina & Borkovec, 1994, Tallis, Davey and Bond, 1994). On the other hand, poor mental health may cause micro worry. The more anxious depressed people are, the more threatening potential problems are likely to appear to them. They are likely to assess their ability to cope with threats as less adequate, and hence to worry more about these threats. Finally the occurrence of events that threaten the self directly cause relevant micro worries and undermine mental health.

Individuals who suffer from poor mental health may be so preoccupied with their own problems that they have neither the time nor the psychological energy to attend to problems external to the self or to extensions of self. Those enjoying positive mental health are less self-preoccupied and are therefore able to attend to problems in the society and world around them that concern the welfare of others (Hamilton, Lynch, Naginey, Peters and Piske, 1989). Thus poor mental health precludes macro worries and good mental health permits them.
The current conceptualization of worries suggests two facets of worries: (1) The object whose welfare is threatened (e.g., self, in group, society, world); (2) the domain of life to which worry refers (health, finances, safety, etc). Levy and Guttman (1975) designated object and domain facets as part of their definition of worries, though in somewhat different terms than ours. Bronfenbrenner (1986) provides one rational for expecting that four objects may be distinguishable. He theorized that four different levels of social ecology that parallel the four objects of worries (self in group, society, world) are important for understanding human development and behaviour. Levy and Guttman (1975) distinguished three objects of worries: self and family, the state, and a residual category of other objects. They conducted empirical analysis for the community as a whole. However, in order to identify the life domains of worries, it is desirable to examine as comprehensive a potential set of domains as possible. As another source of ideas for potential domains, that is the comprehensive set of motivational types of values indentified by Schwartz (1992). Values are relevant because they point to the desired end states that people seek to attain or maintain in life. Worry is elicited when the attainment or maintenance of these desired states is threatened. On these bases, we identified seven potentially distinct life domains: health, safety, environment, social relations, meaning (in life), achievement (in work and studies), and economics.

The number of different life domains of worries that individuals actually discriminate is an empirical question. To the extent that domains
that domains are distinct, they should have different influences on the
intensity. Life domains should elicit measurably different reactions from
respondents. Empirically, the intercorrelations among the full set of
worries should reveal subsets of worries that represent identifiable life
domains.

Winston Churchill once said: "When I look back on all these
worries I remember the story of the old man who said on his death bed
that he had a lot of trouble in his life, most of which never happened" (Peter, 1977). Most past theory and research had conceptualized worries
as a subtype of anxiety whose presence serves as an indicator of poor
mental health (reviewed in Davey & Tallis, 1994; Eysenck, 1992).
Boehnke, Schwartz, Stromberg and Sagiv (1998) distinguished two types
of worries, according to the object whose welfare is threatened "Micro"
worries have as their object the self or those with whom one identifies
closely (in group or extension of self). "Macro worries have as their
object entities external to the self the wider society world, or universe.
They theorized and presented data to support the view that micro
worries (e.g. "that my parents will die") are indeed related both to
cognitive and affective indexes of poor mental health. On the other
hand, macro worries (e.g. "unemployment in our country") are unrelated
to mental health or, perhaps even positively related to well-being (e.g.
Boehnke, 1995, Doctor, Goldenring, & Powell, 1987; Griffin & Prior,
1990).
Boehnke, Schwartz et al. (1998) suggested a second facet on which worries differ, in addition to the object (micro/macron) facet. Each worry refers to a particular domain of life. Seven different domains of life cover the domains proposed in various worries instruments; health, safety, environment, social relations, meaning in life, achievement in work and studies and economics. Each worry combines at least one element from the object facet and one from the domain facet. For example, the worry "hostility of people in the world to one another" combines the macro object with the social domain, and the worry "my life being boring" combines the micro object with the meaning domain. The object and life domain facets of worries cross-cut one another and are conceptually independent. The conceptual definition of worries proposed by Boehnke, Schwartz et al. (1998), and supported in their research can be summarized as follows: A worry is an emotionally disturbing cognition that a state of an object (micro or macro) in some domain of life (health, safety, etc.,) will become (or become more, or remain) discrepant from its desired state. This broad definition applies both to the daily worries that may plague anyone and to the prolonged, intense and uncontrollable worries associated with severe anxiety (Borkovee, Robinson, Pruzinsky & Depree, 1983). The idea that worries entail a perceived discrepancy from the desired state of an object is the key to the theoretical link we will draw between worries and personal values. As goals, a person's values point to the broad states that he or she views as more or less desirable. One who values social justice highly, for e.g., can usually be assumed to desire a state of justice in the
world, whereas one who attributes little importance to this value typically cares little about the state of justice in the world. And one who values fame is likely to view public recognition as a desirable end-state, a state rejected by one who values humility. If values define the desired states a person pursues, and worries entail perceived discrepancies from these desired states, than a person's worries should be a function of his or her values. Adopting a social cognitive perspective (Markus & Zajonc, 1985, Pervin, 1989) it specify three mechanisms that may link individual differences in value priorities to individual differences in worries.

**Life Domains of Worry** : Life domains, the second orthogonal facet of worry, specify different types of desired states may that be threatened. The worries in a particular life domain should therefore correlate most positively with the values whose motivational goal corresponds most closely to the desired state of the life domain. For e.g. the intensity of worries about achievement in work or studies should correlate most strongly with the importance of achievement values. Negative correlations should be found when the motivational goal of the values conflicts with the desired state of the life domain. For e.g. the intensity of safety worries should correlate negatively with the importance of stimulation values.

These expectations are consistent with the emphasis in social psychology on specificity as a key to relations among attitudes - behaviour associations are stronger the more the features of the two sets of variables correspond (Ajzen and Fishbein, 1977).
A study conducted by Sjoberg, Lennart (1998) on worry and risk perception. Results shows that perceived risk and worry are indeed weakly correlated.

Joormann, Jutta and stober, Joachim (1997) studied about the Measuring facets of worry. This study, therefore, examined the Worry Domains Questionnaire (WDQ's) structure by use of confirmatory factor analysis comparing models of different factor structures. In the 1st sample of 466 participants, a 5 - factor model yielded the best fit to the data, characterized by highly correlated yet distinct domain of every day worrying as they were originally proposed. This model was cross-validated with a second sample of 503 participants, showing stable factor loadings across samples. Whereas these analysis displayed a good fit of the five factor representation for the item based models, overall fit of all models was more prominent when items were aggregated.

Zebb, Barbara J. and Beck, J. Gayle (1998) studied that "Is there really a difference between Worry and Anxiety". This study conducted upon 189 university students (aged 17-51 yrs). Three worry scales and 4 measures of anxiety were compared in relation to measures of negative affect (e.g. depression, confusion) tended to be more closely related to anxiety than to worry. Where as problem-solving style tended to be more closely related to worry than to anxiety. Personal control did not show a differential relationship to anxiety or worry. However, negative affect, perceived problem solving abilities and personal control were more strongly related to worry than to anxiety.
A study carried out by Borkovec, T.D.; Ray, William J. and Stober, Joachim (1998) describes worry as a cognitive phenomenon intimately linked to affective, physiological, and interpersonal behaviour process. It suggests that the very private experience of worry is developmentally connected to enmeshed childhood relationship with the primary care giver and is currently associated with significant interpersonal problems, especially those involving tendency to be overly nurturing to others. At the physiological level worry is characterized peripherally by parasympathetic deficiency and autonomic rigidity and centrally by left-frontal activation.

Dugas, Michel J., Fresstom, Mark H.; Ladouceur, Robert; Rheaume, Josee et al. (1998) studied the worry themes in primary generalized anxiety disorder and secondary generalized anxiety disorder and other anxiety disorders. The result suggested that primary GAD worry more about the future as compared to secondary GAD. Although worry about immediate problems may not differentiate GAD patients from other anxiety disorder patients, high level of worry about future events may be a distinguishing feature of GAD.

ALIENATION

Alienation means the display of such life relationships of a subject with the surrounding world in which the products of the subject's activity, the subject himself, as well as other individuals and social groups, are conceived as opposite to the subject, this opposition ranging from
difference to rejection and hostility. This is expressed in corresponding emotional experiences, viz, feeling of isolation, solitude, rejection, loss of one's ego, etc. The notion of alienation should not be confused with the alienation of the personality in an antagonistic class society. As a social process, Alienation is characterized by the transformation of man's activity and also of man's properties and capabilities into something independent of and dominant over the person in question. In social psychology, Alienation is used to characterise interpersonal relations in which the individual is set off against other individuals groups and the whole of society to come to experience a certain degree of isolation. Such conflicting relations within a group are caused by the fact that the values, conditioning joint activities are violated, and also by loss of the feeling of solidarity, when an individual in the given group perceives the other group members as alien and hostile to himself, rejecting their common norms, laws and prescriptions. Social psychologists in the west explain such alienation primarily by individually typical traits of personality. Sigmund Frued used the concept to explain the pathological development of a personality in culture alien and hostile to man's natural character, this showing in the neurotic loss of one's individuality (depersonalisation). In this case, Frued, thought that the unconscious is the decisive factor in individual behaviour, which in his view, leads to antagonism between that individual and the social environment. In child psychology, the notion of alienation is applied to express the essential factor in the establishment of the child's self-consciousness, in the development of his reflexive ability.
In early age, the child feels merged with the surrounding world, unable to distinguish himself from his vital activity. In the later stages of ontogenesis, the notion of alienation towards himself, adults, equals norms of behaviour and social demands that are expressed in rejection, disagreement, negativism. Basing on joint activity and communication, the individual develops an ability to look upon himself through the eyes of other people and to accept their attitudes.

The term alienation is derived from the original Latin noun which in turn is derived from the Latin verb alienare meaning 'to take away' or 'remove' (Klein, 1966). The Latin usage of the term alienation has resulted in two distinct meanings of the concept. The first meaning was derived from the Latin usage of the term in the context of transfer of ownership of property. In this context the use of the term alienation meant the "transfer of ownership of something to another person". The second meaning of alienation was derived from the Latin usage of the verb alienare meaning "to cause a separation to occur". In this sense, alienation referred to a "state of separation or dissociation" between the two elements (Klein, 1966).

The term alienation is a good example of 'Panchreston' - a term coined by Hardin (1956) to refer to scientific concepts which is attempting to explain all, essentially explain nothing.

The concept of alienation has a long history in theology, philosophy and social criticism, and a much shorter one in contemporary social sciences. It is the very diversity of this legacy which has
contributed to both the richness of the intellectual tradition of the concept and the ambiguity that currently surrounds it (Finifter, 1972).

In psychology and psychiatry, alienation is considered as a state of psychological isolation, interpersonal distrust, lack of feeling of competence, uncrystalized sense of identity and feeling that the individual lacks meaning and authenticity in his life. When the link between the individuals 'real' and 'ideal self' is lost, selfestrangement or the alienation from the self is experienced.

The term alienation owes its derivation from the word 'alien' meaning 'foreign'. If this is the meaning that is chosen, then a man who is alienated would in some sense be foreign or separated from himself. He is a stranger in his own society, one who does not belong to anywhere or anybody. The concept of alienation originated with Hegel who used it to denote the distance between mind and reality, and denotes states causing self-alienation, loss of self identity and a feeling of depersonalization the cause of which is traced back to some environmental pressures.

According to the 'existentialists' view, it is a separation of the individual from the real self, because of preoccupation with abstractions, and the necessity for conformity to the wishes of others and the dictates of social institutions. The alienation of contemporary man from others, and from himself is one of the dominant themes of the existentialists. Seeman (1959) states that alienation refers to a more comprehensive relationship between personality and social system than does deprivation.
Alienation is the condition of feeling of distinct from, isolated from, and to some degree opposed to the dominant social group. Seeman (1959, 1967) classifies the concept of alienation in terms of five major components one of these being the sense of powerlessness. The alienated ones believe themselves powerless to influence their own lives or the lives of others. Social introversion and depression characterize alienated individuals as reported by Gould (1969).

Seeman (1971) has pointed that the concept of alienation has been popularly adopted as the signature of the present epoch. It has become routine to define our troubles in the language of alienation and to seek solutions in those terms. But signatures are sometimes hard to read, sometimes spurious and sometimes too casually used. They ought to be examined with care". Similar concern was expressed by Johnson (1973), who characterized the concept of alienation as being capable of carrying a deal of feeling"in an inexplicit, perplexing, and deeply annoying way". Although in recent years many psychologists and sociologists have attempted to demystify and operationalise the concept (Lawler & Hall, 1970; Lodahl and Kejner, 1965; Saleh & Hosek, 1976; Seeman, 1971; Vroom, 1962), none of them seem to offer a scientifically organized and meaningful view of the concept that could have broad generality across cultures.

In an extensive survey of various phenomenon of alienation, Schacht (1970) has discussed the central semantic connected with the term. Stripped to its essence the word signifies separation (distance) between two or more entities.
Alienation refers to certain perceptions and feeling that some people have about themselves, and about one or more aspects of their social environment, as these two (self and environment) relate to one another. An alienated man is any person drifting in a world that has little meaning for him, and over which he exercises little power, a stranger to himself and to others. Social scientists and mental health professionals have begun to see evidence of widespread alienation as a major element of modern life.

For Horney (1946) a developing child's failure to fulfill his needs leads to the experience of "basic anxiety"; this leads to a process of negation of the 'real self' and its substitution by the 'ideal self' whose characteristics are designed to manipulate the environment to meet these unfulfilled needs when the link between the individual's real 'ideal self' is lost, selfestrangement or the alienation from the self is experienced. Horney (1946) comments, "we cannot suppress or eliminate essential parts of ourselves without becoming estranged from ourselves... the person looses interest in life because it is not he who lives it, he cannot make any decisions because he does not know what he really wants; if difficulties mount he may be pervaded by sense of unreality - an accentuated expression of his paramount condition of being unreal to himself.

For Horney (1950), alienation is remoteness from the real life. It refers to deformation and impairment of the total personality. The modern man becomes more and more alienated from himself, from his
fellowman, leisure, body and sex, from his feeling and his creative potentials. Thus, all pervasive alienation has become the main phenomenon of our culture. Fromm (1955) emphasised that alienation in the modern society is almost total. It pervades the relationship of man to his work, the things he consumes, his fellowman and to himself, when he is unable to maintain these relationships, he is in a state of alienation. According to Sullivan (1953), the goal of human behaviour is to become an acultured social being by way of relationship with others, common living with them, and attainment of status and recognition among them. The alienated individual does not experience himself to be a member of society which he could not have close relationship. Thus, alienation is related to Sullivan's conceptualization of interpersonal behaviour.

Fromm (1955) used the term alienation in the contemporary social psychological literature. He elaborated Marx's concept of alienation and adopted to contemporary situation. He defined alienation as "a mode of experience in which the person experiences himself as an alien. He has become estranged from himself. He does not experience himself as the centre of his world, as the creator of his own acts but his acts and their consequences have become his masters whom he obeys or whom he may even worship". The alienated person is not having contact with himself and with any other person. Fromm finds alienation in modern society almost total which pervades the relationship of men to his work to the things he consumes, his fellows and to himself.
According to Hajda (1961), alienation is an individual's feeling of uneasiness or discomfort which reflects his exclusion or self exclusion from social and cultural participation. It is an expression of no belonging or non-sharing, an uneasy awareness or perception of unwelcome contrast with others. In this sense, alienation, is a social phenomenon, a feeling that may be experienced in some fashion by any member of a given society.

According to Fromm (1963), self-alienation involves a lack of contact between an individual's conscious-self, and his productive potential. By alienation he meant a mode of experience in which the person experiences himself as an alien. He becomes estranged from himself.

Gould (1966), defined alienation as a general or core syndrome consisting of feelings of pessimism, cynicism, distrust, apathy, and emotional distance. According to him, "this syndrome consists of a composite of personality and attitude dimensions including the following a devaluation of peers; a generalized distrust of others; a rejection of socially approved "rules" of interpersonal conduct; social introversion, psychic and somatic complaints; depression and "yes saying" with its various psychodynamic implications of conflicts, poor impulse control, ambivalence, and a disparity between feelings and behaviour."

Whittaker (1967) conducted a study on an alienated non conformist youth, locally known as non students. The profile of those non-students, as a group, indicated that they were more intellectually
oriented, less authoritarian, and tended to be more psychologically maladjusted. They were high on estheticism, complexity, autonomy, religious (liberal) orientation, and impulses expression, and lower on personal integration, anxiety level, practical outlook and masculinity.

Erikson (1968) dealt the concept of alienation with the problem of identity among young. He observed that an inability to solve the childhood conflicts may lead the school-age individual to develop an estrangement for himself and his task. According to Sidney (1970), alienation in adolescents is a mental process through which necessary physical and psychic distance from parents and society is achieved. It is a defence against painful ideas and effects associated with disruption with catharsis to past relationships.

Laing (1971) believes that the causes of alienation lies in the social structure. According to him the modern civilization separated the inner and outer layers of existence the 'mind' and the 'body', 'me here' and 'you there', experiences. Laing, is of the view that the so called 'normal' person is alienated with the split of the self, which he considers to be an essential feature of repressive normality. Laing (1967) comes down on society much harder and concludes that the whole question of abnormality is simply social lack of crystalization of his identity contributes towards his psychological alienation because without knowing who one is, the individual is not sure of the meaning of his experiences and his self worth without which the capacity to have bounds of affection, relation with others remains ineffective.
According to Coleman (1976) alienation is the consequence of anomie. 'Anomie' refers to a state of disregulation in which mutually agreed upon social norms are no longer effective in controlling man's action. It is a disruption of value system so that there is a "lack of widely shared norms to guide and control". Its symptoms are break up in relationships. Alienation according to Coleman (1976) is reflected in rootlessness, a lack of authentic relationship with others, a confused sense of self-identity, inability to find satisfying values and meanings and a belief that one is powerless to do anything that will have any significance or effect.

James (1978) characterised alienation by three independent dimensions: (a) a feeling of personal incapacity, (b) a rejection of conventional rules, (c) a rejection of conventional criteria for success.

Dictionary of Psychology (1988) defines alienation as 'a feeling of being completely an alien or a stranger to the surroundings one exists in. It is a feeling of apartness, strangeness, the absence of warmth or friendly relationships with people." (Berne, Atkinson and Woodworth, 1988).

In the various attempts that have been made to define alienation, little attention has been given to the distinction between alienation from self and alienation from society (Srole, 1956, Nettler, 1957, Dean, 1961, Hajda, 1961). Because of the failure to make this distinction the characteristics that define alienation for one theorist may be precisely those which distinguish the non-alienated man in the eyes of another theorist.
Seeman's variants of alienation (1959) include conceptions of self and social alienation. Browning, et al. (1961) made an attempt to overcome the adhoc nature of Seeman's presentation eliminates the self estrangement.

Featherman and Otto (1975) showed that the two forms of alienation i.e., self-estrangeent and powerlessness are affected by different patterns of structural and personality antecedents. Originating at various stages in the first half of the life-cycle. McKinney (1975) in a study found that alienation, which is characterised by lack of value clarity was related to LOC. Alieatioin was significantly higher in subjects who were externally than those who are internally controlled.

Sexton (1983) found that alienation and dogmatism were positively related concepts. Alienation and dogmatism were associated with several commonly hold personality traits that centred around anxiety, low self-esteem, social estrangement, manifested feelings of hostility, aggression, loneliness, rejection and isolation.

To make the distinction between self and social alienation is however, more than an exercise in conceptual clarity (Taviss, 1969). For the very phenomenon of alienation may be seen as having its origin in the self-society interaction. That is to say, alienation results from disjunction between social demands and values and individual needs and inclinations. Given tension between self and society, no ideal-type extreme forms of resolutions are possible: (1) social alienation - in which individual selves may find the social system in which they live to be
Oppressive or incompatible with some of their own desires and feel estranged from it and (2) self-alienation - in which individual selves may lose contact with any inclinations or desires that are not in agreement with prevailing social patterns, manipulate themselves in accordance with apparent social demands, and/or feel incapable of controlling their own actions. The socially alienated maintain distance from society, while the self-alienated engage in self-manipulatory behaviour so as to eliminate this distance. Although both types of alienation are indicative of tension in the self-society relationship, in the case of social alienation the onus of blame is placed on the society, whereas in the case of self-alienation the self is seen to be responsible. Hence not only is the behaviour of the socially alienated different from that of the self alienated, but the underlying attitude toward society is different.

According to Taviss (1969) social-alienation and self-alienation result from disfunctions between social demands and values, individual needs and inclinations. He added that various social changes that occurred in the Indian society over the last half century combined to produce greater looseness or flexibility in society, providing less rigid guidelines of behaviour, and leading to the self manipulatory activities of self-alienation.

In this present study investigator has taken the sample of kith and kins of chronic disorders patients. Therefore, it becomes necessary to give clinical description of those diseases which have been into consideration.
Description of Diseases:

1) Bronchial Asthma: Bronchial asthma is a common disease; 15% of children report an episode of wheezing characteristic of asthma within the previous year, 5% have a diagnosis of asthma, and 1% have severe disabiling asthma. In adults, 2-5% have a clinical diagnosis of asthma. Asthma prevalence has increased over the past few decades and until recently this trend was matched by a slow increase in asthma deaths (currently 1800/ year in England and Wales). While air pollution is not causally linked to asthma, there is little doubt that it can contribute to asthma morbidity and mortality.

Asthma is defined as a chronic inflammatory disorder of the airways, characterised by reversible airflow obstruction causing cough, wheeze, chest tightness and shortness of breath. Inflammation of the bronchial wall involving eosinophils, most cells and lymphocytes, together with the cytokine and inflammatory products of these cells, induces hyper-responsive ness of the bronchi so that they narrow more readily in response to a wide range of stimuli. Narrowing of the airway is usually reversible, but in some patients with chronic asthma and bronchial wall inflammation may lead to irreversible obstruction of airflow. The airflow obstruction, which characteristically fluctuates markedly causes mismatch of alveolar ventilation and perfusion and increase the work of breathing. Being more marked during expiration it also causes air to be 'trapped' in the lungs. A narrowed bronchus can no longer be effectively cleared by coughing up the mucus formed by the
disease process, and many of the bronchi become obstructed by mucus plugs. This is usually a conspicuous finding at autopsy. Respiratory arrest may occur within a few minutes after the onset of a severe episode. Death from asthma may also occur from alveolar hypoventilation and severe arterial hypoxaemia in the patient exhausted by a prolonged attack.

2) (i) Osteoarthritis: OA (OA, osteoarthrosis or degenerative joint disease) is not a single disease. Rather it is the end result of a variety of patterns of joint failure. To a greater or lesser extent it is always characterised by both degeneration of articular cartilage and simultaneous proliferation of new bone, cartilage and connective tissue. The proliferative response results in some degree of remodelling of the joint contour. Inflammatory changes in the synovium are usually minor and secondary.

Clinical Features: The joints most frequently involved are those of the spine, hips, knees and hands. The disease is confined to one or only a few joints in the majority of patients. Osteoarthritis with prominent involvement of the knees and hands as well as osteoarthritis confined to the knees or hips. The symptoms are gradual in onset. Pain is at first intermittent and is provoked by the use of the joint and relieved by rest. As the disease progresses, movement in the affected joint becomes increasingly limited, initially as a result of pain and muscular spasm, but later because of capsular fibrosis, osteophyte formation and remodelling of bone.
ii) Rheumatoid Arthritis: Rheumatoid Arthritis is the most common form of chronic inflammatory joint disease. In its typical form, Rheumatoid Arthritis is a symmetrical, destructive and deforming polyarthritis affecting small and large synovial joints, with associated systemic disturbance, a variety of extra-articular features and the presence of circulating antiglobulin antibodies (rheumatoid factors). Characteristically, the course of the disease is prolonged with exacerbations and remissions but a typical, asymmetrical and incomplete forms are not uncommon.

Clinical Features: In the majority of patients the onset is insidious, with joint pain, stiffness and symmetrical swelling of a number of peripheral joints, but other disease patterns can occur. Initially, pain may be experienced only on movement of joints, but rest pain and prolonged early morning stiffness are characteristic features of all kinds of inflammatory arthritis.

3) Coronary Heart Disease: Heart Disease gives rise to relatively limited range of symptoms. Differentiation of disease conditions therefore requires emphasis on factors which provoke the symptoms and subtle differences in the way in which they are described by the patient.

Symptomatic Features:

Angina: This is a chocking or constricting chest pain which comes on with exertion, is relieved by rest, and is due to myocardial ischacmia. It is commonly felt retrosternally and may radiate to the left or more rarely the right arm, to the throat, jaws and teeth, or through to the back. The
pain may be described as squeezing, crushing, burning or aching, but seldom stabbing. Patients may describe a choking sensation simulating breathlessness.

The pain may be brought on or exacerbated by emotion, and is frequently made worse by large meals or a cold wind. It is relieved by nitrates. Unstable angina describes a pattern of severe angina which may be precipitated by minimal exertion, or may occur spontaneously, and may culminate in infarction.

**Myocardial Infarction**: The pain is similar in nature and distribution to angina but is more severe, persists at rest, and does not respond to nitrates. These are usually features of sympathetic nervous system activation and vomiting is common. There may be anxiety and a frightening feeling of impending death. In some patients and especially the elderly, the symptoms are atypical and may stimulate other conditions.

**Aortic Dissection**: The pain is severe, sharp and tearing, often felt in or penetrating through to the back, and to abrupt in onset.

**Pericarditic Pain**: This is felt retrosternally to the left of the sternum, or in the left or right shoulder. It characteristically varies in intensity with movement and the phase of respiration. It is described as 'sharp' and may catch the patient during inspiration or coughing.

**Musculoskeletal Chest Pain**: It may vary with posture or movement; can be brought on by exertion but often does not cease rapidly on
resting; and is very commonly accompanied by local tenderness over a rib or costal cartilage.

**Oesophageal Pain**: The pain can mimic that of angina very closely, is sometimes precipitated by exercise and may be relieved by nitrates. It is usually possible to elicit a history relating chest pain to eating, drinking or oesophageal reflex. It may coexist with angina.

4) **Cancer**: Cancer is a malignant tumor or a maligneoplasm. Neoplasm or tumor is 'a mass of tissue formed as a result of abnormal, excessive, uncoordinated, autonomous and purposeless proliferation of cells. The branch of science dealing with the study of neoplasms (cancer) or tumors is called oncology (oncos = tumour, logoo = study). Neoplasms may be 'benign' when they are slow growing and localised without causing much difficulty to the host, or 'malignant' when they proliferate rapidly, spread throughout the body and may eventually cause death of the host. The common term used for all malignant tumours is cancer coined by 'Hippocrates'. The word 'cancer' means crab thus reflecting the true character of cancer since, it adheres to any part that it seizes upon in an obstinate manner like crab.

Cancer is of 3 types:

1) Carcinomas.
2) Sarcomas.
3) Undifferentiated.

**Grading and staging of cancer**: 'Grading' and 'Staging' are the two systems to determine the prognosis and choice of treatment after a
malignant tumour is detected. Grading is defined as the macroscopic and microscopic degree of differentiation of the tumour, while stating means extent of spread of the tumour within the patient.

**Risk Factors**: Based on the epidemiological studies, a number of endogenous host factors and the environmental factors have been implicated in predisposition to neoplasia.

They are described below:

1) **Hereditary Factor**: In general, the risk of developing cancer in relatives of a known cancer patient is almost three times higher as compared to control subjects. For example, retino blastoma, neurofibromatosis, cancer of the breast etc.

2) **Environmental and Cultural Factor**: We are surrounded by an environment of carcinogens which we eat, drink, inhale and touch. For example: Cigarette smoking, Alcohol abuse, tobacco, cancer of cervix, penile cancer, betel nut cancer, industrial and environmental substances certain constituents of diet.

3) **Age**: Generally cancers occur in older individual's past 5th decade of life, but this is not definite.

4) **Sex**: Most tumours are generally more common in man than in women except cancer of the breast, gall bladder, thyroid and hypopharynx. Cancer of the breast is the commonest cancer in women throughout the world while lung cancer is the commonest cancer in men. The differences in incidence of certain cancers in the two sexes may be
related to the presence of specific sex hormones.

5) **Acquired conditions**: A large number of tumours; agents which can induce tumors are called carcinogens.

Carcinogens are a variety of extrinsic agents which are broadly divided into 4 groups:

a) Chemical carcinogens  
b) Physical carcinogens  
c) Hormonal carcinogens  
d) Biological carcinogens

**Clinical Aspects**: When the diagnosis of cancer is suspected on clinical examination and on the other investigations, it must be confirmed. The most certain and reliable method which had stood the test of time is the histological examination of biopsy, though recently many other methods to arrive at the correct diagnosis these are 1) Cytological Methods 2) Tumour Markers (3) Immunological methods.

5. **Diabetes**: Diabetes mellitus is a chronic clinical syndrome characterised by hyperglycaemia due to deficiency or defective response of insulin. It is estimated that approximately 1% of population suffers from diabetes mellitus. Insulin is elaborated by the pancreas.

**Classification**: Diabetes mellitus is of two types.

1) Primary or idiopathic diabetes.  
2) Secondary diabetes.
(1) Primary or idiopathic diabetes mellitus the common form is currently divided into two major categories.

(i) Type I diabetes previously also termed juvenile onset diabetes, or insulin dependent diabetes mellitus (IDDM).

(ii) Type II Diabetes, previously also called maturity onset diabetes, or non-insulin dependent diabetes mellitus (NIDDM). It is further divided into two types: Obese and non-obese type II diabetes.

**Etiopathogenesis in Type I Diabetes**: In type I diabetes there is deficiency of insulin resulting from reduction in B cell mass. These patients therefore, respond to exogenously administered insulin. Currently, the pathogenesis of type I diabetes is explained on the basis of three sufficient evidences in support. These are: genetic susceptibility, autoimmunity and certain environmental factors.

**Etiopathogenesis of Type II Diabetes**: Type II diabetes or maturity-onset diabetes, or non insulin dependent diabetes mellitus (NIDDM), is more common and constitute 80-90% cases of diabetes. Type II diabetes is further of two subtypes - obese and non-obese.

(i) Genetic factors (ii) obesity (iii) Insulin receptor defect.

Type II diabetes is a complex multifactorial disease involving disturbed insulin secretion and 'insulin resistance' due to genetic factors, obesity and fault in the insulin receptors.

(2) Secondary diabetes mellitus is occurrence of hyperglycaemia associated with some identifiable causes such as due to chronic
pancreatitis, post panceatechomy, hormone-producing tumours, certain drugs, haemochromatosis and genetic endocrinologic disorders.

6) **Tuberculosis**: Tubercle bacillus or Koch's bacillus (named after discovery of the organism by Robert Koch in 1882) called *Mycobacterium tuberculosis* causes, tuberculosis in the lungs and other tissues of the human body. The organism is a strict aerobe and thrives best in tissues with high oxygen tension like in the apex of the lung.

**Incidence**: Factors contributing to higher incidence of tuberculosis are malnutrition, inadequate medical care, chronic debilitating conditions like uncontrolled diabetes, alcoholism etc. and immuno compromised states like AIDS.

**Mode of Transmission**: Human beings acquire infection with tubercle bacilli by one of the following routes.

1) Inhalation of organisms present in fresh cough droplets or in dried sputum from an open case of pulmonary tuberculosis.

2) Ingestion of the organisms leads to development of tonsillar or intestinal tuberculosis. Due to self-swallowing of infected sputum of an open case of pulmonary tuberculosis or ingestion of bovine tubercle bacilli from milk of diseased cow.

3) Inoculation of the organisms into the skin.

4) Transplacental route from mother to foetus.

**Spread of Tuberculosis**: The disease spreads in the body by various routes.
a) Local spread.
b) Lymphatic spread.
c) Haematogenous spread.
d) By the natural passages.

Hypersensitivity and Immunity in Tuberculosis: Tubercle bacilli as such do not produce any toxins. Tissue changes seem in tuberculosis are a result of host response to the organism.

Types of Tuberculosis: Lung is the main organism affected in tuberculosis. Depending upon the type of tissue response and age, the infection with tubercle bacilli is of 2 main types.

(i) Primary Tuberculosis: The infection of an individual who has not been previously infected or immunised is called primary tuberculosis or Ghon's complex or childhood tuberculosis.

(ii) Secondary Tuberculosis: The infection of an individual who has been previously infected or sensitised is called secondary tuberculosis. Secondary tuberculosis occurs most commonly in lungs.

Clinical Features of Tuberculosis: The clinical manifestations in tuberculosis may be variable depending upon the location, extent and type of lesions. However, in secondary pulmonary tuberculosis which is the common type, the usual clinical features are as under.

1) Referable to lungs: Such as productive cough, may be with haemoptysis, pleural effusion dyspnoea, orthopnea etc. Chest X-ray may show typical apical changes like pleural effusion, nodularity miliary or diffuse infiltrates in the lung parenchyma.
2) Systemic features - such as fever, night sweats, loss of weight and appetite. Long standing and untreated cases of tuberculosis may develop systematic secondary amyloidosis.

**HYPERTENSION**

Systemic hypertension i.e.an elevated arterial blood pressure, is a major health problem, particularly in the developed countries. Hypertension is associated with increased risk for a variety of cardiovascular disorders and is a major risk factor for atherosclerosis. Treatment of hypertension can prolong life. A persistent and sustained high blood pressure has damaging effects on the heart (hypertensive heart disease), brain (stroke or cerebrovascular- accident), kidneys (benign and malignant nephrosclerosis) and eyes (hypertensive retinopathy).

Hypertension is generally classified into 2 types :

1) Primary or essential hypertension in which the cause of increase in blood pressure is unknown. Essential hypertension constitutes about 90-95% patients of hypertension.

2) Secondary hypertension - in which the increase in blood pressure is caused by diseases of the kidneys, endocrines or some other organs. Secondary hypertension comprises 5-10% cases of hypertension.

According to the clinical course, both essential and secondary hypertension may be benign or malignant.

Benign hypertension is moderate elevation of blood pressure and the rise is slow as the years pass. About 90-95% patients of hypertension
have benign hypertension.

Malignant hypertension is marked and rapid increase of blood pressure to 200/140 mm Hg or more and the patients have papilloedema retinal haemorrhages and hypetensive encephalopathy less than 5% of hypertensive patients develop malignant hypertension and life expectancy after diagnosis in these patients is generally less than 2 years if not treated effectively.

ETIOLOGY

The etiology of secondary hypertension that comprises less than 10% cases has been better understood, whereas the mechanism of essential hypertension that constitutes about 90% of cases remains largely obscure. In general, normal blood pressure is regulated by 2 haemodynamic forces - cardiac output and total peripheral arteriolar resistance. Factors which alter these two factors result in hypertension. The role of kidney in hypertension, particular serum creatnine and uraemia develop soon if malignant hypertension is not treated aggressively. Approximately 90% of patients die within one year from causes such as uraemia, congestive heart failure, and cerebrovascular accidents.

Effects of Hypertension: Systemic hypertension causes major effects in 4 main organs - heart and its blood vessels, nervous system, kidneys and eyes.

RESEARCH OBJECTIVES

The main objectives of the present study are:
1. to determine the relationship between mental health and worry scores among male, female, younger and older subjects.

2. to determine the relationship between mental health and alienation scores among male, female, younger and older subjects.

3. to determine the relationship between worry and alienation scores among male, female, younger and older subjects.

4. to determine the difference between male and female, younger and older subjects in the relationship scores of mental health and worry.

5. to determine the difference between male and female, younger and older subjects in the relationship scores of mental health and alienation.

6. to determine the difference between male and female, younger and older subjects in the relationship scores of worry and alienation.

7. to determine the partial correlations between mental health and worry scores (when the variable of alienation is partialed out) among male, female, younger and older subjects.

8. to determine the partial correlations between mental health and alienation scores (when the variable of worry is partialed out), among male, female, younger and older subjects.

9. to determine the partial correlations between worry and alienation scores (when the variable of mental health is partialed out), among male, female, younger and older subjects.
10. to determine the significance of partial r at the .95 confidence interval among male, female, younger and older subjects.

11. to determine the multiple coefficient of correlations between scores actually earned and scores predicted on the mental health from the two variables worry and alienation scores (i.e. to what extent mental health scores are related to worry and alienation) among male, female, younger and older subjects.

12. to determine the significance of multiple R at the .95 confidence interval among male, female, younger and older subjects.