MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

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GUEST EDITORIAL

ELDER ABUSE IN THE NEW ERA OF COVID 19

On 15th June 2020, World Elder Abuse Awareness Day will be celebrated with the theme of "Lifting Up Voices". On this day, the World Health Organisation (WHO), calls for an urgent, whole-of-government action to protect older people against violence, abuse and neglect. As reported that more than 15% of the elderly were affected by some form of abuse in the year 2019. WHO is more concerned and expecting that elder abuse will rise significantly during the Pandemic COVID-19. HelpAge India conducted the survey 'The Elder Story: Ground Reality During Covid-19' 65% of the participants reported that their livelihood impacted by the COVID-19. However, it is claimed that only 1 out of 24 cases of abuse is reported, because of fear of family members, stigma, unawareness and cultural values. It can be said that there is an underestimation of elder abuse as compared to the actual rate of elder abuse.

WHO defines the abuse as *"a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person"*. Elder abuse can take various forms, including financial, physical, psychological and sexual, and can also be the result of intentional or unintentional neglect.

The pandemic has created a 'negative atmosphere' around the elderly. Older adults are not only facing social restriction but also the restriction imposed by their family members, caregivers and close relatives. At the same time, lockdown and quarantine measures have limited access to essential service and resulting in an increased risk of neglect. Among the elderly, women are the most 'vulnerable' and 'most affected' due to their dependency on others, poor financial resources and longer life span. Elder abuse is more commonly experienced by those who have poor social support, strained interpersonal relationship, living in shared living situations, history of mental illness, cognitive impairment, frail, etc.

(Cont'd on Page 2)

Most common perpetrators are family members, which could be due to a high rate of burnout, stress, substance use, financial problems, family problems affecting the family members and are more during the Pandemic COVID-19.

The elder abuse has a negative consequence ranging from physical injuries like minor scratches, bruises, broken bones to long-lasting psychological problems, including depression, anxiety, and vulnerable to a financial scam.

So, what healthcare professionals or Government can do?

Healthcare professional doing telephonic or video conferencing, have a unique chance to observe the older people in their natural settings, can observe for signs of unsafe situations, and providing support to those who are not attending the clinic regularly. Healthcare professionals can also monitor caregiver stress, burden, and can provide brief counselling, problem-solving strategies and appropriate referrals. Pandemic also provides an opportunity to conduct more research which would help in better understanding and estimation of elder abuse.

The Government should implement policies and programme to make the children and family members too, need to be sensitised about the needs and rights of their elderly family members. The older people should be educated about the facilities, support systems, legal provisions and non-formal support networks, accessible and available to them with the help of local authorities or social welfare committee. For instance, “Food for Life” to identify the elderly, who were struggling to pay for food and provide application support to help them apply for food benefits during the COVID-19. The Government and healthcare professionals should work in collaboration with NGOs like HelpAge India, Dignity Foundation, Age well foundation providing a range of services to meet the social needs of older adults, including home-delivered meals, personal care services, health promotion and chronic disease management, transportation, and social engagement. The focus should be on community participation in understanding the signs of elder abuse and providing advice via radio, television, social media or print media on how the victim of abuse can seek help and receive support safely.

We should take a pledge that during the Pandemic of COVID 19, we can not let one catastrophe breed another. We will stay connected together, calling older people, checking on an elderly neighbour, writing a card or letter, can all be positive steps to ensure the elderly safety and social justice.

“I call upon Governments and all concerned actors to design and carry out more effective prevention strategies and stronger laws and policies to address all aspects of elder abuse. Let us work together to optimize living conditions for older persons and enable them to make the greatest possible contribution to our world.”

Dr Aseem Mehra,
Assistant Professor, Psychiatry
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Growing up, many of us aspire to be doctors. I was one of them. The noble image that the word 'Doctor' represents was very attractive to my impressionable mind. Soon after graduating my pre-university, my joy in getting enrolled to become a doctor was beyond measure. It was a dream come true!

As I entered the third year of medicine and was allowed to see patients for the first time, I was determined to be the best student I could be. Armed with larger than life ideals I started to attend bedside clinics. I could say the same for my most of the classmates who were posted in the same unit with me. Our clinics would start at 11.00 am and some, if not most patients would look forward to seeing us as we were a lively bunch with who they could interact. We didn't have the work load that the residents had and so were perhaps approachable. They could ask us anything they wanted regarding the condition they were suffering from (about which we would read up so we could answer them), ask for meaning of test results, request sometimes to for us to liaison with their doctors and sometimes even make small talk.

We soon, as a bunch, we became very close to one particular patient who was admitted with breathing problems due to COPD. He looked forward to seeing us daily as it perhaps made this long stay more bearable. We were also helpful to the degree we could at our level. He soon got better and was discharged. On the last day of his hospital stay, he gave each of us a pen to thank us for our effort. I remember keeping that pen in my drawer at home for many months, as it a precious token of gratitude. It filled my young heart with pride to look at it!

I was a first generation doctor in our family. When a family friend who was also a doctor came home, I promptly told him about the "gift". I expected that he would congratulate me for the good work. However, to my amazement, he told me that perhaps it was not so wise to become so attached to patients or accept presents. This was my first experience in learning about need to maintain an emotional balance while dealing with patients. Had the patient and the token present become more important to me than necessary? Would I be able to maintain the ability to be "a nice doctor" without becoming too attached?

In the years that followed, this incident became an important incident in learning to maturely handle interactions with patients. I would always look back and grade my responses to situations and be wary of emotional attachments to patients beyond what was necessary. I knew too much involvement may look and be unprofessional. However the degree to which it would affect one had not dawned on me yet! During my years as an intern, a patient in the ward I worked in was suffering from pneumonia. One day during routine ward work, a sudden call from the ward nurse alerted all the doctors of an emergency in the ward. The aforementioned patient had collapsed. All of a sudden, the ward became a place of chaos. Immediately resuscitation was attempted. I was asked to monitor the patients pulse. I did my duty as I looked on at the scene that ensued. This was the first time I had witnessed such an event. I was very scared as the patient was not responding as expected. After several minutes and after many attempts at reviving the patient, I saw everyone backing off and declaring the patient as no more. I was shocked! I could still feel a pulse! I repeatedly expressed to my seniors in horror that I still could feel a pulse, and they should continue the efforts. The assistant professor walked up to me and shook his head. He asked me to check the chest with a stethoscope. To my dismay I didn't hear anything. He told me that it was perhaps my own pulse that I felt as I held the patients wrist!! I was astounded that this could happen! My sense of touch, my mind had deceived me. Such is the need on our part to believe that our patients will make it.

Several years hence, as a Psychiatrist this incident has stayed on in my mind. This serves me as a reminder that our faculties can fail in the presence of strong beliefs. Our mind is very powerful. It works subtly to help us and sometimes to even to fool us. This awareness can perhaps help us when we deal with more emotional issues, as we do in psychiatry. Human bias is common. In a field of medicine, particularly Psychiatry where empathy is an important factor not only for engaging a patient but also in the healing process, it is important to understand that such biases can occur easily even before we begin to notice them. Empathy therefore needs emotional involvement without projecting our own emotions on to situations!

Dr. Radhika Madhusoodan, Consultant Psychiatrist, Bangalore

SPECIFIC LEARNING DISORDER

Scientist Albert Einstein, American President John F Kennedy, Hollywood filmmaker Steven Spielberg and Entrepreneur Steve Jobs– have all carved a niche and made it big in their respective fields. They share a common history of struggling through school years owing to academic difficulties. Yes, they all are reported to have a 'learning disability' of reading and writing.

What is it?

Specific Learning Disorder (SLD) is a disability in one or more of the basic physiological processes involved in understanding or in using language, spoken or written which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations.

ICD-10 describes it as 'Specific Developmental Disability of Scholastic Skills' whereas DSM 5 calls it 'Specific Learning Disorders' with subtypes specified in both- Specific Reading Disorder/Dyslexia, Specific Spelling Disorder/Dysgraphia, Specific Disorder of Arithmetic Skills/Dyscalculia

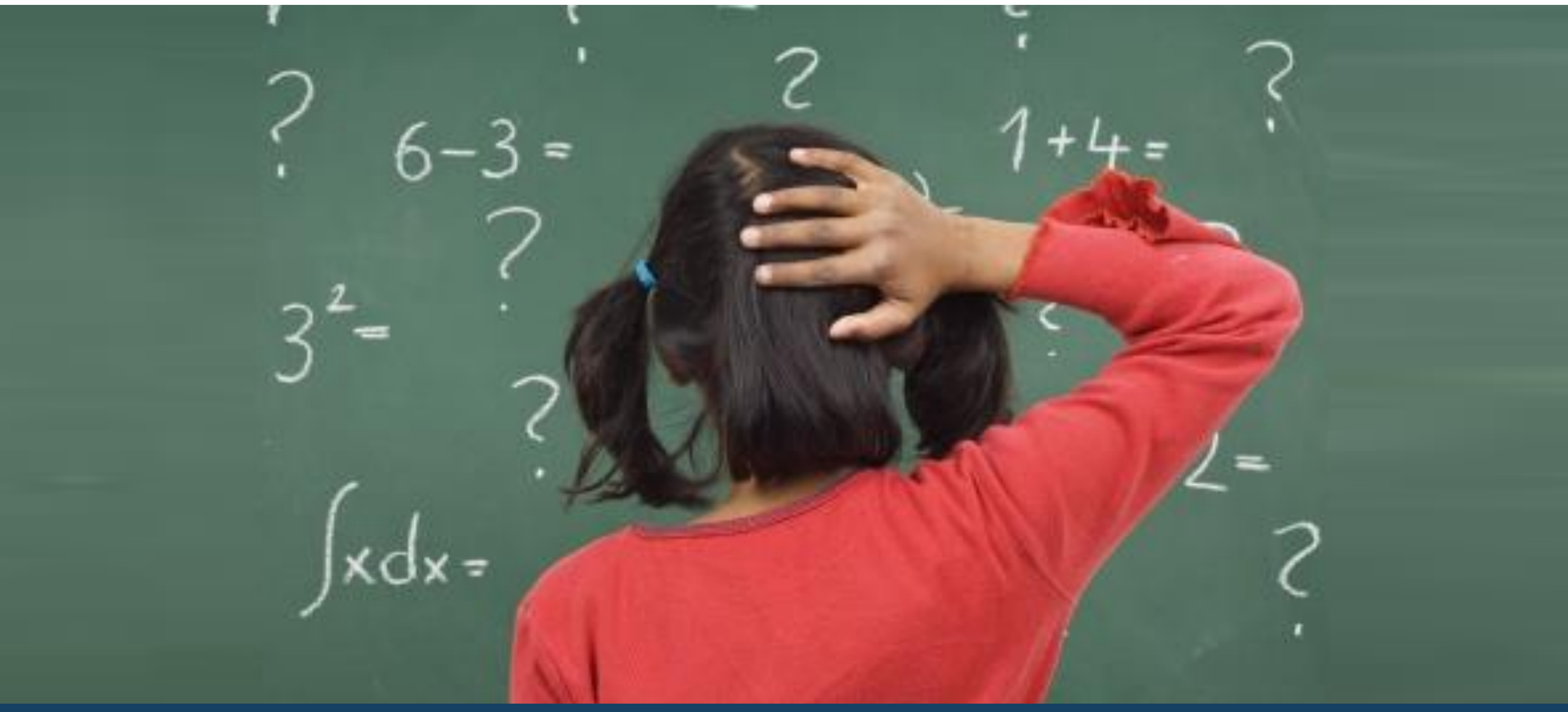
It occurs despite normal intelligence and can persist through adulthood. In India, 5-17% of the children are affected and is common in boys than girls.

Causes

It is caused by an interplay between genetic and environmental factors leading to a developmental malfunction in certain areas of the brain. The condition often runs in families and some children exhibit developmental delay in speech and language.

It does **NOT** occur as a result of low intelligence, neurological deficits, visual/hearing problems, lack of opportunity to learn or inadequate teaching techniques.

Functional neuroimaging in children with reading disability reveals lower activation in dorsal and ventral regions of left hemisphere with right hemisphere over-activation.



Presentation

Parent of an SLD child may use words such as 'lazy', 'dumb', and 'stupid', not being 'at par' with classmates, not able to 'catch up' despite efforts, doesn't pay attention, incomplete notes, spelling mistakes, inability to complete homework/exam papers or has secondary symptoms such as school refusal, poor motivation, somatic complaints, aggression or oppositional behaviour.

A child with **Reading Disorder** (commonest) will have difficulties in reading as well as writing. He/she reads slowly and hesitantly, reads word by word and without punctuation, reads 'b' for 'd' or 'ben' for 'den', mirror reading – reads 'was' for 'saw', omits, substitutes or adds words to a sentence.

A child with **Writing Disorder** usually avoids writing whenever possible, has poor handwriting, writes slowly, mixes small and capital letters, writes letters/numbers backwards- 'p' for 'q', '14' for '41', mirror writing- 'saw' for 'was', etc.

A child with **Arithmetic Disorder** takes longer time to solve problems, makes mistakes in arithmetic problems involving addition, subtraction or multiplication by 0 or 1 (1+1=1, 5-0=0), makes mistakes in problems involving same or sequential numbers (6-6=6, 4+5=6) and has difficulty in keeping unit, tens and hundredth places.

Assessment

Diagnosis involves an evaluation of medical, cognitive, educational and psychological factors. Detailed history, physical examination, visual acuity and hearing tests, standard psychometric assessments of cognitive abilities and academic skills like IQ testing/ NIMHANS Index for SLD / Wide Range Achievement Test / Wechsler Individual Achievement Test are performed. The child's reading and writing skills will be significantly lower than the level expected for similar age, intelligence and school placement.

SLD maybe associated with other comorbid conditions such as

- ✓ ADHD (Attention Deficit Hyperactivity Disorder), Conduct Disorder
- ✓ ODD (Oppositional Defiant Disorder)
- ✓ Low frustration tolerance/aggression
- ✓ Low self-esteem
- ✓ Anxiety and
- ✓ Depression

Management

Remedial education is the mainstay of treatment. Ideally, a multi-disciplinary team comprising a Psychiatrist, Psychologist, Special educator, Occupational therapist, Language & Speech therapist and a Paediatrician must be involved. Parents, school teachers, special educational services and support groups play a significant role.

Various linguistic, phonetic and multisensory methods are used to improve the reading/writing skills of the child. **Accommodations** (use of larger size pen/pencils, grippers, spell checkers, calculators, audiobooks, touchpad devices, special papers with tactile feedback, etc) and **Modifications** (such as oral assignments, extra time, lower academic expectations, lower level of mathematics, etc) can be considered. Regular practice, revision and reinforcement help the child in overcoming his/her disability.

Children with milder forms often eventually learn to read well enough to succeed in school. But, some with severe forms may never be able to read well and may need training for vocations that don't require strong reading/writing skills. Seeking professional help aids in early identification and management of this problem. Some, with this help, may even go on to succeed and achieve accolades and accomplishments.

Dr. Chaitra Hiremath,
Consultant Psychiatrist,
Hubli

TRANSCULTURAL PSYCHIATRY

DANCE EDUCATION

In psychiatry, starting from seeking help to rehabilitation back to community; 'Stigma' spreads its wings making the job of a mental health professional a difficult one. At the same time, it bothers patients with mental health issues in ways more than the biological processes in responding to treatment. Culture, a broad term which encompasses social behaviour and norms existing in our society, plays a significant role in affecting stigma. When utilized in a constructive way, it can turn out as a weapon to fight that stigma.

Out of this was born our novel idea which was generated with this intension of using mythological stories to educate common people about mental illness and thus reduce the stigma associated with it.

Dance - a highly influential and attractive art form - when used effectively, can be used as a medium of education. It is said in Natyashastra written by Bharatamuni, which is highly revered in any Indian classical dance form, that the initial intent when Lord Brahma – the creator- created this art form was to educate society; bring back the norms in place. Till today, most of the classical arts conclude at a spiritual note of eternal yearning of the soul for the supreme soul, which is now considered as an important and integral part of mental health as well. Given the nuances of Bharatanatyam – one of the Indian Classical Artform, it is easy to depict mythological stories. The fact that they are so innate in our culture makes it that much more easy for people to relate to and understand. Though the stories remain same, the interpretations can be different and relevant to current scenario or the problem at hand. I am writing on the experience of using one such story from Ramayana to depict depression and thus enhance the knowledge, change attitude and practice among the public.

Ahalya, one of the sacred ladies, as per Hindu scriptures was the wife of Sage Goutama. She was cursed to be a stone by her husband for the mistake of falling for Indra-who entices her, to be only revived by Lord Rama later. Lord Rama reunites her with her husband and brings back her glory. The story line is very relevant to the current society where following stressors, people end up in depression. In the severest of cases, there is a condition called *Catatonia* where people maintain the same postures for hours and become completely withdrawn from the surroundings just as if turned into a stone.

TRANSCULTURAL PSYCHIATRY

DANCE EDUCATION

Society, at large, continues to treat individuals with Depression with a callous and insensitive attitude. However, what these individuals need is compassion, empathy, with proper medical and Psychiatric care supplemented by supportive psychological work and rehabilitation back to society just as how Lord Rama treated Ahalya.

An attempt to bring this out through dance was well received at National Mental Health Conference in 2018 at NIMHANS Bangalore. The advantage of this approach is that people connect to it instantly. Dance makes the information more palatable and keeps audience engaged. Further attempts to use such stories might help break the barriers of stigma towards mental health in the society is ongoing. It also opens up a pandora's box of possibilities to use art form to discuss social banes like gender inequality, domestic violence and other not-so-comfortable socio-psychological issues.

To me, this is more of a relevant social message that these art forms should be giving than just focusing on spirituality, which is of course the ultimate goal to be met in the hierarchy of needs.

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PhD Scholar (Dept. of Psychiatry), NIMHANS, Bangalore

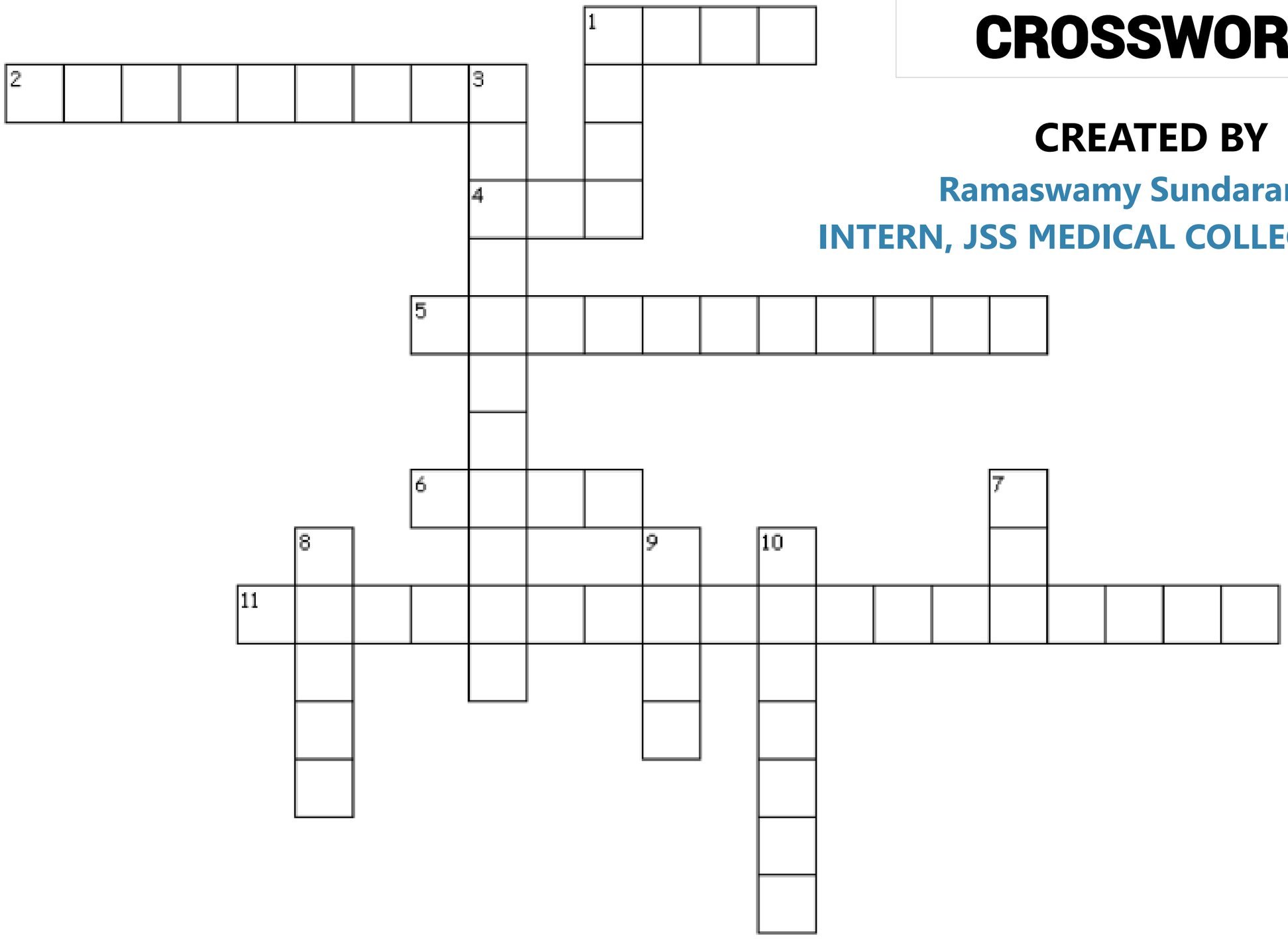
ANSWERS TO THE CROSSWORD APPEARING ON PAGE 8

ACROSS
1. Rett
2. Echolalia
4. ODD
5. Contingency
6. UTAH
11. Dementia Infantilis

DOWN
1. RPWD
3. Atomoxetine
7. BKT
8. MEP2
9. WAIS
10. Angular

SOLVE THE CROSSWORD

CREATED BY
Ramaswamy Sundararajan
INTERN, JSS MEDICAL COLLEGE, MYSORE



ACROSS

1. Syndrome affecting females, diagnostic of mid-line stereotypic behavior and causing patients to be wheelchair bound after 15-20 years of age

2. Speech problem commonly seen in Autism

4. Disorder with Age<10 years where child shows opposition and defiance to parents

5. Management technique where motivational incentives and rewards are used for a child to develop a life skill

6. Criteria for diagnosis of ADHD

11. Heller syndrome also known as

DOWN

1. Autism is identified under this act of the constitution

3. SNRI used in the management of ADHD

7. More commonly used IQ Assessment in India

8. Gene mutation causing Rett syndrome

9. Worldwide IQ scale

10. Gyrus involved causing dyslexia

ANSWERS TO THE CROSSWORD ARE ON PAGE 7

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

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