

# PSYCHIATRIC SOCIAL WORK:

## UNIT I

Psychiatric Social Work: Definition and Concept, Historical Development in India and Abroad

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### Structure

- 1.1 Aims And Objectives
  - 1.2 Introduction
  - 1.3 Concept And Nature Of Psychiatric Social Work
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### 1.1 AIMS AND OBJECTIVES

- ❖ To know the meaning and nature of Psychiatric social work
- ❖ To learn about the historical development of psychiatric social work in India and Abroad

### 1.2 INTRODUCTION

Psychiatric social work is a specialized type of medical social work that involves supporting, providing therapy to, and coordinating the care of individuals who are severely mentally ill and who require hospitalization or other types of intensive psychiatric help. Psychiatric social workers complete a variety of tasks when working with clients, including but not limited to psychosocial and risk assessments, individualized and group psychotherapy, crisis intervention and support, care coordination, and discharge planning services. Psychiatric social workers are employed in a wide range of settings, ranging from intensive inpatient wards to outpatient psychiatric clinics.

Psychiatric social work is a challenging and very demanding profession. Social workers in this field must work closely with individuals suffering from complex and hard to manage conditions, who are in deep emotional distress and/or who may be a danger to themselves or others. Psychiatric social workers may also encounter difficulties in getting clients the resources and support they need to fully address their problems. However, some individuals

gravitate to this work for its constant intellectual and professional challenges, and for the opportunity to help deeply vulnerable populations.

### **1.3. 0. PSYCHIATRIC SOCIAL WORK**

Psychiatric Social Work, a specialized branch of Social work, which concerns with theoretical as well as clinical work and the knowledge of Psychiatry-which primarily deals with problems of the mind and associated disorders. The essential purpose of Psychiatric Social Work is to help the people with problems of the mind and/or with behavior problems or we can say precisely the problems of mind and brain and their solutions.

It has grown as the result of the need felt and its realization for people with mental or emotionally disturb could be helped more effectively by understanding their social and/or environmental factors responsible for the problems of mind and brain in their management. Professionally trained Psychiatric Social Worker is the qualified member of psychiatric team treating comprehensively the patients with psychiatric disorders or behavioral problems. These professionals utilize social work principle, techniques for the purpose of diagnosis, patient care and treatment and finally plan the rehabilitation of the patients in the family and in the community. Besides they also provide other services to mentally challenged people like therapeutic treatment, social rehabilitation, crisis intervention or outreach services in the community.

A psychiatric Social Worker (PSW) works in close association with psychiatrist, child guidance clinics, social services department as the team in the psychiatric hospital; and they also extend their work in families and communities for mentally challenged people. The role and responsibilities of the psychiatric social worker is fast increasing never before and he is no longer confine to the hospital or psychiatric clinic, but they are accepting the new challenges as the mental health hygienist in various public activities and helping the preventive mental schemes of the government for the people.

Different Legislations related to the care of the mentally disabled and those related to empowering the people facing various challenges in medical, health, human resource development and rehabilitation domains enlarged the scope of Psychiatric Social Workers in our country. However, the numbers of professionally qualified psychiatric social workers who are available in our country are very limited.

#### **1.3.1 NATURE OF PSYCHIATRIC SOCIAL WORK**

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Mental health professional includes various professional includes all practitioner who offers their services for improving an individual's mental health or to treat mental illness include psychiatrists, Clinical/Psychiatric social workers, clinical psychologists, , psychiatric nurses, mental health counsellors, professional counsellors, pharmacists, as well as many other professionals like medical anthropologists. These professionals often treat comprehensively the psychiatric illnesses, disorders, conditions and other issues, however, their scope of practice varies cases to case.

### **1.3.2. OBJECTIVES OF PSYCHIATRIC SOCIAL WORK**

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social

context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity, and strive to end discrimination, oppression, poverty, and other forms of social injustice. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values:

- ❖ Service
- ❖ Social Justice
- ❖ Dignity and worth of the person
- ❖ Importance of human relationships
- ❖ Integrity
- ❖ Competence
- ❖ This constellation of core values reflects what is unique to the social work profession.

### **Check Your Progress 1**

**Note:** Use the space provided for your answer

1. Define Psychiatric social work

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2. Bring out the nature of the psychiatric social work

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## **1.4. HISTORICAL DEVELOPMENT IN INDIA AND ABROAD**

### **1.4. 1 HISTORICAL DEVELOPMENT IN INDIA**

Till about 17th century all abnormal behavior was believed to be act of the 'devil' i. e. 'Against God', 'Mentally ill' were considered evil & described as witches. Gradually over

the passing time, mental illness was considered as 'deviant behavior & mentally ill were considered socially unacceptable & put in jails along with other criminals. In the modern era, there was a shift from 'evil' to 'ill. Mentally ill were called as 'mad' or 'insane' and were placed in special places called as 'asylums'. However, gradually these asylums became the place for human exploitation. Phillipe Pinel was the first Psychiatrist to free these mentally ill from asylum. Clifford Beers work 'The mind that found itself' brought in light the treatment meted out to these people in asylums, resulting in a strong reaction to the plights of mentally ill. This uproar resulted in starting of 'mental-hygiene' movement.

### **Ayurveda**

Mental disorders are represented in Ancient India in various types of literature. The aetio-genesis of these disorders was thought to be endogenous because of provoked humours like vatonmad, Pittonmad & Kaphonmand. Exogenously the causes were attributed to sudden fear or association with ill influence of certain mythological gods or demon, Charak Samhita designated Psychiatry as 'Bhuta Vidya'.

The description of personality is to be in terms of sathvik, Rajasik & Tamasik representing intellectual & moral, emotional & passionatic & impulsive respectively & Tamsik is more or less near mental subnormality or angry. Treatment of mental disorders mainly included psychotherapy, physiotherapy, shock, drug treatment, hypnotism & religious discourses by Sages. Psychotherapy used to be in the form of talismans, charms, prayers & sleeping in temples with rituals. The indigenous manner of giving shock to the patient was terrorizing them by snakes, lions, elephant or men dressed as bandits. Then use of 10 to 100 years old medicated ghee, Drugs Cordfolia, horse radish (shigru) with asafetida & rock salt, centella Asiatic (brami) with catechu & honey & powder of roots of serpentine were widely used.

### **Unani System**

Najabuddin Unhammad (1222 A. D), an indian physician, described seven types of mental disorders viz. :-Sauda-a- Tabee(Schizophrenia); Muree Sauda (depression); Ishk ( delusion of love); Nisyan (Organic mental disorder); Haziyan (paranoid state); Malikholia-a-maraki (delirium). Psychotherapy was known as Ilaj-I-Nafsani in Unani Medicine.

### **Siddha System**

'Siddhi' means achievement and Siddhas are men who have achieved results in medicine, as well as yoga and tapas. The great saga 'Agastya', one of the 18 Siddhas has contributed greatly to the Siddha system of medicine of the South. He formulated a treatise on mental diseases called as 'Agastiyar kirigai Nool ', in which 18 psychiatric disorders with appropriate treatment methods is described.

On the recommendation of Bhore committee (in 1946), All India Institute Mental Health was set up in 1954, which became the National Institute of Mental Health And Neurosciences in 1974 at Bangalore.

Hence, first community Mental Health unit (CMHU) was started with the Dept. of Psychiatry at NIMHANS in 1975. For short term training of primary care personal, a Rural Mental Health Center was inaugurated in Dec'1976 at Sakalwara, 15 km from Bangalore. Mental Health clinic was opened in a General Hospital in Bangalore to involve General Practitioners in Mental Health, Seminars and orientation programs for General Practitioners & school teachers were conducted. The first training program for Primary Health Care was started in 1978-79. During 1978-1984 Indian Council of Medical Research funded & conducted a multicentre collaborative project on 'severe Mental Morbidity' in Bangalore, Baroda, Calcutta & Patiala. Various training programs for psychiatrists, Clinical Psychologists, Psychiatric Social Workers, Psychiatric nurses and Primary Care doctors were conducted at Sakalwara unit between 1981-82 (Ministry of health & family welfare, 1989).

Till early sixties, Mental Hospitals were the only place available for the treatment of mentally ill. However, as compared to the number of mental ill patients, the services available were very less. Hence General Hospital Psychiatric Units were started to deal with the Increasing number of patients.

The first GHPU was started in R. G. Kar Medical College & hospital, Calcutta in 1933 & GMC R. J. J. group of Hospital Bombay in 1938. (khanna et al 1974). The number has gradually increased since then. Gradually GHPU started the PG training centres at Delhi, Chandigarh, Lucknow, Bombay, Madurai etc resulting in development of District Psychiatrist unit.

### **Mental Health Camps in India**

The first psychiatric mental health camp in India was organised in 1972, at Bagalkot, a taluka town of Mysore. Earlier some service centers were organized by members of team of Kripamayee Nursing Home, Miraj. Following this, Indian Psychiatric Society also started taking active interest in Mental Health camp organization and various health camps were arranged in different parts of India (such as Nandi, Ghosh, Sarkar, Banerjee in 1978, Luktuke in 1976).

### **Voluntary Health Sector (VHS) in Mental Health**

There have been strong mass media movement all over India in last decade where various issues related to Mental Health are brought in public domain. The social movements in relation to Darubandi are doing commendable work and are very well known. Other organization like SCARF (Chennai), Richmond fellowship foundation (Banglore), Cadbum are also helping people in rehabilitation and integrating them in the society

In these various organizations, active efforts have been taken to improve quality of care of patients & rehabilitate them in society. Various self help groups such as Alcohol Anonymous, Narcotic Anonymous, have been organized by people. The major effort of VHS is evident in the area of suicide & Deaddiction where various kind of activities are being carried out to help people in crisis eg : Sanjeevani in Delhi, Sneha in Madras, Prerna in Mumbai.

### **Psychiatric Social Work**

The establishment of Mental Health organization under the directorate of Health services was first recommended in 1946 by the health survey & development committee of the government of India. The first Psychiatric Social worker was appointed in the Child Guidance Clinic started in 1937 by Sir Dorabji Tata Graduate School of social work (now Known as Tata Institute Of Social Sciences) in Mumbai. Banerjee was the pioneer of Psychiatric Social Work training in India; Institute of training in America appointed her the leader of Department of Medical & Psychiatric Social Work established in 1948. The other Social Workers & psychiatrists who gave a major boost to Psychiatric Social Work in India were Vidyasagar, Sarada Menon, U. B. Kashyap, B. D. Bhatia, P. B. Buckshey.

Gradually training for social work started in various centers such as National Institute of Neuropsychiatry in Bangalore (now known as NIMHANS) Indian Council of Mental Hygiene (Institute of Psychiatry & Mental hygiene).

Lunatic Asylum act, Act 36 of 1856 was modified to form Indian Lunacy Act, Act 4 of 1912. The enactment of act resulted in opening of new asylums and improvement in the condition of asylums. The name lunatic asylum was changed to mental hospital in 1920. In 1946, the Bhore committee recommended changes in Indian Lunacy Act 1912, as it had become outdated. Indian Psychiatric Society formed in January 1947 quickly acted on the recommendation and a committee consisted of Dr. J. Roy, major R. B Davis, Dr. Hasib was formed. It was finally enacted on 22nd May 1987.

### **Revolution in Psychiatry**

In the 20th century, the work of Freud and 'B. F. Skinner & J. B. Watson' gave a scientific combination of biological & social theories to explain the etiology of mental illness.

The history of psychiatry had witnessed 3 major revolutions that have given its present status. First Revolution occurred when it was believed that sin & Witchcraft are responsible for mental illness and mentally ill were chained in jails & asylums. They were considered as outcaste from society. Second revolution was the advent of psychoanalysis; that explained the etiology of psychiatric disorders. Third revolution was the development of community Psychiatry that resulted in the integration of mental health care in the community.

#### **1.4.2. THE HISTORICAL DEVELOPMENT OF PSYCHIATRIC SOCIAL WORK IN THE WESTERN WORLD**

In the early period when psychiatrists had to work unaided, they rarely had the time to probe into the patient's personal or social history without which it was impossible to get a complete picture of patient in relation to the problem. In consequence, the diagnosis was very often merely conjectural, limited to the physical symptoms and psychological factors. These were based mostly on hurried physical examinations of the patient, and without any understanding of the patient's personal and social background, which had necessarily so much to do with the nature and extent of the problem.

The evolution of psychiatric social work was the result of the awareness about the paramount need to look into the social implications and personal background of the patients, and the need to maintain detailed case records indicating the patient's reaction to treatment over long periods. Thus psychiatric social workers are charged with the responsibility of gathering social data, examining the social responses and interpreting all these in relation to the main task of reaching meaningful diagnosis and initiating effective treatment.

Psychiatric social work as a profession had its origin in the West in the second decade of the nineteenth century. However, there has been a lot of confusion about the term, psychiatric social work. As far back as 1929, two different definitions of psychiatric social work were formulated in USA. The first definition emphasizes the setting in which social case work is practiced. It defines psychiatric social work as, "Social case work established within psychiatric agencies as a form of service essential to the medical program of such agencies.

The second definition lays stress on the qualitative aspect of the practice irrespective of setting. It defines psychiatric social work as a practice possessing certain qualities, deriving from knowledge of psychiatric concepts and forms the ability to adapt them to the social case work process.

According to the second definition, the work of social workers, who find new positions in the family welfare agencies or child welfare agencies, has to presume that all activities of psychiatric social workers are related to psychiatric social work.

A third definition has also been given that, "Psychiatric social workers are those who work with psychiatrists as opposed to those who do not". In that sense a social worker working in a family welfare agency or any agency where the service of a part time consultant psychiatrist is available will say that hers is psychiatric social work.



### Check Your Progress 1

Note: Use the space provided for your answer

1. Describe the treatment practices according to Siddha System and Ayurveda

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2. Explain the historical development of psychiatric social work in the western world

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### 1.5. SUMMARY

Psychiatric Social Work, a specialized branch of Social work, which concerns with theoretical as well as clinical work and the knowledge of Psychiatry-which primarily deals with problems of the mind and associated disorders. The essential purpose of Psychiatric Social Work is to help the people with problems of the mind and/or with behavior problems or we can say precisely the problems of mind and brain and their solutions. It has grown as the result of the need felt and its realization for people with mental or emotionally disturb could be helped more effectively by understanding their social and/or environmental factors responsible for the problems of *mind* and *brain* in their management. It is widening its branches even today giving service to many psychologically disturbed persons

### KEY WORDS

- ❖ Psychiatric social work ,
- ❖ Dignity and worth of the person
- ❖ Importance of human relationships
- ❖ Integrity
- ❖ Competence
- ❖ Ayurveda
- ❖ Yunani

## **SELF-ASSESSMENT QUESTIONS AND EXERCISE**

1. What do you mean by psychiatric social work?
2. Explain the objectives of psychiatric social work
3. What is the nature of psychiatric social work?
4. Elaborate the historical development of psychiatric social work in India and western world

## **1.6. FURTHER READINGS AND REFERENCES**

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## **UNIT II**

Current status as a field of specialization. Case work, group work, and community organization in the psychiatric services; limitations and difficulties faced in psychiatric social work practice; psychiatric epidemiologist in India.

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### **Structure**

- 2.1 Aims and Objectives
  - 2.2 Introduction
  - 2.3. Current Status of Psychiatric Social Work
  - 2.4. Case Work in Psychiatric Services
  - 2.5. Group Work in Psychiatric Services
  - 2.6. Community Organization in Psychiatric Services
  - 2.7. Limitations and Difficulties of Psychiatric Services
  - 2.8 Psychiatric Epidemiologist in India.
  - 2.9 Summary
  - 2.10 Further reading and References
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### **2.1 AIMS AND OBJECTIVES**

- ❖ To find out the current status of Psychiatric Social Work
- ❖ To know about the case work, group work and Community organization
- ❖ To understand the challenges of Psychiatric Social Work

### **2.2 INTRODUCTION**

Clinical social workers diagnose and treat mental health conditions as well. They provide individual, family, and couples therapy, and they assist with depression, anxiety, family problems, and other mental health or behavioral issues. They may work in private practice or at a mental health or therapeutic facility. Social work is a field where trained professionals work for the welfare of individuals, communities, families and groups. Social work enables people and communities to deal with challenges and enhance their wellbeing. It helps to promote social change and empowers people for social and economic development.

## **2. 3. CURRENT STATUS AS A FIELD OF SPECIALIZATION.**

During the course of many bachelor's and master's degree programs, aspiring social workers may decide to specialize in specific fields of practice. Specialization allows social workers to gain more experience and knowledge in their field of interest and possibly increases their chances of employment. For example, many school social work positions often require specific education and experience in a school setting. Common areas of specialization include clinical, school, and child and family social work.

Psychiatric social workers provide mental health services to individuals with high needs. They may perform psychotherapy and even diagnose mental illness.

Duties vary according to work setting. Social workers in inpatient settings often have primary responsibility for putting together the discharge plan. This is not something that is filled out right before discharge – it's an ongoing process during much of the time the person is hospitalized. The goal is ambitious: that the person will have the resources to function optimally within the community. Hospital stays are shorter than they were in the past, but patients sometimes need to transition to a residential care center or a day program.

Social workers who are employed at psychiatric hospitals also do psychosocial assessments and provide therapy. They are in frequent contact with the family members of patients. They meet with other members of the mental health team (psychiatrists, nurse practitioners etc.) to discuss patient care. If the patient is involved in any legal procedures, the social worker may have a role in information gathering.

Psychiatric social workers may also be employed in outpatient centers, working with juveniles and adults. They perform psychotherapy and assessments, educate the patient and his or her family, and make referrals as necessary. Mental health therapies include more than just talk. Social workers may, for example, employ Eye Movement Desensitization and Reprocessing with young trauma survivors.

Master's level social workers serve as case managers for individuals who have severe needs, those who may require periodic hospitalization as well as intensive use of community resources. Clients may include those with schizophrenia and those with complex sets of co-occurring conditions.

Governmental agencies and residential care facilities are among the other employment options for psychiatric social workers. Some eventually go into private practice as psychotherapists.

### **Check Your Progress I**

Note: Use the space provided for your answer.

1) What are the mental health services provided by psychiatric social work?

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## 2.4. CASE WORK IN PSYCHIATRY SETTING

Social casework has been a predominant social work method of practice in psychiatric setting. Casework involves wide variety of activities in various settings, aimed to help individuals, couples and families to cope up more effectively with problems which impaired their socio-occupational functioning. Casework practitioners (psychiatric social worker) work face to face with the clients (patients), their family, and sometime visit their community to provide services. They perform many roles besides delivering direct psychosocial service; they also work in collaboration with other professionals, organisations and institutions, and act to advocate with agencies, administrators, policy makers, boards and legislatures. These practices must reflect in contemporary Indian literature particularly in published casework reports but we hardly find that.

Casework method based on systematic and orderly practice experiences which includes a processes of intake, social study and diagnosis, treatment, termination and follow up towards problem solution and social functioning among individuals, couples and families. There are more than fourteen models in social work practice which also implies in psychiatric setting. Many of the models were extensively elaborated by Robert and Nee and Turner, while others were cited in the social work literature. These social casework reports based on some of these models which are mostly referred to practice in psychiatric setting.

These models included:

- (1) Psychosocial model,
- (2) Problem solving model,
- (3) Behaviour modification,
- (4) Crisis intervention,
- (5) Family therapeutic model and
- (6) Task Centred model.

All these models has theoretical base which has been taken from various disciplines like psychology and sociology. In western countries, social work is well stabilized and occupies a major place in mental health care not only in terms of number but also in terms of getting prominence, recognition, and adequate role and responsibilities. One of the major reasons behind that is practice of psychiatric social work (PSW) is firmly bonded with these models. In literature one can easily find out social work interventions particularly casework practices includes various psychological approaches, viz., psychoanalysis, psychodynamic, cognitive

behavioural etc. In many countries, they are licensed for psychotherapy and all other therapies.

Whereas in India, psychiatric social workers are preferred for auxiliary mental health services, though their presence in the mental health field completed more than seven decades. There have been arguments of success and failure in helping the clients, the matter of training and competencies etc. It could be because a large number of social workers are practicing in mental health without an adequate qualification/training which gives a wrong impression to fellow professionals in multidisciplinary team and in the community about the competencies of social worker. It often results to poor recognition and inadequate allotment of role or responsibilities. Secondly the trends in training, practice and documentation also, some time contributed negatively. The present publications of PSW case reports articulate various theoretical frameworks in social casework practice.

Documentation should matter to every practicing social worker, student or trainees considering entry into the profession. It is a vital professional responsibility in which ongoing training is needed. Social workers often have a negative response to documentation - it is the barrier for many professionals' existence. To many social workers, it means spending time away from their true passion of working with the clients, responding to unnecessary bureaucratic demands, and tending to tedious and boring details. Many overworked social workers do not appreciate the requirement for case recording and often delay the task.

### **Check Your Progress II**

Note: Use the space provided for your answer.

- 1) What is the purpose of social case work in the treatment of psychiatric illness?

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- 2) List out the models of social case work

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## **2.5. SOCIAL GROUP WORK IN PSYCHIATRIC SETTING**

Social work with groups has played an important role in transforming the way we think about clients and about the helping process. Science has made the discovery that infants who are

isolated from other human beings succumb to inattention. Psychologists have observed that learning can actually be enhanced by associations with others.

## **ROLE OF PSYCHIATRIC SOCIAL WORKER**

The Clinical Psychiatric Social Work may include one or more of the following:

- Intake
- Reception- Accepting the patient
- Diagnosis / Analysis of Patient
- Treatment
- Rehabilitation of Patient
- Pre- convalescent
- Pre-Parole Services
- Follow- Up: after care
- Case History
- Case Work with Patient
- Case Work with Relative
- Orientation of the Staff
- Advocating for care
- Program planning and development
- Providing education and resources
- Administration of community services or programs
- Assessment of client needs for macro community programs or services
- Coordination and/or evaluation of service delivery
- Advocacy on behalf of persons or groups with unmet service needs
- Analysis and development of social welfare policy
- Organizational analysis
- Provision of training about community needs and problems
- Human Right of Psychiatric Patients

As mentioned previously, psychiatric social workers' main goal is to stabilize and support people experiencing intense psychological distress or behavioral issues that are threatening their safety and well-being, or the safety and well-being of others. Psychiatric social workers accomplish this goal through a combination of diagnostic assessments (ex. psychosocial assessments and risk assessments), individual and group therapy, and care coordination/case management services.

### **Diagnostic Assessments**

One of the most important tasks that psychiatric social workers have is conducting different diagnostic assessments of patients' mental health in order to determine their specific

psychological issues and needs. The main assessment that psychiatric social workers conduct is the psychosocial assessment, which requires that the psychiatric social worker gather the following information:

- ❖ Primary and secondary psychological conditions (ex. depression, severe anxiety, PTSD, schizophrenia, bipolar disorder, etc.)
- ❖ Behavioral issues (substance abuse, violence, problems with emotional regulation, etc.)
- ❖ Familial, social, cultural, and occupational background
- ❖ Physical health status and medical treatment history
- ❖ Mental health status (as measured by tests that measure mood, cognition, motor skills, perception, etc.)
- ❖ Mental health treatment history
- ❖ Current medications and treatment support systems

Psychiatric social workers may use information gained from the psychosocial assessment to also complete risk assessments, which are targeted evaluations of whether an individual may experience an adverse outcome in their current state and situation. Psychiatric social workers use risk assessments to determine the level of care that a patient needs (ex. hospitalization, an inpatient psychiatric hold, or intensive outpatient psychotherapy).

### **Care Coordination (Case Management)**

Once they have determined the mental health status and treatment history of their patients, psychiatric social workers are responsible for ensuring that their patients receive the mental health support they need. They accomplish this goal by:

- ❖ Developing a patient treatment plan in collaboration with medical and mental health staff, using information from the psychosocial assessment
- ❖ Monitoring a patient's progress throughout his or her treatment
- ❖ Communicating with the treatment team as needed regarding developments in a patient's mental health status
- ❖ Explaining different treatment options and plans to patients
- ❖ Connecting patients to relevant resources within and outside the treatment facility
- ❖ Coordinating safe and effective discharges when the time comes for patients to transition to a different treatment facility or back home

Psychiatric social workers are also often responsible for keeping medical and mental health treatment records to ensure continuity of care if/when patient's transition to different psychiatric settings or providers.

### **Individual and Group Psychotherapy**

Depending on their work setting, psychiatric social workers may deliver short-term or long-term psychotherapy to patients, utilizing different clinical social work methods according to each patient's individual psychological situation and needs. Psychotherapeutic methods that they may use include but are not limited to cognitive behavioral therapy, harm reduction



techniques (for behavioral issues such as chemical dependency), motivational interviewing, dialectical behavioral therapy, mindfulness training, and experiential therapy.

### **Check Your Progress III**

Note: Use the space provided for your answer.

1) List the information which have to be collected from the client

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2. What are the purpose of group psychotherapy?

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## **2.6. COMMUNITY ORGANIZATION IN PSYCHIATRIC SERVICES**

Community psychiatry means providing community mental health services to the persons and families with mental illness within the community using community resources. The community settings may be any religious place, that is, Dharamsala, Gurudwara, persons own house or any other place in community.

Community psychiatry in India is almost 6 decades old. It was started as an effort to involve families of mentally ill persons in the care of persons admitted to Amritsar Mental Hospital in the 1950s. Today, the integration of mental health care in to general health service covers almost all the districts of India under District Mental Health Programme (DMHP) in 12th five year plan along with wide variety of community-level facilities and initiatives to address the areas of mental health promotion, prevention, and treatment of mental disorders in community. From a situation of almost no community care in the 1st half of 20th century to current situation of mental health care in community, private sector and voluntary sectors is a sign of satisfaction and achievement.

## **2.7. CHALLENGES OF PSYCHIATRIC SOCIAL WORK**

Psychiatric social work is a very demanding and difficult profession. Psychiatric social workers must provide intensive and at times holistic support to people who are suffering from

incredibly severe, complex, and multifaceted mental health and behavioral issues. In addition, seeing individuals in acute suffering, and who may pose a danger to themselves and/or others, on a daily basis can prove disconcerting and draining for some professionals in the field.

“It’s hard to describe how to prepare for watching a patient be restrained, a child receive sedation, the assaults that can be witnessed that make the job hazardous,” Ms. Clark said, “Being aware, knowing safety precautions is vital for keeping safe and keeping the unit safe for others.”

Psychiatric social work can be unpredictable and dangerous, as Ms. Paffenroth explained to OnlineMSWPrograms.com. “One of the most challenging aspects of my job is the potential danger. When going out into the community to do evaluations I do not know what to expect,” she said, “I try to gather as much collateral information as possible before going, however you still do not know what you are walking into much of the time.”

The hazards of the job are not the only challenge that psychiatric social workers encounter. “For me I have never found the needs of my patients to be the challenge; rather, connecting my patients with a finite amount of resources has always been the most frustrating part of my work,” Ms. Clark noted, “Additionally, process and structural problems of the way social and mental health services are distributed, managed and funded are equally as frustrating.”

### **Check Your Progress IV**

Note: Use the space provided for your answer.

1) List the challenges of psychiatric social work.

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## **2.8 PSYCHIATRIC EPIDEMIOLOGY IN INDIA.**

Epidemiological studies report prevalence rates for psychiatric disorders from 9.5 to 370/1000 populations in India. Most of the epidemiological studies done in India neglected anxiety disorders, substance dependence disorders, co-morbidity and dual diagnosis.

The psychiatric social workers whom we interviewed encouraged professionals in the field to develop a plan for strong and consistent self-care. “I believe the largest asset a student can possess is a commitment to the patients and really good self-care,” Ms. Clark said.

Mr. Berman described the importance of establishing boundaries between one’s professional and personal life, and engaging in self-care practices in order to stay balanced and energized at work. “It has been challenging to set boundaries between my work and personal life that

will allow this career to be sustainable in the long-term. I have started forcing myself to leave work on time, no matter if not everything is done,” he said, “Because the truth is no matter how hard you work, it will never be enough. I have also become more committed to my own weekly therapy, which is important for self-care and professional development.”

Ms. Paffenroth also explained how, on the job, awareness and caution are extremely important. “The best way to address the safety challenges is to be very aware,” she advised, “This starts by asking the referring party if the individual has a history of violence or has made any threats of violence, gathering as much about the individual's history as possible. Once on scene, continue to be aware of your surroundings, do not enter someone's home if you feel threatened or unsafe. We always go out in teams of two and we always make safety a priority.”

Various epidemiological studies from India have estimated the prevalence of mental disorders between 5.82% and 7.3% and the resources available to manage the huge burden of these disorders are insufficient, inequitably distributed, and used inadequately which lead to treatment gap in the tune of more than 75%.

The National Mental Health Survey of India-2016 conducted on a nationally representative sample of 34802 individuals, which were sampled from 12 states of India. The results show the prevalence rate for any mental disorder is 10.6% and nearly 150 million Indians are in need of active interventions.

Similarly, India has an estimation of 62.5 million alcohol users, 8.7 million cannabis users, and 2 million opiate users, of whom 17%–26% are dependent users. There are only 124 deaddiction centers run by the MOH and FW in addition to 401 Treatment cum Rehabilitation Centers and 41 drug awareness and counseling centers supported by MoSJE (MSJE, 2008). Majority of these centers lack infrastructure, trained workforce, and insufficient funds. Moreover, many people do not seek treatment due to lack of motivation, perceived stigma, need of treatment not felt, time-consuming process, lack of awareness, etc.

Studies that have assessed factors that influence access to mental health care have emphasized the following barriers: Stigma and discrimination, inherent belief that nothing could help, seeking help being a sign of weakness, denial, embarrassment to seek help, poor awareness, economic policies, lack of resources, unequal distribution of resources, insufficient facilities, poor allocation of funds, lack of availability and accessibility of treatment, lower socioeconomic status, low education, poorly developed services, and beliefs in supernatural powers. A study by Reddy et al. have found out various reasons for not seeking help, which were further grouped under the following factors: Lack of awareness about the illness, religious beliefs, lack of family support, financial constraints, family dynamics, family's tolerance about symptoms, lack of insight about illness, families resilience, community beliefs regarding mental illnesses, and others. In each patient, a complex interplay of several of these factors prevents the family from seeking psychiatric treatment.

### **Check Your Progress V**

Note: Use the space provided for your answer.

1. What are the factors that influence access to mental health care?

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### **2.9 SUMMARY**

Social workers recognize the primary importance of human relationships. They understand that relationships between people are important vehicles for change, advocacy and equity. ... They improve relationships among people in order to restore and promote the functionality of clients, their families and communities. They use the methods of social case work, group work and community organization in their treatment process of psychiatric ill patients.

### **KEY WORDS**

- ❖ Psychiatric Assessment
- ❖ Case work
- ❖ self-care
- ❖ Group Work
- ❖ Community psychiatry
- ❖ Limitations

### **SELF-ASSESSMENT QUESTIONS AND EXERCISE**

1. What are the utility of case work method in the psychiatric setting?
2. List out the models practiced in the case work practice
3. Enumerate the role of psychiatric social worker
4. What are the challenges of psychiatric social work in India?

### **2.10. FURTHER READINGS AND REFERENCES**

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## **UNIT III**

Historical development of Psychiatry as a Field of Specialization: attitudes and beliefs pertaining to mental illness in ancient, medieval and modern times

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### **Structure**

3.0 Aims and Objectives

3.1. Introduction

3.2 Historical Development of Psychiatry as a Field of Specialization

3.3. Attitudes and Beliefs Pertaining to Mental Illness in Ancient, Medieval and Modern Times

3.4 Summary

3.5 Further Readings and References

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### **3.0 AIMS AND OBJECTIVES**

- ❖ To study on the historical development of psychiatric social work in various period
- ❖ To analyses the beliefs and attitude of people on the mental illness

### **3.1 INTRODUCTION**

History is a record of opportunities, recognized and informed, that produce profound changes in a given field. History of psychiatry and psychiatric nursing illustrates this, and is based on this concept. In this unit, you will study how psychiatric nursing of today has developed from the time of in-humane care to the care of the mentally ill. As you know that mental illness was always associated with ignorance superstition and fears. Mentally ill patient went through a lot of torture and problems for lack of development in the field of psychiatry. With the introduction of understanding of the human behaviour during the latter part of the 19th century, it brought in the change in care and attitude towards the mentally ill patients.

### **3.2 HISTORICAL DEVELOPMENT OF PSYCHIATRY AS A FIELD OF SPECIALISATION**

Patient care has changed dramatically since 1930's and psychiatric nurses have kept pace with the changing trends of care. In 1882, "celebration for psychiatric nurse" was held at Virginia, and the Mclean Asylum Training School for nurses was identified as a pioneering institution in mental health. It was the first formally organized training school conducted within a

mental hospital. In 1882, Mclean Hospital also initiated training in Psychiatric Nursing at Waverly, Massachusetts. In 1886, 15 women graduated in the 1st division. So in this unit you will study about the development of psychiatric nursing, in general and Indian psychiatric nursing, in particular. You will also learn about the major contributions in the field of psychiatry and psychiatric nursing.

The earliest treatment of mental disorders was practiced by Stone Age cave dwellers. For certain mental disorders, the early Shaman or medicine man, treated the disorders by means of an operation now called trephining. This operation was performed with crude stone instrument, making a hole in the skull. This opening was called a trephine. It was presumed that the evil spirit will escape through it.

### **3.2.1. HISTORICALLY SIGNIFICANT PERIOD**

The following categories of periods are identified historically:

#### **The Period of Persecution**

Earlier Treatment of the intently sick depended on men's various superstitious beliefs. It was thought that sounds and motions are the factors of illness of health, black spirit or black magic was harmful and white magic and good spirit did not bring illness. Patients with mental illness were thrown out of society and beaten up by the people. During this period no nursing was required as nobody was allowed to keep any relationship with these patients. They were tortured and left on their own.

#### **Period of Segregation**

To prevent the mentally ill patients from straying into streets, they were put separately in asylums. In England, these patients were put in the 'Bethlem Asylum' for the first time. Because of its uncontrolled activities and defining noise made by the patients the English word 'Bedlam' was derived for Bethlem. The Government funded these hospitals but patients did not have adequate conditions to live. During this period the field of psychiatry had not developed. The aim was to segregate patients from the general public.

#### **Humanitarian Period**

During this period more and more asylums were set up. Physicians got interested in working on mental illnesses. In the later part of the century, Phillippe Pinel in France and William Tuke in England opened the chains of mentally ill. More patients were taken care on humanitarian grounds. In 1792, William Tuke founded the York Retreat Hospital in England and provided total care to the patients without restrains or chains. During this period also no mention of nurses was made.

In 1773, in the United States mental patients were admitted to Pennsylvania Hospital, but no special training were given to nurses. Nurses with general nursing qualification looked after mentally ill patients.

### **Beginning of Scientific Attitude**

Now the development of insanity was considered as illness. By this time, Jean Martin Charcot practiced hypnotism. Sigmund Freud (1856-1939), founder of psychoanalysis, believed in hypnotism for easing psychic tension. Emil Kraepelin (1856-1926) classified the mental illness.

### **Period of Prevention**

In the 20th century, psychological clinics for problem children were established. In 1950, the National Association of Mental Health was formed (sponsored by Doctors). In 1953, wide publicity was given to mental illness. In 1960, the first worldwide mental health year was celebrated.

Psychiatry got its name as a medical specialty in the early 1800s. For the first century of its existence, the field concerned itself with severely disordered individuals confined to asylums or hospitals. These patients were generally psychotic, severely depressed or manic, or suffered conditions we would now recognize as medical: dementia, brain tumors, seizures, hypothyroidism, etc. As was true of much of medicine at the time, treatment was rudimentary, often harsh, and generally ineffective. Psychiatrists did not treat outpatients, i.e., anyone who functioned even minimally in everyday society. Instead, neurologists treated "nervous" conditions, so named for their presumed origin in disordered nerves.

Around the turn of the 20th century, the neurologist Sigmund Freud published theories on the unconscious roots of some of these less severe disorders, which he termed psychoneuroses. These disorders impaired relationships and work, or produced odd symptoms such as paralysis or mutism that could not be explained medically. Freud developed psychoanalysis to treat these "neurotic" patients. However, psychiatry, not neurology, soon became the specialty known for providing this treatment. Psychoanalysis thus became the first treatment for psychiatric outpatients. It also created a split in the field, which continues to this day, between biological psychiatry and psychotherapy.

Psychoanalysis was the dominant paradigm in outpatient psychiatry for the first half of the 20th century. In retrospect it overreached, as dominant paradigms often do, and was employed even for conditions where it appeared to do little good. Empirical evidence of its efficacy was scarce, both because psychoanalysts largely shunned experiments, and because analytic interventions and outcomes are inherently difficult to study this way. Nonetheless, many case reports alleged the benefits of psychoanalysis, and subsequent empirical research has tended to support this.

Meanwhile, clinical psychologists championed the use of cognitive and cognitive-behavioral psychotherapies. Coming from an experimentalist tradition (the "rats in mazes" stereotype of academic psychology), clinical psychologists empirically validated the use



of cognitive-behavioral therapy (CBT) for depression, anxiety, and other named disorders. Standardized therapy could be conducted by following a treatment manual; targeted symptom improvement documented success or failure. This empiricism meshed well with the "evidence based medicine" movement starting in the 1990s, to the further detriment of analytic and dynamic therapies. Whether treated by a psychiatrist with a prescription pad or a psychologist with a CBT manual (or both), emotional complaints were first categorized and diagnosed, and then treated by sharply focusing on the specific defining symptoms of the diagnosis.

Notwithstanding the Decade of the Brain and lavish public and private investment, pharmaceutical innovation dried up in the 2000s. No new classes of medication or blockbuster psychiatric drugs were discovered. Moreover, previously unrecognized or under-appreciated side-effects of widely used medications hit the headlines. SSRIs were implicated in increased suicidal behavior, and some patients reported severe "discontinuation syndromes" when stopping treatment. Atypical neuroleptics were associated with a "metabolic syndrome" of weight gain, increased diabetes risk, and other medical complications. Adding insult to injury, the millions spent on basic brain research led to no advancement in our understanding of psychiatric etiology, nor to novel biological treatments. And to top it off, pharmaceutical companies were fined repeatedly and for huge sums for promoting powerful, expensive psychiatric medications for unapproved uses.

Psychiatry's reputation suffered for it. Once the doctors for society's hopeless and forgotten, later the subtle explorers of individual psyches, office-based psychiatrists are now too often viewed as mere technicians, attacking emotional symptoms with one prescription after another. Getting to know the person behind the symptoms is left to non-psychiatric therapists, obscuring the often close connection between medication response and psychology.

Healing the rift between biological psychiatry and psychotherapy was foreshadowed in the 1970s by George L. Engel's bio psychosocial medical model and by Eric R. Kandel's laboratory work on the cellular basis of behavior. (Kandel's classic 2001 paper is well worth reading.) Even at the height of the medicalization of psychiatry in the 1980s and 90s it was recognized that unconscious dynamics affect the doctor-patient relationship, and that interpersonal factors strongly influence whether patients feel helped with treatment. It is time again to acknowledge that many outpatients, probably most, seek treatment not for discrete symptoms but for diffuse dissatisfaction, stormy relationships, unwitting self-sabotage, dissociative reactions, and other misery that cannot readily be reduced to DSM diagnostic criteria. The convenient fiction that people's feelings can be distilled into a "problem list" is not so convenient after all.

The future of psychiatry can be neither "brainless" nor "mindless." History points too many conditions once thought to be "mental" (general paresis, cretinism, senility, seizures, etc.) that are now known to be medical. Brain research is essential, as more such examples are sure to come. It is equally clear that we are nowhere near analysing and treating human psychology at the neural level. That may be possible someday, but for now any such claims are absurdly

premature. The distinction between medical and psychological will likely become less sharp in the years ahead, as certain genetic or other biological differences will be linked to psychological vulnerabilities. Nonetheless, the uneasy tension between biological and psychological psychiatry will not end soon; we are better off embracing it instead of choosing sides. A robust psychiatry of the future will surely claim a wide purview, from the cellular basis of behavior, to individual psychology, to family dynamics, and finally to community and social phenomena that affect us all.

### **Check Your Progress I**

Note: Use the space provided for your answer.

1. How the mentally ill persons were treated at the beginning?

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2. What is the focus on psychoanalytic theory?

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### **3.2.2. PSYCHIATRY IN ANCIENT VEDIC INDIA**

The descriptions of various mental illnesses in ancient Indian texts are probably the oldest such accounts. Two well-known Ayurvedic manuscripts, the Charaka Samhita by Charaka, and the SushrutaSamhita by Sushruta, have established the roots of modern Indian medicine. The ancient Indian scripture, Atharva-Veda, mentions that mental illness may result from divine curses. Descriptions of conditions similar to schizophrenia and bipolar disorder appear in the Vedic texts. A vivid description of schizophrenia is also found in Atharva-Veda. Other traditional medical systems such as Siddha, which recognize various types of mental disorders, flourished in southern India. Great epics such as the Ramayana and the Mahabharata made several References to disordered states of mind and means of coping with them. The Bhagavad Gita is a classic example of crisis intervention psychotherapy. Another interesting contribution of the Ayurveda is its knowledge regarding the diet-disease relationship and the association of a disease with a specific physical constitution. Diagnosis was entertained by the five senses and supplemented by interrogation. According to the ancient system, diagnosis was based on cause (nidana), premonitory indications (purvarupa), symptoms (rupa), therapeutic tests (upashaya) and natural history of the development of the disease (samprapti). According to Sushruta, the physician (chikitsyak), the drug

(dravya), the attendants or the nursing personnel (upasthata), and the patient (rogi) are the four pillars on which rests the success of the therapy. The highest patronage to the science of Ayurveda was given by the Buddhist kings (400-200 BC).

Close to the roots of Hindu mythology, Najabuddin Unhammad (1222 AD), an Indian physician propagated the Unani system of medicine as he described seven types of mental disorders; Sauda-a-Tabee (Schizophrenia); Muree-Sauda (depression); Ishk (delusion of love); Nisyan (Organic mental disorder); Haziyan (paranoid state) and Malikholia-a-maraki (delirium). Psychotherapy was known as Ilaj-I-Nafsani in Unani Medicine. The great sage 'Agastya' formulated a treatise on mental diseases called as 'AgastiyarkirigaiNool', in which 18 psychiatric disorders with appropriate treatment methods were described. CharakSamhita had described various attributes for a hospital including its location, details of equipments, food and cleanliness and model code of conduct for physicians, nursing staff and ward attendants.

The *tridoshic philosophy* is still widely accepted among modern Indian patients. The history of psychiatry in India has witnessed major changes in the past. The first revolution occurred when it was believed that sin and witchcraft are responsible for mental illness and the mentally ill were chained in jails and asylums. Then with the advent of psychoanalysis, etiology of psychiatric disorders was explained. Third was the development of community psychiatry.

### **3.2.3. PSYCHIATRY IN PRE-COLONIAL INDIA**

During the reigns of King Asoka, many hospitals were established for patients with mental illness. According to the scribes of Asoka Samhita, hospitals were built with separate enclosures for various practices including keeping the patients and dispensing treatments prevailing during those times. A temple of Lord Venkateswara at Tirumukkudal, Chingleput, Tamil Nadu, contains inscriptions on the walls belonging to the Chola period. There are some ancient evidences of propagation of alienation of mentally ill patients in Shahdaula's Chauhas in Gujarat and Punjab. Though there is not much evidence for development of psychiatry in the Moghul period, there are References to some asylums in the period of Mohammad Khilji (1436- 1469). There is also some evidence of the presence of a mental hospital at Dhar near Mandu, Madhya Pradesh, whose physician was Maulana Fazulur Hakim. There are some historical evidences from the pre-colonial literature that modern medicine and modern hospitals were first brought to India by Portuguese during the seventeenth century in Goa, though documentary evidences are not in good shape to substantiate the claims.

The political instability prevailing in the 1700s saw development of lunatic asylums in Calcutta, Madras and Bombay. It is interesting to observe that these three cities grew up in the beginning largely with British enterprise which conceptualized the segregation of mentally ill patients in mental asylums and their supervision by trained people more in sync with the western conceptualization. The need to establish hospitals became more acute first to

treat and manage Englishmen and Indian 'sepoys' employed by the British East India Company. Warren Hastings, the first Governor General, during his regime in 1784 introduced the 'Pitts India Bill' according to which the activities of the Government of the East India Company came under the direction of a "Board of Control" and systematic reforms and welfare actions were taken during Lord Cornwallis (1786-93) rule. It was during his rule that there is a Reference of the first mental hospital in this part of India at Calcutta recorded in the proceedings of Calcutta Medical Board on April 3, 1787, which became the Reference point of inception of colonial influence on development of psychiatric care in India.

### **3.2.4. PSYCHIATRY IN COLONIAL INDIA**

Ernst (1987) described the growth of mental asylums in British India as a 'less conspicuous form of social control'. Mental hospitals (or asylums as they were called) in India were greatly influenced by British psychiatry and catered mostly to European soldiers posted in India at that time. Their function was more custodial and less curative.

Development of lunatic asylums was apparent in the early colonial period from 1745 to 1857 till the first revolution for Indian Independence was started. The earliest mental hospital in India was established at Bombay in 1745, which was made to accommodate around 30 mentally ill patients. Surgeon Kenderline started one of the first asylums in India in Calcutta in 1787. Later, a private lunatic asylum was constructed, recognized by the Medical Board under the charge of Surgeon William Dick and rented out to the East India Company. The first government run lunatic asylum was opened on 17 April 1795 at Monghyr in Bihar, especially for insane soldiers. The first mental hospital in South India started at Kilpauk, Madras in 1794 by Surgeon Vallentine Conolly. During this period, excited patients were treated with opium, given hot baths and sometimes, leeches were applied to suck their blood. Music was also used a mode of therapy to calm down patients in some hospitals. The mentally ill from the general population were taken care of by the local communities and by traditional Indian medicine doctors, qualified in Ayurveda and Unani medicine.

The mid-colonial period from 1858-1918 witnessed a steady growth in the development of mental asylums. This period was significant for the enactment of the first Lunacy Act (also called Act No. 36) in the year 1858. The Act was later modified by a committee appointed in Bengal in 1888. During this period, new asylums were also built at Patna, Dacca, Calcutta, Berhampur, Waltair, Trichinapally, Colaba, Poona, Dharwar, Ahmedabad, Ratnagiri, Hyderabad (Sind), Jabalpur, Banaras, Agra, Bareilly, Tezpur and Lahore. Techniques of 'moral management' systems which were developed and implemented in this period in the west were also adopted in India. Drug treatments for psychiatric conditions were also introduced into India in this period, e.g., chloral hydrate. These were largely aimed at controlling patient behaviour and also of allowing the patient some respite from his/her condition through sleep. The onset of World War I in 1914 signalled the beginning of a new and distinct period in which strands of continuity were pulled up, in which significant changes took off in the Indian psychiatric system.

Under the Indian Lunacy Act 1912, a European Lunatic Asylum was established in Bhowanipore for European patients, which later closed down after the establishment of the European Hospital at Ranchi in 1918. It was the far-sightedness, hard work and the persistence of the then superintendent of the European Hospital (now known as the Central Institute of Psychiatry), Col Owen A R Berkeley-Hill, that made the institution at Ranchi a unique centre in India at that time which attracted many European patients for treatment. Berkeley-Hill was deeply concerned about the improvement of mental hospitals in those days.

The years after 1914 were characterized by gradual expansion rather than building projects and the most significant of these of the period were hangovers from the pre-1914 period. Mental Asylum at Ranchi first opened in 1918 as a hospital for European patients. The sustained efforts of Berkeley-Hill not only helped to raise the standard of treatment and care, but also persuaded the government to change the term 'asylum' to 'hospital' in 1920. The Parsees during that period were keen to spend large amounts of money to guarantee care in modern psychiatric institutions for those who were considered insane in their own community, often guided by financial rather than therapeutic reasoning. The origins of psychiatric rehabilitation in India can be traced to innovative service programs, which were initiated at the Central Institute of Psychiatry (CIP) in 1922 when Occupational Therapy Unit started at this place. Hydrotherapy started in 1923 and during the same time the hospital started to raise interest of public in mental hygiene and prophylaxis, taking initiatives in preventive aspects of psychiatry. Techniques similar to token- economy were first started in 1920 and called by the name "Habit Formation Chart". Girindra Shekhar Bose first founded the Indian Psychoanalytical Association in 1922 in Calcutta and Berkeley-Hill started the Indian Association for Mental Hygiene at Ranchi. He was one of the earliest practitioners of psychoanalysis in India who used this technique to help British patients to adjust to their lives after the ravages of World War I. CIP was one of the first centers outside Europe to start Cardiazol-induced seizure treatment in 1938, Electroconvulsive Therapy (ECT) in 1943 and Psychosurgery in 1947. Rauwolfia extracts in the form of Santina, Serpasil and Meralfen were also used for treating psychotic conditions in late 1940s.

In the year 1922, CIP got affiliation from the University of London to start Diploma in Psychological Medicine. Grant Medical College, Bombay (now Mumbai) had a Professor of Psychiatry, significantly an Indian, by the year 1936. A memo noted in the archives shows that the number of visits he was to make to the NM Mental Hospital, Thane was to be 'two per week during the term, when he also gave instructions to the students of the Grant Medical College, Bombay. A library on mental health started in 1918 at CIP with 300 books and journals which dated back to 1910. Child guidance clinic was first established in 1937 at Sir Dorabji Tata Graduate School of Social Work in Bombay. The establishment of Mental Health organization under the Directorate of Health Services was first recommended in 1946 by the health survey and development committee of the Indian Government. The first psychiatric outpatient service, precursor to the present-day general hospital psychiatric units (GHPU), was set up at the R.G. Kar Medical College, Calcutta in 1933 by Ghirinder Shekhar

Bose. This was followed by a surge of such units with Masani opening one at JJ Hospital, Bombay in 1938 and Dhunjibhoy opening one day weekly clinic at Prince of Wales Medical College (now Patna Medical College) in 1939.

In 1946, a health survey and development committee, popularly known as the “Bhore Committee,” surveyed mental hospitals. The Health Survey and Development Committee report submitted by Col. Moore Taylor in 1946 reported numerical and professional inadequacy and suggested a focus on training of personnel and students in psychiatry, promotion of occupational and diversionary therapies, and separate child psychiatry units. The committee suggested improvisation and modernization of most hospitals, attachment to medical colleges, and establishment of proper mental health. The World War II saw a separation of military psychiatry from psychiatry in general in India in which the history of modern psychiatry in India seemed to have returned to its origins.

### **3.2.5. PSYCHIATRY IN INDEPENDENT INDIA: THE FORMATIVE YEARS**

A new phase of development of mental hospitals started after India's independence in 1947. The government of India focused upon the creation of GHPUs rather than building more mental hospitals. Emphasis was placed upon improving conditions in existing hospitals, while at the same time encouraging outpatient care through these units. A few new mental hospitals, notably at Delhi, Jaipur, Kottayam and Bengal, were added. Mid-1950 witnessed rapid development in the spread to GHPUs in India. In 1957, Dutta Ray started a psychiatric out-patient service at Irwin Hospital (now G.B. Pant Hospital), in New Delhi. In 1958, N.N. Wig started the first GHPU at Medical College, Lucknow, with both in-patient and out-patient psychiatric services and a teaching program as part of the Department of Medicine. Neki started a similar unit at Medical College, Amritsar a few months later. In the next 25 years most of the teaching hospitals and major general hospitals in the private or government sector had GHPUs which were managed by emerging mental health professionals joining services after completing their post-graduation in psychiatry.

By the 1960s, traditional institutions like CIP (Ranchi) and Madras Mental Hospital/Asylum offered a range of specialized services, including child and adolescent clinics. Geriatric, epileptic and neuropsychiatric services were added to complete the range of comprehensive OPDs. Another important innovation in the 1960s was the concept of a day hospital. Slowly, alternative accommodations were explored for patients who had recovered, but could not return to their families. CIP started the Department of Clinical Psychology in 1949 which happens to have the first clinical psychology laboratory in the country. CIP also took initiatives in community mental health services as one of the earliest rural mental health clinic was started at Mandar near Ranchi in 1967.

An industrial psychiatric unit was started at Heavy Engineering Corporation (HEC) at Hatia, Ranchi in 1973. Opening of psychiatry units in general hospitals gave psychiatrists an

opportunity to demonstrate their knowledge and skills in the management of neurotic and psychosomatic disorders.

On the recommendation of the Bhole committee, All India Institute Mental Health was set up in 1954, which became the National Institute of Mental Health and Neurosciences (NIMHANS) in 1974 at Bangalore. The first training program for Primary Health Care was started in 1978-79. During 1978-1984 Indian Council of Medical Research funded and conducted a multicentre collaborative project on 'severe mental morbidity' in Bangalore, Baroda, Calcutta and Patiala. Various training programmes for psychiatrists, Clinical Psychologists, Psychiatric Social Workers, Psychiatric nurses and Primary Care doctors were conducted at Sakalwara unit during 1981-82. Combating stigma and widening the social network of patients were regarded as core elements of a successful rehabilitation programme. During the last 50 years mental health activities have moved from care of the mentally ill to include prevention and promotion of mental health. Keeping with the reforms in community psychiatry, the first psychiatric mental health camp in India was organized in 1972, at Bagalkot, a taluka of Mysore.

Mention must be made of attempts by Wig to use yoga as a therapeutic tool. This period also witnessed efforts to define the core elements of an Indian approach to psychotherapy in the form of a guru-chela relationship. The efforts continued in the 1960s at NIMHANS as there was widespread international acceptance of such approaches, which are known under the rubric of 'family interventions'.

### **3.2.6. PSYCHIATRY IN INDEPENDENT INDIA: ERA OF CONSOLIDATION**

As the Government of India embarked on an ambitious national health policy that envisioned "health for all by the year 2000," early drafts of the National Mental Health Program were formulated, subsequently adopted by the Central Council of Health and Family Welfare, in 1982. Since its inception, there has been development of a model District Mental Health Program, and development of training materials and programs for practitioners and academicians.

The first draft of Mental Health Act that subsequently became the Mental Health Act of India (1987) was written at Ranchi in 1949 by R.B. Davis, then Medical Superintendent of CIP, S.A. Hasib, from Indian Mental Hospital, Ranchi and J Roy, from Mental Hospital, Nagpur. Initial attempts by the Indian Psychiatric Society to bring about change were unsuccessful. In 1959-60, reforms were considered but no consensus was reached. In the 1980s, there was a resurgence of activity resulting in the passage of the Mental Health Act in 1987.

#### **The Erwadi tragedy**

In 2001 a horrific incidence took place at Erwadi in which 26 persons with mental illness died in a tragic fire accident. The response of the general population, the administrators, the

politicians, the press and the professionals was one of shock and outrage. The press seized the moment and wrote about similar situations, in Hyderabad, Ranchi, Ahmedabad, and Patiala. The National Human Rights Commission called for a Report. The Supreme Court initiated action on the matter. As a result, many changes not only in Erwadi but also in the different parts of the country started taking shape, which proved to be a yardstick which revamped mental health services in the country.

Research in psychiatry started rolling with commencement of publication of first journal dedicated to mental health, The “Indian Journal of Neurology and Psychiatry” in 1949. The Indian Journal of Psychiatry started in 1958 and has now completed 50 golden years of continuous enrichment in the field of psychiatry in India. The journal got indexed in National Library of Medicine, the Catalogue of Index Medicus as the present review has been written in 2009. Psychoanalytically oriented literature and theoretical texts dominated the research literature from 1947 to 1960. During the second phase of psychiatric research (1960- 1972), a distinctive trend emerged as research publications moved from individual psychopathology to the interface between the individual and society and group behaviour.

The Mudaliar Committee also noted the serious shortage of trained mental health manpower and recommended the development of the European Mental Hospital at Ranchi (now CIP) into a full-fledged training institute. A formal training program for clinical psychologists (Diploma in Medical Psychology) also commenced at NIMHANS in the year 1955 and was later converted into an M. Phil in Medical and Social Psychology in 1978. In keeping with the recommendations of the Mudaliar Committee, the Central Institute of Psychiatry started training for clinical psychologists in 1962.

Girinder Shekhar Bose founded the Indian Psychoanalytical Association in 1922 in Calcutta. Berkeley-Hill, in 1929, founded the Indian Association for Mental Hygiene. D. Satyanand was another analyst who received his personal analysis by Berkeley-Hill. In 1935, the Indian division of the Royal Medico-Psychological Association was formed due to the efforts of Banarasi Das. In 1946, Nagendra Nath De consulted R. B. Davis of the European Mental Hospital, Ranchi and T. A. Munro, an advisor in Psychiatry to the Indian Army and decided to revive the association. The decision to form the Indian Psychiatric Society, the national organization of psychiatrists in India was taken in the meeting convened by R.B. Davis in Delhi on 7<sup>th</sup> January 1947 during the annual congress of Indian Science Congress at Delhi University.

## **Check Your Progress II**

Note: Use the space provided for your answer.

1. When and where the first mental hospital started in India?

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2. What are the causes of Ervadi incident in Tamil Nadu?  
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### **3.4 ATTITUDES AND BELIEFS PERTAINING TO MENTAL ILLNESS IN ANCIENT, MEDIEVAL AND MODERN TIMES**

In this section, we will examine how past societies viewed and dealt with mental illness.

#### **Greco-Roman Thought**

Rejecting the idea of demonic possession, Greek physician, Hippocrates (460-377 B.C.), said that mental disorders were akin to physical disorders and had natural causes. Specifically, he suggested that they arose from *brain pathology*, or head trauma/brain dysfunction or disease, and were also affected by heredity. Hippocrates classified mental disorders into three main categories – melancholia, mania, and phrenitis (brain fever) and gave detailed clinical descriptions of each. He also described four main fluids or **humors** that directed normal functioning and personality – *blood* which arose in the heart, *black bile* arising in the spleen, *yellow bile* or *cholera* from the liver, and *phlegm* from the brain. Mental disorders occurred when the humors were in a state of imbalance such as an excess of yellow bile causing frenzy/mania and too much black bile causing melancholia/depression. Hippocrates believed mental illnesses could be treated as any other disorder and focused on the underlying pathology.

Also important was Greek philosopher, Plato (429-347 B.C.), who said that the mentally ill were not responsible for their own actions and so should not be punished. He emphasized the role of social environment and early learning in the development of mental disorders and believed it was the responsibility of the community and their families to care for them in a humane manner using rational discussions. Greek physician, Galen (A.D. 129-199) said mental disorders had either physical or mental causes that included fear, shock, alcoholism, head injuries, adolescence, and changes in menstruation.

In Rome, physician Asclepiades (124-40 BC) and philosopher Cicero (106-43 BC) rejected Hippocrates' idea of the four humors and instead stated that melancholy arises from grief, fear, and rage; not excess black bile. Roman physicians treated mental disorders with massage and warm baths, with the hope that their patients be as comfortable as possible. They practiced the concept of "*contrariiscontrarius*", meaning opposite by opposite, and introduced contrasting stimuli to bring about balance in the physical and mental domains. An example would be consuming a cold drink while in a warm bath.

## **The middle Ages – 500 AD to 1500 AD**

The progress made during the time of the Greeks and Romans was quickly reversed during the middle Ages with the increase in power of the Church and the fall of the Roman Empire. Mental illness was yet again explained as possession by the Devil and methods such as exorcism, flogging, and prayer, the touching of relics, chanting, visiting holy sites, and holy water were used to rid the person of the Devil's influence. In extreme cases, the afflicted were confined, beat, and even executed. Scientific and medical explanations, such as those proposed by Hippocrates, were discarded at this time.

Group hysteria, or **mass madness**, was also seen in which large numbers of people displayed similar symptoms and false beliefs. This included the belief that one was possessed by wolves or other animals and imitated their behavior, called **lycanthropy**, and a mania in which large numbers of people had an uncontrollable desire to dance and jump, called **tarantism**. The latter was believed to have been caused by the bite of the wolf spider, now called the tarantula, and spread quickly from Italy to Germany and other parts of Europe where it was called **Saint Vitus's dance**.

Perhaps the return to supernatural explanations during the Middle Ages makes sense given events of the time. The Black Death or Bubonic Plague had killed up to a third, and according to other estimates almost half, of the population. Famine, war, social oppression, and pestilence were also factors. Death was ever present which led to an epidemic of depression and fear. Nevertheless, near the end of the middle Ages, mystical explanations for mental illness began to lose favour and government officials regained some of their lost power over nonreligious activities. Science and medicine were once again called upon to explain mental disorders.

## **The Renaissance – 14th to 16th Centuries**

The most noteworthy development in the realm of philosophy during the Renaissance was the rise of **humanism**, or the worldview that emphasizes human welfare and the uniqueness of the individual. This helped continue the decline of supernatural views of mental illness. In the mid to late 1500s, Johann Weyer (1515-1588), a German physician, published his book, *On the Deceits of the Demons*, that rebutted the Church's witch-hunting handbook, the *Malleus Maleficarum*, and argued that many accused of being witches and subsequently imprisoned, tortured, hung, and/or burned at the stake, were mentally disturbed and not possessed by demons or the Devil himself. He believed that like the body, the mind was susceptible to illness. Not surprisingly, the book was met with vehement protest and even banned from the church. It should be noted that these types of acts occurred not only in Europe but also in the United States. The most famous example was the Salem Witch Trials of 1692 in which more than 200 people were accused of practicing witchcraft and 20 were killed.

The number of **asylums**, or places of refuge for the mentally ill where they could receive care, began to rise during the 16th century as the government realized there were far too many people afflicted with mental illness to be left in private homes. Hospitals and

monasteries were converted into asylums. Though the intent was benign in the beginning, as they began to overflow patients came to be treated more like animals than people. In 1547, the Bethlem Hospital opened in London with the sole purpose of confining those with mental disorders. Patients were chained up, placed on public display, and often heard crying out in pain. The asylum became a tourist attraction, with sightseers paying a penny to view the more violent patients, and soon was called “Bedlam” by local people; a term that today means “a state of uproar and confusion” (<https://www.merriam-webster.com/dictionary/bedlam>).

## **Reform Movement – 18th to 19th Centuries**

The rise of the **moral treatment movement** occurred in Europe in the late 18th century and then in the United States in the early 19th century. Its earliest proponent was Phillipe Pinel (1745-1826) who was assigned as the superintendent of la Bicetre, a hospital for mentally ill men in Paris. He emphasized the importance of affording the mentally ill respect, moral guidance, and humane treatment, all while considering their individual, social, and occupational needs. Arguing that the mentally ill were sick people, Pinel ordered that chains be removed, outside exercise be allowed, sunny and well-ventilated rooms replace dungeons, and patients be extended kindness and support. This approach led to considerable improvement for many of the patients, so much so, that several were released.

Following Pinel’s lead in England, William Tuke (1732-1822), a Quaker tea merchant, established a pleasant rural estate called the York Retreat. The Quakers believed that all people should be accepted for who they were and treated kindly. At the retreat, patients could work, rest, talk out their problems, and pray (Raad & Makari, 2010). The work of Tuke and others led to the passage of the County Asylums Act of 1845 which required that every county in England and Wales provide asylum to the mentally ill. This was even extended to English colonies such as Canada, India, Australia, and the West Indies as word of the maltreatment of patients at a facility in Kingston, Jamaica spread, leading to an audit of colonial facilities and their policies.

Reform in the United States started with the figure largely considered to be the father of American psychiatry, Benjamin Rush (1745-1813). Rush advocated for the humane treatment of the mentally ill, showing them respect, and even giving them small gifts from time to time.

Despite this, his practice included treatments such as bloodletting and purgatives, the invention of the “tranquilizing chair,” and a reliance on astrology, showing that even he could not escape from the beliefs of the time.

Due to the rise of the moral treatment movement in both Europe and the United States, asylums became habitable places where those afflicted with mental illness could recover. However, it is often said that the moral treatment movement was a victim of its own success. The number of mental hospitals greatly increased leading to staffing shortages and a lack of funds to support them. Though treating patients humanely was a noble endeavour, it did not work for some and other treatments were needed, though they had not been developed yet. It

was also recognized that the approach worked best when the facility had 200 or fewer patients. However, waves of immigrants arriving in the U.S. after the Civil War were overwhelming the facilities, with patient counts soaring to 1,000 or more. Prejudice against the new arrivals led to discriminatory practices in which immigrants were not afforded moral treatments provided to native citizens, even when the resources were available to treat them.

Another leader in the moral treatment movement was Dorothea Dix (1802-1887), a New Englander who observed the deplorable conditions suffered by the mentally ill while teaching Sunday school to female prisoners. She instigated the **mental hygiene movement**, which focused on the physical well-being of patients. Over the span of 40 years, from 1841 to 1881, she motivated people and state legislators to do something about this injustice and raised millions of dollars to build over 30 more appropriate mental hospitals and improve others. Her efforts even extended beyond the U.S. to Canada and Scotland.

Finally, in 1908 Clifford Beers (1876-1943) published his book, *A Mind that Found Itself*, in which he described his personal struggle with bipolar disorder and the “cruel and inhumane treatment people with mental illnesses received. He witnessed and experienced horrific abuse at the hands of his caretakers. At one point during his institutionalization, he was placed in a straightjacket for 21 consecutive nights.” (<http://www.mentalhealthamerica.net/our-history>). His story aroused sympathy in the public and led him to found the National Committee for Mental Hygiene, known today as Mental Health America, which provides education about mental illness and the need to treat these people with dignity. Today, MHA has over 200 affiliates in 41 states and employs 6,500 affiliate staff and over 10,000 volunteers.

## 21st century

DSM-IV and previous versions of the Diagnostic and Statistical Manual of Mental Disorders presented extremely high comorbidity, diagnostic heterogeneity of the categories, unclear boundaries that have been interpreted as intrinsic anomalies of the criteria, neo-positivistic approach leading the system to a state of scientific crisis. Accordingly, a radical rethinking of the concept of mental disorder and the need of a radical scientific revolution in psychiatric taxonomy was proposed.

### Check Your Progress III

Note: Use the space provided for your answer.

1. What are the classification of mental illness according the Heraclitus?

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2. Who is the proponent of moral treatment movement for the mentally ill persons?

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### **3.5 SUMMARY**

Social psychiatry is a branch of psychiatry that focuses on the "interpersonal" and cultural context of psychiatric disorder and psychiatric wellbeing. It involves a sometimes disparate set of theories and approaches, with work stretching from epidemiological survey research on the one hand, to an indistinct boundary with individual or group psychotherapy on the other. History is a screen through which the past lightens the present and the present brightens the future. Psychiatry by virtue of its ability to deal with human thoughts and emotions and provide a pathway for healthy minds provides an important platform towards being a mentally sound human being and largely the society. This review takes a sneak peek into the foundations of modern psychiatry in India. The description is largely based on the time frame, which provides a better understanding of the factual information in each period starting from the Vedic era and culminating in the post-independence period. General beliefs on mental illness include "individuals with mental illness are dangerous, their behavior in interpersonal relationships cannot be controlled and can be inappropriate, and their illness cannot be treated"

### **KEY WORDS**

- ❖ Specialization
- ❖ Attitudes
- ❖ Belief
- ❖ "neurotic"
- ❖ Asylum
- ❖ Mental illness

### **SELF-ASSESSMENT QUESTIONS AND EXERCISE**

1. Elucidate the historical development of psychiatric social work in India
2. Bring out some milestone development in the psychiatric social work in the west
3. What are the salient features of Reform Movement – 18th to 19th Centuries?
4. Narrate the conditions and treatment process during Vedic period in India

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## **UNIT IV**

Concepts of normality, abnormality and mental health; classification of mental illness: diagnostic statistical Manual (DSM) iii-R; international classification of diseases (ICD)

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### **Structure**

- 4.1 Aims and Objectives
  - 4.2 Introduction
  - 4.3. Concept of Normality and Abnormality
  - 4.4. Mental Health
  - 4.5 Classifying Mental Illness
  - 4.6. Diagnostic Statistical Manual (DSM) III-R;
  - 4.7. International Classification of Diseases (ICD)
  - 4.8. Summary
  - 4.9 Further Reading and Referencess
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### **4.1 AIMS AND OBJECTIVES**

- ❖ To understand the characteristics of Normality and abnormality
- ❖ To know the concept and nature of mental health
- ❖ To study the classification of Mental illness
- ❖ To study DSM and ICD

### **4.2 INTRODUCTION**

A psychological disorder is a condition characterized by abnormal thoughts, feelings, and behaviors. However, defining what is “normal” and “abnormal” is a subject of much debate. Definitions of normality vary widely by person, time, place, culture, and situation. “Normal” is, after all, a subjective perception, and also an amorphous one—it is often easier to describe what is not normal than what is normal.

Abnormality is the significant deviation from commonly accepted patterns of behavior, emotion or thought, while normality is the absence of illness and the presence of state of wellbeing otherwise called normalcy. Something becomes abnormal when it interferes with the things a person wants to accomplish.

The DSM is a central element of the debate around defining normality, and it continues to change and evolve. Currently, in the DSM-5 (the fifth edition), abnormal behavior is

generally defined as behavior that violates a norm in society, is maladaptive, is rare given the context of the culture and environment, and is causing the person distress in their daily life. Specifically, the goal of the DSM-5 is to identify abnormal behavior that is indicative of some kind of psychological disorder.

### **4.3. CONCEPT OF NORMALITY AND ABNORMALITY**

Normality is usually considered to be the common occurrence, whilst abnormality is usually defined as undesirable behaviour and psychological disorders. It is important to distinguish between them because of the purpose of diagnosing patients and dictating the treatment of disorder. A diagnostic manual (usually, DSM-V) is used in these instances, however there does not seem to be a clear definition between normality and abnormality as psychological disorder may vary between individuals, social or cultural groups. Sometimes abnormality is judged through subjective experiences of the patients' and their not feeling 'normal', however this may be a problem as some people with mental disorders may not know they have a problem, hence there are currently three criteria to judge abnormality, usually through statistical infrequency, violating social norms and being harmful to oneself or others.

#### **Normality:**

The common pattern of behaviour found among the general majority is said to be the behaviour of the normal. Normal people exhibit satisfactory work capacity and earn adequate income. They conform and adjust to their social surrounding.

They are capable of establishing, satisfying and acceptable relationship with other people and their emotional reactions are basically appropriate to different situations. Such people manage to control their emotions. Their emotional experiences do not affect their personality adjustment though they experience occasional frustrations and conflict. These people who adjust well with themselves, their surroundings and their associates constitute the normal group.

#### **Characteristics of Normal behaviour:**

- ❖ A perception of reality.
- ❖ A positive attitude towards oneself, acceptance of weakness and pride in strengths.
- ❖ Capacity for withstanding anxiety and stress.
- ❖ Adequate in work, play and leisure.
- ❖ Willingness to use problem solving approaches in life process.
- ❖ Capacity to adapt oneself to current situation.



**Abnormality:**

The concept of abnormality is defined as the simple exaggeration or perverted development of the normal psychological behaviour. In other words, it deals with the usual behaviour of man. The unusual or maladapted behaviour of many persons which do not fit into our common forms of behaviour is known as abnormal behaviour.

Abnormality refers to maladjustment to one’s society and culture which surrounds him. It is the deviation from the normal in an unfavorable and pathological way. According to Brown (1940) abnormal psychological phenomena are simple exaggerations (over development or under development) or disguised (i.e., perverted developments) of the normal psychological phenomena.

**Characteristics of abnormality**

- ❖ Change in person’s thinking process, memory, perception adjustment.
- ❖ Work efficacy will be reduced
- ❖ Forgetfulness
- ❖ Unhappiness
- ❖ Unable to cope
- ❖ Worried, anxious disturbance in daily routine activities.
- ❖ No respect will be given to others or self.
- ❖ Lack of gratification.
- ❖ Lack of self confidence

**Check Your Progress I**

Note: Use the space provided for your answer.

1. What are the criteria of normality?

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2. What is the criteria of abnormality?

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#### 4.4. MENTAL HEALTH

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Over the course of your life, if you experience mental health problems, thinking, mood, and behaviour could be affected. Many factors contribute to mental health problems, including:

- Biological factors, such as genes or brain chemistry
- Life experiences, such as trauma or abuse
- Family history of mental health problems

Mental health problems are common but help is available. People with mental health problems can get better and many recover completely.

According to the World Health Organization, however, mental health is “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”

To make things a bit clearer, some experts have tried coming up with different terms to explain the difference between ‘mental health’ and ‘mental health conditions’. Phrases such as ‘good mental health’, ‘positive mental health’, ‘mental wellbeing’, ‘subjective wellbeing’ and even ‘happiness’ have been proposed by various people to emphasise that mental health is about wellness rather than illness. While some say this has been helpful, others argue that using more words to describe the same thing just adds to the confusion.

As a result, others have tried to explain the difference by talking about a continuum where mental health is at one end of the spectrum – represented by feeling good and functioning well – while mental health conditions (or mental illness) are at the other – represented by symptoms that affect people’s thoughts, feelings or behaviour.

The concept that mental health is not merely the absence of mental illness was unanimously endorsed, while the equivalence between mental health and well-being/functioning was not, and a definition leaving room for a variety of emotional states and for “imperfect functioning” was drafted.

The proposed definition is reported herewith:

*Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship*

*between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium.*

The addition of a note explaining what is meant in the definition by the expression “universal values” is deemed necessary, in the light of the misleading use of this expression in certain political and social circumstances. The values we are referring to are: respect and care for oneself and other living beings; recognition of connectedness between people; respect for the environment; respect for one's own and others' freedom.

#### **4.5 CLASSIFYING MENTAL ILLNESS**

From the Latin term “insania” for insanity to the use of “mania” and “melancholia” in Greek to denote a chaotic frenzy and depression, there has been a rich vocabulary used to discuss mental illness since ancient times. But the first attempt to classify such afflictions was by the Greek physician Hippocrates in 400 BC, who believed that mental illness stemmed from imbalances of a person's black bile, yellow bile, phlegm, and blood. Different imbalances resulted in particular symptoms which could be split into the following categories: Mania, Melancholy, Phrenitis (brain inflammation), Insanity, Disobedience, Paranoia, Panic, Epilepsy, and Hysteria.

Inspired by botanical taxonomy (the classification of plants), a French physician called François Boissier de Sauvages de Lacroix published a system of classifying illness in 1763. This classification included mental illnesses, subdivided into four categories: 1) Hallucinations, 2) Morositates, 3) Deliria, and 4) Folies Anomales. Within these categories were some familiar symptoms including induced vomiting, mania, amnesia, hypersexuality, panic, and insomnia. Other symptoms, like “the uncontrollable impulse to dance” and “non-aggressive delirium with accompanying sadness caused by the devil” are a world away from the Western psychiatric manuals we know today.

The 19th century saw more attempts to classify mental illness. In Germany, Karl Kahlbaum published his ‘Classification of Psychiatric Diseases and Mental Disturbances’ (1863), positing a system which classified mental illnesses by their symptoms. Rejecting the tradition of labelling a symptom as a particular illness, he conceptualised psychiatric diagnoses as clusters of symptoms: mania as a symptom of a disorder instead of a disorder in itself. Kahlbaum employed many terms that we still use today including Dysthymia, Cyclothymia, Catatonia, Paranoia, and Hebephrenia. Inheriting Kahlbaum's ideas, Emil Kraepelin, in the late 19th and early 20th century, proposed a system in which a disorder was defined not only by the symptoms that constitute it, but also by the patterns and course in which it presents. Famously, he differentiated between Psychotic Disorders and Affective Disorders, providing the foundations for what we now refer to as Schizophrenia and Bipolar Disorder.

## **4.6. DIAGNOSTIC STATISTICAL MANUAL (DSM) III-R;**

The DSM-IV was originally published in 1994 and listed more than 250 mental disorders. It was produced by the American Psychiatric Association and it characterizes mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual,...is associated with present distress...or disability...or with a significant increased risk of suffering" but that "...no definition adequately specifies precise boundaries for the concept of 'mental disorder'...different situations call for different definitions" (APA, 1994 and 2000). The DSM also states that "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorders."

**The DSM-IV-TR** (Text Revision, 2000) consisted of five axes (domains) on which disorder could be assessed. The five axes were:

**Axis I:** Clinical Disorders (all mental disorders except Personality Disorders and Mental Retardation)

**Axis II:** Personality Disorders and Mental Retardation

**Axis III:** General Medical Conditions (must be connected to a Mental Disorder)

**Axis IV:** Psychosocial and Environmental Problems (for example limited social support network)

**Axis V:** Global Assessment of Functioning (Psychological, social and job-related functions are evaluated on a continuum between mental health and extreme mental disorder)

The axis classification system was removed in the DSM-5 and is now mostly of historical significance. The main categories of disorder in the DSM are:

provide a five-factor translation of the personality disorders provided within and proposed for the American Psychiatric Association's DSM [Diagnostic and Statistical Manual] / indicate how each of the DSM-III-R (as well as fourth edition DSM [DSM-IV]) personality disorders can be translated as maladaptive extreme variants of the five basic factors of personality / after describing each of the 11 DSM-III-R personality disorder categories, we then consider three new diagnostic categories under review: negativistic (NEG), self-defeating (SDF), and depressive (DPS) personality disorders / end the chapter with a discussion of the sadistic disorder, which is a personality disorder category that, like the passive-aggressive disorder (PAG), is likely to be dropped from the DSM-III-R's set of 11 in the DSM-IV

## **4.7. INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)**

The International Classification of Diseases (ICD) is an international standard diagnostic classification for a wide variety of health conditions. The ICD-10 states that mental disorder

is "not an exact term", although is generally used "...to imply the existence of a clinically recognisable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions." Chapter V focuses on "mental and behavioural disorders" and consists of 10 main groups:

- F0: Organic, including symptomatic, mental disorders
- F1: Mental and behavioural disorders due to use of psychoactive substances
- F2: Schizophrenia, schizotypal and delusional disorders
- F3: Mood [affective] disorders
- F4: Neurotic, stress-related and somatoform disorders
- F5: Behavioural syndromes associated with physiological disturbances and physical factors
- F6: Disorders of personality and behaviour in adult persons
- F7: Mental retardation
- F8: Disorders of psychological development
- F9: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- In addition, a group of "unspecified mental disorders".

Within each group there are more specific subcategories. The WHO is revising their classifications in this section as part of the development of the ICD-11 (revision due by 2018) and an "International Advisory Group" has been established to guide this.

## Check Your Progress II

Note: Use the space provided for your answer.

1. What are the factors contributing to mental health?

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2. Define mental health?

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3. What do you mean by classification of mental illness?

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4. Expand: DSM IV & ICD 10

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5. Who said that that mental illness stemmed from imbalances of a person's black bile, yellow bile, phlegm, and blood?

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#### **4.8. SUMMARY**

People who are mentally ill can have considerable difficulty with their thinking, their mood, or their behaviour. Mental illness is not the same as experiencing normal stress and sadness. One main difference is that mental illness causes significant distress and impairs functioning, making it difficult to cope with the demands of everyday life. In other words, when people are mentally ill, they can't manage activities of daily living, work effectively, or maintain relationships. Their overwhelming distress is not just a reaction to daily events, and they are not behaving that way on purpose. Just like a physical illness, when a mental illness is not recognized and treated, it can worsen and will last for an unnecessarily long time. The DSM also states that "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorders."

#### **KEY WORDS**

- ❖ Normality
- ❖ Abnormality
- ❖ Mental health
- ❖ DSM IV
- ❖ ICD 10
- ❖ Personality disorder

## **SELF-ASSESSMENT QUESTIONS AND EXERCISE**

1. What is normality?
2. Bring out the characteristics of normality
3. What are the criteria for abnormality?
4. Define mental health (WHO)
5. What are the major classification of illness according to DSM IV?
6. Give detail report on ICD 10

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## **UNIT V**

Psychiatric assessment: interviewing, case history taking; sources of intake, mental status examination; formulation of psychosocial diagnosis

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### **Structure**

5.1 Aims and Objectives

5.2. Introduction

5.3. Psychiatric Assessment

5.3.1 Interviewing

5.3.2. Case History Taking

5.3.3. Mental State Examination

5.4 Formulation of Hypothesis

5.5 Summary

5.6 Further reading and References

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### **5.1 AIMS AND OBJECTIVES**

- ❖ To know the psychiatric assessment process
- ❖ To get knowledge on diagnosis
- ❖ To study the various elements of diagnosis

### **5.2. INTRODUCTION**

A mental health assessment is designed to: diagnose mental health conditions such as anxiety, depression, schizophrenia, postnatal depression, eating disorders and psychotic illnesses. Differentiate between mental and physical health problems. Assess a person referred because of problems at school, work or home. A psychiatric assessment is most commonly carried out for clinical and therapeutic purposes, to establish a diagnosis and formulation of the individual's problems, and to plan their care and treatment. This may be done in a hospital, in an out-patient setting, or as a home-based assessment. Mental status examination evaluates different areas of cognitive function.

### **5.3. PSYCHIATRIC ASSESSMENT:**

A psychiatric assessment, or psychological screening, is the process of gathering information about a person within a psychiatric service, with the purpose of making a diagnosis. The



assessment is usually the first stage of a treatment process, but psychiatric assessments may also be used for various legal purposes. The assessment includes social and biographical information, direct observations, and data from specific psychological tests. It is typically carried out by a psychiatrist, but it can be a multi-disciplinary process involving nurses, psychologists, occupational therapist, social workers, and licensed professional counselors

### **5.3.1 INTERVIEWING**

The psychiatric interview is undertaken primarily in order to establish a diagnosis. It includes history-taking and the clinical examination of the mental state. However, the psychiatric interview is much more than a diagnostic process. It also helps to establish rapport between patient and doctor and to educate and motivate the patient.

Interviewing patients also serves an important therapeutic purpose. This is the goal for patients during psychotherapeutic consultations, but it also applies to all other patients for whom the opportunity to discuss problems with a sympathetic listener is often helpful.

The diagnostic process in psychiatry differs from that in other medical disciplines in that:

- It relies almost exclusively on history-taking and clinical examination
- The account obtained from the patient must be corroborated by information from the patient's partner, children or other relatives, or from the family doctor, social worker or teacher, as appropriate.

Interviewing such third parties should only be undertaken with the patient's fully informed consent. However, such corroborative interviews should be the rule rather than the exception because psychiatric patients may, consciously or unwittingly, conceal important information. Verbal accounts from patients and third parties should be supplemented by written records from family doctors, hospitals or schools when appropriate. This is especially the case for events that occurred many years ago or for which the patient has only a second-hand account from parents or others.

Psychiatric interviews should be conducted in macroscopic settings that facilitate the patient's privacy and comfort and ensure the doctor's safety. These goals are relatively easy to achieve in psychiatric outpatient clinics but present challenges when patients are interviewed in their home (privacy and safety) or in general medical hospital departments (comfort, privacy and safety), and may be impossible to achieve in some settings, for example police stations or prisons.

### **5.3.2. CASE HISTORY TAKING**

Taking a psychiatric history has things in common with any clinical history you take. The major difference is in the social and developmental history, which we cover in more depth.

The areas you need to cover include:

- presenting complaint/history of presenting complaint
- Past psychiatric history
- Past medical history
- Medication
- Family history
- Family psychiatric history
- Personal history –
  - ❖ birth & early life
  - ❖ school & qualifications
  - ❖ higher/further education employment
  - ❖ psychosexual history
  - ❖ forensic history
  - ❖ substance use

#### **Premorbid personality**

It's not always appropriate to ask all of the questions all of the time. Sometimes it can be better to leave gaps to fill in later, especially if your patient is particularly suspicious and paranoid, or acutely distressed. Some of the history can be gathered from old notes, and from speaking to an informant.

Start off with open questions and focus in on areas with more specific, closed questions as necessary. This gives the patient a chance to talk about their experiences and concerns, whilst allowing you to get the information you need. Over time you will develop your own style of interviewing. You need to feel comfortable with the style you adopt, so that your questions don't seem awkward or forced.

#### **Presenting Complaint & History of Presenting Complaint**

In the extracts shown, Jan encourages Mrs. Down to describe the problem in her own words. At first, she is not very specific, but with gentle prompting and some echoing of her own words back to her she soon elaborates the problem and talks more freely. Jan then picks up on the complaint of tiredness and asks about specific problems with sleep, aimed at eliciting symptoms of depression. He then goes on to ask about other associated symptoms.

Appendix 1 sets out the symptoms of depression as classified in DSM-IV and ICD-10

### **Past Psychiatric History**

Remember that the patient's understanding of their illness may be different from the formal diagnosis. Corroborative evidence such as previous notes is often helpful. Don't get bogged down with rambling accounts of past admissions if these are frequent; rather, get the basic facts such as rough dates and length of admissions, treatment given and follow-up arrangements.

### **Medication**

The patient's beliefs about their medication can give useful insight into what they believe is wrong with them. Remember to ask about side effects and compliance and bear in mind possible drug interactions.

### **Family History**

The family history should give you a good indication of a person's family relationships. Find out which members of the family they feel close to, and why. Equally, reasons for discord within the family should be explored. Bear in mind social, psychological and genetic risk factors for mental illness, and remember to ask about family psychiatric history

### **Personal History**

Personal history is important, as it helps you to understand what has led to your patient becoming the person they are. It's easiest to work through this in chronological order, remembering that some of the information may have been gathered earlier on.

Things you need to ask about briefly include:

- Family of origin;
- Early experiences;
- Schooling;
- Friendships;
- Qualifications;
- Further or higher education.

You can then move on to ask about the following areas:

- Employment history;
- Interests and current friendships
- Significant relationships, marriage and children

Psychosexual history

- Forensic History
- Use of alcohol and illicit drugs

### **Premorbid Personality**

Unless you know what the person is usually like, it's difficult to fully understand how their illness has affected them. In asking about premorbid personality, the information from a third party or informant can be particularly helpful. Think about coping styles, interests and activities and how the person usually relates to other people.

### **Risk Assessment Questions:**

These are answered in the interview on the DVD:

1. What kinds of risk are we concerned with?
2. What are the indicators for a risk of self-harm and suicide?
3. How can you manage an immediate risk of self-harm and suicide?
4. What is the longer term management?
5. How is repeated self-harm managed?
6. What are the risk factors for violence?
7. How can you manage the risk of violence?
8. What are the indicators of risk relevant to the Mental State Examination?
9. When should risk be assessed?

### **5.3.3. MENTAL STATE EXAMINATION**

The mental state examination is an important clinical skill. You will become more accomplished at performing it the more you practice. Some areas of the mental state examination will be covered in your history taking and will not necessarily need to be revisited. What is important is that you develop a framework in your mind so that you are aware of gaps still to be filled in. It can help to start with a list written down, with space to write in the relevant sections. This will help you to be methodical, but be careful not to be too rigid, and remain empathic.

Areas we look at in the mental state examination

- **Appearance and Behaviour**
- **Speech**
- **Mood**

- **Thought**
- **Perception**
- **Delusions**
- **Cognition**
- **Insight**

### **Appearance & Behaviour**

Assessment of appearance and behaviour takes place from the first meeting and throughout the interview. In general you need to consider:

- Eye contact and rapport
- Clothing
- Hygiene
- Facial expressions
- Motor behaviours
- Signs of autonomic arousal
- Affect\*

\* When we talk about a person's affect we're referring to how people convey their mood by their behaviour. A "normal" affect, within reason, would be described as reactive and appropriate - that is, laughs at a joke, or cries when sad.

### **Role play (group work):**

Try these short role play exercises. Take it in turns to play the role of patient, doctor and observers, and discuss as a group.

- Patient attending their GP presents with back pain, but their appearance and behaviour prompt the doctor to ask questions about depressive symptoms.
- GP has been asked to see a patient by their spouse. The patient isolated and grandiose and doesn't think anything is wrong – puts any problem down to spouse "trying to put a spanner in the works".
- Patient at GP surgery wanting sick note - employer is fed up with frequent late starts and brief (self-certified) absences and has asked for an official sick note. The patient is clearly drunk.

To assess Appearance & Behaviour in various mental states, go to the following buttons. Watch the vignettes and note down your observations as you go.

## **Speech**

Speech can be described in terms of its form and volume and content. Form of speech includes the rate, rhythm and fluency of speech, all of which may be affected by mental illness. The content of speech – what the person actually says - reveals their thoughts. Usually we do have some conscious control over which thoughts we vocalize.

## **Mood**

Mood is often described in terms of elevated or depressed mood, but it is also important to enquire about other mood states such as anxiety and panic. Ask the patient to describe their mood subjectively; you also need to assess their mood and affect objectively. Associated symptoms can be enquired about here if they have not been covered while taking the history

## **Thought**

Thought is described in terms of Form and Content.

The café sequence illustrates the connection between thought content and speech. Note that we often edit our thoughts before expressing them in speech, although facial expressions and body language might betray what we are really thinking. Thought content may be revealed by what the person says, but you will also need to ask questions about their thoughts. Obsessional thoughts, anxious thoughts, and overvalued ideas all need to be considered as they may not be volunteered by the patient. Do their thoughts seem clear to them or muddled, do they have ruminations on particular themes, and do their thoughts trouble them.

The animated sequences Trains of Thought illustrate various abnormalities of the form of thought. These can be described by a number of terms, and illustrate the breakdown of normal thought processes in psychotic states:

**Thought block** - the flow of thought stops abruptly. This may be interpreted by the patient as

**Thought withdrawal** - the experience of thoughts being removed by third party

**Thought insertion** - thoughts are experienced as alien, not arising from oneself but being placed there by a third party

**Thought broadcast** - represents a loss of the internal quality of thought, as the patient experiences their thoughts as being accessible to everybody; this is similar but not identical to the patient "hears" their own thoughts as they arise

**Derailment** occurs when the thought process changes track abruptly and is similar to knight's move thinking and is a more extreme example of loosening of associations

**Flight of ideas** is particularly seen in mania. The association between each thought is clear if sometimes unusual.

## **Perceptions**

At the beginning of the perception section, a second voice is heard. Think about your reaction to this voice. Was it disconcerting at all? Where did you think the voice was coming from? Did you find it difficult to follow what the lecturer on-screen was saying?

This voice was a representation of how, to the person experiencing hallucination, the perception is real.

Hallucinations may be experienced in any sensory modality, but are most commonly auditory. A number of characteristics of auditory hallucinations are particularly important. These are: voices giving a running commentary on the person's actions; command hallucinations - that is, voices giving orders; and voices arguing in the third person.

## **Delusions**

Delusions have been described as “un-understandable”, and yet we need to try to understand what they mean to our patient.

Definition:

“A delusion is a false, unshakeable idea or belief which is out of keeping with the patient's educational, cultural and social background; it is held with extraordinary conviction and subjective certainty.”

A. Sims: Symptoms in the Mind: an introduction to descriptive psychopathology. WB Saunders (2nd ed. 1995)

## **Cognition**

You will get a general impression of your patient's cognitive state as the interview progresses, from their vocabulary, level of education and how easily they recall important personal information and dates. Unless you detect a problem, for most people you can briefly screen the following areas:

- Orientation for time, person and place
- Registration - ability to repeat new information such as a name and address -
- Recall - repeating the new information five minutes later
- Concentration and attention - spelling WORLD backwards or serial sevens
- General knowledge - name of prime minister, recent news intersect.

## **Insight**

One of the questions you need to ask yourself about each patient you see is, why has this particular person presented with this particular problem at this particular time? The patient's ability to answer that question for you during the course of the interview is one measure of

their insight. This is true for all patients to some extent, not just those with psychiatric problems.

Difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them. It is a bit like a personal story or narrative that a psychologist or Formulation is the process of making sense of a person's other professional draws up with an individual and, in some cases, their family and caregiver

### **Check your progress I**

Note: Use the space provided for your answer.

1. Why personal and past history of the patient is essential?

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2. How the wrong belief of the person is called?

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3. What do you mean by thought block?

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4. What is insight in psychiatric?

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### **5.4 FORMULATION OF HYPOTHESIS**

In many settings, clinical psychologists use formulation to provide a holistic context to medical diagnoses such as cancer, learning disability, stroke, dementia, and so on. The issue of diagnosis is more controversial in psychiatry, where it raises the question of whether formulation is used as an addition to, or an alternative to, psychiatric diagnosis.



Everyone who comes into contact with mental health services will have had a rocky and often extremely traumatic road leading up to that point. They will almost certainly be given a diagnosis – anything from ‘depression’ to ‘ADHD’ or ‘schizophrenia.’ But that tells us very little about the individual, and nothing at all about the context and impact of their difficulties. A formulation, on the other hand, can be best understood as co-constructing the personal meaning of the client’s life story. It is ‘a process of ongoing collaborative sense-making’ (Harper and Moss 2003) which summarizes the client’s core problems in the context of psychological theory and evidence and thus indicates the best path to recovery. Unlike diagnosis, it is not about making an expert judgment, but about working closely with the client to develop a shared understanding which is likely to evolve over the course of the therapeutic work. And, again unlike diagnosis, it is not based on deficits, but draws attention to talents and strengths in surviving what are nearly always very challenging life situations.

Best-practice psychological formulation (DCP, 2011) is, therefore, based on fundamentally different principles from psychiatric diagnosis. It is the difference between the message “you have a medical illness with primarily biological causes” and “your problems are an understandable emotional response to your life circumstances.” Clearly, these explanations cannot both be true. They are not only different; they are contradictory. People who are offered both models simultaneously, as happens when we try to dilute biomedical approaches with psychosocial ones or add formulations to diagnoses, become deeply entangled in this confusion. The overall message to service users comes across as follows: “You have an illness which is not your fault, but you retain responsibility for it and must make an effort to get better, but you must do it our way because we are the experts in your illness.” Muddled thinking leads to muddled practice, and both staff and service users can become trapped, frustrated, and demoralized in the resulting confusion.

## **Check your progress II**

Note: Use the space provided for your answer.

1. What is formulation?

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2. What do you mean by biological causes?

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## **5.5. SUMMARY**

Having a mental health assessment gives your doctor a picture of the way you think, feel, reason and remember. The mental health test assesses your emotional wellbeing via a series of questions and also includes a physical examination.

As a priority your doctor will determine if you are at risk of hurting yourself or others. For children, the mental health assessment will be tailored to the child's age and stage of development.

A mental health assessment is designed to:

- diagnose mental health conditions such as anxiety, depression, schizophrenia, postnatal depression, eating disorders and psychotic illnesses
- differentiate between mental and physical health problems
- Assess a person referred because of problems at school, work or home.

## **KEY WORDS**

- ❖ Psychiatric interview
- ❖ Premorbid
- ❖ MSE
- ❖ Delusion
- ❖ Mood
- ❖ Insight
- ❖ Perception
- ❖ Formulation

## **SELF-ASSESSMENT QUESTIONS AND EXERCISE**

1. What is psychiatric assessment?
2. Explain the need of interview in the psychiatric assessment
3. What are the components of case history taking
4. What are the components of MSE?
5. What is premorbid personality?
6. What is delusion?
7. What is the need of looking the appearance in the psychiatric assessment?
8. Explain the thought process in the psychiatric assessment
9. Explain the formulation of hypothesis

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## **UNIT VI**

Psychiatric Illness: neuroses, psychoses, organic and functional, culture bound syndromes, personality disorders, sexual deviations, alcoholism and drug dependence

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### **Structure**

- 6.1. Aims and objectives
  - 6.2. Introduction
  - 6.3. Psychiatric illness
    - 6.3.1. Neuroses
    - 6.3.2. Psychoses
    - 6.3.3. Organic
    - 6.3.4. Functional
  - 6.4. Culture bound syndromes
  - 6.5. Personality disorders
    - 6.5.1 Cluster a
    - 6.5.2. Cluster b
    - 6.5.3. Cluster c
  - 6.6. Sexual deviations
  - 6.7. Alcoholism and drug dependence
  - 6.8. Summary
  - 6.9 Further Reading and References
- 

### **6.1. AIMS AND OBJECTIVES**

- ❖ To know the various psychiatric illness and its implications
- ❖ To understand the sexual deviation
- ❖ To know about the alcoholism and drug dependence

### **6.2. INTRODUCTION**

Mental health, an essential component of health, is a state of well-being, an aptitude of the mind to work normally and respond appropriately to environmental stimuli. One speaks of mental disorders when this state of well-being is disturbed by specific conditions (depression,

schizophrenia, bipolar disorders). The individual is then incapable of adapting to difficult or painful situations and maintain his psychic equilibrium.

### **6.3. PSYCHIATRIC ILLNESS**

Mental illness, also called mental health disorders, refers to a wide range of mental health conditions — disorders that affect your mood, thinking and behavior. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviors.

Many people have mental health concerns from time to time. But a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function.

A mental illness can make you miserable and can cause problems in your daily life, such as at school or work or in relationships. In most cases, symptoms can be managed with a combination of medications and talk therapy (psychotherapy).

#### **6.3.1. NEUROSES**

Neurosis (plural: neuroses) is a class of functional mental disorders involving chronic distress but neither delusions nor hallucinations. Neuroses are characterized by anxiety, depression, or other feelings of unhappiness or distress that are out of proportion to the circumstances of a person's life. They may impair a person's functioning in virtually any area of his life, relationships, or external affairs, but they are not severe enough to incapacitate the person. Affected patients generally do not suffer from the loss of the sense of reality seen in persons with psychoses.

Psychiatrists first used the term neurosis in the mid-19th century to categorize symptoms thought to be neurological in origin; the prefix "psycho-" was added some decades later when it became clear that mental and emotional factors were important in the etiology of these disorders. The terms are now used interchangeably, although the shorter word is more common. Both terms, however, lack the precision required for psychological diagnosis and are no longer used for that purpose.

#### **Types**

Obsessive-compulsive disorders are characterized by the irresistible entry of unwanted ideas, thoughts, or feelings into consciousness or by the need to repeatedly perform ritualistic actions that the sufferer perceives as unnecessary or unwarranted. Obsessive ideas may include recurrent violent or obscene thoughts; compulsive behaviour includes rituals such as repetitive hand washing or door locking. The drug clomipramine has proved effective in treating many patients with obsessive-compulsive disorders.

Somatoform disorders, which include the so-called hysterical, or conversion, neuroses, manifest themselves in physical symptoms, such as blindness, paralysis, or deafness that are not caused by organic disease. Hysteria was among the earliest syndromes to be understood and treated by psychoanalysts, who believe that such symptoms result from fixations or arrested stages in an in

In anxiety disorders, anxiety is the principal feature, manifesting itself either in relatively short, acute anxiety attacks or in a chronic sense of nameless dread. Persons undergoing anxiety attacks may suffer from digestive upsets, excessive perspiration, headaches, heart palpitations, restlessness, insomnia, disturbances in appetite, and impaired concentration. Phobia, a type of anxiety disorder, is represented by inappropriate fears that are triggered by specific situations or objects. Some common objects of phobias are open or closed spaces, fire, high places, dirt, and bacteria.

Depression, when neither excessively severe nor prolonged, is regarded as a neurosis. A depressed person feels sad, hopeless, and pessimistic and may be listless, easily fatigued, slow in thought and action, and have a reduced appetite and difficulty in sleeping.

Post-traumatic stress disorder is a syndrome appearing in people who have endured some highly traumatic event, such as a natural disaster, torture, or incarceration in a concentration camp. The symptoms include nightmares, a diffuse anxiety, and guilt over having survived when others perished. Depersonalization disorder consists of the experiencing of the world or oneself as strange, altered, unreal, or mechanical in quality.

### **6.3.2. PSYCHOSIS**

The word psychosis is used to describe conditions that affect the mind, where there has been some loss of contact with reality. When someone becomes ill in this way it is called a psychotic episode. During a period of psychosis, a person's thoughts and perceptions are disturbed and the individual may have difficulty understanding what is real and what is not. Symptoms of psychosis include delusions (false beliefs) and hallucinations (seeing or hearing things that others do not see or hear). Other symptoms include incoherent or nonsense speech, and behavior that is inappropriate for the situation. A person in a psychotic episode may also experience depression, anxiety, sleep problems, social withdrawal, lack of motivation, and difficulty functioning overall.

#### **Symptoms of Psychosis**

Psychosis doesn't suddenly start. It usually follows this pattern:

**Warning signs before psychosis:** It starts with gradual changes in the way you think about and understand the world. You or your family members may notice:

- A drop in grades or job performance
- Trouble thinking clearly or concentrating
- Suspiciousness or unease around others

- Lack of self-care or hygiene
- Spending more time alone than usual
- Stronger emotions than situations call for
- No emotions at all

### **Signs of early psychosis:**

- Hear, see, or taste things others don't
- Hang on to unusual beliefs or thoughts no matter what others say
- Pull away from family and friends
- Stop taking care of yourself
- Not be able to think clearly or pay attention
- Symptoms of a psychotic episode: Usually you'll notice all of the above plus:

### **Hallucinations:**

**Auditory hallucinations:** Hearing voices when no one is around  
**Tactile hallucinations:** Strange sensations or feelings you can't explain

**Visual hallucinations:** You see people or things that aren't there, or you think the shape of things looks wrong

**Delusions:** Beliefs that aren't in line with your culture and that don't make sense to others, like:

- Outside forces are in control of your feelings and actions
- Small events or comments have huge meaning
- You have special powers, are on a special mission, or actually are a god

### **Psychotic disorders**

Psychotic disorders can be triggered by stress, drug or alcohol use, injury, or illness. They can also appear on their own. The following types of disorders may have psychotic symptoms:

#### **Bipolar disorder**

When someone has bipolar disorder, their moods swing from very high to very low. When their mood is high and positive, they may have symptoms of psychosis. They may feel extremely good and believe they have special powers.

When their mood is depressed, the individual may have psychotic symptoms that make them feel angry, sad, or frightened. These symptoms include thinking someone is trying to harm them.

#### **Delusional disorder**

A person experiencing delusional disorder strongly believes in things that aren't real.

## **Psychotic depression**

This is major depression with psychotic symptoms.

## **Schizophrenia**

Schizophrenia is a lifelong disease that is generally accompanied by psychotic symptoms.

## **Difference between Neuroses and Psychoses**

The distinction between psychotics and neurotics in general are symptomatic, psychopathological and therapeutic.

1. Psychoses involve a change in the whole personality of the person in whom it appears, while in psychoneuroses only a part of the personality is affected. With the development of psychoneuroses, there is often no marked outer change of personality of any kind. As Meyer puts it, a psychoneuroses is a part reaction, while a psychoses is a total one.

2. In a psychoses, contact with reality is totally lost or changed. The reality contact practically remains intact in a psychoneurotic, though its value may be quantitatively changed. In fact insight and reality have the same meaning for them as the rest of the community.

3. The changes in the reality values of the psychotic, psycho- pathologically is partly expressed through projection, for example, the strong belief that one is being constantly watched. Projection of this sort often based on a sense of guilt, subjective but unconscious, does not occur in the psychoneuroses.

4. Language, which is a means of communication, is the symbolizing function for social adaptation. In the psychoneuroses language as such is never disturbed, whereas in the psychoses language often undergoes gross distortion.

5. Some psychoses are primarily organic. Even in the functional psychoses organic factors enter into the etiology. The psychoneuroses on the other hand are predominantly socially conditioned. Horney has therefore remarked "Psychoneurotic is the individual who deviates in his behaviour from the norms accepted by his culture because of anxiety and who feels lonely and inferior because of this deviation."

6. In psychoanalytic theory the psychoses may be differentiated from the psychoneuroses in terms of the amount of ego and libido regression and in terms of the topographical location of the conflict. In psychoses therefore the libidinal regression goes as deep as the early anal period i.e., beyond the level of reality testing.

Psychoses may therefore be considered dynamically as a disorder in which the ego loses much of its contact with reality and is more concerned with the forces of the id. The psychoneurotic on the contrary, suffers libidinal regression only to the phallic or late anal period as his conflict may be considered as a struggle between the forces of the id and the ego, in which the ego maintains its contact with expressed reality. The regression is only to the level of reality testing and so the neurotic retains insight and does not deny reality.



7. As regards etiology Page says that in psychoneuroses the psychogenic factors and heredity are of considerable importance, whereas neurophysiological and chemical factors are insignificant. On the other hand, in psychoses, heredity, toxic and neurological factors are the determining agents. Psychogenic factors as such may or may not be important.

8. So far as general behaviour is concerned, in the neurotic the speech and thought processes are coherent and logical. There are little or no delusions, hallucinations and confusion in case of psychoneurotic. On the contrary, in case of the psychotics speech and thought processes are incoherent, disorganised, bizzare and irrational. There is constant confusion. Delusion and hallucination are marked symptoms.

9. Neurotics are capable of self-management, partial or completely self-supporting, are rarely suicidal. They do not need hospitalization on the other hand; psychotics are incapable of self-management. They often attempt to commit suicide and need hospitalization or equivalent home care.

10. The personality of the neurotic undergoes little or no change from normal self. A neurotic has good insight. In case of a psychotic, on the other hand, there is radical change in personality; insight is partially or completely lost.

### **6.3.3. ORGANIC PSYCHOSES**

Many medical conditions can affect brain function and cause symptoms of hallucinations and delusions. For example, dementia is the gradual and progressive loss of intellectual abilities, such as remembering, thinking, paying attention, and perceiving; it is often a chronic condition. Delirium, which commonly occurs in patients with dementia, is a clouded, confused state of consciousness and is usually only a temporary condition. Dementia is the principal syndrome in the most common and widespread organic psychosis, Alzheimer disease. An elderly person with this disease experiences chronic confusion and loss of memory and may experience paranoia or other personality changes. The memory loss becomes increasingly far-reaching, and the patient gradually becomes lethargic and inactive; death is the end result. The course of the disease may last from 2 to 20 years. Disturbances in the blood supply to the brain caused by cerebral arteriosclerosis (hardening of the arteries) produce symptoms similar to those of Alzheimer disease. Other medical conditions associated with psychoses include thyroid disease, vitamin deficiencies, liver disease, epilepsy, Parkinson disease, and encephalitis. Disorders of sleep or prolonged sensory deprivation can also cause hallucinations and delusions.

Many drugs can alter brain function and cause symptoms of psychoses. For example, certain drugs—such as narcotics to treat pain, levodopa for Parkinson disease, prednisone for inflammation, and digitalis for heart conditions—can give rise to hallucinations and delusions. Perhaps the greatest cause of these symptoms in otherwise healthy individuals is drugs of abuse, such as alcohol, cocaine, and hallucinogenic drugs (e.g., LSD [lysergic acid diethylamide], PCP [phencyclidine], and Ecstasy [3, 4-methylenedioxymethamphetamine]).

Chronic alcoholics often exhibit psychotic symptoms. Alcohol-induced brain damage can also result in memory defects and a major decline in intellectual abilities and social skills (see alcoholism).

#### **6.3.4. FUNCTIONAL PSYCHOSES**

Schizophrenia is the most common and the most potentially severe and disabling of the psychoses. Symptoms of schizophrenia typically first manifest themselves during the teen years or early adult life. The primary symptoms are the presence of hallucinations and delusions, disorganized speech and behaviour, a lack of emotional expression, and a marked lack of energy. In order for a definitive diagnosis of schizophrenia to be made, these symptoms must be present for at least six months and must impair the person's ability to function. The course of the disease is variable. Some schizophrenics suffer one acute episode and then permanently recover; others suffer from repeated episodes with periods of remission in between; and still others become chronically psychotic and must be permanently hospitalized.

Despite prolonged research, the cause or causes of schizophrenia remain largely unknown. It is clear that there is an inherited genetic predisposition to the disease. Thus, the children of schizophrenic parents stand a greatly increased chance of themselves becoming schizophrenic. While no causative link has been identified, many neurological findings have been noted in the examination of schizophrenic patients. These include subtle problems with coordination, changes in brain structure such as enlarged cerebral ventricles, and abnormal electrical signaling in the brain. In addition, the levels of several neurotransmitters (chemicals that facilitate the transmission of nerve impulses), particularly dopamine and glutamate, are altered in the brains of schizophrenic individuals.

The symptoms of schizophrenia can be treated, but not cured, with such antipsychotic drugs as chlorpromazine and other phenothiazine drugs and by haloperidol. These medications affect neurotransmission in the brain. For example, haloperidol has strong ant dopaminergic actions that facilitate the regulation of dopamine activity and thus reduce certain symptoms of schizophrenia. Psychotherapy may be useful in alleviating distress and helping the patient to cope with the effects of the illness.

Other functional psychoses include mood disorders, which are also known as affective disorders. Examples include bipolar disorder and major depressive disorder. Mood disorders are characterized by states of extreme and prolonged depression, extreme mania, or alternating cycles of both of these mood abnormalities. Depression is a sad, hopeless, pessimistic feeling that can cause listlessness; loss of pleasure in one's surroundings, loved ones, and activities; fatigue; slowness of thought and action; insomnia; and reduced appetite. Mania is a state of undue and prolonged excitement that is evinced by accelerated, loud, and voluble speech; heightened enthusiasm, confidence, and optimism; rapid and disconnected ideas and associations; rapid or continuous motor activity; impulsive, gregarious, and

overbearing behaviour; heightened irritability; and a reduced need for sleep. When depression and mania alternate cyclically or otherwise appear at different times in the same patient, the person is termed to be suffering from bipolar disorder. Bipolar patients also frequently suffer from delusions, hallucinations, or other overtly psychotic symptoms. Bipolar disorder often first manifests itself around age 30, and the disease is often chronic. Many bipolar patients can be treated by long-term maintenance on lithium carbonate, which reduces and prevents the attacks of mania and depression. However, the suicide rate associated with severe bipolar disorder is high, ranging from an estimated 5 to 15 percent of patients.

Depression alone can be psychotic if it is severe and disabling enough, and particularly if it is accompanied by delusions, hallucinations, or paranoia. Mania and many cases of depression are believed to be caused by deficiencies or excesses of certain neurotransmitters in the brain, particularly norepinephrine and serotonin. Therefore, antidepressant drugs that act to reestablish normal norepinephrine and serotonin levels are often effective for bipolar and major depressive disorders. Treatment often involves the administration of a tricyclic antidepressant (e.g., amitriptyline, amoxapine, or imipramine) or an agent from a class of antidepressants known as monoamine oxidase inhibitors (e.g., phenelzine, tranylcypromine, or selegiline). Shock (electroconvulsive) therapy is useful in some cases, and psychotherapy and behavioral therapy may also be effective.

Paranoia is a special syndrome that can be a feature of schizophrenia (paranoid schizophrenia) and bipolar disorder or that can exist by itself. A person suffering from paranoia thinks or believes that other people are plotting against or trying to harm, harass, or persecute him in some way. The paranoid exaggerates trivial incidents in everyday life into menacing or threatening situations and cannot rid himself of suspicions and apprehensions. Paranoid syndromes can sometimes be treated or alleviated by antipsychotic drugs.

The functional psychoses are difficult to treat; drug treatments are the most common and successful approach. Psychoanalysis and other psychotherapies, which are based on developing a patient's insight into his or her presumed underlying emotional conflicts, are difficult to apply to psychotic patients.

### **Check your progress I**

Note: Use the space provided for your answer

1. What are the neuroses?

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2. What is the major factor of psychoses?

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3. What are the types of hallucination?

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4. What is schizophrenia?

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5. What is functional Psychoses?

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## **6.4. CULTURE BOUND SYNDROME**

Culture plays a decisive role in coloring the psychopathology of various psychiatric disorders. However some psychiatric syndromes are limited to certain specific cultures. These disorders are called culture specific or culture bound syndrome. The last two decades have witnessed an increased interest in the cross cultural study of psychiatric disorders

Culture-specific syndrome or Culture-bound syndrome is a combination of psychiatric and somatic symptoms that are considered to be a recognizable disease only within a specific society or culture. There is no objective biochemical or structural alterations of body organs or functions, and the disease is not recognized in other cultures. The term culture-bound syndrome was included in the fourth version of the Diagnostic and Statistical Manual of Mental disorders (American Psychiatric Association, 1994) which also includes a list of the most common culture-bound conditions. According to DSM IV culture-bound syndrome denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category.

Majority of CBS share the following characteristics:

- Categorized as a disease in that culture
- Widespread familiarity in that culture
- Unknown in other cultures
- No objectively demonstrable biochemical or organ abnormality
- Treated by folk medicine/ traditional healers

In India, common culture bound syndromes are Dhat Syndrome, Possession Syndrome, Koro, Gilhari syndrome, Bhanmati, Compulsive spitting, culture-bound suicide (sati, santhra), ascetic syndrome, Jhinjhinia etc.

### **Possession Syndrome**

Diagnosable under Dissociative disorders. Patient is possessed usually by 'spirit/soul' of deceased relative or a local deity. Speaks in changed tone, even gender changes at times if the possessing soul is of opposite sex. Usually seen in rural areas or in migrants from rural areas. Majority of these patients are females who otherwise don't have any outlet to express their emotions. Treatment includes careful exploration of underlying stress which precipitated the possession attack. Also to decrease any secondary gains patient may be getting from this behaviour. •

Antidepressant Syndrome is seen in all parts of India

- Many religious shrines hold special annual festivals where hundreds of people get possessed simultaneously
- These people are looked upon as special by their families and villages which reinforce the secondary gains
- Included in ICD-10 under Dissociative disorders

Antidepressants and anxiolytics are helpful in certain cases Syndrome is seen in all parts of India Many religious shrines hold special annual festivals where hundreds of people get possessed simultaneously These people are looked upon as special by their families and villages which reinforce the secondary gains Included in ICD-10 under Dissociative disorders

### **Dhat Syndrome**

Dhat syndrome is a clinical entity recognized both by general public as well as medical practitioners in which nocturnal emissions lead to severe anxiety and hypochondriasis, often associated with sexual impotence. Patient usually presents with various somatic, psychological and sexual symptoms. Patient attributes it to the passing of whitish discharge, believed to be semen (Dhat), in urine.

Dhat is derived from sanskrit word 'Dhatu' meaning precious fluid. SusrutaSamhita (ancient Indian text of surgery) has described 7 Dhatus in the body. Dhatus are elixir of the body. Disturbances of it can cause physical and mental weakness. Of all seven, Semen is considered to be the most precious.

The belief is further reinforced by traditional healers and perpetuated by friends and elders who had suffered from this syndrome

- The term was first used by Wig in 1960
- A whitish discharge is blamed by patient to be responsible for the physical and mental symptoms which patient suffer from
- However there is no objective evidence of such a discharge
- Sometimes patient also reports of foul smelling semen and less viscous semen
- Generalised weakness,
- Aches and pains all over body

### **Culture bound suicide**

Sati : self-immolation by a widow on her husband's pyre According to Hindu mythology, Sati the wife of Daksha was so overcome at the demise of her husband that she immolated herself on his funeral pyre and burnt herself to ashes. Since then her name 'Sati' has come to be symptomatic of self-immolation by a widow. Was seen mostly in Upper Castes notably Brahmins and Kshatriyas.

Banned in India since 19th century. Only one known case since 1904 (in Rajasthan)

- Jouhar : Suicide committed by a women even before the death of her Husband when faced by prospect of dishonour from another man (usually a conquering king)
- Most notable example is Rani Padmini of Chittor (Rajasthan) to evade the invading army of Sultan from Delhi in 15th century
- More recently, hundreds of women killed themselves by jumping in wells

### **JhinJhinia**

- Occurs in epidemic form in India
- Characterized by bizarre and seemingly involuntary contractions and spasms
- Nosological status unclear

### **Bhanmati Sorcery**

This CBS is seen in South India. It is believed to be due to psychiatric illness i.e. conversion disorders, somatization disorders, anxiety disorder, dysthymia, schizophrenia etc.

- Nosological status unclear

### **Suudu**

It is a culture specific syndrome of painful urination and pelvic “heat” familiar in south India, especially in the Tamil culture. It occurs in males and females. It is popularly attributed to an increase in the “inner heat” of the body often due to dehydration. It is usually treated by the following:

1. Applying a few drops of sesame oil or castor oil in the navel and the pelvic region
2. Having an oil massage followed by a warm water bath
3. Intake of fenugreek seeds soaked overnight in water. The problem has also been known to exist in other parts of South India and the methods of treatment are also similar

### **Check your progress II**

Note: Use the space provided for your answer

1. What is the dhat syndrome?

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2. What is the cultural bound syndrome?

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## **6.5. PERSONALITY DISORDERS**

A personality disorder is a type of mental disorder in which you have a rigid and unhealthy pattern of thinking, functioning and behaving. A person with a personality disorder has trouble perceiving and relating to situations and people. This causes significant problems and limitations in relationships, social activities, work and school.

In some cases, you may not realize that you have a personality disorder because your way of thinking and behaving seems natural to you. And you may blame others for the challenges you face.

Personality disorders usually begin in the teenage years or early adulthood. There are many types of personality disorders. Some types may become less obvious throughout middle age.

## **Symptoms**

Types of personality disorders are grouped into three clusters, based on similar characteristics and symptoms. Many people with one personality disorder also have signs and symptoms of at least one additional personality disorder. It's not necessary to exhibit all the signs and symptoms listed for a disorder to be diagnosed.

### **6.5.1. Cluster A personality disorders**

Cluster A personality disorders are characterized by odd, eccentric thinking or behavior. They include paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder.

#### **Paranoid personality disorder**

- ✓ Pervasive distrust and suspicion of others and their motives
- ✓ Unjustified belief that others are trying to harm or deceive you
- ✓ Unjustified suspicion of the loyalty or trustworthiness of others
- ✓ Hesitancy to confide in others due to unreasonable fear that others will use the information against you
- ✓ Perception of innocent remarks or nonthreatening situations as personal insults or attacks
- ✓ Angry or hostile reaction to perceived slights or insults
- ✓ Tendency to hold grudges
- ✓ Unjustified, recurrent suspicion that spouse or sexual partner is unfaithful

#### **Schizoid personality disorder**

- ✓ Lack of interest in social or personal relationships, preferring to be alone
- ✓ Limited range of emotional expression
- ✓ Inability to take pleasure in most activities
- ✓ Inability to pick up normal social cues
- ✓ Appearance of being cold or indifferent to others
- ✓ Little or no interest in having sex with another person

#### **Schizotypal personality disorder**

- ✓ Peculiar dress, thinking, beliefs, speech or behavior
- ✓ Odd perceptual experiences, such as hearing a voice whisper your name



- ✓ Flat emotions or inappropriate emotional responses
- ✓ Social anxiety and a lack of or discomfort with close relationships
- ✓ Indifferent, inappropriate or suspicious response to others
- ✓ "Magical thinking" — believing you can influence people and events with your thoughts
- ✓ Belief that certain casual incidents or events have hidden messages meant only for you

### **6.5.2. Cluster B personality disorders**

Cluster B personality disorders are characterized by dramatic, overly emotional or unpredictable thinking or behavior. They include antisocial personality disorder, borderline personality disorder, histrionic personality disorder and narcissistic personality disorder.

#### **Antisocial personality disorder**

- ✓ Disregard for others' needs or feelings
- ✓ Persistent lying, stealing, using aliases, conning others
- ✓ Recurring problems with the law
- ✓ Repeated violation of the rights of others
- ✓ Aggressive, often violent behavior
- ✓ Disregard for the safety of self or others
- ✓ Impulsive behavior
- ✓ Consistently irresponsible
- ✓ Lack of remorse for behavior

#### **Borderline personality disorder**

- ✓ Impulsive and risky behavior, such as having unsafe sex, gambling or binge eating
- ✓ Unstable or fragile self-image
- ✓ Unstable and intense relationships
- ✓ Up and down moods, often as a reaction to interpersonal stress
- ✓ Suicidal behavior or threats of self-injury
- ✓ Intense fear of being alone or abandoned
- ✓ Ongoing feelings of emptiness
- ✓ Frequent, intense displays of anger
- ✓ Stress-related paranoia that comes and goes

#### **Histrionic personality disorder**

- ✓ Constantly seeking attention
- ✓ Excessively emotional, dramatic or sexually provocative to gain attention
- ✓ Speaks dramatically with strong opinions, but few facts or details to back them up
- ✓ Easily influenced by others
- ✓ Shallow, rapidly changing emotions

- ✓ Excessive concern with physical appearance
- ✓ Thinks relationships with others are closer than they really are

#### **Narcissistic personality disorder**

- ✓ Belief that you're special and more important than others
- ✓ Fantasies about power, success and attractiveness
- ✓ Failure to recognize others' needs and feelings
- ✓ Exaggeration of achievements or talents
- ✓ Expectation of constant praise and admiration
- ✓ Arrogance
- ✓ Unreasonable expectations of favors and advantages, often taking advantage of others
- ✓ Envy of others or belief that others envy you

### **6.5.3. Cluster C personality disorders**

Cluster C personality disorders are characterized by anxious, fearful thinking or behavior. They include avoidant personality disorder, dependent personality disorder and obsessive-compulsive personality disorder.

#### **Avoidant personality disorder**

- ✓ Too sensitive to criticism or rejection
- ✓ Feeling inadequate, inferior or unattractive
- ✓ Avoidance of work activities that require interpersonal contact
- ✓ Socially inhibited, timid and isolated, avoiding new activities or meeting strangers
- ✓ Extreme shyness in social situations and personal relationships
- ✓ Fear of disapproval, embarrassment or ridicule

#### **Dependent personality disorder**

- ✓ Excessive dependence on others and feeling the need to be taken care of
- ✓ Submissive or clingy behavior toward others
- ✓ Fear of having to provide self-care or fend for yourself if left alone
- ✓ Lack of self-confidence, requiring excessive advice and reassurance from others to make even small decisions
- ✓ Difficulty starting or doing projects on your own due to lack of self-confidence
- ✓ Difficulty disagreeing with others, fearing disapproval
- ✓ Tolerance of poor or abusive treatment, even when other options are available
- ✓ Urgent need to start a new relationship when a close one has ended

### **Obsessive-compulsive personality disorder**

- ✓ Preoccupation with details, orderliness and rules
- ✓ Extreme perfectionism, resulting in dysfunction and distress when perfection is not achieved, such as feeling unable to finish a project because you don't meet your own strict standards
- ✓ Desire to be in control of people, tasks and situations, and inability to delegate tasks
- ✓ Neglect of friends and enjoyable activities because of excessive commitment to work or a project
- ✓ Inability to discard broken or worthless objects
- ✓ Rigid and stubborn
- ✓ Inflexible about morality, ethics or values
- ✓ Tight, miserly control over budgeting and spending money

Obsessive-compulsive personality disorder is not the same as obsessive-compulsive disorder, a type of anxiety disorder.

### **Check your progress II**

Note: Use the space provided for your answer

1. What is the personality disorder?

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2. What is the characteristics of antisocial personality disorder?

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## **6.6. SEXUAL DISORDERS**

Defining Sexual Disorders A sexual disorder (or sexual dysfunction) is a problem with sexual response that causes a person psychological distress. Sexual dysfunction generally refers to a difficulty experienced during any stage of a normal sexual activity as described below.

Sexual disorders are divided into two broad categories, the paraphilias and gender identity disorders. Few psychopathologies arouse greater public emotion or fascination than do these conditions. Consensual paraphilias, such as the erotic interest in pain, have given rise to hidden subcultures, analogous to the gay communities of previous decades. Nonconsensual paraphilias, such as the erotic interests in children or in rape, motivate persons to engage in sexual offenses, leading legislators to enact mandatory sentences and establish sex offender registries. Cases of transsexualism and cases of highly unusual paraphilias, such as the erotic interests in nonhuman animals or in being an amputee, have been featured in contemporary entertainment media and documentaries (e.g., Lawrence, 2006; Williams & Weinberg, 2003).

### **Paraphilia**

The term paraphilia denotes any powerful and persistent sexual interest other than sexual interest in copulatory or precopulatory behavior with phenotypically normal, consenting adult human partners. Paraphilias may be classified under two broad headings: (1) Those in which the sexually interesting object is something other than phenotypically normal humans between the ages of physical maturity and physical decline and (2) those in which the sexually interesting activity is something other than copulatory or precopulatory behavior with a consenting partner.

### **TYPES OF PARAPHILIAS**

**Voyeurism:** watching an unsuspecting/non-consenting individual who is either nude, disrobing, or engaging in sexual activity

**Exhibitionism:** exposing one's own genitals to an unsuspecting person

**Frotteurism:** touching or rubbing against a non-consenting person

**Sexual masochism:** being humiliated, beaten, bound, or otherwise suffering

**Sexual sadism:** the physical or emotional suffering of another person

**Pedophilia:** sexual activity with a child that is prepubescent (usually 13 years old or younger)

**Fetishism:** sexual fascination with nonliving objects or highly specific body parts (partialism). Examples of specific fetishisms include somnophilia (sexual arousal by a person who is unconscious) and urophilia (deriving sexual pleasure from seeing or thinking about urine or urinating)

**Transvestism:** cross-dressing that is sexually arousing and interferes with functioning

**Autogynephilia** is a subtype of transvestism that refers specifically to men who become aroused by thinking or visualizing himself as a woman.

**Other specified paraphilia:** some paraphilias do not meet full diagnostic criteria for a paraphilic disorder but may have uncontrolled sexual impulses that cause enough distress for the sufferer that they are recognized. Examples of such specific paraphilias include necrophilia (corpses), scatologia (obscene phone calls), coprophilia (feces and defecation), and zoophilia (animals).

## SEXUAL DYSFUNCTIONS

Sexual dysfunctions can be lifelong or acquired, generalized or situational and result from psychological factor, physiological factor, combined factors and numerous stressor including prohibitive cultural mores, health and partner issues, and relationship conflicts.

Male hypoactive sexual desire disorders □ This dysfunction is characterized by a deficiency or absence of sexual fantasies and desire for sexual activity for a minimum duration of approximately 6 month. □ A reported with 6 % of men ages 18-24, and 40 % of men ages 66-74 have problems with sexual desire.

A: persistently or recurrently deficient sexual/erotic thoughts or fantasies and desire for sexual activity. The judgment of deficiency is made by the clinician, taking into account factor that affect sexual functioning, such as age and socio-cultural contexts of the individual's life.

**Women may experiencing** sexual dysfunction may experience either/or both inability to feel interest or arousal, and they may often have difficulty achieving orgasm or experience pain in addition.

Lack of, or significantly reduced, sexual interest/arousal as manifested by at least 3 of the following: 1. Absent/reduced interest in sexual activity. 2. absent/reduced sexual/erotic thoughts or fantasies. 3. Reduced initiation of sexual activity and typically unresponsive to partner's attempts to initiate. 4. absent sexual excitement/pleasure during sexual activity in almost all. 5. absent sexual interest/arousal in response to any internal or external sexual or erotic cues. (Written, verbal, visual)

Male Orgasmic Disorder • Failure or marked difficulty to have orgasm, despite normal sexual excitement, during coitus. • An uncommon disorder, it often presents as restarted ejaculation. • Also c/d delayed ejaculation: a man achieves ejaculation during coitus with great difficulty. • The cause can be biological (post-prostate surgery, drug induced) or psychological (marital conflicts).

**Normal anatomic sex.**  Persistent and significant sense of discomfort..  Marked preoccupation with the wish to get rid of one's genitals & sex characteristics.  Diagnosis is made after puberty.

Primary Transsexualism: 1. early childhood onset 2. Homogeneous category 3. 2 main types- Male primary Transsexualism & female Transsexualism

Secondary Transsexualism: 1. later onset 2. Heterogeneous category 3. Majority of these patients are male transsexuals

Making the person reconcile with anatomic sex 2. Arrange sex-change to the desired gender.

Dual-Role Transvestism- • It is characterized by wearing of clothes of opposite sex in order to enjoy the temporary experience of membership of the opposite sex. • No desire of permanent sex change • No sexual excitement accompanies the cross-dressing

Intersexuality: • The patients with this disorder have gross anatomical & physiological aspects of other sex. 1. External genitals 2. Internal sex organs 3. Hormonal disturbances,(testicular feminization syndrome) 4. Chromosomes,(turner's syndrome)

### **Check your progress III**

Note: Use the space provided for your answer

1. What is the paraphilia?

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2. What is transvestism?

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## **6.7. ALCOHOLISM AND DRUG DEPENDENCE**

Alcohol and other drug problems are concerns of the public health and justice systems, including the criminal, civil, and juvenile branches. The impact of alcohol and other drug problems in the justice system are not limited to cases involving drug-related offenses. Alcohol and other drug problems compound many of the complex

issues the justice systems handle every day, including assault, vandalism, child abuse, and divorce.

In today's world, health and safety at the workplace has become of utmost importance. A lot of people associate the aspect of health and safety with protective clothing such as safety shoes and safety helmets. However, health and safety implies more than just the physical aspects, but also the social and psychological aspects.

Drug and alcohol abuse cause health and safety concerns of a physical, psychological and social nature at the workplace such as:

- Accidents
- Absenteeism
- Inefficiency
- Problems between staff members

### **Alcoholism**

Alcoholism is the most serious form of problem drinking, and describes a strong, often uncontrollable, desire to drink. Sufferers of alcoholism will often place drinking above all other obligations, including work and family, and may build up a physical tolerance or experience withdrawal symptoms if they stop.

Alcoholism is sometimes known as alcohol addiction or alcohol dependence. It's slightly different to 'harmful drinking' which is an occasional pattern of drinking which can cause damage your health.

### **Signs or symptoms of alcoholism**

It can be tricky to spot the signs of alcoholism as alcoholics can be secretive about it and can become angry if confronted.

However, if someone close to you is showing any of the following signs, it may be that they're suffering from alcoholism:

- ✓ A lack of interest in previously normal activities
- ✓ Appearing intoxicated more regularly
- ✓ Needing to drink more in order to achieve the same effects
- ✓ Appearing tired, unwell or irritable
- ✓ An inability to say no to alcohol
- ✓ Anxiety, depression or other mental health problems
- ✓ Becoming secretive or dishonest

## **TREATMENT OF ALCOHOLISM**

In many cases, the first step of treating alcoholism is acknowledging there is a problem. As with many health problems the second step is to seek help from a healthcare professional, like your local GP who can refer you to a specialist.

A doctor will diagnose alcoholism when three or more of the following have been present together in the past year (1):

- ✓ An overwhelming desire to drink
- ✓ An inability to stop or to control harmful drinking
- ✓ Withdrawal symptoms when stopping drinking
- ✓ Evidence of alcohol tolerance
- ✓ Pursuing the consumption of alcohol to the exclusion of alternative pleasures
- ✓ Continuing to drink despite clear evidence of harmful consequences
- ✓ There are different treatments available for people diagnosed with alcoholism but a key stage of treatment is detoxification.

Detox involves stopping drinking completely so that the body can adjust to being without alcohol. During this time, a person may experience alcohol withdrawal symptoms.

Ongoing treatment generally falls into one of three main camps:

- ✓ Psychological
- ✓ Psychosocial
- ✓ Psychological and psychosocial treatments can involve counselling to help you understand and change your attitude towards drinking.

**Cognitive Behavioural Therapy (CBT)** can also be offered to help change negative thought patterns which lead to drinking.

**Mutual help such as AA** help partly because of the new network of support a person gains and also because people adjust their thinking and their attitudes to themselves and others.

**Pharmacological treatments** (i.e. medications) can also have a role in preventing relapse for some people who are trying to abstain, or trying to reduce their drinking.

Substance abuse: The excessive use of a substance, especially alcohol or a drug. (There is no universally accepted definition of substance abuse.)



## **Substance Abuse**

A definition of substance abuse that is frequently cited is that in DSM-IV, the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) issued by the American Psychiatric Association. The DSM-IV definition is as follows:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)

Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

## **Symptoms and Signs of Substance Abuse**

Friends and family may be among the first to recognize the signs of substance abuse. Early recognition increases the chances for successful treatment. Signs to watch for include the following:

- Giving up past activities such as sports, homework, or hanging out with new friends
- Declining grades
- Aggressiveness and irritability
- A significant change in mood or behavior
- Forgetfulness
- Disappearing money or valuables
- Feeling rundown, hopeless, depressed, or even suicidal
- Sounding selfish and not caring about others
- Use of room deodorizers and incense
- Paraphernalia such as baggies, small boxes, pipes, and rolling paper
- Physical problems with unclear cause (for example, red eyes and slurred speech)
- Getting drunk or high on drugs on a regular basis

- Lying, particularly about how much alcohol or other drugs he or she is using
- Avoiding friends or family in order to get drunk or high
- Planning drinking in advance, hiding alcohol, and drinking or using other drugs alone
- Having to drink more to get the same high
- Believing that in order to have fun you need to drink or use other drugs
- Frequent hangovers

Most substance abusers believe they can stop using drugs on their own, but the majorities who try do not succeed. Before treatment for the addictive behavior can be directly addressed, the substance abuse sufferer might need help in lessening physical withdrawal from alcohol or other drugs they have been using. That initial phase of treatment is called detoxification or "detox." It often requires inpatient hospital treatment.

#### **Check your progress IV**

Note: Use the space provided for your answer

1. What are the symptoms of alcoholism?

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2. What impacts of substance abuse?

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### **6.8. SUMMARY**

A mental disorder, also called a mental illness or psychiatric disorder, is a behavioral or mental pattern that causes significant distress or impairment of personal functioning. Mental disorders are usually defined by a combination of how a person behaves, feels, perceives, or thinks. A personality disorder is a type of mental disorder in which you have a

rigid and unhealthy pattern of thinking, functioning and behaving. A person with a personality disorder has trouble perceiving and relating to situations and people. Sexual disorders are divided into two broad categories, the paraphilias and gender identity disorders.

## **KEY WORDS**

- ❖ Neuroses
- ❖ Psychoses
- ❖ Cultural bound syndrome
- ❖ Personality disorder
- ❖ Sexual deviation
- ❖ Dependence

## **SELF-ASSESSMENT QUESTIONS AND EXERCISE**

1. What are the warning symptoms before psychoses?
2. Explain bipolar disorder
3. What are organic psychoses?
4. Explain cultural bound syndrome
5. Explain the personality disorders with all its clusters
6. What is avoidant personality?
7. Explain the types of paraphilia
8. What are the symptoms and signs of alcoholic disorder?

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## **UNIT VII**

Mental Handicap: Definition, classification, clinical types and causes, cerebral palsy: clinical types, causes, associated disabilities; epilepsy: definition, types, causes, management; ageing: biological, social and psychological problems

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### **Structure**

7.1. Aims and Objectives

7.2 Introduction

7.3. Mental Handicap (Intellectual Disability)

7.4. Cerebral Palsy: Clinical Types, Causes, Associated Disabilities

7.5. Epilepsy: Definition, Types, Causes, Management

7.6. Ageing: Biological, Social and Psychological Problems

7.7. Summary

7.8 Further Readings and References

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### **7.1. AIMS AND OBJECTIVES**

- ❖ To understand the various characteristics of mental handicap
- ❖ To study about causes, symptoms and treatment process of Cerebral palsy and epilepsy
- ❖ To know the various problems of ageing

### **7.2 INTRODUCTION**

Mental retardation is cognitive limitation as characterized by scores greater than 2 standard deviations below the mean on a valid intelligence quotient (IQ) measure, with limitation of adaptive function in communication, self-care, and daily living skills at home or in the community, or social skills. It persists throughout adulthood. Diagnosis of mental retardation is made if an individual has an intellectual functioning level well below average and significant limitations in two or more adaptive skill areas. Adaptive skills are the skills needed for daily life. Such skills include the ability to produce and understand language (communication); home-living skills; use of community resources; health, safety, leisure, self-care, and social skills; self-direction; functional academic skills (reading, writing, and arithmetic); and work skills.

### **7.3. MENTAL HANDICAP (INTELLECTUAL DISABILITY)**

Intellectual disability (ID), once called mental retardation, is characterized by below-average intelligence or mental ability and a lack of skills necessary for day-to-day living. People with intellectual disabilities can and do learn new skills, but they learn them more slowly. There are varying degrees of intellectual disability, from mild to profound.

Intellectual disability has limitations in two areas. These areas are:

Intellectual functioning. Also known as IQ, this refers to a person's ability to learn, reason, make decisions, and solve problems.

Adaptive behaviors. These are skills necessary for day-to-day life, such as being able to communicate effectively, interact with others, and take care of oneself.

#### **CAUSES OF INTELLECTUAL DISABILITY:**

Genetic conditions. These include things like Down syndrome and fragile X syndrome.

Problems during pregnancy. Things that can interfere with fetal brain development include alcohol or drug use, malnutrition, certain infections, or preeclampsia.

Problems during childbirth. Intellectual disability may result if a baby is deprived of oxygen during childbirth or born extremely premature.

Illness or injury. Infections like meningitis, whooping cough, or the measles can lead to intellectual disability. Severe head injury, near-drowning, extreme malnutrition, infections in the brain, exposure to toxic substances such as lead, and severe neglect or abuse can also cause it.

#### **Signs of intellectual disability**

There are many different signs of intellectual disability in children. Signs may appear during infancy, or they may not be noticeable until a child reaches school age. It often depends on the severity of the disability. Some of the most common signs of intellectual disability are:

- ✓ Rolling over, sitting up, crawling, or walking late
- ✓ Talking late or having trouble with talking
- ✓ Slow to master things like potty training, dressing, and feeding himself or herself
- ✓ Difficulty remembering things
- ✓ Inability to connect actions with consequences
- ✓ Behavior problems such as explosive tantrums
- ✓ Difficulty with problem-solving or logical thinking



## **7.4. CEREBRAL PALSY**

Cerebral palsy is the term applied to a group of children with motor impairment and related service requirement. It is a disorder of movement. The word cerebral palsies was coined by William Osler in late 1880s.

### **Definition**

Rosenbaum et al described a group of permanent disorder of the development of movement and posture, causing activity limitation, that are attributed to non-progressive disturbances that occurred in the developing fetal or infant brain.

In gist the Cerebral Palsy is a) disorders of movement or posture leading to motor impairment that b) develop very early in life c) can be attributed to cerebral abnormality, and d) although the clinical signs change with the child's development.

In general, cerebral palsy abnormality neither resolves nor deteriorates. It is a physical condition of a person who has difficulty either producing movement, preventing movement or controlling movement following injury to the brain before or during birth or in the first five years of life.

### **CAUSE OF CEREBRAL PALSY**

The brain damage may be due to one of the number of factors. Near half of the cases of cerebral palsy have no known causes.

#### **Prenatal causes (before birth)**

- Hemorrhage
- Hemorrhage (bleeding) in a specific area of brain is a common cause with premature children who develop cerebral palsy.
- Infection
- Infection may be passed from mother to child in the womb. An example of this is the passing on of cytomegalic-virus (CMV) to the unborn child.
- Environmental Factors
- Mother can get affected by what she eats or drinks or by breathing dangerous poisons in the air, which can be passed to the child before birth. Toxoplasmosis is an infection which may be acquired from eating raw or uncooked meat, from cats or contaminated soil. The infection can pass on to the child.
- Heredity
- There has been speculation that a small number of cases may be hereditary.

#### **Perinatal causes (At or around the time of birth)**

Lack of oxygen to the brain (Asphyxia)

## **Postnatal causes**

- Head injury
- Head injuries sustained during the first five years of life may cause Cerebral Palsy (CP).
- Infection
- Infections such as meningitis contracted in early life can cause CP.

## **DIFFERENT TYPES OF CEREBRAL PALSY**

### 1) Spastic Cerebral Palsy (Pyramidal)

Spastic CP is caused by damage to the cortex. The child will be stiff in one or more limbs and possible all over.

### 2) Athetoid Cerebral Palsy (extra-pyramidal)

Athetoid CP is caused by damage to the basal ganglia and /or cerebellum. The child may be floppy in one or more limbs, possibly all over whilst many may have high or fluctuating tone with accompanying constant uncontrolled movements.

### 3) Ataxic Cerebral Palsy

Ataxic CP is caused by damage to the cerebellum. The child will be unsteady.

### 4) Mixed Cerebral Palsy

Mixed CP is a term used for types of cerebral palsy which do not fit neatly into the one of the other classification above.

### 5) Other types

It includes dystonia, where posture distorts intermittently.

## **Classification of cerebral palsy**

### *Topographical classification*

CP is most commonly classified topographically (in terms of the parts of the body affected and the extent of the disability).

#### **QUADRIPLEGIA**

All four limbs are affected

#### **DIPLEGIA**

All four limbs are affected but the legs more so than the arms. This is a common if CP occurs due to a premature birth.

#### **PARAPLEGIA**

Both legs are affected

## TRIPLEGIA

Three limbs are affected

## HEMIPLEGIA

One side of the body is affected. This is type of CP that can be the result of a bleed on the brain prior to birth.

## Classification of Cerebral Palsy

### Physiological

It refers to description by type of movements.

1. Spasticity (Stiff)
2. Athetosis (Floppy)
  - a. Tensional (sometimes tense)
  - b. Non-tensional (not tense)
  - c. Dystonic (muscle lack of strength)
  - d. With tremor (muscle quiver)
3. Rigidity (Stiff or no movement)
4. Ataxia (movement irregular and jerky)
5. Tremor
6. Atonia (rare; muscle lack vigour)
7. Mixed ( combination of some or all of the above)
8. Unclassifiable

### Topographical

Topographical classification refers to the parts of the body that are affected.

1. Monoplegia: affects one limb
2. Paraplegia: affects only the legs
3. Hemiplegia: affects one side of the body
4. Triplegia: affects Three limbs
5. Quadriplegia (tetraplegia): affects all four limbs
6. Diplegia: affecting both halves uniformly: bilateral paralysis

## **7.5. EPILEPSY**

Epilepsy is defined as a disorder of brain characterized by an liability to recurrent epileptic seizures. It is a complex symptoms caused by variety of pathological process in the brain.

### **Definitions**

According to Jackson “an occasional, excessive, and disorderly discharge of nerve tissue, the discharge occurs in all degrees; it occurs in all sort of conditions of ill health at all ages, and under innumerable circumstances”.

### **Causes of epilepsy**

Epilepsy can have many causes. Where the cause is clearly identified, the epilepsy is categorized as symptomatic (i.e. of known cause). Where no cause is known, the epilepsy is known as cryptogenic (i.e. hidden cause). Where the epilepsy is predominantly of genetic (or presumed genetic) origin, it is categorized as idiopathic.

Every function in the human body is triggered by messaging systems in our brain. Epilepsy results when this system is disrupted due to faulty electrical activity.

In many cases, the exact cause is not known. Some people have inherited genetic factors that make epilepsy more likely to occur.

Other factors that may increase the risk include:

- head trauma, for instance, during a car crash
- brain conditions, including stroke or tumors
- infectious diseases, for instance, AIDS and viral encephalitis
- prenatal injury, or brain damage that occurs before birth
- developmental disorders, for instance, autism or neurofibromatosis

It is most likely to appear in children under 2 years Trusted Source of age, and adults over 65 years.

What a patient with epilepsy experiences during a seizure will depend on which part of the brain is affected, and how widely and quickly it spreads from that area.

The CDC note Trusted Source that the condition "is not well understood." Often, no specific cause can be identified.

## **SYMPTOMS OF EPILEPSY**

The main symptom of epilepsy is repeated seizures. If one or more of the following symptoms are present, the individual should see a doctor, especially if they recur:

- a convulsion with no temperature (no fever)

- short spells of blackout, or confused memory
- intermittent fainting spells, during which bowel or bladder control is lost, which is frequently followed by extreme tiredness
- for a short period, the person is unresponsive to instructions or questions
- the person becomes stiff, suddenly, for no apparent reason
- the person suddenly falls for no clear reason
- sudden bouts of blinking without apparent stimuli
- sudden bouts of chewing, without any apparent reason
- for a short time the person seems dazed and unable to communicate
- repetitive movements that seem inappropriate
- the person becomes fearful for no apparent reason; they may even panic or become angry
- peculiar changes in senses, such as smell, touch, and sound
- the arms, legs, or body jerk, in babies these will appear as a cluster of rapid jerking movements

The following conditions need to be eliminated. They may present similar symptoms and are sometimes misdiagnosed as epilepsy:

- high fever with epilepsy-like symptoms
- fainting
- narcolepsy, or recurring episodes of sleep during the day
- cataplexy, or periods of extreme muscle weakness
- sleep disorders
- nightmares
- panic attacks
- fugue states, a rare psychiatric disorder
- psychogenic seizures

## **TYPES OF EPILEPSY**

Experts now divide epilepsy into four basic types based on the seizures you're having:

1. Generalized epilepsy
2. Focal epilepsy

3. Generalized and focal epilepsy
4. Unknown if generalized or focal epilepsy

### 1. Generalized Epilepsy

If you have this type of epilepsy, seizures start on both sides of the brain (or quickly affect networks of brain cells on both sides). This type of epilepsy has two basic kinds of seizures:

**Generalized motor seizures.** These used to be called "grand mal" seizures. They cause your body to move in ways you can't control, sometimes dramatically. Tonic-clonic seizures are one example. When it hits, you lose consciousness and your muscles stiffen and jerk. Other types you may hear your doctor talk about include clonic, tonic, and myoclonic.

**Generalized non-motor (or absence) seizures.** They used to be called "petit mal" seizures. Some specific types you may hear your doctor mention are typical, atypical, and myoclonic.

During this type of seizure, you may stop what you're doing and stare into space. You may also do the same movements over and over, like smacking your lips. These types of seizures are generally called "absence" seizures because it's like the person isn't really there.

### 2. Focal Epilepsy

In this type of epilepsy, seizures develop in a particular area (or network of brain cells) on one side of the brain. These used to be called "partial seizures."

Focal epilepsy seizures come in four categories:

**Focal aware seizures.** If you know what's happening during the seizure, it's an "aware" seizure. These used to be called "simple partial seizures."

**Focal impaired awareness seizures.** If you're confused or don't know what's happening during your seizure -- or don't remember it -- it's an impaired awareness seizure. These used to be called "complex partial seizures."

**Focal motor seizures.** In this type of seizure, you'll move to some extent -- anything from twitching, to spasms, to rubbing hands, to walking around. Some types that you may hear your doctor talk about are atonic, clonic, epileptic spasms, myoclonic, and tonic.

**Focal non-motor seizures.** This type of seizure doesn't lead to twitches or other movements. Instead, it causes changes in how you feel or think. You might have intense emotions, strange feelings, or symptoms like a racing heart, goose bumps, or waves of heat or cold.

### 3. Generalized and Focal Epilepsy

Just as the name suggests, this is a type of epilepsy where people have both generalized and focal seizures.

### 4. Unknown if Generalized or Focal Epilepsy

Sometimes, doctors are sure that a person has epilepsy, but they don't know whether the seizures are focal or generalized. This can happen if you were alone when you had seizures,

so no one can describe what happened. Your doctor may also classify your epilepsy type as "unknown if generalized or focal epilepsy" if your test results aren't clear.

## **TREATMENT**

Doctors generally begin by treating epilepsy with medication. If medications don't treat the condition, doctors may propose surgery or another type of treatment.

### **Medication**

Most people with epilepsy can become seizure-free by taking one anti-seizure medication, which is also called anti-epileptic medication. Others may be able to decrease the frequency and intensity of their seizures by taking a combination of medications.

Many children with epilepsy who aren't experiencing epilepsy symptoms can eventually discontinue medications and live a seizure-free life. Many adults can discontinue medications after two or more years without seizures. Your doctor will advise you about the appropriate time to stop taking medications.

Finding the right medication and dosage can be complex. Your doctor will consider your condition, frequency of seizures, your age and other factors when choosing which medication to prescribe. Your doctor will also review any other medications you may be taking, to ensure the anti-epileptic medications won't interact with them.

Your doctor likely will first prescribe a single medication at a relatively low dosage and may increase the dosage gradually until your seizures are well-controlled.

Anti-seizure medications may have some side effects. Mild side effects include:

- ❖ Fatigue
- ❖ Dizziness
- ❖ Weight gain
- ❖ Loss of bone density
- ❖ Skin rashes
- ❖ Loss of coordination
- ❖ Speech problems
- ❖ Memory and thinking problems
- ❖ More-severe but rare side effects include:
  - ❖ Depression
  - ❖ Suicidal thoughts and behaviors
  - ❖ Severe rash
  - ❖ Inflammation of certain organs, such as your liver
- ❖ To achieve the best seizure control possible with medication, follow these steps:

Take medications exactly as prescribed.

- ❖ Always call your doctor before switching to a generic version of your medication or taking other prescription medications, over-the-counter drugs or herbal remedies.
- ❖ Never stop taking your medication without talking to your doctor.
- ❖ Notify your doctor immediately if you notice new or increased feelings of depression, suicidal thoughts, or unusual changes in your mood or behaviors.
- ❖ Tell your doctor if you have migraines. Doctors may prescribe one of the anti-epileptic medications that can prevent your migraines and treat epilepsy.

At least half the people newly diagnosed with epilepsy will become seizure-free with their first medication. If anti-epileptic medications don't provide satisfactory results, your doctor may suggest surgery or other therapies. You'll have regular follow-up appointments with your doctor to evaluate your condition and medications.

## **Surgery**

Neurosurgeons performing epilepsy surgery

Epilepsy surgery

When medications fail to provide adequate control over seizures, surgery may be an option. With epilepsy surgery, a surgeon removes the area of your brain that's causing seizures.

Doctors usually perform surgery when tests show that:

- ❖ Your seizures originate in a small, well-defined area of your brain
- ❖ The area in your brain to be operated on doesn't interfere with vital functions such as speech, language, motor function, vision or hearing
- ❖ Although many people continue to need some medication to help prevent seizures after successful surgery, you may be able to take fewer drugs and reduce your dosages.

In a small number of cases, surgery for epilepsy can cause complications such as permanently altering your thinking (cognitive) abilities. Talk to your surgeon about his or her experience, success rates, and complication rates with the procedure you're considering.

## **Therapies**

Device placement in vagus nerve stimulation

- ❖ **Vagus nerve stimulation**



- ❖ Electrode placement and device location in deep brain stimulation
- ❖ Deep brain stimulation
- ❖ Deep brain stimulation
- ❖ Deep brain stimulation

Apart from medications and surgery, these potential therapies offer an alternative for treating epilepsy:

**Vagus nerve stimulation.** In vagus nerve stimulation, doctors implant a device called a vagus nerve stimulator underneath the skin of your chest, similar to a heart pacemaker. Wires from the stimulator are connected to the vagus nerve in your neck.

The battery-powered device sends bursts of electrical energy through the vagus nerve and to your brain. It's not clear how this inhibits seizures, but the device can usually reduce seizures by 20 to 40 percent.

Most people still need to take anti-epileptic medication, although some people may be able to lower their medication dose. You may experience side effects from vagus nerve stimulation, such as throat pain, hoarse voice, shortness of breath or coughing.

**Ketogenic diet.** Some children with epilepsy have been able to reduce their seizures by following a strict diet that's high in fats and low in carbohydrates.

In this diet, called a ketogenic diet, the body breaks down fats instead of carbohydrates for energy. After a few years, some children may be able to stop the ketogenic diet — under close supervision of their doctors — and remain seizure-free.

Consult a doctor if you or your child is considering a ketogenic diet. It's important to make sure that your child doesn't become malnourished when following the diet.

Side effects of a ketogenic diet may include dehydration, constipation, slowed growth because of nutritional deficiencies and a buildup of uric acid in the blood, which can cause kidney stones. These side effects are uncommon if the diet is properly and medically supervised.

Following a ketogenic diet can be a challenge. Low-glycemic index and modified Atkins diets offer less restrictive alternatives that may still provide some benefit for seizure control.

**Deep brain stimulation.** In deep brain stimulation, surgeons implant electrodes into a specific part of your brain, typically your thalamus. The electrodes are connected to a generator implanted in your chest or your skull that sends electrical pulses to your brain and may reduce your seizures.

## Check your progress I

Note: Use the space provided for your answer

1. What is mental retardation?

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2. Define epilepsy?

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3. What is the characteristics of hemiplegia?

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4. What is focus epilepsy?

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## **7.6. AGEING**

Ageing is the process during which structural and functional changes accumulate in an organism as a result of the passage of time. The changes manifest as a decline from the organism's peak fertility and physiological functions until death.

In humans, ageing represents the accumulation of changes in a human being over time, encompassing physical, psychological, and social changes. Reaction time, for example, may slow with age, while knowledge of world events and wisdom may expand. Ageing is among the greatest known risk factors for most human diseases: of the roughly 150,000 people who die each day across the globe, about two thirds die from age-related causes.

Ageing is not a pathology 'per se', but it favours the emergence of a number of diseases. What are the main symptoms of ageing (that is, the processes that affect all individuals) and what are the major diseases that arise with age?

Obviously, ageing is not a pathology; it is a fact of life. As far as the symptoms are concerned, our hair turns white, men may go bald, hear less, and so on. Then there are factors that may increase the risk of disease: the pancreas ages and stops secreting insulin, we may develop diabetes, we may put on weight, our blood vessels may narrow, our blood pressure

may rise leading to a stroke or a heart attack. Unhealthy living habits such as smoking and drinking compound the risk.

Inevitably, the ageing process is associated with illness. Rates of cancer, heart failure and dementia rise in older people. And as age increases, morbidity rates also increase, at least until the age of 80. From the age of 80 or 90 onwards, we find people who have avoided these diseases, either for genetic reasons or thanks to the environment in which they have lived. These people are known as “escapers” or “survivors” and we can learn a great deal from them. Of course, most of us, for better or for worse, will suffer diseases associated with ageing.

## **PROBLEMS OF AGEING**

Never before the problem of the aged have been of central concern in our society. The span of life is growing because of higher standards of living and the life extension techniques developed by medicine. But the changes in the social structures have left the elderly isolated, neglected within the family and the society. They do not have any meaningful role to perform in the family and the society. These people who were once very active and responsible suddenly have to confine themselves to four walls or with other elderly people, thus leading to many psychological and emotional problems. The growing recognition of this problem is reflected in increasing discussions, legislations, policies and services to the elderly which will improve the lives of the elderly.

## **BIOLOGICAL-PHYSIOLOGICAL PROBLEMS**

The biological-physiological aspects of aging include both the basic biological factors that underlie aging and the general health status. Since the probability of death increases rapidly with advancing age, it is clear that changes must occur in the individual which make him or her more and more vulnerable to disease. For example, a young adult may rapidly recover from pneumonia, whereas an elderly person may die.

### **Digestive system**

Loss of teeth, which is often seen in elderly people, is more apt to be the result of long-term neglect than a result of aging itself. The loss of teeth and incidence of oral disease increase with age, but, as programs of water fluoridation are expanded and the incidence of tooth decay in children is reduced, subsequent generations of the elderly will undoubtedly have better teeth than the present generation.

### **Nervous system**

Changes in the structures of the brain due to normal aging are not striking. It is true that with advancing age there is a slight loss of neurons (nerve cells) in the brain. The total number of

neurons is extremely large, however, so that any losses probably have only a minor effect on behaviour. Since the physiological basis of memory is still unknown, it cannot be assumed that the loss of memory observed in elderly people is caused by the loss of neurons in the brain.

Neurons are extremely sensitive to oxygen deficiency. Consequently, it is probable that neuron loss, as well as other abnormalities observed in aging brains, results not from aging itself, but from disease, such as arteriosclerosis, that reduces the oxygen available to areas of the brain by reducing the blood supply. Genetic and environmental factors, such as exposure to certain chemicals, smoking, or lack of exercise, may also contribute to memory impairment and reduced cognitive ability in the elderly. For example, increased waist circumference and obesity later in life are linked to thinning of the cerebral cortex and cognitive decline; the cerebral cortex is composed primarily of neuronal cell bodies, the deterioration of which is associated with memory and cognitive impairment.

## **Vision**

Visual acuity (ability to discriminate fine detail) is relatively poor in young children and improves up to young adulthood. From about the middle 20s to the 50s there is a slight decline in visual acuity, and there is a somewhat accelerated decline thereafter. This decline is readily compensated for by the use of eyeglasses. There is also reduction in the size of the pupil with age. Consequently, vision in older people can be significantly improved by an increase in the level of illumination.

Aging also brings about a reduction in the ability to change the focus of the eye for viewing near and far objects (presbyopia), so that distant objects can ordinarily be seen more clearly than those close at hand. This change in vision is related to a gradual increase in rigidity of the lens of the eye that takes place primarily between ages 10 and 55 years. After age 55 there is little further change. Many people in their 50s adopt bifocal glasses to compensate for this physiological change.

## **Hearing**

Hearing does not change much with age for tones of frequencies usually encountered in daily life. Above age 50, however, there is a gradual reduction in the ability to perceive tones at higher frequencies. Few persons over age 65 can hear tones with a frequency of 10,000 cycles per second. This loss of perception of high frequencies interferes with identifying individuals by their voices and with understanding conversation in a group but does not ordinarily represent a serious limitation to the individual in daily life. Listening habits and intellectual level play an important role in determining the ability to understand speech, so

that there is often a disparity between measurements of pure tone thresholds and ability to perceive speech.

### **Social Problem**

The position and status of senior citizen have been seriously undermined by factors such as changing values, growing individualism and rising aspirations for consumer goods as a result of the impact of education, urbanization, westernization and Industrialization, lesser number of children due to acceptance of small family norm and hence greater vulnerability in the matter of dependence, migration of younger members to cities for alternative source of livelihood, acute paucity of accommodation in urban areas and the exorbitant rents which act as a strong disincentive for bringing old parents to live with the children.<sup>8</sup> Participation of women in employment in cities in white collar jobs leaving the old, unattended during day time creating stress situations of prompting the younger generation to press for separate residences so that they will not be burdened with problems, complexities of modern life and living which discount the value of the traditional systems and places a lateral transmission of knowledge in contrast to vertical transmission from the older generation, thereby devaluing the knowledge and experience of the old.'

The last pace of social change accentuates the intergenerational differences in values and life styles. Larger investments on the education than in the past and upbringing of children, which together with the inflationary pressures causes disproportionately greater hardships to the old. The total economic dependency status of most of the old people in the absence of old age security benefit has, in fact, multiplied the problem.

The status of the elderly female has additionally been affected due to lesser importance assigned to socio-religious ceremonies in which her knowledge and advice were valued and lesser use of her knowledge and experience in child rearing due to greater reliance on modern medicines, technology and information. The above factors have undermined in status, care and protection of the elderly persons that was provided by joint family, the kinship group and the community institutions and social system, which are themselves in the process of disintegration. These factors are operative even in remote rural areas.

### **Economic problems:**

Forced retirement at 65 has reduced the income of the individuals and makes them dependent on other family members for their economic needs. And increase in expenditure adds to their economic issues. Even the pensioners are not able to manage their expenses within that meager pension income. They have to compromise with their living conditions, medical care etc. Many insurance companies do not provide adequate coverage of adequate

coverage of the medical care of major illness. They either have to go without medical care, or forced to spend their life savings on the episode of the severe illness.

Low income has a strong impact on older people's ability to cope with life's circumstances. Lack of adequate income weakens their capacity to maintain an environment that is life supportive. Most families still have strong emotional ties with their older parents though they play a less important role in financial support and do not share the same household.

### **Psychological or Emotional Problems**

The process of ageing and other psychological or emotional changes that take place due to ageing process cannot be uniform for all elderly persons because the state of their living is dependent on various factors such as nature of composition, economic background of the family, nature of relationships etc.

Nevertheless, social surveys of the life and problems of the elderly and retired persons have shown that there are many common social and emotional problems from which most of the elderly people suffer. To mention a few, the elders usually suffer from loneliness, boredom and depression, which are largely the outcome of absence of fruitful and satisfying activity, absence of likeminded friends and associates around the locality, and lack of respect, affection and attention from their family members, which gradually turns into indifferences and in some cases even into deliberate teasing and torturing on the part of the younger members of their own families.

The situation becomes still worse if the old couples have to live alone by themselves and it becomes unbearable, if one of them is a chronic patient or dead. This sort of situation may happen with the rich elderly persons also who have been deserted by their sons or whose sons have left them for the sake of their occupations living behind them old parents to suffer psychological trauma silently.

The institutionalization of the aged makes it clear that cultural rather than biological factors are of prime importance to the content of status. Burgers observes, old age emerges as a social problem where economic competition works at every level there by creating a decline in the role and status of the old and non-earning members. Generally, the aged people are to face much more problems than others due to their physical unfitness. The status of old man varies from society to society. In some societies, such as the Eskimos used to freeze their old people to death and some other bury them alive. In Japan the aged are treated with respect and are considered as source of wisdom. United states in contrast, old people generally are pushed aside as useless. The elderly persons are left to sit idle and eventually die in old age homes. These problems are believed to have arisen out of numerous pressures, both external and internal, which have been impinging hard on traditional social life.

**Other forms of Abuse:**

**Sexual Abuse:** which is non-consensual sexual contact that ranges from violent rape to indecent assault and sexual harassment by caretakers. Sexual abuse is particularly vicious if the victim cannot communicate well, or is physically and/or environmentally unable to protect him-/ herself. Sexual assault is usually categorized under physical abuse.

**Spousal Abuse:** can entail physical, emotional and sexual abuse, financial exploitation and neglect in a life-long or recent partnership.

**Medication Abuse:** refers to the misuse of medication and prescriptions, deliberately or accidentally, by not providing needed medication, or by administering medication in dosages that sedate or cause bodily harm to the older person. Further specific forms of abuse can also be identified in the scientific literature on the subject.

**Abandonment, or Desertion:** of older persons by individuals who are responsible or have assumed responsibility for their care.

**Economic Violence:** to gain control over older individuals' assets can, in some contexts, be aggravated by economic, social and political structures that condone or indirectly encourage the violence. Older persons are at risk of economic violence due to physical weakness and lack of ability to resist violence. Where they have assets of importance to a household's welfare, such as pension income or ownership of a house, they may be pressured to forego their rights to the assets. Instances of rape have been reported to force women to relinquish assets, as well as instances of expropriation and banishment of widows from the family home.

**Scapegoating:** describes instances where older people (usually women) are identified and blamed for ills befalling the community, including drought, flood or epidemic deaths. Incidents have been reported where women have been ostracized, tortured, maimed or even killed if they fail to flee the community. In so fleeing, these individuals may lose their immobile assets.

**Community Violence:** affects older persons through generalized feelings of fear, which increase their overall sense of insecurity, as well as through direct violence. Criminal violence, including common assault, robbery, rape, vandalism, delinquency, drug-related violence and gang warfare can influence households and communities by inhibiting members' access to basic services, health care and socializing, as well as by direct victimization.<sup>91</sup>

**Check your progress II**

Note: Use the space provided for your answer

1. What do you mean by ageism?

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2. What is Abandonment, or Desertion in the old age?  
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### **7.7 SUMMARY**

There are so many problems the aged are facing these days. They are Social, Psychological, Economical, and Medical, in nature. With the impact of the modernization among the young members of the community, the traditional norms and values have been affected. The attitude and behaviour of the younger generation have also been changing. Now they are objecting to follow the traditional norms and values of joint family. After going through a good deal of discussion on the problems of the aged it can be concluded that the old persons are no more enjoying the love, affection and respect from the other members of the family. Their presence, experience and blessing are considered a must for all-round development of the family. In a society where they command respect the aged feel that their life is worthy and they to make the family fully developed.

### **KEY WORDS**

- ❖ Cerebral palsy
- ❖ Disability
- ❖ Epilepsy
- ❖ Ageism
- ❖ Biological and psychological problems

### **SELF-ASSESSMENT QUESTIONS AND EXERCISE**

1. What is mental retardation?
2. What are the signs of intellectual disability?
3. Define Cerebral Palsy
4. Explain the types of cerebral palsy
5. Bring out the classification of cerebral palsy
6. What are the causes of epilepsy?
7. What are the symptoms of epilepsy?



8. Explain the treatment process of epilepsy?
9. Narrate the biological problems of aged
10. Elaborate the various problems of the old person

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## UNIT VIII

Suicide: causes, indications, prevention; childhood disorders: behaviour disorders; eating, elimination, sleep and speech disorders; childhood psychoses: autism, schizophrenia

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### Structure

- 8.1 Aims and Objectives
  - 8.2 Introduction
  - 8.3 Suicide: Causes, Indications, Prevention
  - 8.4 Childhood Disorder:
    - 8.4.1 Behaviour Disorders
    - 8.4.2 Eating
    - 8.4.3 Elimination
    - 8.4.4 Sleep Disorders
    - 8.4.5 Speech Disorders
  - 8.5 Childhood Psychoses:
    - 8.5.1 Autism,
    - 8.5.2 Schizophrenia
  - 8.6 Summary
  - 8.7 Further Readings and References
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### 8.1 AIMS AND OBJECTIVES

- ❖ To study about the various causes and prevention of suicide
- ❖ To know on the childhood disorder
- ❖ To understand the childhood psychoses

### 8.2 INTRODUCTION

Suicide often stems from a deep feeling of hopelessness. The inability to see solutions to problems or to cope with challenging life circumstances may lead people to see taking their own lives as the only solution to what is really a temporary situation, and most survivors of suicide attempts go on to live full, rewarding lives. Depression is a key risk factor for suicide; others include psychiatric disorders, substance use, chronic pain, a family history of suicide, and a prior suicide attempt. Impulsiveness often plays a role among adolescents who take their life.

If a person deemed at risk due to any of the above exhibits sudden mood changes—even a suddenly upbeat mood—or completely new behaviors, they may be actively suicidal. Those who speak about being a burden to others, having no reason to live, feeling trapped or in unbearable pain may also be contemplating suicide.

Statistically, suicide occurs most frequently among people ages 45 to 54. Women are more likely than men to attempt suicide; men are more likely than women to complete the act.

### **8.3SUICIDE**

Suicide is the act of killing yourself, most often as a result of depression or other mental illness.

Suicidal ideation, also known as suicidal thoughts is thinking about, considering, or planning suicide. The range of suicidal ideation varies from fleeting thoughts, to extensive thoughts, to detailed planning.

#### **Causes**

Suicidal ideation can occur when a person feels they are no longer able to cope with an overwhelming situation. This could stem from financial problems, death of a loved one, a broken relationship, or a devastating or debilitating illness.

The most common situations or life events that might cause suicidal thoughts are grief, sexual abuse, financial problems, remorse, rejection, a relationship breakup, and unemployment.

The following risk factors may have an impact on the probability of someone experiencing suicidal ideation:

- ✓ a family history of mental health issues
- ✓ a family history of substance abuse
- ✓ a family history of violence
- ✓ a family history of suicide
- ✓ a feeling of hopelessness
- ✓ a feeling of seclusion or loneliness
- ✓ being gay with no family or home support
- ✓ being in trouble with the law
- ✓ being under the influence of alcohol or drugs
- ✓ for children, having disciplinary, social or school problems
- ✓ having a problem with substance abuse
- ✓ having a psychiatric disorder or mental illness
- ✓ having attempted suicide before
- ✓ being prone to reckless or impulsive behavior
- ✓ possessing a gun
- ✓ sleep deprivation

## **Symptoms**

A person who is experiencing or could experience suicidal thoughts may show the following signs or symptoms:

- ✓ feeling or appearing to feel trapped or hopeless
- ✓ feeling intolerable emotional pain
- ✓ having or appearing to have an abnormal preoccupation with violence, dying, or death
- ✓ having mood swings, either happy or sad
- ✓ talking about revenge, guilt, or shame
- ✓ being agitated, or in a heightened state of anxiety
- ✓ experiencing changes in personality, routine, or sleeping patterns
- ✓ consuming drugs or more alcohol than usual, or starting drinking when they had not previously done so
- ✓ engaging in risky behavior, such as driving carelessly or taking drugs
- ✓ getting their affairs in order and giving things away
- ✓ getting hold of a gun, medications, or substances that could end a life
- ✓ experiencing depression, panic attacks, impaired concentration
- ✓ increased isolation
- ✓ talking about being a burden to others
- ✓ psychomotor agitation, such as pacing around a room, wringing one's hands, and removing items of clothing and putting them back on
- ✓ saying goodbye to others as if it were the last time
- ✓ seeming to be unable to experience pleasurable emotions from normally pleasurable life events such as eating, exercise, social interaction, or sex
- ✓ severe remorse and self-criticism
- ✓ talking about suicide or dying, expressing regret about being alive or ever having been born

## **Prevention**

The following may help lower the risk of suicidal ideation and suicide attempts:

- ✓ getting family support, for example, talking to them about how you feel and asking them to meet your health provider and possibly attend sessions with you
- ✓ avoiding alcohol and illegal drugs
- ✓ avoiding isolation and staying connected to the outside world, as much as possible
- ✓ doing exercise
- ✓ eating a well-balanced, healthful diet
- ✓ getting at least 7-8 hours continuous sleep in every 24-hour period
- ✓ removing any guns, knives, and dangerous drugs, for example, by giving them to a trusted friend to take care of
- ✓ seeking out things that give you pleasure, such as being with friends or family you like, and focusing on the good things you have

- ✓ attending a self-help or support group, where you can discuss issues with people who understand, get help from others, and help people with similar problems to get through their difficulties
- ✓ seeking and following treatment

The National Institute for Mental Health (NIMH) suggests the following tips for helping someone who may be going through a crisis:

- ❖ Asking them if they are thinking about suicide. Studies show that asking does not increase the risk.
- ❖ Keeping them safe by staying around and removing means of committing suicide, such as knives, where possible
- ❖ Listening to them and being there for them
- ❖ Encouraging them to call a helpline or contacting someone the individual might turn to for support, for example, a friend, family member, or spiritual mentor
- ❖ Following up with them after the crisis has passed, as this appears to reduce the risk of a recurrence

### **Check your progress I**

Note: Use the space provided for your answer

1. What is suicide?

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2. What are causes of suicide?

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## **8.4. CHILDHOOD DISORDERS**

Childhood disease and disorder, any illness, impairment, or abnormal condition that affects primarily infants and children—i.e., those in the age span that begins with the fetus and extends through adolescence.

Childhood is a period typified by change, both in the child and in the immediate environment. Changes in the child related to growth and development are so striking that it is almost as if the child were a series of distinct yet related individuals passing through infancy, childhood, and adolescence. Changes in the environment occur as the surroundings and contacts of a totally dependent infant become those of a progressively more independent child and adolescent. Health and disease during the period from conception to adolescence must be understood against this backdrop of changes.

There are a great diversity of childhood disorder forms and causes. Some of these disorders are primarily disorders of the brain, while others are more behavioral in nature. Brain-based disorders are caused by neurochemical problems or structural abnormalities of the brain. They can be innate (i.e., appearing at or shortly after birth); or they may result from a physical stress such as illness or injury, or an emotional stress, such as trauma or loss. Behavioral problems, on the other hand, are outward signs of difficulty displayed at home, at school, or among friends in an otherwise physically healthy child. Like brain-based problems, behavioral problems may also result from physical or emotional stress. Note that the division between brain-based and behavioral disorders is somewhat arbitrary in many cases. Brain-based disorders such as ADHD clearly impact a child's behavior in school and at home, and vice versa, many disorders previously thought to be primarily behavioral in nature have turned out to have a biological component to them.

Common childhood mental illnesses and developmental disorders include Autism and similar Pervasive Developmental Disorders, Attention Deficit and Hyperactivity Disorder, Learning Disabilities, Adjustment Disorders, Oppositional Defiant Disorder, Conduct Disorder and Depression, Bipolar Disorder and Anxiety Disorders.

#### **8.4.1. BEHAVIOR DISORDERS**

Behavioral disorders involve a pattern of disruptive behaviors in children that last for at least 6 months and cause problems in school, at home and in social situations. Behavioral disorders involve a pattern of disruptive behaviors in children that last for at least 6 months and cause problems in school, at home and in social situations. Nearly everyone shows some of these behaviors at times, but behavior disorders are more serious.

Behavioral disorders may involve:

- ❖ Inattention
- ❖ Hyperactivity
- ❖ Impulsivity
- ❖ Defiant behavior
- ❖ drug use
- ❖ criminal activity

## **CAUSES A BEHAVIOUR DISORDER**

A behavioral disorder can have a variety of causes. According to the University of North Carolina at Chapel Hill, the abnormal behavior that is usually associated with these disorders can be traced back to biological, family and school-related factors.

- ❖ Some biological causes may include:
- ❖ Physical illness or disability
- ❖ Malnutrition
- ❖ Brain damage
- ❖ Hereditary factors

Other factors related to an individual's home life may contribute to behaviors associated with a behavioral disorder:

- ❖ Divorce or other emotional upset at home
- ❖ Coercion from parents
- ❖ Unhealthy or inconsistent discipline style
- ❖ Poor attitude toward education or schooling

### **Signs of a Behavioral Disorder**

Someone who has a behavioral disorder may act out or display emotional upset in different ways, which will also vary from person to person.

## **EMOTIONAL SYMPTOMS OF BEHAVIOUR DISORDERS**

Some of the emotional symptoms of behavioral disorders include:

- ❖ Easily getting annoyed or nervous
- ❖ Often appearing angry
- ❖ Putting blame on others
- ❖ Refusing to follow rules or questioning authority
- ❖ Arguing and throwing temper tantrums
- ❖ Having difficulty in handling frustration

### **Physical Symptoms of Behavior Disorders**

Unlike other types of health issues, a behavioral disorder will have mostly emotional symptoms, with physical symptoms such as a fever, rash, or headache being absent. However, sometimes people suffering from a behavioral disorder will develop a substance abuse problem, which could show physical symptoms such as burnt fingertips, shaking or bloodshot eyes.

Behavioral disorders include:

## **ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)**

According to Centers for Disease Control and Prevention, ADHD is a condition that impairs an individual's ability to properly focus and to control impulsive behaviors, or it may make the person overactive. ADHD is more common in boys than it is in girls. According to the Wexner Medical Center at Ohio State University, males are two to three times more likely than females to get ADHD.

## **Oppositional Defiant Disorder (ODD)**

ODD is a behavioral disorder characterized by hostile, irritable and uncooperative attitudes in children, according to Children's Mental Health Ontario. Children with ODD may be spiteful or annoying on purpose, and they generally direct their negative actions at authority figures.

## **CONDUCT DISORDER**

Conduct disorder is a serious behavioral and emotional disorder that can occur in children and teens. A child with this disorder may display a pattern of disruptive and violent behavior and have problems following rules.

**Symptoms of conduct disorder** vary depending on the age of the child and whether the disorder is mild, moderate, or severe. In general, symptoms of conduct disorder fall into four general categories:

**Aggressive behavior:** These are behaviors that threaten or cause physical harm and may include fighting, bullying, being cruel to others or animals, using weapons, and forcing another into sexual activity.

**Destructive behavior:** This involves intentional destruction of property such as arson (deliberate fire-setting) and vandalism (harming another person's property).

**Deceitful behavior:** This may include repeated lying, shoplifting, or breaking into homes or cars in order to steal.

**Violation of rules:** This involves going against accepted rules of society or engaging in behavior that is not appropriate for the person's age. These behaviors may include running away, skipping school, playing pranks, or being sexually active at a very young age.

## **PREVENTATIVE MEASURES**

The best way to prevent emotional disturbance in your teen is to correct the factors in their home or school life that could be contributing to the problem. Here are some steps you could take:

- ❖ Create consistency in your teen's life and maintain a positive environment
- ❖ Provide clear expectations and direct instructions to your teen for home and school life



- ❖ Correct factors in your teen's environment that are negative and encourage undesirable behavior
- ❖ Punish undesirable behavior while rewarding desirable behavior
- ❖ Have a plan for conflict resolution
- ❖ Invest in your teen's life and encourage their participation and belonging at home and at school

#### **8.4.2. EATING DISORDER (ED)**

Eating Disorders describe illnesses that are characterized by irregular eating habits and severe distress or concern about body weight or shape.

Eating disturbances may include inadequate or excessive food intake which can ultimately damage an individual's well-being. The most common forms of eating disorders include Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder and affect both females and males.

#### **Types of Disordered Eating**

The three most common types of Eating Disorders are as follows:

**Anorexia Nervosa**-The male or female suffering from anorexia nervosa will typically have an obsessive fear of gaining weight, refusal to maintain a healthy body weight and an unrealistic perception of body image. Many people with anorexia nervosa will fiercely limit the quantity of food they consume and view themselves as overweight, even when they are clearly underweight. Anorexia can have damaging health effects, such as brain damage, multi-organ failure, bone loss, heart difficulties, and infertility. The risk of death is highest in individuals with this disease.

**Bulimia Nervosa**-This eating disorder is characterized by repeated binge eating followed by behaviors that compensate for the overeating, such as forced vomiting, excessive exercise, or extreme use of laxatives or diuretics. Men and women who suffer from Bulimia may fear weight gain and feel severely unhappy with their body size and shape. The binge-eating and purging cycle is typically done in secret, creating feelings of shame, guilt, and lack of control. Bulimia can have injuring effects, such as gastrointestinal problems, severe dehydration, and heart difficulties resulting from an electrolyte imbalance.

**Binge Eating Disorder**- Individuals who suffer from Binge Eating Disorder will frequently lose control over his or her eating. Different from bulimia nervosa however, episodes of binge-eating are not followed by compensatory behaviors, such as purging, fasting, or excessive exercise. Because of this, many people suffering from BED may be obese and at an increased risk of developing other conditions, such as cardiovascular disease. Men and women who struggle with this disorder may also experience intense feelings of guilt, distress,

and embarrassment related to their binge-eating, which could influence the further progression of the eating disorder.

### **Causes of Disordered Eating**

EDs are complex disorders, influenced by a facet of factors. Though the exact cause of eating disorders is unknown, it is generally believed that a combination of biological, psychological, and/or environmental abnormalities contribute to the development of these illnesses.

*Examples of biological factors include:*

- ❖ Irregular hormone functions
- ❖ Genetics (the tie between eating disorders and one's genes is still being heavily researched, but we know that genetics is a part of the story).
- ❖ Nutritional deficiencies

*Examples of psychological factors include:*

- Negative body image
- Poor self-esteem

### **TREATMENT FOR EATING DISORDER**

**Treatment for an ED** is usually comprised of one or more of the following and addressed with medical doctors, nutritionists, and therapists for complete care:

**Medical Care and Monitoring-**The highest concern in the treatment of eating disorders is addressing any health issues that may have been a consequence of eating disordered behaviors.

**Nutrition:** This would involve weight restoration and stabilization, guidance for normal eating, and the integration of an individualized meal plan.

**Therapy:** Different forms of psychotherapy, such as individual, family, or group, can be helpful in addressing the underlying causes of eating disorders. Therapy is a fundamental piece of treatment because it affords an individual in recovery the opportunity to address and heal from traumatic life events and learn healthier coping skills and methods for expressing emotions, communicating and maintaining healthy relationships.

**Medications:** Some medications may be effective in helping resolve mood or anxiety symptoms that can occur with an eating disorder or in reducing binge-eating and purging behaviors.

### **8.4.3. ELIMINATION DISORDERS**

Elimination disorders occur when children who are otherwise old enough to eliminate waste appropriately repeatedly void feces or urine in inappropriate places or at inappropriate times. The two disorders that fall under this category are Enuresis and Encopresis.

**Encopresis** is the repeated passing of feces into places other than the toilet, such as in underwear or on the floor. This behavior may or may not be done on purpose.

**Enuresis** is the repeated passing of urine in places other than the toilet. Enuresis that occurs at night, or bed-wetting, is the most common type of elimination disorder. As with encopresis, this behavior may or may not be done on purpose.

#### **Symptoms of Encopresis**

In addition to defecating in improper places, a child with encopresis may have other symptoms, including:

- Loss of appetite
- Abdominal pain
- Loose, watery stools (bowel movements)
- Scratching or rubbing the anal area due to irritation from watery stools
- Decreased interest in physical activity
- Withdrawal from friends and family
- Secretive behavior associated with bowel movements

#### **Causes Encopresis**

The most common cause of encopresis is chronic (long-term) constipation, the inability to release stools from the bowel. This may occur for several reasons, including stress, not drinking enough water (which makes the stools hard and difficult to pass), and pain caused by a sore in or near the anus.

Another possible cause of encopresis is a physical problem related to the intestine's ability to move stool. The child also may develop encopresis because of fear or frustration related to toilet training. Stressful events in the child's life, such as a family illness or the arrival of a new sibling, may contribute to the disorder. In some cases, the child simply refuses to use the toilet.

#### **Prevention of Encopresis**

Encopresis caused by constipation can often be prevented by ensuring the child is drinking adequate amounts of water and maintaining a high fiber diet. Although it may not always be possible to prevent encopresis, getting treatment as soon as symptoms appear may help reduce the frustration and distress, as well as the potential complications related to the disorder. In addition, being positive and patient with a child during toilet training may help prevent any fear or negative feelings about using the toilet.

#### **8.4.4. SLEEP DISORDERS**

Sleep disorders are conditions that result in changes in the way that you sleep. A sleep disorder can affect your overall health, safety and quality of life. ... Some of the signs and symptoms of sleep disorders include excessive daytime sleepiness, irregular breathing or increased movement during sleep.

Sleep disorders involve problems with the quality, timing and amount of sleep, which cause problems with functioning and distress during the daytime. There are a number of different types of sleep disorders, of which insomnia is the most common. Other sleep disorders are narcolepsy, obstructive sleep apnea and restless leg syndrome.

In some cases, sleep disorders can be a symptom of another medical or mental health condition. These sleeping problems may eventually go away once treatment is obtained for the underlying cause. When sleep disorders aren't caused by another condition, treatment normally involves a combination of medical treatments and lifestyle changes.

#### **Symptoms of Sleep Disorders**

Symptoms can differ depending on the severity and type of sleeping disorder. They may also vary when sleep disorders are a result of another condition. However, general symptoms of sleep disorders include:

- ❖ Difficulty falling or staying asleep
- ❖ Daytime fatigue
- ❖ Strong urge to take naps during the day
- ❖ Irritability or anxiety
- ❖ Lack of concentration
- ❖ Depression

#### **Causes of Sleep disorder**

Sleep problems can be caused by various physical, medical, psychiatric, or environmental factors. It is true that about half of the people over the age of 65 have some type of sleep disorder.

Sleep problems can be caused by various factors. Although causes might differ, the end result of all sleep disorders is that the body's natural cycle of slumber and daytime wakefulness is disrupted or exaggerated.

Factors that can cause sleep problems are:

- ❖ Physical (such as ulcers)
- ❖ Medical (such as asthma)
- ❖ Psychiatric (such as depression and anxiety disorders)
- ❖ Environmental (such as alcohol)

Short-term or acute insomnia can be caused by life stresses (such as job loss or change, death of a loved one, or moving), an illness, or environmental factors such as light, noise, or extreme temperatures.

Long-term or chronic insomnia (insomnia that occurs at least three nights a week for a month or longer) can be caused by factors such as depression, chronic stress, and pain or discomfort at night.

A common cause of chronic insomnia is a conditioned emotional response. Thoughts about the sleep problem (e.g., "What if I don't fall asleep tonight?") and behaviors that develop around the sleep problem (e.g., sleeping in and napping, ruminating in bed) tend to maintain insomnia symptoms.

#### **8.4.5 SPEECH DISORDERS**

Speech disorders can affect the way a person creates sounds to form words. Certain voice disorders may also be considered speech disorders. One of the most commonly experienced speech disorders is stuttering. Other speech disorders include apraxia and dysarthria.

*Apraxia* is a motor speech disorder caused by damage to the parts of the brain related to speaking.

*Dysarthria* is a motor speech disorder in which the muscles of the mouth, face or respiratory system may become weak or have difficulty moving.

##### **Cause of Speech disorders**

- Vocal cord damage
- Brain damage
- Muscle weakness
- Respiratory weakness
- Strokes

- Polyps or nodules on the vocal cords
- Vocal cord paralysis

People who have certain medical or developmental conditions may also have speech disorders. Common conditions that can lead to speech disorders are:

- Autism
- Attention deficit hyperactivity disorder (ADHD)
- Strokes
- Oral cancer
- Laryngeal cancer
- Huntington's disease
- Dementia
- Amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease

### **Symptoms of a speech disorder**

Depending on the cause of the speech disorder, several symptoms may be present. Common symptoms experienced by people with speech disorders are:

- Repeating sounds, which is most often seen in people who stutter
- Adding extra sounds and words
- Elongating words
- Making jerky movements while talking, usually involving the head
- Blinking several times while talking
- Visible frustration when trying to communicate
- Taking frequent pauses when talking
- Distorting sounds when talking
- Hoarseness, or speaking with a raspy or gravelly sounding voice

## Check your progress II

Note: Use the space provided for your answer

1. Mention any four childhood disorders

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2. What is bulimia nervosa?

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3. What is encopresis?

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4. What is sleep

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5. What is dysarthria?

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## **8.5. CHILDHOOD PSYCHOSIS**

Psychosis is defined as the presence of disruptions in thinking, accompanied by delusions or hallucinations, along with an alteration in the thought processes, termed a thought disorder.

### **8.5.1. PSYCHOSIS (SCHIZOPHRENIA) IN CHILDREN**

Schizophrenia and other psychotic disorders are medical illnesses that result in strange or bizarre thinking, perceptions (sight, sound), behaviors, and emotions. Psychosis is a brain-based condition that is made better or worse by environmental factors - like drug use and stress. Children and youth who experience psychosis often say "something is not quite right" or can't tell if something is real or not real. It is an uncommon psychiatric illness in young children and is hard to recognize in its early phases.

Childhood-onset - Most children with schizophrenia show delays in language and other functions long before their psychotic symptoms (hallucinations, delusions, and disordered thinking) appear. In the first years of life, about 30% of these children have transient symptoms of pervasive developmental disorder, such as rocking, posturing, and arm flapping. Childhood-onset of psychosis may present with poor motor development, such as unusual crawling, and children may be more anxious and disruptive compared to those with later onset.

It is especially important to pay attention to sudden changes in thoughts and behaviors. Keep in mind that the onset of several of the symptoms below, and not just any one change, indicates a problem that should be assessed. The symptoms below should not be due to recent substance use or another medical condition.

#### **Early Warning Signs**

- ❖ Feeling like their brain is not working
- ❖ Feeling like their mind or eyes are playing tricks on them
- ❖ Seeing things and hearing voices that are not real
- ❖ Hearing knocking, tapping, clicking or their named being called
- ❖ Confused thoughts
- ❖ Vivid and bizarre thoughts and ideas
- ❖ Sudden and bizarre changes in emotions
- ❖ Peculiar behavior that seem unusual
- ❖ Increased sensitivity to light, sounds, smells or touch
- ❖ Concept that people are "out to get them"
- ❖ Fearfulness or suspicion that isn't warranted



- ❖ Withdrawal from others
- ❖ Severe problems in making and keeping friends
- ❖ Difficulty speaking, writing, focusing or managing simple tasks

### **Treatment**

Early diagnosis and medical treatment are important. It is especially important that children and youth with the problems and symptoms listed above receive a complete evaluation. These children may need individual treatment plans involving other professionals. A combination of medication and individual therapy, family therapy, and specialized programs (wraparound services, early psychosis treatment) is often necessary. Changes in life style (keeping stress low, taking fish oils), additional supports (therapy and school support) and psychiatric medication can be helpful for many of the symptoms and problems identified.

Making the choice about whether or not to use medications can be difficult. Second-generation (atypical) antipsychotic drugs are usually tried first because they may cause fewer side effects than standard drugs. Serious side effects of second-generation antipsychotic drugs can include weight gain, diabetes and high cholesterol. Currently, the Food and Drug Administration approves the use of two second-generation drugs in children ages 13-17.

Parents need to ask their family physician or pediatrician to refer them to a child and adolescent psychiatrist who is specifically trained and skilled at evaluating, diagnosing, and treating children with schizophrenia.

### **8.5.2. AUTISM**

**Autism** spectrum disorder appears in infancy and early **childhood**, causing delays in many basic areas of development, such as learning to talk, play, and interact with others. Some **children with autism** have only mild impairments, while others have more obstacles to overcome.

#### **Causes of Autism Symptoms and Signs**

- ❖ Abnormal Body Posturing or Facial Expressions.
- ❖ Abnormal Tone of Voice.
- ❖ Avoidance of Eye Contact or Poor Eye Contact.
- ❖ Behavioral Disturbances.
- ❖ Deficits in Language Comprehension.
- ❖ Delay in Learning to Speak.
- ❖ Flat or Monotonous Speech.
- ❖ Inappropriate Social Interaction.

## Causes of Autism

Exactly why autism happens isn't clear. It could stem from problems in parts of your brain that interpret sensory input and process language.

- ❖ Autism is four times more common in boys than in girls. It can happen in people of any race, ethnicity, or social background. Family income, lifestyle, or educational level doesn't affect a child's risk of autism.
- ❖ Autism runs in families, so certain combinations of genes may increase a child's risk.
- ❖ A child with an older parent has a higher risk of autism.
- ❖ If a pregnant woman is exposed to certain drugs or chemicals, like alcohol or anti-seizure medications, her child is more likely to be autistic. Other risk factors include maternal metabolic conditions such as diabetes and obesity.

## Treatment of Autism

There's no cure for autism. But early treatment can make a big difference in development for a child with autism. If you think your child shows symptoms of ASD, tell your doctor as soon as possible.

What works for one person might not work for another. Your doctor should tailor treatment for you or your child. The two main types of treatments are:

- ❖ Behavioral and communication therapy to help with structure and organization. Applied Behavior Analysis (ABA) is one of these treatments; it promotes positive behavior and discourages negative behavior. Occupational therapy can help with life skills like dressing, eating, and relating to people. Sensory integration therapy might help someone who has problems with being touched or with sights or sounds. Speech therapy improves communication skills.
- ❖ Medications to help with symptoms of ASD, like attention problems, hyperactivity, or anxiety.

## Check your progress III

Note: Use the space provided for your answer

1. Mention any four early symptoms of schizophrenia

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## 2. What is autism?

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### **8.6 SUMMARY**

Suicide is a desperate attempt to escape suffering that has become unbearable. Blinded by feelings of self-loathing, hopelessness, and isolation, a suicidal person can't see any way of finding relief except through death. But despite their desire for the pain to stop, most suicidal people are deeply conflicted about ending their own lives. They wish there was an alternative to suicide, but they just can't see one. Mental illness, alcoholism or drug abuse previous suicide attempts, family history of suicide, or history of trauma or abuse Terminal illness or chronic pain, a recent loss or stressful life event Social isolation and loneliness.

Those contemplating suicide often don't believe they can be helped, so you may have to be more proactive at offering assistance. Saying, "Call me if you need anything" is too vague. Don't wait for the person to call you or even to return your calls. Drop by, call again, and invite the person out. Encourage positive lifestyle changes, such as a healthy diet, plenty of sleep, and getting out in the sun or into nature for at least 30 minutes each day. Exercise is also extremely important as it releases endorphins, relieves stress, and promotes emotional well-being.

Childhood disorders, often labeled as developmental disorders or learning disorders, most often occur and are diagnosed when the child is of school-age. Although some adults may also relate to some of the symptoms of these disorders, typically the disorder's symptoms need to have first appeared at some point in the person's childhood. Proper intervention on time will help them to come out and function well in the day today activities.

### **KEY WORDS**

- ❖ Suicide
- ❖ Childhood disorders
- ❖ Behaviour
- ❖ Eating disorder
- ❖ Autism
- ❖ Schizophrenia

### **SELF-ASSESSMENT QUESTIONS AND EXERCISE**

1. What are the symptoms of suicide?
2. Enlist the emotional symptoms of behaviour disorder

3. Explain the types of eating disorder
4. What is binge eating disorder?
5. Highlights the treatment of eating disorders
6. Narrate the causes of encopresis
7. What are causes of sleeping disorder?
8. Enumerate the causes of speech disorder
9. What are the early warning symptoms of schizophrenia?
10. Bring out the causes of autism
11. Sketch out the treatment of autism

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## **UNIT IX**

Scholastic backwardness: symptoms, causes and management; attention deficit disorders

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### **Structure**

9.1 Aims and Objectives

9.2. Introduction

9.3 Scholastic Backwardness: Symptoms, Causes and Management

9.4. Attention Deficit Disorders

9.5 Summary

9.6 Further Readings and References

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### **9.1 AIMS AND OBJECTIVES**

- ❖ To know about the symptoms and treatment process of Scholastic Backwardness and Attention deficit disorders

### **9.2 INTRODUCTION**

Academic achievements are considered a benchmark of a child's intelligence. In today's competitive society, scholastic underachievement is a major concern among parents and teachers. Scholastic achievement assumes significance as it is a key factor for personal and professional growth in most cases. Scholastic Backwardness affects child's education, achievements, self-esteem, employment and marriage prospects. Childhood development occurs mainly in physical, emotional, social and academic domains, which are interrelated. A disturbance in any of the four areas may affect development in other areas. The determinants of SB or factors associated with SB are complex, multiple and range from neuro developmental disorders, psychological and behavioral disorders, physical illnesses, learning disorders and various social and environmental factors

### **9.3 SCHOLASTIC BACKWARDNESS**

Scholastic Backwardness is one of the commonest educational problems encountered in children, and consists of the fact that the child's performance at school falls below the expectations, i.e. according to the level of his intelligence.

## **Etiology**

Various constitutional and neurological disorders resulting in maturational lags in the sensory, motor, perceptual, and integrative mechanisms have been held responsible for the differences noted in auditory and visual discrimination, laterality, memory, thinking, the use of symbols and expressive language, which are all every essential for the learning processes.

- Learning Disabilities
- Emotional Disturbances
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Chronic Illness
- Mental Retardation

Many of these factors may also be overlapping and coexistent. Apart from these, developmental disabilities such as hearing impairment, visual impairment, language disorders and environmental affects also contribute to learning difficulties in children and challenge vulnerable children further.

## **Risk factors for scholastic backwardness**

- Hearing impairment
- Visual impairment
- Prematurity, low birth weight
- Medical factors
- Neurodevelopmental disorders
  - ❖ Specific learning disability
  - ❖ ADHD
  - ❖ Tourette syndrome
  - ❖ Slow Learners

## **Causes of Scholastic Backwardness**

The reasons for scholastic backwardness can be broadly categorized into causes in the child, or in the environment or both.

### **1. Causes in the Child (Internal Factors)**

a) Low intelligence - A Child with mild delay in milestones of development (either borderline intelligence – IQ: 70 – 85% or mild mental retardation – IQ: 50 -70%).

b) Learning Disability - About 10% of school going children have learning disorders. Their intelligence will be average or above average. They have problems only in reading, writing, spelling or arithmetic skills. Learning disorders are of four types – Reading disorder (Dyslexia), Disorder of written expression (Dysgraphia), Mathematics disorder (Dyscalculia) and Mixed disorder of scholastic skills.

c) Physical Problems – Chronic illnesses, problems in vision or hearing.



- d) Attention Deficit Hyperactivity Disorder (ADHD) – Because of the inability to sustain attention, children with ADHD cannot concentrate in studies.
- e) Emotional Problems - Anxiety or low mood due to any stress will lead to deterioration in academic performance.
- f) Lack of Motivation and Inadequate Time Management

## **2. Causes in the Environment (External Factors)**

- a) Discordant environment at school (conflict with teachers or peer group).
- b) Poor discipline at home (marital discord among parents, alcoholism / drug abuse in family members)
- c) Sibling rivalry
- d) Overambitious attitude of parents

## **Evaluation of Scholastic Backwardness**

1. Look for external factors
2. Rule out physical problem
3. Behavioral analysis
4. Assessment of intelligence
5. Assessment of scholastic skills
6. Psychological evaluation

## **Remedial Strategies for Scholastic Backwardness**

One of the pertinent characters of scholastic backwardness is that they learn slowly and unevenly. They are unable to cope satisfactorily with the usual educational standards of the ordinary school. However with proper guidance and care they are capable of being educated. One important thing about the scholastic backwardness is that most of the backward children are not identified till they attend school. Conscious efforts are being made to help the child after being identified. The psychologists specify that the remedy for backwardness lies mainly in their nature and extent of the cause which produces it. Each case is unique and requires specific remedial measures. Some important remedial strategies are given below.

### **1. Elastic curriculum:**

Educationists may take care in preparing the curriculum for scholastically backward children. It should be as flexible as possible to suit the requirements of the individual students. They

are interested in concrete perceptual experiences. So attention must be given to the framing of curriculum.

2. **Remedial instruction:**

Generally, teaching experts provide remedial instruction for backward child or slow learners. First the deficiencies are need to be determined and confirmed by the experts and give such children some diagnostic tests. The following points are taken in to consideration for smooth working of a diagnostic programme.

- a. Gradation of teaching materials may be carefully done taking the capacity and requirements of children in to consideration.
- b. Short frequent lessons should be introduced instead of long lessons.
- c. Experts should be aware of the fact that a friendly approach in remedial teaching is conductive.
- d. To generate interest, social skills and confidence, priority should be given to art, music and drama.
- e. Practice, drill and review should be given importance. Repetition and direction should also be emphasized

3. **Provide healthy environment:**

Emphasize should be given in providing healthy environment to backward children. The school atmosphere of children should be healthy and reasonably free. Sometime poor environmental factors contribute a lot towards backwardness. So, they should be removed as early as possible.

4. **Periodical medical check-up:**

Physical anomalies are important contributory factors for backwardness in education. Poor health and other malfunctions also have similar effects. So, special medical check-up should be arranged.

5. **Give Motivation:**

Scholastically backward child lacks the experience of reinforcement. Fear of failure and disinterest are pertinent in their daily school activities. Adequate and appropriate measures should be taken to improve their academic status. When a slight improvement is noticed some motivational techniques may be used to stimulate. A teaching expert should try to instill confidence in children.

6. **Give Individual attention:**

The teaching expert may place emphasize on recognition of individual differences among students. They also should respect the individuality of the child through the helpful environment. Complete freedom should be given to children to budget their own time to bring out their assignment forte.

7. **Adopt special methods of teaching:**

Backward children require simple and short methods of instruction based on concrete experiences. Verbal instruction should be limited.

8. **Home visits by the Teachers:**

To make family environments sophisticated and healthy, the teachers should take interest in visiting the homes of the parents and advise them accordingly. An unfavorable home environment and autocratic homes are important factors for scholastic backwardness. Teacher should suggest some remedial measures to parents to improve the home environment.

9. **Maintain progress records:**

Assessment of children's progress is essential for recommending their entry into a higher group. There should be regular evaluation of the progress of the child. The records of evaluation should be properly preserved. These records are essential for individualized treatment.

## **9.4. ATTENTION DEFICIT DISORDER**

Attention deficit disorder (ADD) is a neurological disorder that causes a range of behavior problems such as difficulty attending to instruction, focusing on schoolwork, keeping up with assignments, following instructions, completing tasks and social interaction.

### **Common Characteristics**

- ✚ Children with ADD without the hyperactivity component may appear to be bored or disinterested in classroom activities.
- ✚ They may be prone to daydreaming or forgetfulness, work at a slow pace and turn in incomplete work.
- ✚ Their assignment may look disorganized as well as their desks and locker spaces.
- ✚ They may lose materials at school and at home or misplace schoolwork and fail to turn in assignments.
- ✚ This can frustrate teachers, parents and result in the child earning poor marks in class. Behavior intervention may counter the child's forgetfulness.

### **Diagnosis**

If you suspect your child has ADD with or without hyperactivity, talk to your child's school counselor, teacher or physician about appropriate treatment. If you have any concern, begin these discussions today. Pediatrician may recommend seeing a child psychologist who can do formal testing on your child to both see if she fits the criteria for ADD, and where she happens to be on the spectrum. Not only can this testing help differentiate ADD from other

issues which may be causing difficulty with school work, but can be used to follow a child's response to interventions over time.

### **Treatment**

ADD is sometimes treated with stimulant medications such as Ritalin. In some cases, stimulant medications can help students with ADD stay on-task and focused. However, some stimulant medications have been associated with serious side effects. As a result, many parents hesitate to use Ritalin, Adderall or other medications to treat ADD.

Whether or not parents choose to medicate their children, most physicians and child psychologists suggest that a behavior intervention plan should be developed to help teach kids adaptive behavior skills and reduce off-task and inattentive behaviors.

This may be even more helpful than drug use, especially because some students diagnosed with ADD or ADHD actually don't have these conditions but behave as if they do due to personal or family problems. Behavior intervention plans can help students with problem behaviors, whether they actually have ADD or exhibit ADD-like behaviors.

Certainly, there is an advantage of behavior intervention plans long term, as these adaptations may result in permanent improvement in concentration skills which medication cannot provide.

### **Check your progress I**

Note: Use the space provided for your answer

1. What is scholastic backwardness?

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2. What is major classification of scholastic backwardness?

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3. What is dyslexia?

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4. What is dyscalculia?

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5. What is ADD?

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### **9.5 SUMMARY**

Scholastic backwardness is a universal problem which affects academic and social progress of students. Therefore, it becomes imperative for caregivers, teachers, psychologists, and pediatricians to identify this condition early and take effective steps to help such students. The causes are complex and multifactorial. Combination of family/social factors, personal factors, neurodevelopmental factors and school related factors are responsible. It is possible to identify high risk children using these factors and intervene early. This has implications for teachers and parents involvement to help in student achievement. Since, psychological disturbances play a significant role in SB, counseling for the students, teachers and parents individually can help in appropriate academic achievement.

### **KEY WORDS**

- ❖ Scholastic backwardness
- ❖ Attention deficit disorder
- ❖ Specific learning disability
- ❖ ADHD
- ❖ Tourette syndrome
- ❖ Slow Learners

### **SELF-ASSESSMENT QUESTIONS AND EXERCISE**

1. What are the risk factors of scholastic backwardness?
2. What are the causes of scholastic backwardness?
3. Discuss the ways to prevent scholastic backwardness?
4. What are the common characteristics of ADD?
5. Explain the treatment process of ADD

## 9.6 FURTHER READINGS

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## **UNIT X**

Therapeutic Intervention in Psychiatric Illness: psycho education, cognitive therapy, group psychotherapy, family therapy, marital therapy: scope and types

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### **Structure**

- 10.1 Aims and Objectives
  - 10.2 Introduction
  - 10.3 Psycho-Education
  - 10.4. Cognitive Therapy
  - 10.5 Group Psychotherapy
  - 10.6. Family Therapy
  - 10.7. Marital Therapy
  - 10.8 Summary
  - 10.9 Further readings and References
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### **10.1 AIMS AND OBJECTIVES**

- ❖ To study and understand various therapeutic intervention for psychiatric illness

### **10.2 INTRODUCTION**

Interventions can be applied to individuals and used in group settings, such as rehabilitation centers and psychiatric treatment institutions. Intervention is a tool that may be used with people who have dementia, borderline-personality disorder, emotional problems, addictions, eating disorders, dangerous sexual habits, or difficulty adhering to a medication schedule or other type of treatment. An intervention effort is often made to try to prevent people with known problems who cannot or will not help themselves from relapsing into undesirable behavior. Crisis intervention is used when someone is experiencing an immediate crisis, such as a suicide threat or attempt.

Therapeutic Intervention. A therapeutic intervention is an effort made by individuals or groups to improve the well-being of someone else who either is in need of help but refusing it or is otherwise unable to initiate or accept help.

It is one of a number of therapies regularly used to treat a variety of conditions such as depression, persistent self-harm and personality disorder. Psychosocial interventions for psychoses involve a number of interventions including working with drug treatment, therapies and rehabilitation strategies.

### **10.3 PSYCHO-EDUCATION**

Psych education refers to the process of providing education and information to those seeking or receiving mental health services, such as people diagnosed with mental health conditions (or life-threatening/terminal illnesses) and their family members. Though the term has been in use for most of the 20th century, it did not gain traction until movements addressing the stigmatization of mental health concerns and working to increase mental health awareness began in earnest.

#### **The Purpose of Psycho education**

Psychoeducation, the goal of which is to help people better understand (and become accustomed to living with) mental health conditions, is considered to be an essential aspect of all therapy programs. It is generally known that those who have a thorough understanding of the challenges they are facing as well as knowledge of personal coping ability, internal and external resources, and their own areas of strength are often better able to address difficulties, feel more in control of the condition(s), and have a greater internal capacity to work toward mental and emotional well-being.

Many individuals who have a mental health condition know little or nothing about the condition they have been diagnosed with, what they might expect from therapy, or the positive and negative effects of any medications they may be prescribed. Literature on these topics given to them by medical professionals may be confusing or otherwise difficult to comprehend and thus of little help.

Offered in both individual and group formats, psycho education can benefit the individual diagnosed, parents and other family members, and caregivers and friends. It is not an approach to treatment in itself but represents an important early step in treatment, as it offers those individuals involved in a person's care information on both how to offer support and how to maintain their own emotional health and overall well-being and provides them with the opportunity to develop a thorough understanding of the mental health concern(s) affecting their loved one. Participating in psychoeducation may have a positive impact on quality of life.



## **Psycho-education Process**

Psychoeducation may be general or highly specified and can be provided in a number of ways, though it is broadly steered by four main goals: transfer of information, medication and treatment support, training and support in self-help and self-care, and the provision of a safe place to vent emotional frustrations.

All of the following may constitute psycho-education:

- ❖ A therapist explaining to a person in therapy the ways a mental health condition might impact function
- ❖ A psychiatrist describing how a prescribed medication can counteract symptoms of a mental health condition
- ❖ A psychiatric hospital providing support and education to family members of those receiving treatment
- ❖ Formal classes designed to educate the population about both specific mental health conditions and mental health in general
- ❖ Classroom behavior management assistance for students diagnosed with behavioral concerns
- ❖ Self-help and support groups designed to encourage those diagnosed with mental health concerns to share strategies and information with one another.

Some people might receive psychoeducation through online or electronic formats such as DVDs, CDs, or other audiovisual materials, though others may choose to participate in sessions with a mental health professional.

## **Structure of Psycho Education**

Although psychoeducation can involve indirect “free-flowing” discussion, a certain amount of structure needs to be involved in order to make sure the program stays on track. Each psychoeducation session will have specific goals and content. The structure of psychoeducation is determined by whether the program involves the individual with the disorder or only involves the family or peers.

The medical aspects of the condition by identifying and defining the diagnosis, the prognosis, the biology and psychology. How the condition may affect your future in terms of physical limits, how this will affect your mind set and how to think positively.

The stigma attached to your diagnosis, how this is affected by the media and what can be done to combat and manage the stigma. The stigma associated with many physiological and psychological conditions can impact significantly on your self-esteem and self-worth. Firstly you must alter the stigma that you associate with you illness then you can work to help other people understand your condition through education.

Healthy lifestyle behaviours that will help to manage the condition.

Stress management- why do need to manage our stress levels and how does high stress lead to the worsening of symptoms?

Understanding self-esteem, self-image, self-efficacy

Treatment- For many disorders adherence to medication is a very important factor in maintaining and managing the condition. The information will answer questions about the medication that includes: What it does? How does it work? What are the benefits? What are the side effects or adverse effects? When and how often it must be taken? Why it is important to it at certain intervals? What happens when the medication is not taken? And so on. Another important aspect of treatment are the types of psychotherapies that are available and suitable to help the patient deal with the psychological effects of the condition and what is the cost, the effectiveness and the cost effectiveness of these psychotherapies?

### **Check your progress I**

Note: Use the space provided for your answer

1. What is psycho-education?

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2. What are the purpose of psycho-education?

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## **10.4. COGNITIVE THERAPY**

Cognitive therapy (CT) is a type of psychotherapy developed by American psychiatrist Aaron T. Beck. CT is one of the therapeutic approaches within the larger group of cognitive behavioral therapies (CBT) and was first expounded by Beck in the 1960s. Cognitive therapy is based on the cognitive model, which states that thoughts, feelings and behavior are all connected, and that individuals can move toward overcoming difficulties and meeting their goals by identifying and changing unhelpful or inaccurate thinking, problematic behavior, and distressing emotional responses. This involves the individual working collaboratively with the therapist to develop skills for testing and modifying beliefs, identifying distorted thinking, relating to others in different ways, and changing behaviors. A tailored cognitive case conceptualization is developed by the cognitive therapist as a roadmap to understand the individual's internal reality, select appropriate interventions and identify areas of distress.

## **Purpose**

Psychologist Aaron Beck developed the cognitive therapy concept in the 1960s. The treatment is based on the principle that maladaptive behavior (ineffective, self-defeating behavior) is triggered by inappropriate or irrational thinking patterns, called automatic thoughts. Instead of reacting to the reality of a situation, an individual automatically reacts to his or her own distorted viewpoint of the situation. Cognitive therapy focuses on changing these thought patterns (also known as cognitive distortions), by examining the rationality and validity of the assumptions behind them. This process is termed cognitive restructuring.

Cognitive therapy is a treatment option for a number of mental disorders, including agoraphobia, Alzheimer's disease, anxiety or panic disorder, attention deficit-hyperactivity disorder (ADHD), eating disorders, mood disorders, obsessive-compulsive disorder (OCD), personality disorders, post-traumatic stress disorder (PTSD), psychotic disorders, schizophrenia, social phobia, and substance abuse disorders. It can be useful in helping individuals with anger management problems, and has been reported to be effective in treating insomnia. It is also frequently prescribed as an adjunct, or complementary, therapy for patients suffering from back pain, cancer, rheumatoid arthritis, and other chronic pain conditions.

Negative and unrealistic thoughts can cause us distress and result in problems. When a person suffers with psychological distress, the way in which they interpret situations becomes skewed, which in turn has a negative impact on the actions they take. CBT aims to help people become aware of when they make negative interpretations, and of behavioral patterns which reinforce the distorted thinking. Cognitive therapy helps people to develop alternative ways of thinking and behaving which aims to reduce their psychological distress.

Cognitive behavioral therapy is, in fact, an umbrella term for many different therapies that share some common elements. Two of the earliest forms of Cognitive behavioral Therapy were Rational Emotive Behavior Therapy (REBT), developed by Albert Ellis in the 1950s, and Cognitive Therapy, developed by Aaron T. Beck in the 1960s.

## **CBT Assumptions:**

- The cognitive approach believes that mental illness stems from faulty cognitions about others, our world and us. This faulty thinking may be through cognitive deficiencies (lack of planning) or cognitive distortions (processing information inaccurately).
- These cognitions cause distortions in the way we see things; Ellis suggested it is through irrational thinking, while Beck proposed the cognitive triad.
- We interact with the world through our mental representation of it. If our mental representations are inaccurate or our ways of reasoning are inadequate then our emotions and behavior may become disordered.

## TREATMENT TECHNIQUES

Cognitive therapy is usually administered in an out-patient setting (clinic or doctor's office) by a therapist trained or certified in cognitive therapy techniques. Therapy may be in either individual or group sessions, and the course of treatment is short compared to traditional **psychotherapy** (often 12 sessions or less). Therapists are psychologists (Ph.D., Psy.D. Ed.D., or M.A. degree), clinical social workers (M.S.W., D.S.W., or L.S.W. degree), counselors (M.A. or M.S. degree), or psychiatrists (M.D. trained in psychiatry).

Therapists use several different techniques in the course of cognitive therapy to help patients examine thoughts and behaviors. These include:

- *Validity testing.* The therapist asks the patient to defend his or her thoughts and beliefs. If the patient cannot produce objective evidence supporting his or her assumptions, the invalidity, or faulty nature, is exposed.
- *Cognitive rehearsal.* The patient is asked to imagine a difficult situation he or she has encountered in the past, and then works with the therapist to practice how to successfully cope with the problem. When the patient is confronted with a similar situation again, the rehearsed behavior will be drawn on to deal with it.
- *Guided discovery.* The therapist asks the patient a series of questions designed to guide the patient towards the discovery of his or her cognitive distortions.
- *Journaling.* Patients keep a detailed written diary of situations that arise in everyday life, the thoughts and emotions surrounding them, and the behavior that accompany them. The therapist and patient then review the journal together to discover maladaptive thought patterns and how these thoughts impact behavior.
- *Homework.* In order to encourage self-discovery and reinforce insights made in therapy, the therapist may ask the patient to do homework assignments. These may include note-taking during the session, journaling (see above), review of an audiotape of the patient session, or reading books or articles appropriate to the therapy. They may also be more behaviorally focused, applying a newly learned strategy or coping mechanism to a situation, and then recording the results for the next therapy session.
- *Modeling.* Role-playing exercises allow the therapist to act out appropriate reactions to different situations. The patient can then model this behavior.

Cognitive-behavioral therapy (CBT) integrates features of behavioral modification into the traditional cognitive restructuring approach. In cognitive-behavioral therapy, the therapist works with the patient to identify the thoughts that are causing distress, and employs behavioral therapy techniques to alter the resulting behavior. Patients may have certain fundamental core beliefs, known as schemas, which are flawed, and are having a negative impact on the patient's behavior and functioning. For example, a patient suffering from **depression** may develop a social phobia because he/she is convinced he/she is uninteresting and impossible to love.

A cognitive-behavioral therapist would test this assumption by asking the patient to name family and friends that care for him/her and enjoy his/her company. By showing the patient that others value him/her, the therapist exposes the irrationality of the patient's assumption and also provides a new model of thought for the patient to change his/her previous behavior pattern (i.e., I am an interesting and likeable person, therefore I should not have any problem making new social acquaintances). Additional behavioral techniques such as **conditioning** (the use of positive and/or negative reinforcements to encourage desired behavior) and systematic **desensitization** (gradual exposure to anxiety-producing situations in order to extinguish the **fear** response) may then be used to gradually reintroduce the patient to social situations.

### **Strengths of CBT**

1. Model has great appeal because it focuses on human thought. Human cognitive abilities has been responsible for our many accomplishments so may also be responsible for our problems.
2. Cognitive theories lend themselves to testing. When experimental subjects are manipulated into adopting unpleasant assumptions or thought they became more anxious and depressed (Rimm & Litvak, 1969).
3. Many people with psychological disorders, particularly depressive , anxiety , and sexual disorders have been found to display maladaptive assumptions and thoughts (Beck et al., 1983).
4. Cognitive therapy has been very effective for treating depression (Hollon & Beck, 1994), and moderately effective for anxiety problems (Beck, 1993).

### **Limitations of CBT**

1. The precise role of cognitive processes is yet to be determined. It is not clear whether faulty cognitions are a cause of the psychopathology or a consequence of it.  
Lewinsohn (1981) studied a group of participants before any of them became depressed, and found that those who later became depressed were no more likely to have negative thoughts than those who did not develop depression. This suggests that hopeless and negative thinking may be the result of depression, rather than the cause of it.
2. The cognitive model is narrow in scope - thinking is just one part of human functioning, broader issues need to be addressed.
3. Ethical issues: RET is a directive therapy aimed at changing cognitions sometimes quite forcefully. For some, this may be considered an unethical approach.

## Check your progress II

Note: Use the space provided for your answer

1. What is CT?

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2. What is modeling in CT?

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## 10. 5. GROUP PSYCHOTHERAPY

Group therapy is a form of psychotherapy that utilizes personal interaction with people who have shared experiences to help each individual process, cope, and grow. There are many different applications for group therapy, including drug rehabilitation, grief counseling, and post-traumatic stress disorder (PTSD) support, to name a few.

Group therapy is defined as a form of psychotherapy in which a group of patients meets to discuss a common problem. Group counseling sessions take place under the guidance and supervision of a licensed mental health counselor or psychologist. A group therapy session is not a free-for-all conversation; rather, the leader gives the group a set of rules designed to help facilitate conversation, connection, and growth among the individuals assembled.

The size of therapy groups may vary, and the number of participants is not a critical factor when setting up a group therapeutic session. More important is that the individuals who are assembled have similar experiences. The process of sharing personal information with the group and learning from others' stories is the foundation of a successful group therapy session.

Interaction based on similar experiences is just one way in which group therapy differs from couples therapy. Although it is possible to schedule a therapeutic session with a small group of people with whom you have existing relationships, group therapy works best by helping individuals to reach outside of their existing social circles to connect with strangers dealing with similar issues.

## **The Role of Group Therapy**

Although most therapeutic sessions aim to help individuals gain a sense of ease, autonomy, and control over their lives, the goal of group therapy is slightly different from the goal of individual therapy. Group therapy tends to be most beneficial for those who are working through issues that affect many people. Most frequently, group therapy is recommended as part of a larger therapeutic strategy to help encourage sharing, bonding, and coping.

There are two primary types of goals in group therapy:

- Process goals
- Outcome goals

Process goals are those that relate to the process of understanding personal concerns and relating to other individuals during a group session. This is often thought of as the healing process. Outcome goals are the behavioral changes that individuals seek to achieve by participating in group therapy.

The fundamental goal of group therapy is to initiate a sense of belonging or relatability through understanding, which is achieved by sharing common experiences. For this reason, group therapy is most effective when utilized to address a specific concern common to all members of the group. This universal reliability is essential to the group's success.

## **The Principles of Group Therapy**

In *The Theory and Practice of Group Psychotherapy*, Irvin D. Yalom outlines the key therapeutic principles that have been derived from self-reports from individuals who have been involved in the group therapy process:

1. The instillation of hope: The group contains members at different stages of the treatment process. Seeing people who are coping or recovering gives hope to those at the beginning of the process.
2. Universality: Being part of a group of people who have the same experiences helps people see that what they are going through is universal and that they are not alone.
3. Imparting information: Group members can help each other by sharing information.
4. Altruism: Group members can share their strengths and help others in the group, which can boost self-esteem and confidence.
5. The corrective recapitulation of the primary family group: The therapy group is much like a family in some ways. Within the group, each member can explore how childhood experiences contributed to personality and behaviors. They can also learn to avoid behaviors that are destructive or unhelpful in real life.

6. Development of socialization techniques: The group setting is a great place to practice new behaviors. The setting is safe and supportive, allowing group members to experiment without the fear of failure.
7. Imitative behavior: Individuals can model the behavior of other members of the group or observe and imitate the behavior of the therapist.
8. Interpersonal learning: By interacting with other people and receiving feedback from the group and the therapist, members of the group can gain a greater understanding of themselves.
9. Group cohesiveness: Because the group is united in a common goal, members gain a sense of belonging and acceptance.
10. Catharsis: Sharing feelings and experiences with a group of people can help relieve pain, guilt, or stress.
11. Existential factors: While working within a group offers support and guidance, group therapy helps member realize that they are responsible for their own lives, actions, and choices.

### **Advantages of Group Therapy**

- Group therapy allows people to receive the support and encouragement of the other members of the group. People participating in the group can see that others are going through the same thing, which can help them feel less alone.
- Group members can serve as role models to other members of the group. By observing someone successfully coping with a problem, other members of the group can see that there is hope for recovery. As each person progresses, they can, in turn, serve as a role model and support figure for others. This can help foster feelings of success and accomplishment.
- Group therapy is often very affordable. Instead of focusing on just one client at a time, the therapist can devote his or her time to a much larger group of people.
- Group therapy offers a safe haven. The setting allows people to practice behaviors and actions within the safety and security of the group.
- By working in a group, the therapist can see first-hand how each person responds to other people and behaves in social situations. Using this information, the therapist can provide valuable feedback to each client.



### Check your progress III

Note: Use the space provided for your answer

1. What are the two primary type of group psychotherapy?

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2. What is universality in group psychotherapy?

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3. What is altruism in group psychotherapy?

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## 10.6. FAMILY THERAPY

### Definition

Family therapy is a type of psychotherapy that involves all members of a nuclear family or stepfamily and, in some cases, members of the extended family (e.g., grandparents). A therapist or team of therapists conducts multiple sessions to help families deal with important issues that may interfere with the functioning of the family and the home environment.

### Purpose

The goal of family therapy is to help family members improve communication, solve family problems, understand and handle special family situations (for example, death, serious physical or mental illness, or child and adolescent issues), and create a better functioning home environment. For families with one member who has a serious physical or mental illness, family therapy can educate families about the illness and work out problems associated with care of the family member. For children and adolescents, family therapy most often is used when the child or adolescent has a personality, anxiety, or mood disorder that impairs their family and social functioning, and when a stepfamily is formed or begins having difficulties adjusting to the new family life. Families with members from a mixture of racial, cultural, and religious backgrounds, as well as families made up of same-sex couples who are raising children, may also benefit from family therapy.

## **Goal of Family Therapy**

The goal of family therapy is to work together to heal any mental, emotional, or psychological problems tearing your family apart (Lee, 2010). What is the Goal of Family Therapy To guide a family towards a healthy life, family therapists aim to aid people in improving communication, solving family problems, understanding and handling family situations, and creating a better functioning home environment (Family Therapy, 2017A).

The goals of family therapy depend on the presenting problems of the clients

- A family member is suffering from schizophrenia or severe psychosis: The goal is to help other family members understand the disorder and adjust to the psychological changes that the patient may be undergoing;
- Problems arising from cross-generational boundaries, such as when parents share a home with grandparents, or children are being raised by grandparents: The goal is to improve communication and help the family members set healthy boundaries;
- Families deviating from social norms (unmarried parents, gay couples raising children, etc.): The goals here are not always to address any specific internal problems, but the family members may need help coping with external factors like societal attitudes;
- Family members who come from mixed racial, cultural, or religious backgrounds: The goal is to help family members further their understanding of one another and develop healthy relationships;
- One member is being scapegoated or having their treatment in individual therapy undermined: When one family member is struggling with feeling like the outcast or receives limited support from other family members, the goal is to facilitate increased empathy and understanding for the individual within their family and provide support for them to continue their treatment;
- The patient's problems seem inextricably tied to problems with other family members: In cases where the problem or problems are deeply rooted in problems with other family members, the goal is to address each of the contributing issues and solve or mitigate the effects of this pattern of problems;
- A blended family (i.e., step-family): Blended families can suffer from problems unique to their situations. In blended families, the goal of family therapy is to enhance understanding and facilitate healthy interactions between family members (Family Therapy, 2017B).

## **Common reasons for seeking family therapy include:**

- When a child is having a problem such as with school, substance abuse, or disordered eating
- A major trauma or change that impacts the entire family (i.e. relocation to a new house, natural disaster, incarceration of a family member)

- Unexpected or traumatic loss of a family member
- Adjustment to a new family member in the home (i.e. birth of a sibling, adoption, foster children, a grandparent entering the home)
- Domestic violence
- Divorce
- Parent Conflict

**Benefits of Family Therapy**

This more holistic approach to treating problems within a family has proven to be extremely effective in many cases. In family therapy, families can work on their problems with the guidance of a mental health professional in a safe and controlled environment.

The benefits of family therapy include:

- ❖ A better understanding of healthy boundaries and family patterns and dynamics;
- ❖ Enhanced communication;
- ❖ Improved problem solving;
- ❖ Deeper empathy;
- ❖ Reduced conflict and better anger management skills

**Check your progress IV**

Note: Use the space provided for your answer

1. Define Family therapy?

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2. What is the purpose of family therapy?

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**10.7. MARRIAGE THERAPY**

In recent years, there have been changes about the notions of family and family life. In many developed as well as developing countries', for example, approximately over 40 per cent of

new marriages end in divorce. Many people choose not to marry and there are increasing variations, such as single-parent families and homosexual families. In addition, there is greater diversity in people's expectations such that men no longer are expected to be the sole or main breadwinners and there are expectations about greater sharing of domestic roles, such as childcare. Arguably, some of these changes are less extensive than might be assumed. For example women, even if they work outside the home, tend to take on the bulk of domestic duties as well.

Generally speaking the marriage/couples therapy is a help for the partners remaining in a difficult, conflicting and critical relation preventing from obtaining closer intimacy and greater satisfaction in being together. So, instead of proposing a married couple in the middle of a divorce a marriage therapy, the therapist should undertake a divorce mediation suggesting rather the new organisation of life than staying in a realm of feelings.

The main objectives of marital/couples therapy

- ❖ a support of marriage/couple in identifying sources of conflict;
- ❖ a help to each partner in determining their own participation in the conflict;
- ❖ a help in realisation of the mutual expectations;
- ❖ a help in defining the rules of functioning of a relationship, fulfilling roles, defining the limits of internal boundaries (individual) and external boundaries (separating the relationship from the rest of the world);
- ❖ an improvement in mutual verbal communication (to avoid further misunderstandings) and nonverbal communication (to make it easier and more clearly to express feelings);
- ❖ an assistance in constructive conflict resolution;
- ❖ a help in deciding whether to continue the relationship or to part (note: the responsibility for this decision lies exclusively within the spouses/partners).

**The key features of family therapy are as follows:**

- Family therapy is a branch of psychotherapy that works with families and couples in intimate relationships
- The main feature of family therapy is treatment of more than one family member in the same therapeutic session;
- Family therapy is a form of psychotherapy that involves all the members of a nuclear or extended family;
- Marriage and family counselling or therapy is counselling or therapy that focuses on the well-being of primary relationships and systems;
- In family therapy, the family system as a whole - not just one family member identified as having the "problem" - is treated;

- Family therapy deals with problems involving family structure and family interaction patterns;
- This approach regards the family, as a whole, as the unit of treatment, and emphasizes such factors as relationships and communication patterns rather than traits or symptoms in individual members; and
- Family therapy is becoming an increasingly common form of treatment as changes in society are reflected in family structures. It has led to two further developments that are couples therapy, which treats relationship problems between marriage partners or gay couples; and the extension of family therapy to religious communities or other groups that resemble families.

### **Principles of effective couple's therapy**

1. Changes the views of the relationship. Throughout the therapeutic process, the therapist attempts to help both partners see the relationship in a more objective manner. They learn to stop the "blame game" and instead look at what happens to them in a process involving each partner. They also can benefit from seeing that their relationship takes place in a certain context.
2. Modifies dysfunctional behavior. Effective couples therapists attempt to change the way that the partners actually behave with each other. This means that in addition to helping them improve their interactions, therapists also need to ensure that their clients are not engaging in actions that can cause physical, psychological, or economic harm.
3. Decreases emotional avoidance. Couples who avoid expressing their private feelings put themselves at greater risk of becoming emotionally distant and growing apart. Effective couple therapists help their clients bring out the emotions and thoughts that they fear expressing to the other person. Attachment-based couple therapy allows the partners to feel less afraid of expressing their needs for closeness. According to this view, some partners who failed to develop "secure" emotional attachments in childhood have unmet needs that they carry over into their adult relationships.
4. Improves communication. Being able to communicate is one of the "three C's" of intimacy. All effective couple therapies focus on helping the partners to communicate more effectively. The therapist may also provide the couple with didactic instruction to give them the basis for knowing what types of communication are effective and what types will only cause more conflict. They can learn how to listen more actively and empathically, for example.
5. Promotes strengths. Effective couple therapists point out the strengths in the relationship and build resilience particularly as therapy nears a close. Because so much of couple therapy involves focusing on problem areas, it's easy to lose sight of the other areas in which couples function effectively. The point of promoting strength is to help the couple derive more enjoyment out of their relationship.

## Check your progress V

Note: Use the space provided for your answer

1. What is the aim of marital therapy?

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2. What is decreased emotional avoidance?

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## 10.8 SUMMARY

It is one of a number of therapies regularly used to treat a variety of conditions such as depression, persistent self-harm and personality disorder. Psychosocial interventions for psychoses involve a number of interventions including working with drug treatment, therapies and rehabilitation strategies. Psychoeducation refers to the process of providing education and information to those seeking or receiving mental health services, such as people diagnosed with mental health conditions (or life-threatening/terminal illnesses) and their family members. The sooner people seek mental health intervention, the less intense treatment they will have to endure. Many people hope their symptoms will just go away, but mental illness gets worse over time. Early intervention allows people to gain coping mechanisms while they are still capable of using them. This prevents the need for medication in some, and reduces the dosage and frequency needed for those who require medication regardless. It prevents people from turning to harmful and even deadly coping mechanisms such as substance abuse, self-harm, and even suicide.

## KEY WORDS

- ❖ Therapeutic intervention
- ❖ Psychiatric illness
- ❖ Psycho-education
- ❖ Altruism
- ❖ Marital therapy
- ❖ Cognitive process

- ❖ Universality
- ❖ Family therapy

## **SELF-ASSESSMENT QUESTIONS AND EXERCISE**

1. Enlist the purpose of psycho-education
2. Write on the process of the Psycho-education
3. Sketch out the structure of the psycho-education
4. What are the basic assumptions of CT?
5. Explain the treatment techniques of CT
6. Enumerate the principles of Group Therapy
7. What are the goals of family therapy?
8. What are the expected outcomes of the family therapy?
9. Give the objectives of marital therapy
10. Elaborate the principles of marital therapy

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## **UNIT XI**

Behavior therapy: principles and techniques, ECT, chemotherapy, psychosurgery and mega vitamin therapy; occupational therapy (purpose and concept)

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### **Structure**

- 11.1 Aims and Objectives
  - 11.2. Introduction
  - 11.3. Behaviour Therapy
  - 11.4. ECT
  - 11.5 Chemotherapy
  - 11.6 Psychosurgery
  - 11.7 Mega Vitamin Therapy
  - 11.8 Occupational Therapy
  - 11.9 Summary
  - 11.10 Further readings and References
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### **11.1 AIMS AND OBJECTIVES**

- ❖ To understand the techniques and process of behaviour therapy
- ❖ To study ECT
- ❖ To know about chemotherapy, psychosurgery and mega vitamin therapy; occupational therapy

### **11.2. INTRODUCTION**

Psychological treatment is sometimes called ‘psychotherapy’ or ‘talking therapy’. It involves talking about your thoughts with a professional to:

- better understand your own thinking and behaviour
- understand and resolve your problems
- recognize symptoms of mental illness in yourself
- reduce your symptoms
- change your behaviour
- Improve your quality of life.

Evidence shows that psychological treatments work well for emotional, mental and behavioural issues. Psychological treatments are useful for people of all ages, including children. They can help people from different cultural, social and language backgrounds. One can have psychological treatment in an individual session, as part of a group, or online.

### **11.3. BEHAVIORAL THERAPY**

Behavioral therapy is an umbrella term for types of therapy that treat mental health disorders. This form of therapy seeks to identify and help change potentially self-destructive or unhealthy behaviors. It functions on the idea that all behaviors are learned and that unhealthy behaviors can be changed. The focus of treatment is often on current problems and how to change them.

The behavioural approach to therapy assumes that behaviour that is associated with psychological problems develops through the same processes of learning that affects the development of other behaviours. Therefore, behaviorists see personality problems in the way that personality was developed. They do not look at behaviour disorders as something a person has but that it reflects how learning has influenced certain people to behave in a certain way in certain situations.

Behaviour therapy is based upon the principles of classical conditioning developed by Ivan Pavlov and operant conditioning developed by B.F. Skinner. Classical conditioning happens when a neutral stimulus comes right before another stimulus that triggers a reflexive response. The idea is that if the neutral stimulus and whatever other stimulus that triggers a response is paired together often enough that the neutral stimulus will produce the reflexive response. Operant conditioning has to do with rewards and punishments and how they can either strengthen or weaken certain behaviours.

#### **Assumptions of Behavioral therapy**

1. Based on principles & procedures of scientific method
  2. Deals with client's current problems (as opposed to analysis of historical determinants) & factors influencing them & factors that can be used to modify performance
  3. Clients expected to assume an active role by engaging specific actions to deal with their problems
  4. Emphasizes teaching clients skills of self-management, with expectation they're responsible for transferring what's learned in office to everyday lives
  5. Focus on assessing overt & covert behaviors directly, identifying problem, & evaluating change
- . Emphasizes a self-control approach in which clients learn self-management strategies

7. Interventions individually tailored to specific problems “What treatment, by whom, is the most effective for this individual with that specific problem & under which set of circumstances?”

8. Emphasis on practical application Interventions applied to ALL facets of daily life in which maladaptive behaviors are to be decreased & adaptive behaviors are to be increased 10. Therapists strive to develop culture-specific procedures & obtain clients’ adherence & cooperation.

### **Basic Behavioral Principles**

Behavior therapy involves the application of the principles of learning and behavior. Classical conditioning is used to explain the acquisition of abnormal behaviors through contingency learning; in PTSD, this might account for the pairing of certain sounds (loud bangs or breaking glass) with arousal and escape or avoidance behavior. Operant conditioning, with its principles of positive reinforcement, negative reinforcement, and punishment accounts for behavior through an analysis of the conditions or consequences that follow it. In PTSD, negative reinforcement might account for maintaining the core symptoms of avoidance, for example. Extinction occurs when a behavior ceases to be reinforced and may be helpful in eliminating particular behaviors by the withholding or preventing of reinforcement. The principles of discrimination, stimulus control, and generalization are important in understanding how particular stimuli elicit particular responses and how these same responses may be generalized across a wider range of stimulus situations or how a particular behavior might be brought adaptively under more appropriate stimulus control.

### **Behavior Therapy Techniques**

#### **1. Behavioral Homework Assignments**

With this technique, the therapist requests that you complete homework between therapy sessions. These assignments may consist of real-life behavioral experiments where you are asked to try new responses to situations discussed during your therapy sessions.

#### **2. Biofeedback**

This is a patient-guided treatment that instructs you to control pain, brainwaves, body temperature, muscle tension, and other bodily functions and processes by means of visualization, relaxation, and other practices. For some people, positive reinforcements are used as rewards for those who produce the correct biofeedback response during the treatment session. The name biofeedback refers to the biological signals that are sent back to you in order for you to develop new strategies for controlling them.

#### **3. Cognitive Behavioral Therapy (CBT)**

CBT assimilates features of behavior modification into the conventional cognitive restructuring approach. The therapist works alongside you to identify the thoughts that lead to

the destructive behavior. CBT helps some people who have fundamental core beliefs (called schemas), which are flawed and have a negative impact on functioning and behavior.

#### **4. Cognitive Rehearsal**

With this remedy for behavior, the therapist guides you through a step-by-step process where difficult situations are faced. To deal with these life occurrences, you must work on rehearsing the steps mentally. The goal is to prepare the patient for when these situations occur in real life.

#### **5. Conditioning**

With conditioning, the therapist uses specific reinforcements to encourage desired behavior. The gold star, or other reward, reinforces and increases the wanted behavior by associating it with something positive.

#### **6. Contingency Contracting**

Another therapy used by psychologists is contingency contracting, where the therapist you outline together a written or verbal contract of desired good behaviors. Sometimes the contract has positive reinforcements connected to the appropriate behaviors and negative ones associated with maladaptive actions.

#### **7. Extinction**

You can modify a behavior through ignoring the action. By ignoring the behavior you will often lower its tendency for appearing again. The therapist teaches you to ignore your behavior and not give reward or notice when it occurs.

#### **8. Flooding**

With flooding, you are exposed directly to the anxiety or stress-provoking situation that he fears most. This is done through mental visualization or real life contact. An effort is made to relinquish the fear response in the patient.

#### **9. Journal Therapy**

When the therapist used journal therapy, you are asked to keep a detailed record of daily feelings, thoughts, and actions when certain situations come forward. Journaling helps make you aware of your maladaptive thoughts and opens your eyes to their consequences on your behavior.

#### **10. Meditation**

Meditation, a form of stress reduction, improves behavior by altering brain chemistries. This technique is a toll for improving thinking and evaluating one's self. To reach your goals, you meditate. During meditation sessions, you recall stored memories from areas of the brain and used this information positively.

## **11. Modeling**

The modeling technique allows you to learn a new behavior through observation.

## **12. Progressive Relaxation**

With progressive relaxation, you completely relax all of the muscle groups of the body and use calm, even breathing to allow tension to escape. This activity is used by therapists for a relaxation exercise to relieve stress and anxiety, and as a means of preparing you for systematic desensitization.

## **13. Rehearsed Behavior**

During rehearsed behavior exercises, the therapist asks you to engage in role-playing actions where the therapist acts out appropriate responses or behaviors to a given situation.

## **14. Systematic Desensitization**

This therapy exposes you to a situation that you fear, either in a role-playing circumstance or in real life. The therapist employs relaxation techniques to help you cope with your reaction and eventually eliminate your stress and anxiety altogether. With repeated exposure and obtaining the desired response, you gradually become desensitized to the old, maladaptive response.

## **15. Validity Testing**

With validity testing, you are asked to check the validity of the automatic thoughts you encounter. The therapist will ask you to defend or produce evidence that a thought or belief is real or true. Once you are unable to verbalize the challenge, a damaged nature of that schema is revealed to you.

## **11.4. ELECTROCONVULSIVE THERAPY (ECT)**

Electroconvulsive therapy (ECT) is a procedure, done under general anesthesia, in which small electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental health conditions.

ECT often works when other treatments are unsuccessful and when the full course of treatment is completed, but it may not work for everyone.

Electroconvulsive therapy (ECT) can provide rapid, significant improvements in severe symptoms of several mental health conditions.

### **ECT is used to treat:**

Severe depression, particularly when accompanied by detachment from reality (psychosis), a desire to commit suicide or refusal to eat.

Treatment-resistant depression, a severe depression that doesn't improve with medications or other treatments.

Severe mania, a state of intense euphoria, agitation or hyperactivity that occurs as part of bipolar disorder. Other signs of mania include impaired decision-making, impulsive or risky behavior, substance abuse, and psychosis.

Catatonia, characterized by lack of movement, fast or strange movements, lack of speech, and other symptoms. It's associated with schizophrenia and certain other psychiatric disorders. In some cases, catatonia is caused by a medical illness.

Agitation and aggression in people with dementia, which can be difficult to treat and negatively affect quality of life.

### **ECT Performance**

Prior to ECT treatment, a patient is given a muscle relaxant and is put to sleep with a general anesthesia. Electrodes are placed on the patient's scalp and a finely controlled electric current is applied. This current causes a brief seizure in the brain.

Because the muscles are relaxed, the visible effects of the seizure will usually be limited to slight movement of the hands and feet. Patients are carefully monitored during the treatment. The patient awakens minutes later, does not remember the treatment or events surrounding it, and is often confused. The confusion typically lasts for only a short period of time.

ECT is usually given up to three times a week for a total of two to four weeks.

ECT can be beneficial and safe in the following situations (American Psychiatric Association)

- ✓ When a patient's depression is resistant to antidepressant therapy
- ✓ When other medical ailments prevent the use of antidepressant medication
- ✓ When the patient is in a catatonic stupor
- ✓ When the depression is accompanied by psychotic features
- ✓ When treating bipolar disorder, including both mania and depression
- ✓ When treating mania
- ✓ When treating patients who have a severe risk of suicide
- ✓ When treating patients who have had a previous response to ECT
- ✓ When treating patients with psychotic depression or psychotic mania
- ✓ When treating patients with major depression
- ✓ When treating schizophrenia

## **Risks of ECT**

Although ECT is generally safe, risks and side effects may include:

**Confusion.** Immediately after treatment, you may experience confusion, which can last from a few minutes to several hours. You may not know where you are or why you're there. Rarely, confusion may last several days or longer. Confusion is generally more noticeable in older adults.

**Memory loss.** Some people have trouble remembering events that occurred right before treatment or in the weeks or months before treatment or, rarely, from previous years. This condition is called retrograde amnesia. You may also have trouble recalling events that occurred during the weeks of your treatment. For most people, these memory problems usually improve within a couple of months after treatment ends.

**Physical side effects.** On the days of an ECT treatment, some people experience nausea, headache, jaw pain or muscle ache. These generally can be treated with medications.

**Medical complications.** As with any type of medical procedure, especially one that involves anesthesia, there are risks of medical complications. During ECT, heart rate and blood pressure increase, and in rare cases, that can lead to serious heart problems. If you have heart problems, ECT may be more risky.

## **11.5. CHEMOTHERAPY**

Chemotherapy is an aggressive form of chemical drug therapy meant to destroy rapidly growing cells in the body. It's usually used to treat cancer, as cancer cells grow and divide faster than other cells. A doctor who specializes in cancer treatment is known as an oncologist. They'll work with you to come up with your treatment plan.

Chemotherapy is often used in combination with other therapies, such as surgery, radiation, or hormone therapy. This depends on:

- the stage and type of cancer you have
- your overall health
- previous cancer treatments you've had
- the location of the cancer cells
- your personal treatment preferences

### **Reason for Chemotherapy**

Chemotherapy is primarily used to:

- ✓ lower the total number of cancer cells in your body
- ✓ reduce the likelihood of cancer spreading

- ✓ shrink tumor size
- ✓ reduce current symptoms

If you've undergone surgery to remove a cancerous tumor, such as a lumpectomy for breast cancer, your oncologist may recommend that you have chemotherapy to ensure that any lingering cancer cells are killed as well.

Chemotherapy is also used to prepare you for other treatments. It could be used to shrink a tumor so it can be surgically removed or to prepare you for radiation therapy.

In the case of late-stage cancer, chemotherapy may help relieve pain.

Besides treatment for cancer, chemotherapy may be used to prepare people with bone marrow diseases for a bone marrow stem cell treatment and it may be used for immune system disorders. Doses much lower than those used to treat cancer can be used to help disorders in which the body's immune system attacks healthy cells, like lupus or rheumatoid arthritis.

## **Side Effects**

Chemotherapy can produce adverse effects that range from mild to severe, depending on the type and extent of the treatment. Some people may experience few to no adverse effects.

### **1: Nausea and vomiting**

Nausea and vomiting are typical side effects. Doctors may prescribe antiemetic drugs to help reduce the symptoms.

### **2: Hair, nails, and skin**

Chemotherapy can lead to hair loss.

Some people may experience hair loss, or their hair may become thin or brittle a few weeks after starting some types of chemotherapy. It can affect any part of the body.

The skin may become dry and sore and oversensitive to sunlight. People should take care in direct sunlight, including:

### **3: Fatigue**

Some people may experience fatigue. They may experience this most of the time or only after certain activities.

### **4: Hearing impairment**

The toxins in some types of chemotherapy can affect the nervous system, leading to: tinnitus, or ringing in the ears, temporary or permanent hearing loss



## **5: Infections**

Chemotherapy can cause the number of white blood cells, which help protect the body from infection, to fall. This leads to a weakening of the immune system and a higher risk of infections.

These include:

- ✓ washing hands regularly
- ✓ keeping any wounds clean
- ✓ following appropriate food hygiene guidelines
- ✓ getting early treatment if a person suspects an infection

## **6: Bleeding problems**

The person may experience:

- ✓ easy bruising
- ✓ more bleeding than usual from a small cut
- ✓ frequent nosebleeds or bleeding gums

## **7: Anemia**

Red blood cells carry oxygen to all the tissues in the body. Chemotherapy can cause levels of red blood cells to fall. This will lead to anemia.

## **8 Pregnancy and fertility**

People often lose interest in sex during chemotherapy, but this usually returns after treatment.

**Fertility:** Some types of chemotherapy can reduce fertility in men and women. This often, but not always, returns after treatment is over. However, people who wish to have children in the future may consider freezing sperm or embryos for later use.

**Pregnancy:** It is not entirely clear how different types of chemotherapy may affect a growing fetus. If a woman needs chemotherapy during pregnancy, a doctor may recommend waiting until after the first 12–14 weeks because this is the time when the fetus's organs are developing rapidly. Chemotherapy can begin after the first trimester if a doctor considers it necessary.

## **9. Cognitive and mental health problems**

Up to 75% Trusted Source of people report problems with attention, thinking, and short term memory during chemotherapy. For up to 35% of these people, cognitive problems may continue for months or years after treatment.

## **11.6. PSYCHOSURGERY**

Psychosurgery is a field of surgery which consists of stereotactic operations on the brain aimed at altering abnormal physiology by severing certain connections between the frontal lobe and the rest of the brain, including the cortex, the nuclei or other brain pathways, which may appear to function normally or abnormally, in order to reduce mental and/or physical suffering in otherwise untreatable patients.

Psychosurgery is one of the oldest forms of surgery, and physicians have been attempting to treat psychological conditions with brain surgery for generations. Trephination is likely the oldest form of psychosurgery and involved drilling holes in the brain to alleviate a wide variety of symptoms ranging from epilepsy to psychosis. There is evidence of trephination on prehistoric human skulls.

In the mid-20th century, psychosurgery greatly increased in popularity, with numerous hospitals and clinicians engaging in the practice. Psychosurgery included split brain operations, removal of brain tissue, and other brain manipulation tactics. Results were mixed, and psychosurgery frequently resulted in extreme side effects, health problems, and even death. People sometimes underwent psychosurgery against their will or after receiving a questionable diagnosis that may or may not have constituted an actual mental disorder. Consequently, there was significant backlash against psychosurgery and it decreased significantly in the 1960s and 1970s. Many people now view psychosurgery as the product of a barbaric understanding of human behavior.

## **11.7. MEGAVITAMIN THERAPY**

Megavitamin therapy is the use of large doses of vitamins, often many times greater than the recommended dietary allowance (RDA) in the attempt to prevent or treat diseases. Megavitamin therapy is typically used in alternative medicine by practitioners who call their approach orthomolecular medicine. Vitamins are useful in preventing and treating illnesses specifically associated with dietary vitamin shortfalls, but the conclusions of medical research are that the broad claims of disease treatment by advocates of megavitamin therapy are unsubstantiated by the available evidence. It is generally accepted that doses of any vitamin greatly in excess of nutritional requirements will result either in toxicity (vitamins A and D) or in the excess simply being metabolised; thus evidence in favour of vitamin supplementation supports only doses in the normal range

Megavitamin therapy must be distinguished from the usual 'vitamin supplementation' approach of traditional multivitamin pills. Megavitamin doses are far higher than the levels of vitamins ordinarily available through western diets. A study of 161,000 individuals (post-menopausal women) provided, in the words of the authors, "convincing evidence that

multivitamin use has little or no influence on the risk of common cancers, cardiovascular disease, or total mortality in postmenopausal women"

Although megavitamin therapies still largely remain outside of the structure of evidence-based medicine, they are increasingly used by patients, with or without the approval of their treating physicians, often after recommendations by practitioners of orthomolecular and naturopathic medicine. The proposed efficacy of various megavitamin therapies to reduce cancer risk has been contradicted by results of one clinical trial.

The rationale behind megavitamin therapy is that providing substantially more vitamin will increase the amount that is available for the body utilize, in order for it to be healthy. Thus, even if an individual lacks or has a defect in a component (enzyme) necessary to break down vitamins, he/she could benefit from having more of the substrate (vitamin) around for the body to use.

Typically, 10 to 20 times the recommended dose of a vitamin is used under medical supervision for megavitamin therapy. It is highly recommended that a trained professional be consulted that can follow the progress of treatment. They can be helpful in assessing negative side effects and making necessary modifications to the therapy.

### **The risks of Megavitamin Therapy:**

Vitamin A and D are important for proper development (Example: eye, tissue, bone growth) and bone mineral metabolism, respectively. However, when there is too much in the body, vitamins get stored and could cause chronic toxicity in the liver.

Symptoms associated with excess vitamin A storage are:

- ✓ Fatigue
- ✓ Abnormal hair growth
- ✓ Pain in the long bones
- ✓ Skin peeling (desquamation)

Symptoms associated with excess vitamin D storage are:

- ✓ Weakness
- ✓ Anorexia
- ✓ Lethargy

Azotemia (in extreme chronic overdose, where abnormal levels of nitrogen containing compounds are present in the body)

Note: When an individual suffers from malabsorption (observed with certain liver, kidney, and bone diseases), he/she may require a higher dosage of vitamins than what is typically recommended. A healthcare provider must be consulted for a vitamin regimen under such circumstances.

Vitamin B6, a water-soluble vitamin, is important for amino acid metabolism. Water-soluble vitamins at very large doses over long periods of time have been associated with:

- ✓ Peripheral neurotoxic effects
- ✓ Sensory neuropathy
- ✓ Although the symptoms are known to dissipate once the treatment is stopped, there may be irreversible effects.

Vitamin C, also water-soluble, is required for normal growth, development, etc., and is essential for the absorption of iron by the body. Very high doses of Vitamin C could cause:

- ✓ Nausea
- ✓ Diarrhea
- ✓ Acidity
- ✓ Kidney stones, etc.

## **11.8. OCCUPATIONAL THERAPY**

The practice of occupational therapy means the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life.

Occupational therapy is a client-centred health profession concerned with promoting health and wellbeing through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement. (WFOT 2012)

### **Function of Occupational Therapists**

#### **Assessment**

The occupational therapy process is based on initial and repeated assessments. The occupational therapist together with the person they are working with focus on individual and environmental abilities and problems related to activities in the person's daily life. Assessment includes the use of standardized procedures, interviews, observations in a variety of settings and consultation with significant people in the person's life.

## **Planning**

The results of the assessment are the basis of the plan which includes short and long-term aims of treatment. The plan should be relevant to the person's development stage, habits, roles, life-style preferences and the environment.

## **Intervention**

Intervention focuses on programs that are person oriented and environmental. These are designed to facilitate the performance of everyday tasks and adaptation of settings in which the person works, lives and socializes. Examples include teaching new techniques and providing equipment which facilitate independence in personal care, reducing environmental barriers and providing resources to lessen stress.

## **Cooperation**

Occupational therapists recognise the importance of teamwork. Cooperation and coordination with other professionals, families, caregivers and volunteers are important in the realisation of the holistic approach.

## **Check your progress I**

Note: Use the space provided for your answer

1. What are the basic principles of behaviour therapy?

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2. What is flooding?

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3. What do you mean by systematic desensitization?

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4. What is chemotherapy?

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5. Give the reasons for using chemotherapy

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## 11.9 SUMMARY

The purpose of psychotherapy is to explore thoughts, feelings, and behaviors with the goal of problem -solving or achieving higher levels of functioning. Psychotherapy aims to increase the individual's sense of their own well-being. It involves talking about your thoughts with a professional to:

- better understand your own thinking and behaviour
- understand and resolve your problems
- recognize symptoms of mental illness in yourself
- reduce your symptoms
- change your behaviour
- Improve your quality of life.

One of the biggest dangers of untreated mental health problems is the risk for relapse. The sheer trauma itself of progressed mental illness is enough to make people more vulnerable for relapse even after initial treatment and recovery. Receiving intervention when the problem is still minor prevents the problem by the various therapies according to the needs. It will save the person from becoming as traumatizing. Early awareness makes it easier to for people to self-identify early signs of recurring mental health symptoms. It also arms people with healthy coping mechanisms to prevent recurring symptoms from becoming unmanageable.

## KEY WORDS

- ❖ Behaviour
- ❖ Classical conditioning
- ❖ Flooding
- ❖ Systematic desensitization
- ❖ ECT
- ❖ Chemotherapy
- ❖ Psychosurgery
- ❖ Megavitamin therapy
- ❖ Occupational therapy

## SELF-ASSESSMENT QUESTIONS AND EXERCISE

1. Bring out the assumptions of BT
2. What are the techniques of BT?
3. Explain in short on ECT
4. Narrate the effects of chemotherapy
5. Write a short note on a) Psychosurgery b) Megavitamin therapy
6. What are the functions of occupational therapist?

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## **UNIT XII**

Scope of Psychiatric Social Work practice: roles and functions of a psychiatric social worker with regards to the problems of patients and their families

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### **Structure**

12.1 Aims and Objectives

12.2 Introduction

12.3. Scope of Psychiatric Social Work

12.4 Functions of a Psychiatric Social Worker with Patients

12.5 Functions of a Psychiatric Social Worker with the Family

12.6 Summary

12.6 Further readings and references

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### **12.1 AIMS AND OBJECTIVES**

- ❖ To study the various role of psychiatric social worker
- ❖ To know about the role of psychiatric social worker with patients and their families

### **12.2 INTRODUCTION**

Role of social work in mental health Social workers are trained to understand and assess that the mental illnesses experienced by individuals, families, groups and communities are not caused or determined by a single factor. There may be intrinsic personal factors, combined with familial, psychological, economic, health, educational, employment, legal or other societal issues that contribute and pose obstacles to people achieving positive mental health and wellbeing. These environmental stressors are the social determinants of physical and mental health and are a central focus for social workers in supporting people with a mental illness.

Social workers focus on analysing whether change needs to occur at the individual level, as well as in other domains. This interactive and systemic analysis distinguishes social work from other health professions in the mental health sector. In their commitment to human rights and social justice, professional social workers advocate for the rights of clients against the discrimination, reduced opportunities and abuse they can experience. Through therapeutic interventions and the mobilisation of services and supports, mental health social workers enhance the person's social functioning, promote recovery and resilience and aim to reduce stigma.

## **12.3 SCOPE OF PSYCHIATRIC SOCIAL WORK PRACTICE**

Social workers initiate and lead the introduction and delivery of new programs and services. Social workers practice in specialist mental health and generalist settings across the age and illness spectrum in numerous roles including: clinical mental health social worker, caseworker, case manager, family support worker, drug and alcohol counsellor, child and family counsellor, rehabilitation worker, crisis counsellor and therapist.

The settings and fields of social work mental health practice include, but are not limited to:

- **Public mental Health:** clinical, community, residential, inpatient and emergency department settings. Psychosocial outreach, recovery and rehabilitation.
- **Adult mental health:** Working as part of multidisciplinary teams, social workers provide Individual/family/career assessment, intervention, treatment and support, including coordination of discharge planning.
- **Private practice:** Self-employed mental health social workers providing counselling and therapeutic interventions. These can be direct fee for service or through government-funded initiatives.
- **Community teams:** Working as case managers or lead clinicians in combination with multidisciplinary teams including psychiatrists, particularly with disorders such as schizophrenia, bipolar disorder and eating disorders.
- **Child and adolescent mental health teams:** As part of multi-disciplinary teams, in lead or clinician roles, supporting the mental health needs for children of ages 0 to 18 years and their families. This can include inpatient and/or community setting
- **Primary mental health care:** Longer term therapy for more high prevalence disorders such as anxiety and depression where the psychiatric risks are not of a severe and enduring nature.
- **Tertiary mental health services:** Assessment, case management, crisis intervention, rehabilitation and inpatient treatment. This can also include involvement in the implementation of community treatment orders as psychiatric case managers.
- **Prevention programs:** Working in an educational context, social workers are based at or attached to schools, educational settings and in the early childhood sector.
- **Perinatal services:** Community-based multidisciplinary teams supporting expectant or new mothers and partners, focusing on those at risk of a mental illness or disorder.
- **Maternity support services:** As an inpatient service, supporting new mothers and parents generally, and when risks of post-natal depression or other emerging needs are identified.
- **Aged mental health:** Liaising closely with family members, community teams, GPs, aged care facilities in the coordination of discharge planning and transition to community or to an aged facility.

- Indigenous communities: Mental health and wellbeing services to Indigenous communities.
- Specialist services: Including forensic services, transcultural mental health Services, prison mental health services

## **12.4 ROLES AND FUNCTIONS OF A PSYCHIATRIC SOCIAL WORKER WITH REGARDS TO THE PROBLEMS OF PATIENTS**

In general, types of psychiatric social workers include inpatient psychiatric social workers, emergency and crisis services psychiatric social workers, and outpatient psychiatric social workers. Depending on their work setting and specific role, some psychiatric social workers may fulfill tasks in all three areas—inpatient, outpatient, and emergency services.

### **Inpatient Psychiatric Social Workers**

- ❖ Inpatient psychiatric social workers work in the psychiatry departments of hospitals and medical centers with patients who have been hospitalized for debilitating or dangerous psychological and/or behavioral issues, such as severe substance abuse, psychosis, bipolar disorder, schizophrenia, and other conditions.
- ❖ Psychiatric social workers in inpatient hospital settings complete many different tasks to support patients, including conducting psychosocial assessments to determine patients' mental health status and needs; providing psychotherapy and other clinical services to help clients address their emotional, behavioral, and mental health challenges;
- ❖ communicating and coordinating with the larger treatment team to optimize clients' physical and mental health care; connecting clients with relevant resources and services;
- ❖ Facilitating clients' transition to other care facilities or back to daily life through discharge planning and follow-ups.
- ❖ In hospital settings, inpatient psychiatric social workers play a very important role in identifying and advocating for patients' needs as part of a larger medical team.
- ❖ "In hospital settings psychiatric social workers are an integral part of the multi-disciplinary team, making recommendations for treatment, rehabilitation, and social service connections
- ❖ "Within the hospital setting psychiatric social workers can make an enormous difference in the patients' material reality through therapeutic interventions and by connecting them with valuable social services, which has the potential to improve their circumstances.
- ❖ Advocates for the patient, pushing for more time when needed and better placements."

- ❖ In addition to daily communications with the treatment team for a given client or group of clients, inpatient psychiatric social workers meet regularly with medical staff to develop and alter a client's treatment plan as needed.
- ❖ "Treatment for all patients is team based and all the disciplines meet four times a week in order to discuss the most appropriate treatment and care for the patient."

### **Psychiatric Emergency Services and Crisis Response Social Workers**

- ❖ For patients who are undergoing acute crises or are in danger of hurting themselves or others, psychiatric social workers conduct psychiatric assessments, short term crisis support, and care coordination as part of a crisis or emergency services team. Environments that employ crisis service psychiatric social workers include emergency care teams that work as part of a larger medical center and crisis services at public health departments.
- ❖ Crisis and emergency services psychiatric social workers work with clients for a brief period of time to assess their needs, help them obtain the intensive care they require, and possibly recommend them for involuntary hospitalization.
- ❖ Crisis service environments tend to be more short-term than inpatient hospital psychiatric settings, as patients are generally directed to hospitals and/or intensive care facilities where they can receive longer-term and more comprehensive care.

### **Outpatient Psychiatric Social Workers**

- ❖ Outpatient psychiatric social workers provide therapy and care coordination services to individuals who do not require immediate hospitalization, but who still struggle with severe mental illness and debilitating emotional and/or behavioral issues; oftentimes patients in outpatient psychiatric settings are at risk of needing hospitalization, or have been recently discharged from an inpatient setting.
- ❖ Outpatient psychiatric social workers tend to work for a longer period of time with patients, and can even follow them through multiple systems to help support them as they transition from intensive care back home or to another facility.
- ❖ Provide individual therapy for patients with a variety of mental health needs including depression, anxiety, and PTSD,"
- ❖ They conduct various groups including Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, and Seeking Safety, among others."

## **12.5 ROLE OF SOCIAL WORKERS ENGAGED IN WORKING WITH FAMILIES**

The social worker engaged in working with families is often involved in multi-tasking, taking up the appropriate role according to the need and issue at hand. Listed below are a few roles that social workers take up while working with families.

**Facilitator:** Social workers initiate their role by simply facilitating and encouraging family members to communicate. Sometimes, families have barely spoken to each other for months by the time they seek professional help. The social worker acts as a neutral third party, helping family members share their fears, concerns or disappointments in a non-confrontational way. Probes are designed to help families to discover the underlying causes of their problems. For example, if a child is misbehaving, it may not be because he disrespects his parents, but rather because he is troubled by the stress in his parents' marriage. A social worker would help him articulate and vent these thoughts and disturbed feelings, so the entire family could discuss and understand perfectly that these are the disturbing factors hindering their peaceful living.

**Advisor or Guide:** Social workers suggest immediate solutions, even if short-term, to help families work through problems or defuse potentially volatile situations. A social worker will often attempt to stabilize the family unit, including addressing individual members' issues, for interventions to be more effective. For example, if one family member has a serious drug or alcohol problem, the social worker may recommend undergoing or having a treatment facility before continuing with therapy. Or, if one family member has a mental illness such as depression or bipolar disorder, the social worker may advise him to visit a psychiatrist who can prescribe medications to help him manage his condition.

**Mentor:** Social workers take up the role of a mentor and enable venting of mounted feelings that members face frequently or occasionally which disturb their peace of mind and peaceful living. Bottling up of feelings often results in undesirable consequences and hence channelizing them properly is one way to handle feelings and thoughts for behavior to be rational and appropriate. Social workers also provide guidance and support for the members of the family for amicable living.

**Advocate:** Social workers act as advocates and work on taking up the cause of their clients. They represent the client in different forms and advocate the benefit and well-being of the unit. During therapeutic sessions, they also take up advocacy roles for a particular member to represent his/her viewpoint that may play a crucial role in the dynamics of the therapeutic intervention. Catalyst: Social workers often act as catalysts in bringing about change in the family unit. The arguments placed, clarifications sought, communications held and therapies conducted all bring about a dynamic change process in the minds of the members for a decent, dignified, respected and peaceful living.

**Counselor:** The social worker also takes up the role of a counselor, if need arises. The goal of family counseling is to help families create a home atmosphere where family members can communicate with and support each other through times of conflict, quarrel and disagreement with one another. A conflict can have many causes, including poor relationships, substance abuse, behavioral problems, or financial or work concerns. Conflicts can arise between parents and their children. They can also occur in the marriage. The social worker counsels the members and thereby enhances their family relationship.

## Check your progress I

Note: Use the space provided for your answer

1. What is tertiary mental health care?

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2. Psychiatric social worker as mentor- explain

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3. What are the role psychiatric social worker as counsellor?

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## 12.6 SUMMARY

Social workers provide a significant contribution to the field by maintaining a dual focus on both the individual and family/contextual domains, and it this understanding that distinguishes social work from other health professions in the sector. Social workers are regularly involved with individuals and families experiencing complex social, psychological, family and institutional dynamics. Social workers offer a unique and valuable contribution in providing appropriate and targeted services and therefore have a clear role in the provision of effective mental health services.

Individuals and families have different reactions to mental health disorders, both in terms of conditions that are emerging and those resulting from a situational crisis. Social workers contribute greatly to their clients and organisations by undertaking evidence-informed assessments and interventions. The social work assessment process takes into account the impact of biomedical factors and the range of psychological, social and other needs of the individual experiencing mental health disorder. Within this framework social workers respect the primacy of the individual's rights (within medico-legal requirements) and work towards developing skills and confidence to assist individuals and their families maintain control of their lives and take responsibility for recovery and wellbeing. Social workers recognise the individual's role in treatment planning and the individual's right to have a knowledgeable, skilled practitioner who is guided by ethical practice.

## KEY WORDS

- ❖ Psychiatric social worker
- ❖ Inpatient ward
- ❖ Outpatient ward
- ❖ Crisis and emergency ward
- ❖ Mentor
- ❖ Counsellor
- ❖ Advocate

## SELF-ASSESSMENT QUESTIONS AND EXERCISE

1. Explain the scope of psychiatric social work practice
2. Explain the roles of psychiatric social worker in IP
3. What are the roles of psychiatric social worker in OP?
4. Elaborate the functions of psychiatric social worker with family

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## **UNIT XIII**

1) Psychiatric OPD'S 2) psychiatric specialty clinics 3) de-addiction centres, 4) child guidance clinics; rehabilitation of psychiatric patients: role of the social worker in rehabilitation - planning, mobilisation, reintegration of the patient in the family and community, Principles and models of psychiatric rehabilitation; role of the psychiatric social worker in team work.

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### **Structure**

13.1 Aims and Objectives

13.2 Introduction

13.3 Role of Psychiatric Social Worker in Psychiatric OPD'S

13.4 Role of Psychiatric Social Worker in Psychiatric Specialty Clinics

13.5 Role of Psychiatric Social Worker in De-Addiction Centres

13.6. Role of Psychiatric Social Worker in Child Guidance Clinics

13.7 Role of Psychiatric Social Worker in Rehabilitation of Psychiatric Patients

13.8 Principles of Psychiatric Rehabilitation

13.9role of the Psychiatric Social Worker in Team Work

13.10 Summary

13.11 Further readings and references

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### **13.1 AIMS AND OBJECTIVES**

- ❖ To know the roles of psychiatric social worker in various settings
- ❖ To understand the roles of psychiatric social worker in rehabilitation of psychiatric patients

### **13.2 INTRODUCTION**

Psychiatric social workers provide mental health services to individuals with high needs. They may perform psychotherapy and even diagnose mental illness. Duties vary according to work setting. Social workers in inpatient settings often have primary responsibility for putting together the discharge plan. This is not something that is filled out right before discharge – it's an ongoing process during much of the time the person is hospitalized. The goal is ambitious: that the person will have the resources to function optimally within the community. Social workers who are employed at psychiatric hospitals also do psychosocial assessments and provide therapy. They are in frequent contact with the family members of

patients. They meet with other members of the mental health team (psychiatrists, nurse practitioners etc.) to discuss patient care. If the patient is involved in any legal procedures, the social worker may have a role in information gathering.

### **13.3 ROLE OF PSYCHIATRIC SOCIAL WORKER IN OUT PATIENT DEPARTMENT (OPD'S)**

#### **Outpatient Psychiatric Social Workers**

- ❖ Outpatient psychiatric social workers provide therapy and care coordination services to individuals who do not require immediate hospitalization, but who still struggle with severe mental illness and debilitating emotional and/or behavioral issues; oftentimes patients in outpatient psychiatric settings are at risk of needing hospitalization, or have been recently discharged from an inpatient setting.
- ❖ Outpatient psychiatric social workers tend to work for a longer period of time with patients, and can even follow them through multiple systems to help support them as they transition from intensive care back home or to another facility.
- ❖ Provide individual therapy for patients with a variety of mental health needs including depression, anxiety, and PTSD,”
- ❖ They conduct various groups including Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, and Seeking Safety, among others.”
- ❖ Social workers in outpatient settings deliver services that touch all areas of their patients’ lives. The following are key functions and tasks performed by social workers in outpatient health care settings (Gibelman, 2005; Grobman, 2005):
- ❖ Identification, assessment and treatment of mental health conditions, such as depression and anxiety;
- ❖ Case management/care coordination, particularly for individuals with chronic and/or complex medical conditions;
- ❖ Patient navigation, especially for patients moving among different health care levels (e.g., inpatient, outpatient, home health, or long-term care);
- ❖ Identification and referral for specialized services, such as drug and alcohol treatment, legal services, financial and employment counseling, and housing support; ■ Education and support programming (e.g., diabetes education, parenting classes, domestic violence support programs) for individual and groups;
- ❖ Assistance with entitlements, medications, transportation, and advance directives;
- ❖ Assessment and intervention in domestic violence and child abuse situations;
- ❖ Counseling on end-of-life issues;
- ❖ Outreach and coordination with other community resources and agencies; and
- ❖ Community-level advocacy on behalf of patients and families.

## **13.4 ROLE OF SOCIAL WORKER IN PSYCHIATRIC SPECIALTY CLINICS**

### **1. Performs Intakes and Evaluations**

A social worker is often one of the first professionals a patient has contact with when he seeks treatment in a psychiatric setting. Before a patient can receive treatment, he must complete an intake and evaluation process. In many cases, social workers are the main providers of these services in a psychiatric setting. The assigned social worker will meet with the client to perform an intake, which usually consists of obtaining general identifying information, medical insurance information, previous history of medical and psychiatric treatment and the presenting problem, or the reason the patient is seeking treatment at this time.

### **2. Formulates Treatment Plans**

Once a client has completed the evaluation process, a social worker will formulate a treatment plan. A treatment plan consists of a proposed course of treatment based on the patient's presenting problem and any other problems identified during the evaluation. Depending on the patient's specific concerns and problems, a social worker may consult other professionals, such as psychiatrists or psychologists, to ask for assistance in treatment plan formulation. This is usually the case, for example, if a patient presents with severe psychiatric symptoms, such as delusions or suicidal tendencies that require medication or other, more intense forms of intervention.

### **3. Intervenes in Crisis Situations**

A social worker in a psychiatric setting is usually involved in crisis intervention, which may include providing telephone crisis coverage, helping walk-in patients who require immediate treatment and offering community referrals to patients who need specific types of emergency assistance, such as housing or food. The goal of psychiatric social worker in such situations is often to evaluate whether the patient can return to his normal level of functioning or whether to provide additional, more long-term treatment or assistance. For example, a psychiatric social worker who helps a severely depressed walk-in patient might decide to admit the patient to a short-term care unit for additional monitoring and treatment, with the patient's consent.

### **4. Provides Treatment and Other Services**

A psychiatric social worker provides a wide range of treatments and other services to patients based on their specific presenting problems. Some of the treatments and services a psychiatric social worker might provide include short-term psychotherapy, play therapy with children, substance abuse counseling, cognitive-behavioral therapy, group counseling, family therapy, supportive counseling, case management and advocacy. In addition, a psychiatric social worker often provides consultation to other professionals involved in a patient's care. This might include discussing a patient's progress in treatment with family doctors or private therapists, as long as the patient has provided written consent.

## **5. Consultancy**

Clinical psychologists also often act as consultants within psychiatric facilities. They might consult with other professionals to educate them about psychological treatments or encourage the use of specific psychological interventions, when appropriate. For example, a clinical psychologist might consult with a psychiatrist to determine whether psychotherapy could be useful in a patient's treatment, or whether a patient might benefit from psycho-educational techniques. They also participate in multidisciplinary team meetings and help other professionals understand the psychological aspects to treatment.

### **13.5 ROLE OF SOCIAL WORKER IN DE-ADDICTION CENTRE**

Working with substance use is part and parcel of social work practice. It is part of a social worker's statutory obligations as well as their duty of care. As evidence shows, it is increasingly a feature in the caseloads of all social workers regardless of specialism. Further, it often overlaps with people experiencing mental distress and domestic violence too. While it is more obvious in child protection work and among those working with people experiencing mental distress, they are not alone. Increasingly social workers working with older people, disabled people, parents (out with child protection), and young people leaving care, are encountering problematic substance use. Social workers are not expected to be experts in everything. Given the breadth of a social worker's reach into the lives of individuals, families and communities, they never will be prepared for every set of circumstances that may arise. However, clarity about one's role when working with particular issues is vital. Substance use is one such area.

The roles will also vary depending on the social worker's level of experience and seniority as well as on their role, service environment, and service model. As social workers become more experienced and move into management and mentoring roles, their knowledge and skills would be expected to develop and inform their support and supervision of less experienced staff. Advanced and principal social workers and managers would also be expected to take a strategic leadership role ensuring that responses to substance use are embedded in the organisation.

The following three key roles are the starting point for social workers in relation to substance use:

#### ***1. To engage with the topic of substance use as part of their duty of care to support their service users, their families and dependents.***

Engaging with the topic of substance use is a legitimate and necessary part of social work practice. While it is also a specialist area of practice, it is an issue that cuts across all service user groups. Whether the social worker's focus is on adults' or children's service user groups, social workers need to accept that substance use, its identification, assessment and

appropriate intervention is part of their role. Evidence shows that many social workers are not consistently engaging with the topic and do not feel it is their responsibility or duty to do so.

***2. To motivate people to consider changing their problematic substance using behaviour and support them (and their families and carers) in their efforts to do so.***

Social workers meet people at different points in their substance using histories, therefore different levels of motivation and support will be required. The key is to ensure that the motivation and support offered maximizes the likelihood of behaviour change, even with people who are highly resistant. Adversarial discussion will lead only to entrenchment of positions and result in the opposite of the desired outcome. Done well, the motivation and support will move many people to consider changing their substance use or to take action with the social worker's support. However, some people will choose not to change their substance use despite the best efforts of their social worker.

### **13.6 ROLE OF PSYCHIATRIC SOCIAL WORKER IN CHILD GUIDANCE CLINICS**

The social worker in the clinic adopts a different methods of treatment. Some of them may be classified as follows:

#### **1. Work with the child.**

The social worker has to work with the child in order to modify the child's behaviour by means of interviews or play sessions or both. The treatment is directed to the child as a whole. Here his total personality is studied and treated accordingly in such a manner that he feels adjusted satisfactorily to his environment—his family, his neighbourhood, and his school.

#### **2. Work with the family.**

The social worker has to work with the family consisting of parents, siblings or kith and kin with whom the child comes in contact. The child's conduct is much influenced by their behaviour. The social worker is often required to acquaint the family with the problem facing the child. He is called upon to instruct the family to modify their attitude towards the child who would be inspired to change his own behaviour.

#### **3. Work with the community.**

As the child is a part and parcel of the community, the social worker has to approach the various organisations in the community to pool their resources to help the child.

As the child is a part and parcel of the community, the social worker has to approach the various organisations in the community to pool their resources to help the child. For example, the school teacher who teaches the child or the matron of the boarding-school has a lot of influence on the behaviour of the child. Therefore, it is incumbent upon the social worker to

interview the teacher or the matron or both and explain to either or both of them the problem facing the child.

#### **4. Provision of specific therapeutic aids.**

The psychiatrist takes up the responsibility for treatment of children with intra-psychic problems. Here also the psychiatric social worker's co-operation is necessary. It is true that "psychotherapy is the essential feature but not the whole of psychiatric treatment which, working for the patient's comfort and smoothness of functioning, cannot be carried out in a vacuum" 3

Environmental treatment is an indispensable part of it. It is the psychiatric social worker who deals with the environmental problems. She co-operates with the school teacher, men in charge of the recreational centres and social agencies and also with the community to modify the situational stresses and strains.

when the psychiatrist does the psychotherapy, it is the social worker who interprets to the clinic the feelings and attitudes of the child's relatives, interprets the clinical findings and plans to parents, teachers, and other social agencies, and thereby forms a link between the clinic, the home, and the community.

The social worker also contributes a lot to the understanding of the "whole" child by the clinic. She brings to the clinic the knowledge of the social and emotional milieu in which the patient lives, relates himself and develops his attitudes and conflicts. As the social worker visits the house of the child or his school, she brings to the clinic the first-hand knowledge of the environment of the child.

#### **5. Follow-up work.**

The psychiatric social worker do the home visit in a regular intervals to monitor the progress and give the suitable helps and referral services if needed

- Thus, the psychiatric social worker is a therapist, an educationalist. "Her personal liaison in the stream of social traffic provides a centrifugal dissemination of understanding of psychiatric work with children."
- Child guidance clinics should regard a trained psychiatric social worker as an important specialist and an integral part of a team in the clinic which can contribute substantially to a total study of the child, to diagnosis and treatment

### **13. 7 REHABILITATION OF PSYCHIATRIC PATIENTS**

The treatment of mental health disorders usually includes two aspects: the actual treatment itself, and rehabilitation. Treatment focuses on reducing the symptoms of an illness that are present in the patient. In the case of a person with fever, the goal of treatment is to bring down the body temperature.

Unlike in the case of physical illnesses where medication or surgery may provide a complete cure, mental disorders require medication along with other forms of treatment. The type of treatment administered to the patient depends on their diagnosis, the severity of the illness, as well as their physical and emotional state. A person may need a combination of some of these forms of treatment: medication, therapy, counseling, hospitalization, brain stimulation treatments and psychiatric rehabilitation. Often, the lines demarcating treatment and rehabilitation may be blurred.

Psychiatric rehabilitation is an aspect of treatment that focuses on helping the person return to an optimal level of functioning and to achieve their life goals. This is brought about by providing medical, psychological and social input. There is no strict boundary between treatment and rehabilitation.

Not all persons with mental illness require rehabilitation. For many patients, medication or a combination of medication and therapy is sufficient to help them get back to a functional life. For some others, rehabilitation may be that essential final part of the treatment cycle.

Also referred to as psychosocial rehabilitation, psychiatric rehabilitation refers to the mental health discipline that involves providing all the resources needed to help mentally ill patients reintegrate themselves back to society. This is different from de-institutionalization wherein patients with mental health problems are not allowed to leave the hospital or institution.

Psycho rehab requires a multidisciplinary approach to be successful and it involves the following:

**Recovery** – One of the first steps of rehabilitation is to guarantee the recovery of patients. While some of them may not completely recover, the rehab will help them cope with their symptoms more effectively.

**Empowerment** – Once the patients go back to society, they will be subjected to the standards and expectations of others. For many of them, it will be difficult, more so if others learn of their background and predicament. However, when the patients are empowered and motivated, they are more likely to sustain themselves and even rise above these expectations.

**Collaborative** – There is more than one professional helping these patients to recover and move forward from their illness. In fact, most of those that offer rehabilitation programmes are organizations with teams that are composed of psychiatrists, social workers, and community-trained workers, to name a few.

**Personalized** – Rehabilitation programmes provided to patients are according to a set of standards, guidelines, and existing methods that can be modified according to the needs, skills, and overall personality and outlook of the patient. Rehab cannot succeed without the patient's active participation and interest. The rehab is expected to focus on building up or reinforcing the innate strengths of these patients.

In the end, the goal of psychiatric rehabilitation is to give the patients hope, motivation, respect for oneself, as well as social, economic, and other types of skills so they can reintegrate themselves back to the society more efficiently and effectively.

### **The rehabilitation process**

The rehabilitation process usually begins with the psychiatrist or other mental health professional speaking to the patient and family, to find out the patient's strengths and interests. At this point, what is most required is for the family to have a realistic understanding of the individual's capabilities, and to set realistic expectations of them. For instance, a person with a severe mental illness may not be able to socialize or perform in certain kinds of tasks. The family needs to understand that, rather than put pressure on them to conform to their expectations.

Once the family understands the person's skills and limitations, they may recognize that the person can lead a happy, satisfactory life according to their own preferences, and with a set of expectations more suited to their circumstances.

In some cases, the psychiatrist or other mental health professional may engage repeatedly with the person to build a rapport, and understand any problems the patient may be facing, and the family's outlook towards their illness. The psychiatrist is then able to help them envision a better life despite the limitations posed by their mental illness.

The team then proceeds to assisting patients in determining the steps they need to take to achieve their specific objectives. They will also present the resources that will be helpful and will be unique to the circumstance (individualized approach).

Typically, psych rehab programmes offer the following;

- Health and wellness support including nutrition or diet
- Symptom relief management through the use of correct medications
- Reduction of stress and distress through different techniques including meditation
- Introduction to the right support groups
- Building up of the patient's own support group that can be composed of other patients in rehab, family, friends, and even colleagues at work
- Medical services such as consistent long-term counseling and accessible physician care (including urgent and emergency care)
- Legal assistance
- Education through enrollment in vocational schools or colleges
- Work placement
- Housing such as apartment living or group homes



## **Involvement of family in rehabilitation**

When a person is diagnosed with a mental health disorder, the family or caregiver also has to cope with the diagnosis. In addition, there are other factors that make coping difficult: a changed perception of who the patient is, what they are capable of, and what their role in the family will be. The caregivers and family also need additional support to help them live with the diagnosis. Rehabilitation helps the family come to terms with the diagnosis, the altered circumstances, and their expectations of the person with the illness. It also helps the family to understand the person's strengths and create opportunities for them to make a meaningful contribution at home, or in the society.

The involvement of the family is an extremely important aspect of the rehabilitation process. Psychiatrists say that the positive and active support of family members forms the most effective part of the rehabilitation process. When a family spends a considerable amount of time and effort assisting their loved one, it increases the person's chances of picking up new skills or setting new goals. This will, in turn, help the family as well.

## **The psychiatric Social Worker's Role in Rehabilitation**

The psychiatric Social Worker in Rehabilitation aims to work collaboratively with patients and their family to assist the patient in maximising their quality of life. The psychiatric Social Worker in Rehabilitation is committed to and guided by values of social inclusion, justice, anti-discriminatory practice and promoting self-determination.

The psychiatric Social Worker completes a psychosocial assessment of all patients referred to the service and works closely with the multi-disciplinary team. This assessment identifies areas of social, emotional and environmental factors which are significant in the patient's life. The psychosocial assessment enables the Medical Social Worker, along with the patient, to identify areas in which support may be needed and to plan appropriately for this. The psychiatric Social Worker endeavours to apply to community services to support a safe discharge. The psychiatric Social Worker offers advocacy, emotional support and provides information to patient, families and those impacted by illness and concerned about personal circumstances/ issues

Social workers are key contributors in the rehabilitation and recovery of patients in inpatient rehabilitation facilities. Their roles may include:

- The initial screening and evaluation of patients and families.
- Helping patients and family members deal with the many aspects of the patient's condition – social, financial, and emotional.
- Helping patients and families understand their illnesses and treatment options.
- Acting as an advocate for patients and families – including as an advocate for the patient's health care rights.

- Aid and expedite decision-making on behalf of patients and their families.
- Educating patients on the roles of other members on their recovery team – including physicians, nurses, physical therapists, etc.
- Crisis intervention
- Providing a comprehensive psychosocial assessment of patients.
- Educating patients and families about post-hospital care.
- Helping patients adjust to their inpatient rehab setting.
- Coordinating patient discharge and continuity of care following discharge.

### **Serving as a Patient/Family Advocate**

As mentioned, one of the key roles that social workers serve in an inpatient rehabilitation setting is as a patient advocate. The importance of helping the patient understand and adjust to hospital procedures, understand medical plans, and assisting the patient's family with financial planning is crucial.

The social worker's role as an advocate also includes maintaining open lines of communication between the patient, family, and other members of the health care team. He or she also will learn each family's dynamics while understanding its strengths – and encouraging the use of these strengths.

Indeed, the pressure on families as a loved one moves through the health care system can be intense and there's a lot to learn in a short time. Social workers ease this pressure on all levels, whether it regards the plan of treatment or financial needs.

### **REINTEGRATION OF THE PATIENT IN THE FAMILY AND COMMUNITY**

People with severe mental illness no longer spend years of their lives in psychiatric institutions. They may have multiple residential, vocational, educational and social needs and wants. A person with severe mental illness wants and needs more than just symptom relief. People who have a mental illness need similar opportunities and responsibilities as other members of the community. This is the basic human rights applicable for everyone.

In developed countries, there has been a major shift in the focus of care from hospitals to the community, from recovery to rehabilitation. Both rehabilitation and reintegration are parts of the same process. Rehabilitation focuses on people regaining valued roles in their communities with success and satisfaction.

The concept of reintegration is defined by three keystone goals –

- Have a meaningful, responsible activity, in most cases derived from competitive employment that gives a purpose to daily life.
- Live independently and have a place of one's own.
- Effectively function within a circle of family and friends.

Rehabilitation begins from the time treatment is initiated. As patient shows improvement, discharge is planned. Support from known and trusted people both within the mental health institution and outside is very much essential. Like in IHBAS (Institute of Human Behaviour & Allied Sciences) and in any other Government Mental Health Institution where admissions of mentally ill persons are done as per Mental Health Act, 1987, at least 50% of such admissions are through reception order. While reintegration of persons with mental illness with their family may be possible to some extent in voluntary cases or cases admitted under section 19 of Mental Health Act, 1987, the same is not the case for persons admitted through reception order.

The prime aim of the reintegration is to reunite the patient with the family. It is of very essential for the patient to be free and comfortable in the family rather than any other places. A positive impact on quality of life and psychological symptoms in patients, siblings and parents could be found. In the case of no family members to support then it goes to the community reintegration. The community as a team have the responsibility to take care of the sick patient. Here come the role of the Government and the Non-government Organization to give the support and knowledge in reintegrating the psychiatric patients.

### **13.8 PRINCIPLES OF PSYCHIATRIC REHABILITATION**

All psychiatric rehabilitation service providers should be guided by the PRA Code of Ethics and Multicultural Principles.

All people receiving services should request that all services they receive reflect PRA's Core Principles and Values, Multicultural Principle and definition of psychiatric rehabilitation.

**Principle 1:** Psychiatric rehabilitation practitioners convey hope and respect, and believe that all individuals have the capacity for learning and growth.

**Principle 2:** Psychiatric rehabilitation practitioners recognize that culture is central to recovery, and strive to ensure that all services are culturally relevant to individuals receiving services.

**Principle 3:** Psychiatric rehabilitation practitioners engage in the processes of informed and shared decision-making and facilitate partnerships with other persons identified by the individual receiving services.

**Principle 4:** Psychiatric rehabilitation practices build on the strengths and capabilities of individuals.

**Principle 5:** Psychiatric rehabilitation practices are person-centered; they are designed to address the unique needs of individuals, consistent with their values, hopes and aspirations.

**Principle 6:** Psychiatric rehabilitation practices support full integration of people in recovery into their communities where they can exercise their rights of citizenship, as well as to accept the responsibilities and explore the opportunities that come with being a member of a community and a larger society.

**Principle 7:** Psychiatric rehabilitation practices promote self-determination and empowerment. All individuals have the right to make their own decisions, including decisions about the types of services and supports they receive.

**Principle 8:** Psychiatric rehabilitation practices facilitate the development of personal support networks by utilizing natural supports within communities, peer support initiatives, and self- and mutual-help groups.

**Principle 9:** Psychiatric rehabilitation practices strive to help individuals improve the quality of all aspects of their lives; including social, occupational, educational, residential, intellectual, spiritual and financial.

**Principle 10:** Psychiatric rehabilitation practices promote health and wellness, encouraging individuals to develop and use individualized wellness plans.

**Principle 11:** Psychiatric rehabilitation services emphasize evidence-based, promising, and emerging best practices that produce outcomes congruent with personal recovery. Programs include structured program evaluation and quality improvement mechanisms that actively involve persons receiving services.

**Principle 12:** Psychiatric rehabilitation services must be readily accessible to all individuals whenever they need them. These services also should be well coordinated and integrated with other psychiatric, medical, and holistic treatments and practices.

### **13.9 ROLE OF SOCIAL WORKER IN THE HEALTH CARE TEAM**

The term teamwork has become a commonplace in health care organisations in the 21st century. Teams are viewed as important functioning units and the potential benefits of teamwork are duly recognized as well as applauded. Depending on the level of integration, teamwork is distinguished by such terms as multidisciplinary interdisciplinary and trans-disciplinary. In multidisciplinary teamwork, experts from different disciplines are associated with the client, but each one is accountable for his or her disciplinary activities. The interdisciplinary teamwork presupposes interaction among various disciplines. The resource persons perform diversified activities, but also are liable for the group effort. Trans-disciplinary teamwork has these characteristics to a greater extent. Representatives of various disciplines work together, but only one or two team members actually provide the services. In health care setting, social workers work in the interdisciplinary 60 Social Work Intervention with Individuals and Groups or Trans-disciplinary team. Medical professional or psychiatrist,

medical or psychiatric social worker, clinical psychologist, occupational therapist, trained nurse, etc. are the members of health care team. The important functions of social worker associated with this team are as follows:

1. He notes down the social history pertaining to the patient's childhood and school performance, home condition, inter personal relationships in the family, job performance, psycho-sexual history, attitudes, hobbies, interests, etc. in order to understand or analyse patient's perennial problems in the context of present difficulties. This background information collected by the social worker and the medical professional's or psychiatrist's report as well as the findings of the psychologist help to diagnose and plan treatment.
2. Social worker expounds the nature of disease or illness to the patients and their family members. He also explains how frequently the same disease can occur, what would be its impact at the individual level or at the group level, and the treatment procedures recommended by the doctors.
3. A social worker, as a member of health care team, can help the patient and family to find out the way towards better social adjustment. In this regard, he may provide emotional support and bring environmental modification by working with the employer or educational institution or family member or neighbourhood.
4. Many a time, lack of resource makes it difficult for a patient to receive appropriate medical or psychiatric care. Hence, social worker pools community resources in order to provide money or Social Work in Health Care Sector 61 medicines or clothes or prosthesis to the poor patients, so that they can continue treatment as per the advice of the doctor. Apart from this, social workers also keep in touch with other social agencies available in the community, who refer the cases regularly to the clinic. This helps in proper co-ordination of services.
5. Activities related to group work with the patients and their family members are undertaken by the social workers in order to provide recreational facilities, necessary awareness and therapeutic inputs. Group work is supposed to be used as a primary activity in the psychiatric institutions where long-term cases exist, but tentatively, only 24.1 per cent social workers consider it as primary function (Verma, 1991). The fact is that most psychiatric departments provide services mainly through OPD (Out Patient Department). Though CGCs (Child Guidance Clinics) accentuate on the group work/ therapy while working with children, very few CGCs organise group activities involving the parents for the purpose of therapy, counselling and education. Apart from psychiatric setting, group work method is generally neglected by the social workers, especially in institutional health care services.
6. Social worker helps the client in rehabilitation. In health care setting, rehabilitation is a process of helping a patient to return to normal life or attain the best possible lifestyle following a serious illness or injury. It may be social rehabilitation (restoration of family and social relationships) or psychological rehabilitation (restoration of personal dignity and confidence) or vocational rehabilitation

(restoration of the capacity to earn a livelihood). 62 Social Work Intervention with Individuals and Groups

7. Facilitating in referral services is one of the important functions of social worker. Referral service means linking a client or patient with an agency or programme or professional person that can and will provide the service needed by the client. In medical setting, a patient may be referred to a clinic or polyclinic or nursing home or hospital. In psychiatric set up, a patient can be referred to CGC (if child is having behaviour problem) or de-addiction centre (if alcoholic or drug addicted) or psychiatric department (for more opportunities pertaining to the therapeutic inputs) or mental hospital (to deal with the chronic and acute mental patients requiring physical treatment). The extent to which cases are referred to medical social workers or psychiatric social workers by other members of the health care team is an important indicator of the recognition of social work services.
8. Social worker gets involved with the follow up of the patient and his family, so as to stabilize the gains made during treatment. In medical or psychiatric institutions, in order to carry out follow-up activities, patients or their families who visit OPD are interviewed to assess the progress made by the patients after discharge. In CGCs, follow-up includes a greater degree of self-investment on the part of social workers in conducting interviews with the children, their parents and relatives, visiting homes and schools, etc. in order to ascertain the outcome of the intervention.
9. Social worker is also associated with the teaching, supervision and staff development activities. In order to provide social work knowledge, he teaches undergraduate and post-graduate level medical students, social work students, physiotherapy as Social Work in Health Care Sector 63 well as occupational therapy students, nursing students, etc. and supervises interns, student social worker (for field work), para-professionals, volunteers and the like. With a view to upgrade the performance of the staff, social worker also organises seminars, conferences and workshops inside or outside the hospital.
10. Records that are maintained regularly and have clarity and objectivity are important for the continuation of treatment of the client, organisational development and social research. Social workers take the responsibility of maintaining these case records, registers, files and correspondence for future guidance and research purposes. It is found (Verma, 1991) among the social workers that tentatively, 87 per cent and 97 per cent regularly maintain registers and case sheets. Very few social workers, i.e., almost 12 per cent and 19 per cent up-to-date their process records and summary records, respectively.
11. Research work includes activities of varying complexion from the formulation of research problem, development of hypotheses, selection of methodology, data collection, data analysis, to report writing. Off and on, it is found that the social worker is involved in each phase of these research activities, which forms a part of their functions. But it is also pragmatic that none of the social workers carries out independent research work. They regard it as an auxiliary function.

12. In order to carry forward 'Mental Hygiene Movement' and propagation towards 'Health For All – Now', social workers keep in touch with the community by dint of write ups in periodicals, audio-visual 64 Social Work Intervention with Individuals and Groups methods, radio, TV, etc.
13. A social worker associated with a health care team also acts as a promoter of community residential care provider. People who have no families or whose families can no longer care for them at home and who do not belong to a hospital or nursing home require community residential care.
14. Apart from all the aforesaid functions, social worker attends emergencies as and when required. There are two types of emergencies, i.e., medical emergencies and social emergencies. Burns, cardiac problems, poisonings, traumas, etc. are the true medical emergencies. Social emergencies include cases of child abuse, spousal abuse, elder abuse, rape and so on. All these have some common characteristics, i.e., they are unexpected, happen suddenly, endanger the patient's life, and the patients or families are not prepared for the same. As a result, patients or families face uncertainty, numerous questions, a flood of emotions and a need to plan response to the situation. Social worker, in this context, provides support in reducing the degree of uncertainty and in understanding as well as gaining control over the situation.

### **Check your progress I**

Note: Use the space provided for your answer

1. What is social history of patient?

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2. What do you mean by crisis intervention?

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3. What is follow up works of social worker?

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4. What is rehabilitation?

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5. What is reintegration into community?

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### **13.10 SUMMARY**

Psychiatric social workers provide mental health services to individuals with high needs. They may perform psychotherapy and even diagnose mental illness. Duties vary according to work setting. Social workers who are employed at psychiatric hospitals also do psychosocial assessments and provide therapy. Social workers support individuals and their families through difficult times and ensure that vulnerable people, including children and adults, are safeguarded from harm. Their role is to help in improve outcomes in people's lives. They maintain professional relationships and act as guides and advocates. The potential contribution of social work to the rehabilitation of patients is such a broad topic that it is first necessary to locate within it those aspects which are discussed in the present paper. As will become clear, rehabilitation provides a particularly convenient focus for considering the relationship between psychiatrists and social workers as occupational groups, and our chief purpose is to discuss this relationship—which is currently vexing all concerned. We shall place ourselves in context by recalling at once that social work forms but a part of a wide range of welfare and personal social services.

### **KEY WORDS**

- ❖ Social history
- ❖ Rehabilitation
- ❖ Reintegration
- ❖ Mobilization
- ❖ Crisis intervention
- ❖ Multidisciplinary team



## **SELF-ASSESSMENT QUESTIONS AND EXERCISE**

1. Bring out the role of social worker in OPDs
2. Enlist the role of social worker in specialty clinic
3. Write the role of social worker in child clinic
4. Elaborate the rehabilitation process
5. What are the principles of psychiatric rehabilitation?
6. Explain the role of psychiatric social worker in multidisciplinary team

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## **UNIT XIV**

concepts of therapeutic community, partial hospitalisation, day care centers, half way homes, sheltered workshop and transitory homes; national mental health programme; district mental health programme

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### **Structure**

- 14.1. Aims and Objectives
  - 14.2 Introduction
  - 14.3 Therapeutic Community
  - 14.4 Partial Hospitalization
  - 14.5 Day Care Centers
  - 14.6 Half Way Homes
  - 14.7 Sheltered Workshop
  - 14.8 Transitory Homes
  - 14.9 National Mental Health Programme
  - 14.10 District Mental Health Programme
  - 14.11. Summary
  - 14.12. Further Readings and references
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### **14.1. AIMS AND OBJECTIVES**

- ❖ To know about the therapeutic community
- ❖ To understand various types of rehabilitation centre and homes
- ❖ To study the National and District mental health programme

### **14.2 INTRODUCTION**

Therapeutic community is a participative, group-based approach to long-term mental illness, personality disorders and drug addiction. The approach was usually residential, with the clients and therapists living together, but increasingly residential units have been superseded by day units. Disciplinary sanctions for violations help to maintain structure for TC participants and staff and ensure that participants' lives are orderly and productive. Routines include morning and evening house meetings, job assignments, group sessions, seminars, scheduled personal time, recreation, and individual counseling

### **14.3 THERAPEUTIC COMMUNITY**

*A therapeutic community is a treatment facility in which the community itself, through self-help and mutual support, is the principal means for promoting personal change.*

*In a therapeutic community residents and staff participate in the management and operation of the community, contributing to a psychologically and physically safe learning environment where change can occur.*

The therapeutic community (TC) as a model of treatment is based on family and community. It is fundamentally a self-help approach which strives to sustain the main characteristics of a prosocial and positive family environment. This includes structure to provide order in daily living; nurturance through physical and psychological safety; individual acceptance and encouragement, conditional only upon honest participation; and the transmission of healthy values\*.

The TC is designed to intensify those life experiences that help individuals learn about themselves, gain self-esteem, develop self-respect, learn about others, and foster mutuality and respect for others. In so doing, concepts of responsibility, authority and meaningful codes of behaviour are established. There is an expectation for clients to be responsible for maintaining values and codes of behaviour held important to the community.

The total 24-hour house environmental milieu (surroundings) of the therapeutic community (TC) provides a unique opportunity for therapy. Formal structured group and individual therapy sessions are of major importance, but so too are the more reality-based therapies of working together, recreating together, relaxing together, decision-making, problem-solving, empathizing, reaching out, helping and teaching. All activities are considered part of therapy, and are directed towards assisting the person to develop their skills and identity and work toward managing their own recovery. Even the most fundamental necessities, such as laundry, cooking, maintenance and office work can be therapeutic, and are also vital in developing essential life skills. In fact work is one of the most distinctive components of the therapeutic community (TC) model.

The work hierarchy of the TC is integral to the functioning of the program and strengthens the peer community through the transmission of values such as community mindedness, right living and recovery. TC residents are responsible for the practical tasks that sustain the day to day operations of the community. The TC model provides a structured system with graded levels of responsibility which are taken up by residents as they move through the program.

Therefore, when a person enters the community they are only asked to take responsibility for themselves. A 'buddy' is assigned to all new residents, and this person provides support to the new person to help them adjust to the community. As the person's emotional, physical and mental health begins to improve, they are able to begin the process of change. At the same time, they take on more responsibility within the community, 'buddy' other new residents, and take on work areas, such as head of the gardening or kitchen departments. In

this way they learn how to be responsible, to practice positive behaviours and norms and to change self-defeating lifestyles.

### **Value of peer support**

The example that residents who have successfully left the program are able to provide to others who are still struggling is also very important. Those in recovery serve as role models to others. The program will continue to welcome back those who have finished the residential stage of treatment for social, education and support activities. This will include relapse prevention programs, outreach counselling and support and other social activities.

One of the benefits of TC treatment in general is the fact that many of the staff are themselves in recovery, and this provides a very powerful message to residents of the benefits and success of treatment. Many ex-consumers of the service are involved through the volunteer program as mentors to current TC members and, through the provision of training opportunities, as members of staff.

### **Three key elements of the TC model are:**

- Community as method
- Staged approach
- Holistic and Multidimensional approach

### **Community as Method**

The profound distinction between the TC and other treatments and communities is the use of community as a method for changing the whole person (De Leon, 2000: p 92).

As such, at a TC the community is the agent for change. The community is made up of staff and resident members, with resident members having clear “ownership” of the environment as, for the period of engagement in the program, the TC is their home. As such the resident members have input into decision making processes and participate in maintaining the facility.

### **Staged Approach**

Typically there are different stages of a TC, with resident members having increased responsibilities and gaining privileges and status as they move through the stages. Attainment of each stage recognises increased personal awareness and growth demonstrated through behaviour, attitudes and values. Residents who have progressed through the stages play a significant peer support and role modelling function to newer residents at the TC. The staff's role as community managers facilitates interactions between the individual and the community, supporting socialisation while at the same time maintaining the social order of the TC.

## **Holistic and Multidimensional Approach**

The TC is also multidimensional and works with the whole person. As such it provides nurturance through “three meals, housing, clothing, cosmetic accessories, as well as medical, dental, and various social and legal advocacy services”. It also addresses a range of individual needs that would enhance re-entry, such as providing training, vocational skills development, parenting skills etc. More importantly, however, the therapeutic element of every activity, job function or interaction is aimed at enhancing the personal growth of the resident member.

## **14.4 PARTIAL HOSPITALIZATION**

Partial hospitalization, also known as PHP (partial hospitalization program), is a type of program used to treat mental illness and substance abuse. Those who choose partial hospitalization programs are able to live at home, but they spend three to five days per week at the treatment center. These programs may be offered in hospitals or community mental health centers.

Partial hospitalization refers to a comprehensive, short-term, intensive, clinical treatment program. With regard to level of treatment, partial hospitalization is a step below inpatient hospitalization but more concentrated than traditional outpatient care. Clients are generally referred to partial programs when they are experiencing acute psychiatric symptoms that are difficult to manage but that do not require 24-hour care. The goal of treatment is to help the client and prevent or reduce inpatient hospitalization. This level of care can also be used as a “step down” program for those clients who have completed an inpatient or residential program. Those who choose partial hospitalization programs are able to live at home, but they spend three to five days per week at the treatment center. These programs may be offered in hospitals or community mental health centers. Clients experiencing acute distress in their lives may benefit from a partial hospitalization program. These programs help clients understand their illness, adjust to medication schedules, build coping skills, and set recovery goals that will enable them to return to functioning.

Most partial hospitalization programs include the following treatments:

- ❖ Individual and group therapy
- ❖ Psycho-education
- ❖ Skill-building
- ❖ Psychiatric medication assessments and check-ins

## **14.5 DAY CARE CENTRE**

### **Definition**

Day care refers to the care provided for infants and toddlers, preschoolers, and school-aged children, either in their own homes, in the home of a relative or other caregiver, or in a center-based facility.

## **TYPES OF DAY CARE**

### **Center-based care**

Center-based care may also be labeled child or daycare centers, nursery schools, or preschools. These facilities care for children in groups. They may have different sponsors, including universities, schools, churches, social service agencies, independent owners or chains, and employers. Many parents choose center-based care because they believe the presence of multiple caregivers, larger groups of children, and state inspections make them both safer and more dependable. Some parents also consider these types of centers a better learning environment for their children.

The National Association for the Education of Young Children (NAEYC) issues recommendations relating to the organization and structure of daycare centers, particularly those that provide care for infants and toddlers. These recommendations are considered to be the minimum standards a daycare center should observe. Their recommendations concerning staff to child ratios are as follows:

### **Family childcare providers**

Family childcare providers offer care for children in the provider's home. Requirements differ from state to state. However, the majority of states require that providers be regulated if they are watching more than four children. Many states may have a voluntary regulation process in place for those providers caring for four or fewer children. Regulations usually require providers to meet minimum health, safety, and nutrition standards. In addition, they are usually required to have a criminal background check. Some states yearly inspect the homes of family childcare providers, and many require ongoing training. Parents often make this childcare choice because they prefer their children to stay in a more home-like environment. This arrangement may be less expensive and more flexible than center-based care. Parents may also believe that their children are better off in smaller groups with a single caregiver.

The American Academy of Pediatrics recommends that family childcare providers should have six children or fewer per one adult caregiver, including the caregiver's own children. The total number should be fewer if infants and toddlers are involved. No caregiver who works alone should be caring for more than two children younger than two years of age.

### **In-home caregivers**

In-home care occurs in the child's own home. This care includes both live-in and live-out nannies and baby-sitters. Most in-home caregivers are not state-regulated, though many nanny-placement agencies are subject to state regulation. If in-home caregivers receive childcare subsidy payments, they may be required by many states to have a criminal background check done, and a very few states have minimal health and safety training requirements.

**The advantages of in-home caregivers are:**

- ❖ Children receive one-on-one care.
- ❖ Children may be safer and feel more secure in their own home.
- ❖ Parents may feel they have more control over the type of care their children receive.
- ❖ There is the possibility of more flexible scheduling.
- ❖ Care will usually be available even if the child is ill.
- ❖ There are also disadvantages to in-home care. These include:

**14.6 HALFWAY HOME (HOUSES)**

Halfway Houses provide community rehabilitation service for discharged mental patients after a period of medical treatment to facilitate re-integration into the community.

**Purpose and objectives**

The overall objective of halfway houses for discharged mental patients is to provide a transitional period of residential care to facilitate residents to achieve an optimal level of functioning for the purpose of community re-integration by

λ Establishing a reasonably stable pattern of life, alleviating the effects of institutionalization and developing their capacity to cope with daily living; and

λ Providing a supportive environment conducive to personal development and independence

**Nature of service**

The services provided by Halfway Houses include:

- a) Accommodation
- b) Provision of food and meals
- c) Developing understanding of and ability to cope with mental illness
- d) Development and training of life skills such as:
  - i) Self-care skills
  - ii) Social and communication skills
  - iii) Community living skills
  - iv). Work habits
  - v) Domestic skills
  - vi). Group living skills
  - vii) Positive use of leisure time
- e) Facilitation of the re-alignment of relationship with family members



#### f) Preparation for discharge from the halfway house

The ultimate goal of rehabilitation is to make persons with mental illness independent in all aspects of their lives -- financial, social, relationships building and maintaining. Rehabilitation services shall be offered in various settings, including mental health establishments, community centres and homes.

### **Halfway Houses in the Correctional Process**

Within the criminal justice system, halfway houses have been used for several target populations. Mandatory releases and parolees who are in need of a transitional facility and the services it can offer have been significant target groups. A halfway house is an institution that allows people with physical, mental, and emotional disabilities, or those with criminal backgrounds, to learn (or relearn) the necessary skills to re-integrate into society and better support and care for themselves. A halfway house is a residence located in the community where people are placed to either (1) serve all or part of a sentence, or (2) serve a period of time after being released from federal prison, in order to prepare for reentering the community.

Halfway houses are also frequently used for probationers as an alternative to incarceration. Many houses can now offer study and diagnostic services to aid the courts in their sentencing decisions. Inmates who are released from institutions prior to mandatory release or parole are using halfway houses as prerelease, work release, and educational release centers. Some houses serve neglected juveniles or juveniles adjudged delinquent as alternatives to detention facilities or training schools. Finally, many halfway houses limit their target populations to criminal offenders with special problems, such as drug abusers, alcoholics, and individuals with psychiatric problems.

## **14.7 SHELTERED WORKSHOP**

A sheltered workshop (SW) provides persons with disabilities a training environment specially designed to accommodate the limitations arising from their disabilities, in which they can be trained to engage in allowance-generating work process, learn to adjust to normal work requirements, develop social skills and relationships and prepare for potential advancement to supported/ open employment where possible. It is a welfare-oriented service without an employer/employee relationship between the workshop operators and the trainees.

### **Purpose and objectives**

The objective of Sheltered Workshop is to provide vocational rehabilitation service through:

- Training opportunity in a planned environment

- opportunities for work adjustment and advancement with the ultimate objective of enabling persons with disabilities to move on to supported and open employment where possible
- Training to persons with disabilities to develop and maintain social and economic potential

**The services provided by Sheltered Workshop include**

- a) Training in work habits
- b) allowance-generating work skills training
- c) on-going assessment on progress of trainees
- d) Provision of activities to meet developmental and social needs
- e) Provision of work-related referrals and referrals for other appropriate services where required.

## **14.8 TRANSITIONAL HOUSING**

Transitional housing refers to a supportive – yet temporary – type of accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, support (for addictions and mental health, for instance), life skills, and in some cases, education and training.

“Transitional housing is conceptualized as an intermediate step between emergency crisis shelter and permanent housing. It is more long-term, service-intensive and private than emergency shelters, yet remains time-limited to stays of three months to three years. It is meant to provide a safe, supportive environment where residents can overcome trauma, begin to address the issues that led to homelessness or kept them homeless, and begin to rebuild their support network.”

Historically, transitional housing programs were situated within dedicated, building-specific environments, where there was more common space and less private space than might be the case in permanent housing environments. However, as the concept of transitional housing has evolved, new approaches that incorporate scattered-site housing are now being adopted. In such cases, some of the transitional ‘supports’ are considered portable.

Transitional housing, as an approach, has long been seen as part of the housing continuum for people who are homeless, and in particular for sub-populations such as youth. However, in recent years it has become somewhat controversial, particularly in light of the success of Housing First models, which do not require ‘readinesses for a transition.

## **14.9 NATIONAL MENTAL HEALTH PROGRAMME AND POLICY**

The Central Council of Health and Family Welfare (India) formed an expert group in 1980 which recommended about the implementation of National Mental Health Programme. The group submitted the report in August 1982. The National Mental Health Programme appeared almost simultaneously with the National Health Policy (1993). The objective of NMHP are as under:

- 1) To assure availability and accessibility of minimum mental health care for all in the foreseeable future particularly to the most vulnerable and under privileged sections of population.
- 2) To encourage application of mental health knowledge in general health care and in social development.
- 3) To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

**The following three aims specified in the NMHP in planning mental health services for the country:**

- 1) Prevention and treatment of mental and neurological disorders and their associated disabilities.
- 2) Use of mental health principles in total national development to improve quality of life.
- 3) Application of mental health principles in total national development to improve quality of life.

Two strategies, complimentary to each other, were planned for immediate action:

- 1) Centre to periphery strategy: Establishment in all district hospitals, with out-patient clinics and mobile teams reaching the population for mental health services.
- 2) Periphery to center strategy: Training of an increasing number of different categories of health personal in basic mental health skills with primary emphasis towards the poor and the underprivileged, directly benefiting about 200 million people.

The mental health care service was envisaged to include three component or sub programmes: treatment, rehabilitation and prevention.

### **A) Treatment Sub-programme**

- 1) Multiple levels were planned. Village and subcentre level: Multi-purpose works (MPW) and health supervisors (HS) under the supervision of medical officer (MO) to be trained for:
  - i) Management of psychiatric emergencies.

- ii) Administration and supervision of maintenance treatment for chronic psychiatric disorders.
- iii) Diagnosis and management of grandmal epilepsy, especially in children.
- iv) Liaison with local school teacher and parents regarding mental retardation and behaviour problems in children.
- v) Counselling in problem related to alcohol and drug abuse.

2) **Primary health Centre (PHC):** Medical Officer aided by health supervisor to be trained for:

- i) Supervision of Multi-Purpose Works Performance.
- ii) Elementary Diagnosis.
- iii) Treatment of Functional Psychosis.
- iv) Treatment of Uncomplicated Psychosocial Problems.
- v) Management of Uncomplicated Psychosocial Problems.
- vi) Epidemiological Surveillance of mental morbidity.

3) **District hospital:** It was recognized that there should be at least one psychiatrist attached to every district hospital which should have 30-50 psychiatric beds. The psychiatrist in a district hospital was envisaged to devote only a part of his time in clinical care and greater part in training and supervision of specialist health workers.

4) **Mental hospital and teaching psychiatric units:** The major activities of these higher Centre of psychiatric care include:

- i) Help in the care of difficult cases,
- ii) Teaching,
- iii) Specialized facilities like occupational therapy units, psychotherapy, and counselling and behaviour therapy.

### **B) Rehabilitation Sub-programme**

The components of this sub-programmes include maintenance treatment of epileptics and psychotics at the community levels and development of rehabilitation centers at both the district level and the higher referral centers.

### **C) Prevention Sub-programme**

Prevention is to be community based with the initial focus on prevention and control of alcohol related problems. Later problems like addictions, juvenile delinquency and acute adjustment problems like suicidal attempts are to be addressed. The other approaches designed to achieve the objective of the National Mental Health Programme are:

- 1) Integration of basic mental health care into general health services.
- 2) Mental health training of general medical doctors and para-medical health workers.

## **14.10 DISTRICT MENTAL HEALTH PROGRAMME, TAMIL NADU**

DMHP is a community based mental Health care programme based on the guidelines of National Mental Health Programmes fully funded by the Government of India with the prime objective of reaching the unreached.

In Tamilnadu, DMHP was launched in 1997 in Trichy and it was extended to Madurai and Ramnathapuram in 2001. Based on the efficacy of the project, the Government of India has extended the programme in another 13 districts in a phased manner in Tamil Nadu.

### **Aim of the Implementation of DMHP**

- To ensure **availability and accessibility of mental health care** to all the most vulnerable and under-privileged.
- **Integration of Basic Mental Health care** with general health services.
- To **promote Community Participation** in the mental health services and to stimulate efforts towards **Self-help**.
- To **Increase Awareness** about mental health in general public.

### **Objectives of DMHP**

- **Early detection and treatment** of patients within the community itself.
- To see that the patients and their relatives **do not have to travel long distances** to go to hospital or nursing homes in the cities.
- To take **pressure off the mental hospitals**.
- To **reduce the stigma** attached towards mental illness through change of attitude and public education.
- To **treat and rehabilitate** patients discharged from psychiatric hospitals within the community.

### **Components of District mental health programme**

1. Training programmes of all workers in the mental health team at the identified Nodal Institute in the State.
2. Public education in the mental health to increase awareness and reduce stigma.

3. For early detection and treatment, the OPD and indoor services are provided.
4. Providing valuable data and experience at the level of community to the state and Centre for future planning, improvement in service and research.

**Salient features of District Mental Health Programme-Tamil Nadu:**

- Ten bed Psychiatric wards have established in all the districts were DMHP is being implemented and also equipped with the necessary medical equipment as follows : Boyles Apparatus, Blood Pressure Apparatus, Ophthalmoscope
- Psychiatrists are posted in all the districts, filling up the post of Psychologists & Psychiatric Social worker is in process.
- Basic Psychiatric Medicines are available at the PHCs level in the Programme Districts.
- The Suicide Prevention Centre is established in all the 16 DMHP districts.
- In a nationwide survey on the overall satisfaction with quality of services provided under the District Mental Health Programme, Tamil Nadu especially **Madurai topped scoring 9.6 out of 10.**
- Formed an advisory committee to monitor the functioning of DMHP at district level in which the District Collector is a Chairman and the members of the family federation are one of the committee members.
- Periodical Monitoring is being done by the Secretary at the State Level and by the respective collectors at district level.

**Check your progress**

Note: Use the space provided for your answer

1. What is peer support?

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2. What are the elements of TC?

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3. What is half-way home?

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4. What are the components of DMHP?

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5. What is transitory home?

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### **14.11 SUMMARY**

In some TCs, people with various longstanding emotional problems spend time and engage in therapy together in an organised and structured way, without drugs or self-damaging behaviour, so that a new life in outside society is made possible. There are others living in TCs who cannot live normally in society (for reasons such as severe learning disability or persistent psychosis) and engage in an interdependent form of group living which helps them to have a more fulfilling life and achieve their maximum social potential. The workings of the therapeutic communities themselves are the main method, and through these social and group processes, change and growth are promoted. Halfway houses are safe living environments that help people re-enter society and avoid relapse into substance abuse, crime or homelessness. They set residents up for success by teaching them life skills and allowing them to practice those skills while living in a structured environment. High-quality learning centers develop programs that nurture trusting relationships with their peers, teachers, and parents. In order to learn these skills, the child needs to feel secure with their caregiver or teacher. National mental health programme increases awareness & reduces stigma related to Mental Health problems. It also provides service for early detection & treatment of mental illness in the community.

## KEY WORDS

- ❖ Therapeutic community
- ❖ Partial hospitalization
- ❖ Peer support
- ❖ Day care centre
- ❖ Half-way home
- ❖ National Mental Health Programme
- ❖ Training
- ❖ Awareness

## SELF-ASSESSMENT QUESTIONS AND EXERCISE

1. Elaborate the therapeutic community
2. Explain the key elements of TC
3. Write a short note on partial hospitalization?
4. Bring out the types of day care centre
5. Enlist the objectives of half-way homes
6. Explain in short on sheltered workshop
7. Write in detail on the national mental health programme in India
8. Bring out the salient features of District Mental Health programme

## 14.12 FURTHER READINGS

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# MODAL QUESTION PAPER

**TIME: 3 HOURS**

**MAXIMUM MARKS: 75**

## **SECTION – A (10 x 2 = 20 Marks)**

**Answer All Questions**

- 1) Define mental health
- 2) Give any four characteristics of abnormality
- 3) What is avoidant personality?
- 4) Enlist the emotional symptoms of behaviour disorder
- 5) Bring out any four causes of scholastic backwardness
- 6) Give the objectives of marital therapy
- 7) What is delusion?
- 8) What are the types of paraphilia?
- 9) Define cerebral palsy
- 10) What do you mean by reintegration?

## **SECTION – B (5 x 5 = 25 Marks)**

**Answer All Questions**

11. (a) Explain nature of psychiatric social work  
(Or)  
(b) Explain the utility of case work method in the psychiatric setting
12. (a) Write down the treatment process of ADD  
(Or)  
(b) Explain the types of eating disorder
13. (a) Bring out the signs of intellectual disability  
(Or)  
(b) Narrate cultural bound syndrome
14. (a) Write down the techniques of BT  
(Or)  
(b) Explain the various problems of old person
15. (a) Elaborate the key elements of Therapeutic Community  
(Or)  
(b) Write the functions of psychiatric social worker with family of the patient

## **SECTION – C (3 x 10 = 30 Marks)**

**Answer Any THREE Questions**

16. Explain the historical development of psychiatric social work
17. Elaborate the MSE
18. Discuss the role of psychiatric social worker in the team work
19. Bring out the principles of psychiatric rehabilitation
20. Narrate the significance of national mental health programme in India