MINDS NEWSLETTER

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Seven Sections in every Issue

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MINDS

Wellbeing begins in our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

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From The Desk of the Editor:

Positive Psychology: Scientific Explorations of Human Strengths

"What is wrong with the people?" question guided the thinking of most mental health professionals till the last decade. Now 21st century unfolds another question, "What is right about people?" It is the heart of positive psychology, which is the scientific and applied approach to uncovering people's strengths and promoting their positive functioning. Martin Seligman, a Psychologist from University of Pennsylvania has ignited the recent explosion of interest in positive psychology. It is a science of positive subjective experience, positive individual traits, and positive institutions promises to improve quality of life and prevent the pathologies. It seeks a balanced, more complete view of reality that includes both the positive and negative. Spending mental energies on avoiding certain unwanted outcomes tends to make people reactive towards situations, while thinking of what we want to happen helps to keep the negative away. So let's begin our journey in positive way and explore our hidden potentials!!

Naresh Nebhinani

Guest Column: Down The Memory Lane… **'An eye opening experience'**

I had joined the Department of Psychiatry at JJM Medical College, Davangere in 1984 and an incident then had a lasting impact. I had a classmate who was married and both were indeed the role models as to "How a couple should be"! Unfortunately he lost his wife during puerperium due to embolism and I visited him to console his bereavement. He was crying and thumping his chest which appeared an overreaction from a doctor to 'death of wife'. The efforts of his relatives to console him were in vain.

They requested me to talk to him, but all the conventional methods proved futile. I finally called him aside and took him into confidence and suggested with my usual forte that 'these things do happen' and also 'we will all see to it that he will be married off again after 3 months'. He started crying even more and was inconsolable. A while later he was cursing me and his comment really opened my eyes – 'Rao, you are hopeless and you are not my friend. You are telling me that my marriage will be held 3 months later. How can you be so heartless? Tell me what I should do tonight'!!

Yes, Woody Allen was right when he said 'LOVE is the answer. But while you're waiting for the answer, sex raises some pretty good questions'**.** It made me realize one cannot throw off sex even in the best of relationships. Every problem and each of the problem cases has something sexual, apparent or hidden and to look into it provides lasting benefit. Do remember always – it pays!

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Invited Article

Internet addiction

Background-Definition-Concept-- Subtypes

Usage of internet is a universal phenomenon. However, when the usage becomes uncontrollable despite having damaging consequences for the user, it is labeled as 'addiction'. The existence of internet addiction (IA) as a discrete disorder was first proposed, albeit not seriously, in 1995 by Ivan Goldberg, a New York psychiatrist. But 1996 study by Kimberly Young of the University of Pittsburgh triggered the controversy. IA is also known as *problematic internet use*. Initially IA was conceptualized as an impulse control disorder (in line with pathological gambling) and later as addictive disorders because of its clinical, phenomenological, and biological overlap. Five subtypes of IA has been recognized: cyber sexual addiction (internet pornography), cyber relational addiction (adult chat rooms), net compulsion (online gambling), information overload (excessive web searching), and computer addiction (gaming).

Nosological status

Internet addiction falls under the broad rubric of behavioural addiction. Till the advent of DSM-V, behavioural addiction is not accepted nosologically.

IA criteria by Young (1998) requires 5 or more following criterion to be fulfilled over a period of 6 months: Preoccupation; tolerance; withdrawal; using longer than intended; unable to cut down-stop internet use; jeopardized relationship and functionality; deceiving family members /therapist about internet use; and using internet to control dysphoric mood.

Epidemiology & comorbidity

Two large-scale general population surveys from the US and Norway described a point prevalence of IA as 0.7% and 1% respectively. An Indian study amongst college students of Mumbai has observed similar prevalence figure (0.7%), another study done amongst school students found IA in 12% of respondents. Although the percentage (0.7-1%) seems to be meager, the huge number of internet users would make it enormous in terms of absolute figure. Young age, male gender, higher educational achievement, and financial stress are found to be positively associated with *problematic Internet use.* Comorbidity with IA is a rule rather than exception. Mood disorders (major depression and bipolar disorder), substance use disorders, attention deficit hyperactive disorder and impulse control disorders are the common co-morbidities.

Treatment

Pharmacologic and psychotherapeutic interventions specific to problematic Internet use have not yet received adequate testing in large, rigorous studies. Amongst medications SSRI (like escitalopram) and naltrexone were tried with limited success. Of the psychotherapy approaches, cognitive behavioral therapy (CBT) has received the most empirical investigation. Although not systematically studied, developing and nurturing real life social relationship, improvement in social and problem solving skills, restricting online behavior to predetermined goal and time, and parental control or supervision could have preventive value.

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Consultation Liaison Psychiatry

Focus: 'Gastroenterology'

Irritable bowel syndrome

Irritable bowel syndrome (IBS) is a functional gastrointestinal (GI) disorder associated with high morbidity. It is characterized by abdominal pain or discomfort and altered bowel habit in the absence of specific organic pathology. Throughout the world, about 10–20% of adults and adolescents have symptoms consistent with IBS, and most studies show a female predominance. For its diagnosis, recurrent abdominal pain or discomfort at least 3 days per month in the last 3 months (with symptoms for 6 months prior to diagnosis) associated with two or more of following should be present: improvement with defecation; onset associated with a change in frequency of stool; and onset associated with a change in form of stool.

In brief the disease result as a complex of altered GI motility, visceral hyperalgesia, psychopathology, post infectious IBS, abnormal serotonin pathways and altered gastrointestinal microbiome. Four bowel pattern may be seen in irritable bowel syndrome – IBS-D (diarrhea predominant), IBS-C (constipation predominant), IBS-M (mixed diarrhea and constipation), and IBS-A (alternating diarrhea and constipation).

It is important to establish an effective physician-patient relationship and make a positive firm diagnosis to reassure the patient once the diagnosis of IBS is made. IBS is a multifactorial disease hence it needs integrated treatment approach which includes dietary modifications, psychological therapies, and pharmacotherapy like antispasmodic, stool-bulking agents, antidiarrheal agents, antidepressants, antiflatulence therapy, serotonin receptor agonist and antagonists, and modulation of gut flora. Serotonin antagonist (alosetron) is helpful in IBS-D type and serotonin agonist (tegaserod) helpful in IBS-C type. Tricyclic antidepressants (e.g. desipramine) are found to be useful in IBS-D type by delaying whole gut and orocecal transient, whereas SSRI accelerate orocecal transit so its efficacy in IBS-C needs further confirmation.

Reducing stress may reduce the frequency and severity of IBS symptoms. A recent systematic review by Park et al (2014) revealed positive effects of relaxation therapy on IBS symptoms in adults. NICE clinical guidelines recommend that consideration should be given to psychological treatment strategies such as cognitive behavioural therapy (CBT), hypnotherapy and/or psychological therapy such as deep or abdominal breathing, progressive muscular relaxation, guided imagery, visualization techniques, yoga, Pranayam, meditation etc.

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

- ☒ Patients with schizophrenia are violent.
- ✓ Studies indicate that patients of schizophrenia are no more violent than normal individuals. People with schizophrenia are more likely to be victims of violence than perpetrators.
- ☒ Patient with schizophrenia can never recover.
- ✓ For a majority if schizophrenia is diagnosed quickly and treated aggressively there is a good prognosis for being able to live comfortably in society.
- ☒ Schizophrenia treatment requires hospitalization.
- ✓ Most of the times hospitalization is not required except in case of acute exacerbations in which self-harm or harm to others is suspected.
- ☒ Patient with schizophrenia can't do anything.
- ✓ Patients have specific interests and potentials in different areas. A famous example is of great Mathematician John Nash who won a Nobel Prize in Economics after recovering from schizophrenia.

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. Alexithymia is

a) Pathological sadness b) Affective flattening c) Inability to recognize feelings d) Inappropriate mood

2. Hallucination more commonly a feature of organic brain lesion is

a) Visual b) Auditory c) Olfactory d) Tactile

3. Order of loss of orientation in patient with delirium is

a) Time, place, person b) Place, time, person c) Person, time, place d) Person, place ,time

4. Confabulation is defect of

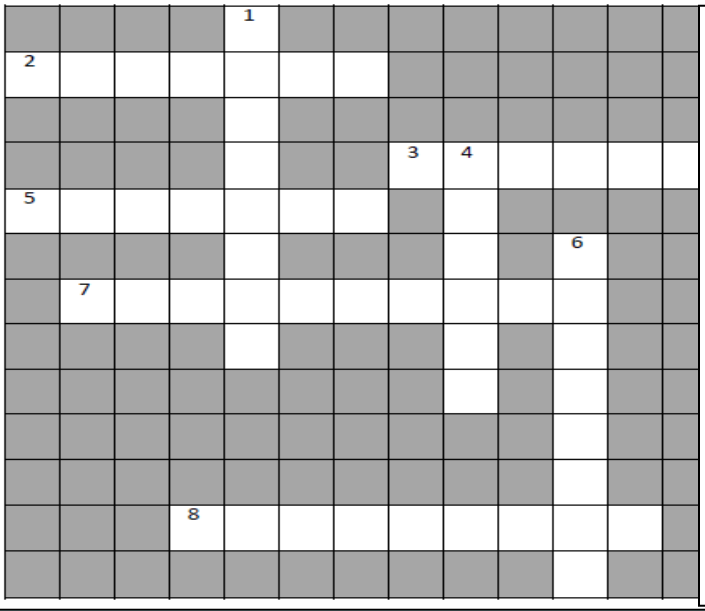
a) Memory b) Attention c) Concentration d) Intelligence

5. Most common substance abuse in India is

a) Alcohol b) Tobacco c) Cannabis d) Opium

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

Can you cross the crosswords!!!



Across

2. Feeling of apprehension
3. Absence of emotion –lack of interest
5. Loss of memory
7. Fear of strangers
8. Sadness or hopelessness

Down

1. Fixed and false belief that cannot be changed
4. Irrational and disable fear
6. Pervasive, unwanted suspicious and mistrust of people

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

ANSWERS:

MINDS QUIZ

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

CROSS WORDS

ACROSS

2. Anxiety
3. Apathy
5. Amnesia
7. Xenophobia
8. Dysphoria

DOWN

1. Delusion
4. Phobia
6. Paranoid

uick Response Code for the Website

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