Services of the Journal Committee, Executive Council & Secretariat

Instructions to Authors

Editorial
Challenges and Controversies in Contemporary Psychotherapies
K. S. Sengar

Presidential Address
Psychological Interventions in Child Mental Health
Manju Mehta

Kang Oration
Clinical Psychologist and Hospital Administration
Amool Ranjan Singh

Research Articles

Comprehensive Neuropsychological Rehabilitation to Improve the Quality of Life of Stroke Patients Suffering from Aphasia.
Harsimarpreet Kaur, Ashima Nehra and Rohit Bhatti

Prevalence of Behavioural Problems in School Going Children of Tezpur City
Maitrayee Dutta, Masroor Jahan and Ranjan Kumar

Adapting Cognitive Behaviour Therapy for India: Potential Barriers and Possible Solutions
Andrew Beck and B.S. Virudhagirinathan

Relapse among Persons with Alcohol Dependence Disorder: Does Assertiveness Matter?
Sony, M S and Manickam, L S S

Factors Influencing Hopelessness in College Students
Nisha Sachdeva and Naveen Grover

Neuropsychological Pattern of Performance and its Implication for Rehabilitation in Schizophrenia- A Hospital Based Study
Rupesh Kumar Chaudhry, Pankaj Kumar and Bholeshwar Prasad Mishra

Executive Functions in Medicated Vs Drug Naïve Patients with Obsessive Compulsive Disorder
Archana Bharti, Kiran Bala and Basudeb Das

Representational Drawings of Children With Autism
Ashum Gupta and Rekha Negi

Does Self-Rating of Prospective Memory Correspond With the Performance on Objective Measures?
Devvrata Kumar, Surdeo Pahan and Priyadarshee Abhishek

Mental Health Clinics

Use of Audio Feedback in Cognitive-Behavioural Treatment of Social Phobia
Deepika Srivastav, G. S. Kaloiya and Naveen Grover

Metacognitive Training (MCT) in Facilitating Awareness of Metacognition and Delusion: A Case Study of Delusional Disorder
Sanjay Kumar Bhogta, K. S. Sengar and Amool R. Singh

Test Review
RINPAS Family Relations Test: A Projective Test for Children (RINPAS FRT: PTC)
Dr Manju Mehta,
Editorial

Challenges and Controversies in Contemporary Psychotherapy
K.S. Sengar

Therapies belong to variety of disciplines – psychology, psychiatry, social work, and counselling, to name just a few – and apply different principles from different perspectives in their respective areas of work with people who come to them for help. With expending horizon of mental health issues and for all diversity every therapist who takes up work in clinic, community center, general or psychiatric setup, or elsewhere faces an array of contemporary challenges as well as controversies.

Defining mental health profession as part of mental health workforce with any precision presents complex challenges, especially in light of the fact many therapists work and identify more than one mental health profession (for example, a therapist may be both a social worker and marriage and family therapists. But this is reality, as there is scarcity of trained and qualified mental health professional in the world. In India, there are approximate fifteen thousand psychiatrists, one thousand five hundred clinical psychologists, one thousand psychiatric social workers and six hundred trained psychiatric nurses which is in no way even near to the requirement of 125 crore population of the country. Mental health services are also delivered by general physicians rehabilitation counsellors, and school counsellors. Majority of therapists practice technical eclectism and use a variety of methods in formulating clients problems and devising treatment and rehabilitation plans. In fact, multimodal therapists are technical eclectics (e.g. they employ multiple methods without necessarily endorsing the theoretical positions from which they were derived (Pope & Wedding, 2011).

As the field of psychotherapy has matured, integration has emerged as mainstay. Clinicians now acknowledge that there are certain inadequacies and potential value in every theoretical system. This has resulted to look across school boundaries to see how patients can benefit from other ways of conducting psychotherapy. Although, various label are applied to this movement e.g. eclectism, integration, reapproachment, prescriptive therapy etc. The ultimate goal is to enhance the efficacy and applicability of psychotherapy (Norcross & Beutler, 2011).

Nearly everyone agrees and classify psychotherapy as legitimate part of medical practice without any requirement that its use by restricted to psychiatrists. However, psychiatrists now devote the majority of their time to medication management and far fewer psychiatrists are being trained to provide psychotherapy to their patients (Moran, 2009). Hence, clinical psychologists are practicing psychotherapy most. No therapist works in isolation. All therapists must prepare themselves and cope with frequently challenging scenario especially in context to manifestation of various types of psychosocial and economic factors. Several studies suggest a shift away from longer term psychotherapies. Olfson et al (2002) examined changes that occurred between 1987 and 1997. They found that more and more physicians are getting involved in treatment of depression with psychotherapy besides medication. These physicians are of generally primary health care level. The situation in country like Indian is different, as general physicians are treating various psychological disorders adequate understanding and training to treat the same. Due to lack of awareness and scarcity of the mental health professionals, psychotherapy has not picked up the pace with advancement of technology. General population’s understanding about psychotherapy is very limited and many time efficacy of psychological treatment is questioned.

To push to put therapy on sound scientific footing, led to the concept of empirically...
supported therapies (ESTs). Proponents of ESTs believed that each form of therapy need to be tested in carefully controlled experimental research. The results would show which therapies actually worked and which, though well intended, did nothing to help the patients or worse, were harmful. The concept of empirically supported therapy, appealing to so many in theories, has turned out to be different and at times controversial to put in to practice. Western and Bradley (2005) note that evidence based practice is construct (i.e. an idea, abstraction or theoretical entity) and thus must be operationalized (e.g. turned into some concrete form that comes to define it) The way it is operationalized is not incidental to whether its net effect turn out to be positive, negative or mixed.

One challenge is that a therapy cannot be described simply as “effective” any more than psychological tests can be described simply as “valid” or “reliable. The validity and reliability of the psychological tests do not exist in the abstract. They must be established for a specific population (e.g. identifying malingering), for a specific setting (e.g. school or forensic), and for a specific population (e.g. adults who can read & write). Paul, Gorden L acknowledged this complexity in 1967 when many were searching for therapies that were “effective”. Paul wrote that both therapists and researchers must confront the questions “what treatment by whom, is most effective for this individual with that specific problem, an under which sets of circumstances?” David Barlow (2004) reviewed research showing the importance of these complex sets of variables. He notes for example. He notes for example, that studies show “therapist variable such as experience contribute to successful outcome. But this research on therapist variables occurs in the contest of considering, first and foremost, the presenting pathology of the patients”. He further concludes there are three overriding principles in evaluating the robustness of (psychotherapies) …… First, it is important to match the psychological intervention to the psychological or physical disorder. Second, it is important to match the treatment to the patient and therapists characteristics. ………….. Finally, the evaluation of treatments must be considered in context of the actual settings in which the treatments are provided. The daunting complexity of the research needed to investigate a particular psychological therapy adequately stands in stark contrast with the sheer number of available therapies. Kazdin (2008a&b) for example notes that there are more than 550 psychological interventions for children and adolescents but only a relatively small minority have been subjected to research.

The continuing revolution of digital revolution has great potential for transforming the relationship between clinicians and patients. New media tools like web blogs, instant messaging platforms, video chat and social network are reengineering the way doctors and patients interacts (Hawn, 2009). Digital technology has brought about various changes and challenges for therapists in another area of practice; the storage and transmission of records. Even though the widely hailed paperless office has not come to pass for most therapist, many therapists use computers to administer, score and interpret psychological tests and other assessment instruments. Many use computer for recording information about their clients and notes on psychotherapy sessions. How can therapists make sure that this confidential information is restructured to those authorized to see it? It may seem reasonably easy challenge but therapists and patients have been stunned by instances in which supposedly secure information fell in to wrong hands.

Again another important issue relates to the therapist’s sexual involvement with patient or non sexual physical touch and sexual feelings. No circumstances or rational justify sexual involvement with patient. The prohibition continues to be fundamental to the profession for may reasons including the issue of harm to the patients. It is important to distinguish
therapist - patient sexual involvement from two very different phenomena. First, nonsexual physical touch is clearly different from sexual involvement. Pope et al. (1994) documented the ways in which nonsexual physical touch with therapy had acquired" a guilt by association" with sexual touch. The review of research and other professional literature found no harm of nonsexual touch per se, although context and culture, religion and meaning should be always be considered before touching a patient when consistent with patient’s clinical needs and the therapist approach. Nonsexual touch can be comforting, reassuring, grounding, caring and an important part of healing process. When discordant with clinical needs, context, competence, or consent, even the most well intentioned nonsexual physical contact may be experienced as aggressive, frightening, intimidating, demeaning, arrogant, unwanted, insensitive, threatening or even intuitive. Nonsexual multiple relationship and boundary issues are also important to be understood by therapist. Sound judgement about nonsexual boundaries always depends on context. Nonsexual boundary crossing can enrich therapy, serve the treatment and management plan and strengthen the therapist – client working relationship. They can also undermine the therapy, sever the therapist – patient alliance and cause immediate or long term harm to the patient (Pope et al., 2008). To what extent nonsexual relationship to be expanded has to be decided and judged by the concerned clinician keeping in view the welfare of the patient as well as the ethical consideration of the profession.

REFERENCES


Presidential Address

Psychological Interventions in Child Mental Health

Manju Mehta

Abstract

The Clinical Psychologist can have significant contributions in the area of Child Mental Health. For a mental health professional, working in this area is very rewarding as the response to intervention is generally appreciable and more rapidly noticeable. The field, though challenging, comes with an unsurpassed feeling of satisfaction. The set up of child psychology also generally facilitates greater independence in working environment. Child psychology has become more relevant within the domain of clinical practice, as in a majority of such cases, non pharmacological interventions are required, and considered to be essential to effective treatment planning and execution. Non pharmacological interventions come with their own set of advantages – primarily, they are perceived as non-threatening by the child owing to their interactive nature and the active involvement of family members. focus on specific symptoms and emphasis on learning. These interventions are aimed at not only the reduction of symptoms and the resultant distress, but also lay emphasis on learning. They also have a preventive and remediative focus and employ strategies for teaching life skills, coping skills & social skills. The scope of child psychology broadens beyond the individual child to help caregivers/family members to deal with the child. As childhood, and the developmental years, lay a foundation for later life; the long term goals of child psychology and the subsequent benefits cannot be overlooked.

There are various forms of interventions used in managing childhood problems. These are- Psycho-education, Cognitive Behavior Therapy, Family Therapy and Play Therapy. These techniques have also been used in pain management, stress management and life skill training for children. There have been a number of research studies to assess their efficacy in Indian children. There are some randomized clinical trials on CBT based interventions. There are many challenges in the practice of these therapies such as engaging the child/adolescent in therapy process, acceptance by parents, compliance, problems with follow-up, explanation of therapeutic strategies, time/cost effectiveness and adequate training of professionals.

INTRODUCTION

Child Mental Health is an important and upcoming specialisation under mental health profession. Children between ages 3 years to 15 years are registered in this clinic. Many psychiatry departments and teaching and non teaching hospitals have special clinics designated as Child Guidance Clinic or Child Psychiatry Units. Currently the age range of children in these clinics has increased - from birth to 3 years, labelled as Infant Psychiatry, and 12 to 18 years is called adolescent psychiatry. The clinics are called Child and Adolescent Mental Health Clinics. This speciality is not limited to hospital setup only, but extends to schools also.

Clinical Psychologists have made very important contributions in this field. The psychologist working in this specialty find the work very satisfying as often only few therapy sessions are required for improvement in child’s behaviour. There is constant feedback from parents and children, which enables them to review and modify their approach as and when identified, thereby leading to faster gains. In this area, clinical psychologists can work independently and the problems with which children present are challenging. Clinical psychologists have an important role in this field as psychosocial influences have great impact on the child mental health as family environment, school and peer group interact with child’s temperament.
Psychological Interventions

Psychological interventions for children differ significantly from those that are employed for use with adults. With children and adolescents, a more developmental focus is required with special emphasis on other contributing factors such as family, peer group, social structure and emotional development. Social attribution and social information processing models (Dodge, 1993; Garber & Flynn, 2001) are two common approaches incorporated in the use of psychological interventions with children.

Need for mental health services in children is for life skills training, promoting well-being, preventing emotional and behavioural problems, intervention for these problems and identification and management of serious mental disorders. According to WHO and studies conducted in India, 20-30% children/adolescents have emotional problems and 3-12% of children/adolescents have serious mental health problems (ICMR, 2000). Pharmacological management is helpful in serious mental health problems like childhood psychosis, depression and severe anxiety. Psychological interventions can be useful as an adjunct therapy in serious mental health disorders, and first choice of treatment for mild to moderate behavioural and emotional problems. Need for non pharmacological intervention is greater in the child psychiatry set up because it is non-threatening, interactive, with active involvement of family members and employs focus on specific symptoms, emphasis on learning coping skills, social skills, anxiety management and anger management. This type of intervention has long term benefits.

Aims of Psychological Intervention in Children are Manifold:

- Prevention and Remediation Services
- Symptom Relief/ Reduction of Distress
- Teaching life skills, coping skills & social skills
- Helping caregivers/family members to deal with the child

Psychological interventions have applications for both preventive and intervention. In many disorders it is the only method of management, it’s indications are for following disorders-

- **Developmental Disorders**: Autism, Mental Retardation, Specific Learning Disability
- **Behavioural Disorders**: ADHD, Conduct disorder, Behavioural Problems, Enuresis, Thumb Sucking, Substance Use
- **Affective Disorders**: Anxiety, Phobia, OCD, Depression
- **Somatoform Disorders**: Headache, Recurrent Abdominal Pain

School Based Intervention:

Intervention can be carried out in other settings like in school setting. School teacher’s are given training, and involved to deal with behavioural problems. School based programmes are required as school children display variety of problem behaviours, they are due to increased stress in family, competition with peers, expectations from teachers. There is limited access to mental health resources and problem of stigma. Coping skills training and help children to develop cognitive and behavioural strategies to solve their problems. School mental health can be organized for promotion of mental health, management of mild specific learning disability, stress management and training to develop coping skills.

Adaptation and Research in India:

Psychological Therapies are very important, yet to be effective they should be adapted according to culture. Thus we have researched and developed some intervention modules like - Psycho-education, Cognitive Behavior Therapy, Family Therapy, Play Therapy, Pain Management, Stress Management and Life skill training.

Coping Skills Training Module for Children was given to school children, pre and post assessment was done to assess its efficacy. The 6 sessions consisted of training in problem solving, anxiety management, emotions and rational thinking, social skills, anger management and bringing it all together.
Specific Learning Disability (SLD) is a problem where children find difficulty in coping with academic tasks with average intelligence. This problem is being recognized by teachers and parents but not many standard management strategies are available. There is need to address management of problems both in academic and non-academic areas. There is also need to have strategies for management of SLD in regional languages. Training parents and teachers to engage them as co-therapists/co-educators. It is important to make learning strategies fun for the child. To fulfill these objectives an ICMR study was carried out titled - Development & Dissemination of Intervention Strategies for Specific Learning Disabilities in this a training guide for parents & teachers of children with specific learning disability was developed.

CLINIC BASED INTERVENTIONS

These have been developed by Department of Psychiatry, All India Institute of Medical Sciences, New Delhi for training of children with Intellectual Disability, Attention Deficit Hyperactivity Disorder, Anxiety Disorder, Depression, Somatoform Disorder and Substance Abuse Disorder.

Intellectual Disability:

Management of intellectual disability cannot be addressed with pharmacotherapy or psycho-education alone. Parent Training to teach self care, basic academic and social skills training is necessary, for this mothers—the primary caregiver were trained on the principles of Behavior Modification as training of techniques can be done in structured manner. 50 Mothers, both working and housewives in the age range of 20-35 years were given 2 sessions per week. Total 10 Sessions, (initial 3 sessions were in group and later 7 sessions were individual sessions) were given. All the sessions were of one hour duration. Training was imparted through practical demonstration, manual and video recording. Pre and post assessment revealed increase in skill development in children and decrease in problem behaviour.

Attention Deficit Hyperactive Disorders (ADHD):

Mongia, Mehta and Sagar (2008) developed a Psycho-educational Module for management of ADHD. 10 sessions module comprised of Parental education, training using behavior therapy and cognitive behavior therapy principles for improving attention and reducing associated behavioural problems.

Anxiety and Depression:

Prevalence of Anxiety and Depression is increasing at an alarming rate in children and adolescents due to psychosocial stresses in academics and personal lives. They report examination anxiety, social anxiety, phobias. Low mood, Irritability, School refusal, Social withdrawal and somatic complaints. CBT based therapy is best suited in such cases. With Adolescents are developing a computerized model based on CBT techniques. Its effectiveness is being assessed on pre- post treatment research design.

Somatoform Disorders:

In this disorder child is unable to express his, psychological conflicts, family plays important role in maintaining illness behavior and doctor shopping increases stress on family and child. The six session module imparts training for both child and the family. Dutta et al. (2008) Explored alternative therapeutic forms – art and play to treat children with somatic complaints. Abdominal pain and headache was the commonest problem. With nondirective play therapy significant improvement was reported. Psycho-education was given to family members.

Substance Abuse:

This is a growing problem in both school going and street children. Majority of the adolescents are brought for treatment of Inhalant use. There is need for culturally adapted strategies such as coping skills for various problems, Involvement of family members as co-therapists helps in cooperation from parents and monitoring at home. Sharma et al. (2009) developed a brief CBT Based Module for Adolescents with Substance Abuse. The module has 6 sessions- Motivation enhancement
and Psycho-education, Identification of high risk situations, Coping Strategies, Craving Management, Social Skills Training and Family Counselling.

**Obsessive Compulsive Disorder:**
OCD has been seen to have paediatric onset in some cases, with children as young as age 6 reporting to outpatient services for treatment. ERP has effectively been tested with children and adolescents, with newer modalities such as computer assisted and self help modes of treatment are being explored (Kapoor, 2013).

**Stress Management For Students**
Increase in stress amongst students is well documented. Stress has negative impact on examination performance, interpersonal relationship and in sports. Stress management helps in overcoming many problems in students. Brief, simple and easy to practice strategies can reduce stress in students. These are Relaxation Exercises, dealing with exams, Problem Solving, Time Management, Cognitive Restructuring, Setting Realistic Goals, Positive Thinking and Positive Self Statement. These strategies can be demonstrated to students in 2 hour single sessions with follow up booster session.

**CHALLENGES:**
Working with children and adolescents is not very easy, one has to understand developmental perspectives of the client. The psychotherapy techniques though similar in theory, is different in practice. It is challenging to engage the child/adolescent in therapy process. The therapy should be accepted by parents, as this will ensure compliance. There are problems with follow-up, as the child has to depend on others and the school schedules may call for attending them after school hours. Explanation of therapeutic strategies should be done in simple language. At present not many trained professionals are available, so more professionals, man power should be developed. Intervention modules should be cost effective and brief.

**NEW DIRECTIONS**
To be at par with the rest of the world and meeting with technological advances, there is need to develop self-help manuals, computerized and internet based CBT Modules. Today’s adolescent are more computer friendly, thus these modes of delivery are more acceptable to them. Culturally adapted manuals for therapy and translation of therapy manuals for regional languages needs to be developed. Transdiagnostic CBT, multimodal therapeutic modules and metacognitive therapies have to adapted to our cultural needs. Moreover, these methods can also bridge the gap of demand and supply- clients and professionals. We need to have controlled randomized studies, efficacy studies for process and outcome research.

**REFERENCES**


Comprehensive Neuropsychological Rehabilitation to Improve the Quality of Life of Stroke Patients Suffering from Aphasia.

Harsimarpreet Kaur 1, Ashima Nehra 2 and Rohit Bhatia 3

Abstract

Aphasia is the most striking cognitive sequelae of strokes & attempts to rehabilitate patients have been undertaken for many years. Neuropsychological rehabilitation (NR) reduces the cognitive, emotional, psychosocial & behavioural deficits caused by an insult to the brain. Therefore, a Comprehensive NR (CNR) with aphasia therapy was designed and aimed to improve the language functioning of patients suffering from stroke. Methodology: On an OPD level, 5 cases of post stroke aphasia after 8 months to 1.5 years of stroke with education > 10 years, age 37 to 65 years were included. ABA design was used where neuropsychological assessment with Indian Aphasia Battery (IAB) assessing 5 domains. The CNR comprised of NR along with Aphasia Therapy. NR Sessions lasted for 4-8 weeks. Results: Wilcoxon sign rank test reveals that the neuropsychological assessment post CNR shows a marked improvement in the total IAB scores & Acoustic Problems. The other domains also show the effectiveness of the CNR with aphasia therapy which are clinically, but not statistically significant due to the small sample. Conclusion: Therefore, a larger sample size is needed to prove the effectiveness of this programme. A CNR with aphasia therapy can help in improving the language & quality of life of patients suffering from stroke.

Key Words: Aphasia, Neuropsychological Rehabilitation, Stroke, Neuropsychology
Adapting Cognitive Behaviour Therapy for India: Potential Barriers and Possible Solutions

Andrew Beck¹ and B.S. Virudhagirinathan²

Abstract

Although Cognitive Behaviour Therapy (CBT) is a part of the training on several mental health training programmes and a course has been developed in Chennai there is a considerable unmet need for this therapy in Indian mental health services. This paper describes the context for developing CBT training course and feedback from trainees of the second wave of training as to what they believe are the likely barriers to developing this therapy in Indian mental health services. Fourteen participants in a week long CBT training programme were asked to complete a semi-structured questionnaire regarding likely barriers to developing this therapy. Participants identified the availability of supervision, the need for training which emphasised practical skills over theoretical knowledge and the need for wider institutional support at local, state and national level as likely barriers. Developing training courses and promoting CBT as a credible option in major presenting mental health problems in all these domains was seen as crucial in developing this model in India. It was concluded that Good links with UK training courses are currently being developed which will support Indian mental health workers to develop and adapt this model in the Indian context.

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Relapse among Persons with Alcohol Dependence Disorder: Does Assertiveness Matter?

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Abstract

Relapse is very common among persons with alcohol dependence disorder and the correlates of relapse are diverse. Assertiveness is the ability to act in harmony with ones values and self esteem without hurting others and its relation to relapse requires exploration. The study aims to understand whether assertiveness could be one of the factors that is associated with alcohol dependence disorder. Fifty three males with alcohol dependence disorder, who were repeatedly relapsing and were attending various Deaddiction centers in Kollam and Thiruvananthapuram districts of Kerala State and a matched controlled group of 46 non alcoholic persons drawn from the same localities based on convenient sampling, in the age range of 18-54 were recruited for the study. Apart from the personal data schedule and alcohol history taking proforma for assessing various parameters related to drinking, Malayalam version of Rathus Assertiveness Schedule was used to assess assertiveness. The mean score of assertiveness of the experimental group was found to be 0.30 and that of the control group was 12.04 and the t value was 3.38, significant at .001 level. When the assertiveness score of the persons who are abstainers (n=18) and who are currently on relapse (n=35) were compared, no significant difference was obtained. No significant difference was obtained between assertiveness and other variables of age, religion, domicile, marital status and SES. Assertiveness appears to be one of the factors that is associated with relapse and therefore assertiveness training needs to be included as one of the key component of the relapse treatment programs as well as the de-addiction counseling programs.

Key words: Relapse, Alcohol Dependence Disorder, Assertiveness, Rathus Assertiveness Schedule.

Factors Influencing Hopelessness in College Students

Nisha Sachdeva1 and Naveen Grover2

Abstract

The aim of this study was to understand the factors influencing hopelessness in college students. Three hundred and forty eight (348) male and female undergraduate students from various colleges of Delhi were selected through purposive sampling. The major tools used in the study were a Personal Data Sheet, Beck’s Hopelessness Scale (BHS), Personality Diagnostic Questionnaire - 4th version (PDQ-4), ICPS Family Functioning Scale (ICPS-FFS) and Quality of community Life questionnaire (QOCL). SPSS 17 software was used for statistical analysis. The results revealed that there are significant correlations between hopelessness and personality disturbance, hopelessness and family functioning, hopelessness and peers relations and hopelessness and quality of community life. All the above factors except quality of community were found to be significant predictors of hopelessness.

Key Words: Hopelessness, Personality, Family functioning, Peer relations, Quality of Community life

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Neuropsychological Pattern of Performance and its Implication for Rehabilitation in Schizophrenia- A Hospital Based Study

Rupesh Kumar Chaudhry¹, Pankaj Kumar² and Bholeshwar Prasad Mishra³

ABSTRACT

The Present study was aimed to understand the Neuropsychological Pattern performance and its implication for rehabilitation in Schizophrenia. The study was conducted at Dayanand Medical College & Hospital, Ludhiana, India. A total of 30 known schizophrenic patients (diagnosed as per the ICD-10 criteria), both indoor as well as out-door, were evaluated for their intellectual and memory functioning using verbal intelligence test (Indian version which has four subtests i.e. Information, Digit span, Arithmetic and comprehension), Alexander’s Pass- along test (to see the executive function) and PGI Memory Test. The morning doses of the psychotropic drugs were withheld at the time of evaluation. Patients with any other medical disorders and with active substance abuse were excluded from the study. The result of the study reflects that females were having more deficit on attention and concentration parameter in comparison to males. On Executive function parameter significant deficit was noticed in majority of the patients irrespective of the sex. Regarding the memory functioning of these subjects, remote memory and delayed recall appeared highly affected areas irrespective of the sex. Schizophrenic patients show significant deficits in their neuropsychological functioning though the pattern differs gender wise. This shows that combining pharmacological treatment with behavioural approaches might represent the best chance for improving general functioning and quality of life of schizophrenic patients.

Key words- Schizophrenia, Neuropsychological, Pattern performance

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Executive Functions in Medicated Vs Drug Naïve Patients with Obsessive Compulsive Disorder
Archana Bharti¹, Kiran Bala² and Basudeb Das³

ABSTRACT
Several studies have found that OCD subjects have selective neuropsychological deficits in executive functioning (e.g. set shifting ability, response inhibition, and decision making), non-verbal (e.g., visual) memory, and visuospatial and visuo-constructional skills. Many studies found no deficits in non-verbal memory, set-shifting, response inhibition, decision making and planning functions. Findings of neuropsychological studies of OCD are inconsistent. There is limited research on executive functioning in medication-naive, never treated OCD patients and no study compared drug naïve and medicated OCD with that of normal controls. In this study, we assessed 25 drug naïve, 25 medicated OCD patients and 25 normal participants matched for age, gender, and years of education on the executive tests-SWM, SRM, and SOC. Results revealed that there was no significant difference between drug naïve OCD and on medication OCD group on executive function tests. Both drug naïve OCD and on medication OCD group performed significantly poor on executive function in comparison to normal controls. It is concluded that medicated Vs drug naïve patients of OCD performed at a comparable level on executive function tests: SWM, SRM, and SOC. There were no effects of medication on executive function tasks in OCD.

Key words: Executive Function, Medication, Obsessive- Compulsive Disorder

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Representational Drawings of Children With Autism
Ashum Gupta¹ and Rekha Negi²

ABSTRACT
In the present study, the representational drawings of autistic children, typically developing children and younger typically developing children were compared and scored for visual realism in terms of omission errors and commission errors for the discrete and contextually placed objects. For the purpose of assessing autism, Childhood Autism Rating Scale was administered. Results showed that children with mild autism expressed meaning in the drawings of discrete objects in the same manner as the typically developing groups. However, they were found to be impaired in the drawings of contextual objects. These findings were interpreted as evidence of an impaired conceptualization and weak central coherence in autism.

Keywords: Representational Drawing, Visual Realism, Intellectual Realism and Weak Central Coherence.
Does Self-Rating of Prospective Memory Correspond With the Performance on Objective Measures?

Devvrata Kumar¹, Surdeo Pahan² and Priyadarshee Abhishek³

ABSTRACT

Self-report measures are often used to assess prospective memory. However, there are equivocal findings about the correlation between self-report and objective measures of this memory system. Present study was conducted to see if the score of a self-report measure (Prospective and Retrospective Memory Questionnaire) correlates with scores derived from performance on prospective memory tasks. Findings reveal that the self-rating does not correlate with the level of performance on either event- or time-based prospective memory tasks. Findings have been discussed in the light of their practical implications.

Case Report

Use of Audio Feedback in Cognitive-Behavioural Treatment of Social Phobia:

Deepika Srivastav¹, G. S. Kaloiya² and Naveen Grover³

ABSTRACT

Social Phobia involves the fear of social situation. Phobias are generally considered to be learned fears, acquired through direct conditioning, vicarious conditioning and the transmission of information or instructions. Conditioning is a form of learning during which new association develops between a stimulus and responses to that stimulus. The present case study of Mr S, 35 year old, married, male, working as a tailor, highlights the development of social phobia and use of audio feedback in cognitive behavioural treatment. Symptoms started after the comments by a relative about his appearance. He started avoiding others due to fear of comments. Slowly he started to avoid social gatherings as he would think that someone might again comment on his appearance. This fear generalized in other aspects of life as started causing occupational and interpersonal difficulties. To treat his problem twelve sessions of Cognitive Behaviour Therapy including audio feedback was used. Following cognitive behavioural management there was improvement in the symptoms and it was maintained over follow up.

Keywords: Audio feedback, Phobia, Conditioning, Exposure, Relaxation, Cognitive Therapy.
Delusional disorder is an uncommon psychiatric condition characterized by the development of either a single or a set of related delusion (WHO, 1992). There is increasing empirical support for the role of metacognition in the vulnerability and maintenance of psychotic experiences like delusional beliefs (Freeman et al., 2002; Morrison et al., 2005). This study is evaluating efficacy of metacognitive training facilitating in awareness of current state of metacognition and ameliorating cognitive biases with a case of delusional disorder. Findings of present case study suggest that metacognitive training has significant role in facilitating awareness of metacognition and reduction substantial symptoms of delusions of the patient.

**Keywords:** Metacognitive Training (MCT), Metacognitions, Delusions, Delusional Disorder.