Homoeopathic Psychiatry E-Magazine

(Journal of Psychiatry in Homoeopathy)

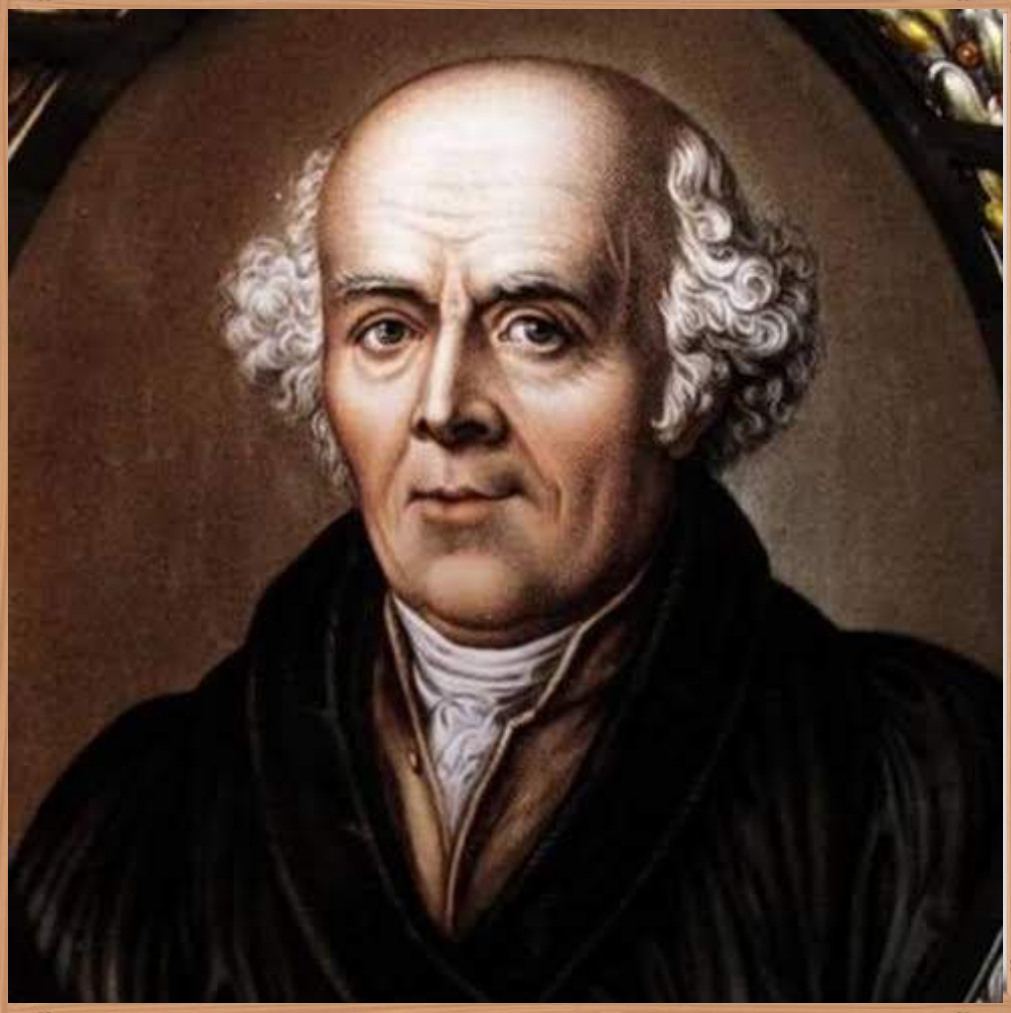
10-Oct-2023

"Mental Health is a Universal Human Right"

Homoeopathic Psychiatric Association

Annual Publication

Dr. Christian Friedrich Samuel Hahnemann



10 April 1755 - 2 July 1843

(Meissen, Germany) (Paris, France)

In homage to the visionary healer, Dr. Christian Friedrich Samuel Hahnemann, the pioneer of Homoeopathy and a compassionate psychiatrist. His tireless dedication to holistic healing and unwavering commitment to mental well-being continue to resonate through the ages. Let us walk in his footsteps, merging science and compassion to nurture a healthier world.

INTRODUCTION

Dear Readers,

This E-Magazine is a monumental project celebrating our one-year milestone, representing not only our achievements but also a valuable resource and possesses the ability to enlighten and inspire. The magazine serves as an invaluable tool for Homoeopathic Psychiatry students, providing a platform for sharing insights, experiences, and knowledge. For our students, it's a window to the practical world of psychiatry, where real-life cases and discussions come to life.

Our association, devoted to the field of Homoeopathic Psychiatry, stands as a testament to the unwavering commitment of our members, the dedication of our healthcare professionals, and our relentless pursuit of excellence in holistic mental healthcare. Over these years, we have grown in strength and vision, building a passionate community dedicated to mental health and the practice of homoeopathy.

Established in 2018 by a small group of dedicated individuals, our association embarked on a mission to challenge the stigma surrounding psychiatry and underscore its vital role in homoeopathic medicine. We recognized the significance of mental symptoms in holistic treatments and endeavored to raise awareness about the importance of Homoeopathic Psychiatry in our daily practice.

Homoeopathic Psychiatry, at its core, embodies the essence of holistic healthcare, understanding the intricate link between mental and emotional well-being and physical health. Our approach is deeply personalized, delving into the family lineage and even at the DNA level by considering the unique experiences, lifestyles, constitutions, temperaments, and diathesis through individualization. We firmly believe that true healing goes beyond symptom management, addressing the root causes of mental and emotional distress.

As we continue to expand and evolve, we are excited about the possibilities and the positive impact we can collectively make on mental healthcare in Kerala. We believe our association is not merely an organization; but a platform for learning, sharing, and nurturing by considering that mental health is an integral aspect of holistic well-being.

Our E-Magazine also aims to inspire students and faculties of Homoeopathy across India. It symbolizes what a dedicated group of individuals can achieve when committed to a noble cause. We want students and faculties throughout India to recognize the potential of holistic mental healthcare and appreciate the importance of addressing mental and emotional well-being in the practice of Homoeopathy.

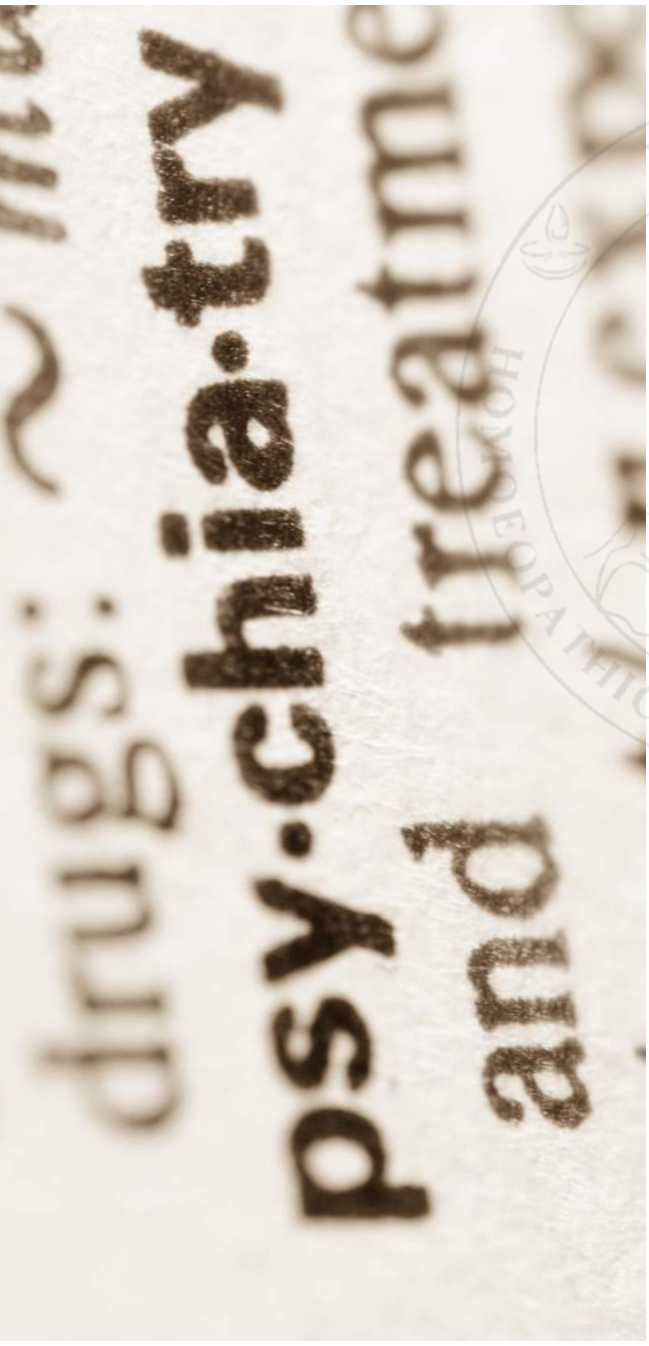
As we continue to expand our horizons, we hope this E-Magazine becomes a source of enlightenment, a catalyst for change, and a beacon of inspiration for all who trust in the power of holistic Homoeopathic healthcare. We invite you to join our journey, to learn, share, and grow together, making a difference in the world of Homoeopathic Psychiatry.

Our heartfelt gratitude to all the guiding lights and inspiring souls who have lent their wisdom and support, illuminating our path to craft this wonderful magazine. Your contributions have breathed life into our vision, making this journey a resounding success. Thank you for being a part of the Kerala Homoeopathic Psychiatric Association, where together, we can shape the future of holistic mental healthcare.

Warm regards,
Dr. Ramiz Ibrahim
Secretary

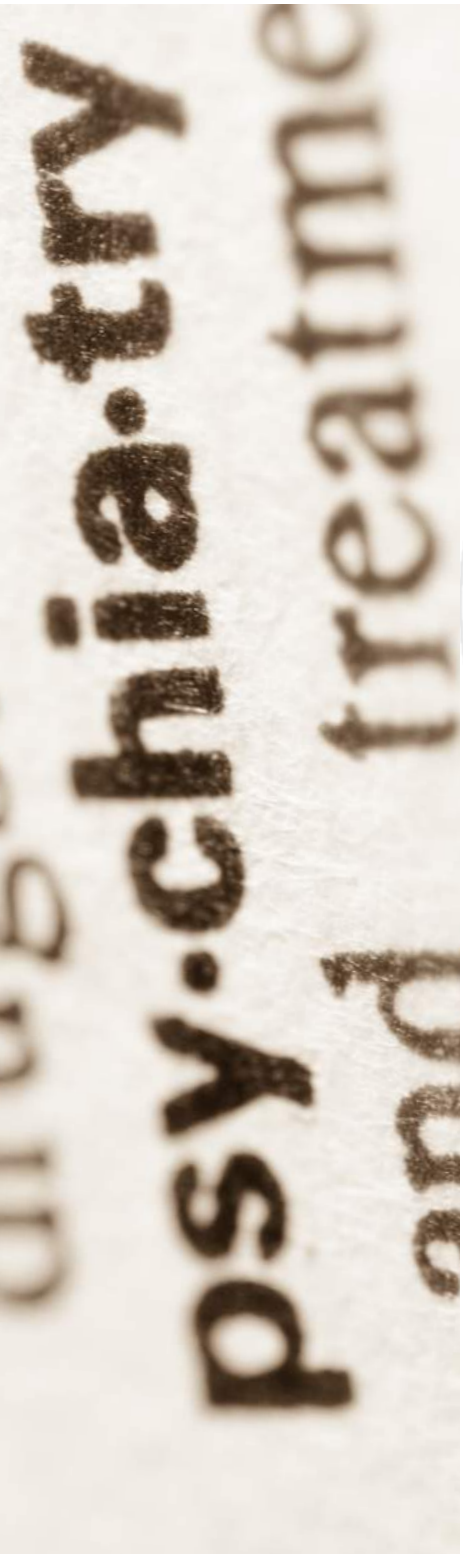
E- MAGAZINE

CONTENTS



E-MAGAZINE

CONTENTS



EDITORIAL BOARD

01 EDITOR'S NOTE

Dr A.S.Mridul
MD (HOM psy)
Chief Editor

On behalf of the Editorial Board it is with great pride and sincere privilege that I am writing this message to present Journal Of psychiatry In Homeopathy , the first online magazine of Homeopathic Psychiatric Association. Launching this new magazine would not have been possible without the great and much appreciated contributions from the members and other doctors who loves and live for the betterment of Homeopathy. Our team expects similar sort of sincere dedication from the writers in near future. The magazine wishes to serve as a National forum for showcasing and acknowledging the achievements and works of Homeopathic doctors in the field of Psychiatry. The emergence of a new magazine comes from a long process , hence all essential steps to make it a high caliber scientific publication were taken. We hope you will enjoy reading our first issue. We invite you to submit your best articles for publication. Thanking you all from the bottom of heart

02 EDITORS

Dr. Justina M Steefan

Dr. Freeda M Joseph

Dr. Sreeja K R

03 ADVISORS

Dr. Ramiz Ibrahim

Dr. Jithin M Ouseph

Dr. Rema Ramkumar

Message from the President

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Dear Readers,

It is my privilege to address you as the President of the Homoeopathic Psychiatric Association of Kerala. Our association is dedicated to advancing the field of homoeopathic psychiatry and promoting mental health in our community.

In the face of the challenges that the world has witnessed over the past few years, mental health has become a paramount concern. The COVID-19 pandemic has underscored the importance of holistic approaches to mental well-being, and homoeopathic psychiatry offers a unique perspective in this regard.

Through our collective efforts, we aim to raise awareness about the benefits of homoeopathic treatments in mental health, emphasizing the mind-body connection and the individualized approach that is at the heart of homoeopathy. We are committed to fostering collaboration among practitioners, researchers, and healthcare professionals to explore new horizons in this field.

In the pages of this magazine, you will find articles, case studies, and insights from experts in homoeopathic psychiatry. Our goal is to provide you with valuable information that can empower you to make informed decisions about your mental health or the health of your loved ones.

I invite you to join us on this journey of discovery and healing. Together, we can work towards a healthier and happier Kerala, where mental well-being is a priority for all.

With warm regards,
Dr K. P Thajuddin
President, Homoeopathic Psychiatric Association
Kerala

Message from Vice president

Dr Rema Ramkumar
BHMS MD Psychiatry
Cheif Consultant Remedy Homoeopathy Speciality Clinic, Senior Consultant at Psychiatry Speciality Clinic AIHMS Thrissur, Kochi.

Dear Members and Colleagues,

I am honored to address you as the Vice President of the Homoeopathic Psychiatric Association of Kerala. Our journey in the realm of homoeopathic psychiatry has been one of dedication, innovation, and unwavering commitment to holistic mental health.

As we gather here once again to share knowledge, insights, and experiences in the pages of our journal, let us reflect on the profound impact our field has on the well- being of individuals and communities. Homoeopathy, with its individualized approach, has the power to heal not just the symptoms but the very essence of a person's mental health.

In this ever-evolving landscape of psychiatry, let us continue to explore the synergies between traditional homoeopathy and modern psychiatric practices. Let us delve deeper into research, case studies, and clinical experiences to strengthen our understanding and refine our methodologies.

I encourage each member to contribute their expertise, ideas, and discoveries to enrich our periodical literature. Together, we can ensure that our association remains at the forefront of homoeopathic psychiatry, providing hope and healing to those in need.

Thank you for your unwavering support and dedication to our mission. Let this journal be a testament to our collective passion for promoting mental well-being through the principles of homoeopathy.

Warm regards,
Dr. Rema Ramkumar
Vice President
Homoeopathic Psychiatric Association Kerala

Message

Dr.K.C.Muraleedharan

Mental health is an essential component of health, and it is a well-accepted statement in the current medical scenario that there is no health without mental health. The importance of mental health is a renewed concept in modern medicine, but ever since it conception, Homoeopathy, as holistic science has been intensely and rigorously following Mind as a basis in the evolvement of disease conceptualization. Every mental rhythm in human beings either positive or negative gives Homoeopathic physicians, a clue for an in-depth assessment of individualization. The disease concept and homeopathy concepts really merge at one point in the mental features but certainly differentiate the core to be identified to make a homoeopathic prescription. This is still a vague area as considered in other physical diseases. Modern Homeopathic physicians have immense knowledge in medical science which can be a boon for blending the core in patients through shreds of evidence.

WHO has given immense importance to mental health as 13% of the population are disabled with any one of the mental conditions. Moreover, many physical diseases such as HIV, autoimmune diseases, endocrine disorders etc. are contributing to the escalation of mental disabilities. The specialty in Homoeopathy is not devoid of individualization and violation of other basic principles, rather it helps a homeopathic physician to deeply indulge in the sea of knowledge as suggested by our Master. Knowledge of the physician is not only important for treatment but it helps physicians to identify the situation and apply ethically appropriate responses.

There is a growing body of evidence for the usefulness, effectiveness, and efficacy of homoeopathy in some of the mental health disorders such as Schizophrenia, Depression, Substance Abuse, ADHD, Autism etc. and there are many ongoing studies in this vital area. Psychiatry in Homoeopathy is highly relevant in the arena of treatment as most of the modern medicine approaches are rigorous and adversely affect the patient's quality of life. Considering the various aspects, developing, and engaging the patients through Homeopathy medicines will be the new emerging area in coming years, considering the burden of the psychiatry disease.

In a nutshell, mental health is inseparable from any disease condition which is a postulated and reconfirmed hypothesis in Homoeopathy. We should be very proud of such scientific evidence created by our masters. It is our duty to enrich the mental symptoms in real disease conditions and psychiatry diagnoses through rigorously created evidence through research.

In the endeavor to create awareness among the Psychiatrists in Homeopathy, this e-magazine initiative will definitely help the profession at large and the stakeholders in particular. I appreciate the team for their hard work and dedication to bringing the first edition of this e-magazine to the profession.

With best wishes for all future endeavors of Homoeopathic Psychiatric Association!

Dr.K.C.Muraleedharan,
Asst.Director(H) &Officer Incharge,
National Homoeopathy Research Institute in Mental Health,
Kottayam, Kerala, India.

Message

Dr. Girish Navada U K.
MD (Hom).

Hearty Congratulations To 'Homoeopathic Psychiatric Association of Kerala' office bearers and the members.

I am all the more pleased because we have started a momentum to develop and publish academic works which is very essential for any practitioner of homoeopathy nevertheless homoeopathic psychiatrist in particularly as vast area of scope in clinical, academic and research activities, I am hopeful that this trend will continue flourish and comes out in volumes of works in future. We the teams of homoeopathic psychiatrist work together to achieve great heights wish and congratulate the team of psychiatry to bring out this product.

Dr. Girish Navada U K
Professor & HOD
Department Of Psychiatry
Father Muller Homoeopathic Medical College & Hospital
Mangaluru

Message

Dr. K. S. Lalithaa

My sincerest felicitations to the distinguished members of the Homoeopathic Psychiatric Association for their auspicious undertaking: the presentation of the seminar titled "Exploring the Frontiers in Homoeopathic Psychiatry," in commemoration of World Mental Health Day. Your resolute commitment to the realms of holistic mental health solutions is nothing short of commendable. The forthcoming E-Magazine promises to be a veritable treasure trove, offering enlightenment and enrichment to a discerning readership. Your tireless efforts in the advancement of homoeopathic psychiatry represent a beacon of excellence in the field, and for this, we are profoundly grateful. Please accept my warmest appreciation for your unwavering dedication to the cause of mental well-being.

Dr. K. S. Lalithaa
Prof&Head
Department of Psychiatry
Vinayaka Missions Homoeopathic Medical college and Hospital
Seeragapadi
Salem
Tamilnadu

Message

Dr. Manilal .S.
MD (Hom). MBA.

Dear Esteemed Members of the Homoeopathic Psychiatric Association of Kerala,

I extend my warmest greetings to each one of you as we embark on a remarkable journey of knowledge dissemination. In today's fast-paced world, effective communication stands as the cornerstone of success in any endeavor. It is the bridge that connects ideas, initiatives, and individuals, allowing us to progress, learn, and achieve our shared goals.

I am delighted to share my profound appreciation for the Association's pioneering effort in launching its very first E-Magazine. This momentous step signifies the Association's commitment to innovation and its dedication to promoting excellence in the field of psychiatry, all while embracing the digital age.

On behalf of our institution, I extend my heartfelt best wishes to the Homoeopathic Psychiatric Association of Kerala for this pioneering initiative. May the E-Journal be a platform that ignites intellectual curiosity, encourages dialogue, and leads to groundbreaking discoveries in the realm of psychiatry.

Once again, congratulations to the Homoeopathic Psychiatric Association of Kerala on the launch of this E-Magazine, and may it flourish as a beacon of knowledge and innovation in the years to come.

With Best Wishes
Dr. Manilal S
Director
MNR Homoeopathic Medical College and Hospital,
Sangareddy, Telangana

Message

Dr Mansoor Ali KR MD (Hom)

Excited to see that an e-magazine is published by Homoeopath Psychiatry Association of Kerala that aims to provide knowledge, ideas and research findings between Homoeopathic psychiatrists and Homoeopathic professionals across the globe. I wish all success to this esteemed e- magazine.

Dr Mansoor Ali KR
Professor, HOD, Department of Repertory
Govt Homoeopathy Medical College
Calicut . 673010

Message

Dr.Maha Bhushan Singh
MD (Psy) PGDGC,MSc Clinical Psy.

Your magazine will undoubtedly excel, allowing us to exchange our medical insights, particularly in the realm of homeopathic psychiatry for mental illness treatment and maintenance. This endeavor promises to elevate homeopathic psychiatry to new heights, and I trust it will extend its reach beyond Kerala to become a nationwide treasure. Sharing experiences through this publication will foster collective learning, minimize errors, and offer daily opportunities for growth. Most importantly, it will unite us in promoting homeopathy as a primary medical approach. Thank you for the invitation.

Dr.Maha Bhushan Singh
MD (Psy) PGDGC,MSc Clinical Psy.
Assistant Professor RKDF University Bhopal Consulting
Psychiatrist Prayas Psychiatric Hospital and
Rehabilitation Centre Bhopal.
President
Indian Homeopathic Psychiatric Society

Our First In-person Meet Up

Our Second In-person Meet Up

Homoeopathic Psychiatric Association of Kerala

Annual Report

As we turn the pages of time and reflect on the remarkable years that have passed, it is with immense pleasure, in my capacity as the secretary, that I present the Annual Report of our Homeopathic Psychiatric Association. Within these pages, you will find a record of our collective journey, achievements, and aspirations spanning the past years. This report stands as a testament to the unwavering commitment of our members and the unwavering dedication of our healthcare professionals in the realm of homeopathic psychiatry. As we delve into the following pages, I extend a warm invitation for you to join us in celebrating the significant milestones, successes, and innovative strides that have defined our association in our continuous pursuit of holistic mental healthcare.

We've been gathering online since 2018 with the shared goal of establishing an association dedicated to homeopathic psychiatry. Recognizing the significant role of mental symptoms in homeopathic treatments, our journey began with a virtual connection. However, challenges, such as the covid-19 pandemic and flooding in Kerala, prevented us from meeting in person. During this period, our online meetings helped us not only to grow our association but also to support those who were affected.

Despite these obstacles, we maintained our connection through online discussions, fostering our commitment to our cause. Finally, we decided to convene an offline meeting to strengthen our association further.

On October 16, 2023, we marked a significant milestone as we convened our first in-person meeting at Shalimar Regency. During this gathering, we made crucial decisions and set the course for the future of our association. During this meeting, we decided to name our association 'Kerala Homoeopathic Psychiatric Association,' but due to legal constraints, we officially registered it as

'Homoeopathic Psychiatric Association'

We established the objectives and bylaws of our association and subsequently registered it under the Society Registration Act XXI(1860) as KKD/CA/192/2023 in Kozhikode for formal registration.

Additionally, we discussed designing a logo, which we currently use as our official logo.

During the meeting, we also formed a core committee and an executive committee from among the members in attendance to oversee the functioning of the association. They are as follows:

Core Members

Ψ President	: Dr. Thajuddin K P
Ψ Vice President	: Dr. Rema Ramkumar
Ψ Secretary	: Dr. Ramiz Ibrahim
Ψ Joint Secretary	: Dr. Jithin M Ouseph
Ψ Treasurer	: Dr. Tinu Mathews

Executive Members

: Dr.Mridul A S

: Dr.Hasan Jawahar K : Dr.Sreeja K R

: Dr.Neethu Raj

: Dr.Saja P

: Dr.Freeda M Joseph

Our association presently comprises 24 regular members from various districts of Kerala.

To become a Life member or Regular member, an individual is required to complete their postgraduate degree in psychiatry following the completion of BHMS and should preferably be enrolled in the Travancore Cochin Medical Council (TCMC).

Regular Members

1.Dr. Thajuddin K P
2.Dr. Sreeja K R
3.Dr. Deepak Thilak
4.Dr. Tinu Mathews
5.Dr. Anu Upendranath
6.Dr. Mridul A S
7.Dr. Rema Ramkumar
8.Dr. Diana R
9.Dr. Manu Manjith S
10.Dr. Hasan Jawahar K
11.Dr. Arjun B Raj
12.Dr. Radhika P
13.Dr Jithin M Ouseph
14.Dr. Ramiz Ibrahim
15.Dr. Deena Davis C
16.Dr. Akhila A L
17.Dr. Neethu Raj
18.Dr. Justina M Steefan
19.Dr. Saja P
20.Dr. Jaseel AhammedN P
21.Dr. Freeda M Joseph
22.Dr. Deepak K P
23.Dr. Chandini
24.Dr. Muhamed Gasal

To qualify as a student member, one must enroll in a homoeopathic psychiatry degree program at any college after successfully completing BHMS. Only few students have been registered so far.

Student Members

: Dr. Ayisha E K

: Dr. Shifa K

: Dr. K Madhavi Priyanka

: Dr. Liza K.B

: Dr. Anna Alex

: Dr. S Sudheer Kumar

: Dr. Arya B Prasad

: Dr. Aswathy B.A

: Dr. Fasila Aliyar

: Dr. Keerthy P V

: Dr. Ameena S

: Dr. Revathi Ravikumar

: Dr. Sakthi Silvan

: Dr. Rajikrishna R C

: Dr. Rehna Rahim

We've also made the decision to welcome other Homoeopathic doctors, postgraduate students, practitioners of other systems of medicine, and all medical graduates as **associate members** of our association.

To date, we have conducted 10 online meetings and one offline meeting on May 14th at Dr. Hassan's Apollo Seabreeze in Calicut.

Each meeting includes a psychiatric clinical case discussion session where an associate member presents a case. At the end of the presentation, other associate members engages in discussions. We welcome everyone's experiences and insights during these sessions.

Here are the topics our association members have discussed so far.

Sl. No	Name of the Associate	Date of meeting	Topic Presented for the clinical discussion
1	Dr. Neethu Raj	10/11/2022	Alcohol addiction
2	Dr. Saja P	10/12/2022	Adjustment disorder
3	Dr. Freeda M Joseph	10/01/2023	Phobic anxiety disorder
4	Dr. Justina M Steefan	10/03/2023	Learning disorder
5	Dr. Anu Upendranath	10/07/2023	Chronic fatigue syndrome & fibromyalgia
6	Dr. Akhila A L	10/08/2023	Delusional disorder
7	Dr. Deepak K P	10/09/2023	Psychosis in Mania

Throughout our journey as an association, we've engaged in a wide array of important discussions. These conversations have spanned various vital topics, including the exploration of significant signs, symptoms, and psychiatric medications. The collaborative exchange of knowledge has been a cornerstone of our association, offering members the invaluable opportunity to learn and
develop from one another's experiences.

Being part of this association brings forth a unique benefit - the chance to gain insights and wisdom from our esteemed senior doctors. These individuals bring a wealth of experience to the table, serving as mentors and guides in our professional growth. Notably, our clinical case discussions have emerged as a pivotal avenue for this knowledge sharing.

These discussions offer us real-world context for our learning, enabling us to dissect and analyze cases encountered in our everyday practices. They provide us with a deeper comprehension of the nuances of psychiatric medicine, allowing us to refine our diagnostic skills and treatment approaches. The practical insights shared during these sessions have played a pivotal role in enhancing our ability to deliver effective care to our patients.

Works Done

1.We prepared objectives and bylaws, had them signed by core and consecutive members, updated them, and successfully registered them in the month of March 2023.

2.We're in the process of opening a bank account, and it's taking a little longer because our members are located in different areas of Kerala. Now that all the paperwork is completed, we expect the account to be ready by the end of September.

3.After updating the bank account, we will begin collecting membership funds. The fees are as follows: Rs. 5000 for life membership, Rs. 1000 for associate members, and Rs. 500 for student members.

4.As an association, we have organized approximately 9 clinical meetings led by different members, especially those who have recently graduated. Our senior core members have contributed significantly to these discussions, sharing valuable clinical experiences that have proven to be quite beneficial. These meetings have also provided a platform for addressing and recovering minor errors in case presentations.

5.We also delved into discussions about numerous homeopathic medicines that possess very distinct mental characteristics, which were new and enlightening for our newly joined members. This information about medicines has the potential to guide us in addressing several important clinical conditions.

6.We also discussed plans to introduce a postgraduate (PG) course in homoeopathic psychiatry at government homoeopathic medical colleges

in Kerala. We've already submitted letters, and we've received positive responses from the Kerala government regarding the establishment of an outpatient department (OPD). However, there are still a few more steps to be taken to make this course a reality.

7.We've also explored different job opportunities for homeopathic psychiatry doctors in both state government and national AYUSH missions. Soon, we'll have the eligibility to place our associates in these positions. Otherwise, there's a risk that the government might fill these roles with individuals holding different degrees or even consider
eliminating those posts.

8.We've designed several medical day posters to raise awareness among the public. These efforts not only contribute to public education but also help in promoting our association.

9.Our second in-person meeting took place in Calicut on May 14, 2023, at Dr. Hassan's Apollo Seabreeze apartment. During this meeting, we discussed various association agendas. Unfortunately, only a few doctors were able to attend the meeting.

10.We have initiated a project to thoroughly study the psychiatry syllabus from both the Karnataka State Board and the Tamil Nadu State Board of Homoeopathy to compile this information along side the syllabus of Kerala University of Health Sciences (KUHS). By doing so, we aim to provide a convenient resource for postgraduate students in Homoeopathic Psychiatry from other states to access the Kerala syllabus more easily.

11.To celebrate our one-year milestone, we're creating an online magazine. We've asked all our associate doctors to write at least one article. We've also invited experts in homeopathy and homeopathic psychiatry to share their insights and convey an inaugural message.

12.We've invited our associate doctors to contribute by designing a cover page for our magazine and suggesting a name for it. We want to express our appreciation for their efforts in a special way, either through motivating words or by rewarding them based on the quality and creativity of their submissions. The core committee will decide the rewards accordingly.

13.Additionally, we've reached out to homeopathic businesses and clinics to advertise in our magazine. This magazine will be a great way to celebrate our achievements and share useful information with our community.

14.We've also decided to create a social media platform for promoting our association, sharing advertisements, and updating posters.

15.Since conducting an in-person meeting in October is challenging, we've decided to organize an online webinar. We're considering inviting a renowned homoeopath or even a homoeopathic psychiatrist to lead the session. Additionally, we plan to use this webinar as an opportunity to inaugurate our online magazine. We'll be extending invitations to other homoeopaths and homoeopathic students to join us for this event.

Pending Works

1. We have a plan in progress to update a case proforma that includes consent and is associated with our organization, but it hasn't been finalized yet.

2. We're on the edge of creating a website also, but the high cost and our current inability to open a bank account have led to a delay in this project. Our foundational work for the website is completed, but we still need to update the data and consultant details.

3. We've also had intentions to conduct fundamental psychology sessions for our associates. However, these sessions are still pending due to limited time schedules.

4. Another important ongoing initiative is our effort to engage in discussions with allopathic authorities in charge of the mental hospitals in both Calicut and Trivandrum. Our goal is to explore the possibility of collaborating and securing medical officers to establish a psychiatric outpatient (OPD) & inpatient (IPD) department.

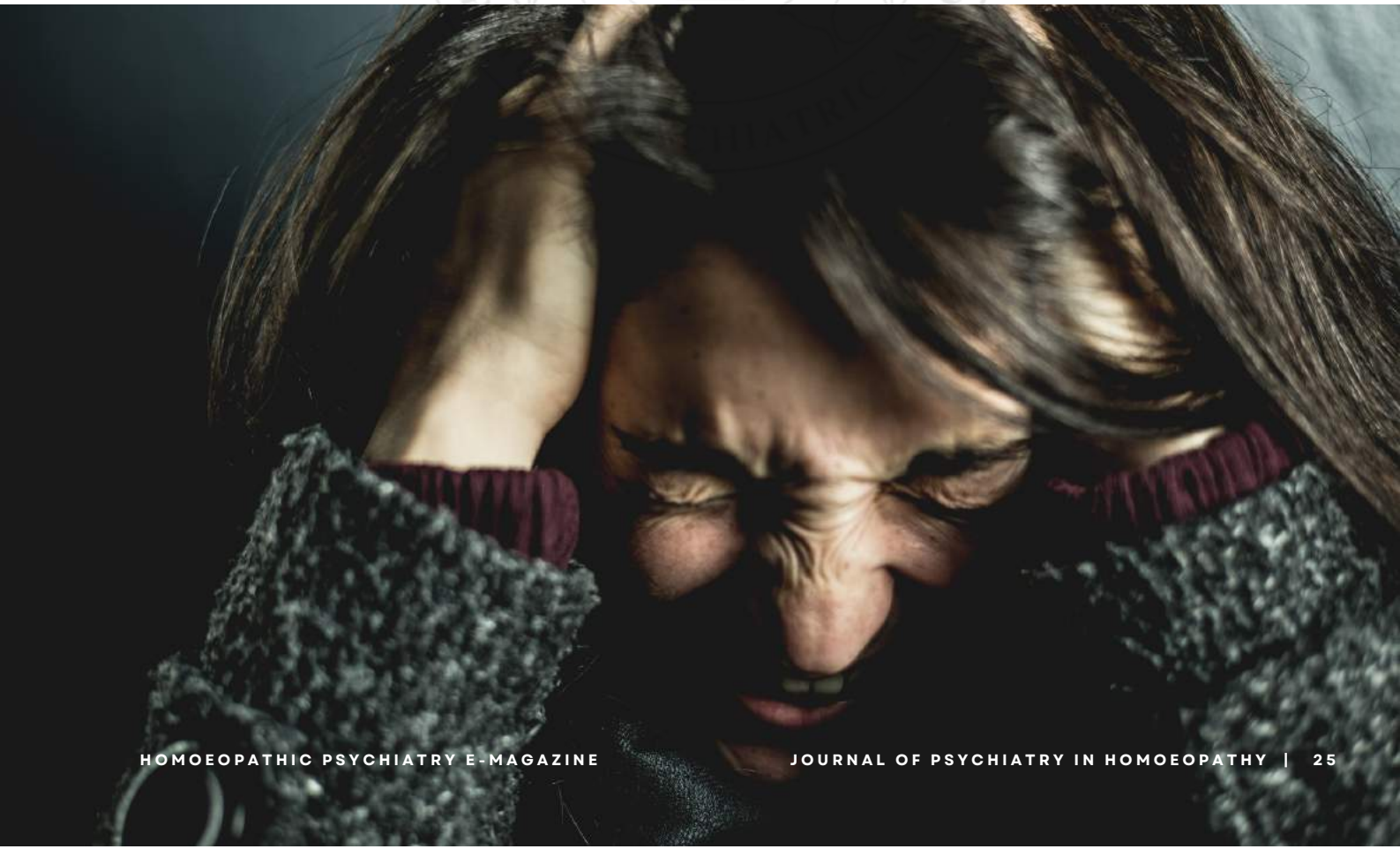
5. Another task on our to-do list is to schedule a meeting with the Health Secretary to introduce our association and discuss the importance of specific postings under various health projects in Kerala.

Report by:
Dr. Ramiz Ibrahim
Secretary
Homoeopathic Psychiatric Association, Kerala.

HOLISTIC APPROACH IN TREATING ANXIETY NEUROSIS: A HOMEOPATHIC PERSPECTIVE

Abstract:

This study delves into the effectiveness of homeopathic medicine, particularly centesimal potency, coupled with psychotherapy, in the treatment of anxiety neurosis. The research encompassed 30 randomly selected cases, revealing substantial improvements in 60% of the population. Notably, 18 cases displayed significant improvement, while 5 cases experienced complete remission following 6-10 months of treatment and subsequent follow-up. These findings advocate for the integration of homeopathy and psychotherapy in managing anxiety neurosis, showcasing the potential for enhanced clinical outcomes and overall well-being.



ANXIETY NEUROSIS

Anxiety neurosis is a prevalent mental health disorder affecting a significant portion of the global population. Its multifaceted nature necessitates a comprehensive therapeutic approach. This study investigates the efficacy of homeopathic treatment, specifically centesimal potency, synergized with psychotherapy, in addressing anxiety neurosis.

An estimated 4.05% of the global population has an anxiety disorder, translating to 301 million people. The number of persons affected has increased by more than 55% from 1990 to 2019.

Methodology:

Sample Selection: 30 cases of anxiety neurosis were randomly selected.

Treatment Protocol: Homeopathic medicine in centesimal potency was administered alongside psychotherapy sessions for 6-10 months.

Follow-Up: Regular follow-ups were conducted to assess progress and modify the treatment plan as necessary.

Results:

Out of the 30 cases studied, 18 cases (60%) displayed significant improvement in their clinical symptoms and general health status. Furthermore, 5 cases (16.67%) were completely cured of their anxiety neurosis following the prescribed treatment and subsequent follow-up.

Discussion:

The positive outcomes observed in this study underscore the potential of integrating homeopathic medicine, particularly centesimal potency, with psychotherapy in the treatment of anxiety neurosis. Homeopathy, known for its holistic approach, addresses the underlying causes of the disorder, aiming for a more profound and lasting impact.

The study's key findings are as follows:

1. Anxiety neurosis is more prevalent in males (60%) than in females (40%).

2. Majority of cases (43.4%) fall within the age group of 25-35 years, with 30% between 35-45 years, 20% between 15-25 years, and 6.6% above 45 years.

3. Palpitation was the main complaint in all cases, with various intensities. Nervousness and easy fatigability were significant manifestations in 30% of cases.

4. Patients had the illness for varying durations, with 46.6% experiencing it between 16-24 months and 23.4% for over 4 years. 5. Treatment durations varied, with 66.7% requiring treatment for 6-8 months and 33.3% up to 10 months.

6. Psoric miasms dominated in 56.6% of cases, followed by psora-syphillitic in 40%.

7. Arg Nit. was frequently indicated (16%), along with other remedies in specific cases.

8. Various potencies were prescribed, ranging from 30th to CM, depending on the case.

9. Significant improvement was observed in 60% of cases, full cure in 16.67%, and slight improvement in 6.66%. 16. All patients were introverted, with varying levels of neuroticism and anxiety.

Conclusion:

The findings from this study accentuate the efficacy of homeopathic treatment, utilizing centesimal potency in conjunction with psychotherapy, as a promising avenue for managing anxiety neurosis. The notable improvement observed in 60% of the cases and the complete remission in 16.67% indicate the potential for enhanced clinical outcomes and improved overall well-being. This integrated approach advocates for a more comprehensive and individualized therapeutic strategy in the treatment of anxiety neurosis

Dr K. P Thajuddin

BHMS, MD (Psychiatry),

PG Dip in Child, Adolescent & Family Counseling

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AN INTEGRATIVE REVIEW ON THE UNDERSTANDING AND MANAGEMENT OF PREMENSTRUAL SYNDROME IN HOMOEOPATHIC PERSPECTIVE

ABSTRACT

Background:
Premenstrual syndrome (PMS) is a common disorder in women of reproductive age causing significant distress in social activities and quality of life.

Objective: To compile existing evidences and available literature to determine whether there is possibility for future research to make evidence in the role of homoeopathic medicines in the management of PMS.

Methods: Author has done an integrative review to understand the condition through both experimental and non-experimental studies. Articles published on the topic of PMS in English from any time are included. Electronic databases such as Google scholar, PubMed, Wiley online library etc. are used for the extensive search. Diagnostic criteria as per DSM –V are narrated in tabular form. Rubrics from repertories and medicines with therapeutics are also included.

Result:
Total of 6 articles was found. 2 among them are Randomized controlled trials. Remedies indicated are Folliculinum, Lachesis, Lac caninum Melisa offcinalis etc.

Conclusion:
Though there is scarcity in published articles, the existing literature shows there is amble scope for future research in the management of PMS with homoeopathic medicines.

KEY WORDS:
Premenstrual syndrome (PMS), Premenstrual Dysphoric Disorder (PMDD), Homoeopathy, Complementary and Alternative medicine(CAM)

Introduction

Premenstrual syndrome (PMS) is a common disorder in women of reproductive age and is characterized by at least one physical, emotional, or behavioural symptom, which appears in the luteal phase of the menstrual cycle and resolves shortly after the onset of menses.[1] The spectrum of symptoms is wide and the most common are breast tenderness, bloating, headache, mood swings, depression, anxiety, anger, and irritability. They must interfere with daily personal and occupational life during two menstrual cycles of prospective recording.[2]

The most severe form of PMS, defined as premenstrual dysphoric disorder (PMDD) is a somato-psychic illness triggered by changing levels of sex steroids that accompany an ovulatory menstrual cycle.[3] These are common disorders of menstrual cycle and Symptoms may appear anytime between menarche and menopause. Premenstrual disorders cause significant distress or interfere with work, school or usual social activities and lower quality of life. [4]

The reported prevalence estimates of PMS in India have ranged from 14.3% to 74.4% and PMDD between 3.7% to 65.7%.[5,6,7,8] Although the peak age of receiving a clinical diagnosis is in the 30s[9],recently revealed that 70% of individuals with PMDs had symptom onset in adolescence, suggesting that early life factors may contribute importantly to etiology.[10]Cohort study by Lu D et al suggest that childhood adiposity is associated with higher risk of PMDs and higher burden of premenstrual symptoms in young adulthood. [11]

The increased prevalence of PMS or PMDD was associated with the consumption of tea, coffee, sweet or sweetened beverages, junk food and food intake under stress. Positive correlation with the lack of physical activity or leading a sedentary lifestyle was also found in studies. [8, 12.13, 14] Literature says there is association between adverse childhood experiences and PMD.[15]

PMDD was included as a new diagnostic category of depressive disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [16, 17] and recently (2019) coded as a gynaecological diagnosis in the World Health Organization's International Classification of Diseases (ICD-11). The diagnostic criteria for PMS and PMDD are given in table no 1 & 2 respectively.

Alterations in the levels of sex steroids, especially progesterone by altering the chemistry of central nervous system after crossing the blood brain barrier is one of the factor responsible for PMDD. Amygdala, hippocampus, hypothalamus and frontal cortex have wide distribution of progesterone receptors.[18]

Personality traits and negative attitudes toward menstruation cause dysfunctional coping and maladaptation to physiological menstrual cycle changes, thus determining distress and functional impairment.[19]

Women with severe PMDD/PMS are at higher risk of developing postpartum depression, suicidal disposition, bipolar disorders, substance abuse and eating disorders.

Table 1: Diagnostic criteria for PMS [3]

Affective symptoms	Somatic symptoms
Depression	Tenderness of breast
Irritability	Abdominal bloating
Anxiety	Headache
Confusion	Swelling of extremities
Social withdrawal	

Table 2: Diagnostic criteria for PMDD [3]

In the majority of menstrual cycles at least 5 symptoms must be present in the final week before the onset of menses and become minimal or absent in the week after menses.	
One among the following	Marked affective lability
	Marked irritability, anger, interpersonal conflicts
	Marked depressed mood, hopelessness, self-deprecating thoughts
	Marked anxiety, tension, feeling of being keyed up on edge
One of the following additionally	Decreased interest in usual activities
	Subjective difficulty in concentration
	Lethargy, easy fatigability, marked lack of energy
	Change in appetite, overeating, specific food craving
	Hypersomnia or insomnia
	Sense of being overwhelmed or out of control
	Physical symptoms of breast tenderness, muscle and joint pain, bloated sensation, and weight gain
Symptoms are associated with clinically significant distress or interference with work, relationship with others, decreased productivity, and efficiency	
Disturbance is not merely an exacerbation of the symptoms of another disorder	
1st criterion should be confirmed by a prospective daily rating during at least two menstrual cycles	
Symptoms not attributable to the physiological effects of a substance	

The Menstrual Distress Questionnaire (MEDI-Q) is a new tool originally developed in Italian that comprehensively evaluates menstrual-related distress. It is a valid and reliable instrument for the assessment of menstrual distress and its impact on psychological well-being. This tool can be utilized in research and clinical settings to comprehensively investigate the impact of menstruation on various populations, identify and monitor menstruation-related disorders promptly and effectively, and to evaluate the effectiveness of targeted treatments for menstrual distress. [20] The first-line treatment for PMDD consists of selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine, paroxetine, sertraline. [21]

Combined hormonal contraception (CHC) is another alternative to treatment. It works by the blockade of an ovulatory surge of sex steroids since premenstrual symptoms are not observed during anovulatory cycles. [22] CHC may lead to side effects, such as deterioration of mood, especially in vulnerable women who are with a previous diagnosis of mood, anxiety, or eating disorders. [23] Mild to moderate PMS could benefit from relaxation techniques and psych education, while severe PMS and PMDD required Cognitive behaviour therapy. [24] Complementary and alternative medical therapies (CAM) are sometimes preferred by women for alleviating of menstrual associated pains. Curcumin supplementation in women with PMS and dysmenorrhea led to a significant improvement. [25]Herbal extracts, Vitamin D, minerals like Calcium and Zinc, dietary supplements rich in Omega 3 fatty acids are shown some benefits though literature shows notable limitations with CAM. [26]

METHODS

Search has been done in electronic databases such as Google scholar, Pub med, Wiley on line library to get the available literature, control trials, Systematic reviews and Case studies related to Premenstrual syndrome and homoeopathy. The search has been limited to English language and all time publications up to August 2023. Published dissertations were excluded. Collected rubrics related to premenstrual syndrome from different repertories and compiled. Homoeopathic medicines with indications after referring different materia medica books are also included.

RESULT:

6 published articles were found. Among this 2 are RCTs, 1 open label study, 1 case series, 1 feasibility study and 1 pilot study. These are discussed under discussion section. Rubrics related to PMS are obtained from Synthesis repertory, Murphy's repertory and Boger Boenninghausen's repertory.

DISCUSSION

Homoeopathy has shown its role in different gynaecological conditions like polycystic ovarian syndrome [27, 28, 29], infertility [30] Dysmenorrhoea [31, 32] etc. There shows evidence for the curative power of homoeopathy in different psychiatric illnesses related to gynaecological conditions like menopausal depression, [33] Postpartum depression [34] etc. Whether in adolescence, where the hormonal cycle is still irregular, leading to equally irregular cycles, or in the climacteric, where the decrease in hormone secretion also generates irregularities, conditions such as anovulation, dysmenorrhea, water retention, and the premenstrual tension syndrome are commonly present, apart from the possibility of hormone replacement and stimulation of physical activity, less can be done with conventional therapy. However, such conditions find important applicability in homeopathy, in accordance with the adequate individualization of the symptoms. [35] Swanandh sukla etal in a randomised control trial found Homoeopathic medicine Melisa officinalis to be more effective in the management of PMS than homoeopathic similimum. [36] But materia medica couldn't detect any special relation for this remedy with PMS. Only in Lotus Materia medica by Robin murphy, this remedy is narrated in detail and that too says only about insomnia, depression and tension headache and no relation mentioned with menses.[37] A double blind randomized controlled trial by Yakir M et al showed individualised homoeopathic medicines are more effective in alleviating the symptoms of PMS in comparison to placebo.[38]

A care series by Danno K et al showed Folliculinum as the most prescribed homoeopathic medicine followed by Lachesis . most common PMS noticed were irritability, aggression and tension, mastodynia, weight gain and abdominal bloating. 21 women among 23 cases reported improvement in their quality of life(QoL).[39] A feasibility study by Klein-Laansma etal showed it is feasible to use a semi-standardised protocol for individualised homeopathic prescribing in PMS, in daily practice.[40]An open study of 32 patients used Folliculinum 9C as the first prescription and the duration of treatment was 2-4 months. 88% of patient showed satisfactory response to treatment. [41] In 2019, Yakir et al. published the results of a 'gold standard' (placebo-controlled double-blind randomised) clinical trial on the effectiveness of homeopathy for women suffering from premenstrual syndrome. This study, conducted in Israel, confirmed the positive findings of a smaller pilot study by the same research team: both studies showed beneficial effects of individualised homeopathic treatment in terms of symptom relief, a reduction in days taken as sick leave and decreased use of conventional medication.[42] A pilot study done at Department of Complementary Medicine, University of Exeter shows there is scope for conducting a randomised, placebo-controlled, double-blind trial to investigate the value of hypericum as a treatment for premenstrual syndrome.[43]

Reportorial aspect

Synthesis repertory [44]

1. Mind- menses before
2. Mind -irritability- menses before
3. Mind -anger menses before
4. Mind -sadness menses before
5. Mind- company aversion menses during
6. Mind- laziness menses before
7. Mind -confusion of mind menses before
8. Mind -despair menses before
9. Mind -anxiety menses before
10. Mind -sentimental menses before
11. Mind- suicidal disposition menses before
12. Mind -weary of life menses before
13. Mind -weeping menses before
14. Mind- indifference menses before
15. Mind -kill desire to menses before
16. Mind -morose menses before
17. Mind -mood changeable menses before
18. Generals -food and drinks sweets desire menses before
19. Sleep -sleepiness menses before <
20. Stomach -appetite ravenous menses before
21. Abdomen -distension menses before
22. Head -pain menses before<

Murphy [45]

- Female premenstrual syndrome
- Female premenstrual syndrome- before and after <
- Female premenstrual syndrome- breast <

Boger Boenninghausen's repertory [46]

- Conditions of aggravation and amelioration in general -menses at start of
- Conditions of aggravation and amelioration in general -menses better during

Therapeutics

Folliculinum, Lac can, Lach., Bov., Calc., Calc P., Cupr., Sep., Nat m, Nux vom are some of the homoeopathic remedies mentioned for premenstrual syndrome. [43] Indications of different remedies are given in Table no. 3

Table No- 3. Homoeopathic medicines with indication in PMS [47, 48, 49]

No	Medicine	Indication
1.	Folliculinum	Abnormalities at the time of ovulation and the days before menstruation especially of a premenstrual dysphoric syndrome or menstrual disorders in general, despite the modality that the start of the period causes improvement. Gets lost in devotion. Pressure of a personality or a group on an individual; a dominant or possessive parent, friend or marriage partner; and certainly where there is intolerant religious dominance. Irritability before menses.
2	Lac Caninum	Too early, profuse menses. Flow in gushes. Breasts swollen, painful before and better on appearance of menses. Despondent with visions of snakes
3	**Calc carb**	Head ache before menses. Too early menses, too profuse with vertigo and tooth ache. Hot swelling breasts tender before menses. Fears loss of reason, misfortune.
4	Phytolacca	Irritable breasts before and during menses. Ovarian neuralgia of right side. Mammae hard and very sensitive. Better from warmth
5	Bovista	Diarrhoea before and during menses. Menses too early and profuse. Flow < night. Cannot bear tight clothing around waist. Traces of menses between menstruation. Awkwardness. Everything falls from hands. Enlarged sensation
6.	Conium mac	Breast enlarge and painful before and during menses. Rash before menses. Ill effects of suppressed sexual desire or suppressed menses or excessive indulgence. Weak memory and unable to sustain any mental effort.
7.	Lachesis	Menses too short and feeble. All pains relieved by the flow. Acts especially well at the beginning and close of menstruation. Great loquacity. Mental labour best performed at night. Religious insanity with derangement of the time sense.
8.	Luna	Mood changeable before menses. Strings of dark blood. Menses returns two days after ceasing.
9.	Nux vomica	Anxiety before menses. Menses always irregular. Pain in the sacrum with dysmenorrhoea. Constant urging to stool.

10.	Natrum mur	Menses irregular. Suppressed menses. Hot burning menses. Irritable and gets into a passion about trifles. Consolation aggravates. Awkward and hasty. Tears with laughter. Wants to be alone to cry.
11.	Sepia	Indifference to those loved best. Irritable and want to be alone. Anger before menses. Bearing down sensation as if everything would escape through vulva. Must cross limbs to prevent. Too late and scanty menses with sharp cutting pains.
12.	Chamomilla	Mood changeable before menses. Profuse discharge of clotted, dark blood, with labour like pains. Impatient, snappish with whining restlessness. Mental calmness contraindicates.
13.	Pulsatilla	Suppressed menses from wet feet. Changeable and intermittent flow. Weeps easily. Timid and irresolute. Morbid dread of opposite sex. Mentally an April day.
14.	Sulphur	Sweet desire before menses. Sleepiness more before menses. Anxiety before menses. Too late and scanty menses. Acrid flow making parts sore.
15.	Cuprum met	Cramps extending to chest, before, during or after suppression of menses

CONCLUSION

Though there is limited number of published articles in the role of homoeopathy in management of premenstrual syndrome, the available literature shows there is amble scope for future research in the management of PMS with homoeopathic medicines with different study designs and large samples.

CONFLICT OF INTEREST

The author has no conflicts of interest to declare

ETHICAL CONSIDERATION

As this review is an analysis of data already collected, ethical approval is not acquired.

REFERENCES

1.Yonkers KA, O'Brien PM, Eriksson E: Premenstrual syndrome. Lancet. 2008; 371(9619): 1200–10. 10.1016/S0140-6736(08)60527-9

2. Guidelines for Women's Health Care: a Resource Manual. 4th ed. Washington, DC. American College of Obstetricians and Gynecologists. 2014; 607–613.

3.Sadock BJ, Sadock VS, Ruiz P Synopsis of psychiatry. 11th ed.Wolter Kluwer, New delhi.2015: 841

4.Mishell DR Jr. Premenstrual disorders: epidemiology and disease burden. Am J Manag Care. 2005;11(16 Suppl): S473–9.

5.Durairaj A, Ramamurthi R. Prevalence, pattern and predictors of premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD) among college girls. New Indian J OBGYN. 2019;5(2):93–8. [Google Scholar]

6.Kavitha P, Shanmughavadivu R. A study on the prevalence of premenstrual syndrome and its relation with anthropometric indices. Int J Pharmacol Physiol. 2015;1(1):27–32. [Google Scholar]

7.Raval CM, Panchal BN, Tiwari DS, Vala AU, Bhatt RB. Prevalence of premenstrual syndrome and premenstrual dysphoric disorder among college students of Bhavnagar, Gujarat. Indian J Psychiatry. 2016;58(2):164–70. doi: 10.4103/0019-5545.183796. [PMC free article] [PubMed] [CrossRef] [Google Scholar]

8.Bhuvaneswari K, Rabindran P, Bharadwaj B. Prevalence of premenstrual syndrome and its impact on quality of life among selected college students in Puducherry. Natl Med J India. 2019;32(1):17–9. doi: 10.4103/0970-258x.272109

9.OsbornE, Wittkowski A, Brooks J, BriggsPE, O'Brien PMS. Women's experiences of receiving a diagnosis of premenstrual dysphoric disorder: a qualitative investigation. BMC Womens Health. 2020;20(1):242.

10.LuD, Aleknaviciute J, Bjarnason R, Tamimi RM, Valdimarsdóttir UA, Bertone-Johnson ER.Pubertal development and risk of premenstrual disorders in young adulthood. Hum Reprod. 2021;36(2):455-464.

11.Lu D, Aleknaviciute J, Kamperman AM, Tamimi RM, Ludvigsson JF, Valdimarsdóttir UA, Bertone-Johnson ER. Association between childhood body size and premenstrual disorders in young adulthood. JAMA network open. 2022 Mar 1;5(3):e221256-.

12.Mishra A, Banwari G, Yadav P. Premenstrual dysphoric disorder in medical students residing in hostel and its association with lifestyle factors. Ind Psychiatry J. 2015;24(2):150–7. doi: 10.4103/0972-6748.181718.

13.Negi P, Mishra A, Lakhera P. Menstrual abnormalities and their association with lifestyle pattern in adolescent girls of Garhwal, India. J Family Med Prim Care. 2018;7(4):804–8. doi: 10.4103/jfmpc.jfmpc_159_17.

14.Kamat SV, Nimbalkar A, Phatak AG, Nimbalkar SM. Premenstrual syndrome in Anand district, Gujarat: a cross-sectional survey. J Family Med Prim Care. 2019;8(2):640–7. doi: 10.4103/jfmpc.jfmpc_302_18.

15.Yang Q, Þórðardóttir EB, Hauksdóttir A, Aspelund T, Jakobsdóttir J, Halldorsdottir T, Tomasson G, Rúnarsdóttir H, Danielsdottir HB, Bertone-Johnson ER, Sjölander A. Association between adverse childhood experiences and premenstrual disorders: a cross-sectional analysis of 11,973 women. BMC medicine. 2022 Feb 21; 20(1):60.
16.Epperson CN, Steiner M, Hartlage SA, et al.: Premenstrual dysphoric disorder: Evidence for a new category for DSM-5. Am J Psychiatry. 2012; 169(5): 465–75. 10.1176/appi.ajp.2012.11081302 \
17.American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC. American Psychiatric Association. 2013
18.Brinton RD, Thompson RF, Foy MR, et al.: Progesterone receptors: Form and function in brain. Front Neuroendocrinol. 2008; 29(2): 313–39. 10.1016/j.yfrne.2008.02.001
19.Del Mar Fernández M, Regueira-Méndez C, Takkouche B: Psychological factors and premenstrual syndrome: A Spanish case-control study. PLoS One. 2019; 14(3): e0212557. 10.1371/journal.pone.0212557
20.Vannuccini S, Rossi E, Cassioli E, Cirone D, Castellini G, Ricca V, Petraglia F. Menstrual Distress Questionnaire (MEDI-Q): a new tool to assess menstruation-related distress. Reproductive BioMedicine Online. 2021 Dec 1;43(6):1107-16.
21.Yonkers KA, Kornstein SG, Gueorguieva R, et al.: Symptom-Onset Dosing of Sertraline for the Treatment of Premenstrual Dysphoric Disorder: A Randomized Clinical Trial. JAMA Psychiatry. 2015; 72(10): 1037–44. 10.1001/jamapsychiatry.2015.1472
22.Hammarbäck S, Ekholm UB, Bäckström T: Spontaneous anovulation causing disappearance of cyclical symptoms in women with the premenstrual syndrome. Acta Endocrinol (Copenh). 1991; 125(2): 132–7. 10.1530/acta.0.1250132
23.Lundin C, Danielsson KG, Bixo M, et al.: Combined oral contraceptive use is associated with both improvement and worsening of mood in the different phases of the treatment cycle-A double-blind, placebo-controlled randomized trial. Psychoneuroendocrinology. 2017; 76: 135–43. 10.1016/j.psyneuen.2016.11.033
24.Kancheva Landolt N, Ivanov K: Short report: Cognitive behavioral therapy - a primary mode for premenstrual syndrome management: systematic literature review. Psychol Health Med. 2021; 26(10): 1282–93. 10.1080/13548506.2020.1810718
25.Arabnezhad L, Mohammadifard M, Rahmani L, Majidi Z, Ferns GA, Bahrami A. Effects of curcumin supplementation on vitamin D levels in women with premenstrual syndrome and dysmenorrhea: a randomized controlled study. BMC complementary medicine and therapies. 2022 Jan 22;22(1):19.

26.Carlini SV, Lanza di Scalea T, McNally ST, Lester J, Deligiannidis KM. Management of Premenstrual Dysphoric Disorder: A Scoping Review. International Journal of Women's Health. 2022 Dec 31:1783-801.
27.Prathiba R, Nesakumar A. Polycystic Ovarian Syndrome (PCOS)-A Case Study With Constitutional Homeopathic Treatment. Journal of Pharmaceutical Negative Results. 2023 Jul 1;14(3).
28.Arora G, Goyal A. Polycystic ovarian syndrome with obsessive-compulsive disorder treated with homoeopathy: A case report.
29.Billah MA, Abdul Hakim SK, Vignesh Kumar S. Management of Polycystic Ovarian Syndrome (PCOS) with Constitutional Homoeopathic Medicine-A Case Report. Int. J. of AYUSH Case Reports. October-December. 2022;6(4).
30.Panda SK, Sahoo AR, Nayak C, Kanungo S. Homoeopathic management of infertility due to blockage of fallopian tube– A case series. Indian J Res Homoeopathy 2022;16(2):178-186.
31.Reddy TA, Sreevidhya JS. A Clinical Study to Assess the Effectiveness of Belladonna in Various Potencies in Primary Dysmenorrhoea of Adolescent Girls. International Journal of Research in AYUSH and Pharmaceutical Sciences. 2022 May 22:610-4.
32.Bhatt R, Gupta A, Simran D, Purnima A, Trivedi V, Shah S. Usefulness of Homoeopathic Medicines in the Cases of Dysmenorrhoea. Alternative & Integrative Medicine. 2022.
33.Panda BP, Gohel R, Chatterjee A, Joshi N, Lathiya R. A STUDY OF THE SCOPE OF HOMOEOPATHY IN MANAGEMENT OF MENOPAUSAL DEPRESSION. International Journal of Pure Medical Research. 2022 Apr 1.
34.Kumar AS, Reddy GG. Postpartum Depression and its Homoeopathic Management. International Journal of Homoeopathic Sciences 2022; 6(3): 01-03
35.Mello ML, Cabo DJ, Takeuti IS. Homeopathy and women's health: gynecology and homeopathy. Revista da Associação Médica Brasileira. 2023 Aug 4;69: e2023S113.
36.Shukla S, Roy S, Pawar G, Valke A. To study the effectiveness of Homeopathic medicine Melissa Officinalis 200CH versus Homeopathic simillimum in case of premenstrual syndrome (PMS) in females of age group 15-45years–A Randomized controlled trial.
37. Murphy R. Lotus Materia Medica.3rd revised ed. Noida: B Jain Publishers;2022
38.Yakir M, Kreitler S, Brzezinski A, Vithoulkas G, Oberbaum M, Bentwich Z. Effects of homeopathic treatment in women with premenstrual syndrome: a pilot study. British Homeopathic Journal. 2001 Jul;90(03):148-53.
39.Danno K, Colas A, Terzan L, Bordet MF. Homeopathic treatment of premenstrual syndrome: a case series. Homeopathy. 2013 Jan;102(01):59-65.

40.Klein-Laansma CT, Jansen JC, Van Tilborgh AJ, Van der Windt DA, Mathie RT, Rutten AL. Semi-standardised homeopathic treatment of premenstrual syndrome with a limited number of medicines: Feasibility study. Homeopathy. 2010 Jul;99(03):192-204.
41.Martinez B. Folliculinum: Efficacy in premenstrual syndrome. British Homeopathic Journal. 1990 Apr;79(02):104-5.
42.van der Werf ET, Mulder LT, Roberts ER. Women with premenstrual syndrome (PMS) benefit from individualised homeopathic treatment. Homeopathy. 2019; 108:256-69.
43.Stevinson C, Ernst E. A pilot study of Hypericum perforatum for the treatment of premenstrual syndrome. BJOG: An International Journal of Obstetrics & Gynaecology. 2000 Jul;107(7):870-6.
44.Schroyens F. Synthesis: repertorium homoeopathicum syntheticum; the source repertory. New Delhi: B Jain ; 2006
45.Murphy R. Homoeopathic medical repertory; a modern alphabetical repertory. Rev ed. New Delhi; B Jain;2004
46.Boger CM. Boenninghausen's Characteristics Materia Medica & Repertory with word index with corrected & revised abbreviations. Reprint ed. New Delhi; B Jain Publishers: 2008
47.FOLLICULINUM- A matrimonial remedy to prevent infertility. Indications and results in treatment of anovulatory female cycle disorders. By Dr. Christina Ari. (article on folliculinum source internet)
48. https://www.materiamedica.info/en/materia-medica/william-boericke/index#N
49. https://www.materiamedica.info/en/materia-medica/john-henry-clarke/index

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A CASE OF FEVER WITH BEHAVIOURAL DISORDER TREATED HOMOEOPATHICALLY

Dr TINU MATHEWS

A Mother brought her child to my clinic with her older sister, who had a 103°F fever, loose stools, decreased appetite, and increased thirst. She also had tantrums and wouldn't let anyone besides her mother touch her. In between fiercely hugging her mother, the youngster seemed a bit sleepy. I was worried that she may suddenly fall into a convulsive condition because the temperature was rising so quickly.

She screamed that I had touched her again while I examined her, which set off her weeping fits and tantrums. She gritted her teeth and expressed her rage at me. I immediately administered Belladonna 1m of the drug. However, the fever is not going away. I questioned her mother once more: Is this untouchability exclusive to me or this particular situation ?

Her mother then revealed that she behaves in a similar manner with teachers, other older pupils at school, and even her older sister at home. I then asked her about her obstetrical background. She briefly said that there was a lot of stress at that time. Since her husband was pressuring her to terminate this kid, they divorced. He also engaged in illicit relationships. I asked the day before the fever because the case was an acute fever. Her mother left her alone that day and went into town.

The child then started weeping after that. She sobbed bitterly for a while. The next morning she had a fever.

I provided a dose of Ignatia1m due to the acute sorrow element, and ailments factor the temperature went down within an hour. Additionally, the little child was with the mother when she arrived two weeks later to counsel the older sister.

I'm in awe of the youngster's joy and energy as she plays with me and lets me touch her without any issues. Her instructors at school have also informed her mother that she has significantly altered her demeanour in social situations. Her mother observed her seated on the instructor's lap. And being courteous to everyone.....

Dr. Tinu Mathews
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Mental calmness through Homeopathy

In the rapidly evolving and bustling world we live in today, mental calmness has become a vital attribute for maintaining our overall well-being. As we navigate through a digitally connected era, where information overload and constant stimulation have become the norm, achieving and nurturing a sense of psychological calmness has become crucial.

> WHY IS MENTAL CALMNESS SO IMPORTANT IN THE PRESENT ERA? FIRSTLY, OUR MENTAL HEALTH PLAYS A PROFOUND ROLE IN OUR OVERALL QUALITY OF LIFE.

Why is mental calmness so important in the present era? Firstly, our mental health plays a profound role in our overall quality of life. As we strive to excel in various aspects, such as work, relationships, and personal goals, the pressure and stressors we encounter can be intense. Mental calmness acts as an antidote to these stressors, allowing us to respond to them in a thoughtful and centered manner, rather than being overwhelmed and consumed by them.

Secondly, mental calmness enhances our ability to focus and concentrate.

In a world filled with distractions and constant multitasking, maintaining a calm state of mind allows us to filter out the unnecessary noise and concentrate on the tasks at hand. This heightened focus not only improves our productivity but also promotes efficiency and quality in what we do. Furthermore, mental calmness contributes to better decision-making. When our minds are calm and clear, we are less influenced by impulsive emotions and can think through situations more objectively. This enables us to make sound judgments, avoiding knee-jerk reactions that may lead to regrettable outcomes.

In a world where decisions impact our lives in numerous ways, cultivating mental calmness empowers us to make choices that align with our values and long-term goals.

Moreover, mental calmness promotes emotional well-being. It allows us to build resilience and cope with the challenges we face, ensuring that setbacks do not overly affect our mental and emotional states. By fostering a calm mindset, we can approach adversities with a balanced perspective, which facilitates problem-solving and emotional stability. In turn, this leads to greater overall contentment and a sense of peace within ourselves.

Homeopathy as a holistic system of medicine is the best way to achieve mental stability safely and permanently. In this era of chaos and uncertainty we homeopaths offer the patient a complete care where patient is taken care of all the distress from its root level to attain complete cure.

Take care of your mental well-being, and may you find the calmness amidst life's chaos.

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FORTIFYING MENTAL HEALTH: STRATEGIES FOR PREVENTION AND WELL-BEING

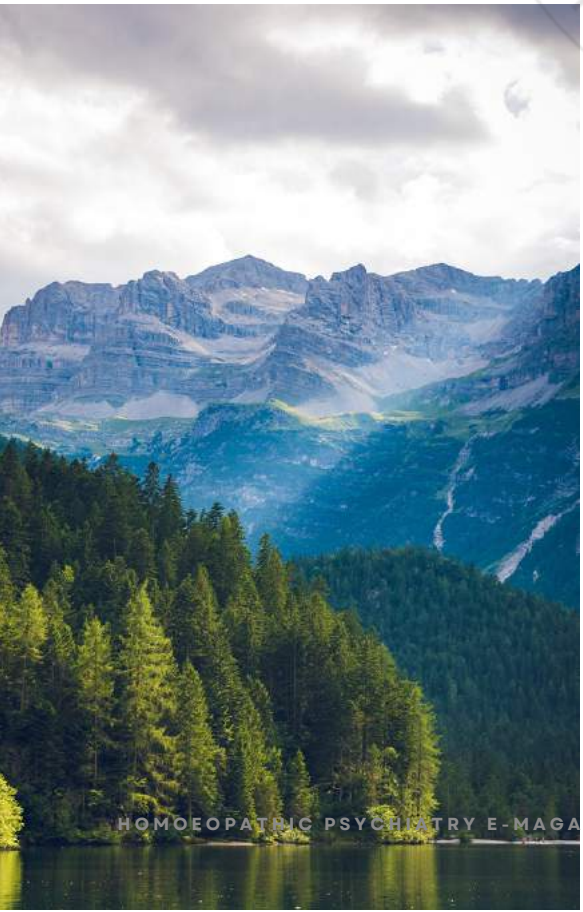
In an increasingly fast-paced and demanding world, safeguarding our mental health has never been more crucial. While seeking treatment for mental health issues is essential, proactive prevention plays an equally significant role. In this article, we'll explore strategies for fortifying mental health, promoting well-being, and preventing the onset of mental health challenges.

Understanding Mental Health

Before diving into prevention strategies, it's vital to recognize the importance of mental health. Mental health encompasses our emotional, psychological, and social well-being. It influences how we think, feel, and act, and it plays a role in our ability to handle stress, relate to others, and make choices. Good mental health isn't just the absence of a mental disorder; it's about thriving, resilience, and achieving our full potential.

The Importance of Prevention

Prevention is a cornerstone of public health, and mental health is no exception. Preventing mental health issues can reduce personal suffering, enhance quality of life, and lower healthcare costs. Here are some strategies to consider:
enhance mental well-being.



1. Promote Awareness

Start by increasing awareness about mental health. Reducing the stigma around mental health issues encourages open conversations and early intervention. It's crucial to recognize that anyone can experience mental health challenges, and seeking help is a sign of strength.

2. Build Resilience

Resilience is the ability to bounce back from adversity. Developing resilience can help protect against mental health problems. Practices like mindfulness, meditation, and yoga can enhance emotional well-being and resilience.

3. Maintain Healthy Relationships

Strong, supportive relationships are crucial for mental health. Cultivate healthy connections with friends and family and seek help when conflicts or challenges arise. Good relationships provide a buffer against stress and can enhance emotional well-being and resilience.

4. Physical Health Matters

Physical and mental health are interconnected. Regular exercise, a balanced diet, and adequate sleep all contribute to overall well-being. Physical activity, in particular, releases endorphins, which are natural mood lifters.

5. Manage Stress

Stress is a common trigger for mental health issues. Learning effective stress management techniques like deep breathing, progressive muscle relaxation, and time management can be invaluable in preventing mental health challenges.

6. Seek Professional Help

If you notice persistent changes in your thoughts, feelings, or behaviors, don't hesitate to seek help from a mental health professional. Early intervention can prevent the worsening of symptoms and improve outcomes.

7. Practice Self-Care

Make self-care a non-negotiable part of your routine. This includes setting aside time for activities you enjoy, practicing relaxation techniques, and taking breaks when needed.

CATEGORIES OF PREVENTIVE STRATEGIES

Mental health prevention involves three primary stages aimed at promoting well-being, reducing the risk of mental health issues, and addressing concerns early. These stages are
often referred to as primary, secondary, and tertiary prevention. Here's an overview of each stage:

1. Primary Prevention: Promoting Mental Wellness

Primary prevention focuses on promoting mental wellness and preventing the onset of mental health issues in the general population. It involves strategies that target everyone, regardless of their mental health status. The key elements of primary prevention include:

• Public Awareness: Educating the public about mental health, reducing stigma, and promoting positive mental health practices. This can be achieved through public campaigns, community workshops, and school programs.

• Promoting Resilience: Building emotional resilience and coping skills in individuals to better manage life stressors. Programs in schools and workplaces that teach stress management, mindfulness, and emotional intelligence can be beneficial.

• Creating Supportive Environments: Creating social and physical environments that foster mental well-being. This includes promoting safe and supportive communities, reducing discrimination, and improving access to resources. • Lifestyle Factors: Encouraging healthy
lifestyles, such as regular exercise, balanced nutrition, adequate sleep, and reduced substance abuse, which can have a significant impact on mental health

2. Secondary Prevention: Early Intervention• Access to Treatment: Ensuring that individuals
Secondary prevention focuses on identifying andhave access to appropriate mental health
intervening in mental health issues at an earlytreatments, which may include therapy,
stage, with the goal of preventing them frommedication, hospitalization, or other forms of
worsening. Key elements of secondarycare.
prevention include:• Rehabilitation: Providing support for
• Screening and Assessment: Identifyingindividuals to regain their functionality and
individuals who may be at risk for mentalindependence. This could involve vocational
health issues through regular screenings andrehabilitation, social skills training, or housing
assessments. This can occur in healthcare settings,support.
schools, workplaces, and community programs.• Supportive Communities: Creating communities
• Timely Intervention: Providing timely andthat are inclusive and supportive of individuals
appropriate interventions for individuals whowith mental health conditions, reducing stigma,
show early signs of mental health concerns. Thisand promoting their integration into society.
may include counseling, therapy, or support• Ongoing Care: Offering ongoing care and
groups.support to individuals with chronic mental
• Crisis Management: Ensuring that crisishealth conditions to help them manage their
helplines and support services are readilysymptoms and prevent relapses.
available for individuals in acute distress, with
the aim of preventing crisis situations from
escalating.
• Education and Training: Offering training
programs for healthcare providers, educators,
and community members to recognize and
respond to mental health issues effectively.
3. Tertiary Prevention: Treatment and Recovery
Tertiary prevention focuses on individuals who
already have a diagnosed mental health
condition. Its goal is to provide treatment,
support, and rehabilitation to help individuals
recover and manage their conditions effectively.
Key elements of tertiary prevention include:

• Crisis Management: Ensuring that crisis intervention services are available for individuals experiencing acute episodes of mental illness. By implementing these three stages of mental health prevention, society can work toward reducing the incidence of mental health issues, providing early intervention when needed, and supporting individuals on their path to recovery and well-being.

Preventing mental health issues and promoting overall well-being is a responsibility we all share. By raising awareness, building resilience, nurturing relationships, maintaining physical health, managing stress, seeking professional help when necessary, and practicing self-care, we can fortify our mental health and create a more mentally healthy society.

Remember, mental health is as important as physical health, and investing in prevention today can lead to a brighter, more mentally healthy future for us all.

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AN ATTEMPT TO GET THE HANG OF PARANOID SCHIZOPHRENIA WITH HOMOEOPATHIC APPROACH

ABSTRACT

Paranoid schizophrenia is one of the subtypes of schizophrenia which is characterised mainly by the presence of delusions of persecution or grandeur. It usually manifests the first episode of illness at an older age than patients with catatonic or disorganised schizophrenia. Homoeopathy is a system of medicine which has a holistic concept in approach and treating the patient. The treatment is not only based on the disease diagnosis but also based on the individual peculiarities of the patient. This approach makes homoeopathic remedies very effective in treating paranoid schizophrenia and also in all age group.

Key words: Paranoid schizophrenia, homoeopathic treatment, constitutional medicine, types of mental diseases.

INTRODUCTION

Schizophrenia is considered to be one of the most puzzling disorders in psychiatry. It has a disruptive psychopathology that involves cognition, emotion, perception and other aspects of behaviour. Paranoid schizophrenia is one of the subtypes of schizophrenia which is characterised mainly by the presence of delusions of persecution or grandeur. In DSM-IV, paranoid type schizophrenia is marked by hallucinations or delusions in the presence of a clear sensorium and unchanged cognition. Disorganised speech, disorganized behaviour, and flat or inappropriate affect are not present to any significant degree. The delusions (usually of a persecutory or grandiose nature) and the hallucinations most often revolve around a particular theme or themes. Because of their delusions, these patients may attempt to keep the interviewer at bay, and thus they may appear hostile or angry during an interview. This type of schizophrenia may have a later age of onset and a better prognosis than the other subtypes. The illness appears earlier in men than in women. The exact aetiology is still unknown. Genetic, biological, environmental, and psychological factors are considered to play a vital role in the development of paranoid schizophrenia.

Homoeopathy treats the person as a whole, which means the treatment is based on the patient's body, mind, emotional and pathological condition. Hence homoeopathic treatment can be considered to be the most curative, non toxic and modern treatment. According to the homoeopathic understanding of health, body and mind are dynamically interconnected and that both directly influence each other.

EPIDEMIOLOGY

India and Sri Lanka have a higher prevalence rate of schizophrenia. Patients with paranoid schizophrenia have a life time prevalence of 0.5% to 2.5% of the general population across racial, sociocultural and national boundaries. An earlier age of onset has been noted in males in the western studies, whereas no such differences have been demonstrated in India. Frequency of illness is found to be higher in high socio-economic class.

The incidence of paranoid schizophrenia is believed to be about 0.17 per 1000 of schizophrenia. Incidence rates reported from India have been higher than in the west. The paucity of incidence studies in India could be due to the absence of demarcated catchment areas for health service delivery, lack of case registers and cost-effectiveness of conducting a community survey. In active stage of the disease, those affected may use illogical sentences or react with uncontrolled anger or violence. Their behaviour may or may not be predictable.

AETIOLOGY

The aetiology is explained on the basis of biological theories, psychological theories and sociocultural theories.

Biological theories

Genetic hypothesis: The concordance rate of monozygotic twins is 46% and for dizygotic twins is 14%. If one parent has affected, the chances of the child developing are 10-12%. If both parents have affected, chances of the child developing increase to about 40%.

Biochemical theories: This is probably due to a functional increase of dopamine at the postsynaptic receptor, though other neurotransmitters such as serotonin, GABA and acetylcholine are also presumably involved.

Brain imaging: Cranial CT scan, MRI scan and post-mortem studies show enlarged ventricles and mild cortical atrophy. PET scan shows hypo frontality and decreased glucose utilisation in the dominant temporal lobe.

Psychological theories

Stress: Increased number of stressful life events before the onset or relapse probably has a triggering effect especially in a genetically vulnerable person. According to this hypothesis, higher the genetic vulnerability in a person, lesser the environmental stress needed to precipitate a relapse.

Family theories:

These include schizophrenogenic mothers, lack of real parents, dependency on mother, anxious mother, parental marital schism or skew, double blind theory, communication deviance and pseudo mutuality.

Information processing hypothesis:

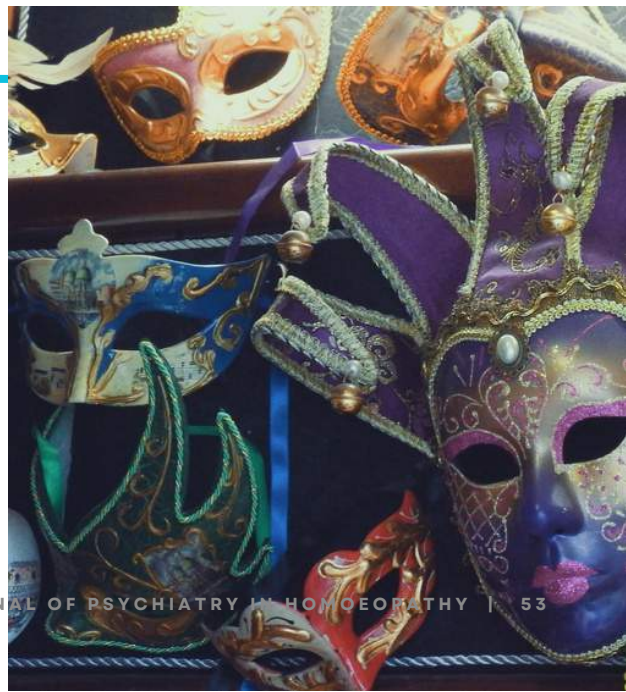
Disturbances in attention, inability to maintain a set, and inability to assimilate and integrate precepts are common findings.

Psychoanalytical theories:

According to Freud, there is regression to the preoral and oral stage of psychosexual development, with the use of defence mechanisms of denial, projection, and reaction formation. Ther is a loss of ego-boundaries with a loss of touch with reality.

Sociocultural theories

It was found to be more common in lower socioeconomic status. Higher rates have been found among some migrants, not only among the first generation migrants but also among the second generation.



CLINICAL FEATURES

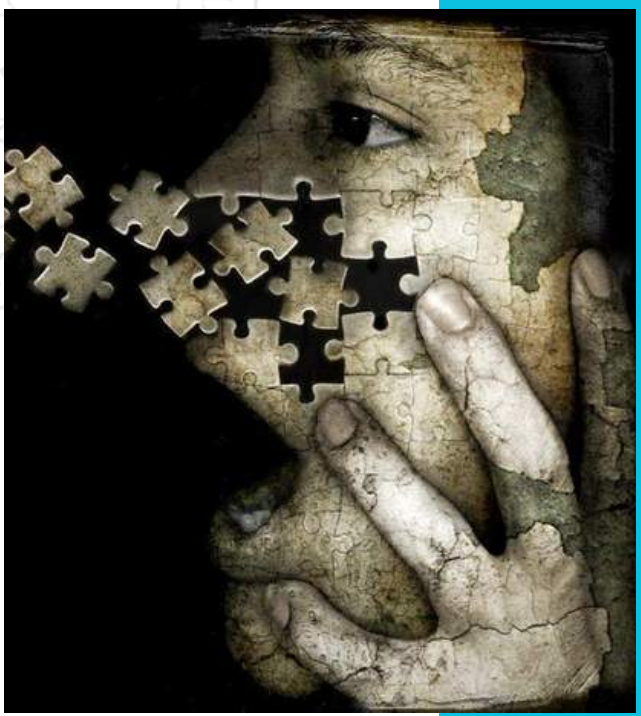
Of all clinical type of schizophrenia, the paranoid type is the most homogeneous and the least variable. The paranoid form of schizophrenia, however, is relatively distinct from the others, and often persists true to type throughout its course. Primary delusions followed by secondary delusional interpretations are the leading symptoms, and, together with hallucinations, can remain almost the only disorder in a chronic psychosis lasting for years. A full-blown paranoid development can only be seen while the personality is relatively intact, as gross symptoms of thought disorder and catatonic and volitional disturbances will interfere with its appearance.

Remissions after a longer paranoid psychosis are usually only approximations to a social adjustment.

MANAGEMENT

The treatment of Paranoid schizophrenia can be discussed under the following major headings

1. Somatic treatment
    a. Pharmacological treatment
    b. Electro-convulsive therapy (ECT)
    c. Miscellaneous treatments
2. Psychosocial treatment and rehabilitation



Homoeopathic approach

Homoeopathy is a system of medicine founded by the celebrated physician Dr. Samuel Hahnemann (1755-1843) of Germany. It is based on the principle that “like cures like”. In practice, this means that a medicine capable of producing certain effects when taken by a healthy human being is capable of curing any illness that displays similar effects.

The foremost merit of Homoeopathy is that while curing one disease it does not create another as found mostly in allopathic treatment. And also even a new or unknown disease can be correctly and successfully treated when the symptoms of the disease are unknown.

Homoeopathy achieves its ends and accomplishes its purposes by the use of single, simple, pure drugs; refined and deprived of their injurious properties and enhanced in curative power by the pharmacodynamical processes of mechanical comminution, trituration, solution and dilution according to scale; in minimum or infinitesimal doses, administered by the mouth; the remedy having been selected by comparison of the symptoms of the sick with the symptoms of drugs produced by tests in healthy human subjects; under the principle of symptom similarity.

The homoeopathic antipsoric medicine having been chosen as well as possible to suit the morbid symptoms, and given in the appropriate potency and in the proper dose, the physician should as a rule allow to finish its action without disturbing it by an intervening remedy.

Electro convulsive Therapy (ECT)

Paranoid schizophrenia is not a primary indication for ECT. The indications for ECT include

1. Catatonic stupor
2. Uncontrolled catatonic excitement
3. Acute exacerbation not controlled with drugs
4. Severe side-effect with drugs, in presence of untreated schizophrenia.

Usually 8-12 ECTs are needed (although up to 18 have been given in poor responders) administered two or three times a week.

Miscellaneous treatments

Psychosurgery is not a routinely indicated treatment. It is a treatment which is extremely rarely used in clinical practice. When used, the treatment of choice is limbic leucotomy (a small sub caudate lesion with a cingulated lesion) in some cases with severe and very prominent depression, anxiety and obsessional symptoms. Severe deteriorated patients are unlikely to benefit. The maximum benefit would be in acute episodes, but antipsychotics are far better obviously both in efficacy and safety. Many other methods such as megavitamin therapy, dialysis, malaria therapy, high dose propranolol and insulin coma therapy have been used in past but are no longer used in clinical practice due to either poor evidence for efficacy and/or risks to the patient.

Psychosocial treatment and rehabilitation

Psychosocial treatment is an extremely important component of comprehensive management of schizophrenia. It can be divided in following steps

1. Psychoeducation of the patient and especially the family / carers regarding the nature of the illness, and its course and treatment. It helps in establishing a good therapeutic relationship with the patient and the family. It also involves explaining the stress-vulnerability model of schizophrenia to the patient and carer(s).
2. Group psychotherapy is particularly aimed at teaching problem solving and communication skills. This can be conducted in a form which is known as the 'social skills training package'.
3. Family therapy: Apart from psychoeducation, family members are also provided social skills training to enhance communication and help decrease intrafamilial 'tensions'. Attempts are also made to decrease the 'expressed emotions' of 'significant others' in the family. The family members awareness is raised regarding decreasing expectations and avoiding critical remarks, emotional over-involvement, and hostility.

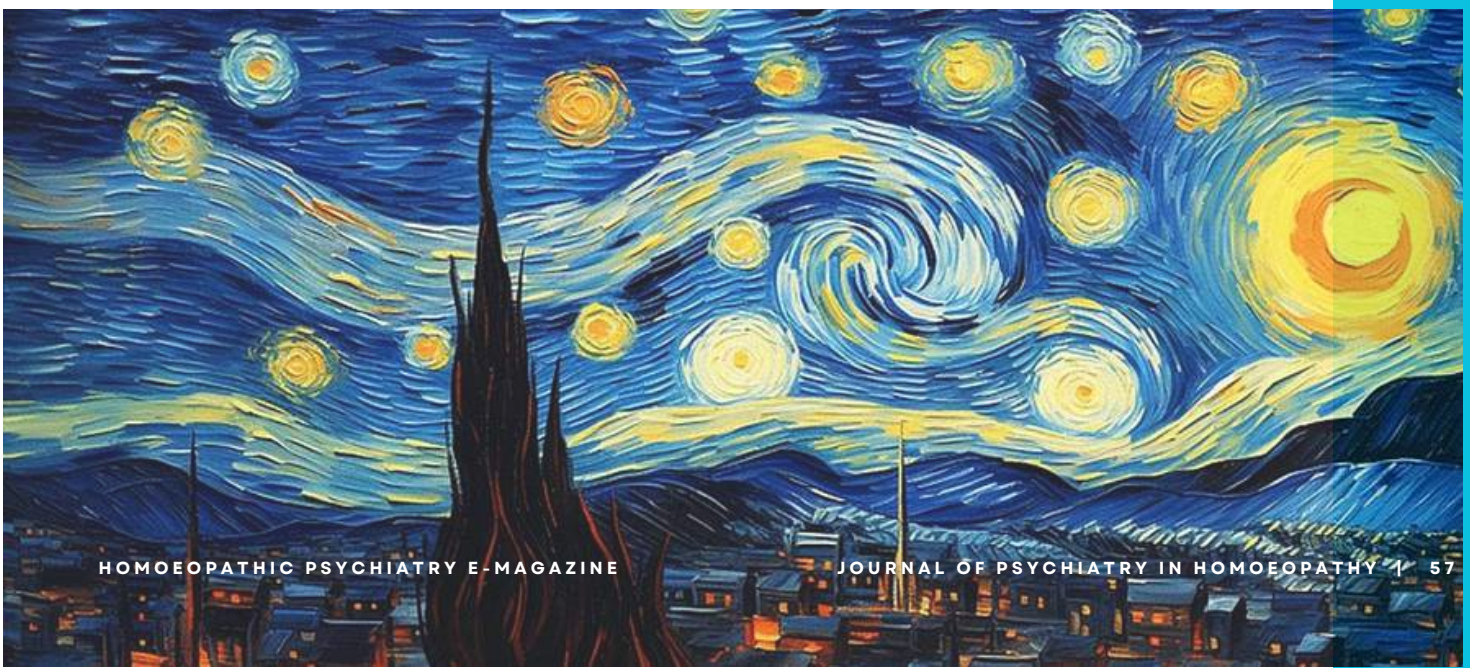
4. Milieu therapy or therapeutic community includes treatment in a living, learning or working environment ranging from impatient psychiatric unit to day-care hospitals and half-way homes.

5. Individual psychotherapy is usually supportive in nature.

6. Psychosocial rehabilitation is used, usually along with milieu therapy. This includes activity therapy, to develop the work habit, training in a new vocation or retraining in a previous skill, vocational guidance, independent job placement, sheltered employment or self – employment, and occupational therapy.

DISCUSSION AND CONCLUSION

There is no doubt that paranoid schizophrenia has been called “arguably the worst disease affecting mankind, even AIDS not excepted”. It consists of variable, but profoundly disruptive, psychopathology that involves cognition, emotion, perception and other aspects of behaviour since its early description by Kraepelin, the concept of schizophrenia has undergone considerable modification to become the disorder it is today. The cause of paranoid schizophrenia is not known making its treatment more complex. A person with paranoid schizophrenia may not have any outward appearance of being ill. People with paranoid schizophrenia vary widely in their behaviour as they struggle with an illness beyond their control.



Homoeopathy treats the person as a whole, which means the treatment is based on the patient's body, mind, emotional and pathological condition. Hence homoeopathic treatment can be considered to be the most curative, non toxic and modern treatment. Homoeopathy treats the person as a whole, which means the treatment is based on the patient's body, mind, emotional and pathological condition. Hence homoeopathic treatment can be considered to be the most curative, non toxic and modern treatment. In view of the fact that it works with the person's own vital force towards equilibrium and healing, it will influence the brain chemistry and assist the patient in resuming psychological strength and symmetry.

In conclusion, the Homoeopathic understanding of health believes that body and mind are dynamically interconnected and that both directly influence each other. Thus Homoeopathic treatment might have a better chance to relieve the symptoms of paranoid schizophrenia giving the patient an improved awareness of their disease and a deeper self-consciousness, thus contributing to permit the patient a healthier life quality.

BIBLIOGRAPHY

1. Ahuja N. A short text book of psychiatry. 7thedition. New delhi: Jaypee publishers (p) ltd; 2011.

2. Sankaran R. The spirit of homoeopathy. 3rdedition. Mumbai: Homoeopathic medical publishers; 1999.

3. Vyas J. N. Textbook of postgraduate psychiatry. Vol 1. 2nd Reprint edition.New delhi: Jaypee brothers medical publishers (p) ltd; 2008.

4. Allan T. et al. Psychiatry. 2ndedition. Vol II. USA. John wiley& sons ltd; 2003.

5. Gross M et al. Clinical psychiatry. 3rd edition. Reprint . Delhi: AITBS Publushers and distributers; 2006

6. Close S. The genius of homoeopathy lectures. Reprint edition.New delhi: B. Jain publishers (p) ltd; 2005.

7. Hahnemann S. The chronic diseases their peculiar nature and their homoeopathic cure. Augmented edition. New delhi: B. Jain publishers (p) ltd.

8. Clarke J. H. The prescriber. Reprint edition. New Delhi: B. Jain publishers (p) ltd; 1998.

9. Boericke W. Boericke's new manual of homoeopathic material medica with repertory. Third revised & augmented edition based on ninth edition. New delhi: B. Jain publishers (p) ltd. 2015.

10. Allen H.C. Allen's keynotes rearranged and classified with leading remedies of the materiamedica and bowel nosodes. 10th edition. New delhi: B Jain publishers (p) ltd. 2015.

11. Boger C.M. A synoptic key of the material medica. Rearranged and augmented edition, 3rd Impression.New delhi: B Jain publishers (p) ltd. 2015.

12. Dr Phatak S.R. Materia medica of homoeopathic medicines. Second revised and enlarged edition, Reprint edition. New Delhi: B. Jain publishers (p) ltd. 2015.

13. Boger C. M. Boenninghausen's characteristics material medica. Reprint edition. New delhi: B. Jain publishers (p) ltd.

14. Bailey P. M. Homoeopathic psychology personality profiles of the major constitutional remedies. 12th impression. New delhi: B. Jain publishers (p) ltd, 2016.

15. Burt W. H. Physiological material medica. Reprint edition. New Delhi: B. Jain publishers (p) ltd.1995.

16. Ghosal. Homoeopathic practical material medica of 332 remedies. 4th revised edition.New Delhi: B. Jain publishers (p) ltd. 1999.
17. Dr Gibson D. Studies of homoeopathic remedies. South Asian edition. New delhi: Reed elsevier India (p) ltd. 2007.
18. Tarkas P. I. et al. A select homoeopathic material medica. Revised and augmented edition. New delhi: B. Jain publishers (p) ltd. 2002.
19. Dr Banerjea S. K. Synoptic memorizer of material medica. 6th Impression. New delhi:B. Jain publishers (p) ltd. 2014.
20. Dr Patil J. D. Gems textbook of homoeopathic material medica. Ist edition, 2nd Impression.New delhi: B. Jain publishers (p) ltd. 2015.
21. Das A. K. A treatise on organon of medicine. 2nd edition. Part 1, 2, 3. Kolkata: Books and allied (p) ltd. 2007.

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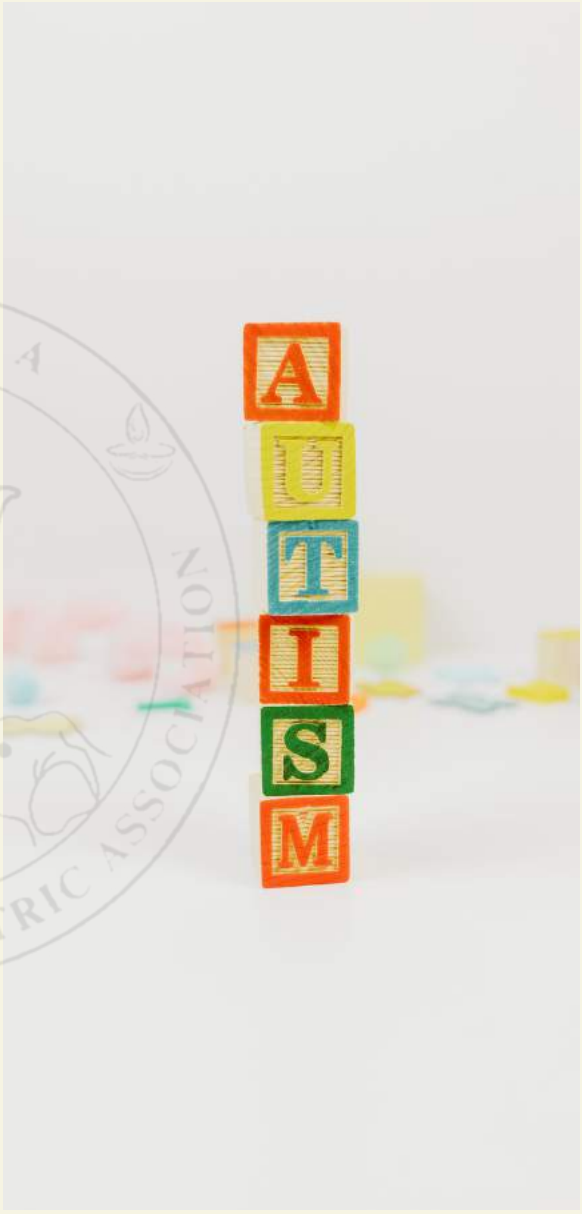
Understanding Autism, its Characteristics approach with few homoeopathic medicine

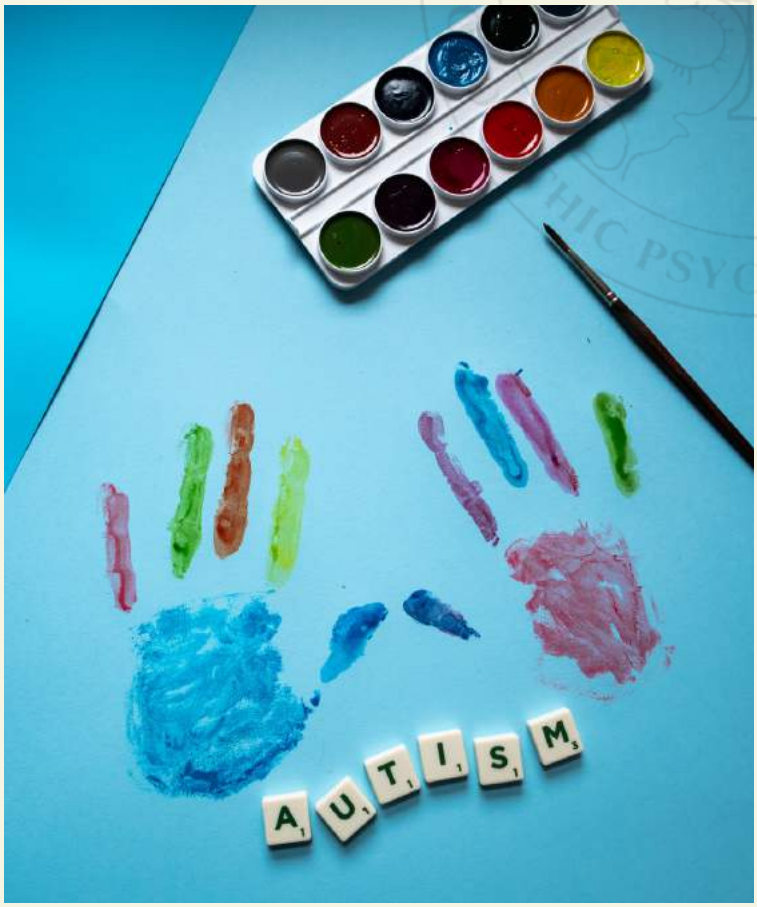
Autism is characterized by severe and pervasive impairments in several important areas of development: reciprocal social interaction and communication as well as behaviour,
and imagination. In order to be diagnosed with autism, the behavioural symptoms in all of the above-named areas must be present by age 3. Even if the parents often notice that something is wrong during infancy, it is very difficult to diagnose autism before the age of eighteen months.

This is because the behavioural symptoms used to establish the diagnosis have not clearly emerged developmentally until that age. The majority of children with autism also have a learning disability (mental retardation), although a few have average intelligence. Many also have epilepsy, and visual and hearing impairment are over-represented in this group. Persons with Asperger's syndrome, which is a condition resembling autism, have average or above average intelligence.



Estimated, 1 in 100 children has autism.

Autism is a life-long disability. There is currently no known cure for autism. On the other hand, many children with autism can develop significantly with early, well- planned and individually tailored educational efforts in specially adapted settings.



One of the primary objectives is to help the child develop functional communication. The educational approaches must focus on knowledge about the unique ways that children with autism learn. Various ABA strategies (Applied behaviour analysis) as well as the structured teaching method in the TEACCH-model (Treatment and Education of Autistic and related Communication Handicapped Children) are examples of such specially-tailored educational strategies for persons with autism.

The autism spectrum or pervasive developmental disorders (PDD)

The autism spectrum is an umbrella term for many diagnoses with similar symptoms.

Autistic disorder is the full syndrome within the autism spectrum. It is often abbreviated to “autism”. Most people with autism also have a learning disability. Yet even persons with average intelligence may have autism. This is often referred to as high-functioning autism or a high-functioning person with autism, which is a more correct term.

Asperger’s syndrome (or Asperger’s disorder) is autism in persons with average or above average intelligence without the severe linguistic difficulties seen in autism.

Pervasive developmental disorder NOS (NOS = not otherwise specified) or atypical autism are often used as synonyms. These diagnoses mean that the person does not fulfil all the criteria for autism or Asperger’s syndrome, but nonetheless has serious difficulties of a similar nature.

Childhood disintegrative disorder is very rare and means that a child develops autism after the age of 2 or 3 years of age. The child has a normal development up until this.

Autism spectrum disorder (ASD) is a term for a group of developmental disorders described by:

- Lasting problems with social communication and social interaction in different settings
- Repetitive behaviors and/or not wanting any change in daily routines
- Symptoms that begin in early childhood, usually in the first 2 years of life
- Symptoms that cause the person to need help in his or her daily life

The term “spectrum” refers to the wide range of symptoms, strengths, and levels of impairment that people with ASD can have. The diagnosis of ASD now includes these other conditions:

- Autistic disorder
- Asperger’s syndrome
- Pervasive developmental disorder not otherwise specified

Although ASD begins in early development, it can last throughout a person’s lifetime.

SIGNS AND SYMPTOMS OF ASD

Not all people with ASD will show all of these behaviours, but most will show several. People with ASD may:

- Repeat certain behaviors or have unusual behaviors
- Have overly focused interests, such as with moving objects or parts of objects
- Have a lasting, intense interest in certain topics, such as numbers, details, or facts
- Be upset by a slight change in a routine or being placed in a new or overstimulating setting
- Make little or inconsistent eye contact
- Tend to look and listen less to people in their environment
- Rarely seek to share their enjoyment of objects or activities by pointing or showing things to others
- Respond unusually when others show anger, distress, or affection
- Fail or be slow to respond to their name or other verbal attempts to gain their attention
- Have difficulties with the back and forth of conversations
- Often talk at length about a favorite subject but won't allow anyone else a chance to respond or notice when others react indifferently
- Repeat words or phrases that they hear, a behavior called echolalia
- Use words that seem odd, out of place, or have a special meaning known only to those familiar with that person's way of communicating
- Have facial expressions, movements, and gestures that do not match what they are saying
- Have an unusual tone of voice that may sound sing-song or flat and robot-like
- Have trouble understanding another person's point of view, leaving him or her unable to predict or understand other people's actions

People with ASD may have other difficulties, such as sensory sensitivity (being sensitive to light, noise, textures of clothing, or temperature), sleep problems, digestion problems, and irritability.

People with ASD can also have many strengths and abilities. For instance, people with ASD may:

- Have above-average intelligence
- Be able to learn things in detail and remember information for long periods of time
- Be strong visual and auditory learners
- Excel in math, science, music, and art

LARGE VARIATIONS

Persons with autism often differ greatly from each other in many ways, even though the effect of having autism is always serious. For example, the degree of autism is said to vary from severe to mild; similarly, the level of abilities can vary from severe learning disability to having above average intelligence. It is also common that persons with autism have other conditions such as various genetic syndromes, epilepsy, depression or attention-deficit/hyperactivity disorder, to name a few. A person may thus have severe autism as a component in a multiple impairment together with a moderate or severe learning disability, with epilepsy, and thus be maximally disabled, or have a lesser degree of autism and a high level of ability. The variations in the degree of severity of the behavioural expressions for autism are large and also dependent on the individual's personality, age and level of development.

HOMOEOPATHIC THERAPEUTICS

Conventional medicine is mostly used to treat some of the symptoms but is never used to cure or provide remedies for autism. A proper professional homeopath will be able to guide you to get the best results for your child and reduce all the problems of autism, if not outright cure it. Some of the medications that could be used to treat autism are as follows:

1. **Carcinosin** - This is very helpful in children affected by autism who are talented, but are obsessive, compulsive, stubborn and also have sleep related issues. These children may also have addictive disorders.
2. **Agaricus** - This medication is very good for children who may be mentally and physically awkward and show symptoms like indifference, muttering, talking, shouting or singing but not answering to direct calls or questions.

Agaricus is very effective for children who suffer from involuntary jerking when they are awake.

4. Androctonus - A child or a patient who tends to swing wildly from a stable good mood to a destructive mode can be calmed down or evened out by Androctonus. These children also exhibit behaviors of suspiciousness and quickness to act on their compulsion.

5. Helleborus - This is a very effective medication when the child is slow and under active and seems to be depressed most of the time. Some of these children may also have muscular weakness and helleborus is very effective in treating them

REFERENCES

1. Volkmar FR, et al. (2009). Pervasive developmental disorders. In BJ Sadock, VA Sadock, eds., Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 9th ed., vol. 2, pp. 3540-3559. Philadelphia: Lippincott Williams and Williams.
2. American Psychiatric Association (2013). Neurodevelopmental disorders. In Diagnostic and Statistical Manual of Mental Disorders, 5th ed., pp. 31-86. Washington, DC: American Psychiatric Association.
3. Zachor DA (2006). Autism. In FD Burg et al., eds., Current Pediatric Therapy, 18th ed., pp. 1219-1226. Philadelphia: Saunders Elsevier.
4. Johnson CP, et al. (2007, reaffirmed 2010). American Academy of Pediatrics clinical report: Identification and evaluation of children with autism spectrum disorders. Pediatrics, 120(5): 1183-1215.
5. Myers SM, et al. (2007, reaffirmed 2010). American Academy of Pediatrics clinical report: Management of children with autism spectrum disorders. Pediatrics, 120(5): 1162-1182.

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THE PROBLEMATIC CHILD

by Dr Jithin Ouseph

A "problem child" is a term often used to describe a child who exhibits challenging or disruptive behavior that goes beyond typical childhood misbehavior. These challenges may encompass a range of issues, including disobedience, aggression, temper tantrums, academic difficulties, and social problems. It's important to note that labeling a child as a "problem child" can be stigmatizing and oversimplifies the complexities of their behavior and underlying causes.

Several factors can contribute to a child's problematic behavior:

Environmental Factors: Home environment, family dynamics, and exposure to violence or instability can greatly impact a child's behavior.

Emotional and Psychological Factors: Children may struggle with emotional regulation, trauma, anxiety, or attention disorders, leading to problematic behavior.

Learning Disabilities:

Undiagnosed or unaddressed learning disabilities can result in academic difficulties, leading to frustration and acting out.

Social Factors: Peer pressure, social isolation, or bullying can contribute to behavioral problems.

Parenting Styles: Inconsistent discipline, neglect, or overly permissive parenting can influence a child's behavior.

Genetic Factors: Some children may have a genetic predisposition to certain behavioral or mental health issues.

The common behavioural problems which make a child "The Problem Child" according to their age which liked to be manifested are

Infancy, (0-2 years)

which encompasses the first two years of a child's life, is a critical developmental period marked by significant physical, emotional, and psychological changes. During this time, infants and toddlers may exhibit various behaviors and characteristics, some of which include:

(i) Persistent Weeping and Crying:

- Infants communicate primarily through crying during their early months. It's their way of expressing needs such as hunger, discomfort, or fatigue.

(ii) PICA (mud, chalk, sand, etc.) and other eating disturbances:

- PICA is a behavior where a child ingests non-food items like mud, chalk, or sand. It can be concerning and may indicate nutritional deficiencies, sensory exploration, or other underlying issues.

(iii) Head Banging, Pulling of hair:

- Some infants and toddlers engage in self-soothing behaviors like head banging or hair pulling. These actions are often rhythmic and can be related to sensory stimulation or a coping mechanism for emotional distress.

(iv) Breath Holding:

- Breath-holding spells can occur when a child briefly stops breathing, often in response to frustration or anger. This behavior can be alarming but typically resolves on its own and is usually not harmful.

(v) Thumb Sucking:

- Thumb sucking is a common self-soothing behavior in infants and toddlers. It provides comfort and a sense of security. Most children naturally outgrow this habit as they get older.

(vi) Excessive fear:

- Infants and toddlers may exhibit fear of unfamiliar people, objects, or situations. This is a normal part of their cognitive and emotional development as they learn about their surroundings.

(vii) Fear of separation or excessive dependency:

- Separation anxiety is a common developmental milestone during infancy and toddlerhood. It involves a child becoming distressed when separated from their primary caregiver. This phase typically peaks around 8-10 months of age and gradually diminishes as the child matures.

Other Behavioural problems are

Pre school age (2-6 years)

(i) Nightmares or sleep disturbances.

(ii) Tantrums and temper with aggressiveness, Hyper-activity.

(iii) Crying, shouting, jealousy to siblings, clinging to mother or emotional reactions.

(iv) Enuresis (Bed wetting) and Encopresis.

(v) Masturbation.

(vi) Nail biting and Thumb sucking.

(vii) Stammering, stuttering lalling or speech disturbances.

(viii) Tics or habit spasms.

Understanding these behaviors in the context of preschool-age development can help parents and caregivers provide appropriate support and guidance. It's essential to remember that each child is unique, and while some behaviors may be challenging, they are often a part of the natural progression of a child's growth and development.

School age (6-13 years)

(i) School Phobia.

(ii)Comprehending or learning difficulties. Dyslexia.

(iii) Obstinacy, stubbornness and dependency.

(iv) Anti-Social behaviour like lying, stealing and vandalism etc.

In this age group, children are going through significant cognitive, emotional, and social development. They are forming their identities and dealing with various challenges related to school, peer relationships, and family dynamics. It's important for parents, caregivers, and educators to maintain open lines of communication, provide appropriate support, and seek professional help when behavioral or learning challenges persist or worsen. Early intervention and understanding can greatly aid children in navigating these critical years of development.

> There are no problem children. Only children who need help with problems.
>
> L.R. Knost

Adolescence (13 years and above)

(i) Masturbation.

(ii) Sexual indulgence like homosexuality lesbianism, incest and heterosexuality.

(iii) Criminal activities or delinquent behaviour.

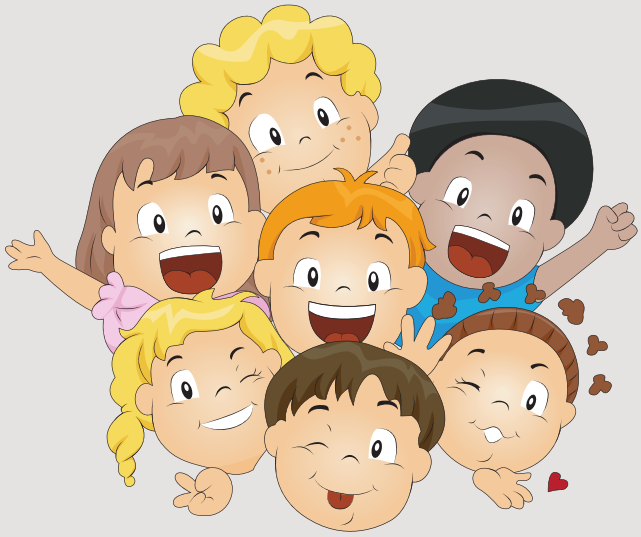
(iv) Suicidal thoughts and tendency.

Adolescence is a period of exploration, self-discovery, and growth. It's essential for parents, caregivers, and educators to maintain open lines of communication with adolescents, provide guidance and support, and be vigilant for signs of emotional distress or behavioral issues. Addressing these concerns with empathy, professional help when necessary, and a nonjudgmental attitude can help adolescents navigate this challenging phase successfully.

A problematic child, often labeled as such due to challenging or disruptive behavior, is a complex issue that requires a multifaceted approach. It's crucial to recognize that behind the challenging behaviors lie a variety of underlying factors, including environmental influences, emotional and psychological needs, learning difficulties, and social interactions. Labeling a child as a "problem" oversimplifies their situation and can be stigmatizing.

Understanding and addressing the needs of a problematic child involves a combination of assessments, interventions, and support systems. Early identification of underlying issues, such as learning disabilities, emotional distress, or family dynamics, is essential. Equally important is providing a nurturing and consistent environment, effective discipline strategies, and access to appropriate therapies and counseling.

Furthermore, it's vital to approach the child with empathy and patience, recognizing that their behavior often serves as a way of expressing unmet needs or coping with challenges. Collaborative efforts between parents, caregivers, educators, and mental health professionals are key to helping a problematic child overcome their difficulties and develop into a well-adjusted and thriving individual.



Ultimately, the journey of understanding and supporting a problematic child is a journey towards providing the child with the tools and resources they need to reach their full potential, navigate life's challenges, and build a brighter future.

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Unravelling the Challenge of Addiction Disorders among Young Adults in Kerala

Kerala, often referred to as "God's Own Country," is celebrated for its natural beauty, vibrant culture, rich traditions, delectable cuisine, beautifully designed houses and buildings, high literacy rate, profound human relationships, and a strong emphasis on physical and social health. However, beneath this picturesque landscape and healthy lifestyle lies a very concerning issue that silently spoils the state by gripping the young adult population – the challenge of addiction disorder.

As our society evolves, so do the challenges faced by our youth. Mental health issues are becoming a growing concern, impacting their physical and social well-being.

Through this article, I am aiming to shed light on the prevalence, causes, and significance of adopting a holistic approach with Homoeopathic Psychiatry to combat addiction disorders in young adults of Kerala.

Kerala, like any other region, is not immune to the global rise in addiction disorders. Substance abuse, alcohol addiction, gaming addiction, and internet addiction have become prevalent among young adults, often leading to severe consequences on their personal and professional lives. The combination of peer pressure, stress, easy access to substances, and societal misconceptions about addiction have contributed to this alarming situation.

Certain factors play an important role in the development of these addictive disorders, such as

1. Peer Influence: The desire to fit in and gain acceptance among peers often leads young adults to experiment with substances, which can ultimately lead to addiction.

2. Stress and Anxiety: The competitive nature of modern-day living and academic pressure can push young adults towards self-destructive coping mechanisms like substance abuse or excessive internet use.

3. Family Dynamics: Dysfunctional family environments, lack of emotional support, and a history of addiction within the family can increase the risk of addiction disorders in young adults.

4. Accessibility: The easy availability of drugs and alcohol, especially among urban youth, makes it challenging for them to resist temptation.

5. Mental Health Issues: Young adults with underlying mental health disorders, such as depression and anxiety, may turn to substances to self-medicate, worsening their condition.

Homoeopathic Psychiatric Association of Kerala offers a holistic approach towards understanding and treating addiction disorders in young adults. Unlike conventional medicine, which primarily focuses on symptom management,

Homoeopathic Psychiatrists delve deeper into the individual's physical, social, emotional and mental aspects to address the underlying imbalances that contribute to these addictive conditions. A few methods for that are:

1. Individualized & Personalized Approach: Each young adult's addiction experience is unique, and Homoeopathic Psychiatry customizes treatment plans based on their specific symptoms, personality traits, and addictive behaviour.

2. Detoxification and Rehabilitation: Homoeopathic psychiatric remedies are effective in gently detoxifying the body from addictive substances and supporting the rehabilitation process. This helps in minimizing withdrawal symptoms and cravings, making the recovery journey more manageable.

3. Addressing Underlying Emotional Issues: Homoeopathic Psychiatry addresses emotional imbalances, such as anxiety, depression, and low self-esteem, which are often linked to addiction disorders. Providing mental and emotional support, helps young adults cope with their addiction triggers more effectively.

4. Stress Management: Homoeopathic remedies offer stress-relief solutions and techniques to help young adults manage stress and anxiety without resorting to addictive substances.

5. Lifestyle Modification: Homoeopathic Psychiatry encourages positive lifestyle changes, including adopting a balanced diet, engaging in regular physical activity, and practicing mindfulness techniques, to promote overall well-being and prevent relapse.

6. Parental Guidance: In this context of addiction, the Homoeopathic Psychiatric Association also emphasizes the importance of parental guidance. Open communication, defined boundaries, and unwavering support are the keys. Seeking professional help, staying informed, role-modelling healthy behaviours, and encouraging positive activities all contribute to a holistic approach from the Homoeopathic Psychiatric viewpoint for overcoming these.

Addiction disorders have become a pressing concern for the young adult population in Kerala, posing significant challenges to their well-being and future prospects. A holistic approach is essential to combat this issue effectively, where Homoeopathic Psychiatric Medicine provides a promising solution.

By understanding the root causes, providing individualized treatment, addressing emotional imbalances and guiding the parents, our Homoeopathic Psychiatric doctors empowers the young adults to break free from addiction and lead healthier, fulfilling lives. Embracing this integrative approach can pave the way for a brighter future for the young adults of Kerala, promoting overall mental health and well- being of our society.

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"Deciphering the Gut-Brain Mechanism: Paving the Path to Mental Wellness"

Discovering the Gut-Brain Link: A Journey to Better Mental Health

In our pursuit of mental well-being, there's a fascinating discovery that's changing the game—the Gut-Brain Axis (GBA). This intricate system is like a secret bridge between your gut and your mind, and it's holding some of the most promising clues to understanding and addressing mental health challenges

The history of the gut-brain connection dates back to the nineteenth century when concepts of dyspepsia and neurasthenia gastrica highlighted the influence of the gut on emotions and thoughts.

The Gut-Brain Axis: A Crucial Nexus for Mental Health

In our pursuit of mental well-being, there's a fascinating discovery that's changing the game—the Gut-Brain Axis (GBA). This intricate system is like a secret bridge between your gut and your mind, and it's holding some of the most promising clues to understanding and addressing mental health challenges.

Your Gut's Role in Mental Health: A Hidden Hero

One of the most exciting things about the GBA is its impact on mental health. Think about stress and inflammation, two common foes in the battle against mental disorders. When they come knocking, the GBA activates what's called the HPA axis, releasing cortisol, a stress hormone that sends ripples throughout your body and brain. It's a key player in the world of stress-related mental disorders.

Microbiome-Gut-Brain Axis: A Microscopic Revolution

Your gut is home to a bustling community of microorganisms, like a mini-city in your digestive tract. Astonishingly, these little residents produce neuroactive molecules that can affect gut peristalsis, sensation, and even brain function. Dysbiosis, an imbalance in the gut microbiota, has been linked to a spectrum of central nervous disorders and mood disorders.

The Role of Diet and Lifestyle

Your lifestyle and dietary choices also play a significant role in shaping the GBA's influence on your mental health. A balanced diet rich in fiber and nutrients supports a diverse gut microbiome, which in turn can positively impact your mood and cognitive function. Regular physical activity and stress management techniques can further enhance the harmony between your gut and brain.

Environmental Factors and Mental Health

It's not just what you eat and how you live; environmental factors also come into play. Studies suggest that exposure to natural environments, such as green spaces, can promote a healthier gut microbiome and contribute to improved mental well-being. Conversely, urban living and high-stress environments may disrupt the delicate balance of the GBA, potentially increasing the risk of mental health issues.

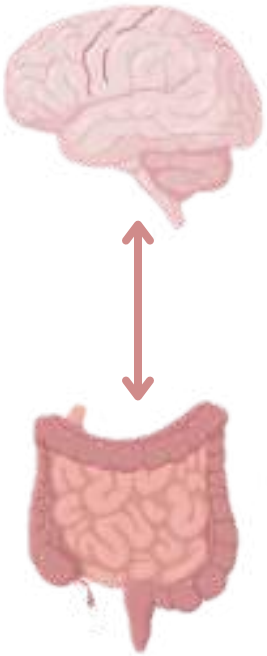
The Gut-Brain Connection Across the Lifespan

The Gut-Brain Axis (GBA) is a lifelong companion that begins its influence before we're even born. In early development, it lays the foundation for mental well-being by shaping the formation of neural pathways.

Research suggests that the microbial inhabitants of a baby's gut, acquired during birth and early infancy, have a profound impact on cognitive and emotional development. Nurturing this connection during infancy is like planting the seeds for lifelong mental well-being.

Throughout childhood and adolescence, the GBA continues to play a pivotal role. The balance of gut microbiota and the quality of nutrition become critical factors. Imbalances in the gut microbial community during these formative years have been linked to developmental and behavioral disorders. Furthermore, the GBA's influence on mood regulation and cognitive function can significantly affect academic and social success. Moving into adulthood, the GBA's impact reaches its zenith, with stress taking a central stage in mental health

Lastly, in the golden years, the GBA's significance persists. Changes in gut microbiota composition due to aging can influence cognitive decline and the development of neurodegenerative diseases. Recognizing the GBA's impact on mental health in later life becomes crucial for preserving cognitive function and emotional well-being, ensuring a high quality of life during our senior years.



Gut- Brain Axis

A New Hope for Mental Health Treatment

Here's where it gets exciting. Thanks to our growing understanding of the GBA and the MGBA, new possibilities for mental health treatments are on the horizon. Probiotics and antibiotics are being explored as tools to manipulate gut microbiota and influence GBA interactions. These developments hold promise for more targeted and effective treatments for mental disorders, offering hope to millions.

The Gut-Brain Axis is an incredible revelation in the world of mental health. Its influence on everything from stress to the microscopic world of gut bacteria underscores its vital role in our mental well-being. As we continue to explore this hidden connection, we stand at the brink of potentially transformative breakthroughs in how we treat and prevent mental disorders. It's a journey that offers hope and new possibilities for anyone seeking better mental health.

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ADJUSTMENT DISORDERS: BRIDGING THE GAP BETWEEN STRESS AND MENTAL HEALTH - AN IN-DEPTH ANALYSIS

ABSTRACT

Adjustment disorders are characterized by an emotional response to a stressful event. It is one of the few diagnostic entities in which an external stressful event is linked to the development of symptoms. Typically the stressor involves financial issues, a medical illness, relationship problems etc. This article explores the domain of Adjustment Disorder, investigating its general management strategies, and delving into the application of Homoeopathy in Adjustment Disorders.

INTRODUCTION

In today's world, Adjustment Disorder is alarmingly prevalent, affecting approximately 12% of the global population.

According to a survey conducted by the WHO WPA, involving 4887 psychiatrists worldwide, Adjustment Disorder stands out as one of the most frequently diagnosed mental health conditions, ranking 7th out of 44 categories.

Despite its widespread occurrence, this disorder has been significantly under-researched, receiving minimal attention. Recent redefinition of Adjustment Disorder in the ICD 11 has elevated it from a residual category to a fully recognized syndrome, sparking new avenues for research and understanding.

Given its prevalence and evolving diagnostic criteria, it is crucial to comprehensively comprehend, diagnose, and treat this condition in the contemporary context.

DEFINITION

'Adjustment Disorder (F43.2) is the state of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of stressful life events.'

The onset is usually within one month of occurrence of the stressful event or the life change, and the duration of symptoms usually does not exceed six months, except in the case of prolonged depressive reaction.

The manifestations vary, and include depressed mood, anxiety, worry (or a mixture of these), a feeling of inability to cope, plan ahead or continue in the present situation and some degree of disability in the performance of daily routine.

HISTORY

The earliest comprehensive clinical understanding of Adjustment Disorder and its appropriate treatment can be traced back to the 11th century when the physician-philosopher Avicenna provided the first recognizable description. The concept of Adjustment Disorder has been present since DSM I in 1952 when it was termed Transient Situational Personality Disorder. This designation was later altered to Adjustment Disorder in DSM III in 1980 and was included in ICD 9 in 1978.

For a considerable period, this diagnosis remained overlooked in both research and clinical practice and was surrounded by controversies. Some viewed it as a fabricated condition designed to aid clinicians in addressing mild cases that did not fit any other diagnosis.

Others considered it a medicalization of life problems. However, its status gained recognition when it was repositioned under Neurotic, Stress-related, and Somatoform Disorders in ICD 10. Recent studies have proposed specific criteria for diagnosing Adjustment Disorder, elevating its standing as a comprehensive diagnosis.

ETIOLOGY

Nature of Stressor: The group diagnosed with adjustment disorder showed a higher level of recognition of the stressor compared to other diagnoses. It was disproportionately represented in the 'higher stress category.'

Modifiers of Stressor: Stress has been identified as the causal factor for Adjustment Disorder. Vulnerability to stress constitutes another risk factor. Various factors and modifiers play a role in determining who will develop Adjustment Disorder after experiencing stress.

DIAGNOSTIC GUIDELINES

Diagnosis depends on a careful evaluation of the relationship between:

a. Form, content and severity of symptoms

b. Previous history and personality

c. Stressful event, situation or life crisis.

The presence of this third factor should be clearly established and there should be strong, though perhaps presumptive, evidence that the disorder would not have risen without it.

SUB TYPES

1. Brief Depressive Reaction F43.20

   A transient, mild depressive state of duration not exceeding one month.

2. Prolonged Depressive Reaction F43.21

   A mild depressive state occurring in response to a prolonged exposure to a stressful situation but of duration not exceeding two years.

3. Mixed Anxiety and depressive reaction F43.22

Both anxiety and depressive symptoms are prominent, but at levels no greater than specified in mixed anxiety and depressive disorder or other mixed anxiety disorder.

4. With predominant disturbance of other emotions F43.23

The symptoms are usually of several types of emotions, such as anxiety, depression, worry, tensions and anger.

5. With predominant disturbance of conduct F43.24

The main disturbance is one involving conduct.

6. With mixed disturbance of emotions and conduct F43.25

Both emotional symptoms and disturbance of conduct are prominent features.

7. With other specified predominant symptoms F43.286

COURSE AND PROGNOSIS

With appropriate medical intervention, the overall prognosis for adjustment disorder is generally favorable. Most patients are able to restore their previous level of functioning within a span of three months. However, it's crucial to note that certain individuals, particularly adolescents, diagnosed with adjustment disorder might later develop mood disorders or substance-related concerns. Adolescents typically require an extended recovery period compared to adults.

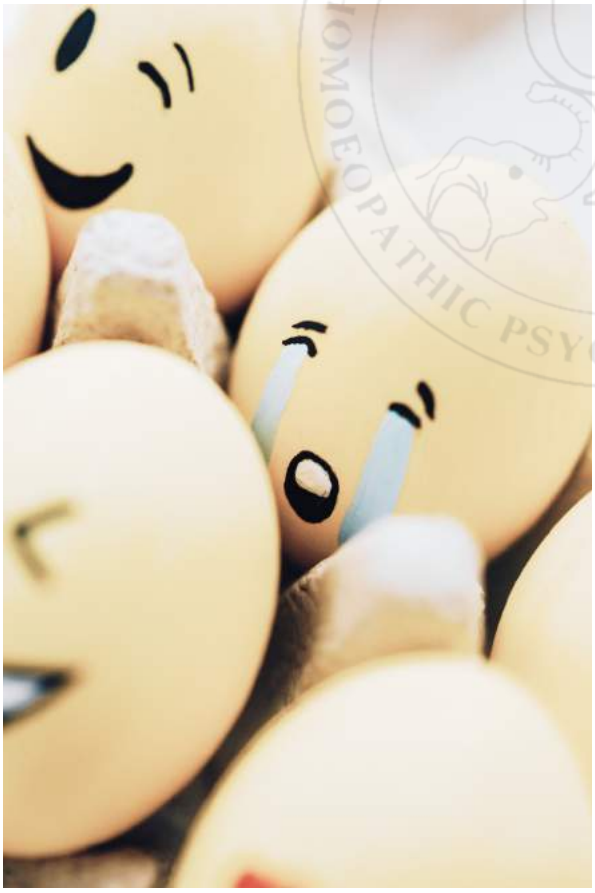
CULTURAL PERSPECTIVE

Cultural perspective considers the evidence that most cultures have an entity named for a process whereby an individual is stressed to the point of symptom development. The particular cultural variety of Adjustment disorder will be affected by

- The nature, intensity, and meaning of the stressor in question
- The nature of the modal personality configuration of the people involved, which includes style and/or rules about behavior and emotional expression
- Idiosyncratic features of the self in question
- The meaning that adjustment disorder has in the culture

ASSESSMENT

- Diagnostic Interview for Adjustment Disorder (DIAD), which is a structured clinical interview for adjustment disorder based on the DSM-5 criteria. The DIAD includes 29 items that aim to identify symptoms associated with a stressor, and evaluate the levels of distress and functional impairment associated with these symptoms.
- The Adjustment Disorder–New Module (ADNM) has been developed for the ICD-11 diagnosis of adjustment disorder, and is available as a structured clinical interview or self-report questionnaire.



GENERAL MANAGEMENT PSYCHOTHERAPY

Psychotherapy stands as the preferred treatment for adjustment disorders. Group therapy, especially for individuals experiencing similar stresses, proves beneficial. Successful therapy can lead patients to emerge stronger post-adjustment disorder, even if no previous pathology was apparent. Often, people think psychotherapy isn't necessary due to clearly identifiable stressors in adjustment disorders, believing the disorder will naturally resolve.

However, psychotherapy aids adaptation to irreversible or prolonged stressors and acts preventively if the stressor eventually resolves.

CRISIS INTERVENTION

Crisis intervention and case management are brief therapeutic approaches designed to assist individuals with adjustment disorders in swiftly resolving their situations. These methods employ supportive techniques, suggestions, reassurance, environmental adjustments, and, when required, hospitalization.

HOMOEOPATHIC APPROACH

Homeopathy is a therapeutic approach rooted in the Law of Similar, where successful application depends on Individualization and Susceptible Constitutions. Disease, as per this perspective, represents the total response of an organism to adverse environmental factors, conditioned by inherited and acquired constitutional factors, and manifesting through emotional, intellectual, and physical symptoms.

In the clinical practice of homeopathy, understanding the patient's spiritual essence and true identity is crucial. The approach cannot merely focus on isolated symptoms or specific organic dysfunctions; instead, it must consider the patient as a whole. Illness, being a reaction to an unfavorable environment, is shaped not only by the factors causing it but also by the individual's constitution. A person's constitution encompasses their physical and mental makeup, evident through physical characteristics, desires, aversions, reactions, as well as emotional and intellectual attributes.

Our master, Dr. Hahnemann, believed that diseases result from disturbances in the vital force governing the body. Derangements in the vital force manifest as morbid signs and symptoms. According to this perspective, there are no isolated local diseases; no organ can become diseased without a prior disturbance in the vital force.

Therefore, treating an individual as a whole, rather than focusing on specific parts, is the fundamental principle of homeopathic treatment.

Similarly, when individuals encounter the same stressor, their responses differ markedly due to their unique characteristics. Each person reacts uniquely owing to their individuality. Therefore, it is crucial to approach each patient in a personalized and holistic manner to ensure an effective and comprehensive cure. This involves considering not only the specific stressor but also the individual's overall physical, mental, and emotional well-being for a thorough and individualized treatment approach.

RECENT ADVANCEMENTS

ICD 11 AND DSM V:

Conceptualization of adjustment disorder, however, is currently in a state of transition. With the most recent revisions of DSM-5 and ICD-11, Adjustment disorder has been increasingly recognized as an important target for research.

DIAGNOSTIC CRITERIA:

The historical narrative for adjustment disorder in DSM and ICD has been described elsewhere and provides a useful background to the current criteria.

In DSM-5, adjustment disorder was reclassified to sit alongside PTSD and ASD in the Trauma- and Stressor-Related Disorders chapter. Despite this, the diagnostic criteria remained effectively unchanged from the DSM-IV, as the committee decided that any proposed any changes would be a theoretical given the lack of research that had been conducted in to the disorder. The focus of the DSM 5 approach to Adjustment disorder has remained on distress impairment associated with a stressor that is judged to be excessive (relative to cultural norms).

On the other hand, the ICD-11 introduced changes that marked a significant paradigm shift. In line with DSM, ICD recognized adjustment disorder as a stressor related disorder by categorizing it within the chapter Disorders Specifically Associated with Stress. It diverges from DSM by conceptualizing adjustment disorder as a failure to adapt to a stressor as evidenced by preoccupation with the stressor and its consequences.

CONCLUSION

The concept of diagnosing adjustment disorder raises numerous questions within the medical community. Despite its high prevalence, this disorder has been significantly under-researched and lacks substantial attention. One reason for this neglect is the frequent misrecognition of the disorder, often leading to misdiagnosis and inappropriate treatment. Historically perceived as a mild condition in comparison to other psychiatric disorders, recent studies in this area have revealed its severity, urging for its recognition as a full-threshold diagnosis.

Remarkably, even though adjustment disorder ranks among the most common diagnoses in both adults and adolescents at risk of suicide, it has received minimal academic focus. Research assessing the effectiveness of medical interventions has only recently commenced, indicating a vast scope for further in-depth studies in this critical medical domain.

REFRENCES

❖ Lakshmi, Guru Prasanna, Effectiveness of an Integrative Approach on Adjustment Disorder, Psychology and Behavioural Science International Journal. 2017 Aug 10, 5:4.

❖ Reed GM, Correia JM, Esparza P, Saxena S, Maj M. The WPA-WHO global survey of psychiatrists' attitudes towards mental disorders classification. World Psychiatry. 2011 Jun;10(2):118-31.

❖ Maercker A, Lorenz L. Adjustment disorder diagnosis: Improving clinical utility. The World Journal of Biological Psychiatry. 2018 June22;19(sup1):S3-13.

❖ Bachem R, Casey P. Adjustment disorder: A diagnosis whose time has come. Journal of Affective Disorders. 2018 Feb 1;227:243-53.

❖ Casey P, Doherty A. Adjustment disorder: implications for ICD-11 and DSM-5. The British Journal of Psychiatry. 2012 Aug;201(2):90-2.

❖ WHO Geneva, The ICD 10 Classification of Mental and Behavioral Disorder, A.I.T.B.S Publishers and Distributors, 149-151.

❖ Benjamin James Sadock , Virginia AlrottSadock , PeroRiuz, Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 9th Edition, Vol II, 2187- 2196.

❖ Patricia Casey, Adjustment disorder from controversy to clinical practice, Oxford University Press.

❖ Micahel G. Gelder, Nancy. C. Andreasen, Juan J Lopez, John R Geddes, New Oxford Textbook of Psychiatry, 2nd edition, Vol I, Oxford University Press, 716-721.

❖ Luc De Schepper, Hahnemannian Textbook of Classical Homeopathy for the Professional, B Jain Publications, 143-153

❖ Kent, J T, Lectures on Homoeopathic Philosophy, 7th edition, B Jain publishers,31-38.

❖ ML Dhawale, Hahnemannian Totality Symposium, Standardization V,Symposium Council, B.4-B.7, B.53.

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PSYCHIATRIC CORRELATION OF ATOPIC DERMATITIS AND ITS HOMOEOPATHIC MANAGEMENT

Abstract

Atopic dermatitis or atopic eczema is a chronic relapsing inflammatory skin condition. It is the cutaneous expression of the atopic state characterized by patches and plaques of erythema, scaling, lickenification with pruritus. The disease often begins in infants and toddlers, presenting as erythematous and pruritic maculopapular eruptions. AD was the commonest dermatosis in children registered to a paediatric dermatology clinic where it constituted 28.46% of all registered patients patients. This article reviews knowledge about the atopic dermatitis, diagnostic criteria, general management, psychological treatment and homoeopathic management.

Keywords:

Atopic dermatitis, Central nervous system, Immunoglobulin E, Type 2helper T cells, Histamines, Cytokines, Leukotrienes, Neuropeptides, Neurotism, Homoeopathic management.

Introduction

The field of psychodermatology focuses on the interaction between the mind, the brain, and the skin. Skin is an organ of expression, and responds to emotions with blushing, pallor, piloerection, and perspiration. The interaction between mind, brain and the skin are variable; psychopathological factors can play an etiological role in the development of skin disorders or exacerbate pre-existing skin disorders. Atopic dermatitis is a chronic inflammatory disease of skin, characterized by pruritus, mild to severe erythema, scaling, excoriation, and lichenification of the skin. [1,2]. Which is commonly distributed in ante cubital and popliteal fossae or may be widespread1. The onset is usually in the first year of life and clinical course improves by puberty. Both sexes are affected, but boys are some what more affected during the infantile phase.[3]

The disease can be divided into three stages; infantile atopic dermatitis, occur ring from 2 months to 2 years of age; childhood atopic dermatitis, from 2 to 10 years; and adult atopic dermatitis. In all stages pruritus is the hallmark. Itching often precedes the appearance of lesions, hence the concept that atopic dermatitis is “the itch that rashes”.[4]

CLINICAL CRITERIA FOR THE DIAGNOSIS OF ATOPIC DERMATITIS PRURITUS AND SCRATCHING

- **Course marked by exacerbations and remissions.**
- **Lesions typical of eczematous dermatitis**
- **Personal or family history of atopy such as asthma, allergic rhinitis, food allergies or eczema.**
- **Clinical course lasting longer than 6 weeks.**[1]

Risk factors

Individuals with atopic dermatitis may have a personal or family history of atopic disease groups such as allergic rhinitis, allergic conjunctivitis, bronchial asthma etc.

Pathophysiology

Pathophysiology involves multiple factors including genetic, environmental, and psychological factors, which interact with underlying psycho neuro immunological mechanisms, leading to multifactorial pathogenesis. Patients with atopic dermatitis have a genetic predisposition, and about two-thirds of them have a positive family history of atopic dermatitis.

In acute stage of atopic dermatitis, in uninvolved skin the cutaneous microenvironment favors a humoral immunity with predominance of mast cells, eosinophils, IGE and circulating TH2 lymphocytes. In the acute immune response, serum IgE plays a major role in pathogenesis and binds to mast cells basophils and Langerhans cells. An acute response is triggered by IgE mediated inciting antigen (food items such as milk, eggs, wheat; aeroallergens like dust, mites, pollen), which is presented to T cells. A persistence of irritative mechanical (scratching)and inflammatory stimuli can result in chronic phase.

Individuals are more vulnerable to experience itching in response to minor stimuli and emotional upsets, resulting from CNS arousal, which can enhance the vasomotor and sweat responses in skin and lead to lowered itch threshold, which triggers the scratch response. The sensation of pruritus is modulated by itch specific C receptors on unmyelinated sensory nerve fibers and is mediated by histamines, cytokines, leukotrienes, and neuropeptides.

Psychopathology

Individuals with atopic dermatitis have been found to have increased anxiety and depression. The severity of pruritus was directly correlated with severity of depressive symptoms. Depression and anxiety can magnify the itch perception and enhance the scratching behavior. The emotional state in atopic dermatitis children is closely related to the severity of dermatitis. Adult patients with atopic dermatitis are found to have chronic anxiety disorders and a tendency to internalize anger in conflicted relationships. [2]

General management

Infants and children

Stress, heat, sweating, and external irritants may precipitate an attack of itching and dermatitis. Hot baths, alkaline soaps, vigorous rubbing and scrubbing are to be avoided. Water should be kept tepid. Immediately after bathing, an evaporation barrier should be applied to the skin.

Adults

Over bathing must be avoided and soap used only on the axillae, anogenital region, and scalp. The patient should not wear wool, because its fibers are irritating. The patient should be aware that emotional stress can be an important factor in causing exacerbations. [4]

Treatment

The role of Psychiatric treatments in patients with atopic dermatitis includes reduction of itching or scratching, treatment of associated anxiety and depressive symptoms, and improvement in conflicted relationships.

Habit reversal training-behavioral modalities focus on interrupting the vicious cycle of itching and scratching.

Psychotherapeutics treatment such as cognitive behavioral therapy, relaxation training, meditation and stress management are clearly more effective than standard somatic-medical treatments alone. The psychological treatments were effective in reducing anxiety, depression, and neurotism thus providing stable adjunctive treatment response to standard medical care of atopic dermatitis. Combinations of psychotherapeutic interventions resulted in reduction of the itch-scratch cycle, less use of local and systemic steroids, and longer periods of remission. [2]

Homoeopathic management

Reportorial approach

Symptoms related to atopic dermatitis from different repertories have been given below.

Pocket manual of Homoeopathic Materia Medica and Repertory William Boericke

Skin -eczema
Skin-eczema-face
Skin -eruptions, dry, Scaly
Skin-pruritus, ameliorated from scratching.
Skin-pruritus, followed by bleeding, pains, burning. [5]

Repertory of Hering'sguiding symptoms of our Materia Medica-Calvin B Knerr

Skin-eruptions-eczema
Skin-eruption-bleeding
Skin-eruption-mental condition (derangement)
Skin-eruption -eczema-itching
Skin-eruption -desquamation. [6]

Kent's Repertory of the Homoeopathic Materia Medica

Skin-eruptions-eczema
Skin-eruptions-eczema-itching-perspiration-aggravation
Skin-itching-scratch until it bleeds, must.
Sleep-sleeplessness-itching, from. [7]

Repertorium Homoeopathicum syntheticum - Dr. Frederik Schroyens

Skin-eruptions-eczema -atopic
Skin-eruptions-eczema-childhood since
Skin-eruptions eczema-itching
Skin-eruptions-eczema-discharging Face-eruptions-eczema-moist [8]

Synthesis repertory

Skin-eruptions -eczema
Ars, Anthracinum, Calc, Cal.sulph, Graph, Hep. sulp, Dulc, Nat.mur, Rhus.tox, Phos, Sulph, Sep, Psor

Some of the medicines found to be useful in cases of atopic dermatitis are discussed below. But these medicines should be prescribed according to symptom similarity.

Arsenicum album

Burning pains; the affected parts burn like fire, as if hot coals were applied to parts >heat, hot application. Symptoms generally worse from 1-2 pm,12-2am. Skin dry, scaly, itching burning and swellings. Oedema, eruptions, papular, dry, rough [9] and scaly. Black vesicles and burning pain. Worse by cold and scratching. [5]

Graphitis

Unhealthy skin. Eruptions upon the ears, between fingers, toes and on various parts of body, from which oozes a watery, transparent, sticky fluid9. Rawness in bends of limbs, groins, neck, behind ears <warmth, at night>wrapping up. [5]

Psorinum

The body has a filthy smell, even after bathing. Dry, scaly eruptions disappear in summer, return in winter. Sleepless from intolerable itching. Driven to despair with excessive itching. Eruptions easily suppurates.[9] Eczema behind ears5. Crusty eruptions all over. Herpetic eruptions, especially on scalp and bends of joints with itching. Worse from warmth of bed.[9]

Rhus tox

Eczema of the lower limb.[10] Skin is red, swollen with intense itching.[5] Burning eczematous eruptions with tendency to scale formation. Night sweat with much itching eruptions. [9]

Sepia officinalis

Itching in various parts of skin. Itching worse in bends of elbows and knees. Itching is not better by scratching<sweating[5] warmth of bed, hot applications. [9]

REFERENCES

1.Kasper D, Fauci A, Hauser S, Longo D, Jameson J, Loscalzo J. Harrison's principles of internal medicine, 19e. New York, NY, USA: Mcgraw-hill; 2015.306,309 pg.

2.Kaplan HI, Sadock BJ. Comprehensive textbook of psychiatry, Vol 2. Williams& Wilkins Co; 1989.2340-41,42.

3.Kanwar AJ, De D. Epidemiology and clinical features of atopic dermatitis in India. Indian J Dermatol.2011 Sep- Oct;56(5):471-5. doi: 10.4103/0019-5154.87112. PMID:22121256; PMCID: PMC3221201.

4.Arnold HL, Andrews GC, Odom RB, James WD. Andrews' diseases of the skin: clinical dermatology. (No Title). 1990 Jan.69 pg.

5.Boericke W. Pocket Manual of Homoeopathic Materia Medica & Repertory: Comprising of the Characteristic and Guiding SymptomsofAll Remedies (clinical and Pathogenetic [sic]) Including Indian Drugs. B. Jain publishers; 2002.311- 12,534,554,588,906-907,912-913 pg.

6.Knerr CB, Herring C. A Repertory of Herring's Guiding Symptoms of our Materia Medica. FA Davis; 1896.1802,1154 pg.

7.Kent JT. Repertory of the homoeopathic materia medica. B. Jain Publishers; 1992.12531312,1328 pg.
8.Katz T. Synthesis-Repertorium Homoeopathicum Syntheticum. Edited by Frederik Schroyens. London: Homoeopathic Book Publishers. ISBN 0982274493. l129.1852 pg.
9.Allen HC. Keynotesand characteristics with comparisons of some of the leading remedies of the MateriaMedica with Bowel Nosodes. B. Jain Publishers; 2002.43,140,247-248 pg.
10. Kent JT. Lectures on Homoeopathic Materia medica. New Delhi, India: Jain Publishing Company; 1980.883pg.

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HOMOEOPATHIC APPROACH TO SCHIZOPHRENIA- A REVIEW

Introduction

Schizophrenia is characterized by significant impairment in reality testing and alterations in behavior manifest in positive symptoms, negative symptoms and psychomotor disturbances. Schizophrenia affects approximately 24 million people or 1 in 300 people (0.32%) worldwide. It is equally prevalent in males and females. Age of onset is 10-25 years in males and 25-35 years in females.

Many biological, psychological and family theories have been proposed regarding the etiology of schizophrenia. Genetics constitute a crucial risk factor to schizophrenia. Substance abuse is common in schizophrenia patients. Alcohol increases the psychotic symptoms. Cannabis use precipitate schizophrenia in susceptible individuals. However nicotine improves cognitive impairment in such patients.

Schizophrenia is an illness that happens to a person with a unique psychological makeup. There is no such thing as treatment to schizophrenia. All therapeutic interventions must be tailored to the unique needs of the individual patient. Homoeopathy is a science which treats each case based on individualizing symptoms. Medicines are tailored according to the characteristics of the individual not on the nosological basis. This study is done to have a brief review of the role of Homoeopathy in schizophrenia.

Methodology

A narrative review was done by searching Pubmed, IJRH and google scholar. Reference books related to medicine and homoeopathy were also reviewed. The search used the keywords like Schizophrenia, Homoeopathy, psychiatry, hallucinations, paranoia, ICD-10, DSM-5, etc.

Homoeopathic concept of schizophrenia

Master Hahnemann has given detailed description of mental disease under aphorism 210 to 230 in Organon of medicine. According to his philosophy, schizophrenia comes under third category of mental disease which has a doubtful origin. Mental diseases are considered to be of psoric origin and require antipsoric treatment for their complete restoration

Previous research on schizophrenia in Homoeopathy

There are few published studies on Schizophrenia in Homoeopathy. A prospective, non-comparative, open-label observational study carried out from October 2005–September 2010 by Central Council for Research in Homoeopathy revealed a significant difference in the Brief Psychiatric Rating Scale score at the end of the study. Sulphur, Lycopodium, Natrum muriaticum, Pulsatilla and Phosphorus were found to be the most useful medicines in treating schizophrenic patients in that study. There are few other studies showing usefulness of Homoeopathic medicines in the treatment of schizophrenia. To the best of our knowledge, there is no published literature on randomized controlled trials conducted on schizophrenia in Homoeopathy.

CASE TAKING OF SCHIZOPHRENIA PATIENTS

General principles

The following points should be noted during case taking of schizophrenia patients:

- Confidentiality
- Reliability of the source
- Rapport
- Empathic interventions
- Alert about transference and counter transference
- Initially open ended questions, later more specific questions (aph 87-89)
- Patients especially paranoid, may feel threatened and need to be reassured that they are safe
- Premature advice and interpretation should not be done
- Actively hallucinating individuals may be inattentive & distracted
- Paranoid patients may be suspicious of the purpose of the interview. So adapt interview to match the capacity & tolerance of the patient.
- They may not interpret the experience of hallucinations. It is useful to begin with general question : “do you ever hear someone talking to you when no one else is there”
- Ask for the content of hallucination

- Ask specifically for command hallucinations especially any suicidal or homicidal commands
- Test the strength of the belief in hallucination : “does it seem that the voices are coming from inside your head?”
- Do not challenge the delusions of the patient
- maintain a respectful distance from paranoid patients
- Suspiciousness may be increased by overly warm interview
- avoid sustained direct eye contact which may be perceived as threatening
- Avoid body postures that are threatening to the patient
- Rather than sitting face to face, psychiatrist may sit more side by side, looking out in case of paranoid patients.
- Safety should be the priority
- Terminate interview if patient’s agitation increases

Totality of symptoms

While constructing totality of symptoms in cases of schizophrenia, characteristic mental symptoms and physical concomitants must be given importance.

Mental symptoms are of three categories:-

1. Common symptoms of schizophrenia
2. Premorbid mental characters
3. Mental Characteristics (that individualize the patient) – higher rank, guide us to similimum.

Common symptoms of schizophrenia like delusions, hallucinations, suspiciousness etc has less value in selecting the remedy unless qualified. Consider the following symptoms while constructing the totality:

- Qualified mental generals
- reaction as a whole to bodily environment
- Cravings and aversions
- Menstruation
- Perspiration
- Sleep pattern
- Family History of corporeal Diseases
- Mental Ailments from (Where family history of Mental Disease is absent)

How to overcome difficulties in tracing the symptoms

- Skillful observation (aph 90)- schizophrenics are usually disheveled. Note down murmuring, posturing
- Confirm mental symptoms from friends and relatives (aph 84, 218). Observe expression of the patient's friend and relatives while patient narrating the symptoms.
- Ask about mother's state during pregnancy.
- Occupation and area of work are to be noted.
- How about relationship with friends, wife, family and social relationship.
- Try to establish rapport with the patient, so that the patient may reveal everything.

DR HAHNEMANN'S INSTRUCTIONS REARDING CASE TAKING

- Aph 210- 212 : state of disposition should be noted particularly with totality to determine the remedy
- Aph 218 : corporeal symptoms from patient's friends should be considered
- Aph 219 : consider the symptoms during lucid interval
- Aph 228: Auxillary mental regimen-To furious mania we must oppose calm intrepidity and cool, firm resolution, to doleful, querulous lamentation, a mute display of commiseration in looks and gestures, to senseless chattering a silence not wholly inattentive, to disgusting and abominable conduct and to conversation of a similar character total inattention. We must prevent the destruction and injury of surrounding objects, without reproaching the patient for his acts, and everything must be arranged in such a way that the necessity for any corporeal punishments and tortures may be avoided.
- Contradiction , eager explanation, rude corrections should be avoided
- Physician must pretend to believe them to be possessed of reason

SOME RARELY INDICATED HOMOEOPATHIC MEDICINES IN SCHIZOPHRENIA

Anholonium lewinii

They are the type of people who feel, even at an early age, that they do not belong to society, that they are something apart. They become distrustful and resentful toward society, and can have "existential anxiety." Anhalonium young people will be inspired by spiritual ideals and inclined to follow a path of inquiry and selfless renunciation and eventually turn to drugs. A form of intoxication accompanied by wonderful and a sensation of increased physical ability.

Also visions of monsters and various gruesome forms. Distrust and resentment. Exaggerated reverberation of ordinary sounds. Ideas and visions penetrate the individual's consciousness in too rapid a succession, seeming to impose themselves upon the individual, who cannot control them. He seems unable to resist them; he is compelled to attend to them, even to respond to them verbally. The peculiarity of Anhalonium in this regard is that the involuntary visions, which are often quite colorful, do not frighten the individual.

Actea racemosa

Insanity from suppressed eruptions & flow, menses; during pregnancy, labor, after labor. Mental and physical symptoms alternate. Acute psychosis during climacteric. If we ask questions, they will give u so much of information that you do not need. Unclear in her descriptions.You feel that they do not listen to you, they only listen to their inner thoughts. Suspicious of everybody. Fears those in the house will kill him (delusion of persecution). In acute mental conditions they will not even take the remedy. Aversion to those she loved best before. Illusion of hearing: she hears knocking & rumbling in house, believes that someone is running about. Illusion of a mouse running under her chair.

Cannabis indica

Cannabis indica is the one who is locked inside the house. This is not an ordinary house but a palace. Thus although he is very well provided materially, he is lonely. Inhibits the higher faculties and stimulates the imagination to a remarkable degree. A condition of intense exaltation, in which all perceptions and conceptions, all sensations and all emotions are exaggerated to the utmost degree. Subconscious or dual nature state. Apparently under the control of the second self, but, the original self, prevents the performance of acts which are under the domination of the second self. Produces the most remarkable hallucinations and imaginations, exaggeration of the duration of time and extent of space, being most characteristic. Extremely happy and contented, nothing troubles. Ideas crowd upon each other. Feels as if top of head were opening and shutting and as if calvarium were being lifted. Uncontrollable laughter even at serious remarks. The limbs and parts seem enlarged. Hears voices, bells, music, in ecstatic confusion. Imagines himself in a room of which the walls gradually close in upon him. Incoherent talking. When he speaks it seems as though someone else is speaking.

Hears the noise of colours; swims in an ocean of sounds; feels a cloud of music and perfume around himself; sees stars in his plate and the firmament in his soup dish; his vomit looks to him like the head of a hippopotamus, then like a bunch of worms; sees a silent army marching by, which is identified as the army of ages going by into eternity; has hallucinations of riding on horseback, of seeing blue water; thinks he is swimming or that he is captain of a vessel; water seems to be delicious nectar. He hears someone calling him, hears himself shouting and singing even when he doesn't do so in reality. He hears noise from a waterfall, which turns into the sounds of shouts of men shouting.

Anacardium

They feel isolated and unprotected and may need somebody to be with them all the time for support, yet at the same time they have an aversion to being with people, especially strangers: aversion to company. They can be real misanthropes, with a fear of associating with others. Eventually they will reach a stage of paranoia where they suspect everybody and feel that they are being followed, pursued by others who want to do them harm. Irresistible desire to curse. Fixed ideas. Hallucinations; thinks he is possessed of two persons or wills. Clairaudient, hears voices far away or of the dead. Strange temper, laughs at serious matters and is serious over laughable things. He hears voices commanding him to do this or that. Hallucinations: a demon sits on one shoulder and an angel on the other.

Mancinella

Fear: of getting crazy; of evil spirits. Fear of being possessed or taken away by evil spirits, the devil. Often seen in girls at puberty, after being frightened (e.g. horror movies) or because of strong religious upbringing. Afraid to pronounce the word 'devil'. Other fears like: Dark, ghosts, something bad will happen, crowds, cancer, etc.

CONCLUSION

Schizophrenia is a chronic psychiatric condition which requires treatment tailored to the needs of each patient. Homoeopathy can offer effective individualized treatment. More evidence based researches like randomized controlled trials are needed to prove the effectiveness of Homoeopathy in schizophrenia.

References

- International Classification of Diseases, Eleventh Revision (ICD-11), World Health Organization (WHO) 2019/2021
- https://www.who.int/news-room/fact-sheets/detail/schizophrenia

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (5 ed.) (DSM 5). Arlington,V A, APA; 2013
- 4. Ahuja N. A Short Text book of Psychiatry(7 ed.), New Delhi. Jitendar P Vij. Jaypee brothers, Medical publishers (P) Ltd 2011, P71
- 5. Henriksen, M. G., Nordgaard, J., & Jansson, L. B. (2017). Genetics of Schizophrenia: Overview of Methods, Findings and Limitations. Frontiers in Human Neuroscience, 11, 250542.
- 6. Sadock James Benjamin.Synopsis of psychiatry. 11ed.New Delhi. Wolters Kluwer(India) Pvt Ltd; 2015
- 7. Gabbard O Glen. Psychodynamic Psychiatry in clinical practice. 5 ed. New Delhi. CBC Publishers & distributors Pvt Ltd; 2017
- 8. Hahnemann S. Organon of medicine.5 ed.New Delhi:B Jain publishers;2002
- 9. Oberai P, Gopinadhan S, Sharma A, Nayak C, Gautam K. Homoeopathic management of Schizophrenia: A prospective, non-comparative, open-label observational study. Indian Journal of Research in Homoeopathy. 2016;10(2):108-18.
- 10. Gupta G. Schizophrenia and Homoeopathy: A Review. Alternative Therapies in Health & Medicine. 2023 Jul 1;29(5).
- 11. Moorthi SK, Radhika P, Devasia MN. Homoeopathy as an add-on treatment for schizophrenia: A case series.
- 12. Jayakumar M, Lalitha KS. A clinical study on paranoid schizophrenia and its homoeopathic management. IOSR journal of dental and medical sciences May. 2019;18(05):52-6.
- 13. Gilla D, Akhila AL, Raj N. Two Cases of Schizophrenia Treated with Individualized Homoeopathy. International Journal of High Dilution Research-ISSN 1982-6206. 2022;21(cf):89-102.
- 14. Boericke W. Boericke's New Manual of Homoeopathic Materia Medica with Repertory. New Delhi: B Jain Publishers (P) LTD; 2011
- 15. Sankaran R. The Soul of Remedies: Homoeopathic Medical Publishers;2014
- 16. Vithoulkas G. Materia Medica Viva. Greece: International Academy of Classical Homeopathy; 1997
- 17. Allen H C. Allen's Keynotes. 10 ed. New Delhi: B Jain Publishers (P) LTD; 2005
- 18. Kent J T. Lectures on Homoeopathic Materia Medica. New Delhi ; B. Jain Publishers (P) LTD;2009
- 19. Clarke JH. The Prescriber: How to Practice Homoeopathy.3 ed.New Delhi: B. Jain Publishers; 1998.
- 20. Schroyens frederick. Repertorium Homoeopathicum Syntheticum. 9.1. New Delhi:B Jain; 2014

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Individualized Homoeopathic Treatment of Social phobia: A Case Report

ABSTRACT

Background: 'Social phobia' is an anxiety disorder that places a significant physical, emotional and financial burden on patients and society. It had a chronic course associated with the development of co-morbidities. Although it is treatable, this disorder is under diagnosed, so that the affected individual do not receive appropriate treatment. Homoeopathy is an established system of medicine with proven effectiveness in certain mental health issues, but there is scarcity of literature on its usefulness in management of social phobia **Objectives:** The purpose of this Case Report is to put forward the usefulness of individualized homoeopathic medicine in the management of social phobia. **Method:** A case of social phobia reported in psychiatry out-patient unit treated by classical Homoeopathy is presented in this case report. The case was assessed at baseline and follow up visit with in 6 month. **Result:** American psychiatric association phobia scales [APAS], score of 38 at baseline turned to 0 within 6 months and maintained .There was remarkable improvement in fear as well as the general improvement of the patient after homoeopathic intervention. **Conclusion:** Individualized homoeopathic medicine is useful in reducing social phobia symptoms.

Keywords: American psychiatric association phobia scales [APAS], Individualized Homoeopathy, Silicea, Social phobia

INTRODUCTION

Phobia is defined as an irrational fear of specific object, situation or activity, often leading to persistent avoidance of the feared object, situation or activity .1 The word phobia was formulated from a Greek word “phobos”, meaning panic fear and terror . 2Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat .3Social phobia is characterized by excessive fear of embarrassment, humiliation, or rejection when exposed to possible negative evaluation by others when engaged in a public performance or social interactions. It is also referred to as social anxiety disorder (SAD).4 Social Phobias are classified under Phobic anxiety disorders (F40.1) in ICD 10. 5As per DSM V social phobias are mentioned as a subtype of Anxiety disorders.6

Social phobia has a worldwide prevalence of 5 to 10% and a lifetime prevalence of 8.4 to 15%.4Social anxiety disorder is the third most common mental disorder behind substance use disorder and depression and is the most typical anxiety disorder. These disorders are more common in less educated, unmarried, lower socioeconomic status.4 Risk factors are Parental over protectiveness, parental loss and separation, physical and sexual offenses, adverse or traumatic events

during childhood, history of childhood fears or night terrors, stress full events especially a loss, leaving the parental home, stepping into a romantic relationship, and becoming a parent, the experience of grief or bereavement early in life .Phobic disorders are mostly heritable.6

Malfunctioning of the amygdala and associated brain structure may give rise to phobias.7 Neurotransmitter γ-aminobutyric acid (GABA) inhibits the amygdale neurons which is necessary for the expression of fear. Increased Dopamine and Norepinephrine play a key role in amygdale activation. 850 % of social phobic symptoms are accompanied by a surge of plasma epinephrine which distinguishes it from panic attack.9

Social Phobia can cause serious life impairment, impaired social activity and reduce time and productivity at work. 10Phobic disorders can cause severe emotional distress, leading to anxiety disorders, depression, suicidal ideation and substance related disorders, especially alcohol abuse or dependence. 11There are several rating scales for measuring phobias. 12

For ease of use, particularly for individuals with more than one anxiety disorder, scales have been developed by American Psychiatric Association (APA) to have the same format (but different focus) across the anxiety disorders, with rating of behavioral symptoms, cognitive ideation symptoms, and physical symptoms relevant to each disorder.6 Social phobia are commonly treated by exposure-based therapy, applied tension, applied relaxation, cognitive therapy, benzodiazepines, selective serotonin reuptake inhibitor. Certain psychotherapy training modules consume long time with relapse in most of the cases, which in turn causes financial burden to the family. Most of the pharmaco-therapeutic interventions are associated with tolerance, dependence, relapses upon discontinuation and potential side effects.10,13 In this context safe and effective alternative treatment regimen should be explored in this area.

CASE REPORT

An 18-year-old female presented with fear of going into social places such as school, hospital, and temple. She had a lack of interest in studies and was not going to school due to fear for the last 1 month. Complaints started 3 years back when she was in the eighth standard. There were conflicts between her parents. She was tensed about that, became lazy for going to school and had difficulty in studying. She had not attended classes for 2 months at that time. She attended a counselling session but didn't find it helpful.

She had fear of exams but she got 92.6% marks in the tenth standard. Complaints gradually increased when she joined class entrance examinations coaching. Her father and uncle had a history of psychiatric problems. She was sensitive with weeping tendency and easily frightened by slight noises. She had profuse perspiration in her palms. Desired salt and averse to chicken, beef, sweets. Thermal reaction was chilly.

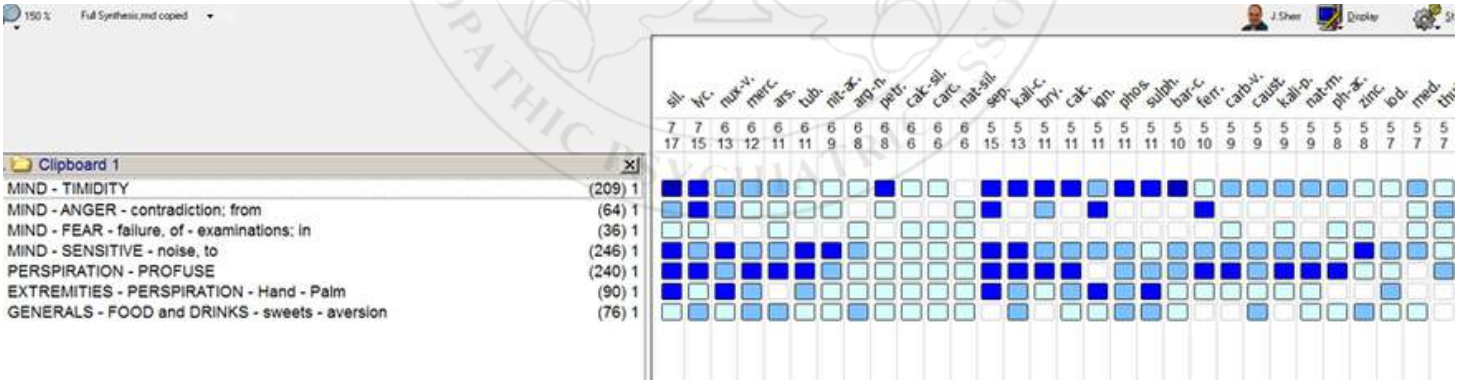
Diagnosis and Assessment

Case was diagnosed as : Social phobia (F40.1) as per ICD-10. Baseline assessment was done with APAS and during subsequent follow ups of 1, to 6months.

Intervention

Totality was erected and subjected to Repertorization in RADAR 10 (synthesis) repertory. Rubrics considered and the repertorial totality may be referred to in Figure no.1. Based on the totality of symptoms a single dose of Silicea 200/1 Dose was prescribed on the first visit followed by Sac lac for 1 month. In the following visits as the patient reported remarkable improvement in his mental distress, the remedy was allowed to continue its beneficial action and Sac lac was continued for the patient's satisfaction. Patient didn't receive any other medicine or any specific behavioral therapy except for a general counseling from the physician. Hence the results are attributable to the prescribed medicine.

REPERTORY CHART



APAS score at baseline: 38

First prescription:

Rx- SILICEA 200- 1 dose. Sac lac- 2 weeks.

Table 2: APA Severity assessment scale for SAD scores in the follow-up

	Baseline	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
Score	38	30	26	21	17	7	0

RESULTS

The case was assessed at baseline and follow up visits with APAS . APAS total score of 38 at baseline turned to 0 within 6 month. There was remarkable improvement after the very first visit and the sustained progress continued . Emotional stability of the patient was restored and there was improved quality of life of the patient.

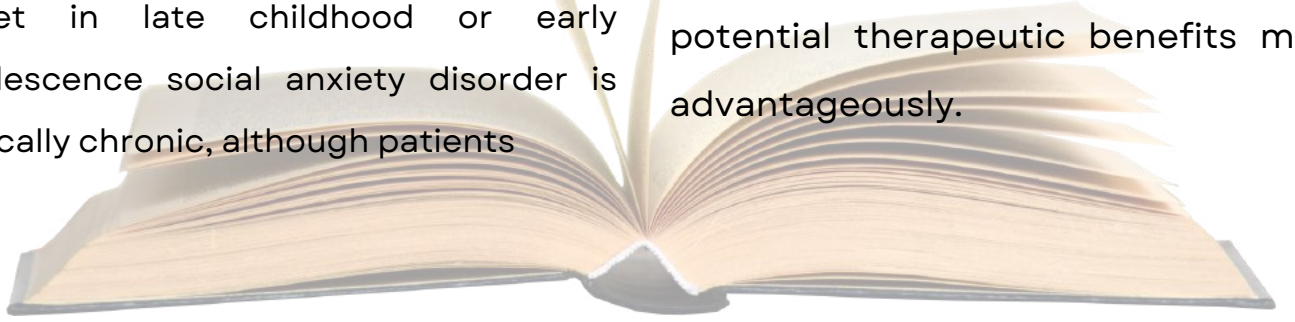
DISCUSSION

In the above case, there was considerable difference in the social phobic symptoms as well as in the general well-being of the patients after homoeopathic intervention. As the patients were not taking any other treatment or specific behavioral therapies during this 1-year period, the causality for the sustained improvement can be attributed to the prescribed homoeopathic medicines. Although most phobias develop in childhood and adolescence, it is possible for phobias to develop at any age.

Social anxiety disorder tends to have its onset in late childhood or early adolescence social anxiety disorder is typically chronic, although patients whose symptoms do remit tend to stay well. This can include disruption in school or academic accomplishment and interference with job performance and social development.3 Nowadays, Anxiety Disorders are a common problem among young adults. It may be due to their lifestyle and the influences of social media. Homoeopathic medicines are effective in making changes in their psyche, removes preconceived notions, enhance healing at the core, and allow gentle restoration to health.

CONCLUSION

This case illustrates that social phobia is amenable to treatment with individualized homoeopathic medicines which helps in reducing anxiety symptoms as well as behavioral issues in a person. Well-planned, methodologically sound studies are necessary to bring out the effectiveness and to utilize the potential therapeutic benefits more advantageously.



REFERENCES

1. Sadock BJ, Sadock VA, Ruiz P, Kaplan &Sadock's Synopsis of Psychiatry, Eleventh edition, Wolters Kluwer private limited New Delhi, 2018.407 [9O]

2. Marks IM. The classification of phobic disorders. Br J Psychiatry 1970;116:377-86.

3. Ahuja NA. Short Text book of Psychiatry. 7th ed. New Delhi: Jaypee Brothers Medical Publishers (P) Limited; 2011.

4. Rose GM, Tadi P. Social Anxiety Disorder. StatPearls [Internet]. 2021 Jan 31

5. World Health Organization The ICD Classification of Mental and Behavioural Disorders (10thed) Delhi, A.I.T.B.S. Publishers& Distributors;2007

6. American Psychiatric Association Diagnostic and statistical manual of Mental Disorders (5thed.) DSM-V. Washington, D.C, APA;1994

7. Winerman L. Figuring out phobia. Monit Psychol 2005;36:96. Available from: http://www.apa.org/monitor/julaug05/figuring. [Last accessed on 2020 Apr 02]

8. Garcia R. Neurobiology of fear and specific phobias. Learning & Memory. 2017 Sep 1;24(9):462-71.

9. Dr. Bhatia MS, Essentials of Psychiatry, 8th edition, CBS publisher, Delhi 2016, 250.

10. Singh J, Singh J. Treatment options for the specific phobias. Int J Basic Clin Pharmacol 2016;5:593-8.

11. Preda A, Bienenfeld D. Phobic Disorders Clinical Presentation; 2018. Available from: https://wwwemedicine.medscape.com/article/288016- clinica. [Last accessed on 2020 Apr 04].

12. Antony MM, Orsillo SM, Roemer L, editors. Practitioner's Guide to Empirically Based Measures of Anxiety. United States: Springer; 2001.

13. Bandelow B, Michaelis S, Wedekind D. Treatment of anxiety disorders. Dialogues Clin Neurosci 2017;19:93-107

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ART AND PSYCHIATRY

"Mystical Desires"----Knife painting
By Dr.Sreeja.K.R

Even in early 1800s, professionals were understanding mental illnesses through visual arts. They utilized images of people will mental illness created by artists. Later on beyond doing the portrayals of patients psychiatrists concentrated on art talents of patients. They took initiative in collecting and exhibiting those works.[1]

Hermann Rorschach the creator of famous psychiatric assessment tool Rorschach' ink blot was a psychiatrist as well as a good painter. He faced struggle to decide his career as both art and psychiatry attracted him. When he was in the medical school he spent his Saturdays at nearby art museum. He used to ask his friends what they felt on seeing each painting.

During his medical school time he attended the lectures of Carl Jung and became familiar with the works of Freud and Bleuler. He started working in an asylum after choosing psychiatry as his career. He kept visual patient files that included photographs and drawings by Rorschach. He had a childhood interest of making inkblots and creating story about them. His interest continued into adulthood. He further refined his final inkblots with his artistic skills so that each contained carefully placed contours which gave the idea or image of specific objects to most people. He could find that people perceive differently and he started using this for assessment and thus formed his famous Inkblot test. [2]

Vincent Van Gogh- A great artist, from his name evolved the term' Van Gogh syndrome'- a synonym for Non-suicidal Self-Injury seen in psychiatric patients. In fact, it is not even clear that Van Gogh was psychotic, one day he quarreled with his housemate, cutoff a part of his left ear and presented it to a maid in a brothel. Van Gogh wrote lucid letters, with no evidence of thought disorder or delusions, to his brother Theo on the day of the incident. Contemporaneous accounts from his physician and Theo describe Van Gogh as distressed immediately after the incident, but there is no suggestion of psychosis. Van Gogh committed suicide in 1890. A striking feature of van Gogh's famous painting "The Starry Night" is the yellow corona surrounding each star. The use of yellow characterizes many of the paintings of this Dutch post-impressionist, and much speculation surrounds van Gogh's fascination with this vibrant pigment. Because numerous disorders have been diagnosed posthumously in this artist, various theories have been proposed to explain how van Gogh's physical state may have influenced his work. Two theories center on why he used so much yellow. First, he was fond of absinthe, a popular liqueur, excessive consumption of which may cause the consumer to see all objects with a yellow hue. A second and more likely explanation involves overmedication with digitalis. People receiving large and repeated doses of this drug often see the world with a yellow-green tint. They complain of seeing yellow spots surrounded by coronas, much like those in "The Starry Night."[3]

'Starry night'—Painting by Van Gogh

Art therapy:

Art-making began gaining recognition as a treatment and positive coping mechanism around the 1940s. Adrian Hill engaged in art-making while recovering from tuberculosis and was the first to use the term "art therapy."[4][5] The development of art therapy comes partly from the artistic expression of the belief in unspoken things, and partly from the clinical work of art therapists in the medical setting with various groups of patients.[6]

How does art therapy help with mental health?

Symptoms of a mental illness can lower motivation, decrease cognitive abilities. These negative consequences of mental illness can lower self-esteem and confidence and cause one to withdraw from much needed social support. Through engagement with art-making, art therapy increases self-efficacy or a sense of mastery because the client tries something new. Art therapy also provides a nonthreatening way to explore emotions the client might be avoiding. Creating art can help the client see themselves as more than their illness and can also connect them to others, thus enhancing their identity and reducing their sense of isolation. A systematic review of the effectiveness of art therapy for nonpsychotic mental health disorders was conducted by Uttley et al. (2015) and concluded that art therapy is effective for people with nonpsychotic mental health disorders.[7]

The synthesis report by World Health Organization's (WHO) on the role of the arts for improving well-being found two main areas of how engaging in the arts benefits health such as prevention and promotion as well as management and treatment.[8] Fancourt et al (2019) found that engagement in the visual arts helps people gain insight, distracts from negative feelings, express strong emotions, reduce stress, and improve one's sense of self-worth. Researchers have also found that engaging in arts lowers the level of Cortisol, the stress hormone.[9]

REFERENCE

1.Rastogi M, Kempf JK. Art therapy for psychological disorders and mental health. In Foundations of Art Therapy 2022 Jan 1 (pp. 335-377). Academic Press.

2.https://www.britannica.com/biography/Hermann-Rorschach

3. Wolf P. Creativity and chronic disease. Vincent van Gogh (1853-1890). West J Med. 2001 Nov; 175(5):348. doi: 10.1136/ewjm.175.5.348. PMID: 11694494; PMCID: PMC1071623.

4.Waller D, Dalley T. Art therapy: A theoretical perspective. Art therapy: A handbook. 1992 Jun 1:3-24.

5. .Van Lith T. Art therapy in mental health: A systematic review of approaches and practices. The Arts in Psychotherapy. 2016 Feb 1;47:9-22.

6.Hu J, Zhang J, Hu L, Yu H, Xu J. Art therapy: a complementary treatment for mental disorders. Frontiers in psychology. 2021 Aug 12;12:3601.

7.Uttley L, Scope A, Stevenson M, Rawdin A, Buck ET, Sutton A, Stevens J, Kaltenthaler E, Dent-Brown K, Wood C. Systematic review and economic modelling of the clinical effectiveness and cost-effectiveness of art therapy among people with non-psychotic mental health disorders. Health Technology Assessment. 2015;19(18).

8.World Health Organization. Regional Office for Europe. (2019). Intersectoral action: the arts, health and well-being: sector brief on arts. World Health Organization. Regional Office for Europe. https://iris.who.int/handle/10665/346537

9.Fancourt, D., Garnett, C., & Müllensiefen, D. (2020, January 13). The Relationship Between demographics, Behavioral and Experiential Engagement Factors, and the Use of Artistic Creative activities to Regulate Emotions. Psychology of Aesthetics, Creativity, and the Arts. Advance online publication. http://dx.doi.org/10.1037/aca0000296

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LEARN ADJUSTMENT DISORDER WITH HOMOEOPATHY

DR REHNA RAHIM

Adjustment disorder is a very common disorder in the present time. An average of 12% of the total population suffers from adjustment disorder. The predominant symptom is acute onset of depression or anxiety.

In a worldwide survey of 4887 psychiatrists, conducted by the WHO WPA, it was found that adjustment disorder is among the most often diagnosed mental disorders.

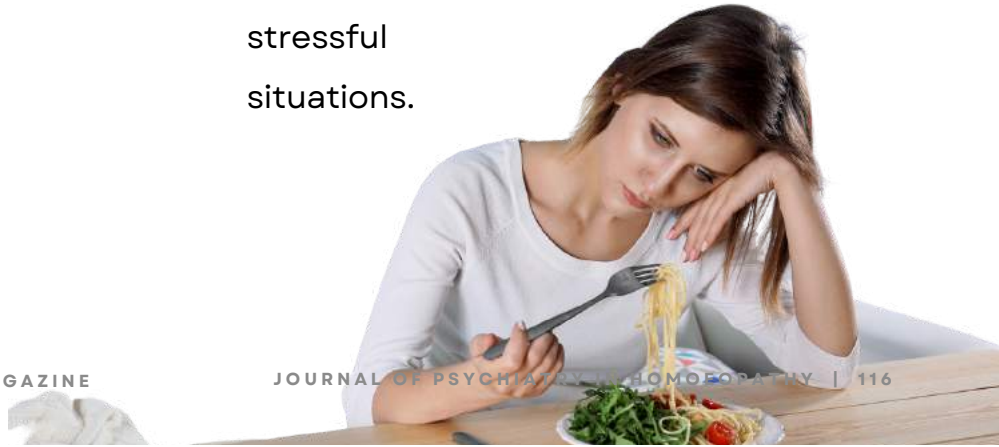
It is the states of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of stressful life events. [F.43]

The onset is usually within one month of occurrence of the stressful event or the life change, and the duration of symptoms usually does not exceed 6 months, except in the case of prolonged depressive reaction. The manifestations vary, and include depressed mood, anxiety, worry (or a mixture of these), a feeling of inability to cope, plan ahead or continue in the present situation and some degree of disability in the performance of daily routine. The symptoms can show mixed features too as mentioned in DSM 5 as there are 6 types of adjustment disorder. Symptoms do not always subside as soon as the stressor ceases. If the stressor continuous the disorder may become chronic.

The disorders can occur at any age, but the most frequently diagnosed in adolescents. The common precipitating stressors for adolescents are any school problems, peer group issues, relationship issues and divorce of parents and substance abuse. Among adults, common stressors are like marital problems, divorce, moving to a new environment , financial problems and having any serious medical conditions or being hospitalised other than these any natural calamities, unexpected tragedies also cause it.

Other disorders from which adjustment disorder must be differentiated include major depressive disorder, brief psychotic disorders, GAD, substance related disorders and PTSD.

Numerous psychoanalytic studies have shown that different people can respond differently to the same stress in different ways. Additionally, they have underlined the influence of the mother and the immediate environment on a person's eventual ability to cope with stress. Each child creates a special set of defense mechanisms during their early development to deal with stressful situations.



With appropriate treatment the overall prognosis of an adjustment disorder is generally favourable. Most patients return to their previous level of functioning within 3 months. Adolescence usually requires a longer time to recover than adults.

Adjustment Disorder simply means the failure to adapt to a stressful event. Psychotherapy and counselling plays a major role in treating them. It will help to reduce the stress and helps the patient to cope up with the stressor. The patient needs aware of significant dysfunction that the stressor has caused and strategies to overcome it. Several Crisis intervention and management also aimed at helping to resolve the problematic situations quickly by supportive techniques, suggestion, reassurance etc.

Even though it is a very common disorder, is very much under-researched and only little attention is given to this disorder. It may also be mistaken for other disorder and treated accordingly. Psychological impact of such problem is one of the least spoken topics. Master Hahnemann classified the psychological disorder in one sided disease category, which have a very few symptoms and difficult to cure.

Homoeopathy has far greater scope in such Psychiatric disorders as compared to conventional medicine as it is based on the concept of totality of symptoms and Individualization which makes this system unique and trustworthy and also provide rapid, gentle and permanent cure. During the period of treatment even though stressor persisted, we can make the patients to regain their confidence and improve their functioning. Homoeopathic constitutional medicines play a crucial role in helping them manage their symptoms more efficiently. We could possibly reduce the distressing symptoms of the patient with homoeopathic treatment alone without any possible adverse effects. There are various groups of medicine in Homoeopathy, which are more helpful in the cure of mental and behavioural disorders, specially adjustment disorders like Gelsemium, Sepia officinalis, Ignatia amara, Pulsatilla, Nux vomica, Cal.carb, Lyopodium clavatum, Stramonium etc. We can effectively treat adjustment disorder through the complementary use of homoeopathy and psychotherapies.

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DEFINITION

Dream is a physiologically and psychologically conscious state that occurs during sleep and is often characterized by a rich array of endogenous sensory, motor, emotional, and other experiences.

- Dreams occur most often, but by no means exclusively, during periods of REM sleep
- The dreams experienced by the individuals during their night sleep represents a fare description of ones altered consciousness.
- People can have dreams both in their NREM AND REM sleeps, However, a large amount of these dreams are experienced by them in their REM sleep.
- On an average, a person may dream 4 to 6 times each night.
- In their dreams peoples may became kings, queens, beggars, war and day time heroes, and what they lose the real identity and reaching unique states of their altered consciousness.

- In addition to experiencing dreams in normal way, the people are found to act out their dreams in the forms of nightmares, night terrors, sleep walking and engaging in undesirable behavior

NIGHTMARES

- Are bad dreams
- Occuring during ones REM sleep
- Not making people move around as happens to them in a night terror experience
- Some of them proving too much terrifying to the dreamer
- Vividly remembered on the part of dreamers immediately on waking

NIGHT TERRORS

- These are also bad dreams.
- Representing a state of panic[eg; unable to move or breath] experienced by dreamers in their sound sleep
- Occurring during ones NREM sound sleep
- Making dreamers act upon on their dreaming experience in the form of sitting up, screaming, running around the sleeping room, defending the self from unseen attack etc. while remaining under the state of their sound sleep
- Generally, forgetting what happened during a night terror episode

SLEEP WALKING OR SOMANAMBULISM

- People are found to walk or engaged in activities as guided to them in their dreams.
- Most sleep walkers typically do not remember the episode the nextday
- Besides this, some people are found to commit

NATURE OF DREAMS

- Dreams manifest desires
- Dreams are the expression of repressed and forebidden desires
- Most dreams are wish fulfilment
- We sleep because of dreams
- Dreams disclose our unconscious mind towards life problems
- Pathological condition are detected through dreams.

CLASSIFICATION OF DREAMS

KLEINS CLASSIFICATION

1.PREMONITORY DREAMS

Those dreams which leave the impression of some future significance.

2.PROPHETIC DREAMS

It is direct indication or a clue regarding future events

3.PRADOMIC DREAM

When a prophetic dream conveys distorted meaning, it is called pradomic dream . You may see a dream of extraction of teeth. You wake up and find your teeth hale and healthy.

4. RECURRENT DREAM

That recur from time to time.

These dreams occurs in neurotic people who have suffered a lot during given period of time, saya soldier who has terrifying war experiences.

Another classification of dreams

1.COLLECTIVE DREAMS

The dreams which are seen by more than one people at a given time.

2.KINESTHETIC DREAMS

Dreams related to floating, soaring, falling etc.

3.PARALYTIC DREAMS

Where an individual becomes almost paralyzed after experiencing a horrifying dream.

Why we dream, and what do we dream about?

❓ For explaining the mechanism of dreams there are two mentionable views or theories prevailing at this time namely

1.Freuds view point
2.The activation synthesis theory

FREUDS VIEWPOINT ABOUT DREAMS

- According to freud the desire for the wish fulfilment regarding the conflicts, events, and desires experienced by the individuals in their past are represented at their present in symbolic form in their dreams.
- For the interpretation of the content of each dream reported by each individual we must try to pay more attention to its latent meaning of a dream is hidden, or latent, only expressed in symbols and it can be interpreted in a proper way by an analyser.
- However, the viewpoint held by freud for the explanation of the mechanism of dreams is quite erroneous as it involves total subjectivity in the interpretation of the dreams on the part of the analyser.
- Every analyser may be seen to interpret it in its unique way.

THE ACTIVATION SYNTHESIS THEORY

- It is put forward by Hobson and Mc Carley[1977]
- According to this theory, our dreams are the products of activity going on in a particular part of our hind brain known as pons [responsible for relaying messages between the cerebellum and cortex]
- The part played by pons for experiencing dreams in our sleeping cycles has been narrated by Ciccarelli and White in the following words
- The pons in the brainstem sends random signals to the upper part of the brain during REM sleep.
- These random signals pass through thalamus, which sends the signals to the proper sensory areas of cortex.
- u Once in the cortex, the association areas of cortex, responds to the random activation of these cortical cells by synthesizing a story or dream, using bits and pieces of life experiences and memories.
- u The viewpoint provided in this theory has been further improved by Hobson and colleagues by renaming the theory as Activation-information-mode model or AIM.
- u In this model they have opined that information accessed during awakening hours of concurrent period such as same day, previous day or last few days rather than the experiences or memories belongs to the childhood or remote past is reflected in ones dreams

OTHER THEORIES OF DREAMS

- Supernatural theory of dreams
- Physiological theory of dreams
- .Psycho neurological interpretation of dreams
- .Pearls theory of dreams
- .Mark solms theory of dreams
- Jie zhangs continual activation theory of dreams

DAY DREAMS

- Day dreams can be compared to a type of imagination
- In day dreams individual dreams in a awake state
- A day dream typically look towards the future as if planning for possible action, only it is not a serious plan, nor necessarily a plan which could work in real life but it is merely a plan of imagination
- Tendency of daydream mostly in introverted persons.

CLINICAL APPLICATION

- The importance of dreams in relation to sickness is well known to homoeopathy prior to era of freud.
- The proving of various drugs has certainly brought the significance of dreams, forward
- Moreover dreams are the expression of the inner man
- It is ascribed to general symptom
- Case taking without considering dreams remains incomplete.
- If the dreams occurs frequently then should be given priority.
- Students are directed to consult a repertory, especially from kentian school
- Of couse, free association and dream analysis will be of immense value in the treatment of sickness along with our therapeutic measurers.

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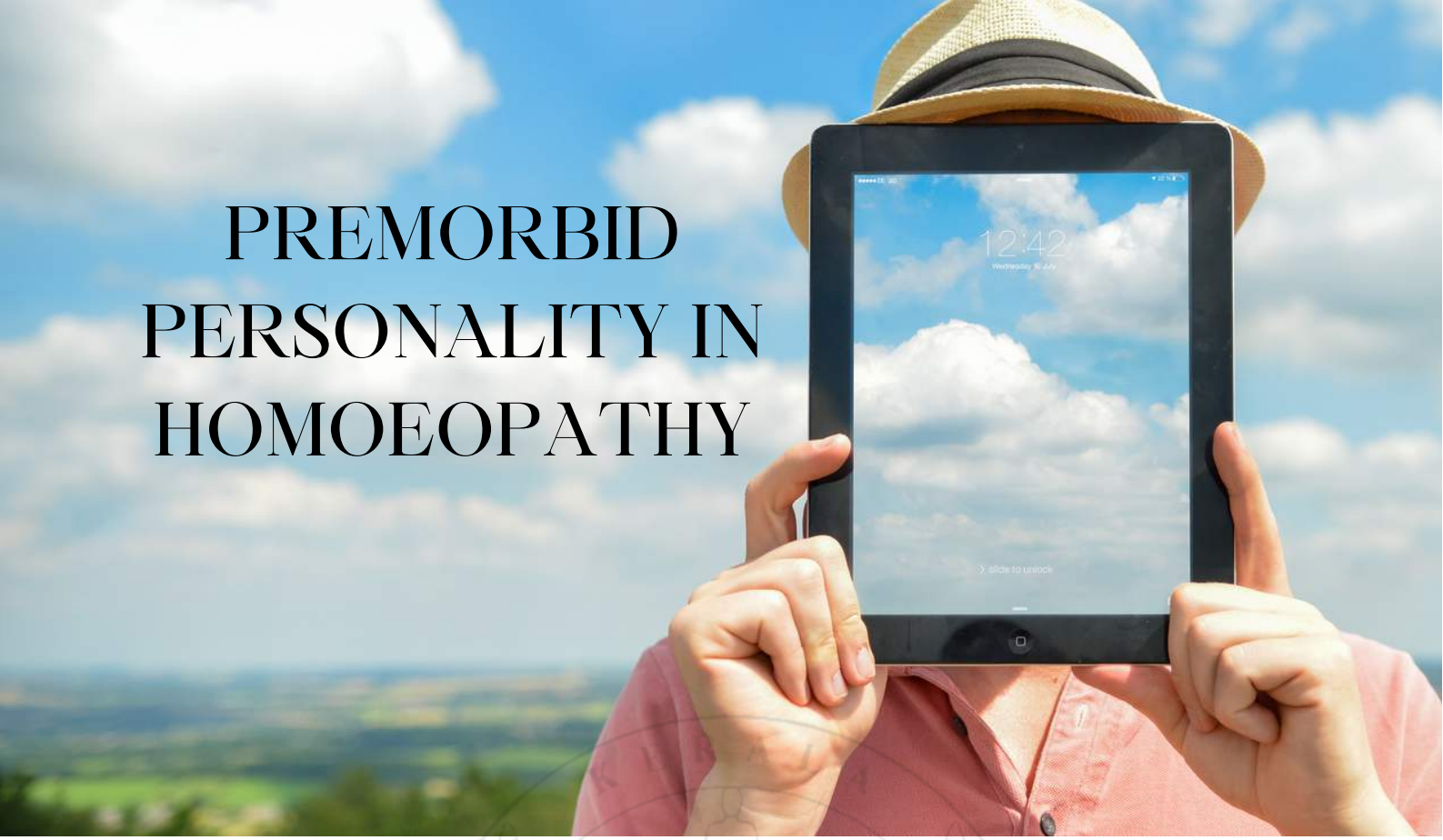

PREMORBID PERSONALITY IN HOMOEOPATHY

Introduction

Homoeopathy is a holistic system of medicine that recognizes the interdependence of physical, emotional, and mental well-being. It is based on the principles of “like cures like” and the law of minimum dose, which means that a substance that can cause symptoms in a healthy person can be used to cure similar symptoms in a sick person, but in a highly diluted form. Homoeopathy also considers the individuality of each patient, and the importance of identifying and treating the underlying cause of the illness rather than just treating the symptoms.

Premorbid personality is the term used to describe a person’s personality traits, behaviour patterns, and emotional responses before the onset of an illness. Homoeopathy recognizes that an individual’s premorbid personality plays an important role in the development of illness and the selection of the most appropriate remedy for treatment. The personality of the patient is at least as important as the physical characteristics in individualizing the case and finding the similimum.

The concept of premorbid personality in homoeopathy

Premorbidity refers to the state of functionality prior to the onset of a disease or illness.

It is most often used in relation to psychological function (e.g. premorbid personality or premorbid intelligence), but can also be used in relation to other medical conditions (e.g. premorbid lung function or premorbid heart rate). In psychology, premorbidity is most often used in relation to changes in personality, intelligence or cognitive function. Changes in personality are common in cases of traumatic brain injury involving the frontal lobes.

Homoeopathy recognizes that each individual is unique and that their physical, mental, and emotional characteristics are interrelated. According to Homoeopathy, an imbalance in any of these aspects can lead to the development of disease. Thus, Homoeopathy emphasizes the importance of identifying and treating the underlying cause of an illness rather than just treating the symptoms.

In Homoeopathy, a person's premorbid personality is considered an essential component in understanding their overall health and wellbeing. It is believed that an individual's personality traits, behavior patterns, and emotional responses can provide valuable information about the underlying causes of illness. The individual's personality is taken into account when selecting the most suitable remedy for their treatment.

Homoeopathic remedies are chosen based on the principle of "similarity". That is, a remedy that can produce symptoms similar to those experienced by the patient is selected for treatment. In order to identify the most appropriate remedy, the Homoeopath needs to know about the patient's physical symptoms, emotional responses, and personality traits.

Layers

The majority of people remain in the same constitutional state for the whole of their lives. In other words, their vital force will resonate with the same remedy from birth till death, excluding periods of acute illness. Traumatic experiences, both physical and psychic, can shift a person's vital force to a different frequency, forming a new

layer, but more often they cause a deterioration of functioning within the same layer. Thus a relatively healthy, symptom-free Natrum Muriaticum person will develop chronic sinusitis and claustrophobia following a long divorce settlement, which remains until homoeopathic help or other deep healing methods are used. These new symptoms are still within the scope of Natrum Muriaticum, and the remedy will simply return the patient's vital force to a healthier 'octave' of the Natrum Muriaticum wavelength. Without treatment the new symptoms may remain until further trauma causes another deterioration in health, this time to (say) chronic bronchitis and recurrent depression, still within the Natrum Muriaticum layer. Given the stability of the chronic layers, a patient's past medical and psychological history can provide useful information which can help to confirm the constitutional remedy.

Some people are born with several layers of pathology, which they inherited from their parents. They will usually continue to express the uppermost layer until the correct homeopathic remedy dissolves it, revealing the one underneath. However, some characteristics of the deeper layers can show through from time to time, both physically and psychologically. Thus a Natrum Muriaticum person with an underlying Phosphorus layer may exhibit some of the spontaneity, naivety and openness of Phosphorus but the most dominant characteristics will fit Natrum Muriaticum, especially those that constitute the problem for the patient. Inherited layers of pathology frequently correspond to the miasmatic remedies-Psorinum, Syphilinum, Medorrhinum and Tuberculinum. When these layers have been removed one often finds 'non-miasmatic' remedy layers underneath. However, it often happens that a person is born with only one constitutional layer, whether it be miasmatic or not, and treatment will simply rebalance the vital force within the same layer. Thus a person may benefit from occasional doses of the same constitutional remedy throughout his or her life.

Additional layers of pathology may be acquired after birth by exposure to traumatic influences,

be it psychological trauma, direct physical injury, or infectious disease. For example, a person may develop a Medorrhinum state after acquiring gonorrhoea, or a Natrum Sulphuricum state after a head injury. A relatively common example is the acquisition of a Natrum Muriaticum state after a shock. It must be remembered, however, that the majority of patients who present in a Natrum Muriaticum state after a bereavement or shock were already Natrum before the event. Similarly, many patients who present with venereal disease in a Thuja state were already Thuja before acquiring the disease.

Apart from acute diseases which produce a temporary change in level, change from one layer to another is uncommon except as a result of homoeopathic treatment. It does sometimes happen that a person spontaneously 'grows out' of one constitutional state and into another. This occurs particularly during childhood, when some Calcareas and Pulsatillas change into other types. Calcarea is especially common in infancy, which means that many Calcarea infants will change into different types as they get older. This is not a pathological change and is not reversed by correct prescribing unless the previous state involved pathology that was not cured but was suppressed. Most toddlers go through a Pulsatilla stage between the ages of one or two and four. Again, the majority of these Pulsatilla children grow into a different adult type by the age of five. Very few remain constitutionally Pulsatilla after this age.

Homoeopaths acknowledge certain groupings of body mind symptom patterns which a person has and which correspond with the sensitivity of a particular homoeopathic medicine. The word “symptom” here is most broadly defined as any sensation that is discomforting or that limits a person’s physical or psychological functions. Homoeopaths also inquire into what factors, which they call “modalities,” seem to aggravate or ameliorate these sensations. In addition to prescribing on these factors, a homoeopath may utilize information about the person’s body type, temperament and disposition, and behavioral tendencies to determine the appropriate medicine.

Conclusion

Premorbid personality in homoeopathy is a fundamental concept that recognizes the uniqueness of every individual. It involves understanding the inherent, constitutional, and characteristic traits of the person before the development of any health condition. This understanding guides the homoeopath in selecting a remedy that resonates with the individual's unique constitution and helps restore harmony and balance. By addressing the underlying imbalances and stimulating the body's healing abilities, homoeopathy provides personalized and holistic treatment. The concept of premorbid personality not only aids in selecting remedies but also enriches the therapeutic relationship, leading to more effective and compassionate healing.

Several homoeopathic remedies are known to have specific affinities with certain types of premorbid personalities. These remedies are derived from various sources, such as plants, minerals, animals, and even disease products. Homoeopathy follows the principle of "like cures like," which means that a substance that can produce symptoms in a healthy person can cure similar symptoms in a sick person. Therefore, the homoeopath seeks a remedy that corresponds to the individual's premorbid personality and the symptoms they are experiencing.

For example, a person with a strong sense of responsibility, perfectionism, and a tendency to suppress emotions might benefit from the homoeopathic remedy Nux Vomica. On the other hand, a person who is sensitive, introverted, and fears abandonment might be better suited for the remedy Pulsatilla. These remedies resonate with the underlying personality traits and help restore balance and harmony in the individual.

Furthermore, premorbid personality assessment serves as a valuable tool in preventive healthcare by identifying susceptibilities and potential health risks before they manifest into full-blown diseases. It empowers homoeopaths to provide proactive guidance to patients, promoting overall well-being and resilience.

Ultimately, premorbid personality in homoeopathy reflects the philosophy of treating the person, not just the disease.

Through a comprehensive understanding of the individual's constitution and characteristics, homoeopathy continues to stand as a powerful and compassionate system of medicine, offering hope and healing to patients seeking a truly personalized and holistic approach to health. As homoeopaths continue to integrate this concept into their practice, the field of homoeopathy will flourish as an essential and integral part of modern healthcare.

References

1. MacKillop J, Ray LA. The etiology of addiction: a contemporary biopsychosocial approach. Integrating Psychological and Pharmacological Treatments for Addictive Disorders. 2017 Jul 6:32-53.

2. World Health Organization. The ICD Classification of Mental and Behavioural Disorders. 10 ed. Delhi: A I. T.B.S. Publishers & Distributors: 2007

3. American Psychiatric Association. Diagnostic and statistical manual of Mental Disorders.DSM-V.St ed. Arlington, V.A: APA; 2013.

4. Bhatia M S. Essentials of Psychiatry. St ed. New Delhi: CBS Publishers& distributorsPut.Ltd; 2018: 486-488

5. Sadock V J, Sadock VA, Ruiz P. Kaplan & Sadock's Synopsis of Psychiatry.I* ed.New Delhi: M, Wolter Kluwer publishers Pvt Ltd; 2018.

6. Ahuja N. A short textbook of psychiatry. 7 ed. New Delhi: Jaypee brothers medical publishers; 2011; 163-165

7. Sadock J B, Sadock VA, Ruiz P. Kaplan & Sadock's Comprehensive textbook of Psychiatry. 9th ed. Philadelphia, Lippincott Williams& Wilkins 2 2009;(2):3542-3544.

8. Skewes MC, Gonzalez VM. The biopsychosocial model of addiction. Principles of addiction. 2013 Jan 1;1:61-70.

9. Rogers J. Homoeopathy and the treatment of alcohol-related problems. Complementary Therapies in Nursing and Midwifery. 1997 Feb 1;3(1):21-8.

10. Gopi K S. Homoeopathy for drug addiction. 2020 April. https://www.linkedin.com/pulse/homoeopathy-drug-addiction-dr-ks-gopi

11. Boericke W. New Manual of Homoeopathic Materia Medica & Repertory. New Delhi: B. Jain Publishers; 2002.

12. Kent JT. Repertory of the homeopathic materia medica. 12th impression. New Delhi: B Jain Publishers; 2014

13. Amanda L.What Exactly Is the Biopsychosocial Model of Addiction? https://www.psychologytoday.com/us/blog/understanding-addiction/202107/what-exactly-is-the-biopsychosocial-model-addiction

14. Miller PM. Principles of addiction: Comprehensive addictive behaviors and disorders, Volume 1. Academic Press; 2013 May 17.

15. Miller PM. Principles of Addiction: Comprehensive Addictive Behaviors and Disorders. San Diego: Elsevier Science & Technology; 2013.

16. Duncan PM. Substance Use Disorders. A Biopsychosocial Perspective. Cambridge: Cambridge University Press; 2020.

17. Young RM. Craving and Expectancies. In: Miller PM, editor. Principles of Addiction: Coprehensive Behaviors and Diseases. San Diego: Elsevier Science and Technology; 2013. pp. 425–433.

18. Noordsy DL, Mishra MK, Mueser KT. Models of relationships between substance use and mental disorders. In: Miller PM, editor. Principles of Addiction: Coprehensive Behaviors and Diseases. San Diego: Elsevier Science & Technology; 2013. pp. 489–494.

19. Kassel JD, Veilleux JC, Heinz AJ, Braun AR, Conrad M. Emotions and Addictive Processes. In: Miller PM, editor. Principles of Addiction: Comprehensive Addictive Behaviors and Disorders. Amsterdam: Elsevier Science & Technology; 2013. pp. 213–222.

20. Wangensteen T, Hystad J. A Comprehensive Approach to Understanding Substance Use Disorder and Recovery: Former Patients' Experiences and Reflections on the Recovery Process Four Years After Discharge from SUD Treatment. J Psychosoc Rehabil Ment Health. 2022;9 (1):45-54.

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ANXIETY AND MINDFULNESS

Anxiety is an emotion characterized by feelings of tension, worried thoughts and physical changes like increased blood pressure; this is according to American psychological association. Anxiety can affect our daily life and is one of the most prevalent mental disorders existing. The major symptom, that is present during this disorder are restlessness, uncontrollable feeling of worry, increased irritability, difficulty concentration, sleep disturbances etc. Most of us may have experienced such symptoms in some phase of lie. But people with Generalised anxiety disorder (GAD) will experience them at persistent or extreme, long lasting anxiety and worries about nonspecific life events, objects, and situations. The other classifications of Anxiety disorders are:

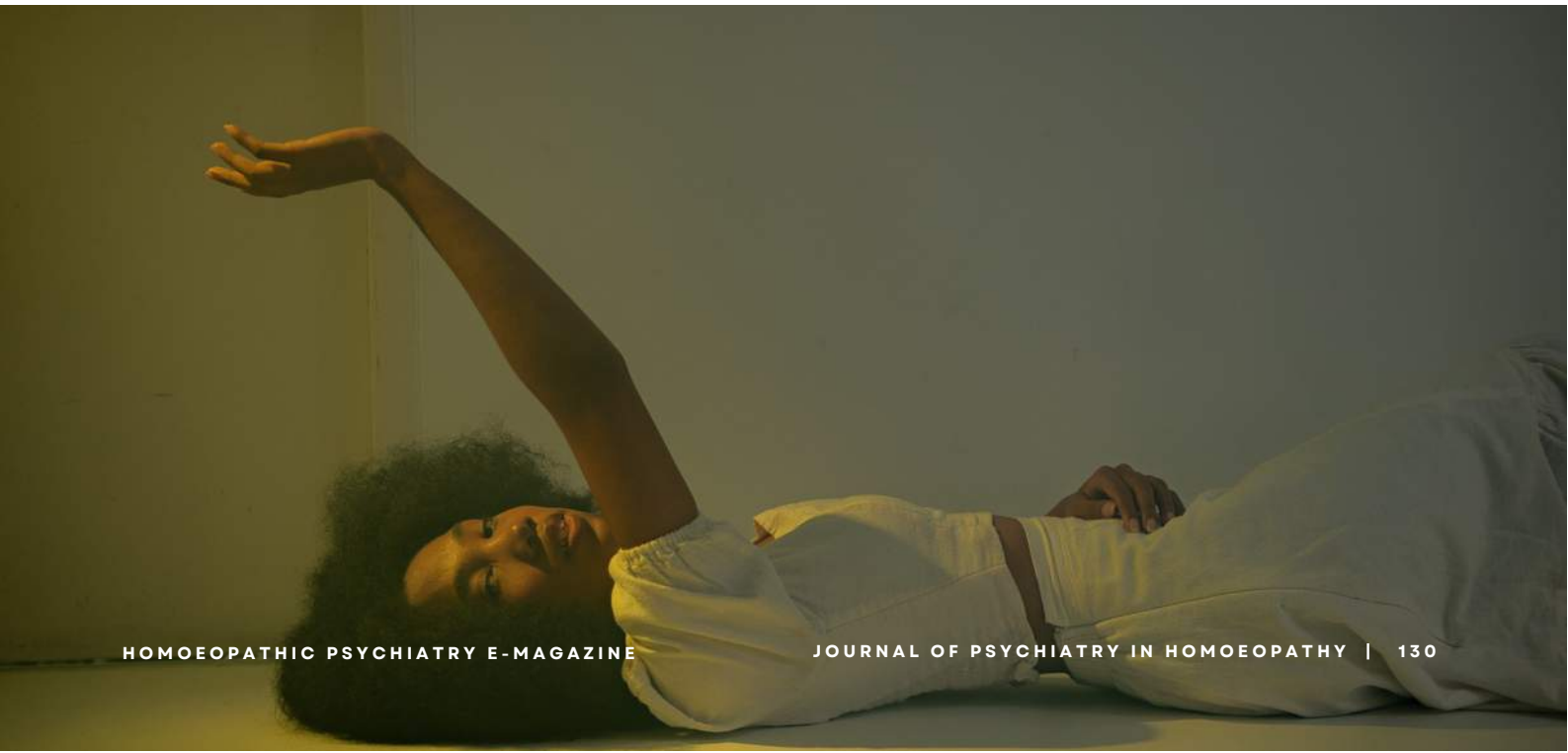
A) Panic disorder: Brief or sudden attack of terror

B) Specific phobia: This is a fear and avoidance of a particular object or situations.

C) Selective mutism: Sometimes children or adults may experience a situation where they cannot speak in certain areas.

D) Social anxiety: This is the anxiety or fear from the judgement of society.

When coming to the causation, it is merely due to the disrupted modulation within the central nervous system. The theories suggest that low serotonin activity and elevated noradrenergic system activity leads to anxiety.



Mostly psychotherapy proves to be helpful in managing anxiety disorders in mild forms. So in this mindfulness truly proves to be helpfull.

Mindfulness are governed with 3 major components which is:

A) Intention- Choosing to cultivate awareness of oneself.

B) Attention- Attentiveness to the present moment.

C) Attitude- Attitude of being non judgmental, being kind and curious.

During mindfulness, techniques are adopted to reduce anxiety. The first thing we can do is the mirror talk; say to yourself “I am happy! I am confident! I will sure win this battle!”

Will power and confidence is the better tool to win our negative thoughts. The techniques that can be adopted are:

1) 54321 Technique: Focus on 5 things that you can see, 4 things you can hear, 3 things you can smell, 2 things you can feel, and 1 thing you can taste. Simply, activating our 5 senses to cut down our negative thoughts.

2) Intention setting exercises: Setting aside a little time in the morning to set intentions that will help our minds to start a day with clear mind.

For e.g.:- journaling, reading, meditation etc.

3) Deep breathing exercises: Taking long deep breaths.

4) Candle study exercise: Gazing candle or 5 minutes and observing our thoughts, let them pass, without judgement.

5) Mindfulness of eating: Do eat or even a tea can be used as a weapon, do observe, how it feels to make the tea, colour of tea leaves, the sound of kettle, the shape of mug, what the tea taste like, with happiness.

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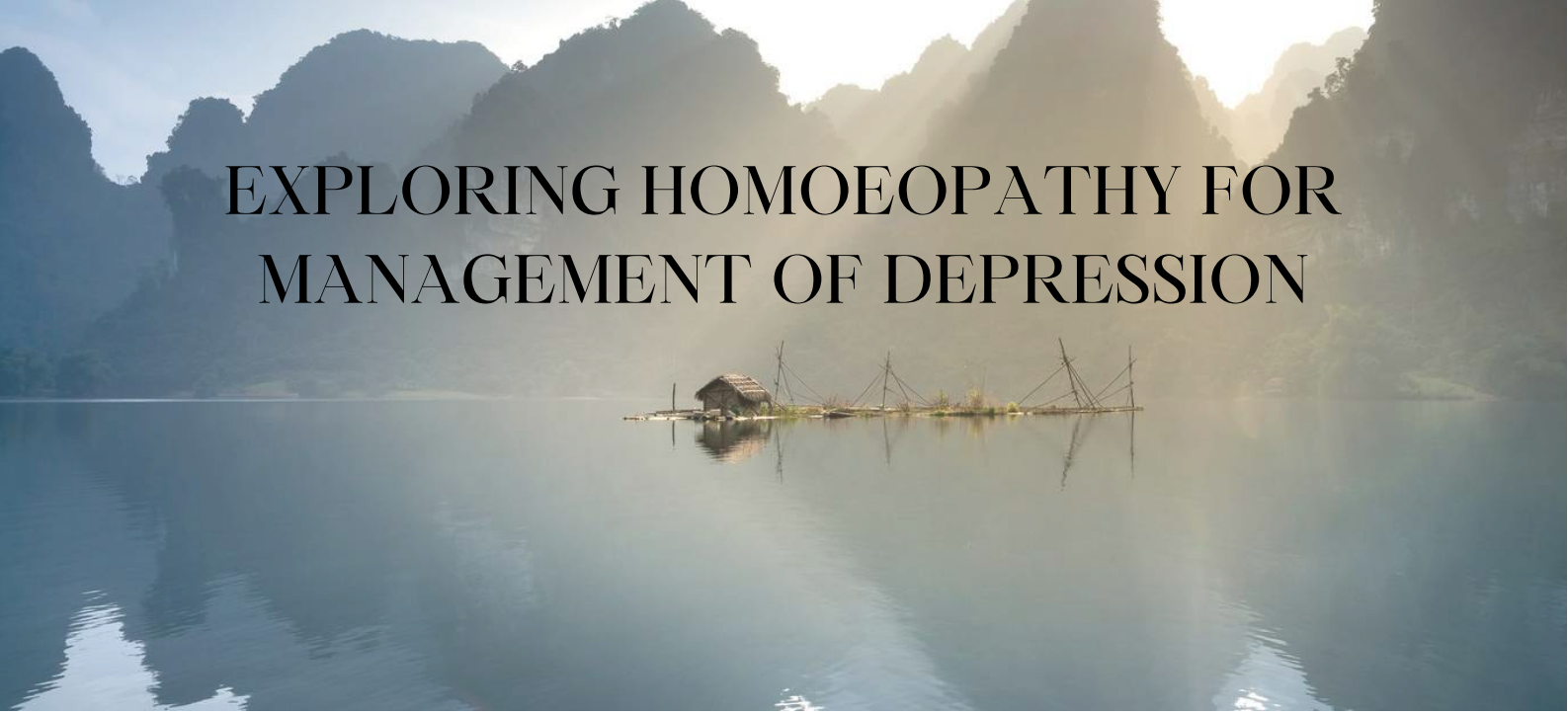

EXPLORING HOMOEOPATHY FOR MANAGEMENT OF DEPRESSION

Homoeopathy is a complementary and alternative system of medicine that uses highly diluted substances to stimulate the body's natural healing processes. When it comes to depression, homeopathy takes a holistic approach, considering not only the emotional symptoms but also the individual's physical and mental constitution. While some individuals report experiencing relief from depressive symptoms through homeopathic remedies, it's important to note that the scientific evidence supporting the efficacy of homeopathy for depression is limited.

Depression symptoms can vary from mild to severe and can include:

Feeling sad or having a depressed mood

Loss of interest or pleasure in activities once enjoyed

Changes in appetite – weight loss or gain unrelated to dieting

Trouble sleeping or sleeping too much

Loss of energy or increased fatigue

Increase in purposeless physical activity (e.g., inability to sit still, pacing, handwringing) or slowed movements or speech (these actions must be severe enough to be observable by others)

Feeling worthless or guilty

Difficulty thinking, concentrating or making decisions

Thoughts of death or suicide

Symptoms must last at least two weeks and must represent a change in your previous level of functioning for a diagnosis of depression.

- Also, medical conditions (e.g., thyroid problems, a brain tumor or vitamin deficiency) can mimic symptoms of depression so it is important to rule out general medical causes.

Homoeopathic medicines for depression

(1)Arsenicum album:

Anxious, insecure, and perfectionistic people who need this remedy may set high standards for themselves and others and become depressed if their expectations are not met. Worry about material security sometimes borders on despair. When feeling ill, these people can be demanding and dependent, even suspicious of others, fearing their condition could be serious.

(2)Aurum metallicum:

This remedy can be helpful to serious people, strongly focused on work and achievement, who become depressed if they feel they have failed in some way. Discouragement, self-reproach, humiliation, and anger can lead to feelings of emptiness and worthlessness. The person may feel worse at night, with nightmares or insomnia.

(3)Calcarea carbonica:

A dependable, industrious person who becomes overwhelmed from too much worry, work, or physical illness may benefit from this remedy. Anxiety, fatigue, confusion, discouragement, self-pity, and a dread of disaster may develop. A person who needs this remedy often feels chilly and sluggish and easily tires on exertion.

(4)Causticum:

A person who feels depressed because of grief and loss (either recent or over time) may benefit from this remedy. Frequent crying or a feeling of mental dullness and forgetfulness (with anxious checking to see if the door is locked, if the stove is off, etc.) are other indications. People who need this remedy are often deeply sympathetic toward others and, having a strong sense of justice, can be deeply discouraged or angry about the world.

(5)Cimicifuga:

A person who needs this remedy can

be energetic and talkative when feeling well, but upset and gloomy when depressed–with exaggerated fears (of insanity, of being attacked, of disaster). Painful menstrual periods and headaches that involve the neck are often seen when this remedy is needed.

(6)Ignatia amara:

Sensitive people who suffer grief or disappointment and try to keep the hurt inside may benefit from this remedy. Wanting not to cry or appear too vulnerable to others, they may seem guarded, defensive, and moody. They may also burst out laughing, or into tears, for no apparent reason. A feeling of a lump in the throat and heaviness in the chest with frequent sighing or yawning are strong indications for Ignatia. Insomnia (or excessive sleeping), headaches, and cramping pains in the abdomen and back are also often seen.

(7)Kali phosphoricum:

If a person feels depressed after working too hard, being physically ill, or going through prolonged emotional stress or excitement, this remedy can be helpful. Exhausted, nervous, and jumpy, they may have difficulty working or concentrating–and become discouraged and lose confidence. Headaches from mental effort, easy perspiration, sensitivity to cold, anemia, insomnia, and indigestion are often seen when this remedy is needed.

(8)Natrum carbonicum:

Individuals who need this remedy are usually mild, gentle, and selfless –making an effort to be cheerful and helpful, and avoiding conflict whenever possible. After being hurt or disappointed, they can become depressed, but keep their feelings to themselves. Even when feeling lonely, they withdraw to rest or listen to sad music, which can isolate them even more. Nervous and physically sensitive (to sun, to weather changes, and to many foods, especially milk), they may also get depressed when feeling weak or ill.

(9)Natrum muriaticum:

People who need this remedy seem reserved, responsible, and private– yet have strong inner feelings (grief, romantic attachment, anger, or fear of misfortune) that they rarely show. Even though they want other people to feel for them, they can act affronted or angry if someone tries to console them, and need to be alone to cry. Anxiety, brooding about past grievances, migraines, back pain, and insomnia can also be experienced when the person is depressed. A craving for salt and tiredness from sun exposure are other indications for this remedy.

(10)Pulsatilla:

People who needs this remedy have a childlike softness and sensitivity– and can also be whiny, jealous, and moody. When depressed, they are sad and tearful, wanting a lot of attention and comforting. Crying, fresh air, and gentle exercise usually improve their mood. Getting too warm or being in a stuffy room can increase anxiety. Depression around the time of hormonal changes (puberty, menstrual periods, or menopause) can often be helped with Pulsatilla.

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INTELLECTUAL ASSESSMENTS

WHAT IS INTELLIGENCE?

Different psychologists have variously defined intelligence. But the commonest future in most definitions is that intelligence is the ability to learn, the ability to carry on the higher process of thought, especially abstract thinking and the ability to adapt to new situation. Variation of Intelligence follows the 'normal distribution' in any population. In psychology it is termed 'Intelligence'. In ancient India our great Rishis named it 'Viveka'.

Definitions of Intelligence:
Definitions given by various psychologists:

David Wechsler (1944):
"Intelligence is the aggregate or global capacity of an Individual to act purposefully, to think rationally, and to deal effectively with his environment".

Binet (1905):
"Intelligence is the ability of an Individual to direct his behavior towards a goal".

It makes us conclude that intelligent behavior is divided into two categories – theoretical and practical, abstract and concrete.

"INTELLIGENCE CONSISTS OF AN INDIVIDUAL'S THOSE MENTAL OR COGNITIVE ABILITIES WHICH HELP HIM IN SOLVING HIS ACTUAL LIFE PROBLEMS AND LEADING A HAPPY AND WELL CONTENTED LIFE".

INTELLECTUAL ASSESSMENTS:

Intellectual assessment and intelligence testing refer to the evaluation of an individual's general intellectual functioning and cognitive abilities. It is very important for patients presenting with impairments of higher cognitive functioning such as memory, language, and reasoning. Because these higher cognitive functions are highly correlated with intelligence, intelligence assessment allows the examiner to interpret scores of memory, language, and reasoning performance in light of basic intellectual abilities.

Intellectual Functioning:

Intelligence tests typically gauge an individual's general intellectual capacity, often termed as IQ (intelligence quotient), and are commonly administered by clinical psychologists in various community settings or by school psychologists in educational institutions. A higher IQ score generally implies greater intellectual ability. However, it's important to note that this single score provides an overview of overall functioning without offering insight into the specific factors influencing it. Crucially, a global IQ score doesn't pinpoint areas of strength or weakness in a person's cognitive abilities, making it insufficient for understanding their learning style or educational needs. To gain a more comprehensive understanding, it's advisable to combine this single measure with other sources of information, such as assessments of cognitive skills, to better assess an individual's skills and requirements.

Cognitive Abilities:

Psychologists have shifted their focus from general intelligence to cognitive abilities in an effort to better understand children's learning and learning difficulties. Cognitive abilities encompass the various skills that collectively constitute an individual's overall intelligence.

Unlike older theories that treated intelligence as a single, all-encompassing ability, contemporary theories recognize intelligence as a multifaceted concept comprising numerous distinct abilities. Recent research suggests that this perspective of multiple abilities offers a more accurate explanation for why individuals excel in certain tasks while struggling with others.

METHODS OF ASSESSING INTELLIGENCE:

These various theories aim to elucidate the structure and characteristics of intelligence, and they diverge in their interpretations. Multifactor theories emphasize the necessity of distinct subtests to assess different ability factors, which implies a requirement for different intelligence tests based on these theories.

However, some of the most renowned and widely employed intelligence tests do not strongly align with any particular theory. Consequently, they incorporate subtests and generate an overarching summary score. Notable examples of these intelligence tests include the Stanford–Binet Intelligence Scale and three tests devised by David Wechsler, each tailored to different age groups.

STANDARDIZED AND NORM-REFERENCED TESTS:

The predominant methods for assessingintellectual ability involvestandardized intelligence tests, which are norm-referenced. These tests often produce scores with an average performance set at 100. The term "IQ" (or Full Scale IQ, FSIQ) is the traditional label for these scores, and it primarily corresponds to the Wechsler Scales of Intelligence, closely associating with global intelligence assessment. Alternative tests may employ different terminology for scores that convey similar concepts, such as General Intellectual Ability (GIA) or Mental Processing Index (MPI).

Standardized tests:

Intelligence tests, often presented as a series of individual tasks or subtests, are typically administered one-on-one, although group-administered versions also exist. These tasks are designedto offer snapshots of an individual's intelligence or cognitive abilities, and each task yields a standardized score. They are termed"standardized" because each task is presented to every examinee in the same consistent manner. When standardized tests are employed, performance is believed to reflect a person's distinct cognitive capabilities, while also considering potential errors stemming from factors like an individual having an off day or imperfections in the test itself.

Norm-referenced tests:

To gauge how an individual's performance compares to others, test scores are compared to the test's established norms. These norms are initially determined during the test's development phase, involving large and diversegroups of individuals that often represent the general population in terms of factors like age, gender,race/ethnicity, geographic region,and socioeconomic status. These norms help establish the typical range of performance. For instance, if a child answers three questions correctly on a vocabulary test and the norms indicate that most children of the same age typically answer 8 to 10 questions correctly, we can infer that this child's vocabulary skills are below average compared to their peers. Most intelligence tests follow both norm-referenced and standardized principles. Typically, these tests are designed so that the average score falls at 100, with about two-thirds of the population scoring between 85 and 115, considered within the normal range.

Common intelligence tests:

Frequently used norm-referenced tests encompass a range of assessments, including:

1. Wechsler Preschool and Primary Scale of Intelligence (WPPSI)
2. Wechsler Intelligence Scale for Children (WISC)
3. Woodcock–Johnson Tests of Cognitive Abilities (WJ)
4. Stanford–Binet Intelligence Scale (SB)
5. Differential Abilities Scale (DAS)
6. Kaufman Assessment Battery for Children (KABC)

Additionally, there are abbreviated measures of intelligence like the Wechsler Abbreviated Scale of Intelligence (WASI) and the Kaufman Brief Intelligence Test (K–BIT). These assessments have undergone updates and re-norming over time. It is advisable to use the most recent edition of these tests to ensure the utilization of current test norms.

OTHER SCALES OF INTELLECTUAL ASSESSMENTS:

1. Cognitive Assessment System – II used for ages 5 -17 years.
2.Kaufman Assessment Battery for Children (K-ABC)used for ages 2 to 12 years.
3. Kaufman Adolescent and Adult Intelligence Test (KAIT) used for ages 11 to 85+ years.
4. Peabody Picture Vocabulary Test – III (PPVT-III) used from age of 4 years to adulthood.

ACHIEVEMENT TESTS:

1. Woodcock – Johnson Psycho-Educational battery Revised (W-J)used from kindergarten to 12 years.
2. Wide Range Achievement Test – 3, Levels 1 and 2 (WRAT-3) for ages 1 to 75 years.
3. Kaufman Test of Educational Achievement, Brief and Comprehensive Forms (K- TEA) for ages 1 to 12 years.
4. Weschler Individual Achievement Test (WIAT) used from kindergarten to 12 years.

USES OF INTELLIGENCE TESTS:

1. To determinethe eligibility of candidates for activities such as admissions, interviews, scholarships, and responsibilities.
2. To efficiently categorize students as bright, average,or dull for educational purposes.
3. To facilitate the promotion of individuals in academic, occupational, and social contexts.

4. To assessone's potential and predict theirlikelihood of success.
5. For diagnostic purposes in identifying exceptional children, including gifted, academically challenged, and mentally retarded students.
6. To supportresearch in the fieldsof psychology, sociology, and education.

INTELLECTUAL DISABILITY:

Intellectual disability, previously known as mental retardation, can result from a variety of environmental and genetic factors, leading to a combination of cognitive and social impairments. The American Association on Intellectual and Developmental Disability (AAIDD) defines intellectual disability as a condition characterized by significant limitations in both intellectual functioning (such as reasoning, learning, and problem solving) and adaptive behavior(including conceptual, social,and practical skills),emerging before the age of 18. The severity levels of intellectual disability are classified in DSM-5 as mild, moderate, severe, and profound. The term "borderline intellectual functioning," which previously described individuals with a full-scale IQ in the range of 70 to 80, is no longer considered a diagnosis in DSM-5. DSM-5 also introduces a disorder called "Unspecified Intellectual Disability" (Intellectual Developmental Disorder), designed for individuals over 5 years of age who are challenging to evaluate but are strongly suspected of having intellectual disability.

Certain genetically based cases of intellectual disability are associated with specific and predictable behavioral phenotypes. These behavioral patterns can be found in genetically determined syndromes like Down syndrome, Fragile X Syndrome, Prader-Willi Syndrome, Cat's Cry (Cri-du-Chat) Syndrome, Phenylketonuria, Rett syndrome, Neurofibromatosis, Tuberous Sclerosis, Lesch-Nyhan Syndrome, Adrenoleukodystrophy, Maple Syrup Urine Disease, and other enzyme deficiency disorderssuch as Hartnup disease, galactosemia, and glycogen storage disease, among others.

ASSESSMENT SCALESOF INTELLECTUAL DISABILITY:

Scales used for Intelligence test for ID are:

1. Wechsler Preschooland Primary Scale of Intelligence (WIPPSI),
2.Wechsler Intelligence Scale for Children (WISC),
3.Wechsler Adult Intelligence Scale (WAIS).
4.Stanford-Binet Intelligence Test,
5.Differential Abilities Scales (DAS),
6.Woodcock Johnson Test of Cognitive Abilities,
7.Comprehensive Test of Nonverbal Intelligence (CTONI)

Scales used for Achievement test for ID are:

1. Woodcock-Johnson Tests of Achievement (WJ),
2. Wechsler Individual Achievement Test (WIAT),
3. Wide Range Achievement Test (WRAT),
4. Kaufman Test of Educational Achievement (KTEA)

HOMOEOPATHIC THERAPEUTICS FOR INTELLECTUAL DISABILITY:

1. BARYTA CARBONICUM:

• Children who are retarded in growth.
• They do not like to talk to strangers.
• They hide behind the door or mother on seeing strangers
• They are usually shy and timid in nature
• Loss of memory in children.
• Children has diminished attention and cannot be taught
• Swelling and induration of glands.

2. BARYTA MURIATICUM:

• Children who are slow to learn or understand
• They find it difficult to concentrate on one thing
• Foolish behavior, idiotic, imbecile and timid
• No desire to play
• Cross and irritable
• Frequent urination and screams before urination.

3. SILICEA:

• Child is nervous, cross and irritable
• Fear of pointed objects
• Very obstinate and arrogant in nature
• Oversensitive physically and mentally
• Children with large head and open fontanelles
• Profuse sweating of head, palms and soles
• Distended abdomen
• Cervical and salivary glands are indurated

4. SYPHILINUM:

• Emaciated children with falling of hair
• Wedged teeth and flattened nose
• Loss of memory, misplaces words in sentences
• Excessive salivation which flows out at night during sleep
• Acts well as an intercurrent medicine.

5. TUBERCULINUM:

- Hopeless and has aversion to mental work
- Easily irritable and changeable nature
- Desire to travel, cosmopolitan in nature
- Very hyperactive
- Fear of domestic animals especially dogs
- Screams and talks during sleep
- Epileptic convulsions in mentally challenged children
- Takes cold easily, frequent attacks of respiratory infections
- Enlarged glands
- Acts best as an intercurrent medicine.

BIBLIOGRAPHY:

1.	Ortiz SO, Lella SA, Canter NA. Intellectual ability and assessment: A primer for parents and educators. Bethesda: National Association of School Psychologists. 2010:1-4.
2.	www.sciencedirect.com › intellectual-assessment
3.	Morgan CT, King RA, Robinson NM. Introduction to psychology. New York.
4.	Sadock BJ, Sadock VA. Kaplan & Sadock's concise textbook of clinical psychiatry. Lippincott Williams & Wilkins; 2008.
5.	Mangal SK. General psychology. Sterling Publishers Pvt. Ltd; 2013 Aug 1.
6.	Schalock RL, Luckasson R, Tassé MJ. An overview of intellectual disability: Definition, diagnosis, classification, and systems of supports. American journal on intellectual and developmental disabilities. 2021 Nov;126(6):439-42.
7.	Kishore MT, Udipi GA, Seshadri SP. Clinical practice guidelines for assessment and management of intellectual disability. Indian journal of psychiatry. 2019 Jan;61(Suppl 2):194.
8.	Catherine R. Coulter, Homoeopathic Sketches of Children's types, Ninth House Publications, Berkeley Springs, West Virginia; 2001.
9.	William Boericke, Boericke's New Manual of Homeopathic MateriaMedica with Repertory, Third Revised and Augmented edition based on Ninth Edition, B.Jain Publishers (P) Ltd, New Delhi.
10.	Allen.H.C, Allen's Keynotes, Tenth edition, B Jain Publishers (P) Ltd, New Delhi.

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UNDERSTANDING OF DEPRESSION WITH HOMOEOPATHIC PERSPECTIVE

INTRODUCTION

As per the American Psychiatric Association, depression, also recognized as major depressive disorder (MDD), is a prevalent and severe medical condition that negatively impacts one's emotional well-being, thought processes, and behaviours. Fortunately, this condition is treatable. Depression presents itself through feelings of sadness and a diminished interest in previously enjoyable activities, potentially resulting in a variety of emotional and physical difficulties. Additionally, it can impede one's ability to perform effectively in both professional and personal spheres."

The symptoms of depression can range in intensity from mild to severe, and they may encompass:

- Experiencing feelings of sadness or a consistently low mood.
- Losing interest or pleasure in activities that were once enjoyable.
- Undergoing changes in appetite, resulting in unexplained weight loss or gain.
- Struggling with sleep patterns, either experiencing insomnia or oversleeping.
- Feeling persistent fatigue or increased tiredness.
- Demonstrating heightened, aimless physical activity (e.g., restlessness, pacing, and handwringing) or experiencing slowed movements and speech (with the caveat that these changes are noticeable to others).
- Battling feelings of worthlessness or guilt.
- Encountering difficulties with thinking, concentration, or decision-making.
- Contemplating thoughts of death or suicide.

To receive a depression diagnosis, these symptoms must persist for a minimum of two weeks and signify a noticeable alteration from the previous level of functioning.

PREVALENCE OF DEPRESSION

The global lifetime prevalence of depression, anxiety, and stress among adolescents and young adults varies widely, estimated to range from 5% to 70%. An Indian study even reported no cases of depression among college-going adolescents. In an effort to shed light on the current scenario, a cross-sectional study was conducted in Ranchi city, India, to gauge the prevalence of depressive, anxiety, and stress-related symptoms, both dimensionally and categorically, among young adults. The study employed a stratified sample of 500 students, chosen to be representative of the city's college-going population, which stands at around 50,000 individuals. From this sample, 405 participants were included in the final analysis. The findings revealed a spectrum of symptoms, ranging from mild to extremely severe: depressive symptoms were present in 18.5% of the population, anxiety in 24.4%, and stress in 20%. Clinical depression was identified in 12.1% of the participants, and generalized anxiety disorder affected 19.0%. Notably, comorbidity between anxiety and depression was significant, with approximately 87% of individuals with depression also experiencing an anxiety disorder.

A cross-sectional survey was conducted among 594 women from 18 wards within Amabalappuzha North Panchayat, utilizing the cluster sampling technique. The study gathered data on various aspects, including sociodemographic factors, health factors, and behavioural factors, by having investigators administer a semi-structured questionnaire to the women.

The findings revealed that the prevalence of Major Depression among middle-aged women stood at 26.09%, as determined by the PHQ-9 diagnostic criteria, and 24.2% when considering a PHQ-9 cut-off score of ≥ 10. Interestingly, as age increased, there was an ascending trend in the prevalence of Depression observed up to the age of 55 years, followed by a slight decline. Additionally, certain factors were associated with a higher prevalence of Depression among the participants. This included widowed individuals, among whom the prevalence was 43.37%, as well as women not in a marital relationship (41.38%). Furthermore, a history of postpartum Depression was found to be a significant factor, with an odds ratio (OR) of 3.471. Similarly, women experiencing peri-menopausal symptoms had a prevalence of 40.28% and an odds ratio of 2.86 in relation to Depression.

RISK FACTORS FOR DEPRESSION

1) Biochemistry
2) Genetics
3) Personality Factors
4) Environmental Factors

TYPES OF DEPRESSION

Depressive disorders encompass a range of conditions, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). These include:

1. Disruptive Mood Dysregulation Disorder
2. Major Depressive Disorder (including major depressive episodes)
3. Persistent Depressive Disorder (Dysthymia) Premenstrual Dysphoric Disorder
4. Substance or Medication-Induced Depressive Disorder
5. Depressive Disorder Due to Another Medical Condition
6. Other Specified Depressive Disorder
7. Unspecified Depressive Disorder

DIAGNOSTIC GUIDELINES IN ICD-10 AND DSM-5

In the ICD-10, depression is primarily classified under the code "F32" for depressive episodes.

F32.0 - Mild depressive episode
F32.1 - Moderate depressive episode
F32.2 - Severe depressive episode without psychotic symptoms
F32.3 - Severe depressive episode with psychotic symptoms
F32.8 - Other depressive episodes
F32.9 - Depressive episode, unspecified

DSM-5 CLASSIFICATION OF DEPRESSION:

In the DSM-5, depression is classified as "Major Depressive Disorder" (MDD). Major Depressive Disorder is characterized by the presence of specific criteria, including the following:

1. Depressed mood most of the day, nearly every day
2. Markedly diminished interest or pleasure in activities (anhedonia)
3. Significant weight loss or gain, or changes in appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive guilt
8. Diminished ability to think or concentrate, or indecisiveness
9. Recurrent thoughts of death, suicidal ideation, or a suicide attempt.

DIFFERENTIAL DIAGNOSIS

- Bipolar Disorder
- Dysthymia (Persistent Depressive Disorder)
- Anxiety Disorders
- Post-Traumatic Stress Disorder (PTSD)
- Substance-Induced Mood Disorder
- Medical Conditions
- Adjustment Disorder
- Schizoaffective Disorder
- Personality Disorders
- Grief and Bereavement
- Premenstrual Dysphoric Disorder (PMDD)
- Somatization Disorders

DEPRESSION IN THE MIASMATIC PERSPECTIVE

Depression, as a mental and emotional disorder, can be seen from a miasmatic perspective, primarily through the lens of psora:

Psoric Depression: Homeopaths may view some forms of depression as having a psoric origin, particularly when it is associated with a sense of inner imbalance, vulnerability, and a predisposition to chronic health issues. Psora is often linked to suppressed emotions or chronic stress, which can contribute to depressive symptoms.

HOMOEOPATHIC REMEIDES

- Arsenicum Album: This remedy is indicated for individuals who experience restlessness, anxiety, and fear along with depression. They may have perfectionist tendencies and feel worse at night.
- Aurum Metallicum: Aurum is recommended for individuals with deep depression, often related to feelings of worthlessness or guilt. They may have suicidal thoughts and a desire for isolation.
- Ignatia Amara: Ignatia is suitable for individuals who experience depression after grief, loss, or emotional shocks. They may have mood swings, weep easily, and have difficulty expressing their emotions.
- Natrum Muriaticum: Natrum Muriaticum is indicated for individuals who suppress their emotions, especially grief, leading to chronic depression. They may appear reserved, with a preference for solitude, and can be sensitive to criticism.
- Pulsatilla: Pulsatilla is recommended for individuals who have a tendency to weep easily and crave sympathy and comfort. They may experience mood swings and clinginess.
- Sepia: Sepia is considered when individuals with depression feel overwhelmed by their responsibilities and have a sense of indifference towards loved ones. They may experience irritability, fatigue, and a lack of interest in activities they once enjoyed.
- Lycopodium: Lycopodium is prescribed for individuals who have a fear of failure, low self-esteem, and anticipatory anxiety. They may also experience digestive issues alongside depression.
- Staphysagria: Staphysagria is indicated for individuals who suppress their anger and may experience depression as a result. They may have feelings of humiliation, victimization, and resentment.
- Cimicifuga Racemosa: This remedy is considered when depression is accompanied by physical symptoms like headaches, muscle tension, and body aches. There may also be mood swings and irritability.
- Aconitum Napellus: Aconitum is suitable for individuals who experience acute, sudden depression, often following a shock, fright, or traumatic event. There may be intense anxiety and restlessness.
- Kali Phosphoricum: This remedy is indicated for individuals with physical and mental exhaustion, especially due to prolonged stress. They may experience weakness, nervousness, and irritability.
- Causticum: Causticum is recommended for individuals with depression that stems from a sense of injustice, grief, or loss. They may have a strong desire to help others and may be deeply empathetic.

CONCLUSION

Homeopathic perspective on depression provides a holistic and individualized approach to understanding and treating this complex condition. By tailoring remedies to a person's unique emotional state, mental symptoms, and physical constitution, homeopathy aims to address the root causes of depression and restore balance on multiple levels. While considering miasms like psora offers insights into underlying predispositions, it's essential to emphasize that homeopathic treatment should be administered by a qualified practitioner as part of a comprehensive mental health care plan, which may include counselling, lifestyle adjustments, and collaboration with other healthcare professionals when necessary. This approach offers hope for those seeking healing, resilience, and improved overall well-being.

REFERENCES

- Stringaris A. What is depression? J Child Psychol Psychiatry. 2017 Dec;58(12):1287-9.
- Reynolds EH, Wilson JV. Depression and anxiety in Babylon. J R Soc Med. 2013;106(12):478-481. doi:10.1177/0141076813486262.
- Tipton CM. The history of "Exercise Is Medicine" in ancient civilizations. Adv Physiol Educ. 2014;38(2):109–117. doi:10.1152/advan.00136.2013.
- Nair MK, Paul MK, John R. Prevalence of depression among adolescents. Indian J Pediatr. 2004 Jun;71:523-4.
- Garber J, Weersing VR. Comorbidity of anxiety and depression in youth: implications for treatment and prevention. Clin Psychol Sci Pract. 2010 Dec;17(4):293.
- Sahoo S, Khess CR. Prevalence of depression, anxiety, and stress among young male adults in India: a dimensional and categorical diagnoses-based study. J Nerv Ment Dis. 2010 Dec 1;198(12):901-4.
- Archana PS, Das S, Philip S, Philip RR, Joseph J, Punnoose VP, Lalithambika DP. Prevalence of depression among middle-aged women in the rural area of Kerala. Asian J Psychiatry. 2017 Oct 1;29:154-9.
- Sjöberg L, Karlsson B, Atti AR, Skoog I, Fratiglioni L, Wang HX. Prevalence of depression: Comparisons of different depression definitions in population-based samples of older adults. J Affect Disord. 2017 Oct 15;221:123-31.
- Dobson KS, Dozois DJ, editors. Risk factors in depression. Elsevier; 2011 Sep 2.
- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Washington, D.C., APA; 2013.

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UNDERSTANDING OF PSYCHIATRIC EMERGENCIES WITH HOMOEOPATHIC PERSPECTIVE

INTRODUCTION

DEFENITION-A Psychiatric Emergency is a disturbance in thought, mood and/or action which causes sudden distress to the individual/others and sudden disability or death, thus requiring immediate management.

A psychiatric emergency is any disturbance in thoughts, feelings, or actions for which immediate therapeutic intervention is necessary. For a variety of reasons–such as the growing incidence of violence, the increased appreciation of the role of medical disease in altered mental status, and the epidemic of alcoholism and other substance use disorders–the number of emergency patients is on the rise.

The widening scope of emergency psychiatry goes beyond general psychiatric practice to include such specialized problems as the abuse of substances, children, and spouses; violence in the form of suicide, homicide, and rape; and such social issues as homelessness, aging, competence, and acquired immune deficiency syndrome (AIDS). The emergency psychiatrist must be up to date on medicolegal issues and managed care. This section provides an overview of psychiatric emergencies in general and in adults in particular

GENERAL PSYCHIATRIC EMERGENCIES

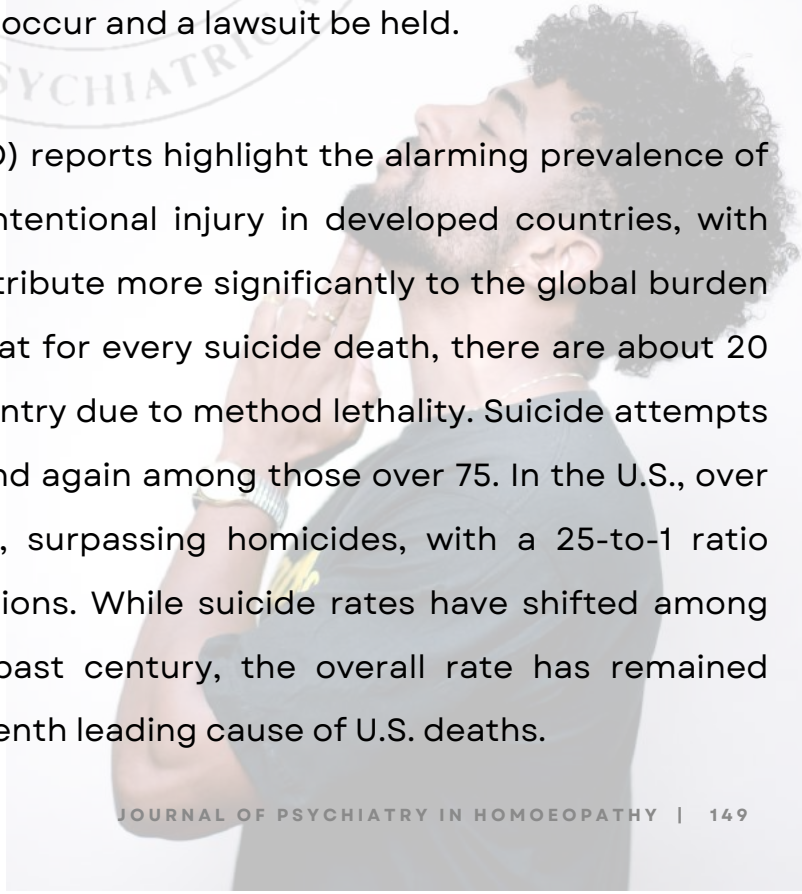
1. Suicide
2. Violent patients
3. Rape and sexual abuse
1. Anorexia nervosa
2. Acute psychotic episode with excited behavior and violence:
4. Alcohol & drug withdrawal syndrome & delirium tremens.
5. Depressive stupor or catatonic syndrome.
6. Acute stress reaction with dissociative conversion disorder.
7. Panic disorder with panic attacks.
8. Dystonic reaction due to psychotropic drugs.

SUICIDE

In psychiatry, suicide is the primary emergency, with homicide and failure to diagnose an underlying potentially fatal illness representing other, less common psychiatric emergencies. Suicide is to the psychiatrist as cancer is to the internist–the psychiatrist may provide optimal care, yet the patient may die by suicide nonetheless. Thus, suicide is impossible to predict, but numerous clues can be seen. There are also some generally accepted standards of care that facilitate risk reduction, as well as lessen the likelihood of successful litigation, should a patient death occur and a lawsuit be held.

Epidemiology

World Health Organization (WHO) reports highlight the alarming prevalence of suicide as a leading cause of intentional injury in developed countries, with projections indicating it will contribute more significantly to the global burden of disease. WHO data reveals that for every suicide death, there are about 20 suicide attempts, varying by country due to method lethality. Suicide attempts peak among those aged 15-24 and again among those over 75. In the U.S., over 35,000 suicides occur annually, surpassing homicides, with a 25-to-1 ratio between attempts and completions. While suicide rates have shifted among specific populations over the past century, the overall rate has remained relatively stable, ranking as the tenth leading cause of U.S. deaths.



Prevention/intervention programs

Strategies for preventing suicide have been implemented in most countries, with varying degrees of success. Prevention strategies are typically grouped under universal (population-wide) strategies, selective strategies (targeting sub populations or environments within the larger population that could be at increased risk) or indicated strategies (in at risk individuals who have already exhibited some form of suicidal behaviour or ideation). For these individuals, treatment strategies relying on psychotherapy or pharmacotherapy may also be indicated alone or in combination, depending on the characteristics of the individual.

The relatively stable rates of suicide and suicidal behavior over time highlight the need for greater attention to prevention and intervention efforts. A recent systematic review of suicide prevention programs revealed that restricting access to lethal means and training physicians to recognize and treat depression and suicidal behavior have shown impressive effects in reducing suicide rates. Means-restriction programs can decrease suicide rates by 1.5–23 percent, while primary-care physician education and training programs show reductions of 22–73 percent. Although effective prevention programs exist, the fact that many people engaging in suicidal behavior do not receive treatment of any kind underscores the need for greater dissemination of information and further development of prevention efforts.

MANAGEMENT

Effective suicide prevention in psychiatric patients involves comprehensive assessment and treatment. While some patients may have severe, chronic suffering or personality disorders, most suicides can be prevented with proper care. Assessment includes a thorough psychiatric history, mental state examination, and evaluation of depressive symptoms, suicidal thoughts, intents, plans, and attempts. Factors like lack of future plans, giving away property, and recent losses increase risk. Hospitalization decisions depend on several factors, including diagnosis, severity of depression and suicidal ideation, patient and family coping abilities, living situation, social support, and risk factors.

Legal and ethical factors are important, with liability issues often arising from suicides in psychiatric hospitals. Courts expect periodic patient evaluation, secure treatment plans, and staff adherence to these plans. While suicide and attempted suicide have different legal implications, aiding a suicide can lead to punishment.

The management of suicide risk now emphasizes psychosocial interventions alongside primary psychiatric disorder treatment. Brief interventions aim to inform individuals about suicidal behavior, raise awareness, encourage safety planning, and develop practical strategies for crisis management. Longer-term psychosocial interventions like cognitive therapy (CT) and cognitive behavior therapy (CBT) have shown effectiveness in reducing self-harm. Dialectical behavior therapy (DBT), collaborative assessment and management of suicidality (CAMS), and mindfulness-based interventions also contribute to comprehensive suicide risk reduction.

VIOLENT PATIENTS

The most significant predictors of violent behavior include excessive alcohol consumption, a history of previous violent acts leading to arrests or criminal activity, and a history of childhood abuse.

Recognizing these predictors is crucial for designing effective interventions and ensuring the safety of both the patient and others involved.

RAPE AND SEXUAL ABUSE

Rape and sexual abuse represent traumatic experiences that require immediate and sensitive intervention. Rape involves coercing an unwilling victim into sexual acts, often accompanied by threats of physical harm, and can have lifelong psychological consequences. It is essential to provide immediate support, medical attention, and legal guidance to victims. Sexual abuse can take various forms, including genital manipulation, inflicting pain, and forced sexual activity, and may also lead to long-term psychological distress. While most perpetrators are male, both male and female victims exist, and the risk is highest among women aged 16 to 24. Victims often experience emotions such

as shame, humiliation, anxiety, confusion, and outrage, sometimes blaming themselves for the assault. Clinicians should offer nonjudgmental support, inform patients about available medical and legal services, and consider the patient's comfort with the gender of the clinician conducting the evaluation. A private evaluation is crucial, and a detailed history of the attack should be obtained, with the patient's consent. Collecting evidence, such as semen and pubic hair, can aid in identifying the perpetrator, and meticulous documentation is essential for potential legal proceedings.

ANOREXIA NERVOSA

Anorexia nervosa primarily affects females and is characterized by a refusal to maintain a healthy body weight, a distorted body image, a fear of gaining weight, and the absence of at least three menstrual cycles. This disorder typically emerges after puberty but can occur in children as young as 9 to 10 years. In severe cases, when weight loss approaches 30 percent of body weight or metabolic disturbances become severe, hospitalization is necessary to address the risk of starvation, dehydration, and associated medical complications.

ACUTE PSYCHOTIC EPISODE WITH EXCITED BEHAVIOR AND VIOLENCE

An acute psychotic episode with excited behavior and violence can manifest with delusions, hallucinations, disorganized thinking, and mood incongruence. It is essential to rule out drug or alcohol intoxication and conduct a thorough mental state examination to diagnose psychotic disorders or manic episodes. Management involves administering antipsychotic drugs like haloperidol or risperidone. If patients refuse medication, mobilizing at least three individuals to restrain them may be necessary.

ALCOHOL AND DRUG INTOXICATION, WITHDRAWAL SYNDROMES, AND DELIRIUM TREMENS

Alcohol and drug intoxication, withdrawal syndromes, and delirium tremens can lead to delirium, characterized by clouded consciousness, reduced attention, altered perception, and fluctuations in symptoms throughout the day. Delirium often includes symptoms such as confusion, agitation, disorientation, hallucinations, and disturbed sleep. Proper management involves ruling out other causes of delirium and confirming alcohol or drug intoxication or withdrawal through history and symptoms. Timely detoxification with oral diazepam, thiamine, chlorpromazine, and amitriptyline is essential.

DEPRESSIVE STUPOR AND CATATONIC SYNDROME

Depressive stupor and catatonic syndrome are characterized by extreme psychomotor slowing, social withdrawal, refusal to eat or drink, and a risk of severe dehydration and starvation. These conditions require immediate medical attention. Treatment involves initiating intravenous fluids, placing a nasogastric tube for feeding, and administering oral antidepressant and antipsychotic medications. Hospitalization is often necessary to stabilize the patient's condition.

ACUTE STRESS REACTIONS WITH DISSOCIATIVE CONVERSION

Acute stress reactions with dissociative conversion disorders involve the manifestation of physical or psychological symptoms in response to overwhelming psychological conflicts or stressors. These symptoms often present as physical complaints without underlying pathology. Management includes providing reassurance, identifying stressors, and offering psychoeducation.

Techniques such as muscle relaxation, abdominal breathing exercises, mindfulness practice, and positive self-talk can help prevent future symptoms. In rare cases, short courses of anxiolytic drugs like diazepam may be required.

PANIC DISORDER

Panic disorder with panic attacks can mimic serious medical conditions, causing significant fear and distress. Management involves conducting a relevant history and examination, ruling out life-threatening conditions, and providing reassurance. Patients should be taught relaxation and breathing exercises and positive self-talk. In exceptional cases, short courses of anxiolytic medications like diazepam may be needed to manage symptoms.

DYSTONIC REACTION DUE TO PSYCHOTROPIC DRUGS

Dystonic Reaction Due to Psychotropic Drugs: Dystonic reactions are acute adverse extrapyramidal effects that can occur as a side effect of antipsychotic drugs like haloperidol and chlorpromazine. These reactions involve involuntary muscle contractions that can affect various body parts, including the face, neck, trunk, pelvis, and extremities. Although such reactions have become less common with the use of newer antipsychotic drugs like risperidone and olanzapine, they can be distressing for patients and their families. Dystonic reactions are typically not life-threatening but need prompt medical attention if they occur.

PSYCHIATRIC EMERGENCIES IN CHILDREN:

Children and adolescents rarely seek psychiatric intervention independently, so most evaluations are initiated by parents, relatives, teachers, therapists, physicians, or child protective service workers. These referrals can vary from life-threatening situations such as suicidal behavior, physical abuse, and violent behavior to non-life-threatening but urgent referrals involving exacerbations of serious psychiatric disorders or disruptive behaviors.

Major Classification of Pediatric Psychiatric Emergencies:

Life-threatening emergencies include:

1. Suicidal Behavior Assessment: Suicidal behavior is a common reason for emergency evaluations in adolescents. Despite minimal risk in very young children, all cases of suicidal ideation or behavior, regardless of age, should be evaluated carefully. The assessment should focus on the circumstances, lethality, and persistence of the suicidal intent. It should also evaluate the family's ability to provide appropriate supervision. Decisions regarding hospitalization depend on factors such as the psychiatric status of the child, the presence of psychosis, severe depression, or marked ambivalence about suicide.
2. Violent Behavior and Tantrums Assessment: When dealing with a violent child or adolescent, the immediate priority is to ensure the safety of both the child and staff members. Calming techniques, physical restraint when necessary, and psychiatric evaluation are used to manage violent behavior. Medication may be administered if required.

3.Fire Setting: Fire setting, whether accidental or premeditated, is assessed to determine the risk involved and whether any underlying psychopathology exists in the child or family members. Preventing further incidents and treating underlying issues are critical components of management.

4.Child Abuse: Physical and Sexual : Child abuse can manifest as physical or sexual abuse and may result in fear, guilt, anxiety, depression, or ambivalence in the child. Assessments should include interviews with the child and family members and observation of family interactions. Physical indicators, when present, can aid in the diagnosis.

5.Neglect: Failure to Thrive: Neglect can lead to failure to thrive in infants, and it often results from the inability of parents or caregivers to provide adequate care. Immediate reporting to child protective services is necessary, and decisions regarding hospitalization or outpatient treatment depend on the child's safety and family cooperation.

Urgent non life-threatening situations include:

1. School Refusal: School refusal can arise due to various factors, including separation anxiety. It requires intervention to prevent the persistence of this dysfunctional pattern.
2. Munchausen Syndrome by Proxy: Munchausen syndrome by proxy is a rare form of child abuse where a parent or caregiver fabricates or causes illness or injury in a child. Recognition and intervention are vital to protect the child from further harm.

HOMOEOPATHIC PERSPECTIVE

In homoeopathy, mental and emotional disorders, including those related to suicidal thoughts, are treated based on the individual's unique symptoms and constitution. Here are some key homeopathic remedies that may be considered for individuals experiencing suicidal thoughts or related mental health issues:

1. Anacardium: This remedy is indicated for individuals who have fearfulness about the future, feelings of being surrounded by enemies, a helpless state of mind, and sluggishness. They may have an irresistible desire to curse and swear, fixed ideas, and hallucinations. Anacardium can be helpful for those with tendencies toward self-harm.
2. Antimonium Crudum: This remedy may be considered for individuals who experience loathing of life, suicidal thoughts with a desire to commit suicide, great sadness, and weeping. They may also have anxious reflections about the present or future and exhibit sentiments of distrust.
3. Antimonium Tartaricum: Individuals needing this remedy may have suicidal thoughts, senseless frenzy, and an inclination toward suicide.

Mental lassitude, weakness of mind, timidity, and restlessness are common symptoms.

4.Aurum Metallicum: This remedy is indicated for those with suicidal ideas and insanity resulting from depressing emotional troubles. They may experience religious mania related to hepatic disorders, hallucinations of sight, and a sense of being unfit for this world.

5.Psorinum: Suicidal thoughts, hopelessness, and despair of recovery are symptoms that may lead to considering Psorinum. This remedy is often associated with deep-seated chronic issues.

6.Arsenicum Album: Arsenicum is suitable for individuals with great anguish, restlessness, and fear of death. They may have suicidal thoughts and lack the courage to carry them out. This remedy is particularly indicated for anxiety-related conditions.

7.Staphysagria: This remedy may be helpful for those with violent outbursts of passion, hypochondriacal tendencies, sadness, and extreme sensitivity to what others say. Suicidal thoughts accompanied by a fear of death and a history of anger and insults may indicate the need for Staphysagria.

Natrum Sulphuricum, Carcinosin, Capsicum, Heparsulph, Ignatia, Mercurius, Pulsatilla, Rhus Tox, Alumina, Argentum Nitricum, Kali Brom, Naja: These are additional homeopathic remedies that may be considered based on the individual's unique constitution and symptoms.

REFERENCES

1. American Psychiatric Association Diagnostic and statistical manual of Mental Disorders (5thed.)DSM-V.Washington,D.C,APA;1994

2. World Health Organization The ICD Classification of Mental and Behavioral Disorders (10th ed) Delhi, A.I.T.B.S.Publishers& Distributors;2007

3. Sadock BJ, Sadock VA, Ruiz P, Kaplan & Sadock's Synopsis of Psychiatry, Eleventh edition, Wolters Kluwer private limited New Delhi, 2018.407

4. Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and suicidal behavior. Epidemiologic reviews, 30(1), 133–154. https://doi.org/10.1093/epirev/mxn002

5. Turecki, G., Brent, D. A., Gunnell, D., O'Connor, R. C. , Oquendo, M. A., Pirkis, J. and Stanley, B. H. (2019) Suicide and suicide risk. Nature Reviews Disease Primers, 5, 74. (doi: 10.1038/s41572-019-0121-0)

6. Kaplan, H. I., Sadock, B. J., &Grebb, J. A. (1994). Kaplan and Sadock's synopsis of psychiatry: Behavioral sciences, clinical psychiatry (7th ed.). Williams & Wilkins Co.

7. World Health Organization. Preventing suicide: a global imperative [online], https://www.who.int/mental_health/suicide-prevention/world_report_2014/en/ (2014). A systematic overview of the global epidemiology of suicide and suicide attempts, including country-specific data and an assessment of key prevention strategies

8. Brent, D. A., Bridge, J., Johnson, B. A. & Connolly, J. Suicidal behavior runs in families. A controlled family study of adolescent suicide victims. Arch Gen Psychiatry, 1145-1152 (1996).

9. Monk M. Epidemiology of suicide. Epidemiol Rev. 1987;9:51–69.

10. Baldessarini RJ, Hennen J. Genetics of suicide: an overview. Harv Rev Psychiatry. 2004;12:1–13.

11. Traskman-Bendz L, Mann JJ. Biological aspects of suicidal behaviour. In: Hawton K, van Heeringen K, editors. The international handbook of suicide and attempted suicide. 1st. Chichester, United Kingdom: John Wiley & Sons; 2000. pp. 65–77

12. Hahnemann S, Organon of Medicine, 5th ed. Translated by R.E.Dudgeon, B. Jain Publishers (P)Ltd;2000.

13. Boericke W. New manual of homoeopathic materia medica and repertory: B. Jain Publishers; 2001

14. Glasgow Coma Scale. (1974). Lancet, 2(7872), 81-84.

15. Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mini-mental state." A practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research, 12(3), 189-198.

16. Pierce, D. W., & Suominen, K. (2011). "Suicide intent scale." In J. J. Mann, M. M. Oquendo, & D. A. Brent (Eds.), The International Handbook of Suicide Prevention (pp. 329-340). Wiley.

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HOMOEOPATHIC MANAGEMENT OF TOBACCO USE DISORDER; A CASE REPORT

Abstract : Tobacco use disorder is common among individuals who use cigarettes and smokeless tobacco daily and is uncommon among individuals who do not use tobacco daily or who use nicotine medications. Tolerance to tobacco is exemplified by the disappearance of nausea and dizziness after repeated intake and with a more intense effect of tobacco the first time it is used during the day. Homoeopathy outlook the disease through a multifactorial approach and provide long-lasting results. A case of 40 years old male is reported with symptoms of severe nicotine dependency. Staphysagria 1M was selected after detailed case taking and repertorization with due consultation with materia medica.. A significant improvement according to Fagerstrom Test for Nicotine Dependence (FTND) were observed.

Keywords: Tobacco Use Disorder, FTND, Homoeopathy, Staphysagria

Introduction:

Tobacco use disorder (TUD) is the most prevalent, deadly, and costly of SUDs (Substance Use Disorders).1The prevalence of addiction to nicotine, the primary psychoactive substance in tobacco, surpasses all other SUDs.2 It is also one of the most ignored, particularly by psychiatrists, because despite recent research that shows commonalities between tobacco dependence and other substance use disorders, tobacco dependence differs from other substance dependencies in unique ways.3

Tobacco does not cause behavioral problems, hence few tobacco-dependent persons seek or are referred for psychiatric treatment.4Tobacco is a legal drug and most persons who stop tobacco use have done so without treatment.5 Thus a common, but erroneous, view is that, unlike alcohol and other illicit drugs, most smokers do not need treatment.6

According to ICD-10 the most characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed) alcohol, or tobacco.7 There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.8 Tobacco use disorder is common among individuals who use cigarettes and smokeless tobacco daily and is uncommon among individuals who do not use tobacco daily or who use nicotine medications.9

Premature deaths attributable to tobacco are rising, an estimated 10 million deaths per year globally by 2030, while 70% of total deaths contributed by developing countries.10 The chance of non-communicable diseases (NCDs), such as cardiovascular, respiratory diseases, and cancer, increased by smoking.11 Parental smoking is responsible for new born death due to sudden infant death syndrome (SIDS), complications of low birth weight, prematurity, and other conditions. Along with the health burden, the economic loss attributable to smoking increased to a great extent which was equivalent to 1.8% of the world's annual gross domestic product (GDP). The burden was substantially shared by developing countries 12

CASE PROPER :

A 40 years old male patient presented with complaints of smoking cigarettes 20-30 per day, persistent desire to cut down tobacco use, craving to use tobacco for the last 20 years. He started smoking at 20 years old. Occasionally he had interference with work due to smoking. He had the symptoms of irritability, anxiety, restlessness and depressed mood if he stop smoking abruptly. Patient had intense desire to quit smoking but he couldn't achieve it by himself.

Treatment History- No treatment was taken.

Past History

Chickenpox-20 yrs of age - allopathy-relieved

No history of other major illness

Family History- Father- Nicotine Dependence

Physical Generals.

His appetite and decreased thirst was normal. Sour eructations. Desire salt and vegetables Bowel and Bladder: regular, Sleep: Sound

Thermal reaction of patient- Chilly

Mental Generals – Desire to be alone, anxiety about trifles, weakness of memory, religiousness, laziness

General Physical Examination

Patient is moderately built and moderately nourished, No pallor, cyanosis, icterus, clubbing, oedema, lymphadenopathy, Temperature: 98.6° F. (Afebrile), Height: 155 cms, Weight: 56kgs, Pulse rate: 72bpm, Respiratory rate: 18cpm. BP-120/80 mm of Hg

Mental Status Examination

Patient was conscious and co-operative. EEC maintained properly, IPR-good, speech was normal in rate, tone, volume and reaction time. Affect- appropriate, mood-euthymic. No delusions and hallucinations. He was well oriented to time, place and person memory, attention was good and judgment intact. Insight-grade 6

Investigations

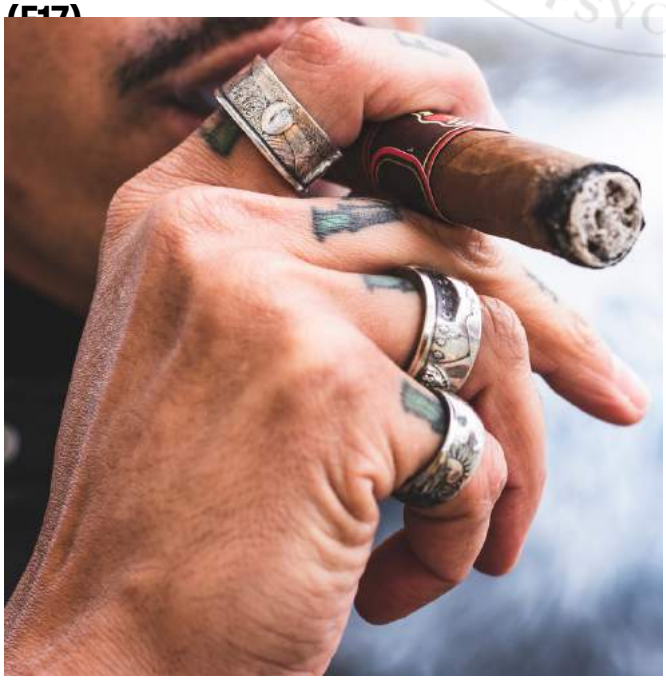
R/E Blood Examination - All parameters were within normal limit

Fasting blood glucose -106 mg/dl

Nicotine metabolite screening in Urine- Positive

SCALE USED – Fagerstrom Test for Nicotine Dependence (FTND). It is used at baseline and follow ups to assess the severity of nicotine dependency

Clinical diagnosis –Mental and Behavioral Disorders due to Use of Tobacco (F17)



Analysis of the case

After analyzing the symptoms of the case the characteristic mental and physical generals and particular symptoms were considered for framing the totality. Anxiety about trifles, easy irritability were included in totality.Miasmatic evaluation for the symptoms were done. Considering the above symptomatology, systemic repertorization was done with the help of Radar 10 software. The Repertorization chart is given in Fig 1.

STAPHYSAGRIA 1M/1D was prescribed on first visit (29/03/21) by considering the reportorial totality and miasmatic background. The patient improved markedly in mental symptoms. Improvement in nicotine dependency were assessed with the help of Fagerstrom Test for Nicotine Dependence in presence of psychiatrist. It is given in table 1. The detail of follow up is in Table 2

Discussion and Conclusion

Homoeopathy is a holistic system of medicine and treating the patient based on totality of symptoms. In this case, prominent mental symptoms considered were anxiety about trifles and easy irritability. STAPHYSAGRIA 1M was prescribed based on the basis of symptoms similarity. Got marked improvement in nicotine dependency within 6 months duration.

Reportorial totality

Mind- Anxiety, trifles about
Mind –Irritability easily
Mind – Laziness
Mind- Memory, weakness of memory
Mind- Religious affections, too much occupied with religion
Food and Drinks- Salt desire
Food and Drinks- Tobacco desire
Food and Drinks- Vegetable desire

Fig 1. Repertorisation Chart

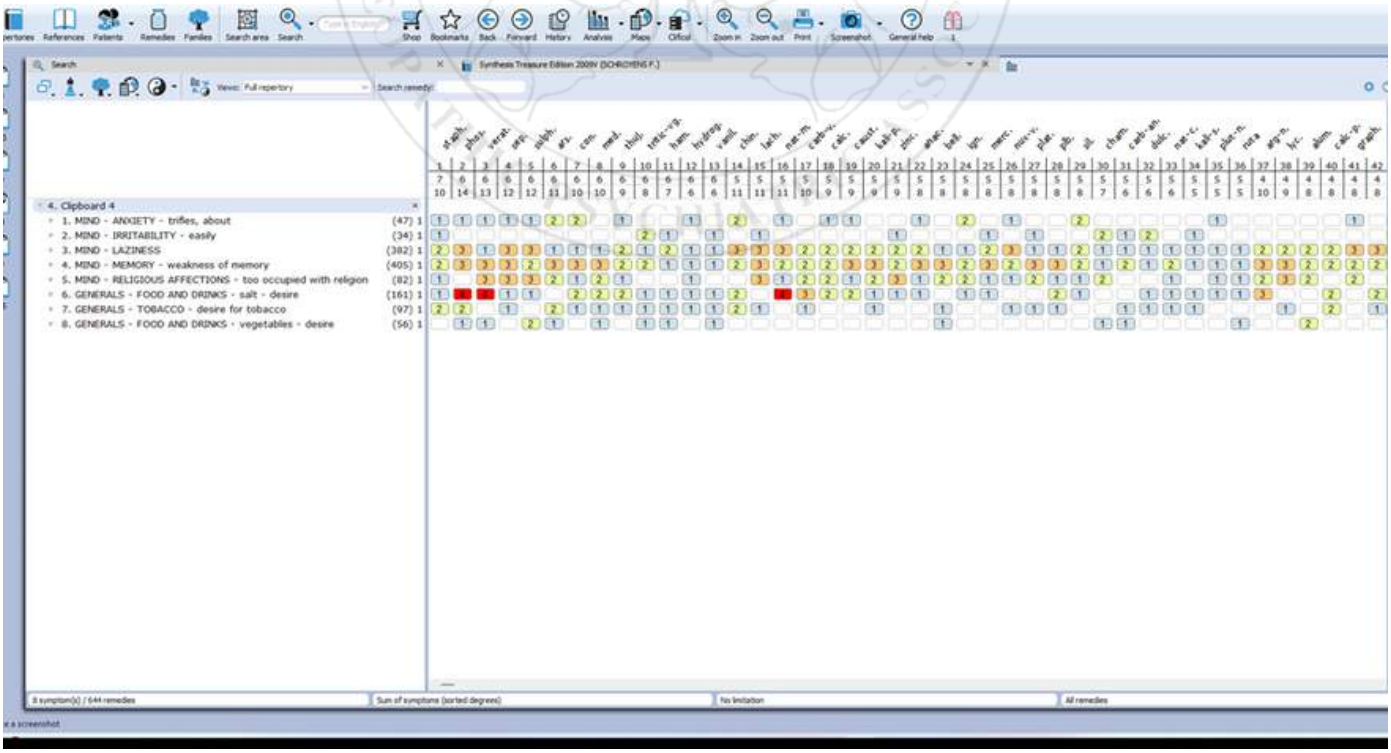


Table 1
SCORING ON FAGERSTROM TEST FOR NICOTINE DEPENDENCE

FOLLOW UP	FTND
BASE LINE- 29/03/21	10
28/04/21	10
28/05/21	8
27/06/21	5
27/07/21	3
27/08/21	1
27/09/21	0

Medicinal prescription

RX,

STAPHYSAGRIA 200/1D (on 29/03/21)

FOLLOWUP

Table 2: Timeline including follow-up of the case

Follow-up date	Indications for prescription	Medicine with doses
28/04/21	Craving for tobacco- Persists Number of Cigarettes smoked per day- Reduced (<20/day) Generals- Good	STAPHYSAGRIA 1M/ 1 DOSE

Follow-up date	Indications for prescription	Medicine with doses
28/05/21	Feels better in general Craving for tobacco-Reduced, yet persists Number of cigarettes smoked per day-Reduced (10-15/day) Generals-Good	STAPHYSAGRIA 1M/ 1 DOSE
27/07/21	Feels better in general Craving for tobacco-Reduced, yet persists Number of cigarettes smoked per day-Reduced (<10/day), Patient can abstain smoking for 2-3 days	STAPHYSAGRIA 1M/ 1 DOSE
27/08/21	Generals-Good	STAPHYSAGRIA 1M/ 1 DOSE
27/09/21	General improvement Craving for nicotine-reduced++ Smoking occasionally in a week Generals-good	PLACEBO

References

1. Piper ME, Smith SS, Schlam TR, Fleming MF, Bittrich AA, Brown JL, Leitzke CJ, Zehner ME, Fiore MC, Baker TB. Psychiatric disorders in smokers seeking treatment for tobacco dependence: relations with tobacco dependence and cessation. Journal of consulting and clinical psychology. 2010 Feb;78(1):13.

2.Hitsman B, Moss TG, Montoya ID, George TP. Treatment of tobacco dependence in mental health and addictive disorders. The Canadian Journal of Psychiatry. 2009 Jun;54(6):368-78.

3.WHO REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2021 Addressing new and emerging productsJha P.
4.The hazards of smoking and the benefits of cessation: a critical summation of the epidemiological evidence in high-income countries. Elife. 2020 Mar 24;9:e49979.
5.Kaplan and Sadock's Comprehensive Textbook of Psychiatry - 50th Anniversary Edition (Set of 2 Volumes) Product Bundle – 1 June 2017 by Benjamin J. Sadock (Author), Virginia A. Sadock (Author), Dr. Pedro Ruiz MD (Author)
6. Baumeister RF. Addiction, cigarette smoking, and voluntary control of action: Do cigarette smokers lose their free will?. Addictive behaviors reports. 2017 Jun 1;5:67-84.
7.The ICD-10 Classification of Mental and Behavioural Disorders (Clinical Descriptions and Diagnostic Guidelines)
8.Bilano V, Gilmour S, Moffiet T, d'Espaignet ET, Stevens GA, Commar A, Tuyl F, Hudson I, Shibuya K. Global trends and projections for tobacco use, 1990–2025: an analysis of smoking indicators from the WHO Comprehensive Information Systems for Tobacco Control. The Lancet. 2015 Mar 14;385(9972):966-76.
9. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2019 Jan 30].
10.Yoo JE, Han K, Shin DW. From the IASLC Tobacco Control Committee. Journal of Thoracic Oncology.;17(6):730-3
11.Naavaal S, Malarcher A, Xu X, Zhang L, Babb S. Variations in cigarette smoking and quit attempts by health insurance among US adults in 41 states and 2 jurisdictions, 2014. Public Health Reports. 2018 Mar;133(2):191-9.
12.Cataldo JK, Dubey S, Prochaska JJ. Smoking cessation: an integral part of lung cancer treatment. Oncology. 2010;78(5-6):289-301

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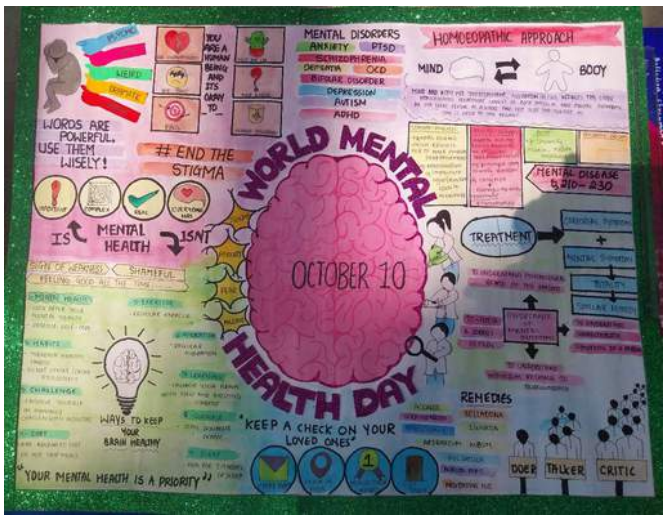
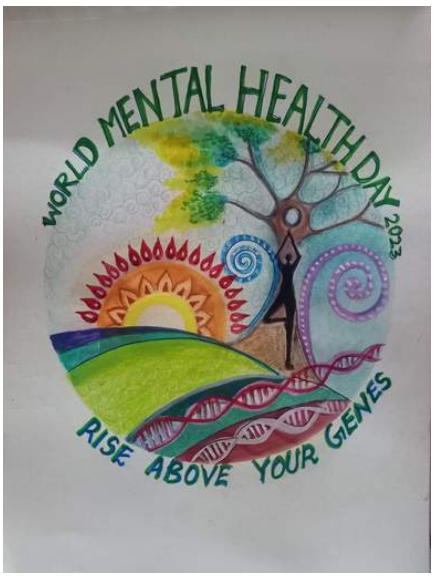
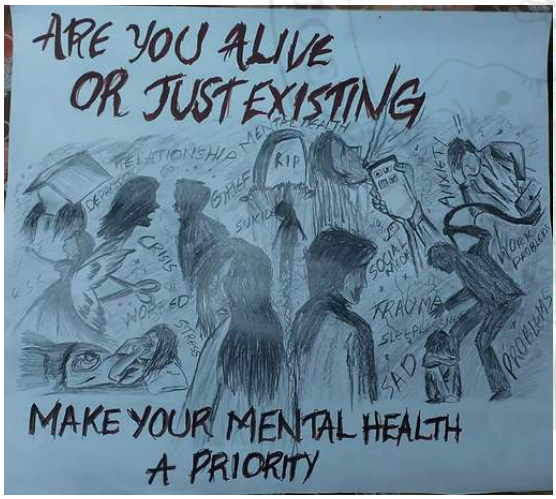
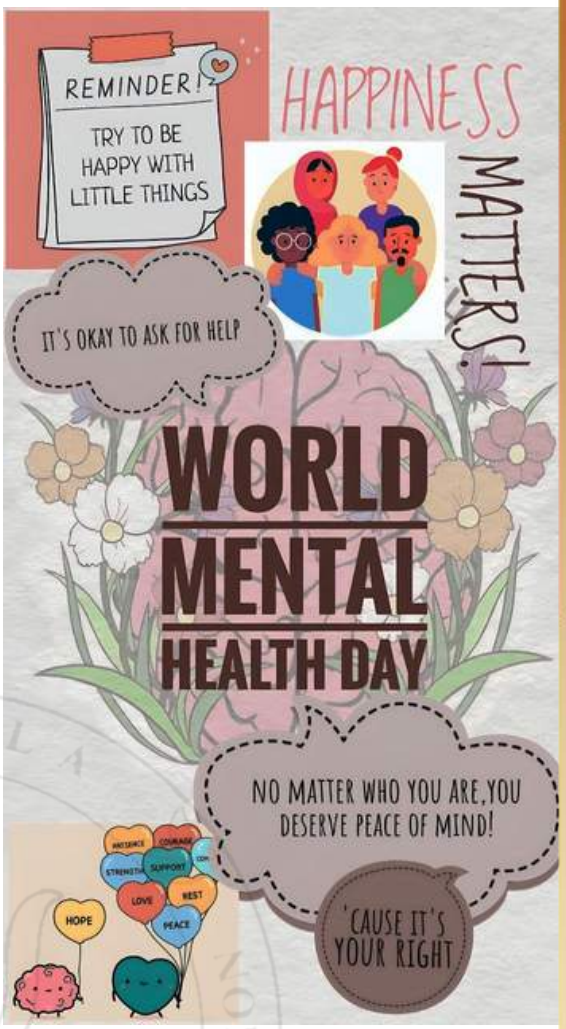
POSTER MAKING CONTEST- MENTAL HEALTH DAY









10 October 2023

World Mental Health Day

"Our Minds, Our Rights"

World Mental Health Day 2023 is an opportunity for people and communities to unite behind the theme 'Mental health is a universal human right" to improve knowledge, raise awareness and drive actions that promote and protect everyone's mental health as a universal human right.

Homoeopathy has the potential to achieve positive mental health.

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KNOW THE SIGNS
STRESS
DARKNESS
STUCK
STIGMA
THERE'S NO SHAME IN REACHING OUT
GET EXPERT HELP
YOUR MENTAL HEALTH IS IMPORTANT
World Mental is UNIVERSAL Health 2023
END the STIGMA
SELF LOVE
IMPORTANT!
When Others are focusing on external symptoms creating asylum's for mental illness ;
Our Master Hahnemann talks about internal cause of the disease advocate treatment for mental illness considering diet, sleep, hygiene to achieve mental health.-Richard haehl
PEACE
A WELL TAKEN CASE IS HALF CURED
FOLLOW
Get regular health screenings
Stay Active
LIFESTYLE MODIFICATION
Poster by Dr.Vimal Kasar
MD FATHER MULLER
HOMOEOPATHIC MEDICAL COLLEGE MANGLORE


MENTAL HEALTH AS AN UNIVERSAL RIGHT!
TAKE CARE OF YOUR MIND
Speak up , share with friends
Aphorism 210 to 230
Depression
Post-Traumatic Stress Disorder
Common Types of Mental Disorders
Panic Disorder
Bipolar Disorder
Schizophrenia
Dementia
Phobias
Choose Wisely
POSITIVE MIND
POSITIVE VIBES
POSITIVE LIFE
Ask for help!
eat well
sleep min 8h
get outside
favorite music
sports exercise
limit screen time
WORLD MENTAL HEALTH DAY


" DONT Isolate yourself"
Talk about your feelings
WORLD MENTAL HEALTH DAY
Get Enough Sleep
It's okay to take medication
Homoeopathic pills
Mental Health is a Universal Human Right
LOVE YOURSELF
Stay Positive
Let's END the stigma of mental illness
Don't BELIEVE Every Thing You Think

Gratitude

In an era where mental well-being is of paramount importance, the Homeopathic Psychiatric e-magazine promises to be a valuable resource for those seeking innovative and comprehensive insights into the wholistic psychiatric care.

The birth of a dedicated homeopathic psychiatric e-magazine is a significant milestone, one that promises to enlighten and inspire the field of mental health in profound ways. As we navigate the complexities of mental well-being, the holistic approach offered by homeopathy can provide new perspectives and solutions.In today's society, someone who is receiving mental treatment will be stigmatised if others find out. Society must understand that, similar to any disease, a change in our brain's chemical activity leads to mental illness. In this context, the publication of this e-magazine is very relevant. This e-magazine, which is the prime initiative of the homoeopathic psychiatric association, stands for the upliftment of mentally sick people and creates awareness for their rehabilitation. The homeopathy medicines with less side effects are very beneficial for mentally challenged people. I have no doubt that this magazine will be a valuable resource for practitioners, researchers, and all those who seek a deeper understanding of mental health care. May it serve as a beacon of knowledge, fostering innovation, and collaboration within the field of homeopathic psychiatry.

Lastly, our sincere gratitude extends to all our well-wishers who supported this endeavor and contributed time & dedicatIon for its grand success. We appreciate the tireless efforts of our magnificent magazine committee, all the articles authors, and all those individuals who worked hard to make this magazine a grand success.

Treasurer

Dr. Tinu Mathews

Homoeopathic Psychiatric Association

of Kerala

World Mental Health Day

10-Oct-2023

"Mental Health is a Universal Human Right"

-Mental health isn't a privilege, it's a birthright. Let's strive for a world where understanding and compassion form the bedrock of mental well-being. Every individual, every mind, deserves this fundamental human right.-

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