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

E-MAIL : editormind@gmail.com | WEBSITE: www.mindsnewsletter.com

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

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.

Dr. Geetha Jayaram,
Professor,
Schools of Medicine (Psychiatry), Health Policy and Management, Nursing, Global Health, and The Armstrong Institute for Patient Safety
Professor, Cooper Medical School at Rowan University, NJ.
Director, Center for Global Community Psychiatry.
gjayara1@jhmi.edu

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.

Dr Shankar Kumar
Assistant Professor,
Department of Psychiatry,
Bangalore Medical College, Bengaluru

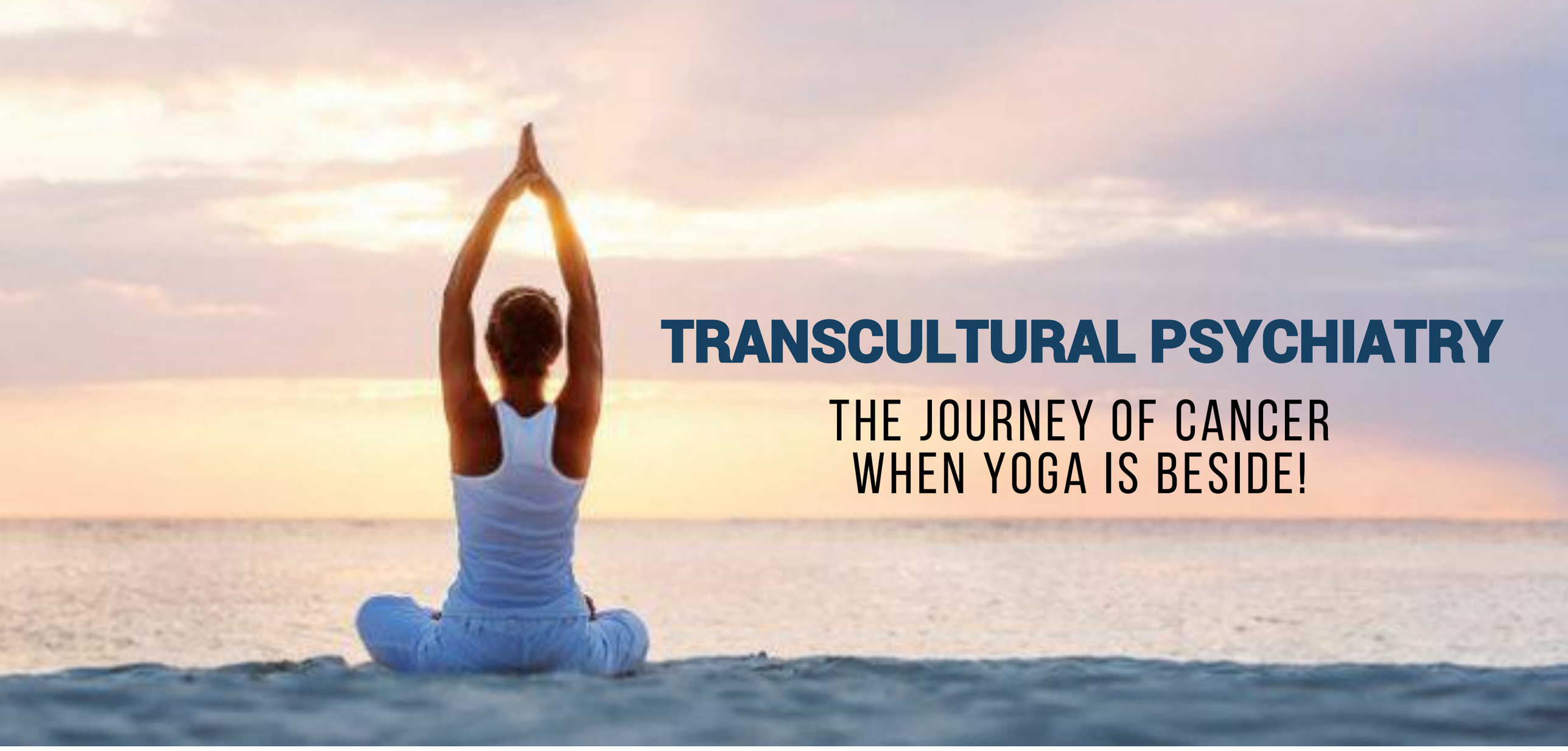
shankarkjs@gmail.com

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?

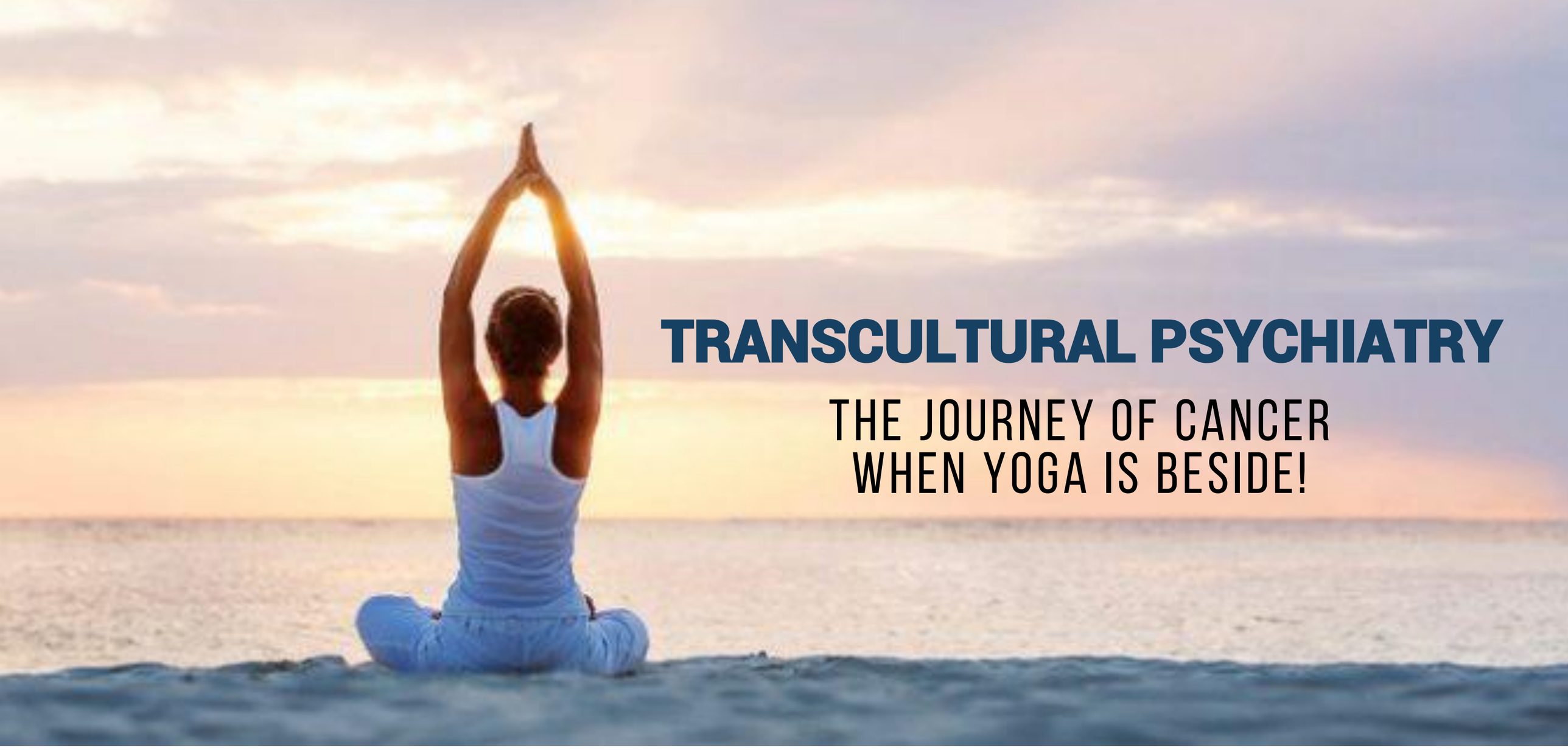
It is advised cancer patients to do *Yoga* right from the time of diagnosis.

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*

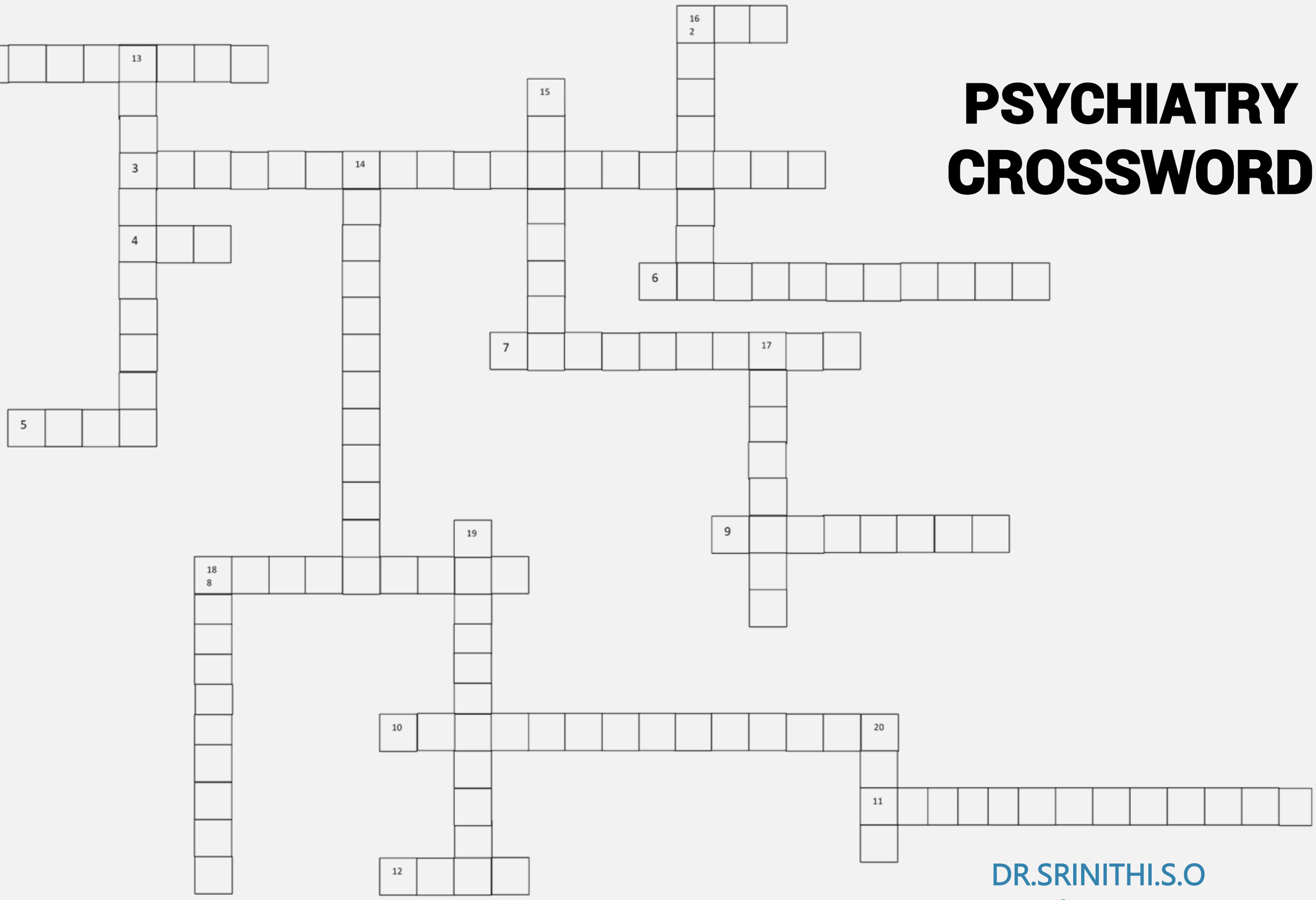
The effect of cancer is not limited to the patients. It can affect the entire family including caretakers. A caretaker will have to compromise on their personal life and constant caregiving can lead to *'burn-out'*. So, it is better to engage caretakers along with their loved ones for *Yoga* sessions.

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!

Dr. Usha Rani M.R
BAMS, Msc (Yoga), PhD (Yoga),
Research Officer, NIMHANS, Bengaluru
ushaayog@gmail.com

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

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