

poor insight was made according to DSM-5. He was started on fluoxetine 20 mg/day, which was given under his mother's supervision. After 15 days of treatment, the mother reported improvement in reassurance-seeking behavior, and after one month of treatment, the patient reported improvement in the repetitive doubts. In three months, he was found to sustain the improvement and had improvement in socio-occupational functioning. Also, his Y-BOCS score decreased to 6, and his BABS score reduced to zero with good insight. There were no adverse effects reported. After recovery, he was thankful and attributed the symptoms to stress after reading and watching videos about dog bites.

Discussion

Very few cases have been reported about clinical kynanthropy, and treatment consensus for it is still evolving. Our case posed a diagnostic dilemma and an interesting treatment outcome. The major finding was overvalued idea not amounting to delusion, with elevation in obsessive-compulsive rating scores. No affective component preceding the overvalued idea was identified. Fishbain had reported a similar case with a diagnosis of monosymptomatic hypochondriacal psychosis, wherein the patient had a delusional belief of having contracted rabies.⁷ However, in our case, the belief was not held with delusional fixity, as the patient was actively seeking reassurances. The presentation was in line with body dysmorphic disorder; however, the preoccupation wasn't limited to bodily defects. Illness anxiety and somatic symptom

disorder could be other differentials, but in this case, the belief wasn't related to health or acquiring the illness. Ruling out other causes of this presentation and based on psychopathological findings, the patient was diagnosed with OCD with poor insight. He was started only on SSRI, in contrast to previous reports where a combination of antidepressants and neuroleptics were considered, and the patient achieved remission.⁸

Thus, cases presenting with obsessive-compulsive related disorders with poor insight need rigorous psychopathological analysis, objective assessments, and reliable informants for precise treatment. An adequate trial of SSRI in such cases can prevent superfluous medications and neuroleptic exposure.

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The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Is Maslow's Hierarchy of Needs Applicable During the COVID-19 Pandemic?

To the Editor

Maslow's "hierarchy of needs" is a well-known theory of motivation that ranks the needs of

individuals according to their perceived importance. It is visualized as a pyramid, with the more indispensable needs at the base and the least essential at the peak. Maslow theorized that humans are typically motivated to attain lower basic needs before satisfying their higher human needs, although he later stated that

based on external factors or individual differences, there might be exceptions.¹ He also argued that failure to meet needs at various stages of the pyramidal model could lead to both physical and mental illness.

As the pandemic continues to bring the world to its knees, people worldwide

are affected by its impact, ranging from quarantine and isolation to suffering and death. Different groups of people have been impacted by COVID-19 differently and to varying extents. Certain vulnerable groups such as the children, the older adults, and those with existing medical conditions are more severely affected by the pandemic. Children faced with school closures and lockdown experienced hopelessness and powerlessness,² congruent with an increase in the prevalence of accidental injuries and suicides.³ Another special population that comes into focus is healthcare workers. Frontline healthcare workers have had to bear the mental impact of directly providing care to COVID-19 patients in high-risk settings, resulting in increased levels of depression, anxiety, insomnia, and distress.⁴

Let us examine how Maslow's hierarchy of needs is relevant in these times.

Physiological Needs

Many individuals are now driven by more fundamental necessities than they were before. Because many people's job conditions have altered, satisfying basic requirements may now be more of a concern. Because so many individuals are under home-bound orders, doing other activities that one usually does to maintain physiological health may not be possible at this time.⁵⁻⁷

Safety Needs

Some people's primary objective right now is to keep themselves and their families safe. They will be most likely be doing their best to fulfill this demand for achieving safety. They must learn as much as they can about the infection rate in their region and never put pressure on themselves to achieve higher-order needs.⁵⁻⁷

Social Needs

If you live with a caring family, your basic human needs will be satisfied. If you don't feel connected to your surroundings, this might be a difficult time for you. Daily family activities are a good way to stay in touch with your loved ones. FaceTime, group chats, and positive social media channels are all good ways to communicate.⁵⁻⁷

Esteem Needs

A vital component of professional wellness is what Maslow defines as esteem,

which is used to define respect, fairness, and control as the four levels of needs.

Self-Actualization

In our adapted framework, self-actualization is defined as realizing one's full professional potential, whether as a clinician, researcher, educator, or leader, which Maslow defined as realizing one's full potential in athletics, poetry, or science. Maslow asserts that a person can only satisfy these higher order demands by their own efforts.⁵⁻⁷

Maslow's hierarchy of needs can be used as a framework to create interventions to tackle mental health issues like burnout in physicians.⁸ The level of satisfaction of basic needs was related to scores of neuroticisms and belief in an internal locus of control,⁹ which show that the fulfilment of basic needs directly impacts one's psychological health and ability to cope with stressors. All five levels of human needs in the original Maslow's hypothesis are interdependent and a change in one level of need would affect the satisfaction of one or more needs at the same or different level. This apparent flexibility in utilizing Maslow's hierarchy of needs makes the relationship between each level a bidirectional one. For example, during the pandemic, many nations announced countrywide lockdowns, which even led to closure of basic outpatient departments of major hospitals. Instead, patients with mild to moderate illnesses were asked to have access to teleconsultation services where they could find the doctor for their specific illnesses. Such needs were fulfilled only when the basic needs for those patients like food supplies, medicines, and internet facilities were already available to them even during the lockdown.¹⁰

In creating models for psychosocial interventions that are molded after Maslow's hierarchy of needs, flexibility is required to link all tiers of the hierarchy interdependently and view the individual in equilibrium. This means that each need can be linked to many other needs despite their arrangement in the hierarchy, and a cause-effect model can be used to explain or predict the changes in needs an individual goes through. For example, when the individual's physical health deteriorates, their ability to maintain social circles and access to other protective factors deteriorates too, causing a deterioration in their mental health. This decline in mental

health may result in further deterioration in psychological needs such as self-esteem and love and belonging, which ensnares the individual into a depressive rut that seals the positive-feedback loop, creating a self-perpetuating cycle.

In other words, the positioning of mental health in Maslow's hierarchy may have undergone a change during the COVID-19 pandemic. This, however, needs to be formally tested. Increased focus is needed to maintain basic needs, particularly, of individuals in quarantine and isolation, if they are to preserve their mental health needs. From an interventional perspective, Maslow's hierarchical model provides a framework for intervention both from an individual and community perspective, particularly when it is integrated with social indicators of health; this understanding may have significant public health implications as nations try to stabilize and recover from the impact of COVID-19 pandemic and limit mental health sequelae.

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Covid-19 and Tele-Health: Time to Move from Practice to Policy

To the editor,

The COVID-19 pandemic has resulted in several changes in the landscape of health-care service delivery. Many care providers have adopted virtual health delivery to circumvent disruptions caused by the pandemic-related physical restrictions and ensure continuity of health-care services.¹ The term “telehealth” refers to remote delivery of health-care services using telecommunication technology. It encompasses a range of approaches, including, but not restricted to, direct video-based communication, the use of apps and web-based platforms for remote monitoring, and collaborative video consultations involving health-care providers at both ends. Evidence suggests that telepsychiatry consultations are as reliable

as in-person encounters concerning clinical assessments, treatment outcomes, and client satisfaction.^{2,3} Consequently, there has been an increase in telepsychiatry services with time, particularly following the onset of the COVID-19 pandemic. Several policy changes were implemented in the past year to smoothen the practice of telepsychiatry and address barriers and concerns related to licensing, security, prescribing, and reimbursement.⁴ Here, we propose some more issues that may be relevant for consideration by health-care institutions and policymakers for better organization of telehealth services during and beyond the pandemic:

1. There is a need to vertically integrate digital mental health-care delivery between psychiatric institutions and community health services. This will also pave the way for a stepped care approach and decongest tertiary care services in countries like India with a high treatment gap in psychiatry.⁵

2. Mental health training programs should have a separate module on telepsychiatry and licensing requirements. A dedicated curriculum that focuses on a competency-based approach to training in telepsychiatry, both in didactic and clinical curricula, with defined sub-competencies for each level of competency, may be considered. The competencies should be aligned to the principles laid out in the telepsychiatry guidelines. Regulatory agencies such as the National Medical Commission should oversee the development and implementation of these modules.
3. Use of Health Insurance Portability and Accountability Act (HIPAA)-compliant platforms to ensure safety and privacy for consumers should be considered; currently, such practices have limited uptake in low- and middle-income countries like India.⁶ Regulatory agencies should spell out the recommended