MINDS

Wellbeing begins in our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

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Articles on Psychiatry from over 20 specialities!!

Contribution from More than 50 Authors!!

Seven Sections in every Issue

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From The Desk of the Editor — The "New" Mental Health Care Bill.....What's New?

Finally, the much-awaited Mental Healthcare Bill 2013 was introduced in the Rajya Sabha by health minister Ghulam Nabi Azad on the 19th August, 2013. Drafted in consonance with international commitments, the Bill — that will repeal the Mental Health Act, 1987 — widens the definition of mental illness; the proposed law defines such disorders as "a disorder of mood, thought, perception, orientation and memory which causes significant distress to a person or impairs a person's behaviour, judgement and ability to meet the demands of daily life and includes mental conditions associated with the use of alcohol and drugs but does not include mental retardation". Here are some of the major talking points of the Mental Healthcare Bill 2013:

A. Decriminalizes attempted suicides.
B. The ability to choose treatment options by giving 'advanced directive' to the patients.
C. Ensure equality and dignity for the mentally ill.
D. Medical insurance to cover mental health treatment.
E. Ban on archaic and barbaric treatment methods like direct ECT.

Is it old wine in a new bottle?? Or is it a major stride after 26 long years!!! The bill needs to be debated upon for its logical conclusion.

Dr. Kiran Kumar K., *MD*, Consultant Psychiatrist, Bangalore.

Guest Column: Down The Memory Lane..... The confused patient who convinced me!

This incident happened sometime in early part of 1980's, after I started working in Manipal. When I left the OPD after the day's work there was this gentleman waiting outside the OP whom I had seen as patient that day. When I looked at him questioningly he just nodded to mean nothing. After I started to go to my quarters I found him coming behind me. I could see him following me till I reached my quarters and wondered if he is stalking me. After few minutes of entering my house there was a bell at the door and when I opened the door there he stood with a nervous smile. "Just I want to know the diagnosis you have made in my case." I could recall it and said "Depression." He immediately asked "Neurotic or endogenous?" I knew this person has read about depression somewhere and come prepared to ask me questions. Those were the days we spoke of neurotic and endogenous distinction, the former being 'dysthymia' and the latter 'major depression' in current classification. In fact I thought he would be happy to know that he has neurotic depression, the benign form. To my surprise he looked horrified and said in a sinking tone "Are you sure?" I was bit puzzled and said "What is the matter? Why are you so worried? After all what you have is a minor form of depression." For that he replied in a quivering tone "That means I will have to suffer whole my life with this depression. The endogenous one clears completely in few months. I would prefer to have that", as though I could do him a favour by just changing the diagnosis. With difficulty I controlled myself from bursting into laughter and told him to come next day to discuss about the issue. He left with the disappointment on his large face. I told myself with amusement, "He ultimately has proved that my diagnosis was indeed correct."

Dr. Shripathy M Bhat is a senior Psychiatrist and Professor at KMC, Manipal.

Invited Article

MIXED ANXIETY AND DEPRESSIVE DISORDER (MADD)

This is one of the most common disorders in general practice. Consultants from other specialties prescribe Amitryptiline (Tryptomer) alone or in combination with chlordiazepoxide to most of the patients with so called 'vague symptoms'. If one looks closely, 'mixed anxiety depressive disorder' would be the most common diagnosis that can be given to these patients! Thus these groups of patients have symptoms of both anxiety and depression but neither in sufficient severity to meet criteria for independent diagnosis.

Nosological status: it is classified in WHO ICD-10 under anxiety disorders (Code: F41.2). DSM-IV TR describes this in appendix.

Epidemiology: Information on sex, age at onset, chronicity, course and treatment is less. Thus there is scope for research in this area. Prevalence varies from 0.8- 2.5% in epidemiological studies and from 5-15% in primary care settings.

Clinical Features: Such patients usually report consistent low or dysphoric mood for at least 1 month, accompanied by additional symptoms that include prominent worries, anxious feeling, restlessness along with some autonomic symptoms (tremor, palpitations, dry mouth, stomach churning etc). Often these patients present with somatic symptoms like headache, neck pain, back aches, indigestion etc and mood / anxiety symptoms come up only on enquiry by treating doctor. There may be significant distress but functional impairment is usually minimal. It is important to differentiate this condition from other anxiety disorders, major depressive disorder (meet specific criteria), adjustment disorder (presence of stressful life event), grief, dysthymia etc. It is important to enquire about suicidal ideation in routine practice so that a life is saved by early diagnosis and treatment of severe depression.

Treatment: Pharmacological treatment includes use of Selective Serotonin Reuptake Inhibitors, Serotonin Norepinephrine Reuptake Inhibitor. Medications should be given in recommended doses so that patient is relieved of symptoms. Non-pharmacological treatments like cognitive behavioral therapy, relaxation, yoga are also helpful. Duration of treatment is controversial but it should be for at least 3-6 months after remission of symptoms or for at least duration of past episode if present.

Prognosis: As many as 50% patients may receive lifetime diagnosis of General Anxiety Disorder / Major Depressive Disorder.

Importance: All doctors should be made aware that this condition as it is not so uncommon in general practice, it is often not recognized (miss the diagnosis) causing significant suffering to patients. Referral of patient to a Psychiatrist may be fruitful in order to avoid continuation of morbid state.

Dr. Manik C. Bhise *M.D.* **Psychiatry**
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FOOD FOR THOUGHT: Undergraduates /Interns/Postgraduates can write in their own words on topic "Stimulants in Depression" in not more than 500 words and mail it to editormind@gmail.com. Best write up will be posted in Facebook group of MINDS Newsletter.

REFRAME -Let Awareness Reframe Assumption: **Myths & Facts about Dissociative [conversion] disorders: F 44**

- ☒ Conversion disorder is synonymous with Malingering
- ✓ Conversion disorder is a mental illness characterized by the loss or alteration of physical functioning without any physiological reason. These physical symptoms are the result of emotional conflicts or needs and are unconscious in nature.
- ☒ Hysteria is conversion disorder.
- ✓ Hysteria is used since antiquity, but in reality it is a misnomer (wandering uterus=Hysteria) and hence its use is avoided and use of diagnostic term like conversion or dissociation is considered appropriate and less stigmatizing.

DEPRESSION AND CANCER

"The good Physician treats the disease, the great physician treats the patient who has the disease" said Sir William Osler.

Likewise treatment of cancer patient is not complete if you do not address the associated psychological distresses with the disease. Depression is one of the common psychiatric conditions seen in patients diagnosed with cancer. Fatigue, decreased appetite and sleep problems which are usually considered to be due to cancer and its therapies may be primarily related to depression itself. 40 to 50% of cancer patients have some depressive symptoms before, during or after cancer directed therapy. It has to highlighted here that depression may not be just psychological reaction to diagnosis of cancer. Some cancers like that of head of pancreas may present with depression for the very first time itself, even the chemotherapy and other interventions can impair the biological system, that lead to depression.

Symptom formation:

The word 'cancer' itself brings distress in the minds of patients. It is conceived as a noncurable, painful condition with lengthy, costly treatment and fatal outcome.

The patient once diagnosed with cancer, do not accept the diagnosis initially, may deny it, they take 2-3 opinions, then goes through the phases of blaming his fate, god and may develop depression early.

Series of various diagnostic investigations that the patient undergoes like CT, MRI, PET CT, Endoscopies and biopsy for diagnosis and staging of cancer add to the distress.

Going through various treatments and its associated side effects also cause depression. The changes in physical appearance due to surgical procedures like loss of breast in a woman, facial disfigurement in head and neck cancer surgeries, loss of a limb in extremity cancer surgeries make the patient go through depression.

The chemotherapy with its associated nausea, vomiting and especially hair fall makes the patient avoid social company.

The Radiotherapy side effects like skin and mucosal reactions, diarrhea, swallowing difficulties increase the level of depression which is already there with diagnosis.

The prolonged treatment with its associated financial implications makes the patient feel guilty of being burden to his family and make him depressed.

During follow-up visits also, every time he undergoes investigations, he goes through the fear of re-detecting the disease and depression.

Diagnosis:

National comprehensive cancer network guidelines version 2011, has set a screening tool in the form of distress thermometer to identify the kind of distress the patients are undergoing. Hamilton Depression Rating Scale (HAM-D) and Becks depression inventory (BDI) are the most widely used instruments for measuring the severity of depression.

Remedial measure:

Every patient once diagnosed with cancer should also be evaluated by qualified clinical psychologist or a colleague Psychiatrist, who will diagnose and assess the severity of depression; throughout the course of diagnosis, treatment and follow-up of cancer patient and initiate the necessary treatment. Appropriate pharmacotherapy and psychological interventions help the patient in coping up with all aspects of disease and its management. The family members also undergo psychological distress as the fear of losing their loved one looms over them. It is essential to deal with them also as they form important support group for the patient who is going through the turmoil. This is an important area where more Indian studies are needed. Oncologist, psychiatrist, clinical psychologist should interact & discuss the evidence based strategy to optimize cancer patient care

Dr. Nirmala Srikantia,

Head of Radiation Oncology, BGS Global Hospital, Bangalore.

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

UG n PG

MINDS QUIZ

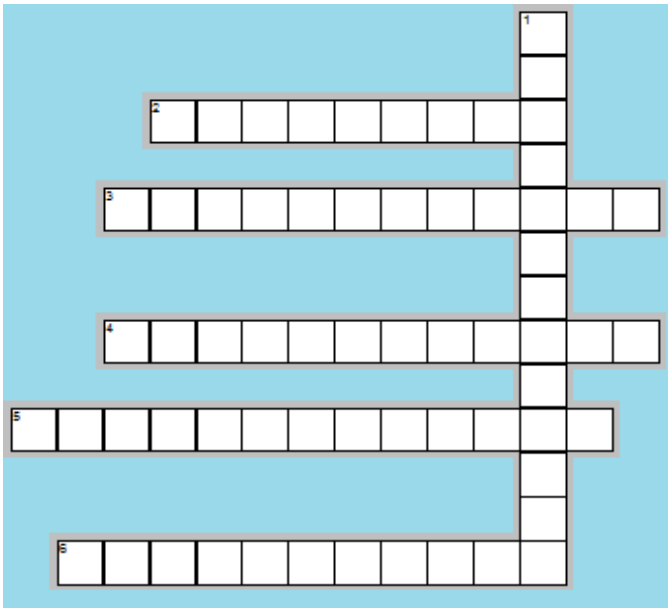
1. Which among the following is a neurotic defense mechanism
   a. Regression b. Humour c. Denial d. Repression

2. All are first generation antipsychotics except
   a. Pimozide b. Haloperidol c. Risperidone d. Thoridazine

3. The onset of autism is usually before the age of
   a. 3 years b. 4 years c. 5 years d. 6 years

4. The person who established new ,humane treatment for inmates of asylum and called morale treatment of insanity is
   a. Johann Reil b. Philippe Pinel c. Benjamin Rush d. Thomas Sutton

Can you cross the crosswords!!!



Identify The Famous Persons!

Across

2. Concept of Archetypes
3. Coined the word 'Dissociation'
4. Theory of Individual Psychology
5. Father of Psychology
6. Introduced the word Eragasiology

Down

1. The four 'A's of Schizophrenia

ANSWERS

MINDS QUIZ
1. Repression
2. Risperidone
3. 3 years
4. Philippe Pinel

CROSS WORDS
ACROSS
2. Carl Jung
3. Pierre Janet
4. Alfred Adler
5. Sigmund Freud
6. Adolf Meyer

DOWN
1. Eugen Bleuler

MINDS Newsletter was launched in July 2011 as a Monthly Newsletter on Psychiatry for doctors & medical students for creating awareness and continued medical education. You can receive a free e-copy of MINDS by an e-mail request to editormind@gmail.com, or by just SMS MINDS to Editor: +91 9886496528/ Asst. Editor: +91 9481819637, or join us **www.facebook.com/minds.newsletter.**

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