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ANALYSIS AND PREDICTION OF PSYCHOLOGICAL SYNDROME IN MULTIPLE AGE GROUP PEOPLE

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ABSTRACT

Psychological Syndrome of Personality disorders are having significant, but often unrealized, public health importance. Researchers and practitioners who have worked on assessment methodology in India have demonstrated that clinical diagnosis has a low reliability when compared with semi-structured interviews; and have attempted to increase the feasibility of the standardized use of International Psychological syndrome Examination, a semi-structured interview developed by the World Health Organization (WHO). Studies on epidemiology demonstrate that none of the general population studies have employed standardized interviews, and hence, they grossly underestimate the prevalence of personality disorders in the community. The clinical epidemiology studies have employed questionnaires and interviews developed in the West, mostly without local adaptations, with discrepant results. However, these studies show that personality disorders are common in the clinical population and that rates vary across sub populations. While, there are a few reports attesting the theoretical importance of the role of culture in the formation and expression of personality disorders, empirical literature from India in this area is scanty. In the same manner, there are few reports on the treatment of personality disorders, while, important areas such as service delivery, etiology, and validity of personality

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syndromes, are unaddressed. The study of psychological syndrome in India is getting too mature and stable, with researchers showing increased familiarity with the methodological nuances of this complex area of research.

Keywords : Personality disorders, research, epidemiology

INTRODUCTION

Psychological disorders, also known as mental disorders, are patterns of behavioral or psychological symptoms that impact multiple areas of life. These disorders create distress for the person experiencing these symptoms. The following list of psychological disorders includes some of the major categories of psychological disorders listed in the Diagnostic and Statistical Manual of Mental Disorders as well as several examples of each type of psychological disorder.

Many organizations are dedicated to working at a grassroots level, one-on-one with patients in rural regions of the developing world in order to shed light on the issue of mental illness. Mental illness is typically a neglected issue in the developing world and is generally not even spoken of or recognized as a medical condition. At The MINDS Foundation, we are dedicated to changing the world's view on mental illness and providing the resources and care these patients deserve.

MENTAL HEALTHCARE IN INDIA

As per the reports, there are only 5000 mental health professionals in India. One in five people in India live with a mental illness. According to the World Health Organization (WHO), countries like India devote less than 1% of their health budgets to mental health compared to 10%, 12%, 18% in other countries.

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Throughout developing countries there is neglect towards the issue of mental health1. Facilities are overcrowded, underfunded, and located few and far between. A major problem in developing countries is the existence of stigma towards mental illness and neurological disorders. Many patients are misunderstood as weak or dangerous. They are more likely to be the victims of violence rather than the perpetrators; it is an issue of human rights. This stigma leads to isolation, loss of social support, and psychological distress

While there are as many as two crore (20 million) Indians suffering from mental illnesses, the country has only 3,500 psychiatrists and 1,500 psychiatric nurses to treat them. According to the Head of the Department of Psychiatry at New Delhi's G B Pant Hospital R C Jiloha, an estimated 1-2% of India's 100-crore plus population suffer from major mental disorders and about 5% of the population from minor depressive disorders. Most of the psychiatrists are based in cities or private hospitals. However, government hospitals face an acute shortage, although they are the ones which treat the poor. In the United States there are 45,615 psychiatrists8.

Everyone feels anxious, worried or stressed out sometimes and life can seem overwhelming. People get caught up with all kinds of destructive thoughts that have a negative effect on their perceptions and behaviours. This isn't uncommon or unnatural - it's just part of our brain chemistry and there are certainly things that can be done to help get you back on track.

MENTAL ILLNESSES

The different manifestations of these symptoms are termed mental illness. Mental illnesses are no different to any other illnesses - they have a biological basis. In the same way as cancers develop as a result of both external and internal factors, so too do mental illnesses.

Common mental illnesses include:

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- Depression
- Anxiety/ Phobias
- Eating Disorder
- Stress

Severe mental illnesses include:

- Schizophrenia
- Bipolar disorder (Manic depression)
- Clinical depression
- Suicidal tendency
- Personality disorder

A good source of information on mental illnesses is the NAMI website - alternatively, visit our 'Resources' section for more online information.

SEVERE MENTAL ILLNESS

One of the famous organization, The Banyan works with people who suffer from severe mental illness: commonly Bipolar disorder or Schizophrenia. Their illness is sometimes combined with other psychological issues including personality disorders or mental retardation and with social issues including a history of abuse, deprivation, lack of education and extreme poverty.

It means that sufferers are dealing with symptoms such as hallucinations, mood fluctuations and other cognitive distortions as well as struggling to survive within their environment. This pushes them deeper into their illness as the appreciation and desire for a different life fades from their consciousness. Once symptoms are under control it takes significant efforts in psychological

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modeling, rehabilitation and training to give them the strength, independence and more importantly, yet more difficult to impart, the motivation to take part in the world around them; in control of their illness and positive about their participation in their own future.

Severe mental illness can be overcome: it depends on the individual's capacity and their receptiveness to intervention. In some instances the sufferer will spend the rest of their life on medication, requiring personal care and support; as would those with any other chronic disease. Others go on to lead 'normal' lives as part of families and communities - a testament to their triumph over their illness.

When we are under prolonged stress, our brains search desperately for ways to relieve the pressure. Often, if a person cannot find effective ways of coping or does not have a good support system, they can end up sinking deeper into negative thoughts and behaviours that affect daily functioning. As our bodies and minds are closely linked, a cycle of reinforcement develops that creates or exacerbates an internal imbalance.

Some of the effects of this imbalance can include:

- Persistent negative thoughts including a preoccupation with death or suicide
- Difficulty concentrating
- Low energy or severely fluctuating energy levels
- Hearing voices
- Wanting to spend excessive amounts of time alone
- Inappropriate and uncontrollable behaviour: excessive anger or sadness for example
- Severe paranoia

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Each of our lives is precious for its unique potential - if something within you is dragging you down, affecting your abilities and therefore holding you back, you should address it and give yourself the tools and the strength to get on with your life.

ADJUSTMENT DISORDERS

This classification of mental disorders is related to an identifiable source of stress that causes significant emotional and behavioral symptoms. The diagnostic criteria listed by the DSM-IV diagnostic criteria included:

(1) Distress that is marked and excessive for what would be expected from the stressor

(2) Creates significant impairment in school, work or social environments.

In addition to these requirements, the symptoms must occur within three months of exposure to the stressor, the symptoms must not meet the criteria for an Axis I or Axis II disorder, the symptoms must not be related to bereavement and the symptoms must not last for longer than six months after exposure to the stressor.

The DSM-V (released in May of 2013) moved adjustment disorder to a newly created section of stress-related syndromes.

ANXIETY DISORDERS

Anxiety disorders are those that are characterized by excessive and abnormal fear, worry and anxiety. In one recent survey published in the Archives of General Psychology1, it was estimated that as many as 18% of American adults suffer from at least one anxiety disorder.

Types of anxiety disorders include:

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- Generalized anxiety disorder
- Agoraphobia
- Social anxiety disorder
- Phobias
- Panic disorder
- Post-traumatic stress disorder
- Separation anxiety

DISSOCIATIVE DISORDERS

Dissociative disorders are psychological disorders that involve a dissociation or interruption in aspects of consciousness, including identity and memory. Dissociative disorders include:

- Dissociative disorder (formerly known as multiple personality disorder
- Dissociative fugue
- Dissociative identity disorder
- Depersonalization/derealization disorder

EATING DISORDERS

Eating disorders are characterized by obsessive concerns with weight and disruptive eating patterns that negatively impact physical and mental health. Types of eating disorders include:

- Anorexia nervosa
- Bulimia nervosa
- Rumination disorder

FACTITIOUS DISORDERS

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These psychological disorders are those in which an individual acts as if he or she has an illness, often be deliberately faking or exaggerating symptoms or even self-inflicting damage to the body. Types of factitious disorders include:

- Munchausen syndrome
- Munchausen syndrome by proxy
- Ganser syndrome

IMPULSE-CONTROL DISORDERS

Impulse-control disorders are those that involve an inability to control impulses, resulting in harm to oneself or others. Types of impulse-control disorders include:

- Kleptomania (stealing)
- Pyromania (fire-starting)
- Trichotillomania (hair-pulling)
- Pathological gambling
- Intermittent explosive disorder
- Dermatillomania (skin-picking)

MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION

This type of psychological disorder is caused by an underlying medical condition. Medical conditions can cause psychological symptoms such as catatonia and personality changes. Examples of mental disorders due to a general medical condition include:

- Psychotic disorder due to epilepsy
- Depression caused by diabetes
- AIDS related psychosis

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- Personality changes due to brain damage

NEUROCOGNITIVE DISORDERS

These psychological disorders are those that involve cognitive abilities such as memory, problem solving and perception. Some anxiety disorder, mood disorders and psychotic disorders are classified as cognitive disorders. Types of cognitive disorders include:

- Alzheimer's disease
- Delirium
- Dementia
- Amnesia

MOOD DISORDERS

Mood disorder is a term given to a group of mental disorders that are all characterized by changes in mood. Examples of mood disorders include:

- Bipolar disorder
- Major depressive disorder
- Cyclothymic disorder

NEURODEVELOPMENTAL DISORDERS

Developmental disorders, also referred to as childhood disorders, are those that are typically diagnosed during infancy, childhood, or adolescence. These psychological disorders include:

- Intellectual Disability (or Intellectual Developmental Disorder), formerly referred to as mental retardation

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- Learning disabilities
- Communication disorders
- Autism
- Attention-deficit hyperactivity disorder
- Conduct disorder
- Oppositional defiant disorder

PSYCHOTIC DISORDERS

Psychotic disorders are those that involve a loss of contact with reality. People experiencing psychotic disorders may experience hallucinations and often display disorganized thinking. Delusional beliefs are another common characteristic of this class of psychological disorders. Types of psychotic disorders include:

- Schizophrenia
- Delusional disorder

SLEEP DISORDERS

Sleep disorders involve an interruption in sleep patterns. These disorders can have a negative impact on both physical and mental health. Examples of sleep disorders include:

- Narcolepsy
- Sleep terror disorder
- Sleepwalking disorder
- Primary insomnia

SOMATOFORM DISORDERS

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Somatoform disorder is a class of psychological disorder that involves physical symptoms that do not have a physical cause. These symptoms usually mimic real diseases or injuries. It is important to note somatoform disorders differ from factitious disorders; people suffering from somatoform disorders are not faking their symptoms.

- Conversion disorder
- Somatization disorder
- Hypochondriasis
- Body dysmorphic disorder
- Pain disorder

SUBSTANCE RELATED DISORDERS

Substance-related disorders are those that involve the use and abuse of different substance, such as cocaine, methamphetamine, opiates and alcohol. These disorders can include dependence, abuse, psychosis, anxiety, intoxication, delirium and withdrawal that results from the use of various substances. Examples of substance-related psychological disorders include:

- Alcohol abuse
- Caffeine-induced anxiety disorder
- Cocaine withdrawal
- Inhalant abuse

Nimhans also estimates that at least 35 lakh Indians need hospitalisation on account of mental illnesses. But the country has only 40 institutions that are equipped to treat patients suffering from mental disorders. The total number of beds is less than 26,000. Of these 40 institutions, only nine are equipped to treat children. Moreover, many of them are medieval-era, asylum-style institutions with high boundary walls, artificial barriers and patients kept in solitary confinement.

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"We need to get out of this 'mental hospital' structure. More importantly, we need to stop reinforcing negative stereotypes of the mentally ill," says Vandana Gopikumar, member of the policy group appointed by the Union health ministry to frame a national mental health policy.

A report published in the June 2011 edition of The Lancet states that one in every two adolescents globally suffers from neuropsychiatric disorders. The study also estimates that one in five adolescents has an emotional, learning or development disorder while one in every eight has a serious mental disorder. The most common of these are depression, alcohol abuse, schizophrenia and bipolar disorder comprising more than 45 per cent of the disease burden among young people in the age group of 10-24, the study adds.

"At least 20 per cent of Indian children suffer from some form of mental disorder, of which about 2-5 per cent are serious disorders," says Manju Mehta, Professor, Department of Psychiatry, at Delhi's All India Institute of Medical Sciences. "Irritability, sleeping and eating disorders and obsessive compulsive disorders, if ignored, could later manifest as more serious concerns," she adds.

"I'm not sure about the figures for India but children are just as susceptible to mental disorders as adults though their treatment modules have to be very different," says Shekhar Seshadri, Professor, Child and Adolescent Services, Department of Psychiatry, nimhans.

"The figures in India are similar to those carried in The Lancet edition," says a nimhans official who refused to come on record.

"Coping with the growing number of mentally ill is an uphill task. The biggest hurdle is that we have not managed to integrate mental health into the Government-run Primary Health Centres (PHC) in India. The more we isolate mental health, the more we create barriers," says Gopikumar, who founded The Banyan with Vaishnavi Jaikumar to rehabilitate mentally ill and

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destitute women in Chennai. The organisation has helped more than 1,500 destitute women find homes and rehabilitated 1,000 mentally ill people in the last 15 years.

India's District Mental Health Programme is currently trying to include mental illness treatment in PHCs but has been able to do so only in 125 of the 625 districts till now.

Suneel Raj, a counsellor with Sneha, an organisation in Kerala working for the mentally ill, says the number of calls on their 'suicide helpline' has increased nearly 30 per cent in the last two years.

In Bangalore, between January and December 2010, six software professionals committed suicide; at least three of them were being treated for severe depression before they ended their lives.

Mental health counsellor Rahul Rao, 36, uses drama techniques to comfort patients from conflict zones. "There are queues that stretch at least a kilometre outside each psychiatrist's clinic in Kashmir. Each patient gets less than 20 minutes. What can a doctor do in such circumstances?" he asks.

"The disorders that we are talking about don't include post- and pre-partum depression and similar conditions. Mental health is as much a socio-economic problem as a psychological one. Till we learn to treat it as a development problem, it's going to be tough," says women's health specialist Dhanashree, 45, who works in rural Andhra Pradesh. Gopikumar echoes Dhanashree's sentiment. "More than 40 per cent of the mentally ill are homeless. Even if they get a 'fit to go' certificate from an asylum, they have nowhere to go," she says.

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NIMHANS estimates that India needs at least 12,000 psychiatrists. The reality is, there are less than 3,500 registered psychiatrists in the country. That's approximately one psychiatrist per 3,00,000 people.

Even China, with over 100 million reported cases of mental illness, has one psychiatrist per 1,00,000 people whereas in countries like Australia, the number is as high as 100-150.

The World Health Organization estimates that by 2020, mental depression will be the largest cause of disability worldwide. It also says that by 2025, mental illness will catch up with heart disease or may even overtake it as the biggest global health concern.

A NIMHANS study has found that more than 35 per cent patients who go to see a general practitioner report psychological concerns. The alarm bells are ringing loud and clear.

Non-communicable diseases account for a growing burden on the health systems of developing countries. The effective management of these diseases typically requires a collaborative effort across the health workforce as well as continuing care for months or even years. In resource-poor areas, a “task-shifting” strategy can be beneficial, in which community or lay health workers (with oversight from primary-health-care practitioners and specialists) provide “front-line” care, instead of physicians and trained nurses. There is growing evidence of the effectiveness of such task-shifting in the management of some chronic conditions, including infection with the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS),[2,3] diabetes[4] and some mental disorders. Although the strategy appears particularly attractive in the many low-income countries with inadequate numbers of physicians and trained nurses, there is considerable institutional resistance to the widespread implementation of the strategy and also concern that the quality of care will deteriorate. There is a clear need for more studies comparing the health outcomes of patients attended by lay health workers with those of patients attended by

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physicians and trained nurses. There is also a need for more studies in which the cost–effectiveness of the task-shifting strategy is evaluated.

Depression and anxiety, two of the most prevalent non-communicable disorders, are often encountered in primary-care settings. Depression is predicted to become the leading cause of disability-adjusted life years by the year 2030. Depressive and anxiety disorders are classified separately in the tenth revision of the International statistical classification of diseases and related health problems (ICD-10). In public-health interventions, however, they are often grouped together as "common mental disorders" because they show a high degree of comorbidity, have similar epidemiological profiles and respond to similar treatments.

In several studies, collaborative stepped care led by lay health workers has been found to be successful in the primary care of depression and/or anxiety in low- or middle-income countries. This approach encourages the most effective sharing of tasks between medical, specialist and non-medical staff. There are various "steps" or levels of treatment, with the most intensive treatments reserved for the most severe cases. Used together, the collaborative-care and stepped-care components of this strategy can maximize the efficient use of scarce resources, especially in those public health facilities where case management has previously been relatively poor. In the MANAS trial, the effectiveness of this approach in the primary care of patients with depression and/or anxiety was investigated in Goa, India. The design, implementation and general effectiveness of this cluster-randomized controlled trial have been described in detail elsewhere. Both public and private facilities were included in the trial because in India's private facilities, the quality and costs of care are both generally higher than in public facilities. For example, private facilities offer repeated consultations with the same physician and are primarily financed with out-of-pocket payments from the patients. In contrast, many patients attending a public facility may see a different physician on each visit but will not pay for any of the consultations.

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The present study evaluates the cost–effectiveness and cost–utility of the MANAS trial. We hoped that the additional resources needed to train, pay and supervise the lay health workers used in the "task-shifting" approach to the primary care of common mental disorders would promote recovery and reduced disability in a more cost–effective manner than more conventional care. In any particular country, the CHOICE programme of the World Health Organization (WHO) deems an intervention to be highly cost–effective if it generates an extra year of healthy life for an amount no greater than the country's per capita gross domestic product.

Mental disorders afflict 5 crore of the Indian population (5%) and need special care. 80% of our districts do not have even one psychiatrist in public service. WHO estimates of 2001 indicate a prevalence level of about 22% of individuals developing one or more mental or behavioral disorders in their lifetime in India.

CONCLUSION

The field of disorder issue is at an incipient phase of improvement in India. From a circumstance of practically no articles particularly centered around personality pathology work the 1980s, there is currently a trickle. Then again, to date, the center is naturally however altogether on clinical the study of disease transmission. Despite the fact that there are not many methodologically strong studies, the expanding commonality with the field and its methodological subtleties wood screws well for what's to come. There is clearly a requirement for better and more studies in connection to identity issue on approach and the study of disease transmission (especially group mulls over), and additionally on social and classificatory issues. There is additionally a requirement for studies to populate the unlimited open swathes as far as etiology, clinical characteristics, evaluation, administration, course and conclusion, and on the different verbal confrontations that check the identity issue field, for instance, whether identity issue, as conceptualized today, are substantial elements; the limit issues between identity issue

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and ordinary identity qualities from one viewpoint and mental state issue on the other; and the association of identity issue in dimensional or straight out terms.

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