

Block

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CRISIS AND TRAUMA COUNSELLING AND FAMILY THERAPY

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BLOCK 4 CRISIS AND TRAUMA COUNSELLING AND FAMILY THERAPY

In the previous Blocks of this Course, various applications and interventions involved in working with children and adolescents, working with couples, and working with physical illness and self abuse were discussed. In this Block, “Crisis and Trauma Counselling and Family Therapy”, you will be introduced to various theoretical approaches and applications in dealing with crisis and trauma as a counsellor and family therapist. This Block consists of five Units.

Unit 15 is on “**Psychosocial Support in Disasters to Children and Adolescents**”. The Unit in the initial part explains the meaning of disaster, crisis and trauma. Further, the Unit explains at length various categories of traumatic experiences like community and school violence, domestic violence, medical trauma, etc. The Unit discusses the impact of disasters on children and adolescents. In the latter part of the Unit, various approaches which help to recover from disaster at different developmental levels have been discussed.

Unit 16 is “**Psychosocial Support in Disasters to Adults and Families**”, which mainly deals with support in crisis to adults and families. The Unit explains the disasters and crisis situations in adulthood and discusses various aspects of providing psychosocial support to adults and family. The Unit emphasizes on Disaster Management in the end.

Unit 17 is entitled “**Gender and Mental Health Problems**”. The Unit starts with gender influences in mental health problems and reasons for the same are explained. Gender biases and sexual harassment and abuse are dealt with at length in the Unit. Therapeutic interventions for harassment and abuse are discussed at the end of the Unit.

Unit 18 is on “**Geriatric Problems and Disorders**”. It focusses on common health problems in late life, with particular reference to mental health problems of older people. Various aspects of caregiver interventions and approaches to handling old age issues have also been discussed.

Unit 19 is “**Yoga Therapy, Mental Health and Well-Being**”. The Unit starts by explaining the meaning and definition of Yoga. It explains the concept of health and disease from the perspectives of both WHO and the Upanishads. The techniques of integrated approach of yoga therapy for well-being have been discussed at length. Precautions have been described. Various yoga therapy practices and *asanas* have been described alongwith the techniques and benefits of the same.

UNIT 15 PSYCHOSOCIAL SUPPORT IN DISASTERS TO CHILDREN AND ADOLESCENTS

Structure

- 15.1 Introduction
- 15.2 Meaning of Disaster
 - 15.2.1 Definition of Crisis
 - 15.2.2 Definition of Trauma
- 15.3 Categories of Traumatic Experience/Disaster
 - 15.3.1 Community and School Violence
 - 15.3.2 Complex Trauma
 - 15.3.3 Domestic Violence
 - 15.3.4 Early Childhood Trauma
 - 15.3.5 Medical Trauma
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 - 15.3.7 Neglect
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 - 15.3.10 Sexual Abuse
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- 15.4 Children and Adolescents and Their Response to Disaster
 - 15.4.1 Young Children
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- 15.5 Recovery from Disaster
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- 15.7 Advice for Parents/Caregivers
- 15.8 Let Us Sum Up
- 15.9 Glossary
- 15.10 Answers to Check Your Progress Exercises
- 15.11 Unit End Questions
- 15.12 Further Readings and References

15.1 INTRODUCTION

Our minds, our brains, and our bodies are set up to make sure that we make danger a priority. Things that are dangerous change over the course of childhood, adolescence, and adulthood. For very young children, swimming pools, electric outlets, poisons, and sharp objects are dangerous. For school-age children, walking to school, riding a bicycle in the street, or climbing to high places present new dangers. In adolescents, access to automobiles, weapons, drugs, and time on their own, especially at night, are new dimensions to danger. Dangers change depending on where children live and on their families' circumstances. Also, dangers change over with the history of societies and cultures.

As children and adolescents grow up, they continually learn about different types of dangers. While most families try to make their lives and that of their children safer, however, terrible things sometimes happen within and outside the family. They can happen suddenly without warning. Children may experience different traumas over the course of childhood and adolescence. Some traumas, such as child abuse or witnessing domestic violence, may happen repeatedly over a long period of time.

Objectives

After studying this Unit, you will be able to:

- Define the term 'disaster' which includes 'crisis' and 'trauma';
- Explain the different categories of traumatic experiences;
- Understand the response to disaster according to developmental level; and
- Explain the meaning of recovery from trauma or disaster and interventional ways for different age-groups of children.

15.2 MEANING OF DISASTER

15.2.1 Definition of Crisis

A *crisis* is an event or a series of events that is unforeseen, unpredictable, seemingly unmanageable, and potentially dangerous. A crisis is defined by the person who is experiencing the event. A crisis can include an element of threat that causes a person to fear for their safety or the safety of others. However, a crisis could also be a seemingly harmless event that the person or people involved do not have the skills or resources to deal with.

"People are in a state of crisis when they face an obstacle to important life goals — an obstacle that is, for a time, insurmountable by the use of customary methods of problem solving" (Caplan, 1961). "...an upset in equilibrium or the failure of one's traditional problem-solving approach which results in disorganization, hopelessness, sadness, confusion, and panic" (Lillibridge and Klukken, 1978). "...crisis is a perception or experience of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms" (James and Gilliland, 2001).

In order for any situation to be considered as a crisis the following must occur:

- The event or series of events must be considered stressful by the person or people involved.
- The person or people involved do not have the tools, strategies and resources to manage the situation in an effective way.

Anything can be a crisis, depending on the experiences, resources and abilities of the person involved. For instance, all of the following examples are potential crises:

- A child is late for school
- A child loses his house keys and is locked out of the house
- A child loses his best friend through change of school or death
- A child or adolescent witnesses a horrific car accident
- A child is physically abused or sexually abused

Losing a set of keys and being late for school may or may not be a crisis. It would probably depend on whether or not the child has a good attendance record at school, whether or not there are back-up neighbours available where the child can stay etc. If this is the only negative thing that has happened to the child, he or she would probably be able to cope with this event, find a way to solve the problem and move on with their day. On the other hand, if this is one negative event in a series of many others, the child or adolescent may need much more support to cope with the same problem.

15.2.2 Definition of Trauma

Trauma is the reaction to or result of being involved in some sort of crisis. *Physical trauma*, for instance, refers to when a person or people have physical injuries as the result of being involved in a critical incident such as an accident, fight, abusive incident, etc. Children or adolescents may be suffering from *psychological trauma* which is the result of experiencing extreme stress that overwhelms their ability to cope with the event. This extreme stress is generally in response to powerful and extreme crises (otherwise known as *traumatic events*) such as accidents, traumatic deaths, natural disasters, crimes, sexual or physical assault, witness to grotesque death or violence, and other violent events. Other types of crises that commonly result in psychological trauma are chronic or repetitive experiences such as child abuse, neglect, family violence, war trauma and torture. Generally, in order for a crisis to be traumatic (or to result in psychological trauma), it would involve threats to life or bodily integrity, or a close encounter with violence and death, and result in feelings of loss of control, powerlessness, helplessness, terror, and threat of annihilation.

The DSM-IV states that a traumatized person:

“Has experienced an event outside of the range of usual human experience that would be markedly distressing to almost anyone; a serious threat to his or her life or physical integrity; serious threat or harm to his/her children, spouse or other close relatives or friends; sudden destruction of the home or community; or seeing another person seriously injured or killed in an accident or by physical violence”.

Dangers can become “traumatic” when they threaten serious injury or death. Traumatic experiences also include physical or sexual violation of the body. The witnessing of violence, serious injury, or grotesque death can be equally traumatic. In traumatic situations, children experience immediate threat to themselves or to others, often followed by serious injury or harm. They feel terror, helplessness, or horror because of the extreme seriousness of what is happening and the failure of any way to protect against or reverse the harmful outcome. These powerful, distressing emotions go along with strong, even frightening physical reactions, such as rapid heartbeat, trembling, stomach ache, and a sense of being in a dream.

There are large-scale dangers like disasters, war, and terrorism that threaten large numbers of children and families all at the same time. There are dangers that are particular to a community or neighbourhood, like crime, school violence, or traffic accidents. And there are dangers that come from within the family through domestic violence and child abuse.

<p>Check Your Progress Exercise 1</p> <p><i>Note:</i> a) Read the following question carefully and answer in the space provided. b) Check your answer with that provided at the end of this Unit.</p> <p>1. What does disaster constitute?</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

15.3 CATEGORIES OF TRAUMATIC EXPERIENCE/DISASTER

Traumatic experiences fall into a number of categories. These have been explained in the following sub-sections.

15.3.1 Community and School Violence

Community violence includes predatory violence (for example, robbery) and violence that comes from personal conflicts between people who are not family members. It may include brutal acts such as shootings, rapes, stabbings, and beatings. Children may experience trauma as victims, witnesses, or perpetrators.

School violence includes fatal and non-fatal student or teacher victimization, threats to or injury of students, fights at school, and students carrying weapons to school, etc.

15.3.2 Complex Trauma

The term *complex trauma* describes the problem of children’s exposure to multiple or prolonged traumatic events and the impact of this exposure on their development. Typically, complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment—including psychological

maltreatment, neglect, physical and sexual abuse, and domestic violence—that is chronic, begins in early childhood, and occurs within the primary care giving system. Exposure to these initial traumatic experiences—and the resulting emotional dysregulation and the loss of safety, direction, and the ability to detect or respond to danger cues—often sets off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood.

15.3.3 Domestic Violence

Domestic violence sometimes called *intimate partner violence*, *domestic abuse*, or *battering*, includes actual or threatened physical or sexual violence or emotional abuse between adults in an intimate relationship. This clinical definition is broader than the legal definition, which may be restricted to acts of physical harm. Domestic violence can be directed toward a current or former spouse or partner. Studies suggest that the majority of children who are exposed to domestic violence are young; under the age of 8. Data regarding children and adolescents who are exposed to domestic violence is scarce due to strong taboos about discussing and acknowledging such experiences. But report of domestic violence is on rise now.

15.3.4 Early Childhood Trauma

Early childhood trauma generally refers to the traumatic experiences that occur to children aged 0-6. These traumas can be the result of intentional violence such as child physical or sexual abuse, or domestic violence, or the result of natural disaster, accidents, or war. Young children may also experience traumatic stress in response to painful medical procedures or the sudden loss of a parent/caregiver.

15.3.5 Medical Trauma

Paediatric medical traumatic stress refers to reactions that children and their families may have to pain, injury, and serious illness; or to “invasive” medical procedures (such as surgery) or treatments (such as burn care) that are sometimes frightening. Reactions can affect the mind as well as the body. For example, children and their families may become anxious, irritable, or on edge. They may have unwanted thoughts or nightmares about the illness, injury, or the hospital. Some people may avoid going to the doctor or the hospital, or lose interest in being with friends and family and in things they used to enjoy. As a result, they may not do well at school, work, or home. How children and families cope with these changes is related to their thoughts and feelings about the illness, injury, or the hospital; reactions can vary, even within the same family.

15.3.6 Natural Disasters

A *natural disaster* is any natural catastrophe (for example, tornadoes, hurricanes, and earthquakes) or any fire, flood, or explosion that causes enough damage that local, state, or government agencies and disaster relief organizations are called into action. Disasters can also result from a man-made event (such as a nuclear reactor explosion), but if the damage is caused intentionally, it is classified as an act of terrorism.

15.3.7 Neglect

Child neglect occurs when a parent or caregiver does not give a child the care she or he needs according to its age, even though that adult can afford to give that care or is offered help to give that care. *Neglect* can mean not giving food, clothing, and shelter. It can mean that a parent or caregiver is not providing a child with medical or mental health treatment or not giving prescribed medicines the child needs. Neglect can also mean neglecting the child's education. Keeping a child from school or from special education can be neglect. Neglect also includes exposing a child to dangerous environments. It can mean poor supervision for a child, including putting the child in the care of someone incapable of caring for children. It can also mean abandoning a child or expelling the child from home.

15.3.8 Physical Abuse

Physical abuse means causing or attempting to cause physical pain or injury. It can result from punching, beating, kicking, burning, or harming a child in other ways. Sometimes, an injury occurs when a punishment is not appropriate for a child's age or condition. Physical abuse can consist of a single act or several acts. In extreme cases, it can result in death.

15.3.9 Refugee and War Zone Trauma

Refugee and war zone trauma include exposure to war, political violence, or torture. Refugee trauma can be the result of living in a region affected by bombing, shooting, or looting, as well as forced displacement to a new home due to political reasons. Some young refugees have served as soldiers, guerrillas, or other combatants in their home states and their traumatic experiences may closely resemble those of soldiers.

15.3.10 Sexual Abuse

Child sexual abuse includes a wide range of sexual behaviours that take place between a child and an older person or alternatively between a child and another child/adolescent. Behaviours that are sexually abusive often involve bodily contact, such as touching, fondling of genitals, and intercourse. However, behaviours may be sexually abusive even if they do not involve contact, such as of genital exposure, verbal pressure for sex, and sexual exploitation for purposes of prostitution or pornography.

15.3.11 Traumatic Grief

Childhood traumatic grief may occur following the death of someone important to the child when the child perceives the experience as traumatic. The death may have been sudden and unexpected (e.g., through violence or an accident), or anticipated (e.g., illness or other natural causes).

The distinguishing feature of childhood traumatic grief is that the trauma symptoms interfere with the child's ability to go through the typical process of bereavement. The child experiences a combination of trauma and grief symptoms so severe that any thoughts or reminders, even happy ones, about the person who died can lead to frightening thoughts, images, and/or memories of how the person died.

15.4 CHILDREN AND ADOLESCENTS AND THEIR RESPONSE TO DISASTER

15.4.1 Young Children

Young children depend on the protection provided by adults and older siblings to judge the seriousness of danger and to ensure their safety and welfare. They often don't recognize a traumatic danger until it happens, for example, in a near drowning, attack by a dog, or accidental scalding. They can be the target of physical and sexual abuse by the very people they rely on for their safety. Young children can feel totally helpless and passive. They can cry for help or desperately wish for someone to intervene. They can feel deeply threatened by separation from parents or caretakers. They have the most difficulty with their intense physical and emotional reactions. They become really upset when they hear cries of distress from a parent or caretaker.

15.4.2 School Age Children

School age children start to face additional dangers, with more ability to judge the seriousness of a threat and to think about protective actions. They usually do not see themselves as able to counter a serious danger directly, but they imagine actions they wish they could take, like those of their comic book heroes. So, in traumatic situations when there is violence against family members, they can feel like failures for not having done something helpful. They may also feel very ashamed or guilty. They may be without their parents when something traumatic happens, either on their own or with friends at school or in the neighbourhood. Sexual molestation occurs at the highest rate among this age group. School age children get scared of the speeding up of their emotions and physical reactions, adding new fears to the danger from outside.

15.4.3 Adolescents

With the help of their friends, adolescents begin a shift toward more actively judging and addressing dangers on their own. This is a developing skill, and lots of things can go wrong along the way. With independence, adolescents can be in more situations that can turn from danger to trauma. They can be drivers or passengers in horrible car accidents, be victims of rape, dating violence and criminal assault, be present during school or community violence, and experience the loss of friends under traumatic circumstances. During traumatic situations, adolescents make decisions about whether and how to intervene, and about using violence to counter violence. They can feel guilty, sometimes thinking their actions made matters worse. Adolescents are learning to handle intense physical and emotional reactions in order to take action in the face of danger. They are also learning more about human motivation and intent and struggle over issues of irresponsibility, malevolence, and human accountability.

Children and adolescents react to natural disasters, which strike quickly and without warning such as earthquake, tsunami etc. with fear, but they are traumatic for children if they don't know what to do. When emergencies or disasters interrupt children's routine, children may become anxious. Limited understanding and the inability to articulate their feelings, puts very young children at a special disadvantage. In a disaster, they'll look to adults for help. How adults around them react to an emergency gives them clues on how to act. If adults react with

alarm, a child may become more scared. They see adult fear as proof that the danger is real. If parents, caregivers, teachers seem overwhelmed with a sense of loss, a child may feel their losses more strongly. Children's fears also may stem from their imagination.

After a disaster, children are most afraid that:

- The event will happen again.
- Someone they know will be injured or killed.
- They will be separated from the family.
- They will be left alone.

Children are as affected by disaster as adults, although they might react to it very differently. How they react to a crisis situation depends on how old they are and the nature of loss they have experienced. For example, young children may sometimes feel guilty and scared, have trouble falling asleep, may start to wet their bed after having been dry, cry a lot without reason and cling to their mothers.

Adolescents typically are going through an individuation phase of development. Their sense of "who they are" at this point in their lives may be tied to their possessions and friends. Having to change schools may be traumatic and telling friends that they are living in a temporary shelter, can be equally difficult. Adolescents can regress, become very angry and revengeful, and express their feelings by yelling and fighting or by indulging in alcohol and nicotine use and abuse. Some also respond by isolating themselves from parents and family members and withdrawing.

All these behaviour mentioned above are usual and common responses, established after a trauma. With time, through care by loved ones and the rebuilding process, these symptoms decrease and everyday functioning is resumed.

15.5 RECOVERING FROM DISASTER

15.5.1 Factors in Recovery from Trauma

How children or adolescents recover from trauma depends a lot on the different ways that their lives are changed by what happened. There may be a dramatic change because of the loss of a family member or friend during the traumatic situation. Dealing with both post-traumatic and grief reactions can make recovery much more difficult. A cascade of additional stresses and adversities often follow trauma and loss experiences. These can seriously reduce the emotional comfort and practical help that children and adolescents can get from their family, friends, school, or community.

Children are different in their temperaments, in their worries and fears, in their personal strengths, and in the ways they go about handling problems. These differences can influence recovery from trauma. For example, anxious children respond with more fear, may respond to trauma reminders with greater fears of recurrence, and have a lot more trouble calming down or being reassured. They may have more difficulty determining the danger of a later situation.

As children grow up, they learn from their experiences and form a picture of what the world is like. What is it that they learn from traumatic experiences?

They may learn positive things about how they conduct themselves in the midst of danger, of the heroic efforts of others to protect or rescue, and of the helpful support trauma survivors may receive afterwards. However, children may also take on “traumatic expectations”. Their view of the world, its safety and stability, help govern how they behave. Children and adolescents are forming a world view that is constantly changing. Trauma experiences can create the sense that things can go horribly wrong at a moment’s notice that no one can really provide protection, and that laws don’t really work. Adolescents can then think it is not worth working toward a better future or that it is better not to get close to others just to lose them in a tragic way.

Children and adolescents are building up confidence in the “social contract”, a trust that the rules of a family, community, or society are fair and look after the best interests and welfare of its members. After family violence, young children may learn that feelings of love can be betrayed through abuse. If abuse occurs in the larger community, they may conclude that children can be taken advantage of by adults in positions of authority.

15.5.2 Crisis Counselling

Recovering from a traumatic event takes time, and everyone heals at his or her own pace.

The behaviours/symptoms of trauma which need to be attended to more intensively are explained below. When symptoms such as those mentioned below are seen, crisis counselling needs to be given:

- Symptoms show no indications of decreasing i.e., the symptoms are ongoing and their intensity is more
- Symptoms increase in severity
- Symptoms become very distressing to the child or family
- Symptoms interfere with the sleep, appetite and daily routine of the child
- Symptoms interfere with social functioning of the child with friends, relatives and others
- Symptoms interrupt his/her attendance at school/work.

In order to heal from psychological and emotional trauma, children and adolescents must face and resolve the unbearable feelings and memories that have been long avoided.

Trauma treatment and healing involves:

- Processing trauma-related memories and feelings
- Discharging pent-up “fight-or-flight” energy
- Learning how to regulate strong emotions
- Building or rebuilding the ability to trust other people

Crisis Counselling is not long term and is usually not more than 1 to 3 months.

The focus is on single or recurrent problems that are overwhelming or traumatic. Crisis counselling provides education, guidance and support. Crisis counselling is not a substitute for children and adolescents who need and are not receiving intensive or long term psychiatric care. Crisis counselling may involve outreach, work within a community and is not limited to hospitals. There are universal “elements” in the process by which a crisis counsellor can help children/ adolescents face and move past distressing and traumatic events in their lives.

15.5.3 The Elements of Crisis Intervention

- a) *Education*: There is a natural ability within humans to recover from a crisis provided they have the support, guidance and resources they need. The very heart of crisis intervention is to face the impact of a crisis. In most cases, a crisis involves normal reactions, which are understandable, to an abnormal situation. An effective crisis counsellor provides information, activities and structure that will help the child to recover and move past the crisis. More importantly, crisis counselling will ensure that the victims do not prolong a crisis and create more problems in their life and the lives of others. Confrontation through information and discussion may be an important part of crisis intervention. For example, a counsellor on examination helpline, may work on ensuring that the adolescent who is feeling overwhelmed by the exam next day does not compound his problems by acting on the thoughts of running away from home.
- b) *Observation and awareness*: Increasing self-awareness and recognizing the impact of one’s own behaviour can lead to choices that promote recovery and wellness among children and adolescents undergoing trauma. In some cases, family dynamics and communication problems within families can prolong a crisis. E.g., on a suicide helpline a counsellor may work on helping a child or adolescent recognize that it is intense anger/ frustration towards the situation that is making the client feel like harming himself/ herself. The counsellor may suggest that while it may take longer to sort out the entire issue, the physical restlessness could be immediately addressed by slamming pillows around or going for a jog.
- c) *Discovering and using our potential*: Every crisis represents an opportunity for personal growth and to discover one’s highest potential and true self. While support is important, this does not mean that the child/ adolescent in crisis should not be allowed, encouraged and sometimes required to make decisions and take action to resolve the crisis and improve the quality of their life.
- d) *Understanding the problem*: While the intent of the child or adolescent may be to make life better, their behaviour can be misguided, misunderstood and less effective than they expect. Self-understanding as well as understanding how others may keep us “stuck” are important keys to recovery.
- e) *Creating necessary structure*: The most important aspect of crisis intervention and counselling is to provide a social “container” for the difficult experience so that children and adolescents can express, explore, examine and become active in ways that help ensure the crisis is not prolonged. It involves identifying necessary activities and routines in their

life during times of distress that provide comfort and support. These do not include alcohol, nicotine and other drugs.

- f) *Challenging irrational beliefs and unrealistic expectations:* Few people, during times of crisis, have the necessary skills to fully examine what they are thinking, what they assume and what they expect from their self and from others. Depending upon the maturity and developmental level, a crisis counsellor helps in examining the irrational thoughts, because they influence how the child or adolescent feels and responds.
- g) *Breaking vicious cycles:* Many crises are the result of vicious cycles. A painful crisis can lead a person to avoid and escape how they feel. Unhealthy escape and avoidance of emotional pain and distress may involve the use of drugs, alcohol, thrill seeking etc. Taking the role of a “victim” can cause others to rescue a person in crisis or lead to secondary gains. Vicious cycles start with behaviours that are intended to avoid or escape emotional pain, but ultimately these avoidance and escape behaviours create more problems or the same problem and can actually prolong a crisis. The counsellor will work with the identification of such cycles and helping the child or adolescent break them by substituting more healthy, positive and constructive behaviours.
- h) *Create temporary dependencies:* During a crisis, the child or adolescent may be encouraged to develop temporary healthy dependencies on others in the environment such as a teacher, other relatives or significant others to provide a sense a safety and continuity.

Every disaster situation has an agency that has been identified and charged with the responsibility. It is always important for counselling personnel's to be a part of an established and recognized crises intervention team when they repond to disasters.

15.6 SUGGESTED SUPPORT AND INTERVENTIONS BY DEVELOPMENTAL LEVEL

Some suggested strategies for providing support are given below. Some of the interventions are relevant to all providers of care for children, while others are more specifically targeted at parents. The interventions aim to enhance children's feelings of protection and security, sense of control, facilitate attachment to caregivers and peers, and increase a sense of belonging to a wider cultural community.

15.6.1 Pre-School Children (ages 0-5)

- Reassure and comfort the child
- Allow him to talk, but do not force him to talk
- Allow flexibility of rules—in school/at home
- Limit media exposure—not showing gory/shocking pictures which may be traumatic to them
- Encourage physical activity and games

- Encourage other activities for self expression and ventilation of feelings such as drawing/painting/ collage

15.6.2 Primary Age Children (ages 6-12)

- Give individual attention
- Encourage physical exercise
- Allow to ventilate, be patient with repetitive talk
- Do not interrupt/belittle their feelings
- Never force them to talk—be willing to wait for them to open up/be patient
- Give structured work schedules to follow
- Relax rules, but be firm that responsibilities need to be met with
- Encourage activity relevant to their community
- Encourage expressions—by storytelling, dramas, skits, drawing, painting, singing, etc.
- Teach drills such as a form of discipline; what to do in case of an emergency — in the form of physical/fire drills

15.6.3 Adolescents (ages 13-18)

- Spend time with them and explain to them what is happening
- Relax timing and rules but be firm that they need to complete their tasks
- Allow them to talk/ventilate
- Encourage group activity to avoid isolation
- Encourage group activity to express and share their feelings
- Explain clearly how alcohol and drugs as a method of coping can be unproductive and harmful
- Engage parents/family/caregivers in discussions for additional support.

Responsibilities, in brief, of a trained disaster management professional include:-

Integrate community with overall relief and rehabilitation activities

Strengthen local resources

Provide information

Enable people to help themselves

Establish support information centers

Involve other sectors and NGOs

Help bereaved families

Help the physically injured and their families

Help severely mentally disturbed persons

Help orphans/widows and others in special need

Debrief rescue workers

15.7 ADVICE FOR PARENTS/CAREGIVERS

The role of adults is extremely important in providing psychosocial support for children and adolescent survivors of a disaster. Some of the suggestions that can be made to them are given below. These are :-

- Model a healthy coping behaviour. Parents should follow regular time and routine as far as possible. Ensure that children also do the same and restart their schooling activities.
- Spend time with the children playing and sharing thoughts and feelings.
- Keep the family together. Suggest to the caregivers or parents that while they look for housing and assistance, they should try to keep the family together as much as possible and make children a part of what they are doing to get the family back on its feet. Children get anxious, and they'll worry that their parents won't return.
- Calmly and firmly explain the situation. As best as they can, tell children what they know about the disaster. Explain what will happen next. For example, say, "Tonight, we will all stay together in the shelter." Get down to the child's eye level and talk to them.
- Include children in recovery activities. Give children manageable chores that are their responsibility. This will help children feel they are part of the recovery. Having a task will help them understand that they have a role and responsibility too.
- Teach your child how to recognize danger signals. Make sure your child knows what warning systems (horns, sirens) sound like.
- Explain how to call for help. Teach your child how and when to call for help.
- Help your child memorize important family information. Children should memorize their family name and address.
- They should also know where to meet in case of an emergency. Some children may not be old enough to memorize the information. They could carry a small index card that lists emergency information.

With time, these physical and emotional reactions reduce. Help by a caring adult can assist the child/adolescent to get control of the anxiety and get back to normalcy. However, sometimes due to the intensity, severity and chronicity of the trauma some children and adolescents may develop post-traumatic reactions which may require more intensive therapy. There is no easy way to know when children need to be referred to a qualified professional for continued intervention. Below is a list of behaviours that could indicate just such a need:

- When the child verbalizes or indicates extreme anger, desire to hurt self or others, suicidal ideation/wishes, or past delinquent acts.
- Consistently expresses self in somber or self-deprecating terms.
- Repeated acting out aggressively or violently.

- Developmentally inappropriate behaviour — regression, precociousness, or repeated inappropriate sexual behaviour.
- Repeated isolation of self.
- Fire setting and other destructive acts.

The purpose of crisis counselling is to help the child or adolescent deal with a crisis. Chronic exposure to stress or trauma can lead to mental illness, so it is important that crisis counsellors have the skills and knowledge to help clients cope with current stressors and trauma. Crisis counselling is not intended to provide psychotherapy, but instead to offer short-term intervention to help children receive assistance, support, resources, and stabilization. Traumatic experiences can lead children and adolescents to be more compassionate, to work harder to make the world better and safer, and to do something valuable with their lives.

15.8 LET US SUM UP

The children/adolescents and their families can be affected by several crises which if left unattended can lead to emotional and psychological trauma. Disaster situations like the tsunami induce very severe anxiety and loss of control/comprehensibility in children/adolescents. Most of them show some changes in behaviour due to this excessive anxiety. The behaviour depends upon age, development and loss. Behavioural changes can be immediate or late; short or long lasting.

15.9 GLOSSARY

- Command** : The direction of members and resources of an organization in the performance of the organization's roles and responsibilities. Authority to command is established in legislation or by agreement and operates vertically within an organization.
- Communications** : Specifically, the means of communications, for example, roads, railways, telephone lines, radio, television, fax, and internet. Broadly, dissemination of disaster management messages using a variety of means to people and organizations at various stages of the disaster cycle.
- Comprehensive Approach** : The development of disaster arrangements to embrace the aspects of prevention, preparedness, response and recovery.
- Control** : Control is the overall direction of the activities in a given operation.
- Coordination** : The bringing together of organizations and resources in accordance with the requirements imposed by the threat or impact of the emergency.

- Coping** : Coping is the manner in which people and organizations act, using existing resources within a range of expectations of a situation to achieve various ends. Coping capabilities are a combination of all the strengths and resources that are useful in reducing the effects of disasters.
- Disaster** : An event, either man-made or natural, sudden or progressive, the impact of which is such that the affected community must respond through exceptional measures.
- Disaster Management** : There could not be a single organization solely responsible for all aspects of disaster management. The management task is to bring together, in an integrated organizational structure, the resources of many organizations that can take appropriate action in times of disasters.
- Disaster Plans** : An agreed set of arrangements for preventing, mitigating, preparing for, responding to and recovering from a disaster. A formal record of agreed disaster management roles, responsibilities, strategies, systems and arrangements.
- Disaster Risk Management** : A development approach to disaster management, this focuses on underlying conditions of the risks which lead to disaster occurrence. The objective is to increase capacities to effectively manage and reduce risks, thereby reducing the occurrence and magnitude of disasters.
- Disaster Support Plans** : Refers to those plans, which are designed to address specific hazards and are used in support of national disaster planning arrangements. Aircraft crashes are an example of such plans.
- Prevention** : Regulatory or physical measures to ensure that disasters are prevented or their effects mitigated.
- Public Awareness** : The process of informing the public as to the nature of the hazard and actions needed to save lives and property prior to and in the event of a disaster.
- Recovery** : The coordinated process of supporting disaster affected communities in reconstruction of the physical infrastructure and restoration of emotional, social, economic and physical well being.

- Relief** : The provision of immediate shelter, life support and human needs of persons affected by a disaster.
- Vulnerability** : A set of prevailing or consequential conditions composed of physical, socioeconomic and/or political factors that adversely affect the ability to respond to disasters. Vulnerabilities can be physical, social, or attitudinal and can be primary or secondary in nature. Strategies that lower vulnerability also reduce risk.

15.10 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Disasters by definition could vary greatly in extent of damage, victimization, and origin. Typically, disasters :-
 - affect several people or entire communities,
 - are unexpected or sudden,
 - have an element of danger,
 - cause injury or loss of human life, and
 - cause property damage or loss.

15.11 UNIT END QUESTIONS

1. Write a paragraph about why you would like to be trained in disaster management.
2. Describe use of crisis counselling in dealing with a trauma with the help of an example.

15.12 FURTHER READINGS AND REFERENCES

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The National Child traumatic stress network <http://www.nctsnet.org>

UNIT 16 PSYCHOSOCIAL SUPPORT IN DISASTERS TO ADULTS AND FAMILIES

Structure

- 16.1 Introduction
- 16.2 Concept and Meaning
- 16.3 Disaster/Crisis with Adults
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16.1 INTRODUCTION

Adults experience trauma in the form of catastrophic natural or life events, assault and rape, loss of a significant person, abusive relationships, POW experiences, occupational trauma from military / police work, violent crime, exposure to violence, and other severe stresses.

Trauma can produce Post Traumatic Stress Disorder (PTSD) in the survivor. Ongoing stress will produce PTSD in children later in life; adults generally only develop PTSD in response to specific traumatic events or a series of traumatic events. Symptoms of PTSD include hyper vigilance, free floating anxiety (dysphoria), hyper startle, hyper arousal (being “on guard” all the time), etc.

Objectives

After studying this Unit, you will be able to:-

- Explain the disaster or crisis with adults involving different stages of life and family;
- Understand psychosocial support with adults including essential elements and indicators; and
- Explain the psychosocial support with the family in terms of tasks of helping, training and disaster management.

16.2 CONCEPT AND MEANING

People naturally develop coping mechanisms when they have been traumatized. These are learned survival skills, which work to protect the psyche during and immediately following the trauma. Eventually these coping mechanisms work against healthy emotional functioning. An example is the inability to trust based on childhood abuse; this protects the child during the abusive episodes, but later severely compromises intimacy and adult relationships.

Symptoms of Trauma and PTSD include:

“The symptom profile of adults who were abused as children includes posttraumatic and dissociative disorders combined with depression, anxiety syndromes, and addictions. These symptoms include (1) recurrent depression; (2) anxiety, panic, and phobias; (3) anger and rage; (4) low self-esteem, and feeling damaged and/or worthless; (5) shame; (6) somatic pain syndromes (7) self-destructive thoughts and/or behaviour; (8) substance abuse; (9) eating disorders: bulimia, anorexia, and compulsive overeating; (10) relationship and intimacy difficulties; (11) sexual dysfunction, including addictions and avoidance; (12) time loss, memory gaps, and a sense of unreality; (13) flashbacks, intrusive thoughts and images of trauma; (14) hyper vigilance; (15) sleep disturbances: nightmares, insomnia, and sleepwalking; and (16) alternative states of consciousness or personalities.”

- Joan A. Turkus, M.D.

Trauma recovery deals with reworking the trauma based attachments to form healthier adult coping skills. Strangely, many trauma survivors unconsciously seek out people, activities, or engage in behaviours that “mirror” their original trauma. This is the mind’s way of attempting to rework the trauma based attachment. Trauma recovery attempts to bring these trauma based attachments into consciousness and learn new coping skills. “That was then, this is now – today I can take care of myself and make healthier choices.”

16.3 DISASTER /CRISIS WITH ADULTS

16.3.1 The Common Crisis of Early Adulthood

A) The Common Problems in Intimate Relationship

The early adulthood is the time of a crisis feeling and a feeling of tension between isolation and intimacy. The desire for heterosexual relationship, which is started from adolescence, touches the highest peak at the age of 20 to 35 usually. If that particularly desirable relationship is socially sanctioned; it helps to build

positive approach of life of two persons who love each other and want to get maturity of their love by the social recognition through marriage.

When both life partners' expectations and preferences are synchronous, the satisfaction comes in married life.

After getting married by love-affair or by negotiation, it is often observed one or both the couple does not maintain an unselfish, faithful and caring approach to other.

Sometimes it seems a serious problem in marital relationship like: Somebody creates unusual domination, which hurts self respect of the opposite one; makes partnership by untruthful means; causes a trauma for partner; physical incapacity to make happy conjugal life; polygamy or debauchery habits; mistrustfulness; indifference to give security and support; or over all when there is a scarcity to understand each other in each and every aspects in conjugal life causes hopelessness in married relationship.

The victim first tries to rule out the reason behind unnatural behaviour, next finds the way out or tries to cope with it, but when he/she has to suffer monotonously in the same sort of situation without any solution for long, the inner spirit wants freedom but due to social non-acceptance in maximum cases he/she has to accept the unhealthy environment to live and has to pretend having leading a happy marital relationship. That's why his/her inner spirit is deviated from healthy state, is failed to compensate any more.

B) Common Disturbances Coming from Working Field

If the potentiality of the person is higher and in comparison to that the quality of job he is doing is less valuable; if the earning is not satisfactory; working environment is not favourable; if the person has to go through various types of ill experiences in working field like deprivation, partiality, humiliation, is badly accused/is not involved, after giving sincere labor credit goes to other; boss is short tempered, hard to please in nature or complex minded; colleagues are non co-operative or fault finder; in business recurrent failures leads to hopelessness; creative persons when going through a sort of job where there is no scope of creativity or have not enough independency to do work in own way etc. are the common causes that produce frustration and immense dissatisfaction in working field.

Career Changing Tendency:

- When the person is nervous, there is often a tendency to change his/her occupation to get more satisfaction.
- Those who can fix their destiny, having self controlling power and risk taking tendencies; they can shift often for achieving the target in career.
- Situational factors like dissatisfaction in present job, painful events in personal life (divorce, maladjustment in family or the death of a loved one) may lead the individual to shift life's goal by changing the occupation.

16.3.2 Phases of Middle Adulthood

Generative stagnation is a two key term at this stage.

The middle adulthood is the time to concentrate to fulfill the basic needs to

maintain the familial status, concentration and care to family and children and performing job with much more responsibility in each and every sphere of various sectors of life. A new process of growth starts.

The person who has completed his/her early adulthood phase by close, stable and unselfish relationships or without facing much trouble; usually he/she is creative and is involved in preparing the next generation for life within the culture and they are generative and feel satisfaction in their career as well as in family life. But those who have failed to be generative or productive in this way, go through the stunting of personal growth or stagnation in life.

When a person suffers in Mid-life Crisis, the whole life becomes miserable by negative emotion of unhappiness and sadness. He tends to be confused. His/her unhealthy situation comes to own self in the form of big question – “Why with me?”, “What do I do now?”, “Where do I go from here?”, “Is it my fate for rest of the life?”, “How did I fail after making an honest effort?”

These are the common pains, which break the healthy harmony and surely this is the time for a turn over or a change in life for those unlucky persons to avoid the suffocative situation.

Crisis in Middle Adulthood: Age 45–65

Erikson stated that the primary psychosocial task of middle adulthood—ages 45 to 65—is to develop *generativity*, or the desire to expand one’s influence and commitment to family, society, and future generations. In other words, the middle adult is concerned with forming and guiding the next generation. The middle adult who fails to develop generativity experiences *stagnation*, or self-absorption, with its associated self-indulgence and invalidism.

Perhaps middle adulthood is best known for its infamous *midlife crisis*: a time of reevaluation that leads to questioning long-held beliefs and values. The midlife crisis may also result in a person divorcing his or her spouse, changing jobs, or moving from the city to the suburbs. Typically beginning in the early- or mid-40s, the crisis often occurs in response to a sense of mortality, as middle adults realize that their youth is limited and that they have not accomplished all of their desired goals in life. Of course, not everyone experiences stress or upset during middle age; instead they may simply undergo a *midlife transition*, or change, rather than the emotional upheaval of a midlife crisis. Other middle adults prefer to reframe their experience by thinking of themselves as being in the prime of their lives rather than in their declining years.

During the *male midlife crisis*, men may try to reassert their masculinity by engaging in more youthful male behaviours, such as dressing in trendy clothes, taking up activities like scuba diving, motorcycling, or skydiving.

During the *female midlife crisis*, women may try to reassert their femininity by dressing in youthful styles, having cosmetic surgery, or becoming more socially active. Some middle adult women try to look as young as their young adult children by dyeing their hair and wearing more youthful clothing. Such actions may be a response to feelings of isolation, loneliness, inferiority, uselessness, nonassertion, or unattractiveness.

Middle-aged men may experience a declining interest in sexuality during and following their male climacteric (male menopause). Fears of losing their sexual ability have led many men to leave their wives for younger women to prove to others (and to themselves) that they are still sexually capable and desirable. In contrast, middle-aged women may experience an increasing interest in sexuality,

which can cause problems in their primary relationship if their significant other loses interest in sexual activity. This leads some middle-aged women to have extramarital affairs, sometimes with younger sexual partners.

The field of life-span development seems to be moving away from a *normative-crisis model* to a *timing-of-events model* to explain such events as the midlife transition and the midlife crisis. The former model describes psychosocial tasks as occurring in a definite age-related sequence, while the latter describes tasks as occurring in response to particular life events and their timing. In other words, whereas the normative-crisis model defines the midlife transition as occurring exactly between ages 40 and 45, the timing-of-events model defines it as occurring when the person begins the process of questioning life desires, values, goals, and accomplishments.

16.3.3 Crisis of Late Adulthood

While the volume of research on the differential vulnerability of older people to disasters is limited, there is some evidence about how older people respond. Older people are particularly vulnerable to physical danger and injury. There is also evidence that frail older people who live alone or in long-term care settings are particularly vulnerable to emergencies due to their complex physical, social and psychological needs.

About 80% of older adults have at least one chronic condition that makes them more vulnerable than healthy people during a disaster or major incident. These conditions often stem from physical infirmity and injury, and they may have sequelae that are not direct consequences of the disaster. Chronic conditions, especially when they are combined with the physiological, sensory, and cognitive changes experienced as part of aging processes, often result in frail older adults having special needs during emergencies. Planning and coordination are essential to meet these needs. The features of services that help to prepare responders and practitioners to protect and assist older adults during a disaster include:

- enabling professionals from diverse fields to work and train together;
- ensuring that advocates for older adults participate in community-wide emergency preparedness; and
- using community mapping to identify the areas in which many older adults live.

The research shows that approaches that integrate humanitarian aid, welfare provision, and psychosocial and mental healthcare in which domestic, community and institutional interventions are brought together are more likely to be effective for older people than single approaches that are planned and delivered separately.

Older people are frequently involved in major incidents of all kinds. The kinds of services that they require are similar to those required by people of all ages. The psychosocial response services for older people should not be separated from those that are provided for adults of working age and children given the community and family orientation that is recommended. However, planners, commanders of responses to major incidents and practitioners should be aware of the increased vulnerability of older people to the direct and indirect psychosocial effects of catastrophes of all kinds and to the effects on them of their families' experiences. They should modify their plans accordingly.

16.4 DISASTER/CRISIS WITH FAMILY

Services for Families

- a. In the absence of effective services, the burden that falls on families and the risk factors that relate to them can be associated with worsening family and personal problems. Problems that are experienced by adults may also place children at greater risk of developing psychosocial problems. All services, including those in other parts of the caring system and in other agencies, should focus on the needs of children and younger people and their families.
- b. Specialist services with staff that are skilled in working with families should focus on providing intervention services for children, younger people and other family members. However, there may be only a limited number of practitioners who are able to perform competently these wider functions following a disaster or traumatic event.
- c. Interventions that have been found to assist people who have problems soon after a disaster or major incident include:
 - helping families to identify the cause of the stress;
 - limiting further exposure to the causes of stress; and
 - advising families about rest and maintaining their biological rhythms (for example going to sleep at the same time each night and eating at regular intervals).

16.5 PSYCHOSOCIAL SUPPORT TO ADULTS

It involves both listening and guiding. Survivors typically benefit from both talking about their disaster experiences and being assisted with problem-solving and referral to resources. The following section provides some grassroot level suggestions for workers.

16.5.1 Establishing Rapport

Survivors respond when workers offer caring eye contact, a calm presence, and are able to listen with their hearts. Rapport refers to the feelings of interest and understanding that develop when genuine concern is shown. Conveying respect and being nonjudgmental are necessary ingredients for building rapport.

16.5.2 Active Listening

Workers listen most effectively when they take in information through their ears, eyes, and “extrasensory radar” to better understand the survivor’s situation and needs. Some tips for listening are:

Allow silence – Silence gives the survivor time to reflect and become aware of feelings. Silence can prompt the survivor to elaborate. Simply “being with” the survivor and their experience is supportive.

Attend nonverbally – Eye contact, head nodding, caring facial expressions, and occasional “uh-huhs” let the survivor know that the worker is in tune with them.

Paraphrase – When the worker repeats portions of what the survivor has said, understanding, interest, and empathy are conveyed. Paraphrasing also checks for accuracy, clarifies misunderstandings, and lets the survivor know that he or she is being heard. Good lead-ins are: “So you are saying that” or “I have heard you say that”.

Reflect feelings – The worker may notice that the survivor’s tone of voice or nonverbal gestures suggests anger, sadness, or fear. Possible responses are, “You sound angry, scared etc., and does that fit for you?”. This helps the survivor identify and articulate his or her emotions.

Allow expression of emotions – Expressing intense emotions through tears or angry venting is an important part of healing; it often helps the survivor work through feelings so that he or she can better engage in constructive problem-solving. Workers should stay relaxed, breathe, and let the survivor know that it is OK to feel.

16.5.3 Some Do’s And Don’t’s

Do say:

These are normal reactions to a disaster.

It is understandable that you feel this way.

You are not going crazy.

It wasn’t your fault; you did the best you could.

Things may never be the same, but they will get better, and you will feel better.

Don’t say:

It could have been worse.

You can always get another pet/car/house.

It’s best if you just stay busy.

I know just how you feel.

You need to get on with your life.

16.5.4 Indicators Essential for Disaster Counselling

The human desire to try to fix the survivor’s painful situation or make the survivor feel better often underlies the preceding “Don’t say” list. However, as a result of receiving comments such as these, the survivor may feel discounted, not understood, or more alone. It is best when workers allow survivors their own experiences, feelings, and perspectives.

In mental health terms, a crisis refers not to a traumatic event or experience, but to how an individual responds to the situation. The events that trigger this crisis can run the gamut of life experience, from developmental hurdles (such as going through puberty) to natural disasters to the death of a loved one. Crisis counselling can help individuals deal with the crisis by offering assistance and support.

The roots of modern day crisis counselling date back to World War I and World War II. Prior to this time, soldiers who exhibited significant psychological reactions to the experiences they had at war were frequently seen as weak or

even disloyal. However, it soon became apparent that soldiers who were immediately offered treatment fared much better than their untreated counterparts.

16.5.5 Elements of Crisis/Disaster Counselling

Crisis counselling is intended to be quite brief, generally lasting for a period of no longer than a few weeks. It is important to note that crisis counselling is not psychotherapy. Crisis intervention is focussed on minimizing the stress of the event, providing emotional support and improving the individual's coping strategies in the here and now.

Like psychotherapy, crisis counselling involves assessment, planning and treatment, but the scope of it is generally much more specific. While psychotherapy focusses on a wide range of information and history, crisis assessment and treatment, crisis counsellor focusses on the client's immediate situation including factors such as safety and immediate needs.

While there are a number of different treatment models, there are a number of common elements consistent among the various theories of crisis counselling.

1. Assessing the Situation

The first element of crisis counselling involves assessing the client's current situation. This involves listening to the client, asking questions and determining what the individual needs to effectively cope with the crisis. During this time, the crisis counselling provider needs to define the problem while at the same time acting as a source of empathy, acceptance and support. It is also essential to ensure client safety, both physically and psychologically.

2. Education

People who are experiencing a crisis need information about their current condition and the steps they can take to minimize the damage. During crisis counselling, mental health workers often help the client understand that their reactions are normal, but temporary. While the situation may seem both dire and endless to the person experiencing the crisis, the goal is to help the client see that he or she will eventually return to normal functioning.

3. Offering Support

One of the most important elements of crisis counselling involves offering support, stabilization and resources. Active listening is critical, as well as offering unconditional acceptance and reassurance. Offering this kind of nonjudgmental support during a crisis can help to reduce stress and improve coping. During the crisis, it can be very beneficial for individuals to develop a brief dependency on supportive people. Unlike unhealthy dependencies, these relationships help the individual become stronger and more independent.

4. Developing Coping Skills

In addition to providing support, crisis counsellors also help clients develop coping skills to deal with the immediate crisis. This might involve helping the client explore different solutions to the problem, practicing stress reduction techniques and encouraging positive thinking. This process is not just about teaching these skills to the client, it is also about encouraging the client to make a commitment to continue utilizing these skills in the future.

16.6 PSYCHOSOCIAL SUPPORT FOR FAMILY

16.6.1 Four Tasks of Helping

- To accept the reality of the loss
- To work through the pain of grief
- To adjust to an environment in which the dead person is missing
- To relocate emotionally the deceased person and move on in life

16.6.2 Training

The training of the personnel/individual for crisis/disaster counselling with the family or group may be achieved through a three-step agenda:

- 1) By imparting essential counselling skills to voluntary agency personnel in order to facilitate them to provide psychosocial care.
- 2) Monitoring the care process through simple recording systems.
- 3) Implementing the psychosocial care programme and assessing its scope periodically.

The focus of the training is on:

- _ Ventilation
- _ Empathy
- _ Active Listening
- _ Social Support
- _ Externalisation of interest
- _ Value of relaxation
- _ Spirituality, and
- _ Referral techniques

16.6.3 Disaster Management

The lessons from the crisis and trauma intervention include preparedness for disasters, provision of psychosocial support and identification and management of psychological distress.

i) Building Community Mental Health Services

It is inevitable that when mental health services are inadequate, the response to additional demands made by any disaster will be poor. The long term planning of any disaster management must include strengthening of existing mental health services, which should be based in the community rather than in psychiatric hospitals. The key components of community mental health care, apart from offering support and treatment, must include public education and reduction of stigma towards psychiatric disorder. Therefore, public education and stigma reduction must involve teachers and community leaders, e.g. religious leaders, who can then respond rapidly in the time of disasters. Teaching psychological distress in schools and colleges provides a long term investment which will be worthwhile in the long run.

The community level workers form the core of the identification and screening of psychological distress and can be used to provide psychological first aid and culturally appropriate and acceptable interventions. In addition, their knowledge of the local set up, families and kinships is likely to be invaluable in planning medium to long term interventions.

ii) Coordination

Perhaps the most important component of managing disasters is by a clear chain of command, where it is clearly defined as to who has what responsibility, and what sources can be accessed at that level. There will be good will from around the globe and donations which must be spent in a coordinated manner. Although various NGOs will have a considerable amount of experience in dealing with distress and disaster, their knowledge of the local culture, language and customs may not be sufficient to deliver services as required. One way of coordinating, especially in a state, is by getting one ministry, be it Health Ministry or Social Welfare, to take the lead. In large geographical areas, the command structure can be divided into districts where district coordinators can take the lead and deal with resources – as was done in Tamil Nadu.

Coordination does not end with the initial phase. In the intermediate and long term, this coordination becomes more important to allocate the resources which meet the needs of the individuals and families affected by the disaster. Within this role, training becomes of crucial importance to build capacity so that preparedness for future disasters is in place. Joint responsibilities need to be discussed and put in place. Training needs to be organised according to previous experience. Especially vulnerable groups must be identified and a process of tracking may be required.

iii) Long Term Mental Health Plan

The initiatives launched in different states need to be consolidated with adequate resources and funding. These plans must include teaching and training for reducing stigma towards psychological distress. As the community itself is the front line staff for providing services within the first 12 hours, it is crucial that these resources and their resilience are built upon. Long term mental health plans must be a priority at both central and local levels. Long term rehabilitation must be encouraged.

iv) Strategic Alliances

From within the community to outside, from social and psychological components through national and international stakeholders, alliances must be formed with clear lines of communication, coordination and chain of command. Donor agencies must form a key part of the alliances.

v) Evaluation

It is only appropriate that evaluation of any intervention is conducted thoroughly and adequately. The response at every level and in every phase must be evaluated. The strengths and weaknesses of each intervention must be transparent so that lessons can be learnt across nations for preparedness and delivery of services for future disasters. It is crucial to have structures for assessments and evaluation so that not only lessons are learnt for future events but also for resource allocation and training purposes.

Check Your Progress Exercise 1

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

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

1. Factors that influence the impact of any particular traumatic event upon an individual include:
 - a) Prior history of mental illness
 - b) Prior history of traumatic experiences
 - c) Level of social support and connection
 - d) Past-year exposure to non-traumatic significant life events
 - e) All of the above
2. Assessment of stress reactions a week or more after a traumatic event usually proves more useful in identifying individuals who are at risk of enduring distress than assessment in the initial days following a traumatic event.
 - a) True
 - b) False

16.7 LET US SUM UP

Natural disasters including earthquakes, floods, cyclones and hurricanes and human-caused disasters like terrorism, racial conflicts and war are striking with frightening regularity in various parts of the world causing large scale death and destructions. Studies and research has revealed that disaster survivors bear a substantial burden of mental health problems. Increased alcohol and substance abuse is a well documented co-morbid factor accompanying post-traumatic stress disorders and other psychological disorders.

Reliable data on the magnitude of psychosocial distress in the community are an essential part of an evidence-based response to any disaster. These data have three main functions:

- i. Providing evidence-based culturally appropriate response based on their needs and magnitude of the distress
- ii. Providing evidence for the impact of psychosocial relief efforts
- iii. Providing quantitative basis for appropriate allocation of resources at the correct level

Appropriate valid instruments in appropriate languages should be available as a part of disaster preparedness plans.

A clear plan should be in place to determine which instruments for assessment of psychosocial distress will be used, when and by whom.

Validated questionnaires (quantitative) for needs assessment and mental health status of the affected population should be readily available to all stakeholders and be clear as to who the depository for such information is and who will distribute and collect these.

16.8 GLOSSARY

- Coping capacity** : The manner in which people and organisations use existing resources to achieve various beneficial ends during unusual, abnormal and adverse conditions of a disaster phenomenon or process.
- Disaster risk management** : The systematic management of administrative decisions, organisation, operational skills and abilities to implement policies, strategies and coping capacities of the society or individuals to lessen the impacts of natural and related environmental and technological hazards.
- Disaster risk reduction** : The systematic development and application of policies, strategies and practices to minimise vulnerabilities, hazards and the unfolding of disaster impacts throughout a society, in the broad context of sustainable development.
- Empowerment** : A process in which individuals learn by their own actions to become fully engaged in shaping their development potential. The process is necessarily self-led, but benefits from facilitation by supporting actors.
- Human vulnerability** : A human condition or process resulting from physical, social, economic and environmental factors, which determine the likelihood and scale of damage from the impact of a given hazard.
- Resilience** : The capacity of a system, community or society to resist or to change in order that it may obtain an acceptable level in functioning and structure. This is determined by the degree to which the social system is capable of organising itself, and the ability to increase its capacity for learning and adaptation, including the capacity to recover from a disaster.
- Risk** : The probability of harmful consequences, or expected loss of lives, people injured, property, livelihoods, economic activity disrupted (or environment damaged) resulting from interactions between natural or human induced hazards and vulnerable conditions. Risk is conventionally expressed by the equation: Risk = Hazard x Vulnerability.
- Sustainable development** : Development that meets the needs of the present without compromising the ability of future generations to meet their own needs. It contains within it two key concepts: the concept of 'needs',

in particular the essential needs of the world's poor, to which overriding priority should be given; and the idea of limitations imposed by the state of technology and social organisation on the environment's ability to meet present and future needs.

16.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. (e)
2. (a)

16.10 UNIT END QUESTIONS

1. Give four examples of facing a crisis recently by people in your region.
2. As a counsellor, how would you provide psychosocial support to the family facing crisis and trauma.

16.11 FURTHER READINGS AND REFERENCES

[Http://Www.crisiscounseling.com/Handouts](http://Www.crisiscounseling.com/Handouts)

<Http://Www.theravive.com/services/trauma-counselling.htm>

<http://www.similima.com/org59.html>

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World Health Organization (2006). Resources For Psychosocial Support In Disaster Management. India

UNIT 17 GENDER AND MENTAL HEALTH

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- 17.12.3 Cognitive Behavioural Family Therapy
- 17.12.4 Ecological Approaches to Treatment
- 17.12.5 Trauma-Focused Cognitive Behavioural Therapy
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- 17.12.7 Play Therapy
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- 17.12.9 Yoga Therapy

17.13 Let Us Sum Up

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17.15 Answers to Check Your Progress Exercises

17.16 Unit End Questions

17.17 Further Readings and References

17.1 INTRODUCTION

Harassment and abuse or maltreatment are common terms these days. It could be physical abuse, verbal abuse, psychological abuse, sexual abuse, or neglect.

A four year old girl Y was sexually molested by her thirteen year old brother X. X was an outgoing lovable boy. A fourteen year old girl M was having sexual relations with a boy sixteen years old N. M and N got interested in X and started molesting X when he was only eight years old.

Radha, a fifteen year old girl, was beaten regularly by her stepmother. Her stepmother would find some pretext to verbally abuse her and beat her with 'dammini' (wooden stick).

Manas, a twelve year old boy, one day on return from the farms, was stopped by a group of three older boys and was asked to remove his clothes. On refusal, Manas was first beaten and then his clothes were ripped off. Then suddenly village Sarpanch passing by stopped on hearing shouts for help. On seeing the Sarpanch the older boys ran away.

A forty year old woman, Zahira lived separately from her husband. She had two children. Zahira was working as a school teacher. When the principal of the school came to know that Zahira lived separately from her husband, he started making advances towards her. He would on pretext

of work, make her stay late at evenings, ask to check question papers and class notebooks of students by sitting in front of him.

Shoahen got recently married to a boy working as a clerk in a government office. Her parents gave her dowry of items they could afford. Suddenly after a few months of marriage, Shoahen's husband asked her to bring air-conditioner from her father. Shoahen's father gifted her one air-conditioner. Then after some time her husband asked her to bring five lakh rupees from her father as he wanted to start a business. At this time her father could not give her money which led to a misery story for Shoahen at her husband's behest.

Annie was married to Josel for seven years now. They had twin sons, 6 years of age, both going to school. After children joined preschool Annie resumed work. Both Annie and Josel were Information Technology (IT) professionals working in different multi-national companies. Annie started noticing that from last six months, Josel seemed to be absorbed in something else. Earlier she thought he was working hard in the company and putting late night hours for work. Then suddenly one day in market she saw Josel standing very close to one female about the same age group as them. She enquired this from Josel who got annoyed at Annie saying you don't trust me. He also refused to answer any question. Annie felt very guilty about her behaviour. After some time one of her office colleagues informed her that her husband was seen with another woman in a nearby hotel in close proximity. To this narration also Josel again abused her and told her she does not trust him. But, now Annie got confused and stayed upset most of the time.

Mrs. and Mr. Khambana are senior citizens living in a city. They have three sons all married living in their house. None of their sons listen to them, spend time with them, take them to doctor, care for them or bother about them. Daughters-in-law give them food rarely. The old woman is being forced to cook for themselves for most of the times. The old couple has to look after themselves by themselves only.

Above are few of the incidents which portray harassment and abuse across generations, genders, age, region and religion. Harassment and abuse are universal in nature, and have a detrimental impact on the physical as well as mental health of the individual.

Even as a lay person if one looks around, one finds that in a large proportion of cases, the victims of harassment and abuse are female. Needless to say, the intensity and/or duration of abuse does contribute to mental health issues and problems.

In the present day Indian society, there is a significant number of people clinically diagnosed as having defined mental disorders. This segment, however, represents only the tip of the ice-berg. There are millions of others who could benefit from the services of mental health professionals, but never reach them, even though they are suffering from mental health problems or are at risk of being affected by the same, due to their difficult life circumstances. Sufferance of abuse and harassment constitutes a significant risk factor.

After studying this Unit, you will be able to:

- Appreciate the gender biases in mental health problems;
- Explain the biological and social vulnerability, gender roles and gender-based violence;
- Outline different types of abuse;
- Delineate the sexual harassment and abuse problems;
- Explain the role of counsellor/family therapist in dealing with harassment and abuse; and
- Understand the prevention strategies of harassment and abuse.

17.2 GENDER AND MENTAL HEALTH – FOUNDATIONAL ASPECTS

Mental health problems are among the most important contributors to the global burden of disease and disability.

Gender is a critical determinant of mental health and mental illness. The morbidity associated with mental illness has received substantially more attention than the gender specific determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity.

Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks.

Gender differences occur particularly in the rates of common mental disorders – depression, anxiety and somatic complaints. These disorders, in which women predominate, affect approximately 1 in 3 people in the community and constitute a serious public health problem.

Research shows that socially constructed differences between women and men in roles and responsibilities, status and power, interact with biological differences between the sexes to contribute to differences in the nature of mental health problems suffered, help seeking behaviour of those affected and responses of the health sector and society as a whole. However, it is important to remember, when reviewing available evidence in this regard, that there are major gaps. More is known about differences between males and females in some mental health problems such as depression and schizophrenia than others; about adult men and women than about adolescents and children; and about the situation in industrialised countries than in the developing world.

Although there do not appear to be sex differences in the overall prevalence of mental and behavioural disorders, there are significant differences in the patterns and symptoms of the disorders. These differences vary across age groups. In childhood, most studies report a higher prevalence of conduct

disorders, for example of aggressive and antisocial behaviours, among boys than in girls.

During adolescence, girls have a much higher prevalence of depression and eating disorders, and engage more in suicidal ideation and suicide attempts than boys. Boys experience more problems with anger, engage in high-risk behaviours and commit suicide more frequently than girls. In general, adolescent girls are more prone to symptoms that are directed inwardly, while adolescent boys are more prone to act out. In adulthood, the prevalence of depression and anxiety is much higher in women, while substance use disorders and antisocial behaviours are higher in men. In the case of severe mental disorders such as schizophrenia and bipolar depression, there are no consistent sex differences in prevalence, but men typically have an earlier onset of schizophrenia, while women are more likely to exhibit serious forms of bipolar depression.

In older age groups, although the incidence rates for Alzheimer's disease – a degenerative disease of the brain which usually occurs after 65 years of age – is reported to be the same for women and men, women's longer life expectancy means that there are more women than men living with the condition. With the exception of China and parts of India, the rate of death by suicide is higher for men than women in almost all parts of the world. Again, although men die by suicide more frequently than women do, suicide attempts are reported to be consistently more common among women than men.

17.3 UNDERLYING FACTORS

17.3.1 The Interaction Between Biological and Social Vulnerability

Genetic and biological factors play some role in the higher prevalence of depressive and anxiety disorders among women. Mood swings related to hormonal changes as a part of the menstrual cycle are documented by some studies.

In the case of antenatal and postnatal depression, the interaction of psychosocial factors with hormonal factors appears to result in an elevated risk. For example, marital disharmony, inadequate social support and poor financial situation are associated with an increased risk of postnatal depression. Women may also experience considerable psychological distress and disorders associated with reproductive health conditions and problems.

Women may also experience considerable psychological distress and disorders associated with reproductive health conditions and problems. Infertility and hysterectomy have been found by some studies to increase women's risk of affective/neurotic syndromes. In contrast to the vast literature on women's reproductive biology and mental health, especially from industrialized countries, there is little research on the contribution of men's reproductive functioning to their mental health, from either developing or industrialized countries.

17.3.2 Gender Roles

A large number of studies provide strong evidence that gender based differences contribute significantly to the higher prevalence of depression and anxiety

disorders in girls and women when compared to boys and men. For example, the lower self esteem of adolescent girls when compared to boys in the same age group, and their anxiety over their body-image is known to result in a higher prevalence of depression and of eating disorders in adolescent girls when compared to adolescent boys. The feeling of a lack of autonomy and control over one's life is known to be associated with depression. Socially determined gender norms, roles and responsibilities place women, far more frequently than men, in situations where they have little control over important decisions concerning their lives.

Studies from industrialised countries have reported that the frequent exposure of low-income women to uncontrollable life events such as illness and death of children or of husbands, imprisonment, job insecurity, dangerous neighbourhoods and hazardous workplaces places them at a significantly higher risk of depression than men. The same problems in men may be associated with abuse of alcohol or other drugs, and violence.

A study from China suggests that the distress caused to women by factors such as arranged marriages, unwanted abortions, in-law problems and an enforced nurturing role precipitates psychological disorders. On the other hand, the socialisation of men to not express their emotions and to be dependent on women for many aspects of domestic life may contribute to high levels of distress among them when faced with situations such as bereavement. Many studies from the US and UK report that a greater proportion of widowers experienced mental and physical health problems than did widows, although both women and men were vulnerable to illnesses and ailments on losing a spouse.

17.3.3 Gender Based Violence

Data, although fragmentary, indicate strong associations between gender based violence and mental health. Depression, anxiety and stress-related syndromes, dependence on psychotropic medications and substance use and suicide are mental health problems associated with violence in women's lives.

Social research indicates that depression in women is triggered by situations that are characterized by humiliation and entrapment. There is also evidence about the chronic nature of much gender based violence and its direct link to increased rates of depression. The prevalence of violence against women is alarmingly high (WHO, 1998). Further, violence in the home tends to be repetitive and escalate in severity over time. Females in the home may have to suffer from violence at the hands of the spouse/partner as well as other family members

17.4 GENDER BIASES

17.4.1 Meaning of Gender Biases

Gender bias occurs in the treatment of psychological disorders. Doctors are more likely to diagnose depression in women compared with men, even when they have similar scores on standardized measures of depression or present with identical symptoms.

Female gender is a significant predictor of being prescribed mood altering psychotropic drugs. Gender differences exist in patterns of help seeking for psychological disorder. Women are more likely to seek help from and disclose mental health problems to their primary health care physician while men are more likely to seek specialist mental health care and are the principal users of inpatient care. Men are more likely than women to disclose problems with alcohol use to their health care provider. Gender stereotypes regarding proneness to emotional problems in women and alcohol problems in men appear to reinforce social stigma and constrain help seeking along stereotypical lines. They are a barrier to the accurate identification and treatment of psychological disorder. Despite these differences, most women and men experiencing emotional distress and /or psychological disorder are neither identified nor treated by their doctor. Violence related mental health problems are also poorly identified. Women are reluctant to disclose a history of violent victimization unless physicians ask about it directly. The complexity of violence related health outcomes increases when victimization is undetected and results in high and costly rates of utilization of the health and mental health care system.

17.4.2 Women's Mental Health: Some Facts

- Depressive disorders account for a greater proportion of the disability from neuropsychiatric disorders among women compared to men.
- Leading mental health problems of the elderly are depression, organic brain syndromes and dementias. A majority are women.
- More than three-fourths of people affected by violent conflicts, civil wars, disasters, and displacement are women and children.
- There is a high lifetime prevalence rate of violence against women including sexual violence.

Depression, anxiety, psychological distress, sexual violence, domestic violence and escalating rates of substance use affect women to a greater extent than men across different countries and different settings. 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.

Almost 1 in 5 individuals attending primary health care in developing countries suffer from anxiety and/or depressive disorders. In most centres, these patients are not recognized and therefore not treated. Communication between health workers and women patients is extremely authoritarian in many countries, making a woman's disclosure of psychological and emotional distress difficult, and often stigmatized. When women dare to disclose their problems, many health workers tend to have gender biases which lead them to either over-treat or under-treat women.

Research shows that there are 3 main factors which are highly protective against the development of mental problems especially depression. 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.

17.4.3 Management of Gender Biases

To promote mental health, across genders, it is important to focus on the following:

- Gender sensitive health promotion
- Meeting the needs of individuals, carers and families to better understand personal mental health issues
- Increasing mental health literacy
- Improving health professionals' knowledge on the relationship between gender and mental health
- Creating an inventory of good practice and disseminating knowledge about the same
- Adopting a gendered approach in the context of research and health policy in the future
- Taking into account the perceptions, beliefs and attitudes of males and females across lifecycle
- Promoting and strengthening the comparability and compatibility of gender-specific information on mental health through the development of appropriate data
- Identifying that mental health is produced socially
- Recognising that the presence -absence of mental health is a social indicator and requires social and individual solutions

17.5 SOCIOPSYCHOLOGICAL PERSPECTIVES ON GENDER DIFFERENCES IN MENTAL HEALTH

A gender approach to health means to distinguish biological and social factors while exploring their interactions, and to be sensitive to how gender inequality affects health outcomes. A gender approach to mental health provides guidance to the identification of appropriate responses from the mental healthcare system, as well as from public policy, decisions and treatment of these problems in under-reported groups, and also increases potential for greater public participation in health. Gender differences in mental disorders extend beyond differences in the rates of various disorders or their differential time of onset or course and include

a number of factors that can affect risk or susceptibility, diagnosis, treatment and adjustment to mental disorder, as well as rehabilitative aspects.

Effective strategies for mental disorders prevention and risk factors' reduction cannot be gender neutral, while the risks themselves are gender specific. Gender-based differences may emanate from a biomedical (genetic, hormonal, anatomical, physiological); psychosocial (personality, coping, symptom reporting); epidemiological (population-based risk factors); or even a more global perspective.

Traditional gender roles define masculinity as having power and being in control in emotional situations, in the workplace, and in sexual relationships. Acceptable male behaviours include competitiveness, independence, assertiveness, ambition, confidence, toughness, anger and even violence (to varying degrees). Males are expected to avoid such characteristics associated with femininity as emotional expressiveness, vulnerability (weakness, helplessness, insecurity, worry), and intimacy (especially showing affection to other males).

Traditional femininity is defined as being nurturing, supportive, and assigning high priority to one's relationships. Women are expected to be emotionally expressive, dependent, passive, cooperative, warm, and accepting of subordinate status in marriage and employment. Competitiveness, assertiveness, anger, and violence are viewed as unfeminine and are not generally tolerated as acceptable female behaviour.

Women are often expected to perform a number of roles at the same time: wife, mother, homemaker, employee, or caregiver to an elderly parent. Meeting the demands of so many roles simultaneously leads to stressful situations in which choices must be prioritized. Additional sources of stress common to women include victimization, assertiveness, and physical unattractiveness. Victimization is a constant concern due to the power differential between men and women. Assertiveness may be stressful for women who have had little experience in competitive situations. Physical unattractiveness may cause some women who adhere to unrealistic standards of feminine beauty to experience shame, or place them at risk for developing eating disorders. Women considered unattractive may also suffer discrimination in the workplace or in admission to higher education. In addition, the double standard of aging in contemporary society means that all women will eventually have to cope with the stigma of unattractiveness simply through growing older.

Mood swings related to hormonal changes as a part of the menstrual cycle are documented by some studies. In the case of antenatal and postnatal depression, the interaction of psychosocial factors with hormonal factors appears to result in an elevated risk. For example, marital disharmony, inadequate social support and poor financial situation are associated with an increased risk of postnatal depression. Women may also experience considerable psychological distress and disorders associated with reproductive health conditions and problems.

Situations that typically produce stress for men are those which challenge their self-identity and cause them to feel inadequate. If their identity closely matches a traditional male role, they will experience stress in situations requiring subordination to women or emotional expressiveness. They will also experience stress if they feel they are not meeting expectations for superior physical strength,

intellect, or sexual performance. Research indicates that men who strictly adhere to extreme gender roles are at higher risk for mental disorders.

Gender stereotypes regarding proneness to emotional problems in women and alcohol problems in men, appear to reinforce social stigma and constrain help-seeking along stereotypical lines. They are a barrier to the accurate identification and treatment of psychological disorders. Women's mental health affects others in society. Their increasing presence in the workforce means that their mental health affects national productivity. Their social role as caregivers means that their mental health affects the mental health of their children and elderly parents. Moreover, understanding the needs of adolescent girls for services is important for many mental disorders, especially those that affect large numbers of young women, such as mood, anxiety and eating disorders.

Because gender interacts with other social determinants, women's strain due to stressful life events is a consequence of their differential sensitivity to events. Chronic strain, low mastery, and rumination have been found to be more common in women than in men. The same could well be a contributory factor in mental problems experienced.

17.6 GENDER DIFFERENCES IN MENTAL HEALTH PROBLEMS

17.6.1 Anxiety Disorder

Research indicates that anxiety disorders are more prevalent in women than in men, and women with anxiety disorders are more likely than men to experience comorbid depression. Panic with agoraphobia, generalized anxiety disorder (GAD), as well as social phobia is more common in women than men; while prevalence rates for obsessive-compulsive disorder (OCD) are approximately equal for men and women.

17.6.2 Mood Disorders

A number of large epidemiological studies have consistently found that women are more likely than men to experience depressive disorders. It has been observed that the increased prevalence of depression in women begins in adolescence and is a cross-cultural phenomenon. Although most exogenous stressors influence the risk for depression similarly in both women and men, women appear to be more likely to become depressed in response to interpersonal difficulties (particularly within their close family networks), and men appear more likely to become depressed in response to occupational difficulties (job loss and work problems).

17.6.3 Bipolar Disorder

Although bipolar disorder occurs equally frequently in men and women, there are significant gender differences in its course and manifestation. It has generally been accepted that women with the disorder appear to experience more depressive episodes than do men with the disorder, whereas men experience more manic episodes, even though there may not be significant gender differences in the total number of episodes.

17.6.4 Anxiety Disorder

Research indicates that anxiety disorders are more prevalent in women than in men, and women with anxiety disorders are more likely than men to experience comorbid depression. Panic with agoraphobia, generalized anxiety disorder (GAD), as well as social phobia is more common in women than men; while prevalence rates for obsessive-compulsive disorder (OCD) are approximately equal for men and women.

17.6.5 Eating Disorders

Most of the cases of anorexia nervosa and bulimia nervosa occur in women. These illnesses typically develop in puberty and are more common in industrialized societies. Women are far more likely than men to experience an eating disorder, and many women with eating disorders have comorbid depression.

17.6.6 Sleep Disorders

The risk for sleep-related difficulties rises during certain reproductive phases of women's lives. Other common causes of insomnia include depression and anxiety disorders, side effects of medications (e.g., bronchodilators, blood pressure medications, decongestants), and use of alcohol, caffeine, nicotine, and illicit drugs. A number of medical conditions (e.g., asthma, chronic obstructive pulmonary disease, sleep apnea) produce insomnia by causing shortness of breath at night. Disruptions in circadian rhythm commonly caused by jet lag or rotating work shifts can produce insomnia. A restless limb syndrome, characterized by discomfort in the legs and sometimes in the arms, can also disrupt sleep.

17.6.7 Alcoholism

The prevalence rate of alcoholism in men is significantly higher than that in women. Nevertheless, alcoholism in adult women is not uncommon; and its prevalence is estimated to be rising. Some physiological aspects add to the problem of alcoholism in women.

Gender-specific physiological differences cause women to become more intoxicated than men when they drink an equal amount of alcohol per unit of body weight. Research studies indicate that alcohol-related medical complications (e.g., peptic ulcer, liver disease, anaemia, and cerebral atrophy) develop more quickly in women, and women have higher relative mortality rates from alcoholism than men.

17.6.8 Drug Abuse

As with alcohol abuse, the rates of abuse of hallucinogens and opiates are higher in men than in women. Women may be motivated to use stimulants for weight control purposes. Rates of prescription drug abuse are higher in women, possibly because women go to doctors more often than do men. Also, women who abuse drugs or alcohol are more likely than men to have comorbid psychiatric diagnoses and thus to receive prescription medications (e.g., sedatives).

Check Your Progress Exercise 1

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

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

1. Why is there a need to address gender bias concerns in the society?

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Research studies indicate that gender has an impact on the overall well-being of the individuals. Differences among men and women are outstanding and need to be addressed. This Unit has tried to encompass the various issues related to the well-being of the gender groups in relation to mental health. In the course of examining the interface of gender and mental health, it is important to take into cognisance and address aspects of harassment and abuse, as these constitute a major social menace that is extracting a heavy toll in the context of mental health and well-being.

17.7 TYPES OF HARASSMENT AND ABUSE

Various types of harassment and abuse are existent in the society today. According to the age group, these can be classified as follows:

- Child abuse
- Adolescent abuse
- Adulthood harassment and abuse
- Old age abuse and neglect

According to the type of maltreatment, abuse can be classified as follows :-

- Physical abuse
- Verbal abuse
- Sexual abuse
- Psychological abuse
- Neglect

In the following sections of this Unit, we will discuss harassment and abuse from the maltreatment perspective across the life span.

17.7.1 Physical Abuse

Physical abuse means harsh behaviour which often leads to injury. During childhood, physical abuse at times is quite harsh which is also called corporal punishment. We all know that parents at times scold, slap or beat their child to stop misbehaviour. But if this physical beating becomes regular, torturous and/or harms the child; whether it is by parents, teachers, siblings, relatives, elders in the community, known or unknown persons, it constitutes physical abuse of the child.

Physical abuse is also observed among the older individuals. Adolescents fighting with each other, road rage, gang war crimes are some resultants of physical abuse.

In many parts of the world, women are physically beaten by their husband. In India, at times in-laws also physically abuse the women. Sometimes, though, man is also physically beaten by the wife.

Older generations with age and physical weakness become weak and fragile. Now-a-days, it has come to light that their children, now in their prime ages, beat their parents which could be for seeking parental property, money, showing autonomy, etc.

17.7.2 Verbal Abuse

Verbal abuse is quite common in all people irrespective of race, region, religion and society. Abusive language in some cultures constitutes a part of expressing love and care for loved ones. But, verbal aggression when too much leads to a lot of stress and psychological distress in the person who is verbally abused, of whichever life span age group that person may be of.

17.7.3 Sexual Abuse

Sexual abuse and harassment could be of different types. It could be sexual harassment at workplace, incest, rape, unnatural sex, etc. This would be discussed in detail in the next Section.

17.7.4 Psychological Abuse

Psychological abuse is because of emotional stress to the person which crosses the threshold that individual can bear. Psychological abuse is evident across the life span. Individuals consider themselves worthless, unloved, unwanted, uncared, isolated, neglected etc. Psychological abuse increases the risk factors among the individual. Some individuals may also develop resiliency due to presence of some special person like – teacher, sibling, parent, relative, idol/role model etc. in the life of the individual who helps the person to tide over the stress.

17.7.5 Neglect

Neglect is shown by uncaring, unloving, isolation behaviour by the person whom we consider important for ourselves. The care and warmth provided by the parents of a young child cannot be replaced by anything/anyone. The expectations

of the parent to be cared and looked after by their child (ren) during old age especially in Indian sub-continent and collectivistic societies are quite prominent.

Wife's expectation to be cared, valued, accepted, loved, respected especially by her husband and his family members is common throughout the world across regions and religions. Similar is the husband's expectation to be cared, loved, valued and respected by her wife and the family members. Any opposition of these expectations leads to feeling of neglect by the individual – child, parent, wife husband, etc. Likewise, when situations and life circumstances are opposed to the general expectations of the social norms, it leads to distress in the individual.

This psychological abuse and neglect manifests itself in many types of mental health problems in the individual; as you are already familiar with.

17.8 SEXUAL HARASSMENT AND ABUSE

In this Section we will focus on sexual harassment and abuse. Females are more prone to sexual harassment than men. Sexual harassment among children is also quite common.

17.8.1 Pedophilia

Sexual abuse of young children—both girls and boys by adults or late adolescents is commonly called pedophilia or pedophilic behaviour. This kind of abuse has been a recent phenomena or is reported now.

17.8.2 Incest

Incest is the sexual intercourse between relatives among whom the society considers it as taboo. Depending upon the social norms and culture of a particular society, it could be a taboo among blood relatives, clan-group, same village, same lineage, same household, etc. The various types of incest existing in the society are as follows:-

- *Between parent and child*

Here mother may have illicit relation with her own son; father may have illicit relation with his own daughter. Such relations with adopted children are also not permitted.

- *Between step-relations*

Here, a step-parent could have sexual relations with step-child(ren).

- *Between adults and children*

Here, known adult relative or someone known in the family may have illicit relation with the child(ren).

- *Between siblings*

Here, both of the siblings could be minors, or one may be minor and other a late adolescent or adult.

- *Between step-siblings*

Here, siblings are in step-relationships, both of the siblings could be minors, or one may be minor and other a late adolescent or adult.

- *Between consenting adults*

Here, both the sexual partners, in whatever relationship are mature and adults, doing sexual activity with conscious agreement. It could be consenting adult parent-child relation; adult parent-step child relation; siblings; cousins in relationships; sexual relations with persons not permitted through marriage /clan lineage/village/etc.

Incest is not always consented. It is many times forced. Incest in the family is at times the most unreported intrafamilial abuse since, most of the times, because of shame, guilt, fear, it goes unreported. Incest during young ages, especially on females is forced by brother, brother-like figure, father, father-like figure, etc. It may be because of the absence of a strong 'father' figure in the family, or, unfortunate circumstances which provide opportunity to other adults to make the 'younger ones' their prey.

17.8.3 Sexual Harassment

Sexual harassment is intimidation, bullying or coercion of a sexual nature or the unwelcome or inappropriate promise of rewards in exchange for sexual favours (Wikipedia).

Sexual harassment includes unwelcome sexually determined behaviour (whether directly or by implication) through physical contact and advances; demand or request for sexual favours; sexually coloured remarks; showing pornography; and any other unwelcome conduct of sexual nature.

Sexual harassment or exploitation of women at work place is on a rise with women entering the work force.

17.8.4 Eve Teasing

Eve teasing is a common term used in Indian sub-continent to describe obscene behaviour towards women in public areas and/or roads. It is a euphemism (Wikipedia). It refers to all such harassments women face in public places which are related to sexual ridicule, provocative statements and derogatory public harassment of women. Eve teasing outrages the modesty of women by word, gesture or act (Wikipedia).

17.8.5 Molestation

Molestation is the act of subjecting women or children to unwanted sexual advances or improper sexual acts or activity. Child molestation is also on rise in India now. Molestation also includes touching of private parts, exposure of genitalia, taking of pornographic pictures, etc. Molestation includes those offences that use force or assault to outrage the modesty of women. Many times children don't report it and develop psychosomatic problems.

17.8.6 Rape

Rape is a type of sexual assault which is linked with forced sexual intercourse initiated by a person on a person who does not consent to it. Generally, in India rape victims are women or female children. The initiation could be by one or more than one person. Rape could be by both people known or unknown to the victim. There are some reports of male-male and female-female rapes especially taking place in prisons and hostels. Rape among married couples is also being reported these days. Undoubtedly, rape outrages the modesty of the victim which has serious lingering consequences on the victim's well-being.

17.8.7 Abuse by Women

These days a number of incidents are being reported by husbands and his family members regarding harassment and abuse faced by them because of the wife/daughter-in-law. At workplace, at times men also face sexual harassment at the hands of female bosses. This is a crime which is also quite under-reported in India.

Check Your Progress Exercise 2

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

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

1. Enumerate harassment and abuse that can be faced by a six year old boy.

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17.9 EFFECT OF SEXUAL HARASSMENT AND ABUSE

Sexual harassment and abuse has a long lasting impression in the memory of the abused. It leaves a lasting impression of being hurt and used by the perpetrators on the minds of the abused. Children who are sexually abused when quite young also do not forget such bad memories. To help such persons it is important to understand the effect of sexual harassment and abuse on the minds of abused, perpetrator and family members of the offended person.

17.9.1 Effect on the Abused/Survivor of Sexual Assault

Rape victim is affected by both physical trauma and psychological trauma. Deaths of rape victims are also reported. Rape has a tragic impact on the physical health, reproductive health, mental health and social well-being of the victim.

Impact on physical and reproductive health is as follows:-

- Vaginal bleeding, if uncontrolled leads to death
- Vaginal infection
- Fibroids
- Genital irritation
- Pain during intercourse
- Decreased sexual desire
- Chronic pelvic pain
- Urinary infections
- Pregnancy
- HIV/AIDS
- Sexually Transmitted Diseases (STDs)

Impact on psychological health and social well-being is as follows:-

- Stigma
- Betrayal
- Decreased sexual desire
- Pain during intercourse even with consent
- Self blame - The victim blames herself for doing something which led to her rape. It is the most common feeling among abused victims. They might blame their character or their actions for not being appropriate
- Shame - Victim feels ashamed and lacks courage to face the society at large
- Fear - Fear of men, fear of place and situations which could evoke or bring back the bad memories
- Isolation - Victim isolates herself from the social world
- Lack self care and self love - Stops looking after oneself
- Anger and aggression - In the early phase after sexual abuse the victim is angry towards self and later towards others

- Suicidal ideation - She may develop suicide ideation and also try to attempt suicide
- Poor self esteem - Victim thinks poorly of herself
- Post-traumatic stress disorder
- Anxiety
- Among children who are abused eating disorder or other psychosomatic conditions may be seen
- Mental health disorders
- Skin diseases are also observed in children who are sexually abused
- Not trusting the world
- Disgust at oneself
- Unaccepting the inevitable and going into delusions
- Lose confidence in one's own abilities
- Become too prudent for social acceptance
- Feels powerless
- Repression of the event is never complete

17.9.2 Effect of Abuse on Children

Effect of abuse on young minds leaves harsh lines on their psyche. Following effects may be seen on children:-

- *Physical health* - Too much of physical abuse could lead to some physical injury to the child. Johnson (2002) said that too much vigorous shaking of an infant by the caregiver back and forth causes a rapid acceleration and deceleration of the brain within the skull, this was termed as shaken baby syndrome. This could lead to severe brain damage, and lead to vomiting, seizures, coma or death of the baby.
- *Behaviour problems* - The child may show behaviour problems and/or mental health disorders. Anxiety, non-trust to the others around, eating disorder, angry outbursts, fits, disruptive behaviour, unsocial behaviour, antisocial behaviour, depression, reculsion to oneself, aggression, mood changes, etc. are observed in children who are abused when young. Regressive behaviour (bed wetting, thumb sucking etc.) are also shown. There may be anxiety attacks and insomnia problem.
- *Impact on quality of attachment in close relationship* - The abused child finds it difficult to develop secure positive and healthy attachments with others. Later on adult romantic attachments are also not of high quality as the victim is not able to trust and rely on others easily.

- *Cognitive abilities* - Cognitive abilities like language, speech, memory retention are impacted upon in children who are abused.
- *Long term effect of sexual abuse* - Finkelhor and Browne (1986) reported that long term effect includes poor self-esteem, difficulty in trusting others, anxiety, feelings of isolation and stigma, depression, self-destructive tendencies, sexual maladjustment and substance abuse.

17.9.3 Effect on the Family of the Victim

Effect of sexual abuse is seen on the whole family – all of the family members of the victim. They feel helpless, ashamed, guilty and powerless. They have to face the world — its questions, mirage of helping hands which disappear once they go near them. If the perpetrator is a part of the family or known to the family, the family system is threatened to break down or get more closure. Blaming each other, self blame by mother, anger and aggression towards others is quite common.

If the perpetrator is a part of the family, then he has an important role to play in the family which leads to divided loyalty as well as distress among the family members.

Foster and adoptive parents of the abused child feel more distressed and responsible for the plight of their child.

17.9.4 Effect on the Perpetrator and his Family

Most of the men who molest, abuse and victimize are members known to the victim. These men are often highly valued for their good social behaviour and upholding values in the society in general. They live a double faced life! Family members and victims have confused, contradicting feelings towards them. Most of the family members might be dependent on the perpetrator, and thus not repel him completely as well as accept them at heart. Life for all concerned becomes upheaved.

Women also at times sexually abuse male/females - adult or child. They find themselves in powerful situation or hierarchy to do the same. This is a way of asserting power by the offenders, whether male or female.

17.10 ELDERLY ABUSE

Physical abuse and psychological abuse with elderly population is becoming a recurrent problem in India also. Industrialisation and urbanisation has led to increased materialism in the society which has both positive and negative impact on the people. On one hand it has improved the living standards of people, increased the life span, improved health conditions and on the other hand it has made youngsters more materialistic and individualistic in nature. Neglect of elderly parents by their children is becoming increasingly common in India too.

17.11 ROLE OF COUNSELLOR AND FAMILY THERAPIST

Counsellor and family therapist plays an important role to retrieve the mental and social well-being of the offended, offender and their family members. Counsellor and family therapist should definitely portray genuineness, positive regard, empathy, belief, patience towards the client. As family therapist you have to be careful to maintain neutrality with family members containing both offender and offended and at the same time be empathetic towards the offended.

Teach the parents to impart sex education, knowledge about appropriate and inappropriate touches, show of love and affection, understand what are sexual advances, etc. to their child appropriate to the child's age.

Elderly feel neglected and worthless after leading a productive life as their children no more care for them. It is important to make the family to be re-integrated and get involved with each other. In cases, where sons have moved apart, contact needs to be established and maintained through phone calls, letters, emails, etc. The elderly couple has to be made to re-learn staying with each other and caring for each other as a couple. Involvement of the elders in some productive and socially useful work will help to give elders a sense of being useful and needed in the society.

17.12 THERAPEUTIC INTERVENTIONS

The therapeutic interventions mentioned below have been explained in earlier Courses/Blocks to you. Here, we will study about them in brief.

17.12.1 Supportive Therapy

Supportive therapy is a psychotherapeutic approach and it integrates psychodynamic, cognitive-behavioural and interpersonal conceptual theories. The main role of the therapist is to reinforce healthy and adaptive pattern of behaviour and thoughts in the abused person. It is one of the most commonly used therapy with abused and neglected children (Weiss, 2008). According to Weiss, the primary goal of supportive therapy is to help the children cope with feelings and memories associated with their maltreatment and to improve their sense of self and relationships with them. William Friedrich (2002) approaches children's maltreatment by addressing three main issues — attachment to caregivers; behavioural regulation; and self perceptions.

Therapy provides a source of support, care and nurturance to the abused children in the beginning. Trust has to be developed in this relation which is quite difficult for the abused to develop in the therapist. Later on therapy helps the child to accept and understand their feelings, thoughts and actions. With therapy they develop insight into their thoughts and feelings. Relaxation techniques are taught. Involve child in art and sports activities. Unconditional positive regard by the therapist to the child provides correcting the self-perceptions of worthlessness or guilt that interfere with the child's self-esteem and self efficacy (Weiss, 2008).

17.12.2 Parent Training

Parent training helps to teach parents to socialise their children in more effective ways. This therapy is provided to caregivers who physically abuse or neglect children (Weiss, 2008). According to Weiss, in this therapy, parents are shown how to attend to children's activities and positively reinforce appropriate behaviour; give clear and developmentally appropriate commands to maximise children's compliance; ignore inappropriate behaviours and avoid hostile-aggressive displays; and use noncoercive forms of discipline, such as time out (with young children) and response cost (with older children and adolescents).

This therapy has also been mentioned as behavioural parent training.

17.12.3 Cognitive Behavioural Family Therapy

Cognitive behavioural family therapy is extensively used in varied types of abuse and with different life span age groups of the abused and their family members. It helps them to form realistic expectations, develop problem solving skills, remove cognitive distortions, improve coping skills, improve quality of parent-child relations etc.

17.12.4 Ecological Approaches to Treatment

Weiss (2008) stated that treatment for child maltreatment, must address the family's needs across multiple levels of functioning. The ecological therapist, according to him, has to first assess the family's strengths and weaknesses across — children's characteristics, parents' characteristics, family and work environment, peers, school, neighbourhood, and larger community. According to Swenson & Chaffin (2006), the therapist and the family has to design the treatment programme that acknowledges the family's weaknesses across ecological contexts but capitalizes on the family's strengths.

17.12.5 Trauma-Focussed Cognitive Behavioural Therapy

Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT) integrates principles of exposure therapy, cognitive restructuring, parent training, and family support. It is especially used with sexually abused children. Weiss (2008) outlines goal of TF-CBT is to help children identify and manage negative emotions associated with the traumatic experience. Here, the child is taught to STOP the unwanted thoughts and memories by being able to manage the stopping of the appearance of the bad repulsive memories. Then the child is exposed to memories and the therapist teaches a relationship between memories and reality and action. The child is encouraged to write or draw or illustrate their traumatic experiences. The therapist tries to reframe children's maladaptive thoughts about the abused experience (Weiss, 2008).

17.12.6 Cognitive Restructuring with Adolescents

Sexually abused older children and adolescents often have mood disorders, consider themselves worthless, used, have negative thoughts for the outer world themselves, and people close to them, afraid to get-in close to any one. Therapists while challenging cognitive distortions help these youths to find ways to think about their abusive experiences (Heflin & Deblinger, 2003).

17.12.7 Play Therapy

Play therapy is extensively used with maltreated children to help the child reach catharsis, express oneself and get over the past experiences. It may be used also in conjunction with another therapy or by itself.

17.12.8 Meditation and Relaxation Techniques

Now, use of meditation techniques and relaxation techniques are extensively being used to help the abused cope with their anxiety, mood disorders, and cope with the past and look forward to the future in a positive frame of mind.

17.12.9 Yoga Therapy

Yoga has been known to help cure illness and promote well-being through ancient times in India.

Yoga helps to alleviate stress, reduce anxiety and promote happiness. Yoga when done in groups leads to inter and intra well-being of all the group members. Yoga promotes well-being even if it is performed individually.

In another Unit we will learn about this in detail.

Check Your Progress Exercise 3

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

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

1. Enumerate therapies which can be used with elderly abuse.

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17.13 LET US SUM UP

Mental health is individually as well as globally affected by gender. It is known that coping strategies of both men and women are different. Perceptions, conflict handling and resolution among the two sexes have been different from time immemorial. From pre-historic times, males and females have been designated prescribed roles and responsibilities, one of a protector and the other as a nurturer. Here, we will not get into the detailed differences among the roles and responsibilities of the genders, as we presume that by now you would be aware of the same - these differences could be because of genetics, hormones, anatomy, physiology, personality, and are socio-physio-psychological in nature. We expect you to correlate the various personality theories studied in various Courses, information about gender roles and needs for counselling studied earlier

to the mental health issue, to be able to answer questions such as why the gender differences lead to varied mental health issues among the masses.

Stereotypical attitudes largely affect mental health treatment by healthcare workers such as doctors, counsellors and family therapists. Both women taking drugs or alcohol and men crying would be looked down upon. And, thus would influence the self report of the same by the individual in need of help. Counsellors and family therapists need to be gender sensitive and sensitized towards the needs and concerns of both the genders as in reality rather than as it should be. Notes of being victimized by people known and others has to be probed to lead a right guideline of the causative factors of mental health problems. Use of violence by self or others on self or others also needs to be ascertained.

Situations that typically produce stress for men are those which challenge their self identity and cause them to feel inadequate. Experiences requiring subordination to women or emotional expressiveness would lead to stressors increasing mental health pressures on men.

Gender differences in mental health problems like schizophrenia, mood disorder, bipolar disorders, anxiety disorder, eating disorder, sleep disorder, substance use, etc. are known to exist and prevalence of the same need to be further studied.

In this Unit, we read about the types of harassment and abuse and its effect on the offender, offended and their family members. Sexual harassment and abuse have been extensively covered in this Unit. As borne out even by casual observations most of the victims of harassment and abuse are female. Harassment and abuse are closely linked to mental health problems. Abuse among the older generation has also been discussed. Therapeutic interventions used for treatment of harassment and abuse have also been described in detail.

17.14 GLOSSARY

Eve-teasing	: Describes obscene behaviour towards women in public areas and/or roads.
Gender roles	: Socially learned behaviours in a given society or community, that defines activities, tasks and responsibilities as masculine and feminine.
Incest	: Sexual intercourse between close relatives among whom the society considers it as taboo.
Molestation	: Act of subjecting women or children to unwanted sexual advances or improper sexual acts or activity.
Pedophilia	: Sexual abuse of young children—both boys and girls by adults or late adolescents.
Rape	: Sexual assault linked with forced sexual intercourse.

Sex : Biological difference between men and women.

Sexual harassment : Unwelcome sexually determined behaviour (whether directly or by implication) through physical contact and advances; demand or request for sexual favours; sexually coloured remarks; showing pornography; any other unwelcome physical, verbal or non-verbal conduct of sexual nature.

17.15 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. For addressing safety concerns and social factors, and to help promote well-being.

Check Your Progress Exercise 2

1. A six year old boy can face verbal abuse, physical abuse, neglect, molestation, rape and pedophilia.

Check Your Progress Exercise 3

1. Yoga practices, meditation and relaxation techniques, ecological approaches to treatment, and supportive therapy may be used as per the specific individual needs of the elders.

17.16 UNIT END QUESTIONS

1. Discuss the role of therapy in helping adolescent patients get over with sexual abuse memories of childhood.
2. What do you understand by harassment and abuse. Describe different types of harassments you see occurring in your region.

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UNIT 18 GERIATRIC PROBLEMS AND DISORDERS

Structure

- 18.1 Introduction
- 18.2 Demographic Ageing
- 18.3 Common Health Problems in Late Life
- 18.4 Ageing and Disability
- 18.5 Ageing and Mental Health
- 18.6 Mental Health Problems of Older People
 - 18.6.1 Delirium
 - 18.6.2 Dementia
 - 18.6.3 Depression
 - 18.6.4 Other Psychiatric Disorders
 - 18.6.5 Suicide and Suicidal Behaviour
- 18.7 Caregiver Interventions
- 18.8 Let Us Sum Up
- 18.9 Answers to Check Your Progress Exercises
- 18.10 Unit End Questions
- 18.11 Further Readings and References

18.1 INTRODUCTION

In almost every country, the proportion of people aged over 60 years is growing faster than any other age group, as a result of both longer life expectancy and declining fertility rates. This population ageing can be seen as a success story for public health policies and for socioeconomic development, but it also challenges society to adapt, in order to maximize the health and functional capacity of older people as well as their social participation and security.

India is home to more than 76 million people older than sixty years as per Census India 2001. This age group, currently 7.4% of the population, is expected to grow dramatically in the coming few decades. Low public awareness and low priority for health care of older people allows even conditions like dementia remain hidden problems. Depression is much more prevalent than dementia and can have profound negative effects on the quality of life of an older person. There is a growing realization of the need for interventions aimed at improving the mental health and well being of older people.

Health problems in general and mental health problems in particular are important determinants of quality of life in late life. Many seniors live active and healthy

lives. But as we age, our bodies and minds change. Some changes may just be part of normal ageing, while others may be a warning sign of a medical problem. It is important to know the difference. This Unit will make an attempt to introduce the health care and related issues of people above the age of sixty years and will summarize the interventions which are helpful for people who experience mental health problems in late life.

Objectives

After studying this Unit, you will be able to:

- Understand the public health aspects of demographic ageing;
- Describe the common health problems of late life;
- Describe the common mental health problems of late life;
- Recognize clinical features of delirium, dementia and depression;
- Provide emotional support to older people with health problems;
- Recognize the need for assistance in activities of daily living;
- Recognize the caregiver issues in care of older people;
- Recognize the burden of care and its implications;
- Inform and educate caregivers of older people;
- Support the families who provide home-based care;
- Provide emotional support to caregivers; and
- Provide tips for better care by families engaged in home-based care.

18.2 DEMOGRAPHIC AGEING

Reduced birth rates with increasing life expectancy is leading to an increase in the proportion of older people in our population and this phenomenon is called demographic ageing. This will result in a sharp increase in the number of older people with neuropsychiatric disorders. Many of them would require some kind of assistance in daily living. Demographic changes occur along with rapid social restructuring and economic turbulence in developing countries. These are difficult times for the region as we have to meet the health care needs of the growing number of older people in our society. What is most remarkable about the demographic ageing in developing countries is the rapidity with which this is occurring here. In the developed world the demographic transition occurred over a period of many decades and allowed these societies enough time to make adjustments.

There are many interesting facts about ageing. The World Health Organization (WHO) has listed 10 facts on ageing and the life course (<http://www.who.int/features/factfiles/ageing/en/index.html>).

These are summarized here. Let us go through each one of these:

Fact 1

Ageing is a global phenomenon. The world's elderly population — people 60 years of age and older — is the fastest growing age group. By 2050 about 80% of the elderly will be living in developing countries. Population ageing is occurring in parallel with rapid urbanization: in 2007 more than half of the world's population lived in cities. By 2030 that figure is expected to rise to more than 60%.

Fact 2

Population ageing is a triumph of modern society. It reflects improving global health, but also raises special challenges for the 21st century in both developing and developed countries. In 2005, life expectancy in countries like Japan and France was already more than 80 years. Life expectancy is also rising in developing countries.

Fact 3

Vast health inequalities persist, as is clear from differences in life expectancy at birth. For example, while Japan has the highest life expectancy in the world at 82.2 years, in several countries in Africa the figure is as much as 40 years lower.

Fact 4

Within countries, health inequalities are also significant. For example, in the United States of America higher socioeconomic groups can expect to live up to 20 years longer than those from lower socioeconomic groups.

Fact 5

By 2050, close to 80% of all deaths are expected to occur in people older than 60. Health expenditure increases with age and is concentrated in the last year of life — but the older a person dies, the less costs are concentrated in that period. Postponing the age of death through healthy ageing combined with appropriate end-of-life policies could lead to major health care savings.

Fact 6

Healthy older people also represent a resource for their families, communities and economies. Investing in health throughout life produces dividends for societies everywhere. It is rarely too late to change risky behaviours to promote health: for example, the risk of premature death decreases by 50% if someone gives up smoking between 60 and 75 years of age.

Fact 7

Effective, community-level primary health care for older people is crucial to promote health, prevent disease and manage chronic illnesses in dependent and frail patients. In general, training for health professionals includes little if any instruction about care for the elderly. However, they will increasingly spend time caring for this section of the population. WHO maintains that all health providers should be trained on ageing issues, regardless of their specialism.

Fact 8

Disasters and emergencies severely impact the most vulnerable, including older people. As examples: the highest percentage of fatalities in Indonesia caused by the 2004 Indian Ocean tsunami was in people 60 years of age and older, and the majority of the 2003 heat wave victims in Europe were people 70 years of age and older. Policies to protect older persons during emergencies are urgently required.

Fact 9

In older age, the risk of falls increases and consequences of injuries are far more serious. This leads to significant health, human and economic costs.

Fact 10

Elder abuse is on the increase as the population ages and social dynamics change. WHO estimates that between 4% and 6% of older persons worldwide have suffered from a form of elder abuse - either physical, psychological, emotional, financial or due to neglect. Elder abuse is an infringement of human rights.

Check Your Progress Exercise 1

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

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

1. What do you mean by demographic ageing?

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18.3 COMMON HEALTH PROBLEMS IN LATE LIFE

The world is ageing fast. It is of paramount importance that health care workers are well versed with the diagnosis and management of the so called “four giants” of geriatrics (memory loss, urinary incontinence, depression and falls / immobility) as well as the chronic diseases that are common in later life and that can often be prevented or delayed. They include hypertension, diabetes, arthritis, chronic obstructive airway diseases etc. However, prevention requires reaching the individual before the disease takes hold. Most preventative health care and early disease screening takes place in Primary Health Care (PHC) centres within health systems. These centres play a critical role in the health of older people worldwide at the local level.

Check Your Progress Exercise 2

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

1. Which are the so called “four giants” of geriatrics?
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2. Which health care facility should ideally play a crucial role in health care of older people?
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18.4 AGEING AND DISABILITY

Neuropsychiatric disorders are more prevalent in older age groups and these disorders tend to be chronic in nature and usually lead to functional impairment. The Global Burden of Disease (GBD) report indicates that dementia is one of the main causes of disability in later life. Older people are particularly likely to have multiple health conditions. Chronic physical diseases affecting different organ systems can coexist with mental and cognitive disorders. These multiple pathologies will interact in complex ways to create difficulties in performing important tasks and activities (disability), and in determining needs for care (dependence). Dementia probably has a disproportionate impact on capacity for independent living. Presence of disability often results in the individual needing assistance for personal activities of living, which would then be qualified as dependence.

The experience of limitations or disability happens in the contexts of partners, family and friends. Comprehensive health and social care systems prevalent in the economically developed countries to a great extent compensate for the less prominent role played by the family. However, even in these societies, most of the care for older people are provided by families, a fact often overlooked. Facilities for assisted living are not widely available in India and these can be very expensive. Almost all disabled older people are being cared at home by co-resident caregivers in India.

Disability increases with age. We have limited information on the proportion of older people with disability in India. The ability to carry out activities of daily living can be compromised in late life due to a number of neuropsychiatric conditions including dementia. Everyday Abilities Scale for India (EASI) was developed to assess cognitive disability (REF). This scale with 12 items looks at disability arising from possible cognitive problem among older people. Functional impairment (defined as inability to carry out four or more activities) was found to be more prevalent in older age groups.

18.5 AGEING AND MENTAL HEALTH

Ageing is also associated with decline in physical and mental health. Declining memory is a common complaint. There is reduction in muscle strength and stamina. Exercise tolerance becomes less. Sensory systems usually has reduced ability in late life in many older people. Vision and hearing may get affected due to age related changes or degenerative conditions. As age advances the incidence and prevalence of many diseases increase. Medical illnesses are very common in later years of life.

Social isolation, loss of spouse, close relatives and friends due to death is also more frequent in late life. Reduced birth rates with increasing life expectancy is leading to an increase in the proportion of older people in our population and this phenomenon is called demographic ageing. Loneliness, reduced social support and need for assistance in activities of daily living are common stressors in later years of human life. Depressive symptoms are common in late life. Old age increases the risk for cognitive disorders especially progressive conditions like degenerative dementias .

Check Your Progress Exercise 3

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

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

1. List important stressors in late life.

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18.6 MENTAL HEALTH PROBLEMS OF OLDER PEOPLE

Doctors and policy makers are responsible for shaping the health care system of the country. Health care services should meet the requirements of all sections of the society. Medicine must change itself to serve the increasing number of older people in the society .Though this appears perfectly logical, there seems to be little take up in this direction. For older people, mental health conditions are an important cause of morbidity and premature mortality (Prince et al., 2007). Dementia and depression are common mental health conditions of late life and are emerging as major public health challenges in ageing societies like ours. India with its huge population probably need to cater to the needs of a very large number of older people with mental health problems than most other countries. Delirium is less frequent, but is a medical emergency which could be mistaken for another psychiatric problem. Delay in diagnosis could be fatal though many cases are reversible if detected early. Most often these are due to an underlying medical problem.

Check Your Progress Exercise 4

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

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

Say whether the following statements are true or false:

- i) Mental health conditions are an important cause of morbidity and premature mortality for older people.
- ii) Dementia and depression are two important mental health problems in late life.
- iii) Delirium is a medical emergency and early detection is important.

18.6.1 Delirium

Delirium or acute confusional state is a common medical emergency in older people. This is caused by a transient, usually reversible, cerebral dysfunction characterized by clouding of consciousness. Delirium usually occurs in association with a physical illness. It could well be the presenting feature of a medical problem. Common medical conditions like pneumonia, urinary tract infection or electrolyte imbalance may present as delirium. Delirium has to be considered and ruled out in all cases of sudden onset behavioural disturbance in older people. The diagnosis of delirium is often missed. Misdiagnosis as psychosis is also common. People with preexisting dementia can develop delirium and may present with recent sudden worsening of cognitive function and behavioural disturbance. Delirium in elderly is often caused by multiple causes. Delirium in late life is a medical emergency and needs prompt identification, detailed evaluation and intensive care.

Delirium should be considered as the first possibility in all late onset acute behavioural problems in older people. It is treatable and reversible in many instances if detected early in the course. Identification of the cause and prompt management is critical for good outcome. Untreated delirium is associated with increased morbidity and mortality rate. Patients who develop delirium during hospitalization have a mortality rate of 22-76% and a high rate of death during the months following discharge.

Risk factors for delirium in elderly are:

- Advanced age (especially >80 years)
- Severe illness (especially cancer)
- Dehydration
- Dementia

Signs and symptoms of delirium are:

- Clouding of consciousness
- Difficulty maintaining or shifting attention

- Disorientation
- Illusions
- Hallucinations
- Fluctuating levels of consciousness — Symptoms tend to fluctuate over the course of the day, with some improvement in the daytime and maximum disturbance at night.
- Reversal of the sleep-wake cycle
- Neurological symptoms like Dysphasia, Dysarthria, Tremor

Disorientation to time and place and memory impairment are the classical symptoms. Person has inability to recall the time of the day, he might mistake day for night time or think he/she is at home when he/she is in the hospital. Incontinence of urine, motor restlessness, especially more at night time and sleep disturbance could also be present. Abnormalities in perception, especially visual hallucinations or illusions also can be seen. The person is noted to be less alert and could be less responsive and drowsy at times. This is usually accompanied by the symptoms and signs of the primary illness which causes delirium.

Check Your Progress Exercise 5

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

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

1. What is the first possibility to be considered if an otherwise normal older person suddenly develops abnormal behaviour?

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2. What is the most prominent symptom in delirium?

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18.6.2 Dementia

Dementia is a syndrome which is usually chronic, characterized by a progressive, global deterioration in intellect including memory, learning, orientation, language, comprehension and judgement due to disease of the brain. It mainly affects older people; about 2% of cases start before the age of 65 years. After this, the prevalence doubles every five years. Dementia is one of the major causes of disability in late-life.

The dementia syndrome is linked to a number of underlying causes and diseases in the brain. The common causes accounting for 90% of all cases are Alzheimer's disease, Vascular dementia, Dementia with Lewy bodies and Frontotemporal dementia. Alzheimer's disease and Vascular dementia are two most common

causes and together they account for more than 50% of dementia cases in the community. Less common causes of dementia (like hypothyroidism, chronic infections, brain tumours, subdural haemorrhage, normal pressure hydrocephalus, metabolic conditions, and toxins or deficiencies of vitamin B12 and folic acid) are particularly important to identify as these conditions may be treated partially by timely medical or surgical interventions and the dementia syndrome could be reversed fully or partially. These are sometimes referred to as “Reversible Dementias”.

Symptomatic treatment may delay the relentless course of the disease and ameliorate the troublesome behavioural symptoms in Alzheimer’s disease, Vascular dementia and other dementias. Timely support can help people with dementia and carers alike.

The standard treatment goals of dementia management include:

- Early diagnosis
- Optimization of physical health, cognition, activity and well being
- Detection and treatment of Behavioural and Psychological Symptoms of Dementia (BPSD)
- Educating carers and providing long term support to carers

People who suffer from dementia need to be treated with patience. Their dignity and personhood should always be respected. The carers require support and guidance. Their needs should be determined and attended to. Carers have to be educated about the course and symptoms of dementia. They could also be trained to manage many symptoms including behavioural symptoms at home.

Partially effective treatments are available for most core symptoms of dementia. These treatments are all symptomatic. They often help to reduce the severity of symptoms, but do not alter the progressive course of the disease. Importantly, psychological and psychosocial interventions (sometimes referred to as ‘non-pharmacological’ interventions) may be as effective as drugs, but have been less extensively researched, and much less effectively promoted.

Cholinesterase Inhibitors (ChEIs) and NDMA receptor antagonists can lead to useful improvements in cognitive function, behavioural symptoms and daily functioning but their cost-effectiveness has not yet been established (National Institute for Health and Clinical Excellence, 2007). Recommendations regarding their use will depend upon affordability and availability of specialist support. These drugs are less expensive in India when compared to other countries. However, poorer sections in India may not be able to buy them. Hence, there must be an attempt to make these drugs available through the public run health care services along with other psychotropic drugs.

Behavioural and Psychological Symptoms of Dementia (BPSD)

For BPSD, antipsychotic drugs are effective minimally, although they may be very helpful for some patients, particularly amongst those with aggression as a main problem. There are serious concerns about their safety with an increased risk of death (Schneider, Dagerman & Insel, 2005) and cerebrovascular adverse events (Schneider, Dagerman & Insel, 2006). For these reasons, a brief duration of anti-psychotic drugs may be recommended with specialist input, particularly

when severe and distressing behaviour is troublesome and there is an imminent risk of harm. Physical health assessment, carer training and support are all indicated.

A large literature is available regarding the wide-ranging potential benefits of carer interventions in dementia (Sorensen, *et al.* 2006). There are several systematic reviews and meta-analyses which have shown the benefit of carer interventions in preventing or delaying hospitalization or institutionalization. Psycho-educational interventions require the active participation of the carer. Studies on carer education and training intervention indicate much larger treatment effects on carer psychological morbidity and strain (e.g. Dias *et al.*, 2008).

The caregiver needs continuous help and support from other family members. Those who received support from others seem to cope better. Poorer families also need financial support to compensate them for the financial losses incurred. The government should consider providing financial assistance to those families and this can take the form of monthly income support for the carer as well as payments towards medical expenses of the patient.

Ideally, we should aim at improving the understanding about dementia. It is easy to name the condition as Alzheimer's Disease or other dementias. Failure to intervene, defeats the purpose. This can happen if we fail to acquire a scientific understanding of the condition. Naming is important and necessary for identification, but understanding is the key to management and improving care. Carers, the families and the civil society need to know more about dementia. We should be aware of the fact that there are several ways of helping people with dementia. We all need to have a better understanding about the meaning of having dementia and its implications. A lot can be done to improve the quality of life of the person with dementia and the lives of people who provide home-based care. It is essential to realize the importance of early intervention strategy and use a public health model for dementia care.

There is some evidence from studies with other chronic diseases like hypertension and diabetes mellitus that intervention programmes for vascular disorders and risk factors would possibly help in dementia prevention too. Greater integration of care and increased use of chronic disease prevention and management approach is desirable.

18.6.3 Depression

Depressive disorders are common in late life. Prevalence rates for depression in a community sample of elders have varied widely. Recent Indian studies suggest higher prevalence of depression (Rajkumaret *et al.* 2009; Jain & Aras, 2007).

Determinants of Geriatric Depression

The determinants of late life depression are definitely multiple. The major factors associated with depression are:

- Genetic factors
- Biological factors
- Physical factors

- Psycho-social factors
- Economic factors

There is evidence of specific relationship between physical illness and depression in at least three areas:

1. Depression presenting as physical illness
2. Physical illness presenting as depression
3. Influence of physical disease on the course and outcome of depression

Depression can be physically disabling. Fatigue, sleep disturbance and loss of appetite may be compounded by self-neglect, inactivity, and a reduction in patient's motivation to take treatment for physical illness. Depression is a common reaction to a physical disability. The fact that depression is apparently reactive does not mean that the patient may not benefit from appropriate antidepressant therapy in addition to treatment for physical disorder.

Five possible reasons leading to presence of depression in physical illness are as follows:

1. Depression may be a consequence to treatment
2. Depression may be a consequence of organic brain diseases
3. Depression may be a psychological reaction to physical illness
4. Depression may predispose the individual to onset of physical disease
5. The behavioural consequences of depressed mood may cause or complicate physical ill health through starvation, self neglect and self harm.

Moreover, the physical disorder and disability may increase the individual's vulnerability to other adverse life events that predispose to depression and also inhibit recovery from depression.

Concurrent symptoms of co-morbid physical illness and cognitive impairment can lead to under-diagnosis of depression. Emergency room visits are usually due to suicidal behaviour, refusal to eat, intense agitation, or due to severe fear and paranoia. Antidepressants may be prescribed by medical specialists to ameliorate depression.

Agitation is a state of restlessness. It is experienced by the patient as inability to relax and is seen by the observer as restless activity. When agitation is severe, patient cannot sit for long time and usually paces up and down. It is a common in older patients with psychosis and depression. It can also occur in dementia and akathisia.

Severe psychomotor agitation is often relieved by small doses of antipsychotics. However, drugs have to be used judiciously in older people. Suicidal rates are high in this age group and suicidal behaviour should lead to detailed psychiatric evaluation. Early identification and prompt management of depression can be life saving.

Counselling, psychotherapy and family therapy is very important. Information and education about depression will help. Emotional support is important. Removing negative cognitions, arousing hope and dealing with pessimistic

thoughts and low self esteem can be achieved through counselling and family therapy. Frequent sessions are important.

18.6.4 Other Psychiatric Disorders

Psychosis in late life could be broadly classified into two groups based on the onset of the illness. There are many individuals who have psychotic illness with onset in adult life and is at present older than sixty years. Late onset psychotic illness is rather rare and would require careful evaluation to rule out brain or related organic pathology.

18.6.5 Suicide and Suicidal Behaviour

Older adults have the highest risk of death by suicide of all age groups. Suicidal behaviour in elderly is more planned and deliberate, and means are more lethal. All older people with history of suicidal ideation or attempt are at very high risk for suicide. Evaluation for psychiatric morbidity is very important. Depression should be treated aggressively if present. Undetected, untreated depression is the most important cause for suicidal behaviour in older people. This has to be explained to the patient, caregivers and family members. Identification and adequate treatment of depression can indeed prevent a number of suicides in older people. Depression could be missed especially when it is present along with disabilities and medical problems in an older person. Clinician should never ever dismiss depressive symptoms and suicidal behaviour as insignificant in an older person.

18.7 CAREGIVER INTERVENTIONS

Women are more likely to be carers than men. Provision of sustained personal assistance carries its own burden. The provision of intensive informal care to frail older people can have profound consequences for the carer. This is particularly so if the older person has a cognitive impairment. The responsibilities of caring often constrain social participation and necessitate withdrawal from the work force. Intensive caring can have adverse effects on the psychological health of carers. There is consistent evidence that carers are more at risk of mental health problems, particularly stress and depression, than other adults of the same age. It has been well recognized that 'carers' also require support and assistance. One of the aims in providing services to carers is to reduce these negative effects of carer stress by supporting carers.

All caregiver interventions should focus on three ingredients :

1. Information and education
2. Caregiver support
3. Guidance for home-based care

Caregiver support is important in management of late life mental health problems. Management of disabled older people with behavioural disturbance can be very stressful for the families. Identifying and managing behavioural symptoms of dementia and provision for caregiver support are important. Care can be delivered by trained primary care teams, with a paradigm shift towards chronic continuing care and community outreach. Care delivery will be more efficient when integrated with that of other chronic diseases, and more broadly based

community support programmes for the elderly and disabled. To be successful, all efforts in psychogeriatric service development need to be supported by a clearly spelt out policy on long-term care and political commitment.

Future directions

Care provision for mental health problems of late life is less than adequate. Major conditions like dementia remain as hidden problems. There are no accurate estimates for the treatment gap for dementia in India in general, but this is likely to be huge. There are several major barriers to closing this treatment gap including the low levels of awareness about dementia and depression as medical disorders. The most significant barrier is the very low human resource capacity for the care of people with mental disorders. This scarcity of resources is true for all mental disorders across the continuum of life and has been systematically documented in the recent Lancet series on Global Mental Health (Saxena, et al. 2007). We lack the economic as well as the human resources to achieve widespread coverage of specialist services. Moreover, specialist services which tend to focus mostly on medical interventions may have only a limited role in the long-term care of older people with mental health problems, especially those with conditions like dementia. When we develop services, we should cater to the requirements of home-based care and address the diverse medical and psychosocial health needs of the affected persons and their caregivers. This bottom up approach is necessary for better acceptance of mental health care by the community. To be sustainable the services should meet the needs and aspirations of the communities they serve. Development of culturally appropriate interventions at affordable costs is important. Public and low-cost service providers have an important role in services provision.

It is important to note that mental illness is seldom an isolated event among elderly people; thus, co-morbidity with other mental illnesses and physical health problems is typically the rule. The most common problems include deficits of vision and hearing, hypertension, diabetes mellitus, arthritis and cardiovascular disorders. Thus, an ideal model of care for mental disorders in older people must fully address their physical health needs as well. There is a need to raise awareness about mental disorders in late-life in the community and amongst health professionals, and to improve access to appropriate health care for the elderly with mental illness. Health education should aim at educating health workers and the community to recognize the common symptoms of mental disorders and, in particular, to stress that depression and dementia are real disorders and not just the natural consequences of ageing.

Integration with other services

In India there is a large network of government run primary health centres and hospitals which work side by side with extensive private health care and not-for-profit providers. Manpower shortage and poor infrastructure are common in the government system. Implementation of decentralized planning under the new *panchayathi raj* system of governance has opened up opportunities to develop and test models for dementia care. One such initiative began at the Talikulam Rural Development Block in the Thrissur District of Kerala that (Shaji et al., 2002 & 2003) involved working closely with the *anganwadi* workers and the community leaders and developing a service for older people as well as running a monthly mental health clinic to address problems of the older people. The community based dementia care module developed can be useful for training health volunteers.

Palliative care and care of older people

Indian Association of Palliative Care has formally declared its resolve to provide services for older people with disabling conditions like dementia through their community care network. The palliative care model in community care is unique by the partnership between health activists, health care professionals and specialists in palliative care. Clinicians with special interest/ training in dementia care or psychogeriatric care can also consider linking with similar community care initiatives. An alliance between the clinician, caregiver and the health worker can help. Health workers like, Accredited Social Health Activists (ASHA) or other community health workers can be trained to identify people with dementia and other unmet mental health needs (Shaji *et al.*, 2002). They could then be trained to deliver simple interventions at home as part of their community work.

Community care for older people with mental health problems

There are three important steps in the development of responsive community-based services. The first is to identify people with dementia or other mental health problems needing help. The second step is the assessment of identified cases and the needs of the caregiver. Then health workers after receiving more training can provide simple home-based interventions. The focus should be on improving the quality of life of the patient and the caregivers. The ingredients of the intervention should include educating the family and the caregivers about the illness and its management, and assisting the caregiver in managing distressing symptoms. Special attention should be given to the assessment and management of behavioural symptoms as well as impairment in basic activities of daily living. Simple cost-effective intervention strategies will have the potential for wider application in the community.

Attention needs to be directed towards the development of age-appropriate long-term care policy. There have to be mechanisms for ensuring the social protection of older persons. Conditions like dementia are important causes of dependency among older people. Community based services can address the needs of people affected by a wide variety of disabling and incurable conditions. A network of nurses and doctors with expertise can supervise and support such initiatives. Dementia care can be delivered as part of such initiatives (Prince, et al., 2009).

Depression is more prevalent than dementia and is eminently treatable. There is a need to equip primary care to identify and manage depression and other mental health problems of late life. Outreach services need to include health care of older people as a priority. Linking of outreach services with primary care and specialist psychogeriatric care should be attempted. Well informed community health workers can play a key role in scaling up of services.

18.8 LET US SUM UP

This Unit has focussed on the concept of demographic ageing and the common health problems; particularly mental health issues during old age. Delirium, dementia and depressive disorders are common in late life, as are suicidal tendencies. A concerted effort needs to be made at the individual, family community and public health service provision levels to address these problems, and to foster the physical and mental health of the elderly.

18.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Reduced birth rates with increasing life expectancy is leading to an increase in the proportion of older people in our population and this phenomenon is called demographic ageing.

Check Your Progress Exercise 2

1. Memory loss, urinary incontinence, depression and falls/immobility.
2. Primary Health Care centres

Check Your Progress Exercise 3

1. Loneliness, reduced social support and need for assistance in activities of daily living are common stressors in later years of human life.

Check Your Progress Exercise 4

1. (i) True, (ii) True, (iii) True

Check Your Progress Exercise 5

1. Delirium
2. Clouding of consciousness

18.10 UNIT END QUESTIONS

1. With the help of examples, discuss ageing and mental health in the Indian sociocultural context.
2. How can the mental health problems in old age be addressed effectively? Analyse, giving examples.

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UNIT 19 YOGA THERAPY, MENTAL HEALTH AND WELL-BEING

Structure

- 19.1 Introduction
- 19.2 Definitions of Yoga
- 19.3 Concept of Health and Disease
 - 19.3.1 Concept of Health and Disease According to *Panchakosha* Theory (*Taittiriya Upanishad*)
 - 19.3.2 Causes of Disease According to *Yoga Vasista*
 - 19.3.3 Causes of Disease According to *Pathanjali Yoga Sutras*
 - 19.3.4 How to Overcome *Kleshas* and *Vikshepas*?
 - 19.3.5 Stress According to Yoga and Its Management in *Bhagavada Gita*
 - 19.3.6 How Yoga Helps?
- 19.4 Techniques of Integrated Approach of Yoga Therapy
 - 19.4.1 *Annamaya Kosha* Practices
 - 19.4.2 *Pranamaya Kosha* Practices
 - 19.4.3 *Manomaya Kosha* Practices
 - 19.4.4 *Vignanamaya Kosha* Practices
- 19.5 Precautions
- 19.6 Yoga Practices
- 19.7 Applications
- 19.8 Scientific Evidence Related to Yoga in Psychiatric Disorders
- 19.9 Let Us Sum Up
- 19.10 Glossary
- 19.11 Answers to Check Your Progress Exercises
- 19.12 Unit End Questions
- 19.13 Further Readings and References

19.1 INTRODUCTION

Yoga is a way of life and has a history of more than 5000 years. Scientific and technological advance has made man highly creative, at the same time sensitive also. Due to the frenetic pace of modern life, we are coming across modern stress related diseases more often. Man has conquered many contagious and infectious diseases, but widespread psychiatric and psychosomatic ailments are posing a great challenge. This is the reason currently worldwide people are looking for alternative system of medicine to get a solution in this regard. Yoga is considered worldwide under the Complementary and Alternative system of Medicine (CAM) interventions.

It is well known that Yoga is becoming more popular all over the world. Main objective of Yoga is to integrate personality of an individual at all levels of existence. i.e physical, mental, emotional, intellectual and spiritual

dimensions of all round personality development. Shri Aurabindo describes yoga as a practical Psychology, which can be used as a tool by all human beings to realize the human potential and there by fulfill the cosmic laws of evolution. A foundation of Yoga lies in *Vedas, Upanishads, Puranas, Smritis, Bhagavada Gita, Pathanjali Yoga sutras* etc. Pathanjali has explained importance of yoga on positive mental health in the sutras. So Yoga seems to have a role to play a preventive and therapeutic Psychiatry. In this chapter, special emphasize is given on psychological counseling aspects of Yoga also known as Indian psychology along with Yoga practices.

Objectives

After studying this Unit, you will be able to:

- Understand the importance of yoga for healthy life;
- Differentiate different types of yoga and their uses; and
- Appreciate the use of yoga in counselling and family therapy.

19.2 DEFINITIONS OF YOGA

In most of the definitions of Yoga, it can be seen that importance is given to positive mental health. This shows Yoga has a role in modifying brain functions.

मनः प्रशमनोपायः योग इत्यभिधीयते।

manah praśamanopāyau yoga ityabidhēyate
Yoga is the skill to calm down the mind
- *Yoga Vashishta*

योगश्चित्त वृत्ति निरोधः।

yogaścitta vṛtti niroḍaḥ
Yoga is the process of cessation of mental modifications
- Patanjali Yoga Sutra (PYS) I: 2 (>2000 years)

समत्वं योग उच्यते।

Equilibrium state of mind is Yoga -Bhagavadgita(>5000 years)

19.3 CONCEPT OF HEALTH AND DISEASE

World Health Organization (WHO) defines Health as not merely an absence of disease but as a state of physical, mental, emotional and spiritual well-being.

Health and Yoga: Health depends on equanimity in all these 5 levels i.e *Ahara* (Food), *Vichara* (Thinking), *Vyayama* (Yoga/Exercise), *Vihara* (Lifestyle) and *Virama* (Relaxation). In brief, health depends on all round personality development at physical, mental, emotional, intellectual and spiritual levels as described by Shri Aurabindo

Disease (Vyadi): Diseases are due to violation of nature's laws. Causes of diseases according to "Sankhya philosophy" are physical and mental causes (*Aadhibhautika*). Physical diseases are caused due to imbalance in humors (*vata, pitta* and *kapha doshas*). Mental diseases are caused due

to the desires and desires bring about instability in the mind. Subsequently if desires not fulfilled gives rise to Psychiatric disorders. Six enemies of mind are *avishadvargas*, they are *kama* (desire), *krodha* (anger), *lobha* (lust), *moha* (attachment) and *matsarya* (hatredness)

19.3.1 Concept of Health and Disease According to Panchakosha Theory (Taittiriya Upanishad)

It explains about the five sheaths of human existence. They are :-

1. *Annamaya kosha* (Physical sheath)
2. *Pranamayakosha* (Vital sheath)
3. *Manomaya kosha* (Mental sheath)
4. *Vignanamaya kosha* (Intellectual sheath)
5. *Anandamayakosha*. (Blissful sheath)

In *anandamaya kosha* man is in perfect harmony and balance in all levels of health. At *vignana maya kosha* there are movements but they are channelized in proper direction. It is in the *manomaya kosha* level the imbalances start as yoga texts says in the form of *adhis*. *Adhis* are of two types, *samanya* and *sara*. *Sara* (essential) is responsible for birth and death of the body, where as *samanya* are called psychosomatic diseases. When mind is agitated in the *manomaya kosha* percolates into the physical sheath through *pranamaya kosha*. This disturbance in the mind causes violent fluctuations in the flow of *prana* in the *nadis*. Due to these instabilities in the *nadis*, the food does not get digested properly. There by arises *ajeernatvam* (non-digestion) & *atijeernatvam* (over digestion). This concept was given in the yoga texts as stimulation of digestive fire/secretion in certain yoga practices.

Normally our body physiology through (homeostasis) tries to maintain normal health. But if it exceeds the homeostasis threshold due to frequent violation of laws of nature, we tend to get different diseases

19.3.2 Causes of Disease According to Yoga Vashista

In *Yoga vashista*, given emphasise on cause of sorrow is only attachment to worldly life.

Mental afflictions and physical diseases are the two causes of sufferings. Relief from them would be happiness and their termination is called liberation. Also mental affliction (disturbed mind) is the cause for physical diseases.

19.3.3 Causes of Disease According to Pathanjali Yoga Sutras

Patanjali who is known as the father of yoga described the obstacles (*Chitta Vikshepas*) in the path of attaining a state of sound mental health. These obstacles are disease, lack of interest, doubt, indecision, carelessness, sensual gratification, living under illusion, wrong perception, sorrow, despair, unsteadiness of the body and irregular breathing (PYS I:30 & I:31). There

are five types of *Kleshas* (afflictions) which disturb the equilibrium state of consciousness. They are *Avidya* (ignorance), *Asmita* (ego), *Raga* (attachment), *Dvesa* (Anger), and *Abhinivesa* (fear of death). Patanjali has prescribed *Ashtanga* (eight-limbed) Yoga also called Raja Yoga to get rid of these *Kleshas* (PYS II: 3 & 28). The eight limbs of Ashtanga Yoga are *Yama* (restraints), *Niyama* (observances), *Asana* (postures), *Pranayama* (breathing practices), *Pratyahara* (withdrawal of senses), *Dharana* (concentration), *Dhyana* (meditation) and *Samadhi* (realization of the true Self or Atman).

19.3.4 How to Overcome *Kleshas* and *Vikshepas*?

To get rid of these *Klesas* and *vikshepas*, Patanjali has prescribed the following eight *sadhanas*. It can be seen that in all these definitions positive effects of Yoga on mind are recorded. Practice and detachment are the means for control of mental disturbances. *Abhyasa* means repeated practices such as *Yama*, *Niyama*, *Asana* and *Pranayama*. *Vairagya* means freedom from desires and passions that could be attained by the practice of *Dharana*, *Dhyana* and *Samadhi*. Further Patanjali suggested *Vitarka badhane pratipakshabhavanam* means to obstruct thoughts which are inimical to yoga, contrary thoughts should be brought (PYS II: 33) and also emphasized to develop friendship, gladness and indifference being thought of in regard to subjects, happy, unhappy, good and evil respectively which pacify the *chitta* (PYS I:33).

19.3.5 Stress According to Yoga and its Management in Bhagavada Gita

i) What is stress according to Yoga?

Stress is speed at all the levels of human existence from *annamaya kosha* to *manomaya kosha*.

ii) How stress builds up according to Bhagavada Gita?

While contemplating the objects of the senses, a person develops attachment for them and from such attachment lust develops & from lust anger arises. From anger complete delusion arises and from delusion bewilderment of memory. When memory is bewildered intelligence is lost and when intelligence is lost one falls down again into the material pool. This is how stress builds up according to Bhagavada Gita.

iii) How stress can be overcome?

Stress can be overcome by practicing these three

- a) Action in relaxation (work without stress): Shri Krishna says to Arjuna that, perform duty equipoised by abandoning all attachment to success or failure and suggest such equanimity is called Yoga (Bhagavada Gita)
- b) Developing happiness is within: Shri Krishna said, when a man gives up all varieties of desire for sense gratification, which arise from mental concoction and when his mind thus purified, finds satisfaction in the self alone, then he is said to be in pure transcendental consciousness or steady in consciousness. (Text 55–Division of faith Bhagavada Gita)

- c) **Maintaining Balance:** One who is not disturbed in mind even amidst the threefold miseries or elated when there is happiness and who is free from attachment, fear and anger is called a sage of mind.

19.3.6 How Yoga Helps?

Yogic therapy emphasizes treating patient rather than disease. Yoga works by:

1. Reducing stress
2. Improving body's own resistance power (Immunity)
3. Changing the behaviour pattern and attitude towards life.
4. Improving over all lifestyle of a person and other several benefits

19.4 TECHNIQUES OF INTEGRATED APPROACH OF YOGA THERAPY

Yoga therapy is a branch of science which deals with the yoga techniques for the treatment of different diseases. The basis of Yoga therapy is *panchakosha theory*.

Yoga therapy practices according to Panchakosha:

Annamaya kosha practices: Sukshma vyayama, kriyas, asanas, yogic diet

Pranamaya kosha practices: Pranayama, breathing exercises

Manomaya practices: Yama, niyama, Pranava japa, dharana, bhakti yoga

Vignana maya kosha practices: Notional corrections, Happiness analysis

Anandamaya kosha: Karma Yoga, Bhagavada Gita

19.4.1 Annamaya Kosha Practices

- i) **Diet (Proper food):** Diet has an important role in health and well being. It was mentioned in the *Chandogya Upanishad* that "Diet is required for the development of person's body. Diet not only has an effect on the body but also on the mind".

According to Hata Yoga pradeepika:

Moderate diet (Mitāhāra) :

This has been given great importance in the *Hatha Yoga Pradeepika* (HYP I:58) as *Mitahara* (Moderate diet). 'Moderate diet' is defined as agreeable, sweetish (Fresh, sweet fruits of all types), leaving one-fourth of the stomach free, eaten as an offering to God.

According to Bhagavada Gita:

The Bhagavada Gita classifies diet into *Satvik*, *Rajsik* and *Tamsik* diet. A *Satvik* diet is good for those who are practicing Yoga and also to preserve mental health of an individual. *Sathvik* foods (BG 17.8) enhance quality of life, purity, strength, contentment, joyousness are juicy, unctuous, steady and pleasing to the heart, which are liked by Satvikas. These Satvik foods

nourish the body and mind such as green leafy vegetables, fruits, cereals, pulses, milk and others.

ii) **Asana**

Asana in sanskrit means posture. There are 82 important asanas. However, no asana is prescribed exclusively for treating psychiatric disorders. In the *Yoga Sutra* 2500 years ago, Patanjali describes *asana* as the third of the eight limbs of *Raja Yoga*.

How to practice asana?

According to Patanjali, *asana* is defined as postures, which give stability and comfort. By lessening the natural tendency for restlessness and meditating on the unlimited, posture becomes firm (*sthiram*) and pleasant (*sukham*) i.e., it should be practiced with ease and concentration on infiniteness).

Following are the essential features of Asana:

- *Vinyasa* - steps
- *Svasakrama* - breathing pattern
- *Dristi* - vision
- *Sthiti* – position
- *Vishranti* – Relaxation

Benefits of Asana: By the practice of *asanas*, one can overcome dualities (that are causes of disease). Also practice of *asana* makes practitioner to overcome dualities, i.e., there is no longer joy or sorrow, heat or cold, honour or dishonour, pain or pleasure (balanced state of mind and body).

According to *Hata Yoga Pradeepika* (HYP) by Swatmarama:

- *Asana* is said to make one mentally stable because it reduces *Rajo guna* that causes fickleness of the mind.
- Heaviness of body is due to increased *tamo guna* and *asana* removes this.
- Imbalances in the humours of the body – wind, bile and phlegm (*vata*, *pitta* and *kapha*) - are the main causes for different diseases, which can be removed by the *asanas*.

Therapeutical and physiological benefits of Asanas:

1. Loosen the joints, stretch and relax the muscles
2. Tranquilize the mind
3. Improves physical revitalization

iii) **Kriyas:** There are six yogic purification processes described in *Hatha Yoga* and *Gheranda samhita*. They are *dhouti*, *vasti*, *neti*, *trataka*, *nauli* and *kapalabhati*.

Classification of kriyas according to different regions of the body

- 1 Nasal cavity: *Sutra neti. Jala neti and kapalabhati*
- 2 Eyes: *Trataka*
- 3 Gastro intestinal tract: *Vamana dhouti, vastra dhouti, nauli, vasti and others*

Benefits:

1. To cleanse the inner organs of our body by activating and revitalizing the organs, by toning up their functions,
2. Ensuring desensitization and by developing deep internal awareness.
3. Restore inner homeostatic equilibrium.

Precaution: One who is having excess of fat and phlegm must practice these purifactory practices. However those who have balance in three humors (*doshas*) need not to practice them.

19.4.2 *Pranamaya kosha* practices

Suitable practice of *Pranayama* and breathing exercises help to remove the random agitations in the flow of *prana* (vital energy) in *pranamaya kosha*. Hence ailments are handled at this level.

i) PRANAYAMA: *Pranayama* (Sanskrit: *Prānāyāma*) - composed of two sanskrit words; *Prāna* means life force or vital energy (breath) and *āyāma* means to lengthen or gain mastery. So mastery over *prana* is called *pranayama*. Controlling the motion of inhalation and exhalation of breath with retention is called *pranayama* (PYS II 49)

Pranayama has three phases:

- a) Inhalation (*Puraka*): Breathing in as much air as possible.
- b) Retention (*Kumbaka*): Retaining the breath for half the time taken for *puraka*.
- c) Exhalation (*Rechaka*): Gradually breathing out this air over almost the same time taken for *puraka*.

Features of *Pranayama*

Pranayama is performed by emphasizing on the posture (*asana*), length and duration of the breath and the number of times breath is taken. These are typically done in sitting postures. They are often practiced in conjunction with *asanas*.

Text Benefits

Pranayama removes covering of the mind, i.e., practice of *Pranayama* destroys illusion, ignorance, desire & delusion which obscure the intelligence and make inner light of wisdom to shine (PYS II: 52) and mind becomes fit for concentration (PYS II: 53).

According to Swatmarama in *Hatha Yoga Pradeepika*:

- Freedom from diseases may be achieved through the proper practice of *Pranayama* (along with right food and *Bandhas*). (HYP II:16,17)
- Purification of *nadis* facilitates leanness and brightness of the body (HYP II -19).

Different types of *Pranayama*: In *Hata Yoga Pradeepika*, the following eight are mentioned such as *suryabhedana*, *ujjayi*, *sitkari*, *sitali*, *bhastrika*, *bhramari*, *murcha* and *plavini*. Although it may be difficult to practice last two *pranayamas*, the first six have been extensively used in treating different diseases. *Pranayama* is best practiced in a sitting posture and with eyes closed in a quiet ambience. All through the procedure the mind must remain focused on the movement of air in and out of the body. One may even avoid concentrating on an image or *mantra*.

19.4.3 *Manomaya Kosha Practices*

Operation at this level is possible by first two limbs and last three limbs of *Ashtanga* yoga. That is by practicing *Yama*, *niyama*, *dharana*, *dhyana* and *samadhi*. To handle and to gain control over the basic cause of mental agitations, yoga techniques which control the emotions by *Bhakti* yoga (prayers, chants, *namavalis*, *stotras* etc) is being used.

i) *Yama, niyama, dharana, dhyana practices according to Pathanjali Yoga sutras:*

Yama (Self disciplines): It is the control of the body, speech and mind. The *yama* as are five in number. They are *Ahimsa* - non violence, *Sathya* – truthfulness, *Astheya* - nonstealing, *Bramhacharya* – celibacy, *Aparigraha* - non receiving are various disciplines (constraints). PYS II 30.

Niyama or the obedience of proper conducts: It is too five in number. They are:-

Shaucha - purification of body and mind,

Tapas – austerity,

Santosha – contentment,

Svadyaya - self study,

Ishwara pranidhana - surrendering to the highest power are the *niyamas* (PYS II 32).

Dharana: is holding the mind on to some particular object (PYS III: 1)

Dhyana: A steady and continuous attention directed towards the object of concentration is meditation. – PYS III: 2

ii) *Bhakti Yoga: Chanting Mantras & slokas for culturing the emotions*

Bhakti is the science of emotional culture. It is the path of love and devotion (*Bhagawada Gita*). The process of enlightenment found through worship of God.

Categories of Bhakti Yoga: There are two kinds of *Bhakti* Yoga:-

1. *Kamyā Bhakti*: Devotion towards god for material and personal fulfillment.
2. *Nishkamyā Bhakti*: Devotion towards god without any material and personal fulfillment.

Universal and individual mantas are: *Mahamrityunjaya mantra*, *Gayatri mantra* chanting, 'Om Namah Shivaya', 'Om Namo Bhagavate Vasudevaya', 'Om Namo Narayana', 'Soham', 'Om'.

Benefits of chanting Mantras/slokas/prayer

- Repeated chanting of the *mantra/sloka/prayer* leads to one-pointed concentration.
- Through chanting of *mantras*, the mental processes are balanced, energies will be distributed properly and there will be elimination of mental tensions.
- Harnessing the right brain functions which are the seat of emotions and creativity etc. Science of emotion culturing develops the right brain and there by harmonizes the left and right part of the brain effectively.

19.4.4 Vignanamaya Kosha Practices

The basic understanding is the key to operate at *Vignanamaya kosha*. Upanishads are the treasure of knowledge. It is the lack of inner *Jnana* which is responsible for many wrong habits, agitations etc.

Happiness Analysis (Ananda Mimamsa)

To understand nature of bliss, that is, the inner peace. Happiness comes from within and is not dependent on material possessions or physical enjoyment. We have never analyzed our self completely. We tend to assume that happiness is in the object of enjoyment, for example, *Jamun*: If you have more *jamun*, you may not be happy. Complete happiness is a state of silence, where one is no longer troubled by unnecessary thoughts and feelings. It is a state of perfect peace and freedom. *Sukha* is inside not in outside. This is the secret of happiness.

19.4.5 Anandamaya Kosha Practices

Practice of *karma Yoga* enables us to change the attitude of greed and deep attachment to material possessions and enjoyment towards the realization that happiness is within and each one of us in our causal state is *ananda* embodied.

Concept of Karma Yoga

Karma Yoga is the Yoga of action, but the action done in a special way. Means the action done with meditative awareness.

Components of Karma Yoga

1. **Meditative awareness:** Controlling the senses by the mind, as Shri Khrishna said benefits are improves concentration.

For example : Concentration on the job helps us to work more efficiently.

2. **Service:** Our actions are done for the sake of the world and for the benefit of others.
Benefits: Relationship with other people become more positive and harmonious.
3. **Non-attachment:** It is an anti-stressor.
Benefits: If we are not attached to something then we are not afraid to lose it, so fear decreases.
4. **Non-expectation:** doing activity without expecting personal reward and performing actions without craving results.
5. **Appropriate life directions (*Swadharna*):** one should remain aware of one's own personal *dharma* in the sense of both one's appropriate life direction and the duty that comes from it.
6. **Positive attitude:** Reduce the pessimistic view of thinking and enhance positive way of thinking.
For example: Swami Niranjan's question is when you see a rose; do you see the beautiful flower or the thorns? The choice is yours.
7. **Efficiency:** We may define efficiency as doing the work as cleanly, neatly, quickly, economically and effectively as possible.
8. **Equanimity:** Balance of mind in success or failure, praise or criticism, fame or disgrace etc.
9. **Non ego involvement**
10. **All our activities surrendered to the higher power**

19.5 PRECAUTIONS

i) **Precautions to be taken to practice *Asanas, Sukshma vyayama* and *Pranayama*:**

Before the practice:

1. The urinary bladder and bowels should be emptied.
2. A minimum of four hours gap should be given after taking full meals, two and half hours after a light breakfast and one hour after taking tea/coffee/juice/other liquids.
3. Avoid even water for half an hour before the practice.

During the practice:

1. Care should be taken not to give any jerky movements/ strain to the body and mind (while doing the practice, do not go beyond the anatomical limitation for a given individual).
2. Breath should not be kept on hold at any point of Yoga practice.

After the practice:

1. A minimum of fifteen minutes gap should be given before taking tea/coffee/juice, bathing, doing any exercise and half an hour before having meals.

Note: For practicing relaxation techniques/ meditation, these restrictions may be relaxed.

ii) General therapeutic precautions:

1. Except relaxing postures, *pranayama* and meditation, other practices should be avoided in conditions like hernia, peptic ulcer, chest pain, ischemic heart disease and slipped disc.
2. Those who have undergone recent abdominal surgery may avoid these practices for three to six months according to the severity.
3. During menstruation limit practice to relaxing *asanas* such as *Shavasana* and *Makarasana*. Meditation may be done by stretching both the legs forward.
4. Similarly, during first three months of pregnancy, limit practice to techniques/ *Asanas* such as *Shavasana*, *Makarasana*, Meditation and some *Pranayamas*. Some *asanas* can be practiced in the next six months (second and third trimester). Patient may consult an expert yoga physician for guidance in this regard.

The yoga practices should be started under supervision. Yoga as treatment for depression should be considered only when prescribed for the individual patient. Based on the clinical status of the patient, some practices may have to be avoided.

19.6 YOGA PRACTICES

There are few Yoga therapy practices mentioned below with technique and benefits.

I. YOGIC SUKSHMA VYAYAMA

Sukshma and *Sthula Vyayama*

- **Samasthithi: Stand straight with the feet together. Hands to be kept by the sides of the thighs with eyes wide open**

MANI BANDHA SAKTI VIKASAKA (Wrists)



- Stretch out your two arms straight in front of the chest at shoulder level, keeping them parallel to the ground.
- Make loose fists of your hands (palms facing down).
- Now, move the fists up and down from the wrists with force. Arms should be kept as stiff as possible. Keep normal breathing throughout the practice.
- Repeat ten times.

KAPHONI SAKTI VIKASAKA (Elbows)



- Stretch the arms straight downwards beside the body, palms facing forward and make fists.
- While inhaling, bend the arms at the elbows and raise your clenched fists forward to the level of shoulders with a jerk. Then while exhaling stretch the arms downwards again with a jerk.
- Repeat it ten times.

Note:

- The elbows should remain stationary.
- The fists / palms must come up to the level of the shoulders and then down straight.
- The fists / palms must not touch the shoulders when going up, nor touch the thighs when coming down.

BHUJA-VALLI SAKTI VIKASAKA (Arms)



- Begin with both of your arms hanging relaxed by the side of your body; then raise it sideways above your head with the palm outward.
- Neither the arms should go up and down together but arms must not touch the head nor do the hands touch each other. The arms must not touch the thigh when coming down.
- Keep normal breathing throughout the practice.
- Bring it down both the arms in the same manner.

SPINAL TWISTING



- Spread the legs about one foot apart.
- Raise the hands sideways parallel to the ground while inhaling.
- Keep the legs firm on the ground and twist to the right, keeping the right hand straight.
- Simultaneously twist the neck and look at the tip of the fingers.
- Bend the left hand at the elbow to bring the hand close to the chest.
- Come back while inhaling.
- Repeat the same on the left.
- Gradually increase the speed to your maximum capacity.
- Repeat it for 10 times each.
- Slow down the speed and stop the practice.
- Relax in *samasthi*.

JOGGING: 2 minutes

Slow Jogging:

- Make loose fist of your hands and place them on the chest.
Collapse and relax your shoulders.
- Start jogging on your toes slowly. Jog for about 1 minute.



- Lean backward a little and now as you increase the speed again, try to raise the knees higher and higher. Raise the knees forwards so that try to reach the chest level.
- Repeat for 10 times at your maximum speed.
- Slow down the practice coming back to the stage of slow jogging again.
- Continue slow jogging for a few rounds, count for 5 times.

SURYA NAMASKAR - Sun salutation (In 12 steps)

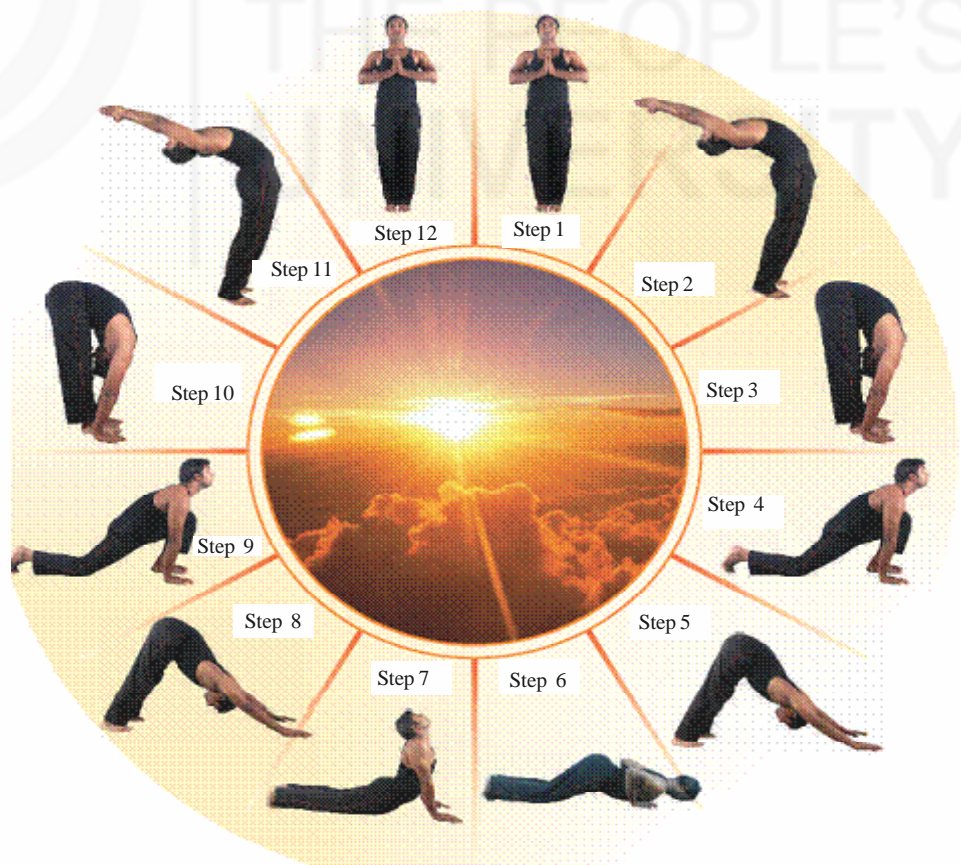
Step 1: Stand straight with the feet together facing east in the morning i.e, the direction of the rising sun with folded hands (**Pranamasana**). Breath normally.

Step 2: Inhale and slowly raise the hands upwards and bend the body slightly backwards at the waist region (**Hastha uttanasana**).

Step 3: Now exhale and bend forward slowly so that the hands touch the ground by the side of the feet, while the head touches the knees. Legs have to be kept straight without bending the knees (**Padahasthasana**).

Step 4: Inhale normally, then while exhaling take the left leg backwards smoothly. The right leg and the palms should be on the ground in the same line. Inhale, look up and expand the chest (**Asva sanchalanasana**).

Step 5: While exhaling, take the right leg also backwards and lift the body to form a triangle. Look downwards (**Parvatasana**).



Step 6: While exhaling, place the forehead, palms, chest, knees and toes on the ground. Rest of the body parts should be above the ground.

The hip portion should be slightly elevated from the ground (*Astanga namaskarasana*).

Step 7: Inhale and lift the forehead, chin, neck, expand the chest and look up. Keep the elbows in a semiflexed position (*Bhujangasana*).

Step 8: While exhaling, lift the body from the waist region upto toes so as to form a triangle, look downwards (*Parvatasana*).

Step 9: While inhaling, bring left leg forward so that the left leg and the palms are on the ground in the same line (*Asva sanchalanasana*).

Step 10: While exhaling, bring both the legs together so that both the hands has to touch the ground by the side of the feet, while the head touches the knees. Legs has to be kept straight without bending the knee (*Padahasthasana*).

Step 11: While inhaling, slowly raise the hands upwards above the head and bend the whole body slightly backwards at the waist as far as possible (*Hastha uttanasana*).

Step 12: While exhaling, stand straight with the feet together facing east i.e, the direction of the rising sun with folded hands (*Pranamasana*). Breathe normally.

This completes one round of *Suryanamaskara*.

Benefits:

- This practice brings about general flexibility of the body preparing it for *asanas* and *pranayama*.
- Energizes the entire neuroglandular and neuro muscular system of the body.
- Useful in patients with decreased appetite, fatigue, obesity, constipation, psychiatric disorders such as anxiety and depression.

Note:

1. Breathing has to be done in a systematic manner. If the practitioner cannot adjust himself in the beginning in terms of breathing, they can keep normal breathing whenever they will be in the final position.
2. Breath should not be kept on hold at any point.

Limitations:

- It should be avoided in case of backache and acute abdominal disorders.

ASANAS: PRACTICES, TECHNIQUE & BENEFITS

STANDING SERIES OF ASANAS

ARDHA CHAKRASANA (Half wheel pose)

- Stand straight with the feet together. Hands to be kept by the sides of the thighs with eyes open (Standing *samasthiti*). Then stand with your legs separated as far as possible.

- Support the back at the waist by the palms, fingers together pointing forward supporting the waist.
- Inhaling, bend backwards from the lumbar region as far as possible. Try to maintain the posture with normal breathing and without losing the balance. This is called *asanasthiti*. Exhaling, slowly come back to the samasthithi.
- Relax for a while in standing position by keeping the legs apart and placing both the hands behind in locked position (Standing *vishranti sthithi*).
- Feel the changes in the breathing and stretched part.

Benefits:

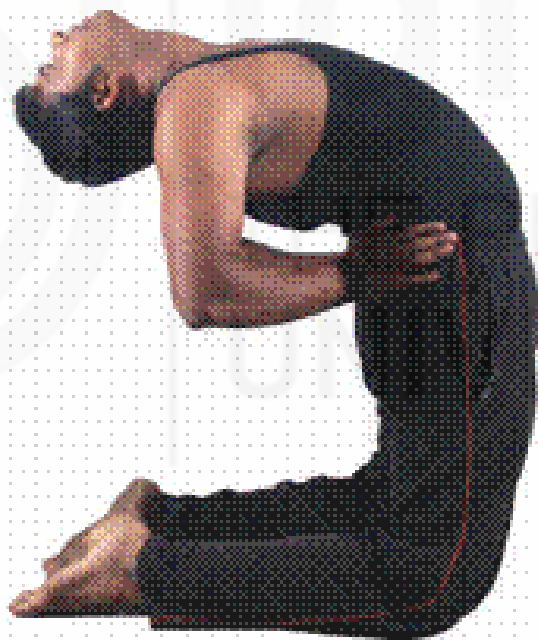
- Improves the balance of the body

Limitations:

- It should be avoided in case of vertigo and acute abdominal disorders

SITTING SERIES OF ASANAS

ARDHA USTRASANA (Camel pose)



- Sit in *Vajrasana* & then come to kneeling down position on the floor (*Samasthithi*)
- Keep the knees about one foot distance apart and the sole of the foot facing upwards with toes pointing backwards. Keep the hands on the respective waist region. While exhaling, bend backwards as much as possible. This is called *asanasthithi*.
- Maintain for few seconds in this final position with normal breathing
- Inhale and come back to the kneeling down position
- Relax for a while by spreading both legs extended apart in forward direction & keeping both the hands on the ground beside the respective

hips. Taking neck slightly backwards for few seconds (*sitting vishranti sthiti*).

- Feel the changes in breathing and stretched part.

Benefits:

- This stretches the thoracic and neck region, there by regulating the thyroid and stimulates the respiratory organs functions.
- Increases the functions of digestive system.

Limitations:

- People with severe back ailments should not attempt this posture.
- Proceed cautiously in knee joint pain

PRONE SERIES OF ASANAS

BHUJANGASANA (Serpent pose)



- Lie down in *makarasana* posture & bring the legs together (*Prone samasthiti*).
- Bend both the upper limbs at the elbows; place the palms on the ground under the shoulder.
- Inhaling, raise the forehead, chin, neck, chest and the abdomen. Keep the eyes closed. Maintain the posture for sometime with normal breathing. This is called *asanasthiti*.
- While exhaling slowly bring the body back to the ground, starting from the abdomen, thorax, chin and forehead on the ground in order.
- Relax in *makarasana* (*Prone vishranti sthiti*). Feel the changes in breathing & stretched part.

Note: Keep the elbow in a semi flexed position.

Benefits:

- Reduces the abdominal fat.
- Beneficial in digestive disorders.

Limitations:

- Proceed cautiously in cervical spondylosis.
- It has to be avoided in people having slip disc.

SUPINE SERIES OF ASANAS

PAVANAMUKTHASANA (Wind releasing pose)

- Lie on the back. Bring both the hands and legs together. Keep the head in a comfortable position. Gently close the eyes (*Supine samasthi*).
- Inhaling, slowly raise the legs together without bending at the knees till it forms about 45 degree to the ground. Raise the legs further to 90 degree. Bend both the lower limbs at the knee joint. Raise the head and shoulder slowly and place the chin in between the knees. Simultaneously place the upper limb around the knees. Maintain the final posture for few seconds with normal breathing. This is *asanasthithi*.
- Exhaling, release the head and chest, then release the hands.
- Exhaling, release the legs upto 90 degree to the ground and release the legs 45 degree further to the ground, then bring it on the ground.
- Then relax in shavasana (*Supine vishranti sthiti*) and feel the changes.

Benefits:

- Abdominal muscles are toned up.
- Beneficial in flatulence, constipation, hyperacidity, indigestion, malabsorption and helps reducing abdominal fat.
- Useful in impotence.

Limitations:

- Persons with acute abdominal disorders should not practice this *asana*.

VIPARITHAKARANI MUDRA

Samasthiti: Supine

- Lie on the back. Bring both the hands and legs together. Keep the head in a comfortable position. Gently close the eyes (*Supine samasthi*).
- Inhaling, slowly raise the legs together without bending at the knees till it forms about 45 degree to the ground. Raise the legs further to 90 degree. Now give support to the waist region with the hands. Raise the legs to the vertical position and keeping the trunk at an angle of 45 degree to the ground, so that weight of the body rests on the shoulders. Chin should not press against the chest. Close the eyes and feel comfortable. This is *asanasthithi*.
- Focus awareness on the perineum.
- Exhaling, release the legs upto 90 degree there by 45 degree to the ground, then bring it on the ground.

Then relax in *shavasana* (*Supine vishranti sthiti*) and feel the changes.

Benefits:

- Useful in gastrointestinal disorders, Varicose veins, piles, hernia and menstrual disorders.

- This asana practice improves venous drainage and hence increases circulation to the pelvic organs, abdominal and chest region.
- Regulates thyroid functions.

Limitations:

- People with Cervical spondylosis, low back ache, acute abdominal disorders and hypertension should not practice this posture.

SHAVASANA



- 5 minute
- Lie down on back in *shavasana*
- Phase I: Feel the abdominal movements, Observe the movements of abdominal muscles going up and down as you breathe in and out normally.
Observe 3 cycles.
- Phase II: Synchronize the abdominal movements with deep breathing. The abdomen bulges up with inhalation and sinks down with exhalation.
Observe 3 cycles.
- Phase III: As you inhale deeply and slowly, energize the body and feel the lightness and taking only positive thoughts into the mind. As you exhale completely collapse all the muscles, release the tension and enjoy the relaxation and getting rid of negative thoughts from the mind.
Observe 3 cycles.
- Chant “AAA” in a low pitch while exhaling. Feel the vibrations in the lower parts of the body.
- Slowly come up from either the right or the left side of the body.

Benefits:

- It helps to relax all the muscles and nerves of the body.
- Useful for stress related physical or mental tiredness.
- Useful in patients suffering from insomnia.

KRIYA

KAPALABHATI

The Technique of *Kapalabhati* involves forceful exhalations (active) and inhalation happens automatically (passive).



- Sit comfortably in a meditative posture, either *vajrasana* or *padmasana*, with closed eyes. Keep the spine erect.
- Exhalations should be active and forceful, whereas inhalations should be totally passive. It is accompanied by up and down abdominal movement. Exhalation should be done as quickly as possible at the rate of 60 strokes/ minute. Gradually increase it to 120 strokes/ minute, according to the capacity. The individual would observe an automatic suspension of breath at the end of the practice.
- Chant “A” Kara for two times. Enjoy the relaxation state of the mind.

Benefits:

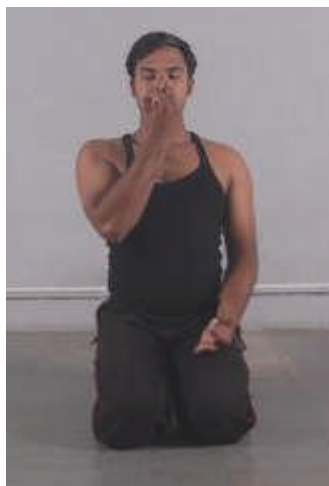
- Brain cells are invigorated.
- Massages the abdominal organs and muscles.
- It reduces the distractions of mind and prepares it for meditation.
- Beneficial in digestive disorders such as hyperacidity, indigestion etc.

Limitations:

- Kapalabhati is to be avoided in case of moderate and severe high blood pressure, ischemic heart disease, vertigo, epilepsy, hernia, gastric/ duodenal ulcer, slip disc and spondylosis.

PRANAYAMA

SURYANULOMA VILOMA PRANAYAMA



- Sit comfortably in any meditative posture either *vajrasana* or *padmasana* with closed eyes. Keep the spine erect. Adopt *Nasikagra Mudra*.
- Close the left nostril with the ring finger. Inhale and exhale slowly through the right nostril only. Feel the air going in and coming out of the nostrils.
- Keep the left nostril closed all the time during the practice. One cycle of inhalation and exhalation forms one round.
- Start with 9 rounds increase upto 21 rounds according to the capacity.

Benefits:

- Useful in depression.
- Helps to burn excessive calories in the body, so it is useful in obesity.

Limitations:

This practice should be avoided in hypertension, epilepsy and ischemic heart disease.

BHASTRIKA PRANAYAMA



- *Bhastrika practice* is the bellows breathing technique in which the breath is forcibly drawn in and out through the nose in equal proportions, like the pumping action of the bellows.
- Sit comfortably in any meditative posture either in *vajrasana* or *padmasana* with closed eyes. Keep the spine erect.
- Make a fist of your both the hands and bring it in front of the respective shoulders.
- Inhale, raise your both the hands up and exhale, bring your hands in front of the chest forcefully with equal force. This mimics the bellow of a smith.
- Continue for 10 – 15 rounds in the beginning and increase the number of rounds according to the capacity.

- Chant “A” *Kara* for two times. Enjoy the relaxation state of the mind

Benefits:

- *Bhastrika* practice stimulates the whole body, improves circulation and invigorates the nerves.
- It stimulates the abdominal organs by increasing the circulation
- It mobilizes excessive fat from the abdominal region.

Limitations:

- *Bhastrika pranayama* has to be avoided in case of moderate and severe high blood pressure, ischemic heart disease, vertigo, epilepsy, hernia, gastric/duodenal ulcer, slip disc and spondylosis

PRANAVA JAPA: AUM/OM chanting



- Inhale slowly and completely.
- Adopt *Brahma mudra* and while exhaling chant ‘A U M’/OM in a low voice.
- Feel the sound resonance through out the body.
- Repeat nine times.

Benefits:

- Improves concentration
- Overcomes mental afflictions

Check Your Progress Exercise 1

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

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

- 1) In what does the foundation of Yoga lie?
.....
.....
.....
- 2) What are all the dimensions on which balanced health depends according to Yoga?
.....
.....
.....
- 3) In which level eventually imbalance gets started causing psychosomatic diseases?
.....
.....
.....
- 4) What are the causes of disease according to *Pathanjali Yoga sutras*?
.....
.....
.....
- 5) What is stress according to Yoga?
.....
.....
.....
- 6) How does stress build up according to Bhagavad-Gita?
.....
.....
.....
- 7) Which kind of diet should one take to attain mental health?
.....
.....
.....
- 8) What are the essential features of *Asana*?
.....
.....
.....
- 9) What are the characteristics of a *karma Yogi*?
.....
.....
.....

19.7 APPLICATIONS

Depending on the condition, Yoga therapy practices tend to get varied. Here there is a brief description of yoga practicing techniques in few psychiatric disorders.

1. **Depression:** Special focus should be given on fast practices like sukshma vyayama, fast surya namaskara, fast breathing exercises and back bending postures. Precaution should be taken not to give relaxation techniques and meditation for more than 10 minutes duration.
2. **Anxiety disorders/Headache:** Special focus should be given on slow practices such as breathing exercises, relaxation techniques, cooling pranayamas and meditation. Relaxation technique and meditation should be given for longer duration.
3. **Psychosis:** Special focus should be given on alternate fast yogic practices followed by slow practices. Precaution should be taken not to teach meditation for these patients and eyes should be opened while practicing asanas.

Note: Before teaching Yoga in patients with psychiatric disorders, Yoga therapy consultant/physician guidance and psychiatrists/counsellors/family therapists guidance is necessary.

19.8 SCIENTIFIC EVIDENCE RELATED TO YOGA IN PSYCHIATRIC DISORDERS

Shapiro et al (2004) showed that practicing Yoga back bends results in increases in positive moods and decreases in negative moods. Practice of back bending postures may have the potential benefit in helping an individual cope with depressed affect. They have found significant reductions in depression, anger, anxiety, neurotic symptoms in the 17 completers. Eleven out of the completers achieved remission. Sharma et al (2006) showed that Sahaj Yoga practice improved the cognitive domains of verbal working memory, attention span, visual-motor speed, executive functions in patients with depression. Duraiswamy G et al., 2007 have shown in patients with schizophrenia that, subjects in the yoga group had significantly less psychopathology than those in the physical exercise group at the end of 4 months. They also had significantly greater social and occupational functioning and quality of life

Yoga has been shown to have significant effect on brain neurotransmitters like GABA. Result suggests that the practice of yoga should be explored as a treatment for disorders with low GABA levels such as depression and anxiety disorders. (Streeter et al., 2007). Hence yoga has been found to be useful in treating various medical and psychiatric disorders, including stress-related disorders.

19.9 LET US SUM UP

To summarize, yoga is a way of life. Main objective of Yoga is to integrate personality of an individual at all levels of existence. i.e physical, mental,

emotional, intellectual and spiritual dimensions of all round personality development. Health depends upon five important dimensions such as keeping balance in proper *Ahara* (Food), *Vichara* (Thinking), *Vyayama* (Yoga/Exercise), *Vihara* (Lifestyle) and *Virama* (Relaxation). Diseases are due to violation of nature's laws. A *Satvik* diet is good for those who are practicing Yoga and also to preserve mental health of an individual. *Karma Yogi* is service oriented, non attached to life, non expectation towards others, has positive attitude, non ego involvement and other qualities, which enable one to attain mental health. It is in the *manomaya kosha* level the imbalances start as Yoga texts say in the form of *adhis. Chitta Vikshepas* and *kleshas* are obstacles in the path of attaining a state of sound mental health and later one disturbs the equilibrium state of consciousness. According to Yoga stress is spread at all the levels of human existence from *annamaya kosha* to *anandamaya kosha*. Main causes of sufferings are desires according to Bhagavad Gita. Research evidence revealed Yoga appears to be a promising intervention for anxiety, depression and schizophrenia since it is cost-effective and easy to implement. It produces many beneficial effects in terms of emotional, psychological and biological measures, as supported by observations of several studies across the globe.

Hence yoga can be useful on attaining positive mental health and also the essence of knowledge can be a boon for counseling the patient with various ailments.

19.10 GLOSSARY

Asanas	: Different postures of the body.
Bandhas	: Means stopping or blocking the flow of spiritual energy in a specific channel (nadi) of the body by a particular yogic posture.
Bhagavada Gita	: Is a sacred Hindu scripture, though its philosophies and insights are intended to reach beyond the scope of religion and to humanity as a whole.
Chitta	: It is the mind, faculty of reasoning and emotion
Dosha	: Each and every gross body has certain constitution of three doshas i.e vata, pitta and kapha.
Gheranda Samhita	: Is a manual of yoga taught by Gheranda to Chanda Kapali. Unlike other hatha yoga texts, the Gheranda Samhita speaks of a sevenfold yoga.
Hata Yoga Pradeepika	: Is a classic Sanskrit manual on Hatha Yoga, written by Svami Svatmarama, a disciple of Svami Gorakhnath which includes asanas, kriyas, pranayama, bandhas etc..
Kriyas	: These are body purificatory practices.
Kleshas	: Are mental afflictions.

Nadis	: Are the channels through which the energies of the subtle body are said to flow.
Prana	: Is the notion of a vital, life-sustaining force of living beings and vital energy.
Puranas	: Are texts usually give prominence to a particular deity, employing an abundance of religious and philosophical concepts.
Rajo guna	: Quality of passion, activity restlessness, aggressiveness.
Raja Yoga	: Is concerned principally with the cultivation of the mind using meditation (<i>dhyana</i>) to further one's acquaintance with reality and finally to achieve liberation. Raja Yoga is also called as <i>astanga Yoga</i> .
Smriti	: Refers to a specific body of Hindu religious scripture and it denotes tradition in the sense that it portrays the traditions of the rules on dharma, especially those of lawful virtuous persons.
Satvik	: It means simple, plain without any show off in relation to life, or spicy in relation to food.
Sukshma vyayama	: Subtle exercises of yoga.
Tamo guna	: The quality of darkness. It causes ignorance, delusion, foolishness, and inertia.
Upanishads	: Are philosophical Yoga texts of the Hindu religion.
Vedas	: The texts constitute the oldest layer of Sanskrit literature and the oldest scriptures of Hinduism.
Yoga Vashishta	: Is a Hindu spiritual text, traditionally attributed to Valmiki. It recounts a discourse of the sage Vasistha to a young Prince Rama, during a period when the latter is in a dejected state.
Yoga Sutras of Patanjali	: Is a Hindu scripture and foundational text of Yoga. It forms part of the corpus of Sutra literature dating to India's Mauryan period.

19.11 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

- 1) The foundation of Yoga lies in *Vedas*, *Upanishads*, *Puranas*, *Smritis*, *Bhagavad-Gita*, *Pathanjali Yoga Sutras* etc.
- 2) Health depends upon five important dimensions such as keeping balance in proper *Ahara* (Food), *Vichara* (Thinking), *Vyayama* (Yoga/Exercise), *Vihara* (Lifestyle) and *Virama* (Relaxation)

- 3) In *anandamaya kosha* man is in perfect harmony and balance in all levels of health. At *vignana maya kosha* there are movements but they are channelized in proper direction. It is in the *manomaya kosha* level that the imbalances start, as Yoga texts say, in the form of *adhis*.
- 4) Obstacles and afflictions such as *Chitta Vikshepas* and *kleshas* are in the path of attaining a state of sound mental health and later one disturbs the equilibrium state of consciousness.
- 5) Stress is speed at all the levels of human existence from *annamaya kosha* to *anandamaya kosha*
- 6) While contemplating the objects of the senses, a person develops attachment for them, and from such attachment lust develops, and from lust anger arises. From anger, complete delusion arises, and from delusion, bewilderment of memory. When memory is bewildered, intelligence is lost, and when intelligence is lost, one falls down again into the material pool.
- 7) A *Satvik* diet is good for those who are practicing Yoga and also to preserve mental health of an individual. *Satvik* foods (BG 17.8) enhance quality of life, purity, strength, contentment, joyousness, are juicy, unctuous, steady and pleasing to the heart, which are liked by *Satvikas*. These *Satvik* foods nourish the body and mind such as green leafy vegetables, fruits, cereals, pulses, milk and others.
- 8) *Asana* has to be practiced by keeping the following steps in mind to achieve great success. These steps are systematic breathing pattern, vision, position, feeling changes and relaxation during and after the yoga practice.
- 9) *Karma Yogi* is service oriented, non attached to life, has no expectations from others, has positive attitude, non ego involvement and other qualities, which enable one to attain mental health.

19.12 FURTHER READINGS AND REFERENCES

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MCFT-007 COUNSELLING AND FAMILY THERAPY: APPLICATIONS AND INTERVENTIONS (MCFT-007)

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