Chapter - I
Introduction
INTRODUCTION

Health experts are sending out an international alert that mental health problems are dramatically increasing worldwide. Data on mental and behavioural disorders account for major proportion of global burden of diseases and reveal significant and growing public health problem. Morbidity, disability and lifetime prevalence rates for any kind of psychological disorders are higher than previously thought. Rates are increasing in recent cohorts and affect nearly half the population (Kessler, McGonagle, Zhao, et al., 1994; Murray & Lopez, 2002; WHO, 2008; 2012).

In World Health Report (2001), WHO had drawn attention to the fact that nearly 45 crore estimated to be suffering from mental and behavioural disorders globally. Worldwide more than one in three people in most countries report sufficient criteria for at least one disorder at some point in their life. It had been further warned that many countries would be unable to cope with a predicted boom in mental illness over the next decade.

Recently, it has been reported that four of the 10 leading causes of disability in the United States and other developed countries are mental disorders (Sixty-Sixth World Health Assembly, WHA 66.8, May 2013). In the US, it has been estimated that about 24 percent of people 18 or older or about 44 million adults experience a mental illness or substance related disorder during the course of any given year. An estimated 2.6 percent or about 4.8 million people suffer from a severe and persistent mental illness. An additional 2.8 percent or about 5.2 million adults experience a mental illness that seriously interferes with one or more aspects of their daily life, such as their ability to work or relate to other people. 9 to 13 percent of children between the ages of 9 and 17 suffer from a serious emotional disturbance that
is, a disorder that severely disrupts a child’s daily functioning in the family, school or community. Prevalence estimates in industrialized countries indicate that from 14 to 20 percent of individuals near age 18 suffer from a diagnosable mental disorder. 27 percent of adult Europeans in all have been affected by at least one mental disorder in the past 12 months (WHO, 2008).

Documented evidences report that in India over 125 million people suffer from mental illnesses. Accordingly, nearly one percent of the Indian population suffers from serious mental disorder and 5-10 percent from moderate disorders requiring psychiatrist help. The prevalence of mental health issues ranges from 10 to as many as 370 people per every 1,000 population in various parts of the country (Ganguali, 2000; ICMR, 2005; Math & Srinivasaraju, 2010; Times of India, Oct 10, 2012).

Prevalence rates have increased due to poverty, illiteracy, urbanization, industrialization, discrimination and poor diagnostic methods. Thus, one of the most neglected invisible problem of the society in a developing country like India is the burden of mental problems, their effects and outcomes in the coming years.

What so ever, mental illnesses are associated with significant long term disability which manifests in both decreased physical and social functioning. Poor Mental health significantly contributes to a cycle of poverty where people who experience social hardship are at increased risk, and conversely those with mental illness are at higher risk of poverty. Despite potentially crippling cost of mental illness, low-income countries contribute less than one percent of their health expenditure to mental health.
Global and Hidden Burden

According to WHO fact sheet-N218 (WHO, 2001), mental health problems have the undefined and hidden burden. Mental illnesses affect the functioning and thinking processes of the individual, greatly diminishing his or her social role and productivity in the community. In addition, because mental illnesses result in disability and last for many years, they take a tremendous toll on the emotional and socioeconomic capabilities of relatives who care for the patient, especially when the health system is unable to offer treatment and support at an early stage.

The undefined burden of mental problems refers to the economic and social burden for families, communities and countries. Although obviously substantial, this burden has not been efficiently measured. This is because of the lack of quantitative data and difficulties in measuring and evaluating. The hidden burden refers to the burden associated with stigma and violations of human rights and freedom. As this burden is difficult to quantify, it is a major problem throughout the world, as many cases remain concealed and unreported.

Whatsoever, mental disorders make a substantial contribution to the global burden of diseases, a global measure of so-called disability adjusted life years (DALY’S) assigned to a certain disease, which is a sum of years lived with disability and years of life lost due to this disease. Neuropsychiatric conditions account for 14 percent of the global burden of diseases. Within non-communicable diseases, they account for 28 percent of the DALY’S more than cardiovascular diseases or cancer (World Economic Forum, 2011).

However, it is estimated that the real contribution of mental disorders to the global burden of diseases is even higher amongst others due to complex interactions and co-morbidity of physical and mental illnesses. While mental disorders include a range of illnesses, depression is the most common and is pervasive worldwide. It has also been found that the most frequent disorders
are anxiety, alcoholism, dementia, schizophrenia, somatoform and substance dependence disorders.

Using the DALYs measure, major depression ranked second only to ischemic heart disease in magnitude of disease burden in established market economies. Schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder also contributed significantly to the total burden of illnesses attributable to mental disorders (World Economic Forum, 2011).

Moreover, mental illnesses are serious medical illnesses, which cannot be overcome through will power only and are not related to a persons’ character or intelligence. Mental illnesses usually strike individuals in the prime of their lives, often during adolescence and young adulthood. Though, all ages are susceptible, but the young and the old are especially vulnerable (WHO, 2012).

Although interventions for the treatment of mental disorders are available, but the proportion of those who would need treatment but do not receive is very high. This so called treatment gap is estimated to reach about 76 to 85 percent for low and middle – income countries and 35 to 50 percent for high income countries. Even those who are treated are often treated inefficiently or in an inhuman way (Kohn, Saxena, Levav & Saraceno, 2004). Without treatment the consequences of mental illnesses for the individuals and society are staggering in the form of unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives.

Whatsoever, the treatments for mental illnesses today are highly effective and between 70 and 90 percent of individuals experience significant reduction of symptoms and improved quality of life with a combination of
pharmacological and psychosocial treatment and support systems. With appropriate effective medication and a wide range of services tailored to individual needs, most people who live with serious mental illnesses can significantly reduce the impact of their illness and find a satisfying measure of achievement and independence. For this, early identification and adherence to treatment is of vital importance. By ensuring access to the treatment and support systems that are proven effective, recovery is accelerated and the further harm related to the course of illness is minimized.

Unfortunately, mental illnesses are considered taboo and types of behavioral disorders rather than health hazards. So the rate of people coming out in public and looking for medical intervention is very low.

Stigma

Many people hold negative stereotypes of those with a mental illness and act on rigid, negative stereotypes in a discriminatory way (Byrne, 2000). In most societies mental illnesses carry a substantial stigma or mark of shame. The mentally ill are often blamed for bringing on their own illness and others may see them as victims of bad fate, religions and moral transgression, or witchcraft. The stigma associated with all forms of mental illness is strong but generally increases more as individual’s behaviour differs from that of the ‘norm’.

Stigma refers to any characteristic of a person that at least some people do not like. Stigma can include race, age, accent, physical disability or disease, unattractiveness, obesity or sexual orientation including mental illnesses (Frable, 1993; Neuberg, et al., 1994; Rodin & Price, 1995). When an individual interacts with a stigmatized person, the experience is perceived as threatening, blood pressure increases and performance is poorer (Blascovich, et al., 2001). As with any other type of prejudice, stigmatization is most often based on irrational assumptions. Nevertheless, the emotions that are aroused
may be quite strong and easily transferred to someone else. Stigma deprives people of their dignity and interferes with their full participation in society.

Stigma can be defined as a mark of shame, disgrace or disapproval which results in an individual being shunned or rejected by other. Clausen (1981) saw stigma as a buzz word, arousing more emotional reaction than words like devaluation and discrimination.

The most important theoretical work on stigma is undoubtedly done by Goffman (1963), who defined it as an attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one. Elsewhere, Goffman defined stigma as the relationship between an attribute and a stereotype. Further, Goffman (1963) differentiated three types of stigma: abominations of the body (physical deformities or handicaps), blemishes of individual character (mental disorder, alcoholism, drug addiction, homosexuality, criminality), and social impairments (race, nationality, religion, caste or class). He further emphasized strongly that stigma is a characteristic that is imputed by society to a given attribute and is not inherent in the attribute itself.

Second conceptual framework was developed by Jones, et al. (1984) in their book Social Stigma: The Psychology of Marked Relationships. They used the term "mark" as a descriptor that encompasses the range of conditions considered deviant by a society that might initiate the stigmatizing process. Stigma takes place when the mark links the identified person via attribution processes to undesirable characteristics that discredit him or her in the eyes of others. Jones, et al. (1984) identified six dimensions of stigma. Concealability indicates how obvious or detectable the characteristic is to others. Course highlights whether the stigmatizing condition is reversible over time, with irreversible conditions tending to elicit more negative attitudes from others. Disruptiveness indicates the extent to which a mark strains or obstructs
interpersonal interactions. *Aesthetics* reflects what is attractive or pleasing to one's perceptions; when related to stigma, this dimension concerns the extent to which a mark elicits an instinctive and affective reaction of disgust. *Origin* refers to how the condition came into being. In particular, perceived responsibility for the condition carries great influence whether others will respond with unfavorable views and/or punishment toward the identified offender. The final dimension, *Peril* refers to feelings of danger or threat that the mark induces in others. Threat, in this sense can either refer to a fear of actual physical danger or exposure to uncomfortable feelings of vulnerability.

Whatsoever, stigma is universal, as all societies establish the means of categorizing persons and determine which human attributes are praiseworthy and which are discrediting. Stigmatization thus varies according to time, place, and circumstance (Link, et al., 1989, 1991). Further, Link and Phelan (2001) conceptualized that stigma is entirely dependent on social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination. Groups with less power may label, stereotype and cognitively separate themselves from groups with more power. Link and Phelan (2001) constructed a definition that connects component concepts under a broad umbrella term they call stigma. In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of "us" from "them". In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes.

Stigma is also understood by the processes identified as attributions (Weiner, 1986). In this formulation, attributions about why a negative event
occurred, especially the stigmatized person's perceived control over the cause, has great influence over how others will think of and behave toward that person. Attribution theory explains that certain negative traits can discredit the person to whom they are ascribed, whereas according to labeling theory symptoms and behaviour are seen as violations of social norms or products of situations rather than as the expressions of psychopathology (Schlosberg, 1993).

Stigmatization is an interactive social process and the blame lies not only with the person carrying the stigma. It also refers to the reaction of other people, or even to include the attitude and behaviour of both the victim and the perpetrator. Accordingly, felt or internal stigma or self–stigmatization refers to the shame and expectation of discrimination that prevents people from talking about their experiences and stops them seeking help. Enacted, external stigma or discrimination refers to the experience of unfair treatment by others. Felt stigma can be as damaging as enacted stigma since it leads to withdrawn and restriction of social–support. Scheff (1998) has argued that the emotion of shame is central to stigma and that shaming processes can have powerful and hurtful consequences for stigmatized persons.

Thus, stigma is a "matter of degree" and vary across stigmatizing circumstances such as schizophrenia, depression, obesity, HIV status, short stature, diabetes, and cancer. With regards to mental illness, Cumming and Cumming (1965) theorized stigma as a "loss", a stain on one's good name, a loss of reputation, a reduced social competence. They argued that stigma acquires its meaning through the emotion it generates within the person bearing it and the feeling and behavior toward him/her of those affirming it. Thus, patients may feel shame or inferiority because they have been in a mental hospital, and this may lead them to behave in a manner that induces others to respond in ways consistent with this sense of stigma. Stigma is likely
to be felt when patients or their families cannot exempt the patient from the loss of a valued attribute.

Further, the labeling theory or "societal reaction" perspective to mental illnesses also has relevance for the conceptualization of stigma. Scheff (1966) presented a sociological model for mental illness, one that is the polar opposite to the medical or psychiatric model. Mental illness, rather than being viewed as an abnormal condition within the individual, is seen as a label attached to persons who engage in certain types of deviant activities. The symptoms and abnormal behavior characteristics of the mentally ill are taken as violations of social norms, products of situations, rather than the result of some personal predisposition or specific psychopathology. Persons labeled mentally ill structure their deviance to conform to the behavioral expectations and cultural stereotypes of the mentally ill. Chronic mental illness is thus a social role, and the societal reaction is the most important determinant of entry into that role.

More so, sociologists perceive hospitalization negatively, in terms of stigma, because it tends to reinforce the very behavior it is supposed to correct. It is then difficult for the deviant to return to his/her former level of functioning as the status of patient causes unfavorable evaluations by self and others. Labeling theory assumes that when ex-patients are re-hospitalized it is due to the effects of social rejection, conditions having nothing to do with the person's mental illness.

Whatsoever, because of stigma, persons suffering from mental illness are often rejected by friends, neighbors and employers and denied for equal participation in family life, normal social networks and productive employment, leading to aggravated feelings of rejection, loneliness and depression. Stigma has a detrimental effect on ability to access health services, the type of treatment and level of support received and acceptance in the community and
thereby recovery from mental illnesses. Mansouri and Dowell (1989) reported stigma as a significant source of distress for people with severe and enduring mental illness in a community-support programme, where it correlated with low self-esteem. Marks as ‘Mentally ill’ carries internal (secrecy, lower self-esteem and shame) and external (social exclusion, prejudice and discrimination) connotations. Rejection of people with mental illness also affects the family and caretakers and leads to isolation and humiliation.

More so, despite scientific advances and rise of the medical model, stigma has not gone away (Read & Law, 1999; Byrne, 2000). Fear of stigma is the most commonly reported reason why individual with mental health problem do not seek help (Corrigan, 2004). In this regard, Sayce (2000) argued that the focus should move from the psychiatric patient to the people or agency causing the stigma. None the less, Desforges, et al. (1991) hypothesized that contact with someone with mental illness predicts less prejudice and more positive behaviour. Corrigan and Penn (1999) believed that contact will be productive only if there is equal status between the stigmatized and stigmatizer.

Whatsoever, Jones, et al. (1984) suggested that cause of the illness shapes how society perceives individual’s personal responsibility for the condition. Stigma and perceived etiology are thus closely linked. People’s belief about the etiology of mental disorders contribute to their perception of individual with mental illness. Therefore, investigating the linkages of different causal explanations and attributions for mental illnesses with stigmatization is crucially important.

**Causal Attribution**

Causal attribution represents cognitive processes that are not understood easily through traditional concepts or easily measured through the available methodology (Solomon, 1978; Miller, et al. 1981; Watkins, 1986; White,
1991). It seems reasonable that causal attributions ultimately may be arrived at through an understanding of dispositional and situational factors as phenomena that are not static, dichotomized, and easily predictable occurrences, but fluid, dynamic, and influenced potentially by multiple variables (psychiatric labels, setting, particular behavior, theoretical orientation, sociocultural factors).

Moreover, even when the meaning of a causal attribution is clear, the attributor may perceive the cause quite differently than the researcher. As Weiner (1979) has noted, the placement of causal attribution in terms of causal dimensions may vary greatly from person to person, as well as from situation to situation. Relationships between causal dimensions and the consequences of the attribution process, such as affective reactions and expectancies of future success, suggest that people do process information concerning causality in terms of causal dimensions.

Psychiatric labels lead the observer to focus on internal causes of behavior that are indeed internally caused and to otherwise focus externally, and shape judgment properly. Certainly, in some cases, behaviors may arise in substantial part from disturbances within the person. Forming personality attributions for a behavior that is symptomatic of a person’s illness may also be justified. Jones and Nisbett (1972) coined the phenomenon “fundamental attribution error” and suggested that individuals are more inclined to attribute their own behavior to external (situational) causes, whereas an observer is more inclined to attribute the person’s behavior to internal (dispositional) causes. Penn, et al. (1994) similarly suggested that labels may be stigmatizing to the extent that they suggest the person has control over the behavior and subsequently could be “blamed” for the behavior.

As the field of psychology has developed, perceived causes of mental health difficulties have changed, and simultaneously the public’s view of what
constitutes a mental illness has evolved. Post World War II psychoanalysis promoted the belief that mental disturbances resulted from problematic relationships between parents and children, where as Star (1955) found that people did not characterize many of the disorders as mental illnesses. According to Link, et al. (1999) perceptions of mental illness have changed since 1955, as most people attributed schizophrenia and major depression to a combination of biology and stressful life circumstances. People also cited chemical imbalance in the brain, upbringing and a person’s bad character as causing various mental illnesses.

Psychosocial stress is the favored cause for mental illness, whereas biological factors are less frequently endorsed. Psychosocial stressors include life events such as the death of a loved one, relationship problems, and financial or work-related strain. These psychosocial stressors are commonly endorsed as causal for both depression and schizophrenia. Biological causes are implicated less frequently for both disorders, although they are more frequently endorsed in lay causal theories of schizophrenia than depression (Angermeyer & Dietrich, 2006; Angermeyer & Matschinger, 2005; Jorm, 2000; Jorm, Christensen, & Griffiths, 2005).

It is possible that psychosocial causes are endorsed more frequently because they are better understood by the lay public, whereas biological theories might seem more abstract and are therefore endorsed less frequently. Alternatively, the lay public might truly believe that the psychosocial factors play a greater role in causing mental illness than the biological for all disorders. Among professionals, the most widely held scientific belief is that both biological and environmental factors contribute to mental illness (Butcher, Mineka, & Hooley, 2009).
Further, the diathesis-stress model suggests that individuals with mental illness are born with a biological predisposition for mental illness, and that an environmental trigger can lead to the development of a mental illness.

According to attribution theory, the perception that an individual is capable of controlling a mental illness results in anger, whereas the perception that an individual is incapable of controlling a mental illness results in pity, sympathy, or helping behaviors toward the individual. Biological causal explanations promote the belief that individuals with mental illness are not capable of controlling their behavior, whereas environmental causal explanations promote the belief that individuals with mental illness are capable of controlling their behavior; thus, according to attribution theory, biological explanations can help reduce stigma (Link, et al., 2004). Consistent with attribution theory’s suggestion that biological explanations will have a de-stigmatizing effect, several major mental health advocacy groups have endorsed a biological model for mental illness in their efforts to combat stigma (Corrigan, et al., 2002; Phelan, 2002).

It has also been indicated that the public tend to view people as responsible for their disorders and attribute mental illnesses to low morals or weak character (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). Blame toward the mentally ill leads to anger and social avoidance. When people are educated about the biological explanation for mental illness, they are less likely to blame, avoid, or feel anger toward people with mental illnesses (Corrigan, et al., 2002; Corrigan & Watson, 2004). Thus, promoting the biological model to convey that mental illness is a brain disease reduces stigma (Corrigan & Watson, 2004).

In contrast to attribution theory, genetic essentialism holds that “genes are the unchangeable basis of a person’s identity,” and therefore, a genetic model of mental illness may worsen stigma by increasing desired social
distance and promoting the idea that mental illnesses are serious, persistent, and dangerous (Rusch, Todd, Bodenhausen, & Corrigan, 2010). It has also been pointed out that social distance is more closely linked to discrimination than is perceived responsibility, and thus, the negative effects of genetic models may outweigh the positive impact of such models. Among individuals with mental illness, a genetic model increased explicit self-reported responsibility, as well as implicit associations between mental illness and guilt.

As predicted by the genetic essentialism argument, the stigmatization of schizophrenia has increased specifically, since the medical model gained popularity (Bennett, et al., 2008). Increased public knowledge of the genetic factors of schizophrenia has led to a public rejection of and reluctance to form relationships with individuals with schizophrenia (Crisp, 2005; Bennett, et al., 2008). One explanation for this finding is that while biological explanations have been helpful in reducing stigma for purely physical disorders, they may not have the same de-stigmatizing effect for disorders with a behavioral component, such as schizophrenia (Bennett, et al., 2008).

Biological causal beliefs about mental illness lead people to desire increased social distance from the mentally ill (Griffiths & Christensen, 2004). In this regard, Phelan (2002) stated that the genetic explanation of mental illness has a weak influence on ‘casual’ social distance but a strong influence on ‘intimate’ social distance. Crisp (2005) opined that as the biological model has gained popularity, desired social distance from individuals with schizophrenia has increased.

However, biological model has a less ambiguous effect on perceptions of dangerousness than on desired social distance. Dangerousness stigma, or the perception that individuals with mental illness are dangerous, generates prejudice and discrimination toward the mentally ill. Corrigan and Cooper (2006) deconstructed dangerousness stigma by examining the prevalence rates
of violence committed by the mentally ill. They concluded that despite the weak association between mental illness and violence, the public perception is that the association is strong. Media portrayals of the mentally ill as violent have likely contributed to the perception that individuals with mental illness are dangerous. There are many negative outcomes associated with dangerousness stigma; among them are fear, avoidance, segregation, and support for coercive treatment (Corrigan & Cooper, 2006). People fear what they do not understand, and many people do not have knowledge about mental illnesses (Fink & Tasman, 1992). People often do not understand genetics either, and the pairing of two unknowns can heighten levels of stigma (Bennett, et al., 2008).

Biological explanations may also suggest that individuals with mental illness are fundamentally different and physically distinct, which exacerbates differences between mentally ill and “normal” people (Phelan, 2002). Taken to the extreme, the biological explanation may imply that individuals with mental illness are a different species (Corrigan & Watson, 2004). The biological model may increase stigma toward families of individuals with mental illness, as well. Bennett, et al. (2008) found that genetic attributions increased levels of associative stigma toward close relatives of individuals with schizophrenia. Society may begin to blame family members for passing on bad genes. Furthermore, new labels for family members, including “carrier” or “at risk,” may emerge (Phelan, 2002).

Luchins (2004) argued that changing the label of serious mental illnesses to “brain diseases” will not reduce stigma alone, and that more fundamental changes like improving treatment and financial situations of the mentally ill are necessary. He explained that the “brain disease” label for mental illnesses is problematic for three reasons: it is less descriptively accurate than the terms “mental illness” or “psychiatric illness”, it is often not substantiated by scientific evidence, and it does not target the real cause of
stigma. Luchins (2004) highlighted the difference between a mental illness and a brain disease and explained that the term “brain disease” describes neurological illnesses that involve dysfunction due to structural damage to the brain, whereas the term “mental illness” describes dysfunctional feelings, thoughts, and behaviors that do not affect brain structure. Neurological diseases can result in symptoms of mental illnesses, but mental illnesses cannot result in signs of neurological diseases. Therefore, the primary setback to the brain disease model is that it reduces mental health treatment to medication treatment; although medication alone can relieve symptoms, it cannot return an individual to normal mental health. Instead of conceptualizing mental health treatment as medication treatment, it has been suggested that understanding of physical illnesses should be broadened to include social and psychological dimensions. The most common diseases cardiovascular disease, hypertension, diabetes, and lung cancer are caused by lifestyle choices, and therefore, all illnesses, not just mental illnesses, are caused by a combination of psychological, social and biological factors.

Researchers have explored how biological and environmental causal beliefs influence stigma differently with the goal of determining which model reduces stigma more effectively. Findings have indicated that the biological and environmental model each reduce stigma in some ways and contribute to it in others (Bennett, Thirlaway & Murray, 2008; Corrigan, et al., 2002; Phelan, 2002; Corrigan & Watson, 2004; Griffiths & Christensen, 2004; Jorm & Griffiths, 2008). Angermeyer and Klusmann (1988) endorsed recent psychological factors, personal issues and family causes over biological causes.

Whatsoever, it is evidenced that perceived stigma and causal attribution of stigmatized person and caregivers have significant effect on treatment adherence. Medication adherence can be expected to reduce symptoms of severe mental illness and thus reduce victimization.
Treatment Adherence

Mental illness symptoms and bizarre behaviour can lead to tense and conflicted situations, which may result in patient’s victimization—either because others become violent toward the patient or because the patient lashes out physically and others react with stronger violence. However, by facilitating adherence and ensuring more consistent follow-up, it is possible to reduce symptoms, improve better functioning and judgments.

There are various terms used to describe behaviours related to treatment adherence. The commonest and most traditional term is compliance, which suggests a passive approach where the patient faithfully (and often without question) follows the advice and direction of the healthcare provider. It denotes a paternalistic point of view of the practitioner–patient relationship. However the term has negative connotations and suggests yielding, complaisance and submission (Vermeire, et al., 2001). Inherent to all the various definitions of compliance is the assumption that medical advice is good for the patient or that rational patient behaviour means following medical advice precisely.

Another term concordance is the patients’ considered choice. Concordance indicates the extent to which what patient thinks about what is asked matches what the health caregiver thinks the patient actually does. Similarly, adherence has also been proposed as an alternative to compliance which reduces attribution of greater power to the doctor in the doctor-patient relationship. Adherence is a collaboration between the patient and healthcare provider regarding health-related decisions. Utilizing this terminology (adherence) with the patient assists in fostering ownership and the continuation of treatment decisions by the patient. The term adherence incorporates the broader notions of concordance, cooperation and partnership. Still another term used is persistence, which is the ability to see a prescribed therapy through
to its intended completion, in other words, beginning therapy and continuing to use the medication and refill the prescription until instructed otherwise.

Adherence may be measured using either process-oriented or outcome-oriented definitions. Outcome-oriented definitions use the end-result of treatment, e.g. cure rate, as an indicator of success. Process-oriented indicators make use of intermediate variables such as appointment-keeping or pill counts to measure adherence (Urquhart, 1996). The extent to which these intermediate outcomes correlate with the actual quantities of prescribed drugs taken is unknown (Volmink & Garner, 2000; Urquhart, 1992).

While affirming the utility of the Health Belief Model, Cohen and colleagues (2000) evaluated factors that might contribute to adherence. Interestingly, marriage was the only demographic variable that was positively associated with adherence among patients with depression, suggesting that the social environment may play a role in adherence. Number of researchers (Lader, 1983; Fawcett, 1995; Sirey, et al., 2001) further emphasized the importance of the social context in health-related actions. They tested how adherence is affected by perceived stigma that is, the belief that most people will devalue and discriminate against persons with mental illness and those who use psychiatric treatment. Thus, the degree of stigma that patients perceive predict both treatment non-adherence and treatment discontinuation. Another model that highlights the role of social support systems in treatment decisions is the Network Episode model (Pescosolido & Boyer, 1999). This model conceptualizes mental health service use as a social process that is negotiated through contacts with the community, the treatment system, and social service agencies. Thus, decisions about scheduling an appointment or filling a prescription are greatly affected by contacts with others, who may or may not be supportive of the need for these services. The importance of the social environment within the context of care was also recently acknowledged.
in a number of reports that encouraged researchers to examine how health is influenced by social contexts such as families, neighborhoods, schools, work sites, and political jurisdictions (Kirchstein, 2000).

It has been shown that caregivers vary in their beliefs about the causes of depression, attributing it to psychosocial, genetic, or cognitive problems (Jacob, et al.,1987). In concordance with research on how patients' attributions of the causes of their illness can affect their treatment, caregivers' attributions and fear of stigma may have a similar effect on patients' treatment behavior. Sirey, et al (2005) hypothesized that if caregivers showed high levels of cognitive and attitudinal attributions and high levels of perceived stigma before treatment was initiated, medication adherence would be decreased, whereas high levels of medical and biological attributions would predict increased adherence.

In this regard, one of the most frustrating experience faced by medical scientists is having a recovered patient return recurrence of symptoms because the patient, his family or both together had decided to discontinue the treatment. The disappointment is compounded if the patient despite a prediction of poor outcome, had shown excellent recovery. Similar dissatisfaction is faced by psychiatrists who find their chronic psychotically ill patients relapse after discontinuing medication having shown good improvement and are now unmanageable and violent.

Whatsoever, the process of seeking, receiving and following treatment and advice has many stages and many opportunities for non-compliance. Donovan and Blake (1992) suggested different types of non-compliance including: delay in seeking care (population at risk), non participation in health programmes (screening), breaking of appointments (follow-up), failure to follow doctors instructions (treatment). Further types can be distinguished like receiving a prescription, but not having it made up at a pharmacy
(primary non-adherence), taking an incorrect dose, taking the medication at wrong times, forgetting one or more doses of the medication, stopping the treatment too soon, either by ceasing to take the medication sooner than the doctor recommended or failing to obtain a repeat prescription (secondary non-adherence) (CMAG, 2012).

All this suggests that resistance to taking drugs is profound and pervasive. Whatever be the means of defining the problem this issue has become serious and governs the future doctor patient relationship. Non-adherence to prescribed treatment regimens jeopardizes the outcome of treatment for every medical and psychiatric condition and has been called other drug problem, which is universally true.

More so, psychiatric disease itself is a significant barrier to adherence and many affected patients have complicating co-morbid conditions. Denial of illness and lack of insight compound the problems in psychiatric patients. Another difficulty is that there are number of agencies involved in a patient's care. More important is general belief system about medicines in terms of harm, overuse, side effects, benefits, etc. which at a larger extent influence treatment adherence behaviour. Thus, the complexity of issues makes diagnosis, care and treatment more difficult, with severe users being at higher risk of relapse, readmission to hospital and suicide. Over all, as a result care can be fragmented and process of recovery may be delayed.

**Recovery**

Recovery in the field of mental health services is actually a complex of ideas, which can be understood most simply as hope that someone, particularly suffering acutely from a serious and persistent mental health problem, can reclaim life or create a newly meaningful one. "Recovery-oriented" systems of care, then, are those that help rather than hinder individual in "recovery." But admittedly, that broad definition fails to capture what the range of
meanings that "recovery" in the context of mental illness means and has meant to different actors - individuals with mental illness, family members, service providers, and policy makers - over time.

Recovery is the personal process that people with mental health conditions experience in gaining control, meaning and purpose in their lives. For some, recovery means the complete absence of the symptoms of mental illness. For others, recovery means living a full life in the community while learning to live with ongoing symptoms. Recovery involves changes in the way individuals with mental health conditions think, act and feel about themselves and their lives (Anthony, 1993; Deegan, 2003).

The term has been used for many years to refer to a remission or reduction of symptoms. In 1937, Abraham Low, a psychiatrist working in state mental hospitals in Illinois founded a group called "Recovery, Inc." devoted to structured self-help groups to provide "after-care" for recently discharged hospital patients, which focused on reducing relapses through social coping skills, goal-setting, and increasing self-confidence. Certainly the concept of recovery is familiar to the field of addictions treatment (Davidson & White, 2007).

The recovery movement began in the 1970s primarily as a civil rights movement aimed at restoring the human rights and full community inclusion of people with mental health issues. Recovery approaches are viewed by the consumer movement as an alternative to the medical model with its emphasis on pathology, deficits and dependency. There is no single description or definition of recovery, because recovery is different for everyone. However, central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person’s right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination.
Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life. For others, recovery implies the reduction or complete remission of symptoms. It has been shown that hope plays an integral role in an individual's recovery. According to Anthony (1993), recovery is a shared process and experience. People face the challenge of recovery when they experience the crises of life, such as the death of a loved one, divorce, physical disabilities, and serious mental illnesses. Successful recovery does not change the fact that the experience has occurred, that the effects are still present, and that one’s life has changed forever. Rather, successful recovery means that the person has changed, and that the meaning of these events to the person has also changed. They are no longer the primary focus of the person’s life. Recovery is also seen as a unique journey into finding purpose in one's life (Davidson, 2003; Deegan, 2003; Mead & Copeland, 2000; Ridgway, 2001; Roe & Lachman, 2005; Wisdom, et al., 2008). Others included hope, acceptance, engagement in social life, active coping and reclaiming a positive sense of self in the process of recovery (Ridgway, 2001; Lovejoy, 1982; Leete, 1989; Unzicker, 1989).

Specifically, psychological recovery has been described as "...the establishment of a fulfilling and meaningful life and a positive sense of identity founded on hopefulness and self determination" (Andresen, et al. 2003). This definition is in contrast to those based on symptoms and functioning, which have become the mainstay of mental health outcome measures. In keeping with the philosophies of the consumer recovery movement, the stage model of psychological recovery and the related measures reflect the tenets of the positive psychology movement by focusing on building an authentic and fulfilling life, regardless of ongoing symptoms or treatment. Recovery is not cure, stabilization or maintenance – it is a self-directed process of reclaiming meaning and purpose in life. The goal is to become the unique, awesome,
never repeated human being that we are called to be (Deegan, 2001). With a
growing international movement to transform mental health services into
becoming recovery-oriented, the model helps to bridge the gap between
established outcome goals and demands of consumers for a more holistic
approach in mental health services. The measures offer an alternative or
complementary method of assessing an individual’s progress, or evaluating a
treatment approach or a service.

Deegan (1996) also discussed the nonlinear nature of recovery and
how recovery is frequently interspersed with both achievement and setbacks.
Glover (2012) described recovery as self-righting – a natural process that
people undertake, usually unconsciously, in response to difficulties and
distress that interrupt the status quo of daily life. Glover’s (2012) model
reflects the efforts that people undertake in their personal recovery journeys
through a set of five processes: from passive to active sense of self; from
hopelessness and despair to hope; from others’ control to personal control and
responsibility; from alienation to discovery and from disconnectedness to
connectedness. Le Boutillier, Leamy, Bird, Davidson, Williams and Slade
(2011) developed an overarching conceptual framework to aid the translation
of recovery guidance into practice.

The stage model of psychological recovery (Andresen, Oades &
Caputi, 2003, 2006, 2011) comprises four psychological processes occurring
over five stages. The psychological processes of recovery were derived from
the experiential accounts of many consumers. The four processes include,
Hope: finding and maintaining hope for recovery and a better future;
Responsibility: taking responsibility for wellness and control of life generally;
Identity: establishing a positive identity, and Meaning: finding meaning and
purpose in life. Further, the five stages of recovery are briefly described as:
Moratorium: a stage of hopelessness and self-protective withdrawal;
Awareness: the realization that recovery and a fulfilling life is possible; Preparation: the search for personal resources and external sources of help; Rebuilding: taking positive steps towards meaningful goals and Growth: a sense of control over one's life and looking forward to the future.

About the interconnectedness of personal recovery and clinical recovery. A growing number of commentators argued that the two types of recovery are complementary and support one another (Slade, 2009; Wood, et al., 2010; Glover, 2012). There is general agreement in the research that while recovery is much broader than symptom improvement, alleviation of distress associated with symptoms and assistance to manage the illness make an important contribution (Slade, 2009). There is also agreement that an increased sense of wellbeing regardless of continuing symptoms can contribute to a reduction in those symptoms or in their severity (Davidson, et al., 2006).

Accordingly, it has been deliberated that though stigma potentially limits the prospects of recovery for persons with mental illness, central areas of concern are treatment-adherence behavior, self-esteem management, and social adjustment.

On the conclusive note, it is noteworthy here that mental, neurological and behavioral disorders are common to all and cause immense suffering. More so, the undefined and hidden burden adversely affect the overall functioning. In addition, the chronic nature of these illnesses takes a tremendous toll on the emotional and socio-economic capabilities of the caregivers. Further, the stigma attached to mental illnesses is so pervasive that vulnerable population is reluctant to accept it and unwilling to seek professional help. Whatsoever, the stigmatization of person with mental illness continues to be a primary deterrent to prevention and treatment efforts. Furthermore, non-compliance and non-adherence to medical advice results in poor prognosis and repeated relapse. It has also been shown that patients as well as caregivers
vary in their causal beliefs attributing to psychosocial, cognitive, biological or genetic bases and in turn perceiving these diseases as more permanent and non-recoverable.

Thus, the complexity of diagnosis, co-morbid conditions (like, substance - dependence, negative and irrational beliefs, lack of social support, denial of illness and treatment) compound the problems in persons with mental illnesses.

Whatsoever, recent advances in psycho-physiological and neurobiological researches and technological developments have led to a new way of thinking about mental illness/health in particular, and health/illness in general as the product of a combination of factors including biological characteristics (genetic predisposition, neural mechanisms), behavioral factors (life style, stress, health beliefs) and social conditions (cultural influences, family relationships, social support).

This comprehensive bio-psycho-social model of mental health establishes the strong linkage between the various disciplines, namely psychiatry, clinical, social and health psychology, general, para and alternative medicines and healing techniques. More recent developments in the areas of positive psychology, cognitive science, neuroscience and their interdisciplinary integrations like cognitive, social and positive neuroscience have opened the new vistas of addressing mental health issues. It has been discovered that there are human strengths at subjective, individual and group level that act as buffers against mental illnesses and positively contribute to curative, rehabilitative and preventive strategies (Snyder & Lopez, 2002).

Realizing the increasing incidence and poor prognosis of mental illnesses on one hand and developments in the subjects aiding in better diagnosis, treatment and positively visualizing the flip side on the other, it is
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urgently required to enhance mental health awareness and literacy among population at large and vulnerable, at risk and victimized groups in particular. The focus on building human strengths to the forefront in the treatment and prevention of mental illnesses and to address mental health from a complete, comprehensive and holistic perspective may facilitate the advancement of the present knowledge and direct the future actions for betterment of human health.