The Rehabilitation Psychologist

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Professional's Section:

Role of Rehabilitation Psychologist in Sarva Siksha Abhiyaan (SSA)

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Children and adults with intellectual and other developmental disabilities are more likely to be diagnosed with a severe behavior disorder or mental health diagnosis than are their typically developing counterparts. This dual diagnosis of cognitive and behavioural impairments places additional strain on parents and teachers and may be overlooked or underreported by health care providers. Furthermore, children with developmental disabilities and behaviour or mental health disorders are at greater risk for difficulties in school; are more likely to be placed in out-of-home residential care; and, as adults, are more likely to have problems in the workplace (McIntyre L L, 2008). Rehabilitation Psychologist will help:

1. Identify children with special needs by screening tests
2. Confirm the findings of screening with Assessments to rule out emotional disturbances, psychosocial deprivation and minimal brain injury as the reason or cognitive impairments in children.
3. Teacher and parent in rehabilitation or challenging behaviours by behaviour modification
4. The child with cognitive training to improve rate of information processing
5. Team of professionals like speech and physiotherapist and special educator in maintaining rehabilitative sustenance.

Laura Lee McIntyre and Leonard Abbeduto (2008) Parent Training for Young Children With Developmental Disabilities: Randomized Controlled Trial. American Journal on Mental Retardation, 113(5), pp. 356-368.

Privileges Denied: Borderline Intellectual functioning (BIF)

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Dear Reader,

We are happy to report on work done by the Executive Committee from the inception of the Association:

1. Requisition Letter to Ministry of Social Justice and Empowerment to include "Rehabilitation Psychology" as essential qualification for the posts of Psychologists in Disability Rehabilitation centres all over India.
2. Requisition Letter to Rehabilitation Council of India to include "Rehabilitation Psychology" as essential qualification for the posts of Psychologists in Disability Rehabilitation centres all over India: In response, RCI has sent an email to ARPI that it would put forward the issue to the relevant expert committee and the decision shall be communicated to the Association.
3. Letter of awareness on the course, content and relevance of Psychological services in disability rehabilitation has been written to Director General to ICMR and Secretary to Government of India for Ministry of Health and Family Welfare.
4. Letter of request to include "Rehabilitation Psychologist" in the team of Rehabilitation Professionals in BHAVITA CENTRES (A State Government Scheme to rehabilitate children with special needs CwSN in Andhra Pradesh)
5. Launched Website: www.rehabilitationpsychologist.org

The possibility of carrying out early detection in cases of BIF and being able to implement the appropriate interventions as soon as possible is impossible during early childhood. This is because neither the knowledge nor the tools required to do so have been available to date. However, the challenge of early detection for BIF cases should be of great importance, for several reasons. The suspicion of the condition in the first years of life would allow us to reduce the barriers to access to services and, consequently, to implement interventions whose objective is to prevent negative evolution of the child. However, early detection seem to be a challenge, given that there are no visible features to identify a child with BIF, nor are there discriminating behavioural phenotypes. Although, it is difficult to imagine diagnostic and screening batteries for BIF different from the developmental batteries used to diagnosis overall developmental delay (a concept that is used for ages below 5---6 years), it would therefore be necessary to use the existing batteries systematically in situations in which there is a suspicion of BIF. These batteries could be complemented with more specific neuropsychological examinations and with measures focused on behavioural abilities. In short despite the difficulties, early detection should be specifically incorporated in health, social and school spheres, to make it possible to ensure that these individuals are integrated in society according to principles of justice, equality and diversity (Carulla et al.2013). Masi (1998) reports clinical considerations just as emotional disorders can interfere with intellectual functioning, cognitive dysfunction can interfere with conceptualizations of reality, reduce the ability of adolescents to deal successfully with emotional tensions as well as pubertal transformations, and disrupt relations between the individual and the outside world. These developmental risks are also present in persons who are intellectually borderline whose IQ range from 71 to 84 (ICD-10 -World Health Organization, 1992). They are more than one standard deviation below the average, but do not fall into the diagnostic category of mental retardation (IQ less than 70), which is more than two standard deviations below the average.

Consequently, BIF turns out to be an invisible clinical entity. Despite its magnitude, its prevalence cannot be quantified, its diagnosis has not been implemented (so it does not appear in current diagnostic systems) and there are no eligibility criteria to ensure explicit access to social or health services, protections and benefits when they are needed. In the same way as patients having mild ID, individuals with BIF represent a significant percentage of the population and require a considerable amount of support and attention at different moments in their lives. However, the scientific literature ignores this population, just as the specialised services for ID and the services for developmental disorders do (Carulla et al.2013).

Such Complications as the background, Carulla reports a conceptual framework to tackle this problem and mentions 10 points statement

POINT 1

BIF is a "health meta-condition that requires specific public health, educational and legal attention". It features with cognitive dysfunctions associated with an intellectual quotient between 71 and 85,which determines a deficit in the individual's functioning with respect to both restriction in activities and limitation of social participation

POINT 2

The child population with BIF is more vulnerable than the general population, which is why we pose the challenge of achieving early detection, a psychopathological assessment and assessment of the specific learning potential in these cases

POINT 3

Mental health problems are more frequent in BIF than in the general population, which is why a specific psychopathological assessment is necessary in these cases. This assessment needs to be incorporated into the cognitive profile and to the profile of functioning as part of the BIF assessment

POINT 4

In the stage of childhood-adolescence, there is a need to define the concept of BIF on the basis of criteria that allow restriction of a group of individuals that, without intellectual functioning, cannot follow the educational process like the majority of same age children and social environment

POINT 5

Individuals with BIF require some support that facilitates school, work and social adaptation and, in some cases, specific health attention

POINT 6

The difficulties of legal and administrative accessibility (e.g., eligibility for certificate of disability and others) supported by the population with BIF cause a need for help that has to be corrected

POINT 7

The objectives of early detection, assessment and attention for individuals with BIF must be specifically incorporated in health, social,

educational, labour and legal spheres, to develop a society based on the principles of justice, equality and diversity

POINT 8

Encouraging research on the different aspects of BIF is needed, from the health perspective as well as the social, educational, labour and legal perspectives

POINT 9

Training on BIF for the professionals in the various spheres that are involved is required

POINT 10

Territorial spaces of interdepartmental co-ordination must be promoted, along with the transmission of knowledge among professionals, users, participants and the various sectors involved (e.g., health, education, labour, social action, the legal system, etc.)

Salvador-Carulla L, García-Gutiérrez JC, Ruiz Gutiérrez-Colosía M, Artigas-Pallarès J, García Ibáñez J, González Pérez J, et al (2013). Borderline intellectual functioning: consensus and good practice guidelines, Revista de psiquiatrí□a y salud mental 2013 Jul-Sep;6 (3):109-20.

Masi, Gabriele; Marcheschi, Mara; Pfanner, Pietro (1998). Adolescents with Borderline Intellectual Functioning: Psychopathological Risk, Adolescence, Vol. 33, No. 130

http://www.questia.com/library/journal/1G1-65306465/adolescents-with-borderline-intellectual-functioning

Visitor's Section:

Brain and Behavior: Seizures (series-4)

Clonazepam:

Clonazepam also belongs to a class of medications called benzodiazepines. Benzodiazepines are tranquilizers (sedatives) that prevent or stop seizures by slowing down the central nervous system. Therefore it is very good in controlling abnormal activity.

Uses

I. Clonazepam is used alone or with other seizure medicines to treat absence and myoclonic seizures (especially in Lennox-Gastaut syndrome), and can help stop seizure clusters. (An example of a cluster might involve a person who has one complex partial seizure in the morning and three or four more seizures over the course of the day, just once a month.)

II. A person who typically has a prolonged warning before seizures (a particular symptom, an unusually long aura, or a series of small seizures) may be able to prevent the larger seizure by taking clonazepam when the warning begins.

III. For seizures that mainly occur during sleep or shortly after awakening, giving clonazepam or another benzodiazepine at bedtime can be very effective in controlling the seizures and improving sleep.

Adverse Effects

As a result, common symptoms include: tiredness, dizziness, unsteadiness, impaired attention and memory, irritability, hyperactivity (in children), drooling (in children), depression (usually in adults), nausea and loss of appetite. Scientific studies show that about half of people treated for seizures with clonazepam experience drowsiness and about 30% have problems with coordination. In some cases, these problems diminish with time; however, problems with thinking and behavior are greater with clonazepam than with seizure medicines like Carbamazepine, and Phenytoin.

Side effects can be managed by changing the prescription in a way that has been discussed (newsletter, volume II, issue 6) with regards to clobazam. Most people who take clonazepam have no side effects or mild side effects that go away with no lasting harm. But a few people have serious reactions. Such as an allergic reaction (difficulty breathing; closing of the throat (angioedema of the larynx); swelling of the lips, face, or tongue; or hives), sores in the mouth or throat (could mean a blood problem, further investigations necessary), yellowing of the skin or eyes (Jaundice, liver toxicity), rash, hallucinations, severe confusion, or changes in vision.

Tolerance to clonazepam develops compared to other benzodiazepines including clobazam. If the dosage is increased gradually over a long period, subtle changes in personality (such as irritability, depression, or decreased motivation) or problems such as impaired memory may go unnoticed or be considered natural for that person.

High doses sometimes are prescribed, especially for those with developmental disabilities. Problems with thinking and behavior may result. If the dose has been increased gradually over many months or years, it can be hard to separate the effects of the clonazepam (or other benzodiazepines) from the effects of other medications, seizures, and other neurological and psychological disorders.

An important concern when people with epilepsy take clonazepam or other benzodiazepines is the risk that seizures will become more frequent or more severe if the medicine is reduced or stopped. The longer the person has been taking clonazepam and higher the dosage, greater the

tolerance and therefore higher the risk of worsening seizure control. Even small, gradual dose reductions can temporarily increase seizure activity, but the long-term decrease in effects like drowsiness and depression often makes the change worthwhile.

Also, as is the case with other sedatives, sometimes clonazepam makes people feel sleepy or uncoordinated. Patients who have had their doses changed or increased or have been started on clonazepam or other benzodiazepines should be careful and avoid driving and using heavy machinary for some days. Clonazepam and other benzodiazepines are most likely to cause psychological dependence.

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Use of Clonazepam in Panic disorder:

Clonazepam was initially licensed as an anti-epileptic agent, but its use in a wide variety of psychiatric conditions, including panic disorder (PD) has now been well established.

This overview evaluates the current role of clonazepam alone or in combination with antidepressants and/or behavioral therapy in the treatment of PD. We review the data establishing the use of clonazepam in the treatment of PD as well as new information, particularly confirmation of longterm efficacy and safety. We also discuss a regimen for safely tapered withdrawal of clonazepam, the characteristics of the respiratory subtype of PD, and CO2-induced panic attacks as a diagnostic measure and predictor for therapeutic success.

It has been shown that panic attacks can more readily be induced by CO2 in PD patients with the respiratory subtype than those with the non-respiratory subtype. More than 25 years after the first report of efficacy in PD in 1984, clonazepam, alone or combined with selective serotonin reuptake inhibitors (SSRIs) and/or behavioral therapy, remains an important therapeutic modality for the management of PD.

References:

1. Nardi AE, Machado S, Almada LF, Paes F, Silva AC, Marques RJ et al. (2013). Clonazepam for the treatment of panic disorder, Current Drug Targets, 14(3), 353-64.

Feedback from our readers

"I have seen a copy of esteemed news letter "The Rehabilitation Psychologist" Vol. III No. of 25th January 2014. Thanks.
Very useful and important information you have covered about Brief Report of Census 2011, which is an important source data for all our future planning, budget, research, work and planning for annual and five year plan of activities of our NGO."

Reshma Shah from Gujarat
(e-mail correspondence on March 13th)

Hi
I was invited to be a Member of this Group at its very inception but this is the first time I cannot resist posting a message. In the mid nineties when the RCI formed a Committee to explore the possibilities of introducing training programmes in India in the area of Rehabilitation Psychology, I was the Chairperson of the Committee. This Committee shaped the M.Phil programme in Rehabilitation Psychology and recommended its introduction. As the Chairperson, I consider it my duty to record the outstanding contributions made by late Rita Peshawaria and the major inputs by Dr Saroj Arya for this effort. A few years later Late E.G.Parameswaran Committee recommended that a PG diploma in Rehab Psychology be introduced.
It is gratifying to note the emergence of Rehabilitation Psychology as a Profession and the formation of the Association of Rehabilitation Psychologists - India (ARPI).The quality of the web site of the ARPI is outstanding. The logo of the Association is symbolic and sublime. The recording of the Vision and the Mission is unequivocal and precise. It is a pleasure to go over the utilitarian contents of the present and the previous editions of the news letters. In an era wherein the I,Me,Myself philosophy reigns supreme those responsible for the emergence of the ARPI have set an example by maintaining a low profile which borders on anonymity. Anyone visiting the ARPI web site would find that they are rewarded well beyond expectations.
Here is wishing ARPI all Success and a Bright future in the service of the Society at large.

Prof. G. G. Prabhu
(comment posted in "Indian Psychologists group" on April 12th)