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: DSM-5: A New Era in Nosology?

As a specialized domain within health sciences, psychiatric diagnostic classification has evolved under the influence of the biopsychosocial model. The complexities inherent in psychiatric nosology are so paramount that psychiatric classifications have been in need of explanation as much as the conditions they are supposed to account for!! The DSM-5 was published on May 18, 2013, superseding the DSM-IV-TR. The new DSM-5 is organized under 3 sections and the following striking changes are present;

- Change from Roman to Arabic numeral system to have the manual be more amenable to updates in psychiatry and neuroscience (e.g., DSM-5.1) and, therefore, more of a "living document".
- Upcoming ICD-10-CM codes are in parentheses after the current ICD-9-CM codes.
- Elimination of multi-axial system. DSM-5 has moved to a nonaxial documentation of diagnosis (formerly Axes I, II, and III), with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V).
- Reordering of chapters that loosely follow a developmental pattern and that groups disorders with overlapping features/symptoms.

As clinicians, we want a nosological system that is easy to use with good validity and reliability, can guide treatment decisions, provides useful information about likely disease course and outcomes, and allows us to easily communicate about disease nature with patients, families, payers, and health care administrators. Hopefully the current DSM-5 classificatory system will ensure all of the above.

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

Guest Column: Down The Memory Lane…… The Idiosyncratic Abbreviation

During the PG days at NIMHANS, once we, my friend and I, were discussing some academic stuff in the ward. There was a junior PG sitting along. The junior remarked that she was unable to understand our discussion as we were using many abbreviations. We started explaining the abbreviations to her. Meanwhile a patient, who was on a bed nearby, an engineering student not being able to continue his course due to schizophrenia, came to us and started saying something which we could not understand because of gross disorder of form. It was totally incoherent. The junior told him "I am unable to understand what you are saying." To this he said, "That is because I am also using abbreviations." This particular sentence of his was the not only coherent, it was relevant too. Having said this he went away. It was obvious that he was listening to our conversations. I remember this incident as it made me think whether the persons with schizophrenia do really use 'abbreviations' of their own. My search for the answer lead to read about thought disorder in schizophrenia and in fact I realized that the 'metonyms' and 'neologisms' they use have some resemblance to the abbreviations we use for our convenience. And the difference is that there usage of such vocabulary happens to be idiosyncratic rendering their speech incoherent.

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

Invited Article

Gender Dysphoria (Gender Identity Disorder)

"There's a gender in your brain and a gender in your body. For 99 percent of people, those things are in alignment. For transgender people, they're mismatched. That's all it is. It's not complicated, it's not a neurosis. It's a mix-up."

~ Chaz Bono, aptly described the condition of a transgender.

Although GID/Transsexualism/Gender Dysphoria gained lot of attention in last few years, it is well documented in Indian mythology in the form of Ardhanarinateshwara, Bruhandda (character lived by Arjun in Mahabharata), Shikhandi (brother of Draupadi) etc. For many years the patients were known as transgenders and Hijaras. But with the modern midas touch of medical advances the picture is changing dramatically by removing the transgender state and making them socially acceptable complete men or women as per patients wish.

To understand transsexuality one must understand concept of sex and gender. Sex is what seen as (external appearance) whereas Gender being the identity what one feels. Feeling of incongruence between sex and gender is called gender dysphoria. Transexualism is extreme form of dysphoria where one feels he or she is trapped in a wrong body. The disorder is found in 1 in 30,000 to 40,000. It is four times more common in males than females.

Etiology is not clear, but many factors are implicated like – genetic factors like 54 genes are linked with gender dysphoria, unusual neurodevelopment like sexually dimorphic nuclei are found in hypothalamus, altered fetal and perinatal androgens, faulty rearing practices and overvaluing opposite gender, absence of same gender parent in childhood etc.

Clinical picture often shows, patients are continually occupied with the desire of being identified by opposite gender, Often cross-dressing, being comfortable with opposite gender troop – boys tends to be more effeminate, girls more masculine. The confirmation of diagnosis is done after following criteria are fulfilled: sense of discomfort and inappropriateness about ones gender; a wish to get rid of ones genitalia and desire to live life as a member of opposite sex; the discomfort has been continuously present over the period of 2 years and is not limited to period of stress; an absence of physical intersex or genetic abnormality and; absence of mental disorder.

Treatment option includes hormonal therapy, sex reassignment surgery, psychosocial interventions and psychotherapy. The patient's battle is mostly long and lonely. The fight is not only against gender identity but initially against self, then family, society, medical, surgical and very much legal too. Being Psychiatrists, it is essential to keep ourselves updated & aware about this sensitive issue, as decreasing the pain of the patient is our first priority, after all its not related to "genitals", it's very much related to "mind "and also felt in mind.

Dr. Pallavi A Joshi, M.D., D.P.M.,
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FOOD FOR THOUGHT: Undergraduates /Interns/Postgraduates can write in their own words on topic "Biology of Suicide" 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 Anxiety Disorders**

- ☒ If a patient is suffering from anxiety disorder, it is important to avoid stress and situations that make him feel "stressed.".
- ✓ Avoiding anxiety tends to reinforce it. It is better to face it than to avoid it.
- ☒ Panic attacks are caused by the curse of demons or gods.
- ✓ The genesis of Panic disorder is based on the biopsychosocial model of etiology.
- ☒ There is no cure for Anxiety disorders.
- ✓ Most Studies implicate that combination of Pharmacotherapy and Psychotherapy bring on remission.

The "Mind" of a Neonatal Specialist

Neonatology in India is probably in the best phase ever. The state of the art Neonatal Intensive Care Units (NICU), the qualified personnel and supporting staff have made this branch of Pediatrics as exciting as ever. The challenges faced day in and day out are tremendous and are to be handled in an intelligent and delicate manner.

The increased survival of Low Birth Weight babies including Preterm, and the survivors of Neonatal Intensive Care admissions, NICU Graduates as we call, have to be followed up closely to prevent future morbidity. The Psychiatric dimension of this rapidly emerging branch has been ignored. The first and foremost role of a consultation liaison Psychiatrist in an NICU setting is to assist parents in understanding the nature and significance of each admission. The liaison psychiatrist is the infant's voices with the families and the staff.

Like all special settings the staff in Neonatal units remain in a constant state of tension often unclear of their own responses. The distorted communication between staff and parents is often seen unless it's coordinated. The Psychiatrist forms a perfect blend of the Profession and the Parental concerns.

Kaplan and Mason, have brilliantly described the stages of parental reactions to the birth of a sick infant.

1. Anticipatory grief and depression
2. Acceptance of the fact of the birth of a sick infant
3. Resumption of relationship to the child
4. Parents come to see infant's special needs and come to act upon understanding.

Usually it is the second stage which is the most difficult and takes longer time but it is totally dependent on the Childs condition. The Psychiatrist plays an important role in this setting.

Caring for premature infants is very stressful undertaking. The staffs' sense of omnipotence is constantly under threat by any unexpected deterioration in the neonate's condition and this may affect the ability to provide optimal care. Many professionals find it difficult to cope with parental inquiries and constant reassurance seeking behavior. A false garb of confidence may provide misleading information which may be very harmful in the long run. The Psychiatrist can play a crucial role here and relieve the professionals of their anxious behavior.

The Psychiatrist can play a very helpful role in running of a neonatal unit. With the psychological aspect effectively handled, allied professionals would be able to work more efficiently. In many units the Neonatologist himself handles complex situations; however psychological care by professionally trained people is reassuring. We are likely to see more and more Liaison Psychiatrists in the Neonatal units in the near future.

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UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

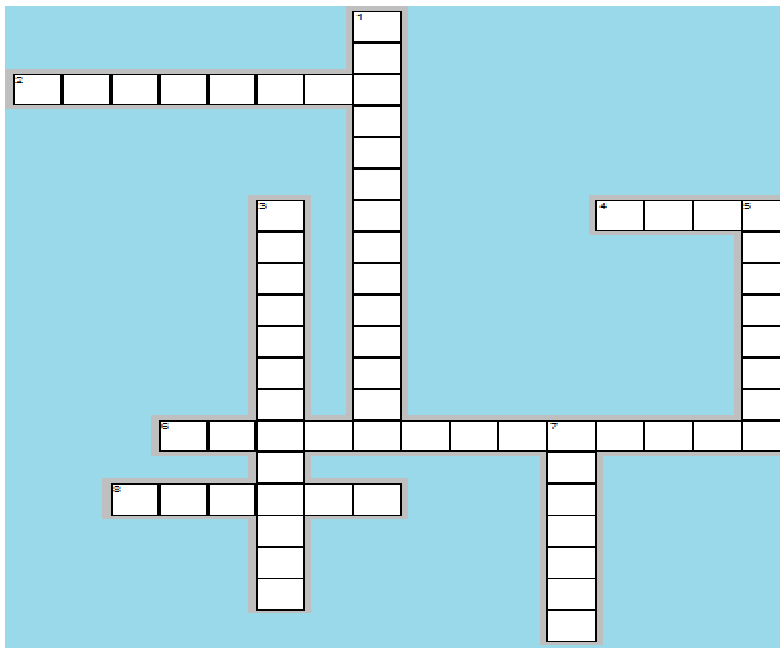
UG n PG

MINDS QUIZ

1. All are parasomias related to NREM sleep except
   a. Confusional arousal b. Sleep walking c. Sleep terrors d. Recurrent Sleep Paralysis
2. Epigenetic psychosexual and psychosocial development was given by
   a. Sigmund Freud b. Eric Erikson c. Margaret Mahler d. Karl Abraham
3. The antidepressant which is most likely to lower the seizure threashold is
   a. Fluoxetine b. Bupropion c. Trazadone d. Mianserine
4. Amotivational syndrome is caused due to heavy ,chronic use of
   a. Cocaine b. Cannabis c. Opium d. None of the above

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!!! Phenomenology



Across

2. Normal range of mood
4. Pervasive and sustained feeling tone
6. Unconscious filling of gaps in memory
8. Dulled emotional tone associated with detachment or indifference

Down

1. Abnormal fear of closed or confining spaces
3. False sensory perception
5. False, fixed, unshakable belief
7. Feeling of apprehension caused by anticipation of danger

ANSWERS:

MINDS QUIZ

1. Recurrent Sleep Paralysis
2. Eric Erikson
3. Bupropion
4. Cannabis

CROSS WORDS

ACROSS

2. Apathy
4. Mood
6. Confabulation
8. Euthymia

DOWN

1. Claustrophobia
3. Anxiety
5. Delusion
7. Hallucination

Quick Response Code for the Website

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