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CASE REPORT

DEMONETIZATION AND PSYCHIATRIC DISORDER: A SERIES OF THREE CASES

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ABSTRACT

Introduction: Demonetization of currency which occurred on 8th November 2016 was an unexpected move. Which came with negative and positive effects in the country.
There were reports about denial of health care to those without valid currency, we have come across three cases in which the illness manifestation was soon to the declaration of it.
Case discussion: Retrospective, chart based study. 3 cases were studied. First case was a 46 yr male with no family or past history of psychiatric illness, was diagnosed to have Other Acute and Transient Psychotic Disorder with associated acute stress, treated with antipsychotics .Second case was 27 yr male, with family history of psychiatric illness, diagnosed to have Mania and was treated with antipsychotics and mood stabilizer. Third case was 31 yr male, with past history of Bipolar Disorder. He was diagnosed Bipolar affective disorder, current episode mania and was treated with antipsychotics and mood stabilizer.
Conclusion: There were only three cases in the series. However we propose during major psycho-social events in the society at large, practicing psychiatrist has to be in the look out of clinical presentations related to it.

INTRODUCTION

Demonetization of currency valued INR 500 and 1000-which together accounted for 86% of cash in circulation- on 8th November 2016 was an unexpected move. Negative and positive effects of it were discussed in details in various forms, including Indian Parliament. This included likely fall in Gross Domestic Productivity with its ripple effect in farming and small market sectors. Defeat of counter currency, cash hoarders and funding for corruption & terrorism were highlighted by opposite side (1). The legality of the decision is under challenge in Apex courts on the basis of infringement on the right to property. The warning of Indian Supreme Court about the possible riots arising from affected people in distress proved unsubstantiated. Contrary to the belief promoted by media, the average Indian accepted and approved it as evidenced by the results in favor of ruling party in the elections held soon after in different parts of country.

Common man's Nationalist feeling and sense of sacrifice for a good cause might have been working for its positive acceptance. Hope for transparency and wish for failure of big houses unlawfully amassing wealth also might have contributed to it. But as opined, the sudden announcement did make many nervous. They were fearful; especially about the rumor that devaluation of gold and land is impending. Waiting in the queue made many restless. "The idea that it is possible to de-legitimize their life's labor is to shake the foundations on which one's life is constructed. The older generation felt hurt to self -esteem because of their inability to do e- business."(2).

There were reports about denial of health care to those without valid currency, where up to 60% to 70% people seek treatment from Private sector (3) and Health Insurances are yet to spread, this was inevitable. Media reported 58 deaths in the country, related to demonetization (3). However there is no report about the impact of demonetization in India, except an editorial in a reputed journal (4).

In the clinical services of Psychiatric Department of our medical college, we have come across three cases in which the illness manifestation was soon to the declaration of it. Their case records were picked up and information gathered. Only a period of three months were considered.

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Cases

Case 1

Mr. R 46 yr male auto driver from Lower Socio economic status was brought to casualty on 12/11/ 2016 because of sleeplessness, talkativeness and increased socializing for prior two days. Symptoms started four days after declaration of demonetization and main theme of talk was justifications for the same. He was initiating debates in village gatherings and easily agitated to opposing views. There was no family or past history pointing to any psychiatric illness. Pre-morbidly he was described by others as anxious and oversensitive. Mental status examination showed increased psychomotor activity, talk was increased in volume and tone with reduced reaction time. Main theme in the content of thought was demonetization. His emotion was elated. He had impaired judgment and insight was absent.

He was treated as acute psychosis and according to ICD-10 met the criteria of F23.81 (Other Acute and Transient Psychotic Disorder with associated acute stress), was managed as inpatient with antipsychotics (Chlorpromazine & olanzapine). After one week he was discharged when symptom free and followed up in the OP on weekly basis. His last follow up was one month after discharge, he was remaining symptom free.

Case 2

Mr. A 27 yr male, B Com failed, belonging to lower socioeconomic status was brought to casualty on 21/11/2016 because of reduced sleep, increased talk, over activity, overspending, over socialization and anger outbursts since 1week. He was distressed about his loss of job following demonetization. There was family history of psychiatric illness, pre-morbidly described as stubborn and anxious and with habit of using alcohol and cannabis. Mental status examination showed increased psychomotor activity, increased tone and volume of speech, flight of ideas, elated mood and absent insight.

According to ICD-10, he met the criteria of F30.1(Mania without psychotic symptoms) and was treated as inpatient with antipsychotics (Olanzapine & Chlorpromazine) and mood stabilizer (Lithium). Discharged after 10 days when he was symptom free, but never came up for follow up.

Case 3

Mr. S, 31 yr male, petty merchant belonging to lower Socio-economic status was brought to casualty on 19/11/2016 due to sleeplessness, over talkativeness and anger outbursts since 1 week. He was expressing worry about three lakhs rupees he was keeping for improvement of business. He had episodes of mental illness in the past and received treatment after diagnosis of Bipolar Disorder. He was remaining symptom free after last episode 20 yrs back and was on not on prophylactic treatment. His pre-morbid personality was described as sensitive and easily worried. Mental status examination showed increased psychomotor activity; increased volume and tone of talk, flight of ideas and pre occupation with ill effect of demonetization and elated mood. He had impaired judgment and absent insight. According to ICD-10, he met the criteria of F31.1(Bipolar affective disorder, current episode mania without psychotic symptoms) and was treated as inpatient with antipsychotics (Trifluoperazine and Olanzapine) and mood stabilizer (Sodium Valproate). After two weeks he was discharged symptom free. He was followed up weekly for 1 month, then once in month for two months as outpatient. Last visit was on 24/5/17 and he was maintaining symptom free status

DISCUSSION

There were no cases with a diagnosis of non-psychotic diseases. Psychotic conditions due to its disruptive nature of symptoms, are brought to hospitals for treatment. Anxiety or mild depressions are common presentations at times of facing stress, but will be considered as understandable reaction. When the cause is universally known those symptoms will be appreciated as normal and no one will consider it as a disease requiring treatment. It might have resolved on its own, as the stress was only temporary. The first patient was hailing the decision; the second was really affected negative and third had only an apprehension about it. It appears the strain due to stress is more important in the development of illness, rather than the meaning of it.

All three patients were males. The psychosocial reasons explaining more men than women in hospital setting contrary to that in community may be still holding. Or perhaps demonetization affected them more as usually men earn and manage money in Indian culture. The first case had no predisposition while the second case had predisposition in terms of positive family history. The third case was a diagnosed case and was in remission for decades. Hence the question of cause, precipitation or coincidence could not be answered.

It is still a controversy whether the presenting complaint is because of psycho-social adversities or mental illness. Studies on suicide are an example of this. Psychiatrist diagnose them while developmental scientist high light socio-political reasons. Pharma-molecules or socio-political solutions for countering farmers suicide is still debated upon (5). It is logical to assume both act complimentary in the development of morbidity and mortality. Perhaps in the times of social stresses, the mentally ill or predisposed succumb to it first. Their defense mechanisms might be already in a compromised state or the responsible neurotransmitters might be at the verge of crossing normal limits.

This was only report of case series and not systematic survey. The cases selected from inpatient setting of a tertiary care teaching hospital. The study was done retrospectively and chart based. There were only three cases in the series. No conclusions hence can be drawn and generalizations to population are not envisaged. However we propose during major psycho-social events in the society at large, practicing psychiatrist has to be in the look out of clinical presentations related to it. This will enrich science of mental health and might make us wiser in understanding the conversion of normalcy to illness

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