Monthly Newsletter on Psychiatry for Doctors & Medical Students
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# FROM THE EDITOR'S DESK...

## DON'T SHOOT THE MESSENGER

Recently a 16 year old burst onto our TV screens. She voiced her concerns on the climate change crisis looming large over the world and chose a succinct phrase of *"how dare you"* to showcase her angst. The audiences, however, were divided.

The quickest searches made by the uninitiated about her on the internet found pages dedicated to her clinical diagnosis of *Asperger's syndrome with OCD with Selective Mutism*. It now became easy to explain each of her behaviours. Her parents faced her brunt upfront before the world got to see it...They were coerced into veganism, giving up on flight travel and taking up cycling. The truant youngster later upstaged her protests outside of the Swedish parliament for an entire academic year demonstrating her inflexibility in thinking. Her narrowed field of interest saw her making it to documentaries and world's fanciest lists. When she brought on a condescending facial expression as a negligent world leader walked in at the UN Summit, it emphasized to us intellectuals, the need for social skills training in people like her who have deficits in social perception. Once her case was deconstructed, it was and is quite easy to take pot-shots at the mindset of her unscrupulous parents who seem to be riding high on her organized claim to fame.

All said and done, most of us missed the focal point. She was a child asking for help against a problem that should seem more personal than distant. Her voice choked with emotions is not a measure of distress due to contamination obsessions! Why must it be so hard for us to see people beyond their clinical labels? Is it a matter of difficulty in trusting what a person with a psychiatric illness has to say otherwise? The example of Greta Thunberg stands true to the point raised.

"The world must need all kinds of thinkers - visual thinkers, pattern thinkers and verbal thinkers", said Dr. Temple Grandin, an American professor in Animal Science having lived her life with Autism herself.

Dr. YAMINI. D and Dr. SUHAS CHANDRAN

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# GOING DOWN MEMORY LANE

As I began to write this article, it dawned on me how *'going down memory lane'*, is an important and universal diagnostic and therapeutic tool vital for the survival of every healthcare professional.

As a medical student in the 1970's, I was taught the universal skill of 'history taking'. This was to master the art of eliciting a chronological history from a patient, to understand the course and progress of symptoms and thus to ascertain the pathology or diagnosis. This was nothing but simply mastering the science of inquisitively questioning the patient to *'go down the memory lane'* i.e. 'can you recall when you first experienced the abdominal pain?'; 'when did you first experience auditory hallucinations?'.

As I progressed in my training and practice, both as a Doctor and Psychiatrist, I experienced the need to take each patient *down an antiquated memory path* by specifically asking a question of every new patient, 'how would you describe your childhood?', 'Do you recall any traumatic experiences during formative years?'. Such an exploration of subjective experiences of yester years helps understand a patient's thinking and behaviour patterns and thus the potential to bring about corrective interventions.

In my training in the late 1980's as a Psychotherapist, I can now in retrospect understand Freud's incessant desire to understand the repressed memories of the unconscious. This is an art and a quest to lance the patient's emotional abscess and thus release the pain of somatoform manifestation of underlying emotional distress. In such cases, it is an enforced opening of the gates of *'let us go down the repressed memory lane'*.

As I metamorphosed in the 1990's from a Psychotherapist to a Cognitive Behaviour Therapist, I had to yet again delve into the patient's early life experiences and thus understand the 'core beliefs' of the patient. This belief system is absolute and deep-rooted in the patient's *'memory lane'* of early life experiences or traumatic events of the past. Little does one realise the importance of *'going down the memory lane'* for therapeutic gains and improving quality of life.

At the start of the new millennium, I began the practice of Eye Movement Desensitization and Reprocessing (EMDR). This is a therapeutic intervention, specifically used for the treatment of Post-Traumatic Stress Disorder. More recently, EMDR has been used for a host of other physical and mental health problems, including somatoform pain, unresolved grief etc. The fundamental therapeutic intervention is to bring about an emotional and cognitive change by asking the patient to recall the *'troubling memories of the past'* traumatic event from the ubiquitous memory lane. The therapist thereafter invokes cognitive interweaves for the troubling memories to reduce the emotional experience of pain and suffering provoked by *'memories of the past trauma'*.

On each occasion, when the traumatic memory of the past is processed, new memories emerge, as the unconscious mind submerges itself into the repressed *'memory lane'* and evokes new thoughts and memories that are processed until the distress is reduced.

It is thus apparent that *'going down memory lane'* is a necessary skill and tool, both for physicians and psychiatrists. It is of tremendous diagnostic and therapeutic importance. We are constantly taught to keep moving forward and not look back. However, to achieve the objective of a journey to travel to the end of the road, it is every so often important to revert the travel, so that the experiences of the past could be put to an advantage for the betterment of the travel for the future. Whether it is childhood to old age, love to grief, sorrow to joyfulness, compassionate nationalism to aggressive globalisation, or simple understanding of progression of pathology from the nascent growth of a cell to its cancerous state, it would be at one's peril if one were to choose not to meditate every so often on that huge experiential learning that one can achieve from *'going down the memory lane'.*

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# THE GROWING WORLD OF INFANT MENTAL HEALTH

A common phrase heard throughout a doctors training journey is "Prevention is better than cure". This became very apparent for psychiatrists while treating acute mental illness in adults. We realized that for many of our patients standard treatments were insufficient in reducing morbidity due to delayed onset of treatment. So a lot of emphasis was placed on youth mental health and early intervention: the earlier the treatment was commenced, even in what is known as prodromal phase (before the onset of active symptoms), the better the outcome. Over time, we realized that even in this group of young patients, there were some who had experienced trauma and adverse events in childhood that negatively affected their prognosis in adulthood. So it was important to mobilise efforts in child and adolescent mental health. But for some children even this seemed too little, too late. You may have guessed where I'm heading with this. Ultimately we now know that many risk factors for mental health conditions are established as early as while the foetus is in the development stage: during pregnancy and first two years of infancy. So we can see why focusing on infant mental health can help reduce lifelong risk factors for an individual.

## SO LETS START AT THE VERY BEGINNING...

When a pregnant woman is affected by stress, anxiety, depression or severe mental illness, it has a negative impact on the developing foetus. The risk of preterm delivery goes up and babies are smaller than gestational age.

Apart from many other factors, exposure to high levels of cortisol in the womb, leads to these babies being more fussy, having reduced facial responses and being less alert. If the mother remains unwell or becomes even more unwell after delivery, babies then go on to have difficulties in regulating their emotions, and difficulties with attachment.

## INFANT ATTACHMENT

Attachment in early years is often a basis of relationships throughout an individual's life and is a growing field of research in mental health. Attachment is a behavioural system that, when aroused, inhibits all other systems such as hunger, exploration, etc. The main function of attachment is to regulate stress in the infant by consistent availability of a familiar and responsive care giver. A reasonably secure availability of a care giver regulates the hypothalamic-pituitary axis and forms the foundation of overall development.

# THE GROWING WORLD OF INFANT MENTAL HEALTH

Infants may generate their own self regulating mechanisms in response to stress. But presence of a reliable and consistent parent, enables these strategies to work. Infants learn about their own emotional states by mirroring through an attentive parent. Needless to say if a parent is depressed, withdrawn or chaotic, giving contradictory signals, it can have quite a negative impact on the infants ability to manage his/her emotions, be confident in exploring away and feel safe to return to the parent. Donald Winnicott, a well known paediatrician and psychoanalyst, said “There’s no such thing as a baby”. Babies form the development of their “true self” only in the context of their relationship with their immediate environment.

Depending on the type of environment, infants develop different types of attachment, which we’ve now learnt can lead to different ways of relating as adults.

» **Secure attachment** can lead to confident and self possessed adult relationships.

» **Insecure-avoidant attachment** can lead to avoidance in expressing ones needs.

» **Insecure-resistant attachment** causes an individual to believe that only high intensity expressions are responded to

» **Insecure-disorganised attachment** can lead to incoherent strategies in dealing with stress

This can then lead to a myriad of problems in later years:

» Unmet dependency needs

» Relationship difficulties

» Emotional dysregulation

» Anxiety: OCD, Eating disorders

» Self esteem issues

» Substance abuse

» Depression

» Antisocial/borderline personality structure

**TREATMENT STRATEGIES:** Apart from treating the mental illness in the mother or primary care giver, many therapies have been developed to improve the infant attachment and bonding. Such as circle of security, parent-infant psychotherapy, parent interaction guidance, video feedback therapy. Parents are guided to manage their own difficulties and respond to the infant in a consistent and reliable manner, leading to more secure forms of attachment. Many therapies for adults also use attachment as a focus, such as dialectical behaviour therapy, mentalisation based therapy and attachment focused family therapy, among others. Through these therapies patents can learn to recognise and regulate their emotions and develop secure relationships.

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**ANSWERS TO THE CROSSWORD APPEARING ON PAGE 7**

(1) Phobia
(2) Autism
(3) Gedankenlautwerden
(4) Entgleisen
(5) Witzelsucht
(6) Trichotillomania
(7) Insomnia
(8) Paraprosopia
(9) Schizophasia
(10) Bruxism
(11) Dementia
(12) Stigma
(13) Kuru
(14) Delirium
(15) Dejavu
(16) Amnesia
(17) Doppelganger
(18) Abulia
(19) Confabulation
(20) Bulimia

# TRANSCULTURAL PSYCHIATRY

## #DROPTHEPHONE

Psychiatry as a field has been evolving since its very beginning and hence the spectrums of diagnosis have also expanded with the same .The spectrum to join the ever growing visual field of psychiatrists is the newest entrant 'internet addiction'.

Multiple studies have paved the way for the inclusion of this with a criteria of its own. Agreement to the presence of this is in the present generation is met with a resenting yes but how bad is the real situation. The thought of it simmering to break out in the coming generation makes it a serious cause for concern.

Before we begin to help others, the addiction within us has to be addressed. The number of doctors glued to the phones around us itself drives the old adage home; To help oneself before we help others. The discussions on burnout among doctors is a raging issue but little do we know that interacting with another stethoscope holder would help alleviate some steam. How many of us do really involve doing the same is the primary question. Coffee corners, nursing stations, lecture halls have all turned to mini internet cafes wherein each one is engaged in his own world of hashtags and blue ticks with invisible walls separating each one of us.

The fact that just as people on the other side of the consultation room experience varied possible emotions, we too feel the same. Doctors waiting to ventilate are many, the only thing missing are ears to heed to them. The times we would have heard a fellow doctor mentioning some stress and would have changed his affect immediately for the next ticket number.

Hence the hashtag: *why don't we put these things down and start talking!*

These phones are the epitome of the concept of *"Social Paradox"* wherein we are social in the unreal world but not so much in the real one. Burnout is a brewing topic and this has added fuel to the same. The need for an amiable work environment is definitely the primary criteria which each one of us would sincerely yearn for in a workplace, but little do we realise that once in the system, the key to the same is with each one of us. A simple smile can obliterate the walls of anxiety and help anyone settle in. The quote "Making one person smile can change the world, not the whole world, but his world" definitely does stand true.

There is no denying the fact that the field we are in is definitely draining and has pulled us down on certain days but a careful rewind would remind us of someone we knew that we spoke to about and hence why not wear the cloak of selflessness and light up someone else's day.

The fact that our specialty does deal with this does put us at an added advantage of being the fore for helping others. We can take the initiative on holding interactive sessions, reach out initiatives and the most basic of them all: smile with a communicable happy affect.

We do speak of depression and other psychiatric disorders being the next big thing in the future, and hence we should be capable to detect it and not culpable. Lets help our fellow doctors to say *"C'est la vie"* and move on with a smile, that the barriers they face are for them alone.

We do repeat that this journey is only once, so why not take the decision to *Drop the fown, the phone and the negativity*.

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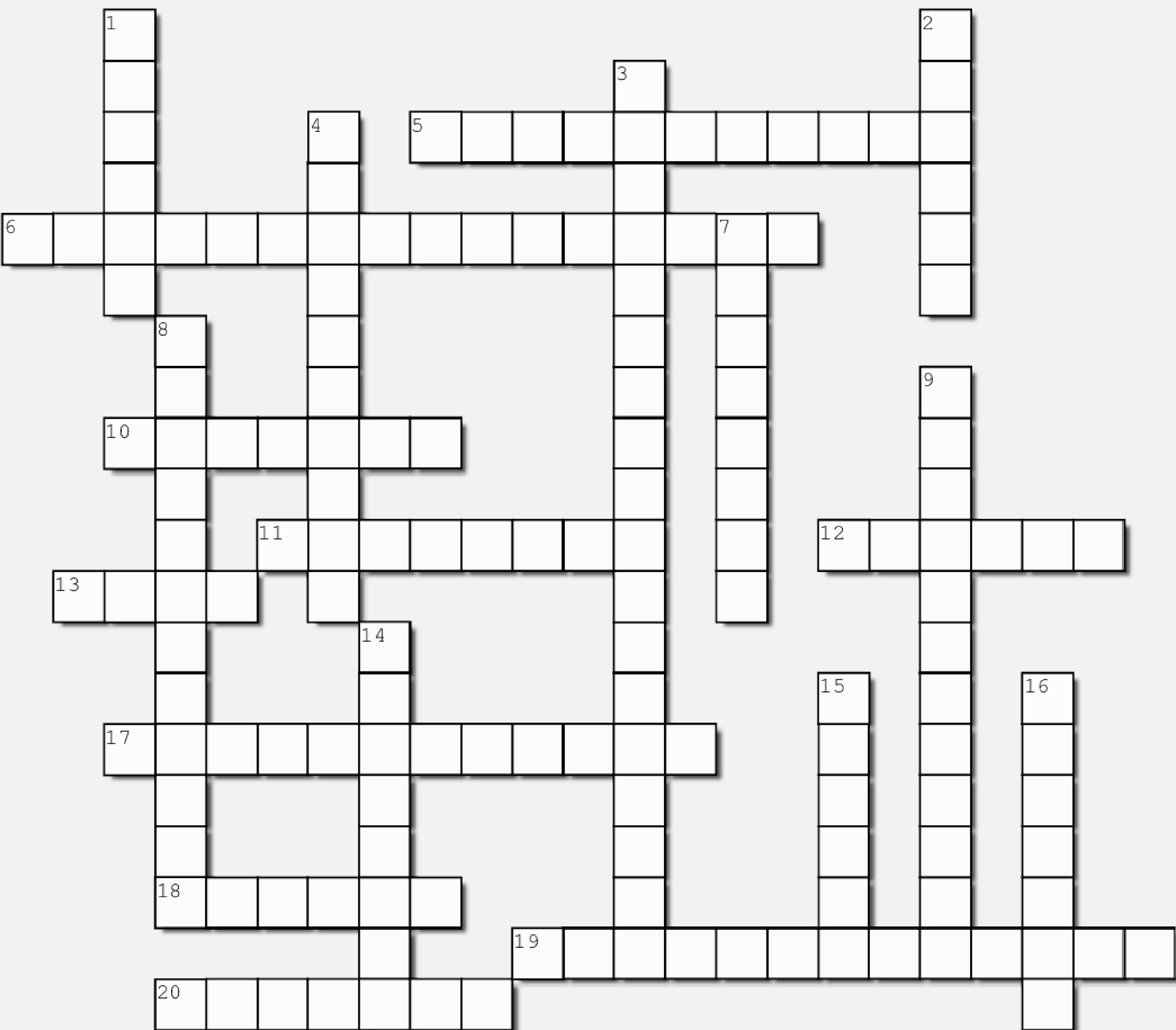


INDRA DHANUSH.U
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# Can you cross the crosswords!!!

DOWN:

1. Irrational fear
2. Disability of learning and communication
3. Overwhelmed by thoughts
4. Derailment of thoughts
7. Burning the midnight oil
8. Feeling someone's face transform into a monster
9. Word salad
14. Insanity
15. Feeling that a particular event had already happened before
16. Loss of memory

ACROSS:

5. Tendency to tell inappropriate joke
6. Hair pulling disorder
10. Nocturnal teeth grinding
11. Declining mental abilities
12. Social unacceptability
13. Laughing sickness
17. Double trouble
18. You cannot decide
19. Confusion of imagination with memory
20. Make a pig of yourself

ANSWERS TO THE CROSSWORD ARE ON PAGE 5

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Your suggestions are important to us, kindly send them to:
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