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Monthly Newsletter on Psychiatry for Doctors and Medical Students

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From The Desk of Editor........ MUSIC THERAPY

Music therapy is the clinical and evidence-based use of music interventions to address physical, emotional, cognitive, and social needs of individuals. Music therapy can involve playing music, singing, creating music, moving to music, listening to music, or teaching a person to play music.

Goodman has identified three phases that describe the healing ability of music - magical, religious and scientific healing. The scientific phase started with Greek philosophers like Socrates, Aristotle and Plato. Traditional systems of healing in India such as Ayurveda and Yoga systems include various musical treatment approaches. Human nervous system processes music in different ways - perceptual, emotional, autonomic, cognitive and behavioral or motor processing. Dopamine, endorphins and nor-epinephrine are involved in neurochemistry of music.

Broadly two basic types of music therapy are described - active and receptive. In the active form, the client makes music either alone or with a therapist or within a group, whereas in the receptive form the client is made to listen to music, exclusively. Most common approach used in the Indian form of music therapy is the "raga-based approach." It basically involves the application of musical pieces focusing on the swara patterns. This approach is found to be stimulating, anxiolytic and sedative

There is evidence for benefit of music in people with insomnia. Many studies reported reductions in symptoms of depression among those randomized to music therapy in combination with psychotherapy. In a recent study in patients with schizophrenia found that the experimental group that received music therapy showed significantly higher improvement in positive symptoms, negative symptoms, general psychopathology scores and quality-of-life.

The advantage of music therapy is that it creates an alternate mode of communication to patients who have limited ability to speak and understand language. Music therapy for people with dementia can reduce anxiety, depression and agitated behavior. Substance use disorders and music therapy-studies are going on with positive note.

Studies have been done on children with autism and intellectual disability. The results showed a significant positive effect on communication skills and only marginal effect on behavioral problems. Children with specific reading disability receiving music therapy improved significantly on word decoding, word knowledge, reading comprehension and the test total.

Music therapy has various applications in the field of medicine especially in psychiatry. There is a need for further studies in India.

Sunil Kumar G Patil

I was sitting in my bed room watching the the tree outside in the early hours of the morning. I heard the sound of the cookoo, coo, coo, and was lost in the voice. Suddenly my niece "said aunty see the bird it is black and can't believe its voice is so melodies"!

My thought stuck back where in I was in Psychiatry OPD when I was startled by the voice and its owner.

I was in my psychiatric OPD seeing patients, taking history. Usually commercial sex workers with drug abuse, transgenders who were opting for re constructive surgeries were referred to me for evaluation.

There were three of them, two were for the surgeries. They were accompanied by another lady; this lady was very sophisticated with tight jean and top. Hair was with a modern pixel cut and light make up with dark lipstick. She was dusky and with sharp features. She was very attractive.

The two patients were transgender. I took the history. When questioning them they told that in school they were noticed by their school boys. They were taunted for their looks and behaviour which was like females.

They also said they felt they were females in male physic. They wanted to be females. They were attracted to males. They had sexual contact with Boys in school. After their 10thstd left their homes and started living with the transgender community. Their livelihood is working in a massage parlour and commercial sex work. They had come for reconstructive surgeries.

I asked them is it so necessary to undergo the surgery, Immediately the lady accompanied them said" yes madam" to function completely and satisfy our partner; My god I was shocked to hear her voice, felt a negative feeling. She immediately noticed and said "madam see how your face changed after I spoke, I am also a transgender .I have undergone all surgeries except my vocal cord. I have a partner and living with him from 10 yrs and want to be a perfect wife to him. Only my voice is to be changed and for that I need 3 lakhs. I will undergo! ".

She also said "madam, I am educating my sister who is doing her IAS preparation. My brother is doing BE". I know the pain of being a transgender and I would like to be a voice to fight for them and I help them. I felt small in front of her and became speechless.

Dr. Kasthuri, Associate Professor, Dept. Of Psychiatry, MVJMC&RH, Bengaluru

REFRAME – Let Awareness Reframe Assumptions: Myths and Facts Psychiatric Consultation

- ☒ Psychiatrist only talks! What is this treatment?!
  - ✓ Psychiatrists "Listens" and offers advice on how to cope with issues faced by the patient
- ☒ Psychiatrist will force medications on you
  - ✓ Management plans are almost always would be discussed with patients or relatives depending on insight
- ☒ Consulting Psychiatrist means you are 'CRAZY' , 'INSANE' and 'WEAK'
  - ✓ Acknowledging that you have a mental illness and trying to overcome your limitations is a brave thing
- ☒ Why should I meet a psychiatrist? My family doctor will help me out!
  - ✓ Psychiatrists are trained extensively in Psychiatry, Psychopharmacology and Psychology
- ☒ I stopped taking medications, now I have my symptoms again!, it's the psychiatrists fault!"
  - ✓ Stopping the medication requires slow tapering, which a qualified psychiatrist can do, do not stop or manage medications on your own.

Dr. Mukesh B M, Junior Resident (IIyr), Vydehi Institute of Medical Sciences and Research Center, Bengaluru

Invited Article

Premature MortalityAmong People With Severe Mental Illness (SMI)

Mental illness (MI) accounts for one third of all years lived with disability throughout the world, and despite its tragic position as the leading cause of global disease burden, MI is underappreciated for its impact on overall population health. For instance, over three decades of research into the morbidity and mortality of individuals with severe mental illness (SMI) has consistently revealed mortality rates two to three times higher and a life expectancy of ***25-30 years shorter*** compared to the general population. While public descriptors of people with MI have included *"in need of help","unpredictable","violent" and "dangerous"*, mention of shortened life span or risk of dying is absent. These omissions imply a poorly informed public; SMI is now clearly known to be associated with premature mortality and in this sense should be considered potentially fatal.

Contrary to popular belief, the main causes of premature death are not drug overdose or suicide, but rather, preventable illnesses such as cardiovascular disease, diabetes, tuberculosis and HIV/AIDS. Incidence of other preventable conditions, such as obesity and respiratory disease, is also much higher among patients with SMI. This is aptly expressed by a mental health care professional as "We talk about people with MI and people with diabetes, and smokers and the obese, and so on and so on. We're talking about the same people – just with different labels."

Such findings bring significant questions: what is the cause of this disparity in mortality/morbidity? What can health care professionals do to help reduce this gap? We know SMI being complex disorders with multifactorial etiology, the factors responsible for premature mortality are multimodal.

A recent report by the Early Onset Illness and Mortality Working Group outlines several factors that may contribute to poor physical health of people with SMI. Some factors, such as those related to the **mental illness itself** and **socioeconomic status**. Other contributing factors include **behavior and lifestyle** and **poor preventative medical care**, both of which are more easily modifiable with the assistance of medical care practitioners. Undoubtedly the cause of premature mortality also includes factors like, poor access to care, stigma preventing the seeking of care, reduced insurance reimbursement for mental illnesses, insufficient workforce of mental health clinicians, inadequate funding for research on mental illnesses, and more.

Despite the ***"right to health"*** having become law in 126 countries worldwide, this huge loss of life among people with mental illness needs to be recognized as a human rights disgrace. Key Actions that can be taken to improve both the physical and mental health of people with SMI as proposed by WHO are;

1) Create protocols for both the physical and mental health needs of patients with severe mental disorders in the following areas: prevention, identification, assessment and treatment., 2) Improve access to general health services through the integration of physical and mental health services, 3) Work to overcome the stigma often associated MI and end discrimination that sufferers often endure.

Through education and advocacy, mental health care professionals can improve standards of care to include more comprehensive, integrated, and robust care for mental illness and other medical conditions with a focus on prevention, treatment, resilience, and recovery.

To conclude, individuals with SMI are potentially vulnerable along biological, psychological, and social dimensions, and they may have complex and multiple comorbid medical conditions and diseases, fragile social circumstances, and other co-occurring conditions that contribute to premature mortality. We need to recognize that this work is a far-reaching public health challenge that will require highly coordinated, integrated, multicomponent responses at local and national levels.

Dr. Kiran Kumar K, MD Psychiatry, Associate professor, Vydehi Institute of Medical Sciences Bengaluru

LOOK DEEP INTO THE EYE OF RESTLESS PATIENT

It was a beautiful chilled snowy morning few years back in December. Me and my senior rushed to OPD canteen after finishing morning class and had aloo parata, makkan, cup of tea in a canteen attached to OPD building at around 9.00 am. I was supposed to clear at least 70 to 100 OPD patients usually as any other PGIans.

PGI Chandigarh being an imperial tertiary care research institute and ranked best in India; we usually get referred patients from Haryana, Punjab, J & K, UP, Bihar, other northern Indian states and Nepal.

Our first OPD patient was a fair cute thin young girl, may be in her early 10 years of age, from a remote village in Haryana. Her parents were humble, dressed in traditional Haryanvi attire and had anxious tiered look. Being first OPD patient implies that they are in our campus 1 day prior to OPD appointment and must have stood in Q from 5 am on that day to take OPD card.

Her parents told in sad helpless humble tone in beautiful Haryanvi language that her daughter is not behaving normally. I could sense from her file that they would have consulted few local hospitals, underwent many blood tests and the reason for sad anxious look on her parents face.

Further history taking revealed that her performance in school had gone down dramatically in few years and had repeated absenteeism from school. She used to stay alone in home, avoided playing with her friends and mingling with her relatives. From past few months her world is her home, her 2 little brothers and parents.

I observed that kid while talking to her parents and found she is not comfortable on her chair. I thought its may be due the presence of other patients and their care givers in same room being attended by my co-PGs. Usually 2 doctors will sit in 1 OPD room and we simultaneously see our patients.

I took her along with her parents to examination room to take detailed history and to make her comfortable. While going to room, her gait was not normal. Even while resting on bed, she was not comfortable. She frequently changed positions, picking things whichever she found nearby like bedsheet, window cover and she repeatedly poked her finger into her nose. She couldn't establish eye contact with me, she was very anxious.

I started examining her while talking to her parents. Her vitals were fine, limited general physical examination was fine except for she was too thin for her age and her BMI was low. It was difficult to flex her limbs, all her limbs were rigid. Her respiratory, cardiovascular and abdomen systems were fine except for it was difficult to flex her limbs and all her limbs were rigid.

Thanks to my teachers, seniors, co-PGI friends and exposure to similar past patients. I could sense what I am dealing with. Immediately took my torch and examined her eyes. It looked like a KF ring, and then I called my opthal friend in next building to do a slit lamp examination for this kid. After referring, I continued to attend other patients. As expected, I received call from friend after 1 hour saying, it's a KF ring.

We gave name of WILSONS disease with neuro-psychiatric manifestation to her plight.

We took special care of the patient as her parents were humble gentle villagers. Co-ordinated with our bosses, other departments, completed work up in few days (imaging, endoscopy, rest of necessary blood and urine tests). We started her on Triantine, Baclofen, Clonazepam, Risperidone initially but due to unaffordability Triantine which was imported from elsewhere had to be stopped and was started on Zinc. Patient recovered and recovered in few weeks.

We did screening test to her family for WILSONS disease as it's inherited in autosomal recessive form. Luckily no one had it at that time. Pardon me for not remembering the genetic analysis report of her family. Wish and hope, she and her family is doing fine.

Dr. Yogananda M N, MD Medicine (PGI) Assistant Professor, Bowring hospital, Bengaluru (doctoryogananda@yogisclinic.in)

UG n PG

An exclusive Section for Undergraduates and Postgraduates

UG n PG

MINDS QUIZ

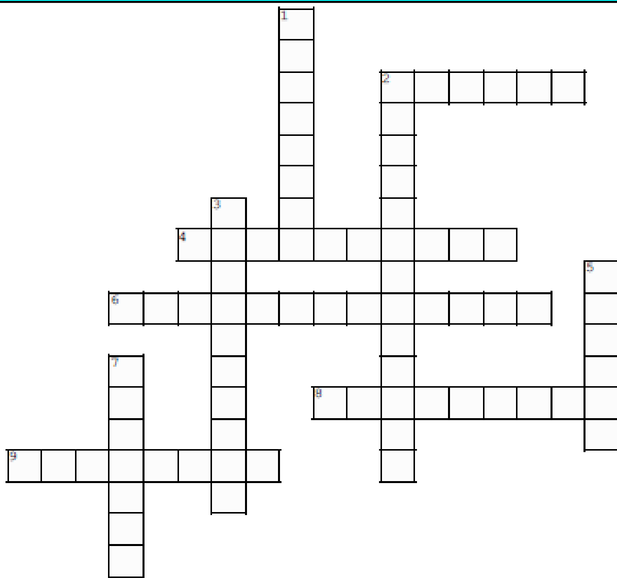
1. The delusional belief that the person is already dead is …….. syndrome:
   A. Fregoli B. Clerambuant C. Cotard D. Ekboms

2. Collective unconsciousness proposed by
   A. Freud B. Adler C. Jung D. Bowlby

3. Which of the following Drugs has High affinity for D4 receptors and low affinity for D2
   A. Clozapine B. Risperidon C. Amisulpride D. Haloperidol

4. Receptors involved for SideEffect of Ejaculatory failure in typical antipsychotics
   A. Alpha 1 adrenoreceptors B. H1 Receptors C. Alpha 2 adrenoreceptors D. D2 receptors

5. Which of the following disorder has equal gender distribution?
   A. Grief Reaction B. OCD C. Deliberate Self Harm D. alcohol abuse



CAN YOU CROSS THE CROSS WORD

Across

2. . Computer programme involving an interviewer and PSE to diagnose psychiatric conditions
4. An illusion caused by increase in attention
6. The effects of Amisulpiride on Tubero-infundibular pathway
8. First rank symptoms given by
9. a cold distant and eccentric person

Down

1. This drug is a Diphenylbutylpiperidine
2. Use of private words in written language
3. Amnesia relating to painful,repressed memories
5. 'Humanistic Theory' proposed by
7. Russell's sign seen in

Dr. Mukesh B M, Junior Resident (IIyr), Vydehi Institute of Medical Sciences and Research Center, Bengaluru

ANSWERS

MINDS QUIZ

1. C
2. C
3. A
4. A
5. B

Dr. Mukesh B M, JR, VIMS&RC, Bengaluru

CROSS WORDS

ACROSS

2. Catego
4. Pareidolic
6. Galaactorrhoea
8. Schneider
9. Schizoid

DOWM

1. Pimozide
2. Cryptographia
3. Catathymic
5. Roger
7. Bulimia

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