MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

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FROM THE EDITOR'S DESK...

MAKE HAY WHEN THE SUN IS SHINING!

With the rising recognition of the importance of mental health and consequent increase in identification and diagnosis of psychiatric disorders, it is imperative that psychiatry be given more importance during UG education. It is also a well-known fact that exposure to psychiatry in undergraduate (UG) medical education is minimal, with a 2-week clinical posting and internship rotation. High quality psychiatry teaching is crucial not only for the future of psychiatry, but for future provision of holistic medical care as well. Medicine being a university course, UG psychiatry education should be led by academic psychiatrists, with all psychiatrists having a professional duty to contribute to the teaching and training of the next generation of doctors.

UG psychiatry postings are also notoriously known for being taken advantage of through bunking and frequent leaves by students. By altering their learning experience, making it more interactive and engaging, making it relevant to their clinical work as doctors, challenging them with complexities of psychiatric care and innovative research ideas, students' interest in the subject and seriousness to learn can be efficiently utilized.

The Medical Council of India's (MCI) competency based UG curriculum for the Indian Medical Graduate-2018 is a paradigm shift in the approach to UG medical teaching. The competencies related to psychiatry have 19 topics and 117 outcomes, with both horizontal and vertical integration into multiple semesters and other subjects. Its introduction has been a fortunate coincidence, and this restructuring of UG medical curricula to enhance integration may yield added value, including the potential to improve attitudes and break down the silos into which psychiatry has been forced.

(Cont'd on Page 2)

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- Articles on Psychiatry from over 22 specialities!!
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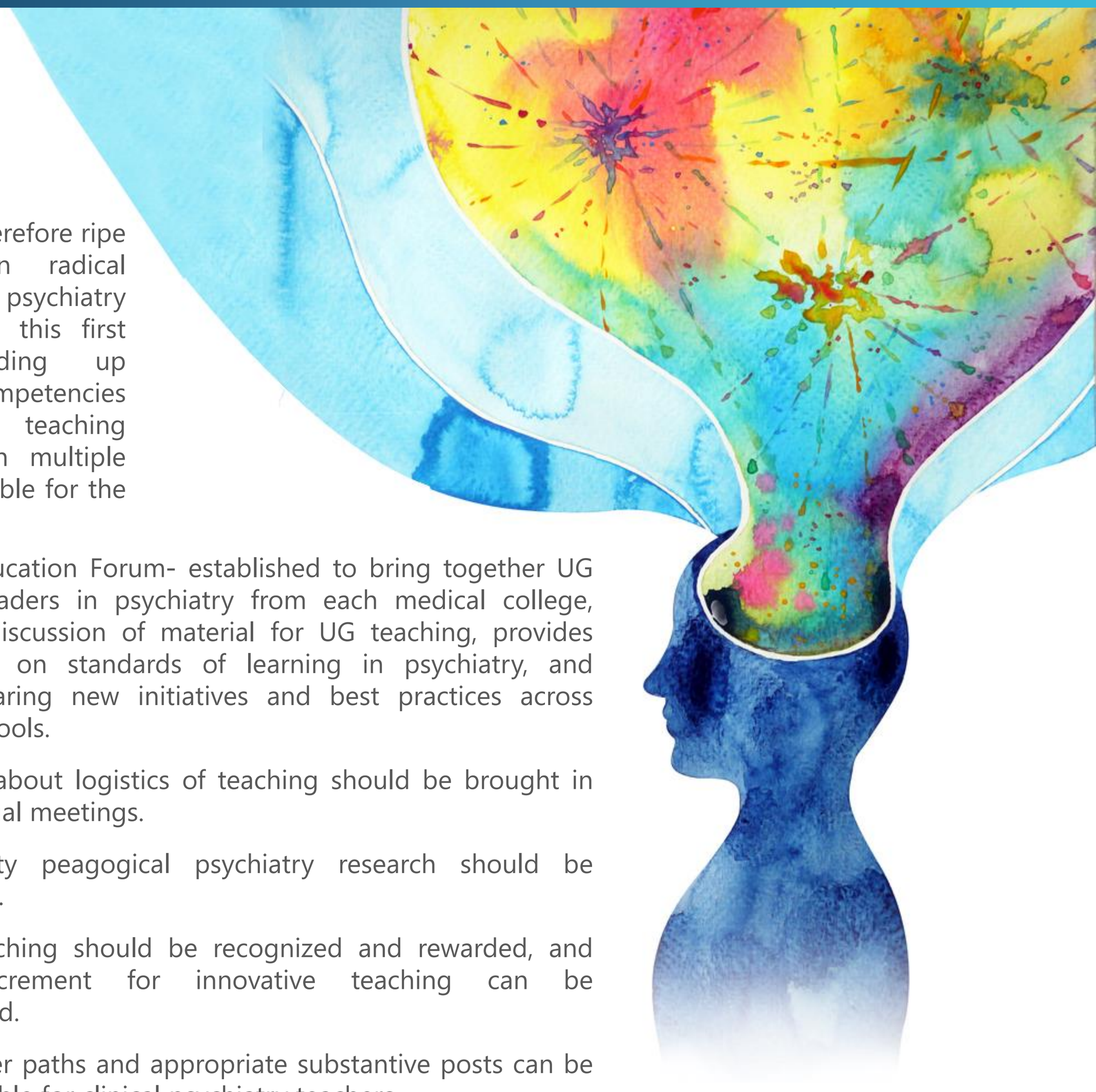

The time is therefore ripe to bring in radical changes in UG psychiatry teaching, and this first entails building up teachers' competencies in the new teaching methods, with multiple avenues available for the same:

- The UG Education Forum- established to bring together UG teaching leaders in psychiatry from each medical college, promotes discussion of material for UG teaching, provides agreements on standards of learning in psychiatry, and enables sharing new initiatives and best practices across medical schools.
- Discussion about logistics of teaching should be brought in faculty annual meetings.
- High quality peagogical psychiatry research should be encouraged.
- Quality teaching should be recognized and rewarded, and service increment for innovative teaching can be implemented.
- Viable career paths and appropriate substantive posts can be made available for clinical psychiatry teachers.
- UG Psychiatry Education Forums can be started, comprising of psychiatry teachers, UG students and current psychiatry postgraduates, with each contributing a different perspective, thereby helping effectively tailor teaching programs.

We suggest that UG psychiatry teaching be integrated throughout the course and alongside other specialties, which may normalize approaches to mental health, and this may help (along with other measures) to improve general attitudes about psychiatry at the same time as improving knowledge and skills. This is important not only for increased recruitment of more UGs to psychiatry, but also to foster a good understanding of mental health for all future doctors regardless of their ultimate career destination.

DR. SUHAS CHANDRAN AND DR. YAMINI D

HOW MY PATIENT TAUGHT ME TO EMBRACE PATIENT CENTRED CARE?

Any medical career is full of memories; some good and some not so good. Often, patients are the biggest teachers, teaching us lessons that are transformative. I count myself fortunate to have had one such transformative doctor-patient interaction quite early in my postgraduate residency at JIPMER. It changed my approach to practicing psychiatry as well as medicine in general.

An elderly gentleman was referred to us with medically unexplained physical symptoms including sleep disturbances. I was assigned the responsibility to work him up. After the work-up was done, I discussed the case with my consultant who suggested that I could provide him with supportive psychotherapy. Additionally, because Indians generally don't like to go back empty handed from a doctor's clinic, he also suggested that I add some B-complex tablets, with a suggestion that he would get better on it.

I did so and after a few weeks, patient reported feeling better and resumed functioning. As the psychotherapy sessions drew to a close, my role was reduced mainly to prescribing B-complex tablets. After a couple of months of doing this, I suggested that he need not spend 200 rupees for the bus fare to come and collect vitamin tablets worth 50 rupees and that he could refill them at a nearby pharmacy.

He sounded like he was taken aback at my suggestion. As I was wondering what wrong I had done, he told me that vitamin tablets from outside did not work as well as the one prescribed in JIPMER. With a dismissive wave of my hand, I laughed him off and told him that it must be all in his mind. What happened next was totally unexpected. He sought my permission to ask something beyond the bounds of consultation. I gave him my consent.

He first asked me if I was a religious person. I said, "Yes, very much." Subsequently, when he learnt that I hail from Thrissur in Kerala, he asked me whether and how often I visit the Guruvayurappan temple, about 30 km from my place. I told him that I make it a point to visit the temple every time I go home. His response was spontaneous - "There you have it doctor. God is everywhere. Then, why do you travel 30 km and specifically go to this temple every time? Because you have faith in the deity. Similarly, I have faith in JIPMER and that is why I prefer to come here, see you and buy the tablet".

I understood his reasoning. There is no point arguing with faith. The take home message for me was simple; it is not only the medicine we prescribe, but a lot of other intangibles such as doctor patient relationship and response expectancy that may drive patient response. Perhaps, this is more relevant to psychiatry than any other branch of medicine because psychiatry is uniquely positioned to integrate science and humanism. From that moment onwards, my practice of psychiatry has been increasingly accommodative of patient values, context and concerns. And at the very least, clinical encounters have become more fulfilling.

I have to thank the elderly gentleman for giving me such a profound lesson early in my career.

Dr Vikas Menon
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COMPETENCY BASED MEDICAL EDUCATION (CBME): WHAT AN UNDERGRADUATE SHOULD KNOW?

In last one year, Competency Based Medical Education (CBME) has been the buzz word in medical colleges across the country. This article is an effort to explain the basic concept of CBME, the strengths and weakness of CBME, keeping undergraduates in mind.

Before we begin the discussion on CBME, it is essential to understand the concept of "competency". Competency is defined as an observable ability of a health professional related to a specific activity that integrates knowledge, skills, values, and attitudes. Hence CBME aims to impart undergraduates not only with knowledge, but also with skills, values and attitudes. To explain with a simple example, a final year undergraduate student will not only be tested for his theoretical knowledge of normal delivery (competency here is to conduct a delivery), but also his skills to conduct a normal delivery in a simulated environment and counsel the family member about the procedure and possible risks involved (all these days the teaching-learning and assessments involved predominantly knowledge domain). Hence one important difference between CBME and traditional teaching method is equal importance to the all three domains of learning i.e knowledge, Psychomotor and attitude in both teaching learning and assessment.

Formative assessments have important role to play in the implementation of CBME.The learner is periodically assessed, and constructive feedbacks are given about his performance. Continuing with the above example, the student may be asked to conduct a vaginal delivery in skill lab, using mannequins, following which the feedback will be given about his psychomotor skills. One should note here that MCI has prescribed a set of core competencies is almost all subjects, which the learner must acquire in order to complete the requirement of the subject.

Unlike the traditional curriculum, which was criteria oriented (two months' compulsory rotation posting in Obstetrics and Gynecology) CBME is outcome oriented (to be able to demonstrate the stages of normal labor in simulated environment). It is also said that CBME is time flexible, which means every learner will be allowed to learn at his own pace rather than in a fixed time frame.

Integrated teaching is another important component of the CBME curriculum being implemented across the country. Integrated teaching is supposed to ensure the continuity in learning and also enable the learner to better connect the knowledge of basic specialties with the clinical practice. For example, as a part of early-clinical exposure (which is an integral part of MCI prescribed CBME curriculum), after a theory class on female reproductive system, a visit to labor room may be organized for the first-year students for better understanding of applied anatomy and physiology of labor. Alternatively, Anatomy department may co-ordinate with Gynecology department to jointly conduct a class on the applied anatomy of a vaginal delivery.

To conclude CBME is an outcome oriented and learner centric curriculum which aims to produce medical graduate, who can cater the needs of the community (a doctor who is a good clinician, good communicator, team leader, displays professionalism, and a life long learner). However, there are various hurdles in implementing CBME, to name a few: the medical teachers who are not well-versed with new curriculum, apprehension on the part of students about the new curriculum, the need for extra resources (e.g. skill labs) and manpower, the challenge of making it a time flexible curriculum etc. Nevertheless, it is a paradigm shift in the field of medical education in the country and every teacher and student should work for the its successful implementation.

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TRANSCULTURAL PSYCHIATRY

POSSESSION SYNDROME: THE ENCHANTING TURMOIL

The very word “possession” often conjures up images of writhing humans uttering gibberish with a shaman nearby reciting incantations. This is a scenario which almost every Indians are familiar with- stories passed on through folktales or through other media such as televisions. These are culturally patterned form of altered states of consciousness which is often attributed to possession by a spirit or demon or deities for whatever reason. Debate has raged on throughout history on whether to consider this a mental illness. However, larger consensus has now proven that possession is indeed a manifestation of neurosis, thus requiring medical intervention.

Under ICD 10, possession syndrome falls under the rubric of Dissociative Disorders as Trance and Possession Disorder (F44.3). ICD 11 will retain trance and possession disorders but they’ll be split into “trance disorder” and “possession trance disorder”. So what exactly is possession syndrome? It is an episodic disruption of behaviour during which it is presumed that the subject’s personality has been replaced by that of spirit or a deity or a demon or a dead relative. Possessions can be voluntary or involuntary. The former enjoys a high status in society while the latter is considered to be an affliction. It can affect a single individual or groups of people as reported in various literatures. Possession syndrome has been reported from all around the world. While dissociative identity disorder is reported mostly in Western countries, possession appears to be more prevalent in India. This may be because beliefs in polytheism and reincarnation are more prevalent in India while there is higher social approval of role playing in the West.

Like *susto* of Latin America and *hwa-byung* of Korea, possession syndrome is an illness of attribution that has intrinsic meaning to the person suffering from it. This central belief that his or her body has been taken over by an external agent gives meaning to the clinical manifestations of possession. The purpose, symptoms, and consequences of possession are highly influenced by the fabric of the culture of which he/she is a part of. It is often precipitated by events causing any kind of emotional distress such as death of a loved one, interpersonal conflicts, economic problems etc. It has been speculated that possession is a way for physically and emotionally neglected people to communicate their needs. Let’s consider the following hypothetical scenario: a childless woman who’s been ostracized by her family and society at large for failing to “perform her duty as a woman”. She’s excluded from major religious events and her husband’s infidelity may be tolerated to the point of being encouraged. One day this hypothetical woman goes into a trance, frantically moving her limbs about, and in a slightly changed voice and tone, claims to be the spirit of a goddess. When she becomes aware of her surroundings she’s unable to recollect the preceding events. Thereafter she goes into a trance everyday and people come to “worship” her seeking remedies for her ailments. Her status in the society increases and she finally receives from her family and the society what she’s been craving- respect.

TRANSCULTURAL PSYCHIATRY

POSSESSION SYNDROME: THE ENCHANTING TURMOIL

This is just one of many ways in which possession states can manifest. Common symptoms include, but are not limited to: loss of control over one's actions, loss of awareness of surroundings, loss of personal identity, change in tone of voice, loss of sense of time, loss of subjective perception of pain-sensitivity etc. Numerous studies across varied cultural groups have reported higher cases of possession among women of lower educational background. Is it because this is the only culturally acceptable way for socially oppressed individuals to act out intolerable psychological conflicts? Or is there something deeper which we are unable to link?

Possession cases often present challenges in diagnosis and treatment. As mental health practitioners, it is imperative to note that possession-like states can also be seen in conditions such as obsessive compulsive disorder, schizophrenia, depression, and temporal and frontal lobe lesions. As in all psychiatric phenomena, possessions should be understood in the context of culture. The general tendency to attribute a person's belief in possession to psychosis or culture-bound syndrome should be avoided.

Treatment should be aimed at removing psychological conflict. Patient and family members should be psychoeducated about the nature of the illness. Family members should be advised not to reinforce patient's behaviour. Pharmacological management can be done for accompanying conditions such as depression or anxiety. Early intervention ensures a good prognosis.

Dr. Meesha Haorongbam
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ANSWERS TO THE CROSSWORD APPEARING ON PAGE 7

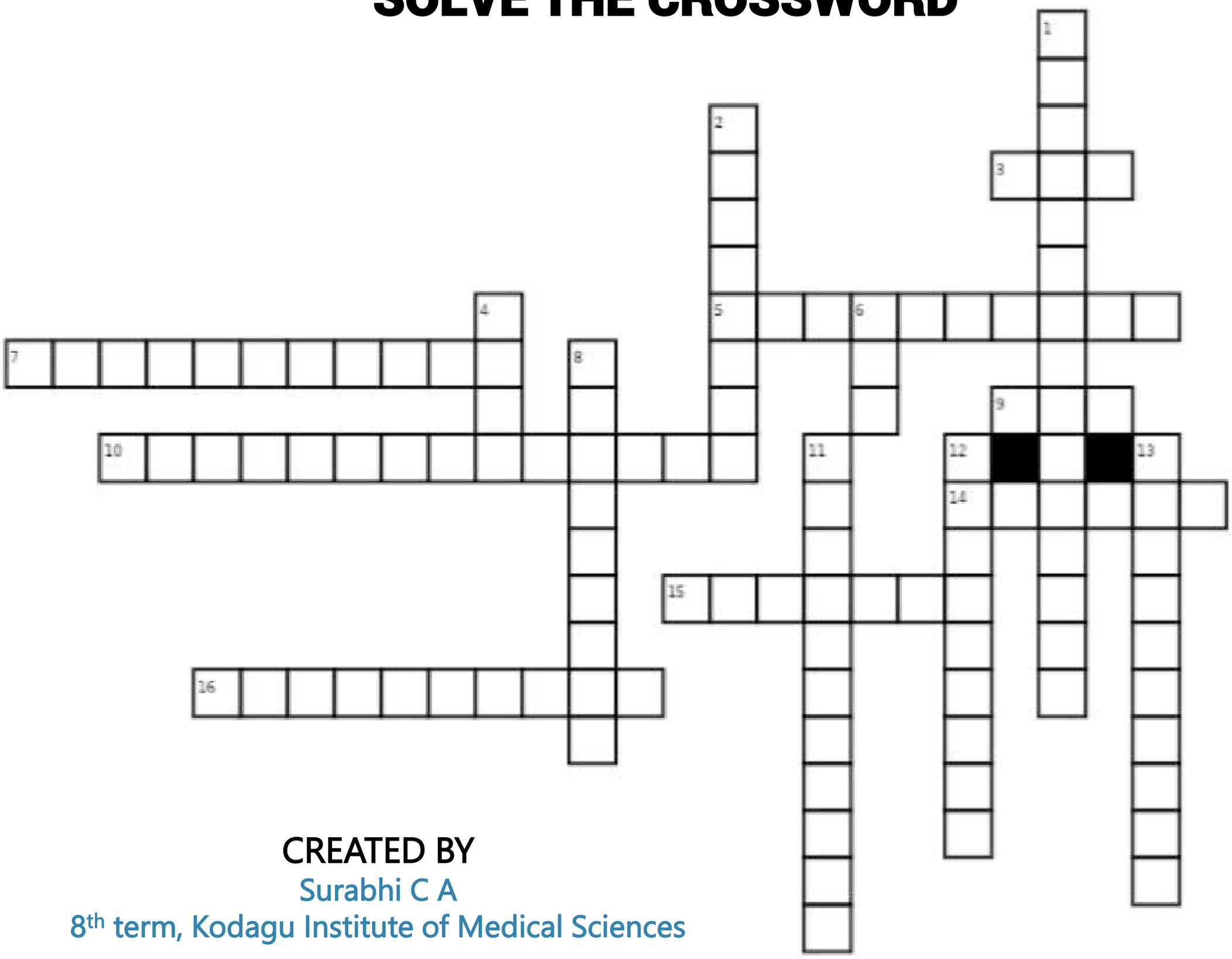
DOWN

1.Kotard's delusion
2.Tourette
4.Pain
6.OCD
8.Serotonin
11.Sitophobia
12.Asyndesis
13.Folie a Deux

ACROSS

3.CAM
5.Encopresis
7.Unio mystica
9.REM
10.Savant Syndrome
14.Stupor
15.Fifteen
16.Johann reil

SOLVE THE CROSSWORD



CREATED BY
Surabhi C A
8th term, Kodagu Institute of Medical Sciences

DOWN

1. Walking corpse syndrome
2. Rani mukherjee has this in hichki
4. We've all experienced this at some point in our lives
6. Danielle Radcliffe suffers from this
8. First biomarker identified in autism spectrum disorder
11. Fear of eating
12. Connect unconnected ideas and images
13. Sharing of delusions between two persons

ACROSS

3. Screening test for delirium
5. Fetal incontinence in children
7. Feeling of mystic unity with infinite power
9. Stage of sleep with high brain activity
10. Unusual abilities which is above average in autistic children
14. State of being mute.unresponsive.conscious.immobile
15. Maximum score in GCS
16. Coined the term psychiatry

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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