MINDS
Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students
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GUEST EDITORIAL

Potential role of Private Practitioners in Teaching in Medical Colleges

A narrow definition of a teacher is someone whose occupation is to instruct students in a school or college. In its true spirit, a 'teacher' is a person who helps students to acquire knowledge competence or virtue. The recent decision of the Board of Governors of the Medical Council of India to the proposal to allow private practitioners as visiting faculty in medical colleges is a progressive step forward and would help break barriers in teaching and learning.

Doctors in private practice acquire vast clinical experience. It is true in India that the latest advancements in equipment and skills first reach the private sector before it percolates into institutional systems. A large and 'interested' human resource which was hitherto kept out of the medical education system will now be able to share their knowledge with students. The students who needed to attend conferences to learn new skills will now have the opportunity to be able to learn these from visiting faculty in their own classrooms. Conversely, teaching is also a way for the doctor in private practice to refresh her knowledge and stay rooted to the basic skills which she acquired as a student.

A large percentage of students eventually go on to work in the private sector after their course. But their training probably does not give them enough experience or orientation to expectations in the real world. The private sector also serves multiple sections of society in different innovative ways. This interaction with private practitioners would be a great way for the students to get exposed to the various opportunities available to her and make informed career choices. This move would also open up exciting avenues for collaborative research between institutions and private centers.

(Cont'd on Page 2)

- Publishing from 2011
- Articles on Psychiatry from over 22 specialities!!
- Contribution from More than 50 Authors!!
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Potential role of Private Practitioners in Teaching in Medical Colleges

It is heartening to note that some centers in the country already have this system in place. A notable example is the Department of Psychiatry, KMC, Manipal which; supported by the MAHE, has been inviting national and international visiting faculty to interact with their students. The department also organizes study tours for their students to visit various centers in the private sector doing innovative work in the area of mental health.

While the MCI decision is an exciting opportunity for both doctors in the private sector to engage in teaching and for students to get exposed to newer avenues for learning, it must be borne in mind that this does not replace the important role played by the full-time faculty. A visiting faculty cannot fulfil the important duties of imparting basic clinical skills day to day bedside teaching and mentoring of the students. There will need to be enough safeguards in place to ensure that the genuinely interested doctor in private practice who has a passion to be involved in teaching and can add value to learning gets the opportunity to the mutual benefit of both the doctor, the student and the institute.

Dr. Rishikesh V. Behere
India Alliance Intermediate Fellow
Associate Consultant Psychiatry
KEM Hospital Research Center, Pune
Adjunct Faculty, Psychiatry, KMC Manipal.

As a post graduate, working with clients in therapy, many experiences have stayed with me through the years. With the passage of time and having the privilege of working with clients with difficulties, learnings from some of these experiences have been reinforced.

One such memory is that of losing a client to suicide. As a young trainee professional, I was besieged by doubts- of having made a mistake, about my own competence and abilities, of having missed signals or steps in a protocol. Feelings of loss and grief seemed to have no place in this context as it was supposed to be about the client and the family that had lost a member. Focusing on oneself and one's emotions and reactions seemed weak, self indulgent and the wrong response!

Fortunately, the systems put in place for training took over. In discussion with my therapy supervisor, I was able to process many of my feelings and responses. The team undertook a clinical audit of the case and we were able to reach some understanding of what transpired from a factual perspective. In informal, personal discussions with other members, I found that I was not the only one grappling with the loss of my patient. However, I perceived some resistance, stigma and barriers in being able to share personal sadness and grief. Subsequent reading helped me understand the possible reasons- fear of censure or judgment, feelings of shame, guilt, denial. Consequences include low self-confidence, feelings of anger and inadequacy. Many professionals report intrusive and avoidant thoughts about their client's suicide.

Over a period of time, I was able to reach a balance of examining what could have been done differently versus what was out of my control. This was a challenging equilibrium to reach. Our training emphasizes anticipation, control and the necessity of not making mistakes. Acceptance that when it comes to suicide, a client is likely to be influenced by a multitude of factors beyond our control is challenging. Mental health professionals are, inevitably, likely to experience client suicide despite their best efforts to avert this crisis.

Over the years, like many mental health professionals, I have unfortunately, had to deal with client suicide on occasion. Established protocols and systems along with experience have helped me cope on one level. At another, many emotions, questions and reflections remain, to be grappled with and made peace with.

An important learning from my training period that has served me well has been the necessity to acknowledge my grief and emotions, to share and discuss with peers, seniors and to facilitate communication with younger colleagues and postgraduates. Client suicide is a professional and personal trauma for every clinician. It needs attention and clinicians need to be trained to care for themselves.

Dr. Vidya Sathyanarayanan
Professor of Clinical Psychology, Department of Psychiatry
St John's Medical College Hospital

EPILEPSY – UNDERSTANDING ITS PSYCHIATRIC ASPECTS

Epilepsy is defined as the tendency to have recurrent unprovoked seizures. Worldwide, the prevalence of Epilepsy (recurrent seizures) is about 1%, whereas the lifetime prevalence of experiencing a seizure is approximately 5%.. Between 10 and 50%of patients with epilepsy have psychiatric symptoms. It is important for all doctors to get acquainted with epilepsy and its psychiatric aspects, so as to prevent misdiagnosis and inaccurate treatment.

Psychiatric aspects of epilepsy may be related to:

- Psychosocial consequences of diagnosis.
- Psychiatric syndromes directly attributed to epilepsy.
- Neuro-psychiatric effects of medications.

Psychosocial consequences of diagnosis :

A diagnosis of Epilepsy brings with it myriad psycho-social consequences like unemployment, dependency, restricted activities (potential hazard in driving, risk of drowning), stigma and ostracism.

Psychiatric symptoms directly attributed to epilepsy:

Pre-ictal:

- **Prodromal symptoms:** a variety of vague symptoms may be experienced by patients, hours or days leading up to the seizures. Example: tension, dysphoria ,insomnia etc.
- **Aura:** may occur immediately prior to seizure onset. They are
  - Stereotyped e.g autonomic or visceral aura (epigastric sensation)
  - Derealization and Depersonalization experiences
  - Cognitive symptoms (dysphasia, psycho-experiential phenomenon like deja vu, Jamais vu, fugue)
  - Affective symptoms (anxiety, euphoria)
  - Perceptual experiences (hallucinations, illusions)

Ictal:

- **Automatism:** simple or complex stereotyped (repetitive) movements that tend to be disorganised and purposeless. There is amnesia for automatism and the patient seems 'out of touch.
- **Epilepsy Partialis Continuans:** a condition of prolonged Complex Partial seizures lasting hours to days (confused with Psychosis, Delirium). Can have variable behavioural, perceptual, cognitive symptoms and periods of amnesia.
- **Ictal Violence -** with rare exception, ictal violence consists only of random shoving, pushing, kicking, or screaming. This behaviour is fragmented, unsustained, ineffectual, and, most important, unaccompanied by rage or anger. To be differentiated from Belligerence or resistive violence, a different form, occurs when patients fight against restraints during their ictal or postictal period.

Post Ictal:

- **Post-Ictal Delirium:** A confessional state characterised by disorientation, inattention, variable levels of consciousness, at times paranoia. Can last hours to days.
- **Post ictal agitation:** However, seizures occasionally lead not to somnolence, inactivity, and withdrawal, but rather to agitation, i.e., postictal agitation.

EPILEPSY – UNDERSTANDING ITS PSYCHIATRIC ASPECTS

If seizures involve the brain's language region it can cause transient aphasia. Similarly, if the seizure focus includes the cortical areas involved with motor function, patients may have a Todd's Hemiparesis (transient postictal monoparesis or hemiparesis, usually lasts minutes to hours)

- **Post-Ictal Psychosis:** usually follows a cluster of seizures or an increase in the frequency of seizures. At times withdrawal of anti-convulsant therapy may lead to psychotic features. A period of non-psychotic interval (hours to days) is observed following a seizure, followed by a brief psychotic episode.

Inter Ictal:

- **Brief Inter-ictal Psychosis:** also known as 'alternating psychosis' (there is an inverse relation between severity of epilepsy and severity of psychosis). Psychotic episode occurs unrelated to a seizure, when there is good control of epilepsy. The seizures are antagonistic to psychosis, where EEG normalizes during psychosis, known as 'forced normalization'
- **Chronic inter-ictal 'schizophrenia-like' psychosis:** about 10 times more common in epileptics than in general population. Commonly seen in Temporal Lobe Epilepsy, more common in early onset severe epilepsy. Usually has a chronic course and tends to have more affective symptoms.

Other presentations:

- **Cognitive Deterioration:** Due to cerebral hypoxia with repeated seizures and neurological effects of anticonvulsant medication.
- **Mania:** manic features are more commonly seen with right sided temporal lobe epilepsy.
- **Neurosis:** epileptics have 50% risk of depression, with suicidality risk about 5 times compared to general population and 25 times greater in focal seizures. 5 to 10% patients of epilepsy can have conversion disorder, with increased risk for 'psychogenic non-epileptic seizures'
- **Personality traits:** a controversial phenomenon associated with chronic Temporal Lobe Epilepsy. The classic traits include religiosity, hypergraphia, hyposexuality, 'sticky' personality.

Anti-Epileptic Drugs (AED) - induced cognitive impairment develops most often following rapid introduction, high doses, elevated serum concentrations, and a regimen with more than one AED. Toxic levels, in general, cause memory difficulties, intellectual dulling, and inattention. In addition, AED-induced forced normalization may lead to psychiatric disturbances.

To quote Hippocrates "Primum Non Nocerum" (First Do No Harm). It is only by acquiring medical acumen through knowledge and practice that we can follow this dictum.

Dr. Mansi Vora
Consultant Psychiatrist,
Westcoast Institute of Neurosciences, Mumbai.

TRANSCULTURAL PSYCHIATRY

CAREGIVER BURDEN

Caregiver is an individual who has the responsibility of meeting the physical and psychological needs of the patient. Majority of the mental illness have an intense and unpredictable course placing the caregiver at a great risk of mental and physical health problems. The physical, emotional, social, financial toll of providing care is termed as caregiver burden. It is the stress perceived by caregiver due to the existing situation. Family burden is therefore of highest priority which would contribute to the long-term care of the patient.

They generally encounter problems communicating with professionals about their caregiving experience. Caregiver burden is reportedly a critical determinant for negative caregiving outcomes.

Predictors of caregiver burden

An established link between expressed emotions and the clinical outcome of the patient has been widely studied. Similarly researchers have found the link between the expressed emotions and caregiver burden. Caregiver having high expressed emotions in the form of criticality, over involvement, hostility were associated with higher scores on stress and anxiety.

Other predictors of burden involve

- Diagnosis of mental illness
- Duration of contact with patient
- Relationship of caregiver with patient
- Coping skills of caregiver
- Availability of resources
- Institutionalization
- Poor social support

Presenting signs and symptoms

Worry, loneliness, fatigue, irritability, anxiety, reduction in quality of care, social isolation, restriction of their personal activities, disturbances in sleep and appetite

Pathogenesis of health effects in caregivers

Caring for someone with psychiatric illness is associated with a higher level of stress than caring for someone with functional impairment from other chronic medical illnesses. Any amount stress activates the hypothalamic pituitary adrenal axis (HPA axis). After exposure to stressful stimuli, the hypothalamus releases corticotropin releasing hormone (CRH), which stimulates the pituitary gland to release adrenocorticotropic hormone (ACTH). ACTH in turn triggers the release of glucocorticoids from the adrenal cortex. During the same time the sympathetic nervous system is activated to release epinephrine from the adrenal medulla and norepinephrine from sympathetic nerves.

Activation of the acute stress response is life saving and prepares the organism to avoid impending danger, enhances attention and increases energy. In contrast chronic stress has negative consequences on health.

TRANSCULTURAL PSYCHIATRY

CAREGIVER BURDEN

Evaluating stress / burden in caregivers

The assessment of burden has become a challenging task for most researchers because cultural, ethical, religious and other personal values may influence perception of meaning and consequences of burden.

Stressful life events are inevitable, but it is important to identify those at increased risk for negative outcomes, assess the degree to which the caregiver's life and health maybe negatively affected, and the interventions that can be used to reduce the burden on the family.

- Brief clinical screening questionnaire for care givers
- Scale to assess expressed emotions
- Allowing enough time to the family to express their concerns with respect to care of the individual patient
- Clinician should remain alert to stress related symptoms
- Caregivers feedback sessions

Recognizing the psychological, behavioural and physical effects of caring for their loved ones is an opportunity for primary prevention.

Interventions to treat caregiver burden

- General measures include improving the home care, adult day care, routine friendly visit, use of assistive equipment
- Psychological interventions mainly include support groups or psycho educational sessions for caregivers.
- Pharmacological interventions include use of anxiolytics and antidepressant medication for associated mood symptoms affecting their functionality.

Dr. Shilpi Sharma
MBBS, DPM, DNB Resident,
Vidyasagar Institute of Mental Health & Neurosciences, Delhi

ANSWERS TO THE CROSSWORD APPEARING ON PAGE 8

1) Hysteria
2) Parasomnia
3)Apotemnophilia
4) Akathesia
5) Neologism
6) Jetlag
7) Hypomania
8) Frotteurism
9) Naltrexone
10) Catatonia
11) Agarophobia
12) Actigraphy
13) Triskaidekaphobia

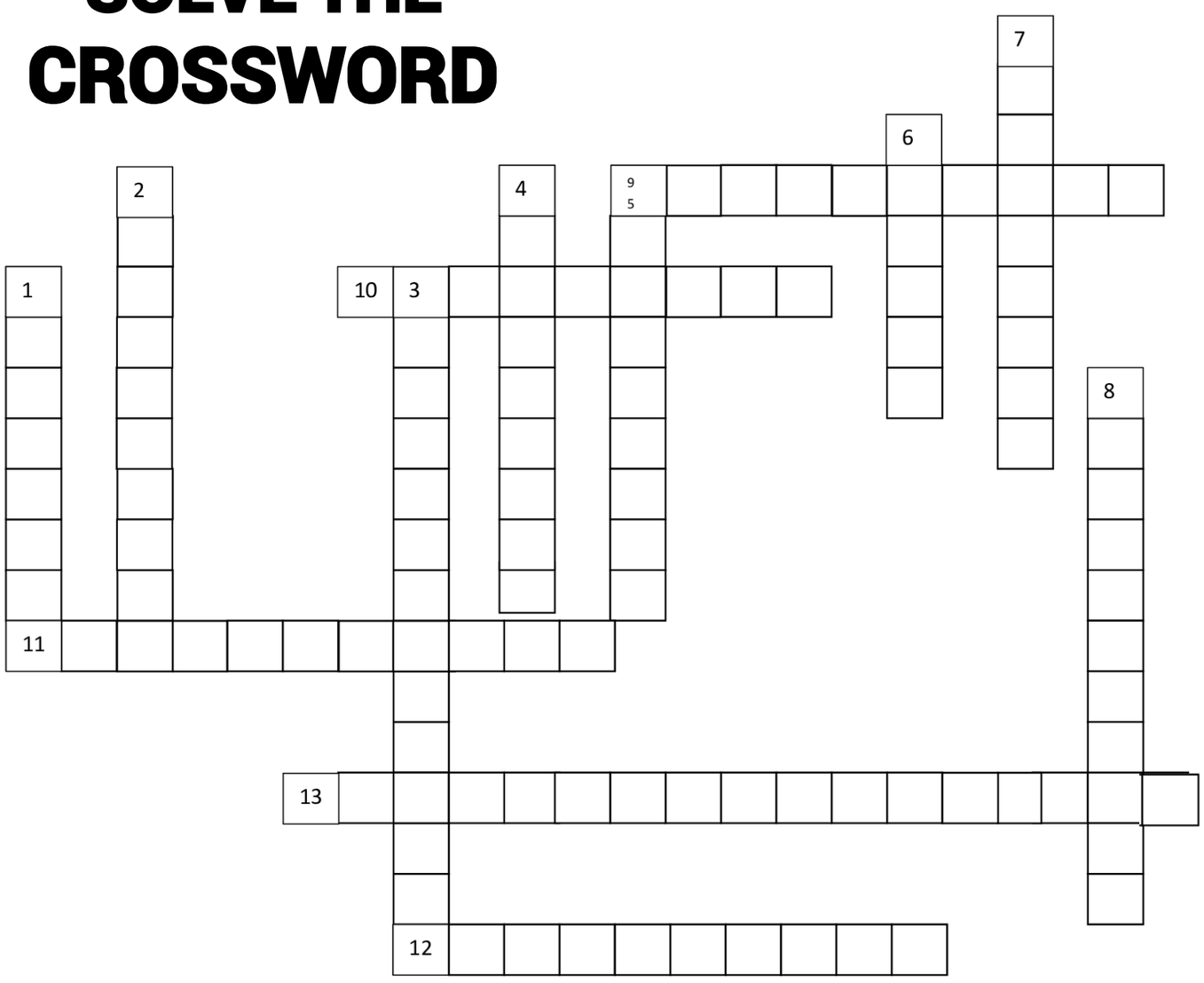
THE UNDERGRADUATE SECTION

VIEW FROM MY ROOFTOP

Glistening rooftops of tin huts in the distance,
the shimmer of sunlight bouncing off the windows of a car
slowly winding its way up the hills disappearing around the bends,
reappearing on the other side.
The farmer walks through his flooded fields
a small stick figure
knee deep in water; half naked
burnt almond in the summer sun.
On the street below:
the father holds tightly onto his daughter's hand
while she struggles to break free her tiny feet in her dusty school shoes,
rebel,
kicking up the dust on the road with every step;
the labourer returns from his day of work
his jute bag frayed at the edges, the head of a hammer sticking out
he squints his eyes against the brightness of the setting sun
and keeps his eyes on the road
his shirt grimy, untucked softly flutters in the wind;
the school bus turns the corner leaning heavily to one side,
and the happy babel of children
breaks the oppressive air of small-town silence,
their faces are flushed red
the water bottles around their neck
jiggling up and down with every bump on the road.
The whole thing is theatrical like a play that plays out
over and over again
and everyday
I drag my chair close to the stage
and watch…

- **DR. TSHERING ILLAMU**
1st Year Junior Resident
NIMHANS

SOLVE THE CROSSWORD



DOWN

1) Uncontrollable emotion
2) Unusual behavior during sleep
3) Desire to remove body parts by amputation
4) Motor restlessness
5) New words invented by the patient
6) Alteration to bodily circadian rhythm due to longdistace and transmeridian travel
7) Less severe form of mania
8) Non consensual rubbing of genitalia against a stranger

ACROSS

9) Drug used to treat alcohol dependence
10) Psychomotor immobility
11) Fear of being alone in public
12) Non invasive method of recording human rest/ activity
13) Fear of number 13

CREATED BY
SHIVAKUMAR. A
Medical Intern, Yenepoya Medical College, Mangalore

ANSWERS TO THE CROSSWORD ARE ON PAGE 7

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

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