

BENGAL JOURNAL OF PRIVATE PSYCHIATRY

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Editor Speaks

This is the second issue of BJPP with me as Editor. Unfortunately, lack of articles has delayed publication of this issue.

I take this opportunity to invite members to contribute their research findings or review articles to this journal. To keep the journal alive and think of getting it indexed we need a steady flow of article from our members

With regards,

Prof. (Dr.) Debasish Sanyal

Editor, BJPP

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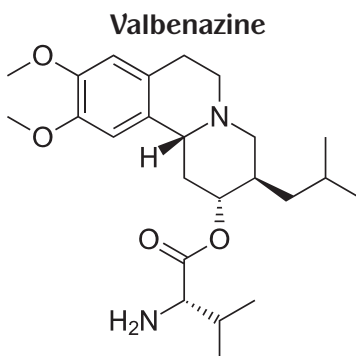
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Valbenazine (Ingrezza), a new drug in the management of adult patients with Tardive Dyskinesia

Dr. Ranjan Bhattacharyya*

Valbenazine (Ingrezza) capsules are indicated in the management for Tardive dyskinesia. ¹The U.S. Food and Drug Administration recently approved Ingrezza (valbenazine) capsules to treat adults with tardive dyskinesia (11 th April, 2017). This is the first drug approved by the FDA for this condition.² Tardive dyskinesia is a neurological disorder characterized by repetitive involuntary movements, usually of the jaw, lips and tongue, such as grimacing, sticking out the tongue and smacking the lips. Tardive dyskinesia can be disabling and can further stigmatize patients with mental illness. The chemical structure of valbenazine is given below.²



The most common adverse effect is somnolence (in more than 5% cases which is almost twice the rate of placebo). The patient shouldn't perform activities requiring mental awareness such as operating a motor vehicle or operating hazardous machinery.

It causes QT prolongation and should be avoided in cases of congenital long QT syndrome or in arrhythmias associated with prolonged QT interval. The other common adverse effects are anticholinergic side effects, balance disorders and falls, headache, akathisia, vomiting, nausea and arthralgia.

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Valbenazine is a reversible vesicular monoamine transporter 2 inhibitor (VMAT 2) which is a transporter that regulates monoamine uptake, indicated for the treatment of adults with tardive dyskinesia. It has no action in VMAT 1 receptor or other monoamine receptors. The initial dose to be administered is 40mg once daily, dose to be increased after one week to 80 mg/day. It can be taken with and without food. The recommended doses for patients with moderate to severe hepatic impairment are 40 mg daily. The dose reduction is based on tolerability in known CYP2D6 poor metabolizers. It shouldn't be used with concomitant MAO inhibitors and CYP 3A4 inducers. It's a highly protein bound drug (99%)

The safety has been evaluated in 3 placebo control trial, each of 6 weeks duration (fixed dose, dose escalation, dose reduction) involving 445 patients. The patients were 26 to 84 years old with moderate to severe tardive dyskinesia and had concurrent diagnoses of mood disorder (27%) or schizophrenia/schizoaffective disorder (72%). The mean age was 56 years. A total of 3% patients on Valbenazine and 2% patients on placebo discontinued because of adverse reactions. The AIMS (Abnormal Involuntary Movement Scale), a 12- item scales was the primary efficacy measure for the assessment of severity of tardive dyskinesia. A total 234 patients were enrolled with 29 (12%) discontinuing prior to completion of the placebo controlled period. The mean age was 56 (range 26-84). The patients were 54% male and 46% female.

The limited data available on use of Valbenazine (INGREZZA) in pregnancy but animal studies on rats and rabbits didn't show any risks during the period of organogenesis at doses up to 1.8 to 24 times. But when Valbenazine was administered orally to pregnant rats during the period of organogenesis through lactation shows increase risk of stillbirths and postnatal pup mortality at 0.4 to 1.2 times the MRHD (maximum recommended human dose). The safety and effectiveness of Valbenazine have not been established in paediatric patients. There is no dose adjustment required for elderly patients. In moderate to severe hepatic and renal insufficiency the dose adjustment is required.

References

1. INGREZZA product information. Neurocrine Biosciences, Inc CP-VBZ-US-0175.
2. <https://en.wikipedia.org/wiki/Valbenazine> last accessed on 23/05/2017
3. <https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm552418.htm> last accessed on 23/5/2017.

OCD associated with Bipolarity - a complex case for management

Dr. Abhruchi Chatterjee

- **Case report:**

A 16 year old male, master x, presented in a psychiatric OPD of a general hospital along with his parents with the chief complaints of apprehension, fearfulness, restlessness, sudden anger outbursts, recurrent thoughts, gradually deteriorating academic performances, poor attention and concentration, sleep disturbances since last approximately 3 years. The symptoms developed slowly over time, started with difficulty in sustaining attention, restlessness and recurrent thoughts. Then gradually there was pervasive low mood following gradual deterioration of academic performance. Thereafter he developed guilt feeling, feeling of hopelessness, worthlessness and since last 1 year at times he expressed death wishes in several occasions. Since last few months he started collecting pictures of ghosts and a few magical beliefs came into his mind. The symptoms developed gradually, continuous course with waxing and waning, but never reached baseline.

According to his parents, he was a late child with paternal and maternal age of 40 and 38 accordingly. It was uncomplicated pregnancy, and there was no postnatal complication. Developmental milestone was normal and according to parents he had reputation as a good student. But since his childhood his social skill was poor and had very few friends. When asked, he told that he had no friend as most of them used to ridicule at him.

There was no history of sudden unresponsiveness, convulsion, head injury or muttering to self.

In the family, the maternal grandfather had a psychotic episode in late life and was treated by psychiatrist. Mother has anxiety symptoms but never received treatment from anywhere.

The patient was previously seen by consultant psychiatrist and psychologist. At the beginning he was tried with psycho-social interventions like supportive counseling, attention enhancing exercises. Psychometric assessment was done, IQ found to be average, projective test revealed obsessive compulsive features. Among pharmacotherapy received, he was started with Fluoxetine 20mg, continued for 3 months. There was partial improvement of symptom.

Thereafter he was on Cap. Atomoxetine 25mg and continued for 2 months without much response. The parents reported occasional anger outburst while on medication. He was not on medication or any other treatment since 6 months before the first visit.

During the first visit his main concern was gradual deterioration in academic performance, low mood, lethargy, difficulty in mixing with others, feeling that others discuss and crack joke on him. On further interview, he revealed that he used to have recurrent thoughts mainly while alone. He also told even at times, the thoughts are quite bizarre. His parents' main concerns were gradually deteriorating academic performance, preoccupied behavior, lethargy and sudden anger outburst at times.

- He was previously diagnosed to have hypothyroidism and was on 50 mcg Thyroxin.
- His provisional diagnosis was deferred. The differential diagnoses were following:
 - a. Obsessive Compulsive disorder with predominantly obsessive thoughts
 - b. Prodromal stage of Psychosis
 - c. Schizotypal disorder
 - d. Bipolar affective disorder (early onset) current episode depression

The patient was started on Fluoxetine 20mg /day for 10 days, thereafter 40mg/day, along with Risperidone 0.5 mg/day.

On the first follow up (after 21 days) he was slightly more communicative, reaction time slightly improved, but complained of slight agitation, restlessness since last 4-5 days. Sleep better than before. When asked, he told that there is not much reduction in the recurrent thoughts but a slight improvement in the attention/ concentration has been observed. He was continued on the same regime, but Propranolol 10 mg twice daily was added. After a month, he was better, more communicative. But parents complained that at times he used to show fearfulness and often used to express magical thoughts. He was collecting pictures of ghosts and mysterious faces, but couldn't exactly tell the reason for his collection. Risperidone was increased to 1mg/day. In the next follow up he showed marked improvement. He started going to school regularly, but at times used to complaint that others were looking at him, often discussing about him. Risperidone was increased to 2 mg/day and Fluoxetine was reduced to 20 mg/day. His parent in between reported that he again started avoiding school as he felt threatened that others were discussing and conspiring against him. Next time, when he was interviewed he told that he used to hear voices of several people discussing about him. He also expressed his anguish that some of his friends might harm him. He also felt that others get to know about his thoughts.

The provisional diagnosis was changed to 'Paranoid Schizophrenia'. Fluoxetine was stopped and Risperidone was increased to 3 mg/day and Trihexyphenidyl 2mg/day was added. After

continuation of medication for a month there was not much improvement in symptomatology and complained of sleep disturbances. Risperidone was tapered down to 2 mg for 2 weeks, then 1 mg to continue. Olanzapine 5 mg was added. In 2 weeks there was improvement in symptom profile, auditory hallucination got reduced considerably. Risperidone was stopped and Olanzapine was increased to 10 mg/day. Trihexyphenidyl 2mg and Propranolol 10 mg BD was continued. In a month there was considerable improvement in symptoms like hallucination, delusion and thought broadcasting. But complained of excessive sedation, weight gain, lethargy and poor motivation.

The family wanted another opinion and went for a consultation from a teaching institute in Southern India. The treating doctor agreed with the diagnosis, but was concerned with the adverse effects due to Olanzapine. He got treatment on in-patient basis. Olanzapine was tapered down to 5 mg and Aripiprazole 5 mg/ day was added. The department planned for tdCS (Transcranial direct current stimulation) for the index patient and he had undergone 5 episodes of tdCS over 10 days. Aripiprazole was increased gradually to 10 mg and then 15 mg/day, Propranolol was continued while Olanzapine was stopped. Not much improvement was found after continuing Aripiprazole 15mg, Propranolol 10mg BD and Clonazepam 0.5 mg sos for 1 month. Auditory hallucination, persecutory and referential delusion increased though sedation was less and the patient was more active. He was at times restless and had sleep disturbance. The patient was also receiving psycho-social therapy in the form of supportive psychotherapy along with pharmacotherapy.

Blonanserin 4 mg BD was added and Aripiprazole was tapered down gradually. Partial response was obtained after 3 weeks; Blonanserin was further increased to 12 mg/day initially, thereafter to 16 mg/day. After a month, the patient was much improved, there was significant reduction in symptomatology, but extra pyramidal symptoms were seen in 16 mg with slurring of speech. Trihexyphenidyl was increased to 2 mg BD and Blonanserin was reduced to 12mg /day. Though the positive symptoms were controlled but the patient complained of low mood, anhedonia, poor concentration and lack of energy. Escitalopram 5 mg was added and increased to 10 mg after 10 days. Depressive and anxiety symptoms were slightly reduced but again there was slight elevation of psychotic symptoms. Escitalopram was tapered down and stopped. Aripiprazole was again added in lower dose of 2.5 mg and gradually increased to 5 mg/day. The patient was doing well on a combination of Blonanserin 12 mg/day, Trihexyphenidyl 4mg/day, Propranolol 20 mg/day and Aripiprazole 5mg/day along with supportive psychotherapy.

Currently he is attending school. Communication, socialization improved though at times he is still having auditory hallucination, referential ideas, poor attention, concentration and obsessive thoughts. He is adhering to the regime and at this moment leading functional life.

A Comparative Study on Effective Intervention for Autistic Children

Dr. Isha Chakraborty
Dr. Gautam Bandopadhyay

A Comparative Study on Effective Intervention for Autistic Adolescents for a large number of years, I have had a continued interest in the many facets of autism and how it can present itself in people, specifically in adolescents. I have volunteered at a public school in Arizona, U.S.A., a government-funded school in Kolkata, India, and a non-governmental organization (NGO) also in Kolkata, India to analyse different intervention methods over the past six years. Intervention methods are diverse approaches to combating the various impairments caused by Autism. In order to maintain the privacy of these three institutions, they will be referred to as “Institute A,” “Institute B,” and “Institute C,” respectively. Combining my observations and research, I have come to the conclusion that autistic adolescents often suffer from hypersensitivity, lack of communication skills, or absence of emotional attachment. To ensure success post-adolescence, child-specific training methods incrementally modified for different goals is a better technique to follow in replacement of ineffective group intervention.

Autism can present itself very contrastingly in different adolescents, and it can be placed on a spectrum. Not all adolescents exhibit the same or even similar symptoms, but there have been a number of blanket symptoms used to classify autistic adolescents e.g., hypersensitivity, lack of communication skills, or absence of emotional attachment. Hypersensitivity is when autistic adolescents experience their senses too acutely or often not at all. Lack of communication skills can entail adolescents being nonverbal, semi-verbal, and verbal. For nonverbal and semi-verbal adolescents, newer methods are tailored for a specific child ranging from creating hand signs or using sensory touch signals. Verbal adolescents might be able to communicate in short sentences; however, a larger number of adolescents cannot formulate their own thoughts into sentences without being prompted. There is a strong disconnect between the stereotype that autistic adolescents cannot feel emotion and the reality that most cannot portray the emotions that they feel. The reciprocation of emotions is a challenge for autistic adolescents which correlate to an absence of emotional attachment. Some adolescents are only mildly affected by these symptoms, and others can be significantly affected.

At Institute A in Arizona, U.S.A., I worked in the special education department of a “regular” government-funded public school where over twenty adolescents with different disabilities were expected to learn the same concepts together. The department was the most underfunded of the school, causing all of the students to have to learn in one large room together. The ages of these adolescents ranged from three-year-olds to eleven-year-olds, and suffered from a vast number of disabilities such as blindness, Autism, deafness, Down Syndrome, to say in the least. This intervention method is known as group intervention, and can often include a number of students at different places on the learning curve all taught together. With only one teacher in the room, any event was a challenge whether that be moving to a new topic or eating lunch. There was little to no room for actual improvement in these adolescents when they were all being treated the exact same way despite their obvious differences.

Similarly to Institute A in Arizona, U.S.A., Institute B in Kolkata, India, was also funded by the government with a low teacher to student ratio, averaging about one teacher to nine students. This institute only featured students on the Autistic Spectrum and also implemented group intervention for their students. These students ranged from three years old to twenty-five years old, and they were taught more of life skills such as ironing clothes, opening mail, and serving food. The school was severely under-funded with about twenty rupees (approximately 0.29 dollars) per student with around fifty students in the facility in total. There was little to no infrastructure, but the adolescents were at least grouped by level of disabilities – to increase the odds for improvement.

Group intervention is detrimental to the success for autistic adolescents in a countless number of ways. It can rush the intervention process by forcing an adolescent to reach a goal too quickly and instigate an immediate loss of any progress prior to that goal. For example, if a teacher is instructing students how to count numbers in sequential order to a group of students of varying disabilities who are all eight years old, half of the class might absorb the content immediately by imitating their fellow classmates. However, the student will most likely forget both the correct sequence of numbers as well as the significance of each number in the future because they will not always be given the opportunity to mimic their peers. Learning important concepts in group interventions causes deficits in the long run.

Contrastingly to both Institute A and B, my work at Institute C concluded that child-specific training methods yield the most success for autistic adolescents. Institute C was a private NGO with a strong teacher-to-student ratio being 1:1. This school focused on intervention methods tailored to each adolescent, only working with their assigned teachers, referred to as their “trainers.” The students ranged from six years old to eleven years old, many coming to this institute after being in schools practicing group intervention; the students all came

from upper-middle class backgrounds, monthly fees being 8000 rupees (approximately 118 dollars). Child-specific training methods in this specific institute were classified under three branches: Signs, Touch, and Verbal Commands.

Nonverbal and semi-verbal adolescents were taught using hand gestures made for every student with rewards given for remembering and/or using the hand sign to communicate until it became involuntary. Touch commands were similar in that the trainers could create aspects to relate a communication element to. For example, a tap on the wrist could mean the child was hungry. These were very useful in also facilitating the emotional connection between student and trainer since the students often became very affectionate and attached after working with them for a long period of time. Lastly, verbal commands helped to bridge the lack of communication skills were often a loud command was said with no emotion to help the adolescent understand the task without context and still be able to perform it with ease. Verbal commands were less specific on the level of the adolescent's disability, but more based on the child's learning goals.

Furthermore, child-specific methods allow for each adolescent to work at their own pace and reach their personal goals while following their own routine. Using these methods are extremely individualized which can separate autistic adolescents from each other, often perceived as counterintuitive. However, this initial partition will allow the adolescents to improve well on their own, and can make the assimilation into a group environment easier later on, stimulating their success in social interactions. Therefore, Institute C's implementation of child-specific intervention methods is the most effective method of intervention for autistic adolescents because the individualized attention helps the adolescents reach their full potential and eventually, enter the real world.

Abstract

The overall purpose of this study was to determine what kind of intervention methods will ensure success for autistic adolescents. Intervention methods are diverse approaches to combating the various impairments caused by Autism. This paper discusses effective intervention methods for autistic adolescents, determining that child-specific intervention methods are the most fruitful for the success of these students. The study was conducted over the course of six years in Arizona, U.S.A. and Kolkata, India to collect observations on the cause of the behavior of autistic adolescents to determine ways to achieve different learning goals. Combining my observations and research, I have come to the conclusion that autistic adolescents often suffer from hypersensitivity, lack of communication skills, or absence of emotional attachment. To ensure success post-adolescence, child-specific training methods incrementally modified

for different goals is a better technique to follow in replacement of ineffective group intervention that result in more deficits in the long term.

About the 1st Author

The author of this paper is Isha Chakraborty, a sophomore at Monta Vista High School in Cupertino, California, U.S.A. She has cultivated her interest in the Autism Spectrum for over six years, and hopes to foster her research for the rest of her life. Chakraborty has always had an inclination towards STEM (Science Technology Engineering Math) fields, and is exploring a career in Computer Science. Her goal, in respect to Autism, is to create a smart device to aid in intervention methods.

A Case of Modafinil Induced Mania in a child suffering from Narcolepsy

Dr. Debasish Sanyal¹

Malati Ghosh²

Drugs with a definite propensity to cause manic symptoms include levodopa, corticosteroids and anabolic-androgenic steroids. Antidepressants of the tricyclic and monoamine oxidase inhibitor classes can induce mania in patients with pre-existing bipolar affective disorder. Drugs which are probably capable of inducing mania, but for which the evidence is less scientifically secure, include other dopaminergic anti-Parkinsonian drugs, thyroxine, iproniazid and isoniazid, sympathomimetic drugs, chloroquine, baclofen, alprazolam, captopril, amphetamine and phencyclidine. Other drugs may induce mania rarely and idiosyncratically. Management involves discontinuation or dosage reduction of the suspected drug, if this is medically possible, and treatment of manic symptoms with antipsychotic drugs or lithium.

- Modafinil is a novel compound first approved as a wakefulness-promoting agent in narcolepsy as excessive sleepiness associated with antipsychotics like clozapine and olanzapine (Thorpy Book). Modafinil, though is being sometimes used to treat clozapine induced excessive day time sleepiness, there are case reports of exacerbation of psychosis with modafinil use (Kishi et al 2004, Narendran et al AGP 2002). Manic switch was not more common with modafinil than with placebo. (ED-Am J Psychiatry 164:8, August 2007)
- Modafinil may cause CNS effects similar to those caused by other CNS agents (e.g., changes in mood and, theoretically, activation of psychosis, mania, or suicidal ideation) Stahl
- Narcolepsy is a chronic disorder of sleep, that presents typically between 10 and 25 years of age and is characterized by excessive day time sleepiness (EDS), rapid eye movement (REM) intrusion phenomenon such as cataplexy, sleep paralysis and hypnagogic hallucination (Panossian and Avidan Book). Narcolepsy has been reported to be associated with co-morbid psychiatric disorders like depression and schizophrenia. (Panossian and Avidan).

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- However there are very few case reports of narcolepsy per se being switched to mania with modafinil treatment. We report a case of diagnosed narcolepsy switching to mania with treatment and also discuss the management problems faced in such cases.
- AP a 14 year old Hindu student was free of the present symptoms till 2 year ago, when his parents noticed occasional dropping of head with sleepiness persisting for 10-15 minutes and then becoming completely alert once again. These episodes were repeated several times per day. Gradually the episodes became more frequent and started occurring in other setting outside home like school, so much so that the parents had to change the school. Within 2-3months it was also noticed that he fell into ground when he used to laugh strongly, or dropped remote control device while watching TV at the height of excitement. The parents then consulted a neurologist and on polysomnographic examination it was found that his REM latency was 9.8 minutes, which was well within the sleep onset REM range, and so he was diagnosed as a case of Narcolepsy Cataplexy syndrome.
- He was prescribed Modafinil, initially 200 mg and gradually increased upto 300mg when the sleep attacks subsided, but the cataplectic attacks were going on. So imipramine was added and a dose of 75 mg was built up gradually when the cataplexy was controlled and he was doing fine.
- But within 3 months the parents noticed overt changes in his behavior in the form of excessive talkativeness, meddling into others affairs, irritability, got interested in movies with excessive sexuality (which was not his self previously) and showing bossiness towards others and telling that he knew everything
- A psychiatrist was consulted and a manic episode was diagnosed. Initially dose reduction was tried but it was found that whenever modafinil dose was reduced more than 100 mg or imipramine dose was reduced more than 12.5 mg the symptoms returned. So divalproex was added and was increased upto 750 mg but as no improvement was found and he started gaining weight divalproex was substituted with lithium. Lithium dose was 400 mg when his serum lithium level was found to be 0.9mEq/L, but still no improvement was found. Along with lithium carbamazepine was added without any avail, so ultimately risperidone was tried with partial benefit.

Development of Bengali Bars (Bengali Anxiety Rating Scale)

Subrata Mullick*

Malati Ghosh**

Debasish Sanyal***

ABSTRACT

Introduction -Anxiety is a very common clinical condition in psychiatry. Locally adapted instruments to assess anxiety are lacking. This study planned to develop a locally validated instrument.

Material and Method-Initial collection of items from different existing scales were done. A panel of subject experts was consulted to select items. The items were translated back into Bengali by translation retranslation back translation method. A 7 item BARS(Bengali Anxiety Rating Scale) was developed. This scale was then used in a pilot study among anxiety disorder patients attending Psychiatry OPD in a Medical College.

Results. Majority of patients (91 i.e. 79.13%) were male. Female subjects were older (41 ± 8.79 years) than male subjects (34.1 ± 8.6 years). The observed age difference was statistically significant.. All items show almost similar endorsement, internal consistency of the scale was very high (Cronbach's Alpha=0.935). All items show strong & significant correlation with each other and with BARS total. Item deletion does not improve internal consistency. Thus plan to delete any item was abandoned. All BARS items 7 BARS total showed significant positive correlation with HARS total. The scale HAS single factor solution explaining 72.25% of variance. The factor shows strong loading with individual items of the scale (all loading >0.8)

INTRODUCTION

The anxiety disorders like generalized anxiety disorder has an estimated current prevalence in general medical practice of 2.8% to 8.5%¹⁻³ and in the general population of 1.6% to 5.0%⁴⁻⁶ whereas depression in clinical settings has generated substantial research, there have been far fewer studies of anxiety. In part, this may be because of the paucity of brief validated measures for anxiety compared with the numerous measures for depression.^{7,8}

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This study planned to develop a locally validated instrument.

Material and Method

Initial collection of items from different existing scales were done. A panel of subject experts was consulted to select items. The items were translated back into Bengali by translation retranslation back translation method. A 7 item BARS(Bengali Anxiety Rating Scale) was developed. This scale was then used in a pilot study among anxiety disorder patients(predominantly GAD) attending Psychiatry OPD in a Medical College.

Results: Majority of patients (91 i.e. 79.13%) were male. Female subjects were older (41 ± 8.79 years) than male subjects (34.1 ± 8.6 years). The observed age difference was statistically significant. Table 1 AND 2 shows the item summary of BARS. All items show almost similar endorsement, internal consistency of the scale was very high (Cronbach's Alpha=0.935). Table 3 shows inter-item correlations of BARS scale. All items show strong & significant correlation with each other and with BARS total.

Table 4 shows the effect on internal consistency when item deletion was attempted from BARS. Clearly, item deletion does not improve internal consistency. Thus plan to delete any item was abandoned. Table 5 shows correlation between BARS individual items & Bars total with HARS total. All BARS items 7 BARS total showed significant positive correlation with HARS total. Table 6 A shows result of Principal Component Analysis (factor Analysis) performed on BARS. The sampling adequacy and sphericity of the data was adequate. The scale showed single factor solution explaining 72.25% of variance. The factor shows strong loading with individual items of the scale (all loading >0.8).

Table 1: Summary of Bars Scale Data

Item Statistics

	Mean	Std. Deviation	N
BARS01	1.1217	.89978	115
BARS02	1.3304	.90536	115
BARS03	1.3043	.77430	115
BARS04	1.4087	.88749	115
BARS05	1.0696	.87581	115
BARS06	1.3304	.84523	115
BARS07	1.3826	.82273	115
BARSTOT	8.9478	5.10906	115

Table 2: Internal consistency of scale

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.935	.936	7

Table 3: Inter item correlations of the bars scale

Correlations

		BARS01	BARS02	BARS03	BARS04	BARS05	BARS06	BARS07	BARSTOT
BARS01	Pearson Correlation	1	.736**	.563**	.607**	.869**	.823**	.588**	.877**
	Sig. (2-tailed)		.000	.000	.000	.000	.000	.000	.000
	N	115	115	115	115	115	115	115	115
BARS02	Pearson Correlation	.736**	1	.544**	.562**	.712**	.830**	.688**	.857**
	Sig. (2-tailed)	.000		.000	.000	.000	.000	.000	.000
	N	115	115	115	115	115	115	115	115
BARS03	Pearson Correlation	.563**	.544**	1	.749**	.641**	.582**	.738**	.802**
	Sig. (2-tailed)	.000	.000		.000	.000	.000	.000	.000
	N	115	115	115	115	115	115	115	115
BARS04	Pearson Correlation	.607**	.562**	.749**	1	.550**	.672**	.697**	.811**
	Sig. (2-tailed)	.000	.000	.000		.000	.000	.000	.000
	N	115	115	115	115	115	115	115	115
BARS05	Pearson Correlation	.869**	.712**	.641**	.550**	1	.727**	.559**	.854**
	Sig. (2-tailed)	.000	.000	.000	.000		.000	.000	.000
	N	115	115	115	115	115	115	115	115
BARS06	Pearson Correlation	.823**	.830**	.582**	.672**	.727**	1	.737**	.906**
	Sig. (2-tailed)	.000	.000	.000	.000	.000		.000	.000
	N	115	115	115	115	115	115	115	115
BARS07	Pearson Correlation	.588**	.688**	.738**	.697**	.559**	.737**	1	.837**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000		.000
	N	115	115	115	115	115	115	115	115
BARSTOT	Pearson Correlation	.877**	.857**	.802**	.811**	.854**	.906**	.837**	1
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	
	N	115	115	115	115	115	115	115	115

**. Correlation is significant at the 0.01 level (2-tailed).

Table 3 shows inter-item correlations of BARS scale. All items show strong & significant correlation with each other and with BARS total.

Table 4: Effect on internal consistency when attempts were made to shorten scale

Item Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
BARS01	7.8261	18.847	.825	.841	.922
BARS02	7.6174	18.993	.797	.730	.925
BARS03	7.6435	20.354	.737	.731	.930
BARS04	7.5391	19.531	.737	.668	.930
BARS05	7.8783	19.231	.795	.813	.925
BARS06	7.6174	18.993	.868	.832	.918
BARS07	7.5652	19.739	.778	.722	.927

Table 4 shows the effect on internal consistency when item deletion was attempted from BARS. Clearly, item deletion does not improve internal consistency. Thus plan to delete any item was abandoned.

Table 5: Correlation of bars total & individual item scores with hars total

Correlations

		HARSTOT
BARS01	Pearson Correlation	.670**
	Sig. (2-tailed)	.000
	N	115
BARS02	Pearson Correlation	.544**
	Sig. (2-tailed)	.000
	N	115
BARS03	Pearson Correlation	.446**
	Sig. (2-tailed)	.000
	N	115
BARS04	Pearson Correlation	.472**
	Sig. (2-tailed)	.000
	N	115
BARS05	Pearson Correlation	.573**
	Sig. (2-tailed)	.000
	N	115
BARS06	Pearson Correlation	.650**
	Sig. (2-tailed)	.000
	N	115
BARS07	Pearson Correlation	.539**
	Sig. (2-tailed)	.000
	N	115
BARSTOT	Pearson Correlation	.657**
	Sig. (2-tailed)	.000
	N	115
HARSTOT	Pearson Correlation	1
	N	115

**. Correlation is significant at the 0.01 level

Table 5 shows correlation between BARS individual items & Bars total with HARS total. All BARS items 7 BARS total showed significant positive correlation with HARS total.

Table 6A: Result Of Principal Component (Factor) Analysis Performed on bars
Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.058	72.251	72.251	5.058	72.251	72.251
2	.771	11.015	83.266			
3	.456	6.507	89.773			
4	.310	4.426	94.199			
5	.197	2.817	97.015			
6	.121	1.725	98.741			
7	.088	1.259	100.000			

Extraction Method: Principal Component Analysis.

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.837
Bartlett's Test of Sphericity	Approx. Chi-Square	749.632
	df	21
	Sig.	.000

Figure 1: Scree Plot of the principal component analysis of bars

Scree Plot

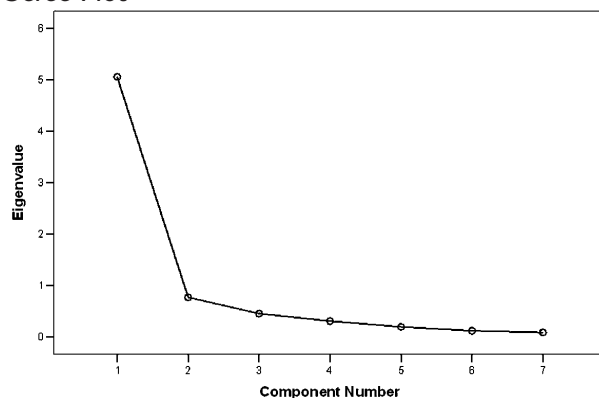


Table 6B: Loading of individual items with the component extracted from bars as seen in Table 10A
Component Matrix^a

	Component
	1
BARS01	.876
BARS02	.857
BARS03	.803
BARS04	.808
BARS05	.853
BARS06	.908
BARS07	.840

Extraction Method: Principal Component Analysis

^a1 Component extracted

Table 6A shows result of Principal Component Analysis (factor Analysis) performed on BARS. The sampling adequacy and sphericity of the data was adequate. The scale single factor solution explaining 72.25% of variance. The factor shows strong loading with individual items of the scale (all loading >0.8).

DISCUSSION

The salient findings of this study are----

Demographic variables-----

- 1) Majority of patients (91 i.e. 79.13%) were male. Female subjects were older (41 ± 8.79 years) than male subjects (34.1 ± 8.6 years). The observed age difference was statistically significant.
- 2) All items of BARS show almost similar endorsement, internal consistency of the scale was very high (Cronbach's Alpha=0.935).
- 3) All items show strong & significant correlation with each other and with BARS total.
- 4) Internal consistency of the BARS did not improve when item deletion was attempted.
- 5) All BARS items & BARS total showed significant positive correlation with HARS total.
- 6) Principal Component Analysis (factor Analysis) performed on BARS show that the scale has a single factor solution explaining 72.25% of variance. The factor shows strong loading with individual items of the scale (all loading >0.8).

The findings above indicate that BARS is a locally adapted valid instrument to assess anxiety. The scale's strong correspondence with internationally acclaimed HARS shows its concurrent validity. The single factor solution of BARS is an added positive point in favor of BARS because it means that the scale measures mainly anxiety. The scale being shorter than HARS and is adapted in Bengali language, ease of administration is high.

Shortcomings of the study---

- 1) The sample size of the study was small.
- 2) The study subjects were from psychiatric setup and not from general medical setting or non-patient population. Thus, applicability of this scale in such population needs to be studied.
- 3) Epidemiological studies to determine cut-off values of scale score against standardized structured interviews like SCID needs to be done.
- 4) Confirmatory factor analysis to check the factor structure of the scale on larger population needs to be done.
- 5) The capacity of the scale to discriminate between depression and anxiety needs to be explored.

- 6) The bench marks for categorization of anxiety into mild/severe etc needs to be done from large studies involving milder anxiety patients.
- 7) Gender wise differences noted in this study need further exploration in large scale studies.

Thus, with its limitations , BARS seems to be a valid instrument for assessment of anxiety. More wide use of this scale in different settings is likely to yield huge amount of clinically relevant information which is likely to be useful for better patient care.

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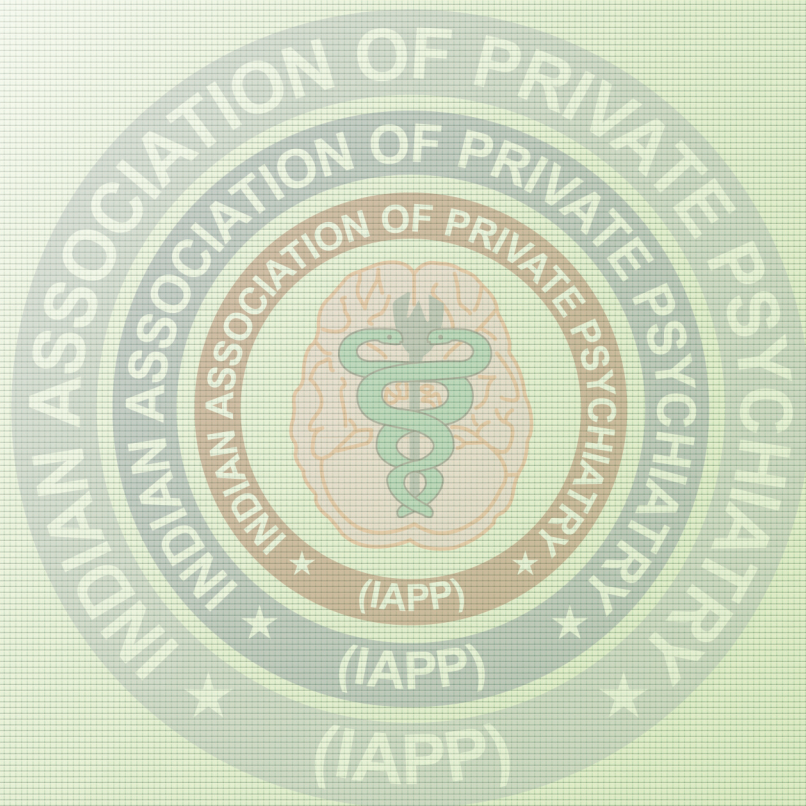
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