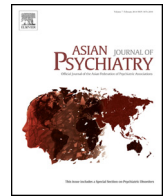




Contents lists available at [ScienceDirect](#)

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp



Development and validation of NIMHANS screening tool for psychological problems in Indian context

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ARTICLE INFO

Article history:

Received 1 April 2013

Received in revised form 18 February 2014

Accepted 22 February 2014

Available online xxx

Keywords:

Screening

Psychiatric morbidity

Screening tool

ABSTRACT

Screening for psychiatric morbidity helps to identify disease, enable initiation of treatment and intervention to reduce mortality and suffering from psychological problems. There is a dearth of such scales in India and South East Asia. The present work aims to develop and validate the NIMHANS screening tool for psychological problems in Indian context. 754 (229 normal subjects and 525 clinical subjects) were taken from the community and in-patient and out patient psychiatric setting of the hospital. Socio-demographic datasheet and the newly developed tool were administered on them. Split half reliability of the tool was .84. Score of 12 & 24 and above indicated presence of psychiatric distress in normal and clinical group respectively. Discriminate validity developed with sensitivity of .76 and specificity of .82. The NIMHANS screening tool for psychological problems has a utility in screening out psychiatric distress in the community.

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1. Introduction

Psychological problems are common in general population and results in considerable suffering and economic loss among the people having major depressive disorder, anxiety disorders, obsessive-compulsive disorder and substance use related problems. 9.5–370 per thousand of populations have mental and behavioral disorders (Surya, 1964). Proportion of mental illnesses in adult population was 39.9%, amongst them 36.2% were males and 42.2% were females (Barua et al., 2007).

About one third of psychiatrically ill people do not get diagnose for their psychological problem (Deva, 1997). There are a number of reasons for this. Patients who see their primary care doctors tend to somatize their emotional distress, and present with physical symptoms rather than overt psychological symptoms (Chaturvedi et al., 2006). Medical history is often taken in conditions of little privacy thereby discouraging patients from sharing sensitive aspects of their distress (Goldberg, 1995). In addition, primary care practitioners tend to have limited time in which to obtain a psychiatric history. It is seen that 25–30% of the patients presenting to primary care physicians have psychiatric problems

(Schulberg and Burns, 1988). In everyday practice, fewer than 5% of medical inpatients received psychiatric intervention. This is likely due to a number of factors, including under – identification of psychiatric symptoms and stigmatization of psychiatric intervention (Karasu et al., 1980). It is compounded by some additional disadvantages likes: (a) lack of social awareness, (b) prevailing social taboos, (c) legal and socio cultural constraints, (d) poor doctor–patient interaction due to less number of psychiatrists and large number of patients, and (e) lack of health care management infrastructure.

One method of increasing recognition of an illness is to screen them. Several screening instruments exist for a variety of psychiatric disorders. They are Present State Examination or PSE (Wing and Giddens, 1959), Psychiatric Status Schedule or PSS (Spitzer et al., 1968; Spitzer and Endicott, 1969), modified Current and Past Psychopathology Scales (CAPPs) (Endicott and Spitzer, 1972), Schedule for Affective Disorders and Schizophrenia or SADS (Endicott and Spitzer, 1978), and Structured Clinical Interview by DSM-III (Spitzer, 1983) and General Health Questionnaire (Goldberg, 1978).

In a study (Isaac and Kapur, 1980), sensitivity as well as cost of three different methods (interviewing, questionnaire and details case history evaluation) were compared for psychiatric case detection in rural setting. The cost of the simplest method was one-ninth (interview) and that of the method of medium complexity (questionnaire), one-fifth of the cost of the most

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sophisticated method (case history evaluation) (Isaac and Kapur, 1980). The Health of the Nation Outcome Scale (HONOS) psychometric properties was established for routine use in mental illness service. 129 mental health professionals at 17 sites rated 934 patients from eight diagnostic categories; 250 were also rated on a range of comparison scales. HONOS is sensitive to change across time and to differences in illness type and severity, and has a sufficient degree of both construct and criterion related validity (McClelland et al., 2000). Brief self-report screening instrument (Mood Disorder Questionnaire) validated for bipolar spectrum disorder yielded sensitivity (.73) and very good specificity (.90) (Robert et al., 2000). Short screening tool (brief symptom rating scale-5) to identify psychiatric morbidity was developed among 721 medical inpatient. Internal consistency (Cronbach alpha) coefficients of the BSRS-5 ranged from .77 to .90. The test–retest reliability coefficient was .82. Concurrent validity coefficients between the sum score of BSRS-5 and the General Severity Index of BSRS-50 ranged from .87 to .95. With 6+ as the cut-off score for psychiatric cases, the rate of accurate classification of BSRS-5 was 76.3% (78.9% sensitivity, 74.3% specificity, 69.9% positive predictive value, 82.3% negative predictive value) (Lee et al., 2003).

Indian Perspective: Personality: Research articles pertaining to personality measures and studies have been amongst one of the earliest concerns in modern Indian psychiatry as evidenced by the use of projective techniques, such as, Rorschach Inkblots for various clinical groups. Early research interest was on development/use of other personality measures like inventories, especially Eysenck, Maudsley, MMPI or in mutual comparisons with one another (Gupta et al., 1976). There was a brief interest in getting authenticated translated versions of these inventories in vernacular (Abraham et al., 1977; Arora and Varma, 1980) or studying specific sub aspects of personality types or profiles in relation to specific psychiatric manifestations (Sahasi et al., 1990). In this connection, measurement of personality traits – either psychotism–neuroticism (Pershad et al., 1972) was developed.

Cognition: The ‘Bender Gestalt Test’ was tried to discriminate organic/functional disturbances in psychiatric patients. The study of thought disturbances in major mental disorders was focused, along with difficulties in recognition (Pershad and Wig, 1976) and memory. Almost after a decade and half later, interest in cognitive research underlying mental disorders got revived with the belated arrival of neuropsychology as a discipline. Last decade has seen development of AIIMS, PGI and NIMHANS neuropsychology battery.

Diagnostic: Various tests came in this area are PGI Health Questionnaire (Wig and Verma, 1973), General Health Questionnaire (Jacob et al., 1997). The purpose and expectation from these tests/measures was to tell the diagnostician whether a given patient had a particular disorder or not based on a numerical score or cut off point.

Rationale for the present work: As the psychiatrist–patient ratio is inconsistent, it is very difficult for the expert too, to concentrate on each case holistically, e.g. evaluating the personal and family history in detail, doing thorough physical examinations, laboratory investigations, psychometric tests, etc. before making a diagnosis. Thus a string of under or over diagnosis, erratic medications, bizarre patient–follow up and rehabilitation measures are frequent coexistence in the psychiatric scenario in the third world countries including India. In recent years, however, there have been several attempts at developing tools specifically for the Indian population, ex: tools for assessing intelligence, attitude, problem solving, reading etc. The success of these tools and the growing mental disorders signify a need for the development of tools based for measurement and assessment of common psychiatric symptoms and disorders.

There are no Indian norms for these widely used scales in clinical and research setting. It underscore the need for development of screening instruments to identify subjects at risk for psychiatric morbidity in the South East Asia community. The present work aims to develop and validate the NIMHANS (National Institute of Mental Health & Neurosciences) screening tool for psychological problems in Indian context with generation of items/ domains for the assessment of psychiatric morbidity and their psychometric properties.

2. Materials and methods

2.1. Aim

To develop and validate the NIMHANS screening tool for psychological problems in Indian context.

2.1.1. Objectives

- (i) To generate items for assessment of psychological distress/ psychiatric morbidity.
- (ii) To identify the domains from the categories of items in the tool.
- (iii) To establish the psychometric properties of the screening tool.

2.2. Sample

754 subjects (229 healthy and 525 clinical) were taken from the community (apartments, companies–private and public, institutions–private and public), in–patient and out patient psychiatric setting of the hospital. They were male and female above age 18 years, literate and illiterate having ability to speak and read English/Hindi/Kannada. Subjects with history of neurological and psychiatric illness were excluded. Whereas in clinical group along with above mentioned criteria, person–seeking consultation for psychological problems including substance use were included. Subjects with history of neurological problem and language deficits were excluded. The permission from Institute ethic committee was obtained for the same.

Socio–demographic datasheet and developed questionnaire were administered. Clinical group was also evaluated for psychiatric diagnosis using International Classification of Disease–10 (ICD–10).

2.3. Procedure

A socio–demographic data sheet for relevant biographical details and other relevant information was prepared. This includes details about name, age, sex, education, occupation, marital status, total family income and language. It was collected for all the 754 subjects. The groups were matched for age and education.

2.4. Phase I – Item development for tool

Items for the scale were generated through review of literature, focus group discussions of mental health professional (profession working in the mental health area for 5 years or more) as well as available scales/tool for assessment of psychological problems/ morbidity. The 88 items were evolved for Anxiety, Depression, OCD, Mania, Psychosis, Substance Abuse and General (somatoform and behavioral addiction).

The items were examined for their cultural relevance. All those items that were felt to be culturally irrelevant were omitted. The items, which were ambiguous or vague items, were not included in the tool. After this exclusion, 66 items were retained.

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