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MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 6 *Issue 9* *September, 2016*

From the Desk of Editor — Connect, Communicate and Care

'Suicide' – In the recent past, a commonly heard 'breaking news' in every news channel, sensationalized in all possible and sometimes inappropriate ways, has become cliché. It is however, not so for the bereaved, as also for those in the health profession. It is, for us, an issue that bears great importance, and one that we cannot dismiss lightly. Suicide is moving up constantly in the charts of the leading causes of death and currently ranks second, in the age group of 15-29, the very group that is the future of every nation. According to WHO, globally, 40 persons commit suicide every second and 25 times more than this number attempt suicide! It is a multidimensional event, resulting from a complex interaction of bio-psycho-social factors, and not just the result of mental illness. Many a times, it is an event that can be prevented. Stigma attached to it is immense and poses a huge hurdle in prevention of the event at the community level. Suicide prevention interventions can be at three levels: *Universal* – targeting general population, *selective* – targeting high risk groups, and *indicated* – known/vulnerable cases. We as health professionals have a role in each of these levels, with the maximum possible contribution in selective interventions. Identifying and reaching out to those who are at risk is of utmost importance. Hence the theme – *"connect, communicate and care"* adopted by International association for suicide prevention (https://www.iasp.info) on this year's *World Suicide Prevention Day on September 10th.*

Guest Column: Down The Memory Lane... — Covert Medication

I recall my experience of a long time ago when the term 'covert medication' was yet to be coined. I maintained that the primary interest was, as always, patient care and welfare. The ethics and sensitivity of surreptitiously giving medication was not given much thought. The issue seemed very clear – the patient was very sick, was refusing medication and hence had to be treated for his and the family's sake.

Mr X came accompanied by his sister to discuss his wife's 'illness'. She suspected his fidelity, tracked his movements, was quarrelsome and argumentative got easily agitated and was losing sleep. Her behavior had worsened over time and as a result her day to day routines were affected. She blamed him for all the problems, refused to take professional help and felt he needed treatment. Hence he requested that she be given medication so that when she improved she would cooperate and come for a consultation. His sister agreed with him. I prescribed Haloperidol liquid telling him how to use it and asked him to be in touch with me while educating him of possible EPS. He was advised that she should be brought for consultation at the earliest. He reported a week later saying that he was not able to give her the medicine regularly as she was very vigilant. But he felt that his speech had slowed and he was feeling stiff. He exclaimed, 'I think she has been giving me the same medicine.'

It transpired that she went to discuss her problem with a psychiatrist who suggested that she gives her husband this medicine and report to him!

My views on covert medication have evolved since then. I feel, in order to avoid mishaps like this, patient clinical care should factor in ethical sensitivity.

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

Substance use disorders in adolescents- an overview

Background: The adolescent substance use has become a major public health concern worldwide including India. World Health Organization estimates say that 25-90% of children have ever used a drug. National household survey from India reports that adolescents constitute around 20% of all current drug users. Majority of the adult drug users initiate substance use during adolescents with 'Gateway drugs' like tobacco, alcohol and inhalants which are licit and easily available. Longitudinal studies found that earlier is the age of initiation of substances, greater is the chance of developing substance use disorder in adulthood. Moreover, they are also at a higher risk of lifelong negative consequences that include academic failure, chronic health problems, and violent crime. Substance use is strongly associated with the leading causes of death among US teenagers including motor vehicle crashes, unintentional injuries, homicides and suicides. Substance use also contributes to a large number of other health problems, such as depression, conduct disorder, and unplanned sexual activity. Identification and treatment of substance user adolescent poses challenge on the health system.

Etiology: There are multiple behavioral, environmental and familial risk factors that make adolescents more likely to initiate and continue substance use. It has been shown that as the number of risk factors increases, the likelihood of adolescent substance use greatly increases. Early age of onset of drug use increases risk of drug related problems in future. The risk factors are as follows: a) Behavioral characteristics- Impulsivity, Aggression, Sensation seeking, Inability to delay gratification, Lack of religiosity, Psychopathology; b) Environmental factors include- peer pressure, affiliation with deviant or delinquent peers, easy drug avail- ability and relaxed laws and regulatory policies; c) Familial facto- stressful life events, deficient parental support or supervision, parental and sibling sub-stance use; d) Co-morbidity-psychiatric comorbidities like Attention Deficit Hyperkinetic Disorder, conduct disorder.

Diagnosis: As treatment seeking rate is poor among adolescents, screening for substance use during visit to a physician may improve the rate identification. Screening tools like CRAFT are used routinely for the purpose of screening. The HEADSS acronym is a guide for the psychosocial interview for adolescents that ask about Home, Education, Activities, Drug and Alcohol Use, Sexuality, And Suicide. If the screening indicates a possibility of substance use, an in-depth interview is carried out. Depending upon the presence of various symptoms like craving, withdrawal, tolerance, preoccupation and few other, diagnosis of dependence, harmful use or abuse to a certain substance is made using diagnostic systems like DSM-5 or ICD-10. These are few indicators with which adolescents are referred to a physician by parents or teachers:

- ✓ Problems controlling mood and behavior
- ✓ Inability to concentrate in the classroom
- ✓ Often found drowsy during the classes
- ✓ Change in Academic Performance
- ✓ Absenteeism
- ✓ a change in peer group
- ✓ loss of interest in favorite activities
- ✓ deteriorating relationships with family members and friends
- ✓ changes in eating or sleeping habits
- ✓ Weight loss
- ✓ Bruises and other marks on arms or other vein-laden areas (neck, behind knees), bloodshot eyes, sniffling nose, dilated pupils, etc.

Management: The treating physician must ensure confidentiality to build up trust with adolescents and to minimize drop-out. The treatment of adolescents with substance abuse should take into account age, sex, ethnicity, cultural background, and readiness to change. It involves a system of professionals like pediatricians, psychiatrists and therapeutic interventions which include pharmacological agents and psychological interventions like motivational interviewing, brief intervention, as well as family and community support.

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Obesity and psychiatric disorders – Endocrinologist's perspective.

Obesity is a medical condition in which excess of body fat has accumulated to the extent that will have a negative impact on health. Currently obesity is one of the leading causes of non-communicable diseases like type 2 diabetes, coronary heart disease, osteoarthritis and OSA. Obesity is due to genetic susceptibility, excess of food intake and lack of physical activity.

Obesity and psychiatric diseases are interrelated, probably at genetic origins as well. Impaired appetite regulation, emotional regulation, circadian rhythm and related endocrinal disturbances and disordered eating behaviors often co-exist even before the onset of psychiatric disorders as well as clinical obesity. Recent studies have showed that, in obese peoples there is increased incidence of mood disorders like major depression, dysthymia and maniac and hypomanic episodes. Food is often used as a coping mechanism by those with obesity particularly when they are sad, frustrated and lonely. In many obese patients, there appears to a perpetual cycle of mood disorder, over eating and weight gain. In addition to depression, anxiety, other problematic eating behaviors are mindless eating, frequent snacking on high calorie diet, overeating and night eating. Binge eating disorder (at least 2 days /week over 6 months) causes weight gain. Obese patients are usually compared with peers and are criticized. They internalize themselves putting them at risk of mood disorder, anxiety, substance abuse. They usually suffer low self-esteem and feel uncomfortable with their bodies (body image dissociation). So behavioral therapy should be involved in the program of lifestyle modification along with diet and exercise in obesity.

Some of the Antidepressant drugs are associated with significant weight gain- Paroxetine, Amitriptyline, and Mirtazapine. So in patients with obesity and depression use of drug which are weight neutral like Bupropion and fluoxetine can be substituted. Many of the newer Antipsychotics drugs were associated weight gain as a side effect, for example- Olanzapine, and Risperidone, whereas Ziprasidone and Aripiprazole have lesser risk of weight gain compared to other drugs. Some of the endocrine diseases associated with obesity (Cushing's syndrome and hypothyroidism) have underlying psychiatric manifestations like depression, anxiety and psychosis. So while evaluating for psychiatric diseases with obesity always looks for endocrine causes of obesity.

Obesity often contributes to cause and effect of psychiatric disorders and hence for effective management of obesity, underlying psychiatric problem should be addressed.

Dr. Raghu M S, MD, DM, Consultant Endocrinologist at JSS Medical College Hospital, Mysuru, KA. Email: dr.msraghu@gmail.com

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

☒ *Mental Illnesses are the cause for suicide*

✓ Though mental illnesses are a major factor for suicide, it is not always associated with mental illness nor is suicide a mental illness by itself.

☒ *If a person often threatens to commit suicide for trivial problems, it can be safely ignored*

✓ Any communication regarding suicide, in whatever form, should never be ignored but assessed appropriately

☒ *A person who is scared of dying will not commit suicide*

✓ There is no evidence for this statement but in fact this may be risk factor by itself for a suicidal attempt

☒ *Talking openly about suicide with patients may stimulate them to commit the same*

✓ Discussing about suicidal ideations actually helps in better understanding of patient's problems and also helps in preventing the same

☒ *Advising not to commit suicide and telling about the moral values and consequences would make patients revise their decisions to kill oneself*

✓ Helping patient to cope with the problem is the key rather than over-enthusiastic and premature advices or lectures during counseling. In fact this is better avoided as it may not be prudent but rather worsen the scenario.

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

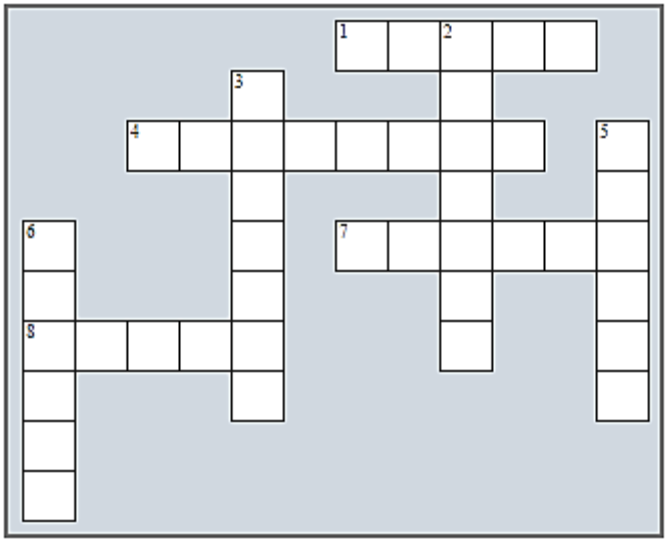
UG n PG

MINDS QUIZ

1. **Who among these first used Electro-convulsive therapy on a *human subject*?**
   (a) Karl L Kahlbaum (b) Ugo Cerletti (c) Friedrich Meggendorfer (d) Ladislas J Meduna
2. **Which of these would be the *last choice* in treating a patient with suicidal ideations**
   (a) Fluoxetine (b) Lithium (c) Clozapine (d) Electro-Convulsive Therapy
3. **Electro-convulsive therapy is known to have established efficacy in all of these *except***
   (a) Catatonia (b) Resistant seizures (c) Resistant depression (d) OCD
4. **Which of these is the *most consistent* risk factor for suicide**
   (a) Current Mood Symptoms (b) Family history of suicide
   (c) Past history of Suicidal attempt (d) Family History of Mental illness
5. **Which of these marker is more likely to be *found low* in CSF of suicide victims**
   (a) 5-Hydroxy Indoloacetic acid (b) Vanillyl Mandelic Acid (c) AcetylCholine (d) Dopamine

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. Psychodynamic psychotherapy based on the principles of psychoanalysis (5)
4. Classified psychosis as manic depressive psychosis and dementia praecox (8)
7. Theory of self-actualization (6)
8. Individual psychology which saw individuals as unique biological entities (5)

Down

2. Epigenetic principle which is the basis of stages of ego development across the life cycle (7)
3. Phenomenological approach in psychiatry (7)
5. Mother Child attachment central to attachment theory (6)
6. Cognitive development in children based on principles of genetic epistemology (6)

Compiled by Mr. Saurav Nayak, Final MBBS, AIIMS, Bubaneshwar (Odisha)

ANSWERS

MINDS QUIZ

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

CROSS WORDS

ACROSS
1. Freud
4. Kraeplin
7. Maslow
8. Adler

DOWN
2. Erikson
3. Jaspers
5. Bowlby
7. Piaget

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