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- Contribution from More than 50 Authors!!
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Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 9 *Issue 11* *May, 2019*

From the desk of Editor

Greetings to everyone from the editorial team of MINDS.

We are back with yet another issue.This issue covers a patient's account of her experience of premenstrual dysphoric disorder to her psychiatrist and the basics of depression with regards to what it is and is not. Apart from these, we have the regular sections on 'down the memory lane' by a senior psychiatrist, quiz and a crossword.

Hope all of you enjoy reading the latest issue of the MINDS newsletter, find it useful and send us your opinion and suggestions to improve it further.

Dr. Bindu Annigeri

Guest Column: Down The Memory Lane…

The Professional Journey of A Psychiatrist:contd. from April issue

As a Consultant:

Establishing Psychiatry practice those days was very easy. All it required was a table and a few chairs and proper consultation space. A regular liaison with a nearby nursing home would be sufficient to carry out most of the biological therapies like abreaction, ECT and bio feedbacks. But practice for a PG teacher is tough as time is a limiting factor. Patients cannot be charged based on the time spent. The other important thing for a young practitioner is to effectively handle transference and counter transference reactions.

The balancing and the management of multiple roles in teaching, research, patient care, private practice and family needs could be very tough. There were times when I had to go to bed after 1 am and get up by 6am. The stress of handling so many disturbed patients and families can take a toll on one's health. One can never afford to ignore this important aspect. There are a few psychiatrists who venture further into media in the pursuit of sensitizing and educating masses of various issues related to mental health and a few more who deal with various socio cultural maladies which cannot be solved by clinicians. One shall clearly identify the potentials and deficiencies in his own personality and plan their career. Only a gifted few can be all-rounders. tried to avoid unnecessary exposure to media and advertisements in promoting practice.

Maturity and Burn out:

At a juncture in life after attaining most of the things which one aimed for, starts the burn out at different levels and varying dimensions. Nobody can be an exception to it. Along with that, one would also get professional maturity on certain clinical issues

DOWN THE MEMORY LANE CONTD….

I realized at least a few insights which should be made known as they are not taught in the curriculum properly.

1. The art of the clinical practice is enhancing the compliance of the treatment. The maintenance of the follow up is really a test of the clinician's ability. It goes a long way in providing the professional satisfaction. There are some simple things which would enhance treatment adherence and earn one a good name as clinician.

- To achieve this prescriptions should be short. Long acting or depot preparations can be used when there is non-adherence.
- Identify the adverse effects of the drugs and effectively minimize them.
- Listen to the patient and consider his difficulty about continuing the medication.
- Once daily dose if possible under supervision is the best way to improve adherence.
- Take note of adverse events which may not be relevant to the clinician, but considered important by the patients and families.
- Before writing a prescription make sure that you can justify it.
- Consider yourself on the other side of the table as if you are the patient and consider the possibility of you accepting the given prescription.

2. Spirituality in practice.

- We never take this aspect seriously during our early career but it has a very serious impact on the outcome of the disease and the patient's adjustment. You may feel that medical science is secular and you shall not get involved in religion as it is highly personal.
- But spirituality has no religion and it is one's ability to connect to the universe and one's existence.
- Consider the patient's concepts of health and disease in his spiritual context and utilise it for his betterment.
- One need not propagate a religious practice or impose something deceiving the patient, but you can always use whatever concepts patient harbours for the beneficial effects on his overall health.

Last but not the least, is the P**rofessional burn-out**. It can happen to any clinician and not necessarily to Psychiatrists. One should identify it early and address it adequately. If not addressed properly it can affect patient care as well as the doctor- patient relationship.

To address the issue, the following strategies can be of help.

1. Restrict the number of patients being seen per day to decrease the exhaustion.
2. Improve the quality of care you are providing by devoting more time to each patient. It enhances professional satisfaction.
3. Cultivate alternative professional activities like frequent interactions with colleague/ juniors.
4. Taking up teaching can stir up the interest in the profession again.
4. Devote more time to family and friends to avoid boredom.
5. Make sure that your health parameters are regularly monitored.
6. Take frequent breaks from profession by doing other non-professional activities.

The outcome and success of anybody's professional journey depends on how long one enjoyed one's profession and how much one was of help to others rather than the amount of wealth earned.

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INVITED ARTICLE

DEPRESSION: A RENEWED PERSPECTIVE

Depression or Major Depressive Disorder (MDD) is one of the major psychiatric disorders. It has an estimated 12 mo prevalence of 6.7% and the lifetime prevalence of any mood disorder is approximately 20%, according to a US based study. It is the fourth leading cause of disability adjusted life years worldwide. This shows the magnitude of the problem and hence the need to understand it better.

This chapter is aimed at clarifying some of the many misconceptions with regards to the disorder and also to touch upon conditions which might present as/ with depressive symptomatology.

Misconceptions busted:
Note: The following section is presented in a manner that the 'myths'/'misconceptions' are denoted by '**M**' and the clarifying facts are denoted by '**F**'.

M: 'Feeling sad/ low' is the same as actually having "Depression'.

F: It is not uncommon for us to hear people saying that they have depression, be it non-psychiatrists, no-medicos, or laymen. But what does that actually mean?

Feeling sad when your day is not going well is quite natural and may even be short-lived.

To make a clinical diagnosis of Depression, it requires the presence of certain criteria, which take into account the number, severity, and duration of said symptoms.

According to the International Classification of Disorders -10 (ICD-10), combinations of the following symptoms have been outlined.

- Persistent and pervasive low mood,
- Lack of interest in activities,
- Easy fatigability/ lack of energy,
- Reduction in attention and concentration,
- Low self-confidence or self-esteem,
- Feeling guilty/ unworthy,
- Feeling pessimistic,
- Suicidal ideation,
- Disturbances in sleep, and
- Disturbances in appetite.

Along with these, a constellation of various other symptoms may also be present.

M: Depression is a sign of weakness.

F: Depression can inflict ANYONE; but, the partial truth in the statement is that those with less adaptability and inadequate coping skills may run a greater risk of developing depression.

M: Depression affects only women.

F: Depression affects both, men and women, but it is twice as common in women as in men. This difference can be attributed to hormonal influences, childbirth, differing psychosocial stressors, and certain behavioural patterns in women.

M: Depression is a disease of the middle-aged.

F: Depressive disorder occurs across all age groups, though the usual peak age is in the fourth decade. However, recent data suggest that the incidence of depression before the age of 20 years is on the rise.

M: "It is all in your head". "You just have to cheer up!"

F: As simple a statement as it may seem, but depression has various aetiologies. The role of serotonin, norepinephrine, dopamine and a multitude of other neurotransmitters are key factors. Besides these biological factors, genetic, psychological, familial, and social factors may contribute too.

M: Only psychiatrists can handle/ treat those with 'mental illnesses'.

F: Contrary to popular belief, patients with psychiatric disorders can be diagnosed and treated by other doctors also, provided they have a basic knowledge regarding the condition(s). The role of a psychiatrist is mandated by treatment resistance or presence of comorbities or when certain other nuances have to be applied.

M: All psychiatric medications are sedatives/ addictive.

F: No, not all psychiatric medications are sedatives in the strict sense, but yes, many of them have sedation as a common side-effect. Also, they are not 'addictive' or dependence producing, barring classes like benzodiazepines, which carry an abuse potential.

M: Psychiatric medications have to be taken life-long.

F: It is sufficient that the treatment duration spans an entire 6-9 months course for a single episode of depression. However, in recurrent cases, the course may require longer durations for maintenance or prophylaxis.

M: "All you need is a break." " Yoga and meditation will heal you."

F: Depression cannot be treated with yoga, meditation, or other similar relaxation techniques as stand-alone strategies. These may have an adjunctive role in the maintenance phase of the disorder.

M: All who commit suicide are depressed.

F: Depression cannot be held responsible for all cases of suicide. However, the presence of depression increases the risk of suicide to 10% from the usual 0.01% in the general population.

M: Shock treatment will damage your brain permanently.

F: Electro-convulsive therapy i.e. ECT or 'shock treatment', as it is popularly known, has such an infamous reputation. In reality, it is a very useful, promising, and in some instances the preferred treatment option. It expedites the response, is cost-effective, and also has minimal side-effects.

Conclusion:

Thus it is now clear that depression is a fairly common disorder which sometimes is under-diagnosed, over-diagnosed, or even misdiagnosed. It highlights the ramifications of this disorder in the personal, professional, familial, and social fronts, for the burden of disease is very high. Hence, a reasonable, thorough know-how about depression is the need of the hour.

Dr. N. Iyshwarya, Consultant Psychiatrist,

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PMDD- A Patient Perspective

What I went through: I am a 37-year-old lady living with Pre-Menstrual Dysphoric Disorder(PMDD). I was diagnosed with PMDD last year. I had realized I had severe PMS since I was 25 but it was limited to only physical symptoms like back pain, headache, bloating, breast tenderness and fatigue though many women with PMS also have some irritability, anger, sad moods.

But PMDD- is a monster version of PMS. When I was around 32, I began to notice that my PMS was not just the physical discomforts but along came a plethora of mood swings. I would get extremely irritable, snappy, weepy and anxious. I would get into a self - loathing mode and question every decision I had made in the past. Even a small chore would seem overwhelming. I was flying off the handle with the slightest provocation and many a times without any. All these would happen about ten days prior to my periods and my family members had to face my wrath, my weeping and all my irrational behavior. It left them wondering what was going on with me and they did not have the faintest idea that it was related to my menstrual cycle. With the onset of my periods a sense of calm would prevail. Last year I started having disturbed sleep and I would be very agitated the next day. After a few days, I started having panic attacks –I would wake up in the middle of my sleep sweating, my heart racing with a feeling of impending doom.

What I did : I met my general physician who got my ECG, TMT, thyroid and other blood tests done and everything turned out to be normal. But my anxiety and irritability continued. Slowly I started to become dysfunctional. My anxiety levels kept going up anticipating another attack. When my anxiety hit the roof, I also started having severe stomach irritation/IBS. I thought I was going mad. My physician asked me to meet the psychiatrist. The psychiatrist after hearing me out diagnosed me with PMDD. I felt relieved. My madness had a name after all and it is a medical condition which would last till menopause!

The symptoms could vary, anything from mood swings, depression or hopelessness, intense anger, conflict with others, feeling anxious, decreased interest in usual activities, withdrawal from social relationships, feeling fatigued, feeling of being overwhelmed, sleep problems, cramps, breast tenderness ,headaches, joint or muscle pain, becoming sad and tearful easily, palpitations and suicidal thoughts.I was prescribed anti- depressants to get relief from the symptoms. Within two weeks my anxiety came down and so did my IBS symptoms.

What I recommend: My roller coaster rides with PMDD taught me a few things which I want to share for those going through a similar journey.

Don't hesitate to take medical help and follow their advice. Have regular follow ups

Be regular with medication doses.Have a routine for exercise, meditation, yoga and exposure to sunlight.

Take some proactive steps to manage the condition:

1. Download Period Tracker and mark your "Moody days". Make an effort to tell your immediate family about the moody days.
2. Try not to get into any arguments/ conflicts during these days.
3. Exercise self-restraint when you want to say something negative which you may regret later.
4. When the bad mood strikes, it is a downward spiral. It may be very tempting to sulk in your bed and cry your heart out, but go hit the gym or go meet a friend.

Family support critical

1. Do not hesitate to discuss what you are going through and get their understanding and support.
2. Ensure you spend quality time when the mood is good and thank them for what they do.

I am still in the middle of the journey. The symptoms persist, but I am able to accept and manage it better and believe I am on my way to tame the monster!

Article Courtesy- Dr.Harsha G.T, Assistant Professor, Dept. Of Psychiatry, BGS Global Institute of Health Sciences, Bangalore

UG n PG

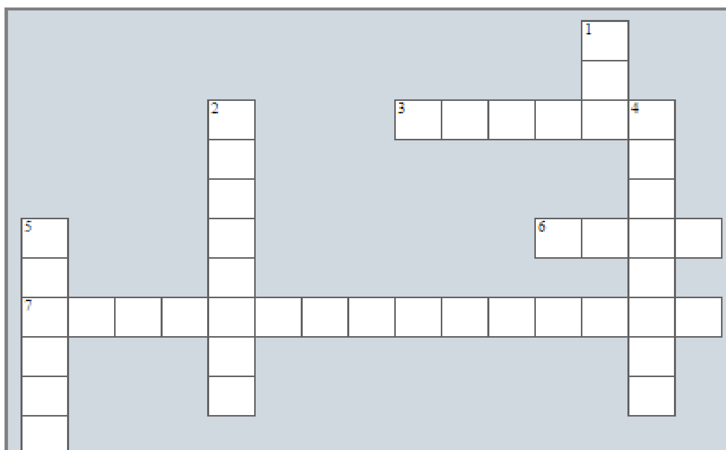
AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

UG n PG

MINDS QUIZ

1. **Gestalt Therapy was developed by**
   a. Kurt Schneider b. Fritz Perls c. John Bowlby d. Sigmund Freud
2. **A severely depressed patient started on antidepressant medications presents after 1 week with history of excessive speech, overfamiliarity, euphoric affect, grandiose ideas, irritability and reduced need for sleep. What is the phenomenon called as?**
   a. Rapid Cycling b. Manic Switch c. Manic Relapse d. Affect destabilization
3. **Which of these is not a Selective Serotonin Reuptake Inhibitor (SSRI)**
   a. Fluoxetine b. Escitalopram c. Atomoxetine d. Paroxetine
4. **Which is not a feature of Dementia with Lewy Bodies?**
   a. Fluctuating cognition b. visual hallucinations. c. Parkinsonism d. Hyperorality

Can You Cross the Crosswords!!!



ACROSS:

3. Reaction caused by tyramine in this food content when MAO inhibiters are given
6. Emergent side effect of stimulants characterized by involuntary, spasmodic, stereotyped movement of small groups of muscles.
7. Serious heamatological adverse effect of clozapine.
8. Syndrome caused by toxicity of this neurotransmitter characterized by hyperpyrexia, diaphoresis, diarrhea and hyperreflexia

DOWN:

1. Acronym for the serious adverse effect of potent antipsychotics characterized by hyperpyrexia, muscle rigidity, delirium and autonomic instability.
2. Extrapyramidical side effect of potent antipsychotics consisting of slow, sustained contractions leading to relatively sustained postural deviations.
4. Side effect of SSRIs affect this sexual phenomenon in men
5. Subjective feeling of motor restlessness manifested by a compelling need to be in constant movement.

ANSWERS

MINDS QUIZ

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

CROSS WORDS

ACROSS

3. Cheese
6. Tic
7. Agranulocytosis
8. Serotonin

DOWN

1. NMS (Neurolept Malignant Syndrome)
2. Dystonia
4. Erection
5. Akathesia

MINDS Newsletter was launched in July 2011 as a Monthly Newsletter on Psychiatry for doctors & medical students for creating awareness and continued medical education. You can receive a free e-copy of MINDS by an e-mail request to editormind@gmail.com

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