Chapter – 1

INTRODUCTION
CHAPTER I

INTRODUCTION

Mental health is crucial to the overall wellbeing of individuals in all societies. Physical, mental and social parameters are vital for Health standards of all human beings and these are closely interwoven and deeply interdependent. No programme can be considered complete without adequate provision for the treatment of mentally ill and for the promotion of positive mental health. Mental disorders are widely recognized as a major contribution to the global burden of disease worldwide. A persistent negative attitude and social rejection of people with mental illness has prevailed throughout history in every social and religious culture. Of all the health problems, mental illness is poorly understood by the general public. Such poor knowledge and negative attitude towards mental illness threaten the effectiveness of patient care and rehabilitation. Mental disorders are not the exclusive preserve of any special group, they are truly universal. Mental health is an integral and essential component of health. The WHO preamble states that “Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”, suggesting that there is no health without mental health.

HEALTH

“Health is not mainly an issue of doctors, social services and hospital. It is also an issue of social justice.”

Health is a common theme in most cultures. In fact, all communities have their concept of health, as part of their culture. The oldest meaning of health is the “absence of disease”. In some cultures health and harmony are considered equivalent, “Harmony” being defined as “being at peace with the self, the community, God and cosmos.” The ancient Indians and Greeks shared
this concept and attributed disease to disturbances in bodily equilibrium of what they called “humours”

Modern medicine is often accused for its preoccupation with the study of disease and neglect of the study of health and there is no single yardstick for measuring health. Health is recognized as a fundamental human right and a world-wide social goal and also major instrument of overall socio-economic development and creation of a new social order.

Health is the overall condition of a living organism at a given time. It is the soundness of the body, freedom from the disease or abnormality and the condition of optimal wellbeing. People want to be healthy, but environment forces can attack the body or the person may have genetic malfunctions. The main concerns in health are preventing disease and healing damage caused by injuries and biological attacks.

The maintenance and promotion of health is achieved through different combination of physical, mental and social well-being together sometimes referred to as the “Health triangle”. The W.H.O’s 1986 Ottawa for charter for health promotion further stated that health is not just a state, but also a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources as well as physical capacities. Focusing more as lifestyle issues and their relationship with functional health, Alameda country study suggested that people can improve their health, via exercises, enough sleep, maintain a healthy body weight, limiting alcohol use and avoiding smoking. The ability to adapt and to self-manage, have been suggested as core components of human health (Alameda Country study, 2005).

WORLD HEALTH AND RELATED SOCIO ECONOMIC PROBLEMS AND TRENDS

Health problems and socio-economic problems are intimately interlinked. In many countries the health and related socio economic situation
is unsatisfactory and future trends are not encouraging. In addition, tremendous disparities exist among countries, and these are growing, disparities are also exist within countries.

Nearly 1000 million people are trapped in the vicious circle of poverty, malnutrition, disease, and despair that gaps their energy, reduces their work capacity and limits their ability to plan for the future. For the most part they live in the rural areas and urban slums of the developing countries. The depth their deprivation can be expressed by a few statistics. The average life expectancy at birth is about 72 years in the developed Countries, it is about 55 years in the developing countries. In Africa and Southern Asia, it is only about 50 years. whereas only between 10 and 20 out of every 1000 Infants born in the developed countries die during first year, the infant mortality rate in most developing countries ranges from nearly 100 to more than 200 per 1000 live births. (WHO Geneva Global Strategy for Health for All, by the year 2000). Whereas the death rate for children between 1 and 5 years old is only about 1 per 1000 in most developed countries, it averages about 20 in many developing countries and more than 30 in Africa South of the Sahara. Of every 1000 children born into poverty in the least developed counties, 200 die within a year, another 100 die before the age of 5 years, and only 500 survive to the age of 40 years.

**Causes of death and disease**

Most deaths in most developing countries result from infections and parasitic diseases. These are closely related top prevailing Social and economic Development. About a tenth of the life of an average person in a developing country is seriously disrupted by disease. The parasitic diseases in particular are chronic and debilitating, and they are endemic in most poverty-stricken areas. In the developed countries, on the other hand, about half of all deaths are due to cardiovascular diseases, a fifth to cancer and a tenth to
accidents. These problems are increasing in the developing countries too. Environmental health problems due to Industrialization and Urbanization are assuming growing importance as these same problems could affect developing countries as they build up their industries. As chronic diseases increase, people grow older. In recent years there has been a steady increase in mental disorders, and in social pathology such as Alcohol and drug abuse, Lung cancer, as well as other chronic lung diseases due to smoking and obesity due to over eating, are common phenomena.

**Under Nutrition**

In contrast, in the developing countries, under nutrition afflicts hundreds of millions of people, reducing their energy and motivation.

**Literacy**

Literacy is of major importance for health, it enables people to understand their health problems and ways of solving them, and facilitates their active involvement in Community health activities. Whereas the adult literacy rate is almost 100% in industrialized countries, it is only 28% in the least developed counties. Some 900 million adults in developing countries can neither read nor write, and only 4 out of 10 of their children complete more than three years of primary school.

**Economic Situation**

The economic situation has also a direct bearing on health, while the Gross National Product (GNP) is far from being an ideal economic indicator, particularly in relation to health for all, since it does not reflect the degree of equity in the distribution of resources, and nevertheless, it is still the economic indicator in most common use. In general, with some notable expectation, countries with a high Gross National Product, have a low infant
mortality and high life expectancy. As for the growth of the GNP per capita, the prospects for most developing countries as estimated by United Nations Bodies are that they will drop between 1980 and 1985 to less than 2% a year. The per capita income of people living in the least developed countries is likely to grow by not more than 1% a year—an average of only US $ 2 or 3 per individual. There will even be a reduction in per capita income for the more than 140 million people in the low income countries of Africa South of the Sahara.

Health System

To add on to the difficulties health systems are poorly organized in most counties of the world. Tremendous inequalities exist between the developed and developing countries. In the latter, approximately two-thirds of the population do not have reasonable access to any permanent form of health in most countries, developing and developed alike, the overwhelming proportion of resources for the delivery of health care is concentrated in the large cities. In addition, these resources are devoted to expensive, highly sophisticated technology serving a small minority of the population to the neglect of primary health care for the majority. Even in the most highly developed countries, explosive costs of health care are demanding this, although it is not really necessary.

Management

Deficient planning and management, including inadequate cooperation with other social and economic sectors, is another affliction of health care delivery system in many countries. Inadequate training in health management and the insufficient use of good managerial practices, also lead to inefficiency in the use of resources in these countries.
Health Manpower

In many countries health personnel are not appropriately trained for the tasks they are expected to perform, or not provided with the equipment and supplies they require. Health manpower varied greatly from country to country and includes a wide variety of different categories of people fulfilling different functions in different societies, depending on their social and economic conditions and cultural pattern. (Global Strategy for Health for All by the year 2000).

“Staying healthy is not a So Daunting Task” a sound health is a prerequisite for an individual to stay fit, kicking and remain in good frame, so as to be enabled to contribute one’s utmost, win laurels and in the process, lead a stress-free happy life. Sound health of people also implies a strong community and a vibrant nation. However, it is so unfortunate that a vast majority of people do not keep physically or and mentally healthy duo to ignorance, lack of health awareness and faulty lifestyle and in stray cases, want of funds. In fact many of the diseases that affect mankind can be averted by adopting simple preventive measures at home. It is with a view to impress on the necessity of keeping good health for population that WHO has earmarked 7th April as the ‘World Health Day’ (TNAI BULLETIN, 2013).

DEFINITIONS OF HEALTH

Health is one of those terms which most people find it, difficult to define. Therefore, many definitions of health have been offered from time to time, including the following

1. Health is defined as “the condition of being sound in body, mind or spirit, especially freedom from physical disease or pain” (Webster).

2. The widely accepted definition of health is that given by the World Health Organization (1948) “Health is a state of complete physical, mental and social wellbeing and not merely an absence of disease or
infirmity”. In recent years, this statement has been amplified to include the ability to lead a “socially and economically productive life”.

3. Health is the level of functional or metabolic efficiency of a living organism. In humans it is the ability of individuals or communities to adopt and self-manage when facing physical, mental or social challenges (Huber, M., 2011).

Positive Health

The state of positive health implies the notion of “perfect functioning” of the body and mind. It conceptualizes health, biologically, as a state in which every cell and every organ is functioning at optimum capacity and in perfect harmony with the rest of the body. Psychologically health is a state in which the individual feels a sense of perfect wellbeing and of mastery over his environment. Socially, as a state in which the individual’s capacities for participation in the social system are optimal (Twaddle, and Hassler, 1977).

HEALTH DIMENSIONS

Health is multidimensional. The WHO’s definition envisages three specific dimensions – the physical, the mental and the social and also include other dimensions such as spiritual, emotional, vocational and political dimensions. As the knowledge base grows, these dimensions may be expanding and these dimensions function and interact with one another, each has its own nature, and for descriptive purposes will be treated separately.

Physical dimensions

The physical dimensions of health are probably the easier to understand. The state of physical health implies the notion of ‘perfect functioning’ of the body. It conceptualizes health biologically, as a state in
which every cell and every organ is functioning at optimum capacity and in perfect harmony with the rest of the body.

A sign of physical health in an individual are: “a good complexion, a clean skin, bright eyes, lustrous hair, not too fat, a sweet breath, a good appetite, sound sleep, regular activity of bowels and bladder, easy smooth coordination of bodily movements, all senses are intact, the resting pulse rate, blood pressure and exercise tolerance within the range of normality for the age and sex. These limits are set by observation of a large number of “normal people”, who are free from evident disease.

**Mental dimensions**

Mental health is not mere absence of mental illness. Good mental health is the ability to respond to the many varied experiences of life with flexibility and sense of purpose. More recently, mental health has been defined as “a state of balance between the individual and surrounding world, a state of harmony between oneself and others, coexistence between the realities of the self and that of other people and that of environment. Although mental health is an essential component of health, the scientific foundations of mental health are not yet clear. Therefore we do not have precise tools to assess the state of mental health.

**Social dimensions**

Social well-being implies harmony and integration within the individual, between each individual and other members of the society and between individuals and the world, in which they live. Social health is rooted in “positive material environment” which focus on financial and residential matters and “positive human environment” which is concerned with the social net work of the individual.
**Spiritual dimensions**

Spiritual health in this context refers to that part of the individual which reaches out and strives for meaning and purpose in life. It is the intangible “something” that transcends physiology and psychology. It includes integrity, principles and ethics, the purpose in life, commitment to some higher being and belief in concepts that are not subject “state of the art” explanation.

**Emotional dimensions**

Historically the mental and emotional dimensions have been seen as one element. However, experts in psychology have been relatively successful in isolating these two separate dimensions. Mental health can be seen as “knowing” or “cognition” while emotional health relates to “feeling”. With this new data, the mental and emotional aspects of humanness may have to be viewed as two separate dimensions of human health.

**Vocational dimensions**

The vocational aspect of life is a new dimension. Work often plays a role in promoting both physical and mental health. For many individuals, the vocational dimension may be merely a source of income. To others, this dimension represents the culmination of the efforts of other dimensions as they function together to produce what the individual considers life “success”.

**Other dimensions**

Other dimensions are: Physiological dimension, Cultural dimension, Socio-economical dimension, Environmental dimension, Educational dimension, Nutritional dimension, Curative dimension and Preventive dimension.
MENTAL HEALTH

Mental health is the most essential and inseparable component of health. It is the state of mind in which the individual can experience sustained joy of life while working productively, interacting with others meaningfully and facing up adversity without losing capacity to function physically, psychologically and socially. It is undoubtedly a vital resource for nation’s development and its absence represents a great burden to the economic, political, and social functioning of the nation. A healthy individual is not only physically healthy, but is also mentally healthy. The modern concept of health extended beyond the proper functioning of the body. It includes sound, efficient mined and controlled emotions. Mental health is today recognized as an important aspect of one’s total health status. It is a basic factor that contributes to the maintenance of physical health as well as social effectiveness. There is no health without mental health.

Unfortunately, in most parts of world, mental health and mental disorders are not regarded with anything like the same importance as physical health they have been largely ignored or neglected (WHO Report 2001).

Half of the world population is affected by mental illness with an impact on their self-esteem, relationships and ability to function is everyday life, an individual’s emotional health can also impact physical health and poor mental health can lead to problems such as substance abuse, economical problems etc.

Maintaining good mental health is a crucial to living a long and healthy life. Good mental health can enhance one’s life, while poor mental health can prevent someone from living an enriching life (Richards, K.C.et al., 2010).

One of the key for good health is positive mental health. A few short decades ago, the mind and body were considered independent entities. Recently researchers have discovered that psychological factors can induce all kind of illness, not merely mental ones. They include conditions like
hypertension, peptic ulcers, bronchial asthma etc. Some major mental illnesses such as schizophrenia and depression have a biological component.

“A mentally healthy person feels right towards others”

A sound mind in a sound body has been recognised as a social ideal for many centuries. Mental health is not exclusively matter of relation between the persons, it also a matter of relation of the individual towards the community. He lives in, and towards the social institutions which for a large part guide his life, determine his way of living, working, leisure, and the way he earns and spends his money, the way he sees happiness, stability and security.

In 1950, a WHO Expert Committee on Mental Health stated that mental health is influenced by both biological and social factors. It is not a static condition but subject to variations and fluctuation of degree, the committee’s conception implies the capacity in an individual to form harmonious relations with others, and to participate in, or contribute constructively to, changes in his social and physical environment. It implies also his ability to achieve a harmonious and balanced satisfaction of his own potentially conflicting instructing drives in that it reaches an integrated synthesis rather than the denial of satisfaction of his own potentially conflicting instinctive drives in that it reaches an integrated synthesis rather than the denial of satisfaction to certain instinctive tendencies as a means of avoiding the thwarting of others.

DEFINITIONS OF MENTAL HEALTH

1. Mental health is defined as ‘The adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness’ (Karl Menninger, 1947).

2. Mental health is the capacity of an individual to form harmonious relationships with others and to participate in or contribute constructively to changes in social environment (WHO, 1950).
3. Mental health is defined as ‘Simultaneous success at working, living and creating the capacity for mature and flexible resolution of conflicts between instincts, conscience and reality’ (American Psychiatric Association, 1950).

4. Mental health described on level of psychological well-being or an absence of a mental disorder, mental health include an individual’s ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience.

Components of Mental health
- The ability to accept self.
- The capacity to feel right towards others.
- The ability to fulfill life’s tasks.

Criteria for Mental Health
- Adequate contact with reality.
- Control of thoughts and imagination.
- Efficiency in work and play.
- Social acceptance.
- Positive self-concept.
- A healthy emotional life.

Indicators of Mental health
Jahoda, (1958) has identified six indicators of Mental Health those are:
1. A positive attitude towards self.
2. Growth, development and the ability for self-actualization.
3. Integration: Integration includes the ability to adaptively respond to environment and the development of a philosophy of life.
4. Autonomy: Refers to the individual’s ability to perform, in an independent self-directed manner.

5. Perception of reality: This includes perception of the environment without distortion.

6. Environment mastery: This indicator suggests that the individual has achieved a satisfactory role within the group, society or environment.

CHARACTERISTICS OF A MENTALLY HEALTHY INDIVIDUAL

• Has ability to make adjustment.
• Can remain unhindered by emotional conflict.
• Does not demonstrate any pathological symptomology.
• Has a philosophy of living and can confirm to and follow that philosophy.
• Finds satisfaction and fulfillment in exercising and expanding his potential.
• Can establish and maintain a meaningful relationship with others.
• Shows emotional maturity in his behavior, and develops a capacity to tolerate frustrations and disappointments in his daily life.

SAFETY SIGNS FOR MENTAL HEALTH

1. A tolerance, easy-going attitude towards yourself as well as others.
2. A realistic estimate of your own abilities, neither under estimating nor over estimating.
4. Ability to give love and consider the interest of others.
5. Liking and trusting other people.
6. Ability to take life’s disappointment in stride.
7. Feeling part of a group and having a sense of responsibility towards neighbors and fellowmen.
8. Acceptance of your responsibilities and doing something about your problems as they arise.

9. Ability to plan ahead, and to set realistic goals for yourself.

**CULTURAL & RELIGIOUS CONSIDERATION**

Mental health is a socially constructed and socially defined concept, that is different socialites, group, cultural, institutions & professionals have very different ways of conceptualizing its nature and causes, determining what is mentally healthy, and deciding what interventions, if any one appropriate thus, different professionals will have different cultural, class, political and religion background, which will impact the methodology applied during treatment. Research shows that there is stigma attached to mental illness.

**MENTAL HYGIENE**

Mental hygiene is the science of promoting mental health and preventing mental illness through the application of psychiatry and psychology. A more commonly used term today is mental health. In 1980, the modern mental hygiene movement took root as a result of public reaction to Clifford beer’s autobiography, A Mind That Found Itself, which described his experiences in institutions for the insane.

**Purposes of Mental hygiene**

There are three purposes according to Crow and Crow(1951).

1. The prevention of mental disorders through an understanding of the relationship that exists between wholesome personality development and life experiences.

2. The therapeutic and preservative approach: The preservation of the mental health of the individual and of the group.
3. The curative approach: The discovery and utilisation of therapeutic measures to cure mental illness.

The most modern approach is the preventive approach, adopted from the field of public health. It is based on the principle that the best way to ensure that individuals are well adjusted to surround them with environmental influences which will enable each person to develop his full potentialities, to attain emotional stability, and to achieve personal and social adequacy (Kaplan and Baron, 1952). Preventive mental hygiene begins in the home, and its principle is important even in the school and other areas.

MENTAL HYGIENE PRINCIPLES IN STAGES OF GROWTH

The growth can be divided into a few stages called the prenatal, Childhood, adolescence, maturity or adulthood and old age. At every stage, the individual has to make certain adjustments. If the growth is properly guided, particularly in infancy and early childhood, the individual can develop into a mentally healthy adult. Adequate growth mainly depends on favourable environmental and personality factors.

MENTAL HYGIENE IN THE PRENATAL PERIOD

The emotional experiences of the mother during pregnancy have a considerable bearing on the attitude of the mother towards the new born child, and thus upon the relationships between the two. If mother had a happy pregnancy, the baby enters a world, to a large measure, prepared to welcome baby happily. Sontag in review of the general subject of the relation of the foetus and mother, points out that the emotional strains of the mother influence the foetus. A mother may be afraid of being neglected by her husband for the time being or of being injured or deformed. Yet another may be afraid of the economic consequences of another child. In some homes, the customs of postnatal care may make the mother anxious throughout the
prenatal period. The new born infant depends wholly on the mother for normal development and early adjustments which can be made easy by a mother who is mature, non-hostile and who receives the new child warmly and happily.

**MENTAL HYGIENE IN INFANCY**

Infancy refers to the period of growth from birth to the end of the first year. Birth is a situation of great anxiety, tension and terror for the infant. The infant needs warmth, comfort, acceptance and nourishment, again the infant need to be loved and recognised consistently. Giving love to the child is to satisfy the emotional needs, which are as important as physical needs. It is necessary for parents to see that the general emotional atmosphere in the home is healthy and warm. Quarrel and conflicts should be avoided in the presence of children. The physical environment should be clean and orderly, their physical needs should be met as adequately as possible. Adequate satisfaction of physical needs forms a preliminary basis for mental health.

**MENTAL HYGIENE IN EARLY CHILDHOOD**

Early childhood or the preschool period ranges from 2 to 6 years. The child during this period learns to walk, run, climb, jump and balance. He develops a number of body skills and fine motor or muscular coordination. He also develops sensory perception, he learns to speak and capable of practical thinking and solving simple problems. The child experience emotions and also learned to tolerate a certain degree of frustrations and deal with difficulties independently. Thus it is a period of rapid physical, intellectual, and socio-emotional growth.

The atmosphere in the home and the parental treatment play an important role in the promotion of mental health of the child in yearly years. The atmosphere in the home should be that of love and understanding.
MENTAL HYGIENE IN LATER CHILDHOOD

This period covers the early school period. It ranges from 6 to 12 years. It has been described differently by various psychologists, some call it a smart age because the child thinks knows everything and does not hesitate to inform others. It also regarded as the dirty age because the child glories in being dirty, slovenly and careless in his appearance. This latter part of this period is termed as the gang age because the major concern of every normal boy or girl is to be accepted by his peers and to be regarded as a member of their group. The child still needs affection from parents the physical needs should be looked after, both in the home and in the school. Provision should be made in the school and in the home for emotional expansion and self-expression to prevent the development of problems such as stammering, reading retardation, excessive daydreaming, aggressiveness or anxiety.

MENTAL HYGIENE IN ADOLESCENCE

Adolescence is the period which begins at the end of the childhood and closes at the beginning of adulthood. It ranges from 13 to 19 years. It is a period of transition from childhood to maturity. Adolescence is a period of rapid physical, intellectual, emotional and social growth. The adolescent needs guidance and emotional emancipation from parents is essential for proper growth towards adulthood. Adolescents who enjoy affection, encouragement, appreciation and trust from those who mean something to them, especially parents, develop into happy, confident and socially adjusted adults.

MENTAL HYGIENE IN ADULT HOOD

This period consists of young adulthood (18-35 years) and middle age (35-50 years). If the period of infancy, childhood and adolescence have been those of satisfaction and adequate adjustment, the young adult will enter his
life well-equipped. The adult, too, like the child and adolescent needs security, Self-realization and recognition.

MENTAL HYGIENE IN OLD AGE

The age of 60 years and above is commonly considered as old age. In India, people feel and grow old much earlier. It is a period of retirement from active work. Old people also show a gradual decline in mental ability. Memory, attention, thinking and ability to learn new things are affected, besides a gradual impairment in muscular coordination. The resistance to disease and injury diminish. The loss of employment which reduces economic security, and loss of certain status in society given by the job has many psychological reactions. The participation in community life, is naturally restricted all the feelings are aggravated if they lose their partner or if they are forced to live apart from each other or their family.

Many of the emotional problems that arise on account of old age, physical deficiency and sickness can be prevented by a regular educational Programme that is called as Preventive Geriatrics. It promotes positive health, and prevention and early detection of premature disabilities and provides care for the elderly who are sick or chronically ill. The sustenance of mentally healthy attitude depends on the adequate satisfaction of some fundamental emotional needs in all these stages.

MENTAL ILLNESS

Mental health problems are increasing and it is important to anticipate and prevent the problem to avoid minor problems from becoming chronic and to rehabilitate those who were already mentally ill. Mental illness on the other hand is maladjustment in living. It produces a disharmony in the person’s ability to comfortably or effectively meet human needs and functions within a culture. In other words a mentally unhealthy person loses his ability
to respond according to the expectation he has for himself and the demands that society has for him. For long, the mentally ill were considered to be possessed by devils. Patients were locked up in tall jail-like buildings and removed from the centres of population, alienated from the rest of the society.

During the 20th century, psychiatry began to make scientific advances. Mental health problems have long been recognised in every society. Communities had their own mechanism of handling these problems, many of which are gradually replaced by modern science. A greater understanding of mind and behaviour from all dimensions has revolutionised the efforts of managing these problems in today’s society. The organisation of services for those with mental health problems has moved from crude, primitive methods, to more sophisticated, technologically driven approaches with combination of pharmacological and non-pharmacological methods.

“Neglect of Mental Aspects in Well Being” assisted by the diagnostics, modern medicine has achieved many milestones in treatment and control of many diseases to achieve the objective of holistic wellbeing, mental, emotional and cultural aspects have been sidelined. It is time that, we recognize body and mind as twin aspects of a single entity and address the pathology in an integrated manner. To raise awareness towards the problem of mental disorders, Mental Health Day is observed on October 10th, every year. The theme for 2014 year was, ‘Living with Schizophrenia’. In India, the recent government initiatives like strengthening mental institutions, enhancement of PG seats in psychiatry shall hopefully control the mental disorders (TNAI BULLETIN, 2014). Thousands of people with mental illness around the World are deprived of their human rights. The theme for 2015 year was “Dignity in Mental Health” (WHO, 2015).
According to the World Health Organization’s Health Report on “Mental Health New understanding, New Hope”, during the life time, people as a whole have 25% chances of having mental illness or behavioral problems at some point of time of their lives. Mental illness has several effects on the person, on the person’s family and the community at large. Those are:

- Stigma and discrimination.
- Family hardship.
- Cost of the community.
- Reduced quality of life.
- Unemployment and disability.
- Suicide.

THEORETICAL APPROACHES TO MENTAL ILLNESS

The treatment of the mentally ill and their management depend mainly on the philosophy related to mental health and mental illness.

Medico-Biological Model

Medico biological model views emotional and behavioural disturbances as diseases like any other illness. The pathological process can be located to a part of the body or brain. These illnesses can be diagnosed, classified and labelled. They have characteristic mental symptoms or syndromes, course and prognosis and can be treated with physical or somatic treatments, such as drug, surgery, chemicals and or hormones. The treatment process is similar to that of any medical illness where the physician examines, diagnoses and prescribes the treatment. In this approach the physician is in-charge and the hospital remains the place of treatment. The researchers are being
concentrated on genetic, biochemical or neurological changes affecting in disturbed behaviour.

**Psychoanalytical model**

Psychoanalytical model as known by most people, is attributed to Sigmund Freud even though various modifications were made to Freud’s theory later. Psychic determinism is the major assumption in this approach. The basic belief is that all behaviours and dreams, even if they seem accidental, have some causal relationship to the previous experiences of the individual. The unconscious, that is, the unaware part of the mind is given an important role here. The individual might have undergone traumatic and painful experiences in the early part of life. The memory of these traumatic experiences are absent in the individual, as these experiences have taken shelter in the unconscious part of the mind. These unconscious traumatic experiences are in conflict with the ego and the ego brings out a defence mechanism. The behaviour that is seen in the individual may be an outcome of those ego defences. In order to resolve these conflicts, the individual needs help, as memories of these have to be brought out from the unconscious to the conscious level. It is believed that various psychoanalytical methods can express these traumatic experiences and bring them into awareness. The aim of therapy is to bring out the repressed feelings associated with the conflict, making the symptoms disappear. The psychoanalytical approach is based on the following theoretical explanation about the structure of mind. Freud explained that mind consists of Id, Ego and Superego.
**Id**: is seen as the psychic energy derived from basic drives and instincts.

**Ego**

It inhibits the primary instinctive drives in order to balance with reality thus helping the individuals to exist with others.

**Super Ego**

It is the moral part of the mind. Freud also explained the personality development in various stages and the influence of successful mastery of each stage on the adult personality. These stages are explained in five stages.

1. **Oral Stage**

This is infancy where the goal is the gratification of oral needs. Ego development begins towards the end of this stage. Until then the Id dominates the infant. Fixation at this stage will be demonstrated as Narcism, over optimism or over pessimism. Envy or jealousy will be part of this individual. The adult behaviour may show dependency on smoking, alcoholism, overeating, and nail biting and drug addiction. As an adult he may be incapable of trusting anybody.
2. Anal Stage

At this stage the child will be toilet trained. A successful mastery of this stage will make the person more autonomous and capable of independent action without guilt or shame or self-doubt. He will be capable of working with others without being oppressive or too submissive. The adult anal fixated character will be lack of self-confidence, stubbornness, self – righteousness and possessiveness. Fixation characters will show trait of sloppiness, constant fluctuation, anger and sadomasochism.

3. Phallic Stage

The psychic energy shifts to the genital area at the age of three to five. The major developmental task at this stage is a sense of achievement. “Oedipus” or “Electra complex”, which means erotic feeling towards the parent of opposite sex, is a characteristic of this stage. If this is resolved successfully the child will develop personal resources and will be capable of regulating his or her own motivation for constructive resolution of everyday life problems. The unsatisfactory resolution of this stage will result in difficulty with sexual identity, homosexuality and fixation of Oedipus or Electra complex.

4. The Latency Stage

This is from five to eleven years of age. The characteristics of this stage are increased control over instinctive drives, sublimation of libido and aggressive drives. Child’s interest is more towards the outside world. Sexual roles are confirmed and child develops skills in self-directed work and can have pleasure in work and achievement. Unsuccessful resolution results in inferiority feelings. Later on, it may be demonstrated as intensively obsessive behaviour.
5. Genital Stage

This is the stage where independent personality develops. A heterosexual relationship is the major developmental task at this stage. Unsuccessful resolution results in personality problems related to self-identity.

Behavioural Models

This model is based on learning theories. All behaviour is learned. There is stimulus and response. When the stimulus gets associated with another stimulus the second stimulus can evoke the same response as the previous one. Proponents of behavioural theories give importance only to the behaviours or symptoms not to the dynamics. They do not worry about the cause and effect of behaviour. Hence history and developmental factors become meaningless. The present behaviour, if it is maladaptive, needs to be extinguished. Pavlov’s (1936) Classical conditioning and Skinner’s (1953) Operant conditioning are being used as the basic foundations. Behaviour can be reinforced. Positive reinforcement can be used to increase the probability of the behaviour being repeated. Negative reinforcement decreases the possibility of the recurrence of the behaviour. There are, also accidental reinforcement of behaviour as seen in phobia. Behaviour also can be shaped to the closest expected by careful manipulation of the reinforcers. Behavioural modification therapy, reinforcement therapy and aversion therapy are few of the terms related to this approach to mental illness.

Social Interpersonal model

Social interpersonal model claims that the previously mentioned models ignore the impact of society and groups on the behaviour of the individual. The key concept on the sociological school of thought is that the mental illness is a label because of certain behaviours of the individual which
are not in agreement with the expected standards. In other words, it is a label
given to non-confirming behaviour. The labelling makes the individual to be
what he is labelled as. Thus behaviours that are often called symptoms,
acquire meaning only when considered within their social context. They de-
emphasize the individual’s dynamics. Harry stack Sullivan (1953) emphasized
modes of interaction as the real focus of psychiatric enquiry. He says that self
is a constant build-up of a child’s experience. Self develops in the process of
seeking physical satisfaction of bodily needs and security. The emphasis is on
interaction between organism and the environment, not on impulses, drives,
goals, etc. The interpersonal school of psychiatry, in general, focuses on social
context than sociological perspective. It takes a developmental-interpersonal
view of self.

The General Systems Theory

Karl Menninger (1963) emphasized the individual’s functioning in the
social system. A system’s well-being depends upon the amount of stress on it
and the effectiveness of the coping mechanism. He explains that mental
illness is an impairment of self-regulation in which comfort, growth and
production are surrendered for the sake of survival at the best level possible
but at the sacrifice of emergency coping devices. Emphasis in therapy
according to system approach is on current conflicts, restoration of impaired
systems to functioning and subsequent reintegration of the restored function
into future coping strategies. Clients are approached in a holistic way
considering the interaction between biophysical, psychological, spiritual and
economical and socio-cultural dimensions. Therapy focuses on assisting
troubled persons to gain a useful lifestyle. Establishing constructive
interpersonal relationship is important in this approach.

The above theories are useful in understanding the diagnosis,
treatment and rehabilitation of mentally ill people.
HISTORICAL OVERVIEW OF PSYCHIATRY

The attitude towards mental illness and treatment of mentally ill have undergone considerable changes through the years though there have been progressive periods and dark ages. In India one can observe a mixture of the most modern scientific therapies and ancient superstitious approaches. An overview of the historical development shows that the treatment of mentally ill has been influenced by man’s belief about himself, his fellow man and his environment. Demoniac influence was thought to be the cause of peculiar behaviour of individual.

Occasionally very respectable treatment was provided to mental patients by those who believed that mentally ill were possessed by gods, and goddesses. As they were attributed with driven power they stayed in temples. Charaka Samhitha(1st Century AD) had referred to psychiatry as Buthavidya and did not believe in demonology. Personality was basically divided into three types they are:

• Sathvik, which worked at a high intellectual and moral level.
• Rajasik, when the functioning was mostly on the emotional level.
• Tamasik, can be said as mental retardation.

Mental disorders were called as Unmada and they were said to be caused by either endogenous factors or possession of gods (Aganthuka). In Ayurveda, Apasmara (Epilepsy) was explained as derangement of the intellect and mind. Intoxication was considered under Mada. Faint was considered as Murcha and was considered due to occlusion of the channels of blood or of the nutrient fluid by Doshas. Psycho-therapeutic process was given an important place in the treatment at that time. Daivavyaprasrasya Cikista that is threatening, fear, happiness, sorrow, and gratification were thought to be the way to change the ideas. Worships, sacrifices and Yoga for the gratification of respected favorites such as Gana and Rudra were also in use. Occult
treatment was used by way of application of holy wards, mantras and Japas. Medical treatments consisted of Ghrtas (clarified butter). Many vegetable preparations were in use, one of them is Rauwolfia Serpentina which brought good results.

Asclepiades, referred as the father of psychiatry. His contribution was by way of advocating simple hygienic measures, such as diet, bath, massage, emetics and bloodletting in place of mechanical restraints. Harmonic music and water therapy were also suggested for this purpose in 9th Century AD.

After 4th Century AD, the care of mentally ill did not progress at the same rate as the centuries just before and after Christ. The method of treatment at this period were tortures, dungeons, ridicule, jails and asylum. It was not just custodial care, but barbaric. Law was more for property management than for care of the individual. This was the case all over the world. Temple sleep was practiced in India.

SOME IMPORTANT MILE STONES IN PSYCHISTRY

- In 1773, the first Mental hospital in the United States was built in Williamsburg, Virginia.
- In 1793, Phillip Pinel removed the chain from mentally ill patients confined in Bicetre, a hospital outside Paris, thus brings about the first revolution in psychiatry.
- In 1812, the first American text book in Psychiatry was written by Benjamin Rush, who is referred to as father of American Psychiatry. Prior to 1860, emphasis in psychiatric institutions was on custodial care, and this was provided by attendants and the psychiatric care was poor.
- In 1912, Eugene Bleuler, a Swiss Psychiatrist coined the term ‘Schizophrenia’ and New Indian Lunacy Act, came in to force.
- In 1927, Insulin shock treatment was introduced for schizophrenia.
In 1936, Frontal lobotomy was advocated for the management of psychiatric disorders.

In 1938, Electro Convulsive Therapy (ECT) was used for the treatment of psychosis.

In 1939, Development of psychoanalytical theory by Sigmund Freud led to new concepts in the treatment of mental illness.

In 1946, The Bhore Committee presented the situation with regard to mental health services. Based on its recommendations, five mental hospitals were set up at Amritsar (1947), Hyderabad (1953), Srinagar (1958), Jamnagar (1960) and Delhi (1966). An all Indian Institute of mental health was also started at Bangalore (currently known as NIMHANS).

In 1949, Lithium was first used for the treatment of mania.

In 1952, Chlorpromazine was introduced which brought a revolution in Psycho-pharmacology and changed the whole pattern of mental health care.

In 1963, The Community Mental Health Centres Act was passed.

In 1972, The first half way home started in India was started by Medico-Pastoral Association in Bangalore, and first Day Care Centre also started in Bangalore by group of House wives in 1974, under the name of FRIENDS of NIMHANS. Today, there are more than 50 such centres located in different parts of India.

Community based rehabilitation is very appropriate in the Indian cultural setting, where social and community bonds are quite strong and deep-rooted. The emerging view is that CBR (Community Based Rehabilitation) Programme for the mentally ill should integrate with the existing Community Development Programme, especially in the area of disability, so that there is no duplication and waste of resources.
• In 1978, The Alma-Ata Declaration “Health for All by 2000 AD” posed a major challenge to Indian mental health professionals.
• In 1980, The Government of India called for experts for assessing the mental health needs.
• In 1981, Community Psychiatric Centres were set up to experiment with Primary Mental health Care Approach at Raipur Rani, Chandigarh, and Sakalwara, Bangalore.
• In 1982, National Mental Health Policy and brought National Mental Health Programme.
• In 1987, The Indian Mental Health Act was passed.

The NIMHANS Crash Programme

It was at the initiative of the director, DR R.M Varma and that of Dr Karan Singh, Minister of Health in the Central Government, that a Crash Programme for community based mental health was introduced at NIMHANS. A Community Psychiatry Unit was also started in Oct 1975.

The National Mental Health Programme

The National Mental Health programme was launched in 1982, the objectives of this programme are:
• To ensure the availability of mental health care for all, particularly to the most vulnerable and under privileged sections of the population.
• To encourage the application of mental health knowledge in general health care and in social development.
• To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.
RESTRUCTURING OF THE NATIONAL MENTAL HEALTH PROGRAMME

The District Mental Health programme (DMHP), the basic Unit of the NMH, was field tested in 1985 in the Bellary district of Karnataka under the NIMHANS, Bangalore. DMHP was undertaken during the Ninth Five Year Plan (1997 – 2002) in phased manner with an outlay of Rs 2.8 billion and eventually 25 districts in 20 states were covered. After approval by the Ministry of Health and Family Welfare, the Planning Commission, the Ministry of Finance and the Cabinet Committee on Economic Affairs the restructured NMHP was formally launched by health secretary at National Workshop held at Vigyan Bhavan, New Delhi on 22 October 2003. The National Workshops on mental health care for the state health administrators held at NIMHANS in 1996. The district model was adopted in many districts. It is anticipated that in the Tenth Five year plan, it would be extended to 100 districts. In Eleventh Five Year Plan the DMHP will be extended to 200 districts. In Twelfth Five Years Plan the DMHP will be extended to the remaining 193 districts.

OBJECTIVES OF DMHP

To provide community mental health services through decentralization of treatment from specialized mental hospital based care to primary health care services.

- Training of mental health team at identified nodal institutions.
- Increase awareness and reduce stigma related to mental health problems.
- Provide services for early detection and treatment of mental illness in the community.

LEGAL AND ETHICAL ISSUES

At the time of independence, mental health care in India was confined to mental hospitals and was governed by the Indian Lunacy Act 1912. In 1987,
the Mental Health Act was enacted, but there was considerable delay in its implementation.

There are two Acts concerned with the care and treatment of the mentally ill.

- The Indian Lunacy Act of 1912.
- The Indian Mental Health Act of 1987.

**The Indian Lunacy Act (1912)**

It is derived from English Lunacy Act, 1890 and it contains eight chapters’ deals with preliminary information and definitions, Procedure to be followed to admit a psychiatric patients into mental hospital, care, treatment and discharge.

**The Indian Mental Health Act**

Mental Health Act was introduced in Rajya Sabha in 1981. The Mental Health Bill became the Act of 1987 on 22\textsuperscript{nd} May, 1987. Mental Health act has been derived from MHA of England and Wales (1959) amended in 1982.

**Reasons for Enactment**

The attitude of the society towards the mentally ill has changed considerably and it is now realized that no stigma should be attached to such illness, as it is curable practically when diagnosed at an early stage.

This act contains ten chapters deals with preliminary information and definitions, establishment of central and state authorities for regulation, provides guidelines for establishment and maintenance of Psychiatric Hospitals / Nursing Home, procedures for admission and detention, in Psychiatric Hospitals /Nursing Homes, procedure to be followed for the discharge of mentally ill persons from a Mental Hospital, judicial enquiry regarding mentally ill persons possessing property, their custody and
management of property, ways and means to meet the cost of maintenance of mentally ill persons detained in psychiatric hospitals / nursing homes, protection of human rights of mentally ill person, procedures to be followed for the establishment and maintenance of Psychiatric Hospitals / Nursing Home, and procedures to be followed by the medical officer in-charge of the Hospital or Nursing home.

DEFINITIONS OF MENTAL ILLNESS

• Mental and behavioral disorders are understood as clinically significant condition characterized by alteration in thinking, mood or behavior associated with personal distress and impaired functioning. (WHO, 2001)

• People who fail to fulfill their roles and carry out responsibilities or whose behavior is inappropriate to the situation are viewed as, ‘Mental Illnesses.

• A clinically significant behavior or psychological syndrome or pattern that occurs in an individual and associated with distress or disability or significantly increased risk of pain, disability, lack of freedom and death. (American Psychiatric Association, 2000)

Mental Illness - Stigma

Attitudes and beliefs about mental illness are shaped by personal knowledge about mental illness, knowing and interacting with someone living with mental illness, media stories and past restrictions e.g. health insurance restriction, employment restrictions, adoption restriction (Corrigan, et.al., 2004, Wahl, 2003) when such attitudes and beliefs are expressed positively, they can result in supportive and inclusive behaviours, when such attitudes and beliefs are expressed negatively, they may results in avoidance, exclusion from daily activities, exploitation and discrimination.
Meaning of Stigma

Stigma has been described as “a cluster of negative attitude and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental illness (President’s New Freedom Commission on Mental Health, 2003).

The prevailing view of health related to stigma is that it refers to perceived, enacted or anticipated avoidance or social exclusion and not to an individual blemish or mark (Goffman, 1963, Weiss, Ramakrishna and Somma, 2006,).

Consequences of stigma

Only about 20% of adults with a diagnosable mental disorder (Wang, et.al., 2005) or with a self-reported mental health conditions (Hennssy, et.al., 2012).

➢ Stigma about mental illness can discourages disclosing that they have mental health problems which may prevent treatment and recovery.
➢ Stigma can result in limited life opportunities
➢ Stigma possess barriers for public health prevention efforts designed to minimize onset of mental illness and the prevention or worsening of symptoms over time.
➢ Stigma can result in prioritization for public resources allocated to mental health services.
➢ Stigma can result in poorer quality of care.
➢ Unequal access to educational opportunities, employment, supportive community, including friends, and family.

These disparities in education, employment, and access to care can have summative long term negative consequences. Most people with serious and persistent mental illness are unemployed and live below the poverty line, and may face major barriers to obtaining descent, affordable housing (US
Department of Health and Human Services, 1999). These individuals may need a number of additional social support e.g. job training, peer support networks to live successfully in the community, but such support may not be available.

Other individuals with depression and anxiety might avoid disclosing their symptoms and instead adopt unhealthy behaviour to help them cope with their distress (e.g. smoking, excessive alcohol use, binge eating). These behaviour can increase their risk for developing chronic diseases, worsening their overall health over time, recent studies have found an increased risk of death at younger ages for people with mental illness. (Colton and Manderscheid, 2006).

**CHARACTERISTICS OF MENTAL ILLNESS**

1. Disturbances of mental functions like thinking, emotions, intelligence, memory, attention, orientation, perceptions etc.
2. Rowdy, violent, assaultive, destructive, abusive, suicidal or homicidal behaviour.
3. Anxiety, tension, irritability, poverty of concentration, diminished work efficiency, irrational fears, unwanted ideas, repetitive meaning less activities.
4. Somatic symptoms like headache, weakness, anorexia, constipation, diarhoea, sleeplessness, palpitation and breathlessness, at rest, without any organic cause.
5. Somatic syndromes produced by emotional disturbances which involve autonomic nervous system i.e. psychosomatic diseases like peptic ulcers, bronchial asthma etc.
6. Antisocial behaviour like criminality, sexual perversions, addiction to drug and alcohol.
7. Incomplete development of mental faculties (Mental Retardation).
8. Disorder of cerebral function due to emotional disturbances e.g. Epilepsy.

CAUSES OF MENTAL ILLNESS

No one single factor is held responsible. Multiple factors are incriminated. Interaction of all these is commonly observed.

Biological Factors

- Heredity
- Constitution and physique
- Physiological changes in the body at puberty, menstruations, involution, etc.
- General cerebral dysfunction.
- Trauma, particularly head injury.
- Infection like acute, sub-acute and chronic.
- Biochemical, metabolic and endocrine disturbances.
- Dehydration and deficiency states.
- Drugs, chemicals, heavy metals and alcohol.
- Physical defects and physical illness.

Psychological Factors

Strained interpersonal relationship at home, place of work, school, college, etc.

Childhood Insecurities

Due to pathological personality types of parents, faulty attitude of parents like over strictness, over leniency, abnormal parent child relationship like over protection, rejection, inconsistency, favouritism, unhealthy comparison, deprivation of child’s essential psychological and social needs etc.
Educational or Scholastic Problems

Unhealthy comparison and favouritism made by teachers, discriminations made on the basis of economical classes and social caste, over strictness, inadequate recreational and library facilities, lack of proper sitting arrangements, transport, light and ventilation, controversies and rapid changes in the curriculum etc. Social and recreational deprivations resulting in boredom, isolation, alienation.

Sexual difficulties

Arising out of improper sex education, unhealthy attitudes towards sexual functions, guilt feelings about masturbation, pre and extramarital sex relations, worries about sexual perversions.

Marriage problems

Marriage problems like forced bachelorhood, disharmony due to physical, emotional, social, educational or financial incompatibility, childlessness, too many children.

Occupational difficulties

These are due to unhappy working conditions, strained relationships with superiors or colleagues, shift systems, lack of job satisfaction, intermittent employments, temporary employment, and unemployment.

Economical or Financial Conditions

Poverty, debts, associated conditions like gambling, alcoholism, prostitution etc.
Family situations

Strained interpersonal relationship, broken home due to death, divorce, too big family, very small family, cultural and religious traditions.

Migration

Particularly from villages to cities for earning livelihood leading to loneliness, maladjustment to the fast tempo of city life, generation gap from the family members etc.

Adverse Physical Environment

Like neighbourhood influences, problems due to overcrowding, lack of housing, slums, pollution, etc.

Precipitating factors

These factors are described as “stress” can be classified as:

1. Physical stress: like war, starvation, famine, earth quakes, floods, cyclones, fire, house collapse, migration etc.

2. Physiological stress: like puberty, pregnancy, child birth, involution, fever, drugs, systemic diseases, etc.

3. Psychological stress: like strained interpersonal relationship, family and marital disharmony, sexual maladjustment, death of a family member, occupational and financial difficulties, etc.

Individuals, who have a low threshold to tolerate stress, have very little capacity to accumulate tension in the unconscious mind. They are more susceptible to the development of mental illness.

Failure in the resolution of psychological conflicts results in accumulation of tensions in the unconscious mind. This tension is handled by the individual through various mental mechanisms known as “Defence” and is thus prevented from reaching the threshold. Any stress physical, physiological
or psychological acting as “the last straw on the camel’s back” triggers off the tension and precipitates the various psychiatric illness.

**DIAGNOSIS OF MENTAL ILLNESS**

Mental illnesses are diagnosed by detailed history, physical and psychiatric examination. Laboratory, radiological investigations also used to rule out systemic disorders. Psychological investigations like intelligence tests, personality tests, aptitude and cognitive function tests.

**MISCONCEPTIONS ABOUT MENTAL ILLNESS**

Beliefs about mental illness have been characterized by superstition, ignorance and fear those are:

- Mental illness is caused by supernatural power and is the result of a curse or possessions by evil spirit.
- Mentally ill people show bizarre behavior.
- Mentally ill people are dangerous: People who have or had a mental illness are viewed with suspicion and as dangerous persons.
- Mental illness is something to be ashamed of.
- Mental illness is not curable.
- Mental illness is contagious.
- Mental illness is hereditary.
- Marriage can cure mental illness.
- Mental hospitals are places where only dangerous mentally ill individuals are treated and restraint is a major form of treatment.

**CLASSIFICATION OF MENTAL DISORDERS**

There are two major classifications of Mental Disorders

1. **ICD 10 (International Statistical Classification of Disease and Related Health Problems)-1992.** This is WHO’s classification of mental illness
for all diseases and related health problems. The chapter ‘F’ classifies psychiatry disorders as Mental and Behavioural disorders and codes them on an alphanumeric system from F00 to F99.

2. DSM IV (Diagnostic and Statistical Manual)-1994. This is the classification of mental disorders by the American Psychiatric Association. The pattern adopted by DSMIV is of multi axial system.

The five axes of DSMIV are:
AXIS I  Clinical psychiatric diagnosis.
AXIS II  Personality Disorders and Mental Retardation.
AXIS III  General medical conditions.
AXIS IV  Psychological and environmental problems.
AXIS V  Global assessment of functioning in current and past one year.

INDIAN CLASSIFICATION OF MENTAL ILLNESS

In India Neki, (1963), Wig and singer, (1967), Vahia, (1961) and Varma (1971) have attempted some modifications of ICD8 to suit Indian conditions. They are broadly grouped as follows:

I. Psychosis

Fig. 1.2 : Schizophrenia, Mania, Depression and Organic Psychosis

II. Neurosis

- Anxiety neurosis
- Depressive neurosis
- Hysterical neurosis
• Obsessive compulsive neurosis
• Phobic Neurosis

III. Special disorders
Childhood disorders
• Conduct disorders
• Emotional disorders

IV. Personality disorders
• Sociopath
• Psychopath

V. Substance abuse
• Alcohol abuse
• Drug abuse

VI. Psycho physiological disorders

VII. Mental retardation
• Mild
• Moderate
• Severe
• Profound

I. TYPES OF PSYCHOSIS
1. Functional Psychosis
a) SCHIZOPHRENIA

The word ‘schizophrenia’ was coined in 1908 by Swiss Psychiatrist Eugen Bleuler. It is derived from the Greek words Skhizo (split) and Phren (mind).
Definition

Schizophrenia is a psychotic condition characterised by a disturbance in thinking, emotions, volitions, and faculties in the presence of clear consciousness, which usually leads to social withdrawal.

Clinical manifestations

Schneider’s first rank symptoms of schizophrenia: Kurt Schneider proposed the first rank symptoms of schizophrenia in 1959. The presence of even one of these symptoms is considerable strongly suggestive of schizophrenia. They are:

- Hearing one’s thoughts spoken aloud (audible thoughts or thought echo).
- Hallucinatory voices in the form of statement and reply (the patient hear voices discussing him in the third person).
- Thought withdrawal (thoughts cease and subject experiences them as removed by some external force).
- Thought insertion (subject experiences that his thoughts are escaping the confines of his self and are being experienced by others around).
- Delusional perception (normal perception has a private and illogical meaning).
- Somatic passivity (bodily sensations especially sensory symptoms are experienced as imposed on body by external forces).
- Made volition or acts (one’s own acts are experienced as being under the control of some external forces, the subject being like robot).
- Made impulses (the subject experiences impulses as being imposed by some external force).
- Made feelings or affect (the subject experiences feelings as being imposed by some external forces).
Treatment

Antipsychotic drug, Electro convulsive therapy (ECT), Psychological therapy, Behaviour therapy, Social skill training, Cognitive therapy, family therapy and psychosocial rehabilitation.

2. AFFECTIVE OR MOOD DISORDERS

Mood disorders are characterized by disturbance of mood, accompanied by a full partial manic or depressive syndrome, which is not due to any other physical or mental disorder.

Biological theories

Genetic hypothesis

Genetic factors are predisposing an individual to mood disorders. The life time risk for:

- The first degree relatives of patients with bipolar mood disorder is 25% and of normal controls is 7%.
- The life time risk for the children of one parent with mood disorder is 27%.
- Both parents with mood disorder is 74%.
- Monozygotic twins is 65% and for dizygotic twins is 15%.

Biochemical theories

- Deficiency of Norepinephrine and serotonin leads to depression and they are elevated in mania.
- Dopamine, GABA and acetylcholine are also involved.

Psycho Social theories

According Freud (1957) depression occurs due to loss of a “loved objects” and fixation in the oral sadistic phase of development. In this model, mania is viewed as a denial of depression.
**Behavioural theory**

According to this model depression is conditioned by repeated losses in the past.

**Cognitive theory**

According to this theory depression is due to negative cognitions which include:

- Negative expectations of the environment.
- Negative expectation of the self.
- Negative expectations of the future.

**Sociological theory**

Stressful events e.g. death, marriage, financial loss before the onset of the disease.

**Other factors**

**Constitution and physique**

Pyknic body build is more commonly associated with manic-depressive psychosis.

**Personality**

Melancholic, anxious and obsessional personalities are more predisposed to depression. Extroverted individuals are more prone to get mania.

**Temperament**

Cyclothymiacs temperament (i.e. swings of mood-elation and dejection) is more often observed in patient diagnosed as manic-depressive disorder.

**Seasons**

The incidence of depression is reported to be high in summer months.
Sex: Both sexes are affected.

a. MANIC EPISODE

This is a type of functional psychosis. The disease is characterised by triad of symptoms, viz. elevation of mood, flight of ideas and increased psychomotor activity. The life time risk of manic episode is about 0.8-1%. This disorder occur episodes lasting usually 3 to 4 months, followed by complete recovery.

Clinical features

Disturbance of mood

Elevation of mood like euphoria. The patient is boisterous, jovial, sparking and has an excessive satisfaction with his own self and circumstances. Sometimes the mood is irritable and legible also.

Disturbance of thinking

Flight of ideas is the typical symptom, the association between the words and ideas are superficially determined, the stream of ideas is very rapid. The goal keeps on changing and the patient jumps from one subject to another.

The Talk

Talk is forceful and the pressure of speech is raised, conversation is impossible. The patient is argumentative and assertive. Attention is distractible and any external stimulus sets off a new train of ideas.

Disturbance of behaviour

Increased psychomotor activity is the characteristic change in behaviour. Restlessness and over activity, doing everything in excess. Putting
into action several schemes but not completing any. Decorating himself extravagantly. Over activity interferes with sleep and nutrition and exhausts the patient. Degradation of conduct (soiling and smearing), sexual assault and exposures. Destructiveness, rowdism, criminal activities, homicidal tendencies. The patient may suffer from delusions of grandeur, suspiciousness, hallucinations of the auditory variety and excess consumption of alcohol or drugs.

**Treatment**

Mood stabilizers drugs to control the manic episodes. ECT can also be used for acute manic excitement if not responding to drugs. Psycho-therapy, Behaviour therapy, Social skill training, Cognitive therapy, psychosocial rehabilitation.

**b. DEPRESSIVE EPISODE**

Depression is a widespread mental health problem affecting many people. The life time risk of depression in male is 8 to 12 % and in female it is 20 to 26%. Depression occurs twice as frequently in women as in men.

**Definition**

The depression is characterised by triad symptoms, viz. sadness of mood, poverty of ideas and psychomotor retardation.

**Clinical manifestations**

The various symptoms can be grouped into physical, emotional and psychological.

**a) Physical symptoms**

Common symptoms are feeling of tired, listless and fatigue, insomnia, anorexia and loss of body weight, abdominal discomfort, hot flushes, vague aches and pains in the body, tingling and numbness, dryness of the mouth,
constipation, urinary frequency, menstrual changes like Amenorrhoea, Menorrhagia, Sexual disturbances like diminished sex drive, interest, and impotence, Cardiovascular disturbances like pain in the chest, palpitation, breathlessness, headache, giddiness, blurred vision, dermatological disturbances like Pruritus, rash, excessive or diminished sweating, Neurodermatitis, etc.

b) Emotional symptoms

A wide variation in quality as well as severity is observed. Common symptoms are loss of cheerfulness, diminished enthusiasm, crying spells, lack of confidence, irritability, phobias, obsessions, anxiety, feeling of guilt, ideas of worthlessness, uselessness and hopelessness, suicidal tendency.

c) Psychological symptoms

These emerged gradually and remain unnoticed for a very long time. They are seldom reported by the patient. Common symptoms are psychomotor retardation i.e. slowing down of physical and mental functions, agitation, avoiding people and social responsibilities, tendency to postpone and indecisiveness, neglect of daily routines and work, negativism and stupor, impaired concentration and forgetfulness, delusions of various types like somatic, guilt, paranoid, etc. illusions and hallucinations, unexplained worries and anxieties.

Treatment

Hospitalization indicated in severe attack of depression, suicidal and homicidal tendencies, and delusional depression. Anti-depressive drugs, ECT, Psychotherapy, Occupational therapy, Work therapy, Art therapy, Music therapy etc.
c. BIPOLAR MOOD DISORDER

This is characterised by recurrent episodes of mania and depression in the same patient at different times. The patient is treated according to the episodes of mania and depression.

3. ORGANIC PSYCHOSIS

Organic psychosis characterised clinically by disturbances of consciousness, memory, intelligence, and orientation.

Types of organic psychosis

a) Acute or Toxic Confusional Psychosis or Delirious State: This condition has rapid onset, alternations in the state of consciousness marked. Patient often be wilder, disoriented, exited, agitated, visual prove fatal if not attended to promptly. This condition associated with alcohol, meningitis, head injury, etc.

b) Chronic or Dementing Psychosis: This condition has gradual onset, alteration of consciousness not marked, disoriented, memory disturbances, intellectual deterioration and circumstantiality.

AETIOLOGY

a) Acute organic psychosis :

1. Intracranial infections e.g. meningitis, encephalitis, systemic infections.
2. Drug intoxication.
3. Head injury.
4. Congestive cardiac failure.
5. Epilepsy.
6. Metabolic disturbances like uremia, hypoglycemia etc.
8. Endocrine disorders like hyperthyroidism.
b) Chronic Organic Psychosis:
1. Congenital cranial anomaly, spastic paraplegia, mongolism.
2. Infections of brain due to syphilis.
3. Degenerative disorders like Alzheimer’s disease, pick’s disease, etc.
4. Metabolic and endocrine disorders e.g. Hypocalcaemia, Cushing’s syndrome, and Myxedema etc.
5. Other factors are same as acute brain disorder.

Management
Depends upon the cause. Fluids and electrolytes replacement therapy, symptomatic treatment, massive Vitamin therapy, ECT, Occupational therapy, Recreational therapy and suitable rehabilitation with the help of a psychiatric social worker.

II. PSYCHONEUROSIS OR NEUROSIS
This is a group of mental illness which are described as “minor” symptoms. They do not interfere with his capacity for insight and judgement, person has ties with reality are intact, and mental dysfunctions are comparatively of milder form in contrast to psychosis. Biological factors like heredity, constitution, endocrine factors, metabolic and biochemical abnormalities are not considered as significant causes in the illness. Environmental factors are rated as more important causes.

TYPES
1. Anxiety neurosis
2. Phobic neurosis
3. Obsessive compulsive neurosis
4. Hysteria-conversion or dissociation reaction
1. ANXIETY NEUROSIS

Anxiety reaction is a neurotic state of chronic apprehension with recurrence of acute anxiety symptoms.

Aetiology

Age : Childhood, adolescence, and involution are the periods most susceptible to this illness.

Sex : Incidence is equal in both sexes.

Personality : Persons with anxious, inadequate and obsessive personalities are more susceptible to this illness.

Precipitation : Physical factors, psychological or physiological stress of moderate to severe degree triggers off the illness. Factors like difficult family situations, occupational, and financial difficulties, heavy responsibilities without adequate support, prolonged or debilitating physical illness like influenza commonly precede the onset of the illness.

Clinical manifestations : They are broadly grouped into:

Physiological : These are due to autonomic nervous system imbalance and commonly include palpitation, shortness of breath, tremulousness and unsteadiness, dryness of mouth and diminished appetite, headache, and heaviness of head, giddiness and blurring of vision, frequency of micturition, and diarrhoea, excessive sweating particularly in palms and soles. On examination, one finds tachycardia, elevation of blood pressure, increased respiration rate, exaggerated deep reflexes.

Psychological : Worries, nervousness, apprehension, irritability and a morbid fear as, difficulty in concentration and
forgetfulness, sleep disturbances, including night mares, vague somatic symptoms, and reduction in efficiency, felling fatigued and tired.

**Treatment**

: Hospitalization is necessary for acute reactions. Drugs, psychotherapy, social case work and counselling. Psychophysiological therapy. In recent years, a therapy based upon Patanjali Yoga which employee’s psychological principles of controlling the mental voluntary neuromuscular functions as well as autonomic nervous system through physical exercises, breathing exercises, relaxation and meditation has been reported to be effective as tranquillisising drugs. Other therapies like bio-feedback techniques and behaviour therapy.

2. PHOBIC NEUROSIS

Unexplained and irrational morbid fears about animate or inanimate objects are known as phobia. These are considered normal when they occur in certain situations or certain ages e.g. children up to 6 to 8 years. The phobias are more common in women with an onset in late second decade or early third decade. Onset is sudden without any cause.

**Aetiology**

- Environmental factors are rated as more significant causative factors.
- Age: Children and adolescents are more susceptible.
- Personality: Anxious, inadequate, and obsessive personalities are more prone to get.
- Parent and Child relations: more often abnormal psychologically traumatic experiences during infancy and early childhood are commonly found in the life histories.
Clinical manifestations

In early stages, the symptoms usually come up when the patient is confronted with the phobic object or situations. These symptoms include palpitations, tremulousness, shortness of breath, perspiration, and giddiness, dryness of mouth, a sensation of collapse, and a fear of impending doom. This state of panic lasts as long as the patient has to face the phobic object or situations. In latter stages of the disease, the patient develops a state of chronic apprehension and symptom of chronic anxiety state.

The common phobic objects are insects, animals, house pets, pins, and needles. The common phobic situations are darkness, brightness, depth, height, closed spaces, open spaces and moving vehicles. Diseases like tuberculosis, cancer, leprosy, sexually transmitted diseases, heart diseases etc.

3. OBSESSIVE COMPULSIVE NEUROSIS

Obsessions are persistent recurrence of unwelcome ideas. The patient does not enjoy getting those ideas, patient feels miserable and guilty and makes the possible efforts to remove them from mind without any success. The ideas are usually centred around sex, religion, dirt, and germs.

Compulsions are irresistible urges to carry out meaningless and irrational activities. If the patient does not carry out impulse, patient experiences discomfort and tension, this tension gets released only when acts out impulse.
Aetiology

Incidence of obsessional reactions is not known. The suggested aetiology factors are:

1. Hereditary: The disease is transmitted through genes.
2. Monozygotic twins have higher incidence than for dizygotic twins. Familial tendency have shown that 35% of the first degree relatives of obsessive-compulsive disorder patient are also affected with the disorder.
3. Age: Majority of the patients are under the age of 40 years.
4. Sex: women seem to be suffering from this illness more often than men.
5. Biochemical influences: A number of studies suggest that the Neuro – transmitter may be abnormal.
6. Intelligence: Patient suffering from this disease tend to be above average intelligence.
7. Environmental factors: like harsh affectionless, strict toilet training, parental disharmony, illness of the parent, increase of responsibilities beyond the capacity of persons are frequently found in the histories of these patient.
8. Organic brain disorders: Encephalitis, head injury are frequently reported in the history of past illness.
9. Personality: Ritualistic and rigid behaviour, over conscientiousness, meticulousness, fondness for punctuality and orderliness.

CLINICAL MANIFESTATIONS

Mild obsessional states are seen as normal in children as well as in adults in states of fatigue or in convalescence. These are transient and usually do not interfere with comfort and working efficiency, they disturb only when the degree of obsessional state is moderate or severe.
Obsessional thoughts

Usually of a religious, philosophical or scientific subject. Contrast ideas like ideas of religion followed by ideas of sex. They are usually unpleasant and shocking to the patient.

Obsessional images

These are vividly imagined scenes, often of a violent disgusting kind involving abnormal sexual practices.

Obsessional doubts

These may concern actions that may not have been completed adequately. The obsession often implies some danger such as forgetting to turn off stove or not locking door. It may be followed by a compulsive act such as the person making multiple trips back into the house to check if the stove has been turned off.

Obsessional urge

These are compulsions i.e. acts which the patient realizes as foolish, useless or even dangerous e.g. repeated hand washing which a patient does because of the haunting ideas that the hands get dirty whatever has been touched and, therefore, need cleaning. When the symptoms become severe the patient may develop additional symptoms of anxiety reaction and depression.

Treatment

Antidepressants, Anxiolytics, Behaviour therapy, Supportive Psychotherapy and ECT therapies are used.
4. HYSTERIA – CONVERSION OR DISSOCIATION REACTION

Hysteria is a type of neurosis characterised by somatic psychological symptoms without any organic basis. Psychological factors like stress and conflicts are associated with onset of disease.

Aetiology

There is sufficient evidence to suggest that the symptoms are psychogenic and that the environmental factors are the most important aetiological factors.

Age : The peak incidence is between the ages of 20 to 30 years. Children and old people also show a high incidence of this illness.

Sex : The incidence is higher in women than in men.

Intelligence : People with low intelligence suffer from hysteria more often.

Personality : Commonest in hysterical personality. Characteristic are dramatizing and exhibiting, attention seeking, immature, shallow and superficial emotional relationships.

Marital status : Hysteria is reported to be more common in the unmarried, the widowed and the divorced.

Socio-cultural factors : Hysteria is more common in primitive, developing and less sophisticated or cultured societies.

Parent-child relationship : History of unhappy child-hood that is abnormal parent-child relationship, broken home etc.

Clinical manifestations

There is wide variety of somatic and psychological symptoms. Symptoms of conversion reaction which can be divided into motor, sensory or visceral.
Motor symptoms: These are two types:

- Paresis paralysis involving a part of the body like monoplegia, hemiplegia, paraplegia etc.
- Hyperkinesia e.g. tremors, occupational and writer’s cramp, convulsions or fits etc.

Sensory symptoms

These can be in the form of anaesthesia, hypothesia, hyperaesthesia and paraesthesia. This can affect all the general sensations such as touch, pain, and temperature. Special sensory symptoms like sight, hearing, smell and taste can also be disturbed in the same way e.g. blindness, deafness etc.

Visceral symptoms

Common ones are hiccough, vomiting, dyspnoea, dysphagia, aphonia, etc.

Psychological symptoms

Somnambulism, amnesia, trance, fugue i.e. an altered state of consciousness where the patient travel long distance over period of days and has amnesia for the entire episode, multiple personalities, Ganser’s syndrome where in the patient complaint of pseudo dementia and has circumstantiality.

Treatment

Isolation of the patient from pathogenic environment in acute attacks and no visitors should be allowed to meet the patient. Placebo therapy like intramuscular injection of distilled water sometimes helps in relieving symptoms because the patients are very suggestible. Drugs, Abreactive therapy, Hypnosis and Psychotherapy also useful.
**Social therapy**

A detailed history has to be taken from the patient and family members in order to handle immediate problems and to provide guidance, and counselling to the patient and family members for better adjustment.

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**III. PSYCHOLOGICAL DISORDERS OF THE CHILDHOOD AND ADOLESCENCE**

All the types of psychiatric illnesses seen in adults are observed in children also, though the symptomology may be different in the two groups.

- **Behavioral problems of children. Antisocial e.g.** stealing, lying, begging, truancy from home, drug addiction, alcoholism, sexual perversions, criminal offences, other delinquency traits.

- **Non anti-social behavior:** Habit disorders like thumb sucking, nail biting, bed wetting, masturbation, pica, over eating, stammering.

- Personality disorders like shyness, day dreaming, aggressiveness, temper tantrums, sensitiveness, obstinacy, restlessness etc.

- Scholastic problems like refusal to go to school, truancy from school, scholastic backwardness, specific learning disorders.

- Psychosomatic symptoms like anorexia, vomiting, constipation, diarrhea etc. Causes, signs and symptoms and treatment same as adults.

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**Causes of behavioural problems**

Exact cause is not clear but important factors are:

1. Hereditary predisposition and constitution.
2. Physical defects and physical illness.
3. Intelligence: Low as well as high.
4. Unhealthy parent child relationship and abnormal parental attitudes like overprotection, rejection, favoritism, unnecessary comparison, negligence, over leniency, over strictness, inconsistency, etc.
5. Ignorance on the part of the parents about the psychological needs of the child like love, security, play, discipline, recognition, independence, protection etc.

6. Illness of the parents: Mental as well as physical.

7. Disharmony between parents.

8. Broken home due to death, divorce, separation from one or both parents because of their occupation.

9. Attitude of grandparents.


11. Illegitimacy.

12. Social and cultural factors e.g. methods of upbringing family living etc.

13. Physical environment like overcrowding, slums, poor sanitation and hygiene etc.


**Management**

The treatment of behavioral problems of children is best carried out in a child guidance clinic with the team of psychiatrist, psychiatric social worker, clinical psychologist and paediatrician. Each team member has a distinct role to play in the treatment of the child. The detailed history of the problem and psychosocial background is collected by the psychiatric social worker from the parents. The child is put in the play room which is a necessary part of the clinic and it is necessary to help the child to adjust to the clinic through the play activities. The child is also examined by the paediatrician to rule out any physical illness. Psychotherapy, behavioral therapy, counselling, play therapy etc. In addition, the child is given drugs whenever necessary. The Psycho-Social Worker takes up the case for case work along with the psychiatrist to correct the disturbances in the interpersonal relationship in the family,
problems at school, problems in the neighbourhood which are affecting, etc. Follow up of cases at regular intervals is carried out to prevent relapse.

IV. PERSONALITY DISORDERS

The illness included in this group are characterised by the absence of any psychotic or neurotic pattern of behaviour, any mental deficiency, any brain tissue damage. These illness disturb the harmonious social adjustment.

Definition

The definition of abnormal personality according to ICD 9 defined as one in which there are deeply ingrained maladaptive pattern of behaviour recognizable by the time of adolescence or earlier and continuing through most of adult life.

Personality disorders that are characterised by enduring pattern of behaviour that are inflexible and maladaptive and cause distress or interference with functions. (American Psychiatric Association, 1994).

Aetiology

1. Hereditary factors: Chromosomal abnormalities or genetic predisposition.
2. Personality: Schizoid personality, paranoid personality, Histrionic personality due to disturbed parent-child relationships.
4. Maternal deprivation, particularly during the infancy and early childhood.
6. Unhealthy physical environment like overcrowding, slums, poor hygiene and sanitation.
7. Mental Retardation.

Treatment of Personality disorders

Personality disorders is often difficult to treat. Drug therapy has a very little role and may be used if associated with mental illness like depression or psychosis present. Individual and group psychotherapy, therapeutic community, and behavioural therapy may be beneficial.

1. EATING DISORDERS

The two most important eating disorders are:

- Anorexia nervosa, and
- Bulimia nervosa

Anorexia Nervosa

Anorexia nervosa is characterized by highly specific behavioural and psychopathological symptoms and significant somatic signs. Majority are females and the onset is during adolescence. The core psychopathological feature is the dread of fatness, weight phobia and a drive for thinness.

Clinical Features

- There is an intense fear of becoming obese. This fear does not decrease even if the person loses weight grossly and becomes very thin.
- The body weight is 15 percent below the standard weight.
- There is a body image disturbance. The patient is unable to perceive the body size accurately.
- The pursuit of thinness may take several forms. Patients generally eat little and set themselves daily calorie limits (often between 600 and 1000 calories). Some try to achieve weight loss by inducing vomiting, excessive exercise, and misusing laxatives.
• Other signs and symptoms are secondary to starvation and include sensitivity to cold, delayed gastric emptying, constipation, low blood pressure, bradycardia, hypothermia and amenorrhea in females.
• Vomiting and abuse of laxatives may lead to a variety of electrolyte disturbances, the most serious being hypokalemia.
• Hormonal abnormalities also may be seen.

Treatment
Neuroleptics, appetite Stimulants, antidepressants and psychological therapies such as individual therapies, behaviour therapy, Cognitive therapy and family therapy.

BULIMIA NERVOSA
Bulimia nervosa is described as repeated bouts of over eating and a preoccupation with control of weight that leads to self-induced vomiting.

Clinical manifestations
• Irresistible craving for food: In which large amount of food are consumed within short period of time.
• Attempt to counteract the effects of over eating by self-induced vomiting.
• There is usually no significant weight loss.

Management
Drug therapy, group therapy, family therapy and cognitive behaviour therapy.

2. SLEEP DISORDERS
Sleep disorders divided into sub types:
1. Dyssomnias
   - Insomnia
   - Hypersomnia
   - Disorders of sleep-wake schedule.

2. Parasomnias
   - Stage IV disorders
   - Other disorders.

Causes
   - Medical illness: Any painful or uncomfortable illness, heart disease, respiratory diseases, Hypothalamus or brain stem lesions, delirium, rheumatic and other musculoskeletal disorders, old age etc.
   - Alcohol and drug use
   - Psychiatric disorders: Mania, depression, schizophrenia, and anxiety disorders.
   - Social causes: Financial loss, separation or divorce, death of spouse, retirement, stressful life situations etc.
   - Behavioral causes: Naps during the day, irregular sleep hours, lack of physical exercise, excessive intake beverages in the evening e.g. coffee, disturbing environment such as heat, cold and noise.

Management
   A thorough physical and psychiatric assessment, treatment for physical and psychological problems, drugs, progressive relaxation, meditation, yoga, stimulus control therapy like go to bed for seep only.

Sleep hygiene
   Regular and daily physical exercises, avoid fluid intake and heavy meals before bed time, avoid caffeine intake such as tea, coffee, cola drinks etc.
before going to sleep, avoid reading or watching television while in bed, back rub, warm milk and relaxation exercises, sleep in a comfortable environment.

3. SEXUAL DISORDERS

In ICD10 gender identity disorders, disorders of sexual preference and sexual development and orientation disorders are listed under Disorders of Adult personality and Behaviour (F6), While sexual dysfunctions are listed under Behavioural syndromes Associated with Physiological Disturbances and physical Factors (F5).

Psychological and Behavioural Disorders Associated with Sexual Development and Maturation (F6)

Homosexuality

In this, sexual relationships are maintained between persons of the same sex. Female homosexuals are called as ‘ lesbians’ and male homosexuals are called ‘ gay’.

Treatment

Behavior therapy like aversion therapy, covert sensitization, systematic desensitization, Supportive Psychotherapy, Psychoanalytic psychotherapy.

Disorders of sexual preference (ICD10-F6) or Paraphilia (DSMIV)

In Paraphilia, sexual arousal occurs persistently and significantly in response to objects, which are not a part of normal sexual arousal. These disorders include:

- **Fetishism:** Sexual arousal occurs with a non-living object which is usually intimately associated with the human body. The fetish object may include bras, underpants, shoes, gloves, etc.
• **Transvestism:** Sexual arousal occurs by wearing clothes of the opposite sex.

• **Sexual sadism:** The person is sexually aroused by physical and psychological humiliation, suffering or injury of the sexual partner.

• **Sexual masochism:** Here the person is sexually aroused by physical or psychological humiliation or injury inflicted on self by others.

• **Exhibitionism:** In this the person is sexually aroused by the exposure of one’s genitalia to an unsuspecting stranger.

• **Voyeurism:** This is a recurrent tendency to observe unsuspecting persons naked (usually of the other sex) and engaged in sexual activity.

• **Frotteurism:** This is a persistent or recurrent involvement in the act of touching and rubbing against an unsuspecting, non-consenting person.

• **Pedophilia:** It is characterized by persistent or recurrent involvement of an adult in sexual activity with animals.

• **Zoo philia (Beastiality):** Involving in sexual activity with animals.

• **Other paraphilia:** Sexual arousal occurs with urine, feces, enemas, etc.

**Treatment**

• Behavior therapy: aversion therapy.

• Psychoanalysis

• Drug therapy: Antipsychotics have been used for severe aggression associated with Paraphilia.

**V. SUBSTANCE ABUSE OR SUBSTANCE DEPENDENCE**

Dependence is a state of psychic and sometimes also physically characterised by compulsion to take the drug on continuous or periodic base in order to enjoy its psychic effect, tolerance is present and person may be dependent on one or more drugs.
**Abuse:** It refers to maladaptive pattern of substance use that impairs health in a broad sense.

**Withdrawal state:** A group of signs and symptoms recurring when a drug is reduced in amount.

**The major dependence producing drugs are:** Alcohol, Opioids, Cannabis, Cocaine, Amphetamines, Nicotine, Hallucinogens e.g. LSD and Phencyclidine, sedatives and hypnotics, e.g. Barbiturates, other stimulants, e.g. Coffin.

**Aetiology**

**Biological factors**
- Genetic vulnerability: Family history of substance use disorder, e.g. twin studies suggest that genetic mechanism might account for alcohol consumption.
- Withdrawal and reinforcing effects of drugs.
- Co morbid medical disorder (e.g. to control chronic pain)

**Psychological factors**
General rebelliousness, sense of inferiority, poor impulsive control, low self-esteem, loneliness, unmet needs, pleasure seeking, sexual immaturity, desire to experiment, desire to escape from reality. Psychological trauma during infancy and childhood, disturbed parent-child relationship, and parental disharmony are more common.

**Social factors**
Religious reasons, peer pressure, urbanization, unemployment, poverty, overcrowding, poor social support, effects of television, and other mass media, occupation like where substance use is more common in chefs,
bar men, executives, salesmen, actors, entertainers, army personnel, journalist, medical personnel.

**Easy availability**

Taking drugs prescribed by the doctors’ e.g. Sedative drugs, taking drugs that can be brought legally without prescription (e.g. Nicotine, opioids).

**Psychiatric disorders**

Substance use disorders are more common in depression, anxiety disorders, personality disorders, and occasionally organic brain disorder.

**Alcohol dependence syndrome**

Alcohol refers the use of alcoholic beverage to the point of causing damage to the individual society or both. The rate of absorption of alcohol into the blood stream is more rapid than its elimination. Absorption of alcohol into the blood stream is slower when food is present in the stomach.

A concentration 80 to 100 mg of alcohol per 100 ml considered as intoxication. A person with 200 mg to 250 mg will be toxic, sleepy, confused, and thought process will be altered. If blood level is 300 mg / 100 ml of blood the person may lose consciousness. A concentration of 500 mg /100 ml is fatal. All the symptoms change according to tolerance.

**Medical and social problems of alcoholic dependence**

Central nervous system: Peripheral neuropathy, epilepsy, head injury, cerebella degeneration.

Cardiovascular system: Alcohol cardiac Myopathies, myocardial infarction.
Gastrointestinal system: Gastritis, peptic ulcers, carcinoma of the stomach, fatty liver, cirrhosis of the liver, hepatitis, liver cancer, pancreatitis, malabsorption syndrome.

Miscellaneous: Protein malnutrition, vitamin deficiency disorder, peripheral muscle weakness, acne, sexual dysfunction.

Withdrawal syndrome

Heavy drinking over period of time followed by decrease in the amount of alcohol in the body is likely produce withdrawal symptoms. These are: Simple withdrawal syndrome and delirium tremens.

Simple withdrawal syndrome

It is characterized by mild tremors, nausea, vomiting, weakness, irritability, insomnia and anxiety.

Delirium tremens

It occurs usually within 2 to 4 days of complete abstinence from heavy alcohol drinking. It is characterised by clouding of consciousness, disorientation to time and place, poor attention span, visual hallucinations, grossly tremulous hands, ataxia, autonomous disturbances such as sweating, fever, tachycardia, raised blood pressure, Pupillary dilatation and other symptoms like dehydration with electrolyte balances, insomnia, Leucocytosis and impaired liver function. Death may occur due to cardiovascular collapse, infection, hyperthermia and self-inflicted injury.

Alcohol-induced psychiatric disorders

Dementia, mood disorder, suicidal behaviour, anxiety disorder, psycho sexual dysfunction, delusions, hallucinations and seizures.
Treatment

A full assessment of current medical and social problems. Treatment of withdrawal from alcohol by detoxification, Vitamin B complex, psychotherapy, behavioural therapy, social case work, family counselling, vocational rehabilitation and also patient may referred to alcoholic anonymous which helps the patient in a supportive way to adjust himself in his social environment.

Drug Dependence

Drug dependency is a state of psychic and sometimes also characterized by compulsion to take the drug on continuous or periodic basis in order to enjoy its psychic effects and also to avoid the discomfort of its absence, tolerance is present and person may be dependent on one or more drugs.

Clinical manifestations

The drugs produces euphoria, acute brain syndrome or chronic brain syndrome, personality changes, antisocial activities and abstinence results in physiological and psychological withdrawal symptoms.

Treatment

Very difficult and unsatisfactory. Withdrawal of the drug slowly or abruptly, hospitalization and withdrawal symptoms can be managed by detoxification therapy. Maintenance therapy by psychotherapy, behavioural therapy, group therapy and family therapy and relaxation therapies.

Prevention of substance use disorder

- Reduction of over prescribing by the doctors.
- Identification and treatment of family members.
• Introduction of social changes is likely to affect drinking patterns in the population such as putting up the price of alcohol, abolishing the advertisement of alcoholic drinks.
• Controls on sales by limiting hours or banning sales in supermarkets.
• Government measures like restricting the availability of alcohol.
• Strengthen the individual’s personal and social skills to increase the self-esteem and resistance to peer pressure.
• Health education to college students and the youth about the dangers of substance abuse through mass media.
• Create awareness among the public.
• An overall improvement in the socio-economical condition of the population.
• Early detection and Counseling, Detoxification, drop in centers, identifying high risk situations and developing strategies to deal with them.
• Continuing social support is usually required when the person makes the transition to normal work and living.

VI. PSYCHOSOMATIC ILLNESS/ PSYCHO PHYSIOLOGICAL DISORDERS

These are illnesses wherein somatic symptoms and structural changes in the viscera are caused by repressed intrapsychic conflicts.

Aetiology

• Biological predisposition: Family history, biochemical alteration.
• Personalities like suppression of anxiety, frustration, calm, depressed, low self-worth, self-pity etc.
• Extreme psychological stress like severe emotional stress, crisis and traumatic life events.
• Other factors: Poor coping strategies, occupational difficulties, smoking, increased disturbance in functions of sympathetic nervous system, excessive exercises, life threatening illness, repressed anger etc.

Types
1. Cardiovascular: Hypertension, heart disease, cardiac neurosis.
2. Gastrointestinal system: Peptic ulcer, irritable bowel syndrome, ulcerative colitis, obesity, eating disorders.
3. Respiratory: Bronchial asthma, Hyperventilation.
5. Endocrinal: Diabetes, Hyperthyroidism.

Clinical manifestations
The symptom varies based on the causes.

Treatment
The patients have not to be treated for their cause alone. Careful attention has to be given to the emotional and psychological factors. A psychologist may have to be included in the medical team managing these patients. Occasionally anti-anxiety and anti-depressants may be helpful.
Psychotherapy, Social therapy, Psycho-physiological therapies like Yoga, Biofeedback, Exercises etc.

VII. MENTAL RETARDATION

“Mental retardation refers to significantly sub average general intellectual functioning resulting in or associated with concurrent impairments in adaptive behaviour and manifested during the developmental period” (American Association on Mental Deficiency, 1983).

‘Significant sub average’ is defined as an Intelligent Quotient (IQ) of 70 or below on standardized measures of intelligence. The upper limit could be extended to 75 or more, depending on the reliability of the intelligence test used.

Aetiology

Genetic factors: Chromosomal abnormalities like Down’s syndrome, trisomy syndrome, Turner’s syndrome, Cat-cry syndrome, etc.

Metabolic disorders: Phenylketonuria, Wilson’s disease, Galactosemia, etc.

Cranial malformations: Hydrocephaly and Microcephaly, diseases of the brain like tuberous scleroses, neurofibromatosis, epilepsy etc.

Prenatal factors: Infections like rubella, cytomegalovirus, syphilis, toxoplasmosis and herpes simplex.

Endocrinal disorders like hypothyroidism, diabetes mellitus.

Physical disorders and damage: Injury, hypoxia, radiation, anaemia, emphysema.

Substances: like lead, certain drugs, substance abuse etc.

Perinatal factors: Birth asphyxia, prolonged birth, prematurity, jaundice, instrumental delivery resulting in head injury.
Postnatal factors like encephalitis, measles, meningitis, septicaemia, accidents, and lead poisoning.

Environmental factors and socio-cultural factors: Cultural deprivation, low socio-economic factors, and child abuse.

**Classification**

- Mild Mental Retardation (Educable) 50-70 IQ
- Moderate Mental Retardation (Trainable) 35-50 IQ
- Severe Mental Retardation (Dependent retardation) 20-35 IQ
- Profound Mental Retardation (Life support) < 20 IQ

**Behavioural manifestations**

**Mild Retardation**

This is commonest type of mental retardation accounting for 85 to 90% of all cases. These individuals have minimum retardation in sensory-motor areas. They can read up to VI standard in school and can achieve vocational and social self-sufficiency with little support.

**Moderate Retardation**

About 10% of mentally retarded come under this group. Communication skills develop much slowly in these individuals. They can be trained to support themselves by performing semiskilled or unskilled work under supervision.

**Severe Retardation**

Severe mental retardation often recognized early in life with poor motor development and absent or delayed speech and communication skills. Most of them require a great deal of assistance and structured living arrangements.
Profound Retardation

This group accounts for 1 to 2 percent of all mentally retarded. The achievement of developmental milestones is markedly delayed. They require constant care and supervision. Associated physical disorders are common.

\[
IQ = \frac{\text{Mental age}}{\text{Chronological age}} \times 100
\]

Care and Rehabilitation of the mentally retarded

- The prevention and early detection of mental handicaps.
- Regular assessment of the mentally retarded person’s attainments and disabilities.
- Advice and support for families.
- Provision for education, training for each handicapped persons.
- Medical, psychiatric and psychological, out patients, day patients, or inpatients and other services.

PSYCHOLOGICAL ISSUES AMONG SPECIAL POPULATION

PROBLEMS OF ADOLESCENCE

Rate of depression, bipolar disorders, attempted of suicide, conduct disorders, schizophrenia, anti-social activities, agoraphobia and juvenile crime like rape, sexual abuse, and substance abuse usually increased.

PROBLEMS OF ELDERLY

Aging is a natural progressive declining in body systems. Old people suffer from physical problems such as immobility, instability, incontinence, decreased vision and hearing and intellectual impairment.
**Psychological problems**

Delirium, dementia, agitation, crying spells, feeling of worthlessness, hopelessness, helplessness, irritability, wandering, assaultiveness, diminished changes leads to criminal behaviour or suicidal tendencies.

**Social problems**

Harassment, ill-treatment, exploitation, separation from dear ones, living alone, etc.

**Management**

Drug therapy, ECT, psychotherapy, life review therapy, cognitive training, relaxation therapy, counselling, patient and family education.

**PSYCHIATRIC DISORDERS RELATED TO WOMEN**

- Premenstrual syndrome
- Psychiatric disorders associated with child birth
- Menopausal syndrome

**PREMENSTRUAL SYNDROME**

Some women experience various psychological manifestations 5 to 10 days before the onset of menses and lasts till the end of menses. These symptoms are sadness, anxiety, anger, irritability, labile mood, decreased concentration, suspiciousness, insomnia, hypersomnia, suicidal or homicidal ideations, craving for certain foods, lethargy, libido changes, decreased motivation and social withdrawal. This premenstrual syndrome not only affect social but also occupational functioning, leading to various degree of maladjustment.

**Management**

Progesterone therapy, oral contraceptives, diuretics and antidepressant drugs, psychotherapy, cognitive behavioural therapy.
PSYCHIATRIC DISORDERS ASSOCIATED WITH CHILD BIRTH

There is an increased risk of mental illness associated with child birth are:

1. Mental illness in pregnancy
2. Puerperal mental disorders

Predisposing factors

Neurotic traits, marital tensions, history of previous abortion.

Common disorders are: Depressive neurosis, phobic anxiety, obsessive compulsive disorders. In most conditions these conditions may resolve by the second trimester of pregnancy.

Management

Reassurance, counselling and drug therapy followed depends on the condition and risk of teratogenic effects of the foetus.

PUERPERAL MENTAL DISORDER

• Postnatal blues
• Postnatal depression
• Puerperal psychosis

Postnatal blues

Postnatal blues are transient, a self-limiting condition with serious after effects. Most of the women recover from the blues within a day or two. It occurs at any time between the third and tenth post-natal day. It is considered as normal reaction to child birth and affects 70 to 80% of post-natal mothers.

Predisposing factors

More common in Primi gravida women due lack of experience regarding care of the baby.
**Clinical manifestations**

Women experiences unfamiliar episodes of crying, irritability, depression, emotional liability, insomnia, poor concentration and fear of handling the baby.

**Management**

Reassurance and psychological support regarding care of the baby.

**Postnatal depression**

Postnatal depression is the most neurotic disorder during postnatal period. It occurs in 10% to 15% of women. Women experience within the first postpartum month. A majority of women recover spontaneously. This condition is manifested as poor concentration, feeling of guilt about their poor mothering skills, lack of interest in activities, social withdrawal, tiredness, irritability, anxiety, worry about the baby and sleep disturbances.

**Management**

Counselling, cognitive psychotherapy, anti-depressivedrugs and good family support.

**Puerperal psychosis**

The onset of disease is very sudden, commonly occur within first postnatal week. Incidence observed approximately 1-2 per 1000 births. Primigravida, unmarried mothers, past history of schizophrenia may predispose to puerperal psychosis.

**Clinical manifestations**

Insomnia, early morning walk, labiality of mood, sudden tearfulness, fear, abnormal behaviour like excitement, restlessness, or sudden withdrawal, suicidal or infanticide threats, excessive guilt, depression and anxiety.
Management

Hospitalization, drug therapy, and supportive psychotherapy. ECT in severe psychosis.

Menopausal syndrome

Menopause is the cessation of ovulation, usually between 45 and 53 years of age. This condition is characterised by physiological changes as well as psychological manifestations such as worrying, depression, anxiety, irritability, difficulty in concentration, and decreased self-confidence.

Management

Psychological support, hormonal replacement therapy, counselling and psychotherapy.

PREVENTION OF MENTAL ILLNESS

In the 1960s, Psychiatrist Gerald Caplan described levels of prevention specific to psychiatry. The concepts of prevention of mental illness contains primary, secondary and tertiary prevention.

Primary prevention

It includes all measures which serve to foster healthy development and effective coping behaviour. It covers genetic counselling, providing adequate prenatal and neonatal services and ensuring conditions in the family which ensure optimal development and functioning of children. Public measures such as housing projects to eradicate slums, social legislation to provide equal educational and job opportunities for the underprivileged are part of primary prevention measures. Primary prevention seeks to prevent the occurrence of mental disorder by strengthening individual, family, and group coping abilities.
Primary prevention has become increasingly identified with “health education “and the concept of individual and community responsibility for health.

**Secondary prevention**

Emphasises the early detection and prompt treatment of adjustment problems at the individual and community levels. Research has helped us to identify people at high risk, for example, school dropouts or children of alcoholic or mentally ill parents, and risk factors such as peer rejection, work stress, caregivers of chronically ill people, etc.

**Tertiary Prevention**

It includes prevention of complications and rehabilitation by prompt and intensive in-patient treatment with the aim of prevention of the disorder from becoming chronic. This can ensure that the mentally ill individual will return to his home or work as early as possible. The emphasis is on brief hospitalization and long-term follow-up care. Rehabilitation is the process of enabling the individual to return to highest possible level of functioning. Psychiatric rehabilitation starts with a comprehensive medical diagnosis and functional assessment. Reduction of impairment by various psychotherapeutic agents. Remediation of disabilities through skill training such as training in self-care, vocational training, recreational and leisure skills. Remediation of disabilities through supportive interventions like community support programmes.

**PSYCHIATRIC REHABILITATION**

Severe mental disorders figure among the leading cause of disability and burden to the world. Psychiatric rehabilitation in India divided into two phases. In the first phase, comprising the first 25 years since independence, most of the services were hospital based and largely confined to the
government mental hospitals. The emphasis was on keeping the long-stay patient occupied with some form of work or activity. In the second phase, from the early 1970s efforts being made to reintegrate the patient with family and the community. Delivery of rehabilitation services through Hospital based services and Community based services.

**REVIEW OF LITERATURE**

**INTRODUCTION**

The consequences of mental illness are often beyond the direct symptoms of the illness which affects the person’s social and economic well-being and all aspects of life. Studies showed that without a strong support system, many will not manage their illness effectively, leading to poor outcomes and increased hospitalization. People with mental illness remain one of the most marginalised groups in society. They are often isolated from family and friends. They may experience family instability, poverty, unemployment, stigma and exclusion. These problems often lead to lower living standards, which in turn can result in high rates of deaths and earlier deaths.

Today researchers have become interested in viewing the problems faced by mentally ill and their family members. Much research has been undertaken on various aspects of mental illness. A review of literature presented in this chapter in four aspects.

1. **STUDIES RELATED TO MENTAL ILLNESS.**
2. **STUDIES RELATED TO ATTITUDE OF THE PEOPLE TOWARDS MENTAL ILLNESS.**
3. **STUDIES RELATED TO STIGMA TOWARDS MENTALLY ILL.**
4. **STUDIES RELATED TO SOCIAL SUPPORT SYSTEM TOWARDS MENTAL ILLNESS.**
STUDIES RELATED TO MENTAL ILLNESS

Elnagar, M. N. et al., (1971) population based survey conducted on mental health in an Indian rural community. Study results indicates that nearly 1% population in India suffers from serious mental disorders and 5 – 10% from moderate disorders, requiring psychiatric help.

Nandi, D.N. et al., (1975) across sectional study to assess the changes, if any, in the prevalence of mental disorders in rural community after an interval of 20 years in the context of its changing socio-economic conditions. A door to door survey of the prevalence of psychiatric morbidity in two villages was conducted by a team of psychiatrists. Study results indicated that the level of psychiatry morbidity showed no statistically significant change. The morbidity pattern however showed some interesting changes.

Martin, R.L. et al., (1980) a one year prospective follow-up with the sample of 44 women on psychiatric status after hysterectomy, the authors suggest that when hysteria is diagnosed, therapeutic decisions regarding hysterectomy should be based on objective finding rather on complaints, in that woman with hysteria may be placed at risk of hysterectomy on the basis of psychiatric rather than gynaecologic illness.

Venkoba Rao, A., (1981) study on mental health and aging in India. Data collected from the geriatric patients at geriatric clinics, found that the number of patients diagnosed increased over a four-year period. The gender ratio was skewed towards males, with the most common disorder being depression (39.9%) followed by organic brain syndrome (34.3%), paranoid illness, and neurosis.

Venkoba Rao, A. and Madhavan, T., (1982) a gerio-psychiatric morbidity survey conducted in a semi-urban area near Madurai. Study reports suggested that psychiatric morbidity 8.9% in a sample aged above 60 years.

Gautam, S. et al., (1982) study on post-partum psychiatric syndrome: an analysis of 100 cases. Research in Asian countries has demonstrated a wide
range of prevalence of postnatal depression from 3-36% mothers after child birth. Results concluded that majority of postnatal depression are self-limiting through, if untreated, the process of resolution may take up to 6 -12 months.

Shirala, K.A and Kanwar, S., (1987) a demographic study on mental illness and hill women. The study results stated that women belonging to rural community in Himachal Pradesh had significantly more symptoms of somatic disorders and anxiety than men, and this was strongly associated with lack of education, poverty and low caste.

Nothorst-Boos, J. and Vonschoultz, B., (1992) this study aimed at to understand the psychological reactions and sexual life after hysterectomy with and without oophorectomy. A sample of 678 women were interviewed, the results concluded that most of the women experienced negative feelings towards sexual life.

Bhogale, G.S and Sudarshan, C.Y., (1993) data collected from geriatric patients attending a general hospital psychiatric clinic. Study results indicated that a majority of cases had functional psychosis (43.7 %), while 19.8% had a neurotic illness.

Nancy, Avis E. et al., (1994) a longitudinal analysis of the association between menopause and depression with the sample of 2565 women aged 45 to 55 years. Results show that natural menopause not associated with increased risk of depression for experiencing. Long per menopause period (at least 27 months) associated with increased risk of depression.

Gregoire, A.J.P. etal., (1996) this article examine the transdermal oestrogen for treatment of severe postnatal depression, with the sample of 61 women with major depression, which began with in three months of child birth and persisted for up to 18 months postnatally, the study results concluded that transdermal oestrogen is an effective treatment for postnatal depression.
Hansenne, M. et al., (1996) study conducted on suicidal behaviour in depressive disorders. Study sample includes depressive inpatients with and without history of suicide attempt. The results indicate that patient who attempted suicide exhibit lower cortical resources and poorer cortical performance than patients without history of suicidal attempt.

Wolfersdorf, M.et al., (1996) this study focused on electro dermal activity and suicide behaviour. There may be a connection between suicidal tendencies, electro dermal activity. The experiment done on 11 female patients with personality disorders and histories of suicide attempts were compared with those of age paralleled non-suicidal depressive patients. This study results stated that electro dermal activity lesser the suicidal behaviour.

Babu, R.S. and Sengupta, S.N., (1997) study conducted on problem drinkers in general hospitals. In accordance with the growing abuse of alcohol, hospital admission rates were increased in India, nearly 20 -30 % of hospital admissions are due to alcohol related problems in mental care setting.

Nandi, P.S.et al., (1997) a study on psychiatric morbidity of the elderly population of a rural community in West Bengal. Study concluded that (61%)were found to have psychiatric illness with females having significantly higher rates than males.

Reddy, M.V. and Chandrashekar, C.R., (1998) a meta-analysis on prevalence of mental and behavioural disorders in India. Study results stated that prevalence of schizophrenia to be 2.7 (2.2 -3.3 / 1,000) population. The prevalence of psychotic depression and neurotic depression rates to be 13.9 in rural areas and 35 .7 / 1,000 population in urban areas.

Mizuno, E.et al., (1999) the aim of this study is to study the effectiveness of a stress management program for family care givers of the elderly at home. This program is a series of five weekly 90 minute sessions including psycho education, problem solving techniques and relaxation training. Subjects were 56 primary care givers looking after relatives with
dementia or disability at home. These results indicated that our programme was effective in managing stress of caregivers.

Srinath, S and Girimaji, S.C., (1999) an epidemiological study on child and adolescent mental health problems and mental retardation in India. This study reported that the psychiatric and emotional problems prevalence vary from 25 to 356 per 1,000 in field services.

Marika, V., (1999) study conducted on depression symptoms and emotional state in parents of disabled and non-disabled. The study results shows that parents especially mothers of children with disability have significantly more emotional states and also significantly more depressive symptoms.

Ganguli, H.C., (2000) epidemiological findings on prevalence of mental disorders in India. This study based on review of 13 studies, the study results identified the prevalence to be 2.5/1,000 (urban 2.5 and rural 3.6), even with a rate of 2.5-2.7/1,000, it is estimated that India has nearly 2.5 million schizophrenics needing care at any point of time.

Goodman, E. and Capitman, J., (2000) study carried out on depressive symptom and cigarette smoking among teens. Study results stated that current cigarette smoking was the stronger predictor of developing high depressive symptoms in the age group of teenagers.

Najman, J.M. et al., (2000) postnatal depression myth and reality. Maternal depression before and after the birth of child. Study results indicate most of the mothers’ experience periods of depressed mood after the birth of their baby, these periods are generally of short duration and of lesser intensity than a major depression.

Murali Madhav, S., (2001) an epidemiological study on prevalence of mental disorder in India. Study based on analysis of ten Indian studies on psychiatry morbidity to estimate the median value of prevalence rates. Study results identified that urban morbidity rate was 2 per 1000 higher than the
rural rate. The results will be useful to mental health planners and administrators for planning the national mental health programme.

Jawor, M. et al., (2001) a study on anxiety-depressive disorders after hysterectomy, the results of study and clinical observation shows that half of the group of women operated suffer from anxiety depressive disorders as a cause of the operation and a quarter of all those operated require specialist help.


Lee, S.H., (2002) the quasi-experimental study to examine the effects of Aromatherapy Massage on Depression, Self-esteem, Climacteric symptoms in the middle-aged Women. Results indicated that Aromatherapy massage was effective to reduce depression and climacteric symptoms in middle aged women.

Thara, R.et al., (2003) an ethnographic, qualitative study on women with schizophrenia and broken marriages-doubly disadvantaged? Part I: Patient perspective. The study conducted with the sample of 75 mentally ill women who were separated or divorced. Findings suggest the stigma of being separated / divorced was often more acutely felt both by families and patients than that of mental illness per se.

Katie Lemon, (2004) an assessment of treating depression and anxiety with aromatherapy. This investigation studied the effects of aromatherapy in reducing depression and anxiety. Study results indicated that a significant difference between aromatherapy and control groups. The test group showed a marked improvement by aromatherapy.

administered with suicide survivors and mental health professionals. The indications can be powerful resources for therapists and their clients.

Seshadri, V. et al., (2004) a study on prevalence of depression and its effect on quality of life in patients with epilepsy: A community based study and a comprehensive rural epilepsy study in South India. The total sample consists of 450 epilepsy patients, results shows a significant number of people with epilepsy suffering with depression which interfere with their quality of life.

Janssen, P.A. et al., (2005) this study examines the utility of acupuncture for substance abuse treatment in the Downtown Eastside of Vancouver. Study results stated that acupuncture act as an adjunct therapy for reduction of substance use.

Kim, M.J. et al., (2005) a quasi-experimental design with a sample of 40 patients enrolled in the Rheumatic Centre, South Korea. The study results stated that aromatherapy has major effect on decreasing pain and depression levels.

Cohen, Lee S. Et.al., (2006) a study on risk of depression among 460 Boston women between the ages of 36 and 45. Study results shows that women had never diagnosed with major depression, but those who entered peri menopausal during the study period were almost twice as likely as those who did not to develop significant symptoms of depression. The risk was greater in perimenopause women who also had hot flushes.

Okuyama, T. et al., (2007) a comparative study on mental health literacy in Japanese cancer patients: ability to recognize depression and preference of treatments with Japanese lay public. A sample of 100 lung cancer patients and 300 lay public were selected for study. Study results concluded that only 11% of cancer patients recognize the presence of depression in the vignette, while 25% of lay public did. Study findings stated that cancer patients' knowledge about mental illness and its treatment were
insufficient. Psychological education may reduce patient related behaviours to seek and to utilize optimal mental health care in cancer patients.

Hogberg, G. and Hall Storm, T., (2008) this study conducted on active multimodal psychotherapy in children and adolescents with suicidality. The aim of this study was to describe and evaluate the clinical pattern of 14 youth with presenting suicidality and to estimate therapy effectiveness. This study suggest that a mood map based multi model treatment approach with active technique might be of value in the treatment of children and youth with suicidality.

He, Y. et al., (2008) series of cross-sectional population sample surveys carried out in 17 countries in different regions of the world. Study results stated that specific mood and anxiety disorders occurred among persons with arthritis at higher rate than among persons without arthritis.

Kumar, S.G. et al., (2008) a community based cross sectional study to assess the prevalence and pattern of mental disability in rural community, Karnataka. The study results stated that prevalence and pattern of mental disability was found higher in female than male and the prevalence was higher among elderly age group and illiterates. There is simple scope for community based rehabilitation of the mentally disabled.

Hepburn, S.R. et al., (2009) the study conducted to examine the effects of mindfulness-based cognitive therapy on thought suppression and depression in individuals with past depression and suicidality. The study results indicated that MBCT for suicidality may reduce thought suppression.

Weinmann, S. et al., (2009) a systematic review on influence of antipsychotics on morbidity in schizophrenia. The results stated that antipsychotic drugs and higher mortality showed a significant association for one or more anti-psychotics.

Yim, V.W.C. et al., (2009) review on the effects of aromatherapy for patients with depressive symptoms. This review was conducted among five
databases to identify all peer-reviewed Journal papers that tested the effects of aromatherapy in the form of therapeutic massage for patients with depressive symptoms. The results were based on six studies examining the effect of aromatherapy on depressive symptoms in patients with depression and cancer. Some studies showed positive effects of this intervention among these three groups of patients.

Williams, J.M. et al., (2010) trail design and protocol on staying healthy after depression. This is the first trail of Mindfulness-Based Cognitive therapy to investigate whether it is effective in preventing relapse to depression and to explore the use of Mindfulness-Based Cognitive therapy for most severe recurrent depression that in people who become suicidal when depressed. Study results stated that this therapy is most useful to reduce depression.

Patel, V. et al., (2010) a trial was conducted to test the effectiveness of an intervention led by lay health counsellors in primary care setting to improve outcomes for the people with depression and anxiety disorders. This trial results found that an interventions by trained lay counsellor can lead to improvement in recovery from depression.

Andrews, G. et al., (2010) a Meta - analysis on computer therapy for the anxiety and depressive disorders is effective, acceptable and practical health care. Study results conclude innovative approaches like self-help books or internet based self-help programmes have been shown to help reduce or treat depression.

Rajkumari Guptha and Harpreet Kaur, (2010) examined the stress among the parents of mentally retarded children. Study conducted with the sample of 102 parents, 30 of them had children without disability. Results show that, most of parents of children with mental retardation experience higher mental stress as compared to the physical stress.

Anitha Ravi Kausal, (2010) this study sought out construct a tool for assessment and quantification of psychosocial status of renal patients in
developing countries. Who are on haemodialysis, waiting for renal transplantation. The study results stated that psychological problems can be easily assessed by using psychological assessment tool (PAT - 5). Early identification of psychological problems can prevent the depression in these patients.

Wilkinson, S.M.et al., (2010) a randomised controlled study to test the effectiveness of Aromatherapy Massage in the management of anxiety and depression in patients with cancer. Study conducted with sample of 288 cancer patients, results shows that Aromatherapy massage does not appear to confer benefit on cancer patients’ anxiety and depression in the long-term, but is associated with clinically important benefit up to 2 weeks after the intervention.

Sreevani, R. et al., (2011) a descriptive research approach was adopted on stress levels among wives of alcoholics and non-alcoholics. The results showed that the wives of alcoholic-dependent individuals experience high levels of stress from husband’s alcoholism.

Kunjalatha Gogoi, et al., (2011) non experimental, descriptive, comparative and cross sectional survey was conducted to assess the knowledge of family members in Rural and Urban areas in Assam. Study results concluded that by assessing the knowledge of family members, different programmes of intervention can be planned by psychiatric nurses in the Hospital.

Annie John, P. and Sailaxmi Gandhi, (2012) a study on talk therapy for depression. This study conducted with sample of 600 depressive patients in NIMHANS Bangalore who had not been helped by medication revealed that patients improved more when they were in therapy and on medication than when they were only taking medication.

Sreekanth, K.P., (2012) study to assess the effects of planned activity therapy on social functioning and self-care abilities of Schizophrenic patient in
Government Mental Health Centre, Kozhikode. The sample of 60 schizophrenic patients, as 30 each in experimental groups and control group. The findings indicates that planned activity therapy is effective in improving social functioning of schizophrenic patients.

Swar nalatha, N., (2013) a cross-sectional, observational, community based study on the prevalence of depression among the rural elderly in Chittoor District with the sample of 400 subjects, study results concluded that the prevalence of depression was high among the elderly, the female sex, illiteracy, a low socio-economic status, those who were living alone, those who were economically partially dependent and those who were totally dependent for the activities of daily living.

Honagodu, A.R. et al., (2013) a systematic review of randomized controlled trails of group of psychotherapy in depression in persons with HIV has been conducted. The results shows that group of cognitive behavioural therapies are acceptable psychological interventions for person with HIV and comorbid depression.

Jayalaxmi, N., (2013) an experimental study on yoga and anxiety level of neurotic patients. In this study 30 male subjects with anxiety neurosis were selected as the sample for study, the findings of the study concluded that regular yoga practices such as Asana and Pranayama for over a period of 30 days for one hour a day, resulted in reduction of anxiety levels in neurotic patients and also helped in decreasing pulse rate, blood pressure.

STUDIES RELATED TO ATTITUDE OF THE PEOPLE TOWARDS MENTAL ILLNESS

Younis, Y.O., (1978) a comparative study on attitude of Sudanese urban and rural population to mental illness. A systematic sample of 200 Sudanese individuals (100 males and 100 females) attending 4 health centres (2 urban and 2 rural) were interviewed. Study results concluded that more rural people than urban opted for religious healing as a method of treatment. Religious
factors and people’s concept of mental illness seem to influence their tolerance of deviant behaviour.

Malla, A. and Shaw, T., (1987) a comparative study conducted on female nursing students who had completed an instructional and experiential training programme regarding attitudes towards mental illness: the influence of education and experience with students who had just entered the same programme. The study results showed that students who had completed their training were better able to perceive the presence and severity of mental illness. Ng, S.L. et al., (1995) community’s’ attitude towards the mentally ill. Results stated that having known a person with mental illness facilitates more intimate relationship with people with a mental illness. Most respondents, who had been in contact with the mentally ill held informed and enlightened views. Knowledge regarding mental illness helps to develop positive outlook for the future of the rehabilitation of people with mental illness.

Angermeyer, M. C and Matschinger, H., (1996) focused on relative’s beliefs about the causes of schizophrenia. Opinion of general public in Germany shows that biological factors are responsible for schizophrenia, while the general public stated that psychological factors, especially stress related factors were responsible for the development of this illness. This discrepancy to relatives’ greater exposure to the knowledge of psychiatric experts as well as their having to deal with their own feelings of guilt.

Jorm, A.F. et al., (1999) the aim of this paper was to compare the Australian public’s attitudes towards people who have been treated for mental disorders with the attitudes of general practitioners, psychiatrists and clinical psychologist. The study respondents are the Australians, both the public and professionals rated outcomes as poorer and discrimination as more likely for the person with schizophrenia than for the one with depression. The professionals made more negative ratings than the public, although the clinical psychologist had similar attitudes to the public about depression.
Morrison, E.F. and Thornton, K.A., (1999) a case study is used to study the influence of Southern spiritual beliefs on perception of mental illness. This study results useful for psychiatric nurses to assist the hospitalized patients.

Sheikh, S. and Furnham, A., (2000) cross-cultural study of mental health beliefs and attitudes towards seeking professional help. It was concluded that culturally determined casual beliefs of mental distress contribute to attitudes towards seeking professional help for psychological problems for Asians and the Pakistan groups.

Al-Adawi, S. et al., (2002) a study on perceptions and attitude towards mental illness in Oman. This study compare the responses elicited from medical students, relatives of psychiatric and the general Omani public on the causes of mental illness. Both medical students and the public rejected a genetic factor as the cause of mental illness, instead they favoured the role of spirits as the etiological factor for mental illness.

Althaus, D. et al., (2002) study on knowledge and attitude of the general public regarding symptoms, aetiology and possible treatment of depressive illness. A sample of 1426 were selected for study. Results indicated that depression is regarded as a serious illness. 69% of the population considered antidepressants would lead to personality changes, 80% of the population considered antidepressants to be addictive. This suggested that future information campaigns should aimed at describing depression as an often chronic disease similar to diabetes or hypertension.

Gaebel, W. et al., (2002) study conducted on public attitude towards people with mental illness in six German Cities; results of a public survey under special condition of schizophrenia. A total of 7246 German speaking persons aged 16, study conducted by telephone using standardized questionnaire. 33.1% of the interviewers were able to name the causes of Schizophrenia. 76.5% interviewers believe that people with schizophrenia often or very often need prescription drugs to control their symptoms.
Hegerl, U. et al., (2003) public attitude towards treatment of depression: effects of an information campaign. This study conducted in 2000 and 2001 by telephonic survey in the German Cities, most of the people considered depression is a serious illness that can be treated fairly by a professional and found that well known bad reputation of psychotropic drugs still prevails.

Ozmen, E. et al., (2003) the survey was conducted in 2000 using face to face interview in the houses of 707 adults in 24 different districts of Istanbul on the knowledge and attitudes of the public towards depression and associated socio-demographic factors. The results indicates 78.9% diagnosed the depression vignette as a mental disorder. 86.6% of the sample considered “social environmental factors” and 68.2% “weak personality” to be as the cause of depression. Most of the people perceived depression as social problems, believes that depression could be treated by drugs and has incorrect knowledge about drugs and treatment, and is in doubt about the acceptance of depressive patients in society.

Lauber, C. et al., (2003) a study on Do people recognizes mental illness? Factors influencing mental health literacy. Multiple logistic regression analysis of an opinion survey conducted in a representative population sample in Switzerland (n=844). The depression vignette was correctly recognized by 39.8% where as 60.2% of the respondents considered as crisis. The Schizophrenia vignette was correctly identified by 73.6% of the interviewees. The low knowledge about mental disorders, particularly depression, confirms the importance and the need to increase mental health literacy.

Hugo, C.J. et al., (2003) community attitudes towards and knowledge of mental illness in South Africa. This study conducted by structured interviews (n=667), these data suggested that stigma and misinformation regarding mental illness exist, Influencing preferred treatment mobility and help seeking behaviour.
Sagduyu, A.et al., (2003) relatives’ beliefs and attitudes towards schizophrenia: an epidemiological investigation. Study results concluded that most of the relatives of schizophrenic patients identified a mental disorder when a schizophrenia case was described, but they had insufficient information about the term schizophrenia. Labelling patients as mentally ill had a negative effect on relatives’ attitudes towards schizophrenia.

Ozmen, E. et al., (2004) public attitudes to depression in urban Turkey. A public survey 707 subjects were included. Study results stated that more than half of the subjects stated that they would not marry a person with depression, and nearly half of the Subjects stated that they would not rent their house to a person with depression. One quarter of the subjects stated that depressive patients should not be free in the community. There is still considerable stigmatization associated with the depression.

Angermeyer, M.C. and Matschinger, H., (2004) in their study aimed to understand the public attitude to people with depression. This study concluded that there has been an increase in the readiness to feel pity and also a slight increase in the tendency to react aggressively, the expression of fear remained unchanged.

Nakane, Y. et al., (2005) Study assessed the public beliefs about causes and risk factors for mental disorders: A comparative study of Japan and Australia. The study results in both countries, the major differences in casual beliefs were that Australians were more likely to believe in infection, allergy and genetics. While Japanese were more likely to endorse ‘nervous person’ and ‘weakness of character’. For risk factors, Australians tented to believe that women, the young and the poor were more at risk of depression, but there were not seen as higher risk group by Japanese.

Jorm, A.F. et al., (2005) the present study was conducted on public belief about causes and risk factors for mental disorders. First survey of 2031 Australians, in 1995, and second survey was conducted in 2003-2004 with
sample of 1823. Study concluded that there has been an increase in belief about genetic causes of mental illness due to publicity about the human genome project and related scientific advantages.

Angermeyer, M.C.et al., (2005) population surveys on public attitude towards psychiatric treatment. An international comparison study conducted in Bratislava, Slovak republic and Novosibirsk, Russia. Respondents from all three countries were equally inclined to seek help from mental health professionals. In all three countries psychotherapy was the most favoured modality, followed by psychotropic medication. Although natural remedies were more frequently recommended in Bratislava and Novosibirsk, meditation/yoga was more popular among the German public. Respondents who adopted biological causes tended to recommend psychotropic medication more frequently.

Ozmen, E. et al., (2005) a study on public opinions and beliefs about the treatment of depression in urban Turkey. A public survey conducted with the sample of 707. Study results concluded that psychological and social interventions are more effective than pharmacotherapy and antidepressants are harmful and addictive.

Gureje, O .et al., (2005) community study of knowledge of and attitude to mental illness in Nigeria. A total of 2040 individuals participated in this study. Results stated that poor knowledge of causation was common. Negative views of mental illness were wide spread. There is wide spread stigmatization of mental illness in the Nigerian community.

Read, J. et al., (2006) conducted study on prejudice and schizophrenia. This study stated that an evidence based approach to reducing discrimination would seek a range of alternatives to the ‘mental illness is an illness like any other’ approach, based on enhanced understanding, from multi-disciplinary research, of the causes of prejudice.
Angermeyer, M.C. and Dietrich, S., (2006) a review of population studies on public beliefs about and attitudes towards people with mental illness. Results concluded that majority of studies are descriptive in nature, there is still much to be done to provide an empirical basis for evidence-based interventions to reduce misconceptions about mental illness and improve attitudes towards persons with mental illness.

Chong, S.A. et al., (2007) perception of the public towards the mentally ill in developed Asian country. A national wide survey using a structured questionnaire was conducted on those aged between 15 and 69 years. This study explained that people felt that mental health problems were dangerous and felt that the public should be protected from them.

Donovan, R.J. et al., (2007) a state wide telephone survey on people’s beliefs about factors contributing to mental health, implications for mental health promotion with the sample of 1, 500 adults was conducted in Western Australia. The study results concluded that the vast majority of people had negative connotations to the words mental health, but had positive connotations to the term mentally healthy persons.

Mojtabai, R., (2007) this study examined recent trends in Americans attitude towards mental health treatment seeking and beliefs about the effectiveness of such treatment. The sample included 5, 388 participants from the national comorbidity survey in 1990 – 1992 and 4, 319 from the national comorbidity survey-replication in 2001-2003. Study results concluded that attitude of younger participants improved more than attitudes of middle aged participants.

Ng, T.P. et al., (2008) this study aimed at to understand the health beliefs and help seeking for depressive and anxiety disorders among Singapore adults with the sample of 2, 801, study results stated that help seeking was predicted by poor self-rated mental health and acknowledged mental illness but not by health beliefs and social support.
Schomerus, G. et al., (2008) a study on public attitude towards prevention of depression by telephonic interview with sample of 1016, results concluded that the public entertains favourable attitudes and beliefs about prevention of depression that do not conflict with evidence based programmes. This study thus encourages implementation of population based prevention programmes.

Baby, R.S.et al., (2009) this study aims to assess the attitude and reasons of medication compliance and non-compliance among the patient with schizophrenia attending out patients in India. Results shows the prevalence of non-compliance in the selected setting is 38.7 %. This study findings strongly recommends the need to develop a standard protocol for carrying out adherence counselling to all patients.


Mac Laren, D.et al., (2009) the aim of this study is to incorporating socio cultural beliefs in mental health services in Kwaio, Solomon Islands. This provides a greater potential to support prevention, treatment and recovery journeys to advance the community’s social, emotional and spiritual wellbeing.

Kermode, M.et al., (2009) study conducted on attitude to people with mental disorders. A cross-sectional mental health literacy survey was undertaken in late 2007. The results stated that majority of people did not agree that the problems experienced in the vignettes were a real medical illness.
Wolkenstein, L. and Meyer, T.D., (2009) a study on what factors influence attitudes towards people with current depression and current mania. A sample of 188, age 16-34 years were taken and their attitudes towards that persons were assessed. This study revealed that familiarity with the phenomenon of mental illness turned out to influence the attitude towards affective episodes, familiarity turned out to be a factor positively influencing the attitude towards depression, it turned out to have a rather negative influence on the attitude towards mania.

Rusch, N.et al., (2011) a study on Knowledge and attitudes as predictors of intentions to seek help for and disclose a mental illness. Study results stated that increase knowledge and positive attitudes about mental illness among the general population may improve the extent to which individuals seek help for and disclose a mental illness.

Bener, A. and Ghuloum, S., (2011) study on gender differences in the knowledge, attitude and practice towards mental illness in a rapidly developing Arab society with representative sample of 3,300, the study results shows that more women than men believe that mental illness is due to possession by evil spirit. Also nearly half of the woman thought traditional healers can treat mental illness. This belief was significantly lower in men, some women considered people with mental illness as dangerous, a belief also significantly lower in men. The study reveals that men had better knowledge, beliefs and attitudes towards mental illness than women.

Ganesh, K., (2011) a cross sectional study on knowledge and attitude of mental illness among general public of Southern India. Study conducted with the 100 subjects, study results indicates knowledge of mental illness among the general public was quite poor and suggests the need for strong emphasis on public education to increase mental health literacy among general public to increase awareness and positive attitude of people towards mental illness.
STUDIES RELATED TO STIGMA TOWARDS MENTAL ILLNESS

Link, B.G. et al., (1999) the author used nationwide survey on public conception of mental illness; labels, causes, dangerousness, and social distance (n=1444), results concluded that majority of the public identifies schizophrenics (88%) and major depression (69%) as mental illness mainly due to stressful circumstances, that smaller proportions associate alcohol (49%) or drugs (44%) abuse with mental illness and the symptoms of mental illness remains strongly connected with public fears about potential violence and with a desire for limited social interaction.

Arikan, K.et al., (1999) study conducted to analysing the public awareness of the effectiveness of psychiatric treatment may reduce stigma. This study conducted with the sample of 700 final year university students of Istanbul. On the basis of this finding, it can be suggested that drawing public attention to the therapeutic advances in psychiatry may lead to a decrease in stigmatization.

Leiber, C., (2001- 2002) NARSAD conducted national wide survey to determine leading myths, misconceptions about mental illness are pervasive and the lack of understanding can have serious consequences for millions of people who have psychiatric illness. Study results stated that Misconceptions about mental illness contribute to the stigma, which leads many people to be ashamed and prevents them from seeking help.

Sirey, J.A.et al., (2001) this study examine the perceived stigma and patient – rated severity of illness as predictor of antidepressant drug adherence .Study findings concluded that the stigmatization of persons with mental illness continues to be a primary different to prevention and treatment efforts.

Lee, Rachel S.et al., (2002) study on internalized stigma among people living with HIV- AIDS and behaviours. The study results stated that individuals
who experienced high internalized HIV stigma contributed significantly to levels of depression, anxiety and hopelessness.

Corrigan, P.W.et al., (2004) this study tests a stigmatizing attitude about mental illness and allocation of resources to mental health services. Study conducted with the sample of 54 individuals, study results showed that significant attitudinal correlates with resource allocation preferences for mandated treatment, but no correlates to rehabilitative services. Implication of these findings on strategies that seek to increase resources for mental health programmes are discussed.

Lauber, C.et al., (2004) this study focused on factors influencing social distance toward people with mental illness. This study results suggests that the level of social distance increases if situations imply social closeness. Demographic factors such as age, gender, and the cultural background influence social distance, more knowledge about the mental illness especially Schizophrenia, may increase social distance.

Lauber, C.et al., (2005) study was conducted on lay beliefs about the treatment for the people with mental illness and their implications for anti-stigma strategies. With the sample of 1737. The results stated that medical treatment proposal are influenced by adequate mental health literacy.

Vant’ t Veer, J.T.et al., (2006) a study on ‘determinants’ that shape public attitudes towards the mentally ill. The results concluded that stereotypical beliefs about mental patients e.g. untrustworthiness, aggressiveness, causing disturbances related to more social distance from mental illness.

Sushrut Jadhav, S.et al., (2007) comparative study between rural and urban community dwellers in India on stigmatization of severe mental illness in India. Study results concluded that rural Indian’s showed significantly higher stigma scores than urban Indian population.
Adewuya, A.O. and Makanjuola, R.O., (2008) A cross sectional survey was carried out on social distance towards people with mental illness with the sample of 2078. This study stated that there is emerging evidence of a high level of social distance and stigmatization of mental illness.

Jorm, A.F. and Griffiths, K.M., (2008) Study conducted on the public stigmatizing attitudes towards people with mental disorders: how important are biomedical conceptualizations. The results stated that biomedical conceptualization are not the major cause of stigma, rather it is the behaviour associated with mental illness and the belief that this is because of personal weakness.

Ojeda, V.D. and Bergstresser, S.M., (2008) study aimed at to examine the gender, race-ethnicity, and psychosocial barriers to mental health care. Findings imply a need to reconsider the roles of gender, race-ethnicity and socioeconomic status within investigations of psychosocial barriers to care.

Roelandt, J.L. et al., (2010) the aim of this study was to describe the representations of insane, mentally ill and depressive persons, in a representative sample from the French general population. Results of the 36,000 individuals included in this study, over 75% associated the words “insane” and “mentally ill” with violent and dangerous behaviour and the term “depressive” with sadness, isolation and suicide. The results show the need to think over the best way to fight against stigma and discrimination, in order to reduce psychiatric patients’ social exclusion.

Aromaa, E. et al., (2011) a study on personal stigma and use of mental health services among people with depression in a general population in Finland. A cross sectional data conducted with sample of 5160, the study results stated that people with depression showed more social tolerance towards people with mental problems. They also carried more positive views about the antidepressants.
STUDIES RELATED TO CARE AND SOCIAL SUPPORT SYSTEMS TOWARDS MENTAL ILLNESS

Kapur, R.L., (1975) study on mental health care in rural India: A study of existing pattern and their implications for future policy. This study specify, 75% of those suffering from severe mental illness were still being taken for treatment to the traditional folk healers.

Cobb, S., (1976) study stated that social support as a moderator of life stress. The importance of social support is to have the Cushing effect of life stressors on the mental wellbeing and social wellbeing of an individual.

Moudgil, A. C. et al., (1985) noticed that those parents who get maximum social and emotional support from spouse and family members, parents, relatives and friends, experience less stress and problems.

Jorm, A.F.et al., (1997) study on the “Mental Health Literacy”. A survey of the public’s ability to recognize mental disorders and their belief about the effectiveness of treatment. This study concluded that if mental disorders are to be recognized early in the community and appropriate interventions sought, the level of mental health literacy need to be raised. Further, public understanding of psychiatric treatments can be considerably improved.

Jorm, A.F., (2000) this study examine the mental health literacy. Public knowledge and beliefs about mental disorders. This study cannot recognize specific disorders or different types of psychological distress. Much of the mental health information most readily available to the public is misleading. There is some evidence that mental health literacy can be improved. If the public’s mental health literacy is not improved, this may hinder public acceptance of evidenced-based mental health care.

Mc Alpine, D. D and Mechanic, D., (2000) a telephonic survey conducted on utilization of speciality mental health care among persons with severe mental illness: the role of demographic, need, insurance and risk at United Nations. The study results concluded that persons with mental illness
have high level of economic and social disadvantages. Persons cared by insurance programme are over six times more likely to have access to speciality care than the uninsured persons.

Thara, R. and Srinivasan, T.N. et al., (2000) how stigmatising is schizophrenia in India. Study mainly focused on the absence of any clear welfare policies for women increases the stigma. Stigma has been more reported in women than men, women care givers also reported more stigma and may felt depression and sorrow, which was greater if the patient was a women.

Angermeyer, M.C .et al., (2001) a population survey on “what to do about mental disorder- help- seeking recommendations of the lay public”. A sample of 1564 included in the study. The study results concluded that the lay support system plays a significant role in initially dealing with mental illness. Lay public’s opinion has to be taken into account of in mental health care planning to make services more acceptable to the consumer and their social network.

Dey, A.B .et al., (2001) a recent prospective study on evaluation of the health and functional status of older Indians as a prelude to the development of a health programme. Study conducted with the sample of 1, 586 patients from a speciality geriatric clinic at the AIIMS, New Delhi, provides information about the health and functional status of older Indians seeking health services. Results revealed that 95 % of the subjects were the above the age of 80 and that 87 % of them sought medical attention for an acute illness. About one-third of a subject of 209 subjects had a psychiatric illness, while depression accounted for50 % of all psychiatric illness.

Raghuram, R.et al., (2002) a paper on traditional community resources for mental health. The study gave a positive report on temple healing and showed that the affectionate and caring atmosphere lowered the brief Psychiatric Rating Scale count in patients, without use of medications.
Kitchener, B.A and Jorm, A.F., (2002) the present study examined the mental health first aid training for the public: evaluation of effects on knowledge, attitudes and helping behaviour. This Study was conducted with the sample of 210 participants, study results stated that mental health first aid training appears to be an effective method in improving mental health literacy which can be widely applied.

Tanaka, G.et al., (2003) the world psychiatric association promotes global anti-stigma programmes, the present study examined the effects of a lecture on mental health on public attitudes towards mental illness. The present study suggests the effectiveness of the type of educational programme in reducing stigma attached to mental illness and disorder.

Khandelwal, S.K. et al., (2004) an epidemiological surveys done in India on mental disorders to demonstrate the prevalence of mental morbidity in rural and urban area of the country. A number of non-Government organization have also initiated activities related to rehabilitation programmes, human lights of mentally ill people and school mental health programmes.


Rahman, A.et al., (2008) the neglected ‘m’ in MCH programmes – why mental of mothers is important for child nutrition. These research findings suggested that maternal depression may be the risk factor for poor growth in young children in developing countries, with the effects of depression affecting not only this generation but also the next.

Mac Laren, D.et al., (2009) the aim of this study is to incorporating socio cultural beliefs in mental health services in Kwaio, Solomon Islands. This
provides a greater potential to support prevention, treatment and recovery journeys to advance the community’s social, emotional and spiritual wellbeing.

Raghu Appasani, et al., (2010) this study aimed at to determine the effectiveness of psycho educational programme on improving mental health literacy in the rural district of Vadodara, Gujarat, India, nineteen rural area villages were selected for the study. The study results suggest that an educational Interventions related to mental health care results in less stigmatizing attitudes among population.

Review Conclusion

A review of the above studies drives forth the point that the primary barriers to mental health are the lack of accessibility, social stigma, economical stress and lack of awareness. Individuals suffering from mental illness particularly those living outside major cities often have limited access to medical professionals, facilities and resources. In India data related to mental illness is lacking at all levels. India, the second most populated country of the world with population of 1,027 billion the population is predominantly rural, and 36% of people still live below poverty line there is continuous migration of rural people into urban slums, creating major health and economical problems, people with mental disorders experience discrimination as a consequence of stigmatizing attitudes that are largely socio- culturally constructed. Thus, there is a need to understand local contexts in order to develop effective programmes to change such attitudes. The public has insufficient knowledge about mental disorders and their treatment. Hence there is a need to recognize the mental disorders early in the community and appropriate intervention support, the level of mental health literacy need to be raised, public understanding of psychiatric treatment can be considerably
improved. Reviews related to mental illness is very few in India compared to other countries.

**STATEMENT OF THE PROBLEM**

Mental disorders have an economic impact on societies and on the quality of life of individuals and families. They are common, affecting more than 25 percent of people at some time during their lives. They are also universal, affecting people in all countries and societies, individuals of all ages, women and men, the rich and the poor from urban to rural environments.

Mental illnesses cause massive disruption in the lives of individuals, families, and communities. It is estimated that one in four families has, at least one member currently suffering from a mental illness. These families are required not only to provide physical and emotional support but also to bear the negative impact of stigma and discrimination present in all parts of the world.

There is a wide gap between availability and implementation of effective interventions e.g. in India, treatment rates for schizophrenia and epilepsy are reported to be 20% of all cases in need of treatment, compared to 80% for the same disorder in the West. Discrimination occurs when a person is treated differently from another person in the same or similar circumstances. It is a result of belief in the stereotypes of people with experience of mental illness leading to prejudice, which in turn leads to discrimination.

People with experience of mental illness often rely on family members as part of their support mechanism. The relationships with family members may be the closest relationship that we have. Discrimination against and stigma of, people with experience of mental illness is widespread. It has an impact on the self-esteem and recovery of people with experience of mental illness as well as affecting all aspects of people lives. Although some nations
have been successful in fighting against stigma and increasing acceptance of the mentally ill, lack of awareness is very evident in India and other developing countries.

Mentally ill people are labelled as “different” from other people and are viewed negatively by others. Stigma remains a powerful negative attribute in all social relations. Stigma and discrimination discourage people to seek diagnosis and treatment. If they disclose that they experience serious discrimination from their loved ones and people around them. Stigma and discrimination are part of complex systems of beliefs about the mental illness.

Mental illness has been shrouded in sigma and superstition since a long time in India, instead of offering help to the mentally ill. Most of us treat them with suspicion, ignorance, or cold-hearted apathy. Mental illness is rising at epidemic rates around the world, including India. WHO predicts that 20 % of India’s population, will suffer from some form of mental illness by the year 2020. The rising crime rate, rampant corruption and general unrest in people are clear signs that mental health and wellbeing need our attention. This careless attitude towards mental health is mirrored by the Government and medical institutions where mental health is regarded almost as an afterthought. Barely 1- 2% of health budget is dedicated to mental health, in comparison to 10 to 12 % in other countries. Psychiatry is not considered lucrative like other medical specialities. Psychology too is misunderstood and ignored field in our country. It is not a surprise then that, young people choose not pursue mental health as a profession and we continue to treat mental illness like the white elephant in the room.

The major barriers to effective treatment of mental illness include lack of recognition of the seriousness of mental illness and lack of understanding about the benefits of services. Policy makers, Insurance companies, Health and Labour policies and the public at large - all discriminate between the physical and mental health problems. Hence there is an urgent need to
educate the public about causes, treatment and prevention of mental illness. A better understanding regarding mental illness amongst the public would presumably lessen stigmatization and encourage prompt utilization of available mental health services, which in turn leads to improve the quality of life by promoting positive attitude towards mental illness. The value of the mental health in primary health care has been noted worldwide and focusing efforts in this area has become a priority. India, which has had a lead in formulating the National Mental Health Programme in 1982, one of the first among the developing countries, and initiating the integration of mental health in primary health care nearly quarter century ago, has still not done enough. There is also the larger problem of the chronic mentally ill in the community. The stigma of mental illness awaits major initiatives to fight the discrimination experienced by the patient and their families.

India started training to primary health care workers in 1975, forming the basis of the national mental health programme formulated in 1982. Currently Government supported 25 districts level programme in 22 states. The positive aspects of the NMHP is the enhanced recognition and services being available to large population. However the programmes and initiatives have not really spread to the population. One of the important goal of NMHP is integration of mental health in primary health care. Even today, the mental health services are not integrated in primary health care. Mental health services in India are neglected area which needs immediate attention from Government, Policy Makers, Civil Society or Organizations. NMHP(National Mental Health Programme) and NRHM(National Rural Health Mission) programmes shown very little efforts so far to provide health services in rural areas. ASHAs (Accredited Social Health Activist) under NRHM is an opportunity to provide mental health services at door steps in rural areas.

The review of available literature brought for the fact that there had been only small scale studies were found which had touched the fringe of the
mental illness covering very small sample. There had been virtually no empirical study about the mentally ill in the state of ‘Andhra Pradesh except for one study one community based study on the elderly in Chittoor District. There had been no study on the mentally ill in Anantapuramu District till date. In the context of the growing incidence of mental illness worldwide and the threat for India to have 25 per cent of its population to go mentally ill 2020, it becomes necessary to estimate the incidence of mental illness as prevalent in various places, so that the care and support systems can be evolved to cope up the challenges that await us by 2020. Places with peculiar topography and geographical and climatic conditions, which have bearing on the physical and mental health of people calls for research and evolving suitable interventions.

To address these vital missing research gaps that the present intensive study tries to understand deeper into the causes, types of mental illness, treatment, recovery percentage, relapse of the disease, attitude of people towards mental illness and it also tries to understand the stigma and the problems faced by the family members of mentally ill in a drought prone area of Anantapuramu District of Andhra Pradesh.

**OBJECTIVES OF THE STUDY**

1. To document the Socio- Economic and Demographic background of mentally ill patients in Anantapuramu District.
2. To identify the causes and incidence of mental illness in Anantapuramu District.
3. To understand the types and treatment of mental illness in Anantapuramu District.
4. To identify the reasons for the delay in accessing the treatment in Anantapuramu District.
5. To study the difficulties faced by family members of mentally ill in Anantapuramu District.
6. To study the association between Socio-Demographic variables of mentally ill and knowledge levels of family members of the mentally ill.

HYPOTHESES

The following hypotheses were formulated while pursuing the above objectives

1. Multiple factors commonly observed as causation of mental illness.
2. There is significant association between Stigma and Mental illness.
3. Demographic variables of mentally ill significantly influence the knowledge of Family members of mentally ill.

i. There is significant association between age of mentally ill and knowledge levels of family members of mentally ill.
ii. There is significant association between the gender of the mentally ill and the Knowledge levels of the family members of the mentally ill.
iii. With respect to Religion, there is significant association between religions of mentally ill and knowledge scores of family members of mentally ill.
iv. There is significant association between Caste of mentally ill and knowledge levels of family members of mentally ill.
v. With respect to marital status, there is significant association between marital status of mentally ill and knowledge levels of family members of mentally ill.
vi. There is significant association between knowledge levels of family members of mentally ill with their current residence.
vii. With regard to type of family, there is significant association between type of family and knowledge level of family members of mentally ill.
viii. With regard to type of family, there is significant association between types of family and knowledge level of family members of mentally ill.
METHODOLOGY

i. RESEARCH DESIGN

The design adopted for this study is descriptive design which is to understand and describe with accuracy the socio-demographic background of the mentally ill patients and their families, the clinical manifestations, incidence, causes, treatment of mental illness, stigma and problems faced by the patient and family members of mentally ill in Anantapuramu district of the state of Andhra Pradesh.

ii. UNIVERSE

The Universe of the study was identified by the number of patients registered during twelve months on an average of 800 per month as per the Register maintained, in the Psychiatric Department, at Government General Hospital, Anantapuramu. It was decided to cover a sample of 50 per cent of the average mentally ill patients, as Sample for the present research study. The Mentally ill patients were mentally not sound to participate in the study. Hence the family members of mentally ill patients who accompany these patients were chosen as the Sample for this study.

iii. SAMPLE

Purposive Sampling Method was adopted to select the respondents for this study. As this research studies about the mentally ill patients a sample of 400 mentally ill patients were selected purposefully to ensure representativeness of gender, age, location, and type of mental illness from among the mentally ill registered in the Psychiatric Department of the Government General Hospital, Anantapuramu.
iv. TOOLS FOR DATA COLLECTION

For the purpose of collecting information for the study, a structured Interview Schedule in English language was carefully prepared, which consists of 2 major sections. The initial data collection was done with a structured Interview Schedule to elicit the information pertaining to socio-demographic profile of the mentally ill and their family members, the causes, type of mental illness, treatment, progress of the disease, recovery, stigma, and attitude of the people towards mentally ill.

v. PILOT STUDY

The researcher conducted pilot study to ascertain the feasibility of conducting the research at Psychiatric Department of the Government General Hospital, Anantapur. The Interview Schedule was tried on small sample of 10 respondents in Out-patients as well as In-patients of the Psychiatric Department at the Government General Hospital, Anantapuram. During the Pilot study the purpose and need of the study was explained to the family members. After pre-test few questions were included some were deleted and some were modified to elicit correct and relevant data. The final form of the interview schedule was thus determined.

vi. DATA COLLECTION

The Interview Schedule was administered to the sample of 400 respondents. The aim of the study and answering mode were explained, each question was asked in the same manner to all the respondents. The answers were recorded in the Interview Schedule. Efforts were made to check and cross check the information provided by the family members of mentally ill. The Data collection was carried out from March 2012 to June 2013.
vii. LIMITATIONS OF THE STUDY

The present study has been carried out only with family members of mentally ill patients. Responses were not collected directly from the patients, because they were not sound mentally to understand and to give appropriate answers. The present study has been limited to the age group of 15 years to 65 years. Epilepsy and Mentally Retarded people have not been included in the purview of this research.

viii. DATA BASE AND ANALYSIS

The data for the present study, was collected from the primary and secondary sources. The primary data was collected from the family members of the patient. The secondary data was collected from the patient’s records pertaining to diagnosis, treatment and prognosis of the disease. The collected data was carefully checked and cross checked and was codified and entered into computer for tabulation by using SPSS package. Tables were drawn and inferences were deciphered from the tables. Analyses were made by using by simple statistical tools like percentages, mean distribution, Standard Deviation and Chi–Square Test.

SCHEME OF PRESENTATION

The present study has been divided into as many as five Chapters and a brief summary of each Chapter is furnished here under.

The I Chapter provides an introduction in which the health, mental health, mental illness, mental illness theories, mental health acts, mental health programmes. It also contains a brief review of the literature of the study, methodology of study which contain problem statement, objectives of the study, hypothesis formulated, the research design, the universe, the sample, the tool for data collection, the pilot study, the data collection, the limitations of the study, and the data base and analysis.
The **II Chapter** presents the setting of the study which contains district profile, mental health statistics of Global, India, Andhra Pradesh and Anantapuram District.

The **III Chapter** deals with Socio- economic profile of the respondents, which serves as the background for the study.

The **IV Chapter** happens to be the core chapter of the thesis which deals with Socio – medical analysis of the mentally ill and attitude of family members were assessed by using attitude scale. Knowledge scores of family members were compared with demographical variables of mentally ill patients.

The **V Chapter** brings forth the Findings, Summary, Conclusion and suggestions for future studies.