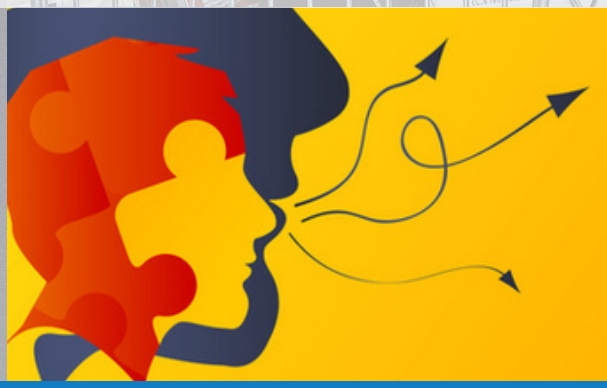
FEBUARY 2021 | VOL 11 | ISSUE 2

MINDS
Wellbeing begins in Our MINDS
MONTHLY NEWSLETTER ON PSYCHIATRY FOR DOCTORS & MEDICAL STUDENTS



EDITORIAL

Changing research paradigm

The clouds of the COVID-19 pandemic seem to be settling with the advent of various vaccines against the coronavirus. World is looking ahead with optimism and a sense of normalcy seems to be prevailing once again. Nevertheless, the sediments of the COVID-19 pandemic would take time and perhaps keep reminding us of the fragility of life on earth. We quickly adapted to newer ways and some of them now qualify as the newly set norm as part and parcel of our lives. One of the most drastic changes observed during a pandemic is the trends in research methodology. It seems that the number of publications has increased sharply during the COVID-19 pandemic with the rapid adaptation to online research tools such as a web-based surveys. No doubt online research tools have strategic advantages in the stringent condition of a lockdown, wherein the other research methodologies are rendered unfeasible. The online survey is quick and cost-effective which makes it the preferred choice for most health and social scientists. The pressing condition of a pandemic demands quicker processing of information relevant to the general public. Hence, most of the COVID-19 related research was exempted from the usual ethical research approval and thus institutes processed articles at a faster rate. Several journals, likewise, published COVID-19 related special issues to bridge the gap of COVID-19 related information. The culture of preprint and faster peer review also has contributed to the inflation of publications during the COVID-19 pandemic.

More so, the government diverted or withheld research funds due to economic slowdown and encouraged research relevant to public safety and the COVID-19 pandemic. Because of lack of funds most social and behavioral scientists turned to use a much cheaper and quicker way of research, which is another reason why online survey tools have flourished. Unlike physical survey, online survey tools capture a wider population and are sophisticated to reach marginalized populations such as LGBT and commercial sex workers. Apart from all these advantages, there are downfalls too. Online surveys attract various errors such as unequal coverage due to the uneven distribution of internet availability and accessibility. There is always the possibility of duplication and keeping the anonymity of an individual is a challenge. Researchers need to be upgraded in their technical knowledge and skills to carry out online research effectively while maintaining ethical standards

Dr. Ajay Kumar

ANSWERS TO THE CROSSWORD ON PAGE 9

Across

2.CAG
4.ADHD
8.FRIEDREICH ATAXIA
9.RETT SYNDROME
10.DANTROLENE

Down

1.VASCULAR DEMENTIA
3.FIBROMYALGIA
5. DOWN'S SYNDROME
6. ROPINIROLE
7.LAMOTRIGINE

Contribution

"AFTERMATH"

We always remember the blazing flame, the last few moments of spark.
But what about the ash that remains, and then the eternal dark?

Sadness comes in waves, but guilt?
Guilt wants to watch us drown.

The first thing you remember is the last thing they said.
And the last thing you remember is every time they wished they were dead.
A dry humour, "Bro, I'd rather die."
And they did. They did die.
And the next time someone says these same words, you wonder.
You wonder if you should've realised; if this was your blunder.
It is jarring to realise that existential crises are 'relatable' to the youth.
Millennial humour is our way of coping to a pain that will never soothe.
But what else are we supposed to do?

After the waves of sorrow and pain, comes a tsunami of regret.
The times you didn't pick their calls, the times you couldn't stay.
The times you dismissed their concerns, the times you made them pay.
The debt is forever unfulfilled- a friendship severed abrupt.
Regret serves no purpose, it doesn't cause enough hurt.
Self-blame, on the other hand, kicks you right into the dirt.
You should've seen the signs, you should've done something.
In their last few days, what joy did you bring?
It's hard to deal with loss, and self-loathing is an excellent distraction
But after some point, it too loses its traction.

The first laugh after bearing loss brings with it, insurmountable burden.
You laugh. You smile. And then the smile fades and you pause.
Because for a fraction of second, you forgot about the loss.
How can you forget about the loss, when the loss is all you are?
The smile stays off for a while, and you are jarred.
Even an inkling of happiness feels like a disrespect to their memory.
And so, you delve into a cycle of pain, sorrow and worry.
A new form of guilt lounges in your head, rent-free.
The guilt that you are living, and the world is yours to see.
That you get to breathe, to smile, to just...be.

Time does not heal all wounds; it just makes you forget.
You miss their face, their eyes, the way their voice is set.
But after a while, the edges of memory get blurred.
You forget their gait, and their favourite word.
The self-loathing has stopped, and you're too tired for the pain.
All you can do is try to honour their memory, even if it's in vain.

Years later, you're watching a movie, and the intrusive thought interrupts-
"She would've loved this, wouldn't she?"
And it hits you- how much of the world she was yet to see.
So you do what you must do,
And you try to see more of the world, on behalf of them too.

Chitra Alse
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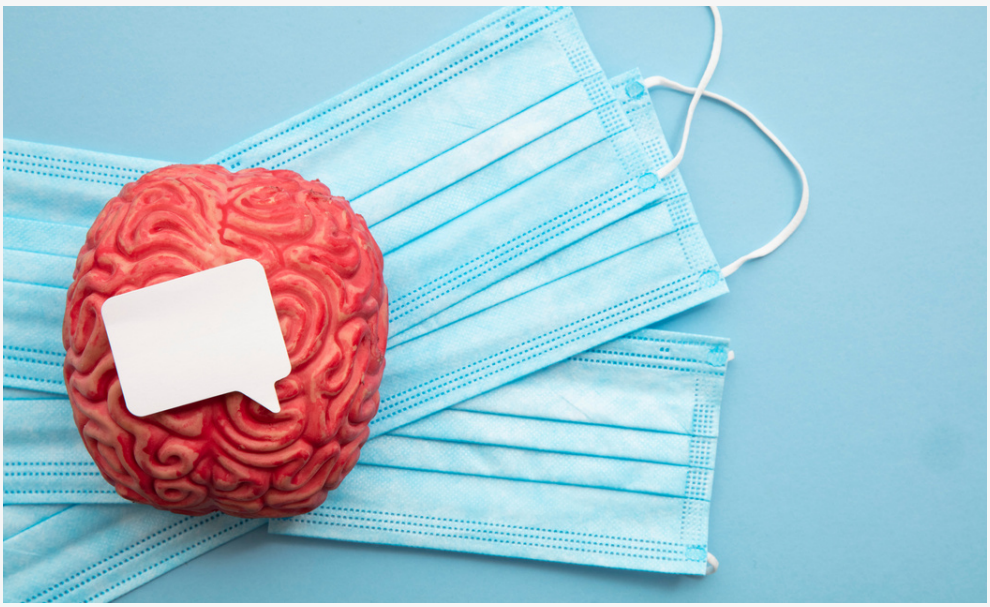
DOWN THE MEMORY LANE

By virtue of being a resident at one of India's premier mental health institutes, NIMHANS, I had good exposure to psychiatry, diagnoses and management of psychiatric illnesses. Case discussions, seminars and solving complicated cases was a challenging journey. At the end of residency, I was very eager to start my practice and test my knowledge in the field. That's when... the roller coaster ride started. Outside NIMHANS the general perception of a psychiatrist is equivalent to that of a counsellor. The knowledge about psychiatry and mental health is extremely poor among the general public. Our own medical fraternity would ask me if I could mind read them. I was called to counsel patients who would cry. Terms like CBT, REBT, Psychotherapy were Greek and Latin to my fellow professionals. Counselling was the general term. Any person who needs psychiatry help would be asked to consult me not for treatment but for counselling!!!! If only psychiatric illnesses could be cured by 10 minutes of talking.

As a part of DMHP (District Mental Health Program), I was supposed to teach, rather create awareness among all cadres of health staff including health assistants, staff nurse, pharmacists and doctors. However, during the initial days almost everyone resisted training. They even told us that they were overburdened and wouldn't be treating mentally ill patients. The whole team was ridiculed and mortified. I once heard someone calling me "mental madam". Ever since that, I usually start the training sessions by educating them to respect each and every person they meet and especially people with mental illness, to not ridicule or humiliate them. There is now a gradual change in the thought process however it's a work in progress.

In the rural areas where the presumption about paranormal activities and superstition is very high, the concept of treating them with medication is a trying task. We have been successful in few situations. For instance, there was this patient in the village of Sakaleshpur. It is a remote village in western ghats with no access to psychiatric hospital. She was diagnosed to have Paranoid Schizophrenia 15 years back. However, due to poor treatment adherence she continued to be symptomatic. After an awareness programme, one of the ASHA workers informed us about this patient. With help of this worker, we were able to visit the family and motivate them to stick to treatment. The medical officer in charge was also eager to learn and help. After training, the Medical officer was confident of the usage of parental antipsychotics.



The patient started showing improvement after 3-4 months of regular treatment. Every fifteen days a health staff from PHC would visit the house and finally after 4 months the patient agreed to visit PHC for regular medication. Currently, the patient still has cognitive deficits however her self-care and social functioning has drastically improved.

Improvement in the health and behavior of this patient motivated several others in that locality to seek treatment. With constant effort of the team in the last 3-4 years the number of people visiting psychiatry OPD at Taluk Hospitals have increased exponentially. We are trying to train each and every person in health department to recognize mental health issues and to motivate the family to seek help. Every ASHA worker has been educated on the signs and symptoms of mental illness. They refer to me as MANASIKA DOCTOR and discuss about cases they see in the periphery. They call us for home visits when some families do not listen to them. Our team is just a phone call away from each and every health worker in our district. There still is a long way to go, to when a person with mental illness can walk into the OPD without any hesitation. The stigma around mental health has definitely reduced but it is a work in progress.

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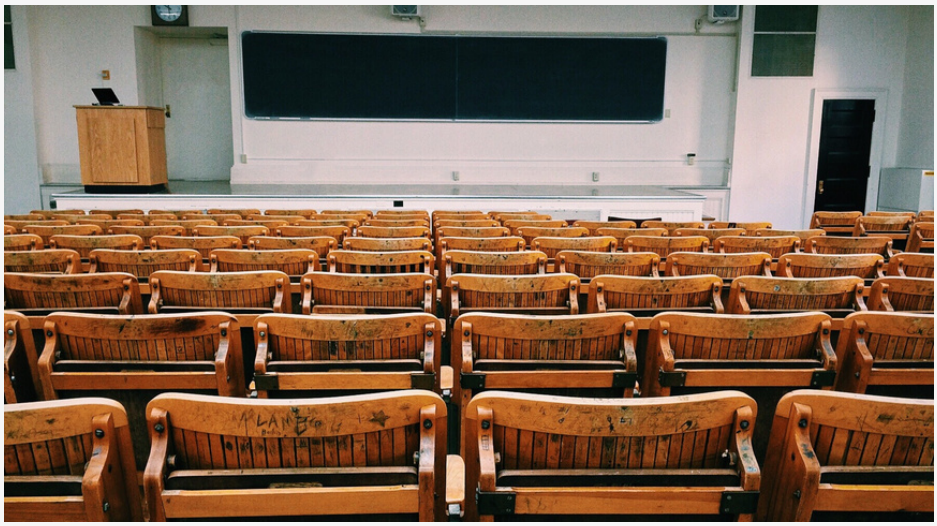
INVITED ARTICLE

BEING A TEACHER IN THE FIELD OF PSYCHIATRY :

Well, what does it feel being a teacher in the field of Psychiatry? How did the journey of being a teacher in Psychiatry start?

Once a month an hour for psychiatry, 5 batches at once for one faculty, turning up to empty lecture halls, later, the struggle to find contact numbers of class representatives and arrange students to come for classes, 15-20 students turning up despite being told, the very next month, mass bunk due to internals. 4 out of 5 batches posted for clinical postings would never report, the one batch reporting used to have less than 50 % attendance and maximum of 5-6 days of attending. The excuse was inevitably of internal assessments and lack of study time. Academic cell, least concerned about taking classes, attendance completely ignored, anyhow, no internal marks needed to be sent to university as “Psychiatry does not have any relation with UG training whatsoever”. The only valid signature was on the internship completion certificate and that is when UGs used to know there exists a department called Psychiatry.

This scenario is what welcomed me after I returned enthusiastically finishing post-graduation from a premier institute which has high academic culture. As a beginner, these above things always intrigued me of why people weren’t concerned about mental health and training. *Is it lack of having exams and no mandatory attendance? Is the subject too difficult? Is it the stigma that no one even considered psychiatry as a career? Does it lack lustre of a fancy super speciality or even other broad specialities? Lack of money in the field?*



As the years passed, though meagre, but focussed interactions with interested students and faculties of other colleges occurred. The one thing that gradually became clear is that the above questions are not the primary hurdles for people not turning up. It is, in fact the lack of engagement from our side. Second, the attitude of 'just leave it the way it is, why do you want it to improve?' kind by management. Lack of pull by positive reinforcement and lack of push by negative reinforcement results in static motivation. How to improve the participation was the next question. The answer is to keep interacting with students in whatsoever opportunity that arises. It may be in various non-teaching events like IPS KC quiz, prize exam, ICMR STS fellowships, voluntary research projects. Start doing various programmes, camps, kindling the speakers, writers, artists and performers to showcase their talents in the field of mental health. The upcoming CBME syllabus has provided 40 hours of teaching and 45 days of clinical postings, which is a considerable 100% increase despite which not even one certifiable competency is needed for graduation. The subject is not even considered for exams in the UG period. Though this may maintain the status quo, the opportunities for interaction with students are ample. This can be utilized in non-didactic ways of teaching like case-based learning, small group discussions, bedside teaching, roleplays and psychodramas. These type of teaching methods need proper training of teachers of psychiatry and standardization. The need of the hour is to engage teachers in learning teaching methodologies. Steps towards the standardization and faculty development are being taken up by IPS KC task force for UG and PG training.

The journey ahead is still long and open for more such opportunities, to see psychiatry training for UGs to improve. The outcome would be a confident young medical graduate who would be able to identify and take appropriate course of action for mentally ill persons with the right kind of attitude and perhaps, take up psychiatry as a career.

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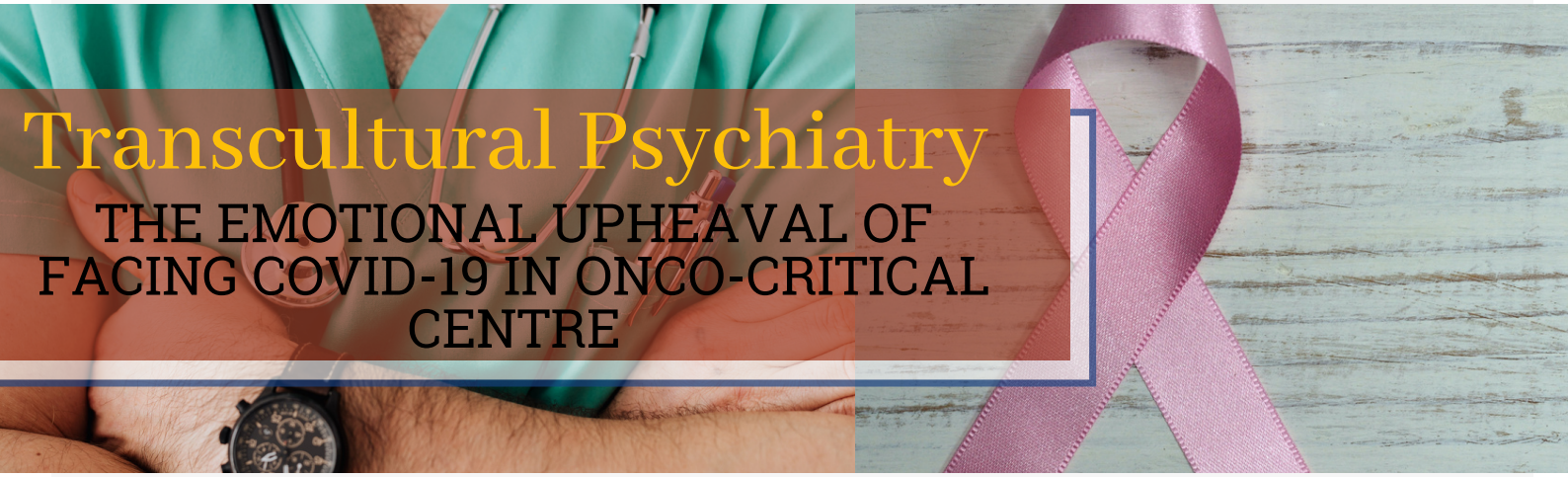

Transcultural Psychiatry

THE EMOTIONAL UPHEAVAL OF FACING COVID-19 IN ONCO-CRITICAL CENTRE

The New Year bells ushered in with all positive hopes, wishes from family and friends. However, the mumble about novel corona virus was in the mind of health care workers alas without comprehending the enormous avalanche on physical and mental health it would unleash....

Uncertainty existed about the communicability of the virus; the fear started creeping in regarding the morbidity and mortality. Our unique environment catered to malignancy patients which placed additional dilemma about managing the cases due to immunocompromised status.

The initial trauma was immense amongst intensivists and critical care nursing team due to fear of cross infection between patients and health care workers. It took a while for preparedness for the anticipated pandemic, which was negated by WHO protocols, peer collaboration, personal research, and active discussion amongst intensivists. This enabled the health care team to mentally face the positive patient without the fear of getting infected themselves or infecting their families.

After protocols were put in place, creating an isolation intensive care unit, we started treating patients. Healthcare personnel started getting infected in spite of all adequate precautions; fear increased multifold due to a void about the nature of illness. The mounting death toll and media input worldwide made us wonder whether it was even safe to work compromising our own personal health and our family. The end result of the stress was reflected in few of our oncology healthcare workers who quit their jobs for family safety.

The magnitude of stress anticipated was even much higher than expected, which made us realize that we need to strengthen our team by counselling. The critical care team decided to boost the morale of co-workers by augmenting their personal health, i.e., by encouraging nutritious diet, supplements, adequate Covid breaks and addressing their family concerns. This assuaged the apprehension of doctors and nurses to persevere and serve the patients.

As days passed, the infectivity rate was in the upward trend and it made us frightful about the working environment. We realized that the fear was smouldering within our cortex unaware of the consequences it was having on our mental wellbeing. For instance, the Covid RT PCR sensitivity and specificity, effectiveness of changing protocols as the pandemic marched mercilessly.

There was this young patient who had dreams of overseas education and future ideas. She was diagnosed with leukaemia, received bone marrow transplant and was eager to begin her new life. However, she had to face the brut of pandemic, remained positive for several months unlike other cases with no antibodies. Although all aggressive measures were in place, she deteriorated day by day and eventually succumbed.

The trust factor plummeted between co-workers due to asymptomatic carrier state and further isolating ourselves, i.e., eating alone, no informal exchanges, which led to social apathy, sleeplessness, and poor appetite. The above issues were taken into consideration by intensivist team via phone counselling and periodic zoom meetings. This was supported by management at every step. However, it still haunted us, as some of the senior oncology consultants were managed in isolation ICU who required O2 support, positive-pressure ventilation and aggressive treatment and gradual decline in working force. This led to rock-bottom feeling of life and death and surviving this disaster became the paramount importance.

With the herald of new Covid variant, our mental preparedness may perhaps be in a better state compared to the novel Covid 19 experience. Being an onco-critical care centre, we are aware the cross-infectivity rate and criticality rate will be higher in contrast to any other multispeciality centres; one question remains though whether liberation is in sight!

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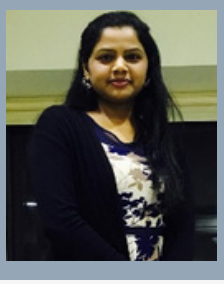

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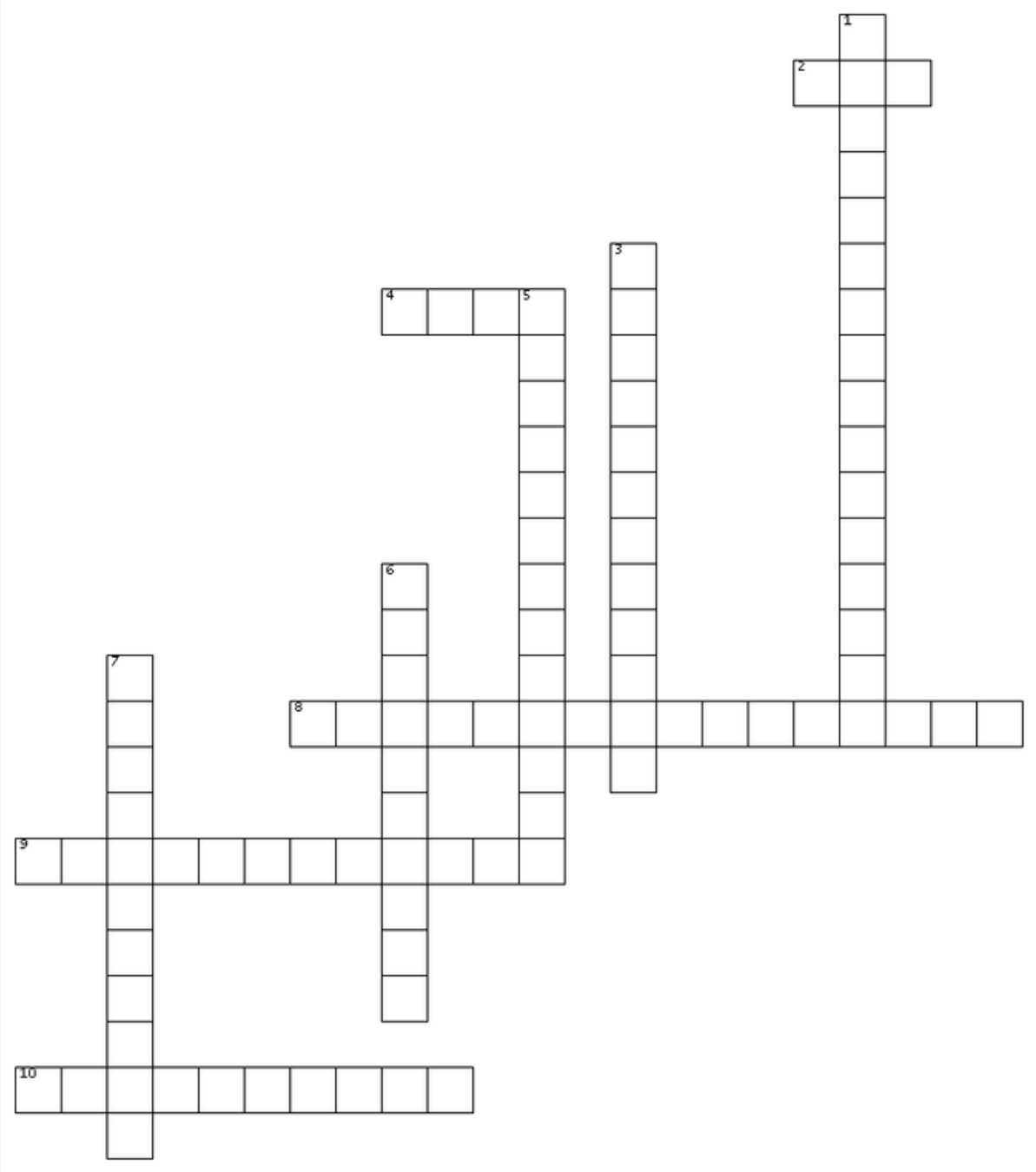
THE UNDERGRADUATE SECTION

CROSSWORD



CREATED BY

Dr.Ramaswamy Sundararajan

Across

2. 40-year-old male patient presents with worsening neurological symptoms and sudden jerky movements. History of similar symptoms in patient's father. This disease is characterised by abnormal expansion of what repetitive sequences?
4. 9-year-old boy is brought to the office for a well-child examination. Parents give history of poor scholastic performance by patient. There is history of the child creating a ruckus in class and not listening to the teacher. Child is known to be "energetic" at home as well and he never rests. Diagnosis?
8. 5-year-old boy is brought with complaints of lack of balance while walking. Review of symptoms shows this lack of balance has progressed. He also has minimal slurring of speech. After genetic testing, it is determined that there is a defective FXN gene. Diagnosis?
9. 4-year-old female, who was on the 50th centile for height and weight and was developing suitably was brought in to the office with developmental delay since a year. Mother also gives history of child waving her arm continuously without stopping and also resorts to head banging similarly. On examination patient is noted to have microcephaly and stunted growth. What syndrome is this?
10. 50-year-old male patient on treatment with IV Risperidone for acute psychosis has fever (104 F), delirium and rigidity in all extremities. Patient is started on a drug that decreases intracellular calcium concentration. That drug is?

Down

1. 68-year-old male patient with history of cerebrovascular accident, is brought by his son with complaints that the patient has been very forgetful over the last 2 years, even forgetting who his son is lately. There is 40-year pack history. On examination, patient has mild tremors with decreased deep tendon reflexes of all extremities (grade 2/5). Diagnosis?
3. 50-year-old female presents with pain and stiffness in all her joints, with history also suggestive of depression. Patient is unable to perform her day job properly. On examination, there are multiple points of tenderness over soft tissue both in upper and lower limbs. Diagnosis?
5. 55-year-old male is brought to the hospital with significant memory impairment. History suggests intellectual disability, congenital cardiac anomalies with patient having flat facies, epicanthic folds and oblique fissures. Patient is diagnosed with early onset Alzheimer's disease. What predisposed the patient to Alzheimer's?
6. 30-year-old male patient, comes with history of involuntary shaking of his leg when he is asleep. Symptoms have been present for a few months and patient claims that walking around during an episode makes him feel better. Patient is started on a drug that selectively stimulates dopamine D2 receptors
7. 29-year-old pregnant female with period of gestation 12 weeks, is diagnosed with bipolar disorder and is started on a medication that is safest during pregnancy. What drug is this?