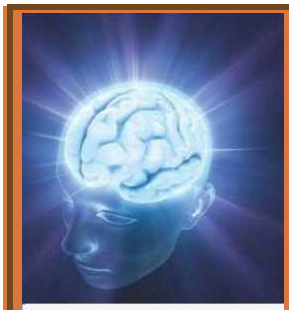

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MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 10 *Issue 10* *October, 2017*

From The Desk of Editor..... Mental Health in Medical Students

Medical colleges train students to become physicians who would take care of the health of the future population. This training involves high level of motivation, intelligence and stamina.

As per recent survey, significant numbers of medical students with mental health issues feel they are under-supported.

Stress experienced by medical students is more than other undergraduates due to its course, content and complexity of knowledge. Medical students are vulnerable due to undesirable consequences like burnout, social isolation and lack of leisure time which usually will lead to undesirable coping mechanism like substance abuse and self harm.

Medical students can suffer from various mental health issues like depression (11%), anxiety (7%), and various addictions (alcohol, smoking, and internet). Lack of awareness about mental health issue among these students is of major concern. They do not approach for help due to barriers like stigma, fear of lack of confidentiality, fear of rejection by friends, cost factors, fear of record, and also fear of unwanted intervention. Most mental health issues can be addressed easily if appropriate intervention is started early. There is a need to increase awareness of mental health issues by establishing psychological support to the students within the system.

Dr. Sunil Kumar G Patil

REFRAME – Let Awareness Reframe Assumptions: Myths and Facts about Mental Illness

- ☒ Mental health issue are rare in medical students
- ☑ Mental health issue are more in medical students compared to other fields
- ☒ Seeking help for emotional issue is a sign of weakness
- ☑ Actually its sign of strength and also right thing to do for your health
- ☒ If I have mental health condition, I cannot pursue my degree
- ☑ They can do their choice of career with proper professional intervention
- ☒ I may not get job if I have mental health condition
- ☑ No individual can be discriminated at work place on the basis of mental health issues as per law
- ☒ Once I am on medications I have to take lifelong for mental health issue
- ☑ Many mental health issues can be addressed by counseling but if they require medication it depends on condition and severity

Dr. Sunil G Patil, Assistant Professor, Dept of Psychiatry, MVJMC & RH, Hoskote, Bengaluru

The last week saw us celebrating the World Mental Health Day with emphasis on 'well-being at the workplace' as Mental health being adversely affected by stress, internal conflict, time and energy demands, is now at an all-time high. To illustrate the above is a typical case. Mr. S a young intelligent 23 year old IT professional, from a non-consanguineous joint family, with a family history of 'Anxiety Disorder ' in his father, came with the complaints of " inability to concentrate, poor self-esteem, anxious, apprehensive and fatigued since 1 year following, his joining the job. At the company he was 'on the bench' and the rumors of being laid off any time soon were worrying him. Besides this, he complained of indulging in a number of 'meaningless' repetitive rituals like adjusting his shirt, aligning his elbows on the armrest of the chair, positioning his laptop and office materials as well as his legs in a particular way , walking in a particular manner, making peculiar throaty noises "Because of a bubble which keeps coming up" disturbed sleep and poor appetite. On the home front it was noticed that he had certain repetitive ritualistic actions before his bath time and at meal times. He had overprotective parents and an abusive over critical elder brother. Early history did not reveal him to have any significant developmental or medical issues, though premorbidly, he was apprehensive, suffered from feelings of insecurity and low self-esteem and did not have too many close friends, hobbies or an active outdoor life. A Diagnosis of Obsessive Compulsive Disorder was entertained and as he was intelligent and highly motivated, and had a compliant and cooperative family who were ready to support all treatment plans, a package programme comprising of High intensity CBT (including exposure and response prevention following training in Deep Muscular Relaxation Techniques, followed by SD (Systematic Desensitization) Cognitive monitoring, therapeutic initiatives aimed at increasing his self-esteem, a systematic sleep and daytime schedule and family counseling was attempted. After two to four weeks of intensive daily sessions in the clinical setting and follow up, daily practice sessions at home, patient and family reported around 80% decrease in his symptoms. He rejoined work got selected on a project, and was coping reasonably well, in spite of very heavy demands from his client. Since the last 8 months, he reports his graph (feeling of being in control and sense of wellbeing) is "steadily peaking to an optimum".

Surely, this is a time to take serious stock of the impact of stress, be it at the work or the academic front. Special emphasis in the wellbeing of students, especially that of medical students is imperative at this moment, as more and more, it is being reported that their health, creativity and intellectual productivity is seriously compromised by stress. At this juncture it goes without saying, that student coping in medical colleges must be enhanced psychological support, social/health activities, mentorship and intellectual stimulation and that proper measures to ensure the above must be in place, as our students of today are the backbone of the Workforce of tomorrow

Dr Elizabeth. Daniel, Former Prof. Clinical Psychology Kasturba Medical College & Yenepoya Medical College, Mangalore, currently Consultant Clinical Psychologist JNCASR Jakkur Bengaluru)

CARE PATHWAYS IN PSYCHIATRY- AN EVOLUTION

Psychiatry is an evolving science, though faced by the criticisms of antipsychiatry movement in the past that psychiatry is not a science and there cannot be any psychiatric disorders. Thomas Szasz in his controversial article of 1960 mentioned any disorder with psychological symptoms have pure biological origin and involve brain dysfunction. A decade later George Engel convincingly gave a holistic approach to the etiopathology of psychiatric disorders that more or less masked the antipsychiatry movement. This model is called 'Biopsychosocial model', which considers biological, psychological and social factors as precipitating, predisposing, perpetuating and protective factors in various combinations in the causation of psychiatric disorders. Thus it was widely accepted and became popular compared to other narrow pathways of care like psychodynamic model, cognitive behavioral model, interpersonal model etc.

Psychiatry however was integrated into the medical model of care even before antipsychiatry movement. The last 5 to 6 decades have seen rapid advancement in the management of psychiatric disorders- both psychological and pharmacological. Cognitive behavioural therapy and interpersonal therapy in general continue to be the most useful therapies even today. There have been innumerous medications approved and available. Social and vocational rehabilitation involve the key social therapies. All these components form the comprehensive management under biopsychosocial model. We further have Mental Health Act, guiding us through the patient care and an action plan through 'National Mental Health Program'. Thus we are much comfortable today in managing patients. Yet this doesn't appear to be the final answer. Mental morbidity continues to be in the rising trend!

Maslow in 1954 explained his 'Hierarchical needs' that includes the biological needs, safety needs, love and belongingness needs, esteem needs and self-actualization needs to be satisfied in that order, for an individual to evolve mentally. In short it is the 'Roti-Kapda-Makaan' proverb of India. That is, whatever the mental illness is, the recovery starts with having basic necessities first. This appears to be an ideal situation for every individual irrespective of the psychiatric disorders. However, as far as psychiatry is concerned, the most recent advancement in the pathways to care appears to be on the lines of this good old Maslow's theory. William Anthony in 1993 explained the 'Recovery model' of care. This model essentially imposes responsibility of mental illness and recovery from illness on the patient himself and assists him throughout the process. This involves meeting the essential needs of the patient from the step one which may include helping with finances, shelter and food.

This happens through case management, where a case manager is the key contact to the patient (client). This model is also known as client centered approach. The case manager works through the recovery goals of the client. Recovery here is not the cure. It is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. All the needs such as food, shelter, financial assistance, job, medication, counseling/psychotherapy etc are provided as needed through the mediation of a case manager to facilitate the process of recovery. It is also a collaborative approach including patient in the decision making process rather than being paternalistic. Thus recovery is a resilience that the patient is expected to develop eventually. The government funds the entire care pathway.

This approach is currently followed in countries like UK, USA, South Africa, Australia, New Zealand and Canada. This appears to be the best answer for care of the mentally ill. However an interesting point here is that even Recovery model has no robust positive evidence base. Further, there is no significant positive change in the mental morbidity in those countries, with more than a decade of implementation of this model. Yet it is an approach believed to deliver the best. But it is not feasible to be implemented in all countries. Further the predominantly medical model of care in countries like India cannot be said to be a failure. All pathways to care have definitely been beneficial. There is no best answer yet. Considering that Psychiatry is a complex and evolving science, it is time for contemporary psychiatrists to think beyond recovery.

Dr Anil Kumar M Nagaraj, Specialist pathway Psychiatry Registrar, North Western Area Mental Health Services Melbourne

OCULAR AND VISUAL SIDE EFFECTS OF PSYCHOTROPIC DRUGS

Psychotropic medications have the potential to induce numerous unwanted ophthalmic side effects. Even though the percentage is less, the significance is high.

Following are the ocular changes.

1) **Ocular Surface Changes**
   Phenothiazines can lead to impaired endothelial pump function, causing severe corneal edema leading to visual disturbance. Chlorpromazine (dose>2g/day) causes corneal epithelial keratopathy- it has a distinctive pattern of swirling lines/fine streaks in the epithelium. It causes minimal visual disturbance and usually regresses with dose tapering.
   Tricyclic antidepressants (TCAs) and Clozapine may cause decreased lacrimation. Persistent tear film instability and dry eye syndrome affects the ocular surface and vision. Prompt lubrication is required.
2) **Ocular pigmentation**
   It can be Pigmentation of the skin, conjunctiva, cornea or lens and Pigmentation retinopathy. The first may cause minimal to no changes to vision, while the latter may lead to irreversible degenerative retinopathy. Chlorpromazine is known to accumulate in the skin of the eyelid, conjunctiva, posterior corneal stroma, lens and uveal tract. Photosensitization of the tissue proteins occurs in areas of increased sun exposure after accumulation of the drug in these tissues. Protective sun wear and reduced sun exposure is recommended.
3) **Lenticular opacities (Cataract)**
   Chlorpromazine and thioridazine can cause bilateral asymmetric anterior subcapsular opacity**.** Few drugs can cause hyperglycemic status leading to early diabetic cataract. These opacities may not reverse with cessation of the causative agent, may need cataract surgery**.**
4) **Accommodative Interference**
   TCAs, selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs) and norepinephrine reuptake inhibitors (NRIs) have been shown to cause both mydriasis {non-severe and transient visual changes} and cycloplegia {paretic effect on the ciliary muscle causing blurred near vision}. Management of accommodative disability may require an appropriate spectacle prescription until the condition improves.
5) **Angle Closure Glaucoma**
   TCAs {Amitriptyline, Imipramine}, SSRIs (Fluoxetine, Paroxetine), SNRIs having anticholinergic effects can cause an acute angle closure with pupil block in a patient with anatomically narrow angles. The mechanism is mydriasis in an already crowded angle. Cessation of the medication, with or without initiation of other medical intervention, halts the condition and can save vision. A traditional laser peripheral iridotomy (LPI) would not be beneficial. Thus, these drugs should be prescribed cautiously in patients with narrow angles. Furthermore warranting a detailed evaluation of the eye and follow up.
6) **Retinopathy and Optic Nerve Involvement**
   Drug toxicity can affect both the retinal pigment epithelium (RPE) and the neurosensory retina, which is not easily cleared and can lead to potential damage. Deposition of thioridazine (>800 mg/day) and chlorpromazine, may take place in the retina. Phototoxic stress causes peripheral vision loss, nyctalopia, permanent vision loss and complete blindness as damage progresses. Early detection and intervention can prevent permanent visual consequences. Benzodiazepines and Clonazepam ('white-dot-like' retinopathy) causes retinal toxicity. Lithium causes optic disc swelling leading to blurred vision. Resolution of this pathology has been seen with cessation of drug. All these indicates need for yearly screening for retinopathy or papillopathy
7) **Impaired Sensory Perception**
   Carbamazepine and benzodiazepines can reduce central and paracentral color vision and Contrast sensitivity. Changes to sensory perception indicate a need for monitoring visual function above and beyond visual acuity. Regular color vision and contrast sensitivity testing should be done.
8) **Ocular Motility Disorders**
   Carbamazepine, Topamax and SSRIs all have been associated with oculogyric crisis. Benzodiazepines can cause dysfunction of saccades and smooth-pursuits and nystagmus. Lithium causes downbeat nystagmus which can be reversed with termination of the medication. Carbamazepine can cause Diplopia, oscillopsia, gaze-evoked nystagmus, gaze palsies, downbeat nystagmus and periodic alternating nystagmus.

Take home message

Psychiatrists, Ophthalmologists and patients need to be aware of medication-induced adverse effect. Early prevention and intervention can avoid most of the serious and potentially irreversible ocular toxicities.

Dr. Pallavi B A, Assistant Professor, Dept. of Ophthalmology, MVJMC & RH, Hoskote, Bengaluru

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

UG n PG

MINDS QUIZ

1. Burnout refers to
   A. Psychological issue B. Medical disorder C. Legal issues D. All

2. Burnout Syndrome has the following dimensions
   A. Emotional exhaustion B. Depersonalization C. Low professional efficacy D. All

3. Burnout Syndrome affects
   A. Work performance B. Self-esteem C. Psychological health D. All

4. Burnout syndrome affects
   A. Students B. Workers C. Both D. None

5. Burnout syndrome can be managed by
   A. Leisure time B. Relaxation techniques C. Health coping skills D. All

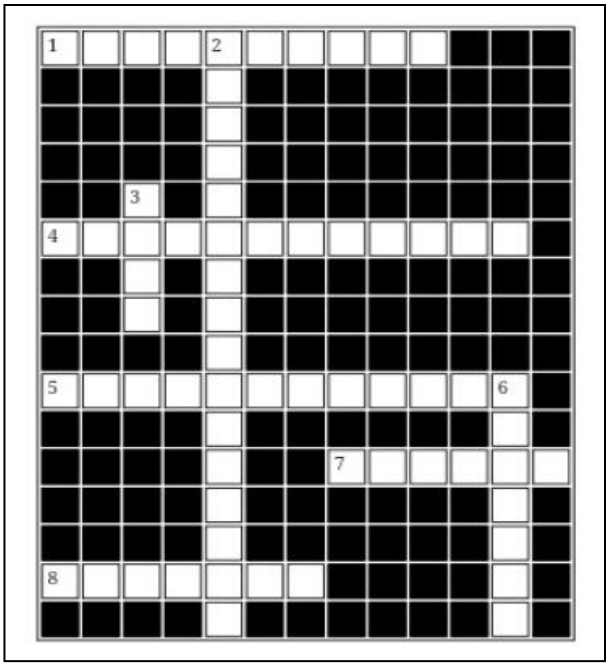
Can You CROSS THE CROSS WORD

Across

1. Pseudopodia fantastica seen in(10)
4. Hypersomnia, hyperphagia, hypersexuality seen in ___ ___ syndrome(6,6)
5. Cluster B consists of disorders considered on a ___ continuum(12)
7. Chinese culture bound syndrome associated with discomfort,panic and uncontrolled movement thought to be due to improper martial art technique (2,4)
8. Demyelination of corpus callosum in chronic alcoholics(7)

Down

2. People who have non 24 hour sleep wake cylces due to non-entrained circadian rhythm are aka-____(16)
3. Pervasive developmental disorders associated with progressive slowing of head growth,language impairment and repetitive hand movements,commonly seen in girls-___ syndrome(4)
6. Elevated NAA levels on MR spectroscopy seen in ___ disease(7)



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QR Code for MINDS website

ANSWERS

MINDS QUIZ
1. Psychological issues
2. All
3. All
4. Both
5. All

CROSS WORDS

ACROSS
1. Munchausen
4. Kleinelevine
5. Psychopathic
7. Qigong
8. Bignami

DOWN
2. Hypernycthemeral
3. Rett
6. Canavan

Dr. Faris Basheer (PG) MVJMC & RH

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