MEDICAL AND PSYCHIATRIC SOCIAL WORK
Master of Social Work (M.S.W.)

Semester – IV, Paper - II
Lesson Writers

Prof. Saraswati Raju Iyer
Professor,
Dept. of Sociology & Social Work
Acharya Nagarjuna University,
Nagarjuna Nagar, Guntur.

Prof. V. Venkateswarlu
Professor,
Dept. of Sociology & Social Work
Acharya Nagarjuna University,
Nagarjuna Nagar, Guntur.

Prof. M. Trimurthi Rao
Professor,
Dept. of Sociology & Social Work
Acharya Nagarjuna University
Nagarjuna Nagar, Guntur.

Prof. K. Dhanalakshmi
Professor,
Dept. of Sociology & Social Work
Acharya Nagarjuna University
Nagarjuna Nagar, Guntur.

Editor

Prof. Saraswati Raju Iyer
Professor,
Dept. of Sociology & Social Work
Nagarjuna University,
Nagarjuna Nagar,
Guntur.

Director
Dr. NAGARAJU BATTU
MBA., MHRM., LLM., M.Sc. (Psy).,MA (Soc)., M.Ed., M.Phil., Ph.D.,
CENTRE FOR DISTANCE EDUCATION
ACHARAYANAGARJUNAUNIVERSITY
NAGARJUNANAGAR – 522510
Ph:0863-2346208,2346222,
0863-2346259(Study Material)
Website: www.anucde.info
e-mail:anucdedirector@gmail.com

M.S.W – MEDICAL AND PSYCHIATRIC SOCIAL WORK

First Edition : 2023No.

of Copies :

Published by:
Dr. NAGARAJU BATTU,
Director
Centre for Distance
Education,Acharya
Nagarjuna University

Printed at:

FOREWORD

Since its establishment in 1976, Acharya Nagarjuna University has been forging a head in the path of progress and dynamism, offering a variety of courses and research contributions. I am extremely happy that by gaining 'A' grade from the NAAC in the year 2016, Acharya Nagarjuna University is offering educational opportunities at the UG, PG levels apart from research degrees to students from over 443 affiliated colleges spread over the two districts of Guntur and Prakasam.

The University has also started the Centre for Distance Education in 2003-04 with the aim of taking higher education to the door step of all the sectors of the society. The centre will be a great help to those who cannot join in colleges, those who cannot afford the exorbitant fees as regular students, and even to housewives desirous of pursuing higher studies. Acharya Nagarjuna University has started offering B.A., and B.Com courses at the Degree level and M.A., M.Com., M.Sc., M.B.A., and L.L.M., courses at the PG level from the academic year 2003-2004onwards.

To facilitate easier understanding by students studying through the distance mode, these self-instruction materials have been prepared by eminent and experienced teachers. The lessons have been drafted with great care and expertise in the stipulated time by these teachers. Constructive ideas and scholarly suggestions are welcome from students and teachers involved respectively. Such ideas will be incorporated for the greater efficacy of this distance mode of education. For clarification of doubts and feedback, weekly classes and contact classes will be arranged at the UG and PG levels respectively.

It is my aim that students getting higher education through the Centre for Distance Education should improve their qualification, have better employment opportunities and in turn be part of country's progress. It is my fond desire that in the years to come, the Centre for Distance Education will go from strength to strength in the form of new courses and by catering to larger number of people. My congratulations to all the Directors, Academic Coordinators, Editors and Lesson-writers of the Centre who have helped in these endeavors.

Prof. Raja Sekhar Patteti
Vice-Chancellor
Acharya Nagarjuna University

MASTER OF SOCIAL WORK (M.S.W)

SEMESTER – IV : Paper - II

402SW21 : MEDICAL AND PSYCHIATRIC SOCIAL WORK

SYLLABUS

UNIT - 1

Medical and Psychiatric Social Work: Origin, Nature and Scope - Health and Illness: Definition, Concept, Factors Influencing Health, Indicators of Health - Systems of Medicine in India.

UNIT - 2

Sociological Perspectives on Illness, Access to Health Care, Social Epidemiology - Nutrition, Childhood Disorders - Cancer, Leprosy, T.B., HIV/AIDS.

UNIT – 3

Community Health - Primary Health Care, Health Education and Communication - Hospital as a Social System.

UNIT - 4

Normal and Abnormal Psychology - Meaning and Scope, Historical back ground of Abnormal Psychology, Symptoms and Syndromes.

UNIT - 5

Classification of Mental Disorders: Psychotic and Neurotic Disorders, Psycho-somatic Disorders – Treatment of Abnormal Behaviour: Alcoholism and Drug Addiction - Role of Social Worker in the Fields of Medical and Psychiatric Social Work.

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CONTENTS

LESSON – 1

MEDICAL AND PSYCHIATRIC SOCIAL WORK: ORIGIN, NATURE AND SCOPE

OBJECTIVE:

The objective of this lesson is to explain the origin, nature, objectives and scope of medical and psychiatric Social Work.

STRUCTURE:

1.1 INTRODUCTION:

Medical Social Work (MSW) is a sub-discipline of social work, also known as Hospital Social Work and Healthcare Social Work. Medical social workers typically work in a hospital, outpatient clinic, community health agency, skilled nursing facility, long-term care facility or hospice. Social workers in this field have a graduate (post-graduate) degree or a bachelor's degree with a graduate/post-graduate diploma in healthcare specialization and work with patients and their families who face specific psycho-social barriers. Medical social workers assess patients' and families' psycho-social functioning, environmental and support needs and intervene. Interventions may include connecting patients and families to essential resources and support in the community, providing psychotherapy, supportive counselling, grief counselling, or helping patients expand and strengthen their network of social supports. Medical social workers typically work on an interdisciplinary team with professionals of other disciplines (such as medicine, nursing, physical, occupational, speech and recreational therapy, etc.)

The prevalence of illness and premature death due to lack of awareness, access to good medical care or failure to take advantages of care mental or psycho-social disorder have long made medical care a topic of prime concern to the field of medical social work. We have come to realize that success of medical care or treatment is based as much on the adequacy of the delivery system as it is on the knowledge and skill of the medical personnel and social worker. Medical care is an important field of practice for social workers who play significant roles in facilitating the delivery in social services at the individual groups and community.

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

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

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

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

1.2 NATURE OF MEDICAL AND PSYCHIATRIC SOCIAL WORK :

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

Psychiatric social work is a specialized type of medical social work that involves supporting, providing therapy to, and coordinating the care of individuals who are severely mentally ill and who require hospitalization or other types of intensive psychiatric help.

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

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

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

1.3 OBJECTIVES OF MEDICAL AND PSYCHIATRIC SOCIAL WORK :

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

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

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

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

Objectives of Medical Social Work:

Helping people enlarge problem solving and coping abilities. Facilitating interaction between individuals and others in their environment. Helping people obtain resources. Making organizations responsive to people influencing interactions between organizations and institutions.

Aims and Objectives of Hospital/Medical Social Work

The main goal of Medical Social Worker is to provide proper services for the patient, basically for the vulnerable patient with co-operation with the NGO or the donation of philanthropist or warm hearted people. According to Encyclopedia of Social Work purposes of hospital social work include:

1. Helping people facing illness, trauma-related crises, or disability to understand and manage the psychosocial impact on their lives and on significant relationships and to make decisions and plan for the future.
2. Facilitating adaptive coping patterns and adjustment to chronic illness or disability and assisting with reintegration or adaptation to new environments
3. Participating in multidisciplinary teams and providing insight and understanding of the psychosocial dimensions of the medical circumstances affecting particular patients and families
4. Identifying and arranging community supports and practical resources to facilitate discharge from hospital or transfer to alternative care facilities
5. Assisting with anticipatory grief and mourning, counseling people facing death, and providing other bereavement-related services to members of the family, including making practical arrangements.
6. Assessing the needs of selected patient populations, networking with community organizations, and developing services to meet these needs, including support and psycho-educational groups, educational forums, socialization, and reintegration activities;
7. Identifying potential neglect, abuse, and exploitation in vulnerable populations and involving authorized agencies;
8. Supporting institutional goals and purposes and encouraging institutional responsiveness to patient needs(Ross, 1995)

According to **Minahan (1981)** the objectives for social work in hospitals are consistent with following objectives:

1. Helping people enlarge problem solving and coping abilities;
2. Facilitating interaction between individuals and others in their environment;
3. Helping people obtain resources;
4. Making organizations responsive to people influencing interactions between organizations and institutions; and
5. Influencing social environment policy (Ross, 1995).

Deputy Director (Treatment & Probation) of social services department Momotaz Begum, said that to emphasize psychological affairs for ensuring the full treatment of the patients.

1. To build up Report and collect social-economic and related information to assist the doctors to full cur the patients.
2. To identity the poor and vulnerable patients from outdoor and includes them within the medical social service.
3. To send the identified patients to the related department and doctor.
4. To admit the patients in the hospital by the basis of prescription of the doctors and assist in treatment process.
5. To build up relationship between the patient and doctor.
6. To assist poor patients by giving them medical, blood, artificial parts of the body, spectacles, and crèche etc.

7. To assist mental disorder type of patients using psycho therapy.
8. To keep the long periodical indoor patients from anxiety with proper communication with his/her family.
9. To motivate the patients for operation.
10. To counsel the illiterate patients for family planning, maternal and child health care and the way to prevent the transmitted diseases.
11. To send the patients to the home with financial help.
12. To admit abandoned child of the hospital in the baby home a child family (Shishu Paribar)
13. To rehabilitate the poor patients within social service department under the poverty alleviation program.
14. To follow-up the treatment and rehabilitation process of the patients.

Objectives of Psychiatric Social Work:

The objectives of psychiatric social work encompass a wide range of goals aimed at addressing the mental health needs of individuals, families, and communities. Psychiatric social work is a specialized field within social work that focuses on providing support, advocacy, and interventions for individuals with mental health challenges. The objectives of psychiatric social work can be categorized into several key areas:

1. Assessment and Diagnosis: One of the primary objectives of psychiatric social work is to conduct comprehensive assessments of individuals experiencing mental health issues. This involves gathering information about the individual's psychological, social, and environmental circumstances to understand the nature and severity of their mental health concerns. Psychiatric social workers use standardized assessment tools and clinical interviews to aid in the diagnosis of mental health disorders.

2. Treatment Planning and Coordination: Psychiatric social workers play a crucial role in developing and implementing treatment plans for individuals with mental health issues. This involves collaborating with other mental health professionals, such as psychiatrists, psychologists, and nurses, to ensure that the individual receives comprehensive care. Treatment planning may involve therapy, medication management, and referrals to community resources.

3. Advocacy and Empowerment: Another important objective of psychiatric social work is to advocate for the rights and needs of individuals with mental illness. Psychiatric social workers work to empower their clients by promoting self-determination and autonomy in decision-making regarding their mental health care. This may involve advocating for access to quality mental health services, housing, employment, and social support.

4. Crisis Intervention: Psychiatric social workers are trained to provide crisis intervention services for individuals experiencing acute mental health crises. This may involve conducting risk assessments, safety planning, and connecting individuals to emergency mental health services. The objective is to stabilize the individual during a crisis and prevent further harm.

5. Education and Prevention: Psychiatric social workers engage in educational initiatives aimed at promoting mental health awareness and preventing mental illness within communities. This may involve conducting workshops, trainings, and outreach programs to reduce stigma, increase mental health literacy, and promote early intervention.

The objectives of psychiatric social work are multifaceted and encompass assessment, treatment planning, advocacy, crisis intervention, and education. By addressing these objectives, psychiatric social workers play a vital role in promoting the mental health and well-being of individuals and communities.

Functions of a Medical/Hospital Social Worker

The primary function of a medical social worker is the practice of social case work to help the patients with social problems created by their illness. The other main functions of a medical social worker are:

1. Participation in program planning and policy formulation of the agency;
2. Participation in community organization;
3. Participation in educational programs;
4. Participation in social research;
5. Consultation (Pathak, 1961)

According to the Association's Statement of Standards, social service departments in hospitals may appropriately engage:

1. Practice of medical social case work;
2. Development of the medical social program within the medical institution;
3. Participation in development of social and health programs in the community;
4. Participation in the educational program for professional personnel;
5. Medical social research (Goldstine, 1955).

Some of the areas that the MSW will assist the patient and/or the family are:

1. Multi-issue counseling
2. Personal and family problems
3. Needs for indigent medication programs
4. Abuse, neglect, and exploitation issues
5. Unsafe living conditions
6. Coping with life threatening or life limiting diseases
7. Inadequate housing
8. Unemployment and disability issues
9. Psychosocial support
10. Referrals for services such as: meals on wheels, oxygen, medical equipment needs

The following functions of the medical social worker have been spelled out the Joint committee of the **American Hospital Association** and t**he Medical Social Work Section of the National Association of Social Workers**-

1. Aiding the health team in understanding the significance of social, economic and emotional factors in relation to the patient's illness, treatment and recovery.
2. Helping the patient and his family in their understanding of these factors to enable them to make constructive use to medical care.
3. Promoting the well-being and morale of the patient and his family.
4. Participating in the educational programs of other members of the health team.
5. Assisting the hospital in giving better patient care through its various services.

6. Facilitating the productive utilization of community resources to meet the needs of patients and their families.

It is estimated that about half of all patients who see doctors come with psychosomatic illness involving personal, emotional, and family problems. Thus, it is apparent that persons who are qualified to help with social factors are important members of the comprehensive treatment team. Their services are related to- (1) direct help to the patient, and (2) indirect aid through assistance to the family and /or others.

Help to the patient is related to –

(a) intake,
(b) hospitalization,
(c) release, and
(d) aftercare (Skidmore & Thackery, 1964).

Dr. Alter Stated that medical social workers try to accomplish three things: Vorsorge, Fiirsorge, and Nachsorge- prevention, hospital treatment, later treatment. At the eleventh session of the **Indian Conference of Social the Work held in Hyderabad in December, 1959,** the following functions of Hospital Social Work have been suggested-

a) Dealing with social and emotional problems of patients and their families which come in the way of adequate treatment, care and rehabilitation of patients.
b) Acting as a liaison between the hospitals the patient, his family and the community and interpreting the treatment to patient and his family also the hospital to the community.
c) To bringing the information of the physical and psychological environment of the patient to the doctor for better of his care.
d) Mobilizing existing community resources and develop new services where they were lacking e. g. convalescent home, workshops for the physical and mentally handicap, clubs and hostels for mental patients, etc.(Cabot, 1928).

After analyzing the above opinion functions of Hospital Social Workers can be explained as follows:

Screening and Case Finding

Access to social work service is determined through screening and case finding every patient cannot be sun by a social worker. Similarly not all health providers can anticipate or interpret patient needs or know when to request social work services. Screening and case including may be done through reviewing patient charts, reports or other automatic referral mechanism. Screening criteria usually include a combination of psychosocial factors, illness factors and outcome factors. The patient's age economic and living circumstances, support systems, mental status, individual and family and skills in coping and adaptation, disease chronicity degree of disability and likelihood of death all are included in screening criteria. Sometimes brier interviews are necessary to clarity need and case finding. Screening may be of two types; preadmission screening and post admission screening (Ross, 1995).

Crisis Intervention

Crisis intervention is needed when hospitalization is unplanned, emergent and experienced as a crisis. When recovery is uncertain hospital social workers needs to apply the

skill of crisis intervention. Crisis intervention promotes coping ability to face adversity by supporting hope, offering relevant information, providing reassurance and emotional support, helping set attainable goals, rehearsing alternative outcome, and finding meaning social workers use crisis intervention for stabilizing crisis situation then proceeds to counseling and discharge planning (Ross, 1995).

Psychosocial Assessment and Formulation of Treatment Plan

Many Richmond in his book Social Diagnosis (1917) first urged on the importance of collection psychosocial data of the patient for understanding the patient and his environment. Psychosocial assessment is a compulsory duty for all medical social workers. The assessment including gathering demographic information, assessing patients mental and physical family history, citing patient mental problems each as digression or compulsion and evaluating patients for such risk as suicide and abuse. Medial social workers must be adept at communicating with people about sensitive issues and ailing to spend time getting to know patients and their families for successful completion of psychosocial assessment(Ross, 1995).

Discharge Planning

When a patient is being released from a medical setting, a social worker is usually behind the scenes making sure that the patient receives the proper medical follow up a medical social worker might assist the family in scheduling physical therapy or post-hospital medical appointments. If a patient is depressed or anxious upon discharge, the social worker might provide a referral for counseling services

Paper work and Record Keeping

Most medical social workers have piles of paper work to get through on a daily basis. They are required to document all services that are put into place for each patient. They may also be required to summarize counseling sessions and complete progress notes. Medical social workers fill out referrals for patients for necessary services. Each setting has a different way of maintaining its documentation, yet medical social worker are required to complete paper work in a timely manner. As a member of treatment team Hospital social workers activities are recorded in patient's medical record. It reflects the skill and competence of Hospital social worker in dealing with patient. Most of the hospital social work departments require worker to keep record of every patient including demographic data, type of problem encounter, type of service provided, outcomes, follow up and referral data (Ross, 1995).

Communication

Communication is priority when medical social workers team with medical professionals. They are required to follow up with doctors and nurses, and to discuss physical and mental complications or issues. In some settings, medical social workers advocate for patients with other medical professionals. Moreover, hospital social worker communicates with various agencies to utilize internal and external resources for the betterment of patients and their families

Therapy

Providing therapy or counseling is an important function of Hospital Social Worker. Medical social workers provide counseling to patients and their families. If a patient arrives at a nursing home and appears depressed, the social worker completes a psychosocial

evaluation and provides counseling. Some settings required that social workers make referrals for patients to receive counseling services outside of their agencies because those social workers do not have the time to provide long term counseling. In other settings, however, social workers serve as therapists to patients and assist with mental health issues on a regular basis.

Others include:

Counselling for individuals, couples and families — for situations in which patients suffer from poor mental health states (e.g. depression, anxiety), and coping and adjustment difficulties. (e.g. due to loss of limb through amputation, loss of hearing, caring for family members suffering from dementia or grief and bereavement issues)

Risk assessment — assessing risk of self-harm (e.g. suicide) and to others (e.g. family violence, elder abuse, child abuse).

Financial assessment and fund management — identifying and referring cases for financial assistance.

1.4 SCOPE OF MEDICAL AND PSYCHIATRIC SOCIAL WORK :

Medical and psychiatric social work students study clinical evaluation of mental illness based on their field experience, child and adolescent mental health, adult mental health issues, case work, therapeutic therapy, testing, and more through their academic studies.

Social workers initiate and lead the introduction and delivery of new programs and services. Social workers practice in specialist mental health and generalist settings across the age and illness spectrum in numerous roles including: clinical mental health social worker, caseworker, case manager, family support worker, drug and alcohol counsellor, child and family counsellor, rehabilitation worker, crisis counsellor and therapist.

SCOPE OF MEDICAL SOCIAL WORK

Assessment:

1. A complete psychosocial assessments of patients who have come for medical treatment at General Hospital including families, carers and significant others.
2. Do risk assessment and comprehensive interventions for children who have been sexually abused and neglect, family violence, suicide and rape.

Counselling and therapeutic interventions

1. The counselling, and therapeutic interventions aimed at helping sick persons in the hospitals, their family members and carers adjust to hospital admission.
2. The interventions also been address adjustment to diagnosis trauma, possible role changes, emotional and social responses to disease and its related treatment.
3. Medical social workers also been provides grief, loss and bereavement supportive counselling to strengthen the emotional capacity of patients and others.
4. Helping the patients/family members in participating the comprehensive intervention in reaction to chronic health condition and brings mediation conflict resolution.
5. Conduct periodical group work and support programme including psycho-education.

6. Provides supports to sick and vulnerable patients in crisis to navigate and communicate their needs and wishes within the hospital system.
7. Acute services provided to emergency crisis care department due to traumas which resulting in sudden traumatic injury or death or natural disasters.

Advocacy

1. Advocacy on behalf of the emergency patients to health care providers for quality care for terminally ill persons. Advocating for change on an organizational and system level.

Case Management and Multidisciplinary Work:

2. Social workers do referrals to other services based on the needs of the patients.
3. Social workers should ensuring communication and understanding about post-hospital care treatment among patients/family and health care team members.
4. Provide education to hospital staff members on patient psychosocial context and needs.
5. Collaboration and promoting communication among health care team members, and coordinating in patient discharge, continuity of care planning.
6. Responsibility in series of statutory functions relevant to local legislative requirement.

Resource education and practical assistance:

1. Social workers should mobilize resources and support in accessing information and financial assistance to the poor and needy patients.
2. Educate the patients and family members on the levels of health care, roles of health care team, and also assisting patients and their families in communicating with members of health care teams in understanding medical information and advance care planning.

Policy, program design and research:

1. Supporting and guiding the implementation of patients centred models of care at hospitals or health care institutions.
2. Preparing, developing policy, design and evaluation of programs for the upliftment of patients life.
3. Engaging in research and publishing peer reviewed journals.

Administrative functions:

1. The clerical aspects such as maintaining records, registers, and relevant patients records, organizing and planning day to day activities of the department, supervision and consultation with the staff as well as the volunteers and maintain effective liaison.
2. Involved in the planning and implementation of the department programmes for patients care and for the staff development.

Career Opportunities:

The Scope of Medical Social Work is so in its nature. In earlier all government hospitals appointed the medial social worker and psychiatric social worker as separate entity and the

job allocation for them is also entirely different. In the year 1974 the Government of Tamil Nadu has brought the two separate carder into a single umbrella called as Social Welfare Officer. Other than the hospitals the scope is very limited for Medical social workers. In aboard the scope of social workers is at large, the only conditions is the concern person has to do a 6 months diploma course in the field of social work (any specialization), and register into the international social work and earn money.

The settings and fields of social work mental health practice include, but are not limited to:

- **Public mental health:** clinical, community, residential, inpatient, and emergency department settings. Psychosocial outreach, recovery, and rehabilitation. Public mental health services play a crucial role in providing care and support to individuals across various settings. In clinical settings, mental health professionals diagnose and treat patients through therapeutic interventions and medication management. Community programs focus on prevention and early intervention, offering support groups, counselling, and educational initiatives. Residential facilities offer a safe and structured environment for individuals with severe mental illnesses, while inpatient and emergency department settings prioritize crisis intervention and stabilization. Additionally, psychosocial outreach programs aim to connect individuals with necessary resources and support their integration into society, while recovery and rehabilitation services empower individuals to regain control over their mental health and lead fulfilling lives.
- **Adult mental health:** Working as part of multidisciplinary teams, social workers provide individual, family, and career assessment, intervention, treatment, and support, including coordination of discharge planning. They collaborate with other healthcare professionals to develop comprehensive care plans tailored to each patient's specific needs. Social workers also play a crucial role in advocating for their clients' rights and ensuring that they have access to the appropriate services and accommodations. In addition to their direct work with patients, social workers often engage in community outreach and education to promote mental health awareness and reduce the stigma surrounding mental illness.
- **Private practice:** Self-employed mental health social workers provide counselling and therapeutic interventions. These can be a direct fee for service or through government-funded initiatives. Private practice is a common career path for mental health social workers who want to have more independence and control over their work. In this setting, they can set their own schedules, choose their clients, and provide services that align with their own therapeutic approaches. These social workers often work with a wide range of clients, from individuals struggling with anxiety and depression to couples seeking relationship counselling. While private practice can be financially rewarding, it also requires business skills and marketing efforts to build a client base and maintain a successful practice.
- **Community teams:** Working as case managers or lead clinicians in combination with multidisciplinary teams including psychiatrists, particularly with disorders such as schizophrenia, bipolar disorder, and eating disorders. Community teams provide a collaborative approach to therapy, allowing social workers to work closely with other professionals to provide comprehensive care for clients with complex mental health needs. This type of work requires strong communication and coordination skills, as well as the ability to navigate the complexities of the healthcare system. Additionally, social workers in community teams may also be involved in advocating for clients and connecting them with resources in the community to support their ongoing recovery.

- **Child and adolescent mental health teams:** As part of multi-disciplinary teams, in lead or clinician roles, support the mental health needs of children ages 0 to 18 and their families. This can include inpatient and/or community settings. In child and adolescent mental health teams, social workers play a crucial role in supporting the mental health needs of children and their families. They may work in lead or clinician roles, providing therapeutic interventions and coordinating care for children from ages 0 to 18. Whether in an inpatient or community setting, social workers help connect families with the appropriate resources and services to promote ongoing recovery and wellbeing.
- **Primary mental health care:** Longer term therapy for more high-prevalence disorders such as anxiety and depression where the psychiatric risks are not of a severe and enduring nature. Social workers may also provide primary mental health care, which involves longer-term therapy for common disorders like anxiety and depression that do not pose severe and enduring psychiatric risks. Through individual or group therapy sessions, social workers help children and their families manage their symptoms and develop coping strategies. By offering ongoing support and guidance, social workers contribute to the overall well-being and recovery of individuals experiencing mental health issues.
- **Tertiary mental health services:** Assessment, case management, crisis intervention, rehabilitation, and inpatient treatment. This can also include involvement in the implementation of community treatment orders as psychiatric case managers. Tertiary mental health services play a crucial role in providing comprehensive care to individuals with severe mental health conditions. These services involve intensive assessment, case management, crisis intervention, and rehabilitation, as well as inpatient treatment when necessary. Additionally, social workers may be involved in the implementation of community treatment orders, serving as psychiatric case managers, and ensuring that individuals receive the necessary support and treatment to promote their recovery and overall well-being.
- **Prevention programs:** Working in an educational context, social workers are based at or attached to schools, educational settings, and the early childhood sector. They work to identify and address the social, emotional, and behavioural needs of students, as well as provide support and resources to families. Social workers in prevention programs aim to reduce risk factors and increase protective factors in order to prevent mental health issues and promote positive development. They may also collaborate with other professionals, such as teachers and counsellors, to create a supportive and inclusive school environment.
- **Perinatal services:** Community-based multidisciplinary teams supporting expectant or new mothers and partners, focusing on those at risk of a mental illness or disorder. These perinatal services aim to provide comprehensive support to these individuals during this vulnerable period, addressing any mental health issues and helping them navigate the challenges of pregnancy and parenthood. Through a holistic approach that may include counselling, education, and coordination with other healthcare professionals, social workers play a crucial role in promoting the well-being of both the mother and her child. By identifying and addressing risk factors early on, these services improve the chances of a healthy, happy start for the entire family.
- **Aged mental health:** Liaising closely with family members, community teams, GPs, and aged care facilities in the coordination of discharge planning and transition to the community or an aged facility. These services aim to provide comprehensive care for older adults with mental health issues. They work closely with family members, community teams, GPs, and aged care facilities to ensure a smooth transition from

hospital to community or to an aged facility. The goal is to support the mental health and well-being of older adults by addressing any emerging needs and providing the necessary resources and assistance for their recovery and overall quality of life.

- **Indigenous communities:** Mental health and wellbeing services to Indigenous communities. These services aim to address the unique cultural and historical factors that contribute to mental health issues within Indigenous communities. They provide culturally sensitive and appropriate care, working closely with community leaders and elders to ensure that the needs of the community are met. The services also focus on building resilience and promoting healing within the community, recognizing the importance of cultural identity and connection to land in mental well-being.
- **Specialist services:** Including forensic services, transcultural mental health services, and prison mental health services. Specialist services play a crucial role in addressing mental health issues within Indigenous communities. Forensic services work to understand the complex interaction between historical trauma, cultural dislocation, and mental health problems, ensuring that appropriate interventions and support are provided. Transcultural mental health services focus on bridging the gap between Western models of mental health and Indigenous cultural beliefs, offering culturally appropriate treatments and therapies. Additionally, prison mental health services aim to address the unique challenges faced by Indigenous individuals within the criminal justice system, providing tailored support to promote rehabilitation and reduce recidivism rates.

1.5 SUMMARY :

Psychiatric Social Work, a specialized branch of Social work, which concerns with theoretical as well as clinical work and the knowledge of Psychiatry-which primarily deals with problems of the mind and associated disorders. The essential purpose of Psychiatric Social Work is to help the people with problems of the mind and/or with behaviour problems or we can say precisely the problems of mind and brain and their solutions. It has grown as the result of the need felt and its realization for people with mental or emotionally disturb could be helped more effectively by understanding their social and/or environmental factors responsible for the problems of *mind* and *brain* in their management. It is widening its branches even today giving service to many psychologically disturbed persons. Social workers provide a significant contribution to the field by maintaining a dual focus on both the individual and family/contextual domains, and it this understanding that distinguishes social work from other health professions in the sector. Social workers are regularly involved with individuals and families experiencing complex social, psychological, family and institutional dynamics. Social workers offer a unique and valuable contribution in providing appropriate and targeted services and therefore have a clear role in the provision of effective mental health services. Individuals and families have different reactions to mental health disorders, both in terms of conditions that are emerging and those resulting from a situational crisis. Social workers contribute greatly to their clients and organisations by undertaking evidence-informed assessments and interventions. The social work assessment process takes into account the impact of biomedical factors and the range of psychological, social and other needs of the individual experiencing mental health disorder. Within this framework social workers respect the primacy of the individual's rights (within medico-legal requirements) and work towards developing skills and confidence to assist individuals and their families maintain control of their lives and take responsibility for recovery and wellbeing. Social workers recognise the individual's role in treatment planning and the individual's right to have a knowledgeable, skilled practitioner who is guided by ethical practice.

1.6 KEY WORDS :

Psychiatric social work
Dignity and worth of the person
Importance of human relationships
Integrity

1.7 SELF-ASSESSMENT QUESTIONS AND EXERCISE :

1. Discuss the nature and scope of psychiatric social work.
2. Explain the objectives of psychiatric social work
3. What is the nature of psychiatric social work?
4. Explain the scope of psychiatric social work practice?

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Prof. Saraswati Raju Iyer

LESSON – 2

HEALTH AND ILLNESS: DEFINITION, CONCEPT

OBJECTIVE:

The objective of this lesson is to explain the definition, concept, philosophy of health. Concept of disease, disease causation, web of disease causation.

STRUCTURE:

2.1 INTRODUCTION:

Good health or a healthy life is composed of five dimensions, namely: physical, intellectual, emotional, social, and spiritual. These good health parameters were advocated by WHO while defining the concept of health and are ratified by the participant countries. Mind and body are so closely related with each other that disturbance in one part sends the message and is exhibited in the form of symptoms. These symptoms are in a way a non-functional activity of the bodily organs. There are various procedures to read these symptoms with a variety of instruments as well as with non-performance of activity of organs in the body. Therefore, it is important to understand and read the symptoms of body and to ensure the balance of mind, spirit, and body. This integration puts health in the format of multidimensionality.

2.2 DEFINITIONS OF HEALTH :

- State of freedom from pain, illness and disabilities (based on bio-medical concept).
- The condition of being sound in body, mind or spirit and especially freedom from physical disease or pain (based on psychological concept).
- Relative state of freedom from pain and discomfort and continuous adaptation and adjustments to the environment to ensure optimal functioning (based on ecological concept).
- A sound mind in a sound body, in a sound family, in a sound community environment (based on holistic concept).

But WHO states the definition, which is very popular comprehensive and accepted universally in 1994 as under: “Health is a state complete physical, mental, social, and spiritual well-being and not merely an absence of disease or infirmity”. This definition reflects holistic view because it recognizes well-being of an individual as a whole. This definition indicates positive health because it refers to complete stale of wellbeing and not only the absence of disease. It means that every organ and system in the body functions normally and the body is able to perform all the functions normally, the individual is able to adjust with himself and with others and with his environment etc.

2.3 PHILOSOPHY OF HEALTH :

Philosophy of health refers to our knowledge, beliefs and feelings about health. From the above discussions about health concepts, the following philosophy can be derived:

i. Health is essential for every individual to have useful and quality life and is therefore considered as a basic human right.
ii. Health is something which is to be earned. It cannot be gifted by anyone.
iii. Therefore individual, family and community have to get involved and take responsibility at their own level to promote, protect and maintain their health. The state government need to support people by providing health related services.
iv. Health is an essential element of productive life, because without being healthy, the individual will not be able to perform daily living activities, concentrate and put in required time and efforts to work and earn.
v. Health is part and parcel of National Development because healthy people can contribute to overall developments of the nation and this overall development in return can promote and protect health of people.
vi. Health is a social goal i.e. goal to be achieved by all, by the joint efforts of individual, family and community.

2.4 CONCEPT OF HEALTH :

Health is considered as an important part of human life by all communities. But its concept or the meaning differs with each community and each individual in a community, depending upon their socio-cultural and environmental conditions. It is also seen that the concept of health changed over time depending upon scientific and socio-economic developments and advancements. Ancient Indian history reveals the practice of comprehensive concept of health during Vedic period. It emphasized on health promotion and health maintenance through practice of good environmental sanitation and personal rules and regulations. Health also included physical, mental, social and spiritual aspects of life.

Over the years, this concept was lost under the influence of changing sociocultural and environmental conditions. Health from there onwards was viewed as absence of disease. This concept still prevails among under privileged and underdeveloped communities. Health is usually neglected until disease/sickness occurs. However, for the past few decades there has been a change in the concept of health. Health is considered as a fundamental human right. It is also considered a social goal to be achieved by all to lead economically productive and useful life. This goal is popularly known as "Health For All" (HFA) which was adopted by WHO in 1977 and accepted by all the member countries. India also adopted this goal of HFA since then. The concept of health also varied among various professional groups e.g. medical scientists, social scientists, environmental scientists, etc. which brought about

changes in the concept of health. You will now learn about these changing concepts in the following sub-sections.

2.5 CHANGING CONCEPTS OF HEALTH :

Health is not constant. It changes from time to time under the influence of continuous changes throughout the world. A brief description of changing concepts of health is given in this sub-section and also highlighted.

i) Biomedical Concept:

According to this concept health is viewed as freedom from disease i.e. individual is considered healthy only if he does not have any disease. It also stresses that ill health is caused by disease producing organisms e.g. typhoid is caused by salmonella typhosa, cholera by cholera vibro. The human body is considered as a machine and disease is due to breakdown of this machine. 'The doctor's or any other health worker's work is to repair this machine.

This concept of health ignored the role of social, environmental and cultural factors in disease causation. This model was found to be inadequate to solve the problems of malnutrition, chronic diseases like diabetes, peptic ulcer, drug abuse and accidents. Since these diseases are not caused by disease producing organisms hut by other causative factor e.g. inadequate nutrition, lack of exercise, over exertion, emotional stress, pollutants etc.

ii) Ecological Concept:

According to this concept health is viewed as a harmonious relationship between man and his environment, and disease as maladjustment of the man to his environment. There is a continuous adaptation and adjustment of human being to his environment. There is a feeling of wellbeing, relative absence of pain and discomfort when man is able to adjust with his environment and feeling of ill health when he is not able to adjust. According to ecological concept health is viewed as continuous harmonious relationship between mall and his environment. It means as long as human beings follow desirable natural principles of healthful living, they can live healthy and happy life.

Once this balance between man and his environment is disturbed, there is maladjustment and it can cause various diseases. For example, industrialization and urbanization, increasing population and overcrowding, transport etc. have resulted in pollution of air, water and soil.

iii) Psychological Concept:

According to this concept health is not only affected by disease producing organisms, physical environmental conditions and harmful personal practices hut also gets affected by various other factors such as social, psychological, cultural, economic and political. For example, initially health problems like peptic ulcer, high blood pressure, diabetes, heart problems and mental health problems are mainly due to various psycho-social and cultural factors. Therefore, all the factors including biomedical, environmental and psycho-social-cultural and economic factors need to be considered white assessing health status of people at any time.

iv) Holistic Concept:

According to this concept human being is considered as a whole person comprising of body, mind and soul. He lives under the influence of various factors in his environment/community. These factors include biological, physical, environmental, social, psychological, cultural, economic and political resources available in the community. These factors influence and determine total health of body, mind and soul i.e. physical, mental, social and spiritual health. This concept emphasized on promotion and maintenance of health. Holistic concept of health is comprehensive concept.

Mechanistic View

Long back in the 19th century it was viewed that every illness was the disturbance, exaggeration, cessation of a corresponding normal function of the human body. This was a mechanistic approach where the human body was compared to a machine which, if affected by disease would obviously breakdown. Implicit in this notion was the concept of health as merely absence of disease. This concept is also termed as the germ theory of disease and ill-health. This theory, however, failed to explain the causal factors of major psycho-social problems in the society like malnutrition, social diseases, mental illness, diseases related to ecological degradation. There was a need felt to change the concept of health.

Psycho-social Paradigm

This concept of health visualized the importance of the social, cultural, political, economic reasons for influencing health and causing ill-health. This concept, in fact, realized and emphasized upon the psycho-social stressors in life that caused ill-health. Some of the psychosocial stresses are related to:

a) economic stressors	-------- inadequate family resources for basic survival
b) social	-------- starvation status in society belonging to high class of society or under privileged social groups
c) cultural	-------- social taboos hindering functioning effectively
d) occupational	-------- exploitation
	-------- hard, long hours of labour
	-------- lack of rest and sleep
	-------- insufficient wages
	-------- accident and disability and related psychological setback
e) familial	-------- status in family
	-------- role expectations
	-------- early marriage
f) personal	-------- poor-self esteem
	-------- frustration

Medical ecology, which conceives disease as a convergence in time, space and within the person of the patient of environmental stimuli (organic, inorganic, socio-cultural) thus asserts a relationship between environment, disease and man.

As indicated above, ‘the environment’ in which we live is an ecosystem or an integration of physical and social relations. Therefore, the conditions of ill-health are usually

the result of a multiplicity of events, and, a correlation between environment and ill-health is not easy.

Scientists determine environmental factors through clinical testing of the disease and its causal agents, but this is only half the story. What is necessary is to deconstruct some of the social and physical relations in order to establish preventive health measures. It is through such an exercise that we can identify some of the environments that are directly related to ill-health.

WHO has defined health as a state of "complete physical, mental and social well-being and not merely the absence of disease and infirmity". Implied in this definition is the 'physical, mental, social well-being' which is of prime importance for the maintenance of optimum level of health. Well-being is defined as a harmonious relationship between individuals, groups within the physical, biological and socio-cultural environments. This holistic view of health which encompasses many other dimensions of health has been depicted here below:

Human Health-------- holistic View

The holistic view of health encompasses:

a) *Individual and Group Health*

Individual and group health being determined by human biology, the environment, the ways of life of the community, and the health care system.

b) *The Family and Family Health*

The family is one of the oldest and strongest social institutions. Its members share genetic traits, environment, general attitudes, and life styles. Through their interactions and mutual dependencies, the family functions as a unit; factors impinging on one member affect all other member to some degree.

The state of health of one member and his response to illness influences and is influenced by physical and psychological support mechanisms operating within the family. A child's growth and development reflect the interaction of genetically determined biological factors and the family environment. Poor housing, overcrowding, inadequate food, and inadequate education affect all members of the family, and behaviour patterns, including those governing health care, are shared by the family. It is logical, therefore, to consider the health needs and problems of the family as a whole and to deal with individual health problems within the framework of a comprehensive family health programme.

Families are the basic productive and reproductive units of society. So, it is there the efforts for reproductive health and safe motherhood must be focused upon. For effective change to happen, women must be given more choice and men must accept more responsibility. Only then can health interventions begin to be really effective in improving lives. Family health, therefore, must be a key element of reproductive and other health policies.

Reproductive health affect and is also affected by other aspects of life:

i. nutrition

ii. health during infancy and childhood
iii. adolescent sexual behaviour and fertility
iv. unwanted pregnancy
v. life styles
vi. environment
vii. status of woman
viii. individual health
ix. family health: including women's health, adolescent behaviour and health of the aged
x. community health

c) *Health in the Village (Rural) Environment*

It is important to distinguish between the village (rural) and the city (urban) environments because of the basic differences in the hazards to health in these external environments.

In the village environment, infrastructural development is creating an adverse environment for those not benefiting from rapid industrialization. Infrastructure, an integral part of industrialization and urbanization, has helped to change people's relationship with land, technology and production. Those in the subsistence sector are increasingly marginalized by these forces. The landless and others, whose means of survival is being appropriated through the capitalisation of human and natural resources, are those who suffer the highest rates of mortality and morbidity.

d) *Health in the Rural Workplace Environment*

The workplace too promotes both health and disease. If the workplace does not provide basic amenities and job security, it adversely affects the health and productivity of the workers. In addition, the workplace has an impact on those who live around it, on the families of the workers, and all those people affected by any alterations in the physical environment due to pollution hazards.

The factors that impinge on a persons' health can be found in many settings, within the home or at the workplace, in the rural or urban environments.

e) *Health in the Home Environment*

The home environment plays a crucial role in the prevention of diseases, not merely by providing physical surroundings such as a house, or access to potable drinking water, but also, and more importantly, in terms of its non-physical and psycho-social dimension. The home environment helps to condition a fixed set of habits and behaviours and it determines our linkages with the community, the natural surroundings outside and the larger society. These are all important factors in the kind of health that is maintained. A good home environment then plays a very important role in achieving good health.

f) *Community Health*

Community health refers to the health status of the members of the community, to the problems affecting their health, and to the totality of health care provided for the community. The assessment of health requires an understanding of the general population to be served. Major categories of information required on health are outlined in the following paragraphs.

1) **Demographic Data**

-------- Present and projected population according to age, sex, location
-------- Population density
-------- Migration
-------- Life expectancy
-------- Probable birth rates
-------- Literacy rates

2) **Environmental Characteristics**
-------- Housing conditions
-------- Working conditions
-------- Educational opportunities
-------- Sources of water supply, water quality
-------- Waste water disposal and water pollution control
-------- Solid wastes management, including sanitary handling and disposal
-------- Vector control and the control of alternative hosts of disease
-------- Environmental pollution
-------- Climate
-------- Structural organization and administration of environmental health services

Thus, the holistic interpretation of health would be to take into account the cultural dimensions of health, including the beliefs, customs, practices connected with health and disease besides the interplay of social, economic and political factors. It also includes relating such a holistic perspective to the overall culture of the concerned community.

2.6 CONCEPT OF ILLNESS AND DISEASE :

ILLNESS

Britannica Dictionary definition of ILLNESS

1 [noncount] **:** a condition of being unhealthy in your body or mind

- Her body was not able to defend itself against *illness*.
- Hundreds of soldiers died from *illness* and hunger.
- He showed no signs of *illness*.
- mental *illness*

2 [count] **:** a specific condition that prevents your body or mind from working normally **:** a sickness or disease

- Scientists have not yet found a cure for this *illness*.
- cancer, diabetes, and other *illnesses*
- an acute/chronic *illness*
- She died at the age of 60 after a brief/long *illness*.

The literal meaning of the term disease (i.e. dis-ease) is without ease or uneasiness. According to Oxford Dictionary "Disease is defined as condition in which the body, some part or organ of the body is impaired and does not function normally." In other words, disease is defined as departure/deviation from complete state of health and wellbeing which includes physical, mental, social and spiritual aspects.

2.7 CONCEPT OF DISEASE CAUSATION :

Before 19th century, occurrence of any disease was considered to be the curse of god or evil spirit/bad air. In 19th century disease producing micro-organisms were discovered. It was found drat every single disease was caused by one specific organism (disease agent) e.g. cholera due to cholera vibrio, tuberculosis due to tuberculosis bacterium etc. 'This refers to one to one relationship between causative organism and the disease as shown in the schematic model below. This concept of disease causation is popularly known as germ-therapy. Biomedical concept of health stresses on germ theory. But this-theory has many limitations. The disease is rarely caused by single disease agent. It depends on number of other factors related to the man i.e. host and his environment. For example, everyone exposed to disease germs does not get the disease e.g. tuberculosis, unless the host is undernourished, susceptible to get the disease and liver under unhygienic conditions i.e. environment which contributes to causation of tuberculosis.

Disease is caused only when there is an interaction of age & host and environment. It means disease will occur only if the host is weak, the agent is strong and enters the host through right channel and in sufficient amount, and when the environment conditions facilitate the interaction of host and agent e.g. poor environmental sanitation malnutrition of a child and contaminated water can cause diarrhoea. This model implies that disease will not occur without sufficient interaction of these three factors and will remain in balanced state. This is called as slate of Health Equilibrium. This model is applicable only to infectious diseases. It is not applicable to chronic and degenerative diseases like cancer, diabetes, cardiac diseases and mental disorders etc. These diseases are caused by interaction of various factors discussed under web of causation.

2.8 WEB OF DISEASE CAUSATION :

The model is ideally suited to study the chronic disease, where the specific disease agent (causative organism) is not known, but disease occurs due to interaction of multiple factors related to life style, human behaviour and environmental conditions. This model suggests variety of interventions like avoidance t of smoking, diet control, exercises and regular checkups in cardiovascular diseuse etc.

2.9 SUMMARY :

The changing concepts of health are Biomedical, Ecological, Psychosocial, and Holistic. The concept of health traditionally means free from disease and according to WHO definition "Health is a state of complete physical, mental, social and spiritual wellbeing and not merely an absence of disease or infirmity". We also discussed about the various dimensions of health. Physical dimension refers to the physical wellbeing, mental dimension relates to the ability of a person to adjust in various situations, social dimension means the relationship of individual to others. If an individual feels satisfied, experiences happiness in all these dimensions is said to enjoy positive health. The factors which determine the health of a person are heredity - the effect of genes on physical and physiological and psycho-social

characters of an individual, the environment e.g. physical, biological and psychosocial and the life style and level of income and education. We have also learnt that healthy and hygienic practices and good environment are also essential for good health.

2.10 KEY WORDS :

1. Holistic
2. Dimensions
3. Ecology
4. Heredity

2.11 SELF-ASSESSMENT QUESTIONS AND EXERCISE :

1. Define health and its concept?
2. Define illness and its concept?
3. Explain the concept of health and illness?
4. Explain the determinants of health?

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Prof. Saraswati Raju Iyer

LESSON – 3

FACTORS INFLUENCING ON HEALTH

OBJECTIVE:

The objective of this lesson is to explain the factors influencing on health and determinants of health.

STRUCTURE:

3.1 INTRODUCTION:

The study of health from a sociological perspective unveils a complex interplay of factors that extend far beyond individual choices or genetic predispositions. Understanding health in society requires a comprehensive exploration of the intricate web of influences that shape well-being, illness, and the overall health outcomes of individuals and communities. This examination encompasses a broad spectrum of factors operating at various levels, from individual behaviours to societal structures, and highlights the need for a multidimensional approach to health research and policy-making.

Health, in this context, is not solely defined by the absence of disease but is intricately linked to the social, economic, cultural, and environmental contexts in which individuals live. This exploration delves into the sociological perspectives that contribute to our understanding of health, emphasizing the significance of frameworks such as the structural-functional perspective, the conflict perspective, the symbolic interactionist perspective, and the social constructionist perspective. Each of these perspectives offers unique insights into the ways in which societal structures, power dynamics, cultural norms, and individual interactions shape the experience of health and illness.

Furthermore, this discussion extends beyond traditional perspectives to encompass emerging influences on health, including technological advancements, global health challenges, and the dynamic role of media and information dissemination. The aim is to provide a holistic overview of the multifaceted factors that influence health, recognizing that addressing health disparities and promoting equity requires a nuanced and interdisciplinary approach.

In the following exploration, we will delve into the diverse determinants of health, categorizing them into individual, interpersonal, community, societal, and environmental factors. By comprehensively examining these influences, we can gain deeper insights into the complexities of health and pave the way for informed strategies that promote well-being on a broader scale.

3.2 FACTORS INFLUENCING HEALTH :

1. Individual-Level Factors:

- **Genetics and Biology:** Genetic factors play a role in determining an individual's susceptibility to certain diseases and health conditions. Additionally, biological factors such as age, sex, and physiological functioning contribute to health outcomes.
- **Behavioural Choices:** Personal lifestyle choices, including diet, physical activity, substance use, and sexual behaviour, significantly impact health. Unhealthy behaviours like smoking or a sedentary lifestyle can increase the risk of various diseases.
- **Mental Health:** Psychological well-being and mental health are integral components of overall health. Factors such as stress, anxiety, depression, and coping mechanisms can influence physical health outcomes.
- **Access to Healthcare:** The ability to access and utilize healthcare services is a critical individual-level factor. Barriers such as financial constraints, lack of health insurance, or geographical distance can limit access to timely and appropriate healthcare.

2. Interpersonal Factors:

- **Social Support:** The presence of strong social networks and supportive relationships can positively influence health. Social support provides emotional, instrumental, and informational assistance, which can enhance coping mechanisms and resilience in the face of health challenges.
- **Family Dynamics:** Family structures, dynamics, and relationships contribute to health outcomes. Supportive families can positively impact an individual's health, while dysfunctional family environments may lead to stress and health challenges.
- **Peer Influences:** Social interactions with peers, friends, and colleagues can shape health-related behaviours. Peer pressure, social norms, and shared activities can influence lifestyle choices and risk-taking behaviours.

3. Community and Societal Factors:

- **Economic Status:** Socioeconomic factors, such as income, education, and employment, profoundly influence health. Individuals with higher socioeconomic status generally have better access to resources that promote health, including nutritious food, safe housing, and healthcare.
- **Cultural and Social Norms:** Cultural beliefs and social norms shape health behaviours and practices within a community. Cultural factors can influence perceptions of health, acceptable treatment options, and help-seeking behaviours.
- **Educational Opportunities:** Access to education is linked to health outcomes. Higher levels of education are associated with better health knowledge, healthier lifestyle choices, and improved access to economic opportunities that support health.
- **Health Policies:** Government policies related to healthcare, public health, and social welfare play a crucial role in shaping the health of populations. Policies addressing issues such as healthcare access, environmental regulations, and social equality can impact health outcomes.

4. Environmental Factors:

- **Physical Environment:** The quality of the physical environment, including air and water quality, housing conditions, and exposure to pollutants, can impact health. Environmental factors contribute to the prevalence of diseases and conditions such as respiratory problems, infectious diseases, and chronic illnesses.
- **Built Environment:** Urban planning, infrastructure, and the availability of recreational spaces influence physical activity levels and overall health. Access to safe and walkable neighbourhoods can promote active lifestyles.
- **Climate and Geography:** Climate conditions and geographic location can affect health, influencing the prevalence of certain diseases, nutritional patterns, and exposure to natural disasters.

5. Occupational Factors:

- **Workplace Conditions:** The nature of one's occupation and workplace conditions can impact health. Exposure to occupational hazards, job stress, and the availability of health-promoting policies in the workplace all contribute to overall well-being.
- **Work-Life Balance:** The balance between work and personal life is crucial for health. High levels of work-related stress, long working hours, and lack of flexibility can negatively affect mental and physical health.

6. Biopsychosocial Factors:

- **Biological and Psychological Interaction:** The interaction between biological factors (genetics, physiology) and psychological factors (mental health, coping mechanisms) is known as the biopsychosocial model. This model recognizes the interconnectedness of biological, psychological, and social factors in influencing health outcomes.

7. Health Literacy:

- **Understanding and Knowledge:** Health literacy refers to an individual's ability to obtain, process, and understand health information to make informed decisions. Limited health literacy can hinder individuals from effectively managing their health, understanding medical instructions, and making informed healthcare choices.

8. Media and Technology:

- **Information Influence:** Mass media, including digital platforms, can shape health behaviours and perceptions. Information disseminated through media channels can influence attitudes toward health, impact health-related decision-making, and contribute to the spread of health-related misinformation.
- **Technology Use:** The use of technology, including smartphones and wearable devices, can impact health monitoring, access to health information, and the adoption of health-promoting behaviours.

9. Political and Policy Influences:

- **Healthcare Policies:** Governmental policies related to healthcare, public health, and social welfare have a significant impact on health. Policies that address issues such as

healthcare access, vaccination programs, and health education can shape population health outcomes.

- **Global Health Diplomacy:** International relations and global health policies can influence health outcomes on a global scale. Collaborative efforts, trade agreements, and responses to global health crises all play a role in shaping health at the international level.

10. Health Behaviours and Social Networks:

- **Social Determinants of Health:** Social determinants such as income, education, and occupation influence health behaviours and access to resources. These factors contribute to health inequities and disparities.
- **Health Behaviour Models:** The Health Belief Model, Social Cognitive Theory, and the Transtheoretical Model are examples of frameworks that explore how individual health behaviours are influenced by perceived risks, social support, and stages of behaviour change.

11. Crisis and Catastrophes:

- **Natural Disasters and Emergencies:** Events like earthquakes, hurricanes, or pandemics can have profound effects on health. They can disrupt healthcare systems, lead to displacement, and contribute to mental health challenges.
- **Conflict and War:** Sociopolitical conflicts and wars impact health by causing displacement, disrupting healthcare services, and exposing populations to violence, trauma, and disease.

12. Cultural Competence:

- **Cultural Influences:** Cultural competence in healthcare recognizes the impact of cultural beliefs, values, and practices on health. Understanding cultural diversity helps healthcare providers tailor interventions and communication to meet the unique needs of diverse populations.
- **Cultural Competence in Healthcare Delivery:** The ability of healthcare systems to provide culturally competent care can enhance patient trust, satisfaction, and adherence to medical recommendations.

13. Social Justice and Equity:

- **Health Equity:** Health disparities and inequities, often linked to social determinants, reflect unjust differences in health outcomes across different population groups. Addressing social justice issues is essential for achieving health equity.
- **Structural Inequities:** Discrimination, racism, and other forms of structural inequities contribute to health disparities. Advocacy for social justice involves addressing these underlying issues to create a more equitable and just society.

14. Access to Nutritious Food:

- **Food Security:** The availability and accessibility of nutritious food influence overall health. Lack of access to fresh and healthy food, known as food deserts, can contribute to poor nutrition and related health problems.

- **Nutrition Education:** Knowledge about nutrition and healthy eating habits is crucial for preventing diet-related diseases. Nutrition education programs can empower individuals and communities to make healthier food choices.

15. Community Engagement:

- **Community Empowerment:** Engaging communities in health decision-making and interventions can lead to more sustainable and culturally relevant health outcomes. Empowered communities are better positioned to address their unique health challenges.
- **Community-Based Participatory Research (CBPR):** Collaborative research involving community members and researchers can provide insights into local health issues and contribute to the development of effective interventions.

16. Migration and Health:

- **Migration Patterns:** Migration and mobility can impact health, as individuals may face challenges related to adapting to new environments, accessing healthcare in host countries, and dealing with social isolation.
- **Migrant Health Policies:** Policies related to migrant health, including access to healthcare services, protection from exploitation, and the recognition of the unique health needs of migrant populations, are critical for promoting health equity.

17. Social Media and Health Communication:

- **Health Information Dissemination:** Social media platforms play a significant role in disseminating health information. The spread of accurate information, as well as misinformation, can influence health behaviours and perceptions.
- **Online Health Communities:** Participation in online health communities provides individuals with opportunities to share experiences, seek support, and access health information. However, the quality and reliability of information in these communities vary.

Determinants of Health

Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.

"Health care is an important determinant of health. Lifestyles are important determinants of health. But... it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place." WHO Director-General Dr Margaret Chan.

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considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.

The context of people's lives determine their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants, or things that make people healthy or not, include the following and many others:

The determinants of health include:

- the social and economic environment,
- the physical environment, and
- the person's individual characteristics and behaviours.

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- Income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.
- Education – low education levels are linked with poor health, more stress and lower self-confidence.
- Physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions
- Social support networks – greater support from families, friends and communities is linked to better health. Culture - customs and traditions, and the beliefs of the family and community all affect health.
- Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.
- Health services - access and use of services that prevent and treat disease influences health
- Gender - Men and women suffer from different types of diseases at different ages.

Let us look at few important determinants of health which are discussed below:

1. Heredity/Human Biology: Health is determined to a great extent by genetics. Similarly, gender of an individual also plays a very important factor here. For instance, if we look at women, one finds that, in last few decades it is reported that women are seen to record the higher rates of chronic and acute sickness and thereby tend to find and have a higher mortality rate as compared to men.

2. Environment: Environment has a very important role to play on the wellbeing of humans. Environment can be both external as well as internal. The former contains those things and

materials which human being is exposed after conception. Whereas the latter comprises in itself each and every part of the component, every organ every part, and so on.

3. Lifestyle: Lifestyle means the way people live. In today's time, one finds that lifestyle plays a very important role in the health of human beings. Poor sanitation, personal hygiene and cleanliness all tend to have a very important role in the overall health of humans.

4. Resources: the resources that help to maintain health of an individual are socio economic conditions, education, economic status, occupation of an individual, political system, etc.

5. Others: Apart from all these various other factors such as language, diet, hygiene, habits such as smoking, consuming alcohol, and so on also have a role to play.

Improving Health Worldwide

WHO have identified three "common interventions" for improving health conditions worldwide:

1. Education

A large number of studies have demonstrated a strong link between better education and better health, and education has been shown to be a reliable predictor of lower mortality rates. The probability of being in good or very good health is higher for people with university or post-secondary education.

2. Social Protection

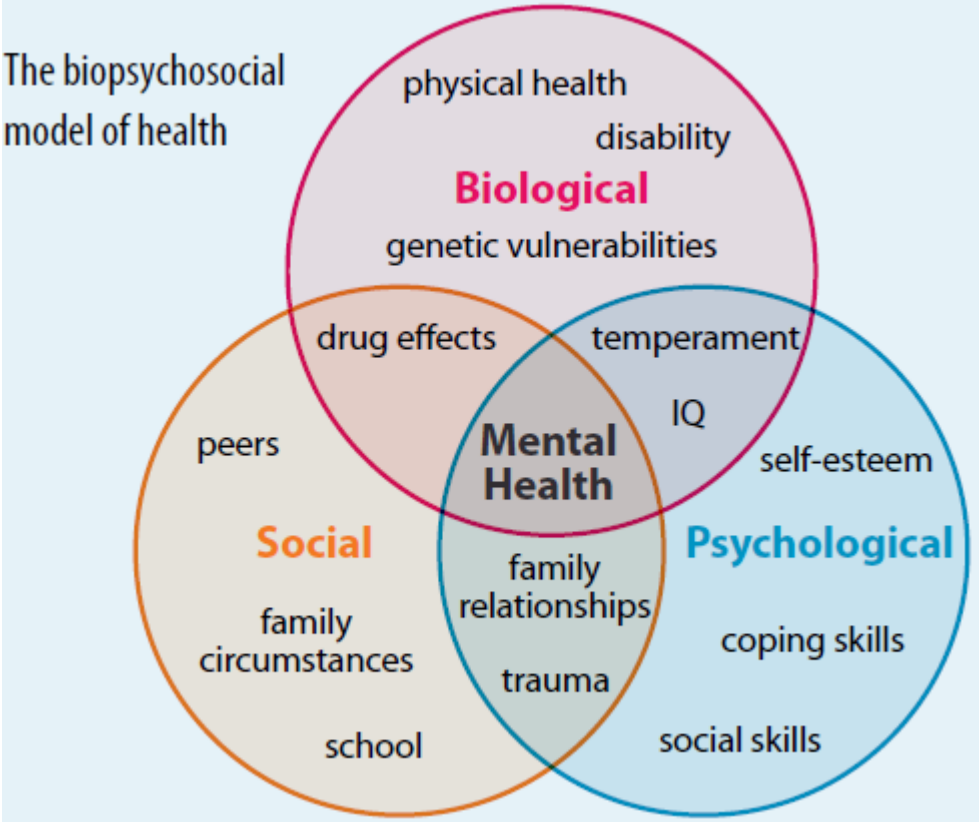
Countries with some sort of social protection (i.e. a safety net or social security system) show improved health and economic outcomes in circumstances where people become unable to earn a living.

3. Urban Development

The physical environment where communities live has a great impact on the health of the residents. Factors which have a negative impact on health include overcrowding, damp living conditions and crime (in particular fear of crime). The WHO concludes that health outcomes "are largely determined by the accessibility to adequate housing and to healthy and safe urban environments and by transport conditions".

Relevance to Rehabilitation

In our contact time with our patients, we spend a lot of time understanding their health and social status. In other words, we explore the determinants that might be affecting their health and in particular ones that we can influence. The model we use to analyse and understand these determinants of health is the biopsychosocial model of health care.



It is essential that healthcare workers dedicated to improving health increase their effectiveness by addressing the "upstream" causes of health in the community and by engaging in ways to change the broad policies, systems and environments that shape the social and economic conditions that, in turn, so strongly influence health. Swain et al. describe opportunities for the health-care professional to address social determinants of health. They suggest that to be most effective at improving the health of families and communities and to ensure the greatest impact for the investment of resources, health professionals need to expand their repertoire of skills and activities both with their individual patients and in the policy arena.

3.3 SUMMARY :

Health is a multifaceted and intricate outcome influenced by a myriad of interconnected factors across various dimensions. On a biological level, genetic predispositions play a role in shaping an individual's susceptibility to certain health conditions, contributing to the intricate tapestry of one's overall well-being. Behavioural factors, encompassing lifestyle choices such as diet, physical activity, and substance use, hold significant sway over health outcomes, underscoring the importance of personal choices in shaping one's health trajectory. Socioeconomic factors, including income, education, and employment status, are pivotal determinants that influence access to resources, healthcare services, and overall quality of life.

The intricate interplay of social and cultural factors, which includes the presence of social support, adherence to cultural norms, and the dynamics of local communities, contributes to shaping health behaviours and influencing individual perceptions of well-being. Environmental considerations, ranging from air and water quality to the broader climate and geographical factors, are crucial elements that directly impact health outcomes.

Psychological well-being, encompassing mental health and stress levels, adds another layer of complexity to the health equation, highlighting the interconnectedness of physical and mental aspects of health. Beyond individual factors, the influence of family and peer networks, access to education, community characteristics, and the integration of technology into healthcare practices further shape the intricate web of determinants affecting health outcomes. Issues related to occupational health and safety, cultural and social stigmas associated with health conditions, and the availability of community resources all contribute to the nuanced and complex fabric of factors that collectively influence health.

Addressing these multifaceted determinants requires a comprehensive and collaborative approach, acknowledging the interconnected nature of these factors. Creating equitable and accessible healthcare systems demands an understanding of the broader social, economic, and environmental contexts that contribute to health disparities. Thus, a holistic understanding of health determinants is essential for the development of effective public health strategies and interventions aimed at promoting overall well-being.

3.4 KEY WORDS :

1. Social
2. Environment
3. Hereditary
4. Health
5. Society

3.5 SELF-ASSESSMENT QUESTIONS AND EXERCISE :

1. Explain the factors influencing health?
2. Examine the determinants of health with relevant examples?

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Prof. Saraswati Raju Iyer

LESSON – 4

INDICATORS OF HEALTH AND SYSTEMS OF MEDICINE IN INDIA

OBJECTIVE:

The objective of this lesson is to explain the indicators of health, systems of medicine in India

STRUCTURE:

4.1 INTRODUCTION :

Indicators of health are measurable factors that provide insights into the overall well-being of individuals and populations. These indicators help assess the effectiveness of healthcare systems, identify health trends, and guide public health interventions. Here is an elaborate discussion on various indicators of health:

4.2 INDICATORS OF HEALTH :

1. Mortality Indicators:

Mortality Rate: This is the number of deaths in a population over a specific period, often expressed per 1,000 or 100,000 individuals. It helps assess the overall health of a population and identify trends in causes of death. For example, if a community has a high mortality rate due to heart disease, policymakers and public health officials could implement initiatives promoting healthy eating and exercise to reduce the prevalence of this condition. They can then track changes in the mortality rate over time to evaluate the effectiveness of their interventions.

Life Expectancy: The average number of years a person can expect to live, often calculated at birth. Life expectancy is a key indicator of the overall health and quality of life of a population. For instance, suppose a country has a life expectancy of 70 years at birth. Policymakers might analyze the data and identify that a significant portion of the population dies prematurely due to tobacco-related illnesses. In response, they could implement anti-smoking campaigns, increase taxes on cigarettes, and provide accessible healthcare services to support smoking cessation. By monitoring changes in life expectancy over time, policymakers can evaluate the success of these interventions in improving the overall health and quality of life for their population.

2. Morbidity Indicators:

Incidence and Prevalence: Incidence measures the number of new cases of a specific disease in a given population over a defined period, while prevalence reflects the total number of existing cases. These indicators help understand the burden of diseases within a community. By tracking the incidence and prevalence rates of specific diseases, public health officials can identify areas of concern and allocate resources accordingly. Additionally, morbidity indicators allow for the monitoring of disease patterns and the effectiveness of prevention and treatment strategies. Overall, these indicators provide valuable information for public health planning and interventions to improve the health outcomes of individuals and communities.

Disability-Adjusted Life Years (DALYs): DALYs combine years of life lost due to premature death and years lived with disability, providing a comprehensive measure of the overall burden of disease. This measure takes into account both the quantity and quality of life lost due to illness or disability. By calculating DALYs, health officials can prioritize interventions and allocate resources to address the diseases and conditions that have the greatest impact on population health. This information helps in making informed decisions about public health policies and programs, ultimately leading to improved health outcomes for individuals and communities.

3. Behavioural and Lifestyle Indicators:

Tobacco and Alcohol Consumption: Monitoring the prevalence of tobacco and alcohol use helps gauge the risk of associated health conditions such as cardiovascular diseases and cancers. By tracking the rates of tobacco and alcohol consumption, health officials can identify trends and patterns that may contribute to the development of these diseases. This data can then be used to implement targeted prevention and intervention strategies, such as public awareness campaigns and regulations on the sale and advertising of these substances. Ultimately, reducing tobacco and alcohol use can lead to a decrease in the burden of related health conditions and an improvement in overall population health.

Physical Activity Levels: Sedentary lifestyles contribute to various health problems. Indicators related to physical activity help assess the prevalence of this risk factor. These indicators include measures of time spent in physical activity, such as the number of hours spent sitting or engaging in moderate-to-vigorous exercise. By collecting data on physical activity levels, public health officials can identify populations at higher risk for diseases related to sedentary lifestyles. This information can then be used to develop targeted interventions, such as exercise programs or workplace wellness initiatives, to promote increased physical activity and improve overall population health.

Dietary Habits: Monitoring dietary patterns, including the consumption of fruits, vegetables, and processed foods, provides insights into nutrition-related health risks. These insights can help public health officials develop educational campaigns and interventions aimed at promoting healthier eating habits. For example, if data reveals a high consumption of processed foods in a certain population, officials can implement initiatives to increase access to fresh, nutritious foods and educate individuals on the benefits of a balanced diet. By monitoring dietary habits, public health officials can address nutrition-related health risks and work towards improving the overall well-being of the population.

4. Access to Healthcare Indicators:

Healthcare Coverage: The percentage of the population with access to healthcare services, including those covered by health insurance or other healthcare programs. This indicator is crucial in understanding the level of healthcare accessibility within a population. By analyzing the percentage of individuals with healthcare coverage, officials can identify gaps in the healthcare system and develop strategies to ensure that everyone has access to necessary medical services. Improving healthcare coverage can lead to better health outcomes and reduce healthcare disparities among different socioeconomic groups. Additionally, it can contribute to the early detection and prevention of diseases, ultimately promoting the overall well-being of the population.

Healthcare Utilization: Examining the frequency of healthcare service utilization, such as regular check-ups and preventive care, provides insights into access to and utilization of healthcare services. Understanding healthcare utilization patterns can help identify barriers to accessing care, such as the limited availability of healthcare providers or a lack of transportation. By analyzing these patterns, policymakers can implement targeted interventions to increase utilization and ensure that individuals receive the necessary care they need. This information can also be used to allocate resources effectively and efficiently, ensuring that healthcare services are accessible to all members of the population.

5. Socioeconomic Indicators:

Income and Poverty Rates: Socioeconomic status significantly influences health outcomes. Monitoring income levels and poverty rates helps identify vulnerable populations. Understanding the socioeconomic indicators of income and poverty rates is crucial in identifying vulnerable populations who may face barriers to accessing healthcare. By monitoring these indicators, policymakers can gain insights into the social and economic factors that contribute to health disparities. This information can guide the development of targeted interventions and policies aimed at reducing poverty and improving access to healthcare services for those in need. Moreover, it allows for the allocation of resources towards areas with higher poverty rates, ensuring that healthcare services are distributed equitably and effectively.

Education Levels: Higher levels of education are often associated with better health outcomes. Indicators related to education can provide insights into disparities in health. For example, individuals with higher levels of education are more likely to have better health literacy, enabling them to make informed decisions about their health and access appropriate healthcare services. Additionally, education can improve employment opportunities and income levels, which in turn can positively impact access to healthcare. By addressing educational disparities and promoting equal access to quality education, we can address health disparities and improve overall population health.

6. Environmental Indicators:

Air and Water Quality: Monitoring pollutants and contaminants in the air and water helps assess environmental health risks and potential impacts on population health. By monitoring air and water quality, we can identify areas that are at higher risk for pollution-related health issues such as respiratory problems and waterborne diseases. This information can then be used to implement measures to reduce these risks and protect the health of the population. Additionally, tracking environmental indicators allows for early detection of any emerging threats to public health, enabling timely interventions and mitigating potential health crises.

Overall, monitoring air and water quality plays a crucial role in maintaining a healthy environment and promoting population health.

Access to Green Spaces: The availability of parks and green spaces contributes to physical and mental well-being. Indicators related to access to green spaces can reflect the environmental health of a community. For instance, communities with ample parks and green spaces tend to have lower rates of obesity and higher levels of physical activity among residents. These indicators also highlight the presence of recreational opportunities, which can improve mental well-being by providing a space for relaxation and stress reduction. Ensuring equitable access to green spaces is essential for promoting population health and creating inclusive communities where everyone can enjoy the benefits of nature. Additionally, monitoring indicators related to the maintenance and quality of these green spaces can help identify areas in need of improvement or investment, ultimately enhancing the overall environmental health of a community.

7. Quality of Life Indicators:

Subjective Well-Being: Assessing individuals' self-reported well-being, life satisfaction, and happiness provides a holistic measure of health beyond traditional clinical indicators. Understanding individuals' subjective well-being is crucial in assessing the overall quality of life in a community. By taking into account factors such as life satisfaction and happiness, we can gain a comprehensive understanding of the population's mental and emotional health, which is equally as important as physical health. This data can inform policy decisions aimed at improving the overall well-being and happiness of the community, leading to a more inclusive and prosperous society.

Social Support: The presence of social networks and support systems is a crucial indicator of mental and emotional well-being. Strong social support systems have been shown to contribute to higher levels of subjective well-being. When individuals have a network of friends, family, and community members to rely on, they are better equipped to navigate life's challenges and experience a sense of belonging and connectedness. This support can provide emotional validation, practical assistance, and a sense of security, all of which contribute to overall well-being. Therefore, fostering social support networks is an essential aspect of promoting the mental and emotional health of a community.

8. Global Health Indicators:

Infectious Disease Rates: Monitoring the incidence and prevalence of infectious diseases on a global scale helps identify emerging health threats and track the effectiveness of public health interventions. By monitoring infectious disease rates globally, public health officials can identify areas that require immediate attention, such as regions experiencing a sudden increase in cases. This information allows for the implementation of targeted interventions to prevent the further spread of the disease and protect vulnerable populations. Additionally, tracking the effectiveness of public health interventions helps refine strategies and allocate resources more efficiently, ultimately improving global health outcomes.

Access to Clean Water and Sanitation: Basic necessities like clean water and sanitation are fundamental to preventing waterborne diseases and ensuring population health. Lack of access to clean water and proper sanitation facilities can lead to the spread of diseases such as cholera, dysentery, and typhoid. Improving access to clean water and sanitation not only

improves overall health but also reduces the burden on healthcare systems. By investing in infrastructure and education, communities can prevent the transmission of waterborne diseases and improve the well-being of their population.

9. Maternal and Child Health Indicators:

Maternal Mortality Rate: The number of maternal deaths per 100,000 live births is a critical indicator of maternal health and the quality of maternal healthcare services. The maternal mortality rate is a crucial indicator that reflects the effectiveness of healthcare systems in providing adequate care to pregnant women. High maternal mortality rates often indicate insufficient access to skilled healthcare professionals, inadequate prenatal care, and limited access to emergency obstetric care. By addressing these issues and improving maternal healthcare services, communities can significantly reduce maternal deaths and ensure the well-being of both mothers and their children.

Childhood Immunization Rates: Monitoring the rates of childhood immunization helps assess the level of protection against preventable diseases in the pediatric population. By monitoring childhood immunization rates, healthcare professionals can identify areas where immunization coverage is low and implement targeted interventions to improve vaccination rates. This is crucial in preventing outbreaks of vaccine-preventable diseases and protecting the overall health of children. Additionally, monitoring immunization rates can help identify disparities in access to healthcare services, allowing for the development of strategies to ensure equitable access for all children. Ultimately, increasing childhood immunization rates leads to healthier communities and a reduced burden on healthcare systems.

10. Health Inequality Indicators:

Health Disparities: Examining differences in health outcomes among different demographic groups helps identify inequalities and target interventions to reduce health disparities. By monitoring immunization rates among different demographic groups, healthcare providers can gain valuable insights into potential health disparities. For example, if certain racial or ethnic groups have lower immunization rates, it may indicate barriers to accessing healthcare services within those communities. This information can then be used to develop targeted interventions and strategies to overcome these barriers and ensure equitable access to immunizations for all children. Ultimately, addressing health disparities through increased immunization rates can lead to improved health outcomes and a more equal healthcare system for all.

Access to Preventive Services: Disparities in access to preventive services, such as vaccinations and cancer screenings, can highlight inequities in healthcare access. Socioeconomic status, education level, geographic location, and cultural beliefs are just a few of the variables that can affect these disparities. For example, low-income communities may face financial barriers to accessing preventive services, while rural areas may have limited healthcare infrastructure. Additionally, cultural beliefs and mistrust in the healthcare system can contribute to lower immunization rates among certain populations. By identifying and addressing these barriers, healthcare providers and policymakers can work towards ensuring that all individuals have equal access to preventive services, reducing health disparities, and promoting overall well-being.

4.3 INDIAN SYSTEMS OF MEDICINE :

The Indian System of Medicine is of great antiquity. It is the culmination of Indian thought of medicine which represents a way of healthy living valued with a long and unique cultural history, as also amalgamating the best of influences that came in from contact with other civilizations be it Greece (resulting in Unani Medicine) or Germany (Homeopathy) or our scriptures/sages which gave us the science of Ayurveda, Siddha as also Yoga & Naturopathy. Like the multifaceted culture in our country, traditional medicines have evolved over centuries blessed with a plethora of traditional medicines and practices. With an increase in lifestyle related disorders there is a worldwide resurgence of interest in holistic systems of health care, particularly with respect to the prevention and management of chronic, non-communicable and systemic diseases. It is increasingly understood that no single health care system can provide satisfactory answers to all the health needs of modern society. Evidently there is a need for a new inclusive and integrated health care regime that should guide health policies and programs in future. India has an advantage in this global resurgence of interest in holistic therapies as it has a rich heritage of indigenous medical knowledge coupled with strong infrastructure and skilled manpower in modern medicine.

(i) Ayurveda

Ayurveda is a classical system of healthcare originating from the Vedas documented around 5000 years ago and currently recognized and practiced in India and many countries of the Indian subcontinent. It is one of the oldest healthcare systems that take a holistic view of the physical, mental, spiritual and social aspects of human life, health and disease. Scattered references of health, disease and use of natural sources for treatment were initially made in the Vedas (particularly in Rigveda and Atharvaveda) and around 5000 to 3000 B.C. the knowledge of Ayurveda was first comprehensively documented in the compendia called Charak Samhita and Sushruta Samhita. According to Ayurveda, health is considered as a basic pre-requisite for achieving the goals of life - Dharma (duties), Arth (finance), Kama (materialistic desires) and Moksha (salvation). As per the fundamental basis of Ayurveda, all objects and living bodies are composed of five basic elements, called the Pancha Mahabhootas, namely: Prithvi (earth), Jal (water), Agni (fire), Vayu (air) and Akash (ether). The philosophy of Ayurveda is based on the fundamental correlation between the universe and the man. Ayurveda imbibes the humeral theory of Tridosha- the Vata (ether + air), Pitta (fire) and Kapha (earth + water), which are considered as the three physiological entities in living beings responsible for all metabolic functions. The mental characters of human beings are attributable to Satva, Rajas and Tamas, which are the psychological properties of life collectively terms as ‘Triguna’. Ayurveda aims to keep structural and functional entities in a state of equilibrium, which signifies good health (Swasthya). Any imbalance due to internal or external factors leads to disease and the treatment consists of restoring the equilibrium through various procedures, regimen, diet, medicines and behaviour change. The treatment approach in the Ayurveda system is holistic and individualized having preventive, curative, mitigative, recuperative and rehabilitative aspects. The preventive aspect of Ayurveda is called Svasth-Vritta and includes personal hygiene, daily and seasonal regimens, appropriate social behaviour and use of materials & practices for healthy aging and prevention of premature loss of health attribute. The curative treatment consists of Aushadhi (drugs), Ahara (diet) and Vihara (life style). Ayurveda largely uses plants as raw materials for the manufacture of drugs, though materials of animal and marine origin, metals and minerals are also used.

(ii) Unani

The Unani System of Medicine originated in Greece and passed through many countries before establishing itself in India during the medieval period. This system is based on the teachings of Hippocrates and Gallen, developed into an elaborate Medical System by Arabs. It is based on well-established knowledge and practices relating to the promotion of positive health and prevention of diseases. The Unani system became enriched by imbibing what was best in the contemporary systems of traditional medicines in Egypt, Syria, Iraq, Persia, India, China and other Middle East countries. The system of medicine was documented in Al-Qanoon, a medical Bible, by Sheikh Bu-Ali Sina (Avicena, 980-1037 AD), and in Al-Havi by Razi (Rhazes, 850-923 AD) and in many other books written by the Unani physicians. The literature of the Unani system is mostly found in Arabic, Persian and Urdu languages. The Unani System is based on the Humoral theory i.e. the presence of blood, phlegm, yellow bile and black bile in a person. The temperament of a person can accordingly be sanguine, phlegmatic, choleric and melancholic depending on the presence and combination of humours. According to Unani theory, the humours and medicinal plants themselves are assigned temperaments. Any change in quantity and quality of the humours, brings about a change in the status of the health of the human body. A proper balance of humours is required for the maintenance of health. Treatment in Unani consists of three components namely preventive, promotive and curative. Unani system of Medicine has been found to be efficacious in conditions like Rheumatoid Arthritis, Jaundice, Nervous Debility, and Skin Diseases like Vitiligo & Eczema, Sinusitis and Bronchial Asthma. For the prevention of disease and promotion of health, the Unani System emphasizes six essentials (Asbab-e-Sitta Zarooria):-

(a) Pure air
(b) Food and water
(c) Physical movement and rest
(d) Psychic movement and rest
(e) Sleep and wakefulness
(f) Retention of useful materials and evacuation of waste materials from the body. There are four forms of treatment in Unani medicine- Ilaj bid Dawa (Pharmacotherapy), Ilaj bil Ghiza (Deitotherapy), Ilaj Bid Tadbir (Regimenal Therapy) and Ilaj bil Jarahat (Surgery). Regimenal Therapy (Ilaj Bid Tadbir) is a special technique/ physical method of treatment to improve the constitution of body by removing waste materials and improving the defense mechanism of the body and protect health. Some of the special techniques are Fasd (Blood-letting), Hijama (Cupping), Dalk (Massage), Taleeq-e-Alaq (Leeching), Hammame-Har (Turkish Bath), Riyazat (Exercise), Amal-eKai (Cauterization).

The Unani system of medicine offers various methods of treatment which are used for specific and complicated diseases. It emphasizes the use of naturally occurring, mostly herbal medicines and also uses some medicines of animal, marine and mineral origin.

(iii) Siddha

The Siddha System of medicine is one of the ancient systems of medicine in India having its close bedd with Dravidian culture. The term Siddha means achievements and Siddhars are those who have achieved perfection in medicine. Eighteen Siddhars are said to have contributed towards the systematic development of this system and recorded their experiences in Tamil language. The Siddha system of Medicine emphasizes on the patient,

environment, age, sex, race, habits, mental frame work, habitat, diet, appetite, physical condition, physiological constitution of the diseases for its treatment which is individualistic in nature Diagnosis of diseases are done through examination of pulse, urine, eyes, study of voice, Colour of body, tongue and status of the digestion of individual patients. System has unique treasure for the conversion of metals and minerals as drugs and many infective diseases are treated with the medicines containing specially processed mercury, silver, arsenic, lead and sulphur without any side effects. The strength of the Siddha system lies in providing very effective therapy in the case of Psoriasis, Rheumatic disorders, Chronic liver disorders, Benign prostate hypertrophy, bleeding piles, peptic ulcer including various kinds of Dermatological disorders of non-psoriatic nature.

(iv) Yoga

The word "Yoga" comes from the Sanskrit word "yuj" which means "to unite or integrate." Yoga is about the union of a person's own consciousness and the universal consciousness. It is primarily a way of life, first propounded by Maharshi Patanjali in systematic form Yogsutra. The discipline of Yoga consists of eight components namely, restraint (Yama), observance of austerity (Niyama), physical postures (Asana), breathing control (Pranayam) restraining of sense organs (Pratyahar), contemplation (Dharna), meditation (Dhyan) and Deep meditation (Samadhi). These steps in the practice of Yoga have the potential to elevate social and personal behaviour and to promote physical health by better circulation of oxygenated blood in the body, restraining the sense organs and thereby inducing tranquility and serenity of mind and spirit. The practice of Yoga has also been found to be useful in the prevention of certain psychosomatic diseases and improves individual resistance and ability to endure stressful situations. Yoga is a promotive, preventive rehabilitative and curative intervention for overall enhancement of health status. A number of postures are described in Yoga literature to improve health, to prevent diseases and to cure illness. The physical postures are required to be chosen judiciously and have to be practiced in the correct way so that the benefits of prevention of disease, promotion of health and therapeutic use can be derived from them. Studies have revealed that Yogic practice improves intelligence and memory and help in developing resistance to situations of stress and also help individuals to develop an integrated personality. Meditation can stabilize emotional changes and prevent abnormal functions of the vital organs of the body. Studies have shown that meditation not only regulates the functions of the sense organs but also strengthens the nervous system. Yoga today is no longer restricted to hermits, saints, sages but has gone to every home for the global health promotion. Yoga as a part of peoples' lifestyle has aroused a world-wide awakening and acceptance.

(v) Naturopathy

Naturopathy is rooted in the healing wisdom of many cultures and times based on principal of natural healing. The principals of natural healing. The principles and practices of Naturopathy are integrated in the life style, if the people observe living close to nature. Naturopathy is a cost effective drugless, non-invasive therapy involving the use of natural materials for health care and healthy living. It is based on the theories of vitality, boosting the self-healing capacity of the body and the principles of healthy living. Naturopathy is a system of natural treatment and also a way of life widely practiced, globally accepted and recognized for health preservation and management of illnesses without medicines.

Naturopathy advocates living in harmony with constructive principles of Nature on the physical, mental, social and spiritual planes. It has great promotive, preventive, curative as well as restorative potentials. Naturopathy promotes healing by stimulating the body's inherent power to regain health with the help of five elements of nature – Earth, Water, Air, Fire and Ether. It is a call to "Return to Nature" and to resort to a simple way of living in harmony with the self, society and environment. Naturopathy advocates 'Better Health without Medicines'. It is reported to be effective in chronic, allergic autoimmune and stress related disorders. The theory and practice of Naturopathy are based on a holistic view point with particular attention to simple eating and living habits, adoption of purificatory measures, use of hydrotherapy, cold packs, mud packs, baths, massages, fasting etc.

(vi) Homoeopathy

The Physicians from the time of Hippocrates (around 400 B.C.) have observed that certain substances could produce symptoms of a disease in healthy people similar to those of people suffering from the disease. Dr. Christian Friedrich Samuel Hahnemann, a German physician, scientifically examined this phenomenon and codified the fundamental principles of Homoeopathy. Homoeopathy was brought into India around 1810 A.D. by European missionaries and received official recognition by a resolution passed by the Constituent Assembly in 1948 and then by the Parliament. The first principle of Homoeopathy 'Similia Similibus Curentur', says that a medicine which could induce a set of symptoms in healthy human beings would be capable of curing a similar set of symptoms in human beings actually suffering from the disease. The second principle of 'Single Medicine' says that one medicine should be administered at a time to a particular patient during the treatment. The third principle of 'Minimum Dose' states that the bare minimum dose of a drug which would induce a curative action without any adverse effect should be administered. Homoeopathy is based on the assumption that the causation of a disease mainly depends upon the susceptibility or proneness of an individual to the incidence of the particular disease in addition to the action of external agents like bacteria, viruses, etc.

Homoeopathy is a method of treating diseases by administering drugs which have been experimentally proved to possess the power to produce similar symptoms on healthy human beings. Treatment in Homoeopathy, which is holistic in nature, focuses on an individual's response to a specific environment. Homoeopathic medicines are prepared mainly from natural substances such as plant products, minerals and from animal sources. Homoeopathic medicines do not have any toxic, poisonous or side effects. Homoeopathic treatment is economical as well and has a very broad public acceptance. Homoeopathy has its own areas of strength in therapeutics and it is particularly useful in treatment for allergies, autoimmune disorders and viral infections. Many surgical, gynecological and obstetrical and pediatric conditions and ailments affecting the eyes, nose, ear, teeth, skin, sexual organs etc. are amenable to homoeopathic treatment. Behavioural disorders, neurological problems and metabolic diseases can also be successfully treated by Homoeopathy. Apart from the curative aspects, Homoeopathic medicines are also used in preventive and promotive health care. In recent times, there is an emergence of interest in the use of Homoeopathic medicines in veterinary care, agriculture, dentistry, etc. Homoeopathic medical education has developed in seven specialties in post-graduate teaching, which are Materia Medica, Organon of Medicine, Repertory, Practice of Medicine, Pediatrics, Pharmacy and Psychiatry.

4.3 SUMMARY:

In conclusion, indicators of health serve as critical metrics in assessing the well-being of individuals and populations. From traditional measures like mortality rates and disease prevalence to more nuanced indicators such as quality of life and mental health, these metrics provide a comprehensive understanding of overall health. The evolving landscape of health indicators also incorporates social, economic, and environmental factors, recognizing the intricate interplay between these elements and individual well-being. As societies progress, the importance of preventive measures and health promotion becomes increasingly evident, shifting the focus from mere absence of disease to the attainment of holistic health. Continuous advancements in healthcare research and technology further refine our ability to measure and interpret health indicators, empowering policymakers and healthcare professionals to make informed decisions. Ultimately, a holistic approach that considers a diverse range of indicators is essential for fostering a society where individuals not only live longer but also lead fulfilling and vibrant lives.

The diverse systems of medicine in India, including Ayurveda, Unani, Siddha, Yoga, Naturopathy, and Homeopathy, contribute to the rich tapestry of healthcare practices in the country. Each system has its unique principles, philosophies, and methodologies, rooted in ancient traditions and cultural contexts. While they may differ in their approaches, they all share a holistic perspective, aiming to restore balance and promote overall well-being. Ayurveda, with its emphasis on balance among the body, mind, and spirit, utilizes natural remedies, diet, and lifestyle practices to prevent and treat diseases. It emphasizes individualized approaches based on one's dosha constitution. Unani medicine, influenced by Greek principles, focuses on the balance of the four humours. It incorporates herbal medicines, dietary modifications, and physical therapies to restore health. Siddha medicine, rooted in ancient Tamil culture, emphasizes the balance of the three doshas.

It employs herbs, minerals, and meditation techniques to maintain harmony and treat ailments. While Yoga is primarily a spiritual and philosophical practice, it also encompasses a therapeutic aspect. Yoga involves physical postures, breathing exercises, and meditation to promote physical, mental, and spiritual well-being. Naturopathy relies on the body's inherent ability to heal itself by adopting natural therapies like nutrition, hydrotherapy, and lifestyle modifications. It emphasizes preventive care and lifestyle management. Homeopathy is based on the principle of "like cures like," using highly diluted substances to stimulate the body's healing response. It is known for its individualized approach and minimal side effects. These systems coexist alongside conventional allopathic medicine, providing individuals with a range of options for healthcare.

While some controversies and debates surround their efficacy, many people find these alternative systems valuable for certain health conditions or as complementary approaches to conventional medicine. In the contemporary healthcare landscape, there is a growing recognition of the importance of integrating traditional and alternative systems with modern medicine. This holistic approach aims to provide comprehensive and patient-centered care, acknowledging the strengths of each system and fostering collaboration for the benefit of individuals' health and well-being. Ultimately, the coexistence and integration of these diverse systems contribute to the pluralistic healthcare environment in India, offering individuals a spectrum of choices to address their health needs.

4.5 KEYWORDS :

1. Mortality
2. Morbidity
3. Quality of life
4. Ayurveda
5. Unani
6. Sidda
7. Yoga
8. Naturopathy
9. Homeopathy

4.6 SELF ASSESSMENT QUESTIONS :

1. Explain the indicators of health?
2. Examine the systems of medicine in India?

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Prof. Saraswati Raju Iyer

LESSON – 5

SOCIOLOGICAL PERSPECTIVES ON ILLNESS

OBJECTIVE :

The objective of this lesson is to explain the definition of illness, conceptualising illness and sickness, differentiate disease, illness and sickness, illness as deviance, stages of illness, acute illness and chronic illness, experiencing chronic illness, sociology of illness, relationship of health and illness.

STRUCTURE :

5.1 INTRODUCTION :

The sociological perspective on illness offers a unique lens through which we can understand the intricate interplay between individuals, society, and health. One fundamental aspect of this perspective is the conceptualization of illness as a form of deviance. In sociological terms, illness can be viewed as a departure from the established norms of health, disrupting the expected state of well-being within a society. This perspective prompts us to explore the social construction of health and illness, recognizing that societal norms and values influence not only how we define illness but also how we respond to it.

Understanding the stages of illness is crucial in the sociological examination of health. From the initial recognition of symptoms to seeking medical attention and the subsequent interactions with healthcare systems, each stage reflects the dynamic relationship between individuals and their social environment. These stages are not merely biological processes but are deeply embedded in social contexts, shaped by cultural beliefs, economic factors, and institutional structures.

Experiencing illness, from a sociological standpoint, goes beyond the biological dimensions. It involves an exploration of how individuals navigate through the social, emotional, and psychological aspects of being unwell. Sociologists delve into the lived experiences of individuals, examining the impact of illness on identity, relationships, and

social roles. This holistic approach enables us to comprehend illness not only as a medical condition but as a socially situated phenomenon.

The sociology of illness further emphasizes the role of social factors in shaping health outcomes. This perspective acknowledges that health is not solely determined by individual choices and behaviours but is profoundly influenced by broader societal forces such as inequality, social norms, and structural constraints. By examining the distribution of health resources, access to healthcare, and social determinants of health, sociologists uncover the intricate web of factors that contribute to health disparities within populations.

The relationship between health and illness is a central theme in the sociological exploration of well-being. It underscores the interconnectedness of these concepts, highlighting that health is not merely the absence of illness, but a complex interplay of biological, social, and psychological factors. This perspective prompts us to question conventional dichotomies and encourages a more nuanced understanding of health and illness as intertwined elements of the human experience. In exploring these sociological perspectives on illness, we gain valuable insights into the societal dynamics that shape our perceptions, experiences, and responses to health challenges.

5.2 CONCEPTUALISING ILLNESS AND SICKNESS :

According to what constitute health, medical sociology differentiates the concepts of disease, illness and sickness. What is meant to be healthy is a difficult question to address. Defining the concept of health is complicated because it is influenced by different factors. The dominant biomedical model defines health as absence of disease with specific symptoms and particular causes. Psychological approach expands on this scientific model and incorporates the subjective assessment of the state of health. Socio-cultural approach on the other hands deals with the social factors influencing the health of the people. Different positions on health produced multiple positions on what is not health. Disease, illness and sickness are thus three aspects of being non-healthy.

5.3 DIFFERENTIATE DISEASE, ILLNESS AND SICKNESS :

“Disease is something an organ has; illness is something a man has” (Helman 1981: 544). In medical sociology, disease is the professional definition of what constitute not healthy. It is a biological abnormality caused by specific physical dysfunctions. Medicine is used to diagnose the causal factors and treat the disease to maintain healthy state. Here, disease is uniform across community and culture. Production of scientific medical knowledge and its distribution is part of this biomedical process. Patient and professional relationship is always hierarchical and body of the patient is treated as an excluded physical entity.

On the other hand, patient’s view of disease is defined as illness. The subjective experience of illness may not be similar to the biomedical definition of disease. Layman’s perception of what constitute health and illness is culturally specific. It is influenced by the local beliefs about disease, social and familial status of the patient, age and gender factors, state level policy interventions, nature of medical care systems etc. influence the subjective experience of illness. Previous experience of illness, physical capacity of patient etc. are also important factors. Thus, subjective experience of illness is context specific and thus its expressions also vary.

Sickness is defined as social perception of disease. It is influenced by nature of social roles and hierarchy of disease and social distribution of disease. It is complimented with biomedical definition of disease and individual perception of illness. “Sickness exists when people are defined by others as having a problem that requires a therapeutic response” (Twaddle and Hessler, 1987: 101). In his study on personal narratives of illness, Robinson (1990) distinguish illness, sickness and disease based on the trajectory of their focus.

The relationship between illness, sickness and disease is complex. Biomedical explanations of disease, personal illness narratives and social legitimation of disease are not exclusive aspects of non-healthy but are inter related in multiple ways. In illness narration the focus is personal goal of better life, and social status is the concern of the social perception of sickness and biomedical model is engaged with medical diagnosis and treatment to maintain the physical impairment.

5.4 ILLNESS AS DEVIANCE :

Illness is generally considered as deviance from the social system. This understanding of illness is influenced by the functionalist approach to health and medicine. Analogy of society and body is the basic of this approach where like any dysfunction of a single organ effect the entire functioning of the body as a whole, illness is a social deviance form the normal functioning of the society. Parson (1951) explains disease as a deviance from the normal social role. He explains sick role as a temporary role of the patient during illness period who is formally exempted from the everyday social roles. Influenced by this understanding of disease, later studies consider illness also as a social deviance. Freidson (1971) regard illness as a form of physical and social deviance from the normalcy. He says that physical consequences of illness may not change but the social dimensions of it is culturally specific; depends on the norms and values of the society.

Illness behaviour

- Why some people are consulting doctor for minor symptoms and not others?
- What cause people to interpret symptoms in different ways?
- How will you know that you are ill and should medicate?
- Why is that variations in the utilisation of medical services?
- How do people come to feel ill?

These are some of the questions which arise when dealing with individual perception of illness. Cultural variations in the subjective experience of illness make it complex and context specific. Illness behaviour is a means to understand these complexities. “Illness behaviour refers to the ways in which symptoms are perceived, evaluated, and acted upon by a person who recognises some pain, discomfort or other signs of organic malfunction”. (Mechanic and Volkart, 1961:52)

Individuals are active and critical with their own complex idea about what constitute health and modes of treatment for illness. Meaning of actions for individuals is important factor to be studied than just observing the actions. Thus, an interpretative approach should be developed to the layman’s conception of illness. This lay perspective may contradict professional definitions or compliment but it has unique role in the decision making of the patients and influence largely on the subjective experience of illness. Individual accept some

symptoms as serious according to their idea of normalcy in everyday life. This decision making is influenced by many factors like age, gender, financial position, family structure, occupation etc. For example, for a coolie, back pain to certain intensity may not be an illness but for a teacher the initial stage of its occurrence itself must be a state of illness. Here we can see how occupational variation influences the illness behaviour of individuals. In other situation, children's health is a priority which requires urgent treatment but the old age health issues are approached as a normal condition. Here, the age factor is crucial in decision making regarding medical treatment. Gender also plays an important role in the nature of illness behaviour. For example, a girl grown up in a family with open space for woman equal to men might consider the menstrual pain as a biological state and depending on the severity of pain will go for medication. But a girl with a background of sexist childhood socialisation might perceive the same pain as a burden and may be reluctant to share with others and won't go for medical consultation. This clearly shows how familial status and social circumstances influence the individual illness behaviour in defining what constitute health and where the illness state starts and how to proceed with it further.

This is a long process which starts with occurrence of physical discomfort followed by individual acceptance of illness. Individual decision making for further treatment of illness is influenced by many social and cultural factors. Suchman (1965) in his study on illness narratives explains different stages of illness experience which reflects on relationship between social structure and medical orientation.

5.5 STAGES OF ILLNESS EXPERIENCE :

1. Symptom experience: It is the stage where physical discomfort is experienced. Then individual recognise and emotionally response to it and proceed for some measures to maintain the balance of the body. Observing the entire process is the major feature of this stage.

2. Assumption of the sick role: If the individual accepts the existence of illness, then they transform in to the stage of sick role where individual relinquish some social roles. Here, illness is perceived as a social deviance. Transforming in to sick role exempt individual from some of the normal social roles.

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3. Medical care contact: This is the point in which individual seek medical care. This involves self-medical care to rational choice of biomedicine, practicing alternative medical practices like folk medicines, ayurveda etc. In this stage authenticity of the physical illness from the professionals is crucial.

4. Dependent-Patient role: In this stage individual perform the dependent patient role by accepting the professional treatment measures. Nature of this role is influenced by the nature of the illness, individual's ability to cope up with the situation, nature of familial support, social approach towards the particular disease etc. Accordingly patient approach for further treatment by experimenting complimentary medical practices.

5. Recovery and rehabilitation: This stage depends on the type of illness whether it is acute or chronic. For the patients who is recovered from the illness go back to their normal social role and those continue with the disease tries to resume the normal role to a certain extend along with the sick role.

5.6 ACUTE ILLNESS AND CHRONIC ILLNESS :

Any illness constitutes a disruption and a discontinuance of an ongoing life (Bury 1982). Severity of illness influence illness behaviour. According to the duration of the illness, it is divided into two: acute and chronic illness. In general, illness which sustains for less than three months and is cured is considered as acute illness which includes cold, various kinds of fever etc. Acute illness is a transitory period after which the normalcy of daily life can be attained. Chronic illness are the prolonged and mostly uncured diseases; for example, cardiovascular diseases like hyper tension, stroke etc., respiratory problems like asthma, diseases like AIDS, cancer etc.

5.7 EXPERIENCING CHRONIC ILLNESS :

Chronic illness is not just a severe physical problem which requires long term medical treatment. It creates ethical dilemmas, identity crisis, isolation and many other psychological issues. Restricted social interaction and isolation from daily life activities is a consistent issue faced by chronic ill patients. Chronic ill patient will be in a vulnerable stage which will make the life so normal that everyday life is arranged only in a way to reduce the growth of illness. The experience of chronic illness is influence by many factors like; nature of the disease, for example social stigma related to disease like AIDS will affect patient's perception of self and influence social interaction. Age is a crucial factor because if a young man who is the bread winner of the family fall ill then the familial approach to him will be so different compared to a man with an age of 60 above. Thus, the experience of chronic illness is a complex phenomenon.

Kathy Charmaz (1991) explains three major stages of chronic illness in his study on the relationship between identity and self-formation among chronic ill patients.

1. **As an interruption in life:** This is the initial stage where illness is considered as in interruption in life. Patient keep hope of recovery and do anything for it. Here, the disease is perceived as something external and maintains the self as before.
2. **As an intrusive illness:** In this stage illness is accepted as permanent part of life and efforts are taken to maintain a balance in health condition by preventing further development of the illness. Here, the patient loses some control over the life but measures are taken to maintain self-esteem.
3. **As an immersion in illness:** This is a critical situation where the disease starts to dominate the daily life of the patient. Loss of control over the physical body makes them depend on others and the social life is also restricted. This is a stage where new self is created and the identity changes with the shift in the nature of social interaction.

5.8 SOCIOLOGY OF ILLNESS :

Disease, as defined by doctors, is an abnormal condition affecting the body of an organism and is based upon the observation of biological pathology. The conception of disease is 'objective', 'scientific' and based on the biomedical model of pathology which is the basis of modern medical thought. In contrast to the 'objective view of disease, the concept of illness refers to the person's subjective experience of ill health. It goes beyond the biological and physical consequences of disease, affecting the person's subjective well-being

and their social functioning. Illness is recognized by departures from the person's normal state of being and by altered feelings which may be diffuse.

To be ill, then, is not simply to be in a physically altered state, but also to be in a society altered condition which is normally disruptive of everyday life and is undesired. Illness is both personal and social. The individuals who feel ill are likely to talk to others in their attempts to make sense of their physical symptoms and feelings of 'disease' and departure from normal functioning. While they may draw upon biomedical ideas and knowledge to make sense of their illness, people also use other ideas which are current in their social groups both to make sense of their illness and to decide what action, if any, should be taken. For example, ideas of what constitutes 'flu', how to recognize it, and how to treat it (feed a cold, starve a fever). Such 'lay theories' of illness may be complex and detailed, and provide explanations which link the experiences of illness to the personal and social circumstances of the ill person in ways which may be more consistent and believable to them than professional medical explanations.

5.9 RELATIONSHIP OF HEALTH AND ILLNESS :

Cornwall's qualitative study of east Londoners (1984) shows the way in which general perceptions of health (level of functional or metabolic efficiency of a living being) and illness (poor health resulting from disease of body or mind) as 'matters that are largely beyond the control of individual reflect ideas and experiences other than areas such as paid work'. These general perceptions are broadly based upon medical ideas and in everyday life are modified by taking account of the individual circumstances (e.g. the nature of work) and characteristics (e.g. the weak constitution) of individuals.

People also differentiated between whether illnesses were 'normal' (infectious diseases), 'real' (disabling and life-threatening diseases) or 'health problems which are not illness' but which are linked to natural processes such as ageing or reproduction. It was also recognized that not all illnesses were treatable. Donovan (1986) similarly shows how the health beliefs of Afro-Caribbeans and Asians linked their health behaviour their life situations and cultural beliefs. For example, in both groups of respondents, diet was seen as linked to health and illness, and use of remedies such as herbal teas or 'hot' and 'cold' foods was part of their cultural beliefs and world view. Among Asians, dietary practices were also linked to religious beliefs and practices.

5.10 THE SICK ROLE :

Another unique contribution of sociology of health has been the study of the 'sick role', which expanded into a broader study of illness experience. This area includes the social role of the patient, illness behaviour, illness/patient careers, and the ways that these factors shape and are shaped by doctor-patient interaction. Talcott Parson's (1951) work on the sick role was the foundation for the sociological examination of illness and the expectations placed on those who are ill. Mechanic (1962) worked on illness behaviour.

Medical anthropologists have long studied illness in part as a way to examine the values in a society or group in the face of uncontrollable events, sociologists brought a greater interest in the impact of role expectations, norms, and sanctions, and the accommodations or lack thereof for the needs of those with illnesses or disabilities. This work includes rich ethnographic studies of illness experiences (e.g., Roth and Conrad, 1987;

Charmaz, 1991), as well as research on factors affecting the decisions to seek care (Berkanovic, Telesky, and Reeder, 1981), and patterns of healthcare utilization (Mechanic, Cleary, and Greenly, 1982).

5.11 SUMMARY :

In conclusion, the sociological perspectives on illness offer a profound lens through which we can understand the intricate interplay between health, society, and individual experiences. Illness, not just as a medical condition but as a socially constructed phenomenon, challenges us to rethink traditional notions and consider the broader societal influences shaping our perceptions of health and well-being. The conceptualization of illness goes beyond a mere biological perspective, acknowledging the social, cultural, and psychological dimensions that contribute to its definition. The differentiation between disease, illness, and sickness highlights the complex and multifaceted nature of health-related experiences, emphasizing the subjective and socially influenced aspects of health.

Viewing illness as deviance prompts us to question established norms and recognizes the impact of societal expectations on the experiences of individuals dealing with health challenges. The stages of illness, from symptom recognition to seeking medical attention and coping with the consequences, underscore the dynamic nature of the relationship between individuals and their social environment. Distinguishing between acute and chronic illness further deepens our understanding of the temporal aspects of health experiences. The chronicity of certain conditions introduces a unique set of challenges, influencing not only the individual's physical health but also their identity, relationships, and overall quality of life. The sociology of illness delves into the lived experiences of individuals, exploring how social factors shape and are shaped by the experience of being unwell.

This perspective recognizes the importance of context, culture, and societal structures in understanding the impact of illness on identity, self-concept, and interpersonal relationships. Finally, the intricate relationship between health and illness reflects the interconnected nature of these concepts. By recognizing health and illness as dynamic and interdependent elements of the human experience, sociological perspectives challenge us to move beyond dichotomous thinking and consider the complex web of factors that contribute to well-being. In embracing these sociological insights, we gain valuable perspectives on health that extend beyond the biomedical model. Sociological perspectives on illness prompt us to consider the broader societal dynamics that shape our perceptions, experiences, and responses to health challenges, ultimately contributing to a more holistic understanding of health and well-being in the context of our social world.

5.12 KEYWORDS :

1. Illness
2. Disease
3. Health
4. Sick

5.13 SELF ASSESSMENT QUESTIONS :

1. Analyze sociological perspectives of illness.
2. Define and differentiate illness and sickness.

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Prof. Saraswati Raju Iyer

LESSON – 6

ACCESS TO HEALTH

OBJECTIVE:

The objective of this lesson is to explain access to health.

STRUCTURE:

6.1 INTRODUCTION:

The term “access” is commonly used in two ways. Firstly, having access to anything means the potential and capability to utilize a service. Having access to any sort of service means in simple terms that the particular kind of service is available for use and further that there exist systems which would further allow for service to be utilized following contact with the health care service provider. Secondly, access means as actual procedure of admission into the process of utilizing the service.

Access to health is a fundamental pillar of societal well-being, encompassing a range of interconnected aspects that determine an individual's ability to obtain timely and appropriate healthcare services. This multidimensional concept involves not only the availability of healthcare resources but also factors such as affordability, geographical proximity, and the quality of services provided. In exploring access to health, we navigate through the dynamic landscape of healthcare systems, current trends, and the various dimensions that influence individuals' pathways to care.

At its core, access to healthcare involves the ease with which individuals can enter and utilize the healthcare system. This includes considerations of physical accessibility, where geographical barriers, transportation availability, and the distribution of healthcare facilities play crucial roles. Moreover, financial accessibility is a significant determinant, addressing the affordability of healthcare services, insurance coverage, and the economic considerations that might impede or facilitate an individual's ability to seek and receive necessary medical attention.

Examining current trends in access to health unveils the evolving landscape of healthcare delivery. Rapid advancements in technology, changing demographics, and shifting healthcare policies contribute to the dynamic nature of access. Understanding these trends is essential for policymakers, healthcare providers, and communities alike to adapt and enhance healthcare systems to meet the evolving needs of diverse populations.

Healthcare services, comprising preventive care, diagnostics, treatment, and follow-up, are central to discussions on access to health. The quality and comprehensiveness of these services significantly impact health outcomes. An equitable and accessible healthcare system ensures that services are not only available but also tailored to meet the diverse needs of individuals, considering factors such as cultural competence, language, and individual preferences.

The broader healthcare system, which encompasses institutions, professionals, policies, and funding mechanisms, plays a pivotal role in shaping access to health. The effectiveness and efficiency of a healthcare system are critical in determining the overall accessibility of services. Understanding the structural components of healthcare systems helps identify potential barriers and opportunities for improvement, fostering a more inclusive and responsive approach to healthcare delivery.

In delving into the multifaceted concept of access to health, we embark on a journey to uncover the challenges, disparities, and opportunities within healthcare systems. Recognizing the interconnected nature of geographical, financial, and quality-related barriers, we gain insights into the complex factors that influence individuals' ability to access and benefit from healthcare services. As we navigate through the contemporary landscape of healthcare, understanding and addressing these aspects of access to health are essential for building a more equitable and effective healthcare system that meets the diverse needs of our societies.

6.2 ASPECTS OF ACCESS TO HEALTHCARE :

1. Availability: it means the availability of resources for delivering an intervention. For instance, the number of health facilities or the technology available in relation to the target population is very important factor.

2. Accessibility: when any kind of service is available it is necessary for it to be located in a close proximity so that people are able to take advantage and use it in a good way. There occurs two main dimensions of accessibility: firstly, physical access and secondly affordability. Time is also very important in this context. As such when an individual travels to any kind of health facility located in the area and the waiting time there is very well associated with the individual’s perception of that particular access of the services.

3. Acceptability: when any health service or health service provider is found to be appealing and encouraged by people making them to visit that particular health service then it is said to be acceptable in people’s eyes. Accessibility tends to include many non-financial factors such as religion, culture, beliefs, gender, etc.

4. Contact: this is seen as the actual contact which takes place between the service provider and the user.

5. Effectiveness: effective coverage is the proportion of the population in need of an intervention who have received an effective intervention.

Access and utilization as a continuum: any sort of contact and touch with the health care service provider form a continuum and access might be defined as some point on this

continuum. Further, there exists many potential events and series in the process of contact and utilization of services which tend to indicate access.

- When a person happens to live to close proximity to any particular health care service provider.
- When a person is fully aware and conscious of his or her need for any particular services.
- When the person is fully aware and conscious of his or her need for the services provided by the health care setting.
- When the person is in contact telephonically with the health care service provider.
- When the person is in contact via the internet with the health care service provider.
- The individual enters the health care setting.
- When there exists communication between individual and a health care worker.

Furthermore, equity is seen to be an important aspect when it comes to allocation of resources. In terms of health care, health care resources should always be distributed among people and groups according on the basis of need. Equity in terms of access to services has two aspects: first, Horizontal equity exists when groups with equal needs have equal access to health care and secondly, Vertical equity exists when groups with different needs have appropriately different access to health care. Furthermore, the health needs of different sort of groups may tend to vary. It differs in terms of quantity as well as it differs in terms of quantity.

Further, in a given state of health, different groups and people may happen to rate their perceived health in a totally different manner. As such when faced with different health groups one finds that they tend to have different health needs. Thereby it is necessary that one identifies groups whose needs are not met up. Now when an individual happens to take into consideration the financing of health services, equity then means the level to which equitable consideration is made in relation to its ability to pay. Similarly, inequalities in health may occur in terms of socioeconomic status of an individual and one finds that further there exists many sorts of health measures to be associated with lower socioeconomic status. Tudor Hart has described this process. He says that there exists ‘inverse care law’ which means that there exists a situation whereby people in deprived areas are seem to have greater health needs but on an average level they are the ones who lack access to health care facility. This type of generalization has received a very well documented support all over the nation.

Furthermore, Goddard and Smith (1998) point out that health care needs and specialties of different people and groups are not homogenous. They reiterate the same by saying that it is the deprived and least marginalized section of group of people who happen to experience much more numerous and complex health problems than the ones who are found to be affluent. For instance, if we look at the prevalence of smoking one finds that it shows a strong inverse association with the socioeconomic status of an individual or group but smoking cessation needs to be much more intense in groups with lower socio-economic status due to the presence and prevalence of various other factors which are associated with the same such as that to be which relates to education or income as such. Culyer and Wagstaff (1993) highlighted and said that equity in health care should entail distributing health care in such a way as to get as close and feasible to an equal distribution of health’. Thereby it is very much evident and clear access to health care are more limited in deprived social groups.

6.3 CURRENT TRENDS IN TERMS OF HEALTHCARE :

In the United Kingdom, the government responded in favour with the concern about access to health care with the NHS Plan. The NHS plan highlights on the policy framework which focuses on the development of services with the aim of resolving some of the problems of access in the NHS.

Service developments are found to aim at improving access to health care in two main areas: the interface between the individual, or community, and primary care services, and the interface between primary and secondary care services. Further one finds that those working with the NHS plan have argued on the fact that there occurred a wide gap between health needs and health services. They have said that this was due to the reason that there lied chronic underfunding with a less staff presence, lack of hospital beds, and so on. Further, it was argued that patients experienced too much waiting time in the hospital, and there was presence of too much variability across the country in levels and quality of service. The NHS plan now proposes upon in modernizing. This they argue can be done by changing the systems of service delivery in order to promote patient empowerment and education. Furthermore, the plan incorporates and gives a lot of suggestions and remedies. This will include facilities and pathology; multidisciplinary teams focused on particular groups and conditions; mix of nurse, therapist, consultant and GP-led services; fast access to acute settings when needed; access to nonacute inpatient settings where appropriate; timely discharge into appropriate settings.

6.4 HEALTH CARE SERVICES :

The purpose of health care services is to improve the health status of the population. The scope of health services varies widely from country to country. There is now broad agreement that health services should be: (a) Comprehensive (b) available and accessible (c) acceptable (d) provide scope for community participation (e) available at a cost the community and country can afford. These are the essential ingredients of primary health care which forms an integral part of the country's health system of which it is the central function and main agent for delivering health care.

6.5 HEALTH CARE SYSTEM :

The health care system is intended to deliver the health care services. It constitutes the management sector and involves organizational matters. In India, it is represented by five major agencies which differ from each other by the health technology applied and by the source of funds for operation. These are:

i) Public Health Sector

a) Primary health care
Primary health centres
Sub-centres

b) Hospitals/health centre
Rural hospitals
District hospital/health centre
Specialist hospitals
Teaching hospitals

c) Health Insurance Schemes
Employees State Insurance
Central Govt. Health Scheme

d) Other Agencies
Defence Services
Railways

ii) Private Sector

b) Private hospitals, polyclinics, nursing homes and dispensaries
c) General practitioners and clinics

iii) Indigenous System of Medicine
Ayurveda and siddha
Unani and Tibbi
Homoeopathy
Unregistered Practitioners

iv) Voluntary Health Agencies
v) National Health Programmes

Primary Health Care in India

In 1977, the Government of India launched a Rural Health Scheme, based on the principle of "Placing people's health in people's hands". It is a three tier system of health care delivery in rural areas based on the recommendation of the Srivastav committee in 1975. The Government of India is committed to achieving the goal of health for all through primary health care approach which seeks to provide universal comprehensive health care at a cost which is affordable. In 1983 India evolved a National Health Policy based on Primary health care approach. Steps are already underway to implement the National Health Policy objectives towards achieving Health for All. These steps are described below:

1) Village Level

One of the basic tenets of primary health care is universal coverage and equitable distribution of health resources. That is, health care must penetrate into the farthest reaches of rural areas, and that everyone should have access to it. To implement this policy at the village level, the following schemes are in operation:

a) Village Health Guide Scheme
b) Training of Local Dais
c) ICDS Scheme.

a) Village Health Guides

A village health guide is a person with an aptitude for social service and is not a full time government functionary. This scheme was introduced with the idea of securing people's participation in the care of their own health. The health guides are now mostly women. The

health guides come from and are chosen by the community in which they work. They serve as links between the community and the governmental infrastructure. They provide the first contact between the individual and the health system the health guides undergo a short training period of 3 months with the stipend of Rs. 200 per month. The health guides are expected to do community health work in their spare time of about 2 to 3 hours daily for which they are paid an honorarium of Rs. 50 per month and drugs worth Rs. 600 per annum.

b) Local Dais

Most deliveries in rural areas are still handled by untrained dais who are often the only people immediately available to women during the perinatal period. An extensive programme has been undertaken under the rural health scheme, to train all categories of local dais (traditional birth attendants) in the country to improve their knowledge in the elementary concepts of maternal and child health and sterilization besides obstetric skills. The training is for 30 working days. Each dai is paid stipend of Rs. 300 during her training period.

c) Anganwadi Worker

There is an Aganwadi worker for the population of 1000 in ICDS scheme. There are 100 such workers in one ICDS Project. The Anganwadi worker is selected from the community she is expected to serve. She undergoes training in various aspects of health, nutrition, and child development for 4 months. She is part time worker and paid honorarium of Rs. 200-250 per month for the services rendered, which includes health check-up, immunization, health education, supplementary nutrition, non-formal preschool education etc.

2) Sub-Centre Level

The sub-center is the peripheral outpost of the existing health delivery system in rural areas. At present the function of sub centers are limited to mother and child health care, family planning and immunization.

3) Primary Health Centre Level

The concept of primary health center is not new to India. The Bhore committee in 1946 gave the concept of a primary health centre as a basic health unit, to provide as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. After many changes from time to time in the structure and working of primary health center the National Health Plan (1983) proposed reorganization of primary health centres on the basis of one PHC for every 30,000 rural population in the plains and 20,000 for hilly regions.

4) Community Health Centres

As on 30th June 1996, 2424 CHC were established by upgrading the primary health centres. Each CHC covering a population of 80,000 to 1.20 lakh with 30 beds and specialists in surgery, medicine, obstetrics and gynecology, pediatrics with X- ray and laboratory facilities. For strengthening preventive and promotive aspects of health care.

Hospital:

Apart from the primary health centers the present organization of health services of the government sector consists of rural hospitals, district hospitals specialist hospitals, and teaching institutions.

a) Rural Hospitals

It is now proposed to upgrade the rural dispensaries to primary health centres. These centres will have an epidemiological wing attached to them.

b) District Hospitals

There are proposals to convert the district hospital into district health centre. A hospital differs from a health centre in the following respects.
i) In a hospital, services provided are mostly curative, in a health centre the services are preventive, promotive and curative–all integrated.
ii) A hospital has no definite area of responsibility. Patients may be drawn from any part of the country. A health centre is responsible for a definite area and population.
iii) The health team in a health centre is a optimum "mix" of medical and paramedical workers; in a hospital, the team consists of only the curative staff, i.e. doctors, pharmacy, nurses etc. Experience has shown that the health of the community cannot be improved by multiplying hospitals alone.

Central Government Health Scheme:

This scheme provides comprehensive medical care to central Government employees. The scheme is based on the principle of cooperative efforts by the employee and the employer, to the mutual advantage of both.

In this scheme there are following facilities:

i) Out patient care through the network of dispensaries.
ii) Supply of necessary drugs
iii) Laboratory and X-Ray investigation
iv) Hospitalization facilities at Govt. as well as private hospitals.
v) Pediatric services including immunization.
vi) Family welfare services etc.

Other Agencies

Defence Medical Services

Defence services have their own organization for medical care to defence personnel under the banner "Armed Forces Medical Services". The services provided are integrated and comprehensive embracing preventive, promotive and curative services.

Health Care of Railway Employees

The Railways provide comprehensive health care services, through the agency of Railway hospitals, health units and clinics. Health check-up of employees is provided at the

time of entry in to service and thereafter at yearly intervals. There are lady medical officers, health visitors and midwives who look after the MCH and school health services.

Private Agencies

India's private practice of medicine provides a large share of the health services available. The doctor population ratio for the country as a whole is 1:2100. Most of them tend to congregate in urban areas. They provide mainly curative services. The private sector of the health care services is not organized. Some statutory bodies like the Medical Council of India, and Indian Medical Association regulate some of the functions and activities of the large body of private registered medical practitioners.

Indigenous System of Medicines

The practitioners of indigenous systems of medicine (e.g. Ayurveda, Siddha, Homoeopathy etc.) provide the bulk of medical care to the rural people. Ayurvedic physicians alone are estimated to be about 3.37 lakhs. The Government of India is studying the question of how indigenous systems of medicine could best be utilized for more effective or total health coverage.

6.6 SUMMARY :

In conclusion, access to health stands as a crucial determinant of societal well-being, reflecting the intricate interplay of various factors that shape individuals' ability to obtain essential healthcare services. The multifaceted nature of this concept encompasses not only physical accessibility but also considerations of affordability, quality, and the broader dynamics within healthcare systems. As we navigate through the evolving landscape of healthcare, it becomes evident that current trends play a pivotal role in shaping access to health. Technological advancements, demographic shifts, and policy changes contribute to the dynamic nature of healthcare delivery, requiring ongoing adaptation and innovation to ensure that healthcare systems remain responsive to the diverse needs of populations. The significance of healthcare services in the context of access cannot be overstated.

Quality and comprehensive services, ranging from preventive care to treatment and follow-up, form the backbone of accessible healthcare. A focus on equity, cultural competence, and individualized care enhances the inclusivity of healthcare services, addressing the diverse needs and preferences of individuals. The healthcare system itself, comprising institutions, professionals, policies, and funding mechanisms, plays a central role in determining the overall accessibility of services. A well-structured and responsive healthcare system fosters inclusivity, ensuring that barriers to access are minimized and that individuals can navigate the system with ease. In the journey to understand and improve access to health, it is crucial to recognize and address the disparities and challenges within healthcare systems. By acknowledging the interconnected nature of geographical, financial, and quality-related barriers, we pave the way for targeted interventions and policy changes that enhance accessibility, promote health equity, and ultimately contribute to better health outcomes for diverse populations. As we strive for a future where access to health is a universal reality, continuous efforts are needed to adapt healthcare systems, policies, and practices. By prioritizing inclusivity, affordability, and quality in healthcare delivery, we can create a more equitable and effective system that empowers individuals to take charge of their health and ensures that no one is left behind in the pursuit of well-being.

6.7 KEY WORDS :

1. Healthcare System
2. Access
3. Technology
4. Healthcare Infrastructure
5. Health Disparities

6.8 SELF-ASSESSMENT QUESTIONS AND EXERCISE :

1. Examine the healthcare disparities. How can policymakers address these challenges to create a more equitable healthcare system?
2. Describe the elements of a resilient healthcare system. How can a healthcare system effectively respond to global health crises and emergencies?

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Prof. V. Venkateswarlu

LESSON – 7

SOCIAL EPIDEMIOLOGY AND NUTRITION

OBJECTIVE:

The objective of this lesson is to explain meaning, definition, scope, components and uses of social epidemiology. Explain nutrition, its uses and functions.

STRUCTURE:

7.1 INTRODUCTION:

Epidemiology is the study of health and diseases in the population in a society, and is concerned with the amount and types of epidemic or endemic diseases that affect communities; their incidence and prevalence in different population groups, in relation to their total environmental situations, including ways of life and living; and the mortality and morbidity to which they give rise and incapacitate them.

Epidemiology is the common and main approach to both preventive as well as social medicine. Social epidemiology is that branch of epidemiology concerned with the way that social structures, institutions and relationships influence health. Contemporary approaches favour a multi-causal and process model of the way an individual stays well or becomes ill. The attack is multi-causal because the health states of most compelling interest appear to rest on a concatenation of biological vulnerability, psychological dynamics, ecological causes, and social situational expectations. It is processual because an illness is not conceived as a single event that impinges on a stationary organism but, instead, as a sequence of malfunctions, phased in and out with the exigencies of experience as individuals and families move along the arc of life. The current thrust of social epidemiology may be phrased as an effort to assess the links between the lifestyles of populations, their total configuration of actions and reactions in social times and space, and the health risks to which those populations are vulnerable. In this thrust, investigators clearly require a conceptual model of causation that goes beyond the germ theory of disease and that pays as much attention to social, ecological, and psychological agents as to microorganisms. The older medical rhetoric—what's he got and what's good for it?—is giving way to a much more complicated question, or series of questions, that might be put thus: What is it about his way of life that

cushions or exacerbates certain health risks, and how may he/she be helped to live with the burden of chronicity?

7.2 MEANING AND DEFINITION :

The word epidemiology was first coined by Hippocrates. It has been derived from two Greek words: epi meaning upon and demos meaning people; which meant 'what is upon the people'. This naturally interested the early physicians, as they sought to designate by a special word, the large number of persons or groups of people in any locality, who were afflicted by the same disease at about the same time, as if the disease came upon them as wrath of the Gods; and consequently, caused great public alarm and panic, as death occurred in large number of cases simultaneously. The study of epidemic was, therefore, designated epidemiology and these persons as epidemiologists; and it embraced the study of not only the causes, but also the consequences of epidemic diseases; and both together, to devise methods for their control. "An epidemiologist is an investigator who studies the occurrence of disease or other health-related conditions or events in the defined population."

Hippocrates, the father of medicine, discusses the relationship between occurrence of disease and the physical environment. For example, the cases of disease fitting the description of malaria were found to occur in the vicinity of marshy land and swamps. There are epidemics of plague during different periods in past. There were also epidemics of leprosy, small-pox, malaria, yellow fever, and syphilis. Cholera, a major epidemic occurred in England as well as in India. Many people died because of these epidemics. John Snow's quashing of the London cholera epidemic in 1954 is a classic example of how epidemiological methods can be used to limit disease and deaths. His achievement was even more remarkable because it occurred 30 years after Louis Pasteur proposed his 'germ theory of disease'. It was not until 1883 that Robert Koch discovered the bacteria that causes cholera, bacterium vibrio cholerae. From this early use for the description and investigation of communicable disease, epidemiology has developed into a logical field of science. Epidemiological methods are used to evaluate everything from the effectiveness of vaccines to the possible causes of occupational illnesses
and unintentional injury deaths.

7.3 SCOPE OF EPIDEMIOLOGY :

It is clear from the above, that the major tasks of epidemiologists are to study and describe the following:

- Patterns of diseases, either as epidemics or endemics
- Whether confined to small groups in communities, in rural or urban areas; or widespread over large section of the society
- How they recur in certain seasons of the year, or exhibit cyclical variations once in five or seven-year periods by study of seasonal and long-time trends
- Whether they occur in certain age-groups, sex-groups, or occupation groups
- Whether they are caused by loss of immunity in the human host or, increase in numbers or, greater contacts with the intermediary host, or reservoir hosts, and interactions between all these together
- Increased virulence or new strains of the bacterial, or virus agents and the like, assisted by physical, chemical and mechanical agents, which assist transmission of infection to human hosts

- Variations in the environmental factors including physical factors and social conditions such as customs, habits and living conditions, which tend to bring all the above factors together, throwing their weight and balance against the human host, and upsetting the natural equilibrium of health towards disease status (Gladston, 1953).

Thus, epidemiology is concerned with the study of several variations in the pattern and distribution of diseases, which determine their incidence and prevalence of cases and deaths among groups of population both in time and place; to devise priorities and targets in health programmes, determine strategy and techniques in their effective and economical prevention and control, suggest suitable administrative machinery and organization including social strategies; and finally assess their uses to the group or community they serve.

7.4 COMPONENTS OF EPIDEMIOLOGY :

The components of epidemiology essentially refer to the epidemiologic triangle. The epidemiologic triangle is made up of three parts: agent, host and environment. These are:

(i) Agent

The agent is the microorganism that actually causes the disease in question. An agent could be some form of bacteria, virus, fungus, or parasite.

(ii) Host

The agent infects the host, which is the organism that carries the disease. A host doesn't necessarily get sick; hosts can act as carriers for an agent without displaying any outward symptoms of the disease. Hosts get sick or carry an agent because some part of their physiology is hospitable or attractive to the agent.

(iii) Environment

Outside factors can affect an epidemiologic outbreak as well; collectively these are referred to as the environment. The environment includes any factors that affect the spread of the disease but are not directly a part of the agent or the host. For example, the temperature in a given location might affect an agent's ability to thrive, as might the quality of drinking water or the accessibility of adequate medical facilities.

7.5 SOCIAL EPIDEMIOLOGY AND ECOLOGY OF DISEASE :

How variations in age, sex and occupation groups, seasonal or cyclical variations impact epidemic or endemic diseases and how far they influence mortality and morbidity patterns are described below:

1. Age-sex and occupation groups

Infectious diseases are common among early age groups, and degenerative diseases among older age-groups, while some like tuberculosis and cancer are common among adolescents and adults. However, the age distribution of mortality does not necessarily follow the morbidity patterns; generally, mortality and morbidity curves are U-shaped, with increase at the two ends of life; while in certain diseases the morbidity curve may be reversed, due to increased strains and stresses of middle-aged occupational groups. Again, the case-morality

rates vary with age and sex groups; as for example pneumonias, dysenteries and certain virus and eruptive fevers which are fatal among the younger age groups, while typhoid and typhus fevers are much milder. Fractures are much more serious among older age-groups, as also coronary heart disease, diabetes and kidney disease which tend to be fatal among the old. Further, the age of the patient may determine the clinical type of the disease and these types may change again among the occupation groups and each vary from time to time, with changing structure of society and economic conditions; such as diabetes and hypertension which are becoming more common at much younger ages.

2. Seasonal, cyclical and space variations

Among epidemics, water-borne infections like cholera, typhoid and dysentery follow the wake of the monsoons and several insect-borne diseases are subject to seasonal variations. Further, all endemic diseases caused by insects such as plague, typhus and relapsing fever are seasonal, as insects populations vary with metrological seasons.

3. Mortality and morbidity

Mortality data are in their very nature more accurate than morbidity, as deaths occurs only once for any person. In acute killing diseases, mortality rates will give a fair picture of the distribution and their relative importance, but for mild and relatively non-fatal illnesses, such as common-cold, eruptive fevers among children, asthma and rheumatoid arthritis, deaths are a poor description of their frequency and distribution. In the same disease, there may be differences; as mortality data can be used for p.falciparum malaria which is a killing disease, but not for p.vivax or quartan malaria, where morbidity would be more appropriate.

4. Infectious diseases

Registration of sickness is generally limited to notifiable infectious diseases, as it is compulsory, for early information to public health departments, taking necessary action. However, this does not happen all the time, as the responsibility for notification rests with the head of the family or individual.

Ecology and Disease

Since the triad of agent, host, and environment comprises its traditional core, epidemiology can be described as that aspect of human ecology that relates to the states of health and disease. Epidemiology is the “science concerned with the health of the populations or communities. The compass of this science is to describe states of health and their variation, to discover the determinants of the variations observed, and to use what is discovered to devise and test ways of preventing and controlling ill health.” In literature, the earliest recognition of the role of the environment can be found in the Hippocratic writings, in the treatise Airs, Water, and Places. Here, one finds everything from physique and fecundity to sexual and war-like temperament ascribed to the influence of the purity of water and violence of seasonal change. Since that time, personae medicae of all persuasions—court physician and itinerant healer, philosopher and empirick, chronicler of epidemics and tender of “fluxes, argues, botches and boils”, modern scientist and traditional herbalist—have found it necessary to pay heed to environmental influences, however, much they may have disagreed as to their consequences (Hippocrates, 1881).

7.6 USES OF EPIDEMIOLOGY :

The epidemiological studies are very useful in the health studies to:

- Determine the frequency of a disease in the community
- Find distribution of the disease in the population with regards to qualitative attributes and quantitative variables as observed in the susceptible population.
- Identify the cause of a disease of unknown etiology
- Study the natural history of the disease
- Evaluate health intervention measures or activities Diseases
- Provide data base for health planners

This is measured by determining their effectiveness in reducing prevalence of the disease, and feasibility of the proposed measure being applied in the community on a large scale, keeping in view the financial constraints, manpower requirements and available time.

7.7 NUTRITION AND NUTRIENTS :

Food provides nourishment to the body and enables it to stay fit and healthy. The food that we eat undergoes many processes, like, first the food is digested, then it is absorbed into blood and transported to various parts of the body where it is utilized. The waste products and undigested food are excreted from the body.

Nutrition is the process by which food is taken in and utilized by the body.

Nutrition = Eating Digestion Absorption Transportation Utilization

7.8 NUTRIENTS AND THEIR FUNCTIONS :

Nutrients are the chemical substances present in food and are responsible for nourishing the body.

Nutrients are of two types:

1. Macronutrients
2. Micronutrients

Both macronutrients and the micronutrients are equally essential for good health. Each nutrient plays a significant role in the body.

1. Macronutrients

These are present in large quantities in foods and are also required in large amounts by the body. Carbohydrates, proteins, fats and oils are macronutrients.

A. Carbohydrates

(i) Available carbohydrates

Carbohydrates are present in a large quantity as *starch* in cereals, legumes, pulses and potatoes. They are present as *simple* carbohydrates in sugar, jaggery, fruits, honey and milk. Starch and sugars are easily digested and provide energy to the body.

(ii) Unavailable carbohydrates or dietary fibre

They are present in the form of cellulose and hemicellulose which are not digested in our body. They add bulk to the stool and help in easy defecation process. Energy can be derived from carbohydrates, fats and proteins and it is measured in kilo calories. However, carbohydrates are cheapest sources of energy. If there is a short supply of carbohydrates and fats in our body, proteins are utilized for energy production. Function of proteins is to provide for body building. Therefore, carbohydrates have to be consumed in proper amounts to spare proteins for body building purpose.

Functions of carbohydrates are summarized here:

- Carbohydrates provide *energy*
- Carbohydrates are the *main source* of energy
- Carbohydrates *spare proteins* for body building function
- Dietary fibre increases the bulk in stool and *helps in defecation* 1 gm of carbohydrate gives 4kcal of energy. Kilocalorie is the measure of energy in food.

Food sources of carbohydrates are:

- Cereals - wheat, rice, bajra, maize, etc.
- Pulses - Rajma, channa, all dals
- Roots and tubers - potatoes, sweet potatoes, beetroot and tapioca
- Sugar, jaggery

B. Proteins

Proteins are needed in the body for body building. 1 gm of protein gives 4kcal of energy. Proteins are made up of smaller units known as amino acids. There are all together 22 amino acids, out of which there are 8 amino acids which our body cannot manufacture. Rest of the amino acids can be manufactured by the body. Essential amino acids are those which our body cannot manufacture and hence have to be supplied through the diet. Non-essential amino acids are those amino acids which our body can manufacture.

Functions

(i) Needed for growth, maintenance and repair of tissues.
(ii) Necessary for production of enzymes, hormones, antibodies, haemoglobin, etc.
(iii) Help in the clotting of blood
(iv) Provide energy, if necessary

Sources

- Meat, poultry, fish, eggs
- Milk, cheese, paneer, curd
- soybeans, peas, pulses,
- cereals, nuts and oilseeds like til, groundnuts, etc.

Special features

(i) Animal proteins, i.e., proteins from meat, eggs, milk, etc., are better than vegetable proteins, i.e., proteins, from pulses, cereals, etc. This is because proteins from vegetable sources do not contain all essential amino acids.

(ii) Including two or more sources of vegetable proteins in each meal helps to improve the quality of proteins and their utilization.

C. Fats and Oils

Fats and oils are the concentrated source of energy in our diet. 1 gm of fat gives 9 kcal of energy. Fats are made up of small units called fatty acids. The nature of fats is dependent on the type of fatty acids present. Fatty acids may be saturated or unsaturated. Saturated fatty acids are found in solid fats whereas oils contain more of unsaturated fatty acids. Vegetable oils are rich in unsaturated fatty acids. Do you know there is a difference between fats and oils? If a substance is liquid at room temperature it is called oil and if it is solid at the room temperature, it is known as fat.

Functions

i. Provide concentrated source of energy
ii. Reduce the use of proteins for energy
iii. Carry fat soluble vitamins (A, D, E, K) into the body and help in the absorption of these vitamins
iv. Help to maintain body temperature. The layer of fat under the skin helps to conserve body heat
v. Act as a cushion to certain vital organs
vi. Help in growth of tissues

Sources

- Cooking oils, ghee, butter
- Oilseeds, nuts
- Meat, poultry, fish, eggs
- Whole milk, cheese

Special features

i. Fats improve the texture as well as absorb and retain flavours making meals more appetizing.
ii. Fats have properties that help them to remain in the stomach longer and prolong the feeling of fullness.

2. Micronutrients

Other important nutrients which are present in small quantities in foods but are essential for our body are called micronutrients. These are minerals and vitamins and are required in very small quantities. If these micronutrients are not eaten in required amounts, it results in deficiency diseases. Minerals and vitamins are called micronutrients.

1. Vitamins

Our body contains very little quantity of vitamins, however, you will be surprised to know that they are responsible for all the major functions of the body. These vitamins are of two types: (i) Fat soluble: A,D,E and K, (ii) Water soluble: B and C

Nutrients	Functions	Sources
Vitamin A	(i) Essential for proper functioning of eyes, that is, vision in dim light (ii) Necessary for healthy skin and linings of nose, mouth, throat, eyes, ears, lungs and other organs	- Liver, eggs, fish liver oils - Milk and its products - Green leafy vegetables - Yellow or orange fruits and vegetables such as pumpkin, carrot, papaya, mango, etc.
Vitamin D	(i) Necessary for formation and maintenance of strong healthy teeth and bones (ii) Helps in the proper absorption and utilization of calcium and phosphorus in the body	- Exposure of skin to sunlight - Eggs, liver, fish liver oils - Milk, butter - Refined oils and ghee fortified with vitamin D
Vitamin E	Prevents destruction of certain substance in presence of oxygen	- All cereals, pulses, vegetable oils
Vitamin K	Necessary for clotting of blood	- Formation in the intestines by bacteria normally present there - Green leafy vegetables - Egg, liver
Vitamin B There are eight B vitamins. Together they are called Vitamin B complex. These are thiamine B1 and Riboflavin B2, niacin etc.	(i) Necessary for utilization of carbohydrates in the body (ii) Necessary for normal functioning of nervous system (iii) Essential for proper growth (iv) Helps body organs to function normally (v) Needed for formation of red blood cells (vi) Helps in digestion and improves appetite.	- Liver, poultry, meat, fish, eggs - Whole green cereals and pulses - Green leafy vegetables and milk
Vitamin C	(i) Necessary for the formation of the substance that holds cells together (ii) Needed for strong teeth and bones (iii) Helps in the production of haemoglobin (iv) Helps in the utilization of other nutrients in the body (v) Helps in fighting the germs causing diseases	- Citrus fruits like amla, orange, lemon, guava etc. - Green leafy vegetables - Sprouted pulses such as grams

Minerals

Minerals constitute a very small amount of the total body tissues. However, these are essential for many vital processes and also for the maintenance of the body. In total, there are about 19 minerals required by the body in various amounts.

Calcium: Calcium and phosphorus are available in sufficient quantities in milk, curd, green leafy vegetables, ragi and oil seeds. Other foods also provide fair quantity of calcium. The major function of calcium is the formation and development of bones and teeth. Calcium is also required in blood clotting and muscular contraction.

Calcium is necessary for bone formation, blood clotting and muscular contraction. Deficiency of calcium in the body results in poor bone development, particularly in children, women and elderly. The deficiency disease is known as osteoporosis. In this, the bones become brittle and people become prone to frequent fractures.

Iron: Iron is required in very small quantity by the body. It is an important material present in haemoglobin which is a part of red blood cells and is responsible for the red colour of blood. Whole grain cereals and pulses are the major sources of iron in our diet. Other sources of iron are green leafy vegetables, egg yolk, liver and meat. In our country, majority of the population, especially women and children, suffer from iron deficiency disease called anaemia.

Young girls (12-18 yrs.) need move iron rich foods in their diets because of loss of iron during the menstrual cycle. Extra iron is also needed during pregnancy for healthy development and growth of the focus.

This is not because people do not consume food which are rich in iron but because the absorption and utilization of iron is poor. This is due to the presence of certain naturally occurring constituents in food called oxalates and phytates. These oxalates and phytates are called *inhibitors* of iron. Vitamin C and proteins help in better absorption of iron and are known as *enhancers of iron.* Iron is essential for haemoglobin formation.

Iodine: Iodine is an important substance present in thyroxine hormone produced from thyroid gland. Thyroxine regulates various functions of the body. We get iodine from water and food. The foods which grow in iodine rich soil provide iodine for us. Sea foods are also rich in iodine. Iodine deficiency disorder is known as goitre or enlargement of the neck region. Deficiency of
iodine causes mental retardation in children. Recent studies have shown a direct link between iodine deficiency and academic performance of children. Iodine deficiency disorders have been identified in many parts of India.

Iodine is necessary for growth and development. To avoid goitre, we must have iodine rich food sources in our daily meals. Iodized salt is a good source of iodine and we must consume it instead of the non-iodized salt. Make iodized salt a part of your daily diet. Certain foodstuff like cabbage, cauliflower, radish, ladies' finger, oilseeds etc., contain substances known as *goitrogens* which interfere with the body's ability to produce and use thyroxine. These goitrogens are destroyed on cooking. Therefore, these foodstuffs should be cooked before eating.

7.9 SUMMARY :

In conclusion, the study of social epidemiology represents a crucial lens through which we can understand and address the intricate interplay between social factors and health outcomes within populations. By examining the distribution and determinants of health and disease through a social context, social epidemiology provides valuable insights into the root causes of health disparities. It underscores the impact of socio-economic status, education, race, and other social determinants on health outcomes, guiding interventions and policies aimed at reducing health inequalities. As societies evolve, the field of social epidemiology continues to adapt, incorporating new methodologies and technologies to enhance our understanding of the complex relationships between society and health. Emphasizing the importance of social justice and equity, social epidemiology plays a pivotal role in shaping public health strategies that aim not only to treat illness but also to create environments that promote health and well-being for all.

In conclusion, the study of nutrition is paramount for understanding the intricate relationship between diet and human health. Nutrition encompasses a broad spectrum of topics, including the types of nutrients essential for the body's proper functioning and the diverse functions they perform. From macronutrients like carbohydrates, proteins, and fats that provide energy to micronutrients such as vitamins and minerals that play vital roles in various physiological processes, a balanced and well-rounded diet is crucial for overall well-being. The functions of nutrients extend beyond mere sustenance; they influence growth, development, immune function, and the prevention of various diseases.

The significance of nutrition is underscored by its role in preventing malnutrition, obesity, and a range of diet-related disorders. As research in nutrition advances, our understanding of dietary patterns, nutritional requirements, and their impact on health evolves, contributing to the development of personalized dietary recommendations. Ultimately, the field of nutrition emphasizes the importance of making informed dietary choices to support optimal health. By recognizing the intricate interplay between nutrition and well-being, individuals and societies can adopt healthier eating habits and implement policies that promote nutritional awareness and accessibility. In doing so, we move towards a future where nutrition is not only a means of sustenance but a cornerstone for a healthy, vibrant, and fulfilling life.

7.10 KEY WORDS :

1. Epidemiology
2. Disease
3. Health
4. Nutrition
5. Vitamins
6. Minerals
7. Health Disparities

7.11 SELF-ASSESSMENT QUESTIONS AND EXERCISE :

1. Explain Social Epidemiology and its functions?
2. Describe Nutrition, its types?

3. Examine the uses of Nutrition?

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Prof. V. Venkateswarlu

LESSON - 8

CHILDHOOD DISORDERS

OBJECTIVE :

The objective of this lesson is to explain definition of childhood disorders, common conditions, symptoms, consequences, barriers to treatment, diagnosis, treatment.

STRUCTURE :

8.1 INTRODUCTION :

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

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

Although, for the most part, the diseases of childhood are similar to those of the adult, there are several important differences. For example, certain specific disorders, such as precocious puberty, are unique to children; others, such as acute nephritis—inflammation of the kidney—are common in children and infrequent in adults. At the same time, some diseases that are common in adults are infrequent in children. These include essential hypertension (high blood pressure of unknown cause) and gout. Finally, a major

segment of pediatric care concerns the treatment and prevention of congenital anomalies, both functional and structural.

Apart from variations in disease due to differences between children and adults, certain other features of diseases in children need to be emphasized. Infectious disorders are prevalent and remain a leading cause of death, although individual illnesses are often mild and of minor consequence. Most instances of the common communicable diseases, such as measles, chicken pox, and mumps, are encountered in childhood. Disorders of nutrition, still of great concern, especially but not exclusively in developing countries, are of extreme importance to the growing and developing child. The unique nutritional requirements of children make them unusually susceptible to deficiency states: vitamin-D deficiency causes rickets, a common disorder of children in developing countries, and only rarely causes any disease in adults. The major environmental hazards that endanger the health of young children are either unavoidable, as in air pollution, or accidental, as in poisoning and in traffic injuries. Older children, especially adolescents, are exposed, as are adults, to environmental hazards that they deliberately seek, such as cigarette smoking and the use of alcohol and other drugs.

Childhood Disorders

Childhood disorders, often labeled as developmental disorders or learning disorders, most often occur and are diagnosed when the child is of school-age. Although some adults may also relate to some of the symptoms of these disorders, typically the disorder's symptoms need to have first appeared at some point in the person's childhood. It is not unusual for a child to have more than one disorder.

Childhood disorders are typically identified as exhibiting significant changes in behavior, emotional regulation, social skills, or cognitive development that are not associated with normal stages of childhood development or other medical conditions. These changes must occur frequently over a long period of time, causing significant distress and impacting daily functioning. The delays or disruptions in behavior, emotional regulation, thinking, and social skills would be experienced at home, school, or other social settings.

Because of the seemingly carefree nature of their lives, children have been thought not to suffer from mental and emotional disorders. However, studies have indicated that children do, in fact, suffer from disorders typically thought to occur only in adults. Learning and conduct disorders, substance abuse, conditions such as autism and depression, and suicide are common in our young population.

When children develop mental or emotional disorders, parents often blame themselves. But childhood disorders are likely caused by a combination of many factors. It is important to recognize the problem and seek treatment as soon as possible. Often these conditions can be treated effectively, allowing our children to grow into happy, productive adults.

8.2 COMMON CONDITIONS :

Common conditions or childhood disorders include:

- **Attention-deficit/hyperactivity disorder (ADHD).** Compared to other children, children with ADHD experience difficulties with attention, focus, concentration, or hyperactivity, or a combination of types. Symptoms must be significant enough to impact daily functioning in the home, school, or other social settings.
- **Anxiety disorders.** Anxiety disorders in children may appear as frequent worries, fears, or anxiety that affects daily functioning. Examples of anxiety disorders include generalized anxiety, separation/social anxiety, or obsessive-compulsive disorder.
- **Autism spectrum disorder (ASD).** ASD is a neurological disorder that typically presents before age 3. ASD varies in severity and looks different between individuals, but typically manifests as issues with communicating, socializing with others, and emotional dysregulation.
- **Depression and other mood disorders.** Depression can be defined as persistent sadness and loss of interest in things, significant enough that it impacts daily functioning at home, school, or other social settings. Bipolar disorder may lead to major mood swings, which present as depressive episodes or manic episodes (or both), and potentially results in risk taking or self-destructive behaviors.
- **Oppositional Defiance Disorder (ODD).** A pattern of angry or irritable mood, argumentative and/or defiant behavior, or vindictiveness toward people in authority lasting at least six months.
- **Post-traumatic stress disorder (PTSD).** PTSD in children is a time of prolonged emotional distress connected to a traumatic event(s), which typically presents as nightmares, disturbing images or flashbacks, distressing memories, and reactivity (disruptive behaviors or emotional outbursts).
- **Eating disorders.** In children, eating disorders are defined as a preoccupation with food, body image or an ideal body type, disordered thinking about weight and weight-loss, and unsafe eating and dieting habits that can be harmful, and even life threatening. Eating disorders typically lead to emotional, social, and physical dysfunction.
- **Schizophrenia.** This disorder is usually characterized by significant distortions in thoughts and perceptions which alter a person’s reality and lead to hallucinations, delusions, and marked behavioral changes.

8.3 CAUSES OF CHILDHOOD DISORDERS :

Unfortunately, children suffer from childhood disorders right from birth. These disorders may be genetic or birth defects. Children may also develop childhood disorders because they are exposed to emotional trauma or stress very early in life. Childhood disorders may also occur because of an imbalance of chemicals in a child's brain or a brain injury that the child undergoes early in life. Life experiences like physical stress, abuse, or loss are other factors that may contribute to a child developing strong mental disorders during their formative years. Pregnant or expecting women may be exposed to viruses or toxic chemicals during their pregnancy journey, which may culminate in childhood disorders for their children.

8.4 SYMPTOMS OF CHILDHOOD DISORDERS :

Children's symptoms vary depending on the type of mental illness, but some of the general symptoms include:

- Changes in school performance, such as poor grades despite good efforts
- Abuse of drugs and/or alcohol

- Inability to cope with daily problems and activities
- Changes in sleeping and/or eating habits
- Excessive complaints of physical ailments
- Defying authority, skipping school, stealing, or damaging property
- Intense fear of gaining weight
- Long-lasting negative moods, often accompanied by poor appetite and thoughts of death
- Frequent outbursts of anger
- Loss of interest in friends and activities they usually enjoy
- Significant increase in time spent alone
- Excessive worrying or anxiety
- Hyperactivity
- Persistent nightmares or night terrors
- Persistent disobedience or aggressive behavior
- Frequent temper tantrums
- Hearing voices or seeing things that are not there (hallucinations)

8.5 WARNING SIGNS :

Children are constantly developing, growing, and changing, which can make identifying a mental health disorder more difficult. Sometimes it can be hard to differentiate between what is normal childhood development versus symptoms that may indicate a mental health disorder. Therefore, it is critical to speak with your child's pediatrician if you notice any significant changes in your child's mood, behavior, social skills, or cognitive development that has become more frequent over a sustained period. Your child's pediatrician can help direct your next steps and connect your child with a mental health professional who can perform an evaluation and assessment and determine any potential diagnosis and appropriate treatment plan.

There are some common warning signs to look for if you believe your child is struggling with a mental health disorder or condition. Common warning signs include:

- Persistent feelings of sadness and loss of interest
- Difficulties in attention, focus, and concentration, or hyperactivity
- Thoughts about harming oneself (self-harm or suicidal thinking)
- New or excessive thoughts about death and dying
- Withdrawing from or avoiding social interactions
- Emotional or behavioral outbursts and reactivity (anger, irritability, impulsivity)
- Major changes in mood, behavior, or personality
- Noticeable changes in eating habits
- Abnormal weight loss or weight gain
- Sleep disturbance
- Frequent somatic complaints (stomachache, headache, chronic pain)
- Changes in academic performance
- Skipping school

If you notice any of the above warning signs, consider contacting your child's pediatrician or contacting a mental health professional to have your child evaluated. The earlier you can identify a mental health disorder, the better the treatment outcomes.

8.6 CONSEQUENCES OF CHILDHOOD MENTAL AND DEVELOPMENTAL DISORDERS :

The consequences of these disorders include both the impact during childhood and the persistence of mental ill health into adult life. In childhood, the impact is broad, encompassing the individual suffering of children, as well as the negative effects upon their families and peers. This impact may include aggression toward other children and distraction of peers from learning. Children with mental and developmental disorders are at higher risk of mental and physical health problems in adulthood, as well as increased likelihood of unemployment, contact with law enforcement agencies, and need for disability support.

8.7 BARRIERS TO TREATING CHILDHOOD MENTAL HEALTH DISORDERS :

It can be difficult to understand mental health disorders in children because normal childhood development is a process that involves change. Additionally, the symptoms of a disorder may differ depending on a child's age, and children may not be able to explain how they feel or why they are behaving a certain way.

Other factors might also prevent parents from seeking care for a child who has a suspected mental illness. For example, parents might be concerned about the stigma associated with mental illness, the use of medications, and the cost or logistical challenges of treatment.

What should I do if I suspect my child has a mental health condition?

If you're concerned about your child's mental health, consult your child's health care provider. Describe the behaviors that concern you. Talk to your child's teacher, close friends, relatives or other caregivers to see if they've noticed changes in your child's behavior. Share this information with your child's health care provider.

How do health care professionals diagnose mental illness in children?

Mental health conditions in children are diagnosed and treated based on signs and symptoms and how the condition affects a child's daily life. To make a diagnosis, your child's health care provider might recommend that your child be evaluated by a specialist, such as a psychiatrist, psychologist, clinical social worker, psychiatric nurse or other mental health care professional. The evaluation might include:

- Complete medical exam
- Medical history
- History of physical or emotional trauma
- Family history of physical and mental health
- Review of symptoms and general concerns with parents
- Timeline of child's developmental progress
- Academic history
- Interview with parents
- Conversations with and observations of the child
- Standardized assessments and questionnaires for child and parents

The Diagnostic and Statistical Manual of Mental Disorders (DSM), a guide published by the American Psychiatric Association, provides criteria for making a diagnosis based on the nature, duration and impact of signs and symptoms. Another commonly used diagnostic

guideline is the International Classification of Diseases (ICD) from the World Health Organization.

Diagnosing mental illness in children can take time because young children may have trouble understanding or expressing their feelings, and normal development varies. Your child's health care provider may change or refine a diagnosis over time.

How is mental illness in children treated?

Common treatment options for children who have mental health conditions include:

- **Psychotherapy.** Psychotherapy is also known as talk therapy or behavior therapy. Psychotherapy is a way to address mental health concerns by talking with a psychologist or other mental health professional. With young children, psychotherapy may include play time or games, as well as talk about what happens while playing. During psychotherapy, children and adolescents learn how to talk about thoughts and feelings, how to respond to them, and how to learn new behaviors and coping skills.
- **Medication.** Your child's health care provider or mental health professional may recommend a medication — such as a stimulant, antidepressant, anti-anxiety medication, antipsychotic or mood stabilizer — as part of the treatment plan. Your child's provider will explain risks, side effects and benefits of drug treatments.

How can I help my child cope with mental illness?

You will play an important role in supporting your child's treatment plan. To care for yourself and your child:

- Learn about the illness.
- Consider family counseling that treats all members as partners in the treatment plan.
- Ask your child's mental health professional for advice on how to respond to your child and handle difficult behavior.
- Enroll in parent training programs, particularly those designed for parents of children with a mental illness.
- Explore stress management techniques to help you respond calmly.
- Seek ways to relax and have fun with your child.
- Praise your child's strengths and abilities.
- Work with your child's school to secure necessary support.

8.8 RISK FACTORS IN CHILDREN'S BEHAVIOURAL DISORDERS

The causes of ODD, CD and ADHD are unknown but some of the risk factors include:

- Gender – boys are much more likely than girls to suffer from behavioural disorders. It is unclear if the cause is genetic or linked to socialisation experiences.
- Gestation and birth – difficult pregnancies, premature birth and low birth weight may contribute in some cases to the child's problem behaviour later in life.
- Temperament – children who are difficult to manage, temperamental or aggressive from an early age are more likely to develop behavioural disorders later in life.
- Family life – behavioural disorders are more likely in dysfunctional families. For example, a child is at increased risk in families where domestic violence, poverty, poor parenting skills or substance abuse are a problem.

- Learning difficulties – problems with reading and writing are often associated with behaviour problems.
- Intellectual disabilities – children with intellectual disabilities are twice as likely to have behavioural disorders.
- Brain development – studies have shown that areas of the brain that control attention appear to be less active in children with ADHD.

8.9 DIAGNOSIS :

The first step for diagnosis is to reach out to your child's pediatrician if you or another trusted individual notices any warning signs or changes in your child's mental health. Once you have spoken to the pediatrician, it may be decided to refer your child to a mental health professional. Mental health professionals include a mental health counselor, a behavioral specialist, a psychiatrist, child psychologist, etc. Whichever mental health professional your child is referred to, he or she will make a diagnosis based on symptoms, symptom frequency, symptom duration, and whether the symptoms are affecting your child's daily functioning or normal life activities. Typically, a diagnosis is made within the first 1-3 (sometimes more) sessions.

A mental health professional will do an initial intake and take time to evaluate and assess your child's mental health and provide a diagnosis if your child meets specific criteria. A parent, both parents, or legal guardian will accompany the child to his or her appointment and often, the mental health professional will meet with the parent and child together, individually with the client, or sometimes with the parent alone for part of a session.

8.10 BARRIERS TO TREATMENT :

There are several barriers to treatment. Childhood is a time of normal development, growth, and change. Sometimes it can be difficult for caregivers to distinguish between healthy development and symptoms of a mental disorder or condition. Additionally, children often have a hard time articulating their emotions, thoughts, or the reason why their behaviors have changed. Furthermore, especially with children, caregivers may worry about the stigma that still surrounds mental health.

It is critical that anytime a caregiver notices a warning sign or has concern for a child's mental health, that they reach out to the appropriate supports. The sooner the mental health disorder or condition is identified and appropriately diagnosed, the sooner a mental healthcare professional can pursue appropriate treatment for your child, which often leads to better outcomes.

8.11 TREATMENT :

Untreated children with behavioural disorders may grow up to be dysfunctional adults. Generally, the earlier the intervention, the better the outcome is likely to be.

A large study in the United States, conducted for the National Institute of Mental Health and the Office of School Education Programs, showed that carefully designed medication management and behavioural treatment for ADHD improved all measures of behaviour in school and at home.

Childhood disorders may pose a challenge to not just the child but also the family around them, but the good news is that they can be treated. While a childhood disorder may not have a cure, children can learn coping mechanisms to deal with them to keep them at bay. There are multiple treatment options for childhood mental disorders. As a caregiver, it is important to remember that the earlier you get your child treatment, the better the treatment outcomes. Depending on the type of disorder, doctors and therapists often recommend cognitive behavioural therapy or medication.

Let's take a look at the treatment associated with common childhood disorders. Treatment is usually multifaceted and depends on the particular disorder and factors contributing to it. Some of the most common treatments include:

- Parental education – for example, teaching parents how to communicate with and manage their children.
- Family therapy – the entire family is helped to improve communication and problem-solving skills.
- Cognitive behavioural therapy – to help the child to control their thoughts and behaviour.
- Social training – the child is taught important social skills, such as how to have a conversation or play cooperatively with others.
- Anger management – the child is taught how to recognise the signs of their growing frustration and given a range of coping skills designed to defuse their anger and aggressive behaviour. Relaxation techniques and stress management skills are also taught.
- Support for associated problems – for example, a child with a learning difficulty will benefit from professional support.
- Encouragement – many children with behavioural disorders experience repeated failures at school and in their interactions with others. Encouraging the child to excel in their particular talents (such as sport) can help to build self-esteem.
- Psychotherapy. Often, children may be asked to go to therapy to curb their behaviour. Therapy may be for their cognitive abilities or interpersonal. Children may be asked to go in for psychoanalysis, supportive psychotherapy or psychodynamic psychotherapy. Psychotherapy, also referred to as talk therapy, is one of the most common treatment options for mental health disorders. However, because children tend to struggle with articulating their emotions or understanding their behaviors, mental health professionals may use play therapy or other alternative therapies, as well as sometimes involving a parent, both parents, or legal guardian in the sessions to help children navigate the therapeutic process and experience improvement. Psychotherapy allows children a safe space to be able to express their thoughts and feelings and work toward healthy change, growth, and healing.
- Medication. Medication is used to help control impulsive behaviours. Medication can be an effective and safe form of treatment when a mental healthcare provider or medical professional determine that it is appropriate for your child. Medications can be used to help treat anxiety, depression, ADHD, mood disorders, and many other mental health conditions. Your child’s provider will discuss the benefits, side effects, or any potential risk before prescribing the medication.

8.12 SUMMARY :

In conclusion, the study of childhood disorders is a multifaceted exploration into the complexities of mental health during the formative years of human development. The understanding of childhood disorders has evolved significantly over time, shaped by

advancements in psychology, psychiatry, and developmental science. The recognition of childhood disorders as distinct entities with unique characteristics and developmental considerations underscores the importance of specialized approaches in assessment, diagnosis, and intervention. Early pioneers in child psychology, such as Jean Piaget and Erik Erikson, laid the groundwork for comprehending the intricacies of cognitive, emotional, and social development. Contemporary research and diagnostic frameworks, such as the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition), provide a comprehensive guide for identifying and classifying childhood disorders.

These frameworks acknowledge the diversity of experiences and emphasize the importance of considering cultural, familial, and environmental factors in understanding and addressing mental health challenges in children. Effective intervention strategies involve a collaborative effort between parents, educators, mental health professionals, and the broader community. Early identification and timely intervention play a crucial role in mitigating the impact of childhood disorders on the overall well-being and future trajectories of affected individuals. Moreover, the field continues to evolve with ongoing research into the neurobiological, genetic, and environmental factors influencing childhood disorders. Advances in evidence-based treatments, therapeutic modalities, and community support services contribute to a more holistic and nuanced approach to addressing the needs of children experiencing mental health challenges. In conclusion, a compassionate and informed understanding of childhood disorders is essential for fostering resilience, promoting healthy development, and creating supportive environments that enable children to thrive emotionally, socially, and academically.

8.13 KEYWORDS :

1. Childhood disorders
2. Development psychology
3. Child psychiatry
4. Mental health in children

8.14 SELF ASSESSMENT QUESTIONS

1. Why is early identification and intervention crucial for addressing childhood disorders?
2. How can mental health professionals incorporate cultural competence into the assessment and treatment of children with diverse backgrounds?

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Prof. V. Venkateswarlu

LESSON - 9

CANCER, LEPROSY

OBJECTIVE:

The objective of this lesson is to explain symptoms, causes, risk factors, complications and prevention of Cancer and Leprosy.

STRUCTURE:

9.1 INTRODUCTION TO CANCER:

Cancer, a pervasive and formidable challenge in the realm of healthcare, encompasses a diverse array of diseases characterized by uncontrolled cell growth. The impact of cancer is profound, affecting millions of lives globally and necessitating a comprehensive understanding of its nuances. This exploration unfolds the multifaceted dimensions of cancer, from its subtle early symptoms such as fatigue, unexplained weight loss, and persistent pain, to its complex etiology involving genetic mutations, environmental exposures, and lifestyle choices. Understanding risk factors, which span from age and family history to environmental influences, becomes crucial in appreciating individual susceptibility. However, hope and empowerment emerge through preventive measures, where embracing a healthy lifestyle, avoiding tobacco, and maintaining proper nutrition play pivotal roles.

Diagnostic approaches in cancer, involving meticulous assessments, imaging studies, and biopsies, are fundamental for timely and accurate identification. The landscape of cancer treatment has evolved significantly, featuring an array of modalities like surgery, chemotherapy, radiation therapy, immunotherapy, and targeted therapies. Early detection

through regular screenings enhances the efficacy of these treatments and holds promise for improved outcomes.

As we embark on this exploration, the overarching goal is to unravel the complexities of cancer, emphasizing the need for collective efforts in prevention, early detection, and innovative treatments. By delving into the intricacies of symptoms, causes, risk factors, prevention strategies, diagnostic methods, and evolving treatments, we contribute to a broader understanding of cancer and propel the ongoing journey towards a future where its impact is mitigated and lives are improved.

9.2 SYMPTOMS OF CANCER:

The symptoms of cancer can vary widely depending on the type and location of the cancer, as well as its stage. Some common symptoms include:

- **Fatigue:** Persistent and unexplained tiredness.
- **Unexplained Weight Loss:** Losing weight without intentional changes in diet or exercise.
- **Pain:** Chronic or increasing pain, which can be localized or widespread.
- **Changes in Skin:** Changes in the color, size, or appearance of moles, as well as the development of new skin abnormalities.
- **Changes in Bowel or Bladder Habits:** Persistent changes such as constipation, diarrhea, or blood in the stool or urine.

It's important to note that not everyone with cancer will experience these symptoms, and some cancers may be asymptomatic until later stages.

9.3 CAUSES OF CANCER :

Cancer arises from genetic mutations that accumulate in a cell's DNA. These mutations can occur spontaneously or be triggered by various factors, including:

- **Tobacco and Smoking:** Smoking is a leading cause of lung cancer and is also associated with cancers of the mouth, throat, esophagus, and more.
- **Radiation Exposure:** Ionizing radiation, whether from medical procedures, environmental sources, or occupational exposure, can increase the risk of cancer.
- **Chemical and Occupational Exposures:** Exposure to certain chemicals, such as asbestos, benzene, and formaldehyde, can contribute to cancer development.
- **Viruses and Infections:** Some viruses, like HPV, hepatitis B and C, and human immunodeficiency virus (HIV), can increase the risk of certain cancers.

9.4 RISK FACTORS :

Several factors can increase an individual's risk of developing cancer, including:

- **Age:** The risk of cancer generally increases with age, as genetic mutations accumulate over time.
- **Family History:** Inherited genetic mutations can increase susceptibility to certain types of cancer.
- **Environmental Exposures:** Prolonged exposure to carcinogens in the environment or workplace.
- **Medical Conditions:** Certain pre-existing conditions, such as chronic inflammation or certain genetic syndromes, may elevate cancer risk.

9.5 COMPLICATIONS OF CANCER :

Complications of cancer can affect various aspects of health:

- **Metastasis:** The spread of cancer cells to distant organs or tissues, forming new tumors.
- **Organ Dysfunction:** Tumors can interfere with the normal function of organs and tissues.
- **Weakened Immune System:** Cancer and its treatments can suppress the immune system, making the body more susceptible to infections.
- **Cachexia:** Severe weight loss, muscle wasting, and weakness, often seen in advanced stages of cancer.

9.6 PREVENTION OF CANCER :

While not all cancers can be prevented, adopting a healthy lifestyle can reduce the risk:

- **Tobacco Avoidance:** Quit smoking and avoid exposure to secondhand smoke.
- **Healthy Diet:** Consume a balanced diet rich in fruits, vegetables, whole grains, and lean proteins.
- **Physical Activity:** Engage in regular exercise to maintain a healthy weight and reduce the risk of certain cancers.
- **Limit Alcohol:** Moderation in alcohol consumption, as excessive drinking is linked to an increased risk of certain cancers.
- **Protection Against Infections:** Practice safe sex and get vaccinated against viruses like HPV and hepatitis.

Regular screenings and early detection are crucial for certain types of cancer, allowing for prompt intervention and improved treatment outcomes. Individuals with a family history of cancer or other risk factors should consult with healthcare professionals for personalized advice and screening recommendations.

9.7 DIAGNOSIS OF CANCER :

Diagnosing cancer involves a combination of medical history assessment, physical examinations, imaging studies, laboratory tests, and sometimes, a biopsy. Here's a breakdown of the diagnostic process:

- **Medical History and Physical Examination:** The healthcare provider discusses the patient's symptoms, risk factors, and overall health. A physical examination may reveal signs of cancer or other health issues.
- **Imaging Tests:** Various imaging techniques, such as X-rays, CT scans, MRIs, and PET scans, help visualize the internal structures of the body and identify abnormalities, including tumors.
- **Laboratory Tests:** Blood tests, urine tests, and other laboratory analyses can provide information about the presence of certain substances or markers associated with cancer.
- **Biopsy:** A biopsy involves the removal of a small sample of tissue for examination under a microscope. This is often the definitive method to confirm a cancer diagnosis, determine its type, and understand its characteristics.
- **Genetic Testing:** In some cases, genetic testing may be recommended to identify specific genetic mutations that could influence treatment decisions or assess the risk of developing certain cancers.

9.8 TREATMENT OF CANCER :

Cancer treatment varies based on the type, stage, and location of the cancer, as well as the patient's overall health. Treatment options typically include a combination of the following:

- **Surgery:** Surgical removal of tumors or affected organs is a common treatment for localized cancers. It is often the primary treatment for solid tumors.
- **Chemotherapy:** Chemotherapy involves the use of drugs to kill or slow the growth of cancer cells. It can be administered orally or through intravenous infusion and may be used before or after surgery.
- **Radiation Therapy:** This treatment uses high-dose radiation to target and destroy cancer cells. It can be delivered externally or internally, depending on the type and location of the cancer.
- **Immunotherapy:** Immunotherapy boosts the body's immune system to recognize and attack cancer cells. It includes monoclonal antibodies, checkpoint inhibitors, and other therapies that enhance immune responses.
- **Hormone Therapy:** Hormone therapy is employed for cancers that are influenced by hormones, such as breast and prostate cancers. It aims to block or interfere with hormone production or action.
- **Targeted Therapy:** Targeted therapy involves drugs that specifically target molecules involved in cancer cell growth. It is often used for cancers with specific genetic mutations.
- **Stem Cell Transplantation:** In some cases, high-dose chemotherapy or radiation is used to eliminate cancer cells, followed by a stem cell transplant to replace damaged or destroyed bone marrow.
- **Precision Medicine:** Precision medicine involves tailoring treatment based on the specific genetic characteristics of a patient's cancer. This approach aims to maximize effectiveness and minimize side effects.

9.9 INTRODUCTION TO LEPROSY :

Leprosy, also referred to as Hansen's disease, is a chronic infectious condition caused by the bacterium Mycobacterium leprae. This disease primarily affects the skin, peripheral nerves, mucous membranes, and eyes, presenting a range of symptoms that can lead to significant physical and social implications. Individuals with leprosy often exhibit hypopigmented or reddish skin patches, nerve damage resulting in loss of sensation and muscle weakness, nodules on the skin, and, in severe cases, ocular involvement leading to blindness. Despite advances in medical knowledge, leprosy carries historical stigma, contributing to discrimination and isolation of affected individuals.

The transmission of leprosy is not fully understood, but it is believed to occur through respiratory droplets, particularly in prolonged close contact with untreated individuals. Risk factors include compromised immune systems, genetic predisposition, and geographical residence in certain tropical and subtropical regions where the disease is more prevalent. The social and cultural impact of leprosy is profound, perpetuated by historical misconceptions, leading to social exclusion and discrimination.

Preventive measures are crucial in addressing leprosy. Early diagnosis and timely treatment with multidrug therapy (MDT), a combination of antibiotics such as dapsone, rifampicin, and clofazimine, are essential to prevent complications and reduce transmission.

Chemoprophylaxis, involving the administration of antibiotics to close contacts, further aids in preventing the spread of the disease.

The diagnostic process for leprosy involves a comprehensive clinical examination and a skin biopsy, which helps confirm the presence of Mycobacterium leprae. Treatment aims not only to cure the infection but also to address potential complications, such as permanent nerve damage and disfigurement. Supportive care, including rehabilitation services like physical therapy, is often necessary for those affected.

Public health initiatives play a crucial role in addressing leprosy. Awareness campaigns, community engagement, and the reduction of social stigma are integral components of global efforts to control and eliminate the disease. Research and innovation continue to advance diagnostics, treatment strategies, and our understanding of leprosy's immunological aspects, with the ultimate goal of eliminating leprosy as a public health concern globally. In conclusion, while leprosy poses significant challenges, concerted efforts in early detection, treatment accessibility, and social inclusion can pave the way for a future where leprosy is effectively controlled and eventually eradicated.

9.10 SYMPTOMS

Leprosy manifests in various ways, and the symptoms can be classified into two main types:

Paucibacillary (PB) Leprosy (Mild)

Single or a few skin lesions.

Hypopigmented or reddish patches on the skin.

Loss of sensation in affected areas.

Nerve involvement may lead to muscle weakness.

Multibacillary (MB) Leprosy (Severe)

Numerous skin lesions.

Enlarged nerves, particularly in cooler areas of the body (such as elbows and knees).

Loss of sensation and muscle weakness.

In some cases, involvement of the eyes, leading to blindness if untreated.

9.11 CAUSES :

Leprosy is caused by the slow-growing bacterium Mycobacterium leprae. The exact mode of transmission is not fully understood, but it is thought to occur through respiratory droplets released by infected individuals. Not everyone exposed to the bacteria develops the disease, suggesting a complex interplay of genetic and environmental factors.

9.12 RISK FACTORS :

- **Close Contact:** Prolonged and close contact with untreated individuals with leprosy.
- **Immune Response:** Individuals with a weakened immune system may be more susceptible.
- **Genetic Factors:** Some genetic factors may contribute to increased susceptibility.

- **Geographical Location:** Leprosy is more prevalent in certain tropical and subtropical regions.

9.13 COMPLICATIONS :

- **Permanent Nerve Damage:** Loss of sensation and muscle weakness due to nerve damage, leading to disability.
- **Disfigurement:** Skin lesions and nodules can cause permanent disfigurement.
- **Blindness:** Ocular involvement may lead to blindness.
- **Social Stigma:** Historical misconceptions and social stigma surrounding leprosy can contribute to discrimination and isolation.

9.14 PREVENTION :

- **Early Diagnosis and Treatment:** Timely identification and treatment of leprosy cases to prevent the spread of the disease and minimize complications.
- **Chemoprophylaxis:** Administration of antibiotics to close contacts of individuals with leprosy to prevent transmission.

9.15 DIAGNOSIS :

Diagnosing leprosy involves a combination of clinical assessment and laboratory tests:

- **Clinical Examination:** Healthcare professionals examine skin lesions, assess nerve function, and look for other symptoms.
- **Skin Biopsy:** A small sample of skin is taken for laboratory analysis to confirm the presence of Mycobacterium leprae.

9.16 TREATMENT :

Leprosy is treatable with multidrug therapy (MDT), which typically includes a combination of antibiotics such as dapsone, rifampicin, and clofazimine. The treatment duration varies based on the type and severity of leprosy and may range from several months to a few years. Early diagnosis and treatment are crucial to prevent complications and reduce the risk of transmission.

Individuals with leprosy may also receive supportive care, including rehabilitation services such as physical therapy, to manage symptoms and prevent disability. Public health efforts focus on early detection, treatment, and reducing social stigma to effectively control and eliminate leprosy.

9.17 SUMMARY :

In conclusion, cancer is a complex and multifaceted group of diseases characterized by uncontrolled cell growth, with symptoms that can vary widely depending on the type and stage. Understanding the various aspects of cancer, including its causes, risk factors, prevention strategies, diagnosis, and treatment options, is crucial in the ongoing global effort to combat this widespread health challenge. Symptoms of cancer, ranging from fatigue and unexplained weight loss to changes in the skin and persistent pain, serve as critical indicators that prompt individuals to seek medical attention. However, the diversity of cancer types necessitates a nuanced approach to diagnosis, which often involves a combination of medical history assessments, physical examinations, imaging studies, laboratory tests, and biopsies. Cancer's causes are multifactorial, involving genetic mutations, environmental exposures, and

lifestyle choices. Risk factors such as age, family history, and certain environmental exposures contribute to an individual's susceptibility. However, embracing a healthy lifestyle, avoiding tobacco, maintaining a balanced diet, engaging in regular physical activity, and limiting alcohol intake are vital preventive measures.

Advancements in cancer research have led to various treatment modalities, including surgery, chemotherapy, radiation therapy, immunotherapy, hormone therapy, targeted therapy, and precision medicine. The choice of treatment depends on factors such as the type and stage of cancer, as well as the patient's overall health. Early detection through regular screenings enhances the effectiveness of treatment and improves outcomes. Preventing and effectively managing cancer require a comprehensive and collaborative approach that encompasses public health initiatives, education, research, and accessible healthcare. Ongoing efforts in cancer prevention, early detection, and innovative treatments offer hope for improved survival rates and enhanced quality of life for individuals affected by cancer. As we strive towards a future where cancer is more effectively controlled and ultimately eradicated, emphasis on awareness, research, and supportive care remains paramount.

In conclusion, leprosy, despite its historical stigmatization, is a curable yet complex infectious disease that affects various aspects of an individual's health and well-being. The symptoms, ranging from skin lesions to nerve damage, highlight the diverse nature of the disease. While the exact transmission mechanisms remain incompletely understood, the importance of early diagnosis and timely treatment cannot be overstated. The social and cultural impact of leprosy, perpetuated by historical misconceptions, underscores the need for comprehensive public health initiatives that not only focus on medical interventions but also address societal attitudes and reduce discrimination.

Efforts to prevent leprosy encompass early identification, multidrug therapy, and chemoprophylaxis for close contacts, all crucial components in breaking the chain of transmission. The diagnostic process involves a combination of clinical examination and laboratory tests, including skin biopsy, providing a comprehensive understanding of the disease's presence and severity. Treatment with antibiotics, rehabilitation services, and ongoing support contribute to the overall well-being of affected individuals. Public health campaigns, community engagement, and education are vital to dispel myths, reduce social stigma, and ensure accessibility to treatment. The global goal of eliminating leprosy as a public health concern requires collaboration, research, and continued innovation to improve diagnostics, treatment modalities, and understanding of the disease's complexities. In essence, the narrative around leprosy is evolving from one of fear and ostracization to one of hope and inclusivity. As scientific advancements and public health initiatives progress, there is optimism that leprosy can be effectively controlled and, ultimately, eradicated, paving the way for a world where individuals affected by leprosy can live without prejudice, lead fulfilling lives, and contribute to their communities.

9.18 KEYWORDS :

1. Cancer
2. Leprosy
3. Causes
4. Symptoms
5. Prevention

9.19 SELF ASSESSMENT QUESTIONS :

1. Discuss the causes and prevention of Cancer?
2. Analyze the risk factors and complications of Leprosy?

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Prof. V. Venkateswarlu

LESSON - 10

TUBERCULOSIS, H.I.V./A.I.D.S.

OBJECTIVE:

The objective of this lesson is to explain symptoms, causes, risk factors, complications and prevention of Tuberculosis and HIV/A.I.D.S.

STRUCTURE:

10.1 INTRODUCTION TO TUBERCULOSIS :

Tuberculosis (TB) is a serious illness that mainly affects the lungs. The germs that cause tuberculosis are a type of bacteria. Tuberculosis can spread when a person with the illness coughs, sneezes or sings. This can put tiny droplets with the germs into the air. Another person can then breathe in the droplets, and the germs enter the lungs.

Tuberculosis spreads easily where people gather in crowds or where people live in crowded conditions. People with HIV/AIDS and other people with weakened immune systems have a higher risk of catching tuberculosis than people with typical immune systems.

Drugs called antibiotics can treat tuberculosis. But some forms of the bacteria no longer respond well to treatments.

10.2 SYMPTOMS :

When tuberculosis (TB) germs survive and multiply in the lungs, it is called a TB infection. A TB infection may be in one of three stages. Symptoms are different in each stage.

Primary TB infection. The first stage is called the primary infection. Immune system cells find and capture the germs. The immune system may completely destroy the germs. But some captured germs may still survive and multiply.

Most people don't have symptoms during a primary infection. Some people may get flu-like symptoms, such as:

- Low fever.
- Tiredness.
- Cough.

Latent TB infection: Primary infection is usually followed by the stage called latent TB infection. Immune system cells build a wall around lung tissue with TB germs. The germs can't do any more harm if the immune system keeps them under control. But the germs survive. There are no symptoms during latent TB infection.

Active TB disease: Active TB disease happens when the immune system can't control an infection. Germs cause disease throughout the lungs or other parts of the body. Active TB disease may happen right after primary infection. But it usually happens after months or years of latent TB infection.

Symptoms of active TB disease in the lungs usually begin gradually and worsen over a few weeks. They may include:

- Cough.
- Coughing up blood or mucus.
- Chest pain.
- Pain with breathing or coughing.
- Fever.
- Chills.
- Night sweats.
- Weight loss.
- Not wanting to eat.
- Tiredness.
- Not feeling well in general.

Active TB disease outside the lungs: TB infection can spread from the lungs to other parts of the body. This is called extrapulmonary tuberculosis. Symptoms vary depending on what part of the body is infected. Common symptoms may include:

- Fever.
- Chills.
- Night sweats.
- Weight loss.
- Not wanting to eat.
- Tiredness.
- Not feeling well in general.
- Pain near the site of infection.

Active TB disease in the voice box is outside the lungs, but it has symptoms more like disease in the lungs.

Common sites of active TB disease outside the lungs include:

- Kidneys.
- Liver.
- Fluid surrounding the brain and spinal cord.
- Heart muscles.
- Genitals.
- Lymph nodes.
- Bones and joints.
- Skin.
- Walls of blood vessels.
- Voice box, also called larynx.

Active TB disease in children. Symptoms of active TB disease in children vary. Typically, symptoms by age may include the following:

- **Teenagers.** Symptoms are similar to adult symptoms.
- **1- to 12-year-olds.** Younger children may have a fever that won't go away and weight loss.
- **Infants.** The baby doesn't grow or gain weight as expected. Also, a baby may have symptoms from swelling in the fluid around the brain or spinal cord, including:

    - Being sluggish or not active.
    - Unusually fussy.
    - Vomiting.
    - Poor feeding.
    - Bulging soft spot on the head.
    - Poor reflexes.

When to see a doctor

The symptoms of tuberculosis are similar to symptoms of many different illnesses. See your health care provider if you have symptoms that don't improve with a few days of rest.

Get emergency care if you have:

- Chest pain.
- Sudden, severe headache.
- Confusion.
- Seizures.
- Difficulty breathing.

Get immediate or urgent care if you:

- Cough up blood.
- Have blood in your urine or stool.

10.3 CAUSES

Tuberculosis is caused by a bacterium called Mycobacterium tuberculosis.

People with active TB disease in the lungs or voice box can spread the disease. They release tiny droplets that carry the bacteria through the air. This can happen when they're speaking, singing, laughing, coughing or sneezing. A person can get an infection after inhaling the droplets.

The disease is more likely to spread when people spend a lot of time together in an indoor space. So the disease spreads easily in places where people live or work together for long periods. Also, the disease spreads more easily in crowded gatherings.

A person with a latent TB infection cannot pass the disease to other people. A person taking drugs to treat active TB disease usually can't pass the disease after 2 to 3 weeks of treatment.

Drug-resistant TB

Some forms of the TB bacteria have become drug resistant. This means that drugs that once cured the disease no longer work.

This happens, in part, because of naturally occurring genetic changes in bacteria. A random genetic change in a bacterium might give it some quality that makes it more likely to survive the attack of an antibiotic. If it does survive, then it can multiply.

When antibiotic drugs aren't used correctly — or drugs fail to kill all the bacteria for another reason — the conditions are ideal for more-resistant versions of the bacteria to get established and multiply. If these bacteria are passed on to other people, a new drug-resistant strain can grow over time.

Problems that can lead to such drug-resistant strains of bacteria include the following:

- People didn't follow directions for taking the drugs or stopped taking the drugs.
- They weren't prescribed the right treatment plan.
- Drugs were not available.
- The drugs were of poor quality.
- The body didn't absorb the drugs as expected.

10.4 RISK FACTORS :

Anyone can get tuberculosis, but certain factors increase the risk of getting an infection. Other factors increase the risk of an infection becoming active TB disease.

The Centers for Disease Control and Prevention recommends a TB test for people who have an increased risk of TB infection or active TB disease. Talk to your health care provider if you have one or more of the following risk factors.

Risk of TB infection
Certain living or working conditions make it easier for the disease to pass from one person to another. These conditions increase the risk of getting a TB infection:

- Living with someone with active TB disease.
- Living or traveling in a country where TB is common, including several countries in Latin America, Africa, Asia and the Pacific Islands.
- Living or working in places where people live close together, such as prisons, nursing homes and shelters for homeless people.
- Living in a community identified as being at high risk of tuberculosis.
- Working in health care and treating people with a high risk of TB.

Risk of active TB disease
A weakened immune system increases the risk of a TB infection becoming active TB disease. Conditions or treatments that weaken the immune system include:

- HIV/AIDS.
- Diabetes.
- Severe kidney disease.
- Cancers of the head, neck and blood.
- Malnutrition or low body weight.
- Cancer treatment, such as chemotherapy.
- Drugs to prevent rejection of transplanted organs.
- Long-term use of prescription steroids.
- Use of unlawful injected drugs.
- Misuse of alcohol.
- Smoking and using other tobacco products.

Age and active TB disease
The risk of a TB infection becoming active TB disease changes with age.

- **Under 5 years of age.** Until children reach age 5, they have high risk of a TB infection becoming active TB disease. The risk is greater for children under age 2. Tuberculosis in this age group often leads to serious disease in the fluid surrounding the brain and spinal column, called meningitis.
- **Age 15 to 25.** People in this age group have an increased risk of developing more-severe active TB disease in the lungs.
- **Age 65 and older.** The immune system weakens during older age. Older adults have a greater risk of active TB disease. Also, the disease may be more difficult to treat.

10.5 PREVENTION :

If you test positive for latent TB infection, you may need to take drugs to prevent active TB disease.

Preventing the spread of disease
If you have active TB disease, you'll need to take steps to prevent other people from getting an infection. You will take drugs for four, six or nine months. Take all of the drugs as directed during the entire time.

During the first 2 to 3 weeks, you will be able to pass TB bacteria to others. Protect others with these steps:

- **Stay home.** Don't go to work or school.
- **Isolate at home.** Spend as little time as possible among members of your household. Sleep in a separate room.
- **Ventilate the room.** Tuberculosis germs spread more easily in small, closed spaces. If it's not too cold outdoors, open the windows. Use a fan to blow air out. If you have more than one window, use one fan to blow air out and another to blow air in.
- **Wear face masks.** Wear a mask when you have to be around other people. Ask other members of the household to wear masks to protect themselves.
- **Cover your mouth.** Use a tissue to cover your mouth anytime you sneeze or cough. Put the dirty tissue in a bag, seal it and throw it away.

Vaccinations

In countries where tuberculosis is common, infants often are vaccinated with the bacille Calmette-Guerin (BCG) vaccine. This protects infants and toddlers who are more likely to have active TB disease in the fluid surrounding the brain and spinal cord.

The vaccine may not protect against disease in the lungs, which is more likely in the United States. Dozens of new TB vaccines are in various stages of development and testing.

10.6 INTRODUCTION TO H.I.V./A.I.D.S. :

Acquired immunodeficiency syndrome (AIDS) is a chronic, potentially life-threatening condition caused by the human immunodeficiency virus (HIV). By damaging your immune system, HIV interferes with your body's ability to fight infection and disease.

HIV is a sexually transmitted infection (STI). It can also be spread by contact with infected blood and from illicit injection drug use or sharing needles. It can also be spread from mother to child during pregnancy, childbirth or breastfeeding. Without medication, it may take years before HIV weakens your immune system to the point that you have AIDS.

There's no cure for HIV/AIDS, but medications can control the infection and prevent progression of the disease. Antiviral treatments for HIV have reduced AIDS deaths around the world, and international organizations are working to increase the availability of prevention measures and treatment in resource-poor countries.

10.7 SYMPTOMS :

The symptoms of HIV and AIDS vary, depending on the phase of infection.

Primary infection (Acute HIV)

Some people infected by HIV develop a flu-like illness within 2 to 4 weeks after the virus enters the body. This illness, known as primary (acute) HIV infection, may last for a few weeks.

Possible signs and symptoms include:

- Fever
- Headache
- Muscle aches and joint pain
- Rash
- Sore throat and painful mouth sores
- Swollen lymph glands, mainly on the neck
- Diarrhea
- Weight loss
- Cough
- Night sweats

These symptoms can be so mild that you might not even notice them. However, the amount of virus in your bloodstream (viral load) is quite high at this time. As a result, the infection spreads more easily during primary infection than during the next stage.

Clinical latent infection (Chronic HIV)

In this stage of infection, HIV is still present in the body and in white blood cells. However, many people may not have any symptoms or infections during this time.

This stage can last for many years if you're receiving antiretroviral therapy (ART). Some people develop more severe disease much sooner.

Symptomatic HIV infection

As the virus continues to multiply and destroy your immune cells — the cells in your body that help fight off germs — you may develop mild infections or chronic signs and symptoms such as:

- Fever
- Fatigue
- Swollen lymph nodes — often one of the first signs of HIV infection
- Diarrhea
- Weight loss
- Oral yeast infection (thrush)
- Shingles (herpes zoster)
- Pneumonia

Progression to AIDS

Access to better antiviral treatments has dramatically decreased deaths from AIDS worldwide, even in resource-poor countries. Thanks to these life-saving treatments, most people with HIV in the U.S. today don't develop AIDS. Untreated, HIV typically turns into AIDS in about 8 to 10 years.

When AIDS occurs, your immune system has been severely damaged. You'll be more likely to develop diseases that wouldn't usually cause illness in a person with a healthy immune system. These are called opportunistic infections or opportunistic cancers.

The signs and symptoms of some of these infections may include:

- Sweats
- Chills
- Recurring fever
- Chronic diarrhea
- Swollen lymph glands
- Persistent white spots or unusual lesions on your tongue or in your mouth
- Persistent, unexplained fatigue
- Weakness
- Weight loss
- Skin rashes or bumps

10.8 CAUSES :

HIV is caused by a virus. It can spread through sexual contact, illicit injection drug use or sharing needles, contact with infected blood, or from mother to child during pregnancy, childbirth or breastfeeding.

HIV destroys CD4 T cells — white blood cells that play a large role in helping your body fight disease. The fewer CD4 T cells you have, the weaker your immune system becomes.

How does HIV become AIDS?

You can have an HIV infection, with few or no symptoms, for years before it turns into AIDS. AIDS is diagnosed when the CD4 T cell count falls below 200 or you have an AIDS-defining complication, such as a serious infection or cancer.

10.9 HOW HIV SPREADS

To become infected with HIV, infected blood, semen or vaginal secretions must enter your body. This can happen in several ways:

- **By having sex.** You may become infected if you have vaginal, anal or oral sex with an infected partner whose blood, semen or vaginal secretions enter your body. The virus can enter your body through mouth sores or small tears that sometimes develop in the rectum or vagina during sexual activity.
- **By sharing needles.** Sharing contaminated injection drug paraphernalia (needles and syringes) puts you at high risk of HIV and other infectious diseases, such as hepatitis.
- **From blood transfusions.** In some cases, the virus may be transmitted through blood transfusions. Hospitals and blood banks screen the blood supply for HIV, so this risk is very small in the U.S. and other upper-middle-income countries. The risk may be higher in low-income countries that are not able to screen all donated blood.
- **During pregnancy or delivery or through breastfeeding.** Infected mothers can pass the virus on to their babies. Mothers who are HIV-positive and get treatment for the infection during pregnancy can significantly lower the risk to their babies.

10.10 HOW HIV DOESN'T SPREAD

You can't become infected with HIV through ordinary contact. That means you can't catch HIV or AIDS by hugging, kissing, dancing or shaking hands with someone who has the infection.

HIV isn't spread through the air, water or insect bites.

10.11 RISK FACTORS

Anyone of any age, race, sex or sexual orientation can be infected with HIV/AIDS. However, you're at greatest risk of HIV/AIDS if you:

- **Have unprotected sex.** Use a new latex or polyurethane condom every time you have sex. Anal sex is riskier than is vaginal sex. Your risk of HIV increases if you have multiple sexual partners.
- **Have an STI.** Many STIs produce open sores on your genitals. These sores act as doorways for HIV to enter your body.
- **Use illicit injection drugs.** People who use illicit injection drugs often share needles and syringes. This exposes them to droplets of other people's blood.

10.12 COMPLICATIONS :

HIV infection weakens your immune system, making you much more likely to develop many infections and certain types of cancers.

Infections common to HIV/AIDS

- **Pneumocystis pneumonia (PCP).** This fungal infection can cause severe illness. Although it's declined significantly with current treatments for HIV/AIDS, in the U.S., PCP is still the most common cause of pneumonia in people infected with HIV.
- **Candidiasis (thrush).** Candidiasis is a common HIV-related infection. It causes inflammation and a thick, white coating on your mouth, tongue, esophagus or vagina.
- **Tuberculosis (TB).** TB is a common opportunistic infection associated with HIV. Worldwide, TB is a leading cause of death among people with AIDS. It's less common in the U.S. thanks to the wide use of HIV medications.
- **Cytomegalovirus.** This common herpes virus is transmitted in body fluids such as saliva, blood, urine, semen and breast milk. A healthy immune system inactivates the virus, and it remains dormant in your body. If your immune system weakens, the virus resurfaces — causing damage to your eyes, digestive tract, lungs or other organs.
- **Cryptococcal meningitis.** Meningitis is an inflammation of the membranes and fluid surrounding your brain and spinal cord (meninges). Cryptococcal meningitis is a common central nervous system infection associated with HIV, caused by a fungus found in soil.
- **Toxoplasmosis.** This potentially deadly infection is caused by Toxoplasma gondii, a parasite spread primarily by cats. Infected cats pass the parasites in their stools, which

may then spread to other animals and humans. Toxoplasmosis can cause heart disease, and seizures occur when it spreads to the brain.

Cancers common to HIV/AIDS

- **Lymphoma.** This cancer starts in the white blood cells. The most common early sign is painless swelling of the lymph nodes in your neck, armpit or groin.
- **Kaposi's sarcoma.** A tumor of the blood vessel walls, Kaposi's sarcoma usually appears as pink, red or purple lesions on the skin and mouth. In people with darker skin, the lesions may look dark brown or black. Kaposi's sarcoma can also affect the internal organs, including the digestive tract and lungs.
- **HPV-related cancers.** These are cancers caused by human papillomavirus (HPV) infection. They include anal, oral and cervical cancer.

Other complications

- **Wasting syndrome.** Untreated HIV/AIDS can cause significant weight loss, often accompanied by diarrhea, chronic weakness and fever.
- **Neurological complications.** HIV can cause neurological symptoms such as confusion, forgetfulness, depression, anxiety and difficulty walking. HIV-associated neurocognitive disorders (HAND) can range from mild symptoms of behavioral changes and reduced mental functioning to severe dementia causing weakness and inability to function.
- **Kidney disease.** HIV-associated nephropathy (HIVAN) is an inflammation of the tiny filters in your kidneys that remove excess fluid and wastes from your blood and pass them to your urine. It most often affects Black or Hispanic people.
- **Liver disease.** Liver disease is also a major complication, especially in people who also have hepatitis B or hepatitis C.

10.13 PREVENTION :

There's no vaccine to prevent HIV infection and no cure for HIV/AIDS. But you can protect yourself and others from infection.

To help prevent the spread of HIV:

- **Consider preexposure prophylaxis (PrEP).** The combination oral drugs emtricitabine plus tenofovir disoproxil fumarate (Truvada) and emtricitabine plus tenofovir alafenamide fumarate (Descovy) can reduce the risk of sexually transmitted HIV infection in people at very high risk. PrEP can reduce your risk of getting HIV from sex by about 99% and from injection drug use by at least 74%, according to the Centers for Disease Control and Prevention. Descovy hasn't been studied in people who have receptive vaginal sex.

The FDA recently approved cabotegravir (Apretude), the first injectable PrEP to reduce the risk of sexually transmitted HIV infection in people at very high risk. The injection is given by a health care provider. After the first two monthly injections, cabotegravir is given every two months. The injection is an option in place of a daily PrEP pill.

Your health care provider will prescribe these drugs for HIV prevention only if you don't already have HIV infection. You will need an HIV test before you start taking any PrEP. The test should then be done every three months for pills or before each injection for as long as you're taking PrEP. Your health care provider will also test your kidney function before prescribing Truvada and continue to test it every 6 to 12 months. Other regular testing may also be needed.

You need to take the pill form every day or closely follow the injection schedule for cabotegravir. They don't prevent other STIs, so you'll still need to practice safe sex. If you have hepatitis B, you should be evaluated by an infectious disease or liver specialist before beginning therapy.

- **Use treatment as prevention (TasP).** If you're living with HIV, taking HIV medication can keep your partner from becoming infected with the virus. If you make sure your viral load stays undetectable — a blood test doesn't show any virus — you won't transmit the virus to anyone else through sex. Using TasP means taking your medication exactly as prescribed and getting regular checkups.
- **Use post-exposure prophylaxis (PEP) if you've been exposed to HIV.** If you think you've been exposed through sex, needles or in the workplace, contact your health care provider or go to the emergency department. Taking PEP as soon as possible within the first 72 hours can greatly reduce your risk of becoming infected with HIV. You will need to take medication for 28 days.
- **Use a new condom every time you have sex.** Use a new condom every time you have anal or vaginal sex. Women can use a female condom. If using a lubricant, make sure it's water-based. Oil-based lubricants can weaken condoms and cause them to break. During oral sex use a nonlubricated, cut-open condom or a dental dam — a piece of medical-grade latex.
- **Tell your sexual partners if you have HIV.** It's important to tell all your current and past sexual partners that you're HIV-positive. They'll need to be tested.
- **Use a clean needle.** If you use a needle to inject illicit drugs, make sure it's sterile and don't share it. Take advantage of needle-exchange programs in your community. Consider seeking help for your drug use.
- **If you're pregnant, get medical care right away.** If you're HIV-positive, you may pass the infection to your baby. But if you receive treatment during pregnancy, you can significantly cut your baby's risk.
- **Consider male circumcision.** There's evidence that male circumcision can help reduce the risk of getting HIV infection.

10.14 SUMMARY :

In conclusion, tuberculosis (TB) and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) stand as significant global health challenges, each presenting unique symptoms, causes, risk factors, complications, and prevention strategies. TB, a bacterial infection primarily affecting the lungs, manifests with symptoms such as persistent cough, weight loss, and fatigue. On the other hand, HIV/AIDS, a viral infection targeting the immune system, may initially show mild symptoms or remain asymptomatic, leading to a higher risk of opportunistic infections. TB is caused by the Mycobacterium

tuberculosis bacterium, while HIV is caused by the human immunodeficiency virus. The coexistence of TB and HIV is a particularly challenging scenario, as one infection can exacerbate the progression of the other, leading to severe health complications. Risk factors for TB include close contact with an infected person, weakened immune system, and certain environmental conditions, whereas HIV transmission primarily occurs through unprotected sexual contact, sharing of contaminated needles, or mother-to-child transmission during childbirth or breastfeeding. Complications of TB and HIV/AIDS extend beyond the immediate health impact, affecting the socio-economic fabric of communities. TB can lead to chronic illness, disability, and economic burden, while HIV/AIDS poses long-term challenges in managing the virus, opportunistic infections, and addressing societal stigma. Preventive measures for TB include vaccination, early diagnosis, and completion of the prescribed antibiotic treatment. Preventing HIV/AIDS involves practicing safe sex, avoiding sharing of needles, and utilizing antiretroviral therapy (ART) to manage HIV progression. In addressing these interconnected public health challenges, a holistic and integrated approach is crucial. Combating TB and HIV/AIDS requires collaboration between healthcare systems, governments, and communities. Raising awareness, reducing stigma, and promoting accessible healthcare services are pivotal steps toward preventing, managing, and ultimately eradicating these diseases. As the global community works towards achieving health equity, advancements in research, improved diagnostics, and increased access to treatment are essential in the ongoing fight against TB and HIV/AIDS.

10.15 KEYWORDS :

1. Tuberculosis
2. H.I.V/A.I.D.S
3. Causes
4. Symptoms
5. Prevention

10.16 SELF ASSESSMENT QUESTIONS :

1. Discuss the causes and prevention of Tuberculosis?
2. Analyze the risk factors and complications of H.I.V/A.I.D.S?

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Prof. V. Venkateswarlu

LESSON – 11

COMMUNITY HEALTH, PRIMARY HEALTH CARE

OBJECTIVE:

The objective of this lesson is to explain definition, factors influencing community health, components of primary health care.

STRUCTURE:

11.1 INTRODUCTION:

Traditionally, a community has been thought of being confined to a geographic area with specific boundaries, for example, a neighbourhood, city, country, or state. However, in the context of community health, a community is an aggregate of people who share certain common characteristics. Community is also related with a particular geographical location, race, ethnicity, age, and occupation who are having common interests for particular problems and having a common bonding (Turnock, 2004).

Communities are characterized by following features:

- Membership: community people have a sense of common identity and belongingness.
- They share a common language, rituals, and ceremonies.
- Their values and norms are common.
- Members have a mutual influence and also influenced by each other.
- Their needs are shared and committed to meet their common needs.
- They are also connected by emotions in terms of their common history, experiences and mutual support (Israel et al., 1994).

Examples of communities include the people of a city (location); a community, say the Dravidian community of South India (race), the tribal community example Odisha (ethnicity), seniors (age), doctors and teachers (occupation), or local union members (common bond). A community may be small— as the group of people who live in accommodation provided in the hostels at college or university or as large as the individuals who make up a nation. “A healthy community is a place where people provide leadership in assessing their own resources and needs, where public health and social infrastructure and

policies support health, and where essential public health services, including quality healthcare, are available" (Institute of Medicine, 2003).

11.2 DEFINING COMMUNITY HEALTH :

Prior to defining community health, a similar concept, i.e. public health is discussed. The laymen use these two terms interchangeably in various health fields. Most people are referring to the collective health of those in society and the actions or activities taken to obtain and maintain that health. Public health is an inclusive concept. When the activity is done publicly to assure the conditions in which people can be healthy is called public health. The public health system, which has been defined as certain actions and activities taken in formal structure by the government, private, voluntary organizations, and by individuals (Institute of Medicine, 1998), is the organizational mechanism of providing such conditions. People regard public health as the responsibility of government like providing sanitation, potable water, vaccination, control and prevention of epidemics, etc. Community health refers to the health status of a defined group of people and the actions and conditions to promote, protect, and preserve their health (Mckenzie, 2008).

Personal health activities are individual actions and decision making that affect the health of an individual or his or her immediate family members. These activities may be preventive or curative in nature but seldom directly affect the behaviour of others. Choosing to eat nutritious food, regular exercise, avoiding smoking, etc., are examples of personal health activities.

Community health is concerned with the health problems among different groups of population. Such concerns with health problems of population groups inevitably lead to a broad range of interests, i.e. from the cause, prevention, and control of diseases—nutritional or otherwise. Thus, community health includes identification of nutritional and health problems and causes, prevention, and control of diseases.

However, the community health has replaced, in some countries, the terms of public health, preventive medicine and social medicine. A EURO symposium in 1966 defined community health as including "all the personal health and environmental services in any human community, irrespective of whether such services were public or private ones". In some instances, community health is used as a synonym for 'environmental health'. It is also used to refer to 'community healthcare'. Therefore, a WHO expert committee in 1973 observed that without further qualification, the term 'community health' is ambiguous, and suggested caution while using the term.

Community health is defined more broadly and encompasses the entire gamut of community-organized efforts for maintaining, protecting, and improving the health of the people. It involves motivation of the individual and groups to change their patterns of behaviour. In addition, it also seeks to plan medical care to achieve optimal health of the members of the whole community. Previously, the subject of community health was covered under Hygiene, Public Health or Preventive and Social Medicine.

In community health, instead of studying individuals as a patient, it is essential to understand that:

- The patient represents the community
- Diagnosis of disease in the community, (referred to as community diagnosis) is essential

- Planning treatment for the community is the objective.

For example, a single case of a cholera patient detected in a village is a danger signal. It shows that the disease is present in the community, there may be many cases of it and unless checked, its spread will grip the whole village. So, the appropriate measures for treatment and control of the disease are planned in advance. Since it is a water-borne disease, water sources—river, wells, or underground water are examined for infection and accordingly treated. In addition, necessary treatment for the affected people and precautions such as vaccination for vulnerable people is also done. Community diagnosis may require relevant data such as given below. These are collected and interpreted.

- Age and sex distribution in the population under study and its distribution in social groups—in the community.
- Crude birth rate, infant mortality rate, maternal mortality rate, child death rate, prenatal mortality rate and neonatal post- neonatal death rate, etc.
- Incidence and prevalence of certain diseases in the area.

Besides investigating health problems, it is also essential to find out the various social and economic factors in the area influencing the above data. This helps in identifying the basic health needs and health problems faced by the community. After studying all the problems, the priorities are established and community action is planned. This involves a health service system which plans for improvement of water supplies, immunization, health education, control of specific diseases and it requires health legislations. Such health services are planned at individual level, family level, and at the level of community. It is also essential that healthcare is planned in such a way that it could be easily utilized by all and encourages people
to participate. Another positive feature of community action is that it brings coordination between voluntary organizations and government agencies engaged in overcoming similar problems.

11.3 FACTORS INFLUENCING COMMUNITY HEALTH :

Community health activities are activities that are aimed at protecting or improving the health of a population or community. These include activities such as maintenance of accurate birth and death records, protection of food and water supply, and participating in a vaccination drive. Community health depends on the interplay of a number of complex factors which exert their influence on the lifestyle of the individual. Some of them are beyond the control of the individual, while others are more amenable to personal manipulation. Four major interrelated determinants can be identified. They are:

Genetics :

Genetics is a very important determinant of health and it operates in several ways. Certain individuals are born with specific genetic abnormalities, which give rise to particular nutritional problems. It is well known that diabetes shows a familial tendency. Certainly, the children of two diabetic parents have about one in four chances of developing the disease at some stage of their lives. If only one parent is affected, the chances are reduced to about one in eight. You must have observed that obesity in children is also more common when the parents themselves are over-weight. In this case, environment also has an influence. Environment, lifestyle and nature of occupation may be responsible to predispose the

condition of obesity. Heart disease also exhibits familial tendencies. It would be reasonable to suppose
that there is an inborn susceptibility to specific diseases and that the manifestation and seriousness of these is a consequence of life experiences. The more negative factors present in the environment or personal behaviour patterns, the more likely the disease will occur.

Social and Cultural Factors :

Social factors are those that arise from the interaction of individuals or groups within the community. For example, those who live in the metropolitan cities, where life is too fast, experience higher rates of stress-related illnesses than who live in rural societies, where life is simple. Rural areas may not have the same quality of healthcare facilities which are available to the urban people. Besides factors, those cultural factors also influence community health. Culture includes the beliefs, traditions, and values. There are certain types of health beliefs which are present among the communities and they exercise them. The traditions of specific communities for seeking a particular type of treatment for particular type of health problem depict their health behaviour.

Economy of any country or in particular, the economy of the community also influences the health of its people and healthcare facilities. The growth of economy puts its resources towards the health budget and, in turn, it enhances the health of its people.

The National Health Policy by the government is an important political decision which is directly related to the health of the nation. More coverage of people for providing state health facilities is a government decision and in turn, it affects the health of the population.

A number of religions have taken a position on healthcare and health behaviours. For example, some religious communities limit the type of medical treatment their members may receive. Some religious communities do not permit immunization, contraception for family planning, and certain taboos for certain foods. Some religious communities actively address moral and ethical issues such as abortion, premarital intercourse, and homosexuality. Still other religious teach health-promoting codes of living to their members. Obviously, religion can affect a community's health positively or negatively.

The influence of social norms can be positive or negative and can change over time. For example, earlier smoking was accepted in the normal routine, however, by making it an offence in the public place, people have started looking down on a smoker. Thus, the numbers of smokers in the public places have gone down.

Physical Factors :

Physical factors are important in terms their effect on health. They include the influence of geography, the environment, community size, etc. A community's health problems can be directly related to its altitude, latitude, and climate. In a tropical country like, India where there is warm and humid temperature, parasitic diseases and infectious diseases are a leading community health problem. Survival from these diseases is made more difficult because poor soil conditions result in inadequate food production and malnutrition.

Environmental improvements such as better sanitation and education, availability of good food, lead to better health and a large proportion of the decline in mortality and morbidity of the country may be attributed to this. In some instances, environmental influences have been directly or indirectly detrimental to nutritional status. In case of nutrition, the environment provides a framework within which individual choice can operate.

The larger the community, the greater is the range of health problems. Larger population also poses a problem of scarce community resources, and which lead to the scarcity of food and healthcare facilities. The ability of a community to effectively plan, organize, and utilize its resources can determine whether its size can be used to good advantage.

Personal Health Behaviour :

Personal health behaviour denotes the individuals' choice related to health issues. Personal health behaviour is the ultimate decider of the food choices. Individuals will choose whether to smoke or drink, whether to take exercise or be immunized and so on.

The anti-health effects of personal behaviour can be seen to be manifested as:

- Adoption of undesirable health habits
- Rejection of healthcare and non-compliance
- Indirectly a creation of high risk environment

Inappropriate behaviour can lead to health problems. Hence, health education is directed as persuading people to act in their own best interests.

Socio-economic status is an important consideration in health, whether, a cause or consequence, it is linked with other major detriments. Poor mental capability may lead to reduced progress in education and subsequently restricts job opportunities. Lower income, in turn, will restrict food choice. Lack of education may affect personal decision making skills and contribute to underuse of services and bind more to traditions and beliefs. In order to control this, what is to be done? Should one make an attempt to control environment and services or should one concentrate on influencing personal behaviour?

Health Services :

Provision of health services will affect health status. For example, if no nutrition and health education is available, then people are not able to seek help for nutritional problems. It is likely that nutritional problems like vitamin A deficiency and non-deficiency continue to exist and the nutritional status of the community will be deteriorated. The nature of services whether preventive or curative is also important, otherwise mortality and morbidity rates among vulnerable segments of the community will be on the increase plane. One of the problems of services is that they are often underutilized by the people who would benefit from them most.

Basing services in the community rather than in the hospital may help to make them more accessible and, therefore, increased utilization.

11.4 INTRODUCTION TO PRIMARY HEALTH CARE :

Primary health care can be defined as an 'Essential Health care based upon practical, scientifically sound, and socially acceptable methods and technology that has been made universally accessible to individuals and families in the community through their full participation and at a cost that the country and the community can afford.' According to the Universal Declaration of Human Rights at the international level in 1948, 'Everyone has the right to a standard of living adequately for the health and well-being of themselves and their families.' The preface to the constitution of WHO, additionally declares that every individual has the privilege to appreciate the 'highest feasible standard of health'. The 30th World Health Assembly in May 1977 stated that 'the main social target of governments and WHO in the coming decades should be the fulfilment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life'.

11.5 COMPONENTS AND PRINCIPLES OF PRIMARY HEALTH CARE :

The components of primary health care system are:

- Educating people on current health problems and methods of preventing and controlling them
- Promotion of suitable nutrition and food supply
- Sufficient supply of safe water and basic sanitation
- Maternal and child health care, along with family planning services
- Vaccination against communicable diseases
- Prevention and control of endemic diseases
- Suitable treatment of common diseases and injuries
- Continuous supply of essential drugs

In the WHO–UNICEF global gathering at Alma–Ata (USSR) in 1978, the legislatures of 134 nations and various deliberate offices required a progressive way to deal with social insurance, proclaiming that the 'existing gross inequality in the health status of people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable'.

On the basis of that, there are four principles, which govern the primary health care:

I. Appropriate technology: Appropriate technology means 'Technology that is scientifically sound, adaptable to local needs, and acceptable to those who apply it and those for whom it is used, and that can be maintained by the people themselves in keeping with the principle of self-reliance with the resources the community and country can afford.' There is no point in utilising
expensive technology, when there are cost-effective and scientifically acceptable technologies available in the market.

II. Equitable distribution of resources: Everyone, despite their paying ability, must have equal access to healthcare services. In present scenario, the healthcare services are more concentrated in the urban areas instead of in slum areas, with vulnerable rural population, which leads to inequality. Therefore, the objective of PHC is to reach the balance by moving the focus of health system from urban areas to areas with more needy population.

III. Community participation: One of the fundamental factors of PHC is the association of people, their families, and communities to encourage them with respect to their own health and welfare. The general inclusion by PHC can't be accomplished, without the contribution and participation of the local community. One of the Indian methodologies to improve community participation is through the utilisation of village health guides and trained *Dais*. They are chosen by the local community and trained locally with the conveyance of PHC. By overcoming social and communication barriers, they provide PHC in manners that are acceptable to the community.

IV. Intersectoral coordination: In addition to health care sectors, PHC includes related sectors and areas of national and society advancement, particularly, horticulture, animal husbandry, food industry, training, education, public works, communication, housing, and others. The country may need to recheck its managerial structure and system, move their assets, and propose suitable enactment to guarantee coordination in order to achieve such co-ordination. An imperative part of it is also to plan with different sectors to avoid any redundancy of exercises or rework.

11.6 PRIMARY CARE: A NEW COURSE OF ACTION AND IMPLICATIONS :

In the WHO–UNICEF global gathering at Alma–Ata (USSR) in 1978, the primary health care system was emphasised, especially with regards to developing countries. It was stressed that the primary health care system should be considered as a first point of contact between a person and the health care system. It should be available and affordable for all, irrespective of the fact whether a country is developed or not. It was also concluded that when it comes to design and administration, health care personnel should work with other organisations and disciplines for complete national development. With primary health care system, there is a rapid increase in the number of practice nurses. Their role has also expanded from the traditional caring services to other sophisticated ones like chronic disease management, health promotion, new patient registration health checks, counselling, advice, investigation, treatment, and health assessments of elderly people.

The benefits of primary health care, especially with regards to economic is not easy to understand. This is because PHC's impact has been on broad scale and interrelated with other sectors, which makes it difficult to quantify it. However, an international study of thirteen high income countries with regards to primary care's strength concluded that strong primary care is connected to improved population health and lower health expenditure.

11.7 SUMMARY :

In the context of community health, a community is an aggregate of people who share certain common characteristics. Community is also related with a particular geographical location, race, ethnicity, age, and occupation who are having common interests for particular problems and having a common bonding. Personal health activities are individual actions and decision making that affect the health of an individual or his or her immediate family members. These activities may be preventive or curative in nature but seldom directly affect the behaviour of others. Community health involves motivation of the individual and groups to change their patterns of behaviour. In addition, it also seeks to plan medical care to achieve optimal health of the members of the whole community. Previously, the subject of community health was covered under Hygiene, Public Health or Preventive and Social Medicine. Community health activities are activities that are aimed at protecting or

improving the health of a population or community. These include activities such as maintenance of accurate birth and death records, protection of food and water supply, and participating in a vaccination drive.

Primary health care can be defined as an 'Essential Health care based upon practical, scientifically sound, and socially acceptable methods and technology that has been made universally accessible to individuals and families in the community through their full participation and at a cost that the country and the community can afford.' In the WHO–UNICEF global gathering at Alma–Ata (USSR) in 1978, the primary health care system was emphasised, especially with regards to developing countries. It was stressed that the primary health care system should be considered as a first point of contact between a person and the health care system.

11.8 KEY WORDS :

1. Public Health
2. Community Health
3. Health
4. Primary Health Care
5. Community

11.9 SELF-ASSESSMENT QUESTIONS AND EXERCISE :

1. Elaborate upon the social and cultural factors affecting community health?
2. Discuss the variations in the meaning of the term 'community medicine'?
3. What are the components of primary health care system?
4. Discuss the principles, which govern the primary health care?

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Prof. M. Trimurthi Rao

LESSON – 12

HEALTH EDUCATION AND COMMUNICATION

OBJECTIVE:

The objective of this lesson is to explain the objectives, principles, contents, communication in health education, approaches, barriers, approaches for removal of barriers to health education.

STRUCTURE:

12.1 INTRODUCTION:

Health education as a discipline is very much misunderstood both in its content and as a service for the individual and the community. It has got varying connotation ranging from public relation activity of the health department to transmission of information from health expert to lay public.

Health education is defined as a process that informs, motivates and helps people to adopt and maintain healthy practices and lifestyles, advocates environmental changes as needed to facilitate this goal and conducts professional training and research to the same end.

It is a process aimed at induction of healthful behaviour and de-learning of customs, prejudices and practices which are detrimental to health. Health education requires active involvement of people in achieving the goal of health.

Health education and communication form integral components of public health strategies aimed at empowering individuals and communities to make informed decisions about their health and well-being. Through targeted initiatives, these efforts seek to disseminate knowledge, foster positive behavioural changes, and enhance overall health literacy. In exploring health education and communication, we delve into the objectives, principles, contents, barriers, and approaches that collectively contribute to the promotion of a healthier society.

The primary objective of health education and communication is to impart knowledge and skills that empower individuals to make informed decisions regarding their health. By promoting awareness, disseminating accurate information, and encouraging healthy behaviours, these initiatives aim to prevent diseases, promote well-being, and contribute to the overall improvement of public health.

Several principles guide effective health education and communication efforts. Tailoring information to the needs and cultural context of the target audience is paramount. Additionally, engaging and interactive methods, such as community involvement, peer education, and multimedia platforms, enhance the effectiveness of communication. The principles also emphasize the importance of promoting equity, ensuring that health education reaches diverse populations, including those with varying levels of literacy and socio-economic backgrounds.

The contents of health education and communication programs are diverse, covering a wide range of topics such as nutrition, physical activity, mental health, disease prevention, and reproductive health. These contents are designed to address the specific needs and priorities of the target audience, providing practical information and skills that can be applied in everyday life.

Despite the potential benefits, various barriers can impede the success of health education and communication initiatives. Limited access to resources, low health literacy, cultural differences, and competing priorities are some of the challenges that need to be addressed. Overcoming these barriers requires a nuanced understanding of the target population and the implementation of strategies that consider the unique contextual factors influencing health behaviours.

Different approaches are employed to effectively deliver health education and communication messages. Community-based interventions, school programs, workplace initiatives, and online platforms are examples of diverse approaches that cater to specific settings and audiences. These approaches often involve collaboration between health professionals, educators, community leaders, and other stakeholders to ensure a comprehensive and tailored approach.

Health education and communication play pivotal roles in promoting public health by empowering individuals and communities to make informed decisions about their well-being. The objectives focus on knowledge dissemination and behaviour change, guided by principles that emphasize cultural relevance, engagement, and equity. The contents cover a broad spectrum of health-related topics, while barriers necessitate careful consideration of contextual factors. Approaches vary, incorporating community-based, school-based, and online strategies to ensure widespread reach and impact. Overall, an effective and holistic approach to health education and communication contributes significantly to building a healthier and more informed society.

12.2 OBJECTIVES OF HEALTH EDUCATION :

With these concepts health education has the following objectives.

1. **Informing people:** Reasonable understanding of birth, aging, death and disease is now available as a result research and discoveries in medical field. Knowledge about prevention of disease and promotion of health is also available from these

discoveries. Informing people about the knowledge of health promotion and health protection is the first goal of health education. Exposure to knowledge will create awareness of health problems, need for healthy life style and will also put responsibility on people for their own health.

2. **Motivating people:** Creation of awareness is not sufficient to expect people adopt healthy life style. People need to be motivated to change their habits and ways of life. These changes being behavioural changes, health education is similar to influencing a "consumer" to make his choice and decision but towards healthy actions and ways of life.
3. **Guiding them into action:** People need help to adopt and practice healthy life style, which may be totally new to them. To achieve this there is a need for creation of a setting from where health education can be disseminated. In other words, there has to be an infrastructure for health education and related services and people need to be encouraged to utilize these services.

12.3 PRINCIPLES OF HEALTH EDUCATION :

Education is a process to bring about change in behaviour. Like all behavioural processes, there are several psychological aspects of learning. Learning cannot take place unless the student wants it. The process of education involves the following steps:

- **Interest:** People are not likely to listen to something in which they do not have any interest. People will only have interest in issues that affect them, i.e., their "felt needs". In presence of low literacy as in our older population the "felt needs" may have to be aroused in minds of people by the health professionals before the process of health education starts.
- **Participation:** Education is best when there is active learning. Thus, participation of the learners in the process is key to success in health education.
- **Known to unknown:** Health education needs to be a gradual process. People start from the base line of their knowledge and proceed to gather new information, which must have a link to existing knowledge. New information makes understanding of problems easier.
- **Comprehension:** Health education must be in tune with the comprehending capacity of the learner. The learner must understand the meaning of all technical terms and the implications of the change in behaviour.
- **Reinforcement:** It is unlikely that the process of learning will be complete in the first occasion. Most people need to be told again and again at intervals for the desired result. It is especially true for older people.
- **Motivation:** Desire to learn is guided by motive, which being a secondary motive (primary motives are hunger, sex and survival) is usually guided by positive forces (reward) or negative forces (punishment). Every aspect of health education, therefore, must accompany a motivating factor for the best possible results.
- **Learning by doing:** The best way of learning is by doing. Every lesson of health education should include a practical component from which the subjects learn by doing the activity.
- **Soil, seed and sower:** For effective health education, the recipient (soil) must be receptive because of the felt need. The message on health (seed) must have a scientific basis. The medium of transmission (sower) must be attractive and acceptable.

- **Good human relations:** The personality of the health educator has important bearing on the process of learning. A friendly and sympathetic health educator usually gains the confidence of the learner and is likely to succeed in bringing about the desired behaviour change. In addition, it is well known that people tend to follow peers and leaders. Endorsement of a health campaign or an educational activity by a community leader or popular personality often achieves much better results than other means.

12.4 CONTENTS :

Contents of health education are often very wide and require to be oriented towards the recipient's felt needs. The contents of a health education programme for older people should include**:**

- **Human biology:** The older subject and their family should be informed about the biological changes in structure and function of the body in relation to aging. They must also be informed about the difference between age-related changes and pathological states.
- **Family health:** Information regarding human growth and development needs to be included in the message to provide a correct perspective of human aging.
- **Nutrition:** Health educator must guide older people and their family to understand the principles of balanced diet, nutritive value of food, value for money spent on food, storage, preparation, cooking etc. In addition, older people need to know about the food that improves their bowel movement, protects against disease and improves health.
- **Hygiene:** Education on hygiene should be about personal hygiene and environmental hygiene. Education on personal hygiene should include information on bathing, clothing, toilet, washing of hands before eating, care of feet, nails and teeth; prevention of indiscriminate spitting, coughing and sneezing; and inculcation of clean habits. Education on environmental hygiene should include information on maintaining clean home, need for fresh air and light, ventilation, hygienic storage, disposal of waste, sanitation, disposal of human excreta, food sanitation, vector control etc. Though creation of hygienic environment requires mobilization of resources in the community, the role of the individual in maintaining the environmental hygiene cannot be neglected.
- **Control of communicable and non-communicable disease:** Information on common communicable and non-communicable diseases specific to old age and as well as all age groups needs to be included in health education because older people are often consulted for their wisdom in all matters of health and diseases.
- **Mental health:** Cognitive and affective disorders are extremely common in older subjects. In addition, there has been a rise in mental illness in the general population also. Older people need to be educated regarding adjustment to their changing role in family and community as a result of old age and retirement. In addition, education regarding dementia, depression, anxiety and bereavement needs to be provided.
- **Prevention of accidents:** Modern day life has very high risk of accidents and disasters. Older people are especially vulnerable to accidents and their complications because of their physiological decline and higher risk of fractures and life-threatening injury.
- **Use of health services:** Older people need to be educated to use the health services available in the community to the maximum extent. They must also be encouraged to

participate in national health programmes designed to promote health in old age and prevent disease.

12.5 COMMUNICATION IN HEALTH EDUCATION :

The basis of education is communication i.e. transferring information to the learner to bring about behaviour change. The components of this process of communication include communicator or the health educator who must have clear knowledge about the:

- subject of education
- objectives to be achieved at the end
- audience
- methods of communication

The theme or message in education must be:

- in tune with the objectives of education
- in tune with the "felt needs" of the audience
- clear and understandable
- timely and appealing

The characteristics of the recipients or audience greatly influence the total communication process. The socio-cultural nature, the psychological make-up to grasp the message and past experience of the recipient with such information determines the ultimate impact of the exercise on change in behaviour.

There are several means of transmitting the message. Each method has its advantage as well as disadvantage. Approaching each individual directly carries greater value compared to indirect mass approach in terms of impact but requires larger resources. Two-way approach clears doubts in the mind of the recipient but again requires greater time in comparison to one-way approach of mass contact. Informal methods *are* more appealing but the message can be lost in between the discussion whereas formal approaches carry importance and are effective.

The medium or channel of communication is an important factor in determining the effectiveness of communication. It depends on the nature of message, the size of the audience, the time at disposal, the speed of communication and the cost of communication.

The communication can be through non-verbal visual method that is through printed words, diagrams and pictures, gestures, symbols etc. Certain degree of education and intelligence is required on the part of the recipient for its effectiveness. The media also needs to be attractive to catch attention.

Verbal communication is made through the use of audio and audio-visual medium. No educational or intellectual pre-requisites of the recipient are required in verbal communication.

Use of audio-visual aids improves effectiveness of communication and health education. These include:

a) **Auditory aids:** radio, microphone, tape-recorder, amplifier etc.
b) **Visual aids:** chalk-black boards, leaflets, posters, charts, models, specimens, exhibits, filmstrips, slides.
c) **Audio-visual aids:** television, video-films, films.

Each of these media has advantages and disadvantages. Though audiovisual aids improve the impact of the message, what really matters in terms of impact is the content of the message.

12.6 PRACTICE :

Health education can be carried out at three levels-individual and family, group, and population.

Individual and family approach: The individual and family can be given health education at all points of their contact with health care system at each level (primary, secondary and tertiary) and by any health professional (doctor, nurse, health worker, etc.). At the time of disease and illness, the individual and the family is extremely receptive to advice on diet, causation and prevention of disease, immunization, personal hygiene, environmental hygiene, etc. While working with individual and the family it is important that the health educator gains the confidence and creates an atmosphere of friendship and trust. The learner can be encouraged to discuss, argue and ask questions so that the impact of education on behaviour is maximal and can lead to effective change. The limitation of individual and family approach is that only small number can be educated by this method including those who reach the system.

Group approach: There are several groups in the society e.g. school children, mother, industrial workers, office workers, pensioners, patients etc. Educating the group on health-related matter is an effective method. However, the topic of health education to each group is different. To achieve the best result the topic and the medium must be chosen carefully. The methods of group teaching can be through:

- Lecture and speech to small groups using films, charts, flash cards and exhibits.
- Group discussion with encouragement to express ideas clearly, listening to others, criticizing a new concept and reaching a conclusion.
- Panel discussion with 4 to 8 speakers addressing a topic with participation of the audience.
- Symposium of a series of lectures by different people on one or more related topics.
- Workshop involving experts and participants to carry out group discussion and make plans.
- Role' playing and simulated exercise
- Demonstration

Population approach: Health education of the population by using mass media is a very useful method. The mass media used for health education are: television, radio, print media (newspapers and periodicals), film, posters, pamphlets, booklets, direct-mailing, health exhibition and museum and folk media.

Mass media is not a very effective medium for achieving change in behaviour as the communication is always "one-way". However, these are useful in creating public awareness and providing information.

12.7 BARRIERS

There are several barriers to a successful educational programme. Some common barriers are the following:

a) **Physiological:** The older person may not be able to hear or see the educator or may not understand the expressions due to impaired cognition.
b) **Psychological:** The older person may not be in a receptive state of mind due to depression, anxiety or inability to concentrate.
c) **Environmental:** The learning place may be situated at a great distance which the older person may not be able to travel due to lack of transport or inability to walk. The learning place may be noisy, congested, poorly lighted and may be inaccessible for the older person which prevents active participation.
d) **Socio-cultural:** The greatest barrier to learning comes from socio-cultural issues such as level of education and understanding, religious beliefs, customs and taboos. Misconceptions about ill health and old age as unavoidable part of life are other barriers to learning.
e) **Attitudinal:** Lack of faith in health services, denial of health needs and apprehensions about the service are serious barriers to learning.

12.8 APPROACHES FOR REMOVAL OF BARRIERS TO HEALTH EDUCATION :

a) **Identify the problem:** It is essential that the health educator identifies the nature and the extent of the barrier by assessing the altitude towards health and observing the health practices in the family and the community.
b) **Options:** The health educator should then consider various options to overcome the barrier.
c) **Choose option:** From various options the educator chooses one and defines a strategy to carry the chosen option.
d) **Identify largest group:** The largest group in the target population is identified and the strategy is applied.
e) **Assess:** The health educator assesses the impact of the programme and reviews the strategy to improve its effectiveness.

12.9 SUMMARY :

In conclusion, health education and communication emerge as indispensable tools in the pursuit of public health and community well-being. Through the multifaceted lens of objectives, principles, contents, barriers, and approaches, these initiatives aim to empower individuals with the knowledge and skills needed to make informed decisions about their health. The overarching objective of health education and communication, centred on promoting awareness and encouraging positive behavioural changes, aligns with the broader goal of disease prevention and health improvement.

Guided by principles emphasizing cultural relevance, engagement, and equity, these initiatives strive to bridge gaps in health literacy and cater to the diverse needs of communities. The rich and varied contents of health education and communication programs,

spanning nutrition, physical activity, mental health, and disease prevention, reflect a comprehensive approach to addressing the holistic nature of individual well-being. Tailored to specific populations and contexts, these contents equip individuals with practical information that can be applied to enhance their overall health. However, the effectiveness of health education and communication is not without challenges. Barriers such as limited resources, low health literacy, and cultural differences necessitate thoughtful strategies to overcome obstacles and ensure the inclusivity of health initiatives. Recognition of these barriers is crucial for designing programs that are responsive to the unique needs of diverse populations. The diverse approaches employed in health education and communication, including community-based interventions, school programs, workplace initiatives, and online platforms, underscore the flexibility and adaptability required to reach varied audiences. Collaborative efforts involving health professionals, educators, community leaders, and stakeholders amplify the impact of these initiatives and contribute to building a culture of health at different levels. In essence, the field of health education and communication represents a dynamic and evolving landscape that holds immense potential for fostering positive health outcomes. By addressing the complexities of health-related challenges through informed, culturally sensitive, and engaging strategies, we pave the way for a more enlightened and empowered society. As we continue to refine and expand these efforts, the cumulative impact on public health can be transformative, creating a future where individuals and communities are equipped to thrive through informed health choices and behaviours.

12.10 KEY WORDS :

1. Health education
2. Healthy lifestyle
3. Communication
4. Change in behaviour
5. Barriers

12.12 SELF-ASSESSMENT QUESTIONS :

1. Enumerate the contents of a health education programme.
2. Explain the components of communication.
3. Examine the barriers in health education.

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Prof. M. Trimurthi Rao

LESSON – 13

HOSPITAL AS A SOCIAL SYSTEM

OBJECTIVE:

The objective of this lesson is to explain the hospital as a social system, organization, structure and functions.

STRUCTURE:

13.1 INTRODUCTION :

The hospital, beyond its role as a medical institution, functions as a complex social system intricately woven into the fabric of society. As a social system, the hospital is not merely a physical structure where medical care is provided; rather, it is a dynamic organization shaped by social interactions, hierarchies, and cultural influences. This perspective allows us to examine the hospital not only as a healthcare provider but also as a social entity with organizational structures, functions, and a profound impact on the community it serves.

At its core, a hospital is an organization, a structured entity designed to deliver healthcare services to individuals in need. The organizational aspects of a hospital encompass a hierarchy of roles, responsibilities, and departments, creating a system that functions collaboratively to fulfill its healthcare mission. Understanding the hospital as an organization allows us to explore the intricate relationships among healthcare professionals, support staff, and administrators, each contributing to the overall functioning of the institution.

The structure of a hospital is a critical aspect that determines how it operates and interacts with its environment. This includes physical layout, departmental organization, and the distribution of resources. Examining the structure of a hospital provides insights into how spaces are allocated for patient care, administrative functions, and specialized medical services, shaping the overall patient experience and the efficiency of healthcare delivery.

The functions of a hospital extend far beyond the provision of medical treatment. Hospitals serve as hubs for diagnosis, treatment, and rehabilitation, and they play a vital role in medical education, research, and public health initiatives. The multifaceted functions of hospitals highlight their significance not only as places of healing but also as institutions

contributing to the advancement of medical knowledge and the well-being of the broader community.

In the context of modern Indian hospitals, the organizational landscape reflects a blend of traditional practices and contemporary healthcare systems. Modern Indian hospitals are characterized by a diverse range of services, advanced medical technologies, and a commitment to providing holistic healthcare. The organizational structure often mirrors global standards, with specialized departments, professional hierarchies, and a focus on patient-centred care. However, the cultural and socio-economic diversity of India also influences the organizational dynamics, leading to unique challenges and innovations in healthcare delivery.

In examining hospitals as social systems, organizations, and structures, we gain a comprehensive understanding of their multifaceted roles in society. Beyond being medical facilities, hospitals are social entities shaped by cultural, organizational, and structural elements. Recognizing hospitals as integral components of social systems prompts a deeper exploration of their impact on individuals, communities, and the broader healthcare landscape.

13.2 HOSPITAL AS A SOCIAL SYSTEM :

In a social system, the elements are human beings or social groups interacting with each other. When interactions are directed towards the fulfilment of certain goals, they are patterned and there exists an ordered relationship, they interact with each other for facilitating their counterparts, and there is a motivational force which operates along with the aforesaid factors the social structure may be termed as a social system. The various sub-systems of a social system may also be seen as a social system. For studying any social system, the boundaries of the social system interact with several other social systems and are greatly affected by these other systems and thus there is a systemic linkage.

Sorokin (1951) views social system as an organization that possesses a set of enforced, obligatory norms defining in details the rights, duties, social positions and functions, roles and proper behaviour of each and all its members towards one another, outsiders and the world at large; a set of prohibited actions-relations sanctioned by punishment, and a set of recommended non-obligatory norms of conduct. According to him, “the social system is composed of the patterned interaction of members. It is constituted of the interaction of plurality of individual actors whose relations to each other are mutually oriented through the definition mediation of pattern of structured and shared symbols and expectations.” There needs to be an organized social structure, the functioning of which will form the social system. There can be various structural components of the social system. Parsons (1959), states, “a social system may be analyzed on four levels of generality so far as its units are concerned:

1. Individuals in roles are organized to form what we call collectivities i.e. individuals are considered as a whole group.
2. Both roles and collectivities, however, are subject to ordering and control, by
3. Norms which are differentiated according to functions of these units and to their situations, and by
4. Values which define the desirable kind of system of relation.

13.3 HOSPITAL AS AN ORGANIZATION :

Hospitals are typically large institutions with a diversity of activities and personnel within them. While the hospital is chiefly a setting for medical practice, it has, by virtue of being an organization, many characteristics of its own. Hospitals have been analyzed from a variety of perspectives, but sociological work has focused on the hospital as a social organization, drawing on general sociological work on organizations, and on the experiences of patients and staff (Morgan et al., 1985).

As other work organizations in modern society, the hospital displays many of the attributes of bureaucracy that were delineated by Max Weber (Gerth and Mills 1946). It is a rational organization with an elaborate, systematic division of labour and a high degree of specialization of structure according to a principle of hierarchy, and governed by impersonal roles and norms.

The hospital, however, differs from the Weberian paradigm in several aspects which causes conflict and further limits the efficiency of the hospital's performance as an organization. One of these aspects is attributed to the fact that the functioning and governance of the hospital is premised on a number of parallel lines of professional authority (Perrow, 1965). Each of the numerous professional groups in the hospitals has its own department and set of services with varying amount and styles of control over its specialized work. There are also paramedical professionals and call professionals under its supervision. These include physicians, nurses, technicians, social workers, clerks just to name a few. An organization with weak internal structures and high complexity is hypothesized to be more informal than bureaucratic, rely more on mutual negotiations than on administrative fiats to coordinate and control action and have a more pluralistic symbolic culture (March and Olsen, 1979).

Hospitals have changed more dramatically than any other kind of corporation, from small philanthropic endeavours to the centre of complex health services. They have grown in size, complexity, and technology and are even considered as a big business (Rakich and Darr, 1978). However, hospitals are different from other complex organization in terms of their nature of work particularly in terms of human relations. Following are the features of hospital organizations:

- The first goal of the hospital organization is the welfare of the patient whereas in others it might be corporate profit. Since health is the right of every individual, therefore, the profit making motive of the organization in case of hospital is minimal. Public interests supersede profit-making. Hospital owes its responsibility towards society. In the actual situation, there is a diversity of goals and aims of different personnel and subsystems within hospitals' organization. Sometimes, there are situations when patient care, research activities are contradictory and it gives rise to conflicting situations in the hospital organization.
- Hospital organizations are often called bureaucratic organizations where there is rank and file system. The hospital organization has formal and written rules and regularities and there are formal procedures to control its members. For example, each hospital displays the duty chart of doctors, nurses and other personnel. It is mandatory for each patient to give his/her consent before an operation and medication cannot be released simply on the will of the patients. Paradoxically, the hospital is in continuous operation (Fox, 1989). Automatically, this requires the high cost which in turn, hampers the efficiency of bureaucratic system.

- The hospital is a 'people-centric' organization where the goals are linked to individuals working in the organization, therefore, the technology cannot replace the people who are working. The working force of the hospital requires integrity, skills, motivations and behaviours of its members to achieve the goal of the hospital for patients' care. Despite the drastic change in modern complex organizations and growth of technological innovations in medical practice, the working force of people of hospital cannot be replaced by machines. At the same time, hospital organization has all sorts of working people ranging from cleaner/sweeper to the highly specialized surgeon. To coordinate the work of all these personnel, coordination is required and that is termed as hospital management.
- Hospital organization does not have a single line of authority. Many studies have investigated the power structure of hospitals and found that there are 'dual lines of authority' or 'power in triad' (Mishler, 1981; Taylor, 1975). Administrators are responsible for managing the administrative problems, physicians for patient care, researchers are for research in their respective area, etc. Each group of personnel has its own norms, communication network, and hierarchies. However, professionals, like doctors, possess a certain degree of independence and autonomy in their work. Besides that there are situations of conflict between senior and junior doctors, between matron and nurses, etc. Theoretically, this arrangement permits a sharing of power among the groups, but one of them may dominate the organization depending on particular problems or tasks that the hospital must emphasize at any given time (Perrow, 1986).

Thus, to conclude, that the hospital organization has generic conflicts, i.e. conflicts which are characteristic to hospitals. These conflicts sometimes help in solving the potential problems in advance. Since hospitals deal with the problem of life and death situations, therefore, the hospital organization cannot afford to allow any sort of negligence in dealing with the patients. Thus, in all hospitals, organization is always under the pressure of physical and psychological stress. Recently, there is a growth of corporate culture in the hospital organization.

Although corporate culture is a Western concept, but more and more corporate hospitals are developing in other parts of the world. It is necessary to understand the corporate culture. Corporate culture is diverse, but it is defined as "patterns of belief or shared meaning, fragmented or integrated, and supported by various operating norms and rituals which exert a decisive influence on the overall ability of the organization to deal with the challenges that it faces (Morgan, 1986)". In the previous approaches of hospital organizations, the normative element, which includes customs, and cultures are more important. However, with the growth of corporate sector, the hospital organizations are also affected by corporate culture.

13.4 STRUCTURE AND FUNCTIONS OF A HOSPITAL :

For the functioning of a hospital organization, a few functional pre-requisites are essential. Parsons' social system model deals with four functional problems: (1) Adaptation, (2) Goal attainment, (3) Pattern maintenance and tension management, (4) Integration. Loomis (1960) described and analyzed social system in terms of nine elements: (1) Belief, knowledge, (2) Sentiments, (3) End goal or objective, (4) Norms, (5) Status and role, (6) Rank, (7) Power, (8) Sanction, and (9) Facility. He has summarized his views in a Personality Articulated Structural Model. He, like Parsons, prescribes social conditions for action.

Georgopoulos and Matejko (1967) have studied complex social system in terms of six problem areas:

1. Organizational goals, member goals and their attainment
2. Availability and allocation of organizational resources
3. Organizational coordination
4. Social interaction
5. Intra-organizational strains and conflicts resolution
6. Organizational adaptation

The major functional dimensions of hospital organization or social system are discussed below:

- **Goal attainment:** The goal of a hospital is to provide medical care. It includes doctor's role performance, healthcare, patient satisfaction, and patient care. Doctor's role performance helps in providing proper medical care and these results in higher patient satisfaction.
- **Tension management:** The process of tension-management is important for internal stability of the hospitals. Tension management includes variables like criticism, harassment, appreciation, and trust. It could be seen that avoidance of criticism and harassment were significantly correlated with appreciation and trust in the work-groups.
- **Professional growth:** In case of professionals, learning is very important. Professional learning, use of abilities, work-motive and management of problems constitute the professional growth of the doctors.
- **Member goals:** The goals of hospital functionaries appear to be different from organizational goals. The member-goals are mainly individualistic and related to pay, promotions, working hours and benefits.
- **Work environment:** The work is determined by reputation of the hospital, working hours, liking for work and work group, guidance, etc. If the hospital performs well in these variables then that hospital is rated good.
- **Adaptation:** The adaptation factor is important for adjusting with external environment. The variables noticed are: use of improved work methods, fulfilment of community needs, clarity of rules, and use of abilities.
- **Assistance:** The role performance of paramedical staff and auxiliary staff plays an important part in functioning of the hospital social system. The variables which cluster in this factor specially relate to the role for sweepers and nursing professionals, work according to rules and management of problems. In professional organizations assistance provided by subordinate staff seems to play an important role.
- **Involvement:** This factor related to the involvement of hospital employees in the hospital social system. The clustering of items related to work encouragement, desire to continue working in the same hospital, help by superiors and avoidance of conflict.
- **Coordination and integration:** The variables which have high factor loadings are: avoidance of conflicts, inter-departmental coordination, and timing of everyday activities, and nurses' role performance.
- **Values:** Values are related with values of the hospital functionaries. The values governing superior-subordinate interaction, trust, directions and appreciations have high correlation with good hospital.

13.5 FUNCTIONS OF A HOSPITAL AS A UNIT :

Hospitals are among the most complex organizations in modern society, characterized by extremely fine division of labour and an exquisite repertory or collection of technical skill. The major hospitals embrace multiple goals, chiefly patient care, teaching, and research. It is at once a hotel, a treatment centre, a laboratory, a university. Because the institution's work is so specialized, staffed by a variety of professional and technical personnel, there are very important problems of co-ordination and authority.

Paramount in the social structure are relationships between patients and hospital staff and among staff members. The patient, both client and product of the organization, enters a therapeutic situation in which his style is largely passive. He/she encounters the physician—like himself, a 'guest' of the hospital—and the nurse, who is the full-time symbol of the organization's atmosphere. The physician is undergoing a shift from his/her older charismatic role toward a more nearly bureaucratic niche in the hospital. Staff relationships are distinguished by unclear patterns of authority and intense competition for spheres of competence and prestige. The physician is implicated as the professional least amenable to hierarchical control and the leading figure in skill and status. Although the hospital illustrates vital, unresolved issues in the organization of work, it flourishes under the impetus of professional zeal and patients' needs.

13.6 ORGANIZATION OF MODERN INDIAN HOSPITALS :

Hospitals in India are replicas of the Western hospitals in almost all aspects. The misappropriate grafting of hospitals in India has eventually given rise to many ambiguities in the medical as well as in the socio-cultural fields. The hospital as an institution in India is the apex of modern medical system which is subserved by dispensaries, primary health centres and sub-centres all over the country. Hospitals in India are a welcome diffusion for a handful of urban patients and for many rural patients.

A patient who is not accustomed to undergo a sick role and that too in a totally new atmosphere, cannot be the real beneficiary of the hospital. This is the case at least in most of the cases. The bureaucratic set up of the hospital has been spoiled by preferential treatment. The hospitals in India are running with below average staff, doctors and other medical requirements. In other words, the managerial administrative atmosphere is 'sick'. The hospitals are not taking other smaller medical institutions as complementary to the comprehensive healthcare process; rather these are expected to act as subservient to the hospital.

13.7 SUMMARY:

In conclusion, viewing the hospital as a social system unveils its intricate role in the fabric of society, extending beyond a mere healthcare facility to a dynamic organization shaped by social interactions, structures, and functions. Understanding hospitals as organizations underscores the complexity of their internal hierarchies, roles, and responsibilities, emphasizing the collaborative efforts of healthcare professionals and support staff in delivering comprehensive medical care. Examining the structure of hospitals provides insights into the physical layout, departmental organization, and resource distribution, influencing the overall efficiency of healthcare delivery and the patient experience. The multifaceted functions of hospitals, encompassing diagnosis, treatment, education, research,

and public health initiatives, highlight their pivotal role in advancing medical knowledge and contributing to the well-being of communities. In the context of modern Indian hospitals, the blend of traditional practices with contemporary healthcare systems reflects the unique healthcare landscape of the country.

While these hospitals adhere to global standards in terms of organizational structures and specialized services, they also navigate the challenges and opportunities presented by India's cultural and socio-economic diversity. Recognizing hospitals as social entities prompts a holistic understanding of their impact on individuals and communities. Beyond their immediate role in healthcare, hospitals serve as hubs of learning, research, and community well-being. This perspective encourages ongoing exploration and adaptation in response to the evolving needs of society, fostering a continuous commitment to improving healthcare delivery and addressing the diverse health challenges faced by individuals and communities. Ultimately, the hospital as a social system stands at the intersection of medical care, organizational dynamics, and societal influences, playing a vital role in shaping the health and well-being of populations.

13.8 KEYWORDS :

1. Hospital
2. Social system
3. Organization
4. Indian hospitals

13.9 SELF ASSESSMENT QUESTIONS :

1. Discuss Hospital as a Social System.
2. Explain Hospital as an Organization.
3. Examine Structure and Functions of a Hospital.
4. Describe the functions of a hospital as a unit.
5. Examine Organization of modern Indian hospitals

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Prof. M. Trimurthi Rao

LESSON – 14

NORMAL AND ABNORMAL PSYCHOLOGY- DEFINITION AND CONCEPT

OBJECTIVE :

The objective of this lesson is to explain the definition and concept of normal and abnormal psychology.

STRUCTURE :

14.1 INTRODUCTION :

Normal and abnormal psychology constitute foundational concepts within the field of psychology, offering insight into the vast spectrum of human behaviour, emotions, and mental processes. These terms, while subjective and culturally influenced, serve as crucial frameworks for understanding and categorizing psychological phenomena. In exploring normal and abnormal psychology, we navigate through the definitions and concepts that underpin the diverse and complex range of human experiences.

Normal psychology refers to the study of typical or expected patterns of behaviour, emotions, and cognitive processes within a given population. It involves understanding how individuals' function in their everyday lives, exploring healthy psychological development, and identifying the norms and standards that characterize typical human experiences. Normal psychology provides a baseline for assessing mental well-being, allowing psychologists to explore the commonalties and variations in human thought and behaviour.

Conversely, abnormal psychology focuses on atypical patterns of behaviour, emotions, or cognition that deviate from the norm and may indicate mental health challenges. Abnormal psychology delves into the study of psychological disorders, exploring the causes, symptoms, and treatment options associated with conditions that disrupt an individual's functioning or well-being. It recognizes the diversity of human experiences and seeks to understand and address deviations from expected psychological norms.

The concepts of normal and abnormal psychology are dynamic and subject to cultural, societal, and historical influences. What may be considered normal in one cultural context could be viewed as abnormal in another. Additionally, evolving societal attitudes and advances in psychological research continually shape our understanding of these concepts, challenging previously held assumptions and expanding our knowledge of the human mind.

As we explore the definitions and concepts of normal and abnormal psychology, it is essential to recognize the fluidity and context-dependent nature of these terms. Individuals vary widely in their experiences, and psychological health exists on a continuum. Moreover, cultural diversity contributes to the complexity of defining normalcy and abnormality, emphasizing the importance of cultural sensitivity in psychological assessments and interventions.

The concepts of normal and abnormal psychology provide frameworks for understanding the range of human experiences and mental well-being. Normal psychology explores typical patterns of behaviour and cognition, serving as a reference point for understanding healthy psychological functioning. Abnormal psychology, on the other hand, focuses on deviations from the norm, delving into the complexities of psychological disorders and the factors influencing their development. As our understanding of these concepts evolves, so too does our ability to support individuals in navigating the rich tapestry of human psychological experiences.

14.2 DEFINITION OF NORMALITY :

'Normality' has, at various times and by different people, been defined in a number of ways.

Sociocultural normality

Every society has its own characteristic pattern of normal behaviour and beliefs. A definition of sociocultural normality embraces the rules, or norms, governing what are considered appropriate in a particular society. What is considered normal dress in a Western society is not appropriate dress in a traditional Islamic society. In some cultures, it is quite common to eat dog. In others, cannibalism is practised. Neither of these foods are part of a normal diet in contemporary Australia.

Functional normality

Mental health professionals often use the term normality to describe an individual who has a useful and satisfying life without causing harm to others or suffering from personal distress. If a person can function within their society, they are considered to be .

Every person on the planet has a brain, a nervous system that guides their behaviour, commonly referred to as personality, and mental abilities, which are typically known as intelligence. Despite these commonalities, every individual in the world possesses unique characteristics that set them apart from others. Therefore, it is challenging to precisely define the concept of normality in contrast to abnormality. However, there are certain characteristics that can be associated with normal behaviour, reflecting individual well-being. Measuring normal behaviours presents many challenges, as the term 'normal' is often used in a narrow context concerning beliefs, emotions, relationships, conflict, leadership, performance, and more. In psychological terms, normality refers to individual behaviour that aligns with the most prevalent behaviour in society. The difficulty in reaching a consensus on what constitutes normal behaviour arises from the fact that normality depends on various factors contributing to the common well-being in society, rather than being self-imposed or absolute.

14.3 DEFINITION OF ABNORMALITY :

Abnormality is known as unusual patterns of behaviour, emotion, and thought. It can be understood as a potential indication of a mental disorder, as it represents behavioural characteristics which they are associated with conditions that may point to a mental and/or

psychological disorder. Therefore, abnormal actions are unexpected because they are deviate from typical or usual behaviour. There are several criteria to consider when examining what constitutes typical or usual behaviour, because as it is not uncommon for all people to exhibit certain forms of prolonged behaviour. Consequently, definitions of abnormality vary due to the different methods of defining it, including statistical infrequency and deviation from social norms. In short, Abnormality refers to dysfunctional and socially deviant behaviours but there are many mental health professionals use different elements from multiple areas. However, psychoanalytic suggests that abnormal behaviours stem from unconscious thoughts, desires, and memories.

14.4 CONCEPT OF NORMALITY AND ABNORMALITY :

The term normal comes from the Latin word, 'norma', a 17th century Latin word which literally means 'carpenter's square', or right angle, whereas the term, 'normalis' derived from 'norma' means 'made according to a carpenter's square.' In the 19th century Latin, 'norma' meant rule or pattern and the term 'normalis' meant confirming to rules, common standards, regular, usual. So, since 19th century, the term 'normal' in English derived from the Latin term, 'normalis' means confirming to rules, standards, or a pattern. The term abnormal comes from a summation of two Latin terms ab+norma, where ab means off, away from, deviate and norma means rule so 'abnormalis' in Latin means deviating from a fixed rule or irregular. So, its English derivative, abnormal means not conforming to rule, deviating from a type, standard, contrary to system or law, irregular, unnatural.

Thus, normality implies confirming to rules, standards, patterns, whereas abnormality means deviation from rules, standards. When you say, "Oh! She is abnormal as she is behaving absurdly"; "Come on, it is normal for him to cry if he has lost his beloved pet", who sets these rules and standards? It is individuals as members of groups, community, and society who set the rules or standards to be followed by all the members.

However, since these are value-laden terms, what may be considered, 'normal' by some people may be considered as 'abnormal' by others and vice versa. This becomes more challenging as not only the subject matter of the field of abnormal psychology, but also its very nomenclature depends on the clear distinction between normality and abnormality. Experts agree that it is almost impossible to discuss abnormal behaviour (psychopathology) without the framework of values. Hence, it has been suggested that values should be explicitly put forth while defining normality and abnormality. Let us consider the concepts of normality and abnormality defined by various experts in the following section:

(1) Criteria of Normality

Sheldon J. Korchin (1986) has based his views of normality on the survey conducted by Offer and Sabshin (1966) on the varied meanings of normality in the different fields of study such as psychology, anthropology, sociology, and psychiatry:

- **Normality as Health**

It means absence of sickness is normal. Thus, a person who does not have any pathology, i.e., who is symptom-free and is not hospitalized or underwent treatment is normal. It implies that most of the people are normal, while only some are abnormal.

● Normality as Ideal (Utopia)

It goes a step further from viewing normality as health, i.e., as being symptom free. It says that normality does not mean, 'only being free from disease but it means achieving the ideal state, such as Roger's fully functioning person, or Maslow's self-actualized person, or Allport's mature personality. However, you must have noticed the term, 'utopia' in parentheses. Utopia means an imagined place or state of thing in which everything is perfect or ideal. This raises another question, i.e., what is perfect or ideal? There is no clear-cut and single answer to this question, as what is perfect for one person may not be so for another. People's values define 'perfect' or 'ideal' state. Since values entail biases so is has not been possible to conclusively define the ideal or perfect state. Thus, being in an ideal state is imaginary and impossible to achieve. Freud, therefore, has referred to normality as ideal fiction. Nevertheless, it is an important criterion as the goal of psychologist is to help people achieve health and optimum level of functioning.

● Normality as Average

Nature tends to distribute a given attribute or phenomenon in the world in such a way that most of the cases representing that attribute have similar values, while only a few cases have extreme values. If a mean or average is calculated of these values, then most of the cases tend to cluster around the mean, while those with extreme values tend to fall away from the mean or average. In statistics, such a distribution of cases is known as normal distribution and is graphically represented by a bell-shaped curve, called the normal probability curve. The cases clustering around average are conceptualized as normal while the cases at the extreme as abnormal.

According to statistical theory, cases clustering around average are normal while the cases falling away from average at either side are abnormal. Moreover, the farther away a case is from average, the more abnormal it is.

Statistical description is believed to be scientific. However, it is not value free since we do not describe both the extremes equally as abnormal. For example, a person can have an IQ, which deviates from average on either side of the normal probability curve, i.e., it can be significantly above or below average, but we describe only the IQ significantly 'below' average as abnormal. Nonetheless, the concept of normality as average is utilized widely in clinical practice for diagnosis and assessment.

● Normality as Socially Acceptable

Social norms determine normality, i.e., behaviour which confirms to the social norms is normal. This implies that we should neither seek not accept the universal definitions of normality. Rather, normality is a socially specified concept. According to Ralph Linton (1956), "The tests of absolute normalcy are the individual's ability to apprehend reality, as understood by his society, to act in terms of this reality, and to be effectively shaped by his society during his developmental period. The test of relative normalcy is the extent to which the individual's experience has given him a personality conforming to the basic personality of his society."

In 1930s anthropologists gave the concept of cultural relativism to describe the role of society in defining the normal behaviour of an individual. According to cultural relativism, what may be considered as normal in one society may be considered as abnormal in another

society, e.g., possession by a goddess is normal in some Asian societies while it may be considered as a mental disorder by western societies. A problem, however, in defining normality as socially acceptable is that it entails a risk of encouraging conformity and non-conformity as a criterion for normality and abnormality, respectively. Conformity to social or cultural norms is taken as a sign of normality, however, rigid conformity may be pathological. For example, rigid conformity to social norms laid down by an autocrat is pathological, whereas non-conformity to such behaviour is normal.

This has been clearly illustrated by Milgram's classical study. In his study, Milgram showed that the participants were ready to give electric shocks (participants were made to believe that they were giving actual electric shocks) to the other participants (confederates) in the other room despite listening their screams. Most of the participants showed conformity to the researcher's instructions even if it meant hurting others. Very few participants showed non-conformity. Thus, we can see that conformity to social norms may not always be 'normal'.

● Normality as a Process

Normality defined as a process defines it temporally. That is, over the time, as an individual passes through different developmental phases, his/ her behaviour is evaluated according to the given phase. Thus, babbling is considered to be normal for an infant, but as an abnormal behaviour for a 5-year-old child or for an adult.

DEFINING NORMALITY :

'Normality' has, at various times and by different people, been defined in a number of ways.

Sociocultural normality

Every society has its own characteristic pattern of normal behaviour and beliefs. A definition of sociocultural normality embraces the rules, or norms, governing what are considered appropriate in a particular society. What is considered normal dress in a Western society is not appropriate dress in a traditional Islamic society. In some cultures, it is quite common to eat dog. In others, cannibalism is practised. Neither of these foods are part of a normal diet in contemporary Australia.

Functional normality

Mental health professionals often use the term normality to describe an individual who has a useful and satisfying life without causing harm to others or suffering from personal distress. If a person can function within their society, they are considered to be .

(2) Criteria of Abnormality

Several criteria of abnormality have been identified (Lilienfeld, 2014). The more someone meets these criteria, the greater the possibility for them to show abnormality.

● Distress

In psychology, distress can be defined as mental suffering or mental agony. Thus, any cognition, emotion and/or action causing mental suffering or mental agony in an individual may indicate abnormality. However, distress does not always indicate abnormality. Further, presence of abnormality does not always lead to distress. For instance, a person who reports

distress due to worrying about an impending job interview cannot be labled as 'abnormal'. Furthermore, a person suffering from an abnormality such as anxiety or depression reports distress, whereas another person suffering from an abnormality such as the manic phase of bipolar disorder, or substance use disorder, or antisocial personality disorder does not report distress.

● Social Discomfort

Another indicator of abnormality is violation of an implicit or unwritten rule by an individual that causes discomfort to others. For example, to greet someone is an implicit rule. However, you feel uncomfortable if a stranger in a crowd suddenly rushes to you, greeting you excitedly with a forcible handshake. But you also have a sense of discomfort if someone known to you doesn't greet you at all or discreetly greets you and rushes away. Thus, whether this behaviour can be categorized as abnormal depends on the situation.

● Maladaptive Behaviour

Maladaptive behaviour causes impairment in personal, occupational, and social functioning of an individual and thus it is an indicator of abnormality. Does maladaptive behaviour always lead to impaired functioning? Consider the cases of two individuals Ms. D. and Mr. J. While Ms. D. suffers from obsessive-compulsive disorder where washing compulsion led to elaborate cleaning rituals that significantly interferes with her daily life functioning, affecting her psychological and physical well-being. On the other hand, Mr. J has an antisocial personality disorder due to which he indulges in extreme risk-taking behaviours, endangering his life as well as that of others. But rather than considering it as maladaptive, Mr. J enjoys his behaviour. Though, Mr. J's behaviour is not maladaptive to himself, but it is maladaptive for others. Hence, it is clear from the example of Ms. D and Mr. J that a behaviour which is maladaptive either toward self or society or toward both is an indicator of abnormality.

● Standard Deviation

Abnormality is also defined in terms of deviation from normal, i.e., being away from normal is abnormal where the 'ab' means away. In other words, rarity is an indicator of abnormality. However, rare does not always means undesirable. For example, in case of IQ, a score which is significantly above or below mean is away from normal, hence both the scores should be considered as abnormal. However, while the score significantly below the mean indicates intellectual disability (ID) and referred to as 'abnormal', the score significantly above the mean score indicates 'genius' and is not referred to as 'abnormal' though it is also away from the mean.

● Culturally Unexpected/Violations of the Standard Rules of the Society

Culturally unexpected action or an action that violates the standard rules of the society is taken as an index of abnormality. For example, going into a trance or being possessed by a ghost or a goddess is accepted in Indian culture. However, it is context dependent. Thus, if an individual goes into a trance in an overnight religious gathering called, 'jaagaran', it is seen as normal. However, if a person shows the same behaviour in a daily life setting like school, office, or home, it is interpreted as 'abnormal' as going into a trance during daily life routine is not culturally expected. It is clear from the above discussion that there is neither a

necessary nor a sufficient criterion for defining normality and abnormality. That is, there is neither a single criterion that is present in all the normal or abnormal behaviour, nor there is any single criterion that is enough to indicate normality or abnormality. Nevertheless, there are several criteria, which indicate abnormal behaviour or psychopathology and need intervention for the wellbeing of the individual as well as society.

14.5 SUMMARY :

In conclusion, the exploration of normal and abnormal psychology illuminates the dynamic and multifaceted nature of human experiences within the realm of mental health. Normal psychology serves as a foundation for understanding typical patterns of behaviour and cognition, offering insights into the diverse and common aspects of human functioning. It provides a benchmark against which psychological health can be assessed, fostering an appreciation for the range of normal variations that contribute to the richness of human existence. Conversely, abnormal psychology directs attention to deviations from these expected norms, delving into the complexities of psychological disorders. The study of abnormal psychology underscores the need for comprehensive understanding, compassion, and effective interventions to address the challenges individuals face when their mental well-being is compromised. It is crucial to acknowledge the cultural, societal, and historical influences that shape our perceptions of normalcy and abnormality. The fluid and context-dependent nature of these concepts emphasizes the importance of cultural sensitivity in psychological assessments, ensuring that diverse perspectives are considered in the evaluation of mental health. As the field of psychology continues to evolve, our understanding of normal and abnormal psychology expands, challenging preconceptions and promoting a more inclusive approach to mental health. Recognizing that psychological well-being exists on a continuum and that individuals navigate unique journeys; psychologists strive to provide support and interventions that consider the complexities of the human mind. Ultimately, the concepts of normal and abnormal psychology contribute to a nuanced understanding of the human experience, fostering empathy, awareness, and a commitment to promoting mental health and well-being across diverse populations. By embracing the dynamic nature of these concepts, we empower individuals to navigate their psychological landscapes with resilience and compassion, recognizing the richness inherent in the tapestry of human diversity.

14.6 KEYWORDS :

1. Normal
2. Normality
3. Abnormal
4. Abnormality
5. Criteria
6. Psychology
7. Normal psychology
8. Abnormal psychology

14.7 SELF ASSESSMENT QUESTIONS :

1. Define normal psychology and its concept.
2. Define abnormal psychology and its concept.

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Prof. M. Trimurthi Rao

LESSON – 15

HISTORICAL BACKGROUND OF ABNORMAL PSYCHOLOGY

OBJECTIVE :

The objective of this lesson is to explain the historical background of abnormal psychology.

STRUCTURE:

15.1 INTRODUCTION:

The historical development of psychiatry in India is a fascinating journey that unfolds across ancient civilizations, colonial influences, pre-colonial resurgence, and the post-independence era. This narrative offers a nuanced understanding of how the perception, treatment, and societal response to mental health have evolved over the centuries in the diverse and culturally rich landscape of India.

In ancient India, mental health was approached holistically, emphasizing the interconnectedness of the mind, body, and spirit. Traditional practices such as yoga, meditation, and Ayurveda reflected a comprehensive understanding of well-being. As the Indian subcontinent transitioned through different historical periods, including the colonial era, there emerged a complex interplay between indigenous healing practices and the introduction of Western psychiatric models.

The colonial period brought significant changes, marked by the establishment of mental asylums and the imposition of Western medical concepts on mental health. This period witnessed a shift towards institutionalization and the stigmatization of mental illness. The consequences of this era continue to resonate in contemporary perspectives on mental health in India.

The pre-colonial resurgence saw a renewed interest in traditional healing practices, with efforts to integrate indigenous knowledge with modern approaches. This period reflects a re-evaluation of cultural sensitivity in mental healthcare, setting the stage for a more inclusive understanding of mental health that recognizes the diversity of sociocultural contexts in India.

Post-independence India witnessed the expansion of psychiatric services, the integration of mental health into primary healthcare, and the development of community-based initiatives. National programs and policies aimed at destigmatizing mental illness and raising awareness underscore the commitment to addressing mental health on a broader scale.

In this exploration of the historical development of psychiatry in India, we embark on a journey through time, unravelling the layers of cultural, societal, and medical influences that have shaped the landscape of mental health. Understanding this historical context provides a foundation for comprehending the challenges and opportunities that exist in contemporary mental health practices, as India strives towards a more inclusive and culturally sensitive approach to mental well-being.

15.2 PSYCHIATRY IN ANCIENT VEDIC INDIA :

The descriptions of various mental illnesses in ancient Indian texts are probably the oldest such accounts. Two well-known Ayurvedic manuscripts, the Charaka Samhita by Charaka, and the Sushruta Samhita by Sushruta, have established the roots of modern Indian medicine. The ancient Indian scripture, Atharva-Veda, mentions that mental illness may result from divine curses. Descriptions of conditions similar to schizophrenia and bipolar disorder appear in the Vedic texts. A vivid description of schizophrenia is also found in Atharva-Veda. Other traditional medical systems such as Siddha, which recognize various types of mental disorders, flourished in southern India. Great epics such as the Ramayana and the Mahabharata made several References to disordered states of mind and means of coping with them. The Bhagavad Gita is a classic example of crisis intervention psychotherapy. Another interesting contribution of the Ayurveda is its knowledge regarding the diet-disease relationship and the association of a disease with a specific physical constitution. Diagnosis was entertained by the five senses and supplemented by interrogation. According to the ancient system, diagnosis was based on cause (nidana), premonitory indications (purva-rupa), symptoms (rupa), therapeutic tests (upashaya) and natural history of the development of the disease (samprapti). According to Sushruta, the physician (chikitshak), the drug (dravya), the attendants or the nursing personnel (upasthata), and the patient (rogi) are the four pillars on which rests the success of the therapy. The highest patronage to the science of Ayurveda was given by the Buddhist kings (400-200 BC).

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

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

etiology of psychiatric disorders was explained. Third was the development of community psychiatry.

15.3 PSYCHIATRY IN PRE-COLONIAL INDIA :

During the reigns of King Asoka, many hospitals were established for patients with mental illness. According to the scribes of Asoka Samhita, hospitals were built with separate enclosures for various practices including keeping the patients and dispensing treatments prevailing during those times. A temple of Lord Venkateswara at Tirumukkudal, Chingleput, Tamil Nadu, contains inscriptions on the walls belonging to the Chola period. There are some ancient evidences of propagation of alienation of mentally ill patients in Shahdaula's Chauhas in Gujarat and Punjab. Though there is not much evidence for development of psychiatry in the Moghul period, there are References to some asylums in the period of Mohammad Khilji (1536- 1569). There is also some evidence of the presence of a mental hospital at Dhar near Mandu, Madhya Pradesh, whose physician was Maulana Fazulur Hakim. There are some historical evidences from the pre-colonial literature that modern medicine and modern hospitals were first brought to India by Portuguese during the seventeenth century in Goa, though documentary evidences are not in good shape to substantiate the claims.

The political instability prevailing in the 1700s saw development of lunatic asylums in Calcutta, Madras and Bombay. It is interesting to observe that these three cities grew up in the beginning largely with British enterprise which conceptualized the segregation of mentally ill patients in mental asylums and their supervision by trained people more in sync with the western conceptualization. The need to establish hospitals became more acute first to treat and manage Englishmen and Indian 'sepoyees' employed by the British East India Company. Waren Hastings, the first Governor General, during his regime in 1784 introduced the 'Pitts India Bill' according to which the activities of the Government of the East India Company came under the direction of a "Board of Control" and systematic reforms and welfare actions were taken during Lord Cornwallis (1786-93) rule. It was during his rule that there is a References of the first mental hospital in this part of India at Calcutta recorded in the proceedings of Calcutta Medical Board on April 3, 1787, which became the References point of inception of colonial influence on development of psychiatric care in India.

15.4 PSYCHIATRY IN COLONIAL INDIA :

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

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

blood. Music was also used a mode of therapy to calm down patients in some hospitals. The mentally ill from the general population were taken care of by the local communities and by traditional Indian medicine doctors, qualified in Ayurveda and Unani medicine.

The mid-colonial period from 1858-1918 witnessed a steady growth in the development of mental asylums. This period was significant for the enactment of the first Lunacy Act (also called Act No. 36) in the year 1858. The Act was later modified by a committee appointed in Bengal in 1888. During this period, new asylums were also built at Patna, Dacca, Calcutta, Berhampur, Waltair, Trichinapally, Colaba, Poona, Dharwar, Ahmedabad, Ratnagiri, Hyderabad (Sind), Jabalpur, Banaras, Agra, Bareilly, Tezpur and Lahore. Techniques of 'moral management' systems which were developed and implemented in this period in the west were also adopted in India. Drug treatments for psychiatric conditions were also introduced into India in this period, e.g., chloral hydrate. These were largely aimed at controlling patient behaviour and also of allowing the patient some respite from his/her condition through sleep. The onset of World War I in 1915 signalled the beginning of a new and distinct period in which strands of continuity were pulled up, in which significant changes took off in the Indian psychiatric system.

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

The years after 1915 were characterized by gradual expansion rather than building projects and the most significant of these of the period were hangovers from the pre-1915 period. Mental Asylum at Ranchi first opened in 1918 as a hospital for European patients. The sustained efforts of Berkeley-Hill not only helped to raise the standard of treatment and care, but also persuaded the government to change the term 'asylum' to 'hospital' in 1920. The Parsees during that period were keen to spend large amounts of money to guarantee care in modern psychiatric institutions for those who were considered insane in their own community, often guided by financial rather than therapeutic reasoning. The origins of psychiatric rehabilitation in India can be traced to innovative service programs, which were initiated at the Central Institute of Psychiatry (CIP) in 1922 when Occupational Therapy Unit started at this place. Hydrotherapy started in 1923 and during the same time the hospital started to raise interest of public in mental hygiene and prophylaxis, taking initiatives in preventive aspects of psychiatry. Techniques similar to token- economy were first started in 1920 and called by the name "Habit Formation Chart". Girindra Shekhar Bose first founded the Indian Psychoanalytical Association in 1922 in Calcutta and Berkeley-Hill started the Indian Association for Mental Hygiene at Ranchi. He was one of the earliest practitioners of psychoanalysis in India who used this technique to help British patients to adjust to their lives after the ravages of World War I.CIP was one of the first centers outside Europe to start Cardiazol-induced seizure treatment in 1938, Electroconvulsive Therapy (ECT) in 1943 and Psychosurgery in 1947. Rauwolfia extracts in the form of Santina, Serpasil and Meralfen were also used for treating psychotic conditions in late 1940s.

In the year 1922, CIP got affiliation from the University of London to start Diploma in Psychological Medicine. Grant Medical College, Bombay (now Mumbai) had a Professor

of Psychiatry, significantly an Indian, by the year 1936. A memo noted in the archives shows that the number of visits he was to make to the NM Mental Hospital, Thane was to be 'two per week during the term, when he also gave instructions to the students of the Grant Medical College, Bombay. A library on mental health started in 1918 at CIP with 300 books and journals which dated back to 1910. Child guidance clinic was first established in 1937 at Sir Dorabji Tata Graduate School of Social Work in Bombay. The establishment of Mental Health organization under the Directorate of Health Services was first recommended in 1946 by the health survey and development committee of the Indian Government. The first psychiatric outpatient service, precursor to the present-day general hospital psychiatric units (GHPU), was set up at the R.G. Kar Medical College, Calcutta in 1933 by Ghirinder Shekhar Bose. This was followed by a surge of such units with Masani opening one at JJ Hospital, Bombay in 1938 and Dhunjibhoy opening one day weekly clinic at Prince of Wales Medical College (now Patna Medical College) in 1939.

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

15.5 PSYCHIATRY IN INDEPENDENT INDIA: THE FORMATIVE YEARS :

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

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

An industrial psychiatric unit was started at Heavy Engineering Corporation (HEC) at Hatia, Ranchi in 1973.Opening of psychiatry units in general hospitals gave psychiatrists an opportunity to demonstrate their knowledge and skills in the management of neurotic and psychosomatic disorders.

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

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

15.6 PSYCHIATRY IN INDEPENDENT INDIA: ERA OF CONSOLIDATION :

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

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

The Erwadi tragedy

In 2001 a horrific incidence took place at Erwadi in which 26 persons with mental illness died in a tragic fire accident. The response of the general population, the administrators, the politicians, the press and the professionals was one of shock and outrage. The press seized the moment and wrote about similar situations, in Hyderabad, Ranchi, Ahmedabad, and Patiala. The National Human Rights Commission called for a Report. The Supreme Court initiated action on the matter. As a result, many changes not only in Erwadi

but also in the different parts of the country started taking shape, which proved to be a yardstick which revamped mental health services in the country.

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

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

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

15.7 SUMMARY :

In conclusion, the historical development of psychiatry in India is a rich tapestry woven through the various epochs of its past. Examining the trajectory from ancient times through the colonial era to pre-colonial and independent India provides valuable insights into the evolving understanding and treatment of mental health in the country. Ancient India witnessed a holistic approach to mental well-being, as reflected in texts like the Ayurveda and the Atharva Veda. Mental health was considered an integral part of overall health, and spiritual practices, including yoga and meditation, were recognized as therapeutic interventions. The emphasis on mind-body-spirit interconnectedness laid a foundation for a nuanced understanding of mental health. The colonial period marked a significant shift, as Western medical models were introduced. The establishment of mental asylums reflected changing perceptions of mental illness, often characterized by stigmatization and isolation. Western psychiatric concepts dominated, albeit with limited cultural sensitivity, leading to challenges in addressing the diverse sociocultural contexts of mental health in India. Pre-colonial India saw a resurgence of interest in traditional healing practices and a re-evaluation of indigenous knowledge. Efforts were made to integrate traditional and modern approaches, recognizing the importance of cultural competence in mental healthcare. This period laid the

groundwork for a more inclusive and culturally sensitive approach to mental health. Post-independence, India witnessed the expansion of psychiatric services, integration of mental health into primary healthcare, and the development of community-based initiatives. Efforts were made to destigmatize mental illness and promote mental health awareness. The National Mental Health Programme and subsequent policy initiatives underscored a commitment to addressing mental health at a national level. In conclusion, the historical journey of psychiatric development in India reflects a complex interplay of indigenous wisdom, colonial influences, and evolving societal attitudes. Today, the field is characterized by a growing recognition of the importance of cultural context, community-based interventions, and the integration of traditional and modern approaches. As India continues to navigate the dynamic landscape of mental health, the historical perspectives provide a foundation for shaping more inclusive, culturally sensitive, and effective mental health policies and practices.

15.8 KEYWORDS :

1. Normal
2. Abnormal
3. Historical background
4. Psychology

15.9 SELF ASSESSMENT QUESTIONS :

1. Analyze the historical background of abnormal psychology.
2. Discuss abnormal psychology in the present day context.

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Prof. M. Trimurthi Rao

LESSON – 16

ABNORMAL PSYCHOLOGY: SYMPTOMS AND SYNDROMES

OBJECTIVE:

The objective of this lesson is to explain the symptoms and syndromes of abnormal psychology.

STRUCTURE:

16.1 INTRODUCTION :

Abnormal psychology is a specialized field that investigates deviations from typical patterns of behaviour, thought processes, and emotional experiences. Central to the study of abnormal psychology are symptoms and syndromes, which serve as crucial indicators of mental health disorders. Symptoms represent observable manifestations, subjective experiences, and behavioural patterns that deviate from societal norms. Syndromes, on the other hand, are clusters of symptoms that frequently co-occur, forming recognizable patterns associated with specific mental health conditions.

Understanding symptoms involves exploring disruptions in cognitive processes, emotional responses, behavioural patterns, physical manifestations, and social interactions. These symptoms provide valuable insights into the individual's mental well-being and contribute to the diagnostic process. Syndromes, as recognizable constellations of symptoms, aid mental health professionals in classifying and diagnosing various disorders, fostering a more systematic and targeted approach to treatment.

In this exploration of symptoms and syndromes in abnormal psychology, we will delve into specific categories, examining the diverse manifestations that contribute to our understanding of mental health challenges. This nuanced approach allows for a comprehensive exploration of the intricate interplay between psychological, biological, and social factors that influence mental health. As we navigate this landscape, we aim to unravel the complexities associated with abnormal psychology, ultimately contributing to a more compassionate and informed approach to mental health care.

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

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

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

Symptoms of mental illness

Signs and symptoms of mental illness can vary, depending on the disorder, circumstances and other factors. Mental illness symptoms can affect emotions, thoughts and behaviors.

Examples of signs and symptoms include:

- Feeling sad or down
- Confused thinking or reduced ability to concentrate
- Excessive fears or worries, or extreme feelings of guilt
- Extreme mood changes of highs and lows
- Withdrawal from friends and activities
- Significant tiredness, low energy or problems sleeping
- Detachment from reality (delusions), paranoia or hallucinations
- Inability to cope with daily problems or stress
- Trouble understanding and relating to situations and to people
- Problems with alcohol or drug use
- Major changes in eating habits
- Sex drive changes
- Excessive anger, hostility or violence
- Suicidal thinking

Sometimes symptoms of a mental health disorder appear as physical problems, such as stomach pain, back pain, headaches, or other unexplained aches and pains.

When to see a doctor

If you have any signs or symptoms of a mental illness, see your primary care provider or a mental health professional. Most mental illnesses don't improve on their own, and if untreated, a mental illness may get worse over time and cause serious problems.

If you have suicidal thoughts

Suicidal thoughts and behavior are common with some mental illnesses. If you think you may hurt yourself or attempt suicide, get help right away:

- Call your local emergency number immediately.
- Call your mental health specialist.
- Contact a suicide hotline.
- Seek help from your primary care provider.
- Reach out to a close friend or loved one.
- Contact a minister, spiritual leader or someone else in your faith community.

Suicidal thinking doesn't get better on its own — so get help.

Helping a loved one

If your loved one shows signs of mental illness, have an open and honest discussion with him or her about your concerns. You may not be able to force someone to get professional care, but you can offer encouragement and support. You can also help your loved one find a qualified mental health professional and make an appointment. You may even be able to go along to the appointment.

If your loved one has done self-harm or is considering doing so, take the person to the hospital or call for emergency help.

16.2 SYMPTOMS IN ABNORMAL PSYCHOLOGY :

1. Cognitive Symptoms

Distorted Thinking

- **Cognitive Distortions:** These include irrational thoughts, such as overgeneralization, catastrophizing, or black-and-white thinking.
- **Delusions:** Fixed, false beliefs that are resistant to reasoning or contrary evidence.

Poor Concentration

- **Attention Deficit:** Difficulty sustaining attention, being easily distracted, or struggling with multitasking.

2. Emotional Symptoms

Intense Emotions

- **Depression:** Prolonged feelings of sadness, hopelessness, and loss of interest in previously enjoyable activities.
- **Anxiety:** Persistent and excessive worry, fear, or uneasiness.

Mood Swings

- **Bipolar Disorder:** Episodes of mania (elevated mood, increased energy) alternating with depressive episodes.

3. Behavioural Symptoms

Changes in Sleep Patterns

- **Insomnia:** Difficulty falling asleep or staying asleep.
- **Hypersomnia:** Excessive sleepiness, often leading to extended hours of sleep.

Changes in Appetite

- **Anorexia Nervosa:** Severe restriction of food intake leading to significantly low body weight.
- **Binge Eating Disorder:** Consuming large amounts of food in a short period, accompanied by a sense of loss of control.

4. Physical Symptoms

Fatigue

- **Chronic Fatigue:** Persistent, unexplained fatigue that is not alleviated by rest.

Aches and Pains

- **Somatization:** The expression of psychological distress through physical complaints such as headaches, stomach-aches, or muscle pain.

5. Social Symptoms

Social Withdrawal

- **Avoidant Personality Disorder:** Extreme shyness, fear of rejection, and avoidance of social interactions.
- **Social Anxiety Disorder:** Intense fear of being judged or embarrassed in social situations.

Impaired Social Functioning

- **Autism Spectrum Disorder:** Challenges in social communication, difficulty forming relationships, and engaging in repetitive behaviours.

6. Psychotic Symptoms

- **Hallucinations :** Perceptions in the absence of external stimuli, commonly involving hearing voices but can also include visual or tactile hallucinations.
- **Delusions :** Fixed, false beliefs that are resistant to reasoning and not in line with cultural or societal norms.

7. Coping Mechanisms

- **Maladaptive Coping :** Engaging in behaviours that provide short-term relief but are detrimental in the long run, such as substance abuse, self-harm, or avoidance.

8. Impulse Control

- **Impulsivity :** Difficulty controlling impulses, leading to actions without considering the consequences, common in disorders like ADHD and certain personality disorders.

16.3 SYNDROMES IN ABNORMAL PSYCHOLOGY :

1. Anxiety Disorders :

- **Generalized Anxiety Disorder (GAD) :** Excessive worry about a variety of topics, often accompanied by physical symptoms like muscle tension and restlessness.
- **Panic Disorder :** Recurrent and unexpected panic attacks, characterized by intense fear and physical symptoms such as chest pain and shortness of breath.

2. Mood Disorders :

- **Major Depressive Disorder :** Persistent low mood, loss of interest, changes in appetite or sleep patterns, and feelings of worthlessness.
- **Bipolar Disorder :** Alternating episodes of mania (elevated mood, increased energy) and depression.

3. Schizophrenia Spectrum and Other Psychotic Disorders

- **Schizophrenia :** Delusions, hallucinations, disorganized thinking, and negative symptoms like social withdrawal.

4. Eating Disorders

- **Anorexia Nervosa :** Intense fear of gaining weight, leading to severe restrictions in food intake.
- **Bulimia Nervosa :** Episodes of binge eating followed by compensatory behaviours like vomiting or excessive exercise.

5. Neurodevelopmental Disorders

- **ADHD (Attention-Deficit/Hyperactivity Disorder) :** Inattention, hyperactivity, impulsivity, and difficulty in organizing tasks.
- **Autism Spectrum Disorder :** Challenges in social communication and behaviour, repetitive movements or interests.

6. Personality Disorders

- **Borderline Personality Disorder :** Intense and unstable relationships, self-image, and emotions.
- **Antisocial Personality Disorder :** Persistent patterns of disregard for others' rights, lying, impulsivity, and lack of remorse.

7. Trauma and Stressor-Related Disorders

- **PTSD (Post-Traumatic Stress Disorder) :** Intrusive memories, flashbacks, avoidance of reminders, and hyperarousal following exposure to a traumatic event.

8. Obsessive-Compulsive and Related Disorders

- **OCD (Obsessive-Compulsive Disorder) :** Distressing, intrusive thoughts (obsessions) leading to repetitive behaviours or mental acts (compulsions) to alleviate anxiety.

9. Dissociative Disorders

- **Dissociative Identity Disorder (DID) :** Presence of two or more distinct personality states, often accompanied by memory gaps.
- **Depersonalization-Derealization Disorder :** Feeling detached from one's own body or the external world.

10. Somatoform Disorders

- **Conversion Disorder :** Presence of neurological symptoms (such as paralysis or blindness) without a medical explanation.
- **Illness Anxiety Disorder :** Excessive worry about having a serious illness despite medical reassurance.

11. Sleep Disorders

- **Insomnia Disorder :** Difficulty falling asleep, staying asleep, or having non-restorative sleep.
- **Nightmares and Sleep Terrors :** Disturbing dreams causing fear or intense reactions during sleep.

12. Disruptive, Impulse-Control, and Conduct Disorders

- **Oppositional Defiant Disorder (ODD) :** Persistent patterns of anger, irritability, defiance, and vindictiveness.
- **Conduct Disorder :** Persistent patterns of violating societal norms and the rights of others.

13. Feeding and Eating Disorders

- **Avoidant/Restrictive Food Intake Disorder (ARFID) :** Limited food preferences leading to nutritional deficiencies without concerns about weight or appearance.
- **Pica :** Eating non-nutritive, non-food substances persistently.

14. Communication Disorders

- **Stuttering :** Disruptions in the normal flow of speech, often involving repetitions or prolongations of sounds.
- **Language Disorder :** Difficulty in understanding or using words in context.

16. Disruptive Mood Dysregulation Disorder (DMDD)

Severe and recurrent temper outbursts out of proportion to the situation, with persistent irritability or anger between outbursts.

16.4 SUMMARY :

In conclusion, the study of symptoms and syndromes in abnormal psychology is pivotal for unravelling the intricacies of mental health disorders. By examining deviations from typical patterns in behaviour, cognition, and emotion, we gain valuable insights into the challenges individuals face in their daily lives. The exploration of symptoms allows us to identify observable manifestations and subjective experiences, providing a foundation for understanding and categorizing mental health conditions. Syndromes, characterized by clusters of co-occurring symptoms, play a crucial role in diagnostic processes, enabling mental health professionals to recognize and classify specific disorders. This systematic approach facilitates targeted interventions and personalized treatment plans tailored to the unique needs of individuals experiencing mental health challenges. As we navigate the diverse landscapes of anxiety, mood, psychotic, and neurodevelopmental disorders, among others, it becomes evident that mental health is a complex interplay of biological, psychological, and social factors. The holistic understanding of symptoms and syndromes fosters empathy, reduces stigma, and promotes a more nuanced approach to mental health care. In the ongoing pursuit of knowledge in abnormal psychology, continued research, awareness, and advocacy are essential. By appreciating the diversity of human experiences and recognizing the significance of symptoms and syndromes, we contribute to a society that values mental well-being and supports individuals on their journey towards mental health and resilience.

16.5 KEYWORDS :

1. Symptoms
2. Syndromes
3. Abnormal
4. Psychology

16.6 SELF ASSESSMENT QUESTIONS :

1. Analyze the symptoms in abnormal psychology.
2. Discuss the syndromes in abnormal psychology.

14.9 REFERENCES :

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Prof. K. Dhanalakshmi

LESSON – 17

CLASSIFICATION OF MENTAL DISORDERS: PSYCHOTIC AND NEUROTIC DISORDERS

OBJECTIVE :

The objective of this lesson is to explain the definition of classification, purpose, different types of mental disorders, understanding Neurosis vs. Psychosis, difference, treatment options.

STRUCTURE:

17.1 INTRODUCTION :

Like any growing branch of medicine, in psychiatry there has been rapid changes in classification to keep up growing research data dealing with epidemiology, symptomatology, prognostic factors, treatment methods & new theories for causation of psychiatric disorders. ′ At present there are two major classifications in psychiatry, namely, ICD10(1992) and DSM-5(2013). In both the ICD and DSM, the mental disorders are at present grouped by their symptoms, in categories that compose the classification. ′ The Classification of Mental Disorders is also known as Psychiatric Nosology or Psychiatric Taxonomy.

17.2 DEFINITION OF CLASSIFICATION :

It is a process by which complex phenomena are organized into categories, classes or ranks so as to bring together those things that most resemble each other and to separate those that differ.

Mental Disorder

Mental disorder, also called a mental illness or psychiatric disorders, is a behavioral or mental pattern that cause significant distress or impairment of mental functioning.

17.3 PURPOSE OF CLASSIFICATION :

- ❖ Enable us to care for our patients.
- ❖ To make general acceptable diagnosis.
- ❖ To facilitate communication between psychiatrists, other doctors and professionals.
- ❖ To carry out high- quality research & based on epidemiological data to plan services.

17.4 NEUROSIS AND PSYCHOSIS ARE DIFFERENT TYPES OF MENTAL DISORDERS :

Neurosis is a minor disorder that is characterized by physical and mental disturbances. Neurosis is a mild mental disorder not arising from organic diseases – instead, it can occur from stress, depression or anxiety.

Psychosis is a major personality disorder characterized by mental and emotional disruptions. It is much more severe than neurosis – often impairing and debilitating the affected individual.

17.5 UNDERSTANDING NEUROSIS VS. PSYCHOSIS :

Throughout history, we've used a variety of definitions, both colloquial and clinical, for neurosis and psychosis. These definitions have changed many times and continue to be debated today. Here's what you need to know about psychosis and neurosis, including how these conditions are alike and how they differ.

17.6 BASIC DEFINITIONS OF NEUROSIS AND PSYCHOSIS :

- **Neurosis:** A term used to describe some mental health conditions. Typically involves expressions of obsessive behaviors, hypochondria, an intense need for control, dissociative states, depression, or anxiety. This is not a term used in clinical diagnosis, and some people view neurosis as a personality trait that we all have to some degree.
- **Psychosis:** A term used within clinical diagnosis to describe an abnormal mental state. This mental state can involve experiencing delusions, paranoia, hallucinations, and difficulty telling what's real and what's not. This can lead to distressed emotional states and disorganized speech.

Both conditions can produce excessive amounts of stress and can make day-to-day life difficult in some situations.

Neurosis

Neurosis is a set of mental disorders that involve chronic distress, but they do not include delusions and hallucinations. Neurosis is also known as neurotic disorder or psychoneurosis and is of different types:

- Hysteria.
- Impulse control disorder.
- Obsessive-compulsive disorder.
- Anxiety.
- Obsessive-compulsive personality disorder.

Neurosis involves sadness, depression, irritability, anxiety, anger, confusion, and so on. We can say that neurosis is the inability of a person to change their life pattern and the inability to develop a more complex, satisfying personality.

- Neuroses are generally rooted in ego defense strategies, but both are not the same. Defense strategies are a common way of maintaining a sense of self. The thoughts that give rise to struggle or difficulties can be called neurosis.
- A person suffering from neurosis faces an unconscious conflict and emotional distress, which leads to different mental problems. The person might also be neurotic due to some natural disaster that he witnessed and cannot overcome the thoughts leading to emotional instability.
- Neurosis can happen to a person who has been through a traumatic event, and the thoughts of the events make it difficult for him to forget the incident and cause anxiety, which is a primary symptom of neurosis.
- Every person constructs his ideal image by the experiences he has gone through, his needs, fantasies, and the facilities given to him. A person tends to get into ego defense mechanisms at times and when these mechanisms lead to emotional distress, we call it neurosis.
- Psychologists and psychiatrists conduct the treatment of neurosis in various ways. Helping the ill person to start being aware of feelings, traumatic memories, repressed impulses that cause the symptoms, and then helping the person to have a growth in his personality by deeper self-understanding can cure neurosis.
- A person can also be cured by watching or learning from examples. Discussing thoughts that contribute to the symptoms of neurosis and gradually replacing those thoughts with better interpretations of surroundings can be quite useful in curing neurosis.
- The conventional way of providing medicines can also work for a neurosis patient. Shock therapies can resolve some cases. Most therapists go with a combination of all the different treatments to help the person get better with the conditions.

Psychosis

A serious mental illness that causes hallucinations, delusions, faults in judgments, and other such processes is called psychosis. The term refers to the Greek word psyche, which means soul or breath. In other words, psychosis happens when a person has forgotten the essence of his life, and the person has designed their view of life, which is not shared by others.

- The primary symptoms of psychosis consist of delusions and hallucinations. That means a person is in a state of imagination, and he thinks that he is living in that image rather than actual reality.
- A person who has psychosis tends to commit suicide or have suicidal tendencies. The change in the function of the brain usually causes delusions and hallucinations.

Psychosis is of two types:

1. Functional psychosis.
2. Organic psychosis.

- The most common and severe psychosis is Schizophrenia. The symptoms appear in the teen years. Disorganized speech, lack of emotional expression, and lack of energy are the major symptoms besides hallucinations and delusions.
- The above symptoms, which lasted for more than six months, can disable a person's functioning. The duration of the disease is not constant. Clinical scans and history are

vital in the diagnosis of psychosis. Early detection of the disorder can help in improving the outcomes in the long term. Later discovery can affect and cause acute phases of psychosis.

- The diagnosis of psychosis is done through scanning and also questioning the family about the behavioural changes. Many diseases can show symptoms of psychosis, such as brief psychotic disorder, Schizophrenia, delusional disorder, bipolar psychosis, schizoaffective disorder, depression, and postpartum.
- The traditional curing or treatment methods include antipsychotic drugs. A stay in the hospital is a must when the phase of the ailment is acute. At times when a patient goes out of control, tranquilization is used for immediate relaxation of the person so that he does not harm himself.
- The use of psychotherapy will also help in treating residual symptoms and cognitive symptoms of psychotic disorders.
- If the patient is in the phase of maintenance, the family and the surroundings need to see that no interventions are happening; it can cause a psychotic episode.
- Sometimes psychosis can be secondary and a hint to a bigger problem such as brain tumour, Alzheimer's disease, some kinds of epilepsy, and HIV.

Similarities of neurosis and psychosis

Neurosis and psychosis have some likenesses, which leads some people to use these terms interchangeably. However, as you've seen they have very different definitions.

Both involve mental health conditions that can cause anxiety, depression, panic attacks, and agitation. Often people with these conditions find it difficult to control their train of thought, and they may have difficulties related to generalized anxiety, executive function, and decision-making.

In both neurosis and psychosis, symptoms can likely affect personal and professional relationships.

17.7 DIFFERENCES BETWEEN NEUROSIS AND PSYCHOSIS :

Psychosis refers to a specific category of abnormal mental states. Because neurosis is not a clinical term and can mean different things to different people, it can be hard to tell where the line is between the two terms.

The main difference between psychosis and neurosis lies in perspective.

A person experiencing episodes of neurosis might experience periods of unhappiness or feel overwhelmed by work, family, and life in general. They might also worry or have obsessive thoughts. However, they can usually recognize anxious thoughts and understand the impact these thoughts have on their life and relationships.

A person experiencing episodes of psychosis, on the other hand, may be unable to find that perspective. They can experience hallucinations and/or delusions, which include hearing voices or seeing things that others don't. Occasionally they may also believe they

have special powers, become suspicious of family and friends, or believe someone means them harm.

Another difference is that experiencing psychosis more frequently requires medication to control thoughts and behavior. A person with neurosis may only need counseling or behavioral therapy.

It's important to note that neurosis is not a term that is included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). It is not a term that is usually used in a clinical diagnosis.

Examples of neurosis versus psychosis

Psychosis and neurosis aren't mental illnesses in themselves, but rather categories of mental health symptoms. Here's a breakdown of conditions in which psychosis or neurosis might appear:

	Psychosis	Neurosis
Obsessive-compulsive disorder		X
Depression	x	X
Generalized anxiety disorder		X
Social phobias		X
Eating disorders		X
PTSD		X
Bipolar disorder	x	
Delusional disorder	x	
Schizophrenia disorder	x	
Narcisstic personality disorder		X

Neurosis and Psychosis Difference Table

Neurosis	**Psychosis**
The set of neuro-physical disorders that occur in a specific clinical phenomenon due to the absence of psychical phenomena.	Psychosis is a severe mental disorder that can be identified by loss of contact along with reality and profound disturbance in relationships with people, leading to ill social health.
Neurosis also has fearful neurosis, hysteria, neurasthenia, phobic disorders, etc.	The types of psychoses are a bipolar affective disorder, schizophrenia, chronic hallucinations, epilepsy, senile dementia, etc.
Neurosis does not affect the personality of the being.	Changes in personality are evident in the case of psychosis.
The contact with reality is not entirely changed but is undoubtedly affected.	Contact with reality is lost or changed.
The affected person is aware of his surroundings.	The affected person is not aware of his disorder or his surroundings.
Communication and language are not affected by neurosis.	There is a certain discrepancy in communication and language.
There is no hallucination or delusion for a person suffering from neurosis.	Delusion and hallucination are the main symptoms in the case of a person who has psychosis.
There is no organic reason for the cause of neurosis, and it is a purely functional illness.	Pathofunctinal and pathomorphological changes within the body accompany psychosis. The anatomical structure of neuro cerebral substances is affected.
Biological, psychological, socio-psychic climate, socio-economic, and pedagogical factors can cause neurosis.	Genetic, environmental, and biochemical factors can cause psychosis.
The person affected by neurosis can take care of themselves and are suicidal in rare cases. There is no necessity for hospitalization.	The person who has psychosis cannot take care of themselves. They tend to suicide and must get treated at the hospital.
Psychological treatment is a must for giving social and moral support for a person suffering from neurosis.	Antipsychotic medicines, social support, and psychological therapy are compulsory for a person affected by psychosis.

Can neurosis be a good thing?

Neurosis is only a problem when it causes anxiety or disrupts life. It can, however, be beneficial under certain circumstances.

For example, due to your experience with anxiety and depression, you might show greater empathy to those who are currently going through those negative emotions. And if you can tend to overthink, you might easily foresee negative outcomes and avoid dangerous risks.

The key is learning how to harness anxious thoughts for your benefit, and it's an excellent goal to work with a therapist to achieve.

Can one person have both neurosis and psychosis?

Neurosis is an unofficial term used to describe some mental conditions, and psychosis is an official label for some symptoms experienced under certain mental conditions. So it's very possible that someone could have multiple mental health conditions that could involve episodes of both neurosis and psychosis.

For example, someone could have OCD and schizophrenia and would likely experience both neurosis and psychosis within the total list of their symptoms. This isn't because of a connection between the two, it's just an overlap of symptoms.

Some research has found that it's fairly common Trusted Source for some people to experience episodes of both neurosis and psychosis in the full scope of their mental health symptoms.

Can neurosis turn into psychosis?

Despite their connection, neurosis doesn't turn into psychosis. If episodes of both are present, it's most likely due to multiple, overlapping conditions. Comorbidity (or having more than one) within mental health conditions is quite common.

It is possible for your anxiety to become so severe that symptoms of paranoia can develop, but this isn't psychosis.

If you're concerned about your mental health symptoms escalating, it can be helpful to keep a journal of your symptoms and discuss it with your therapist or psychiatrist.

17.8 TREATMENT OPTIONS FOR NEUROSIS VS. PSYCHOSIS :

Whether you or a loved one lives with psychosis or neurosis, it's possible to cope with both mental disorders. Learning how to manage stress and anxiety might decrease symptoms, but talking with a mental health professional to determine the underlying cause of the neurosis or psychosis is the best way to address them.

Because these terms represent a wide spectrum of mental health symptoms, the treatment methods also vary greatly but may include therapy, psychiatric medications, or in-patient treatment at a psychiatric ward.

Learn more about how to find the right therapist for you or how to find a psychiatrist, even without insurance.

Get support for neurosis and psychosis

If you or a loved one is living with neurosis or psychosis, know that you're not alone. While mental health conditions can sometimes have negative associations, there's no shame in being open about your mental health or seeking treatment for it. The organizations below may be able to help you on your journey:

- NAMI: National Alliance on Mental Illness or NAMI Family Support Groups
- SAMHSA: Substance Abuse and Mental Health Services Administration
- Neurotics Anonymous 12-Step Recovery Program
- International OCD Foundation
- Mental Health America
- Rethink Mental Illness
- Wounded Warrior Project
- BEAM: Black Emotional Mental Health Collective
- Asian Mental Health Collective
- The Trevor Project for LGBTQ Youth

If a loved one experiences neurosis or psychosis, be empathetic and allow them to talk about their feelings. Expressing themselves can improve their outlook, and your reassurance can boost their confidence. Work with them to help them find treatment options that can help improve their quality of life and experience less stress — not through any attempt to "fix" them.

17.9 SUMMARY :

Neurosis is an unofficial term used to talk about a spectrum of mental health conditions that involve anxiety, obsessive thoughts, and dissociative episodes. Psychosis is an official label for some symptoms of mental health conditions. These episodes involve seeing or hearing hallucinations, extreme emotional distress, and delusional beliefs.

Some people use the terms neurosis and psychosis interchangeably, but they represent very different elements of mental health conditions and their symptoms. Understanding their differences can help you get the right type of support and treatment, which can improve the quality of your life.

In short it should be understood that Neurosis and psychosis are not similar types of mental disorders. Neurosis is less significant and only a mental impact that can be cured by support from peers and also discussions with experts. Psychosis is a severe ailment that is both emotional and functional. The person with psychosis has a madness and can harm himself if not cared for properly. Hospitalization is a must to some extent in neurosis and a greater extent in psychosis.

17.10 KEYWORDS :

1. Classification
2. Mental disorders
3. Psychosis
4. Neurosis

17.11 SELF ASSESSMENT QUESTIONS

1. Discuss the classification of mental disorders?
2. Examine the treatment options for Neurosis and Psychosis?

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Prof. K. Dhanalakshmi

LESSON – 18

PSYCHOSOMATIC DISORDERS-
TREATMENT OF MENTAL DISORDERS

OBJECTIVE:

The objective of this lesson is to explain the psychosomatic disorders, types, treatment, types of psychological disorders, factors underlying abnormal behaviour, dealing with abnormal behaviour, key takeaways.

STRUCTURE:

18.1 INTRODUCTION :

Psychosomatic means mind (psyche) and body (soma). A psychosomatic disorder is a disease which involves both mind and body. Psychosomatic disorders are illnesses involving a physical and psychological component. Often people who develop these disorders have a genetic predisposition to mental health issues and then experience highly stressful life events. A psychosomatic disorder can be a physical illness exacerbated by a mental health issue, a mental health issue worsened by a physical illness, or a mental health issue which is experienced with physical symptoms. Due to the suspected mental health contribution, many of these disorders are treated, at least in part, by an antidepressant medication.

Example of Psychosomatic disorders

Kevin has lots of bizarre symptoms that are concerning to him. Sometimes he feels like he has a lump in his throat that's so large he can't swallow. Sometimes he loses his hearing for several hours at a time and then regains it for no known reason. Other times he loses feeling in his left hand and he is unable to move his fingers.

18.2 WHAT ARE PSYCHOSOMATIC DISORDERS? :

Psychosomatic disorders are conditions which cause troublesome, distressing physical symptoms, caused by the autonomic nervous system not functioning correctly. The autonomic nervous system controls involuntary actions within the body - such as your heart rate, blood pressure, digestion as well as other functions. There are many different symptoms and types of conditions which can result from this.

18.3 WHICH DISEASES ARE PSYCHOSOMATIC? :

To an extent most diseases are psychosomatic - involving both mind and body. There is a mental aspect to every physical disease. How we react to disease and how we cope with disease vary greatly from person to person There can be physical effects from mental illness. For example, with some mental illnesses you may not eat, or take care of yourself, very well which can cause physical problems.

Some physical diseases are thought to be particularly prone to be made worse by mental factors such as stress and anxiety. For example, these include:

- Psoriasis.
- Eczema.
- Stomach ulcers.
- High blood pressure.
- Heart disease.

It is thought that the actual physical part of the illness (the extent of a rash, the level of the blood pressure, etc) can be affected by mental factors. Many people with these and other physical diseases say their mental state can affect how bad their physical disease is at any given time.

Some people also use the term psychosomatic disorder when mental factors cause physical symptoms but where there is no physical disease found. For example, a chest pain may be caused by stress and no physical disease can be found.

How can the mind affect physical diseases?

It is well known that the mind can cause physical symptoms. For example, when we are afraid or anxious we may develop symptoms of anxiety. These are good examples of psychosomatic symptoms.

How are psychosomatic disorders diagnosed?

These conditions are diagnosed by a doctor. Sometimes you may need to see a specialist to be diagnosed.

You may need medical tests, depending on your symptom or condition. These conditions can be difficult to diagnose and it may take some time for your medical team to make the diagnosis to help you start the right treatment.

Treatments for psychosomatic disorders

Each disease or symptom has its own treatment options. In these conditions it is often important to take into account physical, mental and social factors which may be contributing

to a disease. Therefore, treatments such as medication, seeing a therapist, occupational therapist or starting treatments to ease stress, anxiety, depression, may help if they are thought to be contributing to your symptoms.

Treatments for psychosomatic disorder includes:

- **Psychotherapy:** This is also known as talking treatment. ...
- **Psychoanalysis:** This therapy is used to treat depression and anxiety disorder. ...
- **Cognitive behavior therapy (CBT):** CBT focuses on the examination of the patient's thoughts and beliefs that impact his/her mental condition.

Prevention of psychosomatic disorders

At present, we don't think they can be prevented. Hopefully further research looking at this will help us to understand if this might be possible in the future.

What is the outlook for people with psychosomatic disorder?

These conditions and symptoms can improve or go away completely with the right treatment. It depends on the condition or symptom you have, and relies on finding what treatments work for you. This is where working together with your medical team can make a big difference to your condition.

18.4 TYPES OF PSYCHOSOMATIC DISORDERS :

Psychological Issue

The first type of psychosomatic disorder involves a medical issue likely made worse by a psychological issue. This is often a presumption, as research has not found a specific physical cause of the medical condition. Instead, researchers have found mental health issues often accompany it. This link is also suspected because effective treatment often involves the use of antidepressant medications. Examples of this type of psychosomatic disorder are fibromyalgia, irritable bowel syndrome, or multiple chemical sensitivity.

Example:

Jon can be easily described as being a really anxious guy. He feels nervous in almost any situation and around most people, unless he knows you really well. He's also incredibly sensitive to being around certain non-natural substances. He can't stand to be near a freshly painted room, or in a carpeted room instead of one with hard floors. He can barely tolerate sitting in the waiting room at his doctor's office because of the vinyl chairs. Jon will feel nauseated, light headed, his nose will become stopped up, and sometimes his chest will feel tight. The odd thing is that Jon smokes a pack of cigarettes a day, and this doesn't seem to bother him at all. Jon's health checks out just fine and his doctor concludes he has multiple chemical sensitivities, or an unexplained sensitivity to different chemicals for unknown reasons, with an inconsistent presentation of symptoms.

Medical Conditions

The second type of psychosomatic disorder involves mental health symptoms which are made worse by a medical condition. This could be due to adjusting to a life-altering medical diagnosis such as cancer, or even diabetes.

Psychosomatic Disorder Treatment Options

The term psychosomatic disorder is used to refer to a condition in which a physical disease is thought to be caused or made worse by mental stress or related factors.

Since this disorder correlates with the mind and body, its treatment also involves remedial measures from both medical and psychological fields.

A person with a psychosomatic illness is first screened for the presence of stress factors before the appropriate treatment is provided.

18.5 TREATMENTS FOR PSYCHOSOMATIC DISORDER :

Each person experiences different medical illnesses due to physical stress. Physical diseases caused by mental factors can be treated either through medication or surgeries; however, the complete cure from this condition can be achieved only when the cause for the generation of the mental stress is identified. Thus, the therapies to alleviate these psychological factors like stress, anxiety, and depression are essential to healing the physical disease.

- **Psychotherapy:** This is also known as talking treatment. Here, the doctor and the patient have an interaction about the mental status and lifestyle events that the patient experiences. This interaction helps the therapist to analyze the particular mental illness that the patient is suffering from to provide the appropriate therapy.

- **Psychoanalysis:** This therapy is used to treat depression and anxiety disorder. It is a lengthy process that involves two to five sessions per week for several years. The psychoanalyst will make a note of the patient's childhood memories and dreams that play a role in the patient's mental status.

- **Cognitive behavior therapy (CBT):** CBT focuses on the examination of the patient's thoughts and beliefs that impact his/her mental condition. This form of therapy helps to overcome those feelings of the patient that lead to an alteration in his/her behavior. It enables the patient to overcome negative situations like depression, anger, phobias, and chronic pain, to name a few. Sessions can vary based on the severity of the patient's condition.

- **Group psychotherapy:** Group psychotherapy typically involves 5 to 15 patients in a group under a trained psychiatrist. They are given the practice to attain a normal balanced attitude. This therapy is for patients who have relationship difficulties, medical illness, etc. The group assembles in a private place for 1 to 2 hours every week.

- **Electroconvulsive therapy (ECT):** This type of therapy IS mainly provided for patients with severe depression and other mental conditions. It involves the transition of a stable electric current through the brain in order to trigger its activity to relieve symptoms of mental illness. ECT is given for a period of one month with certain intervals and is safer and more effective as compared to treatment with medication.

- **Hypnotherapy:** Hypnosis induces a trance-like (unconscious) state in which the conscious control of the mind is suppressed and the subconscious mind is revealed, through which the hypnotist can understand the state of mind of the patient. Hypnotherapy is used to treat stress-related disorders like insomnia and other conditions that are worsened by tensions like irritable bowel syndrome, psoriasis, and eczema, for example.

- **Abreaction therapy:** This is a therapy used to relieve the emotions associated with traumatic events. The duration required for this type of therapy is longer as compared with other therapies and is not used widely.

- **Acupuncture therapy:** The basic principle of this therapy is stimulating the points in the body by use of needles, to correct irregularities in the flow of energy through channels known as meridians. This is primarily used to treat anxiety and depression. Sessions may vary on the basis of the patient's relief from stress factors. Many patients sense a deep feeling of relaxation after acupuncture treatment.

Auxiliary treatments for psychosomatic illness

- **Pharmacotherapy:** This is a supportive treatment provided along with psychotherapy and ECT. It reduces depression and anxiety by administration of antidepressants and anxiolytics, respectively. This therapy improves the mental disturbances in the patient only after several weeks.

- **Psychosomatic physiotherapy:** This therapy focuses on attaining better health for the patient by regulating the emotional balance in the mind.

- **Exercises:** Physical activity is known to improve both bodily and mental health in psychic patients by relieving them of psychiatric and social disabilities. In fact, studies have suggested that exercises can improve social interaction, physical body perception, etc.

- **Yoga:** In mentally ill patients, breathing methods (pranayama) and meditation are quite effective to relieve stress. When the breath is held, the muscles are strained so that the stress, fear, and other factors are rejected for a certain time. Prolongation of the time period has an effect on the thoughts and feelings of psychosomatic patients.

- **Osteopathy:** This therapy involves the employment of hand pressure (massage) to reduce stress. The objective of this manual medicine is to provide a positive influence on the nervous, circulatory, and lymphatic systems of the body. The therapy helps to reduce anxiety and pain and provides an opportunity for the patient's body to heal itself.

- **Lifestyle changes:** Limiting caffeine intake, eating a balanced diet, having vitamin supplements, and avoiding alcohol and smoking can also relieve anxiety to a particular extent.

18.6 FACTORS UNDERLYING ABNORMAL BEHAVIOUR :

In order to understand something as complex as abnormal behaviour, psychologists use different approaches. Each approach in use today emphasizes a different aspect of human behaviour, and explains and treats abnormality in line with that aspect. These approaches also emphasise the role of different factors such as biological, psychological and interpersonal, and socio-cultural factors. We will examine some of the approaches which are currently being used to explain abnormal behaviour.

Biological factors influence all aspects of our behaviour. A wide range of biological factors such as faulty genes, endocrine imbalances, malnutrition, injuries and other conditions may interfere with normal development and functioning of the human body. These factors may be potential causes of abnormal behaviour. We have already come across the biological model. According to this model, abnormal behaviour has a biochemical or physiological basis. Biological researchers have found that psychological disorders are often related to problems in the transmission of messages from one neuron to another. You have studied in Class XI, that a tiny space called synapse separates one neuron from the next, and the message must move across that space. When an electrical impulse reaches a neuron's ending, the nerve ending is stimulated to release a chemical, called a neurotransmitter. Studies indicate that abnormal activity by certain neurotransmitters can lead to specific psychological disorders. Anxiety disorders have been linked to low activity of the neurotransmitter gamma aminobutyric acid (GABA), schizophrenia to excess activity of dopamine, and depression to low activity of serotonin.

Genetic factors have been linked to mood disorders, schizophrenia, mental retardation and other psychological disorders. Researchers have not, however, been able to identify the specific genes that are the culprits. It appears that in most cases, no single gene is responsible for a particular behaviour or a psychological disorder. Infact, many genes combine to help bring about our various behaviours and emotional reactions, both functional and dysfunctional. Although there is sound evidence to believe that genetic/ biochemical factors are involved in mental disorders as diverse as schizophrenia, depression, anxiety, etc. and biology alone cannot account for most mental disorders.

There are several psychological models which provide a psychological explanation of mental disorders. These models maintain that psychological and interpersonal factors have a significant role to play in abnormal behaviour. These factors include maternal deprivation (separation from the mother, or lack of warmth and stimulation during early years of life), faulty parent-child relationships (rejection, overprotection, over-permissiveness, faulty discipline, etc.), maladaptive family structures (inadequate or disturbed family), and severe stress.

The psychological models include the psychodynamic, behavioural, cognitive, and humanistic-existential models. The psychodynamic model is the oldest and most famous of the modern psychological models. You have already read about this model in Chapter 2 on Self and Personality. Psychodynamic theorists believe that behaviour, whether normal or abnormal, is determined by psychological forces within the person of which s/he is not consciously aware. These internal forces are considered dynamic, i.e. they interact with one another and their interaction gives shape to behaviour, thoughts and emotions. Abnormal symptoms are viewed as the result of conflicts between these forces. This model was first formulated by Freud who believed that three central forces shape personality — instinctual

needs, drives and impulses (id), rational thinking (ego), and moral standards (superego). Freud stated that abnormal behaviour is a symbolic expression of unconscious mental conflicts that can be generally traced to early childhood or infancy.

Another model that emphasizes the role of psychological factors is the behavioural model. This model states that both normal and abnormal behaviours are learned and psychological disorders are the result of learning maladaptive ways of behaving. The model concentrates on behaviours that are learned through conditioning and proposes that what has been learned can be unlearned. Learning can take place by classical conditioning (temporal association in which two events repeatedly occur close together in time), operant conditioning (behaviour is followed by a reward), and social learning (learning by imitating others' behaviour). These three types of conditioning account for behaviour, whether adaptive or maladaptive.

Psychological factors are also emphasized by the cognitive model. This model states that abnormal functioning can result from cognitive problems. People may hold assumptions and attitudes about themselves that are irrational and inaccurate. People may also repeatedly think in illogical ways and make over generalizations, that is, they may draw broad, negative conclusions on the basis of a single insignificant event.

Another psychological model is the humanistic-existential model which focuses on broader aspects of human existence. Humanists believe that human beings are born with a natural tendency to be friendly, cooperative and constructive, and are driven to self-actualize, i.e. to fulfil this potential for goodness and growth. Existentialists believe that from birth we have total freedom to give meaning to our existence or to avoid that responsibility. Those who shirk from this responsibility would live empty, inauthentic, and dysfunctional lives.

In addition to the biological and psychosocial factors, socio-cultural factors such as war and violence, group prejudice and discrimination, economic and employment problems, and rapid social change, put stress on most of us and can also lead to psychological problems in some individuals. According to the sociocultural model, abnormal behaviour is best understood in light of the social and cultural forces that influence an individual. As behaviour is shaped by societal forces, factors such as family structure and communication, social networks, societal conditions, and societal labels and roles become more important. It has been found that certain family systems are likely to produce abnormal functioning in individual members. Some families have an enmeshed structure in which the members are overinvolved in each other's activities, thoughts, and feelings. Children from this kind of family may have difficulty in becoming independent in life. The broader social networks in which people operate include their social and professional relationships. Studies have shown that people who are isolated and lack social support, i.e. strong and fulfilling interpersonal relationships in their lives are likely to become more depressed and remain depressed longer than those who have good friendships. Socio-cultural theorists also believe that abnormal functioning is influenced by the societal labels and roles assigned to troubled people. When people break the norms of their society, they are called deviant and 'mentally ill'. Such labels tend to stick so that the person may be viewed as 'crazy' and encouraged to act sick. The person gradually learns to accept and play the sick role, and functions in a disturbed manner.

In addition to these models, one of the most widely accepted explanations of abnormal behaviour has been provided by the diathesis-stress model. This model states that psychological disorders develop when a diathesis (biological predisposition to the disorder) is

set off by a stressful situation. This model has three components. The first is the diathesis or the presence of some biological aberration which may be inherited. The second component is that the diathesis may carry a vulnerability to develop a psychological disorder. This means that the person is 'at risk' or 'predisposed' to develop the disorder. The third component is the presence of pathogenic stressors, i.e. factors/stressors that may lead to psychopathology. If such "at risk" persons not are exposed to these stressors, their predisposition may actually evolve into a disorder. This model has been applied to several disorders including anxiety, depression, and schizophrenia.

18.7 DEALING WITH ABNORMAL BEHAVIOUR :

According to the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM 5), there are nearly 400 different psychological disorders. Some of these disorders fit the definition of "disease," a problem that impairs functioning and that mostly stems from biological causes. Common examples include bipolar disorder and schizophrenia.

Other "disorders" impair functioning but are determined by a more diverse array of causes, some of which are psychological and social/cultural in nature. In this sense, these conditions are not true "diseases." Examples include anxiety disorders, depression, addictive disorders, and eating disorders.

The distinction between "diseases" and "disorders" helps to suggest appropriate treatments. In general, diseases require biological intervention. Research suggests, for example, that medication is very successful in helping individuals to manage symptoms that accompany bipolar disorder and schizophrenia.

18.8 TYPES OF PSYCHOLOGICAL DISORDERS :

Psychological disorders are defined as patterns of behavioral or psychological symptoms that impact multiple areas of life. These mental disorders create distress for the person experiencing symptoms.

The Diagnostic and Statistical Manual of Mental Disorders is published by the American Psychiatric Association (APA) and is used by mental health professionals for a variety of purposes. The manual contains a listing of psychiatric disorders, diagnostic codes, information on the prevalence of each disorder, and diagnostic criteria.

Some of the categories of psychological disorders include:

- Substance use disorders
- Mood disorders, such as depression and bipolar disorder
- Anxiety disorders, such as social anxiety disorder, panic disorder, and generalized anxiety disorder
- Neurodevelopmental disorders, such as an intellectual disability or autism spectrum disorder
- Neurocognitive disorders like delirium
- Personality disorders, such as borderline personality disorder, avoidant personality disorder, and obsessive-compulsive personality disorder

18.9 HOW UNDERSTANDING ABNORMALITIES CAN IMPROVE LIVES :

Abnormal psychology may focus on atypical behavior, but its focus is not to ensure that all people fit into a narrow definition of "normal." In most cases, it is centered on identifying and treating problems that may be causing distress or impairment in some aspect of an individual's life. By better understanding what is "abnormal," researchers and therapists can come up with new ways to help people live healthier and more fulfilling lives.

18.10 KEY TAKEAWAYS: TREATMENT OF ABNORMAL BEHAVIOR :

1. Psychological treatment is provided by mental health professionals in a variety of settings. The two most common types of treatment are psychotherapy and pharmacological treatment.
2. Psychotherapies come in a variety of theoretical orientations and formats. The most common treatment orientations are psychodynamic, humanistic, behavioral, cognitive, biomedical, and integrated. The four main formats of psychotherapy are individual, group, couples, and family.
3. Research suggests that psychotherapy generally helps patients to make positive changes in their lives, but some types of treatment are more effective for particular conditions than others.
4. Culture influences a variety of factors important to treatment. Decreased access, racism, and Eurocentrism contribute to unequal outcomes for patients from marginalized groups, but measures such as multicultural competence may help to alleviate these inequalities.
5. Effective prevention programs reduce environmental risk factors for mental illness and build up strengths. Prevention efforts might focus on promoting health, increasing competence, or building resilience.

What is Psychological Treatment?

- **Mental health professionals:** Psychologists, medical doctors and nurses, social workers, and licensed counselors who provide psychological treatment.
- **Psychotherapy:** An ongoing relationship between a patient and a therapist, in which the two discuss the patient's experiences and symptoms.
- **Pharmacological treatment:** When a mental health professional prescribes a drug for a patient to alleviate psychological distress.

18.11 TREATMENT ORIENTATIONS AND FORMATS :

- **Theoretical orientation:** A therapist's belief system about the cause and nature of psychological distress and the appropriate treatment, which influences the therapist's choice of techniques and treatment goals.
- **Dream interpretation:** A psychodynamic therapy technique that analyzes the meaning of symbols from dreams to help access the unconscious.
- **Free association:** A psychodynamic therapy technique in which the patient is instructed to "think out loud" to help access the unconscious.
- **Transference:** A term from psychodynamic therapy to describe when feelings directed at one person become redirected to another person, often the therapist.
- **Self-actualization:** A term from humanistic therapy that refers to an individual's ability to live up to his or her full human potential.

- **Client-centered therapy:** The most popular humanistic therapy, which views patients as "clients" and focuses on authenticity and healthy self-concept; created by Carl Rogers.
- **Unconditional positive regard:** A client-centered technique in which the therapist communicates positive feelings and acceptance to the client, regardless of what the client says or does.
- **Active listening:** A client-centered technique in which the therapist verbally and non-verbally communicates interest in what the client is saying in order to encourage openness.
- **Gestalt therapy:** A humanistic therapy that maintains that psychological distress occurs when patients focus on what could be, rather than on the present moment; developed by Fritz Perls
- **Existential therapy:** A humanistic therapy based on the theory that psychological distress occurs when life lacks meaning; popularized by Irving Yalom.
- **Learned helplessness:** A phenomenon described by behaviorists in which an individual, frustrated by failed attempts to escape an adverse situation, gives up all efforts to escape it.
- **Applied behavioral analysis (ABA):** A behavioral therapy technique used to identify factors in the environment that are reinforcing or punishing certain behaviors.
- **Token economies:** A technique used in behavioral therapy to reinforce positive behaviors with tokens, which can be exchanged for other rewards.
- **Systematic desensitization:** A behavioral therapy used to treat phobias by gradually associating feared stimuli with relaxing stimuli; created by Joseph Wolpe.
- **Aversion therapy:** A behavioral therapy used to decrease the frequency of a habitual behavior by pairing it with an aversive stimulus.

18.12 SUMMARY :

In conclusion, the realm of psychosomatic disorders, which represent a profound interconnection between the mind and the body, necessitates a comprehensive understanding for effective treatment of mental disorders. Psychosomatic disorders manifest as physical symptoms with underlying psychological causes, emphasizing the intricate link between emotional well-being and physical health. Several disorders fall under the umbrella of psychosomatic conditions, including somatic symptom disorder, illness anxiety disorder, and conversion disorder. These conditions often blur the lines between mental and physical health, emphasizing the importance of an integrated approach to treatment. The treatment of psychosomatic disorders involves a multifaceted approach that addresses both the psychological and physical aspects of the condition.

Psychotherapy, particularly cognitive-behavioral therapy (CBT), serves as a cornerstone in treating psychosomatic disorders. CBT helps individuals recognize and modify dysfunctional thought patterns and behaviors that contribute to the physical symptoms. Additionally, pharmacotherapy may be employed to manage specific symptoms or underlying psychiatric conditions. Medications such as antidepressants or anxiolytics may be prescribed to alleviate psychological distress, thus contributing to the improvement of physical symptoms. Complementary and alternative therapies, including mindfulness-based stress reduction (MBSR), relaxation techniques, and biofeedback, can also play a significant role in managing psychosomatic disorders. These approaches focus on enhancing self-awareness, stress reduction, and the mind-body connection. Collaborative and patient-centered care is essential in treating psychosomatic disorders, involving a multidisciplinary

team comprising mental health professionals, physicians, and other healthcare providers. The holistic approach recognizes the intricate interplay between mental and physical health, fostering a comprehensive and individualized treatment plan. In conclusion, understanding, and addressing psychosomatic disorders necessitates a nuanced approach that acknowledges the complex interrelation between psychological and physical well-being. Through tailored treatments encompassing psychotherapy, pharmacotherapy, and complementary interventions, individuals grappling with psychosomatic disorders can embark on a path toward improved mental and physical health. The evolving landscape of mental healthcare underscores the importance of continued research and collaborative efforts to refine treatment strategies and enhance the well-being of those affected by psychosomatic disorders.

18.13 KEYWORDS :

1. Psychosomatic
2. Mental disorder
3. Treatment
4. Abnormal psychology

18.14 SELF ASSESSMENT QUESTIONS :

1. Analyze the treatment for psychosomatic disorders.
2. Discuss the types and treatment for mental disorders.

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Prof. K. Dhanalakshmi

LESSON – 19

ALCOHOLISM AND DRUG ADDICTION

OBJECTIVE:

The objective of this lesson is to explain the signs of alcohol or drug dependence, recognizing and reducing the problem, recognizing signs of drug use, stages of intervention, risk factors, complications, prevention.

STRUCTURE:

19.1 INTRODUCTION :

It is often difficult for people to recognize that they have become dependent on alcohol or other drugs. They may see it as a temporary situation because they are in physical pain or because they are dealing with a difficult situation such as grief, loss, anxiety or trauma.

Asking for help when you first suspect you have a problem is important so that you can get support to make changes. The earlier you reach out the better – but it's never too late.

19.2 SIGNS OF ALCOHOL OR OTHER DRUG DEPENDENCE :

Some signs that you may have an alcohol or other drug problem are:

- changed eating or sleeping habits
- caring less about your appearance
- spending more time with people who drink or use drugs to excess
- missing appointments, classes or work commitments
- losing interest in activities that you used to love

- getting in trouble in school, at work or with the law
- getting into more arguments with family and friends
- friends or family asking you if you use alcohol or other drugs
- relying on drugs or alcohol to have fun or relax
- having blackouts
- drinking or using drugs when you are alone
- keeping secrets from friends or family
- finding you need more and more of the substance to get the same feeling.

Often it is family and friends who first recognize that a person they care about has an alcohol or drug problem. They may have noticed them acting differently – being withdrawn, always tired, increasingly hostile or easily upset. They may ask the person straight out if they are using alcohol or other drugs.

If that happens to you, you might feel threatened or criticized. Try to remember that they're trying to look out for your wellbeing. A positive first step would be to listen, reflect, and be honest with yourself about what they had to say.

19.3 RECOGNIZING AN ALCOHOL AND DRUG PROBLEM :

There is no particular type of person who becomes dependent on alcohol or other drugs. It can happen to anyone.

What starts as occasional use of a drug or one prescription of pain-relieving medication, for example, can get out of control as time passes – especially in times of pain or stress. You may find you need bigger doses to get the same feeling or to lessen the pain. Eventually, you may depend on the drug to feel good or to get through your day.

Other signs that you are becoming dependent on alcohol or other drugs include:

- having intense urges for the substance – this could be once a day or several times a day
- needing more of a substance to get the same effect
- fixating about making sure you have a constant supply of the substance
- spending money on the substance, even when you cannot afford it
- cutting back on social or other activities
- not meeting your work, family or study responsibilities
- lying to people about your alcohol or drug use when they ask
- doing things that are illegal so you can get the substance, such as stealing
- taking risks such as driving when you are under the influence of the substance
- trying but failing to stop using the substance
- experiencing withdrawal symptoms when you try to stop taking the substance.

19.4 REDUCING OR STOPPING USE OF ALCOHOL OR OTHER DRUGS :

Cutting down on alcohol or other drugs is hard to do because repeated alcohol or drug use makes the body more dependent and changes the brain. Brain scans of people who are dependent on alcohol or other drugs often show changes in the areas of the brain that help you learn and remember and make decisions.

The best thing you can do is to talk to someone you trust so you do not have to deal with this challenge alone.

Getting help for alcohol or other drug dependence

If you think that you or someone close to you has an alcohol or other drug problem, speak first with your local doctor. There are Doctors who are accessible 24-hour-a-day giving information and advice by maintaining anonymity and keeping the information confidential. You can talk to a professional counsellor who is experienced in alcohol and drug-related matters, and they can start you on the right track.

19.5 DRUG ADDICTION – SUBSTANCE USE DISORDER :

Overview

Drug addiction, also called substance use disorder, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medicine. Substances such as alcohol, marijuana and nicotine also are considered drugs. When you're addicted, you may continue using the drug despite the harm it causes.

Drug addiction can start with experimental use of a recreational drug in social situations, and, for some people, the drug use becomes more frequent. For others, particularly with opioids, drug addiction begins when they take prescribed medicines or receive them from others who have prescriptions.

The risk of addiction and how fast you become addicted varies by drug. Some drugs, such as opioid painkillers, have a higher risk and cause addiction more quickly than others.

As time passes, you may need larger doses of the drug to get high. Soon you may need the drug just to feel good. As your drug use increases, you may find that it's increasingly difficult to go without the drug. Attempts to stop drug use may cause intense cravings and make you feel physically ill. These are called withdrawal symptoms.

Help from your health care provider, family, friends, support groups or an organized treatment program can help you overcome your drug addiction and stay drug-free.

Symptoms

Drug addiction symptoms or behaviors include, among others:

- Feeling that you have to use the drug regularly — daily or even several times a day
- Having intense urges for the drug that block out any other thoughts
- Over time, needing more of the drug to get the same effect
- Taking larger amounts of the drug over a longer period of time than you intended
- Making certain that you maintain a supply of the drug
- Spending money on the drug, even though you can't afford it
- Not meeting obligations and work responsibilities, or cutting back on social or recreational activities because of drug use
- Continuing to use the drug, even though you know it's causing problems in your life or causing you physical or psychological harm
- Doing things to get the drug that you normally wouldn't do, such as stealing
- Driving or doing other risky activities when you're under the influence of the drug

- Spending a good deal of time getting the drug, using the drug or recovering from the effects of the drug
- Failing in your attempts to stop using the drug
- Experiencing withdrawal symptoms when you attempt to stop taking the drug

Recognizing unhealthy drug use in family members

Sometimes it's difficult to distinguish normal teenage moodiness or anxiety from signs of drug use. Possible signs that your teenager or other family member is using drugs include:

- **Problems at school or work** — frequently missing school or work, a sudden disinterest in school activities or work, or a drop in grades or work performance
- **Physical health issues** — lack of energy and motivation, weight loss or gain, or red eyes
- **Neglected appearance** — lack of interest in clothing, grooming or looks
- **Changes in behavior** — major efforts to bar family members from entering the teenager's room or being secretive about going out with friends; or drastic changes in behavior and in relationships with family and friends
- **Money issues** — sudden requests for money without a reasonable explanation; or your discovery that money is missing or has been stolen or that items have disappeared from your home, indicating maybe they're being sold to support drug use

19.6 RECOGNIZING SIGNS OF DRUG USE OR INTOXICATION :

Signs and symptoms of drug use or intoxication may vary, depending on the type of drug. Below you'll find several examples.

Marijuana, hashish and other cannabis-containing substances

People use cannabis by smoking, eating or inhaling a vaporized form of the drug. Cannabis often precedes or is used along with other substances, such as alcohol or illegal drugs, and is often the first drug tried.

Signs and symptoms of recent use can include:

- A sense of euphoria or feeling "high"
- A heightened sense of visual, auditory and taste perception
- Increased blood pressure and heart rate
- Red eyes
- Dry mouth
- Decreased coordination
- Difficulty concentrating or remembering
- Slowed reaction time
- Anxiety or paranoid thinking
- Cannabis odor on clothes or yellow fingertips
- Major cravings for certain foods at unusual times

Long-term use is often associated with:

- Decreased mental sharpness
- Poor performance at school or at work
- Ongoing cough and frequent lung infections

K2, Spice and bath salts

Two groups of synthetic drugs — synthetic cannabinoids and substituted or synthetic cathinones — are illegal in most states. The effects of these drugs can be dangerous and unpredictable, as there is no quality control and some ingredients may not be known.

Synthetic cannabinoids, also called K2 or Spice, are sprayed on dried herbs and then smoked, but can be prepared as an herbal tea. A liquid form can be vaporized in electronic cigarettes. Despite manufacturer claims, these are chemical compounds rather than "natural" or harmless products. These drugs can produce a "high" similar to marijuana and have become a popular but dangerous alternative.

Signs and symptoms of recent use can include:

- A sense of euphoria or feeling "high"
- Elevated mood
- An altered sense of visual, auditory and taste perception
- Extreme anxiety or agitation
- Paranoia
- Hallucinations
- Increased heart rate and blood pressure or heart attack
- Vomiting
- Confusion
- Violent behavior

Substituted cathinones, also called "bath salts," are mind-altering (psychoactive) substances similar to amphetamines such as ecstasy (MDMA) and cocaine. Packages are often labeled as other products to avoid detection.

Despite the name, these are not bath products such as Epsom salts. Substituted cathinones can be eaten, snorted, inhaled or injected and are highly addictive. These drugs can cause severe intoxication, which results in dangerous health effects or even death.

Signs and symptoms of recent use can include:

- Feeling "high"
- Increased sociability
- Increased energy and agitation
- Increased sex drive
- Increased heart rate and blood pressure
- Problems thinking clearly
- Loss of muscle control
- Paranoia
- Panic attacks
- Hallucinations
- Delirium
- Psychotic and violent behavior

Barbiturates, benzodiazepines and hypnotics

Barbiturates, benzodiazepines and hypnotics are prescription central nervous system depressants. They're often used and misused in search for a sense of relaxation or a desire to "switch off" or forget stress-related thoughts or feelings.

- **Barbiturates.** An example is phenobarbital.
- **Benzodiazepines.** Examples include sedatives, such as diazepam (Valium), alprazolam (Xanax), lorazepam (Ativan), clonazepam (Klonopin) and chlordiazepoxide (Librium).
- **Hypnotics.** Examples include prescription sleeping medicines such as zolpidem (Ambien) and zaleplon (Sonata).

Signs and symptoms of recent use can include:

- Drowsiness
- Slurred speech
- Lack of coordination
- Irritability or changes in mood
- Problems concentrating or thinking clearly
- Memory problems
- Involuntary eye movements
- Lack of inhibition
- Slowed breathing and reduced blood pressure
- Falls or accidents
- Dizziness

Meth, cocaine and other stimulants

Stimulants include amphetamines, meth (methamphetamine), cocaine, methylphenidate (Ritalin, Concerta, others) and amphetamine-dextroamphetamine (Adderall XR, Mydayis). They're often used and misused in search of a "high," or to boost energy, to improve performance at work or school, or to lose weight or control appetite.

Signs and symptoms of recent use can include:

- Feeling of happy excitement and too much confidence
- Increased alertness
- Increased energy and restlessness
- Behavior changes or aggression
- Rapid or rambling speech
- Larger than usual pupils, the black circles in the middle of the eyes
- Confusion, delusions and hallucinations
- Irritability, anxiety or paranoia
- Changes in heart rate, blood pressure and body temperature
- Nausea or vomiting with weight loss
- Poor judgment
- Nasal congestion and damage to the mucous membrane of the nose (if snorting drugs)
- Mouth sores, gum disease and tooth decay from smoking drugs ("meth mouth")
- Insomnia
- Depression as the drug wears off

Club drugs

Club drugs are commonly used at clubs, concerts and parties. Examples include methylenedioxymethamphetamine, also called MDMA, ecstasy or molly, and gamma-hydroxybutyric acid, known as GHB. Other examples include ketamine and flunitrazepam or Rohypnol — a brand used outside the U.S. — also called roofie. These drugs are not all in the same category, but they share some similar effects and dangers, including long-term harmful effects.

Because GHB and flunitrazepam can cause sedation, muscle relaxation, confusion and memory loss, the potential for sexual misconduct or sexual assault is associated with the use of these drugs.

Signs and symptoms of use of club drugs can include:

- Hallucinations
- Paranoia
- Larger than usual pupils
- Chills and sweating
- Involuntary shaking (tremors)
- Behavior changes
- Muscle cramping and teeth clenching
- Muscle relaxation, poor coordination or problems moving
- Reduced inhibitions
- Heightened or altered sense of sight, sound and taste
- Poor judgment
- Memory problems or loss of memory
- Reduced consciousness
- Increased or decreased heart rate and blood pressure

Hallucinogens

Use of hallucinogens can produce different signs and symptoms, depending on the drug. The most common hallucinogens are lysergic acid diethylamide (LSD) and phencyclidine (PCP).

LSD use may cause:

- Hallucinations
- Greatly reduced perception of reality, for example, interpreting input from one of your senses as another, such as hearing colors
- Impulsive behavior
- Rapid shifts in emotions
- Permanent mental changes in perception
- Rapid heart rate and high blood pressure
- Tremors
- Flashbacks, a reexperience of the hallucinations — even years later

PCP use may cause:

- A feeling of being separated from your body and surroundings
- Hallucinations

- Problems with coordination and movement
- Aggressive, possibly violent behavior
- Involuntary eye movements
- Lack of pain sensation
- Increase in blood pressure and heart rate
- Problems with thinking and memory
- Problems speaking
- Poor judgment
- Intolerance to loud noise
- Sometimes seizures or coma

Inhalants

Signs and symptoms of inhalant use vary, depending on the substance. Some commonly inhaled substances include glue, paint thinners, correction fluid, felt tip marker fluid, gasoline, cleaning fluids and household aerosol products. Due to the toxic nature of these substances, users may develop brain damage or sudden death.

Signs and symptoms of use can include:

- Possessing an inhalant substance without a reasonable explanation
- Brief happy excitement
- Behaving as if drunk
- Reduced ability to keep impulses under control
- Aggressive behavior or eagerness to fight
- Dizziness
- Nausea or vomiting
- Involuntary eye movements
- Appearing under the influence of drugs, with slurred speech, slow movements and poor coordination
- Irregular heartbeats
- Tremors
- Lingering odor of inhalant material
- Rash around the nose and mouth

Opioid painkillers

Opioids are narcotic, painkilling drugs produced from opium or made synthetically. This class of drugs includes, among others, heroin, morphine, codeine, methadone, fentanyl and oxycodone.

Sometimes called the "opioid epidemic," addiction to opioid prescription pain medicines has reached an alarming rate across the United States. Some people who've been using opioids over a long period of time may need physician-prescribed temporary or long-term drug substitution during treatment.

Signs and symptoms of narcotic use and dependence can include:

- A sense of feeling "high"
- Reduced sense of pain
- Agitation, drowsiness or sedation
- Slurred speech

- Problems with attention and memory
- Pupils that are smaller than usual
- Lack of awareness or inattention to surrounding people and things
- Problems with coordination
- Depression
- Confusion
- Constipation
- Runny nose or nose sores (if snorting drugs)
- Needle marks (if injecting drugs)

19.6 WHEN TO SEE A DOCTOR :

If your drug use is out of control or causing problems, get help. The sooner you seek help, the greater your chances for a long-term recovery. Talk with your health care provider or see a mental health provider, such as a doctor who specializes in addiction medicine or addiction psychiatry, or a licensed alcohol and drug counselor.

Make an appointment to see a provider if:

- You can't stop using a drug
- You continue using the drug despite the harm it causes
- Your drug use has led to unsafe behavior, such as sharing needles or unprotected sex
- You think you may be having withdrawal symptoms after stopping drug use

If you're not ready to approach a health care provider or mental health professional, help lines or hotlines may be a good place to learn about treatment. You can find these lines listed on the internet or in the phone book.

19.7 WHEN TO SEEK EMERGENCY HELP :

Seek emergency help if you or someone you know has taken a drug and:

- May have overdosed
- Shows changes in consciousness
- Has trouble breathing
- Has seizures or convulsions
- Has signs of a possible heart attack, such as chest pain or pressure
- Has any other troublesome physical or psychological reaction to use of the drug

19.8 STAGING AN INTERVENTION :

People struggling with addiction usually deny they have a problem and hesitate to seek treatment. An intervention presents a loved one with a structured opportunity to make changes before things get even worse and can motivate someone to seek or accept help.

It's important to plan an intervention carefully. It may be done by family and friends in consultation with a health care provider or mental health professional such as a licensed alcohol and drug counselor, or directed by an intervention professional. It involves family and friends and sometimes co-workers, clergy or others who care about the person struggling with addiction.

During the intervention, these people gather together to have a direct, heart-to-heart conversation with the person about the consequences of addiction. Then they ask the person to accept treatment.

Causes

Like many mental health disorders, several factors may contribute to development of drug addiction. The main factors are:

- **Environment.** Environmental factors, including your family's beliefs and attitudes and exposure to a peer group that encourages drug use, seem to play a role in initial drug use.
- **Genetics.** Once you've started using a drug, the development into addiction may be influenced by inherited (genetic) traits, which may delay or speed up the disease progression.

Changes in the brain

Physical addiction appears to occur when repeated use of a drug changes the way your brain feels pleasure. The addicting drug causes physical changes to some nerve cells (neurons) in your brain. Neurons use chemicals called neurotransmitters to communicate. These changes can remain long after you stop using the drug.

19.9 RISK FACTORS :

People of any age, sex or economic status can become addicted to a drug. Certain factors can affect the likelihood and speed of developing an addiction:

- **Family history of addiction.** Drug addiction is more common in some families and likely involves an increased risk based on genes. If you have a blood relative, such as a parent or sibling, with alcohol or drug addiction, you're at greater risk of developing a drug addiction.
- **Mental health disorder.** If you have a mental health disorder such as depression, attention-deficit/hyperactivity disorder (ADHD) or post-traumatic stress disorder, you're more likely to become addicted to drugs. Using drugs can become a way of coping with painful feelings, such as anxiety, depression and loneliness, and can make these problems even worse.
- **Peer pressure.** Peer pressure is a strong factor in starting to use and misuse drugs, particularly for young people.
- **Lack of family involvement.** Difficult family situations or lack of a bond with your parents or siblings may increase the risk of addiction, as can a lack of parental supervision.
- **Early use.** Using drugs at an early age can cause changes in the developing brain and increase the likelihood of progressing to drug addiction.
- **Taking a highly addictive drug.** Some drugs, such as stimulants, cocaine or opioid painkillers, may result in faster development of addiction than other drugs. Smoking or injecting drugs can increase the potential for addiction. Taking drugs considered less addicting — so-called "light drugs" — can start you on a pathway of drug use and addiction.

19.10 COMPLICATIONS :

Drug use can have significant and damaging short-term and long-term effects. Taking some drugs can be particularly risky, especially if you take high doses or combine them with other drugs or alcohol. Here are some examples.

- Methamphetamine, opiates and cocaine are highly addictive and cause multiple short-term and long-term health consequences, including psychotic behavior, seizures or death due to overdose. Opioid drugs affect the part of the brain that controls breathing, and overdose can result in death. Taking opioids with alcohol increases this risk.
- GHB and flunitrazepam may cause sedation, confusion and memory loss. These so-called "date rape drugs" are known to impair the ability to resist unwanted contact and recollection of the event. At high doses, they can cause seizures, coma and death. The danger increases when these drugs are taken with alcohol.
- MDMA — also known as molly or ecstasy — can interfere with the body's ability to regulate temperature. A severe spike in body temperature can result in liver, kidney or heart failure and death. Other complications can include severe dehydration, leading to seizures. Long-term, MDMA can damage the brain.
- One particular danger of club drugs is that the liquid, pill or powder forms of these drugs available on the street often contain unknown substances that can be harmful, including other illegally manufactured or pharmaceutical drugs.
- Due to the toxic nature of inhalants, users may develop brain damage of different levels of severity. Sudden death can occur even after a single exposure.

Other life-changing complications

Dependence on drugs can create a number of dangerous and damaging complications, including:

- **Getting an infectious disease.** People who are addicted to a drug are more likely to get an infectious disease, such as HIV, either through unsafe sex or by sharing needles with others.
- **Other health problems.** Drug addiction can lead to a range of both short-term and long-term mental and physical health problems. These depend on what drug is taken.
- **Accidents.** People who are addicted to drugs are more likely to drive or do other dangerous activities while under the influence.
- **Suicide.** People who are addicted to drugs die by suicide more often than people who aren't addicted.
- **Family problems.** Behavioral changes may cause relationship or family conflict and custody issues.
- **Work issues.** Drug use can cause declining performance at work, absenteeism and eventual loss of employment.
- **Problems at school.** Drug use can negatively affect academic performance and motivation to excel in school.
- **Legal issues.** Legal problems are common for drug users and can stem from buying or possessing illegal drugs, stealing to support the drug addiction, driving while under the influence of drugs or alcohol, or disputes over child custody.
- **Financial problems.** Spending money to support drug use takes away money from other needs, could lead to debt, and can lead to illegal or unethical behaviors.

19.11 PREVENTION :

The best way to prevent an addiction to a drug is not to take the drug at all. If your health care provider prescribes a drug with the potential for addiction, use care when taking the drug and follow instructions.

Health care providers should prescribe these medicines at safe doses and amounts and monitor their use so that you're not given too great a dose or for too long a time. If you feel you need to take more than the prescribed dose of a medicine, talk to your health care provider.

Preventing drug misuse in children and teenagers

Take these steps to help prevent drug misuse in your children and teenagers:

- **Communicate.** Talk to your children about the risks of drug use and misuse.
- **Listen.** Be a good listener when your children talk about peer pressure and be supportive of their efforts to resist it.
- **Set a good example.** Don't misuse alcohol or addictive drugs. Children of parents who misuse drugs are at greater risk of drug addiction.
- **Strengthen the bond.** Work on your relationship with your children. A strong, stable bond between you and your child will reduce your child's risk of using or misusing drugs.

Preventing a relapse

Once you've been addicted to a drug, you're at high risk of falling back into a pattern of addiction. If you do start using the drug, it's likely you'll lose control over its use again — even if you've had treatment and you haven't used the drug for some time.

- **Follow your treatment plan.** Monitor your cravings. It may seem like you've recovered and you don't need to keep taking steps to stay drug-free. But your chances of staying drug-free will be much higher if you continue seeing your therapist or counselor, going to support group meetings and taking prescribed medicine.
- **Avoid high-risk situations.** Don't go back to the neighborhood where you used to get your drugs. And stay away from your old drug crowd.
- **Get help immediately if you use the drug again.** If you start using the drug again, talk to your health care provider, your mental health provider or someone else who can help you right away.

19.12 SUMMARY :

In conclusion, alcoholism and drug addiction pose significant challenges to individuals, families, and communities, requiring a multifaceted approach to address the complex nature of these disorders. Recognizing the signs of alcohol or drug addiction is a crucial first step, as these conditions often manifest in behavioral, physical, and social changes. Identifying the problem early allows for timely intervention, offering a higher likelihood of successful outcomes. Reducing or stopping alcohol and drug abuse involves a combination of individual determination, social support, and professional intervention. An overview of alcoholism and drug addiction reveals the profound impact these disorders can have on mental and physical health, relationships, and overall quality of life. Intervening at different stages of addiction is essential for effective treatment. Early intervention, such as

counseling and support groups, can prevent escalation of the problem. In more advanced stages, comprehensive treatment programs, including behavioral therapies and medical interventions, may be necessary to address the physical and psychological aspects of addiction.

Several risk factors contribute to the development of alcoholism and drug addiction, including genetic predisposition, environmental influences, and individual vulnerabilities. Recognizing these risk factors allows for targeted prevention efforts, such as education, awareness campaigns, and community support programs. Complications arising from alcoholism and drug addiction are diverse, affecting mental health, physical well-being, and social functioning. Co-occurring disorders, legal issues, and strained relationships are common complications that underscore the need for integrated treatment approaches. Preventing alcoholism and drug addiction involves a combination of public health initiatives, education, and community support. Creating awareness about the risks, promoting responsible drinking, and providing accessible resources for individuals at risk are key components of preventive efforts. In conclusion, addressing alcoholism and drug addiction requires a comprehensive and compassionate approach. Early recognition of signs, timely intervention, and a combination of medical and behavioral treatments contribute to successful outcomes. By understanding the risk factors, complications, and implementing preventive measures, society can work towards reducing the prevalence of alcoholism and drug addiction, fostering healthier individuals and communities.

19.12 KEY WORDS :

1. Addiction
2. Alcoholism
3. Substance abuse
4. Intervention
5. Treatment

19.13 SELF ASSESSMENT QUESTIONS :

1. What are the signs and symptoms of alcoholism and drug addiction?
2. Examine the effective ways to reduce or stop alcohol and drug abuse?
3. Discuss the stages of intervention for individuals struggling with addiction?
4. Analze the risk factors that contribute to the development of alcoholism and drug addiction?

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Prof. K. Dhanalakshmi

LESSON – 20

ROLE OF SOCIAL WORKER IN THE FIELDS OF MEDICAL AND PSYCHRIATRIC SOCIAL WORK

OBJECTIVE :

The objective of this lesson is to explain Social work practice in health care setting, role and responsibilities of social workers, areas for practice in health care social work and in psychiatric health.

STRUCTURE :

20.1 INTRODUCTION :

Social work is a profession for those with a strong desire to help in improving people's lives. Social workers help people function better in their environment, deal with their relationships and solve personal and family problems. The constant growth, demands, and changes in health care have had a serious impact on the viability and need for social workers in all areas including settings of health care and child welfare and development. Access to timely, comprehensive and equitable health care for individuals varies considerably, with significant percentages of many segments of population having only limited access to health care. Ensuring rights to survival, development, protection and participation to children form the scope of social work profession.

Currently, health care social workers provide services across the continuum of care in various settings. Social workers are present in public health, acute and chronic care settings providing a range of services including health education, crisis intervention, supportive counseling and case management. Professional social workers are well equipped to practice in the health care field, because of their broad perspective on the range of physical, emotional and environmental factors that have an effect on the wellbeing of individuals and communities.

20.2 SOCIAL WORK PRACTICE IN A HEALTH CARE SETTING :

The social work profession's earliest concerns were with making health care services available to the poor and with improving social conditions that bred infectious diseases such as tuberculosis. As the social work role expanded, social workers joined other health

professions in the delivery of high-quality services. Today, social workers can be found in every component of the health care system.

The basic values of social work, from promoting an individual's right to self-determination to having an attitude of empathy for the individual, are the foundation of social work practice. When confronting dilemmas or needs in health care, social workers can use the principle of client's self-determination in matters where clients faced with such issues. Social workers have skills in cultural awareness and cultural competence, in which social work practice respectfully responds to, and affirms, the worth and dignity of people of all cultures, languages, classes, ethnic backgrounds, abilities, religions, sexual orientation and other diverse features found in individuals. Social workers look at the person-in-environment, including all the factors that influence the total health care experience. Social workers practice at the macro and micro level of health care and thus have the ability to influence policy change and development at local, state and central levels and within systems of care. Social work research in health care benefits not only individuals and families, but also the very existence, effectiveness, and validation of the profession.

20.3 ROLE AND RESPONSIBILITIES OF SOCIAL WORKERS IN HEALTH CARE SETTINGS :

In the public health arena, social workers are a valuable resource for the development of treatment plans for patients, for locating supportive resources, and in facilitating referrals. Under the auspices of government and non-government public health organizations and institutions, social workers often provide behavioural and social assessments along with mental health assessment, treatment, and short-term or ongoing case management. Social workers may also work in the community as planners or community organizers capable of engaging groups of people, neighborhoods, or entire communities to address social problems such as drug abuse or teen pregnancy.

Social workers working in health care settings should integrate theory and practice

The social worker uses knowledge about, and psychosocial implications of, illness, injury, and health conditions to provide social work services to clients and families to help them manage and cope with the impact of such health matters. Social workers have expertise in communication; navigating systems of care, resources, client and family coping skills; and the comprehensive impact of health conditions on the client. With the person-in-environment perspective, social workers look at all of the influences and aspects of a person's life to complete a thorough assessment and treatment plan with the client, family and other health care professionals. Essential areas of knowledge and understanding about health care include:

- the roles and functions of social work in health care
- the psycho-social needs of clients and families
- the physiological elements of illness and their impact on psychosocial functioning
- the psychological and spiritual needs of clients and families and how to ensure that they can be addressed
- community resources to assist clients and families
- laws, regulations and policies affecting clients, families and social work practice
- evidence-based practices and social work research in health care
- the needs of special populations.

Assessment and intervention strategies

Assessment is a fundamental process of social work practice. Treatment and intervention strategies/plans require that social workers both assess and reassess client needs and modify plans accordingly. Social work assessments in health care settings include considering relevant factors and the needs of the individual client and the family. The health status of populations and of individuals is assessed for many reasons. A comprehensive, culturally competent assessment includes:

- past and current health status including genetic history of family health
- the impact of health conditions or treatments on cognitive, emotional, social, psychological, or physical functioning
- social history, including current living arrangement and household environment
- work, school, or vocational history
- stage in the life cycle and related and relevant developmental issues
- cultural values and beliefs, including views on illness, disability, and death
- family structure and the client's role within the family
- social supports, including formal and informal support systems
- behavioural and mental health status and current level of functioning, including history, suicide risk and coping styles
- financial resources.

Comprehensive assessments shall address unique needs relevant to special populations, including children, people with severe and persistent mental illness, people with substance use disorders, victims of violence or trauma, homeless people and people with physical or psychiatric disabilities.

Intervention through interdisciplinary input

Intervention plans are steps identified by the health social worker, in collaboration with the client and with other members of the team, to achieve objectives identified during assessment. Social workers should be able to adapt practice techniques to best meet client needs within their health care setting to work effectively with individuals across the life-span, with different ethnicities, cultures, religions, socioeconomic and educational backgrounds, and across the range of mental health and disability conditions. Intervention plans may include:

- strategies to address needs identified in the assessment
- information, referral, and education
- individual, family, or group counseling
- vocational, educational, and supportive counseling
- psycho-educational support groups
- financial counseling
- case management
- discharge planning
- interdisciplinary care planning
- collaboration
- client and systems advocacy.

Addressing client's multiple needs

In Social work case dealing requires the professional social worker to develop and maintain a therapeutic relationship with the client, which includes linking the client with resources that provide a range of services, resources and opportunities to enhance successful quality outcomes for the client. Culturally competent case dealing is both micro and macro in nature and requires interdisciplinary care planning and collaboration with other professionals to maintain a team-oriented approach. Case dealing may include having regular meetings with the client and family and assisting the client to navigate systems. The scope of services would include the following:

- psychosocial assessment including diagnosis, interventions and treatment plans
- financial assessment, planning and intervention
- case facilitation
- client and family counseling
- crisis intervention
- quality improvement
- resource mobilization
- outcome evaluation
- teamwork
- client/family education.

Social workers act as educators

Social workers have a formal role as educators. Social workers gain knowledge and expertise in the health practice setting from other professionals and from formal education, work, or teaching experience. They have the knowledge and skill to implement the principles of learning theories in education programs, activities and resources. They communicate and collaborate with departments and other staff to foster client education. They serve with other members of the health care team for program and resource development, planning, implementation and evaluation. Social workers use a variety of methods to define and identify learning needs of individuals and families. Assessment identifies the educational needs based on the expressed needs of individuals, family members and significant others. The social worker identifies deficiencies in the knowledge base of the client and works with the client to obtain the needed information and resources. Social workers collaborate with the health care team to design educational activities to meet the client's needs, to deliver the activities in a method that facilitates the learning needed, and to evaluate the process in an integral, ongoing and systematic manner.

Social workers should engage in Health education

Health education is concerned with change in the knowledge, feelings and behaviour of people. In its most usual forms, it concentrates on developing such health practices as are believed to bring about the best possible state of well-being. Health education helps individuals, families, and communities to promote their health by their own actions and efforts. The health educator is there to help them to achieve their health goals through the educational process- a process based on the faith that every human-being has the inherent potential to develop, to rise higher and higher when suitable environment is created and opportunities are given. It recognizes the human worth and dignity. Health education involves health promotion and disease prevention (HP/DP) programming, a process by which a variety

of interventions are planned, implemented and evaluated for the purpose of improving or maintaining the health of a community or population.

Social workers should maintain records or documentation of social work services

The importance of clear, concise and organized documentation reflects the features of quality social work services and often serves as the mode of communication between a social worker and other professionals and clients. There are core elements that need to be included and responsibilities to follow in record keeping. The elements and responsibilities of thorough and comprehensive documentation include the following:

- comprehensive assessment and services delivered to the client and client systems, including the development of a plan of care
- ongoing assessments, interventions and treatment planning
- referral sources and collaborations
- dates, times and descriptions of client and client system contacts
- documentation of outcomes
- reason for case closure or transfer
- written permission to release and obtain information, where ever appropriate
- documentation of compliance with confidentiality rights and responsibilities
- documentation of receipts and disbursements.

Health care social workers should actively participate in research activities

Social workers have a responsibility to be familiar with the literature crucial to their area of practice. As professionals, social workers in all settings have a mandate to improve the knowledge of the field and this can best be accomplished through participation in research activities. Venues where health care social workers might help to develop, implement, or evaluate research include in-client and out-client hospital-based settings, community or home health agencies. Rich data sources that permit opportunities for quantitative and qualitative research exist within these entities. Social workers may help physicians, nurses, pharmacists and others recruit individuals and encourage study participation and adherence to medication regimens; they can also help clients manage problems that may hinder adherence and retention, such as challenging life circumstances and demands from family members.

Social worker as a supervisor

The purpose of supervision is to enhance the clinical social worker's professional skills and knowledge, to enhance competence in providing quality client care. Supervision aids in professional growth and development and improves clinical outcomes. Experienced social workers shall offer guidance and consultation to students, interns, and less experienced peers. Consultation and guidance are separate from supervision, and may be offered in mentoring opportunities.

20.4 AREAS FOR PRACTICE IN HEALTH CARE SOCIAL WORK :

Today, apart from the general hospitals and medical colleges, Social workers are placed in psychiatric hospitals, child guidance centers, cancer hospitals, family planning clinics, Drug de addiction centers, blood banks, etc. Social workers are also working with the community outreach programmes of hospitals and Non-Governmental Organizations.

Social Workers in the General or Specialty Hospital

Social workers being an integral part of the health set up, their role bears special significance. Purpose of medical social work is to help each individual sick person in matters of personal and social adjustment including rehabilitation in the society through the use of patient's capabilities as well as community resources. Medical Social Work Services are organized in various OPDs, Wards, Clinics and Casualty by professionally qualified social workers designated as Medical Social workers. They provide the following services to the indigent, needy and deserving clients:

- The Medical social worker acts as the doctor's mouthpiece and furnishes information to the client about the following: his or her illness, how it occurs, how it spreads, and how it can be controlled. She/he helps to remove the patient's doubt and misconceptions about the diseases and its treatment. She/he ensures the patient cooperates fully with the doctor and accepts the treatment wholeheartedly.
- For patients needing hospitalization, the Medical social worker helps in the smooth transition from home to hospital, and after discharge, back from hospital to home.
- She/he collects information about the patient's family, occupation and socio-cultural background and prepares his medico- socio history. She/he provides the social history to the doctor. She/he helps the doctor to see the correlation between the medical and the social data. She/he assists the doctor decide the social recommendation for solving the patient's medical problems.
- The Medical social worker works with the client and family and provides them emotional support and helps them with stress management. She/he explains to them the changes that have to be made in the home conditions, in cooking etc., for the benefit of the client.
- She/he conducts group sessions for the in- patients and their attendants.
- She/he participates in all the field activities of the hospital and medical college. She/he obtains people's cooperation in multidisciplinary camps, cataract camps, sterilization camps, blood donation camps, HIV/AIDS Awareness Camps.
- She/he arranges for financial assistance to the patient for treatment, hospitalization, transportation, etc. from welfare agencies in the community. If client requires legal help, she/he arranges for it. If client has come from a long distant place, she/he arranges for low -cost lodging for his family members.
- If there is fear of the patient losing his job because of illness and myths associated with it, She/he meets the employer, dispel the myths and convince the employer not to terminate the services of the patient.
- The Medical social worker participates in the teaching and training activities of the department of preventive and social medicine. She/he takes classes for medical, nursing, dental and pharmacy students.
- She/he actively takes part in the research activities of the medical colleges or hospitals.
- She/he provides recreational services to the inpatient by organizing film shows, video presentations. etc., and by providing toys and playthings for children.

20.5 SOCIAL WORKERS IN THE AREA OF PSYCHIATRIC HEALTH :

Social workers in the area of psychiatric health and substance abuse assess and treat individuals with mental illness or substance abuse problems, including abuse of alcohol, tobacco, or other drugs. Such services include individual and group therapy, outreach, crisis intervention, social rehabilitation and training in skills of everyday living. They also may

help plan for supportive services to ease clients' return to the community. Social workers are likely to work in hospitals, substance abuse treatment centers, or individual and family services agencies. These social workers may be known as clinical or Psychiatric social workers. They have a vital role to play in patients' wellbeing:

- The psychiatric social worker makes thorough study of the environment of the client covering such aspects as home, work and social life and brings out significant facts which have some bearing on his maladjustments. This study enables her to prepare a systematic case history of the client which throws light on the tension and difficulties in the client's life and also help him to assess the positive and negative aspects of the environment.
- The psychiatric social worker very often explains the client or relatives what the problem is and what is involved in psychiatric treatment, so that their anxiety is allayed and they can cooperate in the treatment. The social worker has to help the relatives of the mentally ill, to accept the diagnosis and the psychiatric recommendations. The social worker aids the psychiatric treatment by social treatment, i.e. treatment of environment problems. The social worker works with the clients, his relative and others, directly connected with him in modifying their attitudes. The social worker also tries to bring about a better adjustment between the client and his family. Social treatment is also geared towards after care. The social worker has to follow up a discharged case carefully. And also the client's ability to support himself and his ability to support his family must be restored.
- To enlist the cooperation of other social agencies for better discharge of functions of one's own agency and for stimulating interest in dealing with common problems effectively. By working cooperatively with various agencies, the psychiatric social worker is able to interpret her agency and its functions to the community so that the community can seek its aid in time and also give its timely assistance to the agency. A psychiatric social worker needs to bear in mind that she should not get so deeply involved in intensive treatment of the maladjusted individual that s/he fails to recognize the importance of general social problems and, therefore may not take interest in programmes for social change. She needs to study social conditions, develop resources in the community and participate in community planning.
- Students of psychiatric social work, nursing students, medical students and staff of the agency where the psychiatric social worker is employed as a mental hygiene supervisor or consultant may participate in the training programme.
- In prenatal and postnatal clinics and nursery schools the psychiatric social worker apart from direct casework service into the clients, when necessary, imparts mental health education to parents. Sometimes her services are required to promote mental health education in the community. Her work may involve community organization, publicity, assisting in community surveys, studying mental hygiene needs of communities, development of facilities for more adequate hygiene needs of communities, development of facilities for more adequate provision for prevention and treatment of mental disease and so on.
- Psychiatric social worker participates in the determination and formation of agency policies with a view to socializing the agency set up to meet the needs of clients better.
- Psychiatric social worker maintains social records for the purpose of social statistics. A full report enables a worker to diagnose the social problems better and check-up her social treatment plan. This will also enable her to know whether s/he is going in the right direction or not. Recording also helps her in acquiring the habit of observing and writing description carefully.
- The psychiatric social worker can be of immense assistance in the field of research. S/he enables the patients to accept psychiatric recommendation and encourages the patient to

continue the treatment. Thus, Psychiatrists are in a position to observe the result of any particular treatment in which they are interested. The psychiatric social worker can render help in promoting social research too. She observes the social component of illness, behaviour disorders, etc. and finds out that the Community resources are inadequate and can throw much light on the deficiencies. Case records of the agency provide ample data for social action for promoting the cause of welfare of patients and their families.

- This psychiatric social worker attached to hospitals has to respond to the problem of home sickness as well as the boredom of long treatment. S/he may organize a recreation club with the help of the members of the staff and the patients and encourage the latter to develop hobbies. Such activities contribute much to the patient's recovery. Through organized recreational programmes the patients learn group participation, take up responsibility for their behaviour, learn discipline in a congenial atmosphere and also overcome their personality defects like shyness, withdrawn behaviour, negativism etc.
- The psychiatric social worker is gaining wider acceptance in community planning. A large part of the Mental Health needs in many communities is for communitywide preventive services. It is natural that the psychiatric social worker be invited to contribute to the task of educating the general public in strengthening mental health. It requires that psychiatric social workers take part in various local and state programmes devoted to his end.

20.6 SUMMARY :

In conclusion, the role of social workers in medical and psychiatric settings is pivotal and multifaceted, contributing significantly to the holistic well-being of individuals and communities. Operating at the intersection of healthcare and social services, social workers play a crucial role in addressing the complex psychosocial needs of patients and their families. In medical settings, social workers act as advocates, providing support and resources to individuals facing health challenges. They navigate the intricate web of medical, emotional, and social complexities that accompany illness, assisting patients in accessing necessary services and facilitating communication between healthcare providers and patients. Within psychiatric settings, social workers contribute to the comprehensive care of individuals experiencing mental health issues. They work collaboratively with multidisciplinary teams to formulate treatment plans, offer counseling and therapeutic interventions, and address the social determinants impacting mental health. Social workers also play a key role in destigmatizing mental health concerns and promoting awareness within the community. The emphasis on patient advocacy, empowerment, and addressing social determinants of health distinguishes the social worker's role. Whether supporting individuals through medical crises or helping them navigate the challenges of mental health, social workers foster resilience, facilitate coping mechanisms, and promote overall well-being. Additionally, social workers contribute to the development and implementation of policies and programs that address social inequalities, advocate for vulnerable populations, and enhance the accessibility and quality of healthcare services. Their work extends beyond individual interventions to systemic and structural levels, aiming to create a more just and equitable healthcare landscape. In conclusion, the role of social workers in medical and psychiatric settings is instrumental in fostering a holistic and patient-centered approach to healthcare. Their commitment to addressing the psychosocial dimensions of health, advocating for patient rights, and contributing to broader social change underscores the indispensable nature of social work in promoting the well-being of individuals and communities within the healthcare system.

20.7 KEY WORDS :

1. Social worker
2. Medical
3. Psychiatric
4. Patient

20.8 SELF ASSESSMENT QUESTIONS :

1. Examine the role of social worker in Medical settings?
2. Analyze the role of social worker in Psychiatric settings?

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Prof. K. Dhanalakshmi

402SW21

MODEL QUESTION PAPER

MASTER OF SOCIAL WORK (MSW)

SEMESTER – IV

PAPER – II - MEDICAL AND PSYCHIATRIC SOCIAL WORK

Time: Three hours **Maximum: 70 marks**

Answer any five questions, all questions carry equal marks.

1. Explain the origin and importance of medical and psychiatric social work in India.
2. Discuss the factors influencing health and discuss the indicator for good health.
3. Discus the sociological respective on illness.
4. What is HIV/AIDS? Explain its preventive measures,
5. Discuss the primary health care system in India.
6. Discuss the importance of health education and communication.
7. Define normal and abnormal psychology, discuss the meaning and scope of normal and abnormal psychology.
8. Discuss the feature and causes for abnormal human behaviour.
9. Explain the psychotic and neurotic disorder
10. Discuss the role of social welfare in medical and psychiatric social work.