MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 6 *Issue 11* *November, 2016*

- ❖ Published from 2011
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- ❖ Contribution from More than 50 Authors!!
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From the Desk of Editor — Mental Health Gap

Mental health gap is a term used to indicate the number of people with mental illness not able to get the treatment, expressed as percentage of total number of mentally ill. Excluding a very few developed nations, most of the other countries have a huge mental health gap. In our country, the availability of qualified psychiatrist is still less than 1 per a lakh population! Recently concluded National Mental Health Survey – 2016# revealed that the prevalence of any mental disorder is 10.6% which translates to around 150 million people are in need for active mental health interventions. Though there are numerous direct and indirect causes for this gap, the one worth mentioning relevant to the intent of this newsletter is poor exposure to psychiatry in under graduate curriculum and unfortunately no steps are being taken at policy making level to improve this! So most of the Indian Medical Graduates may not be much confident in managing mental health problems. But with such an amount of gap existing, it is almost certain that every doctor would be encountering many mentally ill in their practice but not in a comfortable position to treat. WHO has come up with version 2 of mental health gap (mhGAP) intervention guide## in non-specialized setting which helps non-psychiatrist doctors to deal with mental illness with evidence based protocols. This may help in closing the gap to some extent when suitably backed up by Government policies and financing to scale up mental health services.

- Dr. Gopal Das. C. M

Guest Column: Down The Memory Lane… Sexually 'Unconscious'

In the early years of my practice in the 1980's I saw a 30 year old mother of two who was referred to me by a neurologist colleague with a h/o episodes of 'unconsciousness' of one month's duration. It was reported that she would lose 'consciousness' between 11pm and 6am every day. During this period she would be 'unresponsive' to verbal and physical stimuli. She continued her day time household chores as usual with no change in her ability to care for the children and family. A psychological evaluation revealed that they were a very happy and sexually active and satisfied couple till about a month and a half back. Sometime before this 'illness' started her husband was introduced to pornographic video cassettes by his friend. After watching these for a few days he started having several and severe doubts about the quality of his sexual life that he had rated so far as good. How was it that that the person in the porn movie could perform for such a length of time and with so many variations!? In comparison his performance was so poor! He decided that his wife should also see the films and together they would work on improving their sexual life. They could watch the film at 10pm after the children went to sleep. She was shocked when she saw the film, felt it was unnatural and in disgust refused to see it again. Her husband insisted that they see the film so they could educate themselves and emulate what they had seen. When her protests fell on deaf ears she started falling 'unconscious' at 10pm and would be so till 6pm when she would have to get up to attend to the children. She clearly thwarted all his attempts.

In therapy the husband was educated about the nature of pornography, the professional actors involved and how far removed it was from reality. It was far from an educational film! With the dawning of insight there was a change of attitude in him. She stopped falling unconscious and they returned to their original sexually satisfying life.

Dr. Ravishankar Rao, Senior Consultant Psychiatrist, Bengaluru. rsrao90@hotmail.com

Attention Deficit Hyperactivity Disorders in Adults

ADHD is a behavioral and neurocognitive condition characterized by developmentally inappropriate and impairing levels of gross motor over activity, inattention, and impulsivity. ADHD is usually noticed at the pre-school age. Due to hyperactivity and impulsivity, child is often termed as difficult to handle, nuisance because of disruptive and intrusive nature. This affects social relationships, learning and academics & self-esteem

Concept of Adult ADHD

Earlier, ADHD was thought to be a childhood disorder and subsides as child matures. But now, research has shown that more than 2/3rd of childhood ADHD continues to adulthood albeit hyperactivity reduces. Various surveys and studies have shown the prevalence of Adult ADHD between 2-5%. Teenager or young adult with ADHD continues to have inattention and impulsivity along with low self-esteem, identity deficits and negative world view, high novelty seeking and boredom proneness may lead to explore drug use at an early age, engage in high risk behaviors for thrill and endanger themselves and also experiment with sexuality and may involve in high risk sexual behaviors.

What is the importance of recognizing Adult ADHD?

Because of lack of awareness regarding the concept of ADHD itself in Indian scenario, many childhood ADHD cases does not get diagnosed or fail to reach medical attention. Once such children reach teenage and young adulthood, they are likely to land up into troubles which are mentioned above. If only the outcomes such as early onset substance use, sexually transmitted diseases, injuries sustained or co-morbid conditions like depression and anxiety are treated, the underlying traits of ADHD maintains the problem and leads to recurrence. Evidence bases, though not as robust as for childhood ADHD, clearly tells Adult ADHD which is often the root cause of above problems is a potentially treatable condition.

How to recognize adult ADHD?

To consider possibility of adult ADHD in any young adult presenting

1. With substance use especially, early onset dependence and multiple drug use
2. Aggressive behavior or bad and explosive temper, temper tantrums
3. Impatient and easily agitated
4. Persistent poor performance in academics and occupation resulting frequent change in settings & drop outs
5. Poor inter personal relationships, multiple relationships
6. High risk sexual behavior, promiscuous, casual sex and in young adults being treated for sexually transmitted diseases especially HIV infection
7. Frequent injuries and frequently engaging in risky activities like rash driving, speeding
8. Frequent law breaking and petty crimes

Diagnosis of Adult ADHD essentially has all the criteria required for childhood ADHD as mentioned in DSM-IV/DSM-V and ICD-10 but presentations may differ in adult life when suspected for the first time. To diagnose ADHD, onset must be in childhood and presence of ADHD in childhood is a must.

Common Screening and assessment tools for adult ADHD

- ADHD Adult Self-Report Scale V1.1 (ASRS V1.1) 6-item screener as well as 18-item symptom checklist
- Wender – Utah Rating scale
- Conners' Adult Attention-Deficit Rating Scale (CAARS)
- The Wender-Reimherr Adult ADD Scale (WRAADS)
- Barkley's Current Symptoms Scale–Self-Report Form

Treatment of Adult ADHD

As in children, stimulants are the main stay of pharmacotherapy in adults with ADHD. However, there is relatively less evidence base for usage of these medications in adults compared to children. Methylphenidate (MPH) belonging to the class of stimulants carries the highest evidence for treatment of adult ADHD. It is available in immediate release and sustained release formulations. Other medications with lesser evidences are Atomoxetine, Nortryptiline, Bupropion & Modafinil. Psychological Management of ADHD in adults may be done using Cognitive-Behavioural Therapy, Interpersonal therapy, Anger Management techniques, Activity scheduling and time management, Attention enhancing Tasks.

Dr. Shankar, Assistant Professor, Dept. of Psychiatry, BMC&RI, Bengaluru, shankarkjs@gmail.com

Psychiatric aspects related to dialysis and renal transplant

Let me start with an incidence which shook me off from my slumber. I believed that my communication skills and ability to diagnose depression were reasonably good till this incidence. A well-educated middle aged male with diabetes, hypertension and end stage renal disease who was recently initiated on dialysis came to the clinic. He was cheerful to talk and was well aware of the need for regular dialysis for survival. During the session where we were discussing options for his treatment he surprisingly wished to withdraw from dialysis. Withdrawing from dialysis is a major decision. The clinical implication of such a decision was that he would die in one or two weeks. I failed to comprehend what made him take such a decision. He was financial well off and had good family support. His only argument on why he took such a decision was that he did not want to prolong life artificially and he did not have any other responsibilities to fulfill. I asked him if he was depressed which he denied. I then sought help of my psychiatry friends who diagnosed him as having depression. After medications and counseling sessions this particular patient was willing to continue dialysis.

The diagnosis of depression can be confounded by patients who do not realize they are clinically depressed or who deny "being depressed" even when directly asked; this is due in part to the stigma long associated with mental illness. Incidence of psychiatric illness is more common in dialysis patients than what it seems to be. One meta-analysis has estimated that the point prevalence of depression was 37 percent in sharp contrast with general population where point prevalence of major depression was 3 percent.

Depression in dialysis patients is associated with increased morbidity and mortality. The estimated probability of hospitalization was 12 percent greater in patients with depressed affect. Depression in dialysis patients is also associated with a 40 to 50 percent increased risk of all other causes of mortality. Given the large incidence of depression in ESRD patients, huge implications on morbidity and mortality, and difficulty in diagnosis; it is prudent to have periodic screening for depression. Many patients on dialysis do well if individual psychotherapy is administered during the dialysis sessions itself.

The role of psychiatrists in managing issues related to renal transplantation is proving to be vital as both the recipient and donor should go through pre-and post procedure assessments and follow ups. Wherever feasible, a bio-psycho-social approach in the assessment is advisable. At times, the assessing psychiatrist might also need to talk about the patient's feelings about death and dying and facilitate ventilation regarding the same. Along with assessment, it is also important to ensure that both patients and their families have understood the transplant process fully. The live donors should be informed of the probable risks, benefits and consequences of donation in a complete and understandable fashion.

The post-transplant period is another critical phase wherein apart from medical & surgical team monitoring the progress, psychiatrists need to put in their efforts to evaluate and intervene as necessary. The psychological issues could be related to direct adverse effects of immunosuppressants being used or as indirect distress due to various other physical & cosmetic side effects. The drug interactions between psychiatric medications and immunosuppressants again calls for expert opinion to carefully weigh the potential benefits and risks. Additional psychiatric care is required in cases of graft rejection/failure.

Overall a psychiatrist forms an integral part of the multidisciplinary team involved in care of End Stage Renal Disease (ESRD) patients.

Dr Manjunath J. MD, DM (Nephrology), Associate Professor, Department of Nephrology,Father Muller Medical College and Hospital, Mangalore - 575002. Ph. 7795069393

REFRAME -Let Awareness Reframe assumptions: Myths & Facts about 'Tobacco Use Disorders'

- ☒ *Tobacco use is just a common habit which most of the people have now a days*
- ✓ Tobacco use in varying severity is classified as addictive disorder in International classification of Diseases under Mental & Behavioral Disorders (category F).
- ☒ *Tobacco is not as addictive as 'drugs' like cocaine and heroin*
- ✓ Tobacco with its psychoactive substance called 'Nicotine' is one of the most addictive substances, probably more than any drug, perhaps addictive from the first use itself in vulnerable individuals.
- ☒ *Quitting tobacco is easy with just 'will power'*
- ✓ In fact most of the people especially with moderate and heavy use find it difficult to quit just by 'will power' and frequently relapse within few days
- ☒ *Medicated chewing gums as shown in ads can be used whenever in the place of tobacco to quit it*
- ✓ When not used properly, without sufficient replacement dose calculated per day & individualized to each person, it may be ineffective as nicotine gums often fail to give full effect of tobacco products. This is the basis of Nicotine Replacement Therapy (NRT)
- ☒ *There are no effective treatments for Tobacco cessation*
- ✓ There are established treatments, using partial agonists like Varenicline, and other medications like Bupropion and Nortriptyline, along with NRT and psychosocial therapies, long term (> 1year) abstinence rates are high.

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

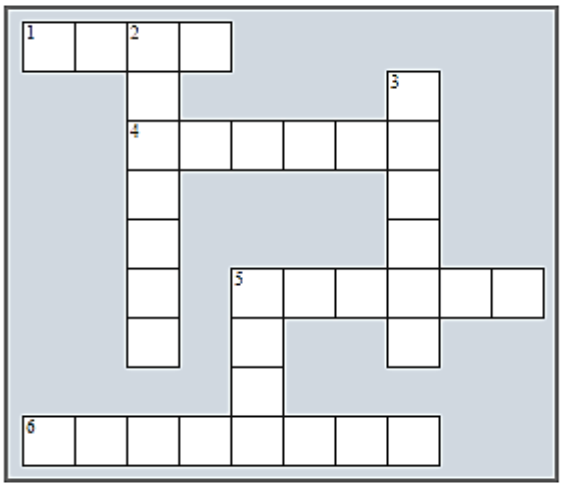
UG n PG

MINDS QUIZ

1. **Which one of these is a dopamine partial antagonist (dopamine stabilizer) class of antipsychotic?**
   (a) Haloperidol (b) Risperidone (c) Aripiprazole (d) Olanzapine
2. **Which one of these is a typical subcortical dementia?**
   (a) Alzhiemer's Disease (b) Binswanger's Disease
   (c) Fronto-temporal Dementia (d) Dementia with Lewy Bodies
3. **Which of these is called sleep hormone?**
   (a) Histamine (b) Dopamine (c) GABA (d) Melatonin
4. **Which one of these psychotherapies is typically used in Obsessive Compulsive Disorder**
   (a) Exposure & Response prevention (b) Interpersonal therapy
   (c) Flooding (d) Systematic Desensitization
5. **All of these are defense mechanisms except**
   (a) Projection (b) Displacement (c) Catharsis (d) Rationalization

Note: You can now request for any explanations to MINDS QUIZ answers by just an email to editormind@gmail.com

Can you cross the crosswords!!!



Across

1. This disease was the earlier name for fronto-temporal dementia
4. Lack of will or initiative
5. Refusal to accept external reality because it is too threatening, a defense mechanism
6. Mini-mental status examination is constructed by

Down

2. Intense desire to take alcohol or any substance, an important criteria for diagnosing substance dependence
3. Syndrome of extrapyramidal side effect of antipsychotic drugs with perioral tremors named after this animal
5. A culture-bound syndrome in India with central theme around loss of semen or vitality leading to asthenia

ANSWERS

MINDS QUIZ

1. c
2. b
3. d
4. a
5. c

CROSS WORDS

ACROSS
1. Pick
4. Abulia
5. Denial
6. Folstein

DOWN
2. Craving
3. Rabbit
5. Dhat

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