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MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors and Medical Students

Volume 7 *Issue 02* *February, 2017*

From the Desk of Editor — Modern Medicine, Religion-Culture & Spirituality

Have we ever thought that what would happen to our advices and prescriptions once patient leaves our consultation room? It may not be as simple as – "I have advised and he would follow it". He goes back to his home which has its own unique bio-psycho-social-religious-cultural and spiritual environment. Patient's response to our advices is strongly influenced by dynamic interactions in this environment. Especially in diseases which are more insidious in the onset, slower in progression and less understood about the outcomes, the above said factors come into foreground. Patients have to adjust, cope and live with the disease (and diagnoses) which demand a lot of change in the above environment. Modern Medicine and particularly psychiatry has been considering biological-psychological and social dynamics in outcomes of chronic and non-communicable disorders like Essential hypertension, Diabetes and most of the mental illnesses but somehow adopted a secular view through decades. Though less discussed, religious-cultural and spiritual aspects in fact play an invisible but significant role in shaping patient's responses, attitudes, coping and adjustment. These are elusive in a routine clinical interaction but when considered and explored, would help in understanding the patient as a complete person and also his responses. Moreover, this would help in devising approaches that feel more friendly and practicable to the patient and help in coping better to the life with disease. It starts with 'not dismissing' the patient's belief models out rightly but in turn respecting it and working our way through those, correcting the myths and taking advantage of good practices.

- ***Dr. Gopal Das C M***

Guest Column: Down The Memory Lane... — Fatal (!?) Greif Reaction

A 54 year old man was brought to my outpatient clinic with the history of abnormal behavior characterized by crying spells, blank staring, unusual laughing to self, reduced interaction and speech, withdrawn behavior and poor self-care, lethargy, reduced sleep and food intake since he lost his son 2 days back in a road traffic accident. Though expected in the context, family members found laughing to self as unusual as he had never behaved this way when he lost his wife 2 years back and never had any hospitalizations or major illness. After a thorough physical and mental status examination, patient had reduced blink rate with blank expression on face, psychomotor retardation and mutism. Patient would follow simple verbal commands though with a delayed reaction time and localized pain accurately. There were no focal neurological deficits and normal reflexes. Differentials of acute stress reaction, grief reaction & catatonic state were formed in my mind and did explain them with a caution that I wanted to evaluate for any possible underlying neurological adversities and hence needs to be subjected to investigations including brain imaging. But the family members somehow seemed pretty convinced about the first few differential diagnoses and did not agree for admission and wanted medicines plus counseling for stress! I had to end up prescribing a sedating antidepressant and SOS basis hypnotic and said let's postpone counseling for next visit! It was only after 2 days they rushed to hospital with the patient in an unresponsive state. They said they did forget telling that patient had several vomiting episodes before as they thought it may had been due to acidity for having skipped meals. Emergency CT brain revealed a large right parital bleed in MCA territory. It's only then they agreed to take him to a more specialized neuro-emergency setup and stopped asking for counseling to make him talk! Time and again, such experiences give us opportunities to take the role as a doctor first and then attempt psychological approach even when there are seemingly convincing clinical picture with something else perilous underlying.

Dr. T. R. Srinivas, Professor & HOD, Dept. of Psychiatry, Basaveshwara Medical College & Research Center, Chitradurga

Dhat Syndrome

The term "Dhat syndrome" was coined by Prof. N. N. Wig to explain the distress resulting from semen loss in people belonging to South East Asian culture. It is considered as a culture bound syndrome of the South East Asia. The 10th edition of International Classification of Diseases (ICD-10), considers it as a distinct diagnostic entity under psychiatric disorders.

In South East Asian culture, the ancient religious texts describe semen to be highly precious. It is considered that semen is formed from food extract, through multiple steps of ultrafiltration; hence much emphasis was given in its preservation. Loss of semen is considered as a threat to the physical as well as mental wellbeing.

Usually, the patients with Dhat syndrome are having poor level of education and often belong to low to middle socio-economic strata. They are young males, who are unmarried or newly married. Over past several decades, researchers attempted to understand the phenomenology of Dhat syndrome. Patients with Dhat syndrome often present with various psycho-somatic symptoms. The clinical manifestations of Dhat syndrome can be classified in following domains.

- *Psychological symptoms*: Anxiety, low mood, worry, apprehension, lack of interest in pleasurable activities, hopelessness
- *Somatic symptoms*: Decreased energy, fatigue, feeling tired, disturbance of sleep & appetite, sexual dysfunction, burning micturition, weakness, backache, non-specific pain symptoms
- *Cognitive symptoms*: Forgetfulness, lack of concentration, illness preoccupation

Often patients attribute their symptoms to semen loss in urine, during nocturnal emission, during defecation, and by masturbation. Atypical symptoms are also been reported, where patients wrongly perceived their mucoid discharge per anum as semen and expressed their undue distress to its loss. An entity similar to dhat syndrome is also being discussed in females of same culture. It has been reported that females of reproductive age give undue significance to non-pathological vaginal discharge and manifest with above mentioned symptoms. They attribute their symptoms to loss of genital secretion. This entity is described as "Female Dhat syndrome".

Psychiatric co-morbidities are very common in patients with Dhat syndrome. Recent multi-centric study on Dhat syndrome revealed sexual dysfunction to be the most common co-morbidity followed by depression and anxiety disorders. As symptoms of patients with Dhat syndrome simulate with depressive disorder, somatoform disorder and anxiety disorder, it is often misdiagnosed. A long term follow up study attempted to see the diagnostic stability of Dhat syndrome. It was found that the diagnosis changes in about two third of patients in long term follow up.

Due to phenomenological resemblance with other psychiatric disorders, instability of diagnosis in long term and high association of co-morbidities, it struggles to maintain its place in the diagnostic system as a distinct diagnostic category.

Suggested readings:

1. Udina M, Foulon H, Valdés M, Bhattacharyya S, Martín-Santos R. Dhat syndrome: A systematic review. Psychosomatics. 2013 Jun 30;54(3):212-8.
2. Kar SK, Sarkar S. Dhat syndrome: Evolution of concept, current understanding, and need of an integrated approach. Journal of human reproductive sciences. 2015 Jul 1;8(3):130.
3. Grover S, Avasthi A, Gupta S, Dan A, Neogi R, Behere PB, Lakdawala B, Tripathi A, Chakraborty K, Sinha V, Bhatia MS. Phenomenology and beliefs of patients with Dhat syndrome: A nationwide multicentric study. International Journal of Social Psychiatry. 2016 Feb;62(1):57-66.

Dr. Sujit Kumar Kar, MD (Psy), Assistant Professor, Department of Psychiatry, King George's Medical University, Lucknow-226003, U.P, India

Trichotelomania and Trichobezoar

Colloquially termed as a hairball, it's a collection of impacted hairs along with ingested food formed in the stomach and sometimes intestine. A commonly described term by veterinary physicians formed in the stomach of animals that is occasionally vomited up when it becomes too big. Felids and rabbits are especially prone to hairball formation since they groom themselves by licking their fur, and thereby ingest it.

Found in people with Trichotillomania - a form of impulse control disorder characterized by a long term urge to pull and ingest hair. Though many people with trichophagia may not clinically develop the bezoar, it's typically seen in young ladies with long hair. An extension of gastric trichobezoar all along the small bowel is termed Rapunzel Syndrome.

There is an intense sense of tension before pulling hair typically gratifying with pulling. It's associated with obsessive compulsive disorder, nail biting, skin picking, tics and eating disorders. Presentation may be with loss of hair on scalp, eyebrows, eyelashes etc. to dermatologists. Some patients with a conscious irresistible urge seek help for impulse control while quite a few may land up as surgical patients with features of vomiting, intestinal obstruction, poor weight gain in children etc.

Its characterized by three distinct age groups- preschool children, adolescents and adults. Preschool children pull their hair unknowingly, usually from the scalp, usually at bed times, along with nail biting and thumb sucking and occasionally sibling rivalry. It follows a benign course with spontaneous resolution.

Preadolescents and young adults, predominantly females are the most commonly affected and are the ones who benefit predominantly with therapy. They tend to have chronic and relapsing courses. Treatment consists of cognitive behavioral therapy (habit reversal training) where the individual is trained to learn to recognize their impulse to pull and also teach them to redirect this impulse. Other forms include biofeedback, hypnosis, acceptance and commitance therapy. Medications with antidepressants have been tried with fair success rates. With the dawn of mobile technology, mobile apps (1st App for Pulling and Picking, PullFree: A Strategy-Based App for Trichotillomania) exist to help log behavior and focus on treatment strategies. Wearable devices and smart watch applications that track the position of users' hands and send sound or vibration notifications can be used to notify users of passive hair pulling.

Adult patients usually have an underlying psychiatric disorder and have a protracted course. They are better served by treating their disorders. Patients with surgical problems require endoscopic or open surgical retrieval of the bezoar.

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REFRAME -Let Awareness Reframe Assumptions: Myths & Facts about 'Grief Reaction'

☒ *Grief reaction is a mental illness.*

✓ *Grief reaction is a normal response after loss of someone/thing valuable. However abnormal grief is coded at various sections in various classificatory systems namely Z63.4 in ICD-10 as uncomplicated bereavement, F 43.2 under adjustment disorders and more recently in DSM-5 under Section – 3 listing emerging measures and models with title Persistent complex bereavement disorder which is complicated grief lasting more than an year*

☒ *Grief reaction occurs only after death of someone*

✓ Though common after death, it can happen before the death – as anticipatory grief and also occurs in case of loss of most valued things in life including organs, job, position and wealth etc.

☒ *Greif reaction has to be treated*

✓ As it is a normal reaction, it is generally not treated with any form of medication or structured psychotherapies but person with grief needs emotional support to cope up better and get back to usual routine earlier.

☒ *Grief reaction is generally severe in females*

✓ It can happen in both genders in various intensities which are determined chiefly by intimacy and importance of the lost person, suddenness of the loss and psychosocial adjustment of the bereaved

☒ *Greif reaction happens immediately after the loss*

✓ It usually happens immediately after the loss but it can happen before the loss as in the case of anticipatory grief and also it can happen as a delayed response days and weeks after the loss.

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

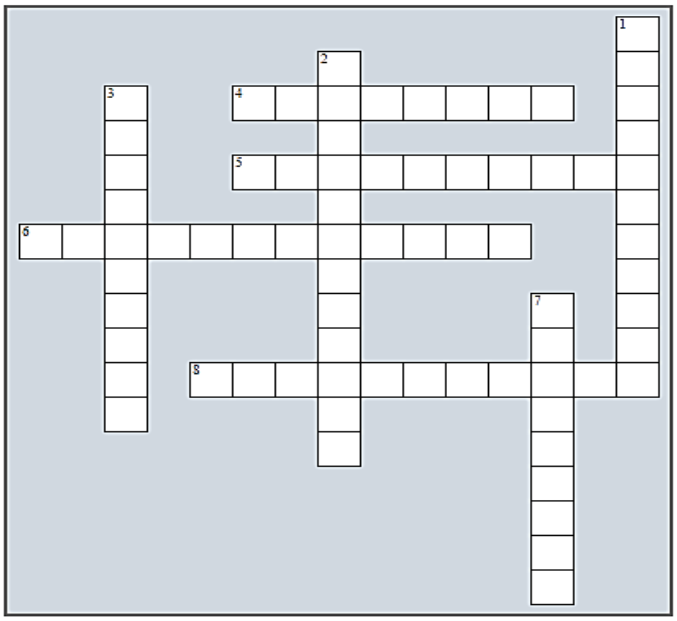
UG n PG

MINDS QUIZ

1. **A young male presented with intense nervousness at places like cinema hall thinking that he would get urgency to go to toilet and gets embarrassed for disturbing others by blocking their view while he walk out repeatedly. What is the likely diagnosis**
   a. Inflammatory Bowel Syndrome b. Claustrophobia c. Agoraphobia d. Panic Disorder
2. **Which of these drugs is known to have its primary action through sigma (σ) receptors?**
   a. Escitalopram b. Tianeptine c. Buspirone d. Opipramol
3. **All except one is not a part of triad of delirium**
   a. Extensor Plantar Reflex b. Reversal of Sleep Wake Cycle
   c. Disorientation d. Imapired attention span
4. **All of these are Ionotropic Glutamate Receptors except?**
   a. NMDA b. AMPA c. Kainate d. GIRK
5. **Concept of Social Learning Theory is given by**
   a. Pierre Janet b. Albert Bandura c. Jean Piaget d. Erik Erikson

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

4. CNS side-effect unique to Clozapine
5. Metabolic syndrome (i.e. T2DM, dyslipidemia and weight gain) is a major adverse effect of this agent
6. Acts as a partial agonist at D2 receptor
8. Atypical anti-psychotic most commonly associated with QTc prolongation

Down

1. Increase in the serum levels of this hormone is a major drawback of the new generation anti-psychotic
2. First FDA approved drug for psychosis associated with Parkinson's disease
3. Effective in bipolar depression
7. Effective in patients with refractory schizophrenia

Compiled by Dr. Swayamjeet Satpathy, Intern, AIIMS Bhubaneswar

QR Code for MINDS website

ANSWERS

MINDS QUIZ
1. c
2. d
3. a
4. d
5. b

CROSS WORDS

ACROSS
4. Seizures
5. Olanzapine
6. Aripiprazole
7. Ziprasidone

DOWN
1. Risperidone
2. Pimavanserin
3. Quetiapine
7. Clozapine

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