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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 Editor — Stigma within Us

Is there anybody who is happy to be ill or not worried at all on learning that he is ill? Ranging from emotional and social reactions to being ill, variations occur in inflammatory markers like CRP, kinins, IL-6, neurosteroids and even the hippocampal structures, indicating biological changes. These can occur in response to stress, in all types of illnesses, and especially in chronic disorders. That all illnesses have a psychological angle is well known, and they deserve some interest in the psychiatric perspective. Whether this progresses to a diagnosable mental disorder or not, the involvement of the mind is most often ignored, not because of ignorance but because of the stigma that these disorders evoke. This is unfortunately happening in the well learned and highly intellectual members of our own fraternity. Well, it would be useful if we could pose ourselves one single question. How many of us are ready to get ourselves or our close relatives treated for even mild mental disorders, even after it has been diagnosed and we are aware that it can be treated. As doctors, if we bear stigma deep in our minds and are unable to step out of this zone, we would definitely not be able to address the issue of stigma in the patient's relatives, making our treatment efforts rather incomplete. Working on stigma is essential to make true WHO's definition of Health, with each of us contributing in our own little way.

- Dr. Gopal Das. C. M

Guest Column: Down The Memory Lane... — Unmarried Female Patient!

I was a senior resident then .I was eager to learn & teach. There was an unusual patient. She was 28 yr. old, unmarried. She was brought with history of harassing a married man. She claimed that they were in a relationship and later he abandoned her for another lady. She frequently visited his house and was compelling him to marry her. Owing to the social embarrassment caused by her behavior, her family had brought her for Psychiatric evaluation. With lot of enthusiasm to work up an unusual case & teach the students, I had multiple interviews with her. I was attempting to elicit a borderline personality history.

Within next few weeks, I joined a medical college. To my surprise, this patient followed me to the new hospital and insisted on seeing me. Also she started expressing romantic feelings towards me. My efforts to send her back to the previous institute were in vain. Our psychologist, other doctors and even group 'D' staff, who tried to convince her to leave me alone & go back, failed. She was insisting that I loved her.

She started coming more frequently to OPD & would wait for me for long hours. Some days, I had to escape from OPD through back door. Later she traced my phone number and started calling me at home. My wife's counselling also was futile. She would call my number 20-25 times till midnight. Those days, I had developed phobia for phone ringtone. One day while I was starting my bike, she suddenly came & snatched my bike key & went away. I walked back home helplessly. Next day she came back and returned the keys. I had tried to explore her personality and had become a victim of her delusion of love. Since then, I learnt a lesson to be very cautious with unmarried female patients and especially those with personality disorders.

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Neuropsychiatric aspect of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infection (PANDAS)

Pediatric Autoimmune Neuropsychiatric Disorders associated with Streptococcal infection (PANDAS) is a unique constellation of signs and symptoms that exist in a subset of children with rapid onset or exacerbation of obsessive-compulsive disorder (OCD) and/or tic disorders. This is due to an initial autoimmune reaction to a Group 'A' Beta Hemolytic Streptococcal (GABHS) infection which produces antibodies that interfere with the basal ganglia function. According to the National Institute of Mental Health (NIMH), five clinical characteristics that define the PANDAS group are the presence of OCD and/or tic disorder, pre-pubertal age of onset, abrupt onset and relapsing-remitting symptom course, association with neurological abnormalities (adventitious movements or motor hyperactivity) during exacerbations, and a temporal association between symptom exacerbations and a Group-A beta-hemolytic streptococcal (GABHS) infection.

In addition to the OCD and tic symptoms, these PANDAS children experiences a variety of other neuropsychiatric symptoms, including emotional lability, irritability, temper tantrums, hyperactivity, inattention, separation anxiety, handwriting changes and enuresis etc.

The relapsing–remitting course of PANDAS is in striking contrast to the gradual onset and persistent symptoms typically seen in childhood-onset OCD and also differs substantially from the waxing and waning course of tic disorders.

Treatment for the PANDAS subgroup of children with OCD is not different from treatment of others with this diagnosis. Use of combined behavioral therapies and low doses of selective serotonin reuptake inhibitors (SSRIs) has been recommended. Children with PANDAS appear to be unusually sensitive to the side-effects of SSRIs and other medications, so it is important to ''start low and go slow'' when using these medications. A throat culture should be done and if it is positive, a single course of antibiotics will usually get rid of the streptococcal infection and allow the PANDAS symptoms to subside. IV immunoglobulin therapy is generally recommended only for severe or persistent cases.

Group A Streptococcal infections being highly endemic in India, it is likely that the prevalence of PANDAS is relatively higher as compared to non-endemic regions; however, very little information regarding this is available in the Indian literature. This can be attributed to an inadequate awareness regarding this disorder and infrequent liaising among the various specialties. A good cross referral between the pediatricians and the psychiatrists can serve in decreasing and eliminating the morbidity and the disability associated with this disease.

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Trichotillomania

Trichotillomania is a disorder characterized by inability to control over pulling one's own hair from various parts of a body resulting in noticeable hair loss. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), places trichotillomania in the category of obsessive-compulsive and related disorders. Though the exact etiology of trichotillomania is not known, the genetic, environmental and temperamental factors are distinguished. Individuals with trichotillomania has higher risk of comorbid mood disorders, especially Depressive disorders and frequency of anxiety symptoms are higher. Common co-occurrence of other body focused impulse control disorders like skin picking and nail biting has been noted.

Hair pulling can occur in any area of the body where hair grows. The scalp is the most common area, followed by the eyelashes and eyebrows. Patients frequently complain of unexplainable alopecia or hair loss, because they typically conduct the pulling or plucking behavior in private and often deny engaging in it especially children. Sometimes patients may report hair loss related directly to hair pulling or plucking. Some individuals tend to avoid social situations so that they can maintain the privacy to engage in hair-pulling behavior. Sometimes patients may present with anxiety associated with their hair-pulling behavior. This common presentation consists of areas of hair loss with broken hairs of varying lengths arranged in a circular pattern, with unaffected hairs surrounding the area of hair loss (Friar Tuck sign). Dermoscopy shows black dots, coiled hair, shafts of varying lengths with fraying or split ends.

A high index of suspicion is essential for the diagnosis. Often it is misdiagnosed as alopecia areata or tinea capitus. The specific DSM-5 criteria for trichotillomania (hair-pulling disorder) are as follows:

- Recurrent pulling out of one's hair, resulting in hair loss
- Repeated attempts to decrease or stop the hair-pulling behavior
- The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The hair pulling or hair loss cannot be attributed to another medical condition (e.g., a dermatologic condition)
- The hair pulling cannot be better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance, such as may be observed in body dysmorphic disorder)

Currently available evidence suggests that the first line of treatment for trichotillomania is behavioral treatment and intervention, with a focus on self-awareness & affective regulation. Habit reversal training is a specific type of behavioral intervention with established efficacy. A psychiatrist should be consulted when a serious psychiatric disorder is suspected. Selective serotonin reuptake inhibitors (SSRIs) have been tried in few cases.

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REFRAME -Let Awareness Reframe assumptions: Myths & Facts about 'Stress'

☒ *Stress is the event or situation which creates pressure on us*

✓ Stress is actually the response of our body to those environmental, physical and social events and situations which are called stressors.

☒ *Psychiatric illnesses are always caused by stress*

✓ Psychiatric disorders are multifactorial and often stress precipitates and accelerates an underlying vulnerability to develop into a clinical syndrome and often maintains it.

☒ *Taking vitamin pills and herbals cure and prevent stress*

✓ Stress management is a holistic and behavior oriented program which focuses on lifestyle modification along with medication whenever needed and is not as simple that few vitamin and herbals at market cures it and prevents it.

☒ *Stress management strategies are same and anyone can make use of it*

✓ Stress is highly individualistic and so are the stress management strategies. So it has to be tailor made and practical enough to implement it.

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

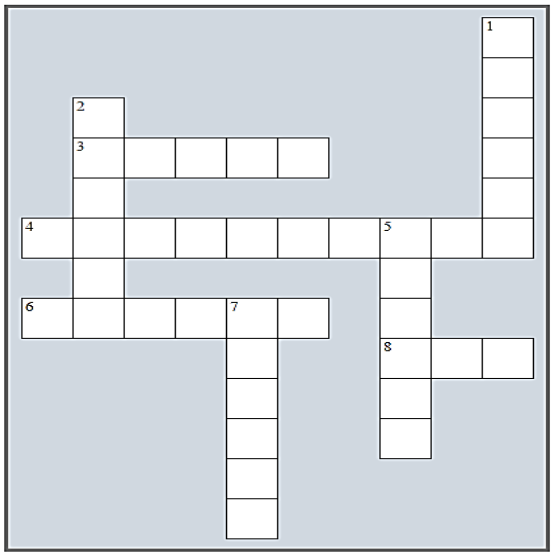
UG n PG

MINDS QUIZ

1. **Who among these described the *Grief cycle***
   (a) Jean Piaget (b) Kubler Ross (c) Otto Veraguth (d) Carl Jung
2. ***World Mental Health day* is observed on**
   (a) September 10th (b) April 7th (c) October 21st (d) October 10th
3. **All of these are used in treatment of *Parkinson's Disease* ***except***
   (a) Rasageline (b) Amantadine (c) Entacapone (d) Haloperidol
4. **All are used as biomarkers for *alcohol abuse* ***except***
   (a) Erythrocyte Transketolase (b) Gamma Glutamyl Transferase
   (c) Carbohydrate Deficient Transferrin (CDT) (d) Mean Corpuscular Volume (MCV)
5. **Which area of the brain is called *the reward center***
   (a) Amygdala (b) Thalamus (c) Nucleus Accumbens (d) Hippocampus

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

3. Named syndrome of delusional parasitosis and infestation
4. Perception of vivid familiar patterns from a random stimulus, usually visual
6. Neurodevelopmental disorder characterized by impaired social interaction, language and stereotypies.
8. Involuntary spasmodic stereotyped movement of small groups of muscles

Down

1. Persistent, pathological, unrealistic, intense fear of an object or situation
2. Feeling that current situation is already seen or experienced
5. Hormone secreted by adipose tissue which inhibits hunger
7. Widespread generalized responses of the body to various situations or events

ANSWERS

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

CROSS WORDS
ACROSS
3. Ekbom
4. Pareidolia
6. Autism
8. Tic
DOWN
1. Phobia
2. Dejavu
5. Leptin
7. Stress

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