PSYCHOSOCIAL TREND OF MENTAL ILLNESS

(Post Traumatic Stress Disorder (PTSD)and Disability)

IN NEPAL

DISSERTATION
SUBMITTED

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NEPAL HEALTH RESEARCH COUNCIL

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LIST OF TABLES:

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ABSTRACT:

" Psychosocial Trend of Mental illness (PTSD and Disability) in Nepal". In this study, 330-sample population was selected. Among them 300 population were torture survivor belongs to mid and far-western part of Nepal and 30 sample population were non-tortured. They were selected randomly.
. In this study, B. POST-TRAUMATIC STRESS DISORDER, QUESTIONS K 22-K45 was used to detect the PTSD reactions and WHO-DAS-II CORE QUESTIONS was used to detect the condition of disability among the psychiatric patients.

PTSD symptoms among the sample population:

Among the330 sample population 301(91.2%) had experiences of recollection of the event, 298(90.3%)had distressing dreams of event,303 (91.8%) re-experiencing, 302(91.51%) feeling distress when reminded of trauma, 310(93.93%) physical arousal, 313(94.84%) avoidance of trauma thoughts, 248(75.15%) avoidance of trauma reminding situation. Similarly, 102(30.90%) had experienced psychological amnesia, 256(77.57%) diminished interest in activities, 250(75.75%) feeling of detachment from others, 201(60.90%) restricted affection, 278(84%) sense of foreshortened future, 282(85.45%) sleep disturbance, 286(86.66%) irritability/anger, 291(88.18%) difficult in concentration, 264(80%) exaggerated startle response, 262(79.39%) had the symptoms of loss of interest in social participation.
Among them 34(10.30%) of tortured sample population had found acute type of PTSD symptoms 18(5.45%) chronic and 277(83.93%)had delayed type of PTSD symptoms in which the respondents were suffering for more than a year.

Disability among the tortured sample population:
In past 30 days of interview, 228(69.09%) respondents had bad, and 35(11.67%) had very bad overall health condition among 330 tortured sample population. Among them, severe problem in 166(50.30%) and 86(26.06%) had extreme problem for standing for a long time (more than half an hour), 189(57.27%) had severe and 12(3.63%) had extreme problem for taking care of household responsibilities. 172(52.12%) had severe and 37(11.21%) had extreme difficulties in learning new task. 171(51.81%) sample population had severe and 44(13.33%) had extreme difficulties for joining social or cultural function. 222(67.27%) had severe and 50(15.15%) had extreme emotional affected by health problem. 1823(55.45%) sample population were feeling severe problem in concentration and extreme for 46(13.93%) sample population. 155(46.96%) sample population had felt severe and 44(13.33%) extreme difficulties in walking for long distance (half an hour) .87(26.36%) sample population had felt severe problem in bath and 14(4.24%) had felt extreme difficult. 85(25.75%) had felt severe and 17(5.15%) had extreme difficulty in getting dress on. 143(4.33%) sample population had felt severe and 41(12.42%) had extreme problem for dealing with unknown person, and for 128(38.78%) severe and 20(6.06%) extreme problem for maintaining friendship. 163(49.39%) sample population had experienced severe and 34(10.30%) extreme difficulties in day-today work and 210(63.63%) had severe and 56(16.96%) had extreme interference with life by such difficulties .

Among them 34(10.3%) felt difficulties overall for a week, 65(19.69%) felt for two weeks, and 85(25.75%) for a month in the past 30 days. Among them 86(26.06%) population felt totally unable to carryout usual activities or work because of health condition for a week and 59(17.87%) had felt unable for 2 weeks, and 1(0.30%) for a month respectively.
Among them 52(15.75%) had cut or reduced usual activities for a week, 32(9.69%) had for 2 weeks and 32(9.69%) had for a month because of health condition. But other respondents had not felt so difficulties even though they are suffering from physical and psychological problems among them.

In the conclusion, the psychosocial trend of mental illness seems more prevalence for PTSD and disability in the trauma exposed area during the Maoist movement. In the study, most of the tortured population found suffering from disability related to PTSD rather than non-tortured sample population. Most of them had found multiple functional complaints and it shows torture and violence is one of the root cause of PTSD and disability. The Disability problem is higher within the population of having severe PTSD problems. In this critical socio-political situation of Nepal, the public mental health services are needed in the Maoist affected areas. They may need of psychosocial as well as clinical intervention.

CHAPTER: ONE

INTRODUCTION

1.1 Nepal in Brief:

Location: Nepal is a sovereign independent Hindu Kingdom, that lies on the lab of the highest mountain ranges of the Himalayas. The Mount Everest is one of the highest peaks of the world.

Roughly rectangular in shape, the country is located between 26.22 to 30.27 ' North latitude and 88.12' East longitude. Nepal Covers an area of 147,181 sq. Km. with an average Length of 550 miles (880 Km.) and width of 120 miles (192 Kms.). Only about one sixth of the remaining land if covered by high hills, Snow Mountains and forest. The northern boundary of Nepal is linked with the Tibetan region of the people Republic of China On the east it border with Sikkim and West Bangel Uttar Pradesh western and Southern side and Bihar (India).

Topography: Nepal displays a unique variety of geographical settings ranging from the tropical southern low land to the Tibetan plateau known as the roof of the world. Between these marginal Zones there are three varied regions that make up a remote and picturesque Nepal- the tarai or the plains, the central hills and valley region and the Northern high lands. The geographical phenomenon described best as the stairs to the sky that has bought about a wide spectrum of natural and culture features of almost unique variety. The Nepalese defy the imposing mountains that divide them and sanctify the fertile river that unite them.

The Tarai region: The Tarai regions, a narrow tropical belt comprises the first foothills of the Himalayan massif. The land ranges from 500 to 4000 ft. in attitude and roughly covers 17 percent of the country's total area. It holds about 44 percent of the population and two thirds of the cultivated land. The heavily forested chure (Shivalekh) Range abruptly rising from the plains shelter's a wide array of wildlife including some of the few Asian rhinoceros, elephants, wild buffaloes, tigers and deer.

The central Hill and valley region: North of the Tarai region raises the central Hill region within a latitudinal range of 2000 to 16000 ft. The longest and biggest mountain range, Mahabharat Lekh, lies in this region. The region constitutes a broad complex of hills and valleys and provides an area much eroded by a large network of streams and rivers. The midland holds about 60 percent of the total land area of Nepal and more than half (56 percent) of its population (1981 census). The physical structure of the land in marked by the major north-south rivers Karnali, Gandaki and Koshi of all the geographical regions of Nepal; the mid-land is most ideal for human settlement. Altitude and climate provide extremely favorable conditions for almost any kinds of vegetation. Thus, the Nepalese civilization has eventually risen in the valleys of the mid-land, Kathmandu valley, being the largest one has become the focal point of cultural and economic activates and thus here stands the capital of the kingdom.

The Northern Highlands: North of the central hill region, raises the great Himalayas. This perpetually snow covered region lies at on attitude of 16,000 ft. to 29,000 ft. above sea level. The great Himalayans in this region embraces eight of the earth's tallest mountain peaks towering high above an unparallel mountain world. Owing to its differences in elevation, Nepal experiences an exceptional climatic variation. One experiences a hot summer in the tarai, while it is spring in the hill still winter in mountains. Thus, in Nepal more or less five clearly defined climatic zones exist from north to south, tropical sub-tropical temperate, alpine, and sub-arctic types of climatic zones, varying in altitudes from 3,000 ft. 6000 ft. 12,000 ft. to and above 12,000 ft. respectively.

The dominant climate influence is the southeast monsoon; rainfall is concentrated in the monsoon period and varies between 1000 cm to 2000cm. The end of the monsoon followed by a dry winter, which reaches its coldest period from December to February, Then becoming progressively warmer until the beginning of the next monsoon. The transition phases during February- march and September -October experience moderate and pleasantly warm temperatures in the mid lands. Bur in the higher elevations season verification is less apparent. In the high mountain the cold season is considerably longer. In the extreme month, beyond the great mountain range, the land lies in the rain shadow and is little influenced by the monsoon. In the general, rainfall is highest in the east and lowest in the west and almost absent in the extreme north.

The mean annual temperatures are 15.5 degree Celsius for the entire country, increasing from north to south.

1.2. RELIGION:

The great religions of the east, Hinduism and Buddhism practiced by the people of Nepal in peace and harmony. The old animistic belief, assimilated by the gods of Hinduism and Buddhism has survived. Ancient festivals are relevant and blood sacrifices still persists

Religious is more than faith to the people of Nepal. It is rather a way of life deeply rooted in cultural practice and social customs are always visible integrated with all human activities. The fact that there are as many idols as men and as many temples as houses seems almost true when one walks around the streets of the capitals, Kathmandu.

Siddhartha Gautam, eventually know as lord Buddha, was born in Lunbini in the southern plains of Nepal. Nepal's most important Hindu shrine is dedicated to lord Pashupatinath, guardian spirit of Nepal. Besides Hinduism and Buddhism other religious are also practiced in the Kingdoms.

1.3.Culture:

Nepal has colorful culture and traditions. The people of Nepal are a curious combination of Mongolian and Aryan influences. Though many of the ethnic groups of Nepal retain physical features of their Mongoloid origin, Culturally they are influenced more from the south where Indian lies. The most commonly used classification for studying the people of Nepal is as follows:

1. The people of the Himalayan region
2. The people of the middle hills and the valley
3. The people of Tarai

Approximately 36 ethnic groups exist in Nepal. The most well Known of these are the Brahmin, Chhetris, Newars, Sherpas, Rais, Limbus, Tamangs, Gurungs, Thakuris And the Tharus. The Hindu cultural area is the southern half of Nepal where Hinduism is Predominantly practiced. The main characteristics of the Hindu culture area are as follows:

a. A cast system which is some what more flexible among the " Paharis" (The middle hills people)
b. A strict avoidance of beef.
c. An agricultural economy based on wet rice culture in which the in inhabitants sedentary.
d. Sanskrit Hindus rites are performed
e. The inhabitants consist of Brahmins, Chhetris and others Hindu castes who are the descendants of the ancient immigrants from the Indian plains, Pre-Aryan indigenes and their admixture
f. Nepali, a dialect of the indo-Aryan language is spoken as a lingua franca, along with other related Sanskrit based language in Tarai. The Bhote Cultural area lies in the

Northern most section of the country where Tibetan Buddhism and Bonism are influential. The Bhote culture trends to be reflection of the order cultural strata of central Tibetan. The main characteristics of the Bhote cultural area are as follows:

A. A non- caste society where women enjoy great freedom.
B. Consumption of meat including beef (Yak meat) and liquor is permitted.
C. Paternalism ,trade and agricultural from the basis of the economy with the first one being most important.
D. Tibetan Buddhism and bon rites performed
E. The inhabitants are mainly Bhote (Tibetans) on origin
F. Tibetan dialects are spoken as the lingua franca.

The middle hills and valleys cultural area is inabilities the Thakuris , Gurung, Magar and others similes ethnic groups and is sandwiched between the Hindu and Bhote cultural areas at an average elevation of between 2000 to 3200 meters above sea level . The cultural characteristics of these Himalayan ethnic groups are indigenous shamanistic animism to which is added a sending of Hinduism and Tibetan and Buddhism. Naturally, the variation of Himalayan culture is wide. For example, Bhote-Gurung(Tibetian Gurungs) in the higher altitudes are under strong Buddhistic influence while Hinduism is more prominent among the Magars at he lower elevation . The main characteristics of the Himalayan cultural areas are as follows:

a. No strict caste system can be observed in the majority of the Himalayan ethnic group .
b. Consumption of meat and liquor is more frequent than among the hindus but they tend to avoid the beef.
c. Pastoralism, trade and agricultural are the basis of the economy among which agriculture is the main occupation.
d. Syncretic ritual practices – a complex amalgam in which native animism, Hinduism and the Tibetan Buddism can be observed.
e. Mongoliod features are predominant.
f. Some speak their own Tibetan-Burman native languages; some in the north peak Tibetan dread while those in the southern section speak Napali. The thakuris are even bilingual and trilingual

All along the middle belt of Nepal are to be found numerous ethnic groups of Tibetan to Burman origion . For the Brahmions and chhetris , too this is a traditional area of settlement . Brahmins and chhetris are the most influential groups in Npeal . They are the most of Brahmins from Indian who entered Nepal through the North-West in the 12th century A.d. The ruling shah dynasty also belongs to this group. The Brahmins and chhetris are to be found al over the country, through they are mainly concentrated in the middle hills and the valley regions. They have always imposed their alleged superior cultural and religions practices on those group they have come in contract with. Many of the ethnic group of Nepal have thus increasingly adopted Hindu customs and beliefs. This phenomenon has been described as sanskritisation of Nepal.

The Newars too have influenced Nepalese life and cultural to a great extent. They are the original inhabitants of Kathmandu valley. Their influence has been felt in the fields of arts, crafts and trade. They are also well-known entrepreneurs of the valley.

References :

1. Iijma , S. (Ed.) Changing aspects of modern Nepal: Relating to the ecology , Agriculture and her people , Institute for the study of languages and cultural of Asia and Africa , Tokyo , 1977, pp.69-71
2. Ibid.
3. Ibid.
4. Shah , R. an Introduction to Nepal , Ratna Pustak Bhandar, Kathmandu, p. 281.

1.4.*EDUCATION:*

Education Play a major role for the overall development of an individual as well as of the country. If the main objectives of development is to raise the quality and they should not be left illiterate. Thus increasing the literacy rate among the people has been taken as one of the very important aspects among many others developmental activities. The literacy rate for the entire population is estimated to be 33 percent, but the female literacy rate is only about 18 percent. Literacy is a very serious problem and poses am great challenging.

In almost all developing countries education is one of the hung and very extensive systems reaching for down into the community levels. In Nepal also it is a hung and growing system which is as follows

Number of primary school (class 1-5) –12000

Number of lower secondary school (6-7)-3729

Number of secondary schools (8-10_-1400

No. V.D.C. is without a minimum of one primary school catering to the children. All the parents are motivated and encouraged to get their children enrolled in the primary schools . His majesty's Government of Nepal is fully committed in making primary education up to class V fee and available to all children six to ten years of age.

Number of students at Primary level –300,000

Number of lower secondary level – 270,000

Total number of student at primary + lower secondary levels 3,000,000

Total numbers of teacher for all these student is about 80,000 . Among them certified teachers constituted about 38 percent.

In higher education the number of students enrolled in different educational to be 64,480 in the year 1987, an increase of about 5.5 percent as compared to the previous year. How ever the number of students enrolled in technical institutes was estimated to have reduced by 3.9 percent in the same year. Thus, the total number enrolled for higher education during 1986-87 was 78490 of which Tribhuvan university campus enrolled 61,133 and the private sector campus enrolled 17,357 students.

No. of teachers in higher Education :

Professors, Readers lectures and asst. Lectures –422(1987)

Instructors, co-instructors and ass. Instructors 496(1987)

No. of colleges (Campus):

The following are the number of different types of campus in Nepal :

Engineering :	3
Medicine:	
Community Medical Assistant :	3
Health Assistant	1
Staff Nurse	5
Assistant Nurse Midwife:	3

Institute of Medicine:	1
Agriculture:	4
Forestry	2
Science	18
Law	8
Business & Management	19
Humanities	29
Education	13
Sanskrit	2
Multiple (Science, Humanities, Commerce)	28
Private Campus:	
Science	6
Law	8
Business & Management	36
Humanities	53
Medicine	1

Female literacy Program: The literacy rate among the female is very low especially in the rural areas. For this reason, Promotion of female education plays a very important role in the development of Nepal. If the females are literate, they make an effort to make their children also literate. Thus with the aim of making the female population also participate in the whole educational system, His Majesty's Government of Nepal has been carrying out different programs like scholarship and non-formal education programs.

Adults literacy programs: Beyond the formal system of education equally extensive is the non-formal education sector network and catering to thousands of adults every year. About 80,000 adults every year are provided with basic reading, writing and arithmetic, together with knowledge and skills relevant to their daily lives . Different plans are being worked out by the ministry of education and culture to provided non-formal skills and job oriented education about 455,280 adults by encourage different V.D.C. and class organizations schools, social organizations , governmental or non governmental organizations to organize and conduct such programs with their own financial assistance and the necessary books and others materials at cost price.

1.5Transportation and communication:

Until the first half of the 20th century Nepal operated almost entirely human and animal power to provide transportation and communication. Although Nepal is small in size, Transportation from one place to another is very difficult due to climate and geographical conditions of the kingdom.

Transportation and communication plays a vital role in the development of any country. Nepal is a land locked county, so that road and air transport are great possibilities. Since the onset of democracy in Nepal hundred of the kilometer of road have been constructed to reach from north to south and from east to west. Nepal had only 276 kms. of motor able road in 1951 . This has significantly increased to 6,306 kms. to this date of which 2,744 kms. are asphalt or graved 1,180 kms. of gravel and 2,322 kms. of distance Road . The first electrically operated.

Air transportation is one of the most important alternative means of transport to remote and hilly parts of the country where the road construction is very difficult and expensive. The Royal Nepal Airlines corporation, flies to 43 destinations with in the Himalayan Kingdom.

Communication: In the field of telecommunication, there are 85 wireless stations, which cover all the districts of Nepal. However, they provided only basic services and the main focus of the developmental plans has been forward the installation of telephone services

A total of 28,204 telephone lines were distributed as of 1987 covering 27 cities the country. At present Nepal tele-Corporation operates 30 telephone exchanges throughout the nation with a total capacity of 49,230 lines . Recently, Nepal has started the subscribers telephone dialing and systems for dialing within the country and outside .

Nepal TV was established in 1998. Transmission which was originally limited to kathmandu valley has now been extended to the eastern and southern parts of the country reaching about 13.5% of the total population. Extension of the transmission to 37% of the population is planned by the end of 1989.

Nepal received and also provides national and International news coverage through the sagarmatha earth satellite station, which was established in 1987. This station is able to link with international communication systems

There is one general post office in the capital 74 district post office and 1459 additional post offices. It is planed that 20 new sub-post offices and 40 additional post offices be added during 1989.

Reference

1.Statistical year book of Nepal, HMG / NPCS /CBS/ ram shah path , Kathmandu, Nepal , 1987.

1.6. TOURISM,ECONOMY AND TRADE:

Tourism: Tourism is also on of the major income sources for Nepal. In 1956 a tourist Development Board was established under the department off Industry to promote tourism. A separate Department of Tourism was set up in 1957 and the ministry of tourism was then founded to develop better arrangements to promote the tourism industry.

References :

1. Dept. of Tourist, Ttripureswor , Kathmandu Nepal (1980)

Economy: Nepal is predominantly an agricultural country about 91% of the total population are engaged in agriculture . The share of agriculture to GDP is estimated to be 58% and agriculture to supplies about 80% of the overall industrial raw materials. Thus agricultural is central to national Development strategy. Major items exported by Nepal to India and others country.

Trade : Trade, both international and external has a major role to play in the economic development of a country. A developing country like Nepal cannot meet its entire requirements by its own resources only. To fulfill the growing needs of the people and developmental works, the import of goods and services have become essential. Foreign trade according to necessity and can be a stimulus to the economy development program of a country and police of the government can be leading factor . It is with the help of foreign trade that a part of a country 's domestic resources can be exchanged for capital good and raw materials.

Nepal is a country land locked between Indian and china. The pattern of Nepal 's trade has been confined not only by the nature of her economy but by her geographical position as well *2,. These two factors have led Nepal to concentrate foreign trade exclusively with its two neighboring countries India and china.

Nepal trade has been heavily concentrated with India not only for geographical, but for cultural, political as well as by the reason of the quality of product. Nepal depends on India, majority of

the trade crisis with India during the past few years it has been shown that Nepal is solely dependent on India for the running of small industries. Nepal has a very limited option to diversify its trade with the countries other than India because of its landlocked position.

References:

1. Nepal tourism master plan, ministry of tourism Ktm.p 21
2. Malhotra , R.c. Nepal s overseas teade , indistrial digesst NIDC , Kathmandu 1969, p-37

1.7. HEALTH SERVICES AND PUBLIC HEALTH :

The development of health service in Nepal started in 1956. Prior that there were only a few hospitals rendering curative services. In the field of public health, a malaria control program was the first to be initiated in the Chitwan valley in 1953,jointly by His Majesty's government of Nepal and the World Health Organization. Since then many public health programs have been carried out, new hospitals, and health centers and posts have been established. Health manpower is being developed within the country and outside, and new specialties are being made available for prevention, control and treatment of different diseases.

Despite many years of effort, Nepal is still confronted with many health problems such as; malaria, hepatitis, meningitis, encephalitis, diarrhoial diseases, tuberculosis, and acute respiratory tract infections are very common. Gastrointestinal parasitic diseases are endemic. Neoplastic diseases are also frequently seen. Alcohol and other Psychotropic substances abuse are increasing in a very rapid rate.

Health Statistics:

*Life expectancy (in year)	52.8
*Infant Mortality rate per 1000 live birth	105.3
*Crude Birth rate	43/1000
*Crude Death rate	18/1000
*Annual Population growth rate	2.57
*Total Fertility rate	5.8

Health Manpower:

* Doctors	879
*Kaviraj (Ayurvedic Physician)	22
*Auxillary health workers	1773
* Kaviraj (Ayurvedic Aux. health worker)	165
*Nurses	601
*Auxillary Nurse Midwife	2062
*Community Health Volunteers	5600

Health Institutes:

*Number of Hospitals	101
*Number of Health Posts	816
*Number of Ayurvedic Aushadhalaya	155

Ratio of Health Institutions and manpower to the population : (1988: estimated population 18 millions);

*Hospital	1: 187,438
*Health Post	1: 22,051
*Doctor	1: 20,471
*Nurse	1: 6,757
*Hospital Bed	1: 4,333

Health for all by the year 2000 (HFA 2000) resolution by the Thirtieth World Health Assembly in May 1977 states that the main social target of the government and of WHO in the coming decades should be the attainment of the highest level of health by all people by the year 2000. This will make them capable of working productively and enable them to participate actively in the social life of the community in which they live. On the background of health and other socioeconomic problems especially in the third world countries , the International Conference in Primary Health Care – Alma Ata 1978 declared that primary health care is the key to attain such a level of health . It is desirable, therefore that every individual should have access to primary health care and beyond it to all levels of comprehensive health systems .

Nepal is one of the signatories in the WHO charter of HFA 2000 and has formulated the document "Planning for meeting the basic needs of the people ". The health policies adopted during the first, second, and third five years plan period (1956-70), primarily addressed problems of mass communicable disease like malaria, small-pox, leprosy, and tuberculosis, through unipurpose vertical projects. The concept of integrated community health services approach had been adopted by the fourth plan (1975-80) with the aim to extend integrated services through out the country. Basic health services for all the people has been adopted by the sixth plan (1980-85) to achieve the target of HFA/2000 of Alma Ata Declaration. In order to reach the people with the primary health message and thereby raise the health awareness, participation of voluntary community health leaders at the lowest politico-administrative level, i.e., the VDC ward level , has been accepted and introduced in this plan.
This plan have been worked out and implemented gradually to achieve the following targets:
*To reduce the population growth rate below 2%
*To increase the life expectancy from 51to 65 years
*To reduce the present infant mortality rate of 111/1000 to 45/1000 live birth
*To make one health worker (doctor, para-medical staff, ayurvedic practicner and others) available for every 3000people.
*One nursing staff to be made available to a population of 600.
*Service of a community health volunteer to be available for a group of 500 people.
*Reduction of the distance between the households and the most peripheral health Service unit.
Thus to achieve these mentioned targets, various structural changes at different planning levels of administration and service institutions have already taken place.
*Each district will have a District Health and population Committee (DDC) president with other members from different social organizations, the district public health officer, and the district hospital doctor. This committee will decide on the health policies, other technical and administrative aspects of the health sector for that particular district.

- Each district already has a " District Public Health Office" directly responsible to the District Health and Population Committee and Regional Director of the Health Services, and then finally to the ministry of Health at the central level .

*The District Public Health Office will be responsible for carrying out extended integrated primary health services through the peripheral health post, the number of these health posts being nine for each district and one for each nine Ilaka (region) of a district .

- The ministry of health has initiated the Health Volunteer Program. According to this scheme, there will be a health volunteer (at least one) in each ward of the VDC. They will be selected from a "Mother's Group". They will be responsible to provide health education, minor

treatment and preventive health services to the people of the wards by the year 2000, there will be about 48,000 volunteers all over the country . The ratio of the volunteers to the population is expected to be 1:500. This is quite a new approach for the development of manpower in the health sector.

Levels of services :

1. H.M.G. , Ministry of Health with different divisions .
- Public Health , Nursing, Indent and procurement, Planning ,Manpower development and International and National Training , Curative, Administrative. All the different projects like family planning and maternal and child Health, Malaria Control Program, Expanded Immunization program, Diarrheal Disease Control Program, etc. have been integrated in the Public Health Division.
2. Central Referral Hospitals in Kathmandu with different specialties, Tribhuvan University Teaching Hospital, etc.
3. Regional Directorates of Health Services with Regional Hospitals and Zonal Hospitals (Referral Hospitals for District Hospitals and District Health posts).
4. District Public Health Office with District Hospital and Health post in different Ilakas(Regions).
5. Community Health Volunteers at the most peripheral levels .

Thus from the above levels of health services and manpower it becomes evident that the whole structure is like a pyramid , the apex being the ministry of health and the base being the community health volunteers and the Ilaka (Region) health posts.

Major mile Stone of development of Modern Mental Health Care in Nepal

1961: Psychiatric out patient services started in Bir Hospital.
1965: In patient Psychiatric unit was established in Bir Hospital(5beds).
1972: Psychiatric services started in the Tri-chandra Military Hospital Kathmandu.
Two Private Psychiatric Clinics established with the Gradual addition of in patient Facilities.
1976: Father Thomas Gafney started a rehabilitation center for Nepali drug abusers.
1982: Second Psychiatrist arrived in the Psychiatric department of Bir Hospital.
1983-84: Non Governmental organizations were started in the fields of mental Retardation and drug abuse.
1983: Establishment of first community Mental Health program in Lalitpur District through CHDP.
Started of Drug abuse Preventio Program.
Two expatriate Psychiatrists available in Nepal
1984: Separation of the Psychiatric Department of Bir Hospital and creation of mental hospital.
1985: Shift of Mental Hospital to Lagankhel Lalitpur.
1986: Starting of out patient services at the T.U. Teaching Hospital . Doubling of theory class hours of MBBS program.
The development of Nepali version of the present state examination.
Collaboration between IMO and mental health program , UMN.
Establishment of drug and poisoning unit at TUTH.

1987: Return of one UMN Psychiatrist.
Availability of Psychiatric nurse at teaching hospital.
Started of the inpatient unit of the YU teaching hospital.

1988: Started M.A. degree in Psychology in T.U.
1989: Establishment of the mental health project, IOM (from 18 months)- taken as first phase.
1990: Establishment of "Center for Torture Nepal (CVICT) for the rehabilitation of torture victim suffering from mental problem too.
1991: Started the second phase and CMH program in morang district.
1992: Started the Kaski program.
1994: Started the second phase of the MPH .
1995: Started of Drug Abuse Demand Reduction project.
Banke and Syangja district program were started.
creation of the first regional program.
1995: Started of major human resources development (HRD) in mental health as linkage.
1996: Construction of drug abuse treatment center .
1997:*Adaption of the National Mental Health Policy and plan by the HMG of Nepal in February.
*Establishment of the three years residency, M.D. in Psychiatry in April .
*First Clinical Psychological Services in public hospital setting started in Teaching Hospital in Nov.
*M..Phil.in Clinical Psychology was started in T.U.Teaching Hospital Kathmandu.

NUTRITION AND DIET : The World Health Organization states: " The leading manifestations of malnutrition in WHO's South – East Region are: protein energy malnutrition, iron deficiency anemia, goiter, and related manifestations of iodine deficiency, vitamin-A deficiency and nutritional blindness . The first two conditions occur predominantly in women and children."It also states that "The viscous cycle of infection and malnutrition continues to take a heavy toll on children in developing countries. It is estimated that more than 100 million children below 5years of age in South –East Asia Region suffer from mild to moderate forms of malnutrition. The Complementary nature of infection and malnutrition is reflected in the high child mortality rate for the region , amounting to more than 10 per 1000 children in the 1-4 years age , largely due to infections super-imposed on malnutrition.
Malnutrition has been one of the major cause of death, in Nepal, especially among children below the age of five . Lack of enough nutritious food, diarrhea and other intestinal diseases cause malnutrition . Sixty percent of deaths are associated with malnutrition . Fifty three among 75 districts of Nepal have been declared food deficient districts and more than 50 percent of the population lives below the poverty line.
PRENATAL CARE : The fetus brain achieves 80 percent of its development while the body develops to only 20 percent of its adult size in the prenatal stage. Therefore during this crucial period of the brain's growth the fetus must receive sufficient nourishment through the mother's healthy diet. Pr0teins, fats, carbohydrates, vitamins, minerals, and water are the nutrients in daily food that one needs. Lack of these nutrients obviously causes one to be under-nourished . Malnutrition is one of the primary causes leading to mental retardation in in developing countries . It is more often than not, deeply interwoven with poverty and disease. It is known that malnutrition and severe under-nutrition in the pregnant women and the young children can lead to the irreversible condition of the children's physical and mental development. Lack of protein in the peak period for the development of the babies' brain during the last three months before birth and the first two years of life. Rechardson et.al.(1973) also shows that malnutrition has caused children to be behind in physical growth, it has also caused backwardness, immaturity in School, behavior as well as retardation in overall growth . A malnourished person is very often the target for all types of infections. A nutritional survey of Nepal revealed that 5.15 percent of the children investigated are suffering from severe malnutrition, 55-65 percent

need acute surveillance and only 29-30 percent are "normal babies". according to the USAID survey this figure is reduced to 7.3 percent for a "normal child".
There are two possible periods of brain vulnerability: one occurs during the first 12to 18 weeks of fetal life when multiplication neuroblasts is very active . The other occurs during the period when the main brain growth spurts up towards the end of the second year of life . During this period there is growth of glial tissues, establishment of synapses and myelination. Thus there is a period of two and a half years during which a fetus or infant is at risk of serious reduction in the number of brain and glial cells , providing the period of under nutrition is serious and prolonged. Children exposed to under nutrition are also likely to be deprived in other ways , for example socially and emotionally.

BREST FEEDING : Brest milk is the most important for the newly born infant. Besides being naturally rich in protective substances for certain infectious diseases, it also contain the vital element glucose (in the form of lactose) which is the main food used by the infant brain .
Besides providing the necessary diet for the infant, breast feeding also ensures close and natural contact between the mother and infant. This establishes beneficial emotional link between the mother and the child. If the mother's diet is not proper and well balanced, her breast milk will not be rich enough in lactose content resulting in decreased glucose utilization and consequent alteration of the child's brain structure which can lead to mental retardation.

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1.8.BELIEFS ABOUT ILLNESS AND MEDICINE:

Modern Medicine has been an integral part of Nepalese society and is growing rapidly .In spite of this role, modern medicine has not been able to play an active role in most villages of Nepal. For less developed countries like Nepal, based with severe resource constraints, consumption of modern medicine services for the masses appears almost impossible. With a doctor for every 20,471 population (Statistical Year Book 1987) the majority of the population are out of close reach to modern medicine and medical personnel. Though the people know that there exists new alternatives to the traditional treatment , it is because of their inability to reach these facilities, lack of sufficient information and financial constraints that have made them resort to traditional treatment methods . Thus, the majority of people are left in the hands of untrained, Tantrik and traditional healers, who opt for medical herbs, mantras and amulets as an alternative to modern medicine.
In a study done by Dr. Christine Wright in Lalitpur, Nepal, it was found that 61 percent of her patients had been or were currently attending traditional healers and she suspected this figure was under-reported . Only 11.6 percent had sought specialist psychiatric care , and another 20 percent other forms of allopathic care.

Another study done by Dr. N.M. Shrestha , showed that in about 83 percent of cases, patients had consulted medical personnel before coming to the clinic. While 43 percent had consulted both healing and medical personnel, 9 percent had had no consultation of any kind.

For most people in Nepali villages , a doctor trained in the western system is the last resort . First, all local remedies are tried. Then if they do not succeed , modern doctors are opted and sought for. In local belief, diseases are ascribed to a variety of factors, connected with the supernatural environment and influences. As Linda Stone describes in her article : One link is maintained between a person and the planets, as determined by astrological calculations. A misalignment between one's self and the planets spell misfortune . A person in this condition is said to in a state of *graha bigrayko* (his astrological position has gone wrong), sometimes also expressed as 'the planet gods have become angry before him.'

THE NATURAL ENVIRONMENT : Under the category fall diseases believed to be caused by natural circumstances, like bad weather or contaminated food . according to the ancient Hindu theory of 'Humours', illness and foods are classified into the hot (garmi) or cold(sardi) categories. Garmi foods include popped corn , chicken, mutton, wheat, mango , chilli, pepper, eggs, cooked cucumber, lentils, biscuits, sugar, tea,home-made wine(raksi), milk bread(both millet and wheat), onion, clarified butter(ghee), all spices, ginger, garlic, turmeric(besar), tobacco, mustard oil, and apples etc. *Sardi* food include boiled corn, chicken, mutton, pumpkin, tomatoes, pulses, candy, raw cucumber, rice beer(chhang), radish, lime, lemon, tangerine, potato, beans, and gourd. However , no reason is given for the classification of these foods . Health involves a balance in the garmi and sardi , if an imbalance occurs, illness is bound to result Cures for these illnesses consist in eating food of the garmi type , if the origin is sardi and vice versa . Thus, for example garmi headaches, caused by spending too long in the Sun, are cured by resting in the shade(sardi) . Also if one has a toothache, which is sardi , it is cured by a bottle of local wine (raksi), which is believed to be a garmi food. .

SUPERNATURAL INFLUENCES: Traditional healers are classified into janne,jharphu-ke, Gubhaju, Baidhya, Dhami-jhankri,Lama, and Sadhu etc. Baidhyas are classified in two different terms ; those who have acquired some healing arts through traditional methods, and not from any school of training.

Under the supernatural influences, diseasesare believed to be caused by sorcery , witchcraft, spirits of dead person, planets and gods, . Diseases are believed to be cured by appeasing the goddess and offering gifts and sacrifices. Sometime this becomes very expensive because sacrifices such as; goats, chicken, etc. mean a lot of money for a local villagers , however they are still opt for it. Evil spirits are said to inter the body of a person and cause a particular disease, thus the expression "Bhoot Lagyo" (a demon has attacked himself) . Mental retardation and other mental problem is regarded as this type of disease by most of the people in Nepal.

There are estimated to be between 400,000 to 800,000 traditional healers in Nepal, about 1in 25 people (Sattaur O. , 1986 , Nepal).

In Palpa, there are a large number of such practitionars: Lama, Brahmin, Magar, and more marginalised caste, this the name used locally for what are now generically known as Dhami-Jhankris, as well as female Newar mediums (Deoma), and Ayurvedic practitioners both Hindu and Buddhist (Dr. Ian, Harper,1999).

Diseases can also be caused by a combination of natural and supernatural influences for example, food can be adulterated by a witch or Bokshi and thus make a person sick.

A final overriding link between man and meta-physical universe which pertains to illness is the concept of fate (Karma) . Often the notion of karma is involved as an ultimate explanation for one's illness for instance , if a person is repeatedly ill through witchcraft, he may claim that his "bad Karma" or "ill fate" accounts for his being so susceptible to bokshi's(witch's) jealously and

anger(Stone,L.,1976).Thus, it could be due to the strong belief in fate or Karma that has made many people show a lack of interest in illness prevention or treatments.

DIAGNOSIS: The traditional healers singly and in combination usually administer the following methods for diagnosis a disease or illness both.

1. Finding out (symptoms in) the diet of the patient.
2. Casting a horoscope.
3. Examining a patients' pulse (the pulse is examined at three different places by local village healers –hence the villager's dissatisfaction when a doctor examines the pulse just once).
4. Examining the rice grains (used in ritual worship) and reading the pattern formed by them.
5. Causing the patient to go into a trance, so that the spirit causing the disease can be questioned.

TREATMENT: The faith healers use a lot of different methods to treat the various types of diseases. Some of the most common methods used are as follows:

1. Changing the dietary habits depending on the *Sardi* (cold) , *Garmi* (hot), nature of the illness.
2. Giving the patient *Ayurvedic* or herbal medicines prepared by the local practioners or *Baidyas.*
3. Offering puja (worship) to the gods and spirits.
4. Exorcism; one of the methods is to use a tantrik mantra (prayer):
   the healer blows into a glass of water (phuk garne) and the patient is made to drink it , or the mantra is written on a piece of rice paper and is sealed into an amulet and worn . there are two types of amulets: *Jantars* and *Buti* : A *Jantar* contains a *mantra* written on paper and folded into a piece of cloth and worn around the neck on a string. It is usually worn by adults only. A *Buti* contains "medicines" that are usually herbal plants and animal parts, eg., the claw of a leopard , skin of a jackal, etc. These are brought from the jungle or high mountain areas. They are again wrapped into a cloth and worn around the neck. *Buties* are usually worn by children.

   In the conclusion , though many people do know about the existence of western medical practitioners and western medicine, it should not be forgotten that the local remedies are still foremost in demand. Most people are trying both ways of remedies at the same time, i.e., visiting the doctor and also taking a chance with the local faith healers. People now do believe that a doctor and western medicines is the only sure solution for treating illness. However, their faith with the local healing practices is also still strong .

SOCIO-CULTURAL VALUES ON SPIRITUAL PRACTICES AND MENTAL HEALTH :

Socio-cultural values on spiritual practices of the people also play an important role in order to maintain the equilibrium of mental health. In this context Narendra N. Wig, (1995) expressed in his lecture as; "Along with that also came the realization that :1) the spiritual values are not the monopoly of any single culture: each and every culture , East or West,had deeply experienced and examined such issues and 2) in the matters of health , science alone cannot provide all the answers. The spiritual dimension is an essential and important aspect of health particularly mental health.(p.3).

According to Hindu philosophy , 'most often quoted text is from *Srimad Bhagwad Gita* describing the balanced person as one who has controlled his mind, emotions and senses.

For understanding the concept of mental health, perhapsmore important tha any one quote is the broad Hindu view of life as summed in the well known four ends or broad aims of life *(PURUSHARTHA).* These are *DHARMA, KAMA, ARTHA, and MOKSHA. DHARMA* is

righteousness, virtue or religious duty. *KAMA* refers to fulfillment of our social needs and includes material gain, acquisition of wealth and social recognition. *MOKSHA* which is very typical Hindu concept means liberation or release from worldly bondage and union with the ultimate reality.

These four aims are a beautiful example of harmony of different dimensions of life: *Kama* as the biological dimension, *Artha* , as the social dimension, and Moksha as the spiritual dimension . "Dharma appears to be more as central axis around which life rotates. If you pursue Kama or Artha without Dharma , the long term result is suffering for the individual and others around him or her."

In India dr. Vahia's work on the role of yoga in the treatment of anxiety disorders is well known but it is no more a novelty and now yoga as a therapy is regularly used in many centers. One can multiply such examples from Japan. South-East-Asia or Africa. The fact remains that cultural and religious methods are now very much a part of what goes on in the name of mental health practice in most of the countries of Asia and Africa.

Alan Roland, who recently wrote a book "In Search of Self in India and Japan." He has proposed a four parts structural theory of the self that includes: 1) familial self ,

2) Individualized self, 3) spiritual self and 4) expanding self. According to Roland the spiritual self, which Freud ignored, remains "deeply engraved in the pre-conscious of all Indians". He further states that "to interpret spiritual strivings, merely as a manifestation of psychological conflict, would be grossly misleading".

Traditionally mental health has been a bridge between medical science and humanities.This special position should not be given up. A secular medical science with out a spiritual basis slowly tends to become mechanized, (N.N. Wig,1994).

Such evidences show the strong faith in traditional healers. So, Dr.Sarah Acland,(1999) says in "JHANKRI SEMINARS": "Patients have enormous faith in traditional healers, because their practices are in line with prevailing beliefs about the causation of illness; and because western practices do not always make much sense to such people .It may be that traditional healers are more appropriate for rural Nepal, as well as better accepted . And it is far from certain that they are ineffective, especially in neurotic disorders."

Even though they have long practice, 'Jhankri tradition' seems to be improved scientifically .So, 'Jhankri Seminar in mental health were incorporated in the community mental health work with the following objectives;

*To improve relationships.

*To share information particularly about the health posts activities , and provide basic information about illness , especially mental illness , in acceptable way,

*To understand traditional healer methods and disease concepts,

*To investigate what they regard as problems relating to illness,

*To develop a referral system to health post ,

*To lay the foundations for grass root education from their side" (mental health project, 1999).

Attitude to mental illness changed, if very slowly and this is very hard to measure . Adhikari and Denison, this year ,found that knowledge and attitudes to mental illness in south Lalitpur were very much improved from the previous survey in 1990. Pasupati Mahat's survey in 1997 showed that trained Jhankris would refer patients to the health post, where as those untrained definitely wouldn't"(Mental health project, 1999).

"Mental disorders are traditionally thought to be caused by invisible forces such as ghosts, bad spirits, dead ancestors, witches and enemies, epilepsy and mental disorders are also attributed to the suffers sin of the past life for which god has punished in the life. The concept of these illnesses being a disease is not generally accepted, and hence neither are modern methods of treatment . Based on these beliefs, worship of gods and goddess and visiting traditional healers

(shamans) who can free them from evil spirits is commonly done. Traditional rituals such as mantras , giving empowered water to drink and beating drums to free the client from possession by evil spirits are believed by the client and his family to be as the effective healing methods.

Some scientific study of shaman's healing potential has shown that religious faith not only promotes good health ; but also aids recovery from various illnesses. Family members also pay due attention to the patient's diet and ensure adequate rest till he/she recovers fully. Thus faith healers help many patients with emotional disorder, dissociate disorder, relation problems and some of the self-limiting physical illness by their traditional methods of healing . Such methods are comparable to the modern psychological methods of treatment such as counseling or psychotherapy. Blowing mantras, giving empowered water to drink and religious ceremony all seem to employ the placebo effect in order to cure patients and reduce the impact of stress of hormones such as adrenaline and nor-adrenaline.

On one hand they are seen to be helping many patients suffering from psychological and minor physical problems , but on the other hand they are also seen to be harming many patients who have serious mental or physical illness due to their ignorance . So community awareness of the modern medical treatment available is the basic need along with orientation training of the faith healers to educate them about the availability and effectiveness of medical treatment . This will help to reduce harm and promote referral to the right place and in the right time (Dr. K.D. Upadhya&K.J.Pol. 1999) .

Such traditional healers apply different techniques in order to treat their patients.

Dr. Kapil Dev Upadhaya and Klaee Jan Pol found in their study in kaski and syangja districts that Fu Fu (43) ,akhat(15), Herbal medicine(13), Tantrik Method(10), Worshiping gods(7), pulse feeling(6), Astrology(5),Ayurvedic medicine(13), dhup(3), Jhak(2), Dhangro (1), Jaddibuti (1), among 77 respondents.

dor any disorder the healers sees his client between one and five times. Almost 11% do not think it is necessary to have follow-up on any disease. The average number of follow-up is 2.6.

However , the majority of the healers, even if they think that the cause may be amental disease will give their own traditional treatment instead of sending the patients to the health post.

Most of the healers offer, services, which are free of charge but accept whatever their clients offer them in cash or in kind. So the tantrik healers are easily available , cheap, acceptable to the villagers as their beliefs and values are the same that of the client.

Traditional healers pass their healing powers to a male member who is thought to be religious and able to take on the responsibilities . It is also believed that spirit who possesses the faith healer during trance is usually his dead ancestor(K.D.Upadhya, K.J.Pol ,1999).

They had concluded as "The primitive notion that illness is sign of sin, possession by the devil, or witch, is deep rooted in the Nepalese community . Treatment of such illness either by worship to gods and goddesses or by faith healing rituals are the accepted and most easily available method.So the traditional healers are in a way , such as the specialist for illness that are believed to be caused by invisible forces . The emotional support given to the patient and the family members by faith healers appears to have a marked healing effect in emotional disorders(Ibid p.p. 166,167).

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1.9.FAMILY PATTERN AND HEALTH PRACTICES :

Marriage:

Arrange Marriage : In most Hindu groups , marriage is by arrangement. However love marriage also occur but less frequently , and mainly in urban centers. According to Hindu philosophy marriage between two persons is believed to be pre-ordained by the fact that they were partners in their previous life (HANDS,1982,p.13). The bond of marriage is considered very sacred. However, there are different practices among other ethnic group of non-Aryan origin . Marriages occur by elopement or capture also. There are others who have very flexible rules about marriage and divorce . This is very common among the mountain or high land people .

Trial Marriage: In the Sherpa community, a trial marriage is very much accepted. Polyandry and polygamy are also found common among the high land people. Polygamy can be seen common among the older generation but not with younger generation in these days.

Common Wife: Among the Lama ethnic group in Himalayan region (western & northern part of Nepal) such as: Humla, Jumla, Mustang etc. all brothers could be sharing one common wife. One brother looks after the fields and the others could be going to the low lands to fetch goods pr holding some sorts of business turn by turn. Thus, they travel, work and are husbands on a rotation basis.

Child Marriage: Child marriage , once very common, has declined, but can still be seen in certain ethnic groups. The reason for traditional pattern of early marriage has been the preference to complete the marriage ceremonies before the girl reaches menarche. Especially, in Tarai region child marriage is found common (Bennett,L.,1976,p.2).

Close Relation Marriage: Close Relation marriage is common in Gurung,Magar,Tamang, Thakuri etc. community . Usually they prefer to marry with maternal relationship. There is more possibility to transmit the hereditary diseases. They are more susceptible for some of the mental disorder too.

Pregnancy and Child Birth: For the Nepalese women , child bearing is the paramount test of her identity and worth as a human being . Child rearing is also the most enjoyable and rewarding of her many tasks (Bennett,L. 1976, p.2.).

Pregnancy is taken as a source of pride. Infertile and barren women suffer from shame and uneasiness . Male superiority is authority structure in a Hindu family. A son is a very valued family member in Nepal as the family line and performs funeral rites upon the death of his parents. These rites are believed to ensure their passage to heaven.

The family makes sure that the pregnant women gets rich and nourishing foods. Ghee, meat, liver, milk, fish, eggs, curds, and syrup filled sweet called jeri, and chaku is favored. Some will

not eat meat or eggs for religious reason. Certain hot and sour foods like Pickle or achar is however, forbidden even though the pregnant woman may take it. Honey is believed to cause abortion.

There are traditional beliefs to be followed by pregnant Nepali women. She is not allowed to go to the temple after the fifth months of pregnancy. Then after the eighth month, she is not allowed to cook food or to touch water which her elders drink . However, they are allowed to and occupied with household chores like washing clothes, dishes and utensils right up until delivery. Most deliveries in the rural areas usually take place at home with the help of a Sudeni or traditional birth attendants (mid-wife).

The room in which delivery takes place is kept very warm by burning a fire. This is done even during the hot, summer months. The mid-wife massage the woman in labor and helps in cleaning the baby after birth. A cloth or Patuka is tied very tightly around the mother's abdomen to make the placenta come out. It has been found in many cases that not only the placenta , but also the uterus often comes out (prolapsed uterus) (Bennett,L.,1976).

It is usually the mid-wife who cuts the umbilical cord, but it is the mother herself who does it in case the mid-wife is a high caste woman. for the purpose , old blades , rusty knives or sickles are used. often the cord is sealed with cow dung, especially in the Tarai region. These practices often endanger the lives of the mother and the child because they cause a high risk for tetanus infection.

In some ethnic groups the placenta is kept in a clean , clay pot covered with out cutting the curd. The cord is cut only after the fourth day. Thus , only the mother is allowed to touch the baby until the curd is cut.

The mother and the new born baby is believed to be unclean till eleventh days after birth. Thus, on the morning of the eleventh day purification and name giving ceremony called *nuharan,* that is performed. Among ethnic groups other than Brahmans and Chhetris. This can be performed on the fourth or fifth day.

Child Rearing Practices: Families in Nepal are fond of babies, both boys and girls. The rearing of a child is seen as a natural, organic process. It goes on at its own pace, more or less, regardless of what the child's parents do. Many do follow the traditional methods of baby care. In reality , this is done for economic reasons. It involves informal skills learned by apprenticeship, which are accepted by society easily and have deep cultural values. Breast feeding is the accepted method of nourishment. Powdered milk and other cereal foods are available and given to the babies. But in urban areas only, where one is more apt to afford it.

The mother starts nursing the baby on the third day , as it is believed that milk starts flowing only then. Until this time the infant is fed with ghee, sugar, and water, cow's milk, and lito (the paste of rice flour and ghee with hot water or milk). This period is dangerous for the infant as these foods may be contaminated. No supplementary foods are given until Pasni (the rice feeding ceremony), which is after five months for girls, and six months for boys. After this, the baby is fed soft rice with lentils or vegetables broth. In Nepal, there exists a cultural attitude which prompts parents to differ to the wishes of their child. If a child does not wish to eat he/ she will be allowed to go with out eating. No attempts at direct discipline are made.

skin stimulation as shown by Ashley Montague and others is one of the basic needs of the infant not unlike hunger, sleep etc. Montague claims that skin is the first sense organ to be stimulated in the new born since the other sense organs are still developing . Preverbal skin stimulation can be done through breast feeding, holding, cuddling, and caressing (Montague,A., 1978).

In Nepal, mustard oil massages are given to the newly born child daily. The massage not only stimulate the skin, but also it is believed to stimulate muscles, bones, joints, and internal organs' systems as well as oiling preserves the skin, along with saving the skin from irritation and infection. People in Nepal also oil the fontanel which makes the skull bone strong. It is believed that when the child grows up he/ she can be able to carry load on it. Thus, it seems that

traditional Nepalese ways caring for the baby are equally advanced as those proponents of the current trend of skin stimulation (Pradhan, HB., 1985,p.19).
For the newly born baby , pillows are made of the mustard seed. According to the people , mustard seed protects the babies from getting cold, gives proper shape to the head by its rolling motion from side to side and prohibits the head from getting dry. The pillow mechanically shields the head from cold because more than half of the head is covered with the pillow, if it is used properly. This type of a pillow is usually used for three to four months.

1.10.4. Hygiene and Cleanliness: Training children in hygiene and cleanliness is attempted very casually . Every child's hands and face are washed after eating meals , but may not be true before meals. Food that has fallen may be picked up and eaten . Bathing for children is forbidden on Sunday, Wednesday and after being dark as there is the fear that evil spirits will bring misfortune to the child. To prevent earaches and deafness, mustard oil is poured into a child's ear. But , in reality there is much deafness and ear infection caused by pouring the oil.
Toilet training is viewed casually. Dirty rags are often used as diapers . If the rag is soiled with urine , they are not formally washed but only left in the sun to dry. Thus, this causes rash among the children . Children often use kitchen garden ,path ways, or even court yard to defecate. Parents do not disapprove of this action. The concept of fecally transmitted diseases is still widely unknown in Nepal.

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2. MENTAL HEALTH

Abnormal Behavior in our times: The seventeenth century has been called the age enlightenment , the eighteen , the age of freedom , the nineteen , the age of progress and t twentieth the age of satisfying way of the life has probably never been an easy one, it seems have become increasingly difficult in modern times.

Wars have disrupted both personal and national life leaving in their wake grief destruction a social unrest. Economic fluctuation and inflection have taken their loll in unemployme *dislocation and poverty for million of the people. Racial prejudice with in impersonal feeli of superiority hatred and resentment hurts both the individual the community. Urban socie* with its high mobility disrupted friendships and loss of extended family bonds place increasin stress on the home. Unhappy marriage and home broken by divorce bring bust an disillusionment and competition and in personal bureaucracy tend to "dehumanize" th individual load to a loss of meaning in human existence and opportunity –leading to socia pressures that periodically erupt in violence . The wasteful use of our natural resources, couple with the pollution of air, water and soil, threatens. The life –support system of all who travel o the spaceship earth and ever-present threat of global atomic war further aggravates our activities At the some times, traditional values and beliefs no longer seen self evident; we lack th comforting religious and social absolutes that provided security for our fore beard. The stress c the modern life in indicated by the incredible amount of tranquilizers, sleeping pills an alcoholic beverages consumed in our society by the emergence of heart attacks as the leadin cause of death in our society .

Abnormal behavior has for good reason been designated the country s number-one heal problem. This does not mean that effective personality adjustment in impossible in modern lif It does not mean, how ever that many of us encounter serious difficulties in dealing with th life problems particularly problems pertaining around unlimited personal relationships a search for values contributing to a meaning full and fulfilling way of life. Thus the study abnormal behavior (Mental illness) may be of great help in fostering personal adjustment a growth and in reducing the great toll of misery and productivity that mental disorders a exacting in our country(J.C. Coleman,1982).

Background of mental illness : A brief review of a few cases of mental disorders from histo and literature will be of value in giving us a broader perspective , for most of the forms of serv mental disorder that we see today have observed and reported in other ages too.

Views carried over from history : Some of the earliest historical writings –Chinese Egypti Hebrew and Greek- provide striking case histories " of disturbed individuals. Saul, king of Isr in the eleventh century B.C. Suffered from recurrent manic–depressive episodes. During attack of Mania (excitement) he stripped of all his clothes in a public place. On another occasi he tried to kill his son Jonathan.

Cambyses , King of Persia in the six century B.C. was one of the first alcoholics on recor His alcoholic excesses were apparently associated with periods of uncontrollable rage dur which he behaved " as a madman not in possession of his senses" (whitwell 1936,p.38)

Many of the notables of later Greece and Rome inciuding Socrates, Alexander the great, jul caeser apparently suffered from mental disorder .

In more recent times , George III of England –known as the " mad monarch " showed a vari of symptoms including periods of intensive excitement and over activity . The Fre

philosophers Jean Jacques Rousseau (1712-1778) developed marked paranoid symptoms during the later part of his life . He was obsessed with fear of recent enemies and thought that Prussia England , France , the King priests and others were waging a terrible war against him .
The manes of other philosophers painters writers musicians and celebrities who suffered emotional disturbances would make a long list .
On one occasion van cogh cut off his ear and sent it to a prostitute, an action apparently performed in a state of clouded consciousness resulting from his epileptic condition Schopenhauer chepin and John stuart Mill suffered from attacks of depression Burns Byon and poe used alcohol excessively .
Many rulers and conguerors have been able to indulge seemingly sadistic inclinations . Attila the Han is remembered mainly for the withlessness and barbarity of his conquests. Queen mary I of England ,better known as "bloody Mary " was responsible for the marian persecution –the wholesele buring of protestants as heretics during the years 1553 to 1558.
In reviewing these historical instance of abnormal behaviour, it should be made clear that we are to some extent evaluation this behaviours in the light of present –day concepts of mental disorder . In their own day , some of these people were looked on as perfectly normal and others as only eccentric or unusual.

Ideals carried over from literature and drama : ong before abnormal psychology became an area of scientific study , the masters of fiction and drama developed many brilliant and moving characterizations insight into the subjective quality of obsessive , violent jealousy . Many of the characters in the plays of William Shakespeare portray the development of abnormal behavior with clinical accuracy.
The writings of Greek poets and dramatists certain many allusion to abnormal behavior. In his play Media, Euripides (480-406 B.C.). The first intimation of incest motives in the shaping of human behaviours . Aeschylus clearly described delusional and hallucinatory symptoms arising out of serve feeling of remorse and guilt . Of course literature annot privide either the theoretical or practical basis for understanding and treating specific cases of abnormal behaviours . But it does complement psychology in giving a different kind of understanding of such behaviours .

Abnormal Behavior in ancient times : Although human life presumably appeared on earth some three million of more years ago, written records extend back only a few thousand years. Thus our knowledge of primitive man if very limited and often based on extrapolation from so-called primitive people s who remained isolated and relatively static into modern times. Beginning with the Egyptian and other ancient civilizations historical information becomes more reliable, although far from complete.

Demonology among the ancients: The earliest treatment of mental disorders was practiced by stone age cave dwellers some half million years ago for certain forms of mental disorders including sever headaches and developed convulsive attacks, the early shaman, or medicine man treated the disorders by means of an operation now called repining. This operation was performed with crude stone instrument and consisted of chipping away are area of the skull in the from of a circle until the skull was cut though. This opening, called a trephine , presumably permitted the evil spirit that supposedly was causing all the trouble to escape and incidentally may have relieved a certain amount of pressure on the brain.

Early philosophical and medical concepts : During the golden age of Greece considerable progress was made in the understanding and treatment of mental disorders . Originally membership in medical priest hood of the Greek temples of healing was hereditary but gradually

outsiders were admitted and various "schools" began to from. it was in one of these groups that Hipocrates received his early training .

Hippocrates; The great Greek physician Hippocrates (460-3777 B.C. } has been called the father of modern medicine . He denied the intervention of deities and demons in the development of disease and insisted that mental disorders had natural cause and required treatment line other disorders. His position was unequivocal : for my own part , I don't believe that the human body if ever befouled by a god " (Lewsis, 1941,p.37). Hippocrates emphasized the view, earlier set forth by pythagors , that the brain was the central organ of intellectual activity and that mental disorders were due to brain pathology as well as heredity and predisposition and head injuries could cause sensory and motor disorders.

Hippocrates classified all the varieties of mental disorder in to three general categories-mania melancholia and phrenitis and game detailed clinical descriptions of the specific disorder included in each category, Such as alcohol delirium and epilepsy .

Hippocrates emphasis on natural cause clinical observations and brain pathology in relation to mental disorder was truly revolutionary like his contemporaries however , hippocrates had very little knowledge of physiology .(Greek physicians were poor physiologists and anotomists because they deified the human body and dared not dissect it) Thus in his concept of four humoros –blood black bile yellow bileand phlegm . Hippocrates apparently conceived the notion of a balance of physiological processes as essential to normal brain functioning and mental health.

For the treatment of melancholia, Hippo crates prescribed a regular and tranquil life, sobriety and abstinence from all excesses a vegetable diet, continence exercise, short of fatigue and bleeding if indicated. He realized the clinical importance of dreams for understanding the personality of the patient.

Plato and Aristotle : The problem of dealing with mentally disturbed individuals who committed criminal acts studied by great philosopher Plato(429-347 B.C) . He made it clear that such persons were obviously not responsible for their cats and should not receive punishment in the same way as normal person ..... Someone may commit an cat when mad or afflicted with disease.... Let him pay simply for the damage; and let him be exempt from other punishment.

The question of whether mental disorders could be caused by psychological factors like frustration and conflict was discussed and rejected by the celebrated systematist Aristotle (384-322B.C.), who was pupil but not a follower of plato. Aristotle generally followed the Hippocratic theory of disturbances in the bile. Later Roman and Greek Physicians who continued in the Hippocratic tradition were Asclepiades, Aretaeus,and Galen: among them Asclepiades(born C. 124B.C.) was the first to note the difference between acute and chronic mental disorder, and to distinguish between illusion, delusions , and hallucinations .

In the middle Ages, with the collapse of Greek and Roman civilization, medicine as well as other scientific pursuits suffered an almost complete eclipse in Europe. There was a tremendous revival of the most ancient superstition and demonology. Human beings now became the battleground of demons and spirits who waged eternal war for the possession of their souls.

The last half of the Middle Ages saw a peculiar trend in abnormal behavior, involving the widespread occurrence of group mental disorders that were apparently mainly causes of hysteria.

In the middle ages treatment of the mentally disturbed was left largely to the clergy. Monasteries served as refuges and places of confinement. During the early part of the medieval period, the mentally disturbed were treated with kindliness. Much store was set by prayer, holy water, sanctified ointments, the breath or spittle of priests, the touching of relics, visits to holy places, and mild forms of exorcism. When a devil possesses a man or controls him from within with disease, a spew-drink of lupine, bishopswort, henbane, garlic. Pound these together, add ale and

holy water (cockayne, 1864-1866) . It was generally believed that cruelty to people afflicted with "madness" was punishment of the devil residing within them and when "Scourging" proved ineffective , the authorities felt justified in driving out the demons by more unpleasant methods . Flogging, starving, chains, immersion in hot water , and other torturous methods were devised in order to drive out the demons from the body.

During the later parts of the fifteenth century, it became the accepted theological belief that demoniacal possessions were of two general types: (a) Possessions in which the victim was unwillingly seized by the devil as a punishment by god for past sins, and

(b) Possessions in which the individual was actually in league with the devil. The latter persons were supposed to have made a pact with the devil , consummated by singing in blood a book presented to them by Satan which gave them certain supernatural powers .

They could cause pestilence, storms, floods, sexual impotence, injuries to their enemies, and ruination of crops, and could rise through the air, cause milk to sour, and turn themselves into animals. In short, they were witches.

To be convicted of witchcraft was a most serious matter. The penalty usually followed one of three general forms. There were those who were beheaded or strangled before being burned, those who were burned alive, and those who were mutilated before being burned. The treatment accorded a mentally disordered man caught in the wrong period of history is illustrated in the following case:

"In Konigsberg in 1636 a man thought he was God the father; he claimed that all the angels and the devil and the son of God recognized his power. He was convicted. His tongue was cut out, his head cut off, and his body burned" (Ziboorg & Henry, 1941, p.259).

There seems to have been little distinction between the Roman and the Reformed churches in their attitudes toward witchcraft and large numbers of people were put to death in this period.

"A French judge boasted that he had burned 800 women in sixteen years on the bench; 600 were burned during the administration of a bishop in Bamberg. The Inquisition, originally started by the church of Rome, was carried along by Protestant churches in Great Britain and Germany. In Protestant Geneva 500 persons were burned in the year 1515. In Treves some 7000 people were reported burned during a period of several years" (Bromberg, 1937, p.61).

The full horror of the witch mania and its enthusiastic adoption by other countries, including some American colonies, took place during the sixteenth and seventeenth centuries. And though religious and scientific thought began to change gradually , the basic ideas of mental disorder as representing punishment by god or deliberate association with the devil continued to dominate popular thought until well into the nineteenth century.

2.2. MENTAL DISORDER (MENTAL ILLNESS) AND TREATMENT :

Many attempts have been made to define mental illness (Clare 1979, Caplan et al. 1981; Fulford 1989); In general medicine there are three types of definition: absence of health, presence of suffering, and pathological process whether physical or psychological.

Mental illness can be defined in terms of psychopathology, characterized by 'evident disturbance of part functions as general efficiency'. In psychiatry part functions refer to perception, memory, learning, emotion, and other such psychological functions (Michael Gelder et al. 1983. pp. 56,57).

At present, the concept of mental disorder is significantly being concern scientific and described as ; In DSM –III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptoms (distress) or impairment in one or more important areas of functioning (disability) . In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society . (When the disturbance is limited to a conflict between an

individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder) (APA, 1980, p.6).

The Abnormal: Among the unselected life records, there would also be found a small group of equally spectacular and unusual cases that deviated from the normal in an unfavorable or pathological direction . Included in this abnormal group would be individuals marked by limited intelligence, emotional instability, personality disorganization, and character defects, who , for the most part , led wretched personal lives and were social misfits or liabilities. These abnormal deviants, who constitute about 10 percent of the general population, are usually classified in to four main categories: Psychoneurotic, Psychotic, Mentally defective, and antisocial personalities.

1. *Psychoneuroses:* Individuals who "go to pieces" easily when confronted with a difficult or trying situation and exhibit a variety of mental and physical symptoms that persist for several weeks or months are known as "Psychoneurotic." Typical mental symptoms are anxiety, feeling of inner tension, restlessness, idea of inadequacy, inability to concentrate, loss of memory, absurd fears, and obsession. Physical symptoms , which are essentially repercussion of internal emotional disturbances, include headaches, upset stomach, excessive fatigue , and loss of sensory and motor functions. Psycho-neuroses are relatively mild personality disorders that distress and inconvenience the patient but do not disrupt his social adjustment or interfere with his every day activities to the point of necessitating supervision or compulsory commitment to a mental hospital. His personality remains intact and his grasp of reality is not distorted . The four types of Psycho-neuroses most generally recognized are hysteria, neurasthenia, Anxiety State, and psychasthenia .

2.Psychoses: Psychoses are severe mental disorders that tend to shatter the integration of the personality and disrupt the individuals social relationships. The behavior of the Psychotic is too bizarre, unreasonable, and inappropriate to be understood by a normal person. It is necessary to supervise closely, or hospitalize, Psychotic patients, because they are incapable of adequate self-management and their peculiar and unpredictable actions constitute a potential threat to the welfare of others. Psychotic individuals are so unbalanced mentally that they are not legally responsible for their actions. In the eyes of the law, they are insane. Unpleasant delusions and hallucinations are just as real. The patient who imagines that he is being persecuted by some secret organization is genuinely terror-stricken, and he flees from one city to another to evade his persecutors.

Without any apparent cause, they become violently excited, depressed, ,or irritable. There is no logical relation between the motivating situation and the emotional responses. Sad news from home may evoke laughter; good news, tears; or either may have no effect. Usually the patient is confused, bewildered, disoriented, incoherent speech and thought process is retarded and ineffective. The final out come may be a permanent impairment of the total personality, or the individual may make a surprising recovery with few, if any residual symptoms. Psychoses can also be classified such as Schizophrenia, manic-depressive Psychoses, Paranoia and Involutional Melancholia.

3.*Mental Deficiency*: Mental Deficiency is a general category, which includes variety of individuals who, because of subnormal or retarded mental development, are unable as children to profit from regular School instruction, and adults are incapable of adequate self-management or self-support. These individuals are also classified as; amends or feeble-minded. Feeble-mindedness is differentiated from the mental deterioration that results from various psychoses by a deficiency of intelligence dating from birth or early life. As adults, they can be trained to do simple routine tasks that will contribute to their support but they are incapable of adequate self-

management in society. They can protect them-selves against common physical dangers, but are helpless when exposed to ordinary social dangers. They do not fully understand the social significance of their actions and must be carefully supervised.

The dullest of the mental defectives never learned to walk, talk, or feed them selves. In adaptability to life situations they show less intelligence than animals, and even knowing enough to come to in, out of the rain. Even as adults, they must be treated as helpless infants.

Mental defectives have limited intelligence. Intelligence is a complex function that has been defined as the ability to learn useful information and skills, adapted to new problems and conditions of life, profit from past experiences, engage in abstract and creative thinking, employ critical judgment, avoid errors, surmount difficulties and exercise foresight. These feeble-minded are markedly deficient in all these attributes. The teaching of mental defectives is a slow and tedious process.

For convenience in classification, individuals having I.Q.'s ranging from 110 to 130 are considered bright, over 130 superior, 70 to 90 dull, and under 70 are classified as mental defective. Degree of Deficiency depending on the extent of their defects, the feeble-minded are classified as idiots, imbeciles and morons, mongolism, microcephaly, traumatic amentia, hydrocephalic, cretinism, congenital syphilis, sclerotic amentia, amaurotic family idiocy, phenylphyruvic oligophrenia etc. (James D. Page, 1947).

2. *Antisocial Personalities:* Including in this category are two overlapping, but more or less independent groups that share a common propensity for antisocial behavior , one group is made up of convicted law violators, the other consists of individuals with psychopathic personalities.

Depending on their age, law violators are classified from a legal point of view as delinquents or criminals. a small proportion of criminals are mentally defectives, but a great majority possess average intelligence and some have superior mental ability. All personality types are found in the criminal group (James D. Page 1982, pp. 2-10, 355-374).

2.4.CAUSES OF MENTAL ILLNESS:

The causation of any particular behavior pattern is tremendously complex, and even with the information we do have it is all but impossible to predict how given circumstances will affect given individuals (James C. Coleman, 1982,p.135).

Different factors are responsible for abnormal behavior such as , biological factors, that seem particularly relevant to an understanding of the development of maladaptive behavior: (a) genetic defects, (b) constitutional liabilities,(c) physical deprivations: (e.g.malnutrition, sleep deprivation &fatigue etc.) (d)disruptive emotional process;

(e) brain pathology. Each of these categories encompasses a number of conditions that influence the quality and functional intactness of our bodily equipment .

Psycho-social factors such as; psychic trauma or severe stress and marital difficulties or marital instability, maternal deprivation, pathogenic family pattern, (faulty parent-child relationship-rejection, over protection, restricts, over permissiveness and indulgence, unrealistic demands, faulty discipline, communication failure, undesirable parental models etc.) , maladaptive family structures-(inadequate family, disturbed family, antisocial family disrupted family etc.),early psychic trauma, pathogenic interpersonal relationships; devaluating frustrations;-In contemporary life, there are a number of frustrations that lead to self-devaluation and hence are particularly difficult to cope with. Among these are failure, losses, personal limitations and lack of resources, guilt, and loneliness, value conflict; such as, conformity vs. nonconformity, caring vs. noninvolvement, avoiding vs. facing reality, fearfulness vs. positive action, integrity vs. self-advantage, sexual desire vs. restraints, pressure of modern living: Each person faces his own unique pattern of pressure, but in general way most of us face the pressures of competing with

others, meeting educational, occupational and marital demands and coping with the complexity and rapid pace of modern living.

In addition to the biological and psychosocial factors that we have reviewed as conducive to abnormal behavior in our society, there are other conditions especially characteristic of our time place in history that put stress, directly, on most of us. Among these are the problems of war and violence, group prejudice and discrimination, economic and employment problems and rapid social change and existential anxiety (James C. Coleman, 1982, pp.135-181).

2.5. ANXIETY AND POST TRAUMATIC STRESS DISORDER (PTSD):

Anxiety Disorder: Anxiety Disorders are abnormal states in which the most striking features are mental and physical symptoms of anxiety characterized bydifferent psychological and physical symptoms, which are not caused by organic brain disease or another psychiatric disorder . Anxiety Disorders are divided as follows:

(i) Generalized Anxiety Disorders in which anxiety is unvarying and persistent ;

(ii) Phobic Anxiety Disorders in which anxiety is intermittent and arises in particular circumstances;

(iii) Panic Disorder in which anxiety is intermittent and unrelated to particular circumstances (Michael Gelder et al., 1983, p.160).

2.5.2. POST TRAUMATIC STRESS DISORDER (PTSD):

PTSD is a type of Phobic Anxiety Disorder characteristically include experiences that in some way repeat the traumatic event , often as intrusive ideas accompanied by unbidden feelings. This compulsive repetition may be associated with the other maim set of symptoms , those of denial states, for instance, numbness or unresponsiveness to, or reduced involvement with the external world (J.P. Wilson, B. Rophael 1993, p. 54).

Symptoms of PTSD: Post Traumatic Stress Disorder followed the symptoms of exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity ; or witnessing an event that involves death , injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm , or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear , helplessness, or horror , (or in children , the response must involve disorganized or agitated behavior). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness and persistent symptoms of increased arousal. The full symptom picture must be present for more than one month, and disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, DSM IV, 1996, PP.424,425). Painful guilty feelings about surviving, phobic avoidance of situations or activities that resemble or symbolize the original trauma may interfere with interpersonal relationship and lead to marital conflict, divorce, or loss of job, are the associated features with PTSD. The following symptoms of impaired affect modulation, self-destructive and impulsive behavior, dissociative symptoms; somatic complaints; feeling of ineffectiveness, shame, despair, or hopelessness, feeling of permanently damaged, a loss of previously sustained beliefs, hostility, social withdrawal; feeling constantly threatened; impaired relationships, with others; or a change from the individual's previous personality characteristics which are commonly associated with an interpersonal stressor (e.g. childhood sexual or physical abuse , domestic battering, being taken hostage, incarceration as a prisoner of war ,or in concentration camp, torture in police custody).

There my be increased risk of panic disorder, Agoraphobia, obsessive – compulsive Disorder, social phobia, specific phobia, major Depressive Disorder, somatization Disorder, Substance related Disorders. It is not known to what extent these disorders precede or follow the onset of Posttraumatic Stress Disorder.

Intrusive experiences and psychic numbing (emotional anesthesia) are two major symptoms that lead to the diagnosis of Post traumatic Stress Disorder . Unbidden images , dreams, and nightmares frequently occur . in rare instances , the patient may experience dissociative states that last for hours or days; during these states he or she may compulsively relive the event . Recurrent or prolonged episodes of depression, anxiety, guilt, shame, and rage are also common. Minor stimuli may trigger explosive, hostile behavior. In addition, the disorder may include components of sympathetic nervous system hyper arousal, such as difficulty relaxing or falling asleep, with persisting tachycardia, sweating, and pupillary dilation.(John P. Wilson et al . 1993,).

Etiology of PTSD: Generalized anxiety disorder appears to be caused by stressors acting on a personality predisposed by a combination of genetic factors and environmental influences in childhood(Michael Gelder et al , 1983).The stressor event that produces the syndrome is usually one that would evoke significant symptoms in most people. And that lies outside the range of such common experiences as simple bereavement, chronic illness, business loss, or marital conflicts, rapes, muggings, assaults, military combat, torture, natural disasters, traumatically frightening or painful medical experiences, deaths of loved ones, and accidents, such as air plane and car crashes, can all evoke the reactions that characterize PTSD. The most prominent features of such events are the sudden helplessness and shocking perceptions they provoke.

Prevalence: Community –based studies reveal a life time prevalence for posttraumatic Stress Disorder ranging from 1% to 14% ,with the variability related to methods of ascertainment and the population sampled. Studies of at-risk individuals (e.g. combat veterans, victims of volcanic eruptions or criminal violence) have yielded prevalence rates ranging from 3% to 58% .

Course: PTSD can occur at any age , including childhood. Symptoms usually begin within the first three months after the trauma although there may be a delay of months, or even years ,,before symptoms appear. Duration of the symptoms varies , with complete recovery occurring within three months in approximately half of causes , with many others having persisting symptoms for longer than twelve months after the trauma.

A latency period of months or even years may intervene between the stressful event and the maximum symptomatic response that could be diagnosed as;

**Acute* : The symptoms persist for less than three months.

**Chronic:* The symptoms lasts for three months or longer.

**Delayed onset:* This indicates that at least six months have passed between the traumatic event and the onset of the symptoms.

2.5.The Role of Trauma in Mental Illness:

About 60% of persons diagnosed as having a mental disorder have experienced a severely stressful life event in the 2 weeks preceding the onset of that disorder . In contrast, about 20% of comparison groups not diagnosed as having a mental disorder have experienced a stressful event in the previous 2 weeks (Brown & Harris, 1978). Paykel (1978) summarized such studies as indicating that in the months following a traumatic life event , there is a six fold greater risk of suicide, a two fold greater risk of depressive disorders and a slight increase in the risk of developing a schizophrenic syndrome.

Besides leading to post traumatic and adjustment disorder, stressful experiences can lead to concomitant physiological disturbances and can contribute to other anxiety disorders. Preexisting episodes of separation trauma have been suggested as a predisposition to panic

disorders (Klein, 1981). In addition , serious or threatening life events have been implicated in the onset of phobic disorders. For example, Weekes (1978)found that the majority of 528 agoraphobic men and women reported that either sudden or prolonged stress created by difficult life situations was an antecedent to the development of their anxious states of mind; Only 5%could offer no cause. Of course, these are impressionistic, retrospective data.

Most studies show marked individual differences among stress – response subjects ; the person who seemed most disturbed before an event is not always the one who develops a disorder afterward. Nonetheless, it does seem to hold true that more previous trauma a person experiences, the more likely he or she is to develop symptoms after a stressful life event experimentally, persons with more previous trauma found vicarious stress more disturbing(Horowitz,1975).

When stressors become extreme, as in extended combat or in concentration camps, the rate of morbidity increases . Champman (1962), for example, reported that a post disaster psychiatric syndrome may be found in from 0% to 30% of victims , depending on the severity of the stressor .

An up-to-date and fully comprehensive set of studies evaluated victims of the 1972. Buffalo Creek flood in west Verginia, which wreaked sudden, on expected devastation with considerable loss of life (Erikson , 1976; Gleser, Green, &Winget, 1976, Lifton & Olson, 1976; Titchener & Capp, 1976). Up to 2years after the flood, survivors showed symptoms of intrusive recollection, reactive anxiety, depression and social dysfunction comparable to levels of distress found in patients treated in mental health clinics for anxiety and depressive disorders. Workers exposed to dead and dismembered bodies after a disaster may themselves suffer post traumatic stress disorders or trauma, there may be a long latency period followed by manifestation of altered social function (Newman , 1976 ;Terr , 1981).

Perhaps the most studied personal disaster is the death of a loved one. Reports of increased morbidity of surviving spouses have been questioned, but clearly the death of a loved one may lead to suicidal ideation and to increased use of potential toxins, such as cigarettes, alcohol, and mood-altering drugs. A comparison of reactions by two groups of persons whose parents have died . Those who sought brief therapy for symptomatic grief reactions after the death and those who did not , was reported by Horowits and colleagues (Horowitz, Krupnick, Kaltreider,Wilner, leong,& Marmar ,1981); a summary of the levels of distress in both groups is shown high levels of distress on stress-specific self report answers, such as the Impact of Event Scale (IES)(Horowitzs, Wilner, and Alvarez,1979) , were noted by some subjects in both groups , but a significantly greater proportion of the of the patient group had high levels of signs or symptoms. Individuals whose spouse or parents dies appear more likely to experience pathological grief reactions if the preexisting relationship was characterized by guilt and anger as well as by strong attachment (Horowitz, 1990). Deaths that are unexpected , complicated, or experienced in some way as "unfair" are also harder to assimilate in mourning .Escalating consequences such as economic difficulties , social disengagement , and disruption of place of residence , can increase the risk of pathological response, and feelings of hopelessness and helplessness will increase the likelihood of depressive reactions . In general , human contact provides major sustenance in grief. The lack of such contact may make mourning difficult and lead to increased likelihood of psychological morbidity (Clayton, 1975)

2.6.PREVENTIVE AND CURATIVE MEASURES OF PTSD:

There is a tendency in our population to hide psychological or mental symptoms. This makes the doctor difficult to diagnose mental illness and time and money is wasted for unnecessary investigation .

There are two types of measures are useful according to the severity of the emotional problem.(anxiety or PTSD). They are as:

Psychotherapy: This type of therapy consists of different types of soothing techniques for the equilibrium of mind and body, that can not be separated each other. Body and mind both should be relaxed for proper functioning. Every body should be careful about his/ her own mental or emotional health. The trauma victim frequently suffers from nightmare, flashback of unpleasant memories and feels terror and seeks help of others. Such symptoms of symptoms may occur for a month or more. In this situation a professional psychotherapist or psychiatrist can help them. Different techniques of psychotherapy are most helpful for anxiety management such as; counseling, cognitive-behavioral therapy, relaxation training, anxiety management training, yoga therapy, exposure therapy, desensitization as; Eye Movement Desensitization Reprocessing (EMDR), Emotional Freedom Technique (EFT), self control technique etc.

Treatment with drugs: Prescribing drugs usually may be the risk factor of side effect and dependence even though it helps to control emotional disturbances within short period. But psychotherapy takes long time to cure even though it is safe. The common drugs to control the anxiety disorder are Benzodiazepines- Diazepam, Buspirone, and Beta-adrenergic antagonists etc.

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CHAPTER –THREE

3.THE PSYCHO-SOCIAL TRENDS OF MENTAL ILLNESS IN NEPAL

The Psychosocial trend of mental illness is found more complex and critical in present situation. Terror and violence is dominating over public life pattern, which is being insect even in their home or within their family. The changing socio-cultural values are also affected in mental health of people. Most of people are not aware of mental health. They have misconception and appropriate practices of traditional healer and make them worst. At present situation, most of the people in Maoist movement affected region in Nepal are being the victim of trauma. 'Traumas hurt, not only cause terrible physical injuries but emotional injury as well which can be for more painful and take much longer to heal the effect of trauma can be a lingering feeling that your world has charged utterly'. (C. Herbert & Ann more u\et more 1999).

Although everyone encounters many intensely upsetting and stressful situations during the course of their lives, not many of these would be considered traumatic events. An experience can be described as traumatic when a person's normal ability to cope has been completely overwhelmed by a terrible event.

There are many way's in which traumas can occur usually. An event would be considered traumatic if a person had experienced or been a witness to an event that involved actual or threatened death or serious injury. There might also have been a threat

To this person's or other people's physical integrity so that they feared physical harm would come to them. This threat could have been so over whelming that the person would have experienced intense fear, helplessness or horror, would some of the time during the event (DSM-jv, 1994)

There are many different types of traumatic events, they are mainly divided into three categories: man made disasters, natural disasters and acts or violence, crime or terrorism (Hodgkinson & Stweart, 1991). Man-made disasters imply that the trauma had occurred because of a human error or and error made b a machine or a system, deranged by humans including transport disaster's air disasters, maritime disaster, fire and gas explosions, severe electric shock, building collapses, environmental disasters .

Natural disasters include earth quacks, floods, hurricanes, forest fires, volcano eruptions etc and actor violence, crime and terrorism include act of domestic violence, stabling, hold ups and robberies, shooting, bomb explosions Rae, sexual abuse, acts of in humanity such has torture, hostage taking wars etc man made disasters and the traumas caused by acts of violence crime and terrorism are often harder to adjust to and come to terms with them natural disasters(c. Herbert &A. wetmore, 1999). The result of the study prove that torture victims seem more suffered emotional as well as physical difficulties other them victims or natural disaster's (see Table 4.4)

Reference: Claudia Herbert & ann wet more, 1999, overcoming traumatic stress, Robin son Publishing Ltd. 1999.

3.1 *STATEMENT OF THE PROBLEM:*

This is the age of anxiety, due to the development of science and technology, the world is being too narrow and the individuals are being the slaves of routine. They don't have time to care others. Selfishness and the trends of individualism, power seeking behavior as well as criminal behavior, overcome humanity in this world. The individuals are being the helpless creatures in the crowd of people. War and violence, family conflict, domestic violence, street children, political and social crime, drug abuse, prostitution, alcoholism, sexual abuse, pathological gambling, divorce, suicide, murder, rape, torture, terrorism, etc. are the products of power seeking as well as individualistic behavior, that is pathological life style. Always, such situation produce the variety of psychopathological or emotional problems such as; anxiety, depression, stress, PTSD, anger, irritation, conflict, sleep disturbance, nightmare, night terror, sexual dysfunction or marital conflict etc., which are the sources of psychosocial maladjustment. Such type of emotional problems are not considered as illness in Nepali society even though it is needed the immediate treatment and care in the supervision of professional clinical psychologist or psychiatrist . Such cases are not needed for hospitalization, they can be treated in the normal social situation. Only severe type of behavior disorders as; psychoneurotic, psychotic, or schizophrenic, and other mentally defective individuals are considered as mentally ill. They are small numbers in our community. There are misconception and wrong practices for mentally ill people in our society. People believe that mental illness occurs due to the influences of witchcraft or spirits of dead soul and they depend on the traditional healers or Dhami-Jhankri for the treatment of mental illness. The condition might be worst due to wrong practice even though it can be easily detected and treated in the clinical situation. The present psychosocial situation in our society is being more unfavorable due to unstable psycho-political situation. The mass media is also playing an important role, through which children as well as adults are learning negative unhealthy life pattern with wrong cultural practice as the name of civilization. The children can easily copy the negative character of actor or actress, so, terror or violence character should be prohibited for the children. The special program should be constructed for the children, which could teach the moral lesson. Mental health is most important so, we all, should be aware for the emotional as well as physical equilibrium, the dysfunction of emotional equilibrium bring maladjustment as a psychosocial problems.

3.2 *OBJECTIVES OF THE STUDY:*

This study aims to examine the prevalence of psychosocial trauma among the out door mental patients(tortured and non-tortured) as follows:

1. To assess the prevalence of Post Traumatic Stress Disorder (PTSD) among the tortured and non-tortured population.
2. To assess the prevalence of Disability among the trauma survivor (tortured and non-tortured population).
3. To assess the psychosocial trend of PTSD and Disability.

3.3. SIGNIFICANCE OF THE STUDY:

There are limited works performed in the field of mental health. This is the subject is being least preferred even though it is most important one. It is needed to identify the significant problems in the field of public mental health in curative as well as preventive aspects. In Nepal mental health service is least developed and neglected by government or public in the comparison of physical health. All of the functions of the human body systems are controlled by the nervous system, which is considered as mental health. If any disturbance is occurred in the brain function life pattern of an individual will be spoiled. So, this subject is also equally an important to develop as physical health. In this context, this study may play an important role to support for planning mental health program in the community, where people are suffering and

the psychosocial intervention is needed. The outcomes of the study will be helpful to individual or community for the awareness and emotional management. This study is helpful not only for psychiatric point of view but also planner, researcher, health personnel, teacher, social worker, students as well as layman who are interested in this field could be benefited .It will help to pave the way for further study in this field.

3.4. REVIEW OF LITERATURE:

There are very few works that have been done in the field of mental health in Nepal. The subject " Mental Health" can not be neglected in health care and public health practices. Mental health is equally an important subject as physical health, it can not be separated each other. The field of mental health is also rich with modern science and technology, but not enough. The public concept and beliefs about mental health are too primitive, traditional and irrational in Nepalese culture. So it is needed to start to work in different aspects of mental health such as; preventive, curative, as well as public awareness that should be integrated with physical health.

In this context there are no sufficient literature found, yet, some relevant facts are tried to cite from different sources.

The trend of Mental Illness: More than 10 percent of Nepalese suffer from various mental illnesses. Men and women, irrespective of any educational and socio-ecomic status or caste, can suffer from mental illness. As high as one in four of all patients have mental health problems. Men suffer more from drug and alcohol abuse while women suffer mainly from depression, anxiety disorders and conversion disorders. About one percent of total population suffers from severe mental illness like schizophrenic and other forms of psychoses. More than 25 percent of those who seek medical care for physical symptoms (Dr. Shishir K.Regmi, 2001).

T.B.Ustun,(1999) agreed that mental health has long been neglected in health and public health practice- much as persons with mental disorders have been segregated and seen as different ,unreal and incurable. Consequently health professionals have trivialized the issue of mental illness yet, mental health disorders cause significant disability and considered globally exceed either HIV or cancer in terms of numbers affected. It is essential that researchers and public health professionals work together to resolve the enormous public health crisis presented by mental disorders. In short, we must "mainstream" mental health.

Mental illness is a phenomenon known to effect people in societies through the world (Wittkower and dubreuil,1971). In Nepal researchers have noted cases of it, and described means of treatment (Peters1979;Stone,1977;224-247)though, as yet ,there have been no studies that deal in detail with the subject. Thus without information on the amount and types of mental disorders that affect people in Nepal, one must look to surveys from India and abroad for suggestions about the extent and pattern of the problem.(D. M.Shrestha et al).

Generally , one finds 1-2 percent of most populations affected by a severe mental disorder , and for personality and reactive disorders the figures are higher amounting to nearly 2-5 percent(Kapur,1979:27.Of course ,these figures must be seen as rough estimates for there is much variation in the rates of particular psychiatric disorders across the surveys (Parabhu ,1976:266).Yet, even considered conservatively, they suggest that as many as 280,000 people in Nepal maybe in need of psychiatric attention.(Ibid, pp.1-3).

In the field of mental health, community based program in primary health care level is also been started, which is good sign to help for the survivor of emotional or behavior disorder. In the course of treatment some mental health camps were organized in some western part of Nepal and reported the outcomes with the following psychosocial trend of mental illness in Nepal;

In Syangja health camp, 109 psychiatric (including epilepsy) were seen. Among them 27.5%depression, 23%epilepsy, 9.2%schizophrenia, 8.3% anxiety disorder, 2.8% parkinsonism, 1.8% alcohol dependence, 1.8% febrile convulsions and 12.8% others were found.

Similarly, 118 mental patients were seen in Kaski district . Among them 20.34 % depression, 9.32 % epilepsy, 5.935 alcohol dependence, 0.0084% schizophrenia, and affected disorders 4.24% mental retardation, and anxiety neurosis,1.69 % migraine headache, 0.0084% adjustment disorders 2.54% hyper tension and 49.15% other types of behavior disorders were found.

The trend of mental illness or the work load in psychiatry is gradually increasing as patients from Kaski (62%), Syangja (10.2%, Tanahun (10.4%), Parbat (6.2%) Baglung(3.2%), Lamjung(2.3%), Gorkha(1.5%) Myagdi(1.2%)and from other adjoining districts(3%),all together 1037patients were examined as new cases ,among them 548 (52.8%) were males, and 489(47.1%) females from 17th July,1997to august , 1998. Among them mood disorder (29%), neurotic, stress related and other somatoform disorder (24.2%), epilepsy (18.3%) schizophrenia, schizotypal and delusional disorders (10.5%), psychoactive substance abuse (7.3%), migraine headache (1.8%), mental retardation (1.2%), fabric convulsion (0.6%), others(6.5%) were found (Kapil D. Upadhya,1999).

At least about 20% 0f general population suffer from mental illness at any point of time. At least 2%of the population will be suffering from severe and treatable psychiatric illness. This means mental health problems are a major disease burden within the community. Proper treatment and care of mental disorders can reduce the disability significantly.

20% of all adult patients who present to the hospital, health center or health posts and who present with somatic symptoms show psychiatric morbidity. Proper diagnosis and treatment of these patients is not an extra work , effective treatment of these patients also means effective health service to the people.

More than 80% of newly diagnosed cases of epilepsy can now be successfully treated and controlled with anti-epileptic drugs (Phenobarbitone), an effective treatment for >50%of epilepsy cases at primary health care level (Ibid,p.40).

He found till 22August,1999, that 276(43.6%) epilepsy,84(13.21%)psychosis , 224(35.22%)depression,34(5.35%) anxiety neurosis, 12(1.89%) hysteria,6(0.93%) others impairments from Kaski, Syangja, Tanahaun,and Baglung hospitals who are on regular treatment and follow up; cases cured , referred or defaulter are not included.

In another study, S.K. Khandelwal and et al.(1999) had found depressive disorder16(20%), mixed anxiety and depressive disorders 9(11.25%), suicidal attempt5(6.25%),alcoholism 8(10%),delirium9(11.25%), dementia 7(8.75%),mental retardation 2(0.5%), having no psychiatric illness24(30.0%).All of them were interviewed clinically to determine their psychiatric diagnosis as per ICD-10.

Thirty percent of cases received no psychiatric diagnosis, while as much as 70% received a psychiatric diagnosis and 20% of cases were diagnosed to have depressive disorders and including major depressive disorders (11.25%) , when cases of suicidal attempts (6.25%)were combined with the category of depressive disorders, then depressive illness in this sample reach37.5%. These data was collected from BPIHS hospital, which is situated in the western region of Nepal. Many studies have found quite a high prevalence rate for depressive disorders in medically ill patients ranging from 20-40 % (Kathol & Petty, 1981:Mayou&Hawton,1986: Rodin &Voshart, 1986) very similar to our rates. (S. K. Khandelwal, 1999).

similarly, S. K. Regmi & et al. (1999), found that , mostof the service seekers were those who were suffering from neurotic , stress-related and somatoform disorders (42%), followed by the patients suffering from mood disorders (37.23%) , schizophrenia, schizotypal and related disorders (8.7%) and mental and behavioral disorders due to use of psychoactive substances . The largest diagnostic group in the 150 patients attending the psychiatric O.P.D. was neurotic and related disorders (anxiety neurosis 12.7%, adjustment disorder 2%, hysterical illness 2.7%, and somatization disorder 2%,)followed by depression and schizophrenia Nepal et al, 1986. Wright (1987) had found that 32% of the patients were suffering from epilepsy, 25%from psychosis and 13% from depression. Sharma(1987) described 42% of patients in his study to be suffering from depression, 17% from neurosis and 16 % from epilepsy. In the study by Shrestha

(1987) , 63.7% of the patients were suffering from psychosis, 18% from neurosis and 6% from epilepsy.
These findings are also similar to the findings of the study by Dube(1970), which was conducted in the rural community of Uttar Pradesh (India), in which about 44% of the patients were suffering from neurotic and related disorders and 9.1% from schizophrenia. However, the studies conducted in the out-patients in other parts of the world are rather similar to the finding of shrestha (1987) in which most of the patients were suffering from psychitic disorders and less were suffering from neurotic disorders (Choo, 1997,UYS et al, 1995), (S.K. Regmi,1999).

D. M. Shrestha et al, 1983 in their study in Kathmandu that reactive, somatoform disorders depersonalization disorders, and depression, have the highest prevalence amongst females. Out of 24 cases of reactive disorders 18 were females and 5 were males. similarly, out of 16 cases of somatoform disorders 15 were females and only one was male, and all of the depression and 2cases of depersonalization were female .
On the other hand, schizophrenic and substance use disorders were found exclusively amongst males. The rates for schizophrenic disorders are too low to test the significance of this finding. On the other hand, socio-cultural conditions clearly exclude females from the use of intoxicating substances. Though there is higher prevalence rate amongst males for epilepsy and anxiety disorders, the rates are also to low to make general observations and test for significance.
The cases of reactive and somatoform disorders tend to cluster amongst the 21-30 and
31-40 age groups, which correspond to their preponderance amongst females. However, as opposed to most studies, rates of depression do not increase with age with the highest rates found amongst the oldest age level. They are somewhat broadly distributed with the usual pattern of cases not being found in the lowest age-level. Schizophrenic and anxiety disorders are confined to the cluster amongst the 10-20 and 21-30 age groups.
Substance use disorders were diagnosed if there was excessive and habitual use of either alcohol or cannabis which disrupted the individuals social relation or were damaging to the emotional or physical well-being of the individual. The problem of alcohol use was found amongst in the 31-50 age groups, while rates of cannabis abuse were greatest in the 21-30 age group.
There was found misconception and wrong beliefs that for schizophrenia, bipolar affective disorders (manic depressive psychoses), somatoform disorders (i.e., conversion disorder-seizures) and epilepsy, people sought help, considered these cases seriously disruptive and were experience by individuals as extremely distressful, they are considered as form of madness (bahula), those who becoming 'mad ' are considered to act bizarre, speak irrationally become angry and often violent.
In the cases of madness people not only used local ritual treatment but sought the help of medical specialists while for those having fits or involuntary possession, treatment was obtained only from ritual curesrs whether successful or not.
The villagers believed that in the cases of schizophrenia and bipolar affective disorder, initially some form of witchcraft had occurred, and for treatment, the family sought the help of local ritual healers and worshipped certain deities(D.M.Shrestha & et al, 1983).
The study of Dr. N.M. Shrestha (2000) represents the trend of mental illness of the population, who are seeking help in hospital with supervision of clinical personnel as; undifferentiated schizophrenia 61(47.275%), paranoid 35(27.125%), catatonic 33(25.575). Among them, under15years of agel (0.775%),15-29 years 70 (54.250%), 30to 49 years 50(38.750%),50to64 years 6(4.650%)65years above 2(1.530%).Among them male 73(56.575%) female 56 (43.425%). Their marital status was married 83(64.325%), single 34(26.350%), widow/widowers/divorced/separated 12 (9.300%). It means 15to 49years and married male people seems more susceptible for schizophrenia than other age group, single and female.

Mental Retardation & Disability: Similarly, in a study of AWMR/Maryknoll Fathers, Kathmandu ,1998, found the highest percent of mental retardation and other disabilities among the Lama people of Humla district mid-western developmental region. 310(16%)of the total 2,225 families or 29 out of 31 families had one or more member with some kind of disabilities, and 50%of the families in Solukhumbu district had some problems of disabilities.

Among 237 mentally retarded individuals, 83(35%) had speech and hearing impairment, 32(13.5%) with speech, hearing and physical,26(11%) with speech impairment, speech impairments combined with other disabilities were the most common among the mentally retarded persons. Only 25% of the mentally retarded with other disabilities (adults) are found married where as 60% of the adults with handicaps without retardation are found married and there is no sex differences among the married mentally retarded adults. 11(5%) out of 237 mentally retarded persons were born to mothers at the age of 35 years and above. Thus late pregnancy is found to be one of the cause of mental retardation. 26(11%) of the total mental retardation causes were found to have low birth weight. 38(16%) and 14(12%) cases had premature and complicated birth respectively.18percent of the handicapped persons (both mental retarded & other disabilities) were born to mothers, whose health were in poor and difficult condition during their prenatal periods. Similarly 15% were born to mothers whose perinatal condition was difficult and poor.

It is found that 18%of mental retarded and other disable had poor postnatal, and 4% of serious infections during infancy and 10% had a history of chronic malnutrition due to various reasons as well as 29% had a history of prolonged fever during infancy and early childhood. Only 60% of the disabled people found to be engaged in either helping with domestic or doing some productive work. About 30to35% were not engaged in any type of work. Only 6to 7% needed some kind of regular supervision and care from other persons in the family (D.M. Shrestha & et al, 1989).

Emotional problems among general people: Simpson et al (1996) had found in their comparative study among Australian & Nepalese people that the Australian men and women did not differ significantly on the CES-D . However, the Nepalese men obtained significantly higher depression scores than women. Jenkins et al.(1991) argued that , with cultural change ,cultural biases against women become less sanctioned. These changes were noted in India by Jenkins et al. (1991) and they may also be under way in Nepal . Thus in the context Nepal's new cultural identity ,women may be less at risk of depression than men. In fact, Nepalese women actually had significantly lower depression scores than the Nepalese men found in the current study , a finding that contradicts most previous research . However, Carstairs & Kapur (1976) obtained a similar gender difference among villagers in India. In the study of P.L.Simpson&et al. , the Australian participants had higher life satisfaction scores than the Nepalese participants; In fact , among the Nepalese participants , depression was largely independent of life satisfaction .Negative emotion might be interpreted by the Nepalese as a normal feature of human experience , one that does not automatically lead to feelings of frustration or dissatisfaction . In contrast ,Australians may be more likely to include perceptions of negative emotion in evaluations of the quality of their lives (P.L. Simpson & et al.1996).

Another survey was conducted among the Tribhuvan University, Kathmandu, Nepal. It was found that 31.66% sample population had neurotic and 53.33% had shown depressive trend. Male students had higher possibilities of depressive trend than female students, but female students had higher possibilities of neurotic trend than male. So that more than fifty percent sample population need some kind of psychosocial or psychiatric support (R.K.C., S.N. Shrestha, D.M. Dongol, 2000).

Mental Disorders are projected to increase to 15% of the global disease burden, and unipolar major depression could became the second leading factor in the disease burden. World Health report 1999, presents the global disease burden as infection17.2% respiratory 10.7%, cardiac

10.5%, mental disorder 9.7%, substance use 1.8%, suicide1.6%, malignancy 5.8%, HIV 5.1% and others 37.6% (T. Bedirhan ustun,1999).

The people are involved in different pathological activities, gambling is also one of them. Studies of persons in gamblers anonymous or treatment facilities have estimated rates of pathological and problem gambling at between 7% and 14%, with increased comorbidity with depression, suicidal tendency, and substance abuse (Renee M. Cunningham-Williams, et al.1998). They had noted in their study, that in terms of psychiatric comorbidity, problem gamblers were more likely than non-gamblers to meet criteria for major depression, phobias, somatization "syndrome", antisocial personality disorder, alcoholism and nicotine dependence (Ibid, pp.1093-1095).Public conception or beliefs play an important role in shaping social responses to the people for mental illness .In one of their study , Bruce G.Link, & et al. noted that only the vignette depicting Paranoid schizophrenia was identified by a majority(75%), simple schizophrenia was identified as mental illness by only 34%, alcoholism by 29%, anxiety neurosis by 18%, "disturbed child" by 14%, and compulsive phobia by 7%. They had concluded their findings that "we find a strong connection between mental disorders and perceived likelihood of violence. This coupled with the fact that such perception is strongly associated with attitudinal social distance makes us pessimistic regarding the current status of public beliefs about mental illness. If the symptoms of mental illnesses continue to be linked to fears of violence. People with mental illness will be negatively affected through rejection, through a reluctance to seek professional help for fear of stigmatization, and through fear-based exclusion by processes such as the " not in my backyard" responsible. Perhaps we have begun the "veritable revolution" in people's ideas that star believed was necessary, but we are far from completing it."

It means the perception & attitude (Social or individual), play an important role for psychosocial impairment. In this context S.N. Shrestha , (2000), says " Attitudes influence perception and perception determines the course of actions or adjustments to different situations in life . Attitudes thus generate positive or negative valence to people, institutions, or events in life as a result of past pleasant or unpleasant experiences with them. when one is guided absolutely by the selfish motives with out any regard for others' sentiments, his personality loses sense of justice for others and his behaviors are directed accordingly toward others. No one in the world likes the lack of reciprocity from others because life on earth is sustained by emotional bond." So attitude need to correct positively to strengthen the emotional bonds, which are so vital for human existence in the society. In his PH.D, thesis, S.N. Shrestha (1988) had mentioned "The modern age of individualism " embraces much pressure in day today life. The collectivistic 'we feeling' has vanished and the individualistic 'I feeling ' has emerged. The result is domination of matter over mind leading to commercialization of human relations. Thus , the market prices are soaring high and the emotional bonds are breaking up as a result of which the 'individual' is pressurized by the overwhelming burden of "financial and emotional stresses". He had presented an interesting equations in which the entire situation can be depicted as; B=F(I)E, In which, B= Behavior, F= financial stress, I= Individual with all aspirations and intellectual endowments, and E = Emotional stress. It means, inability to cope with the overwhelming stress, the individual succumbs and reacts in psychopathological manner as; BN=F (I) E . In which, BN= normal behavior and

F(I) E = Individual dominating the financial and emotional stress.

Though there are several forms of abnormal behavior , the clinical experience reveals that man suffers mostly from depression, anxiety reaction and begin essential hypertension-the 'villainous triad' of the modern age of Individualism (S.N. Shrestha,1988).

Kline (1964), agreed that, the humanity has much suffered from depression than from any other single disease. Dunlop (1965) has revealed that the prevalence of depression is at least five times greater than that of schizophrenia. Sorenson & Stromgrem (1961) have discovered that 3.9% of the population above 20 years of age suffers from depression at some specified time in life.

Grinker &et al. (1961), have revealed that depressive cases including both neurotic and psychotic depressions constitute 50% of the first admission to private hospitals and clinics (Ibid).

Depression in the older population is a major health issue, both because of its high prevalence and because of its adverse health consequences. About 12% to 20% of community- dwelling older persons suffer from symptoms of depression (Broadhead & et al. 1990&Boekman,& et al. 1995).

Depressed persons are likely than nondepressed persons to engage in unhealthy behaviors, such as; smoking,, excessive alcohol intake, physical inactivity, and unhealthy eating habits (Aneshensel C. Huba G,1983,). It may cause worsened health status over time. Depression may also discourage persons from obtaining adequate medical attention and social support, which in turn may result in a decline in physical health (Brenda & et al.1999). He found that depressed persons were slightly older, were more likely to be female, were less educated having lower incomes than nondepressed persons. At base line, the mean age of the sample was found 72.8 years (SD=5.9), with range of 65to 103 years; 58.7% were female; 43.7% had fewer than 9 years of education and 25.5% had a household income below $5000.

A slightly higher percentage of depressed subjects (89.8%) than of non-depressed subjects (79.8%) had seen their physician in the year before base line (Ibid).It has been hypothesized that depressed persons are less likely than others to seek medical treatment (Katon W. Sullivan ,1990,).They persistent somatic symptoms of depressions ,such as; fatigue, and pain, may effect physical disability levels over time . Depressed persons tend to amplify these somatic symptoms (Ibid).

War and violence related emotional problems: The horror of the concentration camps during the Nazi persecution in the second world war was surely beyond normal imagination, and only those who actually experienced it were able fully to understand its extent. The same is true for torture, and it has been questioned by Forest (1982) whether the psychological experience and mental consequences can be fully unveiled through medical and psychological examination. The most important aspects of torture are almost never told in the testimonies. Torture is such a violent experience that it leaves a wound so deep that it is very difficult to heal and might persist for many years(Danish Medical Bulletin, 190,p.28).

Danish Medical Association studied the mental symptoms and mental complaints at the time of torture that they were registered in 136 persons (68%) fear due to arrest and torture has not been included. Sleep disturbances were the most frequent complaints 103 persons (51%). Nightmares were the commonest sleep disturbance reported by 80 , difficulty in falling by 54 and interrupted sleep by 32 persons respectively.

Anxiety was the next most frequent mental symptoms (52persons)followed by irritability (48 persons), 37 persons (18%) reported severe depression, in 24 of these cases suicidal wishes were presented , and in 8 cases actual suicide attempts were described.

14 persons described hallucinations in connection with the torture and detention. They were purely visual in 9 cases, audiovisual in 3, visual and olfactory in 1, and auditory in 1. The circumstances leading to the hallucinations were described as follows:

Six persons developed the hallucinations after very hard and intensive torture 2to 14 days (median 3days) after the arrest and start of torture. Two persons suspected that the hallucinations resulted from taking "secret" medication, without a medical indication. In the future 2 persons, the hallucinations began during psychiatric treatment of other mental symptoms, including depression and suicidal attempts. In one case, visual hallucinations began in relation to a head injury inflicted by the torture. One person, who also attempted suicide, developed visual and olfactory hallucinations about food during a long period when he was blindfolded. Two women developed visual hallucinations 2-3 weeks after the arrest: in one the hallucinations began after

she was forced to witness the torture of a cell mate; the other, who attempted suicide after being set free , was later admitted to a mental hospital for treatment.
Four persons with hallucinations were later admitted to psychiatric hospitals. At the time of torture, 24 persons (2 women and 22 men) complained of sexual problem. Twenty one persons received psychiatric or psychological treatment or both immediately after their release. Six persons were admitted to psychiatric hospitals: 4 persons with hallucinations have been described earlier, one person was admitted after 3days and nights without food or liquids, and one after serious trauma to the head. The highest prevalence was in the group aged 21 to 25 years, but the association with age was not statistically significant.

Emotional impairment in Nepal due to torture: In order to the treatment rehabilitation of torture victims, CVICT had reported in annual report of 1999,2000 and 2001 that depression 176,anxiety 82, psychotic disorders 26, PTSD 28, others 18, and number of psychiatric consultation 171 in 1999 but it seem to increase the cases in 2000 as; depression 188, anxiety 147, psychotic disorder 69, PTSD 20 and others 20 and 82(20%) depression, 76(18%) anxiety, 46(11%) psychiatric disorder, 21(5%) PTSD,8(2%) others psychiatric problems respectively (see in the table). This information signifies that torture or violence is also playing vital role to increase behavior disorders impairment in social adjustment due to traumatic experiences in the society.
Distribution of Psychiatric symptoms among the CVICT clients:

Psychiatric Problems	1999	2000	2001
Depression	176	188	82
Anxiety	82	147	76
Psychotic disorder	26	69	46
PTSD	28	20	21
Other Psychiatric disorder	18	20	8

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Similarly, Mark Van Ommeren,2000 had worked among the Bhutanes Refugees in Nepal. He had done a comparative study among tortured and non-tortured Bhutanese Refugees of 526 sampled population in each group. He found the following results of Post Traumatic Stress Disorders (PTSD) symptoms shown in the table:

Table: 1 Post Traumatic Stress Disorder (PTSD) symptoms among 526 Tortured and 526 Matched Non-tortured Bhutanese Refugees:

Post Traumatic Stress Disorder Symptoms	Tortured N= 526		Non-tortured N= 526		Statistic *	P
	N	%	N	%		
Recollections of the event	85	16	60	11	x2=4.4	.036
Distressing dreams of events	117	22	32	6	x2=51.5	<.0001
Re-experiencing	117	22	25	5	x2=64.7	<.0001
Distress when reminded of trauma	105	20	34	6	x2 =41.9	<.0001
Avoidance of trauma thoughts	140	27	19	4	x2=100.7	<.0001
Avoid situations reminding of trauma	156	30	13	2	x2=131.8	<.0001
Psychogenic amnesia	26	5	1	0	binomial	<.0001
Diminished interest in activities	61	12	25	5	x2=17.5	<.0001
Detachment from others	125	24	68	13	x2= 21.0	<.0001
Restricted affect	42	8	16	3	x2= 12.5	.0004
Sense of foreshortened future	100	19	24	5	x2=48.5	<.0001
Sleep disturbance	149	28	132	25	x2=1.3	.25
Irritability	142	27	99	19	x2= 9.0	.003
Difficulty concentrating	163	31	91	17	x2=28.3	<.0001
Hypervigilance	62	12	30	6	x2=11.7	<.0001
Exaggerated startle response	91	17	38	7	x2=26.7	<.0001
Physiological arousal	107	20	21	4	x2=63.4	<.0001

*The reported chi-square values are the result of Mc Nemar's chi-square tests (df=1). If fewer than 25 cases had different values for the two dichotomous variables, the binomial distribution was used to compute the significance level.

PTSD, Depression , and Anxiety Symptoms: With the exception of sleep disturbances and recurrent intrusive distressing recollections of the event the tortured refugees , as a group, suffered significantly more on each the DSM-III-R PTSD symptoms (see in Table). A diagnosis of PTSD was significantly more common in the tortured group than in the non-tortured group(14%v.3%;McNemarx2 (1)=40.6;p <.0001).

In addition, the tortured refugees as a group had significantly higher cumulative HSCL-25 Anxiety scores (17.9 (SD=6.1) v.16.4 (SD=43); paired-t(525)=4.8;P< .0001) and cumulative HSCL –25 depression scores (22.6 (SD =7.0)v 21.3 (SD=4.9); paired-t (525)=3.7; p<.001. Using a mean HSCL-25 item score of 1.75 as cut-off value, significantly more tortured cases had high anxiety scores (43%v.34%;McNemar x2(1)=8.1; p= .004) and high depression scores (25% v. 14%; McNemar x2(1)=19.6;p<.0001) (Mark Van Ommeren,2000, pp.43,44).

Over the last few years, Amnesty International has increasingly expressed concern about the deteriorating human rights situation in Nepal in the context of a Maoist insurgency that started in February 1996. Recently, Amnesty International and Nepal's national human right organizations have been drawing attention to the large number of extra-judicial killings, disappearances and torture by the police. It is found that the number of people died in Maoist insurgency is more than 657in 2001 and the Maoist had also killed about 388 people including police and civilians as well as they had tortured. It is clear that villagers are being victimized by the conflict (CVICT, 2001).

In this context, Center for victims of Torture Nepal (CVICT) had provided medical, psychosocial as well as legal rehabilitation services for 1290 torture survivors in 2001. Their most common physical symptoms included musculoskeletal symptoms (body ache, backache, joint pain, muscle pain), respiratory symptoms (chest pain, cough) and central nervous systems (burning sensation, headache, giddiness), Anxiety, sadness, irritation, suicidal feelings nightmares, fear of police, loss of appetite, and sleep disturbance are found to be the most common psychological symptoms. Among them 82(20%) had depression, 76(18%) anxiety, 46(11%) psychiatric disorder, 21(5%) PTSD and 8(2%) other psychiatric problems were found (CVICT, 2001).

During this period, most of the people in Maoist insurgency areas are being the victim of trauma, suffering from re-experiencing the traumatic event, dissociative flashbacks, avoidance of thought or feelings associated with the trauma, the avoidance of situations that arouse memories of the trauma, amnesia about the trauma, generally diminished interest in significant life activities, feeling of detached or estranged from others, a restriction of ability to feel intensely and pessimistic sense regarding the future, stressing that the end will come soon. The sufferer will also experience a state of hyper arousal, characterized by at least two of the following: difficulty sleeping, irritability or angry outburst, difficulty concentrating, hyper vigilance, an exaggerated startle response, physiologic reactivity when exposed to symbols of the trauma.

The symptoms must last at least 1 month, but when they occur the usually persist without proper treatment. They may occur years after the experience of the trauma, if they disappear, with or without treatment, they may recur even after symptom-free periods lasting decades. (Stephen M. Sonnenberg, 1988).

Stephen M. Sonenberg, 1988, says that soldiers who worked in safe areas, shipping the bodies of the war dead back to the United States, had a high PTSD casualty rate during Vietnam war. It means during the period of violence, there is high risk of PTSD problems in the community. So it is needed proper psychosocial support in Maoist insurgency areas as soon as possible.

Similarly, Wietse Tol, 2002, had found in his study that more than half of the torture survivors interviewed scored over the cut-off point of 50 or higher on the 17 items of the PCL-C (56%). Moreover, using the diagnostic criteria of the DSM-IV, two thirds of the population could be diagnosed with PTSD on a moderate level (67%), 47% suffered from PTSD on a severe level and 10% reached the PTSD diagnosis on an extreme level.

Three quarters of the population was in substantial emotional distress (74%). When anxiety scored 80% and depression scored 73%. Co morbidity was very high among the disorders. People who scored positive on the PTSD analysis also scored positive for anxiety in 64% of the cases. This percentage was about the same for depression, namely 62% (Wietse Tol, 2002, p.25).

For the Disability, in his report, people rated their health generally as moderate or bad in the last month (35% and 37% respectively).The rest rated their health as good(9%) and as very bad (12%). Moreover they reported that a health problem was currently generally severely or extremely interfering with their life in the last month (32% for both). The difficulties were present for a very varied number of days within this month, the mean amount was 18 days (SD=10.24).

Because of this health problem people generally had to cut down or reduce their usual activities. Most people could not perform any activities or had to reduce their activities for at least a week (62% and 64% respectively). Many people could not perform usual activities or had to reduce activities for more than two weeks (25% and 21%respectively). The unemployed population reported about the same interference with their activities as the employed population. Of the unemployed population half the population reported a disability level over 89.60 (severe, 49%). Within the employed population 48% reported being disability at or over this level (Wietse Tol, 2002, p.27).

Through these literatures, we can imagine the psychosocial trend of mental illness in Nepal. Such studies help further insight for the improvement of mental health of the people. Generally, people understand that health is only physical health. But mental health is also the integral part of health. Generally, people do not mention their mental problems to the doctor, only physical problems the are found to be mentioned. Mental health can not be neglected. From these studies, we may conclude that the trend of emotional problem is increasing day by day due to social unrest, political changes, population growth, rapid development of science and technology, war and violence, crime, commercializing attitude, individualism, loss of faith on humanity etc. which may be helpful to develop value conflict, low life satisfaction, cultural or traditional conflict, family or social conflict, financial and emotional or social stress, disruption of social norms and values, feeling of insecurity etc. Such situation may be the causes of emotional disorder that lead maladjustment and unhealthy coping behavior in the society, that may be irrational in normal life pattern.

Still now, Nepalese socio-cultural values are not improved toward the mental health, prevailing misconception and ill treatment toward the mental patients.

For public awareness about mental health, all of the health related personnel should work together in holistic approach by which people could be benefited most.

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3.5. HYPOTHESIS:

Natural disasters as well as war and violence or torture are responsible for Psychopathology especially Post traumatic Stress Disorder (PTSD) and Disability. PTSD characteristically included the experiences of traumatic event in repeated manner.
PTSD symptoms influence for psychosomatic problems as well as disabilities.
Psychological or Physical torture is responsible for PTSD and Disability.

3.6. ASSUMPTION:

People of Nepal are experiencing a number of unbearable painful trauma. This is the century of terror, violence and anxiety. Most of the countries in the world are involving in war and violence or terror. So, we can say that this is the century of terror, conflict and anxiety. In this unfavorable socio-political situation general people are experiencing different psycho-somatic problems such as; feeling of insecurity, loss of self confidence,family conflict, anxiety, depression, stress, PTSD, headache, low life satisfaction, worthlessness, suicidal tendency, etc. as the result of war, violence and terror as well as political or social conflict.
In this context the study will play an important role to assess the emotional distress and psychosocial problems in the present social situation. Most of the victims of torture, sexual abuse, domestic violence, rape accident and other natural disasters etc. may develop PTDS symptoms. They are extremely needed psychosocial intervention as well as physical treatment immediately. It may be the great influenced after starting the Maoist movement (since 1995) to the general people in Nepal.

3.7.DEFINITION:

Mental Disorder: The mental disorder is conceptualized as clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptoms) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Post Traumatic Stress Disorder (PTSD): A posttraumatic stress disorder (PTSD) characteristically include experiences that in some way repeat the traumatic event, often as intrusive ideas accompanied by unbidden feelings. This compulsive repetition may be associated with the other main set of symptoms.

Disability: Inability to work properly physically or mentally due to dysfunction of health condition in daily activities.

Anxiety Disorder: Anxiety disorders abnormal states in which the most striking features are mental and physical symptoms of anxiety or variety of phobic disorders.

Panic Attack: The sudden onset of intense apprehension fearfulness, or terror, often associated with feelings of impending doom.

Social Phobia: Inappropriate anxiety is experienced in situations in which the person is observed and could be criticized.

Disease: refers to objective pathology;

Illness: is subjective awareness of distress;

Sickness: refers to a loss of capacity to fill normal social roles.

Impairment: is an analogous to disease, referring to a pathological defect .

Disability : is the stable persistent limitation of physical or psychological function which results from impairment and the individual psychological reaction to it;

Handicap: is analogous to sickness, referring to continuing social dysfunction, arising from inability to fill individual and social exactions Michael Gelder et al.1983. p.58).

Torture: Torture is defined by CVICT as "the infliction of severe mental or physical suffering by the state's law enforcing institutions or armed oppositions, for any reason, on a person under the physical control of the perpetrator".

3.8. LIMITATION OF THE STUDY :

The sample population were collected among the out door patients having emotional problems of Mental Hospital, Lagankhel, Lalitpur, and Bheri Zonal Hospital, Nepalgunj, Banke as well as the patients seeking help in Centre for Victim of Torture (CVICT), Nepalgunj including health mobile camps in Kanchanpur, Rukum, Rolpa, Jajarkot, and Salyan districts. For this study 330 sample population were selected randomly from the population of having emotional disorders including male and female. Among them 30 were non-tortured sample population and 300 were trauma (torture) victims.

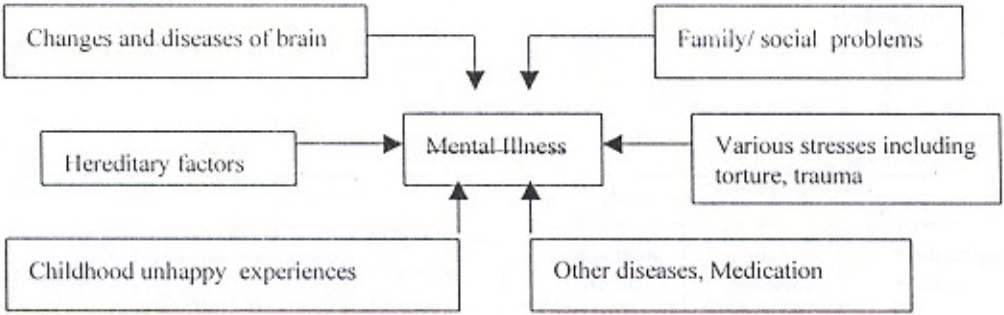
3.9. ORGANIZATION OF THE STUDY:

For this study, Center for Victim of Torture (CVICT), Mental Hospital and other related organizations are mostly thankful for providing the opportunity for the collection of sample population. Nepal Health Research Council / WHO, is thankful for providing the student grant for the study. The Department of Health and Physical Education, faculty of Education, T.U. is mostly respected for me to provide the opportunity for this study for M.Ed. degree.

Due to technical and financial problem, it took more than one year to complete the study, because this subject is so complicated.

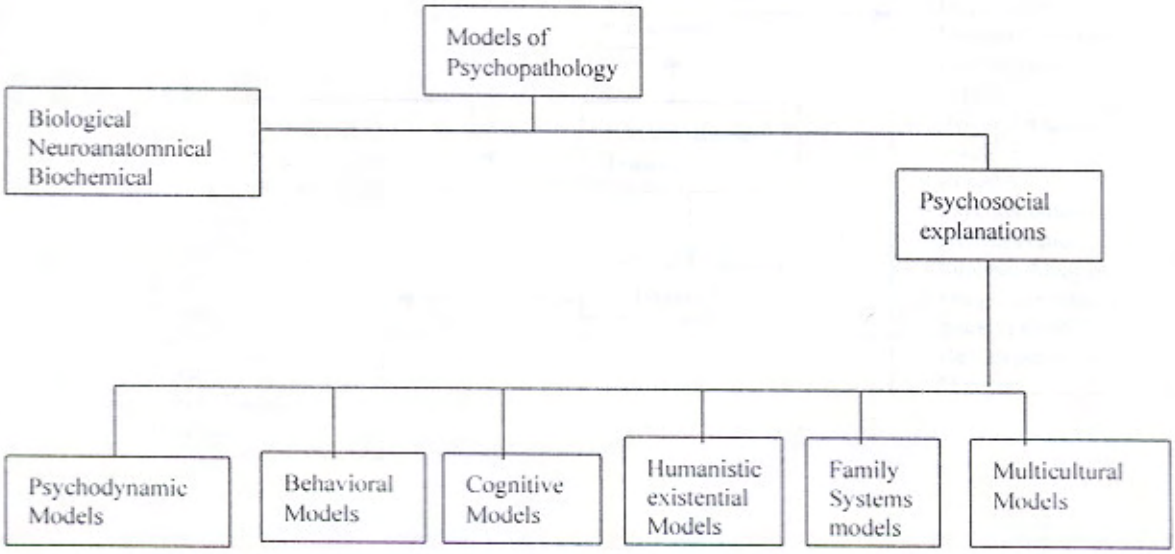
3.9.CONCEPTUAL FRAMEWORK

1.CAUSES OF MENTAL ILLNESS

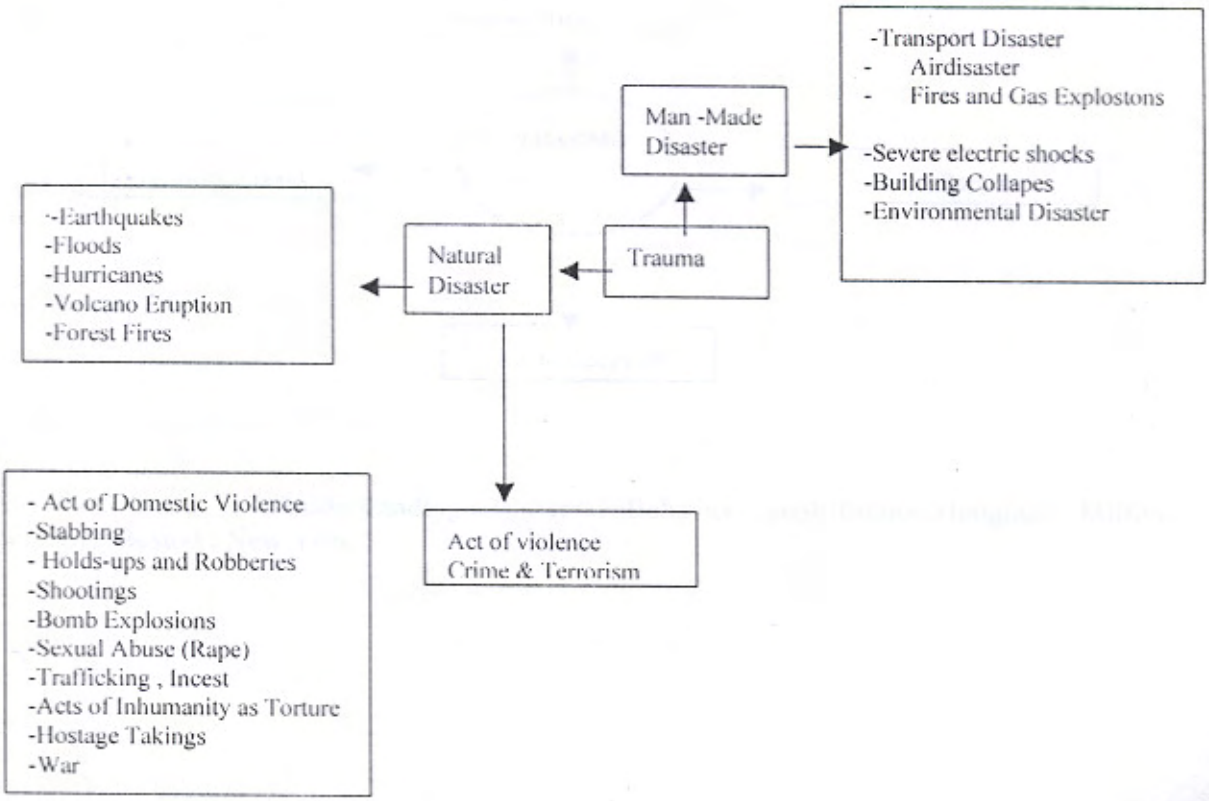


2.The Major Models of Psychopathology

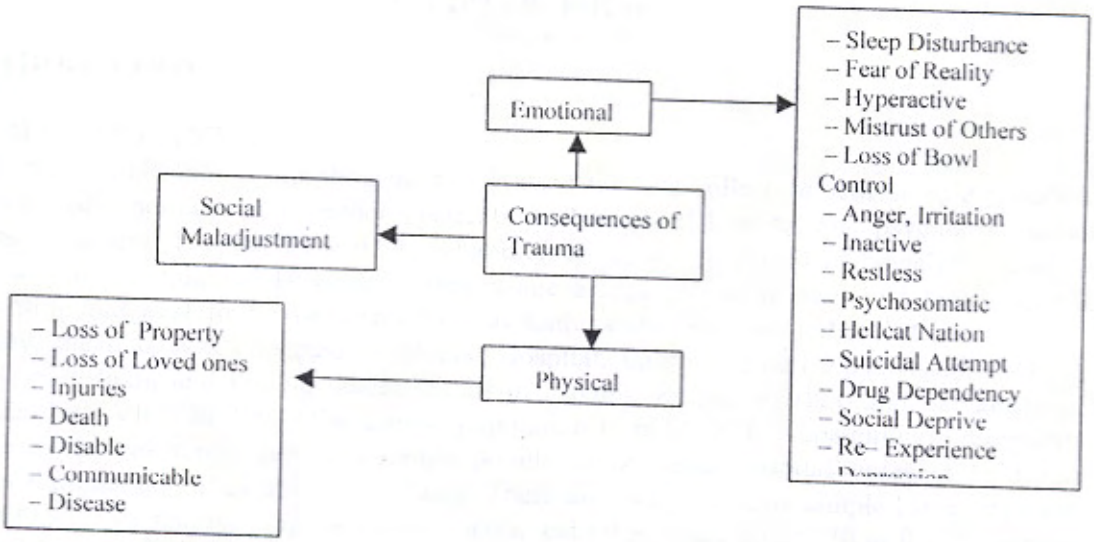
Attempts to explain abnormal behavior have resulted in more than a hundred explanations. The major models of psychopathology however are displayed here.



3. *CAUSES OF TRAUMA*

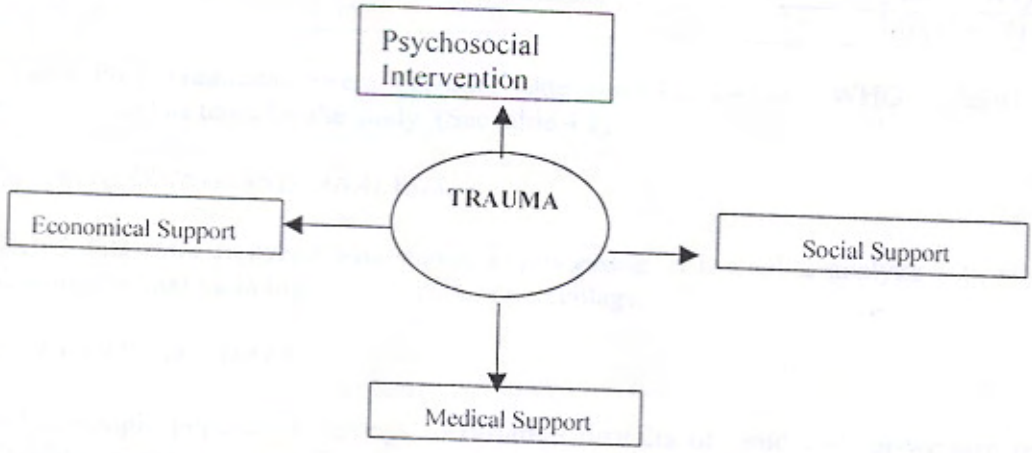


4.CONSEQUENCES OF TRAUMA



5.MANAGEMENT OF TRAUMA

(Holistic approach)



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CHAPTER- FOUR:

4.METHODOLOGY

4.1. DATA COLLECTION:

In this study random sampling method is used for data collection. The sample population were selected randomly from outdoor patients in the mental hospital and psychiatric outdoor patients in general hospital as well as rehabilitation center (CVICT) in Nepalgunj who had psychosomatic complaints. There are different age groups including male and female samples representing mid-western, far-western as well as Kathmandu valley and other districts.

Basically, the data was collected in Mental Hospital, Lalitpur, Bheri Zonal hospital, Banke, CVICT, Nepalgunj and mobile health clinics in Rukum, Rolpa, Jajarkot, and Salyan districts organized by CVICT in 2001. The sample population from CVICT, Nepalgunj are representing the mid and far- western region. The sample population of mental hospital represent the different districts Kathmandu valley and out of valey. There are two groups of sample , one large group (300 or90.90%) is representing the torture victim and other small group (30 or 9.10%) represent non-tortured population. Among them 268 (81.21%) male and 62(18.79) female respondents (See table 4.1).

Table: 4.1 DISTRIBUTION OF POPULATION FREQUENCY (District wise).

Sex	CVICT	Rolpa	Rukum	Jajarkot	Salyan	Hospital	Total %
Male	111	9	55	54	15	24	268(81.21)
Female	20	5	15	16	0	6	62 (18.79)

In this study Post Traumatic Stress Disorder Questions k22-k45,and WHO- DAS-II Core Questions were used as tools for the study. (See table 4.2)

4.2.DATA PROCESSING AND ANALYSIS:

The collected data were analyzed with statistical processing. It is tried to analyze with relevant data processing method includingchi-square, and percentage.

4.3. DESCRIPTION OF DATA:

The selected sample population belongs to different districts of mid and far-western region Banke, Bardiya, Surkhet, Dang, Kailali, Kanchanpur, Rukum, Rolpa, Salyan, Jajarkot Dailekh, Aacham, Kalikot, etc. who are torture survivors . Other hospital outdoor patients belong to Lalitpur, Kathmandu, Bhaktapur, Nuwakot, Kavre, Dhading, Udayapur, Siraha, Mahottari, Baglung, Banke, Bardiya, Kailali, districts etc. They belong to different age groups and education levels.(See table 5.1)

DISTRIBUTION OF AGE & EDUCATION:

Table : 5.1

Age Distribution (Yrs.)	N	%	Educational level	N	%
>15	2	(0.6)	Literate	100	(30.3)
16-30	142	(43.03)	Illiterate	96	(29.09)
31-60	179	(54.24)	Under SLC	74	(22.42)
<60	7	2.12)	SLC	28	(8.48)
			College	32	(9.7)
N.	330	(100)		330	(100)

In the study, there were two groups of tortured and non-tortured individuals. They were experiencing the emotional impairment and seeking the help of psychiatrist or psychologist . Most of the torture survivor were found to have the symptoms of post traumatic stress disorder (PTSD) but less among the non-tortured individuals. Among the total sample population 2(0.60%) had direct combat experience, 30(9.09%) had witnessed someone being badly injured or killed or raped, 1(0.30%) was raped, 6(1.82%) experienced of touching genitals by others against their will. 57 (17.38 %)respondents were seriously physically assaulted, 204 (62.19%) were threatened with weapon, hold captive or kidnapped and 286(87. 19%) were tortured respectively. Most of them were experienced different types of psychosocial or emotional trauma once in their life and developed the symptoms of posttraumatic stress disorder (PTSD) . After the event 288(96.65%) of torture victims experienced recollection of the event, 280(93.96%) distressing dreams of event, 291(97.65%) re-experience, 289(96.98%) distress when reminded of trauma, 241(81.88%) sweating, heart beat, tremble, when reminded of trauma, 296 (99.33%) avoidance of trauma thoughts, 239(80.20%) avoidance of situations reminding of trauma, 99(33.22%) psychogenic amnesia, 235(98.86%) diminished interest in activities, 232(77.85%) detachment from others, 185(62.08%) restricted affection,262(87.92%) sense of foreshortened future, 261(87.58%) sleep disturbance, 267(89.60%) irritability and anger, 271(90.94%) difficult concentrating , 241(80.87%) loss of interest for social participation, 247(82.88%) exaggerated startle response etc.

Among the non-tortured respondents, the symptoms of PTSD were found but less than torture survivors. (See table 5.2.).

4.3.1. DATA Collection Method :

In this study 330 sample population were selected randomly and interviewed them . Among Them 30 (9.10%) population belonged to mental hospital Lagankhel and Bherizonal hospital, Banke and 300 (90.90) Sample population were selected from center for victims or Torture (CVICT) , The rehabilitation center for torture victims They were selected from the group of having psycho-somatic complaints. Among them 267
(80.91%) were mail and 63 (19.09%) female representing different districts or western part as well Kathmandu valley See table 4.1 .

Basically the data was collected in mental hospital and Bherizonal hospital for non –torture group and from CVICT in the health mobile clinic in Rukum , Rolpa, Jajarkot and salyan were main source of torture group of sample population . The sample population from CVICT Nepalgunj are representing of mid and far-western regions of different districts or sample population there from mental hospital represents adjoining districts of Kathmandu valley and the sample population from Bheri zonal hospital represent adjoining districts Banke .

Table No. 4 .1
SAMPLE POPULATION DISTRIBUTION:

Tortured						Non-tortured	Frequency
Sex	CVICT	R ukum	Jajarkot	Salyan	Rolpa	Hospital	T %
Male	110	55	54	15	9	24	267 (80.91)
Female	21	15	16	0	5	6	63(19.09)
N							330(100%)

Among them 30 sample population including 24 male and 6 female respondents belonged to non torture group and 300 respondents including 243 male and 57 female belonged to the tortured group of having different psychosomatic complaints. This sample population represents the different ethnic groups as well as age and education level too, see table 4.2 Age and education level .

TOOLS:-

In this study B post- TRAUMATIC STRESS DISORDER, QUESTIONS K22-K45 was used to detect the PTSD reactions and WHO- DAs -П core questions was used detect the condition of disability among the psychiatric patients. See table 4.3 see in appendix –1 in detail (see in table 4.2) .

Table 4. 2 Tools and Sex Distribution

Tools Used	Sample	Size	Total
1. Post–Traumatic stress Disorder Questions K 22–k 45 Composite International Diagnostic Interview (CIDI) WHO, 1996.	Male 267	Female 63	 330
2. WHO–DAs-Пcore Questions (Disability)			

Reference

1. World Health organization (WHO), 1996, composite Internal Diagnostic interview (CIDI) interviewer 's Manual & core version 2.0 Post-Traumatic Stress Disorder Question's K 22 –K 45

2 . WHO, WHO-DAS П core Questions .

4.3.2. DATA PROCESSING AND ANALYSIS:

In this study, the collected data were processed in to relevant statistical tool and described in tables .

CHAPTER – FIVE

5. PRESNATION OF DATA.:

5.1 DESCRIPTION :

The findings and statistical products are presented in relevant chart and in tables to describe the data.

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5.2 *Survey Finding*:

In this study, the sample population were selected from different districts representing mid and for western regions as well as Kathmandu valley and adjoining districts. Such as Banke, Bardiya Kailali, Kancharpur Dang Salyan, Rolpa Jajarkot Rukum, Dailekha , Baitadi Adcham Kalikot etc. They were trauma victim or torture group . The other group of non-tortured sample population were selected an the mental hospital out door patients and psychiatric out door patients from Bheri Zonal Hospital, Nepalgunj. They represent from Lalitpur, Kathmandu, Bhaktapur, Nuwakot , Kavre, Dhading Udayapur, siraha, Baglung, Mahttari Banke, Bardiya, Kailali etc. They belong to different ethnic groups, age groups, and sex.

In this study, there were two types of sample population were selected. In the first group there are 300 respondents were selected among the trauma victims and in another group only thirty respondents were selected from the general psychiatric out door patient to detect the trued of trauma and disability with in the groups for both groups same tools were used PTSD check list & disability .
Check List (see Table 4.3)

5.2.1 PTSD among the torture victims:

In the first group, the sample population who were trauma victim consisting 243 (81%) male, and 57 (19%) Female among these sample population 2 (0.67%) respondents had direct combat experiences in the 12(4%) respondents had experiences of life threatening accident 30 (10%) respondents had witnessed some or being badly injured or killed. 1(0.33%) respondent was rapped, 6 (2%) respondents had bitter experiences of the touching their genitals against their will or tried to rape, in this group the large number of respondents were seriously physically assaulted threatened with weapon hold captive or kidnapped and tortured 58 (19.33)205(68.33%) respectively.

After experiencing such types of traumatic event they had developed certain types of psychosomatic symptoms which were detected by the used of PTSD checklist and Disability checklist.

Almost they had multiple psychosomatic complaints such as 290 (96.66%) respondents had positive response of having the symptom recollection of the event 282 (94 %) had distressing dreams of event 293(97. 66%) had experiencing 291(97%) had distress when reminded of trauma, 293(97.66%) had symptoms of sweating, heart beat, tremble when reminded trauma. In their mind frequently come the thoughts of avoidance trauma for 298 (99.33%) situational reminding trauma for 241 (80.33%) responded. Among them 99(33%)had complaints of experiencing of psychogenic amnesia 237 (79%) had diminished interest in activities, 234 (78%) had complaints of restricted affection Among the sample population 24 (88%) respondent had positive response for having sense of foreshortened future, 263, (87.66%) sleep disturbance, 268(89.33%) mutability or anger, 273 (91%) had difficulty in concentration 249 (83%) had exaggerated starter response 243 (81%) had loss of interest for social participation . Among them 287 (95.67%) had complaints of being upset for the problem for 234 (78%) respondents felt the interference of day to day activities by such problems. Among them

99(33%) respondents had head injury and 158 (52.67%) were being unconscious during event (torture) 274 (91.33%)had concurred much more danger.
After the event 64 (21.3 3%) had told their problems to the doctor and 74(24.67%) told to the professionals in account of their treatment,71(23.67%)had drugs or alcohol to control their mental or physical problems before gong to doctors or professional s. (see table 5.3)
Due to negative social attitudes towards mental illness, people do not like to expose their problem, because it loose social status after having mental problems.
Only severe types of mental patients used to consult mental hospital or psychiatric clinic otherwise minor emotional disorders are not considered as illness. General public have misconception about the conditional disorders or mental illness that ill fate or with or may cause of emotional disorder.
They had developed such symptoms in different frequencies after the exposure of event among them 39 (13%) respondents had experienced such types of emotional problems form the same day event 171(57%0 respondents had experienced such problems within a week after the event 27 (9%) experienced within a month after the event 30(10%) within six months, 2(0.67%) experience such problems within a year and 6 (2%) respondent had experienced after more than a year of events .
Among 300 trauma survivors 5 (1.67%) had lasting such problems for less than one month 17(5.67%) respondent had experienced for less than 6 months 15 (5%) respondents had experienced such problems for less than a year had experienced such PTSD symptoms for more than a year or having delayed type of PTSD symptoms. (See in table 4.4)

5.2.2 PTSD among non-tortured population:

Similarly, Among The non tortured group (30 or 9.09%) of total population (330), 11 (36.67%) respondents had answered positively for recollection of the event, 16 (55.33%) respondent had the feeling of distressing dreams of event , 10 (33.33%) respondent had the symptoms of re-experiencing. 11(36.67%) 17(56.67%) 15(50%), 7 (23.33%), 3(10%) , 19 (63.33%), 16(53.33) respondents had experienced distress when reminded of trauma ,Avoidance of trauma thoughts, avoidance of situations reminding of trauma psychogenic, diminish interest in activities and detachment form others respectively in this way, they had responded for restricted affection sense of foreshorten future sleep disturbance, irritability /anger, difficult for concentration ,exaggerated startle response and loss of interest for participation in social function are 11 (36.67 %), 14(46.67%), 19 (63.33%), 18(26.67%) 15 (50%) and 19 (63.33%) respectively . Among them 3 (10%) respondents had experienced such feelings form the same day of event, 3 (10%) in that week, in that month, 1(3.33%) respondents had experienced such symptoms for less them year for less them year and 14 (46.67%) respondent had experienced for them 1 year.

From this finding we can discuss about the severity of traumatic experiences is increasing among the tortured population rather than non- tortured population. During the Maoist movement in Nepal large number of population are being experienced trauma, mostly in the Maoist affected regions. Among 300 respondents 263 (87.67%)respondent found delayed type of posttraumatic stress disorder,in which they are suffering form such symptoms for more then one year . It means large number population in Maoist affected regions needed psychosocial intervention with medical treatment. They are out of reach to achieve psychosocial as well as medical support among the non tortured population, small number in general population are found trauma victim of accident natural disaster, domestic violence rape etc. present context in Nepal
After the event, most of the torture victims experienced different type of psychosomatic or medically unexplained problems and develop the symptom of disability,(see in table 4.5)

5.2.3 Disability among tortured population:

Such type of respondents were found of having multiple psychosomatic complaints so, it is tried to asses the level of disability at same time for same respondents.

Among the 300 trauma survivors only 8(2.67%) had experienced good overall heath in past 30 day 45(15%) had experience moderate 212(70.67%) bad and 35(11.74%)had very bad. 7(2.33%) had experiencednone,26(8.67%) had mild, 24(8%) moderate 158(52.67%) severe and 85(28.33%) had extreme difficulty in standing for a long period (30minutes).For taking care of house hold respond sibilates, 14 (4.7%) had experienced no any difficulties,17(5.67%) mild,22(7.33%) moderate182(60.67%) sever and 12 (4%) had felt extreme difficulties . Due to their health problem for learning new task 36(12%) had felt no any problems, 26 (8.67%) mild, 35 (11. 67%) had felt moderate, 166(55.33%) had felt severe and 37 (12.33%) had experienced severe difficulties.

Similarly 31 (10.33%) had no any problem for joining community or social activities but 28 (9.33%) had mild 36 (12%) moderate, 161 (53.67%) had severe and 44 (14.67%) had extreme difficulties.

Due to Physical health problem 6 (2%) had no any affect in mental health or emotional heath ,but 8 (2.67%) had mild 25 (8.33%) had moderate 211 (70.33%) had severe and 50 (16 . 67%) had extreme affect emotion only . Among the them 26 (8.67%) had felt no any concentration problem ,but 20(6.67%) had mild, 33 (11%) had moderate 177 (59%)had severe and 44 (14.675) had extreme difficulties in concentration for ten minutes or longer. For walking long distance (for 15 minutes or longer), 26 (8.67%) had felt no any difficulties but 32(10.67%) had mild 48 (16%) moderate, 150 (50%) severe and 44 (14. 67%) had felt extreme difficulties . For bath and getting dressed 75 (25%) and 68 (22.67%) had felt no any difficulties but 44 (15.33%) and 63(21%) had mild 80 (26.67%) and 69 (23) had moderate ,85(28.33%) and 83 (27.67%) had severe as well as 14(4.67%) and 17 (5.67%) had extreme difficulties .

For dealing with unknown person and maintaining friendship 34 (11.33 %) and 69 (23%) had no any difficulties, but 42 (14 %) and 35 (11.67%) had mild 48 (16%) and 53 (17.67%) had moderate, 135(45%) and 123(41%) had severe as well as 41 (13.67%) and 20 (6.675) had felt extreme difficulties. For day to day work and overall difficulties interfere with life 17(5.67%) and 7 (2.23%) had no any interference with life, but 31 (10.33%) and 15((5%)had mild, 59 (d19.67%) and 27 (9%) had moderate 159 (53%) and 195 (65%) had severe as well as 34 (11.33%) and 50 (18.67%) had extreme difficulties respectively.

Among them 43 (14.33%) respondents were suffered from these difficulties for within a week, 72 (24%) respondents were suffered for within two weeks, and 91 (30.33%) suffered for within a month in the past 30 days within past 30 day 89(29.7%) were being totally unable to came out their usual activities or work because of any health condition for within a week 54 (18%) for within 2 weeks 38 (12.67%) for within a month. Only 181 (60.33 %) felt totally unable to carryout usual work

Among them 65 (21.67%) respondents had cut back or reduce their usual activities or work for with a week, 41 (33.33%) respondents had cut back for within weeks and 32 (10.67%) had cut back for within a month because of any health condition only 138 (46%) respondent had cut back or reduce usual activities or work because of health condition, but 162 (54%) respondent s didn't felt so.

5.2.4 Disability among non-tortured population:

Among the non-torture population, 16 (53.33%) respondents ad feeling bad overall health in past 30 days 8 (26.67%) respondents has feeling difficult standing for long time (30m.) similarly 7 (23.33%), 6 (20%) 10 (33.33%) 11 (36.67%)6(20%) 5(d16.67%) respondent were felt difficult for taking care of house hold responsibilities, learning new task, for joining social

activities, emotions affect by health problem concentration and long distance (15 m.) respectively. Similarly 2 (6.67%) 2(6.67%) 8 (26.67%) 5 (16.67%)4 (13.33%) 15(50%) respondents had felt difficulties in bath getting dressed, dealing with unknown person, maintaining friendship day today work, as well as overall difficulties interfere with life respectively (see in table 4.5) .

This finding shows the relation between traumatic symptoms and disability symptoms. So in order to rehabilitate the trauma victim both physical as well as psychosocial problems should be managed or treated carefully in integrated holistic manner.

Table 4.4

Posttraumatic stress Disorder (PTSD) Symptoms among tortured and non-tortured sample population.

Post Traumatic stress Disorder Symptoms	Tortured (N=300)		Non tortured (N=300)			
	N	%	N	%	X2 of %	P.0.01 (6.635)
Recollection of the event	290	96.67	11	36.67	26.10	<0.01
Distressing dreams of event	282	94.20	16	53.33	10.77	<0.01
Reexperiencing	293	97.67	10	33.33	30.62	<0.01
Distress when reminded of trauma	291	97.00	11	36.67	26.33	<0.01
Sweating, heart beat, tremble when reminded of trauma	293	97.67	17	56.67	5.18	>0.01
Avoidance of trauma thoughts	298	99.33	15	50.00	15.64	<0.01
Avoidance of situation reminding trauma	241	80.33	7	23.33	30.25	<0.01
Psychogenic amnesia	99	33.22	3	10.00	11.42	<0.01
Diminished interest in activities	237	79.00	19	67.33	1.49	>0.01
Detachment from others	234	78.00	16	53.33	4.26	>0.01
Restricted affection	187	62.00	11	36.67	6.37	>0.01
Sense of foreshortened future	264	88.00	14	46.67	12.07	<0.01
Sleep disturbance	263	87.67	19	63.33	3.6	>0.01
Irritability /Anger	268	89.33	18	60.33	5.37	>0.01
Difficulties in concentration	273	91.00	18	60.00	5.96	<0.01
Exaggerated startle response	249	83.00	15	50.00	7.69	<0.01
Loss of interest for social participation	243	81.00	19	63.33	1.92	>0.01

Chi- square is drawn from the percentage of the data between tortured and Non-tortured sample population because sample population were not equal of two groups. (D.f.= 1).

The product of Chi-square seems significant except some of them, such as, hyper arousal (Sweating, heart beat etc.), loss of interest in activities, detachment from others, restricted affection, sleeps disturbance, irritability/anger, and loss of interest in social function. It may be the cause of common reaction reactions to other psychiatric problems.

Note: Among tortured sample population, the types of PTSD reaction can help for the diagnosis as follows:

Acute type PTSD –22 (7.33%) ,symptoms last less than 3 months.
Chronic type PTSD – 15 (5 %), the symptoms last 3months or longer.
Delayed type PTSD - 263 (87.67%), the symptoms last more than a year.

Table: 4.5 Disability symptoms among tortured (300) and non - Tortured (30) sample population.

	Very good	Good	Moderate	Bad	Very bad
Overall health		8(2.67%) *1(3.33%)	45(15%) *13(43.33%)	212(70.67%) *16(53.33%)	35(11.67%)
	None	Mild	Moderate	Severe	Extreme
Standing for long period	7(2.33%) *2(6.66%)	26(8.67%) *8(26.67%)	24(8%) *11(36.67%)	158(52.67%) *8(26.67%)	85(28.33%) *1(3.33%)
Taking care of house	14(4.67%) *2(6.67%)	17(5.67%) *9(30%)	22(7.33%) *14(46.67%)	182(60.67%) *7(23.33%)	12(4%)
Learning new task	36(12%) *2(6.67%)	26(8.67%) *9(30%)	35(11.67%) *11(36.67%)	166(55.33%) *6(20%)	37(12.33%)
Problem in joining social function	31(10.33%) *1(3.33%)	28(9.33%) *9(30%)	36(12%) *11(36.67%)	161(53.67%) *10(33.33%)	44(14.67%)
Emotionally affected by health problem	6(2%)	8(2.67%) *2(6.67%)	25(8.33%) *16(53.33%)	211(70.33%) *11(36.67%)	50(16.67%)
Concentration for ten minutes or more	26(8.67%) *1(3.33%)	20(6.67%) *10(33.33%)	33(11%) *12(40%)	177(59%) *6(20%)	44(14.67%) *2(6.67%)
Walking for ½ hrs.	26(8.67%) *3(10%)	32(10.67%) *16(53.33%)	48(16%) *5(16.67%)	150(50%) *5(16.67%)	44(14.67%)
Problem in bath	75(25%) *14(4.67%)	46(15.33%) *8(26.67%)	80(26.67%) *6(20%)	85(28.33%) *2(6.67%)	14(4.67%)
Problem in getting dress	68(22.67%) *16(53.33%)	63(21%) *8(26.67%)	69(23%) *4(13.33%)	83(27.67%) *2(6.67%)	17(5.67%)
Dealing with unknown person	34(11.33%) *5(16.67%)	42(14%) *10(33.33%)	48(16%) *7(23.33%)	135(45%) *8(26.67%)	41(13.67%)
Maintaining friendship	69(23%) *9(30%)	35(11.67%) *13(43.33%)	53(17.67%) *3(10%)	123(41%) *5(16.67%)	20(6.67%)
Problem in daily work	17(5.67%) *2(6.67%)	31(10.33%) *13(43.33%)	59(19.67%) *11(36.67%)	159(53%) *4(13.33%)	34(11.33%)
Overall difficulties interfere with life	7(2.33%) *1(3.33%)	15(5%) *2(6.67%)	27(9%) *11(36.67%)	195(65%) *15(50%)	56(18.67%)

-Note: * symbol denotes non-tortured sample population, and without any symbol denotes tortured sample population.

Difficulties present overall in the past 30 days:

For: 1 week - 28

2 week - 61

1Month – 79

Difficulties present Overall in the past 30 days:

1 week - 81

2 week - 54

1 month – 1

Cut back or reduce usual activities or work because of any health condition:

1 week - 50

2 week - 31

1 month - 32

CHAPTER: VI

6. DISCUSSION & CONCLUSION:

In the references to the broad view point of socio-political, cultural, ethnical, religious, geographical, educational, poor economical, health and different other aspects, such types of studies play an important role in the field of public mental health.

At the present situation, people are feeling insecurity in their own home or home country due to the unending series of terror or violence. The people are killed or kidnapped from their home, some are being refugee in their own country, some women are being the victim of rape, some unlucky children are loosing their parents, some people are being disable. Certainly the situation is being extremely terrible for those people who are living in such conflicting areas. This study also represent those unlucky people who are living in terror and violence situation.

From this study, we can say that most of the people are suffering from mental as well as physical problems due to terror and violence in the Maoist affected areas. Mainly, they are suffering from anxiety, depression, PTSD, as well as disability with other emotional reactions. Regarding the psychological consequences of torture or violance, the first hypothesis, it is clear from the results there is a high prevalence of psychopathology within this population, (especially PTSD and Disability). In the similar context wietse (2002) had found in his study that PTSD was highly prevalent as well as anxiety and depression and highly experienced disability in daily life within the conflicting areas in Nepal.

In the study, it is found that, the level of psychopathology among the people living in conflict areas and who have been tortured because of this conflict ,clearly signals a need of proper treatment for this population.

The study of Mark Van Ommeren among Bhutanese refugees, and Wietse's study, 'PTSD was highly prevalent as well as anxiety and depression.' in conflicting areas of Nepal. That also support positively for this result that there are both psychological as well as physical consequences are lasting in their life for the torture victims.

In this study, the psychosocial trend of PTSD and Disability, symptoms are higher in tortured population rather than non-tortured population. CVICT report also shows that tortured population is highly prevalent for psychosomatic or psychopathological problems.

In this study, between two groups of sample population (tortured and non-tortured), tortured population found severe problems of PTSD and disability rather than non-tortured population. Among the non-tortured population (getting treatment in mental or general hospital) found the similar symptoms (such as sleep disturbance, irritation, loss of interest in social function, loss of concentration etc.) due to other psychosocial problems rather than trauma. But most of the tortured population has the symptoms of psychopathology (PTSD, Anxiety, Depression, Feeling of Disability as well as functional problems etc.) related to trauma.

In the conclusion, CVICT's work in this field is highly appreciable, but it is not sufficient. So it is recommended that to provide the community mental or general health services for their crisis intervention (psychologically or physically) in the conflicting areas by concerned organization as soon as possible. Because, terror and violence always affect to the member of the whole community.

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APPENDIX

TOOLS OF STUDY

I. PTSD CHECKLIST

II. WHO-DAS , DISABILITY CHECKLIST

PTSD CHECKLIST

Section K

K22 Now I would like to ask you about extremely stressful or upsetting events that sometimes occur to people. Some events like that are listed on Card K1.

अब म तपाईलाई मानिसहरूमा कोही बेला हुने सारै नराम्रा अथवा साह्रै दुःख लाग्ने घटनाहरूका बारेमा सोध्न चाहन्छु ।

[Only the first sentence was translated.]

ASK K22.1-K22.11. CODE IN COL. I.

	COL.I		COL.II WORST EVENT	
	NO	YES	NO	YES
1. Did you ever have direct combat experience in a war ? तपाईले कोही बेला लडाइमा सिधै भिड्नु परेकोथ्यो ?	1	5	1	5
2. Were you ever involved in a life-threatening accident ? तपाईको जीवनलाई नै खतरा पुऱ्याउने दुर्घटनामा कोही बेला तपाई पर्नुभो ?	1	5	1	5
3. Were you ever involved in a fire, flood or other natural disaster ? आगलागी, भेल, बाढी, पैरो वा अरू घटनाजस्तै भुइचालो, चटघाङ इत्यादिमा तपाई कोइबेला पर्नुभो ?	1	5	1	5
4. Did you ever witness someone being badly injured or killed or raped ? कोइ मान्छेलाई नराम्ररी घाइते बनाउँदै गरेको वा मार्दै गरेको वा बलात्कार गर्दै गरेको कोही बेला तपाई आफैले देख्नुभो ?	1	5	1	5
5. Were you ever raped, that is someone had sexual intercourse with you when you did not want-to, by threatening you, or using some degree of force ? अब म तपाईलाई केही व्यक्तिगत प्रश्नहरूको बारेमा सोध्दै छु । अप्ठेरो नमानी, बताई दिनुहोला किनकी यो कुरा गोप्य राखिनेछ । तपाई कोही बेला बलात्कारमा पर्नुभो ? मतलब तपाईले नचाहँदा नचाहँदै बल प्रयोग गरेर वा धम्क्याएर तपाईसँग कसैले गोप्यसम्बन्ध गऱ्यो ? (लोग्ने मान्छेको हकमा मलद्वारमा मैथुन गर्ने वा मुखमा मैथुन गर्ने,) [Now I am going to ask you some private quetions. Please do not feel odd while answering it, for it will be treated with confidentiality. (In case of male, the question relates to anal or oral sex)]	1	5	1	5
6. Were you ever sexually molested, that is someone touched or felt your genitals when you did not want them to ? तपाईले नचाहँदा नचाहँदै कसैले तपाईका गोप्य अङ्गहरूमा हात लायो वा छोयो ?	1	5	1	5
7. Were you ever seriously physically attacked or assaulted ? तपाईलाई कसैले कोही बेला मर्ने गरी/मार्ने कुटपिट गऱ्यो ?	1	5	1	5
8. Have you ever been threatened with a weapon, held captive, or kidnapped? तपाईलाई कसैले कोही बेला हातहतियार देखाएर धम्क्यायो वा जबर्जस्ती पक्रेर लग्यो वा थुन्यो ?	1	5	1	5

9. Have you ever been tortured or the victim of terrorists ? तपाई कोइबेला कुटपीटमा/कुराईपिटाइमा/यातनामा पर्नुभो ? [Have you ever been tortured?]	1	5	1	5
10. Have you ever experienced any other extremely stressful or upsetting events ? तपाईले कुनै अरू नराम्रो दुख लाग्ने घटनाको अनुभव कोही बेला गर्नु भएको छ ? Have you ever been tortured or the victim of terrorists ? IF YES, ASK: Briefly, what was the most stressful or upsetting experience of this sort that ever happened to you ? (यदि छ भने) तपाईसँग भएको यस्तो सबैभन्दा दुःख लाग्दा वा नराम्रो लाग्ने घटना कुन थियो । DESCRIPTION :_____ _____ _____ IF OTHER EVENTS IN 10 ARE ONLY BEREAVEMENT, CHRONIC ILLNESS, BUSINESS LOSS, MARITAL OR FAMILY CONFLICT, BOOK, MOVIE, OR TELEVISION, CODE 1. OTHERS CODE 5.	1	5	1	5
11. Have you ever suffered a great shock because one of the events on the list happened to someone close to you ? लिष्टीमा भएका कुनै घटना तपाईको नजिकका छरछिमेकी वा नातागोतामा घटचो भनेर कोइबेला तपाईलाई पीर लागो ? IF YES, ASK: Briefly, what was the event that you found most stressful or upsetting when it happened to someone close to you? यदि पीर लागेको थियो भने, तपाईको नजिकको कसैलाई घटेको सबैभन्दा दुःख लाग्ने वा नराम्रो घटना कुनै थियो त ? DESCRIPTION :_____ _____ IF EVENTS IN 11 ARE ONLY BEREAVEMENT, CHRONIC ILLNESS, BUSINESS LOSS, MARITAL OR FAMILY CONFLICT, BOOK, MOVIE, OR TELEVISION, CODE 1. OTHERS CODE 5	1	5	1	5

IF NO 5'S IN COL. I SKIP TO END OF CIDI

IF ONLY ONE 5 IN COL. I CODE 5 FOR THAT EVENT IN COL. II AND ASK K22A.1. OTHERS SKIP TO K22A.2

K22A 1 You mentioned that you have experienced (EVENT CODED 5 IN COL.I). Did this happen only once in your lifetime or more than once ? IF ONCE, SKIP TO K22B, OTHERS ASK: Of these times, was one of them more stressful or upsetting than the others ? SKIP TO K22B.
तपाई (EVENT CODED 5 IN COL.I) परेको कुरा भन्नु भो । त्यो/ती घटनामा तपाई जीवनभरीमा एकपटक मात्र पर्नुभो कि त्योभन्दा धेरै पटक ?
IF ONCE, SKIP TO K22B, OTHERS ASK
ती समयमा भएका घटनाहरू मध्ये कोइ एउटा चाहिं अरूसबै घटनाभन्दा सारै दुःख लाग्ने वा नराम्रो थ्यो ?SKIP TO K22B.

2. You said that you have experienced (EVENTS CODED 5 IN COL.1). Of those events, which was the most stressful or psetting? तपाईले (EVENTS CODED 5 IN COL.1) अनुभव बताउनु भो । ती घटनाहरू मध्ये सबैभन्दा नराम्रो वा पीर लाग्ने कुन थियो ? CODE 5 FOR THAT EVENT IN COL. II

K22B FOR EVENT CODED 5 In COL. II, ASK: How old were you when (EVENT) happened ?
त्यो (EVENT) घट्दा तपाई कति वर्षको हुनुहुन्थ्यो ?
AGE:_____/_____

K22C FOR EVENT CODED 5 IN COL. II, ASK: When it happened, did you feel terrified ?
जब यस्तो घटना भो त्यतिबेला तपाई सारै डराउनु भो ?
NO.....1
YES.....5

K22D FOR EVENT CODED 5 IN COL. II, ASK: When (EVENT) happened, did you feel helpless ?
जब त्यो (EVENT) भो, तपाईलाई कसैले सहारा दिदैनन् भन्ने लागो ?
NO.....1
YES.....5

Now I would like to ask you about the time after the stressful or upsetting experience happened to you .
नराम्रो घटना पछिको समयको बारेमा अब म तपाईलाई सोध्न चाहन्छु ।

ASK K23 TO K45 FOR EVENT CODED 5 IN COL. II.

K23 Did you keep remembering (EVENT) even when you didn't want to ?
तपाईले सम्झन नचाहे पनि त्यस्तो नराम्रो (EVENT) सम्झना/यादमा आइरह्यो ?
NO.....1
YES.....5

K24 After it, did you keep having bad dreams or nightmares about it ?
घटना भएपछि तपाईले यसको बारेमा डर लाग्दा वा नराम्रो सपना देखिराख्नु भो ?
NO.....1
YES.....5

K25 Did you suddenly act or feel as though (EVENT) was happening again even though it wasn't ?
(EVENT) आइनलागेको भए पनि फेरि घटना घटिरहेको जस्तो गरेर एक्कासी झझल्को लागो / आयो ?
NO....1
YES....5

K26 Did you get very upset when you were reminded of it ?
जब तपाईलाई कसैले यसको बारेमा सम्झायो वा याद गरायो त्यतिबेला तपाईलाई साह्रै नराम्रो लागो/दुख लागो ?
NO....1
YES....5

K27 Did you sweat or did you heart beat fast or did you tremble when you were reminded of (EVENT) ?
जब तपाईलाई कसैले (EVENT) बारे सम्झायो वा याद गरायो तपाईलाई पसिना आयो ? वा तपाईको मुटु छिटोछिटो धड्क्यो ? वा तपाईको हात गोडा काँप्यो ?
NO....1
YES....5

PLEASE NOTE THAT WE DO NOT USE SKIP RULE AT THIS PLACE.

K28 After (EVENT) did you have more trouble sleeping ?
(EVENT) पछि तपाईलाई सुत्नमा सधैभन्दा बढी समस्या भो ?
NO....1
YES....5

K29 After it, did you feel unusually irritable or lose your temper a lot more than is usual for you ?
यो घटना पछि तपाई पहिलाभन्दा बढी झकर्नै गरेको जस्तो लागो अथवा पहिलेको भन्दा बढी रिसाएको जस्तो लागो ?
NO....1
YES....5

K30 After it, did you have difficulty concentrating ?
यो घटना पछि तपाईलाई एकचित्त भएर ध्यान दिएर काम गर्न गाह्रो भो ?
NO....1
YES....5

K31 After (EVENT) did you become very much more concerned about danger or very much more careful ?
(EVENT) पछि तपाईले खतराको बारेमा सारै धेरै ध्यान दिनुभो ?
NO....1
YES....5

K32 After (EVENT) did you become jumpy or easily startled by ordinary noises or movements ?
(EVENT) पछि तपाई साधारण होहल्ला, आवाज वा हलचलबाट सजिलै झस्कनु भो वा नर्भस हुनुभो ?
NO....1
YES....5

PLEASE NOTE THAT WE DO NOT USE SKIP RULE AT THIS PLACE.

K33 Did you deliberately try not to think or talk about (EVENT) ?
तपाईले अबदेखि (EVENT) को बारेमा केही पनि सोच्दिन वा कोहीसित कुरा पनि गर्दिन भन्ने विचार गर्नुभो ?
NO....1
YES....5

K34 Did you avoid places or people or activities that might have reminded you of it ?
घटनाको बारेमा याद वा सम्झना गराउने ती ठाउँहरू वा मानिसहरू वा कामकाजबाट तपाई तर्केर/जोगिएर हिड्नुभो ?
NO....1
YES....5

K35 After (EVENT) was your memory blank for all or part of (EVENT) ?
(EVENT) पछि तपाई (EVENT) को बारेमा केही पनि नसम्झने वा केहीकेही मात्र सम्झने हुनुभो ?
NO....1
YES....5

IF EVENT CODED 5 IN COL. II. IS WITNESS OF AN ACCIDENT (K22.4) OR EVENT HAPPENED TO RELATIVES OR FRIENDS (K22.11), SKIP TO K36. OTHERS ASK:

A. Did you suffer a head injury as a result of (EVENT) ?
(EVENT) को कारणले तपाईको टाउकोमा घाउ/चोट लागो ?
NO.....1
YES.....5

B. Were you unconscious for more than ten minutes ?
तपाई १० मिनेटभन्दा बेसी समयसम्म बेहोस हुनुभो ?
NO.....1
YES.....5

K36 After (EVENT) did you lose interest in doing things that were once important or enjoyable for you ?
(EVENT) पछि पहिलापहिला रामो लाग्ने वा आनन्द लाग्ने कामकाज गर्ने तपाईको चाहना हरायो ?
NO.....1
YES.....5

K37 After (EVENT) did you feel more isolated or distant from other people ?
(EVENT) पछि तपाईले आफुलाई अरू मान्छेबाट बेसी टाढा वा एक्लो ठान्नु भो ?
NO.....1
YES.....5

K38 After (EVENT) did you find you had more difficulty experiencing normal feelings such as love or affection towards other people ?
(EVENT) पछि तपाईले अरू मान्छेलाई गर्ने माया, स्नेह जस्ता साधारण कुरा पनि अनुभव गर्न नसक्ने हुनुभो ?
NO.....1
YES.....5

K39 After (EVENT) did you begin to feel that there was no point in thinking about the future anymore ?
(EVENT) पछि जिन्दगीको बारेमा अरू बढी सोच्नु बेकार जस्तो लागो अथवा हरेश खानु भो ?
NO.....1
YES.....5

IF K23 TO K39 ALL CODED 1, SKIP TO END OF CIDI. [Note that skip rule has been changed.]

K40 You said that you had problems after (EVENT) like (SX CODED 5 IN K23 TO K39). How soon after (EVENT) did you start to have any of these problems ? CODE LOWEST NUMBER.
तपाईले भन्नु भो (EVENT) पछि तपाईसँग(SX CODED 5 IN K23 TO K39) जस्ता समस्याहरू थिए । (EVENT) घटेको कति समय पछि तपाईमा यी मध्ये कुनै समस्या देखा परो ?
SAME DAY.....1
THAT WEEK.....2
THAT MONTH.....3
WITHIN 6 MONTHS.....4
WITHIN 1 YEAR.....5
MORE THAN 1 YEAR.....6

IF MORE THAN 1 YEAR, ASK: How old were you ?
तपाई कति वर्षको हुनु हुन्थ्यो ?
AGE:_____/_____

K41 How long did you continue to have any of these problems because of (EVENT)?
(EVENT) को कारणले भएका यी मध्ये कुनै समस्याहरू (कति वर्ष, कति दिन वा कति महिना) सम्म रहे ? CODE LOWEST NUMBER.
LESS THAN 1 WEEK.....1
LESS THAN 1 MONTH.....2
LESS THAN 6 MONTHS.....3
LESS THAN 1 YEAR.....4
MORE THAN 1 YEAR.....5

K42 When was the last time you had any of these problems as a result of (EVENT) ?
(EVENT) को कारणले तपाईसँग भएका यी समस्याहरू मध्ये कुनै समस्या पिछाडिपल्ट कहिले थियो ?
REC: 1 2 3 4 5 6
AGE REC: ____/___

K43 Did you tell a doctor about the problems that occurred as a result of (EVENT) ?
(EVENT) को कारणले भएका ती समस्याहरूका बारेमा तपाईले डाक्टरलाई भन्नुभो ?

NO.....1
YES.....(SKIP TO 2).....5

1. Did you tell any other professional ?
अरू कुनै जान्ने मान्ने व्यवसायीलाई भन्नु भो ?

NO.....1
YES.....5

2. Did you take medication, or use drugs or alcohol more than once for the problems which occurred as a result of it ?
घटनाको कारणले भएका ती समस्याले गर्दा तपाईले औषधी (दवाई वा लागु पदार्थ वा जाँडरक्सी इत्यादि एकपटकभन्दा बढी खानुभो ?

NO.....1
YES.....5

3. Did the problems which occurred as a result of it interfere with your life or activities a lot ?
घटनाको कारणले भएका ती समस्याले तपाईको जीवनमा वा कामकाजमा धेरै बाधा पुऱ्यायो ?

NO.....1
YES.....5

K44 Have you ever been very upset with yourself for having the problems which occurred as a result of (EVENT) ? (EVENT) का कारणले भएका ती समस्याहरूले गर्दा तपाई कोही बेला आफैदेखि (आफ्नो बानिदखि) दिक्क हुनुभो ?

NO.....1
YES.....5

K45 Have the problems which occurred as a result of (EVENT) ever kept you from going to a party, social event or meeting ?
(EVENT) को कारणले भएका ती समस्याहरूले तपाईलाई कोही बेला भोजभतेर, सामाजिक (जमघट,विहा, पूजा इत्यादि वा सभा) मिटिङमा जान अप्ठेरो पुऱ्यायो ?

NO.....1
YES.....5

WHO-DAS , DISABILITY CHECKLIST

WHODAS II (12-Item Interviewer Administered Version)

INSTRUCTION:
SAY TO RESPONDENT:

The interview is about difficulties people have because of health conditions. *(HAND FLASHCARD #1 TO RESPONDENT).* By health condition I mean diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems and problems with alcohol or drugs.
यो कुराकानी / अन्तवार्ता स्वास्थ्यको कारणले गर्दा मानिसमा आईपर्न सक्ने कठिनाई बारेको हो । यंहा स्वास्थ्य सम्बन्धि समस्या भन्नाले लामो समयसम्म रहने अथवा थोरै समयमै ठिक हुने बिभिन्न रोगहरु , चोटपटकहरु , मानसिक (मनको)वा भावनात्मक समस्याहरु र जांडरक्सि वा लागुपदार्थ सेवन जस्ता कुराहरु पर्दछन ।

I remind you to keep all of your health problems in mind as you answer the questions. When I ask you about difficulties in doing an activity think about *(POINT TO FLASHCARD #1).*
यी प्रश्नका जवाफ दिदा तपाईको स्वास्थ्य सम्बन्धि समस्यालाई मनमा राख्न अनुरोध गर्दछु ।जब म तपाईलाई काम गर्दा परेको अप्ठ्यारोको बारेमा सोध्छु , त्यसबेला तपाईले यी कुराहरुको बारेमा सोच्नुहोस ।

- Increased effort
  बढी मेहनत (बल) गर्न परेको
- Discomfort or pain
  दु:खाई वा असजिलो
- Slowness
  ढिला / सुस्ती
- Changes in the way you do the activity
  तपाईले सधै गर्ने भन्दा फरक तरिकाले गर्न परेको

(POINT TO FLASHCARD #1). When answering, I'd like you to think back over the last 30 days. I also would like you to answer these questions thinking about how much difficulty you have, on average over the past 30 days, while doing the activity as you usually do it.
उत्तर दिदा तपाईले गएको एक महिना लाई सम्झनुहोस । गएको एक महिनामा सधैं जसो गर्ने कामकाज गर्दा खेरी तपाईलाई कतिको अप्ठ्यारो परेको थियो , यसबारे सोचेर जवाफ दिनुहोस ।
(HAND FLASHCARD #2 TO RESPONDENT). Use this scale when responding. *(READ SCALE ALOUD):* None, mild, moderate, severe, extreme or cannot do.
जवाफ दिदा सोधिएको समस्याले गाह्रो हुदै भएनकी , अलिकति गाह्रो भयाकी , ठिकठिकै गाह्रो भयोकी , धेरै गाह्रो भयोकी , साह्रै गाह्रो भयो , त्यो भन्नुहोस ।

(FLASHCARDS #1 AND #2 SHOULD REMAIN VISIBLE TO THE RESPONDENT THROUGHOUT THE INTERVIEW.)

WHO-DAS-II CORE QUESTIONS:

		Very good	Good	Moderate	Bad	Very Bad
H1	**How do you rate you overall health in the past 30 days?**	1	2	3	4	5
	Read choices to respondent. *गएको एक महिनामा तपाईको स्वास्थ्य कस्तो थियो ?*					

SHOW FLASHCARD #2 to participant

In the last 30 days how much difficulty did you have in:
गएको एक महिनामा तलका कुराहरु गर्न तपाईलाई कतिको गाह्रो भयो ?

		None गाह्रो हुदै भएन	Mild अलिकति भयो	Moderate ठिकठिकै भयो	Severe धेरै भयो	Extreme साह्रै गाह्रो भयो /Cannot do गर्न सकिएन
S1	**Standing for long periods such as 30 minutes?** लामो समयसम्म (जस्तै आधा घण्टा सम्म)उभिरहन कतिको गाह्रो भयो ?	1	2	3	4	5
S2	**Taking care of your household responsibilities ?** घरको कामकाज गर्न कतिको गाह्रो भयो ?	1	2	3	4	5
S3	**Learning a new task, for example, learning how to get to a new place?** नयां काम वा सिप सिक्न जस्तै नयां खाने कुरा बनाउने , नयां ठाउमा जाने जस्तो कुरामा कतिको गाह्रो भयो ?	1	2	3	4	5
S4	**How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?** गाउँघरमा हुने काममा अरुले जस्तै सहभागी हुन (जस्तै भोज भतेरमा जाने चाडपर्व मनाउने वा अन्य काममा) कतिको गाह्रो भयो ?	1	2	3	4	5

S5	**How much have you been emotionally affected by your health problems?**	1	2	3	4	5
	तपाईको स्वास्थ्य सम्बन्धि समस्याले तपाईको मनमा कतिको भावनात्मक असर पाह्रयो ?					

		None	Mild	Moderate	Severe	Extreme/ Cannot do
	In the last 30 days how much difficulty did you have in: गएको एक महिनामा तलका कुराहरु गर्न तँपाईलाई कतिको गाह्रो भयो ?					
S6	**Concentrating on doing something for ten minutes?** कुनै काममा दश मिनेट सम्म ध्यान दिनु पर्दा कति गाह्रो भयो ?	1	2	3	4	5
S7	**Walking a long distance such as kilometer [or equivalent]?** लगातार आधि घण्टा सम्म हिडदा कतिको गाह्रो भयो ?	1	2	3	4	5
S8	**Washing your whole body?** तपाईलाई जिउ नुहाउन कतिको गाह्रो भयो ?	1	2	3	4	5
S9	**Getting dressed ?** कपडा लगाउन कतिको गाह्रो भयो ?	1	2	3	4	5
S10	**Dealing with people you do not know?** नचिनेको मान्छे सग व्यवहार गर्नु पर्दा कतिको गाह्रो भयो ?	1	2	3	4	5
S11	**Maintaining a friendship ?** साथीहरुसगंको सम्बन्ध कायम राख्न कतिको गाह्रो भयो ?	1	2	3	4	5
S12	**Your day to day work?** दैनिक कामकाज गर्न कतिको गाह्रो भयो ?	1	2	3	4	5
H2	**Overall, how much did these difficulties interfere with your life?** अन्त्यमा भन्नुहोस , माथीका समस्याले तपाईको जिवनमा कतिको बाधा पुह्रयाएको थियो ? *Read choices to respondent.*	1	2	3	4	5

H3	**Overall, in the past 30 days, how many days were these difficulties present?** गएको एक महिनामा यी समस्याहरुले *कति दिन अप्ठेरो* पार्‍यो ?	RECORD NUMBER OF DAYS _____/_____
H4	**In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?** गएको एक महिनामा स्वास्थ्यको कारणले कति दिन सम्म तपाईले सधै गर्ने काम ठ्याम्मै गर्न सक्नु भएन ?	RECORD NUMBER OF DAYS _____/_____
H5	**In the past 30 days, not counting the days that you were totally unable, for how many**	RECORD NUMBER OF DAYS

WHO-DAS-II CORE QUESTIONS:

H1. पछिल्लो एक महिना भित्रमा तपाईको स्वास्थ्य कस्तो रह्यो ?	धेरै राम्रो १	राम्रो २	ठिकै ३	नराम्रो ४	धेरै नराम्रो ५

पछिल्लो एक महिना भित्रमा तलका कुराहरुमा तपाईलाई कत्तिको गाह्रो भयो ?	१	२	३	४	५
S1) लामो समयसम्म उभिरहन जस्तै आधा घण्टा सम्म उभिरहन	गाह्रो भएन	अलिकति गाह्रो	अलिधेरै गाह्रो	निकै धेरै गाह्रो	गर्नै सकिन
S2) घरको कामकाज गर्न (जिम्मेवारी)					
S3) नयां काम सिक्न					
S4) अरुले जस्तै गाउँघरमा हुने काममा सहभागी हुन जस्तै भोज भतेरमा जान, चाड पर्व मनाउन वा अन्य					
S5) तपाईको स्वास्थ्य सम्बन्धि समस्याले तपाईको भावनामा कत्तिको असर पार्‍यो	असर पारेन	थोरैअसर पार्‍यो	अलि धेरै असर पार्‍यो	निकै धेरै असर पार्‍यो	एकदम धेरै असर पार्‍यो
S6) कुनै काममा दश मिनेटसम्म मन लगाउन	गाह्रो भएन	अलिकति गाह्रो	अलि धेरै गाह्रो	निकै धेरै गाह्रो	गर्नै सकिन
S7) टाढासम्म हिड्न जस्तै एक किमी सम्म हिड्न (१५मिनेटसम्म हिड्न)					
S8) नुहाउन					
S9) लुगा लगाउन					
S10) नचिनेको व्यक्तिसंग व्यवहार राख्न					
S11) साथीहरुसंग मिल्न/मित्रता कायम गर्न					
S12) दैनिक कार्य गर्न					

H2) तपाईको जीवन साथिका समस्याले कत्तिको बाधा पुर्‍याएको छ?	बाधा पुर्‍याएको छैन	थोरै बाधा पुर्‍याएको छ	अलि धेरै बाधा पुर्‍याएको छ	निकै बाधा पुर्‍याएको छ	अति धेरै बाधा पुर्‍याएको छ
H3) पछिल्लो एक महिना भित्रमा यी समस्याहरुले कति दिन पिरोल्यो?	दिन संख्या ----------/----------				
H4) पछिल्लो एक महिना भित्रमा स्वास्थ्यको कारणले कति दिनसम्म तपाईले पूर्णरुपमा दैनिक कार्य गर्न सक्नु भएन?	दिन संख्या ----------/----------				
H5) पछिल्लो एक महिना भित्रमा माथी भन्नु भएको पूरा काम गर्न नसकेका दिन बाहेक अन्य कति दिन स्वास्थ्यको कारणले तपाईले कम काम गर्न बाध्य हुनु भयो?	दिन संख्या ----------/----------				

days did you cut back or reduce your usual activities or work because of any health condition? _____/_____

गएको एक महिनामा माथि भन्नुभएको ठयाम्मै काम गर्न नसकेका दिन बाहेक अरु कति दिन स्वास्थ्यका कारणले सधै गर्ने कामकाज कम गर्नु परेको थियो ?

WHODAS-II Flashcard 1:

Health Conditions:

स्वास्थ्य अवस्थाहरु

- **Diseases, illnesses or other health problems**
  रोग लागेको, बिरामी परेको वा अरु स्वास्थ्य समस्याहरु
- **Injuries**
  चोटपटक
- **Mental or emotional problems**
  मनका समस्याहरु
- **Problems with alcohol**
  जाँड रक्सी सम्बन्धि समस्या
- **Problems with drugs**
  लागु पदार्थ सम्बन्धि समस्या

Having difficulty with an activity means:

काम गर्न गाह्रो भएमा भन्नाले निम्न लिखित कुराहरु जनाउछ :

- **Increased effort**
  धेरै परिश्रम गर्न परेको
- **Discomfort or pain**
  असजिलो वा पीडाको अनुभव
- **Slowness**
  ढिला-सुस्ती
- **Changes in the way you do the activity**
  सधै गर्ने भन्दा फरक

Think about the past 30 days only

गएको एक महिना बारेमा मात्र सोच्नुस ।

WHODAS-II Flashcard 2:

1	2	3	4	5
None	**Mild**	**Moderate**	**Severe**	**Extremely / Cannot Do**
गाह्रो हुदै भएन	अलिकति गाह्रो भयो	ठिकठिकै गाह्रो भयो	धेरै गाह्रो भयो	साह्रै गाह्रो भयो /गर्नै सकिएन