“Education is a liberating force, and in our age it is also a democratising force, cutting across the barriers of caste and class, smoothing out inequalities imposed by birth and other circumstances.”

—Indira Gandhi
Block 2

SPECIFIC ISSUES ON MENTAL HEALTH

UNIT 1
Deliberate Self-Harm and Suicide 5

UNIT 2
Problems Related to School 20

UNIT 3
Problems Related to Sex 47

UNIT 4
Problems Related to Work Area 65
**Expert Committee**

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairperson</td>
<td>Prof. Vimala Veeraraghavan</td>
<td>IGNOU, New Delhi</td>
</tr>
<tr>
<td>Former Emeritus Professor</td>
<td>Prof. Dinesh Kataria</td>
<td>M.G.M. Medical College, Indore, M.P.</td>
</tr>
<tr>
<td>Discipline of Psychology</td>
<td>Prof. R. C. Jiloha</td>
<td>Govt. Medical College, Chandigarh</td>
</tr>
<tr>
<td>IGNOU, New Delhi</td>
<td>Prof. T. B. Singh</td>
<td>Institute of Behavioural Sciences, Gujrat</td>
</tr>
<tr>
<td>McFT 007 - Programme Coordinators: Prof. Neerja Chadha, Professor of Child Development, SOCE, IGNOU, New Delhi &amp; Dr. Amiteshwar Ratra, Asst. Professor, STRIDE, IGNOU, New Delhi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>McFT 007 - Programme Coordinators: Prof. T. B. Singh, Professor, Clinical Psychology, Institute of Behavioural Sciences, Gujrat Forensic Sciences University, New Delhi &amp; Dr. Rajeev Dogra, Clinical Psychologist, PGIMS, Rohtak</td>
<td></td>
<td></td>
</tr>
<tr>
<td>McFT 007 - Programme Coordinators: Dr. Swati Patra, Associate Professor, Discipline of Psychology, SOSS, IGNOU, New Delhi</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Programme Coordinator**

- Dr. Swati Patra
- Associate Professor
- Discipline of Psychology
- SOSS, IGNOU, New Delhi

**Course Coordinator**

- Dr. Swati Patra
- Associate Professor
- Discipline of Psychology
- SOSS, IGNOU, New Delhi

**Course Writer**

**Unit 1:** Adapted from MSCCFT Programme of IGNOU (Unit 14, Block 3, MCFT 007 – Programme Coordinators: Prof. Neerja Chadha, Professor of Child Development, SOCE, IGNOU, New Delhi & Dr. Amiteshwar Ratra, Asst. Professor, STRIDE, IGNOU, New Delhi)

- Unit Writer (Unit 14 of MSCCFT): Dr. Rachna Bhargava, Sr. Lecturer, Dept. of Psychiatry, GMCH, Chandigarh & Ms. Swati Kedia, Clinical Psychologist, Delhi

- Unit Adaptation: Dr. Swati Patra, Associate Professor of Psychology, SOSS, IGNOU, New Delhi

**Unit 2:** Dr. Ruchi Shukla, Asst. Professor, Department of Educational Psychology & Foundations of Education (DEPFE), NCERT, New Delhi

- Dr. Swati Patra, Associate Professor of Psychology, SOSS, IGNOU, New Delhi

**Unit 3:** Prof. T S Sathyanarayana Rao, Department of Psychiatry, JSS Medical College and Hospital JSS University, Mysore

- Dr. Abhinav Tandon, Lecturer, Department of Psychiatry, MLB Medical College, Jhansi

**Unit 4:** Dr. Preetam Khandelwal, Associate Professor, Faculty of Management Studies (FMS), University of Delhi, Delhi
Block Editor

Unit 1 (Unit 14 of MSCCFT): Prof. Mathew Verghese, Head, Family Psychiatry Centre, NIMHANS, Bangalore; Prof. Neerja Chadha, SOCE, IGNOU, New Delhi; & Dr. Amiteshwar Ratra, Asst Professor, STRIDE, IGNOU, New Delhi

Unit 2: Prof. Vimala Veeraraghavan, Former Emeritus Professor, Discipline of Psychology, IGNOU, New Delhi.

Unit 3: Prof. R.K. Chadda, Psychiatrist, Dept. of Psychiatry, AIIMS, Ansari Nagar, New Delhi.

Unit 4: Dr. Swati Patra, Associate Professor of Psychology, SOSS, IGNOU, New Delhi.

Material Production

Mr. Manjit Singh
Section Officer (Publication)
School of Social Sciences, IGNOU

October, 2014
© Indira Gandhi National Open University, 2014
ISBN-978-81-266-

All rights reserved. No part of this work may be reproduced in any form, by mimeograph or any other means, without permission in writing from the Indira Gandhi National Open University.

Further information on Indira Gandhi National Open University courses may be obtained from the University's office at Maidan Garhi, New Delhi-110 068.

“The University does not warrant or assume any legal liability or responsibility for the academic content of this course provided by the authors as far as the copyright issues are concerned”

Printed and published on behalf of the Indira Gandhi National Open University, New Delhi by Director, School of Social Sciences.
Lasertypesetted at Graphic Printers, 204, Pankaj Tower, Mayur Vihar, Phase-I, Delhi-110091.
Printed at:
BLOCK 2  SPECIFIC ISSUES ON MENTAL HEALTH

Introduction

Block 2 of MPC 053 deals with Specific Issues on Mental Health. Society is changing rapidly under the influence of globalization. Interpersonal relationships become more complex and cases of stress, depression and suicide are rising. This Block will address issues of self harm and suicide that are increasing in occurrence due to rise in our aggression level, low frustration tolerance and impulsiveness. You will also learn about problems in our intimate relationships. Further, you will also learn about mental health issues in specific areas such as school and work area.

Thus, in Block 2 of MPC 053, we will be focusing on Specific Issues on Mental Health.

Unit 1 deals with “Deliberate Self Harm and Suicide”. Here you will be learning about the concepts of self harm and suicide, the causal factors and ways to prevent it.

Unit 2 describes “Problems Related to School”. It deals with the main problems of aggression, bullying, stress and substance abuse that the children and adolescents in the school engage in. The Unit also describes the assessment of the mental health problems in the school and talks about the management of the problems.

Unit 3 is on “Problems Related to Sex”. In this Unit you will understand the various common sexual disorders. The intervention techniques/treatments for the sexual disorders or dysfunctions are also described.

Unit 4 deals with “Problems Related to Work Area”. It talks about mental health in the context of the changing world of work. You will learn about the various mental health problems associated with the work place and how this has an impact on the mental health, efficiency and productivity of the employees in the organization. The Unit also discusses mental health in the context of vulnerable populations such as children, women and people with disabilities. The issue of work place mental health policy is also described.
1.0 INTRODUCTION

Self-harm, self-inflicted violence, self-injurious behaviour or moderate self-mutilation is defined as a deliberate, intentional injury to one’s own body that causes tissue damage or leaves marks for more than a few minutes.

Several synonyms have appeared in the literature including para-suicide, attempted suicide, deliberate self-harm, deliberate self-poisoning, and more recently simply “self-harm”. In this unit, you will learn and understand deliberate self-harm and suicide – their causes and prevention.

1.1 OBJECTIVES

After studying this Unit, you will be able to:

- define self-harm and suicide;
- describe epidemiology of self-harm and suicide;
- know the risk factors associated with self-harm and suicide;
- explain the causes of self-harms and suicide;
- describe the importance of prevention of self-harm and suicide; and
- discuss the management of patients who self-harm and attempt suicide.
1.2 MEANING AND DEFINITION

World Health Organization (1986) defined self-harm as, “an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences”. On the other hand, suicide is defined as the act of deliberately killing oneself.

Self-harm is a complex behaviour that can be best thought of as a maladaptive response to acute and chronic stress, often but not exclusively linked with thoughts of dying. It is a form of non-fatal, self-destructive behaviour that is believed to occur when an individual’s sense of desperation outweighs his/her inherent self-preservation instinct.

The word suicide was first used by the English author Sir Thomas Browne in 1642 in his treatise “Religio Medici”. The word originated from SUI (of oneself) and CAEDES (murder). Suicide is a complex phenomenon determined by several factors. It not only affects the individual but also family and friends. It also impacts the community and the larger society in terms of loss of valuable human resource. There are several terms related to suicide: suicidal ideation, attempt and completion of the act.

Suicidal ideation refers to the thoughts about suicide. This may again consist of ideas of intent or death wishes; reflecting the degree of seriousness.

Suicide attempt refers to the acts taken by the individual to die. It may result in failure attempts where the individual could not die despite the attempt to die. In the other case, it is only an attempt and results in deliberate self harm or intentional self harm. They intentionally injure themselves but do not have an intention to die.

Completed suicide refers to suicide attempt resulting in death. It is marked by ‘intent’ or ‘intentionality’ and ‘lethality’. Intent is inferred by the nature, elaborateness, confidentiality and secrecy of the suicide plan; and also attempts to finish the unfinished tasks of life and sort of trying to wind up things in his life. Lethality refers to the degree of severeness of the method used for suicide where the person sees the attempt as a final one.

1.3 EPIDEMIOLOGY

Data from developed countries suggest that about 1 in 200 people attempt self-harm. Two thirds of patients who self-harm are less than 35 years old and two thirds of people in this age group are female. There is particular concern that the rate in young men aged 15-24 years of age is rising more quickly than in any other group. Here, it should be emphasized that self-harm and suicide are related yet somewhat different phenomena, and this is best illustrated by the differences in their epidemiological features. Suicide is more common in older men while self-harm is more common in younger women; and the gap between the two genders seems to be widening as the rate of suicide among men is increasing (as is the case also for self-harm in young men).

The importance of deliberate self-harm behaviour is illustrated by the subsequent risk of suicide, which, in the subsequent year, is at least 100 times more in those who have self-harmed as compared to the general population and the risk of suicide is about 3%
even after 10 (or more) years of the first attempt. The risk of repetition of self-harm is also extremely high; up to 40% will go on to repeat, including 13% in the first year. Self-harm is found to be one of the top five causes of acute medical admissions for both men and women.

Suicide has been found to be the third leading cause of death among the youth worldwide. The suicide rate in India is comparable to that of Australia and the USA and the increasing rates during recent decades is consistent with the global trend (Radhakrishnan & Andrade, 2012).

Data on suicide in India are available from the National Crime Records Bureau (NCRB), Ministry of Home Affairs. As per the report of NCRB (2010), of late, suicide rates show an increasing trend in India. NCRB 2010 Report cites consumption of poison as the most common mode of suicide. Followed by it are hanging, self-immolation, drowning, jumping from buildings as other commonest modes of suicide in India.

Table 1.1 gives the features that predict repetition of self-harm or eventual suicide.

**Table 1.1: Features which predict repetition of self-harm or eventual suicide**

<table>
<thead>
<tr>
<th>Repetition of self-harm</th>
<th>Eventual suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>- A history of self-harm prior to current episode</td>
<td>- Older age</td>
</tr>
<tr>
<td>- Psychiatric history, especially as in-patient</td>
<td>- Male gender</td>
</tr>
<tr>
<td>- Current unemployment</td>
<td>- Previous attempts</td>
</tr>
<tr>
<td>- Lower social class</td>
<td>- Psychiatric history</td>
</tr>
<tr>
<td>- Alcohol or drug-related problem</td>
<td>- Unemployment</td>
</tr>
<tr>
<td>- Criminal record</td>
<td>- Poor physical health</td>
</tr>
<tr>
<td>- Antisocial personality</td>
<td>- Living alone</td>
</tr>
<tr>
<td>- Hopelessness</td>
<td></td>
</tr>
<tr>
<td>- High suicidal intent</td>
<td></td>
</tr>
</tbody>
</table>

**Self Assessment Questions 1**

1) Which of the following terms should not be used interchangeably with self-harm?
   i) Self-injury
   ii) Para-suicide
   iii) Self-inflicted violence
   iv) Deliberate self-poisoning
   v) Suicide

2) While interviewing a client who is facing family-related stressors, you see cut-marks on her wrists. On asking, she reveals that she indulged in self-harm (i.e.
slashed her wrists) on a few occasions about 6 months back after a break-up. She also informs that now she is much more stable and settled in life. Should you be concerned about the possibility of recurrence of self-harm? Give reasons for your answer.

- Yes
- No

1.4 CAUSES

This aspect can be viewed from several perspectives, such as:

- Individual's motive for committing the act;
- Intentions at the time of the act;
- Functions served by the act of self-harm;
- Social precipitants; and
- Mental health reasons.

1.4.1 Intentions and Motives

Self-harm may involve little pre-mediation or may have been contemplated for some time. Some individuals, especially the elderly, may have serious suicidal ideas before the act and survive only as a result of misjudgement or chance events. The motivation for self-harm may appear to be complex and very personal. Given below are examples of motives given by some individuals who have self-harmed:

- “It expresses emotional pain or feelings that I’m unable to put into words!”
- “It’s a way to have control over my body because I can’t control anything else in my life”
- “I usually feel like I have a black hole in the pit of my stomach, at least if I feel pain it’s better than feeling nothing”.

Suicidal intent is said to be the extent to which the person wishes to die at the time of committing the act. While it can be difficult to assess the difference between an attempt to self-harm and to commit suicide in some situations, as many individuals are ambivalent about the intent to die and the reported intent may change fairly quickly, it is clear that most people who attempt self-harm do not wish to die; rather it serves various other functions, e.g. an attempt to regain some control over oneself; to combat feelings of inner emptiness; or simply to express unbearable pain. This is discussed in greater details in the next section.

1.4.2 Functions Served by Self-Harm

Klonsky (2007), on the basis of examination of empirical literature, delineated seven functions served by the act of self-harm; as shown in Table 1.2.
### Table 1.2: Functions of Self-Harm

<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affect Regulation</td>
<td>To alleviate acute negative affect or aversive affective arousal</td>
</tr>
<tr>
<td>Anti-suicide</td>
<td>To replace, compromise with, or avoid the impulse to commit suicide</td>
</tr>
<tr>
<td>Feeling generation</td>
<td>To end the experience of depersonalization or dissociation</td>
</tr>
<tr>
<td>Interpersonal-influence</td>
<td>To seek help from (or manipulate) others</td>
</tr>
<tr>
<td>Interpersonal boundaries</td>
<td>To assert one’s autonomy or a distinction between self and other</td>
</tr>
<tr>
<td>Self-punishment</td>
<td>To derogate or express anger towards oneself</td>
</tr>
<tr>
<td>Sensation-seeking</td>
<td>To generate exhilaration or excitement</td>
</tr>
</tbody>
</table>

**Affect regulation:** It is believed that an early family environment that does not validate (support or corroborate) the experiences of the growing child may impair his/her ability to cope with emotional distress. Individuals from these environments and/or with genetic disposition for emotional instability are more prone to use self-harm as a maladaptive affect-regulation strategy.

**Anti-suicide:** Individuals may use self-harm as a coping mechanism for resisting urges to attempt suicide. From this perspective, self-harm may be thought of as a means of expressing suicidal thoughts without risking death.

**Feeling generation:** It has been suggested that individuals who self-harm may have experienced dissociation (a perceived detachment of the mind from the emotional state or even from the body) when loved ones were perceived as absent (e.g. a very erratic or depressed mother) for prolonged periods (this is psychologically very distressing to the child). Episodes of dissociation or depersonalization may then recur (later in life) in response to intense emotions. Causing injury to oneself creates physical sensations that interrupt a dissociative episode, and leads one to regain a sense of self.

**Interpersonal-influence:** At times self-harm may be used to influence (or even manipulate) people. Self-harm has often been conceptualized as a cry for help, a means of avoiding abandonment, or an attempt to be taken more seriously or otherwise affect people’s behaviour. For example, an individual might self-injure to elicit affection from a significant other (e.g. parents, spouse).

**Interpersonal boundaries:** Individuals who self-harm are thought to lack a normal sense of self due to insecure attachment with early attachment figure(s) and a subsequent inability to individuate (form a cohesive self-identity). Self-harm (e.g. cutting) as a deliberate or autonomous act is perceived as an assertion of one’s identity or autonomy; and thus an affirmation of a distinction between oneself and others.

**Self-punishment:** Self-harm can be an expression of anger or derogation towards oneself. It has been hypothesized that individuals who self-harm have learned from their environments to punish or invalidate themselves.

**Sensation-seeking:** Self-harm may be perceived as a means for generating excitement or exhilaration in a manner similar to Russian roulette (a potentially lethal game of chance in which participants place a single round in a revolver, spin the cylinder, place the muzzle against their head and pull the trigger).
### 1.4.3 Social Factors

Those who are isolated or living in areas of socio-economic deprivation have increased rates of suicide and deliberate self-harm. Vulnerability or predisposing factors such as early loss or separation from one or both parents, childhood abuse, unemployment, and absence of living in a family unit are also found to be contributory. Evidence also suggests that the person may have suffered an excess of life events, especially in the month before the self-harm attempt. Frequently, the type of events experienced by younger people is related to relationship difficulties, but in older people it is more likely to be health or bereavement related.

Certain factors in the family’s environment may also be important, such as parental discord and violence, parental depression or substance abuse, role models of suicidal behaviour in the family, abuse of all kinds (e.g. physical, verbal or sexual) and bereavement.

### 1.4.4 Mental Health Factors

Mental health difficulties are frequently seen in individuals who self-harm. Individuals diagnosed with certain types of mental disorder are much more likely to self-harm. These include depression, psychotic illnesses like schizophrenia, phobias, alcohol and substance problems and personality disorders. Sometimes, repetitive self-injury is also seen in individuals with mental retardation; however, this must be differentiated from the deliberate self-harm caused with a conscious intent of harming oneself.

Certain psychological characteristics are more commonly found among the group of people who self-harm; including hopelessness, impulsiveness, aggression, inflexible and impulsive cognitive style, impaired decision-making, poor coping skills, poor frustration-tolerance, and poor problem-solving abilities.

While nearly all mental disorders have the potential to increase the risk for suicide, studies show that the most common disorders among people who die by suicide are major depression and other mood disorders, and substance use disorders, schizophrenia and personality disorders (Bertolote & Fleischmann, 2002). Findings regarding the relationship between mental disorders and suicide mostly come from “psychological autopsy” studies. These in-depth investigations rely on interviews with family, close friends, and others who were in close contact with the person who died by suicide, in order to identify factors that likely contributed to the death. Such studies have consistently found that the overwhelming majority of people who die by suicide—90% or more—had a mental disorder at the time of their deaths. Often, however, these disorders had not been recognized, diagnosed, or adequately treated (Bertolote & Fleischmann, 2002).

Depression has been found to increase the risk of suicide. Even in case of bullying, the high school students who had symptoms of depression at the time they were bullied were found to have suicidal ideation and behaviour in post-high school follow up. On the other hand, the bullied youth who did not have co-existing depression had significantly lower risk for later mental health problems (Klomek, et al, 2011).

### Understanding suicide

Suicide is precipitated by a wide range of factors that interplay with each other to influence the act of suicide. As reported by Gajalakshmi and Peto (2007), a complex array of factors such as poverty, low literacy level, unemployment, family violence, breakdown of the joint family system, unfulfilled romantic ideals, inter-generational conflicts, loss of job or loved ones, failure of crops, growing costs of cultivation, huge
debt burden, unhappy marriages, harassment by in-laws and husbands, dowry disputes, depression, chronic physical illness, alcoholism/ drug addiction, easy access to means of suicide contribute to committing suicide.

Exposure to completed and attempted suicide in the family has also been found to increase suicide risk among family members by providing a “social model” of self-harm behaviour (de Leo & Heller, 2008). Imitative behaviour (“contagion”) plays a role in the precipitation of suicide. Recent studies have concluded that media coverage of suicide is connected to the increase—or decrease—in subsequent suicides, particularly among adolescents (Sisask & Varnik, 2012). High volume, prominent, repetitive coverage that glorifies, sensationalizes or romanticizes suicide has been found to be associated with an increase in suicides (Bohanna and Wang, 2012). There is also evidence that when coverage includes detailed description of specific means used, the use of that method may increase in the population as a whole (Yip et al., 2012). The emerging phenomenon of “cyber- suicide” in the internet era is a further cause for concern (Rajagopal, 2004; Birbal et al., 2009).

Various theories have attempted to explain suicide. Biological theories cite the role of neurotransmitters in the causation of suicide and underlie the genetic basis of suicidality. On the other hand, sociological explanations emphasize the role of society in causing the suicide act. e.g., Emile Durkheim explains suicide in terms of social integration and social regulation. Thus suicide is viewed not on an individual level, but at a community and societal level.

Psychoanalytic theory of Freud talks about ‘death instinct’ as a basic instinctual force which in some situations may be turned inward to harm oneself. Other theories have also discussed about sense of hopelessness, stress, extent of perceived threat to life as contributing to suicidal behaviour.

<table>
<thead>
<tr>
<th>Self Assessment Questions 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Self-injury should not be termed self-harm if it is due to:</td>
</tr>
<tr>
<td>i) Desire to seek attention</td>
</tr>
<tr>
<td>ii) Desire to manipulate others</td>
</tr>
<tr>
<td>iii) Childhood abuse</td>
</tr>
<tr>
<td>iv) An underlying mental illness</td>
</tr>
<tr>
<td>v) An inability to solve problems</td>
</tr>
<tr>
<td>vi) Mental retardation</td>
</tr>
</tbody>
</table>

1.5 PREVENTION

The ideal method of protection against self-harm is prevention, i.e., reduction of number of new cases as well as prevention of further self-harm in individuals who have harmed themselves at least once. The former can be attained by using public health measures that can modify social, economic, and biological conditions, such as reduction of poverty, violence, divorce rates, and promotion of a healthy lifestyle. Also, measures for mental health promotion and life-skill training (e.g. in schools) are useful ways for prevention of self-harm and suicide.

Clinicians can minimize the risk of self-harm and suicide among their patients/clients by thoroughly assessing for the presence of psychiatric illnesses, being aware of clinical
Specific Issues on Mental Health

and social situations that might precipitate self-harm and initiating treatment with or facilitating access to treatment for patients with psychiatric disorders. Also, they can do a careful risk-assessment; provide easy access to help for psychosocial problems and also scrutinize prescriptions (medication). Educating patients and their families about mental illness (if any), and the safe storage of medications and pesticides also is useful in prevention of self-harm and suicide.

1.6 MANAGEMENT

Important principles of management are:

- Establishing adequate rapport with the patient
- Privacy and maintenance of confidentiality
- Conduct interview safely and with adequate time
- Let patient tell their story
- Question relatives and friends about what patient has recently said

Illustrative Case

A 24-year-old man presents to a counsellor’s office complaining of difficulty falling asleep. During the interview, he says that something is wrong — he has no energy, is crying almost every day, has lost his usual healthy appetite, and has started using alcohol frequently in an attempt to fall asleep. He admits that he sees the world as hopeless and has considered driving his motorcycle into a wall. He says that he would not kill himself, however, because suicide is a sin, and his parents would be saddened and shamed by such a death. Until his girlfriend left him two months earlier, he had never had these symptoms. Also due to not being able to sleep, he is reaching office late since a few days and getting scolded by his boss everyday. In frustration, he has started engaging in cutting himself whenever the thought of suicide or his girl-friend occurs to him. He wants help in sleeping but fears the impact of treatment on his ability to continue his job which involves a lot of driving. History also revealed presence of depressive symptoms in mother, and frequent fights between the parents. Patient’s premorbid personality revealed poor frustration tolerance and a high need for achievement.

1.6.1 Assessment

There are countless ways that someone may self-harm, the most common being cutting, used by over two thirds of those who self-harm followed by self-poisoning (e.g. overdose of medications, use of pesticides). The other methods of self-harm include burning, punching, etc. A person with self-harm may exhibit signs like cuts, scratches, burns or scars, bruises or even broken bones. There may be other give-aways like missing razors or pills, or razors/medicine wrappers/pesticide bottles found in the dustbin.

The purpose of the assessment is to identify factors associated with suicidal behaviour, to determine the motivation for the act, to identify potentially treatable mental disorders, and to assess continuing risk of suicidal behaviour. It also includes assessment and treatment of the patient’s physical condition, having a basic understanding of medico-legal issues, and drawing up and implementing a treatment plan.

All patients presenting with deliberate self-harm should be offered not only a sensitive assessment of risk, but of psychological and social needs as well. The main issues to be determined in the assessment process are:
What were the patient’s intentions?

Do the patient still want to die?

Are there current mental health difficulties?

What is the risk of further self-harm or suicide (assessment of risk)?

Are there any current medical or social problems (assessment of need)?

Assessor should regularly inquire about current depression, hopelessness, and suicidal ideation. The risk of suicide should be considered imminent if the patient reports the intention to die, has a suicidal plan, and has lethal means available. Expressions of despair and hopelessness also suggest an imminent risk. A common myth is that enquiring about suicide would put ideas into the patient’s mind. However, that is not the case and it is important to ask in detail about whether the patient has any intention of committing suicide and he/she should be allowed free expression. Useful questions in relation to hopelessness, wish to die, and suicidal ideas that should be considered in any evaluation for self-harm can be formulated as follows:

- Are things so bad to make you take such a step?
- Who all are there in your family? What do they think about this?
- How do you see the future? Do you think that things would work out?
- Do you ever feel that life isn’t worth going on with?
- Do you think that you might do something to harm yourself?
- What stops you from carrying it out?
- Have you ever felt like this before? If so, how frequently and under what circumstances?

On the basis of assessment, a formulation may be reached that includes:

- **Long-term vulnerability factors:** It includes early loss or separation from parents, difficult relationships with parents, or abuse in early life. Although sexual abuse has been highly associated with self-harm, emotional or physical abuse is also important. Enduring psychological characteristics and other psychiatric problems need to be identified.

- **Short-term vulnerability factors:** These are current difficulties in relationships and lack of social support, work or health related problems, drug and alcohol misuse, or exacerbation of psychological symptoms.

- **Precipitating factors:** These are usually stressors experienced in the few days immediately prior to self-harm. Again relationship problems, financial worry, anniversaries, deaths or other losses can act as precipitators to the act of self-harm.

<table>
<thead>
<tr>
<th><strong>Self Assessment Questions 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) A 13 year old girl comes to you with presenting complaints of not being able to adjust to new school and feeling low, and you see lots of cut-marks on her arms. How should you react?</td>
</tr>
<tr>
<td>i) Ask the child</td>
</tr>
<tr>
<td>ii) Ask the parents</td>
</tr>
<tr>
<td>iii) Ignore, as no one has complained of self-harm</td>
</tr>
</tbody>
</table>
On the basis of the above three factors (long-term/short-term vulnerability and precipitating factors), make a formulation of the illustrative case given in 1.6.

1.6.2 Treatment

A crisis intervention model is often most appropriate, when initiating treatment. At the end of the interview, the assessor should be able to plan what action is to be taken collaboratively with the patient. This may involve treating any underlying mental illness or substance abuse appropriately, counselling, improving lifestyle, helping patient to develop coping skills to resolve stressful situations.

**Useful Tips when Dealing with a Case of Self-Harm**

- Understand that self-harming behaviour is an attempt to maintain a certain amount of control which in and of itself is a way of self-soothing
- Let the person know that you care about him/her and are available to listen
- Encourage expressions of emotions including anger
- Don’t make judgemental comments or order the person to stop the self-harming behaviour - people who feel worthless and powerless are even more likely to self-injure

Management of persons who engage in deliberate self-harm should focus on three major areas:

- Immediate medical management of self-harming behaviour
- Management of underlying psychopathology (medications and psychosocial therapies)
- Measures to prevent the recurrence of self-harming behaviour

Support, and especially company, should be mobilized, especially in the short term. A significant aspect of such intervention is the elimination of the patient’s access to potentially lethal means of suicide. Other health strategies that may prove important are telephone helplines, and more global social support measures. The patient may be given a “crisis-card”, which carries advice about seeking help in the event of future suicidal feelings. Self-help booklets may also be helpful in reducing repeat attempts in those without a borderline personality disorder.

Some of the specific psycho-therapeutic modalities that have been used with the individuals who self harm are:

*Problem-solving therapy:* Problem solving therapy is a brief treatment aimed at helping the patient to acquire basic problem solving skills, by taking him through a series of steps:
Identification of personal problems;

Constructing a problem list which clarifies and prioritizes them;

Reviewing possible solutions for a target problem;

Implementing the chosen solution;

Reappraising the problem; and

Reiterating the process.

The therapy also includes training in problem-solving skills for the future. It usually involves about six sessions lasting one hour, with some reading materials and work to be undertaken between sessions. Problem solving therapy has been shown to be an effective treatment for self-harm and mood and social adjustment.

**Dialectical Behaviour Therapy (DBT):** This treatment was introduced to primarily help those who engage in chronic and repetitive self-harm, particularly when they have associated borderline personality characteristics. This treatment is intensive, involving a year of individual treatment, group sessions, social skill training, and access to crisis contact. Treatment studies indicate that DBT is effective in reducing some of the features associated with patients with borderline personality disorder, particularly self-harming behaviour.

**Family therapy:** Family therapy has been found to be especially useful for adolescents and young adults who self-harm. It has been found that many adolescents who self-harm have family problems. Moreover, when an adolescent or young adult engages in self-harm, it can be a very distressing event for the family members. They may be confused about their role or feeling guilty about the child’s act. It is important to establish an alliance with family members (without taking sides) by empathizing with their situation and giving them a reflective listening.

The main aim of family therapy is to help the adolescent and her/his family to resolve the difficulties that lead to self-harm. Family therapy is focused on improving communication and problem-solving within the family. It can also help to restore the equilibrium of the family system if it had been negatively affected by the episode of self-harm. Finally, family therapy may help in prevention of further episodes of self-harm.

Certain key issues may need to be addressed in family therapy:

- **Privacy:** Parents of children who harm themselves often fear that their child may self-harm behind closed doors. The youngster demands privacy by stating, “I am independent, leave me alone,” while at another level he may be testing whether the parents are able to understand the unsaid, “I am hurt and I need your help.” These conflicting messages need to be dealt in family therapy sessions wherein the competing tension within each conflict can be taken up in discussions. The issue of parent-child boundaries must be continually addressed and appropriate roles must be clearly defined and reinforced.

- **Suicide and serious harm:** A clear contract for ensuring that the adolescent does not intend and will not seriously harm him/her self may be made (a written and signed “No suicide contract”). It often has the conditions for immediate hospitalization spelled out. Parents also need continuous support in setting limits to unacceptable behaviours (saying “No” firmly but without harshness) despite their worries of sparking a self-harm episode.
Specific Issues on Mental Health

- **Balancing needs and desires**: Families often need help on where to draw a line between freedom and firm limits. The role of the therapist is to facilitate understanding between family members as to their needs and desires and also to negotiate some practical compromises between competing interests. Helping families acquire strategies for communicating and negotiating even in the midst of charged emotional encounters also models to the adolescent the need to use problem-solving strategies and directly address tough issues rather than acting them out.

- **Cutting and blame**: Often the adolescent who indulges in self-harm attributes it to external stressors, which is very often the parents and their behaviour, “My parents just don’t understand me; they think I am still a kid and can’t make any decisions”. On the other side, parents may take this to heart and assume that they, solely, are responsible for their child’s dysfunctional behaviour. Thus, the goal in therapy is to place the blame squarely to where it belongs. If it’s the adolescent’s mistake, then it’s the therapist skills that would come handy in making him/her accept the mistake without losing face. One way of achieving it is to make the parents talk about their “faults” when they were adolescents. Also, the adolescent should be appreciated for honestly accepting their role in their behaviour and the parents can be quieted in their critical, judgmental and “I told you so” attitude.

**Pharmacological and clinical management**: Antidepressants have a proven role when depression or anxiety is detected but are unlikely to have a role in cases where mood disorder has been carefully excluded. Psychiatric admission remains a valuable option when risk is high and/or serious mental health problems cannot be otherwise resolved. Regular follow up reduces the subsequent rate of deliberate self-harm.

<table>
<thead>
<tr>
<th>Useful tips that can be given to patients for stopping self-harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Writing about how you are feeling.</td>
</tr>
<tr>
<td>- Doing relaxation exercise.</td>
</tr>
<tr>
<td>- Distraction (doing some pleasurable activity).</td>
</tr>
<tr>
<td>- Going for a run, brisk walk, dancing, any form of exercise.</td>
</tr>
<tr>
<td>- Talk to a friend or your therapist — have a list of people you can ring.</td>
</tr>
<tr>
<td>- Find meaningful activities to do (e.g. voluntary work).</td>
</tr>
<tr>
<td>- Do not keep extra medicines/pills or pesticides in the house.</td>
</tr>
<tr>
<td>- Do not keep sharp objects (e.g. knife, blade etc.) near you.</td>
</tr>
</tbody>
</table>

Early detection of suicidal ideation and prevention measures are crucial. Various steps such as community awareness, media guidelines regarding reporting suicide, and helplines can work in the prevention of suicide. Further, counseling centres and NGOs can also contribute towards this. A multidisciplinary team consisting of psychiatrist, general physicians, psychiatric nurses, psychiatric social workers, and NGOs play a significant role in addressing the issue of suicide that contributes to a major loss of potential human resource.

1.7 **REFERRAL**

Risk of subsequent suicide is particularly high in those with high unresolved suicidal intent, depressive disorder, chronic alcohol and drug misuse, social isolation, and current physical illness.
The most common psychiatric condition associated with suicide or serious suicide attempts is depression, and also rates of depression are substantial after self-harm. Depression is a strong predictor of further self-harm. Suicidal thoughts and behaviour are state related in depression; and resolution of the depression will almost invariably alleviate thoughts of suicide. Personality disorders, alcohol and substance abuse, anxiety disorders, and schizophrenia are also frequently associated with suicidal behaviour. About 20% of those who attempt self-harm repeat it multiple times. This group is much more likely to include individuals with persistently maladaptive ways of coping, typically in the form of unhelpful personality traits. Chronic alcohol and drug problems are a strong risk factor for self-harm and eventual suicide. Current intoxication at the time of self-harm may indicate an impulsive (disinhibited) attempt, but its link with chronic alcohol problems should be explored and taken seriously.

Physical illness can be very distressing, especially when progressive or unpredictable. In a large multi-centered transnational study, 50% of people had a physical illness at the time of the attempt for which they had sought help. Frequently, physical illness is a risk factor for complete suicide without a previously detected attempt. Isolation is a risk factor for suicide and particularly for self-harm. The majority of suicides in the elderly involve those who are single or widowed.

Frequent repeaters, those with alcohol and substance use problems, those with physical or mental illness, and those who are isolated also require input from specialist mental health professionals. It is also recommended that adolescents and elderly people warrant a mandatory specialist assessment. Patients with one or more of these risk factors should be offered enhanced care that may include inpatient or outpatient follow up care, a list of local support resources, and, where possible, self-help material.

Self Assessment Questions 4

1) List some of the therapist’s characteristics when dealing with a patient with history of self-harm.

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

1.8 LET US SUM UP

Self-harm is more common than it is usually believed. It is usually defined as an expression of personal distress. An individual episode of self-harm might be an attempt to end life. Self-harm may be more common in young females but it may occur in any age group and in both genders. Various ways of harming self are used, with cutting and self-poisoning being the most common. The nature and meaning of self-harm vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion, and should not be presumed to be the same. Many people self-harm as a way of coping or escaping from a painful situation. Many biological, familial, social and psychological factors have been implicated in self-harm. Management includes immediate medical management of injury and then long-term help to deal with underlying issues. While dealing with individuals with self-harming behaviour, it is essential for the counsellor to maintain an empathic and non-judgemental approach in both assessment as well as treatment; and adopt evidence-based and longer-term strategies to help individuals with self-harm problems.
1.9 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) (v) Suicide
2) Yes. A person who indulges in self-harm once (whatever be the reason) has a very high probability that he/she may do it again.

Self Assessment Questions 2

1) Option (vi) - Mental Retardation. Self-injury that has not been carried out without an understanding of its nature and consequences, as in the case of mental retardation, is not considered self-harm.

Self Assessment Questions 3

1) Option (i) - As a counselor, you should never ignore such signs. It is important to approach the patient in an empathic and non-judgmental manner and enquire about the injury marks. It is also important not to talk to family members before talking to the patient.
2) Long-term vulnerability factors: Depression in mother, conflictual family environment, dysfunctional personality variable, like, poor frustration-tolerance
   Short-term vulnerability factors: Break-up with girl-friend, difficulties in office, symptoms of depression
   Precipitating factors: Distressing thoughts about suicide and his girl-friend, lack of sleep

Self Assessment Questions 4

1) Therapist should be empathic, non-judgmental, good listener, and be able to deal with counter-transference issues.

1.10 REFERENCES AND SUGGESTED READINGS


UNIT 2 PROBLEMS RELATED TO SCHOOL

Structure

2.0 Introduction

2.1 Objectives

2.2 School and Mental Health

2.3 Problems in School
   2.3.1 Learning Problems
   2.3.2 Behavioural Problems
      2.3.2.1 Stress
      2.3.2.2 Aggression and Violence
      2.3.2.3 Bullying
      2.3.2.4 Substance Abuse

2.4 Children with Special Needs in School

2.5 Assessment of Problem Behaviour in School Children
   2.5.1 Functional Behavioural Assessment
      2.5.1.1 Steps in Functional Behavioural Assessment

2.6 Management of Problem Behaviour in School Children
   2.6.1 Counselling and Psychotherapy
   2.6.2 Behaviour Modification
   2.6.3 Family Counseling Therapy
   2.6.4 Play Therapy
   2.6.5 Preventive Measures
   2.6.6 Referral

2.7 Policy Initiatives and Interventions

2.8 Let Us Sum Up

2.9 Answers to Self Assessment Questions

2.10 Unit End Questions

2.11 References and Suggested Readings

2.0 INTRODUCTION

In the developmental life span of human beings, certain phases of life are more critical for development than other phases though all have their equal importance. The physical and mental development are rapid during childhood to adolescence, as the basic structures that were laid down in the fetal months of the person become fully developed during this period. At the same time the psychological wellbeing and mental health of the person are products of the interaction between the environment and the genetic predispositions which help develop the personality of the individual. The environment consists of both physical and social environment, the latter comprising of the family and the society at large. While the family is expected to nurture and protect the individual, the society and the community set up social norms that the person has to follow as he grows up from childhood to adulthood.
The child is subjected to social influences as he or she enters the school. The cognitive and all round personality development take place in the school as the child goes through the processes of learning the three R’s and interacting with his peers. All these aspects contribute to the mental health of the child who is growing up. Teaching and learning are the basic activities in school which involve the development of cognitive capabilities and interactional abilities in the child.

Change by its very nature is stress inducing (Schein, 1992), and education by its nature challenges the individual in the teaching learning processes thereby, contributing to making the individual more stable and mature, capable of higher thinking and balanced development of personality. These changes are indeed a challenge to the mental health of the child and at the onset of adolescence these challenges intensify and add to the stress. In almost all but a few children, these challenges contribute to the skill development at all levels that is, physical, mental and social areas.

At the time of entering the school, these young children who are initiated into education have not yet mastered the social skills necessary to build relationships. Even the concept of self is not yet strong enough to help them differentiate between their and others’ belongings. This stage of growing up leads to conflict, heightened emotions, mental trauma and ill-health if not handled appropriately and with consideration, love and affection. It is therefore important to understand that during school years, the child’s mental health is more vulnerable and in quite a few cases needs special attention.

As is well known, schools are part of the larger social unit. The child spends the most formative years of life in the school during which the foundation for personality are laid. During these formative years as children and then as adolescents, they tend to acquire many habits which are more difficult to change at a later stage or in adult years. Since the young children and adolescents are the future of the society, it becomes very crucial to make sure that they are mentally healthy. It is also well known that children not only develop many habits during the school years, they also tend to develop many problems related to mental health. For instance if they are bullied too much and do not get the needed support, love and affection, they may develop a fearful trait or become too withdrawn. Their self esteem may go down and they may lose their self confidence. It is therefore important to make the school years as healthy as possible so that children develop the right kind of attitude, habits, traits and stability. The school environment should be such that children not only learn the 3 R’s but also develop healthy attitude, higher level cognitive functions and develop into a mature and mentally and physically healthy person. If the environment in the school is negative many mental health problems may arise and children may not be able to develop into a mentally healthy individual. There are of course many causes that may lead to problems related to mental health. In this Unit, you will learn about mental health problems related to school and their assessment and management.

### 2.1 OBJECTIVES

After studying this Unit, you will be able to:

- explain the importance of mental health for school children;
- describe the various problems in schools that affect the mental health of school children;
- elaborate the process of assessment of mental health problems;
- discuss the management and prevention measures for mental health problems related to school children; and
explain policy initiatives and interventions with regard to promoting mental health among school children.

2.2 SCHOOL AND MENTAL HEALTH

Much of the growing days of children are spent in schools where they get to understand themselves and their environment better and through this they also learn about their physical world. Next to the child’s family the school plays an important role as an agent of socialization. The school has the major responsibility of inculcating in children discipline, healthy competitiveness, striving for excellence, learning all about the rights and wrongs or the do’s and don’ts, developing healthy relationships and adhering to social norms as well as learning how not to deviate from the norms as it may lead them to difficulties.

The young child is provided opportunities by the school to learn to explore and experiment both academically and in dealing with others as well as becoming aware of his own strengths and weaknesses. This exploration is not always pleasant and smooth as it may lead the child into areas that have the potential to escalate into problems, as for instance the child may face the problem of being bullied in school. In certain cases the child may manifest problems related to psychological and physical stresses. These may lead them at times to substance abuse, smoking, disobedience, violence and aggression.

A child brings to school with him/her their past experiences at home and elsewhere, in addition to genetic predispositions, self concept, capabilities and abilities along with learning styles, family values and expectations. All of these factors interact with the school system and characteristics of the environment, the teacher and his or her own experiences with the school, home and students with whom they have interacted earlier.

The mental health of students is challenged every day in school in terms of their learning, interactions with teachers and peers and their ability to cope with the classroom and school’s demands and expectations. A child who is able to cope with all these develops a better self concept, positive attitude towards school and peers whereas a child who is not able to cope with these and who also has difficulties at home, develops a negative attitude towards school and suffers from feelings of failure and thus poor mental health.

Poor mental health in students is reflected in their high drop-out rate, lack of discipline within them, poor self control, impulsivity and rising instances of violence on school campus, etc.

Mental health according to the World Health Organization (WHO) is ‘a state of well-being 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’. A healthy mental state of students is essential as it empowers the student to flourish and develop in the right direction, thereby fostering developmental competencies in them. The ultimate goal of the schools is to equip children towards greater achievement, and learn healthy way of competing and excelling their own selves in all academic and other areas. These will help the child to make a healthy, positive and successful transition to adulthood, and help him or her to meet the growing demands of the society. Where students acquire the necessary pre-requisites along with the right/appropriate knowledge and skills necessary to lead productive and successful lives, they are also ensured of positive mental health.

At the same time, it must be remembered that success during school life does not depend on academic achievements alone, but vital to it are also developing a healthy personality and emotional competencies, which lead to psychological wellness. Students have certain personality dispositions, for example extroversion and introversion. While
extroversion helps children to interact with others easily, share their joys and sorrows with their peers and family members, introversion makes children draw into themselves and manifest more of shyness and hesitate to interact with peers and others.

Some children also show mood swings, uncontrollable behaviours, impulsivity etc., which may make them lose interest in work and play, and they may even refuse to go to school. Some children are irritable and difficult to control, while certain other children lose confidence in themselves and show considerable indifference to societal norms and family’s demands. In some cases children may lie, steal and play truant from school and home. Such behaviours are indicative of problems within the child and if these continue for a long period of time they will need psychological help to overcome their problems. If the difficult phase doesn’t last too long and the child appears to be coping with everyday life, there’s probably nothing to worry about. However, if the behaviour continues then it requires intervention and assistance.

<table>
<thead>
<tr>
<th>Self Assessment Questions 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Explain the importance of mental health for the school children.</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
</tbody>
</table>

2.3 PROBLEMS IN SCHOOL

Schools are centres of learning for children and not only they learn the required academic courses (curricular activities), motor and psychological skills such as problem solving, thinking etc., but also develop many congenial characteristics and personality traits through co-curricular and extra curricular activities. Development of their personal, social and emotional aspect of personality are also influenced by the school. The ways in which the child copes with the activities required by the school and the time demanded of them, determine how well she/he succeeds in the school. Failure to cope with these expectations and demands may result in stress, frustration, anxiety and low self esteem in these children.

Now let us consider some of the problems children face in their school life. These can be categorized into (i) Learning problems and (ii) Behavioural problems.

2.3.1 Learning Problems

Schools emphasize the acquisition of the three R’s: reading, writing and arithmetic. Majority of time and effort of the child are expected to be devoted to these areas. While most children do acquire proficiency in these, a few may experience problems in reading, writing and arithmetic. A variety of factors may cause these problems, which include the age of the child, IQ level, childhood psychiatric problems like Down’s syndrome, personality disorder etc., the academic support at home, instructional environment at school, language and cultural background of the child and so on.

All these and other related factors may contribute to problems of learning difficulties, academic underachievement or poor performance in children. Psychosocial factors such as unhealthy child rearing practices, socio-economic status, environmental factors, cultural values etc., lead children to develop low self esteem, psychopathic traits, violent
Specific Issues on Mental Health

and disruptive behaviours. Also as a result of all these negative factors, children may manifest specific learning disabilities diagnosed particularly when children are engaged in academic activity in school.

Learning Disability is a neurological disorder that involves deficiency in one or more of the basic psychological processes required for understanding and using language, spoken or written. Such children despite having average to above average intelligence, perform poorly in academic tasks such as reading, writing and arithmetic. Thus there is discrepancy between the actual and expected performance of the child based on intellectual ability. Learning disability needs to be identified early in the children and appropriate intervention measures be taken to deal with it. Remedial programmes aim at improving the academic skills of the children with learning disability. Individualized programmes give the most benefit. Various learning strategies are suggested, for instance, Deshler et al (1983) suggested a learning strategy acronymed as ‘SMART’.

S – set a goal; M- make a plan; A- attempt a plan; R- review; T- try.

Teachers play a crucial role in identifying slow learners and children having learning difficulties and learning disabilities. Appropriate study skills, time management, preparing a study schedule etc. will help the learning process of the children. In addition, encouragement and adequate resources would also help them overcome their learning difficulties.

You will read further about specific learning disabilities in Unit 2 of Block 3 of this course (MPC 053).

2.3.2 Behavioural Problems

Children also face various behaviourl problems in the school. Academic pressure, lack of coping skills, interpersonal difficulties, negative influence of peer group, unhealthy school as well as home environment may all together or singly lead to stress, maladjustment and other behavioural problems in children. Family disturbances, lack of close relationships and love, lack of parental involvement, alcoholic parents, sibling rivalry and so on add to the challenges faced by children at school. The pressure, frustration and anxiety may lead the children to engage in behaviours that are termed as mentally unhealthy. Such children may resort to bullying, abusing, stealing, telling lies, fighting and even taking to drugs and committing petty or major crimes. Let us discuss below some of the behavioural problems in the school children.

2.3.2.1 Stress

It is well known that in most cases, the schools are all about discipline, work, marks and positions. Though the schools start at 7 a.m. in the morning and end at around 2 p.m. (in some schools, it is almost full day, from 10.30 a.m. to 4 p.m.), the activities associated with schooling continue much beyond that time into the late evenings. The students go for tuitions and hobby classes along with making files and projects for the classwork which are all supposed to be for fun. In addition, travelling long distances in stuffed buses and other means of crowded transport to reach school and back home can all make schooling very unfriendly to the child. Even play is now for competition and everyone wants their child to be an all-rounder so that his/her chances of success in life are guaranteed. As a result of all these, schools have now become a major source of stress for the children.

According to the Oxford Dictionary of Psychology, stress is a ‘psychological or physical strain or tension generated by physical, emotional, social or circumstantial events or experiences that are difficult to manage or endure’.
Psychologists have also differentiated between good stress and bad stress. Good stress impacts positively on performance and is known as 'eustress'. On the other hand, bad stress which impacts performance negatively is known as 'distress'. The relationship between stress and performance has been graphically presented in the Yerkes-Dodson Law given by psychologists Robert M. Yerkes and John Dillingham Dodson in 1908. The law states that till a point, stress helps in enhancing the performance of a person by arousing his level of performance, but beyond that critical point, it starts to negatively impact the performance.


Similarly, the school climate must be such that it makes the child work at his/her optimum best without creating a situation of distress. However, this is a critical balance to achieve given the fact that the system and nature of education has made the process of schooling more stressful than ever before. With syllabus targets to fulfill and the competitions rising, schooling as of today lead to stress in the children unless handled properly. Of course, there are counselors being appointed in the school who could take care of some of the stress but not all schools have a counselor.

Another important issue is the close and continuous monitoring and evaluation of the students, the school, and the teachers by the educational administrators which all put pressure also on the teachers who in turn pressurize the students to perform at a higher level contributing to unhealthy competition that cause high level of stress on children. In addition to all these aspects, the migrant students add to the diversity of the background of students making teaching and learning stressful for both the teacher and the taught. Further, in India, many families have first generation learners who have little or no support in their learning endeavors; thus making schooling stressful for the child, parents and the teachers who have to put in extra efforts to help these students to continue in the school and not dropping out of the school system.

Thus stress in school can result from adjusting to the school, adjusting to the curriculum, learning the subjects/courses, forming friendship with the peer, performing well in the curricular and co-curricular area, competing with the classmates, living up to expectations of the parents and teachers and so on. During the adolescent stage, stress also results from accepting oneself with the growing physical and psychological changes, belonging to the peer group, forming relationship with the opposite gender, being confused...
about one’s identity etc. All these have negative repercussions on the academic success of the adolescents.

Stress is the basis for nearly all mental health problems and is the reason behind increasing cases of depression, self-harm and suicide amongst children. Lack of proper guidance and counseling, lack of awareness about coping strategies, absence of strong family bonds and ineffective communication, and lack of resiliency in children result in the latter taking the drastic step of self-harm or suicide. This is especially evident during the crucial school board examination time. In order to help children avoid such extreme step, there are a number of helpline and counseling available for children and their parents.

The increasing stress amongst students is a cause of great concern amongst psychologists, educationists as well as the government. Various programs and policies are being worked out to help the child in handling and reducing the stress faced by them. The Indian government recently took a policy decision of undoing the board exams for the class 10 students in order to reduce the burden of students at that age. It is too much stress for the child who is too young to cope and also because these results are too early an assessment of the child’s potential and disposition. The results push a child into choosing a stream of education that might not finally be the area of his/her interest.

Models of Coping

Several models of coping with stress have been suggested by experts and the major ones are:

1) Problem focused vs emotion focused model
2) Approach vs avoidance model
3) Factor analytic model.

These three models are described below:

1) Problem focused Vs. Emotion-Focused Model

This model was put forward by Lazarus in 1974. This model differentiates between ‘direct action’ and ‘intra-psychic coping’. While in intra psychic coping, the person focuses on regulating the emotions accompanying the stressor, in the problem focused coping, the focus is on managing the stressor (Singhal, 2004).

2) The Approach/Avoidance Model

This model differentiates between the coping strategies on the basis of the disposition of the person. In the approach model, the individual tries to identify the problem and its components and tries out ways and means to solve the same. However, in the avoidance model, the person will look for ways to run away from the problem. Those who use the avoidance model are more passive and try to run away from stressful situations (Peterson, Harbeck, Chaney, Farmer and Thomas, 1990).

3) Factor-Analytic Model

This model, put forward by Dise-Lewis(1988), shows four factors of adolescent coping i.e. acceptance coping, emotion-focused coping, avoidance coping and active coping.

The above are some of the coping models that can be used to help cope with stress. Teachers and parents also can help the children deal with stress by emphasizing development of open communication, strong ties with the family, sibling and the peer,
engaging in physical recreation that will release the negative energy of stress and adopting a positive attitude. Awareness of the availability of professional help and motivating the parents to approach them whenever necessary will also help the children manage stress in an effective way.

### Self Assessment Questions 2

1) What are the type of problems faced by school children?
   ..................................................................................................................................................
   ..................................................................................................................................................
   ..................................................................................................................................................
   ..................................................................................................................................................

2) As a learning strategy, what does SMART stand for?
   ..................................................................................................................................................
   ..................................................................................................................................................
   ..................................................................................................................................................
   ..................................................................................................................................................

3) Differentiate between emotion focused and problem focused coping.
   ..................................................................................................................................................
   ..................................................................................................................................................
   ..................................................................................................................................................
   ..................................................................................................................................................

#### 2.3.2.2 Aggression and Violence

Psychologically ‘aggression’ refers to ‘behaviour by one person/persons intended to cause harm to another person/persons’. It is demonstrated in actions and through use of harsh words or criticism, or express orally and in action the hostile feelings against others. In extreme form aggression may end up in destructive behaviour towards another person or animals or even objects, such as breaking a TV or a radio or something which is valuable.

Today students are exposed to aggression and violence everywhere, e.g., violence in the media, on the road, within families, and also in public places, which all have a strong impact on their personality and behaviours. They tend to imitate aggressive behaviour of others as witnessed by them in their life and tend to consider aggression as an acceptable part of their life. Children see and observe as well as imitate adults and even their peers who use aggression to get things done as they wish and desire. As aggression becomes a way of life for the children, they tend to be unconcerned about the consequences of their actions and behaviour.

It is well known that children witness violence in society in many forms and in schools particularly they see their teachers and also peers indulging in violence. Even in play schools, children see their peers snatching things from other children, pushing others to get to their target and competing with each other aggressively to get teacher’s attention etc. In some cases it may be merely verbal aggression such as abusing one another or
using harsh and abusive words that they have heard at home, in the family, in school or in the community. All these behaviours if not checked in time and at the first time it occurs, may progress to more harmful behaviours like ragging of newcomers in educational institutions, substance abuse, murder, rape etc.

Frustration Aggression Hypothesis of John Dollard, Neal E. Miller et al. (1939) which was further developed by Miller, Roger Barker et al. (1941) and Leonard Berkowitz (1969) explains aggression as the result of blocking, or frustrating of efforts that a person directs towards the attainment of a goal. Another theoretical position is that of the Social Learning theory as given by Bandura (Bandura and Walters in 1963, 1977). In a classic experiment they showed that children who were watching a ‘Bobo doll’ being beaten up by another child on the screen showed the same type of aggression as the child when they were given a bobo doll to deal with. Thus the experiment demonstrated how children learn a behaviour, aggressive or otherwise through watching and imitating another person’s behaviour. If this logic is applied, one can understand how a child learns aggression as well as other negative behaviours from their environment, from their parents and significant others in their life.

Continued aggression and unchecked violent tendencies may lead to conduct disorders in children. These disorders are marked by persistent antisocial behaviours in children and adolescents that result in significant problems and distinctly lowered performance in academic and non academic areas. This also adversely affects their social functioning, that is in terms of interacting with peers, siblings and family members including parents. Conduct disorder is usually marked by two major symptoms, viz., aggression and delinquency. Aggression may be directed towards people, e.g. peers and classmates; or animals, e.g. cruelty towards animals; or objects, e.g., destroying property etc. The aggression can also turn towards self in terms of self harm and suicidal tendencies. On the other hand, delinquency refers to antisocial behaviours which includes lying, stealing, physical and sexual assaults (specially in adolescence), running away from home and school termed as truant behaviour.

It is natural for many children to lie on one or the other occasion, and if this is ignored by the adults or appreciated as a playful behaviour, such a behaviour may turn out to be a persistent problem in lying. This can also progress to stealing and then denying that they ever stole anything. Children may also exhibit disobedience, defiance and temper tantrums which can be considered ‘normal’ at a particular stage of their development, but children do outgrow these behaviours as they grow up and enter the next developmental stage. However, if these behaviours persist and are not age-appropriate or developmental-stage appropriate, these may have to be considered as a symptom of some underlying psychological disorder and the child should be taken for consultation to a psychologist.

Childhood conduct disorder often continue into adolescence and adulthood unless appropriate and timely interventions are taken. Childhood aggression, violence and delinquent behaviours become high risk factors and are considered forerunners of antisocial behaviour and alcohol and substance abuse in adulthood.

**Prevention of aggression and violence in schools:**

Since there appears to be an increase in violent and aggressive behaviours in children at schools, remedial measures can be taken up by the school itself as well as by the family, community, and the society. In fact these four institutions should together put in efforts to reduce violence whether at school or elsewhere. One of the ways in which this can be done within the school is that the teachers should be especially careful not to encourage such behaviours and where necessary immediate action with suitable punishment should be enforced after informing the child the reason for such punishment.
Parents too at home should make sure that unwanted and negative behaviours such as aggression or violence in children are not tolerated and appropriate punishment is consistently given (whenever such behaviours occur) in terms of depriving the child from going out to play or watching a TV programme etc. Corporal punishment should be avoided by both teachers and parents and this aspect has also been presented as a policy by the government. Positive reinforcement for pro-social behaviour, time out and loss of privilege for aggressive behaviours would help to control instances of aggression. Teachers and parents should be role models for children and make sure that they themselves do not show any aggressive or violent behaviours in their day to day life. Despite all efforts, if the child continues to manifest aggression, anger etc., they have to be taken up for counseling through which they can be helped to control their anger and aggression even in provocative situations. Furthermore, not only efforts should be towards reducing aggressive and violent behaviours in children, but also at a positive level they must be helped to develop skills to maintain peace, tolerance and calmness.

Family interventions may be crucial, where aggression and violent behaviours within the family and negative interactions amongst the family members (such as faulty parental communication and inadequate and inappropriate child rearing) impact children and encourage them to start using similar negative and violent behaviours in their interactions and dealing with others in school or elsewhere. In such cases training of parents in regard to appropriate child rearing and positive interaction and communication amongst family members including between parents, help considerably.

2.3.2.3 Bullying

Bullying is being recognized as a rising menace in the school system all over the world. Basically it refers to an unequal power relationship between the victim and the perpetrator, and also, the episodes are repeated over time. (Olweus & Roland, 1983; Olweus, 1993; Rigby, Smith & Pepler, 2004; Roland, 1989a).

Bullying is one form of aggressive and violent behaviour that occurs in schools especially when teachers are not observing the children’s interactions and quite often out of school premises also. Bullying can take the form of verbal abuses, physical assault, derisive comments, teasing and ganging up against a child or some children. As a result of this, some children who are unable to handle their aggressive peers, may refuse to go to school and also may develop many kinds of physical ailments such as stomach aches and cramps thereby avoiding attending school. This kind of behaviour, when occurs too often and prevents the child from attending school, indicates that the child is facing some deep rooted problems in school or at home or elsewhere, one of which could be bullying. Parents seldom relate such behaviour as skipping school by their child, to bullying. Non-attendance of school by the child may also lead to poor grades in academics and loss of interest in studies as well as school as a whole.

Bullying needs to be taken seriously by schools, families and the whole community because it blocks the feelings of safety and happiness in children replacing the same with anxiety, fear, low self-esteem etc. Bullying behaviour may include pushing, hitting, damaging property and causing psychological trauma, like threatening, verbal shouting, screaming and use of abusive language directed towards the self-respect and esteem of the child. Cyber bullying is also on the rise these days where children use the social media to bully others. The bully and the victim both are at risk of mental health problems like anxiety, stress, substance abuse and in the long run may even get on the wrong side of the law.

Bullying may arise as a result of the bully experiencing feelings of jealousy towards a
fellow student or to simply project themselves as powerful, tough and popular. Bullying tendencies may also be a result of the bully himself/herself getting bullied somewhere else possibly by their families, teachers or peers in their locality. It is unfortunate that some of these children come from families where the parents, siblings or relatives are bullies themselves. Sometimes when children do not get adequate attention from their families they start bullying weaker/vulnerable others around them to get attention.

Being a guardian and mentor of the student, the teachers have an important role and should be aware of ways to diffuse such situations. Some of the ways to do this are – conducting surveys of the school to identify/determine the number and frequency of incidents and areas where bullying and verbal aggression occur (during recess, hallways, passages and bathrooms). Discuss bullying and verbal aggression (nature, sources, signs, prevention) at class meetings, conduct role plays within the school between two children, one a bully and the other a victim, and make the children realize what bullying does to an individual. Measures to prevent bullying must be taken not only in schools, but also in the community. Discussions about bullying and its serious consequences on the victim should also be discussed at PTA/PTO meetings. Such discussions could also be taken up at both school-wide and grade-level assemblies. Clear rules in regard to bullying should be established and should be accompanied by the type of punishment that it would entail. Normally children do not indulge in bullying unless they are themselves subjected to bullying at home or in society or they have certain negative personality traits that predispose them to bullying.

Not only children who indulge in bullying but also those who are bullied or victims of bullying, do have certain personality traits which make them more susceptible to bullying. It is also known that all children do not get bullied and even if some do get bullied, can handle the bullies very effectively. There are however some children who are basically timid, shy, withdrawn, and some may also lack self confidence and have poor or low self esteem. These children tend to become victims of bullying more often than those who have self confidence and can protect themselves from bullying. In some cases the victim may change into a bully himself in order to prevent being bullied. Or he may join the gang of bullies and thus do what the gang bids and in the process may also lose interest in academics and various other school related activities.

**Prevention of bullying in schools**

Bullying is not only detrimental to the mental-health of the victim but also is a sign of mental ill-health in the bully. If this behaviour is left unchecked in the school, it might lead to increase in instances of violence both in school and outside of it. It may also be noted that some victims of bullying may react by turning bullies themselves. If such violent and negative behaviours go unchecked and unpunished, these children may become all the more confident that they will not be punished and thus continue their act of bullying. Further bullying is also known to increase the risk of suicide and self-harm in the victims.

Prevention of bullying to an extent has been discussed earlier. It is important to note that schools need to recognize, solve and prevent bullying, and also discourage such behaviour and similar ones among its students. Some of the measures that could be considered in this regard include the following:

i) Organising workshops and group sessions in which role play could be used to make children learn appropriate responses to bullying and teasing. Also these group sessions could be used for motivating all students to be reasonable and responsible in their behaviour. During these sessions, teachers or the counselor may use art, stories, and activities for promoting appropriate social behaviour.
Slightly more attention may be given to children who are physically weak and slender or suffer from physical handicap, and thus are more prone to be bullied and teased.

Teachers should themselves be careful not to use any negative remarks or use derogatory terms and unwanted criticisms when they deal with children who may not come up to their expectations.

Avoiding corporal punishment, abusive language, holding and communicating prejudices during discussions would help a great deal in reducing this problem, as children will learn from teachers not to assault, or be prejudicial towards some children or use abusive language.

Set up clear rules and punishment for breaking the rules. The punishment given for breaking rules should be applicable to all children, should be immediate on breaking the rule and should also be consistent in that children will know that punishment would definitely follow if they break rules.

There should also be a mechanism of monitoring and supervision of children who tend to bully within or outside of the school, when travelling in school bus etc.

It may be kept in mind that more than negative and harsh punishment, the school teachers, principal and administrators should use more of positive intervention and help when bullying or taunting occurs.

Encourage reporting of bullying incidents.

The principals, teachers and administrators along with student leaders of different classes must meet regularly to review the bullying incidents and take suitable measures.

Create a trusting environment so that both the bully and the victim can confide and talk to authorities about their problems.

Where there is a need the school could refer the bully and/or the victim to psychological counseling in order to help them overcome their aggression, violence and bullying.

Role of parents and family in preventing bullying:

Parents have an important role to play in handling bullying not only at home and neighbourhood but also in schools. The following measures are suggested for the same:

If bullying by their child is reported by the school or by the parents of other children, they should take immediate action.

They could help their child to learn how they can get the same thing done without resorting to bullying.

They should help the child understand what happens to the child who is bullied.

On their part at home parents must make sure they do not bully the child to obey them and do what they desire the child to do.

They should act as role models for their children by using positive non violent methods to solve a problem or issue.

They must make it clear to their children that bullying at any place will not be tolerated and would warrant punishment.
vii) They should nurture and build self-esteem and self-confidence in their child so that he or she neither bullies nor become victims to bullying.

viii) Rewarding children with praise and appreciation for showing consideration to others would help in a big way.

ix) Making their children aware of the existence of bullies in school and outside and how to handle them with confidence would also help.

x) Parents should create an environment at home which gives importance to developing feelings of togetherness and bonding, where children can learn positive ways of dealing with difficult situations either at school or in the neighbourhood.

xi) The parents should be a friend and philosopher to their own child so that he can trust parents and communicate their problems without any hesitation.

xii) Parents must help the child learn to be assertive in situations where it is required. e.g. when facing a bully, the child can ask the bully to STOP that behaviour quite assertively and not show timidity or fear.

xiii) Where necessary, the parent should take the principal or the teacher into confidence and request their help to prevent such bullying.

xiv) If one’s own child is timid, shy and withdrawn despite all the help that they give, it would be better to seek the help of an expert (a psychologist or school counselor) to help the child develop skills to overcome the deficiencies in his personality.

The above mentioned measures can go a long way in not just curbing bullying behaviour in students but also helping them not to develop other bad habits and thus make them mentally healthy.

2.3.2.4 Substance Abuse

As children reach the age of adolescence they have a strong tendency to explore the world and their environment. This is a time when the growing individual experiences strong peer pressure to join them in what they are doing, school and parental pressure to perform at a higher level of academic achievement and so on. This is also the time when the young individual goes through considerable physical and physiological changes with increased hormonal activity. The youngster is now physically grown up and looks like an adult but is yet not psychologically grown up. He is still a child in his thinking, reactions and responses though he may try to act like an adult only to be chided by adults not to do so. This is the time when the youngster has also to plan for his future occupation and settling down in life. All these add to stress in the adolescent youngster. This is the time when he has many questions to ask, and often questions the norms and standards set by the family and society. He argues with parents and other adults and has an opinion of his own regarding almost all issues in life. He needs to develop a self identity and thus tends to question adult’s activities and decisions. This is a passing phase but yet needs to be handled properly and the youngster has to be guided in the right direction. If this stage is not appropriately handled either by the school or parents, the youngster may fall into the gang of undesirable people and may also be tempted to try smoking, drinking, use of drugs and many such undesirable activities in which the gang members may be indulging. This is the time they try out many things that the adults do, however, they are not yet ready or mature enough to handle the demands of adulthood. Added to these problems in growing up, there are varied demands on him from his peers, the school and family. If no proper help is available they may stray off
into many behaviours which may be considered unacceptable as for instance, drinking, indulging in antisocial activities, substance abuse etc.

In the past couple of decades, there has been reports that school students indulge in drinking alcohol and using drugs etc. Influence of the peer group combined with low frustration tolerance, aggressive tendencies, and easy availability of drugs lead to increasing use and abuse of substances by these youngsters. They appear to be least concerned with its ill consequences. Furthermore, substance abuse has serious implications for one’s physical, emotional, social as well as personal functioning. At the personal level, there is academic deterioration, decreased social contact, lying, stealing, violence, changes in eating and sleeping habits and an overall change in the behaviour pattern. All these cause a huge economic and social burden to the society.

Several explanations have been advanced for substance abuse by the youngsters and of these, lack of harmony in the family, stress of family demands, conflicts with peers, relationship with opposite sex members, and other social relationships have been viewed as some of the important factors.

<table>
<thead>
<tr>
<th>Self Assessment Questions 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) How can parents and teachers help in controlling aggressive behaviour?</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>2) What do you mean by bullying?</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>3) What steps can be taken by teachers with regard to bullying?</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
</tbody>
</table>

In addition to the above problems exhibited by children in the school context, there are few other problems manifested by some of the children in school. These require psychological or psychiatric help and include the following:

*Temper tantrums:* Behaviour characterized by shouting, screaming, crying, throwing and kicking, lying down on the floor for paltry and insignificant events. This can happen at a very young age as young as 3 years old or can manifest in adolescence. These normally should cease as the individual grows up but if these behaviours continue despite all efforts to help the child reason, then it is important to take the individual for psychological consultation.
Specific Issues on Mental Health

Attention problems, impulsive & hyperactive behaviour: In this, the youngster has difficulty in focusing attention on learning tasks, shows impulsivity and overactive behaviour. He disturbs the class, his peers and classmates, snatches away their things and does not abide by the teacher or any rules of the class room.

Acting out behaviour: This is considered as ‘attention seeking’ behaviour, in which the child misbehaves and does things to attract the attention of the teacher and as well as his classmates.

Oppositional defiant behaviour: The child shows defiant attitude towards authority, is argumentative and non compliant. At times some children even show their anger and indulge in aggression.

Phobias: These are irrational and intense fear of things, objects, animals, insects etc. and in some there may also be school phobia, that is, despite all efforts of the parents, the child refuses to go to school.

Depression: The child here is unhappy and sad and does not mix with anyone, remains isolated and withdrawn with a few crying spells for no specific reason. Such a depression may even lead to self harming behaviour and in extreme cases suicidal behaviours.

Anxiety: Varied types of anxiety may be manifested by a child which may include separation anxiety (anxiety about being away from parent especially mother even for a short while.) These children are apprehensive of some harm that may come to their parents when they are away in school or other places.

Stealing and Lying: Many times these behaviours may even be considered normal or playful when the child takes away the bag or pencil or colours from another child. With guidance from teachers and parents the child learns that such behaviours should be avoided and thus do not indulge in these behaviours. However if stealing and lying continue even after the child has passed that stage of development, these are considered abnormal and need psychiatric or psychological consultation.

2.4 CHILDREN WITH SPECIAL NEEDS IN SCHOOL

Children with special needs can be of the following categories, viz., (i) physical disabilities such as visual and hearing impairment or physical handicap; (ii) those who are intellectually lower than the average IQ child; (iii) those with learning disabilities and (iv) exceptional children or gifted children with high IQ level. All these children need special and differential teaching learning processes without which they may not be able to benefit from the schooling. The fourth category ‘exceptional children’ deviate from the normal or average children in physical, emotional, social and cognitive aspects to such an extent that they cannot benefit from regular classroom instruction and practices. They require modification in the regular instructional practices and require special educational challenging programme at their level so as to benefit from the teaching learning process in the regular school. In addition there are children who have emotional problems that need to be handled before they can benefit from the teaching learning process in regular school. Also, some children come from such a background (e.g. first generation learners, disadvantaged students etc.) that they are called the ‘socially disadvantaged’ children. They also need special attention and modified educational programme so as to benefit from regular school teaching processes.
More specifically the following are the different groups of children having special needs:

- Mental retardation
- Visual impairment
- Hearing impairment
- Physical handicap (cannot use their limbs, hands or legs)
- Learning disabled
- Slow learners
- Children with emotional and behavioural problems
- Socially handicapped (disadvantaged)
- Exceptional children or the gifted children

Here, we need to differentiate between the terms impairment, disability and handicap which are sometimes used interchangeably when talking about children with special needs.

*Impairment* refers to the loss or damage of any part of the body or organ, e.g., loss of a leg or arm.

*Disability* refers to the loss of function as a consequence of the impairment, e.g., inability to walk because of the loss of the leg.

*Handicapped* refers to the restriction or limiting of the normal way of functioning. It refers to a problem or a disadvantage that a person with a disability or an impairment encounters when interacting with the environment. A person with a disability is not considered handicapped unless it results in personal, social, educational or vocational problems. In the above example, if the person uses an artificial leg and carries out the normal functions, s/he is not handicapped.

Integration of children with special needs in the mainstream and inclusive education are the approaches advocated for such children. Specially designed curriculum and instruction, and provision of special facilities and services would help these exceptional children develop and achieve to their optimum. Inclusive school setting will minimize behavioural problems in children with special needs, provide a supportive, least restrictive school environment, nurture their educational and social needs, ensure acceptance and respect for their differences.

### 2.5 ASSESSMENT OF PROBLEM BEHAVIOUR IN SCHOOL CHILDREN

Assessment is a crucial step in understanding and managing the problem behaviours in school children. It serves the following functions:

- Defining the problem
- Selecting the appropriate treatment
- Specifying the treatment objectives
- Setting the goals

A problem behaviour can show an ‘excess’ or ‘deficit’, i.e., when the behaviour occurs with very high frequency or duration, it is called as excessive behaviour; and when it
Specific Issues on Mental Health

occurs at a very low rate, it is called deficit behaviour. Thus a problem behaviour is a disruptive or maladaptive behaviour that hampers the normal functioning of the child and has a negative impact on those around him.

A problem behaviour has 3 features:

- Extreme behaviour in either direction
- Chronicity
- Socially and culturally unacceptable

Assessment of the problem helps in clearly identifying the problem and operationally defining it. An operational definition describes the behaviour in terms of what is observed and seen. Objectivity, clarity and completeness are important for operational definition. Functional analysis is a crucial part of assessment procedure.

2.5.1 Functional Behavioural Assessment

Functional behavioural assessment is conducted to identify the underlying causes of behaviour. It helps in finding out specific contributors to the problem behaviour observed in the child. The first step in the process is to define the problem behaviour, i.e., to describe it in concrete terms. It includes describing the behaviour in such a way that it is easy to communicate about it, simple to measure and record. This concreteness in description of the problem behaviour helps in deciding the appropriate intervention. You can see how behaviour is concretely defined in the following Table.

<table>
<thead>
<tr>
<th>Problem Behaviour</th>
<th>Concrete Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ramesh is hyperactive.</td>
<td>Ramesh does not sit in his assigned place in the class. He moves around the class frequently.</td>
</tr>
<tr>
<td></td>
<td>Ramesh goes out of the classroom without taking permission.</td>
</tr>
<tr>
<td>Deepti is aggressive.</td>
<td>Deepti hits other students in the class when they do not share pencil, eraser etc. when she asks for it.</td>
</tr>
<tr>
<td></td>
<td>Deepti beats other students in the playground when they go ahead of her while racing or playing other things.</td>
</tr>
</tbody>
</table>

The child’s behaviour is observed carefully and systematically in a variety of situations such as in the classroom, on the playground, during assembly, at lunch break, at home, etc. and the specific characteristics of the behaviour are recorded in detail.

The next step after defining the problem behaviour is to determine the functions of the problem behaviour. For this, functional behavioural assessment is conducted.

2.5.1.1 Steps in Functional Behavioural Assessment

Direct Assessment: This follows the A-B-C approach. It refers to Antecedents (what happened before the behaviour), Behaviour (description of the behaviour as it happened), and Consequences (what happened after the behaviour).
<table>
<thead>
<tr>
<th>Antecedents (A)</th>
<th>Behaviour (B)</th>
<th>Consequences (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother did not allow Sita</td>
<td>Temper tantrum</td>
<td>Mother conceded and allowed her to see TV</td>
</tr>
<tr>
<td>to watch TV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing homework</td>
<td>Failed to understand,</td>
<td>Feeling of inadequacy, feeling of being no good</td>
</tr>
<tr>
<td></td>
<td>could not do homework</td>
<td></td>
</tr>
</tbody>
</table>

B is modified by controlling A and altering C. This is done by identifying not only the conditions that precede and trigger the behaviour, but also the reinforcing consequences that sustain it. The antecedents and consequences of the target behaviour may be overt, objectively observable conditions or covert mental events reported by the person, whose behaviour is to be modified.

The frequency, duration and severity of the behaviour are also recorded. A ‘symptoms diary’ can be maintained regarding this by the teachers and the parents.

**Indirect Assessment:** Structured interview method is used to collect information about the behaviour from parents, teacher, peer and any other significant person in the child’s life. The child may also be interviewed to know his/her perception and perspective. The information focuses on:

- When does the behaviour occur
- Who is present when the behaviour occurs
- Where it does not occur
- What precedes the behaviour, i.e., the nature of the interaction or activities that happened before the behaviour
- What happened after the behaviour
- What can be the acceptable behaviour to replace this problem behaviour

**Data Analysis:** All the information are then compiled and analyzed. This helps us to determine what function the behaviour is serving for the child; whether it helps the child to get attention, or get reward, or avoid responsibility, or avoid doing homework etc.

**Tentative Hypothesis:** Based on the above, tentative hypothesis or solutions are framed and tested out. Once the relevance or the functions of the problem behaviour is known, the hypothesis predicts the conditions under which the behaviour is most and least likely to occur (the antecedents) as well as the consequences that maintain the behaviour. Environmental manipulation is done to test the hypothesis. If the hypothesis is found correct, it’ll lead to the planning of behaviour intervention plan. If the hypothesis is not proved, then a new hypothesis needs to be formulated after analyzing the data again.

**Behaviour Intervention Plan:** Intervention plan is devised to decrease or modify the maladaptive problem behaviour. It focuses on teaching more appropriate behaviour that serves the same function as the disruptive problem behaviour by manipulating the antecedents and/or the consequences of the behaviour.

In the assessment of the problem behaviour, one should always remember to collect information from multiple sources and methods, and focus on specific contextual factors. Socio-cultural and environmental factors play an important role in contributing to the origin and maintenance of the behaviour. Careful analysis of all the factors will lead to an effective behaviour intervention plan. We should take note of the principle of multiple causality and multiple effect when analyzing the problem behaviour. A single problem
Specific Issues on Mental Health

may have a number of causes, e.g., refusal to go to school may be due to punitive class teacher, inability to understand classroom teaching, bullying or abuse etc. Similarly, a single factor may lead to a variety of problems, e.g., domestic violence may lead to withdrawal, bed-wetting, aggressiveness, headache, and nail-biting etc.

Self Assessment Questions 4
1) What is ‘handicapped’?
....................................................................................................................
....................................................................................................................
....................................................................................................................
....................................................................................................................

2) Describe the three features of a problem behaviour.
....................................................................................................................
....................................................................................................................
....................................................................................................................
....................................................................................................................

3) What is the ABC approach?
....................................................................................................................
....................................................................................................................
....................................................................................................................
....................................................................................................................

2.6 MANAGEMENT OF PROBLEM BEHAVIOUR IN SCHOOL CHILDREN

Consistency is the key to management of problem behaviours in children. Coupled with this, there should be acceptance, respect and positive interactions with the child. Management of the problem behaviour is multi-faceted. All the stakeholders including parents, teachers, the peer group, and the child himself need to be involved in the management of problem behaviour. While discussing the behavioural problems under section 2.3.2 above, we have also described the handling and managing of these problems. In addition to these, here we’ll learn about the general techniques for the management and prevention of the problem behaviours.

2.6.1 Counselling and Psychotherapy

Counselling aims at establishing a warm and genuine relationship with the child. It facilitates the child opening up and expressing his fears, anxieties and concerns in the secure atmosphere of counselling. Counsellor analyzes the problem, understands it from different perspectives, and suggests intervention plans to manage and overcome the problem behaviour. There are different approaches to counselling such as,

*Psychoanalytical counselling*: focuses on the early childhood experiences of the client. It aims at catharsis through the technique of free association. It uses play, drawing,
painting, drama and dance as medium that facilitate free expression of child’s feelings and emotions.

Client centered counselling/person centered counselling: is a non directive approach to counselling. The therapist is non-critical, non-judgemental and non-evaluative. It emphasizes the innate potential of the individual to solve his problems. The therapist is required to extend unconditional positive regard and genuineness in the counselling relationship.

Cognitive behavioural therapy: the focus is on cognitions and thoughts of the child that is causing the problem behaviour. The child is helped to identify the irrational and dysfunctional thought patterns and change them to rational positive thoughts and self talk. A daily record of dysfunctional thoughts can be maintained by the child/adolescent in which the situation, thoughts, feelings and behaviour can be recorded.

2.6.2 Behaviour Modification

Behaviour modification is based on the principles of learning. Any behaviour that is learned can be unlearned. It uses the principles of reinforcement to modify inappropriate and disruptive behaviour and to promote more adaptive and appropriate behaviour. It views that problem behaviours are consequences of poor contingencies of reinforcement and punishment. If the problem behaviours are maintained by reinforcement from the environment (e.g. attention, encouragement, praise etc.) or if the deficit problem behaviours are due to lack of adequate reinforcement or due to punishment (e.g., excessive criticism, scolding, beating, ignoring, neglect etc.), the environment is modified and appropriate reinforcements are selected and administered which in turn reduces the problem behaviours leading to their extinction in course of time.

There are many techniques of behaviour modification which includes the following:

i) Positive and negative reinforcements

ii) Aversion therapy

iii) Token economy methods

iv) Cognitive behaviour therapy

Reinforcement consists of rewards and punishments given to the child whenever he indulges in negative behaviour. Such reinforcements change the negative into positive behaviours which are reinforced by rewards. Rewards can range from giving the child a compliment, granting of a special privilege, etc whenever the child shows the desirable behaviour. Negative reinforcement may take the form of removal of a favourite object or taking away a privilege such as watching a favourite TV programme. Or the child may be placed in isolation or time out until the child changes his negative behaviour to positive or desirable behaviour.

Aversion therapy on the other hand uses conditioning the person to change his behaviour in order to avoid unpleasant consequences. e.g. in deaddiction from alcohol / drugs procedure, the individual is given a liquid or injection which induces vomiting just before he is given the alcohol to drink. Immediately the person starts vomiting (due to the effect of the medicine/injection) which is extremely unpleasant to the person, and thus in order to avoid this extremely unpleasant vomiting, he avoids taking alcohol and thus extinction of alcohol intake behaviour takes place.

Token economy method makes use of the principle of earning tokens by showing good behaviour which the child later on can exchange for rewards.
Cognitive behaviour modification involves teaching the individual to recognize his unrealistic or negative thoughts which distort his reality. The individual learns to examine irrational beliefs that lead to negative behaviours. The methods used in this include role play, being asked to defend thoughts that distort reality etc.

The steps in behaviour modification include,

- Defining the undesirable behaviour in a clear and precise manner
- Analyzing the significance of the problem, i.e., the function it serves
- Designing an appropriate behaviour intervention plan
- Reinforcing the desirable behaviour consistently and clearly to shape behaviour

Behaviour modification is a here and now approach. It focuses on the present and determines the factors responsible for the problem and addresses it accordingly.

### 2.6.3 Family Counseling Therapy

Earlier therapies focused on individual symptomatic behaviours. However, with the increasing recognition of the role and influence of the family on the child’s behaviour, family counseling and family therapy were developed. Family counseling does not consider the child’s problem in isolation but in the family and social context in which the child functions. The problem behaviour in the child is considered as a reflection of the dysfunction in the family system. The communication, interaction and interrelationship patterns within the family are examined to explain the origin and maintenance of the symptom in the child. Parental education and training also form a crucial part, in that the parents are educated about the child rearing practices that they engage in and how these impact the child’s development and behaviour. Family members especially the care givers are trained with regard to effective communication practices and management of their child’s behaviour.

### 2.6.4 Play Therapy

Children feel most comfortable while playing. Play is their natural medium of expression. Further, children can express themselves better through the medium of play than through verbalization. When play is used in a systematic and therapeutic way to deal with the behavioural, social and emotional difficulties of children, it is called play therapy. Play helps them to open up and express their feelings, emotions, fears, anxieties and stress and find ways and means to deal with them. As the child engages in play, using various toys, the therapist tries to find out themes and patterns and derive meaning in the play. Just as the adults ‘talk out’ their difficulties during counselling, the child ‘plays out’ his feelings and problems during play therapy sessions.

Sigmund Freud was the first to use play in therapy aimed at discovering the unconscious fears and concerns of his client. Various play therapies have been advocated such as Psychoanalytic play therapy, Jungian play therapy, Adlerian play therapy, Relationship play therapy, Release play therapy, Axline’s play therapy. Virginia Axline’s play therapy based on Rogers therapy is widely used. Play therapy is used successfully for various problems such as school problems, fear, excessive anger, excessive shyness, worrying, psychosomatic problems etc.

### 2.6.5 Preventive Measures

Prevention is always better than cure. The problem behaviour of the child will have its origin either in the home, family setting, school setting or it may be due to his own
personality characteristics and predispositions. Hence if we present a proper environment to the child at home and school, it'll help him/her grow and develop optimally; the occurrence of problem behaviours in them will reduce significantly or can be eliminated completely.

Prevention is the best form of intervention that is cost effective and, time and energy saving. Routine screening and early identification help in diagnosing the potential problems and prevent them from arising through psychological counseling etc. The following measures if taken will help children to have a stable and conducive atmosphere to develop a stable and balanced personality and approach both at home and school.

- Accept the child as she/he is
- Recognize his/her good qualities and strengths
- Praise the child for doing a good job
- Rules and consequences must be clear to the child and they should be followed consistently by both adults and children.
- It is ideal to involve the child while framing rules and regulations
- Be firm and consistent in disciplining the child.
- Promote confidence and self esteem in the child
- Provide clearly established routines and structures
- Encourage, motivate and reward the child for good study and good behaviour
- Provide opportunities to the child to excel and succeed
- Provide guidance to the child when he is confused or find difficulty in handling a situation
- Teach the children life skills that are needed at different stages of development.

The focus of prevention should be to nip the problem in the bud, prevent the problem from growing and stopping the negative behaviour from the beginning itself. Establishing clear rules and guidelines, rearranging the classroom seating plans, interpersonal skills training, anger management training, interest and involvement in the child’s life, helping child to inculcate proper values through adults and peers acting as role models, and provide opportunities for the child to develop appropriate attitudes and pro-social behaviour, will all together definitely help prevent the negative behaviour in the school children.

### 2.6.6 Referral

In some cases, the problem behaviour may be of such severity that it becomes difficult to manage the same by parents, family members or teachers. In such cases it is always advisable to refer the child to a professional counselor or mental health professionals such as clinical psychologists, trained counselors, psychiatrists or psychiatric social worker.

### 2.7 POLICY INITIATIVES AND INTERVENTIONS

India lists education in the concurrent list of the constitution making the State and the Center equally responsible for the education of the child. The central government has been from time to time coming up with policy intervention in education. These initiatives
Specific Issues on Mental Health

though not binding on the States have been adopted by most of them. The national policy of education is meant to help and guide the States in their efforts to make education meaningful, and application oriented in a uniform manner all over India, at the same time giving weight to the language, region and cultural norms existing in the States concerned.

While physical health of children in schools is being given considerable importance and the schools in India do follow the UN charter in regard to the same, mental health of children in schools is rather given low priority. While school going children are given many prophylactic medicines to prevent many illnesses, there is no effort to do the same at mental health level. Presently some efforts are made by the government to appoint psychological counsellors to identify and help children with psychological and psychiatric disorders. NGOs and others join to train teachers regarding identification of children needing special education and how to treat them in classroom so that they gain self confidence and self esteem and finally get also integrated in the mainstream of schooling. But all these efforts are far and few and thus the impact of these measures have not been felt by the schools or parents or the community and society.

Education is not limited to bringing every child to school through Right to Education Act. This perhaps is the beginning of a long association which if carried out effectively has the potential to place India on the world map with young skilled professionals as its greatest resource. This would make India one of the youngest nations with great potential for growth and determining the course of the world. However, such a move also has the potential of going drastically wrong with the creation of ‘educated illiterates’ who have the certificates of being literate but do not have the skill to prove and reap the benefits of this education. The schools admitting a diverse population of students with lateral entry, migrant students, first generation learners, differently abled and very different background, require effort on the part of the school administration and specially the teacher to engage and involve these students in education. These students have a high vulnerability to develop many negative behaviours as the school and the teachers as well as the administration do not handle the diversity differentially and effectively. Therefore special care needs to be taken that the policy initiative does not backfire. This view is reflected in the many clauses included in the RTE Act (2009) which includes the following:

a) Prohibits physical punishment and mental harassment;
b) Prohibits screening procedures for admission of children;
c) Rejects capitation fee;
d) Prohibits private tuition by teachers and
e) Prohibits establishing schools without recognition
f) Provides for development of curriculum in consonance with the values enshrined in the Constitution.

All the above are expected to ensure the all-round development of the child, building on the child’s strengths, his knowledge, potentials, and talent and render the child free of fear, trauma and anxiety through a system of child friendly and child centred learning (http://mhrd.gov.in/rte).

The ‘Rashtriya Madhyamick Shiksha Abhiyan’ (RMSA) also launched in 2009 provides for constituting an Academic committee which will be responsible for all academic activities including planning, management, monitoring, supervision, reporting and
collection of data for Secondary Education Management Information System (SEMIS). The academic committee will be responsible for ensuring quality and equity in education in schools, would try to reduce the barriers of different socio economic strata from which children come, reduce gender differentiation, recognize differential disabilities in children and accordingly make the teaching suited to all groups of children etc. Also they recommend high level of attendance in classes by both teachers and students, training of teachers on a continuing basis, arranging for guidance and counseling to students, recognition to student achievements, instituting in each school co-curricular and extra curricular activities which all will finally contribute to an over all academic and personality development of students and teachers. (Source: (http://schooleducation.uk.gov.in/files/pdf/RMSA.pdf).

The above mentioned initiatives are still in the formative stage and require greater efforts to implement the schemes realistically and translate it into reality.

### Self Assessment Questions 5

1) Describe the features of client centred counseling?

2) Outline the steps in behaviour modification.

3) Why is prevention of school related problems important?

---

### 2.8 LET US SUM UP

The mental health problems in schools are on the rise and the initiatives are too few and far between. The problems associated with schools should not be viewed as trivial and self-correcting because children may develop many undesirable attitudes and behaviours while in school, and if these are left unchecked may eventually become implanted as children’s personality attributes. A mentally unhealthy child means the loss of a potential resource. The experiences of a child in the school should be such that they equip the child with the right attitudes, values and skills that make him/her a mentally healthy person who will effectively contribute to the society.

The state governments, psychologists, counselors alongwith educators and social workers have a great role to play in addressing mental health problems in schools and bringing
in preventive measures to promote the mental health of school children. School is the ideal place for innovative preventive programmes that would offset the negative elements in the school as well as in the teaching-learning processes, and thereby help children grow up into mentally healthy individuals.

2.9 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Mental health of students is important for fostering developmental competencies, successful transition to adulthood, to lead productive and fruitful life, academic achievements, emotional competencies and psychological competencies needed for learning.

Self Assessment Questions 2

1) The types of problems faced by the school children can be categorized as Learning problems and Behavioural problems.

2) SMART stands for S – set a goal; M- make a plan; A- attempt a plan; R- review; T- try.

3) In emotion focused coping, the person focuses on regulating the emotions accompanying the stressor while in the problem focused coping, the focus is on managing the stressor.

Self Assessment Questions 3

1) The parents and teachers should be especially careful not to encourage or reward aggression in any form. Use of positive reinforcement for pro-social behaviour, and time out and loss of privilege for aggressive behaviour helps to control instances of aggression. They should also be role models to the no use of aggressive or violent behaviour.

2) Bullying refers to an unequal power relationship between the victim and the victimiser, and that the episodes are repeated over time.

3) Teacher can take the following steps: to help the bully feel like they belong and are cared for by (i) creating a trusting environment so that both the bully and the victim can confide and talk to authorities about their problems (ii) reinforcing with praise by specifically describing students positive behaviour (iii) encourage and counsel students specially the bullies to reflect and introspect to assess their behaviours and (iv) develop empathy in both the bully and the victim for stopping bullying behaviour and restricting reaction and mental health problems in the victims.

Self Assessment Questions 4

1) Handicapped refers to the restriction or limiting of the normal way of functioning. It refers to a problem or a disadvantage that a person with a disability or an impairment encounters when interacting with the environment. A person with a disability is not considered handicapped unless it results in personal, social, educational or vocational problems.

2) The three feature of a problem behaviour are as follows:
   - Extreme behaviour in either direction
● Chronicity

● Socially and culturally unacceptable

3) The ABC approach refers to Antecedents (what happened before the behaviour), Behaviour (description of the behaviour as it happened), and Consequences (what happened after the behaviour). It is part of functional behavioural assessment.

**Self Assessment Questions 5**

1) Client centred counseling is a non directive approach to counseling. The therapist is non-critical, non-judgemental and non-evaluative. It emphasizes the innate potential of the individual to solve his problems. The therapist is required to extend unconditional positive regard and genuineness in the counselling relationship.

2) The steps in behaviour modification include,
   - Defining the undesirable behaviour in a clear and precise manner
   - Analyzing the significance of the problem, i.e., the function it serves
   - Designing an appropriate behaviour intervention plan
   - Reinforcing the desirable behaviour consistently and clearly to shape behaviour

3) Prevention of the school related problems is important as this will help to nip the problem in the bud, prevent the problem from growing and stopping the negative behaviour from the beginning itself.

**2.10 UNIT END QUESTIONS**

1) Describe the behavioural problems faced by children in school.

2) Take a case from Newspaper or magazine who has shown mental health problems. Analyze the institutional/school factors that might have caused it.

3) Explain the steps in functional behavioural assessment.

4) Describe the preventive measures for mental health problems in schools.

5) Discuss the role of parents and teachers in managing bullying in school.

**2.11 REFERENCES AND SUGGESTED READINGS**


Dollard, Miller et al. (1939). The hypothesis suggests that the failure to obtain a desired or expected goal leads to aggressive behaviour. *Frustration and aggression*, Yale University Press, New Haven, ISBN 0-313-22201-0

http://books.google.co.in/books?hl=en&lr=&id=M47vCHp1mUAC&oi=fnd&pg=PP2&dq=theories+of+aggression&ots=Du6sDT8SwN&sig=Tm7ZpuiGu5gMdMC9r5ITuMQ67w#v=onepage&q=theories%20of%20aggression&f=false


http://mhrd.gov.in/rte


Miller, Barker et al. (1941). *Symposium on the Frustration-Aggression Hypothesis*, *Psychological Review*, No. 48, pp. 337-366


Rigby K. (Eds.), *Bullying in schools. How successful can interventions be?* Cambridge: Cambridge University


UNIT 3 PROBLEMS RELATED TO SEX

Structure
3.0 Introduction
3.1 Objectives
3.2 Sexuality
3.3 Problems Related to Sex and Sexual Dysfunction
  3.3.1 Classification of Sexual Dysfunction
  3.3.2 Epidemiology of Sexual Dysfunction
  3.3.3 Etiology of Sexual Dysfunction
  3.3.4 Common Sexual Problems and Dysfunctions: Clinical Picture
  3.3.5 Sexual Dysfunction: Diagnostic Evaluation
  3.3.6 Management of Sexual Dysfunction
3.4 Gender Identity Disorders (Gender dysphoria)
3.5 Paraphilias
3.6 Homosexuality
3.7 Let Us Sum Up
3.8 Answers to Self-Assessment Questions
3.9 Unit End Questions
3.10 References
3.11 Suggested Readings

3.0 INTRODUCTION

Love and intimacy form the foundation of any relationship. The characteristics of an intimate relationship include an enduring behavioural interdependence, attachment and need fulfillment. Intimate relationships include friendships, dating and marital relationships and spiritual relationships. Intimacy does not necessarily mean sex. Every human interaction offers the possibility of love, “a strong feeling of deep affection”. Love is a total submission of will, the absolute dedication of the entire being to the beloved. Sternberg has described three components of love: intimacy, commitment and passion. Passionate love is marked by a strong sexual longing.

‘Sex’ (as commonly used in English language) refers to male or female based on biological characteristics. However ‘gender’ refers to public lived role as male or female; gender identity refers to the social identity of the individual. Gender identity (usually set before 18 months of age) in a child is irreversibly established before 3 years of age. Psychosexual disorders can be broadly grouped under 3 categories: sexual dysfunctions, gender identity disorders and paraphilias. In this unit, we will be discussing about common problems related to sex and psychosexual disorders.

3.1 OBJECTIVES

After studying this Unit, you will be able to:

- explain the basic concepts of human sexuality;
- describe the problems related to sex and sexual dysfunction;
• discuss the etiology and epidemiology of sexual dysfunction; and
• know the common psychosexual disorders and their management.

3.2 SEXUALITY

Sexuality is a multi-dimensional concept which includes the desire for sex, the sexual act and values, and beliefs about sex. (Kaiser, 1996). It is an important aspect of the personality of an individual and has physical, intellectual, psychological and social dimensions. Sexuality involves the whole experience of a person’s sense of self, ability to form relationships, and feelings about themselves. Sexual desire is an innate urge of animals and humans alike. The pleasures associated can be some of the most delightful joys experienced by the human being. It should not be ignored or become a boring act, just for the purpose of progeny.

**Sexual identity** is the pattern of a person’s biological sexual characteristics. **Gender identity** is a person’s sense of maleness or femaleness. It is firmly established by the age of 2 or 3 years. **Sexual orientation** describes the object of a person’s sexual impulses: heterosexual, homosexual, or bisexual. **Sexual behaviour** includes desires, fantasies, pursuit of partners, autoeroticism, and all the activities engaged to express and gratify sexual needs. Normal sexual behaviour brings pleasure to both partners, involves foreplay and stimulation of the primary sex organs including coitus; it is devoid of inappropriate feelings of guilt or anxiety and is not compulsive. In accordance with a patient centered approach, a sexual problem exists when an individual comes with difficulty in sexual functioning which may be associated with behaviourial, affective or cognitive symptoms.

Sexual functioning and its disorders have been described in significant detail in ancient writings of India like Vatsayana’s ‘Kamasutra’. There have been significant contributions from others like Masters and Johnson. The main theme in Kamasutra appears to be the expression of Indian attitude toward sex as a central and natural component of Indian psyche and life.

Sexuality of an individual is an interplay of varied factors; hence an interdisciplinary approach is required (see Fig 1).
3.3 PROBLEMS RELATED TO SEX AND SEXUAL DYSFUNCTION

Sex is an integral part of human life. Though the Indian society is going through changes in attitude towards sex, sexuality and sexual behaviour, open discussion and communication regarding these in the family is still a taboo. There are many myths and misconceptions related to sex and sexual behaviour that creates problems in sexual relationship. Patriarchal attitude, gender and cultural norms of the traditional Indian society concerning expression and conduct related to sex and sexuality may lead to problems of sexual abuse, incest, sexual harassment and rape. Though the scenario is changing, there are also issues about sexual orientation. There are various disorders also related to sex described as Sexual Dysfunctions in DSM V (2013).

DSM V (Diagnostic and Statistical Manual of Mental Disorders 5th Edition) defines Sexual Dysfunctions as “a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person’s ability to respond sexually or to sexual pleasure.” Sexual dysfunctions have been further subdivided into subtypes depending on the duration and other criteria: subtypes include: Lifelong vs acquired and Generalized vs situational. Further i) partner’s and individual vulnerability factors, ii) relationship factors, iii) psychiatric comorbidity, iv) cultural, and v) general medical factors need also to be considered.

Classically, sexual inadequacy refers to some specific disruption of the ‘sexual response cycle’, as described by Masters and Johnson in 1970. Sexual response cycle encompasses phases of desire / appetite, excitement or arousal – plateau, orgasm and resolution, both in men as well as women.

3.3.1 Classification of Sexual Dysfunction

WHO’s International Classification of Diseases, 10th edition (ICD-10) classifies the sexual dysfunctions as below:

- Lack or loss of sexual drive. (includes frigidity)
- Sexual aversion and lack of sexual enjoyment (sexual anhedonia)
- Failure of genital response (erectile dysfunction or impotence)
- Orgasmic dysfunction (inhibited orgasm, anorgasmia)
- Premature ejaculation
- Non-organic vaginismus
- Non-organic dyspareunia.
- Excessive sexual drive (nymphomania)

The detail classification as mentioned in ICD 10 is given in the box below.

ICD – 10- W.H.O.(World Health Organization) Classification

<table>
<thead>
<tr>
<th>F52: Sexual Dysfunctions, not caused by organic disorder or disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>F52.0 Lack or loss of sexual drive</td>
</tr>
<tr>
<td>F52.1 Sexual aversion and lack of sexual enjoyment</td>
</tr>
</tbody>
</table>
Specific Issues on Mental Health

F52.2 Failure of genital response
F52.3 Orgasmic dysfunction
F52.4 Premature ejaculation
F52.5 Non-organic vaginismus
F52.6 Non-organic dyspareunia
F52.7 Excessive sexual drive
F52.8 Other sexual dysfunctions not caused by organic disorders or disease
F52.9 Unspecified sexual dysfunction, not caused by organic disorder or disease

F64: Gender Identity Disorders
F65: Disorders of Sexual Preference (Includes Paraphilias)
F66: Psychological and behavioural disorders associated with sexual development and orientation
F66.0 Sexual maturation disorder
F66.1 Ego dystonic sexual orientation
F66.2 Sexual relationship disorder
F66.8 Other psycho sexual development disorders
F66.9 Psychosexual development disorders-unspecified

3.3.2 Epidemiology of Sexual Dysfunction

Sexual dysfunctions are quite common but they remain under reported due to various reasons like cultural factors, personal nature of the problem, etc. Further, frequency of reporting and seeking help for sexual problems varies due to i) availability of medical facility ii) inadequate knowledge of individuals, and iii) cultural constraints.

According to the famous sex therapist couple Masters and Johnson, around 50% of all Americans have been reported to have sexual problems sometime during their life. Prevalence increases with age in both sexes; about 40-45% of adult women and 20-30% of adult men have at least one sexual dysfunction. The Committee on Epidemiology/Risk Factors of Sexual Dysfunction in 2004 reported incidence for erectile dysfunction as 25-30/1000 person in a year. Prevalence of erectile dysfunction increases with age going up to 20-40% in 60+ population.

Prevalence rates for ejaculatory dysfunction range from 9% to 31%. Prevalence of low sexual desire in women varies from 17-55%, disorders of arousal and lubrication from 8 to 15% and orgasmic dysfunction is seen in 25% of 18 to 74 year old women.

The prevalence of ED varies with age as mentioned below:

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Erectile Dysfunction (ED) : Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40</td>
<td>1-9%</td>
</tr>
<tr>
<td>40-59</td>
<td>2-9%</td>
</tr>
<tr>
<td>60-69</td>
<td>20-40%</td>
</tr>
<tr>
<td>70+</td>
<td>50-75%</td>
</tr>
</tbody>
</table>
In an Indian clinic based study from Mysore (Rao, 2003), 6% of the males had sought psychiatric help primarily for sexual problems in a tertiary care teaching hospital. Sexual misconceptions constitute a large number of cases presenting with sex related problems in the Indian studies.

### Self Assessment Questions 1

1) Explain the terms “Love”, “Intimacy” and “Sex”.

2) What do you understand by “Human Sexuality”?

3) Discuss epidemiology of erectile disorders.

### 3.3.3 Etiology of Sexual Dysfunction

Human sexual response involves biological, interpersonal social and cultural factors. For the successful completion of the sexual act, the important components include presence of sexual drive (libido), an attractive partner, and an environment free from distraction and anxiety, allowing in turn erection, penile insertion into vagina and coital movements leading to orgasm. Impotence may result if any of these factors is unavailable, e.g., poor libido, unattractive partner or threatening environment. Anxiety, worry, shame, guilt or fear may cause impotence. Ignorance, and a feeling that acts like masturbation and nocturnal emissions make one ‘weak’, also contribute towards impotence. The wife’s unfavourable comments or concern regarding her husband’s virility aggravate the situation.

Diagnosis of sexual dysfunction is not made if the problem is better explained by mental disorder like depression, a psychosocial stressor, substance use or a general medical condition.

### Psychological Causes

**Socio-cultural factors:** Culture and religious values significantly influence sexual attitude of individuals. Sexual abuse, hasty sexual encounters, emotional trauma in childhood or adolescence can have a predominant negative impact on the sexuality of an individual.
**Individual factors:** Performance anxiety may develop due to self-imposed high standards, which is based on a ‘fantasy model’ of what is seen, heard or read in popular fiction, movies, etc. and may be detrimental. Monitoring one’s own sexual expertise, pleasure (spectatoring); myths, particularly concerning semen, masturbation and menstruation have a negative impact.

**Relationship and partner factors:** Anger, being passive or aggressive, choosing inappropriate time for sex, making oneself physically and psychologically repulsive to partner, finding excuses like claiming exhaustion, feigning illnesses, lack of trust and poor communication skills can make a healthy relationship strained.

Common causes of sexual dysfunction are listed as below:

- Relationship and partner factors (poor communication, partner’s sexual problems, marital discord)
- Psychiatric comorbidity and individual factors (anxiety/depression, other psychiatric disorders)
- Poor body image, performance anxiety
- History of sexual or emotional abuse
- Cultural factors (attitude towards sexual activity)
- General medical disorders
- Drugs (antihypertensives, antidepressants, sedatives, antipsychotics etc.)
- Alcohol and psychoactive substance use

Some of the characteristic psychological factors that act as predisposing, precipitating, perpetuating factors in males and females are detailed below in Table 1.

<table>
<thead>
<tr>
<th>Predisposing factors</th>
<th>Precipitating Factors</th>
<th>Maintaining Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Upbringing in a hostile environment</td>
<td>- Unreasonable expectations</td>
<td>- Performance anxiety (males)</td>
</tr>
<tr>
<td>- History of traumatic sexual experience</td>
<td>- Relationship problems/ Infidelity</td>
<td>- Lack of Intimacy</td>
</tr>
<tr>
<td>- Poor knowledge (Sexual function)</td>
<td>- Partner’s sexual dysfunction</td>
<td>- Impaired self-image</td>
</tr>
<tr>
<td>- Traumatic emotional experiences in early age</td>
<td>- Stress, psychiatric disorders (Anxiety/ Depression)</td>
<td>- Sexual myths</td>
</tr>
</tbody>
</table>

**Note:** Some of precipitating factors may later act as maintaining factors.

**Biological Causes**

**General medical disorders:** This includes a broad range of disorders like: Diabetes, hypertension, neurological disorders (spinal cord lesions), malignancies, traumatic cause, endocrine disorders.

**Drugs:** Sexual dysfunction may be caused by drugs used for treatment of other disorders; commonly implicated among these are: antihypertensives, antidepressants, antipsychotics, antiandrogenic drugs (digoxin), benzodiazepines.
3.3.4 Common Sexual Problems and Dysfunctions: Clinical Picture

We will be discussing common psychosexual dysfunctions here including psychogenic impotence, premature ejaculation, vaginismus, inhibited orgasm and dyspareunia. We will also touch upon masturbation and Dhat syndrome (a culture bound syndrome seen commonly in the Indian sub continent).

**Psychogenic impotence or erectile dysfunction**: Impotence refers to persistent or recurrent and partial or complete failure in a male to attain or maintain erection of penis sufficient for vaginal penetration and completion of sexual activity. It can be primary or secondary. In primary impotence, the man has never been able to achieve and maintain penile erection sufficient to perform coitus. In secondary impotence, a man, who was once able to perform coitus, developed impotence later. In selective impotence, the man is able to have coitus with certain women but not with others. For example, a person may be impotent with his wife but not with a prostitute.

**Premature ejaculation**: Premature ejaculation (PME) is characterized by ejaculation occurring with minimal sexual stimulation, or before or shortly after penetration. To make a diagnosis of PME, the complaint should be recurrent and persistent. A man can be termed as having PME, if he cannot control ejaculation for a sufficient length of time during intravaginal containment to satisfy the partner on at least half of the occasions.

PME is almost always functional in origin. It is very common in young men but most acquire control as they gain experience, and may form 35-40% of the patients presenting to psychosexual clinics in India.

Previous contact with prostitutes or premarital sex in situations where discovery would be embarrassing is responsible for the genesis of dysfunction, since in such places sex act has to be done quickly and the patient becomes conditioned to achieve orgasm rapidly. In an ongoing relationship, an adverse comment or a taunting response by the partner is often responsible for maintaining the problem.

**Inhibited Female Orgasm or Anorgasmia**: Inhibited female orgasm is characterized by recurrent and persistent inhibition of the female orgasm, as manifested by the absence of orgasm after a normal sexual excitement phase. This also includes consistent non-orgasmic response to all forms of physical stimulation, such as manual clitoral stimulation by the partner, masturbation and oral genital contact. If a woman is orgasmic in dreams or fantasies alone, she would also be considered primary non-orgasmic.

Non-orgasmic women may be otherwise symptom-free or experience frustration in a variety of ways including pelvic complaints such as lower abdominal pain, itching and vaginal discharge as well as increased tension, irritability and fatigue. Religious orthodoxy, negative psychosocial influence and male impotence are often the causes. Anorgasmia can also be drug induced. Psychotropic drugs are known to cause anorgasmia.

In situational orgasmic dysfunction, a woman has experienced at least one instance of orgasmic expression, regardless of whether it was induced by self or partner manipulation.

In management, the woman is directed to masturbate, sometimes using a vibrator. The shaft of the clitoris is the masturbatory site usually preferred by women, and orgasm depends on adequate clitoral stimulation. Cyproheptadine can reverse drug induced anorgasmia.

**Vaginismus**: Vaginismus is a severe psychophysiological syndrome severely affecting
women’s sexual response adversely, if not totally, and impeding coital function. The musculature investing the perineum and the outer third of the vagina contracts spastically due to a completely involuntary reflex, stimulated by imagined, anticipated or real attempts at vaginal penetration. It is a classical example of psychosomatic illness. A definite diagnosis of vaginismus cannot be established without the specific clinical support that only direct pelvic examination can provide.

Religious orthodoxy, psychological traumas, dyspareunia and homosexual orientation are the aetiological factors which produce vaginismus. Anxiety due to any other sexually related issue can also lead to vaginismus. Treatment consists of sex education, relaxation exercises and use of graded dilators.

**Dyspareunia:** Dyspareunia refers to recurrent and persistent pain occurring before, during, or after intercourse in either men or women. It is much more common in women and is often accompanied by vaginismus. An intact hymen or the bruised remnants of the hymenal ring, episiotomy scars, Bartholin’s glands infection and various forms of vaginitis or cervicitis are the usual causes. Insufficient lubrication and thinning of vaginal mucosa are often responsible in postmenopausal women. Cause should be treated.

**Dhat Syndrome:** Dhat syndrome is a culture bound syndrome of sexual dysfunction. Culture bound syndromes refers to a group of symptom clusters seen in a particular culture. Dhat syndrome is common in the Indian subcontinent. Patients often present with complaints of passage of a whitish discharge with urine, described as ‘Dhat’, believed to be semen by the patient, although there is no objective evidence of such discharge. The word ‘Dhat’ has been derived from the Sanskrit word Dhatu’, meaning the elixir that constitutes the body. Semen is known by the name ‘Viria’ in Hindi in India, derived from a Sanskrit word meaning bravery, power, or strength, or that which generates power and greatness. Charak Samhita, another ancient treatise on Indian medicine, describes a disorder resembling Dhat syndrome by the name ‘Shukrameha’ (spermaturia), in which the patient passes semen resembling urine or urine mixed with semen. In Ayurveda, the Indian system of medicine, loss of semen in any form is considered to lead to depletion of physical and mental energy. This belief is deeply ingrained in the Indian culture and is responsible for the symptoms of Dhat syndrome.

Malhotra & Wig (1975) called dhat a ‘sex neurosis of the Orient’. A typical case presents with multiple somatic complaints along with feelings of physical and mental exhaustion, attributed to the passage of semen in urine. Apart from a whitish discharge with urine there are no other urinary symptoms. Urine examination fails to reveal any abnormality. Dhat syndrome is commonly seen in young males in the Indian subcontinent, especially in those from the lower socioeconomic strata of India and the subcontinent, as a mixture of neurotic features of asthenia, anxiety, depression, phobia and hypochondria in patients, who are usually young and attribute the myriad of symptoms to loss of semen in urine, in nocturnal emission, ‘bad dreams’, semenuria, masturbation or sexual intercourse. As the misplaced fear and ignorance are the core features of this syndrome, treatment primarily involves sex education and counseling.

**Masturbation:** Masturbation is considered a normal activity and part of sexual development in humans. Though religious institutions look down upon it as a sin, scientific evidence is contrary to it. However guilt associated with it is almost universal. It is considered as a method of releasing sexual tension in teenagers and lays the foundation for a healthy sexual life as adults. A number of misconceptions are associated with masturbation leading to guilt over earlier habits.
- It is bad.
- It causes blindness
- It leads to energy depletion.
- It is not a normal part of sexual development.
- People in relationships do not masturbate.
- Masturbation is not natural.

**Sex Addiction:** Sex addiction, as defined by Ewald, refers to engaging in any sexual activity that eventually transcends beyond any normal sexual practices to the point of losing control. There are broad range of sexual behaviours that may control the person’s life; like compulsive masturbation, pornography, ongoing affairs, prostitution and telephone sex to name a few. An addict may spend an excessive amount of time devoted to the arrangement and recoveries of these sexual activities and will have a hard time trying to end the behaviours if they are able to at all.

<table>
<thead>
<tr>
<th>Self Assessment Questions 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Explain the psychological and biological factors associated with sexual dysfunction.</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>2) Discuss briefly about Dhat syndrome.</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>3) Discuss briefly about the misconceptions associated with masturbation.</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
<tr>
<td>...........................................................................................................................................</td>
</tr>
</tbody>
</table>
3.3.5 Sexual Dysfunction: Diagnostic Evaluation

Clinicians and patients both find themselves uncomfortable while working up through the sexual history. Developing rapport followed by a very sensitive history taking is important; the clinician should be empathic and non-judgmental. A physical examination is a must in all the cases. Both recent and past sexual history should be covered.

Patient’s current complaint, sexual practices, fantasies and goals, intimacy issues with partner, relationship problems, history regarding masturbation, sexual orientation and past history of sexual abuse need to be noted. The development of sexual identity from childhood and the effect of family members, other significant individuals and life events on the sexuality of the individual should be discussed. The effect of children, professional commitments and extramarital or premarital relationships if any, on the sexual life of the couple needs discussion. It is necessary to understand relationship difficulties among the couple, whether partner is sympathetic towards the problem, their expectations and motivation for treatment. High risk sexual behaviours should be enquired into.

Differences in socio-economic level, age, gender and culture between the clinician and the patient can be barriers towards adequate history taking. Females are usually reluctant to express their sexual problems, more so in the Indian context. Men with erectile dysfunction may have normal libido and ejaculatory function. Usually, psychogenic impotence begins suddenly, may be situation specific and is accompanied by normal nocturnal and early morning tumescence. Desire disorders and aversion disorders are encountered far more frequently in practice than expected earlier. However, organic erectile dysfunction starts gradually, presents consistently and there would be loss of early morning erections.

Laboratory studies should include blood tests for complete blood count, blood urea, serum creatinine, lipid profile, blood sugar, urine analysis, thyroid function and other endocrinal tests as required. Nocturnal penile tumescence, intracavernous pharmacologic injection using a vasodilating agent like papaverine, phentolamine & prostaglandin E1, Doppler studies may be indicated. In cases of organic causes, the patient should be referred to a urologist.

Differentiating features between psychogenic and organic sexual dysfunctions are given in Table-2. Areas to be covered in history taking of sexual disorders is given in Table-3.

### Table 2: Differentiating features between psychogenic and organic sexual dysfunction*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Organic</th>
<th>Psychogenic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Older (except trauma or surgery)</td>
<td>Younger</td>
</tr>
<tr>
<td>Onset</td>
<td>Gradual</td>
<td>Acute</td>
</tr>
<tr>
<td>Circumstances</td>
<td>Global</td>
<td>Situational</td>
</tr>
<tr>
<td>Symptom Course</td>
<td>Consistent or progressive</td>
<td>Intermittent</td>
</tr>
<tr>
<td>Desire</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Organic risks</td>
<td>Present</td>
<td>Absent, variable</td>
</tr>
<tr>
<td>Partner problem</td>
<td>Secondary</td>
<td>At onset</td>
</tr>
<tr>
<td>Anxiety and fear</td>
<td>Secondary</td>
<td>Primary</td>
</tr>
</tbody>
</table>

Table 3: History taking for sexual disorders

<table>
<thead>
<tr>
<th>Identification</th>
<th>• Includes age, sex, education, profession, address, ethnicity, relationship status, sexual orientation, religion, social class, current stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current sexual functioning</td>
<td>• Type of sexual problem; onset, course, duration, aggravating and relieving factors; generalized or situational; with a particular partner only or multiple partners</td>
</tr>
<tr>
<td></td>
<td>• Details of current sexual functioning—frequency, communication, foreplay</td>
</tr>
<tr>
<td>Past sexual history (from childhood to being an adult):</td>
<td>• Family attitude towards sex; family environment and parental attitudes; obtaining information/misinformation about sex: at what age; masturbation, experiences related to any sexual interaction. Adult sexual activities: premarital and post marriage (frequency, first experience, masturbation, conflict with spouse)</td>
</tr>
<tr>
<td>Other issues</td>
<td>• Sexual abuse, chronic illness, paraphilic disorder, gender identity dysphoria, psychiatric history (anxiety, depression), substance abuse, poor general medical condition</td>
</tr>
</tbody>
</table>

3.3.6 Management of Sexual Dysfunction

Individual psychotherapies were the most common intervention for sexual dysfunction before 1970. The classic psychodynamic theories stressed on the early developmental conflicts as the core issue for sexual dysfunction. Hence resolution of these conflicts would lead to acceptance of sexual impulses to the ego and resolution of the problem. However, in actual practice behavioural techniques and other pharmacological therapies are often required for the management:

Sex therapy (Dual Sex Therapy) ideally includes involvement of both the patient and the partner for satisfactory outcome. Therapy should emphasize that there is no use blaming one’s partner or oneself, that sex is a mutual act between two individuals, and it is not something a man does to a woman or woman to a man. It can be a form of interpersonal communication at a highly intimate level; enhanced social communication benefits the relationship. Educating the couple, improved communication, heightening sensory awareness, and sensate focus exercises are taught to the couple. The assessment and treatment need to be tailored depending upon one’s setting, profession, specialty and most important of all, the type of the problem encountered in the client.

Behavioural techniques

Sexual dysfunction is considered as a maladaptive behaviour by behavioural therapists. Using a hierarchy of anxiety provoking sexual interactions, the client is systematically desensitized.
Annon (1974) proposed a graded intervention popularly called as PLISSIT MODEL wherein the individual letters stand for: P = Permission giving; LI = Limited information; SS = Specific suggestion; IT = Intensive sex therapy.

The therapy involves primarily sensitization, desensitization techniques. The general principles are applicable to majority of the inadequacies encountered in clinical practice. The major guide-lines to be followed are:

i) **Educating the couple/client:** The couple is advised to talk on issues bothering them in a nonjudgmental way, encourage partners to see, hear and understand each others’ perception and teach verbal and non-verbal communication skills, in general and during sexual activity in particular.

ii) **Setting the framework for the therapy:** Inform ground rules of the therapy, dispel negative and sensational images of sex therapy and allow the couple to recognize and take responsibility for much of their treatment. The treatment has to be tailored towards the couple which acts as a marital unit, focusing in particular on the problems associated with the marital unit.

iii) **Proscribe sex:** It is recommended not to indulge in sexual activity till specifically asked so as to take off performance anxiety and pressure.

iv) **Sensate focus exercises:** These are structured exercises, about 3-5 sessions assigned between the visits. Help couple recognize that sexual activity is not limited to sexual intercourse and that ‘Pleasing’ and ‘Receiving Pleasure’ can be enjoyable without being regarded as foreplay or a preliminary to sexual intercourse. The couple may progress slowly from non-demanding pleasure i.e. pleasing to explore one’s own feelings about the experience from non-genital area to breasts and then to penile pleasing. Various stimulation methods are taught and the couple is advised to try different intercourse positions which may not necessarily lead to completion of sexual intercourse. One of these stimulation methods is using fantasies for stimulation, to avoid obsessive concerns termed ‘spectatoring’.

v) **Systematic Sensitization and Desensitization:** ‘Start-Stop Sensitization’ technique used for premature ejaculation is one of the most common and useful techniques under this heading. Here one partner provides manual stimulation to the other and is stopped at a signal from him when orgasm becomes imminent. Repeating this activity for certain duration of time, leads to some degree of control over ejaculation. Further the partners are advised to try intra vaginal containment, usually in female superior position. Partners should increase the rhythmic movements until the man gives the signal to stop. After a pause, they should repeat the act. With repeated attempts, the partners learn how to prolong the pleasure of intercourse while containing the urge to ejaculate. Similar desensitizing and sensitizing techniques are utilized in treating psychogenic erectile and orgasmic dysfunctions in men, and arousal and orgasmic dysfunctions in women. In women, with progressive stimulation of clitoral and other genital areas by partner, arousal is experienced without demand or pressure of intercourse.

**Integrated Sex Therapy**

Usually sex therapy is integrated with other treatment modalities when it is better termed as “Integrated Sex Therapy”. Supportive, psychodynamic (in certain cases), insight orientated psychotherapy and particularly behaviour therapy form part of the sex therapy program and lead to better results.
In “syndyastic sexual therapy” the focus is more on attachment dimension of sexuality. This improves intimacy and bonding in the couple and improves sexual functioning. Thus, the concept of *syndyastic sexual therapy* puts fulfilment of psychosocial fundamental needs into the focus of therapy, which makes it quite different from all other treatment methods.

<table>
<thead>
<tr>
<th>Self Assessment Questions 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Describe history taking in sexual disorders.</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>2) What do you mean by dual sex therapy?</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>3) What does PLISST stand for?</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
</tbody>
</table>

**Pharmacotherapy for sexual dysfunction**

**Pharmacological Mangement**

In recent years, a number of drugs have been introduced for treatment of impotence and premature ejaculation. These drugs improve inflow of blood into the penis and improve erection. These include sildenafil, tadalafil and vardenafil. These drugs are effective irrespective of the etiology of the erectile dysfunction. Patients who have benefited are those who have had erectile dysfunction due to psychogenic causes, spinal cord injury, diabetes mellitus and prostate surgery. Patients also benefit irrespective of age or baseline severity of erectile dysfunction. The magnitude of the benefit however varies. This means it does not produce a magic erection; rather it improves the strength of the erection, the duration of the erection, and the number of occasions on which the erection is satisfactory.

Selective Serotonin Reuptake Inhibitors (SSRIs) and dapoxetine have got efficacy in delaying ejaculation in patients with premature ejaculation.

**Testosterone** is definintively effective only in cases of hypogonadism. It can increase the desire but has no effect on erectile functioning. Female low sex drive and anorgasmia can be tried under careful monitoring. **Hormone Replacement Therapy (HRT)** with estrogen in case of menopausal women as vaginal function, particularly lubrication is determined by them.
In some selected cases when psychotherapy, behaviour techniques and drugs fail or seen to be not very effective, vacuum devices, injections and implants, vibrators are found to be relatively effective. Ultimately, the success of sex therapy depends on a host of factors. Therapy duration ranges from 6 weeks to more than a year in occasional cases. More than half of the cases of erectile dysfunction and almost all the cases of premature ejaculation respond to combination of therapies.

3.4 GENDER IDENTITY DISORDERS (GENDER DYSPHORIA)

The term gender refers to the public lived role as male or female. Gender identity refers to social identity of an individual; an individual’s identification as male, female or some other category.

In DSM-5, the term gender identity disorder has been removed and replaced by gender dysphoria. Gender dysphoria refers to distress that accompanies the incongruence between one’s experienced and expressed gender and one’s assigned gender.

Intersexuality: Develops where there was ambiguity at birth regarding child’s external genitalia. Examples include androgen sensitivity syndrome or congenital adrenal hyperplasia.

Sexual maturation disorder: Here the person suffers from uncertainty about his or her gender identity or sexual orientation which causes anxiety or depression.

Dual role transvestism: The subject wishes to lead a double role, spending part of his time as a male and part as a female.

Transsexualism: is a gender identity disorder characterized by a persistent belief to be of the opposite sex. A male transsexual believes that he will grow up to be woman and lose his genitals. A female transsexual tends to present masculine appearance and behaviour. These individuals are characterized by behaviour of cross dressing before the age of 4 years in 75% of the individuals. No specific factor has been established conclusively. Early upbringing, lack of proper parental identification etc, are the causes. Treatment involves psychotherapy, behaviour modification, family therapy and in some selected cases sexual reassignment surgery.

3.5 PARAPHILIAS (SEXUAL DEVIATIONS OR PERVERSIONS)

The term ‘paraphilia’ is derived from the Greek words “para” which means next to and “philia” meaning love. Paraphilias are characterized by intense and persistent sexual interest in an object (may be inanimate) other than the genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners”.

DSM-5 has further described Paraphilic Disorders as disorders based on,

1) anomalous activity preferences: further subdivided into (i) courtship disorders (voyeuristic disorder, exhibitionistic disorder and frotteuristic disorder) & (ii) algolagnic disorders which involve pain and suffering (sexual masochism disorder and sexual sadism disorder); and

2) anomalous target preferences: (i) towards humans (pedophilic disorder) & (ii) directed elsewhere (fetishistic disorder and transvestic disorder)
Paraphilias are rare and occur mostly in men. They are characterized by recurrent intense sexual urges and sexually arousing fantasies generally involving either non-human objects, suffering or humiliation of oneself or one’s partner or children or other non-consenting persons. For the paraphilic patient, the imagery is persistent, the fantasies evoked are necessary for erotic arousal, for the relief from non-erotic tension and for sexual excitement and orgasm. Many paraphilics feel no distress and show impairment in the capacity for reciprocal affectionate sexual activity. No known genetic or biological factors have been implicated in its etiology. Upbringing, problems in mother-child relationship has been implicated. History of being sexually abused as children is common among these groups.

Other paraphilias include: bestiality or zoophilia, exhibitionism, fetishism, frotteurism, masochism, sadism, pedophilia, transvestism, and voyeurism.

### 3.6 HOMOSEXUALITY

The shift in understanding of homosexuality from being pathological to a normal variant of human sexuality occurred in the late 20th century. It was accepted as a normal variant by American Psychiatric Association in 1973 and by World Health Organization in 1992. Research has demonstrated that people with homosexual orientation do not have any psychological dysfunction and there is a distinction between desire, behaviour and identity; hence acknowledging the multidimensional nature of sexuality. Psychiatry uses terms like homosexuality, heterosexuality, bisexuality and trans-sexuality to encompass all related issues; however sociology argues for lesbian, gay, bisexual and transgender (LGBT), which focuses on identities. Research has led to the understanding that homosexuality is not a single phenomenon and that there may be multiple phenomena within the construct of homosexuality. People with homosexual orientation face conflicts in accepting their homosexual feelings (ego-dystonic homosexual orientation), more so in a hostile social environment.

Treatment of gender identity disorders and paraphilias is difficult and time consuming, often needs professional intervention. The recommended treatments are:

- To decrease deviant sexual arousal
- To develop heterosexual arousal
- To develop skills or social interaction with members of the opposite sex
- To provide training in assertiveness
- To provide training in empathy
- To attain sexual knowledge and
- To treat sexual dysfuction with the marital unit

Gay-affirmative psychotherapies help people cope with same-sex orientation. There is no evidence for the effectiveness of sexual conversion therapies; research data has shown very limited success with aversive therapies for homosexual orientation.
3.7 LET US SUM UP

Human sexuality is a multi-dimensional concept and involves the whole experience of a person’s sense of self. Sexual disorders are often underdiagnosed and undertreated, even when the diagnosis is made. Any of the psychosocial or biological factors may be involved in the etiology of sexual problems. Culture bound syndromes have significant importance particularly in the light of a particular culture; like Dhat Syndrome in the Indian culture. Sexual disorders are underdiagnosed and more-so undertreated, once the diagnosis is made. Recent research in this field has opened new avenues, for the use of novel approaches, in the understanding of sexual disorders.

3.8 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Love is a strong feeling of deep affection. Sternberg has described three components of love: intimacy, commitment and passion. The characteristics of an intimate relationship include an enduring behavioural interdependence, attachment and need fulfillment. Intimate relationships include friendships, dating and marital relationships and spiritual relationships. Intimacy does not necessarily mean sex. Sex as commonly used in English language, refers to male or female based on biological characteristics.

2) Sexuality is a multi-dimensional concept which includes the desire for sex, the sexual act and values, and beliefs about sex. (Kaiser, 1996). It is an important aspect of the personality of an individual and has physical, intellectual, psychological and social dimensions. Sexuality involves the whole experience of a person’s sense of self, ability to form relationships, and feelings about themselves.

3) Prevalence rates for ejaculatory dysfunction range from 9% to 31%.

Self Assessment Questions 2

1) Psychological factors include a) Socio-cultural factors, b) Individual factors, and c) Relationship and partner factors. Biological factors that explain sexual
dysfunction include general medical disorders such as diabetes, hypertension, neurological disorders (spinal cord lesions), malignancies, traumatic cause, endocrine disorders; and drugs.

2) Dhat syndrome is a culture bound syndrome of sexual dysfunction. Dhat syndrome is common in the Indian subcontinent. Patients often present with complaints of passage of a whitish discharge with urine, described as ‘Dhat’, believed to be semen by the patient, although there is no objective evidence of such discharge.

3) Misconceptions regarding masturbation include:
   - it is bad
   - it leads to energy depletion
   - it is not natural
   - it is not a normal part of sexual development

**Self Assessment Questions 3**

1) History taking in sexual disorders includes identification data, current sexual functioning, past sexual history, chronic illness, psychiatric history, substance abuse etc.

2) Dual Sex Therapy ideally includes involvement of both the patient and the partner for satisfactory outcome. The therapy emphasizes that there is no use blaming one’s partner or oneself and sex is a mutual act between two individuals.

3) PLISSIT stand for: P = Permission giving; LI = Limited information; SS = Specific suggestion; IT = Intensive sex therapy.

**Self Assessment Questions 4**

1) The term Gender identity disorder has been removed and replaced by gender dysphoria in DSM -5. It refers to distress that accompanies the incongruence between one’s experienced and expressed gender and one’s assigned gender.

2) Paraphilias are characterized by intense and persistent sexual interest in an object (may be inanimate) other than the genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners.

### 3.9 UNIT END QUESTIONS

1) Discuss the etiology of sexual dysfunction.

2) Describe the management of sexual dysfunction.

3) Explain behaviour therapy for sexual disorders based on the PLISSIT MODEL.

4) Describe homosexuality with particular focus on India.

5) Discuss the interrelationship between stress, intimacy and sexual disorders in the modern society.

### 3.10 REFERENCES

disorders. Published by Indian Psychiatric Society:144-32.


### 3.11 SUGGESTED READINGS


Sathyanarayana Rao TS, Jacob KS. The reversal on gay rights in India. Indian J Psychiatry 2014;56:1-2

UNIT 4  PROBLEMS RELATED TO WORK AREA

Structure

4.0  Introduction

4.1  Objectives

4.2  Definitions
  4.2.1  Mental Illness
  4.2.2  Mental Health
  4.2.3  Mental Health Problems

4.3  The Changing World of Work and Mental Health
  4.3.1  Globalization
  4.3.2  Urbanization and Migration
  4.3.3  Information Technology
  4.3.4  Small and Medium-sized Workplaces

4.4  Understanding Mental Health Problems in the Workplace
  4.4.1  Depressive Disorders
  4.4.2  Substance Abuse
  4.4.3  Anxiety Disorders
  4.4.4  Work Related Stress
  4.4.5  Psychotic Disorders
  4.4.6  Mental Retardation
  4.4.7  Co-morbidity
  4.4.8  Post Traumatic Stress Disorder (PTSD)

4.5  Impact of Mental Health Problems
  4.5.1  Increased Absenteeism
  4.5.2  Decreased Productivity
  4.5.3  Increased Costs
  4.5.4  Indirect Costs
  4.5.5  Employees and their Families
  4.5.6  Stigma
  4.5.7  The Community

4.6  Risk Factors for Mental Health Problems
  4.6.1  Individual Risk Factors
    4.6.1.1  Biological Factors
    4.6.1.2  Psychological Factors
    4.6.1.3  Social Factors
  4.6.2  Organizational Factors

4.7  Vulnerable Populations
  4.7.1  Women
  4.7.2  Children
  4.7.3  People with Disabilities

4.8  Workplace Mental Health Policy
  4.8.1  Step 1 – Analyzing the Mental Health Issues
Mental health problems are the outcome of a complex interaction between biological, psychological, social and environmental factors. People spend a large part of their adult life at work, which satisfies their personal, economic and social needs. However, there is growing evidence today that not only the content of our work but also the context of work can play a role in the development of mental health problems in the workplace. Worldwide data also indicate that mental health problems have a direct impact on workplaces through increased absenteeism, accidents, reduced productivity, and increased costs. They also result in a number of employees eventually dropping out of work.

According to the WHO report (2005), some common mental health problems include depression, anxiety, substance abuse and stress that affect individuals, their families, co-workers, and the broader community. An employee may develop mental illness prior to employment or during employment. While there are employees who can successfully manage their illness without any effect on their work life; some may require workplace support for a brief period of time and a minority will require ongoing workplace strategies.

The workplace is thus, an appropriate environment to educate and raise individuals’ awareness about mental health problems. For example, promoting good mental health practices are useful in early identification of the symptoms of problems, and also help in networking with local mental health services for referral and treatment for the benefit of employees. However, it must be acknowledged that some mental health problems need specific clinical care and monitoring, as well as special considerations for the integration or re-integration of the individual into the workforce (ILO, 2000).

International organizations, such as the European Union (EU), World Health Organization (WHO) and International Labour Organization (ILO) have increasingly emphasized the importance of promoting mental health and well-being at work, and developed countries such as the UK, US and EU member countries are also paying attention to mental health issues at workplaces. However, in India awareness about mental health is still very low among employers and HR managers. While they are conscious about terms such as workplace stress, stress management and burnout, most of them either ignore or are largely unaware of the importance of promoting mental health and the impact of mental health issues at workplace.

In this Unit, we will understand the changes in the workplace and its relationship to mental health problems, describe the various types of problems that may be encountered in the workplace, examine the consequences and costs of mental health problems at
the workplace and explain strategies to prevent and reduce their impact on the employees and on the workplace.

4.1 OBJECTIVES

After studying this Unit, you will be able to:

- examine the relationship of the changing world of work to mental health;
- describe the various mental health problems encountered at the workplace;
- discuss the impact of mental health problems at the workplace;
- explain the various risk factors for mental health problems and describe some vulnerable population in this context; and
- explain the importance of formulating a mental health policy at the workplace, the key steps involved in developing a policy and the critical barriers and solutions in implementing them.

4.2 DEFINITIONS

4.2.1 Mental Illness

Mental illness is a term that refers to a set of medical conditions that affect a person’s thinking, feeling, mood, ability to relate to others and daily functioning. Sometimes referred to as mental disorders, mental health conditions or neuropsychiatric disorders, these conditions affect hundreds of millions of people worldwide (WHO, 2005).

4.2.2 Mental Health

Mental health is more than the absence of a mental disorder (World Health Organization, 2001). It includes concepts such as subjective well-being, perceived self-efficacy, autonomy, competence, and the achievement of one’s intellectual and emotional potential. People who are mentally healthy may occasionally face stress-related symptoms and emotional distress, but these are within the normal range and appropriate to the situation. A person’s mental health is affected by individual factors and experience, social interactions, the environment, and societal and cultural norms and expectations (World Health Organization, 2004b). A key component of an individual’s mental health is the ability to adequately fulfill his or her roles, including capacity to work.

4.2.3 Mental Health Problems

Mental health problems are symptoms associated with a mental disorder, but which are not of sufficient severity to be diagnosed as a mental disorder. For example, stress results in a number of symptoms associated with mental disorders, including distress and feelings of not being able to cope. However, these are not usually of such severity that a mental disorder can be diagnosed. While mental health problems can cause significant suffering for individuals and their family, and have a negative impact on work performance, they do not necessarily lead to the development of a mental disorder (WHO, 2005).

4.3 THE CHANGING WORLD OF WORK AND MENTAL HEALTH

In the last two decades we have all witnessed rapid changes in working conditions in the industrialized countries, related to globalization and modern communication
Specific Issues on Mental Health

technologies. This has led to more competition which has resulted in increasing demands for speed, efficiency, productivity, and meeting tighter deadlines. In countries, such as China, South Korea and India, these changes have been even more swift and dramatic, especially in the big cities. Besides, repeated economic recessions, such as the one that started in 2008, have contributed to further instability and have increased the restructuring of organizations and changes in manufacturing techniques, resulting ultimately in the reduction of personnel. Let us examine in more detail some of these current social and economic conditions that can play a major role in the development of work related mental health problems.

4.3.1 Globalization

Globalization has influenced individuals, families and the society in general. On the one hand, globalization has brought in changes in the workplace that has resulted in increased income of employees, improved working conditions, facilitate access to education and training, thus having a positive effect on the mental health of employees. On the other hand, globalization may also have a negative impact on employment and working conditions. For example, studies indicate that the increase of large multinational companies has resulted in greater decentralization, outsourcing and flexible work environments. This has brought about large variations in the conditions of work and also exposure to occupational hazards (Rantanen, 1999).

Globalization has also resulted in the emergence of new industries, such as the assembly industry in which 90% of employees are women or children, and workplaces are often influenced by unstable jobs, low wages, long working hours, sexual harassment, temporary contracts and subcontracting (Gutierrez, 2000). Although these new industries make valuable contribution to the national economy, their undesirable working conditions are likely to have a negative impact on the mental health of employees and their families.

4.3.2 Urbanization and Migration

The necessity to find work has also resulted in many workers migrating to other countries having stronger employment opportunities or better working conditions. The International Labour Organization (ILO) estimates that there are about 120 million workers living outside their country of origin, representing 3% of the global labour force. Migration also occurs from the rural areas to the urban areas in the same country. People move out of their native place and migrate to the cities in search of greener pastures.

Internal migrants in India constitute a large population: 309 million internal migrants or 30 per cent of the population (Census of India 2001), and by another estimate, 326 million or 28.5 per cent of the population (NSSO 2007–2008). Estimates of short term migrants vary from 15 million (NSSO 2007–2008) to 100 million. Most short-term migrants belong to socioeconomically deprived groups, such as Scheduled Castes or Scheduled Tribes, having negligible educational attainment, limited assets and resource deficits. Out of the total internal migrants, 70.7 per cent are women (Census of India 2001). Marriage is given as the prominent reason for female migration in both the rural and urban areas – 91 per cent of rural female migrants and 61 per cent of the urban female migrants (NSSO 2007–2008). Migration for employment-related reasons is given as the prominent reason for male migration in both rural and urban areas – 29 per cent rural male migrants and 56 per cent of urban male migrants (NSSO 2007–2008). Migrants face denial of basic entitlements including access to subsidized food, housing, drinking water, sanitation and public health facilities, education and banking services and often work in poor conditions devoid of social security and legal protection (www.unicef.org/india/1_Overview_(03-12-2012).pdf).
Thus, while migration can have a positive effect on the mental well-being of an employee, it can also be the source of stress through an increased risk of exposure to poverty and exploitation, difficulties in integrating into a new culture, and the loss of social support networks including the family.

4.3.3 Information Technology

Today, information and communication technology can permit work to be performed in different physical locations creating different challenges for employees. While some may enjoy the freedom associated with working at home, for others it may suggest isolation and loss of social support associated with working alone, causing stress and increased risk of developing a mental health problem. Boundaries between home and work have become blurred at present compromising the conventional separation between work and the private sphere (Kanter, 1977).

4.3.4 Small and Medium-sized Workplaces

Working conditions in small and medium-sized businesses differ considerably. Several such businesses are family-based and often operate outside regulatory frameworks increasing the likelihood of psychosocial risks. Exposure to physical, biological, mechanical and chemical hazards is likely to have consequences for employees’ mental as well as physical health.

Self Assessment Questions 1

1) What do you mean by mental health problems?

2) Name three factors contributing to the development of work related mental health problems.

4.4 UNDERSTANDING MENTAL HEALTH PROBLEMS IN THE WORKPLACE

It may be noted that the term mental disorder is used to refer to clinical syndromes, as classified by ICD-10. However, here, we use the broader term mental health problem (WHO, 2005) to include not only diagnosable clinical syndromes, but also symptoms of emotional distress, which may not be of sufficient severity to warrant a diagnosis of a mental disorder, but nevertheless result in substantial personal suffering and distress and reduce productivity.

Mental health problems can have a disabling effect depending upon the type and severity of the problem, and also other factors such as the availability of social support. Let us
now look at some of the mental disorders and mental health problems that may be found in the workplace.

4.4.1 Depressive Disorders

Depression is one of the most common mental disorders found in the general community and in the workplace. According to WHO (2001), depression is characterized by sadness, fatigue, loss of interest in most activities, and lack of energy. Other features, such as insomnia (or hypersomnia), loss (or gain) of appetite, a tendency to blame oneself, and difficulty concentrating are often present. In its most serious forms, it can lead to suicidal thoughts and eventually to suicide. Depression can be difficult to diagnose and can manifest as physical symptoms such as headache, back pain, stomach problems, or angina.

Depression varies in its severity and the pattern of symptoms. For many, individual symptoms will be of short duration and disappear spontaneously. For others, symptoms persist, with an increasing sense of hopelessness and despair and sometimes suicidal thoughts. With proper treatment, most people recover. The WHO (2005) has estimated that given the current trends, depression will be the second most important cause of disability by the year 2020. In the 15–44 year age bracket, depression is already the second highest cause of morbidity, accounting for 8.3% of the global burden of disease in that age group (World Health Organization, 2001).

**Bipolar affective disorder** is a depressive illness which exists together with episodes of mania, characterized by elated mood, increased activity, overconfidence and poor concentration. It is much less common than depression alone (World Health Organization, 2001), but is associated with significant impairment of work performance and disability.

4.4.2 Substance Abuse

The use of psychoactive substances is a key problem for the workplace. Substances include alcohol, opioids such as heroin, cannabinoids such as marijuana, sedatives and hypnotics, cocaine, other stimulants, hallucinogens, tobacco and volatile solvents. Substance misuse can lead to intoxication, dependence and psychosis (World Health Organization, 2001). The negative effects of inappropriate use of alcohol and drugs include increased absenteeism, decreased productivity, a marked increase in accidents, thefts, and an increased predisposition towards aggressive behaviour, including violence at work and at home.

4.4.3 Anxiety Disorders

While some anxiety is normal, and moderate levels can even improve a person’s performance, people with anxiety disorders have specific and recurring fears that they recognize as irrational, unrealistic and debilitating.

Some examples of common anxiety disorders include panic disorder, agoraphobia (fears of open spaces, leaving home, entering shops, crowds and public places, of traveling in trains, buses or planes), social phobia (fear of eating in public, public speaking, or encounters with the opposite sex), generalized anxiety disorder and obsessive-compulsive disorder. There is growing evidence that the workplace can have an important role in the development of anxiety problems and disorders (Linden and Muschalla, 2007). Severe anxiety can impair a person’s ability to understand new information, plan activities or undertake complex tasks.
4.4.4 Work-related Stress

A regular global trend is the prevalence and severity of stress-related disorders (Cooper et al., 2009). The World Health Organization (2001) identified mental health problems and stress-related disorders as the biggest overall cause of early death in Europe.

Stress is a pattern of emotional (e.g. anxiety, depression), cognitive (e.g. poor concentration), behavioural (e.g. increased alcohol and drugs use) and physical (e.g. increased blood pressure, headaches) reactions to adverse conditions and is characterized by high levels of arousal, distress and feelings of not being able to cope. Stress is not usually classified as a mental disorder, even though it can precipitate both physical and emotional problems (WHO, 2005).

Pressure at work can be positive for employees but it depends on the nature, intensity and length of the pressure, the degree of control of the situation that an individual feels he or she has, the individual’s response, and the existence or absence of protective factors. For example, a worker who is exposed to continued pressure over a long period (excessive workload for a number of months), who feels unable to control the situation (fears losing the job) and has minimal support at work and at home is at risk of the negative consequences of stress.

Exposure to critical incidents such as assaults, sexual or psychological harassment, and accidents is a main source of stress for employees. There is also a rising awareness of the impact of bullying or psychological harassment in the workplace. Psychological harassment include daily humiliations, subtle criticisms, inappropriate remarks concerning a person’s physical or psychological attributes, sexual advances, and inappropriate and unrealistic demands that undermine a person’s dignity. All of these can affect physical and mental health. One consequence of long-term exposure to stress may be burnout. The person feels isolated, intensely fatigued and not achieving anything, accompanied by a sense of loss of control and a sense of failure. It is also often accompanied by physical symptoms such as insomnia, headaches, muscle and joint pains, gastrointestinal symptoms, and lapses in memory.

4.4.5 Psychotic Disorders

Psychotic disorders are associated with marked behavioural problems and abnormal thinking. Schizophrenia is a severe psychotic disorder characterized by distortions in thinking and perception with associated inappropriate emotions. Symptoms can include disturbed behaviour, strong false beliefs (delusions), hallucinations and disturbed thought processes. Typically it commences in late adolescence or early adulthood. The course is variable; for some people it will be chronic or recurrent with residual disability (World Health Organization, 2001).

In India, a comprehensive National-level data on the prevalence of mental disorders is still not available. However, in 2005, the National Commission on Macroeconomics and Health reported that almost 650-700 lakhs people in India (Figure 1) are in need of care for various mental disorders in all age groups and the figure is expected to be 800 lakh by 2015. This estimate excludes a large group of common mental disorders like phobia, anxiety, disassociative disorders, panic states and mild depression and substance abuse. Certain mental illnesses, like unipolar depression is higher among women in 15-44 yrs, while schizophrenia and other mood disorders are found more among men. (Reference: www.who.int/macrohealth/.../Report%20of%20the%20National%20Commission.pdf)
Lack of employment is a major problem for many people with psychotic disorders (World Health Organization, 2001). In the United Kingdom, for example, more than 50% of people with schizophrenia were classed (although not necessarily correctly) as permanently unable to work and only 1 in 8 was employed (Patel & Knapp, 1997). The lack of access to employment can exacerbate a vicious cycle of poverty and worsening mental health.

### 4.4.6 Mental Retardation

Mental retardation is defined in the International Classification of Diseases as “a condition of arrested or incomplete development of the mind characterized by impairment of skills ... which contribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities” (World Health Organization, 1992). The term intellectual difficulties or disabilities is being increasingly used instead of mental retardation. The employment opportunities for people with mental retardation tend to be in low-paid jobs, in small workplaces, where they may be vulnerable to exploitation, with an increased risk of developing other mental health problems.

### 4.4.7 Co-morbidity

Mental and physical health problems are inter-related. For example, people with certain physical disorders, such as hypertension, epilepsy, diabetes, cancer, human immunodeficiency virus (HIV) infection, and tuberculosis, or who have had a myocardial infarction or stroke, have a high prevalence of depression (World Health Organization, 2003a). Such depression not only worsens the individual’s suffering, but also results in lower adherence to medical treatment. There has been growing evidence over the past 20 years of the impact of stress on physical health. For example, acute emotional or physical stress activates the sympathetic nervous system and results in increased heart rate and blood pressure.

Chronic stress may result in long-term circulatory changes. There is also a strong association between chronic pain and mental disorders (Dershet.al, 2002a) and chronic
Different mental health problems themselves often occur together. For example, people with anxiety are frequently also depressed. Similarly, many people with substance use problems also have depression or anxiety.

### 4.4.8 Post-traumatic Stress Disorder (PTSD)

PTSD can occur as an acute disorder soon after a trauma or have a delayed onset in which symptoms occur more than 6 months after the trauma. It can occur at any age. Both natural disasters such as flood, earthquake; and man-made disasters such as war, terrorist attack, rape, assault, imprisonment etc. can lead to PTSD. Post-traumatic stress disorder can lead to personal distress, significant disability and reduced work performance.

#### Self Assessment Questions 2

1) According to the WHO ......................... is estimated to be the second most important cause of disability by the year 2020.
   - (a) anxiety disorder (b) work related stress (c) depression (d) substance abuse

2) The inappropriate use of alcohol and drugs increases predisposition towards:
   - (a) aggressive behaviour (b) fatigue (c) depression (d) insomnia

3) ............................................. is a consequence of long term exposure to stress characterized by feelings of intense fatigue and a sense of isolation and loss of control.
   - (a) post-traumatic stress disorder (PTSD) (b) burnout (c) anxiety disorder (d) psychotic disorder.

4) ............................................. can occur soon after a trauma at any age and can follow a natural disaster or a man made disaster.
   - (a) depression (b) post-traumatic stress disorder (PTSD) (c) chronic stress (d) bi-polar affective disorder

### 4.5 IMPACT OF MENTAL HEALTH PROBLEMS

There is increasing awareness among employers and organizations at the national and international levels that the economic and social costs of mental health problems in the workplace cannot be overlooked. Mental health conditions are the leading cause of DALYs (Disability Adjusted Life Years) worldwide and account for 37% of healthy life years lost from Non-communicable diseases (NCDs). Among these conditions, unipolar depressive disorder, alcohol use disorders and schizophrenia constitute the greatest global burden in terms of disability (WHO, 2011).

Impact of mental health problems on employment and work efficiency needs to be properly understood and managed. Protection and promotion of good mental health in the workplace has long term benefits for the employees, employer as well as the organization. Hence we need to understand this and take concrete steps and make concerted efforts to address the mental health issues at the work place. The workplace can contribute positively to a person’s mental health, may aggravate an existing problem, or may contribute to the development of a mental health problem. Mental health problems, thus have an impact on employers and businesses directly through increased absenteeism, reduced production, increased costs, and reduced profits. They also affect employers indirectly through factors such as reduced morale of staff. Let us examine some of these factors in more detail.
4.5.1 Increased Absenteeism

In many developed countries, 35–45% of absenteeism from work is due to mental health problems (World Health Organization, 2003a). In the United Kingdom, for example, mental health problems are the second most important reason for absence from work, accounting for between 5 and 6 million lost working days annually (Liimatainen & Gabriel, 2000). A study in the United States found that an average of 6 working days per month per 100 workers were lost as a result of mental disorders (Kessler & Frank, 1997).

4.5.2 Decreased Productivity

Even if an employee is not absent from work, mental health problems can cause a significant reduction in productivity. For example, in the United States, the number of “cutback” days (on which less work is done than usual) attributable to a mental disorder averaged 31 per month per 100 workers (Kessler & Frank, 1997). In annual terms, this represents 20 million working days on which employees are not fully productive because of a mental health problem (World Health Organization, 2003a). In a large financial services company in the USA, depression resulted in an average of 44 working days for each employee with depression lost because of short-term disability compared with 42 days for heart disease, 39 days for lower back pain, and 21 days for asthma (Conti & Burton, 1994).

4.5.3 Increased Costs

In the United States, each worker with depression costs his or her employers approximately US$3000. The majority of costs for employers are related to absenteeism and loss of productivity rather than treatment (Harnois & Gabriel, 2000). The Association of Canadian Insurance Companies estimates that 30–50% of disability allowances are paid for mental health problems and that these problems are the leading cause of long-term absence from work. The experience of many employers is that, once an employee has been absent for three months for mental health reasons, it is very likely that the absence will last more than one year (Harnois & Gabriel, 2000).

4.5.4 Indirect Costs

There are numerous indirect costs of mental disorders in the workplace which are difficult to quantify, such as poor work performance, reduced morale, high employee turnover, early retirement and work complaints and litigation.

4.5.5 Employees and their Families

For individuals, mental health problems can lead to a reduced quality of life, as well as having significant economic and social consequences. Absence from work can affect the person’s income, and healthcare costs may result in financial suffering for employees with mental health problems. Many workers, particularly those in low-paid employment or small workplaces, do not have insurance to cover the cost of ill-health or absence from work. They neither have access to health services to treat their mental health problem, nor can they afford to take leave from work required for recovery.

4.5.6 Stigma

Individuals with mental health problems often experience stigma and discrimination (World Health Organization, 2001). The financial and personal burden of having a mental health problem can create a negative vicious cycle, without effective treatment, and thus, may lead to a worsening of the mental health problem. Families also experience
the impact of mental health problems. They may have economic difficulties related to the reduced income and increased health care costs, the stress of coping with altered behaviour, disruption to the household routine, and restricted social activities (World Health Organization, 2001).

### 4.5.7 The Community

The cost of mental health problems to the overall community includes the cost of treatment, especially hospitalization. Other costs to the community include those related to the loss of productivity, loss of lives, consequences of untreated illnesses (for example, increased numbers of people in prison), social exclusion and human rights abuses. Mental health problems in the workplace unfavorably affect the national economy (WHO, 2005).

### 4.6 RISK FACTORS FOR MENTAL HEALTH PROBLEMS

There are several risk factors that increase the likelihood that a mental disorder will develop or that an existing disorder will become worse.

#### 4.6.1 Individual Risk Factors

Mental health problems are the result of a complex interplay between biological, psychological and social factors (World Health Organization, 2001). An understanding of these factors has influenced the development of effective treatments.

##### 4.6.1.1 Biological Factors

Mental health problems are associated with biological factors, such as genetic characteristics and disturbance in neural communications (WHO, 2001).

##### 4.6.1.2 Psychological Factors

Individual psychological factors are associated with the development of mental health problems. For example, children who are separated from their primary caregiver or deprived of nurturing for extended periods of time have a greater risk of developing a mental or behavioural disorder either in childhood or later in life. Similarly, mental or behavioural problems can occur as a result of failing to adapt to a stressful life event.

##### 4.6.1.3 Social Factors

Urbanization, poverty and technological changes are social factors associated with the development of mental health problems. The costs of treatment and lost productivity linked with a mental health problem contribute significantly to poverty, while factors associated with poverty, such as lack of adequate housing and malnutrition also contribute to the development of mental health problems. Social support from colleagues and superiors, joint problem-solving play a significant role in both the perception of stressors and the impact of stress on mental health outcomes (Kortum & Ertel, 2003).

#### 4.6.2 Organizational Risk Factors

There are some significant mental health risk factors in the work situations identified in the following areas of job design and conditions of work (Carson et al., 2007).

1) **Work load and pace**: The critical factor here is the degree of control the worker has over the pace of work, rather than output demand. Machine-paced assembly work may be especially hazardous to mental health.
Specific Issues on Mental Health

2) **Work schedule**: Rotating shifts and night work have been associated with elevated risk for psychological difficulties.

3) **Role stressors**: Role ambiguity (such as uncertainty about who has responsibility for what), which is common in many work environments, has a negative impact on mental health as well as role conflict (incompatible role demands).

4) **Career security factors**: Feelings of insecurity related to issues such as job future or obsolescence, career development, and encouragement of early retirement adversely affect mental health.

5) **Interpersonal relations**: Poor or unsupportive relations among work colleagues significantly increase the risk of unpleasant psychological reactions.

6) **Home-work interface**: Tensions between home and work have consequences for a person’s mental health. For example, conflicting demands of work and home, a lack of support in the workplace for personal commitments, or inadequate support at home for work commitments can increase the risk of developing a mental health problem.

---

**Self Assessment Questions 3**

1) Explain any two impact of mental health problems in the workplace.

.........................................................................................................................
.........................................................................................................................
.........................................................................................................................
.........................................................................................................................

2) What are the social risk factors for mental health problems?

.........................................................................................................................
.........................................................................................................................
.........................................................................................................................
.........................................................................................................................

---

**4.7 VULNERABLE POPULATIONS**

The burden of mental health problems does not equally affect all sections of society. Particular population groups may be at increased risk of developing a mental health problem. At the same time, these groups may experience extra barriers in accessing the required services.

**4.7.1 Women**

Women comprise over 40% of the global labour force, represent 70% of the world’s poor, earn on average two-thirds of the income of men, and spend twice as much time as them on unpaid work (International Labour Organization, undated). In some countries women’s access to education is restricted, which can result in their being employed in hazardous, low-paid jobs. This, in turn, can increase the risk of their developing a mental health problem. Women are also largely responsible for raising children, looking after an elderly parent and managing the household. Attempting to juggle these multiple responsibilities can create stress and contribute to the development of mental health problems. This contributes significantly to absenteeism in the workplace. For example, it has been estimated that, in the United States, one in five employees takes leave of
absence (or even leaves work completely) in order to deal with responsibilities of parents. The aggregate cost of such caregiving, as measured in lost productivity, is estimated at more than US$11 billion a year (Lewis & Cooper, 1999). In India also, with the rising trend of nuclear families, it is the woman who takes the burden of household duties along with their duties at the workplace. Multi-tasking, trying to play the role of a supermom, juggling between the home and work drains out the woman, leaving her vulnerable to mental health problems.

4.7.2 Children

Children represent a substantial proportion of the workforce. There are an estimated 168 million children worldwide in child labour, accounting for almost 11 percent of the child population as a whole. Children in hazardous work that directly endangers their health, safety and moral development make up more than half of all child labourers, numbering 85 million in absolute terms. The largest absolute number of child labourers is found in the Asia and the Pacific region but Sub-Saharan Africa continues to be the region with the highest incidence of child labour with more than one in five children in child labour. Apart from this, a total of 85 million children are involved in hazardous work in the 5-17 years age group and 38 million in hazardous work in the 5-14 years age group (ILO, 2013).

With respect to India, the Census 2001 figures report that there are 1.26 crore working children in India in the age group of 5-14 as compared to the total child population of 25.2 crore. There are approximately 12 lakhs children working in the hazardous occupations/processes which are covered under the Child Labour (Prohibition & Regulation) Act i.e. 18 occupations and 65 processes. However, as per survey conducted by National Sample Survey Organisation (NSSO) in 2004-05, the number of working children is estimated at 90.75 lakh. (http://labour.nic.in/content/division/child-labour.php)

The stresses associated with working under unhealthy conditions may increase a child’s risk of developing a mental health problem, in both short and the long term.

4.7.3 People with Disabilities

People with disabilities, including mental disabilities, are often denied opportunities for meaningful employment, and so remain trapped in a cycle of marginalization, social exclusion and poverty. Unemployment among people who are disabled is far higher than among other individuals of working age, and many disabled people who want to work are unable to do so (International Labour Office, 2002b).

People with mental disorders have the lowest rate of employment of any group with disabilities despite evidence that the majority want to work and could work, if support was provided (WHO, 2005). People with mental disabilities are frequently discouraged because of limited opportunities to obtain work, insufficient incentives for employers to employ people with mental disabilities, financial penalties of employment, stigma and discrimination, such as beliefs that people with mental health problems are not productive (World Health Organization, 2001).

4.8 WORKPLACE MENTAL HEALTH POLICY

In India, mental health is specifically mentioned in the general health policy (WHO Mental Health Atlas, India). India is also working towards framing a mental health policy based on internationally accepted guidelines. The New Mental Health Care Bill, 2013 introduced in Rajya Sabha in August 2013 has fulfilled the gap in the mental health law in the country after India ratified the UN Convention on the Rights of Persons
Specific Issues on Mental Health

with Disabilities that requires harmonization in its laws with those prevalent worldwide. The convention was signed by India on 1 October 2007 and it came into force from 3rd May 2008. While the Union Cabinet in January 2014 approved the amendments in the Mental Health Care Bill with an aim to empower people suffering from mental illness and to protect their rights, the Bill needs to be passed by the Parliament and further assented by the President to replace the Mental Health Act of 1987. The new Mental Health Care Bill marks a complete shift from the existing Mental Health Act 1987 from viewing persons with mental disabilities as persons requiring institutionalization, to persons with autonomy, equal recognition of their rights and full legal capacity (Dhar, 2012)

Workplace mental health is very crucial as it not only affects the productivity but also plays an important role in creating a safe and healthy workplace. Hence there is a need to recognize and promote mental health in the workplace. Both managers and workers have roles to play in building a safe work environment that promotes the mental health of all and provides adequate support to workers with mental illness.

The development and implementation of a workplace mental health policy and program will benefit the health of employees, increase the productivity of the company and will also contribute to the well-being of the community at large. Due to the heavy contributions of the private sector to the economy, employee wellness programs are not only a strategic priority for India but also an economic imperative for organizations (Rajgopal, 2010).

A mental health policy for the workplace helps to define the vision for improving the mental health of the workforce and to establish a model for action. A mental health policy for the workplace can be developed separately, or as part of a broader health and safety policy. Putting the policy in place involves the following steps (WHO, 2005):

Step I: Analyzing the mental health issues
Step II: Developing the policy
Step III: Developing strategies to implement the policy
Step IV: Implementing and evaluating the policy

4.8.1 Step I: Analyzing the Mental Health Issues

A detailed assessment of mental health issues in the workplace, may not be possible until commitment of the management has been secured. In order to garner support from the employer for the development of a policy, its potential cost impact can be demonstrated. In making the business case, for example, general data showing the link between mental ill-health and reduced productivity and increased costs should be presented. A coordinating body, such as a steering committee group, should be established to guide the assessment of the workforce, facilitate consultation with the various stakeholders and coordinate the development of the workplace mental health policy. Involvement of all stakeholders is important in developing the policy. A complete understanding of the issues, includes a detailed assessment of the situation. All available relevant information such as human resources data (e.g. absenteeism records or number of resignations), occupational health and safety data (e.g. accidents or risk assessments), financial data (e.g. the cost of replacing employees who are on long-term disability leave) and health data (e.g. common health problems among the workforce) should be gathered. New information may also be collected based on surveys for example, risk assessments to identify occupational health and safety issues in the work environment, interviews or focus group discussions with key people such as employees, their families, managers, and medical personnel within the organization.
4.8.2 Step II: Developing the Policy

A workplace mental health policy usually entails a vision statement, a statement of the values and principles on which the policy will be based, and a set of objectives. The vision statement presents a general image of the future of mental health in the workplace. It is essential to involve all stakeholders in developing the vision. Values refer to beliefs about what is considered desirable, and principles refer to the standards or rules that guide actions, and emanate from the values. Workplaces have their own values and culture, which should be reflected in a policy. Objectives translate the policy vision into concrete statements of what is to be achieved to improve the mental health of the workforce. They should be specific and attainable within a specified time frame.

4.8.3 Step III: Developing Strategies to Implement the Policy

Strategies are needed to implement the policy. The first task is to review the options for strategies, which can be divided into five main categories

1) increasing employee awareness of mental health issues
2) supporting employees at risk
3) providing treatment for employees with a mental health problem
4) changing the organization of work
5) reintegrating employees with a mental health problem into the workplace.

The specific strategies chosen will depend on the needs of the business and its employees and the resources available. Next, it is important to ensure that sufficient resources are available to implement the strategies. The resources needed might include additional financing (for example, to establish an employee assistance programme) or the redirection of funds that are currently used elsewhere (for example, negotiating with health clinic staff to conduct a mental health awareness campaign). Finally, the plan to implement the policy has to be formulated. The plan should outline the objectives, specific strategies to be used, targets to be achieved and activities to be carried out. The time frame, responsible people, outputs and potential obstacles should be clearly identified.

4.8.4 Step IV: Implementing and Evaluating the Policy

The main actions in implementing and evaluating a mental health policy in the workplace include the following (WHO 2005):

1) Support and collaboration: The mental health policy needs to be disseminated and communicated to all stakeholders to generate support as many policies fail because they are poorly communicated.

2) Careful coordination and monitoring: The implementation process needs to be cautiously coordinated and monitored. The plan should be reviewed and updated as necessary. A process for implementation needs to be established. For example, an individual, a department or a committee might be given responsibility for the implementation of the plan. Regular reporting to the employer, employees, and funders of the policy can be part of the implementation plan.

3) Training: Ensuring that the people who will be leading the implementation process are properly trained is imperative to understand the issues associated with mental health in the workplace. It is also helpful to set up a demonstration project to implement a strategy in one part of the workplace.

4) Evaluation: It is essential to evaluate the effect of the policy and strategies on both individual workers and on the organization. This will also provide support in building an evidence base of effective mental health interventions in the workplace.
### 4.8.5 Barriers and Solutions

Several barriers may be encountered in trying to introduce mental health policies at the workplace. However, a number of solutions can usually be found. Some examples (WHO, 2005) are given below in the Table.

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>BARRIERS</th>
<th>SOLUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>Belief that mental health policy will reduce profits</td>
<td>Provide information to employers on mental health and productivity</td>
</tr>
<tr>
<td>2)</td>
<td>Belief that the workplace is too small</td>
<td>Provide assistance to small workplaces and encourage links between small workplaces and primary health care services</td>
</tr>
<tr>
<td>3)</td>
<td>Resistance from stakeholders</td>
<td>Provide information to stakeholders and use influential people in the workplace to champion mental health and arrange demonstration project.</td>
</tr>
<tr>
<td>4)</td>
<td>Stakeholders do not believe that interventions will be effective</td>
<td>Key opinion leaders, such as medical staff, may be able to convince them of the importance of addressing mental health issues. External experts may also be useful.</td>
</tr>
<tr>
<td>5)</td>
<td>Insufficient resources</td>
<td>Develop low-resource strategies, explore opportunities for redirecting resources from other activities and explore opportunities for external funding</td>
</tr>
<tr>
<td>6)</td>
<td>Fear among employers that focusing on mental health problems will have unforeseeable consequences</td>
<td>Provide relevant information on the impact of mental health issues in the workplace; evidence of effective mental health interventions; show how other businesses have successfully implemented mental health programmes and introduce activities slowly.</td>
</tr>
<tr>
<td>7)</td>
<td>Stigma</td>
<td>Show evidence that challenges the myths of mental illness; invite a speaker who has had experience of a mental illness to speak with staff to educate the workforce.</td>
</tr>
<tr>
<td>8)</td>
<td>Resistance to employ people with mental health problems</td>
<td>Provide information to employers on mental health problems; make sure that employers know about their legal responsibilities; use experiences from other businesses to illustrate positive impact of employing people with mental health problems</td>
</tr>
<tr>
<td>9)</td>
<td>Employees do not attend activities</td>
<td>Involve employees in the planning of activities; ensure that information about the programmes is distributed to employees; ensure that employees are given the time to attend the programme.</td>
</tr>
</tbody>
</table>
**Self Assessment Questions 4**

1) Mention the steps involved in developing a mental health policy as given by the WHO.

2) Write any three barriers in implementing mental health policy at the workplace.

---

**4.9 LET US SUM UP**

In this Unit you learned that workplace is one of the most crucial environments that affect our physical and mental health. Our work life is undergoing substantial and incessant change and several factors linked with globalization have mental health consequences which not only affect individuals but also their families, business and communities. You also learned that employers and managers need to address the mental health needs of their employees by identifying and accepting mental health as a legitimate concern of the organization in the first place. Thus, an understanding of mental health problems as well as the risk elements for mental health problems in the workplace is essential. Companies could benefit by addressing mental wellness at the workplace through a clearly articulated workplace policy on mental health. The development and execution of a workplace mental health policy and programme will benefit the health of the employees as well as the enterprise. However, it is also important to understand the obstacles encountered in implementing such a policy and its solutions. Work organizations also need to be aware of vulnerable populations like women, children and people with disabilities who could be at bigger risk of developing a mental health problem as they experience further barriers in accessing mental health services.

**4.10 ANSWERS TO SELF ASSESSMENT QUESTIONS**

**Self Assessment Questions 1**

1) Mental health problems are symptoms associated with a mental disorder, but which are not of sufficient severity to be diagnosed as a mental disorder.

2) Three factors contributing to the development of work related mental health problems are globalization, migration and information technology.

**Self Assessment Questions 2**

1) (c) depression

2) (a) aggressive behaviour
Specific Issues on Mental Health

3) (b) burnout

4) (b) PTSD

Self Assessment Questions 3

1) Increased absenteeism and decreased productivity are the two impacts of mental health problems in the workplace.

2) The social risk factors for mental health problems are urbanization, poverty and technological change.

Self Assessment Questions 4

1) The steps involved in developing mental health policy as given by WHO are as follows:

   Step I: Analyzing the mental health issues
   Step II: Developing the policy
   Step III: Developing strategies to implement the policy
   Step IV: Implementing and evaluating the policy

2) Three barriers in implementing mental health policy at the workplace are, (a) stigma, (b) insufficient resources, & (c) employees do not attend activities

4.11 UNIT END QUESTIONS

1) Describe how the various changes at the workplace can negatively impact the mental health of the employees.

2) “Mental health problems affect an individual’s functional and working capacity in many ways”. Discuss.

3) Examine the various risk factors for mental health problems.

4) What are the steps involved in putting a mental health policy in place? Identify the barriers encountered in introducing the plan at the workplace.

4.12 REFERENCES


Specific Issues on Mental Health


4.13 SUGGESTED READINGS

About Child labour (http://labour.nic.in/content/division/child-labour.php)


Mental Health Care Bill , 2013 (www.prsindia.org/.../1376983253~~mental%20health%20care%20bill%202013.pdf)

MPC 053
MENTAL HEALTH IN SPECIAL AREAS

BLOCK 1: MENTAL HEALTH IN SPECIAL POPULATION
Unit 1: Child and adolescent mental health
Unit 2: Old age and mental health
Unit 3: Women and mental health
Unit 4: Marriage and mental health

BLOCK 2: SPECIFIC ISSUES ON MENTAL HEALTH
Unit 1: Deliberate self harm and suicide
Unit 2: Problems related to school
Unit 3: Problems related to sex
Unit 4: Problems related to work area

BLOCK 3: DEVELOPMENTAL DISORDERS
Unit 1: Mental Retardation
Unit 2: Specific learning disabilities (Reading, Writing, Maths)
Unit 3: Other learning disabilities (Cerebral palsy, Multiple disabilities)
Unit 4: Assessment and certification
Unit 5: Rehabilitation

BLOCK 4: ADDICTIONS
Unit 1: Alcoholism
Unit 2: Substance abuse and addiction
Unit 3: Tobacco addiction
Unit 4: Gambling, internet and other addictions