# CHAPTER 1
## INTRODUCTION

<table>
<thead>
<tr>
<th>Sr.No.</th>
<th>Details</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Introduction</td>
<td>03</td>
</tr>
<tr>
<td>1.2</td>
<td>History of Fighting Coronary Heart Disease</td>
<td>04</td>
</tr>
<tr>
<td>1.3</td>
<td>Heart’s Anatomy and Function</td>
<td>05</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Size and shape:</td>
<td>05</td>
</tr>
<tr>
<td>1.3.2</td>
<td>The heart has four chambers:</td>
<td>06</td>
</tr>
<tr>
<td>1.3.3</td>
<td>Angina pectoris</td>
<td>09</td>
</tr>
<tr>
<td>1.4</td>
<td>What is a Heart Attack?</td>
<td>09</td>
</tr>
<tr>
<td>1.5</td>
<td>Factors Predisposing to a Heart Attack</td>
<td>13</td>
</tr>
<tr>
<td>1.5.1</td>
<td>Risk factors:</td>
<td>13</td>
</tr>
<tr>
<td>1.6</td>
<td>Symptoms of a Heart Attack:</td>
<td>14</td>
</tr>
<tr>
<td>1.7</td>
<td>Necessary Investigations to Confirm the Diagnosis of a Heart Attack</td>
<td>16</td>
</tr>
<tr>
<td>1.8</td>
<td>Post Heart Attack Treatment</td>
<td>18</td>
</tr>
<tr>
<td>1.9</td>
<td>What is mean by Social Support?</td>
<td>21</td>
</tr>
<tr>
<td>1.9.1</td>
<td>The Meaning of Social Support</td>
<td>23</td>
</tr>
<tr>
<td>1.9.2</td>
<td>The Link between Social Support and Health</td>
<td>23</td>
</tr>
<tr>
<td>1.9.3</td>
<td>How Does Social Support Contribute to Health?</td>
<td>26</td>
</tr>
<tr>
<td>1.9.4</td>
<td>Mobilizing Social Support</td>
<td>27</td>
</tr>
<tr>
<td>1.10</td>
<td>What is mean by Mental Hygiene?</td>
<td>28</td>
</tr>
<tr>
<td>1.10.1</td>
<td>History</td>
<td>29</td>
</tr>
<tr>
<td>1.10.2</td>
<td>Definition</td>
<td>30</td>
</tr>
<tr>
<td>1.11</td>
<td>Characteristic of Mental Health</td>
<td>35</td>
</tr>
<tr>
<td>1.12</td>
<td>Types of Mental Health Assessments</td>
<td>37</td>
</tr>
<tr>
<td>1.13</td>
<td>Emotional Mental Health Issues around the World</td>
<td>38</td>
</tr>
<tr>
<td>1.13.1</td>
<td>Emotional Mental Health Issues improvement</td>
<td>39</td>
</tr>
<tr>
<td>1.14</td>
<td>Traits of Mental Health</td>
<td>40</td>
</tr>
<tr>
<td>1.15</td>
<td>Models of Mental Health</td>
<td>42</td>
</tr>
<tr>
<td>1.15.1</td>
<td>Medical or Biological Model</td>
<td>42</td>
</tr>
<tr>
<td>1.15.2</td>
<td>Psycho-Analytical or Dynamic Model</td>
<td>42</td>
</tr>
<tr>
<td>1.15.3</td>
<td>Statistical Model</td>
<td>43</td>
</tr>
<tr>
<td>1.15.4</td>
<td>Learning Theory Model</td>
<td>43</td>
</tr>
<tr>
<td>1.15.5</td>
<td>Humanistic Model</td>
<td>44</td>
</tr>
<tr>
<td>1.15.6</td>
<td>Socio-Cultural Model</td>
<td>44</td>
</tr>
<tr>
<td>1.15.7</td>
<td>Existential Model</td>
<td>44</td>
</tr>
<tr>
<td>1.15.8</td>
<td>Moral Model</td>
<td>45</td>
</tr>
<tr>
<td>1.16</td>
<td>What is mean by illness Behavior</td>
<td>46</td>
</tr>
<tr>
<td>1.17</td>
<td>Historical Perspectives</td>
<td>47</td>
</tr>
<tr>
<td>1.18</td>
<td>The illness experience</td>
<td>48</td>
</tr>
<tr>
<td>1.19</td>
<td>Influences on Illness behavior</td>
<td>58</td>
</tr>
<tr>
<td>1.19.1</td>
<td>Culture of poverty</td>
<td>58</td>
</tr>
<tr>
<td>1.19.2</td>
<td>Demographic Status</td>
<td>59</td>
</tr>
<tr>
<td>1.19.3</td>
<td>Post experience</td>
<td>59</td>
</tr>
<tr>
<td>1.20</td>
<td>Impact and issues related to Illness behavior</td>
<td>60</td>
</tr>
<tr>
<td>1.20.1</td>
<td>The illness experience and subsequent behavior</td>
<td>61</td>
</tr>
<tr>
<td>1.20.2</td>
<td>Loss of self</td>
<td>62</td>
</tr>
<tr>
<td>1.20.3</td>
<td>Moral work</td>
<td>63</td>
</tr>
<tr>
<td>1.20.4</td>
<td>Devalued self</td>
<td>63</td>
</tr>
<tr>
<td>1.20.5</td>
<td>Chronic Sorrow</td>
<td>63</td>
</tr>
<tr>
<td>1.21</td>
<td>Professional responses to Illness behavior and roles</td>
<td>64</td>
</tr>
<tr>
<td>1.21.1</td>
<td>Lack of Role Norms for individuals with chronic illness</td>
<td>66</td>
</tr>
<tr>
<td>1.21.2</td>
<td>Frameworks and Models for Practice</td>
<td>66</td>
</tr>
<tr>
<td>1.22</td>
<td>Importance of the study</td>
<td>67</td>
</tr>
<tr>
<td>1.23</td>
<td>Chapterlisation</td>
<td>67</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION

1.1 INTRODUCTION:

Coronary heart disease, chronic illness in which the coronary arteries, the vessels that supply oxygen carrying blood to the heart, become narrowed and unable to carry a normal amount of blood. Most often, the coronary arteries become narrowed because of atherosclerosis, a process in which fatty deposits called plaque builds up on the inside wall of an artery. Plaque is made of oily molecules known as cholesterol, fibrous proteins, calcium deposits, tiny blood cells known as platelets and debris from dead cells. Plaque formation often begins in adolescence and progresses very slowly over the course of decades. Gradually, the growing plaque thickens the wall of the artery, reducing the space for blood to flow through.

When its blood supply is reduced, the heart does not receive sufficient oxygen. This oxygen deficit leads to two main consequences: chest pain known as angina pectoris and heart attack, in which part of the heart dies because of oxygen deprivation. Coronary heart disease is the leading cause of death in the United States, responsible for about 515,000 deaths each year.

In modern times the incidence of heart disease is rising steadily. In the United States of America, of the total death, 50% are due to heart disease. Yet only five decades ago this rate was just 10%.

This disease has made inroads into Indian cities as well. Of late, the rate of incidence of heart disease in the big cities of your country has been rising at alarming pace. In Mumbai, for instance, of the 53,000 death registered during the year 1985, 18,000 were due to heart disease. Compared to cities, our villages are still free from the menace.

Why is the incidence of heart disease higher in cities than in villages? Why is its incidence higher in the U.S.A. than in India? Answers to these questions are now slowly unfolding. One thing is clear than this disparity in man-made. It is the result of modern living and process of urbanization.

The most tragic aspect of heart disease is that the part of the heart which is damaged by a heart attack can never be satisfactorily repaired once again. It may get
healed with ordinary cells; but those cells are not like the original cells of the heart, consequently, the heart becomes were forever. Another tragic aspect of the heart attack is that it strikes persons when they are at the peak of their careers. Many people succumb to the very first attack and depart for their Heavenly Adobe.

That is why it is very important that heart disease should be prevented and not allowed to strike. It is easy to avoid a heart attack by acquiring scientific information about the factors causing it and by taking preventive measures in time.

1.2 HISTORY OF FIGHTING CORONARY HEART DISEASE:

The first description of angina pectoris was published by English physician William Heberden in 1772. However, heart attack was not well understood at the time. In fact, throughout the 19th century, sudden death that American physician James Herrick clearly described the relationship between blood clots in the coronary arteries heart attack.

In the early decades of the 20th century, deaths from coronary heart disease began to increase, particularly in the United States and many other industrialized nations. Better hygiene, immunization, and the advent of antibiotics reduced deaths from infectious disease, which had previously been the leading cause of death. More people were living longer, causing the prevalence of coronary heart disease to increase simply because the disease often does not cause problems until people are middle-aged or older. At the same time, standards of living improved in industrialized countries and people began to eat more meat and more fatty food and exercised less.

By the 1940s, coronary heart disease had reached epidemic proportions in the United States. Scientists began to investigate the risk factors that made people vulnerable to the disease. One of the most influential studies was the Framingham Heart study, which began in 1948 and continues today. Initially, scientists tracked more than 5,000 residents of a small town in Massachusetts, collecting data about possible risk factors and the prevalence of heart attacks in the community. This study helped scientists identify three key risk factors for coronary heart disease-high blood pressure, cigarette smoking and high blood cholesterol. Today, the study also includes the children of the original participants and scientists continue to gather information on coronary risk factors.
In the United States, the death rate from coronary heart disease has been declining in recent years. In part, this decline is due to medical advances such as the development of CCUs and clot-dissolving drugs, which have made fewer heart attacks fetal. Other advances, such as various medications, angioplasty and bypasses surgery, prevent some heart attacks. While the incidence of coronary heart disease has lessened as many people have adopted healthier lifestyles, many other people still have habits that put them at risk for coronary heart disease. Experts estimate that more than 46 million adults in the United States smoke, 105 million have cholesterol above 200 mg/dl, 73 million have hypertension, 61 million are obese, 17 million have diabetes and more than 90 million do not exercise at all. Many experts hope that as more people adopt healthier lifestyles, deaths from coronary heart disease will continue to decline.

1.3 HEART’S ANATOMY AND FUNCTION

Every cell in body needs nourishment. But the cells do not get nourishment directly from the food we consume. At first the food is digested and gets absorbed in the blood and thereafter it is made available to every cell in the body through blood circulation. This process shows the importance of blood circulation in the body. The organ responsible for maintaining this circulation of blood is HEART.

Heart is a hollow organ made of muscles. It is located in the lower portion on the left side below the chest. Its rhythmic contraction and expansion movements keep the blood circulating in the body. Contraction of heart is termed systole and the expansion is termed diastole.

1.3.1 SIZE AND SHAPE:
Heart is acorn-shaped organ admeasuring about 12 cm x 9 cm in size. From the viewpoints of shape and size it can be compared with a fist. Its weight is about 250 g. in case of females and about 300 g. in case of males.

It is protected by a double-layered covering called pericardium. It is the function of pericardium to prevent friction between the heart and other surrounding organs during the movements of the heart.

1.3.2 THE HEART HAS FOUR CHAMBERS:

(1) Right atrium (upper chamber)

(2) Left atrium (upper chamber)

(3) Right ventricle (lower chamber)

(4) Left ventricle (lower chamber)

Now let us understand how the blood is circulated in the body as a result of the coordinated functioning of these four chambers.
Impure blood from various parts of the body flows into right atrium from the two superior venae cavae. This chamber of the heart also contains ‘sinus pacemaker’ (senatorial node) which generates heartbeats.

From the right atrium the blood enters the right ventricle passing through the tricuspid valve. Since the tricuspid valve opens only on one side, this blood from the right ventricle cannot re-enter the right atrium. When the right ventricle contracts, the impure blood is pushed towards the lungs via pulmonary arteries. The pulmonary valve stops the blood from re-entering the right ventricle once it has flowed out of the right ventricle.

In the lungs, blood purification takes place. The oxygen inhaled while breathing mixes with the blood and simultaneously the carbon dioxide from the blood
is released and thrown out with the exhaling breath. The blood, thus oxygenated and purified in the lungs, then enters the left atrium via pulmonary veins.

Finally the blood pumped out from the left atrium passes through the mitral valve and enters the left ventricle. Walls of this chamber of the heart are very thick and strong. When this chamber contracts, the blood passes through the aortic valve and is pushed into the aorta, after which it gets circulated through the body.

The process of contraction and expansion of the heart is also known as heartbeats. The process of contraction of heart lasts for about 0.3 second and the process of expansion of the heart lasts for about 0.5 second. The heart of an average normal human being beats 72 times a minute. The rate of heartbeat is generally slow in case of those who are engaged in physical or manual jobs; while it is faster in case of those who live a sedentary life. With each beat, the heart pumps about 70 ml. blood into the aorta. Thus about 5 liters of blood is pumped into the aorta every minute.

Compared to other muscles of the body the muscles of the heart are of a different quality. Continuous activity would soon tire out ordinary muscles; but muscles of the heart never tire. As discussed earlier, each and every cell and organ in the body needs nourishment.
1.3.3 ANGINA PECTORIS

Two coronary arteries, which arise from the aorta itself, carry out the responsibility of providing nourishment to the heart. These coronary arteries are generally as thick as a drinking straw.

A person who suffers from angina pectoris has coronary arteries that are wide enough to supply blood to the heart during normal activities, but too narrow to deliver sufficient blood and oxygen when extra work is required of the heart. An attack of angina develops when the heart must work harder than normal and the muscle cells that make up the heart do not receive enough oxygen.

Angina is typically felt as a heavy, squeezing pain in the center of the chest. The pain may also spread to the neck, jaw, back, and left arm. An attack of angina may last for several minutes and is often brought on by physical activity, emotional stress, cold weather or digestion of a heavy meal—all factors that can increase the heart’s workload. Angina affects more than 6.6 million Americans.

1.4 WHAT IS A HEART ATTACK?

A heart attack, also known as a myocardial infarction, usually occurs when a blood clot forms inside a coronary artery at the site of an atherosclerotic plaque. The blood clot severely limits or completely cuts off blood flow to part of the heart. In a small percentage of cases, blood flow is cut off when the muscles in the artery wall contract suddenly, constricting the artery. This constriction called vasospasm can occur in an artery that is only slightly narrowed by atherosclerosis or even in a healthy artery. Regardless of the cause(s) of a heart attack, the oxygen deprivation is so severe and prolonged that heart muscle cells begin to die for lack of oxygen. About 1.2
million people in the United States have a heart attack every year; the heart attacks prove fatal for about 40 percent of these people.

A person having a heart attack typically feels an intense, crushing pain in the chest, especially on the left side. The pain may radiate to the person’s neck, jaw, and left arm. The pain is often similar to an attack of angina but more intense and longer lasting. Other signs of a heart attack include profuse sweating nausea and vomiting. However, heart attack symptoms can vary greatly among people. In one study, about one-quarter of a people who had a heart attack felt only mild symptoms and did not seek medical attention and about 12 percent experienced no symptoms at all.

Some people have gradually worsening bouts of angina before having a heart attack. For others, a heart attack may be the first signal of heart trouble. No matter what a person’s medical history, anyone who experiences symptoms of a heart attack should go to a hospital without delay. Oxygen deprivation can cause permanent damage to the heart within hours or even minutes, so the faster a heart attack patient receives treatment, the better the chance of survival.

Every cell and organ of the body needs nourishment and oxygen to remain alive. Through the blood, the heart supplies nutrients and oxygen to every cell in the body. For its own nourishment, the heart depends upon the two coronary arteries. As the age of a person advances, his blood vessels become increasingly rigid, brittle and narrow. This process is known as atherosclerosis. Narrowing of the blood vessels impairs the circulation of blood.

Grave consequences ensue when the blood supply to a part of the body or to a vital organ of the body stops completely. If such a block does not get reversed quickly, cells of that part of the body die due to lack of nourishment and oxygen.

In some parts of the body there is a network of alternative (collateral) blood vessels. When there is a blockage in one of the blood vessels, alternative blood vessels expand automatically and begin to convey more blood. In this way necessary blood supply to that part of the body is maintained and the crisis is averted. But the heart has only a few alternative blood vessels. So, when the coronary arteries supplying nourishment to the heart start narrowing, following consequences ensue:

(1) In the initial stage there are no symptoms. In spite of some narrowing of the coronary arteries, the heart continues to get the necessary nourishment.
(2) When the narrowing increases further the nourishment to the heart gets adequate nourishment. But when he engages himself in some physical work, the heart is not able to get the required amount of additional nourishment and consequently sharp chest pain (angina pectoris) occurs. This pain is a precondition of a heart attack.

(3) When the coronary arteries become too narrow, one of the arteries or any of its branches may get fully blocked and a crisis may develop. If this blockage does not get reversed quickly, the tissues of that part of the heart die due to the lack of blood supply. Such a development causes acute angina pain and breathing trouble. This condition is called a heart attack. All the above-described three conditions are shown in the illustrations
When the blood supply to any part of the heart is cut off, that part becomes dead. But no significant changes are noticed in that part for about six to twelve hours. Within eighteen to twenty-four hours after the heart attack, those dead tissues begin to show the changes. The usual color of the heart is pink-red; but the dead part becomes brown in color.

After about two to four days following the heart attack, that dead portion of the heart gets converted into a yellow patch with a red border. During the period ranging from five to ten days following the heart attack, that part becomes increasingly soft and yellow. Thereafter the wound starts healing with the help of cells called
fibroblasts. The complete healing takes about six weeks or more. It is obvious that if the heart attack is severe and if many tissues have been affected, healing would take a longer time.

1.5 FACTORS PREDISPOSING TO A HEART ATTACK:

(1) Physical exertion: The incidence of heart attack has been noticed to be higher generally after a physical exertion to which a person is not accustomed to.

(2) Mental tension or emotional upheaval

(3) Heavy meals

(4) Sudden fall in the blood pressure: Some time the blood pressure drops suddenly during an operation or due to profuse bleeding or due to a shock caused by some incidence. Under such circumstances, a heart attack may occur.

In this way hardening of the arteries is the main underlying cause of a heart attack.

1.5.1 RISK FACTORS:

Some of the risk factors for coronary heart disease are beyond a person’s control. For example, a person’s risk of developing coronary heart disease increases with age. Hereditary factors may also increase the risk for the disease. Males were once thought to be at greater risk of coronary heart disease, but more recent studies show this is not true. About equal numbers of women and men develop coronary heart disease. Heart attack in women are more likely to be fatal than in men. Women tend to develop the disease later in life than men do. This is because the sex hormone estrogen that circulates in women’s bodies helps protects them against atherosclerosis. Therefore, most women do not develop coronary heart disease until after menopause, when levels of protective estrogen markedly decrease.

Other risk factors for coronary heart disease can be changed depending on a person’s lifestyle. These modifiable risk factors cigarette, a sedentary lifestyle, obesity, diabetes mellitus and hypertension (high blood pressure). Perhaps the most
important modifiable risk factor, however, is high blood cholesterol. When excess cholesterol circulates in the blood, it deposits in the wall of the arteries, hastening the progression of atherosclerosis.

The amount of cholesterol in a person’s bloodstream is partially determined by heredity, but it also depends on the amount of cholesterol and animal fat in the diet. In some parts of Asia and Africa where people consume very little fat and cholesterol, total blood cholesterol averages less than 150 milligrams per deciliter and heart attacks are very rare. In the United States, where the typical diet includes many foods high in fat and cholesterol, total blood cholesterol averages about 200 mg/dl, and coronary heart disease is the leading cause of death.

Scientists have learned that cholesterol is especially dangerous when it is carried through the bloodstream as low-density lipoprotein, which is often known as “bad” cholesterol. By contrast, cholesterol in the form of high-density lipoprotein (HDL) actually lowers a person’s risk of heart attack, and HDL is often referred to as “good” cholesterol.

1.6 SYMPTOMS OF A HEART ATTACK:

1) Chest pain: chest pain is the most common and dramatic symptoms of a heart attack. This is acute pain in the chest. Patients describe this pain variously. Some patients say they feel crushing pain in the middle of the chest; others feel excruciating pain in that region. In some cases this pain spreads to some other parts of the body as shown in figure.
Chances of developing chest pain are higher particularly after a physical exertion to which a person is not used to. For instance, many patients complain that they developed chest pain either after climbing a staircase or a hill, or while walking briskly or while jogging or while running to catch a bus or a train and that too after taking a heavy meal. Sometimes psychological feelings or emotions such as anger, fear or mental stress also precipitate a heart attack.

This chest pain lasts for a few minutes to a few hours. Even after the chest pain disappears, some portion of the chest remains tender. The peculiarity of the chest pain caused by a heart attack is that even drugs like nitrates provide no relief to the patients. Only 10 to 15% of the patients develop heart attack without developing chest pain. In rare cases the pain commences in some other part of the body and then spreads towards the chest.

(2) **Breathing**: anyone who develops a heart attack finds it difficult to breathe. It appears that he is gasping for oxygen. In cases of the above-referred 10 to 15% patients who do not develop a heart attack. Such a painless heart attack is generally found to be common in cases of diabetic patients.

(3) **Weakness**: the patient who has a heart attack feels very weak. There are two reasons for that weakness (1) shock and (2) the decreased efficiency of the heart. At the time of contraction, heart pumps less blood into the arteries and consequently the hands and feet are deprived of their adequate supply of blood.

(4) **Profuse perspiration**: a patient who has a heart attack begins to perspire profusely. This profuse perspiration is also a result of the attack.

(5) **Nausea, vomiting and mental tension**: acute chest pain is responsible for causing nausea, vomiting and mental tension. Sometimes the patient may even faint.

Here is a list of other common causes of chest pains:

(1) Due to disorders of the respiratory system: they include pneumonia, pleurisies, hemorrhage in lungs, blockage in a pulmonary artery etc.

(2) Due to disorders of the blood circulation system: they include a partial blockage of a coronary artery, irregular heart-beats etc.
Due to disorders of the digestive system: They include indigestion, flatulence, and inflammation of the esophagus, gall-stone, peptic ulceration inflammation of the pancreas gland etc.

Pericarditis:

Aortitis:

Due to muscular disorder: some time chest pain occurs if a chest muscle is strained.

Besides this, young and unmarried persons develop a peculiar type of chest pain during spring or rain season! Only an experienced physician can diagnose whether a chest pain is due to a heart attack or due to some other cause.

1.7 NECESSARY INVESTIGATIONS TO CONFIRM THE DIAGNOSIS OF A HEART ATTACK:

(1) Electro cardiograph (E.C.G.) : every cell and organ of the body produces electrical waves. The heart also produces unique type of electrical waves. These waves are recorded with the help of an instrument called cardiogram. They are recorded in the form of graph on a strip of paper. This is called a cardiograph.

After a heart attack, the cardiograph registers some abnormalities. By studying this abnormalities a doctor can judge which tissues of the heart are damaged and to what extent.
(2) **Some special blood tests:** In the course of a heart attack some of the cells of the heart get destroyed. Cell membrane of those cells is disintegrated and consequently some enzymes, secretions and substances contained in those cells escape from the cells and mix with the blood. If such substances are found present in the blood examination, it can certainly be stated that the person had suffered a heart attack.

(3) **Some routine blood investigations:** Following a heart attack the while blood cell count goes up and E.S.R. is also reported to be high.
1.8 POST HEART ATTACK TREATMENT:

(1) **Rest**: after a heart attack complete bed rest is very important. Damaged heart cannot function as before and obviously, rest will relieve the heart of some of its burden. Mental peace and composure are also as important as physical rest and mental peace may damage some more muscles and tissues of the heart.

(2) **Fresh air**: a heart patient needs fresh air and pure oxygen and therefore, he should be kept in an uncrowned, airy room.

(3) **Sedatives**: acute chest pain is the leading symptom of a heart attack. Efforts should be made to relieve this pain soon as it increases the mental tension. Generally drugs like path dine and morphine are administered as pain-killers and sedatives.

(4) **Treatment for shock**: sedatives and rest relieve the patient of the shock to some extent. But if the blood pressure has dropped considerably, some medicines should be given to raise it to normal limit. If necessary, the patient should be put on oxygen also.

(5) **Hospitalization**: it is necessary to hospitalize the patient. It has been noticed that the mortality rate in the first four hours after the attack is very high. At the hospital it is easier to cope with any crisis that develops within those four hours. But hospitalization after the first four hour does not serve much useful purpose, there after; the treatment can be given a home also. However, if the heart-beats continue to be irregular or if there is a possibility of developing some complications, hospitalization should not be delayed.

(6) **Diet**: the nature and the quantity of a heart patient’s diet are a vital issue. He should be given low-fat and very low sodium diet.

It is desirable to keep the patient on liquid diet for the first forty-eight hours so that he does not have to chew the food and consequently his muscles get some respite. Items like coconut water, barely water, milk, tea, fruit juices because flatulence they should not be given. But in any case salt should be avoided.

After 48 years following a heart attack, soft and semisolid diet can be given. Any diet that supplies 1,000 to 1,200 calories per day is adequate for the nourishment. Ghee, oil, salt and such other ingredients should be avoided. The diet should
essentially be light and easy to digest. Those items which the patient had earlier found hard to digest should also be avoided. If possible, soft fruits should be included in the diet. Fibrous fruits act as mild laxatives and prevent constipation. However, if constipation develops mild laxative drugs should also be given. It is not desirable that the patient should exert while emptying his bowels. Such an exertion may cause a fresh heart attack. Generally multivitamin and mineral tablets are given as a follow-up treatment after a heart attack. If the patient is able to digest his diet easily and if his appetite develops, quantity of the diet can be gradually increased. Higher intake of food is required particularly when the rest-phase is over and normal activity is resumed.

**Activity:**  The healing process of the damaged portion of the heart takes about six weeks. It is obvious that during this period activity should be rusticated. In the first half of this period. (i.e., first three weeks) total bed rest is very necessary.

**Post-attack rehabilitation:**

In this wide world, each individual is different from his fellow human beings. So, it is but natural that each individual’s life style is also different and hence rehabilitation should also differ. However, here an attempt has been made to suggest a commonly acceptable programmed.

All experts are in unanimity about the requirement of total bed rest minimum for a period of first three weeks after a heart attack. After three weeks normal activities should be resumed gradually if the following conditions are prevailing:

(1) There is no complication, (2) hurts sounds are normal, (3) lungs are normal, (4) There are no significant changes in the size of heart, (5) heart-beats and blood pressure are normal and (6) There is no swelling on the feet.

The patient should be allowed to sit in the bed for a while or make a few movements in the bed for four days from the four week onwards. If these movements are not felt strenuous by the patient, he should be allowed thereafter to sit in a chair for some time or allowed to walk to the toilet during the next 8 to 10 days.

In the sixth week, light domestic activities can be permitted. Here it is necessary to stress the fact that at this stage no such activity should be undertaken by
the patient that is strenuous for him or to which he is not used to. The heart does not recover its original strength even when its wound has healed. Strenuous activity may make the heart weak, enlarged or deformed.

The patient should be encouraged to revert gradually to his normal activity schedule after a period of six weeks from the heart attack. Suggested below is a commonly acceptable program. Gradually increase the domestic activity for the first two weeks. Rest should be taken at short regular intervals. Minimum 9 to 10 hours of sleep should be taken during the night. An afternoon siesta for about an hour is also recommended. Avoid climbing up and down the stairs during this period.

If the above suggested activities are not felt to be strenuous climbing up and down the stairs may be started in the following two weeks. Begin with 10 to 12 steps and gradually increase the number. Walk on the flat ground for some time after climbing down the steps. Slowly increase the amount of walking also. But if breathlessness and chest pain recur it means you are being over-enthusiastic and that you need to take things easy. Return to your normal work schedule after two weeks.

While resuming the normal activities it is essential to have them monitored under expert medical guidance and supervision. Periodic investigations are also necessary. Among them stress-testing is very important. In this test the patient is put on a treadmill or asked to pedal a stationary bicycle. At the end of affixed duration, his heart-beats, blood pressure and heart sounds are examined. In a recently developed test called telemetry, during the exercise the patient’s cardiogram is recorded constantly. These tests are helpful in deciding whether the heart has regained its strength or not and whether it is safe to resume normal activities or not.

In modern times, a heart patient can resume his occupational activities after about three months. Earlier it was believed that a heart patient should remain confined to bed for ever and that he would be unable to undertake any job whatsoever. But this is a false notion. Yes, it is true that he can’t live a happy-go-lucky life full of running around. He has to observe moderation in everything. However, he can lead a happy, active and purposeful life.

A heart patient should preferably take rest after lunch in the form of an afternoon siesta for about an hour. It is also desirable that he should get 8 to 9 hours of sound sleep at night.
If you have already survived a heart attack, do read the following instructions:

(1) Do not carry home your office work. Try to finish the professional work in the office itself.

(2) After reaching home, spend happy hours with your spouse and children.

(3) Develop some interesting hobby. It will break the monotony of your life and reduce your boredom.

(4) Reserve Sundays for yourself and for your family. Forget all your cares and worries.

(5) Spend your holidays at some good resort once or twice every year.

1.9 WHAT IS MEANT BY SOCIAL SUPPORT?

"No man is an island. No man can live alone" Social interaction and interdependence has been very important since ancient times when man started living in groups. This dependence for all important activities continues even today. It was when man started living in groups, that there arose a need of help from others. This need of help from others is called "Support". Human beings need support in every field. In the modern technological society, where people do not have time, even two words by others may prove to be supportive. An individual no doubt, may be capable of doing his task independently but in one or the other form needs support. DAVIS and LOPATA (1996) suggest that Social Support implies to all age groups, especially children, old people and women. Children who have lost their parents in infancy experience loneliness unhappiness as the support received by parents during infancy has been lacking. Similarly women need more social support especially women whose children have been too young who are working, who are pregnant or who have more number of dependents.

Social support - the term is multi-construct. It is defined as the existence and the availability of people on whom we can rely, people who let us know that they care about us values and love us. Social Support is the information from others that one is loved and cared for, esteemed and valued and part of a network of communication and mutual obligation. Such information comes from a friend, a spouse, a lover,
Social Support could be emotional, instrumental, informational or appraisal in nature. There are evidences that Social support is inversely related to the prevalence and incidence of number of physical diseases and mental illness. Individuals experiencing Social Support have lower risk of developing coronary heart diseases and it also facilitates recovery from the same. The direct effect of Social Support is on health, independent of the amount of stress that any individual at any age experience. Individuals with high levels of Social Support may have a greater feeling of being liked and cared for. A high level of Social Support encourages people to lead a healthier lifestyle. Social Support encourages people to lead a healthier lifestyle. Social Support received from friends and relatives provides physical and psychological aid to people of any age group. SIEGAL (1990) notes that the aged who are retired, and whose spouse is expired need more Social Support. Women and men who are working also require Social Support from their life-partner. ALLEN (1991) notes that social network sometimes does not provide enough support. Hence the type of Social Support required by men and women, children and old at various age levels differ. Individual whether male or female, child, orphan, aged etc. could maintain physical and mental health when he/she receives Social Support continuously throughout life. It means Social Support is needed continuously by all individuals throughout life. She/he is able to solve problems, maintain social adjustments and express his/her tension/stress before someone for a balanced personality development. Individuals who are working get relief from organizational strain and stress due to Social Support. The efficacy of Social Support is likely to be dependent on –

(a)  Who is providing support?

(b)  What kind of support is being provided?

(c)  To whom is the support provided?

(d)  For which problems is the support provided?

(e)  When and for how long is the support provided?

The present investigation is an attempt to find the importance of Social Support received by males and females of different age-groups.
Social support:

Some people react better than others to stress and chronic pain, and they tend to be the ones who have greater personal resources for coping. One of the most beneficial personal resources appears to be social support from family members, friends, and health care providers. This section discusses the meaning of social support and suggests possible reasons why social support seems to protect against disease and death.

1.9.1 THE MEANING OF SOCIAL SUPPORT:

What is social support? Although social support has been widely researched, no single definition of the concept has emerged (Sarason & Sarason, 1994) and researchers have used dozens of inventories to measure social support, many of them with questionable reliability and validity (Kaplan, 1994) the term social support refers to a variety of material and emotional supports a person receives from others. The related concepts of social contacts and social network are sometimes used interchangeably, and both refer to the number and kinds of people with whom one associates. The opposite of social contacts is social isolation, which refers to an absence of specific meaningful interpersonal relation. People with a high level of social support ordinarily have a broad social network and many social contacts; socially isolated people have neither.

Social support may be measured in terms of either the structure or the function of social relationships (Wills, 1998). Structural support includes the number of social relationships and the structure of interconnections among these relationships. Functional support includes emotional support, information or advice, and companionship, as well as assistance with financial or material needs. These two measures are not strongly related to each other, but both are related to health.

1.9.2 THE LINK BETWEEN SOCIAL SUPPORT AND HEALTH:

Stress researchers generally agree that a link exists between social support and health; people who receive high levels of social support are usually healthier than
those who do not. Evidence from studies done in California, Georgia, Michigan, and Scandinavia (Wills, 1998) demonstrates that people with higher levels of social support of lower rates of mortality and better health than people with lower levels of support.

The Alamed County Study (Berkman & Syme, 1979) was the first to establish strong link between social support and longevity. This study indicated that lack of social support was as strongly linked to mortality as cigarette smoking and a sedentary lifestyle. Figure 8.5 show that women in all age groups had lower mortality rates than men (as indicated by the height of the bar in the graph). However, for both men and women, as the number of social ties decreased, the death rate increased. In general, participants with the fewest social ties were two to four times more likely to die than participants with the most social ties. This trend was most pronounced from age 30 to 49, and it extended to both men and women.

**Marriage, Gender, Ethnicity, and Social Support**: Marriage (or at least happy marriage) would seem to provide excellent social support for both partners, but the benefits of marriage are not equal for women and men. The studies in the States and Scandinavia that demonstrates the advantages of social support also showed that marriage benefits men more than women (Chesney & Darbes, 1998). The mechanisms of this advantage are not clear, but women’s role as caregiver may be the key. Women tend to provide more care than they receive and may ignore their own health in taking care of their spouses and children.

For older people, marriage may not be as important as having a confidant. A survey of men and women age 65 and older (Oxman, Berkman, Ksl, Freeman, &Barrett, (1992) showed that the more social support these older people experienced, the lower were their levels of depression. Emotional support provided more protection against depression than tangible support, such as a visit from a friend. The older people who never had a confidant were likely to become depressed than were those who had been married, and longstanding confidants were more protective than those gained in more recent years.

The health benefits of having a wife would lead to the prediction that husbands would be more affected by the death of their spouse than would wives. This
prediction is correct (Martikainen & Valkomen, 1996); death of spouse increased mortality risk for the surviving, but men were at greater risk than women. The risk was higher not only for men but also for younger persons of either gender. In addition, the risk was higher during the 6 months following the spouse’s death. Death from heart disease and career increased, but the greatest mortality were from accidental and violent deaths especially suicide. Again, these risks may relate to typical gender roles in which men depend on their wives for support, but women cultivate a larger social network of family members and friends and are thus more likely to receive support after the death of a husband.

Although men gain more from marriage, women gain more from social support, at least up to a point. In the Alameda County Study (Berkman & Syme, 1979), women with few social ties had a substantially higher relative risk for mortality than comparable men (see Figure 8.1). A meta-analysis (Schwarzer & Lippin, 1989) confirmed this finding, revealing that for women the overall correlation between social support and good health was about .20, but for men the correlation was only .08. Many social contacts do not extend (and may decrease) women’s advantage (Orth-Gomer, 1998). A possible explanation for this finding is that woman with many social contacts are overextended, receiving demands for support that may add to rather than detract from their stress.

Does ethnic background play a role in social support? African American and Hispanic American Families have traditions of close extended family relationships that can provide stronger social support than those of many European American families. Analysis of African, American (Neighbors, 1997) and Mexican American (Cstro, Coe, Gutierres, & Saenz, 1996) families indicated that these relationships can be sources of stress as well as support. Indeed, the people who provide support at one time are those who cause problems at others times. An analysis of network characteristics among various ethnic groups (Puglieses & Shook, 1998) revealed only small differences in size of social networks. This study confirmed earlier findings (Berkmen, 1987) concerning white men’s tendency to have smaller social networks and to use social support less than others but revealed some interaction between gender and ethnicity. Example, White men tended to have smaller social networks when they were employed, but employment was not a factor in network size for men
from other ethnic group or for women. the findings from this study suggested that the structure and use of social networks are complex and influenced by a number of factors, including marriage, gender, and ethnicity.

1.9.3 HOW DOES SOCIAL SUPPORT CONTRIBUTE TO HEALTH?

If stress causes illness, then social support may offer some buffer against stress-related illnesses. Evidence suggested that this buffering effect is especially strong for European American men but also applies to others people. What does social support provide that is helpful? What is stressful, even life threatening, about social isolation? Answers to these questions are still not clear, but several possible routes exist for social support to affect health (Wills, 1989). One route is through health-related behaviors, another is through appraisal and coping, and a third is through moderation of psychological responses to stress.

People who are isolated are less likely to have friends and acquaintances who encourage them to protect their health or who insist that they go to the doctor when they are sick. One study (Broman, 1993) showed that social isolation led to unhealthy coping responses such as smoking and abusing alcohol, which can negatively affect health. In addition, people who were more socially involved were likely to use seat belts indicating that integration into a social network can increase safety behavior as well as decrease risk behaviors. Thus, social support networks can encourage people to behave in healthy way. This explanation may contribute to the health, but an increased number of healthy practices is not the only explanation for the link. In the Alameda Country study, for instance of social support still had an independent with mortality. Suggestions and encouragement from friends may enhance healthy behaviors, but they are not the only answer.

People with strong support networks know that assistance is available, so when they experience stress, they may appraise the stressor as less threatening than people who have fewer coping resources (Wills, 1998). Indeed, knowledge of the availability of support (even if that support is not used) can reduce the magnitude of the stress response (Uchino & Garvey, 1997). Support may also directly change
coping strategies such that people with more sources of support are better able to gain information, solve problems, and implement solutions.

Social support may also alter the physiological responses to stress (Chensy & Darbes, 1998). This view is referred to as the buffering hypothesis, which suggests that social support lessens or eliminates the harmful effects of stress and therefore protects against disease and death. Some laboratory research has shown that people react less strongly to stressors when social support is available. Thus, people who have less social support may react more strongly to stress, showing higher levels of neurohormones and more physical damage than people with strong support networks.

Losing his father and his family resulted in Rick’s social support system “falling apart.” In addition, he began to have trouble getting alone with his colleagues at work. Being isolated situation that Rick found most distressing. This lack of a social support system added to his stress. Rick managed to construct another support system through beginning college and becoming more involved in church activities, a strategy that was wise and probably beneficial.

1.9.4 MOBILIZING SOCIAL SUPPORT:

If social support provides health advantages, can people improve their social support through specific efforts? Perhaps so, but increasing social support is not as easy as increasing the number of social contacts. People who are high in hostility receive less social support than those who are lower in hostility (Hardy & Smith, 1988), and increasing the number of social contacts would probably not increase social support for people who are unpleasant or difficult to be friend. (See the Would You Believe…? Box for an interesting alternative.)

One hint concerning increased social support comes from the gender in social support: Women tend to have larger and more active support networks than men. The reason for this difference can be seen in women’s friendship style, which tends to rely on emotional sharing, cooperation, and positive nonverbal signals (Argyle, 1992). Indeed, both men and women prefer to have women as confidants, but women are more likely than men to fulfill this preference. Therefore, women’s tendency to form
such networks gives them an advantage in social support. Men can gain the advantages of a large, active social support network they from such networks.

Are people who are lacking in social support destined to remain so? Two strategies exist to improve social support (Gottlieb, 1996). One strategy involves enhancing existing support sources and the other creates support networks in the form of support groups. Professionals are typically the agents who advise people about restructuring networks to enhance support for families with chronic stress. For example, restructuring might be useful to those caring for a family member with a chronic illness such as Alzheimer’s disease. Support groups are constructed networks consisting of people with similar stressful circumstances. Meeting with others in similar circumstances can give people many valuable experiences, including emotional support, information, and practical help. A huge variety of conditions and to help their families cope. In summary, there are several ways to boost social support, including making changes to allow the formation of more intimate personal relationships, enhancing existing support structure, and joining a support group.

1.10 WHAT IS MEAN BY MENTAL HYGIENE?

The researcher thinks further clarification regarding the difference (if there is a difference) between the two terms would be helpful. I do not understand the need to use "mental hygiene” because to me, "hygiene" refers to cleanliness, and I do not think that mental health has anything to do with cleanliness or the lack thereto.

The development and happiness of any society depends on the standard of its mental health. The mental health of society or a cultural group in turn depends on mental health of its members. Mental health of individuals depends on the availability of favorable social situations and his ability to utilize them. Abilities are almost inherited but their development depends upon individual's efforts and social environment. No achievements is without any cost what so ever Achieving all these at the cost of mental health is really a losing proposition and not a profitable one.

In the course of developing one's abilities and achieving unusual heights if one loses one's mental health then all his efforts are worthless.
In short our abilities and achievements are meaningful and adequately useful only if we are able to sustain our mental health in the process of getting them. In this age of cut throat competition we blindly run like a sheep after the lure of development. In this process, without thinking about our capacities, our interests, our resources, our nature and our mental readiness, we are swept away by the competitive flow, and as a result, after attaining the so called achievements, we might get ourselves tumbled down.

Respect, social status, popularity, power, money, achievements, are desirable in certain respects but they may become meaningless if one breaks down under tension. If he suffers from attacks of acute anxiety, or if he feels insecure and without any reason, he loses his initiative. Our ability to utilize our mental & material powers depends ultimately upon our mental hygiene.

The meaning of mental hygiene is so broad that physical and mental health is automatically included in it. Hurbert Carol says that the mental health of the society can be good if its physical health is good. Skinner says that "Mental hygiene is primarily related with the development of more wholesome human relationships. It means applying to everyday living what has been learned with regard to the behavior of human beings.

Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

1.10.1 HISTORY:

In the mid-19th century, William Sweetzer was the first to clearly define the term "mental hygiene", which can be seen as the precursor to contemporary approaches to work on promoting positive mental health. Isaac Ray, one of thirteen founders of the American Psychiatric Association, further defined mental hygiene as an art to preserve the mind against incidents and influences which would inhibit or destroy its energy, quality or development. Johns Hopkins (2010) An important figure to "mental hygiene", would be Dorothea Dix (2006), a school teacher, who had campaigned her whole life in order to help those suffering of a mental illness, and to bring to light the deplorable conditions into which they were put. This was known as
the "mental hygiene movement". Before this movement, it was not uncommon that people affected by mental illness in the 19th century would be considerably neglected, often left alone in deplorable conditions, barely even having sufficient clothing. Dix's efforts were so great that there was a rise in the number of patients in mental health facilities, which sadly resulted in these patients receiving less attention and care, as these institutions were largely understaffed. Barlow, D.H., Durand, V.M., Steward, S.H. (2009) At the beginning of the 20th century, Clifford Beers founded the National Committee for Mental Hygiene and opened the first outpatient mental health clinic in the United States of America. Clifford Beers Clinic. (2006).

The mental hygiene movement, also known as the social hygiene movement, had at times been associated with advocating eugenics and sterilization of those considered too mentally deficient to be assisted into productive work and contented family life. Taylor R. Francis.

1.10.2 DEFINITION:

“Mental Health is the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well being that respects the importance of culture, equity, social justice, interconnections and personal dignity.”

“Mental health describes a level of psychological well-being, or an absence of a mental disorder. From the perspective of 'positive psychology' or 'holism', mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience. Mental health can also be defined as an expression of emotions, and as signifying a successful adaptation to a range of demands.”

The World Health Organization (2013) defines mental health as "a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". It was previously stated that there was no one "official" definition of mental health. Cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined. [4]

There are different types of mental health problems, some of which are common, such as depression and anxiety disorders, and some not so common, such as schizophrenia and bipolar disorder. Kitchner, BA & Jorm, AF (2002).
“Good mental health is more than the absence of mental illness; it is a positive sense of well-being. For children and young people, it is the ability to learn, play, enjoy friendships and relationships, and deal with difficulties experienced during childhood, adolescence and early adulthood. “Normally, a child’s well-being is the result of healthy individual development within a sympathetic, nurturing environment. In the early years of life, infants make emotional attachments and form the first relationships that lay the foundations for future mental health.”

“As the child grows, his or her emotional, cognitive and social development is nurtured by good relationships with family, peers and community. The mentally healthy child should emerge from this with a clear sense of identity and self-worth, the ability to recognize and manage emotions, problem-solving and communication skills, motivation and a respect for the feelings of others.”

“Mental health is therefore just as important as physical health. It influences how we feel, perceive, think, communicate and understand. Without good mental health, it is difficult for children and young people to fulfill their potential, or play an active part in everyday life.”

According to a W.H.O. expert committee on mental health “Mental health implies the capacity in an individual to form harmonious relations with others, to participate in or contribute constructively to change in his social and physical environment and fully realize his potentialities”

A healthy person is one who has syntaxes (non-parataxis) relationships with others and who reacts to people as they really are, not as symbols of past relationships. Thus emphasis is on interpersonal relationships. Alder defined a healthy personality as one which experiences a sense of identification or one-nests with mankind pathology involves neurotic striving for power as compensation against feelings of inferiority and helplessness.

Allport (1961) gave six salient features for a sound healthy personality.
1. Extension of the sense of self
2. Capable of intimacy, respect and compassion when relating to others.
3. Emotional security (self-acceptance)
4. Realistic perception and skills
5. Self-objectification, i.e. insight and humor
6. A unifying philosophy of life a sense of direction and purpose in life.
The concept of psychological health must focus on the ideal state, i.e. emphasis on the “positive well-being” rather than on disease, statistical or conformity criteria. Health must be defined as a state of physical, social and psychological wellbeing rather than simply as an absence of illness or infirmity. They also stressed the importance of development of human potentials illness is considered to be a reflection of individual response to stress and change in the social cultural, economic and psychological environment.

Mental health has been defined in different ways by different psychologists. For Dubos health implies “a modus Vivendi enabling imperfect men to achieve a rewarding and not too painful existence; while they cope with an imperfect world” whereas, disease connotes, “Failure or disturbance in the organism as a whole or any of its systems” Thus it is believed that if signs of adjective failure are absent a person is psychologically healthy.

Positive striving as the most important quality of health and outlined three basic features of mental health-mastery of environment, a unified or integrated personality and the accurate perception of oneself and the external world.

Emphasized interpersonal competence which is the social skill which give the individual effective control over his interpersonal affairs and help him develop optimally along self-chosen lines. Maslow has given more importance to the kind of society in which a healthy personality can grow according to him there are universal criteria of mental health valid for human race. A number of basic human needs sense of belonging transcend vice, sense of being an integral part of the world and identity) must be gratified in order for man to reach optimal functioning.

Proposed a model of “integrative adjustment” which is characterized by self control” personal responsibility, social responsibility, democratic social interests and ideals. Emphasized on the capacity for awareness and openness to experience, as criterion for a fully functioning person.

Freud lays importance on a persons’ ability “to love and work” as evidence of a balanced and healthy personality by love Freud meant generosity, intimacy, trust, pleasure in the happiness of others and sexual love “work” means productive efforts which give meaning to life and makes one’s existence meaningful more in terms of the absence of pathology, than the presence of valuable attributes. Reich (1949) shared with Freud the tendency to think of health as the absence of pathology. The implicit Freudian concept of psychological health is usually expressed as the “genital
character” as contrasted with the oral or anal character. In the Freudian view of genital character the ego emerges as the powerful controlling agent of the personality with full control over the primitive impulses. The prudential sexual urges are not repressed but transformed into safe and acceptable expression, due to which the person is capable of rational behaviour in accord to the realities of the situations. Thus Freud’s concept of mental health lays emphasis on sexual adequacy also as a sign of health.

Systematically analyzed development from infancy to adulthood and at each psychosexual stage presented a polarity of pathology and health, based on the manner in which the infertile erotic needs and the social attitudes connected with them are expressed. In defining the concept of health, Erikson used the term ego identity. According to him only that person who was emerged positively from every development crisis at each psycho-sexual stage can develop a healthy ego identity, which further leads to a balanced person.

From her many definition of mental health gave the following as criteria of positive mental health.

1. Attitude towards the self-it includes acceptance by the individual of his own self.
2. Growth, development and self-actualization-the extent to which the individual utilizes his abilities.
3. Integration the extent to which the psychic forces are balanced.
4. Autonomy person is self reliant and is able to decide what suits his own needs best.
5. Perception of ability freedom from need distortion and existence of empathy.
6. Environment mastery adequacy in interpersonal relationships adoption and adjustment and efficiency in problem solving.

- Mental well-being

Mental health can be seen as an unstable continuum, where an individual's mental health may have many different possible values. Jetesm Corey (2002) mental wellness is generally viewed as a positive attribute, such that a person can reach enhanced levels of mental health, even if the person does not have any diagnosed mental health condition. This definition of mental health highlights emotional wellbeing, the capacity to live a full and creative life, and the flexibility to deal with life's inevitable
challenges. Many therapeutic systems and self-help books offer methods and philosophies espousing strategies and techniques vaunted as effective for further improving the mental wellness of otherwise healthy people. Positive psychology is increasingly prominent in mental health.

A holistic model of mental health generally includes concepts based upon anthropological, educational, psychological, religious and sociological perspectives, as well as theoretical perspectives from personality, social, clinical, health and developmental psychology.

An example of a wellness model includes one developed by Myers, Sweeney and Witmer. It includes five life tasks—essence or spirituality, work and leisure, friendship, love and self-direction—and twelve sub tasks—sense of worth, sense of control, realistic beliefs, emotional awareness and coping, problem solving and creativity, sense of humor, nutrition, exercise, self care, stress management, gender identity, and cultural identity—which are identified as characteristics of healthy functioning and a major component of wellness. The components provide a means of responding to the circumstances of life in a manner that promotes healthy functioning. The population of the USA in its’ majority is considered to be mostly uneducated on the subjects of mental health. Myers, J.E., Sweeney, T.J., Witmer, J.M. (2000) another model is psychological well-being.

1. Prevention Introduction
2. History of Fighting Coronary Heart Disease
3. Heart’s Anatomy and Function

Mental health can also be defined as an absence of a mental disorder. Focus is increasing on preventing mental disorders. Prevention is beginning to appear in mental health strategies, including the 2004 WHO report "Prevention of Mental Disorders", the 2008 EU "Pact for Mental Health" and the 2011 US National Prevention Strategy. (National Research Council & Institute of medicine (2009).

- Cultural and religious considerations

Mental health is a socially constructed and socially defined concept; that is, different societies, groups, cultures, institutions and professions have very different ways of conceptualizing its nature and causes, determining what is mentally healthy,
and deciding what interventions, if any, are appropriate. Weare, Katherine (2002) Thus, different professionals will have different cultural, class, political and religious backgrounds, which will impact the methodology applied during treatment. Research has shown that there is stigma attached to mental illness. In the United Kingdom, the Royal College of Psychiatrists organized the campaign Changing Minds (1998–2003) to help reduce stigma.

Many mental health professionals are beginning to, or already understand, the importance of competency in religious diversity and spirituality. The American Psychological Association explicitly states that religion must be respected. Education in spiritual and religious matters is also required by the American Psychiatric Association. Richards, P.S., Bergin, A.E. (2000).

1.11 CHARACTERISTIC OF MENTAL HEALTH:

It has always been easier to define mental illnesses than to define mental health. In the United States the American Psychiatric Association has traditionally been the organization to define mental disorders (beginning as early as 1917 when it was known as The Association of Medical Superintendents of American Institutions of the Insane). More recently many have recognized that mental health is more than the absence of mental illness. Even though many of us don't suffer from a diagnosable mental disorder, it is clear that some of us are mentally healthier than others. Here are a few ideas that have been put forward as characteristics of mental health:

• The ability to enjoy life - The ability to enjoy life is essential to good mental health. James Taylor wrote that "The secret of life is enjoying the passing of time. Any fool can do it. There ain't nothing to it." The practice of mindfulness meditation is one way to cultivate the ability to enjoy the present. We, of course, need to plan for the future at times; and we also need to learn from the past. Too often we make ourselves miserable in the present by worrying about the future. Our life metaphors are an important factors that allow us to enjoy life

• Resilience - The ability to bounce back from adversity has been referred to as "resilience." It has been long known that some people handle stress better than others. Why are some Vietnam combat veterans handicapped for life, while others become United States senators? Why do some adults raised in alcoholic families do well,
while others have repeated problems in life? The characteristic of "resilience" is shared by those who cope well with stress.

• **Balance** - Balance in life seems to result in greater mental health. We all need to balance time spent socially with time spent alone, for example. Those who spend all of their time alone may get labeled as "loners," and they may lose many of their social skills. Extreme social isolation may even result in a split with reality. Those who ignore the need for some solitary times also risk such a split. Balancing these two needs seems to be the key - although we all balance these differently. Other areas where balance seems to be important include the balance between work and play, the balance between sleep and wakefulness, the balance between rest and exercise, and even the balance between time spent indoors and time spent outdoors.

• **Flexibility** - We all know people who hold very rigid opinions. No amount of discussion can change their views. Such people often set themselves up for added stress by the rigid expectations that they hold. Working on making our expectations more flexible can improve our mental health. Emotional flexibility may be just as important as cognitive flexibility. Mental healthy people experience a range of emotions and allow themselves to express these feelings. Some people shut of certain feelings, finding them to be unacceptable. This emotional rigidity may result in other mental health problems.

• **Self-actualization** - What have we made of the gifts that we have been given? We all know people who have surpassed their potential and others who seem to have squandered their gifts. We first need to recognize our gifts, of course, and the process of recognition is part of the path toward self-actualization. Mentally healthy persons are in the process of actualizing their potential. In order to do this we must first feel secure.

These are just a few of the concepts that are important in attempting to define mental health. The ability to form healthy relationships with others is also important. Adult and adolescent mental health also includes the concepts of self-esteem and healthy sexuality. How we deal with loss and death is also an important element of mental health. Please consider sharing your own ideas about mental health in the Forum.
1.12 TYPES OF MENTAL HEALTH ASSESSMENTS

Mental health assessments are used to determine whether or not a person has a mental illness. Mental health assessments usually work by exclusion, arriving at the conclusion of mental health after ruling out the possibility of mental illness. There are several types of mental health assessments, including personality disorder tests, mental illness tests and cognitive assessments

- **Personality**

  Personality tests can be used to assess mental health and determine personality disorders, such as avoidant personality disorder and antisocial personality disorder. A personality disorder is a highly persistent and continuous mental health issue that affects a person's ability to interact normally with others. Many people who have personality disorders fail to seek out medical help, thinking that their behavior is normal and that other people are wrong.

- **Disability**

  Mental disabilities are not the same as mental illnesses, but are assessed using mental health instruments. Many patients with Asperger's syndrome are initially screened for schizophrenia, as the two conditions have some symptoms in common. Patients who show certain symptoms, such as paranoia, excitability and social withdrawal, are tested using medical history reviews, IQ tests and personality tests, and are categorized as disabled or mentally ill, depending on the results.

- **Neuropsychological**

  Mental health can be tested using neurological assessment tools, such as brain scans, electric brain imaging and MRIs. Certain mental illnesses, such as schizophrenia and depression, have strong physiological correlation in the patient's brain, such as under or overactive dopamine receptor site activity. A comprehensive brain scan, using various imaging technologies, can add considerable weight to a diagnosis of schizophrenia or depression.

- **Cognitive**

  Cognitive assessments are sometimes used to assess mental health. In most cases, cognitive assessments, such as IQ tests and aptitude tests, are used to rule out physiological conditions, such as brain damage, before a diagnosis of mental illness is given. Certain conditions, including schizoid personality disorder, correlate reasonably well with average to above average IQ. Cognitive assessments can be
useful in distinguishing between mental impairment and mental illness, and thus are essential tools in thorough mental health testing.

- **Situational Problems**

  Some mental health problems are temporary or situational in nature. Conditions such as trauma and post-traumatic stress disorder are often assessed by reviewing events in the patient's life, as they can only be diagnosed with reference to an external cause. Other tools, such as personality testing and cognitive testing, are used in addition to the case history approach. Thus, the assessment process for situational problems is very much holistic in nature.

### 1.13 EMOTIONAL MENTAL HEALTH ISSUES AROUND THE WORLD:

Emotional mental disorders are a leading cause of disabilities worldwide. Investigating the degree and severity of untreated emotional mental disorders throughout the world is a top priority of the World Mental Health (WMH) survey initiative, which was created in 1998 by the World Health Organization (WHO). “Neuropsychiatric disorders are the leading causes of disability worldwide, accounting for 37% of all healthy life years lost through disease. These disorders are most destructive to low and middle-income countries due to their inability to provide their citizens with proper aid. Despite modern treatment and rehabilitation for emotional mental health disorders, “even economically advantaged societies have competing priorities and budgetary constraints”.

The World Mental Health survey initiative has suggested a plan for countries to redesign their mental health care systems to best allocate resources. “A first step is documentation of services being used and the extent and nature of unmet needs for treatment. A second step could be to do a cross-national comparison of service use and unmet needs in countries with different mental health care systems. Such comparisons can help to uncover optimum financing, national policies, and delivery systems for mental health care.”

Knowledge of how to provide effective emotional mental health care has become imperative worldwide. Unfortunately, most countries have insufficient data to guide decisions, absent or competing visions for resources, and near constant pressures to cut insurance and entitlements. WMH surveys were done in Africa (Nigeria, South Africa), the Americas (Colombia, Mexico, U.S.A), Asia and the Pacific (Japan, New Zealand, Beijing and Shanghai in the Peoples Republic of
China), Europe (Belgium, France, Germany, Italy, Netherlands, Spain, Ukraine), and the middle east (Israel, Lebanon). Countries were classified with World Bank criteria as low-income (Nigeria), lower middle-income (China, Columbia, South Africa, Ukraine), higher middle-income (Lebanon, Mexico), and high-income.

The coordinated surveys on emotional mental health disorders, their severity, and treatments were implemented in the aforementioned countries. These surveys assessed the frequency, types, and adequacy of mental health service use in 17 countries in which WMH surveys are complete. The WMH also examined unmet needs for treatment in strata defined by the seriousness of mental disorders. Their research showed that “the number of respondents using any 12-month mental health service was generally lower in developing than in developed countries, and the proportion receiving services tended to correspond to countries’ percentages of gross domestic product spent on health care”. “High levels of unmet need worldwide are not surprising, since WHO Project ATLAS' findings of much lower mental health expenditures than was suggested by the magnitude of burdens from mental illnesses. Generally, unmet needs in low-income and middle-income countries might be attributable to these nations spending reduced amounts (usually <1%) of already diminished health budgets on mental health care, and they rely heavily on out-of-pocket spending by citizens who are ill equipped for it”.

1.13.1 EMOTIONAL MENTAL HEALTH IMPROVEMENT:

Being mentally and emotionally healthy does not preclude the experiences of life which we cannot control. As humans we are going to face emotions and events that are a part of life. According to Smith and Segal, “People who are emotionally and mentally healthy have the tools for coping with difficult situations and maintaining a positive outlook in which they also remain focused, flexible, and creative in bad times as well as good Smith, M; Segal, R. Segal, J. (2011). In order to improve your emotional mental health, the root of the issue has to be resolved.

“Prevention emphasizes the avoidance of risk factors; promotion aims to enhance an individual’s ability to achieve a positive sense of self-esteem, mastery, well-being, and social inclusion”. It is very important to improve your emotional mental health by surrounding yourself with positive relationships. We as humans, feed off companionships and interaction with other people. Another way to improve your emotional mental health is participating in activities that can allow you to relax
and take time for yourself. Yoga is a great example of an activity that calms your entire body and nerves. According to a study on well-being by Richards, Campania and Muse-Burke, “mindfulness is considered to be a purposeful state, it may be that those who practice it believe in its importance and value being mindful, so that valuing of self-care activities may influence the intentional component of mindfulness” Richards, K.C.; Compania, C. Muse – Burke, J.L. (2010).

1.14 TRAITS OF MENTAL HEALTH:

Mental health like physical health is also a condition. And this condition can be recognized by its characteristics features. Roughly speaking a mentally healthy individual would exhibit the following symptoms.

- Adjustability:
  It has been painted out earlier also that one special characteristics of a mentally healthy individual is that he adjusts to a new situation with least delay and disturbance. He makes the fullest possible use of existing opportunities and adjusts to every new situation that presents itself. This does not mean that he is a rolling stone that gathers no moss, but has his own ideas, notions, opinions, is a cell individual who deals coolly and patiently with every novel circumstance, without fear, disturbance, anxiety, complaint or desire to avoid them. He is aware of the fact that change is the principle of life, he is ever prepared for change and always finds some suitable mode of adjustment

- Self-Evaluation:
  A mentally healthy individual evaluating himself properly is aware of his limitation. He easily accepts his faults and makes efforts to get rid himself of them. He introspects so that they may analyze his problems, prejudices, difficulties etc and reduces them to a minimum.

- Maturity:
  Intellectual and emotional maturity is another peculiar sign of mentally healthy individual. The mature mind is constantly engaged in increasing his fund of knowledge, behaves responsibly, expresses his thoughts and feelings with clarity and is prepared to sympathize with others feeling and viewpoints. The healthy individual behaves like a balanced, cultured and sensible adult in all matters.
• **Absence of Extremism** :

Aristotle believed that the ideal man lacks excess in any and every direction and the principle that excess of anything is bad is a golden rule as far as mental health is concerned. Whatever the instinct, if it is allowed to dominate an individual, it will bring him to harm and endanger his mental health. Hence, in order to maintain mental health, one’s life should be integrated, interests should be wide and the personality balanced extremism is no well wishes of mental health.

• **Regular Life** :

Habits are an important element in maintaining mental health forming proper habits in matters of food, clothing and the normal routine of daily life leads to their becoming systematic and regulated, which in the long run, economizes upon energy and time healthy persons performs most of the common function of life with quick assurance and show of neutrality, without any bother and fuss. Their life is a model or regularity, balance and measured calculation.

• **Satisfactory Social Adjustment** :

A healthy individual maintains good adjustment with social situations, and is engaged in some or the other project intended to benefit society. And this is because in modern society the proper development of everyone’s personality can take place only it there is mutual cooperation. The grater the balance of these social relationships and the greater simplicity the better will be the individual’s mental health.

• **Satisfaction From Chief Occupation** :

For mental health it is essential that everyone should find satisfaction from his chief occupation, his vocation. Money is the result of work but if one works only for it, that much time is obviously a waste. If the work interests an individual, it will yield more money, but the same time, a proper illustration of time will bring an increase in his pleasure and happiness. In fact, if one works for interest and maintains it even in the event of a loss in trade or at least the pain of loss is considerably lessened. Health is always, in a given context, dependent upon existing condition, which are they related to the changes taking place in the environment. There are two schools of thoughts concerning mental health. The first largely represented by the medical profession , thinks about mental health as the absence of mental disease, the second school is represented by psychologists, the teaching profession and the psychoanalysts, who have a more positive approach and regard mental health as the
presence of certain psychological characteristics and their effective use. However, broadly three major ideas have been suggested as criteria’s for a healthy when he understand himself and his own motivations, drives, wishes and desires. This leads a person to accept himself and recognize his liabilities and assets, his past and present behaviour in a socio-culturally approved way. The second criteria about a healthy self, views the person from a long time perspective, embracing his entire life span. It has to do with what a person makes of himself, and is often described as self actualization, growth or acquiring his self the third idea is concerned with the process called integration of personality.

1.15 MODELS OF MENTAL HEALTH

A brief review of the basic models of mental health is given below.

1.15.1 Medical or Biological Model:

Many contemporaries have used the model of physical illness as the basis for defining deviant behaviour as has noted “Deviant behaviour is termed pathological and is classified on the basis of symptoms the classification being called diagnosis. The progress designed to change the behaviour are called therapies and are applied to patients in mental hospitals. If the deviant behaviour ceases, the patient is described as cured”, However in later years, this mode has undergone a barrage of criticism initiated by S2 a S2 (1960) and supported. Have also questioned the validity of the medical model.

1.15.2 Psycho-Analytical or Dynamic Model:

The concept of mental health has been related to a balanced personality. As a result, balanced id-ego-superego triad with ego holding a firm grip on external reality is considered to be tantamount to mental health. Fraud conjectured that personality development can be traced to the expression of biological or sexual energy (libido) and the sources of gratification towards which that energy is directed. He explained psychological development as passing through a series of psychosexual stages. The stages were determined primarily by the focus on the expression of libidinal energy on various parts of the body (i.e. oral anal and genital areas), as a source of gratification, as well as, by the psychic mechanisms assumed to be operative during these stages.
Other psychoanalytic systems include the individual psychology of the analytic psychology of, the interpersonal theory of psychiatry of Sullivan (1953), the humanistic psychoanalysis of, and the neo. The most vigorous critics of the dynamic approach are the behavioristic, who hold that Freudian concepts can neither be proved or disproved, i.e. it can’t be empirically tested Mowrer (1961), holds that the impulse or repression theory of neurosis as given by Simund Freud is erroneous as the feels that the feeling of guilt is the central concept in the development of neurosis.

1.15.3 Statistical Model:
This approach measures specific characteristics of people, such as personality traits, syndromes and ways of behaving, and the distribution of these characteristics in the population curve which depicts the majority of people being in the middle as far as any particular characteristic is concerned and very few people fall in at either of the extremes. A normal person implies that he/she does not deviate from the average in a behaviour patterns who deviate, i.e., are judged abnormal utilizing a dimensional approach with in the statistical model measured three dimensions of personality introversion-extroversion neuroticism and psychotics, terms this approach as multivariate experimental psychology and has applied it is measuring anxiety and neuroticism gave the type factor approach. They applied factor analytic techniques to define behaviour patterns and syndromes, with a precision unobtainable by other psychiatric methods. However the statistical methods by itself is inadequate; because it just analyses the data and does not decide what type is to observed.

1.15.4 Learning Theory Model:
This model views psychopathology as a set of learned maladaptive or faulty behaviour which a person develops because the environment reinforces them., for example, maintains that neurotic behaviour is essentially based on persistent habits of learnt or conditioned un-adaptive behaviour which is acquired in situations which generate anxiety. Have effectively synthesized Freud’s dynamic model with that of learning theory in his “principles of psychopathology” has also successfully related learning model to psychopathology. Also explained maladaptive behaviour through social learning theory. This theory has been criticized on a number of grounds including, failure to include data on subjective experience failure to tackle more complex dimensions of behaviour such as love, courage, faith, hope despair etc.
failure to deal with the problems of values and meaning in human existence and failure in initiating personality restructuring in the process of behaviour therapy.

1.15.5 Humanistic Model:

The humanistic model is characterized by its general orientation towards human beings and their potentialities as by any coherent test of principles of personality development and functioning. According to this model, psychopathology is essentially the blocking or distortion of personal growth, which is generally due to one of the given factors.

1. The exaggerated use of ego-defense mechanisms, due to which, the individual becomes increasingly out of touch with reality.
2. Unfavorable social conditions and faculty learning.
3. Excessive stress.

The humanistic model has been criticized for diffuseness and lack of scientific rigor in its conceptualizations.

1.15.6 Socio-Cultural Model:

The chief exponent of this model states that, by the beginning of the present century, sociology and anthropology had emerged as independent scientific disciplines and were making rapid strides in understanding the role of socio-cultural factors in human development and behaviour though the efforts Mead and other contributors like, Ruth Benedict, Ralph Linton, Abraham kurdiner and Franz boas, it became clear that there is a relationship between socio-cultural factors and mental disorders it was also seen that patterns of both physical and mental disorders in a given society may change overtime as socio-cultural conditions change.

1.15.7 Existential Model:

This model emphasizes on our uniqueness as individuals, our quest for values and meaning, and our freedom for self-direction and self-fulfillment. However, the existential model represents a some what less optimistic view of human beings, and places more emphasis on the irrational tendencies of human nature and the difficulties inherent in self-fulfillment, particularly in our bureaucratic and dehumanizing impersonalizing mass society. The existentialist place more faith in the inner experience of the individual, than modern science, in their attempt to understand
human problems constructed the existential theory of anxiety. Other prominent existentialists are.

1.15.8 Moral Model:

The chief exponent of the moral model of psycho-pathological behaviour is Mowers. According to him “so long as we subscribe to the view that, neurosis is a bonafide illness, without moral implications or dimension our position will, of necessity, continue to be an awkward one. And it is here that I suggest that as between the concept of sin (however unsatisfactory it may be in some ways) and that of sickness, sin is indeed lesser of the two evils”.

As long as a person lives under the shadow of real knowledge guilt, he cannot “accept himself” and all our efforts to reassure him will avail nothing. But, the moment (with or without assistance) he begins to accept his guilt and sinfulness, the possibility of readical reformation opens up, and with this individual passes from deep pervasive self-rejection and self-hatred to a new freedom of self-respect and peace.

We will find that, with in psychology, the philosophy about the basic nature of man has undergone a change from the negativistic view of humanists. However, each has, its impact on searches for etiological as well as therapeutic and preventive searches. Each has demonstrated its efficiency for specific problems. Which are, psychoanalysis for maladaptive behaviour caused by inaccessible factors, behaviouristic and existential models focus for everyday coping problems, while the humanistic and existential models focus on the value problems of contemporary life.

Thus, it becomes safer to adopt a global approach in which all different models are incorporated. However, the integrative approach is more innovative, which is echoed in the policy of W.H.O. too, which laid down the guiding principle of a “sound mind in a sound body, and a sound body in a sound society”. The inter disciplinary view requires a need for and acceptance of a unified synergetic view of man and his world. Such an approach has been advocated by when he proposes a “general system theory”, which does not view individual as distinct from their environment but, rather as integral and interacting part of a whole, which is larger and more potent than its components. This theory does not deal with current problems but also forecasts the type of future problems and provides a sound basis for shaping a ‘good’ future of man (Fostering and helping to ensure his well-being and fulfillment.
It appears to be an extension of the interdisciplinary view and goes beyond their view in terms of explanatory principles and capabilities of prediction and control.

1.16 WHAT IS MEANED BY ILLNESS BEHAVIOUR?

Illness behavior describes the various aspects of how patients cope with their illness. The term illness behavior has originally been introduced from Mechanic (1) who also emphasized socioeconomic issues. Illness behavior covers features such as health care use, urging doctors to do investigations, taking medication, being disabled at work, avoidance of physical activity, and expression of symptoms to family members and significant others. Pilowsky introduced the term "abnormal illness behavior" to summarize behavioral aspects that might contribute to the maintenance of the disorder. Interestingly, illness behavior shows only moderate associations with illness severity. This implies that people with the same illness show very different illness behavior, and it highlights the fact that individual and social factors determine a major part of illness behavior.

Anxiety and depression are important features associated with illness behavior. Not only in itself, but also in combination with medical complaints, depression and anxiety are associated with higher health care costs. Another important determinant of illness behavior is somatic complaints. The most frequent somatic complaints are rarely explained by organic diseases but have to be considered as "unexplained" or "somatoform" symptoms. Patients with summarization syndrome (multiple somatic complaints without a medical condition explaining the symptoms) constitute a major part of patients with extraordinary health care use. Patients with somatic complaints in combination with organic illness attributions tend to increase health care use. As somatic complaints are an extremely frequent phenomenon, the health care relevance of this syndrome is substantial.

Most studies have investigated patients at specific institutions or primary care offices. This implies selection biases of the patient samples that could influence the results. Moreover, only patients already showing health care use per definition are included in these studies. Therefore we wanted to investigate associations between illness behaviors with features of mental health in a representative sample of the general population.
1.17 HISTORICAL PERSPECTIVES:

Chronic disease involves not only the physical body, but it also affects one’s relationships, self-image and behaviour. The social aspects of disease may be related to the path physiologic changes that are occurring, but may be independent of them as well. The very act of diagnosing a condition as an illness has consequences far beyond the pathology involved (Canrad, 2005). Freidson (1970) discussed this more than 40 years ago in his writings about the meaning that is ascribed to a diagnosis by an individual and family. It is not merely pathology or a diagnosis anymore and the individual and family develop their own meanings and perceptions of the condition and ultimately their own, unique illness behaviours. The earliest concept of illness behaviour was described in a 1929 essay by Henry Sigerist. His essay described the “special position of the sick”. Talcott Parsons developed this concept further and described the “sick role” in his 1951 work. The social system. A brief examination of the sick role provides context to the illness experience, perceptions and behaviour.

Sick role:

Talcott Parsons a proponent of structural functionalist principles, viewed health as a functional prerequisite of society. From Parson’s point of view, sickness was dysfunctional and was a form of social deviance. From this functionalist viewpoint, social systems are linked to systems of personality and culture form a basis for social order. Parsons viewed sickness as a response to social pressure that permitted the avoidance of social responsibilities. Anyone could take on the role he identified, as the role was achieved through failure to keep well.

Four major components of the sick role include:

- The person is exempt from normal social roles.
- The person is not responsible for his/her condition.
- The person has the obligation to want to become well.
- The person has the obligation to seek and cooperate with technically component help.

Although the sick role may have been accepted when developed by Parsons in the 1950s, it is no longer considered relevant today. American culture for the most
part has embraced a role of self-care and self-management of disease and participation
with care provides to obtain optimal health. Parson’s sick role was based on
assumptions about the nature of society and the nature of illness during a previous
period of time.

1.18 THE ILLNESS EXPERIENCE:

Commonly, healthcare providers are educated in the medical model and
understand its applicability and use in practice. Clients enter a healthcare system with
symptoms, which are then diagnosed based on pathological findings and as such are
treated and cured with medical treatment. For acute disease, this is the pattern. One
isn’t concerned about the client’s illness behaviour associated with appendicitis,
tonsillitis or a fractured leg. An individual may be concerned that the tonsillitis will
return the fractured leg may not heal normally or there may be an adverse event
associated with the appendectomy, but by and large, these concerns pass quickly
because of the acuteness of the event. The United States’ acute care-focused
healthcare system acts upon the pathology that is present, with the goal that an
individual will fully recover from the condition and return to prior from the condition
and return to prior behaviours and roles.

What happens however, when the recovery is incomplete or the illness
continues or becomes chronic in nature? The individual and family have to modify or
adapt previous behaviour and roles to accommodate the chronicity of the condition.
Societal expectations, their own expectations and their health status all influence
illness behaviour. This chapter provides an overview of the illness experience and
corresponding behaviour demonstrated by those with chronic illness-it presents a
sociological view of illness rather than a medical view of illness. It is not meant to be
a comprehensive review of the entire body of knowledge, which is vast.

Illness behavior takes place before one is officially diagnosed. It is directed
toward determining health status in the presence of symptoms. people routinely
experience that may signal disease. Symptoms are a critical element in seeking
medical care, but the presence of symptoms is not sufficient to prompt a visit to the
doctor (Cameron, Leventhal, & leventhal, 1993). Given similar symptoms, some
readily seek help, others are reluctant, and others do not seek help. What factors affect
the decision to seek professional care? Four may shape people’s response to symptoms: (1) personal reluctance to seek care, (2) certain social and demographic factor, (3) the characteristics symptoms, and (4) one’s personal view of illness.

Personal Reluctance:

A discrepancy exists between what people recommend to others and what they report that they themselves would do about seeking health care. A national survey found that most people were willing to advise other people to see a doctor, but with the same symptoms, they were less likely to go to the doctor themselves (Feldmen, 1966). Many people said they would take care of even serious health problems without professional aid. This attitude is consistent with a general reluctance among many people to seek professional health care and a tendency to interpret any symptoms in a way that indicates the lowest level of threat.

Personal reluctance to seek health care may not be consistent for all people. Some research (Klonoff & Lndrine, 1993) has explored the possibility that people think of different body parts in terms affect their willingness to seek help when these body parts develop problems. College students’ rates different body parts alone several dimensions, and their responses showed some differences in willingness to seek care. People viewed some body parts, such as the anus, as stigmatized and other body parts, such as the genitalia, as private, leading to reluctance in seeking medical care for such body parts than for those lower in stigma and privacy. In addition, people were more likely to seek help for body parts perceived as important and vulnerable, such as the heart and blood.

This reluctance may be especially strong for screening procedures, which are often oriented toward disease detection. Thinking about disease detection may be more distressing than considering the adoption of health-promoting behaviors (Millar & Millar, 1995). This distress can contribute to personal reluctance and can provide a barrier for health screening for a variety of conditions. For many people, avoiding screening tests prevents the anxiety. This type of personal reluctance puts people at risk for the disease that these screening procedures can identify.
Social and Demographic Factors:

Aside from a general personal reluctance to go to the doctor, the tendency to seek professional care differs with several social and demographic variables. One of gender. Although women are more likely to use health care than men, the reasons for this difference are somewhat complex. James Pennebaker (1982) found that women report more symptoms than men and hypothesized that women are more sensitive to their internal body signals than men. This sensitivity makes women more likely to perceive and thus to report symptoms but does not make them sicker than men.

Social factors that shape gender roles also influence the gender difference in reporting symptoms (Waldron, 1997). Given the same level of symptoms, the female gender role allows women to seek many sorts of assistance whereas the male gender role teachers’ men to act strong and to deny pain and discomfort. In addition, men’s social role permits them to take more risks, and failure to seek health care is among these risks. Men are more likely to need health care because of such risks as alcohol consumption and job hazards, but women are at greater risk through physical in activity, unemployment, and stress. When all risk factors are controlled, the illness gap between men and women may be quite narrow, although men generally have worse chronic health than women (Verbrugge, 1989).

In addition to gender differences, socioeconomic factors relate to people’s frequency of seeking medical care. People in higher socioeconomic groups experience fewer symptoms and report a higher level of health than people at lower socioeconomic levels (Pennebaker, 1982). Yet when higher income people are sick, they are more likely to seek health care. Nevertheless, poor people are overrepresented among the hospitalized, an indication that they are much more likely than middle and upper-class people to become seriously ill. In addition, people in lower socioeconomic groups tend to wait longer before seeking health care, thus making treatment more difficult and hospitalization more likely. The poor also have less access to medical care, have to travel longer to reach health care facilities, and must wait longer once they arrive at those facilities.

Cultural and social factors also affect how people respond to symptoms. In some cultures, people are socialized not to react with strong emotional to illness,
whereas in other cultures, a strong reaction is expected. David Mechanic (1978) reviewed several studies that reported varying attitudes toward illness in different ethnic groups. Jewish Americans, for example, were more likely to seek professional help, accept the sick role, and engage in preventive medical behavior; Mexican Americans felt were serious and to inflate others that doctors regarded as minor; Irish Americans tended to deny pain stoically. These differences demonstrate the powerful effects of culture and context on the experience of illness and sick role behavior.

Age is yet another factor that influences people’s willingness to seek medical care, with young and middle-aged adults showing the greatest reluctance. Children are more willing to seek help then adolescents, especially male adolescents (Garland & Zigler, 1994). As people age, they must make distinctions between symptoms of aging and those of disease, discriminating between what is normal and symptom that signal problems. This distinction is not always easy, but people tend to interpret problems with a gradual onset and mild symptoms as resulting from age compared to those with sudden onset and mild symptoms as resulting from age compared to those with sudden onset and severe symptoms (Leventhal & Diefenbach, 1991).

People who are able to attribute their symptoms to age tend to delay in seeking medical care, but older adults are not as strongly influenced by this tendency as the middle-aged (Leventhal & Diefenbach, 1991). Although older and middle-aged people did not differ in type of complaint or ease of access of access to health care, older people were quicker to seek medical care for symptoms that they could not identify. This difference may reflect a lack of tolerance for uncertainty in order adults and a desire to deny or minimize the severity of illness in middle-aged adults.

Stress is also a factor in people’s readiness to seek care. People who experience a great deal of stress are more likely to seek health care than those under less stress, even with equal symptoms. Those who experienced concurrent and prolonged stress were more likely to seek care when the symptoms were ambiguous (Cameron, Leventhal, & Leventhal, 1995). When symptoms were clearly health threats, stress was not a factor. Many symptoms are unclear; presenting the possibility that stress sensitizes people to their symptoms and makes them more likely to seek health care.
Ironically, people under stress are less credible when they claim that they are ill. Patients who reported physical and psychological and physical and psychological distress compromised their credibility (Skelton, 1991). When people complain to their friends and family about stress and pain, they are less likely to be judged to have a “real” disease than their complaints center around physical symptoms. In addition, this lowered credibility extends to health care professionals, with nurses and physicians tending to discount the distress of patients who have many complaints. This tendency to discount symptom reports for people under stress may reflect the distinction between the physical and the psychological, with physical complaints having an organic basis and stress-related problems being psychological and thus not “real.” The more psychological complaints people report, the less “real.” Patients reports of physiological symptoms are considered to be.

**Symptom Characteristics :**

In addition to personal and demographic factors, several symptom characteristics influences when and how people look for help. Symptoms themselves do not in evitable lead people to seek care, but certain characteristics are important in their response to symptoms. Mechanic (19780 listed four characteristics of the symptoms that determine one’s response to disease.

First is the visibility of the symptom-that is, how readily apparent the symptom is to the person and to others. A study on intentions to adopt osteoporosis prevention (Klohn & Rogers, 1991) confirmed the importance of the visibility of symptoms. Young women who received messages about osteoporosis as a disfiguring condition were significantly more likely to say that they intended to adopt precautions against osteoporosis than young women who were not alerted to the disfiguring aspects of osteoporosis.

Mechanic’s second symptom characteristic was perceived severity of the symptom. He contended that symptoms seen as sever would be more likely to prompt action than less severe symptoms. This point highlights the importance of personal perception and distinguishes between the perceived severity of a symptom and the judgment of severity by medical authorities. Indeed, patients and physicians differ in their perceptions of the severity of a wide variety of symptoms (Peay & Peay, 1998).
Symptoms perceived as more serious produced greater concern and a stronger belief treatment was urgently needed. Therefore, perceived severity of symptoms rather than the presence of symptoms is critical in the decision to seek care.

The third symptom characteristic mentioned by mechanic was the extent to which the symptom interferes with a person’s life and some evidence (Suchman, 1965) indicates that the degree of incapacitation affected the person’s action in seeking care. The more incapacitated the person is, the more likely he or she is to seek medical care.

Mechanic’s fourth hypothesized determinant of illness behavior is the frequency and persistence of the symptoms. Conditions that people view as requiring care tend to be those that are both severe and continuous, whereas intermittent symptoms are likely to generate illness behavior (Such-man, 1965). Severe symptoms prompt people to seek help, but even mild symptoms can motivate people to seek help if those symptoms persist (Pro-haska, Keller, Leventha, & Levnthal, 1987).

In Mechanic’s description and subsequent research, symptom characteristics alone are not sufficient to prompt illness behavior. However, if symptoms persist or are perceived as severe, people are more likely to evaluate them as indicating a need for care. Thus, people are prompted to seek care on the basis of their interpretation of their symptom, which relates to each person’s view of illness.

**Personal view of Illness:**

Despite a vast amount of knowledge in the fields of psychology and medicine, most people are largely ignorant of how their bodies work and those who have had their disease fully explained to them tend to have inaccurate and incomplete conceptualizations, partly because when people gain information, they integrate it into their existing knowledge structure. If the new information seems information seems incompatible with what they already “know,” they may modify this new information to make it fit their preexisting knowledge rather than changing their knowledge to conform to the new information. This process may, of course, lead to substantial distortions.
One’s personal view of illness spends on both knowledge of the disease and the structure of one’s cognitions. An interest in how these cognitions develop has prompted a number of studies on disease conceptualizations. For example, children often have unrealistic beliefs about why people get sick and how they get well (Burbach & Peterson, 1986). Children’s early concepts of disease can be organized by developmental stage (Bibace & Walsh, 1979). Childhood concepts of disease include a magical possibility of getting sick for no discernible reason. Later, children develop the concept of contagion, and even later they come to understand the mechanisms of how infectious diseases spread. With additional cognitive development, children begin to comprehend that they can do things to control their health. Finally, they from the idea that both psychological and physiological factors can influence health. A high level of cognitive development is probably required to integrate psychological and physiological factors into their concepts of disease.

Surprisingly, a group of college biology majors gave the same sort of explanation of disease as another group of college students who has taken no biology courses (Bibace & Walsh, 1979). Indeed, both groups gave explanations for catching a cold that were quite similar to those given by 7-year-old children. All three groups attributed their colds to such factors as cold weather, insufficient sleep, or not dressing warmly, even though the biology students knew that viruses cause colds. Although biology majors have been exposed to more accurate information about disease than most people, their inclusion of environmental personal factors in the list of things that causes colds seems to reflect acceptance of the idea that disease has several causes—a personal version of the biopsychosocial model of health and illness.

In addition, many people hold beliefs in supernatural causes, such as punishment from God, sinful thoughts, bad blood, and the evil eye (Landrin & Klonoff, 1994). Beliefs in the supernatural as causes for disease appear more commonly among ethnic minorities than Whites in the United States. However, whites too hold beliefs in supernatural causes of disease. For example, 30% of the White college students reported that a lack of faith was at least somewhat important as a cause of sickness (Landrine & Klonoff, 1994). The overall belief in supernatural causes of disease is low for all ethnic groups, but magical thinking concerning disease is not restricted to traditional societies. One study (Nemeroff, 1995) found that such
thinking exists among contemporary U.S college students who rated their lover’s “germs” as less infectious than a disliked peer’s “germs.” Therefore; even people who have knowledge concerning disease processes may not apply that knowledge to their own lives.

Even disorders that are well understood medically may not be well understood by patients. Howard Leventhal and his colleagues (Benyamini, Leventhal, & Leventhal, 1997; Leventhal & Diefenbach, 1991; Meyer, Leventhal, & Gutman, 1985) have explored how people conceptualize various diseases. They have studies four components in the conceptualization of disease: (1) identity of the disease, (2) time line (the time course of both disease and treatment), (3) consequences of the disease, and (4) causes of the disease. Further research (Lau, 1997) has confirmed the factors identified by Leventhal and his colleagues in samples of healthy adults with acute and chronic diseases.

The identified by Leventhal and his associates, is very important to illness behavior. A person who has identified his symptoms as a “heart attack” should react quite differently from one who labels the same symptoms as “heartburn.” The presence of symptoms is not sufficient to initiate help seeking, but the labeling that occurs in conjunction with symptoms may be critical in a person’s either seeking help or ignoring symptoms.

Labels provide a framework within which symptoms can be interpreted. People experience less emotional arousal when they find a label that indicates a minor problem (heartburn rather than heart attack). Initially, they will probably adopt the least serious label that fits their symptoms. For example, Jeff initially interpreted his broken hand as a bruise. To a large extent, a label carries with it some prediction about the time course of the disease, so if the time course does not correspond to the expectation implicit in the label, the person has to reevaluate the symptoms. When Jeff’s hand failed to respond to the ice packs and the pain continued, he began to doubt he had applied. His friends told him he was foolish to ignore the swelling and pain out of a belief that these symptoms would disappear. However, the tendency to interpret symptoms as indicating minor rather than major problem is the source of many optimistic self-diagnoses, and Jeff’s was no exception.
The second component in conceptualizing an illness is the time line. Even though the time course of an disease is usually implicit within the diagnosis, people’s understanding of the time involved is not necessarily accurate. People with hypertension, a chronic disease, tended to conceptualize their disease as acute (Meyer et al., 1985); that is, these patients saw their disease as corresponding to the pattern of most temporary disease, with the onset of symptoms followed by treatment, a remission of symptoms and then a cure. This belief was frequent among patients who had been recently diagnosed as hypertensive, with 40% expressing a belief that they would be cured. It was much less common among those who had stayed in treatment for at least 3 months, with only 12% of these patients holding an acute concept of their disease.

The consequences of a disease are the third component in Leventhal’s description of illness conceptualizations. Again, the consequences of a disease are implied by the diagnosis. However, an incorrect understanding of the consequences can have a profound effect on illness behavior. Many people view a diagnosis of cancer as a death sentence. Some neglect health care because they believe themselves to be in a hopeless situation. Women who find a lump in their breast sometimes delay making an appointment with a doctor (Champion & Miller, 1997), not because they fail to recognize this symptom of cancer but because they fear the possible consequences—surgery and possibly the loss of a breast, chemotherapy, radiation, or some combination of these consequences.

The last component of the personal view of illness is the determination of cause. For the most part, determining causality is more a facet of the sick role than of illness behavior because it usually occurs after a diagnosis has been made. But the attribution of causality for symptoms is an important factor in illness behavior. For example, if a person can attribute the pain in his hand to a blow received on the day before, he will not have to consider the possibility of bone cancer as the cause of the pain.

Attribution of causality, however, is often faulty. People may attribute a cold to “germs” or to the weather, and they may see cancer as caused by microwave ovens or by the will of God. The belief that God’s will and sin play a role in disease is not unusual (Klonoff & Landrine, 1994), and these conceptualizations have important
implications for illness behavior. For conditions they consider to have emotional and natural causes. Even specific physical symptoms may not lead to the interpretation of a physical disease, and people are likely to ignore or use self-treatments for problems they do not consider physical. Therefore, people’s conceptualizations of disease causality can influence their behavior.

**The Sick Role:**

Kasl and Cobb (1966b) defined sick role behavior as the activities engaged in by those who believe themselves ill. For the purpose of getting well. In other words, sick role behavior occurs after a person has been diagnosed. The concept can be traced back to sociologist Talcott Parsons (1951, 1978), who contended that the sick role is based on three assumptions: (1) being sick is not the sick person’s fault, (2) being sick relieves the sick person of normal responsibilities, and (3) a sick person will take steps to get well. This conception includes both rights and privileges for the sick person (Arluke, 1988), but it does not apply well to chronic diseases.

The first person’s assumptions is that being sick is not the sick person’s fault, but research has revealed a tendency to blame the victim for his or her misfortune (Ryan, 1971). This tendency extends to health care workers, who tend to blame patients for their illness (Janis & Rodin, 1979) and patients, who tend to blame themselves when they get sick (Lau & Hartman, 1989). In the case of chronic disease such as heart disease and some cancers, this tendency may not be completely unfounded; these diseases have strong behavioral components, but the sick person is not completely to blame for those diseases. The tendency to consider patients responsible for their disease suggested that lack of blame is not part of many illness episodes.

The second feature of the sick role in our society, according to Parson’s is the exemption of the sick person from normal social, occupational, and family duties. Sick people are usually not expected to go to work, school, or meetings; to cook, clean house, or care for children; to do homework or mow the lawn. Sick people are frequently allowed, and often expected, to stay home and act sick (see the would you Believe…? Box).
The desire to get well is Person’s third component of the sick role. This component also applies more to acute than to diseases may think of their conditions as acute even though they will never be well. Research has confirmed the notion that most people believe disease is a temporary state, even when people have chronic diseases (Lau & Hartman, 1983; Leventhal, Nerenz, & Steele, 1984). When people with hypertention believe they can discontinue treatment because they feel better, these beliefs threaten the treatment outcome.

Alexander Segall (1997) proposed an alternative sick role conceptualization that also includes three components; (1) the right to make decisions concerning health-related issues, (2) the right to be exempt from duties, and (3) the right to become dependent on others for assistance. This alternative includes duties as well as rights: (1) the duty to maintain health as well as to get well, (2) the duty to perform routine health care management, (3) the duty to use a range of health care resources. This formulation expends the sick role concept to allow for conditions posed by chronic diseases as well as for individual and social variation that occurs with different diseases.

1.19 INFLUENCES ON ILLNESS BEHAVIOUR:

Illness behaviour is shaped by socio-cultural and social-psychological factors. What follows in this section are examples of this factors.

1.19.1 CULTURE OF POVERTY:

The culture of poverty influences the development of social and psychological traits among those experiencing it. These traits dependence fatalism, inability to delay gratification and a lower value placed on health. The poor, who have to work to survive, often deny sickness it brings functional incapacity. Different cultures may define and interpret health and illness in a variety of ways. Individuals with chronic illness in the culture of poverty will have different looking illness perceptions and behaviours depending on their unique ethnic origins.
1.19.2 DEMOGRAPHIC STATUS:

Marital status may influence illness behaviour as well. In general, married individuals require fewer services because they are healthier, but utilize other services because they are more attuned to preventive care. Searle, Norman, Thompson and Vedhara (2007) examined the influence of the illness perceptions of clients’ significant others and their impact on client outcomes and illness perceptions. Differences in illness representations of significant others and clients have been shown to influence psychological adaptation in chronic fatigue syndrome and Addison’s disease. Searle and colleagues sought to understand illness representations in clients with type II diabetes and their partners. However, in this study, almost without exception, there was agreement between the illness representations of patients and their partners. Another aim of the study was to determine the influence of the partner of significant other on the clients’ illness representations partially mediated clients’ representations on exercise and dietary behaviours.

Gender may influence illness behavior and “help-seeking” behavior in chronic conditions. Sociologic analysis has suggested that women are more likely than man to seek medical help for nonfatal and chronic illness. Morbidity rates demonstrate that women are more likely to be sick than men and thus seek more professional medical help. Lorber (2000) states that women are not more fragile than men, but are just more self-protective of their health status.

1.19.3 POST EXPERIENCE:

One’s education and learning, socialization and past experience, as defined by one’s social and cultural background, mediate illness behavior. Past experiences of observing one’s parents being stoic, going to work when they were ill, avoiding medical help, all influence their children’s future responses. If children see that “hard work” and not giving in to illness pays off with rewards, they will assimilate those experiences and mirror them in their own lives. Elfant, Gall and perlmuter (1999) evaluated the effects of avoidant illness behavior of parents on their adult children’s adjustment to arthritis. Even after several decades, children’s early observations of their parents’ illness behaviors appear to affect their own adjustment to arthritis. Those clients whose parents avoided work and other activities when ill with a minor
condition reported greater severity of arthritis and its limitations, depression and helplessness when compared to clients whose parents did not respond to minor illness with avoidance (Elfant et al. 1999).

What if parents and adolescents have differing views on illness perceptions? The illness perceptions of 30 adolescents and their parents were compared to see the effects on the adolescents’ outcomes (Salewski, 2003). Parents’ illness representations had little impact on their children’s outcomes. In families with high similarity between the parents’ perceptions and the adolescents’ perceptions, the adolescents reported more well-being (Salewski, 2003 p.587).

In another vein, how parents respond to their children’s health complaints may later influence how the children, as adults, cope with illness. Whitehead and colleagues (1994) studied the influence of childhood social learning on the adult illness behavior of 383 women aged 20 to 40 years of age. Illness behavior was measured by frequency of symptoms, disability days and physician visits for menstrual, bowel and upper respiratory symptoms. Findings included that childhood reinforcement of menstrual illness behavior significantly predicted adult menstrual symptoms and disability days and childhood reinforcement of cold illness behavior predicted adult cold symptoms and disability days. The study’s data supported the hypothesis that specific patterns of illness behavior are learned during childhood through parental reinforcement and modeling and that these behaviors continued into adulthood (Whitehead et al., 1994, p. 549).

1.20 IMPACT AND ISSUES RELATED TO ILLNESS BEHAVIOR:

As illness behavior is described, it is important to reiterate the difference between the terms disease and illness. Disease is the pathophysiology—the change in body structure or function that can be quantified, measured and defined. Disease is the objective “measurement” of symptoms. As Wainwright (2008) states.

Illness is what the client and family experience. It is what the client and family experienced and “lived” by the client and family and includes the “meaning” the client gives to that experience ( Helmag, 2007). Both the meaning given to the symptoms and the client’s response or behavior are influenced by the client’s
background and personality as well as cultural, social and economic contexts in which the symptoms appear.

1.2.0.1 THE ILLNESS EXPERIENCE AND SUBSEQUENT BEHAVIOR:

The diagnosis of a chronic disease and subsequent management of that disease bring unique experiences and meanings of that process to the client and family. The biomedical world disregards illness and its meaning and focuses instead on disease. Disease can be quantified and measured and it can be considered a “black and white” concept. Disease fits into the medical model’s framework.

Illness and the unique meaning that each of us attaches to it, does not fit into a neat little box; it is not black and white, but consists of many shades of gray and thus defies measurement and categorization. Illness is a subjective label that reflects both personal and social ideas about what is normal as much as the pathology behind it (Weitz, 1991). Kleinmann (1985) expressed concern that researchers have “reduced sickness to something divorced from meaning in order to avoid the hard and still unanswered technical questions concerning how to actually go about measuring meaning and objectivizing and quantifying its effect on health status and illness behavior” (Kleinmann, 1985). While realizing the importance of this scientific work, Kleinmann (1985) sees it as “detrimental to the understanding of illness as human experience, because they redefine the problem to subtract that which is mostly innately human, beliefs and feelings”.

The common sense self-regulation model (Leventhal et al., 2001) seeks to explain that individual illness perceptions influence coping responses to an illness. This perspective explains that clients construct their own illness representations to help them make sense of their illness experience. It is these representations that form a basis for appropriate or inappropriate coping responses (Leventhal et al., 2001). Stuifbergen Phillips, Voelmeck Browder (2006) used a convenience sample of 91 women with fibromyalgia to explore their illness representations. Overall, the women had fairly negative perceptions of their illness. Emotional representations explained 41% of the variance in mental health scores. Using the model of Leventhal and colleagues (2001), less emotional distress predicted more frequent health behaviors and more positive mental health scores: whereas those women who perceived their
Fibromyalgia to have more serious consequences and as less controllable were more likely to have higher scores on the Fibromyalgia impact Questionnaire.

Price (1996) describes individuals with a chronic disease as developing an illness career that responds to changes in health, his or her involvement with healthcare professionals and the psychological changes associated with pathology, grief and stress management. This illness career is dynamic, flexible and goes through different stages of adaptation as the disease itself may change.

1.20.2 LOSS OF SELF:

Charmaz (1983) coined the phrase “loss of self” with her research in the 1980s, interviewing individuals with chronic perspective. The influences on the loss of self develop from the chronic condition and the illness experience. Charmaz describes clients’ illness experience as living a restricted life, experiencing social isolation, being discredited and burdening others. Slowly the individual with chronic illness feels his or her self-image disappear; a loss of self, without the development of an equally valued new one.

In another study of 40 men with chronic illness, Charmaz (1994) describes different identity Dilemmas than with women. Charmaz sees these men as “preserving self”. As men come to terms with illness and disability, they preserve. Self by limiting the effect from illness in their lives. They intensity control over their lives. Many assume that they can recapture their past self and they try to do so. They may devote vast amounts of energy to keeping their illness contained and the disability invisible to maintain their masculinity. At the same time, they often maintain another identity at home-thus they a public identity and a private identity to preserve self (Charmaz, 1994).

1.20.3 MORAL WORK:

Townsend, Wyke and Hunt (2006) describe the moral dimension of the chronic illness experience in their qualitative stud. Their work speaks to the fact that moral work is integral to the illness, similar to the biographical and everyday “work”
of Corbin and Strauss (1988). The participants in their study spoke about the need to demonstrate their moral worth as individuals that was their moral obligation to manage symptoms alongside their daily life (Townsend et al. 2006).

1.20.4 DEVALUED SELF:

In a qualitative study of Chinese immigrant women in Canada, Anderson (1991) describes how these women with type I diabetes have a devalued self, not only from the disease but also because of dealing with being marginalized in a foreign country where they do not speak the language. Similar to the “loss of self” described by Charmaz, Anderson discuss women who need to reconstruct a new self. Influencing this devalued self were the interactions with healthcare professionals, which were frequently negative in nature, adding to their stress.

Similarly, eight older women with a chronic disease were asked to describe the meaning of living with a long-term illness. Five themes emerged; loss and uncertainty, learning one’s capacity and living accordingly, maintaining fellowship and belonging, having a source of strength and building anew. However, clearly the guiding premise of each woman was that chronic illness brought about reassessment and formation of a new understanding of self and a sense of being revalued by the world (Lundman & Jansson, 2007).

1.20.5 CHRONIC SORROW:

The concept of chronic sorrow was first described by Olshansky in 1962 when he was working with parents of children with learning disabilities. His conclusion was that chronic sorrow was a natural response to a tragedy instead of becoming neurotic. Two more recent studies discuss the existence of chronic sorrow in individuals with chronic illness. Sixty-one clients with multiple sclerosis were interviewed about chronic sorrow and also screened for depression.

38 of the 61 clients met the criteria for chronic sorrows. The participants in the study described feeling sorrow, fear, anger and anxiety. Frustration and sadness were constantly present or were periodically overwhelming (Isaksson, Gunnarsson
Seven themes were identified; loss of hope, loss of control over the body, loss of integrity and dignity, loss of a healthy identity, loss of faith that life is just, loss of social relations and loss of freedom (Isaksson et al. 2007). Implications for healthcare include providing psychological support for these individuals. How does one provide the appropriate help when the client perceives such significant losses? What realistic help can healthcare professionals provide?

Similarly, Ahlstrom (2007) interviewed 30 adults of working age with average disease duration of 18 years. Sixteen of the 30 adults experienced chronic sorrow. The losses in this study are consistent with other studies on chronic sorrow even though the group was heterogeneous regarding diagnosis.

1.21 PROFESSIONAL RESPONSES TO ILLNESS BEHAVIOR AND ROLES:

Healthcare professionals generally expect those entering the acute hospital setting to conform to sick role behaviors. Most people entering the hospital for the first time are quickly socialized and expected to cooperate with treatment, to recover and to return to their normal roles. Provider expectations and client responses are in line with social expectations and fit with the traditional medical model of illness as acute and curable. When clients are compliant and cooperative, healthcare professionals communicate to them that they are “good patients” (Lorber, 1981). When clients are less cooperative, the staff may consider them problematic or no adherent.

The percentage of individuals with chronic illness entering hospitals is increasing and often these admissions are due to superimposed acute illness or exacerbations of the chronic condition. Many of these individuals have had their chronic illnesses for long periods and have had prior hospital experiences. Multiple contacts with the healthcare system result in loss of the “blind faith” that the individual once had in that system. Individuals with chronic illness seek a different kind of relationship with healthcare professionals, in which there is “give and take” and that can empower the client. The extent to which a client with chronic illness is included in the formulation of his or her treatment plan likely influences the
assumption of responsibility for it and ultimately, its success (Weaver & Wilson, 1994).

Thorne’s (1990) study of individuals with chronic illness and their families found that their relationships with healthcare professionals evolved from what was termed “naïve trust” through “disenchantment” to a final stage of “guarded alliance”. She proposed that the “rules” that govern these relationships should be entirely different for acute illness and chronic illness. Although assuming sick-role dependency may be adaptive in acute illness, where medical expertise offers hope of accrue, it is not so in chronic illness. Individuals with chronic illness are the “experts” in their illnesses and should have the ultimate authority in managing that illness over time.

When individuals with chronic illness are hospitalized, they view the situation quite differently than do the healthcare professionals with whom they interact. Clients with multiple chronic conditions may focus on maintaining stability of their chronic conditions to prevent unnecessary symptoms, whereas their healthcare providers are more likely to focus on managing the current acute disorder. In addition, clients who have had multiple prior admissions are more likely to use their hospital savvy to gain what they want or need from the system. During hospitalization, these individuals may demand certain treatments, specific times for treatment or routines outside of hospital parameters. They may keep track of times that various routines occur or complain about or report actions of the staff as a means to an end they consider important. In a grounded theory study in the United Kingdom, Wilson, Kendall and Brooks (2006) explored how client expertise is viewed, interpreted, defined and experienced by both clients and healthcare professions. With nursing playing a key role in empowering clients with chronic disease to self-manage their conditions knowing how that client expertise is viewed is extremely important. Generally, in this study of 100 healthcare professionals (physician, nurses, physical therapists), the nurses found the expert patients to be more threatening than other healthcare professionals did. The nurses had issues with accountability, perceived threats to their professional power and potential litigation. The data from the study demonstrated that the nurses lacked a clear role definition and distinct expertise in working with patients with chronic disease and were unable to work in a flexible partnership with self-managing patients (Wilson et al., 2006).
1.21.1 LACK OF ROLE NORMS FOR INDIVIDUALS WITH CHRONIC ILLNESS:

Chronic illness requires a variety of tasks be performed to fulfill the requirements of both the medical regimen and the individual’s personal lifestyle. However, there is a lack of norms for those with chronic illness. What is expected of a client recovering from cancer surgery? An exacerbation of rheumatoid arthritis? Assume sick-role behaviors are discouraged, or not? These individuals enter and remain in a type of impaired, “at risk” role. Implicit behaviors for this role are not well defined by society, leading to a situation of role ambiguity. Given this lack of norms, influences on the client include the degree of disability (with different attributes of disability producing different consequences), visibility of the disability and societal views of the disabled as either economically dependent or productive. Without role definition, whether disability is present or not, individuals are unable to achieve maximum levels of functioning. Individuals must adapt their definitions of themselves to their limitations and to what the anticipated future imposes on them because of the chronic condition (Watt, 2000).

1.21.2 FRAMEWORKS AND MODELS FOR PRACTICE:

A review of the literature since the last edition of this book did not yield any new frameworks for caring for those with chronic illness. With chronic illness increasing, evidence-based frameworks need to be developed. As stated previously, not all those with long-term illness. Meeting the psychosocial needs of clients with chronic illness requires a framework or model for practice that differs from that of caring for those with acute, episodic disease. The frameworks that follow are examples and are not intended to be all inclusive.

Disease management models address the physical symptoms of a condition. Some of those models assign an algorithm to the condition where clients receive certain “care” when their blood work is at an inappropriate level or their symptoms “measure” a certain degree of seriousness. These models manage the disease but not
the illness. Illness frameworks and models address the illness experience of the individual and family that occurs as a result of changing health status.

1.22 IMPORTANCE OF THE STUDY:

There are various psychological studies regarding social support, mental hygiene and illness behavior of the people in the various fields. But most of them are separately carried out. There are hardly few studies that examine all this aspect jointly in a single research venture. But they need to be studied jointly for each of them affects the other directly or indirectly. So, the present investigator thought of planning such a venture in a clinical psychological field. As the investigator residing in Junagadh district she thought it was proper to her study all this aspects simultaneously with regard the heart patients of Junagadh district.

It was hoped that this study would provide some important factual information about heart patients. Researcher believes that the effect of various independent variable affect the heart diseases. Ultimately it is the real understanding that provides that unparalleled impact of Age, Education, Vocation etc. So, this study will be very useful to the heart patients, hospitals, doctors and new researchers.

1.23 CHAPTERIZATION:

The content of the thesis is organized in the five chapters as follows:

Chapter 1: Introduction:

In this chapter the investigator has shown how researcher selected the topic for research. Researcher has discussed the historical background and specified the topic of her research and has clarified the objectives of her studies. Then researcher has presented the basic null hypotheses in detail. The three main concepts of social support, mental hygiene and Illness behavior are explained appropriately. Operational definitions of important terms are provided along with the specifications of various variables of the study and at the last the importance and the scope of the present study is clarified.
Chapter-2 : Review of Relevant Literature :

In this chapter, the researcher, has taken a plunge into the vast ocean of the scientific endeavour that has already been put forth in the past. Various studies that have been undertaken with regard to Social support and Mental Hygiene and Illness behavior are reviewed in detail. Studies carried out with regard to certain personal and social factors that contribute or contaminate social support, mental hygiene and illness behaviour also are being reviewed. The review points out the gaps in the previous research. There is no doctoral investigation carried out with respect to social support, mental hygiene and illness behavior of the heart patients. Hardly any such study of these heart patients is, so far, undertaken, especially no psychologist has taken the trouble of finding out the psychology of heart patients. Thus, this is one of the pioneer research in this field.

Chapter-3 : Methodology :

This chapter deals with the type of research design that is employed in carrying out the investigation. It also specifies how the sample was selected from the population and the general description of the sample is also presented. The research tools that are being utilized are also clearly presented. How the data was collected and how the scoring was carried out is also clearly mentioned. The strategy of manipulating the independent variables and the measurement of dependent variables are thoroughly shown. The statistical frame work for analyzing the data and their interpretation is also presented in this chapter.

The researcher has explained the sample, statistical design etc. based on personal data sheet of heart patients.

Chapter-4 : Result and Discussion :

In this chapter, the row scores on dependent variables are analyzed into various tables as well as according to different groupings of the sample. Then the various null hypotheses are tested and verified by the help of correlation, partial correlation and with the help of Anova techniques. The results are discussed in light of these verifications and the information is interpreted in view of the various objectives of the study and ultimately the conclusions are drawn. From the conclusions various suggestions are made to improve the levels of Social support, Mental hygiene and Illness behavior of heart patients.
Chapter-5 : Conclusion, Suggestions, Implications and Limitations:

Overall summary of the research and the essence of conclusion is presented in nutcell in this chapter. Here the limitations of the present study are shown and suggestions for future research are presented properly.

A detailed bibliography is given at the end of all the chapters. Gujarati versions of Social support, Mental Hygiene and Illness behavior scale are attached as appendix after the bibliography.

Now in the second chapter discussion of the review of literature of the present study will be done.