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REFLECTIONS

Do we reflect often?

A Biannual Initiative from IAPP, Karnataka

Volume 5 | *Issue 1* | *January-June, 2018*

From the Desk of the President, IAPP Karnataka

"Misdiagnosis of Psychiatric illness"

My thoughts on misdiagnosis.

As a practicing psychiatrist for over fifteen years, I have had the good fortune to work on a variety of cases. My experience has allowed me to witness first-hand how underlying psychiatric illness mimic physical ailment.

For instance, a patient suffering from swollen joints on consulting a rheumatologist was diagnosed and treated for rheumatoid arthritis over a period of eight years. After eight unsuccessful years of active treatment, the patient was referred to me as there was no improvement. On detailed enquiry and talking to the patient at length, I discovered that the patient was experiencing high stress on a daily basis due to a difficult family situation. Further, his tests revealed that the rheumatoid factor was negative. As his stress levels were unmanageable, I decided to start with medication and psychotherapy. To my astonishment, within a period of two weeks, the patient's symptoms completely disappeared. Like me, the patient was also thoroughly surprised but also greatly relieved of his pain. I suggested to continue his medication & psychotherapy over a period of two years. On showing signs of improvement I tapered and finally stopped his medication. Even after a period of 2 years When we met, the patient did not report of any recurrence.

Similarly, in another case, a middle-aged patient was suffering from diarrhea over a period of three months. He had been treated for hyperacidity with no relief. A friend had referred him to me for an opinion. During our sessions, the patient seemed to exhibit depressive symptoms like sadness, disturbed sleep, loss of appetite and loss of energy. The patient responded well to my treatment and began to show improvement and was stabilized over a short period of time.

I mentioned the above two cases to illustrate my earlier point of view on how a psychiatric condition often mimic physical ailment. Over the years, I have realized that an underlying psychiatric condition can be often overlooked by concentrating on the physical complaints. This approach results in focusing on the symptomatology rather than etiology & most importantly it results in a delay for the patient to receive the right treatment, at the right time.

Further, in my opinion, psychiatry is very different from other specialties due to its highly nuanced nature. I like to spend a lot of time with the patient, listening to him/her talk rather than focusing on the physical symptoms. Although there is a lot of time involved in doing so, I find it is time well spent.

To conclude, I would like to say that I have seen that it is very easy to misdiagnose psychiatric illnesses unless we probe very deep into the issue. I'm sure that many of my colleagues will agree with me on this.

Dr. P. Vijaya Kumar
President, IAPP - Karnataka

From the Desk of Guest editor

'Moderation'

Moderation is the new age 'mantra', though ancient in origin. Socrates (Born 469 BC) was one of the first to state "everything in moderation; nothing in excess", almost 2500 years ago. The Bhagavad Gita says sense objects are like fuel for the mind and senses. The more fuel you give, the bigger the fire. Control the amount of fuel and live in moderation. Buddha (6th to 4th century BC), in his teachings, said that we find glory and wonder by walking the middle way (moderation). Moderation is neither indulgence NOR deprivation, but a commitment to balance and yet wholeness. At a superficial level, it is about avoiding extremes and finding strategies and habits that can be maintained over long term to achieve success. At a deeper level it also means commitment to balance & wholeness, which means living up to your full potential by finding ways to incorporate that balance. Perhaps it is arbitrary, with an inclusion of our own personal preferences: 'what's best for us'. However, the drawback is that we can always deceive ourselves!

Why we are suddenly discussing moderation. All stimuli, after a while, lose their 'Wow'. Boredom sets in and we become restless and unhappy. We look for more stimulation to keep us happy – movies, food, sex, alcohol, substances – all in extremes. Paradoxically, we receive less joy from these stimuli after a while. We therefore develop an insatiable appetite for different stimulation, of which we seek more and more. These stimuli also inevitably lose their 'Wow', and the cycle goes on.

Insatiable appetite for stimulation has been a rule rather than an exception – then and always! In Rome, to celebrate funerals of important men, two prisoners fought to the death, and the winner was freed. This became the central source of entertainment for ordinary Romans. Sensing their need, Julius Caesar held the first games, unconnected to a funeral. Appetite for this sport grew, leading to the building of the Colosseum. With this, Gladiator games took new turns, and became bizarre and bloody. Humans were fed to animals; animals were slaughtered for fun; women, children, blind men, and dwarves were made to fight to their death. Finally, unable to keep up with the costs that the state incurred by these events, they died a natural death in the 6th Century BC.

The moral of the story, if one may call it that, is that greater stimulation will not appease desires, but will increase appetite for them. Higher levels of stimulation tend to damage the delicate mechanism of body and mind for receiving and enjoying pleasure. Overload of the pleasure circuits result in numbness to future enjoyments.

What then needs to be done to revive pleasure. Seek pleasure and enjoyment in things you already are doing now. Enjoy every moment. Cultivate the 'virtue of moderation'. Take time off for the people in your life. They will not always be there. Reconnect with your senses. Rediscover hidden layers of every moment. Savour every sip of what you drink and taste each mouthful of food. Feel 'awe' when you look at the night sky. Wake up to the wonders of the world. Do not walk through life like a zombie! Get acquainted with your attention span, which has become abysmally low, due to an unreasonable expectation for speed. When we watch old movies, things happen in real time, and we are struck by the slow pace, the issue definitely not being the movie! The solution is to stretch your attention span – watch old movies, read the paper, read a book. Stop multi-tasking, as this increases the craving for stimulation more and more. Concentrate your senses and focus on the task at hand. Take a fast from stimulation, and get out into the external world, avoiding a phone, internet, television etc. for at least a day a week. Delay your gratification and enjoy the exquisite pleasure of anticipation. Anticipating a holiday can be just as good and sometimes better than the actual holiday itself!

Moderation avoids extremes, exercises restraint, and is related to self-control. Part of maturity is learning to say 'no' to oneself, that is, to learn the value of moderation. "Be moderate in order to taste the joys of life in abundance" (Epicure). There are opposing schools of thought, however. Those that say 'Stop saying "everything in moderation"! Not all situations can follow the same 'mantra'. For example – there are several individuals who are prone for addiction, thanks to their dopamine reward pathway. For them, there can be no moderation, and abstinence is the rule.

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Then there are those that say 'Anything in life is worth over doing; moderation is for cowards.' (Peter berg). Moderation has been called a virtue to limit the ambition of great men, and to console undistinguished people for their want of fortune and their lack of merit. (Benjamin Disraeli.)

Then again, there are those that say - Stop saying "everything in moderation"! What is life without an occasional week of overeating? What is life if you have to refrain from crying yourself to sleep after a break up! Moderation is reasonable and fair – and a boring waste of time! It is simply too monotonous! Throw moderation to the winds, and the greatest pleasures bring the greatest pains! Complacency kills, say others. It is the 'dumbest rule to live by'! It leads to complacency. It could be a way of not doing anything well!

In all these schools of thought, let us each pick our own. Nothing is totally right or totally wrong, and no one can give us a prescription. We each need to decide which path is most comfortable for us. 'Everything in moderation, including moderation', (Oscar Wilde) seems so right!

Dr. Lakshmi. V. Pandit

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Imbibing Human Values

Basic human values refer to those values which are at the core of being human. The values are considered basic inherent values in humans because they bring out the fundamental goodness of human beings and society at large. Human values are honesty, selflessness, love, sincerity, gratitude, truthfulness, non-violence etc. To understand human values, we have to look at the nature of human beings first. Human beings are but animals. The innate features of animals emerge naturally when there is no appropriate environment for nourishment of human values in individuals. However, many animal lovers would object if we compare animals with human beings on human values! This is because there is much evidence to show animals are superior to humans when it comes to certain human values!!

Human value systems affect us all as it guides our behavior toward each other. Therefore, it becomes important to reflect upon how human values get imbibed in individual. The nature and nurture tussle does help our understanding to some degree. The genes do play a role but only to an extent. Dr APJ Abdul Kalam quoted his parents as the source for the human values he imbibed. Harilal, son of Mahatma Gandhi & Kasturba is quoted as example for zero influence of hereditary factors!!

The next consideration is the environmental influence on human values. The influence of environment is again difficult to establish, as some of the adverse events in life have brought out the best in an individual. For example, Mother Theresa was utterly pained by the killing poverty around her. While these may have adversely influenced someone, it had only added to the beautiful personality that Mother Theresa developed. While it is obvious that education plays some role, a good number of highly educated people display lower human values compared to tribal people.

The million-dollar question is how a larger number of people can imbibe human values? I believe that if we inherit favorable traits, we are blessed; if not, we need to be surrounded by people who, by their thoughts and acts consistently show us its importance. When we face adversities and need to "test ourselves" on human values, we will have to constantly remind ourselves of its importance and choose the right path. The most difficult but also the simplest way to stay in touch with human values is to demonstrate it in action everywhere and at all times!

Dr. Kishor.M

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INTROSPECTION. 6 – Examples of Application

(1) Earlier, three important procedural impediments to acquiring knowledge were listed: (i) First is mistaking facts (of events/ideas) as knowledge; real knowledge being the descriptive and/or explanatory meanings extracted & verified out of the data. This impediment was described in the previous instalment (no. 5). (ii) Second is blindly accepting the opinion of "reputed experts" as 'ready-made' authentic knowledge without bothering to verify them because verification requires some hard work. (iii) Ignoring the hard facts that are either opposed to the 'main-steam of knowledge' or are difficult to accommodate in it, and not including them either as hypothesis or as explanatory systems for further research.

(2) This instalment deals with the **examples** of the second impediment of **blindly accepting the opinion of "reputed experts" as authentic 'ready-made knowledge'** without bothering to verify them because verification requires some hard work.

(A) First example is the concept (or, is 'slogan' a better word?) of "evidence-based-practice" ('EBP') which is being increasingly used in the academic literature since the 1990s and spreading like an epidemic. Though it started off as a kind of an ideological "re-thinking" it is beset with: (i) Un-warranted presumption. (ii) Failure to define what constitutes as 'evidence'. (iii) Vagueness of description of what it really means. (iv) Self-contradiction.

(i) **The 'EBP' is presumptuous:** 'EBP' implies that till then the expertise in clinical practice was not based on evidence and thus 'un-scientific'.

(ii) **Failure to define what constitutes as evidence:** In common usage, the word 'evidence' carries a traditionally accepted meaning to indicate that the supporting facts are of the nature of "Yes" or "no". Even in natural sciences, 'evidence' is in the form of "yes" or "no" answer/s. Let us now, examine the nature of 'evidence' in medical as well as psycho-social sciences. A) almost all the 'evidences' available are statistical in nature with only 'degrees of probability' and 'degrees of confidence'. B) all biological and psycho-social data of 'normality' and of 'pathology' follow Gaussian distribution. C) all research studies in the domain of physical health and mental health depend upon statistical analysis leading to conclusions that are always in terms of probabilities and degrees of confidence.

In addition: 1. Even bio-chemical estimations are subject to errors depending upon the purity and other qualities of the reagents and precision of equipment used. 2. The results of almost all the investigations (bio-chemical, X-rays, and other imaging investigations) require interpretations by experts whose expertise depends upon 'subjective' experience. 3. In addition, there is the fact that the results of such investigations can either be 'false-positive' or 'false-negative.' 4. There are other confounding variables like 'Placebo-effect', 'nocebo-effect', pharmacological effect of a drug being reversed by 'expectation', etc. 5. Thus, the slogan of 'EBP' does not give any clear definition of what constitutes as evidence in psycho-social sciences.

(iii) **Vagueness of description of what it really means:** Three sample descriptions of what 'EBP' is from the published literature is quoted to demonstrate it vagueness: 1. "Formulate a clinical query and retrieve relevant literature. Then, if the conclusions are found appropriate to the individual case, apply the methodology and assess the clinical benefits, side-effect and patient satisfaction". 2. "Conscientious, explicit and judicious use of currently available 'best evidence' in making clinical decisions…" 3. "'EBP' is ability to evaluate clinical literature and use the conclusion along with 'biological reasoning', clinical experience and intuition". The under-lined components in the above descriptions denote purely 'subjective' elements at every step of clinical procedure.

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As pointed out above, such a description invites a few questions: 1. What were the clinicians doing before the appearance of this description of 'EBP'? 2. Were not the clinical experience and intuition the main-stay of clinical practice till the 1990s? How can one reason with probabilities? By common sense, all that one can do is to take a 'hard-decision' (strategically called "calculated risk") of choosing that course of action which is most probable to yield a favourable outcome.3. Earlier to 1990s, were not the clinicians doing their clinical practice on the basis of probability?

Equally vague is the term 'biological reasoning'. Does it mean consideration of role of chemicals and genes? This aspect will be considered in the second example (item no. 4). Even the latest mathematical methodology of dealing with probability, called "Fuzzy-Logic" that is extensively used in modern gadgets just happen to compute "probabilities", just like the clinicians were doing earlier to 1990s.

(iv) **Self-contradiction:** On the basis of the above narrative, a logical question is: In what way is 'EBP' different from the process of clinical decisions that were being adapted earlier to 1990s? If there is no difference, then, what is the purpose served by manufacturing a name for what was happening as if 'automatically' and naturally? In actuality, 'EBP' is nothing but a nomenclature, a new-found 'Baptism', to a methodology that was a standard clinical routine in any sincerely ethical clinical practice. Most probably, as the health care has been transforming itself into an industry with monetary objectives, there is a danger of ethical decline in the practice, and the 'EBP' is meant to serve as a reminder. If so, this purpose needs to be clearly spelt out. Incidentally, there are a few corollaries (logical consequences, or concomitants) to the aspect of clinical decision making that needs to be examined.

(a) In view of the *'probability-nature'* of our professional knowledge, continued learning with regular 'self-audits' is an essential pre-requisite for evolution of the clinician's *"clinical-experience"*. This is what every clinician has ideally been doing all along over the centuries, leading to historical evolution that the health sciences have trodden.

(b) Consequent to the probabilistic nature of 'evidences' available to health sciences, as stated earlier, the clinician's clinical decision is based on the higher degree of probability of favourable outcome under a given set of circumstances. But, because of the probabilistic nature of psycho-social phenomena, there never will be a guarantee that the outcome will always be as expected. This situation can be expressed in scientific terminology: "Every clinical decision is an experiment," of course, with a higher probability of expected result. Similarly, any health policy of a government based on considered opinion of experts will naturally be an experiment.

(c) However, if the practice of 'open-minded' self-audits are regularly carried out, the clinician keeps gaining "clinical experience" such that his successive clinical decisions will happen to be more and more 'correct' more often than those of the less experienced. This fact explains how and why in psychotherapy outcome studies, experienced therapists always fared better. This is the basis, in any culture, of the age-old tradition of "consulting the elders" about any issue.

(B) Second example is the trend called **"Biological Psychiatry"** and/or **"Biological Basis of Psychiatry"**

(a) These phrases, "Biological Psychiatry" and "Biological Basis of Psychiatry" are extensively used by experts and repeatedly quoted and promoted by numerous others to an extent that it has acquired the status of an "established and accepted scientific fact" in the form of Chapters in standard books and even dedicated books.

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Both directly and indirectly, these phrases imply a meaning that clinical phenomena in the field of mental health have biological etiology and hence, manageable through biological means.

(b) Let us consider the above implication as a proposition. One of the scientific principles is to examine the logical viability of any proposition. Such an attempt raises a few questions. (i) First: Except in respect of one or two developmental disorders, is there any bio-chemical or neurotransmitter that is etiologically specific to a psychological or psychiatric symptom or syndrome? (ii) Second: Except in respect of a few developmental disorders, is there any gene that is etiologically specific to a psychological or psychiatric symptom or syndrome? (iii) Third: are there not irrefutable evidences that genetic expressions are modifiable by environmental and psychological factors? (iv) Fourth: Except in respect of epilepsy, is there any pharmacological therapeutic agent that is specific to a symptom or syndrome? (v) Fifth: For the sake of critical examination, even if we assume that certain pharmacological agents are specific to certain symptoms or syndromes, how to explain the wide variability in their effectiveness, approximately similar across all drugs and syndromes (however, with a few exceptions): effective in approximately 30% of patient population; variably effective in approximately 30%, and ineffective in approximately 30%. (vi) Sixth: Are not we repeatedly taught from our under-graduate days that all illnesses have *"multi-factorial"* etiology? (vii) Seventh: How to explain 'placebo' and 'nocebo' effects, and reversal of pharmacological effects by suggestion and expectancy?

(c) Of course, in every moment of human life, many thousands of bio-chemicals and genes are interactively involved in innumerable functions in the human body. This fact does not justify the term "Biological-basis". A scientifically precise of expression would be something like: "'Biological correlates' of psycho-social experiences".

(d) In this context, one cannot help wondering about the rationale for the genesis of such phrases as "Biological basis of Psychiatry" or "Biological Psychiatry". Of course, one ready answer would be that: "the 'explanatory models' involving molecules and genes are more explicit, precise, and much easier than the 'psycho-social models'". It only means that the investigations and studies of 'psycho-social parameters/variables' are not encouraged and financially supported to the same extent as those concerning molecules and genes.

(3) The future evolution of Psychiatry as a *'scientific discipline'* depends very much on correcting and remedying the above imbalance. Otherwise, there is a real danger of the practice of 'psychiatry as a discipline' being taken over by anybody who can intelligently use 'DSM-5' and 'ICD-11' and who are licensed to prescribe medicines. The outcome of such a scenario would be natural extinction of Psychiatry as a discipline. Of course, there is no immediate danger to future of psychiatry under the banner of "Biological Psychiatry". As explained in an earlier instalment, with the ready availability of a pharmaceutical agents for every psychiatric symptom and an equal readiness to prescribe on the part of professionals, successive generations of people will progressively suffer 'dis-use atrophy' of coping-skills. Consequently, there will continue to be an ever-increasing demand for psychiatric services and professionals.

I am not Nostradamus. But, I am just attempting to think along logical lines.

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Children in conflict with law: A Psychiatrist's perspective

A dwelling house was burgled and the aggrieved person gave a complaint to the police and a FIR was filed. The police, after investigation, arrested 4 members in connection with the case and produced them before the Judicial Magistrate. Subsequently, the culprits obtained the bail from the court. At the time of enquiry, one of the accused is found to be a minor as per the records submitted by his advocate and he was considered as a Child in Conflict with Law (CCL). Later, the honorable court transferred the said accused case to Juvenile Justice Board for further proceedings. Under Juvenile Justice (Care and Protection of Children) Act, 2015 when a Magistrate, not empowered to exercise the powers of the Board, shall without any delay forward the child's case immediately, along with the records of such proceedings to the Juvenile Justice Board that has jurisdiction to decide such cases.

Juvenile Justice (Care and Protection of Children) Act, 2015 deals with the children alleged and found to be in conflict with law and children in need of care and protection. The act takes care of their basic needs, protection, development, treatment and social re-integration by adopting a child-friendly approach in the adjudication. The Act also aims at disposal of matters in the best interest of children and provides for their rehabilitation through institutions established under this Act. Juvenile Justice Board (JJB) is a three-member bench constituted by the State Government in every district as per the guidelines of the Juvenile Justice (Care and Protection of Children) Act, 2015. The Board comprises of two social workers, of whom at least one shall be a woman, who is actively involved in giving health, education or welfare activities pertaining to children for at least seven years or a practicing professional with a degree in child psychology, psychiatry, sociology or law and the Board is headed by a Principal Magistrate. As soon as a child alleged to be in conflict with law is apprehended by the police, such a child shall be produced before the Board or before an individual member of the Board (when the Board is not in sitting) within a period of twenty-four hours. In no case, a child alleged to be in conflict with law shall be placed in a police lockup or lodged in a jail.

The primary responsibility of care, nurture and protection of the child shall be that of the biological family or adoptive or foster parents, as the case may be. Every child in the juvenile justice system shall have the right to be re-united with his family at the earliest and to be restored to the same socio-economic and cultural status that he was in, before coming under the purview of this Act, unless such restoration and repatriation is not in his best interest.

A child is presumed to be innocent of any mala fide or criminal intent up to the age of eighteen years and no child in conflict with law shall be sentenced to death or life imprisonment without the possibility of release under the provisions of this Act. All decisions regarding the child shall be based on the primary consideration that they are in the best interest of the child and to help the child to develop to its full potential.

If the child is not released on bail, the process of rehabilitation and social integration shall be undertaken in the observation homes or in special homes or place of safety or fit facility or with a fit person, if placed there by the order of the Board. In Karnataka, there are around 17 observation homes taking care of the needs of children who are in conflict with law. We also have four special homes run by the State Government, two at Bangalore and two at Davanagere. Out of these four special homes, two are exclusively meant for girls.

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In addition, we have a special home ECHO, run by a non-governmental organization at Sumana Halli, Bangalore. These special homes are required for rehabilitation of those children in conflict with law who are found to have committed an offence and who are placed there by an order of the Juvenile Justice Board.

The services that shall be provided, by such institutions include: basic requirements such as food, shelter, clothing and medical attention, appropriate education, including supplementary education, special education, and appropriate education for children with special needs, for children between the age of six to fourteen years, the provisions of the Right of Children to Free and Compulsory Education Act, 2009 shall apply; skill development, occupational therapy and life skill education, mental health interventions, including counselling specific to the need of the child, recreational activities including sports and cultural activities, legal aid where required, referral services for education, vocational training, de-addiction, treatment of diseases where required, case management including preparation and follow up of individual care plan, birth registration and any other service that may reasonably be provided in order to ensure the well-being of the child.

In case of a heinous offence alleged to have been committed by a child (post Nirbhaya case), who has completed or is above the age of sixteen years, the Board shall conduct a preliminary assessment with regard to his mental and physical capacity to commit such offence, ability to understand the consequences of the offence and the circumstances in which he allegedly committed the offence. For such an assessment, the Board may take the assistance of experienced psychologists or psycho-social workers or other experts. Where, the Board after preliminary assessment pass an order that there is a need for trial of the said child as an adult, then the Board may order transfer of the trial of the case to the Children's Court having jurisdiction to try such offences. The Children's Court shall ensure that the child who is found to be in conflict with law is sent to a place of safety till he attains the age of twenty-one years and thereafter, decide to release the child on such conditions as it deems fit or decide that the child shall complete the remainder of his term in a jail.

The State Government shall set up at least one place of safety so as to place a child in conflict with law, who is between the ages of sixteen to eighteen years and is accused of or convicted for committing a heinous offence. Every place of safety shall have separate arrangement and facilities for stay of such children or persons during the process of inquiry and separate facility for children or persons already convicted of committing an offence. All the institutions registered under this Act shall provide the facilities for rehabilitation and re-integration of children back to Society.

In my opinion, Juvenile Justice (Care and Protection of Children) Act, 2015 works towards protecting the children in conflict with law and ensures reformation in young minds. The collaborative approach to reform Juvenile offenders by involvement of all stake holders like parents, social activists, government agencies and a most importantly a psychiatrist ensures a positive and holistic outcome. Therefore, state of Karnataka is playing its role effectively in creating a welfare state by implementing the provisions of the act. The children in conflict with law are well provided for and brought to main stream through proper care, protection and rehabilitation. The Act envisions a crime free society.

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Report of the First Midterm CME of IAPPKB at Indian Medical Association (IMA), Raichur on 7th January, 2018

We at the IAPPKB are happy to inform that we were able to come together after almost a decade of the associations functioning to successfully conduct the First Midterm CME of the IAPPKB at Raichur on 7th January, 2018. This program was successful by the untiring efforts and volunteering of Dr Malipatil V A, an IAPPKB member. It was conducted in association with Raichur IMA (the local branch and the venue host) and Kalyan Karnataka Psychiatric Guild (KKPG).

The program turned out a great success, as many IAPPKB past presidents, members, and others volunteered in the capacity of speakers, chairs, and participants. The nature of topics discussed and the response showed that there was willingness to collaborate amongst community, private and government sectors for overall better mental health of the society at large. The program was attended by about 100 delegates, and there were no financial transactions incurred by IAPPKB.

IAPPKB is as always committed for betterment of the private mental health professionals and the community. We thank the cooperation of the IAPP main office for all the support.

IAPPKB members in action:

1. The first IAPP research project titled "Association between valproic acid levels, biotinidase activity and hair loss in Indian population" with a grant of rupees 4 lacs over a period of two years is sanctioned to Dr Anil Kakunje, Dept of Psychiatry, Yenepoya Medical College, Mangalore. (Largest study till date on this topic with 150 samples)

2. Publications with acknowledgements to IAPP

   - Kakunje A, Sindupriya ES, Prabhu A, Karkal R, Kumar P, Gupta N, Pookoth RK. Topical valproate solution for hair growth. Online J Health & Allied Sci.

     (Accepted for publication)

   - Kakunje A, Sindupriya ES, Prabhu A, Karkal R, Kumar P, Gupta N, Pookoth RK. Valproate: It's effects on hair. Int J Trichology.

     (Accepted for publication)

   - Chapter on Neurobiology of suicide in IAPP book on Neurobiology of Psychiatric disorders

     (To be released in Global Conference of Biological Psychiatry to be held in August 2018 at Mumbai)

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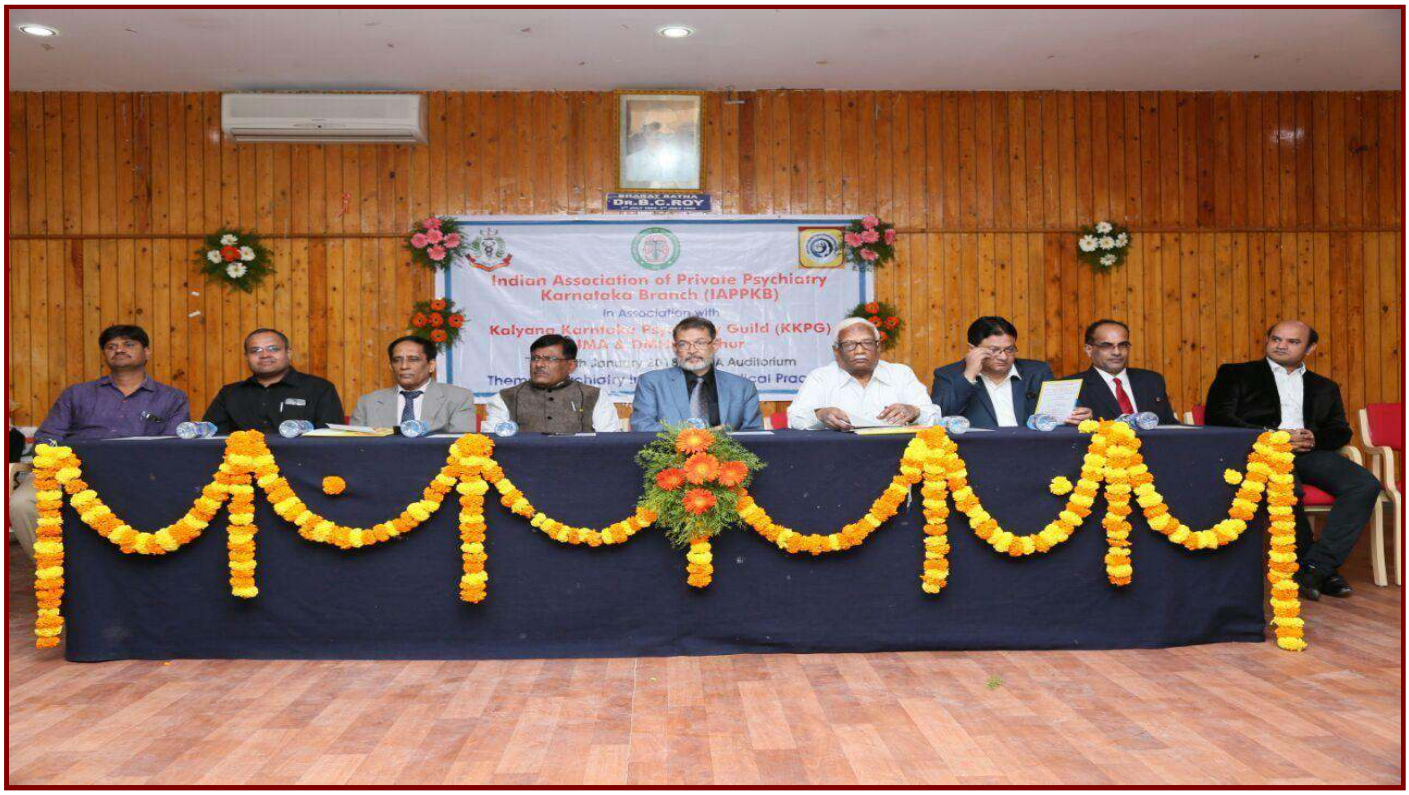
Photographic memories of the event



The dignitaries on the dais

The delegates off the dais