MINDS NEWSLETTER

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Articles on Psychiatry from over 20 specialities!!

Contribution from More than 50 Authors!!

Seven Sections in every Issue

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# MINDS

***Wellbeing begins in our MINDS***


**Monthly Newsletter on Psychiatry for Doctors & Medical Students**

***Volume 4*** ***Issue 10*** ***Oct 2014***


## From The Desk of the Editor: (SIDE) Q!!

Surprised with the jargon?

Throughout the development of a child, important parameters are monitored are child's developmental quotient (DQ) and social quotient (SQ). It is the child's ability to develop various motor, social and language functions as desired appropriate for their age. Later, as child starts attending school and starts studying, intelligence is given maximum importance and IQ becomes a vital parameter to judge their performance. Any deviations in these domains are promptly taken into account and measures are taken to improve them.

Least attended however almost equally important domain is EQ… i.e. emotional quotient, a measure of person's adequacy in areas of self-awareness, empathy, and dealing sensitively with other people. A good EQ helps one to identify emotions of self as well as others and develop reciprocation accordingly. It has been observed that general intelligence and emotional intelligence correlate closely with each other and are integral part of one's success. To develop EQ, we need to reduce our stress, identify & deal with our emotions, improve non verbal communication with others and regularly obtain feedback from others to improve upon empathy and behaviour of self.

Let our IQ get an additional advantage of EQ to create successful MINDs.

**Dr. Shubhangi S. Dere**

## Guest Column: Down The Memory Lane…… A manic episode- a blessing in disguise!

Suman was brought to our department by an attendant from an institute for the destitute women. About five years back she was admitted in institute by a social worker, being found on road in a dishevelled condition, not able to tell her details. After the admission, she gradually recuperated in a few days and became a disciplined and a hardworking inmate of the institute. She would get-up early in the morning and actively participate in all the activities of the institute and would help the attendants to take care of the other elderly disabled inmates. Often, she would entertain the inmates, staff and visitors with her amateur, native singing ability.

In the last fifteen days prior to hospital admission, a gradual worsening change in her behaviour was noticed. She would wake up earlier and awaken the other inmates telling the benefits of rising early in the morning. She would insist and force some of the young inmates to do some exercises. She would talk continuously and go out of her way to greet the visitors. She would often express her happiness by singing and dancing and claim to have an extraordinary power to heal the diseased and the disabled. She was diagnosed with manic episode and with the treatment she started showing remarkable improvement in her behaviour in the very first week and by the end of second week she was all ready to go discharge.

On the day of discharge, during our ward round, she pointed out to a visitor man in adjoining ward and claimed that he was her husband. Despite of our efforts to stop her, she loudly called out at that man and ran out of the ward and embraced that person. We promptly followed her and in very apologetic voice tried to explain to that person about her illness and her strange behaviour.

To our utter disbelief, that person told us with an uncontainable pleasant surprise on his face that he in fact was her husband. Suman had absconded from home about five years back during one of her manic spells and had ended up in a home for the destitute. Her husband had not left any stone unturned to find her and finally when he had given up and lost all his hopes of finding her, he suddenly, just out of the blue, found her!

**Dr. Nilesh Shah. Professor & HOD, Dept of Psychiatry, LTMC & Sion Hospital, Mumbai.**

**Eyeing Psychiatry… A Must 'SEE' Association!!**

Eyes are the windows of soul. Various factors like holding of the gaze, frequency of blinking and the change in pupil size have all being linked to the attention and interest with which a person looks at something.

One of the first things assessed by the psychiatrist which demonstrates the link between eye and psychiatry is an **'eye contact'**. Patients often break off eye contact while talking about issues which when probed turn out to be important stressors hidden by the patient during the interview. Also in pervasive developmental disorders like autism there is lack of eye to eye contact.

Many psychiatric conditions have ophthalmic manifestations. **Schizophrenia** patients have trouble in smooth pursuit movements (jerky movements of the eye known as saccades while following a moving object), gaze fixation, reduced or increased eye blinking. Visual hallucinations occur in delirium, mania and also in socially isolated people. Drug abuse (eg- hallucinogen like LSD) leads to visual hallucinations in the acute as well as later in the form of flashbacks. In the past, following the placement of patch after cataract surgery, patients developed delirium and hallucinations also called 'black patch psychosis'.

**Anxiety disorders** especially post traumatic stress disorder show disordered eye movements. Eye movement desensitization and reprocessing is a therapy targeted at relief of these symptoms. Eyes are often targeted in self-mutilation with or without any psychiatric disorder-ranging from scars on eyelids (due to branding with a hot object on the face) to pulling out of eyeballs.

Various **mental retardation** syndromes like congenital metabolic syndromes like Lawrence moon Biedl syndrome, Ushers syndrome, Bassen kornweig syndrome, Refsums syndrome, and Alstrom syndrome etc. have variety of ophthalmic manifestations. Other genetic disorders associated with mental retardation like Down's syndrome, WAGR syndrome also show much of psychiatric morbidity along with ophthalmic symptoms. Charles Bonnet syndrome occuring in the elderly is manifested by visual pseudo hallucinations and is due to intracerebral pathology. Wilson's disease (hepatolenticular degeneration) features emotional lability, impulsive behavior, frontal lobe disorder, subcortical dementia, depression, anxiety and psychosis alongwith KF ring and sunflower cataract. Blepharospasm which is forcible closure of the eyelids in the form of a tic or twitch can be seen in psychiatric conditions like Tourette's syndrome and tardive dyskinesia. Certain ophthalmic signs helps to differentiate between functional and organic symptom, eg., Dolls eye movement and caloric tests. Fundus examination is an integral part of psychiatric examination to rule out intracranial hypertention.

Certain **psychotropic drugs** like Chlorpromazine and thioridazine cause lenticular opacification, retinopathy, ocular dystonias, accommodation & mydriasis. Lithium causes apraxia of eyelids, blepharospasm and dystonias. Tricyclic antidepressants cause blurred vision and angle closure glaucoma. Topiramate causes angle closure glaucoma, dystonia and acquired myopia. Carbamazepine causes dystonia and impairment of colour vison. Benzodiazepines cause dystonia, loss of convergence and color indiscrimination.

Considering this close knit relation, any patient presenting with psychiatric symptoms, one should also look for ophthalmic manifestation as a part of a holistic approach.

**Dr.Manamohan N., Dr. Sujoy Ray, Dr.Priya Sreedharan, Dr.Ashok. M. V.**

**Department of Psychiatry, St. Johns Medical College & Hospital, Bangalore.**

## Epileptic vs. Non Epileptic Seizures in Children: A Diagnostic Dilemma

**Psychogenic non-epileptic seizures (PNES)** often misdiagnosed as epilepsy, are episodes which alter neurologic function resembling an epileptic seizure but are not accompanied by electrophysiological changes seen with epilepsy. Majority of patients are females of age 15 to 35 years. The pre-disposing factors may include prior abuse (sexual and non-sexual), psychiatric co-morbidities, chronic systemic conditions and personality subtype or other stressors. 10-15% may have co-existent epileptic seizures. Some may have relatives with epilepsy as a role model.

The semiologies may include rhythmic, non-rhythmic or complex motor activities, prolonged motionless unresponsiveness (dialeptic), subjective sensations (non-epileptic auras) or mixed. The clinical clues for PNES may include "ictal" eye closure, "ictal" weeping, fluctuating motor activity with pauses, lack of autonomic features, prolonged duration (often lasting few minutes to hours) with frequent "status" and brief "post-ictal" states. Lack of objective evidence of injury, occurrence in presence of "significant others" and '*La belle indifference*' (i.e. relative lack of concern about symptoms) are other features. There is typically absence of urinary incontinence and tongue bite. These events may be precipitated in the clinic/EEG laboratory by various induction maneuvers. Elaborate laboratory testing is usually not warranted.

In treatment, supportive psychotherapy and family therapy with treatment of co-existent co-morbidities may be prudent. Many of these patients may be on anti-convulsant drugs which need to be stopped with tapering schedule. It is to be remembered that anti-convulsant drug toxicity may increase the frequency or cause dramatic changes in the pattern of PNES.

It is also to be noted that several paroxysmal disorders in childhood may mimic epileptic seizures. These include paroxysmal dyskinesias, episodic ataxias, childhood periodic syndromes (e.g. benign paroxysmal vertigo, benign paroxysmal torticollis of infancy, etc), benign myoclonus, shuddering attacks, self-stimulation/masturbation etc. Hence the presentation of abnormal movements in children needs an elaborative and holistic approach towards diagnosis and management.

**Dr Neeraj Gupta DM (Neonatology)**
**Assistant Professor, Department of Pediatrics, All India Institute of Medical Sciences (AIIMS), Jodhpur, Rajasthan, India**

## REFRAME - Myths & Facts about "Mood Disorders"

 Depression and bipolar disorder are just states of mind or tendency to be 'moody'. A person just needs to "think positive" and they can do away with the problem.
√ Depression and Bipolar disorder are real, treatable illnesses that affect the brain. Significantly excessive fluctuations in the mood state for certain frequency and duration constitute a mood disorder.

 Men don't get depressed.
√ Men are less likely than women to talk about their feelings. However depression is common and instead, men may become irritable, angry, or restless if they are depressed.

 Depression is just self-pity & not any illness.
√ Our culture admires will power and mental toughness and is quick to label anyone who falls back as a looser. But people who have clinical depression are not lazy or simply feeling sorry for themselves. Depression is a medical illness -- a health problem related to changes in the neurotransmitters in the brain. Like other illnesses, it usually improves with appropriate treatment.

 Help means drugs for life.
√ In acute stages of mania or depression, patient need drug therapy. Also many patients do need maintenance therapy. However this is not the 'only' therapy available. In fact, studies suggest that psychotherapy works as well as drugs for mild to moderate depression. Rhythm therapy also is found to be effective in bipolar disorder patients.

 People with depression or bipolar disorder should not marry nor have children.
√ People who have been treated properly for mood disorders can handle their own life and children as anyone else.

UG n PG

# An exclusive Section for Undergraduates and Postgraduates

UG n PG

## MINDS QUIZ

1. A type of anxiety disorder with a history of sudden palpitation, feeling of impending doom and constriction in chest, lasting about 10-15 minutes, after which patient becomes alright is?
a. Generalized anxiety b. Phobic disorder c. OCD d. Panic attack

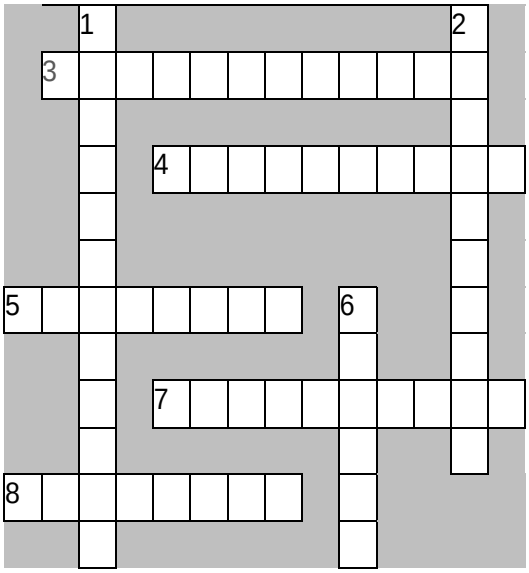
2. A female presents with the history of repeated episodes of slashing wrists and attempted suicide, now she presents with similar history. The diagnosis is?
a. Borderline personality b. Conversion disorder c. Hystrionic personality d. Malingering

3. Organic causes for altered behaviour can be suspected in all the following conditions EXCEPT those with
a. Visual hallucinations b.Family history of psychiatric illness c. Acute onset over 2 days d. Age >50 years

4. Which feature is MOST consistent with an acute psychotic illness?
a. Focal neurological signs
b. Disordered speech or behaviour
c. Impaired cognition
d. Fluctuating mental state

**Reframe & MCQs by Dr Anisha Landage, Resident, Dept of Psychiatry, MGM Medical College & Hospital, Navi Mumbai.**

## Can you cross the crosswords!!!




Across:

3. unconscious internalisation of the qualities of an object or person (12)
4. procedure which brings unconscious conflicts and associated emotions to conscious awareness for the first time (10)
5. this term was coined by James Braid (8)
7. coined the term psychiatry (10)
8. a method used in the treatment of phobias where the person is directly exposed to the phobic stimulus, but escape is made impossible (8)

Down:

1. realistic thinking and planning about future unpleasurable eventsmemory loss (12)
2. repetitive passage of feces at inappropriate time and/or place,after bowel control is physiologically possible (10)
6. .....descibed the Guru-Chela relationship in the patient doctor interaction (6)

**Crossword compiled by Dr Smitha Ramchandra, Resident, Department of Psychiatry K S Hegde Medical College.**

Quick Response Code for the Website

ANSWERS:

MINDS QUIZ
1. d
2. a
3. b
4. b

CROSS WORDS

ACROSS
3. Introjection
4. Abreaction
5. Hypnosis
7. Johannreil
8. Flooding

DOWN
1. Anticipation
2. Encopresis
6. Jsneki

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