MINDS
Wellbeing begins in Our MINDS
MONTHLY NEWSLETTER ON PSYCHIATRY FOR DOCTORS & MEDICAL STUDENTS

FROM THE EDITOR'S DESK

Panic buying amid COVID-19 pandemic

The recent panic buying witnessed across the globe has been attributed to COVID-19 pandemic and has embarked discussion and debate among behavioural scientists. Panic buying can be considered as a sociocultural and behavioural construct and often triggered in the situation of an impending threat, the anticipation of the scarcity of resources, uncertainty, or under the influence of herd behaviour. The pressurising condition perhaps impairs judgment and resulted in excessive purchase and hoarding behaviour. Panic buying behaviour has also been exploited by marketing strategies by creating situation deliberately i.e. by spreading rumours of a limited offer or limited stock.

As a behavioural scientist, it is pertinent to understand the underpinning human psychology and sociocultural factors. It has been seen that any potential threat to life or major disasters awaken survival response and excessive purchasing or buying is one of such unusual behaviour. Panic buying of late, also been popularised as Stock-homes syndrome in the print and electronic media; which sounds similar to Stockholm syndrome but later related to the psychological response of a captive wherein a captive begins to identify closely with his or her captors or kidnappers.

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Incidents of panic buying reported in the past during the 20th and 21st century. A similar phenomenon was noticed during the global influenza pandemic of 1918-19 when panic buying related to Vicks Vaporub® took place resulting in a rise of sales from $0.9 million annually to $2.9 million annually. Similarly, the confrontation between the United States and the Soviet Union in 1962 feared American people enough to press the panic button resulting in panic buying of canned food. In the year 1985, Coca Cola® decided to change its flavour to boost its business, but it led to panic buying so much so that Coca Cola® decided to restore its original flavour.

Nevertheless, there are several such phenomena in the past which reminds us that deep-down we are still the same cavemen dwelling for food and security harbouring behavioural programs for survival!!!

Dr. Ajay Kumar

Artwork

It depicts that stage of the mental health journey at which the symptoms become persistent and severe, jeopardizing the person's lifestyle. The person is unable to seek help and is suicidal.

The symbolism: The girl showing a glum and cold expression sheds a tear. The tear drop that falls on her cheek vaporizes into dark clouds over her head. When it rains, it is seen that the water droplets don't drench her owing to the umbrella she has formed for herself out of her own mind. The water cycle repeats, so does her worsening state. Her mouth is taped, she is unable to seek help. She is thrown into a deteriorating loophole, making her NUMB

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DOWN THE MEMORY LANE

My first rendezvous with child psychiatry

It is a beautiful autumn afternoon here in Chicago, a lazy Sunday afternoon. I am finalizing the slides for a presentation at the American Academy of Child and Adolescent Psychiatry Annual Meeting/International Conference 2020. In the last two years' meetings', I had received an award each, but I was still in fellowship training then. So much has changed this time. It's the COVID era, with lots of uncertainties, over everything. The annual meeting is being held over video conferencing. "Zoom meetings" have taken over life everywhere. Still, I am excited, because this is my first presentation as an Attending Physician, at the prestigious conference, amongst esteemed colleagues from all around the world, brilliant minds!

As I look out the window, I had a thought as to when did I first come into contact with Child and Adolescent Psychiatry? I did Med-School at Bangalore Medical College. I do not recall having any exposure to child psychiatry during my MBBS. It just was not a part of the curriculum. It was neither covered under Pediatrics nor Psychiatry rotations.

However, it was during my Intern year in Internal Medicine rotations as part of the compulsory rotatory internship, that I was manning the gates at the Victoria Hospital. It was a 36-hour shift, which could well beyond the next day's evening. If you're not familiar with internships yet, let me tell you, "internal medicine posting" is a dreaded yet super-transformative and enriching rite-of-passage that every doctor has to go through! It will challenge you; it will change you... for the better, of course. The sheer volume of patients, with varying complexities, poses exciting clinical challenges during that rotations.

On that particular night, two gurneys rolled in, one after the other, a middle-aged man and a middle-aged female, presumably, husband and wife, cases of OP poisoning. The 108 ambulance staff were still trying to piece together information to collect whatever history possible. Me and my fellow-Intern jump into action, initiate CPR, alternating atropine and adrenaline IV, the rest of the nursing staff are trying to help; the IM post-graduate rushed in from the emergency ward. We lost the male patient within 15 minutes of arriving and lost the female patient within the next 20 minutes. It was just too late to save them.

You know, as a doctor, a patient's death is never easy to digest. I needed a moment to process before I jumped into my next patient. That's when I noticed, two beautiful kids, a boy and a girl, who are sitting behind the scene of the CPR and 2 deaths. I ask the nursing staff "who are these?". The nurse responded "these are their kids", pointing to the two patients that laid there motionless.

Suddenly, my mind goes "Oh shoot, I hope these kids haven't been given the OP poison as well! Oh no, I hope the suicide pact did not involve their kids". I got on my knees, almost instinctively, hurriedly but calmly, trying to ask these two kids, further history, as to what transitioned at home that evening. The boy must have been around 7-years old, the girl was around 5-years old. In their way, they narrated how the dad and mom mixed "something" in the rice and consumed it before they started coughing and vomiting. Again, I ask these two kids if they had to also take the "rice". They say "No". (Phew! Goes my mind) I checked their vitals, and we got ECGs on the kids as well.

Later that night, I sat down with both these kids in the corner of the ER hallway, I brought them "bun-and-jam" from the late-night-chai-shop on the hospital campus. It was then, that I realized in conversation with these two kids, that the 7-year-old understood the finality of death; while the 5-year-old was still under the impression that "Mommy and daddy will wake up soon". That was my first rendezvous with child psychiatry and developmental stages of the brain.

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ANSWERS TO THE CROSSWORD ON PAGE 9

Across

2. factitious
4. taijinkyofusho
8. Freudian
9. frontostriatal
10. sss8
11. PNES

Down

1. BDDYBOCS
3. camouflaging
5. DSED
6. OCD
7. ganser

INVITED ARTICLE

Child Pornography : An emerging menace

A pornographic video is created in India 'every 40 seconds' and up to 38% of porn uploaded is deemed to be child abuse. Despite blocking more than 3,522 porn websites during 2017, by the government, experts say 35-40% of content downloaded per day from India is pornography. While Section 67B of the Information and Technology Act (IT Act), 2000 targets the object of child pornography by criminalizing the pornographic depiction of a child, Section 14 of the Protection of Children from Sexual Offenses (POCSO) Act targets the subject of child pornography by criminalizing the use of a child for pornography. Under the IT Act, the storage and consumption of adult porn are not criminalized but the storage and consumption of child porn are criminalized. Despite adequate legal provisions for the protection of children, as per the Indian Child Protection fund (ICPF), data from Pornhub, the world's largest pornography website in the world, unveils that a spike of online child traffic from India by 95% between 24th and 26th March 2020, as compared to pre-coronavirus time. The Indian National Crime Records Bureau (NCRB) found that more than 25,000 pieces of alleged child sexual abuse content have been uploaded to social media platforms in India from January to May 2020. India's internet consumption rose by 13% since the nationwide lockdown was put in place to contain the mammoth pandemic. People are streaming content, logged on to work from home, online classes, entertainment, e-shopping, etc. might have brought this change. Scientists are speculating that Covid-19 may be here to stay, could hit in waves over the next two years. Thus, the prevalence of child pornography may rise.

Victimization through child pornography means that the victimization never ends. Images placed on the internet can never be fully erased or recovered. It carries the potential for numerous problems throughout the lifespan. Child maltreatment often results in immediate deleterious effects on children, spanning from physical problems like injury, pain, hindering proper growth and development, risk sexually transmitted diseases to host of mental health-related issues, like feelings of shame, unworthiness, anger, and confusion, withdrawal, isolation, anxiety, depression, post-traumatic stress disorder. Common sequelae for adult survivors of CSA include mental health problems (e.g., depression, anxiety, substance abuse, posttraumatic stress), relational challenges (e.g., sexual health, intimacy, and increased risk for sexual assault and domestic violence), and spiritual concerns (e.g., shattered assumptions about life, people, and self, as well as changing belief systems, following the trauma). Pornographic content may promote misconceptions related to sexual activity, more so among youth. It may be used by sex offenders to reduce their inhibitions and prepare to offend in child prostitution and trafficking.

Excessive screen exposure takes toll on the nascent mind of the children with slow, long-lasting physical as well as psychological consequences. Decreasing outdoor movements and excessive use of screen can lead to myopia in children. Altered eating habits and sleep cycle results in increased body weight, poor growth, poor immunity and increased susceptibility to common infections. Moreover, the psychological consequences are subtle and difficult to notice by parents. Excessive watching of televisions can possibly affect creativity, reduce explorative nature of children, resulting in a limited repertoire of interests. Increased mood symptoms like irritability and aggression are quite common. Parents often report increased demand by children to use mobile or TV; arguments and defying nature and declining academic performance of children. Increased screen exposure has also been associated with depression, anxiety and even suicide among young adults and adolescence. Moreover, children with attention deficit hyperkinetic disorder have shown to have proneness for internet addiction.

Children are the backbone of a country and are the future. Negative impact on children threatens the future of a country, too. Therefore, the possible surge in child pornography via online platform rings the alarm for immediate attention for its detection and early intervention.

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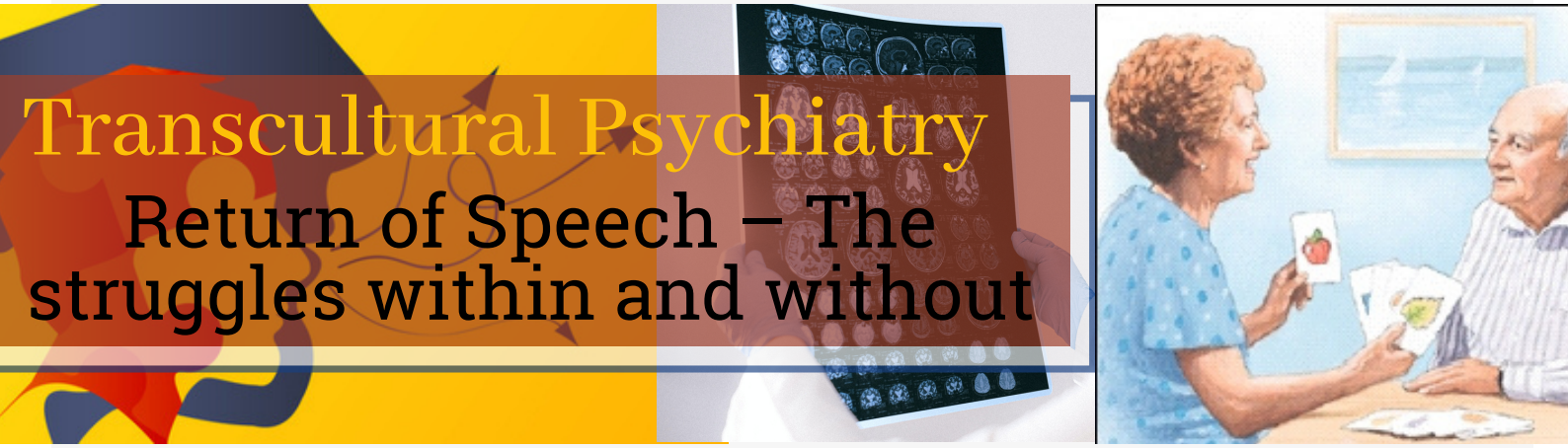


Transcultural Psychiatry

Return of Speech – The struggles within and without

IIt was October 2019 that a 35-year young lady, along with her husband and son, visited my OPD. Her son and husband supported her to move around and also tried to speak on her behalf. This lady had been very energetic as a mother and as a government school teacher. She used to teach mathematics in schools located in the slum areas of Mysore. She was liked by the kids in the school. In October, she suffered a stroke. The event changed her life from being an independent, successful, well respected and a recognized woman to being dependent for everything ranging from activities of daily life to communication and mobility!

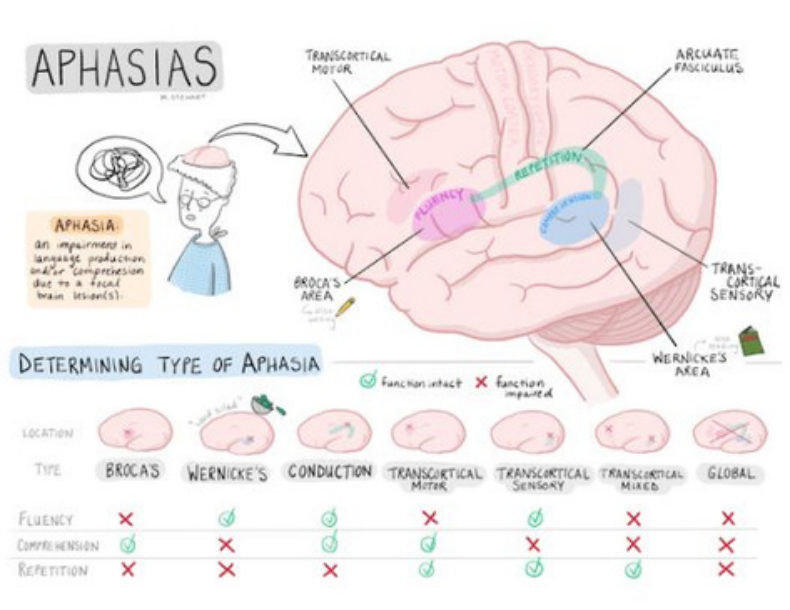
When we evaluated her for her Speech-Language skills, she was diagnosed to have Broca's aphasia. During the assessment, she showed obvious frustration, along with frequent bouts of crying. Her husband and young son were supportive and were providing her with all possible morale support, but her body language clearly showed that she was not happy with the quality of life. We assured her that intensive Speech-Language Therapy along with Physiotherapy for six months could help bring change in her communication and physical skills. Despite our efforts to infuse enthusiasm, it was becoming clear to the family that she may not reach the state that she was in before the stroke.

"Will she talk again and live her life like before?" I have frequently come across these questions from the caregivers of persons with aphasia. My answer to them (husband and her) was, "We will try our best to get her back to talk, walk and work; we all need to work with her to make sure that she is the same wife, teacher, and person that she was. I asked them to give me three months and hope that she improves overtime in her communication skills. Her husband and son had a little sigh of hope on their face.

We started with Speech-Language Therapy and Physiotherapy, but during sessions, she used to show bouts of emotions as she failed to utter any word in the first ten sessions. Her confidence level had taken a blow, but she had great support from her husband and other family members. Her husband used to ensure that she would attend therapy regularly, though she was reluctant. After ten sessions, she started to use a few words and then there was no looking back. Within two months, she was only having subtle issues with naming abilities and writing. At this point, we introduced her to group therapy. This boosted her morale. She used to lead the sessions citing her example. She was a real role model for all the people with aphasia; her zeal to get back to work was very high.

The school authorities were not willing to take her back at work as they needed medical fitness certificate for surety and was procured. Even after that, they permitted her to work in the school on an observation basis for fifteen days only after my insistence. A rather bureaucratic style of functioning! There was a lack of awareness for the re-integration of persons with aphasia in society. Her first experience in school shattered her but she continued.

Later, I got a call from the school headmaster stating, “Sir, we are happy to have her back in the school, and we will do everything possible to make her comfortable here.” Her performance has amazed even me not just in speaking, walking, and being a teacher but even a wife. To my surprise, she started using WhatsApp. The kids were very supportive of her during teaching. In this school, kids from the marginalized section attended; their attitude and support provided to her speak volumes about their concern for their teacher. For this achievement, she was felicitated on an international day for persons with a disability. She delivered a speech during this function.



Her improvement demonstrated to all of us that if we can work in a coordinated, collaborative manner, we can connect any person with aphasia back to work and live with dignity again, provided we use the attitude towards them. We must always remember that we treat the underlying condition as is meant in our profession but treating the affected person as a person can make a lot of difference. As the proverb goes, a good clinician treats the disease, but a great clinician treats the person. Put the person before the disorder.

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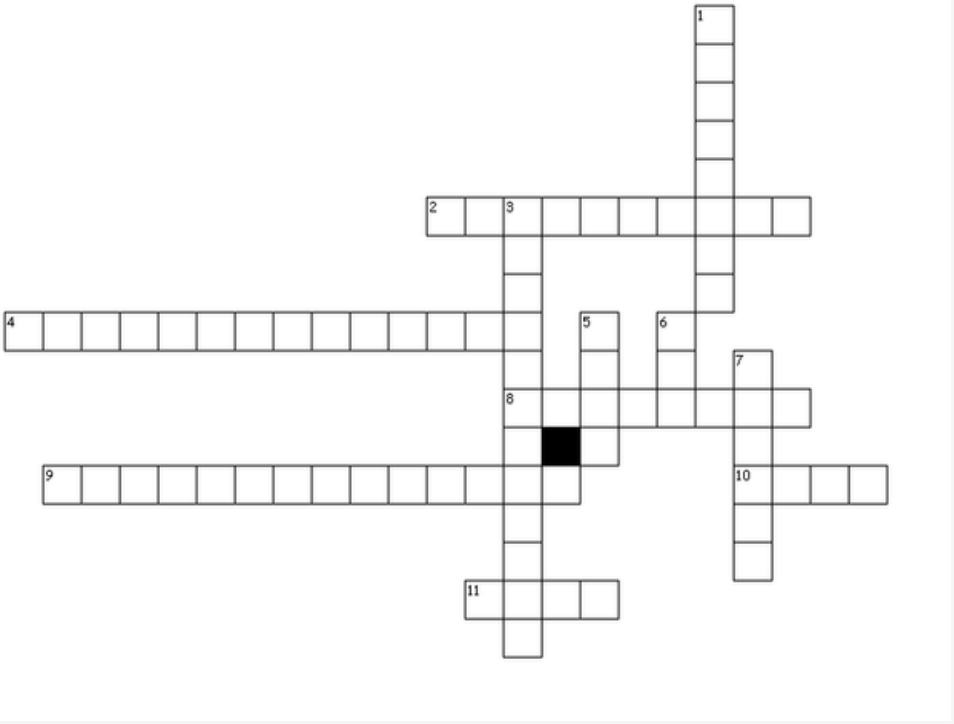
THE UNDERGRADUATE SECTION



CREATED BY

Dr.Ramaswamy Sundararajan

CROSSWORD

Across

2. disorder where there is fabrication or simulation of illness, injury, or impairment in order to receive medical care or concern
4. Japanese and East Asian subset of Western social anxiety disorder characterized by patient's fear of offending or embarrassing others by his or her body
8. theory explaining conversion disorder in which an intolerable affect transforms (converts) into somatic symptoms
9. Body dysmorphic disorder appears associated with brain abnormalities in this region
10. Short form of Scale used to evaluate somatic symptom burden in Somatic Symptom disorder
11. paroxysmal behavior resembling epileptic seizures caused by psychological factors and not ictal epileptiform activity in the brain

Down

1. Validated scales to assess clinical severity in body dysmorphic disorder include this scale
3. Symptom of Body dysmorphic disorder which involves repetitive behaviours like adjusting one's clothing to hide disliked body parts
5. (Short form) was the "disinhibited" subtype of reactive attachment disorder (RAD) in DSM-IV
6. Spectrum on which Body dysmorphic disorder has been categorised in DSM 5 due to increasing overlap
7. Syndrome which is a type of Factitious disorder commonly seen in prison population characterized by somatic conversion symptoms

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