Paper presented

At

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Institutional Rehabilitation: Issues and Challenges

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PREFACE

This seminar has had a long gestation period, and I am especially grateful to those who gently pushed me to get on with this initiative. I am particularly indebted to Dibyajyoti, my colleague and Honorary Director of Mission Ashra. The programme we set for rehabilitation of mentally ill women was at initial stage in the year 2013. I am thankful to you for believing in me and the mission. I have realized that the next generation are quite competent to drive this journey forward, to the suffering world in a more meaningful way. I can say that in a way, this is a transition of leadership, and first time the young team has shown their remarkable interest, patience when my intervention reached its head near the finish line of this seminar.

Thanks to my youngest team from TISS, and particularly to Shreya and Tanya from my office, those who are utilizing their knowledge to deliberate and finally make this happen. Obviously my other team members are sharing their experience for this, including Darshan, Tanaya, Jigyasa and the entire Mission Ashra family, Sukant and other team members, thanks to all of them.

This message is just a thanks giving page where I recognize the contribution of different stakeholders and in this regard, it is incomplete without having the name of Prof. Dr. Sharda Swain, Director MHI Cuttack and in house psychiatrist and assistant professor Dr. Suvendu Mishra. Without their contribution and support, this would not have been possible. From its inception, the mission and the organization cannot forget the contribution of Prof. Dr. NeelamadhabRath, the most patient friendly psychiatrist of our state, whose motivation drives us time to time to continue this journey. And again I am thankful to each and every one, those who are directly or indirectly involved in making this a success.

Gobinda Chandra Pattanaik

(Member Secretary, Peoples Forum)

EDITORIAL

Prof. (Dr.) SaradaPrasanna Swain

Director MHI (COE)

S.C.B.M.C& H, Cuttack

In last decade the Concept of Mental Health rehabilitation has taken a new dimension after alarming increasing burden of homeless mentally ill, not in our state but also in our country.

According to a recent survey done by Govt. of India (through NIMHANS), approximately 10,000 Mentally ill patients are now staying in Psychiatric Hospitals after recovery (because they have not return to their own home since years), which have crowded the Mental Hospitals of the country. In India, there is 30,000 Psychiatry beds in indoor for Mentally ill patients. Out of which 10,000 beds are occupied by homeless mentally ill, then where is space for treatment of acute Mentally ill patients? In Odisha the premier institute Mental Health Institute, Cuttack has approximately 80 homeless mentally ill in the indoor, which is a 150 beded hospital. So it is the time for policymakers, Stake-holders of Govt., N.G.OS and ultimately citizen of the country to think about "MENTAL HEALTH REHABILITATION".

The age old rehabilitation of the country which was persistent since last century "FAMILY" has been broken down now adays because of change of sociocultural dynamics of India. Nobody in family is ready to take care of the near & dear ones by following the foot prints of western civilization. In my own hospital, which is the historic institution of the state, every month 10-15 homeless mentally ill are added, by either left by family members after becoming cured or by admission of homeless mentally ill.

The evolving concept of rehabilitation by peoples forum "ASHRA" is worth exemplary since last 10 years which have expanded from Bhubaneswar to Jharsuguda and Anugul. I have no word to praise the Institution for the starting the concept of rehabilitation by rescuing home-less female mentally ill, even when so called newer Medicare were not available. Can I say "God will reward the persons & institutions"

Lastly I can say I have started a new concept of mental health rehabilitation by involving District legal call NGOs, The Psychiatry social work Department of our Institute, The health & F.W Department of govt. of Odisha and SSEPD Department of govt. of Odisha and lastly all the staffs of Mental Health Institute Cuttack.

Mental Health rehabilitation will take a new shape after the concept of "Mental Health Establishment" in new mental health care act 2017. Which has already came in force. Lastly all Mental Health Professional, NGOs, Govt. sectors and Private sector unite to make a change in the quality of life and living condition of these abandoned human beings making the society free from homeless mentally ill.

Of serving the Homeless Mentally Ill:

"The lights between oceans"

"I have seen yesterdayI know tomorrow"

Prof in Psychiatry, Mental Health Institute, SCB Medical College Cuttack

First time I was meeting the sea at Puri, the ocean and the skies over oceans and its blue vastness. I was a five-year-old child not knowing of the waves at the sea. I fell with a thud of wave, had a taste of the brine-bitter and salty.Coming from the bank of our village pond, a tank of an eight hector the largest known water body. I tasted the salt in water of the sea, almost vomited out. I clung my new sponge chappals that were floating away. I had started crying being afraid of the sea and its salty water. My father grabbed mefrom sand and salt, and I was in tears.

Why the sea water is salty. I had asked my father then the sea water is salty for being filled with human tears -my father told me. The man-kind had cried so much tears! I had a taste of my tears too. At mission Ashra. I have always taste of these oceans of tears.

After almost sixty years later, as a doctor who does not retire and teacher wo refuses to die, I have seen lights in form of my teachers, men and women many institutions as lights. Lights and light housesin between oceans of tears, darkness, tsunamis and storms. I have always been by the side of these lights who are salvaging human garbage, serving the homeless, mentally ill and the most helpless. These have been bridges between dismay and discovery that life can have one more spark, can have hope and victory of the soul, the human spirit.

MY SOUL:

She was moving alone.

She had twenty plastic empty bottles tied to her. Clothes were torn, dirty, so were her tanged locks of hair. She was soaked with dirt, blood semen thorns rashes, and smelled foul. Her eyes were bright with dried tears and mucous.Thumbs and nails studded to her body, and wires and rings. A wandering lady lunatic. I nick named 'Mangla' as she roamed around Manglabagsquare in front of Manglabag police station amid jeers, laughter, filthy jokes and filthier comments. She was preyed upon by drunkards, goons, lump in elements maybeshe traded food for being easy meat never knew what was happening to her when Samaritans of Janani caught hold of her to bring her to thehospital of Mental Health Institute- volunteers of Janani guarding her.

Shopkeepers around obstructed, where are you taking her? To cannibalise her kidneys? Eyes? Police did come to help. She had bitten- jawed and clawed a few. Subjugated, cleaned to undress to give a pair of new clothes-her bottles nails and wires were cut apart.It was a ghastly sight. Her uterusfell apart precedential covered with a white sheet she was rushed to Gynaecologyunit then manned by my friend the most eminent gynaecologist of our country Prof. Purna Chandra Mohapatra of SCB, who volunteered to operate, helped with all medicines and all needfulthat saved her. A chronic schizophrenic. Treatment for mental illness along with operation for the total prolapse of uterus -hysterectomydone to save her started simultaneously.Kalinga Kalyan took over. Janani of Kalinga Kalyan Shelter ManglaDeyBabu, no more Madam Kalpana. Madam BharatiahaveMangla.

In DeyBabu's farm, a self-sustained shelter,Mangala nowmanages orphan babies, calves, rice fields, vegetable patches and other helpless inmates wherewild elephants roam, at times panthers howl and rarely peacocks dance in the background of SankarpurKothi, Damdamani shrine, mountain ranges, foot hills and hillocks, springs and flowers. The Janani – As a Psychiatrist, I call it my Soul.

MY FRIEND - Dealing directly with wanderinglunatics started by patients brought by GobindaPattanaik of People'sForum in the background of super cyclone in 1999. Managing them in to garages of SCB Hospital and its dark lanes. I took help from Kalpana Madam of Sakha – Who provided food and managed them with medicines and injections.The real engagement started in 2003 – when Manglaof Manglabag started it all – from calf love fleeting to companionate – serious affair.

MY BODY -A mentally ill wandering unkempt lady fully naked was in labour pain delivering baby in OMP square and a hundred by standers started watching the free academic childbirth session in obstetrics till volunteers threw open a shawl. They helped in delivery, rescued and brought the patient once more to labour room mother saved, child saved taken care by Archana madam,Rinimadam, Saila madam of Basundhara,Cuttack. Aswasana of GhatiroutPatna a branch of BasundharaCuttack was born – catering to the needs of homeless mentally ill women at Cuttack.

This is the best infrastructure of NGO Odisha. In the riverine back drop across Choudwar to Jagatpur, the ChiefArchitectBhavani Mishra who has a lot of contribution to MHI COE building of its beautification has done a lot for BasundharaMental Health shelter. A School, a hostel,a shelter home conference hall, farmland and orchard spread to around sixth acres. I call it my body, a body that harbours a psychiatrist – a mind that minds mind!

She was mute, tiedto pole in costal northern Odisha for twelve years, GobindaPattnaik and his team of Mission Ashra, People'sForum rescued her, brought her to MHI. We did keep her, treated her cured her till she sang, danced celebrated Diwali, went back to her native place, united to her parents.Thousands and hundred have stayed in Ashra, patients have come from 'Biswa' Sambalpur, Chennai, 'Sneha' of Mumbai.

DibyajyotiBabu, BuluBabu and most affectionate staff nurse superintendent pharmacist and worker all in one, Pratima taking over. Whether I wanted or not I have become a part of mission Ashra.I was there clapping when Gobindababureceived prestigious lady DurgabaiDeshmukh award from then President of India at Ashoka Hall of Presidential palace New Delhi. I was there when Sheetal aliasGudia left mission Ashra with her husband and reunited with her son. I was there when Adyasha, the 1st patient of mission Ashrabreathed her last at Head Quarters Hospital, Khurda, paralysed, yet rose to her feet from death to fall on feet of volunteers of Mission Ashra for the first time talking, giving her thanks while dying. No Psychotropic medicine work in psychosocial vacuum. Themagnificentatmosphere, the affectionate responsible missionary, zeal of People'sForums Mission Ashra as well as the Mother TeresaMissionaries of Charity dealing with mentally ill patients adjacent to boundary of Mission Ashra change, the resistant, refractory wandering lunatics, homeless mentally ill the utmost change.

Mission Ashra team has the Midas touch to turn clay to human and humans to deities we call God!

As a Psychiatrist, the Mission Ashra is my heart

The mentally ill are abed in hospital units, mostly in our Mental Health Institute some deliberately some desperately, some are driven away, some patient reaches us, we cannot, we should not refuse any one. Whether mentally ill or not patients in critical health conditions are thrown in to mental health institute campus either through causalities, dealers of the dark nursing homes and brothers not helping sisters, children not helping old parents, mothers, father abandon their wards and disappear mostly giving false address and names – in helplessness as we leave unwanted babies in church/temple/orphanage gates.

We do keep them as patients govt. provides only meals, we must cater to other essentials. Many of them are aged, injured, drug addicts, some of them are criminal's scot free, psychopaths disrupting ward environment.

One NGO with its volunteers serves destitute and vigilant of negligence wards stink. The paid attendants do not have missionary zeal. They are just zoo keepers. We need angels at hell.

Is has it volunteer Deepak babu, AchutyaBabu in the campus, senior Ram babu withBuddhist zeal and calm vision help our patients and waters, gives life even to plants and animals around. Sevak has a hundred odd old, young patients of dementia and ageing atChhatia – in presence of the Statue of Lord Buddha upcoming – the kind and compassionate one!

Many highest officials in administration have helped MHI COE in mental health Cuttack serve the homeless mentally ill. As Municipal Health Secretary, Anu Garg madam, Aarti Ahuja madam,Sujata Kartikeyan

madam, as Director,Rupa Mishra madam, Pradeep Mohapatra Sir, Swaswat MishraSir, as CollectorSri S N Girish, Sri Niranjan Sahu, among political great figures Sri PanchananKanungo,Sri PrasanaAcharya all have gone out of their ways to help the organisations and our friends. The pediatricSurgeon Dr.PravasSubudhi, Dr.KedarBabu, Pediatrician ofSishuBhavan and Dr, R K Shukla, Dr.AshrumochanSahu, the psychiatrists, Dr, JasobantaMohapatra the psychologist have contributed immensely for the destitute mentally ill.

The Honorable Supreme court helps Honorable Human Right Commission, the honorable state human rights commission, many legal bodies and district administrate police department medical patient Police and post and Manglabag police station. All have helps us and our Mental Health Institute to take care of the homeless mentally ill at the mental health institute and beyond in the community settings in NGO's. We are always grateful to them.

So many road maps, so many plans and orders shine, and decay promises hardly kept or pursued. We all have come a long way.My dearcompanies like the Sun the Intas theInnova, the psycho remedies of Contributing Medication, ensure, many of their officers Bunubabu, Sangrambabu, Kartikbabu, Deepak babu all have contributed along with me in my association with mission Ashra on behalf of MHI.

Dr.Laxmidhar MishraIAS, Rtd.,Ex special rapporteur of NHRC on mental health Sri. Deepak Sarangi, ofNHRC. Dr.Mathur, Central Health Body,Azadall have visited, contributed for the cause of such a movement of servicing the homeless mentally ill- mission Ashra leads this endeavor with a missionary seal par excellence. Basic needs India, the Banyan, the Sneha all have been inspiration in our background.

I do identify with mission Ashra. I am a part of it for last sixteen years with body heart and soul. The Ashra has been a light house of hope dedication the light between oceans of tears. In a way it is one-sidedlove affair.Yours, only yours, yours for ever -me- often. I feel without you 'Ashra' still feel a stranger to myself. Though my fate has been changed over years. I shall always be yours as a psychiatrist. I am the outsider, yet I behave as the insider. The soul within me is your soul. I have seen yesterday. I know tomorrow.

I am – today

Dr. NeelmadhavRath

Management of a child from orphanage in a non-rehabilitation setup: issues and challenges faced

Childhood remains the most lovable and memorable time of one's life. It lays down the foundation stone of a grown up adult with all its early life learning and shaping of one's behavior based upon one's genetic foundation as is inherited. Any deviation from one's normal growth (both in physical and emotional aspects), keeps a long term imprint on the child's cognitive make up which if not properly addressed, might remain for lifetime. A child can be in distress both from his health and emotional perspective. Here we discuss about a distressed child who was an orphan and who presented with behavioral and emotional turmoil along with his assessments and managements form a psychiatric point of view.

A 8 year old muslim boy N was brought to the psychiatry OPD with complains of irritability, decreased interaction and self-mutilation behavior for few weeks. He was brought to the department by a person who is a caretaker of a child welfare home (government registered) and he had with him a document which states that this boy was moved from another child welfare home from a distant place to the present location which is nearby to our hospital. The document also states that N is an orphan and his behavioral problems prompted his current visit to our hospital.

On admission, an intimation was given to the child shelter home about the need for his detailed evaluation and management and they were also updated about his management progress from time to time. N was found to be quite irritable with frequent sobs and he was found to be shunning away from all sorts of social relationships while in the ward. He was visited daily but every attempt to talk with him ended in a failure. He would remain curled up in bed and would rarely get up only to go to the washroom and take his food. A detailed history was not available since the current caretaker knew N for only few days. On physical examination, he was found to be emaciated. His head appeared to be apparently big than his body and there was bilateral eyelid puffiness. There were few cut marks and occasional bruises on his hands which were told by the caretaker to be due to his self-mutilating behavior. A syndromic condition was suspected and a pediatric opinion was sought for ruling out or diagnosing any such. A detailed biochemical workup was done which were within normal limits. He was managed from a multi-pronged perspective. Pharmacologically his irritability, self-mutilatorbehavior and his intermittent catatonic symptoms (mutism, negativism) were managed with a low dose antipsychotic (risperidone) and lorazepam. Lorazepam was gradually tapered over few days after which his mutism and negativism waned off. Risperidone was quite effective to reduce his behavioral problems. A nutritional support was given to him with proper focus on

protein and calorie intake. He was interviewed daily by one resident doctor and the nursing staffs which involved a detailed mental status examination (MSE) that was serially done over days showing improvement in his behaviour. During the initial days of his admission, when he was apparently interacting less, he was given paper and colour pencils to draw out of his mind that was done in an attempt to know his thought process. Gradually, when he started to respond with this management plan, he was often sent outside the ward for a walk along with his caretaker and he would return with a smile on his face. He was discharged and was sent back to his shelter from where he was brought and a regular follow up was planned. The child described above had multiple issues worth assessing. He was an orphan and thus lacked parental care from his early childhood. He lacked a home environment and nurturance while staying in the child home. We did not get any information about whether he was physically or mentally abused in the home due to lack of any third party information source apart from the caretaker who accompanied N but still such a possibility can never be ruled out. Whatever the issues might be, we propose that a holistic management plan (including both short term and long term rehabilitation aspects) should always be taken that would comprise a child's overall development in terms of physical, emotional, nutritional, cognitive and behavioral aspects of development alongside with liaison of all hand-holding parties and stakeholders involved in the care of a child in distress. One should also need to keep the socio-administrative and legal issues in mind while managing such case too.

Article by: Dr. SantanuNath, Dr. Susanta Kumar Padhy, Dr. JIgyansaIpsita, Dr. TanuKumariDr. Shree Mishra, Dr. BiswaRanjan Mishra, Dr. SuraviPatra.

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Destitution and Mental Health

Susmita Rath*MBBS intern*

Guided by Dr.AmritPattojoshi(Professor and HoD Psychiatry at HMCH,BBSR) and Dr.PallabiSahu(Assistant Professor Dept. Of Psychiatry at HMCH,BBSR)

Abstract: This paper presents a bird's eye view of the interrelationship between the destitutes of the world and mental illness. It first gives a broadened definition of poverty and what it encompasses following which the mechanism of how poverty cause mental illness and how mental illness leads to poverty has been explained. These are then backed by evidences and facts which prove the reality of the situation and its depth in the world scenario especially the developing countries and the loopholes on our health plans and government policy setups are discussed. Finally, some general recommendations are given in how the situation can be tackled in a practical basis.

Keywords: Destitution, psychosocial disabilities, depth of poverty, marginalization, social exclusion, human rights violation, MDG(Millennium Development Goals).

Introduction

"The biggest enemy of health in the developing world is poverty."

-Kofi Annan, former Secretary-general of the UN

There is a vicious, self reinforcing cycle of destitution (poverty) associated with mental illness. The relationship between mental illness and poverty is both straightforward as well as a complex one as poverty impacts mental illness both directly and indirectly. People with mental illness often live in chronic poverty. Conversely, poverty can be a significant risk factor for poor physical and mental health. Understanding this broader concept is key to addressing poverty in order to promote mental health and support the recovery of people with mental illness. Even though the definition of poverty varies with social, cultural and political systems, attempts to understand poverty from poor people's perspectives reveal that poverty is a multidimensional social phenomenon. Hence, we begin with the definition of poverty.

Poverty[1]: Poverty is defined as the lack of sufficient income to provide for the basic necessities of life, consistent with the norms of the society in which one lives. Nationally and internationally, there is growing recognition that poverty invokes more than just income deprivation. It can also extend to or result from exclusion from:

1)essential goods and services

2) Meaningful employment and decent earnings

3)adequate and affordable housing

4)safe neighbourhoods with public amenities

5)health and well being

6)social networks

7)basic human rights

The depth of poverty is measured by how far individuals and households fall below the poverty line and by the number of years they stay poor**.**

Mechanism of the interrelationship between poverty and mental health

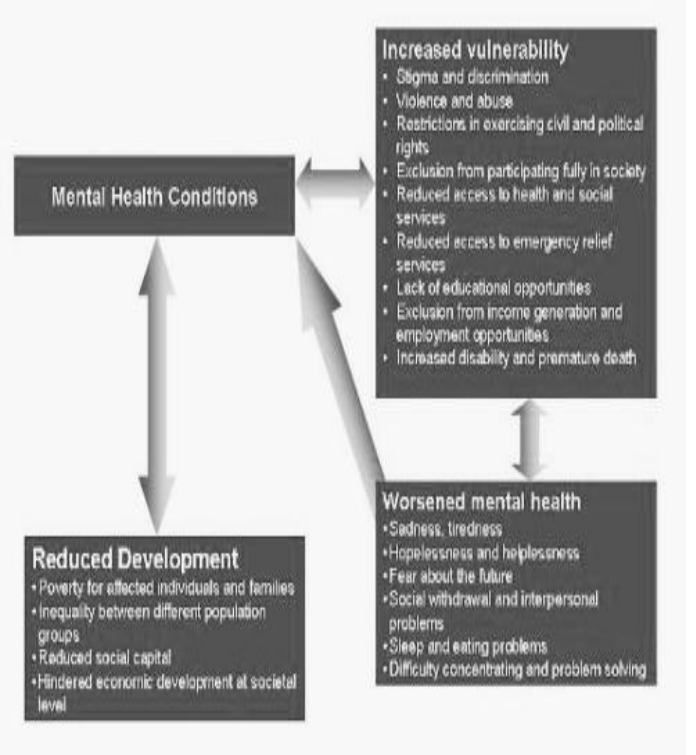
The Fig.1[2]comprehensively showcases the factors from both poverty and mental illness which lead to the creation of the vicious cycle.

Besides these, poverty also affects ongoing health care therapy of the poor as the poor patient cannot engage in therapeutic work due to[1]:

1)worries related to their basic survival

2)clients presenting emotionally and environmentally unstable

3)an absence of their basic needs being met and consequent need to problem solve and identify resources for clients



4)a need to address acute symptoms of distress eg. suicidal ideation, self harm, intent hunger

It is also important to note some factors which lead to the mentally ill facing chronic poverty:

1)lack of sufficient primary health care and community mental health services

2)shortage of safe and affordablehousing which is pivotal to recovery

3)inadequate income support

Moreover, as poverty affects adults of the community, it thus indirectly affects the mental health of the children too. Poverty affects parenting behaviour[4](the parent gets irritable, abusive, aggressive or ignorant and depressed) which leads to impaired child mental health as mostly children and women are at the receiving end of the effects on behaviour of the person responsible to earn for the family. This in turn leads to higher levels of depression and antisocial behaviour amongst the children who later grow up to be poor adults again. Here, it's worth mentioning the effect of depth of poverty on behavioural changes seen in children of the poor. Transient periods of poverty(shallow in depth) do not affect the behaviour of poor children in contrast to longer periods of poverty(chronic poverty or deep in depth) which almost invariably affect the mental health condition of the poor children adversely.

Evidence [2],[5]-[13]:

Studies over the last 20 years indicate a close interaction between factors associated with poverty and mental ill-health[2]:

- Common mental disorders are about twice as common among the poor as among the rich.
- People experiencing hunger or facing debts are more likely to suffer from common mental disorders.
- Common mental disorders are also more prevalent for people living in poor and overcrowded housing.
- Highest estimated prevalence of mental disorders can be found among people with the lowest levels of education or people who are unemployed.

Table 1. **The association of poverty and common mental disorders: evidence from developing countries**

Country	Income group	Sample (*n*, setting)	Measures of psychiatric morbidity[a]	Prevalence of common mental disorders	Association with indicators of poverty[b]
Brazil (*10*)	Upper middle	621, urban	2 stage using SRQ and clinical diagnostic interview	Not reported	Low education <5 years (OR 3.3, P <0.001); less than ¼ minimum wage (OR 3.9, P <0.02)
Brazil (*11*)	Upper middle	1041, urban	CIDI	Major depression: 8.2% (1 month), 10% (1 year)[c]	No schooling vs >9 years (OR 3.9, P <0.001); not working currently (OR 3.6, P <0.001)
Brazil (*12*)	Upper middle	1277, urban	SRQ	22.7% (women 26.5%, men 17.9%)	No education vs school completion (OR 4, P <0.001); low household income (OR 1.76, P <0.001)
Chile (*13*)	Upper middle	3870, urban	CISR	26.7% (women 35.2%, men 17.3%)	Primary education vs higher education (OR 3.4, P <0.01); low social class vs highest (OR 2.7, P <0.01); unemployed vs full-time employed (OR 2.5, P <0.01)
Indonesia (*14*)	Low	1670, rural Sumatra	2 stage design using GHQ and PSE	GHQ case rates: 20%	Less than primary education (OR 1.47, P <0.01); no electricity (OR 2.2, P <0.001); no tap water (OR 1.7, P <0.001)
Lesotho (*15*)	Low	356, rural	1 stage using DIS	22.7% (women 23.5%, men 14.7%)	No association of education with specific diagnoses (panic disorder, generalized anxiety disorder, major depressive disorder and education[d]
Pakistan (*16*)	Low	515, remote rural	2 stage, BSI and clinician diagnostic interview	Women 46%, men 15%; 22% weighted total sample	Literate men and women had lower BSI rates (P <0.05); negative, non-significant correlations with socioeconomic factors
Pakistan (*17*)	Low	664, rural	2 stage with BSI/SRQ followed by clinician interview	Women 66%, men 25%	Inverse relationship with years of education, total household income, number of electrical appliances (P <0.05)
Pakistan (*18*)	Low	259, rural	2 stage with SRQ/PHQ followed by PAS	44.4% (women 57.5%, men 25.5%)	Not passed primary school (OR 3.7, P <0.01); experience of financial or housing difficulty (OR 4.4, P <0.01)
Pakistan (*19*)	Low	269 mothers, urban slum	1 stage locally developed anxiety and depression scale	28.8%	Husband unemployed (OR 4.1, P <0.005); irregular wages (OR 1.8, P <0.02); arguments with husband for economic reasons (OR 10, P <0.001)
Zimbabwe (*20*)	Low	172 women, urban township	2 stage with a screening questionnaire and PSE	15.7% (1 month), 30.8% (1 year)	Unemployment (OR 2.9, P <0.02); below-average income (OR 2.2, P <0.02); overcrowding (OR 2.1, P <0.02); not passed school (OR 3.4, P <0.01)

[a] BSI = Bradford Somatic Inventory; CIDI = Composite International Diagnostic Interview; CISR = Clinical Interview Schedule, Revised; DIS = Diagnostic Interview Schedule; GHQ = General Health Questionnaire; PAS = Psychiatric Assessment Schedule; PHQ = Primary Health Questionnaire; PSE = Present State Examination; SRQ = Self Reporting Questionnaire.
[b] Univariate odds ratios (OR) are presented when the outcome measure of common mental disorders was a categorical variable. The first two studies from Pakistan are the exception to these analyses, because the outcome measure was a continuous score.
[c] No data were presented on overall rates of common mental disorders.
[d] No data were presented in this paper on the risks associated with common mental disorders as a composite diagnostic group.

Fig.2

In relation to severe mental disorders, and schizophrenia specifically, data shows that:

- people with lowest socio-economic status(SES)have 8 times more relative risk of schizophrenia
- People with schizophrenia, in comparison with people without mental disorders, are 4 times more likely to be unemployed or partly employed.
- people with schizophrenia are one third more likely not to have graduated from high school and,
- 3times more likely to be divorced

Best evidence indicates that the relationship between mental ill health and poverty is cyclical: poverty increases the risk of mental disorders and having a mental disorder increases the likelihoods of descending into poverty.

- People living in poverty lack financial resources to maintain basic living standards, have fewer educational and employment opportunities, are exposed to adverse living environments and are less able to access good quality health care.
- These stressful living conditions place people at higher risk of developing a mental disorder
- People who develop a mental disorder may not be able to work because of their illness. Others, because of discrimination, may be systematically denied work opportunities or may lose their existing job.
- Lack of employment drives people deeper into poverty and people are unable to pay for the treatment that they need. In other cases, a great deal of money is spent on ineffective and inappropriate mental health care, which means that people not only end up out of pocket but also fail to get better.
- Supportive community networks help to protect against the adverse effects of illness and poverty. But for people with mental disorders social support systems often disintegrates the stigma and discrimination that they face leads to their marginalization, social exclusion and human rights violations.

- All these factors further worsen their condition and perpetuate the negative cycle between poverty and mental ill- health.

Loopholes in the system

Global data indicates that[2],[5]-[13]:

- ❖ Only 2% of national health budgets is dedicated to mental health
- ❖ 31% of countries have no specified mental health budget at all
- ❖ Although cheap and effective mental health treatments exist, it is estimated that 76 to 85% of people with serious mental disorders do not receive treatments in developing countries.
- ❖ 69% of the beds for mental health care are to be found large psychiatric asylums which are associated with a wide range of human rights violations, instead of general hospitals and community settings.

The millennium development goals currently overlook mental health. But addressing mental health issues will reinforce several of the MDGs:

- ➢ MDG 1-eradicate extreme poverty
- ➢ MDG 4-reduce child mortality
- ➢ MDG 5-improve maternal health
- ➢ MDG 6-combat HIV/AIDS, malaria, and other diseases

Recommendations [3]:

- ❖ mental health services should be integrated systematically into all health services including primary level care
- ❖ Mental health issues should be integrated into broader health policies, programmes, and partnerships.
- ❖ mental health should be included in services during and after emergencies
- ❖ mental health should be taken into account within social services and housing developments

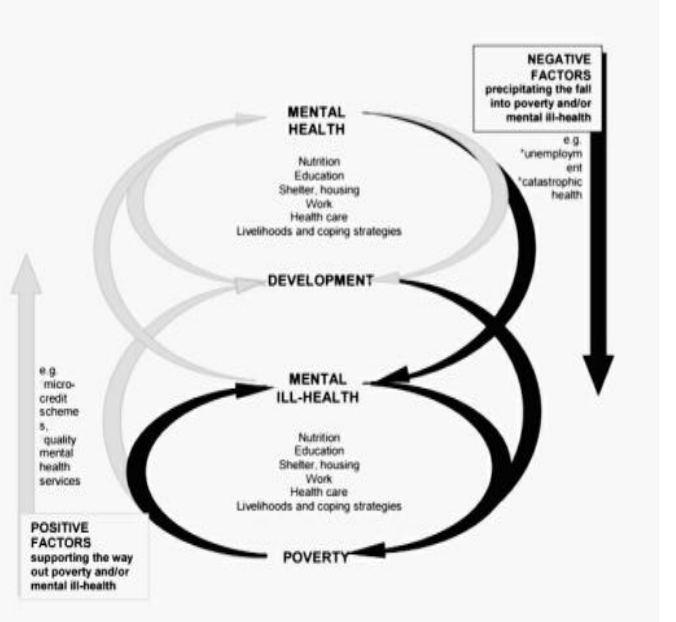


Fig.3

- ❖ mental health issues should be mainstreamed into education, and children with mental and psychosocial disabilities should be supported to access schooling
- ❖ employment and income generating opportunities must be created for people with mental and psychosocial disabilities
- ❖ human rights should be strengthened by developing policies and laws that protect the rights of people with mental and psychosocial disabilities
- ❖ There should be investment in developing the capacity of people with mental and psychosocial disabilities to participate in public affairs, including the support of service user-led movements.
- ❖ Development actors should create mechanisms to involve people with mental and psychosocial disabilities in decision-making processes.

Conclusion:

The world thus, is now striving to fight not only the physical health implications of poverty but the mental health aspects of it too. The mentally ill population should not be subjected to such strong stigma in society and for that a general understanding and tolerance towards them is required not only on the international, national or societal level but on an individual level, efforts made by each one of us at whatever level we are is going to help some mentally ill or destitute on the verge of losing sanity gain some strength and live a

normal life which they very rightly deserve. It's easy though, to talk on stage and conferences about these issues and craft ideas and recommendations to relieve the victims, but the problems faced by the social helpers and healers in the practical field still remain unsolved.

References

[1] Poverty and mental illness- CMHA(Canadian Mental Health Association),Ontario*https://ontario.cmha.ca/documents/poverty-and-mental-illness/*

[2]*Breaking the vicious cycle between mental ill-health and poverty* Geneva, World Health Organization, 2007 (url:http://www.who.int/mental_health/policy/development/en/index.html, accessed September 4 2007; Mental Health Core to Development Information Sheet, Sheet 1)

[3]Mental health, poverty and development(*http://www.who.int/mental_health/policy/development/en/)*

[4] Poverty, parenting, and children's mental health. Jane D. McLeod and Michael J. Shanahan ,*American Sociological Review*, Vol. 58, No. 3 (Jun., 1993),pp.351-366

https://www.jstor.org/stable/2095905

[5] Patel V. Poverty, Inequality and Mental health in developing countries. *In Poverty, Inequality and Health*, ed. D Leon & G Walt, Oxford, Oxford University Press, 2001:247-262

[6]Patel V, Araya R, de Lima M, Ludermir A, Todd C. Women, poverty and common mental disorders in four restructuring societies. *Social Science and Medicine,*1999, 49:1461-1471

[7] Patel V, Araya R, de Lima M, Ludermir A, Todd C. Women, poverty and common mental disorders in four restructuring societies. *Social Science and Medicine,*1999, 49:1461-1471/The onset of common mental disorders in primary care attenders in Harare, Zimbabwe, Psychological Medicine, 1999, 29:97-104

[8]Saraceno B., Barbui C., Poverty and Mental Illness. *Canadian Journal of Psychiatry*, 1997, 42(3):285-290

[9] Mental Health Atlas 2005, Geneva, World Health Organization, 2005.

[10]Miranda and Patel 2005: Achieving the Millennium Development Goals: Does Mental Health Play a Role.

[11]Rahman A, Iqbal Z, Bunn J, Lovel H, Harrington R. *Impact of maternal depression on infant nutritional status and illness: A cohort study,* Arch Gen Psychiatry, 2004, 61: 946-952.

[12]Eg. see Cooper PJ., Tomlinson M, Swartz L, et al., Post-partum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychiatry*, 1999, 175: 554-558)

[13] Unpublished WHO document. Lorenzo Dr and Bertolote JM, *Co morbidity and Mental Health.* Geneva, World Health Organization, 2003.

A Study on Mental Health Status of Elderly Destitute Women in COE MHI SCB Cuttack

Mohanty, S[1].., & Swain .M[2]

1.M.Phil. in Psychiatric Social work 2nd year trainee, Department of Psychiatric Social Work, Mental health institute (COE)SCB Medical, Cuttack, Odisha, India

2. Asst professor, Department of Psychiatric Social Work, Mental health institute SCB Medical, Cuttack, Odisha, India

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ABSTRACT

The rejection by families or society or further away from home, their real selves are lost or submerged under the four wall of hospital settings and negligence the life of the destitute becomes really worse and miserable. Mental health is recognized globally as being of enormous social and public health importance. Mental health problems currently are said to constitute about eight percent of the global burden of disease and more than 15 percent of adults in developing societies are estimated to suffer from mental illness. The aim of the study was to analyze the mental health status of the destitute. The study was descriptive in nature. The purposive sampling method is adopted and 20 respondents were the sample for the study. The interview schedule is the tool adopted for the study. Results are discussed

Keywords: - Destitute, psychological wellbeing, distress & Mental Health Status

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Introduction

Every individual has the right to live a respectful life. The constitution of India assures fundamental requirements of life to every citizen. Destitute woman refers to a female who lacks adequate support and encouragement from family members, relatives, sometimes from the society itself and may lead a miserable lifestyle.(Mubasheer ,2018) "Destitute" in relation to a woman means any female who has no independent source of livelihood or is not being looked after by any family member or relative. When a woman becomes a destitute, she has to face several hardships and disadvantages in day to day life. Sometimes they feel a kind of loneliness, exclusion from the society and others. They may also have to be the victims of sexual abuse, violence, oppression, demoralization, poverty and so on. Some of the factors responsible for destitution are poverty, other types of maladjustment, family relationships, and sexual harassment. Destitution has become a serious offshoot of family as well as a social problem in India(Devereux , 2003)

Need for the study:

The present study is an attempt to contribute to the unrevealing out of this problem. We cannot deny that the existence of destitution in India. This is also true that there are many number of destitute homes exist different parts of India,(Mubasheer ,2018) but for mentally ill destitute homes are very few in Odisha. However, the destitute have to face many numbers of challenges in their day to day life at the chronic ward of the psychiatric hospitals. Through this study, the researchers focus on finding out the mental health status of elderly female destitute. So far our knowledge there is no study on psychiatric destitute patient of Odisha so, this study is an attempt to bridge the gap between the Western and Indian literature and which will be help us for their psychosocial rehabilitation as well as to improve their quality of life.

Methodology:

Aim & Objective:

- To assess the mental health status of the women destitute admitted in destitute ward of MHI (COE) at SCBMCH.
- To see the psychological wellbeing and distress of the above destitute women.

Hypothesis

- There will be no relationship between psychological well being and mental health status.
- There will be no relationship between distress and psychological well being.

Research Design: it is a descriptive, hospital based study.

Sample & Sampling Method

A total number of 20 female are mentally ill destitute patients were recruited from IPD, of M.H.I., C.O.E., SCBMCH, and Cuttack. Purposive sampling is used to select the respondent.

Inclusion criteria for the elderly mentally ill destitute women:

i. Persons declared as destitute by M.H.I,SCBMCH,Cuttack

ii. Patient age range between 30 -50 years

iii. Female gender

iv. At least 2 years of total duration of illness

v. Those who are scored< 18 or = 18 in MMSE

vi. Patient those who give consent for being part of the study.

Exclusion criteria for the elderly mentally ill destitute women:

i. Patient's those who have chronic physical illness and Mental Retardation.

ii. Patient age range <30 yr &>50 yr.

iii.Less than 2 years of total duration of illness

iv. Not ready to give consent for being part of the study.

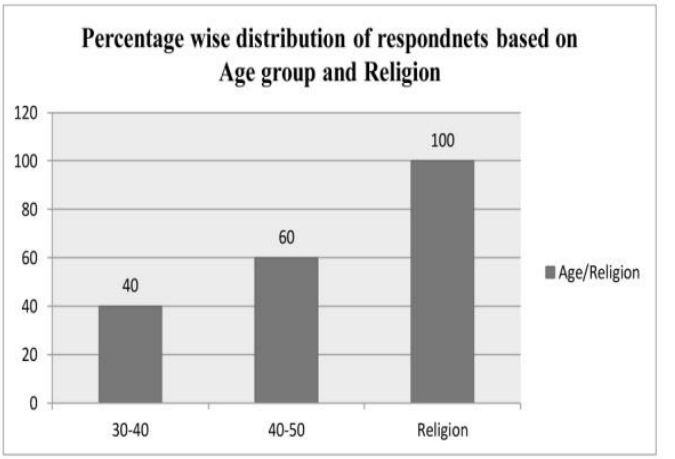
v. Those who are scored >18 in MMSE.

Measures used:

- Socio demographic and clinical Data sheets
- MMSE for screening
- Kessler Psychological Distress Scale, K-10 (Kessle ,2003)
- Ryff's (1995) Scales of Psychological Well-Being (SPWB)(Ryff's,2004)

Results

Socio demographic profile



The above fig. shows that out of 20 respondents, 40% are belong to the age group of (30-40) and the rest 60% are belongs to the age group of (40-50). Also it reveals that all the respondents are belong to the Hindu religion.

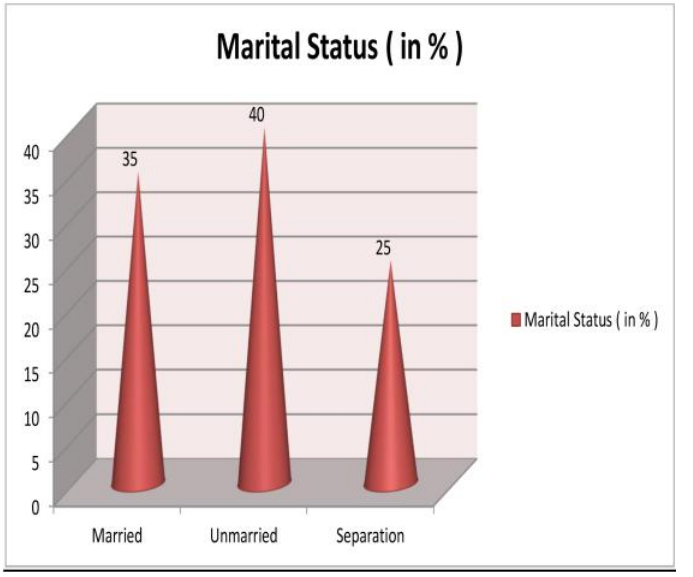
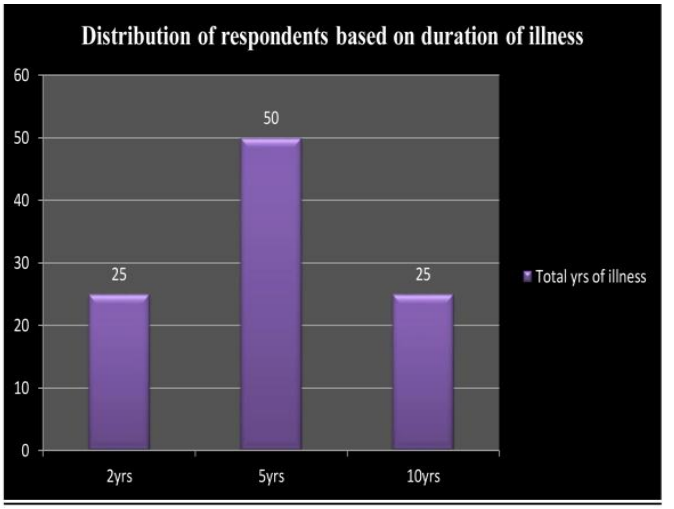
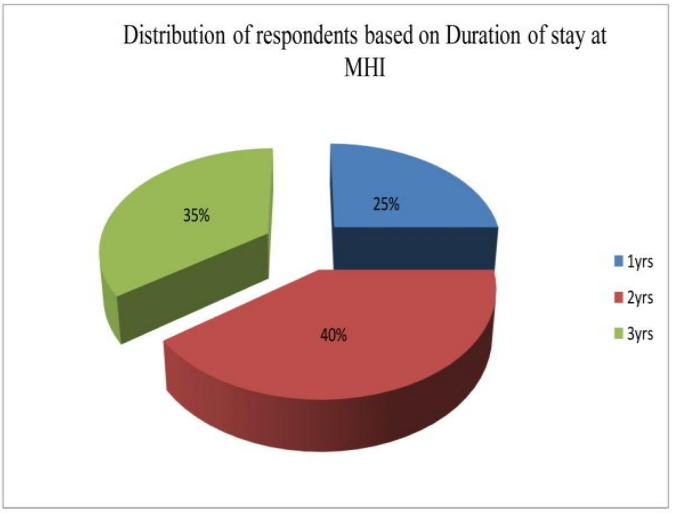


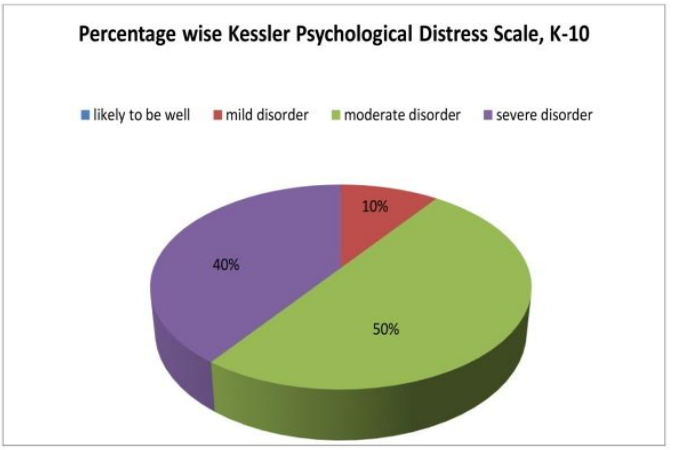
Fig No:02 presents the marital status of the respondents. It shows that 35% are married, 40% are unmarried and other 25% are separated.



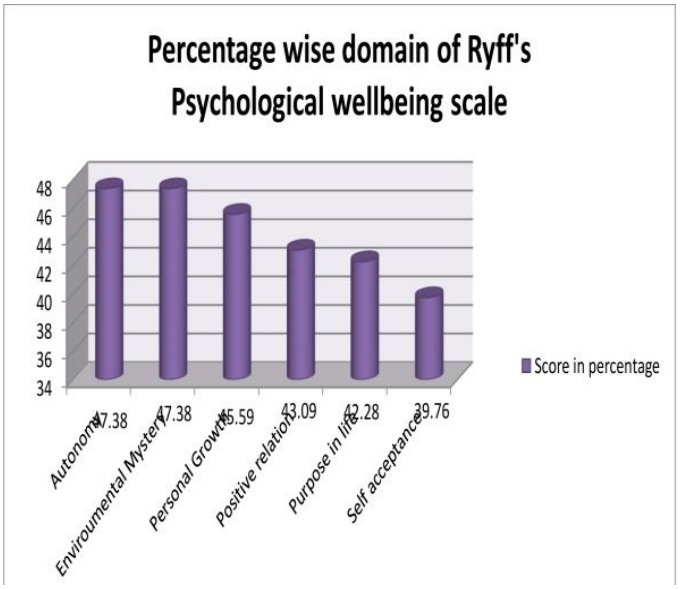
The above fig shows the distribution of respondents based on duration of illness. It reveals that 50% respondents are diagnosed with mental illness from 5 years. The rest each 25% are diagnosed with mental illness from 2 and 10 years.



The above fig. shows that 35% respondents have been staying at MHI from last 3 years whereas the other 40% are staying from last 2 yrs and 25% respondents have been staying from lat 1 year respectively.



The above pie chat shows the likely to be well, mild, moderate and severe level of psychological distress of respondents. It was found that every destitute woman has some level of psychological distress. 10% female destitute are having psychological distress in mild level where as other 50% and 40% respondents are having moderate and severe level of psychological distress respectively.



The above Fig presents the percentage wise domain of Ryff's Psychological wellbeing scale. It shows that all the respondents have 47.38% autonomy and environmental mystery. Also the respondents have the scored 45.59%, 43.09%, 42.28% 39.76% in personal growth, positive relation, purpose in life and self-acceptance.

Discussion

From the above interpretation, it is seen that within the category of respondents majority of respondents are belonging to the age group of (40-50) and also all the respondents belong to the Hindu religion. Most of the respondents are unmarried and also 25% are separated. In terms of duration of illness of the respondents 50% of them are diagnosed with the mental illness from last 5 yrs. Similarly, in terms of duration of stay at MHI maximum of the respondents are staying at MHI from 2 years. However ,the similar study findings was reported by Mubasheer ,2018 .The findings can be also explained on the basis of socio-cultural background of the study population.

Kessler Psychological Distress Scale, K-10 was used to analyze distress level of the respondents. After being applied this scale on each of them it was found that 40% of the respondents are having severe level of distress. This findings also supported by the previous study findings by Downe-Wamboldt B ,1991

Also Ryff's Psychological wellbeing scale use applied on each of the respondents. In this scale there is 6 domains which mention score in high and low level. After being applied this scale on each respondent it was revealed that 47.38% score (low level) was obtained in autonomy dimension which means it concerned about the expectations and important decisions, conforms to social pressures to think and based on evaluations of others, relies on judgments of others. Same score was obtained in environmental mastery which means difficulty managing everyday affairs; feels unable to change or improve surrounding context; is unaware of surrounding opportunities; lacks sense of control over external world. In personal growth domains 45.59% (low level) means a sense of personal stagnation; lacks sense of improvement or expansion over time; feels bored and uninterested with life; feels unable to develop new attitudes or behaviors. In positive relations with others obtained score 43.09% (low level) means trusting relationships with others; finds it difficult to be warm, open, and concerned about others; is isolated and frustrated in interpersonal relationships; not willing to make compromises to sustain important ties with others. In purpose in life domain obtain score 42.28%(low level) means Lack a sense of meaning in life; has few goals of aims, lacks sense of direction; does not see purpose of past life; has no outlook or beliefs that give life meaning. In self-acceptance domain shows that obtain score 39.76%(low level) means Feels dissatisfied with self; is disappointed with what has occurred in past life; is troubled about certain personal qualities; wishes to be different than what one is. This findings also supported by the previous study findings by Dersak R.,2014.

Conclusion

After a critical evaluation about the homeless individuals with mental illness at MHI, SCB Medical it was revealed that though they are living in a building but they are not satisfy with their life. The existing resources don't fulfill their psychosocial wellbeing. So they are living not only with the distress but also with various types of psycho social problems.

References:

1. Mubasheer, N. C. (2018). A Study on Mental Health Status of Elderly Destitute Women in Mysore. *JOURNAL OF SOCIAL WORK EDUCATION AND PRACTICE*, *3*(1), 1-5.

2. Dana R Ambler (2006) "Sexual Function in Elderly Women" A Review of Current Literature" Diamond, Louis publisher's, Delhi. (2006)

3.Devereux, S. (2003). Conceptualising destitution.

4.Devereux, S., Sharp, K., & Amare, Y. (2003). *Destitution in wollo, Ethiopia* (Vol. 55). Institute of Development Studies.

5. Alkire, S., Chatterjee, M., Conconi, A., Seth, S., & Vaz, A. (2014). Global multidimensional poverty index 2014.

6. Acharya, Arpita; Biswas, Krishna. (2014) Destitute Women in Tripura: A Study on their Level of Depression, Hopelessness, and Self-Esteem. Indian Journal of Health and Wellbeing, p. 951-954

7. Walker, P., 1989, Famine Early Warning Systems: Victims and Destitution, London: Earthscan

8. Kessler, R.C., Andrews, G., Colpe, .et al (2002) Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological Medicine, 32, 959-956.

9. Andrews, G., Slade, T (2001). Interpreting scores on the Kessler Psychological Distress Scale (k10). Australian and New Zealand Journal of Public Health, 25, 494-497.

10. Chant, S. (1997). *Women-headed households: Diversity and dynamics in the developing world*. Springer.

11. Spies, G., Stein, D. J., Roos, A., Faure, S. C., Mostert, J., Seedat, S., & Vythilingum, B. (2009). Validity of the Kessler 10 (K-10) in detecting DSM-IV defined mood and anxiety disorders among pregnant women. *Archives of women's mental health*, *12*(2), 69-74.

12. Van Dierendonck, D. (2004). The construct validity of Ryff's Scales of

Psychological Well-being and its extension with spiritual well-being. *Personality and individual differences*, *36*(3), 629-643.

13. Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. Journal of Personality and Social Psychology, 57, 1069-1018

14. Crystal, S. (1984). Homeless men and homeless women: The gender gap. *Urban and social change review*, *17*(2), 2-6.

GROWTH OF MENTAL HEALTH REHABILITATION CENTERS

Somalin Mishra ,*MBBS INTERN*

Guided by Dr.AmritPattojoshi(professor and HOD psychiatry at HMCH,BBSR)and Dr.pallabisahu(Associate professor Dept. Of psychiatry at HMCH,BBSR)

ABSTRACT: This paper goes through the definition of rehabilitation discussing its components, goals it aims to achieve and the services of provides. The paper also discusses the concept of psychosocial rehabilitation and community based rehabilitation and explains their systems in brief. Then it discusses human rights and how it is forgotten in the picture of the mentally ill. It finally focuses on the path of recovery and suggests activities which can help in establishing and regulating properly functioning rehabilitation centers.

KEYWORDS: Community based rehabilitation, psychosocial rehabilitation, human rights, tele rehabilitation,recovery.

INTRODUCTION: Admitting that you have a problem is probably the hardest thing to do. Let's not make it more harder for them.

"BREAK THE STIGMA"

Mental health is a state of well-being in which a person realizes his/her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his/her community[1].

Mental health problems affect 1 in 4 people every year and no one should feel ashamed of it.

REHABILITATION:

What is rehabilitation[2]?

Rehabilitation is defined as “a set of measures that assist individuals who experience ,orare likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments.”

COMPONENTS[3]:

2 components-

i.Decreasing the impact of disabling and handicapping conditions
ii.Enabling disabled people to achieve social integration

GOAL[4]:

People with mental health problems are supported to enable their inclusion and participation in all aspects of community life.

Ensure access to appropriate, timely, affordable and high quality rehabilitation interventions, those who need them.

Goal for middle and high income countries-To increase efficiency and effectiveness by expanding the coverage and improving the relevance, quality and affordability of services.

Goal for lower income countries like India-Focus should be on introducing and gradually expanding rehabilitation services, prioritizing cost-effective approaches.

SERVICES PROVIDED IN REHABILITATION PROGRAMS[5]:

- Inpatient and community based rehabilitation units
- Community rehabilitation units
- Supported accommodation services
- Advocacy services
- Peer support services

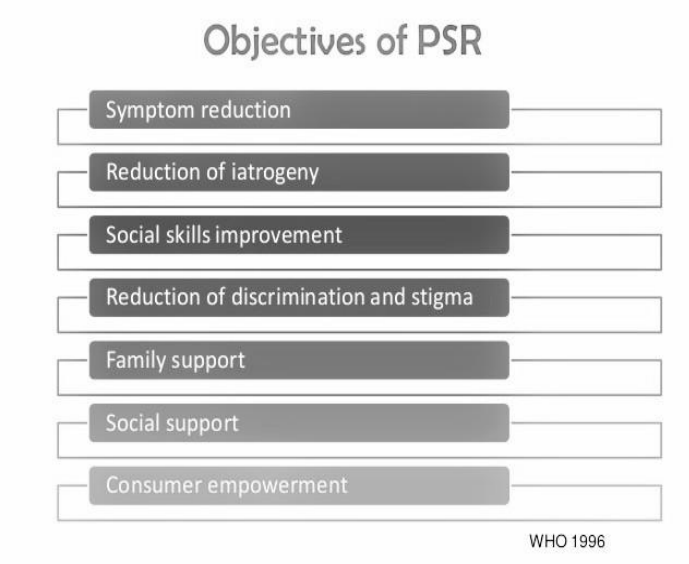
PSYCHOSOCIAL REHABILITATION[6]:

Process that facilitates the opportunity for individuals to reach their optimal level of independent functioning in the community.Assisting persons with long-term psychiatric disabilities to increase their functioning so that they are successful and satisfied in the environment of their choice with least amount of ongoing professional intervention.

FUNDAMENTAL CONCEPTS OF PSR[7]:

- ❖ Sense of hope
- ❖ Pragmatism
- ❖ Skill training
- ❖ Integration of treatment and rehabilitation
- ❖ Continuity of care
- ❖ Community integration

Attention to consumer preferences
FIGURE 1



COMMUNITY BASED REHABILITATION[8]:

The clinical and disability related outcomes for clients within the CBR programs are better than those of clients who received out-patient care alone.

Role of CBR-

Is to promote and protect the rights of people with mental health problems, supporting their recovery and facilitate their participation and inclusions in their families and communities.

IN INDIA[9]:

In very disadvantaged part of rural India,Chatterjee and co-workers, adapted the principles of CBR,specifically the use of local resources and involvement of people with mental health problems, families and local communities, to complement the specialist mental health services and thus improve access, equity and acceptability of the interventions.

HUMAN RIGHTS[10]:

People with mental health problems routinely experience human rights violations.These violations occur in Psychiatric institutions, families and societies, where people with mental health problems are unable to exercise their civil liberties and have limited access to education, employment and housing
All general international human rights conventions are applicable to people with mental health problems and protect their rights through the principles of equity and non-discrimination.

RECOVERY[11]:

Many health professionals considers “recovery”to mean “cure”, but the concept of recovery goes beyond this and considers all aspects of functioning.

Recovery is a process of personal growth and transformation beyond suffering and exclusion;it is an empowering process emphasizing people’s strengths and capabilities for living full and satisfying lives.

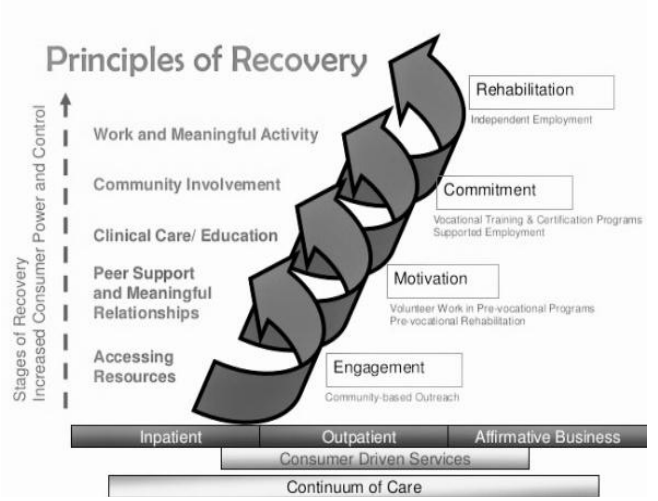
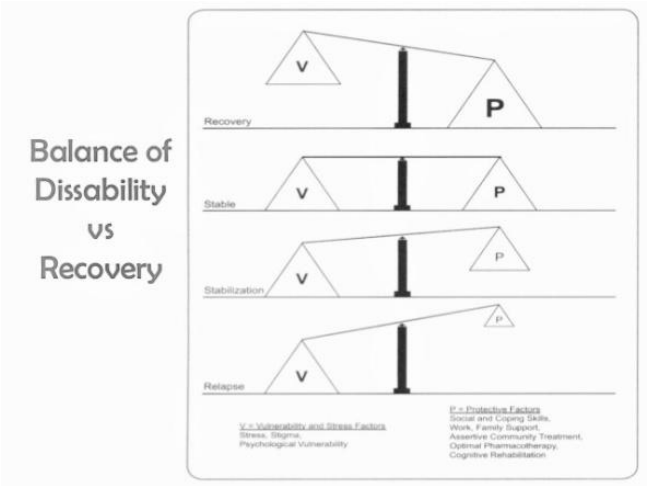


FIGURE 2

- ✓ FIGURE 3



SUGGESTED ACTIVITIES[12]:

- ✓ Promote mental health
- ✓ Facilitate inclusions in CBR programs
- ✓ Overcome stigma and discrimination in the community
- ✓ Changing perceptions of mental health through personal contact
- ✓ Support recovery process
- ✓ Facilitate access to medical care
- ✓ A holistic approach to mental health
- ✓ Facilitate access to psychological support
- ✓ Facilitate access to social Support
- ✓ Facilitate access to livelihood opportunities
- ✓ Support family members
- ✓ Contribute to the empowerment process

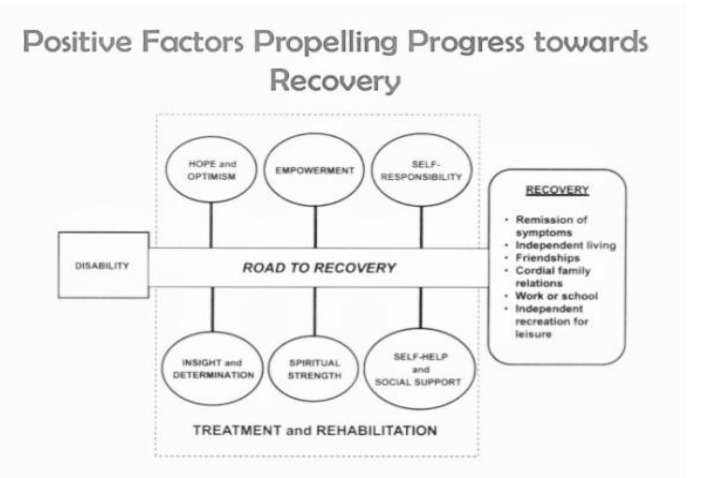


FIGURE 4

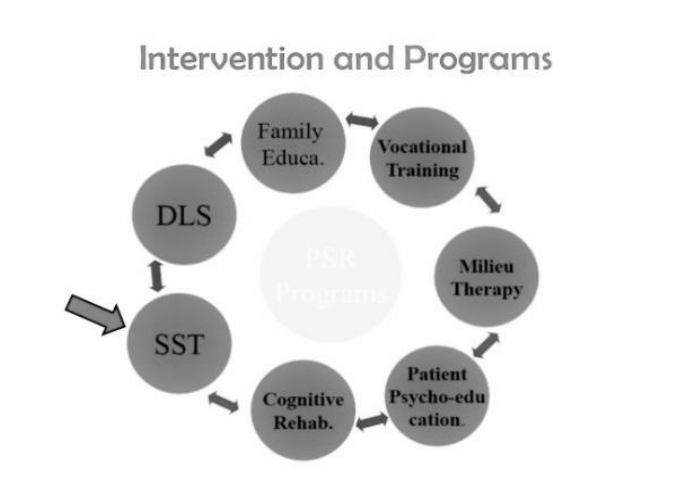
REHABILITATION SETTINGS[13]:

Creating or amending national plans on rehabilitation and establishing infrastructure and capacity to implement the plan are critical to improving access to rehabilitation.

Plans should be based on analysis of the current situation, consider the main aspects of rehabilitation provision-leadership, financing, information, service delivery, products and technologies and rehabilitation workforce and defined priorities based on local needs.

It depends on establishing or strengthening mechanisms for intersectoral collaboration.

1. Relocate or redistribute resources
2. Cooperate internationally
3. Combine public and private financing
4. Target poor people with mental health problems
5. Expanding education and training
6. Recruit and retrain rehabilitation personnel
7. Expanding and Decentralizing service delivery
8. Tele rehabilitation
9. Expanding research and evidence based practice



BARRIERS TO REHABILITATION[14]:

- Lack of resources and health infrastructure
- Lack of strategic planning
- Lack of agency responsible to administer, coordinate and monitor services
- Inadequate health information systems and communication strategies
- Complex referral system can limit access
- Absence of engagement with people with disabilities

ADDRESSING BARRIERS TO REHABILITATION[15]:

The barriers to rehabilitation services provision can be overcome through a series of actions, including-

- Reforming policies, laws and delivery systems, including development or revision of National rehabilitation plans
- Developing funding mechanisms to address barriers related to financing of rehabilitation
- Increasing human resources for rehabilitation, including training and retention of rehabilitation personnel
- Expanding and Decentralizing service delivery
- Increasing the use and affordability of technology
- Expanding research programs, including improving information and access to good practice guidelines.

CONCLUSION :

Looking at the functioning of these newly emerging rehabilitation systems and the various factors which hamper its smooth functioning we can safely conclude that :

CBR has better outcomes than only outpatient visits. So CBR should be encouraged in every community.

There should be reformation of policies and laws and an increase in human resources for rehabilitation including training and retention of rehabilitation personnels.

Eliminating the discriminations let's join hands as a community to ensure accessibility of all towards CBR.

References:

[1],[3],[8]-[12]CBR and Mental health-community-based rehabilitation:CBR guidelines-NCBI-NIH

https:/www.ncbi.nlm.nih.gov

[2],[4],[13]-[15]chapter 4-world health organization

https:/www.who.int>world_report>chapter 4

[5]joint commissioning Panel for mental health

https:/www.icpmh.info>uploads>jcpmh

[6],[7]psychosocial rehabilitation-slideshare

https:/www.slideshare.net

Observers' Report on Long Stay at Mental Hospital

(A Case Study of a Male Destitute Patient)

"Mental illness has left him with no family or home to return to..."

Das Rajlaxmi[1],Hembram Sarathi[2]

Abstract:
Social isolation in people with mental health problems is common and has a significant impact on wellbeing, recovery and community participation. It is important to ask patients about their relationships and whether they wish to improve these and, if so, to address potential barriers. Use should be made of relevant services, according to availability and preference.

Keywords:- Isolation, Psycho-social care, Rehabilitation.

Introduction:

Mental illness may cause a variety of psychosocial problems such as decrease quality of life of patient family member as well as increase social distance for the patient and family caring for the patient. Psychosocial challenges are enhanced by the stigma attached to mental illness, which is a problem affecting not only the patient but also the family as a whole familial and care for a person with mental illness has its advantage, yet it has multiple social and psychological challenges. Coping strategies and skills are important for the wellbeing of the care givers and the patients.

People with mental health problems can experience social isolation affecting all types of relationships, whether with friends or family. Social isolation can be a result of the symptoms of many mental health problems as well as a consequence of the associated stigma, disadvantage and social exclusion that people with mental illness can face. The problem may affect people who are living with others, where it may not be apparent, as well as people who are living alone. People experience severe mental illness often experience social isolation, specifically through stigma, alienation and loneliness. Collaborative plan should include strategies to assist family members and care givers not to isolate from society.

Case Study

Mr. P.A (52 years) diagnosed with chronic schizophrenia and had an entirely different life story to narrate. In spite of having a well educated and reputed family; he is still living as a destitute. Since his family is not willing to take him back, it is far to reach him to his dream home. He has been at the mental hospital for more than 25 years, as his family has abandoned him. He is eagerly waiting to get his discharge from the hospital.

He was lived with a happy family and eldest one, among two siblings. Both of his parents are alive and he has a younger brother. At the times of his birth, normal developmental milestone were achieved. Since his childhood he was stubborn in nature; he always fulfilled all his demands by emotionally black mailing to his parents. He usually likes to remain alone and most of the time he doesn't interact with anybody. He was poor in academic. He studied up to 9th standard and he appeared 4 times board exam but couldn't clear the exam. Failing in exambecame the main reason behind getting depressed and causinghis mental illness. Gradually, he became abusive and assaultivetowards his family members and relatives. Patient had difficulty initiating, performing and maintaining basic activities of daily living. He was suspicious to everyone that all are trying to killhim and later on he became more aggressive and violent, when his demand was not fulfilled and he beaten to his parents, then his family member took him to Berhampur Medical College and consulted with a psychiatristfor better treatment and there he was given electro convulsive therapy. He was maintaining well with medication. After 5 years he relapsed. Patient had been admitted multiple times in different hospital, and then at the age of 25 he was admitted in the inpatient psychiatric hospital at RINPAS in 1993 and was diagnosed as schizophrenia. Long acting depot injections was the preferred mode of medication administration as patient has severe psychiatric symptoms. Then after few days of treatment **his parents left him at hospital. Since 1993 to 2001 he was** treated at RINPAS, Ranchi, Jharkhand as a destitute. After many months of treatment, his mental illness was somehow improved. Then the Govt. of Odisha decided to rehabilitate and brought him from Ranchi to MHI, SCB Medical College. After that, he was treated at destitute ward of SCB medical college, Odisha from 2001 to 2019.

According to his family members there is seen poor prognosis of his illness. Gradually his mental condition is deteriorated; so his family members left him alone. His family members don't want to take him back to their home, as they feel ashamed for his mental illness would degrade to their reputation in the society.

When the patient was attended by the therapist it was observed that:-

He was unkempt and untidy, and looked up older than his actual age. He was always found in sitting position at his bed. His facial expression was always aggressive. He always sits in one place and makes abnormal movement of his hands and also snapping the fingers. At the same time he laughs and mutters to himself and displays classic symptoms of mental illness. He usually wakes up at 8.30 am then drinks a glass of water every morning. Every day, therapists conduct group meeting at 9 am to 10 am; where all inmates used to get engaged with physical exercise, prayer, yoga, meditation and gaming activities. But he never attends and cooperates with them. He does not know how to take care of himself and does not take bath, brush his teeth. Sometimes, the attendants try to give bath and dress him up, but he does not allow any attendants to touch him. If someone tries to touch him; he gets irritated and hits and beats them force fully.

If his inmates want to interact with him; he suddenly gets angry towards them. Breakfast is supplied by the hospital at 10'0' clock, but he never takes food by his hand. Rather he directly eats from his plate and takes close to mouth to the food and starts swallowing and

licking. After eating food he never cleans his plate and throws it outside. He always prefers to have vegetarian food. After having breakfast he stays aloof and never interacts with any hospital staff and co patients. When someone tries to talk with him, he gets irritated, sometimes he quarrels with his inmates. Every week his mother and younger brother is coming to see him and they forcefully make him bathed, brushed his teeth and also make dressed him up properly but during that time he gets irritate and scolds them. Sometimes he remembers to his family and crying a lot, at that time he asks for a mobile from attendant & makes phone call to his mother and talk with her. He feels very happy after talking with his mother.

He never wants to take medicine but by the help of attendants he forcefully took medicine. During day time while other patients are involved in ward activities like supplying of food for patients that time he never involves in any activities and remains silent.

He used to have lunch around at 1pm, while other patients take rest during day time he never get sleep and sits quietly. In the evening time, he sleeps for an hour then after waked up he does involuntary movement of both hands. At 9pm he takes his dinner & go for sleep.

Conclusion:

A mental disorder is "a clinically significant behavioral or psychological syndrome or psychological pattern" that occurs in an individual and that is associated with present disability or with a significantly increased risk of suffering, pain, death, or an important loss of freedom. Although patient belongs to a well established and educated family but still he is surviving as a destitute since more than 25 yrs, due to stigmatization of mental illness his family members has made distance from their blood relation. Could he back to his home? Will his family accept him? Now these two questions are challenging task for us. There is a need of awareness in the family as well as community regarding psychiatric illness to bring them to mainstream of society.

1. **Rajalaxmi Das**, Mphil.Psychiatric Social Work 1st yr, Dept of PSW, MHI, SCBMCH, Cuttack.

2. **Sarathi Hembram**, Psychiatric Social Worker, Dept of PSW, MHI, SCBMCH, Cuttack

REHABILITATION FOR PRISON INMATES: AN UNMET NEED EXISTING OVER CENTURIES

Dr. TanayMaiti

Senior Resident, Department of Psychiatry
Guided by : Dr. Susanta Kumar Padhy , Additional Professor and Head of the Department, Department of Psychiatry,
All India Institute of Medical Sciences, Bhubaneswar

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Abstract: Imprisonment, an age old method of punishment for criminal behaviors is prevalent in Indian legal system as well. Over centuries, the conditions of prisons and forms of imprisonment has changed though the neglect for prison inmates remained mostly same. Multiple committees, manuals or even a long seventy years of post independence made no difference for prison inmates. As a community, the prison population mostly remained confined and socially isolated with minimal options of rehabilitation or attempt to reintegration in the society post their jail term. Considering its specific community structure, the rehabilitation needs, scopes, targets and barriers to them are unique and definitely warrants specific approaches at multiple levels, starting from the policy making to individual prison specific plans.

Keywords:Imprisonment, prison inmates, community, rehabilitation**.**

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a. Indian Prison System and changes over time:

Ancient India mentions about 'danda-niti' which, by its literally sense, means principles of punishments, however specific mentions about prison or imprisonment was not evident in pre-vedic era. Current concept of prison took place during early 17th century when the Portuguese constructed 'Church Prison' at Goa with nearly 200 separate cells followed by East India company established foujdari department, court and gradually building criminal jails, civil jails or mixed ones over time [3] .The conditions of inmates have not changed much though since the very beginning, from no prisoners coming out alive from their detention in ancient time, to keeping people under detention for long even before the actual trial or imprisonment without any legal basis was prominent practice during the British period.

b. Jails in India: Post Independence:

Post 1947, government of India took multiple attempts to improve the conditions of the existing jails and their inmates, including various national and state level plans; but even in 1978, seventh finance commission admitted the poor condition of most of the jails with minimum facilities. In early 80s, National Policy on Prison was proposed by Mulla committee [4, 5]and specific emphasis was proposed both upon in-house and post discharge re-appointment and rehabilitation of every prisoner, but very less has been implemented in reality. The suggestion of turning prison service into a 'professional career service' remained mostly in papers except very few personal initiatives, and multiple instances of denying access to specialized helps or equipment remained prominent through out the country.

1. Prison as a community:

Community, by its very initial definition, is a group of people living in the same defined area, sharing some basic values, organization and interests. A prison, large or small, by its nature fits very much into this definition of a community, as the reasons and background of entering into a prison might be different for every individual, but once inside the prison, the living standard, routine followed or work nature, life goals and post imprisonment targets turns very same for the most

of the inmates. Seeing a prison and prisoners as a separate community, from a sociological aspect rather than mere humanitarian background turned of prominent scientific and research interest in the western community back in early 20th century itself(i.e. research by Thomas Mott Osborne in USA back in 1913) [6], however similar attempts remained poor from this part of the globe.

2.Current status of after care and rehabilitation in India:

After care, a popular concept in institutional rehabilitation, has been defined as a 'service intended for persons who have undergone a certain period of 'care' and 'training' within an institution'.

The model prison manual 2016 [7], published by Government of India, narrates the followings as main objectives of after care service

1. providing help, support and protection to all the released prisoners
2. helping every released person to overcome his/her mental, social and economic difficulties.
3. Helping in removal of any social stigma associated with the person's previous incarceration.
4. Supporting the person in adjusting his/her habits, attitudes, approaches and values as per requirements of community living and also with his/her family, neighbors and work groups.
5. Assisting the process of individual's physical, mental, vocational, economic and social re adjustment and ultimate rehabilitation.

But, reality inside the prison and behind the bars remained far to reach most of these targets. The types of rigorous punishments in India remained mostly hard manually labored works leading to very minimal wages, and options of skilled works, even for those who are already trained in it, are restricted and limited. Scope for new and technology based training for interested inmates haven't progressed far as well.

2. Addressing barriers to rehabilitation, a prison specific approach:

Rehabilitation for any community or population faces some common challenges, and prison population, being one of the most marginalised and stigmatized community, is no exception either. A series of action from national policy making to individual prison specific approaches are needed to expect minimum changes in the concerned field. Some of the specific targets can be

1. National law, policy and rehabilitation plan
2. Expanding and de centralizing service delivery
3. Increasing human resources for rehabilitation, including training and retention of rehabilitation professionals
4. Establishing definite practice guidelines
5. National and zonal monitoring system

3. Future Direction and Conclusion:

The rehabilitation process starts with a) identifying problems and needs of the community or a specific part of it, b) to relate the problems to modifiable and limiting factors, c) defining the target problems and target mediators and select appropriate measures for it, then d) planning, implementing and coordinating the interventions accordingly and e) assess the effects of it [8]

Very clearly all these specific approaches can turn extremely instrumental for the mentioned community here, which not only will improve the quality of life of

the population while under their sentences, but also, chances of better re-settlement in the community with adequate and appropriate vocational placement will help the individual and his/her family/dependents in long term as well, reducing the chances of re-offending or breaking the social norms significantly.

References:

1. The oxford English Dictionary, Vol .vii, p.1385
2. Law Commission of India 39th report, Government of India, Ministry of Law
3. Aspinall et al. "Cornwallis in Bengal, Manchester University Press " 1931, p.115
4. Justice A.N. Mulla committee, Govt. of India 1980
5. K. Borah et al. Jail administration in India: A review of Indian jail reform committee, International Journal of Humanities and Social Science Research: Volume 4; Issue 2; March 2018; Page No. 66-74
6. F. E. Haynes, The Sociological Study of the Prison Community, 39 J. Crim. L. & Criminology 432 (1948-1949)
7. Model Prison Manual 2016, Bureau of Police Research and Development, Ministry of Home Affairs, Govt. of India
8. Steiner WA et al. Use of the ICF model as a clinical problem-solving tool in physical therapy and rehabilitation medicine. *Physical Therapy*, 2002,82:1098-1107. PMID:12405874

PATHWAYS OF CARE OF HOMELESS INDIVIDUALS WITH MENTAL ILLNESS IN MHI, SCBMCH

Tapasa Mallik[1], Sarathi Hembram[2]

[1]M.Phil. in Psychiatric Social work, Department of Psychiatric Social Work, MHI, SCB Medical, Cuttack, Odisha, India
[2]Psychiatric Social Worker, Department of Psychiatric Social Work, MHI, SCB Medical, Cuttack, Odisha, India

Introduction:

Destitution can occur throughout the asylum application process. For instance, it may occur because the limited statutory support received does not enable individuals to live in such a way that their essential living needs are met. In other cases, it might be because upon being refused and unable to return to their country of origin, individuals are unable to work and are ineligible for statutory support. Definitions of destitution vary and many are specific to asylum seekers.

The census of India defined the term "Homeless population" as people who "do not live in a census houses" but rather in open spaces. According to 2011 census out of 1.7million homeless people 50% are suffering from mental illness. Homelessness is a major social & public health concern worldwide which is leading to mental health issues or vice versa. It is a bidirectional phenomenon & it forces the victim to be in a vicious circle from which an escape seems to be very difficult. One of the objective of National mental health program(NMHP) is to increase access to mental health services for vulnerable groups including the homeless. (Lancet 2014:384:1478)

According to section 95(3) of the Immigration and Asylum Act 1999, an asylum seeker is destitute if: "(a) he does not have adequate accommodation or any means of obtaining it (whether or not his other essential living needs are met); or

(b) he has adequate accommodation or the means of obtaining it, but cannot meet his other essential living needs.

AIMS & OBJECTIVE

- To assess clinical profile of homeless individuals with mental illness admitted at Mental Health Institute, SCB Medical college.
- To analyse the pathway of hospitalisation, care and rehabilitation process in the above population.

METHODOLOGY

• A retrospective review of hospital records of Homeless mentally ill persons admitted at MHI, SCBMCH from June 2018 to February 2019

• Data is presented in the form of simple pie chart and histogram and then interpreted through individual cases and comparative manner.

• **Sources of data**

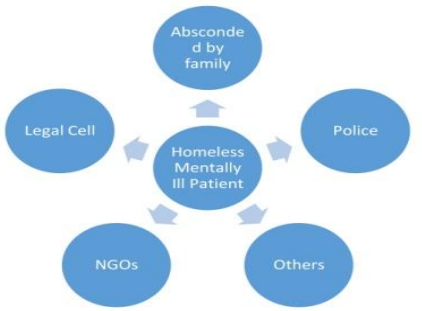
1. Admission register

2. Individual OPD Register

3. Rehabilitation register

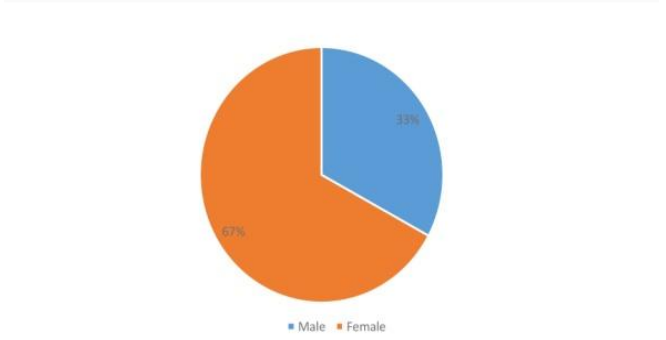
FINDINGS

Fig No: 01 Sources of Admission



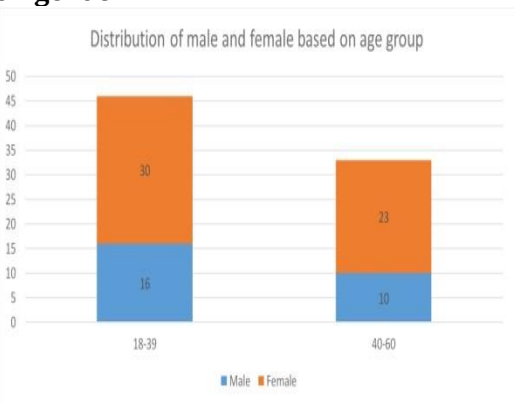
From the above cycle it was revealed that from the different kind of sources, individuals with mental illness are being admitted in destitute ward at MHI. These sources are Legal Cell, Different NGOs, Police, absconded by family and also from other sources.

Fig No: 02 Distribution of male and female based on gender



The above pie chart represents that there is a difference in between male and female homeless individual with mental illness. Out of total homeless individuals with mental illness male are 33% whereas females are 67%.

Fig No:03 Distribution of male and female based on gender



The above fig shows the age group of the male and female homeless individuals i.e. Early Adulthood (age group 18-39) and Middle Adulthood (age group 40-60). It presents that out of 26 male homeless individuals 16 number are under early adulthood and the rest 10 are under middle adulthood age group. Similarly, out of 53 female homeless individuals 30 and 23 are under early adulthood and middle adulthood group respectively.

Fig No.: 04 Distribution of male and female based on Duration of stay at MHI

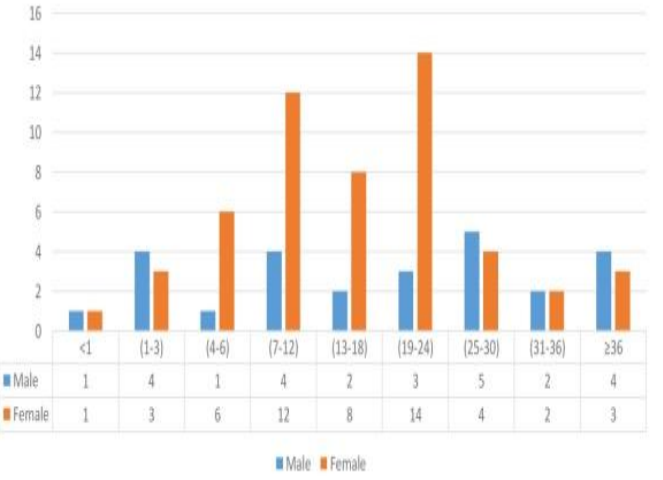
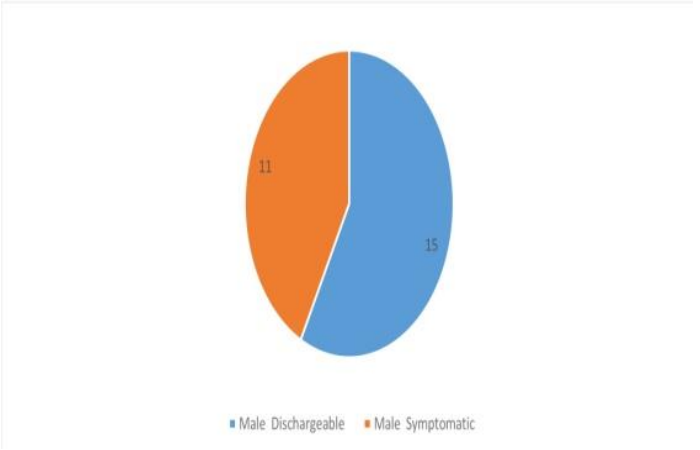


Fig No: 04 presents the distribution of male and female individuals based on duration of stay at MHI. It shows that 4 no. of male and 3 no. of female have been staying more than 36 months at MHI whereas 1 no. of each male and female are staying less than 1 month.

Fig No.: 05 Status of male for rehabilitation



The above fig. shows the status of male and female homeless individuals for rehabilitations. It represents that out of 26 males, 15 males are dischargeable and the rest are symptomatic.

Fig No.: 06 Status of female for rehabilitation

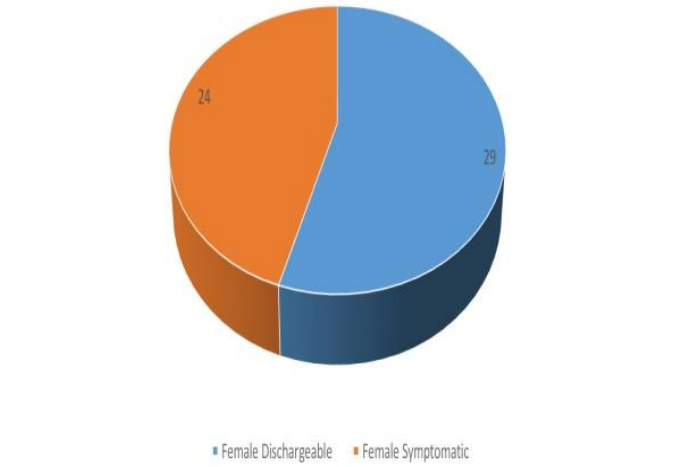


Fig No.: 06 represents that out of total female homeless individuals, 24 are dischargeable and 29 are symptomatic.

Fig No.: 07 Distribution of male and female based on their mental illness

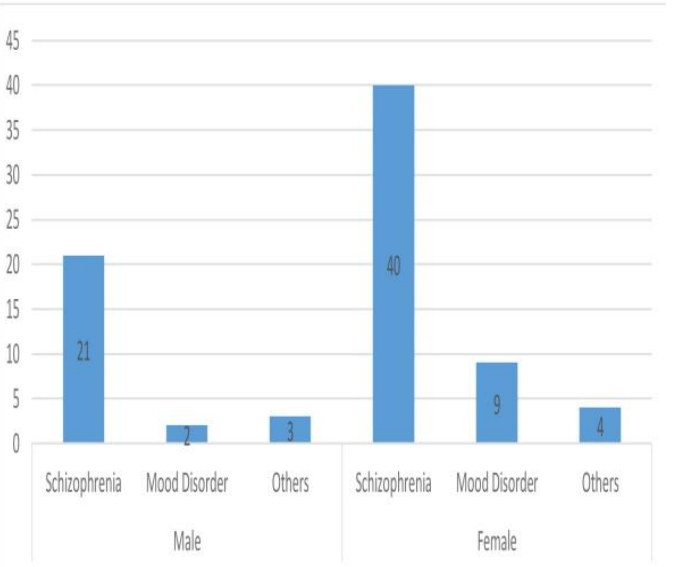


Fig No.: 06 represents that most of them are diagnosed with schizophrenia. It shows that out of total male and female, 21 males and 40 females are having Schizophrenia mental illness. 2 males and 9 females are having Mood disorder and the rest are diagnosed with other mental illness.

Fig No. 07 Rehabilitation Status

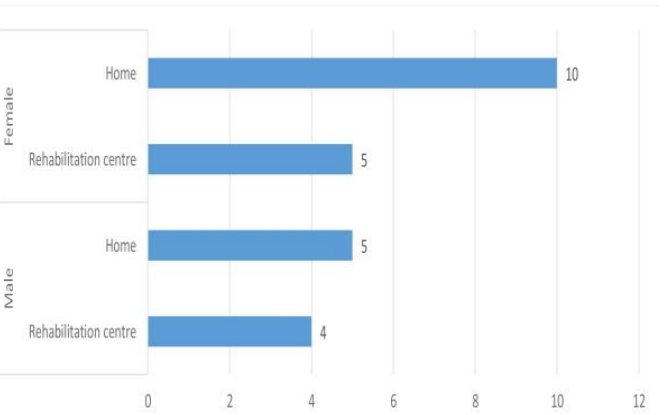


Fig No.: 07 shows the total no. of rehabilitation of homeless individuals with mental illness from June, 2018 to November, 2019. 4 males and 5 females have been rehabilitated to a rehabilitation centre named Sevak Jarashram, Chhatia, Cuttack and other 5 males and 10 females have been rehabilitated to their own home.

Discussion

Looking into the clinical situation of MHI, based on finding it is seen that the sources of admission of homeless individual with mental illness at MHI are basically from Legal Cell, different NGOs, Police, absconded by family and also from some other

sources. Out of total homeless individuals with mental illness male are 33% whereas females are 67%. Within the category of male and female homeless individual with mentally ill more of them are belong to the age group of early adulthood. In terms of duration of staying at MHI however between the durational period of 4-6; 7-12; 13-18 and 19-24 months, female patients are more than male. More numbers of patients are of schizophrenia i.e. 21 males and 40 females followed by mood disorder and some other types of mental disorder. It is also revealed that 15 male and 29 female patients can be rehabilitated to either their own home or any rehabilitation centre based on their improvement in the mental health conditions. From June, 2018 to November, 2019 rehabilitation has been done to both home as well as to rehabilitation centre. Among both male and female, rehabilitation is high to their home and in compare to male, females have been rehabilitated more.

Conclusion

Destitution hinders growth and development of the nation. Homeless mentally ill in India is a big emerging problem which requires immediate and effective intervention. The available resources at MHI are the need based but psychosocial care and other requirements for a human being could be fulfilled by in their family, community and society as well. From this study it is revealed that there are need of mental health awareness programs at grass root level through different possible activities. So that the mental illness stigma can be eradicated from the society. And the human life dignity could have achieved without violating the norms of a healthy life style. It is hoped that all the manageable destitute patients will be rehabilitated the Mental Health Care Act, 2017 will be properly implemented. Also the society as well as the family members should support to them for their care, love and reintegration.

References:

Morris, L. (2009). Asylum, welfare and civil society: a case study in civil repair. *Citizenship Studies*, *13*(4), 365-379.

Benatar, S., & Brock, G. (Eds.). (2011). *Global health and global health ethics*. Cambridge University Press.

Lancet, T. (2014). Health of the homeless.

Abrams, P. (1999). Population Politics: Reproductive Rights and US Asylum Policy. *Geo. Immigr. LJ*, *14*, 881.

Onken, S. J., Dumont, J. M., Ridgway, P., Dornan, D. H., & Ralph, R. O. (2002). Mental health recovery: What helps and what hinders? A national research project for the development of recovery facilitating system performance indicators. *Prepared for National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors.*

A journey from the destitute ward to a dignified life

Dash,B.[1] , & Swain, M.[2]

1. Bijayalaxmi Dash, M.Phil,PSW,2nd yr Trainee, MHI, COE, SCBMCH, Cuttack. Email.bijaya83@gmail.com, Ph.No. 943856997
2. Mamata Rani Swain, Asst.Prof. Dept. of PSW, MHI, COE, SCBMCH, Cuttack. Email.swain.mamta805@gmail.com, Ph.No.9955434047

ABSTRACT

This case illustrates the importance of "a comprehensive psychosocial rehabilitation assessment and strong treatment alliance with a woman diagnosed as a case of BPAD with frequent relapse due to familial arrogance, financial and care burden and social rejection" which made her to live in destitute ward of MHI, (COE), SCBMCH, Odisha. Mrs**.** S.S is a 36 year old Hindu, Separated, Female, educated up to 7th std who was a home maker and lives with her old ill parents and belongs to a Lower Socio Economic Status, hailing from rural area of Jagatsingpur, Odisha. The financial deprivation, social rejection, old age along with physical illness and psychological distress of parents resulted so critically that one day her parents wanted to kill her. After various psycho-social interventions now parents are aware how to deal with the patient, able to recognized the early sign & symptoms and how to involve the patient in various activities and how to appreciate and encourage her. Since one year she is maintaining well in her socio-occupational life with pharmacological and non-pharmacological interventions.

Keywords: Destitute, Bipolar Affective Disorder, Psychosocial Rehabilitation

Introduction:

"The worst cruelty that can be inflicted on a human being is isolation": Sukarno

This case illustrates the importance of "a comprehensive psychosocial rehabilitation assessment and strong treatment alliance with a woman diagnosed as a case of BPAD with frequent relapse due to familial arrogance, financial and care burden and social rejection" which made her to live in destitute ward of MHI, (COE), SCBMCH, Odisha. In India the prevalence rate of psychotic disorders is nearly similar for both the sexes, lifetime prevalence for male and female are 1.5% & 1.3% respectively but current status of male & female is 0.5% & 0.4% respectively. In context to BPAD it is 0.6% male against 0.4% female, where a female predominance was observed for depressive disorders i.e. current female: 3.0% & male: 2.4% (Murthy et al.

2014). At the same time 90% of patients of mental illness admitted to having experienced stigma, and 86 per cent admitted to having experienced discrimination with females reporting more discrimination than males (Pawar et al. 2014).

Brief about the Case

Mrs**.** S.S is a 36 year old Hindu, Separated, Female, educated up to 7th std who was a home maker and lives with his old ill parents and belongs to a Lower Socio Economic Status, hailing from rural area of Jagatsingpur, Odisha. Mrs.S.S has been a client of MHI, CTC for last 15 years and receiving treatment for Bipolar Affective Disorder (BPAD) but since two years she was abandoned by her parents and was staying at female destitute ward of MHI, CTC.

As per the informant when this client was 17 years old started showing depressive symptoms. For which they consulted with several faith healers as well as the priest and spent lots of money on that. But they didn't show any outcome rather the client became more symptomatic. At the mean time a local quack suggested them to bring her M.H.I, Cuttack. The treatment was started and the client was maintaining well on medication. But after one year when the manic episode started family members thought that the symptom are increased so they started doctor shopping. Subsequently the neighbours and extended family members pressured her parents to do her marriage and the parents do that. After marriage due to discontinuation of medicines symptoms exacerbated and client became symptomatic. Later on after 20 days of marriage she returned to her paternal home and after that she never went there nor her husband ever came to her. Subsequently the family members started blaming her, passed critical comments and frequently assaulted the client. Followed by which as per the informant three suicidal attempts was done by the client. Father was the only bread earner of the family and for the repeated hospitalisation of the client as he attended the client at hospital his occupational activity was grossly disturbed. Besides client's father and mother were suffered from physical illness and the family faced the financial crisis. The financial deprivation, social rejection, old age along with physical illness and psychological distress of parents resulted so critically that one day her parents gave her poison to drink but after drinking a little she reacted so painfully that instead of killing her they rescued her by applying local methods. In April, 2016 again she was admitted with manic episode when her parents left her at MHI, COE, SCBMCH, Cuttack due to financial and care burden and ultimately she was recognised as destitute by the institution. With the passage of time she became hopeless and in May 2017 she went in depression and attempted suicide by hanging herself in fan. For the first time she was referred to the Dept. of PSW for intervention. Though during daily group meetings the patient was attended by the therapist but for the 1st time she entered in client's journey of life and tried to walk with her empathetically. The therapist did a case study on client and tried to contact her parents. Initially the parents of the client didn't co-operate and didn't come. But after repeated counselling later on they came to MHI, CTC and from the psychosocial assessment therapist found the following;

Major Psychosocial Issues

- Old age and illness of the caregivers resulting in Financial and Care burden

- Interpersonal conflict and lack of emotional attachment among family members
- Presence of negative expressed emotion in the form of critical comments and hostility causing frequent relapse and rehospitalisation.
- Lack of secondary social support
- One attempt of Filicide as a result of parental burnout

As per the findings the intervention was planned and worked out with the client and her parents.

The Intervention Process

Development of therapeutic relationship

- Therapist tried to established rapport with client. Initially therapist met the client at the ward, greeted and made self-introduction to her. Then she was informed the purpose of the session and what needs to be achieved by the end of session. She was then encouraged to feel free to come forward & share her conflicts. Gradually, rapport was established and her confidence was gained (Priebe et al., 2008).

Psycho education

- To educate the patient and her family about her illness. Barcelona model of psycho-education was used. Therapist psycho-educated to the parents and client about the sign & symptoms, nature & course of the illness along with various pharmacological and non-pharmacological treatment and prognosis of the illness along with the importance of compliance to medications & regular follow up visit.
- To address the negative expressed emotion this session was taken with the parents regarding various negative expressed emotions and their impact on relapse and rehospitalisation. Therapist worked to help family members to become aware of and bring under control any expressed emotion they may be acting out (Colom et al., 2005).

Supportive psychotherapy

- Here the therapist informed the patient regarding the aim of the psychotherapy and how it will help her to reduce her problems. Subsequently, the supportive psychotherapy was done. The therapist used the techniques i.e. Clarification, Reassurance and Emotional ventilation, for her psychological and emotional strengthening (Misch et al., 2006).

Activity scheduling to engaged her in productive work

- Activity Scheduling is a behavioural treatment of mental illness in which client learns to monitor her daily activities, by increasing her pleasant activities productively to increase positive interactions with her environment. Client was encouraged to do daily activities using an activity diary in which she was asked to list out her liking activities. Then activities were chosen as per her interest those are productive and give a positive perspective to her life (Juruena et al., 2012).

Coping skills training

- For better coping in critical situations, the therapist discussed about coping skills by using techniques such as education and suggestion. The client was explained about three main domain of coping such as appraisal-focused coping, problem-focused and emotion-focused coping (Meyer, 2001).

Interpersonal and Social Rhythm Therapy (IPSRT)

- Sessions with the client and family members were conducted in order to inform them body rhythm disturbances such as insomnia and other sleep disturbances, can be corrected or managed by helping patients to set up and stick to healthy sleep routines.
- In this session patient was taught to keep a bipolar mood chartto track their mood states and their daily activities and body rhythms. Patient was advised to complete an interpersonal inventory, noting social interactions, such as conflicts and stresses that have an effect on their daily body rhythms and thus on their bipolar mood disorder.
- The bipolar mood chart was analyzed and discussed during psychotherapy session. Therapists helped patients to establish and maintain steady and stable routines such as taking bipolar medication consistently and going to sleep at regular times. It was also informed to patient this self-monitoring and problem-solving variety of bipolar therapy is effective in helping prevent recurring mood episodes (Frank et al., 2000).

Family Focused Family Therapy (FFT)

- In FFT therapist identified difficulties and conflicts within the family that were contributing to patient and family stress. After that therapist helped the involved family members to find ways to resolve those difficulties and conflicts.
- **Communication Enhancement Training**: In this training the family members discussed about the following skills how to express positive feelings, active listening, making a positive request for change and, expressing negative feelings about specific behaviours.
- **Problem solving skill Training:** In this session problem-solving skill was explained to the parents with the goal of teaching family members to facilitate this important skill and to address specific problem which was impacting the family.
- Client individually trained oncreative problem solving skills & their steps also taught to her such as description of the problem, generating ideas, ideas selection and refinement, idea implementation and evaluation and analysis of action (Miklowitz et al., 2016).

Termination of intervention

As the chances of relapse were very high in this case so to prevent relapse the parents of the clients were educated regarding relapse prevention techniques. They were educated regarding identification of early sign and symptoms, rapid cycle and need of compliance to medication and regular follow-up visit. Besides they were explained regarding the prognosis of the illness. The therapist tried to minimise the high expectation level and encourage the family members to appreciate her productive activities (Bond et al., 2015).

Conclusion

Though the journeywas difficult but at last success came as a ray of hope in Mrs. S.S's life as her parents took her to home. Now parents are aware how to deal with the patient, able to recognize the early sign & symptoms and how to involve the patient in various activities and how to appreciate and encourage her. As a result of various interventions patient was able to manage her anger and other behavioural problems. Mrs. S.S. started working at

their brass workshop; and earning money to meet her life expectancies and contributing to her family expenditures too. Besides she is doing all her house hold activities and taking care of her mother who is suffering from T.B. As per the informant Mrs. S.S is maintaining a good societal relationship with neighbours and other extended family members, she is able to shop from the nearby market place and attending the local functions and social functioning normally. She is maintaining a pleasant familial relationship with extended family members. To a great extend able to handle critical conditions and minor responsibilities. Since one year she is maintaining well in her socio-occupational life with pharmacological and non-pharmacological interventions.

"Sooner or later, your work speaks for itself" : Seth Godin

Refferences:

1. Bond, K., & Anderson, I. M. (2015). Psycho-education for relapse prevention in bipolar disorder: a systematic review of efficacy in randomized controlled trials. Bipolar disorders, 17(4), 349-362.
2. Colom, F., & Lam, D. (2005). Psycho-education: improving outcomes in bipolar disorder. European Psychiatry, 20(5-6), 359-364.
3. Frank, E., Swartz, H. A., & Kupfer, D. J. (2000). Interpersonal and social rhythm therapy: managing the chaos of bipolar disorder. Biological psychiatry, 48(6), 593-604
4. Juruena, M. F. P. (2012). Cognitive-behavioral therapy for the bipolar disorder patients. In Standard and Innovative Strategies in Cognitive Behavior Therapy. InTech
5. Meyer, B. (2001). Coping with severe mental illness: Relations of the Brief COPE with symptoms, functioning, and well-being. Journal of Psychopathology and Behavioral Assessment, 23(4), 265-277.
6. Miklowitz, D. J., & Chung, B. (2016). Family- focused therapy for bipolar disorder: Reflections on 30 years of research. Family process, 55(3), 483-499
7. Misch, D. A. (2006). Basic strategies of dynamic supportive therapy. Focus, 9(2), 173-268.
8. Murthy, R. S. (2017). National mental health survey of India 2015–2016. Indian journal of psychiatry, 59(1), 21
9. Pawar, A. A., Peters, A., & Rathod, J. (2014). Stigma of mental illness: a study in the Indian armed forces. medical journal armed forces india, 70(4), 354-359

Priebe, S., & Mccabe, R. (2008). Therapeutic relationships in psychiatry: the basis of therapy or therapy in itself?. International Review of Psychiatry, 20(6), 521-526.

Struggles of Destitute Women with Mental Illness

Dash K. Sushanta[1]& Hembram Sarathi[2]

Introduction

Mental health may be defined as the capacity of individuals and groups to interact with one another and the environment in ways that promote subjective well-being, optimal development, and the use of cognitive, affective and relational abilities. It is much more than the absence of mental illness.

The mental health has 3 important directions which include emotional, psychological, and social well-being. It depends how an individual or people think, feel, and act. It also helps us to determine to handle stress, relate to others, and make choices. Mental health is important at every stage of life,

In individual life's span some shorts of mental health problems may be experienced and there may be 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 problem are common in all age groups, gender, ethnicity and religious but to recover from mental health problems there are many ways. People with mental health problems can get better recover completely and lives their livelihood with the mainstream.

Mental health problem affect men and women equally but women are more vulnerable to the illness because abusive is often a factor of women mental health problem.

People suffering from mental health problems are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of society. Studies indicate that women are disproportionately affected by mental health problems and that their vulnerability is closely associated with their marital status, work and roles in society.

Women's mental health cannot be considered in isolation from social, political and economic issues. Examination of women's position in society reveals that there are sufficient causes in current social arrangements to account for the excess of depression, anxiety and distress experienced by them.

Women across cultures have been experiencing of neglecting towards economic resources, education, legal and health services, poor physical and mental nurturance, tiredness from overwork, sexual and other forms of physical and mental abuse across

their life span. In addition, the routine of women's lives render them at risk to experience more stress than men. This reflects the women are having greater number of social roles to fulfill as daughter, wife, mother, care-giver and an employee. Furthermore, women's reproductive role as bearer and nurturer of children and the varied roles, produce unique potential for stress related effects.

Setting:

The Centre of Excellence, Mental Health Institute, SCBMCH ,Cuttack is a multi disciplinary institute which provides tertiary level services with a mix of primary and secondary care. It helps to provide better treatment facilities to mentally ill patients. In the first floor there is administration office and emergency wing is functioning while the second floor is dedicated for Male and female patients and third floor is for child adolescence. To ensure quality education to medical students, a conference hall, a library and auditorium has been constructed.

The multidisciplinary teams of MHI, SCB provide clinical and specialized service at optimal level. However, when these women are adequately treated and are found fit for discharge reintegrating them back into society is a big challenge. However, at MHI we have been quite successful in reintegrating and rehabilitating those brought in for treatment from the streets by exploring various options and networking with various government and non government organizations and also in to their families.

Method

Case 1

A 35 year old Ms. L had been on treatment for chronic schizophrenia since more than 2 years. She belongs to state of Uttar Pradesh in India and studied up to 5th std. Her father loves to her very much and she has 3 elder brothers and 1 younger sister. After died of her father she got married at the age of 14. Then she blessed with a baby boy. After that there is quarreling started between husband and wife on the matter of their own son. Her husband blamed her that the child is not his child and he knew that she had affair with a boy before marriage. Then her in laws family tortured her and most of the time they shows assaultive behavior towards her and in the same time her mother also denied to take care of her .Then gradually she started irrelevant talk with in laws and couldn't take care of her own and as well as her child. However with the help of a NGO Basundhara who has been working as an ideal rehabilitation center for children, women and elders in distress, their care, shelter and long term rehabilitation team was able to rescue her. Then Basundhara admitted her in MHI for treatment. Since 1/12/2018 till date she has been under treatment and shows improvement in her condition. She is manageable and able to narrate her history. Now she is looking forward for integration to her own place.

Case 2

Ms. N. is a village girl from rural Odisha was diagnosed with schizophrenia. She had been on treatment since 2 years at MHI, SCBMCH, and Cuttack. She has father, 2 younger brother and 1 younger sister and her mother died of an accident. Ms. N. loves to her mother very much and after death of her, she became under stressed and most of the time she was crying, gradually she remain silent, not doing her daily activities, declined from her regular house hold activities. Before started of illness she was very happy with family members. She is elder among four siblings, because of that priority was given to her but after symptomatic, avoidance of care and affection towards her was occurred. Gradually she has been experienced with negative attitude and behaviors which was shown by her family members. Day by day her symptoms were increased and her condition gets worse. At first her father, younger brother, and sister-in-law

admitted her in MHI, SCB, Medical College and Hospital, Cuttack on 16/3/18. After hospitalization of 2 days her guardian neither left her alone and neither comeback nor took any information about her. While asking her the reason behind it she is unable to express. After residing at hospital for 1 yr and getting adequate care she is now symptom free, manageable at ward. Still Ms. N. is trying to find out the reason why her family member is not coming to take her up and also the institute is also on tracing her family members to handover her to them .

Discussion

With inadequate support and a strong gender bias, the mentally ill women are rarely accepted into the family and are forced to fend for themselves resulting in homelessness. For many women, homelessness follows years of violence and abuse which undermines their self esteem, contributes to the pain of powerlessness, and reinforces the social invisibility of their lives. Persons with mental illness are over-represented among the homeless relative to the general population, and mental illness is most likely one of the much vulnerability that confers risk for homelessness. Mental illness may play a role in initiating homelessness for some. A combination of severe mental illness, a tendency to decompensate in a non structured environment, and an inability or unwillingness to follow through with aftercare contributes to their being involved with the criminal justice system.

Physical Abuse and Abandonment

Passive violation in the form of neglect by families is far more than noted. Incidences of active violation include physical, mental as well as sexual abuse. Mentally ill women are commonly and repetitively abused with rape and other sexual assaults, as well as physical violence. The regular forms of trauma, domestic violence, sexual abuse, vulnerability, stigma and victimization faced by women also have an impact on the mental health.

Unaccountably, society has a very unforgiving attitude towards the mentally ill women, as though they themselves are responsible for their troubles. In many instances the perpetrators are their own family members. Women who face family violence and other forms of victimization, such as abuse by their family of origin are often fleeing from their homes to end up being homeless.

As quoted, "Discarded by families or wandering further and further away from home, their real selves are lost or submerged under layers of dirt and idiosyncrasies- handicaps both primary and secondary. They become non-persons, consciously ignored or worse, paid unhealthy attention. Women are particularly prone being easy targets of sexual abuse. The mentally ill destitute comprise a largely forgotten and unthought-of section of the homeless".

Poor Access to Health Care Facilities

The help seeking and utilization of the existing treatment services by women with mental illnesses is still low despite increasing awareness regarding mental illnesses. A woman with mental illness, though of a severe degree is not brought for treatment in the early stages in comparison to her male counterpart. A married woman, who is ill, loses the support of the husband and his family and is sent to her parent's house, where she would be at the mercy of helpless parents, brothers and sisters-in-law. Sometimes, even the treatment is denied to her by the husband who is the lawful guardian. The mental illness makes the woman incapable of asking for help herself.

Once engaged in the treatment, maintaining them in the treatment may become difficult in the absence of adequate social support. The contacts with the doctors are often in emergency services with no follow up ever maintained. Neglect leading to abandonment and thereby homelessness is one of

the common outcomes in these women. One tragic aspect is that families admit their mentally sick members to homes and asylums by providing false address. Many of those who recover are not accepted back by the family and therefore, the cured patients have no option but to continue to stay at the hospitals wherein they are admitted who provide shelter on humanitarian grounds.

Homelessness

Homelessness has been debated as the cause as well as consequence of mental illness and disability. Women are becoming the fastest growing segment of the homeless population. For many women, homelessness follows years of violence and abuse which undermines their self esteem, contributes to the pain of powerlessness, and reinforces the social invisibility of their lives. The multiple implications and the magnitude of the problem, call for an urgent attention, of all the service providers and policy makers. An attempt is made here to highlight some of the dilemmas and difficulties encountered along with certain case studies providing a glimpse into the lives of women with mental illness.

People with poor mental health are more susceptible to the three main factors that can lead to homelessness: poverty, disaffiliation, and personal vulnerability. Because they often lack the capacity to sustain employment, they have little income. Delusional thinking may lead them to withdraw from friends, family and other people. This loss of support leaves them fewer coping resources in times of trouble. Mental illness can also impair a person's ability to be resilient and resourceful; it can cloud thinking and impair judgment. For all these reasons, people with mental illness are at greater risk of experiencing homelessness.

In a study with the homeless population 91% were diagnosed to be suffering from primary psychiatric illness with about 40% having psychosis and 29% having substance use disorder. For many mentally ill women, homelessness leads to years of violence and abuse which undermines their self esteem, pain of powerlessness and reinforces the social invisibility of their lives. Access to basic health care services as well as mental health services due to the homeless status and mental illness is very poor. In a majority of cases the mentally ill women suffer from fractures, dog bites or other major physical health problems. Upon treatment and subsequent recovery, non-acceptance of the woman by the family, lack of welfare centers in the community push her back to homelessness where the treatment would discontinue.

Legal rights versus mental illness

Mental illness, irrespective of the severity, has often been cited as one of the reasons that deprive a woman of her basic human and civil rights. They often knowingly or unknowingly continue to be marginalized, invalidated, violated and/or ignored. The basic human rights with respect to individuals survival with dignity has to be ensured in all situations as stated in the constitution; but the scenario in case of mentally ill woman is still far from optimal.

As per the law, a person with mental illness cannot sign any document of sale, purchase, lease or any contract. However, the rights are not clear as to an individual's competence during the lucid moments/stabilized stage. In normal circumstances too women face difficulties in exercising their rights but in such instances family members may take undue advantage of this clause to deny the property rights to mentally ill woman.

While it is clearly stated by law that persons with mental illness have the right to live with dignity, in reality, many women with mental illness have been robbed of personal dignity repeatedly. The fundamental rights of fulfillment of the basic needs, right to shelter, right to safety, right on one's own body including right to reproduction as well as the

social rights need are rarely protected in the case of mentally ill women.

The issue of mental (ill) health, and more specifically its profound ethical dimensions, affects us all. The suffering of those with a mental health problem is a reality which we, either as individuals, members of a (professional) group, or members of a given community, cannot ignore, at least not ethically. We should not be indifferent to their suffering. To ignore or to be indifferent to such profound human suffering would be to abandon those in distress and to compound their vulnerability in morally unacceptable and culpable ways. We must not abandon the mentally ill and leave them languishing on the margins of community, of humanity.(Vindhya U. Mental Health Care 2001, pg-86-96)

Conclusion

Women's mental health must be considered within the context of women's lives and cannot be achieved without equal access to basic human rights: autonomy of the persons, education, safety, economic security, property and legal rights, employment, physical health including sexual and reproductive rights, access to health care and adequate food, water and shelter. Women's mental health requires the elimination of violence and discrimination based on sex, age, income, race, ethnic background, sexual orientation or religious beliefs. While both sexes benefit from the above factors and the overall rates of mental illness are similar in men and women, women's unique roles in reproduction, the family and society, their often lower socio-economic status, necessitate special considerations for their mental health.

As responsible mental health professionals and citizens, it is our duty to promote and protect the wellbeing and welfare of persons at risk of harm due to their mental disorders and other mental health problems and correct the wrong conduct and promote the right conduct of the persons around towards those with mental health problems.

It is imperative that when we make legal care accessible to persons who are mentally ill, we need to define a clearer frame work of execution of the rights, benefits and privileges guaranteed to them. Certainly, initiatives aimed at educating the public, promoting mental health through mainstream health promotion activities, establishing preventative mental health programs as an essential component of care provision to people at risk of mental health problems, and promoting research, are all essential to promoting better mental health outcomes. If the stigma attached to mental illness and other mental health problems are addressed appropriately, we could dream of a compassionate society genuinely promoting realization of social justice, equity, access and rights to persons with mental illnesses.

References

[1]. Johnstone MJ. Stigma, social justice and the rights of the mentally ill: Challenging the status quo; Australian and New Zealand Journal of Mental Health Nursing, 2001;10,200-09

[2]. Vindhya U. Mental Health Care: A Review of Gender Differences, International Journal of Diabetes in Developing Countries 2001; 21:86-96

[3]. Kanchan Kumari (2008): Women and children: mental health dimensions. In Nagaraja D & Murthy, Pratima (Eds): Mental Health Care and Human Rights, 234-242, NHRC, New Delhi. [4]. National Commission for Women Report (2007). http://ncw.nic.in/PDFFiles/Mental_health_is_destitution_the_only_answer.pdf

[5]. Sullivan,G., Burnam A., Koegel,P.Pathways to homelessness among the mentally ill. Social Psychiatry Psychiatr Epidemiol, 2000, 35 (10), 444-450.
http://www.ncbi.nlm.nih.gov/pubmed/11127718

[6]. Kumar S, Jeyaseelan L, Suresh S, Ahuja RC. Domestic violence and its mental health correlates in Indian women. The British Journal of Psychiatry 2005; 187: 62-67. 5.

[7]. Chandra P, Carey MP, Carey KB, Shalininananta A, Thomas T. Sexual coercion and abuse among women with a severe mental illness in India: an exploratory investigation. Comprehensive Psychiatry 2003; 44, (3): 205-212.

[8]. Montgomery, Carol RN (1994), Swimming Upstream: The strengths of women who survive homelessness. Advances of Nursing Science, 16(3). http://journals.lww.com/advancesinnursingscience/ Abstract/1994/03000/Swimming_upstream__The_st rengths_of_women_who.6.a spx

[9]. Kendra (2002). Out of Mind, Out of Sight-Voices of Homeless Mentally Ill. East West Books (Madras) Pvt. Ltd.2002

[10]. Bassuk, E.L., Buckner, J.C., Perloff, J.N., and Bassuk, S.S. (1998). Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. American Journal of Psychiatry, 155, 1561-1564.

1. **Sushanta Kr Dash**, Mphil in Psychiatric Social work 1st yr, Dept of PSW, MHI, SCBMCH, Cuttack.

2. **Sarathi Hembram**, Psychiatric Social Worker, Dept of PSW, MHI, SCBMCH, Cuttack.

Reproductive Mental Heath

Rachita Roy[1], Sushrita Das[2]

Guided By **:** Dr. Amrit Pattojoshi (Professor and HOD, Dept. of Pshychiatry, HMCH,BBSR) and Dr. PallabiSahu (assistant Professor, Dept. of Pshychiatry, HMCH,BBSR)

Abstract:

Gender is a critical determinant of mental health and mental illness; women of the reproductive age (from 12 to 45 years) being most vulnerable to depression. According to WHO Symptoms of depression, anxiety and unspecified psychological distress are 2-3 times more common among women than men, whereas addictions, substance abuse and psychopathic personality disorders are more common among men. WHO states that the burden of depression is 50% higher for females than males and Indian with a population of 1.2 billion are reported to be among the world's most depressed. In case of anxiety disorders, females have greater severity of symptoms, have more often comorbid depression and complicated course. Females undergo through stressful situations including childbirth and maternal roles, caring and nurturing the old and sick of the family. In addition women are less empowered due to lesser opportunities of education and respectable employment. Sometimes its hard to know whether the physical changes of pregnancy are symptoms associated with mental illness because they are so similar.Even all being said, the most important aspect remains the recognition of the disease;and an effective and yielding way is through screening. Our primary goal should be to educate ourselves as well as people, in general, not to ignore or neglect the little symptoms that surface in our day to day lives. If we dream for a better mental health care and status, it starts from us.

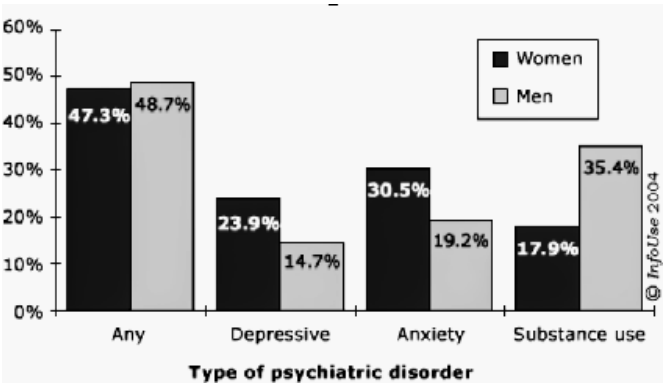
Introduction :

"Mental health is a level of psychological well being or absence of mental illness-the state of someone who is functioning at a satisfactory level of emotional and behavioural adjustment."[(1)]

Gender is a critical determinant of mental health and mental illness; women of the reproductive age (from 12 to 45 years) being most vulnerable to depression. According to WHO Symptoms of depression, anxiety and unspecified psychological distress are 2-3 times more common among women than men, whereas addictions, substance abuse and psychopathic personality disorders are more common among men.[(2)]

WHO states that the burden of depression is 50% higher for females than males and Indian with a population of 1.2 billion are reported to be among the world's most depressed. The prevalence of depression is 9% of major depressive episode is 36 % and the average age of onset of depression is 31.9 years in India. Moreover,

depression is not only the most common women's mental health problem, others include anxiety disorders, postpartum psychosis, premenstrual dysphoric disorder, pseudocyesis, postpartum blues.[3]



In case of anxiety disorders, females have greater severity of symptoms, have more often comorbid depression and complicated course. Both community based studies and studies of treatment seekers indicate that women are , on average , 2-3 times at a greater risk to be affected by CMD. Hormonal factors related to reproductive cycle may play a role in women's increased vulnerability to depression. Another factor independently associated with the risk for CMD are factors indicative of gender disadvantage. These factors include excessive partner alcohol use, sexual and physical violence by the husband, being widowed or separated, low autonomy in decision making, and having low levels of support from one's family. females undergo through stressful situations including childbirth and maternal roles, caring and nurturing the old and sick of the family. In addition women are less empowered due to lesser opportunities of education and respectable employment.[2]

The stigma associated with mental illness not only has a major impact on the sufferer but also on the families. These families are burdened with the care of these patients for almost their entire lives in a great number of cases.

Pre-Pregnancy:

"Having a diagnosed mental health challenge or disorder does not mean that women should not have children" however it does mean that a higher level of support may be need to ensure that women keep well during pregnancy and following childbirth.

Already diagnosed with mental health challenge or disorder such as bipolar disorder, schizophrenia, major depressive disorder, anxiety disorder or postpartum psychosis in a previous pregnancy helps in planning for next pregnancy and following care after birth.[2]

Pregnancy and Change:

Women experience many changes during pregnancy and it is common to find it challenging to deal with all social , economic, emotional and physical changes that occur at this time. Most women will need some support from family and friends to work through these changes and to get ready for the birth of the baby. Some will find it harder than others and may need additional support from community groups and healthcare providers.

Women often report of- major depressive disorder , anxiety disorders, (including panic disorders, generalized anxiety disorder, and obsessive compulsive disorder. Sometimes its hard to know whether the physical changes of pregnancy are symptoms associated with mental illness because they are so similar. For example- feeling very tired having difficulty in sleeping change in appetite and loss of energy are commom symptoms of pregnancy, and so of depression.

Risk groups- Women with a personal or family history of mental health disorders have a higher risk of perinatal mental illness and ideally should plan their pregnancy. This could include an indivisualized treatment plan developed by woman and her healthcare provider. Treatment may include educating the woman of the symptoms and ways to deal with the stress, self care with an emphasis on good sleeping habits, healthy eating, regular exercise, good hygiene and establishing a good a support from the family.[4]

Ante partum Depression:

Depression and pregnancy can be a deadly combination. It affects the thought processes and actions of the individual leading to changes in sleep pattern.

Causes-previous history of depression during childhood or early adulthood (adolescence), hormonal changes, physical changes like weight gain disturbed sleep pattern, history of trauma and abuse, absence of cooperation and support from the partner, unplanned pregnancy , marital problems, financial issues abortions in the past .

Signs and symptoms include- feeling of irritation or agitation, difficulty in concentration, loss of interest in daily activities feeling of sadness and crying all time, no or low energy to carry out day to day tasks , feeling of being worthless , excessive need to sleep or eat and overwhelming feeling of anxiety.

This is pretty major issue and could be easily neglected, but its consequences are worse. Consequences include- preeclampsia vomiting nausea postpartum depression complications with delivery such as premature birth or LBW baby.

As a result the child born becomes prone to other comorbidities like low birth weight, failure to thrive, growth retardation etc. the child becomes neglected .depression in mother could also lead to the baby becoming more irritable and crankier than the normal babies.

Intervention – 1) screening - as we know prevention is better than cure. It is better to treat the symptoms at an early stage and prevent its progression.2)psychotherapy-cognitive behaviourtherapy is helpful in identifying negative thoughts that affect a person's mood it encourages to challenge her beliefs and test the logic behind these thoughts. Interpersonal psychotherapy helps one to esolve any past losses and give her inner strength to manage internal conflicts that cause depression.3) medications- when the condition becomes severe .[(2)]

Postpartum:

Emotional disorder during the postpartum period can occur any time from labour up to one year following the birth of the baby.

Causes- 1.Significant drop in the levels of hormones.

2.Sleep deprivation.

3.Personal or family history of mental health challenges or disorders.

4.Change of role and responsibility in a woman's life.

5.Changes in personal, social and economic circumstances.

Some mental disorders that occur after the baby is born are:

A.Postpartum blues or Baby Blue: experienced by 80% of women. They are temporary emotional distress within the first 3 to5 days after childbirth is very common and is not referred to as a disorder. Usually passes within a week or two. In this, women may be fearful, restless,irritable,tearful,discouraged,sad and helpless.

B.Major Depressive Disorder: the most common mood disorder during the post partum period. Women feel constantly sad or low with changes in sleep or eating habits. They may also feel guilty,worthless or overwhelmed. If the symptoms last for more than two weeks, they may be suffering from a Major Depressive Disorder.

C.AnxietyDisorder:may occur in vulnerable women. Generalized anxiety disorder, panic disorder, obsessive compulsive disorder and post traumatic stress disorder may occur alone or in combination with depressive disorder.

The postpartum period is a vulnerable time for new onset or relapse for women previously diagnosed with Bipolar disorder or a Psychotic disorder. Postpartum psychosis is a rare but serious mental health disorder which may occur very suddenly and requires immediate treatment.

It is important to seek treatment as soon as possible and untreated mental illness can have long term consequences not only for the mother, but also the baby's development.

There are many different kinds of treatments that can help, not always involving medications. With the right kind of support,women can overcome their mental health challenges and begin to enjoy their babies.[5]

Pregnancy Loss:

Pregnancy loss is a unique and often lonely event in a woman's life and can trigger profound grief.Healing is helped through understanding and dealing with any physical and emotional changes.

Physical recovery occurs quite quickly while emotional response and recovery can be more varied. Some women experience more feelings of sadness,depression,anger,guilt or self blame than others.

All losses are not the same ,neither are all reactions to grief. Women may have other losses or needs occurring in her life at the same time and she may require support and information. Future family planning decisions may be difficult at this time and may be best left for when grief is less intense. Women should be encouraged to take time out and make arrangements for private time and rest.

Women may not always have support from family and friends or it may not be enough. There may be skilled people or a support group in the community that might come to their rescue.

INFERTILITY:

Infertility can be a major stress for women and their partners. Studies have found that more than 50% of women receiving infertility treatment felt that infertility was the most stressful experience of their lives.

Women experiencing infertility and undergoing ART may develop mood disorder symptoms:

- Women who continually face the disappointment of not conceiving month after month show more frequent signs of grief, depression and anxiety.
- One study found that women who are infertile for over 12 months are twice as likely to report symptoms of depression than women who conceive within 12 months from decision to become pregnant.
- Extremely high anxiety levels may affect the woman's ability to conceive.

Short term psychological support for women undergoing infertility investigation and treatments may be offered and when necessary, medications will be initiated and monitored.

PMS:

Pre-menstrual syndrome (PMS): between ovulation and when bleeding starts,about 75% of women experience some discomfort and may be quite uncomfortable with headache,cramps,tender breasts or other symptoms.Many find ways of coping with this

Table 1 Diagnostic Criteria for PMS (ACOG)[10]

A. Symptoms must occur during the 5 days before menses for at least 3 menstrual cycles in a row. At least one affective and one somatic symptom must be present.	
Affective Symptoms	Somatic Symptoms
Depression	Breast tenderness
Angry-outbursts	Abdominal bloating
Irritability	Headache
Anxiety	Swelling of extremities
Confusion	
Social withdrawal	
B. Symptoms are relieved within 4 days without recurrence until cycle day 13	
C. Symptoms are present in the absence of medicine, hormone ingestion or alcohol use	
D. Symptoms occur during 2 cycles prospectively	
E. Patient suffer social or economic dysfunction	

ACOG: American College of Obstetricians and Gynecologists

However, 20-40% women are troubled by their premenstrual symptoms which may be physical, behavioral, or emotional in nature. If there is a consistent pattern of bothersome symptoms, affecting how the woman functions in daily life, PMS may be diagnosed.[7]

Self care is an important step. Example:

- Getting enough sleep, rest and relaxation
- Doing some exercise
- Eating healthy
- Doing something for oneself e.g, reading,yoga,enjoying with partner or family etc.
- Down time.

Individual counseling may help in teaching women strategies to reduce unhelpful stress,increase in self communication in relationships. Supplements are often considered by women suffering PMS.[6]

Premenstrual Dysphoric Disorder

It is a somatopsychic illness triggered by changing levels of sex steroids that accompany an ovulatory menstrual cycle. It occurs one week before the one of menstruation and is characterized by irritability, emotional lability, headache anxiety and depression. Somatic symptoms include edema, weight gain, breast pain, syncope and paresthesias.

Treatment of PMDD includes support for patient about the presence and recognitions of symptoms. SSRIs example Fluoxetine and Alprazolam have been reported to be effective. The presence of especially severe symptoms even if cyclical should prompt clinicians to consider about other mood disorders and anxiety disorders.[8]

Conclusion:

Even all being said, the most important aspect remains the recognition of the disease;and an effective and yielding way is through screening. Our primary goal should be to educate ourselves as well as people,in general, not to ignore or neglect the little symptoms that surface in our day to day lives. If we dream for a better mental health care and status, it starts from us.

REFERRENCE

1. https://en.m.wikipedia.org/wiki/Mental_health

2.National Centre for Biotechnology information/mental health,2016.

3.World Health Organization, On Gender and Woman Mental Health, Geneva.

4.Provincial Health Services Authority/Changes in Pregnancy.

5.General Hospital Psychiatry,2006;28 Early Postpartum Depressive Symptoms.

6.J Reproductive Medicine 2006;51/Treatment of Premenstrual Disorders.

7.American College of Obstetricians and Gynaecologists/PMS.

8.Kapalan and Sadock's Synopsis of Psychiatry/11 edition/ch.27/Psychiatry and Reproductive Medicine/Pre-Menstrual Dysphoric Disorder

Highlighting Learning Disorder In School Mental Health

Suprabha Patra[1], Swarup Bindhani[2]

1 MBBS INTERNHi Tech Medical College and Hospital, Bhubeneswar, Odisha, India.
email-kanchi.patra01@gmail.com

2 MBBSINTERNHi Tech Medical College and Hospital, Bhubneswar, Odisha, India.
email-swarupbn420@gmail.com

GUIDED BY-Dr.Amrit Pattojoshi Professor & HOD,DEPT of Psychiatry, HMCH BBSR
Dr.Pallabi Sahu Assistant Professor ,DEPT of Psychiatry, HMCH BBSR

Abstract

Learning disabilities are common and many people with learning disabilities haveconsiderable, and often multiple, mental health problems. Additionally, their health needs areoften overlooked, or misattributed to their learning disabilities, resulting in unnecessarysuffering which could be alleviated by access to the right care and support. LearningDisorders are manifested in school age children and characterised by specific difficulties inlearning that are unrelated to intelligence. In DSM,disorders include reading disorder,dyscalculia,and disorders of written expression. There are various pointers to identify suchchildren during Preschool and school going period. These can be easily identified by parentsand teachers. Such children have various psychiatric comorbidities. Children with learningdisorders are children with Special Educational Needs (SEN). The current scientific approach is toenable the children to integrate into the mainstream educational infrastructure. Remedial inputs forthese children with special needs are given in the mainstream school itself. The concept of inclusiveeducation is the objective of forward looking educational boards all over the world, to enable"Education for all".

INTRODUCTION

Learning disabilities are common and many people with learning disabilities have

considerable, and often multiple, mental health problems. Additionally, their health needs are

often overlooked, or misattributed to their learning disabilities, resulting in unnecessary
suffering which could be alleviated by access to the right care and support. Achieving
equality in health and social care, and education, does not permit the assumption that one size
fits all because reasonable adjustments, as outlined in the Equality Act 2010 (UK Parliament,
2010), are necessary to accommodate individuals' disabilities.(1)
While all NICE guidelines are relevant for people with learning disabilities, this guideline has been produced to highlight reasonable adjustments so that people with learning disabilities

who have mental health problems receive equality of care and support. This guideline

considers:

- anticipatory care aimed at prevention of mental health problems;
- care, support, and recovery for persons with learning disabilities who have mental

health problems; and

- associated support for family and paid carers.

People with learning disabilities deserve to be equally valued and respected. This value and

respect will build an inclusive society enriched by diversity, benefitting all citizens.

People with learning disabilities are people first. Sometimes, additional considerations and

terms, or 'labels', can be helpful as a means to access appropriate care and support, and that

is why the introduction to this guideline now starts by describing the terms that are used

within it.(2)

DEFINITION

LEARNING DISORDERS-Disorders manifested in school age children and

characterised by specific difficulties in learning that are unrelated to intelligence.In

DSM,disorders include reading disorder,dyscalculia,and disorders of written

expression(3)

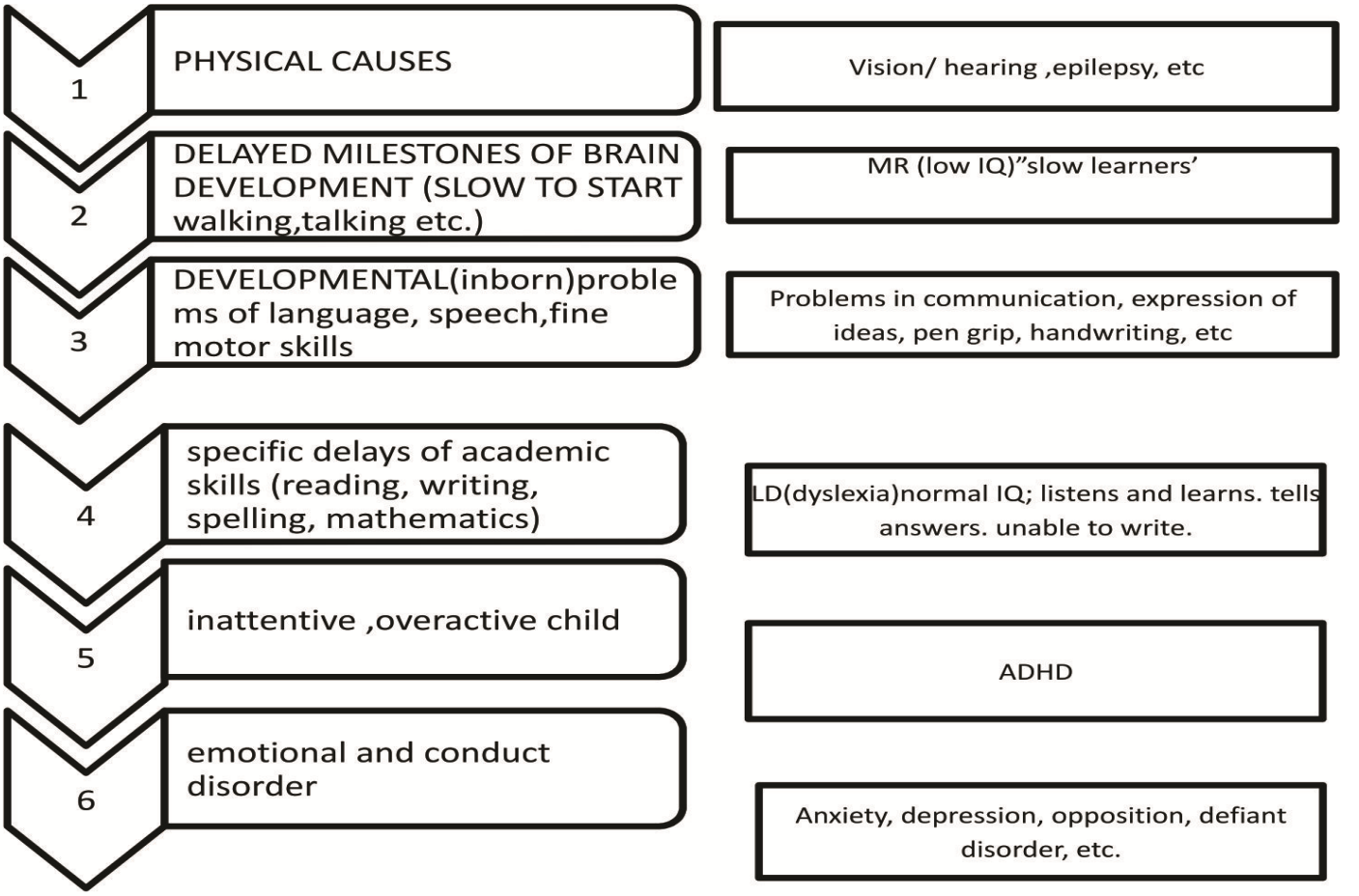
POINTERS FOR IDENTIFICATION (PRE SCHOOL CHILDREN) (4)

- Delayed development in speech
- Poor clarity in speech, poor language development
- Did not crawl, delay in walking
- Clumsy; excessive tripping and bumping
- Difficulty with buttoning, tying shoelaces and using crayons
- Difficulty picking up rhymes, names of colours and shapes
- Difficulty narrating stories in sequence
- Reversing alphabets and numbers (b/d, q/p)
- Confusion with left and right
- Poor attentionconcentration etc.

POINTERS FOR IDENTIFICATION (SCHOOL GOING CHILDREN) (5)

READING	WRITING	ARITHMATIC
Curious to read but prefers being read to	Extremely slow	Not interested
Reading slowly and hesitantly with omission and addition of letter	Spelling are bad	Use fingers for calculation even after 8 years
No attention to punctuation	Grammar and sentence constitution error	Confused with arithmetic signs like "X" and "+"
Miss lines	Inconsistent spelling error	
Unable to interpret	Confuse letters like "b"for"d"and "n"for "u"	Transpose the digits while writssssing eg.2538 becomes 5238
	Omits capitals and punctuations.	
	Poor handwriting	
	Transposed word image eg. "saw"for "was"and "no"for "on"	
	Confused between left and right	

POOR SCHOOL PERFORMANCE CAUSES IN THE CHILD (6)



COMORBIDITY WITH SPECIFIC LEARNING DISORDER(7)

COMORBID DISORDERS	PREVALENCE	AUTHORS
Behavioral and emotional disorders	30%	Sahoo et al.,2015
ADHD	10 -60%	Various studies(Margari et al.,2013)
Inattention difficulties ADHD and dyslexia	20-40%	Halperin et al.,1998;Karande et al.,2017 Sahoo et al.,2015 Hendren et al.,2018
Conduct disorder	6%	Chaudhary and Meghwal.,2015
Depressive disorder	33%	Fristed et al.,1992
Anxiety disorder	20-30% 28%	Prior et al.,1999
ASD and dyslexia	6%	Margari et al.,2013

Language disorders	Varies-around 30-4-% of patients with SLD have a reading disorder.Patient with dyslexia with a specific language disorder vary from 55-77%	Hendren R et al.,2018 Margari et al.,2013

Table 55.8–3.
Example Tiered Interventions for School Mental Health

Tier	Program	Goal
1	**Good Behavior Game**	Classroom intervention with a set of evidence-based strategies and a classroom game to increase self-regulation and cooperation and decrease unwanted behaviors
1	**Life Skills Training**	Group or classroom intervention to promote general social skills, self-management, drug resistance, and violence prevention
1	**Project Achieve**	Group or classroom intervention to prevent alcohol, tobacco, and marijuana use and violence
1	**Project Alert**	Group or classroom intervention to prevent alcohol, tobacco, and marijuana use and violence
1	**Second Step**	Classroom curriculum that teaches socioemotional skills to decrease impulsive and aggressive behavior and increase social competence
2	**Check and Connect**	Individualized intervention for students showing warning signs of disengagement and at risk of dropping out. The program monitors school performance and provides mentoring, case management, and other supports
2	**Coping Power**	Group intervention for children at risk of aggressive behaviors, drug use, and delinquency. Uses cognitive-behavioral techniques to teach children how to cope with anger, anxiety, decrease impulsivity, and develop and improve social, academic, and problem-solving skills
2	**Strengthening Families Program (SFP)**	Increases resilience, reduces risk factors to improve social competencies and school performance, and to reduce problem behaviors, delinquency, and alcohol and drug abuse in high-risk children
3	**Aggression Replacement Training**	CBT-based intervention to help children and adolescents improve social skill competence and moral reasoning, better manage anger, and reduce aggressive behavior
3	**Coping Cat**	CBT-based intervention to help children recognize and clarify anxious thoughts and feelings, develop plans for effective coping, and self-evaluate and reinforce positive coping skills
3	**Cognitive Behavioral Intervention for Traumatized Students (CBITS)**	CBT-based group intervention to reduce symptoms of PTSD, depression, and behavioral problems; improve peer and parent support; and enhance coping skills
3	**Interpersonal Psychotherapy for Depressed Adolescents (IPT-A)**	Short-term manualized intervention focusing on developmental and interpersonal needs of adolescents (12–18 years old); builds communication and social problem solving skills
3	**Stark School-Based Intervention for Depressed Students**	CBT-based intervention for children with depression that teaches self-control techniques, social skills, assertiveness, and relaxation training, imagery, and cognitive restructuring

REMEDIAL STRATEGIES FOR READING,WRITING,SPELLING,ARITHMETIC DISORDERS.

Act of reading comprises of 2 basic processes:-

1.decoding of written form

2.comprehension of the messege produced by the written form

Children with reading disability-quickly learn through the 'sound' modality when you read out to them.

Remediation should be taken into account on the basis of IQ:-emphasis should be given on 1.Reversals of 'B','C','D'.

2.Reluctance to read aloud

3.Tendency to follow the text with finger when reading

"Greater the phonological deficit the higher the degree of reading disorder"

Method- **focus on simplification**

Child should 'decode 'the written symbols into their sounds form

Resultant sound form is meaning fully interpreted in the brain to create Reading Comprehension

Reading Comprehension-can be enhanced

1) **By letting him skip the step of having to read on his own.**
2) **Lesson can be read out and verbally explained to him.**

KEY WORD APPROACH

Ask the child to pick out key words from paragraphs of the Lesson

Help to understand and remember better.

BIRD, Pickwords- feather, birds, nesting habits, beak

This will help the child better understand and remember things.

BASIC SLIGHT VOCABULARY

Words like "on", "no", "of", "etc"

Words can be taught using flash cards and set of common words

PHONIC METHOD	**Difficulty in sound letter association (Phoneme- grapheme)** **Eg dog = /d/o/g/ - child is taught the sounds of letters** ⬇ **Encourage to blend into word**
PHONETIC METHOD	**Phoneme-grapheme correspondence are taught in an organised way** **Starting with – individual letter sounds** ⬇ **Proceeding to families of words that have the same sounds** **Method- it deals with various spelling units systematically** ⬇ **Until words can be broken into patterns (such as 'ar', 'tion', 'tch')** ⬇ **Which the child learns to recognise and read quickly**
SYLLABICATION	**Improve word attack skills i.e. ask the patient to read words by breaking it into respective syllables eg bask/et, mat/ter,stick/er**

Writing disorders are characterised by 2 major defects in the mechanism of handwriting and in written expression skills. Measures should be taken to improve the way the child sits and holds the pen.

The ideal pencil grip is called DYNAMIC TRIPOD GRIP. In this pencil rests comfortably on one finger aided delicately by other 2.

The important steps in the writing process include

- Idea generation
- Idea elaboration
- Organisation

Arithmetic problems includes skill defects such as computational skills, statement sums and concept of time, speed and distance, It also requires language comprehension skills- the child has to understand the sum.

For eg a drum contains 2000 litres of oil. If 750 litres is sold in the morning, and 1100 litres is sold in the evening, how much oil is left in the drum?

Following steps maybe used for better understanding of this problem to the LD child.

R- Read and understand the question
I- identify the keywords and underline them
D-Draw a diagram showing problem in detail
D-Decid.e on the operation
E- Let the child Estimate the answer
S- Solve and recheck
***Maintain a personal checklist to help the child check his work(10)**

CONCLUSION

Children with learning disorders are children with Special Educational Needs (SEN). The current

scientific approach is to enable the children to integrate into the mainstream educational infrastructure. Remedial inputs for these children with special needs are given in the mainstream school itself. The concept of inclusive education is the objective of forward looking educational boards all over the world, to enable "Education for all".

For the concept of inclusive education, the classroom teacher is the most significant contributor as a manager and a therapist. The teacher's role becomes multiple in order to deal with any child with special educational needs.

Constant participatory communication with parents, evolving common teaching strategies to be used inside the class and outside uniformly, communicating with any other agencies involved in remediation etc are important roles which the teacher may have to continuously undertake.(11)

REFERENCE

1)National Institute for Health and Care Excellence(UK),London

2)Fontane,D(1995)Psychiatry,Blackwell Scientific Publications,Oxfordss

3)Kaplan &Sadock's Comprehensive Testbook of Psychiatry-10th edition

4)School Mental Health Through Empowerment The Education Sector

5)Philip John(1997)Learning Disabilities-From Health to Education,Paper presented at the National Conference on learning Disabilities,Chennai

6)World Health Organisation(1992),The ICD-10,Classification of Mental and Behavioural Disorders,Geneva

7)IPS Clinical Practice Guidelines for Management of Psychiatric Disorders in Children & Adolescents

8)American Academy of Child Psychiatry. Code of Ethics.Washington,DC:American Academy of Child Psychiatry;adopted in 2009,revised in 2014

9)Parents E,Johnston J.Trouble children :diagnosing,treating and attending to context.A Hasting Centre special report .Hasting Cent Rep.2011;41(2):S1-S32

10)Strom,R.D.(1969)Psychology for the Classroom,Prentice-Hall,INC;Englewood Cliffs,New Jersey.

11)Child Care Centre (1997),Understanding Children with Learning Disability,Cochin.

Caregivers Burden in Dementia

Sushree Truptimayee Barah[1], Swarnalata Guru[2]

1&2MBBS INTERN Hi-tech Medical College and Hospital ,Bhubaneswar, Odisha, India

Guided By-Dr Amrit Pattojoshi Professor & HOD DEPT of Psychiatry, HMCH,BBSR

Dr Pallabi Sahu Assistant Professor DEPT of Psychiatry, HMCH,BBSR

ABSTRACT

Dementia refers to a disease process marked by progressive cognitive impairment in clear consciousness. Currently 47 million people are affected with dementia in the world and the great majority of whom are cared by their family members. As Dementia is a disease of progressive cognitive impairment, in later stages of the disease, physical assistance can be overwhelming to provide help in activities of daily living, managing incontinence, wandering and co-morbid neurological, psychiatric & cardiovascular conditions. Care giving is physically as well as emotionally demanding, because the patient has less ability to communicate. Hence, caregivers play a major role in treating patients with dementia. Those who care for older adults suffering from dementia experience mixed emotions about their increasing responsibility and the sight of a loved member of a family suffering from a debilitating condition. The most common mental health consequences in dementia caregivers are DEPRESSION, ANXIETY and a condition called BURNOUT which is characterized by frustration, feeling powerless, hopeless, feeling drained of energy, feeling irritable and sad. The interventions for caregiver distress is a multi-component approach which includes education about the demoting illness, emotional support, information about resources, and cognitive behavioural therapy including skill training, anger management, and mood management.

DEMENTIA

Dementia refers to a disease process marked by progressive cognitive impairment in clear consciousness.DSM-5(Diagnostic and statistical manual of Mental Disorders) describes dementia, subsumed under the term NEUROCOGNITIVE DISORDER, as significant cognitive impairment in one or more of domains of complex attention, executive function, learning and memory, language,

perceptual motor ability and social cognition. These deficits represent decline from the previous level of functioning which is noted by individual himself or his family members. [1]

PREVALENCE

Nowadays dementia is becoming a major public health crisis due to global ageing and the number doubles in every 20years. Currently,47 million people are affected with dementia in the world and the great majority of whom are cared by their family members. [2]

DIAGNOSIS AND CLINICAL FEATURES

The hallmark of dementia is cognitive impairment. The patients must demonstrate impairment in one or more cognitive domains as per DSM-5 criteria. [3]

Table 10.3–2.
DSM-5 Criteria for Major Neurocognitive Disorder

A. Significant cognitive decline from a previous level of functioning in one or more cognitive domains, as evidenced by:
   1. Concern from the individual, the clinician or another knowledgeable informant that there has been significant cognitive decline
   2. Significant impairment in cognitive performance, ideally seen on standardized neuropsychological testing, or if that is not available, another clinical assessment
B. Cognitive deficits interfere in independence in daily activities
C. The deficits do not occur exclusively during the course of a delirium
D. The deficits cannot be explained by another mental disorder

Table 10.3–4.
Evaluation of Cognitive Domains

Complex attention	Does the individual have difficulty paying attention?
	Is the individual easily distracted in environments where there are competing stimuli?
	Does the individual have difficulty retaining newly presented information?
	Are routine tasks taking longer than usual?
Executive function	Does the individual have more difficulty with multitasking?
	Is the individual still able to manage their own finances or medications?
	Is more assistance required to plan out activities or instrumental activities of daily living?
	Is more assistance required to make decisions?
	Is the individual having more trouble in large social situations, or finding them less enjoyable?
Learning and memory	Is the individual having difficulty recalling recent events and activities?
	Is the individual repeating himself or herself more often?
	Is the individual needing to rely more on lists or reminders?
	Is the individual misplacing or losing items?
	Does the individual need more reminders to attend to a particular task?
Language	Is there word finding difficulty?
	Is the individual making more grammatical errors in conversation?
	Is the individual forgetting people's names?
	Is the individual making more generalized, vague statements in response to questions?
	Is the individual using more generalized pronouns as substitutes for particular names of items?
Perceptual motor	Is he or she getting lost when travelling or in familiar environments?
	Is he or she having more difficulty using previously familiar tools and appliances?
	Is he or she having difficulty driving a car?
Social cognition	Has the individual or family members noticed a personality change?
	Does the individual appear to be less empathic or more disinhibited in their speech or behavior?
	Is the individual making sexually, politically, or religiously inappropriate

ROLE OF

CAREGIVER IN DEMENTIA

A caregiver is someone who has responsibility for meeting the physical and psychological needs of an infant, child or dependant adult. Primary caregivers are the individuals who help the patient with at least one instrumental activity of daily living such as bathing, eating, dressing, or a person who supervises a disabled patient. It is of two types-formal and informal caregivers. [4]

FORMAL CAREGIVERS-Individuals who are paid to meet the physical and psychological needs of the patient.

INFORMAL CAREGIVERS-Individuals who provide the needs voluntarily like family members and friends. As Dementia is a disease of progressive cognitive impairment, in later stages of the disease,

physical assistance can be overwhelming to provide help in activities of daily living, managing incontinence, wandering and co-morbid neurological, psychiatric & cardiovascular conditions. Care giving is physically as well as emotionally demanding, because the patient has less ability to communicate. Hence, caregivers play a major role in treating patients with dementia.

CAREGIVER BURDEN

Caregivers are generally at greater risk of developing mental health and other health problems than non caregivers. Those who care for older adults suffering from dementia experience mixed emotions about their increasing responsibility and the sight of a loved member of a family suffering from a debilitating condition. The behavioural disturbance in the patient is a major source of care giver burden and increases the risk of caregiver burden.

Caregivers also frequently become isolated from their social support as the patient is no longer engage in their usual social functions. The lack of social support is another risk factor for caregiver s distress. The most common mental health . consequences in dementia caregivers are DEPRESSION, ANXIETY and a condition called BURNOUT which is characterized by frustration, feeling powerless, hopeless, feeling drained of energy, feeling irritable and sad.. Together these conditions are called caregiver distress. In addition to the mental health consequences, there is also increased poor health outcomes in caregivers. Some researchers speculate that the poor health outcomes are the result of poor healthcare behaviours as they do not get sufficient time to attend their own medical appointments,

therefore potentially preventable health problems like hypertension and cardiovascular disease arise. Brent T. Mausbach and colleagues found that an exaggerated norepinephrine response in caregivers is linked to increased cardiovascular disease. These researchers also have associated caregiver stress to reduced immune cell ss2-receptor sensitivity and increased D-dimer marker of hyper coagulability. Janice Kiecolt- Glaser and colleagues found that caregiver distress has a direct effect on immune function through increasing the proinflammatory cytokine interleukin-6. Hence caregiver stress has significant and direct impact

on health.[5]

CAREGIVER PROBLEMS

1. DIRECTLY RELATED TO PATIENT:-

- Debilitating cognitive and functional decline
- Expenditure incurred directly for medical and non-medical purposes.
- Loss of income of the patient.
- Emotional strain of witnessing gradual deterioration of a loved one

2. INDIRECTLY CAUSED BY PATIENT

- Compromising on caring of other elderly and small children at home.
- Increased risk of developing serious physical and mental health problems.
- Caregivers loss of income if t . hey have to give up their job to care.

3. INDEPENDENT PROBLEMS

- Caregivers will be unable to pursue their jobs, studies, own interests and pleasurable activities.
- Interpersonal conflicts among family members.

COGNITIVE DISTORTIONS IN CARERS

- OVERGENERALIZATION :- The person takes a few factor into consideration and makes a conclusion.
- FILTERING/ SELECTIVE ATTENTION :- Only a particular kind of stimuli is paid attention to. Ex.- loss, rejection, unfairness.
- SELF-BLAME :- Distorted thinking style in which carers blame themselves for everything. Self blame binds a person to his/her good qualities and accomplished.
- PERSONALIZATION :- All events are interpreted to have to do with the person and there is very little senses of control of events. Personalization makes one react inappropriately and create emotional problems for themselves and those around them.[6]
    - EMOTIONAL REASONING

REMEDIAL MEASURES FOR CAREGIVER DISTRESS

The interventions for caregiver distress is a multi-component approach which includes education about the dementing illness, emotional support, information about resources, and cognitive behavioral therapy including skill training, anger management, and mood management.

COGNITIVE BEHAVIORAL THERAPY

It is a psychosocial intervention that aims to improve the mental health focusing on changing the unhelpful cognitive distortions and behavior, improving emotional regulation. It includes teaching new information-processing skills and coping mechanism by means of skills training classes and psychoeducation.

SKILLS-TRAINING CLASSES

These classes aim at educating caregivers in stress management, anger management and self care. They teach the caregivers about the causes of dementia, explain the reasons for behaviors of the patient and provide them strategies for managing their anger, mood, and burden. They teaches the caregiver how to refocus their understanding of the care recipient.s behavior, make use of stress reduction strategies like meditation and relaxation training, increase pleasant activities, and find opportunities to take a break from their caregiving responsibilities. Caregivers with low-pretreatment self-efficacy seemed to respond better to these interventions than those with high self-efficacy, although across groups, everyone experienced benefit from these skills-building groups . One of the largest studies of caregiver treatment is the REACH trial, a study of 167 caregiver-recepient dyads, which found that coping and stress management classes were far more effective in managing caregiver depression and burden.[7]

PSYCHOEDUCATION

It provides education to the patient and their family members about the symptoms of dementia, it.s course, consequences and treatment so that they can plan for the future disability. It can also help the family members in the process of caregiving and can also reduce the caregivers. stress.

EDUCATION AND SUPPORT GROUPS

Research shows that even minimal education classes that focus on caregiving-coping strategies and information about dementia have benefit for caregivers for mitigating distress. Robert Woods and colleagues compared a mental health nursing program to support caregivers with the community educational programs and found that community educational programs were as more effective in reducing caregiver distress than the intensive nursing program. [8]

CONCLUSION

Much of the distress experienced by the caregiver is due to their perception of the situation. The demanding task of caring for a person with dementia can impair perception and lead to cognitive distortion. Cognitive Behavioral Therapy aimed towards minimizing cognitive distortions and helping to schedule caregiving activities which will enable the caregiver to reduce distress, thereby avoiding experiencing the feeling of burden and burnout. An agitated patient can adversely affect the mood of already confused patient. Hence behavioral therapy and skill training classes are beneficial for both the caregiver and the patient. [9] One of the most complicated aspect of the treatment is access to the interventions as some caregivers feel they have no time to attend the training classes. Recent studies suggest that interventions can be successfully delivered over telephone and internet. However a study of 299 caregivers receiving multimedia intervention over the internet found that internet interventions provide a low-cost, convenient and effective means of overcoming caregiver distress. [10]

REFERENCES

[1] Dubois B, Hampel H, Feldman HH, et al. Preclinical Alzheimer.s disease: definition, natural history, and diagnostic
criteria. Vol 1 Kaplan & Sadock.s compressive textbook of Psychiatry.

[2] Coyle-Gilchrist ITS, Dick KM, Patterson K, et al. Prevalence, Characteristics, and survival of fronto temporal lobar

degeneration syndromes. Alzheimer.s Disease International. World Alzheimer report 2015-the global impact of dementia:
an analysis of prevalence, incidence, cost and trends.
[3] Manoochehri M, Huey ED. Diagnosis and management of behavioral issues in frontotemporal dementia.Vol 1 Kaplan
& Sadock.s compressive textbook of Psychiatry.
[4] Alzheimer.s Association.2013 Alzheimer.s disease fact and figures. *Alzheimers Dement.*Vol 3 Kaplan & Sadock.s compressive textbook of Psychiatry
[5]Mahoney R, Regan C, Katona C, Livingston G. Anxiety and depression in family caregivers of people with Alzheimer
disease: the LASER-AD study. Vol 3 Kaplan & Sadock.s compressive textbook of Psychiatry
[6] Dias A, Samuel R, Patel V, Prince M, Parameshwaran R and Krishnamoorthy ES.The Impct Associated with caring for a
person with dementia.*International Journal of Geriatric Psychiatry 2004.*Handbook of Dementia
[7] Haley WE, Gitlin LN, Wisniewski SR, et al. Well-being, appraisal, and coping in African-American and Caucasian
dementia caregivers: findings from the REACH study. Vol 3 Kaplan & Sadock .s compressive textbook of Psychiatry.
[8] Boots LM, de Vugt ME, van knippenberg RJ, Kempen GI, Verhey FR. A systematic review of internet-based supportive
interventions for caregivers of patients with dementia.*Int J Geriatr Psychiatry.2014.* Vol 3 Kaplan & Sadock.s compressive textbook of Psychiatry.
[9] Acton GJ and Kang J. (2001) Interventions to reduce the burden of care giving for an adult with dementia: a metaanalysis.
Research in Nursing and Health. Handbook of Dementia..
[10] Haley WE, Bergman EJ, Roth DL, McVie T, Gaugler JE, Mittelman MS. Long-term effects of bereavement and caregiver intervention on dementia caregiver depressive symptoms. Vol 3 Kaplan & Sadock.s compressive textbook of
Psychiatry

Mental health
The vulnerable group- 'women' to the mental health problems.

Anand, A.

Department of Psychology, Utkal University, Bhubaneswar

ABSTRACT:

Women of our society have been subject to various adverse situations in their life time. They are challenged in almost all walks of their life. They have been questioned, suppressed and criticized for issues with minimal or no base. Women play multiple roles in society than men. So it is possible that they are more prone to physical and psychological issues than others. The brain of both men and women have structured differently. They both react differently to the same thing. Studies have been conducted showing that women are facing more issues and more severely than men. Due to social taboos women attendance in mental health centers is very low.

As women are more vulnerable to the disorders as of the studies conducted in the past, we should be more careful to care and treat them and avoid the negligence shown to them.

INTRODUCTION

Mental health is state of psychological wellbeing where the person is aware of his full potential and works productively hence contributing to his own and society's welfare and development. Mental development is as important as physical development. Both the concepts are interrelated. Without being mentally healthy a person cannot be fully productive, hence leading to personal discomfort and dissatisfaction.Women have been facing the mental disorders more than that of men due to various factors and it is important for the society to take steps to empower women with mental health so that she feels it and uses it to her personal and societal purpose.

What is mental health?

Mental health refers to the state of wellness where the person realizes his own potential, can cope with the normal stresses of life, work productively and able to make contribution to his own and community's growth and development. It is a state of psychological wellbeing of a person where he is fully fit and productive. It is the absence of mental disorder.

In a lighter language we can say that it is all about wellness rather than illness. It is very important for us to be well in order to function fully or it may cause psychological tension within us.

Being mentally healthy is equally important as physically healthy. In fact both the concepts are interrelated. If we attain mental health we also can achieve sound physical health. But mental health is a complex term. We can diagnose mental health while other aspects of life functioning correctly. We can say that it refers to cognitively, emotionally and socially healthy.

Women- the vulnerable group:

Men and women are different from each other not only on physical term but also on psychological structures. Women, is itself a complex term. Because from women the life starts and has a lot of role to play in the society. Women are more prone to illness due to various factors.

Women and men's brain have differently wired and structured. So they tend to behave, express, act differently than the opposite gender. Analysis of mental health indices and data reveals that women are more prone to depression, anxiety which is 2-3 times that of men. Whereas men are more prone to substance abuse and addiction related disorders.

WOMENS MENTAL HEALTH FACTS:

- Rates of depression is twice as high as of women as that of men.(41.9% women and 29.3% men)
- Majority of the old age problems such as depression, organic brain syndrome patients are women.
- It estimated that 80% of 50 million people that are affected by violent conflicts such as civil wars, disasters etc. are women and children.
- Life time violence rate of prevalence against women ranges from 16% to 50%.
- One in five women face assault in their life time.

From the above facts we can see that women are more prone conflict arising situations tending them to suffer more and hence getting affected by various mental health issues in their life time.

Women and mental disorders:

The rate and severity of mental disorder is same in case of both men and women. But they differ in terms of onset, course and diagnoses.

VARIOUS MENTAL DISORDERS FACED BY WOMEN IN THEIR LIFE TIME:

BIPOLAR DISORDER:

The type 1 rate is similar than that of men and women but type 2 is more prevalent in women. The age of onset is late in case of women and they face more severe depressive episodes.

SCHIZOPHRENIA:

- The life time prevalence is same in both men and women. Women have later age of onset(25-35)

EATING DISORDER:

- The prevalence rate of anorexia nervosa is 95% and bulimia is 80%.

SUBSTANCE ABUSE:

- Men are more prone to substance abuse than women. Women with other illness tend to be vulnerable to the problem.

PERSONALITY DISORDERS:

- Women are more prone to borderline and histrionic personality disorder, whereas men are more prone to anti-social and narcissistic personality disorder and obsessive compulsive disorder.

We saw that women are more vulnerable to depression that that of men. Here are some factors that are the causes of depression in women.

SOCIAL AND PSYCHOLOGICAL FACTORS:

- This is one of the most important factor that affects the women group. They are more prone to gender based violence such as domestic violence, rape, sexual abuse, family pressure and burden on different aspects of life. Report of UN states that two third of the Indian married women suffer from domestic violence leading to absence in working environment.
- Socio economic status play a part as it fuels sense of various shortcomings and inferiority as women tend to think about family more effectively than others
- They are more vulnerable because they have more role to play in the society and have huge number of responsibilities on their head.

REPRODUCTIVE FACTORS:

- In this case we can say that women face it all whereas men don't experience these problems. These are the inevitable situations women face in their life. These issues lead to various mental disorders as well as depression. They are:
- Menstrual cycle.
- Pregnancy.
- Hormonal problems.
- Postpartum depression.
- Infertility.
- Menopause

BIOLOGICAL FACTORS:

- We can say that depression runs through family. There are genetic make-up that lead to depression. However even if the person has depression it can be eradicated and avoided through healthy environments including encouraging and friendly family and friend circles.
- Various hormones also causes depression in case of women.

SOCIO CULTURAL FACTORS:

- In India women tend to have few or less power than men in the society. They are more suppressed on almost every aspect of life. They are less cared.
- When they face mental problems, the treatment is delayed and also blamed for the illness.
- The treatment is often left to the family of the women rather than her husband.

CURRENT SCENARIO:

It is seen that the awareness is really low among the people. The first thing to be done is to make people learn what mental health is and what a good mental health leads.

A study states that one women in every three men attend psychiatric centers. This shows the stigma of mental illness around the society. It is also seen that there is less accommodation for women in hospitals and lack of availability of resources to admit women in hospital settings. Till date it has been a man's problem not a women's issue. This mentality should be changed.

CONCLUSION:

Women's Mental health cannot be just kept to these said words or certain categories. A woman's mental health must incorporate mental as well as physical wellness throughout the life span.

It should reach beyond the narrow mindset of mere health issues and need to be carefully attended and treated thoroughly in every society. As it is said, women from where it all starts. So we should treat the start and automatically everything will fall on the correct path.

Let us empower the women with all the power and health.

KEY WORDS: Mental health, Vulnerable group-women, Multiple roles and societal pressure**,** Suffering of mental disorders**,** Socialstigma

Women's Mental Health Matters

Dr. Subhasmita Panda

Assistant Professor in Psychology
BJB (Autonomous) College
Bhubaneswar
Odisha
Email: subhasmita81@gmail.com

Abstract

Women form an essential part of the society. As they represent one half of the human resource, their role and contribution to the society is crucial for the development of the society and nation. They play an active role in the life of a human being as mother, wife, friend and care-giver. However, the understanding of women's mental health has always been neglected. The Constitution of India gives women the fundamental right to equality and the right not to be discriminated against on grounds of religion, caste and sex, but there is no mention of health based discrimination between the sexes. Indeed, mental illnesses affect women and men differently. Some disorders are more common in women. Some even argue that women are more "emotional" than men. But the question is why mental illness is more common among women and what are the specific factors that play role in this challenge. This paper is going to analyse various factors that are affecting women's mental health. As a girl child, as young adolescent women face many challenges in their life. Other than this hormonal issues; pregnancy, birth and parenting; discrimination, trauma and stressful life experiences; career goals and relationship are number of factors interact in complex ways to make women more vulnerable to mental illness. Changes can be initiated to overcome this problem by overcoming social stigma, developing a social support system, monitoring self and enriching work.Mental health of women needs to be addressed in a holistic manner because failure to address women's health in general and their mental health in particular has damaging social and economic consequences for communities both in the short andlong term.

Keywords: women, mental health, discrimination, mental illness

Psychosocial profiles of mentally ill destitute patients residing of MHI, (COE),SCBMCH,CTC,Odisha

Behera, L.1, & Swain, M.2

1. M.Phil. in Psychiatric Social work 1st year trainee, Department of Psychiatric Social Work, Mental health institute (COE), SCB Medical, Cuttack, Odisha, India
2. Asst. Professor, Department of Psychiatric Social Work, Mental health institute SCB Medical, Cuttack, Odisha, India

ABSTRACT

The World Health Organization defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. It is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand to change or cope with the environment." (Health Promotion Glossary, p. 1) This Human resources are supremely important asset of nation. The social reality of today chronic mentally ill patients are highly marginalized group that receives limited care and attention from society. The aim of the study was to analyse the socio-demographic profile of destitute patients with mentally illness at MHI, COE, SCB Cuttack Odisha & to find out different factors for being destitute individuals those resides at MHI, COE, SCB Cuttack. The study was descriptive in nature. The purposive sampling method is adopted and 50 respondents were the sample for the study. The Semi-structured questionnaire is the tool adopted for the study. Results will be presented at the time of discussion.

Keywords: - Destitute, psycho-social profiles & Mental ill Status

Aggression among Recovering Addicts: The Role of Self-help Group and Employment

By

Dr. Prangya Paramita Priyadarshini Das
Assistant Professor
Department of Psychology
BJB, Autonomous College,
Bhubaneswar
prangya.ppdasresearch@gmail.com

ABSTRACT:
Self-help groups function to facilitate the recovery process of drug addicts who have chemical dependency and mental disorders. Narcotics Anonymous/Alcoholic Anonymous (Self-help groups) provide the recovering addicts a social network of individuals with similar problems and experiences, since most of these individuals may be isolated from the society due to the social stigma attached to their addiction and mental health. Employment plays an important role in the drug addiction recovery. It provides a very big clue for purpose in substance addiction recovery. Research evidence shows that the recovering addicts involved in self-help groups with employment are less aggressive as compared to the recovering addicts who are not involved in the self-help group and unemployed. The present study involves sixty recovering addicts. Thirty recovering addicts were involved in self-help groups and thirty were not involved in self-help groups. A 2X2 ANOVA was applied to know the effect of self-help group and employment status on the addicts' level of aggression. It was found that interaction effect of self-help group and employment status was significant for aggression. The significant interaction effect makes interpretation of main effect difficult. This is understandable because the social impact of different factors on the person who is in a state of addiction can be very different from that he was recovered and with a social standing through employment and with the support from self-help groups.

Key words: Self-help groups, employment, aggression, recovering addicts, substance addiction recovery.

Significance of Alexithymia in institutionalised long stay patients with Schizophrenia

Shreedata Mohanty,Manasi Panda

Mphil,Psychiatric Social Work 2nd Year Student, Department Of Psychiatric Social Work, Mhi(Coe),Scbmch,Cuttack,Odisha Email.Id-1shreedata@Gmail.Com, 8917650460

, psychiatric social worker, department of psychiatric social work, mhi(coe), scbmch, cuttack, odisha. email.id-Pandamanasi1@gmail.com.

Abstract:

Alexithymia is a term meaning "no words for mood." It has been applied to patients who have marked difficulty in verbal expression of emotions and limited ability to use fantasy. “Homelessness among mentally ill is growing significantly—it has become a major concern, Many families are no longer able or willing to take care of mentally ill relatives so they end up on the streets. Most of the institutionalised long stay patients are often diagnosed with schizophrenia which is marked by fundamental and characteristic distortions of thinking and perception and by inappropriate or blunted affect. **So t**he study focused on chronic schizophrenia patients institutionalised who are having mark difficulty in describing their emotions. Understanting Alexithymia in schizophrenic patients can help us in determining their functionality and ultimately rehabilitating them. Research investigating the alexithymia construct is advancing rapidly and has broadened considerably in recent years as a result of interdisciplinary efforts, new methodologies, and experimental techniques. The Hospital based cross-sectional study was conducted in in-patient department of M.H.I. (COE), SCBMCH, Cuttack, Odisha. The sample size 30 Consisted Patients diagnosis with Schizophrenia. The Toronto Alexithymia Scale (TAS-20) and Positive and Negative Syndrome Scale (PANSS)were administered to assess mental health status. Result will be discussed at the time presentation.

Key words: Alexithymia, Schizophrenia, Institutionalised, Long stay Patients