Kerala Journal of Psychiatry

Volume 27, No 1, Sep 2013

Official Publication of Indian Psychiatric Society, Kerala State Branch

Kerala Journal of Psychiatry

Volume 27, No 1, Sep 2013

Official Publication of Indian Psychiatric Society, Kerala State Branch

Kerala Journal of Psychiatry

Volume 27, No 1, Sep 2013

Official Publication of Indian Psychiatric Society, Kerala State Branch

Contents...

Kerala Journal of Psychiatry - Instructions to Authors

Submission of Manuscripts
All submissions should be e-mailed to editoripskerala@gmail.com . Submitted manuscripts that do not follow our "Instructions to Authors" will be returned to the authors for necessary corrections.
Preparation of Manuscripts
Use text/rtf/doc/docx files. Do not incorporate images in the article file. Email them as separate attachments.
Structure of the Manuscripts
All manuscripts should be structured in the following order

1. Title Page
This page should include
1. Title (no more than 12 words)
2. Name, highest degree, and affiliation of each author
3. Running title of 50 characters or less. This should not contain the authors' names.
4. Type of manuscript (original article, case report, review article, letter to editor, clinical images, etc.)
5. Date and place of the meeting if the paper was presented orally
6. Name, telephone number, email address and mailing address of the author to whom correspondence or requests for reprints should be sent.
7. Total number of pages, word counts for abstract and article, and total number of images and tables in the article.

2. Abstract
Abstracts should be constructed under the following headings:
a. Original Articles: structured abstract within 250 words under following headings
   1. Background (the rationale for the study)
   2. Methods (how the study was done)
   3. Results (major findings)
   4. Conclusions (a discussion of the results)
b. Review articles: an unstructured abstract within 200 words.
   c. Brief Communication: an unstructured abstract within 200 words.
   d. Clinical Images, Letters: abstract not required.

3. Text
The text of original articles should be divided into sections with the following headings:
1. Introduction
2. Material and Methods
3. Results
4. Discussion
Communications should be divided to –
1. Introduction
2. Case report
3. Discussion
Please take care of the following points while preparing the manuscript

a. Use double spacing throughout the manuscript— including the title page, abstract, text, acknowledgments, references, and legends.
b. Use font size 12, Times New Roman, in black colour
c. Number the pages consecutively, beginning with the title page, in the upper right hand corner.
d. The language should be American English.
e. Ethics: In the Methods section of the manuscript, authors must name the ethics review board that approved their study and provide details of informed consent from human subjects plus the

manner in which it was obtained (written or oral).

f. Symbols and Abbreviations: Internationally accepted units, symbols, and abbreviations, including those of the Système international must be used. On first appearance in both abstract and text, place abbreviations and acronyms in parenthesis following the term in full.

g. Names of drugs: Use the official (generic) name throughout; trade (proprietary) names may be placed in parenthesis the first time the drug is mentioned, if necessary.

h. Numbers: Numerals from 1 to 10 are spelt out. Numerals at the beginning of the sentence are also spelt out. Numerical equivalents must precede all percentages – eg: of 100 patients 30 (30%) had visual field changes.

i. Statistics: Whenever possible quantify findings and present them with appropriate indicators of measurement error or uncertainty (such as confidence intervals). Authors should report losses to observation (such as, dropouts from a clinical trial). When data are summarized in the Results section, specify the statistical methods used to analyse them. Avoid non-technical uses of technical terms in statistics, such as 'random' (which implies a randomizing device), 'normal', 'significant', 'correlations', and 'sample'. Define statistical terms, abbreviations, and most symbols. Specify the computer software used. For all P values include the exact value and not less than 0.05 or 0.001. Mean differences in continuous variables, proportions in categorical variables and relative risks including odds ratios and hazard ratios should be accompanied by their confidence intervals.

4. Acknowledgment

Acknowledgments should be listed on a separate page after text.

a. Granting and sponsoring agencies must be clearly acknowledged. Any source of funding must be mentioned here.

b. All contributors who do not meet the criteria for authorship should be listed in this section. Examples include a person who provided purely technical help, writing assistance, or a department chair who provided only general support. People who have aided the author's work in any other important way may also be thanked in this section.

5. References

Authors are responsible for the accuracy of the references. Multiple citations in support of a single statement should be avoided.

a. References should be numbered consecutively in the order in which they are first mentioned in the text (not in alphabetic order).

b. Identify references in text, tables, and legends by Arabic numerals in superscript without bracket after the punctuation marks.

c. References cited only in tables or figure legends should be numbered in accordance with the sequence established by the first identification in the text of the particular table or figure.

d. Use the style of the examples below, which are based on the formats used by the NLM in Index Medicus. The titles of journals should be abbreviated according to the style used in Index Medicus. Use complete name of the journal for non-indexed journals.

e. Information from manuscripts submitted but not accepted should be cited in the text as "unpublished observations" with written permission from the source.

f. Avoid citing a "personal communication" unless it provides essential information not available from a public source, in which case the name of the person and date of communication should be cited in parentheses in the text. For scientific articles, contributors should obtain written permission and confirmation of accuracy from the source of a personal communication.

Articles in Journals

Standard journal article

. Vinekar A, Dogra MR, Sangtam T, Narang A, Gupta A. Retinopathy of prematurity in Asian Indian babies weighing greater than 1250 grams at birth: Ten year data from a tertiary care center in a developing country. Indian J Ophthalmol 2007;55: 55:331-6

List the first six contributors followed by et al.

Volume with supplement

. Shen HM, Zhang QF. Risk assessment of nickel carcinogenicity and occupational lung cancer. Environ Health Perspect 1994; 102 Suppl 1:275-82.

Issue with supplement

. Payne DK, Sullivan MD, Massie MJ. Women's psychological reactions to breast cancer. Semin

Oncol 1996; 23(1, Suppl 2):89-97.

Books and Other Monographs

Personal author(s):

- Ringsven MK, Bond D. Gerontology and leadership skills for nurses. 2nd ed. Albany (NY): Delmar Publishers; 1996.

Editor(s), compiler(s) as author:

- Norman IJ, Redfern SJ, editors. Mental health care for elderly people. New York: Churchill Livingstone; 1996.

Chapter in a book

- Phillips SJ, Whisnant JP. Hypertension and stroke. In: Laragh JH, Brenner BM, editors. Hypertension: and management. 2nd ed. New York: Raven Press; 1995. pp. 465-78.

Electronic Sources as reference

Journal article on the Internet

- Abood S. Quality improvement initiative in nursing homes: the ANA acts in an advisory role. Am J Nurs [serial on the Aug 12];102(6):[about 3 p.]. Available from: http://www.nursingworld.org/AJN/2002/june/Wawatch.htm

Monograph on the Internet

- Foley KM, Gelband H, editors. Improving palliative care for cancer [monograph on the Internet]. Washington: National 2002 Jul 9]. Available from: http://www.nap.edu/books/0309074029/html/.

Homepage of a Web site

- Cancer-Pain.org [homepage on the Internet]. New York: Association of Cancer Online Resources, Inc.; c2000-01 [updated Jul 9]. Available from: http://www.cancer-pain.org/.

Part of a homepage/Web site

- American Medical Association [homepage on the Internet]. Chicago: The Association; c1995-2002 [updated 2001 Aug 23; cited 2002 Aug 12]. AMA Office of Group Practice Liaison; [about 2 screens]. Available from: http://www.ama-assn.org/ama/pub/category/1736.html

6. Legends to Figures and Tables

Type legends (maximum 40 words, excluding credit line)

a. Captions should briefly explain the figures / tables without the use of abbreviations and should be understandable without reference to the text.
b. Using double spacing, with Arabic numerals corresponding to the illustrations.
c. When symbols, arrows, numbers, or letters are used to identify parts of the illustrations, identify and explain each one in the legend.
d. Explain the internal scale (magnification) and identify the method of staining in photomicrographs.

Cover Letter

All submissions must be accompanied by a cover letter. Please write clearly the manuscript title. In the cover letter

a. Mention whether the manuscript is being submitted as an Original Article, Review Article, Brief Communication, Letter to Editor, Abstract, or Other.
b. Include a statement to the editor that the paper being submitted has not been published, simultaneously submitted, or already accepted for publication elsewhere.
c. Include a statement that the manuscript has been read and approved by all the authors, that the requirements for authorship as stated earlier in this document have been met, and that each author believes that the manuscript represents honest work.
d. The author must declare that the manuscript, to the best of the author's knowledge, does not

infringe upon any copyright or property right of any third party.

e. The author must list out any attachments (if any) being sent along with the cover letter:

1. Consent from patients
2. Permission from the copyright owner to reprint any previously published material Please download the template for cover letter provided.

Images

a. Acceptable graphic files include TIFF or JPEG formats. Graphs can be submitted in the original program files. Minimum resolution is 300 dpi or 1800 x 1600 pixels in TIFF format. Each image should be less than 1024 kb (1 MB) in size. Size of the image can be reduced by decreasing the actual height and width of the images (keep up to 1240 x 800 pixels or 5-6 inches
b. Figures should be numbered consecutively according to the order in which they have been first cited in the text.
c. Symbols, arrows, or letters used in photomicrographs should contrast with the background.
d. Titles and detailed explanations belong in the legends for illustrations not on the illustrations themselves.
e. When graphs, scatter-grams or histograms are submitted the numerical data on which they are based should also be supplied.
f. Identifying information, including patients' names, initials, or hospital numbers, should not be present in images unless the information is essential for scientific purposes. If any identifiable images are used, the patient (or parent or guardian) should give written informed consent for publication.
g. If a figure has been published elsewhere, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. A credit line should appear in the legend for such figures.
h. The Journal reserves the right to crop, rotate, reduce, or enlarge the photographs to an acceptable size.
i. Do not send graphs or diagrams as free hand drawings.

Tables

Please do not duplicate information in the text.

a. Number of tables - Review / Original Articles: Maximum of six; Case Reports: Maximum of two.
b. Type or print each table with double spacing on a separate sheet of paper.
c. Tables with more than 10 columns and 25 rows are not acceptable.
d. Number tables consecutively in the order of their first citation in the text and supply a brief title for each.
e. Be sure that each table is cited in the text.
f. For footnotes use the following symbols, in this sequence: *, †, ‡, §, ||,¶ , **, ††, ‡‡
g. Abbreviations should be explained. Place explanatory matter in footnotes, not in the heading
h. If means are used, the standard deviation (or error) and "n" should be included.
i. Report actual values of $p > 0.01$ to 2 decimal places and $p < 0.01$ to 3 decimal places; report $p < 0.001$ as "$p < 0.001$" only.
j. If you use data from another published or unpublished source, obtain permission and acknowledge them fully.

Revised Manuscripts

The following guidelines must be followed.

a. For major revisions, the authors must provide a letter addressing each of the reviewers' comments separately and in point form by first recording the reviewer's comment and following it with the author's response.
b. The author must track all changes made in the revised manuscript.

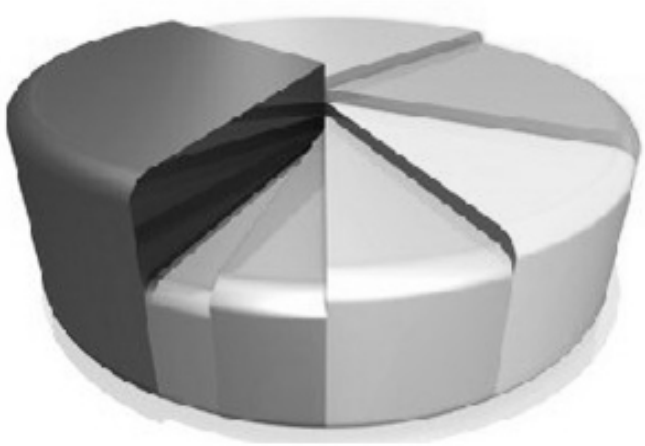
Proofs

The editor reserves the right to correct grammar, spelling, and punctuation, to clarify obscurities and remove redundancies, to improve infelicities of style, to enhance or make appropriate the paper's organization, and to ensure that the paper (text and graphics) conforms overall to the requirements of the journal. No major changes will be made without consulting the author.

Editorial

Mentally Disabled and the Disabilty Acts

PAST, PRESENT AND THE FUTURE



World Facts and Statistics on Disabilities and Disability Issues

Disability affects hundreds of millions of families in developing countries. Currently around 10 per cent of the total world's population, or roughly 650 million people, live with a disability. In most of the OECD countries, females have higher rates of disability than males.

Having a disability places you in the world's largest minority group. As the population ages this figure is expected to increase. Eighty per cent of persons with disabilities live in developing countries, according to the UN Development Program (UNDP). The World Bank estimates that 20 per cent of the world's poorest people have some kind of disability, and tend to be regarded in their own communities as the most disadvantaged. Statistics show a steady increase in these numbers. The reasons include:

a) Emergence of new diseases and other causes of impairment, such as HIV/AIDS, stress and alcohol and drug abuse;
b) Increasing life span and numbers of elderly persons, many of whom have impairments;
c) Projected increases in the number of disabled children over the next 30 years, particularly in the developing countries, due to malnutrition, diseases, child labor and other causes;
d) Armed conflict and violence. For every child killed in warfare, three are injured and acquire a permanent form of disability. In some countries, up to a quarter of disabilities result from injuries and violence, says WHO.

In countries with life expectancies over 70 years of age, people spend on average about 8 years, or 11.5 per cent of their life span, living with disabilities.

Indian Scenario

India is a signatory to UNCRPD (United Nations Convention for Rights of Persons with Disabilities) in 2007.

The population of India as on 1 March 2011 was 121,05,69,573. (15th census report). India added 181 million to its population since 2001, slightly lower than the population of Brazil. The

exact details of disabled is not yet published. WHO report says that more than 10% of the population is disabled in developing countries. Hence we can expect more than 120 million Indians are disabled. Among them the percentage of disabled under behavioral and mental disorders is yet to be found out.

Rehabilitation Council of India Act of 1992/Amendment 2000 and Proposed Amendments

The Rehabilitation Council of India(RCI) was set up as a registered society in 1986.On September,1992 the RCI Act was enacted by Parliament and it became a Statutory Body on 22 June 1993.The Act was amended by Parliament in 2000 to make it more broad based. The mandate given to RCI is to regulate and monitor services given to persons with disability, to standardize syllabi and to maintain a Central Rehabilitation Register of all qualified professionals and personnel working in the field of Rehabilitation and Special Education. The Act also prescribes punitive action against unqualified persons delivering services to persons with disability.

Medical Practitioners with genuine council registration are included in the RCI professional/ personnel list in the proposed amendments.

The Persons with Disabilities Act 1995

This is an Act to give effects to the proclamation of the full participation, equal opportunities and protection of rights of people with disabilities in the Asian and Pacific region. The Act contains fourteen chapters. Blindness, low vision, locomotor disability, hearing impairment, leprosy cured, mental retardation and mental illness (7 items) are the disabilities described under this act.

National Trust Act 1999

This Act protects the need of persons with four developmental disabilities viz, Autism, Cerebral palsy, Mental Retardation and Multiple disabilities. Additional three items are included (total 10) in disability category.

The Rights of Persons with Disabilities Bill, 2012

The new bill which is yet to be passed has the following 18 items as disabilities. Eight new items are included while certain terminologies are changed.

I. Autism spectrum disorder
ii. Blindness
iii. Cerebral palsy
iv. Chronic neurological conditions
v. Deafblindness
vi. Hemophilia
vii. Hearing impairment
viii. Intellectual disability
ix. Leprosy cured
x. Locomotor disability
xi. Low vision
xii. Mental illness
xiii. Muscular dystrophy
xiv. Multiple sclerosis
xv. Specific learning disability
xvi. Speech and language disability
xvii. Thalassemia
xviii. Multiple disability

The important changes from a mental health perspective are autism to autism spectrum disorder, mental retardation to intellectual disability and the inclusion of specific learning disability as a disability.

Definitions of Mental Disabilities under the proposed Bill

'

1. Autism Spectrum Disorder' refers to a neuro-psychological condition typically appearing in the first three years of life that

significantly affects a person's ability to communicate, understand relationships and relate to others, and is frequently associated with unusual or stereotypical rituals or behaviors.

2. 'Intellectual Disability' refers to a condition characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills.

3. 'Mental Illness' refers to a chronic disturbance of mood, thought, perception, orientation or memory which causes significant impairment in a person's behavior, judgement and ability to recognize reality or impairs the persons' ability to meet the demands and acitivities of daily life.

4. 'Specific Learning Disabilities' refers to a heterogeneous group of conditions wherein there is a deficit in processing language, spoken or written, that may manifest itself as a difficulty to comprehend, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual disabilities, dyslexia, dysgraphia, dyscalculia, dyspraxia and developmental aphasia.

'

5. Multiple disability' mean two or more of the specified disabilities listed at S.No.1 to 17 above, occurring in a person at the same time.

Future role of Indian Psychiatric Society

Once the bill is passed shall we have to certify SLD just like any other disability in percentage? Are we ready with a uniform tool? Shall we include all children with genuine learning problems or exclude deserving children with border line intelligence on technical reasons? What to do with children with mild learning difficulties who are labeled as SLD? The problems of children with SLD is only in educational aspect, still I they get all the benefits of a disabled person, life long as per this new bill.

Shall we strain children with severe MR (ID – as per new bill) for academics in normal school and get a 'pass' certificate? If we separate them it is discrimination under law. All these issues ar to be addressed

It is better to have a separate specialty/ task force under IPS as the Rehabilitation specialty is over burdened with many issues.

(References from websites of disabled world .com, censusindia.gov.in and various sites under ministry of social justice. Latest access on August 7, 2013.)

Thomas John
Thomas' Clinic
Poonithura,Kochi-38

Suicide Prevention: We Have More To Do

Dr. V. Sathesh
President IPS Kerala State

Dear friends,

Suicidal Behaviour has become a major public health problem across the world. It is a complex phenomenon that usually occurs along a continuum, progressing from suicidal thoughts, to planning, to attempting suicide, and finally dying by suicide, a tragic outcome of a morbid process. The psychological and social impact of suicide on the family and the community is enormous.

World, Indian and Kerala Scenario:

As per WHO one million people worldwide die by suicide each year. The suicide rate is 16 per 1 Lakh population. This corresponds to 1 death by suicide every 40 seconds. The number of suicide attempts may be up to 20 times the number of deaths by suicide. National suicide rate is 11.2 per 1 Lakh population. This contributes to more than 10% of suicide in the world. .
Kerala ranks 5th in suicide rate after Pudussery, Andaman & Nicobar islands, Sikkim and Chattisgarh. Suicide rate of Kerala is 25.3 per 1 Lakh population. Suicide rate continues to be elevated in Kerala compared to other states. But there is marked improvement when compared to previous rate 10 yrs back (30/1 Lakh in 2002).

SUICIDE PREVENTION

Primary Prevention involves broad modification of social, economic and biological conditions to prevent suicide with population-based intervention rather than focusing on individual risk. It also includes restricted access to lethal methods, promoting positive mental health, promoting a responsible representation of suicide in social and other media, reduction of stigmatization of mental illness and suicide and encouraging help-seeking behavior through public awareness and education campaign.

Secondary Prevention is aimed at minimizing suicide risk in high-risk populations. Early identification of suicidal individuals, accurate diagnosis and effective treatment of mental health problems (Mood disorder and substance-related disorders) are crucial. Improving primary care physician's recognition of psychiatric disorders, suicide risk evaluation, treatment intervention and referral skills are key components of suicide prevention. Providing education for 'Gate keepers' will help in early recognition of risk of suicide and facilitates referral of vulnerable to appropriate assessment and treatment facilities.

Tertiary Prevention is aimed at preventing relapses of suicidal behavior after a suicidal attempt. This also involves work of post-vention – the care, support and treatment of those impacted by suicide.

SUICIDE PREVENTION STRATEGIES

One point to be borne in mind is that suicide is the outcome of a complex set of factors. Bio-psycho-social and other factors should be addressed. Community participation is important. As a life-saving procedure it is our responsibility to move out of consultation room and take lead in applying the prevention strategies.

Strategies in Hospita l/ Institution /Residence involves education of the relative / care giver / bystander in various settings of treatment, ensuring a responsible and efficient care giver / bystander, education of the bystander, supervision of the suicidal patients, ensuring trained staff and safe ward environment, adequate lighting facilities near the patient's place of stay especially in the night, easy access to a resident health staff, absence of any tools or utensils which can harm the life of the inmate etc. If in a hospital, the staff should make a very good therapeutic alliance and through which most of the interactions including the therapeutic ones can be carried out. Through tactful interactions highlighting the merits of life, reminding the suicidal person of his responsibilities towards society and families, explaining to the suicidal patient the plight of dear and near ones in case of suicide and strengthening of suicide-counters are also important.

Prescriptions for medicines are to be given for a few days only. The follow-up can be very frequent in the onset. Safe custody of medicines, ensuring that the patients are taking drugs at the right time and right quantity etc. are also some important preventive steps. Restricting means by control of sale of pesticides, insecticides, acids etc. is necessary. Locked boxes can be used to restrict the availability as tried in Sri Lanka, Tamilnadu etc. Warning signs and emergency remedial care steps may be noted on the box. Emetics also may be added to insecticides to induce vomiting thus preventing further absorption.

School-Based Programme should focus on life-skill education, training of students in tiding over the stressful situations, school-health programme, training of teachers and parents in early detection and management of scholastic backwardness, deviant behavior, dropouts etc. Mental health should be included in the student's syllabus and there should be liaison of school-based programme with mental health services.

Crisis Management System should be regular and efficient even at Taluk level with helpline facilities to address difficulties during periods of crisis. Suicide Prevention Clinics should be started in all mental health care facilities. Promotion of better mental health, stress management, proper financial planning, life-skill development and promotion of help-seeking behavior for health problems are also important steps.

Media both print and visual ones influence people generally and those who are at risk, suggestible and distressed. As far as suicide is concerned there should be a responsible media reporting. The guidelines for media people developed by NIMHANS Bangalore may be followed in reporting suicide. Inclusion of mental health in the curriculum of journalism students is helpful.

Development and up-liftment of weaker sections in the community, support to those who are vulnerable, eradication of poverty and unemployment, control of alcoholism and facilities for early management of alcohol-related problems, writing off debts combined with mental health package etc. are some of the steps in social policy.

Loan Defaulters, women, elderly, alcohol and drug dependent, adolescent etc. constitute special group needing special attention.

Improving Mental Health Care and Training andQuality of Medical Education have also got important role to play in suicide prevention. Extension of National Mental Health Programme to all districts, enhancement of P.G..seats and starting new PG courses, inclusion of psychiatry in MBBS curriculum as a subject with examination are appropriate suicide preventive strategies.

Conclusion: The causes of suicide is multi-factorial. So approach to suicide prevention is multipronged. Let us join our hands to fight this evil to save precious lives.

.'Human being is the most wonderful creation in the universe.
Life is the one which drives it. Don't destroy it, but guard it.
It is everybody's responsibility'

Jai IPS

Original Article

Doctor Patient Relation

Dr. S. D. Singh
Kochin

The period between the birth and death is the life span of an individual. All of us with self training, input from teachers, parent and society grow further during the life span. The absorption of the inputs differs in individuals. The differences of developments during the growing period from birth to death are unpredictable. All are human beings, the homosapeins with uncomparable qualities. It is like the leaves of a mango tree which are almost same in appearance, but when you compare the minute details of each leaves, one can observe that each leaf differs from another one even if all leaves are taken from the same tree. Similarly the in human beings the thoughts, feelings and abilities, preferences differs , like the difference noted in finger prints .Trillions and trillions of peoples might have born and dead, but never the finger print of one individual is same as of another individual. The thoughts and behavior also differs in that way. Why this difference?

Regarding birth one can think of four types of birth for every individual. First is the, cellular birth which takes place exactly at the time of fertilization of the sperm and ovum, the second is the physical birth which is the date of delivery of the individual, which we all say as date of birth, third is the social birth which is the date on which the individual go out of home for a specific ,regular, ongoing, formal situation of recurrent nature, which is usually the first day in the school . Fourth is the emotional birth which may not be a specific date , but can be described as the occasion of a real and deep emotional experience which leaves a mark in the individuals life and memory , may be some events or a chain of events happening during the adolescence .

Death also has also four stages , first state is a Pre-death stage , perhaps that day starts from the time of cellular birth within the mother's womb, because the phenomenon of death can happen at any time after birth , second stage is the sate of awareness of one's own death , which may be during a terminal or fatal illness or few moments just after the unexpected accidental injuries or trauma . Third and really a crowd pulling occasion, is that sate when one remains as a dead body before friends and relatives or unknown people, fourth is the silent but meaningful post death mourning period where there is news paper coverage or a dim light is switched on permanently below the individuals photograph kept on the wall. More than all these the memories of the dead person remains in the inner most memory chamber of intimate people.

The life span of all individuals, from physical birth to physical death can be also divided into five stages

1. **Period of innocence:** From the date of cellular birth/ physical birth to 3 years of age of an infant, is a state where he/she is unable to react or express or coordinate to a perfect creative level, even though within the child the process of learning is happening along with the neuronal developments. The child at this stage reacts for his / her biological needs like hunger and excretory functions. These are done without inhibition anytime anywhere .Nature expects mother to be there to support the child during this period. The process of 'mothering 'a child is of great significance. Greatness of 'motherhood' is beyond words. The inflow of information though the five special senses during this period could be crucial and along with the mothering becomes more significant at this time .Think of the famous saying 'It is from the mother's milk humanity is nourished and it is from mother's lap culture is cradled'

2. **Period of leaning:** This period may be approximately from the age of 3- to 18 (includes child hood and adolescence and early adult hood) .During this period they learn and conceive everything, which comes to their special senses and catch attention. In other words everything under the sun, either they search and reach it or in the flow of life they happen to be part of it. Politics to poetry and animals to animations or sex to sceneries are being learned during this period. Lessons from the school and text books constitute only 25 % of their total learning.

3. **Period of experimentation:** This stage may be from age of 18 to 25 or 30 yrs. Almost , all individuals try to experiment practically what they have seen, heard or observed during the period of learning will try to do it by themselves during this stage. It can be positive things like learning and hunting for knowledge or negative life style alcohol or steps for cheating or corruption .In few cases the period of experimentation continues and will become ongoing for loner time

4. **Period of practical life:** After the leaning and experimentations, they settle down with practical living at professional, personal and social levels. Even though the stage is titled 'stage of practical life' the process of learning and experimentation will continue ,as consequence , the medical doctor learns that civil service is better than medical profession , police officer resigns and start fish processing unit etc. Stability, credibility and presence of mind to manage difficult situations are based not only from the knowledge but also from the lessons of life what they have learned and experimented in the previous stages. The success and down falls are all related with the real lessons learned in life. The ongoing life style is based on three concepts which all of us develop during the first two stages of life. The structure and functioning model of the concepts are (1) Taught concepts (3) Felt concepts (3) Thought concepts. It on the platform of these concepts thoughts behavior and attitudes are formed. The combination of these three basic concepts patient and therapist becomes evident during the therapeutic interactions

5. **Period of ending:** In general to say, successful persons who lived with positive aspects basic concepts will have a glorified last chapter and terminal days. In other words they will be able to accept the realities and will continue to react positively during the terminal hours /days. Others who learned, experimented and

lived in the negative living style may have dark, hard and tragic terminal days. They will keep on challenging the realities including the normal catabolic phenomenon in the terminal stages

Doctor patient relationship:

Between the birth and death all of us including our patients pass through these significant five stages of life. So also, we all implant the three basic concepts with abundant contents in each ones style. In the art of diagnosis in psychiatry and also in any given psychotherapeutic situation or in simple drug treatment situation, for a mature, meaningful, productive and smooth out come a positive outcome, along with the wide and deep knowledge of the doctor , compatibility between the doctor and patient is an essential criteria. It is in this point a 'doctor patient relationship' (DPR), is being developed. This DPR are being regularly evaluated by outsiders, including the family members of patient and public. The results of the evaluation by these outsiders will be proportional to the positive and negative earnings from the five life stages and basic concepts of the doctor and the patient. The value systems, belief systems, cultural, political and religious margins also play significant role, which is being mixed in a desirable proportion to build up a positive DPR. This relation, if it is positive and productive and beneficial to the patient, as the time advances it will extend into a 'doctor – patient – patient's family relation'. To generate such a healthy DPR, extending to the families, a buffer zone is always required to prevent slipping of healthy DPR to personal intimacies of any type or for personal gains. So also the DPR should not slip into personal level animosity. A healthy DPR naturally widens as 'doctor –patient - patients family relation' (DPFR) .It is at this stage the doctor becomes the partial weight bearer and helpful to reduce the disease burden of family members. The members from multiple families start adoring the doctor. If still the doctor has more of positive fragrances, all the professional relation widens and grow to a greater umbrella like 'doctor –community - relations' (DCR).The healthy DPR will percolate down in the family for generations and will disseminate in the society horizontally beyond continents

To conclude, I wish to quote a conversation from the consultation room of a Psychiatrist.

A 70 year old lady brought her 18 year old granddaughter ro the consultation room
'Do you remember me? The old lady asked
'Sorry I am nor able to locate and recollect you' the Psychiatrist replied

'38 years before when I had 'post partum psychosis' you treated me. You may perhaps remember my daughter MS. KB, this girl's mother, who has schizophrenia, now living in USA and still under your care, she visits you once a six months.' she went on narrating the about professional relation of the Psychiatrist with her family members in the last four decades.
The Psychiatrist, nodded to the comments, appreciated with positive gestures and expressed hisgratitude for professional acceptance from a family

The old lady looked at the young grand daughter and said 'Look here - this doctor has been perhaps shouldering a part of our family burden - he has helped us to simplify many issues in our family .S0 you can talk to him all your problems, trust him, I am confident he will help you' With that introduction the old lady went out of the consultation room.

This is exactly, doctor's relation with the community.

Original Article

An introduction to Patient reported outcomes and Quality of Life

Dr. Harish M.T.
Calicut

Patient reported outcomes

Schizophrenia is the most complex disease that can affect humans. It affects most of the special faculties that differentiates us from animals with symptoms from cognitive, affective and psychomotor domains. Characteristic symptoms include delusions, hallucinations and thought disorder according to most diagnostic systems. The disorder affects roughly 1% of the population in its life time and is a major cause of disability. Currently available treatments have considerable effectiveness at the level of symptom control. But how much of this translates in to real world improvement in the life of affected patients and families is a debatable issue. Assessing the real world outcomes of this disorder is a challenging and controversial area. Outcome assessments used could be those that are done by the treating clinicians or by the patients themselves.

Routine outcome assessment using regular collection of Patient reported outcomes (PRO) have become popular in mental health care research[1]. PRO is defined as "any report directly coming from the patients about a health condition and its treatment"[2]. It is usually scored by the patient, based on his own perception without any judgement by the clinician. These measures highlight the role of patients as a 'consumer' of the care being provided.

Patient organizations have been advocating their use in many Western countries. PRO can be thought of as collection of data at treatment level and service delivery level. Collection of treatment level data may help in improving care offered to individual patients and service level data may encourage clinicians to reflect upon their practices. It can also bring in a level of transparency in service provision and improve quality of care if large amount of data can be pooled for analysis. But these measures are not very popular with some for various reasons like time constraints etc. There are controversies in this area.

Clinicians' primary interest would be the improvement of the individual patient under his direct care. Clinical assessments tend to give more importance to symptoms of mental illness, for example psychotic symptoms in a case of schizophrenia as this form the basis of the clinical diagnosis of the disorder. Drug trials also look only at the symptom reduction dimension as these can be shown to be improving with pharmacotherapy. But from the patients' and carers' perspective, deficit symptoms, impairments in activities of daily living (ADL), quality of social life, ability to earn a livelihood and being accepted as a useful person are more proximate concerns. Their difficulty is compounded by the fact that these problems are not easy to describe in words. In an illness like schizophrenia these form the major hurdle in the path towards recovery. Based on focussed group discussions with schizophrenia patients, Fischer et al, as quoted by McCabe[3] had

identified the following six key areas they needed improvement. These are "increasing energy and interest; improving social relations; reducing disturbing or unusual experiences (hallucinations and delusions); reducing confusion and difficulty concentrating; reducing medication side effects; and increasing productive activities such as having a job" [3].

Subjective quality of life, treatment satisfaction, need for care and quality of therapeutic relationship are the commonly used PROs[4]. Subjective quality of life and treatment satisfaction are the most commonly used ones. Some degree of overlap does exist between these areas.

Quality of Life

Quality is defined thus by the Merriam-Webster dictionary.[5] as a degree of excellence. It is generally agreed to be an elusive concept. CDC (Centre for diseases control and Prevention, Atlanta, USA) defines "Quality of life (QOL) is a broad multidimensional concept that usually includes subjective evaluations of both positive and negative aspects of life" [6].

Health related QoL (HRQoL) is a multidimensional concept. CDC says "On the individual level, this includes physical and mental health perceptions and their correlates—including health risks and conditions, functional status, social support, and socioeconomic status. On the community level, HRQOL includes resources, conditions, policies, and practices that influence a population's health perceptions and functional status [6]." Medical outcome study SF-12 and SF-36 were the tools used to measure HRQoL. Later CDC developed a set of questions called Healthy day measures for measuring HRQoL. The core of this is a set of four questions. These are

- Would you say that in general your health is excellent, very good, good, fair or poor?
- Now thinking about your physical health, which includes physical illness and injury, how many days during the past 30 days was your physical health not good?
- Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health not good?
- During the past 30 days, approximately how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

It also has two additional modules - an Activity limitation module with five questions and a Healthy days symptoms module with five questions[6].

Quality of life (QoL) has been used in mental health research as an outcome measure. When the Western countries downsized mental hospitals and large number of patients with severe mental illness began to live in the community, the professional community started paying closer attention to this aspect.

Social, psychological and adaptive domains are usually covered in assessment of qol. Level of functioning in the community is one that can be measured objectively, but many other measures of well-being are subjective. Some aspects can be considered to be more generic, rather than disease specific as these tap general functioning over a broad spectrum of illnesses.

A consensus conference of researchers in schizophrenia was held to look at the components of real world effectiveness of community based practice and how to measure them. Four outcome domains were identified 1) symptoms of disease 2) disease burden 3) treatment burden and 4) health and wellness[7].

Several scales are available for assessing QoL. Important qualities needed for these scales include "(1) sensitivity to change over time (2) sensitivity to treatment effect (3) correlation with symptom severity (4) correlation with global clinical ratings, and (5) correlation with other measures of health-related quality of life[7]"

QoL can have both screening and evaluative functions. As a screening tool it may

help to understand the needs of clinical populations to plan services. But it is more important role would be to monitor clinical progress and rate the outcome. It can help in clinical decision making and as an outcome measure in drug trials, program evaluation and resource allocation. It has been used even as a requirement for approval of new drugs. Health economic analysts use it for decision making considering cost-effectiveness, cost utilization etc[8].

Scales measuring qol can be thought of as direct and indirect types. All the below described scales use psychometric properties and are direct measurements as they use questionnaires or rating scales for assessment. Direct Qol scales could be generic or disease specific, global or multidimensional and self-rated or interviewer rated. Only scales using scoring by the patient can be sued as PROS.

Generic type measures health and wellness over a broad range of clinical conditions with varying severity. An example would be the WHO's family of QOL 100 and WHOQOL Bref, which is a brief version of the same scale. A disease specific scale in Psychiatry would be the 'Quality of life scale for use in schizophrenia' developed by DW Heinrichs, T E Hanlon and WT Carpenter[9].

Indirect measures of qol are a bit more complex and look at how the subjectively felt quality of life translates into more tangible criteria. In contrast to direct scales using psychometric properties, they use econometric or preference-based techniques called 'value and utility scales. These fall in the realm of health economics. But the very notion that objectively tangible criteria have to be used in evaluation of qol which is a subjective attribute[8].

Specialties dealing with mostly acutely patients will be at an advantageous position regarding measuring outcome of treatment as the effect of treatment can be shown easily. This is a little more difficult for specialties dealing with chronic illnesses. Psychiatry has additional problems as cognitive and psychosocial impairments are a major part of the disease[10]

There has been concern about using self-reported measures of QoL in affectively disturbed patients. Atkinson et al [11] have shown that there could be disparity when subjective and objective measures of QoL are compared in different subgroups of patienst with schizophre4nai, affective disorder and physical illness. The schizophrenia goup had subjective score similar to those with physical illness; whereas those with affective illness had much lower scores. But from the findings from objective indicators it was clear that the schizophrenia were having significant more difficulties. Several reasons like poor insight, affective bias, low social involvement, life events etc could be possible explanations for this. Hence some caution is warranted in using subjective scales in those with severe mental illnesses.

Scales used to measure qol

(1) the Lehman Quality of Life Interview (LQLI; Lehman et al. 1982, 1986, 1988),

(2) the Heinrichs-Carpenter-Hanlon Quality of Life Scale (HQLS; Heinrichs et al. 1984), and

(3) the Strauss-Carpenter Level of Function (SLOF; Strauss and

Carpenter, 1977), a brief precursor of the HQLS
The above scales are specific for schizophrenia. But the most widely used scale is the WHO's Quality of life scales.

(4) WHO QoL Bref[12]
This is a scale developed by World health organization. It contains 26 items and is derived from the larger scale called WHO QoL 100. Studies have shown that the short scale has excellent psychometric properties and correlates well with the original longer scale[13]. This has 4 domains instead of 6 in the original WHO QoL 100 - 1: Physical health domain, 2: Psychological domain 3: Social relations domain and 4: Environment. It is widely used in health care research as an outcome measure. It has been translated in to Malayalam[14].

References

1. Stefan Priebe, Eoin Golden, Rosemarie McCabe and Ulrich Reininghaus,. Patient-reported outcome data generated in a clinical intervention in community mental health care - psychometric properties BMC Psychiatry 2012, 12:113 Page 2 of 6 http://www.biomedcentral.com/1471-244X/12/113

2. U.S. Food and Drug Administration (2006) Guidance for Industry. Patient-Reported Outcome Measures: Use in Medical Product Development to Support Labeling Claims. FDA.

3. Rosemarie McCabe, Marya Saidi and Stefan Priebe Patient-reported outcomes in schizophrenia Brit J Psy (2007) 191 (suppl.50), s21^s28.doi:10.1192/bjp.191.50.s21

4. Reininghaus U, Priebe S. Measuring patient-reported outcomes in psychosis: conceptual and methodological review. Br J Psychiatry. 2012 Oct;201(4):262-7.

5. http://www.merriam-webster.com/dictionary/quality accessed on 18/07/2013 at 17.55 pm

6. http://www.cdc.gov/hrqol/hrqol14_measure.htm accessed at 18.27 hours on 04/08/2013

7. Nasrallah HA, Targum SD, Tandon R, McCombs JS, Ross R. Defining and measuring clinical effectiveness in the treatment of schizophrenia. Psychiatr Serv. 2005 Mar;56(3):273-82.

8. Douglas W. Heinrichs, Thomas E. Hanlon, and William T. Carpenter, Jr. The Quality of Life Scale: An Instrument for Rating the Schizophrenic Deficit Syndrome. Schizophrenia Bulletin VOL10.NO. 3,1984

9. Joyce A. Cramer, Robert Rosenheck, Weichun Xu, Jonathan Thomas, William Henderson, and Dennis S. Charney for the Department of Veterans Affairs Cooperative Study Qroup on Clozapine in Refractory Schizophrenia Quality of Life in Schizophrenia: A Comparison of Instruments. Schizophrenia Bulletin, 26(3):659-666, 2000.

10. Lakshmi NP Voruganti, MD, Ronald J Heslegrave, PhD, A George Awad, MD, PhD. Quality of Life Measurement during Antipsychotic Drug Therapy of Schizophrenia. Journal of Psychiatry & Neuroscience 1997; 22:4

11. Mark Atkinson, Ph.D., Sharon Zibin, M.Sc., and Henry Chuang, M.D. Characterizing Quality of Life Among Patients With Chronic Mental Illness: A Critical Examination of the Self-Report Methodology

12. WHO QoL bref, Introduction, administration, scoring and generic version of assessment. WHO, Geneva 1996

13. S.M. Skevington, M. Lotfy, K.A. O'Connell The World Health Organization's WHOQOL-BREF quality of life assessment: Psychometric properties and results of the international field trial. A Report from the WHOQOL Group. Quality of Life Research 13: 299–310, 2004

14. Menon B, Cherkil S, Aswathy S, Unnikrishnan A G, Rajani G. The process and challenges in the translation of WHO QoL Bref to a regional languagr: Malayalam. Ind J Psychol Med 2012; 34:149-52

Original Article

Motivation Enhancing Therapy in Alcoholism

P. N Suresh Kumar, MD, DPM, DNB, PhD, MRC Psych
Professor of Psychiatry, KMCT Medical College
Calicut, Kerala.

Introduction

MET is a systematic intervention approach for evoking change in problem drinkers based on principles of motivational psychology. Treatment is preceded by an extensive pre-assessment battery. The first treatment session (week 1), the second session (week 2), two follow through sessions at week 6 and week 12, is completed within 90 days. It is an effective outpatient treatment strategy requires fewer therapist directed sessions and useful in situations where contact with problem drinkers is limited to few or infrequent sessions. Motivational intervention yielded comparable outcomes even when compared with longer, more intensive alternative approaches.

Stages of Change

People who are not considering change in their problem behavior are described as **precontemplators**. **Contemplators** stage entails individuals beginning to consider both that they have a problem and the feasibility and cost of changing that behavior. As individuals progress, they move on to the **determination** stage, where the decision is made to take action and change. Once the individuals begin to modify the problem behavior, enter the action stage, which normally continues for 3-6 months. After successfully negotiating the action stage, individuals move to **maintenance** stage. If these factors fail, a relapse occurs, and the individual begins another cycle. Ideal path is directly from one stage to the next until maintenance is achieved. The process involves several slips or **relapses** which represent failed action or maintenance. Most who relapse go through the cycle again and move back into contemplation and the change process. Contemplation and determination stages are most critical. Tipping the balance of the pros and cons of drinking toward change is essential for success. In the determination stage, clients develop a firm resolve to take action.

Rationale and Basic Principles

The responsibility and capability for change lie within the client. The therapist's create a set of conditions that will enhance the client's own motivation for and commitment to change. Five basic motivational principles are-

1.Express Empathy

Therapist's role is a blend of supportive companion and knowledgeable consultant. Much

of MET is listening. Reflective listening communicates an acceptance of clients as they are, while also supporting them in the process of change.

2.Develop Discrepancy

Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be. Develop such discrepancy by raising clients' awareness of the personal consequences of their drinking.

3.Avoid Argumentation

Unrealistic attack on drinking behavior tends to evoke defensiveness and opposition and suggests that the therapist does not really understand.

4.Roll with Resistance

How the therapist handles client "resistance" is a crucial and defining characteristic of MET. New ways of thinking about problems are invited. Ambivalence is viewed as normal; and is explored openly. Solutions are usually evoked from the client rather than provided by the therapist.

5.Support Self-Efficacy

self-efficacy" is a critical determinant of behavior change, the belief that one can perform a particular behavior or accomplish a particular task. In this case, clients must be persuaded to change their own drinking and thereby reduce related problems.

Practical Strategies

Phase 1: Building Motivation for Change

ME therapist elicit from the client certain kinds of statements that can be considered to be self-motivating via open-ended questions.

- I assume, from the fact that you are here, that you have been having some concerns or difficulties related to your drinking. Tell me about those.
- Tell me a little about your drinking. What do you like about drinking? What's positive about drinking for you? And what's the other side? What are your worries about drinking?

Listening With Empathy

Listens carefully to what the client is saying, then reflects it back to the client, often in a slightly modified or reframed form.

Advantages: (1) Unlikely to evoke resistance (2) Encourages the client to keep talking and exploring the topic (3) Communicates respect and caring 4) Clarifies for the therapist exactly what the client means (5) Can be used to reinforce ideas expressed by the client.

THERAPIST: What else concerns you about your drinking?

CLIENT: Well, I'm not sure I'm concerned about it, but I do wonder sometimes if I'm drinking too much.

T : Too much for . . .

C : For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning I feel really awful, and I can't think straight most of the morning.

Reflective listening

Reflective listening requires continuous alert tracking of the client's verbal and non-verbal responses and their possible meaning. Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning and questioning in favor of clients own processes.

DOUBLE-SIDED REFLECTIONS

- You don't think that alcohol is harming you seriously now, and at the same time you

are concerned that it might get out of hand for you later.
- You really enjoy drinking and would hate to give it up, and you can also see that it is causing serious problems for your family and your job.

Questioning

An important therapist response. Asks clients about their own feelings, ideas, concerns, and plans.

Presenting Personal Feedback (PFR)

It includes feedback to the client from the pretreatment assessment. Go through the PFR step by step, observe the client and explain each item of information. Allow time for the client (and significant other) to respond. Respond reflectively to resistance statements, perhaps reframing them in a double-sided reflection. Often a client will respond nonverbally, a sigh, a frown, a slow sad shaking of the head, a whistle, a snort, or tears can communicate a reaction to feedback.

Affirming the Client

Seeking opportunities to affirm, compliment, and reinforce the client is helpful in a number of ways including (1) strengthening the working relationship (2) enhancing the attitude of self-responsibility and empowerment (3) reinforcing effort and self-motivational statements and (4) supporting client self-esteem.

Example:
- I appreciate your hanging in there through this feedback, which must be pretty rough for you.

Handling Resistance

It is a legitimate concern. Examples:
- Interrupting—cutting off or talking over the therapist
- Arguing—challenging the therapist, discounting the therapist's views, disagreeing, open hostility
- Sidetracking—changing the subject, not responding, not paying attention
- Defensiveness—minimizing or denying the problem, excusing one's own behavior,

Certain kinds of reactions by the therapist are likely to exacerbate resistance which include-

- Arguing, disagreeing, challenging
- Judging, criticizing, blaming
- Warning of negative consequences
- Seeking to persuade with logic or evidence
- Interpreting or analyzing the "reasons" for resistance
- Confronting with authority
- Using sarcasm or incredulity

Summarizing

It is useful to summarize periodically during a session, particularly toward the end of a session. Elements of client's self-motivational statements, reluctance or resistance may also be included in the summary, to prevent a negating reaction from the client.

Phase2: Strengthening Commitment to Change

Recognizing Change Readiness

Some changes you might observe are
- Client stops resisting and raising objections
- Client asks fewer questions
- Client appears more settled, resolved, unburdened, or peaceful.
- Client makes self-motivational statements indicating a decision or openness to change ("I guess I need to do something about my drinking")

- Client begins imagining how life might be after a change.

The shift from contemplation to action may be a gradual, tentative transition rather than a discrete decision.

Discussing a Plan

The key shift for therapist is from focusing on reasons for change (building motivation) to negotiating a plan for change.

Consequences of Action and Inaction

To ask the client (and SO) to anticipate the result if the client continues drinking as before. What would be likely consequences?

What are the advantages of continuing to drink as before?

Information and Advice

Often the client will ask for key information as important input for their decisional process.

- Do alcohol problems run in families?
- Does the fact that I can hold my liquor mean I'm addicted?

Emphasizing Abstinence

Every client should be given, a rationale for abstinence from alcohol. Advise against a goal of moderation if the client appears to be deciding in that direction. Reasons for advising against a goal of moderation

- Medical conditions
- Psychological problems
- Diagnosis of idiosyncratic intoxication
- Strong external demands on the client to abstain.
- Pregnancy.
- Use/abuse of medications

Dealing with Resistance

The principles used for defusing resistance in the first phase of MET also apply here using gently paradoxical statements.

- Maybe you'll decide that it's worth it to you to keep on drinking the way you have been, even though it's costing you.
- I wonder if it's really possible for you to keep drinking and still have your marriage intact.

The Change Plan Worksheet (CPW)

To be used during Phase 2 to help in specifying the client's action plan. Give the original to the client and retain the copy for the file.

- The changes I want to make are…
- The most important reasons why I want to make these changes are…..
- The steps I plan to take in changing are ….
- The ways other people can help me are…
- I will know that my plan is working if…..
- Some things that could interfere with my plan are…...

Recapitulating

Towards the end of commitment process, once the client is moving toward a firm decision for change, offer a summary which include repetition of the reasons for concern uncovered in Phase 1, client's self-motivational statements, SO's role, the client's plans for change, and the perceived consequences of changing and not changing.

Asking for Commitment

In essence, the client is to commit verbally to take concrete, planned steps to bring about the needed change. If willing, ask him/her to sign the CPW and give the client the signed original, retaining a copy for your file. If clients are unwilling and remain ambivalent, ask them to defer the decision until later. A specific time should be agreed upon to reevaluate and resolve the decision.

Involving a Significant Other (SO)

Involvement of a SO (spouse, family member, friend) can enhance motivational discrepancy and commitment to change and gives an opportunity for firsthand understanding of the problem to provide input and feedback in the development and implementation of treatment goals. SO provide further examples of negative effects of drinking on the family, such as not showing up for meals, missing family celebrations such as birthday parties, embarrassing the family by being intoxicated. The SO can comment favorably on the positive steps undertaken by the client to make a change in drinking. In some cases, SO involvement could become an obstacle in motivating the client to change and could even lead to a worsening.

Follow-up Note

Prepare a handwritten note as a personalized message to be mailed to the client.

Follow through Sessions

The second session is scheduled 1 to 2 weeks after session 1 and should begin with a brief summary of first session. Next two sessions will be with the client alone. Sessions 3 and 4 scheduled for weeks 6 and 12, respectively. They are important as "booster" sessions to reinforce the motivational processes. Sessions 3 and 4 do not include the SO, unless the SO has not already attended two sessions. Send the client a handwritten note or telephone the client a few days before the scheduled appointment.

Drinking Situations

How it occurred. So what does this mean for the future?" "I wonder what you will need to do differently next time?"

Nondrinking Situations

What they did to cope successfully in these situations. Praise clients for small steps, even minor progress.

Treatment Dissatisfaction

If the client is dissatisfied with the treatment reinforce clients for being honest about their feelings, encourage the client to give it a good try for the planned period and see what happens.

In MET a limit of no more than two additional "emergency" sessions may be provided. The SO may be included in these sessions but never be seen alone. Additional treatment may not be provided by any project therapist.

Missed Appointments

Respond immediately by telephone. Clarify the reasons for the missed appointment and affirm the client—reinforce for having come. Handle such concerns in a manner consistent with MET (e.g., with reflective listening, reframing). Send a personal, individualized handwritten note with these essential points within 2 days of the missed appointment.

Telephone Consultation

SOs will contact you by telephone between sessions for additional consultation. This is acceptable, and all such contacts should be carefully documented in the client's file.

Crisis Intervention

Intervene immediately and appropriately. Crisis intervention cannot exceed two sessions. Suicidal thoughts, psychotic behavior, violence are referred to the onsite for further evaluation and consultation.

Review Article

Evidence Based Psychosocial Interventions for Alcoholism

Dr. Shahul Ameen , MD
Psychiatrist, St. Thomas Hospital,
Changanacherry, Kerala.

Alcoholism is a growing public health problem, causing around 5.3% of deaths in those aged under 60 years worldwide (Rehm et al, 2009). It is a common, chronic medical condition that requires long-term multidisciplinary care. Many psychosocial interventions have been found to be effective, and even superior to medications, in prevention of relapse to alcohol use (Miller and Wilbourne, 2002). This article provides a brief overview of the various empirically supported non-pharmacological interventions for alcoholism, with an emphasis on their theoretical basis, indications, major methodologies, and empirical support.

Screening and Brief Intervention (SBI)

Screening using short questionnaires followed by brief intervention (comprising simple advice or psychological counseling) has been found to significantly reduce alcohol consumption in several meta-analyses (Whitlock et al, 2004; Kaner et al, 2007). Such interventions are ideally suited for people who drink in ways that are harmful or abusive, and generally aim to moderate a person's alcohol consumption to sensible levels and to eliminate harmful drinking practices.

Routine medical screening, questions about previous accidents and injuries, screening questionnaires, laboratory tests, etc. may be used to identify suitable candidates for brief interventions. Miller and Sanchez (1993) proposed six elements - summarized by the acronym FRAMES: feedback, responsibility, advice, menu of strategies, empathy, and self-efficacy – as the key ingredients of brief intervention. Goal setting, follow-up, and timing also have been identified as important to the effectiveness of brief intervention (Graham and Fleming, 1998).

Compared to specialized addiction treatment settings, brief interventions give patients a simple way to receive care in a comfortable and familiar setting, and are much cheaper. These can be given in a matter of minutes, and require minimal follow-up.

Efficacy of brief interventions have been demonstrated in primary care settings (Fleming et al. 2002), emergency department settings (Longabaugh et al, 2001), prenatal care settings (Chang et al, 2005), criminal justice settings (Davis et al, 2003) and college settings (Larimer and Cronce, 2002).

Motivational Interviewing (MI)

MI is a series of techniques and a conversation style clinicians can use to enhance a client's motivation to persist with treatment and reduce or stop his alcohol use. MI is most suited for patients in the contemplation stage of the cycle of change who are ambivalent about

continuing their alcohol use. This ambivalence manifests in the clinical scenario as conversations supporting change – called change talk – and arguments against change – called sustain talk. Use of MI techniques help increase change talk and reduce sustain talk and thus resole ambivalence in the direction of change. Therapists are advised to avoid the use of paternalistic or confrontational attitudes and rather adhere to the basic spirit of MI consisting of partnership, acceptance, compassion and evocation. The therapy passes through four stages, namely engaging, focusing, evoking and planning.

More than 200 randomized clinical trials have assessed the efficacy and effectiveness of MI in diverse settings, and have proven that MI is often associated with beneficial outcomes when compared with no intervention or brief advice or when added to other active treatment (Miller and Rollnick, 2013).

Cognitive Behavior Therapy (CBT)

Interactive processes of classical conditioning, operant conditioning, modeling and cognitive mediation are believed to play a significant role in the development of alcoholism (Gorman, 2001). CBT techniques attempt to reverse the influence of these factors, and assist the person develop alternate behaviors that will enable him lead a sober life.

Counter-conditioning techniques like aversion conditioning, stimulus control and cue exposure and response prevention can be used to reduce the ability of alcohol-related stimuli to induce craving and precipitate a relapse (Rimmel et al 1995). Principles of operant conditioning form the basis of interventions like contingency management (Higgins et al, 2003).

Cognitive mediators hypothesized to contribute to maintenance of problem drinking include alcohol expectancies (Brown et al 1987), drinking motives (Cooper 1994), permissive beliefs (Beck et al 1993) and metacognitive beliefs (Spada and Wells, 2006). Strategies like guided discovery, advantages-disadvantages analysis, thought records, identification of cognitive errors and reattribution exercises could be used to identify, explore and restructure these expectancies and beliefs. Behavioral exercises in the form of activity monitoring and scheduling, behavioral experiments, role plays and relaxation training also serve to test and disconfirm expectancies and beliefs (Spada, 2010).

Review by Raistrick et al (2006) found that CBT interventions offer the best chance of success at a reasonable cost. Many of the therapy modalities that received highest positive scores in the Mesa Grande study (Miller et al 2003), a large systematic analysis of problem drinking therapy outcome research, were interventions rooted in CBT theory and practice.

Coping Skills Training (CST)

The social learning approach to alcoholism posits that individuals with deficits in skills for coping with life situations are at increased risk of excessive alcohol use as a coping response. Social-learning based treatment seeks to improve coping skills as a means of preventing relapse to drinking.

Skills included in CST are classified to interpersonal skills and intrapersonal skills. Interpersonal skills usually covered in CST include assertiveness, conversation skills, nonverbal communication, listening skills, giving and receiving positive feedback, giving constructive criticism, receiving criticism about drinking, drink refusal skills, resolving relationship problems and developing social support networks. Relevant intrapersonal skills include managing urges to drink, problem solving skills, increasing pleasant activities, anger management, managing negative thinking, avoiding Seemingly Irrelevant Decisions (SIDs) and planning for emergencies (Monti et al, 2002).

Among three independent meta-analyses, CST interventions were ranked either one (Holder et al, 1991) or two (Miller et al 1995; Finney and Monahan 1996) among alcoholism treatments, based on evidence of effectiveness.

Community Reinforcement and Family Therapy (CRAFT)

CRAFT is a therapy program for the family members or friends of individuals with alcoholism who refuse to get treatment. Here the therapist works with a "concerned significant other" (CSO) to accomplish three

major goals, two of which are focused on the individual abusing alcohol and a third that is directed toward the CSO. The first and ultimate objective is to influence the alcoholic to seek treatment. In the interim, the second goal is to reduce that individual's alcohol use. The third goal is to help the CSO make other positive life changes so that her or his own psychological functioning improves, regardless of whether or not the alcoholic enters treatment.

The program uses a variety of interventions based on functional assessment including a module to prevent domestic violence. The specific procedures involved in CRAFT include building and sustaining motivation of CSOs, functional analysis of the patient's alcohol use, improving communication skills of CSOs, positive reinforcement of reduced alcohol use, discouragement of alcohol using behavior, CSO self reinforcement training, and inviting the patient to enter treatment.

In a review by Roozen et al (2010), CRAFT produced three times more patient engagement than Al-Anon/Nar-Anon, and encouraged approximately two-thirds of treatment-resistant patients to attend treatment. CRAFT has also been found to be effective in a group format (Manuel et al, 2012).

Behavioral Couples Therapy (BCT)

BCT is an evidence-based couple therapy intervention for married or cohabitating alcoholics and their partners. BCT therapists see the alcoholic patient together with the spouse or cohabiting partner to build support for abstinence and to improve relationship functioning. BCT assumes that spouses can reward abstinence, and that alcoholic patients from happier, more cohesive relationships with better communication have a lower risk of relapse.

BCT has two main components: alcohol-focused interventions to directly build support for abstinence; and relationship-focused interventions to increase positive feelings, shared activities and constructive communication. Two main BCT programs guide much of current research on BCT. These two programs differ in their alcohol-focused interventions but are fairly similar in relationship-focused methods.

McCrady's Alcohol Behavioral Couple Therapy (ABCT) program uses a method called "alcohol-focused spouse involvement" (McCrady & Epstein, 2008). It involves teaching the spouse specific skills to deal with alcohol-related situations. The spouse is taught how to reinforce abstinence, decrease behaviors that trigger drinking, decrease behaviors that protect the alcoholic from naturally occurring adverse consequences of drinking, assertively discuss concerns about drinking-related situations, and respond to help the drinker in drink refusal situations.

The Counseling for Alcoholics' Marriages (CALM) Project BCT program uses a "recovery contract" as the main alcohol-focused method (O'Farrell & Fals-Stewart, 2006). In the CALM BCT recovery contract, the couple completes a daily "trust discussion" in which the patient states an intent to stay abstinent that day (in the tradition of one day at a time). The couple agrees not to discuss drinking or drug use at other times, to mark that they had the discussion on a calendar provided, and to end it with a statement of appreciation to each other.

A meta-analysis by Powers et al (2008) concluded that BCT shows better outcomes than more typical individual-based treatment for married or cohabiting individuals who seek help for alcohol dependence. BCT results in greater reductions in substance use, higher levels of relationship satisfaction, greater reductions in partner violence, better child psychosocial outcomes, and more favorable cost outcomes (Ruff et al, 2010; Klostermann et al, 2011).

Mindfulness Meditation (MM)

Mindfulness is defined as the ability to focus open, non-judgmental attention to the full experience of internal and external phenomena, moment by moment. Mindfulness may help alcoholics to accept unusual physical sensations that might be confused with withdrawal symptoms, decentre from a strong urge and not act impulsively, and reduce their susceptibility to act in response to an alcohol cue. Practice of mindfulness may also develop the ability to maintain perspective in response to strong emotional states and mood fluctuations and increase the saliency of natural reinforcers. (Skanavi et al 2011).

A randomized controlled pilot trial by Garland et al (2010) found that mindfulness training significantly reduced stress and thought suppression, increased physiological recovery from alcohol cues, and modulated alcohol attentional bias.

Summary and Conclusion

This review demonstrates that a variety of evidence-based psychosocial interventions are available to clinicians, patients and their families to tackle the growing problem of alcoholism. They target diverse issues like lack of readiness to seek treatment, lack of motivation to persist with treatment, absence of skills necessary to lead a sober life, thought patterns or relationship problems that increase the chances of a relapse, difficulty in surviving alcohol-related cues, etc. It is the duty of all professionals working in this area to get trained in these effective therapies, select the most suitable interventions for any particular patient, and implement them in appropriate ways so that the benefits of these new treatment modalities effectively reach the suffering patients and their families.

References

Beck, A. T.; Wright, F. D.; Newman, C. F.; et al. Cognitive Therapy of Substance Abuse. New York: Guildford Press; 1993.

Brown, S. A.; Christiansen, B. A.; Goldman, M. S. (1987) Alcohol Expectancy Questionnaire: An instrument for the assessment of adolescent and adult alcohol expectancies. Journal of Studies on Alcohol, 48:483-491.

Chang, G.; McNamara, T.K.; Orav, E.J.; et al. (2005) Brief interventions for prenatal alcohol use: A randomized trial. Obstetrics and Gynecology, 105:991–998.

Cooper, M. L. (1994) Motivations for alcohol use among adolescents: Development and validation of a four-factor model. Psychological Assessment, 6:117-128.

Davis, T.M.; Baer, J.S.; Saxon, A.J.; et al. (2003) Brief motivational feedback improves post-incarceration treatment contact among veterans with substance use disorders. Drug and Alcohol Dependence, 69:197–203.

Finney, J.W.; Monahan, S.C. (1996) The cost-effectiveness of treatment for alcoholism: a second approximation. Journal of Studies on Alcohol, 57(3):229-243.

Fleming, M.F.; Mundt, M.P.; French, M.T.; et al. (2002) Brief physician advice for problem drinkers: Long-term efficacy and benefit-cost analysis. Alcoholism: Clinical and Experimental Research, 26:36–43.

Garland, E.L.; Gaylord, S.A.; Boettiger C.A.; et al. (2010) Mindfulness training modifies cognitive, affective, and physiological mechanisms implicated in alcohol dependence: results of a randomized controlled pilot trial. Journal of Psychoactive Drugs, 42(2):177-192.

Gorman, D. M. Developmental processes. In: Heather, N.; Peters, T. J. ; Stockwell, T. (Eds.), International Handbook of Alcohol Dependence and Problems. pp. 339-356, Chichester: John Wiley & Sons; 2001.

Graham, A.W.; Fleming, M.S. Brief interventions. In: Graham, A.W.; Schultz, T.K.; Wilford, B.B. (Eds.), Principles of Addiction Medicine, 2d ed., pp. 615-630, Chevy Chase: American Society of Addiction Medicine; 1998.

Hester, R.K.; Miller, W.R. Handbook of alcoholism treatment approaches: Effective alternatives, 2nd ed., pp. 12-44, Needham Heights: Allyn & Bacon; 1995.

Higgins, S.T.; Silverman, K.; Heil, S.H. Behavioral interventions for problem drinking: Community reinforcement and contingency management. In Johnson, B.; Ruiz, P.; Galanter, MJ (Eds.), Handbook of clinical alcoholism treatment, pp 111-118, Baltimore: Lippincott Williams and Wilkins; 2003.

Holder, H.; Longabaugh, R.; Miller, W.R.; et al. (1991) The cost effectiveness of treatment for alcoholism: a first approximation. Journal of Studies on Alcohol, 52(6):517-540.

Kaner, E.; Beyer, F.; Dickinson, H.; et al. (2007) Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database Systematic Reviews, (2):CD004148.

Klostermann, K.; Kelley, M.L.; Mignone, T.; et al. (2011) Behavioral couples therapy for substance abusers: where do we go from here? Substance Use and Misuse, 46(12):1502-1509.
Larimer, M.E.; Cronce, J.M. (2002) Identification, prevention, and treatment: A review of individual-focused strategies to reduce problematic alcohol consumption by college students. Journal of Studies on Alcohol, (Suppl. 14):148–163.
Longabaugh, R.; Woolard, R.F.; Nirenberg, T.D.; et al. (2001) Evaluating the effects of a brief motivational intervention for injured drinkers in the emergency department. Journal of Studies on Alcohol, 62:806–816.
Manuel, J.K.; Austin, J.L.; Miller, W.R.; et al. (2012) Community Reinforcement and Family Training: a pilot comparison of group and self-directed delivery. Journal of Substance Abuse Treatment, 43(1):129-136.
McCrady, B.S.; Epstein, E.E. Overcoming alcohol problems: A couples-focused program therapist guide. New York: Oxford University Press; 2008.
Miller, W. R.; Wilbourne, P. L.; Hettema, J. E. What works? A summary of alcohol treatment outcome research. In: Hester, R. K.; Miller, W. R. (Eds.), Handbook of Alcoholism Treatment Approaches: Effective Alternatives. pp. 13-63, Boston, MA: Allyn & Bacon; 2003.
Miller, W.R.; Sanchez, V.C. Motivating young adults for treatment and lifestyle change. In: Howard, G., (Ed.) Issues in Alcohol Use and Misuse in Young Adults. Notre Dame, IN: University of Notre Dame Press; 1993.
Miller, W.R.; Brown, J.M.; Simpson, T.L.; et al. What works? A methodological analysis of the alcohol treatment outcome literature. In: Hester, R.K.; Miller, W.R. (Eds.) Handbook of Alcoholism Treatment Approaches: Effective alternatives, 2nd Ed., pp. 278-291, Boston: Allyn and Bacon; 1995.
Miller, W.R.; Rollnick, S. Motivational Interviewing – Helping people change, 3rd Ed., New York ,NY: The Guilford Press; 2012.
Miller, W.R., Wilbourne, P.L. (2002) Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. Addiction, 97(3):265-277.
Monti, P. M.; Kadden, R.; Rohsenow, D. J.; et al. Treating Alcohol Dependence: A Coping Skills Training Guide, 2nd Ed., New York: Guilford Press; 2002.
O'Farrell, T.J.; Fals-Stewart, W. Behavioral couples therapy for alcoholism and drug abuse. New York: Guilford Press; 2006.
Powers, M.B.; Vedel, E.; Emmelkamp, P.M. (2008) Behavioral couples therapy (BCT) for alcohol and drug use disorders: a meta-analysis. Clinical Psychology Reviews, 28(6):952-962.
Raistrick, D.; Heather, N.; Godfrey, C. Review of the Effectiveness of Treatment for Alcohol Problems. London: National Treatment Agency for Substance Misuse; 2006.
Rehm, J.; Mathers, C.; Popova, S.; et al. (2009) Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. Lancet, 373:2223-2233.
Rimmele, C. T.; Howard, M. O.; Hilfrink, M. L. Aversion therapies. In: Hester, R. K.; Miller, W. R. (Eds.), Handbook of Alcoholism Treatment Approaches: Effective Alternatives. pp. 134-147, Boston, MA: Allyn & Bacon; 1995.
Roozen, H.G.; de Waart, R.; van der Kroft, P. (2010) Community reinforcement and family training: an effective option to engage treatment-resistant substance-abusing individuals in treatment. Addiction, 105(10):1729-1738.
Ruff, S.; McComb, J.L.; Coker, C.J.; et al. (2010) Behavioral couples therapy for the treatment of substance abuse: a substantive and methodological review of O'Farrell, Fals-Stewart, and colleagues' program of research. Family Process. 49(4):439-456.
Skanavi, S.; Laqueille, X.; Aubin, H.J. (2011) Mindfulness based interventions for addictive disorders: a review. Encephale, 37(5):379-387.
Spada, M. M. Cognitive Behavioural Therapy for Problem Drinking: A Practitioner's Guide. London, UK: Routledge; 2010.
Spada, M. M.; Wells, A. (2006) Metacognitions about alcohol use in problem drinkers. Clinical Psychology and Psychotherapy, 13, 138-143.
Whitlock, E.P.; Polen, M.R.; Green, C.A.; et al. (2004) Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: a summary of the evidence for the US Preventive Services Task Force. Annals of Internal Medicine, 140:557-568.

Review Article

Postgraduate training in psychiatry in Kerala-current status

Dr. Midhun S.
Junior resident in Psychiatry, Government Medical College, Kozhikode, Kerala

Dr. Nishanth J. H.
Junior resident in Psychiatry, Government Medical College, Kozhikode, Kerala

Dr. Harish M. Tharayil
Professor of Psychiatry, Government Medical College, Kozhikode, Kerala

In India, there are 151 Medical Colleges and Postgraduate Institutes, which admit 390 M.D. degree students in Psychiatry each year, besides which,59Medical Colleges have training facilities for 130 D.P.M. students.

Postgraduate education in psychiatry began in 1975 in Kerala with starting of D.P.M course in Trivandrum medical college, affiliated to Kerala university .There were six seats .MD course was started in Calicut medical college with 2 seats affiliated to Calicut university in 1984.Later MD course was started in Trivandrum, Kottayam and Thrissur.DNB course in psychiatry was conducted in MMM hospital ,Kolencheri and medical trust hospitals earlier. Details of the presently available postgraduate seats are given in table 1. In Kerala 14 colleges are conducting MD psychiatry courses and 5 colleges are conducting D.P.M courses at present. Currently there are 29 MD seats and 11 D.P.M seats in Kerala.

Previously the courses in different colleges were conducted under the different universities of the state. Currently all colleges are under Kerala university of health science (KUHS) except Amrita institute of medical sciences (AIMS) which is a deemed university.

Clinical postings

The pattern of clinical postings in different colleges are given in table 2.It can be found that there are clear discrepancies in the way in which the postings are conducted. Even though KUHS provides a guide line for various clinical postings, these are conducted in a non uniform way in different institutions .Mental hospital postings are not there anywhere except Trivandrum medical college.

Examination pattern

MD: Theory examination is conducted in a uniform manner in all the colleges which is as per medical council of India guidelines. There are four theory papers. But differences are noted in the pattern of practical examinations in different colleges. In Trivandrum medical college one psychiatry long case, one psychiatry short case and one neurology long case are kept for MD

practical examinations. In other places there are two psychiatry short cases along with one neurology long case and a psychiatry long case. The private centers are yet to conduct the pg examinations.Viva has a uniform pattern in all the colleges.

D.P.M: There are one long psychiatry case and one short case each for neurology and psychiatry .For theory there are three papers.

Dissertation

Every MD candidate has to submit a dissertation to the university at the end of the course for appearing in examinations. The protocol of the dissertation should be submitted within six months of joining the course.

Suggestions

- The pattern of clinical postings and examinations needs to be made uniform. Consensus can be achieved in this matter by appropriate authorities including the KUHS, DME, and postgraduate teachers after necessary discussions.
- Community psychiatry may need more emphasis in the present scenario.
- Further specializations and additional short courses can be made available as it may help to enhance the skills of the personnel and may facilitate further research.Specialisation can include geriatric psychiatry, neuropsychiatry, community mental health, child and adolescent psychiatry, addiction psychiatry etc.
- It is difficult to find out a dissertation topic within six month period especially in psychiatry as one may need more exposure in the subject .Hence it is desirable to increase this period to one year.

References

1) Sharma S. Postgraduate training in psychiatry in India. Indian J Psychiatry 2010;52:S89-94.
2) Praveenlal .Mental health care in Kerala: current status. Kerala J Psychiatry January 2000;14(1)

Table 1

College	MD	D.P.M
Govt medical college, Kozhikode	3	0
Govt medical college,Thiruvananthapuram	3	5
Govt medical college,Kottayam	2	0
Govt medical college,Thrissur	4	0
Govt medical college,Alappuzha	1	0
Academy of medical sciences ,Pariyaram	2	0
Amala institute of medical sciences,Thrissur	1	0
Amrita school of medical sciences, Ernakulum	2	1
Dr. Somervell Memorial CSI Hospital & Medical College	2	0
MES medical college ,Perinthalmanna ,Malappuram	1	2
Pushpagiri institute of medical sciences and research centre,Tiruvalla	2	2

Kannur medical college,Kannur	2	0
Jubilee mission medical college and research centre, Thrissur	2	0
Amrita school of medical sciences, Ernakulum	2	1
Total	**29**	**11**

Table 2

POSTINGS	KUHS	KOZ	TVM	KTM	ALP	PAR	THR	AMR	PUS	AMA
NEUROLOGY	2 mon	2 mon	2 mon	2 mon	2 mon	2 mon	2 mon	3 mon	2 mon	1 mon
PSYCHOLOGY	3 mon	15 days (NIMH)	3 mon	1 mon (NIMH)	15 Days (NIMH)	3 mon	15 Days (NIMH)		15 Days (NIMH)	15 Days (NIMH)
INTERNAL MEDICINE & ENDOCRINOLOGY	1 mon	15 days	1 mon	1 mon	1 mon	1 mon	1 mon	3 mon	1 mon	1 mon
CHILD & ADOLESCENT PSY	2 mon	1 Mon (NIMH)	2 mon	1 mon (NIMH)	15 Days (NIMH)	2 mon	1 mon (NIMH)	2 mon (NIMH)	1 mon (NIMH)	1 mon (NIMH)
COMMUNITY PSYCHIATRY	2 mon			15 Days					1 mon	
DEADDICTION	2 mon		2 mon		15 Days (NIMH)	2 mon				
OTHERS		15 days (NIMH-FOREN) 15 days - NEUROSUR		15 days (DMHP IDUKKI)	1 mon (DMHP TVM)		15days (FOREN)		15 days (NIMH FOREN)	1mon (NEUROSUR)

KOZ-Govt medical college, Kozhikode

TVM- Govt medical college, Thiruvananthapuram

KTM- Govt medical college, Kottayam

ALP- Govt medical college, Alappuzha

PAR- Academy of medical sciences, Pariyaram

THR- Govt medical college, Thrissur

AMR- Amrita School of medical sciences, Ernakulum

PUS- Pushpagiri institute of medical sciences and research centre,Tiruvalla

AMA- Amala institute of medical sciences, Thrissur

NIMH-NIMHANS

FOREN-forensic psychiatry

NEUROSUR-Neurosurgery

Case Report

Megaloblastic Anemia as a Sequelae to Schizophrenia

Dr. Varsha vidyadharan
Senior Resident, Department of Psychiatry,
Govt Medical College, Trivandrum

Prof. V. Satheesh
Professor and HOD Department of Psychiatry
Govt Medical College, Kottayam

Introducton

Vit B12 deficiency is common in developing countries and its prevalence ranges up to 67% in Indian population(1). Man depends on nutritional intake for their vit B12 supply(2). Vit B12 deficiency is caused by strict vegetarian diet, pernicious anemia, food-cobalamine malabsorption, gastric surgeries, ileal diseases and pancreatic insufficiency. Vit B12 is an integral component of two biochemical reactions in humans, conversion of L-methyl malonyl co enzyme A to succinyl co enzyme A and transmethylation reaction which is essential for DNA synthesis and maintenance of the myelin sheath by methylation of myelin basic protein.Vit B12 deficiency can affect skin, and cause neuropsychiatric manifestations such as peripheral neuropathy, cerebellar ataxia, optic atrophy, delirium, dementia, psychosis, and mood disorders(3)

Psychiatric syndromes associated with vitB12 deficiency have been reported previously.Psychiatric symptoms in B12 deficiency (4) describes unusual psychiatric manifestations including catatonia and complete remission of symptoms with vitamin B12 therapy, psychiatric syndromes and pernicious anemia(5) describes a patient with B12 deficiency and paranoid delusions, chronic psychosis associated with vit b12 deficiency (6) describes a patient with two year history of psychosis without anemia which responded well to short term antipsychotics and B12 therapy.

Here we report a case of schizophrenic patient who became strict vegetarian since 2 years and developed megaloblastic anemia, He responded well to parenteral cobalamine supplementation and he is under our follow up now.

Mr.V, a 25 year old unmarried male Hindu laborer presented with decreased social interaction, irritability, irregularity in job and keeping aloof for 2 years, he became increasingly religious, disliking his Christian neighbours and avoiding food from Christian hotels. He became a strict vegetarian, and did not allow family members to take non veg food. He kept on staring at the picture of diety as well as lamp in front of it while at home, and visited temple regularly; few instances of unprovoked assaultiveness also present. Over the last one year twice he had jaundice, vomiting and fatigue and had to be admitted in tertiary care centre, He was treated symptomatically and was being worked up as anemia for evaluation .But he got discharged against medical advice, and there was no medications or follow up. Three months prior to 3rd

admission his biological functions worsened, irritability increased and he started muttering and laughing to self .So he was brought to our psychiatry facility. There was no other significant medical history in the past. Past history of abuse of alcohol and smoking was present and he was abstaining from them for the last 2 years. Family history of alcohol dependence and suicide in father was present. There was also history of suicides in maternal grandmother and paternal first cousin and behavioral disturbances in a third degree relative.

On examination eye to eye contact was ill sustained and rapport was difficult. His talk was decreased with poverty of thought content and he had bizarre delusions and restricted affect. His cognitive functions were intact, but he had impaired judgment and poor insight. His PANNS scoring was 74/210 and MMSE scoring 26/30.

Physical examination revealed sparse hair with alopecia, pallor, jaundice, clubbing, glossitis, soft cervical LN, hyperpigmantation of both hands and knuckles. These findings provided the impetus for further evaluation. His Cranial nerves, motor system, sensory system and gait were normal. There was no signs of cerebellar dysfunction.

LAB INVESTIGATION

Hb 6.8gm% [13-15gm%]
TC 3600/mm3[4000-11000]
DC P54 L42 M4
PLC 1.75 lakhs
Peripheral smear – bicytopenia,polychromatasia, pencil cells.
MCV 100fL [80-100]
MCH 31.5pg/cell [26-32]
MCHC 32 g/dl [32-36]
LDH 1430U/L (115-220)
Reticulocytic count 1.5%
Serum ferritin 297ng/mL [29-248]
Vit B12 256 pg/ml [350-650]
Bone marrow – megaloblastic erythroid hyperplasia.

DISCUSSION

Several reports of psychosis secondary to B12 deficiency has been reported earlier. We had also considered organic psychosis secondary to B12 deficiency as the first possibility in our patient. But here there were few points against it. Presence of previous psychiatric symptoms which made the patient strict vegetarian and anemic features following for more than one year suggested the possibility of having non affective psychosis with megaloblastic anemia. Being strict vegetarian the patient had a risk factor for B12 deficiency. He had a family predisposition of psychiatric illness. Marked improvement of psychosis with short term antipsychotics and parental B12 therapy which usually occur in megaloblastic anemia was not seen here. Hence the chance of organic psychosis secondary to vitB12 deficiency was considered as second differential diagnosis.

Although there is definite clinical evidence of psychiatric syndromes associated with low vitamin B12 the latter may sometimes be the consequence rather than the cause of the abnormal mental state since vitaminB12 deficiency can result from inadequate nutrition. Hence the latter may be sequel of a mixed nutritional deficiency in psychiatric patients who have neglected their diet. Before accepting a causal link between vitamin B12 deficiency and psychiatric syndromes Zucker et al(7) suggested four criteria 1, the absence of other organic causes for the mental symptoms 2, a nonrelapsing course 3,poor response to other treatments and 4,a positive and well maintained response to vitaminB12 administration.

As we managed this patient in a psychiatric facility having cost constraints, we have not employed neuro imaging, electrophysiology studies and assays of homocysteine, methymalonic acid to increase the specificity of diagnosis of B12 deficiency.

In view of high prevalence of vit B12 deficiency in Indian population, co existence of B12 deficiency and psychosis is insufficient to establish a causal association. However the possibility of psychiatric symptoms antedating anemia should be considered and hence the patient is under our follow up.

Early surveys have shown that a large

number of psychiatric patients have low serum B12 levels ranging from 6-15%; and this reveals the magnitude of this often overlooked nutritional deficiency which compounds the disease process(8). Co morbidity of B12 deficiency in a psychotic patient is more frequent than organic psychosis secondary to B12 deficiency. But early initiation of parental cobalamine supplementation may be beneficial for both clinical scenarios. Also it is important to treat B12 deficiency as early as possible as the symptoms may be difficult to reverse after a certain duration because of irreversible changes secondary to axonal degeneration.Also deficiency results in diffuse and focal areas of degeneration in the cerebral white matter with little gliosis and grey matter changes,methyl tetrahydrofolate a potential excitatory neurotoxin may be responsible for such neuronal destruction(9)

CONCLUSION

General examination and routine blood investigation findings were the clue in this patient which helped us to evaluate further and reach a diagnosis of megaloblastic anemia.so this case report intends to highlight the importance of general physical examination and basic blood investigations which should be routinely performed in all psychiatric patients.

References

1) Bandishtis, Kharche M. B12 and folate deficiency : incidence and clinical features. Neurology India 2000; 48 : 302-4.
2) Hirtho BR folate and cobalamine in psychiatric illness. Comprehensive psychiatry 1997; 38 : 305- 104.
3) Carney MWP, Chanarin I, Reynold E H et al, neuropsychiatry of megaloblastic anemia. Br medical J 1980; 281: 1036-104.
4) BerryN,SagarR,TripathiBM.CatatoniaandotherpsychiatricsymptomswithvitaminB12 de?ciencyActaPsychiatrScand2003:108:156–159
5) Langdon FW. Nervous and mental manifestation of pre-pernicious anemia JAMA 1995, 45 1635 – 8.
6) Rajkumar A.P,Jebraj.P, chronic psychosis associated with B12 deficiency J Assoc physicians india 2008;56;115-118.
7) ZuckerDK, LivingstonRL, NakraR,ClaytonP.B12 de?ciency and psychiatric disorders:case-reportandliteraturereview.BiolPsychiatry1981;16:197–205.
8) HectorM,BurtonJR. What are the psychiatric manifestations of vitaminB12 de?ciency? JAmGeriatricSociety1988; 36:1105–1112.
9) Lubree, Naikss et al. vitamin B12 deficiency and hyperhomocysteinemia in rural and urban Indians J assoc physicians India 2006; 54 – 775 -82.
10) CatalanoG, MariaC, Catalano DO, EricIR, EmbiPJ, EmbiSC. Catatonia another neuropsychiatric presentation of vitaminB12 de?ciency? Psychosomatics1998; 39:456–460.
11) HealtonEB, SavageDG, BrustJC, GarrettTJ, LindenbaumJ. Neurologicaspectsofcobalaminde?ciency.Medicine1991;70:229–245.
12) LindenbaumJ, Healton EB, Savage D Getal. Neuropsychiatric disorders caused by cobalamin de?ciency in the absence of anemia or macrocytosis. N Engl J Med1988;318:1720–1728.
13) Ralph carnel, MD. Cobalamine deficiency, Annals of Internal medicine vol124; 3, 338 -339.

Case Report

Childhood Disintegrative Disorder

Asfia Khaleel
Junior Resident

Firoz. K
Assistant Professor.

Manoj Kumar
Senior Resident

Rajmohan V.
Assistant Professor.

Raguram T. M.
Professor and Head, Department of Psychiatry,
MES Medical College, Perinthalmanna

Abstract

Childhood disintegrative disorder (CDD), also known as Heller's syndrome or disintegrative psychosis, is a rare condition characterized by marked regression in multiple areas of development after several years of normal development. Estimated prevalence of childhood disintegrative disorder is around 0.11 to 0.64 per 10,000 children. The present report describes the case of an eight year old boy who developed childhood disintegrative disorder after approximately three years of normal development. No neurological abnormalities were found on EEG and MRI. This case is reported as this condition is very rare and no reports from our state have been published.

Keywords: Childhood disintegrative disorder, disintegrative psychosis, Heller's syndrome

Introduction

Childhood disintegrative disorder (CDD), also known as Heller's syndrome or disintegrative psychosis, is a rare condition characterized by marked regression in multiple areas of development after several years of normal development. It was first described by an Austrian educator, Theodore Heller, in 1908. Estimated prevalence of childhood disintegrative disorder is around 0.11 to 0.64 per 10,000 children and only about 100 cases have been reported as the condition is under-diagnosed. Although gender distribution of the disorder is not exactly known, male seems to outnumber female cases with a ratio of 8:1. The prognosis is usually very poor and most individuals are left with severe developmental delay especially in language and social skills.2 The present report describes the case of an eight year old boy who developed childhood disintegrative disorder after approximately three years of normal development. This is probably the first case of CDD to be published from our state.

Case Report

A male child aged 8 years came with complaint of regression of milestones. The patient was absolutely normal till age of 3 years. The child was a product of nonconsanguinous marriage and was born at full term normal vaginal delivery. There were no perinatal maternal infections or complications after birth and he was immunized up to age. The child attained age appropriate motor and language milestones till 3 years of age. The child was toilet trained and was able to control his bowels and bladder. He also attended playschool wherein he learnt to recite poems and stories, could scribble and draw lines. He interacted well with family members and liked playing with other children. At around 3 years of age, he started having regression in communications. His had prominent echolalia and later his sentences become progressively shorter, it was followed by lack of interest in conversation. He started sitting alone all day self-absorbed in play and showed increased anger and irritability. He stopped playing with his friends and did not take part in school activities so family members stopped sending him to school. He would ride the bicycle in circles and would run up and down the house or in circles incessantly.

Soon he stopped calling family members by names, words became fewer and infrequent and would express only basic needs like hunger and thirst verbally. He did not make eye contact and did not show emotions when hugged or patted. He stopped talking completely and would take his mother's hand to show what he needs. Currently he has stopped asking for food and cries if he is hungry, he does not interact even with his parents, is unable to dress, undress or feed himself, has stopped writing or coloring, resists any attempt at making him do it and his speech has regressed to babbling. He responds to call and follows instructions. There is no regression of gross motor milestones and bowel and bladder control are maintained. He is attending special school.

There was no history suggestive of ADHD (attention deficit hyperactivity disorder), MR (mental retardation), seizure disorder, psychosis, exanthematous fever or any medical illnesses. On physical examination, he had attained age appropriate physical development, there were no anomalies and all other systems were within normal limits. On MSE, child did not make eye contact. He was making babbling sounds and was expressing his needs by crying. Did not show any interest in surroundings but was able to comprehend and could obey commands. At lunch time started getting irritable and was assaultive towards parents.

Routine investigations like complete blood count, liver function test, renal function test, EEG (Electroencephalogram) and MRI (Magnetic Resonance Imaging) were done. All the investigations were normal. Hence we planned to do IQ (Intelligence Quotient) assessment and CARS (Childhood Autism Rating Scale) on follow up and get Metabolic screening like TMS (Tandem Mass Spectroscopy), and BERA (Brainstem Evoked Response Audiometry) done, for which he was referred to a higher centre. Parents were psycho educated about the illness. Speech and language therapy, social skills training and special schooling were advised.

Discussion

CDD was included in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, or DSM-IV; however the condition currently falls under the larger rubric of autism spectrum disorders in DSM-5. The cause of childhood disintegrative disorder is unknown. The prevalence of epilepsy is markedly increased in CDD but its role in the pathophysiology of CDD is not known. The present case had no history of seizure and EEG showed no epileptiform activity. It is suggested that CDD and autism may share a common genetic mechanism. Predisposing genetic factors which, when combined with an environmental stress, may activate the production of abnormal protein and result in the deposition of amyloid and cause the disruption of synaptic transmission during the deterioration period. Immunopathogenic processes may be a promising target for future research. The case reported has no family history of pervasive development disorder, and no discernible environmental stressors were present. Children with CDD have at least 2 years of normal

development in all areas—language understanding, speech, skill in the use of large and small muscles, bowel and bladder control and social development. After this period of normal growth, the child begins to lose the skills he or she has acquired. This loss usually takes place between ages 3 and 4, but it can happen any time up to age 10. In this case the decline occurred after 3 years of normal development, which is in keeping with the age range of CDD. To be diagnosed with CDD, a child must show loss or regression in at least two developmental areas with an apparently normal development for at least first 2 years after birth. Usually regression occurs in more than two areas. The areas affected are receptive language skills, expressive language skills, social skills or adaptive behaviors; play with peers, motor skills, and bowel or bladder control, if previously established. The child in our report had definite regression in expressive and receptive language, loss of social and adaptive skill, and play skills. However his motor skills, bowel and bladder control were normal. The child should have abnormal functioning in at least two of following: impaired nonverbal behaviors, failure to develop peer relations with no social and emotional reciprocity, inability to start and maintain conversations with other people and restricted, repetitive and stereotyped behavior. These changes must not be caused by a general medical condition or another diagnosed mental disorder. This child also had impaired peer relation, lack of social reciprocity, and occasional stereotyped behaviors. Hence the diagnosis of CDD was made. Treatment for CDD is very similar to treatment for autism. Currently, there are no pharmacological interventions that specifically target the core symptoms of PDD. The emphasis falls on early and intense educational interventions. Most treatment is behavior-based and highly structured. Educating the parents is also emphasized in overall treatment plan. Speech and language therapy, occupational therapy, social skills development, and sensory integration therapy may all be used according to the needs of the individual child.3 The early identification of CDD and targeted interventions will help to improve the functional status of the child and allay parental anxiety to a certain extent.

References

1. Fombone E. Prevalence of childhood disintegrative disorder. Autism. 2002; 6(2):149-57.
2. Mouridsen SE, Rich B, Isager T. Epilepsy in disintegrative psychosis and infantile autism: a long-term validation study. Dev Med Child Neurol. 1999; 41(2):110-4.
3. Zwaigenbaum L, Szatmari P, Mahoney W, Bryson S, Bartolucci G, MacLean J. High functioning autism and Childhood Disintegrative Disorder in half brothers. J Autism Dev Disord. 2000; 30(2):121-6. .
4. Russo M, Perry R, Kolodny E, Gillberg C. Heller syndrome in a pre-school boy. Proposed medical evaluation and hypothesized pathogenesis. Eur Child Adolesc Psychiatry. 1996; 5(3):172-7.
5. Torrente F, Ashwood P, Day R, Machado N, Furlano RI, Anthony A, et al. Small intestinal enteropathy with epithelial IgG and complement deposition in children with regressive autism. Mol Psychiatry. 2002; 7(4):375-82, 334.
6. Diagnostic and statistical manual of mental disorders: DSM-IV-TR®. American Psychiatric Pub; 2000.

MID TERM CME IPS Kerala State June 2013

A Continuing Medical Education (CME) programme of the Indian Psychiatric Society (IPS), Kerala state branch was inaugurated by Dr. V.Sathesh, President of IPS, Kerala. The CME was organized by the Indian Psychiatric Society, Thrissur branch at Hotel Casino on 16th June 2013. Dr K.S.Shaji was the Organizing chairman and Dr Sebind Kumar was the Organizing Secretary. The theme of the CME was 'Striving for Clinical Excellence'. Dr.K.Praveenlal, Dean of Kerala University of Health Sciences (KUHS) who was the Chief Guest, spoke about the activities of the University in encouraging research in medical education in the state. Dr. Madhavan, Dr Radhakrishanan, Dr. Jayaprakashan, Dr. Harish, Dr. Thomas John, Dr.Mohandas, Dr. James Antony, Dr.Sam Padamadan, Dr. Sebind Kumar, Dr.K.S.Shaji spoke on the occasion. Papers presented on the occasion were on various topics of clinical relevance like Autism by Dr. Sitalakshmy George (Ernakulam), Neutraceuticals by Dr. Rajmohan (Calicut), Therapeutic adherence by Dr. Subramanian (Thrissur) and Alcohol withdrawal by Dr. Shahul Ameen (Changanassery). A debate on the topic of Antidepressant use in Bipolar depression was also organized with speakers being Dr Varghese Punnoose (Calicut) and Dr. Vidhukumar (Trivandrum). The debate was moderated by Dr. Mohan Chandran (Calicut). Medical students who won prizes at National level in psychiatry quiz (Jayaram.S and Arun.M.A from Calicut Medical College and Aleena Andrews and Akhila Arya from Thrissur Medical College) and psychiatry postgraduate student who won best poster award at National level (Dr. Anisha Nakulan, Thrissur Medical College) were felicitated. Master Nihal, 8 yrs, son of Dr Sarin (Asst Prof Dermatology) and Dr Shijin (Asst Prof Psychiatry), who won many outstanding achievements in chess, was also felicitated. More than hundred psychiatrists and psychiatry post graduate students attended.

Thrissur
10/08/13

Dr. Sebind Kumar,
Organizing Secretary,
Ph: 9745145350

IPS KERALA PG TRAINING PROGRAMME 2013

Indian Psychiatry Society(IPS) Kerala Branch and Department of Psychiatry Pushpagiri Medical College, Thiruvalla conducted the Kerala State Post graduate training programme on 18th August from 9am to 4.30pm. It was held at Heart Institute Auditorium Pushpagiri Medical college, Thiruvalla. Dr.Sathesh.V. president, IPS,Kerala presided over the function. The programme was inaugurated by Dr. Thomas Mar Koorilos , Archbishop Thiruvalla. Prof. Roy Kallivayalil HOD, Department of Psychiatry Pushpagiri Medical College welcomed the gathering . Prof. S. Santhakumar and Dr.Jayaprakashan K.P Secretary,IPS,Kerala felicitated the occasion. Dr. Fazal Mohamed A.M, organizing secretary proposed the vote of thanks. Dr.Santhakumar, Calicut the first PG Professor of Kerala was honoured at the meeting by adorning him with a 'shawl of honour' (Ponnada) by the Imm. Past National IPS President Dr. Roy Abraham Kallivayalil

The theme of the PG training program was **"Current Issues Relevant in PG training"**. It was the largest ever programme attended by 95 delegates which included 60 Post Graduate residents of which 46 were Psychiatry PG residents. The programme comprised of two sessions. The morning session was a CME. Prof. S Santhakumar give a talk on 'Story of my Career'. It was chaired by Prof. Kunjichacko M. Jacob and Dr. Fazal Mohamed A. M. Prof. Prof.Dr. Roy Kallivayalil spoke on " Why Social Psychiatry is Important In PG Training". It was chaired by Prof. Kuruvilla Mathew and Dr.Shahul Ameen. Prof Anil Prabhakar talked on "Psychodiagnostic and Psychodynamic formulation". It was chaired by Prof.V Sathesh and Dr. Bobby Thomas. Prof. Reji Thomas presented "Neurological Examination in Psychiatry" which was chaired by Prof. Dr. Tomy Philip and Dr. Joice Geo. "Diagnostic Approach to a child with Poor Scholastic Performance" was presented by Prof. Varghese P. Punnoose and chaired by Prof. Christina George and Dr. Smitha Ramdas.

The highlight of the programme was the post lunch workshop titled **" How to write a good research paper and how to get it published"** by Prof Chittaranjan Andrade, NIMHANS, Bangalore. All the sessions were excellent and the interaction that ensued was lively.

ADHD, EEG & FDA Approval

FDA Approvals > Medscape Medical News First Brain-Wave Test for ADHD Approved by FDA Robert Lowes Disclosures Jul 15, 2013

The US Food and Drug Administration (FDA) today approved the first brain-wave test to help diagnose attention-deficit/hyperactivity disorder (ADHD) in children and adolescents aged 6 to 17 years, the agency announced. The testing device is called the Neuropsychiatric EEG-Based Assessment Aid (NEBA) System. The noninvasive test, based on electroencephalogram technology, computes the ratio of theta and beta brain waves in 15 to 20 minutes.

Children and adolescents with ADHD have a higher theta-beta ratio than those who do not have the disorder.

"The NEBA System along with other clinical information may help healthcare providers more accurately determine if ADHD is the cause of a behavioral problem," Christy Foreman, director of the Office of Device Evaluation at the FDA's Center for Devices and Radiological Health, said in a news release.

The agency based its decision to approve the NEBA System in part on a clinical study of 275 children and adolescents with attention or behavioral issues. Clinicians evaluated all of them using the new brain-wave test along with standard diagnostic protocols and physical exams. An independent panel of ADHD experts reviewed the findings to determine whether each patient satisfied the criteria for ADHD or another condition. The study showed that adding the brain-wave test to a clinical assessment helped clinicians make a more accurate ADHD diagnosis than if they had performed only the clinical assessment.

The NEBA System is made by NEBA Health, in Augusta, Georgia.

More information on the FDA decision to approve the NEBA System is available on the agency Web site.

Dr Thomas John

Research Paper

Study on Injecting Drug Users and Tendency towards Crime

Mr. Muhammed Farooque K.S., M Ed, MSW
Psychiatric Social Worker

P.N.Suresh Kumar, MD, DPM, DNB, PhD, MRC Psych
Professor

AnishP.K., MD
Assistant Professor

K.T.Paulachan, MA, M Phil (Medical & Social Psychology)
Clinical Psychologist

Sushil.K., DPM, DNB
Professor & Head Department of psychiatry
KMCT Medical College
Kozhikode, Kerala, India.

Abstract

Intravenous Drug Users (IDUs) propensity towards crime and sexually transmitted diseases were studied in a non-experimental descriptive approach using simple random method on 60 current IDU population residing in Kozhikode district. Majority were young, males, married, with lower educational status and had reasonable monthly income. Majority started drugs due to peer pressure and the main source of drug was friends. Significant majority had connections with mafia, involved in crimes and spent considerable time in jail. Though the major part of respondents was linked with Suraksha Project of KSACS (Kerala State AIDS Control Society) for receiving needles and syringes, 77% shared needles for injection. Out of 60 IDU, 40 respondents gave consent for STD screening. Among these 2 male were diagnosed to have HIV infection, 5 males with hepatitis B and 5 males with hepatitis C infection. Implications of these findings are discussed with special reference to Indian context.

Key words: Intravenous Drug Users, IDUs, crime, sexually transmitted diseases

Introduction

Drug abuse is defined as self administration of a drug for non-medical reasons, in quantities and frequencies which may impair an individual's ability to function effectively and which may result in social, physical or emotional harm. Drug addiction by drug injection is a historical phenomenon

and ever increased concern world over associated with socio-economic and psycho-physiological disturbances. Injecting Drug Use had been reported in 148 countries and territories together accounting 95% of the world's population. Brazil, China, Russian Federation and United States of America are estimated to have the largest population of IDUs; and together account for 45 per cent of the estimated total worldwide population of IDUs (Health Action, 2010). India with its unique geo-political situations has become vulnerable to drug menace (NACO, 2006). According to Organization for Industrial Spiritual and Cultural Advancement (OISCA, 2013) there are 8600 IDUs in Kerala, among them 2342 (27.23%) are belonging to Kozhikode district.

Drug abuse appears to be determined by a combination of risk factors that include both intrapersonal (genetics, personality, cognition, emotion) and extra personal (socio-cultural, environmental) factors. Injecting Drug Users commonly use sensual drugs that the body has no need for, but that give the user a strong sense of euphoria and pain relief. Sensual drugs activate brain's pleasure centers and it accelerates IDUs drug seeking behaviour. Furthermore when there is no proper and legal means to get drugs, it increases IDUs vulnerability to crimes.

Till date no detailed and formal enquiry into the injecting drug user's relationship with crime has been conducted in Kerala. Keeping these problems in mind the authors conducted a comprehensive study on IDUs towards crime in a selected part of Kozihikode district envisaging the nature and prevalence of drug injection and their associated anti-social deeds.

Objectives

1. To study IDUs tendency towards crime in Kozhikode district
2. To study the social, economic and emotional aspects leading to drug addiction
3. To find out different sources of drugs and its mode of transaction
4. To study the networking of drug addicts in connection with the increasing number of crime

Methodology

A non-experimental descriptive approach was used for this study. The study was conducted at the Department of Psychiatry, KMCT Medical College, Calicut, Kerala. Ethical approval was obtained from the Ethics Committee of the institution. This hospital has a well established psychiatry department with an inpatient capacity of 30 beds. This is a descriptive and naturalistic study. Simple random method was used to collect information from 60 current Injecting Drug Users among the IDU population in Kozhikode district. The data collection was done by using interview schedule. Information was obtained from patient, relatives, colleagues or any available resources.

Results and Discussion

69 % of the respondents belong to the age group of 24 - 44 years. Early stages of youth are more vulnerable for experimentation with drugs. Hence younger generations are not safe in their path of life (Indian Journal of Social Work, 2010). Our respondents might have started experimentation with drugs during adolescence or early adult-hood and still remain as a drug addict/drug injector.

70 % of the subjects were married. Hence majority of the respondent's families are badly affected by drug injection. Drug injection may lead to marital breakdown in imminent future (Madan, 1996). Due to drug addiction these married respondents would be unable to perform their duties in family; therefore the lives of family members who are dependent on these persons will be in darkness. The representation of small number of single/unmarried subjects also points towards a diminishing social structure. Above all these we can't ignore the role of drug addiction behind the ever increasing rate of divorce as mentioned in this study.

Majority of subjects (88%) belong to nuclear family. Nuclear families contribute an

atmosphere more conducive for substance abuse than that of joint families. Kerala's present social system greatly adopts nuclear family system in accordance with the changing social milieu (Purushothama, 2003).3 The shift from joint families to nuclear families resulted in the deterioration of moral values from the main stream society. From the sociological and psychological point of view, joint families are advantaged with more adjustment, mutual trust and support among the members. Today it is lost due to industrialization, urbanization; a bye product of nuclear families (Madan, 1996).

Majority of the respondents (84%) falls under Rs. 2000 – 8000 income group. It shows that almost all IDUs have sufficient means to ensure basic amenities of life. Unfortunately IDUs craving for the drug make their hands empty by spoiling their earnings by spending for injection.

77% of the respondents were suffering from wide variety of physical illnesses. 20% suffer from diabetes, 17% ulcer, 15% headache, 10% hypertension and 5% from other cardiac diseases. Continuous injection of psychoactive substances may gradually lead to the failure of our immune system, and that may eventually result in death due various physical ailments.

43% of respondents spend their leisure time in town and 37% in theatre or clubs. As far as IDUs are concerned, this type of spending leisure time is significantly associated with their high risk behavior, an atmosphere favoring injecting behavior and immoral traffics. Furthermore, remaining outdoor will help the IDUs to interact with the fellow IDUs, which may add to more and more immoral conducts (Naik et al, 1991).

Major proportion initiated injection due to peer pressure. Another 37% initiated injection due to easy accessibility of drug. Parent's inattention regarding children's companionship could be the reason for influence of peer pressure in drug seeking in our study. Moreover, when drug is easily accessible, and if the individual also have an intense desire to experiment with the drug this can mislead our young generations into the unbeatable circles of drug addiction.

For 56% of respondents, friends were the main source of getting drugs and for 40%, mobile venders were the main source. More interestingly, most of these friends were fellow IDUs of the respondents. These friends were getting drug from mobile venders. Thus at least for 96% of respondents, the source of drug was mobile venders. In Kerala, many of the recently conducted police raids centered round bus stations, schools and colleges are the warning signals for us to be vigilant and careful about our children and youth against the menace of drug abuse.

Lower the education higher was the chance for indulging in crime (The code of Criminal Procedure, 2009). In the present study, majority had preference towards drug mafia. The preference towards drug mafia will encourage the growth of favorable atmosphere for drug related crimes. Many times even the regulatory authorities maintains strong tie up with mafias as they knew the strength of drug mafias for their own better prospects. This makes it difficult for implanting laws in our society. Among the 60 respondents, 65% were involved in various crimes. Furthermore for 95% of criminals, the educational status was only up to primary level. Illiteracy and lack of goals in life might have transformed them into criminals. It also necessitates towards the urgency of taking immediate and effective measures to wipe out school drop outs from society.

33% of the respondents spent their time in prison for 1-5 years, 23% for 6-10 years and 12% for 11-15 years. This data further reiterates IDU's propensity towards crime. Drug injection plays a significant role in bringing up criminals; leading to far reaching consequences on the nation (Legal News and views, 2011). When youths spoil their valuable time in prison consequent to drug injection and related crimes it is a curse for the society and nation as well as for individual concerned.

43% of the respondents were actively involved in drug selling. The direct involvement of IDUs in drug selling further highlights the strength of drug mafia. For an IDU drug seller, it is not only a way to earn money but also a solid foundation to procure drug to control his withdrawal symptoms. It also encouraged majority (57%) of our fellow IDUs to choose the same way as the former to control their withdrawal symptoms. Hence it can be interpreted that IDU cannot be under estimated

as a habit disorder of certain individuals but it must be considered as a social disease as it spread darkness in families and societies. So the federal agencies along with the social organizations should take special concern to wipe out drug mafias from society.

The lion's share of the respondents (88%) was linked with Suraksha Project of KSACS (Kerala State AIDS Control Society) for receiving needles and syringes. Only 10% were dependent on medical shops and 2% on drug agents. Despite that 77% shared needles for injection. Out of 60 IDU, 40 respondents gave consent for STD screening. Among these 2 male respondents were diagnosed to have HIV infection, 5 males with hepatitis B infection and 5 males with hepatitis C infection. The WHO Global Burden of Disease Study 2000 found that unsafe injections accounted for 21 million cases of deadly and virulent hepatitis B virus infections, 2 million hepatitis C and 2,60,000 HIV cases (The Week, 2013). As India is the world's second HIV infected country, needle sharing behaviour of IDU community accelerates the possibility for rapid HIV transmission (ICMR Bulletin, 1992). It is very a crucial finding when we correlate needle sharing with their unsafe sex practice as it multiplies the chances for not only HIV but other sexually transmitted infections as well.

Conclusions and suggestions

This study proved that injecting drug users have increased tendency towards crime and deadly sexually transmitted diseases such as HIV, Hepatitis B and Hepatitis C. The researcher hopes that this study will help future researchers for methodologically sound prospective comparative studies and to identify current trends in the respective area. We hope this study can generate awareness among the policymakers, police, social workers and NGOs for preparing adequate and appropriate strategies and programmes to control the uncontrollable nature of IDUs. Furthermore it points towards the fact social values are deplored by the ever increasing number of crimes and immoralities.

References

Health Action, December 2010.

ICMR (1992). Current dimensions and future implications ICMR Bulletin, vol. 22 (11 and 12), November-December.

Legal News and views (2011). Vol 125 (5), May 2011, Lodhi road, New Delhi.

Madan.G.K. (1996). Indian social problems. Allied Publishers Limited, Heredia, Bombay.

NACO (2006). National Behavioral Surveillance Survey. Conducted by National Aids Control Organization.

Naik. T. N. et al. (1991). Intravenous drug users - new risk group for HIV infection in India AIDS, vol. 5, No. 1.

OISCA (2013). Organization for Industrial Spiritual and Cultural Advancement Survey.

Purushothama . G.S (2003). Social problem in India. Himalaya Publishing House, Mumbai.

The code of criminal procedure (1973). Amended by the code of criminal procedure (amendment) Act, 2008 (5 to 2009). Universal law publishing Co.pvt Ltd (2009).

The Indian Journal of Social Work, vol 71(3), July 2010

The Week (2013), Health- July 14, 2013, p 13.

Table-1
Socio - demographic Characteristics

		N	%
Age (Years)	24-34	22	37
	35-44	19	32
	45-54	12	20
	55-64	7	11
Sex	Male	58	96
	Female	2	4
Marital Status	Married	42	70
	Single	18	30
Family Type	Nuclear	53	88
	Joint	7	12
Family Type	0-2000	2	38
	2001-4000	19	32
	4001-6000	12	20
	6001-8001	19	32
	Above 8001	8	13

Table-2
Details of drug use behavior

		N	%
Reason for Drug Abuse	Peer Pressure	27	45
	Accessibility	22	37
	Experimental Desire	11	18

Source of Drug	Shop	1	2
	Friends	34	56
	Mobile Venders	24	40
	Stealing	1	2
Spending Leisure Time	Club	2	4
	Theatre	20	33
	Park	3	5
	Town	26	43
	Home	9	15
Source of Needle and Syringe	Medical shops	6	10
	Project outlets	53	88
	Agents	1	2
Needle Sharing	Yes	40	68

Table-3
Details of Criminal Behaviour

		N	%
Imprisonment (Years)	Nil	19	32
	1-5	20	33
	6-10	14	23
	11-15	7	12
Acceptance by Society	No	52	87
Involvement in Crime	Yes	39	65
Preference Towards Drug Mafia	Yes	40	68
Sexual Orientation	Hetero	57	95
	Homo	3	5

Hand Book Of Disability Certification In Psychiatry

Author : Thomas John
Published in 2012
Page 56, Price 60

'Hand Book Of Disability Certification In Psychiatry' is the first of its kind as far as we know.

Certification is a social responsibility of Govt. doctors and Psychiatrists in Health Services have to attend Medical Boards in the institution as well as in outreach camps and in schools. Assessment of abilities and disabilities of persons with different mental illnesses always poses difficulties and problems especially in outreach camps and schools where large number of applicants are to be screened and assessed within a limited time. Often previous assessment reports or I Q test results are not available with the applicants. The handbook "Disability Certification in Psychiatry" written by Dr Thomas John is a New Year gift to Psychiatrists who have to attend Medical Boards.

Dr Thomas John Kuttichirayil who is the author of the book, retired in 2010 from Health Services. For many years he was the only Psychiatrist in Ernakulam District in health services department. This hand book is the result of his hard work and the strength of the book is his experiences as a Psychiatrist and a Paediatrician in Government Service. He has tried to solve many problems in certification in psychiatry and also was able to clear many doubts especially in case of L.D Certification

First Edition of the book was published in the year 2010. In the foreword Dr V Geetha, D M E had appreciated the spirit behind publishing such a book. In the foreword to second edition published in 2012 January Dr Mohan Isaac, visiting professor NIMHANS Bangalore and Professor of Psychiatry at the University of Western Australia (formerly HOD Department of Psychiatry NIMHANS Bangalore) has described it as a useful companion to all who has to certify the quantum of disability in mental health.

The book is very handy with 56 pages and include 6 chapters dealing with five topics such as Mental Retardation , Mental Illnesses, Autism, Multiple Disabilities and Learning Disorders. The questionnaire for rough estimation of mental age from 3 to 15 years is very useful in screening or crosschecking the IQ done elsewhere so that the certifying doctor is not misguided by reports from inexperienced or unqualified persons. The chapter on Autism includes 'CREPS' Scale developed by the author himself which is very useful and easy to administer. It is worth mentioning that this scale was presented in International Psychiatric Meeting held in Australia last year.

Special mention has to be made on the chapter on Learning Disorders .L D Certification in case of C B S E,I C S E and N I O S have definite protocols and guidelines, hence uniformity. But LD certification in state syllabus is always a menace. There is no uniformity in the state. Difficulties are many starting from [1] large number of students being referred to the department from schools without proper assessment and remedial measures from the school at the last moment.[2]shortage of staff- Clinical Psychologists and Psychiatrists.[3]Unqualified and inexperienced 'psychologists' running private clinics[4]Absence of registered Clinical

Psychologists even in well run and popular private institutions and so on.[5] Most important of all these is the lack of proper assessment tool to ensure uniformity. In this chapter Author has mentioned about these issues and the role of Special Educators. Actually teachers are the experts in this field and they are the key personnel for Grade Based L D Assessment. None of the Govt. institutions in health sector is equipped with special educators to assess the LD problem. Dr Thomas concludes this chapter by mentioning the ideal and practicable procedure for the LD Certification with the present available infrastructure and resources applicable to all states in India.

The specimens of updated Disability Certificate Format and L D Certificate Format (Kerala) are given in Appendices. Author has given the references including page number then and there in brackets. Hence it is easy for the reader to refer these points to know the details of these references. This handbook also contains scales like ADPMR and IDEAS, formulae for calculating percentage of disability in case of multiple disabilities and so on. There could not be two opinions regarding usefulness of this book.

The author admits in his preface that the aspiration and strength to write this book is gained from his valuable experience in Health Services only. Medical Officers in Health Services can be proud of this statement.

Dr. Diljit Bharatan and Dr. Aniamma George
Consultant Psychiatrists,

Attention IPSians of Kerala

We are trying to get our journal indexed. It requires a lot of formalities. Primary things are consistency, regularity and quality of the journal. We require a variety of articles. IPS Kerala has an array of eminent senior academicians, clinicians, researchers and young prodigies. Some of them are well known at national and international level. The main problem of our journal is scarcity of materials. If we all cooperate we can attain our ambition.

Dr Thomas John
Dr C J John
Dr Shahul Ameen