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

—Indira Gandhi

"शिक्षा मानव को बाध्यताओं से मुक्त करती है और आज के युग में तो यह लोकतंत्र की भावना का आधार भी है। जन्म तथा अन्य कारणों से उत्पन्न जाति एवं वर्गेश्त्र विषयाओं को दूर करते हुए मनुष्य को इन सबसे ऊपर उठाती है।"

—इंदिरा गांधी
Block

1

MENTAL HEALTH IN SPECIAL POPULATION

UNIT 1
Child and Adolescent Mental Health 5

UNIT 2
Old Age and Mental Health 26

UNIT 3
Women and Mental Health 44

UNIT 4
Marriage and Mental Health 59
Expert Committee

Prof. Vimala Veeraraghavan (Chairperson)  Prof. Ram Ghulam
Former Emeritus Professor  Head, Dept. of Psychiatry
Discipline of Psychology  M.G.M. Medical College Indore, M.P.
IGNOU, New Delhi  Superintendent - Mental Hospital Indore

Prof. T. B. Singh  Prof. Dinesh Kataria
Professor, Clinical Psychology  Dept. of Psychiatry
Institute of Behavioural Sciences  Lady Hardinge Medical College
Gujarat Forensic Sciences University  New Delhi
Gujrat

Prof. B. S. Chavan  Prof. R. C. Jiloha
Head, Dept. of Psychiatry  Head, Dept. of Psychiatry
Govt. Medical College, Chandigarh  G.B. Pant & Maulana Azad Medical College

Prof. R. K. Chadda  Prof. M. Thirunavukkarasu
Dept. of Psychiatry, AIIMS  President, Indian Psychiatric Society
Ansari Nagar, New Delhi  Head, Dept. of Psychiatry, SRM Medical College

Dr. Rajeev Dogra  Hospital & Research Center, Chennai
Clinical Psychologist  Dr. Swati Patra
Dept. of Psychiatry, PGIMS  (Programme Coordinator)
Rohtak  Associate Professor

Discipline of Psychology  Discipline of Psychology
SOSS, IGNOU, New Delhi  SOSS, IGNOU, New Delhi

Programme Coordinator  Course Coordinator

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

Course Writer

Unit 1, 3 and 4: Prof. Ram Ghulam, Professor, Department of Psychiatry, MGM Medical College, Indore.

Unit 2: Dr. Om Prakash, Associate Professor, Department of Psychiatry, IHBAS, New Delhi.

Block Editors

Unit 1: Dr. Jitendra Nagpal, Psychiatrist, Moolchand Medcity, New Delhi

Unit 2: Prof. Manju Mehta, Professor, Department of Clinical Psychology, AIIMS, New Delhi

Units 3 & 4: Dr. Swati Patra, Associate Professor, Discipline of Psychology, SOSS, IGNOU, New Delhi & Dr. Renu Addlakha, Professor, Centre for Women’s Development Studies, New Delhi

Material Production

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

April, 2015
© Indira Gandhi National Open University, 2015
ISBN-978-81-266-6871-7
All rights reserved. No part of this work may be reproduced in any form, by mimeograph or any other means, without permission in writing from the Indira Gandhi National Open University.
Further information on Indira Gandhi National Open University courses may be obtained from the University’s office at Maidan Garhi, New Delhi-110 068.

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

Printed and published on behalf of the Indira Gandhi National Open University, New Delhi by Director, School of Social Sciences.
Lasertypesetted at Graphic Printers, 204, Pankaj Tower, Mayur Vihar, Phase-I, Delhi-110091.
The Course on “Mental Health in Special Areas” is the third course in the P.G. Diploma in Mental Health (PGDMH) programme of IGNOU. This course will provide you awareness regarding the issues of mental health with regard to specific population. You will also learn about different aspects of mental health in relation to specific contexts such as school, work place etc.

As part of this course, you will have continuous evaluation through assignment and a term-end examination at the end of the year.

The course has four theory Blocks as follows:

THE BLOCKS

Block 1 is on “Mental Health in Special Population”. This Block focuses on mental health in certain specific populations such as child, adolescent, women and old age. It describes various issues related to mental health concerning these populations. After going through this Block, you will be able to understand the mental health needs and issues related to children, adolescent, women and elderly population.

Block 2 is about “Specific Issues on Mental Health”. It talks about some specific issues with regard to mental health. After studying this Block, you will learn about the issues and problems of mental health related to sex, self harm and suicide. You will also be able to understand the mental health problems in the school and work context.

Block 3 is on “Developmental Disorders”. This Block describes the various developmental disorders such as mental retardation and learning disabilities. You will learn about the meaning, nature, symptoms and clinical features of these disorders. Further, you will learn about the assessment, certification and rehabilitation with regard to these disorders. After studying this Block, you will develop an understanding of the nature, symptoms, causes, treatment and prevention of the developmental disorders.

Block 4 is on “Addictions”. This Block describes the various addictions such as alcoholism, tobacco addiction and substance addiction. You will also learn about gambling and addiction to internet. After going through this Block, you will develop an understanding of various types of addictions and the mental health issues related to it.

HOW WILL THIS COURSE HELP YOU

The course will provide you knowledge and understanding about the various mental health issues and concerns related to specific populations. It will enable you to understand the mental health needs and requirements of the children, adolescents, women and the elderly population. Awareness and understanding of the mental health problems in specific areas and specific populations will help you provide appropriate care and support to the concerned individual.
BLOCK 1  MENTAL HEALTH IN SPECIAL POPULATION

Introduction

In MPC 051 and MPC 052, you have learned about the concept of mental health, various mental disorders, and the role of family and culture in mental health. In MPC 053, we will be discussing about mental health and the mental disorders in specific populations such as children, women, and old age persons. Further, you will also learn about mental health issues in specific areas such as school and work area.

Here in Block -1 of MPC 053, we will be focusing on the Mental Health in Special Populations.

Unit 1 deals with “Child and Adolescent Mental Health”. In this Unit, you will learn about the various mental disorders of childhood and adolescence. Their symptoms, treatment and prevention aspects will also be dealt with. In this context, you will also learn about the role of family in child and adolescent mental health.

Unit 2 describes “Old Age and Mental Health”. This Unit will focus on the mental health problems in the elderly or geriatric population. The assessment and clinical features of mental disorders in the elderly will also be described. Finally, you will study about the management aspect of the mental health problems in the elderly.

Unit 3 is on “Women and Mental Health”. This Unit describes the mental health issues and concerns in women. You will learn about the factors affecting the mental health of women and methods to promote and improve women’s mental health.

Unit 4 deals with “Marriage and Mental Health”. The concept of marriage is discussed and the effect of marriage on mental health is deliberated upon here. You will further study about the issues in marital relationship affecting the mental health in this Unit. The mental disorders in relation to marriage and legislation are also described.
UNIT 1 CHILD AND ADOLESCENT MENTAL HEALTH

Structure

1.1 Introduction
1.2 Objectives
1.3 Child Development
   1.3.1 Theories of Child Development
   1.3.2 Milestones of Normal Development
1.4 Principles of Child and Adolescent Diagnostic Assessment
1.5 Mental Disorders of Childhood and Adolescence
   1.5.1 Mental Retardation
   1.5.2 Pervasive Developmental Disorders (PDDs)
   1.5.3 Learning Disorders, Motor Skills Disorder, and Communication Disorders
   1.5.4 Attention Deficit Hyperactivity Disorder
   1.5.5 Conduct Disorder
   1.5.6 Oppositional Defiant Disorder
   1.5.7 Feeding and Eating Disorders of Infancy or Early Childhood
   1.5.8 Tic Disorders
   1.5.9 Elimination Disorders
   1.5.10 Other Disorders
1.6 Role of Family in Child and Adolescent Mental Health
1.7 Let Us Sum Up
1.8 Answers to Self Assessment Questions
1.9 Unit End Questions
1.10 Glossary
1.11 References
1.12 Suggested Readings

1.1 INTRODUCTION

It is in this century that child and adolescent mental health has received significant attention by mental health professionals and its importance for later adulthood development is being recognized. The Human Rights movement, psychoanalytic concepts and various theories of personality have all made a significant contribution to the issues of child and adolescent mental health. In most societies, children and adolescents are considered incomplete, dependent, not very competent and a liability on society. However, more modern view is that children and adolescent are individuals in their own right. Just like adults they have common needs of food, health, shelter and security. In addition they have some special needs e.g., opportunities to grow and develop, care and protection, vocational training and recreational. Children and adolescent are dependent on adults for these needs, so it is not only the responsibility of the parents but also of the society to provide for these needs. The role of society becomes all the more critical.
when we acknowledge that child population is not homogeneous. Large numbers of children have no home, school and family. Children could be living in orphanages, destitute homes, beggars’ homes, juvenile homes, rescue homes and remand homes. They could also be living on the streets. All these groups of marginalized children and adolescents would have psycho-social needs that have to be addressed if they are to be productive adults of the society in the future.

Thus there are significant challenges to the mental health development of children and adolescent that need careful evaluation and intervention by mental health professionals so that young people can achieve their full potential. This Unit will help you learn various mental health disorders in children and adolescents and their management.

1.2 OBJECTIVES

After studying this unit you will be able to:

- discuss the importance of mental health development in children and adolescents;
- describe the normal development of children and adolescents;
- describe various types of mental health disorders in children and adolescents;
- explain the etiology of mental disorders in children and adolescents; and
- list out principles of management of mental disorders in children and adolescents.

1.3 CHILD DEVELOPMENT

It is very important to understand normal physical and mental development before going on to mental health issues. Development results from the interplay of maturation of the central nervous system (CNS), neuromuscular apparatus, endocrine system, and environmental influences e.g., parents and teachers, who can either facilitate or thwart the child’s attainment of his or her developmental potential. This potential is specific to each person’s given genetic predispositions to (a) intellectual level and (2) mental disorder temperament and probably, certain personality traits.

Development of brain is continuous and lifelong process but most rapid growth is seen in early life. At the time of birth, brain weighs 350 grams. At 7 years of age, it is close to 90% of the adult 1,350 grams. Cytogenetic changes such as neuronal differentiation, axonal growth, synapse formation and myelination begin during embryonic stage. Further development of brain continues and synaptic communication between neurons leads to the establishment of functional neural circuits that mediate sensory and motor processing. Most of the development of the human brain happens within the first 20 years of life.

1.3.1 Theories of Child Development

Historically, most cited theorists in child development have been Sigmund Freud, Margaret Mahler, Erik Erikson and Jean Piaget. These theories still have relevance in today’s date. You have gone through some of these theories in MPC 051.

i) Sigmund Freud. Sigmund Freud is the first to discover and submit to theoretical frameworks the importance of early childhood in the development of personality and psychopathology. His data however came from the psychoanalyses of late adolescent or adult patients. He did not systematically observe or treat normal or abnormal children. Those who have done so have added to and revised his concept. Today this theory accounts for some but certainly not all of psychopathology.
ii) **Margaret Mahler.** Mahler observed children and their mothers and evolved a theory of separation-individuation. With the exception of her theory of phases during the first months of life which emphasizes that infants lack alertness and responsiveness, her theory is widely accepted today.

iii) **Erik Erikson.** Erikson has extended development throughout life and at each stage there is a conflict and resolution e.g., basic trust versus mistrust in the first stage. His work emphasizes the individual’s adaptation to society.

iv) **Jean Piaget.** A genetic epistemologist, Piaget studied the behaviors from birth, of his three children and evolved a comprehensive, respected theory of cognitive development. His work reveals infant as an active problem solver.

### 1.3.2 Milestones of Normal Development

Normal motor and sensory, adaptive behavior and personal and social development milestones are described in Table-1.

<table>
<thead>
<tr>
<th>Age</th>
<th>Motor and sensory behavior</th>
<th>Adaptive behavior</th>
<th>Personal and social behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 4 weeks</td>
<td>Hand to mouth reflex, grasping reflex, rooting reflex (puckering lips in response to per oral stimulation), motor reflex (digital extension when startled), sucking reflex, Babinski reflex (toes spread when sole of foot is touched)</td>
<td>Anticipatory feeding – approach behavior at 4 days. Responds to sound of rattle and bell. Regards moving objects momentarily.</td>
<td>Responsiveness to mother’s face, eyes and voice within first few hours of life. Endogenous smile. Independent play (until 2 years). Becomes quiet when picked up. Impassive face.</td>
</tr>
<tr>
<td>4 weeks</td>
<td>Tonic neck reflex positions, predominate hands fisted. Head sags but can hold head erect for a few seconds. Visual fixation. Stereoscopic vision (12 weeks)</td>
<td>Follows moving objects to the midline. Shows no interest and drops objects immediately.</td>
<td>Regards face and diminishes activity. Responds to speech. Smiles preferentially to mother.</td>
</tr>
<tr>
<td>16 weeks</td>
<td>Symmetrical postures predominate holds head balanced. Head lifted 90 degrees when prone of forearm. Visual accommodation</td>
<td>Follows a slowly moving object well. Arms activate on sight of dangling object.</td>
<td>Spontaneous social smile. Aware of strange situations</td>
</tr>
<tr>
<td>Age Group</td>
<td>Milestones</td>
<td>Social/Emotional Development</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>40 weeks</td>
<td>Sits alone with good coordination. Creeps. Pulls self to standing position. Points with index finger.</td>
<td>Matches to objects of middling Attempts to imitate scribble Separation anxiety manifests when taken away from mother. Responds to social play, such as pat a cake and peek-bo. Feeds self biscuit and holds own bottle.</td>
<td></td>
</tr>
<tr>
<td>52 weeks</td>
<td>Walks with one hand held. Stands alone briefly.</td>
<td>Seeks novelty Coopers in dressing.</td>
<td></td>
</tr>
<tr>
<td>15 months</td>
<td>Toddlers Creeps upstairs</td>
<td>Points or vocalizes wants. Throws objects in play or refusal.</td>
<td></td>
</tr>
<tr>
<td>18 months</td>
<td>Coordinated walking. Seldom falls. Walks up stairs with one hand held.</td>
<td>Build a tower of three or four cubes. Scribbles spontaneously and imitates a sitting stroke Feeds self in part, spills. Pulls toy on string. Carries or hugs a special toy, such as a doll. Imitates some behavioral patterns with slight delay.</td>
<td></td>
</tr>
<tr>
<td>2 years</td>
<td>Runs well no falling Kicks large ball Goes up and down stairs alone Fine motor skills increase</td>
<td>Builds a tower of six seven cubes. Aligns cubes imitating train. Imitates vertical and circular strokes Develops original behaviors Pulls on simple garment. Domestic mimicry Refers of self by name Says “no” to mother. Separation anxiety begins to diminish. Organized demonstration of love and protest. Parallel play (Plays side by side but does not interact with other children)</td>
<td></td>
</tr>
<tr>
<td>3 years</td>
<td>Rides tricycle Jumps from bottom steps Alternates feet going up stairs</td>
<td>Builds tower of 9 or 10 cubes. Imitates a three cube bridge Copies a circle and a cross Puts on shoes Unbuttons buttons Feeds self well Understands taking turns</td>
<td></td>
</tr>
<tr>
<td>4 years</td>
<td>Walks down stairs one step to a stead Stands on one foot for five to eight seconds</td>
<td>Copies a cross Repeats four digits Counts three objects with correct pointing Washes and dries own face Brushes teeth Associative or joint play</td>
<td></td>
</tr>
<tr>
<td>5 years</td>
<td>Skips using feet alternately. Usually has complete sphincter control. Fine coordination improves</td>
<td>Copies a square Draws a recognizable man with a head Dresses and undresses self Prints a few letters. Plays competitive exercise games</td>
<td></td>
</tr>
<tr>
<td>6 years</td>
<td>Rides two wheel bicycle</td>
<td>Prints name Copies triangle Ties shoelaces</td>
<td></td>
</tr>
</tbody>
</table>
1.4 PRINCIPLES OF CHILD AND ADOLESCENT DIAGNOSTIC ASSESSMENT

While assessing children and adolescents for mental health problems, it is necessary to keep certain things in mind. Parents and the family are a major influence on the child and adolescents. Many a times, mental health problems are a result of the faulty communication patterns, ineffective interpersonal interactions, and inefficient discipline system in the family. Hence it is important to assess the family system as a whole and get information from family members, parents, guardians, siblings etc. Family history of any mental health problems/disorders also need to be known given the genetic predispositions and environmental influences of many disorders. Assessment also takes into account the normal pattern of child development and deviations from this. Further, in addition to family system, school and the peer group play a significant role in the child’s development. Hence, assessment should also include information from the school, teachers and the peer group.

Self Assessment Questions 1

1) Mention any two theories of child and adolescent development.

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

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

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

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

2) Describe the motor and sensory milestones in two years old children.

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

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

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

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

3) Give an account of milestones of personal and social behavior development in 5-6 years old children.

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

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

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

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

1.5 MENTAL DISORDERS OF CHILDHOOD AND ADOLESCENT

Some of the commonly occurring mental disorders seen in children and adolescents are described below.

1.5.1 Mental Retardation (MR)

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

Person with intellectual disability has limitations in two core areas. These areas are:

- Intellectual functioning. This refers to a person’s ability to learn, reason, make decisions, and solve problems. This is commonly measured as IQ (Intelligence Quotient). The average IQ is in the range of 90-110. A person is considered intellectually disabled if he or she has an IQ of less than 70.

- Adaptive behaviors. These are skills necessary for day-to-day life, such as being able to communicate effectively, interact with others, and take care of oneself. To measure a child’s adaptive behaviors, a specialist will observe the child’s skills and compare them to other children of the same age. Things that may be observed include how well the child can feed or dress himself/herself; how well the child is able to communicate with and understand others; and how the child interacts with family, friends, and other children of the same age.

Intellectual disability is thought to affect about 1% of the population. Of those affected, 85% have mild intellectual disability. This means they are just a little slower than average to learn new information or skills. With the right support, most will be able to live independently as adults.

**Signs and Symptoms**

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

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

In children with severe or profound intellectual disability, there may be other health problems as well. These problems may include seizures, mental disorders, motor handicaps, vision problems, or hearing problems.

**Types of Mental Retardation**

According to ICD 10 classification, mental retardation is of four types depending on Intelligence Quotient (IQ):

i) Mild MR (IQ=50-70)
ii) Moderate MR (IQ=35-50)
iii) Severe MR (IQ=21-35)
iv) Profound MR (IQ=< 20)
Causes for mental retardation are known in only 50-70% of cases and they could be biological or psychosocial causes.

The most common causes of intellectual disability are:

- Genetic conditions. These include Down’s Syndrome and Fragile X Syndrome.
- Problems during pregnancy. Alcohol or drug use, malnutrition, certain infections, or preeclampsia can interfere with fetal brain development and cause mental retardation.
- Problems during childbirth. Intellectual disability may result if a baby is deprived of oxygen during childbirth or born extremely premature.
- Illness or injury. Infections like meningitis, whooping cough, or measles can lead to intellectual disability. Severe head injury, near-drowning, extreme malnutrition, exposure to toxic substances such as lead; and severe neglect or abuse can also cause it.

Management

The primary goal of treatment is to develop the person’s potential to the fullest. Special education and training may begin as early as infancy. This includes social skills development to help the person function as normally as possible. Treatment modalities include,

i) Educational- special schools or classes, remediation tutoring, computer assisted instructions

ii) Pharmacological- Medication may be given for concomitant mental disorder such as attention deficit/ hyperactivity disorder (ADHD) or depression, agitation, aggression and tantrums.

iii) Behavior therapy, e.g. Applied Behavior Analysis based on learning theories, contingency management techniques

iv) Parental and family counseling

v) Individual supportive psychotherapy- Mildly impaired persons with good verbal skills may profit from individual supportive psychotherapy. Activity groups also help to improve socialization.

Prevention

Preventive approaches are as following:

**Genetic**: Prenatal screening for genetic defects and genetic counseling for families at risk for known inherited disorders can decrease the risk of inherited intellectual disability.

**Social**: Government nutrition programmes are available to poor children in the first and most critical years of life. These programmes can reduce disability associated with malnutrition. Early intervention in situations involving abuse and poverty will also help.

**Toxins**: Environmental programmes to reduce exposure to lead, mercury, and other toxins will reduce toxin-associated disability. However, the benefits may take years to become apparent. Increased public awareness of the risks of alcohol and drugs during pregnancy can help reduce the incidence of disability.

**Infections**: The prevention of congenital rubella syndrome is probably one of the best...
examples of a successful programme to prevent one form of intellectual disability. Constant vigilance, such as limiting exposure to cat litter that can cause toxoplasmosis during pregnancy, helps reduce disability that results from this infection.

You will learn about mental retardation in more detail in Unit 1 of Block 3 of this Course (MPC 053).

1.5.2 Pervasive Developmental Disorders (PDDs)

Pervasive developmental disorders are characterized by impairment in social interaction, communication difficulties, and restricted and repetitive behaviors. PDDs include autistic disorder, as well as heterogeneous group of conditions that have similar features to autistic disorder. These are, Autistic disorder, Asperger’s syndrome, Rett’s disorder, Childhood disintegrative disorder, and Pervasive developmental disorder not otherwise specified.

i) Autistic disorder

This is commonest amongst pervasive developmental disorders. Autistic disorder affects 4 in 10,000 persons and male to female ratio is 3:1.

Signs and symptoms

Children with autism have difficulties relating to and communicating with other people.

When they’re babies, they do not look at others a lot. By two years of age, they often won’t respond to their name or smile at others. They might not change their pitch when they’re babbling so it won’t sound like a conversation. They do not imitate others with behavior like clapping or waving.

Children with autism will often repeat a particular behavior over and over, or become fixated on an object. For example, they might repeatedly turn lights on and off, or focus on the wheels of a toy car, rather than playing with the whole car and engaging in pretend play.

Many children with autism also have unusual sensory issues, although this isn’t required for a diagnosis. They might:

- be especially sensitive to sound, which is why they raise their hands to their ears to block out noise
- like the feel of objects, and smell and sniff at everything around them
- want to eat only foods with a certain texture – for example, they’ll be happy to eat soft, smooth food, but will refuse anything lumpy
- Use their peripheral vision a lot, or tilt their heads to look at objects from a particular angle.

Autistic disorder is an organic disorder, concordance in monozygotic (MZ) twins is higher than in dizygotic (DZ) twins. Associated genetic disorders include tuberous sclerosis and fragile X syndrome.

ii) Asperger’s disorder: It is characterized by autistic like disorder without significant delay in language or cognitive development. It may affect a subgroup of highly functioning autistic children. It’s etiology is unknown but studies suggest a relation to autistic disorder.
iii) **Rett’s disorder**: It is neurodegenerative disorder. It has strong genetic basis since it is only seen in girls. Studies indicate complete concordance in MZ twins.

iv) **Childhood disintegrative disorder (Heller’s syndrome)**: Childhood disintegrative disorder (Heller’s syndrome) is distinguished by at least two years of normal development before deterioration to the clinical picture of autistic disorder. Etiology is unknown but this disorder is associated with other neurological conditions, e.g., seizure disorder, tuberous sclerosis, metabolic disorders.

For management of PDDs early intensive special educational intervention is most beneficial. Thus early diagnosis is important. Family support and counseling is crucial; parents should be told that autistic disorder does not result from faulty upbringing. Parents often require strategies for dealing with the child and siblings. Associations and self-help groups exist for parents of children with autistic disorder.

### 1.5.3 Learning Disorder, Motor Skills Disorder and Communication Disorders

Learning disorders (reading disorder, mathematics disorder, disorder of written expression) and learning disorders not otherwise specified; Motor skills disorder (developmental coordination disorder); and Communication disorders (expressive language disorder, mixed receptive-expressive language disorder, phonological disorder, stuttering) share many characteristics and comorbidity. The prevalence of learning and motor skills disorders in general is about 5% and specifically ranges from 1% (for stuttering) to 3% for the other communication disorders.

#### Signs and symptoms

Children with learning disorders have average intellectual functioning and yet they show inability to read, write, spell, do mathematics at the class level despite adequate instruction, repetition and conducive academic environment. On evaluation using standardized test of academic achievement they show errors of omission, reversals, substitution, problems of phonic coding and decoding, visuo-spatial errors etc.

Generally learning, developmental coordination and communication disorders often coexist with one another and with attention deficit and disruptive behavior disorders.

#### Treatment

Low self esteem, school failure and dropping out are common with the disorders. Treatment for the disorders is usually provided in school and involves a multidisciplinary approach involving teachers, school psychologists, special educators and parents. Resource rooms, special class placement, and individualized educational programme (IEP) may be necessary. Speech therapy is often required with communication disorders. Psycho education is crucial and counseling can be very helpful for the individual as well as the family.

### 1.5.4 Attention Deficit Hyperactivity Disorder

Attention-deficit hyperactivity disorder (ADHD) prevalence is probably 3-5%; the male to female ratio is 3-5:1.

#### Signs and symptoms

Inattention, hyperactivity (restlessness in adults), disruptive behavior, and impulsivity are common in ADHD. Academic difficulties are frequent as are problems with
relationships. The symptoms can be difficult to define as it is hard to draw a line at where normal levels of inattention, hyperactivity, and impulsivity end and significant levels requiring interventions begin. To be diagnosed, symptoms must be observed in two different settings for six months or more and to a degree that is greater than other children of the same age.

Based on the presenting symptom, ADHD can be divided into three subtypes—predominantly inattentive, predominantly hyperactive-impulsive, or combined type if criteria for both the other types are met.

An individual with inattention may have some or all of the following symptoms:

- Be easily distracted, miss details, forget things, and frequently switch from one activity to another
- Have difficulty maintaining focus on one task
- Become bored with a task after only a few minutes, unless doing something enjoyable
- Have difficulty focusing attention on organizing and completing a task or learning something new
- Have trouble completing or turning in homework assignments, often losing things (e.g., pencils, toys, assignments) needed to complete tasks or activities
- Does not seem to listen when spoken to
- Daydream, become easily confused, and move slowly
- Have difficulty processing information as quickly and accurately as others
- Struggle to follow instructions

An individual with hyperactivity may have some or all of the following symptoms:

- Fidget and squirm in their seats
- Talk nonstop
- Dash around, touching or playing with anything and everything in sight
- Have trouble sitting still during dinner, school, doing homework, and story time
- Be constantly in motion
- Have difficulty doing quiet tasks or activities

An individual with impulsivity may have some or all of the following symptom:

- Is very impatient
- Blurt out inappropriate comments, show their emotions without restraint, and act without regard for consequences
- Have difficulty waiting for things they want or waiting their turn in games
- Often interrupts conversations or others’ activities

ADHD, particularly the predominantly hyperactive-impulsive type often coexists with conduct disorders or oppositional defiant disorder. ADHD also coexists with learning and communication disorder.
ADHD is thought to reflect subtle, yet unclear, neurological impairments. It is associated with prenatal trauma and early malnutrition. The incidence is increased in male relatives and concordance is greater in MZ than in DZ twins. ADHD children are often temperamentally difficult. In neurotransmitter systems, the clearest evidence is of noradrenergic dysfunction and soft neurological signs are common. Cerebral blood flow (CBF) studies show frontal hypoperfusion; thus frontal lobe dysfunction is suspected allowing for disinhibition. ADHD is probably not related to sugar intake; few patients (perhaps 5%) are affected by food additives. 20-25% of persons with ADHD continue to show symptoms into adolescence. Some into adulthood, especially those with concomitant conduct disorder, become delinquent or later develop antisocial personality disorder.

Management

Management of ADHD requires both medication and behavioral treatments. Drugs reduce disruptive behavior and improve ability to concentrate. Psychological treatment involves school intervention in terms of classroom management, peer tutoring, and parent training. Thus a multimodality treatment including medication, individual psychotherapy, family therapy and special education is necessary for child and family; and even be crucial in moderate to severe cases, given the risk of delinquency.

Self Assessment Questions 2

1) List the types of mental retardation based on IQ.

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

2) What are the signs and symptoms of autistic disorder.

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

3) Describe the treatment of learning disorders.

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

4) Mention the signs of an individual with impulsivity.

..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................
1.5.5 Conduct Disorder

Conduct disorder is diagnosed in childhood or adolescence that presents itself through a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate norms are violated. Conduct disorder denotes a frequency and severity of acts that go beyond normal childhood mischiefs; and is marked by lack of remorse and callousness. These behaviors are often referred to as antisocial behaviors. Indeed, the disorder is often seen as the precursor to antisocial personality disorder. Prevalence ranges from 5-15%.

Signs and symptoms

The DSM-IV-TR definition of conduct disorder focuses on behaviors that violate the basic rights of others and major societal norms. It is diagnosed based on a prolonged pattern of antisocial behavior such as serious violation of laws and social norms and rules. There are no proposed revisions for the main criteria of conduct disorder in the DSM V; there is a recommendation by the work group to add an additional specifier for callous and unemotional traits. Almost all adolescents who have a substance use disorder have conduct disorder-like traits, but after successful treatment of the substance use disorder, about half of these adolescents no longer display conduct disorder-like symptoms. Therefore it is important to exclude a substance induced cause and instead address the substance use disorder prior to making a psychiatric diagnosis of conduct disorder.

Conduct disorder is associated with family instability, including victimization by physical or sexual abuse, family violence (propensity for violence correlates with child abuse), alcoholism and signs of severe psychopathology, e.g. paranoia and cognitive or subtle neurological deficits. It is crucial to explore for these signs that can guide treatment. Conduct disorder often coexists with ADHD and learning or communication disorders. Suicidal thoughts and acts and alcohol and drug abuse correlate with conduct disorder.

Some children with conduct disorder have low plasma dopamine hydroxylase levels. Abnormal serotonin levels have also been implicated.

Management

Multimodality treatment of conduct disorder include individual or family therapy, tutoring or special class placement (for cognitive or conduct problems). Teaching cognitive behavioral and moral reasoning skills is helpful. It is crucial to discover and fortify interests or talents to build resistance to the lure of crime if environment is noxious. If conduct disorder is severe, placement away from home may be indicated.

1.5.6 Oppositional Defiant Disorder (ODD)

ODD is diagnosed if a child does not meet the criteria for conduct disorder, but exhibits behavior such as losing temper, arguing with adults, repeated non-compliance of authority, being angry, spiteful, or vindictive. Oppositional defiant disorder can coexist with many disorders, including ADHD and anxiety disorders. It appears to result from parent-child struggles over autonomy, therefore occurrence increases in families with overly rigid parents and temperamentally active, moody and intense children.

Psychological interventions - individual or family therapy is the intervention of choice. Behavior modification can be helpful.
1.5.7 Feeding and Eating Disorders of Infancy or Early Childhood

i) **Pica**: It refers to repeated ingestion of a nonnutritive substance, inappropriate to developmental level for at least 1 month in infants who do not meet criteria for autistic disorder, schizophrenia, or Kleine-Levin syndrome. Prevalence is unclear; studies report 10-32% is associated with MR, neglect and nutritional deficiency e.g. iron or zinc. Lead or other poisonings can lead to pica. It usually stops in early childhood. Treatment involves testing for lead intoxication and treating if necessary. Since cravings for dirt and ice may relate to iron and zinc deficiencies, such deficiencies should be ruled out. Parent guidance may be necessary. Infrequently, aversive conditioning may also be necessary.

ii) **Rumination disorder**: It refers to repeated regurgitation for at least 1 month following a period of normal eating (in the absence of gastrointestinal dysfunction). Food is brought back into the mouth, ejected or rechewed and swallowed. There is no distress. The condition is rare with onset between 3 and 12 months of age. Little is known of outcome but it ranges from spontaneous remissions to malnutrition, to failure to thrive, to death. Gastrointestinal problems must be ruled out. Treatment involves parental guidance and behavioral techniques, which may include aversive behavior therapy when the disorder is severe.

iii) **Feeding and eating disorder of infancy or early childhood**: It refers to the disorder where children persistently eat inadequately for at least 1 month in the absence of a general medical condition or another causal mental condition that results in failure to gain weight and the loss of significant weight. Onset is before 6 years of age. Because many children with the disorder are temperamentally difficult or developmentally delayed or the caregivers lack patience or are neglectful, counseling of the caregivers is often crucial.

1.5.8 Tic Disorders

Tic disorders onset in childhood (before the age of 18), and are not due to the effects of medication or other medical condition. As many as 1 in 100 people may experience some form of tic disorder, usually before the onset of puberty.

Various types of tic disorders are as follows:

i) **Tourette’s disorder** (Gilles de la tourette’s syndrome)

Tourette syndrome is the more severe expression of a spectrum of tic disorders. There is evidence of genetic transmission with significantly greater concordance in MZ twins than in DZ twins. Prevalence is about 4-5 per 10,000; mean age of onset is 7 years of age; and the male-to-female ratio is 3:1.

**Signs and symptoms**

Tics are movements or sounds “that occur intermittently and unpredictably out of a background of normal motor activity”, having the appearance of “normal behaviors gone wrong”. The tics associated with Tourette’s change in number, frequency, severity and anatomical location. Waxing and waning—the ongoing increase and decrease in severity and frequency of tics—occur differently in each individual. Tics also occur in bouts, which vary for each person.

**Coprolalia** (the spontaneous utterance of socially objectionable or taboo words or phrases) is the most publicized symptom of Tourette’s, but it is not required for a diagnosis
of Tourette’s and only about 10% of Tourette’s patients exhibit it. **Echolalia** (repeating the words of others) and **palilalia** (repeating one’s own words) occur in a minority of cases, while the most common initial motor and vocal tics are, respectively, eye blinking and throat clearing.

In contrast to the abnormal movements of other movement disorders (for example, choreas, dystonias, myoclonus, and dyskinesias), the tics of Tourette’s are temporarily suppressible, nonrhythmic, and often preceded by an unwanted premonitory urge. Immediately preceding tic onset, most individuals with Tourette’s are aware of an urge, similar to the need to sneeze or scratch an itch. Individuals describe the need to tic as a buildup of tension, pressure, or energy which they consciously choose to release, as if they “had to do it” to relieve the sensation or until it feels “just right”. Examples of the premonitory urge are the feeling of having something in one’s throat, or a localized discomfort in the shoulders, leading to the need to clear one’s throat or shrug the shoulders.

The actual tic may be felt as relieving this tension or sensation, similar to scratching an itch. Another example is blinking to relieve an uncomfortable sensation in the eye. These urges and sensations, preceding the expression of the movement or vocalization as a tic, are referred to as “premonitory sensory phenomena” or premonitory urges. Because of the urges that precede them, tics may be experienced as a voluntary, suppressible response to the unwanted premonitory urge. Published descriptions of the tics of Tourette’s identify sensory phenomena as the core symptom of the syndrome, even though they are not included in the diagnostic criteria.

### ii) Chronic motor or vocal tic disorder

It is similar to Tourette disorder. Diagnostic criteria are the same except that there are either single or multiple motor tics or vocal tics, not both. The prevalence is much greater than that of Tourette’s disorder but its severity and social impairment generally are less. Chronic motor or vocal tic disorder and Tourettes disorder frequently occur in the same families. The neurobiology appears to be the same and the treatment is identical to that of tourettes disorder.

### iii) Transient tic disorder

Prevalence is unclear; nonrigorous surveys report that 2-24% of school children have some sort of tic. The male to female ratio is 3:1

**Signs and symptoms**

Transient tic disorders are characterized by:

- Single or multiple motor and/or vocal tics
- the tics occur many times a day
- the onset before 18 years
- the disturbance is not due to direct physiological effect of a substance (drug)

In most cases the tics are psychogenic, increasing during periods of stress and tending to remit spontaneously.

In mild cases treatment may not be needed; however, in severe cases behavioral techniques or psychotherapy is indicated. Medication used for other tic disorder is tried only in severe cases.
1.5.9 Elimination Disorders

Elimination disorders are disorders that concern the elimination of feces or urine from the body. There are two main types of elimination disorders that affect children and occasionally adults.

i) Encopresis - The voluntary or involuntary passage of stool in a child who has been toilet trained, typically over 4 years old. Prevalence is about 1% of 5 year old children. Encopresis is more common in boys than in girls.

Signs and symptoms

The DSM-IV recognizes two subtypes with constipation and overflow incontinence, and without constipation and overflow incontinence. In the subtype with constipation, the feces are usually poorly formed and leakage is continuous, and occurs both during sleep and waking hours.

In the type without constipation, the feces are usually well-formed, soiling is intermittent, and feces are usually deposited in a prominent location. This form may be associated with oppositional defiant disorder or conduct disorder, or may be the consequence of large anal insertions, or more likely due to chronic encopresis that has radically desensitized the colon and anus.

The chance of any physical disorder needs to be ruled out first. Inadequate toilet training can result in child parent power struggles and functional encopresis. Some children may have fear using the toilet. Those with constipation and overflow incontinence can get impacted, have pain on defecating and develop anal fissures. Those with constipation and overflow often have oppositional defiant or conduct disorders. Encopresis often has precipitants e.g. birth of a sibling or parental separation. Encopresis usually brings embarrassment and social ostracism. When encopresis is deliberate, associated psychopathology is usually severe. About 25% of patients also have enuresis. Encopresis can last for years but usually resolves.

Treatment: The child may require individual psychotherapy to address the meaning of the encopresis as well as any embarrassment or ostracism. Behavioral techniques often are helpful. Parental guidance and family therapy often is needed. Conditions such as impaction and anal fissures require consultation with a pediatrician.

ii) Enuresis (bedwetting) - Involuntary urination in children over the age of 5 years old, and is not due to a general medical condition. Prevalence during age 5 years is, 7% of boys and 3% girls; whereas during age 18 years, it is 1% of boys, and rare in girls. The diurnal subtype is the least prevalent and is more common in girls than in boys.

Signs and symptoms

According to DSM IV enuresis is characterized by:

a) Repeated voiding of urine into bed or clothes (whether involuntary or intentional).

b) The behavior is clinically significant as manifested by either a frequency of twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

c) Chronological age is at least 5 years (or equivalent developmental level).

d) The behavior is not due exclusively to the direct physiological effect of a substance
Mental Health in Special Population

(e.g., a diuretic) or a general medical condition (e.g., diabetes, spina bifida, a seizure disorder).

e) Enuresis can be of three types: Nocturnal only; Diurnal only; and Nocturnal and Diurnal both.

In some patients bladders tend to be small requiring frequent voiding. It does not seem to be related to a specific stage of sleep as do sleepwalking or sleep terror disorders. Many patients have no coexisting mental disorder and impairment reflects only the conflict with caregivers, loss of self esteem and social ostracism. Enuresis is likely to coexist with other disorders and can be precipitated by such events as sibling birth or parental separation. Spontaneous remissions are frequent at ages 6-8 and puberty.

Management

i) Pharmacological: Medication is used, but is effective along with psychological interventions.

ii) Behavioral approaches: Record dry nights on a calendar and reward dry nights with a star and 5-7 consecutive dry nights with a gift. A bell and pad apparatus is a successful treatment but is cumbersome.

iii) Psychotherapy: It is not recommended unless psychopathology or other problems coexist, such as reduced self esteem. The parental guidance related to the management of the disorder is often necessary.

1.5.10 Other Disorders

i) Anxiety Disorders

Anxiety disorders in children and adolescents include generalized anxiety disorder, separation anxiety disorder, school phobia, social phobia, obsessive compulsive disorder, posttraumatic stress disorder and panic disorders. The disorders may result from physical or sexual abuse.

Separation anxiety disorder is characterized by children worrying constantly that some harm will befall their parents or themselves when they are away from their parents. It is often a main cause of school phobia. Though genetic transmission is not clear, affected children have been found to have parents with a history of that disorder as well as current panic disorder, agoraphobia or depression. There may be overly strong attachment bond and insecure mother–infant security system.

Management of anxiety disorders involves multimodal treatment including individual psychotherapy, family therapy, parental guidance and counseling, and behavior modification.

ii) Selective Mutism

It is a rare disorder and more common in girls. Diagnostically, it refers to a child who both seeks and comprehends, refuses to talk for at least 1 month (but this period is not limited to the first month of school) in social situation. It begins between age 4 and 8, and usually resolves in weeks to months. It is associated with parental overprotection, parental ambivalence, communication disorders, shyness and oppositional behavior. Treatment can include individual psychotherapy and parents counseling. Serotonin specific reuptake inhibitors (SSRIs) may also be helpful.
iii) Reactive Attachment Disorder of Infancy or Early Childhood

Diagnostically, grossly inadequate caretaking (persistent disregard of physical or emotional needs or repeated change of caretaker) results in markedly disturbed social relatedness in a child who is younger than 5 years. Physically, head circumference is generally normal, weight very low, height somewhat short, and pituitary functioning is normal. There may also be presence of low socioeconomic status and mothers who are depressed, isolated and have experienced abuse. The disturbance is not due to MR or autistic disorder. The earlier the intervention, the more reversible the disorder.

It is of two types:

a) Inhibited type - characterized by failure to initiate or respond to interactions accompanied by apathy, passivity and lack of visual tracking.

b) Disinhibited type - characterized by indiscriminate and shallow sociability.

iv) Stereotypic Movement Disorder

Diagnostically there are repetitive seemingly nonfunctional behaviors for at least 4 weeks e.g. hand shaking, rocking, head banging, nail biting, nose picking, hair pulling that markedly interfere with normal activities or cause physical injury. The disorder is common in MR. It is not diagnosed for behaviors associated with obsessive compulsive disorder, PDDs or trichotillomania. Increased dopamine activity seems to increase stereotypic movements. Pervasive developmental disorder or tic disorder must be absent. Treatment varies if movements increase with frustration, boredom or tension.

v) Childhood Schizophrenia and Depression

Several studies confirm that some children have delusions or hallucinations (auditory or visual). Nevertheless, few children or young adolescents are schizophrenic, and delusions, hallucinations and thought disorder are difficult to diagnose in children. Some children diagnosed as schizophrenic are diagnosed with mood disorder when followed to adolescence. Childhood depression includes behaviors such as withdrawal, crying, avoidance of eye contact, physical complaints, poor appetite, and even aggressive behavior and in some cases, suicide.

Treatment includes antipsychotic medications (although research is limited in this regard), psychotherapy and family therapy. An important aspect of psychological treatment with children is providing a supportive emotional environment that will facilitate effective emotional expression and learning adaptive coping strategies.

**Suicide**: Suicidal behavior is increasing in adolescents and children. Although serious attempts and completed suicides are rare in children younger than 13 years, suicidal ideation, threats and less serious gestures are much more frequent and often a precipitant to hospitalization. It correlates with depression, aggressive behavior and alcohol abuse. Girls have more suicidal ideation and make more suicidal gestures or attempts. Serious attempts and successful suicides correlate with being male and the availability of alcohol, illicit drugs or medications which lower impulse control and can be used to overdose. Angry and impulsive children as well as children suffering from recent emotional trauma may also be suicidal.

vi) Others

Substance related, gender identity, eating, somatoform, sleep and adjustment disorders can also be diagnosed during childhood and adolescence.
1.6 ROLE OF FAMILY IN CHILD AND ADOLESCENT MENTAL HEALTH

Family has a strong influence on the mental health of children and adolescents. Family dynamics plays a vital role in their mental health and illness. Child rearing practices can retard or accelerate development of child mental health. Psychologically and physically broken homes fail to provide a proper and conducive atmosphere for the growth and development of the child. It lacks the warmth, love, care and affection that fosters the self esteem of the child and makes him/her a good human being. Schizophrenogenic parents and refrigerator parents who are cold and apathetic, produce autistic and psychotic child behavior.

Child abuse and neglect is of serious concern which may lead to negative behaviors and disorders in the children. Abusing parents have often been abused themselves in their childhood. They are also antisocial; and suffer from depression and substance abuse. Child sexual abuse has been on the rise which seriously hampers the mental health of our children. Cases of AIDS has also presented the mental health professionals with a multitude of difficult problems, for example, the care of young patients from lower socioeconomic groups. Already grossly inadequate because of insufficient resources, they are further burdened by HIV related illness or the death of parents and relatives.

Family is the first and the most important source of nurturance which plays a crucial role in the physical as well as mental health of our children and adolescents. Awareness and sensitization through guidance and counseling programmes will go a long way to create an enabling family atmosphere for enhancing the mental health of our future generation.

Self Assessment Questions 3

1) Describe the management of conduct disorder.

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

2) What is rumination disorder?

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

3) What do you mean by Tics?

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

4) Differentiate between enuresis and encopresis.

.....................................................................................................................
1.7 LET US SUM UP

The area of child and adolescent mental health has been neglected in the past and is only in the recent years that it has drawn attention of mental health professionals. The prevalence of child and adolescent mental disorders is high and estimated prevalence rate in our country ranges from 8.2-17.2 percent. Most common disorder in this population is mental retardation, followed by special symptoms like enuresis and speech disorder. It is estimated that ten per cent of the child population is in need of special care and treatment. Only one percent gets some care and treatment.

Early diagnosis of various mental disorders such as mental retardation, ADHD, PDDs, conduct disorders, oppositional defiant disorders, eating disorders, rumination disorders, tics, elimination disorders are most important because these disorders affect schooling, learning and overall development of the child. Early identification could be vital in psychoeducation, behavioral treatment, family therapy and social intervention which could help in minimizing disability. Due to paucity of trained personnel and resources, it is essential that not only mental health professionals but also various other stakeholders in this field such as school teachers and caregivers need to be sensitized to these issues so that prevention efforts can further reduce the prevalence of these conditions.

1.8 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Two theories of development are: (a) Erikson’s theory of development has proposed eight stages of development throughout life and at each stage there is a conflict, resolution of which will lead to proper development. His work emphasizes the individual’s adaptation to society; (b) Jean Piaget’s theory of cognitive development which progresses through four stages, views child as an active problem solver.

2) Motor and sensory milestones of development in 2 years old children are as follows: can run well, kick large ball, climbs stairs alone, and fine motor skills increase.

3) Personal and social behavior development in 5 -6 years old children are as follows: can dress and undress oneself, plays competitive games and ties shoe laces.

Self Assessment Questions 2

1) Based on IQ, the types of mental retardation are, Mild MR (IQ 50 – 70), Moderate MR (IQ 35 – 50), Severe MR (IQ 21 – 35), and Profound MR (IQ < 20).

2) Signs and symptoms of autistic disorder are difficulties relating to and communicating with other people; repetition of particular behaviors; and unusual sensory issues.

3) Treatment of learning disorders requires a multi disciplinary approach involving teachers, school psychologists, special educators and parents. Resource rooms, special class placement, and individualized educational programme (IEP) may be necessary. Psycho education is crucial and counseling can be very helpful for the individual as well as the family.
4) Signs of an individual with impulsivity are as follows:
   - Is very impatient
   - Blurt out inappropriate comments, show their emotions without restraint, and act without regard for consequences
   - Have difficulty waiting for things they want or waiting their turn in games
   - Often interrupts conversations or others’ activities

Self Assessment Questions 3
1) Management of conduct disorder includes individual or family therapy, tutoring or special class placement (for cognitive or conduct problems). Teaching cognitive behavioral and moral reasoning skills is helpful. It is crucial to discover and fortify interests or talents to build resistance to the lure of crime if environment is noxious. If conduct disorder is severe, placement away from home may be indicated.

2) Rumination disorder refers to repeated regurgitation for at least 1 month following a period of normal eating (in the absence of gastrointestinal dysfunction). Food is brought back into the mouth, ejected or rechewed and swallowed.

3) Tics are movements or sounds “that occur intermittently and unpredictably out of a background of normal motor activity”, having the appearance of “normal behaviors gone wrong”.

4) Enuresis is involuntary urination in children over the age of 5 years old, and is not due to a general medical condition; whereas encopresis is the voluntary or involuntary passage of stool in a child who has been toilet trained, typically over 4 years old.

1.9 UNIT END QUESTIONS
1) Describe the epidemiology, etiology, clinical features and management of mental retardation.

2) Describe the Pervasive Developmental Disorders.

3) Explain the signs and symptoms of ADHD.

4) Describe the types of tic disorders.

5) Describe the various anxiety disorders in children and adolescents.

6) Describe the clinical features and management of elimination disorders.

1.10 GLOSSARY

Adolescence: the period from beginning of puberty until maturity, commonly starting at the age of 12 years and completing by 18 years.

Attention: conscious and wilful focusing of mental energy on one object.

Autism: a pervasive developmental disorder that has its onset before the age of 3 with delays in social development, communication or play.

Child: any human between infancy and puberty.

Conduct: self-conscious and self-regulatory behaviour as determined by the standards set for the person by his/her social environment.
Development Milestone: a skill regarded as having special importance in development of infants and usually associated with a particular age range.

Diagnosis: the use of scientific or clinical methods to establish the cause and nature of a person’s illness.

Encopresis: an elimination disorder consisting of involuntary defecation not due to organic defect, occurring in a child of 4 years or older.

Enuresis: involuntary passage of urine after the age by which full control of urinary excretion should have been attained; it may be organic or functional.

I.Q.: Intelligence Quotient. The ratio of a subject’s intelligence to his/her chronological age.

Tics: a brief, sudden, rapid, recurrent, rhythmic, stereotyped, irresistible movement or vocalization.

Prevalence: the number of cases of a disease present in a specified population at a given time.

1.11 REFERENCES


1.12 SUGGESTED READINGS

Child Mental Health In India (1992), Edit.-Savita Malhotra, Anil Malhotra, Vijoy Varma. Macmilan India Limited.

Child and Adolescent Psychiatry (1ST Editon), Edit-Dean X. Parmelee and Ronald B. David, Mosby Missaury Press.


UNIT 2    OLD AGE AND MENTAL HEALTH

Structure
2.1 Introduction
2.2 Objectives
2.3 India is Greying
2.4 Mental Health Problems in the Elderly
2.5 Dementia and other Cognitive Disorders
   2.5.1 Clinical Presentation of Dementia
   2.5.2 Clinical Presentation of Delirium
2.6 Geriatric Depression
   2.6.1 Clinical Presentation of Geriatric Depression
2.7 Late-onset Anxiety Disorders
   2.7.1 Clinical Presentation of Late-life Anxiety Disorders
2.8 Late-onset Psychotic Disorders
2.9 Assessment of the Mental Disorders in the Elderly
   2.9.1 General Description
   2.9.2 Functional Assessment
   2.9.3 Mood, Feelings and Affect
   2.9.4 Perceptual Disturbances
   2.9.5 Language Output
   2.9.6 Visuo-spatial Functioning
   2.9.7 Thinking
   2.9.8 Sensorium and Cognition
   2.9.9 Neuropsychological Evaluation
2.10 Management of Mental Disorders
   2.10.1 Management of Dementia and other Cognitive Disorders
   2.10.2 Management of Depression
   2.10.3 Management of Late-onset Anxiety Disorders
   2.10.4 Management of Late-onset Psychotic Disorders
2.11 Let Us Sum Up
2.12 Answers to Self Assessment Questions
2.13 Unit End Questions
2.14 References and Suggested Readings

2.1 INTRODUCTION

Old age is a phase of the life cycle associated with loss of physical functions, and problems in mental faculties. Advancement in medical technology has further contributed to rapid growth in the population of ‘Senior Citizens’ throughout the world. With this, a host of related issues have come to the fore ranging from the physical care, security, engagement, social relations to the mental health concerns in the elderly. In this Unit, you will learn about various mental health problems and disorders affecting our elderly population.
2.2 OBJECTIVES

After studying this Unit, you will be able to:

- identify mental disorders in elderly;
- describe the clinical presentation of mental disorders;
- know the assessment procedure for the mental disorders; and
- discuss the psychological and pharmacological interventions for these disorders.

2.3 INDIA IS GREYING

India is in a process of demographic transition. With the advent of better health facilities, there is a downward shift from a high mortality/high fertility scenario to a low mortality/low fertility scenario. The expectancy of life at birth has increased to 66.21 years in 2012. Life expectancy for women was 68.00 years and for men 64.51 years. The elderly population accounted for 7.1% of total population in 2001 and it is projected to rise to more than 10% by the year 2021. This has resulted in an increased proportion of older people in the total population, termed as the “greying of population”. The elderly population is facing a huge burden of communicable and non-communicable diseases.

With ageing comes changes in our brain. Ageing causes changes in brain size, vasculature and cognition. As we age, our brain shrinks in volume and size. As our vasculature ages, the pressure of blood in the vasculature (blood vessels) rises, which further leads to the chances of stroke and ischemic changes in brain. Memory decline is also associated with ageing. There is a role of neurotransmitters (i.e. brain chemicals), genes, hormones and of course, experience involved in ageing. A healthy life, both physically and mentally, may be protective factor for ageing brain.

However, rapid changes in the family systems in India have made the elderly people more prone to psychological problems.

2.4 MENTAL HEALTH PROBLEMS IN THE ELDERLY

Burden of mental health disorders is increasing in elderly due to ageing of the brain, problems associated with medical diseases and social issues such as breakdown of the family support systems, social isolation and decrease in economic independence. The reported prevalence of geriatric psychiatric morbidity in the Indian community is ranging from roughly 10 to 60 percentages. The mental disorders frequently encountered in Indian elderly include dementia and depression. Other disorders include anxiety disorders, drug and alcohol abuse, delirium and psychosis. Female sex, low education, single status, medical co-morbidities, poor socio-economic status and disability are all well-established factors playing significant role in mental disorders among elderly.

Studies from hospital clinic, community as well as old age homes found depression as the most common mental health problem in geriatric population with prevalence ranging from 20 to 60 percentages of gero-psychiatric patients. Suicide especially due to depression occurs more frequently in the elderly which adds to this problem. Depression is an often-missed diagnosis especially in the medical elderly patients. Dementia seems to be the next silent epidemic in the country. The prevalence of dementia in Indian studies has been shown to vary from 0.84 to 6.7 percentages. Diabetes, depression, hyperlipidaemia, urban living and lack of exercise are independent risk factors for
dementia. Living in joint families and increased intake of polyunsaturated fats conferred protection against dementia. The prevalence of anxiety disorders has been reported to be up to 20 percentages among gero-psychiatric patients.

Let us now discuss in detail some of the major mental health problems in the elderly.

2.5 DEMENTIA AND OTHER COGNITIVE DISORDERS

Cognitive disorders are characterized by a limitation of cognitive functioning as the main feature. These disorders involve impairment in areas of memory, attention, perception, and thinking. Most common mental disorders affect cognitive functions, mainly memory processing, perception and problem solving. These cognitive disorders are dementia, delirium and amnesia.

Dementia syndrome, an important diagnosis in elderly is characterized by impairment in memory, judgment and other cognitive functions. The prevalence of dementia is 2 to 5% in the general population older than 65 years of age and reportedly doubles every 5 years. Of all patients of dementia, 50 to 60% have dementia of the Alzheimer’s type followed by 15 to 30% of vascular subtype. Other common causes of dementia i.e. head trauma, alcohol related dementia and movement related dementia represent 1 to 5% of all cases of dementia.

Another cognitive disorder, delirium is characterized by short-term confusional state and changes in cognitive functions. The prevalence of delirium reported between 10-14% in patients admitted in emergency departments. Patients having age of more than 60 years, having diagnosed with dementia, cerebro-vascular accidents, burns, infections, alcohol withdrawal state are more prone to delirium. Depending on etiology, delirium is further classified into:

1) Delirium due to general medical condition like infection, tumor etc.
2) Delirium due to drugs like cannabis, alcohol etc.
3) Delirium due to multiple causes.
4) Delirium due to other causes like lack of sleep

Amnestic disorder is defined by memory impairment and forgetfulness. Depending on etiology, amnestic disorder is also classified into three sub-categories:

1) Amnestic disorders caused by medical condition like hypoxia
2) Amnesia disorders caused by toxin or medication like cannabis, benzodiazepines.
3) Cause not known

2.5.1 Clinical Presentation of Dementia

Dementia is defined as a progressive impairment of cognitive functions that occurs in clear consciousness. It denotes a decrement of two or more intellectual functions, in contrast to focal or specific impairments such as amnestic disorder or aphasia. The persistent and stable nature of impairment also differentiates dementia from the fluctuating short term cognitive deficits of delirium. Dementia should be distinguished from mental retardation as the former represents an acquired loss of or declining prior intellectual and functional capacities. The diagnosis of dementia is based on the clinical examination and on information provided by patient’s family, friends and employers. Clinically,
dementia diagnosis is entertained with following criteria:

1) Memory dysfunction (especially new learning)

2) At least one additional cognitive deficit (aphasia, apraxia, agnosia, or executive dysfunction)

3) Sufficiently severe to cause impairment of occupational or social functioning and must represent a decline from a previous level of functioning

Memory impairment is typically a prominent feature in dementia. The patient finds difficulty in learning new information and to recall previously learned information. The patients in dementia may also suffer from aphasia (problem in language), apraxia (inability to carry out motor activities despite intact motor functions), agnosia (failure to recognize or identify objects despite intact sensory functions) and disturbance in executive functioning (planning, organizing, sequencing, abstracting). These cognitive deficits cause significant decline in social or occupational functioning from previous level. Important features differentiating types of dementia are:

a) **Dementia of the Alzheimer’s Type**: The patients with this subtype had course of illness characterized by gradual onset and continuing cognitive decline without the evidence of other causes of dementia.

b) **Vascular dementia**: In addition to general symptoms of dementia the diagnosis of vascular dementia requires definite clinical or laboratory evidence in support of vascular cause. The patient of this subtype usually show a decremental and stepwise deterioration than Alzheimer’s dementia.

c) **Dementia due to other general medical condition**: This category includes dementias related to HIV disease, head trauma, Parkinson’s disease, Huntington’s disease, Picks disease and Creutzfeldt-Jacob disease.

d) **Substance induced persistent dementia**: The specific substances that may induce dementia are alcohol, inhalant, sedative, hypnotic or anxiolytics.

We can identify case with dementia by observing the following ten warning signs:

1) Recent memory loss affecting job

2) Difficulty performing familiar tasks

3) Problems with language

4) Disorientation to time or place

5) Poor or decreased judgment

6) Problems with abstract thinking

7) Misplacing things

8) Changes in mood or behavior

9) Changes in personality

10) Loss of initiative
Mr. R, a 65-year-old, illiterate farmer had been performing his usual work of farming. Initially he had some difficulty in performing usual farm activities and made gross errors in home financial management. Gradually, he lost his way to home from fields on several occasions. His intellectual deterioration started interfering in his work. He committed mistakes while sowing seeds in rainy season. Due to this, his sons stopped him to go to fields. He spent most of the time in searching farming equipments at his house. He became quarrelsome and irritable. Eventually, he required assistance in bathing and dressing. When examined 3 years after the first symptoms developed, the patient could not recall correct place and time. He could not recall his home address. He could not remember the age of his two children. He could not recall about the last breakfast he had. His speech was fluent and well-articulated but he finds difficulty in finding words for common objects. He could not perform simple calculations correctly. His interpretation of local proverbs was concrete. He had no insight into the nature of his problems.

2.5.2 Clinical Presentation of Delirium

Delirium is defined by the acute onset of fluctuating cognitive impairment and other behavioral phenomenon. It is frequently missed or misdiagnosed resulting into substantial morbidity and mortality. Hence it is crucial to be aware of the clinical features, diagnose and apply appropriate intervention strategies to deal with it. The clinical features of delirium are as follows:

a) Disturbance of consciousness and attention

The most important feature of delirium is difficulty in sustaining attention, leading to distractibility. The patients having delirium have problem in focusing, sustaining their attention on one topic.

b) Acute change in cognitive functioning

The delirious patient reports problem in learning new information. He may also report disorientation to time, place and rarely to person. Associated clinical features include illusions, hallucinations and delusions.

c) Fluctuating course of symptoms over time

The above mentioned symptoms may develop abruptly and fluctuate rapidly throughout the day. The presence of lucid intervals (normal periods between episodes of delirium) may also be present in delirium.

d) Disturbance of arousal, psychomotor state and sleep

Disturbance of psychomotor activity in delirium include hypoactive, hyperactive and mixed behavioral states. Hypoactive patients may appear apathetic, withdrawn and confused, while hyperactive patients remain overactive and at times aggressive.

e) Other mood and anxiety symptoms

Emotional reactions in delirious patients include mood changes, depression, anxiety, fear, anger, apathy and euphoria.
### 2.6 GERIATRIC DEPRESSION

Depression is considered to be ‘Disorder of losses’—loss of mood (sadness of mood); loss of interest in pleasurable activities (anhedonia); and loss of energy (easy fatiguability). However, disturbed sleep has also been shown to be the most common complaint. Depression may be associated with medical conditions. Short duration of episode and living in joint family has been associated with better outcome.

#### 2.6.1 Clinical Presentation of Geriatric Depression

Depressed mood remains the hallmark for diagnosis of geriatric depression. Elderly patients often report bodily symptoms (aches & pains, gastro-intestinal disturbances) rather than sadness of mood. They also report subjective experience of forgetfulness or memory loss and slow thinking (Pseudo-dementia; ‘dementia of depression’) which should be differentiated from dementia. They may also present with anxiety symptoms, agitation and psychotic symptoms. There is always a high risk of suicide associated with depression in late life. The patient with clinical diagnosis of geriatric depression may present with:

a) **Classical depression:** The patient may present as the classic variant with features of depressed mood, crying spells, easy fatiguability, impaired concentration, loss of appetite, insomnia, ideas of helplessness/ worthlessness and death wishes.

b) **Somatisation:** There are usually high rates of somatisation (bodily symptoms), weight loss and hypochondriasis (concern for serious disease).

c) **Psychotic symptoms:** Among psychotic symptomatology, delusions are more common than hallucinations and the usual content is depressive aggressive (nilhistic, somatic or poverty).
d) **Death wishes and suicide:** Suicidal ideations are well hidden and less commonly reported in the elderly. However, more lethal means are used for committing suicide in elderly.

e) **Masked depression:** The entity of “masked depression” means depression in the elderly can be replaced or masked by multiple somatic complaints.

f) **Behavioural regression:** The patient usually becomes less physically and socially active, neglects personal hygiene and necessary medical treatment, loses contact with friends and family and allow the home environment to become disordered.

g) **Vascular depression:** Vascular depression hypothesis states that, especially in the elderly, a subtype of depressive disorder exists that is caused by vascular brain disease. A substantial portion of elderly individual with depression presents with cognitive impairment particularly in visuospatial ability, psychomotor speed and executive functioning.

### 2.7 LATE-ONSET ANXIETY DISORDERS

Anxiety disorders are thought to be among the most prevalent disorders in older age, with higher rates in older patients with medical co-morbidities. Generalized anxiety disorder (GAD) is the most frequently diagnosed followed by specific phobias. Social phobias, panic disorder are less common. Anxiety disorders in elderly may be associated with medical disorders or exist as independent disorders.

#### 2.7.1 Clinical Presentation of Late-life Anxiety Disorders

Patients with anxiety disorders may be presented with physical symptoms like palpitation, chest pain, choking, giddiness, and tingling numbness; and psychological symptoms like worrying, nervousness, tension, apprehension, anticipatory fear & lack of concentration.

Some unique features in the manifestation of anxiety disorders in older adults include the minimization of psychological complaints, an increase in somatic complaints, and an amplification of external obstacles (i.e., difficulty with transportation, concerns about finances, and fears for the health of family members). GAD often presents as restlessness, irritability, fatigue, insomnia, and muscle tension. The more common phobias of late life include fears of driving, travelling, and falling. Late-onset panic disorder appears to be associated with lower levels of cognitive and somatic distress during panic attacks. In Obsessive Compulsive Disorders, older persons report more contamination and religious obsessions but few rituals involving symmetry or counting. Older adults experience bereavement at much higher rates (up to 20%) than do younger adults.

### 2.8 LATE-ONSET PSYCHOTIC DISORDERS

Elderly are also prone to psychosis like young adults. In late-onset psychosis (also called ‘Paraphrenia’), delusions of persecution and reference and, auditory and visual hallucinations are usually present.

Most common symptoms in late-onset schizophrenia are non-bizarre delusions. Lower levels of negative symptoms, thought disorder, affective blunting and less severity of cognitive deficits are seen in cases of late-onset schizophrenia. Patients with very late-onset schizophrenia have more brain abnormalities, more persecutory delusions and higher rates of visual, tactile & olfactory hallucinations.
2.9 ASSESSMENT OF THE MENTAL DISORDERS IN THE ELDERLY

Evaluating history and clinical interview remain cornerstones of assessment of geriatric patient with mental health problem. Clinician/therapist must determine whether a patient understands the nature and purpose of the clinical assessment. When a patient is cognitively impaired, an independent history should be obtained from a family member or caretaker. A complete history includes identification details (name, age, sex, and marital status), chief complaint, history of the present illness, history of previous illnesses, personal history, and family history. The mental status examination offers a cross-sectional view of how a patient thinks, feels, and behaves during the examination. Symptoms elicited during history need to be thoroughly checked with mental status examination.

2.9.1 General Description

A general description of the patient includes appearance, speech, motor activity, and attitude towards the clinician. Change in motor activity (bodily movements) should be recorded. Many patients with cognitive problems seem to be slow in speech and movement. The patient’s speech may be pressured in cognitive dysfunctions. Tearfulness and overt crying may also occur in depressive and cognitive disorders, especially if the patient feels frustrated about being unable to answer any question.

2.9.2 Functional Assessment

The mental health professional/therapist must evaluate patients for their capacity to maintain independence and to perform the activities of daily life, which include self care, toileting, preparing meals, dressing, grooming, and eating. The degree of functional competence in their routine behaviors is an important consideration in formulating a treatment plan for these patients.

2.9.3 Mood, Feelings and Affect

The therapist should specifically ask the patient about any thoughts of self-harm, loneliness, worthlessness. Low mood and anxiety can also interfere with memory functioning. An expansive or euphoric mood may signal a dementia disorder. Frontal lobe dysfunction of brain often produces witzelsucht syndrome, which is the tendency to make puns and jokes and then laugh aloud at them.

The patient’s affect may be flat, blunted, constricted, shallow, or inappropriate, all of which can indicate a depressive disorder, schizophrenia, or cognitive dysfunction. Dominant lobe dysfunction causes dysprosody, an inability to express emotional feelings through speech intonation.

2.9.4 Perceptual Disturbances

Hallucinations (perception without a sensory stimulus in the environment) and illusions (misinterpretation of sensory stimulus) by patients with cognitive dysfunction can be transitory phenomena resulting from decreased sensory acuity. The therapist must note whether the patient is confused about time or place. Cognitive disorders may cause perceptive impairments like agnosia characterized by the inability to recognize and interpret the significance of sensory impressions.

2.9.5 Language Output

The therapist must assess language output. The aphasias, which are disorders of language
output are related to organic lesions of the brain. Broca’s aphasia is among the common types of aphasia in which the patient’s understanding remains intact, but the ability to speak is impaired.

### 2.9.6 Visuo-spatial Functioning

The therapist may ask a patient to copy figures or a drawing in assessing the visuo-spatial function. A detailed neuropsychological assessment need to be performed when visuo-spatial functioning is obviously impaired.

### 2.9.7 Thinking

The therapist should evaluate any disturbances in thinking. The loss of the abstract thinking (ability to appreciate nuances of meaning) may be an early sign of dementia. Thought content should be examined for phobias, obsessions, somatic preoccupations, and compulsions. Ideas about suicide or homicide should be discussed. The examiner should examine delusions (fixed false beliefs) and evaluate how such delusions affect the patient’s life.

### 2.9.8 Sensorium and Cognition

Sensorium concerns the functioning of the special senses; cognition concerns information processing and intellect.

1) **Consciousness**

Altered consciousness is a sensitive indicator of brain dysfunction in which the patient does not seem to be alert, shows fluctuations in levels of awareness, or seems to be lethargic.

2) **Orientation**

Problem in orientation to time, place, and person is associated with cognitive disorders. The examiner should test for orientation to place by asking the patient to describe his or her present location. Orientation to person may be checked by asking his or her own name. Time is tested by asking the patient the date, the year, the month, and the day of the week.

3) **Memory**

Memory usually is assessed in terms of immediate, recent, and remote memory. Immediate retention and recall are tested by giving the patient six digits or giving days of week to repeat forward and backward. The examiner should record the result of the patient’s capacity to remember. Persons with unimpaired memory usually can recall six digits forward and five or six digits backward. Remote memory can be tested by asking for the patient’s age of marriage, age of eldest child and names of the patient’s parents and children. Recent memory can be assessed by giving the patient the names of three items early in the interview and ask for recall later. Memory of the recent past also can be tested by asking for the patient’s place of residence, including the street number; the method of transportation to the hospital; and some current events. Retention and recall also can be tested by having the patient retell a simple story or names of three items told earlier.

4) **Intellectual Tasks, Information, and Intelligence**

Various intellectual tasks estimate the patient’s fund of general knowledge and intellectual
functioning. Counting and calculation can be tested by asking the patient to subtract 7 from 100 and to continue subtracting 7 from the result until the number 2 is reached. The patient’s fund of general knowledge is related to intelligence. The patient can be asked to name the local elected leader both at village or sub-district or district levels, to name the three adjoining villages or cities near his village, and to give the distance from his village to clinic. The examiner must take into account the patient’s educational level, socioeconomic status, and general life experience in assessing the results of some of these tests.

5) Reading and Writing

The therapist may ask the patient read a simple story aloud or write a short sentence to test for a reading or writing disorder.

6) Judgment

Judgment is the capacity to act appropriately in various situations. Does the patient show impaired judgment? What would the patient do on finding a stamped, sealed, addressed envelope in the street? What would the patient do if he or she smelled smoke in a theater? Can the patient discriminate? What is the difference between a dwarf and a boy? Why are couples required to get a marriage license?

2.9.9 Neuropsychological Evaluation

A thorough neuropsychological examination includes a comprehensive battery of tests that can be replicated by various examiners and can be repeated over time to assess the course of a specific illness. The most widely used test of current cognitive functioning is the Mini-Mental State Examination (MMSE). HMSE is the Hindi adaptation (Ganguli et al., 1995), which assesses orientation, attention, calculation, immediate and short-term recall, language, and the ability to follow simple commands. The MMSE is used to detect impairments, follow the course of an illness, and monitor the patient’s treatment responses. It is not used to make a formal diagnosis. The maximal MMSE score is 30 (31 by HMSE). Age and educational level influence cognitive performance as measured by the MMSE.

Table 1: Hindi Mental Status Examination (HMSE)
(Ganguli et al., 1995)

<table>
<thead>
<tr>
<th>Correct</th>
<th>Wrong</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is it morning or afternoon or evening?</td>
<td>1</td>
</tr>
<tr>
<td>2. What day of the week is it today?</td>
<td>1</td>
</tr>
<tr>
<td>3. What date is it today?</td>
<td>1</td>
</tr>
<tr>
<td>4. Which month is it today?</td>
<td>1</td>
</tr>
<tr>
<td>5. What season of the year is this?</td>
<td>1</td>
</tr>
<tr>
<td>6. Under which post office does your village come?</td>
<td>1</td>
</tr>
<tr>
<td>7. Which district does your village fall under?</td>
<td>1</td>
</tr>
<tr>
<td>8. Which village are you from?</td>
<td>1</td>
</tr>
<tr>
<td>9. Which block or numbered area is this?</td>
<td>1</td>
</tr>
<tr>
<td>10. Which place is this?</td>
<td>1</td>
</tr>
</tbody>
</table>
11. I went to Delhi and brought three things - mango, chair and coin. Can you tell me what are the three things I brought from Delhi? 1 2 3

12. (a) Now can you tell me the names of the days of the week starting from Sunday? 1 2 3 4 5
   (b) Now can you tell me the names of the days backwards? 1 2 3 4 5

13-15. What are the names of the three things, which I told you I have brought back from Delhi? 1 2 3

16. (Show the Subject the wrist watch and pen) Can you see these objects? (If yes, items 17 & 18 apply)[If no, items 17 (a), 18(a)]

17-18. Show him the wristwatch and say, what is this? OR,17(a) (If necessary, identification of watch by touching) What is this? 1 0
   Show him the pen and say - what is this? OR,18 (a) (if necessary identification of pen by touching) What is this? 1 0

19. Now I am going to say something, listen carefully and repeat it exactly as I say after I finish Phrase: “NEITHER THIS NOR THAT” 1 0

20. Now look at my face and do exactly what I do. (Close your eyes for 2 seconds) 1 0

21. First you take the paper in your right hand, then with your both hands, fold it into half once, and then give the paper back to me. 1 2 3

22. Now say a line about your house? (something specifically about your house) NOT INCLUDED IN HMSE TOTAL, If given-1, not given-0

23. Here is a drawing. You must copy this drawing exactly as shown in the space provided here.

Score:
Must draw 2 four sided figure = 1
1 figure should be inside the other = 2
Orientation of the figures should be obviously appropriate = 3

Total score = /31

Self Assessment Questions 2
1) Name the three ‘losses’ present in depression.
....................................................................................................................
....................................................................................................................
....................................................................................................................
....................................................................................................................
....................................................................................................................
2) What are the unique features of anxiety disorders in the elderly?

What is agnosia?

Late onset psychosis is also called _______________.

2.10 MANAGEMENT OF MENTAL DISORDERS

2.10.1 Management of Dementia and other Cognitive Disorders

Dementia

The first step in the treatment of dementia is verification of the diagnosis. Diagnostic exercise of patient with memory problem starts with a good history from both family members and the patient regarding chronological presentation of symptoms and problem behaviours. Evaluation includes questions related to memory loss like becoming lost in a familiar place, asking food again and again, and losing objects. A thorough evaluation of medical history and examination of bodily systems, including neurological examination is must for patient with memory loss. The nature and degree of the cognitive function and activities of daily living should be assessed with Hindi adaptation of Mini-Mental State Examination (HMSE) and Everyday Abilities Scale for India (EASI). The laboratory tests to rule out reversible causes for dementia are: thyroid stimulating hormone, vitamin B12 & folate levels, electrocardiogram, blood sugar & creatinine. Computed tomography of brain is required for patients with memory loss.

Pharmacological Approach

The general treatment approach to patients with dementia is to provide supportive medical care, emotional support for the patient and their families, and pharmacological treatments for specific symptoms. Preventive measures are important particularly vascular dementia which includes changes in diet, exercise and control of diabetes and hypertension (anti-hypertensives or anticoagulants or anti-platelet agents).

Most of the current approved pharmacotherapy of dementia is directed at reversing the known deficient cholinergic transmission. The drugs used for arresting or delaying the progression of dementia are acetyl cholinesterase inhibitors (donepezil, galantamine and rivastigmine) and memantine. Disruptive behavior and aggression can be managed with low dose antipsychotics like quetiapine and risperidone.
Non-pharmacological Interventions

1) Behavioral therapy

Behavioral therapy has been based on principles of conditioning and learning theory using strategies aimed at suppressing or eliminating the undesirable behaviors in dementia and anxiety disorders in elderly. Behavioral therapy requires a period of detailed assessment in which the triggers, behaviors and reinforcers (also known as the ABC: antecedents, behaviors and consequences) are identified and their relationships made clear to the patient. The therapist will often use some kind of chart or diary to gather information about the manifestations of a behavior and the sequence of actions leading up to it. Interventions are then based on an analysis of these findings. Behavioral interventions must be tailored to individual cases.

2) Reality orientation

Reality orientation aims to help people with memory loss and disorientation by reminding them of facts about themselves and their environment. It can be used both with individuals and with groups. In this therapy, people with memory loss are oriented to their environment using a range of materials and activities. This involves consistent use of orientation devices such as signposts, notices and other memory aids.

3) Reminiscence therapy

Reminiscence therapy involves helping a person with dementia to relive past experiences, especially those that might be positive and personally significant, for example, family holidays and weddings. This therapy can be used with groups or with individuals.

4) Alternative therapies

As in other areas of health care, alternative therapies are gaining currently in the treatment of people with dementia like art therapy, music therapy, activity therapy, complementary therapy, aromatherapy, bright-light therapy and multisensory approaches. All of these have received some research attention but efficacy is yet to be established.

5) Brief psychotherapies

There has been an increasing interest in applying some of the brief therapeutic frameworks such as cognitive–behavioral therapy (CBT) and interpersonal therapy to dementia. Interpersonal therapy, as the name suggests, examines the individual’s distress within an interpersonal context. It uses a specific framework in which the individual’s distress is conceptualized through one of four domains: interpersonal disputes; interpersonal/personality difficulties; bereavement; and transitions/life events. Both CBT and interpersonal therapy have limitations, particularly with severe dementia.

In short, patients often benefit from a supporting and educational psychotherapy. They may also benefit from assistance in grieving and accepting the extent of their disability. Patient should be encouraged to focus on the activities in which successful function is possible. Patient should be asked to keep calendars for orientation problem, making schedules to help structure activities and taking notes for memory problems. Emotional problems in family members of patients with dementia should be adequately dealt.

Delirium

For patients with delirium, initial treatment includes medical support, i.e., maintenance of vital parameters (adequate airway, blood pressure, pulse and temperature). The cause of delirium is established through history, physical examination, and laboratory
tests. Specific therapy/intervention is started after identification of precipitant of confusional state. Clinicians also look after and manage excess and confused environmental stimuli present in the vicinity of patient. Patient should be kept in quiet, well-lighted and simply furnished room. Family members and hospital staff should regularly acquaint the patient regarding time, place and person. Restraints should be avoided. For agitated behaviour, low dose antipsychotics (Haloperidol or Risperidone, either oral or intramuscular) may be prescribed. The management of delirium involves the following steps:

1) **Reverse medical problems and provide supportive care:** The primary treatment of delirium is to identify and treat the underlying cause or contributing medical conditions which have a direct bearing on the survival of the patient. For example, in hepatic failure, medication is given to reduce serum ammonium levels. In addition to reversing medical problems, delirious patients may need extra supportive medical care and maintenance of vital parameters for rapid recovery.

2) **Prevent further medical complications:** Benzodiazepines, opiates, anticholinergic agents and other non-essential medications should be avoided.

3) **Use environmental intervention to facilitate reality:** Keeping the patient in quiet environment free of unnecessary stimulation may help in reducing agitation. Frequent familiar clues (clock, calendar) to orientation may also be helpful. Supportive contacts with the patients, family and sometimes staff member are necessary to reassure the patient. The patient can be oriented to staff, surroundings and situations repeatedly, particularly before any hospital procedures. Sensory devices (eyeglasses, hearing aid) also help the patient to get rid of sensory deficits.

4) **Facilitate sleep, cognition and healthy functioning:** Personalized interventions like antipsychotics may be helpful in promoting restful sleep and controlling anxiety. Sleep hygiene must be explained to care givers.

5) **Prevent and manage disruptive behavior:** Control of agitation in delirious patients is essential to prevent self-damage and allowing appropriate examination and treatment. Physical restraint or chemical restraint should be avoided as much as possible. Patient’s bed can be maintained in low position with brakes locked and position the side rails up. Hazard free environment can be maintained by removing unnecessary equipment or furniture. The commonly used antipsychotics are haloperidol, risperidone, in addition to benzodiazepines. The dosage should be low and titration should be slow. Family members can be encouraged to be with patients.

### 2.10.2 Management of Depression

**Assessment**

Older persons may not reveal depressive symptoms so easily, hence needs good observation and clinical skills. More focus of interview is towards motor activity, hopelessness, worthlessness, hallucinations, suicidal ideations and memory problems. The laboratory tests to rule out co-morbid medical conditions are: complete blood counts, thyroid stimulating hormone, vitamin B12 and folate levels (vegetarians), electrocardiogram, fasting blood sugar, serum electrolytes, blood urea and creatinine. Computed tomography of brain is optional for suspected cases of cerebro-vascular lesions.
Mental Health in Special Population

**Treatment**

Antidepressants remain mainstay for treatment of geriatric depression. Newer antidepressants, Specific Serotonin Reuptake Inhibitors (SSRIs) like fluoxetine, sertraline, citalopram and escitalopram can be initiated at lower doses (preferably half of young adult dosage). Gastrointestinal disturbances, weight loss and agitation are commonly reported side effects with SSRIs. Tricyclic antidepressants may be avoided due to postural hypotension and anticholinergic side effects. Families should be involved for support building and motivating patient in activities.

2.10.3 Management of Late-onset Anxiety Disorders

**Assessment**

Anxiety symptom may be part of medical and mental disorders like hypoglycaemia, hyperthyroidism, cardiac arrhythmias, pulmonary emboli, delirium, depression, dementia and psychotic disorder. It could be related to medications like ephedrine, anticholinergic drugs and benzodiazepine withdrawal.

Both pharmacological treatment and behavioural interventions can be given.

2.10.4 Management of Late-onset Psychotic Disorders

Psychotic symptoms in the form of suspiciousness, delusions, hallucinations and agitation are present in schizophrenia and delusional disorders. Family members should be interviewed to explore behavioural disturbances. Patient with psychosis requires a safe environment. Agitated and suspicious elderly needs inpatient hospitalization. Antipsychotic medications may be given.

<table>
<thead>
<tr>
<th>Self Assessment Questions 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Describe the assessment of depression in older persons.</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>2) Explain interpersonal therapy.</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>3) Name the alternative therapies.</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
<tr>
<td>....................................................................................................................</td>
</tr>
</tbody>
</table>
2.11 LET US SUM UP

Geriatric mental health is a neglected issue with poor sensitivity among health professionals. Staunch efforts should be made for understanding mental disorders in the elderly. In the present Unit you learned how these disorders affect various domains ranging from memory, attention, perception to thinking. You also studied about the common mental disorders such as cognitive disorders, depression and anxiety disorders affecting the elderly population. These disorders are associated with significant disability, poor quality of life, and burden on families. There are various methods of treatment modalities available from medication to supportive management. Early detection and intervention can make a major impact on the outcome of these mental disorders.

2.12 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Cognitive Disorders are characterized by a limitation of cognitive functioning as the main feature. These disorders involve impairment in areas of memory, attention, perception, and thinking.

2) The types of cognitive disorders in the old age are dementia, delirium and amnesia.

3) Dementia is defined as a progressive impairment of cognitive functions. The impairment is persistent and stable whereas delirium is marked by fluctuating short term cognitive deficits.

Self Assessment Questions 2

1) The three ‘losses’ present in depression are ‘loss of interest’, ‘loss of energy’, and ‘loss of mood’.

2) The unique features in anxiety disorders in the elderly include the minimization of psychological complaints, an increase in somatic complaints, and an amplification of external obstacles.

3) Agnosia refers to the inability to recognize and interpret the significance of sensory impressions.

4) Paraphrenia

Self Assessment Questions 3

1) The focus in assessment of depression in the older persons is on motor activity, hopelessness, worthlessness, hallucinations, suicidal ideations and memory problems. Laboratory tests are also done to rule out co-morbid medical conditions.

2) Interpersonal therapy examines the individual’s distress within an interpersonal context. It uses a specific framework in which the individual’s distress is conceptualized through one of four domains: interpersonal disputes; interpersonal/personality difficulties; bereavement; and transitions/life events.

3) The alternative therapies are art therapy, music therapy, activity therapy, complementary therapy, aromatherapy, bright-light therapy etc.
2.13 UNIT END QUESTIONS

1) Describe the clinical features of delirium.

2) Discuss the late-life anxiety disorder.

3) Discuss the management of delirium.

4) Explain behavior therapies.

2.14 REFERENCES AND SUGGESTED READINGS


UNIT 3  WOMEN AND MENTAL HEALTH

Structure
3.0 Introduction
3.1 Objectives
3.2 Mental Health in Women
3.3 Factors Affecting Mental Health in Women
   3.3.1 Mental Disorders
   3.3.2 Domestic Violence
   3.3.3 Sexual Violence
   3.3.4 Substance Abuse
3.4 Promotion of Women’s Mental Health
   3.4.1 Policies and Legislation
   3.4.2 Education and Training
   3.4.3 Primary Health Care
   3.4.4 Workplaces
   3.4.5 Community Action
3.5 Let Us Sum Up
3.6 Answers to Self Assessment Questions
3.7 Unit End Questions
3.8 References
3.9 Suggested Readings

3.0 INTRODUCTION
In the earlier Units you learned about mental health in the children and elderly. In this unit you will learn about mental health of women. This has been dealt with in a separate unit as women traditionally had been neglected in the society and relegated to a secondary status in the society. However, women are the pillar of our society. Their contribution is equally important to the society. Yet women’s mental health has not received much attention. Due to the multiple roles women play and the various responsibilities they handle, women may be more susceptible to mental health problems and disorders which require special care and concern to identify and manage it effectively. For example, women entering into marriage in the Indian cultural system face unique set of roles and responsibilities that may have an impact on their mental health. Women may also suffer from depression and other mental health problems during pregnancy and post-partum period. Violence against women also has negative impact on the mental health of women. The present Unit will discuss women’s mental health problems and mental disorders, and the management and intervention aspect of it.

3.1 OBJECTIVES
After studying this Unit, you will be able to:
- explain mental health in women;
- describe the factors affecting mental health in women;
- understand the gender disparities in mental health; and
- describe management strategies and measures for improving women’s mental health.
3.2 MENTAL HEALTH IN WOMEN

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, and some disorders manifest with different symptoms in men and women. Physical health and illness as well as mental health and illness are affected by various biological and psychosocial factors in both women and men. Women and men have differential power and control in the society related to their position, role and status. This also affects their susceptibility and exposure to specific mental health risks and their treatment. Further, this leads to gender-wise difference in the way the socioeconomic cultural determinants affect mental health.

Some facts related to mental health in women

- Leading mental health problems of the elderly are depression, organic brain syndromes and dementias. A majority are women.
- An estimated 80% of 50 million people affected by violent conflicts, civil wars, disasters, and displacement are women and children.
- Lifetime prevalence rate of violence against women ranges from 16% to 50%.
- At least one in five women suffers rape or attempted rape in their life time.

(Source: http://www.who.int/mental_health/prevention/genderwomen/en/)

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 instrumental 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. When women’s health issues have been addressed, activities have tended to focus on issues associated with reproduction – such as family planning and child-bearing – while the mental health aspect of women has received scant attention. Women, throughout their developmental stages ranging from childhood, adolescence, reproductive age, and middle age with menopause have specific psychological needs and requirements. This needs to be understood and taken care of to promote their mental health. Increasingly, women are becoming an essential part of the labor force, and in one-quarter to one third of all households, they are the prime source of income (WHO, 1993, 1995). The multiple roles that women play puts them under greater stress and render them at greater risk of experiencing mental disorders than men in the community.

Gender-specific risk factors

Gender is a significant variable when we talk about the mental health of women. It is a critical determinant of mental health as well as mental illness. Gender has significant explanatory power with regard to susceptibility and exposure to mental health risks and differences in mental health outcomes. The gender specific determinants and mechanisms play an important role in protecting and promoting the mental health of women. Gender affects various aspects of our life leading to differential accessibility and availability of resources and facilities. It also contributes to difference in self evaluation, self concept, style of interpersonal interaction, spirituality, coping with stress and expectations. Sabiha and Pathak (2012), in their study have explored how gender factors interact to influence certain risk factors, help-seeking behaviour, treatment, care and social consequences.
Gender specific risk factors for common mental disorders that disproportionately affect women include gender based violence, low income, income inequality, care giving responsibility and low or subordinate social status in family and society. The common mental disorders that affect women more include depression, anxiety, somatic complaints and eating disorders. They are also faced with sexual violence and domestic violence that escalates their psychological distress. Pressures created by their multiple roles, gender discrimination and associated factors of poverty, hunger, malnutrition, overwork, domestic violence and sexual abuse combine to account for women’s poor mental health. There is a positive relationship between the frequency and severity of such social factors and the frequency and severity of mental health problems in women. Severe life events that cause a sense of loss, inferiority, humiliation or entrapment can predict depression (WHO, 1997).

Depression contributes most significantly to the global burden of disease and it is the most frequently encountered women’s mental health problem (Piccinelli & Homen, 1997). Unipolar or major depression occurs approximately twice as often in women as in men and is predicted to be the second leading cause of global disease burden by 2020 (Murray & Lopez 1996). Higher rates of depression in women reflect a real gender difference in health rather than an artifact of help-seeking behaviour or willingness to report symptoms (Nazroo et. al. 1998; & Patel et. al. 2005). However, there are no marked gender differences in the rates of severe mental disorders like schizophrenia and bipolar disorder that affect less than 2% of the population. Even though there is a difference in the diagnosis, women face poor outcomes with regard to frequency of psychotic symptoms, course, prognosis and long term outcome of these disorders due to poor emphasis on their mental health aspects. The high prevalence of sexual violence to which women are exposed also puts them at high risk of Post Traumatic Stress Disorder (PTSD). The prevalence of alcohol dependence and antisocial personality disorder however are found to be more common in men than women.

The gender differences in the mental disorders may be due to the difference in reporting and communicating to the doctor about it. This again is governed by gender expectations of the society. The patriarchal, authoritarian nature of communication between health workers and women patients makes it difficult for women to express their psychological and emotional distress. Gender biases and stigmatization with regard to mental health problems hampers the availability of proper mental health care to women.

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 and long term. Mental health of women need to be addressed in a holistic manner. Their needs are different, their roles and responsibilities differ, and their access to resources are limited. Hence we need to focus on women’s mental health issues specifically and deal with them adequately.

Self Assessment Questions 1
1) What are the gender specific risk factors for common mental disorders in women?

2) Which disorder is predicted to be the second leading cause of global disease burden by 2020?
As described earlier, women are adversely affected by the following:

- specific mental disorders, the most common being depression and anxiety disorder
- domestic violence
- sexual violence
- substance abuse

### 3.3.1 Mental Disorders

A meta-analysis of 13 epidemiological studies (WHO, 2000) in different regions of India revealed an overall prevalence rate of mental disorders in women of 64.8 per 1000 female population. The rate of common mental disorders such as depression, anxiety disorders and psychological distress are higher for women than men. These findings are consistent across a range of studies undertaken in different countries and settings (Desjarlais et al, 1995). The gender difference in depression is one of the most robust findings in psychiatric epidemiology. A comprehensive review of almost all general population studies conducted to date in the United States of America, Puerto Rico, Canada, France, Iceland, Taiwan, Korea, Germany and Hong Kong, reported that women predominated over men in lifetime prevalence rates of major depression (Piccinelli & Homen, 1997). This difference is documented in clinical and community samples and across racial groups (Kessler et al., 1994; Gater et al., 1998, WHO & ICPE, 2000). Depression may also be more persistent in women (Bracke, 2000) and female gender is a significant predictor of relapse (Kuehner, 1999). Data from the World Bank study revealed that depressive disorders accounted for close to 30% of the disability from neuropsychiatric disorders amongst women in developing countries but only 12.6% of that among men. The disparity in rates between men and women tend to be even more pronounced in underserved populations (World Bank, 1993).

In addition to the higher rates of depression and anxiety, women are much more likely to receive a diagnosis of obsessive compulsive disorder, somatization disorder and panic disorder (Russo, 1990). In contrast, men are more likely to receive a diagnosis of antisocial personality disorder and alcohol abuse/dependence. Women also have significantly higher rates of post traumatic stress disorder (PTSD) than men (Kessler et al, 1995).

In another study in an urban area of Brazil (Blue, Ducci, Jaswal, Ludfemir & Harpham, 1995), it was found that women were almost four times more likely than men to have a positive score on the Short Reporting Questionnaire (SRQ-20), which is indicative of having a mental disorder. A study of primary care attenders in Santiago, Chile found the prevalence of psychiatric morbidity to be 62% in women compared with 39% in men (WHO, 1997). Linzer et al. (1996); and Brown (1998) found women had a higher prevalence of most affective disorders and non affective psychosis and;
men had higher rates of substance use disorders and antisocial personality disorder. Lecrubier & Ustun (1998) report that women predominate in all three disorders—panic attacks, panic disorder and depressive disorder, and the combination of these disorders is linked to a higher rate of suicidality.

Explanations for the gender differences in mental disorders have been discussed in relation to different help-seeking behaviours of the sexes, biological differences, social causes and the different ways in which women and men acknowledge and deal with distress (Paykel, 1991). Blue et al, (1995) argue that while all these factors may contribute to higher rates of depression or psychological problems among women, social causes seem to be the most significant explanation. Women living in poor social and environmental circumstances with associated low education, low income and difficult family and marital relationships, are much more likely than other women to suffer from mental disorders. They conclude that the combined impact of gender and low socio-economic status are critical determinants of mental ill-health (Blue et al, 1995).

Studies in Indian population reveal the poor status of women’s mental health. The social hierarchy in Indian families results in neglect of Indian women's mental health needs. As Isaac and Kapur (1980) report, out of the 313 cases of common mental disorders, only 14 were reported by families. A study by Sandhya (1994) discusses the forced changes in life after widowhood which increases the mental distress of women. Sethi and Manchanda (1978) reported greater stress among female members in the completely joint families, as a result of the ‘conflict emanating from the desire to loosen the traditional family ties’. The traditional bio-medical approach to mental health ignores the impact of socio cultural environment of women. As Astbury (2002) points out, for too many women, experience of self-worth, competence, autonomy, economic independence, and physical, sexual, and emotional safety and security, so essential to good mental health, are systematically denied because they are women. Hence, a culturally sensitive counseling is very crucial for protecting the mental health of women.

An extreme, but common expression of gender inequality is sexual and domestic violence perpetrated against women. These forms of violence contribute to the high prevalence of mental disorders experienced by women. These are described in more detail in the following two sections.

### 3.3.2 Domestic Violence

The prevalence of violence against women (VAW) is alarmingly high (WHO, 1998). Results of WHO multi-country study on women’s health and domestic violence (WHO, 2005) indicated that quarter to more than one-half of women reported being physically abused by a current or previous partner. Women compared to men are at greatly increased risk of being assaulted by an intimate (Kessler, Sonnega, Bromet et al., 1995). Violence in the home tends to be repetitive and escalate in severity over time (AMA, 1992) and encapsulates all three features identified in social research on depression in women: humiliation, enforced inferior ranking and subordination, and blocked escape or entrapment.

Violence results in low self esteem and coping ability of women. It also increases their vulnerability for poor mental health and psychological disorders. Violence—physical, sexual and psychological— is related to high rates of depression and co-morbid psychopathology, including posttraumatic stress disorder (PTSD), dissociative disorders, phobias and substance use and suicidality (Roberts et al., 1998). The severity and duration of exposure to violence are highly predictive of the severity of mental health outcomes, even when other potentially significant factors have been statistically controlled.
in data analysis. This has been found in studies on the mental health impact of domestic violence (Campbell & Lewandowski, 1997; Roberts et al., 1998) and childhood sexual abuse (Mullen et al., 1993).

The prevalence of mental health problems among those who have been abused is alarmingly high. Three population-based surveys have examined the relationship between spouse abuse and mental health problems (Gelles & Harrop, 1989; Mullen, Romans-Clarkson, Walton & Herbison, 1988; and Ratner, 1993). It has been shown from these studies that women reporting a history of spouse abuse have significantly higher scores on measures of psychopathology. They are also more likely to be identified as having a major mental disorder than non-abused women, and there is a positive relationship between the frequency and the severity of abuse and mental health problems. Common mental health problems experienced by abused women include depression, anxiety, post-traumatic stress disorder, stress, insomnia and alcohol use disorders as well as a range of somatic and psychological complaints. Battered women are much more likely to require psychiatric treatment and are much more likely to attempt suicide than non-battered women.

Other cultural specific forms of domestic violence include dowry death and female infanticide. In India, dowry death is perpetrated when dowry-related demands are not fulfilled. The perpetrator is often the husband or the parents-in-law, and frequently females commit suicide (Heise et al, 1994; Desjarlais et al, 1995). Female infanticide is commonly practised in parts of Asia. A survey by Desjarlais et al (1995) indicated that over 50% of women in their sample in China had killed a baby daughter. Women are forced to carry out infanticide due to family pressure and desperate living circumstances, leaving them to deal with the burden of remorse and guilt.

Gender-based violence operates to exert control and superiority over women, further weakening their social position and voice. The fallouts are unemployment, reduced income, less power and autonomy, and lack of control over varied aspects of their lives. This limits their access to resources and services.

3.3.3 Sexual Violence

Sexual violence and sexual harassment affect the mental health of women in a major way. Women experience higher rates of sexual and physical victimization, and more comorbid anxiety, depression and medical illness than men (Brunette & Drake, 1998). Rape, forced prostitution, sexual abuse, sexual remarks and advances etc. leave a major impact on the mind of women. The secondary status of women and the way the society views women are reflected in the objectification of women that leads to many crimes against women.

Owing to the nature of their role, position and status in the society, women face a greater range of stressors in their life, putting them at more risk for their health and mental health. Attitudinal disparities in gender roles and expectations makes them more vulnerable to greater risk for mental health and psychological disorders. Physical and psychological violence against women has negative impact on women and leads to serious mental health consequences. It is denial of basic human rights for women. It is the women who become victims and suffer in a major way in any kind of socio economic political and cultural changes. Rape is widespread throughout the world and even more pronounced in countries going through societal disorganisation and political upheaval. In cases of war and conflicts, it is the girls and women who endure sexual violence.

Health professionals are crucial first responders to rape survivors, yet many receive little training with regard to attending to the mental health aspects of women in such
situation and providing psychological counseling to them. The whole system, including the health care workers, police, lawyers and judges need to be sensitive to the mental health of women who have faced sexual violence.

The trauma of sexual violence may lead to mental health consequences such as anxiety, guilt, fear, avoidance, sexual dysfunction, eating disorder, disturbed sleep etc. The severe mental health consequences include major depression, generalized anxiety disorder, post-traumatic stress disorder, obsessive compulsive disorders, suicidal tendency, and alcohol and drug use disorders. In some countries, women not only have to deal with the emotional and psychological impact of the rape act, but they must also have to contend with cultural beliefs that equate a woman’s worth with her virginity. Instead of providing support to victims of sexual abuse, they are forced to marry the rapist in order to avoid the stigma of individual and family dishonour. Many women turn to prostitution or suicide as a result of the stigma, and others are killed by family members (Heise, et al, 1994). Involuntary prostitution, in which women are transported to distant destinations and sold to bars or brothels, is a major problem. Trafficking for sex is a major issue. Women are exposed to severe physical, psychological and sexual abuse with little opportunity to escape.

Thus women are made victims of a crime which another person has committed. Unfortunately, this is only one such crime where the perpetrator is either considered leniently, not disclosed in the name of family honour, forgiven in the name of masculinity, or easily integrates into the society. Whereas the victim, the woman faces the burden of social stigma, dishonour, disrespect and blame. Instead of getting the much required family and social support, she is isolated on every count which affects her mental health negatively.

Sexual violence is also evident at a more subtle level in the day-to-day living conditions of many women in the under-developing and poor countries. Cultural norms and constraints bind women in their decision-making and leave them with little control over their sexuality. This puts them at great risk of acquiring sexually transmitted diseases (Desjarlais et al, 1995). Sexual harassment has acquired greater proportions in recent times and has become widespread occurring in public transport, on the road, educational institutions and workplaces.

Government and civil society organizations must come forward to tackle this growing menace of violence against women. It is of crucial importance to identify women who have suffered or are currently experiencing violent victimization. When the woman suffers it silently, it increases the severity of mental disorders and leads to higher rates of depression and post traumatic stress disorder. As Mazza & Dennerstein (1996) point out, violence-related mental health problems are poorly identified, victimization histories are not routinely taken and women are reluctant to disclose a history of violent victimization unless physicians ask about it directly. At the same time, violent victimization, especially severe childhood sexual abuse (CSA), significantly predicts admission as an inpatient to a psychiatric facility during adulthood.

Women constitute an equal and important half of our population and society. Hence their well-being and safety need to be given equal importance for the society to progress.

### 3.3.4 Substance Abuse

A recent report prepared by WHO (1993) documents issues related to women’s substance use. Although there are variations between countries, rates of substance abuse by women – particularly abuse of alcohol, tranquilizers and analgesics – are increasing around the world. However, despite increasing rates, services to assist women
are limited. In most countries substance abuse has been traditionally viewed as a problem of men, and as incompatible with a woman’s nature and role in society. Consequently this has led to considerable stigma for women who abuse substances. Even where services exist, they have been developed according to the needs of male substance abusers; women are reluctant to avail of such services not only because of the associated stigma but also due to the cost of treatment.

Support groups and self-help groups can help women deal with the problem. Family members, counsellors, friends and health care workers can provide the much needed care and support to meet the mental health needs of such women. Support resources for substance abusers are counsellor, family members, significant peers and school or treatment staff. Group therapy is an effective intervention method with abusers. It facilitates the process of recovery of addicts.

Sharing of experiences by the abusers shows them ways to empower each other. Self-help groups of abusers are more effective as they generate confidence and help in finding ways to deal with problems. Group therapy is an effective intervention method with abusers. It facilitates the process of recovery of addicts (Gonet, 1994).

<table>
<thead>
<tr>
<th>Self Assessment Questions 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) What are the common mental disorders faced by women?</td>
</tr>
<tr>
<td>2) Name the cultural specific forms of domestic violence.</td>
</tr>
</tbody>
</table>

3.4 PROMOTION OF WOMEN’S MENTAL HEALTH

Promotion of women’s mental health is very crucial to ensure effective contribution from one half of the human resource. As pointed out earlier, women play a multitude of roles that puts a lot of burden on them. The society also has lot of expectations from women who are bound by the socio cultural demands and responsibilities. Hence it is necessary to undertake appropriate intervention strategies to promote and improve the mental health of women.

According to WHO research, there are three main factors that are highly protective against the development of mood disorders, especially depression in women. These are:

- having sufficient autonomy to exercise some control in response to severe events.
- access to some material resources that allow the possibility of making choices in the face of severe events.
- psychological support from family, friends, or health providers is powerfully protective.

(Source: www.who.int/mental_health/prevention/genderwomen/en/)
World Health Organization (WHO-A Focus on Women, 1997) advocates the following things for the promotion of women’s mental health and protect them against violence:

- build evidence on the prevalence and causes of mental health problems in women as well as on the mediating and protective factors;
- promote the formulation and implementation of health policies that address women’s needs and concerns from childhood to old age;
- enhance the competence of primary health care providers to recognize and treat mental health consequences of domestic violence, sexual abuse, and acute and chronic stress in women;
- building the evidence base on the scope and types of intimate partner and sexual violence in different settings and supporting countries’ efforts to document and measure this violence and its consequences. This is central to understanding the magnitude and nature of the problem at a global level;
- strengthening research and research capacity to assess interventions to address partner violence;
- developing technical guidance for evidence-based intimate partner and sexual violence prevention and for strengthening the health sector responses to such violence;
- disseminating information and supporting national efforts to advance women’s rights and the prevention of and response to intimate partner and sexual violence against women; and
- collaborating with international agencies and organizations to reduce/eliminate intimate partner and sexual violence globally.

Gender sensitive services are essential in enhancing the status and offering of mental health care and service to women. It is important to understand the unique needs and requirements of women in relation to the different roles they play. Accordingly, services must be designed and rendered. This will help reduce the gender disparities in mental health diagnosis, care, access and treatment.

A three pronged approach can be adopted for the protection and promotion of women’s mental health such as prevention, treatment and rehabilitation. A comprehensive plan to improve women’s mental health requires action at a number of levels such as: the development of policies and legislation, interventions through population-based settings, ensuring that community services and supports are adequate and accessible, supporting and promoting grassroots activities, and utilizing media-based strategies to promote community awareness of the problem and the means available for its management. The following areas/ aspects can be outlined to address the issue of promotion of women’s mental health.

### 3.4.1 Policies and Legislation

A key area of action is the development and implementation of policies and legislation to overcome gender inequalities for women in health, education and employment and to recognize acts such as physical and sexual abuse as criminal offences. Even if legislation exists, but is not effective; strategies to determine the barriers to its implementation need to be explored and addressed. In some cases policies and legislation may need to be revised; in other cases, it may be necessary to increase community awareness. For example, in relation to violent crimes against women it is not sufficient simply to have legislation or a policy on paper – the criminal justice system, health care workers and
the community at large need to be aware of the policy. It may be noted here that sometimes the legal provisions have been misused to settle scores and take vengeance; thus turn into instruments of oppression rather than protection. However, far from being dejected, this should further underline the importance of having stringent laws, and their fair, objective and honest implementation.

Mental health of women need to be emphasized as a policy matter. It can be included in the District Mental Health Programme so that it can reach to a larger population of women and benefit their mental health.

A focus on gender in the mental health policy will lead to consideration of gender-specific risk factor reduction strategies, as well as gender sensitive services and equitable access to them. Gender-acquired risks are multiple and interconnected. Many arise from women’s greater exposure to poverty, discrimination and socioeconomic disadvantage. The concept of ‘meaningful assistance’ in mental health care needs to be promoted. Meaningful assistance implies a patient centred approach. Gender disparities in mental health will not be reduced until women’s own mental health concerns and life priorities are taken into account in programme design and implementation (Avotri & Walters, 1999).

### 3.4.2 Education and Training

Education and training can be crucial components in bringing in attitudinal and behavioural changes at the individual and societal level. Understanding the unique role played by women is important. Creating awareness about having appropriate attitude and interaction with women is crucial. Child rearing practices also need to take care of the patriarchal approach and develop an appropriate attitude about women. Suitable interventions targeting the social and physical environment can be carried out to facilitate women’s well-being.

Women themselves also need to be aware of the various legal provisions and facilities available for them, e.g., they need to know about the Domestic Violence Act, 2005. They also need to be aware of what constitutes sexual harassment, abuse and violence. Patriarchal value system may block their expression and action; however, women need to know about their rights and exercise it.

Awareness and training of health professionals, health workers and community workers at the grassroots level focusing on women’s mental health are necessary. Various women’s organizations, voluntary agencies and youth groups also need to be sensitized about the mental health needs of women in case of violence against women, abuse and disasters. Primary care setting, workplaces and the criminal justice system are some of the important settings to create awareness regarding the mental health problems experienced by women and ways to improve their mental health. Special groups within communities also require information, education and training in relation to women’s mental health. Roles and responsibilities of the primary health centre physicians, police, magistrates and lawyers etc. who are involved in cases of violence against women need to be clearly understood and any discriminatory attitude towards women need to be addressed. They can extend a positive and responsive service and ensure meeting the mental health needs of women in such situations.

### 3.4.3 Primary Health Care

Primary health care is an important setting in which one can inform both women and men on pertinent issues related to women’s mental health. Primary care is by definition the most accessible form of health care for the population. The primary care setting
Mental Health in Special Population

presents an opportunity to provide comprehensive and holistic care as also opportunities for carrying out prevention and health promotion activities. Providers are regarded as knowledgeable and credible sources of health information and, therefore, have great potential to influence behaviour in a way that furthers the mental health of women. The setting provides an opportunity to raise sensitive and confidential issues, and care providers can adopt a personalized approach to communicate information about mental health in general and about women’s mental health in particular.

Primary health care settings play an important role in the health care of the population. Detection and appropriate diagnosis of psychological disorders, and proper treatment and appropriate referral of it wherever required will contribute in a major way in meeting the mental health care needs of the people. All health care providers need to be better trained so that they are able to recognize and treat the common disorders and do appropriate referral. They need to be aware of the gender specific risk factors and need to be responsive to the psychological issues of women to be able to provide required counseling. Skill in trauma focused counselling is a priority for clinicians in all health sectors who encounter women (Acierno, Resnick and Kilpatrick, 1997).

Women and mental health can be an important agenda of District Mental Health Programme (under National Mental Health Programme). The Government of India has launched the National Mental Health Programme (NMHP) in 1982, keeping in view the heavy burden of mental illness in the community, and the absolute inadequacy of mental health care infrastructure in the country to deal with it. Aims of this programme are,

- prevention and treatment of mental and neurological disorders and their associated disabilities.
- use of mental health technology to improve general health services, and
- application of mental health principles in total national development to improve quality of life.

Primary care providers are critical in helping to recognize mental illnesses among women. Indeed, many individuals with mental illnesses can be diagnosed through primary care physicians and other general medical care providers. This will ensure timely care and treatment. However, as the data suggests, only 2 in every 5 people experiencing a mood, anxiety or substance use disorder report seeking assistance in the year of the onset of the disorder (WHO & ICPE, 2000). Hence, it is crucial that primary health care settings need to be emphasized in the mental health of people. This is particularly important for women, who are at higher risk for the common mental disorders. Women are also more likely than men to visit a primary care setting.

3.4.4 Workplaces

The workplace plays an important role in the mental health of a person. The environment at the workplace and the nature of interpersonal interactions at the workplace can exert a two-way influence. Thus, the workplace can affect the mental health of the person and also the mental well being of the person can affect the work output or productivity. Hence it is important to create a conducive atmosphere at the workplace that will promote and take care of the mental health of women. The workplace offers an opportunity to create awareness and sensitize the men folk also regarding the mental health concerns of women. Education and intervention programmes can be taken up to address mental health issues of women.

Workplace mental health interventions can reduce accessibility barriers, given that
programmes can be conducted during working hours or immediately preceding or following work. It also provides other advantages like the convenience of the workplace for employees to attend programmes, the opportunity to reach a large segment of the working population, the opportunity to make modifications to the physical environment, (e.g. the introduction of policies for alcohol and other drugs), the opportunity to provide structured programmes addressing health issues, and particularly the potential to influence groups – not just individuals – and the associated benefit of being able to alter social norms.

### 3.4.5 Community Action

Activities and programmes at the grassroots level can have a far reaching impact on influencing the conditions and factors influencing women’s mental health. Community-based approaches, facilities and support systems such as child care centres/creches, nursery schools, self-help groups etc. will provide the much needed support to women and reduce their burden and stress. The media can also be used to promote community awareness as well as promote positive and supportive attitude and behaviour in relation to women’s mental health performing the role of advocacy.

Since women can have easy access to community based health care services, improved facilities and gender sensitive counselling services by psychologists, social workers and health care workers will take care of the mental health of women to a great extent.

<table>
<thead>
<tr>
<th>Self Assessment Questions 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Why gender sensitive mental health services are essential?</td>
</tr>
<tr>
<td>.......................................................................................................................</td>
</tr>
<tr>
<td>.......................................................................................................................</td>
</tr>
<tr>
<td>.......................................................................................................................</td>
</tr>
<tr>
<td>.......................................................................................................................</td>
</tr>
<tr>
<td>2) What is NMHP?</td>
</tr>
<tr>
<td>.......................................................................................................................</td>
</tr>
<tr>
<td>.......................................................................................................................</td>
</tr>
<tr>
<td>.......................................................................................................................</td>
</tr>
<tr>
<td>.......................................................................................................................</td>
</tr>
</tbody>
</table>

### 3.5 LET US SUM UP

Women represent 48% of the Indian population and they are the pillar of the family. Yet, women’s mental health is a neglected area. Women not only have a higher risk of developing many psychiatric disorders, especially depression but their access to treatment is also undermined by their subordinate position in a patriarchal society. This Unit highlighted the mental health problems of women and the gender disparity in mental health problems and treatment access.

According to the 1998 World Health Report, “Women’s health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination (WHO, 1998: 6). In every country, gender development continues to lag behind human development (UNDP, 2000) or as an earlier Human Development Report (UNDP,
Mental Health in Special Population

1997) put it: ‘no society treats its women as well as its men’. Research is needed to understand the issues of mental health in women and the gender disparities pertaining to mental health problems. It may be noted that in spite of adverse situations and negative experiences in their life marked by violence and abuse, women also exhibit resilience and the capacity for good mental health.

Hence a comprehensive approach is required to understand the mental health of women and promote it for the benefit of the entire nation.

3.6 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) The gender specific risk factors for common mental disorders in women include gender based violence, low income, income inequality, care giving responsibility and low or subordinate social status in family and society.

2) Depression is predicted to be the second leading cause of global disease burden by 2020.

Self Assessment Questions 2

1) The common mental disorders faced by women include depression, anxiety disorder, somatisation disorder and post-traumatic stress disorder.

2) The cultural specific forms of domestic violence include dowry death and female infanticide.

Self Assessment Questions 3

1) Gender sensitive mental health services are essential because of the unique needs and requirements of women in relation to the different roles they play.

2) NMHP is National Mental Health Programme.

3.7 UNIT END QUESTIONS

1) Discuss the issue of domestic violence and its’ adverse impact on women’s mental health.

2) Explain the role of society in causing mental health problems in women and how society can play an instrumental role in promoting women’s mental health.

3) Gender has a significant influence on the mental health of women. Discuss.

4) Describe the importance of primary health care in meeting the mental health needs of women.

5) How can we make workplaces conducive to the promotion of women’s mental health?

3.8 REFERENCES


Avotri, J.Y. and V. Walters (1999). ‘You just look at our work and see if you have any freedom on earth’: Ghanaian women’s accounts of their work and health. Social Science & Medicine, 48: 1123-1133.

Blue, I., Ducci, M. E., Jaswal, A., Ludermir, B., & Harpham, T. (1995). The mental health of low income urban women: case studies from Bombay, India; Olinda, Brazil; and Santiago, Chile. In T. Harpham & I. Blue (Eds.), Urbanization and Mental Health in Developing Countries. Aldershot: Avebury.


3.9 SUGGESTED READINGS

UNIT 4 MARRIAGE AND MENTAL HEALTH

Structure

4.0 Introduction
4.1 Objectives
4.2 The Concept of Marriage
  4.2.1 Effect of Marriage on Mental Health
4.3 Issues in Marital Relationship affecting Mental Health
4.4 Mental Disorders and Marriage
  4.4.1 Marriage and Schizophrenia
  4.4.2 Marriage and Depression
  4.4.3 Marriage and Alcoholism
  4.4.4 Marriage and Suicide
  4.4.5 Marriage and Anxiety Disorder
4.5 Marriage, Mental Health and Legislation
4.6 Marriage Education and Marital Counselling
4.7 Let Us Sum Up
4.8 Answers to Self Assessment Questions
4.9 Unit End Questions
4.10 References
4.11 Suggested Readings

4.0 INTRODUCTION

Marriage occupies a central place in the life of individual as well as their families. This is especially true in the Indian system where the family starts planning for the marriage of their children and has a greater involvement and role in things related to marriage. It is considered as a big family function. It is coming together of two families which requires understanding and adjustment to each other.

In this Unit, you will learn about marriage playing a significant role in the mental health of the individual. You will also learn about the issues of mental health and mental disorders in the context of marriage. Finally, you will know about marriage and mental illness from legislation and legal viewpoint.

4.1 OBJECTIVES

After studying this Unit, you will be able to:

- explain the concept of marriage;
- learn the various issues in marital relationship affecting mental health;
- know mental disorders and marriage;
- Know about marriage, mental health and Indian legislation; and
- describe ways to address mental health problems in marriage.
4.2 THE CONCEPT OF MARRIAGE

Marriage is one of the most important events of one’s life. It affects the physical health, emotional and psychological well-being, and social status of the person. It not only serves to satisfy the fundamental biological need of sexual gratification through socially acceptable way but also helps the individual to achieve a higher level of personality maturation (Rao, Nambi & Chandrashekar, 2012). Marriage signals the start of Grihasthaashrama of the four ashramas spoken about in the Hindu Dharma Shastras. With marriage, the person starts the real family life. In the context of the Indian society, marriage is not just between two individuals, but also between two families and two cultures. The implications of marriage goes beyond the immediate couple to the families concerned and the community and the society at large. It affects the present, past and future generation also.

Marriage provides social sanction to a physical union between man and woman. It lays the foundation for building up of a family. Marriage is principally acknowledgement of interpersonal relationships usually intimate and sexual between two individuals. Marriage involves legal, social, libidinal, emotional, financial, spiritual, and religious obligations between the couple. It is a complex social institution that needs to be understood clearly and comprehensively so as to benefit from the warm secure and nurturing feeling that it offers rather than feeling trapped by it.

There are a variety of marital patterns such as i) monogamy, ii) bigamy, iii) polygamy, iv) stable marital arrangements/companionship, and v) same-sex marriage. In most cultures monogamy is prevalent, has the social sanction and is held as ideal. Same-sex marriage has been much talked about in recent times. Though many countries do not recognize the concept of same-sex marriage, some countries have legalized it. It may be noted here that same-sex relationship has been studied as an academic subject; and gay and lesbian psychiatry exists as one of the specialty sections of the American Psychiatric Association. In India, even though voices are being raised and people are coming forward in support of homosexuality and lesbianism, still it is being viewed negatively, considered taboo, and also an offence in many sections of the society.

Marriage is a social system influenced by the religious, cultural, community’s norms. In the context of globalization and modern day changes, marriage is also affected by the social changes and the marital laws. The contemporary marriages are more consensual in nature that emphasize the individuality compared to the conventional marriages that aimed at fulfilling one’s duty, procreation and sexual satisfaction. The approach and perception to marriage influences the marital relationship and adjustment of the couple.

4.2.1 Effect of Marriage on Mental Health

Marriage can have positive or negative effects on mental health of the couple depending on their perception and commitment to marriage. Usually marriage has mental health benefits on the couple in the early years as they perceive entering into a committed and happy relationship. However, it may also lead to feelings of anxiety and depression if they feel bogged down by the responsibilities and challenges of marriage. As they progress in this relationship, the extent of understanding and adjustment to each other and to both their families determine to a great extent their satisfaction and happiness. In the Indian context, marriages involve the role of a larger system. Hence it is more challenging, especially for the wife, to fulfill her duties as expected by our patriarchal society.

It has been observed (Bradford et al, 2007) that adults who marry experience higher levels of emotional well-being and less mental illness than do adults who are single or
divorced. Children whose parents don’t get and stay married have increased risk of mental illness that extends long into adulthood. Cohabitation does not typically appear to provide the same mental health benefits as marriage. Overall, research strongly supports the idea that marriage matters for men, women and children’s mental health and emotional well-being.

4.3 ISSUES IN MARITAL RELATIONSHIP AFFECTING MENTAL HEALTH

Marital relationship can be a bliss one. However, a lot of issues may crop up in this relationship between two individuals if they do not consciously focus on maintaining, nurturing and sustaining their relationship. These affect the mental health of the couple that undermine the quality of the marital relationship. Let us discuss about some of these issues below.

Interpersonal Relationship

An important interpersonal task in the marital relationship is to form a couple bond. This is crucial for a healthy marital relationship. With the changing of traditional values, and socio-cultural changes, it becomes very important for the couple to be aware of each other’s expectations and have effective communication. Low level of communication about expectations leads to resentment in the partner that the other person is not caring and understanding. Clear communication helps remove disagreements and misunderstanding. In the Indian context of marriage, it is not only the communication between the spouses, but it also involves communication between the wife and the husband’s family that also has an impact on the mental health of the couple.

Secondary Status of Women

The status of women in the family and society has always been seen as secondary. History reveals that, in most cultures, married women had very few rights of their own. They were considered the property of the husband who had the authority in the relationship. Women could not own or inherit property, or represent themselves legally. This lack of equality between the partners affects the quality of their life and prevents development of a harmonious relationship in the marriage. However, marriage has undergone gradual legal changes, and along with this there has been changes in perception and social mores. There has been focus on changing the status of women, recognizing their rights and respecting their individuality. Though there has been gradual changes in the society’s attitude towards women’s status; a majority of women still suffer inequalities in their marital relationship that affect their mental health negatively.

Sexual Relationship

Sexual fulfillment in marriage contributes a major role to the overall satisfaction in marital relationship. However, couples usually do not realize that such fulfillment has to be worked for and requires a great deal of tolerance, patience, mutual effort and understanding. They need to have realistic assessment of their own and their partner’s sexual interests and abilities, and accordingly adjust. Furthermore, every couple needs to have some basic factual knowledge about the sexual aspects of married life.

However, even though armed with information and knowledge about marriage and marital relationship, couples may experience much anxiety, stress and frustration. A host of factors may contribute towards this: one’s insecurities, myths and misconceptions, lack of knowledge and support, media and peer influence etc. In the context of political,
economic, and technological developments in our culture, the social roles of men and women are changing very fast. The traditional concepts of masculinity and femininity are increasingly being questioned, and this may become a source of marital conflict and affect the sexual relationship. Men trying to exercise their dominant status in the relationship and women resenting the male dominance may not open up to each other in a mutually satisfying way.

Another issue is the modern preoccupation with sexual “efficiency” and “performance” that hampers the development of a satisfying sexual relationship. This is further heightened by the misconceptions, myths and commercial propaganda. When two persons enter into wedlock, each has his/her individuality and they need some time to get to know and understand each other. Even though the couple knew each other beforehand, still the marital relationship brings with it different perceptions, responsibilities and dynamics. Husband and wife may also differ in the intensity of their sexual urges, and also the frequency and techniques of sexual intercourse. It is important to understand that all these are influenced by a combination of biological, social and cultural factors. Sometimes sexual relationship is also manipulated by the spouses to gain an upperhand in the relationship or to fulfill some vested interest. This leads to a strained marital relationship.

Couples may also face problems in their sexual relationship due to their inability to communicate clearly about their sexual wishes and feelings to each other because of fear, shyness, ridicule etc. So either they continue with the routine way or seek out extramarital affairs. The lack of trust and understanding in the sexual relationship affects the mental health of the partners.

Marriage partners may also have to make new sexual adjustments when they become parents. The roles of mother and father also pose new challenges of their own which if not handled properly may affect their marital relationship and consequently, their mental health.

**Duties and Responsibilities**

The traditional patriarchal society has the roles of men and women defined. However, with increasing opportunities for education, training and employment, women of today has developed into self-dependent and self-confident individuals. At the same time they are required to carry out their traditional duties also. In the event of a lack of understanding between the spouses, this can lead to difficulties in adjustment in marriages. There can be two types of marital adjustment such as ‘for adjustment’ and ‘we adjustment’. The former refers to adjustment for the family whereas the latter refers to adjustment of the couple to each other. In ‘for adjustment’, the couple spends time, energy and effort in rearing the family, whereas they try to understand each other in ‘we adjustment’.

The patriarchal conservative attitude prevents men sharing in household and child-rearing work. Rigidity in prescribed roles hampers the development of a smooth relationship. Hence role alterations and role complementarity depending on situational requirements and an attitude of understanding towards each other will enable the partners to maintain their mental health.

**Finance, Work and Retirement**

As the couples move together in their relationship, the finance and work obligations may create tension and stress in their relationship. In the present day world of ever increasing necessities and wants, financial issues can create a major strife between the couples. In addition to it, rearing children also affects their mental health especially in the lack of support system in case of the nuclear family system of present day society. As the couple gets older, retirement and health issues affect their marital relationship.
The increasing acceptance of divorce has dramatically altered the marriage situation. Perception of marriage as permanent is changing. Getting married and divorced without thinking genuinely and hardly about it has marked a dent on the institution of marriage, decreased its value and importance and threatened the structure of the family. Socio cultural factors exert greater pressure and stress on the woman in the event of separation and divorce. It increases the risk of mental illness. Women are more prone to depression whereas men take recourse to alcohol and substance abuse.

Thus various issues arise in the relationship between the married couple. However, it may be noted here that marital conflicts can be turned into opportunities for personal growth. Indeed, they can become a source of strength and contribute to a fuller, more meaningful life. It requires the couples to avoid rigidity, not taking each other for granted and really investing in the relationship by giving their time, effort and energy.

**Self Assessment Questions 1**

1) How does marriage affect mental health?

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

2) Mention any three issues in the marital relationship that may affect mental health of the couple.

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

3) How does rigidity in traditional roles of man and woman affect the marital relationship?

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

4.4 MENTAL DISORDERS AND MARRIAGE

As stated earlier in Section 4.2.1, marriage can have both positive as well as negative impact on one’s mental health. However, the likelihood of the demands of the marital relation increasing the stress level of the couple is more for vulnerable people, which may lead to the development of mental health problems. The interplay between marriage and mental health problems has been studied widely. Disturbance in marital relationship may lead to mental disorders. Further, mental disorders may also cause marital disharmony. A variety of factors may contribute to disturbances in marital relationship and create mental health problems and disorders. These may be extramarital affairs,
separation, divorce, illness of children, problems at work place, either spouse suffering from chronic physical illness or mental illness, financial problems, lack of support system etc. Again, susceptibility to psychiatric morbidity is more in case of vulnerable people.

Let us now see the relationship between marriage and certain mental disorders.

### 4.4.1 Marriage and Schizophrenia

Several studies have examined the relationship between marriage and schizophrenia that point out a low marital rate for schizophrenic patients, and also a lower rate in women than in men. Marital status has been significantly associated with first admission rates, age of onset, course and outcome of schizophrenia. In a 10-country study by WHO (Jablensky et. al., 1992) in which confounding factors such as age, pre-morbid personality traits, and family history were controlled, it was found that married men experienced a statistically significant delay (1-2 years) in the onset of psychotic symptoms compared with single men.

Patients with schizophrenia are more likely to remain single and unmarried than patients in other diagnostic groups. This is particularly true of male patients. The reason may be due to the fact that women tend to marry at younger age than men and are less likely to have experienced an initial psychotic episode. Further, patients with schizophrenia have less fertility and reproduction rates due to lack of interest in social relations, general apathy, loss of sex drive, and lack of opportunity for a sexual relationship due to hospitalization and institutionalization.

Marriage is considered as a one-time event in the life of most women in India. When they suffer from mental disorder such as schizophrenia, it has serious consequences for the life of women. They face hostility from family members, abandonment by the spouse, and rejection from the society. As Nambi (2005) points out, the social, psychological and cultural concomitance of being mentally ill and divorced/separated is particularly severe for the women in the Indian culture. In a study of women with schizophrenia and broken marriages, Thara et.al. (2003) found that the “stigma of being separated/divorced is often more acutely felt by families and patients than that of mental illness per se. Caregiver of these separated/divorced/deserted women suffer much more than the patients themselves with feelings of loss, guilt, frustration, grief, and disappointment.

Many relatives get the woman suffering from schizophrenia married in the mistaken belief that marriage will set it right. They do not disclose the mental illness for fear of rejection. However, in case of an early relapse after marriage, an atmosphere of mistrust and suspicion is created in the family of the spouse that augurs poorly for the outcome of the illness. On the other hand, a psychotic episode after childbirth or after several years of marriage is considered more favorably and does not always result in separation/divorce (Nambi, 2005).

Thara and Srinivasan (1997) found that marital outcome in Indian patients is good with no significant gender differences. The high marital rate (about 70% being married before the onset of the illness), presence of children, a shorter duration of illness at inclusion and the presence of auditory hallucinations at intake were all associated with a good marital outcome. Being unemployed, experiencing a drop in socioeconomic level and the presence of flat affect and self neglect were all associated with a poor marital outcome.

### 4.4.2 Marriage and Depression

Research regarding the role of marital status as a risk factor for depression show that married men have the lowest rate of depression as compared to separated or divorced...
men who tend to have the highest rate of major depression. While marriage confers protection against illness for men, it appears to be associated with higher rates of depression for women. Given the patriarchic nature of our society, women have lesser freedom in their marital relationship and feel oppressed and restricted, which may lead to depression. Marital disharmony, lack of close interpersonal relationships, separation and divorce may lead to major depressive disorders. Constant criticism, humiliation and betrayal creates unhappiness and dissatisfaction in the relationship and leads to mental health problems.

Marital status may both affect mental health and be affected by it. For instance, Bipolar I disorder is more common in divorced and single persons than among married persons. In particular, marriage may reduce depression, anxiety and other symptoms through its effects on social support and intimate connection.

The mental health benefits of marriage may be most pronounced in the early years of marriage and may diminish over time. Similarly, divorce and widowhood could cause a spike in depressive symptoms (which later moderate), as people must contend with upheaval and loss. Focusing on the periods immediately after these marital status changes may overstate the long-term impact of these transitions on depressive symptoms. Studies that estimate the effects of marriage on depressive symptoms have done so by either (1) examining the link between marital transitions and depression, or (2) using controls for baseline mental health and comparing the depressive symptoms of those in stable marital states. Although these techniques are imperfect, the results are highly suggestive of the effects of marriage. In particular, these studies consistently find that transitions into marriage are associated with reduction in depressive symptoms, while transitions out of marriage are associated with increase in them.

4.4.3 Marriage and Alcoholism

Marital relationship suffers severe setback in case of substance abuse and addiction. Alcoholism disrupts the marital life and disturbs the mental health of the spouse. It results in anxiety, depression, stress, abuse, domestic violence and social isolation. It also affects the mental health of the children, destroys the family life, depletes the economic resources and reduces the status within the community. It is mostly the women who suffer greatly and may cause them to even attempt suicide.

4.4.4 Marriage and Suicide

A variety of factors may lead to suicide. In the context of marital relationship, being separated/divorced, being alone and social isolation may cause suicide.

Suicide research in India shows that one-fourth of the persons committing suicide are unmarried and the suicide rate is highest in the first year of marriage. Marital and family problems, which constitute around 50%, need to be addressed in a serious manner. These problems, if ignored or neglected, escalate into major differences between the spouses and leads to conflicts in the family. The higher rate of married women committing suicide may probably be due to marital disharmony, dowry or ill-treatment by the in-laws.

4.4.5 Marriage and Anxiety Disorder

Batra and Gautam (1995) found a high prevalence of neurotic disorders among divorce-seeking couples. The neurotic problems are encountered either as antecedents or consequences of marital disharmony. Anxiety disorder affects the marital relationship and may lead to depression and substance abuse.
4.5 MARRIAGE, MENTAL HEALTH AND LEGISLATION

Mental disorders are a question of fact. It has to be proved in court. It is not a matter of interpretation. The law presumes that sanity and insanity have to be proved. The standard of proof is the preponderance of probabilities. It means that the probability of insanity should be more than the improbability of sanity. The court comes to a conclusion on the basis of not only medical evidence, but also other pieces of evidence. It will be of assistance to the court if the psychiatrist adds a description of the observable behavior in the report. The burden of proving the insanity of the respondent rests on the petitioner. It is the responsibility of the psychiatrist to keep the documents sound. A certificate given by the psychiatrist is only a statement of opinion, and it attains the status of evidence only when its author undergoes cross examination.

Marriage is tagged with lifelong responsibilities. Marriage laws are very important because they determine the validity of a marriage. These laws give husband/wife or his/her family control over a spouse’s affairs; when the spouse is incapacitated, establishes the second legal guardian of a parent’s child and relationship between the families of the spouses. There is close relation between mental health of a person and marriage (soundness and unsoundness).

**Mental Soundness** as described by The Special Marriage Act provides that neither party:

i) is incapable of giving a valid consent to it as a consequence of unsoundness of mind; or

ii) though capable of giving valid consent, has been suffering from mental disorder of such a kind or to such an extent as to be unfit for marriage and the procreation of children, or

iii) has had been subject to recurrent attacks of insanity.

The condition of mental soundness for marriage does not mean that the person to be married must possess a high intelligence quotient. It only requires that he should understand the special nature of the relationship that marriage creates.

**Mental Unsoundness** is described as,

i) the respondent has been incurably of unsound mind, or

ii) has been suffering continuously or intermittently from mental disorder of such a kind and to such an extent that the petitioner cannot reasonably be expected to live with the respondent.

The expression ‘incurably’ of unsound mind cannot be so widely interpreted as to cover feeble-minded persons or persons of dull intellect who understand the nature and consequences of the act and are therefore able to control them and their affairs, and their reaction in the normal way.

The expression of mental disorder means mental illness, arrested or incomplete development of the mind, psychopathic disorder or any other disorder or disability of mind and includes schizophrenia.

The expression ‘psychopathic disorder’ means a persistent disorder or disability of the mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct.
The present provisions of Section 4(b) are substituted by the Marriage Laws Amendment Act, 1976. The original provision was ‘neither party is an idiot or a lunatic’. According to the Marriage Laws (Amendment) Act, 1976, recurrent epilepsy was also a disqualification for marriage. Now that has been removed by the Marriage Laws (Amendment) Act (No. 39 of 1999) with effect from December 1999. In her compilation of 61 cases, Amita Dhanda (2000) found that schizophrenia forms nearly one-third of the diagnostic pattern of causes followed by mild mental disorder/insanity/unsoundness of mind.

The following Acts have a bearing on the legal aspects of marriage:

1) The Special Marriage Act, 1954
2) The Hindu Marriage Act, 1955 (amended eight times from 1956 to 2003)
3) The Dissolution of Muslim Marriage Act, 1939; the Muslim Women Protection of Rights on Divorce, 1986
4) The Parsi Marriage and Divorce Act, 1936 (amended in 1988)
5) The Christian Marriage Act, 1872
6) The Indian Divorce Act, 1869 (amended in 2001)
7) The Family Courts Act, 1984
8) Domestic violence Act, 2005

The matrimonial relief that one can seek includes: Decree for nullity, Restitution of conjugal rights, and Judicial separation.

According to Section 2(v) of the Dissolution of Marriage Act, one of the grounds for dissolution of marriage is impotence. The institution of suit should be applied for within one year for nullity and after one year for divorce. Impotency is classified under mental and behavioral disorders. Impotency means the incapacity to perform sexual intercourse which is full and natural. Refusal to have sex is different from impotence. Impotence is different from sterility. Based on impotence at the time of marriage as per Section 19(1) of the IDA and as per Section 30 of the Parsi Marriage Act, and as per Section 24(ii) of the Special Marriage Act and according to Section 12A of the Hindu Marriage Law, the marriage becomes null and void.

Domestic violence amounts to cruelty and causes mental agony to the sufferer. It is a serious human rights violence against women. According to 498 A of Indian Penal Code if Husband or the relative of the husband subject a woman to cruelty shall be punished with imprisonment which may extend to 3 years. It defines the expression “Domestic violence” to include actual abuse or threat of abuse that is physical, sexual, verbal, emotional or economic. Harassment by way of unlawful dowry demands to the woman or her relatives would also be covered under this definition. It provides for the rights of women to secure housing. It also provides for the right of a woman to reside in her matrimonial home or shared household, whether or not she has any title or rights in such home or household. This right is secured by a residence order, which is passed by the Magistrate.

Thus there are various legal provisions that aim at taking care of the interests of the couple involved in the marital relationship. However, it may be pointed out that laws are a reflection of people’s needs. They are framed with people’s needs, interests and welfare in mind. They make it easier for people to live with each other and try to ensure that
everyone gets fair treatment. However, social and moral behavior cannot be enforced through laws. If laws do not fit or take into account the changing needs and aspirations, people will tend to disregard them. This is why so many people choose to live together in the West instead of marrying, as marriage does not fit their situation. Perhaps it would be better to make marriage fit the people, rather than trying to make people fit the institution.

4.6 MARRIAGE EDUCATION AND MARITAL COUNSELING

Marriage occupies a central place in an individual's life, and has a major impact on their mental health. Hence it is crucial to find ways and means through various preventive and intervention strategies to make effective marital adjustment.

Education and counselling can be two important tools in this regard. Providing information and educating the couple about the meaning of marriage, significance of the marital relationship and the centrality of this relationship in their life will help the couple to get a clear understanding. Marriage education programs work to reduce strife, improve communication, increase parenting skills, increase stability, and enhance marital happiness (Fagan, Patterson & Rector, 2002). Various studies on marriage education programmes indicate that the average couple participating in marriage education programs improved their behavior and quality of relationship so that they were better off than the couples who did not participate in such programs. Significant gains were observed in communication skills, marital satisfaction, and other relationship qualities.

A longitudinal study (Markman et al, 1988, 1993) on a well-known marriage education programme found that, compared with couples without the training, participating couples maintained high levels of relationship satisfaction and sexual satisfaction and lower problem intensity three years after training; they also demonstrated significantly greater communication skills, less negative communication patterns, and greater conflict-management skills up to 12 years after instruction, and reported fewer instances of physical violence with their spouses three to five years after training. Moreover, when follow-up assessments were employed and evaluated, there was not much evidence of diminishing effects.

Pre-marital counselling also helps to dispel the anxieties and apprehensions related to marriage and building a new relationship. Any relationship requires time, energy and effort to initiate, develop and sustain it. The couple needs to understand the nuances of the marital relationship that is intimate and hence requires more sensitivity and responsibility to make it stronger and satisfying. Counselling aims at improving the relationship quality and make the marital bond a source of happiness in the individual's life.

Thus, marriage education services and counselling can help more couples form and sustain healthy marriages by improving the couples relationship, teaching emotion management, dealing with couples satisfaction issues, and solving communication problems.

However, we can note here that westernized model of dyadic therapy only for couples is too simplistic in Indian context. Since marriage in Indian context has more socio-cultural underpinnings, it is necessary to take into account the family also. Marital and family counselling and therapy also play a role in helping establish a satisfying marital relationship.
4.7 LET US SUM UP

In this Unit you learned about marriage and marital relationship in the context of mental health. Marriage has been found to contribute to mental health and well-being. The knowledge that one has a ready source of support contributes to mental health and emotional well-being. Marriage brings in a sense of commitment and increases married people’s sense of meaning and purpose in life, protecting against suicide, depression, and anxiety and encouraging healthy habits. Marriage also boosts children’s mental health by giving them access to the time, energy, and personal and economic resources of two parents. You also learned about mental disorders and how they affect marriage. Mental disorders such as schizophrenia, depression, anxiety disorders and substances abuse is more common in unmarried as compared to married people. Finally, laws related to marriage and the provisions with regard to mental health and marriage were described.

4.8 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Marriage can have a positive as well as negative influence on the mental health of the couple depending on their perception and commitment to marriage. As they progress in this relationship, the extent of understanding and adjustment to each other and to both their families determine to a great extent their satisfaction and happiness.

2) Expectations, ineffective communication and dissatisfaction in sexual relationship may affect the marital relationship and the mental health of the couple.

3) Rigidity in traditional roles of man and woman promotes the patriarchal conservative attitude that prevents men sharing in at household and child-rearing work. This hampers the development of a smooth relationship between the couple especially in the context of changing demands on women in the present society.
Self Assessment Questions 2

1) Mental Soundness as described by The Special Marriage Act provides that neither party:

i) is incapable of giving a valid consent to it as a consequence of unsoundness of mind; or

ii) though capable of giving valid consent, has been suffering from mental disorder of such a kind or to such an extent as to be unfit for marriage and the procreation of children, or

iii) has had been subject to recurrent attacks of insanity.

2) Pre-marital counseling helps to dispel the anxieties and apprehensions related to marriage and building a new relationship. It aims at improving the quality of marital relationship.

4.9 UNIT END QUESTIONS

- Discuss marriage as a social system.
- Describe the relationship of mental disorders and marriage.
- Discuss the importance of sexual relationship for marital happiness.
- Explain the relationship between marriage and soundness of mind.
- Discuss the relationship between marriage and substance abuse.
- Present an account of laws related with marriage and mental illness.
- Explain the behavioral approaches for improving marital relationship.

4.10 REFERENCES


4.11 SUGGESTED READINGS


MPC 053
Mental Health in Special Areas

Block 1: Mental Health in Special Population

Unit 1: Child and adolescent mental health
Unit 2: Old age and mental health
Unit 3: Women and mental health
Unit 4: Marriage and mental health

Block 2: Specific Issues on Mental Health

Unit 1: Deliberate self harm and suicide
Unit 2: Problems related to school
Unit 3: Problems related to sex
Unit 4: Problems related to work area

Block 3: Developmental Disorders

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

Block 4: Addictions

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