- Published from 2011
- Articles on Psychiatry from over 22 specialties!!
- Contribution from More than 50 Authors!!
- Seven Sections in every Issue
- Free e-copy just by an SMS Request!!!

Editor
Dr. Gopal Das. C. M MD
Assistant Professor
BMCH&RC,
Chitradurga (Karnataka)

Assistant Editor
Dr. SuraviPatra MD
Assistant Professor
AIIMS
Bubaneshwar (Odisha)

Recent Past Editor
Dr.Naresh Nebhinani
MD, DNB
Associate Professor
AIIMS Jodhpur (Raj)

Recent Past Asst. Editor
Dr.Siddharth Sarkar
MD, DNB
Assistant Professor
AIIMS. Delhi

For free E-copy!!
Just email us or SMS MINDS <your Email ID> to Editor/Asst. Editor.
Join us on www.facebook.com/minds.newsletter.
Visit www.mindsnewsletter.com

MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors and Medical Students

Volume 7 *Issue 01* *January, 2017*

From the Desk of Editor — Depression – Let's Talk!

Feeling low or sad, loss of interest in activities that we usually enjoy, difficulty in carrying out daily activities because of the above, feeling heavy, less energetic, lethargic, no enthusiasm, nervousness, excessive worries which can't be removed from mind as easily as before, changes in sleep and appetite, unable to concentrate, feelings of guilt, worthlessness and hopeless, no wish to live anymore or thoughts of committing suicide often creeping up into the mind.. Yes, this is how Depression makes its presence. If these symptoms persists for at least 2 weeks, then it is called as Depressive Episode – a common mental illness around the globe occurs irrespective of ethnicity, gender, age, occupation and socio-economic status. But one common question across all these, including to us is how many of us talk openly about our depressive symptoms either in us or persons close to us and feel we need to reach out to seek help? The first thing that comes in mind is what if I am labelled as 'Mentally Ill'! This is the toughest barrier called Stigma prevailing in everyone regardless of their statuses. With this background, it is appreciable that WHO has chosen the theme of current World Health Day 2017 campaign in mental health and particularly in Depression. The Slogan being named as "Depression – Let's Talk". It states that "core of the campaign is the importance of talking about depression as a vital component of recovery. The stigma surrounding mental illness, including depression, remains a barrier to people seeking help throughout the world. Talking about depression, whether with a family member, friend or medical professional; in larger groups, for example in schools, the workplace and social settings; or in the public domain, in the news media, blogs or social media, helps break down this stigma, ultimately leading to more people seeking help." So, let's not hesitate but talk about depression, as it can identify, help in reaching out to help and even cure depression! Come on, Let's Talk and encourage others but more importantly, listen when they talk!

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

Guest Column: Down The Memory Lane... — Pain in the neck!

The neurologist in next chamber does not know Tamil. A Tamil speaking woman has been consulting him with a translator. The translator told she has intolerable neck pain and headache. Local doctor referred her to the neurologist when pain killers did not help. The neurologist was trying with Flunarizine, Clonazepam, Amitriptyline, Topiramate and Escitalopram for sufficient time. One day I was talking to this patient outside his chamber in Tamil. He came out and saw this woman was not in pains. She went in with the interpreter and was in severe pain. No need to say – he requested me to interpret.

I told the interpreter to stay out. He said that she is scared of doctors and she does not want medicines. So she will say that she is fine. Don't believe her, he added.

As soon as I asked her who her pain in the neck is, she said, "My pain in the neck is the translator who is my husband's eldest brother. My husband is totally under the control of this person for business and family management. This brother-in-law forced me into sex and I am in no position to refuse. Only after he had seen me suffering with severe pain, he does not force me. But now, he forces me to consult doctors and take medicines. I know it is because he wants me for sex. He has wife and children. I have teenage sons. My husband is drunk all the time, not in a position to listen to me."

So, please ask, "Who is the pain in neck or who is the headache?" It may clinch not only the diagnosis but also the treatment.

Dr. Saranya Devanathan, Senior Consultant Psychiatrist, Bengaluru, dr.saranya@gmail.com

Invited Article

Internet Addiction (IA)

Most of you who are reading this have obviously downloaded this file from internet and it hardly requires an introduction. We all invariably have access to it through one or the other form and spend varying amount of time working with internet. In this era of smartphones which most of us flaunt, it has reached a stage that it is almost impossible to lead a complete life without internet. In such a situation, where everyone uses internet and are dependent on it for communication, productivity, banking and most importantly entertainment purposes, an increasing number of hours are spent on internet but how fair it is to compare excessive use of internet to addictions such as alcohol, opioid etc. This is a topic of hot debate in mental health and Internet Addiction has not yet been included as a mental or addictive disorder in diagnostic manuals like DSM and ICD. Nevertheless, there are early but considerable research evidences to state that excessive internet use is very much related to other addictive disorders and existing criteria for addictive disorders do apply to internet addiction as well.

There are many definitions given for IA and one of the more pronounced ones are "IA is a psychological dependence on the Internet, regardless of the activity once logged on and characterized by excessive or poorly controlled preoccupations, urges, or behaviors regarding computer use and Internet access that lead to impairment or distress". Similar to addictive disorders, person with IA has craving to use internet and preoccupied with it, having a lack of control on initiating, limiting or cutting down the usage, increasingly more time spent on internet to achieve the satisfaction similar to tolerance in addictions. Due to this, he may have significant problems in relationships, job and financial aspects and yet he is reluctant to limit the use but may even use it as a mode of sole pleasure or relieving the negative mood states. Similar to withdrawal symptoms, person with IA may have significant symptoms when he could not get access to internet like restlessness and agitation, depressed and anxious mood, irritability, fatigue, changes in sleep, appetite and libido, and even aggression.

Internet is a broad term encompassing all types of online as well as offline features like social networking, emailing, banking and productivity, shopping and sales, information sharing, entertainment mainly in the form of multimedia and especially video formats. Potentially IA can be in any of these aspects of internet usages. Cybersex, online gaming and gambling needs a special mention as it has got serious adverse outcomes. Online shopping is also increasingly replacing the real markets and may pose a problem in vulnerable individuals.

Though there are no clear guidelines for diagnosis, there are quite a few validated tools to help in identifying IA like Young Internet Addiction Test (IAT) , the Compulsive Internet Use Scale (CIUS) , the Excessive Internet Use Scale (EIU) , the Problematic Internet Use Questionnaire (PIUQ) , the Chen Internet Addiction Scale (CIAS) , The Addiction Profile Index Internet Addiction Form-Screening Version (BAPINT-SV) , the Internet Addiction Proneness Scale (KS scale) , and Young's Diagnostic Questionnaire (YDQ). The prevalence of IA across studies varies widely from 1-18.7%. There are many strategies for management of OA under research. There are considerable successes with antidepressant medications such as SSRIs and Bupropion. Stimulants like Methyl Phenidate also has been tried. Various forms of behavioral interventions on similar lines with other addictions have been tried. However, one thing to note is the concept of complete abstinence from Internet use may not be realistic goal like other substances but controlling the use by removing unwanted applications and reducing hours spent to minimum possible often helps.

To summarize, IA is not yet marked as a diagnosable mental illness with clearly laid down criteria but definitely fits into addictions. It has to be carefully distinguished from normalcy when interventions are attempted. Interventions are warranted when a person with excessive or problematic usage of internet has trouble in leading a reasonably productive life expected out of him or others being affected by that person's behaviors.

Dr. Deepak. R. S., Assistant Professor, Department of Psychiatry, Basaveshwara Medical College and Research Center, Chitradurga. Email: dpuk@gmail.com

Cognitive deficits - Traumatic brain injury

Traumatic brain injury (TBI) is a significant cause of morbidity and mortality and is becoming a public health concern in India. TBI often results in chronic disability. It adversely impacts cognitive and behavioral functioning and hence results in vocational impairment. TBI can cause a plethora of cognitive impairments. Attention, memory, and disturbances in executive functioning are the most commonly encountered neurocognitive deficits with adverse impact on interpersonal and communication skills. These deficits significantly impair activities of daily living (ADL), employment, social relationships, recreation, and active participation in the community and hence result in disability and distress.

TBI is classified as mild, moderate, and severe depending on the level of consciousness, duration of coma and posttraumatic amnesia (PTA). In moderate to severe TBI, cognition appears to be markedly impaired around 1-month post injury or shortly after resolution of PTA. Cognitive impairments persisting even after 3 months were found to be associated with higher frequency of disability. In moderate to severe TBI, cognitive recovery does not return to baseline even after 2 years of injury. However, cognitive recovery is rapid in patients with mild TBI, returning almost to "normal baseline functioning" within 3 months.

The goal of cognitive rehabilitation following TBI is to enhance the persons' ability to process and interpret information and to improve the person's ability to perform mental functions. Cognitive rehabilitation is best suited for well-motivated and functionally independent persons with mild to moderate impairments. Cognitive rehabilitation is a multidisciplinary approach which includes physician, neuropsychologists, speech-language pathologists, occupational therapists, physical therapist, and social workers. Cognitive rehabilitation consists of diverse interventions tailored to individual needs. Cognitive rehabilitation therapy is divided into two components: restorative and compensatory approach. The restorative approach aims at reinforcing, strengthening, or restoring the impaired skills. It includes the repeated exercise of standardized cognitive tests of increasing difficulty, targeting specific cognitive domains (e.g., selective attention, memory for new information). Compensatory approach teaches ways of bypassing or compensating for the impaired function. Assistive technologies, calendars, electronic memory devices, alarms, or reminders are used as compensatory techniques. Pharmacotherapy based on catecholaminergic and cholinergic augmentation is a useful adjunct in cognitive rehabilitation.

TBI persons who undergo comprehensive holistic neuropsychological rehabilitation achieve greater improvements in community functioning compared to those who received conventional rehabilitation. Comprehensive holistic rehabilitation programme (CHRP) includes individual and group therapies, psychotherapy, psychoeducation, and family therapy. This holistic neuropsychological intervention stresses on metacognitive and emotional regulation techniques that facilitate skill transfer and generalization, behavioral and affective regulation, and community integration.

Dr Apurba Barman, Assistant Professor, Dept. of Physical Medicine and Rehabilitation, AIIMS Bhubaneswar

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

- ✓ *Psychiatrists treat patients by counseling.*
- ☒ *If a common man has this myth, it is understood but when a fellow doctor carries this, it needs to be corrected! Psychiatrists are also specialized medical professionals who have sophisticated pharmacology knowledge and experience using medication, and most often treat mental illnesses using medication while they also use psychotherapy which is a highly structured procedure demanding skills and experience. It should not be equated with lay counseling which serves hardly any therapeutic gains and so do the reference shall not just be for mere 'counselling'!*
- ☒ *Psychiatrists are always serious, nerdy looking, insensitive, highly formal, unfriendly, isolated from others and has strange ways of talking which can't be understood by others*
- ✓ Though it is a stereotype propagated inappropriately since decades, it is a total myth. They do have their persona and passions to pursue and in fact they are a lot of most friendly and humane professionals when approached.
- ☒ *Psychiatrists can read one's mind*
- ✓ No human can read mind of others. This myth is carried because, by their knowledge and experience of working with mind matters, they can see through defenses the patient use and predict better what may be happening inside that makes others think they can read minds.
- ☒ *Dealing with mentally ill throughout their lives, psychiatrists end up contracting mental illness at some point*
- ✓ This is one of the epic myth which is present even in medical students and myth often deep seated, prevent them from taking up careers in mental health! There are absolutely no evidences but on contrary, they have an opportunity to gain many insights into various aspects of life by working closely with patient and family!

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

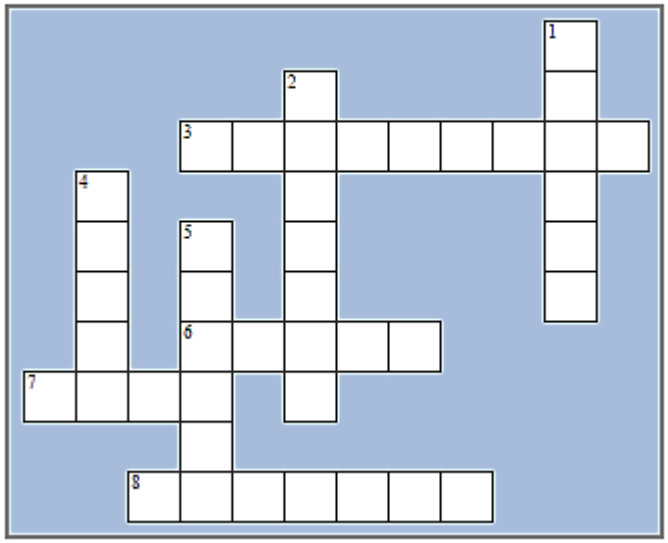
UG n PG

MINDS QUIZ

1. **A middle aged woman is presented with a history of being repeatedly injured by husband during his sleep where he has been shouting violently moving his limbs as though enacting a dream, lasting for few minutes. He is unable to be easily woken up during such episodes. What is the likely diagnosis in husband?**
   a. Sleep terror b. Sleep apnea Syndrome c. REM Behavioral Disorder d. Nocturnal Seizures
2. **Which one of these does not belong to Obsessive-compulsive Spectrum Disorder?**
   a. OCD b. Trichotillomania c. Body Dysmorphic Disorder d. Panic Disorder
3. **All of these are characteristic symptoms of substance dependence syndrome except**
   a. Craving b. Withdrawal Symptoms c. Tolerance d. Depression
4. **What is the pathophysiology of Dopamine type-2 receptors in causation of Tardive dyskinesia?**
   a. Supersensitivity b. Immune mediated c. Desensitization d. Hyperplacia
5. **Hallucination occurring outside the limits of sensory field is called as?**
   a. Reflex hallucination b. Extracampine hallucination c. Pseudo-hallucination d. Functional Hallucination

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

3. Compulsive buying disorder is also called as (9)
6. Infective agent causing Creutzfeldt Jacob Disease is (5)
7. This syndrome is a triad of infantile spasms, hypsarrythmia and developmental regression (4)
8. Degree of personal awareness and understanding of illness (7)

Down

1. Lack of the ability to make gestures or to comprehend those made by others (6)
2. Unusually vivid or exact mental image of objects previously seen or imagined (7)
4. Rare dissociative disorders characterized by a loss of awareness of one's identity (5)
5. This is called as satiety hormone (6)

ANSWERS

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

CROSS WORDS

ACROSS
3. Oniomania
6. Prion
7. West
8. Insight

DOWN
1. Amimia
2. Eidetic
4. Fugue
5. Leptin

QR Code for MINDS website

MINDS Newsletter was launched in July 2011 as a Monthly Newsletter on Psychiatry for doctors & medical students for creating awareness and continued medical education. You can receive a free e-copy of MINDS by an e-mail request to editormind@gmail.com, or by just SMS MINDS<email ID> to Editor: +91 9535383539/ Asst Editor: +91 9438884222 or join our Facebook group @ facebook/mindsnewsletter.
All archives are available in our exclusive website http://www.mindsnewsletter.com/
Enjoy a new way of learning!!!!

Your suggestions are important to us, kindly mail them to editormind@gmail.com& Please pass on the newsletter