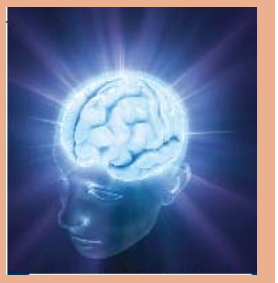

MIND

Your Wellbeing begins here…

MONTHLY NEWSLETTER ON PSYCHIATRY FOR DOCTORS & MEDICAL STUDENTS

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From the desk of Editor

An Innovative Library!!!

There is growing concern that medical students are restricting themselves to examination oriented books rather than reading recommended books and their interest in exploring new books has reached low level in the past decade. Not many are aware that most of the library books in medical colleges cannot be borrowed by students, either they have to be read within library or one should buy a personal copy. Reasons for restricting the borrowing facility are many & that varies from one institution to another. These rules may deprive some students an opportunity to explore the book at their own pace and place. More over students now a days fancy e-books which will increase drastically in near future and e-books are easy to use & carry but most libraries do not have any collection of e-books for free, which may be due to legal issues.

One of the ways to increase student's interest in exploring books is starting Innovative library practices wherein each department can keep a collection of books, which are largely the books gifted by the department or consultants from various sources like publishers, authors, pharma or a willing consultant's personal collection of books and wide e-books collection from all possible sources. These collections can be kept outside the institutional authority but under in-charge of one voluntary student & a faculty; rules of usage can be designed based on mutual interactions. One such Innovative library practice is being experimented at Adichunchanagiri Institute of Medical sciences and students are excited. It's a mutual learning process when we start something new but it does kindle interest among students about books & also attracts talents towards a specialty.

Dr.Kishor.M, Consultant Psychiatrist, Mysore

Guest Column: Down the Memory Lane……

How do I Understand This Case?

Once, Dr. Royadu narrated to me a clinical incident in his practice when he was a general practitioner in Ranibennur. A male daily-wage labourer from a nomadic tribe attended his clinic with severe pneumonia and fever. Explaining the seriousness of the illness, the doctor advised him a course of treatment. The patient wanted to know the approximate cost. After being told, he told the doctor (English translation of North Karnataka dialect), "Doctor, I have to go to work tomorrow to earn money. I have just ten rupees with me now. If you can cure me with this, please do so. Otherwise, I will get back to my family and die peacefully."

When I heard this, I was immediately wonderstruck at this labourer's commitment to his responsibilities, courageous inner-strength, submission to circumstances beyond his means, and more importantly, his sense of contentment in suffering. Here was a man who was not afraid of suffering (symptoms of pneumonia), nor afraid of dying! His sole concern was his responsibility to go to work next day to earn his wages, for which he sought remedy with the resources he had. Beyond that, he was ready to face the consequences peacefully!

I heard this story during the years I was preoccupied with defining mental health. The question, 'how to understand this?' still haunts me. Besides his pneumonia, could he have been mentally ill? Conversely, was he a living example of ideal mental health, irrespective of the sequel to his physical health?

By Dr. C. Shamasundar
Former Prof. of Psychiatry, NIMHANS, Bengaluru

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Consultation Liaison Psychiatry

Focus: Pediatrics; Psychogenic (non-epileptic) seizures (PNES)

Pseudo seizures are attacks that look like epileptic seizures, but are not caused by abnormal electrical discharges. They are better termed as Psychogenic (non-epileptic) seizures (PNES) or non epileptic attack disorders and older terms pseudo seizures or hysterical seizures are discouraged. PNES are a physical manifestation of psychological disturbance and is a somatoform disorder with unconscious production of physical symptoms. PNES falls in to category of conversion disorder with seizures in according to (DSM-IV). PNES are not rare; seen in 20-30% of patients referred for refractory seizures. PNES typically begin in young adulthood (10-18 years) and more frequently seen in women (≈ 70%).

PNES are suspected when the seizures have unusual features. A Specific triggering factors such as traumatic events with, physical or sexual abuse, incest, divorce, death of a loved one, or other great loss or sudden change, can be identified that are unusual for epilepsy. There will be preserved awareness, eye flutter and episode affected by the bystanders. Epileptic seizures are abrupt in onset, eye opening/ widening, tongue biting, ictal cry, post ictal confusion or sleep. Physical and neurological examination in PNES is usually normal. Resistance to antiepileptic drugs in patient diagnosed as epilepsy is usually the first clue for the diagnosis. In malingering and factitious disorders, patient is purposely deceiving the physician or faking symptoms. Somatoform disorders including PNES are real conditions that arise in response to real stresses; patients are not faking them.

The most reliable test for diagnosis is continuous EEG-video monitoring. A small proportion (10%) of patients also have epilepsy. It is important to rule out absence seizures, complex partial seizures, epilepsy with mental retardation, frontal lobe epilepsy.

Most important step in initiating treatment is communicating the diagnosis! Since most of the patients are previously diagnosed as organic disease (eg, epilepsy), there can be disbelief, denial or anger as a reaction. Treatment may involve psychotherapy, stress-reduction techniques (such as relaxation and biofeedback training), and cognitive-behavioral therapy. AEDs should be gradually (not abruptly) stopped. No need to limit activities. No increase risk of motor vehicle accidents.

With proper treatment, the seizures eventually disappear in 60- 70% of adults; the percentages are even higher for children and adolescents. Young patients generally differ from adult patients only in that the stresses are typically less severe. An important factor for better outcome is the early diagnosis.

Dr.S.Suguna *MD*

Assistant Professor of Pediatrics. AIMS

REFRAME: **AWARENESS REFRAMES ASSUMPTION**

MEDICATIONS USED IN SLEEP DISORDERS: MYTHS & FACTS

- ✘ Medications are mainstay in Management of sleep disorders
- ☑ Sleep Hygiene is very important in management of sleep disorders along with recommended usage of medications tailored to patients condition and advised use for specific time period. Caffeine, Alcohol, Tobacco and sleeping in day time should be avoided for better sleep along with regular wake up time.
- ✘ All medications used for management of sleep disorders cause dependence
- ✓ Except Benzodiazepines other medications such as Non Benzodiazepines Sedative Hypnotics like Zolpidem do not cause dependence but some withdrawal features are known to occur when stopped suddenly.
- ✘ Once patients are started on medications for sleep disorders, they have to be continued for rest of life
- ☑ Medications used sleep disorders are recommended for limited period based on evidence based medicine and guidelines of National/International expert groups. It is best to seek information from treating psychiatrist/physician
- ✘ Medications used for sleep disorders disturb normal sleep pattern
- ✓ Newer class of medications recommended for sleep disorders restore and maintain near normal sleep.

By Dr Aparna Subramaniam,Intern, AIMS

FOOD FOR THOUGHT: FOR UGS, INTERNS - YOU CAN WRITE ON "INCREASED NEED FOR CHILD & ADOLESCENT PSYCHIATRY, AS A EMERGING SUBSPECIALITY " IN NOT MORE THAN 500 WORDS AND BEST WRITE UP WILL BE POSTED IN MIND NEWSLETTER GROUP OF FACEBOOK. LAST DATE FOR SUBMISSION IS 25TH, APRIL 2012

Invited Article

STRESS AMONG HEALTH PROFESSIONALS: NEED FOR RESILIENCY

Stress is a consequence of or a general response to an action or situation that places special physical or psychological demands or both on a person. Small amounts of stress ('eustress') can have positive effects by energizing people towards goal, however excessive stress can seriously and negatively impact a person's health and job performance.

To start with, getting into the medical education is like passing through the proverbial eye of the needle. Trainings are long and tedious.

Health-care is a stressful profession and takes its toll at physical, emotional, and mental levels. To effectively care for other people you must take good care of yourself. Medical service involves taking care of other peoples' lives and mistakes or errors could be costly and sometimes irreversible. It is thus expected that the medical doctor and other staffs themselves must be in a perfect state of mind devoid of morbid worries and anxieties. This is however not usually the case because the doctor apart from being affected by the same variables that impose stress on the general population, is also prone to stress because of the peculiarities of his work situation, sleep deprivation, repeated exposure to emotionally charged situations, dealing with difficult patients, conflicts with other staffs and the expectation of the society at large.

The doctor is still perceived as a very comfortable person in our society and expectations are usually high financially and otherwise. Inability to 'meet up' may constitute a significant stress factor in some physicians. Hostile job environment, administrative ineptitude bureaucratic bottlenecks, unavailable/obsolete equipments, unsecured future, delays in promotion and inappropriate capacity utilization can make the job situation very frustrating. This could be compounded in our environment by denied holidays and lack of manpower. Stress creates a health cost to patients in terms of the risk of poorer quality care that is received by patients from stressed or dissatisfied staff. Medical professionals especially doctors are at increased risk for divorce and suicide. Gender specific differences have also emerged with higher stress in women. The 'burnt out phenomenon', a terminology made popular by Felton consists of a triad of emotional exhaustion, depersonalization (treating patients as if they were objects) and low productivity/achievements.

Several factors determine whether an individual experience stress at work or other situations – Subjects perception of the situation, past experience, personality, social support.

Managing stress requires the utilization of basic resiliency skills. What is resiliency? In physics, it is the ability of a material to quickly return to its original form after being bent, stretched, or twisted. Psychological resiliency is the ability of people to return to normal by bouncing back from the ups and downs of life. An optimistic attitude is one of hopeful expectation for positive results. It is this optimistic attitude that pulls resilient people through hard times and puts them back into shape.

The second element of resiliency is to know how to manage stress. Avoid whatever stress by saying "No" and to set limits and also practice unwinding from stress. Such unwinding may be through physical exercise, practice of meditation or yoga. Unwinding from everyday stress can be as simple as taking a slow, mindful walk. The ability to manage stress makes workers more efficient.

The third characteristic of resilient people is that they enjoy life by making the intentional choice to participate in it. Lastly, the medical curriculum should include courses on stress management.

Stress is not what happens to us. It's our response to what happens and response is something we can choose!

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UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

UG n PG

MIND QUIZ

by Dr.Chaitra VHM, Intern, AIMS

Answers at the bottom of page

1. Cognitive model of depression is given by,
   (a) Ellis (b) Beck (c) Godfrey (d) Meicheinbanon

2. Reflex hallucination is a morbid variety of-
   (a) Kinesthesia (b) Parasthesia (c) Hyperesthesia (d) Synanaesthesia

3. Formication and delusion of persecution occurs together in-
   (a) Cocaine (b) Amphetamine (c) Cannabis (d) LSD

4. Somatic passivity is seen in:
   (a) Schizophrenia (b) Depression (c) Body dysmorphic disorder (d) Delusional disorder

Can you CROSS the CROSSWORD?? !!

Across

5. A psychomotor symptom seen in schizophrenia (9)

6. Disease of inability to fall asleep (8)

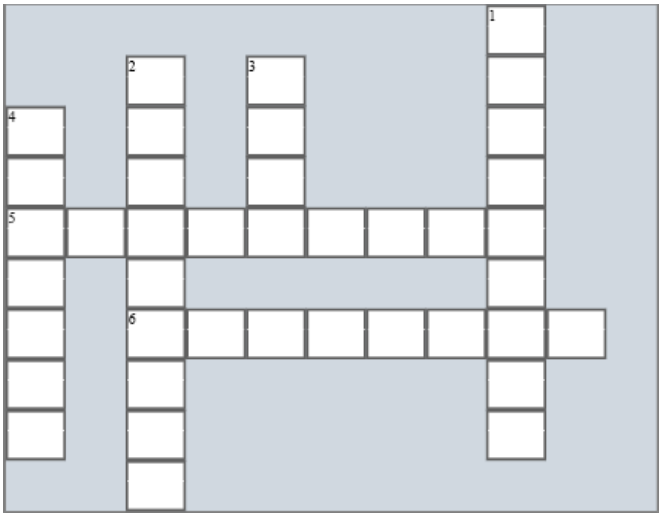
Down

1. Atypical antipsychotic causing agranulocytosis (9)

2. Restlessness caused by anti Psychotics (9)

3. This syndrome is a part of infantile spasms (4)

4. Tactile hallucinations are seen in dependence (7)



LEVEL: NOT SO EASY ANSWERS: GIVEN BELOW

Created by

Dr. Aashish S Nayak MBBS

Answers

MIND QUIZ
1.Beck
2.Synesthesia
3.Cocaine
4.Schizophrenia

CROSS WORDS
ACROSS
4.Catatonia
6.Insomnia

DOWN
1.Clozapine
2. Akathisia
3.West
4.Cocaine

Your opinion is important to us, so feel free & write about the MIND Newsletter to editormind@gmail.com