Bipolar Disorders –The Psychic Pendulum

Abstract: *Bipolar disorder, also known as manic depression, causes serious shifts in mood, energy, thinking, and behavior, from the highs of mania, to the lows of depression. More than just a fleeting good or bad mood, the cycles of bipolar disorder last for days, weeks or months. And unlike ordinary mood swings, those of bipolar disorder are so intense that they interfere with the ability to function normally. Judicious Homoeopathic treatment along with proper counseling may help them to lead a normal life.*

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Introduction

Bipolar disorder, also known as manic depressive disorder or bipolar affective disorder, is a psychiatric diagnosis that describes a category of mood disorders defined by the presence of one or more episodes of abnormally elevated mood clinically referred to as mania or if milder, hypomania. Individuals who experience manic episodes also commonly experience depressive episodes or symptoms or mixed episodes in which features of both mania and depression are present at the same time. These episodes are usually separated by periods of "normal" mood, but in some individuals, depression and mania may rapidly alternate, known as rapid cycling. Extreme manic episodes can sometimes lead to psychotic symptoms such as delusions and hallucinations. The disorder has been subdivided into *Bipolar I, Bipolar II, Cyclothymia* and other types, based on the nature and severity of mood episodes experienced; the range is often described as the *bipolar spectrum*. The onset of full symptoms generally occurs in late adolescence or young adulthood. Diagnosis is based on the person's self-reported experiences, as well as observed behavior. Episodes of abnormality are associated with distress and disruption and an elevated risk of suicide, especially during depressive episodes. In some cases it can be a devastating long-lasting disorder; in others it has also been associated with creativity, goal striving and positive achievements. In serious cases in which there is a risk of harm to oneself or others, generally involve severe manic episodes with dangerous behavior or depressive episodes with suicidal ideation. There are widespread problems with social stigma, stereotypes and prejudice against individuals with a diagnosis of bipolar disorder. People with bipolar disorder exhibiting psychotic symptoms can sometimes be misdiagnosed as having schizophrenia, another serious mental illness.

The current term "bipolar disorder" is of fairly recent origin and refers to cycling between high and low episodes (poles). A relationship between mania and melancholia had long been observed. Genetic factors contribute substantially to the likelihood of developing bipolar disorder and environmental factors are also implicated. We have a considerable number of Homoeopathic medicines which helps to give a social life to such patients. Proper counseling, personal education, psychotherapy also have a role, often when there has been some recovery of stability.

Causes

The causes of bipolar disorder vary between individuals. Twin studies have indicated a substantial genetic contribution, as well as

environmental influence. For Bipolar I, the concordance rates have been consistently put at around 40% in monozygotic twins, compared to 0 to 10% in dizygotic twins. A combination of bipolar I, II and cyclothymia produced concordance rates of 42% vs 11%, with a relatively lower ratio for bipolar II that likely reflects heterogeneity. There is overlap with unipolar depression and if this is also counted in the co-twin the concordance with bipolar disorder raises to 67% (Mz) and 19% (Dz).

Genetic Predisposition

Genetic studies have suggested many chromosomal regions and candidate genes appearing to relate to the development of bipolar disorder, but the results are not consistent and often not replicated. Recent meta-analyses of linkage studies detected only two genome-wide significant peaks, on chromosome 6q and on 8q21. Genome-wide association studies have also not brought a consistent focus, each has identified new loci, while none of the previously identified loci were replicated. Diverse findings in gene dependent study of bipolar disorder point strongly to heterogeneity, with different genes being implicated in different families. Advanced parental age has been linked to a somewhat increased chance of bipolar disorder in offspring, consistent with a hypothesis of increased new genetic mutations. The "kindling" theory asserts that people who are genetically predisposed towards bipolar disorder can experience a series of stressful events, each of which lowers the threshold at which mood changes occur. Eventually, a mood episode can start (and become recurrent) by itself.

Childhood Precursors: Long-term studies indicate that a child who is diagnosed as bipolar disorder may show subtle traits such as subthreshold cyclical mood abnormalities, full major depressive episodes and possibly ADHD with mood fluctuation in early childhood. There may be hypersensitivity and irritability. A history of stimulant use in childhood is found in high numbers of bipolar patients and it causes an earlier onset of bipolar disorder, worse clinical course and independent of attention deficit hyperactive disorder (ADHD).

Life Events And Experiences: Environmental factors play a significant role in the development and course of bipolar disorder, and the individual's psychosocial variables may interact with genetic dispositions. It is evident from prospective studies that recent life events and interpersonal relationships contribute to the likelihood of onsets and recurrences of bipolar mood episodes. There have been repeated findings that between a third and a half of adults diagnosed with bipolar disorder report traumatic/abusive experiences in childhood, which is associated with earlier onset, a worse course of bipolar disorder. Stressful events in childhood are responsible. These stressful events stem from a harsh environment rather than from the child's own behavior. Early experiences of adversity and conflict are likely to make subsequent developmental challenges in adolescence and are likely a potentiating factor in those at risk of developing bipolar disorder.

Neural Processes: Researchers hypothesize that abnormalities in the structure and/or function of certain brain circuits could underly bipolar and other mood disorders. Some studies have found anatomical differences in areas such as the amygdala, prefrontal cortex and hippocampus. However, there remains considerable debate over the neuroscientific findings. Two fairly consistent abnormalities found in a meta-analysis of MRI or CT neuroimaging studies, that groups with bipolar disorder had lateral ventricles which were on average 17% larger than control groups, and were 2.5 times more likely to have deep white matter hyperintensities. There is evidence of hypothalamic-pituitary-adrenal axis (HPA axis) abnormalities in bipolar disorder due to stress. Recent research in Japan hypothesizes that dysfunctional mitochondria in the brain may play a role. Other recent research implicates issues with a sodium ATPase pump, causing cyclical periods of poor neuron firing (depression) and hyper sensitive neuron firing (mania).

Melatonin Activity: It has been suggested that a

hypersensitivity of the melatonin receptors in the eye could be a reliable indicator of bipolar disorder. In small studies, patients diagnosed as bipolar, reliably showed a melatonin-receptor hypersensitivity to light during sleep, causing a rapid drop in sleeptime melatonin levels compared to controls. Another study showed that recovered bipolar patients exhibited no hypersensitivity to light. The extent to which melatonin alterations may be a cause or effect of bipolar disorder are not fully known.

Psychological Processes: Psychological studies of bipolar disorder have examined the development of a wide range of both the core symptoms of psychomotor activation and related clusterings of depression/anxiety, increased hedonic tone, irritability/aggression and sometimes psychosis. The psychotic symptoms increase if there is disruption in circadian rhythms or goal attainment events. There is some indication that once mania has begun to develop, social stressors, including criticism from significant others, can further contribute. There are also indications that individuals may hold certain beliefs about themselves, their internal states and their social world (including striving to meet high standards despite it causing distress) that may make them vulnerable during changing mood states in the face of relevant life events.

In addition, subtle frontal-temporal and subcortical difficulties in some individuals, related to planning, emotional regulation and attentional control, may play a role. Once (hypo) mania has developed, there is an overall increase in activation levels and impulsivity. Negative social reactions or advice may be taken less notice of and a person may be more caught up in their own thoughts and interpretations, often along a theme of feeling criticised. The mood variation in bipolar disorder may result from a complex interaction between internal and external variables unfolding over time.

Signs and Symptoms: Bipolar disorder is a condition in which people experience abnormally elevated (manic or hypomanic) and abnormally depressed states for a period of time in a way that interferes with functioning. It is equally prevalent in men and women and is found across all cultures and ethnic groups and not everyone's symptoms are the same. Scientists believe that bipolar disorder may be caused by chemical imbalances in the brain. Bipolar disorder can appear to be unipolar depression. What distinguishes bipolar disorder from unipolar depression is that the affected person jumps

Common symptoms of bipolar depression

Feeling hopeless, sad or empty.	Appetite or weight changes.
Irritability.	Sleep problems.
Inability to experience pleasure.	Concentration and memory problems.
Fatigue or loss of energy.	Feelings of worthlessness or guilt.
Physical and mental sluggishness.	Thoughts of death or suicide.

Manic Episodes: Mania is generally characterized as follows:

Common signs and symptoms of mania

Feeling unusually "high" and optimistic *or* extremely irritable.	Highly distractible, unable to concentrate.
Unrealistic, grandiose beliefs about one's abilities or powers.	Impaired judgment and impulsiveness.
Sleeping very little, but feeling extremely energetic.	Acting recklessly without thinking about the consequences.
Talking so rapidly that others can't keep up.	Delusions and hallucinations (in severe cases).
Racing thoughts; jumping quickly from one idea to the next.	Sexual drive may increase.

between states of mania and depression. Often bipolar is inconsistent among patients because some people feel depressed more often than not and experience little mania whereas others may predominantly experience manic symptoms.

Depressive Episodes: Signs and symptoms of the depressive phase of bipolar disorder are as tabulated:

Common Signs And Symptoms Of Mania

Feeling unusually "high" and optimistic *or* extremely irritable. Highly distractible, unable to concentrate.

Unrealistic, grandiose beliefs about one's abilities or powers. Impaired judgment and impulsiveness.

Sleeping very little, but feeling extremely energetic.

Acting recklessly without thinking about the consequences.

Talking so rapidly that others can't keep up.

Delusions and hallucinations (in severe cases).

Racing thoughts; jumping quickly from one idea to the next. Sexual drive may increase.

In order to be diagnosed with mania according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) a person must experience this state of elevated or irritable mood, as well as other symptoms, for at least one week. According to the National Institute of Mental Health, "A manic episode is diagnosed if elevated mood occurs with three or more of the other symptoms most of the day, nearly every day, for 1 week or longer. If the mood is irritable, four additional symptoms must be present."

Hypomanic Episode: Hypomania is generally a mild to moderate level of mania, characterized by optimism, pressure of speech and activity, and decreased need for sleep. Some people have increased creativity while others demonstrate poor judgment and irritability. Others experience hypersexuality. These persons generally have increased energy and tend to become more active than usual. They do not, however, have delusions or hallucinations. Hypomania can be difficult to diagnose because it may masquerade as mere happiness, though it carries the same risks as mania. Hypomania may feel good to the person who experiences it. Thus, even when family and friends learn to recognize the mood swings, the individual often denies that anything is wrong.

Common Signs And Symptoms Of Hypomania

Having utter confidence in yourself. Being able to brush off problems that would paralyze during depression.

Being able to focus well on projects Feeling "on top of the world" but without going over the top.

Feeling extra creative or innovative Decreased need for sleep.

Mixed Affective Episodes: In the context of bipolar disorder, a mixed state is a condition during which symptoms of mania or hypomania and clinical depression occur simultaneously. For eg agitation, anxiety, aggressiveness or belligerence, confusion, fatigue, impulsiveness, insomnia, irritability, morbid and/or suicidal ideation, panic, paranoia, persecutory delusions, pressured speech, racing thoughts, restlessness and rage. This combination of high energy and low mood makes for a particularly high risk of suicide.

Associated Features Of Bipolar Disorder: Associated features are clinical phenomena that often accompany the disorder, but are not part of the diagnostic criteria for the disorder.

Cognitive Functioning: Mild cognitive impairment in bipolar disorder is a controversial issue. So called cognitive deficits in bipolar disorder are relatively mild and can only be detected by comparing performance in neuropsychological tests between groups of patients compared to those without the diagnosis. It has been concluded from recent

Common signs and symptoms of hypomania

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Being able to focus well on projects	**Feeling "on top of the world" but without going over the top.**
Feeling extra creative or innovative	**Decreased need for sleep.**

reviews that most individuals who were diagnosed with bipolar disorder but who are euthymic (have not experienced major depression or (hypo) mania for some time) do not show neuropsychological deficits on most tests. Meta-analyses have indicated, by averaging the variable findings of many studies, impaired performance on some measures of sustained attention, executive function and memory, in terms of group averages. The effects of subthreshold mood states and psychiatric medications appear to account for some of the association. It is not known whether specific cognitive deficits are disorder-specific features of bipolar disorder.

Creativity And Accomplishment: While the disorder affects people differently, individuals with bipolar disorder during the manic phase tend to be much more outgoing and daring than individuals without bipolar disorder. In common with other major affective disorders such as unipolar depression, bipolar disorder is found in a large number of people involved in the arts. Some studies have found a significant correlation between creativity and bipolar disorder. Though studies consistently show a positive correlation between the two, it is unclear in which direction the cause lies, or whether both conditions are caused by a third unknown factor. Temperament has been hypothesized to be one such factor. A series of authors have described mania or hypomania as related to higher accomplishment, elevated achievement motivation and ambitious goal setting. One study indicated that greater-than-average striving for goals, and sometimes obtaining them, corresponded with mania.

Diagnosis of Bipolar disorder: Diagnosis is based on the self-reported experiences of an individual as well as abnormalities in behavior reported by family members, friends or co-workers, followed by secondary signs observed by a psychiatrist, nurse, social worker, clinical psychologist or other clinician. The most widely used criteria for diagnosing bipolar disorder are from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* and the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems(ICD-10).*

An initial assessment may include a physical examination by a physician. Some tests may be carried out to exclude medical illnesses such as hypo- or hyperthyroidism, metabolic disturbance, a systemic infection or chronic disease and syphilis or HIV infection. An EEG may be used to exclude epilepsy and a CT scan of the head to exclude brain lesions.

There are several other mental disorders which may have symptoms similar to bipolar disorder. These include Schizophrenia, Schizoaffective disorder, drug intoxication, brief drug-induced psychosis, Schizophreniform disorder and borderline personality disorder. Both borderline personality and bipolar disorder can involve what are referred to as "mood swings".

In bipolar disorder, the term refers to the cyclic episodes of elevated and depressed mood which generally lasts weeks or months. The term in borderline personality refers to the marked lability and reactivity of mood, known as emotional dysregulation, due to response to external psychosocial and intrapsychic stressors; these may arise or subside suddenly and dramatically and last for seconds, minutes, hours or days. A bipolar depression is generally more pervasive with sleep, appetite disturbance and nonreactive mood, whereas the mood in dysthymia of borderline personality remains markedly reactive and sleep disturbance not acute. Some hold that borderline personality disorder represents a subthreshold form of mood disorder, while others maintain the distinctness, though noting they often coexist.

Criteria and Subtypes of Bipolar disorders: There is no clear consensus as to how many types of bipolar disorders exist. In DSM-IV-TR and ICD-10, bipolar disorder is conceptualized as a spectrum of disorders occurring on a continuum. The DSM-IV-TR lists 4 types of mood disorders which fit into the bipolar categories:

Bipolar I: In Bipolar I disorder, an individual has experienced one or more manic episodes with or without major depressive episodes.

Bipolar II: Bipolar II disorder is characterized by hypomanic episodes rather than actual manic episodes, as well as at least one major depressive episodes. Patients with a Bipolar II diagnosis under the DSM IV criteria cannot, by definition, ever have had a manic episode prior to their diagnosis. However, a Bipolar II diagnosis is not a guarantee that they will not eventually suffer from such an episode in the future. Hypomanic episodes do not go to the full extremes of mania. For both Bipolar I and II, there are a number of specifiers that indicate the presentation and course of the disorder, including "chronic", "rapid cycling", "catatonic" and "melancholic".

Cyclothymia: Cyclothymia involves a presence or a history of hypomanic episodes with periods of depression that do not meet criteria for major depressive episodes. A diagnosis of Cyclothymic Disorder requires the presence of numerous hypomanic episodes, intermingled with depressive episodes that do not meet full criteria for major depressive episodes. The main idea here is that there is a low-grade cycling of mood which appears to the observer as a personality trait, but interferes with functioning.

Bipolar NOS (Not Otherwise Specified): Bipolar Disorder NOS, sometimes called "sub-threshold" Bipolar Disorder, is a "catch-all" diagnosis that is used to indicate bipolar illness that does not fit into any of the formal DSM-IV bipolar diagnostic categories (Bipolar I, Bipolar II, or cyclothymia). If an individual seems to be suffering from bipolar spectrum symptoms (eg manic and depressive symptoms) but does not meet the criteria for one of the subtypes mentioned above, he or she receives a diagnosis of Bipolar Disorder NOS. Bipolar NOS can still significantly impair and adversely affect the quality of life of the patient.

Rapid cycling: Most people who meet criteria for bipolar disorder experience a number of episodes, on average 0.4 to 0.7 per year, lasting three to six months. Rapid cycling, however, is a course specifier that may be applied to any of the above subtypes. The definition of rapid cycling "at least four major depressive, manic, hypomanic or mixed episodes are required to have occurred during a 12-month period". There are references that describe very rapid (ultra-rapid) or extremely rapid (ultra-ultra/ultradian) cycling. Ultra-ultra rapid cycling is defined as distinct shifts in mood within a 24–48-hour period.

Challenges Met With Bipolar Disorders

The experiences and behaviors involved in bipolar disorder are often not understood by individuals or recognized by mental health professionals, so diagnosis may sometimes be delayed for 10 years or more and are commonly misdiagnosed Major Depressive Disorder. Anyone with a history of (hypo)mania and depression has bipolar disorder. Flux is the fundamental nature of bipolar disorder. Individuals with the illness have continual changes in energy, mood, thought, sleep and activity. The diagnostic subtypes of bipolar disorder are thus static descriptions, snapshots, perhaps of an illness in continual flux, with a great diversity of symptoms and varying degrees of severity. Individuals may stay in one subtype, or change into another, over the course of their illness.

The diagnosis of bipolar disorder can be complicated by coexisting psychiatric conditions such as obsessive-compulsive disorder, social phobia, panic disorder or attention-deficit/hyperactivity disorder (ADHD). Substance abuse may predate the appearance of bipolar symptoms, further complicating the diagnosis.

The diagnosis of bipolar disorder in children is particularly challenging and controversial. Some who show some bipolar symptoms tend to have a rapid-cycling or mixed-cycling pattern that may not meet DSM-IV criteria. In addition, it can be difficult to distinguish between age-appropriate restlessness, the fidgeting of children with ADHD and the purposeful busy activity of mania. Further complicating the diagnosis is that abused or traumatized children can seem to have bipolar disorder when they are actually reacting to horrors in their lives.

In the elderly, recognition and treatment of bipolar disorder may be complicated by the presence of dementia or the side effects of medications being

taken for other conditions.

PSYCHOSOCIAL TREATMENT: Psychotherapy is aimed at alleviating core symptoms, recognizing episode triggers, reducing negative expressed emotion in relationships, recognizing prodormal symptoms before full-blown recurrence and practicing the factors that lead to maintenance of remission, Cognitive behavioural therapy, family focused therapy and psychoeducation have the most evidence for efficacy in regard to relapse prevention, while interpersonal and social rhythm therapy and cognitive-behavioural therapy appear the most effective in regard to residual depressive symptoms. Treatment during the acute phase can be a particular challenge.

Cognitive behavioral therapy (CBT) helps people with bipolar disorders learn to change harmful or negative thought patterns and behaviors.

Family-focused therapy includes family members. It helps enhance family coping strategies, such as recognizing new episodes early and helping their loved one's.

Interpersonal and social rhythm therapy helps people with bipolar disorder improve their relationships with others and manage their daily routines. Regular daily routines and sleep schedules may help protect against manic episodes.

Psychoeducation teaches people with bipolar disorder about the illness and its treatment. This treatment helps people recognize signs of relapse, so they can seek treatment early, before a full-blown episode occurs. Usually done in a group, psychoeducation may also be helpful for family members and caregivers.

HOMOEOPATHIC REMEDIES

***Agaricus-muscarius*:** Sings, talks, but does not answer. Indifference. *Fearlessness. Delirium* characterized by singing, shouting, and muttering; rhymes and prophesies. Mental depression, languor, confusion, disinterest in working, reading difficulty where the type seems to swim. *Slight stimulation*-shown by increased cheerfulness, courage, loquacity, exalted fancy. *More decided intoxication*-great mental excitement and incoherent talking, immoderate gaiety alternates with melancholy. Perception of relative size of objects is lost, takes long steps and jumps over small objects as if they were trunks of trees-a small hole appears as a frightful chasm, a spoonful of water an immense lake. Physical strength is increased, can lift heavy loads. With it much twitching. *Furious or raging delirium*, screaming, raving, wants to injure himself, etc. *Mental depression, languor, indifference, confusion, disinclination to work*, etc.

Anacardium-orientale: *Impaired memory, Absent mindedness.* Depression and irritability; diminution of senses (smell, sight, hearing). Hallucinations; *thinks he is possessed of two persons or wills.* Anxiety when walking, as if pursued. Profound melancholy and hypochondriasis, *with tendency to use violent language. Very easily offended.* Malicious; seems bent on wickedness. Lack of confidence in himself or others. Suspicious (*Hyos*). Clairaudient, hears voices far away or of the dead. Absence of all moral restraint.

***Aurum-metallicum*:** Mental states of great depression, hopeless, despondent and great desire to commit suicide. Every opportunity is sought for self-destruction. Feeling of self-condemnation and utter worthlessness. Thorough disgust of life. Talks of committing suicide. Peevish and vehement at least contradiction. Constant rapid questioning without waiting for reply. Cannot do things fast enough. Over-sensitiveness to excitement, confusion.

***Crocus-sativus*:** Alternate sin[illegible] and laughing, delusions, hallucinations and have a sudden swing from mania to melancholy. *Oscillating*; pleasant mania; sings and laughs. Happy and affectionate; then angry. Sudden changes from hilarity to melancholy. Vivid recollection from music heard (*Lyc*). Frequent and extreme changes in sensations and mental condition. Anger with violence followed by repentance. *Laughing* mania. Drowsiness and *lassitude*; better by literary labor.

***Hyoscyamus*:** Nervous system profoundly disturbed. It is as if some diabolical force took possession of the brain and prevented its functions. It causes a perfect picture of mania of a

quarrelsome and obscene character. Inclined to be unseemly and immodest in acts, gestures and expressions. Jealous and afraid of being poisoned, etc. Nervous agitation. Very suspicious. Foolish, great hilarity, inclined to laugh at everything. Delirium, with attempt to run away. Low, muttering speech. Light headed and confused.

Ignatia: Changeable mood; introspective; silently brooding. Melancholic, sad, tearful. Not communicative. *Sighing and sobbing*. After shocks, grief, disappointment. Mentally, *the emotional element is uppermost and co-ordination of function is interfered with*. Hence, it is one of the chief remedies for hysteria. It is especially adapted to the nervous temperament-women of sensitive, easily excited nature, dark, mild disposition, quick to perceive, rapid in execution. Rapid change of mental and physical condition, opposite to each other. Great contradictions. Alert, nervous, apprehensive, rigid, trembling patients who suffer acutely in mind or body

Lachesis-muta: Exceedingly talkative. Sad in the morning; no desire to mix. Restless, uneasy; does not wish to attend to business; wants to be off somewhere all the time. Jealous. Suspicious. Nightly delusion of fire. Religious insanity. Derangement of the time sense. Delirium tremens and confusion.

Phosphorus: Fear, dread, feeling insecure, uncertain, restlessness and easily vexed. Great lowness of spirits. Easily vexed. Fearfulness, as if something were creeping out of every corner. Clairvoyant state. Great tendency to start. Over-sensitive to external impressions. Loss of memory. Paralysis of the insane. Ecstasy. Dread of death when alone. Brain feels tired. Insanity, with an exaggerated idea of one's own importance. Excitable, produces heat all over. Restless, fidgety. Hypo-sensitive, indifferent.

Platinum-metallicum: Weeping, crying, impaired thinking, apathy and indifference. Irresistible impulse to kill. Self-exaltation; *contempt for others*. Arrogant, proud. Weary of everything. Everything seems changed. Mental trouble pressed menses. Physical symptoms disappear as mental symptoms develop.

Pulsatilla: Sad, crying readily, weeps when talking, changeable, contradictory. Timid, irresolute. Fears in evening to be alone, dark, ghosts. Likes sympathy. Children like fuss and caresses. Easily discouraged. Religious melancholy. Given to extremes of pleasure and pain. Highly emotional.

CONCLUSION: Bipolar disorder can be a severely disabling medical condition. However, many individuals with bipolar disorder can live full and satisfying lives. Persons with bipolar disorder may have periods of normal or near normal functioning between episodes. For many individuals with bipolar disorder a good prognosis results from good treatment, which, in turn, results from an accurate diagnosis. Because bipolar disorder can have a high rate of both under-diagnosis and misdiagnosis, it is often difficult for individuals with the condition to receive timely and competent treatment. Homoeopathy is a safe way to promote the body's natural ability to heal. Each Homoeopathic remedy has specific documented effects upon the mind and body. The Homoeopathic medicines described here are indicated for mood changes from extreme joy to sadness, and manic-depressive or bipolar tendencies. To achieve most effective result with Homoeopathic medicines, it is adviceable to employ proper counseling, personal education and behavioural therapy in such patient so as to give them a normal social life.

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