MINDS
Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students
Volume 10 Issue 6 December 2019

GUEST EDITORIAL

Potential role of Private Practitioners in Teaching in Medical Colleges

A narrow definition of a teacher is someone whose occupation is to instruct students in a school or college. In its true spirit, a 'teacher' is a person who helps students to acquire knowledge competence or virtue. The recent decision of the Board of Governors of the Medical Council of India to the proposal to allow private practitioners as visiting faculty in medical colleges is a progressive step forward and would help break barriers in teaching and learning.

Doctors in private practice acquire vast clinical experience. It is true in India that the latest advancements in equipment and skills first reach the private sector before it percolates into institutional systems. A large and 'interested' human resource which was hitherto kept out of the medical education system will now be able to share their knowledge with students. The students who needed to attend conferences to learn new skills will now have the opportunity to be able to learn these from visiting faculty in their own classrooms. Conversely, teaching is also a way for the doctor in private practice to refresh her knowledge and stay rooted to the basic skills which she acquired as a student.

A large percentage of students eventually go on to work in the private sector after their course. But their training probably does not give them enough experience or orientation to expectations in the real world. The private sector also serves multiple sections of society in different innovative ways. This interaction with private practitioners would be a great way for the students to get exposed to the various opportunities available to her and make informed career choices. This move would also open up exciting avenues for collaborative research between institutions and private centers.

(Cont'd on Page 2)

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Potential role of Private Practitioners in Teaching in Medical Colleges

It is heartening to note that some centers in the country already have this system in place. A notable example is the Department of Psychiatry, KMC, Manipal which; supported by the MAHE, has been inviting national and international visiting faculty to interact with their students. The department also organizes study tours for their students to visit various centers in the private sector doing innovative work in the area of mental health.

While the MCI decision is an exciting opportunity for both doctors in the private sector to engage in teaching and for students to get exposed to newer avenues for learning, it must be borne in mind that this does not replace the important role played by the full-time faculty. A visiting faculty cannot fulfil the important duties of imparting basic clinical skills day to day bedside teaching and mentoring of the students. There will need to be enough safeguards in place to ensure that the genuinely interested doctor in private practice who has a passion to be involved in teaching and can add value to learning gets the opportunity to the mutual benefit of both the doctor, the student and the institute.

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As a post graduate, working with clients in therapy, many experiences have stayed with me through the years. With the passage of time and having the privilege of working with clients with difficulties, learnings from some of these experiences have been reinforced.

One such memory is that of losing a client to suicide. As a young trainee professional, I was besieged by doubts- of having made a mistake, about my own competence and abilities, of having missed signals or steps in a protocol. Feelings of loss and grief seemed to have no place in this context as it was supposed to be about the client and the family that had lost a member. Focusing on oneself and one's emotions and reactions seemed weak, self indulgent and the wrong response!

Fortunately, the systems put in place for training took over. In discussion with my therapy supervisor, I was able to process many of my feelings and responses. The team undertook a clinical audit of the case and we were able to reach some understanding of what transpired from a factual perspective. In informal, personal discussions with other members, I found that I was not the only one grappling with the loss of my patient. However, I perceived some resistance, stigma and barriers in being able to share personal sadness and grief. Subsequent reading helped me understand the possible reasons- fear of censure or judgment, feelings of shame, guilt, denial. Consequences include low self-confidence, feelings of anger and inadequacy. Many professionals report intrusive and avoidant thoughts about their client's suicide.

Over a period of time, I was able to reach a balance of examining what could have been done differently versus what was out of my control. This was a challenging equilibrium to reach. Our training emphasizes anticipation, control and the necessity of not making mistakes. Acceptance that when it comes to suicide, a client is likely to be influenced by a multitude of factors beyond our control is challenging. Mental health professionals are, inevitably, likely to experience client suicide despite their best efforts to avert this crisis.

Over the years, like many mental health professionals, I have unfortunately, had to deal with client suicide on occasion. Established protocols and systems along with experience have helped me cope on one level. At another, many emotions, questions and reflections remain, to be grappled with and made peace with.

An important learning from my training period that has served me well has been the necessity to acknowledge my grief and emotions, to share and discuss with peers, seniors and to facilitate communication with younger colleagues and postgraduates. Client suicide is a professional and personal trauma for every clinician. It needs attention and clinicians need to be trained to care for themselves.

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EPILEPSY – UNDERSTANDING ITS PSYCHIATRIC ASPECTS

Epilepsy is defined as the tendency to have recurrent unprovoked seizures. Worldwide, the prevalence of Epilepsy (recurrent seizures) is about 1%, whereas the lifetime prevalence of experiencing a seizure is approximately 5%.. Between 10 and 50%of patients with epilepsy have psychiatric symptoms. It is important for all doctors to get acquainted with epilepsy and its psychiatric aspects, so as to prevent misdiagnosis and inaccurate treatment.

Psychiatric aspects of epilepsy may be related to:

- Psychosocial consequences of diagnosis.
- Psychiatric syndromes directly attributed to epilepsy.
- Neuro-psychiatric effects of medications.

Psychosocial consequences of diagnosis :

A diagnosis of Epilepsy brings with it myriad psycho-social consequences like unemployment, dependency, restricted activities (potential hazard in driving, risk of drowning), stigma and ostracism.

Psychiatric symptoms directly attributed to epilepsy:

Pre-ictal:

- **Prodromal symptoms:** a variety of vague symptoms may be experienced by patients, hours or days leading up to the seizures. Example: tension, dysphoria ,insomnia etc.
- **Aura:** may occur immediately prior to seizure onset. They are
  - Stereotyped e.g autonomic or visceral aura (epigastric sensation)
  - Derealization and Depersonalization experiences
  - Cognitive symptoms (dysphasia, psycho-experiential phenomenon like deja vu, Jamais vu, fugue)
  - Affective symptoms (anxiety, euphoria)
  - Perceptual experiences (hallucinations, illusions)

Ictal:

- **Automatism:** simple or complex stereotyped (repetitive) movements that tend to be disorganised and purposeless. There is amnesia for automatism and the patient seems 'out of touch.
- **Epilepsy Partialis Continuans:** a condition of prolonged Complex Partial seizures lasting hours to days (confused with Psychosis, Delirium). Can have variable behavioural, perceptual, cognitive symptoms and periods of amnesia.
- **Ictal Violence -** with rare exception, ictal violence consists only of random shoving, pushing, kicking, or screaming. This behaviour is fragmented, unsustained, ineffectual, and, most important, unaccompanied by rage or anger. To be differentiated from Belligerence or resistive violence, a different form, occurs when patients fight against restraints during their ictal or postictal period.

Post Ictal:

- **Post-Ictal Delirium:** A confessional state characterised by disorientation, inattention, variable levels of consciousness, at times paranoia. Can last hours to days.
- **Post ictal agitation:** However, seizures occasionally lead not to somnolence, inactivity, and withdrawal, but rather to agitation, i.e., postictal agitation.

EPILEPSY – UNDERSTANDING ITS PSYCHIATRIC ASPECTS

If seizures involve the brain's language region it can cause transient aphasia. Similarly, if the seizure focus includes the cortical areas involved with motor function, patients may have a Todd's Hemiparesis (transient postictal monoparesis or hemiparesis, usually lasts minutes to hours)

- **Post-Ictal Psychosis:** usually follows a cluster of seizures or an increase in the frequency of seizures. At times withdrawal of anti-convulsant therapy may lead to psychotic features. A period of non-psychotic interval (hours to days) is observed following a seizure, followed by a brief psychotic episode.

Inter Ictal:

- **Brief Inter-ictal Psychosis:** also known as 'alternating psychosis' (there is an inverse relation between severity of epilepsy and severity of psychosis). Psychotic episode occurs unrelated to a seizure, when there is good control of epilepsy. The seizures are antagonistic to psychosis, where EEG normalizes during psychosis, known as 'forced normalization'
- **Chronic inter-ictal 'schizophrenia-like' psychosis:** about 10 times more common in epileptics than in general population. Commonly seen in Temporal Lobe Epilepsy, more common in early onset severe epilepsy. Usually has a chronic course and tends to have more affective symptoms.

Other presentations:

- **Cognitive Deterioration:** Due to cerebral hypoxia with repeated seizures and neurological effects of anticonvulsant medication.
- **Mania:** manic features are more commonly seen with right sided temporal lobe epilepsy.
- **Neurosis:** epileptics have 50% risk of depression, with suicidality risk about 5 times compared to general population and 25 times greater in focal seizures. 5 to 10% patients of epilepsy can have conversion disorder, with increased risk for 'psychogenic non-epileptic seizures'
- **Personality traits:** a controversial phenomenon associated with chronic Temporal Lobe Epilepsy. The classic traits include religiosity, hypergraphia, hyposexuality, 'sticky' personality.

Anti-Epileptic Drugs (AED) - induced cognitive impairment develops most often following rapid introduction, high doses, elevated serum concentrations, and a regimen with more than one AED. Toxic levels, in general, cause memory difficulties, intellectual dulling, and inattention. In addition, AED-induced forced normalization may lead to psychiatric disturbances.

To quote Hippocrates "Primum Non Nocerum" (First Do No Harm). It is only by acquiring medical acumen through knowledge and practice that we can follow this dictum.

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TRANSCULTURAL PSYCHIATRY

CAREGIVER BURDEN

Caregiver is an individual who has the responsibility of meeting the physical and psychological needs of the patient. Majority of the mental illness have an intense and unpredictable course placing the caregiver at a great risk of mental and physical health problems. The physical, emotional, social, financial toll of providing care is termed as caregiver burden. It is the stress perceived by caregiver due to the existing situation. Family burden is therefore of highest priority which would contribute to the long-term care of the patient.

They generally encounter problems communicating with professionals about their caregiving experience. Caregiver burden is reportedly a critical determinant for negative caregiving outcomes.

Predictors of caregiver burden

An established link between expressed emotions and the clinical outcome of the patient has been widely studied. Similarly researchers have found the link between the expressed emotions and caregiver burden. Caregiver having high expressed emotions in the form of criticality, over involvement, hostility were associated with higher scores on stress and anxiety.

Other predictors of burden involve

- Diagnosis of mental illness
- Duration of contact with patient
- Relationship of caregiver with patient
- Coping skills of caregiver
- Availability of resources
- Institutionalization
- Poor social support

Presenting signs and symptoms

Worry, loneliness, fatigue, irritability, anxiety, reduction in quality of care, social isolation, restriction of their personal activities, disturbances in sleep and appetite

Pathogenesis of health effects in caregivers

Caring for someone with psychiatric illness is associated with a higher level of stress than caring for someone with functional impairment from other chronic medical illnesses. Any amount stress activates the hypothalamic pituitary adrenal axis (HPA axis). After exposure to stressful stimuli, the hypothalamus releases corticotropin releasing hormone (CRH), which stimulates the pituitary gland to release adrenocorticotropic hormone (ACTH). ACTH in turn triggers the release of glucocorticoids from the adrenal cortex. During the same time the sympathetic nervous system is activated to release epinephrine from the adrenal medulla and norepinephrine from sympathetic nerves.

Activation of the acute stress response is life saving and prepares the organism to avoid impending danger, enhances attention and increases energy. In contrast chronic stress has negative consequences on health.

TRANSCULTURAL PSYCHIATRY

CAREGIVER BURDEN

Evaluating stress / burden in caregivers

The assessment of burden has become a challenging task for most researchers because cultural, ethical, religious and other personal values may influence perception of meaning and consequences of burden.

Stressful life events are inevitable, but it is important to identify those at increased risk for negative outcomes, assess the degree to which the caregiver's life and health maybe negatively affected, and the interventions that can be used to reduce the burden on the family.

- Brief clinical screening questionnaire for care givers
- Scale to assess expressed emotions
- Allowing enough time to the family to express their concerns with respect to care of the individual patient
- Clinician should remain alert to stress related symptoms
- Caregivers feedback sessions

Recognizing the psychological, behavioural and physical effects of caring for their loved ones is an opportunity for primary prevention.

Interventions to treat caregiver burden

- General measures include improving the home care, adult day care, routine friendly visit, use of assistive equipment
- Psychological interventions mainly include support groups or psycho educational sessions for caregivers.
- Pharmacological interventions include use of anxiolytics and antidepressant medication for associated mood symptoms affecting their functionality.

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ANSWERS TO THE CROSSWORD APPEARING ON PAGE 8

1) Hysteria
2) Parasomnia
3)Apotemnophilia
4) Akathesia
5) Neologism
6) Jetlag
7) Hypomania
8) Frotteurism
9) Naltrexone
10) Catatonia
11) Agarophobia
12) Actigraphy
13) Triskaidekaphobia

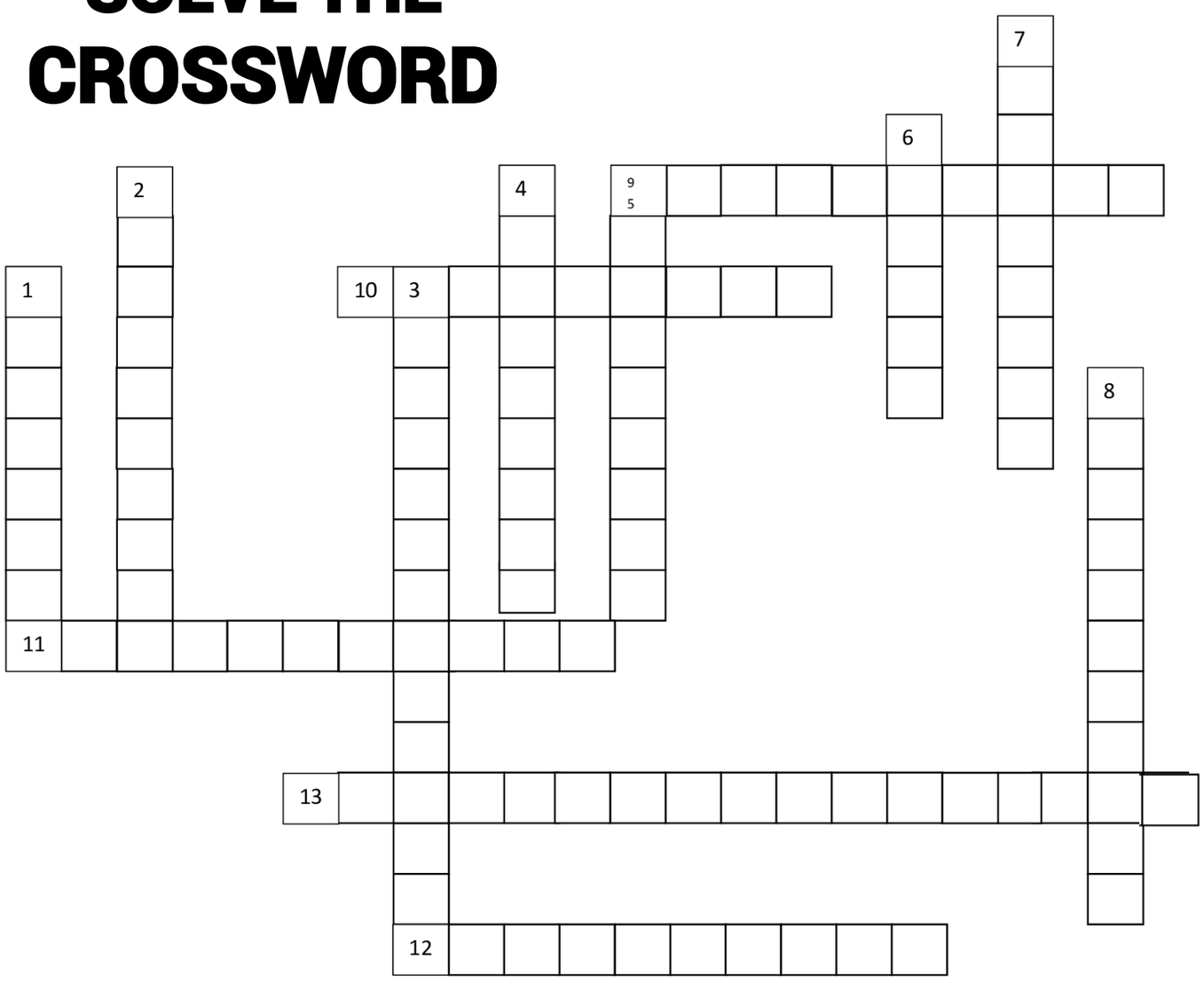
THE UNDERGRADUATE SECTION

VIEW FROM MY ROOFTOP

Glistening rooftops of tin huts in the distance,
the shimmer of sunlight bouncing off the windows of a car
slowly winding its way up the hills disappearing around the bends,
reappearing on the other side.
The farmer walks through his flooded fields
a small stick figure
knee deep in water; half naked
burnt almond in the summer sun.
On the street below:
the father holds tightly onto his daughter's hand
while she struggles to break free her tiny feet in her dusty school shoes,
rebel,
kicking up the dust on the road with every step;
the labourer returns from his day of work
his jute bag frayed at the edges, the head of a hammer sticking out
he squints his eyes against the brightness of the setting sun
and keeps his eyes on the road
his shirt grimy, untucked softly flutters in the wind;
the school bus turns the corner leaning heavily to one side,
and the happy babel of children
breaks the oppressive air of small-town silence,
their faces are flushed red
the water bottles around their neck
jiggling up and down with every bump on the road.
The whole thing is theatrical like a play that plays out
over and over again
and everyday
I drag my chair close to the stage
and watch…

- **DR. TSHERING ILLAMU**
1st Year Junior Resident
NIMHANS

SOLVE THE CROSSWORD



DOWN

1) Uncontrollable emotion
2) Unusual behavior during sleep
3) Desire to remove body parts by amputation
4) Motor restlessness
5) New words invented by the patient
6) Alteration to bodily circadian rhythm due to longdistace and transmeridian travel
7) Less severe form of mania
8) Non consensual rubbing of genitalia against a stranger

ACROSS

9) Drug used to treat alcohol dependence
10) Psychomotor immobility
11) Fear of being alone in public
12) Non invasive method of recording human rest/ activity
13) Fear of number 13

CREATED BY
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ANSWERS TO THE CROSSWORD ARE ON PAGE 7

Your suggestions are important to us, kindly send them to: editormind@gmail.com

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FROM THE EDITOR'S DESK...

ATONEMENT

International Day for the Abolition of Slavery is observed on the 2nd of December each year. It is possibly the cruelest act that humans have unleashed on each other since ages. The images that come to mind when "Slavery" is discussed is varied - the forceful exportation of Africans to many parts of the world, to huddling the Jews minorities in Holocaust Germany, to modern day curses like Child labour, Forced marriage, Bonded labour, Trafficking, and persecution for social dominance.

A recent announcement by the Government of Ghana took the expatriate countrymen by an uneasy surprise. "The door of no return" displayed on Cape Coast castle was changed to "the door of return" boldly jutting into the Atlantic Ocean. This castle that stood testimony to housing the slaves before their absorption into different lands now voices the Ghanaian government's intentions. "Akwaaba anyemi," meaning "welcome, sister or brother" is an earnest effort to call them back to their roots. Germany has attempted at financial recompensation of the descendents of the enslaved Jews as well as tried war criminals through Nuremberg trials and thereafter outlawed symbols that incite hatred among communities. The latest in line is India which feels the obligation to accommodate for persecuted minorities in the neighbouring lands...

Wrong done but can it be amended?? Melanie Klein in her writings states that reparation (actions towards amending a wrong) is a sign of psychic maturity. Donald Winnicott furthered the same point by noting that initial indulgences in Destruction → Sense of personal guilt → Reparation, as a natural developmental tendency just as how a child would feel the sense of indebtedness towards a mother who bore his aggression/Destruction...

It's marvelous to think that the macro-world dynamics can indeed have psychoanalytic underpinning and can carry through trans-generationally!

Dr. YAMINI. D and Dr. SUHAS CHANDRAN

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SMELL SUICIDE

Memory and smell, they say, are closely connected. I am reminded of the distinct smell of organophosphate ('OP' as we all called it) when I recall memories connected to the emergency ward of "KR Aspatre". These memories are mostly of those tiring, sleepless days and nights of my internship. The smell began even before you entered the ward and intensified at its peak as you reached the right corridor of the ward. Most patients admitted with OP poisoning got to stay in that corridor. With mortality rates quite high in those admitted there, honestly, it was a "corridor of uncertainty" (a phrase so own to the cricketer within me). This is the corridor where I first saw 'delirium' (atropine psychosis as one PG told us) and kept seeing some more during the next few days. I recall a pair of interns summoned to every such poisoning case that entered the ward. Even before he/she could get to the bed, this pair would literally attack them on the stretcher with tubes- one pushed through the nose down the stomach and another through the urethra up the blabber. While about to do exactly that, to a teenage boy on one of those nights, we heard a voice of a PG saying "no its not OP, its 'rat'". A wind of "oh no!" struck us. Expressions of resentment as to the fact that this boy, who ingested rat poison (and not something as grave as OP), will occupy the bed with no much intervention to be done and yet having we interns to complete all the notes and mundane procedures. But there were two things for sure- one, he will be discharged the next morning and two, he was 'certainly' not going to die. Next morning rounds time! The senior most physician of the unit (respected but very intimidating) began taking rounds; his 'troop', which obviously included me, joined him. As soon as the troop reached this boy, the PG repeats "no its not OP, its 'rat'". A few second lull follows. The storm (only literal though) that followed this lull, is what made this 12-year old memory live so vividly in me. In his thick voice, SIR advises this teenage boy "visit me in my chamber, I will tell you what to take, how to take and how much to take" (this is an exact translation of his words spoken in Kannada) and moves to the next bed. The whole troop erupted in laughter and hailed his wisdom. But something smelled 'rat'y (if not fishy).

The stupid (that I realized only a year later when I joined psychiatry) in me too laughed. We stupids never knew that be it 'OP' or be 'rat', "suicide" is always "suicide". No one cared what the boy or his parents felt. I do not (perhaps none accept SIR himself) know whether he went to SIR and enhanced his knowledge on how to "commit suicide". I also do not know whether he indeed succeeded in his ultimate pursuit. The 'suicide attempt' to 'suicide death' ratio is 25 i.e. before the ultimate is reached they attempt 25 times. I do not know whether that attempt was first or twenty fifth. None cared to know. It is time that every doctor should know this. It was then as well, anyways it is never too late.

Suicide 'gate keeper training' is getting some (if not a lot) of mileage off late. Training teachers, parents and students the nuances of identifying hinters of suicidality in their wards, children and mates, respectively, is happening at various places. It is time such training percolates onto doctors (the 'tough nuts' as one of my friend calls them), specifically the non-psychiatry ones. If such training targets medical students early in their formative days, sensitization towards such issues can be much stronger. Such training should help them look at every suicide attempt with equal eye and take necessary actions (and avoid not-so necessary ones). Smell 'OP' or not ('rat'), they should smell 'suicide'. Suicide is an epidemic, doctors can certainly 'keep' the gate shut.

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BREAKING THE BAD NEWS: WHAT A DOCTOR SHOULD KNOW?

WHY BREAKING THE BAD NEWS IS IMPORTANT?

Breaking the bad news is undoubtedly an inseparable part of every doctor's life. A physician might need to disclose an incurable and untreatable infection and a surgeon about a malignant tumour to the patient. It is not uncommon for a doctor in the emergency department to declare the demise of the patient to the attendants. These are only some of the common situations of breaking the bad news in day to day practice.

Bad news has been defined as any news which could be perceived as threatening, either to physical or mental well-being and associated with little or no hope for the future. Most of the times, the news is disclosed improperly triggering a plethora of negative emotions from the patient as well as the attendant. Many a times, doctors find themselves underconfident and ill-prepared to divulge such news. There have been instances when such doctors had delegated the task of breaking the bad news to their subordinates or paramedical professionals to avoid embarrassment. Such behaviour can be devastating to the patient-doctor relationship and adversely affect patient outcomes. Hence, it is imperative for doctors to gain skills for breaking the bad news during undergraduate medical training.

HOW SHOULD THE BAD NEWS BE BROKEN?: A PRIMER ABOUT THE PROTOCOLS

Good communication is the cornerstone of breaking the bad news in an appropriate way. A doctor needs to disclose the facts about the diagnosis in an empathetic kind of way, not building up any false hopes. There are several protocols defined internationally to break the bad news such as SPIKES protocol, ABCDE protocol, and BREAKS protocol.

SPIKES protocol was given by Baile et al., 2005. The components of the SPIKES protocol are as follows:

S: Setting up the interview
P: Understanding the perception of the patient
I: Getting the invitation from the patient to disclose the news
K: Providing factual knowledge to the patient
E: Observing his or her emotional responses of the patient and being empathetic towards the patient
S: Explaining the strategy and summarizing the session to the patient

VandeKieft gave the **ABCDE** protocol in 2001. The components of the ABCDE protocol are as follows:

A: Preparing in advance
B: Building a therapeutic relationship
C: Communicating well
D: Dealing with reactions of patient and attendants of the patient
E: Encouraging and validating emotions

Narayanan et al., 2010 proposed the **BREAKS** protocol. The components are as follows:

B: Building the background for breaking the bad news.
R: Establishing rapport
E: Exploring what the patient knows about his or her physical health and illness
A: Announcing the diagnosis
K: Kindling the emotions
S: Summarising the session

BREAKING THE BAD NEWS: WHAT A DOCTOR SHOULD KNOW?

Breaking the bad news: What to do in practice? (based on the summary of the protocols)

Firstly, the environment for breaking the bad news needs to be conducible for both the patient as well as the doctor. The room must be adequately lit and noise-free. Seating must be arranged such that the doctor is able to maintain eye to eye contact with the patient as well as observe the body language of the patient. The doctor must ensure that adequate time is devoted to the session. Hence, it is suggested that the mobile phones must be switched off, and the "Do not disturb" sign at the door can be used to prevent any interruption. It is advisable to have an attendant with the patient who can accompany the patient home after the news is revealed. Most importantly, the doctor must be well prepared regarding the facts and figures about the illness, so that accurate information is provided to the patient.

Then, it is important to assess what the patient knows. Open-ended questions can be asked, such as, "You have been suffering from these symptoms for some time. What do you think the cause could be?" "As you know, the piece of the swelling operated last week has been sent for examination. Why do you think we have done that?". Hence, this provides the perception and the level of knowledge and information possessed by the patient. And, it becomes easier to start from where the patient knows. Furthermore, it provides an opportunity for the doctor to venture towards breaking the news picking up on cues from the patient's conversation. It is also warranted to know about the preference of the patient in terms of what extent he or she wants to know about the condition. Consent from the patient must be taken before disclosing to the attendants, and confidentiality must be ensured.

"A warning statement" such as "I am sorry (regret) to say that you have..", can be given to warm up the patient for hearing the bad news. Medical jargon must be avoided, and information must be provided in a clear way. The sentences need to be brief and not include more than three pieces of information. It is advisable to explain in numericals or percentages about prognosis and survival. The doctor must break the news in a neutral tone and answer the questions in a polite and patient manner. Following type of statements must be avoided.

- "You have the worst form of cancer."
- "Sorry, we can not do anything."
- "You are going to die soon"

Enough time must be given by the doctor for the patient to assimilate the information. Adequate pauses must be given so that the patient can bring out the emotions. Anger, denial, silence, incessant crying are some of the common emotional responses observed. The emotional response of the patient needs to be observed and addressed adequately. It is necessary to be supportive and acknowledge their emotional feelings. Menu of available treatment options must be explained. Finally, the session must end with a summary session. The doctors must ensure that patients are addressed with empathy rather than sympathy. The help of a mental health professional must be sought if the doctor believes that the emotional response is inappropriate or disproportionate or prolonged.

Suggested reading

- Vandekieft GK. Breaking bad news. Am Fam Physician. 2001; 64: 1975-8.
- Narayanan V, Bista B, Koshy C. 'BREAKS'protocol for breaking bad news. Indian J Pall Care. 2010; 16:61-5.
- Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. The Oncologist. 2000;5:302-11.

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TRANSCULTURAL PSYCHIATRY

MIGRATION, MENTAL HEALTH AND CONTEMPORARY CONCERNS

Migration is a universal phenomenon which exists since the times of human evolution or even predates that. All animals including humans migrate. Migration could be for various reasons, but the drive behind all migration is the hope for better condition or escape from the adversities. It is an eternal process since nearly 200 thousand years. We reside in different geographical areas marked by constituent flora, fauna, culture, climate and of course man made geographical boundaries of recent times.

There can be factors that push a civilization from one place to another or there can be factors that attract a civilization in terms of survival versus newer opportunities. In India, patterns of migration have been changing due to socio-cultural, economic, political and legal factors. The legal factors will have a major impact with changing policies, rules and regulations on the lives of at-risk population.

We need to look into the recent developments in the country and the newer changes the elected government is trying to bring. With respect to citizenship and immigration policies, we need to have insights from a mental health professional perspective.

When we look into understanding social factors like constant apprehension, threat, fear of being monitored, difficulty in adjusting to the newer socio-cultural environment, linguistic barriers, all these can have direct implications on neurobiology. Studies show that the neurotransmitter dopamine hyperactivity in the corpus striatum which are established using Positive Emission Tomography are one of the main factors in development of mental illness in these individuals.

Refugees, asylum seekers and irregular migrants are at heightened risk for certain mental health disorders, including post-traumatic stress, depression and psychosis. Since 2015, over 1.3 million refugees and migrants have arrived to European countries by the Mediterranean Sea. In addition, almost 3 million Syrian refugees are living in Turkey.

Numbers continue to increase as people flee their homelands due to human rights violations, persecution, poverty and conflict. Many come to Europe in search of economic and personal opportunities for growth. Once in host countries, they are often met with substandard conditions, uncertainty and instability. The combined result is a growing trend of mental health disorders and attempted suicides among the very populations hoping to escape their challenging situations.

Several studies shows that migrated population can have prevalence of psychiatric illness ranging from 24 to as high as 58 %. Psychiatric disorders especially in schizophrenia was peak in migrants. The refugee adolescents were found to be having low self-esteem and emotional problems. The somatic and neurotic symptoms were also found to be high in migrated population. The overall relative risk of mental illness in migration is 2.9 compared to non-migrant population.

TRANSCULTURAL PSYCHIATRY

MIGRATION, MENTAL HEALTH AND CONTEMPORARY CONCERNS

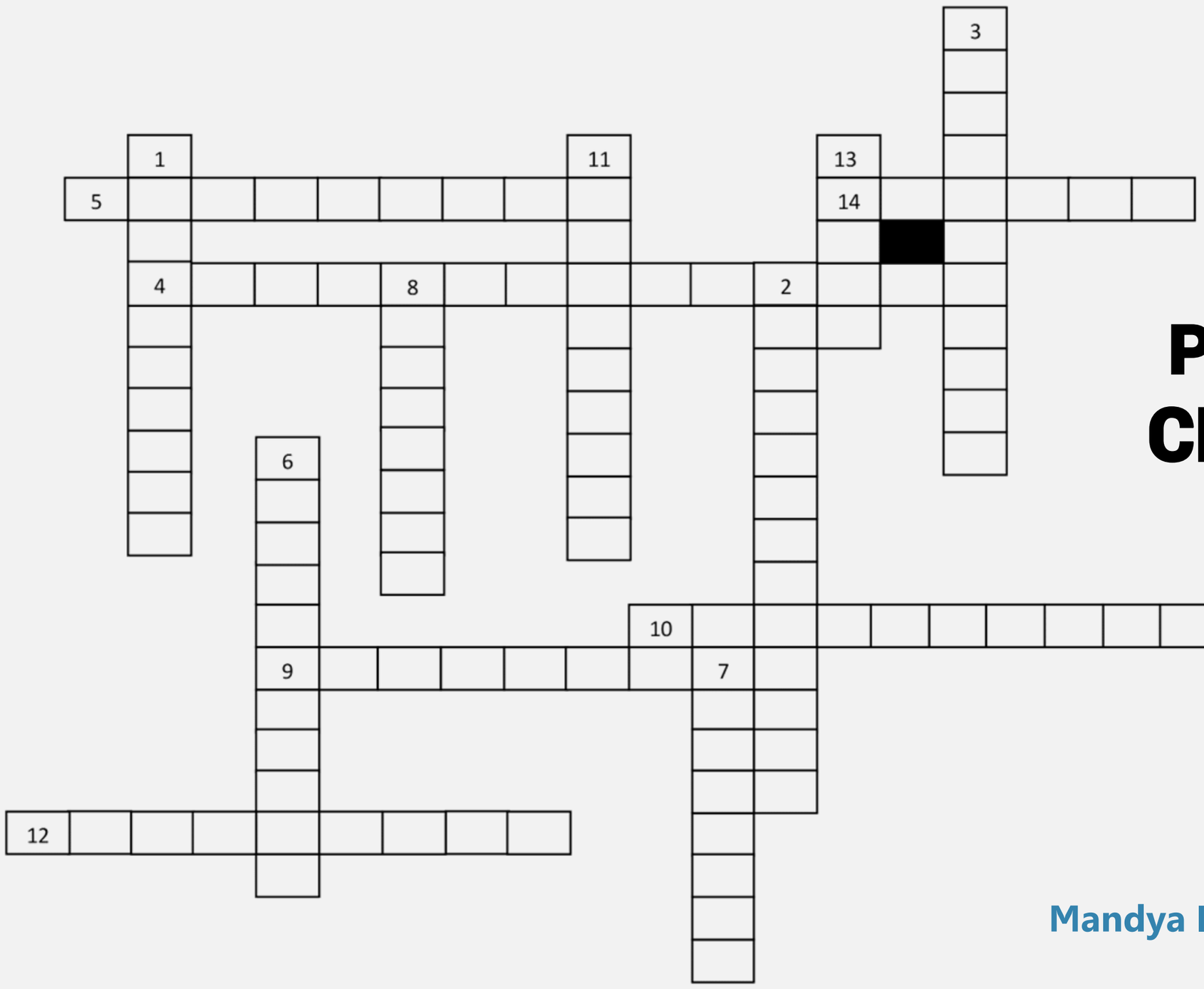
In India, along the Border States there are said to be an average of two million immigrants from different countries. With the new law, these populations can have difficulty in getting integrated into the present or the former community. The tedious task of proving the identity can itself be a significant psycho-social factor. The likelihood of refugee states of these populations poses a significant challenge for mental health professionals in addressing the same.

The measures to tackle this can be at various levels like administrators, community interventions self-help groups and mental health professionals. In the arena of psychiatry, the silence of professionals during partition is still debated on. Along with providing basic shelter, food, security and health care, provision for transcultural mental health units, screening for mental illness, capacity building of the other professionals working in public domain, education en mass on psychiatric manifestations and judicious supply of basic psychiatric drugs. Continued community based interventions and legal aid and care for human rights, can in fact smoothen the whole process from a psychiatric point of view.

Dr. Dayanand,
Junior Resident, Psychiatry,
Bangalore Medical College and Research Institute

ANSWERS TO THE CROSSWORD APPEARING ON PAGE 7

1) Alzheimer's
2) Disinhibition
3) Kleptomania
4) Hypothyroidism
5) Clozapine
6) Agoraphobia
7) Delirium
8) Thalamus
9) Paranoid
10) Trichotillomania
11) Depression
12) Cognition
13) Mania
14) Autism



PSYCHIATRY CROSSWORD

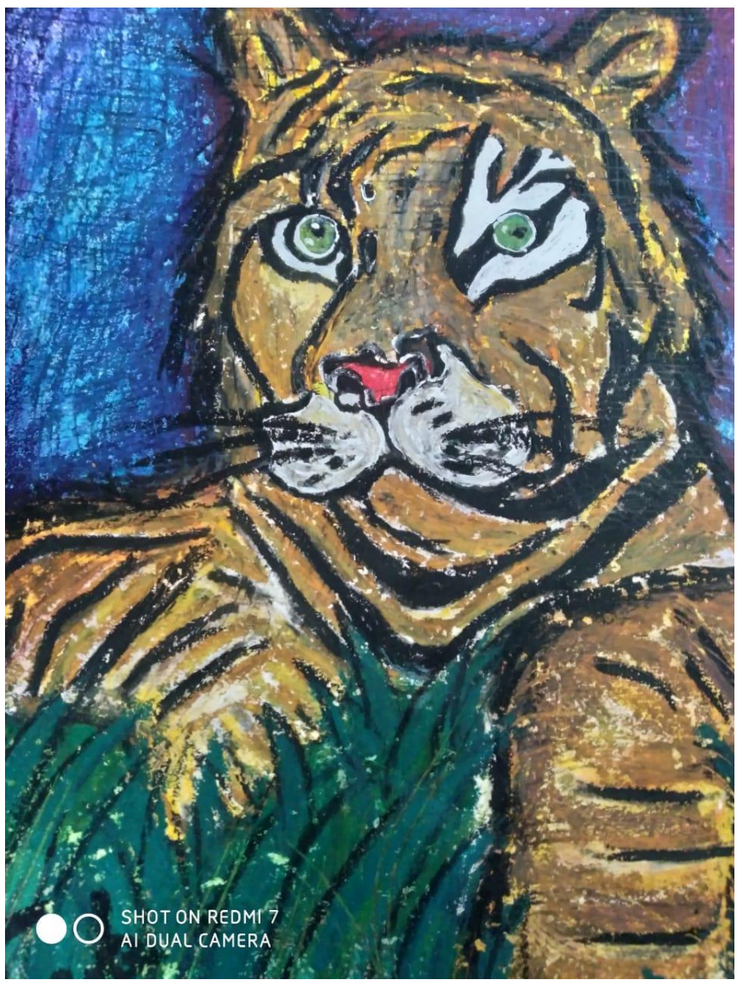
J. Vasundhara
Final year
Mandya Institute Of Medical Sciences

DOWN

1) Most common cause of dementia(10)
2) Clinical feature of frontal lobe lesion(13)
3) Irresistible desire to steal things(11)
6) Fear of certain places (11)
7) Clouding of consciousness (8)
8) Wernicke's encephalopathy involves this part of CNS (8)
11) Most common post-partum psychosis (10)
13) Flight of ideas (5)

ACROSS

4) Reversible cause of dementia (14)
5) Drug of choice for resistant schizophrenia (9)
9) Most common type of schizophrenia (8)
10) Pulling of one's own hair (16)
12) MMSE score used for assessment of (9)
14) Difficulty and learning in communication



CONTRIBUTIONS FROM A CLIENT

Ms Priyanka

ANSWERS TO THE CROSSWORD ARE ON PAGE 6

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MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 10 Issue 4 October 2019

FROM THE EDITOR'S DESK...

READY OR NOT ..... HERE THEY COME!

Violence against women is a prominent public evil, which has been dissected and discussed in social forums over and over again. It has however, enjoyed devious cultural backing at all times. And the legal implications of violent indulgences against women don't seem to have set an effective precedent to prevent future similar events. Rape in all its brutality surfaced yet again a few weeks back. The nation – wide shockwaves that it sent will serve as a reminder to us mental health professionals that there exists a deep crevice between the assumed effectiveness of our services in identifying, preventing, and responding to offenders and the stark reality.

The most common forms of offences are domestic abuse and sexual violence, and victimisation in these cases is associated with a heightened risk of mental illness including suicide. The real issue lies in the dearth of research on how to improve identification and treatment of victims and perpetrators, especially considering mental health services could play a major role in primary and secondary prevention of violence against women.

Sex offenders need to be profiled. Offenders may include those with poor social cognition deficits or those lacking inhibitory control. But it is those with psychopathic traits and high degree of callousness who indulge in predatory aggression and are involved in the deadliest of crimes. Of clinical interest are some of the explanations that have been put forth. The amygdalar under-arousal in their fear circuitry would mean that they forfeit law and rules with knowledge of the same but with no fear of violating them. A sense of entitlement with the constant need to suppress envy for things unattainable leads them to think - If the sex object is sufficiently damaged, she was not worth having in the first place. Deception by tricking unsuspecting victims and coercion feeds their sense of grandiosity. Identification of sexual offenders can help in revamping of the criminal justice system into looking for modifiable and unmodifiable traits and planning further course of action by liasoning with mental health professionals.

Women empowerment needs multimodal strategies. Mental health professionals can support the wellbeing of the victim by helping to rewrite the narratives of shame into narratives of power and by helping to resolve emotions and re-processing the traumatic events in a conducive controlled manner. Social awareness and indoctrination of value system through community participation by psychiatric social workers. These measures can bring a sea of change that is much needed.

Dr. SUHAS CHANDRAN and Dr. YAMINI. D

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KING GEORGE AND QUEEN MARY

As young senior house officers on the medical wards, we worked unlimited hours. Any number of chance events would prolong the day. I describe one such event.

In the early 70s there was not much in terms of psychiatric care practiced on the general wards. Attention was called to patient related incidents causing a great deal of distress. We had one such incident caused by an "Anglo Indian" as the term was, a sailor in the British navy in his 60s who had seen many ports.

He was causing the nuns (administrators) a great deal of concern – yelling out, talking incessantly all night, being hypersexual, asking the women to sit on his lap, walking without clothes on, using profane language, laughing a great deal without any apparent reason, and altogether refusing to cooperate with the staff. I was called to see him at night because they felt he was a nuisance, offensive, and wanted him off the unit. He had been telling them that he had King George on one thigh and Queen Mary on the other and kept calling them to see the royal couple in his bedroom.

On exam, he was clearly in a manic state. I asked him to show me the Royal couple. He did indeed show me the tattooed pictures of the Royals on both thighs. He had served as a sailor in the Royal Navy, with relationships in various ports. He was single, untreated for tertiary syphilis. In the days without current technology, we had to diagnose his condition by doing a lumbar puncture and establishing the diagnosis by careful history taking, and labs, & managing his mania.

What I learned that day was a) to examine a patient without prejudice or rancor, keeping my ears open for any aspect of history that could be missed due to stigma and discrimination; b) that psychiatric illness can be indeed caused by medical conditions affecting the brain; (secondary mania in this case); c) that his meaningful life story and who he was as a person was important for him to relate to us; d) that treatment of the condition was the same as any mania – which we accomplished, and that e)all patients have humane aspects of their lives to offer. Upon recovery, he had many anecdotes of his travels all over the world- much unknown to us.

I discovered I had the makings of a psychiatrist as a house officer and today, I continue to enjoy being one.

Ref:

1. https://en.wikipedia.org/wiki/King_George_and_Queen_Mary

2. de Voux, A., Kidd, S., & Torrone, E. A. (2018). Reported Cases of Neurosyphilis Among Early Syphilis Cases-United States, 2009 to 2015. Sexually transmitted diseases, 45(1), 39–41.

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CHALLENGES IN RECOGNISING AUTISM SPECTRUM DISORDER(ASD) FOR THE FIRST TIME IN AN ADULT

Autism Spectrum Disorders (ASD) describe a range of neurodevelopmental disorders characterised by difficulties in social interaction and communication, as well as restricted, stereotyped and repetitive behaviours. The prevalence of ASD is increasing with 1 in 59 children being identified with ASD according to recent estimates from CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network. One of the reasons for increasing prevalence is the "spectrum" concept of Autism with many individuals having less severe core manifestations. Recent meta-analysis tracing the temporal stability of ASD diagnosis and its severity have reported the diagnosis to be stable through the life-span. Thus, there is a large majority of undiagnosed ASD individuals who come to clinical attention for the "first time" in adulthood.

CHALLENGES IN MAKING A DIAGNOSIS OF ASD FOR THE FIRST TIME IN ADULTS

Most unrecognised individuals with ASD who present for the first time in adulthood are due to psychiatric comorbidities or psychosocial impairments as a result of ASD. These are individuals with no intellectual disability and are cognitively high functioning, with milder ASD symptoms, good verbal skills, no syndromic associations and escape clinical attention in childhood. Some of the clinical mimics are:

ASD and Psychosis: Poor social communication skills, verbosity and pragmatic impairments of ASD resemble negative symptoms and disorganized thoughts/speech of schizophrenia. ASD associated abnormalities in pragmatic behaviors, prosody, paralinguistic behaviors can be mistaken for schizotypal disorder or Mania. Rates of psychosis are also higher in adults with ASD especially with neurocognitive impairments in executive function and theory of mind.

ASD and personality disorders: Difficulty in social interactions and shyness can be mistaken for anxious personality. Emotional dysregulation in ASD with executive function and facial emotion deficits may be mistaken for Borderline personality disorder.

ASD and OCD: Ritualistic behaviors, sensory integration deficits, "need for sameness" in ASD, which are extremely common in adults may be mistaken for OCD. High functioning adults also have high rates of OCD comorbidity which makes the diagnosis extremely challenging.

ASD and mood disorders: High functioning adults with ASD, who present for the first time, may find social interactions draining and prefer solitude, which mimics depression. An insight into their socio-communicative deficits may also lead to demoralisation.

ASD and anxiety disorders: Any change in routine or transitions in life make an individual with ASD anxious and tense making a diagnosis of anxiety disorder extremely common in these individuals.

Individuals with ASD also repetitively experience interpersonal problems and failed social adaptation as a result of their socio-communicative deficits and may also present to a clinical psychologist with these issues.

CHALLENGES IN RECOGNISING AUTISM SPECTRUM DISORDER(ASD) FOR THE FIRST TIME IN AN ADULT

GENERAL MEDICAL CHALLENGES IN ADULTS WITH ASD:

ASD is associated with premature mortality. The expected number of deaths is approximately 2 to 3 times higher than age-matched and sex-matched peers in the general population. Though typical risk factors include Intellectual disability, seizures and accidents, there is accumulating evidence that ASD adults are at a high risk for a large number of medical conditions.

ASD is considered today as a multisystemic disorder with varied presentations. A proportion of individuals with ASD present with gastrointestinal and autoimmune manifestations which go unnoticed in childhood who later present with autonomic dysfunction, sleep issues and sudden death. Rates of obesity, dyslipidemia, metabolic syndrome, coronary artery disease are known to be higher especially in individuals on psychotropics. There is also recent evidence on higher incidence of Parkinson's disease in older adults with ASD.

CHALLENGES IN ASSESSMENT OF ASD IN ADULTS FOR THE FIRST TIME:

The key challenge in assessment is to have a clinical suspicion of ASD in individuals with pragmatic/prosody/paralinguistic abnormalities and social atypicalities and deficits who present with other psychiatric or psychological issues.

ASD assessment in adults should include assessment of core ASD difficulties, early development, medical and family history, behavior, education, employment and a needs assessment. A collateral neurodevelopmental history should be obtained from parents/carers who have known the individual well since early childhood to ascertain the presence of deficits since early childhood.

ASD screening questionnaires available for use with adults include the Social communication questionnaire, Autism Quotient (AQ), Gilliam's Asperger disorder scale, Ritvo Autism Asperger diagnostic scale.

CHALLENGES IN MANAGEMENT OF ADULTS WITH ASD:

No medications are currently licensed to treat the core symptoms of ASD in individuals at any age. Medications are prescribed to treat associated features such as anxiety, depression, OCD, psychosis etc. Adults who are diagnosed for the first time, who are usually high functioning, benefit from CBT for demoralisation and depression, anxiety and social skills. However, retention in therapy is low. There are long term issues regarding marriage and relationships, employment, effective screening and detection of medical issues in this population which needs to be addressed.

CHALLENGES IN RECOGNISING AUTISM SPECTRUM DISORDER(ASD) FOR THE FIRST TIME IN AN ADULT

CHALLENGES IN RESEARCH:

1)Develop diagnostic criteria and instruments for diagnosis and assessment of the needs of older and high functioning adults with ASDs as the current instruments focus mainly on childhood diagnosis.

2) Conduct longitudinal studies of life span trajectories that will examine the progression of behavioral, neuropsychiatric, and medical changes over time and potential mechanisms for recognition and altering these adult trajectories.

3) Conduct neurobiological studies that examine whether findings in young individuals with ASDs are present in older persons with an ASD and that examine the interaction between aging, associated disease, and autistic symptoms in the brain of autistic individuals as they develop in older age.

4) Conduct studies of psychosocial, behavioral, educational, and pharmacological interventions in older individuals with an ASD.

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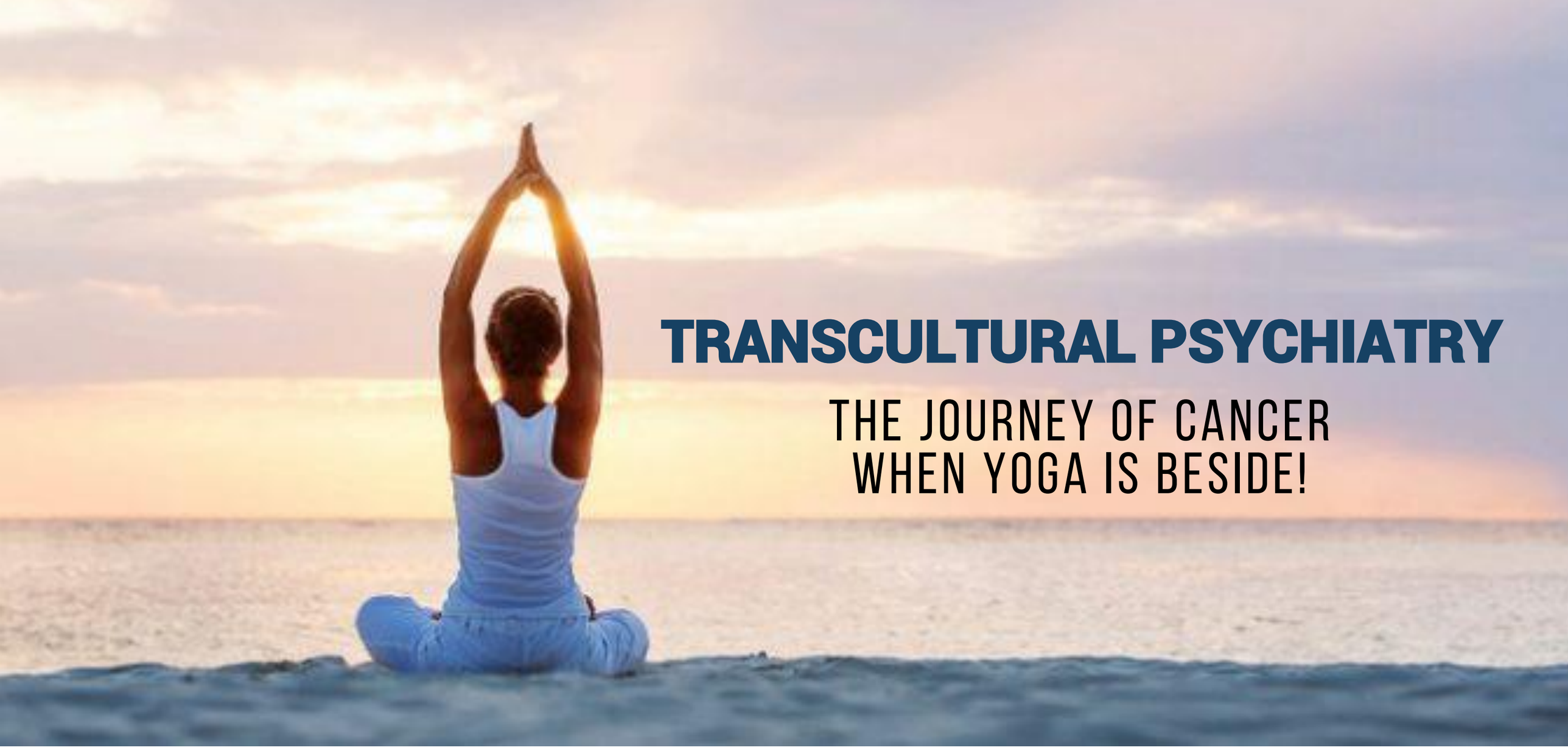
ANSWERS TO THE CROSSWORD APPEARING ON PAGE 8

1) Hara-kiri
2) HPD(Histrionic Personality Disorder)
3) Pfropf schizophrenia
4) OCD
5) PICA
6) Panic attack
7) Narcolepsy
8) Pyromania
9) Hoarding
10) Claustrophobia
11) Hypochondriac
12) PTSD
13) Kleptomania
14) Somnambulism
15) Anorexia
16) Hysteria
17) Paranoia
18) Paraphilia
19) Hippocampus
20) ADHD

'THE SHORTEST EMOTIONAL DISTANCE'

Sketch by Dr. Yamini D
Assistant Professor, Psychiatry,
NIMHANS



TRANSCULTURAL PSYCHIATRY

THE JOURNEY OF CANCER WHEN YOGA IS BESIDE!

Most of the people diagnosed with cancer chose to do *Yoga* after cancer treatment. They do not know that *Yoga* should/can be practised right from the time of diagnosis. This is precisely due to lack of awareness and *Yoga* is considered more as a form of fitness worldwide. There are few or no oncology sectors that provide *Yoga* in adjunct to conventional cancer care treatment.

How can Yoga help a patient?

Cancer the disease per se and its treatment causes a lot of stress in patients. It can leave them depressed, demotivated which in turn has an impact on the treatment outcome, i.e., increased side effects, repeated hospitalisation, etc. This aspect of a patient cannot be dealt with mere medications, but an initiative to enhance their will-power can help them to deal the situation positively.

Does Yoga cure cancer?

Well, there is no scientific evidence to prove that Yoga can cure or prevent any type of cancer. But, many studies have found Yoga to improve quality of sleep, mood and spiritual well being in patients suffering with cancer.

When can one do Yoga?

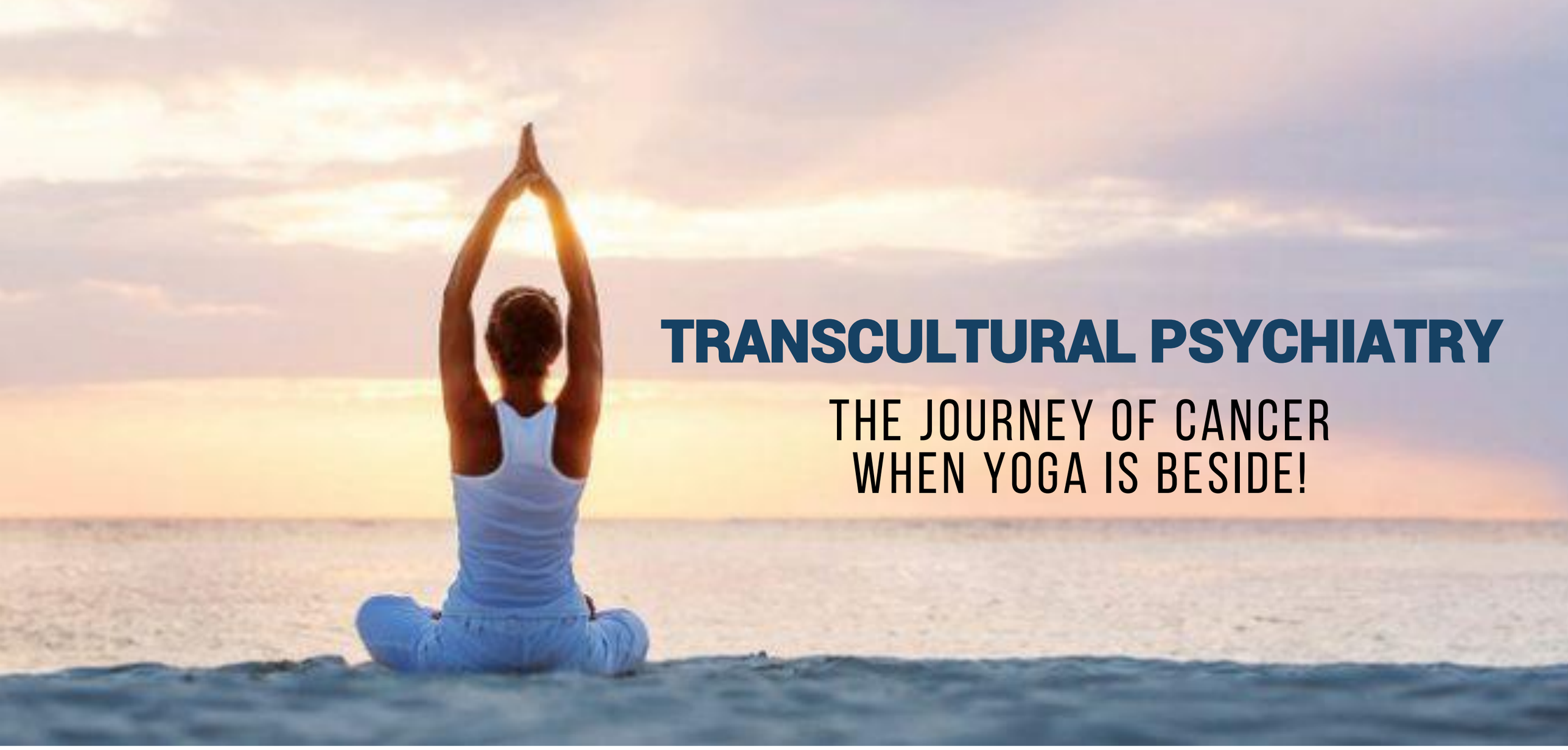
It is advised cancer patients to do *Yoga* right from the time of diagnosis.

Yoga is the ancient science derived out of the Sanskrit word ***'yuj'***, which aims to unite body, mind and spirit. It has eight limbs namely *Yama* (Universal morality), *Niyama* (Personal observances), *Asanas* (Body postures), *Pranayama* (Breathing exercises/control of prana), *Pratyahara* (Control of the senses), *Dharana* (Concentration and cultivating inner perceptual awareness), *Dhyana* (Devotion, Meditation on the Divine), *Samadhi* (Union with the Divine). For practical purposes*, Asanas, Pranayama* and *Yoga Nidra* (relaxation form of *Meditation*) are considered. *Yoga* can be done at all stage of chemotherapy, radiation and surgery. But, it is always safe and advisable that one learns *Yoga* from a *Yoga* expertise preferably one who has been trained in and in consensus with the treating Oncologist.

Following are few tips on how yoga can be incorporated while treatment is on -

- ***Pre-treatment***

'Fear' is a common factor faced by almost all patients before treatment. Although one need some time to overcome fear, the anxiety associated with the fear can be reduced by doing deep breathing practices before chemotherapy/radiation/surgery. A day before every treatment session is a scare, which can be overcome by doing relaxation techniques.



TRANSCULTURAL PSYCHIATRY

THE JOURNEY OF CANCER WHEN YOGA IS BESIDE!

- *During-treatment*

An idle mind is devil's workshop. While the treatment is going on, a patient can be disturbed by thoughts of the future, side effects (hair loss, etc.), disease, finance career, family, etc. By performing breathing practices, one will be able to divert his/her mind from these disturbing thoughts. It is the most feasible form of practice that can be performed even while radiation and chemotherapy is going on.

- *Post-treatment*

The journey of cancer is not easy! It will take some time for an individual to recoup him/herself. But, the *'fear'* of cancer can constantly ponder in one's mind. It can eventually affect their immune system that may trigger the likelihood of cancer recurrence.

It is therefore suggested to indulge in *yoga* regularly post treatment. *Yoga* poses may help to loosen the stiffened muscles; deep breathing/*pranayama* may help relax the mind by reducing stress; *Yoga Nidra* may help in removing the deep-rooted fear. As the stress start reducing, the patient start feeling more positive. This change in attitude can motivate an individual to take care of him/herself and improve their quality of life.

- *Caretakers*

The effect of cancer is not limited to the patients. It can affect the entire family including caretakers. A caretaker will have to compromise on their personal life and constant caregiving can lead to *'burn-out'*. So, it is better to engage caretakers along with their loved ones for *Yoga* sessions.

Stress burns away the innate nature (Care, love and affection) in human beings. While, *Yoga* helps to release stress, revive and be you.

So, now you know what *yoga* can do in the journey of cancer!

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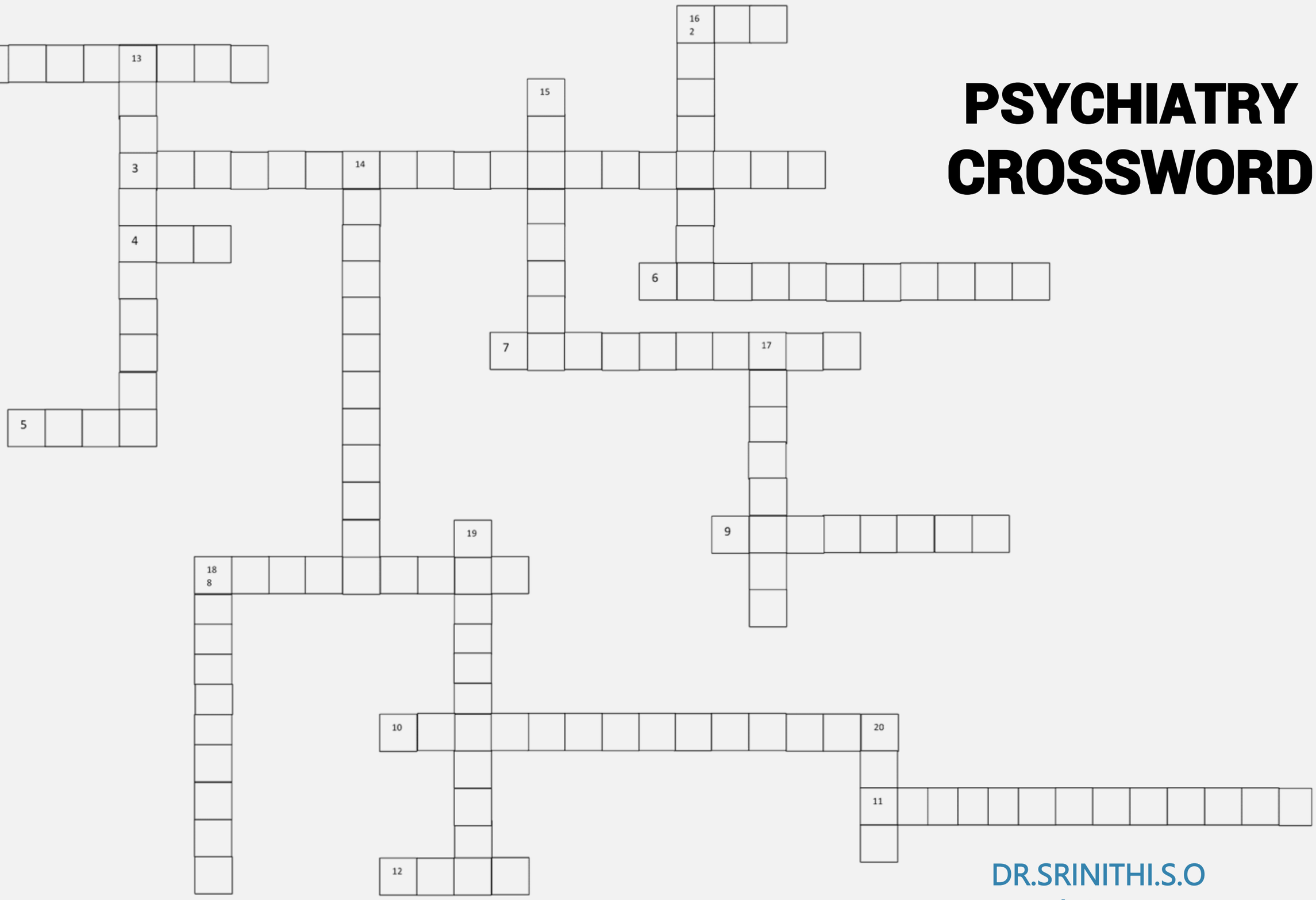
PSYCHIATRY CROSSWORD



DR.SRINITHI.S.O
Intern
THE OXFORD MEDICAL COLLEGE

ACROSS:

1) Japanese ritual suicide
2) Dramatic personality
3) Psychosis grafted upon mental retardation
4) Repetitive thoughts/images/impulses/acts
5) Consumption of non-nutritive substances
6) Fear of impending doom
7) Uncontrollable sleep attacks
8) Pathological fire setting
9) Distress at the thought of getting rid of things
10) Irrational fear of closed spaces
11) Health anxiety
12) Condition associated with flashbacks, nightmares, hyper arousal and anxiety

DOWN:

13) Impulsive stealing disorder
14) Sleep walking
15) Eating disorder with fear of distorted body image
16) Greek term for uterus and earlier symptoms was believed to be due to defect in the womb
17) Revengeful personality trait
18) Sexual perversion
19) Part of brain affected in most common memory disorder
20) Inattentive and easy distractible child

ANSWERS TO THE CROSSWORD ARE ON PAGE 5

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MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 10 Issue 3 September 2019

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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GOING DOWN THE MEMORY LANE

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.

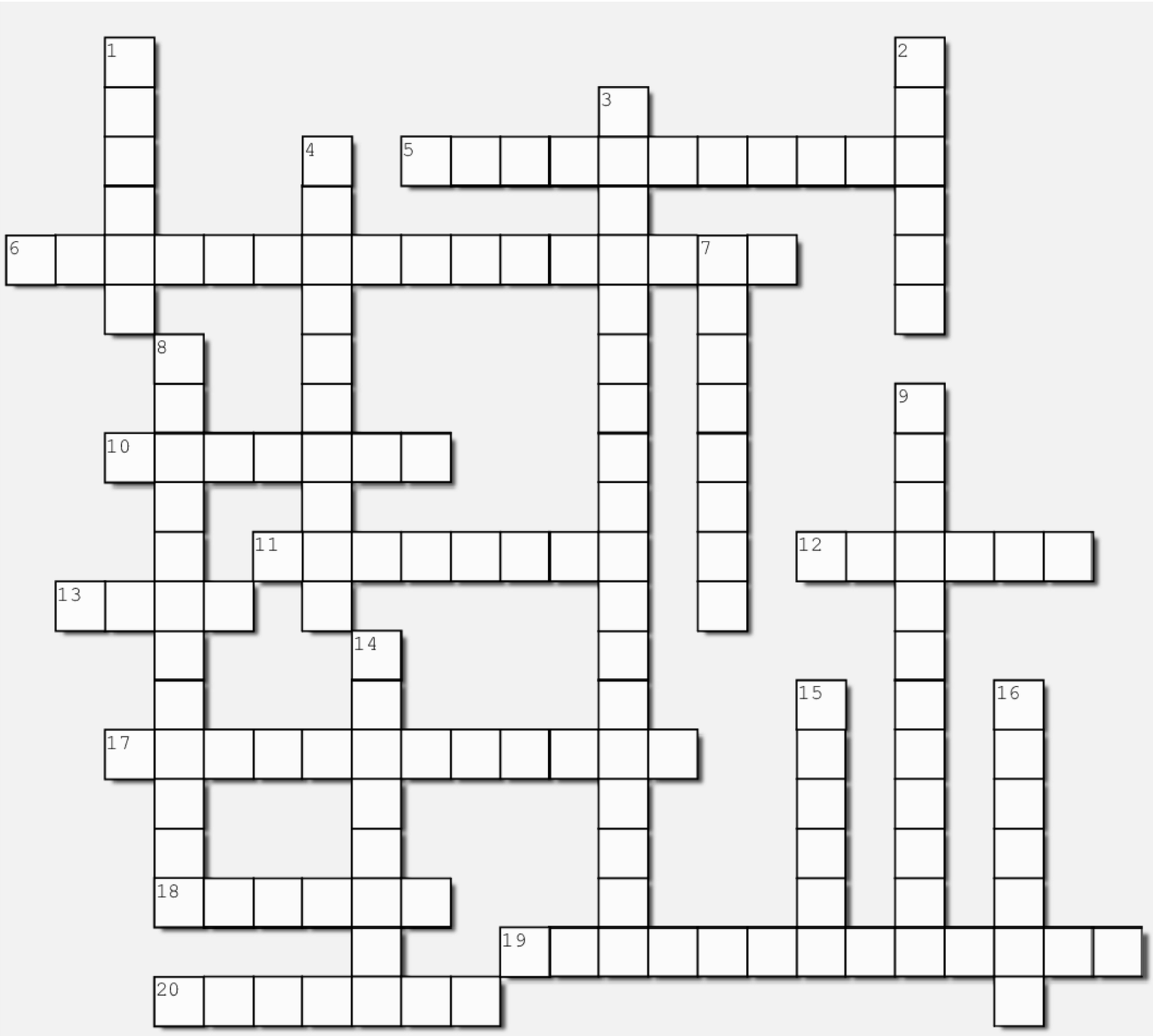
There is no denying the fact that the field we are in is definitely draining and has pulled us down on certain days but a careful rewind would remind us of someone we knew that we spoke to about and hence why not wear the cloak of selflessness and light up someone else's day.

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*.

Dr. Ajay Thomas Kurien
Junior Resident, St. John's Medical College Hospital, Bangalore



INDRA DHANUSH.U
3rd Term
ADICHUNCHANAGIRI INSTITUTE OF MEDICAL SCIENCES

Dr. Vijetha
Radiation oncologist, Cytecare, Hebbal

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

Your suggestions are important to us, kindly send them to:
editormind@gmail.com

MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 10 Issue 2 August 2019

FROM THE EDITOR'S DESK...

"I always like walking in the rain, so no one can see me crying."

-Charlie Chaplin

September 7th 2019 was no ordinary day. The anticipation of becoming the *first* was palpable. Subsequently we were all privy to Mr. K Sivan's emotional breakdown when the Vikram lander carrying the rover of Chandrayaan 2 made a hard surface landing and disengaged with the Earth. There was a delayed uneasiness in a few of us for the ISRO chief's behaviour. 'Men don't cry'. Atleast not the powerful, tough and competitive ones! This notion has long gone unchallenged. But something that's even more vital to question would be the need for him to cry at that juncture.

Why did he cry rather than why did *he cry?*!

Crying predates speech in human evolution. There are 2 underlying concepts that we need to bring to focus. Firstly, humans have the unique ability to assess and predict mental states of others. This is referred to as Theory of Mind or cognitive perspective taking. Mr. Sivan was conscious of the weight of expectations on this project and the sadness that ensued with its failure in the minds of all onlookers. Their sadness meant his sadness(due to the work of *Mirror neurons*) which was reflected in the tears he shed.

Secondly, we may be aspiring to be travelers in space but we are already travelers in time since the time we have understood the concept of "yesterday" and "tomorrow" - Mental time travel! This means to say that each one of us can mentally retrieve past events and also anticipate one's future based on them. Our memory can move back and forth(think ahead) in time. For Mr. Sivan, *Chandrayaan 2* (2019) was the immediate past and *Gaganyaan - India's highly aspirational project of a manned mission in space*, the future (scheduled for 2021). It was almost as if at that point in time Mr. Sivan had a forboding of the times to come. What if Gaganyaan were to meet the same fate as the sister concern??

Both these aspects highlight that crying has little to do with gender and more to do with empathy, episodic memory, emotion-driven systems and the lachrymal duct. For all of us who have had the social conditioning of forbidding men from crying, need to rethink. It is disallowing expression of emotions which is a gross injustice to what makes us human!

Dr. YAMINI. D and Dr. SUHAS CHANDRAN

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AN INITIATIVE SUPPORTED BY THE MINDS UNITED FOR HEALTH SCIENCES AND HUMANITY TRUST

HOLISTIC HEALTHCARE

In the early 1980s, my journey in psychiatry started in a multidisciplinary hospital's psychiatry unit in the city of joy, Kolkata. My mentor, who was a professor of medicine, advised me about integrating medicine, neuromedicine and psychiatry. It was a fascinating experience but involved hard work. During this period I also had work experience in a community based psychiatry in-patient care hospital.

My next journey was to the Central Institute of Psychiatry, Ranchi. There I found a harmonious amalgamation of hospital-based psychiatry care and excellent psychiatry teaching. All this was in the midst of imposing Victorian era buildings, mostly based on the lines of the famous Maudsley Hospital psychiatry model in London. I enjoyed talking to the long-term elderly patients and the senior nursing staff. I was impressed with the hospital organized dances, dinners, sports and cultural activities. There the boundaries between the patients, nurses and doctors vanished beyond the white coats and nurses' caps. It was like a rebirth for the stigmatized patients, in a bigger home away from home.

Next I went to the National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, a place which is now of national importance. There I found a wonderful blend of service and teaching excellence. The excellent bedside ward rounds were enriching to say the least. I learned the principles of the" brain - mindfulness" paradigm along with immense respect for the patients.

In the 1990s, I came back to my home city of Kolkata for mental healthcare services. My experience in the multidisciplinary Ramakrishna Mission Seva Pratisthan Hospital helped develop the spirit of "seva" (service). Together with the patients and their family members I was able to create a "self-help group" called "Srijani" (Creativity) which aimed at bringing out the talents in my patients along with building resilience in them. With age and experience, I have realized that holistic psychiatry is a fascinating journey for me which abolishes myths and misconceptions regarding mental illnesses and helps to bring out the best in everyone, with a paradigm shift from patient hood to personhood and towards human excellence.

Positive Psychology as championed by Martin Seligman, practical Vedanta of Swami Vivekananda and mindfulness-based practices will help all of us towards realizing the goal of holistic health. An understanding of the bio-psycho-socio-spiritual dimension of health and wellbeing will enable us to flourish and reach a "flow state".

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INSOMNIA

"The best bridge between despair and hope is a good night's sleep".

-Matthew Walker

Sleep is fundamentally a physiological drive, just as hunger and thirst are, which is necessary to maintain homeostasis in every human being. Sleep is essential for various physiological functions including energy conservation, hormone secretion, neuronal development, modulation of immune responses, alertness, concentration, memory and performance. Sleep deprivation has been linked to medical conditions including heart disease, diabetes, hypertension, obesity and shorter life expectancy.

Epidemiological studies in India among healthy subjects have reported the prevalence rates of insomnia as 9% to 30%. Among medical students, the prevalence of insomnia is as high as 30% to 40%, and has been associated with higher levels of stress and poorer academic performance.

According to DSM 5, insomnia disorder is diagnosed when there is 'a predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms:

1. Difficulty initiating sleep
2. Difficulty maintaining sleep, characterized by frequent awakenings
3. Early morning awakening with inability to return to sleep.

These symptoms must be present for at least 3 nights per week for 3 months causing significant impairment in functioning, the symptoms not merely being attributable to the effects of a substance or comorbid health conditions.

According to expert consensus, sleep duration recommended for adults is 7 to 9 hours; for teenagers 8 to 10 hours; and for school aged children 9 to 11 hours. The guidelines mention sleep duration of less than 6 hours and more than 10 hours as 'not recommended' for adults; less than 7 hours and more than 11 hours as 'not recommended' for school-aged children.

INSOMNIA

Insomnia is diagnosed based on subjective report and clinical interview which includes inputs from the partner. Sleep diary, questionnaire assessments including Epworth sleepiness Scale and Insomnia Severity Index, can prove to be valuable tools for evaluation. It is important to investigate for the presence of other sleep- related symptoms (snoring, daytime sleepiness, sleep apnoea, sleepwalking) and to rule out comorbidities including gastroesophageal reflux disease, pain conditions, mood disorders, anxiety disorders and substance misuse. Polysomnography, the gold standard to measure sleep, is indicated when insomnia is suspected to be related to other sleep disorders such as sleep related breathing disorders.

Non-pharmacological measures including universal sleep hygiene techniques are the first line options to help improve sleep. These are as follows:

1. Ensuring a healthy lifestyle:
    a. Regular physical exercise.
    b. Healthy diet- with high fibre content and low fat.
    c. Avoid excess consumption of caffeine, alcohol, tobacco or other drugs of abuse.
2. Environment conducive to sleep
    a. Quiet, cool and dark room- wear eye shades if necessary
    b. Comfortable bed
    c. Hide the clock, which otherwise can serve as a reminder of the passing time without getting sleep proving to be more disturbing.
3. Develop good sleep habits
    a. Maintain a regular sleep wake schedule
    b. If not getting sleep in twenty minutes, get out of the bed
    c. Avoid long daytime naps
    d. Relaxing pre-sleep routine- which helps unwinding such as listening to soothing music, warm shower, reading a book.
    e. Reserve the bed for sleep and intimacy

Cognitive behavioural therapy for insomnia which includes sleep hygiene education, cognitive therapy, relaxation therapy, sleep-restriction therapy and stimulus control therapy has been found to have a good evidence base.

Benzodiazepines (triazolam, estazolam, temazepam) benzodiazepine receptor agonists (zolpidem, zopiclone, zaleplon) are suitable for short-term treatment of insomnia. Patients with sleep onset difficulties may benefit from melatonin receptor agonists like ramelteon. Chronic insomnia (>4 weeks) can be treated with low dose sedating antidepressants (trazodone, mirtazapine, amitriptyline). Low dose atypical antipsychotics (quetiapine, olanzapine) is yet another option, especially for patients with comorbid schizophrenia or bipolar disorders.

Medical health professionals should be cognizant of the importance of adequate sleep in their patients and in themselves to ensure optimal mental and physical health. Insomnia should receive medical attention and interventions in an early stage to prevent the deleterious consequences of sleep deprivation on health and functioning.

Dr Kathleen Anne Mathew
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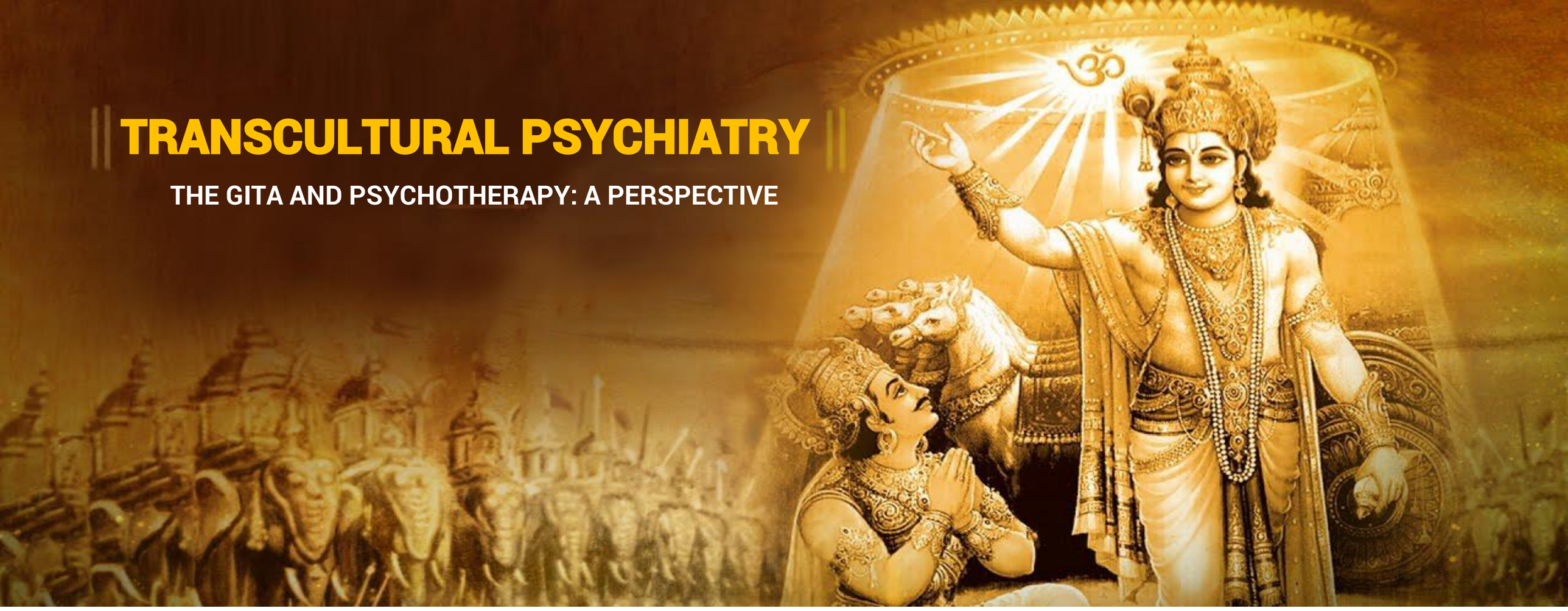
TRANSCULTURAL PSYCHIATRY

THE GITA AND PSYCHOTHERAPY: A PERSPECTIVE



The practice of psychiatry in India is widely influenced by the collective cultural psyche of its citizens. Innumerable stories with robust moralistic conclusions have been handed down across generations, serving as guides for improvement of self and society. Eastern philosophy has recently gained wide recognition by the scientific community. Excellent psychotherapy models have been elucidated and therapeutic implications explored. One such model is briefly described here. The Bhagavad Gita describes the predicament of Arjuna, and the timely intervention by Krishna who can be viewed as the counsellor. Overcome by anxiety, Arjuna questions whether the destruction, ravages and devastation of war are necessary. Reflecting on the consequences of battling his relatives, he is engulfed by a strong sense of guilt. He expresses his despair, saying "my limbs are failing and my mouth is parched. My body trembles, my hair stands on end. The bow slips away from my grip. My mind is rambling and I cannot remain standing upright." It has been hypothesized that these symptoms could correspond to that of an acute, transient situational adjustment disorder with anxiety.

The inaccurate and negative view of reality held by Arjuna correspond to the 'cognitive distortions' described in Beck's cognitive model. Krishna then proceeds to curb Arjuna's false beliefs regarding the world and the nature of his actions. Urging Arjuna to stop holding himself responsible for the destruction, Krishna introduces the concept of the soul, saying "he who knows the soul to be indestructible, unborn, unchanging and immutable; how can such a person slay anyone, O Arjuna or cause anyone to slay?". In this way, Krishna addresses and resolves Arjuna's conflicts, analogous to modern day cognitive behaviour therapy. Throughout his discourse, Krishna emphasizes the importance of action, encouraging Arjuna to perform his duties regardless of the results it brings. This is perhaps the most important concept in The Gita, as obsession with results (future telling) is a prime forerunner of cognitive distortions. Ultimately, Krishna's intervention is successful, as confirmed by Arjuna's final words before the battle "O Krishna, my delusion has vanished and with your grace I have regained good judgment. I stand here with all my doubts cleared and shall act according to Thy word." The western methods of psychotherapy may fall short of complete therapeutic success owing to the Indian socio-cultural background. To circumvent this problem, J.S. Neki proposed the Guru-Chela relationship concept in psychotherapy. The rapport between Krishna and Arjuna can be viewed as effective evidence of this concept of doctor-patient relationship. Given the appeal of the Bhagavad Gita, and its vastly secular content, a detailed and unbiased study on its potential therapeutic implications is warranted.

SANDEEP RAO KORDCAL,
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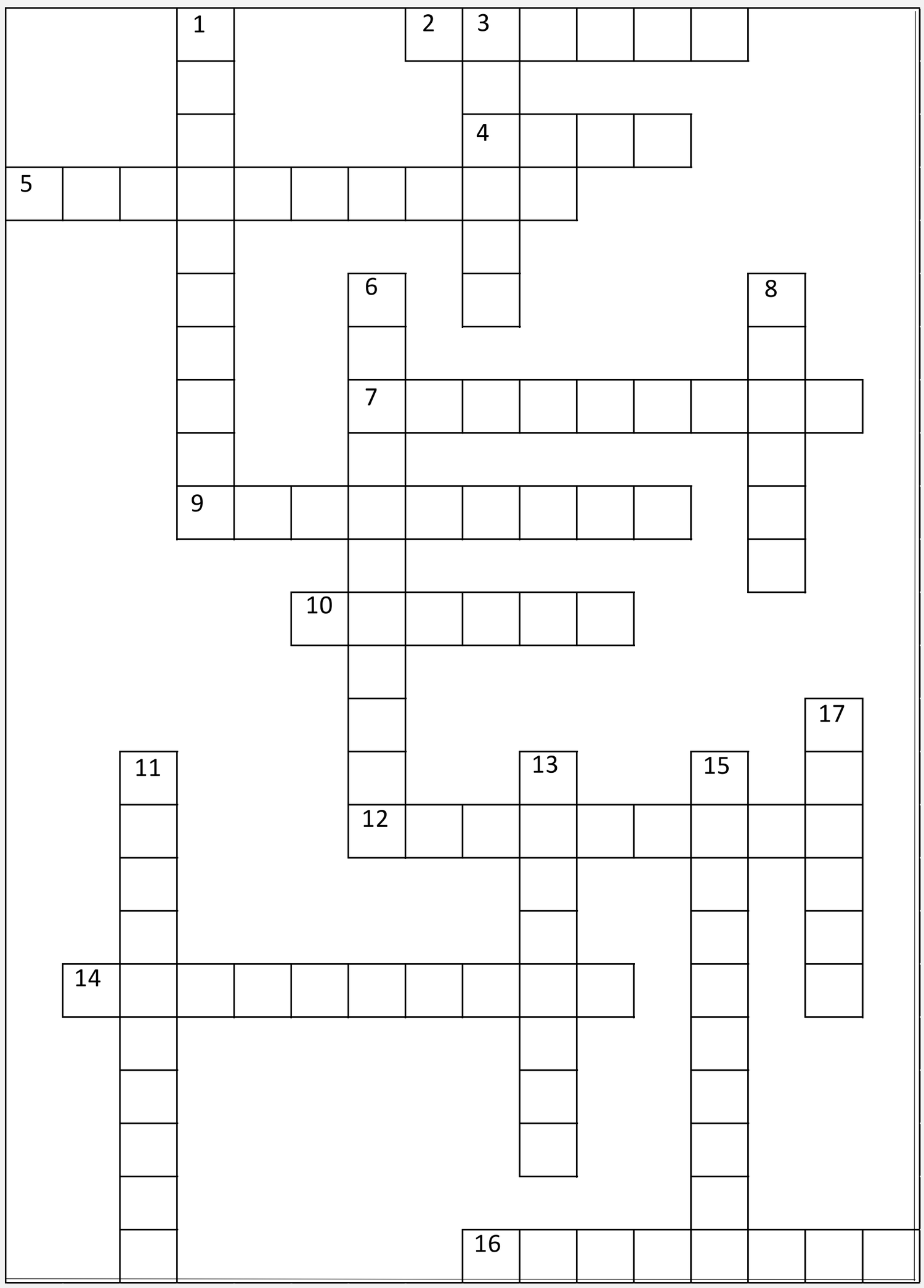
HUMAN INTELLECT - A BOON/CURSE

Dr. JAVAGAL AMITH THEJAS N
2nd Year, MD General Medicine, KIMS, Bangalore

ANSWERS TO THE CROSSWORD APPEARING ON PAGE 7

1. NOMOPHOBIA
2. SAFETY
3. ACTION
4. TICS
5. ECHOPRAXIA
6. PERSECUTION
7. RORSCHACH
8. RECALL
9. ANHEDONIA
10. FUTURE
11. FOLIE A DEUX
12. NEOLOGISM
13. ILLUSION
14. NEGATIVISM
15. DISULFIRAM
16. DOPAMINE
17. REMOTE



Can you cross the crosswords!!!

DOWN:

1. Fear of losing phones (10)
3. Stage of motivation (6)
6. Delusion (11)
8. MMSE (6)
11. Shared delusional D/O (5-1-4)
13. Perceptual misinterpretation (8)
15. Alcohol deaddiction (10)
17. Type of memory (6)

ACROSS:

2. Maslow's hierarchy (6)
4. Tourette's syndrome (4)
5. Imitate actions (10)
7. Ink blot test (9)
9. Lack of pleasure (9)
10. Cognitive triad (beck's)(6)
12. Coining new words (9)
14. Sign of catatonia (10)
15. Neurotransmitter (8)

ANSWERS TO THE CROSSWORD ARE ON PAGE 6

ROMITH MARTIN PEREIRA,
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Mangalore

MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 10 Issue 1 July 2019

FROM THE EDITOR'S DESK...

A man's characteristics can be determined by studying the bumps on his head, was what the science of Phrenology claimed in the early 1800's. The compelling need to disprove this absurd pseudoscience over the centuries may infact, have given rise to the concept of cerebral localization. Ideas are the currency of the future. Today, psychiatry as a medical discipline is becoming increasingly important due to the high recognition of the worldwide burden associated with mental disorders. Surprisingly, however, there is a lack of young academicians choosing psychiatry as a career. This means fewer minds and lesser ideas!

The problem that plagues the Indian system is the poor representation of psychiatry for the undergraduate students in the MBBS curriculum. In addition to providing quality teaching, the factors that need to be enhanced to improve student attitudes include forming a close working relationship with the student, seniors (particularly consultants and post graduate residents) offering encouragement, direct patient contact, emphasizing the scientific basis of psychiatry and making sure that students witness patients getting better. Medical students are the future colleagues and potential successors of psychiatrists: the future standing of the profession lies with their effective education.

Dr. SUHAS CHANDRAN and Dr. YAMINI. D

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In my 15 years in Psychiatry, I have trained in the United Kingdom and in Singapore, before returning to practice in my native city in India. I have been fortunate to witness Psychiatry in varied sociocultural contexts. Working in the last remnants of the mental asylum system made me reflect on deinstitutionalization.

The history of institutional psychiatric care is a fascinating one, and the shift to more community-based care in recent decades comes with challenges and rewards. Our culture has a more family-based role in the care of people with severe and enduring mental illnesses. Though this may provide loving and reliable care, it also brings a burden of caregiver stress and exploitation of vulnerable patients. Conversely, the United Kingdom has a socialistic healthcare system, the National Health Service. This is more geared to a cultural system where the individual is supported by government-provided health and social services, with minimal expectations of support from family. This was previously provided by mental asylums such as the infamous Bedlam Hospital; since the 1980s, a gradual shift to community-based resettlement, mental healthcare and social support has occurred. I was fortunate to work for some years in a Rehabilitation service which covered both long-term institutionalized patients as well as others being rehabilitated to live and work independently in the community. I was fascinated by the hospital - an imposing Victorian building which had been built with 20 wards that had previously accommodated up to 1200 patients! However, in the previous decades, so many people had been moved to community placements and outreach care that the numbers had dwindled to around 300, with many wards shut down. The psychiatric nurses- especially the ones who had worked there for decades- would relate tales of paranormal experiences on nights shifts; anyone who has spent time in these asylums will feel that different atmosphere. I also enjoyed talking to the long- term patients, most of whom were elderly and had spent over 40 years living in the hospital!

They actually had fond memories of the old days, where the hospital functioned as its own community; it even had a farm and workshops for the patient's daily activities. They spoke of how the hospital organized grand dances and dinners for Christmas and other special days. I was impressed by how the patients recalled the nurses and the doctors celebrating with them, the boundaries of white coats and nurses' caps laid aside. It seemed that they felt more relaxed and open with their healthcare professionals, compared to modern ward rounds which are almost as tense as job interviews. Most of all, they conveyed that they felt part of a welcoming community- understandable in a time where a "mad" person was a social outcast. Some people seemed to have developed a positive personal identity and a sense of purpose in the asylum; it seems society needs to try to create that same sense of acceptance and positive regard to make deinstitutionalization work.

Dr. SHALINI JANARDHAN
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GAMBLING DISORDER: WHAT EVERY PSYCHIATRIST NEEDS TO KNOW

DEFINITION: Gambling refers to betting something of value (usually money) on an event whose outcome is unpredictable and determined by chance. Problem gambling refers to gambling that disrupts or damages personal, family or recreational pursuits.

Akin to substance use, gambling too exists on a spectrum of escalating severity (ranging from social or non-problem gambling, through problem gambling, to gambling addiction or gambling disorder). Problem gambling is seen as a less severe form of gambling disorder, where the full set of diagnostic criteria for gambling disorder are not met.

DIAGNOSIS: 'Gambling disorder' as a distinct entity was added in DSM 5 in the section of addictive disorders, along with substance addictions, and is the only behavioural addiction to have been included. The diagnostic criteria for gambling disorder include the following nine of which at least four need to be met for a diagnosis: need to gamble with increasing amounts of money in order to achieve the desired excitement; restless or irritable when attempting to cut down or stop gambling; has made repeated unsuccessful efforts to control, cut back, or stop gambling; is often preoccupied with gambling; often gambles when feeling distressed; chases one's losses; lies to conceal the extent of gambling; has negatively impacted on a job, relationship or work; and relies on others to provide financial help to relieve desperate financial situations caused by gambling.

ADVERSE CONSEQUENCES: They have higher rates of various psychosomatic symptoms (cardiovascular, musculoskeletal, gastrointestinal), and psychiatric problems such as depression, anxiety, substance misuse and personality disorders. Problem gambling can often result in large debts and even bankruptcy, and some resort to crime to fund their gambling. It can also adversely affect the gambler's interpersonal relationships and can result in neglect of the family, domestic violence and child abuse.

LEGAL FORMS OF GAMBLING IN INDIA:

Currently, most forms of gambling are illegal in India except for the State-run lotteries (and that too only 12 States and 5 Union Territories), horse racing, rummy card games and casinos (in only two of the twenty-nine States). However, many Indians gamble illegally. The Public Gambling Act of 1867 remains the only law that regulates gambling in India Gambling at festival fairs is also very popular in India, as they offer a range of legal and illegal gambling opportunities, collectively referred to as 'festival gambling'.

ASSESSMENT

- Detailed assessment of gambling behaviour: Initiation Progression Current frequency (days per week or hours per day)
- Current severity (money spent on gambling proportionate to income)
- Types of games played
- Maintaining factors
- Consequences: financial, interpersonal, vocational, social and legal
- Reasons for consultation, motivation to change and expectations of treatment
- Assessment of suicide risk
- Assessment of psychiatric comorbidity, particularly depression and substance use disorders

Public health prevention strategies to minimize risks of gambling include:

1. Primary prevention measures (aiming to prevent gambling from becoming a problem):
   - Awareness-raising campaigns
   - Social marketing programmes (about various aspects of gambling, its potential for harm, signs and symptoms, how to seek help, etc.).
   - Banning of gambling advertisements and promotions
   - Increasing in-counter-advertising (advertising focusing on gambling - related harm/negative consequences)
   - Limiting the availability of gambling opportunities.

2. Secondary prevention measures (aimed at early diagnosis and treatment):
   - Providing training to staff at gambling venues such as lottery shops (to enable them to recognize problem gamblers)
   - Training non-specialists (primary health care staff, mental health care staff, etc.) in early identification of problem gamblers and training them in providing brief psychological interventions for problem gamblers
   - Training other groups who are likely to come across gamblers (financial/debt advisors, family counsellors, school and college staff, etc.)

3. Tertiary prevention strategies:
   - Provision of a range of appropriate treatments (psychological and pharmacological) for problem gamblers and those affected by someone else's gambling.

TREATMENT

Treatments for gambling addiction can either be pharmacological or psychological (delivered 1:1 or in groups, face to face, online or over the telephone) or both. No medication is licensed for use in this condition although SSRIs, mood stabilizers and naltrexone have all been tried with some success. Psychological treatments (1:1 or in groups) are the mainstay of treating gambling addiction, with cognitive behavior therapy being the most commonly and effectively used (8). Gamblers Anonymous is another popular psychological intervention.

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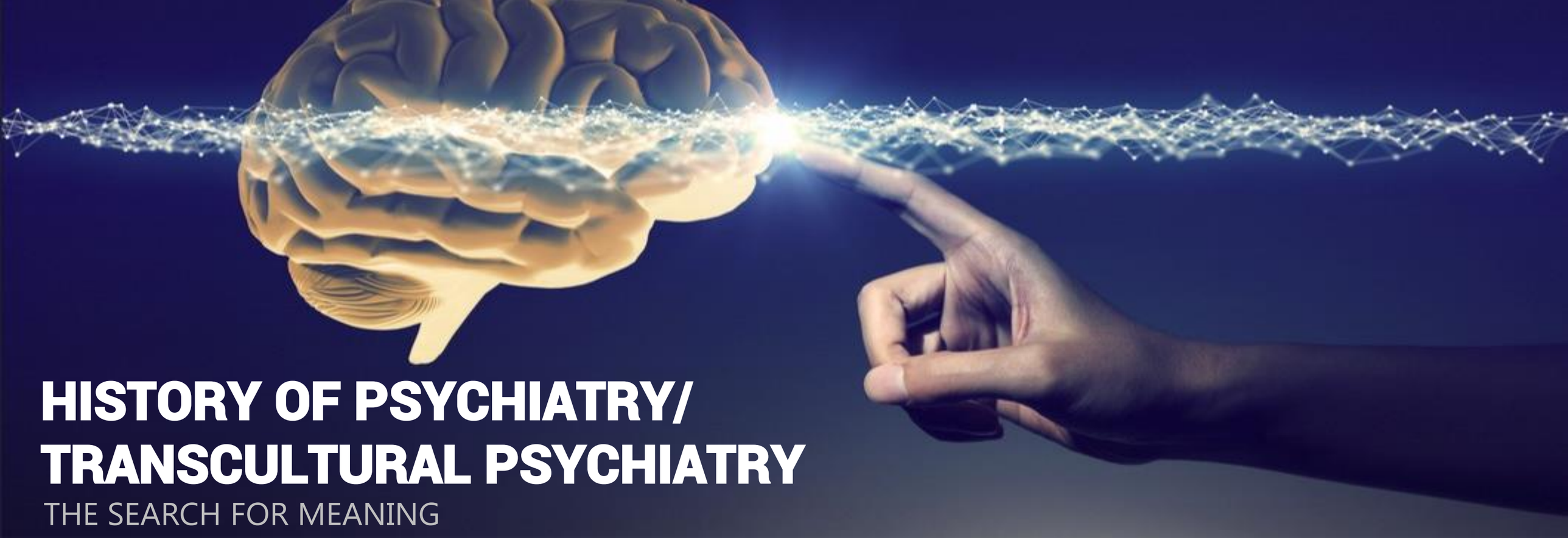
ANSWERS TO THE CROSSWORD APPEARING ON PAGE 6

ACROSS

5. Depression
8. Chlorpromazine

DOWN

1. Othello
2. Formication
3. Superstition
4. Sigmund Freud
6. Petit mal
7. Heinroth



HISTORY OF PSYCHIATRY/ TRANSCULTURAL PSYCHIATRY

THE SEARCH FOR MEANING

In the times of gloom of World War II and its outcomes, in a world torn apart and looking for meaning, Herman Hesse published his novel – 'Siddhartha'. The author teases pertinent questions about meaning of life, inspired by his own depression and personal loss. How can human discontent be overcome? Does wisdom lie within, or around us?

Siddhartha, despite being a resounding 'success' (and knowing it), feels incomplete – like the nagging feeling of having forgotten something, without knowing what. He has an enlightening encounter with the Buddha himself, where he realises that wisdom and enlightenment cannot be taught, it must be experienced by oneself – that is his ironic epiphany. The book itself takes the stance that it does not hold all the answers. It asks some questions that we all come up with, and may help answer some, based on the reader's perception. The same as life – what we interpret about it is based on perception. And we run into trouble when our perceptions become skewed to pathological degrees for various reasons. Thus, is the price for our consciousness – cognitive biases and distortions. It becomes really easy to get stuck in one's own mind, misinterpreting things to disastrous consequences, from affecting our lives from little ways, to deciding to end life altogether.

As a life of comfort, hedonism and unthinking takes over, he forgets all about his hunger, until his general dissatisfaction at life grows and grows to culminate in an epic existential crisis. At this point, the novel takes a hard turn into dark territory. As a man who can no longer see the light at the end of the tunnel, he gives up hope and attempts to take his own life. He stops himself when he has an epiphany from observing the very river in which he almost drowned himself. He goes on to enlighten himself with the help of a serene fisherman, living a life of non- judgment, patience and simplicity. He learns to trust that the answers will come when they do, and no amount of worrying or wanting will make them come any faster. Siddhartha reminds us that such conditions as dissatisfaction, demoralization and existential crises can befall anyone, regardless of success or social standing. This is a crucial message because often, strong but erroneous connections are made between being well off (or not) and being satisfied and content. Its relatability is also a stark reminder that such conditions can befall anyone, regardless of character and context. The commonality also serves to remind that while such conditions are to be taken extremely seriously, they are simultaneously common enough to invoke a sense of solidarity and community. No one is alone in their struggles, and help is always within reach, whether or not it seems to be.

In a time when science is attempting to understand such multi-faceted issues as depression and suicide, this novel is a reminder that the answer is indeed complex, and that until we unravel the mystery (and surely even after), it is important to be compassionate to those who are vulnerable. Scientist or not, trying to solve human problems require not only a deep understanding of the issue, but also of those suffering from it. Human problems require human solutions, and a good understanding of the human condition requires not only the sciences, but lessons from art and the humanities, which usually do a much better job of describing you.

SHRUTHI SATHEESH KUMAR

9th Term MBBS Student, Bangalore Medical College and Research Institute

SILENT

I encroach upon you, like an unwelcomed visitor,
Seemingly harmless, as silent as a predator.

Small whisperings of uncertainty,
A Lilliputian masquerading its enormity.

It grows, slowly, so as not to alarm you,
Like a debt piling, it accrues.

Till all you hear is the noise of despair,
If only you could wake up from this nightmare.

With nowhere to run and no place to hide,
A void weakening you, from the inside.

With no one to hear your silent screams,
And no one to stitch your torn seams,

You take matter into your own hands,
There's only so much a human soul can withstand.

And that's when I win,
When you draw a crimson across your skin.

As the noose tightens and your hands go numb,
I'll be in the shadows, waiting for you to succumb.

If only someone would have paid heed,
You wouldn't be lying here, with the silence of a plea

AARUSHI RAINA

9th Term MBBS Student,
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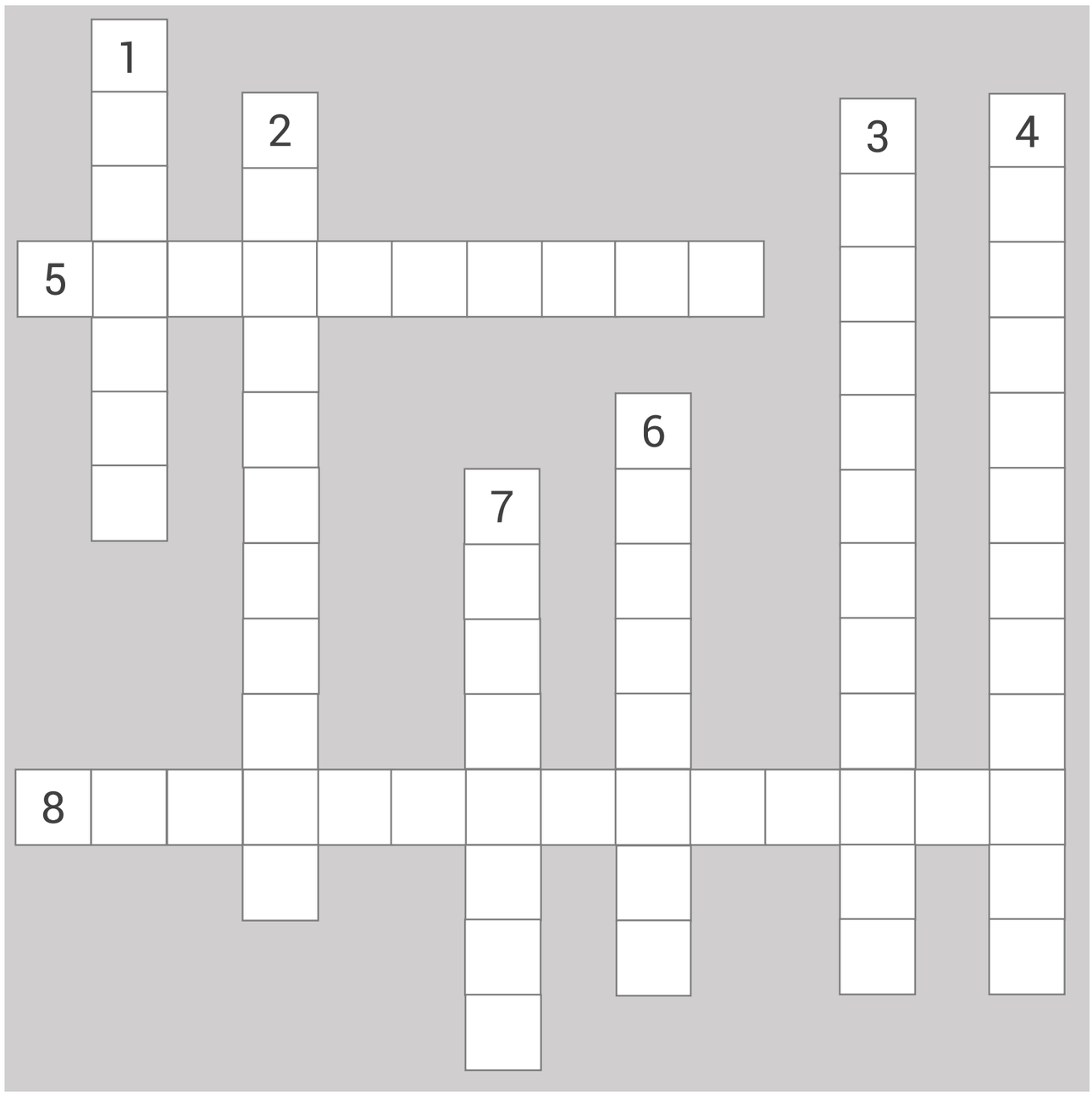
Can you cross the crosswords!!!



ACROSS:

5. Learned helplessness is typically seen in (10)

8. First neuroleptic to be introduced (14)

DOWN:

1. Delusions concerning infidelity of one's spouse is ….syndrome(7)

2. Tactile hallucinations of insects crawling under the skin (11)

3. A false belief, unexplained by reality, shared by a number of people (12)

4. Concept of superego was given by ..(12)

6. In EEG 3 per sec 'spike and dome' waves seen in … epilepsy (8)

7. Term 'psychosomatic' was coined by ..(8)

ANSWERS TO THE CROSSWORD ARE ON PAGE 4

Your suggestions are important to us, kindly send them to
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