MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

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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.

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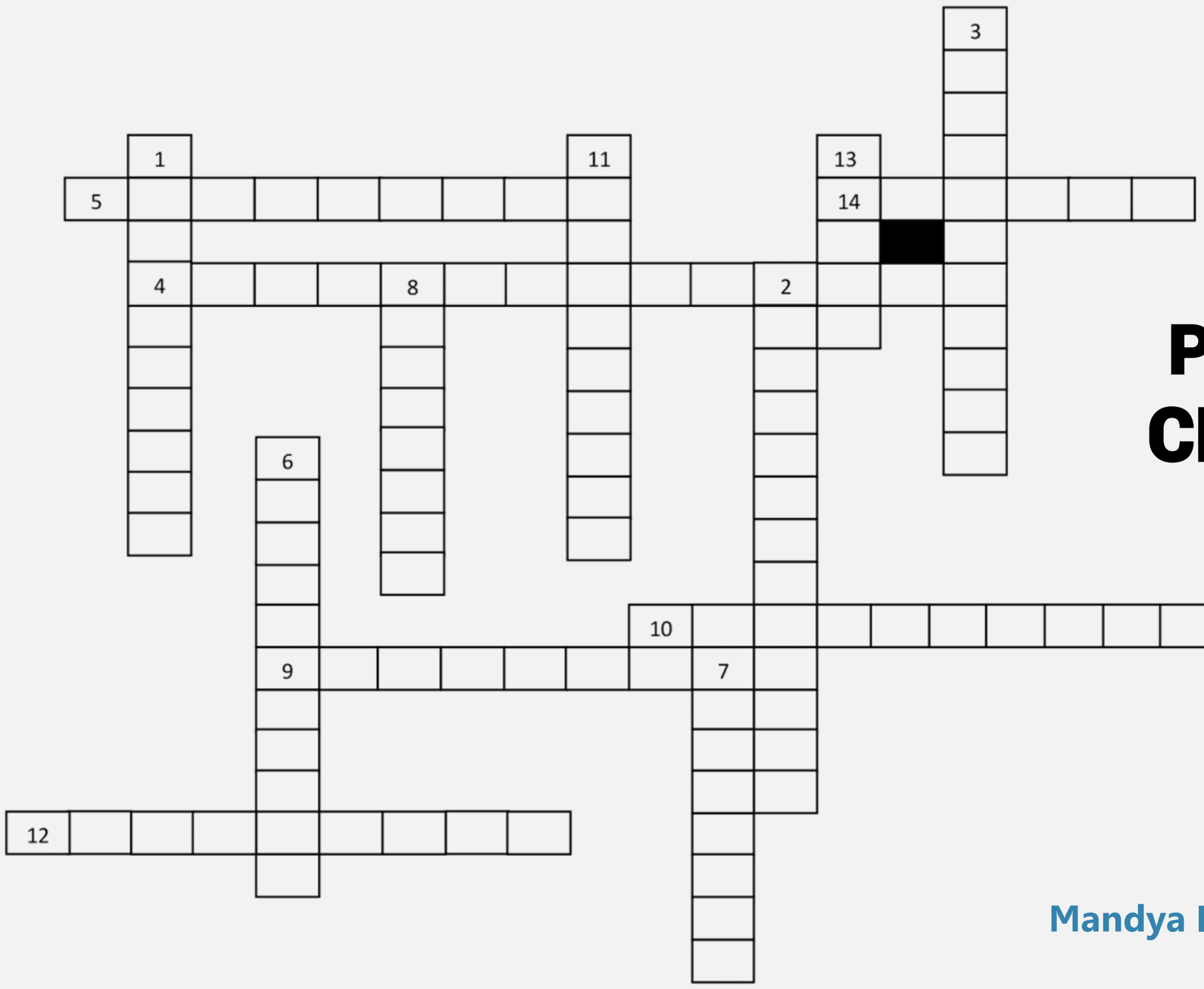
ANSWERS TO THE CROSSWORD APPEARING ON PAGE 7

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

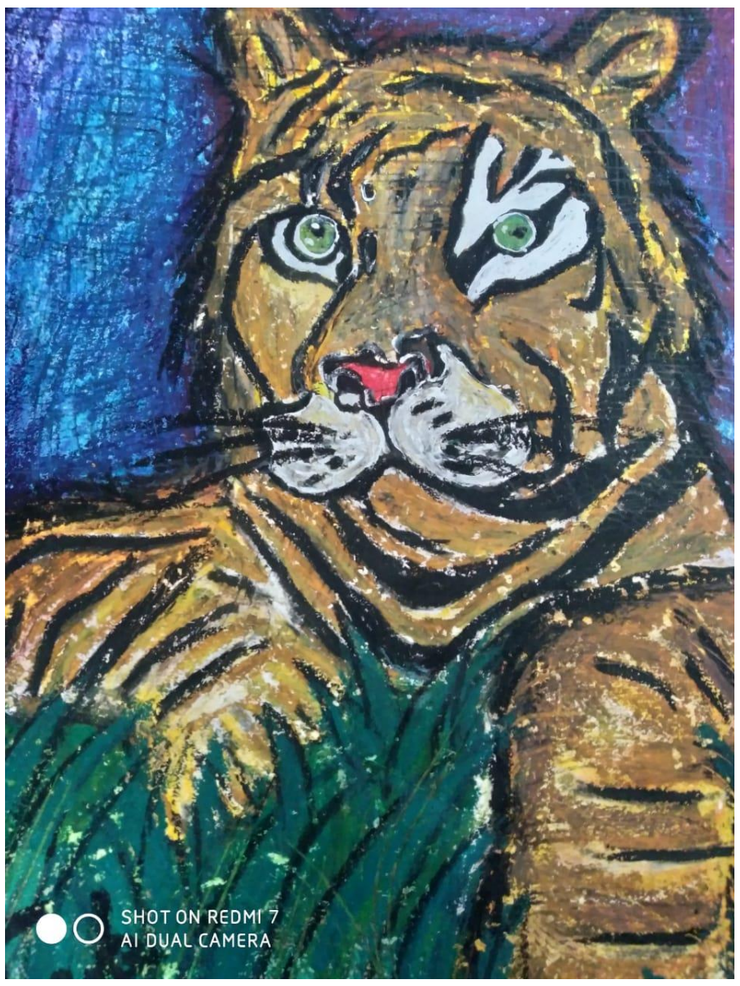
J. Vasundhara
Final year
Mandya Institute Of Medical Sciences

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

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

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