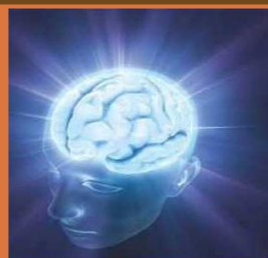

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Wellbeing begins in our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 6 *Issue 2* *February 2016*

From The Desk of the Editor:

Using smartphones for mental health-care

Smartphones have become part of common usage globally, and their access is still gradually rising. You would find smartphone users even in remote villages in India, and the younger generation has taken to using smartphones in a big way. Customizable applications (or 'apps') are easy to install softwares that can be installed on the smartphones and can be designed for a range of functions. Several apps have been developed with regard to mental health care. There are apps that give information about the mental illness, apps that track mood and other symptoms, apps that assist in coping and those which track adherence and provide reminders for medications, for example "*MyMedsSchedule*" and "*Mobilyze*". Some apps have been developed integrating all these features, and can be customized to needs of the patient.

The use of these smartphone apps offers specific advantages. The potential advantages include low cost and easily scalable technology, ability to reach those who find it difficult to personally engage (e.g. patients with anxious avoidant personality disorder), for those who stay far away from treatment providers, and ability for developing a user friendly interface can be developed. However, such apps also have some specific concerns while being used in the real-world scenario. The major issue pertains to confidentiality of the data. Mental health issues are often considered stigmatizing, and security of data access makes a lot of difference on the perception of the end user. Other issues relate to linguistic barriers ease of use of the app, and the ease of use of individuals with psychiatric disorders in using the apps. Still, smartphone apps are likely to redefine the way mental health care is delivered, not through radical transformation, but by being a welcome adjunct to the care process.

Siddharth Sarkar

Guest Column: Down the memory lane 'How Research Helps Manage Patients'

We did a retrospective study of patients attending OPDs of a private clinic and a teaching hospital. There were 126 and 100 cases respectively of sexual problems which formed 2% & 5% of total cases seen were published in the Indian Journal of Behavioral sciences (Vol. 5, No. 2, 1995). The findings were real eye openers for the practitioner of Sexual Medicine:

1. All varieties of sexual problems can present at OPD.
2. Dhat Syndrome is a primary or the only diagnosis in half of the patients.
3. Among specific sexual disorders, Dhat Syndrome was seen in 2/3rd of them.
4. Overall 85% of them had recognizable Dhat Syndrome.
5. Follow up was invariably poor except for Dhat Syndrome
6. Sex education forms the primary line of management in all the cases.
7. Sexual Aversion Disorder seen in females, was the most difficult to treat.
8. Couples had better outcome.
9. Premature ejaculation was the easiest to treat and had the best prognosis.
10. Desire disorders were common and erectile & orgasmic disorders invariably followed it

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Invited Article

Management of alcohol dependence: An overview

The prevalence of alcohol use in India is found to be around 40%, with hazardous use being present in about 15% of the population and dependence pattern being present in about 2% of the population. The increasing sale indices of alcohol across many states emphasizes the need for better knowledge among medical personnel about the management of alcohol dependence and its medical and psychological complications. Following are steps to manage case with alcohol dependence:

Step-1: Assessment of alcohol problem

CAGE questionnaire with the following 4 questions is used as a basic screening instrument to assess alcohol problem. Items are scored as 0 and 1 based on their no and yes replies. Score of 2 or more is significant emphasizing treatment.

1. Have you ever felt you should Cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you ever felt bad or Guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

Step-2: Do the investigations

Complete physical examination to be done. Assess for alcohol related complications and withdrawal symptoms. Complete hemogram, liver function test, lipid profile, ECG, ultrasound abdomen are basic investigations to be done. Other specific investigations as needed can be conducted.

Step-3: Detoxification

It is the process of getting rid of the harmful substances from the body in a controlled and safe manner with benzodiazepines to reduce the withdrawal symptoms like tremors, anxiety, and insomnia and also to reduce the probability of withdrawal seizures and delirium tremens. Long acting benzodiazepines like diazepam and chlordiazepoxide are preferred as they minimize the need for frequent dosing, and effectively control withdrawal symptoms for a longer time. In cases of liver failure, lorazepam, oxazepam, and temazepam are preferred as they are short acting and not metabolized by the liver. The dosage is started high and tapered by 10% per day and stopped by 10 days. Patient may require sedation with injectable antipsychotics in case of agitation due to delirium. Thiamine supplementation orally or parenterally is given in doses of 100-200mg/ day to restore the body's store and to avoid Wernicke's encephalopathy and Korsakoff's psychosis. Withdrawal seizures are treated with benzodiazepines, without any anticonvulsants.

Step-4: Long term management

Pharmacotherapy

- Deterrent agent- Disulfiram – Caution of developing a disulfiram ethanol reaction while taking alcohol
- Anti craving agents- Acamprosate, Baclofen, Naltrexone, Topiramate. Acamprosate and baclofen are not metabolized by the liver and can be given safely in patients with liver dysfunction. Naltrexone is better avoided in patients with liver dysfunction.

Psychotherapy

Motivation enhancement training and relapse prevention counselling are given to maintain abstinence and reduce the chances of relapse.

Step-5: Reaching out to the family members

Spouse counselling is very essential to deal with the family and social issues due to alcoholism. Family therapy and marital therapy are likely to be effective by affording indirect support to the patient. To conclude, alcohol dependence is a complex disorder with multifactorial etiology. Because of this complexity, relapses are quite common and the management has to be planned accordingly anticipating these problems.

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Consultation Liaison Psychiatry

Focus: 'Dentistry'

United we stand against tobacco

Dentists polish teeth to remove stains and take biopsies from the so called 'red and white lesions' of oral mucosa, onco-surgeons treat oro-pharyngeal carcinomas and de-addiction centers strive to help patients quit their habit of tobacco usage by counseling and nicotine replacement therapy (NRT). All the three specialists are different stake-holders in dealing with patients with tobacco usage, which has become excessive and presents with the risk of developing a neoplasm.

Estimates suggest that tobacco use is present in one third of the population. Usage of tobacco can become problematic and lead to dependence. Tobacco dependence is defined as a behavioral pattern in which the use tobacco is given a much higher priority than other behaviors that once had higher value. The features that can present include those of by craving, tolerance, withdrawal, preoccupation, use despite harm, and loss of control. Presence of any three of the six characteristic features can be used to make a diagnosis of tobacco dependence. Chewable tobacco use is seemingly more common in India than smoked tobacco use.

Treatment of tobacco dependence is multi-faceted. Patients who have been taking tobacco often approach to dental surgeons and physicians. Interaction with such health-care providers gives an opportunity to provide brief counseling to such patients. It has been observed that brief counseling is as effective as nicotine replacement and other medications for the treatment of tobacco dependence.

The other means of cessation of tobacco use involves roping in of mass-communication media to provide information to the lay public. Already, the packets of tobacco products contain statutory warnings, with the aim of deterring potential users. Quit-lines are available where patients can dial the number and receive counseling for their substance taking behavior. Furthermore, smart-phone applications can be developed that aims to provide counseling to through the phone itself. Besides, each tobacco intervention initiative designed should have a team of health professionals from all the concerned streams and in hospital scenarios, cross-consultations among specialties while treating a patient with tobacco-use should be a routine practice. This may help in better catering to the needs of patients with tobacco dependence, who are likely to benefit from some form of intervention.

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REFRAME -Let Awareness Reframe Assumption: **Myths & Facts about "Anxiety disorder"**

- ☒ Anxiety is not a normal part of life.
- ✓ Everyone experiences anxiety to some extent, on a daily basis but if your anxiety affects your functioning then it may be an anxiety disorder.
- ☒ People who have anxiety just need to relax.
- ✓ Although relaxation might be a part of the treatment plan, persons with anxiety have difficulty in making themselves relaxed, and may need other forms of treatments.
- ☒ There is no cure for anxiety disorders.
- ✓ Most studies implicate that combination of pharmacotherapy and psychotherapy bring remission from anxiety.

Compiled by Swapnil Tripathi, final year, MBBS student, AIIMS, Jodhpur, Rajasthan

UG n PG

An exclusive Section for Undergraduates and Postgraduates

UG n PG

MINDS Quiz

1. Anterograde amnesia is most commonly seen in:

a) Post traumatic head injury. B) Stroke c) Alzheimer's d) Spinal cord injury

2. A 30 years lady develops acute attack of doom sensation, breathlessness, choking, and palpitation. The most likely diagnosis is

a) Panic disorder. b) Anxiety disorder c) Conversion disorder d) Acute psychosis

3. Which among the following is not used to treat alcohol dependence?

a) Naltrexone. b) Acamprosate c) Disulfiram d) Flumazenil

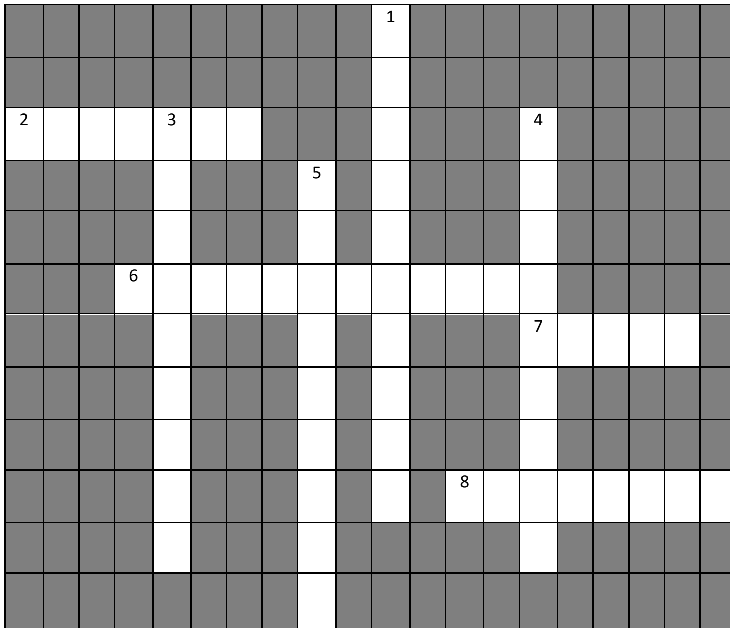
4. All are true about delirium tremens except

a) Coarse tremors. b) Visual hallucinations c) Third nerve palsy d) Confusion

5. All of the following are done in behavior therapy to increase the behavior except

a) Punishment b) Operant conditioning c) Negative reinforcement d) Rewards

Compiled by Swapnil Tripathi, final year, MBBS student, AIIMS, Jodhpur, Rajasthan



Crosswords

Across

2. Very severe elevation of mood
6. Persisting/distressing complaints of increased fatigue with mental efforts (nervous breakdown)
7. Presence of automatic obedience, echolalia and echopraxia precipitated by sudden stimulus.
8. Congenital anomaly due to lithium intake in the period of gestation.

Down

1. Fear of pain.
3. Autism without any significant delay in language and cognitive development (syndrome).
4. Person maintains body posture in to which it is placed
5. Persistent mild depression

Compiled by Swapnil Tripathi, final year, MBBS student, AIIMS, Jodhpur, Rajasthan

Quick Response Code for the Website

ANSWERS

MINDS QUIZ

1. A
2. A
3. D
4. C
5. A

CROSS WORDS

ACROSS

2. Ecstasy
6. Neurasthenia
7. Latah
8. Ebsteins

DOWN

1. Algophobia
3. Aspergers
4. Catalepsy
5. Dysthymia

MINDS Newsletter was launched in July 2011 as a Monthly Newsletter on Psychiatry for doctors & medical students for creating awareness and continued medical education. You can receive a free e-copy of MINDS by an e-mail request to editormind@gmail.com, or by just SMS MINDS to Editor: +91 8003996882/ Asst. Editor: +91 9786022145, or join us

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