PSYCHO-SEXUAL HAZARDS OF I. U. C. D. INSERTION

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The rapid growth of population is a major factor which is strongly retarding India's development as a self-sufficient nation. Today, from far east to west Asia, bold efforts are being made by the countries to tackle the problem in an effective manner. Despite the initial hesitation of some orthodox sections to give whole hearted support, there is a general upsurge for social change in our country and the powerful support of lower class intelligentsia is one of the most significant features that has put the orthodox theologia on the defensive. Realising this, the Government of India has undertaken crash programmes in family planning and has given national shape to this movement. Intrauterine contraceptive device being a comparatively recent innovation, is an extremely valuable addition to the other means available for family planning in India. Considering all its advantages being cheap, reversible and easy to use, it seems to meet the requirements of an ideal contraceptive for India masses. Recent researches in the field and public enthusiasm have also shown that I. U. C. D. is more acceptable method of family planning.

It is ironic to note almost the total absence of studies relating to psycho-sexual hazards of I. U. C. D, one of the ideal method of contraception, in India, by clinical psychologists. Studies concerning gynaecological complications and side effects of loop insertion have been reported by Owaisy (1965), Roy Choudhury (1965), Sinha et. al (1967) and Rozin et. al (1967), and they have found abnormal bleeding, spotting, backache, and abdominal pain, etc, as the commonest complications after loop insertion. Hingorani (1965) reported the conclusions of the studies carried out at All India Institute of Medical Sciences, New Delhi, that there are some side effects of loop insertion specially, gynaecological complications. Recently a few intensive studies regarding psycho-sexual hazards have been reported by trained workers. Sawhney et al (1970) claim to have found that at least one fifth of the population manifests psychiatric symptoms following loop insertion and sterilization. Similar findings about a greater occurence of anxiety and depression have been reported by Wig (1968). In another study Wig (1970) concluded that 20% of the cases showed moderately severe symptoms which were interfering with their social adjustment and sexual symptoms were pre-dominent in causing personal distress.

The study reported herein is part of a large

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research project on Family Planning undertaken by the investigator. One of the main aims of this study was to investigate the genesis of psycho-sexual hazards of loop insertion within a period of six months. Therefore, an attempt has been made in the present paper to find out the various psycho-sexual complications following loop insertion and also to substantiate some of the earlier findings more precisely.

Method and Sample.

Method :— In order to carry out the present investigation and considering the various dependable variables, the following methods were used :

1 Interview Method :—

The subjects under study were interviewed by a clinical psychologist to understand the basic psycho-sexual problems, if any, of each individual concerned after the loop insertion.

2. Questionnaire Method :—

A Questionnaire consisting of two information blanks, I and II was used for each individual, covering various questions regarding identification details, personal, family, and sexual history and duration of loop insertion, positive psychiatric findings and effects of I. U. C. D. on sexual relations.

3. Psychodiagnostic Investigation :—

When required a special psychodiagnostic investigation was also carried out individually to confirm the psychiatric findings.

Sample.

The sample consists of 72 I. U. C. D. inserted ladies of fertility age group which were selected on purposive sampling technique basis from the different Family Planning Clinics of Ranchi, Bihar, India. Each subject of the present study was interviewed at least two to three times within a period of six months after loop insertion.

Result and discussion

An analysis of the results obtained from the present investigation with regard to psychosomatic, psychological and sexual complications arising out of loop insertion is given in the following tables. Percentages have been calculated for the assessment of the occurrence of each complication.

(A) Psychosomatic complications

Psychosomatic symptoms reported by the subjects after loop insertion have been tabulated in table No. I.

Abdominal pain was complained by 41.7 percent of females. Nausea and vomiting was complained by 38.8 percent and backache by 37.5 percent of them. Besides, giddiness was felt by 22.2 percent, headache by 25.0 % and feeling of lethargy by 12.5 % .

Table No. 1

Psychosomatic complaints after loop insertion.

Psychosomatic symptoms	No. of cases	Percentage
Nausea and vomiting	28	38 8
Abdominal pain	30	41.7
Backache	27	37.5
Headache	18	25 0
Giddiness	16	22.2
Feeling of Lethargy	9	12.5

(B) Psychological Complications

To investigate further, a brief psychiatric examination of the loop subjects has been done to find out the frequently reported psychiatric symptoms. The following clinical psychiatric positive findings were obtained :

Disturbances of Sleep

Insomnia was reported by 19.5% of female loop subjects during the early part of night by 2.8%, towards the morning by 5.6% and disturbed sleep by 11.1%. Excessive sleep was also reported by 2.8% of the subjects as shown in the following table No. 2.

Table No. 2

Disturbances of sleep

Disturbances	No. of subjects	Percentage
Early Insomnia	2	2.8
Late Insomnia	4	5.6
Disturbed sleep	8	11.1
Total insomnia	14	19.5
Excessive sleep	2	2.8

Emotional Reactions

The emotional after-effects of I. U. C. D. have been summarised in Table 3. It was found that anxiety level was increased in 18,1% loop subjects, though not to the extent of a clinical anxiety state. Depression (Not amounting to a clinical syndrome) was complained by 13.9% loop subjects. Elation, less than a hypomanic state was reported by 19.4% subjects. Agitation and tension of varying degrees resulted in 16.7% subjects. But majority of the subjects showed no emotional change consequent to loop insertion.

Table No. 3

Emotional, reactions reported after loop insertion.

Emotional Reactions.	No. of subjects.	Percentage of subjects.
Anxiety	13	18.1
Depression	10	13.9
Elation	14	19.4
Agitation & tension	12	16.7

(C) Effect of I. U. C. D. on sexual relations

A point of particular interest which was explored in our study was the effect of I. U. C. D. insertion upon the sexual desire. The following table No. 4 gives the details about sexual desire after loop insertion.

Table No. 4

Sexual desire after loop insertion.

Sexual desire	No. of subjects	Percentage of subjects.
Increased	4	5.6
Decreased	26	36.1
No difference	42	58.3
Total	72	100.0

The table shows that the use of I. U. C. D. increased the sexual desire in 5.6% subjects whereas a significant decrease was complained by 36.1% of the subjects. No change in sexual desire was reported by the remaining 58.3% subjects.

Sexual act after loop insertion

A very significant number (41.7%) of loop subjects reported difficulty in consumation of coitus. In the rest, sexual act was carried out in the manner as before. The table No. 5 indicates the sexual act after loop insertion as reported by the subjects.

Table No. 5

Sexual act after loop insertion

Sexual act	No. of subjects	Percentage of subjects
Same as before	42	58.3
Difficulty in Sexual act	30	41.7
Total	72	100.0

Frequency of sexual intercourse after loop' insertion

Information regarding the frequency of intercourse after loop insertion was also collected to measure the effect of I. U. C. D. on sexual relation. It was found that the frequency of sexual intercourse was increased in 5.6%, decreased in 37,5% of the subjects and the remaining 56.9% of the subjects have not noticed any change in the frequency of intercourse. The data about the frequency of intercourse after loop insertion has been presented in the below mentioned table No. 6.

Table No. 6

Frequency of sexual intercourse after loop insertion.

Frequency of intercourse	No. of subjects	Percentage of subjects
Increased	4	5.6
Decreased	27	37.5
No difference	41	56.9
Total	72	100.0

It is evident, from the findings obtained on sexual relations after loop insertion that the sexual desire, sexual act and frequency of sexual intercourse of the subjects are significantly associated with each other. As the majority of the subjects who noticed the difficulty in sexual contact, complained the decrease in sexual desire, sexual act and frequency of sexual intercourse at the same time. Thus, a notable effect of I. U. C. D. on sexual relations is present.

To sum up, the use of I. U. C. D. leads to various types of complications in about three-fourth of the total female loop subjects.

The most frequent psychosomatic symptom was abdominal pain which was complained by 41.7% of the subjects and next in order were nausea and vomiting as reported by 38.8% subjects. In a small percentage of the subjects, backache, headache, giddiness and feelings of lethargy were complained.

A good percentage of the subjects showed evidence of mild psychological symptoms although not amounting to clinical manifestations.

Anxiety, depression, agitation and tension were observed in females following the loop insertion.

A very striking effect of I. U. C. D. was noticed in the area of sexual contact. There is a decrease of sexual desire in sizeable number of subjects (36.1%), difficulty in sexual act was complained by 41,7% and in about the number (37,5%) there is a decrease in the frequency of sexual intercourse.

Studies of this type might help to guide the Family Planning programme authorities to explore a way in which the programme can be made more effective and successful and also to plan more suitable mental hygiene measures to prevent the occurrence of psycho-sexual complications of loop insertion.

REFERENCES

1. Choudhury, Ranjit Roy (1965), Trial Findings on I. U. C. D., Journal of Indian Medical Association, Calcutta, Vol. 45, No. 2, July 16, 1965, Pp. 91.

2. Hingorani, V. (1965), Recent Advances in Contraceptive Techniques, Journal of Indian Medical Association, Calcutta, Vol. 45, No. 2, July 16, 1965, Pp. 102-105.

3. Owaisy Mumtaj, A. (1965), Intra-uterine Plastic Devices (I U. C. D), a New Contraceptive Technique, The Patna Journal of Medicine, Vol. XXXIX, No 6, June, 1965, Pp. 263.

4. Rozin, S., et. al. (1967), Endometrial Histology and Clinical Symptoms following prolonged retention of Uterine-contraceptive Devices, (Abstract of a paper), Advances in Fertility Control, Vol. 2, No 3, September, 1967, Pp. 37, Excerpta Medica Foundation, London.

5 Sawhney; N. and others (1970), A longitudial Study in Family Planning, Indian Journal of Psychiatry, Vol. 12, No. 3, Pp. 155-168.

6. Sinha, S, K , et. al , (1967), Observation on the Loop, (Abstract of the study), Advances in Fertility Control, Vol. 2, No. 3, September, 1967, Pp. 39, Excerpta Medica Foundation, London.

7. Wig. N. N. (1968), Psycho-social aspects of Family Planning, Indian Journal of Psychiatry, Vol. 10, No. 1, Pp. 29-35.

8. Wig, N. N. (1970), Psychiatric symptoms following Vasectomy, Indian Journal of Psychiatry, Vol. 12, No. 3, Pp. 169-176.

PSYCHIATRIC SOCIAL WORK : PROBLEMS AND PROSPECTS OF INDIA

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In many an earlier writing, I have tried to highlight the need for psychiatric social work in India.[1,2,3] Here I propose to spotlight—as briefly as possible—a few problems that confront the growth of this nascent speciality. My emphasis is based on the following assumptions :

1. The development of psychiatric social work is inevitable in view of the internationally accepted character of modern-dynamic psychiatry.
2. The barriers that hamper the growth of psychiatric social work in India are inherent in the archaic structure of psychiatric institutions and practices. And,
3. A radical transformation is called for to reorient the entire gamut of mental health issues and policies.

(I) Problems

More than a decade ago I conducted intensive field investigations in all the three State mental hospitals in Uttar Pradesh.[4] Realities, in and outside the massive-walled hospitals, looked gloomy then but the fact that mental health issues continue to be eclipsed to date, is far more depressing. A few points would spell out the anatomy of the problem.

1. National Priorities and Mental Health : One can easily see that mental health has been the step child of the planners. Reconstruction of mental health settings and reorientation of mental health policy have conspicuously received little attention in the developmental planning. In spite of having accepted a modern definition of "health"[5], 'physical' aspects of health have received greater emphasis in the planned development. Lack of financial resources is often presented a plea for not implementing the necessary mental health programmes. Besides certain unconscious cultural factors, there appears a politics of mental health supporting status quoism. This is the greatest stumbling block and all those concerned with mental health should launch an integrated programme rather than showing down each other.

2 Team Approach : Those who are aware of the principles of the dynamic psychiatry would fully appreciate the dire significance of the team approach in the context of mental health programmes In fact interdisciplinary team approach is the foundation of modern psychiatry and basis for fuller development of psychia-

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tric social work profession. Nevertheless, there are certain cultural factors in India which thwart the very spirit that is conducive for team work. It may be understood in the context of a centuries old feudally structured hierarchical social system. Different professions thus carry varying social status. This, more often than not, creates problems of subordination and superordination. The desired interdisciplinary coordination results into professional conflicts, rivalaries and prejudices. I have seen reputed psychiatrists questioning and demeaning social worker's role. I am sometimes shocked at the professional chauvinism that some psychiatrists tend to manifest. The situation is bound to continue unless the remnants of feudal-capitalist order are fully annihilated. The low graded professions, the exploited echelons in the hierarchical order, must unite and revolt, if necessary, for attaining the desired social status. Social workers can give a lead in this direction.

3. Misgivings : Professional roles are better executed when properly understood by co-workers. Even qualified social workers are given unprofessional tasks Their specialised professional potentialities thus remain unutilised. Therapeutic operations suffer because of professional misgivings. Psychiatric social workers are specially trained to deal with mental patients and their families in crisis and pre-crisis situations. A better appreciation of their job responsibilities by other dominant professional groups will go a long way towards the growth of psychiatry itself.

4. Personnel and Training : While it is of utmost importance to train all psychiatric personnel in unorthodox style, it is doubly relevant for psychiatric social workers to give an excellent account of their own professional role. Devoted, sharp and brilliant students have convinced even the diehards of the importance of psychiatric social work. On the contrary illequipped, illsuited and unwise persons have sometimes tarnished the image of their own profession. Attractive job conditions and better prospects are neeessary to invite really promising workers to this field. Not all persons are intellectually and temperamentally qualified to become psychiatric social workers. It is therefore very essential that only suitable persons—from the viewpoint of educational background, attitudes and aptitudes—join this area.

5. Negative Attitudes : The public attitudes end societal reactions toward the mentally ill have always been unkind and irrational. Negative community reactions are still rampant. No profession can grow and flourish unless the community wants it. The legislators and policy makers also reflect the society's general feelings. As such the cause of the mentally ill remains neglected due to the widespread negative reactions. A psychiatric social worker mainly works between the patient and his community. A positive attitude is essential for the development of a profession like psychiatric social work. A wholesome societal reaction towards mental health problems will go a long way toward the advancement of dynamic

psychiatry and related professions.[6] This calls for the annihilation of medieval beliefs and attitudes towards mental illness.

II. Prospects

Having overcome the barriers, some of which I have just discussed, the task for the development of psychiatric social work would become easier. Lest the pessimist may win, I reasonably foresee a rosy future for all psychiatric social workers. The path obviously involves certain thorny hurdles. A comprehensive community mental health programme is necessary to cope with the institutional needs of about 8 to 10 million mental patients that remain unattended to.[7] A net work of various types of psychiatric units offering specialised therapeutic facilities to all needy people without any discrimination would require an army of skilled and devoted psychiatric social workers to combat the dark forces against mental health. A challenging opportunity awaits. The Government must immediately look into the long standing mental health issues. It is regrettable that obsolete legal statutes (Indian Lunacy Act 1912) still govern the care and treatment of the mentally ill in India. Besides its total revision, a progressive mental health policy is required.[8]

Integration of social sciences and psychiatry is a happy development and the growth of new desciplines like "sorial psychiatry" is indicative of the fact that the alliances is viable and useful. Of all social scientists—I humbly venture to claim—social workers are better equipped to function in mental health settings and programmes for their professional training and education is based on sound scientific and philosophical foundation. Neglected mental health issues pose a serious challenge to the Government, particularly when our national goal is an egalitarian social order.[9]

REFERENCES

1. Brij Mohan : "Need for Psychiatric Social Work in India", International Social Work, New York, 1970, XIII, 1, 12-17.
2. Brij Mohan : "Medical and Psychiatric Social Work", Social Work Bulletin, Lucknow, 1966, II, 17-22.
3. Brij Mohan : "Limitations of Psychiatric Social Work in India", (in Hindi) Samaj Karya, Varanasi, 1968, 1.
4. Brij Mohan : "Social Work and the Problem of Mental Disorders (A Study of Selected Cases of Mental Disorders in the Mental Hospitals of Uttar Pradesh and in the Districts of Agra, Aligarh and Mathura)", Ph. D. Dissertation, Lucknow University, Typewritten, 1963, Pp. 592.
5. Government of India, Planning Commission, The First Five Year Plan, 1952, Pp. 488.
6. Brij Mohan : "Beliefs and Attitudes Towards Mental Illness", The Journal of Correctional Work, Govt. of U. P., Lucknow, 1970, XVI.

7. Brij Mohan : "Planning and Administration of Mental Health Programmes—With Particular reference to India", Mental Health Digest, U. S. Department of HE & W, Maryland, USA, 1969, I, 8, 35-36.

8. Brij Mohan : "Mental Health Policy and Administration in India", D. Litt, dissertation, Lucknow University, in progress.

9. Brij Mohan : "Social Policy for the Welfare of the Mentally Retarded—A Plea for Reorientation", Indian Journal of Mental Retardation, New Delhi, 1969, 2, 7, 7-13.