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RFP Indian Journal of Medical Psychiatry

May – December 2019
Volume 2, Number 2-3

Contents

Review Article

RFP Indian Journal of Medical Psychiatry
Volume 2 Number 2-3, May – December 2019

A Study on Clinical Depression

Arindam Mandal[1], Mayukh Pandit[2]

Abstract

Depression is a common problem nowadays. Almost one in 15 people suffer from such chronic condition. These disease have become a part of life which if untreated could be hazardous at the later stages of life. Suicide ideation is often developed in the patients of chronic depression. My article focuses upon the types, signs and symptoms, proper treatment management and concluding with positive attitude and prevention ofthisillness as prevention is always better than cure.

Keywords: Suicide ideation; Hazardous

How to cite this article:

Arindam Mandal, Mayukh Pandit. A Study on Clinical Depression. RFP Indian Journal of Medical Psychiatry. 2019;2(2-3):49–51.

Introduction

According to Cambridge dictionary, the word 'depressed' means unhappy and without hope. Depression is a state of feeling very unhappy and anxious without hope for future. Clinical depression also known as major depressive order defined by American Psychiatric Association as common and serious medical illness that negatively affects one feelings andone's thought process.[1] This condition also causes feelings of sadness and loss of interest in activities. According to World health organisation, depression is a common illness affecting worldwide with more than 264 million people.[2] This condition is treatable. There are psycho social treatment which are very effective for mild depression and there are also very effective treatment for moderate to severe depression.

Discussion

In our present era, depression have become so common that it is seen that one in 15 adult's are affected with clinical depression. And one in six people will experience depression at some point of time in their life. It is also seen that women suffer depression more than men. Studies have also shown that one third of women would experience major depressive episodes in their lifetime.

National institute of mental health classifies depressive order in four forms.[3]

Dysthymia

This last for at least two years. There they may have episodes of major depressive order with symptoms persisting for 2 years.

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Postpartum depression

This is suffered by women after giving birth as the name suggests. The experience full blown major depression during pregnancy.

Psychotic depression

This occurs when a person has severe depression and there is a existing form of psychosis such as having delusions and hallucinations.

Seasonal affective disorder

This is characterized by onset of depression during winter months, when there is less natural sunlight.

There is also a disorder which is different from depression but it includes episodes of extremely low moods that makes all the criteria for Major depressive disorder this is known as bipolar disorder where a person also experience extreme high moods called 'mania'.

One main find the signs of clinical depression by proper observation and study for at least two weeks. He must observe the under followings.[4]

1. Persistent sadness would be followed by anxiety, apathy and mood swings.
2. There would be lack of concentration followed by slowness in any type of activities.
3. Where would be signs of constant irritability followed by restlessness an agitation. In women excessive crying have been observed.
4. The patient would be in some neck for excessive sleepiness.
5. There might be signs of loss of appetite for excessive hunger in patients of clinical depression.
6. There would be loss of interest or pleasure in any activities and would have guilt and remorse feelings always.
7. Suicidal thoughts are the most dangerous signs and symptoms of depressed patients because suicide ideation is usually developed in patients of major depressive order.

Clinical depression mayoccur due to various circumstances. There are major cause of clinical depression as followed.[5]

1. Any form of abuse which might be in the form of physical sexual or emotional way might increase the chances of clinical depression in later stages of life.
2. Sadness shock and grief from loss of loved ones may increase the risk of chronic depression.
3. Studies have shown that sometimes depression could be triggered by major medical conditions.
4. Isolation is also a major clinical factor which often leads to depression. This isolation mostly include social isolation.
5. Drugs such as corticosteroids, antivirals have been seen to put their adverse effect as clinical depressions.
6. Sometimes alcohol or drug abuse leads to depression. It is often mistaken that it makes feel better but that is for temporary period, this would ultimately welcome depression.
7. In today's era, social networking could be a major cause of depression in teenagers because of its adverse effect in our central nervous system.

Methods and treatments

Depression falls under the category of treatable in psychiatric disorders. People respond well and get cure after treatment. Before treatment the professional must examine very specifically both physically and mentally.

According to American psychiatric association there are three forms of treatment available which are followed:

Medication

This include antidepressants which are very effective and they have no stimulating adverse effect on patient not experiencing depression. In first one or two weeks they may produce some improvements. Full benefits are usually seen after 3 months generally the professional might recommend the patient continue to take medication for 6 or more month until it improves.

Psychotherapy

Also known as talk therapy: They are used to treat mild to severe form of depression. Cognitive behaviour therapy (CBT) helps the patient to recognise distorted thinking and change behaviour and thought process. This therapy is often used along with antidepressant medication. Significant improvement would be observed by 10 seasons.

Electroconvulsive therapy (ECT): They are most commonly applied for patients with severe condition who generally doesn't show any response

to other treatments. This treatment is done under anaesthesia with electrical stimulation of the brain stop they have been successful after many years of research from 1940 and have lead to improvements.

Conclusion

It is always said that 'Prevention is better than cure'. So to prevent depression one can perform few things. This would include regular exercise which would always create positive vibes and improve our mental health. One must focus on healthy diet and avoid alcohol or drug abuse full-stop sleep is also very important which one should focus on getting a quality sleep.

Depression is a major problem of mental health but with proper diagnosis and treatment, it would it could be cured completely. These chronic problem nowadays is often leading to suicide ideation. One must remember every problem of our life is temporary, so instead of thinking about the problem and developing search chronic conditions of depressive episodes, one must analyze and solve the problem instead. Even if someone becomes the prey of this condition, one must visit mental health professional who could help and improve the patientwho could lead their rest of their lives in a prosperous and healthy way.

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Review Article

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Diabetes and Depression

Hemendra Singh[1], Prarthana Bhat[2]

Abstract

Depression is the common psychiatric illness which is co-existing with diabetes. Depression might increase the underline inflammatory markers which are implicated in diabetes. Untreated depression can lead to worsening of diabetes and its complications. Diabetes and depression are a two way street and they need to be treated with holistic approach which include glycemic control, antidepressants and Cognitive behavioural therapy (CBT) to prevent complications. This article highlights the prevalence diabetes and depression, underlying biological mechanism and various existing approaches for effective management of both conditions.

Keywords: Diabetes; Depression; Psychiatric illnesses.

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Introduction

Depression is a common psychiatric illness which co-exists among patients with diabetes. As per the World Health Organization, nearly 340 million people are affected with depression globally and 300 million people will suffer from diabetes mellitus by 2025.[1,2] From self-report questionnaire and diagnostic interview based studies, the correlation between diabetes and depression has been found to be between 25–35% and 9–14% respectively.[3] The co-occurrence of depression in diabetes can be attributed to several factors, including the psychological and psychosocial effects of the disease, a likely common genetic susceptibility and common pathophysiological abnormalities involving neuroimmunological and neuroendocrinical pathways, as well as organic microvascular brain abnormalities due to the inflammation in the brain.[4] Among those suffering, the prevalence of depression was found to be higher in the lower socioeconomic class, unmarried individulas, and those with poor social support, poor glycemic control and high stressors. The prevalence was also noted to be twice as higher in women than men due to emotional lability. A special insight into the study of depression in the diabetic population of India alone showed that the correlation could be anywhere between 7–84%.[5]

Biology

The correlation between diabetes and depression is a two way street. Depression is associated with significant pathophysiologic changes that may contribute to the increased susceptibility of depressed patients to Type 2 diabetes and/or complications from both Type 1 and Type 2 diabetes. Although the exact mechanisms are poorly understood despite intense research, depression

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is associated with abnormalities in metabolically significant biologic pathways. This results in increased counter-regulatory hormone release and action, alterations in glucose transport function, and increased immune inflammatory activation. Such abnormalities could contribute to insulin resistance and/or pancreatic-islet cell dysfunction thereby leading to diabetes. Once individuals are diagnosed as diabetic, exaggeration of depressive symptoms may be seen due to factors such as inability to adjust to a diabetic diet, increased lapses in filling of oral hypoglycemic medications.[6] It can also be attributed to functional impairment and increased expenses due to the morbidity of the diseases.[6,7,8] To summarize, psychological stress leads to the release of counter regulatory hormones such as glucocorticoids, growth hormone, and catecholamines which counteract the action of insulin by raising blood levels of glucose. Depression is associated with sympathoadrenal activation, hypothalamic-pituitary-adrenocortical hyperactivity, and alterations in the activity of the hypothalamic growth hormone axis. Ameta-analysis of multiple cross-sectional studies.[9] Indicated that patients with diabetes and comorbid depression exhibit poorer glycemic control and greater prevalence of multiple diabetes complications (retinopathy, nephropathy, neuropathy, sexual dysfunction, and macrovascular complications).

Diagnosis

In assessing the prevalence of depression, the observation of cognitive symptoms is more useful than vegetative symptoms. These include weight loss, diminished appetite, hypersomnia, psychomotor retardation, and loss of libido. It was also found that diabetics with severe depression experienced more severe symptoms of diabetes than their non-depressed counterparts. The occurrence of diabetic complications such as retinopathy, nephropathy and macrovascular complications were greater in these individuals.

The impact of depression in diabetes

The increased burden of depression in diabetes has been associated with poor self care, reduced compliance to diabetic diet, poor glycemic control, greater chances of diabetic complications, cognitive impairment, and reduced quality of life. The self-care aspects evaluated were diet, medication, exercise, self-monitoring of blood glucose (SMBG), medical appointments attendance and composite self-care measures. A significant association between depression and diabetic complications has been identified. Quality of life (QoL) is another concern. A systematic review on depression and QoL in patients with diabetes has concluded that QoL (both physical and mental) was significantly impaired in diabetic patients with comorbid depression.[10] Depression and diabetes in combination behave as a double edged sword for increasing rates of mortality due to their impacts of cardiovascular health.

Treatment of depression in diabetes

After establishing several studies that actualize the likely correlation between diabetes and depression, one must choose a drug that not only targets glycemic control, but proves useful for the depression aspect as well.[3] In this regard, nortryptaline was found to decrease depression, but had a negative impact on glucose control. On the other hand, fluoxetine tended to decrease depression and improved glucose control as well by reducing hbA1C and obesity. In patients with diabetic neuropathy, Duloxetine, paroxetine, amitryptilline and desipramine have been more effective antidepressants than fluoxetine, although their advantages must be weighed over their potential side effects such as weight gain, hyperglycemia and orthostatic hypotension. The newer generation antidepressants have been a boon as they have significantly less antiadrenergic and anticholinergic effects and lack quinidine-like action and lethality in overdose. Paroxetine, but not fluoxetine may be highly effective in treating painful diabetic neuropathy.[11] Indeed, in a double-blind, placebo-controlled trial of non-depressed diabetic patients, paroxetine was more tolerable than imipramine but was somewhat less effective than the TCA in reducing symptoms of peripheral neuropathy.[12] However, it must be remembered that the SSRI's are potential inhibitors of cytochrome p450 and therefore they could alter the effectiveness of oral hypoglycemic such as, the thiazolidinedione pioglitazone, the meglitinides, repaglinide, and nateglinide. Therefore, nefazodone, fluoxetine, and fluvoxamine would be expected to confer a risk of problems with hypoglycemia. Moreover, inhibition of the CYP 2C9 isoenzyme by fluoxetine, fluvoxamine, or sertraline would also potentially interfere with CYP 2C9 metabolism of the sulfonylureas tolbutamide and glimeperide. The atypical antidepressant bupropion has minimal inhibition of CYP enzymes, is effective in the treatment of nicotine dependence, and is associated

with minimal sexual dysfunction. A holistic approach to treating depression is also including psychotherapy along with pharmacological therapy since they may help in glycemic control through neurophysiological mechanisms such as reducing stress related hormones and altering the neuropeptides related to stress, appetite and satiety. *Cognitive behavioral therapy* leads to significant improvement in HbA1c and reduces rates of depressive thoughts. Therefore including CBT along with pharmacotherapy is a well rounded approach in targeting depression in diabetics.

Conclusion

To be a great clinician, we must not only see patients as carriers of disease who need to be treated with drugs. Ignoring the psychological burden of a disease leads to treatments that are half as effective as they would be if we saw patients as human beings and health as involving not just physical aspects, but emotional and mental aspects as well. Diabetes is a major life burden, and it is only normal to experience depression, anxiety and poor self care as a result of it. Therefore, it is important to treat the mental aspects that arise out of it. Understanding that depression by itself can increase the inflammatory markers that are implicated to cause diseases such as diabetes is a reminder of how important it is to treat depression and other psychiatric illness in their budding stages so that they don't lead to morbid diseases such as diabetes in the future. Diabetes and depression are a two way street and a double edged sword and they need to treated with not just glycemic controls but antidepressants and CBT as well to achieve improvements in hbA1C and prevent complications such as neuropathy, retinopathy and diabetic foot. Effective treatment of depression in patients with Type 1 or Type 2 diabetes may normalize neuroendocrine and immunoinflammatory hyperactivation, facilitate psychobehavioral adherence to diet and exercise, and improve glycemic control.[13] Understanding this and spreading awareness of this has been the objective behind this article so that it can spread light on treating individuals as human beings and not just carriers of disease.

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Review Article

RFP Indian Journal of Medical Psychiatry
Volume 2 Number 2-3, May – December 2019

Suicide Disease (TN)

Mayukh Pandit

Abstract

Trigeminal neuralgia also called Suicide disease is such a disease which affects lots of lives with its excruciating pain which is felt in the division's of one more branches of trigeminal nerve. These pain is known as worst pain a person can suffer which leads to development of psychiatric disorders and that often leads to suicide. It is believed that more than 50% of sufferers have committed suicide. There are treatment available for these disease for pain relief. The highest pain relief treatment is achieved by a surgical procedure known as MVD which relief pain upto 15 years. But no such treatment plan are there which completely cure such disease. I worked and studied these disease for a long time and I invented and designed an implant and wrote an hypothesis which I believe can cure this incurable Suicide disease. I have added some part of my hypothesis in Author's note at last. I believe people must fight these disease positively and defeat such worst disease with a strong will in themselves.

Keywords: Excruciating pain; Microvascular decompression (MVD); Hypothesis.

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Introduction

Suicide in simple terms can be defined as taking own life voluntarily with an intention. It have been found that majority of those who commits suicide always hadpsychiatric diagnosis at the time of death. The simplest way to conceptualize psychiatric disorder is disturbance of CCA, i.e. Cognition, Conation, and Affector any disequilibrium between three.[6] Suicide disorder as the name suggests a disease which leads to suicide that is a condition known as trigeminal neuralgia which is characterized by excruciating pain in distribution of one or more branches of fifth CN a condition where pain becomes unbearable and patients become prone to develop psychiatric disorder which often leads to commit suicide. These pain is known as the world's worst pain a person can suffer. It is believed that more than 50% of sufferers have committed suicide.

Methodologies

Suicide diseases are treated with medication initially. The medication which are used mostly to

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treat Suicide disease are as followed.[5]

- Carbamazepine (Drug of Choice)
- Baclofen
- Gabapentin
- Oxcarbazepine
- Lamotrigine

The initial treatment usually begins with Carbamazepine which often provide relief of symptoms. But unfortunately the relief provided by Carbamazepine or other drugs which are used for treatment may decrease over time. Side effects such as hyponatremia are seen which may necessitate discontinuation of medication.[1]

So patients eventually requires operative procedures for long term pain relief. Surgical procedures which are used for the treatment for TN are of two categories:

1. Major Surgery
2. Minor Surgery

Major Surgery

These surgical procedures is done under GA and they are carried out on the back of skull specifically at the mastoid region.

These are the following procedures:

- Microvascular decompression surgery
- Rhizotomy
- Radiosurgery

Minor Surgery

These surgery is a non invasive surgical procedures, where an instrument is allowed to pass inside the skull under X-Ray to enter ganglion. These is done under short anaesthetics.

The non invasive surgery are as followed:

- Glycerol injection
- Balloon compression
- Radio-frequency thermocoagulation

Out of all surgical procedures MVD has the highest pain relief period of 12–15 years or more. Dr Peter Janetta in 1967 have proposed these surgical procedures and reported and published in 'The New England Journal of Medicine' about his success. The initial success rate was 82% for complete pain relief. But major complications were also reported such as facial paralysis and leakage of spinal fluid.

Discussion

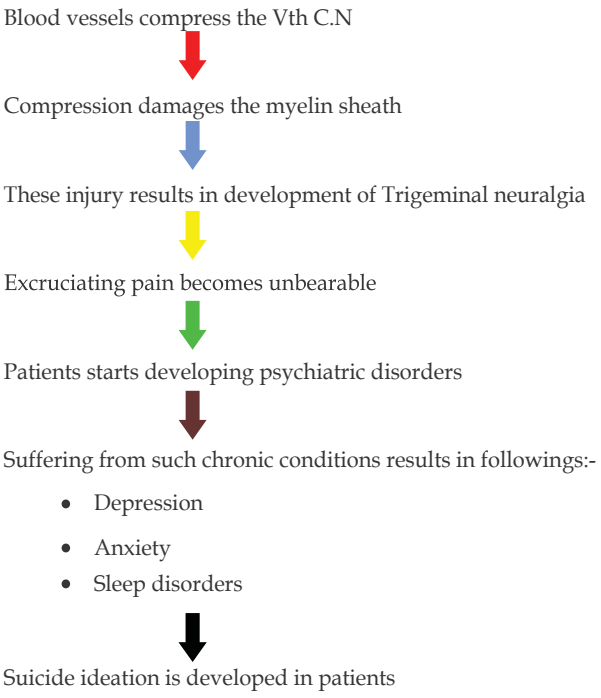
According to International Headache Society, suicide disease is painful unilateral affliction of face characterized by brief electric shock limited to divisions of one or more branches of trigeminal nerve.[3] From my perspective in simple terms, Suicide disease or Trigeminal neuralgia is a chronic conditions characterized by sudden attack of pain lasting from few hours to several days which is confined to distribution of one or more divisions of trigeminal nerve.

Trigeminal neuralgia can be classified as:

1. Typical Trigeminal neuralgia (TN1)
2. Atypical Trigeminal neuralgia (TN2)

Etiology

TN is a condition which mainly arises from blood vessels typically Superior Cerebellar artery which compress the trigeminal nerve when it exits the brain stem. These compression cause damage to protective covering present around the myelin sheath. These injury to myelin sheath are known to cause such chronic conditions of suffering. The excruciating pain which becomes intolerable to patients. After suffering such chronic conditions patient starts developing psychiatric disorders which often results in long term depression, anxiety followed by sleep disorders.[4] At further stages suicide ideation is developed in patients.



Suicide disease may also arise from results of surgeries such as craniofacial surgery, sinus surgery or even oral surgery.

These disorders have been seen affected more in women than men. In some cases it have been found that even simple exposure to wind have stimulated these disease.

Conclusion

I am adding some glimpse of my hypothesis to the context. I recently worked on these incurable Suicide disease and found an excellent cure to these disease. I believe if my hypothesis works, then a permanent pain relief treatment would be achieved. I have invented and designed a surgical implant which would not only cure TN but also might be a treatment procedures for many neuropathic disease.

I am working on these implant and making it more advanced and biocompatible so that no complications can arise from my hypothesis. I am giving my best to make these surgical procedures cheaper than all other surgeries so that everyone can afford these treatment in any part of the nation across the globe. My work would be an achievement that day when it would create a smile in worst pained condition of the face. Suicide disease would be atlas overcome by a beautiful smile. People would get the courage to fight these disease positively and get a permanent cure for pain relief.

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Review Article

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Quality of Life of Schizophrenia Patients: A Review

Poonam Rani Das[1], Suprakash Chaudhury[2], Daniel Saldanha[3]

Abstract

The study of quality of life (QOL) of schizophrenia patients has gained prominence in the last two decades, especially after the introduction of the second generation antipsychotic drugs. As a result of improved prognosis QOL is now considered as a significant outcome measure of schizophrenia treatment, yet the determinants of QOL for schizophrenia patients are not well known. Earlier treatment of positive symptoms was given more importance and less attention was given to treating long term impairment and chronic illness. Now the goal of treatment is to give the patient good quality of life. This is of paramount importance in disorders like schizophrenia where a complete cure is achieved in less number of patients while in the majority there are relapses or long term impairment due to illness.

Keywords: Quality of life; Psychiatric disorders; Treatment.

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Introduction

Schizophrenia is a clinical disorder of unpredictable but profoundly disruptive psychopathology that involves positive, negative, and cognitive symptoms. The disorder affects cognition, emotion, perception and other attributes of conduct. The disease runs a chronic course with variable outcome. The effect of the disorder is always serious and long lasting. Since its initial description various aspects of schizophrenia has been a subject of debate; whether it is a disease of organic etiology, a group of separate entities, a syndrome, a reaction to stress, or an accumulation of maladaptive behaviors. The earliest description of schizophrenia is found in Ayurveda where Charaka described schizophrenia patients as gluttonous, filthy, naked with loss of memory. Krepelin in 1896 used the term dementia precox referring to mental deterioration starting early in life. Bleuler in 1911 coined the term schizophrenia, considering the illness to be a group of disorders rather than a single entity. He described the four primary symptoms-autism, ambivalence, loosening of association and affective flattening as the core of the disorder. Later Schneider identified elevensigns whose presence in the absence of course brain disease was strongly suggestive of a

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diagnosis of schizophrenia and named them as symptoms of first rank. Till the early part of the previous century the outlook for the disorder was bleak. With the advent of electroconvulsive therapy and antipsychotics the prognosis did improve. However, despite advances in treatment many patients are left with long term impairment.

Quality of Life

Now-a-days evaluation of quality of life (QOL) has developed into a significant measure of treatment outcome and well-being of persons affected by psychiatric disorders including schizophrenia.[1-3] Because of its severe and persistent nature, schizophrenia has major consequences for the general health, performance, autonomy, subjective well-being and life satisfaction of those afflicted with it.[4] Many of these patients have lifelong disability, meager income, substantial family stress and may be disconnected from their significant others. Due to the chronicity of the disorder and partial relief of symptoms with treatment, large numbers of patients live in long stay facilities and fail reach adult landmarks as getting married, having children, and being gainfully employed. The subjective QOL of chronic schizophrenia patients have been described using the QOL interview. The findings indicated that, compared with normal controls, individuals with schizophrenia had lower ratings for all QOL indices except satisfaction with health. The largest difference in QOL between schizophrenia patients and the normal control subjects were in the areas of occupation, finances and social life.[5-6] In addition patients with schizophrenia have significantly lesser QOL compared to patients with other psychiatric diagnoses.[7] In 120 outpatients with schizophrenia both objective and subjective life conditions indicated an impaired QOL. The greatest number of discontented subjects were in the domains of work and finance. Clinical factors such as psychopathology strongly influenced the patient's life satisfaction, while demographic characteristics hada feeble effects on the patients self-assessed QOL.[8]

Leisse & Kallert assessed social integration and QOL of schizophrenia patients in complementary care using five groups of patients who lived in a variety of psychiatric facilities or at home either with or without family support. The study examined psychopathology, extent of social disability, subjective QOL with an emphasis on social relationships, recreation, general independence. The five groups differed with respect to socio-demographic variables and the degree of social disabilities. The group differences were particularly evident in the areas of daily social life and leisure activities, highlighting the need for further development of complementary systems of psychiatric care.[9] Priebe et al. evaluated 86 first episode schizophrenia patientsand 51 patients with long-term schizophrenia for objective and subjective QOL. Results were compared with samples of inpatients and outpatients with long term schizophrenia. It was found that subjective QOL was lower in the first episode schizophrenia patients compared to those with long term illness and it changed little with time.[10]

In terms of demographic variables, marital status and gender are believed to be unrelated to subjective QOL.[11-13] However, Shtasel and colleagues reporting on unmedicated schizophrenia subjects, found that females had higher QOL than males.[14] Further, married patients had higher global satisfaction.[5] Studies on the relationship of age with subjective life quality has given contradictory results, including negative correlations[11-13] as well as no correlation.[5]

An Indian study reported that on the WHOQOL - BREF scale subjects with Schizophrenia obtained the least scores on social relationship domain, which was significantly negatively correlated with occupation. Patients who were employed patients obtained better scores on this domain of WHOQOL-BREF. Total monthly income was significantly positively correlated with scores on the social relationship domain and total scores of WHOQOL-BREF. On PANSS scores on positive subscale and total scores were significantly negatively correlated with physical, psychological, social relationship domains and total QOL. Negative subscale PANSS had significant negative correlation with physical and psychological domains and total QOL. General psychopathology subscale of PANSS had significant negative correlation with all subscales of QOL.[15]

In 30 community living schizophrenia patients on medication and equal number of age and sex matched normal controls assessed with WHOQOL and stigma and discrimination scale it was found that 46% of schizophrenia patients faced high stigma and had significantly lower QOL scores. QOL scores were correlated with poor physical conditions, psychological state, environmental factors as well as lack of social support but not with stigma.[16]

Subjective and Objective QOL in Schizophrenia

In schizophrenia subjects psychopathology, as determined by total Brief Psychiatric Rating Scale (BPRS) score, correlated negatively with global life satisfaction and subjective QOL subscales, but not with objective ones. Analysis revealed that subjective measures of QOL were more affected by negative.[17]

In outpatients with schizophrenia there was an inverse relation between patients subjective QOL and their score on the PANSS and the number of psychiatric outpatients visits.[18] A study of 90 first admitted schizophrenia patients found that QOL in schizophrenia is affected by illness as a result of the complex interaction between psychopathology and gender related variables.[19] In 80 individuals with schizophrenia scores on subjective and objective QOL measures were found to be markedly different. It was observed that patients of schizophrenia with symptoms of depression assessed their QOL lower and obtained lower scores on subjective QOL. On the other hand those with poor insight assessed their QOL higher. Future research should take this factor into consideration.[20]

QOL and psychopathology in schizophrenia

Studies evaluating QOL of subjects with schizophrenia have recognized some important influential factors, including social support,[21] unmet need[22] and side effects of drugs.[23] The consensus is that QOL in schizophrenia is significantly negatively impacted by negative symptoms and general psychopathology (e.g., anxiety, depression). On the other hand mixed findings have been reported as far as positive symptoms are concerned.[24] There are substantial variations in the size of the associations among negative symptoms, general psychopathology, and QOL. While few studies have reported large relationships among these measures,[25,26] other studies observed only moderate to small associations.[27,28]

Meltzer and associates reported a link between negative symptoms and QOL, but they also demonstrated a correlation with positive symptoms.[11] However, severe negative symptoms, the presence of tardive dyskinesia, and long duration of illness are all associated with lower QOL.[12] In 70 patients of schizophrenia with mean age 58 years, HRQOL was affected by symptoms of psychosis, psychosocial factors and social maladjustment.[29] Another study found that the severity of negative symptom was not related to poorer QOL but significantly positively correlated with later work-related difficulties, financial dependence, impaired social relationships, inability to enjoy recreational activities and impaired global assessment of functioning.[30]

In 128 schizophrenia patients QOL scores were associated with positive and negative symptoms and the level of functioning. QOL in schizophrenia was more highly related to negative rather than positive symptoms.[26] In a study toexamine the differential relations among psychiatric symptoms and the QOL of inpatients and outpatients with schizophrenia, it was found that negative symptoms and general psychopathology had a markedly stronger relationship with the health-related QOL of elderly outpatients with schizophrenia.[31] Lehman in his study found that low scores on QOL were associated with high ratings on depression and, to a lesser degree, anxiety.[32,33] Patients with depression and anxiety are likely to observe lives in more negatively than real circumstances, resulting in distortion in appraisal of subjective QOL. Several authors reported negative correlation between depression and QOL. These studies however were mostly about subjective QOL. Reine et al. reported a strong association between QOL in schizophrenia patients in a stabilized phase of the disease and depression. QOL was influenced more by depression rather than symptoms of psychosis. Also, in view of the weak correlation between subjective and objective assessment of QOL, the authors recommended simultaneous evaluation of QOL from subjective and objective perspective.[34]

In a cross-sectional study of 80 patients with schizophrenia having duration of illness over 1 year and discharged from a hospital at least 6 weeks earlier were assessed with the PANSS, the St. Hans Rating Scale for Extrapyramidal Syndromes, the UKU Side Effect Rating Scale, the Drug Attitude Inventory, and the Lancashire QOL Profile. The results showed that more than half of all patients were satisfied with their life in general. Subjective dissatisfaction was mainly concerned with mental health and partnership. Higher QOL was associated with cognitive symptoms and employment status, while the depression and anxiety component of the PANSS, parkinsonism, and a negative attitude toward antipsychotic medication negatively influenced the QOL.[35] Gorna et al. evaluated 46 male and 26 female patients of schizophrenia using the WHOQOL-BREF, Social Functioning Scale (SFS) and Calgary Depression Scale for Schizophrenia (CDS) to assess depressive symptoms and its influence on subjective and

objective QOL showed moderate correlation with objective and strong correlation with subjective measures of QOL. The authors concluded that both subjective and objective QOL in schizophrenia is influenced by clinical symptoms of schizophrenia and depression.[36] Positive symptoms and depression were the main clinical factors affecting HRQOL in 157 stable outpatients with schizophrenia.[37]

In schizophrenia patients a number of studies have found strong relationships among general psychopathology, negative symptoms, and QOL in the early course of the illness.[10,38,39] Impaired cognitive function identified by interview-based assessment in 79 schizophrenia outpatients with severe negative symptoms, were a strong predictor of QOL.[40]

Suttajit and Pilakantain evaluated 80 individuals with schizophrenia and found that negative symptoms, low mood, and poor contact with loved ones were the most important predictors of poor QOL. However, positive symptoms, disorganized thought, anxiety/depression, decreased social support and adverse life events were also correlated with QOL.[41]

Although no studies have compared the relations between psychiatric symptoms and QOL for individuals with chronic verses first-episode psychosis, it seems plausible that the recent onset of such a debilitatingillness may enhance the impact of the symptoms of this illnesson QOL. Unfortunately, studies have yet to examine how the relationshipbetween psychiatric symptoms and QOL changes throughout thecourse of schizophrenia and fully elucidate whether such symptomspose increased threats to the QOL of individuals living in thecommunity.

Insight and QOL

In 17 schizophrenia patients discharged from the hospital and recovering from a relapse, QOL was associated with positive symptoms and misattribution on the Scale for Assessment of Unawareness of Mental Disorder (SUMD). No significant correlations were noted between neuropsychological deficits and QOL.[42]

Doyle et al. assessed the manner in which insight influenced schizophrenia patients. He evaluated objective life conditions and the concurrent validity between patients' and clinicians' assessments of patients' global QOL in 40 patients. It was found that in patients with good insight there was a significant correlation between objective and subjective indicators of QOL and also between subjective and external evaluations of global QOL. It was concluded that in schizophrenia subjects with impaired insight the self-report methodology for assessing QOL may not be useful.[43] Ilanit et al. reported that improved insight into having a psychotic disorder was related to reduced emotional well-being, lower vocational status, and less economic satisfaction. Insight into the necessity for, taking treatment was positively correlated with higher emotional well-being. Insight had no relation to the symptoms of psychosis.[44] Another study revealed that remitted individuals with bipolar disorder (BD) and schizophrenia had equally low levels of QOL in all four domains and both subjects with BD and schizophrenia had lower QOL than those in the control group. In individuals with either disorder, insight was negatively associated with QOL on the physical domain, and adverse effects of medication were negatively associated with QOL on the physical and environment domains.[45]

The lack of insight and its influence on subjective QOL and functional capacity was examined by Ashley et al. Results showed that insight interacts with negative symptom severity to predict subjective QOL, while severity of negative symptoms and insight contributed directly to functional capacity. It was concluded that individuals with intact insight are better able to manage their symptoms resulting in improved QOL.[46] A recent review concluded that good clinical and cognitive insight is associated with depression and poorer self-reported QOL.[47]

Neural substrates of QOL

Patients of Schizophrenia who obtained low scores on QOL were found to have lower Grey Matter (GM) Magnetization transfer ratio (MTR) values in the bilateral temporal pole (BA38), the secondary visual cortex (BA18), bilateral insula, vermis and the cerebellum as compared to patients of Schizophrenia with unimpaired QoL.

Significant correlations between MTR values and QoL scores (p <0.005) were observed in the GM of patients in the right temporal pole (BA38), the bilateral insula, the vermis and the right cerebellum. Microstructural changes in areas forming a part functional networks involved in emotional and social interactions processes is related to low QOL in schizophrenia subjects.[48]

QOL and Antipsychotic Medication

Antipsychotic medication is the mainstay of treatment of schizophrenia. The pharmacotherapy of schizophrenia has undergone substantial changes. Research over the past decade has shown that about 80% of patients with schizophrenia respond to drugs, of these 20% recover well after the first attack but 60% and the 20% who do not respond require psychosocial intervention. The discovery of chlorpromazine in early 1950s may be the most revolutionary contribution in the treatment of schizophrenia. Later on other typical antipsychotics were used but these had annoying and debilitating side effects. After the discovery of newer or atypical antipsychotics patients felt more comfortable on medications because these had fewer side effects. These second generation antipsychotics have now become the dominant agents for treating schizophrenia. These agents are related with improved outcome and good psychosocial treatment and rehabilitation.Variety of factors influences the outcome of QOL of patients on antipsychotics. These are side effects, daily dosing, and treatment time, tolerability of medications, impact on cognitive functions, negative and depressive symptoms, compliance, previous experience with medications and social functioning.[49] Michael et al. in 161 stable schizophrenia patients being treated with first or second generation antipsychotics found that both group of subjects had comparable QOL ratings. However, the presence of adverse effects of antipsychotics was associated with reduced ratings in QOL domains of subjective feelings and general activities.[50] In 309 patients randomized to receive olanzapine and haloperidol, the comparison did not show any advantage of olanzapine over haloperidol in terms of treatment adherence, symptoms, EPS and QOL. Benefits in terms of reduction in akathesia and improved cognition were weighed against higher costs and weight gain with olanzapine.[51] Inwon et al. examined an association between the type of antipsychotic drugs administered and the QOL of patients with schizophrenia attending rehabilitation programs in community settings. It was found that QOL of patients on atypical antipsychotics was higher in comparison to patients on conventional antipsychotics even when results were adjusted for age, sex and other socio-demographic variables.[52]

Study by Lieberman et al. with schizophrenia patients receiving olanzapine, quetiapine, ziprasidone, resperidone or perphenazine showed that the common reasons for discontinuing medications was lack of effect or intolerability. Olanzapine had lower discontinuation rate but had different set of side effects but other SGAs were similar to each other and to perphenazine in terms of effectiveness.[53] A study done by Peter et al. to see the effect on QOL of atypical versus conventional neuroleptic medications in subjects with schizophrenia showed that there was no disadvantage in terms of QOL, symptoms and associated costs of care in using first generation antipsychotics rather than second generation.[54] An observational study by Kilian et al. supported this study.[55] Ann and Ahemed compared QOL in schizophrenia patients on first and second generation antipsychotics taking 50 patients on conventional medication and 76 patients on atypical antipsychotic medication. Atypically treated patients showed better QOL than conventionally treated patients.[56] Study by Nuss and Tessier concluded that use of amisulpride in schizophrenia improves the overall QOL.[57] It has been seen in most of the studies that newer antipsychotics results in better QOL and functional outcome. They have good tolerability, less side affects but they are costly in comparison to conventional antipsychotics which can affect the long term compliance of medication. Moreover QOL doesn't depend solely on medications but on resources of rehabilitation and social adjustment.

QOL in Deficit and Non-deficit Schizophrenia

In 1980s deficit schizophrenia was described. This subtype of schizophrenia was characterized by prominent idiopathic or primary negative symptoms. On the other hand nondeficit schizophrenia was characterized by prominent positive symptoms. Patients with deficit schizophrenia differ from other patients of schizophrenia in terms of risk factors, course of illness, family history, functional and structural variables, neurocognitive measures and response to treatment. There is less comorbidity with substance abuse, anxiety and depression. Delamillier et al. assessed QOL in 30 deficit and 112 nondeficit schizophrenia patients. The two groups of patients did not wary in terms of general psychopathology, total score of positive symptoms, or QOL. It was suggested that primary negative symptoms has no impact on subjective QOL.[58]

QOL and relapse in schizophrenia

Boyer et al. (2013) reported that in schizophrenia patients at 2 years follow up QOL as assessed by SF 36 is an independent prognosticator of recurrence of the illness. This area requires further evaluation.

Conclusion

QOL is a vital concept in Psychiatry. Since disorders like Schizophrenia may not respond completely to therapy in many cases the stress is now on improving the QOL of patients. Studies indicate that QOL in schizophrenia is affected by a number of factors including negative, positive and cognitive symptoms, insight, type of medication, side effects of medications, poor physical conditions, psychological state, environmental factors as well as lack of social support.

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Review Article

RFP Indian Journal of Medical Psychiatry
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A Study on Sociopaths

Mayukh Pandit[1], Anil Kumar Agrawal[2]

Abstract

Our universe is diverse in nature with lot's of beautiful minds. But sometimes due to various circumstances this mind could be affected with some sort of mental disorders. Likewise a famous disorder known as antisocial personality disorder was observed which includes two broad terms sociopath and psychopath. This article describes on the lives of sociopath and behavior, aetiology of such disorder, treatment procedures and at last conclusion which elicits a positive attitude towards this disorder.

Keywords: Antisocial personality disorder; Sociopath; Psychopath.

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Introduction

The term Sociopath is made up of two words, i.e. Socio and Path. Socio means social in simple terms but path is derived from Greekword pathos which means 'sick and suffering'. In general terms sociopaths are group of people who aresuffering from psychiatric disorders where they manifest themselves with antisocial personality. Basically sociopath are described as someone who have antisocial personality disorder (ASPD). According to Diagnostic & Statistical Manual of Mental Disorder (DSM), antisocial personality disorder is a personality disorder characterized by long term pattern of disregard for or violation of rights of others.[1]

Those with antisocial personality disorder shows symptoms at early age but this is such a worse type of condition which could be only diagnosed at adolescence stage. Their behaviour is often shaped by environmental factors mostly exposure to abuse or expedient behaviour.

Discussion

The simplest way to conceptualize any psychiatric disorder is disturbance of Cognition, Conation and Affects or any disequilibrium between three.[2] Similarly Sociopathy is a broad term which refers to a pattern ofantisocial behaviour and attitude including manipulative behaviour which often arises from environmental factors. The general epidemiology of anti social personality disorder is seen in 3% to 30% of psychiatric disorder.[3] Sociopathy is often conceptualized as diagnosis but it is not a formal diagnosis. It is invoked

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indiscussing people on anti social spectrum who generally display callous behaviour with little regard for others.

There are behaviour which are very significant in the lives of sociopath which includes under followings.[4]

They always have high manipulative skills and they often appear to be charming. They are often to see dominant and humiliate their victims.

- There is always a significant pathological lying which is seen in sociopathic behaviour. They are extremely convincing and they could even pass the lie detector test.
- They have lack of remorse, shame or guilt.
- They have lack of empathy and they often show callous behaviour.
- They have criminal versatility. They change their image as needed to avoid prosecution. They can even change their life story readily.
- They never blame themselves but blame others even for acts that they had obviously committed.
- They usually has a history of behavioural and academic difficulties.
- Verbal outburst and physical punishments are normal in sociopathic patients.
- They behave they are all powerful they know everything, there is no sense of personal boundaries, no concern for their impact on others.

There is always a misconception regarding differences between psychopath and sociopath.

Both have the common traits of antisocial personality disorder, but they differ in in the traits of behavioural characteristics.

Psychopaths are very calculative in nature. They always plot their moves. They might use aggression but in a laid plan way to get what they want. So they are often termed as 'cold hearted'. Their soul mission is to manipulate others for personal gain, they are also known as skilled actors. On the contrary sociopaths are often term as 'hot headed'. They just express themselves without thinking how others would be affected.[5]

According to Web MD, a key difference between a psychopath and sociopath is whether he has a conscience. Psychopath doesn't haveconscience. Whereas sociopath has conscience, but it's week. They might feel some guilt or remorse, but that doesn't affect their behaviour.

Another misconception regarding antisocial personality disorder is based on their violent instinct. Some people with antisocial personality disorder could be violent but on a general as most of them are found to be not.

They are seen to be use their manipulative behaviour to get what they want. They have no empathy they can hurt anyone to achieve their needs. But if one follows on history of sociopathy violence record, John Gacy name would be highlighted. He used to entertain kids as a clown at birthday parties. People adored him. He was one of the most famous sociopath to ever walk on earth. In 1970 he murdered 32 young men andburied most of them in crawl space under his house. History also had shown authors like Jack Henry Abott who wasn't a serial killer but crime of forgery sent him to the prison. Where he stabbed someone upon escaping from prison. He died by suicide in prison in 2002, but his sociopath charm lives on. His famous quote on section of brainy quotes was quoted as 'One morning I woke up and plunged into psychological shock. I had forgotten I was free'.[6]

Treatments

The treatment for sociopathy is very challenging because it is mostly diagnosed at very last stage of life that is for 40s and beyond.

Psychotherapy is the only therapy which is highly recommended for antisocial personality disorder. Psychotherapy always help the patient with proper management to resist negative behaviour and thoughts. They also improve the patient to develop interpersonal skills, the area where they might lack. Supreme goal should be to reduce the impulsive behaviour which makes sociopath often hostile and versatile. There are no medication which have been approved by FDA to treat antisocial personality disorder. There are medication which might help reduce aggressive and impulsive behaviour. This includes mood stabilizers and antidepressants. The only treatment with very high success rate would be proper support from family and friends. Family members should also be counselled to improve communication with the patient. Love and faith of the family members and friends can cure this condition to some extent.[7]

Conclusion

There is no way to prevent this antisocial personality disorder. There are even no exact cause known for

this disorder. But antisocial behaviour is thought to have its root in childhood so it becomes necessary for parents, teachers and paediatricians who should able to spot the early warning signs so that it might help to identify those at risk. It often discourages if one had loved ones with antisocial personality disorder. With proper psychotherapy, patient with antisocial personality disorder do learn to form strong bonds and positive relationships, be more responsible and respect the boundaries of others. So if your loved ones are suffering from this condition one must consult with mental health professionals who would cure your loved ones so that they lead a prosperous life and stay physically and mentally healthy ahead.

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A Case Study on a Patient of Suicide Disease

Arindam Mandal[1], Mayukh Pandit[2]

Abstract

Suicide disease also known by the name of Trigeminal neuralgia, Tic Dolourex, Fothergill disease. This is such a worse type of condition where it is characterized by sudden attack of pain lasting from few hours to several days and confined to distribution of one or more divisions of the trigeminal nerve. A case report was taken and reported on the basis of patients condition of Trigeminal neuralgia. An analysis is recorded on this article about the aetiology and treatment there are seven surgical procedures and medications which are mentioned in the discussion part.

Keywords: Tic Dolourex, Fothergill disease.

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Introduction

Suicide disease as the name suggest a disease which is characterized by excruciating pain in the distribution of one or more branches of 5th cranial nerve, condition where pain becomes intolerable and patient becomes prone to develop psychiatric disorder which often leads to suicide. According to International headache society, TN is defined as painful unilateral affliction of face characterized by brief electric shock limited to divisions of one or more branches of trigeminal nerve.[1] This pain is known as world's worst pain a person can suffer and it is also believed that more than 50% of people have committed suicide after suffering from such chronic conditions.

Case Report

The following case describes a 55-year-old woman who came with severe pain on left side of her face, in mandibular division of Trigeminal nerve. Her statement was stabbing pain was felt on her left cheeks. Electric shock pain was also radiating and the pain was stimulated with biting and chewing undergoing masticatory forces. She is only working lady and this condition is disrupting her daily activities.

Then full dental examination was done. Cavity were filled and restorations are also performed. But no significant improvements were observed. Analgesics such as Ibuprofen was prescribed as initial treatment by junior physician which did not show any significant improvements.

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Patient was referred to neurologist where upon closer examination, trigger zones were observed on left area of nose, left upper lip and lower chin area.

There is no family history of genetic illness and any other neurological problems. Patient doesn't smoke or drink. She didn't underwent any surgeries in the area of head and neck. Reflex were also normal throughout and toes where going down. Blood pressure was absolutely normal.

A sense of palpation was felt around left lower part of jaw which caused slightacute pain. In primary investigation infraorbital and mental nerve block was given. The brief stabbing pain appear to be relieved which confirm the primary diagnosis of suicide disease. Final diagnosis was made from MRI scan with contrast which revealed a close association of superior cerebellar artery and trigeminal nerve on left part of patients face.

Thus case was concluded with diagnosis of Trigeminal neuralgia after brief investigation. Then medication was given as first line of treatment because of its low cost, doesn't require any invention and has good effective rate.

Discussion

Suicide disease which affects lots of life arises from compression due to multiple sclerosis or a tumour. Compression is created by superior cerebellar artery which offends 5th cranial nerve. This compression leads to demyelination and further development of Trigeminal neuralgia. Stabbing pain become so intolerable for the patient that they start developing psychiatric disorders this often leads to suicide ideation in patients. This pain is even stimulated by simple exposure of wind. Women gets more affected with this disease than men.

In treatment there are medication and surgical procedures available. Initially suicide disease are treated with medication under followed.[2]

- Carbamazepine (Drug of Choice)
- Baclofen
- Phenytoin
- Gabapentin

In surgical procedures there are seven surgery which are performed to relief period of episodes of pain for longer duration more than medication. Out of all surgical procedures microvascular decompression surgery has the highest pain relief period up to 12 to 15 years. This surgery aims at separation of superior cerebellar artery from trigeminal nerve with the use of Teflon sponge.[3] This procedure was proposed by Dr Peter Janetta in 1968.

Conclusion

Suicide disease is one of the world's most pain condition one can suffer. But there are treatments available which can relieve pain for longer period of time. We are also on a deep research for proper treatment of this condition. Patient of suicide disease must fight this disease with positive attitude and a good will. Suicide is not the single option of covering these pain, instead one must fight this battle against such disease and atlas victory would fetch happiness and prosperity in life.

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