Chapter

1

Introduction

Definition, Psychiatry (and branches), Psychology, Psychopathology, Psychoanalysis, Psyche, Personality, Mental Health, Magnitude of Problems in India & World, Burden of Mental Illness, Normality, Mental Health Gap

Psychiatry is in one of the most interesting, exciting, creative, productive and developing phases of its long history. Stimulated by the rapid acquisition of new scientific knowledge, and pressurized by external factors requiring empirically documented objectification, the field is undergoing a significant transformation. but the hypocrisy of a few and the curiosity of others, has made this field also a victim of the fatal preposition "Divide and Rule" and has resulted in new fields such as biological psychiatry, social psychiatry, cultural psychiatry, industrial psychiatry etc. The urgency of the need to merge these tributaries into a single psychiatry is still not sufficiently recognized. Independent of the personal gains, contemporary medicine must recognize and deal with all the aetiopathogenic forces that affect an individual who has become ill. The psychiatric care must be multidisciplinary and interdisciplinary in its perspective.

Before proceeding to understand different mental illnesses, it is essential to know the meanings of various terms commonly used in psychiatry.

A. PSYCHIATRY

The medical speciality concerned with the study, diagnosis, treatment and prevention of mental abnormalities and disorders. The different branches in Psychiatry are : —

a. Child Psychiatry. The science of healing or curing disorders of the psyche in children (i.e. those below 12 years of age). So is the psychiatry concerned with Adolescents i.e. Adolescent Psychiatry.

b. Geriatric Psychiatry. The branch of psychiatry that deals with disorders of old age; it aims to maintain old persons independently in the community as long as possible and to provide long-term care when needed.

c. Community Psychiatry. The branch of psychiatry concerned with the provision and delivery of a coordinated program of mental health care to a specified population.

d. Asylum Psychiatry. The field of Psychiatry that deals with major mental disorders under treatment in institutions (a term coined by *Ernest Jones*).

e. Forensic Psychiatry. (Legal Psychiatry) Psychiatry in its legal aspects, including criminology, penology, commitment of the mentally ill, the psychiatric role in compensation cases, the problems of releasing information to the court, of expert testimony.

f. Social Psychiatry. In psychiatry, the stress laid on the environmental influences and the impact of the social group on the individual. The emphasis is on etiology, purposes of treatment and prevention.

g. Cultural Psychiatry. (Comparative psychiatry) The branch of psychiatry concerned with the influence of the culture

on the mental health of members of that culture. When the focus is on different cultures , the term transcultural psychiatry is used.

h. ***Industrial psychiatry.*** The branch of psychiatry that deals with the worker's adjustment to his job and with the effects of the business organization on its members.

i. ***Descriptive Psychiatry.*** It refers to any system of psychiatry that is based primarily on the study of symptoms and phenomena.

j. ***Dynamic Psychiatry.*** It is concerned with internal unconscious drives or energies that are presumed to determine behaviour.

k. ***Experimental psychiatry.*** It refers to the use of chemical agents in the development of a science of human behaviour, and particularly to research on the properties and pathways of action of the psychotomimetics.

l. ***Pastoral psychiatry***. The branch of psychiatry that relates to religion and particulary, to the integration of psychiatry and religion for the purpose of alleviating emotional ailments—the psychotherapeutic role that the clergyman must often play in his relations to his parishioners.

m. ***Infant Psychiatry.*** The branch of psychiatry concerned with the foetal behaviour, with emphasis on the direct observation of the effect of maternal behaviour (e.g. the effects of maternal sleep, movement, behaviour, drugs, enviormental influences) on foetus.

o. ***Political Psychiatry***. (Psychopolitics) The application of psychiatric knowledge or theory to the process of government (e.g. in shaping a policy).

B. PSYCHOLOGY

The science that deals with the mind and mental process—consciousness, sensation, ideation, memory etc.

a. ***Applied Psychology.*** Utilization of all knowledge available in the areas of psychology, sociology etc., in order to achieve effectiveness in any operation.

b. ***Clinical Psychology.*** Utilization of all knowledge available in the area of psychology for the diagnosis, treatment and prevention of mental illnesses.

c. ***Educational Psychology.*** The branch concerned with the derivation of psychological principles and methods that can be applied directly to problems of education.

d. ***Gestalt Psychology.*** A school of psychology that is concerned primarily with preceptual processes.

e. ***Individual Psychology.*** (a term by Alfred Adler) The assumption of the unity of the individual, an attempt that is made to obtain a picture of this unified personality regarded as a variant of individual life manifestations and forms of expression.

f. ***Rational Psychology.*** Any system of psychology in which a prior assumption (usually of a philosophical or theological nature) form the background into which any observed facts must be fit.

C. PSYCHODYNAMICS

It is the study of mental forces in action. The current usage of the term focuses on intrapsychic processes (rather that interpersonal relationship) and on the role of unconscious motivation in human behaviour.

D. PSYCHOPATHOLOGY

It is the study of significant causes and process responsible for the development of mental disorder, as well as to the various manifestations of these disorders.

E. PSYCHONALYSIS

The separation or resolution of the psyche into its constituent elements. Its different meanings are :

A procedure devised by Sigmund Freud, for investigating mental process by means of free association, dream interpretaion, and interpretation of resistance and transference manifestations.

A theory of psychology developed by Sigmund

Freud out of his clinical experience with hysterical patients.

A form of ***treatment*** developed by Sigmund Freud that utilizes for psychoanalytic procedure and is based on psychonalytic psychology.

F. PSYCHE

Greak word meaning ("The soul" The mind). In modern psychiatry, the psyche is regarded in its own way as an "organ" of the person which like other organs, possess its own form and function, its embryology, gross and microscopic anatomy, physiology and pathology.

G. MIND

It is the functional capacity of brain, (brain is an anatomical structure.) e.g. Intelligence, memory, thinking, emotion, orientation, behaviour, judgement, insight, attention, attitude etc. It is divided into 3 components—Cognition (Intellect), Conation (psychomotor activity) and Affect (emotional part). into—Ego, Id and Superego. (See chapter 2 for details).

H. PERSONALITY

The characteristic way in which person thinks, feels and behaves; the ingrained pattern of behaviour that each person evolves, both consciously and unconsciously as the style of lifeor way of being in adapting to the enviornment. The knowledge of personality helps in understanding the behaviour of normal persons, diagnosing the patient's illnesses, predicting the prognosis and rehabilitating the patients after recovery from illness.

I. PSYCHIATRIST

A medical graduate who has successfully undergone a post graduate training course (of 2 to 3 years) in psychiatry.

J. CLINICAL PSYCHOLOGIST

A graduate who has successfully undergone a postgraduate training course (of 2 years) in clinical psychology.

K. PSYCHOTHERAPIST

A person with special training in psychotherapy. (Medical graduation is not a must).

L. PSYCHOANALYST

A psychotherapist who is trained in the methods of psychoanalysis (usually of Freudian type). A psychiatric qualifiation is considered desirable but non-medical persons also practise psychoanalysis.

M. PSYCHIATRIC SOCIAL WORKER

A graduate in sociology who has successfully undergone a postgraduate training of 2 years in social case work. This consists of knowledge and experience in investigations of the social and cultural milieu of the patients and methods of correcting it whenever it is pathogenic.

N. PSYCHIATRIC NURSE

A nurse who has received special training in the care and management of psychiatric patients.

O. OCCUPATIONAL THERAPST

A graduate who is trained in observing and treating the patients through crafts and recreational activities.

P. MENTAL HEALTH

Psychological well-being or adequate adjustment, particulary as such adjustment conforms to the community accepted standards of behaviour. Some characteristics of mental health are given in Table 1.1.

WHO defines mental health as a state of well being in which every individual realizes his or her own potential, can cape with the normal stresses of life, work productively and fruitfully and is able to make a contribution to her or his community. Mental disorders are generally characterized by some combination of abnormal thoughts, emotions, behaviors and relationship with others.

Normality

WHO considers normality to a state of complete physical, mental and social wellbeing. Mental

Table 1.1. Important Characteristics of Mental Health

Reasonable independence	Ability to show friendliness and love.
Self-reliance	Ability to give and take.
Self-direction	Tolerance of others and of frustrations and emotions.
Ability to do a job.	Ability to contribute.
Ability to take responsibility and make needed efforts.	A sense of humor.
Reliability	A devotion beyond oneself.
Persistence	Ability to get along with others (capacity for intimacy).
Ability to find recreating, as in hobbies.	Cooperation
Satisfaction with sexual identity.	Optimism
Ability to work under authority, rules and difficulties.	Ability to function in both dependent and independent roles.
A sense of competition, collaboration, compromise, satisfaction and security.	

wellbeing presumes absence of mental disorder (A mental disorder as defined by DSM-1V-TR is a behavioral, or psychological or pattern associated with distress (eg. a painful symptom) or with a significantly, increased risk of suffering, death, pain, disability or an important loss of freedom. In addition, the syndrome or pattern must not be merely an expected and culturally sanctioned response to a particular event, such as the death of a loved one. Normality has also been defined as pattern of behavior or personality traits that conform to some standard of proper ways of behaving and being, George Mora defined normality in following contexts.

(i) *Autonormal:* person seen as normal by his or her own society, opposite is Autopathological

(ii) *Heteronormal:* person seen as normal by members of another society observing him or her, opposite is heteropathological.

From functional point of view, normality is described by Daniel Offier and Melvin Sabshir as health; Utopia, average and a process.

A mentally healthy person, while free of gross symptoms, and usually feeling well, is not always happy. The healthy adult may at times have some minor psychiatric symptoms. There are clinical implications of the concept of mental health i.e. in routine examination of patients.

Evaluation of patients who are apparently not mentally ill but who wish professinal help with personal problems.

Selection of treatment goals for psychiatric patients.

Vocational screening. e.g. in Armed forces etc.

Community mental health activities (e.g. in formulating "Mental Health Act", Mental Health Programme etc.)

The problems not attributable to a mental disorder i.e. diagnoses which may be used for persons without mental disease, are:

Marital Problems	Other specified family circumstances.
Other interpersonal problems	Academic problems.
Phase of life problems	Noncompliance with medical treatment

Other—uncomplicated bereavement, parent-child problems, antisocial behaviour, borderline intellectual functioning (usually I.Q. 70-80), malingering etc.

MAGNITUDE OF PROBLEMS IN INDIA
(See Table 1.2 , 1.3 and 1.4)

* Average prevalence of severe mental disorders is 10.6 weighted percent and prevalence of severe mental disorders is atleast 18-20/1000 population; about 3-5 times that number suffer from other forms of distressing and socio-economically incapacitating emotional disorder. (The average prevalence of severe mental disorder is 2 percent).

Table 1.2 Incidence Studies in India

Investigater	Centre	Location	Incidence (per 1000)
Nandi et al (1972)	West Bengal	R	17.6
Nandi et al (1972-73)	"	R	16

Table 1.3. Prevalence of Psychiatric Morbidity in General Population Studies

Investigator	Centre	Location	Prevalence/ (Per 1000)
Surya (1964)	Pondicherry	U	9.5
Sethi et al (1967)	Lucknow	U	72.7
Dube (1970)	Agra	M	18
Gopinath (1970)	Bangaluru	R	16.5
Elnagar et al (1971)	Hoogly	R	27
Sethi et al (1972)	Lucknow	R	39.4
Thacore (1973)	Lucknow	U	81.6
Kapur (1973)	Kota	R	370
Verghese et al (1973)	Vellore	U	66.5
Sethi et al ((1974)	Lucknow	U	67.0
Nandi et al (1975)	West Bengal	R	109
Shah et al (1980)	Ahmedabad	U	47.3
Bhide (1982)	Ootachamand	R	184
Mehta et al (1985)	Vellore	R	14.5
Sachdeva et al (1986)	Faridkot	R	22.12
Trivedi et al (1988)	Pondicherry	R	203.7
Verghese et al (1993)	Ernakulum	R	12.95
Premarajan et al (1993)	Pondicherry	U	99.4
Shaji et al (1995)	Ernakulum	R	14.57
Nandi et al (2000)	West Bengal	R	105.2
Sharma & Singh (2001)	Goa	M	60.2

R = Rural; U = Urban; M = Mixed

* 15-30% who visit general health services (such as a Medical OPD or a Private practioner or a primary health centre) have emotional problems appearing as physical symptoms.
* Average number of new cases of serious mental disorder (incidence) is about 35–40 per lac population.
* About 1-2% children suffer from learning and behaviour problems. Mental retardation is estimated at 0.5-1.0% of all children.
* Among elderly (above 60 years of age) prevalence rate of mental morbidity is about 37% population of aged (i.e. more than 5 million severely mentally ill). This is in comparison to U.K. where the rate is as high as 1 in 4. Geriatric depression is most frequent with a prevalance rate of 22% in men and 28% in women in aged 65 and above.
* Drug abuse surveys have reported the prevalence rate ranging from about 2-40% (Alcohol, tobaco, cannabis and opium are common).
* The common psychiatric illnesses encountered in a General Hospital Psychiatric Clinic are — Neuroses (Depressive neurosis followed by anxiety neurosis), Psychosomatic disorder (e.g. Peptic ulcer, Hypertensions, Tension Headaches etc), Functional Psychoses (MDP depresson, mania and schizophrenia) and Organic Psychoses (Usually delirium). The other disorder e.g.

Table 1.4. Prevalence Rates (per 1000) of Psychiatric Disorders in General Population Studies

Authors	Organic Disorders	Schizophrenia	Affective Disorders	Neuroses	Mental Retardation
Surya (1964)	2.2	1.5	—	5.0	0.7
Sethi et al (1967)	—	2.3/2.5	6.9/7.8	42.5/37.1	22.5/10.5
Gopinath (1970)	23.6	2.4	7.0	2.4	4.7
Dube (1970)	2.9	1.5	0.5	12.7	3.7
Elnagar et al (1971)	4.4	4.3	2.9	14.4	1.5
Sethi et al (1972)	—	1.1	1.5	10.4	25.3
Verghese (1973)	2.6	2.6	0.5	47.6	3.2
Thacore (1973)	2.7	1.9	1.5	71.4	3.7
Nandi et al (1975)	10.4	2.8	37.7	35.8	2.8
Shah et al (1980)	—	1.5	14.8	29.2	1.8
Mehta et al (1985)	7.9	1.9	0.5	—	3.2
Sachdeva et al (1988)	4.5	2.0	13.1	—	2.5
Trivedi et al (1988)	—	2.9	20.8	103	15.5
Premarajan et al (1993)	—	2.5	20.2	53	18.3
Verghese et al (1993)	1.8	2.9	1.8	1.2	2.3
Shaji et al (1995)	—	3.6	3.0	—	2.8

Adjustment disorder, Psychosexual disorders are also not uncommon.

* In a Child Guidance Clinic, the common mental illnesses include mental retardation, emotional and behaviour (conduct) problems, enuresis, hyperkinetic sydrome etc., in a Geriatric Clinic the common disorder are depression, dementia, paranoid disorders etc. (Table 1.5)
* In psychosexual clinics in India, the common problems encountered include 'Dhat syndrome', Premature ejaculation, Erectile impotence include Opiate dependence, Alcohol depen-dence, Polydrug abuse, Cannabis dependence etc.
* Manpower: In India, we have about 8,000–9,000 qualified psychiatrists, 1000 psychologists, 900–1000 psychiatric social workers and 2000 psychiatric nurses.

NATIONAL SURVEYS

The Ministry of Health & Family Welfare entrusted NIMHANS with planning and conducting survey. NMHS-1 conducted in 2015–2016 in 12 states. It provided valuable insights by estimating the burden of mental health problems and understand-ing health-care seeking patterns. Now preparations for NMHS-2 (a, b) are underway with goals to gather essential data for policy and programs, address emerging mental health concerns, and establish comprehensive mechanisms to tackle mental health issues nationwide.

NMHS-1 showed the overall weighted prevalence for any mental illness was 13.7%. Age group between 40 to 49 were predominently affected. Prevalence of substance abuse disorders was highest in 50–59 years (29.4%). There was no gender difference for psychotic disorders but male predominence was seen in alcohol use disorders (9.1% vs 0.5%) and for BPAD (0.6% vs 0.4%) and a female predominance for depressive disorders (3.0% vs 2.4%) and lifetime for neurotic and stress related disorders (F : 5.7%; M : 4.8%). Risk of suicide was 0.9% (high risk) and 0.7% (moderate risk). It was highest in 40–49 years and greater among females. Intellectual disability was 0.6% and epilepsy 0.3%. Mean amount spent for care was AUD (Rs. 2250), schizophrenia and other psychotic disorders (Rs. 1000); dipressive disorder (1500); neuroses (Rs. 1500) and epilepsy (Rs. 1500).

MAGNITUDE OF MENTAL HEALTH PROBLEMS IN WORLD

NIMH-Epidemiological catchment Area Study of US (1984) reported one month prevalence of 151/1000 and life time prevalence of 322/1000; One year incidence of 60/1000 population National Comorbidity Study of US (1994) reported 12 months prevalence as 277/1000 and life time prevalence of 487/1000 population. World Health Report (2001) estimated that nearly 45 crore are suffering from mental and behavioral disorders globally. The global prevalence of mental and behavioral disorders among adult population is estimated to be 10%.

Table 1.5. Prevalence of Psychiatric Morbidity in Child and Adolescent Population Studies

Investigator	Centre	Age Group	Location	Prevalence (Per 1000)
Sethi et al (1967)	Lucknow	0-10	U	94
Dube et al (1971)	Agra	5-14	M	11.7
Einagar et al (1972)	Hoogly	0-15	R	13
Sethi et al (1972)	Lucknow	0-10	R	81
Varghese et al (1974)	Vellore	4-12	U	81.7
Nandi et al (1975)	Kolkata	0-11	R	26
Hackett et al (1999)	Kerala	8-12	U	94
Srinath et al (2005)	Bangaluru	0-16	U	124
Anita et al (2007)	Rohtak	6-14	M	165

R = Rural; U = Urban; M = Mixed

BURDEN OF MENTAL ILLNESSES

It was estimated (1998) that DALY (Disability Adjusted Life years) according to mental illnesses are 22944 (x 1000) and share in total burden of disease is about 8.5% (second highest after cardiovascular disorders among non-communicable conditions). The population with serious disorders is expected to grow by that more if common mental disorders are included. According World Health Report (2001) mental and behavioral disorders contributed to four of ten leading causes of disability, with one in four families suffering the burden. Depression and alcohol use were the commonest disorders in a primary care setting, contributing to nearly 20% of case load. It is estimated that by 2020, 15% of DALY lost would be due to mental and behavioral disorders.

The cost of treating population with mental disorders (prevalence of 20 crore population x cost per month per patient of Rs. 500) is approximately Rs. 20,000 crores.

While 14% of the global burden of disease is attributed to mental and behavioral disorders, most of the people affected -75% in many low income countries - do not have access to the treatment they need. WHO Mental Health Gap Action Programme (MHGAP) aims at scaling up services for mental, neurological and substance use disorders for countries especially with low – and middle –income. The programme asserts proper care, psychological assistance and medications, (read in detail from www.who.int/mental_health/mhgap/en. The treatment gap for various disorder (WHO 2004) is

	Disorder	Treatment Gap
(A)	Schizophrenia (non-affective psychosis)	32.2%
(B)	Depression	56.3%
	Dythymia	56%
	Bipolar/disorder	50.2%
(C)	Panic disorder	55.9%
	GAD	57.5%
	OCD	57.3%
	Alcoholic abuse and dependence	78%

Disability due to Mental Illnesses

Four of the 10 leading causes of disability — major depression, bipolar disorders, schizophrenia and obsessive compulsive disorder — are mental illnesses. The high incidence of mental illness has a great impact on society. Depression alone causes employers to lose over 23 billion dollars each year due to decreased productivity and absenteeism of employees. The Global Burden of Disease Study, conducted by the WHO, assessed the burden of all diseases in units that measure lost years of healthy life due to premature death or disability (disability-adjusted life years, or DALYs). Over 15 percent of the total DALYs were due to mental illness. In 1996, USA spent more than 69 billion dollars for the direct treatment of mental illnesses. Indirect costs of mental illness due to lost productivity in the workplace schools or homes represented a 79 billion dollars for the US economy in 1990.

REVIEW QUESTION

1. Define Psychiatry and enumerate its different branches.
2. Define the terms—Psychology, Individual Psychology, Applied Psychology, Psychoanalysis, Mind and Personality.
3. Define Mental Health. Enumerate the important characteristics of mental health.
4. Define the magnitude of mental problems in India and what is the manpower available to deal with these problems?
5. Enumerate the common psychiatric illnesses seen in a General Hospital Psychiatric Unit. What are the problem seen in day to day practice which are not attributable to a mental disorder?
6. Enlist the basic differences between
   (a) Psychiatry and Psychology
   (b) Psychiatrist and Psychologist.
   (c) Psychotherapist and Psychiatrist
   (d) Gestalt and Individual Psychology.
   (e) Descriptive and Dynamic Psychiatry
   (f) Brain and Mind.
   (g) mhGAP
   (h) DALYs
   (i) Burden of mental illnesses