

# BENGAL JOURNAL OF PRIVATE PSYCHIATRY

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## Girindrasekhar Bose – a versatile Genius

Arabinda Brahma

Professor Girindrasekhar Bose, D. Sc., M.B., FN.L., was born on 30<sup>th</sup> January 1886 in Darbhanga district of Bihar. The Bose family had the reputation for cultural excellence. Girindrasekhar's father Chandrasekhar Bose was the Dewan of the Darbhanga Raj Estate. Girindrasekhar's second brother Rajsekhar Bose was a renowned writer of Bengali literature. Girindrasekhar was the youngest of the four sons and five daughters. Amiable in his behavior, inquisitive by nature, the fair-complexioned boy, Girindrasekhar was much liked by his school friends and teachers.

Throughout his academic carrier Girindrasekhar showed his brilliance. He stood first in the first class in B.Sc exam from Presidency College of Calcutta University in 1905 with record marks in Chemistry honours. Then he passed MB exam in 1910 from Calcutta Medical College. He got special permission for appearing in the M.Sc exam from the University of Calcutta in Experimental Psychiatry in 1917 and stood first in the first class. In 1921 University of Calcutta conferred on him D. Sc Degree for his thesis entitled 'Concept of Repression' which also attracted the attention of Freud, Jones and many other foremost psychoanalysts of the day. He was asked to be on the editorial board of the *International Journal of Psychoanalysis*.

Just after passing the M.Sc in Psychology, Bose joined in Calcutta University as a part time lecturer in abnormal psychology in 1917 and twelve years after he took upon the charge of the department following the persuasion of Dr. Sarvepally Radhakrishnan, who was the then President of Board of higher studies. After taking the charge, he paid attention on many aspects of functioning of a department which proved his administrative brilliance and ability as teacher. Over a period of thirty years (1917 – 1949) he had a galaxy of students, who helped him to spread the 'Psychology Movement in India' through opening of departments in different colleges and universities to teach psychology in Undergraduate and Postgraduate levels.

Being the first student of psychology in India, Girindrasekhar was duty bound to build a strong foundation of psychology in India and world at large. He had the vision as well as the mission to do that job. There are many examples which prove his multi dimensional contributions regarding this. During his leadership in the psychology department of Calcutta University there were several new approaches, viz. modernization of post graduate syllabus of psychology, introduction of psychology as a subject at undergraduate level, making psychology as a subject of study in faculty of Science at University of Calcutta, introduction of Ph. D program in psychology etc. In the revision of Postgraduate syllabus Bose introduced one elective paper. Newer branches of Psychology, e.g. Educational Psychology, Industrial

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Psychology, Social Psychology and Indian Psychology came through this route. Moreover, Applied Psychology section would not have gained a footing in Calcutta University without support of Girindrasekhar Bose.

Girindrasekhar also spent many hours in laboratory to devise apparatus and conducting research. Sand-Motor and exposure apparatus, Big Muscle Ergo graph, Group Pass along test, Group Matching test and Dotting test are few examples of Bose's innovative ideas only.

Girindrasekhar persuaded the authority of Carmichael Medical College (now, R.G.Kar Medical College) to start a psychiatric outdoor clinic in the year 1933, which was also the first of its kind in the whole of Asia. Later, he proceeded to start a non-government mental hospital with 3 beds in Calcutta, known as 'Lumbini Park Mental Hospital' in 1940. It gradually grew into an 80 bed hospital and became a strong platform for research works and practical training for budding psychologists, psychoanalysts and psychiatrists. Because of financial constraint and other ancillary difficulties, the hospital was handed over to the Government of West Bengal in 1970.

He also started a small school named 'Bodhayana' in 1949 for educating normal and abnormal children following psychoanalytical principles. A residential home (Bodhipith) for mentally retarded children was also established in this connection in 1951.

Girindrasekhar Bose was not only one of the eminent psychiatrists and psychologists but also the father of psychoanalysis in India. Bose's innovative ideas and foresight are evident from the establishments of different organizations viz. Indian Psychoanalytical Society (1922), Indian Association for Mental Hygiene (1928), Indian Psychoanalytical Institute (1936) etc. The Indian Psychoanalytical Society was accepted as a constituent member of the International Psychoanalytical Association since its inception. In appreciation of Bose's original contribution to psychoanalysis Sigmund Freud provided direct patronage and support for the affiliation of Indian Psychoanalytical Society, the first of its kind in entire Asia.

After a prolonged suffering, this great personality died on 3<sup>rd</sup> June 1953 at Kolkata.

However, the remaining work of Girindrasekhar Bose has been carried successfully by the Indian Psychoanalytical Society. In 1970, the society started Girindrasekhar Clinic at 14 Parsibagan Lane, Kolkata, to provide psychiatric and psychoanalytical services to mentally ill persons at a moderate cost.

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## Dr.G.S.Bose - a forgotten pioneer of Psychoanalysis in India

Arabinda N Chowdhury

Invited Commentary

Dr.Giridra Sekhar Bose, the father of psychoanalysis in India, was a virtual genius in Indian psychological medicine. Unfortunately, the modern psychiatry in India has failed to focus appropriate light on this brilliant personality which he deserved. Time has come when we should rectify our fault and try to show our respect, appreciation and recognition of his pioneering activities in the arena of mental health science.

Dr. Bose was born on 30 January 1887 and died on 6 June 1953. He had an extraordinary academic career and outstanding scientific thrust. He was honoured with D.Sc. in psychology (first of its kind in the university) for his original psychoanalytical research on "The Concept of Repression". Since 1921 he had academic letter exchange with the then stallworth in western psychoanalysis Sigmund Freud (Bose-Freud Correspondence: 1921-1937) which showed the frank acceptance of Sigmund Freud about the originality of Dr. Bose's thoughts and analysis. Dr. Bose started the Indian Psychoanalytical Society at 14 Parsi Bagan Lane, Kolkata (his own residence) in 1922 which later got recognition from the International Psychoanalytical Association at Vienna. Dr. Bose was the pioneer in the history of psychiatry in the world by setting up the first psychiatry out-patients clinic in a general hospital (the then Carmichael Medical College, presently R.G.Kar Medical College, Kolkata) on 1 May 1933. He was the head of this clinic from 1933 to 1947. I feel proud to have my psychiatry training at this department. He established the indoor facility for mental patients at Lumbini Park, Kolkata on 5 February, 1940. Initially it was started with only three beds but very quickly turned into an 80-bedded indoor facility. The property of Lumbini Park hospital was a denotation from his elder brother Rajsekhar Bose, who was a literary stallworth in the then Bengal. He was very actively associated with the Psychology department of Calcutta University and took a pivotal role in initiating research on applied psychology, setting up of a first psychology laboratory in the country and facilitated different psychoanalytical experimentation. Later he was actively involved in setting up a residential home for the children with mental retardation (Bodhipreeth) and a training school to teach the psychoanalytical science (Bodhayan). He was a relentless worker through out his life to upgrade the treatment modalities for the mental patients.

I think time has come to renew a fresh research initiative on the life and work of Dr.G.S.Bose to highlight his original thinking in psychoanalysis and we should do our best to uphold the banner of Indian Psychoanalytical Society for the welfare of our millions of mental health clients. Long live the Indian Psychoanalytical Society.

- Reprinted from the souvenir published by the G.S. Clinic, Kolkata on the occasion of 125<sup>th</sup> Birth Anniversary celebration of Dr. G.S. Bose in January 2011.

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## School Refusal : Practitioner Review

Soumitra Shankar Datta

Invited Commentary

### Introduction:

School refusal is a common problem encountered by teachers and parents. School refusal is not a diagnosis. It is a heterogeneous problem with multifactorial origins and children and young people require careful assessment and management tailored to individual presentations. School refusal is currently understood as difficulty in attending school associated with anxiety (generalised anxiety, separation anxiety or other emotional fears). It is a child-motivated refusal to attend school or difficulties remaining in school for an entire day<sup>1</sup>. This includes children and young people who do not attend school or want to leave school halfway in the day and also children who have regular morning tantrums or avoidance behaviour with their care-givers to allow them to stay at home. This review is specifically aimed at school refusal and does not cover children with truancy related school absenteeism.

The short term consequences of school refusal include deteriorating academic problems, poor school achievements, difficulty in peer relationships and family difficulties. School refusal can be an early sign of adolescent onset anxiety problems and other psychological difficulties.

In the Indian context, the contextual factors<sup>2</sup> of school absenteeism has been studied in a rural community setting in one study. However this study focused on absenteeism in general and did not specifically study child motivated school refusal or associated mental health difficulties. In another study<sup>3</sup> conducted by the National Institute of Mental Health and Neurosciences, Bangalore, outcome of children referred to a tertiary child psychiatry department was reported. This study reported that 87.5% of children referred for reasons of school refusal had a psychiatric disorder at baseline but majority could be treated successfully and returned to school.

### Epidemiology

Studies show that school refusal can affect up to 5 % of all school aged children<sup>4,5</sup>. Other reviewers have cited figures in the range of 1% to much higher<sup>1</sup>. The prevalence often peaks at the transition years peaking at ages 5-7 years, then 11 years and again at around 14 years. It occurs across all socioeconomic groups, and equally among boys and girls<sup>5</sup>. There is no systematic data available for Indian children due to lack of large scale community based studies.

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### Clinical Presentation

School refusal generally has a gradual onset. It may follow a period of illness related absenteeism. School refusal may be associated with chronic illnesses like asthma and sickle cell anaemia<sup>6,8</sup>. Recurrent headaches have been associated with school refusal in some children. Some children with refusal present with multiple bodily aches and pains, nausea, abdominal pain or headache, in the morning before school. These symptoms often improve after the child knows that they will be able to keep away from school for the day. School refusal may be associated with overt symptoms of anxiety related to fear of tests, teachers, bullying and life stage transitions. Some of the children may want to go to school but can't gather the courage. This is different from children who are truant, who do not show symptoms of anxiety, lack interest in school work, do not abide by school norms and engage in delinquent behaviours<sup>5</sup>.

### Causes and Contributory factors

It is likely that children presenting with school refusal behaviour have a multi-factorial aetiology:

**Child related factors:** Children may want to avoid school because of fear of separating from care-givers or parents. School refusal may be a manifestation of separation anxiety disorder<sup>10,11</sup>. Children can be protective towards their parents and perceive that their being at home would help them to ensure that their parents are safe. They may also get more attention from parents when they avoid school. Although school refusal may be related to anxiety, some diagnostic studies have reported that children with school refusal behaviour often do not have a psychiatric disorder<sup>12</sup>. Their anxiety and avoidance behaviour may be related to psychological processes and sub-threshold anxiety symptoms and not necessarily psychiatric disorders. In a study done in a tertiary hospital in India, however there are reports of high prevalence of depressive symptoms at baseline, in children referred to the department with symptoms of school refusal<sup>3</sup>. There were similar reports of association of school refusal with depression from Japan<sup>13</sup>.

**Family factors:** Parental involvement is a key factor determining child's school attendance and is commonly linked to academic achievement. Parental psychopathology and alcoholism can have direct contributions to the child's mental health. Families of youths with school refusal behaviour are often marked by poor cohesion and considerable conflict, enmeshment, isolation, and detachment. Other contextual risk-factors have been linked to absenteeism such as parental divorce and maltreatment. Children and youths living in disorganized, unsafe, or unsupportive neighbourhoods that include poor adult supervision of attendance are at substantial risk for absenteeism<sup>14,15</sup>.

**School factors:** Unsupportive and inadequate school environment can be contributory to school refusal behaviour. Poor school milieu may be linked to harsh disciplinary practices, rigid regulations, school curricula not meeting a child's individual needs, poor pupil-teacher relationships, insensitivity to diversity issues, and poor attendance management practices. Victims of bullies display higher rates of absenteeism than their peers<sup>1</sup>.

### Evaluation of young people presenting with school refusal

Children and young people with school refusal and their families should be evaluated soon after receiving the referral as it can have a diverse etiology. This has become increasingly important with the increased number of self harm and completed suicide of school age children in India. Assessment of school refusal should include seeing the young person and liaising with parents and teachers. It may be necessary to assess the young person in various settings e.g. clinic, school and home. A recent paper<sup>5</sup> describes some simple steps which may help clinicians in the assessment of school refusal behaviour.

The following steps are useful as a guide (adapted from Sewell, 2008)<sup>5</sup>:

1. It is advisable to go through the child's medical records as that can provide valuable insights. Physical illnesses such as asthma are strongly associated with childhood anxiety disorders and also school refusal.
2. Clinician should attempt to understand the child's emotional world such as fear of loss of a parent; need to protect parent and fear of situations within school as bullying, tests, change of teacher etc.
3. A physical examination may be needed to reassure parents and children and address their concerns.
4. Clinician should get information about the child's academic abilities and achievements, attendance and functioning in school from teachers.
5. If child is attending school on certain days but not on others, it may be useful to observe the child in school. This will give valuable clues about child's interaction with peers.
6. Structured questionnaires (e.g. Child Behaviour Checklist, Strength and Difficulties Questionnaire) and feedback from parents and teachers may be useful, to compare the child's mental state and behaviours in school with that at home.

### Management strategies of young people with school refusal

The primary management strategy of school refusal depends on the underlying cause, diagnosis and psychological processes involved. In certain situations pharmacological management may have a role, however the mainstay of treatment is non-pharmacological. The final goal of treatment is return to fulltime school/educational placement. A 'rapid return' strategy may be useful if the period of absence is short. For longer refusal periods a gradual approach is advocated. Clinicians need to work with parents and teachers and also understand the child's anxiety and concerns.

Psychological and Behavioural Management: Behavioral management strategies involve

fostering helpful alliances between the treating team and child's parents and teachers. Kearney in a recent authoritative review<sup>1</sup> has discussed in details about various strategies which may be useful in different situations with youth and children with school refusal behaviour.

Useful strategies in some of the common scenarios are summarised below (adapted from Kearney, 2008)<sup>1</sup>:

- a) When child is refusing school to avoid difficult situations (e.g. tests)
  - Educate child and teachers regarding anxiety
  - Relaxation training of child
  - Focus on helping the child to learn problem solving skills
  - Psychological treatment of child to modify irrational thoughts or fears
  - Gradual re-exposure to school setting using a hierarchy
- b) When child is refusing school to get attention from others (e.g. from parents)
  - Empower parents to use brief and clear commands
  - Help the family to set a morning routine prior to school
  - Reward children for school attendance
  - Forced school attendance in special circumstances may be useful
  - Advanced planning of meetings between family members to discuss problems
- c) When child is refusing school to get rewards outside of school (e.g. playing videogames sitting at home during school time)
  - Reward children for school attendance
  - Disincentivise non-attendance and not rewarding any non-attendance
  - Help young person to learn to say 'no' to peers (to refuse offers from peers to miss school)
- d) When child is refusing school because of systemic problems (transitions, bullying etc)
  - Encourage better parent-teacher collaboration
  - Review anti-bullying measures in place
  - Try to reduce violence in school environment
  - Improve positive school climate and making transitions easy for students
  - Plan curriculum to meet diverse student needs

#### Pharmacological Management:

Serious psychiatric comorbidity associated with school refusal may be treated with medications when psychological techniques have not been useful or have not helped. Treating underlying depressive disorder may be required when appropriate. One randomised double blind trial published in 2000, suggests that Imipramine and CBT is more efficacious

than CBT and placebo for this group of young people<sup>16</sup>. This finding has been replicated to some extent by another study on anxious-depressed young people with school refusal<sup>17</sup>. However in today's clinical practice fewer young people are treated with tricyclic antidepressant medications due to the risk of sudden cardiac arrests. Sensitive alternative could be Fluoxetine although there is no published evidence available.

#### Outcome of young people with school refusal behaviour

Majority of young people with short term school refusal improve spontaneously or with parental management alone. Longer periods of refusal especially if more than two years, occurring in adolescence, having co-morbid depression and lower IQ are associated with a poorer prognosis<sup>18</sup>. This will require more intensive treatment. It is important to recognise school refusal as an important problem especially for the subgroup of young people reaching school threshold for referral to a mental health service provider. In one study on anxious-depressed young people with school refusal, male gender, higher baseline frequency of attendance, being treated with imipramine and CBT were associated with better outcome<sup>17</sup>. On follow-up, younger age, being last-born, no or one diagnosis, and good baseline functioning predicted a favorable outcome in the Indian context.

#### Conclusion

School refusal is an important public health and educational problem. Its best tackled by multi-agency working between parents and professionals. In certain situations school refusal behaviour may be an outcome of underlying psychiatric problem and this need to be treated early for the benefit of the child. Teachers should ask for professional help whenever appropriate.

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## Executive Control Functions: An Overview

Rudraprasad Acharya<sup>1</sup>, Prof. Malay Kumar Ghoshal<sup>2</sup>

### What does "executive functions" mean?

"Executive functions" is a relatively new term in the neurosciences.

**Luria** is the direct antecessor of the concept of executive functions. He distinguished three functional units in the brain: (1) arousal-motivation (limbic and reticular systems); (2) receiving, processing, and storing information (post-rolandic cortical areas); and (3) programming, controlling, and verifying activity, depending on the activity of the prefrontal cortex. Luria mentions that this third unit has an executive role.<sup>1,3</sup> **Lezak** referred to "executive functioning" to discriminate cognitive functions from the "how" or "whether" of human behaviours.<sup>4</sup> **Baddeley** grouped these 'Executive functions' into cognitive domains that included problems in planning, organizing behaviors, disinhibition, perseveration, reduced fluency, and initiation. Baddeley also coined the term "dysexecutive syndrome".<sup>5</sup>

Speaking more simply, the "executive functions" broadly encompass a set of cognitive skills that are responsible for the planning, initiation, sequencing, and monitoring of complex goal directed behavior. Although a coherent framework of executive control has yet to be developed, two central themes are emerging.

The first theme associates ECF with specific higher cognitive functions such as insight, will, abstraction, and judgment, which are mostly dependent on the frontal lobes.<sup>6,7</sup> This view implies that, like memory or language, the executive cognitive functions are acquired skills that can be directly measured. ECF impairment results in the loss of these capacities.

The second theme emphasizes the cybernetic (from the Greek *kybernetes*, meaning "pilot") aspects of executive function. Executive functions *control* the execution of complex activities. This view implies first that ECF interacts with nonexecutive processes, and second that ECF impairment is made visible only via the disorganized operations of nonexecutive domains. The cybernetic view of frontal function is not necessarily incompatible with the older emphasis on higher cognitive abilities, but it does bring a new emphasis on the dynamic interactions between frontal control systems and the processes they interact with.

For example, consider a daily walk to work. If the route is highly familiar and if traffic is light, our mind can wander. Before we know it, we may have gone a considerable

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distance and negotiated street crossings and turns with little awareness of having done so. In these cases, the control of our behavior occurs in a 'bottom-up' fashion: it is determined largely by the nature of the sensory stimuli and their strong associations with certain behavioral responses.

Suppose, however, that during our walk to work something unexpected happens or we encounter difficulty. For example, we might encounter a busy street that we need to cross. Then, the executive system takes over and we need to 'take charge' of our actions. We pay attention to the people and cars around us to anticipate and accommodate their actions, or we may decide to take an alternate route. Now, straightforward stimulus-response associations are insufficient to govern our behavior. We must use knowledge of our current objective (arriving at work on time and intact) and results from previous experiences to weigh the alternatives and consequences. During this 'controlled mode,' we also engage the basic sensory, memory, and motor processes that mediate automatic behavior. Only now, the environment is not simply triggering these processes. Instead, we use our current goals to shape and control these processes in a 'top-down' fashion.

#### **Two proposed fundamental executive functions**<sup>8-10</sup>

- (1) **"Metacognitive executive functions"** which include problem solving, abstracting, planning, strategy development and implementation, and working memory (the usual understanding of executive functions, generally measured in neuropsychology executive functions tests); these are abilities mostly related with the dorsolateral area of the prefrontal cortex. The dorsolateral prefrontal cortex has been observed to participate in diverse planning, abstracting, problem solving, and working memory tasks.
- (2) **"Emotional/motivational executive functions,"** which is responsible for coordinating cognition and emotion. That means, the ability to fulfil basic impulses following socially acceptable strategies. This function is related with so-called "inhibitory control" of behaviour.

Neural substrate for this inhibitory function resides mainly in the medial and orbital portions of the prefrontal cortex.

#### **Simple conceptual framework for understanding the Executive Functions**<sup>11</sup>

##### **FUNDAMENTAL ABILITY**

Volition

##### **EXECUTIVE PROCESS**

judge, choose, initiate; abstract patterns;  
Suppress habitual responses.

|              |                                          |
|--------------|------------------------------------------|
| Plan/ recall | retrieve information, generate strategy. |
| Program      | program motor activity.                  |
| Implement    | freedom from distraction, execute plan.  |
| Monitor      | attend; judge success.                   |
| Adjust/stop  | change/switch sets; stop.                |

#### **Anatomical Substrates Of Executive Functions**

**1)The Prefrontal Cortex:** Several unique aspects of the prefrontal cortex suggest that it mediates EF. **First**, the prefrontal cortex is connected to more brain regions than any other cortical region. **Second**, the frontal cortices are "metamodal": they receive direct cortical input only from other heteromodal association areas. Thus, they are positioned to act on information that has already been processed at lower levels. **Third**, the prefrontal cortex is the major neocortical target for information processed in the limbic circuits. It is the only cortical region positioned to integrate cognitive and sensorimotor information with emotional valences and internal motivations. **Fourth**, although wide areas of the cortex project into the basal ganglia-thalamocortical circuits, the prefrontal cortex is that system's major target. Thus, the frontal lobe is the only cortical region capable of integrating motivational, mnemonic, emotional, somatosensory, and external sensory information into unified goal-directed action.

**2) Frontal Basal Ganglia-Thalamocortical Circuits:** Certain subcortical lesions can affect ECF either directly or indirectly via frontal cortical metabolic changes. The caudate, putamen, pallidum, nucleus accumbens, and thalamus are related to the frontal cortex through basal ganglia thalamocortical behavioural control "circuits".<sup>12-14</sup> Although each of these circuits passes through different structures, all of the frontal circuits are similar in design.

Three frontal circuits are particularly relevant to executive control: the dorsolateral prefrontal circuit, the lateral orbitofrontal circuit, and the anterior cingulate circuit.<sup>15,16</sup>

**Dorsolateral Prefrontal Circuit:** The dorsolateral convexities of the frontal lobes consist of BA 8-12, 46, and 47. The blood supply for these regions is from the middle cerebral artery. Lesions to this circuit have been implicated in a variety of higher cognitive functions, including goal selection, planning, sequencing, response set formation, set shifting, verbal and spatial working memory, self monitoring, and self-awareness (metacognition).<sup>17-22</sup> The WCST consistently activates dorsolateral frontal regions.

**Lateral Orbitofrontal Circuit:** The "orbit" of the frontal lobes refers to a continuous region including ventral anterior and inferior lateral regions (BA 10-15 and 47). Medial

regions are vascularly supplied by the anterior cerebral artery, and lateral regions lie in the territory of the middle cerebral artery. The orbitofrontal circuit appears to be involved in the initiation of social and internally driven behaviors and the inhibition of inappropriate behavioral responses. Orbitofrontal function may be particularly relevant to risk assessment. Choosing between small but likely rewards and large yet unlikely rewards activates inferior and orbitofrontal regions. Impairment on the "go/nogo" task has been associated with orbitofrontal lesions in animals and humans. Orbitofrontal lesions also lead to clinical features such as environmental dependency and utilization behavior.<sup>23-25</sup>

**Anterior Cingulate Circuit:** Frontal regions involved in this circuit are medially located (BA medial 9–13, 24, and 32), and receive their blood supply from the anterior cerebral artery. The anterior cingulate is important in monitoring behavior and error correction.

#### **Tests for assessment of executive function**

Till date, there is no uniform consensus about which test to be used specifically for assessing executive functions. Several researchers have used different combinations of tests to evaluate these functions. Some of them are mentioned here:

1. California Card Sorting Test
2. Category Test
3. Porteus Mazes
4. Raven's Progressive Matrices
5. Stroop Color-Word Interference Test I, wM(v) Stroop 1935304
6. Tower of London
7. Wisconsin Card Sorting Test
8. CLOX: An Executive Clock Drawing Task
9. Controlled Oral Word Association Test
10. Design Fluency
11. Executive Interview (EXIT25)
12. Go/No-Go
13. Trail Making Test, Part B.

#### **Clinical implications of executive dysfunctions**

Executive dysfunctions are found in a number of psychiatric and neurological disorders. To mention a few:

- Dementia
- Parkinson's disease

- Subcortical stroke
- Psychotic disorders
- Major depressive disorder
- Bipolar affective disorder
- Attention deficit hyperkinetic disorder

Executive dysfunction significantly impairs the decisional autonomy of the patient. Amongst the three components of decisional autonomy, i.e. understanding, intentionality, and noncontrol or voluntariness, most significantly affected are the intentionality and voluntariness. And these leaves patient with significant disability in daily activities.

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## Psychiatric Disorders in Diabetes Mellitus

Mahuya Chatterjee Brahma

### Introduction:

Diabetes is a global epidemic with devastating human social and economic consequences. It affects about 3-4% of adult population worldwide. The prevalence is increasing largely because of the epidemic of obesity and to improved survival rates<sup>1</sup>. Epidemiological data shows that about 50.8 million of people in India are already been affected by diabetes in 2009 and this figure is predicted to rise to about 70 million in 2025. China comes to the second position with about 43.2 million diabetics. India is now designated as the 'Diabetic Capital of World' by World Health Organization and International Diabetic Federation.

Diabetes is defined as a "group of metabolic diseases" that occurs because of defects in either or both insulin secretion and insulin action. It is a chronic disorder accompanied by complications affecting cardiac, cerebral, vascular, renal and neurological systems. Diabetes presents specific challenges to the liaison psychiatrist as the management and prognosis is mainly based on the patient taking responsibility for multiple self-care tasks like diet, exercise, weight reduction, self-monitoring of glucose, foot care and injection sites and adhering to oral medication and insulin injections<sup>2</sup>.

### Classifications of Diabetes:

A new classification has come up with four types of diabetes based on the pathology of the underlying condition:

Type 1 diabetes represents about 10% of all cases of diabetes. It is characterized by an autoimmune destruction of the pancreatic  $\beta$  cells leading to absolute insulin deficiency. It used to be called insulin dependent or juvenile-onset diabetes. The initial presentation usually occurs in children age < 20 years. It has a rapid onset (few months to weeks) characterized by fatigue, weight loss, polyuria and polydipsia.

Type 2 diabetes represents around 85% of all cases of diabetes. The relative insulin deficiency and insulin resistance play a major role in type 2 diabetes. It is a disease of adult onset with a mean age of onset at around 60 years. Usually the person with type 2 diabetes progresses from euglycemia, through a period of impaired glucose homeostasis (prediabetes), to finally reach the stage where the diagnostic criteria are met.

Type 3 diabetes includes a wide range of specific types of diabetes (e.g. pancreatic failure secondary to alcohol-induced pancreatitis).

Type 4 diabetes is known as gestational diabetes.

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**Psychiatric disorders:**

**Depression:** it is the most common psychiatric disorder found in diabetes. For a long time, it was believed that diabetes is psychogenic in its origin. In the 19<sup>th</sup> and early 20<sup>th</sup> century, a theory was come up stating that prolonged anxiety or stressful life events could cause emotional glycosuria<sup>3</sup>. In a recent study, it was found that depression may be a risk factor for the onset of type 2 diabetes<sup>4</sup>. In a systemic review, the mean weighted prevalence of current depression in people with diabetes was estimated to be around 15% with a range of 8-20%<sup>5</sup>. Another US prospective cohort of about 100 youths with newly diagnosed type 1 diabetes revealed that the incidence of depression was 28% during a 10 year follow up period<sup>6</sup>. Moreover, there is good cross-sectional evidence that depression is associated with poorer glycaemic control<sup>7,8</sup>.

**Substance abuse:** alcohol is hypothesized to be diabetogenic. However, the evidence for an association between alcohol consumption and diabetes is inconsistent. Studies have showed that alcohol consumption is associated with reduced diabetes self-care behaviors<sup>9</sup> and worse glycaemic control<sup>10</sup> and it may act as an independent risk factor for developing diabetes complications<sup>11</sup>.

**Anxiety disorders:** studies have revealed that phobic symptoms and anxieties (blood-injection-injury phobia) related to self-injection of insulin and self-monitoring of blood glucose level is common. It is associated with poorer diabetes self-care which in turn may increase glycaemic levels<sup>12</sup>.

**Schizophrenia:** literatures have reported that individuals with schizophrenia are at an increased risk of developing diabetes<sup>13,14</sup>. This susceptibility may be caused by a direct genetic link between these two illnesses. However, weight gain, poor dietary habits and reduced physical activity in schizophrenic patients may play an important role in developing diabetes in this population. Furthermore, use of atypical antipsychotics has been associated with the appearance of diabetes, cardiovascular disease, dyslipidemia, hyperprolactinemia and weight gain<sup>15</sup>.

**Psychological problems:** various psychological problems specific to diabetes can present with marked morbidity and distress and of clinical significance to the liaison psychiatrists<sup>2</sup>.

- Fear of hypoglycemia (especially in type 1 diabetes) may lead to shame, guilt or embarrassment if it occurs in public and helplessness if it occurs when the individual is alone.
- Poorer psychological adjustment to diabetes is associated with poorer glycaemic control<sup>16</sup>. Themes related to stigma, peer pressure, anger and resentment, fear of diabetes complications may be responsible for poor adjustment<sup>17</sup>.

- Self-destructive behavior is found in a group of patients with type 1 diabetes who have severe fluctuations in glucose levels, frequent admissions for recurrent diabetic ketoacidosis and recurrent severe hypoglycemia because of chronic poor glycaemic control<sup>18</sup>.
- Unhelpful diabetes-specific beliefs and behaviors like fear of hypoglycemia, fear of self-injecting and reduced self-efficacy have been found to be associated with poorer glycaemic control<sup>2</sup>.

**Management:**

Psychiatric treatment is required to people with diabetes to improve their diabetes control and to reduce psychological distress. Tricyclic antidepressants for depression in diabetes have been associated with hypoglycemia. The Selective Serotonin Reuptake Inhibitors (SSRI) like Fluoxetine improves both mood and glycaemic control. Duloxetine, a new antidepressant, is found to be beneficial for the reduction of pain with diabetic neuropathy. On the other hand, studies have shown that educational and psychological approaches in diabetes are effective in improving glycaemic control and/or psychiatric morbidity<sup>19</sup>.

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## Depression as presented in Indian scenario & its common symptoms

Asis Acharya

Depression as a mental disorder is encountered in Psychiatric clinic as single most major diagnostic disorder & also in association with Anxiety disorder, obsessive compulsive disorder, in Schizophrenia & in a number of medical disorders as well.

What is the single most disorder commonly found in a mental clinic?

The answer is simple- affective Disorder or more specific Depressive disorder in different degrees.

Not only in psychiatry clinic, in any medical out door, 20 -30% of mental disorders are ultimately caused as a major determining factor & 15% of those are roughly found to be suffering from some depressive ailments. Introduction: Here the aim is to enumerate the various somatic symptoms of depression & their frequency and also to assess their improvement of those varied symptoms after a period of 6 months.

Methods: 50 cases of depressive disorders diagnosed as per ICD-10 criteria in the age group of 20-56 years with a mean age of 33 years, were included in the study from a clinic of Tamluk town in East Midnapur district head QRtrs, & another 50 patients both male & female were chosen from another Town of West Midnapore, Ghatal in 60K.m apart distance. Their mean age was 18 to 54 years with a lower mean age of 31 years. In the Tamluk group there were 32 females & 18 males & in Ghatal analysis there were 40 females & 10 males. Enumeration of their common presenting symptoms were enumerated including both the population:

|                                                                                                 |     |
|-------------------------------------------------------------------------------------------------|-----|
| 1. Head pain & discomfort or reeling of head& neck pain                                         | 52% |
| 2. Multiple pains in extremities, specially in lower extremities & more abounded in females     | 42% |
| 3. Abdominal discomfort, dyspepsia, hyperacidity                                                | 38% |
| 4. Sleep disturbance, including terminal insomnia fragmentary sleep non freshness on awakening, | 48% |
| 5. Loss of appetite                                                                             | 26% |
| 6. Diminution of libido                                                                         | 24% |
| 7. Loss of interest for works activities & toward people                                        | 20% |
| 8. Lack of pleasure                                                                             | 30% |
| 9. Genital pain, pain in female vulva or in rectum or urethral discomfort                       | 05% |
| 10. Suicidal ideas or planning                                                                  | 05% |

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|                                                                       |     |
|-----------------------------------------------------------------------|-----|
| 11. Guilt felling & obsessive rumination over past                    | 08% |
| 12. Itching & dermatological discomforts                              | 04% |
| 13. remorse over sexual feeling coming advrntly                       | 04% |
| 14. Lack Of concentration & forgetfulness                             | 08% |
| 15. Feeling of bad & unwell felling throughout the day                | 12% |
| 16. Chronic musculoskeletal pains for which little remedy is achieved | 10% |
| 17 Guilt feeling, persecutory delusions, & weakness                   | 20% |
| 18. Burning over the whole body & head & neck & shoulders             | 25% |
| 19. Painful pre-menstruation even in multiparous women                | 10% |
| 20. Pain even after sexual union & diminution of libido & time        | 10% |

There are innumerate other presenting symptoms at least one new type in a month which we encounter ultimately which achieves a reasonable recovery on institution of anti-depressant therapy. Apart from them a depressive women may at first be presented with some somatoform conversion symptoms like fits, or other bodily movements which responds ultimately with an anti depression therapy.

Somatisation disorder or multiple vague somatoform various complaints like hypochondriasis responds well to adequate anti depressant therapy. A question may be raised does the depression patients do not complaint of low spirit, sadness, lack of pleasure & loss of interest to usually pleasurable activities. Yes, there number is calculated in this study as limited to 10-12%, who predominately complains of not being well feeling at morning or throughout the entire day. Relating depression to a financial loss or a setback in a love affair or loss of financial status, or death of a near & dear one are narrated as a causative factor in majority of cases.

Results: Somatic presentation like head or neck pain or multiple pains & burning in the extremities or chronic pain are found to be the most significant presenting complaints of depression in our Indian scenario. Awareness to these types of complaints may therefore always raise the possibility of depression in such patients & institution of adequate anti-depressant therapy may give rewarding results to the clinician.

Conclusion: Presentation of depressive symptoms varies over different geographical or cultural or educational status from society to society. In our country setting some major symptoms presentation are enumerated here that may evoke other clinician to report another such more different presentations encountered by them and our somatic symptom logy of depression may be more easier & understandable in that way.

## The Menace Called Alcohol

Sabyasachi Mitra

Alcohol is a substance known since times immemorial; it has perhaps been consumed as early as humanity can be dated back to. It has been largely used for recreational purposes by mostly men over the centuries. It has had its social acceptance and non-acceptance in a cyclical manner in various civilizations across the world. Even a decade back Indian society was rather reluctant to acknowledge Alcohol as something which could be consumed either in public, at home in front of children or in association with elders of the community, however recent trends have completely thrown away such notions and suddenly we see the taboo associated with alcohol exists no more.

Alcohol comes in various forms, the local brew, beer, rum, whiskey, gin, vodka, wines-red and white, and champagne. These vary in their pricing, taste and their alcohol contents. In today's modern society alcohol addiction and alcohol abuse has become one of the most complex, life-threatening issues. Most depressed individuals usually indulge themselves in bars or pubs with their alcohols to escape from their stressful life. It has become increasingly alarming how alcohol does not only attract the adults, but also teenagers these days. Women too are fast catching up with their male counterparts where drinking is concerned. Millions of people enjoy drinking on occasion or perhaps a bit more frequently than they should which is denoted as harmful use of Alcohol. When drinking becomes a routine, and a certain amount of helplessness sets in people become dependent.

It is important for the readers to be aware that like in "Tom and Jerry" its rather unthinkable to find an entire episode of either Tom or only Jerry, likewise it's true for Alcoholics to be unable to restrict their addiction to Alcohol only, and as professionals in this field we tend to see Alcoholics abusing other drugs in association too specially nicotine and cannabis. What is more alarming is that alcohol and nicotine nowadays forms the basics for graduating into other harder drugs like crack, cocaine, heroine and others.

### What is Harmful use of Alcohol?

We doctors dealing with such issues tend to agree that its perhaps all-right for an adult man to consume 21 units of alcohol per week, and an adult female to have 14 units per week with no long term heart related problems however it is important to note that it does not provide any immunity to other physical or mental consequences of long term drinking. A normal beer bottle having 4 units, a bottle of wine is 10 units, 35 mls(a peg) of Vodka, Rum, Whiskey having 1.4 units and alcopops having 1.5 units of alcohol per bottle for example.

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### What is Dependence?

We can call an individual dependent on alcohol when he/she has to consume alcohol daily, failing which he/she tends to have withdrawal symptoms like agitation, restlessness, shaking, sweating, hiccups, retching, hallucinations or epileptic fits.

Unfortunately as these individuals garner some strength or motivation to give up, the withdrawal symptoms play a spoiler and nearly forces them to have a further drink to "calm their nerves" i.e to combat their intense inner restlessness. These are the individuals who need help from a professional at their earliest, as only a detoxification would be able to bring them out of this vicious cycle with a certain degree of certainty.

### What are the Consequences of alcoholism?

Consequences can be categorized under Social, Economical, Physical and Mental aspects.

Social consequences of Alcoholism are profound, as it when affected in teens can affect academics detrimentally, unprotected sex can lead to sexually transmitted diseases and even unwanted parenthood, as small amounts of alcohol gives a "high and loosens up the moral grip" it can lead to unwanted affairs leading to break up of marriages. Party nights experiences high incidences of violence and street fights forcing the police forces to mobilize their strengths at pockets thereby rendering other areas vulnerable to crimes. Adults when dependent run the risk of losing their jobs thus putting their families at risk and gradually move down the social ladder. Driving under the influence of alcohol is a grave danger to the society and we are already noticing a high rise of such accidents in our city and its peripheries. Its also much of a social nuisance to notice alcoholics lying on roads and pavements after losing their consciousness through heavy drinking.

Economical consequences of Alcoholism are huge and ranges from lack of education as the father is unable to pay the school fees to joblessness, prostitution, child laboring, health related costs, premature deaths, crimes, illegal immigration and this list is perhaps never ending.

Physical consequences affect the whole body, for an ease of understanding of our readers I shall follow a head to foot approach, starting from hair-loss, early onset of dementia, blindness, glossitis (infection of the tongue) inflammation of the foodpipe (esophagitis), enlargement of male breasts, malabsorption of vitamins and nutrients, diarrhoea, pancreatitis, liver dysfunction leading to cirrhosis and then to collection of water in the tummy. Further down it shrinks the testicles leading to erectile dysfunction i.e impotence. Neuropathies in hand and limbs are a common occurrence leading to loss of power to walk and grasp objects and also to a persistent and irritating feeling of tingling and numbness leading to long term sleeplessness. Women drinking during pregnancy may deliver deformed babies.

Mentally Alcoholics become a complete wreck, they lose their pride, their social standing, they find themselves drowned in financial debt, without a job, without a wife or kids, without a home to come back to, only surrounded by their drinking buddies who are in and out of hospitals either dying or already dead. Their self care plummets, they are malodorous, decent people tend to avoid their company and thus they are left to their own devices to drink further to drown their sorrows. Alcoholics have a much higher incidence of depression, anxiety, suicidality and dementia disorders secondary to their habit, they are also at a much higher risk of developing various degenerative disorders of the brain.

### Tips

1. If you are needing to drink daily, more so in the mornings...you may be an Alcoholic...seek help !
2. Always measure your drink to know your limits.
3. Never stop drinking suddenly, slowly reduce for health and safety reasons
4. Don't drink and drive
5. City policing should enlist help of sophisticated breath analyzers to keep drunken people of the wheels, thereby keeping our roads safe.
6. Don't drink if you are pregnant
7. Commonly held belief that small amounts of alcohol are beneficial for your heart is true, but remember that other organs are not protected, it's like "dying though liver failure but having a strong heart"!!
8. Detoxification from alcohol is easily available in our city of Kolkata, if needed seek help, it may be too late otherwise
9. It is a mental illness, the family and the society needs to be empathetic and supportive to help such individuals kick this menace.

*The author has a certificate of completion of specialist training in treatment of substance misuse and addictive disorders from United Kingdom.*

**Koro : its origin and socio-pathological aspect**

Arabinda Brahma

**Introduction:**

The first reported case of Koro was published in Western medical literature in 1895. He first introduced the term Koro in relation to the genital retraction pathology. The term 'Koro' used in Indonesia is a Macassaran word that means 'to shrink'. In Malay, *Keruk* is the term for 'to shrink'. There are two sets of word equivalent of Koro in Chinese language: in Mandarin *Suo-yang* and in Cantonese *Suk-yang*. *Suo* or *Suk* means shrinking or contracting and *yang* means male genitalia.

The original oriental culture-bound Koro is now considered as genital retraction syndrome in the world literature. However, the primary etiological focus of Koro (i.e. genital retraction pathology) has shifted towards body-image disturbances during the span of more than hundred years.

The first known medical reference to Koro ('*Suo Yang*') in an epidemic form was reported in Tang district of Guangdong province, China in 1865<sup>3</sup>. After 1950, Koro gained much attention in academic psychiatry. The pioneering research work by Yap<sup>4</sup> on diagnostic status of Koro focusing on the "autopathological" culturally-linked behavioral abnormality is particularly noteworthy<sup>5</sup>.

**Global report of Koro cases:**

Koro publications gained attention of international professional community 1960 onwards. The Koro epidemic in Singapore (1967) and reporting of Koro cases from the western countries helped psychiatrists to attach a new clinical dimension to Koro. 1980 onwards, various publications on Koro highlighted different large-scale Koro epidemics around the world and association of Koro with different psychiatric and physical conditions.

The literature on Koro contains reports of at least nine large epidemics and a Koro-like epidemic from different parts of the world. Koro epidemics were primarily reported from China, Singapore, Thailand, India and Indonesia. Later, new cases were found in other parts of the world, viz. South Africa, New Zealand, Italy, Tanzania, Canada, UK and USA. Association of Koro cases with comorbidities highlighted more on the disturbed body-image perception than its culture-relatedness<sup>5</sup>.

**Clinical picture:**

Koro is usually considered as an acute, brief, self-limiting and solitary episode. However, few reports reveal cases with chronic or recurrent history of Koro attacks<sup>6,17</sup>.

Literature survey on Koro reveals that it may affect a wide range of age group (8-54

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years)<sup>6</sup>. There was a clear-cut predominance of male Koro affected cases, but reports of female cases were not very uncommon<sup>8,9</sup>.

Genital retraction and genital shrinkage are the most frequently reported genital complaint in Koro patients. Retraction of penis (or labia) is commonly found in epidemic settings and is associated with cultural beliefs<sup>10</sup>. Shrinkage, on the other hand, is usually reported in sporadic cases especially in association with organic or psychiatric illnesses. Three types of perception of penile retraction were reported: retraction of penis only, altered shape of penis with retraction and loss of muscular tone of penis with retraction<sup>11</sup>. However, there were cases without any perception of retraction at all and includes complete loss of penile sensation and penile shortening<sup>6</sup>.

In the female Koro cases, the cardinal breast symptom is the complaint of nipple retraction<sup>13</sup>. Literature survey have found some other symptoms like breast pain, shrinkage (flattening) of breast and retraction of whole breast (in the chest cavity)<sup>9,14</sup>.

'Fear of impending death' has been regarded as the primary ideational component of Koro anxiety in males. Dissolution of penis with resultant loss of sexual power is another common ideational component of Koro anxiety. Among the female cases, 'fear of breast damage' was considered as the predominant Koro anxiety<sup>9</sup>. Other ideational symptoms found in different studies are: sex change to female or eunuch, impending madness, sterility, spirit possession or bewitched feeling<sup>15</sup>. The cognition of impending death with genital retraction has strong ethno-cultural beliefs and is intimately associated with Chinese traditional beliefs. According to Taoist medical philosophy, loss of penis may be the harbinger of death because of deficiency of *ching* (male sexual energy that absorbs female *yin* energy during intercourse)<sup>6</sup>.

**Koro epidemics in India:**

A Koro-like symptom as a part of religious experience was reported from India in 1943<sup>15</sup>. However, the first Indian medical report of shrinkage of penis was made ten years later<sup>16</sup>.

A series of research publications of Koro epidemics were made from India since 1982. First publication on large-scale Koro epidemic (83 cases) was from lower Assam (North-east India) region<sup>17</sup>. Later, Chowdhury and colleagues reported 405 cases from North Bengal region of West Bengal<sup>18</sup>. Chowdhury published a series of research findings on different clinical and socio-cultural aspects of Koro cases<sup>5</sup>. He first highlighted the abnormal penis image of male Koro cases.

Very recently a large Koro epidemic took place in West Bengal. It first started in the North Bengal region and after a month spread to South Bengal region including two cosmopolitan cities: Kolkata and Howrah. Mass panic (popularly known as 'Disco') was reported mainly from several remote villages. The Koro affected persons were advised by the local faith-healers to sit in ponds or river for hours while family members were pouring water on them to cure. Some magico-religious healers advised the affected persons to wear garlands made of seeds of pumpkin. They also advised the sufferers and the non-affected family

members to paint lime on forehead, cheek and ear lobules for the purpose of cure as well as prevention <sup>21</sup>.

### Research on Body-image and Koro:

Initial publications on Koro linked it as a disease found solely among the Chinese population. It was considered as a culturally related disease, because of its association with genital retraction malady in the traditional Chinese Taoist yin-yang medical philosophy. Later, researchers like W.G. Jilek viewed Koro as a disturbance of body-image perception. The epidemic expression of Koro was viewed as a paradigm of transcultural metamorphosis pointing more towards socio-cultural and geo-political stress rather than individual castration anxiety or yin-yang imbalance hypothesis <sup>3</sup>. Kirmayer viewed Koro symptoms as a result of sudden alteration in body perception.

### Conclusion:

The psychoanalytical concept of individual castration anxiety of Koro has shifted towards the social cognition, body perception and sexual somatization in the recent years. Future research may explore whether Koro symptoms represent body-image disturbance or express socio-cultural and ethnomedical beliefs <sup>6</sup>.

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## EVENTS

**Annual State Conference of IAPP, West Bengal State Branch**

10 September 2011, Baharampur

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11-12 June 2011, Gangtok, Sikim

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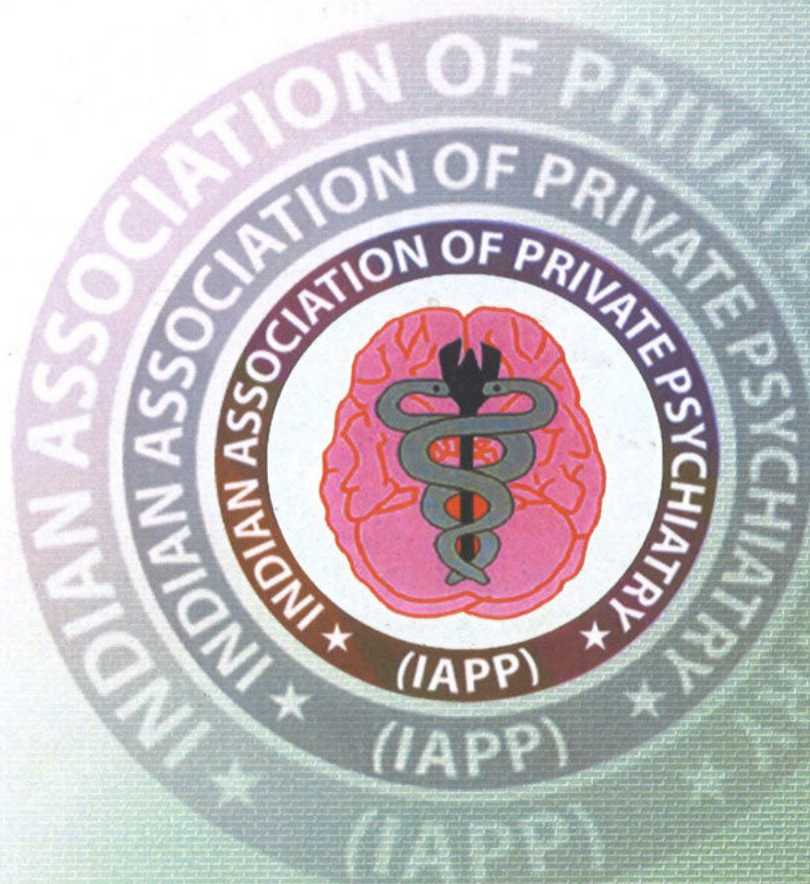
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