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MFT-002 MENTAL HEALTH AND DISORDERS

The Course on “Mental Health and Disorders” is the second Course in the M.Sc. (CFT)/PGDCFT programme of study IGNOU. This Course will orient you towards the mental health, various mental disorders and mental health services provided by the Government of India. We will also discuss the various disabilities in detail. It comprises both theory and supervised practicum components. The theory paper on this is MCFT-002 and supervised practicum MFCTL-002. You have to complete and clear both these components separately. For theory paper MCFT-002, you will have continuous evaluation through an assignment and a term-end examination. For MCFTL-002, you have to work under the supervision of the academic counsellor allotted from the study centre you are attached with. In the end as per the details given in the Supervised Practicum Manual (Bock 5), you have to submit your file to the study centre for evaluation.

The Course also provides comprehensive knowledge on persons with disabilities. This Course provides knowledge and understanding about various mental health disorders, personality disorders, depression etc.

The Course would help you to develop the understanding that is required of counsellor and family therapists to have deeper knowledge about the client’s mental health and disability. The Course consists of four theory Blocks and one Manual for supervised practicum.

THE BLOCKS

Block 1 is on “Introduction to Health and Disorders”. This Block provides you indepth knowledge and understanding about the physical and mental health and disorders. The Block focusses on classification and assessment of mental disorders, nosological systems and positive mental health. The Block emphasizes on dimensions of psycho-social stress and coping styles. We will also discuss the nature and type of chronic physical illness and mental health perspective in chronic physical illness. Further, we will study about the National Mental Health Programmes of Government of India. On studying this Block, you will be able to define physical and mental health, classify and assess various mental disorders and understand the nature and type of chronic physical illness.

Block 2 is titled “Mental Disorder-1”. This Block consist of four units. The Units explain different types of mental disorders, the details include mood disorders, cognitive disorder etc. This Block helps you understand the epidemiology, classification and causes of these mental disorders. This Block also makes you aware of diagnosis and etiology of these mental disorders. The Block further impart knowledge about the substance use disorders. After going through this Block you will be able to understand the characteristics, causes and diagnosis of various mental disorders and substance use disorders.

Block 3 is on “Mental Disorders-II” and it consists of four Units. It continues to talk at length about various types of mental disorders. The Block deals with some other mental disorders, like neurotic disorders, personality disorders, depression, grief and suicide. The Block further discusses the developmental,

behavioural and emotional disorders of childhood and adolescence. The Block emphasizes on classification, causes and epidemiology of these mental disorders. After studying this Block you will be able to understand the cause, classification, epidemiology, assessment and management of mental disorders like neurotic disorders, personality disorders, depression, grief and suicide and developmental, behavioural and emotional disorders of childhood and adolescence.

Block 4 is on “Persons with Disability”. It consists of five Units. The Block orients you towards disability, its possible causes, its precautional and remedial measures. The Block provides detail knowledge on various disabilities like sensory disability, locomotor disability and multiple disabilities etc. The Block also helps you in understanding of mental illness and mental retardation. After going through this Block you will be able to understand various causes, characteristics and rehabilitation for different types of disabilities.

The Supervised Practicum Manual – Block 5

This Block will provide you the framework for hands on experience. The supervised practicum has been planned with the implementation of theory Blocks studied in Course MCFT-002. As a part of practical work you need to carry out case studies of persons suffering with mental disorders by central institutes or special schools. You have to use some structured instruments. The Practical Manual provides you step wise directions for doing the practical activities and recording observation.

Audio and Video Programmes

Various audio and video programmes have been prepared on the different aspects of mental health and disorders in counselling and family therapy. These would be available at your study Centre. It is advisable to keep in touch with the coordinator of your Study Centre so to know about new audio and video programmes. You must go through these audio and video programmes.

HOW WILL THIS COURSE HELP YOU?

The Course will provide you a knowledge about mental health and disorders and help you in understanding the persons with disability. You will be able to identify various types of mental disorders. You can understand the causes, epidemiology and etiology of different types of mental disorders. This Course will also help you in understanding the various causes of disability and the preventive and remedial measures for disability.

BLOCK 1 INTRODUCTION TO HEALTH AND DISORDERS

Introduction

The Block 1 on “Introduction to Health and Disorders” will acquaint you with the knowledge of classification and assessment of mental disorders, understanding the psychological stress and coping. The Block will help you understand about nature and type of chronic physical illness and mental health perspective in chronic physical illness. The Block will also make you aware about the National Mental Health Programme.

Unit 1 entitled “*Notions of Mental Health and Disorders*”, defines mental health and reasons to study mental health. The Unit also describes the various models of mental health. Further, the Unit defines mental disorders and describes various approaches to the classification of mental disorders. The Unit also defines normality and describes the multiple models of normality which focus on different facets of functioning that constitute normality. The later part of Unit deals with positive mental health. It explains various dimensions of positive mental health which include positive psychological functioning and positive social well being. Various models of positive mental health are explained in the end of this Unit. This Unit will help you in understanding the mental health, mental disorders, normality and positive mental health.

Unit 2 is “*Dimensions of Psychological Stress and Coping*”. The focus of this Unit is on stress. The Unit begins with the definition of stress, and its historical aspects. The Unit describes various theories of stress like biomedical perspective, psychological perspective and sociological perspective. The emotional and cognitive models are discussed in detail including the newer models of stress. Stress can be classified in number of ways, the Unit describes the various types of stress which are classified on the bases of nature of stress, on severity of stress, temporal relation of stress response with the stressor and on the duration of stress. Further, the Unit describes the affect of stress on physical and mental health. In the end of this Unit, you will study how to manage stress through various interventions. The Unit will help to understand the stress, its types and various coping styles.

Unit 3 is “*Classification and Assessment of Mental Disorder*”. The Unit has two parts. The former part of the Unit deals with the classification of Mental Disorders which includes the utility of classification and various challenges of classification and diagnosis. History of classification systems and contemporary classificatory systems are also discussed in this Unit. Further, the various categories of mental disorders under ICD-10 are explained including the other aspects of classifications. The later part of the Unit deals with the assessment of mental disorders. In this part the requirement of assessment is emphasized. The steps to carry out assessment are also discussed in detail. The Unit will help you in attaining the knowledge regarding classification and assessment of mental disorders.

Unit 4 is on “*Nature and Type of Chronic Physical Illnesses*”. The association between chronic physical illness and mental illness is described in the beginning

of this Unit. The middle part of the Unit deals with some common and major chronic physical illnesses as along with the psychiatric disorders associated with these diseases such as heart diseases, renal diseases, endocrine and metabolic disorders, oncological disorders and skin diseases etc. The later part of this Unit deals with the psychosocial treatment which includes psychotherapy and behavioural techniques. The Unit will help you in studying the nature and type of chronic physical illness.

Unit 5 is on “Mental Health Perspective in Chronic Physical Illness”. The Unit begins with the definition and understanding of chronic physical illness. The Unit explains the psychological response to illness, it also includes the discussion on subjective variables that can influence an individual’s response to a given illness like personality type, coping styles and defense mechanism. The middle part of Unit deals with the psychosocial adaptation to chronic illness, which include the understanding of basic concepts of psychosocial adaptation. Emotional responses to illness like anger, anxiety and fear, sadness, guilt and shame are discussed and further adaptive and maladaptive behavioural response are also described. The later part of the Unit explains the consequences of chronic illness like stigma, disability, social isolation, family burden etc. The role of care givers is also mentioned in the end of this Unit. After studying this Unit you will be able to understand chronic physical illness through mental health perspective.

Unit 6 is on “National Mental Health Programme”. The Unit begins with the discussion on various types of mental disorders. Further, the Unit explains the National Mental Health Programme (NMHP) which includes its main strategies during the tenth five years plan and status of NMHP at the end of Tenth Five Year Plan. The Unit also makes you aware about the National Mental Health Programme during Eleventh Five Years Plan, it includes understanding District of Mental Health Programme (DMHP) and various associated activities such as mental health services, training and IEC activities. Manpower development schemes in mental health are discussed in the end of this Unit. This Unit will help you to understand to the objectives and status of National Mental Health Programme during the Tenth and the Eleventh five years plans.

UNIT 1 NOTIONS OF MENTAL HEALTH AND DISORDERS

Structure

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- 1.2 Mental Health
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 - 1.2.2 Why Study Mental Health?
 - 1.2.3 Models of Mental Health
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1.1 INTRODUCTION

The World Health Organization (WHO) has defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. This comprehensive definition puts together the different attributes of health for us and makes it clear that the concept of health extends beyond the popularly held notion of health being restricted to physical well being. We can see that this definition of health includes other aspects as well, mental health being one of them.

Mental health deals with one’s psychological and emotional well being. The ability of an individual to lead an independent life, maintain satisfying relationships, to handle usual day-to-day life stress, find a way out of usual difficult situations while having a sense of competence, are all indicators of good mental health. The current Unit focuses on this aspect.

Objectives

After studying this Unit, you will be able to:

- Define mental health and describe concept of mental health;
- Explain the attributes of mental health;
- Describe models and concepts of mental health; and
- Describe concept of normality and positive mental health.

1.2 MENTAL HEALTH

In this section, we will define mental health and its importance in one's life. We will study, why it is important to study mental health. Further, we will discuss various models of mental health.

1.2.1 Definition of Mental Health

As described earlier, mental health refers to an individual's emotional and psychological well-being. It can be defined as "a state of emotional and psychological well-being in which an individual is able to use her or his cognitive and emotional capabilities to function in society and meet the ordinary demands of everyday life". It can also be defined as a state of successful performance of mental functions, in terms of thought, mood and behaviour. This state, in turn, results in productive activities, fulfilling relationships with others, the ability to adapt, to change and to cope with adversity.

However, one must not equate mental health with mere absence of mental abnormality. A comprehensive conceptualisation of mental health would mean a state of well-being in which the individual:

- a) realises her or his own abilities,
- b) can cope with the normal stresses of life,
- c) can work productively and fruitfully, and
- d) is able to make a contribution to the community.

Mental health deals with different aspects of our lives including:

- a) How we feel about ourselves?
- b) How we feel about others?
- c) How we are able to meet the demands of life?

Put in other words, it implies the capacity of an individual to form harmonious relations with others, and to participate in, or contribute constructively to, changes in her or his physical and social environment. Moreover, it is not a static entity; rather it is dynamic and subject to variations and fluctuations. In its positive sense, mental health is the foundation for well-being and effective functioning for an individual and for a community.

Check Your Progress Exercise 1

- Note:** a) Read the following question carefully and answer in the space provided below.
b) Check your answer with that provided at the end of this Unit.

1) What is mental health?

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1.2.2 Why Study Mental Health?

There is no health without mental health. General well-being has been defined as a balanced nourishment of the mind, body and spirit. However, the focus of attention over the years has been the *loss of health state* rather than *the state of health* itself. As a result, the efforts have primarily been aimed at conditions representing the loss of health state (that is, the disease state) and the study of health state *per se* has taken the back seat. An example of such approach can be found out in the popularly held notion that acknowledges the need to remove the obvious distress and dysfunction associated with mental disorders. While this notion is not wrong in itself, it becomes counterproductive beyond a point since, it targets the resolution of this distress and dysfunction as the final goal. One can understand such an approach emerging from the assumption that mental health could be ensured by ensuring the absence of mental disorders. Over the years, especially the last few decades, this assumption has increasingly been challenged.

It has been proposed that mental disorders and mental health are two interrelated but independent constructs that should be measured independently. Thus, rather than being used interchangeably or one subsuming the other, the two constructs require equal attention.

To understand the issue, we can use the example of a student taking a written entrance examination to appear for an interview. To qualify for the interview, one needs to score beyond a cut-off point in the written examination. Thus, a score above the cut-off point or, in other words, absence of a score below the cut-off point would mean that the student has qualified in the written examination and is eligible for the interview. However, it would in no way ensure she or he gets the top rank. To get the top rank the effort has to be aimed at more than merely ensuring the *absence* of a score below the cut-off point. Similarly, the absence of mental abnormality or subnormality would only ensure that the individual is not diseased. In order to ensure the optimum state of health one would require presence of certain additional attributes. So, we can conclude that while absence of mental disorder is a prerequisite to the state of mental well being, a mere absence of mental disorders does not ensure optimum functioning of an individual.

In fact, it has been found that many individuals otherwise free of mental disorder do not feel healthy or function well. Up to 50% of the mental health service

receivers in United States are free from a diagnosable mental disorder. This has to be seen in the light of findings that relatively few adults who are free of any of the mental disorders could be classified as completely mentally healthy. Research has shown us that measures of subjective well-being are related to those of common mental illnesses. Yet the two are governed by certain distinct factors. This parallel but independent relation of the mental disorder and mental health states is reflected in the findings from the upcoming studies which have linked certain physical conditions to the complete mental health states. These findings are significant as they are adding new light to previously held understanding that linked these physical states with the diagnosable mental disorders. Thus, it becomes essential to understand in mental health.

Check Your Progress Exercise 2

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) Why is there a need to study mental health?

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1.2.3 Models of Mental Health

Efforts have been made to explain the concept of mental health in different ways. These models of defining mental health have been directed by the ongoing understanding of the issue and outlook of the individuals attempting to define it. To get a holistic picture one needs to have a basic knowledge of these diverse models. These models of conceptualisation of this issue are being given here for a better understanding of the evolution of this concept.

1) The Biological Model: Mental Health as a Biological Entity

The concept of health, especially the physical health, has been successfully defined in terms of its biological determinants and attributes. It has been a practice over the years to find the underlying basis of the health and thereby a lack of it (diseases/ disorder) in terms of physical factors within the body or the environment. The classical aetiopathogenesis model of the triad of *'the host, the agent and the environment'* is an example of the same. According to this model, a disease causing agent (like a virus) residing in conducive environment (cold and damp conditions) that helps in its survival and spread, on reaching an appropriate host (like a child with reduced immunity) induces the disease. This model has been able to explain almost all the disorders of the body and thus has helped to explore the attributes of health as well.

Attempts have been made to explain the mental health in terms of these and related physical attributes. This model puts the emphasis on the ongoing

physical process within the brain as the governing factor. The human emotions, behaviour and affect that are observable are the outer manifestations of the underlying primary process. While it seems to be a possible and plausible explanation, it has certain shortcomings. The underlying structural, physiological and biochemical basis of most of the mental and behavioural disorders have not been identified and defined yet. Although with ongoing refinement in the investigative techniques these biological underpinnings are being revealed, but it seems unlikely that the complete human behaviour and psychology could be decoded to a set of genes or group of chemicals. Thus, while the biological model is likely to provide a significant contribution to the understanding of the mental health it is unlikely to suffice on its own in this regard.

2) **Mental Health as an Ecological Balance**

From an ecological perspective, we can see one's health as a dynamic function of one's heredity and the current and accumulated effects of one's material and non-material environment. This is what has been described as a type of ecological balance that the mental health provides an individual to cope with the surroundings. As per this model, health and disease are representatives of a state of dynamic equilibrium. While disease means a dominance of negative or unfavourable adaptation of the individual to the environment, health represents a dominance of positive adaptations. Thus, we can conclude that an individual who realises her or his own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community is in a state of positive adaptation and consequently a state of positive mental health. On the other hand, inability to have such an adaptation leads to a loss of mental health state due to the negative adaptation to the surrounding environment.

3) **Mental Health as Capacity to Adjust to Cultural Norms**

Being a social animal, we lead our lives in company of fellow beings and thus need to make necessary adjustments. We are entrusted with different responsibilities and are expected to perform specific roles which help the smooth functioning of the system. This system works at different levels like family, local community, work place, etc. Thus mental health could be seen as one's ability to conform to these roles. By this notion, mental health could be seen as one's ability to have a family, hold a job, conform to local regulations and rules and to derive pleasure out of opportunities that are present. The main limitation of this model is the variable-acceptable norms, across the cultures that would make the definition of mental health very heterogeneous.

4) **Mental Health Defined in Terms of a Theory of Mental Functioning**

This particular model of mental health is based on the underlying theory that governs the understanding of the concept of mental functioning. Multiple attempts have been made to define mental health in terms of different theoretical constructs like that of '*unity of personality*', '*maturity*', '*optimal development*' among others. Thus, someone interested in the area of personality related issues would see the mental health as a function of attributes of personality, while someone else interested in the developmental theories would define the mental health in light of these theories of

development. So, we can make out the main limitation of this approach which is the restricted sense in which it tends to define mental health. It bases the whole construct on a single or at best a few factors and tends to ignore the other equally important ones.

5) **Mental Health as a Subjective State**

It has been suggested that the individuals' feeling state is one of the prime indicators of her or his state of being. While an individual with feelings of happiness, comfort and satisfaction is likely to be healthy and functioning well, a loss of these would bring her or him to treatment or help seeking thus marking the disruption of the healthy state. This sense of subjective well being could be defined in terms of different components:

- i) Life satisfaction,
- ii) Satisfaction with important domains (for example, work satisfaction),
- iii) Positive affect, and
- iv) Low levels of negative affect.

Along with being simplistic this concept relies heavily on a subjective judgment of states of feeling and experiencing.

6) **Mental Health as Social-Emotional Intelligence**

Success of an individual in life is not necessarily proportional to her or his intelligence quotient (IQ). Studies have found those with average IQ scores but higher *Emotional Quotient* (EQ) tend to succeed more than the contemporaries with a higher IQ but lower EQ. EQ is a measure of emotional intelligence which has been defined as the subset of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions. Thus, accurate conscious perception and monitoring of one's own and others' emotions and modification of one's emotions for an appropriate expression could be the driving force behind mental health.

7) **Mental Health as Resilience**

We all are faced with stresses of different types and nature. These emerge from the demands put on us as a result of our interaction with our environment including the fellow beings. The deviance from the mental health that is the mental illness could be seen as states of response to the stressful situations faced by the individual. Thus, the loss of the health state and the emergence of the pathological state would depend on the individual's resources to cope with the stress and her or his use of such resources. The mental health thus could be seen as a function of the individual's resilience. The general explanation for the phenomenon of resilience is that the immediate environment does not fully determine the properties of the organism; that is, that the organism is, at least in part, self-determined or self-organised which, in turn, requires compensatory interactions between parts of the organism and between it and its environment.

8) **Two-Dimensional Model of Mental Health**

The two dimensional model of mental health is based on the constructs of *Personal Wellbeing* (PW) and *Social Adaptation* (SA). Dimension of

Personal Wellbeing relates to the experiences, feelings and emotions of people, along a continuum of satisfaction *versus* dissatisfaction and discomfort. Dimension of Social Adaptation, or adjustment, relates to external and manifest behaviour, that is, to ways in which a person adapts to reality, especially to social reality, and also to the extent to which her or his behaviour is functional in interpersonal context. As per this approach, someone would be considered to be in state of mental health if she or he is able to attain life satisfaction, positive affect, sense of comfort with oneself as well as a satisfaction with important social domains, for example, work satisfaction. A disturbance with either the subjective state or the social maladjustment would disrupt this state of mental well being.

9) The Hybrid Model: Mental Health Defined by Multiple Criteria

The idea of use of multiple criteria to describe mental health stemmed from the observation that it was required to refine the existing views on the concept of mental health since none of them on its own was sufficient to describe it in totality. This led to the acceptance of use of multiple concepts which albeit using different approaches strived for the common goal — that of describing the mental health. Although interesting, this model has an inherent limitation of mixing the technical and the non-technical attributes in such an effort. While such an approach would attempt at inclusion of multiple individual models like *the biological model* (signifying the role of physical factors), *the ecological model* (signifying the role of adaptation to the environment), *the resilience model* (signifying the role of adjustment to stress), it might lead to an understandable overlap. Such a condition might be difficult to resolve based on the less than complete understanding on these individual models. Thus, one might put forth the contribution of the neuro-chemicals, the life stressors and the personality attributes in order to define the construct of mental health, it would be difficult to ascertain the role of each of these individual factors.

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) Enumerate different models of mental health.

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1.3 MENTAL DISORDERS

The understanding of the concept of health is unlikely to be complete without the overview of the related states of disease or disorder. This not only introduces a newer concept but also helps to understand the concept of health better. The traditional approach of defining disorder as a deviation from the health state makes it essential to appraise oneself with this rather extensively studied concept. The term *disorder* represents the conjunction of a syndrome with a clinical course.

1.3.1 Defining Mental Disorders

Mental disorder is a commonly used term in the field of mental health. The safest understanding of this term would be as a term used to define something that is dysfunctional or unhealthy. The word *safest* has been used here to highlight that different meanings are ascribed to the term *mental disorder*. This lack of uniformity results from the lack of definitive etiological understanding of mental disorders. Simply speaking, mental disorders could be seen as disorders of the *conation* (action), *cognition* (thought) or *affect* (feelings). Before we proceed to the definition of mental disorders we do need to keep in mind that no single definition adequately specifies precise boundaries for the concept of mental disorder.

As per the *Diagnostic and Statistical Manual (DSM)-IV* (a diagnostic system developed in USA and used in different countries), mental disorder is a psychological or behavioural pattern that is associated with present distress (that is, a painful symptom) or disability (that is, an impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom. It must currently be considered a manifestation of a behavioural, psychological or biological dysfunction in the individual.

To better understand this seemingly comprehensive definition we can cite the example of an individual who is experiencing a set of clinical features including the depressed mood, ideas of helplessness, decreased appetite and fragmented sleep leading to absenteeism from job. From our personal experiences we can tell that the fluctuations of mood, sleep and appetite have been experienced by all of us at least at some point in time. Moreover, we all feel dejected when we don't get something we want, we all feel frustrated when things don't go our way. So does that mean we all are having a disorder of depression? If we go back to the case of this gentleman in the above example and see it in light of the definition of the mental disorder we would be in a better position to answer this query.

The definition of mental disorder requires the presence of *clinically significant behavioural or psychological syndrome or pattern*. Thus, one needs to have behavioural and psychological syndrome which is characterised by the depressed mood, disturbance of sleep and appetite and altered thought process in the example given above. By the phrase *clinically significant* is meant that the severity and the nature of the features should be of clinical relevance that is requiring clinical attention. So, one needs to ascertain whether the clinical features meet this threshold or not. This would require further elicitation of information from the individual. Although this would be an essential requirement but it would not be

sufficient on its own to diagnose him with depressive disorder. It would require the presence of *association with distress* (that is, feeling depressed in this case) or *disability* (that is, an impairment in functioning at work or social life) or *with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom* (like inability to function as per will or a risk of attempting suicide). If all these conditions are met for a stipulated minimum duration of time (or lesser if of sufficient severity) the individual would be diagnosed as suffering from depressive disorder.

Thus, one needs to distinguish the usual day to day responses and fluctuations from presence of these features at morbid level to give a label to the condition as mental disorder.

Mental disorder has also been defined as an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain. This definition, based primarily on the functioning or lack of it, removes the notion of mental illness as the reason for intervention. It dispenses with the concept of ‘diagnosis’ in this context and offers a broader context to include any deviant behaviour.

However, the syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event. Moreover, the conflict between the individual and the society also does not qualify for a mental disorder. Thus an individual holding religious beliefs or political opinions that are not in keeping with the larger section of the society does not make her or him mentally ill.

1.3.2 Classification of Mental Disorders

Nosology is the study of classification of (mental) disorders. There is a need for classification of psychiatric disorders in order to:

- i) enable communication regarding the diagnosis,
- ii) enhance comprehension of the case,
- iii) help predict the course and prognosis; and
- iv) to facilitate the research.

There can be multiple approaches to the classification of mental disorders:

1) Categorical and Dimensional Systems

The mental disorders can be classified based on two premises. The categorical approach defines a set of criteria and someone having more than a minimum threshold of these criteria for more than a minimum duration of time is given the particular diagnosis. Thus the individual is either having a diagnosis or not. This approach is based on the notion that those with mental disorders are qualitatively different from those without them. On the other hand, the dimensional approach distinguishes the individuals in terms of quantitative variation across a set of factors or dimensions. It is not a mere presence or absence of a feature or trait rather how much it is present or not present that distinguishes a mentally ill from a mentally healthy individual.

2) Classificatory and Typological Approach

As described earlier, categories are defined by a small number of individually necessary and jointly sufficient criteria. Thus, the boundaries are well defined

which makes the individuals within such a category homogeneous with respect to the defining characteristics of that category. The typological approach does not require the presence of all characteristics of the category as essential. Rather the cases are assigned to categories if they sufficiently resemble a typical member of the category.

1.3.3 The Nosological Systems

Different classificatory systems are being used worldwide for the classification of mental and behavioural disorders. Two most extensively used such systems are the Diagnostic and Statistical Manual (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD). The most recent versions of these systems are the DSM-IV TR and ICD-10. These systems use the classificatory approach based on categories.

1) Diagnostic and Statistical Manual-IV TR (DSM-IV TR)

Diagnostic and Statistical Manual-IV TR (DSM-IV TR) defines the diagnostic criteria for each of the mental disorders. The definitions of the disorders usually consist of descriptions of the clinical features. These criteria include a list of features and how many must be present for the diagnosis to be made. DSM-IV TR is primarily an atheoretical classificatory system with regard to causes. It is a multi-axial system that comprises five axes. Axis I and Axis II comprise the entire classification of mental disorders. Axis III lists any physical disorder or general medical condition that is present. Axis IV is used to code psychosocial and environmental problems that contribute significantly to the development or the exacerbation of the current disorder and Axis V is the Global Assessment of Functioning (GAF) Scale.

2) International Statistical Classification of Diseases and Related Health Problems (ICD 10)

Chapter V (coded as F) of ICD-10 lists the mental and behavioural disorders. ICD-10 uses an alphanumeric code composed of a letter followed by several digits. The first digit of the Chapter V diagnostic codes denotes 10 major classes of mental and behavioural disorders: F0 through F9. The multi-axial presentation of ICD-10 is composed of three axes: Axis I comprising of the clinical diagnoses; Axis II comprising of the disablement and Axis III describing the contextual factors. There are also Diagnostic Criteria for Research (DCR) and Primary Health Version of ICD as well.

Check Your Progress Exercise 4

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) What is meant by mental disorder?

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1.4 NORMALITY

While attempting to define the concepts of health and disorder it becomes imperative to understand what is meant by normality. In this section of the Unit we would learn about the concept of normality.

1.4.1 Definition of Normality

Normality has been defined as patterns of behaviour or personality traits that are typical or that conform to some standard of proper and acceptable ways of behaving and being. However, this approach has been criticised because of the value judgment that is inherent to it. It needs a set of well defined criteria that lay out what is *proper* and *acceptable* way of behaving. Not only is it likely to vary with the culture but within the same culture there are likely to be deviations to the well defined and acceptable norm. An individual would be seen as *auto-normal* or *hetero-normal* depending on her or his *conformity* to the concept of normality as set by her or his own or another society, respectively. Similarly, a person would be seen as *auto-pathological* or *hetero-pathological* subject to her or his *non-conformity* to the concept of normality as set by her or his own or another society, respectively. This could be better understood using the example of mourning. There is a wide variation in the culturally acceptable ways of going through grief following loss of a life. While some cultures subsume the open societal expression of the mourning as normal, others might see it as a rather personal event. Thus, if an individual expresses her or his grief in one of the permissive cultures, she or he would be considered normal or usual (*auto-normal*) by that particular culture. However, such an expression would be considered as abnormal by the other culture (*hetero-pathological*). Similarly, an absence of such an expression by the individual would be treated as abnormal by the permissive culture (*auto-pathological*) while it would become normal for the other culture (*hetero-normal*).

1.4.2 Models of Normality

Different attempts have been made to conceptualise normality. This has given rise to multiple models which focus on different facets of functioning that constitute normality.

- 1) **Normality as health:** Disease state has traditionally been seen as a deviation from the normal. Thus, when one is diseased it means that one has lost the usual state of being normal. In this sense health has been equated with normality. It is thus assumed that being free from any disease or disorder by itself makes one healthy and thus normal.
- 2) **Normality as average:** According to this model, the conformity of an individual with the middle ranges of distribution of an attribute makes her or him normal. Those lying at the extremities of this range are likely to be abnormal. Thus individual is seen in context of the whole group rather than in terms of her or his individual potential. Based on this model, normality and abnormality could be represented as the often used bell shaped curve. The majority that is those confined to the central zones would represent the normality, while those falling on the either extremes would be considered as abnormal.

- 3) **Normality as utopia:** While the previous concepts define normality as either absence of certain state (disease state) or conforming to the average, the utopian model sees it as a state of optimal functioning. Thus a mere absence of disease state does not reflect the usual or the normal, rather it is the achievement of highest level of harmonious intra-individual and inter-individual interactions that constitute normality. This ensures that the individual contributes and functions at her or his optimum level.
- 4) **Normality as a process:** Rather than defining normality as a state, this model conceptualises it as an ongoing process governed by the interaction of multiple factors. This reflects the importance of the temporal changes as well as the ever changing dynamic nature of normality.

Check Your Progress Exercise 5

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) What are the different models of normality?

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1.5 POSITIVE MENTAL HEALTH

Health is not merely the absence of disorder and thus is characterised positively in some way or other.

1.5.1 From Health to Positive Health

Mental health is conceived of as a complete state in which not only individuals are free of psychopathology but, also, they are flourishing with high levels of emotional, psychological and social well-being. Mental health and mental disorders don't merely lie at the two opposite ends of a continuum. This gives rise to the positive notion about health which goes beyond the absence of disorder to define the health. The positive health has been described in terms of concept of adaptive functioning, that is one's abilities to reach goals. Thus individuals might have a complete or incomplete mental health. These individuals have been described as those *flourishing* and *languishing* in life, respectively. This would mean that one might be free from all types of mental disorders and yet be having less than adequate or optimum mental health. Thus, an individual who is free from all the diagnosable mental disorders might not still be at the best possible level of psychological functioning. An interpersonal conflict, worries due to some social obligations, less than complete satisfaction with life can all bring her or his psychological well being lower than the optimum level. Complete mental health is more functional and adaptive than moderate mental health. The positive health not only contributes to the effective functioning of multiple bodily systems

when an individual is disease free it also helps him or her to keep free from succumbing to disease and promotes recovery when disease strikes.

1.5.2 The Usual or the Average is Not Necessarily Normal

A commonly made mistake is that of equating the usual or the average with normal. Thus, a phenomenon or attribute is considered normal merely because it is the usually observed variant of it. The same holds true in context of health as well. However, this approach is flawed as the usual or the average might not be the healthiest. For example, those lying on the upper crest of a blood pressure distribution in a population are unlikely to be having their blood pressure in the healthy range. It would be individuals closer to the foot end of the plot that would be having their blood pressure closer to the healthy range. The same would hold true for other health parameters like blood sugar or even intelligence. This concept of health as the set of common states is closely related to the statistical concept of normality. On the other hand, concept of health as the set of ideal state is closely related to the concept of well-being. This notion of positive health is also in keeping with the concept of *holism* which characterises health as the absence of any defect in the pattern of interactions within the organism and between it as a whole and its environment.

1.5.3 Dimensions of Positive Mental Health

In lines of defining a disorder, mental health could be considered as a syndrome of symptoms and signs of positive feelings and positive functioning. This positive psychological functioning consists of different attributes namely:

- i) Self acceptance (to possess a positive attitude toward the self; to acknowledge and accept multiple aspects of self including both good and bad qualities);
- ii) Positive relations with others (to have warm, satisfying, and trusting relationships with others);
- iii) Personal growth (to see self as growing and expanding; to be open to new experiences; to have sense of realising one's potential);
- iv) Purpose in life (to have goals in life and a sense of directedness);
- v) Environmental mastery (to have a sense of mastery and competence in managing the environment); and
- vi) Autonomy (to be self-determining and independent).

Added to the positive psychological functioning are the dimensions of positive social well being, which include:

- i) Social coherence (to be interested in society or social life; to feel society and culture are intelligible, somewhat logical, predictable, and meaningful);
- ii) Social actualisation (to believe that people, social groups, and society have potential and can evolve or grow positively);
- iii) Social acceptance (to have positive attitude towards others while acknowledging and accepting people's differences and complexity);
- iv) Social integration (to have a sense of belonging to a community and to derive comfort and support from community); and

- v) Social contribution (to feel that one's life is useful to society and the output of one's own activities are valued by or valuable to others).

While the dimensions of psychological well being are the reflections of the intra-personal positive functioning of an individual, the dimensions of social well being reflect the positive functioning in the inter-personal realm.

1.5.4 Models of Positive Mental Health

The way concept of mental health has been defined through different models, positive mental health could also be seen in terms of different viewpoints. While it won't be wrong to extrapolate the models of mental health to that of positive mental health, certain additional models are being described here.

1) Mental Health as above Normality

This model defines the mental health as a state of optimal functioning — a state that goes well beyond what is considered as average or normal. This approach regards mental health as *above normal* and recommends the following attributes of mental health. One needs to compare them with the attributes given in the previous sections. A mentally healthy individual should:

- i) Be in touch with her or his own identity and feelings,
- ii) Be oriented toward the future and remain fruitfully invested in life,
- iii) Have a psyche that provides resistance to stress,
- iv) Possess autonomy, perceive reality without distortion, and yet possess empathy and
- v) Be able to work, to love, to play, and to be efficient in problem solving.

2) Mental Health as Positive Psychology

Positive psychology is the study of the conditions and processes that contribute to the flourishing or optimal functioning of people, groups and institutions. The science of positive psychology looks beyond what goes wrong in individuals, families, groups and institutions and aims at what is right and how it could be made better. It aims at mapping the domain of human optimal functioning. Positive psychology sees positive mental health as an amalgam of four components *viz.* talents, enablers, strengths, and outcomes.

By understanding the factors that build strengths, outline the contexts of resilience, ascertain the role of positive experiences, and delineate the function of positive relationships with others, positive psychology contributes to how all of these factors contribute to physical health, subjective well-being, functional groups.

3) Mental Health as Maturity

The mental health could be seen as an ongoing process of attaining maturity. Along with the biological (structural and functional) maturation of the neural systems the evolution of emotional and social intelligence over time contributes to the overall maturity. As one matures she or he finds ways to adjust to the newer and ever widening demands of life and thus by acquiring such skills and by masterly practising those, moves ahead through life. This

mastery over the demands of life stages helps one be free of the distress and possible states of ill health. The positive mental health could be seen as an ongoing process of attaining maturity.

1.5.5 How to go About for a Positive Mental Health

In order to ensure that one has a sound mental health some steps need to be taken. These would help the individual to constantly improve on her or his mental well being and thus functioning. Some of these steps would include:

- 1) **Attention to lifestyle:** One needs to establish a good balance between work and leisure pursuits. In fact it has been said that being normal means ability to work and ability to play.
- 2) **Awareness of mind-body interaction:** Mind-body interaction is at the center for almost all the experiences one is going through. A seemingly bodily phenomenon has psychological underpinning and vice versa. One should be aware of these mind-body interactions and thus deal with the situations and experiences with understanding.
- 3) **Anticipation:** One needs to have a realistic expectation of what can go wrong. This would help one to be prepared for such a situation lest it should arise.
- 4) **Problem solving:** Problems are a part of day-to-day functioning and should be seen as a rule rather than exception. There needs to be a problem solving approach in order to overcome them in the best possible manner with the available resources.
- 5) **Reviewing our lives from time to time:** This involves considering what our aims and goals in life are and whether we are taking steps to achieve them. This would provide the life with a direction and a sense of purpose.

Check Your Progress Exercise 6

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

- 1) How can one ensure a positive mental health for oneself?

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1.6 LET US SUM UP

Mental health is a wider concept that requires an understanding into the closely related but distinct concept of mental disorders. Equally important is the understanding of the concept of normality and positive mental health. These concepts can be understood using different models which have their own

advantages and limitations. To have a better understanding on the issue one needs to take into account all the strengths and limitations of each of the individual models and then build on from there. These models have their underpinnings in the biological, psychological and social school of thoughts from which they have been derived.

1.7 GLOSSARY

Emotional intelligence	:	A subset of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions.
Health	:	A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
Mental disorders	:	Disorders of the conation (action), cognition (thought) or affect (feelings).
Mental health	:	A state of emotional and psychological well-being in which an individual is able to use her or his cognitive and emotional capabilities to function in society and meet the ordinary demands of everyday life.
Normality	:	Patterns of behaviour or personality traits that are typical or that conform to some standard of proper and acceptable ways of behaving and being.
Nosology	:	The study of classification of (mental) disorders.

1.8 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

- 1) Mental health can be defined as a state of emotional and psychological well-being in which an individual is able to use her or his cognitive and emotional capabilities to function in society, and meet the ordinary demands of everyday life. A comprehensive conceptualisation of mental health would mean a state of well-being in which the individual realises her or his own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community.

Check Your Progress Exercise 2

- 1) Mental health is of paramount importance to achieve overall health. A mere absence of mental disorders should not be the only aim to achieve, rather one should aim at having a positive mental health. Mental health not only affects the psychological functioning, it also has an impact on the physical well being of the individual. Thus it becomes important to study about the concept of mental health.

Check Your Progress Exercise 3

- 1) Different models of mental health are as under:
 - i) The biological model,
 - ii) Mental health as an ecological balance,
 - iii) Mental health as capacity to adjust to cultural norms,
 - iv) Mental health defined in terms of a theory of mental functioning,
 - v) Mental health as a subjective state,
 - vi) Mental Health as Social-Emotional Intelligence,
 - vii) Mental health as resilience,
 - viii) Two-dimensional model of mental health; and
 - ix) The hybrid model.

Check Your Progress Exercise 4

- 1) Mental disorder has been defined as a condition that occurs in an individual and that is associated with present distress (that is, a painful symptom) or disability (that is, an impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. Mental disorder has also been defined as an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain.

Check Your Progress Exercise 5

- 1) The different models of normality are:
 - i) Normality as health,
 - ii) Normality as average,
 - iii) Normality as utopia and
 - iv) Normality as a process.

Check Your Progress Exercise 6

- 1) One can work towards a positive mental health by paying attention to lifestyle, having awareness of mind-body interaction, having a realistic expectation of what can go wrong, a problem solving approach.

1.9 UNIT END QUESTIONS

- 1) Define mental health. Explain at least four models of mental health.
- 2) What do you mean by nosological system? Explain classification of mental disorders.
- 3) Define normality and explain four models of normality.
- 4) Discuss the term positive mental health in your words.

1.10 FURTHER READINGS AND REFERENCES

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UNIT 2 DIMENSIONS OF PSYCHO-SOCIAL STRESS AND COPING

Structure

- 2.1 Introduction
- 2.2 Defining Stress
 - 2.2.1 What is Stress?
 - 2.2.2 Stress as Event, Process and Effect
 - 2.2.3 Historical Aspects
- 2.3 Theories of Stress
 - 2.3.1 The Biomedical Perspective
 - 2.3.2 The Psychological Perspective
 - 2.3.3 The Sociological Perspective
- 2.4 Models of Stress
 - 2.4.1 Emotional and Cognitive Models
 - 2.4.2 The Stress Response
 - 2.4.3 Newer Models of Stress
- 2.5 Types of Stress
 - 2.5.1 Classification Based on Nature of Stress
 - 2.5.2 Classification Based on Severity of Stress
 - 2.5.3 Eustress and Distress
 - 2.5.4 Classification Based on Temporal Relation of Stress Response with the Stressor
 - 2.5.5 Classification Based on the Duration of Stress
 - 2.5.6 Other Types of Stress
- 2.6 Stress and Health
 - 2.6.1 Why to Study Stress?
 - 2.6.2 How does Stress Affect Health?
 - 2.6.3 Effect of Stress on Physical and Mental Health
- 2.7 Management of Stress
 - 2.7.1 How to Study Stress?
 - 2.7.2 Interventions for Stress
- 2.8 Let Us Sum Up
- 2.9 Glossary
- 2.10 Answers to Check Your Progress Exercises
- 2.11 Unit End Questions
- 2.12 Further Readings and References

2.1 INTRODUCTION

Man, being a social animal, is constantly in an ongoing interaction with his environment. Life of an individual and/ or group of individuals can't be considered in isolation and one needs to consider the role of others, life events and the immediate and distant environment. These life events and environmental factors exert demands on the individuals which evoke responses in them. The responses are governed by the specific situation and are fueled by the resources available

with a particular individual. The resources might include the intrinsic factors (psychological and physical) and extrinsic factors (other individuals and environmental factors). Also, the situation is dynamic and ever changing. The change is seen both quantitatively (change in severity or intensity) and qualitatively (varied situations). Thus, the responses need to modify accordingly. The current Unit focuses on these aspects that are the life events and situations, the interaction of the individual with them and the responses generated. In other words, the issues related with psycho-social stress and coping would be dealt with in this Unit.

Objectives

After studying this Unit, you will be able to:

- Define stress and describe the concept of stress;
- Describe different theories and models of stress;
- Explain the role of stress in functioning and disease; and
- Have an overview of the management of stress.

2.2 DEFINING STRESS

Stress is something that all of us experience all along our lives. Psycho-social stress, a perceived challenge to well being, is an indispensable and influential part of life. The nature of the stress keeps changing. We would begin by understanding the concept of stress.

2.2.1 What is Stress?

Stress is a commonly used term. It has been used in different contexts with different meanings. It has been studied by different disciplines including psychology, psychiatry, nursing, medicine, sociology, ergonomics, anthropology, pharmacology, physiology and neurobiology.

Stress can be defined as a real or interpreted threat to the physiological or psychological integrity of an individual that results in physiological and behavioural responses. It is said that people strive to obtain and protect resources, stress ensues when there is a threatened or actual loss of resources.

Psychologically stress is a threat, the anticipation of a future confrontation with harm, based on cues which are appraised by cognitive processes.

Stress can also be seen as the reaction of people, who are under excessive pressures and other types of demands placed on them. Wayne Weiten described stress as any circumstance that threatens or is perceived to threaten one's well-being and that thereby taxes one's coping abilities. It can also be conceptualised in terms of an imbalance between the perception of demand and the perception of the ability to cope with it.

2.2.2 Stress as Event, Process and Effect

Stress has been conceptualised in the literature as either a *stimulus* (the cause), a *response* (the result) or as a *process* (in itself) combining both stimulus and response. All three of these models have been utilised in each of the disciplinary

approaches, whilst, there has been a tendency to match between particular models and measurement approaches.

Stress, thus, refers both to an event and the consequences of that event. Thus, the term “stress” subsumes two components: *stressors* (stressful events) and *stress response* (strain). *Stressors* are the events or situations that have a potential to de-sync the homeostasis of the individual. The *stress response* is the change that occurs in the individual to put it back in balance and re-establish homeostasis. Stressors can be either physical or psychological aspects of the external environment or internal factors. The stress response is frequently referred to as the “fight or flight response” in which an “alarm” is set off in the brain and the body prepares for defensive action. In fact, the stressors need not be actually present to elicit the stress response. At times the mere anticipation of the stressor can lead on the stress response.

2.2.3 Historical Aspects

The initial conceptualisation of stress differed from the modern day understanding. In fact, the concept of stress has been through a multitude of changes over the centuries. The use of the term “stress” to represent suffering and adversity dates back to the 15th century. Till the 17th century ‘stress’ was synonymous with notions such as ‘hardship’, ‘straits’, ‘adversity’ or ‘affliction’.

The physiological aspect of the stress, or more precisely the consequent stress response, was looked into by Cannon in the 1920’s. Canon contributed with the introduction of the concept of ‘*fight or flight*’ as an adaptive function of human beings and suggested more speculatively that the physiological processes produced by this reaction were influenced by emotional states.

However, it was not until the middle of the twentieth century that the modern understanding of the concept of stress started assuming its shape. The first modern notion of stress was proposed by Selye in the 1950’s. Lazarus introduced his *psychological theory of stress*.

Parallel to these works, the role of life events in the causation and course of different health conditions was observed and proposed by clinicians. William Harvey in the 17th century and William Osler in the 19th century frequently alluded to the relationship between adverse life events and illness onset. In the early to mid-1800s Philippe Pinel and Amariah Brigham proposed that the expression of mental illness was affected by societal factors including life circumstances.

Over the years the work in this area has explored the newer dimensions and various explanations and models have been proposed. These include the biomedical, psychological and sociological perspectives on stress among others.

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in space provided below.

b) Check your answer with that provided at the end of this Unit.

1) How would you define stress?

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2.3 THEORIES OF STRESS

As mentioned earlier, stress has been studied by different disciplines including psychology, medicine (including psychiatry) and sociology among others. These disciplines have conceptualised stress in light of their governing principles.

2.3.1 The Biomedical Perspective

The biomedical perspective emphasises the adaptive bodily responses to the stressors. Selye's *General Adaptation Syndrome (GAS)* model based on the physiological response of the body to any demand made upon it is an example of this perspective. Thus, stress has been seen as a process and event that can be studied in terms of bodily responses like changes in temperature, blood pressure, heart rate, blood cholesterol levels, urinary catecholamine concentrations, corticosteroid levels, blood glucose concentration etc in response to stress. *Sympathetic-Adrenal Medullary (SAM)* system and the *Hypothalamic-Pituitary-Adrenocortical (HPA)* axis are two pathways that govern these bodily responses to the stressors. *Psychoneuroimmunology* and *psychoneuroendocrinology* are two branches of medicine that deal with the interaction of stress with immune system and endocrinal system, respectively.

Hans Selye introduced the General Adaptation Syndrome (GAS) theory of stress. Selye held that in spite of the change being a normal and inexorable feature of social life, all change is potentially harmful because all change requires adjustment. This early conceptualisation of 'stress' implied that stress was a 'disease of adaptation'. Stress in the General Adaptation Syndrome (GAS) model is characterised by: (i) an alarm reaction where natural resistance is lowered, but body defenses are mobilised; (ii) a resistance stage which leads to increased resistance and adaptation; and (iii) a final stage where the energy for adaptation is exhausted and collapse ensues. The General Adaptation Syndrome (GAS) theory emphasised the non-specificity of the systemic physiological response to the stressor.

2.3.2 The Psychological Perspective

Role of the personality factors, inter-individual variance in stress response is addressed by the psychological perspective on stress. In the stress-suppression model, stress exposure mobilises a 'resource', which then alleviates stress by affecting its appraisal, responses to the stressor, further stress proliferation and/or the relation between stress and ill-health. The stress-deterrent model portrays resources as causally antecedent to stress – resources reduce the exposure to stress (including stress proliferation), rather than its impact on health.

Another model conceptualises stress and resources as having separate and opposite effects while remaining completely independent of one another. Resources counterbalance the stressor, but do not buffer stress because support operates even in the absence of stress.

The *Lazarus theory* has been the main psychologically oriented theory on stress. According to this theory, two concepts are central to any psychological stress theory: *appraisal*, that is, individuals' evaluation of the significance of what is happening for their well-being, and *coping*, that is, individuals' efforts in thought and action to manage specific demands.

Thus, the stress is regarded as a relational concept, that is, stress is not defined as a specific kind of external stimulation nor a specific pattern of physiological, behavioural or subjective reactions. Instead, stress is viewed as a relationship ('transaction') between individuals and their environment.

2.3.3 The Sociological Perspective

Sociological approaches to stress research have tended to focus on analysing differences in group vulnerability with particular emphasis on gender, class, race and cultural differences. The sociological perspective attempts to provide an overall understanding of why health inequalities mirror social inequalities in terms of the social distribution of stress. Sociological approaches to stress seek stressors in the organisation of lives and in the structure of experience rather than among unrelated risk factors.

2.4 MODELS OF STRESS

In this section we will discuss different models of stress. Let us discuss emotional and cognitive models of stress:

2.4.1 Emotional and Cognitive Models

Stress has been defined as an emotional tension rising from life events, or as a feeling of threat to someone's safety or self-esteem. Lazarus defined stress as a stimulus condition that results in a form of disequilibrium in the system, producing a kind of strain and changes in the system. In its broadest sense, stress refers to all physical, psychological or social phenomena that tax or exceed an organism in such a way that physical, psychological or social change results.

The cognitive view of stress focusses on interruption and subsumes the idea of overload. The basic premise of interruption theory is the well-documented finding that autonomic activity results whenever some organised action or thought process is interrupted. *Interruption* is the disconfirmation of expectancy or the non-completion of some initiated action. The degree of autonomic activity caused by the interruption of organised processes depends both on the degree of organisation of the interrupted process and the severity of the interruption.

The gap between the systemic and cognitive viewpoints on stress is bridged by the resource theories of stress. The resource theories of stress are not primarily concerned with factors that create stress, but with resources that preserve well being in the face of stressful encounters. The social and personal constructs proposed include social support, sense of coherence, hardiness, self-efficacy and optimism.

The *Conservation of Resources* (COR) theory assumes that stress occurs in any of three contexts: when people experience loss of resources, when resources are threatened or when people invest their resources without subsequent gain.

2.4.2 The Stress Response

Whenever an individual is faced with a stress it generates response in it. This response is a complex combination of multiple components including emotional (depression, anxiety, anger, rage); physiological (fight-flight, resistance, exhaustion); behavioural (coping strategies, defense mechanisms) factors.

As per Selye's, GAS *alarm* is the first stage. When the threat or stressor is identified or realised, the body's stress response is in a state of alarm. This stage is characterised by the fight-or-flight response. The stage of alarm is followed by the *stage of resistance*. To cope with the ongoing stress, the body begins to try to adapt to the strains or demands of the environment. However, there is a limit to the body's ability to resist and consecutively its resources are gradually depleted. This leads on to the third stage of the stress response that is *exhaustion*. Once all of the body's resources are eventually depleted and the body is unable to maintain normal function, decompensation may result resulting in exhaustion.

2.4.3 Newer Models of Stress

Modern day study of stress and stress response primarily focuses on three models: *stimulus-based model* (also called *objective-stress model*), *response-based model* (also called *subjective-stress model*) and the *interactional model*.

The *stimulus-based model* of stress, based on the biomedical perspective, emphasises the central role of life events or traumas. Thus, stress based on this model is the sum of biological and psychological stimuli caused by any aggression on an organism.

The *response-based model* is based on the psychological perspective and utilizes chronic stressor as a measurement approach. As a result, the stress is the response of an organism to a noxious or threatening condition.

The *interaction model* measures the day-to-day hassles and is governed by the sociological perspective. The process in which environmental demands tax or exceed the adaptive capacity of an organism results into the shape of stress.

Check Your Progress Exercise 2

Note: a) Read the following question carefully and answer in space provided below.

b) Check your answer with that provided at the end of this Unit.

1) Enumerate different models and theories of stress.

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2.5 TYPES OF STRESS

Stress can be classified in different ways. This section deals with different types of stress.

2.5.1 Classification Based on Nature of Stress

Based on the nature of the stress it could be classified as *biological stress* or *psychological stress*. The examples of biological stress would include the pregnancy, road traffic accidents etc. While the psychological stress refers to the frustrations, conflicts and changes that one suffers.

2.5.2 Classification Based on Severity of Stress

Based on the severity, stress could be classified as *everyday stress* or *hassles* and exceptional stress. Examples for everyday stress are job-stress, relationship problems, etc and examples of exceptional stress are combat trauma, rape, etc.

2.5.3 Eustress and Distress

Contrary to the popular belief, stress need not always be bad. In fact, there are two types of stress, namely good stress and bad stress. The *bad stress* has been called as 'distress' while the *good stress* is also known as 'eustress'.

The bad stress makes one anxious and irritable, dampens the spirit due to its adverse psychological and physical effects. Eustress provides stimulation and challenge and is essential for development, growth and change. Good stress can also be related to motivation.

2.5.4 Classification Based on Temporal Relation of Stress Response With the Stressor

Stress can also be classified based on the time course of the stress. The stress could be experienced prior to the actual stressful event, during the course of the event, immediately after the event or after some time has elapsed since the stressful event ended. Charles categorises stress into four types, these are:

- 1) *Anticipatory stress*: Stress caused by concern over the future.
- 2) *Situational stress*: Stress of the moment.
- 3) *Chronic stress*: Stress that persists over time.
- 4) *Residual stress*: Stress of the past.

2.5.5 Classification Based on the Duration of Stress

Based on the duration, the stress could be classified as either *acute stress* (short term) or *chronic stress* (long term).

Fried's Classification

Fried classified stress into three types that are catastrophic stress, acute stress and the endemic stress. The *catastrophic stress* refers to the major disasters affecting a large section of the population. The *acute stress* refers to the result of the stressors that require immediate response. The *endemic stress* refers to the continuing ongoing stress.

2.5.6 Other Types of Stress

‘Cumulative stress’ refers to the amalgamation of current stressors with previous significant traumas that continue to be sources of stress. The term ‘operant stress’ refers to a combination of recent and distal life events as well as chronic stressors that affect an individual at any one point in time. The concept of ‘stress proliferation’ is a sequence of events in which a ‘primary stressor’ leads to ‘secondary stressors’. For example, the loss of a loved one (a life event) may lead to social isolation (chronic stressor).

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in space provided below.

b) Check your answer with that provided at the end of this Unit.

1) How would you classify stress?

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2.6 STRESS AND HEALTH

Now, let us discuss what is the need to study stress and how stress affects health of an individual.

2.6.1 Why to Study Stress?

As explained above, the stress response is body’s usual response to the stressor that is the individual’s way of reacting to the event. This reaction seems to serve an adaptive function in that it helps the individual to effectively deal with the specific situation and restore the state of homeostasis. However, one might not be lucky on every occasion. Depending on the severity of the stressor and individual’s resources, the stressor can overwhelm these adaptive resources. Stressors may tax or exceed the adaptive capacity of an organism, resulting in biological and physiological changes which may be detrimental and place the organism at risk for disease. In fact, it has been stated that with sufficient activation the stress response can become more damaging than the stressor itself. This concept underlies the emergence of much stress-related disease.

2.6.2 How Does Stress Affect Health?

The negative health consequences of stress are well documented. The human response to psychosocial stress is directly implicated in hypertension and subsequent vascular diseases. It is also implicated in reduced immune function, complicated pregnancies, reduced fertility, gastrointestinal disease and psychiatric conditions.

For centuries, physicians and patients have made the association between adverse life events and illness. The relation of the concept of stress with health and ill

health started taking a definitive shape in the 1960s. Since then there has been increase in interest and evidence of psycho-social determinants of health within the field of public health. Stress has been implicated in a number of conditions of disrupted physical and psychological health.

There are two main pathways through which stress can lead to the state of ill-health: *effect on somatic health and disease development* — the direct pathway, and *stress expressed through health-damaging behaviours* — the indirect pathway.

A number of models useful in understanding how psychological stress has an impact on health have been proposed. These include the cardiovascular reactivity hypothesis and allostatic load model. According to the *cardiovascular reactivity hypothesis*, exaggerated cardiovascular responding to stress is a marker or mediator of the development of coronary heart disease and essential hypertension. The *allostatic load model* emphasises the role of the allostasis in maintenance of the body's equilibrium. In allostasis unlike homeostasis, the body does not conserve the same internal state but, rather, establishes a new equilibrium after disruption. While the usual turning on and off these systems is adaptive, overstimulation or malfunctioning of these systems leads to “allostatic load”. This allostatic load can lead to disease over long periods.

2.6.3 Effect of Stress on Physical and Mental Health

Stress has been implicated in different physical and mental diseases and disorders. This association has been reported with cardiovascular conditions (atherosclerosis, myocardial infarction), infectious diseases (viral diseases, such as herpes simplex, influenza, and coxsackie virus), HIV/AIDS, autoimmune diseases (rheumatoid arthritis) and cancers. Stress can play a role in form of a predisposing, precipitating or propagating factor in these conditions. Also it could be responsible for the poor treatment response and relapse. The role of stress on these disorders is mediated through a multitude of factors.

Stress causes activation of the *sympathetic nervous system (SNS)* and the *hypothalamic pituitary-adrenocortical axis*, with responses that include increase in body temperature, blood pressure, heart rate and plasma glucocorticoid concentration. The well-described effects of the SNS are mediated through *alpha* and *beta adrenergic receptors* located on the heart and throughout the vascular system, which includes the stimulation of renin secretion and subsequent increase in *angiotensin II* production. *Psychosocial stress* increases arterial pressure and also has been linked to chronic renal and cardiovascular disease, including hypertension. Long-term effects of social challenges on a number of physiological and behavioural parameters have also been reported, mainly involving the daily rhythms of heart rate and body temperature, food intake and social activity. Stress also alters the immune functions and the mediators of the immune response in the body.

Almost all psychiatric disorders are related to stress in some way or the other. Post traumatic stress disorder (PTSD), acute stress disorder, adjustment disorders, ATPD, enduring personality changes, post-partum disorders, dissociative disorders, depression, schizophrenia have been associated with stress of different kinds. Stress is either a precipitating or an aggravating factor for most of these disorders.

2.7 MANAGEMENT OF STRESS

This section summarises the methods to study stress and the interventions for stress management.

2.7.1 How to Study Stress?

Every individual is subject to the changes in her or his environment. These changes can be due to the interpersonal relations, the situations created by different life events or the demands the life puts on us. Moreover, each individual deals with these events and situations in her or his way depending on the situation, appraisal of the situation and the kind of resources available to deal with them.

There have been three main approaches to the measurement of stress: life events, chronic stressors and daily hassles or uplifts. Events such as birth of the first child, divorce or death of a significant other are examples of life events. *Life events* are discrete, acute, observable events which require major behavioural re-adjustments within a relatively short period of time and are essentially self-limiting in nature. Life events have traditionally been equated with objective, discrete events that are not the result of the individual's psychological function.

Chronic stressors are relatively enduring, persistent or recurrent demands, conflicts, threats, or problems which require readjustments over prolonged periods of time (for example disabling injury, poverty). There are several different types of chronic stressors including frustration of role expectations and role overload; interpersonal conflicts within role sets; inter-role conflict; role captivity; role restructuring; and ambient stressors. As opposed to the life events, chronic stressors are seen as subjective and influenced by emotional functioning.

Hassles and *uplifts* are mini-events, which require small behavioural adjustments during the course of the day (for example, traffic jams).

2.7.2 Interventions for Stress

Since stress beyond the coping capabilities of an individual can be counterproductive it needs to be managed appropriately. Different approaches have been developed to manage the stress.

Two primary approaches to the stress management are *the ecological stress perspective* and *the stress adaptation perspective*. The first of these approaches focusses on changing the environment to better accommodate and reduce stress in individuals across three relevant dimensions like control, uncertainty and social support. The second approach encourages the individual to adapt to the environment to reduce stress and focuses on three factors i.e. generalised expectancies of control, tolerance for ambiguity and self-reliance.

Cognitive-behavioural therapy methods are one of the commonest employed strategies to help individuals deal with stress. Cognitive appraisals about stressful events and the coping efforts related to these appraisals play a major role in determining stress response. These aim at helping individuals become more aware of their own cognitive appraisals of stressful events, to educate individuals about how their appraisals of stressful events can influence negative emotional and behavioural responses and to help them re-conceptualise their abilities to alter

these appraisals and to teach individuals how to develop and maintain the use of a variety of effective cognitive and behavioural stress management skills.

Stress management training, self observation, cognitive restructuring, relaxation training, time management skills and problem solving skills have been used in management of stress.

Check Your Progress Exercise 4

Note: a) Read the following question carefully and answer in space provided below.

b) Check your answer with that provided at the end of this Unit.

1) Enumerate the interventions for stress.

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2.8 LET US SUM UP

Stress is something that all of us experience all along our lives. Psycho-social stress, a perceived challenge to well being, is an indispensable and influential part of life. Stress has been conceptualised in the literature as either a stimulus (the cause), a response (the result) or as a process (in itself) combining both stimulus and response. Stress has been explained in context of the biomedical, psychological and sociological perspectives. Different models of stress are complimentary to each other and help in comprehensive understanding of the concept. Stress impacts both the physical as well as the psychological health and thus is important to study. Various cognitive and behavioural approaches can be used to manage the stress and overcome its adverse effects.

2.9 GLOSSARY

- Cumulative stress** : The amalgamation of current stressors with previous significant traumas that continue to be sources of stress.
- Eustress** : The good type of stress that provides stimulation and challenge and is essential to development, growth and change.
- Operant stress** : A combination of recent and distal life events as well as chronic stressors that affect an individual at any one point in time.

- Stress** : A real or interpreted threat to the physiological or psychological integrity of an individual that results in physiological and behavioural responses.
- Stress response** : The unique set of the emotional, physiological and cognitive factors that lead to a specific response in an individual when exposed to a stressful situation.

2.10 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

- 1) Stress can be defined as a real or interpreted threat to the physiological or psychological integrity of an individual that results in physiological and behavioural responses. Stress can also be seen as the reaction people have to excessive pressures and other types of demands placed on them.

Check Your Progress Exercise 2

- 1) Different theories of stress include:
 - i) The biomedical perspective,
 - ii) The sociological perspective, and
 - iii) The psychological perspective.
- 2) Different models of stress include
 - i) The emotional and cognitive model,
 - ii) The stress response model,
 - iii) Stimulus-based model (also called objective-stress model),
 - iv) Response-based model (also called subjective-stress model), and
 - v) The interactional model.

Check Your Progress Exercise 3

- 1) Stress can be classified in different ways such as
 - i) Based on the nature of the stress (biological or psychological);
 - ii) Based on the severity of stress; as eustress and distress;
 - iii) Based on duration of stress (short term and long term); and
 - iv) Based on temporal relation of stress response with the stressor.

Check Your Progress Exercise 4

- 1) The interventions for stress are:
 - i) Cognitive behavioural approaches,
 - ii) Stress management training,
 - iii) Self observation,

- iv) Cognitive restructuring,
- v) Relaxation training,
- vi) Time management skills, and
- vii) Problem solving skills.

2.11 UNIT END QUESTIONS

- 1) Explain, what do you mean by stress? Name the theories of stress. Discuss any one of them in detail.
- 2) What are the models of stress? Explain at least two in your own words.
- 3) Explain briefly how does stress effect the physical and mental health of individual?
- 4) Describe management of stress in your own words.

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UNIT 3 CLASSIFICATION AND ASSESSMENT OF MENTAL DISORDERS

Structure

- 3.1 Introduction
- 3.2 Classification of Mental Disorders
 - 3.2.1 Utility of Classificatory Systems
 - 3.2.2 Challenges of Classification and Diagnosis
 - 3.2.3 History of Classificatory Systems
 - 3.2.4 Contemporary Classificatory Systems
 - 3.2.5 Categories of Mental Disorders Under ICD-10
 - 3.2.6 Other Aspects of Classification
- 3.3 Assessment of Mental Disorders
 - 3.3.1 Why is Assessment Required?
 - 3.3.2 Carrying Out an Assessment
- 3.4 Let Us Sum Up
- 3.5 Glossary
- 3.6 Answers to Check Your Progress Exercises
- 3.7 Unit End Questions
- 3.8 Further Readings and References

3.1 INTRODUCTION

Broadly, assessment is concerned with the identification of distinguishing features of individual cases, whereas classification is concerned with the grouping of cases according to their distinguishing features. When people with emotional or mental problems seek your professional help, you would need to have adequate knowledge of mental problems or disorders and a systematic approach to assessment. Taking a step-by-step approach to assessment helps to establish the problem and its impact on various aspects of the person's life; and in decisions regarding the next steps in managing the problem.

Objectives

After studying this Unit, you will be able to:

- Differentiate different classificatory systems for mental disorders;
- Understand the various aspects of assessment; and
- Describe the process of carrying out assessment.

3.2 CLASSIFICATION OF MENTAL DISORDERS

When you assess a client, you try to interpret her or his problems in terms of known disorders and assign a label (diagnosis) to the problems she or he is facing. These diagnoses are arranged according to groups of disorders within classificatory systems.

3.2.1 Utility of Classificatory Systems

Knowing the classificatory system can help you in several ways:

- 1) Giving a client a diagnosis can help you to decide about her or his management, as standardised management strategies are known for many diagnoses.
- 2) A diagnosis (which in essence is a summary of clinical information) can help you to predict the course and outcome of the problems the individual is facing.
- 3) A diagnosis can help you in communicating efficiently with other professionals who follow the same classificatory system, regarding the client's problems.
- 4) Diagnoses and classificatory systems can help you to group together (and analyse) individuals with similar set of problems, and thus help you with research.

3.2.2 The Challenges of Diagnosis and Classification

Professionals know the exact cause of most medical conditions. However, a definite cause is not known for the majority of mental disorders. Thus, diagnosis of mental disorders rests upon eliciting signs and symptoms in an individual and assigning a particular label (diagnosis) to these sets of signs and symptoms. In other medical illnesses, the physician can perform certain investigations to establish or refute the diagnosis reached on the basis of clinical signs and symptoms. For example if a patient complains of cough with sputum for more than 3 weeks along with increased body temperature and loss of weight and appetite, the physician often makes a presumptive diagnosis of 'tuberculosis' and then proceeds with investigations (chest X-ray, sputum examination, blood tests, etc.). All these tests can help physician confirm the diagnosis of tuberculosis. As there are few psychiatric diagnosis that can be definitively established by specific investigations, psychiatric classifications are based on disorders defined by sets of signs and symptoms.

3.2.3 History of Classificatory Systems

From a long time, philosophers and researchers alike have tried to classify mental illness into various categories. Noted among them were Hippocrates, Aurelianus, Sydenham, Pinel, Kahlbaum, Griesinger, etc. Initially, mental illness was believed to be due to disturbance of the humoral balance, or a disturbance in the tension of the solid tissues. However, later researchers such as Phillip Pinel linked the occurrence of mental illness to disordered functioning of the nervous system. Subsequently, many researchers unsuccessfully tried to link specific mental illnesses to specific lesions in the nervous system. Finally, Karl Ludwig Kahlbaum introduced the concept of diagnoses based on *symptom complexes* (sets of signs and symptoms), distinction between *organic* (psychiatric disorders with known causes) and *non-organic* (psychiatric disorders without known causes) disorders, and the consideration of age of onset as the basis of classificatory systems.

In the last two decades of the 19th century, Kraepelin used three criteria – clinical description, course of the illness and outcome of the illness to distinguish between the major mental disorders.

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) How can a classificatory system help you in your chosen profession?

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2) How are most mental disorders different from other medical illnesses?

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3) Name some eminent persons associated with the development of psychiatric classification.

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4) What was Kraepelin's approach to the classification of mental illnesses?

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3.2.4 Contemporary Classificatory Systems

The two most common classificatory systems followed by professionals are those advocated by the World Health Organisation (WHO) and the American Psychiatric Association (APA).

1) *International Classification of Diseases (ICD)*

This classificatory system is developed by the WHO to help researchers, clinicians and health specialists to code the diseases and maintain statistical records of their hospitals. This system is updated every few years. The current version being followed is the 10th version of ICD (ICD-10) that was published in 1992. There are a total of 21 chapters in ICD-10, of which the fifth chapter (chapter V) is dedicated to psychiatric illnesses. The version used by mental health professionals for clinical purposes is called the *Clinical Description and Diagnostic Guidelines version*. Other versions of the ICD-10, which are all mutually compatible, are depicted in the table below:

S.No.	ICD 10 Version	Description	Purpose
1	Clinical description and diagnostic guidelines	Contains basic description of each disorder	Mainly for clinicians
2	Diagnostic criteria for research	Each disorder contains specific criteria for diagnosis	Mainly for researchers
3	Primary care version	Contains only 27 main categories, with brief notes on management and referral	Mainly for general physicians who work in the primary care setting
4	Glossary	Contains meanings of various terms used in ICD 10	
5	Cross-walks	A comparison of ICD 10 categories with earlier versions of ICD	

Mental and behavioural disorders of ICD-10 are given code “F”. After the code F, the first digit of the diagnostic codes denotes the 10 major classes (given below) of mental and behavioural disorders.

Codes	Categories
F00 – F09	Organic, including symptomatic, mental disorders
F10 – F19	Mental and behavioural disorders due to psychoactive substance use
F20 – F29	Schizophrenia, Schizotypal and delusional disorders
F30 – F39	Mood (affective) disorders
F40 – F49	Neurotic, stress related and somatoform disorders
F50 – F59	Behavioural syndromes associated with physiological disturbances and physical factors
F60 – F69	Disorders of adult personality and behaviour
F70 – F79	Mental retardation
F80 – F89	Disorders of psychological development
F90 – F99	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

After the first digit, the second and third digits denote further categorisation of the disorder, while the fourth and the fifth digit specify salient clinical characteristics of the diagnosis given by the three-digit code. To provide an example, F32.11 denotes ‘*depressive episode, moderate, with somatic syndrome.*’

This would mean,

- F : mental and behavioural disorders
- 3 : mood (affective) disorders
- 2 : depressive episode,
- .1 : moderate depressive episode
- .11 : presence of somatic syndrome

2) *Diagnostic and Statistical Manual (DSM)*

This classificatory system is developed by the American Psychiatric Association (APA). The 4th edition of DSM (DSM-IV) was published in the year 1994. It has 17 sections as given below:

No.	Section
1	Disorders usually first diagnosed in infancy, childhood or adolescence
2	Delirium, dementia, amnesic, or other cognitive disorders
3	Mental disorders due to general medical conditions
4	Substance-related disorders
5	Schizophrenia and other psychotic disorders
6	Mood disorders
7	Anxiety disorders
8	Somatoform disorders
9	Factitious disorders
10	Dissociative disorders
11	Sexual and gender identity disorders
12	Eating disorders
13	Sleep disorders
14	Impulse control disorders not elsewhere classified
15	Adjustment disorders
16	Personality disorders
17	Other conditions that may be a focus of clinical attention

Here, we will generally discuss ICD-10 a little in detail in the next section.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

Please provide correct answers to the following multiple choice questions:

- 1) When was ICD-10 published?
A) 1982 B) 1987 C) 1992 D) 1994
- 2) Mental disorders are given the following code in ICD-10:
A) D B) E C) G D) F
- 3) How many major classes of mental disorders exist in ICD-10?
A) 10 B) 8 C) 11 D) 17
- 4) When was DSM-IV published?
A) 1982 B) 1987 C) 1992 D) 1994
- 5) How many major classes of mental illness exist in DSM-IV?
A) 10 B) 8 C) 11 D) 17

3.2.5 Categories of Mental Disorders Under ICD-10

As mentioned in the earlier section, mental illnesses are categorised into 10 distinct classes under ICD-10, Chapter V. These classes are briefly described below:

F00 – F09: Organic, including Symptomatic Mental Disorders

This category is for mental disorders, which are causally related to brain damage or disordered functioning of the brain. The main disorders included under this cluster are dementias, delirium, amnesic syndromes, as well as psychiatric syndromes with well-established brain dysfunction (for example organic mood disorder, etc.)

F10 – F19: Mental and Behavioural Disorders due to Psychoactive Substance Use

Under this category, substances, which can cause mental and behavioural disorders, are first listed. This is followed by syndromes, which are likely to be caused by these psychoactive substances. These include – acute intoxication, harmful use, dependence syndrome, withdrawal syndrome, psychotic disorder, amnesic syndrome, residual and late-onset psychosis.

F20 – F29: Schizophrenia, Schizotypal and Delusional Disorders

This cluster contains schizophrenia and its various subtypes, as well as other psychotic disorders such as schizotypal, delusional disorders, as well as acute and transient psychosis.

F30 – F39: Mood (Affective) Disorders

This cluster includes disorders, which affect the mood of an individual, namely manic episode, bipolar affective disorder, depressive episode, recurrent depressive disorder and persistent mood disorder (cyclothymia, dysthymia).

F40 – F49: Neurotic, Stress Related and Somatoform Disorder

This cluster involves those mental disorders, which were previously termed as neurosis. This includes – obsessive compulsive disorder, anxiety disorders, phobias, acute stress and post traumatic stress disorder, dissociative and conversion disorders, somatoform disorders as well as others such as neurasthenia and depersonalisation-derealisation disorders.

F50 – F59: Behavioural Syndromes associated with Physiological Disturbances and Physical Factors

This cluster includes disorders associated with disturbance of normal physiological mechanisms such as sleep, eating and sex. Also included are disorders, which arise along with general medical conditions, as well as abuse of non-dependence substances (such as antidepressants, analgesics, hormones, etc.)

F60 – F69: Disorders of Adult Personality and Behaviour

There are two main clusters of disorders listed under this category. The first cluster is related to disordered functioning of one's personality. The second cluster is related to disorders of adult behaviour, which are not classified elsewhere. This includes – impulse control disorders, disorders of gender identity, sexual preferences and sexual orientation.

The categories listed in ICD-10 after F69 involve disorders that start in childhood or adolescence.

F70 – F79: Mental Retardation

This category has only one disorder (mental retardation). It is a global disturbance in intellectual functioning that starts early in life.

F80 – F89: Disorders of Psychological Development

This category includes disorders that affect specific aspect of intellectual functioning such as language, speech, visuospatial skills and motor coordination. The other major class covered under this category consists of disorders characterised by deviation in development of multiple intellectual abilities, called pervasive developmental disorders like autistic disorders, Rett's syndrome and childhood disintegrative disorders.

F90 – F99: Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence

In contrast to the two earlier categories, which affect intelligence or other aspects of brain development, this category covers disorders that affect the behaviour and emotion of children and adolescents. This category includes – hyperkinetic disorders, conduct disorders, anxiety disorders, tic disorders, disorders related to physiological functioning such as enuresis, encopresis, feeding disorders, pica, etc.

3.2.6 Other Aspects of Classification

There are some categorical distinctions, which were used officially in the past, but are still used, routinely in clinical practice.

1) *Organic versus Functional Illness*

Organic illnesses are those illnesses, which occur due to a demonstrable pathology of the brain or other body systems. Some examples include delirium, dementia, etc. Functional illnesses are by default those, which have no such demonstrable pathology. While this classification looks extremely simple, it has a number of fallacies, for example it suggests (against established facts) that functional illness do not have biological causes, or that non-organic factors (such as psychological or social) are not important

for organic illness. But because of its utility and simplicity this categorisation is often used in clinical practice.

2) *Psychosis versus Neurosis*

The term '*psychosis*' is used to signify severe psychiatric disorders such as schizophrenia, bipolar disorder and other disorders in which symptoms such as delusion and hallucination predominate. In addition, patients with psychotic disorders lack '*insight*' that is, awareness that one has a mental disorder and is 'in need of treatment' into their illness. The term '*neurosis*,' on the other hand, is used to denote disorders where anxiety is the predominant feature. In addition, subjects with neurotic disorders present with insight into their illnesses, and the occurrence of their illness is often linked to the presence of psychological or social factors.

With greater understanding of the psychiatric disorders, it is seen that most of the distinguishing features ascribed to either psychosis or neurosis do not fit all the disorders subsumed under that particular category. For example, it is not necessary that all psychotic disorders are severe in nature, or that every case suffering from neurosis has insight. However, this distinction is simple to use, and has thus survived in clinical practice despite the fact that current classificatory systems tend to avoid the use of these terms.

3) *Multi-axial System of Classification*

Sometimes, the patient's problems may be in more than one single domain. There is a provision in both ICD-10 and DSM-IV to record this information. The purpose of multi-axial classification is to promote a comprehensive, biopsychosocial approach to clinical assessment. There are three axes in ICD-10:

- Axis I** : *Clinical diagnosis* – records all the mental and non-mental conditions (including general medical conditions).
- Axis II** : *Disabilities* – records impairment in performance of basic social roles.
- Axis III** : *Contextual factors* – records problems related to family support, housing, education, law, employment, family history and personal life.

The following multi-axial approach is adopted in DSM-IV:

- Axis I** : All clinical diagnosis, except for personality disorders and mental retardation.
- Axis II** : Personality disorders, mental retardation, and defence mechanism.
- Axis III** : General medical conditions that may be relevant to understanding or managing the patient's psychiatric disorder.
- Axis IV** : Psychosocial and environmental problems relevant to diagnosis, treatment and prognosis of the patient's disorder.
- Axis V** : Global assessment of functioning based on the clinician's judgement.

Check Your Progress Exercise 3

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) What does the class F50 – F59 denote?

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2) Describe the psychosis – neurosis classification in mental illness.

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3) What are the axes used in DSM-IV classification?

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4) What is the difference between the various classes of childhood psychiatric disorders?

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3.3 ASSESSMENT OF MENTAL DISORDERS

When a client comes to you, a detailed evaluation is necessary to understand her or his problems, label them correctly and then help the client to overcome the problems. The detailed evaluation or assessment follows certain principles and is carried out systematically, in a step-wise fashion. At times assessment cannot be carried out in a single sitting and multiple sessions may be required to complete it. The extent of assessment also depends on the setting – outpatient, inpatient, etc.

3.3.1 Why is Assessment Required?

Assessment is required for the following purposes:

- 1) **Establishing a diagnosis:** An assessment should help you to understand the nature of the client's problem and establish a working diagnosis, based on which she or he can take steps to manage her or his problems.
- 2) **Planning treatment:** An assessment should help you to plan the next steps in managing the problems — what needs to be done immediately, and what needs to be done later.
- 3) **Referral to a specialist for further management:** The assessment should help you to know whether the client is in need of your help, or the help of another specialist.
- 4) **Establish rapport and make the client comfortable:** An assessment can help you to break ice with the client and help the client to voice her or his problems freely, without fear of being misunderstood.

3.3.2 Carrying Out an Assessment

The assessment is carried out in the following steps:

- 1) Eliciting history,
- 2) Mental status examination,
- 3) Physical examination,
- 4) Physical investigations,
- 5) Psychological assessment, and
- 6) Assessment Schedules and Rating Scales.

1) Eliciting History

Assessment begins with collecting the socio-demographic information of the client, like age, gender, socio-economic status, etc. In addition, details of the person accompanying the client should also be noted.

You should then elicit information on the problems for which the client has sought your help. Initially you should allow the client to explain her or his problems freely; after this largely spontaneous narration, you can seek clarifications to arrive at an understanding of the problems that can help you in prioritising the course of action.

The elicitation of history should cover the following areas:

History of present problems or illness; any past history of similar problems or other problems of psychological nature; history of medical illness; history of substance use; and family history of psychological or medical problems.

In addition, information is also collected on the *client's early developmental history* (nature of birth and history of birth trauma; developmental milestones; childhood psychological problems such as temper tantrums, bed wetting, or conduct problems; schooling and any problems thereof). Also the *client's occupational history* (jobs, performance, any frequent change of jobs, job satisfaction, etc.), *marital history* (years of marriage, any divorce,

and satisfaction in marital life), *sexual history* (sexual preference, early sexual encounters, current sexual functioning and satisfaction, knowledge and attitude towards sexual intercourse, etc.), and in case of female clients, reproductive and menstrual history. Lastly, you should make an effort to understand the personality of the individual which includes social interaction; predominant mood (and any mood swings); character; attitude towards self, others and work; and predominant interests and hobbies pursued.

2) Mental Status Examination

You should carry out and record a detailed Mental Status Examination (MSE). Carrying out a mental status examination requires considerable skill, which can be learnt by observing skilled interviewers and by practice under supervision.

- i) **General appearance and behaviour:** The mental status examination begins as soon as the client enters the room, with observation of the client's general appearance and behaviour (build and nutrition status, gait, posture, manner of approaching and greeting the counsellor, clothing, behaviour towards the counsellor as well as others in the room, movement of the client, gestures, facial expression, etc.). In addition, appropriateness of these in the given socio-cultural milieu is also assessed.
- ii) **Mood:** You should record both the client's description and also your interpretation of his / her mood. Your interpretation should be based on observation of the client's facial expression and gestures. In addition, the appropriateness of the client's mood to his / her situation should also be assessed and recorded.
- iii) **Speech and thought:** The 'how' of speech is recorded under speech, and the 'what' of speech, is recorded under 'thought'. The rate of speech, quantity of speech, any difficulty / oddity in speech, and flow of speech is observed. In thoughts, the main emphasis is on the content of thought. Commonly recorded thought contents are worries, obsessions and delusions. In additions, ideas with any particular theme are also recorded, for example suicidal and persecutory ideas.
- iv) **Perception:** Here, the patient's interpretations of his sensations are recorded. This could be altered perception in the form of distortions (misinterpretation of a normal sensation) or deceptions (reporting sensations which are not present). An example of distortion of perceptions would be an illusion, in which a person misinterprets the sensory stimulus for example misinterpreting a rope to be a snake. The most prominent deception of perception would be hallucinations; for example a person hears sounds that are absent (others in his vicinity cannot hear that sound).
- v) **Cognitive functions:** Though this is usually recorded and formally tested later in the mental state examination, any gross disturbance is apparent within minutes of the interview. In such cases, precedence must be given to the cognitive functioning. The cognitive functioning assessment should include the following:

Orientation: This is assessed by enquiring about the client's awareness of time (for example, current date, day, time, season and year), place

(for example, home address and the place of interview) and person (for example, identification of attendant / accompanying person).

Attention and Concentration: This can be assessed informally by observing whether the client is able to attend to what is being asked. Formal assessments can also be carried out by some tests designed for this: for example, digit span test, serial sevens (subtracting 7 serially from 100) test.

Memory: This also can be assessed informally by comparing the client's information with his / her attendant, as well as comparing the client's own version at different points of time during the interview. Formal tests of memory are conducted in three domains: immediate memory (for example, ask the client to memorise three items and speak them out after 1 minute and 5 minutes), recent memory (for example, ask the client what food he had the day before the interview, how did he arrive at the place of interview), and remote memory (for example, ask the client some of his personal details such as when did he complete schooling, his previous residences; as well as well-known news information such as names of past presidents, year of independence, etc.). Any impairment during this assessment should prompt the therapist to apply standardised tests for memory.

Note: *If you find significant disturbance in the client's cognitive functions, you should refer the client to an appropriate medical centre for evaluation of medical / neurological conditions, including delirium and dementia.*

vi) Judgement and Insight: You should assess the client's personal judgement (for example her or his views on her or his future), social judgement (for example based on how the client behaves with people around him during the interview), and test judgement (for example giving the client an hypothetical situation and eliciting his response: for example, what would be her or his reaction — if a house is on fire or if a letter with address on the envelope is found). You should also assess the client's insight, which details what the client's thinks and feels about his problems, and the possible solutions to them. Some of the basic questions that should be answered are:

- Is the client aware that she or he is ill?
- Does the client think the illness is physical or mental?
- To what factors does the client ascribe his or her illness?
- Does the client think that she or he needs any treatment?
- What kind of treatment does the client feel that she or he needs?

Check Your Progress Exercise 4

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) What are the various benefits of an assessment?

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physical illness. For example, increased production of thyroid hormones results in anxiety symptoms, similarly decreased production of thyroid hormones result in depression symptoms.

- iii) Some medications given for mental illnesses have significant side effects. The client may need advice regarding their management. For example, a client who is putting on weight while on a second-generation antipsychotic.

Physical examination requires examination of general condition such as pulse, blood pressure, temperature, presence / absence of anaemia, jaundice, cyanosis, thyroid enlargement, etc. In addition systemic examination of cardiovascular system, respiratory system, abdominal system and neurological system is required.

4) Physical Investigations

Physical investigations are necessary to establish or rule out general medical conditions. Some familiarity with basic investigations is useful for the counsellor. A hemogram (to assess the level of haemoglobin, white cell count, etc.), liver function test and kidney function test are often performed before starting psychotropics. Sometimes, detailed investigations such as computerised tomography of the brain, magnetic resonance imaging of the brain, electro-encephalogram (to assess the electrical signals of the brain in order to rule out seizures and other disorders) may be performed.

5) Psychological Assessment

Sometimes, after the history and mental status examination, you may wish to obtain a more detailed assessment of psychological functioning of the client. Psychological assessments are performed by trained personnel (usually psychologists). The following are the domains assessed by psychological tests:

i) Neuropsychological assessment

This is usually performed when there are indications of cognitive deficits in the client during mental status examination. Here in, the assessment may be on intelligence, or other specific areas of cognitive functions. Among intelligence tests, Wechsler Adult Intelligence Scale, Wechsler Intelligence Scale for Children, Stanford Binet test for children, or their adaptations are commonly used. Some of the commonly used cognitive function tests are: Luria-Nebraska test and Halsted-Reitan battery. Standardized Indian adaptations are available for many neuropsychological tests / batteries.

ii) Personality tests

Some of the commonly used personality tests are Minnesota Multiphasic Personality Inventory (MMPI), Eysenk Personality Questionnaire (EPQ) and Multi-phasic questionnaire. Indian adaptations are available for many personality tests.

iii) Projective tests

These are tests in which ambiguous stimuli are given to the individual and responses elicited from her or him. The responses are then analysed

to give a picture on the individual's thinking pattern, personality and also unconscious thoughts and feelings. Some of the commonly used projective tests are Rorschach test, Thematic Apperception Test (TAT) and Sentence Completion Test.

6) Assessment schedules and rating scales

A number of interview schedules have been devised to make clinical assessment more uniform. You would need specific training to use them properly. Some of the well known assessment schedules that help with the diagnosis of mental disorders are: Schedule for Clinical Assessment in Neuropsychiatry (SCAN), Present Status Examination (PSE), Composite International Diagnostic Interview (CIDI), Diagnostic Interview Schedule (DIS), Structured Clinical interview for DSM-IV (SCID), and Schedule for Affective Disorders and Schizophrenia (SADS).

In addition, there are a number of tools that can rate the severity of the disorder that the client is suffering from. These scales help in tracking the progress of the illness, or recovery. Some examples are:

- i) Schizophrenia:** Scale for Assessment of Positive Symptoms (SAPS), Scale for Assessment of Negative Symptoms (SANS), Positive and Negative Symptom Scale (PANSS), Brief Psychiatric Rating Scale (BPRS),
- ii) Mania:** Young Mania Rating Scale (YMRS), Manic State Rating Scale (MSRS),
- iii) Depression:** Hamilton Depression Rating Scale (HDRS), Zung Depression Scale (ZDS), Montgomery Asberg Depression Rating Scale (MADRS), Beck Depression Inventory (BDI),
- iv) Anxiety:** Hamilton Anxiety Rating Scale (HARS), Yale Brown Obsessive Compulsive Scale (YBOCS), and
- v) General health/quality of life:** General Health Questionnaire (GHQ), World Health Organisation Quality of Life Scale (WHO QOL), Global Assessment of Functioning (GAF).

Some of the tools are used by counsellors and family therapists while some are used by psychiatrists or psychologists.

Check Your Progress Exercise 5

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) Why should one perform physical examination as part of assessment?

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2) What are the various types of psychological tests used?

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3) List some scales used for rating mental illness.

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4) List some assessment schedules used for diagnosing mental illness.

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3.4 LET US SUM UP

In this Unit, we have covered two aspects – classification and assessment. In classification, we have learnt the basic concept of classification, including what are the various purposes of classification, the various classificatory systems used as well as the description of various classes under the ICD-10 classificatory system. In the assessment section, the benefits of assessment were learnt along with the various forms of assessment.

3.5 GLOSSARY

Acute and transient psychosis : Disorder in which psychotic symptoms (such as delusions, hallucinations or bizarre behaviour) appear suddenly, and last only for (a total duration) of hours to weeks.

Adjustment disorder : Disorder in which subjective distress and emotional disturbance arise during adaptation to a significant life event. The symptoms appear within one month and resolve within 6 months of the life event.

Amnesic disorders : Disorders characterised by loss of memory.

- Anxiety** : The apprehensive anticipation of future danger or misfortune accompanied by somatic symptoms of tension.
- Conversion disorder** : Disorder in which intrapsychic conflicts that would otherwise give rise to anxiety are instead given symbolic external expression in the form of symptoms that mimic neurological symptoms.
- Delirium** : Delirium is an acute, usually temporary condition characterized by disorientation and attention and memory difficulty. It may be accompanied by hallucinations, anxiety, incoherent speech, restlessness and delusions. It is caused by medical-surgical conditions like high fever, trauma, alcohol withdrawal (delirium tremens), etc. It is an emergency requiring prompt treatment.
- Delusion** : A false belief based on incorrect inference about external reality that is held firmly despite obvious evidence to the contrary. Other members of the person's culture or subculture do not ordinarily accept the belief.
- Delusional disorders** : Disorders in which delusion is the prominent symptom.
- Dementia** : A progressive decline in cognitive function beyond what might be expected from normal aging.
- Depersonalisation** : An alteration in the perception or experience of the self so that one feels detached from (and as if one is an outside observer of) one's mental processes or body.
- Derealisation** : An alteration in the perception or experience of the external world so that it seems strange or unreal (for example, people may look two-dimensional or mechanical).
- Dissociative disorders** : Disorders in which there is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment.
- Encopresis** : Passage of stool in inappropriate places in individuals who are expected to be continent or have already been toilet trained.

- Enuresis** : Involuntary urination after the age at which bladder control would normally be anticipated.
- Factitious disorders** : Psychiatric condition in which an individual presents with an illness that is deliberately produced for the sole purpose of assuming a sick role.
- Gender identity disorders** : Disorder in which a person's inner conviction of being male or female is disturbed.
- Impulse control disorders** : A set of psychiatric disorders in which there is a compelling desire to perform a particular task / activity. Includes intermittent explosive disorder, kleptomania (stealing), pathological gambling, pyromania (fire-starting), and trichotillomania (pulling one's hair out).
- Mental retardation** : Disorder characterised by sub-average cognitive functioning.
- Mood (affective) disorders** : Disorders in which the major problem is mood regulation. Mood may be too low (depression), too high (mania), or too high at some times and too low at others (bipolar disorder).
- Obsession** : A recurrent and persistent thought, impulse, or image experienced as intrusive and distressing. It is recognised as being excessive and unreasonable even though it is the product of one's own mind. This thought, impulse, or image cannot be expunged by logic or reasoning.
- Compulsion** : Repetitive ritualistic behaviour such as hand washing or ordering that aims to prevent or reduce distress or prevent some dreaded event or situation. The person feels driven to perform such actions in response to an obsession or according to rules that must be applied rigidly, even though the behaviours are recognised to be excessive or unreasonable.
- Obsessive compulsive disorders** : Disorder characterised by obsessions and compulsions.
- Personality disorders** : Disorders characterised by rigid and on-going patterns of feeling, thinking, and behaviour. The inflexibility and pervasiveness of these behavioural patterns often cause serious personal and social difficulties, as well as a general functional impairment.

- Phobia** : Persistent, irrational fear of a specific object, activity, or situation that results in avoidance of the feared stimulus. For example agoraphobia — fear of open spaces or of being in crowded public places like markets with resulting fear of leaving a safe place.
- Pica** : Disorder characterised by desire to consume or eat non-nutritive substances (for example, chalk, soil, paper, soap, mucus, ash, etc.)
- Psychoactive substance** : A chemical that acts primarily upon the central nervous system and results in temporary changes in mood, behaviour, consciousness and perception. These drugs are often used recreationally to purposefully alter one’s consciousness.
- Schizophrenia** : A persistent psychotic illness characterized by symptoms such as hallucination in which the persons hears things spoken about him in 3rd person, delusion of his thoughts being known to others without his wish, delusions of his activities or mood being controlled by others, etc.
- Schizotypal disorder** : Disorder characterised by social isolation, odd behaviour and thinking, and unconventional beliefs
- Somatoform disorder** : Disorder characterised by physical symptoms that mimic disease or injury for which there is no identifiable physical cause. The physical symptoms are believed to be related to psychological factors.

3.6 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

- 1) Classificatory system can help in following ways:
 - i) It helps to decide about patient or client problem management, as standardised management strategies are known for many diagnosis;
 - ii) It helps to predict the course and outcome of the client’s problems;
 - iii) It helps in communicating efficiently with other professionals, as they follow the same, standardized classificatory system; and
 - iv) It helps to group and analyse individuals with similar set of problems.

- 2) The diagnosis of most mental disorders is based on a set of signs and symptoms, as there is no known aetiology. However, in other medical illness, a definitive diagnosis can be made by carrying out investigations to establish the diagnosis.
- 3) Some eminent persons associated with the development of psychiatric classification are Hippocrates, Aurelianus, Sydenham, Pinel, Kahlbaum, Griesinger, Pinel, Kahlbaum and Kraepelin.
- 4) Kraepelin used three criteria for the classification of mental illnesses, that are:
 - i) Clinical description,
 - ii) Course of the illness, and
 - iii) Outcome of the illness.

Check Your Progress Exercise 2

- 1) C
- 2) D
- 3) A
- 4) D
- 5) D

Check Your Progress Exercise 3

- 1) Class F50 – 59 denotes: eating disorders, sleep disorders, sexual disorders and abuse of non-dependence producing substances
- 2) Psychosis is characterised by symptoms such as hallucinations, delusions and bizarre behaviour, loss of insight and severe illness. Neurosis is characterised by the predominant presence of anxiety, presence of insight and milder severity of illness.
- 3) The multi-axial approach used in DSM-IV comprises:
 - i) **Axis I** : All clinical diagnosis, except for personality disorders and mental retardation.
 - ii) **Axis II** : Personality disorders, mental retardation and defence mechanism.
 - iii) **Axis III** : General medical conditions that may be relevant to understanding or managing the patient's psychiatric disorder.
 - iv) **Axis IV** : Psychosocial and environmental problems relevant to diagnosis, treatment and prognosis of the patient's disorder.
 - v) **Axis V** : Global assessment of functioning based on the clinician's judgement.

- 4) The mental disorder under class F70–79 is characterised by a decreased intellectual functioning; F80–89 is characterised by deficits in certain areas of intellectual functioning or deviation in intellectual functioning; F90–99 is characterised by disordered behaviour and emotional aspects of childhood.

Check Your Progress Exercise 4

- 1) Benefits of assessment are:
 - i) Establishing a diagnosis as it helps to understand the nature of problem,
 - ii) Planning the treatment as steps in managing the problem can be planned according to priority basis,
 - iii) Referral to a specialist for further management if required, and
 - iv) It helps in establishing rapport and in making the client comfortable.
- 2) The various components of psychiatric assessment are
 - a) Eliciting history,
 - b) Mental status examination,
 - c) Physical examination,
 - d) Physical investigations, and
 - e) Psychological assessment.
- 3) The areas assessed in the ‘General appearance and behaviour’ section of the mental status examination are build and nutrition status, gait, posture, manner of approaching and greeting the counsellor, clothing, behaviour towards the counsellor as well as others in the room, movement of the client, gestures, facial expression, etc. In addition, appropriateness of these in the given socio-cultural milieu is also assessed.
- 4) Following are the cognitive functions assessed in the mental status examination section:
 - i) Orientation,
 - ii) Attention and concentration,
 - iii) Memory,
 - iv) Judgement, and
 - v) Insight

Check Your Progress Exercise 5

- 1) Physical examination is done because:
 - i) Some mental illnesses may have physical manifestations,
 - ii) Some mental symptoms may be the result of physical illness, and
 - iii) Some medications given for mental illness have significant side effects.
- 2) The various psychological tests used can be divided into the following domains:
 - i) Neuropsychological tests,
 - ii) Personality tests, and
 - iii) Projective tests.

- 3) Some examples of tools used in rating of mental illness are:
 - i) Schizophrenia: Scale for Assessment of Positive Symptoms (SAPS), Scale for Assessment of Negative Symptoms (SANS), Positive and Negative Symptom Scale (PANSS), Brief Psychiatric Rating Scale (BPRS),
 - ii) Mania: Young Mania Rating Scale (YMRS), Manic State Rating Scale (MSRS),
 - iii) Depression: Hamilton Depression Rating Scale (HDRS), Zung Depression Scale, Montgomery Asberg Depression Rating Scale (MADRS), Beck Depression Inventory (BDI),
 - iv) Anxiety: Hamilton Anxiety Rating Scale (HARS), Yale Brown Obsessive Compulsive Scale (Y BOCS) for OCD, and
 - v) General health / quality of life: General Health Questionnaire (GHQ), World Health Organisation Quality of Life Scale (WHOQOL), Global Assessment of Functioning (GAF).
- 4) Examples of assessment schedules used for diagnosing mental illness are:
 - i) Schedule for Clinical Assessment in Neuropsychiatry (SCAN),
 - ii) Present Status Examination (PSE),
 - iii) Composite International Diagnostic Interview (CIDI),
 - iv) Diagnostic Interview Schedule (DIS),
 - v) Structured Clinical Interview for DSM-IV (SCID), and
 - vi) Schedule for Affective Disorders and Schizophrenia (SADS).

3.7 UNIT END QUESTIONS

- 1) What is the difference between classification and assessment?
- 2) How did classificatory system come into existence?
- 3) What do you mean by the term 'ICD'. Please mention the categories given by ICD-10.
- 4) Explain the steps of assessment in your own words.

3.8 FURTHER READINGS AND REFERENCES

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UNIT 4 NATURE AND TYPE OF CHRONIC PHYSICAL ILLNESSES

Structure

- 4.1 Introduction
- 4.2 Association Between Chronic Physical Illnesses and Mental Illness
- 4.3 Nature and Type of Illness in Relation to Mental Health
 - 4.3.1 Heart Diseases
 - 4.3.2 Renal Diseases
 - 4.3.3 Endocrine and Metabolic Disorders
 - 4.3.4 Oncological Disorders
 - 4.3.5 Skin Disorders
 - 4.3.6 Gastrointestinal Tract (GIT) Disorders
- 4.4 Psychosocial Treatment
 - 4.4.1 Psychotherapies
 - 4.4.2 Behavioural Techniques
- 4.5 Let Us Sum Up
- 4.6 Glossary
- 4.7 Answers to Check Your Progress Exercises
- 4.8 Unit End Questions
- 4.9 Further Readings and References

4.1 INTRODUCTION

Chronic physical illnesses like heart related disease, diabetes, asthma and risk factors such as obesity, smoking, physical inactivity and heavy drinking are all significantly associated with psychological problems. Psychiatric problems in a person suffering from physical illness may result in increased disability, poor recovery and increased health care expenditure as compared to those suffering from physical illness alone.

In this Unit, you are going to understand the effects and consequences of having psychological problems on patients suffering from chronic physical illnesses. Also, we will study the association of psychological problems with various specific physical illnesses related to vital organs and systems in the body such as heart diseases, renal diseases, hormonal and metabolic disorders, oncological (cancer) disorders, skin disorders and gastrointestinal disorders.

Objectives

After studying this Unit, you will be able to:

- Understand about association between psychiatric disorders and physical illnesses; and
- Learn about the psychosocial management of these conditions.

4.2 ASSOCIATION BETWEEN CHRONIC PHYSICAL ILLNESSES AND MENTAL ILLNESS

The association between chronic physical illnesses and mental illnesses is strong. The history of psychological trauma has been associated with arthritis (joint inflammation and pain), diabetes (increased blood sugar), digestive tract diseases and cancer. Patients with a moderate or severe life-threatening disease are three times at risk for having a psychiatric diagnosis as compared to normal healthy people. Stressful life events are known to play a role in the onset of hormonal disorders (for example, Cushing's syndrome). Hormonal disorders may improve with psychiatric treatment for example insulin resistance to insulin (drug used to treat diabetes) may decrease after treatment with antidepressants (drugs used to treat depression) and similarly, depressive symptoms improve with thyroid hormone replacement. This association is seen in adolescents and children also; adolescents with physical illness have more behavioural or emotional problems and are more depressed compared to normal adolescents.

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

- 1) Is there any association between a psychiatric illness and chronic physical illness? Explain in 2-3 lines.

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4.3 NATURE AND TYPE OF ILLNESS IN RELATION TO MENTAL HEALTH

In this section, we will discuss some common and major chronic physical illnesses along with the psychiatric disorders associated with these diseases.

4.3.1 Heart Diseases

Heart related (*cardiovascular*) illnesses are the leading cause of death in the industrialised world and are increasing in developing countries. *Coronary artery disease (CAD)* is a progressive illness characterised by occlusion of arteries supplying blood to heart leading to *cardiac ischemia*; if not corrected may lead to death. These patients present with complaints of shortness of breath and fatigue, which may be confused with panic or depressive symptoms respectively. Psychiatric disorders frequently occur as complications or as comorbid conditions in individuals with cardiovascular disease. Treatment of psychiatric disorders improves compliance to medication and relieves suffering due to psychiatric illness.

Some of the psychiatric disorders associated with heart diseases are:

1) Depressive Disorder

Approximately 15 to 20 percent of patients with cardiovascular diseases suffer from depression. Depression occurs in large portion of patients after an *acute myocardial infarction* (heart attack). Depression may increase risk of complications in such cases independently or in association with increased smoking or abnormal autonomic function (abnormal heart rhythm). Depression predicts the quality of life in patients suffering from cardiac illness.

2) Anxiety Disorder

The risk of coronary events in anxious patients with myocardial infarction increases by two to five times as compared to non-anxious patients with myocardial infarction. Sudden extreme level of anxiety poses an increased risk of sudden cardiac death.

3) Adjustment Disorders

Life-threatening illness may lead to adjustment disorders because of issues of dependence on others, loss of control as well as anxiety about death itself. This results in profound disruption of social roles and capacity for autonomous functioning.

Check Your Progress Exercise 2

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) How does depression worsen the cardiovascular illness?

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4.3.2 Renal Diseases

Chronic renal failure (CRF) is the end stage kidney disease and is treated by dialysis or renal transplant. It has been reported that 23 per cent of the patients with end stage kidney disease have at least one psychiatric disorder. The persons with renal disease who commit suicide are frequently accompanied by depression.

Some of the psychiatric disorders associated with renal diseases are given below:

1) Depressive Disorder

The depressive disorder is the most common psychiatric disorder and is seen in about 17 per cent of CRF patients; depression increases the chances of suicide.

2) Adjustment Disorders

In the case of end-stage renal disease, adjustment problems start at the time of diagnosis. Patients try to adapt to a chronic physical illness and their dependence on a dialysis to stay alive. Adjustment in cognitive, emotional and behaviour domains is required by patients and their families. Denial as a defense mechanism is often used leading to denial or poor compliance with treatment.

3) Suicide

Suicidal ideas are fairly common in patients with CRF treated by continuous dialysis; 25% of them have various degrees of suicidal ideas. The suicide risk in patients who undergo dialysis is 15 times more than general population. High levels of anxiety increase the suicide risk in depressive patients.

4) Cognitive Deficit

Lower performance IQ scores have been noted in patients with CRF before dialysis. Improvements in short-term memory and attention have been found after starting maintenance dialysis.

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

- 1) Explain the association of psychiatric disorders in patients suffering from chronic diseases in 1-2 lines.

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4.3.3 Endocrine and Metabolic Disorders

Patients suffering from endocrine and metabolic disorders present with psychiatric symptoms early in the course and physical symptoms later as the disease progresses. Following are some of the common endocrinological and metabolic disorders:

- 1) The thyroid gland produces thyroid hormones, triiodothyronine (T_3) and thyroxine (T_4). Two most common thyroid disorders are *hyperthyroidism* (increased thyroid hormone) and *hypothyroidism* (decreased thyroid hormone) most commonly associated with psychiatric illnesses. TSH (thyrotropin) produced by the anterior pituitary, promotes the synthesis and release of thyroid hormones, T_3 and T_4 , from the thyroid gland. Hyperthyroidism presents as nervousness, irritability, fatigue, increased pulse rate, elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, palpitations, menstrual irregularities in females and muscle weakness. Hypothyroidism presents as cold intolerance, constipation, menstrual disturbances in females, breathlessness, dizziness, weight gain, thinning hair, husky voice, decreased pulse rate and elevated levels of lipids in the blood.

- 2) The adrenal gland produces steroid hormones which prepare the organism during stress. *Cushing's syndrome* (hypercortisolism, increased steroid hormones) is characterised by moon facies, abdominal obesity, muscle wasting, slow wound healing, easy bruising, thinning of the skin and osteoporosis. Cortisol levels are found to be increased during stress. *Adrenocortical insufficiency* (decreased steroid hormones) presents with symptoms of weakness, hypoglycemia (low blood glucose levels), nausea, diarrhoea, fever, psychotic symptoms and shock.
- 3) *Diabetes mellitus* is characterised by dysregulation of glucose metabolism in the body. Classic symptoms of Type I/diabetes (early onset) and Type II/diabetes (late onset) include *polyphagia* (increased appetite), *polyuria* (increased urination) and *polydipsia* (increased thirst). Other symptoms might include blurred vision, fatigue, weight loss, poor wound healing, dry mouth and recurrent infections. Most of the morbidity and mortality of diabetes is caused by its long-term complications.

Some of the psychiatric disorders associated with endocrine and metabolic diseases are discussed below:

1) Affective Disorder (Depression/Mania)

Hypothyroidism is commonly associated with depressed mood, impaired memory and concentration and may lead to treatment non-responsive depression. Depression in hypothyroid patients is unlikely to resolve until thyroid levels return to normal. Subclinical hypothyroidism doubles the lifetime risk of developing major depression.

Symptoms of hyperthyroidism may resemble those of a manic episode such as nervousness, insomnia, sudden mood changes, irritability, pressured speech and patients may show increased psychomotor activity.

The majority of patients with *Cushing's syndrome* experience fatigue and depressed mood. Depressive symptoms occur more commonly in female patients than male patients along with emotional lability, irritability, decreased libido and anxiety. Social withdrawal may develop as a result of shame due to change in physical appearance. Manic and psychotic symptoms occur much less frequently than depression, but rise to 40 percent in patients with *adrenal carcinomas*. The symptoms of easy fatigability, muscle cramps, weight loss and lethargy may also lead to a diagnosis of chronic fatigue syndrome.

Depression is more common in persons with diabetes than general population and is a major factor in causing hospital admissions and death in persons with diabetes mellitus. In patients with diabetes having depression, insulin resistance develops; this fact might help in understanding the causal link between depression and diabetes.

2) Psychosis

A psychotic syndrome of *auditory hallucinations* (hearing voices) and *paranoia* (suspiciousness) named *myxedema madness*, has been described in patients with hypothyroidism. In severe cases of hyperthyroidism, visual hallucinations, paranoid ideation and delirium may be seen. In cases of acute adrenal insufficiency, such as after abrupt discontinuation of external steroid

administration, patients may develop psychosis or delirium. Prevalence of diabetes mellitus has been reported to be two to three times in schizophrenia patients as compared to general population.

3) Cognitive Deficits

Cognitive deficits are seen in hypothyroidism, hyperthyroidism and hypercortisolism. High level of cortisol is associated with structural abnormalities in brain like reduced volume of *hippocampus* (an area in brain which is involved in selective attention, learning and memory). Cortisol impairs attention that results in poor discrimination of important information. Approximately 83 per cent of these patients experience deficits in concentration and memory; the severity of these deficits correlates with plasma cortisol levels.

4) Eating Disorders

These disorders occur often in adolescents with diabetes and present challenges in diagnosis and management. Eating disorders should be considered in patients with poor glucose control or multiple episodes of developing complications.

Check Your Progress Exercise 4

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) Which are the common endocrine disorders associated with psychiatric disorders?

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4.3.4 Oncological Disorders

Cancer is said to be the second most common cause of death after heart disease. Patients express emotions ranging from fear, sadness, anxiety and guilt. Over a period of few days the level of stress decreases but in some it continues for long, when the patient should be evaluated and treated for psychiatric disorders. The incidence of psychiatric disorders is approximately 50 percent in cancer patients. Breast cancer remains the most studied but lung cancer is now receiving needed attention. Five symptoms which are found in more than 50 percent of patients are fatigue, worry, sadness, pain and drowsiness. Other symptoms include insomnia, poor appetite, change in taste and decreased concentration. Instrument by the name of *distress thermometer* (National Cancer Control Network) can be used to rate the level of distress, where the patient is asked to rate her or his level of distress in several domains. *Psycho-oncology* is the study of the psychological aspects of cancer.

Some of the psychiatric disorders present in cancer patients are given below:

1) Adjustment Disorders

Adjustment disorders with depressed mood, anxious mood and mixed emotional features are the commonest diagnosis in cancer patients.

2) Depressive Disorders

In patients with different types of cancers, recurrent thoughts of death are common. However, these may not have the morbid intensity and severity that is characteristic of depressed patients. Incidence of depressive disorders is about 20 to 45 percent. Depressive disorders can be due to the relapse of a pre-existing depressive disorder, due to the tumor itself or due to the cancer medications. *Carcinoma* of the pancreas has been reported to be associated with depression at times as the presenting symptom. Despite such high incidence, depression continues to be under diagnosed and undertreated despite high prevalence in patients with cancer.

3) Anxiety Disorder

Anxiety is commonly seen in cancer patients. The cancer itself causes anxiety as drugs used to treat cancer are a common cause of anxiety in cancer patients. Acute stress disorder is the most immediate and shortest lasting type of anxiety disorder (usually less than 30 days). It is associated with intrusion of thoughts and avoidance of stimuli leading to anxiety.

4) Delirium

Patients in delirium present with altered consciousness along with cognitive, perceptual and behavioural abnormalities. It is seen in 15 to 75 percent of cases with advancing disease. Delirium can be caused by the primary disease, by co-morbid physical disorders and by the drugs used for cancer treatment.

5) Insomnia

Insomnia (loss of sleep) is commonly seen in patients with cancer. It may be due to co morbid psychiatric disorders or symptoms of the cancer itself such as pain. Insomnia is recognised but is often mistreated which may cause dependence on hypnotics (sleep producing drugs) or daytime sedation and may worsen symptoms of depression and delirium.

6) Sexual Dysfunction

Cancer patients hide their sexual concerns, because of embarrassment and shame. Sexual dysfunction is reported in breast cancer patients. The type of treatment modality may also lead to sexual dysfunction such as lymph node dissection in testicular cancer may lead to erectile dysfunction. Similarly postsurgical nerve damage associated with prostate, bladder or rectal cancers may lead to loss of ejaculation and sexual impairments.

7) Substance Withdrawal Syndromes

Nicotine dependence is common in patients with thoracic, head and neck cancer; they are at high risk for nicotine withdrawal. Many patients stop smoking abruptly on receiving their diagnosis and may experience severe anxiety symptoms, sometimes associated with dissociative symptoms and bizarre behaviours. Alcohol abuse is fairly common in patients with cancer.

When patients with cancer with history of alcohol abuse are hospitalised, alcohol withdrawal may manifest on the second or third day in the hospital in form of anxiety, poor coping or postoperative delirium; referral to psychiatrist is required to deal with alcohol withdrawal and long term management.

8) Suicide

Suicidal thoughts and wishes are common but the incidence of actual suicide is not more than approximately twice that of the general population. Patients feel guilty, burdened and angry. Hopelessness, pain, anxiety, lack of social support, depression, financial problems and personality disorder are risk factors for suicide.

9) Cancerophobia

The negative reaction to cancer in society often makes it the object of excessive fear. Transient cancerophobia may be a response to a specific event, such as death in family due to cancer. Fixed cancerophobia ranges from a neurotic symptom to a *hypochondriacal fixation* (false strong belief of suffering from serious illness), obsession or a somatic delusion.

Check Your Progress Exercise 5

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) What are the psychiatric disorder symptoms commonly associated with cancer patients?

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4.3.5 Skin Disorders

The initiation, progress and healing of various skin diseases may be affected by the presence of psychiatric symptoms or stress.

- 1) *Atopic dermatitis* is a chronic skin disorder characterised by pruritus (itching) and inflammation (eczema). Scratching in response to the pruritus can lead to excoriations, and infections.
- 2) *Psoriasis* is characterised by skin lesions with clear-cut borders, silvery scales and erythema under the scales. Psoriasis is associated with severe impairment in the quality of life with a substantial negative impact on psychological, vocational, social, and physical functioning.
- 3) *Alopecia areata* is a non scarring hair loss in patches of typically well-demarcated smooth skin.

- 4) *Urticaria* is characterised by circumscribed, raised, pink, usually pruritic lesions of the superficial skin.
- 5) *Acne vulgaris* is a common sebaceous gland disease in which a variety of lesions including scars occur on the face.
- 6) *Primary hyperhidrosis* is excessive sweating in response to mental stimuli that typically affects the palms, soles, and axillae.

Psychiatric disorders associated with skin diseases are discussed below:

1) Stress

Environmental factors like contact irritants, allergens, hormones, climate and stress frequently trigger or exacerbate skin disease. Disease-related stress is mainly due to cosmetic disfigurement and social stigma. Patients with moderate to severe atopic dermatitis are more likely to experience psychiatric problems. Stressful life events often precede the onset and exacerbation of atopic dermatitis. Stress resulting from anticipation of others' reactions to psoriasis predicts patient's disability more than any other variable. The adverse effect of psoriasis on the quality of life can lead to stress that can, in turn, trigger more psoriasis.

Patients with stress-reactive alopecia areata report more depressive symptoms as compared to others. Patients frequently report stress-induced aggravation of acne vulgaris. Itching in acne is correlated with recent stressful life events, depressive symptoms.

2) Anxiety Disorder

Anxiety may exacerbate atopic dermatitis by eliciting scratching behaviour. Excessive worry has detrimental effect on treatment outcome in patients with psoriasis. Anxiety symptoms coexist with adult and childhood onset alopecia areata. Acne interferes significantly with social and occupational functioning, with a positive association between the severity of the acne, anxiety and poor self-image. Even patients with mild to moderate acne experience significant psychological distress and body image concerns. Patients with *chronic urticaria* are frequently depressed and anxious; women are more likely to experience significant psychiatric symptoms.

3) Depressive Disorder

Depressive disorders in patients with psoriasis are associated with severity of psoriasis, reduction in the threshold for pruritus and amplification of itch perception. Psychological factors, including perceived health, perceptions of stigmatisation and depression are stronger determinants of disability in patients with psoriasis than disease severity, location or duration. Many adults with alopecia areata have major depressive disorder. Studies have reported improvement in skin disorders with antidepressant medications.

4) Personality Disorders

Schizoid, avoidant, passive-aggressive and obsessive-compulsive personality disorders have been associated with skin disorders.

5) Other Disorders

- i) **Delusion of parasitosis:** Delusion of parasitosis is the fixed belief that one is infested with living organisms despite a lack of medical evidence of such infestation. Patients experience tactile hallucinations described as crawling, biting or stinging. Patients frequently present to dermatologists. Delusion of parasitosis has been associated with many medical disorders, including tuberculosis, syphilis, blood cancer, diabetes mellitus, vitamin B₁₂ deficiency and liver disease. It may be a part of various psychiatric disorders including depressive disorder, delusional disorders and schizophrenia.
- ii) **Psychogenic excoriation:** Psychogenic excoriation (also called neurotic excoriations, pathological or compulsive skin picking, and dermatotillomania) is characterised by excessive scratching or picking of normal skin or skin with minor surface irregularities. The excoriative behaviour can also have features characteristic of compulsivity and impulsivity. Depressive and anxiety disorders are common in patients with psychogenic excoriation.
- iii) **Trichotillomania:** It is a disorder of chronic hair pulling and has characteristics of both impulsivity and compulsivity. In patients with trichotillomania, commonly seen co-morbid psychiatric disorders are anxiety, mood, obsessive-compulsive, substance use and eating disorders. The most frequent personality disorders associated are histrionic, borderline and compulsive personality disorders.

Check Your Progress Exercise 6

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) What is delusional parasitosis?

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4.3.6 Gastrointestinal Tract (GIT) Disorders

When the corrosive effect of gastric acid overcomes the mucosal surface of the stomach or the intestine, ulceration occurs. *Inflammatory bowel disease (IBD)* is a term used to encompass ulcerative colitis and Crohn's disease. Both ulcerative colitis and Crohn's disease are severe, potentially life threatening disorders involving inflammation of intestinal tissues. Studies have found that the presence of a psychological disorder in IBD is associated with poor and self-perceived functional disability, regardless of symptom severity. The chronic relapsing nature of IBD, the need for debilitating treatments, and its threats to body image and social and sexual functioning can seriously impair psychological wellbeing and quality of life.

Psychiatric disorders associated with gastrointestinal tract disorders are discussed below:

1) Stress

Studies have reported a higher prevalence of psychosocial distress in patients with IBD than in the general population. Inflammatory bowel disease patients in remission have found an association of disease activity with stress. Ulcers often develop in the context of major life difficulties or stress.

2) Depression

A recent synthesis of the literature indicates that depression may exacerbate Crohns disease. Depression in IBD patients also is associated with more visits to both gastroenterologists and primary care physicians.

3) Personality Disorder

An increased vulnerability to stomach ulcers is seen in individuals with high levels of hostility and in those with depression and low ego strength. As the symptoms of IBD often begin during adolescence, personality structure may influence her or his adjustment to GIT disease.

4) Substance Abuse

Cigarette smoking, heavy drinking and drug abuse impair mucosal defenses, thereby increasing propensity to ulcers. Smoking can increase activity in Crohn's disease.

4.4 PSYCHOSOCIAL TREATMENT

The positive impact of psychosocial treatment (relaxation training, stress management) in rehabilitation of patients with chronic physical diseases is well known and is evident in research. Patients with heart diseases who receive psychosocial treatment have greater reductions in emotional distress, blood pressure, heart rate and blood lipid level than comparison subjects. Psychotherapeutic modalities, such as crisis intervention, cognitive problem solving, rational-emotive therapy and supportive therapy with an educational and a psychodynamic focus have beneficial effect. Working with individual patients or groups, the psychotherapies lowers distress, increases self-esteem and self-image, decrease anxiety and give patients a better sense of control.

The first step in starting psychosocial intervention for medically ill patients is to inform them about:

- 1) Impact of psychosocial variables on the illness,
- 2) Information on the impact of social support on the health and
- 3) Influence of stress on the illness.

4.4.1 Psychotherapies

Three different types of psychotherapies are discussed below:

- 1) **Brief individual psychotherapy:** Brief individual psychotherapy focuses on helping patients clarify and normalise their intense conflicted feelings and on setting and achieving short-term goals, especially those related to the illness.

- 2) **Couple or family interventions:** The families should be routinely involved in the treatment of ill or physically dependent patients to increase coping and reinforce communication and bonding.
- 3) **Educational and referral interventions:** Educational and referral interventions maximize the patient's and family's mobilisation and integration into a network of support.

4.4.2 Behavioural Techniques

Behavioural techniques reduce physiological arousal and increase the patient's sense of control. Behavioural techniques, such as active and passive relaxation, desensitisation and distraction are useful in a wide range of situations in oncology, including relief of acute and chronic anxiety related to surgery and painful procedures. Cognitive-behavioural psychotherapy or stress reduction practices, such as meditation and yoga, are useful for many asthma patients. Relaxation training, habit reversal training, cognitive-behavioural techniques and stress management training lead to significant and stable adjunctive treatment in skin diseases. Improvement of alopecia areata has been seen with psychotherapy and relaxation training. Biofeedback-assisted relaxation and cognitive imagery treatment reduces acne severity.

Counsellors can work with friends, families and the persons suffering from chronic physical illnesses. There are many strategies that counsellors use to help people heal and move forward. The patients may be given the following instructions:

- 1) Accept your illness,
- 2) Like yourself as you are, with all your problems, limitations and your appearance,
- 3) Get over the "*Why me?*" attitude so you can solve the problems of today,
- 4) Take total responsibility for your health and never overlook all the help you can get and
- 5) Become an expert on your illness.

4.5 LET US SUM UP

Chronic physical diseases are significantly associated with psychiatric disorders. This association exists in adolescents and children also. Mental illnesses increase the disability and decrease the quality of life in already compromised individual. Since mental illness can affect quality of life in severely ill patients, targeting mental illness in patients with chronic illness may assist in decreasing morbidity, disability and suicide. There is need to employ an integrated, multidimensional approach to healthcare as it is said "It is time to examine mental and physical health as a combined entity in our public health efforts".

4.6 GLOSSARY

Acute myocardial infarction : Heart attack.

Adrenocortical insufficiency : Decreased steroid hormones.

Coronary artery disease	: A progressive illness characterized by occlusion of arteries supplying blood to heart leading to cardiac ischemia.
Cushing's syndrome	: Hypercortisolism, increased steroid hormones.
Diabetes mellitus	: Dysregulation of glucose metabolism in the body.
Hippocampus	: An area in brain which is involved in selective attention, learning and memory.
Hyperthyroidism	: Increased thyroid hormone.
Hypothyroidism	: Decreased thyroid hormone.
Hypoglycemia	: Low blood glucose levels.
Paranoia	: Suspiciousness.
Polyphagia	: Increase appetite.
Polyuria	: Increase urination.
Polydipsia	: Increase thirst.
Psycho-oncology	: Study of the psychological aspects of cancer.

4.7 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

- 1) Yes, there is strong association between a psychiatric illness and chronic physical illness as about 25 per cent or more of those suffering from chronic physical illness suffer from psychiatric disorder. Among the psychiatric disorders, anxiety and depression are the most common disorders in those suffering from physical disorder.

Check Your Progress Exercise 2

- 1) Depression may increase risk of complication in cardiovascular illness independently or in association with increased smoking, abnormal autonomic function (increased sympathetic activation leading to arrhythmia) and platelet dysfunction (increased thrombus formation) seen in depression. It also predicts the quality of life among these patients.

Check Your Progress Exercise 3

- 1) The most common psychiatric disorder in end stage renal disorder is depression. Depression is also closely associated in renal disease patients who commit suicide.

Check Your Progress Exercise 4

- 1) Thyroid endocrine disorders are commonly associated both with depression and mania. Diabetes is commonly associated with depression. Adrenal gland disorders are commonly associated with psychosis and cognitive problems.

- 1) Five symptoms which are found in more than 50 per cent of patients are fatigue, worry, sadness, pain, drowsiness. Depression is even considered as the presenting symptom in patients of prostate cancer.

Check Your Progress Exercise 6

- 1) Delusion of parasitosis is the fixed belief that one is infested with living organisms despite a lack of medical evidence of such infestation. Patients experience tactile hallucinations described as crawling, biting, or stinging. It has been associated with many medical disorders, including tuberculosis, syphilis, chronic lymphocytic leukemia, diabetes mellitus, vitamin B12 deficiency and hepatic disease. It may also be a part of various psychiatric disorders including major depressive disorder, and schizophrenia.

4.8 UNIT END QUESTIONS

- 1) Discuss the association of some major chronic disease and mental illness.
- 2) How do behavioural techniques help the patient? Illustrate with the help of examples.

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UNIT 5 MENTAL HEALTH PERSPECTIVE IN CHRONIC PHYSICAL ILLNESSES

Structure

- 5.1 Introduction
- 5.2 Definition and Understanding Chronic Illness
- 5.3 Psychological Response to Illness
 - 5.3.1 Subjective Variables Influencing an Individual's Response to a Given Illness
- 5.4 Psychosocial Adaptation to Chronic Illness
 - 5.4.1 Basic Concepts of Psychosocial Adaptation
 - 5.4.2 Emotional Response to Illness
 - 5.4.3 Behavioural Response to Illness
- 5.5 Consequences of Chronic Illness
- 5.6 Role of Care-Givers
- 5.7 Let Us Sum Up
- 5.8 Glossary
- 5.9 Answers to Check Your Progress Exercises
- 5.10 Unit End Questions
- 5.11 Further Readings and References

5.1 INTRODUCTION

Each individual reacts to physical illness in her or his unique way. Some overcome it with courage and others have difficulty in overcoming intense emotions like anger, fear, or hopelessness. Various factors affect the response of an individual to an illness and its effect on the illness, for example, denial as a response to an illness may result in delay in seeking treatment. Medical and paramedical personnel working with the patients having chronic physical illnesses should understand their patients' reactions towards their illnesses. It will help to plan the treatment, modulate the patients' behavioural or emotional responses, decrease their distress and improve their medical outcomes. In this Unit we try to view illness as stress and the individual's psychological, emotional and behavioural response to the illness.

Objectives

After studying this Unit, you will be able to:

- Learn about the chronic physical illnesses;
- Discuss the ways in which chronic illnesses affect the persons mentally and physically;
- Understand the needs, challenges and limitations that these persons experience;
- Learn about psychological factors affecting the response to physical illness; and
- Learn in what ways care givers may be affected.

5.2 DEFINITION AND UNDERSTANDING CHRONIC ILLNESS

The term *chronic* comes from the Greek word *chromos*; it means lasting for a long time. Examples of common chronic illnesses include asthma, epilepsy, cancer, diabetes, heart disease and chronic fatigue syndrome. United States National Center for Health Statistics (NCHS) defines a chronic illness as one lasting three months or more. The Commission on Chronic Illness (1956) defines chronic illness as:

“all impairments or deviations from normal which have one or more of the following characteristics: are permanent, leave residual disability, are caused by non-reversible pathological alteration, require special training of the patient for rehabilitation, and/or may be expected to require a long period of supervision, observation or care.”

Chronic illnesses can begin at any time in life from childhood to old age and can create long-term health concerns that require adjustments in normal living. Chronic illnesses may differ in treatment, severity and prognosis. They may lead to disability (visible/invisible or static/progressive) thereby impairing the quality of life. In the life of the patients, their families and others who care for them (for example the whole family is affected when the primary wage earner is the patient), modifications need to be made.

Chronic illnesses may lead to financial, relationship and emotional challenges in addition to physical limitations. Individuals with chronic illnesses may experience loneliness, isolation, embarrassment, fear and concerns about dependency. Separation from family or friends in the hospital or at home when one is ill produces isolation, disconnection and stress. Dependency on others for the most basic tasks can be very stressful for many individuals. Chronic illnesses require the individuals to change their self-view more permanently. The challenges of chronic illness are ongoing and become part of the daily lives for the individuals.

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) What is chronic illness?

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5.3 PSYCHOLOGICAL RESPONSE TO ILLNESS

Mental disorders are often seen in association with physical illnesses. One explanation for this association is a psychological reaction to the distress imposed by a chronic medical condition, life-threatening condition or by the overall severity of the illness. Another explanation is that mentally ill patients may perceive themselves more troubled by medical conditions and therefore tend to seek medical help as compared to mentally healthy patients. Studies about illness perception have shown that people who are depressed consider their general and physical health worse than people who are not depressed. It has been observed in medical settings that patients with depression and anxiety rate their physical functioning worse than mentally healthy patients.

5.3.1 Subjective Variables Influencing an Individual's Response to a Given Illness

The subject of psychological factors affecting medical disorders has become the focus of intense research because intervention at psychological level has demonstrated improvements in medical outcomes and quality of life in individuals with serious medical disorders. Psychological factors may contribute to the initiation (for example psychological stress inducing *myocardial ischemia*) or the exacerbation of the illness (for example, by noncompliance to treatment).

Physicians are adept at identifying immediate physical problem for example disability caused due to cancer but mental health professionals understand patient's subjective experiences of illness. They are often asked to evaluate problematic behavioural or emotional reactions to their illnesses. Response of an individual to the illness depends on personality types, coping styles, and defense mechanisms. Interventions for the patients and their caregivers can be designed based on their emotional and behavioural responses to the chronic illness.

1) Personality Types

Most of the individuals exhibit traits of various personality types. The personality of an individual highlights the adaptive response of an individual during the period of stress for example mildly obsessional patient might appear overly rigid or dependent individual may appear excessively needy. Extreme expression of personality traits may aggravate the situation by developing counter transference in doctors and hospital staff and negative expressed emotions in family members.

Different personality types have different effects on response to physical illnesses and are as follows:

i) Dependent

The dependent patients continuously seek help, are demanding and are unable to solve problems or decide among the various treatment options available. These individuals have more compliant to the treatment and let the physician decide the best course for them. The care of such patients by the family is difficult due to greater desire for the care and their insatiable needs which may evoke aversion in their caregivers. They have limited frustration tolerance and the feeling of abandonment leads to clinging behaviour.

Patients with dependent personality type are helped by appropriate reassurance that they will be taken care of. Limit setting is done by specifying fixed schedule of visits (for example, thrice a week visit) and by setting clear expectations regarding the doctor's time and availability.

ii) Obsessional

Individuals with obsessional personality are meticulous, place a strong emphasis on rationality and like to feel in control over self. These patients focus on details and want to learn all about their medications, diagnoses, tests, etc to such an extent so as to miss the broader picture. They are easily frustrated by the unpredictability of the hospital environment for example, delay or cancellation in any procedure. Illness is considered loss of control over self and emotions which may lead to rigid and inflexible behaviour to accept the treatment.

It is helpful to give them details regarding the illness and its treatment. They should be involved in decision making process. This will generate feeling of control over self and will decrease anxiety and interpersonal friction.

iii) Histrionic

Patients with a histrionic personality can be entertaining and seductive at times. This can be uncomfortable or embarrassing for physicians. They need attention and admiration to avoid anxiety. The patient fear loss of attractiveness, experience illness as a threat to her or his femininity or masculinity; *denial* is common defense mechanism used to avoid anxiety.

It is helpful to encourage these patients to discuss their fears and physicians should balance the warmth and formality.

iv) Paranoid

These patients are guarded, quick to blame and readily feel attacked. They can be easily provoked as they blame external world for their present condition. They are prone to feeling hurt, invaded or exploited by medical procedures. Stress increases paranoid traits such as suspiciousness and they become more guarded and may refuse procedures or tests. They may accuse the physician and may lead to defensive counter transference which may be counterproductive. They do not forgive easily and may maintain lists of grievances.

A good approach to handle such patients is to listen to them patiently without dispute or agreement and explaining in detail the justification for the treatments. They should not be confronted for irrational fears and excessive warmth should be avoided.

v) Narcissistic

They are arrogant, devaluing, demanding and can easily be identified by their reaction. They may question the knowledge and competence of the treating physician. The patient may wish to be seen by only senior doctors and devalue those believed to be inferior to them. They experience illness as a threat to their self-concept of perfection and invulnerability and defense of grandiosity will be heightened. Common comment about these patients

by the staff and caregivers is ‘*who does he think he is?*’ Some physicians tempted are to cater to the unreasonable demands of these patients owing to their power and grandiosity.

The techniques helpful in handling these patients are: providing opportunities to brag or show off which help in rapport building and not to take patients devaluation personally but understand their behaviour as efforts to maintain self-esteem. Use of phrases such as “*you deserve the best*” or “*you deserve no less*” is helpful. If the patient feels recognised as someone unique and special, she or he will feel reassured and will make fewer demands.

vi) Schizoid

Patients of schizoid personality remain aloof, uninterested in social contact and therefore delay any kind of treatment until necessary. The physician often finds it difficult to build rapport or engage the patient in treatment. Illness and hospitalisation evoke fear and intense anxiety as the patient avoids any social contact.

The physician should not force any treatment or social contact. Showing interest, building trust and encouragement can reassure the patient that she or he is safe and will not be intruded on.

Check Your Progress Exercise 2

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) What can be done to handle different personality traits while treating a physical disorder?

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2) Coping Styles

Problems in coping with the chronic illness are common reasons for psychiatric consultation. Patients may respond differently to the diagnosis of chronic illness depending on their coping abilities.

Coping can be *problem-focused coping* that is thoughts and behaviours are used to alter the problem that is causing distress or *emotion-focused coping* means to regulate the emotional response to the problem. Patients will tend to choose problem focused coping strategies when they appraise the situation as being under their control and emotion focused coping styles when out of control.

Mental health professionals can encourage the patients to choose more adaptive coping styles. Patients use trial and error and multiple coping ways

during a given stressful situation. Eight types of coping styles have been suggested, these are:

- i) Confronting (hostile or aggressive efforts to alter a situation),
- ii) Distancing (attempts to detach oneself mentally from a situation),
- iii) Self-controlling (attempts to regulate one's feelings or actions),
- iv) Seeking social support (efforts to seek emotional support or information),
- v) Accepting responsibility (acknowledgment of a personal role in the problem),
- vi) Escape-avoidance (cognitive or behavioural efforts to escape or avoid the problem),
- vii) Planned problem solving (careful thought and efforts to alter the situation), and
- viii) Conducting positive reappraisal (efforts to reframe the situation in a positive light).

It has been proposed that choice of coping strategy is partially dependent on the patient's concept of illness as challenge, enemy, punishment, weakness, relief, irreparable loss or damage. Illness as *challenge* is related to adaptive coping and mental well being whereas illness as *enemy and punishment* are associated with maladaptive coping.

Coping style can be viewed as a trait or as a process and is often coloured by the personality. Patients tend to use the same coping styles as used by them in the past, whether effective or not. Coping styles may change as the nature of stressor changes for example when the diagnosis of breast cancer is made, initially patient may seek social support which may later change to planned problem solving like following up regularly for chemotherapy.

Coping strategies may have positive outcomes or negative outcomes on the illness. Patients who can cope well with a chronic and disabling illness have a fighting spirit; like themselves under all circumstances; believe that they are more than just a body; have a problem-solving attitude towards the challenges.

The factors that may lead to poor coping abilities are: previous psychiatric problems, lack of social support, low educational and economic status and severity of disease at diagnosis.

Check Your Progress Exercise 3

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) What are the types of focus based coping styles?

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2) What are the factors leading to poor coping strategy?

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3) Defense Mechanisms

Defense mechanisms are automatic psychological processes by which the mind confronts a psychological threat (for example, the fear of death or disability) or conflict between a wish and the reality. Defense mechanisms are usually conceptualised as intrapsychic processes that are largely out of the individual's awareness. A basic understanding of the concept of defense and various defense mechanisms can provide the mental health professionals a clue to the patient's emotional or behavioural responses to medical illness.

There is some overlap of the concept of coping with that of defenses but the psychological concept of coping is more behavioural as it involves action (for example, seeking social support or productive problem solving) and is generally a conscious experience.

Patients often employ many different defense mechanisms in different situations or under varying levels of stress. Hierarchy of defense mechanisms is proposed as psychotic, immature, neurotic and mature.

The *psychotic defenses* are away from reality to extreme degree and are employed by psychotic patients. The *immature defenses* are characteristic of patients with personality disorders such as borderline personality disorder. Patients with immature defenses often transmit their shame, impulses and anxiety to those around them. *Neurotic defenses* may go unnoticed as they distort reality less, do not irritate others, are less interpersonal and often involve mental inhibitions. The use of *mature defenses* such as humor or altruism in the confrontation of a stressor such as medical illness helps in fighting against the illness and is appreciated well.

Some of the defense mechanisms are discussed below:

i) Denial

Denial of the illness by the patient is a common reason for seeking consultation by psychiatrist. Denial is construed when the patient rejects the diagnosis, minimises symptoms of the illness, does not seem to appreciate its implications, avoids or delays medical treatment and appears to have no emotional reaction to the diagnosis or illness.

Denial is an adaptive response in certain situations. By denying the consequences of the illness such as death, hope is generated which improves the quality of life. Similarly, denial of certain emotional reactions to the illness such as fear or hopelessness may enable the patient to stay motivated throughout the course of illness. Through denial one may avoid the immediate stress and gradually accept the diagnosis. Some denial is perhaps necessary

for very effective coping with an overwhelming illness. It is reported that denial is also useful during surgery, wound healing and patients awaiting heart transplantation.

Denial is a maladaptive response in certain situations. It may prevent the patient from taking treatment and thus may endanger the patient's health. Denial may lead to adverse consequences like noncompliance after discharge and therefore worsen medical outcome in end-stage renal disease and asthma patients. Denial of the medical outcome has both beneficial and adverse effects as denial in cardiac units after myocardial infarction is reported to result in a better outcome.

Sometimes, the patients judged to be in denial are relatively uninformed about the details of their illness or its prognosis. Therefore, it must be ensured that patients are fully informed about their illness and treatment before diagnosing them to be in denial. When denial is present, direct confrontation should be avoided; gentle, empathic, and nonjudgmental stance is more effective in decreasing the intensity of negative emotions such as anxiety.

ii) Suppression

Under this mechanism, the patients put their fears about illness and treatment aside until a later time. The patients may choose to bring fears into consciousness at any point of time. These patients easily accept treatment and face their illnesses with courage. When suppression is active, denial is considered adaptive.

iii) Repression

In repression, the patient is generally unaware of the internal experiences (fear, wish) and these thoughts or feelings are not easily accessible to consciousness.

Check Your Progress Exercise 4

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) What is the difference between coping style and defense mechanism?

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2) What is the impact of denial on the medical outcome?

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5.4 PSYCHOSOCIAL ADAPTATION TO CHRONIC ILLNESS

Before discussing the emotional and behavioural responses, let us discuss some important concepts of psychosocial adaptation.

5.4.1 Basic Concepts of Psychosocial Adaptation

The basic concepts of psychosocial adaptation are given below:

- 1) **Stress:** Individuals with chronic illnesses face greater frequency and severity of stressful situations. Stress has a significant effect on blood flow to heart and this may be of significance in patients with pre-existing heart disease. Increased stress is experienced when there is threat to one's life and well-being, body integrity, independence and autonomy, fulfillment of familial, social and vocational roles; future goals and plans and economic stability.
- 2) **Crisis:** The sudden onset of life-threatening diagnoses (for example, cancer) and disabilities (for example, spinal cord injury, brain injury, amputation) is highly traumatic. These conditions constitute a psychosocial crisis and the life is affected by disturbed psychological, behavioural, and social equilibrium. The psychological consequences of crisis are long lasting and may evolve into pathological conditions such as *posttraumatic stress disorder* (PTSD).
- 3) **Loss and grief:** The mourning process that occurs for the lost body part or function after the onset of a chronic illness resembles that of the loss of a loved one. The individual exhibits feelings of grief and bereavement. Chronicity of the illness serves as a constant reminder that the disease is permanent and therefore, is a source of chronic sorrow.
- 4) **Body image:** Body image has been defined as the unconscious mental representation or schema of one's own body. It evolves gradually and reflects interaction between sensory (visual, auditory, kinesthetic), interpersonal (attitudinal), environmental (physical conditions) and temporal factors. Chronic illness is believed to alter or distort one's body image. Successful adaptation to chronic illness reflects the integration of physical and sensory changes into a transformed body image whereas unsuccessful adaptation results in physical and psychiatric symptoms.
- 5) **Self-concept:** One's self-concept and self-identity are linked to body image and are often seen as conscious, social derivatives of it. Chronic illness is believed to alter or distort one's self concept. The sense of self (that is, self-identity) may be denied in social interactions with others who respond to the person as "disabled" first (focusing on appearance rather than identity), thereby losing sense of the person's real self.

5.4.2 Emotional Response to Illness

An individual suffering from chronic illness may feel angry, sad, afraid, frustrated, confused, helpless, embarrassed, ashamed or odd. An individual may show multiple emotional responses simultaneously or sequentially to illness and hospitalisation. Understanding the personality, coping style and defense mechanisms adopted by an individual may help to appreciate her or his emotional

response. These emotions may hamper cognitive functions and patient may become confused or unable to concentrate. States of fear and excitement especially acute anger reduce blood flow through already compromised arteries supplying heart and may lead to myocardial ischemia. Heart is very sensitive to acute emotional stress and this may be the cause for sudden death during those states.

Empathic listening to a patient may be useful in revealing the predominant emotional response, which is a clue to the subjective meaning of illness for that patient. The emotional response may have multiple meanings and may change over the course of the illness. Predominant emotional response should not be the sole focus of attention; it may not be directed towards the illness but may be directed towards the physician. Understanding the reason for the elicited emotional response may help the physician in making the patient more acceptable to the treatment and the illness. Educating an individual about the illness can shift the patient's emotional and behavioural response and evoke relief and hope.

Themes Underlying Affective Responses <i>(Emotion and Adaptation by Richard S. Lazarus, 1991)</i>	
Anger	: A demeaning offense against me and mine.
Anxiety	: Facing uncertain, existential threat.
Fright	: An immediate, concrete and overwhelming danger.
Guilt	: Having transgressed a moral imperative.
Shame	: Failing to live up to an ego ideal.
Sadness	: Having experienced an irrevocable loss.
Envy	: Wanting what someone else has.
Relief	: A distressing goal-incongruent condition that has changed for the better or gone away.
Hope	: Fearing the worst but yearning for better.
Happiness	: Making reasonable progress toward the realization of a goal.

Fig 5.1: Some emotional responses to illness

Some of the emotional responses to illness are discussed below in detail:

- 1) **Anger:** It is a common and difficult emotional response especially when it leads to maladaptive behaviour like treatment refusal. Patients with mental disorder or personality disorder are at risk. Anger should be understood as natural response; empathy rather than distancing self from the patient may help to deal with anger better.
- 2) **Anxiety and Fear:** Anxiety is experienced by all in medical illness. Psychoeducation regarding the illness, empathy and reassurance to the patient's specific fears such as pain, death, isolation, disfigurement, dependence and disability can offer significant relief from anxiety. Psycho education would be discussed in detail in an other course.
- 3) **Sadness:** Loss of physical function and inability to work as earlier times may result in sadness. An appropriate message and hope can be given by telling the positive outcomes in patients with similar illness. Psychiatrist may advise medications or psychotherapy in this situation.

- 4) **Guilt:** An individual may experience illness as a punishment for real or imagined sins. Guilt may arise for the behaviour contributing to the illness like risky sexual behaviour, cigarette smoking. *Guilt and attribution mechanisms* that is placing the cause in external world or internal self play a major role. Educating the patient and family and confronting the guilt will help the patient.
- 5) **Shame:** Narcissistic patients and patients attributing the cause of illness to their previous behaviour (for example lung cancer after a long history of smoking) are at risk for this emotional response. It may lead to avoidance of treatment for the particular illness.

Check Your Progress Exercise 5

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

- 1) Which is the commonest emotional response seen in medical illness?

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5.4.3 Behavioural Response to Illness

Patient's response to chronic illness varies from maladaptive to adaptive. Adaptive response helps the physician and the patient in dealing with the illness whereas maladaptive interferes with the treatment. At times, an individual needs to adapt quickly when diagnosed with a chronic illness because quick treatment decisions are to be made by controlling the level of emotional distress. Patient responds on the basis of the illness type, coping ability, ego strength, meaning of the chronic illness at that stage, family and social support. Major concerns are fear of death, dependency, disfigurement, disability and abandonment, as well as disruptions in relationships, role functioning and financial status. Understanding of the above can help in modifying the patient's response from maladaptive to adaptive response.

1) Adaptive Response

Some different types of adaptive response of patients of chronic illness are discussed below:

- i) **Support seeking:** Patients who have good social support network benefit from it during period of stress. Low socioeconomic status and low social support add to psychological risk. Patients can learn from others suffering from the same illness and can feel less alienated from others.
- ii) **Altruism:** Chronic illness decreases the self esteem, confidence and sense of productivity of the individual. Altruistic behaviour is

selflessness or self sacrifice by an individual for the benefit or sake of others. Individual can show altruistic behaviour by helping people suffering from illness by educating them about the illness, raising funds, participating in community programmes for various illnesses. This helps in regaining mood due to sense of gratification by helping others. Physician and the psychiatrist should promote and encourage this behaviour.

- iii) **Change in self regarding life priorities:** Although chronic illness in no way can be beneficial to the patients but it may help patients regain perspective on what is most important to them in life. An individual recently diagnosed with chronic illness may commit himself to take medicines regularly, bring changes in lifestyle or rejoin religious activities. There is personal transformation for the better in the patient and daily stresses do not seem that stressful.
- iv) **Becoming an expert in one's illness:** Learning as much as possible about the illness can be adaptive and can give the individual a greater sense of control as they feel it is easy to have control over known fears rather than imagined ones. Patient's personality, coping style and defense mechanisms will predict how increased knowledge about illness may help in reducing the distress.

2) Maladaptive Responses

Some of the maladaptive responses of patients of chronic illness are given below:

- i) **Non-adherence to medication:** Up to 50 per cent of patients fail to adhere to their prescribed medication regimens and physicians are often not aware of the patient's lack of adherence. Identifying the context of non-adherence can help us find the reasons for non-adherence; it may be persistent or specific to particular therapy or may be generalised. When underlying factors are identified, one can intervene to improve adherence.

Psychological factors for non adherence are:

- 1) Non-adherence as a defense against humiliation and stigma, for example the patient suffering from HIV may stop going to the clinic and stop the medication.
- 2) Non-adherence to counteract helplessness such as wish to be healthy and regain control over self once again may lead to refusal to treatment.
- 3) Anger towards the treating physician or towards the illness may be another psychological motivation for treatment non-adherence.
- 4) Mistrust and paranoia may play a role in non-adherence and the physicians must earn their patients' trust through building rapport and honest communication.
- 5) Co-morbid psychiatric disorders may also lead to treatment non-adherence. Depressed patients may stop treatment due to pessimistic views about illness and may become suicidal. In psychosis the judgment of the patient is poor leading to noncompliance with treatment.

Other factors in non-adherence to treatment:

- 1) Cost of treatment,
- 2) Side effects,
- 3) Inconvenient dosing schedules,
- 4) Lack of information,
- 5) Difficulties with transportation, and
- 6) Different health beliefs than the physician.

Interventions to increase treatment adherence are:

- 1) Non-judgemental attitude and asking patients directly about their adherence,
- 2) Psycho-education of the patient and the family regarding the illness and its treatment,
- 3 Find out any underlying psychological factors or psychiatric illness,
- 4 Find and address any treatment related factors such as side effects and cost,
- 5 Develop rapport with the patient and maintain therapeutic alliance,
- 6 Use positive reinforcement as a motivator when possible, and
- 7 Involve family members in facilitating patient treatment adherence.

ii) Going against medical advice: There may be various reasons for signing out of medical advice like anger or frustration toward the staff or caregivers. Some of the most common motivations for signing against the medical advice are anger at caregivers, overwhelming fear or anxiety, substance craving or withdrawal, desire and impatience with discharge planning or feeling well enough to leave.

Following interventions can be done to prevent the patient signing out of medical advice:

- a) Try to reduce the anger of the patient,
- b) Avoid direct confrontation,
- c) Diagnose and treat any co-morbid psychiatric disorders,
- d) Involve social supports (if they are allied with the treatment plan),
- e) Adequately inform about the illness and its need for treatment,
- f) Assess the patient's capacity to sign out, and

Encourage them to return for treatment if they change their mind.

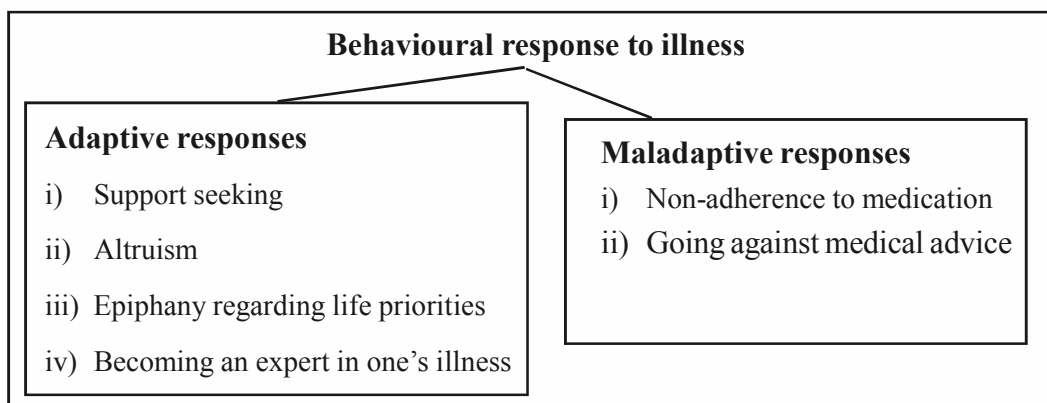


Fig 5.2: Behavioural responses to illness

5.5 CONSEQUENCES OF CHRONIC ILLNESS

The major consequences of chronic illness are discussed below:

- 1) **Stigma:** Restrictions imposed by chronic illnesses lead to deviations from several societal norms (for example utilisation of health care services, occupational stability) and are viewed negatively by society resulting in stigma and discriminatory practices. These stigmatising practices result in increased life stress, reduced self-esteem, withdrawal from treatment and rehabilitation settings.
- 2) **Disability:** There are many different kinds of disabilities—physical, intellectual or mental health related. A disability may be visible or hidden, may be permanent or temporary and may have a minimal or substantial impact on a person's abilities. Chronic illness diminishes the capacity of individuals to respond in satisfactory ways. It disrupts the balance between demands and expectations of a given situation and the capacities of an individual to respond to those demands. A person with disability may be unable to do certain things in the same way that most people in the society are able to do without any adaptation.
- 3) **Social isolation:** Long-term painful thoughts and emotions can lead to alienation, loss of friends, more symptoms, feeling alone, etc.
- 4) **Family burden:** Chronic illness affects not only the lives of those suffering from disease but also those of family members who care for them. Increased financial, physical and emotional responsibility falls upon family members who care for a person with chronic physical illness. In family focused grief therapy, the patient and the family meet together to process the events and anticipate the upcoming loss. It continues for a few sessions after the patient's death, helping the family to consolidate the positive achievements made while the patient was still with them. Counsellor can use individual therapy, family therapy, education, and problem-solving programs as interventions for caregivers of patients with chronic illness.
- 5) **Impact on children and adolescents:** Chronic conditions in childhood and adolescence can affect physical, cognitive, social and emotional spheres of development, with repercussions for siblings and parents as well. It has been reported that parenting a child with a disability is associated with higher levels of stress.

A common consequence of chronic illness and its treatment is *short stature* and *pubertal delay*. Undernutrition is common in many chronic conditions and obesity may result due to limited physical activity. Body image issues related to height, weight, pubertal stage and scarring contribute to decreased self esteem and negative self image that may persist into adult life. Children with chronic illness are at greater risk of social isolation and education disadvantage due to school absenteeism and lack of participation in recreational and sporting activities. The young people with chronic conditions are at much greater loss than adults in the long run.

5.6 ROLE OF CARE-GIVERS

In collaboration with the family it is necessary to develop a plan for managing stress. This plan should comprise of commitment of all family members to work

on the problems, inclusion of all past successful coping strategies and use of strategies that are flexible and reality-oriented.

What families can do? Family members may:

- 1) Provide emotional support and containment,
- 2) Share responsibility for decision making regarding the treatment setting, options and meeting financial costs,
- 3) Maintain stability that is the standard family functions, emotional nurturing, feeding, clothing, sheltering, educating, and socialising must continue, and
- 4) Adapt to change and help the patient to cope with the illness.

Staff providing the services to the patients with chronic illness should understand the psychological response to an illness and behave in an empathic, non-judgemental and caring manner. Medical staff should be sensitive to the needs of the patient and look into the situations where family fails to take adequate care of the patient.

5.7 LET US SUM UP

In this Unit, we studied that mental illnesses commonly co-exist with chronic physical illnesses. Chronic physical illness has profound psychological effect on the affected individuals and their families.

Psychological response of an individual to the illness depends upon personality type such as dependent, obsessional, historionic, paranoid narcissistic or schizoid; coping styles and defense mechanisms. Interventions for the patients and their care-givers can be designed based on their behavioural and emotional responses to the chronic illness. Stress, crisis, loss and grief, body image and self-concepts are some basic concepts of psychosocial adaptation.

It is necessary to have a good grasp of these aspects of the care of such patients and their families, not only in order to be of assistance in alleviating the emotional stresses which chronic illness places on them, but also so as to ensure maximal compliance with the treatment regimen of the illness.

Anger, anxiety, fear, sadness, guilt and shame are some emotional responses to illness. Patient's response to chronic illness varies from support seeking, altruism, change in self regarding life priorities and becoming expert of one's own illness to making non-adaptive response like non-adherence to medication and going against medical advice.

Chronic illness has long term effects on the life of children and adolescents leading to emotional and behaviour problems therefore the need to address the issues at the earliest. There is strong need for general practitioners and psychiatrists to understand the role of psychological factors in physical illness and the need to promote adaptive behaviour for better care.

5.8 GLOSSARY

Altruistic behaviour	: Selflessness or self sacrifice by an individual for the benefit or sake of others.
Body image	: Unconscious mental representation or scheme of one's own body.
Chronic	: Lasting for a long time.
Defense mechanisms	: Intrapsychic processes that are largely out of the individual's awareness.
Emotion-focused coping	: Regulating the emotional response to the problem
Problem-focused coping	: Thoughts and behaviours are used to alter the problem that are causing distress.
Psychotic defenses	: Defense mechanisms away from reality to extreme degree employed by psychotic patients.

5.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

- 1) A chronic illness is the illness lasting three months or more, by the definition of the National Center for Health Statistics (USA). Chronic illnesses may be permanent leaving residual disability, are caused by non-reversible pathological alteration, require special training of the patient for rehabilitation, and/or may be expected to require a long period of supervision, observation or care.

Check Your Progress Exercise 2

- 1) Understanding of the psychology of the patient helps in engaging the patient in the treatment process. Following steps can be taken to handle different personality traits:
 - 1) Appropriate reassurance,
 - 2) Specific schedule of visits (for example, thrice a week visit),
 - 3) Set clear expectations regarding the doctor's time and availability,
 - 4) Educate them regarding the illness, its treatment,
 - 5) Encourage discussion of fears,
 - 6) Balance the warmth and formality,
 - 7) Listen patiently without dispute or agreement,
 - 8) Do not confront for irrational fears,

- 9) Use of phrases such as “you deserve the best” or “you deserve no less” is helpful,
- 10) Do not force any treatment, and
- 11) Reassure the patient that she and he is safe and will not be intruded on.

Check Your Progress Exercise 3

- 1) There can be two types of focus based coping as given below:
 - a) Problem-focused coping: In problem-focused coping, thoughts and behaviours are used to alter the problem that is causing distress. It is used when patients feel that the situation is under their control.
 - b) Emotion-focused coping: Emotion-focused coping type regulates the emotional response to the problem. Patients will tend to choose this coping strategy when they appraise the situation to be out of their control.
- 2) Some of the factors that may lead to poor coping strategy are:
 - 1) Presence of co-morbid psychiatric illness,
 - 2) Personality trait of patient,
 - 3) Lack of social support,
 - 4) Low educational and economic status, and
 - 5) Severity of disease at the time of diagnosis.

Check Your Progress Exercise 4

- 1) The psychological concept of coping is more behavioural as it involves action (for example, seeking social support or productive problem solving) and is generally a conscious experience whereas defense mechanisms are usually conceptualised as intrapsychic processes that are largely out of the individual’s awareness.
- 2) Studies of the impact of denial on medical outcome have reported both beneficial and adverse effects. Denial is beneficial when it gives hope and improves the quality of life, enables a patient to stay motivated, helps to avoid the immediate stress and gradually accept the diagnosis. Denial has adverse outcome if it prevents the patient from taking treatment or endangers the patient’s health, for instance due to noncompliance after discharge. Some denial is perhaps necessary for very effective coping with an overwhelming illness.

Check Your Progress Exercise 5

- 1) Anxiety is seen in almost everybody suffering from medical illness. Psychoeducation regarding the illness, empathy and reassurance to the patient’s specific fears such as pain, death, isolation, disfigurement, dependence, disability can offer significant relief from anxiety.

5.10 UNIT END QUESTIONS

- 1) Define chronic illness. Illustrate with the help of some examples.
- 2) Discuss various subjective variables that can affect the individual’s response to given physical illness.

- 3) Explain psychological adaptation to chronic illness in detail.
- 4) Describe the role of care-giver in psychological adaptation of patient.

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UNIT 6 NATIONAL MENTAL HEALTH PROGRAMME

Structure

- 6.1 Introduction
- 6.2 Types of Mental Health Problems
- 6.3 National Mental Health Programme
 - 6.3.1 National Mental Health Programme During the Tenth Five Year Plan
 - 6.3.2 Status of NMHP at the End of Tenth Five Year Plan
- 6.4 National Mental Health Programme During the Eleventh Five Year Plan
 - 6.4.1 District Mental Health Programme (DMHP)
 - 6.4.2 Manpower Development Schemes in Mental Health
- 6.5 Let Us Sum Up
- 6.6 Glossary
- 6.7 Answers to Check Your Progress Exercises
- 6.8 Unit End Questions
- 6.9 Further Readings and References

6.1 INTRODUCTION

Mental disorders are significant public health issue and pose a tremendous socio-economic burden on community. Neuropsychiatric conditions have an aggregate point prevalence of about 10 per cent for adults. About 450 million people are estimated to be suffering from neuropsychiatric conditions worldwide. In 1990, mental and neurological disorders accounted for 10 per cent of the total lost due to all diseases and injuries. This increased to 12 per cent in the year 2000 and an analysis of trends indicates that the burden will further increase to 15 per cent by the year 2020. The resources available to tackle the huge burden of these disorders are insufficient, inequitably distributed, and inefficiently used, which leads to a treatment gap of more than 75 per cent in many countries with low and lower middle incomes.

In India the prevalence estimates vary between 5.82 per cent to 7.3 per cent. In terms of absolute number suffering from mental illnesses, the prevalence estimate throws up a huge number of about 7 crore persons.

The median number of psychiatrists in India is only 0.2 per 100,000 population compared to a global median of 1.2 per 100,000 population. Similarly, the figures for psychologists, social workers and nurses working in mental health is 0.03, 0.03 and 0.05 per 100,000 population respectively, as compared to a global median of 0.60, 0.40 and 2.00 per 100,000 population respectively. As against an estimated requirement of 11,500 psychiatrists, 17,250 clinical psychologists, 23,000 psychiatric social workers (PSW's) and 3,000 psychiatric nurses only approximately 3,000 psychiatrists, 500 clinical psychologists, 400 PSWs and 900 psychiatric nurses are available at present. The estimated figure is calculated using a norm of 1 psychiatrist per 100,000 population, 1.5 clinical psychologist per 100,000 population, 2 psychiatric social workers per 100,000 population

and 1 psychiatric nurse per 10 psychiatric beds. The existing training infrastructure in the country produces approximately 320 psychiatrists, 50 clinical psychologists, 25 PSWs and 185 psychiatric nurses per year.

Poor awareness about symptoms of mental illness, myths and stigma related to it, lack of knowledge on the treatment availability and potential benefits of seeking treatment are important causes for the high treatment gap.

Most of the data currently available on the epidemiology could be considered as the lowest estimate and only as the tip of the iceberg and still a large amount of illness is lying undiagnosed or misdiagnosed.

Objectives

After studying this Unit, you will be able to:

- Understand the different types of mental health problems;
- Explain the objectives of National Mental Health Programme; and
- Discuss the National Mental Health Programme during the Tenth and the Eleventh Five Year Plans.

6.2 TYPES OF MENTAL HEALTH PROBLEMS

The various types of mental health problems are discussed below:

1) Severe Mental Disorders

The prevalence of severe mental disorders has been estimated to be around 2 per cent of the population by different authorities. Severe mental disorders generally included schizophrenia, bipolar disorders and severe depressions. Depression of any type is now a part of Common Mental Disorders (CMDs) and therefore tends to be included under that group. Severe mental disorders should include organic disorders like dementias which by themselves are increasing sharply. Dementia has been estimated to be round 1.36 per cent in above 65 years age group in a community sample in Delhi. Dementia rates in other part of the country have varied between 2.7 per cent in urban Chennai, 3.5% in rural Thiruporur and 3.4 per cent in Thiruvanniyoor, Kerala.

2) Common Mental Disorders

Generally common mental disorders include depressions, anxiety and related disorders, somatic symptoms of psychological origin and other transient and adjustment disorders. The prevalence in general and primary care setting varies from 20 per cent to 45 per cent. This will indicate that patients coming to a general clinic may show common mental disorders (CMDs) in this range. The prevalence rates in clinic population do not reveal the true picture, as most of them do not go to primary care settings as they may feel that their problems are emotional in nature. They usually rely on methods like prayers, yoga, meditation etc to deal with their psychological problems.

3) Mental Retardation

Mental retardation constitutes another major group which has not been given attention that it deserves. Rates of mental retardation vary from 0.7 to 29.4 per thousand in different studies. All of the Indian studies reported prevalence

in children up to 12 years and some up to 16 years. World over the prevalence of mental retardation is estimated to be around 1%. Indian estimates of 2 per cent in children appear to be underestimates.

4) Alcohol and Drug Abuse

This group is generally missed in the psychiatric morbidity surveys of the adult population as this is difficult to identify in large community surveys. The rates of alcohol and substance use in different populations are as under.

Pondicherry- Surya 3.6/1000 for alcoholism, Premrajan *et al* 34.1/1000 for alcohol dependence syndrome, Bangalore-2.4/1000 Gopinath, Vellore- 4.8 Alcoholism, Agra 1.4 habitual use of alcohol, Hoogly-13/1000 alcohol addiction Chandigarh- 23.7 per cent used alcohol regularly, Lucknow- 50 per cent men above the age of fifteen used alcohol in rural areas, Chennai and Tamil Nadu- Ponnudurai *et al* reported prevalence rate of 16.75 using Michigan Alcoholism screening test, Chakravarthi and Matrubootham reported rates 17 per cent and 33 per cent for men respectively.

Meta analysis by Reddy and Chandrashekar revealed that prevalence rates for alcoholism are around 6.9 /1000 for India; the rates amongst men were 11.9 per cent and for women 1.7 per cent.

NHS survey revealed that alcohol use is seen in 21.4 per cent (62.5 million), cannabis use in 3.01 per cent (8.7 million) opiates in 0.7 per cent (2 million) and any illicit drug use by 3.6% (10.5 million). The picture regarding tobacco use is much worse . There are 240 million tobacco users in 15 years plus age group. Males are 195 million while females 45 million. Prescribed drug misuse is calculated to be 0.3 million.

Alcohol abuse is gradually increasing and rough estimates indicate that nearly 30 per cent of men are current alcohol users and nearly 30 per cent of them suffer from dependence. Tobacco abuse is a major health problem in our country and its use has been gradually increasing. Easy availability and cheap prices are responsible for the increasing use.

Rates of drug and alcohol abuse provide us with the challenges of major mental health problems. The use of alcohol is sharply increasing all over the country and Kerala has become the highest per capita user of alcohol.

5) Psychiatric Problems of Children and Adolescents (CAMDs)

Prevalence rate of psychiatric disorders world wide in children and adolescents (CAMDs) has been estimated to be around 14- 20 per cent (World Health report, 2000). The problem becomes more complex in low and middle income countries where children constitute a large part of the population as in India. There are very poor infrastructural supports for either identification or management of these problems. Poverty, hunger, malnutrition and infection make these problems worse. Indian studies in different centers projected following figures:

- i) Bangalore - 12.5 per cent in 0-16 years
- ii) Community sample in Kerala - 9.4 per cent in 8-12 year old
- iii) Chandigarh - 6.3 per cent in school children
- iv) ICMR study conducted in Lucknow and Bangalore showed the prevalence of CAMDs to be 12.8 per cent in 1-16 year olds.

Various studies estimated prevalence rates of CAMDs between 6-15 per cent. Mental Health Foundation of UK estimates that nearly 20 per cent of children would require mental health consultation in a year while 10 per cent are suffering from a mental health problem at a given time. India is a diverse country and some rich urban areas may have rates similar to Western countries while the deprived populations may have very different rates. None of these studies have studied backward and tribal areas where the rates could be very different.

6) Suicide

This is a very important mental health indicator of any community. The reported suicide rates vary from 3.9 to 38.6 per 100,000 all over the world. Countries passing through social crisis have the highest suicide rates like Hungary and Sri Lanka, while countries with stability and good health care facilities report lower suicide rates for example United Kingdom and Israel. Suicide rate statistics of different countries could also be unreliable as some people hide suicides due to various social and religious reasons. Suicide statistics in India are also very unreliable. The National Crime Records provide data for different states and the country and the figures are around 10 per 100,000. Individual investigators reported rate of 29/100,000 for Jhansi, 43.4/100,000 for rural West Bengal, 33 to 35/100,000 for Bangalore. Suicide statistics in India also show peculiar excess of women in the younger age group. The higher suicide rates for women were reported in Gujarat fifty years ago.

The suicide rates have been always more in men in most of the world. But this peculiar increase found among Indian women points towards psychosocial problems faced by women in our country. Prevention of suicide is a major health issue and many believe that if we can control depression effectively we may be able to reduce suicide rates. Drug and alcohol abuse also appear to be associated with suicide.

7) Miscellaneous Issues

The problems of women would also require special consideration. Mental health issues related to women specifically relate to the reproductive system which shows changes at time of menarche, cyclical changes every month during the reproductive phase and later the change in hormonal pattern after menopause. Pregnancy and child birth give rise to specific mental health problems. Psychosocial stresses and the partisan approach to the girl child are responsible for the development of different stresses in the females in our country. Mental health professionals would need to look into this aspect especially. Women's health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination.

Natural and man made disasters add new dimensions to the mental health scenario. The preparedness to deal with these problems may reduce long term psychiatric morbidity. It appears important that all states and the central government should keep psychiatric (psychosocial) management teams in readiness at all times which could be promptly sent to the disaster site rather than start training such teams after the disaster has struck.

Check Your Progress Exercise 1

- Note:** a) Read the following questions carefully and answer in the space provided below.
- b) Check your answers with those provided at the end of this Unit.

1) Write 2 – 3 lines on following mental health problems.

i) Common mental disorders

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ii) Psychiatric problems of children and adolescents (CAMDs)

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iii) Alcohol and Drug abuse

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iv) Suicide

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6.3 NATIONAL MENTAL HEALTH PROGRAMME

Growing awareness regarding the magnitude of mental health problems in the country, a flurry of health activities in the late seventies which included Alma Ata Declaration, the commitment to provide Health to All by 2000, and the realization that mental health care was possible through the existing primary health care system led to the launch of National Mental Health Programme (NMHP) by the Government of India in 1982.

The NMHP had the following objectives at the time of inception :

- To ensure availability and accessibility of minimum mental health care for all in the near foreseeable future, particularly to the most vulnerable sections of the population.
- To encourage mental health knowledge and skills in general health care and social development.
- To promote community participation in mental health service development and to stimulate self-help in the community.

A model for delivery of community based mental health care at the level of district was evolved and field-tested in Bellary district of Karnataka by National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, starting in the year 1985. It was demonstrated that mental health care delivery was possible in primary care settings by providing a limited number of psychotropic drugs and training primary care physicians and other health personnel in identification and treatment of common mental disorders with short-term trainings. Provision of supervision and support from the program officer and/ or the psychiatrist empowers the public health care system to respond to the mental health needs of the population. Community level IEC (Information, Education and Communication) and simple record, keeping were also part of this mode of providing optimal mental health care in community settings.

This model was adapted as the District Mental Health Programme (DMHP) and it was implemented in 27 Districts across 22 states/UTs in the Ninth Five Year Plan beginning in the year 1996.

6.3.1 National Mental Health Programme during the Tenth Five Year Plan

During the implementation of components of DMHP, it was realised that there was acute shortage of mental health professionals in the country and it was difficult to get trained manpower to run services under DMHP. In addition, National Human Rights Commission (NHRC) reported poor state of affairs in the mental hospitals all over the country. The need was also felt to support the psychiatric wings of medical colleges so as to improve the level of mental health care being made available at tertiary care level. Hence the programme was re-strategised in the year 2003, to incorporate components to address the gaps in the existing programme. It became from single pronged to a multi-pronged programme for effective outreach and impact of mental health services.

Main strategies of NMHP during the Tenth Five Year Plan period were as follows:

- 1) Expansion of DMHP to 100 districts all over the country.
- 2) Strengthening and modernization of State run Mental Hospitals.
- 3) Up gradation of Psychiatry wings in the Government General Hospitals/ Medical Colleges.
- 4) Information, Education and Communication (IEC) activities.
- 5) Research and training in mental health.

District Mental Health Programme (DMHP) was evaluated by NIMHANS, Bangalore, in 2002, and it was found to be effective as a model of community mental health care, whereas mental health care was getting integrated into general health care system and facilities for treatment of mental disorders were being made available close to the community. One of the objectives was to decrease the stigma attached to mental illness and institutional care.

6.3.2 Status of NMHP at the End of Tenth Five Year Plan

Targets achieved at the end of Tenth Five Year Plan are as under:

- i) District Mental Health Programme was implemented in 123 Districts all over the country,

- ii) 75 Psychiatric wings of Medical Colleges received support for upgradation, and
- iii) 26 Mental Hospitals were supported under Modernization of Mental Hospitals scheme.

The following areas of concern or weakness were identified during implementation of the programme:

- i) Poor availability of skilled manpower in psychiatry and allied specialities impeded recruitment of staff for DMHP,
- ii) Low awareness regarding mental illnesses in the community,
- iii) Stigma attached to mental illnesses and institutional care,
- iv) Lack of coordination between state departments for example DMHP being implemented through the Medical Education Department and District health system coming under the Health Directorate,
- v) Lack of community involvement,
- vi) Non-availability of standardised training manuals or modules,
- vii) Many aspects of mental illness were not being addressed at the district and sub-district level for example suicide prevention, workplace stress management, school and college counselling etc., and
- viii) The miniscule trained manpower available for mental health services was largely concentrated in the urban areas.

The following issues and challenges were identified:

- Expansion of DMHP and enhancement of visibility at grass root level by intensive IEC activities,
- Improvement of mental health manpower training infrastructure in the country,
- Filling up manpower gap in the field of psychiatry in general and DMHP in particular,
- Harnessing NGO's help in the community based care of mentally ill,
- Focusing on preventive and promotive components of mental health in addition to treatment of serious mental ailments,
- Training of general practitioners in mental health,
- Development of standardised training manuals for doctors and health care workers, and
- Evolvement of an effective monitoring, evaluation & implementation mechanism for NMHP.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

- 1) Enumerate the main objectives of National Mental Health Programme (NMHP) at the time of inception.

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- 2) List the areas of concern, identified during the implementation of NMHP.

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6.4 NATIONAL MENTAL HEALTH PROGRAMME DURING THE ELEVENTH FIVE YEAR PLAN

Taking into consideration the constraints felt during implementation of NMHP during the tenth plan period and learnings, the strategies for Eleventh Five Year Plan were developed through a series of consultations with the state nodal officers and other stakeholders. It was strongly felt that there was an urgent need to meet the acute shortage of manpower in mental health in the country.

6.4.1 District Mental Health Programme (DMHP)

Accordingly the strategies for Eleventh Plan were revised and District Mental Health Programme was one of its components.

DMHP will be expanded to cover more districts in the country so as to make community mental health care available to wider population. The treatment as well as promotive mental health care components have been incorporated to make it a comprehensive mental health care programme.

The technical team at DMHP will include psychiatrist or trained medical officer, clinical psychologist or trained psychologist, psychiatric social worker or trained social worker, community nurse and record keeper. The team will provide secondary level mental health care at the district level as well as will be responsible for training and supervision of general health staff in the district so as to facilitate the delivery of primary level mental health care through the general health system. District team will be based at the district hospital.

In addition, a two member team consisting of a Programme Manager and a Programme Assistant would form the managerial team for coordination and implementation of DMHP activities at the district level. This will be made available under the *National Rural Health Mission (NRHM)*. This team will implement and monitor the activities of NMHP at the district and subdistrict level.

A psychiatrist, and in his or her unavailability, a medical officer is to be deputed or recruited as Programme Officer-Mental Health (PO-MH) for each district. In case of a medical officer being taken as the programme officer he would be trained in Psychiatry and organisational skills for 4 months at identified institutions.

In addition to existing components of DMHP, which were focused on severely mentally ill, new components like suicide prevention, workplace stress management, adolescent mental health (school) and college counselling services, which could benefit larger section of society, will form part of services to be provided by DMHP during Eleventh Five Year Plan.

Activities Under DMHP

The various activities covered under DMHP are:

1) Mental Health Services

- i) *Early detection and treatment*: Identification and treatment of common mental ailments using the commonly available drugs would be made available at the PHC level under the programme. The Medical Officers would keep a simple record of patients being treated in designated proforma for monthly reporting. The DMHP team would provide supervision and referral support in collaboration with nearest available psychiatrist.
- ii) *Life skills training and counselling in schools*: The present education is achievement oriented rather than child centered. It does not address the needs of all the children or adolescents who in spite of various levels of scholastic competence are capable of learning and need to develop those abilities or skills, which are needed to live an effective and healthy life, coping with adversities in an effective manner.

Life Skills Approach (LSA) promotes empowerment of the adolescents. There is growing evidence of increased rates of adolescent behaviour problems and suicides. Crime, violence, sexual permissiveness, drug abuse, academic competition and school dropout are on the rise among the youth. An empowered adolescent has the competence to cope with the challenges of life using the available resources even amidst such adversities.

Life Skills Education (LSE) is one such program that can be used as a base for various health promotional activities like prevention of tobacco or other drug use, teenage pregnancy, dealing with violence etc.

The life skills, which need to be taught at the schools level especially to adolescents are: critical thinking & creative thinking; decision making and problem solving; communication skills and interpersonal relations; coping with emotions and stress, and self awareness and empathy.

Life skills training would be imparted through master trainers and identified school teachers using manuals or modules prepared for this specified purpose. Additional resources would be provided to address the problem of stress during exam periods so that the children are better equipped to cope with the same.

iii) *Counselling service in colleges*: A significant proportion of students in colleges have recognisable mental disorders in the form of depression, anxiety, somatoform disorders, adjustment disorders, personality disorders and alcohol and drug abuse. Many more students may be suffering from sub-clinical symptoms, and emotional disturbances. These contribute to the observable behavioural abnormalities including:

- Aggression, ragging, being hostile to others, hopelessness and helplessness, apprehensions, severe examination fear,
- Conduct - problems like lying, stealing, running away from home, criminal activity, sexual promiscuity and immoral sexual activities,
- Alcohol and substance abuse and addictions,
- Absenteeism, irregularity in attending the class, dropping out from the course, poor performance or failure in the examination,
- Having medically unexplained somatic symptoms, often getting sick, accident proneness and
- Suicidal attempts.

These will be addressed by training of existing counsellors or teachers in colleges so as to equip them with skills for early identification and management of such problems by counselling and appropriate referral.

iv) *Work place stress management*: The present day working environment generates a lot of stress due to high expectations, poor time management and target oriented approach. High stress levels are found among top level executives as well as low level workers. Workshops for stress management would be conducted at identified workplaces by the DMHP team or NGO or Voluntary Organization partners using standardised training manuals.

v) *Suicide prevention services*: The demanding atmosphere, pressure to perform better, struggle for survival in adverse circumstances, and other such environmental factors lead to increased tendency of suicide. Timely management of such situations can prevent most of suicides and loss of precious lives. The district counselling and crisis center to be established in collaboration with NGOs or other identified partners would provide help through a helpline or counselling services.

vi) *Role of NGO or governmental organisations partners*: NGOs will be involved in implementation of various activities of DMHP.

2) **Training**: All the medical officers and health staff of the district would be trained to provide basic mental health care at the community level. Support and referral services would be available in the form of programme officer or psychiatrist at the district level. Grass root level health workers would be trained for early identification of mental illness and appropriate referral.

- 3) **IEC activities:** There would be extensive IEC activities as part of Behaviour Change Communication (BCC) regarding the signs and symptoms of mental illness and the availability of services under DMHP. Specific BCC strategies would be developed focusing upon the needs of the district in consultation with district IEC officer and other programme partners. NGO or GO (Governmental Organisations) partners would play main role in organising IEC activities.

6.4.2 Manpower Development Schemes in Mental Health

Shortage of qualified mental health professionals was a major constraint in effective implementation of NMHP during the Tenth Five Year Plan. In the Eleventh plan, lot of emphasis has been placed to address the shortage of mental health manpower in the country. These schemes are aimed at increasing the post graduate training capacity in the mental health specialties of psychiatry, clinical psychology, psychiatric social work and psychiatric nursing. The post graduate courses identified specifically to be supported under the scheme are MD/DPM/DNB in psychiatry, M.Phil. in clinical psychology and Psychiatric Social Work (PSW) and Psychiatric Nursing.

The following schemes are under implementation to address the manpower concerns in mental health:

- 1) **Centres of excellence in mental health:** It is also known as *Scheme A*. This scheme aims at establishing Centres of Excellence in the field of Mental Health by upgrading and strengthening identified existing mental health hospitals/institutes for addressing the acute manpower gap and providing state of the art mental health care facilities. These institutes will focus on production of quality manpower in mental health with primary aim to fulfill manpower needs of the NMHP. Budgetary support under the scheme is up to Rs. 30 crore per centre.

It is planned to establish at least 11 Centres of Excellence in mental health under the Scheme during the current plan period. This would result in increase in at least 44 PG seats in Psychiatry, 176 M. Phil. seats in Clinical Psychology & Psychiatric Social Work each and 220 seats in Diploma in Psychiatric Nursing every year. Thus, a total of 616 qualified Mental Health professionals would be produced from these centers annually once these are established.

- 2) **Scheme for Manpower Development in Mental Health:** It is also known as *Scheme B*, this scheme aims at development of Post Graduate training capacity of mental health institutes and medical colleges. This is more cost effective and would cover far more number of institutes, compared to Scheme A. Under this scheme, Government Medical Colleges/ Government General Hospitals/ State run Mental Health Institutes would be supported for starting PG courses or increasing the intake capacity for PG training in Mental Health specialities. Support would be provided to set up or strengthen 30 units of Psychiatry, 30 departments of Clinical Psychology, 30 departments of Psychiatric Social Work and 30 departments of Psychiatric Nursing during the eleventh plan period.

This scheme is expected to generate about 60 Psychiatrists, 240 Clinical Psychologists, 240 Psychiatric Social Workers and 600 Psychiatric Nurses per year.

The manpower development schemes (Scheme A and B) will take care of the requirement concerning trained mental health professionals in the long run. The existing shortage of manpower will be met by training medical and paramedical professionals on medium and short-term basis so as to meet the requirements of trained manpower to support NMHP.

- 3) **Information, Education and Communication (IEC):** An intensive IEC campaign using innovative IEC strategies involving mass media at Central or Regional level to reduce stigma attached to mental illness and increase awareness regarding available treatment and mental health care facilities leading to increased utilization of available services is considered essential element of NMHP. Increased awareness regarding provisions under Mental Health Act 1987 is also required for effective implementation.
- 4) **Research and Training:** Although basic and clinical research in mental health (psychiatry and allied disciplines) is being carried out in the educational/research institutes, there is huge gap in operational and applied research in mental health. This issue will be dealt with by providing funding support and encouraging existing institutes to take up mental health research on priority.
- 5) **Non- Government Organisation (NGO) or Public Private Partnership (PPP) Schemes:** The burden of mental disorders is very high and government efforts need to be supplemented by NGOs/voluntary organizations working in this field. Many of these organizations need financial support to scale up their activities. Mental Health Services for community based rehabilitation, for homeless mentally ill, ambulatory services, geriatric population, out of school adolescents, slum dwellers, other vulnerable groups and areas of mental health not covered in DMHP would be implemented through dedicated and credible NGO partners.

In addition, innovative schemes on pilot basis with involvement of NGOs or PPP (Public Private Partnership) would be funded to make available basic mental health services at grass root level.

- 6) **State and Central Teams:** For effective implementation, close monitoring, supervision and periodic evaluation of NMHP components, dedicated manpower is required at central and state government level.
- 7) **Support for State Mental Health Authorities:** As per Mental Health Act 1987, *State Mental Health Authorities (SMHA)* are entrusted with the task of development, regulation, coordination of mental health services in the States/Union Territories. SMHA is also responsible for implementation of the Mental Health Act (MHA) 1987. However, it has been found that due to unavailability of funds, most of the SMHAs are unable to carry their statutory responsibilities for implementation of Mental Health Act 1987 and development of mental health services in the states. Hence SMHAs will be provided with funds to facilitate their routine work which would lead to improvement in mental health services in the states.

Check Your Progress Exercise 3

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

- 1) List the activities cover under District Mental Health Programme (DMHP).

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- 2) Name the schemes which are under implementation to address the manpower concerns in Mental Health.

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6.5 LET US SUM UP

Looking at the burden of mental health disorders in the country, Govt of India implemented National Mental Health Programme in 1982. However due to lack of sufficient funds, programme could not be implemented in an effective manner. Real breakthrough was made in IXth Five year Plan (1998), when DMHP was implemented in 27 districts under NMHP. This is the community mental health model of care, which was developed taking into consideration mental health scenario in the country. Sensing the need to support psychiatric wings of medical colleges or general hospitals and modernisation of mental hospitals (most of which were established during the British period), IEC and research, additional components were added and NMHP was restructured. However, the programme could not make much success due to acute shortage of mental health manpower in the country. The stigma attached to mental illness prevents optimal utilisation of meagre mental health services available in the country. The Government took a stand to communitise, mental health services and make it a part of general health care delivery system through DMHP implementation. Additional components for example school mental health, college counselling, suicide prevention and workplace stress management have now been included in the DMHP so as to meet the mental health needs of the community.

Mental Health Act was enacted in the year 1987 to look at the admission, discharge, treatment, human rights and guardianship issues of mentally ill.

So the programme has continuously evolved taking into consideration the changing scenario of mental health over a period of time in the country.

6.6 GLOSSARY

BCC	: Behaviour Change Communication
CMHA	: Central Mental Health Authority
CMD	: Common Mental Disorder
DALY	: Disability Adjusted Life Year
DMHP	: District Mental Health Programme
DNB	: Diploma of National Board
DPM	: Diploma in Psychological Medicine
DPN	: Diploma in Psychiatric Nursing
GO	: Government Organisation
ICMR	: Indian Council of Medical Research
IEC	: Information, Education and Communication
LSA	: Life Skills Approach
LSE	: Life Skills Education
MHA	: Mental Health Act
NMHP	: National Mental Health Programme
NGO	: Non Government Organisations
NHRC	: National Human Rights Commission
NIMHANS	: National Institute of Mental Health and Neurosciences, Bangalore
PG	: Postgraduate
PHC	: Primary Health Centre
PPP	: Public Private Partnership
POMH	: Programme Officer, Mental health
PSW	: Psychiatric Social Worker
SMHA	: State Mental Health Authority
SMD	: Severe Mental Disorder
VO	: Voluntary Organization
X th Plan	: Tenth Five year Plan (2002-2007)
XI th Plan	: Eleventh Five year Plan (2007-2012)
UG	: Undergraduate
UT	: Union Territory

6.7 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

1) Check Your Progress Exercise 1

i) Common mental disorders:

Common mental disorders (CMDs) include depression, anxiety and other related disorders. It also includes somatic symptoms of psychological origin and other transient and adjustment disorders. Most of the times the patients sufferings from CMDs do not go to primary care settings as they may feel that their problems are emotional in nature. They usually rely on methods like prayers, yoga, meditation etc. to deal with their psychological problems.

ii) Psychiatric problems of children and adolescents:

The psychiatric problems of children and adolescents are also known as CAMDs. The problem is more complex in low and middle income countries where children constitute a large part of the population. The infrastructural supports for identification and management is very poor and poverty, hunger, malnutrition and infection make these problems worse.

iii) Alcohol and drug abuse:

Alcohol and drug abuse group is generally missed in the psychiatric morbidity surveys of the adult population as this is difficult to identify in large community surveys. Alcohol abuse is gradually increasing and rough estimates indicate that nearly 30% of men are currently alcohol users. Tobacco abuse is a major health problem in India and easy availability and cheap prices are responsible for the increasing use.

iv) Suicide:

Suicide is a very important mental health indicator of any community. Countries passing through social crisis have the highest suicide rate in comparison to countries with stability and good health care facilities. The suicide statistics are not always reliable as some people hide suicide cases due to various social and religious reasons.

2) Check Your Progress Exercise 2

1) National Mental Health Programme (NMHP):

National Mental Health Programme (NMHP) was launched by Government of India in 1982. The main objectives of NMHP at the time of inception were:

- i) To ensure availability and accessibility of minimum mental health care for all in the near foreseeable future, particularly to the most vulnerable section of the population.
- ii) To encourage mental health knowledge and skills in general health care and social development.
- iii) To promote community participation in mental health service development and to stimulate self-help in the community.

- 2) The area of concern, identified during the implementation of NMHP are:
 - i) Poor availability of skilled manpower in psychiatry and allied specialities impeded recruitment of staff for DMHP.
 - ii) Low awareness regarding mental illnesses in the community.
 - iii) Stigma attached to mental illnesses and institutional care.
 - iv) Lack of coordination between state departments for example DMHP being implemented through the Medical Education Department and District health system coming under the Health Directorate.
 - v) Lack of community involvement.
 - vi) Non-availability of standardised training manuals or modules.
 - vii) Many aspects of mental illness were not being addressed at the district and sub district level for example suicide prevention, workplace stress management, school and college counselling etc.
 - viii) The miniscule trained manpower available for mental health services was largely concentrated in the urban areas.

3) Check Your Progress Exercise 3

- 1) The activities covered under District Mental Health Programme are:
 - i) Mental health services,
 - ii) Training,
 - iii) Information, Education and Communication (IEC) activities
- 2) The Schemes under implementation to address the man-power concerns in mental health are:
 - i) Centres of excellence in mental health,
 - ii) Scheme for manpower development in mental health,
 - iii) IEC,
 - iv) Research and training,
 - v) Non-Governmental Organisation (NGO) or Public Private Partnership (PPP) Schemes,
 - vi) State and central teams, and
 - vii) Support for state mental health authorities.

6.8 UNIT END QUESTIONS

- 1) What is the burden of mental health disorders in the country? Why did the Government feel the need to initiate NMHP?
- 2) What are common mental disorders? What are severe mental disorders?
- 3) What is the main problem facing NMHP which hampers effective implementation of the programme? Does stigma related to mental illness hamper delivery of mental health services?
- 4) What component of NMHP relates to community mental health? Why is it important to have an effective IEC strategy under NMHP?
- 5) What is the role of NGOs in NMHP?

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