

# Depression

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## Introduction

Everybody feels depressed or miserable at times. Bereavement, failure to pass an examination or get promotion, being jilted, and losing possessions are common causes of misery in normal people. In psychiatry, depression is used in a specialized sense of the word to mean an illness in which misery is predominant.

The illness depression is characterized by a syndrome or constellation of features:

1. MISERY—unhappiness, dejection, despondency.
2. AGITATION—restlessness, being on edge, unable to settle.
3. PSYCHOMOTOR RETARDATION—slowing up of thinking and doing.
4. LOSS OF GRATIFICATION AND INTEREST—especially from matters and topics unconnected with illness.
5. INSOMNIA—early morning wakening.
6. DIURNAL FLUCTUATION—symptoms are worse in the morning.
7. PREJUDICES, DELUSIONS—of guilt, disease or poverty.
8. MISCELLANEOUS FEATURES (these occur sufficiently high in the rank order of a symptom inventory to warrant inclusion, but not to be numbered separately, in this book)—loss of energy, tiredness (not sleepiness), loss of confidence, vacillation/indecision, loss of appetite and weight, loss of sexual interest and activity, amenorrhoea, constipation, obsessional ruminations or rituals, depersonalization and derealization, suicidal attempts, hallucinations, sad expression, sad posture and gait, tendency to monotonous speech and reduction of gestures.

A simple way of systematizing evidence to be obtained at examination is set out in the following Figure (Figure 1):

## Value Of Lists Of Signs In Depressive Illness

In physical medicine the patient complains of symptoms, whereas the physician finds signs on examination. In psychiatric practice the patient to the doctor does not report many of the phenomena of mental illness. Thus they are better regarded as signs, to emphasize the need to search out actively their presence or absence.

Accomplished physicians have no need for lists of signs and some are depreciatory about them. To leave the student to flounder and divine intuitively what should be made explicit tends to make a mystery where there should be none. Mystery is a dangerous form of ignorance and a ripe breeding ground for superstition, supposition and exploitation. A list of the constituent signs of a depressive illness is only a stage in the acquisition of a more complete and competent knowledge of the condition.

'Pray, Mr. Opie, may I ask what you mix your colors with?' said a brisk dilettante student to the great painter. 'With brains, Sir', was the gruff reply. (Recounted in *Hora subsecivae* by John Brown.)

The clinical picture, which a patient presents, bears as much resemblance to a list of symptoms and signs as a finished picture by John Opie bore to the colors on his palette.

A competent diagnosis can only be made when the basic symptoms and signs are known sufficiently well to permit the physician to recognize the different ways in which they can predominate in their combinations to present apparently unrelated pictures of depression. A patient who is agitated and fearful appears to be suffering from quite a different illness from one who is quiet and retarded. As in general medicine the predominance of one sign or the absence of another may result in an entirely different clinical picture.

**Figure 1. Chart For Systematizing Evidence Of Depression Found At Clinical Examination**

<b>Symptom Or Signs Of Depression</b> With sample of questions asked by examiner to elicit whether present or not	<b>Patient Says</b>	<b>Relatives say</b>	<b>Impression Suggests</b>	<b>Physician Concludes</b>
1. MISERY How are your spirits? How are you in yourself? How do you feel? But you don't feel sad all the time? Have you been feeling depressed or hopeless lately?				
2. AGITATION Do you feel calm or restless? Are you on edge? Keyed up? But you don't feel restless all the time?				
3. RETARDATION Has there been any change in your quickness? Have you felt slowed up in the speed at which you think? Do you find it more difficult to get started? But you are not slowed up all the time?				
4. LOSS OF INTEREST AND GRATIFICATION What do you find worth doing? Have you lost interest in things? But you must be interested in something? What gives you satisfaction?				
5. INSOMNIA How are you sleeping? Do you have difficulty getting off to sleep? Do you wake up earlier than usual? Do you sleep well throughout the night? But you must sleep well on some nights?				
6. DIURNAL FLUCTUATION Do you feel better at any time of the day? Do you feel better mornings or evenings?				
7. PREJUDICES AND DELUSIONS				
8. MISCELLANEOUS Enumerate these				
<b>RECORDING RESULTS</b> If there is a preponderance of evidence that the sign is present, enter +, ++ or +++ according to severity. If there is a preponderance of evidence that the sign is absent, enter --, --- or ---- according to certainty. If you do not know, enter DK.	<b>FINAL CONCLUSION</b>    DATE			

## Examination of the Features of Depressive Illness

### 1. Subjective feeling of misery, etc.

Misery, unhappiness, sadness, dejection, gloom, melancholia, despondency, desolation, depression, distress—by giving a list of words one can hope to communicate the nature of a subjective experience.

Inspection, palpation, percussion and auscultation cannot help one to know what goes on in another's mind. Although the sight of a miserable face, posture and gait, the sound of a miserable monotonous voice, and weeping may suggest a patient is feeling wretchedly unhappy, the best evidence is obtained by asking the standard question: 'How are your spirits?'

If the answer is not to the point a second standard question should be asked:

'How are you in yourself?' Yet a third standard question may be necessary: 'How are you feeling in yourself?'

A patient, such as a farm laborer, with a poor vocabulary may not have the words to describe his feelings. He may approximate and say 'I feel low'. If the examiner points out that the floor is 'low' or 'down', the patient may reverbulate his distress and say 'I feel rough'. If the examiner remarks 'The bark of a tree and sandpaper is rough—how does this apply to you?' the patient may feel the psychiatrist is being sarcastic or simply does not understand him. Or he may become suspicious and hostile even though interrogation has been skilful and sympathetic, and remark 'I'm not imagining it, doctor'. Or he may complain of physical symptoms such as pressure, or psychological symptoms such as 'tiredness', or he may ask for a tonic. If pressed by an impatient doctor he may agree with whatever symptoms are suggested and thus receive treatment for a physical illness.

On the other hand, a patient such as an actor with a good vocabulary and dramatic turn of phrase may overplay a relatively minor upset so that it may be concluded his subjective experience of misery is more extreme than is the case. He may have quarreled with his mistress and amidst tears and protestations become reconciled the following day. It would be a pity to give him electroplexy.

Clearly if a patient is deaf, dull or demented, verbal examination may be protracted, difficult or impossible.

### *Distinction of misery in depressive illness from normal unhappiness*

The misery experienced by a patient with depression is thought to be abnormal or morbid. All people are unhappy at times in their lives. A jilted lover; a recently bereaved widow (provided she loved her husband); a ruined businessman; an unjustly punished child; an individual judged on his age, his race or his color and not on his merits; an unsuccessful candidate in an examination or a conscientious man who is turned down for promotion—all of these know unhappiness. It is a normal emotional response, which would be experienced by the substantial majority of individuals in the community under such circumstances.

How can one decide whether misery is normal or abnormal?

Misery is thought to be abnormal when it fulfils some or all of the following criteria:

*a. It has no adequate cause.* Many patients will find a cause for their misery. Abnormality is suspected because the cause does not seem sufficient to warrant such a response. It is the observer's assessment that the cause is too trivial which matters, not the patient's. If the cause ceases to act and the despair persists it is abnormal. To be miserable following the death of one's husband is normal, following the death of a dog is probably normal, following the death of a budgerigar possibly normal, following the death of a fly not normal.

*b. It is more intense over a longer time than normal misery.* It is difficult to assess the intensity of a subjective experience. No linear scale of measurement can be applied. Thus it is misleading to use crude physical similes such as 'depth of depression' when thinking about it, although such phrases may be invaluable for relations unable to understand more abstract concepts of quality and degree. The evidence that misery is more intense can only be obtained from the patient, providing he has the requisite vocabulary and is sufficiently articulate. Questions could be asked whether the present feeling of un-happiness is more intense than that experienced on previous occasions. Retrospective memory falsification vitiates comparisons of the here and now with the past.

*c. It is more prolonged.* Normal misery is short-lived and one's usual mood returns for increasing periods with occasions of happiness in unexpected ways and situations. A mourning reaction has a more or less characteristic pattern or sequence. The bereaved's first response is to deny the death—'No, no!' 'It must be a mistake.' 'It's all a dream, a joke.' This lasts seconds and is followed by a realization that it is not a dream, people do not make that sort of joke. Then follows acute despair, agitation, panic 'numbness' and sense of futility, which lasts hours or days. Public manifestation, such as weeping and shrieking or a stiff upper lip with a controlled 'Thank you for the information', depends on the customs and mores of the society. This is followed by a more or less sustained grief, the bereaved breaking into tears sometimes at sights or sounds associated with the deceased. After some weeks (usually about twelve) although life will never be quite the same again, the acute phase of mourning is over, and although the person may not enjoy jokes, parties or other social occasions for some time, their accustomed manner of feeling returns. The misery that occurs in a depressive illness may persist, unless treated, for months or years and sometimes for the rest of a person's life. It should be noted, however, that it does fluctuate in degree and is not necessarily continuously sustained. Periods lasting hours, sometimes days, during which the patient is in relatively good spirits, do occur especially at the beginning of the illness.

*d. It is qualitatively different.* Evidence of this qualitative difference can be sought by asking the patient to compare his present despair with his previous experiences of unhappiness—his previous acquaintance with grief. Such evidence is largely dependent on the patient's vocabulary, cooperation and memory. Examination and cross-examination of this evidence is often inconclusive. Another difference recorded by many physicians is that a feature of morbid misery is a loss of hope—the literal meaning of despair. Loss of self-esteem, and prejudiced conclusion that it can never be regained, is another feature of morbid misery not present in normal misery.

*e. It occurs as part of a constellation* of other symptoms and signs, no one of which would enable a diagnosis of depression to be made. When a group of symptoms and signs are observed to have occurred together in a number of different people it is recognized to have clinical identity and called a 'syndrome'. The mental disorder 'depression' is a syndrome, which, as stated, consists of the following 'core' of features:

- i. Subjective misery,
- ii. Restlessness and agitation,
- iii. Psychomotor retardation,
- iv. Loss of interest,
- v. Insomnia (early morning wakening),
- vi. Diurnal mood fluctuation—worse in morning,
- vii. Prejudices and delusions,
- viii. Miscellaneous features.

It is the presence of the associated features (ii) to (vii) that provides supporting evidence that (i) misery is an abnormal experience.

In clinical practice it is not usually difficult to distinguish normal from abnormal unhappiness. Rarely would it be necessary to examine each of these points in a case of depression.

Some patients seem to regard unhappiness as shameful and may refuse to admit to such feelings. In some cases statements of relatives and friends are the main evidence of misery.

## **2. Subjective Feeling Of Restlessness, Agitation, Uneasiness**

The patient may describe this as 'being on edge' or 'unable to settle' or 'keyed up', 'wound up', 'tense', and 'taut'. Uneasiness and agitation are a normal response to attending doctors in general and psychiatrists in particular. The patient should be asked if he feels restless and whether it could be a result of the interview. Was he restless and agitated before the interview? Before he knew he was to see a psychiatrist? For how long has he been restless and on edge? Critical evaluation of all answers is necessary in psychiatric examination. The dangers of suggesting a symptom to a patient are well known. If doubt exists, one should gently try the tenacity with which a patient sticks to his answer. Statements in the form of a question such

as 'You are not restless all the time, are you ?' may allow the patient to retract or lead him to further useful explanation.

Observation of the patient's actions such as wringing the hands, picking the fingers or tremor may be confirmatory or misleading. Parkinsonian tremor is sometimes incorrectly adduced as evidence of emotional agitation.

### **3. Psychomotor Retardation**

This is the slowing down of the speed at which the patient thinks (especially on impersonal topics) and does things (especially unfamiliar tasks).

Sometimes mental functions are so severely slowed that the patient makes no psychological response, sitting still for abnormally long periods gazing ahead and mute—this condition is called 'stupor'.

Sometimes psychomotor retardation is revealed by the pause between the doctor's question and the patient's answer—such delay can be measured with a stopwatch.

To elicit this sign ask the patient: 'Have you become slower in the speed at which you think?' 'In the speed at which you do things?' Maybe a relative, friend or colleague will have noticed a slowing down which is denied by the patient.

Sometimes psychomotor retardation is little more than sluggishness in getting started, a difficulty in initiating tasks.

All degrees of slowing may be found between the patient's normal speed of thinking and doing things and the extreme (but rare) slowing of stupor.

It should be noted that the slowing down or retardation does not affect all action and thought. Repeated agitated wringing of the hands is an example of an action that may be fast. Ruminations about poverty, guilt or hypochondriasis may be rapid with appropriately prompt replies to questions.

Psychomotor retardation fluctuates in degree from time to time as well as from topic to topic or task to task.

### **4. Loss Of Gratification And Interest**

This can only be established if a patient's previous pleasures and interests are known.

An elderly effeminate university don with a lifetime's collection of cut glass and china is unlikely to have been interested in motorcycle scrambles or heavyweight boxing. A retired farm laborer will never have been interested in the finer points of French courtesan music of the eighteenth century. Evidence of previous interests and enthusiasms is best obtained from relatives. A depressed patient may have 'No interest in interests' and give non-committal replies. Nevertheless, at times patients are found to have most unlikely and unpredictable interests.

When a patient is in a state of stupor, interest in all matters appears lost. Stupor is a rare condition. More often absence of psychological response is a deliberate act signifying dislike of the examination or the examiner.

Interest tends to persist in topics that are personal and present and to wane in more impersonal and remote matters.

There is a natural insidious falling-off of interest with age in many people and this process should be distinguished from morbid loss of interest.

The more rapidly interest is lost the more likely is the loss abnormal and symptomatic of disease.

The patient should be asked 'What do you find worth doing?' and later 'Have you lost interest in things?'

A timetable of the patient's day before he became ill may be drawn up and his interests at that time compared with the present. Relatives may be able to give useful information about a patient's interests. They often feel a psychiatrist has not taken due care unless they have been asked questions and allowed to air their views. Often a social worker can obtain their evidence, which can include the patient's interests, in the first place or, less satisfactorily; a questionnaire can be sent to one or more members of a patient's family

In view of the shortage of social workers and the urge for many trained ones to disdain this function to become therapists, an untrained, intelligent man or woman with common sense, integrity and insight can be enabled to make a useful contribution if given a questionnaire and asked to visit the relatives to obtain the answers. The pressure of work may make it essential for a psychiatrist to delegate in this manner in order to meet his commitments. In so doing he forgoes opportunities for observations and evaluation, which may be most valuable.

*See: Model Questionnaire*

### **5. Insomnia**

Usually the patient gets off to sleep but awakens in the early hours of the morning and has difficulty in getting off to sleep again. Sometimes the patient has trouble in getting off to sleep when he goes to bed as well as waking early.

In a few patients no clear pattern of the disorder of sleep can be discerned. A patient's report often conflicts with that given by relatives or nursing staff.

The facts are still further complicated in affluent societies since many patients have been 'taking something to help them sleep' long before they attend a psychiatrist for diagnosis and treatment. The patient should be asked 'How well do you sleep?' 'Do you have difficulty in getting off to sleep?' 'Do you wake up earlier than usual?' 'Can you get off again?'

### **6. Diurnal Mood Fluctuation**

Usually the patient feels worse in the morning; better as the day wears on. In addition, other features of depression (agitation, retardation, lack of interest, despondent ruminations) may fluctuate, improving towards evening.

Having enquired:

'Do you feel better in the morning or evening?' asking may make a contrary suggestion:

'Don't you feel worse when you get tired toward the end of the day?'

By asking contradictory questions the psychiatrist obtains evidence, which not only enables the truth to be unraveled but also gives some measure of the patient's suggestibility and desire to please.

### **7. Prejudices And Delusions**

Firmly held absurd beliefs resistant to reason (prejudices) or impervious to reason (delusions) often occur at some time during the course of a depressive illness.

Sometimes a fixed idea, often hypochondriacal, dominates the picture and may lead to extensive otiose physical investigations. Only the more bizarre prejudices or delusions about illness are likely to be recognized as pathological beliefs. Milder hypochondriacal ideas result in complaints suggestive of physical disorder, which may start the physician on a wild goose chase. When reasonable doubt arises as to whether a patient's complaints are symptoms of depression or physical illness, investigations should be carried out. An X-ray of the lung fields, hemoglobin and erythrocyte sedimentation rate provide useful but not conclusive routine evidence against pulmonary tuberculosis, anemia and infection.

Firmly held ideas or delusions of shame, guilt and unworthiness (younger age-groups), hypochondriacal ideas and bodily disaster (middle age-groups), and poverty (elderly age-groups) are characteristic, but not pathognomonic of depressive illness. The patient may feel the illness is his own fault, revealing a weakness of character, that his future is hopeless and his past unworthy and sinful.

Since young people are likely to have delusions of shame, middle-aged to have hypochondriacal delusions, elderly to have delusions of poverty, and since phenothiazines tend to cause dystonia in young, akathisia in middle-aged, and Parkinsonism in elderly patients, one will from time to time find young people with delusions of shame and dystonia, middle-aged with hypochondriacal delusions and akathisia, and elderly with ideas of poverty and Parkinsonism.

Hallucinations (perception without objective reality) are not uncommon. Occasionally a patient may hear unpleasant voices, in the absence of any sound, accusing or criticizing him (auditory hallucination). For example, a woman hears a voice calling her a prostitute (in societies where this profession is considered abhorrent) a man hears accusations of homosexuality. Such hallucinatory voices are a very disturbing experience; many people (incorrectly) regard them as the hallmark of incurable madness. It is not surprising that unsophisticated patients often attribute such voices to wireless or other modern inventions. The characteristic feature, which suggests that a prejudice, delusion or hallucination is part of\* a depressive illness is that the content is consistent with depression. The popularly used simile is: 'The idea or delusion has a depressive colouring'. It is accusatory, denunciatory, depreciative, hypercritical, recriminatory, remorseful, self-reproachful and often associated with feelings of helplessness and hopelessness.

To elicit the presence of prejudices, delusions and hallucinations the patient should be asked, 'Have you noticed anything strange going on?' A pause should be allowed for a response and then the following questions put, pausing for answers after each: 'Do you think anybody has been criticizing you in any way?' 'Do you ever feel as if somebody has been reading your mind?' 'Do people talk about you when you leave a room?' 'Have there been any plots or conspiracies going on?' 'Are neighbors (colleagues) saying unpleasant things about you?' 'Do you feel you will be better soon? ... ever?' 'Do you blame yourself in any way?' 'Do your thoughts come out loud?' 'Have you heard voices speaking?' 'A man's voice or a woman's voice?' 'Does it come from inside your head or without?' 'Does it say lots of words or just one or two?' Quite often, in practice, it is a patient's relatives who volunteer the presence of delusions or hallucinations. Patients are often guarded and evasive, especially if they think they are going to be 'put away'. It is acceptable to feel grit under the eyes (haptic hallucination) but not to hear voices (auditory hallucination).

### **8. Miscellaneous Features**

There are many other features of depression, which the patient or his relatives may mention. These should be itemized for an individual patient. In Fig. 1 and Fig. 2 the examples given are rumination and poor appetite.

### **Note On The Diagnosis Of Depression**

Most people experience many of the features outlined above at some time or other during their life. It is only when the features occur together and persist to such an extent that they hamper a person's life—

*subjectively* (feels dejected and fails to enjoy life),

*socially* (unable to meet obligations to family and others),

*economically* (unable to work or obtain job satisfaction or advance according to ability)—

that they should be considered pathological.

## **Diagnosing Depression**

The physician should satisfy himself as to whether each of the features is present or not. While doing so he must be prepared to allow a patient to wander from the point, to fail to answer a question and at times to give unsought-for information, patiently waiting until he can be brought back to answer the question asked. Whenever possible, a relative or friend should be interviewed separately and accorded the same consideration. Fig. 2 is an example of recording the signs of depression.

If all of the first six or seven diagnostic features outlined above are present then the patient has a depressive illness.

If four or five of the features are present then the patient probably has a depressive illness.

If two or three of the features are present then the patient possibly has a depressive illness.

If one or two of the features are present then the patient conceivably has a depressive illness.

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\* Not 'caused by' or 'due to', since we do not know the cause of depression. It is wrong to say such features are due to depression – they are part of the associated group of clinical features, which constitute depression.

A diagnosis of depression does not exclude other illness. For example, psychopathy, hysteria, mental subnormality, myxoedema, organic mental disorder—including general paralysis of the insane and intra-cranial tumor—pancreatitis, anemia, myocardial infarction, infectious disease such as influenza, hepatitis or plague and so forth.

**Figure 2: Example of use of chart in Fig. 1 to record findings of depression**

By restricting observations to units of communication such a record acts as a basis for comparison with later observations by different observers.

To total the number of + and — gives a specious numerical exactitude. It would be like adding a number of apples, blackcurrants, bananas, cherries and melons together. The number of fruit would be rather meaningless. The rating in plusses given to misery cannot be usefully added to the rating given to insomnia. Nor does a plus for one feature obtained from one witness cancel out a minus obtained from another. Credibility of witnesses has to be evaluated by the physician who must determine whether a preponderance of evidence exists to show whether a given feature is present.

SIGN	PATIENT SAYS	RELATIVE SAYS	IMPRESSION SUGGESTS	PHYSICIAN CONCLUDES
1. MISERY	++	DK	++	+
2. AGITATION	++	+	++	++
3. RETARDATION	--	-	+	DK
4. LOSS OF GRATIFICATION AND INTEREST	+++	+	+	+++
5. INSOMNIA	++	DK	DK	+
6. DIURNAL FLUCTUATION	+	DK	DK	+
7. PREJUDICES, DELUSIONS	-	-	-	-
8. MISCELLANEOUS i. Rumination (hypo-chondriacal) ii. Poor appetite	+++++	++	+ DK	++++
RECORDING RESULTS + = Present. -- = Absent (inquired after and denied) DK = No evidence available (not asked about or inconclusive answer)			FINAL CONCLUSION DEPRESSIVE ILLNESS PRESENT	

### History (Anamnesis)

Had we but world enough and time it might be best to sit down with a patient and over the next few hours or days encourage him to give his complaints and symptoms in his own words at his own pace. No economy could afford such a disproportionate amount of its gross product to pay the large number of physicians that would be necessary. The physician responsible for treating psychiatric illness in a given population has to use short cuts, which may not be disadvantageous in the long run. A brief 'crisp' history giving the essentials of the patient's complaints, their onset, their duration, their evolution, together with previous illnesses, family illnesses, personality development, work record and socio-economic situation on one side of a sheet of paper may contribute more to the understanding of an illness than a long discursive poorly organized account of many pages.

When obtaining a history of a depressive illness, previous attacks of depression or mania should be carefully sought before excluding them. Previous response to treatment is a valuable guide to present treatment. Previous personality is a guide to diagnosis.

Such a thumbnail sketch of the patient's illness taken with accuracy and affability provides a satisfactory basis for successful treatment and prognosis in most cases.

The obsessional over inclusion of all material on the grounds that it might be germane is an exercise in diligent futility, which ultimately deprives other patients of their share of attention and treatment.

### **Note On Reliability Of Evidence**

The psychiatrist draws his conclusions from the answers he obtains to questions and other information he is given. He provisionally assumes most patients tell the truth\* during his examination. Occasionally a patient deliberately tells lies to deceive a psychiatrist. For example: a prisoner charged with a criminal offence, a mother wishing to be discharged from hospital, or an alcoholic questioned about consumption of alcoholic beverages. Sometimes a patient is untruthful without fully realizing it—for example in compensation neurosis.

Dishonesty can be eliminated to some extent if the patient says contradictory things at different times or what he says differs from what others say.

Sometimes a patient is unable to reply to questions, because, for example, he is dysarthric, dysphasic, demented or even in stupor—in which case a relative or friend may be able to give the evidence necessary to make a diagnosis.

Some patients may not have a sufficiently large vocabulary to understand the meaning of questions asked by the psychiatrist on the one hand or to put their answers into words adequately expressing their subjective distress on the other. This is especially true when the patient speaks a different language from the psychiatrist.

Whenever a leading question or a suggestion is made, such as 'Do you feel restless and unsettled?' and the patient agrees; a contradictory suggestion should be made to test the tenacity with which the patient sticks to his answer. The psychiatrist may say: 'But you don't really feel restless all the time do you?' This enables patients to retract and appreciate they are not meant to please the examiner but to report on how they actually feel rather than meet their fantasy of his expectations.

*\* He is wise to assume that alcoholic and psychopathic patients will not tell the truth.*

### **Note On Rules Of Evidence**

In the practice of law, when truth has to be established between contesting parties, well-defined rules of evidence have evolved and been tested over the centuries.

Direct evidence is the testimony of a witness of what he has himself observed. It is assumed witnesses on oath will speak the truth and unless direct evidence is contradicted, or contradicts it, it is accepted or 'admitted' as the truth. (Compare this lawyer's assumption with the physician's assumption that patients speak the truth.)

Circumstantial evidence is testimony connected with the known fact and is relevant in arriving at the truth of a matter. It is not as satisfactory as direct evidence but is accepted or 'admitted'.

Hearsay evidence is testimony to the fact that a statement was made by a person not called as a witness. Hearsay evidence is deemed to be irrelevant or inadmissible.

In a trial, the party who calls them into court first examines witnesses. After this 'examination in chief' they are cross-examined by the opposite party and then re-examined. Leading questions, i.e. those that suggest their own answer, may be put in cross-examination but not in the 'examination in chief'.

Some of the evidence obtained by psychiatric interrogation would be inadmissible in a law court. The patient gives direct evidence about his subjective experiences, which would be acceptable. Leading questions by the psychiatrist such as 'Are you slowed down?' would be objectionable. As noted, such leading questions are restricted to the cross-examination of witnesses to attempt to contradict their direct evidence. Lawsuits can last days or weeks but a psychiatric examination is usually restricted, by the sheer pressure of numbers of other patients requiring treatment, to less than an hour. Evidence given by relatives and friends is often based on their own observations and is valuable, but it may be hearsay evidence - i.e. not obtained directly by their own observations. Such evidence is often unreliable and in law is inadmissible.

There is a considerable difference, of course, between a witness giving evidence at a trial and a patient giving information to a psychiatrist. It is important that the psychiatrist should not let himself appear to the patient like a fierce prosecuting counsel cross-examining a witness for the defense in a television production or a motion picture. The process of questioning and clarifying answers is not incompatible with courtesy and kindness in medical practice—nor in legal transactions.

## **Clinical Presentations Of Depression**

Owing to a predominance of some features, and mildness or absence of others, depression may present as very different illnesses in different people; and sometimes in the same person at different times. It should be understood that any preponderance of one symptom would automatically modify the manner in which others are presented. Seemingly widely differing clinical pictures are due to differences of severity of the constituent phenomena of the depressive syndrome outlined. They may not be different subgroups of depression, merely different presentations.

### **Depression Sine Depressions**

For example, a patient may complain of apathy, lassitude, retardation, restlessness, loss of interest and early morning wakening but deny feeling miserable. This clinical picture has been called 'depression sine depressione'. It is similar to smiling depression.

### **Smiling Depression**

In some patients, usually intelligent and well educated, misery is not marked and the patient may cover up his symptoms of lassitude, insomnia, rising to the occasion of meeting the psychiatrist. He may talk animatedly, smiling and showing a sense of fun. This preservation of a social facade may be misleading and dangerous. The patient may have attempted to solve his problems by alcohol and, if his symptoms worsen, may attempt final solution by suicide.

### **Agitated Paranoia**

Especially with elderly people, the main feature of depression may be peevish agitation, sometimes with abnormal suspicions, prejudices and delusions, which obscures the misery so that the diagnosis is missed, the effective treatment not given and the patient lives on in a tormented and distressed state of mind. Although a different experience from pain, such mental anguish is almost as unbearable and suicide is common.

### **Agitated Depression (Agitated Melancholia)**

Some people present a clinical picture of depression in which agitation, apprehension and restlessness dominate other symptoms so that the patient appears continuously worked up, frightened and preoccupied to the extent of being inaccessible. Sleeplessness is common and failure to eat or drink for some days may result in dehydration and a 'sunken' look. Neglect of grooming and clothes result in a wild unkempt appearance.

This clinical picture merges with that of mixed manic-depressive state. Some authorities use the term 'agitated depression' synonymously with 'involuntary depression'.

### **Involuntary Depression (Involuntary Melancholia)**

This occurs during the involuntary period between the ages of 40 and 55. Agitation is marked and hypochondriacal ideas of cancer or irremediable disease are common. Nihilistic delusions are less common and not exclusive to involuntary melancholia—they may occur in hebephrenic schizophrenia. Remorse, self-reproach, guilt and feelings of helplessness and hopelessness are very common. Delusions of poverty, of death of relatives and inadequacy of housing often occur. Sometimes a patient will have changed house and home to escape delusory deficiencies of accommodation only to find them (projected) in their new surroundings.

Psychomotor retardation is not prominent—possibly because of displacement by persistent depressive ideas, stereotyped depressive utterances and apprehension.

Depersonalization (feeling unreal) and derealization (external world appears unreal or altered) are often present but usually only disclosed if asked about.

Suicide is common.

For many years ♦Kraepelin considered this type of agitated depression, occurring for the first time at the involuntional period, a separate entity from other forms of depression. Such hunches may be interesting but confuse rather than clarify systematic classification in general descriptive psychiatry, which is essential for the recognition of mental disorder.

### **Physical Illness**

As observed in “Subjective Feeling of Misery, etc”, a patient with a poor vocabulary may not have the words to communicate his subjective experiences and may approximate and describe his disease in terms of physical illness with which he is familiar.

Other patients may unwittingly proffer physical complaints, as if to evade admission of psychiatric symptoms, which they equate with moral weakness.

Presentation of depression with symptoms of dysfunction in the musculoskeletal, alimentary, cardiovascular, neurological, uro-genital and respiratory systems is common. Usually the symptom is atypical in onset, duration, radiation and variation.

Sometimes, for example with pain in the face or back, a physical cause is present and the pain to which it gives rise appears to be distorted by depressive illness. ♦Monrad-Krohn remarked that normally women smile after they have whistled during testing of the seventh cranial nerve. Failure to smile is suggestive of depressive illness.

### **Attempted Suicide**

Many patients with depression first make contact with a psychiatrist following an unsuccessful suicidal attempt. At any given time about 1 person in 100 has attempted suicide. About a quarter of suicidal attempts occur as part of a depressive illness, and suicide is always a risk in patients with depression. Although conditions other than depressive illness (physical illness, loneliness, quarrels) result in suicide or suicidal attempt, depressive illness is the mental disorder with the highest suicidal risk. The likelihood of suicide is greater if the patient is elderly, has marked feelings of misery, futility, worthlessness, remorse and self-reproach. History of a previous suicidal attempt is always a serious omen as is a family history of suicide and the presence of physical illness, especially chronic physical illness.

♦Stengel's monograph Suicide and Attempted Suicide is a mine of information and a paperback book easy to read.

As stated, these different presentations of one illness can only be comprehended clearly if the constituent features of depression are known and the clinical presentation appreciated as resulting from the same ingredients but in different quantities.

### **Stupor**

This is a well recorded but rare condition in which a patient makes no psychological response—is mute and abnormally still. At the same time he preserves a significant antigravity posture (sitting or standing) and gazes ahead for abnormally long periods sometimes with reduced blinking.

### **Unipolar Depression**

♦Leonhard introduced this term in 1959 to denote a depressive illness in which hypomania or mania never occurs, and the premorbid personality tends to be obsessional and sensitive. The incidence of celibacy, divorce and depressive illness in the family is lower, the age of onset later and time in hospital longer than

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♦ Emil Kraepelin, 1856-1962, Professor of Psychiatry, University of Munich

♦ Monrad-Krohn, 1884-1964, Professor of Neurology, Oslo

♦ Erwin Stengel, 1902-73, Professor of Psychiatry, University of Sheffield

♦ K Leonhard, contemporary German psychiatrist

in manic-depressive psychosis, which is referred to as 'bipolar depression'. The terminology derives from the application of the physical analogy of two poles, to depression and mania. Whether such a model helps in the understanding of depression—or whether it applies to depression and mania, which have features in common and may not be antipodal—is not decided. The model is useful for research leading to hypotheses, which can readily be investigated. The criteria for inclusion in the class 'unipolar depression' are probably satisfied by some cases of involuntal depression, some cases of agitated paranoia and some cases of reactive depression. Only about 20 per cent of depressive illnesses occur as part of a manic-depressive psychosis (see p. 66). The remainders are probably capable of several different subgroupings according to genetic, social, endocrine, metabolic and other factors.

The treatment of depression is dictated more by the predominating features than by the diagnostic label attached to a particular group.

### **Reactive Depression**

Some psychiatrists think there are two different types of depression: endogenous and reactive. Others maintain that all depressions are endogenous and what is alleged to be 'reactive' is actually a mild degree of endogenous depression. Yet others compromise and suggest that in most cases both endogenous and reactive components are present. This issue is not settled. Most competent workers accept the possibility that either view may be correct, entertain the possibility that there may be several subgroups of depression and hope for further evidence to settle the controversy. In clinical practice it is not of great importance since one naturally treats a person with depression with drugs where possible, leaving electroconvulsive therapy and psycho-surgery for more urgent or more intractable cases. The drugs given depend on the symptomatology regardless as to whether it is classified as 'endogenous' or 'reactive'.

Nevertheless, the differences should be known and are set out in the following table (Figure 3):

**Figure 3: Endogenous versus reactive depression**

<b>ENDOGENOUS DEPRESSION</b>	<b>REACTIVE DEPRESSION</b>
No obvious cause	Precipitated by a situation or incident
Misery sustained	Misery depends on company—can be jollied up by friends. 'Reactivity as well as reactive'
Retardation marked	Retardation rare, stupor never
Diurnal mood variation	No diurnal mood variation
Wakes up early	Difficulty in getting off to sleep
Loss of sexual appetite	Sexual activity may be unaltered
80% respond well to E.C.T.	20% respond well to E.C.T.

*The percentages given are approximate*

Sometimes an endogenous depression appears to be an extension of a grief reaction.

Sometimes an endogenous depression changes and the features, apart from absence of a precipitating cause, become more like those of a reactive depression.

Occasionally a patient who has had a reactive depression and recovered develops an endogenous depression years later and vice versa.

## **Differential Diagnosis Of Depression**

### **From Misery And Unhappiness**

Whenever misery appears prolonged, intensified and without adequate cause a diagnosis of depression should be entertained and the other features of the syndrome sought to support or dismiss the diagnosis.

### **From Schizophrenia**

*a. Simplex.* The loss of interest, diminished drive diminished emotional response and occasional retardation present in schizophrenia simplex is not usually accompanied by misery, agitation, insomnia and diurnal fluctuation. Schizophrenia simplex is an insidious process starting in the teens.

Depression occurs in children but it is not so common before the age of 25 years and its onset can usually be dated—is less insidious.

Difficulty in diagnosis may arise where a depressive illness has an insidious onset in the teens. Schizophrenia is sometimes ushered in by a depressive illness, 'masquerading as depression'.

*b. Catatonic schizophrenia.* Stupor is usually of acute onset in schizophrenia but is insidious and often less extreme in depression. A history of previous bizarre manic activity suggests schizophrenia whereas previous occurrence of the characteristic features of depression with retardation favour depressive stupor; stereotopies and mannerisms including *Schnauzkrampf* are schizophrenic and against depressive pathology.

Schizophrenia is three times more common in lower socio-economic groups than depression. The schizophrenic is more often thin and asthenic as opposed to the depressive's pyknic body build and whereas the prepsychotic personality in schizophrenia is characterized by apathy and withdrawal, the depressive has been in good contact, outgoing and meticulous and industrious, unless he has a unipolar depression.

*c. Paranoid schizophrenia.* The delusions of depression are consistent with guilt, shame, unworthiness and despair. In schizophrenia various different delusions may exist which are not related to each other and do not give rise to appropriate emotions. Although pathological misery is an inappropriate or incongruous emotion its more or less constant quality in depression distinguishes it from the range of incongruous emotional responses often observed with schizophrenia.

Having outlined the differential diagnosis of depression from the standard subgroups of schizophrenia one must remember ♦Bleuler's remark that the diagnostic exercise is not either depression or schizophrenia but how much of a given illness is depression and how much schizophrenia. It may be that the unknown defect of cerebral function resulting in schizophrenia is allied to that resulting in depression.

#### **From Organic Mental Disorder**

This differentiation arises in elderly people. The presence of euphoria, fatuous behavior, memory defect and the absence of sustained misery favors an organic mental disorder such as senility.

A history of previous depressive or hypomanic illness suggests the patient may be having a recurrence.

Since depressed elderly people do not register events and often do not cooperate during psychiatric examination it may be difficult to obtain evidence to distinguish between depression and the clouding of consciousness found in organic mental disorder.

To complicate matters, since organic mental changes and depressive illness occur so frequently, they will often occur together at the same time in the same person—in which case differentiation is specious. Sometimes presence of both disorders simultaneously can only be known retrospectively after one or other of them has responded to treatment.

The first exercise should be to treat vigorously the organic disorder specifically by the appropriate treatment and generally by intensive administration of vitamin B complex (Parentrovite), ascorbic acid, enemas, increased fluid intake, correction of electrolytes, gentle regular exercise and massage. If these measures do not result in improvement after a week or so, further therapeutic trial by treating depression with appropriate medicines.

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♦ Manfred Bleuler, contemporary Swiss psychiatrist, Burgholzli, Switzerland, son of Eugen Bleuler

## Homoeopathy & Depression

Psychotherapy is not a specific treatment for depression. Psychotherapy is defined as non-physical treatment, which tends to cure or relieve psychiatric illness. Being affable, honest, concerned and sympathetic to a patient is not psychotherapy. It is obviously desirable and helps a patient to contend with the dark days of distress and hopelessness that will elapse before recovery is affected. The specific treatment of depression falls under three headings:

1. Medicines.
2. Electro convulsive therapy (E.C.T.), also called electric shock therapy (E.S.T.), and also called electroplexy.
3. Neurosurgery (Psychosurgery).

Dr. Hahnemann in Organon of Medicine (Para 210-230) considers mental diseases as one-sided diseases of the chronic type affecting the whole psycho-somatic entity where the brunt of derangement has been shifted on the mental aspect of the human organism after the physical disturbances have been suppressed by un-homoeopathic treatment or through some other natural causes (Sec. 115-216).

1. Hahnemann concludes that "almost all mental and emotional diseases are nothing more than corporeal diseases in which symptom of derangement of mind and disposition peculiar to each of them is increased, whilst the corporeal symptoms decline (more or less rapidly), till at length attains the most striking one-sidedness, almost as though it were local disease in the invisible subtle organ of the mind or disposition (Sec. 215).
2. There is another condition where the mental aspect is primarily deranged and these disturbances finding the body slightly yielding to the altered psychological conditions maintain the body in a disturbed condition and continue the psycho-pathological state of the patient. These are also continued in a vicious circle by emotional causes, such as continued anxiety, worry, vexation, wrongs and the frequent occurrences of great fear and fright.
3. Sudden outbreaks of insanity or mania (Precipitated by some exciting factors e. g. fright, vexation, mental shock, abuse of spirituous liquors etc.) may occur during the ordinary quiet course of disease. These may be compared with the sudden flaring of latent psora in physical diseases.
4. There are another group of mental cases where it is difficult to ascertain whether the mind or the body is primarily at fault. There may be corporeal causes or psychological factors e.g. faults of education, bad habits, corrupt morals, superstition, ignorance etc.

### Hahnemann provides a very ingenious diagnostic test:

- (a) If the mental affection proceeds from one or more factors belonging to psychological conditions, they will be improved by "sensible, friendly exhortations, consolatory arguments, serious representations and sensible advice".
- (b) If the mental affection depends on a bodily disease it will be aggravated by the same measures; e.g., depressive type of patients will be still more depressed, plaintive, disconsolate and retiring; the maniac type of them would thereby become still more embittered; and the silly prattler will become more foolish than ever.

### Treatment of Different Types of Mental Diseases

1. In mental diseases resulting from bodily diseases and later transformed into one-sided diseases, treatment consists of a judicious combination of anti-psoric drug-treatment and psychotherapy with carefully regulated mode of life and an appropriate psychical behavior towards the patient on the part of the physician and attendants of the patient. E.g.
  - a) Raving madness should be met by calm fearlessness and firm resolution;
  - b) Painfully disconsolate melancholy should be assuaged by silent compassion expressed through gestures and looks.

- c) Loquacity should be listened to in silence, with some degree of attention;
  - d) Indecent behavior and obscene languages are to be totally ignored;
  - e) In-destructive mental tendencies things should be kept out of his reach to prevent mischief, without reproaching the patient for his acts;
  - f) Treatment of the patient should be managed with a view to absolute avoidance of torture or corporeal punishment of the patient;
  - g) Though compulsion and some amount of physical coercion may be justified in order to make the patient take the medicine, even this can easily be avoided by the administration of such little quantities of medicine (as usually employed in Homoeopathic prescriptions), mixed in his usual drinks without his knowledge.
  - h) Removal of all kinds of external disturbing influence on the patient's mind, as far as possible.
  - i) Contradiction, incessant argument, rude corrections, vituperations, no less than weak and timid submission are altogether out of place and alike detrimental to the improvement and cure of mental cases. e.g. There is nothing that embitters the insane and aggravates their diseases, so much as expressions of contempt and ill-disguised deception.
  - j) The physician and keeper of the insane must always pretend to believe them to be possessed of reason.
2. In mental diseases originating predominantly from psychogenic causes—and if they are of recent origin—psychotherapy should be taken recourse to. Here is the scope for comparatively recently discovered psychoanalytical method of Freud, Yung and Adler. Hahnemann clearly mentions that the patient is to be carefully encouraged to regain self-confidence, to remold his life in the path of rectitude where there had been moral lapses. The physician to the patient should not only be his prescriber but also his friend, philosopher and guide to help the patient to resolve his complexes and revert to healthy growth and development of his personality. Very often the cause of mental derangement lies in the failure on the part of the patient to adjust himself to the situation he finds himself in and through this defect further inroads of unsocial and immoral instincts which lay hitherto dormant in this sub-conscious mind, take place in the surface consciousness. These develop into all the turmoil's, dissociations and disintegrations of personality to render a man misfit in the world of factual reality.
  3. The third type of mental diseases are to be treated exactly in the same line to what is followed in the treatment of acute diseases, attacking individually, which are "generally only a transient explosion of latent psora". When these acute mental attacks burst forth; they should not be immediately treated with anti-psoric but with other homoeopathic remedies covering the acute conditions till the acuteness or violence of the symptoms subside indicating that the psora is reverting to its former latent state. Then comes the stage when anti-psoric treatment should be commenced according to the instructions laid down by Hahnemann for the treatment of all chronic cases.

Hahnemann also mentions in a footnote (123) to Sec. 222 that "it very rarely happens that a mental or emotional disease of long-standing cures spontaneously and they are reckoned as cured persons. But he points out that these are only instances where internal dyscrasia transfers itself again to the grosser corporeal organs".

But a careful scrutiny of patient even in that stage will reveal to the eyes of a discerning homoeopath many symptoms indicating the presence of psoric infection in the state of health of the individual and justifying the need of instituting anti-psoric treatment in the individual concerned.

## Treatment of Depression

### I. Homoeopathic Medicines

In Homoeopathy to name a single remedy on Depression is not easy. One has to take the case of a depressed patient as detailed above and each symptom has to be recorded & repertorized to find the most similar remedy for each individual case.

In repertory you will find all the desired rubrics for each possible symptom of a depressed person e.g. Depression, Sadness, Brooding, Delirium Sad, Determination-gloomy, Discouraged, Dwells-past, Excitement-sadness, Fear-sadness, Grief, Inconsolable, Insanity-sadness, Sighing, Suicidal-sadness, Weeping, weeping –sad thoughts, Fear and so on.

Following constitutional medicines covers majority of depression symptoms:

- ❖ **Sulphur:** Often irritable, depressed, thin and weak, even with good appetite. Egotistical and obstinate. Intellectuals. Busy all the time. Hopeful dreamers. Strong tendency to philosophical or religious reveries with fixed ideas. Irritable. Dull, difficult, thinking, misplaces or cannot find proper words when talking or writing. Absent-minded. Very forgetful. Aversion to do mental or physical work. Averse to business. Lazy hungry and always tired. Childish peevishness in grown people. Very selfish, no regard for others. Religious melancholy. Imagining giving wrong things to people, causing their death.

Foolish happiness and pride, thinks himself in possession of beautiful things, everything looks pretty which the patient takes a fancy to, even rags seem beautiful or immensely wealthy. Philosophical mania, wants to know who made this or that and how. Imagines himself a great man. Melancholy. Sadness. Tired of life. Strong impulsive tendency to suicide by drowning or leaping from a window.

- ❖ **Lachesis:** Nervous, excitable. Great loquacity, rambling, frequently jumping from one subject to another, then sadness or repeats the same thing. Delusions, thinks she is under super human control, thinks she is dead and preparations are being made for her funeral, thinks herself pursued, hated and despised.

Fears, going to sleep, lying down or fears that heart will stop. Restless, uneasy, does not want to attend to business, wants to be off somewhere all the time. Derangement of time sense. Sad in the morning, no desire to mix with the world. Aversion of women to marriage. Persistent erotic ideas without ability.

Religious insanity. (Verat., Stram.) Talks, sings, whistles, makes odd motions. Mocks. Crawls on the floor, spits often, hides, laughs or is angry during spasms. Weak memory. Mistakes are made in writing and speaking. Mentally, worse after sleep. Insane jealousy, suspicious. (Hyos.) Mania from overstudy. Feels full of poison: Hateful. Malice. Mischievous. Predicts the future correctly.

- ❖ **Staphisgaria:** Great indignation about the things done by others or by himself, grieves about the consequences. Humiliation, deep guilt and shame. Believes he will lose his fortune, his wife will leave him. Ailments from reserved displeasure. Very sensitive as to what others say about her. Sadness without any cause with irritability. Ill effects after scolding or punishment. Want of self control. Fear, afraid of his shadow. Effects of anger suppressed or reserved. Rape or sexual abuse. Violent outbursts of passion. Always angry. Gloomy and petulant, throws things. Peevish. Child cries for many things and refuses them when offered. Poor memory. Dwells on sexual matters, prefers solitude. Unsatisfied sexual urge in widows. Sensitive emotionally and physically. Hypochondriacal, sad. Imagines insults. Irritable, nervous, excitable and violent.

- ❖ **Medorrhinum:** Desperate. Sad, tearful and fearful. Cannot concentrate. Weak memory. Loses the thread of conversation. Forgets names, word, her errand. Cannot speak without weeping, tells it over and over again. Time passes too slowly. (Cann-i., Arg-n.) Hopeless of recovery. Things seem strange. Feels life unreal, everything seems unreal. Fears going insane. (Mane.) Apprehensive, anticipates events. Fear in the dark and of someone behind her. Melancholy with suicidal thoughts. Sad, dismal outlook, better weeping. Sensitive, nervous, restless. Everything startles her. Hurried and anxious, irritable. Wild feeling. Impulsive, abrupt, rude, mean, cruel. Persistent ideas,

alternating or erratic states. Cross through day, merry at night. Dread of saying wrong thing. High sex drive. Night people.

- ❖ **Conium:** Patients who are worse when idle. Slow grasp, difficult understanding. Women broken down, tired of life, discouraged, who feel as if they were to cry and swallow and choke as from a lump in the throat. Unable to sustain mental effort. Weak memory. No inclination for business or study. Indifferent. Difficulty in understanding what is read. Depressed, timid, averse to society, yet fears being alone. Superstitious. Periodical insanity of alternating type. While walking on the road wants to hold somebody and abuse him. Trifles seem important. Thinks that animals are jumping on his bed. Sad, dissatisfied with herself and surroundings. Cannot think after using eyes. Cares very little for things, makes useless purchases, wastes or ruins them. Likes to wear his best clothes. Sadness, worse by sympathy. As if great guilt weighed upon him. Excitement causes mental depression. Fears when alone, but dread of strangers or company during menses.
- ❖ **Anacardium:** The Anacardium patient has many mental disorders. Irritability. Clairaudient, hearing voices of persons far away or dead people. Hears voices behind her. Seems to have two wills, one good, one bad. Seems as if in a dream. There is a great propensity to curse, swear and blaspheme in persons not usually known to curse. Bad memory. Absent minded. Senile dementia. Alzheimer's disease. Suddenly forgets names, those around her, what she has seen. There is physical and mental lack of power. Lack of confidence in himself or others. Fear of examination in students. Brain fatigue. Aversion to work. Schizophrenia. Lack of self image. Unsociable. Angry and depressed. Desire to swear and curse. Very easily offended. Suspicious and jealous, (Lach.). Phobias. Anxiety when walking, as if pursued. Manic depression. Profound depression with tendency to use foul, violent language. Malicious, seems bent on wickedness. Hard hearted, cruel. Absence of all moral restraint. Mania. Schizophrenia, (Lach.) Internal conflicts. Thinks he is possessed of two persons or wills. Contradictory impulses. Fear of paralysis. Refuses to eat for fear of being poisoned. Despairs of getting well. There is also a tendency to suicide by shooting, (Ant-c). Hallucinations and religious mania. Clairaudient, hears voices far away or of the dead. Her husband is not her husband, her child is not hers. All appears like a dream. Fixed ideas and delusions of various kinds: That mind and body are separated. That he is double, that a demon and an angel sit on his shoulders telling him offensive or good things. That he sees others face in a mirror but not his own.
- ❖ **Belladonna:** Delirium, frightful images ,furious, rages, bites, strikes. Desire to escape or hide himself. Acuteness of all senses. Changeable moods. Hallucinations, sees monsters hideous faces. Biting, striking ,tearing mania. Fear of imaginary things. Tendency to dance laugh, sing, whistle. Constant moaning. Disinclined to talk. Excitable, easily weeps. Starts in fright at the approach of others. Spits on faces of other persons. Quarrelsome. Craving for snuff. Loss of consciousness.
- ❖ **Hyoscyamus:** Mania, erotic, exposes genitals, sings amorous songs. Laughs, sings, talks, babbles, quarrels. Talkative, obscene, lascivious mania, uncovers body, jealous. Does foolish things, behaves like mad. Inclined to laugh at everything. Delirium with attempt to run away. Muttering delirium. Low, speech with constant carphologia, deep stupor. Fears, being alone, being pursued of water being poisoned, being bitten etc. Fear of being bitten by beasts. Very suspicious. Restless, jumps out of bed, wants to escape. Rage with desire to strike, bite, fight insult, scold and to kill. Thinks one is not at home. Speechless from fright. Confusion. Talks with imaginary persons to dead ones. Imagines things are animals. Plays with fingers. Syphilophobia.-Unconsciousness, can barely be aroused.
- ❖ **Stramonium:** Hallucinations, fixed notions, terrifying delirium etc. Therefore it is a remedy of terrors. Cannot bear solitude or darkness, must have light and company. Dread of darkness and has a horror of shining objects. Fear and anxiety on hearing water run. Sight of water or anything glittering brings on spasms. Devout, earnest, beseeching and ceaseless talking. Paranoid. Schizophrenia. Manic-depression. Fearful hallucinations, which terrify the patient, see ghosts, vividly brilliant or hideous phantoms, and animals, jumping sideways out of ground or running to him. Wildly excited, as in night terrors. Sees ghosts, hears voices, talks with spirits. Rapid changes from joy to sadness. Delusions about his identity, thinks himself tall, double, a part missing. Religious insanity. Stupid, imbecile. Wife thinks husband neglecting her. Man thinks his wife

- faithless. Violent and lewd. Lascivious talk. Exposes himself. Anxiety when going through a tunnel. Active variable delirium, delirium tremens. Delirium with desire to escape. (Bell., Bry., Rhus-t.) Maniac, curses, tears ones clothes with teeth. Raving mania with cold sweat. Violent speech. Wants to kill people or himself.
- ❖ **Psorinum:** Anxiety. Foreboding. Despair of recovery, great despondency, hopeless. Despair from itching. Melancholy, religious, gloomy. Horrid thoughts, suicidal tendency. Feels himself poor. Fears the business will fail. Tear of fire of being alone of becoming insane etc. Aversion to work. Children very fretful, day and night. Peevish, irritable, noisy, easily startled. Severe ailments from even slight emotions. Dull, beclouded mind. Difficult thinking. Feels restless for days before a thunderstorm comes.
  - ❖ **Tuberculinum:** Dissatisfied and restless, always wants a change. Desire to travel, does not want to remain in one place long. Wants to do something different or even to find a new doctor, weary of life. Reckless. Depressed, melancholy, hopeless. Anxious. Whines and complaints with very little ailment. Contradictory behavior, changing moods. Fear of animals of dogs. Averse to cats. Mania and melancholia. Irritable, especially when awakening. Fits of violent temper, wants to fight, throws anything at anyone even without a cause. Desire to use foul language, curse and swear. Sensitive to music. Every trifle irritates, worse awakening. Aversion to mental work. Confusion everything in the room seems strange.
  - ❖ **Veratrum alb:** Melancholy, head hangs down, sits brooding in silence, wants to be alone. Melancholy with stupor and mania. Sits in a stupid manner, notices nothing, Sullen indifference. Amateness. Haughtiness. Frenzy of excitement, shrieks, curses. Aimless wandering from home. Delusions of impending misfortune's. Mania with desire to cut and tear things. (Tarant.) Prays, curses, shrieks in turn. Attacks of pain with delirium driving to madness. Cursing, howling all night. Delirium with violence, loquacity or lewdness during pain. Insanity. Remorse. Busy restlessness. Deceitful, never speaks the truth. Kisses everybody, before menses. Despair about position in society, feels very unlucky. Sings, whistles, laughs. Runs from place to place. Malingering. Thinks herself pregnant. Nymphomania, embraces everybody even objects. Puerperal mania. Religious mania. Talks about the faults of others or scolds. Anguish, fear of death. Despairs of her salvation. Imagines the world on fire. Swallows his own excrement. Imaginary diseases.

## **II. ECT (Electro Convulsive Therapy)**

Electroconvulsive therapy (E.C.T.), also known as electroshock therapy (E.S.T.) and electroplexy, is the most successful treatment for endogenous depression; especially when the cardinal features of psychomotor retardation and early morning wakening predominate. If adequately diagnosed, over 80 per cent of such patients will recover after a course of 4-8 treatments given at 2-4-day intervals over 2 or 3 weeks.

### ***Pretreatment discussion with patient and relatives***

A patient and his relatives should not be promised a cure. A physician can only tell his patients of the likelihood of success. An 80 per cent success rate is high for any form of treatment. The physician has an obligation to make this chance available to his patients.

E.C.T. will not provide a lifetime's immunity to depressive illness. The chances of recurrence at some time during a patient's life are 40-50 per cent, but it is not possible to predict who will or who will not have a further attack.

Patients with depressive illness characteristically have little hope and, when told that electrical treatment is successful in only 80 per cent of cases, jump to the conclusion they will fall into the 20 per cent who do not respond and in their case the illness will recur. Fortunately, the success of the treatment does not depend on the confidence the patient has in it. Telling patients that such faith is not essential affords some relief, but they remain skeptical.

It is unwise to tell a patient a certain number of treatments will be necessary. One can only know how many are desirable according to response. The patient and relatives should be given some idea such as 6-8, but it should be explained that this is approximate—the intention is to give as few treatments as possible.

Patients should be warned that they may feel worse halfway through > treatment (after treatments 2, 3 or 4); in which case, it is essential to 'reap the benefit by continuing to treatments 5, 6 and 7.

During the pretreatment interviews, the patient and his relatives should be warned of forgetfulness, especially immediately after treatment. Memory loss almost invariably recovers within a few hours to a few days of the completion of treatment. In those rare cases where poor memory persists, it is more likely due to a cause operative before the treatment was given.

For this reason, it is well to inquire about memory in the preliminary interviews before treatment and to establish whether recollection has been impaired, the patient has mislaid things, missed appointments or gone to do something—or visited a store—and forgotten what it was they intended to do or buy. With hypercritical, litigious patients formal tests of memory should be carried out and the results carefully recorded for future comparison.

These are simple matters, but the physician who attends to them makes a valuable investment in the treatment situation, allaying much unnecessary fear for the patient and his family and friends.

**Electrical treatment is not usually successful in the treatment of reactive depression and almost never where depression is part of a neurosis.** Such patients who do not respond may give it a bad reputation, which may cause great distress to the relatives and friends of patients who require such treatment and may deter some patients from accepting it and thus deprive them of relatively rapid and safe relief of a state of mind, which often leads to suicide.

A patient who has responded to electrical treatment in the past is likely to respond in the future should the illness recur.

#### ***Frequency of treatments***

As few treatments with as long a time interval between each one as possible is desirable. At the same time, sufficient treatments should be given as close together as necessary to produce the required effect. In most patients, 2 treatments a week with a 2- or 3-day interval for 2 or 3 weeks will be sufficient. When depression is severe and urgency arises, 3 treatments may be given during the first week on say Monday, Wednesday and Friday, and on Monday and Thursday during the second week, and on Tuesday of the third week. More than 3 treatments a week is rarely necessary. If the time between treatments is too long, the beneficial effect is not cumulative.

If treatments are given too close together, agitation, over activity and hypomania may result.

If treatment is abandoned too soon, the beneficial effects may not have been achieved, or if improvement has occurred, it may not be sustained.

If a lapse of 10 days occurs, further treatments should be considered part of a fresh course.

### **III. Neurosurgery (Psychosurgery)**

Most cases of intractable psychotic depression in which obsessional features and tension are prominent will be relieved by a bilateral lower quadrant prefrontal leucotomy.

A depressive illness cannot be described as intractable until chemotherapy has been given an adequate trial, has failed and been tried again, and electroplexy has also failed.

A natural remission occurs for some patients, but it would be absurd for the physician to wait optimistically for a remission that never occurred. A practical, arbitrary rule to avoid procrastination at the patient's expense is that psychosurgery should not be recommended until the depressive illness has failed to respond to adequate treatment and has been present for about 2 years.

A shorter period is perfectly justifiable if the premorbid personality were obsessional, conscientious and industrious whereas delay for several years would be prudent:

- a. In a patient with a less satisfactory history of personal achievement and personality.
- b. When a partial response to treatment has occurred.
- c. When the family or patient is uncertain.

The criteria for neurosurgery are as follows:

- i. The depressive illness is so severe life is not worth living and preferably some reactive features are present.
- ii. Obsessional features and tension are present.
- iii. The premorbid personality was 'good'—preferably an abundance of industry, conscientiousness and obsessiveness.
- iv. Other treatment has been tried, failed and tried again.
- v. The illness has been present for 2 years.
- vi. A second opinion, independent of the local medical psychiatric community and its administration, supports the operation.
- vii. An experienced neurosurgeon and satisfactory preoperative and postoperative conditions are available, viii. Adequate postoperative rehabilitative programmes exist.

If all of these criteria are satisfied, a brilliant result is likely in about 50 per cent of patients and moderate relief will be afforded a further 20 or 30 per cent, but it is unwise to promise the patient too much. It is deceitful to obtain the agreement of a patient or his representatives by exaggerating the chances of a cure. The brilliant result should not be overemphasized, although the possibility should be made known. Subjective relief of agonizing obsessional rumination is in itself sufficient to justify psychosurgery.

Complications, common in the early days of pioneering when large numbers of patients underwent surgery by neurosurgeons who were sometimes semiskilled, are now, under good conditions, negligible. Haemorrhage, meningitis, operative deaths and subsequent inanition are rare and providing minimal trauma is made to the grey matter the incidence of postoperative epilepsy is round about 1 per cent—many cases of which respond to medication. Some deterioration in the ability to score in intelligence tests as high as before the operation may occur and there is a possibility of a personality change characterized by apathy, lack of inhibition, tactlessness and an increased appetite for food and sex. These are small risks to take compared with the risk of suicide, homicide, mutilation of brain or body through attempted suicide on the one hand and the prospect of continued subjective misery and institutional care in a hospital, halfway house or similar home substitute on the other.

Physical treatments such as electroplexy and psychosurgery have been subject to devastating retrospective criticism usually by journalists or by unqualified or aspirant paraprofessionals without adequate experience of, or responsibility for, the treatment of mentally ill people.

Similar emotive, ill-informed criticism was leveled against amputation, enucleation of an eye, castration, cardiac surgery, organ transplant and blood transfusion. Unfortunately the polemical exercises sowing such prejudices are neither all in the past nor without a grain of truth.

The physician has to consider which is the lesser of two evils: untreated illness or unwanted side effects of cure—or attempted cure. It is not possible to answer with scientific precision the questions raised in any individual case. The physician can only give statistical likelihood based on informed opinion—not always a great comfort to the individual concerned.

If the physician remains alerted to the aphorism '*Primum non nocere*'—in the first place do no harm—and secures a truly independent second opinion for his patient, his therapeutic effectiveness and reputation will remain high.

Since the neurosurgeon is professionally responsible for his actions, it is discourteous to take for granted he will automatically comply with the physician's recommendation. The case needs to be made to him.

It is useful to have a case conference with the mental health workers who know the patient and to make the case for and against leucotomy. Opinions should be recorded in writing—conveniently on the back of the suggested chart of criteria for psychosurgery (See Figure 4).

If there is evidence of a reasonable chance of the patient recovering without psychosurgery, further alternative treatment should be given, but it is wise to stipulate a given time as, say, 3 months or 1 year when psychosurgery will again be reviewed in the light of changes, if any, during the intervening period.

No patient should be denied the benefit of psychosurgery to satisfy the principles or prejudices of those not suffering the illness. Equally, no patient should be tricked or coerced into accepting treatment he emphatically rejects.

Even if vacillation and depressive pessimism are at the root of refusal it is wise not to invoke legal powers, if available, to enforce psychosurgery. Arranging outpatient appointments so that the doubtful relatives of a patient under consideration can meet the relatives of a patient who has had the operation can be helpful, but zealous attempts to convert the reluctant should be discouraged.

**FIGURE 4 CRITERIA FOR PSYCHOSURGERY**

<i>CRITERIA FOR LEUCOTOMY</i>	<b>PATIENT SAYS</b>	<b>RELATIVE SAYS</b>	<b>STAFF REPORT</b>	<b>DOCTOR CONCLUDES</b>
1. Is depressive illness of such degree that patient's life is not worth living?				
2. Are obsessional signs and is tension present?				
3. Was patient's previous achievement good (was he industrious, conscientious and obsessional)?				
4. Has alternative treatment been given reasonable trial and failed?				
5. Has the illness persisted long enough (say 2 years) to warrant surgical intervention?				
6. Can a truly independent, reliable second opinion be obtained from an experienced physician?				
7. Is an experienced neurosurgeon with good conditions available?				
8. Are their flourishing postoperative rehabilitative programmes available for the patient?				
<i>OPINIONS of others present: psychologist, social worker, nurse, occupational therapist, rehabilitative therapist and so forth can be noted over page.</i> <b>DATE SET FOR REVIEW:</b> <b>DATE OF LEUCOTOMY:</b>			<b>FINAL RECOMMENDATION:</b>	

*Progress Note 6/12 later:*  
*Progress Note 18/12 later:*  
*Progress Note 3 years later:*  
*Progress Note 5 years later:*

NB The Chart, Fig. 1, is a useful guide in comparing past and present clinical condition and systematizing progress. A new chart should be filled in, preferably before referring to the previous findings.

## Model Questionnaire

### MENTAL HEALTH SERVICE-STRICTLY CONFIDENTIAL

Name of Hospital, Town, County

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\_\_\_\_\_ (Registration No \_\_\_\_\_)  
was admitted on \_\_\_\_\_  
under the care of Dr \_\_\_\_\_ who is the responsible Medical Officer.

The Staff at [Name of] hospital are anxious to do everything they can to promote recovery and discharge of patients admitted with psychiatric and nervous disorders under their care. They would be grateful if you would co-operate by answering the questions on this form to help them to get a complete picture of the illness. Facts should be stated without reserve and will be treated as strictly confidential.

The help of other relatives should be obtained, if necessary, in answering the questions and the replies will be still more valuable if the assistance of the family doctor can be obtained where relevant.

It is realized that it is quite a job to answer all the questions, and that you may not be able to answer some of them, but please make an effort to do as much as you can. If you do not know the answers to some questions please give the name and address of some other relative or close friend who might have the information.

Some of the questions asked may seem odd or of a very private and personal nature. Please do not take offence. If you feel you cannot answer a question just say so on the form.

Name and address of person answering questions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(if you have a telephone please include number) \_\_\_\_\_

Name and address of any other relatives or anyone else who might give further information  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and address of family Doctor \_\_\_\_\_  
\_\_\_\_\_

Name and address of any Doctors or Hospitals under whose care the patient has been \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Please note especially the following:**

(5) Has patient's sleep been affected? \_\_\_\_\_

(6) Has patient's appetite been affected? \_\_\_\_\_

(7) Has patient suffered with headaches or other pains? \_\_\_\_\_

(8) Has patient become untidy in any way? \_\_\_\_\_

(9) Has patient expressed any strange ideas or performed any strange actions? Please give particulars

\_\_\_\_\_  
\_\_\_\_\_

(10) Has patient spoken of suicide? \_\_\_\_\_

(11) Why did admission to hospital become necessary? \_\_\_\_\_

(12) How has the bodily health been since the trouble began? Is there now any bodily disorder to your knowledge? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(13) Do you know of any possible cause for the illness ? Please give your opinion \_\_\_\_\_

\_\_\_\_\_

(14) Has patient been having medicines or tablets? (If you can give any details please do) \_\_\_\_\_

\_\_\_\_\_

What effect, in your opinion, have these tablets, pills or medicines had? \_\_\_\_\_

\_\_\_\_\_

(15) Are there any other observations you could make about the present illness? If somebody else could, please say who.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MENTAL HEALTH SERVICE-STRICTLY CONFIDENTIAL**

**SECTION II. Questions about the Patient's Family**

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(Please note that because a number of questions are asked about the family no criticism is implied. One family in every four has a member with some nervous or psychiatric trouble. Almost every family has had a member with this kind of trouble in the last few generations)

(16) How old were the parents at marriage? \_\_\_\_\_  
Had either been previously married? \_\_\_\_\_  
Were they in any way related? \_\_\_\_\_

(17) If parents (or either parent) are deceased please give cause of death and date \_\_\_\_\_

(18) Please give names and ages of their children (i.e. the patient and his/her brothers and sisters) in their proper order and include, if possible, miscarriages and stillborn children \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was the patient a twin? \_\_\_\_\_

(19) State the occupation (past or present) of the parents and their circumstances \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(20) Have either of the patient's parents, or any of his/her brothers or sisters, or any of his/her grandparents, uncles, aunts or cousins, shown any of the following:

(a) Any kind of nervous disorder \_\_\_\_\_

(b) Any kind of mental trouble; if so where treated \_\_\_\_\_

\_\_\_\_\_

(c) Migraine, fits or convulsions of any kind \_\_\_\_\_

(d) Asthma, diabetes at any age \_\_\_\_\_

(e) Weak mindedness-oddity or eccentricity of any kind \_\_\_\_\_

(f) Intemperance, i.e. drink or the taking of drugs \_\_\_\_\_

(g) Consumption or tuberculosis \_\_\_\_\_

(h) Any other chronic or lasting bodily disease \_\_\_\_\_

(i) Suicide \_\_\_\_\_

(j) Tendency to crime \_\_\_\_\_

(k) Anything else that runs in the family \_\_\_\_\_

**MENTAL HEALTH SERVICE-STRICTLY CONFIDENTIAL**

**SECTION III. Questions about the Patient's Personal History**

---

In which Country was he/she born? \_\_\_\_\_ Nationality? \_\_\_\_\_

Date of birth? \_\_\_\_\_ For married women: Maiden name? \_\_\_\_\_

**PRE-NATAL**

(1) What was the state of health of his/her mother before his/her birth? \_\_\_\_\_

Was the birth difficult in any way? \_\_\_\_\_

**INFANCY (up to 3 years)**

(2) Was the patient easy or difficult to manage as a baby? \_\_\_\_\_

(3) Did he/she have any illnesses or injuries at this time (including fits or convulsions)?  
\_\_\_\_\_  
\_\_\_\_\_

(4) At what age did he/she begin to (a) walk \_\_\_\_\_

(b) talk \_\_\_\_\_

**CHILDHOOD (from 3 to 12 years)**

(5) What was his/her disposition as a child? \_\_\_\_\_

(6) Was he/she looked on as in any way difficult, unusual or backward ? \_\_\_\_\_

(7) What schooling did he/she have and what standard or class did he/she reach ? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did he/she do well at school? \_\_\_\_\_

(8) Did he/she suffer from troubles such as night terrors, sleep-walking, bed-wetting, nail-biting, temper tantrums, St. Vitus's dance and so forth ? \_\_\_\_\_

(9) Was he/she fussy or difficult about food? \_\_\_\_\_

(10) Did he/she have any illnesses or injuries between the ages of 3 and 12 years ? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(11) Were his/her home surroundings happy? Was his/her upbringing unusual in any way? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(12) Did he/she have any unfortunate experience that you know of? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION III. Questions about the Patient's Personal History-continued**

ADOLESCENCE (from 12 to 18 years)

(13) What was his/her disposition during these years? \_\_\_\_\_

Did it change in any way? \_\_\_\_\_

(14) What was his/her occupation? And was he/she successful at it? \_\_\_\_\_

(15) What were his/her interests or hobbies? Did he/she have friends of his/her own or opposite sex? \_\_\_\_\_

Was he/she friendly or shy with the latter? \_\_\_\_\_

(16) Did he/she have any special difficulties relating to sex or any abnormal habits? \_\_\_\_\_

(17) What were his/her home surroundings between the ages of 12 and 18 years? \_\_\_\_\_

(18) Did he/she have any illnesses or injuries between the ages of 12 and 18 years? \_\_\_\_\_

(19) For women: At what age did she have her first menstrual period? \_\_\_\_\_

LATER LIFE

(20) What has been the patient's work at various times and average earnings? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(21) Has he/she had any difficulties connected with his/her work? \_\_\_\_\_

(22) If now unemployed, state for how long and the reason \_\_\_\_\_

(23) What is the patient's usual disposition? Is it always the same or does it alter from time to time? \_\_\_\_\_

Is he/she generally regarded as in any way odd, eccentric or peculiar? \_\_\_\_\_

(24) What are his/her usual interests or hobbies or ways of spending his/her spare time? \_\_\_\_\_

(25) What are or have been his/her habits in regard to drink? Has he/she ever been addicted to drugs? \_\_\_\_\_

(26) Has he/she ever had any serious trouble resulting from a love affair or has he/she had any special difficulties connected with sex? \_\_\_\_\_

(27) If the patient is or has been married, give the date of his/her age at the time. If widowed, divorced or separated, give dates and age in each case \_\_\_\_\_

(28) Has the marriage been unsatisfactory in any way? \_\_\_\_\_  
\_\_\_\_\_

(29) Give particulars of the patient's children, giving their names and ages and including stillbirths and miscarriages in their proper order \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(29a) How many are now alive? What did the others die of? \_\_\_\_\_  
\_\_\_\_\_

(30) Have any of the children shown any of the conditions mentioned in Question 8? Give full particulars \_\_\_\_\_  
\_\_\_\_\_

(31) What bodily illnesses or injuries has the patient had? Give particulars and where or by whom treated \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(32) What has been the general state of his/her health during recent years? \_\_\_\_\_

(33) For women: Have the periods been regular? If they have now ceased, state since when \_\_\_\_\_  
\_\_\_\_\_

Date of onset of last period \_\_\_\_\_

(34) If the patient suffers or has suffered from fits, convulsions, faints or attacks of any kind:

(a) At what age did they start \_\_\_\_\_

(b) When did they cease? \_\_\_\_\_

or, if they still continue how often do they occur? \_\_\_\_\_

(c) Are they specially frequent at any particular time? \_\_\_\_\_

(d) Describe what happens in one of these attacks \_\_\_\_\_

(35) Has the patient had any previous nervous or psychiatric trouble of any kind? If so, give as many particulars as you can and mention whether he/she was treated in any hospital or institution \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(36) Has patient done any military service? Which service? For how long? If invalided out, please give any details you can \_\_\_\_\_  
\_\_\_\_\_

(37) Has the patient had any accidents? YES/NO. When? \_\_\_\_\_

Did the accident result in time off work? \_\_\_\_\_



## References

- ❖ A Short Practice of Clinical Psychiatry By Russell Barton
- ❖ Organon of Medicine 6<sup>th</sup> Edition
- ❖ Homoeopathic Remedy Guide by Robin Murphy

## Warning

Under no circumstances any of the medicines described above should be taken by oneself. Readers are advised to seek the advice of a physician or other qualified health care provider with any questions regarding personal health or medical conditions. Never disregard, avoid or delay in obtaining medical advice from your doctor or other qualified health provider because of something you have read on this site. If you have or suspect that you have a medical problem or condition, please contact a qualified health care professional immediately.