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

Assistant Editor
Dr. Shivanand Manohar.,
DPM, DNB
Consultant Psychiatrist
Mysore

E-mail
editormind@gmail.com

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From The Desk of the Editor:
Child Psychiatric Services in India: The Forgotten Majority!!

India has 440 million children i.e. every fifth child in the world is an Indian! In our country, child mental health services have been neglected in the past 66 years after independence. Organized facilities for psychiatric care of children and adolescents are far and few. According to the WHO statistics, prevalence of disabling mental illnesses among children and adolescence attending urban health care centers ranges between 20-30% and 13-18% in rural areas. Out of these children 3-4% are suffering from serious mental illnesses and require treatment. Only one out of the 100 gets some care and treatment and it is high time that we reach out to 99% of the child population that is being unattended by any agency. The first ever child guidance clinic (CGC) in India was started by the Tata Institute of Social sciences, Mumbai in 1937. In the past 77 years the establishment and development of CGC clinics is occurring in a snails pace and the distribution is skewed with majority of the centers located in the urban metros. It is time for a paradigm shift and to use the available resources both governmental and non governmental to establish holistic child guidance centers with an emphasis on prevention, early detection and treatment of mental illness in children.

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

Guest Column: Down The Memory Lane..... The "Art" of Interview

On a busy OP day my resident reported that the patient, a bank employee, he was allotted for detail work up was not co-operative. He was reluctant to give family history and wanted to talk to me. After making him wait for some time I could call him in. He wanted to talk to me alone. After I sent my resident out the patient asked me if the family details are essential. When I said it would help us to understand his problems better he hesitated for a while and then said: "Doctor, I do not mind telling you that I am born to a prostitute and I do not know who my father is. But I can tell you that my present problems are not due to this fact. I respect my mother for the way she brought me up, gave me education and cared for me. I do not think that she has deprived me of anything I deserved so far. What I am today is due to her dedicated efforts. She has even got me married and I have a loving wife and two children. I have stress at present at my work place and that is why the physician has referred me to you. I did not like to reveal these facts to a junior doctor when I do not know how he would react to them. Am I wrong in doing so?" I did not have a prompt answer to his question as I could empathize with him.

I wonder how often situations like this prevent our patients and their relatives from giving us the facts and may be force them to provide false information to cover up. On such occasions when patient &/or the informant is reluctant to provide an information, may be it is prudent to defer it till such time that its relevance is evident or there is adequate rapport.

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

Invited Article

Nocturnal enuresis

Nocturnal enuresis is a very common condition and has occurred since man's earliest days and the first references may be found in the Ebers papyri of 1550 BC. “Enuresis” is a term which literally means “to urinate within”. The International Children's Continence Society states that nocturnal enuresis is the intermittent involuntary loss of urine that occurs only at night in children five years of age or older without an underlying organic disease as the cause. At five years of age, 15 to 25 percent of children still continue to wet the bed. With each year of maturity, the percentage of bed-wetter’s declines.

Classification of Enuresis:

According to time of day: Nocturnal enuresis/ Diurnal enuresis

According to presence of other symptoms: Monosymptomatic nocturnal enuresis / Polysymptomatic nocturnal enuresis.

According to previous periods of dryness: Primary enuresis/ Secondary enuresis

Proposed mechanisms:

Disturbances in sleep arousal to a full bladder, defect in nocturnal release of vasopressin(which causes increased water absorption and reduced urine production during sleep) hence excessive overnight urine production, reduced bladder capacity caused by overactive bladder.

Risk factors for nocturnal enuresis include: genetic influences, delay in attaining bladder control, constipation, faecal incontinence, daytime urinary incontinence, sleep apnoea, psychological factors.

Assessment consists of a thorough history, physical examination, frequency/volume charts, specific questionnaires, sonography, urine analysis and urine culture.

Interventions used for treating nocturnal enuresis include pharmacological and behavioural. Behavioural interventions include fluid restriction(pre-bedtime fluid intake), lifting (carrying the child, while still asleep, from the bed to allow them to urinate in an appropriate place), scheduled wakening, reward system using positive reinforcement (e.g. star charts) and bladder training (including retention control training), Alarm training. Other nonpharmacologic treatments include hypnosis, biofeedback. Psychotherapy aimed at addressing underlying psychological causative factors and modifying the environment which produced the symptoms. Desmopressin (by decreasing urine volume at night) and imipramine (anticholinergic effect) are the primary drugs used in the treatment of nocturnal enuresis. Pharmacologic treatment is not recommended for children under six years of age.

To conclude nocturnal enuresis is socially and emotionally stigmatizing and can affect self esteem, peer relationships and educational opportunities of sufferers ,hence the need for individualized treatment approach taking into account both the child’s motivation and parent’s perceptions.

“Bedwetting is something children can’t help, and they almost always grow out of it.”

Dr. Sreelatha P Kumar, MBBS, MD; Assistant Professor, MVJ Medical College, Bangalore.

REFRAME -Let Awareness Reframe Assumption: **Myths & Facts about “Child Mental Health”**

- ☒ Psychiatric disorders in childhood result from bad parenting.
- ✓ Bad parenting can influence, but most disorders have biological basis.
- ☒ Therapy is a waste of time in children.
- ✓ There is best evidence for therapies in childhood disorder.
- ☒ Children with dyslexia cannot learn to read.
- ✓ Dyslexic children can learn to read, but with extra help from parents/therapist.

-Compiled by Dr. Raj Kiran D.

Psychiatric aspects in Paediatric Surgery

Paediatric surgeons often deal with complex congenital birth defects, complex mechanical and functional problems involving children. The very word of "Surgery" invokes apprehension, fear in the parents (Only an experienced parent knows how difficult it is!!!). This is because of the complex nature of surgeries that need to be done, their associated complications and long term sequelae.

Hospitalisation increases the potential for unresolved anxiety in a child, which can produce long term psychological trauma. It is a challenging experience for a child as it involves loss of privacy and independence, disruption of daily routines and separation from caregivers. This can manifest behaviourally, emotionally, and psychologically as nervousness, aggression, anger, fear of mutilation, guilt, pain or rage. It may be difficult for the treating surgeons to spend adequate time with the child or family to address all these issues. It is here that the role of a child psychiatrist or a consultation liaison psychiatrist cannot be over emphasized. They provide immense help in tackling psychiatric, psycho-physiological, socio-familial or behavioural problems involved with the family.

Just to cite some examples.....

- A child with Ano-rectal malformation, having completed all stages of surgery (Usually requires 3 surgeries in High/Intermediate varieties) and still continuing to have fecal incontinence is commonly teased by his/her peers, poses a constant stress to the family. She/he gradually becomes withdrawn, may develop psychiatric issues. Psychiatrists need to play a great role in treatment of these children to bring them back into the society, help them lead a normal/near normal life.
- A male child, operated for Hypospadias (a condition where the urinary meatus is located on the ventral aspect of the penis rather than the tip) and had some complications is again teased by his peers for his inability to pee like others .
- A child who is having urinary incontinence due to bladder neck or sphincteric problems is always wet, smelling of urine. He may not be allowed to school, again teased by his peers with constant parental stress.
- A child with Neural tube defects like Meningomyelocoele who needs clean intermittent catheterization or daily enemas to keep him/her dry is always a burden to the family.
- Children with malignancy requiring surgery, chemotherapy, radiotherapy; complications associated may put down an entire family.

Child psychiatrists can play a major role in providing psycho-pharmacologic expertise, family interventions, grief counseling, behaviour modification and therapy to help children cope with their illnesses. In a "liaison" capacity, they can also serve as a resource for physicians, nurses and other professionals. Finally, a team work between the treating Surgeon, Paediatrician and Psychiatrist will help in a long way in the better treatment of these ailing children and bring them back to the society and help them to lead a life as normal/near normal as possible.

Dr.Raghunath.B.V, MS, M.Ch., FPMIS, Assistant Professor, Department of Paediatric surgery, Rajarajeswari Medical College, Bengaluru.

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

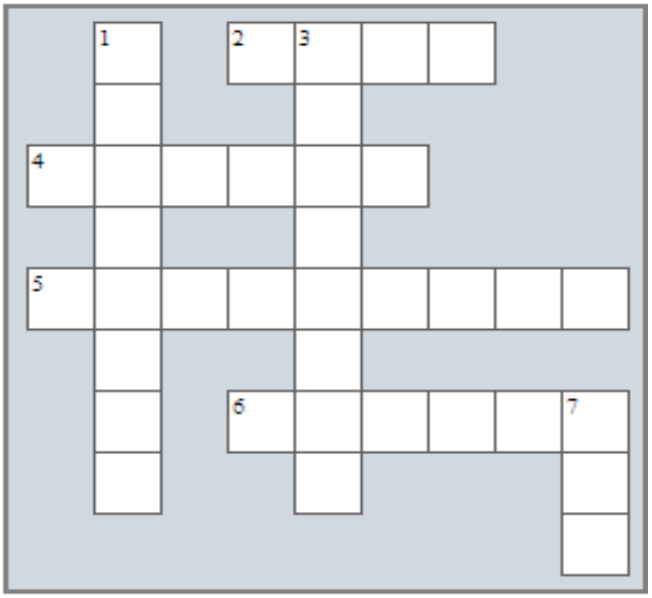
UG n PG

MINDS QUIZ

1. Teratogenic risk for Psychotropic drugs is high between
   a. 1 to 3 weeks b. 4 to 8 weeks c. 10 to 14 weeks d. >14 weeks
2. Treatment of ADHD involves the following drugs except
   a. Amphetamines b. Antidepressants c. Barbiturates d. Lithium Carbonate
3. About Gille de tourette syndrome
   a. Upperlimb Tics b. Appears prior to 7 years of age c. Shouting obscene words d. All of the above
4. Eczema, blonde hair, blue eyes and mental retardation are features of
   a. Phenylketonuria b. Tuberous sclerosis c. Toxoplasmosis d. Cretinism

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:

2. Disorder characterized by poor attention span with distractibility and hyperactivity
4. A pervasive developmental disorder
5. Described 'infantile autism for the first time
6. Has done extensive studies on the nature of children's intellectual development

Down:

1. Repetitive voiding of urine either during day or night at inappropriate places
3. Phonological disorder
7. Sudden, repetitive, abnormal involuntary movement which is purposeless in nature

Compiled by Dr. Smitha Tarachandra.

Quick Response Code for the Website

ANSWERS:

MINDS QUIZ
1. b. 4 to 8 wks
2. c. Barbiturates
3. d. All of the above
4. a. Phenylketonuria

CROSS WORDS

ACROSS
2. ADHD
4. AUTISM
5. LEOKANNER
6. PIAGET

DOWN
1. ENURESIS
3. DYSLALIA
7. TIC

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Enjoy a new way of learning!!!!

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