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A PEER REVIEW BI-ANNUAL JOURNAL

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Message from the editorial board

We take great pleasure in welcoming you to the inaugural issue of our Journal, "The Journal of psychosocial wellbeing. We have created this publication with the intention of providing a space, a voice to all the mental health professionals, researchers and scholars for knowledge, collaboration and interconnectivity.

The journal, a biannual, peer reviewed work aims to create a high-quality publication that will be relevant, challenging, thought-provoking, and inclusive of a diverse range of voices and perspectives of mental health professionals, academic researchers and scholars. We welcome original empirical research, review of the literature, critical commentaries, case studies and book reviews.I hope each one of youwill actively engage with it.

As editorial board member, I am delighted to be a part of this new initiative, which I believe is exactly the type of platform needed to highlight and broaden our perspective for mental health along with the highest values of scientific integrity to which the Journal of Psychosocial wellbeing is inspired with.

Once more, on behalf of the editorial board members, I welcome you to this journal. We look forward to your submissions and to publish your manuscripts.

Aishwarya Raj
Clinical Psychologist
Editorial Board
Journal of Psychosocial Wellbeing

Editorial:

Gap between actual and required Mental Health Professional in India

Pradeep Kumar

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Indian is second largest country(population-wise) in the world and having a unique cultural belief system.According to the World Health Organization (WHO) report, India has one of the largest population suffering with mental illnesses. More than 80% of people do not seek any professional help in India. Approximately 150 million people in India need therapy for their mental health disorders. Yet, less than only 30 million people seek help. The shortage is primarily because of many Indian psychiatrists moving abroad for 'greener pastures'. Surprisingly, both UK and US have more number of Indian psychiatrists than India.Interventions in the form of medicine and psychosocial management can make a huge difference (Mental Health Crisis in India 2019) . A WHO study mentioned that the treatment gap (the number of people with disease who are not in treatment) of mental disorders in developing countries was 76%-85% (Demyttenaere.k et al 2019). National Mental Health Survey (NMHS), also emphasized the treatment gap of any mental disorder in India was reported to be as high as 83% (Gururaj G.et al 2016).

Indian Union Ministry of Health and Family Welfare also mentioned that the country needs around 13,000 psychiatrists. It is essential to achieve an ideal ratio of psychiatrists to population is about 1: 8000 to 10,000 but currently has just about 3,500 - which is about one psychiatrist for over 2 lakh people! With regard to other mental health professionals the ratio is even worse - the need of Clinical Psychologists is 20,000 and there are only 1000 available; for Psychiatric Social Workers, the requirement is 35,000, but only 900 are available, for Psychiatric Nurses, we need 30,000 and only 1500 are available (https:// timesofindia.indiatimes.com). National Crime Records Bureau 2015, highlighted the fact that entire mental health workforce, comprising clinical psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses, stands at 7,000, while the actual requirement is around 55,000.

When we talk about psychiatric social worker, the misinterpretation of the definition of psychiatric social worker, as mentioned in mental health care act 2017 creates new obstacle to minimizing the huge gap.Psychiatric social work is an integral part of a multidisciplinary team in treatment and rehabilitation of person with mental illness, or a person with psychosocial problems.However, professionally qualified Psychiatric social worker are very limited in our country like other mental health professional.

The mental health care act is an ambitious and progressive step in many ways. The Actacts as a bridge to every person with mental illness and provides them the right to access mental health care and treatment from the government. The right includes, affordable good quality and easy access to facilities such as minimum mental health services. However, the implementation will be a key challenge due to the lack of infrastructure and resources available in the country for the treatment of mental illness. The problem is aggravated due to the shortage of mental health care professionals like psychiatrist, clinical psychologist, psychiatric social worker and psychiatric nurses.

The mental health care act 2017 5 defines various mental health professionals which includespsychiatric social worker referring to an individual having post graduate degree in social work and master's in philosophy in psychiatric social work obtained after completion of full time course of two years which includes supervised clinical training from any university recognized by the university grant commission act 1956 or such recognized qualification, as may be prescribed (Mental Health Care Act 2017. Gazette of India).

However till 2016-17 the eligibility criteria for master of philosophy in the psychiatric social work is master of art in either sociology or social work in many pioneer institutions like central institute of psychiatry (CIP),Ranchi,Ranchi Institute of Neuropsychiatry and Allied Sciences (RINPAS),Ranchi and various upcoming institutions where this course was started under the center of excellence scheme (Sinha SK ,Kaur 2011), like institute of psychiatry Kolkata, Government Medical College and Hospital (GMCH) Chandigarh, Pt.B.D.Sharma, PGIMS, Rohtaketc, few private institute institutes like JSS Medical College,Mysore. So, substantially a good number of psychiatric social workers are having a master degree in sociology with master of philosophy in psychiatric social work (Sahu .K Kamlesh 2017) .

The mental health care act empowers the government to set- upcentral mental health authority at national level or state mental health authority in every state. Every mental health institute and mental health professionals including psychiatrist clinical psychologist,psychiatric social worker,psychiatric nurses will have to be registered with this authority. The central authority should publish the list of

registered mental health professional under clause D of sub section 43 and the state authority shall publish the list of registered mental health professionals under clause (d) of sub section(1) of section 55. This particular provision is expected to be interpreted in a very widersense and might be the prerequisite to take part in the various function of mental health care as specifiedby the act. Psychiatric social workers are having a master of arts in sociology with master of philosophy in psychiatric social work might be excluded if in this rule/ regulation will not considerthem equivalent to those who havea master degree in social work and having master of philosophy in psychiatric social work. Subsequently,they will be discriminated on this ground in the various recruitments and also in the executionof various duties as specified in the list.

It must be taken into consideration that various professionals (Psychiatric social workers) as a clinicians and faculties in the field of mental health/mental hospitals/general hospital psychiatric units both in government and non-government sectors, both on regular basis as well as contractual basis.

There is huge shortage of Psychiatric social workers in the country, which is affecting negatively to the care, treatment and rehabilitation of individuals' with mental illness and also widens the huge (50-70 percent) treatment gap of for mental health care.

Through in the same definition after giving this is mentioned "....or such recognized qualification, as may be prescribed". This has given the scope to consider those Psychiatric social workers who have already acquired a master degree in sociology and having master in philosophy in Psychiatric social work as equivalent to those have a master degree in social work and having master in philosophy in Psychiatric social work. So a desperate exception from the psychiatric social worker that the central mental health authority at national level and state mental health authorities and other law implementation agencies willdo justice and not deprived them of their right of continue to be mental health professional and contributes towards the mental health care.

Conclusion: There is huge gap between the people with mental illness and mental health professionals. In another words, we can say that huge difference has been seen between demand and supply. Unfortunately in India, the undergraduate medical courses hardly focus on psychiatry. There are very few mandatory exams in the subject of psychiatry at the medical undergraduate level and the courses are not rigorous. There are not enough seats in medical colleges for post graduate education in Psychiatry. That is a big issue. Another important things are need to be addressed that Mental health acre act is progressive steps, but need to use it in a borderer sense, specially about the mentioned definition of psychiatric social worker. It is right time that the government should think carefully over this acute shortage of mental health professionals in the country and take necessary steps to rectify it.

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Review Article

Ayurvedic Perspective of Geriatrics: An Overview

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ABSTRACT

Old age is the closing period of life span. As people move away from the earlier periods of their lives, they often look back. Many of them usually regret about their lives and they often ignore the future. Basically old age is referred from 60 years onwards of life. Methodology: To review the literature authors browsed the websites like PubMed Central, National health portal, Google scholar, Hindawi etc. Studies from 1998 up till 2018 were taken for reviewing the literature. Keywords used for searching were highlighted as 'Ayurveda', 'Geriatrics', 'Rasaynashastra', 'Aging' and 'Old age' Results and findings: Result studies revealed that the kind of issues that our elderly population encounters stands to be a major concern for health professionals. An increase in the life expectancy rate calls for better medical services and enhanced expertise. This would reciprocate an increase in the aging population. Statistics state that by the year 2020, world would have more than one billion people aged 60 years and above. Out of the total strength 2/3 of it will belong to the developing nations. This rapid increase in the ageing population would lead to a number of disabilities, chronic diseases and illnesses and other health related problems. Conclusion: In this review paper, we are comprehensively detailing the literature transcribed in the Ayurvedic sciences that is related to aging. This review will narrate and describe the process of aging according to Ayurvedicchikitsa as an ancient medical science.

Keywords: Ageing, Geriatric perspective, Ayurveda, Life span, Rasaynashastra

INTRODUCTION

According to Philosopher Adrelt, "Old age becomes difficult for people because their physical abilities decline, they lose social importance when they retire and they may lose their spouse and other loved ones, forcing them to confront their own deaths." Individual is born as a child but he or she does not remain so. Age makes them grow as he or she passes from different phases of life. Growing age contributes to bring about a number of changes in individual's behavior, attitude, intelligence ability physical capacity and maturity. Old age is one of the different phases of life. It is the last stage in one's life in which most of the people develop deficiency either in physical form or psychological form or both. Deficiency in either form makes a person distressed or unsatisfied (Srikanth, 2009).

Ayurveda is one of the most ancient medical sciences in India since time immemorial. The other nations across the globe are also flourishing with the Ayurvedic concepts and principles; however India has been the birthplace of Ayurvedic practices and therapies. The basic principle of Ayurveda revolves around the science of long life thus geriatric health care becomes a prime concern (Babu,2013). Ageing is a natural process which is considered as a time bound phenomenon. A general life span of an individual initiates with birth, passing through different phases like childhood, adolescents adulthood and finally reaching the old age characterizing senility and ultimately death. Still people cherish a long healthy life. According to Ayurvedic principles and therapies, a human life has been considered in scriptures as 100 years of life with each decade characterizing the process of aging in some way which is different with rest others. After death, the jeeva (soul) which is thought to be immortal, transmigrate from one body to the other. The aging process gets accelerated through factors like stress, nutritional deficits, climatic factors, free radical injury, immune disorder and endocrinal factors etc. In the Ayurvedic literature, codes of healthy living have been identified on two parameters viz. personal hygiene and mental hygiene(Babu,2013).

Ayurveda as an ancient medical science has categorized aging as a usual and palliative disease. Aging in literature has also been defined as a gradual process of decay where the physical mental and psychological abilities decline (Devi,et.al. 2010).

DEFINITION OF AGEING

Ageing is the progressive and generalized impairment of functions resulting in the loss of adaptive response to stress and increasing the risk of age related diseases. The overall effect of these alterations is an increase in the probability of dying, which is evident from the rise in age specific death rates in the population. Age changes are those changes in the organism that occur simply as a function of age. True age changes will be observed with considerable regularity across time and place because they are developmental. Most biological phenomenon states that changes with age appear to be driven by this kind of internal developmental agenda.

Other differences observed across age groups represent the effects of social changes that are external to the individual. By all accounts ageing is a relative concept. It does not coincide with the chronological age of the individual. The process of ageing however, does not affect the tissues equally and since the individual is composed of cells tissues and organs ageing is composite of changes occurring in these and then taken as effective as whole(Gupta,2002).

The mechanism of Ageing comprises of genetically determined life span encoded in specific genes, somatic mutation of genes, deprivation and deficiency of important cellular components, wear and tear of important organs by continuous functioning, cross linkage of important cellular components, accumulation of toxic materials e. g. Lipofuscin, cholesterol, accumulation of free radicals and damage of intracellular structures, loss of important genetic material during DNA repair, impaired DNA repair due to deficiency of key enzymes, non-energetic gycosylation of proteins, growth hormone deficiency and accumulation of stress over life time with its resultant effect.

THE AYURVEDIC PERSPECTIVE

Ageing and death have been the concern of mankind from time immemorial. Since man always considered himself as being made in the image of God, a search for immortality has always been a focus of enquiry. In fact in ancient scriptures of Vedas and Upanishads various facts are devoted to this aspect. Longitivity is very much a part of the life style, thinking practices and food habits as given in the shastras (Gupta,2002). It is also considered to be a part of the time cycles or "Yugas". The yugas are the Satyugas, Dwapar, Treta and Kaliyuga. In the Satyuga the life expectancy falls with each yuga, it is being about 50-70 years in Kaliyuga. As we observe there is a general increase in the life expectancy of the world over, attributable to the improved health facilities, improved public health measures and eradication of infectious diseases and other aspects. But it is also true that we are approaching the end of the time cycle (kaliyuga) and passing into another phase of satyuga (Sastri, &Chaturvedi,1998).

Glancing at the historical background of old age in the Indian perspective there is an ancient verse quoted in Upanishad in the form of prayer being offered to God Almighty, "Oh God! Grant our lives with a span of 100 years. During all this period bless us with power of good vision and hearing so that we do not remain dependent on others physically, mentally, emotionally, socially and financially". Such a long life can give rise to a number of physical disabilities and psychological malfunctions. Therefore the pertinent question of senility arising in human beings is automatic. This senility does not have any certain fixed age thus can arise at any age. However the ancient scriptures of medicine have depicted this process at the age of 70 years in males and above 50 years in females. The ancient Ayurvedic thinkers have divided the entire life span of an individual into 100 years, where the ageing process is repeated after every 10 years (Singh, 2015).

According to them the life span of an individual is broadly classified under 10 years each under the following head:

Birth- 10 years: This period is called as the childhood period. Childhood disappears after 10 years.11-20 years: This is the stage of growth and development. Physical development takes place till the age of 20 years.21-30 years: This is the age of physical beauty. The beauty of the body disappears after the age of 30 years.31-40 years: Intellectual and creative power of the brain looses its function after 40 years of age.41-50 years: The lustier of the skin disappears by the age of 50 years.51-60 years: The visionary power of the individual gradually weakens up as one reaches the 60 year mark. 61-70 years:The power of adventure, excitement and risk taking behavior disappears at the age of 70 years.71-80 years: The cognitive power and function of the sensory organs weakens up at the age of 80 years.81-90 years: Mental power in the form of higher and concrete thinking disappears by the age of 90 years.91-100 years: Lastly, deterioration in cognitive and sensible abilities and the entire life span ends at the age of 100 years i.e. death ends the life (Srivastava& Mishra, 2005).

This is the ageing picture given in the ancient scriptures. In the modern age of today, the life span of an individual has deteriorated to an extent. None of the human beings in today's world live in 100 years. The expectancy of life is short as compared to the earlier ages. Therefore all such factors viz. life expectancy, process of senility, process of ageing, process of degeneration of brain cells, process of mental thinking follows swiftly as compared during the ancient age(Srivastava& Mishra, 2005).

The scientists of the modern world attribute this cause of swift deterioration of physical and mental health to the global environmental changes taking place. Ageing process in the present context also changes senility and death. The next pertinent question which arises onto the minds of all is how to fight against senility and death? With the problem of early ageing in today's modern world, the problem of geriatrics, their treatment and cure with geriatric medicine has become very essential. There is a constant and serious need to fight against the physical as well s psychological geriatric changes among the human beings of today's world. This is one of the major reasons of concern behind selecting this topic of old age.

Old age in human beings in itself is a disease. Since old age is an age of physical and mental disabilities and decline therefore during this age the life of an individual becomes dependent. Hence it is in itself a disease. In Indian mythology one of the largest epic Mahabharata quotes the verse of Bhishmapitama saying, "Old age is a miserable condition". He narrates these verses in order to fight out this stage of life.

Therefore a long life is a demand of all human beings so every human being dread old age. The fear of decline in

health and dependency on others creates a sense of insecurity during this age. The physical and mental health both is deteriorated in senility therefore there is strong desire to safeguard the physical and mental fitness.

The ancient scripture of medicine is majorly divided into eight fold branches viz.

Kaya Chikitsameaning General Medicine, Bhut Vidyameaning Mental Psychiatry and Psychological Ailments, Agadtantrameaning Toxicological studies, Shalakya Tantramenaing General Surgery, Shalya Tantrameaning Surgery of ENT, Koumar Bhrityamenaing Pediatrics, Gynaecology and Obstetrics, Rasaynatherapy meaning Geriatrics (Sharma, 2018).

Among all these eight branches Rasayna or geriatric therapy has the characteristics of delaying the geriatric changes taking place within the body. Many kinds of drugs in this therapy are eatable in nature and are taken regularly in our diet example milk, yogurt, ghee, honey etc like substances are included in this category(Sharma,2005).

Such geriatric medicines also prove useful in delaying the process of ageing and thereby enhances in maintaining the physical and mental health, thus increasing the life span of human beings. Many of these drugs produce immune body in the body and thereby increase the span of life with good physical and mental health(Sharma,2005).

In the rasayna therapy there are three types of management viz (Sharma,2005).

a. **Diet:** In the categories of diet are included ghee, yogurt, milk honey etc.
b. **Drugs:** This would include amalkee, haritkee, vidanga, ashwagandha, piphalee etc. and its compounds in many forms.
c. **Pro social behavior:** This includes truthfulness, non violence, avoidance of anti social behavior, morality, kindness, forgiveness and belief in God and prayer, good conduct in society.

The therapy narrated above helps in slowing down the process of senility and death. Many complain of old ages are subsided. Physical and mental health is maintained in elderly. Thus the practical implications of this review would state that Ayurveda as a medicinal therapy and cure has the ability of controlling and treating a disorder through natural sources like diet, plant extracts, home remedy drugs like cumin seeds, turmeric etc. and finally leading a life with good conduct and shunning anti social behavior (Rajalekshmy,et.al. 2016).

Conclusion: Thus this paper reviewed the Ayurvedic perspective of Geriatrics with a special reference to Rasaynashastras and Panchkarma. Rasaynashastra, deals with the health problems of elderly by taking in to measures through which they can minimize the issues and concerns and also with certain therapies can delay the aging process. Panchkarma on the other hand is a radical approach of Ayurveda meant for sanitization the srotas of the body. Thus we can prevent the hazards of aging with the practice of ayurvedic therapies mentioned in the literature.

Limitation: The major limitation of this paper is that Ayurveda being an ancient science of medicine has been ignored by the government to a greater extent. Government rarely comes up with suggestions regarding health policies and upgraded medical facilities for Ayurvedic treatment and therapies, thus limiting the scope of this branch of medicine.

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Original Research Artcle

Effectiveness of Exposure Response Prevention Therapy Among Obsessive Compulsive Disorder

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ABSTRACT :

Background : The study was conducted to determine the effectiveness of exposure response prevention therapy among the obsessive compulsive disorder patients visiting OPD at Govt. psychiatric disease hospital (also known as Institute of Mental Health and Neurosciences, IMHAN-K) Srinagar, Kashmir. Methodology Quasi-experimental pre and post-test control design was used to determine the effectiveness of ERPT among the OCD patients. Purposive sampling technique was used to collect data from OCD patients who fulfilled the inclusion criteria. Data was collected by using Y-BOCS checklist and Social-demographic data sheet. Pilot study was conducted on 7 patients who visited OPD at IMHANS-K, Srinagar. The main study was conducted on 40 patients, among which only 30 have completed the intervention. These 30 patients were further divided into two groups; one group who received only medication and second group received both medication as well as therapy sessions. Our objective was also to find any difference between the two groups in terms of score of Y-BOCS and effectiveness of ERP. Results: showed that the group which received treatment and ERPT sessions showed less score on Y-BOCS comparative to the group which only received the pharmacological treatment. Conclusion the study concluded that ERPT is effective in reducing the symptoms of OCD.

Key words: Exposure Response Prevention Therapy, Obsessive, Compulsive.

INTRODUCTION

Obsessive Compulsive Disorder (OCD) is a common mental illness in which person has recurrent thoughts (obsessions) and behaviors (compulsions) that are time consuming causes distress and impairment in all areas of day today functioning. Obsessive Compulsive Disorder is defined in the DSM 5: APA, as the presence of obsessions, compulsions, or both, that are time consuming and cause marked distress or impairment. According to ICD-10, for a definite diagnosis of OCD, obsession symptoms or compulsive acts, or both, must be present with most of days for at least 2 successive weeks and be a source of distress or interference with activities. OCD is a common disorder that affects adults, adolescents and children around the world and mostly people are diagnosed at the age of 19, boys have earlier onset than girls. In adults twelve- month prevalence is estimated between 1% and 2.3% and a lifetime prevalence of 0.8% - 3%. Obsessive-compulsive disorder was estimated as the 11th leading cause of non-fatal burden in the world in 1990, accounting for 2.2% of total YLD. Exposure Response Prevention is an evidence based and first line treatment for OCD patients. In order to break the vicious cycle of OCD, Exposure Response Prevention Therapy (ERPT) was developed recommended by National Institute of Health and Care Excellence (NICE), most effective and durable with 50-60% recovery. Currently ERP treatments are based on theoretical model given by Foa and Kozak that includes prolonged exposure to obsession cues, focuses at blocking rituals and informal discussion of beliefs conducted in respect to exposure exercises. According to the Introductory Textbook of Psychiatry 2014, exposure with response prevention for a client is achieved through the exposure to a feared situation, event, or stimulus. A compulsive hand washer would be exposed to contaminated objects by choosing to hold them, and then will resist the urge of washing their hands. Duration of exposures is very important factor in treatment of outcomes. Prolonged, continuous exposures were found more effective than short interrupted exposures. The ERP program recommended for adults consist of 15-90 minutes session conducted twice a week for 8 weeks or more. The session begins with 10-15 minutes of discussion of home work and ritual monitoring of previous sessions and the rest of session is devoted to exposure training and response prevention. Several instruments are available to assess the level of OCD symptoms, one of the most commonly used gold standard

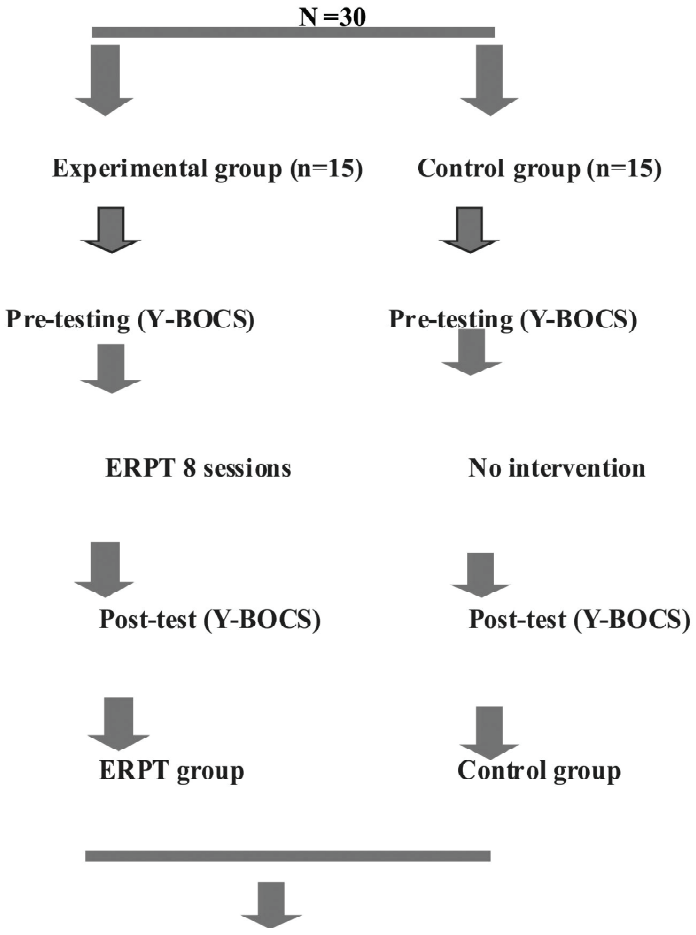
scale is Yale brown obsessive compulsive scale (Y-BOCS) that take 30 minutes to complete and consists of two sections with 10 items (5-obsessions& 5-compulsions). .Since prevalence of OCD is increasing and is very important to help these patients by providing the evidence based treatment in order to help them to overcome the barriers of their daily life. Therefore investigator has selected the problem statement as "A study to determine the effectiveness of Exposure Response Prevention among the Obsessive Compulsive Disorder patients attending OPD at Govt. psychiatric disease hospital Srinagar (IMHANS-K), with an aim to help these patients to improve their longevity.

Multiple research's has been done in different countries to find out efficacy of ERP on OCD patients and few of them are as follows; Grøtte., et al., 2018 conducted a 3 week in-patient treatment of OCD on 187 patients. Out of these, 166 were treatment completers and 21 (11.2%) were dropouts. The result showed a signi?cant effect. Study by Hossein., et al., 2015 on Y-BOCS outcome with a p value of 0.001 that shows a signi?cant decrease in obsessive-compulsive symptoms on post-test. Whereas study by Haven., et al., (2013) conducted a pilot study on 5 OCD patients and delivered ERPT individually within age group of 23-59, who were given treatment for four successive days. Mean Y-BOCS score at pre-test was 23.5 and at post- test was 5.7 which results that ERPT was promising treatment for OCD patients. Rachman, et al., (2011) conducted a study on reducing contamination by exposure plus safety behavior on 80 under graduate students between controlled condition of (ERP) and experimental condition (E & SB). Their findings were significant on pre test post test of contamination OCD, fear, danger and disgust with a p-value of < 0.001. However it was found that exposure with safety behavior was more effective than ERP control group in case of contamination OCD. Above all studies had proven that ERP is very effective in OCD, but to check this out and had a significant and proper assessment on our sample this study was an important need of hour.

METHODOLOGY

Research Approach : A quantitative approach was used to achieve the objectives of the study, and intended to gather the data concerned with the effectiveness of Exposure

Flow chart of the data collection:



Response Prevention Therapy among the OCD patients. It provides an accurate account of characteristics of a particular sample, individuals and intervention. The outcome of quantitative research provides a basis for future research.

Research Design:

The research design is the researcher's overall plan for answering the research questions. The research design used for the present study was quasi-experimental pre-test post -test control design.

Setting of the Study : The setting of the present study was Govt psychiatric disease Hospital (IMHANS-k) GMC Srinagar..

Sample: In this study, sample consisted of 30 OCD patients.

Sampling Technique : Sampling technique is a process of selecting a portion of the population to represent the entire population..In the present study purposive sampling was used for selection of sample; to develop the sampling frame.

DESCRIPTION OF THE TOOL

1) Demographic variables and Clinical profile of study subjects: was developed by author's itself looking at the need of study

3) Y-BOCS Scale: Developed by Wayne Goodman 1989 with reliability (r=0.98)

PROCEDURE

Prior to treatment patients were given introduction of therapy and their willingness to participate, consent was taken, and then Y-BOCS was applied to assess the level of score of OCD on first session followed by psycho education about OCD and ERPT.

Pre-testing : The selected sample administered following tools for identifying the patients suffering from OCD.

Demographic variables Clinical profile

Yale-Brown Obsessive-Compulsive checklist and Scale (Y-BOCS) (Goodman, 1989)

Intervention : Firstly, education was given to the subject to learn about their obsessions and compulsions through OCD graph and how ERPT is utilized to reduce these symptoms. Exposure means slowly facing the situations and beliefs that trigger obsessional fear. Response prevention means that you practice staying in the situation until the anxiety decreases on its own, rather than escaping by doing rituals, for example, not washing or checking. Although these techniques are highly effective, they are also challenging. However, by practicing exposure and response prevention, you will learn that your anxiety actually is reduced as you are exposed more; even if you resist doing rituals. So, exposure therapy helps to reduce obsessional anxiety, and response prevention helps you weaken the habitual pattern of using rituals to reduce obsessional anxiety. It was given to experimental group only for 6 weeks only, with a training of 8 sessions twice weekly.

Post testing: Post test was conducted after 8 sessions of ERPT among the OCD patients of experimental group and control group who were on routine.

Table 1: Frequency and percentage distribution of subjects according to level of severity of OCD score in pre-test. (N=30)

Level of severity	Experimental group Frequency/percentage n=15	Control group Frequency/percentage n=15
<7 (subclinical)	0(0%)	0(0%)
8-15(Mild OCD)	5 (33.3%)	4 (26.7%)
16-23(Moderate OCD)	10 (66.7%)	11 (73.3%)
24-31(Severe OCD)	0(0%)	0(0%)
32-40(Extreme OCD)	0(0%)	0(0%)

RESULTS

Describes the distribution of percentage and frequency of level of severity among subjects.

This table explains that frequency and percentage of subjects were 66.7% as moderate OCD followed by 33.3% in experimental group, simultaneously 26.7% had mild OCD and 73.3% had moderate OCD in control group

Table 2: Percentage and frequency distribution of subjects according to level of severity of OCD in post-test score (N=30)

Level of severity	Experimental group Frequency/percentage n=15	Control group Frequency/percentage n=15
<7 (subclinical)	9 (60%)	0 (0%)
8-15(Mild OCD)	6 (40%)	3 (20%)
16-23(Moderate OCD)	0 (0%)	11 (73.3%)
24-31(Severe OCD)	0 (0%)	1 (6.7%)
32-40(Extreme OCD)	0 (0%)	0 (0%)

Table 3: Findings related to descriptive statistics of Pre-test among control and experimental group of study subjects. (N= 30)

Descriptive Statistics	Mean/SD	Median	minimum	maximum	Range
Experimental group.	17.3333±5.47288	18	8.00	23.00	15
Control group	18.0667±3.99	20	10	23.00	13

Table 4: Findings related to descriptive statistics of Post-test among control and experimental group of study subjects. (N= 30)

Descriptive Statistics	Mean/SD	Median	minimum	maximum	Range
Experimental group.	7.2±3.05	7	2	12	10
Control group	18.20±4.36	18	10	24.00	14

This table depicts that majority level of severity in OCD shifted to subclinical OCD (60%) followed by Mild OCD (40%) in experimental group. At the same time majority of subjects were Moderate OCD (73%) followed by mild OCD (20%) and severe level of OCD was 6.7% in control group.

Table 3 & 4 depicts the mean ± SD 7.3333±5.47288 ,median 18,range 15 ,which was reduced to mean ±SD 7.2±3.05,Median 7,& range 10 in pre-test, post-test of experimental group while as18.0667±3.99),median (18,20),and range 15 & 13 in experimental and control group of pre-test score while as mean ± SD 18.0667±3.99, Median 20,Range 13 that remained same with the value of mean ± SD 18.0667±4.36, Median 18,Range 14 in pre-test, post-test of control group ,this indicates that ERPT was effective and has reduced the level of severity among OCD patients in experimental groups.

This table 5 & 6 shows that there was significant difference while comparing pre-test ,post-test score of Ocd patients in experimental and control group with a p-value of <0.001,that means the intervention Exposure Response Prevention Therapy was effective and reduced the Y-BOCS score of patients in experimental group

Table 5: Comparison of pre-test post-test Score of OCD patients in control and experimental group.

Variables	Pretest Score (YBOCS)		Post Test score (YBOCS)	
	Experimental Group (n=15)	Control Group (n=15)	Experimental Group (n=15)	Control Group (n=15)
Mean	17.3	18.1	7.2	18.2
Std. Deviation	5.47	3.99	3.05	4.36
Mean Difference* (95% Confidence Interval)	-0.7 (-4.32 to 2.85)		-11.0 (-13.82 to -8.18)	
p-value	0.68		<0.0001*	

Table 6: Comparison of pre-test post-test score of OCD patients in control and experimental group (paired t-test).

		Pretest Score (YBOCS)	Post Test score (YBPCS)	Paired Difference* (95% Confidence Interval)	p-value
C Expt o G	N	15	15	10.1 (8.33 to 11.93)	<0.0001*
	Mean	17.3	7.2		
	Median	18	7		
	Std. Deviation	5.47	3.05		
	N	15	15	-0.1 (-0.88 to 0.62)	0.7090

DISCUSSION

The present study was undertaken to determine effectiveness of Exposure Response Prevention Therapy (ERPT) among the obsessive compulsive disorder patients visiting OPD at Govt. psychiatric hospital (IMHANS-K) GMC Srinagar, Kashmir. The data was collected from 30 subjects who were grouped as experimental (n=15) and control (n=15) at Govt. Psychiatric hospital (IMHANS), GMC, Kashmir. The findings of the study are discussed in reference to objectives and hypotheses stated. Maximum pre-test score of subjects 10 (66.7%) had moderate OCD and 5(33.3%) had mild OCD in an experimental group and maximum pre-test score of subjects 11(73.3%) had moderate OCD and 4(26.7%) had mild OCD in control group. Maximum post-test score 9(60%) had mild OCD and 5(40%) had moderate OCD in experimental group and maximum post-test score 11(73.3%) had moderate OCD and 3(20%) had mild OCD and 1 (6.7%) had severe OCD in control group. The findings of this study are similar to findings conducted by Jones, Wootton, Vaccaro (2012), as they have studied clinical case of 80 year old man with 65 years of OCD history where pretest score of Y-BOCS data were collected at baseline and 7 month post-treatment was taken. The scores on the Y-BOCS reduced 65% from 20 (moderate) to 7 (subclinical) at 7-months post-treatment. Whereas our one more objective of our study was to assess the pre-test score of among Obsessive Compulsive Disorder patients of control and Experimental group. The findings of this study revealed that Mean ± SD value was 17.33 ± 5.47, Median was 18 and Range 15 in an experimental group, while as Mean/ SD value was 18.20 /4.36, Median 20, Range13 in control group. The present study findings are similar to the findings of a study conducted by Ranjan, Nath, Preeti (2017) on 11patients to asses pre-test YBOCS score with Mean ± S.D value 28.4 ±2.4 in pre test of group 1 and group 2 and on other 11 patients Mean ±S.D was 28.14 ±2.03 in pre test score.

Objective 2: To assess the post -test scores of among Obsessive Compulsive Disorder patients of control and Experimental group. The findings of this study revealed that Mean ± SD value was 7.2/ 3..05, Median 7, Range10 in an experimental group, and Mean ± SD value was 18.20±4.362, Median 18, Range14 in control group. The present study findings are similar to the findings of a study conducted by Ranjan, Nath, Preeti (2017). One more important objective of our study was to determine the effectiveness of exposure response prevention therapy by comparing pre-test & post -test YBOCS score of control group & experimental group among obsessive compulsive disorder patients.The findings of this study revealed that there is significant decrease of post test score of in an experimental group with a p.value of < 0.001 after exposure response prevention therapy than post-test of control group that shows efficacy of ERPT. The present study findings was supported by the research conducted by Hossein Taghi, Leila, Esmali (2015) on 30 patients whose pre-test was followed by a training of 8 sessions Exposure Response Prevention Therapy. Then post test, was done which signified reduction in OCD symptoms. The present study findings were further supported by the research conducted by Kircanskia , Peris (2015) on 30 patients a randomized controlled trial of exposure

with response or ritual prevention therapy. Which was statistically significant p< 0.001indicating that there was decrease in distress level at the end of exposure therapy which shows significant change at post test of C-YBOCS. One more Objective of our study was to find an association of pre-test score to selected demographic variables and clinical profile of obsessive compulsive disorder patients, which include age , gender , birth order, Habitat, occupation, family type, marital status, income , duration of illness, treatment history, family history. The findings revealed that there was no significant association of demographic variables and clinical profile of OCD patients with pre-test score, hence null hypothesis was accepted at 0.05 level of significance.

On the basis of the findings of the study, following recommendations are put forward for further research

1. A similar study can be conducted with larger sample size to confirm the result of the study.
2. A comparative study can be done on different therapies among OCD patients.
3. A Study can be done on anxiety disorders to determine the efficacy of Exposure Response Prevention Therapy.

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Original Reaserch Article

Cognitive Coping Process and Negative Emotions: A Correlational Study

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Abstract

Coping is a considered as a mechanism relevant to both the experience and management of emotional and physical distress. Coping is inversely related to psychological distress, and coping deficits are observed in a variety of mental disorders. The objective of the study was to investigate the relationship between cognitive coping process and negative emotions like depression, anxiety, stress and anger. 300 Undergraduate college students (both male and female) were selected and their coping process and negative emotions were assessed using Cognitive emotion regulation questionnaire (CERQ), Depression anxiety stress scale (DASS), State-trait anger expression inventory-2 (STAXI-2). Relationships were studied by means of partial correlations, and multiple regression analyses. The result showed that there is a significant positive relationship between less adaptive cognitive emotion regulation strategies like self-blame, other-blame, rumination, catastrophizing, and negative emotions. Findings also show that depression and stress were predicted by self-blame and blaming others, anxiety was predicted by catatrophizing and Blaming other while putting into perspective was the strategy which was inversely related to anxiety. Anger was predicted by self-blame, blaming others while state form of anger was also predicted by catastrophizing. On the basis of the results it can conclude that cognitive coping strategies were found to play an important role in the relationship between the experience of negative events and the reporting of symptoms of depression, anxiety, stress, and anger. Result also suggested that cognitive coping strategies may be a valuable context of prevention and intervention in emotional problems.

Keywords: coping, emotion, psychology, cognitive, psychotherapy

INTRODUCTION

In each and every stages of life, people have to deal with a wide range of stressors and challenges to adapt to the world. Even very young children attempt to modify their environment in simple and primitive ways. As children grow older, their coping repertoire increases and shifts from primarily external, behaviourally oriented coping strategies to more internal, cognitively based ones. It is essential to consider that everyone sees situations differently and has different coping skills. As a result, no two individual will respond exactly the same way to a given situation. Understanding this coping ability is essential during the formation of stressful events. Also Lazarus and Folkman (1984) explained that coping for a constant change in cognitive and behavioural attempts to manage the specific external and/or internal demands are appraised as burdensome. He considered that both problem focused coping (i.e., attempting to minimize distress through modifying oneself or one's environment) and emotion focused coping are adaptive, and the most beneficial approach appears to depend on the nature of the stressful situation. Problem-focused coping is associated with aggressive interpersonal efforts to alter the situation, as well as rational efforts to get the problem solved (Carver et al., 1989). It is seen that problem focused coping strategies may give an individual greater perceived control over their problem, while emotion focused coping strategies may more often lead to a reduction of control over the perceived events.

Gross, Sander Koole and Mun, (1995) remarks that emotion regulation has been linked to the important outcomes like mental health, physical health , relationship satisfaction and work performance which seems vital to learn more about the psychology of emotion regulation also supported by (Hill and Williams 2000). Mauss, Levenson, McCarter, Wilhelm, and Gross, 2005 advocates that because emotion regulation operates on people's emotions, it follows that the effects of emotion regulation can be observed across all modalities of emotional responding, including behaviour, physiology, thoughts, and feelings in which negative emotions are more noticeable. Green, Lino and Hwang (2002) examined the use of particular cognitive strategies for regulating negative in bipolar I disorder(BD-I) and unaffected biological relatives(UR) on 105 patients with BD-I, 124 UR, and 63 healthy controls (HC). In result they found that Emotion regulation strategies of catastrophizing, self-blame, and cognitive reframing techniques may be associated with vulnerability for mood disorders, with the latter active within the general population regardless of biological vulnerability to the disorder. Werner and Goldin (2000) developed an Emotion Regulation Interview (ERI) and used it on 48 patients with a social anxiety disorder (SAD) and 33 healthy controls (HCs). The result suggested that patients with SAD reported greater use of avoidance

and expressive suppression than HCs, as well as lesser success in implementing cognitive reappraisal and expressive suppression. Social anxiety disorder (SAD) is also actively involved in emotional hyper-reactivity and emotion dysregulation.

In a review of the studies it is found that exposure to stress is generally associated with a wide range of negative outcomes, (Higging and Endler 2007), studies suggested that who are exposed to even high levels of stress develop negative outcomes including decreased well-being, increased incidence of disease, post-traumatic stress disorder, generalized anxiety disorder, and major depressive disorder (Ehring and Quack 2010). Szasz, Szentagotai and Hofmann (2005) studied on 73 undergraduate students who endorsed at least a moderate level of state anger to examined the effects of different emotion regulation strategies on the experience and expression of anger. The findings suggested that emotional regulatory techniques showed better response in modifying the experiences and expression of anger rather than suppression techniques

The present study was designed to examine the cognitive coping styles of young adults. As students, at the undergraduate level are often at the stage of a transition to asking their first few steps towards autonomy and carving space for themselves in the world. Yet, it is at this stage they are most vulnerable to the pressures of career, establishing their identity, academic pressure, competition and peer pressures for the use of drugs and alcohol. Thus these students come across different stressors in managing their daily life routines due to which develops negative thoughts and cognition towards life (i.e., depressed mood, anxious, irritation, and frustration) and, in serious cases, suffered from different psychological problems. These academic, economic and interpersonal stressors have been found to induce negative emotions through the mediating role of maladaptive emotion regulation strategies. However, no Indian studies could be found on the coping process and negative emotions of college students. It was for these reasons a need was felt to explore the relationship between emotion regulation and negative emotions in college students

METHODS

Aim of the present study is to assess how the cognitive coping process of emotion regulations related to negative emotions in college students. Objectives of the present study are to investigate the relationship between cognitive emotion regulation with depression, anxiety, and stress.

The sample of 300 regular courses undergraduate students both male & female under the age range of 18-23 years were selected for the study.

TOOLS

Data for the present study was collected using the following tools

1. The Cognitive Emotion Regulation Questionnaire (CERQ) (Garnefski et al., 2001)

The 36-item CERQ assesses individual differences in coping across nine 4-item subscales: self-blame, blaming others, acceptance, refocusing on planning, positive refocusing, rumination, positive reappraisal, putting into perspective, and catastrophizing. Likert-type items (1 = "almost never" to 5 = "almost always") are rated where higher scores represent better coping strategy. (Garnefski et al.,2000).

2. State-Trait Anger Expression Inventory-2 (STAXI-2) (Spielberger, 1999)

The revised 57 item State Trait Anger Expression inventory STAXI-2) consist of six major scales for assessing the state, trait, expression, experience, and control of anger.
a. State anger (S-Ang) scale:- The STAXI-2 state anger(S-Anger) scale is comprised of 15 items that assess the intensity of anger in a particular moment in time
b. Trait anger (T-Ang):- The STAXI-2 trait anger (T-Anger) scale is comprised of 10 items measures individual differences in anger proneness as a personality trait.
c. Anger expression and control scale:- Four eight item scales assess anger expression and control, it also assesses one's propensity to experience anger. The anger expression (AX) index provides an overall measure of the expression of anger that takes both anger expression and control into account. Likert-type items (1 = "not at all" to 4 = "very much so") yield total scores from 10 to 40, in which higher scores represents higher levels of trait anger. Internal consistencies are impressive for both normal adults (as = .84 to .86) and psychiatric patients (a = .87).

3. Depression Anxiety Stress Scales (DASS) (Lovibond & Lovibond, 2002)

The 21-item version of the DASS was used to measure the experience of depression, anxiety, and stress. It consists of three 7-item Likert-type scales (0 = "did not apply to me at all" to 3 = "applied to me very much, or most of the time"). Items in each scale are summed and then multiplied by 2 to produce a range of 0-42. Alpha coefficients are all above .85, and validity has been supported through its correlations with other measures of depression and anxiety. In fact, Antony et al. (1998) suggest that the 21-item DASS has more advantages over the 42-item version, includes a cleaner factor structure and observed smaller correlations between the three scales

Procedure

A pilot study was carried out on a sample of 10 students after taking consent from. Subsequently, the data was collected for the main study. The tests were administered in the group of 20-30. The required instructions for all the questionnaires were printed on their first pages and were explained briefly. Questionnaire includes Socio

demographic form, CERQ, the DASS, and the STAXI-2. Descriptive statistics were used to report the data on socio demographic variables. Partial correlation was used to assess the strength of the associations between the variables of depression, anxiety, stress, anger and cognitive emotion regulation strategies and multiple regression analysis was carried out to obtain a predictive relationship between depression, anxiety, stress, and anger with cognitive emotion regulation strategies.

Results

Partial correlations between all variables controlling for gender is shown in table no.1 that illustrate that self-blame, acceptance, rumination, catasrophization, positive refocus and other blame is highly correlated with depression, self-blame, rumination, catostrophization of thought and other blame have highly positive correlation with anxiety, self-blame, acceptance positive reappraisal, catostrophizing and blaming other have highly positive correlation with stress.

The table of correlation (table 1) showed that catastrophizing and blaming other is highly positively correlated with state anger. High positive correlation was also seen in self-blame, rumination, acceptance, positive refocus, refocusing on plan, catastrophizing and other blame with trait anger. It is also shown in the table that anger expression also has a high positive correlation with self-blame, acceptance, rumination, positive refocus, refocusing on the plan, putting into perspective, catastrophizing and other blame.

Multiple regression analysis for cognitive coping strategies in predicting of depression, anxiety, stress and anger are shown in table no. 2.

Multiple regressions were conducted to determine

Table 1
Partial correlations between all variables controlling for gender (N = 300)

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Depression															
Anxiety	.65**														
Stress	.72**	.60**													
S anger	.44**	.36**	.41**												
T anger	.38**	.35**	.41**	.46**											
Ex anger	.27**	.19**	.20**	.09	.16**										
Self-blame	.36**	.30**	.33**	.19**	.30**	.42**									
Acceptance	.23**	.25*	.17**	.11	.27**	.43**	.61**								
Rumination	.28**	.30**	.28*	.11	.28**	.37**	.61*	.64**							
Positive Refocus	.18**	.18*	.12*	-.00	16**	.47**	.52**	.58**	.64**						
Refocus on Plan	.12*	.14*	.11	-.00	.19**	.37**	.42**	.52**	.52**	.74**					
Positive Reappraisal	.14*	.13*	.15**	-.00	.13*	.40*	.39**	.49	.46**	.60**	.76**				
Putting into Perspective	.11*	.12*	.14*	.11	.19*	.29**	.31**	.42**	.46**	.46**	.53**	.55**			
Catastrophic Thought	.240	.29**	.25**	.29**	.23**	.15**	.31**	.30**	.30**	.18	.19**	.23**	.45**		
Other-blame	.31	.34**	.33**	.29**	.20**	.14**	.41**	.37**	.44**	.30**	.20**	.15*	.33**	.54**	

N=300, (M=123, F=177) ; *: p<.05; **: p<.01;

Table 2

Relationships between cognitive emotion regulation strategies and symptoms of depression, anxiety, stress and anger: multiple regression analysis

Cognitive strategies	Regression analyses with measures of Negative Emotions as dependent variables, ?				
	Depression	**Anxiety**	**Stress**	**State Anger**	**Trait Anger**
Self-blame,	.26**	.10 (ns)	.26**	.14 (ns)	.18*
Acceptance,	-.05 (ns)	.02 (ns)	-.05 (ns)	-.01 (ns)	.08 (ns)
Rumination,	.09 (ns)	.16 (ns)	.09 (ns)	-.03 (ns)	.12 (ns)
Positive refocusing	-.01 (ns)	-.05 (ns)	-.01**	-.13 (ns)	-.14 (ns)
Refocus on plan	-.03 (ns)	.05 (ns)	-.03 (ns)	.04 (ns)	.18 (ns)
Positive reappraisal	.06 (ns)	.03 (ns)	.06 (ns)	-.07 (ns)	-.13 (ns)
Putting into perspective	-.10 (ns)	-.15*	-.10 (ns)	.01 (ns)	.03 (ns)
Catastrophizing	.07 (ns)	.14*	.07 (ns)	.14*	.11 (ns)
Blam-other	.16**	.18**	.16**	.11*	-.01 (ns)

*: p<.05; **: p<.01;

the best set of predictors for depression, anxiety, stress, state anger and trait anger. As the table 2 shows that depression was predicted by self-blame and other blame. The beta coefficient of self-blame is .26 and on blaming other is .16. Blaming other and catastrophizing is positively correlated with anxiety. However putting into perspective is inversely correlated with anxiety.Stress was predicted by self-blame and blaming other and reduced positive refocusing. State anger was predicted by catastrophizing and other blame. The beta coefficient of catastrophizing is .14 and blame other is .11. Trait anger was predicted by self blaming, the beta coefficient of self blaming is .18.

Discussion

This study aimed to assess the relationship between cognitive coping processes and negative emotions (depression, anxiety, stress and anger). The study was conducted on 300 undergraduate students, belonging to different colleges of Delhi and Noida the age group ranged from 18 years to 23 years the participants did not suffer from any psychiatric disorder. The assessment was done in a group setting through three self report questionnaires,

which are cognitive emotion regulation questionnaire (CERQ), Depression anxiety stress scale (DASS), state-trait anger expression inventory-2 (STAXI-2). The results obtained were subjected to statistical analysis using the statistical package for social sciences (SPSS).

In result referring to table 1, the findings suggested that self-blame, acceptance, rumination, catastrophization, positive refocus and other blame is highly correlated with depression. This result clearly confirmed the findings of previous studies showing that self-blame, rumination and catastrophizing as a cognitive emotion regulation style have been found to be associated with depression (Garnefski et al.,2007, Martin & Dahlen 2005), (Mcgee 2001). The result of present study is also consisted with the findings of (Anderson, Miller, Riger, Dill, & Sedikides, 1994) on the separate concept of blame (Nolen-Hoeksema, Parker, & Larson, 1994) on ruminations and (Sullivan et al., 1995) on catatrophizing. As seen in table 2 Depression is predicted by self-blame and blaming others. It shows that the person who use self blaming more as coping would be two and a half time more prone to face depression. The table also shows that depression is predicted by blaming other, as it is mentioned that both kind of blame, i.e, a continuing focus on blaming oneself or another, may form an obstacle to the adaptation to negative life events or trauma (Tedeschi, 1999). Some theories also supported that blaming predicting depression as Beck?s cognitive theory of depression regards self-blame as a primary feature of the disorder (Beck's, 1967). Self-blame and internal attributions for bad events are always associated with depression (Peterson, Christopher; Schwartz, Stanley, 2010).

Table no. 1 showed that self-blame, rumination, catostrophization of thought and other blame have a highly positive correlation with anxiety. From table 2 findings suggested that anxiety is predicted by blaming others and catastrophizing. However, putting into perspective is inversely related to anxiety. Although previous studies have shown that separate cognitive coping strategies, such as self-blame and rumination, are related to poorer emotional well-being, (Gross, 1998). The present study adds to the existing literature by including the separate cognitive coping strategies in one and the same study in order to study their joint contributions to mental health. As seen in the previous studies cognitive coping strategies self-blame, rumination, catastrophizing, blaming others and positive reappraisal were shown to play the most important role in the reporting of symptoms of anxiety (Garnefski, Legerstee, Kraaij, Kommer And Teerd 2002). Through finding we could found that the who more prone to use less adaptive coping strategies like self-blame, catastrophizing and rumination and blaming other more prone to face anxiety and use of more adaptive emotion regulation like putting into perspective decreases the occurrence of anxiety.

In result the findings (table no. 1) suggested that self-blame, acceptance positive reappraisal, catostrophizing and blaming other have a highly positive correlation with stress and referring to table no. 2 finding also suggested that stress was predicted by self-blame and blaming other . Our result is supported by previous studies. As per coping theory that those who engaged themselves in maladaptive cognitive coping strategies will experience greater stress than those who engaged themselves in adaptive cognitive coping strategies (Lazarus, 1993; Lazarus & Folkman, 1984).The present findings supports with this claim and showed, specifically in which cognitive coping strategies appeared to be most problematic with regard to stress situations. In literature, the association between early-life stress and the negative cognitive outcome was also found through review alterations in cognitive function associated with early-life stress. It is suggested that early-life stress is associated with abnormal cognitive function as stress may persist into at least early-adulthood (Hedges and Woon (2010).

In result it can also be seen that stress is found to be associated with positive reappraisal as it reflects through its meaning that thinking of attaching a positive meaning to the event in terms of personal growth, in addition it can say that it is the time in which the young adults trying hard for their personal growth as they want to get more and more pleasurable things, which shows that stress does not occur only in negative events but it could occur in positive events as stress is also be seen in the form of u-stress, (Selye, 1976).

Catastrophizing and blaming other is highly positively correlated with state anger (Table 1). A high positive correlation was also seen in self-blame, rumination, acceptance, positive refocusing, refocus on the plan, catastrophizing and other blame with trait anger. Referring to table no.2 state anger is predicted by catastrophizing and blaming other and trait anger is predicted by self-blame and blaming others. The current findings are similar with previous researches done on the role of irrational beliefs and cognitive distortions in context of anger (e.g., Lopez & Thurman, 1986; Martin & Dahlen, 2004; Zwemer & Deffenbacher, 1984). The result is also corroborated with the previous finding to see the role of cognitive emotion regulation in anger (Martin, Dahlen 2005).

Conclusions

The aim of this study was to assess the relationship between cognitive coping processes and negative emotions. Through the study it can be concluded that greater use of "less adaptive" cognitive coping strategies (i. e rumination, self-blame, blaming others and catastrophizing) are not only positively related to negative emotions of depression, anxiety, stress and anger but they also predict these negative emotions. Whereas "more adaptive" strategies (i,e positive reappraisal, putting into perspective, refocus on planning, positive refocusing, and acceptance) lessens the experience of negative emotions.

The study focuses on the relationship between cognitive coping process and negative emotions. Therefore

the study helps in enhancing understanding of the emotion regulation and coping behavior of the college students. Our youth seems to be a group in which they have negative coping skill however the findings shows that the group has positive coping skills also it is a good indication that they have positive coping skills along with negative coping skills which help them in negative life events to cope adequately than those persons who have negative life events and don't have positive coping skills.

The characteristics of the sample represent that they did not internalize the problem in spite of externalizing problem. They are reactive to the situation through anger than internalizing as depression, anxiety, and stress. However, a high level of anger does not reflect as adaptive functioning.

The understanding of the cognitive coping process of college student through cognitive emotion regulation strategies helps not only the intervention but it also helps in the prevention of their emotional problems or difficulties.

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Original Reaserch Article

Family Functioning among Families of Persons with Psychiatric Disorders and without Psychiatric Disorders

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Background: Psychiatric disorders can have a direct impact on family functioning. Family dysfunction is an indirect factor leading to the relapse of psychiatric disorders. Psychiatric disorders affect the relationship of an entire family. There are various psycho-educational interventions have proved positive effects on burden however very little research has focused on the relationship between family functioning, among families of persons with psychiatric disorders and without psychiatric disorders. **Aim:** The study on examined the family functioning among families of persons with psychiatric disorders and without psychiatric disorders. **Methods:**The research was cross sectional and purposive sampling technique was used for selecting samples. The sample was consisted of 200 families of persons with psychiatric disorders and without psychiatric disorders (100 families with psychiatric disorders and 100 without psychiatric disorders) selected from OPD of Central India Institute of Mental Health and Neuro Sciences (CIIMHANS) Dewada, Chhattisgarh and two nearby areas (Dewada and Kopidi) of CIIMHANS. Interview involved socio-demographics andfamily assessment device.**Result:** The result of the study indicated family functioning has significant differenceamong families of persons with psychiatric disorders and without psychiatric disorders.**Conclusion:** the study suggest the psychosocial interventions need of not only the burden specific but also to enhance overall family environment in order to have better adaptive state among family.

Key Words: Psychiatric illness and family functioning.

INTRODUCTION

Family isthe primary long-term caregiver and an importantresource for persons with psychiatric disorders. Family caregivers play a major role in providing care giving assistance to ill persons and their families.Family functioning defined as the expected interaction and relationship occurring amongst family members and community (Kavanagh, 1922).Family role and influence on the formation of the concepts of health and illness and on the presentation of models for normal and abnormal behaviour (Paterson et al., 2003). Family relationships were trustworthy and rewarding there was less of an impact of the illness on families and their coping with the illness(Fiese and Wamboldt, 2003).

Previous studies have suggested that unhealthyfamily functioning is associated with psychiatric disorders. Abnormal patterns of family functioning are associated with a slower rate of recovery from a depressive episode (Keitneret al., 1995). Patient with depression have been shown to increase relapse and poor recovery after the hospital discharge due to family have high levels of expressed emotion (Hooleyet al., 1986).The affective climate of the family to which a recently manic bipolar patient returns following hospitalization is predictive of his or her subsequent course of illness and social functioning (Miklowitz et al., 1988).Negative family attitudes and interactional behaviors are important predictors of the short-term course of schizophrenic illness (Vaughn et al., 1984). Family functioning does not return to normal in the families of depressed patients, after the remission of an acute exacerbation of major depression(Keitner et al., 1987).Kavanagh, (1992) who found that certain highly critical comment and emotionally over involvement attitudes is expressed by some of the family members of schizophrenic patients are predictive of relapse in the patient's disorder.Weinstock et al., (2006) discoveredthat patients with major depressive disorder and bipolar affective disorderhave similar levels of family impairment. Families of patients in both diagnostic groups generally experience improvement in family functioning from acute episode to recovery, yet average scores at recovery continue to range from fair to poor.Drapalskiet al., (2008) surveyed families with psychiatric illness found that familiesreported a substantial amount of unmet needs. The families have high level of stigma regarding the psychiatric illness.Critical environment and over involvement increased among the family members can be significant factors leading to relapse and poor recovery. Decreasing the number of critical comments overinvolvement in the family may lead to a healthier family situation and a more benign course of the psychiatric disorder (Falloon et al., 1982).

AIM OF STUDY

The study on assess and compare the family functioning among families of persons with psychiatric disorders and without psychiatric disorders.

METHOD AND MATERIAL

The research was cross sectional and purposive sampling technique was used for selecting samples. The sample was consisted of 200 families of persons with psychiatric disorders and without psychiatric disorders (100 families with psychiatric disorders and 100 without psychiatric disorders) selected from OPD of Central India Institute of Mental Health and Neuro Sciences (CIIMHANS) Dewada, Chhattisgarh and two nearby areas (Dewada and Kopidi) of CIIMHANS. Participator was able to understand Hindi or English, those who gave informed consent form and those who have no significant psychiatric co-morbid condition.

Inclusion and Exclusion Criterion

Inclusion criteria of the persons with psychiatric disorders: Person diagnosed with psychiatric disorder according to ICD-10. DCR, age between 20 to 50 years and duration of illness at least 2 to 8 years.

Exclusion criteria of the persons with psychiatric disorders: Person with neurological problem, head injury, mental retardation or other physical illness Inclusion criteria of families of persons with psychiatric disorders and withoutpsychiatric disorders: Gender- both, age between 20 to 50 years, caregiver lived with patient for at least 1 year,

Exclusion criteria of families of persons with psychiatric disorders and withoutpsychiatric disorders:Individuals with major psychiatric illness and neurological illness, individuals with major physical illness, lived with patient less than 3 years and those who did not give informed consent form.

Description of the Tools:

Socio Demographic Data sheet: Semi-structured socio-demographic data sheet was used to obtain background information of the subjects on different dimensions like age, length of stay, education level, family types, socio economic status and domicile etc.

McMasterFamily Assessment Device (FAD; Epstein, Baldwin, & Bishop, 1983):-This scale is designed to assess selfreportedfamily functioning. It scale consisted of 60 items, each with a 4 point scale (1, strongly agree to 4, strongly disagree)with higher scores representing poorer family functioning. Clinical cutoffscores have been specified to identify families that fall within the range ofunhealthy functioning and are included in parentheses following eachMMFF dimension: problem solving (2.2), communication (2.2), roles(2.3), affective responsiveness (2.2), affective involvement (2.1), behaviorcontrol (1.9), and general functioning (2.0).FAD subscales have demonstrated acceptablelevels of test-retest and internal consistency reliability, with Cronbach'salphas ranging from .72 to .92 in prior studies (Miller et al.,1985).

Data Analysis

The statistical analysis was done using Statistical Packages for the Social Science (SPSS)-16 software package for windows. For socio-demographic and variables, descriptive statistics were used such as frequency, percentage, mean, and standard deviation (SD). Chi square test was used for comparing categorical variables and t test was used for comparing continuous variables. Significance level of $P < 0.05$ and $P < 0.01$ was set at the outset of the study.

RESULT

Table-1 reveals that mean age and SD of families with psychiatric disorders were 34.92 ± 7.15. The mean age and SD of families without psychiatric disorderswere 34.55± 7.26 ($t = 0.363$). No significant difference was found in age of among families of persons with psychiatric disorders and without psychiatric disorders.The table also shows that mean stay of length and SD of families with psychiatric disorderswere 11.44 ± 5.12. The mean stay of length and SD of families without psychiatric disorderswere 10.76 ± 4.41. ($t = 0.316$, $P > 0.05$). There was no significant difference in stay of lengthamong families of persons with psychiatric disorders and without psychiatric disorders.

Table-1.Comparison of age and stay of length among families of persons with psychiatric disorders and without psychiatric disorders.

Variables	Group		t-value	*p*	df
	Psychiatric Disorder (N-100)Mean±SD	Without Psychiatric Disorder (N-100) Mean±SD			
Age	34.92 ± 7.15	34.55 ±7.26	0.363NS	0.717	198
Stay of length	11.44 ± 5.12	10.76 ± 4.41	1.005NS	0.316	198

N=Number, SD=Standard deviation,df=Degree of freedom, NS=Not significant

Table-2 reveals that there was no significant difference in education, family types, socioeconomic status, and domicile between both the groups. In education, 18 (18.0%) families with psychiatric disorders and 20(20.0%) families without psychiatric disorders were illiterate, whereas 82 (82.0%) families with psychiatric disorders and 80(80.0%) families without psychiatric disorders were literate; the value of ?2 = 0.130 and P > 0.05.Twelve (12.0%) families with psychiatric disorders and 12(12.0%)families without psychiatric disorders were from joint family, 79(79.0%) families with psychiatric disorders and 77(77.0%) families without psychiatric disorders were from nuclear family and

Table-2.Comparison socio-demographic variablesamong families of persons with psychiatric disorders and without psychiatric disorders.

Variables		Group				
		Psychiatric Disorder (N-100)	Without Psychiatric Disorder (N-100)	$?^2$	*p*	*df*
Education	Illiterate	18 (18.0%)	20(20.0%)	0.130NS	0.718	198
	Literate	82 (82.0%)	80(80.0%)			
Family types	Joint	12(12.0%)	12(12.0%)	0.226NS	0.893	198
	Nuclear	79(79.0%)	77(77.0%)			
	Extended	9(9.0%)	11(11.0%)			
Socio-economic status	Low	43(43.0%)	44(44.0%)	0.136NS	0.934	198
	Middle	38(38.0%)	39(39.0%)			
	High	19(19.0%)	17(17.0%)			
Domicile	Rural	37(37.0%)	34(34.0%)	0.372NS	0.830	198
	Semi-urban	33(33.0%)	37(37.0%)			
	Urban	30(30.0%)	29(29.0%)			

N=Number, df=Degree of freedom, NS=Not significant

9(9.0%) families with psychiatric disorders and 11(11.0%) families without psychiatric disorders were from extended family; the value of ?2 = 0.226 and P > 0.05.Forty three (43.0%) low class in families with psychiatric disordersand 44(44.0%) low class in families without psychiatric disorders, 38(38.0%) middle class in families with psychiatric disordersand 39(39.0%) middle class in families without psychiatric disorders, 19(19.0%) high class in

Table No.3 Comparison of domains of family functioningamong families of persons with psychiatric disorders and without psychiatric disorders.

Variables	Group			
	Psychiatric Disorder (N-100)	Without Psychiatric Disorder (N-100)		
	Mean±SD	Mean±SD	t-value	*p*
Problem Solving	6.54 ± 2.38	3.49 ±0.90	11.968	0.000
Communication	6.46 ± 2.00	3.54 ± 0.88	13.357	0.000
Roles	6.79 ± 1.79	3.52 ±0.96	16.057	0.000
Affective Responsiveness	6.04 ± 2.07	3.44 ± 0.86	11.587	0.000
Affective Involvement	6.56 ± 1.74	3.45 ±0.89	15.890	0.000
Behavior Control	5.79 ± 1.96	3.46 ± 0.82	10.977	0.000
General Functioning	6.29 ± 1.90	3.51 ±0.90	13.202	0.000

N=Number, SD=Standard deviation,

families with psychiatric disordersand 17(17.0%) high class in families without psychiatric disorders;the value of ?2 = 0.136 and P > 0.05. Thirty seven (37.0%) rural area in families with psychiatric disordersand 34(34.0%) rural area in families without psychiatric disorders, 33(33.0%)semi-urban area in families with psychiatric disordersand 37(37.0%)semi-urban area in families without psychiatric disorders, 30(30.0%) urban area in families with psychiatric disordersand 29(29.0%) urban area in families without psychiatric disorders;the value of ?2 = 0.372 and P > 0.05.

Table-3 reveals that there was significant difference in the family functioning domains of problem solving, communication, roles, affective responsiveness, affective involvement, behavior control and general functioning between both the groups.The mean and SD score of problem solving in the families with psychiatric disorders were 6.54 ± 2.38 and in families without psychiatric disorders were 3.49 ±0.90(t= 11.968, P < 0.01). Communication in the families with psychiatric disorders was 6.46 ± 2.00 and in families without psychiatric disorders were 3.54 ± 0.88(t= 13.357, P < 0.01). Roles in the families with psychiatric disorders were 6.79 ± 1.79 and in families without psychiatric disorders were 3.52 ±0.96(t= 16.057, P < 0.01). Affective responsiveness in the families with psychiatric disorders was 6.04 ± 2.07 and in families without psychiatric disorders were 3.44 ± 0.86. (t= 11.968, P < 0.01). Affective involvement in the families with psychiatric disorders was 6.56 ± 1.74 and in families without psychiatric disorders were 3.45 ±0.89 (t= 15.890, P <0.01). Behavior control in the families with psychiatric disorders were 5.79 ± 1.96 and in families without psychiatric disorders were 3.46 ± 0.82 (t= 10.977, P < 0.01). General functioning in the families with psychiatric disorders were 6.29 ± 1.90 and in families without psychiatric disorders were 3.51 ±0.90 (t= 13.202, P < 0.01).

DISCUSSION

The present study found that families of person with psychiatric disorder have higher levels of family dysfunction compared to families of person without psychiatric disorder.There was significant difference in the domains of all family functioning between both the groups.Some earlier studies also suggested and support that psychiatric disorders may be associated with greater family dysfunction than others.Trangkasombat, (2006) reported that families of psychiatric patients were found to have a higher rate of family dysfunction compared on the nonclinical families. Dimensions of family functioning found to be significantly dysfunctional were problem solving, communication, affective responsiveness, affective involvement and roles.Friedmann et al., (1997) conducted the study and suggested that families of psychiatric patients have higher levels of dysfunction compared to nonclinical families. Miller et al., (1986) conducted the study and found that psychiatric families have higher level family dysfunction compared on nonclinical families, addressed this important issue by comparing the family functioning of patients with depression, alcohol abuse, adjustment disorder, schizophrenia, and bipolar disorder to control families. Fristad& Clayton, (1991) found that families of schizophrenic and bipolar patients have significant level dysfunction compared on control families but did not high. Kabacoff et al., (1990) suggested that psychiatric families have greater difference family functioning compared on nonclinical and medical families.Unal et al., (2004) found thatfamilies of patients with bipolar disorder and schizophrenia reported the problems in communication, behavioral control, problem-solving and general functioning to be problematic.Keitner and Miller (1987) found that psychiatric families have worse family functioning and suffering from depression not only in comparison to a non-clinical control group but also compared to families dealing with other parental mental disorders.Saeki et al., (2002) found that depressive families reported significantly worse family functioning than control families especially in problem solving, communication and general functioning.

IMPLICATIONS

- Family intervention especially primary caregivers to provide family counseling and stress, anxiety and depression management technique.
- Primary care givers also provide to psycho-education about the disorders for the relapse/good prognosis of the illness.
- Family therapy can be more fruitful for the management of dysfunction in the family.

LIMITATIONS

- The present study was carried out with a total sample size of 200 and participants from limited area of Central India Institute of Mental Health and Neuro Sciences (CIIMHANS) Dewada, Chhattisgarh
- If a large sample size had been selected, the study would have been more interesting and the results could have been more reliable as well as generalisable.
- The time-bound nature of the study prevented detailed exploration.

CONCLUSION

In conclusion it is revealedthat the families of persons with psychiatric disorders have higher levels of family dysfunction compared to families without psychiatric disorders. Regardless of the specific diagnosis, having a family member in the acute phase of a psychiatric disorder appears to be a risk factor for poor family functioning across many areas, including problem solving, communication, affective involvement, behaviour control, affective responsiveness, role allocation, and general functioning.If family burden increased in care givers it leads to more dysfunction in all other areas. Present study suggests, psychosocial interventions need

of not only the burden specific but also to enhance overall family environment in order to have better adaptive state among family. Therefore, there is wider scope for the psychiatric team to intervene the appropriate strategies to the concerned family.

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Original Reaserch Article

Interplay Between Conflict and Sacred Geography of Kashmir: A Socio Psychological Overview of Hazratbal Shrine

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ABSTRACT

Kashmir is widely known as Pir-i-Wair 'the valley of saint's from the times immemorial. There are innumerable pre-eminent shrines and temples associated with different faiths and Hazratbal being the repository of the sacred hair of Prophet Muhammad PBUH has emerged as a leading pilgrimage center in Kashmir. In times of personal and public troubles the shrine has not only been the source for religious rituals but also served to socio-psychological needs. Among the many functions that are performed by the shrine, the leisure and recreational functions stand out eminently. In times of life crisis and life events a visit to the shrine is considered a Baraka with a strong belief that the radiation of sacredness of the shrine would help in healing the crisis. Notwithstanding an increasing consumption ofmedia, pilgrimage to shrines remains the most important leisure activity in Kashmir.To sum up in this paper the central argument would be to contextualize the social reality of pilgrimage and closely examine the efficacy andrelationship of pilgrimage with the personal/public troubles. Moreover, to analyze 'how the pilgrimage sites help in the sustained integration ofsociety at macro and micro level during the troubled times'. The preservation and protection of shrines are imperative for State and Society as these pilgrimage sites have a crucial role in social order across time and space.Thus, through the qualitative and quantitative approach authors have attempted to establish a sociological knowledge of the contemporary relationship amongst the variables such as personal/impersonal troubles and the pilgrimage to the shrine at Hazratbal.

KEYWORDS : Hazratbal Shrine, Holy Relic, Holy shrine, Leisure,Pilgrim, Pilgrimage.

INTRODUCTION

India with its kaleidoscopic variety and rich cultural heritage is a land of pilgrimage. Travelling for religious purposes has been there since antiquity when people used to visit their respective religious places as a part of fulfilling their religious obligations and also as a prerequisite to achieve the spiritual nirvana. Practically, all religions Hindu, Muslim, Buddhism, Christian, Sikhism and Jainism have their major and minor pilgrimage centers in different parts of the country. According to a status of Export house, India's tourism industry has become one of the important sectors of its economy contributing substantially in the country'sGDP with pilgrimage tourism as its jugular vein. In fact, to a majority of domestic tourists in India, pilgrimage has always been the major motivation.Representing the country in all its diversity, the state of Jammu and Kashmir stands as an epitome especially when it comes to religious tolerance and, hence, pilgrimage tourism. Considered as a holy place by people of all faiths,the state is brimmed with sacred sites thronged by pilgrims from all over the world (Koenig, 1998). An Abode of Gods replete with the sacred places, Jammu and Kashmir expresses itself in tripartite blending of Jammu "City of Temples", Kashmir"Land of Saints"and Ladakh"Land of lamas; Gompas and Monastries".Presenting an awe-inspiring range of holy sites spanning across the length and breadth of the state,each and every pilgrim spot of Jammu & Kashmir Pilgrimage Tourism from Sufism and Hinduism to Islam and Buddhism speaks of a distinct religious heritage(Adler & Jahn, 1933).The entire pilgrimage tourism of the state is structured around a) Jammu Pilgrimage comprised ofRagunath Mandir ,Mata Vaishno Devi, Bawey Wali Mata, Peer Kho, Ranbireshwar Temple,peer Mitha, Panchbakhtar temple, Peer Budhan Ali Shah or Peer Babab) Kashmir Pilgrimage comprised mainly of Shankaracharaya Temple, Amarnath ji,Charar-e-sharif,Hazratbal mosque, Khanqah-e-moulah, Kheer Bhawani, Taktht-e-Suleiman, Hari Parbat Forte, Shrine of saint Makhdoom Sahib, Sikh Gurudwara Chatti Padshahi and c) Ladakh Pilgrimage comprised of Rizong Monastery, Likir Monastery, Lamayuru Monastery, Stakana Monastery, Cave Monastery, Thiksey Monastery, Spituk Monastery and Stongdey Monastery (Adler & Jahn, 1933).

Social- Psychological Mapping of Hazratbal Shrine

Pilgrimage tourismas an act of religious tourism is a vehicle for change towards better and has important role in creating peace and social solidarity at various levels if properly guided by the codes of ethics and conduct that are sourced from religions and socio-cultural values derived from religions. Theholy shrine of Hazratbal being the repository of holy relic

of Prophet Mohammad (PBUH)has been a lightening conductor for the religious fervor, besides being an ambassador of peace(Adler & Jahn, 1933). The shrine because of magnetic strength has emerged as a centre of mass faith attracting the sick, the childless, the blind and pilgrims irrespective of gender, age, class and faith. The various socio-psychological dimensionsof this historic and leadingshrine can be gaugedthrough following themes as:-

- Hazratbal Shrine on the Touch Stone of Conflict:
- Shrine and normalcy
- Reunification of society
- The platform of social cohesion, peace and integration
- Agency of perceptional change and mutual harmony
- The pilgrimage to the shrine and the attendant economy

The continuum formed by two polar ends of turmoil and holy shrines though vibrating out of phase, wherein on one hand, the turmoil characterized by the politicalturbulence lead to a greater social disorder,chaos,alienation, senseofinsecurity andfear psychosis among peopleand thus created aconsiderable gap among different communities and groups leading to disharmony, distrust and hatred for one another and on the other hand,the holy shrines and in particular the Hazratbal shrine haveemerged as vehicles of peace building and mutual harmony by providing a soothing platform to people seeking solace both at the individual and the collective level, thereby mitigating the ill effects of the turbulence(Allins, 1992).

Despite of the dual proliferation of Wahabism and media consumption/access,shrine visiting practices especially that of the Hazratbal Dargah continued unabated for the majority of the masses denounce wahabi brand of Islam and do not simply feel satiated with mass media or religious program broadcasted on TV or radio, etc. (Freud, 1928).It has been highlighted that individuals out of their age old habit of socialization or reutilization of shrine visiting practice usually don't pay a lot of importance to media or other forms of leisure but take pride in seeking both divine blessings and leisure with experience at such revered places Allins, (1992).Being the embodiments of peace despite conflict situation and prolonged turbulence, people continued to visit holy shrines as a coping strategy, thushealing their wounds while enjoying leisure in the form of arranging tea parties in shrine premises, utilizing shrines as the sites of outing, etc.(Freud, 1928).

Usually economy has been often overlooked asanessential element of the complex system of pilgrimage however, the inextricability of the economic component from the ritual and cosmological aspect of pilgrimage can't be bypassed. Fundamentally, every pilgrimage is closely associated with a field of economic exchange as in carnivals, fairs, marketplaces etc.

OBJECTIVES

1. To identify the main reasons pilgrims visit holy shrines.
2. To identify the role of shrines in fostering the communal harmony, peace and integration with due focus on Hazratbal shrine.
3. To provide some indication of future demand for Holy shrines.

METHODOLOGY

To study the socio-psychological dynamics of the Hazratbal shrine, a sample of 150 pilgrims/respondents was selected after purposive random sampling (Koenig, 1992). Accordingly, respondents were selected on the basis of their age groups, educational status, income levels/occupational levels with equal representation to urban and rural pilgrims with the help frequency distribution tables.A pilot study was undertaken to develop the familiarity with the shrine settings and to formulate the questionnaire in order to gather the necessary information. The structured questionnaire was then distributed among 150 respondents selected for the purpose with a response rate of 100%. This was followed by interviews and necessary observation of the devotee behavior to suffice the study qualitatively and also to remove the vagueness because of the structured nature of the questionnaire.

PROCEDURE

In order to carry out the case study of Hazratbal shrine and to collect the preliminary data, a pilot study was undertaken to design and formulate the survey instrument i.e., questionnaire/schedule to get all the relevant information to realize the objectives of the study.The survey instrument was two part questionnaire. The questions in the first part were aimed at getting the socio-demographic profile i.e., gender, occupation, educational qualification, income etc. of the respondents on the basis of which frequency distribution was done as to provide a proportionate representation to the various categories of respondents. The second part comprised the questions based on various indices and relevant to the objectives of study. Besides the questionnaire, the major emphasis was put on observation of the pilgrim behavior and informal talks. To ensure equal representation torural and urban respondents/pilgrims, frequency distribution was undertaken byselecting 75 (50%)respondents each out of the total sample size of 150respondents.Further an equal representation was provided to both genders to makethe study more accommodative.

RESULTS AND DISCUSSION

Table 1
Frequency distribution of respondents based upon their educational status (N=150)

Education Status	Rural (75)		Urban (75)		Total
	N	%	N	%	
Illiterate	28	37.33	25	33.33	53
Under Matric	15	20	17	22.66	32
Under Graduate	19	25.33	18	24	37
Graduation and above	13	17.33	15	20	28

From theabove table,it is obvious that respondents were selected with dueconsiderationto their educational status. As such, the respectiveeducationalstatus ofthe respondents selected in the rural categoryWas(Illetrate-37.33%); (Under Matric-20%); (Under Graduate-25.33%); (Graduation and above-17.33%). Likewise theeducational status of the respondents in the urban sample was (Illiterate-33.33%); (Under Matric-22.26%); (Under Graduate-24%); (Graduation and above-20%).

Table 2
Micro Frequency distribution of respondents based on the age group in rural and urban contexts (N=150)

Age group	Rural (75)		Urban (75)		Total
	N	%	N	%	
Young age group (20-35)	25	33.33	25	33.33	50
Middle age group(36-50)	25	33.33	25	33.33	50
Old age group(above 50)	25	33.33	25	33.33	50

As with the educational status, a proportionate representation was given to the respondents belonging to the specified age groups. Accordingly from each age group one third each(33.33%) of the total sample size in the respective rural and urban category was selected.

Table 3
Classification of the respondents based on their income/occupational status in Rural and Urban Context

Income group	Rural (75)		Urban (75)		Total	
	N	%	N	%	N	%
Below Rs. 4000 PM (Labour class)	39	52	34	45.33	73	48.66
Rs.4000-7000 PM (Service class)	19	25.33	28	37.33	47	31.33
Above Rs.7000 PM (Business class)	17	22.66	13	17.33	30	23.33

To select the respondents from different income/occupational categories, frequency distribution was resorted tothe proportion of rural respondents inthedifferent income categories/ occupational categories was (Labour class-52%); (Service class-25.33%); (Business class-22.66%). Likewise the proportionofurbanrespondentsbelongingtodifferent Income/ occupational categorieswas(Labour class-45.33%); (Serviceclass-37.33%); (Business class-17.33%).Collectively48.66%,31.33%and 20% respondents were selected in the different income/occupational categories.

Table 4
Research objective 1:Why do people visit pilgrimage shines?

Motivations	Number of Pilgrims	Percentage of Pilgrims
Pilgrim or Religious interest	**77**	**51.33%**
Spiritual Purpose	**37**	**24.66%**
Health and Wealth	**30**	**20%**
Leisure and Experience	**6**	**4%**

The above data reveals that pilgrims/people thronging the holy shrines possess an array of motivations ranging from pilgrim or religious interests through spiritual purposes, health and wealth intentions to leisure and experience. This all-round motivation can be attributed to the modern times where turbulence perceived at individual and collective levels has a telling effect on the people, who, therefore, find a refuge in these holy shrines which offer them solace, leisure, answers to health and wealth problems besides help them in attaining spirituality

Table 5

Research objective 2: Perception of pilgrims regarding Holy Shrines being places of peace and integration

Perception of pilgrims regarding Holy Shrines being places of peace and integration	YES	NO	Total
Number of Pilgrims	**137**	**13**	**150**
Percentage of Pilgrims	**91.33%**	**8.66%**	**100**

On the basis of above data, there is no denying of the fact that holy shrines and other pilgrimage sites have emerged as gathering places and places of cultural contact for the diverse pilgrims/visitors visiting these holy shrines. Further, when respondents were asked about the speciality of Hazratbal shrine, in achieving the objectives of peace and integration, a special preference was attached to the Hazratbal shrine by the respondents for being the premiere shrine because of its being repository of Holy Relic of Prophet Mohammad (Saw)- the messenger of peace and also because of its monumental significance alongside the spectacular attendant landscape and the rich accessibility (Kimble, Mcfadden, Ellor, & Seeber, 1995).

Research objective 3:Indications of future demand for holy shrines

Analyzing the broad motivations of the respondents, with which pilgrims visit the holy shrines and as is clear from their responses above, it is obviousthat the holy shrinesbased on their universal appeal serve as pull factors for the pilgrims and as such always hold a sustained demand. Further the additional prospects for the continued growth in demand factor for holy shrines are evidenced in the pilgrims renewed interest in spiritual matters, renewed quest for meaning etc. coupled by the resiliency of thispilgrimage tourism sector to economic downturns.

CONCLUSION:

To sum up, role of shrines in the tech-savvy lives of contemporary societies can't be undermined given their omnipresence in all walks of people's lives. Serving as a connecting link between two extremities of sacred (after worldly affairs) and the profane (this worldly affairs), shrines have evolved as a sustainable means to address the never ending aspirations of the devotees thronging these holy marvels. From individual disorganizations to collective ends, shrines haveemerged as a panacea/universal care to the all-round sufferings of the people, besides being the institutionalized means to attain spirituality and salvation.As ambassadors of peace, the shrines have bridged the gap between the varied diversity of people at both the macro and micro levels. Connecting the Diasporas, building horizons, developing inter-religious faith and the communal ethos, besides leading to attitudinal and perceptional changes at the individual level, shrines have helped in chasing the intangible and impossible. Hazratbal being the most revered and most visited shrine of the valley, has been a spectacular abode of peace by virtue of its magnetic strength andhistorical magnificence. This goes without saying that the shrines have played a significant role in reunification and integration of Kashmir society, rebuilding of social order besides abridging the widened gulf between the various communities (Jung, 1984).

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Original Reaserch Article

Marital Adjustment And Self Esteem in Person with Bipolar Affective Disorders

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ABSTRACT:

Bipolar disorder, frequently referred as manic-depressive illness, is a psychiatric disorder that causes unusual mood shifts, difference in energy shifts, activity levels, and interferes with the ability to carry out everyday tasks. Symptoms of bipolar disorder are severe. These symptoms are different from the usual ups and downs that everyone goes through from time to time. Bipolar disorder symptoms can cause damaged relationships, difficulties in job or low academic performance, and even suicide. However, bipolar disorder is treated, and individuals with this illness can lead a productive life. Here in this study we have administered Marital adjustment and Self-esteem on Bipolar patients (N=30 group) with aim to assess the problem in marital life and self esteem. The patients were chosen randomly. Informed written consent was obtained before assessment from each participant. The groups differed significantly on the self-esteem scores. The differences seem to be because of the different nature of the current episode.

Key Words: Marital adjustment, Bipolar, self-esteem.

INTRODUCTION

Marriage is considered to be one of the most important relationships between a man and women. It involves emotional and legal commitment that is quite important in adult life. Selecting a partner and entering into a marital contract with him/her is considered both maturational milestone and personal achievement. The choice of marital partner is one of the most important decisions that one makes in their life. People marry for many reasons, like; love, happiness, companionship, and the desire to have children, physical attraction, or desire to escape from an unhappy situation (Bernard, 1984). Marriage is a commitment with love and responsibility for happiness, peace, and development of strong family ties. Marriage has also been seen as "socially legitimate sexual union, begun with a public announcement and undertaken with some ideas of permanence; it is assumed with more a less explicit marriage contract, that spells out the reciprocal rights and obligations between the spouses and future children" (Dalack, 1990).

Marital adjustment as 'the state in which there is an over all feeling in husband and wife of happiness and satisfaction with their marriage and with each other' (Thomas, 1977). All the marriages for happiness in one way or other. Most couples marry filled up with both realistic and unrealistic expectations. This is due to the complex nature of marriage and each (Veenboven, 1983). Marital adjustment calls for maturity that accepts and understands growth and development in the spouse. If this growth is not experienced and realized fully, death of marital relationship is inevitable. A relationship between couples is not instantaneous rather a slowly progressive. In a study on 581 couples, 25% individuals disclosed that at some time in the adjustment process, they discussed discovering and 18% had seriously considered it (Leffcourt, 1973). Marital adjustment has been visioned differently by different workers there are six areas of marital adjustment, which is defined by the psychologist, such as, religion, social life, mutual friends, in-laws, money and sex (Lazarus & Delingis, 1983). Yet another psychologist has defined ten areas of marital adjustment such as couple growth, conflict resolution,values, communication, cooperation, affection, sex, money roles and parenthood (Margolin, 1980). A study on marriage and marital adjustment in United States presents social activities and recreation, training and disciplining of children, religion, in law relationship, financial matters, sexual relationship, communication, mutual trust and companionship as the areas of marital adjustment (Simth, 1961).

Self-esteem can be an important part of success. Low self-esteem often leaves people feeling defeated or depressed. It also leads to individuals making bad choices, falling into destructive relationships and failing to live up to their full potential. Self-esteem has become a household word. Everyone including teachers, parents, therapists, and others have focused on boosting self-esteem believing that a high self-esteem will lead to many positive outcomes and benefits (Rosenberg, 1965). Appraisal of the effects of self-esteem is influenced by several factors. Many individuals with high self-esteem often boast their good traits and successes. High self-esteem is a heterogeneous category which encompasses individuals who frankly accept their good qualities along with

narcissistic, defensive, and conceited individuals. In cases with bipolar disorder(BD), self-esteem level is low also in remission period in addition to depressive period (Mileva, Vázquez & Milev, 2013). This was related tonon adaptive coping mechanisms. Self-esteem is generally considered a personality trait that reflects a person's overall sense of value and self-worth. Self-esteem basically refers to how one generally feels about themselves, their abilities, appearance, emotions, attributes and behaviors. Some people have very high self-esteem while others may have very low self-esteem (Coulston et al., 2013).

In one study low self-esteem was studied amongst depressive patients using the Rosenberg Self-Esteem Scale in 24 recovered unipolar and 27 recovered bipolar patients alongwith a normal control group of 26 subjects matched for age and sex. The hypothesis was confirmed only for unipolars; bipolar patients presented a self-esteem score not significantly different from normal scores. It was reflected that self-esteem is not related to clinical characteristics of the disorder, indicating that low self-esteem may be a prime component in a depression-prone personality. The exploration amongst the variables of self-esteem and social adjustment indicated the presence of social conformism in bipolar patients and rigidly set low self-esteem in unipolar patients. These results should stimulate the evaluation of different psychotherapeutic treatments in the long-term psychosocial management of affectively ill patients1.

Self-esteem (SE) and social adjustment (SA) are often impaired during the course of affective disorders; this impairment is associated with suicidal behaviour. The aim of the present study was to investigate SE and SA in unipolar or bipolar patients in relation to demographic and clinical characteristics, especially the presence of suicidality (ideation and/or attempt). Forty-four patients, 28 bipolar and 16 unipolar, in remission for at least 3 months, and 50 healthy individuals were examined through a structured clinical interview. SE and SA were assessed by the Rosenberg self-esteem scale and the social adjustment scale, respectively. The results have shown that bipolar patients did not differ from controls in terms of SE, while unipolar patients had lower SE than bipolar and controls. No significant differences in the mean SA scores were found between the three groups. Suicidality during depression was associated only in bipolar patients with lower SE at remission; similar but not as pronounced was the association of suicidality with SA. It was noted that low Self Esteem in remission tends to be related to the expression of suicidality in depressive episodes of bipolar patients, whereas no such trend is evident in unipolar patients (Daskalopoulou et al., 2002).

One of the prime discussions in the family values is the quality of the relationship between the parents (husband and wife). When the relation between them is satisfactory, the families comfortable and socio performance is improved. Self-esteem is a psychological variable that plays an important role in the lives of people. To intervene with this it is important to focus on the couples' self-esteem which would result in increasing their marital satisfaction and improving the families' efficiency. The past studies indicate that the self-esteem is factor that is effective in the women marital satisfaction rate compared to men (Cohen, Geron & Farchi, 2009). However, very little work is available on this subject from our country hence we planned to carry out this study.

Aim : To study the self-esteem and marital adjustment profile of bipolar patients.

METHOD:

In this cross sectional we study assessed the marital adjustment and self esteem in bipolar patients. For this purpose we randomly selected 30 patients of ICD-10 bipolar affective disorder were selected (15 patients currently depressed, and 15 currently mania) from outdoor unit of the department of Psychiatry, Post Graduate Institute of Medical Sciences, Rohtak. Written voluntary informed consent was taken from all subjects and their caregiver, who fulfilled the inclusion criteria for the study. They were also informed in writing that they may withdraw consent at any time without any adverse effect on their treatment.

SELECTION CRITERIA:

Inclusion Criteria:

1. Age range 18-60 years.
2. Diagnosis of Bipolar affective disorder current episode mania or depressed as per ICD-10
3. Absence of psychotic features.
4. Ability to understand, read and write English
5. Willing to participate and ability to give written consent for the same
6. Caregiver willing to give consent

Exclusion Criteria

Presence of any physical and/or psychiatric (such as personality disorder) morbidity or disability

TOOLS:

Socio-demographic data sheet and Inform Consent Form: Semi-structured socio-demographic data sheet was used to obtain background information of the subjects on different dimensions like age, length of stay, education level, family types, socio economic status and domicile etc. Marital Adjustment Scale: It was developed by Kumar and Rohatgi in 1976. It has adapted for Indian population. It was developed by Kumar & Rohatgi,1976. It has 25 item highly discriminating 'Yes-No' type item. It was found to be .71 to .84 an index of reliability. Rosenberg's Self Esteem Scale (RSES): It was developed by Rosenberg in 1965. The RSES has adapted for

Indian population. The scale was originally developed by Rosenberg. It has 10 items with four point likert scale. All items are rated on a 4-point scale (e.g., from "Strongly agree" to "Strongly Disagree"). Items no. 3, 5, 8, 9 and 10 are scored negatively. Test-retest correlation is typically in the range of 0.82 to 0.88 and Cronbach's alpha for various samples are in the range of 0.77 to 0.88.

RESULT

Table 1

Frequency and percent for Demographic variables

Variables		Frequency (percent)
Gender	Male	16(53.3)
	Female	14(46.7)
Age	20-30	10(33.3)
	31-40	9(30.0)
	41-50	8(26.6)
	51-60	2(6.66)
	61-70	1(3.33)
Family Type	Nuclear	14(46.7)
	Joint	16(53.3)
Residence	Rural	14(46.7)
	Urban	16(53.3)
Education	No formal education	9(30)
	Up to 10^{th}	11(36.6)
	10^{th}-12^{th}	6(20)
	Graduation	3(10)
	Post-Graduation	1(3.3)
Occupation	Farmer	9 (30)
	House wife	14(46.7)
	Govt. job	2(6.66)
	Others	5(16.6)

In the results 53.3% sample were male and 46.7% were female. In the age variable 33.3% were from 20 to 30 years of age, 30% were 31 to 40 years of age, 26.6% were 41 to 50 years of age, 6.66% were 51 to 60 years, and only 3.33% were 61 to 70 years. In the family type 46.7% were belongs to nuclear family and 53.3% were from joint family. Similar results were found in the residence area. In the education 30% were not have formal education, 36.6% have education up to 10th class, 20% have education up to 12th, 10% have education level at graduate level and 3.3% have up to post graduation level. In the occupation 30% were belongs to farmer and 46.7% were housewife, 6.66% have govt. job and 16.6% have different-different occupation such as laborer, pvt. job etc.

Table 2

Descriptive analysis of patients across marital adjustment and self – esteem

Mann-Whitney U Test	Bipolar Mania(n=15) Mean ±sd	Bipolar Dep (n=15) Mean ±sd	Mann-WhitneyU Test p
Marital adjustment	**15.07±3.06**	**13.87±3.33**	**0.325**
Self- esteem	**20.20±3.33**	**11.27±1.98**	**0.000**

In the results (Table 2) it has been revealed that marital adjustment was not differed in bipolar mania and bipolar depression (U=0.325). In the self-esteem both bipolar mania and bipolar depression differed significantly. The mean (SD) value is 15.07 (3.06) and 13.87 (3.33) found respectively in both bipolar mania and depression on marital adjustment. On the self-esteem variable the mean (SD) is as 20.20 (3.33) and 11.27 (1.98).

DISCUSSION

The aim of the study was to assess the marital adjustment and self esteem among the patients suffering from bipolar affective disorder. We chose this subject for the study as very little work is available from our country on this aspect of bipolar affective disorder. It is important to study this aspect, as with the growing time, the family structure is rapidly changing and joint families are gradually getting replaced by the nuclear families. Self-esteem as well as marital adjustment of an individual affects the care giving process and therefore the outcome of the disorder.

We assumed that depressive episode as well as manic episode would have an adverse impact on the self-esteem as well as adjustment process of the married couple. However we did consider that there might be certain qualitative differences in adjustment process due to different psychopathology of the episodes. Hence we preferred to compare the depressed and manic patients with each other on the valid and standard measures of marital adjustment and self-esteem.

Socio demographically we did not find any significant differences in the manic and depressive group. The finding is self-explanatory as the both sample groups were taken from the same study population. Hence, socio demographic differences are unlikely.

The marital adjustment in both groups did not differ statistically though the groups differed in their current episode (Table 2). This similarity in the marital adjustment seems to be because of the nonspecific stress induced by the current episode. In a study by Muke et al (2014) the findings were similar in the schizophrenia and bipolar patients. However, a comparison with the healthy non psychiatric controls would have given us a better understanding about this similarity.

The groups differed significantly on the self-esteem scores .The differences seem to be because of the different nature of the current episode. The patients with depressive syndrome have a negative image about self, whereas the situation is just the opposite in mania (ICD-10). It is quite evident from these findings that marital adjustment makes only a minor contribution to self esteem in the bipolar patients with different current episode. But the current study being cross sectional and involving only a small sample limits its genera liability. These parameters are not taken into consideration for this pilot study. Hence there is a need for more studies in bipolar patients with regards to the determinants of self-esteem.

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Original Reaserch Article

Quality of Life among Female Eldery Living in Old Age Home and Family

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Background:

Ageing is associated with the multidimensional phenomenon which is affected by a combination of physical, psychological and socioeconomic factors in society. Quality of life term is associated with physical, psychological, social and environmental aspect of any individual. Quality of life of any individual is influenced by social factors as poverty, unemployment, migration etc. Now a day's elderly is venerable section of our society but female elderly is more venerable in comparison to male elderly. They faced many difficulties in daily life which is associated with caring, health, emotional support and financial issues. This paper is based on the quality of life of female elderly living in old age home and Family. Social workers can be found in a wide variety of practice setting in field of ageing. The role of the social worker is often unique in theses setting as social work's primary focus is the psychosocial well-being of the female elderly. **Aim:**To assess and compare relationship of Quality of life among female elderly living in old age home and Family. Methods and Materials: A cross sectional research design was adopted for the study and sixty samples were recruited through purposive sampling technique, thirty samples from old age homes and thirty samples from Family. Tools such as socio-demographic data sheet, Quality of Life scale were administered to obtain the data with consent. **Result and Conclusion:** Findings of this study indicate that female elderly living in old age home had better quality of life in compare to elderly female living with family setup.

Key Words : Old age home, Quality of Life, Ageing and Quality of Life.

Introduction :

Old age is the challenging period of human life which is associated with many challenging factors like health, psychological, social and economical aspects. Now a day elderly became a highly vulnerable group in society and their vulnerability increases with age factors. The reason of this vulnerability in society is mainly in lack of employment, financial insecurity, ill health and neglect by people. Modernization, Industrialization and Urbanization is influenced family system of India. Joint family system break into the form of nuclear family system and people of rural area migrated to urban area for better job opportunity. For better life style, education, health and transportation facility people moved to metropolitan city. These factors generated caring of elderly in family. Every one busy in own life no one have time for elderly to communicate.

Quality of Life and Female elderly :

The World Health Organization defines the quality of life (QoL) as "an individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals expectations, standards and concerns. It is a broad-ranging concept, incorporating in a comparing way the person's physical health, psychological state, level of independence, social relationships, and their relationship to salient features of their environment". "The return to a previous level of functioning is a critical parameter to the quality of life construct. They believe that a definition of quality of life must consider the following domains: mobility, self care, daily activities, recreation, socialization, family roles, presentation of self and coping capacities"(Wood-Dauphinee S, & Williams JI 1987) Quality of life is widely recognized as an important concept and measure of outcomes in health care, and the concept is emerging more and more often also in connection with long term care . However, although improving or maximizing the Quality of life of the clients seems to be increasingly mentioned in care policies and development programmes of long term care of older people, it less often is a goal pursued in actual care practices. In our view, among the reasons for this are underdeveloped concepts, structures and processes of evaluation of care outcomes in the long term care of older people. The quality of life of the men and women are living in institutions and non-institutional settings in urban Bangalore District. Elderly living in institutional setting showed high level of Quality of Life than non-institutional setting and there is a significant difference between the institutional and non-institutional elderly men and women in the area of physical, psychological, level of independence, social relationship and environment domains of Quality of Life (Lakshmi Devi S, & Roopa KS. 2013).

Old age Home:

The ageing of the population along with changes in

the family structure and shifts in intergenerational relations has brought into focus issues pertaining to the elderly in India. The growing visibility of old age homes in India points to the needs of elderly, which were not recognized earlier. Old age homes are increasing day by day in our country because elderly spend their old age in sacred places, the migration of children in search of employment opportunities, their maladjustment in family and poverty of the elderly are the major reasons for the Indian elderly to shift to old age homes. The home environments are primarily for those elderly persons who are unable to stay with family members due to any reasons. It is an alternative shelter where elderly persons can share their feeling, liking, experiences with each other staying at this type of settlement. They live in an institutional set-up according to some rule and regulations. The old age homes are indispensable as they are needed to take care of the lonely and forsaken elderly in the evening of their lives. Whenever the family does not provide full protection and security to the aged, the society has to share the burden of looking after them. Nowadays, old age homes are established to take care of the old. Ranchi old age home based study findings indicated that QOL was better of those elderly people who were living in old age home in comparison of those elderly people who were living within family setup (Panday R et al 2015) A Study carried out by to assess and compare Ways of Coping between elderly people living in old age home and within the family setup. Findings of this study indicate that Ways of Coping were better of those elderly people who were living in old age home in comparison of those elderly people who were living within family setup (Panday R et al 2015). There is much research on the problem of the institutionalized old people abroad but in India, very little organized information is available about the problem of the aged living the families and in old age homes.

Aim:

To assess and compare quality of life between female elderly persons living in old age home and within the Family. Methods and Materials: A cross sectional research design method was adopted for the study. The study was conducted at Old age home, D.A.V. Nand Raj and Urse line Society Old age home, Ranchi, Jharkhand. A total 60 people were participated in the study. In this study researcher selected two areas of Ranchi Kantatoli and Kanke for selecting female elderly living in Family. The female elderly living within Family were also told about the aim of the present study and then according to inclusion and exclusion criteria samples were selected through purposive sample technique. Selected samples were informed about the tools for data collection and doubts were clarified. Tools such as Quality of Life were administered to obtain the data.

INCLUSION AND EXCLUSION CRITERIA:

Inclusion criteria for female elderly living in old age home: Educated up to 5th standard, age range between 60-85 years, living in old age home between 2- 8years and willing to participate in study

Exclusion criteria for female elderly living in old age home: There should not be any History of major physical illness. There should not be any History of major psychiatric illness and neurological illness.

Inclusion criteria for female elderly living within Family: Educated up to 5th standard, age range between 60-85 years, willing to participate in study, living with family members and not involve in any occupation and professional work.

Exclusion criteria for female elderly living within Family: There should not be any History of major physical illness. There should not be any History of major psychiatric illness and neurological illness.

Tools:

1. SOCIO-DEMOGRAPHIC DATA SHEET:

It is semi-structured, self-prepared Performa especially drafted for this study. It contains information about socio-demographic variables like age, religion, education, marital status and domicile.

2. QUALITY OF LIFE SCALE (WHOQOL-BREF., Hindi version):

Hindi version of the WHOQOL-Brief has been derived from the original World Health Organization Quality of Life Scale. The Hindi version WHOQOL-Brief Scale is adopted by Saxena et al. (1998). WHOQOL-Brief is a short version of WHOQOL-100 questionnaires. WHOQOL-Brief has been tested in 15 centres including New Delhi and Chennai from India. WHOQOL-Brief contains 26 questions in 4 major domains (i.e. physical health, psychological health, social relationships and environment) to measure the quality of life.

RESULT:

NS= Not Significant

Table no 1 shows the socio- demographic variable between female elderly person who were living in old age home and within family setup. In religion, 24(80%) Hindu and 6(20%) Christian participants were living in old age home while 25(83.33%) Hindu, 4(13.33%) Christian and 1(3.33%) participants were living within family setup. In category, 17(56.66%) Gen, 6(20%) OBC, 1(3.33%) SC and 6(20%) ST participants were living in old age home while 18(60%) Gen, 6(20%) OBC, 3(10%) SC and 3(10%) ST participants were living in family setup. In marital status, 12(40%) married, 3(10%) unmarried, 15 (50%) other (widower and separated) participants were living in old age home while 15 (50%) married, 3(10%) unmarried, 12(40%) other (widow and separated) participants were living within family setup. In education, 15(50%) below matric, 3(10%) matric, 12(40%) above matric participants were living in old age home while

RESULT:

Table-1:

Socio-demographic variables between female elderly living in old age home and with family setup:

Variable		Group		Df	χ^2
		Old age home	Family		
Religion	Hindu	24(80%)	25(83.33%)	2	1.63NS
	Christian	6(20%)	4(13.33%)		
	Other	0	1(3.33)		
Category	GEN	17(56.66%)	18(60%)	3	1.27NS
	OBC	6(20%)	6(20%)		
	SC	1(3.33)	3(10%)		
	ST	6(20%)	3(10%)		
Marital Status	Married	12(40%)	15(50%)	2	1.34NS
	Unmarried	3(10%)	3(10%)		
	Other	15(50%)	12(30%)		
Education	Below Metric	15(50%)	18(60%)	2	2.13NS
	Metric	3(10%)	6(20%)		
	Above Metric	12(40%)	6(20%)		
Residence	Rural	9(30%)	12(40%)	1	1.12NS
	Urban	21(70%)	18(60%)		
Family	Nuclear	18(60%)	15(50%)	1	1.28NS

18(60%) below matric, 6(20%) matric, 6(20%) participants were living in family setup. In residence, 9(30%) rural and 21(70%) urban participants were living in old age home while 12 (40%) rural and 18 (60%) urban participants were living in family setup. In socio-demographic variables there were no significant difference found between both groups.

Table-2 reveals that mean ages of respondents living in old age home were 68.90±6.92. The mean ages of respondents living with family were 68.37±7.71.

Table-2: The difference of age between female elderly living in old age home and Family.

Variable	Group	Mean ± Std. Deviation
Age	Old age home	68.90±6.92
	Family	68.37±7.71

Table -3: Comparison of Quality of Life between Female Elderly living in Old age home and within Family.

Table-3 shows the mean scores and comparison of Quality of Life (domain wise) between female elderly living in old age home and within family setup. Significant group deference was found in term of social health and environmental health

Table -3: Comparison of Quality of Life between Female Elderly living in Old age home and within Family.

Variable	Group		T
	Old age home (N=30) Mean ± SD	Family (N=30) Mean ± SD	
Physical Health	22.75±3.73	20.45±4.07	1.42
Psychological Health	20.40±3.11	18.52±3.09	1.74
Social Health	1.65 ±0.63	2.92±1.10	1.87*
Environmental Health	24.17 ± 2.58	20.02±3.44	1.98**
Total Quality of Life	68.97±9.98	61.91±8.52	2.87*

*=significant at 0.05 Level **=significant at 0.01 Level

between female elderly living in old age home and within family setup. It shows that the mean score of social health of female elderly (2.92 ±1.10) living with family was better than the female elderly (1.65±0.63) living in old age home. There were significant difference were found at 0.05 levels (p?0.05). It indicates that female elderly living with family was better social health than female elderly living in old age home. The mean score of environmental health between female elderly (24.17 ± 2.58) living in old age home was better than the female elderly (20.02±3.44) living with family. There was significant difference was found at 0.01 levels (p?0.01). Its indicate that elderly of female elderly living in old age home was better environmental than the female elderly living with family. The mean score of quality of life between female elderly (68.97±9.98) living in old age home was better than the female elderly (61.93±8.52) living with family. There was significant difference was found at 0.05 levels (p?0.05). Its indicate that elderly of female elderly living in old age home was better quality of life than the female elderly living with family.

DISCUSSION:

In Physical Health domain finding suggested that the mean score of persons who live with family was lower than persons who live in old age home. It is domain of Quality of life scale and in this scale higher scores indicate good quality of life and low score indicate poor quality of life. In old age home good medical facilities were available weekly doctors did proper checkup of every person so the result of Physical Health was better of person living in old age home than person living with family. Person in old age home lived alone so he takes care properly. Some study supported this study that Physical Health was good of female elderly live in old age home in comparison of those people who lived with

family. (Asadullah M et al 2012,Mehra HD et al,2005) A study suggested that better physical health of people who lived in old age home than people lived with family. Psychological Health of persons who were living in old age home was higher than persons who were living with family (Top M, Dikmeta? E ,2015). Person live in old age home with many person who were belonging same age group so person share his feeling with another person in group but in family same age group were not present so person cannot share his problem with other. A stressful family relationships and lack of family care precipitates the poor psychological well-being in family (Litwin H, & Shiovitz-Ezra S 2006). Some study are against our study as female elderly were living alone had a higher level of financial strain, more depressive symptoms low level of life satisfaction (Chou KL, Chi I, 2000). The female elderly lived in old age home faced many psychological problems in comparison of people lived in old age home. Social health was good of those respondents who were living in family because person's interaction many people in family and goes to relative's home, neighbour and religious place (Kotwal N, & Prabhakar B. 2009). In old age home person got very less chance to go anywhere and his interaction with people was also very less so his social health was not good in comparison of person who were living with family. Many other studies also supported this study as researcher also observed that low social worth, feeling of social deprivation due to negligence, sense of isolation and poor social health of those people who live in old age home (Dutta E.1989). A study conducted on adjustment among elderly living in old age home and finding of this study suggested that adjustment of those elderly who are living in old age home is better than elderly are living in old age home(Panday R, & Srivastava P. 2017).. People living in old age home had poor social health because miserable social relationship was inmates of old age home with family, friends and community (Asadullah M et al 2012,) . Elderly has poor social health in old age home because people lived with family devoted most of time to social gathering with people in community and getting more chance to participate in functions of relative, neighbour and friends (Mehra HD et al,2005)). Environmental Health was found better of elderly living in old age home in comparison to elderly living in family because in old age home person got good facilities of housing, sanitation, electricity, water and it was peace full place but those person who live in family get difficulty for these facilities. Many other studies also supported finding of this study as people living in old age home had good environmental health in comparison to people living with family (Asadullah M et al 2012,). Elderly people was satisfied with their living place in old age home so Quality of life of persons who were living in old age home was better than persons who were living with family (Mehra HD et al,2005). In old age home good facilities for living, no family burden, peer group, freedom for anything and envelopment of elderly in extracurricular activities. Person engage whole day in these types of activities and fallow daily routine which assigned in old age home. Other studies also supported this study that people living in old age home had good quality of life (Asadullah M et al 2012,). Elderly people had good quality of life in old age home in comparison to people lived with family (Mehra HD et al,2005) . A study which based on old age home and rural community people and findings of this study suggested that people lived in old age home their quality of life was higher than people live in rural community (Varma GR et al 2010). Institutional settings a higher percentage of elderly showed high Quality of Life as compared to non-institutional setting where none of the elderly men and women respondents showed high level of Quality of Life(Lakshmi Devi S, & Roopa KS. 2013). A study on Quality of life, loneliness and psychological distress of the elderly males and females were living in institutions and non-institutional settings in urban Jammu district (Jamwal N. 2016). The results revealed significant differences on loneliness and quality of life between those living in institutional settings and those living with their families.

LIMITATIONS:

The limitations of the present study are as follows:

1. Being a time bound study sample size of small
2. Data was collected from only two areas of Ranchi, Kanke and Kantatoli.
3. Data was collected from only two old age homes of Ranchi.
4. The samples were selected by using purposive sampling technique.
5. Both genders were including in this study for better understanding compare both gender.

FUTURE DIRECTIONS AND IMPLICATION:

1. The study needs to be carried out on large sample, with comparable representation of both the groups.
2. Elderly person living in old age home and elderly person living within family from various places need to be taken.
3. The future studies must attempt to carry out other social aspect which is related to aging.
4. The scope for intervention by mental health professionals, especially, psychiatric social workers in planning and delivering adequate therapeutic services in the clinical context.
5. Based on the present study finding Psycho-social intervention programme to be developed to enhancing Quality of Life of the elderly persons.

CONCLUSION:

This study is based on cross sectional research design to assess and compare quality of life between female

elderly living in old age home and within the family setup. The findings of the study indicate that female elderly living in old age home have good health because health facilities are available in old age home and doctors came in weekly for proper checkups. Finding also indicate that physical health, psychological health and environmental health of those people living in old age home was better than the people were living in family setup. Social Health was better of those respondents who were living with family setup in comparison over all concluded that female elderly living in old age home has good quality of life in comparison to female elderly living with family. Educating about aging the others family members particularly the young on their role in keeping the elders happy and active and to support them physically, socially and environmentally is equally important. The scope for intervention by mental health professionals are in planning and delivering adequate therapeutic services in the clinical context. Based on the present study finding Psycho-social intervention programme be developed to enhancing Quality of Life of elderly persons. Present study finding would help in implementing the rehabilitation programme for elderly people.

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Original Reaserch Article

Role of Nadi Shadhana Pranayama to Improvement Depressive Symptoms in Individual with Alcohol Dependence.

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ABSTRACT :

Background : Alcohol affects the body in many ways. Some effects are immediate and some accumulate over time and may significant affect physical and mental health. It is one of the major health. This study was done to know whether this pranayama can some effects on patients with alcohol dependence syndrome.**Aims:** Basic objective was this study is to measure the efficacy of NadiShodhana Pranayama on depressive symptoms among persons with alcohol dependence syndrome. **Result & conclusion :** Findings of current study showed that there is significant improvement in patient's depressive symptoms. But both group (experimental and control) improved in similar ways. The efficacy of 'NadiShodhana Pranayama' was not ascertained in this study.

Key Words: Alcoholism, pranayama and nadishodhana.

INTRODUCTION : Alcohol affects the body in many ways. Some effects are immediate and some accumulate over time and may significant affect physical and mental health. It is one of the major health problems in modern era.Harmful uses of alcohol affect health, entire families and communities, and a significant portion of the family budget is often spent on alcoholic beverages. Yoga and meditation have been found beneficiary in mental and behavioral disorders. These treatments are often used adjunctively with psychological treatments. Yoga Sutra mentioned Pranayama as means of attaining higher states of awarenessPranayama calledNadiShodhanais thought to have some beneficial impact on the people's psychological functions.In this study we usedNadiShodhanaPranayamaon alcohol dependence patient. NadiShodhana Pranayama is a one type of Pranayama. NadiShodhanaPranayamais a composition of two important things, e.g. - "Nadi" connotes vigor a channel of the figure, and "Shodhana" the process of purification. This Pranayama filters the nadis of the figures, so it's called NadiShodhana Pranayama. This is also called Anuloma- Viloma Pranayama. So this study was done to know whether this pranayama can some effects on patients with alcohol dependence syndrome. Pranayama is very effective in cardio-respiratory functions (Udupa et al 2003), physiological self-control (Harvey 1983). It enhance the coping with stress and mental health (Koenig, 2006), and decrease the anxiety and depression (Rajagopal, et, al. 2002).

Objective :

Basic objective was this study is to measure the efficacy of NadiShodhana Pranayama on depressive symptoms among persons with alcohol dependence syndrome.

HYPOTHESIS

NadiShodhana Pranayama would not have positive impact on depressive symptoms of individuals with alcohol dependence syndrome.

INCLUSION CRITERIA

Patients diagnosed with as per ICD-10 (DCR), Mental and behavior disorders due to use of alcohol, dependence syndrome active dependence.

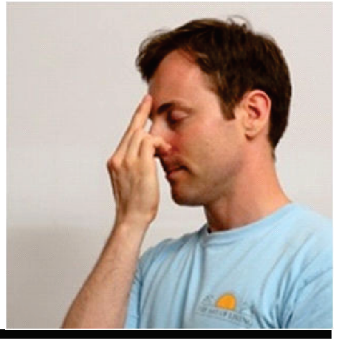
- Patients in the age range of 18 to 45 years.
- Only males would included in the study.
- Education ?8 years.

EXCLUSION CRITERIA

- History of any significant co-morbid physical illness and/or psychiatric illness.
- History of any other substance use or drug dependency except nicotine and caffeine.

Method :

This study was carried out in the Central Institute of Psychiatry, Ranchi. The study was a hospital based experimental study. The purpose of this study was to examine the efficacy of NadiShodhana Pranayama on the patients with alcohol dependence syndrome. This



Pranayama was applied on two groups of patients after

Table-1.1: Changes between experimental and control group in their Hamilton Depression Rating Scale (HAM-D) score:

	Phase of assessment	Group N=50 Experimental group(n=25) Mean ± S.D	Control group (n=25) Mean ± S.D	t	df	P
HAM-D	Pre-assessment	12.08±2.81	13.08±2.34	1.36	48	.178
	Post-assessment	6.44±2.38	8.12± 2.02	2.68	48	.010**

** indicate 0.01 level of significant (p<0.01)

active detoxification phase. One group was given Pranayama and treatment as usual and another group was given only treatment as usual. Patients were selected through purposive sampling technique. HAM-D applied to the subjects of either group. After that, the NadiShodhana Pranayama was given to experimental group in 15 sessions during one month. At the

Table-1.2: Comparisons of stages in Hamilton Depression rating scale at pre and post assessment between experimental and control group (paired t test)

	Phase of assessment	Pre-assessment Mean ± S.D	Post-assessment Mean ± S.D	Paired t value (df=24)	p
HAM-D	Experimental group	12.08±2.81	6.44±2.38	10.480	.000**
	Control group	13.08±2.34	8.12±2.02	11.74	.000**

** indicate 0.01 level of significant (p<0.01)

end of the Pranayama sessions, all the selected subjects re-evaluated by HAM-D.

RESULTS

Table 1.1 shows comparison of Hamilton Depression Rating Scale scores between experimental and control group at various stages of assessment pre and post. The t-test reveals statistically significance difference between both the group at (p<0.01) post assessment when compared across assessment.

Table-1.2 shows statistically significant difference in Hamilton Depression rating scale in both stages in both groups (p<0.01).

The current study was conducted to investigate the efficacy of NadiShodhana Pranayama on Alcohol Dependence Syndrome. The sample population was allotted in two groups, the experimental group received NadiShodhana Pranayama along with pharmacotherapy and psycho social intervention, and on the other hand control group received only pharmacotherapy and psychosocial intervention. The sample population on which our study was conducted was patients suffering from alcohol dependence after their detoxification in their index admission to a tertiary set-up. The experimental group showed significant improvement when comparing pre and post assessment. However, at the end significant changes were seen in both

the groups. It could be because of pharmacological and non-pharmacological treatment they receiving during treatment.

At the end of our study period, there was significant change seen in the HAM- D score over the time across both the groups. The mean ± SD values for the experimental group at the pre assessment were 12.08±2.81and at the post assessment were6.44±2.38.However; the mean ± SD values for the control group at the pre assessment were 13.08±2.34 and at the post assessment were 8.12± 2.02. The difference of values in the two groups makes it clear that the experimental group that received the Pranayama session along with pharmacological and non-pharmacological treatment showed better improvement than the control group. However, when we compared it to the improvement of control group in table it showed that both the groups improved similar way. It could be because of pharmacological and non-pharmacological treatment they receiving during treatment.

Berrettini et al. (1978) observed no significant changes in arterial blood gases were noted after Pranayama.Madan Mohan et al (1986) studied that the changes in heart rate and CRS axis during the inspiratory and expiratory phases of Pranayama type breathing were similar to the changes observed during the corresponding phases of deep breathing.According to Hallgren et al (2014), Yoga can be a feasible adjunctive treatment for alcohol dependence.It was noted that in either group improvement in all these three areas were noted over time. However, these improvements could not be ascertained as the impact of 'NadiShodhana Pranayama' or the mainstream pharmacotherapy and psychotherapy.

Conclusion :

Findings of current study showed that there is significant improvement in patient's depressive symptoms. But both group (experimental and control) improved in similar ways. The efficacy of 'NadiShodhana Pranayama' was not ascertained in this study.

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Case Report

Psychotherapeutic Management of Dissociative Trance and Possession Disorder: A Case Report

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Abstract:

Trans and Possession disorders are commonly reported from developing countries like India. It is well researched that this disorder is a common manifestation of personal distress in a joint family set up, less privileged sections of the society and with people who are less psychologically sophisticated especially common with women between 25-35 years of age. In India this disorder manifests as possession by outside spirit, deity or other powerful entity which is culturally sanctioned given the religious beliefs of the community. Faith healing practices are also high with such people. More often than not dissociation is seen as the defense mechanism in such cases. Such a case of a young woman, 23 years old, married, lower socio economic status, living in a joint family set up presented with complaints of possession during pregnancy leading to miscarriage twice is discussed here. She would tear her stomach during possession episodes which resulted in miscarriage. History suggested that she entered into new environment with marriage and maladjustment with in-laws played havoc on her psyche. The social demand of having a boy child also contributed to the underlying stress. Her personal ambitions, loss of independent entity vs social demands and new roles to be assumed in the family created an internal conflict that resulted in dissociative episodes. The management entailed family psycho-education, sensitization regarding new roles and responsibilities post marriage, good therapeutic alliance with the client, conflict resolution and enhancing coping mechanisms and creating a safe and supportive environment during her third pregnancy.

Key Words : Trans and Possession, Dissociation, Psychotherapy, Supportive Psychotherapy

Dissociative Trance and Possession Disorder is a culture specific disorder, presenting itself in India. The disorder is episodic in nature and presents itself in a 1.6:1female to male ratio (During, E.et al 2011). It is characterised by episodes of partial/full loss of consciousness with an alternate consciousness identified by others in the vicinity of the patient as not the patient's own. In possession episodes, an alternate identity takes over the patient involuntary. Whether these episodes are viewed as divine intervention or mental illness is determined by the kind of alternate consciousness being manifested(Castillo, R. 2019).

The following case discusses one such case and the management of the same.

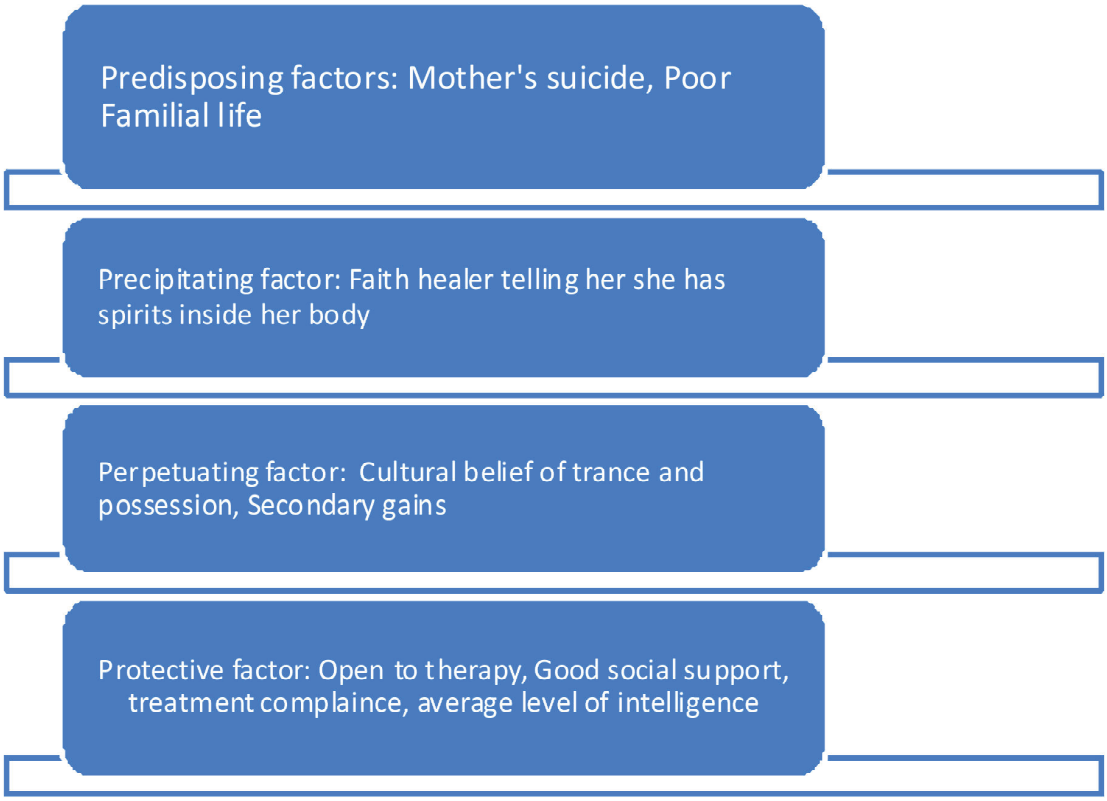
A 23 year old married female,was brought to the Psychiatry Outpatient Department withcomplaints of possession during pregnancy. During these episodes, she would tear at her stomach and had miscarriage twice. They had consulted various faith healers but none of them could help. The couple desperately wanted a child.She had conceived for the first time 2 years back. During the second trimester of her pregnancy a particular episode happened. In the morning when she was partially awake, she heard her sister in law call her name. She woke up and checked with her sister in law who denied calling her, which her husband also confirmed. Worried, she started to think as to how she heard her name which she remembered as being very clear. Because of her persistence her husband took her to a faith healer, who said that she has two spirits inside of her, one of a male and one of a female. He gave her a chant to remember in order to get rid of the spirits. She started doing that on returning home. The next day when she woke up, she started screaming and tearing at her stomach. On trying to help her, she pushed the husband away. This episode lasted for about 20 mins. After the episode when the family members asked as to what happened, she said she could not remember. The very same day again, she made the sound of a man, identified herself as a 'Aamir' and tore at her belly. This too lasted for about 15-20 mins. These episodes continued till the third trimester of her pregnancy. On the day of her delivery when her water broke, she again started screaming and refused to get out of the house and started tearing at her stomach. The child was born still. She was brought to the psychiatry OPD where she was diagnosed with ICD?10 (code F44.3)- Dissociative

Trance and Possession Disorder(WHO.1992).

The Family History was suggestive ofher mother committing suicide when the client was 3 years old. The cause of that was reported to be interpersonal conflict between the patient's father and her mother. The patient's father had dependence on alcohol and passed away at the age of 55 when the patient was 17. She was married soon after. She reported constant conflicts with her Mother-in -law. Her husband was supportive.

Premorbid Personality was suggestive ruminative thinking in the face of any unpleasant event.

Case Formulation



The Therapy goals were to cut down secondary gains and to increase coping skills. The therapy modality was supportive psychotherapy.Initially cognitive behavior therapy was planned, butshe conceived very soon after entering therapy. Hence supportive psychotherapy was done, since the main aim was symptom alleviation and not changing of core schemas, the reaction of which at point of beginning therapy was not predictable.

Process of Therapy

Initial Phase (Sessions1-3)

The initial phase aimed on detailed exploration of history, rapport formation, initiating psycho-education about the illness to family members and introduction to the mode and rationale of therapy. These were attempted to follow sequentially. After detailed history taking, stressors were elicited and rapport building was done. The onset of the illness, course of the illness, life events associated with exacerbations, maintaining factors, coping efforts, belief about problems, psychosocial situations and primary and secondary gains were explored. The client, parents-in- law and the husband were then psycho-educated regarding the nature illness, course, treatment and the prognosis of the illness. The family members were then also explained about primary and secondary gains and were asked to cut them down. Examples from their current situation were taken and different measures to cut it down and the reason was also explained to them. Educating forms a crucial part of supportive therapy (Thurman Mott, 1982). She was also explained that how the presenting problems can be conceptualized and treated with this approach. Current stressors were clarified with the client and she provided an in-depth explanation of her stressors. Setting for catharsis was provided.

Middle phase (Sessions 4-10)

Goals were set in collaboration with the client. The structure of the sessions opened by brief review of the last

session, and discussing the stressors she was facing at the moment and the coping strategies were reviewed.Various situations and events from her life were explored and how they were connected to particular cognitions was facilitated. This was done to explain the suggestibility of her mind and the strength of her belief. The fifth session focused on her understanding of the phenomenon which she had experienced during her last pregnancy.The next few sessions focussed on building the coping strategies of the patient especially with regard to interpersonal communication (Misch,2000). Each session ended summarizing the session and taking feedback from the client.

Termination

The next sessions her progress was reviewed. Antecedent- behaviour and consequence analysis was done for all her reported stressors and one dissociative episode she had in between session. Her fear of having a dissociative episode like in her last pregnancy was addressed. Reattribution was facilitated along with enhancing social support.Sessions were then terminated after this since she was in her third trimester and called for regular booster sessions.By the end of fourteenth session, understanding of the disorder and how it works had improved. Her coping skills were what the most number of sessions were dedicated to and she had shown improvement in that area, reported by the husband too.She delivered a baby at full term without any psychological distress or perinatal complications.

Conclusion

This case is extremely important in understanding the relevance of supportive psychotherapy. Though this form of therapy is underestimated, it was useful in such a case where breaking down existing and maladaptive defences could have proven to be more harmful than just strengthening the existing defences. It's importance lies in using it in the face of immediate threat where there is no scope to change defences but work with what the patient already has. Supportive psychotherapy in dissociative disorder has proved to be beneficial especially when regular sessions could not be held because of the patient's pregnancy status.It also highlights the importance of beliefs and how they play a huge role in every domain of our life. The importance of social support is also crucial in such cases therefore the role of psychoeducation plays a huge role. Even in the face of trying circumstances, coping can be improved without intensive psychotherapy which should be enough to atleast surpass the immediate threat a person is facing.

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