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Contents

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Title of the Journal	Frequency	India(INR) Print Only	India(INR) Online Only	Outside India(USD) Print Only	Outside India(USD) Online Only
Dermatology International	Semiannual	5500	5000	430	391
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Indian Journal of Diabetes and Endocrinology	Semiannual	8000	7500	597	560
Indian Journal of Genetics and Molecular Research	Semiannual	7000	6500	547	508
Indian Journal of Hospital Administration	Semiannual	7000	6500	547	508
Indian Journal of Hospital Infection	Semiannual	12500	12000	938	901
Indian Journal of Medical & Health Sciences	Semiannual	7000	6500	547	508
Indian Journal of Pathology: Research and Practice	Bi-monthly	12000	11500	938	898
Indian Journal of Preventive Medicine	Semiannual	7000	6500	547	508
International Journal of Neurology and Neurosurgery	Quarterly	10500	10000	820	781
International Physiology	Triannual	7500	7000	586	547
Journal of Cardiovascular Medicine and Surgery	Quarterly	10000	9500	781	742
Journal of Global Medical Education and Research	Semiannual	5900	5500	440	410
Journal of Global Public Health	Semiannual	12000	11500	896	858
Journal of Microbiology and Related Research	Semiannual	8500	8000	664	625
Journal of Plastic Surgery and Transplantation	Semiannual	26400	25900	2063	2023
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Journal of Pharmaceutical and Medicinal Chemistry	Semiannual	16500	16000	1289	1250
Journal of Practical Biochemistry and Biophysics	Semiannual	7000	6500	547	508
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Ophthalmology and Allied Sciences	Triannual	6000	5500	469	430
Otolaryngology International	Semiannual	5500	5000	430	391
Pediatric Education and Research	Quarterly	7500	7000	586	547
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Journal of Nurse Midwifery and Maternal Health	Triannual	5500	5000	430	391
Journal of Psychiatric Nursing	Triannual	5500	5000	430	391
Indian Journal of Ancient Medicine and Yoga	Quarterly	8000	7500	625	586
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Indian Journal of Medical Psychiatry	Semiannual	8000	7500	625	586
Indian Journal of Biology	Semiannual	5500	5000	430	391
Indian Journal of Library and Information Science	Triannual	9500	9000	742	703
Indian Journal of Research in Anthropology	Semiannual	12500	12000	977	938
Indian Journal of Waste Management	Semiannual	9500	8500	742	664
International Journal of Political Science	Semiannual	6000	5500	450	413
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Original Article

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Attitude towards Mental Illness among Medical Students and Non Psychiatric Doctors

Vijay kumar M[1], Raghuram Macharapu[2]

Abstract

Objective: To determine the attitude towards mental illness among medical students and non psychiatric doctors of Mamata Medical College.

Materials and Methods: The study was cross sectional, conducted in Mamata Medical College, Khammam, from September 2016 to March 2017. Our study sample contains 150 medical students doing internship in the Mamata Medical College, Khammam, and 100 non psychiatric doctors working in the Mamata Medical College, Khammam, who are willing to participate in the study.

Results: In present study we observed negative attitude towards mental illness among both medical students and non psychiatric doctors. When compared attitude toward mental illness among medical students and non psychiatric doctors, we found that there was no statistically significant difference. Compared to non psychiatric doctors, the medical students had stigma that people with a severe mental illness are dangerous and its more discomfortable talking to a person with a mental illness. Compared to medical students, the non psychiatric doctors had stigma that being a psychiatrist is not like being a real doctor, it is not important that any doctor supporting a person with a mental illness also assesses their physical health. Non psychiatric doctors also had stigma that they don't want to work with a colleague if they had a mental illness.

Conclusion: This study demonstrates the need for educational programs aimed at medical and non psychiatric doctors for providing basic information and thus demystifying mental illness.

Keywords: Attitude towards mental illness; Non psychiatric doctors; Medical students.

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Introduction

Around the world, people with mental illness frequently encounter stigma, prejudice, and discrimination not only by the public, but also by medical students and doctors [1,2]. According to World Health Organization, it was estimated that there are 450 million people in the world currently suffering from some kind of mental illness and constitutes 14% of the global burden of disease [3]. The rate of mental disorders in India is high, which is also observed in other parts of the world [4].

Psychiatry is often perceived 'different' by other medical professionals as much as by a

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common man. This perception of 'difference' may give rise to stigma toward both mental illness and psychiatrists. Psychiatrists are thus both recipients of stigma and agents who can de-stigmatize psychiatry [5]. Psychiatry as a branch of medicine has seen numerous advances in the recent years. Better awareness regarding mental illness is not only essential among the general population but also among health care professionals. Better understanding and knowledge regarding mental illnesses and available effective treatment modalities may help in shaping up a favourable attitude towards mental health and the mentally ill among the public, medical students and most importantly the medical profession at large [6,7].

Basic understanding of psychiatry, outlook toward psychiatric disorders as well as stigma surrounding all its aspects has to be studied. Psychiatric disorders exist all over the world, affecting about 10% of the adult population, at any given point in time [8]. Despite this global presence, negative attitude toward psychiatric disorders has been consistently reported to be prevalent in all sections of society [9].

Negative attitudes toward psychiatric disorders lead to compromised patient care toward mentally ill persons. Negative attitudes toward psychiatric disordershave an impact on the lives of not only the patients, but also their caregivers. This stigma can obstruct the provision of adequate and appropriate services to persons with mental illness [10,11].

To provide effective mental health care forgeneral population, knowledge and awareness regarding psychiatric disorders has to be increased among the general population. In addition to this, it is crucial that the medical fraternity itself is not plagued by prejudicial attitudes [12,13]. A negative attitude toward psychiatry harboured by medical professionals may prove to be a hindrance in providing quality care to the mentally ill persons in need.

A substantial number of patients attending various health care settings suffer from psychiatric disturbances with figures ranging from 15% to 50% [12]. Psychiatric exposure of medical and paramedical staff during training is grossly inadequate which eventually leads to insufficient knowledge and misconceptions about psychiatric illnesses and their treatment [13,14,15].

Mental wellbeing has been considered special since many years, but psychiatrist encounter stigma in their daily practice that affects the recovery process and affects the quality of life of their patients [16]. Profound negative attitudes toward psychiatric illness were documented in the early studies [17]. The stigma associated with mental illness is well-recognized in the West. However, there is insufficient data about stigma in developing countries [18]. Stigmatising attitude among doctors themselves can result in compromised patient care. The attitude of medical students towards psychiatry and psychiatric disorders may be modelled by many attributes that may come into play before and while enrolment in a medical school, such as the role of education providers [19-22].

Many studies have found out strongly negative public attitudes toward the mentally ill. Public opinion might be influenced by doctors. In the present study medical students and doctors, were studied regarding their attitudes toward the mentally ill as some studies found that public opinion was influenced by doctors and medical students [23].

In Indian setting there are very few studies related to attitude towards mental illness. Further research is required to assess the attitude towards mental illness to reduce the stigma and increase the awareness about mental illness among medical students and doctors. The present study was undertaken to find out the attitude of medical students and nonpsychiatric doctors toward mental illness.

Materials and Methods

Place of study: Study was conducted in Mamata medical college, Khammam, Telangana.

Study period: The study undertaken during July 2016 to February 2017 in the department of psychiatry following the college's ethical committee approval.

Study sample: The study sample consists of 150 medical students doing internship in the Mamata Medical College, Khammam,) and 100 nonpsychiatric doctors working in Mamata Medical College, Khammam, who are willing to participate in the study.

Study design: Cross sectional.

Inclusion criteria: All the students who doing internship in mamatha general hospital, and all non psychiatric health care professionals in mamatha general hospital who are willing to participate in study.

Exclusion criteria: students and nonpsychiatric health professionals who not willing to participate, and who had psychiatric illness.

Materials: MICA 2 scale [24] and MICA 4 scale [25] consists of 16 questions each. A person's MICA score is the sum of the scores for the individual items. For items 3, 9, 10, 11, 12, and 16 items are scored as follows: Strongly agree = 1, Agree = 2, Some what agree = 3, Some what disagree = 4, Disagree = 5, Strongly disagree = 6. All other items (1, 2, 4, 5, 6, 7, 8, 13, 14, 15) are reverse scored as follows: Strongly agree = 6, Agree = 5, Some what agree = 4, Some what disagree = 3, Disagree = 2, Strongly disagree = 1. The scores for each item are summed to produce a single overall score. A high overall score indicates a more negative (stigmatising) attitude.

Statistical Analysis

The data obtained was analyzed using Statistical Package for the Social Sciences (SPSS), Version 16. student-t test were used.

Results

In present study observed negative attitude towards mental illness among medical students and non psychiatric doctors. When compared attitude toward mental illness among medical students and non psychiatric doctors, we found that there was no statistically significant difference.

But Compared to non psychiatric doctors, the medical students had stigma that people with a severe mental illness are dangerous and its more discomfortable talking to a person with a mental illness.

Compared to medical students, the non psychiatric doctors had stigma that being a psychiatrist is not like being a real doctor, it is not important that any doctor supporting a person with a mental illness also assesses their physical health. Non psychiatric doctors also had stigma that they don't want to work with a colleague if they had a mental illness.

Table 1: Comparison of mean and SD of medical students towards mental illness with mean and SD of non psychiatric doctors

	Mean	S.D	p value
Medical students	46.07	8.08	0.28
Nonpsychiatric doctors	47.28	9.59	

Statistical analysis had depicted that the mean score of medical students was 46.07 ± 8.08 and that of non psychiatric professionals was 47.28 ± 9.59 and when the mean scores of both the groups were compared, it was found that there was no statistically significant difference between them as depicted in Table no.1. But mean score is high in both groups which suggests that negative attitude towards mental illness is high in both groups.

Table 2: Mean and SD of medical students towards mental illness

S. No	MICA 2 Questionnaire	Mean	S.D.
1	I just learn about psychiatry because it is in the exam and would not bother reading additional material on it.	2.649	1.729
2	People with a severe mental illness can never recover enough to have a good quality of life.	2.668	1.402
3	Psychiatry is just as scientific as other fields of medicine.	2.715	1.56
4	If I had a mental illness, I would never admit this to any of my friends because I would fear being treated differently.	3.046	1.505
5	People with a severe mental illness are dangerous more often than not.	3.68	1.194
6	Psychiatrists know more about the lives of people treated for a mental illness than do family members or friends.	3.84	1.413
7	If I had a mental illness, I would never admit this to my colleagues for fear of being treated differently.	3.370	1.428
8	Being a psychiatrist is not like being a real doctor.	2.172	1.349
9	If a consultant psychiatrist instructed me to treat people with a mental illness in a disrespectful manner, I would not follow their instructions.	2.311	1.539
10	I feel as comfortable talking to a person with a mental illness as I do talking to a person with a physical illness.	3.205	1.248
11	It is important that any doctor supporting a person with a mental illness also assesses their physical health.	2.198	1.316
12	The public does not need to be protected from people with a severe mental illness.	4.145	1.411
13	If a person with a mental illness complained of physical symptoms (such as chest pain), I would attribute it to their mental illness.	2.695	1.292
14	General practitioners should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist.	3.311	1.553
15	I would use the terms 'crazy', 'nutter', 'mad' etc. to describe people with a mental illness who I have seen in my work.	2.178	1.281
16	If a colleague told me they had a mental illness, I would still want to work with them.	2.470	1.115

Medical students had felt that, Psychiatrists know more about the lives of people treated for a mental illness than do family members or friends.

Medical students had felt that, public need to be protected from people with a severe mental illness.

Table 3: Mean and SD of non psychiatric doctors towards mental illness

S. No	MICA 4 Questionnaire	Mean	S.D.
1	I just learn about psychiatry because it is in the exam and would not bother reading additional material on it.	3.049	1.731
2	People with a severe mental illness can never recover enough to have a good quality of life.	2.931	1.470
3	Working in the mental health field is just as respectable as other fields of health and social care.	2.33	1.42
4	If I had a mental illness, I would never admit this to any of my friends because I would fear being treated differently.	3.323	1.593
5	People with a severe mental illness are dangerous more often than not.	3.186	1.191
6	Health/social care staff know more about the lives of people treated for a mental illness than do family members or friends.	4.029	1.505
7	If I had a mental illness, I would never admit this to my colleagues for fear of being treated differently.	3.284	1.575
8	Being a health/social care professional in the area of mental health is not like being a real health/ social care professional.	2.754	1.550
9	If a senior colleague instructed me to treat people with a mental illness in a disrespectful manner, I would not follow their instructions.	2.54	1.709
10	I feel as comfortable talking to a person with a mental illness as I do talking to a person with a physical illness.	2.303	1.041
11	It is important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed.	2.745	1.64
12	The public does not need to be protected from people with a severe mental illness.	3.81	1.38
13	If a person with a mental illness complained of physical symptoms (such as chest pain), I would attribute it to their mental illness.	2.83	1.51
14	General practitioners should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist.	3.38	1.69
15	I would use the terms 'crazy', 'nutter', 'mad' etc. to describe people with a mental illness who I have seen in my work.	2.0	1.194045
16	If a colleague told me they had a mental illness, I would still want to work with them.	2.76	1.415

Nonpsychiatric doctors had felt that, Psychiatrists know more about the lives of people treated for a mental illness than do family members or friends.

Nonpsychiatricdoctors had felt that, public need to be protected from people with a severe mental illness.

Table 4: Comparison of individual parameters of MICA 2 (students) with individual parameters of MICA 4 (doctors)

Question no	MICA 2 mean	MICA 2 S.D	MICA 4 mean	MICA 4 S.D	p value
1	2.64	1.72	3.04	1.731	0.08
2	2.66	1.40	2.93	1.470	0.16
3	2.71	1.56	2.33	1.423	0.05
4	3.04	1.50	3.32	1.593	0.15
5	3.68	1.19	3.18	1.191	0.001 (s)
6	3.84	1.41	4.02	1.505	0.27
7	3.37	1.42	3.28	1.575	0.74
8	2.17	1.34	2.75	1.550	0.0008 (s)
9	2.31	1.53	2.54	1.70	0.17
10	3.20	1.24	2.30	1.041	0.0001 (s)
11	2.19	1.31	2.74	1.645	0.001 (s)
12	4.14	1.41	3.81	1.383	0.12
13	2.69	1.29	2.83	1.516	0.2
14	3.31	1.55	3.38	1.69	0.49
15	2.17	1.28	2.0	1.194	0.56
16	2.47	1.11	2.76	1.415	0.01 (s)

Compared to nonpsychiatric doctors, medical students had stigma that, people with a severe mental illness are dangerous as depicted in question number 5.

Compared to medical students non psychiatric doctors had stigma that, being a psychiatrist is not like being a real doctoras depicted in question number 8.

Compared to non psychiatric health professionals, medical students had stigma that, it's more discomfortable talking to a person with a mental illness as depicted in question number 10.

Compared to medical students, non psychiatric health professionals had stigma that, it is not important that any doctor supporting a person with a mental illness also assesses their physical healthas depicted in question number 11.

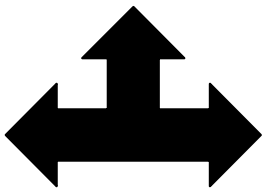
Compared to medical students, non psychiatric health professionals had stigma that, they don't want to work with a colleague if they had a mental illnessas depicted in question number 16.

Discussion

In present study observed negative attitude towards mental illness among medical students and non psychiatric doctors. Similar studies were observed by a number of authors in different countries [26-29].

When the mean scores of both medical students and non psychiatric health professionals groups were compared, it was found that there was no statistically significant difference between them. But both medical students and non psychiatric doctors had stigma that, psychiatrists know more about the lives of people treated for a mental illness than do family members or friends and the public need to be protected from people with a severe mental illness.

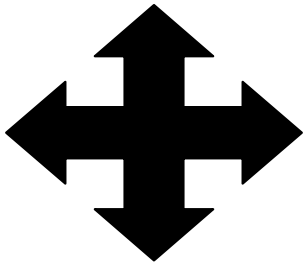
Compared to non psychiatric doctors, medical students had more stigma that:



People with a severe mental illness are dangerous

Its more discomfortable talking to a person with a mental illness

Compared to medical students, non psychiatric doctors had more stigma that:



Being a psychiatrist is not like being a real doctor.

Don't want to work with a colleague if they had a mental illness.

It is not important that any doctor supporting a person with a mental illness also assesses their physical health.

It is integral to recognise the value of changing attitudes and perceptions towards mental illness, to promote equality for people with psychiatric illness. There is a need to educate all students and doctors about psychiatric disorders. For which we may use interventions such as discussions, talks, and awareness sessions in class and tutorials. A recent study examined the effects of three strategies for changing negative attitudes towards mental illnesses: (i) education (which replaces myths about mental illness with accurate conceptions); (ii) contact (which challenges public attitudes about mental illness through direct interactions with persons who have these disorders); and (iii) protest (which seeks to suppress stigmatising attitudes about mental illness) [30].

A recent study in India suggested that students who had undergone psychiatry postings, showing positive attitudes toward people with mental illness [31]. Whereas a significant decrease in negative and stigmatizing views toward mental illness was concluded by other studies after exposure to psychiatry practice [32].

Conclusion

In present study we observed negative attitude towards mental illness among medical students and non psychiatric doctors which demonstrates the need for educational programs aimed at medical and non psychiatric doctors for providing basic information and thus demystifying mental illness.

Limitations

Study sample was collected from only one tertiary care hospital, which was the major limitation of the study and further research can be conducted, so results cannot be generalised to the population.

Conflicts of Interest

There are no conflicts of interest.

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Review Article

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Volume 2 Number 1, January - April 2019

Psychology of Suicidal Person

Harish Rajendra Wade

Abstract

Suicidal behavior is leading cause of injury and death worldwide. Overall 80-90% firearm suicidal methods have died. Suicide affect youngsters from all races and socioeconomic group. Boys succeed in their suicide attempts more frequently than girl's. Suicide patients which have a negative impact upon the quality of care they receive. And also include myths, facts etc. health care professionals to enhance their understanding of their attitudes toward patients who attempt suicide in order to enhance the provision of effective care to them.

Keywords: Suicide; Suicidal patients; Suicidal ideation; Psychology; Depression.

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Believe in yourself and all that you are. Know that there is something inside you that is greater than any obstacle. ***– Christian D. Larson***

Introduction

People attempt suicide because they cannot bear their psychological pain and doubt it will ever get better, imbalance defence mechanism is also important role, people always thinking about their future life and they plan accordingly but if any trauma or serious life threatening moment happen they break their motivation for survival.

Suicide, from Latin suicidium, is "the act of taking one's own life". Attempted suicide or non-fatal suicidal behavior is self-injury with the desire to end one's life that does not result in death [1].

Incidence

1. Over 200,000 farmers in India have died by suicide since 1997, partly due to issues of debt.
2. In China suicide is three times as likely in rural regions as urban ones, partly, it is believed, due to financial difficulties in this area of the country.
3. Most common method is hanging in 56 countries including 53% male suicides and 39% of the female suicides.
4. In developing world 30% of suicides are estimated to occur from pesticide poisoning.
5. firearms 80–90%, drowning 65–80%, hanging 60–85%, car exhaust 40–60%, jumping 35–60%, charcoal burning

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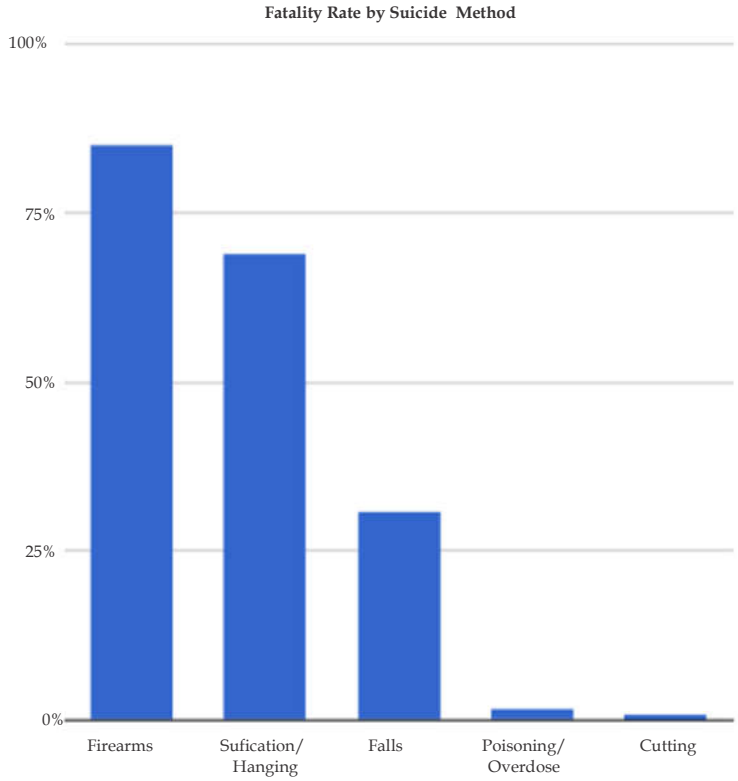
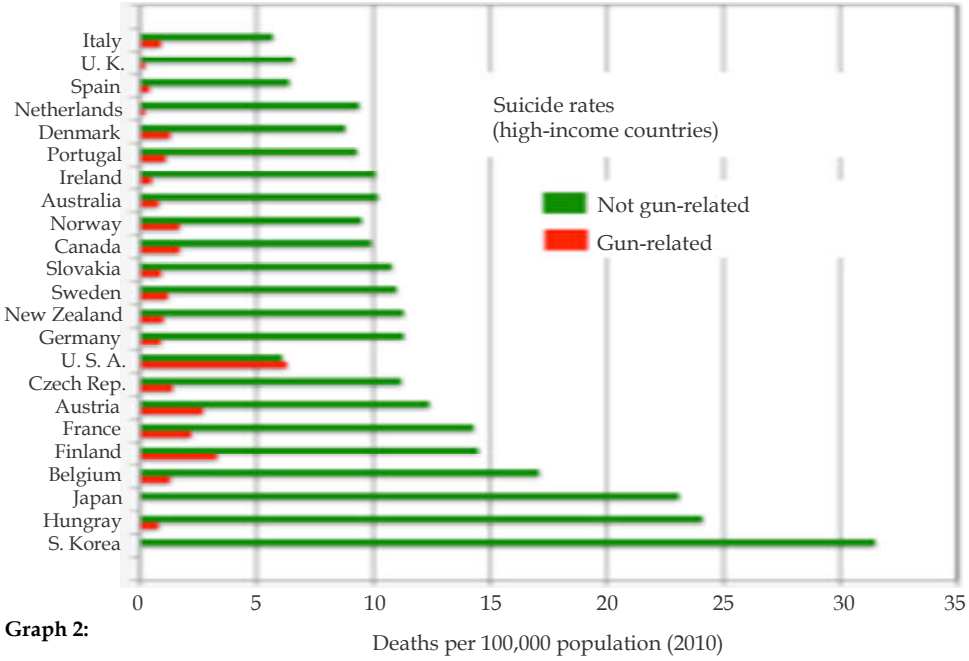
40–50%, pesticides 60–75%, and medication overdose 1.5–4.0%. The most common attempted methods of suicide differ from the most common methods of completion; up to 85% of attempts are via drug overdose in the developed world.

When people kill themselves, they think they're ending the pain, but all they'r doing is passing it on to those they leave behind ***–Jeanette walls***



Graph 1:



Graph 2:

Causes of Suicide

- Family problems (23.7%),
- Illness (21%) [Including insanity/mental illness (6.7%)],
- Unemployment (1.9%),
- Love affairs (2.9%),
- Drug abuse/addiction (2.3%),
- Failure in examination (1.6%),
- Bankruptcy (2.5%),
- Poverty (2.3%),
- Dowry dispute (2.3%). [4]

Increase Risk of Suicide Due To

Hey, you, yes you right there reading this. You're beautiful; you have every reason to live. I love you

1. Hopelessness
2. Poor ability to solve problem
3. Loss of pleasure in life
4. Poor impulse control
5. Depression, anxiousness
6. Loss of a closed one or loved one
7. Loss of a job or social isolation (such as living alone)
8. Never married
9. Poverty
10. Old age – being burden to others

High Risk of Suicidal Behvior In Mental Disorder

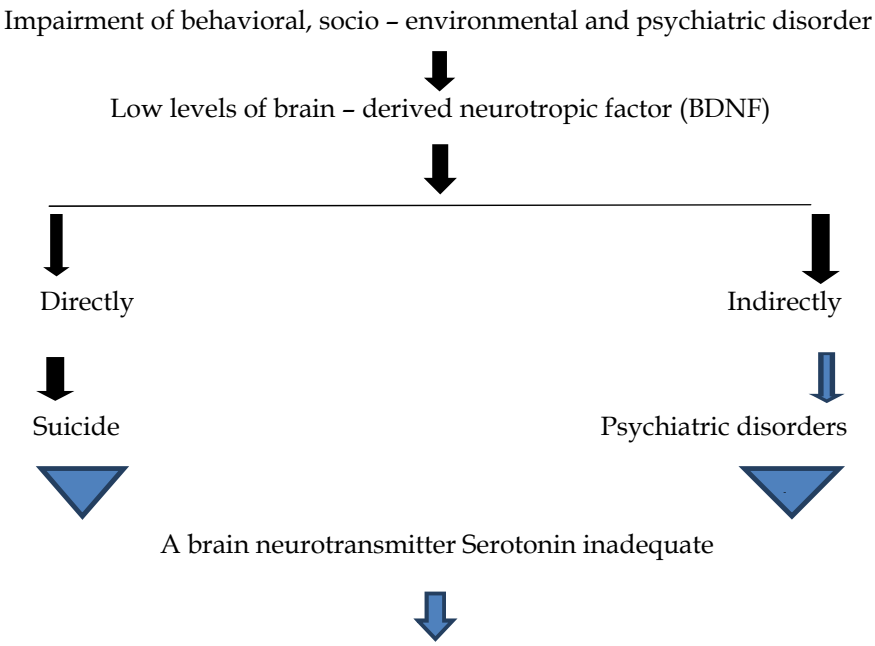
Major depression, posttraumatic stress disorder, obsessive compulsive disorder, schizophrenia, drug or alcohol abuse, dementia, delirium, personality disorder [5].

Patient with incurable or painful physical disorders like, cancer and AIDS

While anyone can become suicidal, there are certain risk factors that make suicide more likely:

- Previous suicide attempt(s)
- Having a family member or friend who recently killed themselves; multiple suicides in the community
- Other recent, significant losses, such as the loss of a relationship or job
- Cultural and religious beliefs supporting suicide (e.g., belief that suicide is a noble resolution of a personal dilemma)
- Alcohol and drug abuse (as this can lower inhibitions and increase impulsiveness)

Pathophysiology



Flow chart 1:

- Feelings of hopelessness
- Access to means of suicide (e.g., a gun, a quantity of pills) [2].

❖ *How to and what to talk to suicidal patients?*

1. Suicidal Patients
2. Patients under your care
3. Those who haven't attempted yet
4. Those who have attempted but (fortunately) survived
5. Colleagues at work
6. Friends and family

Experience happen with me:

I saw one of my closed one individual attempting suicide, trying to fall from terrace. I was a there in a little distance that moment was horrible suddenly I interrupt him and divert their focus to do task. And take away from that danger zone and talked about there problem. he has instinct not do again. I listened his problem and ventilate his feelings.

The Most Dangerous Myth

Myth: *Are you trying to kill yourself, this question increase idea of suicide.*

Fact

- We can check their capacity or thinking pattern of suicidal attempt because of that we can understand a person what they are planning, strategies etc. What he/she losing ? and this can relief their stress, and ventilate his /her positive feelings.
- Talking to a friend or family member about their suicidal thoughts and feelings can be extremely difficult for anyone. But if you're unsure whether someone is suicidal, the best way to find out is to ask. You can't make a person suicidal by showing that you care. In fact, giving a suicidal person the opportunity to express his or her feelings can provide relief from loneliness and pent-up negative feelings, and may prevent a suicide attempt.

What and how to talk to suicidal ideation client …

Ways to start a conversation about suicide:

✓ "I have been feeling concerned about you lately."

✓ "Recently, I have noticed some differences in you and wondered how you are doing."

✓ "I want to know are you free today."

Questions you can ask

✓ Are you trying to defend yourself?

✓ Do you feel you'r losing something?

✓ Why can't you not trying to solve your problem?

✓ Are you thinking hurting yourself?

✓ Are you blaming others?

✓ Have you ever thought about suicide before, or tried to harm yourself before?

✓ How can I help?

What you can say that helps

✓ Do you need any help ?

✓ What kind of help you need ?

✓ You can share your feeling with me or loved one ?

✓ Give me a chance, to correct it''

✓ I may not be able to understand exactly how you feelnow ?, but I support about you and want to help.

When talking to a suicidal person…

Do:

✓ Be yourself and show genuine concern

✓ Listen

✓ Talk confidentiality

✓ Speak with smart words

✓ Allow patient to cry, scream or swear

✓ Take the person seriously

Don't

✓ Don't be irritated keep a patience

✓ Don't force to talk

✓ Be so personal

✓ Argue with the suicidal person.

✓ Act shocked, lecture on the value of life, or say that suicide is wrong.

✓ Offer ways to fix their problems, or give advice, or make them feel like they have to justify their suicidal feelings.

✓ Blame yourself.

Fables- People who talk about suicide do not commit suicide. Suicide happens without warning.

Facts- Eight out of ten people who kill themselves have given definite clues and warnings about their suicidal intentions. Very subtle clues may be ignored or disregarded by others.

Fables- You cannot stop a suicidal person. He/ she is fully intent on dying.

Facts- Most suicidal people are ambivalent about their feelings regarding living or dying. Most are ''gambling with death'' and see it as a cry for someone to save them.

Fables- Once a person is suicidal, he or she is suicidal forever.

Facts- People who want to kill themselves are only suicidal for a limited time. If they are saved from feelings of self-destruction, they can go on to lead normal lives.

Fables- Improvement after severe depression means that the suicidal risk is over. Most suicides occur within about 3 months after the beginning of improvement when the individual has the energy to carry out suicidal intentions.

Fables- Suicide is inherited, or ''runs in families''.

Facts- Suicide is not inherited. It is an individual matter and can be prevented. However, suicide by a close family member increases an individual's risk factor for suicide.

Fables- All suicidal individuals are mentally ill, and suicide is the act of a psychotic person.

Facts- Although suicidal persons are extremely unhappy, they are not necessarily psychotic or otherwise mentally ill. They are merely unable, at that point in time, to see an alternative solution to what they consider an unbearable problem.

Fables- Suicidal threats and gestures should be considered manipulative or attention – seeking behaviour and should not be taken seriously.

Facts- All suicidal behaviour must be approached with the gravity of the potential act in mind. Attention should be given to the possibility that the individual is issuing a cry for help.

Fables- People usually commit suicide by taking an overdose of drugs.

Facts- Gunshot wounds are the leading cause of death among suicide victims.

Fables- If an individual has attempted suicide, he or she will not do it again.

Facts- 50% - 80% of all people who ultimately kill themselves have a history of a previous attempt [3].

Risk Assessment

If you are not willing to risk the unusual you will have to settle for the ordinary

If a friend or family member tells you that he or she is thinking about death or suicide, it's important to evaluate the immediate danger the person is in. Those at the highest risk for suicide in the near future have a specific suicide Plan, the Way to carry out the plan, a Time fordoing it, and an Source to do it.

Help you assess the immediate risk for suicide

- Low – Some thoughts. No suicide plans..
- Moderate – Suicidal thoughts.
- High – Suicidal thoughts more risk to do.
- Severe – Suicidal thoughts. Sure to do suicidal attempt.

Management

Suicide is not an answer, its destruction

- Assess risk
- Remove potential means of suicide
- Be with always one person
- Remove all hazardours things from their surrounding
- Involve in a physical activity like exercise
- Constant observation at all times
- "Suicide-proof" the environment
- Ventilate his negative thoughts
- Prepare a schedule for preventing any suicidal ideation
- Mobilize a support team for the individual
- Document all actions

1. Do not, under any circumstances, leave a suicidal person alone.
2. Take a Advice from a psychiatrist.
3. Follow-up on treatmentIf the doctor prescribes medication, make sure your friend or loved one takes it as directed. Be aware of possible side effects and be sure to notify the physician if the person seems to be getting worse. It often takes time and persistence to find the medication or

therapy that's right for a particular person.

4. Be proactive. Those contemplating suicide often don't believe they can be helped, so you may have to be more proactive at offering assistance. Saying, "Call me if you need anything" is too vague. Don't wait for the person to call you or even to return your calls. Drop by, call again, invite the person out.
5. Encourage positive lifestyle changes, such as a healthy diet, plenty of sleep, and getting out in the sun or into nature for at least 30 minutes each day. Exercise is also extremely important as it releases endorphins, relieves stress, and promotes emotional well-being.
6. Make a safety plan. Help the person develop a set of steps he or she promises to follow during a suicidal crisis. It should identify any triggers that may lead to a suicidal crisis, such as an anniversary of a loss, alcohol, or stress from relationships. Also include contact numbers for the person's doctor or therapist, as well as friends and family members who will help in an emergency.
7. Continue your support over the long haul.
8. As you're helping a suicidal person, don't forget to take care of yourself. Remove harmful means of suicide, such as rope, knives, razors, or firearms. If the person is likely to take an overdose, keep medications locked away or give out only as the person needs them. Continue your support over the long haul. Even after the immediate suicidal crisis has passed, stay in touch with the person, periodically checking in or dropping by. Your support is vital to ensure your friend or loved one remains on the recovery track.
9. Diagnosing the underlying pathology, if any.
10. Psychotherapy, Safety contract / No suicide Pact.
11. Make a safety plan.
12. Medications.

Conclusion

if we think that suicide will help to resolve our problem, so it's completely unrealistic because attempt suicide or completed suicide directly and indirectly affect our family, society, and community but unmet expectation can lead to depressive feelings. We always thinking about one option but if we take some time and think about solution I make sure it will give uncountable solution how to prevent it, when a person feels they have run out of solution to problems, so its impossible find someone that you trust, talk to about your feelings and get support of your own.

Suicide doesn't kill people, sadness kill's them

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Review Article

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Gender Differences in Mania

Suprakash Chaudhury[1], Ajay Kumar Bakhla[2], Vijay[3], Subodh Kumar[4], Swaleha Mujawar[5], Chetan Dewan[6]

Abstract

Gender remains an important determinant of psychological fitness and psychiatric disorders. Biological vulnerabilities may be accentuated and exacerbated by interaction of gender and social determinants. Sex differences in age of commencement of psychiatric disorders, their course, symptom presentation, co-morbidity rates and treatment response have been reported consistently in bipolar disorder. Few workers evaluating differences, according to sex, in presenting symptoms of mania have reported men with mania exhibit higher prevalence of problems in behavior and are able to converse with difficulty. In contrast, female patients even during mania show higher amount of symptoms of depression. More recently women with mania were reported to have higher scores on lability of mood, depression, anxiety, guilt and suicidal thoughts while men obtained higher scores on humor, grandiose ideation, psychosis and motor activity. The finding of clinical differences in mania according to gender emphasizes the need for large scale studies on patients with bipolar disorders to firmly establish whether there exist clinical differences in symptomatology according to gender and measures to improve compliance with treatment. There is a pressing requirement to evaluate the safety of different treatment modalities during pregnancy.

Keywords: Gender; Sex; Mania; Bipolar Disorder.

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Introduction

To a great extent gender affects the power males and females have over the social and economic factors that influence their social position, social status and exposure to risk factors for psychiatric disorders. Thus gender has a vital influence on psychological fitness and psychiatric disorders. The genetic difference between women and men alone do not explain differences in vulnerability, prevalence and symptom presentation of illness. The genes and environment interaction is complex; genetic endowment elicits individual environments (the nature of nurture), and experience modulates the expression of genes [1].

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In most of the psychiatric disorders, the symptomatology, clinical course and outcome have received greater interest while the influence of gender on symptomatology as also the mechanisms that may prevent psychiatric disorders and promote resilience to stress have not received much attention.

Gender Difference is not synonymous with Sex Difference

The increasing tendency of using "Gender" as a substitute for "Sex" has created confusion since they are not synonyms. Sex indicates specific characteristics that are biologically determined. In contrast, gender denotes culturally-and socially-determined distinctions between males and females [2].

Gender is linked to how we are supposed and projected to feel and behave as males and females because of our social and cultural background, and not because of biology [3]. Gender equality implies evenhandedness and fairness in the allocation of duties and reimbursements between males and females [4].

Gender-based differences may originate from a biological, psychological, social and/or epidemiological (population-based risk) factors. Rarely does biology acts alone in the causation of psychiatric disorders. Usually biological vulnerabilities are affected by interaction of social and psychological factors, including gender [5].

In a number of psychiatric disorders gender based differences have been reported in age of commencement and natural history of the disorder, symptom presentation, co morbidity rates and treatment response. The differences are remarkable during childhood, then the pattern of difference changes at puberty, at adulthood and around old age [6]. Male child are more prone to conduct disorders, hyperactivity syndromes, anxiety and depression, autism and learning disabilities.

However around and after puberty the predominance of psychological illness is taken over by girls except substance abuse, schizophrenia, and impulse control disorders [7]. It has been estimated by the World Health Organization that women and children constitute 80% of 50 million people who are forcibly displaced as a result of violent conflicts, wars, and disasters. In their lifetime one in five women are raped or face a rape attempt while 16% to 50% endure violence [8]. Exposure to such stressful life events may lead to psychiatric disease [9].

Gender Difference in Mania

The prevalence of bipolar disorder (BD) is equal in women and men according to epidemiological studies [10], while females have a higher prevalence of depression. There have been suggestions that women experience more depressive episodes than their male counterparts, but the Systematic Treatment Enhancement Program for Bipolar Disorder study found no gender difference with respect to past episodes of mania or depression [11]. It has been suggested that "hard" or "core" bipolarity, characterized by mania or prominent hypomania, may have an equal gender distribution, and possibly a male predominance when defined by minimal associated depression. By contrast, "soft" bipolarity, particularly when defined by mild hypomania or hypomanic symptoms and prominent associated depression, may have a female predominance [12].

Age of onset

In the Epidemiologic Catchment Area study the mean age at onset of mania was 21.2 years [13], whereas the more recent Systematic Treatment Enhancement Program for Bipolar Disorder (STEP–BD) study reported a mean of 17.37 years [14]. A retrospective analysis of all adult patients suffering from first-episode psychosis, mania, or hypomania and reporting for psychiatric treatment in Camberwell, during 1965-1999 revealed onset of mania in men was earlier as compared to women [15]. Though women have an earlier age at onset than men, [16] but they receive the diagnosis of BD on average 4.4 years later than men [15]. This difference in age of commencement of illness is not only of theoretical interest but also is of clinical significance. Early age at onset is associated with poor prognosis: increased rates of psychosis, increased rates of co morbid substance misuse and co morbid psychiatric disorders, increased suicide risk and neuropsychological dysfunction [17].

Course of illness

First episode in BD is likely to be a manic for males and depressive for females [18,19]. Rapid cycling course in female has been one of the most consistent findings [16,20]. The European Mania in Bipolar longitudinal evaluation of medication (EMBLEM) study found a predominance of females with rapid cycling course [21]. Contrary to this, of the individuals entering the STEP–BD trial, 32%

met rapid cycling criteria in the previous year but no correlation was found with female gender and rapid cycling [11].

In females more episodes of depression or dysphoric mania was noted than pure mania [22,23] the average duration of individual episodes of depression was found to be longer in female [24].

Female patients with BD are more prone than bipolar men to experience a sequence of depression followed by mania (sometimes called the DMI pattern) [25], whereas men with BD are more or equally prone to suffer the episode pattern of manic episode followed by depression (the MDI pattern) [18]. A possible relationship between female bipolarity and seasonality was reported [16]. This was further substantiated by a study that reported increase in psychiatric hospitalizations of female BD patients in the spring and fall as compared to a unimodal peak in the spring in bipolar male patients [26]. An Indian study found that resolution of mania settles faster if they exhibit aggression and sexuality, and females settles later specially if they exhibit anxiety and lability [27].

Clinical feature

Classical symptoms of mania as described with the 10th edition of International Classification of Disease, Diagnostic Criteria for research (ICD -10, DCR) are elevated, expansive or irritable and abnormal mood, increased activity or physical restlessness, talkativeness, self -esteem or grandiosity, sexual energy, thoughts racing, loss of normal social inhibitions, decreased need for sleep, distractibility and foolhardy or reckless behaviors. But clinically other atypical features like depression, anxiety, irritability, and psychosis related aggression, paranoia and disorganization are found in part or even dominates the clinical picture.

Factor analytic studies have extracted five factors: dysphoria (depression), increased psychomotor activity, amplified hedonism, irritation with belligerence and psychotic features as features of atypical mania [28]. There is a paucity of studies evaluating differences in presentation of episodes of mania according to gender. Similar to the pattern reported for BD, studies suggests that female patient even during the episode of mania exhibit higher amount of symptoms of depression (mixed mania) compared to male patients [29,30]. On the other hand men suffering from mania are not able to take part in a discussion and show greater behavioural problems [18]. A recent Indian study on mania observed significantly higher grandiosity, humor, motor activity and psychotic symptoms in men while scored significantly higher on dress, mood lability, depression, anxiety, guilt and suicidal ideation [31].

Comorbid conditions

Overall in BD a higher psychiatric co-morbidity is observed in females [32], but substance use and conduct problems are more frequently encountered in males and sexual trauma in females. [15,33]. Some of the important co-morbidities associated with women with BD are:

Anxiety disorders

Comorbid anxiety disorders are common and there is a lesser association with bipolar I disorder than bipolar II disorder [34]. The presence of high anxiety scores in patients with BD is associated with higher rates of cyclothymia, alcohol use disorder and suicide. BD patients with high anxiety respond poorly to treatment with lithium [35].

Thyroid disease

Thyroid disease is more common in BD populations, especially in women, and this finding is present in populations which have not received lithium therapy [36].

Migraine

Females with Bipolar II disorder have increased likelihood of suffering from migraine. In females the occurrence of migraines with BD is associated increased prevalence of comorbid medical problems, whereas in males the presence of migraine in BD is associated with early onset of the disorder and increased occurrence of anxiety disorders [37].

Eating disorders

Studies have found that females suffering from BD have higher prevalence of eating disorders [18].

Pregnancy

During the course of BD in women, a major risk factor for relapse is the occurrence of pregnancy. Some studies have reported the risk of relapse to be

50% [38]. In a small prospective observational cohort study of pregnant women with BD pregnancy was associated with relapse in 71% patients. These episodes were depressive in nature in the majority of cases and nearly half had occurred within the first trimester. Recurrence was more likely if a woman had discontinued medication.[39]. Studies on the consequences of taking antipsychotics and mood stabilizers in pregnant BD women are of small sample size/case reports and have given contradictory results. Lithium use in pregnancy is associated with occurrence of Ebstein's anomaly of the heart [40]. The use of antipsychotics and anticonvulsants during pregnancy is associated with higher occurrence of complication of pregnancy, birth defects, complications during neonatal period, and long term adverse developmental outcomes during childhood [40–45]. In women who were treated with multiple anticonvulsants during the first three months of pregnancy, the risk of fetal malformation was significantly higher when lamotrigine or carbamazepine was used together with valproate, but not when either anticonvulsant was used alone [46]. Treatment with clozapine, olanzapine, risperidone, and quitapine are not reported to cause major fetal malformations. There is limited information on aripiprazole and ziprasidone. Due to its association with cleft lip and palate benzodiazepines should be avoided during pregnancy. Similarly antiparkinsonian drugs should be avoided in pregnant women. Electroconvulsive therapy is safe and effective in pregnant women [32].

Therapeutic issues

The pharmacotherapy of bipolar in female patient is complicated due to its atypical and mixed presentation, associated medical and psychiatric comorbidities, and distinct side effect profile. The salient therapeutic issues restricted to gender variation are summarized here. Gender does not affect pharmacodynamic response of bipolarity to lithium. [47]. Possible gender differences in the pharmacodynamic response of bipolarity to valproate, carbamazepine and atypical antipsychotics have been less systematically evaluated. No data exist, however, to suggest that gender produces clinically relevant changes in the response to these agents. Though reproductive-aged women with BD being treated with valproate (and other mood stabilizers associated with weight gain) should be monitored for menstrual irregularities and hyperandrogenism [48]. Lithium-associated hypothyroidism and weight gain is more common in women, whereas men are more likely to develop tremor [49]. Typical antipsychotic medications and the novel antipsychotic risperidone are associated with increased risk as well as more distressing presentation of hyperprolactinemia in females [50].

Adherence to treatment

In BD patients high rates of nonadherence to treatment of up to 32.9% have been reported in a study in United States of America [51]. A 10 year naturalistic follow up study in Span reported nonadherence to be 6.7% in women versus 39.39% in men. Treatment nonadherence in BD patients is associated with comorbid substance use disorders, marital status, hospitalization, suicide attempts, age at disease onset, family history, health status, functional level, residual cognitive dysfunction, lower level of education and gender [52–54]. Most of the studies have evaluated gender differences in clinical features and there is a dearth of knowledge about the effects, if any, on occupational and social functioning. A few studies have observed that among patients with acute mania lesser number of men than women lived with a partner of resided alone. However, as regards working or taking part in social activities no gender differences have been reported [55].

Conclusion

From the review it is evident that there are clear gender differences in mania. This emphasizes the need for large scale studies to evaluate the various aspects of gender differences in mania and measures to improve compliance with treatment. There is a pressing need to evaluate the safety of different modalities during pregnancy.

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Review Article

RFP Indian Journal of Medical Psychiatry
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Digital Detox "A Day without Applications"

Harish Rajendra Wade

Abstract

If we think of "a day without smart phones" we are no Where, we are ready to compromise our friends, family and relationships just because we are too busy in our smart phones. Too much dependency on smartphones creating in number of difficulties in our daily lives, work place burnout, irritability, frustration, overthinking, depression, mood swings, and many psychological issues such as decreased concentrations & attention and medical alienments such as obesity, hypertension, postural abnormalities are very common.

Keywords: Smartphones; Digital detox; Applications

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Introduction

This one day change will change your pattern of daily living or affect so much, that's depend on you, how you will manage yourself. if we think in present technological world without smartphones, we detach our friend and family, relationship, but because of that we can't give to our self- due to problem solving difficulty, frustration, overthinking, depression, medical diseases, psychological problem detected. We should know the importance of self-realization, and self-perception, self-body image etc. Questions arise who we are?,

Nowadays we act like smartphones is our basic of hierarchy need like food, hunger, sleep, shelter etc. its true or not but YES, smartphones also have added ease life in our life, it's a chain of communication, its easy and smarter way to do work, helpful for multitasking activities.

"Raising awareness of one's own smartphone use can be the first step in the right direction of decreasing smartphone use" often individuals are not aware of the frequency and extent of their smartphone use'' [1].

-Says Dr. Dariakuss
from Nottingham trent university

For some people it's hard to go a day without smartphone, but we all know before invented mobile still people fulfilling life, people were connected to humanity and appreciate others from using communication skills, and even I found without a smartphone for one day will do no harm, but it gives so much relaxation about all application

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Trending issues

Your Smartphones Brand/Model Represent Your Standard/Status of Life.

□ ***Questions arise:***

1. We can't survive or feel awkward.
2. Best selfies competition occur but how we look actually that we forgot and other person not assuming the reality face of your?
3. If that person have costly mobile so I also want?
4. Are you giving time to your friends, family, society?
5. Are you developing your physical strength, skills from internet?
6. Is childhood experience changes? because of smartphones games, attraction.
7. At what age you started controlling, handling the smartphones?
8. Smartphone giving you right direction ?
9. What you are losing or gaining from smartphone?
10. You control yourself or mobile control you? Think about it?

□ ***Got a better result***

In a exam time, examination cell not allowed student to enter a hall with smartphone. It's a because of misusing a smartphone in a exam time and this rules made student to focus on their exam only and fulfilling their tasks. Some of company also not allowed a worker for using a smartphones in their working time, goal is to effective work.

"Let me ask you, "who's the captain, you, or your phone?''

Now, you might bring up a lot of reasons why you need to have your phone with you:

What if your loved one need you?

What if there is some major issue and you need a phone?

You need to connect with your friends

You need to listen music.

These are just a few of the many excuse you might think of. All the reasons are right, but people lived without phones, and they lived happy without them.

□ ***Adjusting to situation***

- Informing the friends or family about it this will prevent everyone from any misunderstanding.
- Involve yourself in activity which doesn't involve smartphone like a discussing on a topic, writing work etc. But if you spend your one day without smartphone you will get to know about your patience capacity.

❖ *Why you should follow 'A day without a smartphone?'*

- Sometimes you firm our behavior in a robotic pattern, our daily pattern.
- You don't realize on social media what is right or wrong? nowadays social media, like application misguide/ changing your cognition according to their benefits.
- To know the difference between humanity and technology.
- To understand our environment.
- To realization of present facts.

❖ ***How you control your smartphone ? way of using smartphone***

- When you wake up in the morning, on the way, to work, on the traveling, sometimes at work,
- When you get from work
- ✓ Its constant
- ✓ I watched a TED talk by doctor Cal Newport and
- ✓ He said "going on social media is like going to the casino''
- ✓ You are anticipating getting likes and you come out of it, you go back in thinking 'I will get the reward'.
- ✓ Next time 'I will get the reward" and you sit and waiting for notification.

Problems encounter

- Difficulty in coping with everyday situations
- Difficulty concentrating and focusing
- Anger

- Illusion – (in extreme) we assume that mobile is with us even though it's not there
- Anxiety or panic episodes
- Intense loneliness and sadness

Experiment

□ I think i was 16 year then i got a phone from that day to the present day i am using a mobile but this one day will give a positive change in my life

We all know 'humanity is involving in technology rising'

Planet earth is changing, we are leaving in a age of constant change with constant battle between humanity and technology,

□ It's like i am doing a fast of "mobile baba" suddenly mood swings occur like i want to know what going on my timelines, any important message came and i can't able to reply them, this all are thought roaming in our mind, to maintained that patience without using a smartphone its horrible and i think its fabulous experiment i have done

□ No mobile phone in a day

□ Positive result

I got extra time, i saved 1 hour from this day

I found myself stress free, everyone in their life facing problem and i found that what are sources of problem therefore ? and that sources is smartphone also included ?

□ ***Negative Result***

- Leaving my cellphone at my phone
- Getting lost
- Patience
- Anxiousness
- I feel like i am behaving like antisocial person
- Looking here and there
- No contact in my hand and even i don't remember any contacts except mother number
- It's i like free but there i was thinking is it good ? or bad ? question arises

Types of bonding with smartphones

1. Using only for calling purpose.
2. For someone way of connecting to friends, an escape, a source of wistful dissatisfaction, an obsession.
3. For advertising our business, name etc.
4. Playing games only
5. Taking pictures.
6. Expressing yourself more important than others.

1. A Smartphones is Like Locker of Our Banks

□ People using smartphones give more priority to their mobile, there is connection between the psychological problems and their use of application its found that student are more obsessive, addictive tendencies toward their smartphones, using internet in genral were also more likely to be anxious, depressed.

□ People who described themselves as tending toward being addicted to the internet and cell phones "scored much higher on depression and anxiety scales'', [1].

-According to researcher Alejandra Lleras

2. Some points to prevent from exposure

□ Use headset.

□ For preganant women avoid contact smartphone to the abdomen.

□ For men: use wallet case.

□ Don't keep your mobile below the pillow at bed time.

□ Don't allow your children to play with or use your mobile.

□ Don't text and drive.

□ Switch off your wi-fi router at night.

□ Eat healthy vegetables.

□ Don't use your mobile before sleeping.

Smart phone health hazards

There is a dangerous side effect occur due to microwave radiation it affect our immune system. We strive to be constantly connected and available. This makes us feel tired, nervous, and absent – minded. we hardly realize that a reason for our fatigue is hidden in our pocket. Some are list below [2].

1. Phantom pocket vibration syndrome

- Checking the mobile that its vibrating but actually its not ringing. this is called as phantom pocket vibration syndrome. This occur between the teenage group who are addicted.

2. Blurred vision

- Messaging or reading news, articles on the internet, we set in a small sized font in our mobile. that gives a lot of pressure on your eyes. After your work you feel dry out and hurt when blinking. Always away your mobile 16 inches from your face. Vision problem person should use bigger font in your mobile. if any symptoms occur contact to ophthalmologist.

3. Brain cancer risk

- Microwave adverse effect on our body and can trigger the development of brain cancer in the future.

According to the research conducted by the international agency for research on cancer, excessive use of cell phones may lead to the formation of such brain tumors as glioma and acoustic neuroma.

4. Sleep disorders: Because alarm set, vibrating and ringing of mobile it affect s our sleep.

5. Neck and back pain.

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Review Article

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Collective Bargaining

Zeeshan Parvez Khan

Abstract

Collective bargaining is usually part of unionized workplace. It is a process that is designed to help employees earn better wages, benefits and working condition. It is also a process which can help employer ensure that they get the best workers, consistency with productivity and a set of standards that every worker can be held to while in the workplace.

Keywords: Negotiation; Employee; Rights; Employer.

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Introduction

An Individual is free to Bargain for himself / herself and safeguard his / her own interest. The phrase 'Collective Bargaining' consists of two words 'collective' Which Implies.

Group action Through its Representative and 'Bargaining' Which suggests negotiation.

Definition

According to marquis and Huston Collective Bargaining may be defined as "Activities Occuring Between Organized labour and management that concern Employee relations such activities include negotiation of formal legal agreement and day to day Interaction between Unions and Management.

Meaning

Collective Bargaining is a procedure which the terms and conditions of employment of workers are regulated by agreements between their bargaining agents and be the employers.

Objectives of Collective Bargaining

1. To maintain cordial relations between the management and workers.
2. To resolve the conflicts and problems relating to wages and working conditions of the workers.
3. To implement the values and interests of the workers by collective action in order to benefit the employers.

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4. To ensure the participation of trade unions in industry.
5. To find the solution on the distinctions of those involved between the workers and management through voluntary negotiations and by arriving at conclusion.
6. To avoid that need for government intervention as it is a voluntary process.

Purposes

1. The main purpose of collective bargaining is the settlement of industrial disputes are conflicts relating to wages.
2. It harmonizes labour relations
3. It promotes industrial enterprise peace by creating equality of bargaining power between the labour and management
4. It improves working conditions
5. It prevents workers from getting into unfair treatment

Unions in Bargaining

A union are labour organization is any organization in which employees participate for the propose of dealing with their employer about grievances, labour disagreements, wages hours of work and conditions of employment

Objective of unions

1. Wages-employees and their union can be expected to ask for ways, which are comparable to those in similar jobs in the local market.
2. Promotion-unions will insist that length of service be a factor in promotions.
3. Layoffs-the union will insist that seniority play a part in regulating lay off qualifications being the junior service employees will be paid off first.
4. Discipline-employees will be disciplined for just cause these is standard in all labour agreements.
5. Grievances procedures-the union will insist that grievance procedure be established whereby management decisions will be reviewable by representative of management and the union if there is still disagreements the dispute will be referred to arbitration.
6. Fringe benefits-pensions vacations and holidays social insurance and general welfare programs will be part of the negotiations with an attempt to make them comparable to the trend in the society.

Constituents of collective bargaining

1. Indication of agreement with definite needs has good scope of importance benefiting the workers.
2. Collective bargaining about the rights of the workers trade union and accountability of the management.
3. About the total salary, bonus, production riles, regulation retirement benefits and other terms and conditions of services as stipulated.
4. Provision for benefits for grievance redressal procedure.
5. To provide the apt method and machinery for the settlement of possible disputes and conflicts.
6. About the detailing bill are the work contract details are the terminal clauses.

Essential Features of Collective Bargaining

1. Group and Collective Action

It is always a collective process in two ways. the workers collectively negotiate for their common interests and benefits so that common interests and benefits so that they and the management jointly arrive at an amicable solution through Negotiations.

2. Strength

In case of bargaining process strength of both parties is equal.

3. Continuous Process

It establishes a regular, systematic and stable relationship between the parties involved it involves not only negotiation of the contract but also the continuous administrating as application of the contract.

4. Flexible

It is flexible and adaptable. Far both parties have to adopt a flexible attitude theatres of collective

bargaining are that both the parties concerned start negotiations with completely different views and concepts but finally react a middle path acceptable to both.

5. Voluntary

It is a voluntary process on the part of the management and the workers. The implementation of the mutual agreement is also a voluntary process since it benefits both the parities.

6. Dynamic

It the past, the concept used to be changing emotional and turbulent but now it has become scientific, fetial and systematic its coverage and style have changed.

7. Power Relationships

It involves an author restive relationship, workers want to gain the maximum from the management and the management wants to extract the maximum from workers by paying as little as possible

8. Bipartite process

The Management and the workers do the collective bargaining the issues directly across the table. There is no third party intervention.

9. Two–part process

It is mutual process where both the parties up the benefits in terms of arriving at the settlement of a dispute passed are not passed.

Steps of Collective Bargaining Process

1. Identification of the problem-

It is to identity the problems in working area that inferences the whole process. Of collective bargaining it also effects the selection of representatives their number period of negotiations and period of agreement that is remedied ultimately.

2. Preparation for Negotiation -

Negotiations are prepared offer detailed planning and implementation of the planned strategies that consumes long period of time. They set-up the objectives to be retrieved through the collective bargaining.

3. Negotiation Procedure -

a) Representatives Who lead the negotiation are selected by the members of the trade union selected by the members of the trade union.

b) They do the review about the existing problem in depth : one who be leads the group with austerity will be decided to lead the negotiation in a successful manner.

c) Particular time and duration will be fixed in advance fixing for negotiations.

d) Always the chief negotiations delivers the problem to the group. narrates its intensity and nature and the ideas and concepts of both parties representatives both the sides are allowed to deliver their verbs about the problems.

e) Representatives from both the side shouldreach the negotiation table with a positive frame the negotiation table with a positive Frome of mind and should try to ascertain what the other party is arguing for far.

f) The process generally culminates in on agreement which is known as labour contract union contract as a labour-management contract.

g) The agreement should be printed and circulated among all the employees so that they known erectly what has been agreed upon between the management and their representatives.

h) Both parties should sign the agreement which in turn becomes a binding must there after be sincerely observed by them.

4. Implementation of Contract –

The implementation of the negotiation process is not met merely by signing the agreement but by the development of good relationship between the workers and the management.

Classification of collective Bargaining

1. Integrative bargaining-

In this type of bargaining both parties may gain their benefits or none gains.

2. Attitudinal Structuring –

This involves reshaping and moulding the attitudes like friendliness or hostility or trust or distrust between weakens and management.

3. *Distributive bargaining* –

   This in values bargaining over the distribution of surplus products which involves the economic issues like salaries wages and bonuses that needs vigilant supervision and control.

4. *In reorganizational Bargaining* –

   This involves carefullyguiding to active agreement with the employees and management Note that even within the union mare may be same disagreements between different groups.

Principles to be Followed By the Management In Collective Bargaining.

1. The Management must Frome and adapt a realistic labour policy that con be applicable practically and which should always alerted and carried out by its represent actives.
2. The management must have the mutual agreement to reform the tribe union or asocialas a beneficial step in the organization.
3. The management staled always deal only with one association or trade unbar in the organization.
4. The management should treat the trade union without any partiality in aides to make it a responsible port of the organization.
5. The management should regularly frame and evaluate the rules and regulations to determine the attitude and degree of comfort of its employees and in fun gain their good-will and cooperation.
6. The management should place vital importance on social considerations while weighing the economic consequences of collective bargaining.
7. The management should analyse before the trade union dies to brig employee problems to its notice and should rather from the conditions in which employees can directly approach the management without taking the help of the trade union as association.

Importance of Collective Bargaining

Ascending to the national commission on labour the best jurisdiction for caller. Tine bargaining and as suet superior to any arrangement involving third-party intervention in matters which essentially concern employers and workers.

Thus Collective Barge vining is important for a number of Reasons-

1. It is democratic method where every employee has the freedom to exercise his/ has right's and the same is implemented by collective bar gaining about the conditions of it is always a voluntary process without any third party intention.
2. It ends in good relationship and under storing between workers and management the employer gain a better insight in the problems and aspirations of workers and the workers become better aware of the economic and technical problems of the industry.
3. If provides adaptable means for adjustment of wages and employment conditions to economic and technological charge in the industry, as a result of which the chances of conflict are reduced.
4. It assists in establishing code that defines the rights and obligations of each party.
5. It provides a solution and alternative to the problems of industrial sickness in industry and ensures old-age pension and other fringe benefits.
6. It facilitates better application of decisions due to the direct involvement of both the parties.
7. It is the significant aspect of labour management relations and extends the democratic relations principle from the political to the industrial field.
8. It evaluates and distributes equitably the benefits derived from industry among all the participants, including, employees, unions, suppliers, management customers and public.

Collective bargaining in nursing

Advantages and disadvantages of collective bargaining-

Advantages-

1. Its provides equal powers bargaining between administrator and staff associate.
2. The benefits of grievance reporting procedure becomes possible for all workers.
3. It is help for stuffing in systematic manner and equitable distribution of work can be established.
4. Professionalism will be enhanced.
5. Able to do the direction and control of the barging process.

Disadvantages-

1. There are cancers for development of adversary relationship between administration and staff associates.
2. But the possible strikers may affect those grievance benefits being reached to the workers may not be prevented.
3. Sometimes not possible if negotiations do not occur properly since union can interfere with the management of the organization.
4. If there is no dispute settled, then it is difficult to promote professionalism.
5. Needs good knowledge and training in the collective bargaining leadership for unions may be difficult to find because many professional nurses have little experience in position of authority.

Conclusion

Negotiations may be competitive collaborative but collaborative negotiations generally have more positive outcomes. A major goals of effective negotiations is to make the other party feel satisfied with the outcome. The focus in negotiation should be create a win-win situation.

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[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006; 35: 540-7.

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Corporate (collective) author

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[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979-2001. www.statistics.gov.uk/downloads/theme_health/HSQ20.pdf (accessed Jan 24, 2005): 7-18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

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