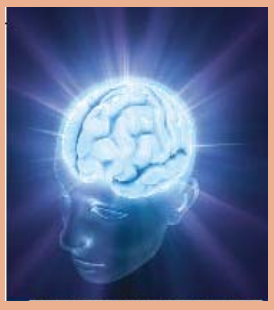

MIND

Your Wellbeing begins here…

MONTHLY NEWSLETTER ON PSYCHIATRY FOR DOCTORS & MEDICAL STUDENTS

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9886412530

Sherin & Thejus of AIMS, who won at IPS-South Zone quiz along with Sri Sri Nirmalanandanatha Swamiji and Principal, AIMS

Dr. Kiran Kantanavar, Intern, AIMS, presenting research paper in Psychiatry at Osmania University & BMC.

From the desk of Editor

Between Regular & Odds, standardizing mindset of faculty to that of students!

Although it has been debated for long on whether it should be mandatory for students to attend required number of classes in medical colleges or is it just enough for student to display necessary skills at end of each term, the mandatory attendance is unlikely to change in near future. Most students feel that 70-80% attendance should be made more liberal. Teachers by far have no objection to that, provided students show necessary knowledge & skill, because learning should not be optional for students once they join medical college. It's here, probably that teachers need to know felt needs of student to certain extent and help them to understand how vital is their knowledge for patients care.

Every batch of students splits in to two group that of Regular (who could clear exams) and Odd batch (those who couldn't clear at some stage). Though no significant differences exist in these groups but their needs seem to be different purely because of overlapping internals, exams, current and carry over subjects. This in turn leads more irregularity for classes, clinics & lack of rapport with teaching faculty. Considering these factors, the teacher has to be in continuous mode of understanding students, thereby benefitting them to maximum extent. It may be rewarding to persistently encourage feedback from students & upgrade teaching to their requirement, finding newer ways to teach what might be essential and to never underestimate even a single student.

Dr.Kishor.M, Assistant Professor in Psychiatry, AIMS

Please Note

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The faculty and students of AIMS can contact
Dr. Kiran Kantanavar, Intern (+917411569877) for hard copies of Newsletter.
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Invited Article

ALTERED BEHAVIOUR IN ADOLESCENCE – NEED FOR EARLY RECOGNITION

The transitional stage of physical and mental human development occurring between puberty and legal adulthood is 'adolescence'. It is derived from a Latin word 'adolescere', meaning 'to grow up'. It is characterized by a number of cognitive, emotional, physical and attitudinal changes. These changes promote personality development on the one hand, and conflict with the surrounding adults, on the other. It is at this phase of life that they begin to view friends and peers as being more influential than their parents. In search of a social identity, they tend to drift away from parents and home in many ways. The stress imposed on them at this stage is immense, making them more susceptible to imbalances in mental health. Sometimes, it becomes difficult to differentiate between normal reaction to their stress, and the onset of mental illness. It thus becomes important for the parent to be vigilant when any altered behaviour emerges.

A healthy adolescent usually copes with most issues that he is challenged with, functioning adequately academically, as well as being socially comfortable with peers and family alike. Some adolescents exhibit irritability, resistance to parental desires, or disregard towards family decisions. Such changes in behaviour, in excess, could well indicate a need for early evaluation.

A withdrawn adolescent, who appears sad and may be found crying at times, with a declining academic performance, could be suffering from a depressive illness. At times, they could be abusive, irritable, quarrelsome and refuse to fall in with family regulations. As opposed to this, if the student were to be making plans well beyond his reach is seen to be excessively happy and cheerful, or overactive, irritable, spending much more money than usual, it is possible that a mood disorder, mania, might be causal.

Despite an average or even good academic performance, some adolescents begin to decline in performance in their late teens. This could be due a variety of causes. However, if this feature is compounded with the person becoming progressively withdrawn, remaining secluded or exhibiting any altered behaviour, it could be a matter of concern. It is possible that they would develop suspiciousness and experience others being against him in some way; abnormal belief's about others controlling him, or hearing voices when no one is around. They would then need a detailed evaluation as they are likely to have a psychotic illness, possibly schizophrenia.

Anxiety is a normal phenomena experienced by most students during their examinations. When it is so severe as to affect their daily routine or their academics, they would need to be brought for help. Excessive cleanliness, much more than the adolescent is used to, repeated washing, checking, or orderliness that hinders his daily routine or affects the family members needs a detailed evaluation for obsessive compulsive disorder or personality disorder.

Missing classes in college regularly, lying about their whereabouts, requiring more money than usual, should raise a suspicion of whether the adolescent has turned to the use of substances (drugs). The current trend through all classes alike is the use of solvent substances, due the easy availability and the affordability.

The fact that adolescents perceive themselves as adults and as '*I do not need guidance of any sort*', and the fact that they seek independence at this phase of life, makes any intervention by the family very difficult. Parents should however stay tuned to their adolescent and pick up any issues early in order to deal with them effectively.

Dr. Lakshmi V Pandit is Professor in Psychiatry at Kempegowda Institute of Medical Sciences

She has keen interest in Child and Adolescent Psychiatry & can be contacted by lvp4562@gmail.com

FOOD FOR THOUGHT: FOR UGS, INTERNS, AND PGS OF AIMS - YOU CAN WRITE YOUR OPINION ON "MANAGEMENT OF BIPOLAR AFFECTIVE DISORDER" IN NOT MORE THAN 500 WORDS AND WIN SURPRISE GIFT FOR THE BEST WRITE UP! LAST DATE FOR SUBMISSION AT DEPARTMENT OF PSYCHIATRY IS 25TH NOV, 2011

Announcements

-> Indian Rheumatology Association is conducting CME for UGs and PGs @ JSS Hospital, Mysore, on 19th Nov 2011. Registration is Free! Please contact Dr. M Mahesh, Assoc Prof of Medicine, JSSMC.Email:doctmahesh@yahoo.com

-> Conference Theme-Parents: Parenting & Partnering, at the XI Biennial National Conference of The Indian Association for Child and Adolescent Mental Health to be held @ St.John's Medical College,17-19 Nov, For registration contact Dr. M V Ashok, Prof in Psychiatry, Organizing Secretary -080-22065290/25526365/25505858

CONSULTATION LIAISON PSYCHIATRY, FOCUS: DERMATOLOGY

Clinically relevant interface between Dermatology & Psychiatry

For generations people have been aware of profound impact the skin disorders have on psychosocial aspects of individuals and vice versa. It is recently that we have been able understand the biological connection between them. Psychocutaneous disorders encompass a wide variety of dermatological diseases that may be affected by the presence of psychiatric symptoms or stress and psychiatric illnesses in which the skin is the target of disordered thinking, behavior, or perception. Important among them are Atopic dermatitis, Psoriasis, Utricaria, Alopecia Areata, Acne Vulgaris, Seborrheic Dermatitis, Trichotillomania and Delusion of parasitosis.

Considering the brevity of space here, only pruritic lesions have been discussed especially the ITCH part! Scratching in response to the pruritus can lead to lichenification, excoriations, and infections. Stressful life events often precede the onset and exacerbation. How stress affects the disorder is unclear, but it may involve interactions between the CNS and the immune system. For example, there is evidence in animal models that corticotropin-releasing hormone (CRH), a principal coordinator of the stress response system, also has pro-inflammatory actions through its activation of mast cells and subsequent release of vasoactive and pro-inflammatory mediators. Well-controlled studies have found adult patients with pruritic lesions tend to be more anxious and depressed than clinical and disease-free control groups. Anxiety or depression may exacerbate lesions by eliciting scratching behavior. In another study of pruritus associated dermatological conditions, depressive symptoms appeared to amplify the itch perception. Many patients report that pruritus is aggravated by emotional distress. Stress-induced pruritus may result from a perturbation of the epidermal barrier function resulting in inflammation and pruritus.

Psychiatric evaluation and treatment is recommended for patients who have comorbid anxiety and depressive symptoms or stressors that may contribute to difficulties in management of the disorder. Different modalities of psychiatric treatment for exist. Some strive to reduce stress and interrupt the vicious circle of itching and scratching. Controlled studies have established that relaxation training, habit reversal training, cognitive-behavioral techniques, and stress management training lead to significant and stable adjunctive treatment responses beyond those of standard medical care, as well as reduce anxiety and depression. Controlled trials of psychotropic drug treatment found that topical doxepin cream was effective in reducing pruritus in dermatitis patients, probably related to doxepin's potent histamine antagonism. Amitriptyline, another antidepressant with histamine receptor antagonism, decreased the fragmentation of sleep and reduced the time spent in stage 1 sleep, which secondarily reduced the amount of scratching during the night.

Overall, liaison with Psychiatry will likely to have better quality of life in such patients & clinicians satisfaction.

FACULTY, DEPT OF PSYCHIATRY, AIMS

REFRAME: AWARENESS REFRAMES ASSUMPTION – ALCOHOL DE-ADDICTION - MYTHS & FACTS

Compiled by –Dr. Pampi Majumder, Resident in Psychiatry, AIMS

- ✘ Once a person quits alcohol after de-addiction he will never relapse again.
- ☑ Majority of patients have recurrent relapse & hence treating team should develop rapport with patients
- ✘ Disulfiram is given immediately once the patient or their relatives seek help for problems due to alcohol.
- ☑ Patients are assessed, whether they are dependent or abusing the alcohol & examined for intoxication, if so then they are detoxified with tapering dose of benzodiazepine & then de-addiction is considered.
- ✘ Alcohol de-addiction can be done without patients knowledge as widely publicized with Disulfiram
- ☑ It is not only unethical & illegal but also dangerous to treat a person without his knowledge with Disulfiram.
- ✘ Alcohol De-addiction involves use of only Disufiram.
- ☑ Most important aspect of management is Motivational Interview wherein patient gets the feedback & decides from the option of medications like Disulfiram/Acamprosate/ Naltrexone etc & Evidence based Counseling.
- ✘ Alcohol De-addiction is a costly process and needs specialized centers.
- ☑ De-addiction can be carried out in any medical institutions at very affordable price.
- ✘ Disulfiram is unsafe and should never be prescribed for Alcohol De-addiction.
- ☑ Disulfiram is the most cost effective drug available when it is used in recommended way & tailored to patient.

UG & PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

UG & PG

MIND QUIZ

1. The first antipsychotic drug discovered was _____
2. Treatment of choice in post partum depression with high suicidal behaviour_____
3. According to WHO ICD-10 classification, Mania can be diagnosed if symptoms persist for_____
4. An antidepressant drug approved in management of smoking cessation _____
5. Among all the known risk factor for suicide, the most important risk factor is_____

Answers at the bottom of page

Can you CROSS the CROSSWORD?? !!

Across:

1. Most common type of delusion is characterized by (8)

3. One of the adverse effects of antipsychotics characterized by abnormal movements (10)

6. Abbreviation for depressive disorder in winter (3)

7. A known culture bound syndrome in India (4)

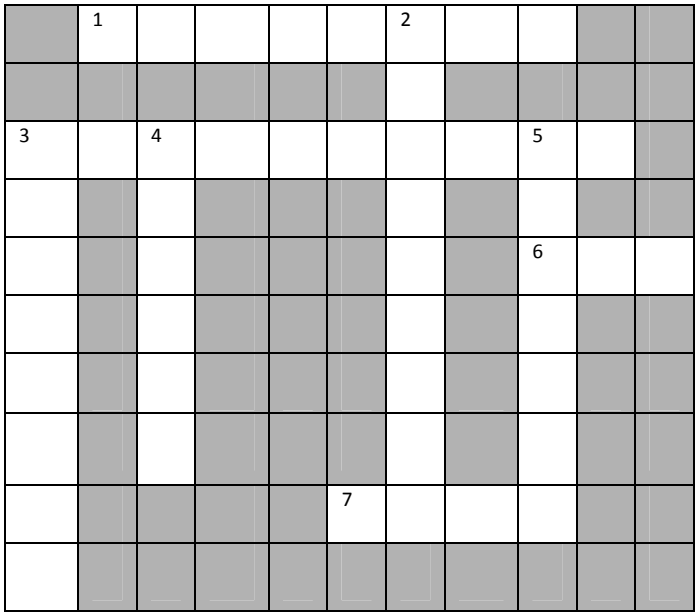
Down:

2. A dream like state although not asleep is called as (8) …… state. E.g. can be during episodes of seizures.

3. Child actor in '*Tare Zameen par'* had (8)……..

4. A state where patient is conscious and alert but doesn't respond to any stimulus (6)

5. Patient is not aware that he has illness i.e., he does not have (8) ……E.g. in Psychotic disorders like Schizophrenia



LEVEL: NOT SO EASY ANSWERS: GIVEN BELOW

Created by
Dr. Aashish S Nayak (Intern), AIMS

Answers

Mind Quiz

1. Chlorpromazine
2. ECT (Electro Convusive Therapy)
3. One week
4. Bupropion
5. Previous attempt

Cross Word:

Across

1. Paranoia
3. Dyskinesia
6. SAD (Seasonal Affective Disorder)
7. Dhat

Down:

2. Oneiroid
3. Dyslexia
4. Stupor
5. Insight

Congratulations!! **Manasa Lingaraju** of 8th term, AIMS has won the prize for best write up on the topic **"AUTISM"**

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