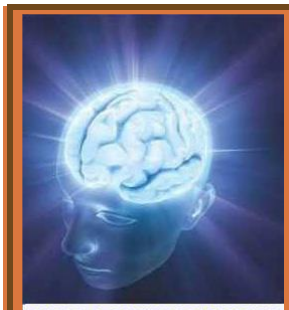

MINDS NEWSLETTER

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- Contribution from More than 50 Authors!!
- Seven Sections in every Issue
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Editor

Dr. Bindu Annigeri
Consultant Psychiatrist
Dept. of Psychiatry
JSS Medical College & Hospital, Mysore

Assistant Editor

Dr. Suhas Chandran
Senior Resident,
Dept. of Psychiatry,
St. John's Medical College, Bangalore

E-mail

editormind@gmail.com

Website

www.mindsnewsletter.com

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MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 8 *Issue 9* *September, 2018*

From the desk of Editor

Greetings to everyone from the editorial team of MINDS.

Metabolic syndrome is a condition which has been the matter of research and discussion in the recent times. Among patients with psychiatric disorders specially, this condition has been gaining a lot of attention. It is a comorbid condition in bipolar mood disorder, schizophrenia, anxiety disorder, substance use disorders etc. Metabolic syndrome among patients with psychiatric disorders may be due to various causes like, developmental/genetic factors, poor physical activity and psychotropic drugs. This may affect the life span of the individuals afflicted with this condition. The mortality is mostly from cardiovascular complications. The outcome is even poor if there is obesity during childhood/adolescence. It is diagnosed if three or more of the following are present; abdominal obesity, high triglyceride, low HDL cholesterol, hypertension, elevated fasting glucose. Patients with mental disorders and those receiving psychotropic drugs should be routinely screened for this condition by monitoring the BP weight, waist circumference, blood sugar and lipid profile at regular intervals. Lifestyle modification has been the most effective modality in managing or preventing metabolic syndrome. Challenging situations would be the patients with negative symptoms (of schizophrenia) and cognitive impairment. Nonetheless, efforts should always be made to educate the patient about this condition.

Dr. Bindu Annigeri

Guest Column: Down The Memory Lane…

Success of good clinical and legal intervention

When I was a lecturer a graduate young male of 23 years of age was brought by his father. He was addicted to alcohol and cannabis. He had relapsed very fast as an outpatient.When suggested treatment as inpatient, he refused to get admitted and threatened police complaint. He was admitted in the open ward under section 19 of Mental Health Act 1987 as per the request from his father and certificates by two Psychiatrists. He went to the police station, but they did not encourage the complaint as the suggested admission was according to the law.

He stayed in the ward for 4 weeks. He was given professional care by our team and was discharged. It was a turning point in his life. He felt that the doctor and his staff cared for him a great deal, took extra trouble and risk to take care of him. He said that sometimes it is necessary to initiate such vigorous measures. He later completed his post graduation, got married and had a long period of abstinence. Most importantly, from then on, every completed year of abstinence from the date of admission he would call me to thank and inform that he is abstinent from alcohol. It was very heartening to listen to him. To have a good out come in the treatment of alcoholism, your actions and importantly your inactions count a lot. You must somehow thread the needle of liability concerns. This teaches that you should treat substance use disorder with more energy and vigor. This will be very rewarding.

Dr. H.Chandrashekar, Professor & Head, Dept. of Psychiatry, Bangalore Medical College and Research Institute. Bengaluru.

A CASE OF ADOLESCENT SUICIDE ATTEMPT

A 15-year-old boy was referred to Narayana Health City from Mysore for management of acute liver failure and to have a potential liver transplant. He had allegedly ingested two tubes of rat poison (yellow phosphorus) after failing to commit suicide by hanging the same day. He presented to us with grade III hepatic encephalopathy for which he was managed with intubation and ventilation and maintaining neuroprotective measures. He underwent 3 sessions of plasma exchange and CRRT(continuous renal replacement therapy) was initiated to control hyperammonaemia and lactic acidosis. He recovered from acute liver failure without the need for a liver transplant. He was then assessed by our paediatric psychiatric team and further management with antidepressants and community support was done.

Globally, suicide by adolescents is on the rise. In India, suicide is the leading cause of death in adolescents. For every unfortunate suicide there are twenty-five failed attempts and countless suicidal thoughts. Fortunately, four out of five teenagers give clear warning signs which can be detected by parents, teachers and caretakers. Timely counseling and referral can save young lives.

Warning signs of Suicide

Verbalizing death wish; Acquiring means of self-harm / suicide; Feeling of hopelessness; Self hatred; Saying goodbye as if this is the last one; Isolation from friends and family, deterioration of social relationships. Excessive anger and aggression, fall in academic performance, reckless driving, drug abuse (alcohol and tobacco).

Parents and teachers being the foremost caretakers are likely to identify the above warning signs much earlier than others. They should remain calm, be empathetic, ensure safety of the teen and help the disturbed adolescent. Professional help from a pediatrician, counselor or psychiatrist may be necessary. Delay or reluctance will worsen the situation. Any change in behavior and loss of interest in activities enjoyed previously for more than two weeks maybe pointers towards a mental disorder.

Many parents wrongly believe that a mention about death wish by a teenager is an attention seeking behavior. Caretakers should take every word **very** seriously. Talking to distressed teens about suicidal intentions makes them feel that parents are caring, nonjudgmental and empathetic. They also feel understood and supported. Parents should help the teen to cope with the stressful situation. Talking to teens about suicidal thoughts does not predispose them to self-harm. Caretakers must take note of “protective factors” which prevent teenagers from ending lives and help them cope with stressors. This learning should begin early in life and the active process of life skills education must continue through teenage and youth.

Protective factors

Life skills and resilience, family and school connectedness, restriction to lethal means, cultural and religious beliefs, strong support system, peer support and trained peer educators. Life is full of everyday challenges and teenagers are vulnerable to the various stressors like academic pressure, competitive sports, peer influence, social media hazards, substance abuse, separation from parents, bullying, disturbed relationships, body image dissatisfaction, sexual identity confusion and uncertainty about the future. Life skills act as vaccines against external influences and internal emotional turmoil. Life skills education by parents and teachers nurtures a mentally strong, resilient and responsible teen who can handle stress and challenges effectively.

Following life skills should be taught to children from a young age:
1) Self awareness: Knowing ones likes, dislikes, strengths and weaknesses 2) Decision making 3) Critical thinking
4) Coping with stress 5) Handling emotions 6) Effective communication 7) Nurturing relationships
8) Personal safety 9) Goal setting
Teaching resilience to children and teenagers is the most vital parental task. Resilient teens are flexible, adjust well to life situations and excel in academics, career and inter personal relationships.

Dr.Akhila Vasanth
Consultant Pediatric Nephrologist, Narayana Health, Bangalore

POSTPARTUM PSYCHOSIS

Psychosis occurring during the first few weeks after delivery is not an uncommon condition. Postpartum psychosis (PP) is characterized by acute onset of mood swings, confused thinking, fearfulness and grossly disorganized behavior. Postpartum psychosis occurs in 1–2/1000 childbearing women within the first 2–4 weeks after delivery. Postpartum psychosis in mothers has significant impact on their health and infant's safety.

The illness has its onset in the early postnatal period, usually the first month after childbirth. Clinically family members report of acute change in patient's behavior i.e. becoming angry easily, not sleeping, reduced care towards the new born and reduced self-care. Later patients may display disruptive behaviors like becoming violent or fearful with delusions of persecution or completely stop talking, while displaying catatonic symptoms in the form of mutism, withdrawn behavior etc. Suicide is not an uncommon outcome in women with postpartum psychosis, more so if the presentation has associated depressive symptoms. Rarely infant related harm and violence may be seen in mothers who are disruptive and have delusions involving the new born child. Among patients who develop postpartum psychosis immediately after childbirth, around 80% have bipolar illness or schizoaffective disorder, while the rest have schizophrenia. A small but significant number of women who have postpartum psychosis are associated with organic causes like Cortico Venous Thrombosis (CVT), pregnancy induced eclampsia and infection. Several factors have been identified that significantly increase the risk of puerperal psychosis; of them past history of puerperal psychosis and family history of bipolarity are important predisposing factors. The presence of the above history increases the risk to up to 50% recurrence of puerperal psychosis.

Puerperal psychosis is an emergency and safety of both mother and infant is the first priority. Puerperal psychosis responds dramatically to antipsychotics and in some patients, there may be a need to use Electro Convulsive Therapy. Neuroimaging should be considered if patients present with symptoms of confusion, headache, seizure or any neurological deficits to rule out CVT. Mood stabilisers, mainly valproate and carbamazepine can be used to treat if the symptoms are predominantly bipolar in nature. Preventing relapse of mental illness during pregnancy and puerperium is important as more than 50% of women will have further episodes in postpartum in future if untreated. Breastfeeding can be continued while the patient is on psychotropic medications as the advantages outweigh the risks to the infant. Antipsychotic medications are secreted through breast milk, but it is less than 10% of that in maternal serum. It is important to watch for side effects in the infant, particularly in Low birth weight infants. Breastfeeding needs to be encouraged as it is known to improve mother infant bonding. Once the acute phase of symptoms remit, then mother should be helped to take care of the child and focus will be on improving mother infant bonding. Parents and couple should be educated for planning future pregnancy in view of higher risk of relapse in future childbirth.

Dr Girish Babu N

Associate Professor, Department of Psychiatry, SDMCMSH, Dharwad

Undergraduate Section

"BURN-OUT" epidemic among Medical Students and Doctors!

Doctors have much higher rates of mental illness, alcohol & drug abuse and suicides among all professions and the general population of the same age and gender. Women doctors are more vulnerable and seem to succumb more easily to depression. **Are we Doctors in denial of these facts?**

Doctors become very good at 'putting on a mask' of professionalism and caring for others, as our Medical Education has trained us to do so. We were never taught to take care of ourselves and often feel guilty for taking time out for ourselves! There is too much shame and social stigma attached to mental illness among medical fraternity. This prevents accessing of help by the troubled person. Hence, there is an urgent need for sensitization and awareness creation among Medicos. To be able to recognize early signs in oneself and among our peers, so as to get timely help; we need to be trained.

Unidentified, Unrelenting and Untreated Stress, Anxiety, chronic lack of Sleep and Exhaustion can progress to Distressed and Disturbed Doctors, to Disorder and Depression; sometimes even Death!

What is Burn-Out and how does it happen to a doctor? Burn-Out is a very insidious and a silent tragedy. Causes are both external and internal. A flame to burn bright needs a wick, fuel and oxygen. To burn steadily it needs protection from wind and rain. Similarly a doctor needs self-love and self-compassion to ensure self-care. To work effectively we need a sense of purpose and fulfillment in the work we do. This can counter-balance the drudgery, the long hours, the pain and suffering we witness and the death of patients we cannot save. If we do NOT give ourselves adequate attention, care and time to rest on a daily basis, we will lose the passion and motivation to keep doing the work we were trained to do. We will stop enjoying the role of care giver, our emotional balance gets upset and the sense of fulfillment from the profession fades very quickly. If we are just working to finish a job, to earn a salary or find it unfulfilling, these are signs that we need help or likely to have a total burn-out!

When 'I' changes to 'WE' even 'I-llness' becomes 'WE-llness'! Hence we have D-4-D; Doctors4Doctors! This is the name of the project initiated by the IMA National Committee for Emotional Health and Emotional Well-being of Medical Students and Doctors in India. We want the Medical Community to come together under D-4-D, to help one another while also helping ourselves to stay healthy, motivated, energized, passionate and compassionate towards ourselves and our patients. When we join hands with fellow doctors, we know we are not alone in facing internal and external challenges and we are confident that we will find the right support, acceptance, empathy and even professional help if we need it, within the D-4-D community.

IMA will collaborate with NIMHANS, IPS and select NGOs working in this space. D-4-D will create Awareness, Advocacy, Emotional Wellbeing, Robust Resilience and Coping Capabilities among UG, PG Medical Students and Doctors in India. **Well-being is the Vaccine against Depression!**

Vision Statement for IMA Project "Doctors-4-Doctors"

"Together, we will make India a country where no medical student or doctor ever feels so isolated, helpless and desperate in life, as to go through burn-out, fall into depression or commit suicide! We will achieve this by doing all we can to create Emotional Well-being, provide training and tools for self-help and offer D-4-D Free Help Lines to those in need!"

Dr. Nilima Kadambi
(M.B.B.S., M.S., M.Ch.)
Bangalore, Karnataka

CHAIRPERSON
IMA National Committee for
Emotional Well-being of Doctors

UG n PG

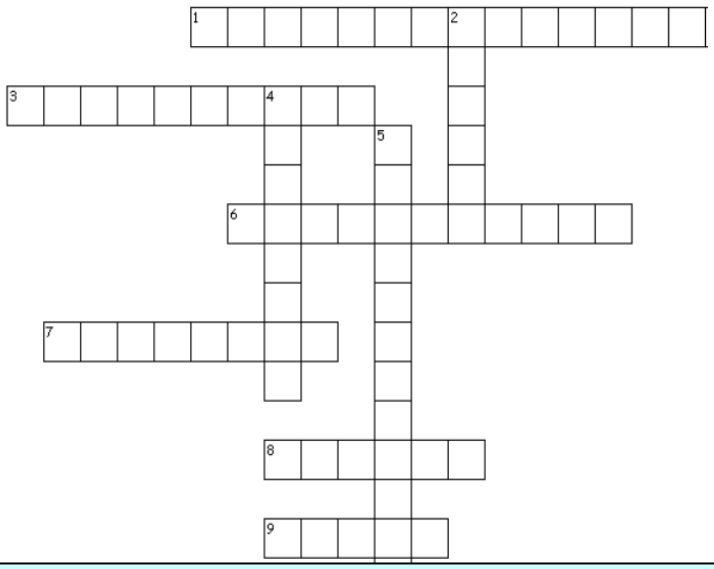
AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

UG n PG

MINDS QUIZ

1. Most specific speech sign of schizophrenia:
   a. Circumstantiality b. Tangentiality c. Neologism d. Clang association
2. Not seen in catatonia:
   a. Catalepsy b. Cataplexy c. Stupor d. Excitement
3. Drug of choice of restless leg syndrome:
   a. Ropinirole b. Aripiprazole c. Haloperidol d. Amisulpride
4. Catastrophic Reaction is seen in:
   a. Depression b. OCD c. Dementia d. Panic disorder
5. Neurotransmitter not raised in delirium:
   a. GABA b. Norepinephrine c. Dopamine d. Glutamate

Can you cross the crosswords!!!



ACROSS

3. Drug that 'revolutionised' schizophrenia treatment
5. Morbid fear of open spaces and leaving familiar settings
7. Defence mechanism used to logically justify irrational behaviour/feelings

DOWN

1. Bush Francis rating scale is used for
2. Fixed, false, firm belief
4. Personality disorder described as emotionally unstable
5. Inability to relax or sit at one place
6. Lack of emotional involvement and interest in one's surroundings

Contributed by Hrishikesh Solunke, Pg in Psychiatry, JSS Hospital, Mysore.

ANSWERS

MINDS QUIZ

1. c
2. b
3. a
4. c
5. a

CROSS WORDS

ACROSS

3.Clozapine
5. Agoraphobia
7.Rationalisation

DOWN

1.Catatonia
2.Delusion
4.Borderline
5.Akathisia
6.Apathy

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

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