Professional Package

For

Medical Doctors for Mental Health

Working in the BPHS in Afghanistan

Mental Health Department of the MoPH
Kabul-group-08

The Professional Package includes:

- **Introduction to Mental Health in BPHS**
- **Psychopathology and intervention techniques**
- **Socio-cultural-interpersonal relationships and conditions in Afghanistan**

Kabul-group-08

In Fall 2008 under the leadership of Dr. Alia, the Head of the Mental Health Department of the MoPH of the Islamic Republic of Afghanistan the following members of the Kabul-group-08 have met for three workgroups and have worked together on the contents of this training manual to support the integration of psychosocial care into the mental health component of the BPHS.

Members:

Dr. Alia Ibrahimzai, (MoPH)
Dr. Sayed Azimi, (EC/MoPH))
Dr. Aminullah Amiri (HOSA)
Dr. Sayed Ataullah (AKU)
Dr. Hafizullan Faiz (HealthNet TPO)
Ahmad Farhad Habib (WfL)
Dr. Iris Jodi (IAM)
Kirsi Jokela (IAM)
Inge Missmahl (EC/MoPH)
Dr. Safiullah Nadeeb (WHO)
Suzana Paklar (medica mondial)
Dr. Fareshta Queedes (HOSA)
Humaira Rasul (medica mondial)
Dr. Wahid Salim (HOSA)
Dr. Bashir Ahmad Sarwari (MoPH)
Dr.Peter Ventevogel (HealthNet TPO)
Maryam Zormaty (WfL)

Responsible for this package: Dr. Azimi
With contributions from Dr. Iris Jordi, Dr.Peter Ventevogel, Inge Missmahl

Integrated Mental Health Approach

The integrated mental health approach has the advantage for the Medical Doctor that he can treat those patients who have mental health problems together with the psychosocial counselor. This will hopefully make the treatment more effective and will reduce medication.
The patient can either first see the MD or the psychosocial counselor. In any case the MD and the psychosocial counselor need to work together well in order to achieve the best possible treatment for the patient. Therefore we have included some thoughts about teamwork.
For mild and moderate Depression, anxiety, phobias, conversion disorders and unexplained somatic complaints, post traumatic stress as a reason for mental health and social problems psychosocial interventions have proofed to be successful.
For patients with severe mental health disorders psychosocial support is important for the family as well as for the patient himself.
Mental Health patient are often fragile and might be very sensitive and retreated.
Therefore it will be good to use and practise the communication skills when talking to such patients.

Before coming to the medical part of this package we want to introduce you to psychosocial counseling, some communications skills and teamwork.

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Psychosocial counselling

Psychosocial counselling is a problem solving and resource orientated approach, which helps people to overcome difficult and stressful life situations and events. Such psychosocial stressors can be the root of mental illness and can eventually lead to chronic illness.
The aim of psychosocial counselling is to enable the client who comes and seeks help to regain a state of psychosocial wellbeing:

- To be able to have good relationships
- Being able to solve conflicts
- To use his/her own and surrounding resources
- To live a meaningful life

- Nowadays many people in Afghanistan feel helpless and powerless. They feel victimised and have the feeling of having no influence on their lives.
- In a victimized state, one accepts whatever he/she faces.
- Most of Afghans feel victimized due to social/cultural restrictions and events such as war, invasions, and migration and their consequences on every day life.

The following factors play an important role in the process of victimization:

- Social factors (tradition, value, politics, war, period of dictators)
- Learned behaviour
- Climate factors

- People feel victimized by the political situation due to living in different situations of occupation, civil war and periods of dictatorship without having had possibilities to do anything about it.
- A further relevant example could be the situation of a Afghan women: According to tradition and culture they are expected to be obedient and even to tolerate violence to a certain degree.

The possibilities of psychosocial counselling

- **Psychosocial counselling** helps to reconnect people who feel victimised to their potential and such enable them again to participate actively in their lives.

- **Psychosocial counselling** also can help people who feel socially isolated for different reasons to be able to reconnect to family and friends.
- **Psychosocial counselling** explores the relationship of somatic, depressive and other symptoms with the problem and searches for possible causes and ways how to resolve such problems.
- **Psychosocial counselling** helps to explore the resources of the person and thus reconnects people with their strong points.
- **Psychosocial counselling** helps when people cannot see a way out of a difficult family situation or other interpersonal conflicts.

The process of counselling

In psychosocial counselling a professional helping relationship between the counsellor and the client will be established. This relationship is built on certain skills of the counsellor and follows certain principles. Both the client and the counsellor together try to find a good and supportive way to deal with the client's problems. The counsellor should avoid being a judgmental advisor as well as showing him/her-self in a superior position. The task is to help the client to find a way how to deal with his problems in a positive and good way.

Why does psychosocial counselling work?

The human relationship between the counsellor and the client is the most important factor in counselling. We all need to have a witness for what has happened to us in our life and what we have experienced. To see and experience empathy from the counsellor helps to connect to own feelings. It helps to reassure people that their feelings and the experiences are true and had a severe impact on their lives.

Many clients with psychosocial problems retreat and are slowly getting in a social isolation within their families. Often they do not want to burden the other members of the family with their experiences. Those experiences might be connected with feelings of shame. For instance, having lost control in a very difficult situation.

We all know the suffering of being separated and of feeling alone. In some magic moments the walls of separation break-down. When psychosocial counselling works the client again might be able to connect to his own self and to his social environment as well as his potential and possibilities. This are the moment we are searching for in psychosocial counselling.

The success of psychosocial counselling depends on the careful chosen psychosocial intervention technique and the skills of the counsellor.

I Communication skills

In dealing with people who are suffering from mental health problems it is not only important what you communicate but also how you communicate.
There are several skills, which can help to improve the communication with the patient and to help the patient already by giving him attention and the feeling that he is understood and seen.
First and most important is the ability to have empathy with the patient and to be able to communicate this understanding and feeling to the patient.

Being empathic is a very important skill, which enables the Medical Doctor to get a very differentiated and clear feeling of the inner-world of the client. In afghan society empathy is a common used characteristic, as family-structures require and use it all the time! Daughters feel the pain of their mothers', when leaving the house very intensive; children also feel the expectations of there parents', as they were there own! And often these produce a very similar feeling in themselves, so that they can understand the inner emotional world of their beloved! This empathic skill should be activated when talking to clients. Put yourself in the shoes of the client and try emotionally to understand and feel how the clients' feelings might make an impact on you. Being empathic does not mean to identify with the client and his problems (feeling as if you were in the same situation as the client.) At all times it is important for the health staff to be able to discriminate between the client and his problems and his own life and problems.

1) Attending skills

- Attending acts as a basis for listening to and observing the client
  - ⇒ Attending well to the client places you in a good position to listen to them, to both their verbal and non-verbal messages!
- There are different ways in which you can show that you are attending to the client:
  - a) **Posture**
    - ⇒ Your posture needs to be “open”, so that you signal that you are willing to engage with the client. Do not cross your arms in front of your chest
    - ⇒ Face the client directly, sit in a centred way,
    - ⇒ Be natural and communicate your interest in you client in your own natural way
    - ⇒ The client will be watchful of you and your reaction to what he says, therefore you need to be aware of the information that your facial expression might convey!

Attending to clients is a way of giving them your presence

2) Observing skills

- The way clients are dressed, their tone of voice, their gestures and postures will give you important information and will either confirm or conflict with their verbal messages. Use your own intuition and knowledge, which comes from your feelings to gain a better understanding of the client.
- Observing clients carefully will help you to develop your understanding of them
- Focusing on the incongruities and inconsistencies between clients' verbal and non-verbal behaviour makes the exploration much easier! Your observation can be communicated to the client in a careful way. This might help the client to dare to say something, which he is afraid to say from himself for whatever reasons.

3) Listening skills

Listening is not just hearing what the client says. It involves attending to, receiving and understanding messages that clients are sending both by what they say and by what they do.

- Your purpose in listening is to reach a common agreement about:
  ⇒ What concerns the client
  ⇒ How the client experiences his/her concerns
- You will be listening "actively", which means that you are listening with purpose and communicating what you have listened to and understood

4) Reflective Skills

Listening is important, but it is not enough! Clients need the counsellor to respond in order to know that they are being heard and understood!

- Reflective skills enable you to communicate your understanding of the client's perspective! You move in his world and you try to get a feeling for this world of your client (empathy)!

- These skills are important for building trust, encouraging exploration, and for discouraging premature judgement and focusing
  - ⇒ They enable you to communicate empathic understanding and acceptance; to check in a non-intrusive way that you have understood; with reflective skills you can structure the talk and also help to give a certain direction without imposing it on the client.

Paraphrasing

- Paraphrasing is the skill of retelling what you understand to be the core message of the client's communication by using your own words!
- Paraphrasing is a key skill, as it allows you to respond in an accepting and non-judgmental way
  - ⇒ It also allows clients to "hear again" what they have said to you, and gives them the opportunity to understand and to modify what they have just communicated
- Paraphrasing intents to:
  1) **Check your perception of what clients have said**
  2) **Communicate the core qualities of acceptance and empathic understanding**
     - ⇒ to show the client that you are with him/her, in pointing out the key statement of the client
  3) **Gain information about how clients see themselves and their concerns**
     - ⇒ Gathering information without imposing a direction!
  4) **To build a trusting relationship**
     - ⇒ Paraphrasing makes it possible to communicate free of judgment and evaluation, which could be really important to the client

- Guidelines for paraphrasing:
  1) Be tentative and offer your perception of what the client has said
  2) Be respectful! Do not judge, dismiss or us sarcasm
  3) Use your own words
  4) Listen to the depth of feeling expressed by the client
  5) Do not add anything to what the client says
  6) Do not evaluate or offer interpretations!

Summarising

Using summaries enables you to bring together clear aspects of the session in an organised way, so that you and your client can look at it from the outside!

- Summaries focus on what the client has said and do not include sharing your own perception
- The most useful summaries are those, which give some coherence and order to what the client has been saying!

For Example:

MD: *From what you have said so far, you seem to feel resentful and angry about the way in which you were treated unfairly by your inlaws. You also seem to compare yourself unfavourably with your sister in law and see your achievements as inferior to hers. Always when this anger is there your headache starts as well.*

Questions

1) **Open questions**

⇒ They allow to receive information and encourage clients' involvement

For example, a client who is talking about arguments with his wife, you might ask:

⇒ *What usually happens when you argue and what happens usually shortly before?*

⇒ *Where do you argue?*

⇒ *How does it usually end?*

⇒ But do not ask questions, which are to broad, as they a very difficult to answer

⇒ Open questions are useful for the beginning of a session, as they give the clients' concern much space

⇒

2) **Closed questions**

⇒ These invite clients to answer "yes" or "no", and are mainly used to gain specific information therefore they have the capacity to silence the most talkative client.

⇒ There is no real exploration possible,

You can see this in the following example:

⇒ **MD:** *Have you told your wife that you have applied for this job?*

⇒ **Client:** *No, not yet.*

⇒ **MD:** *Are you going to?*

⇒ **Client:** *Yes, eventually*

⇒ **MD:** *Do you think she does not like it?*

⇒ **Client:** *Yes, I do.*

⇒ **MD:** *Is it difficult for you to talk to her?*

⇒ **Client:** *Yes, I suppose so.*

⇒ Only use closed questions, when you want to establish certain facts or to check information!

3) **Why- questions**

These questions are unhelpful, as they put pressure on clients to justify or to find "causes" or "reasons"

- In this way you should ask questions:

⇒ **Directly**

Avoid complicated language

⇒ **Concisely**

Be specific and brief

⇒ **Paraphrase** the client's response to check that you understand before asking another question

- Questions will have positive and negative effects
- Well-timed, clear and open questions will have several positive effects

- Positive effects of well-timed, clear and open questions:

1) Help clients to focus and to be specific

2) Help the clients to explore themselves

3) Assist information-gathering

All these skills need to be exercised well.

They must come naturally!

Important is to use them in the right mixture

II Working in a team

- The mental health system (BPHS) established in Afghanistan, offers the possibility to work as an interdisciplinary team! This team consists of illiterate Health workers, midwifes, nurses, MD's and psychological counsellors
- Each group has a specific scope of duties, and a well-coordinated collaboration across these groups has the potential to be successful in treating patients
  - ⇒ Each group should uses the knowledge and the skills offered by the other groups
  - ⇒ A counsellor who is not sure about the physical condition of his patient should ask the MD for advice!

1. Characteristics of the team

As a team you have overlapping tasks, namely coordination, communication, shared responsibility and collaboration

1) For **coordination** it is necessary to learn and to understand the roles and responsibilities of the other team members, so that your team can function effectively
   - ⇒ Therefore try to get familiar with the roles, functions and skills of the different groups
   - ⇒ As the focus of the team should be on the needs of the patient, it is important to gather skills and knowledge of all team members
2) There has to be an ongoing **communication** among team members and with patients and families to ensure that various aspects of patients' needs are integrated and addressed
   - ⇒ Communication is the process of transmitting and understanding information and ideas; so the team develops shared understanding!
   - ⇒ Therefore the team should meet regularly, in order to discuss and to help each other in treating the patients
   - ⇒ The social value of face to face contact should not be underestimated, as trust, respect, team identity and familiarity with one another's way of working are all developed here
   - ⇒ Members who work too much on their own and who loose touch with how their work relates to others can reduce the whole team effectiveness!
3) It should be very clear, in which way the **responsibility** for the work is shared
   - ⇒ Knowing who is responsible for what creates a clear working atmosphere and enables and obligates each member of the team to do his work carefully

Common Mental Disorders

I Depression

From time to time every person feels sad or unhappy, particularly when a person experiences an important loss (e.g., the death of a loved one). This is a normal part of life. Sometimes a person can develop an illness that is characterized by sadness and loss of pleasure. This is called depression. A depression is a mental illness that involves the body, mood, and thoughts. It affects the way the person eats and sleeps, the way one feels about oneself, and the way one thinks about oneself and things. A depression is not the same as feeling unhappy or sad. It is a real disease, which can make the person suffer, just as any other disease. It is not a sign of personal weakness. Depression is the most common mental disorder encountered by primary care doctors. This disease often becomes chronic and interferes with normal functioning and causes pain and suffering to patients and the family as well.

1. Clinical features:

Usually patient presents with physical symptoms; commonly tiredness, headaches and body pain in health facility. Remember depression can not be diagnosed on the basis of physical symptoms. People use a variety of words to describe depression in Afghanistan so doctors must be familiar with them in the area they work. Common symptoms in depression according to importance are as follow:

- Sadness and depressed mood
- Lack of interest or pleasure in all, or almost, all activities
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Hopelessness, helplessness
- Suicidal ideas or attempts
- Insomnia or hypersomnia, early morning awakening
- Psychomotor agitation or retardation
- Poor appetite or weight loss
- Poor concentration and difficulty making decisions

- Anger towards family members and others
- Symptoms of anxiety are also frequently present.

A person does not have a depression if the symptoms:

- happen for only a short time (less than two weeks)
- are part of normal bereavement. After the death of a loved one a person can have many of the symptoms mentioned above but this is not a depression. It can become a depression when the symptoms last too long.
- are a reaction to a new stressful situation. When a person becomes a refugee, s/he can have temporary symptoms like the ones mentioned above. When the stressful factor is not present anymore the symptoms disappear.

People at risk of depression: depression in family, insecure environment, losses of close relatives or friends, substance abuse, especially opium, heroin or alcohol, psychosocial stress: financial problems, unemployment, family problems; chronic, life-threatening physical illness, shyness and being dependent on others, negative thinking about self, future and the world, central nervous system diseases e.g. stroke, Parkinson's disease; medication e.g., for family planning, or for high blood pressure etc.

Depression in women and depression in men:

Depression is more common in women than in men. This can be attributed to several factors including biological differences (after the birth of a baby, a woman is more vulnerable to developing a depression) and more importantly: factors such as social and cultural restrictions and domestic violence.

Men are less likely to develop a depression than women. But many men do still develop a depression. Often the disease is not recognized. Sometimes depression in a man leads to drug or alcohol abuse. Sometimes the depression in a man looks more like irritability and anger, and the feelings of sadness and helplessness are hidden because the man does not wants to show them.

Depression comes in many different types, but each type can have its own unique symptoms and treatments.

Common forms are:

Mild and chronic form of depression: psychosocial interventions help patients to decrease the impact of illness on daily activities. People with mild depression are at an increased risk of severe depression.

Severe depression: This type of depression lasts more than two weeks. Symptoms may include feelings of sadness, loss of interest or pleasure in activities usually enjoyable, and feelings of worthlessness or guilt. This type of depression may result in poor sleep, change in appetite, severe fatigue and difficulty concentrating. Severe depression increases the risk of suicide.

Postpartum depression. It's common for mothers to feel a mild form of distress that usually occurs a few days to weeks after giving birth. Sometimes mother experiences severe symptoms such as feelings of sadness, anger, anxiety, irritability and worthlessness which is called postpartum depression.

Common symptoms are:

- Persistent depressed mood
- Crying spells
- Loss of interest in pleasurable activities
- Changes in sleep , appetite, energy and concentration
- Increased or decreased psychomotor activity, such as staying in bed, pacing or rocking.
- Feelings of hopelessness, worthlessness, excessive guilt, and suicidal ideation.
- Excessive thoughts of maternal inadequacy or neglect of baby

- Psychotic depression: A severe form of depression which is characterized by not only symptoms of depression but also by hallucinations or delusions. Often this patients become delusional or come to believe that their thoughts are not their own or that others can hear their thoughts, or they have lost their job, money, health etc. This type may require combinations of antidepressant and antipsychotic medication for some days until psychotic symptoms are improved.
- Bipolar disorder. These people have recurrent episodes of depression and mania. Some people may have several episodes of depression before having another manic phase, or vice versa. See the section on bipolar disorder for treatment.

2. Possible risks

There are many risks and complications for patient with depression such as suicide attempt, unemployment, relationship problems, substance or alcohol abuse, isolation, manic episode and physical illness.

There is an interrelation between psychosocial stressors and depression:

1) psychosocial stressors can lead to the onset of depression and
2) the depression can lead to increased psychosocial stressors

Common psychosocial stressors related to depression are:

- Family conflicts, relationship problems
- Unemployment or loss of job
- Difficulties in workplace
- Financial problems

3. Mental status examination

During the examination of the patient many changes can be observed, such as:

- Self neglect
- Reserved and decreased talk
- Decreased activity (psychomotor retardation) sometimes agitation
- Feeling of hopelessness, helplessness, guilt and worthlessness
- Death wish or suicidal ideation
- Sometimes crying spells and tearfulness
- Negative view of self, world and future
- Depressed mood
- Poor concentration
-

Some depressed people will deny that they are sad or hopeless.

- They may say they are all right even if something bad has just happened. Often these people complain about physical problems instead. Other patients may be so depressed that they have few complaints and they stay quiet. They are seriously in great danger of killing themselves at some time.

4. Diagnosis

Initially more then 50% of patients with depression in primary care may remain undetected, with physical complaints as presenting complaints. About two thirds of depressed patients present

mainly with somatic symptoms, herewith doctor must be equipped with professional skills to diagnosis depression. Physical examination must be performed for all patients.

- Physical illness such as chronic headaches, hypothyroidism, anemia etc
- Mental disorders such as anxiety disorders, unexplained somatic complaints, substance abuse

Following main questions help diagnosing depression:

- During the past month have you often been bothered by feeling down, depressed, or hopeless?
- During the past month have you often been bothered by having little interest or pleasure in doing things?

If the patient's answers yes to one or two of these main questions the doctors should check fort the other symptoms of depression. In case if there is less then five symptoms listed in the clinical features and the doctor is not sure of diagnosis patient should be sent to psychosocial counselor for further evaluation.

5. Treatment

Most of the patients can be managed in primary care setting. Patients can benefit from a variety of helpful interventions, psychosocial interventions and pharmacotherapy etc. As a rule, the most effective treatments of depression involve a combination of medication and psychosocial interventions. Doctors should educate people about depression symptoms, causes, diagnosis, treatment, decrease ability to solve problems, relapse prevention, importance of follow up.

Psychosocial interventions

Psychosocial interventions are effective in most of the cases. Even with severe depression after symptoms are improved with medication. Psychosocial interventions are the treatment of choice in mild and moderate cases of depression. In difficult cases it is best to combine psychosocial interventions and pharmacological interventions.

While it is not the task of the doctor to provide professional counseling it is important for all medical staff to realize that their attitude and way of talking has an important influence on the patient. The person who is depressed thinks that her/his mood and situation will never change. It is important to remember that this belief of the person with depression is one of the symptoms of the illness.

Depressed people feel extremely lonely, even when there are other people around. It is important to lessen the isolation of a depressed person. It is helpful for a depressed person to have signs that people are supportive. This means that it is necessary to involve the family:

Psychosocial interventions will be discussed in other section.

Use of psychosocial intervention should be considered if any of the following conditions exist:

- Depression is not severe
- Psychotic features are absent;
- A clear psycho-social stressor/stressors exist
- Previous response to psychosocial interventions was positive;
- Psychosocial interventions services are avalable;
- A medical contraindication to medication exists;
- Recovery has not been achieved with medication alone;
- Complicated psychosocial circumstances exist.

A. Biological treatment: Antidepressants are effective medications for depression; available new antidepressants have significantly reduced side effects. Overall, there is little difference in efficacy among antidepressants in treating depression. Antidepressant medications should be considered in the following circumstances:

- Depression is severe or is chronic or recurrent;
- Psychotic features are present;
- Family history of depression exists;

There are many antidepressants available; in the essential medicine list of Afghanistan the following are listed:

- Amitriptyline (10 & 25 tab) is a tricyclic antidepressant (TCA). Common side effects are dry mouth, drowsiness, dizziness, constipation, blurred vision, upset stomach, difficulty urinating. These are seen in the beginning and usually disappear after few days. Side effects should be explained to patient and the family.
- Fluoxetine (20 mg cap) is a SSRI (Selective Serotonin Reuptake Inhibitor) and has fewer and milder side effects. Due to insomnia as one of side effects preferably given in the morning as single dose.

- Duration of treatment with antidepressants is about six months.

- Do not give two antidepressants together!
- When anxiety is prominent and insomnia is problematic a benzodiazepine e.g. diazepam 5-10 mg or Alprazolam (0.25-0.5 mg, not in essential medicine list) can be given for few days.

It is very important for doctors to realize that:

1) diazepam and alprazolam do not have an effect on the depression itself, they only calm the patient down by decreasing insomnia and temporarily reducing anxiety
2) there is an important risk that the patient gets addicted to alprazolam and diazepam. It is the responsibility of the doctor not to create addiction!!!

- When physical illness is present, management must be directed at the underlying condition rather than the depressive symptoms. Remember commonly many physical illnesses occur with depression; in such cases treatment must be directed at the depression as well as the illness. When depression is considered the primary diagnosis then it requires treatment first.

Guideline: Treatment of Depression with Amitriptyline

Step 1: The initial dose of amitriptyline is 50 or 75 mg/day in two divided doses.

Step 2: After a few weeks evaluate the effectiveness. If it does not work the dose can be increased to 150 mg (give 50 mg in the morning and 100 mg at night, or give 150 mg at night)

Step 3: Switch to fluoxetine if:

- amitriptyline did not work after 6 weeks;
- the patient has cardiac disease (e.g., irregular heartbeat or a murmur), epilepsy, or an enlarged prostate; or
- the patient is older than 65 years.

Side effects of amitriptyline include:

- tiredness
- dry mouth
- dizziness when the person changes position from lying or sitting to standing, s/he will feel dizzy due to a drop in blood pressure
- constipation
- blurring of vision

Guideline: Treatment of Depression with Fluoxetine
Step 1: Give fluoxetine capsules 20 mg/day. Step 2: If the dose in step 1 does not work after three weeks, increase dose 40 mg. Side effects of fluoxetine include: • Insomnia • Nausea • Vomiting • Feeling anxious • Sexual dysfunction • Headaches • Diarrhea.

Guideline: Treatment of Psychotic Depression
Step 1: Give amitriptyline plus haloperidol 5 mg plus biperiden.

What Doctors would do?

1. Assessment:

- Exploring symptoms of depression
- Exploring the severity of the symptoms
- Previous episodes, durations and treatments.
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life
- Family involvement and support

Most importantly collect information about:

- Depression in the family
- Physical diseases
- Use of medication
- Use of substances e.g. opium, heroin or alcohol

- Person's personality before illness began
- Changes in the person's life before depression
- Risk of suicide or suicide attempts
- Use of traditional remedies
- Willingness to accept treatment

2. Referral to higher level:

- Symptoms are increasing in severity
- There is high risk of suicide
- There is associated physical illness
- Intervention was not effective
- Psychotic symptoms are present

3. Psychoeducation and counseling:

- Educating patient and the family on the nature of symptoms, duration and its changes over time, possible risk factors, psychosocial stressors, consequences, suicide risk, treatment issues, follow up, relapse and its prevention. Psychosocial counseling is helpful if the case is mild or moderate and psychosocial stressor is present. After starting antidepressant medication it is important to encourage family support. The psychosocial counselor will follow the steps of the manual for psychosocial interventions and try to link the symptoms to the psychosocial stressors in the background. Depending on the nature of the stressor he will develop the treatment plan.

Some tips for health workers when talking with a depressed person:

- Make the person feel comfortable to talk about her/his feelings.
- Emphasize that you will keep secret what s/he tells you.
- Listen attentively and sympathetically.
- Explain that the person has a depression, and tell her/him something about the treatment.
- Give the person hope that this condition will change.

Some things should be avoided when talking to a depressed patient:

- Do not judge, such as saying that s/he is not a good husband/wife/parent.
- Do not 'order' the person to be happy.
- Do not remind her/him all the time how wonderful life is.
- Do not tell the person that the depression is caused by her/his own failures.

- Do not immediately give advice to the person but listen first and see what the person comes up with, and emphasize the good things.

Important tips: what to tell the patient and family about medication:

- It usually takes a few weeks before the medication has its effect on the depression. If the patient's condition has not improved after a few weeks, the doctor can increase the dose.
- Side effects may appear before antidepressant activity does. It is important to be aware that initially the patient feels only effects in the body, while the mood is unchanged. The health worker should inform the family that these effects on the body are not harmful. They are a sign that the medication is working in the person. It should not be a reason to stop taking the medication. Side effects are usually mild and temporary: the effects on the body become less after time, but some of them remain as long as the persons use the medication. When the person stops the medication, these effects will also stop.
- The medication should be taken for a long period of time, often for six months or longer. Patients often try to stop medication soon. They may feel better and think they no longer need the treatment.
- Remember that there are no instant solutions to problems in life.
- Discuss treatment plan with patient
- Antidepressants do not cause dependence
- Always assess the patient for "suicidality" before starting an antidepressant.

Tips on suicide risk:

- Important point is the patient always should be assessed for "suicidality" before starting an antidepressant. In the first two weeks of treatment the suicide risk is increased. In case the patient is suicidal ask a family member to administer the medication. The family needs to know about this risk and watch the patient carefully until he/she is clearly better. Follow up visits need to be frequent in the beginning in case the patient is suicidal.

To find out if the person is suicidal ask some questions directly, as follows:

- Do you think life is not worth living?
- Would you prefer to be dead?
- Have you thought of killing yourself?
- Have you tried to kill yourself or do you have plans to kill yourself?
- Also, ask about previous suicide attempts (previous attempts increase the risk of further suicidal behavior and will give you an idea of what they will do).

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4. Follow up:

Follow up is very important in early weeks of treatment. It can be for assessing compliance, symptoms improvement, counseling, monitoring side effects of medication, evaluation of psychosocial stresses and family support.

Sometimes there is a need for referral to a specialist:

- High risk of suicide
- Failure to respond to usual treatment
- Diagnosis is difficult
- Comorbid conditions in which the other illness or its treatment makes treatment of depression problematic
- Patients with psychotic depression usually needs hospitalization
- Patients with bipolar disorder who represent a higher suicide risk

II Anxiety and stress related disorders

Anxiety and fear are a normal experience in human life. They fulfil actually an essential purpose in circumstances which demand our full concentration and energy because the anxiety reaction prepares us to flee or to fight in situations which mean a real threat to our life (e.g. being involved in a traffic accident, walking alone at night in a deserted street) or a situation which is of great significance in our life (e.g. an exam, giving a talk in front of many people, meeting the fiancée for the first time). The experience of anxiety always involves the whole person, i.e. the thinking, the emotions and the body. It is important to realize that experiencing the symptoms of anxiety is not the same as suffering from an anxiety disorder.

But when anxiety becomes continuous, severe, out of proportion compared to the situation and if it significantly restricts the person in her/his every day life over a long period of time then we diagnose an anxiety disorder. Anxiety disorders are worldwide very common. They can be successfully treated by psycho-social interventions and by medical treatment.

Often patients with anxiety disorders seek the doctor’s help because of the somatic symptoms that belong to it. Treating the somatic symptoms only will not improve the person’s condition. Therefore it is important to recognize anxiety disorders. There are different forms of anxiety disorders as will be described in this chapter. But it is not uncommon that the different forms overlap so that we will find mixed clinical pictures. Also often symptoms of other CMD-disorders are mixed with anxiety symptoms, especially those of depression.

A. Panic attack/disorder

1. Clinical features:

A panic attack is defined as a distinct episode of intense symptoms that primarily involve sympathetic nervous system manifestations. Patients typically have attacks with rapid onset of the physical symptoms and a persistent concern about having an attack. Attacks occur suddenly and typically last less then 30 minutes. They can occur one to several times per week, usually unpredictably, and may interfere with the patient's normal activities and work.

<u>Common symptoms during panic attack are:</u>

A. Neurological symptoms
   - Dizziness or unsteady feeling
   - Paresthesias
   - Trembling and shaking
   - Fainting

B. Respiratory symptoms
   - Shortness of breath
   - Feeling of smothering
   - Choking

C. Cardiac symptoms
   - Chest pain or discomfort
   - Palpitations, heart pounding or tachycardia
   - Sweating

D. Gastrointestinal symptoms
   - Nausea
   - Abdominal distress

E. Psychological symptoms
   - Derealization
   - Fear of losing control, going crazy
   - Fear of dying e.g. having heart attack

F. Miscellaneous symptoms
   - Chills or hot flushes

Most of the symptoms may be present during panic attack with fear of dying is the central one but the severity of symptoms differ with each patient and with each attack. If patient develops fears of having another attack or anticipatory anxiety, this called panic disorder. Patient with panic disorder can have worries of having attack in crowded places. This leads to avoidance behavior such as avoiding:

- Being away from home
- Being without the company of a person
- Going to places where escape is not readily available e.g. buses, weddings, funeral or fatiha, mosque, restaurants, etc

- Eating things that patients believe could provoke panic e.g., foods, medicines, alcohol, caffeine etc

Many events can increase patients fear or provoke panic attack such as hearing that a relative died of heart attack or stroke, watching a severe patient on TV, others talking about death, passing by pharmacy etc

2. **Possible risks**

Risks are social isolation, loss of job, family problems, depression, and suicide, also impaired quality of life and increased utilization of health care resources.

3. Mental status examination

Main findings in mental status examinations are:

- Worried and fearful appearance
- Talks centered on attacks and dying usually with details
- Thoughts of having attacks, dying from heart attack, going crazy, losing control in public, having attack in crowded palaces.
- Feeling surroundings unreal (Derealization)
- Anxious mood, fearfulness
- difficulty concentration

4. Diagnosis

The classic presentation of panic attack may be easily recognized, but it is not uncommon for panic attack to present atypically and thus go unrecognized. The diagnosis of panic disorder is made if the patient has experienced recurrent, unexpected panic attacks and shows at least one of the following characteristics:

- Persistent concern about having another attack (anticipatory anxiety);
- Worry about the consequences of an attack (e.g., suffering a catastrophic medical or mental consequence),
- Significant change in behavior related to the attacks.

Patients diagnosed with panic disorder often have been seen by many doctors and consultants, and often have done costly diagnostic tests. Patients are more likely than others to seek general

medical care, visit the emergency department and take tranquilizers. Patients presenting with panic symptoms should go thorough initial evaluation that goes beyond assessment of their primary somatic complaints such as.

- Avoidance behavior
- Substance use history
- Medical history to eliminate organic etiology
- Psychiatric comorbidity e.g., depression
- Previous treatments e.g. psychiatric, medical
- Family history

5. Treatment

There are many treatment options for patients with panic attack. The treatment includes medications such as antidepressants and benzodiazepine anxiolytic and psychosocial interventions.

Pharmacotherapy:

- The choice is between a fast acting benzodiazepine and antidepressants, which are well tolerated but have a much slower onset of action. Benzodiazepines are rapidly effective, but panic symptoms commonly recur after withdrawal, even with slow tapered discontinuation. For pained disorder essential medicine includes: Alprazolam 0.5-2 mg/day or Diazepam 5-20 mg/day. Due dependence risk its better to try benzodiazepine at the beginning and switch to antidepressant latter.

Common side effects of benzodiazepines:

- Daytime drowsiness
- Impaired memory and concentration
- Respiratory depression, especially in elderly
- Abrupt discontinuation can precipitate epileptic seizures
- Dependence
- Increases depressive effects of alcohol on central nervous system, can lead overdose

Antidepressants reduce severity of symptoms, eliminate attacks, and improve overall quality of life for patients. Do not prescribe two antidepressants together.

Following ADs are included in essential medicine list:

- Fluoxetine 20m-40 mg/day
- Amitryptaline 25-150 mg/day

<u>Important tips for pharmacotherapy:</u>

- Start antidepressants at low doses
- Carefully increase the dose to minimize side effects
- Required doses for panic disorder is similar to that of depression
- Benzodiazepines are useful for anticipatory anxiety not underlying depression
- Patient may require repeated reassurance and explanation about the disorder
- Follow up is important particularly during the initial treatment phase
- If not effective switch to another AD

Many techniques of psychosocial intervention are helpful in panic disorder. At times these interventions may be superior to pharmacotherapy. Psychosocial interventions will be discussed in other section of the manual. Combination of antidepressant plus psychosocial interventions produces the greatest benefit for some patients.

What doctor would do?

1. <u>Assessment:</u>

- Exploring symptoms of panic attack also depression if present
- Exploring nature of the symptoms, frequency, timing and location of attacks.
- Exploring when the symptom started, the situations which trigger the symptom
- Exploring the help seeking behavior e.g. asking family members for going to hospital, going to doctor or emergency room, etc.
- Impact of symptoms on patient's daily life.
- Exploring avoidance behavior such as not leaving home alone, avoiding crowded places e.g. buses, weddings, funeral ceremony, and fatiha etc.
- Exploring presence of psychosocial stressors
- Exploring family support

<u>Most importantly information about:</u>

- Similar illness in the family
- Other physical diseases
- Use of substances e.g. opium, heroin or alcohol
- Person's personality before illness
- Changes in the person's life before the depression
- Risk of suicide or suicide attempts

- Use of traditional remedies

2. Referral to higher level

- Symptoms are severe and attacks are frequent
- Not controlled by adequate pharmacotherapy
- Severe depression coexists
- There is risk of suicide
- Counseling was not effective
- There is associated physical illness

3. Psychoeducation and counseling:

- Either initially or after being treated with a doctor.
- Educating patient and the family on the nature of symptoms, duration and changes over time, possible risk factors, psychosocial stressors, consequences, treatment, follow up, relapse and its prevention is important.

Some essential information for patient and family are:

- Panic attack is common and can be treated.
- Anxiety often produces frightening physical sensations. Chest pain, dizziness or shortness of breath is not necessarily signs of a physical illness; they will pass when anxiety is controlled.
- Panic attack also causes frightening thoughts: fear of dying, a feeling that one is going mad or will lose control. These also pass when anxiety is controlled.
- Mental and physical anxiety reinforces each other. Concentrating on physical symptoms will increase fear.
- A person who withdraws from or avoids situations where attacks have occurred will only strengthen his/her anxiety.
- Discuss treatment plan with patient

Important tips:

- Patient avoids unnecessary medical consultation
- Patient tries talking about his/her problem with trusted friends
- Support of family members without helping to perpetuate the person's symptoms
- This is panic attacks not really heart attacks
- Medication is to cure symptoms and is not toxic to heart or brain
- Side effects means medication started acting on symptoms
- Time is needed for medication to improve symptoms.

4. Psychosocial intervention:

- Depending on the indication such as a traumatic event the steps of the trauma treatment are followed.

5. Follow up:

- Follow up is the essential part of intervention for panic disorder which is for: assessing compliance, symptoms improvement, referral for counseling, risk of suicide, monitoring side effects, evaluation of psychosocial stresses and family support.

B. Generalized anxiety disorder (GAD)

1. Clinical features:

Patients with GAD experience worry or anxiety and a number of physical and psychological symptoms. The main feature is excessive anxiety and worry for most days, symptoms include restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension and sleep disturbance.

Common symptoms are:

Psychological and cognitive

- Worries and fear
- Inability to controlling worries
- Unrealistic assessment of problems
- Poor concentration
- Hypervigilance

Physical and physiological

- Muscle tension
- Irritability
- Fatigue
- Restlessness
- Insomnia

Other symptoms

- Avoidance
- Postponing things
- Poor problem-solving skills

2. Possible risks and complications

Non compliance, dependence on benzodiazepine, depression, substance or alcohol abuse, suicide, problem in workplace etc

3. Mental status examination

Findings in most patients are:

- Worried and restlessness e.g. frequently changing sitting position, walking etc
- Sweating, tremor, rapid breathing
- Concern as if something happens
- Talks about worries in daily life
- Thoughts of fear, apprehension, anticipating a bad incident, worry about health
- Fearful affect
- Difficulty in concentration
- Difficulty in making decision

4. Diagnosis

After obtaining patient history, doctor should try to categorize the anxiety as acute or chronic. Acute anxiety lasts from hours to weeks and is usually preceded by a stressor, in contrast, panic attacks last for minutes. Chronic anxiety lasts for months to years. GAD is distinguished from other medical and psychiatric conditions and normal worrying principally by the long duration of the anxiety and the resultant impairment in daily functioning. GAD should be differentiated from panic attack, depression, substance abuse and medical conditions with anxiety symptoms such as thyrotoxicosis, mitral valve prolapse, carcinoid syndrome etc.

Educate the patient about the following:

- Normal anxiety and physical symptoms of anxiety. People with anxiety disorders are not always aware of some of their symptoms. Careful and thorough explanation alone will often lead to symptomatic improvement.
- Confronting with situation rather than avoiding feared situations
- Dependence on substances, benzodiazepines or alcohol
- How to deal with stressors
- Course and outcome of the illness
- Benefit of relaxation

5. Treatment

Patients with generalized anxiety disorder may respond to psychosocial or pharmacologic therapies or a combination of both approaches.

Pharmacotherapy should be considered for patients whose anxiety results in significant impairment in daily functioning. The anxiolytic most frequently used are the benzodiazepines, all the benzodiazepines are of equal efficacy.

- Diazepam can begin with 2 mg or Alprazolam 0.25 mg, 2-3 times daily. The dosage can be increased every two to three days until the symptoms improve. Benzodiazepine therapy can lead to dependence. The patients most likely to abuse benzodiazepines are those who have a previous history of substance abuse or alcohol.
- Beta blockers such as Propranolol 40-120mg, can be used which relieves worries and fear through control of physical symptoms of GAD.
- Antidepressants such as Fluoxetine 20-40 mg or Amitryptaline 25-150 mg are also helpful; the advantage is that there is no risk of abuse and dependence in long term use. A better approach is that benzodiazepine initially can be tried for less then one week and be continued with an antidepressant latter.

6. **Psychosocial treatment:**

- First the patient has to see the counselor alone in order to build up a trustful helping relationship with the counselor. Often the problem ,which originally was connected to the development of the fear is within the family. Therefore the counselor always must discuss with the client if he is comfortable if family members are involved. This can be very helpful if initially they can provide additional information and thus contribute to the formulation of the treatment plan. In addition, family members should be included in efforts to help patient develop problem-solving skills and can also help decrease the social isolation of patients

What doctor would do?

1. Assessment:

- Exploring physical and psychological symptoms of GAD,
- Exploring severity and frequency of the symptoms.
- Interference with daily activities
- Exploring psychosocial stressors
- Exploring main worries due to GAD.

Most importantly information about:

- Anxiety disorder in the family
- Physical diseases in patient
- Current use of medication and past treatments
- Use of substances or alcohol
- Person's personality before illness
- Changes in the person's life before illness
- Risk of suicide or suicide attempts
- Use of traditional remedies

2. Referral to higher level

- Symptoms are increasing in severity
- There is risk of suicide (if depression is present)
- Physical illness is suspected
- Counseling was not effective

3. Psychoeducation and counseling:

- Either initially or after being treated with medication with a doctor. Psychoeducation should focus on educating patient and the family on the nature of symptoms, duration and changes over time, psychosocial stressors, consequences, risk of suicide, treatment, follow up, relapse and its prevention. The counselor willl also carfully explore the relationship with the symptom and the possible psychosocial stressor and then make a treatment plan.

Some tips:

- Feeling anxious is not patient's fault
- GAD is a treatable condition
- This is not sign of weakness
- Worries are related to daily life but unrealistic
- Discuss treatment plan with patient
- If one treatment doesn't work, another one will
- Daily relaxation to reduce physical symptoms
- Routine activities and exercise
- Medication is used when psychosocial intervention is not helpful
- Side effects are temporary and tolerable.

Psychosocial intervention follows the intervention steps of the first counseling phase. Explores the resources or works if necessary according to the indication of the psychosocial stressors such as a family conflict or issues of honor and shame.

4. Follow up:

- Follow up is similar to panic disorder: assessing compliance, symptoms improvement, referral for counseling, improvement in coping, risk of suicide, monitoring side effects, evaluation of psychosocial stresses and family support.

C. Phobias

1. Clinical features:

A. Social phobia:

Social phobia is a persistent fear of performing in social situations, especially where strangers are present or where the person fears embarrassment. Person fears that others will think he is weak, stupid, or crazy, and exposure to the feared situation provokes an immediate anxiety attack. Patients recognize that their fear is excessive, but their anxiety and avoidance behavior markedly interfere with their daily activities, work, or social life.

Common symptoms:

- Extreme, persistent fear of social situations
- Fear of humiliation or embarrassment
- Exposure provokes extreme anxiety
- Fear recognized as excessive or unreasonable
- Avoidance of situations e.g. avoiding eating, drinking, or writing in public
- Anticipatory anxiety
- Physical symptoms: Palpitation, sweating, blushing, trembling, dry mouth, urgency, rapid breathing, dizziness and in severe cases fainting.

Common situations:

- Public speaking or performing
- Small group discussion
- Asking questions in groups
- Being introduced
- Meeting or talking with strangers

- Being watched doing something (e.g., eating, writing)
- Attending social gatherings
- Using the telephone, public restrooms
- Interacting with important people

B. Specific phobia

This is a fear of specific objects or situations. Most phobias start in childhood, but situational phobias have a second peak of onset among people in 20s.

Common symptoms are:

- Extreme, persistent, and unreasonable fear
- signaled by appearance or anticipation of specific object or situation
- Avoidance of situation or object
- Physical symptoms: Palpitation, sweating, hot flushes, trembling, dry mouth, rapid breathing, dizziness, urgency and in severe cases fainting.
- Specific objects include:
  - Animals: spiders, snakes
  - Natural environment: heights, water, storms
  - Specific situations: driving, flying, tunnels, lifts, bridges, enclosed spaces
  - Blood, injections, injury

2. Possible risks and complications

Patient may develop depression, substance or alcohol abuse and suicidal thoughts also isolation, loss of job, discrimination, family problems and low quality of life.

3. Mental status examination

- Normal appearance
- Alertness
- Avoidance behavior
- Concern with feared object
- Anticipatory anxiety
- Fearful mood

4. Diagnosis

Diagnosis of phobia is not difficult unless other mental disorders coexist. Sometimes person may have more then one phobia. Depression is common disorder coexist with phobias. Substance or alcohol abuses are also common.

5. Treatment

Patient avoids treatment because of fear, shame or stigma. Treatment planning should be done after the benefits and risks of treatment options have been discussed with the patient. Successful treatment for specific phobia is almost exclusively with psychosocial interventions. Medications are of little use. For social phobia pharmacological and psychosocial treatments are helpful. As a rule combined treatment is more effective in difficult cases. Antidepressants, benzodiazepines and beta blockers are effective in the treatment of social phobia. Beta blockers appear to be a clinically effective treatment for mild to moderate social phobias. Benzodiazepines are fast-acting, well-tolerated anxiolytic that have shown efficacy in the acute treatment of social phobia, but there are difficulties with discontinuation due to dependence after long term treatment.

Common doses:

- Fluoxetine: 20-40mg/day,
- Propranolol: 20-40 mg three times a day
- Diazepam: 2-10mg or Alprazolam: 0.25-1 mg or

What doctor would do?

1. Assessment:

- Exploring history of symptoms and related problems
- Exploring the severity of the symptoms.
- Impact of symptoms on patient's daily life.
- Exploring psychosocial stressors

Most importantly information about:

- Similar illness in family
- Physical diseases if any
- Treatment history
- Use of substances or alcohol
- Person's personality be

- Changes in the person's life before illness
- Presence of other mental disorder
- Risk of suicide or suicide attempts
- Current social functioning
- Use of traditional remedies

2. Referral to higher level

- Symptoms are increasing in severity
- There is high risk of suicide
- There is associated physical illness
- Psychosocial care was not effective
- Other mental disorders are present

3. Psychoeducation and psychosocial counseling:

- Educating patient and the family on the nature of symptoms, duration and changes over time, psychosocial stressors, consequences, treatment, follow up, relapse and its prevention.

Tips for Doctors:

- Ensure patient that phobia is a treatable condition
- Discuss treatment plan with patient
- Most phobias develop during childhood and eventually disappear.
- Those that persist into adulthood rarely go away without treatment.
- Majority of patients can completely overcome their fears and be symptom-free
- Social phobias generally develop after puberty, without treatment, can be lifelong
- Confronting the object of fear rather than fleeing, the person becomes accustomed to it and can lose the fear, panic, and dread he or she once felt
- Medications control the anxiety symptoms experienced during a phobic situation
- Discuss ways to challenge these exaggerated fears e. g., patient reminds him/herself, "1 am feeling a little anxious because there is a large crowd. The feeling will pass in few minutes."
- The patient should avoid using alcohol or benzodiazepines to cope with feared situations.

4. Psychosocial intervention

- Follows the intervention steps of the first counseling phase. Technique uses a slow desensitization with exposure therapy, including imagination exercises. Explores the resources

and work if necessary according to the indication of the psychosocial stressors such as a family conflict or issues of honor and shame

5. Follow up:

- Follow up is for: assessing progress and symptoms improvement, referral for counseling, risk of suicide, monitoring side effects, evaluation of psychosocial stresses and family support.

D. Obsessive compulsive disorder (OCD)

1. Clinical features:

OCD is a disorder characterized by obsessions and compulsions. In OCD the person is unable to control thoughts, idea or urges, which force themselves into the mind, repeatedly. These thoughts are disturbing, uncontrollable and unacceptable to the person, which person can not ignore or share with others. Obsessions causes' unbearable anxiety which makes person feel helpless to do anything except perform the particular ritual which reduces the severity of the thought and anxiety. Obsessive-compulsive disorder can occur at any age but most often presents for the first time in adolescence.

A. Obsession: Recurrent, persistent, unwanted thoughts or images causing intense anxiety, some common obsessions are**:**

- Fear of dirt or germs and contamination
- Fear of harming a family member or friend
- Fearing aggressive urges
- Excessive doubts
- Concern with order, symmetry and exactness
- Worry that a task has been done poorly, even knows this is not true
- Fear of thinking evil or sinful thoughts
- Thinking about certain sounds, images, words or numbers all the time
- Doubts that person has not locked the door or turned off the stove

B. Compulsion: Repetitive behavior for reducing high level of anxiety due to obsession, common compulsive behaviors are:

- Checking doors, drawers, switches, shop and appliances to be sure they are shut, locked or turned off

- Washing and cleaning, such as washing hands, showering or brushing teeth over and over again
- Counting of things again and again
- Repeating certain words or phrases
- Repeating actions such as going in and out of a door, sitting down and getting up from a chair
- Ordering or arranging items in certain ways
- Touching certain objects several times
- Praying again and again
- Saving newspapers, mail or containers and or things no longer needed
- Seeking constant reassurance and approval
- Repeating words or counting silently

2. **Possible risks**

Most patients hide their problem and do not seek treatment due to embarrassment and stigma. When OCD is diagnosed usually years have passed without treatment and person has become isolated. Common associated mental disorders are depression, schizophrenia, phobias. There might be suicidal ideation or attempt if depression is severe.

3. Mental status examination

- Neat and reserved appearance
- Uneasy and restless
- Concerned about surroundings of possible contamination etc
- Talks about obsessions
- Repetitive thoughts, ideas, images or urges
- Anxious mood

4. Diagnosis

A clinical interview that elicits a history of intrusive thoughts or behavioral rituals is the primary method of establishing the diagnosis. In most of the cases when OCD patient comes to doctor diagnoses is straightforward. Important questions are:

- Do you wash or clean a lot?
- Do you check things a lot?
- Is there thoughts that keeps bothering you that you want to get rid of but can't?
- Do your daily activities take a long time to finish?

- Are you concerned about orderliness or symmetry?
- Do these problems trouble you?

Long delays in diagnosis often occur, and the shame associated with the disorder may prevent people from talking about symptoms. Several disorders seem to be related to obsessive compulsive disorder, either by the nature of their symptoms, which show similarities to obsessions or compulsions, or by their frequent co-occurrence. Co-existing mental disorders e.g. depression or schizophrenia with OCD needs particular attention. OCD can be part of depression and schizophrenia. Tic disorder also includes obsessive compulsive symptoms but there are involuntary repetitive movements which help differentiate OCD.

5. Treatment plan

Useful methods are psychological interventions which will be discussed in psychosocial intervention and skills. Some people find medication helpful for OCD, either alone or combined with psychosocial treatments. The medications prescribed commonly are antidepressants, such as Fluoxetine (20-40 mg) and clomipramine (75-150 mg).

What doctor would do?

<u>1. Assessment:</u>

- Exploring symptoms of OCD
- Exploring the severity of the symptoms and duration
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life
- Origin of patients thoughts (coming from where?)
- Actions/behaviors to get rid of the thoughts
- Time spend for such behavior

<u>Most importantly information about:</u>

- OCD in the family
- Physical diseases
- Use of medication
- Use of substances or alcohol
- Person's personality before illness
- Changes in the person's life after illness

- Risk of suicide or suicide attempts
- Use of traditional remedies

2. Referral to higher level

- Symptoms are severe
- There is a suicide attempt or risk of suicide
- There is possible associated physical illness
- Initial counseling was not effective

3. Psychoeducation and psychosocial counseling:

Educating patient and the family on the nature of symptoms, obsessions and compulsions, changes over time, psychosocial stressors, consequences, types and duration of treatment, follow up, relapse and its prevention. Some tips to consider:

- OCD is a common problem
- Is a treatable condition
- Discuss treatment plan with patient
- OCD sometimes runs in families
- Friends can support finding help
- Hiding problems makes their treatment difficult.
- Medication and psychosocial interventions are more helpful
- Sticking to treatment plan, even if it's sometimes uncomfortable
- Avoiding substance or alcohol as coping mechanisms
- Involvement in social activities, rather than isolating yourself

4. Psychosocial counseling

- Explores the origin of the problem and then develops a treatment plan according to the indication. In order to reduce the damaging behaviour the counselor follows the intervention steps of the OCD desensitization.

5. Follow up:

Follow up is for: assessing progress and symptoms improvement, referral for psychosocial intervention, assessing risk of suicide, monitoring side effects, evaluation of psychosocial stresses and family support.

III Conversion Disorder

Previously the illness was called hysteria or hysterical neurosis. Conversion disorder is a condition where patients present with neurological symptoms such as numbness, paralysis or fits, but no neurological explanation can be found. These problems arise in response to difficulties in the patient's life but the nature of the association between the psychological factors and the neurological symptoms remains unclear. The psychological conflict or stress may not always be apparent initially, but it becomes evident in the course of obtaining a patient's history.

The symptoms thought to be triggered by acute psychosocial stress that the individual could not process psychologically. The most common reported symptoms are weakness, paralysis, pseudoseizures, involuntary movements (e.g., tremors), and sensory disturbances. Symptoms are not considered to be under voluntary control, and, should not be explained by any physical disorder or known pathological mechanism.

Some common risk factors for dissociation are:

- Childhood traumatic experiences
- Loss of a loved one
- Sexual assault/rape
- Kidnapping
- Torture
- Accidents
- During war
- Use of substances

1. **Clinical features**:

We focus on motor symptoms here. Motor symptoms might include equilibrium or coordination impairment, weakness or paralysis, vocal disorders (hoarseness to aphonia), dysphagia or a choking sensation in the throat, and urinary incontinence. Does not usually follow known anatomical or physiological routes. It is characterized by inconsistency and instability of the presence and severity of the signs and symptoms. Paralyzed limbs might move 'accidentally' while performing activity or when attention is shifted.

Conversion disorder can present with any motor or sensory symptom including any of the following:

- Weakness/paralysis of a limb or the entire body
- Impaired hearing or vision

- Loss/disturbance of sensation
- Impairment or loss of speech
- Non-epileptic seizures
- Fixed dystonia unlike normal dystonia
- Tremor, myoclonus or other movement disorders
- Gait problems

The intensity of the disability is usually to a level that affects activities of daily living. Symptoms are often aggravated by anxiety and tension states, such as the death of a relative or a war situation. Common presentation in Afghanistan is fainting or pseudoseizures which usually mistaken for epileptic attack.

2. Possible risks and complications

Factors indicating favorable prognosis include sudden onset, presence of stressors, short duration between diagnosis and onset of treatment, high level of intelligence, absence of definite psychiatric disorder, and aphonia and blindness as presenting problem. Poorer prognosis is related to severe disabilities with long duration, age above 40 years, and convulsions and paralysis as presenting CS. Many patients have spontaneous remission after outpatient psychotherapy or suggestive therapy.

Patients are at increased risk of:

- Self-harm and suicide attempts
- Substance or alcohol abuse
- Sleep problems, including nightmares
- Development of another mental illness, such as anxiety or depression
- Difficulties in relationships and at work
- Error in diagnosis

3. Mental status examination

Carefully consider the possibility of an organic etiology. There have been suggestions that unnecessary, painful or invasive testing can result in reinforcement and fixation of symptoms and should be avoided when possible.

4. Diagnosis

The diagnosis is frequently clinical, based on history and physical examination. The patient's history include: previous functional disorders, role models among family member or friends, secondary gain, professional relation to medicine, previous psychiatric background, and self-

discharge from hospital. The onset is usually acute and sudden, though there may be a gradual form. Other details in the patient's history include concurrent psychiatric disease, physical or psychological trauma in childhood or close to the presentation of illness, and family history of physical disability.

The signs leading towards a non-organic diagnosis include inconsistent findings, no adjustment between physical and functional findings, and inconsistency between the symptoms and anatomical or physiological systems. There are rarely lead to physical changes or disability, so pressure sores, contractures or muscle atrophy are rare.
The diagnosis of conversion disorder involves three elements - the exclusion of neurological disease eg epilepsy, the exclusion of feigning, and the determination of a psychological mechanism. Each of these has difficulties.

	Epilepsy	**Conversion**
Aura	**Abdominal discomfort, unusual smell or taste,**	**Upset after family discussion and change of mood, or argument**
Onset	**Sudden**	**Slow**
Location	**Any where**	**In presence of others**
Starting factor	**No factor**	**Usually after arguments**
Fall	**Sudden**	**Gradual**
Involuntary movement	**Tonic-clonic, symmetric**	**Irregular**
Frothing	**Present**	**Absent**
Incontinence	**Present**	**Absent**
Tongue bite	**May be**	**Absent**
Cyanosis during attack	**Present**	**absent**
Injury during attack	**Present**	**May be**
Memory of attack	**No**	**Partial**

Doctors must be aware that the diagnosis of conversion disorder does not exclude the presence of underlying disease, and diagnosis should not be made solely on the basis of negative workup results.

5. Treatment

Discuss treatment plan with patient.

<u>Treatment include the following:</u>

1. Explanation. This must be clear and coherent. It must emphasize the genuineness of the condition that it is common, potentially reversible and does not mean that the sufferer is a psychotic. Taking an etiologically neutral stance by describing the symptoms as functional may be helpful but further studies are required. Ideally the patient should be followed up neurologically if needed for a while to ensure that the diagnosis has been understood.
2. Physiotherapy where appropriate when motor symptoms are present
3. Treatment of comorbid depression or anxiety if present.
4. Psychosocial intervention

What Doctors would do?

<u>1. Assessment:</u>

- Exploring symptoms of dissociation
- Exploring the severity of the symptoms.
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life
- Explore risk factors.

<u>Most importantly information about:</u>

- Dissociation in the family
- Similar illness in past
- Use of substances or alcohol
- Person's personality before illness
- Changes in the person's life before illness
- Risk of suicide or suicide attempts
- Use of traditional remedies

<u>2. Referral to higher level</u>

- If the diagnosis is uncertain
- There is associated physical illness
- Initial counseling was not effective

3. Psychoeducation and psychosocial counseling:

- Educating patient and the family on the nature of symptoms, duration and changes over time, possible risk factors, psychosocial stressors, consequences, treatment, follow up, relapse and its prevention.

Important tips:

- Patient to talk about recent stresses or difficulties
- Patient has no voluntary control over symptoms
- Positive reinforcement for improvement.
- Reinforce of symptoms should be avoided.
- Return to usual activities as soon as possible.
- Avoiding prolonged rest or withdrawal from activities.
- Improving coping style

4. Follow up:

- Any patient diagnosed with a conversion disorder should be encouraged to pursue psychosocial follow-up. This can be suggested as a way to reduce and manage stress and lessen exacerbation of physical symptoms. Such follow-up is especially helpful for cases of more serious psychiatric syndromes presenting to in emergency room with physical symptoms.

III Trauma and related problems

Trauma Knowledge

A psycho trauma is an experience where the soul gets badly hurt. This happens usually when a person experiences or is witnessing a life threatening situation or a situation that includes danger of injury which is so severe that the victim is horrified and feels helpless and powerless during and shortly after the event!

Examples of traumatic events which can cause traumatic stress

1. Natural disasters
    - Earth quacke
    - Tsunami
    - Flood
    - Storm
2. Social problems
    - Domestic violence
    - Torture
3. Sexual aggression
    - Rape
    - Sexual abuse
4. Incidents
    - Traffic accident
    - Suicide attack
    - Bomb blast
    - Seeing a dead body
    - War, combat exposure
    - Threatened with a weapon
    - Sudden violent death
    - Serious injury/harm the client caused
    - Attack of wild animal etc.

- The impact of such an experience depends on:

⇒ Length of the experience

⇒ Unpredictability

⇒ Having no control over the situation

Reaction on threat

- We are reacting in three ways when are facing a danger (summarized as 3-F):

⇒ Flight

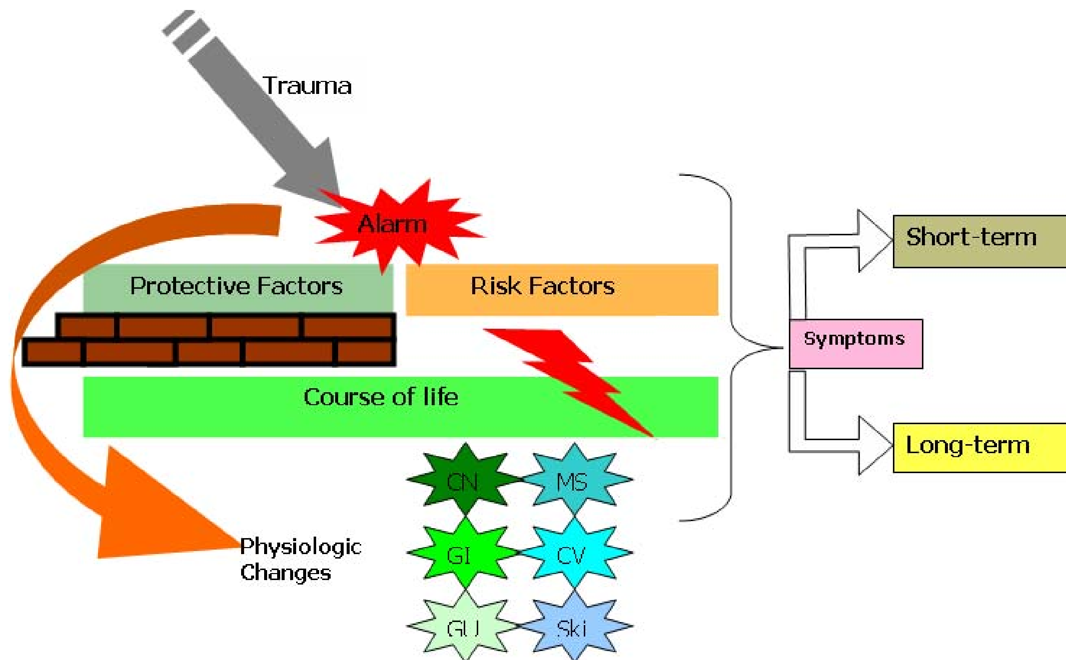
⇒ Fight

⇒ Freeze

Biological explanation:

- These are normal reactions of our psyche in response to those abnormal events.
- As a result we can observe some physiological changes in our body such as:
  - ⇒ Secretion of some hormones like electron, Cortisol, Epinephrine, Norepinephrine
  - ⇒ Activation of the autonomic stress reaction
- Through above mentioned changes, the normal function of the body is affected and resulting in some changes in the following systems:
  - ⇒ Cardiovascular system: Palpitation, Shock
  - ⇒ CNS: Dizziness, Paralysis
  - ⇒ Urinary system: Urinary retention, frequency, uncontrolled urination
  - ⇒ Gastrointestinal system: Diarrhea, Constipation
  - ⇒ Skeletal-muscle: Muscle weakness, relaxation
  - ⇒ Skin: Pallor

- The above mentioned symptoms, signs and reactions can partly be related to the familiarity of such symptoms of a person's psyche and body in advance to the event.
- The alert which is demonstrated during the event by the body and psyche is called **alarm response.**



- Example: *We have the knowledge of a wild animal such as wolf, being dangerous. Therefore whenever we are facing this animal, suddenly our psyche is activated in order to give alarm and to find out the way to taking ourselves out from the danger.*
- Example: *At night you walk and all of a sudden you hear a frightening noise. You feel paralysed and seem to be unable to move.*

Task: Please remember have you yourself ever experienced such a situation? Or have you observed people in such a situation? Describe what you observed and experienced.

If a person recovers from such an experience or not depends on:

Risk factors for suffering of a traumatic event

- Low socioeconomic status
- Bad psychological and physical health
- Bad psychological condition
- Being very young or old
- Chronic sickness, chronic pain, addiction, experience of loss (death, divorce), loneliness etc.

Protective factors

- Social support, having a good social network
- Education/knowledge
- Coping strategies, like dealing with such experiences in an open and direct way
- Having interest in the world
- Good health
- Good knowledge about oneself, abilities resources

Symptoms of trauma

- What we can observe is that in the long run people change through traumatic experiences in perception, in thinking, in relating to other people about their environment and about themselves.
- They often feel like a stranger to themselves and they feel emotionally numb.

1) Short term consequences are Symptoms which appear immediately after a traumatic experience

- Physical reactions: Heartbeat, high blood pressure, tension in the muscles, breath is going high, trembling, digestion problem
- Emotional reactions: Being fearful, desperate helpless and upset, aggressive, shame (because of loss of control), uncontrolled mourning
- Thinking: Difficulties to concentrate, not being able to think, chaos or emptiness in the head, wondering (what would have been if???), accusing oneself, being disorientated
- Behaviour: Is a picture of the emotional state: Restless, nervous, aroused, acting without an aim or plan, numbing behaviour (drugs etc)
- Dissociation: Seeing the happenings from the outside like through a glass wall, believing it is not true.
- Depersonalisation: Own feelings are not considered to belong to oneself, functioning like an automatism

- Corrective factors to treat short-term consequences**:**

⇒ Physical and psychological help and resources
⇒ To create a narrative memory of the event
⇒ To put it in the life context
⇒ To realise its subjective meaning
⇒ Acceptance of change of lifestyle

2) Chronic symptoms can develop some time after the traumatic event, and can be categorized in intrusive and constrictive symptoms:

- **Memory flashbacks:** Sudden appearance of painful memories of the traumatic experience where the person feels the same threatening situation with all the related features of fear from death, panic, escape and preparedness to fight
- **Hyper arousal syndrome:** Hyper vigilance, a constant feeling of escape and preparedness to fight, nervousness, nightmares and somatic symptoms like sleep disorders, increased blood pressure, heart palpitation, shivering.

  ⇒ **Persistent concentration disorders**
- **Avoidance syndrome:** Active avoidance of people and places that remind of the events and a passive avoidance of feelings due to being afraid of experiencing intensive feelings the same as those experienced during the traumatic experience.

  ⇒ **Dissociation**

One of the characteristics of these symptoms is that they are uncontrollable. The person experiences it as if it is part of him/herself, which he does not really know. It acts by its own self. This causes again fear and panic.

According to western diagnosis system it is called a PTSD, if 4 of those symptoms continue to stay and even increase 6 months after the event.

Side effect:

- Victimisation
- Loss of meaning in life
- Loss of identity

This leads very often to more problems:

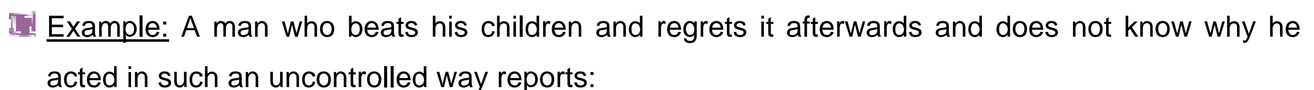
- Fear
- Depression
- Suicidal thoughts and attempts
- Problems in relationships, family
- Sexual problems

- Addiction
- Somatic complaints

Trauma and domestic violence

During the three decades of war, the level of domestic violence has been increasing both in quantity and quality. According to our experience, increasing level of domestic violence can be a result of PTSD.

- One of the characteristics of PTSD symptoms is that they are uncontrollable and the person experiences it as if it is part of him/herself, which he does not really know that it acts by its own self.



Example: A man who beats his children and regrets it afterwards and does not know why he acted in such an uncontrolled way reports:

⇒ *"During the day I am getting more and more nervous and at a certain point, I loose control and when something falls to the ground or someone is shouting loud, I loose control and start beating my children."*

⇒ Through counselling the man can discover how his nervousness is connected to his past traumatic experiences. He can learn to identify the signs of the upcoming arousal and find a way together with the counsellor how to control it.

⇒ Also by treating the PTSD the symptoms diminished to such an extent that they did not have such a negative impact on his life anymore.

- Another characteristic of these symptoms is the feeling that the threatening situation is still there

⇒ The experience is not integrated into the biography and narrative memory of the person.

⇒ Moreover there is no coherent memory of the experience; it is split into different parts.

⇒ This is why such a person always reacts as if he/she is still threatened.

- The whole system of stress regulation is out of balance.
- In a way we have to see that such reactions to such horrible experiences are normal reactions to an extraordinary situation.

- But the impact disrupts family interaction and relationships and damages so the most important resource for Afghan people.

Trauma and social isolation

- These symptoms frequently cause people to retreat within the family and from society.
- They fall into social isolation and cut them off from their most important resource (the family).
- Another point which can be observed if someone feels unable to control his inner life, he starts in a compensatory way to control his outer life. This often hurts the women and children in the family.

Trauma and addiction

- In regard to reduce internal feeling of restlessness and tension, some people are starting to use alcohol or drugs

Referral:

If you discover and diagnose a posttraumatic stress or PTSD case, refer the patient for further treatment to the psychosocial counselor

Severe Mental Disorders or Psychotic disorders

Psychosis is a mental state characterized by loss of contact with reality. During the psychotic state the consciousness is not changed. The symptoms include 'positive symptoms' (phenomena that are present in the person with a psychosis while they are absent in a normal person) such as delusions, hallucinations and thought disorder and 'negative symptoms' (phenomena that are absent in the person with psychosis but are present in normal person). There are usually a number of 'other symptoms' that are often present but are not specific for psychotic disorders: sleep disturbance, agitation, behavior changes, social withdrawal and impaired role functioning.

Delusions

Delusions are false thoughts that are not shared by anyone else in the affected person's environment. The person with delusions is convinced that her/his ideas are the truth, even if there are signs that prove that s/he is mistaken. The person persists with these ideas. Examples:

- Believing that people are trying to poison or kill him/her, even when there is no evidence in support of this notion
- Suspecting that everyone is talking about him/her on the streets or on the radio
- Being convinced that persons have implanted radio equipment in her/his body so that someone else can keep track of her/his actions
- Being certain that s/he has a lethal disease such as cancer or AIDS, while all medical tests show that s/he does not have one
- Thinking that s/he is very famous or rich, when this is known not to be true

Hallucinations

When a person hallucinates, s/he is seeing or hearing things that are not real, and is convinced that they are real.

Examples:

- Hearing things that no one else can hear
- Voices talking to him/her, commenting on him/her
- Voices in her/his head
- Strange sounds or music coming from unknown places
- Seeing things or persons that no one else can see

The person sometimes keeps silent about these things because s/he realizes that other people do not believe him. Often, however, s/he reacts to the hallucinations as if they are real. For example, s/he may talk or shout in response to someone that is not actually there.

Disturbed Thinking

When a person's thinking is disturbed, s/he may talk in a way that other people cannot understand what s/he is saying, or follow her/his line of reasoning. There seems to be no logic behind her/his words. Sometimes the person may even talk pure nonsense, using made-up words or incomplete sentences.

Unusual or bizarre behavior

A psychotic person may also display chaotic behavior, or behavior that is disorganized. When s/he starts an activity, it become a mess or is not completed.

Examples:

- Wearing clothes in a strange or inappropriate way
- Collecting or keeping things that have no value
- Destroying things without realizing what is happening
- Sitting motionless, without moving, for a very long time
- Laughing suddenly when nothing funny has happened
- Crying without a clear reason
- Showing indifference toward things that are generally relevant (for example, food, clothing, money)

Negative Symptoms

By "negative symptom," we are referring to the absence of certain normal or characteristic behaviors.

For example:

- Absence of emotions: the person feels indifferent, nothing seems to make him/her happy, sad or angry
- Absence of initiative: the person does not feel inclined to take action; s/he is not motivated to accomplish anything
- Absence of interest: the things that interested the person before s/he became sick do not interest him/her anymore, such as listening to the radio, hearing news about relatives, discussing politics or economics
- Absence of movement: the person can sit quietly and motionless for a long time

<u>As a general guideline:</u> when a person has more than two of the above mentioned symptoms, a doctor can make a diagnosis of psychosis. This diagnosis may be further supported by observations of the patient's behavior or reports made by the patient's family.

The causes for psychosis are not well established but there are many risk factors for developing psychosis,

<u>Some risk factors are:</u>

Biological	
	Genetic vulnerability Use of substances e.g. cannabis Complication during pregnancy Brain damage and infections Neurodevelopmental problems Changes in neurotransmitters in brain
Psychological	
	Stressful life events, Disturbed family environment, Traumatic experiences, Being sexually abused
Social	
	Bereavement, Displacement, Migration. Witnessing a violence, Being subject to violence,

There are different types of psychosis:

1. Acute psychosis (including psychosis that is induced by drugs such as cannabis)
2. Schizophrenia or chronic psychosis
3. Postpartum psychosis

There are also other disorders that present with psychotic symptoms:

4. Bipolar disorder, mania
5. Depression with psychotic symptoms (for discussion see the section on depression)

6. Organic conditions affecting the brain

I Acute Psychosis

1. Clinical features:

An acute psychosis may be associated with external factors such as the use of, or withdrawal from alcohol or drugs. This is known as 'drug-induced psychosis. Sometimes an acute psychosis can develop in response to a major stress in the person's life.

Common symptoms of acute psychosis are positive symptoms such as:

- Severe behavioral disturbance such as agitation and aggression

Delusions such as:

- Being poisoned or plotted to be harmed,
- Being under black magic (Jado),
- Possession by jinn, being controlled by unknown forces,
- Being cursed or abused,
- Hallucinations e.g. hearing voices or seeing things others cannot or feeling as if insects crawling under skin etc
- Disorganized speech or talking nonsense
- Fearful emotional state or rapidly changing emotions

Acute psychosis is a common psychiatric emergency that may present to health services.
It is confusing, distressing and disruptive for the person and their family.

2. **Possible risks**

- Stigmatization
- Develop into chronic psychosis
- Substance abuse
- Depression and suicide
- Unemployment
- Relationship problem

3. Mental status examination

In acute psychosis one commonly finds these symptoms:

- Change in appearance such as restlessness, agitation or decreased activities, self talk, self laugh, poor rapport, reduced eye contact, low self care, no cooperative, withdrawn.

- Speech: flight of ideas (very fast speed of thought, going from one point to the other), reduced content, slow talk, thought block
- Thought: delusion of persecution and reference, delusion of being controlled, bizarre beliefs
- Perception: Hallucinations such as hearing voices, seeing things, unusual smelling or insect crawling under skin etc
- Inappropriate or rapidly changing emotions
- Problem with concentration
- Problem with abstract thinking
- Poor judgment and insight

4. Diagnosis

Diagnosis is based on clinical findings. No confirmatory laboratory or radiological tests are available, although investigations may be needed to rule out organic causes. Other forms of psychosis should be differentiated from acute psychosis. Tips in diagnosis of acute psychosis:

- Onset is sudden
- Stressor is present
- Prominent positive symptoms e.g. delusions, hallucinations
- Agitation is common

5. Treatment

Treatment of acute psychosis is pharmacologic, psychosocial intervention needed if stressors are present. Appropriate treatment plan should aim at:

- Reducing the degree of disruption created by the psychosis
- Reducing secondary morbidity
- More rapid recovery
- Improving outcomes

The same medication is used for acute psychosis and for chronic psychosis (schizophrenia). The antipsychotic medication is described in the section on schizophrenia.

The main difference is that in acute psychosis the duration of medication can be much shorter (several weeks to months) while in schizophrenia it is much longer. Duration of treatment for acute psychosis is about one month, most patient recover within this period and may not have second episode.

6. Follow ups

Follow up is important in early stage of treatment for adjusting the dose of medication, compliance, assessing side effects and symptoms control, family support or referral to psychosocial care if needed.

II Schizophrenia or Chronic psychosis

Schizophrenia is a severe mental disorder characterized by positive and negative psychotic symptoms. If treated partially or left untreated, schizophrenia can cause significant and long-lasting impairment and disabilities, affecting all aspects of human functioning.

1. **Clinical features**:

Early symptoms of schizophrenia are mild with gradual change in person's behavior. Family members may attribute it to others issues such as work problems, study problems etc. Common early symptoms are:

- Reduced concentration, attention
- Reduced drive and motivation
- Depressed mood
- Sleep disturbance
- Anxiety
- Social withdrawal
- Suspiciousness
- Deterioration in role functioning
- Irritability

Usually such changes go unnoticed by family members for weeks, when full blown symptoms such as agitation, delusions, hallucinations etc appear. When the symptoms trouble the person for longer than 1 month and s/he is unable to function normally for longer than 6 months, we call the disease schizophrenia. In the beginning, the symptoms may not reach a psychotic state. Both positive and negative symptoms can be present in schizophrenia with fluctuating severity. In acute phase positive symptoms are prominent while in chronic cases negative symptoms.

Among the typical positive symptoms of schizophrenia are

- Paranoid delusion: Any delusion that refers back to the self, also called persecutory delusions such being poisoned, plotted for killing, spying etc
- Grandiose delusions such as having special powers or missions
- Delusions of thought interference: that others can hear, read, insert, or steal the patient's thoughts
- Bodily sensations being imposed by some outside agency

- Passivity phenomena: these are delusional beliefs or perceptions that others can control the patient's will, limb movements, bodily functions, or feelings
- Thought echo: The patient hears his/her own thoughts spoken aloud
- Auditory hallucinations as voices speaking about the patient may include a running commentary on the patient's actions.
- Thought disorder: Breaks in the train of thought e.g. thought block and difficulties in abstract thinking for example, cannot explain proverbs or common sayings.

The following negative symptoms are common in schizophrenia:

- Apathy or blunted or flat affect
- Inappropriate affect e.g. Patient smiles when recounting sad events.
- Anhedonia or lack of pleasure in everyday life
- Lack of energy
- Lack of motivation
- Lack of self care skills
- Reduced verbal and non-verbal communication e.g. no eye contact.
- Lack of spontaneity and flow of conversation
- Diminished ability to initiate and sustain planned activity

Other symptoms can be present also:

- wondering around, collecting trash, talking and laughing to self, talking to jinns, unusual physical complaints such as having a snake inside brain, or an animal in the body, absence of body organs, denying recognizing relatives,

2. Possible risks and complications

Common risks of schizophrenia are depression, suicide, substance abuse, relationship problems, and social withdrawal. Early diagnosis and treatment considerably reduces such risks. Delayed treatment can result to:

- Slow and incomplete recovery
- Interference with psychological and social development
- Difficulty in relationships, loss of family and social supports
- Disruption of parenting role in young mothers and fathers
- Disruption of study or employment
- Increased stress in the family

- Poorer prognosis
- Depression and suicide
- Substance abuse
- Unnecessary hospitalization
- Increased economic cost to the community

Course and outcome of schizophrenia:

- About 45 per cent recover after one or more episodes.
- About 20 per cent show constant symptoms and increasing disability.
- About 35 per cent display a mixed pattern, with varying degrees of improvement or deterioration.

3. Mental status examination

The following can be commonly observed in patients with schizophrenia:

- Behavior and appearance: Reduced psychomotor activity (chronic) , or agitation (acute), no eye contact, difficult to establish rapport, reduced self care
- Speech: Thought disorder e.g. low tone and reduced rate of talk or limited content of talk, thought block, losing track of talk, unconnected thoughts etc
- Thought: Delusion: paranoid delusions, delusion of reference, grandiosity, delusion of control e.g. thought broadcast, insertion or withdrawal
- Perception: Hallucinations: auditory, visual, tactile etc
- Mood and affect: blunted affect, inappropriate affect,
- Cognitive functions: problem with concentration, problem, with abstract thinking, poor judgment, lack of insight.

4. Diagnosis

The onset of schizophrenia is generally gradual, and rarely sudden. Characteristic positive symptoms are helpful in diagnosis during acute phase. In acute phase positive symptoms are prominent but negative symptoms also can be present. Early diagnosis is very important, however in most cases patient is brought late for treatment. Advantages of early recognition and treatment are:

- Minimizing: Subjective distress, positive symptoms, anxiety and depression
- Reducing: Frequency of relapse, cognitive deterioration, loss of personal self care skills etc

- Limiting: Social disruption and deterioration, loss of family support and social networks, loss of interpersonal skills etc.

5. Treatment

Management of schizophrenia requires pharmacological, psychosocial, and social approaches, depending on the stage of the illness. The first approach is pharmacologic to control positive symptoms with antipsychotics. Psychosocial interventions can be applied when severity of symptoms are reduced. Psychosocial interventions minimize distress and reduce frequency of relapse and help developing social skills as well.

Specific treatment goals in schizophrenia are the following:

- Ensuring the safety of the patient and family.
- Evaluating and treating precipitating factors.
- Rapidly resolving the patient's psychotic symptoms.
- Establishing an effective and well-tolerated medication regimen.
- Beginning transitional phase to maintenance treatment.

Pharmacotherapy

Most patients with psychosis will benefit from medication especially designed to treat psychosis. These are called Anti Psychotics (AP). There are several types of anti-psychotic medications, such as:

- Chlorpromazine (Largactil)
- Haloperidol (Haldol)
- Flufenazine Decanoate injections

To combat the side effects of the antipsychotic treatment one can add:

- Biperiden
- Trihexyphenidyl

If patient is very disturbed and agitated, rapid control of agitation is essential before starting other steps in treatment. In severe agitation injectable antipsychotics should be tried (chlorpromazine 50 mg IM or haloperidol 5 mg im) These injections can be repeated, however when patient is cooperative switch to oral preparations

Therapeutic indications include short-term management of acute psychoses and agitated states as well as long-term treatment of chronic psychotic disorders such as schizophrenia. There is no

evidence that high doses lead to a more rapid response or to improved efficacy but there is always risk of severe side effects with high doses. Chlorpromazine and haloperidol are listed in essential medicine for treating psychosis.

Injections against acute agitation:

If patient is agitated and endangers others, give injectable antipsychotic medication either

- chlorpromazine 50mg IM or
- haloperidol 5mg IM

Usually one or two injection improves aggressive behavior, after that switch to oral antipsychotics.

Oral antipsychotics

- Chlorpromazine 200 mg at the beginning in divided doses, increase 100 mg every 2-3 days (max 600 mg)
- Haloperidol 5-15 mg, starting with low dose and increase gradually every 2-3 days.

If these do not work properly given in an appropriate dosage for an appropriate duration, it is important find out why. If the treatment does not work because the patient refuses to take tablets by mouth, then switch to injections of flufenazine.

Long acting antipsychotics

When a patient is unable to take the medication orally one can prescribe long acting injections with antipsychotics. In the Afghan Essential Druglist one long acting antipsychotic is mentioned: Flufenazine decanoate (25 mg/ml)

Duration of treatment:

Anti-psychotic medication works gradually. It may take weeks before it shows its full effect.

- Within hours: A patient who is very agitated becomes less aggressive. S/he feels more relaxed and sleepy.
- Within days to weeks: The patient sleeps better and hallucinations (voices/sounds) occur less frequently or are not as loud.
- After weeks: The delusions decrease. The patient may seem less convinced that her/his ideas are the truth, or even doubt about her/his delusions.

In chronic psychosis, the medication has to be taken for a long time—usually for more than a year. The patient should continue even when the symptoms of psychosis seem to have disappeared. Complete instructions should be given to patients and their family members.

Side Effects of Antipsychotics

- Chlorpromazine, haloperidol and flufenazine can all cause side effects. The most important side effects of antipsychotics are:
- Parkinsonism: stiffness, tremor, slow movements, can he managed with oral antiparkinson medication e. g., trihexyphenidyl 2-4 mg/day or Biperidin 2-6mg/day.
- Acute dystonia: acute muscle spasms. Usually of the muscles of the neck or the face (jaw, tongue). It can be managed with inject able benzodiazepines or Antiparkinson medication
- Akathisia: severe motor restlessness. It can be managed with dosage reduction of antipsychotic or a beta-blocker such as Propranolol 20-40m/3times)
- Tardive dyskinesia: a rare complication of antipsychotics which appears after a prolong treatment. It is characterized by abnormal repetitive movements in face, lips, trunk etc. Early recognition and discontinuation of treatment is necessary.

Important tips:

- Discuss treatment plan with patient
- Antipsychotic drugs should be chosen after considering their relative side effects
- Use only one antipsychotic drug at a time
- Start low - go slow
- Use minimum dose required to maintain remission and avoid side effects
- Monitor symptoms and side effects
- Switch to another AP if symptoms does not respond to adequate dose in 4 weeks
- For long term treatment in non compliance, depot injections can be used

Summary table pharmacotherapy (psychosis)

Drug	Indications	Contraindications	Side Effects	Dosage
Chlorpromazine (100 mg tablets; 25 mg/ml injection)	Psychosis Severe agitation and violent behavior in patient with organic disorders	Pregnancy, especially first trimester Severe hypertension Liver damage Young age (not for use in children)	Sleepiness (sedation) Dizziness (orthostatic hypotension) Sexual disturbances Acute muscle	Start with 200 mg in two divided doses two times/day Increase up to 600 mg in two divided doses/day

Drug	Indications	Contraindications	Side Effects	Dosage
	(delirium dementia) Mania Severe agitation and violent behavior		spasm (dystonia) Restlessness of legs Parkinsonism	**Note**: Stop the drug or reduce the dose if the patient's blood pressure drops, particularly when standing up.
Haloperidol (5 mg tablets)	Psychosis Severe agitation and violent behavior in patient with delirium and dementia Mania		Sleepiness (sedation) Sexual disturbances Acute muscle spasm (dystonia) Restlessness of legs Parkinsonism	Start with half tablet of 5 mg/day Increase to 5 mg/day or, if needed, 10 mg/day Usual maintenance dosage is 5–10 mg /day
Flufenazine decanoate (25 mg/ml ampules for intramuscular injection)	Chronic psychotic disorders	Severe acute muscle stiffness with chlorpromazine or haloperidol		Start with half ampule of 25 mg intramuscular injection After 14 days, give 25 mg intramuscular injection Maintenance dosage is 25–50 mg/month

Drug	Indications	Contraindications	Side Effects	Dosage
Biperiden (2 mg tablets; 5 mg/ml ampules for injection)	Side effects from other anti-psychotic medications			For Parkinsonism caused by an anti-psychotic, 2 mg twice daily For severe, acute dystonia, 5 mg IM injection

Psychosocial interventions

Psychosocial interventions in schizophrenia are important. Psychosocial interventions and involving patient in appropriate activities help the patient to:

- Improve social skills
- Contributing to family income
- Divert the mind of the person
- Increase self esteem
- Reduce stigma
- Bring an order to life
- Integrate the person into community

a) Education of Patient

It is important that the patient realizes that s/he has a disease. Often patients with psychosis do not accept this. The health worker should realize that the patient is often extremely fearful and perceives the world as hostile and dangerous. A health worker has to adopt a friendly approach, and explain things in a kind and understanding manner. Try to motivate the patient to go back to work and think of himself/herself as part of the community.

b) Education of Family

- Advise the family that the strange behavior and the agitation of the patient are caused by the disease.
- Discuss the importance of medication.
- Inform them about the importance of minimizing stress:
- Do not argue with the patient about her/his psychotic beliefs. Do not say that you agree with her/his ideas, either, but respect them.
- Avoid confrontation or criticism.
- When the symptoms are severe, rest and withdrawal can be helpful.
- Recommend a structured daily life: the same pattern every day helps the patient feel safe.
- Advise them to find activities that help distract the person from her/his thinking, and make him/her feel valuable.
- Encourage them to find suitable work for the person. Occupational or vocational training and employment in a protected environment will help.
- Discourage the use of hashish.

c) Education of Community

Basic information about the disease can be helpful for neighbors and community leaders. A doctor can ask the community health worker to provide this information.

III Post partum psychosis (PPP)

Psychotic changes can occur after childbirth, a mother may develop an acute and serious psychotic disorder. Symptoms of psychosis often become obvious in the first 2 weeks after the delivery.

Common symptoms are:

- Confusion, disorientation and agitation.
- Bizarre behavior.
- Wandering around
- Self talk or laugh
- Neglect of self care
- Neglect of baby
- Delusions and suspiciousness
- Beliefs that the newborn is possessed or a child of Satan.
- Hallucinations
- Risk of self harm or harming baby
- Labile or inappropriate affect
- No insight of the problem

Women with a personal history of psychosis, bipolar disorder or schizophrenia have an increased risk of developing postpartum psychosis, likewise, women who have a family history of above disorders have a greater chance of developing the disorder. Also women who have had a past incidence of postpartum psychosis are more likely to experience it again in a future pregnancy.

Postpartum psychosis is a mental health emergency and requires immediate attention to prevent risk to mother and the baby. Family members should remain with the patient at all times. Often hospitalization is required for women with postpartum psychosis. If this is not possible or the family of the woman refuses hospitalization the patients needs to be guarded at all times, the family has to ensure that the medication is taken according prescription, and the patients needs to be regularly checked.

Medications used to treat postpartum psychosis are the same of for acute psychosis. Anti-psychotic medications do pass into the mother's breast milk. Subsequently if the mother has been breastfeeding and continues to do so, the baby needs to be monitored for drowsiness or lethargic behavior, and prescribing the least amount of anti-psychotic medication in order for symptom reduction to occur is also crucial.

IV Bipolar disorder: Mania

Clinical features:

Bipolar disorder is defined as episodes of mania or hypomania alternating with episodes of depression. Signs and symptoms of mania (or a manic episode) include:

- Increased energy, activity, and restlessness
- Excessively high mood, euphoria
- Extreme irritability
- Racing thoughts and talking very fast, jumping from one idea to another
- Distractibility, difficulty in concentration
- Decreased need for sleep
- Delusions: unrealistic beliefs in one's abilities and powers
- Poor judgment
- Risk taking behavior e.g. spending too much, starting new business, using more substance or alcohol,
- Increased sexual drive, risk of HIV/AIDS
- Abuse of substances or alcohol, and sleeping medications
- Provocative, intrusive, or aggressive behavior
- Denial that anything is wrong

1. Possible risks

- Abuse of substances or alcohol
- Suicide attempt
- Legal problems
- HIV/AIDS

2. Mental status examination

Main changes that can be observed:

- Restless or agitated person (increased psychomotor activity), anger outburst can be seen, talkative (starts without asking any question), cooperative, well dressed, greets, high self esteem, sarcastic.
- Speech: Talkativeness, flight of ideas and racing thoughts, frequent change of topics

- Thought: Inflated ideas and grandiosity, can have persecution related to grandiosity of being influential
- Perception: hallucinations such as voices telling patient is an influential
- Affect; euphoria (abnormal happiness), irritability
- Distractibility and poor attention
- Poor judgment (Not accepting illness)

3. Diagnosis

Diagnosis of bipolar disorder is made on the basis of symptoms, course of illness, and, when available, family history. Mania typically presents with hyperactivity, an elevated or excessively irritable mood, sleep loss, pressure of speech, and flight of ideas. A mild to moderate level of mania is called hypomania. Psychotic symptoms during mania are often similar to those seen in acute psychosis and schizophrenia, etc.

4. Treatment

Discuss treatment plan with patient and family members. Medication is the key to stabilizing bipolar disorder. Psychosocial interventions are helpful when patient is stable after taking medication. Initial treatment of mania consists of valproic acid or carbamazepine. If the patient is psychotic, an antipsychotic medication is also given. When the patient with bipolar disorder becomes depressed, a selective serotonin reuptake inhibitor (SSRI) e.g. fluoxetine is recommended, while at the same time continue the valproid acid or carbamazepine to prevent that the antidepressives will precipitate hypomania or mania.

Recommendations for pharmacotherapy based on essential medicine list are:

- In initial phase with extreme agitation and dangerous behavior antipsychotics: haloperidol 5mg IM if not available chlorpromazine 50-100mg IM
- As soon as patient is cooperative switch to oral antipsychotics
- When agitation is controlled prophylactic treatment can be started.

<u>Prophylactic treatment:</u> Some anticonvulsants have mood stabilizing property and can be used for treatment of bipolar disorder.

- Valproic acid: 500 to 750 mg daily; lower dosages may be used in hypomania. Sometimes it is appropriate to give as a single bedtime dose; otherwise twice-daily dosing.
- Carbamazepine: 200 to 600 per day; Starting with small doses increase by 200 mg daily every 2 to 4 days , it is appropriate to give a single bedtime dose; otherwise, twice-daily dosing.

Treatment with mood stabilizers requires periodic laboratory tests, initially to monitor the patient's response to the drug.

What Doctors would do?

1. Assessment:

- Exploring symptoms of Mania
- Exploring the severity of the symptoms.
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life
- Exploring risk-taking behavior.

Most importantly information about:

- Bipolar disorder in the family
- Physical diseases in patient
- Use of medication
- Use of substances or alcohol
- Person's personality before illness
- Changes in the person's life before the illness
- Use of traditional remedies
- If the patient is chained

2. Referral to higher level

- Symptoms are severe
- There is a suicide attempt or risk of suicide
- There is possible associated physical illness
- Initial treatment was not effective
- Psychotic symptoms are persistent

Important tips:

- Changes in mood and behavior are symptoms of an illness
- Avoid confrontation with patient, unless to prevent harmful or dangerous acts
- Effective treatments are available
- Hospitalization is for the safety of patient and family members
- Long-term treatment can prevent future episodes.

- Without treatment, patient may become disruptive or dangerous.
- Mania often leads to loss of job, financial problems or high-risk sexual behavior etc.
- Close observation by family members is often needed
- Treatment is more successful with strong support from family
- Stress may put people, who had mania in the past, into extremes mania
- Signs of relapse can be identified by family members
- Regular appointments for follow up is very important
- Stigma and discrimination is common

2. Psychosocial counseling and psycho education:

- Educating patient and the family on the nature of symptoms, duration of episodes and changes over time, risk taking-behavior, psychosocial stressors, consequences including suicide, treatment, follow up, relapse and its prevention.
- Psychosocial intervention depends on the psychosocial stressors and enhanced family support.

3. Follow up:

- During follow-up, doctor should monitor the patient for signs of psychosis, mood swings, violence and self-harmful behaviors and most important for psychosocial interventions. When the patient's condition has become stable, the doctor may not need to see the patient as often, although the frequency of follow-up visits depends on the course of the illness, the patient's adherence to treatment, medication requirements, the need for ongoing psychotherapy and patterns of care in a particular geographic area.

Important tips:

- Monitoring suicidality, change in mood, substance use, sleep patterns and medication compliance.
- Educating patient and family members about features and nature of the illness and the importance of compliance with therapy.
- Setting limits on impulsive behavior in patients with mania which can be discussed in family meetings.

Childhood Mental Disorders

I Mental Retardation

1. **Clinical features**:

Mental retardation is a developmental disability which appears in childhood and is defined by level of intellectual functioning (measured by standard intelligence tests) which is lower then average and results in significant limitation in person's adaptation functioning.

1. Intellectual functioning level is defined by standardized tests that measure the ability to reason in terms of mental age (intelligence quotient or IQ).
2. Mental retardation is defined as an IQ score below 70.
3. Adaptive skills are a term that refers to skills needed for daily life. Such as

- Communication skills: Ability to produce and understand language
- Home-living skills
- Use of community resources
- Social skills and health, safety, leisure, self-care
- Self-direction
- Functional academic skills (reading, writing, and arithmetic)
- Job-related skills.

Low IQ scores and limitations in adaptive skills are the hallmarks of mental retardation. Children who are mentally retarded reach developmental milestones significantly later than expected but not all. IQ is not required in acute cases to make the diagnosis. Diagnosis is based on clinical observation and history.

Common features in mental retardation are:

- Delayed developmental milestones such as
  - Motor: sitting up, crawling, walking, climbing stairs etc
  - Language: delayed speaking, difficulty pronouncing letters or words
  - Social: smiling, recognition of parents and others etc.
- Continued infantile behavior
- Decreased learning ability e.g. difficulties in school, difficulty in learning new things etc.
- Lack of curiosity
- Difficulty in self care
- Failure to meet intellectual developmental markers according to age
- Behavior problems e.g. temper tantrums, head banging, bedwetting, aggression etc

Common behavior problem with MR:

- Self-injuring behavior: skin picking, head banging, biting
- Stereotypy behavior: rocking; hand flapping, certain noise
- Aggression or destruction of households
- Sexually offending behavior: inappropriate touch, hypersexuality, sexual abuse
- Sleep disturbance
- Hyperactivity, frequent move, inability to sit
- Attention deficit; difficulty concentration

Mental retardation comprises four general categories: mild, moderate, severe and profound. Categories are based on scores obtained through use of age-standardized tests of cognitive ability.

Developmental Characteristics Related to Level of Mental Retardation

Mild MR	Moderate MR	Severe MR	Profound MR
>75% cases of MR	10-25% cases of MR	8-10% cases of MR	1-2% cases of MR
IQ: 50 to 70	IQ: 35 to 49	IQ: 20 to 34	IQ: < 20
Slow in all areas	Noticeable delays, especially in speech	Marked and obvious delays; walks very late	Marked delays in all areas
May have no unusual physical signs	May have some unusual physical signs	Little or no communication skills se	Congenital abnormalities often present
Can acquire practical skills	Can learn simple communication	May be taught daily routines and repetitive activities	Need close supervision
Useful reading and math skills up to grades 3 to 6 level	Can learn elementary health and safety habits	May be trained in simple self-care	Often need attendant care
Can conform socially	Can participate in simple activities and self-care	Need direction and supervision	May respond to regular physical activity and social stimulation

Some causes of mental retardation are:

- Congenital infections such as cytomegalovirus, toxoplasmosis, herpes, syphilis, rubella and HIV etc
- Prolonged maternal fever in the first trimester
- Exposure to anticonvulsants or alcohol
- Complications of prematurity, especially in extremely low-birth-weight infants
- Metabolic disorders: hypothyroidism, phenylketonuria (PKU)
- Genetic abnormalities: fragile X syndrome, neurofibromatosis, tuberous sclerosis etc
- Brain Infections e.g. meningitis, encephalitis, etc
- Head Trauma during labor or latter in life
- Chromosomal abnormalities e.g. Down syndrome (trisomy 21)

2. Risks

- Mental health problems such as self injury, aggression, obsessive-compulsive disorder, attention-deficit/hyperactivity disorder, and mood disorders can occur in persons with mental retardation and, when left without treatment, may lead to more challenging behaviors.

3. Diagnosis

- Diagnosis is dependent on a comprehensive personal and family medical history, a complete physical examination and a careful developmental assessment of the child. The diagnosis of mental retardation in young children is frequently missed.

The three most common errors made by clinicians who overlook the possibility of mental retardation are:

- Normal appearance (child does not look retarded)
- Child who is ambulatory is unlikely to be retarded
- If retardation is actually considered, concluding that it is not possible to test young children
- Failing to consider the diagnosis.

Some helpful clues for diagnosis include delayed speech, minor anomalies, hypotonia generally or of the extremities, general inability to do things for self and expressed. Delays in speech development are common and may become more obvious when contrasted with the speech development of a sibling.

Patients with mental retardation often have multiple and sometimes complicated medical problems.

4. Treatment

MR is not a mental disorder but MR person can develop mental disorders e.g. depression, anxiety disorder, psychosis, substance abuse etc. There is not treatment for MR, treatment will focus on associated diseases e.g. epilepsy or coexisting mental disorder. The approach is individualized education and skills training. Psychosocial counseling should be considered for mild to moderate mental retardation. As long as possible medications should not be used to restrict behaviors, except for short-term intervention in patients self harm and are aggressive to others, Medication is needed for other medical problems such as epilepsy. For any mental problems psychosocial intervention should be first choice.

What Doctors would do?

1. Assessment:

- Exploring early difficulties and current problems
- Exploring the severity of problems
- Exploring psychosocial stressors
- Impact of problems on person's daily life.

Most importantly information about:

- Similar problem in family
- Use of substances or alcohol
- Risk of self harm
- Use of traditional remedies

2. Referral:

- Severe behavior problems
- There is risk of suicide
- There is possible associated physical illness
- Initial counseling was not effective
- Psychotic symptoms are present

3. Psychoeducation and psychosocial counseling:

- Educating patient and the family on the nature of symptoms, duration and changes over time, possible risk factors, psychosocial stressors, consequences, treatment, follow up, relapse and its prevention.

Some important tips:

- Early training can help towards independence and self-care.
- There is no cure for mental retardation
- Mental retardation is not the fault of the child
- Mental retardation is not a punishment for the sins.
- Some children may be disruptive or overactive
- A mentally retarded child can learn many things; it just takes them more time and effort than other children.
- Teaching the child requires a lot of patience and encouragement.
- Praise the child when s/he is doing something well than to punish her/him when a mistake is made.
- These children are capable of loving relationships.
- Families may feel great loss or feel overwhelmed by the burden of caring for a retarded child.
- Children and adults to be allowed to function at the highest level of their ability in school, work and family.
- Parents can share practical advice and emotional support.

4. Follow up:

- Follow up depends on the treatment plan for behavior problem, mental disorder and physical conditions doctor takes care of.

Substance abuse and dependence: Heroin and opium

According to 2005 survey conducted by Ministry of Counter Narcotics and UNODC there are some 920000 substance users in Afghanistan from which 150000 is opium user and 50000 is heroin user. This study found that 80% of all users were male, 13% female and 7% were children. On the other hand the most alarming finding was that 15% of heroin users were injecting heroin which puts the figure around 7000 person. Injectable users are prone to getting or spreading HIV/AIDS and hepatitis infections.

1. **Clinical features**:

The term “opioids” includes “opiates” as well as semisynthetic and synthetic compounds with similar properties. The existence of opioid receptors suggested that these receptor sites might be the targets for opiate-like molecules that exist naturally in the brain. Use of opioids causes some behavioral effects such as euphoria, analgesia, sedation and respiratory depression. The euphoric and sedative effects are the reason for continued use. Long term use results to change in learning and stress adaptation response.

<u>The stage of dependence is clinically defined by at least three of the following:</u>

- A strong desire or sense of compulsion to take the substance;
- Difficulties in controlling substance-taking behavior in terms of its onset, termination or levels of use;
- A physiological state of withdrawal;
- Evidence of tolerance;
- Progressive neglect of alternative pleasures or interests;
- Persistent use despite clear evidence of overtly harmful consequences.

Opioid withdrawal

Patients experiencing opioid withdrawal can usually provide an accurate history of their usual dose, the timing of their last dose, and of any other current symptoms. The clinical problem is in differentiating symptoms associated with opiate withdrawal from symptoms that may reflect an underlying medical or psychiatric illness.

In general, opioid withdrawal does not directly cause life-threatening symptoms, seizures, or delirium.

Opioid withdrawal syndrome may resemble a severe flu-like illness. The syndrome is characterized by rhinorrhea, sneezing, yawning, lacrimation, abdominal cramping, leg cramping, piloerection (gooseflesh), nausea, vomiting, diarrhea, and dilated pupils.

The half-life of the opioid causing withdrawal syndrome determines the onset and duration of symptoms. For example, heroin and methadone withdrawal symptoms peak in 36-72 hours and 72-96 hours, respectively, and may last for 7-10 days and at least 14 days, respectively.
Common withdrawal symptoms of opium and heroin are as follow:

Body pain	Increased pulse rate
Restlessness	Rapid breathing
Sleep problems	Salivation
Abdominal pain	Nasal stuffiness
Diarrhea	Vomiting
Trembling muscles and muscle cramps	Strong desire to use again
Anxiety	Sweating
Depression	Enlarged pupils
Sneezing and yawning	Tremors
Irritability	Lack of appetite

2. Risks and complications

Many complications can result from narcotic abuse, the most common being infectious conditions. Effects of chronic use are lowered sexual desire and impotence in men. Injecting heroin can cause infections of the blood. In communities of heroin users HIV/AIDS can be rapidly spread. Infections of the skin and deeper layers are the common infection in heroin dependence.

- Abscesses in skin, and other organs e.g. lungs
- Pneumonia
- Fluid in the lungs
- Liver dysfunction
- Intestinal slowdown
- Seizures
- Loss of menstruation
- Premature and slow growth infants
- Baby withdrawal symptoms if mother is using substance
- Mental disorder e.g. depression

3. Mental status examination

The four central principles of motivational interviewing

I. Express empathy by using reflective listening to convey understanding of the patient's point of view and underlying drives

II. Develop the discrepancy between the patient's most deeply held values and their current behavior (i.e. tease out ways in which current unhealthy behaviors conflict with the wish to 'be good' – or to be viewed to be good)
III. Sidestep resistance by responding with empathy and understanding rather than confrontation
IV. Support self-efficacy by building the patient's confidence that change is possible

3.Diagnosis

A definite diagnosis of 'dependence' is invariably required before substitute medication is initiated. This should take into account clinical examination, history, with corroborating evidence, and results of investigations. In young people, it is extremely important that specialist assessment be organized at the earliest possible stage.

4.Treatment

Management of any patient should be part of a comprehensive plan following detailed assessment. It should also be noted that, although it is the responsibility of all doctors to provide care for both general health needs and substance-related problems to a reasonable standard, practitioners should be aware of their limitations and seek specialist support if necessary. This is especially the case when treating young people.

There are three phase in substance dependence treatment, for a successful treatment all three phases should be completed:

- Motivations in which psychosocial methods are used to prepare patient for detoxification and reduce the amount of substance until withdrawal symptoms are appeared.
- Detoxification here patient stops the substance completely and takes prescribed medication for controlling withdrawal symptoms. Different methods are available for detoxification of opium and heroin dependence.
- Rehabilitation and aftercare. In this phase patient will be rehabilitated and integrated into community. First 6 months after detoxification has the highest rate of relapse, to prevent relapse psychosocial care and family support is very important. Support groups especially joining self help groups are very helpful for people who are recovering from substance dependence.

In the BPHS facilities no specific medications are available for detoxification, stabilization and reduction of opium/heroin dependence.

The goal of opioid tapering is to minimize acute withdrawal symptoms and help patients transition to long-term treatment for opioid dependence. National Drug Prevention Guidelines (Ministry of Counter Narcotics) includes following main approaches for substance use treatment:

- Community based methods
- Alternative approaches to harmful use
- Mass media campaigns
- School based approaches
- Life skills training programs
- Teacher Training
- Testing, Monitoring and evaluation

Some specialized treatment programs use medications targeting the symptoms of opioid withdrawal as the primary means for treating this condition. For example, sedative hypnotics or anxiolytics are used to treat insomnia and/or anxiety, antiemetics are prescribed to treat nausea and vomiting, analgesics are provided for muscle cramps, and antispasmodics are used to treat gastrointestinal cramping.

Important points:

- The key point for introducing pharmacology into treatment is that it alleviates the negative and undesirable behavioral symptoms in treatment and enhances other psychosocial approaches.
- The most successful treatment intervention combines pharmacology with psychosocial skill development.
- Major transmitter systems and neural pathways in the brain play very significant roles in the treatment as it relates to pharmacological intervention.
- Individuals who are addicted and relapse often, despite many treatment episodes, often have an underdiagnosed mental illness, which requires medication.
- Both mental illness and addiction is a disease of the brain. Use of pharmaceuticals is necessary to replace important chemicals that have been displaced, opening up or closing down strategic pathways in the brain necessary to restore health.

Psychosocial interventions are relevant throughout all three phases, mostly once detoxification, reduction or maintenance is established, sustained improvement depends on behavioral change. Although some doctors may be concerned about prescribing aspects because of safety issues, in fact the majority of treatment interventions are psychosocial.

Coping strategies for patients dealing with substance-use problem:

- Self-monitoring (keeping a diary about how much they are using)
- Setting limits for use
- Controlling consumption rates
- Learning refusal skills, assertiveness and relaxation

- Making use of new or alternative rewards
- Identifying and challenging negative automatic thoughts that predispose to substance misuse

What Doctors would do?

1. Assessment:

- Exploring symptoms when substance is taken
- Exploring withdrawal symptoms
- Exploring the severity of the symptoms.
- Mode and frequency of use
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life.

Most importantly information about:

- Substance use in the family
- Physical diseases in patient
- Use of other substances or medication
- Social and financial difficulties
- Person's personality before dependence
- Changes in the person's life before dependence
- Risk of suicide or suicide attempts
- Associated mental disorder

2. Referral to a substance treatment center if:

- Withdrawal symptoms are severe
- There is a suicide attempt or risk of suicide
- There is possible associated physical illness
- Initial counseling was not effective
- Mental disorder is present
- Use of traditional remedies

3. Psychosocial counseling and Psychoeducation:

- Educating patient and the family on the nature of symptoms, duration and changes over time, possible risk factors, psychosocial stressors, consequences, treatment, follow up, relapse and its prevention.

Important tips:

- Patient should not be blamed for substance abuse and related problems
- Controlling or stopping substance use often requires several attempts.
- Stopping or reducing substance will bring mental and physical benefits.
- Using substances during pregnancy will harm the baby.
- With intravenous substance use, there is risk of getting or giving HIV infection, hepatitis or other blood borne infections.
- Relapse is common within first six months after quitting the substance.
- Mental illness can coexist with substance use

4. Psychosocial counselling

- Motivation before detoxification or reduction of use
- Rehabilitation or aftercare: Looking for the psychosocial stressors in the patients life which contributed to the addictive behavior
- Support of the patient and the family to ensure sustainability of the treatment
- Referral to self help groups

5. Follow up:

The first 6 months after detoxification has the highest risk for relapse. Factors for relapse:

- Psychosocial stressors
- Exposure to substance
- Difficult coping strategy
- Mental illness
- Neuropsychiatric impairments
- Physical illness

Benzodiazepines Abuse/Dependence

Benzodiazepines are some of the most commonly prescribed medications in Afghanistan. Familiar names include diazepam and alprazolam. They are useful in the short-term. However, long-term use (after a few weeks) is associated with dependence and withdrawal symptoms.

People can obtain them without prescriptions for their sedating effects, and then use turns into abuse. Abuse can lead to dependence. Doctors may prescribe a benzodiazepine for medical conditions such as anxiety, insomnia, seizure control, alcohol withdrawal, before anesthesia (such as before surgery) etc

High doses of benzodiazepines can produce more serious side effects.

Signs and symptoms of overdose may include the following:

- Drowsiness and confusion
- Dizziness
- Blurred vision
- Weakness
- Slurred speech
- Lack of coordination
- Difficulty breathing
- Coma

Signs and symptoms of chronic abuse can be very nonspecific and include changes in appearance and behavior that affect relationships and work performance.

Followings are common signs and symptoms of chronic abuse:

- Anxiety
- Insomnia
- Anorexia
- Headaches
- Weakness

Dependence and withdrawal occur in only a very small percentage of people taking normal doses for short periods. Dependence can result in withdrawal syndrome and even seizures when they are stopped abruptly. The symptoms of withdrawal can be difficult to distinguish from anxiety. Symptoms usually develop at 3-4 days from last use, although they can appear earlier with shorter-acting varieties.

Possible outcomes on stopping benzodiazepines

- Recurrence of original disorder
- Rebound symptoms - last a few days

Withdrawal syndrome:

- Common symptoms: increased anxiety, tremor, irritability, restlessness, depression, dizziness, sweating, insomnia, nightmares, abdominal pain, tachycardia and hypertension (usually mild)
- Serious symptoms: seizures, delirium, confusion
- Other symptoms: anorexia, nausea, tinnitus, sensitivity to light and sound, sense of unreality in surrounding.

Management of benzodiazepine dependence in non-abusing patients

1. Only make a diagnosis of dependence if patient fits above criteria.
2. Provide education on why benzodiazepines are harmful when used chronically. Explain difficulties that may arise with continued prescribing.
3. Graded discontinuation may be useful

- Consider switching to longer acting benzodiazepine e.g. diazepam. Longer acting forms are less likely to produce rapid onset of withdrawal symptoms.
- Gradually reduce dose e.g. by 10% every 5-7 days. For example, if a patient has been on 40mg of diazepam once daily for a year then begin by reducing the dose to 35mg for a week, then 30mg for a week, then 25mg for a week etc. If this patient developed withdrawal symptoms at a reduction to 30mg then consider going back to 35mg and then reduce to 30mg a week later and so on.
- Have regular contact and consider only prescribing for a week at a time.
- May need a longer period over which to reduce

4. Consider psychosocial counseling for all patients.

Tips on benzodiazepine usage

- Do not prescribe benzodiazepines in someone with a history of drug abuse and dependence
- Prescribe lowest possible doses of benzodiazepines
- Only prescribe for less then 4 weeks
- Remember that patients can get withdrawal symptoms between doses if they are given short-acting benzodiazepines e.g. alprazolam.
- Use only for severe or disabling anxiety or insomnia
- Try alternatives to benzodiazepines, such as, relaxation techniques or low dose antidepressants are used for the short -term treatment of insomnia.
- Advise patients of risk of dependence and impaired reaction times
- Benzodiazepines also cross the placenta leading to neonatal side effects.

Unexplained somatic complaints

The World Health Organization study found functional symptoms to be common and disabling in primary care patients in all countries and cultures studied. Up to half of these patients remain disabled by their symptoms a year after presentation, the outcome being worse for those referred to secondary and tertiary care. The clinical and public health importance of functional symptoms has been greatly underestimated.

What is the cause of functional somatic symptoms?

A variety of biological, psychological, and social factors have been shown to be associated with functional symptoms; the contribution of these factors will vary between patients. With our current knowledge, it is best to maintain neutrality about the cause of functional symptoms. Hence the main task is to identify those factors that may be maintaining a patient's symptoms and disability.

- Precipitating factors: Symptoms may arise from an increased awareness of physiological changes associated with stress, depression, anxiety and sometimes disease and injury. They become important to the patients when they are severe and when they are associated with fears of disease, or belief in disease.
- Predisposing factors: Predisposing factors increase the chance that such symptoms will become important. Some people are probably biologically and psychologically predisposed to develop symptoms. Fear of disease may result from previous experience.
- Perpetuating or maintaining factors: Perpetuating factors are those that make symptoms and associated disability persists. Patients' attempts to alleviate their symptoms may exacerbate them. For example, excessive rest to reduce pain or fatigue may contribute to disability in the longer term. Doctors may also contribute to this by failing to address patients' concern or increasing fear of disease such as by excessive investigation. Maintaining factors that should be focus of treatment in patients with multiple somatic symptoms are:
  - a) Depression, anxiety, or panic disorder
  - b) Chronic marital or family discord
  - c) Dependent or avoidant personality traits
  - d) Occupational stress
  - e) Abnormal illness beliefs
  - f) Iatrogenic factors
  - g) Any pending legal claim

<u>Latrogenic factors in development of unexplained symptoms:</u>

- Appearance of uncertainty and inability to provide an explanation
- Expressed concern about disease explanations
- Failure to convince patient that the complaint is accepted as genuine
- Reassurance without a positive explanation being given
- Ambiguous and contradictory advice
- Excessive investigation and treatment

1. **Clinical features**:

It is important to remember that physical symptoms in USC are real and they are not intentionally produced. USC is more common in women and usually is diagnosed after consultation with many health professionals. Unexplained somatic symptoms become especially problematic when they become recurrent or chronic. Some common, unexplained physical problems seen are:

- Headaches
- Lower back pain
- Pain in arms, legs or joints
- Nausea and vomiting
- Body pain and muscle discomfort
- Difficulty in swallowing
- Chest pains
- Facial pain
- Frequent urination
- Abdominal pain
- Dizziness
- Palpitation or rapid heart beat
- Menstruation problems: excessive bleeding, irregular cycles

USC patients usually have associated symptoms of depression, anxiety and sleep disturbance.

2. **Possible risks and complications**

Raising fears of disease, performing unnecessary investigations and treatments, and encouraging disability are probably common adverse effects of medical consultations. However, denying the reality of patients' symptoms may damage the doctor-patient relationship and drive patients from evidence based care into the arms of the unhelpful, unscientific, and unscrupulous. They often have recurrent depressive symptoms and a longstanding difficulty with personal relationships and may misuse substances or self harm.

3. Mental status examination

Followings are principles of assessment:

- Identify patients' concerns and beliefs
- Review history of functional symptoms
- Consider both disease and functional diagnoses
- Appropriate medical assessment with explanation of findings
- Ask questions about patients' reaction to and coping with symptoms
- Find out what the patient has been told by other doctors (as well as friends, relatives, and alternative practitioners). Does this accord with the medical findings?
- Explore psychological and interpersonal factors in patient's development such as quality of parental care, early abusive experiences, psychiatric history.
- Interview a partner or reliable informant
- Use screening questions for psychiatric and social problems
- Consider interviewing relatives
- After the interview attempt a provisional formulation

4. Diagnosis

- In practice, functional symptoms are often attributed to single cause, which may be pathological such as “a virus” or psychological such as “stress”. The available evidence suggests that biological, psychological, interpersonal, and healthcare factors are all important.
- Most functional symptoms are transient, but some become persistent. Persistent symptoms are often multiple and disabling. Mental disorders such as anxiety, depression, and other disorders highlight psychological processes and the number of somatic symptoms irrespective of the bodily system to which they refer. Depression and anxiety often present with somatic symptoms that may resolve with effective treatment of these disorders. Surprisingly, the more somatic symptoms a person has, the less likely it is that these symptoms reflect the presence of disease and the more likely there is associated depression and anxiety.

5. Treatment

Assessment and management go hand in hand. Management of unexplained somatic complaint is mostly psychosocial and can be done at health facility level. One of the main aims of management is to modify patients' often unrealistic expectations of the medical profession and to remind them of the limits to medicine. In many cases hopes may have been falsely raised, and patients expect either a cure or at least a considerable improvement in symptoms. Instead,

the doctor should attempt to broaden the agenda, with an emphasis on helping patients to address personal concerns and life problems as well as somatic complaints. It is also necessary to encourage them to concentrate on coping rather than seeking a cure.

The ultimate goal of treatment is:

- To reduce the patient's distress, symptoms and disability
- To reduce or limit inappropriate use of medical services and medication

Principles of treatment:

- Explain that the symptoms are real and familiar to doctor
- Provide a positive explanation, including how behavioral, psychological, and emotional factors may exacerbate physiologically based somatic symptoms
- Offer opportunity for discussion of patient's and family's worries
- Give practical advice on coping with symptoms and encourage return to normal activity and work
- Identify and treat depression and anxiety disorders
- Discuss and agree a treatment plan
- Follow up and review

Following key elements for psychosocial approach in developing countries have been proposed:

- Acknowledging that the symptoms, distress and disability are genuine
- Explaining strategy of treatment
- Limiting help-seeking
- Explaining the nature of somatic complaints
- Concentrating on patient's explanatory models
- Avoiding unnecessary treatment and investigations
- Encouraging return to normal activities
- Diary-keeping and monitoring of progress

What Doctors would do?

1. Assessment:

- Exploring symptoms of unexplained somatic complaint
- Exploring the severity of the symptoms.
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life
- Review history of functional symptoms.

Most importantly information about:

- Unexplained somatic complaints in the family
- Identify patients' concerns and beliefs
- Suicidal thoughts or attempt
- Use of substances or alcohol or narcotic pain killers
- Person's personality before current problem
- Changes in the person's life before current illness
- Current psychosocial problems and coping styles
- Attitude of family members towards unexplained somatic complaint
    - Use of traditional remedies
    - Ask questions about patients' reaction to and coping with symptoms
    - Consider interviewing relatives

2. Referral:

- When USC is diagnosed avoid referrals to specialists. Such patients are best managed in primary care settings. Remember patients may be offended by referral to a psychiatrist and seek additional medical consultation elsewhere.

3. Psychoeducation and psychosocial counseling:

- Educating patient and the family on the nature of illness, risk factors, psychosocial stressors, consequences, role of family members in prevention, follow up, mind-body relationship.

Some important tips:

- Care for USC rather than cure
- Try not to eliminate symptoms completely, you can't
- Discuss intervention plan with patient
- Focus on managing the symptoms, not on discovering their cause.
- Chronic USC is not dangerous, even though they cause great discomfort.
- Symptoms are real, and they cause real problems in life
- Symptoms can get better when these people get help for their emotional pain
- Focus on coping and functioning
- Depression, anxiety disorder have similar somatic symptoms
- Narcotic medicines will not cure the problem and can be abused
- Appropriate reassurance e.g., abdominal pain does not indicate cancer.
- Regular exercise makes person feel much better

4. Psychosocial intervention:

- Clearly identifies the origin of the somatic symptoms: Tries to find the situation when the symptom increases and decreases and follows the psychosocial intervention according to the most pressing psychosocial problem.

5. Follow up:

- Either for counseling or assessing improvement, assessing suicidal thoughts, family involvement, and change in coping with stressors.

Self Harm

Self-harm is the act of deliberate hurting or harming him or herself. Self harm usually occurs after a high emotional turmoil or heightened distress following a serious acute family conflict. Self-harm represents a unique response to a particular life situation, a response that is ultimately about the survival of the self, not its destruction. People who self-harm sometimes encounter hostile responses from health staff, especially doctors and nurses working in emergency rooms, in clinical settings. Prevention of self harm and suicide should be included in health policy initiatives. There is also a need for development of treatment approaches apart from BPHS setting. Protocols need to be developed for better management of self harm cases, particularly for use in rural areas where patients first come into contact with the health services.

Self harm is common among young people especially women in Afghanistan.

Common problems preceding self harm:

- Difficulties with parents or family conflict
- School or work problems
- Difficulties with friends
- Physical illness
- Depression
- Low self esteem
- Sexual problems
- Substance abuse and alcohol

1. Clinical features:

People use different methods to self-harm; self poisoning with pesticides and burning is an important cause of mortality in rural areas. The children are learning from people around them, they are live with people who have previously attempted suicide.

Some common methods used in Afghanistan are:

- Burning the body with kerosene
- Hanging
- Drowning
- Swallowing pesticide
- Cutting skin or throat
- Punching the body
- Taking tablets (medicine overdose)
- Throwing self from height

<u>Possible motives or reasons underlying self harm:</u>

- To escape from unbearable suffering
- To change the behavior of others
- To show desperation to others
- To change the behavior of others
- To make other people feel guilty
- To gain relief of tension
- To seek help

2. Possible risks and complications

<u>Common risks are:</u>

- Repeated self harm and suicide
- Depression
- Substance abuse
- Relationship problem
- Discrimination

3. Mental status examination

The purpose of psychosocial assessment is to identify among self-harm patients those who have a mental illness, high suicide risk, co-existing problems such as substance or alcohol problems, and those in social crisis. Those with mental illness or a substance use problem need prompt and effective psychiatric treatment and where other psychosocial problems are identified patients should have access to various forms of social and psychological help.

<u>Important issues in assessment of people who have self harmed:</u>

- Events surrounding the self harm
- Degree of suicidal intent and other reasons for the act
- Current problems
- Possible psychiatric disorder
- Family and personal history
- History of psychiatric disorder or self harm
- Risk of further self harm and or suicide
- Attitudes towards help

Identification of those who are at risk of repetition is considered a key objective of assessment after self harm, but it is difficult to tell how health staffs are good at predicting risk. Risk assessments may influence subsequent management.

Although most cases of self harm is not a suicide attempt but there may be cases with such intention.

Features of self harm that suggests high suicidal intent:

- Conducted in isolation
- Timed so that intervention is unlikely, for example, after parents have left to work.
- Measures to avoid discovery
- Told other people beforehand about thoughts of suicide
- Act had been considered for hours or days beforehand
- Suicide note or message
- No alert for others during or after the act

4. Diagnosis

Signs and symptoms that may accompany suicidal feelings include:

- talking about feeling suicidal or wanting to die
- feeling hopeless, that nothing will ever change or get better
- feeling helpless, that nothing one does makes any difference
- feeling like a burden to family and friends abusing alcohol or drugs
- putting affairs in order (e.g., organizing finances or giving away possessions to prepare for one's death)
- writing a suicide note
- putting oneself in harm's way, or in situations where there is a danger of being killed

6. Treatment

People who self harm should be evaluated for physical damage and psychosocial problem. Some cases e.g. self burning and poisoning needs special care and may need admission. Assessment of psychosocial problems should be done in earliest possible time. In case of mental disorder e.g. depression, treatment should be psychosocial if severe antidepressant can be added. Intervention plan should be discussed with patint.

Most people who self harm do so in response to interpersonal crises and can be discharged for treatment as outpatients. But severe depressive or psychotic disorder, present an ongoing risk for repetition or suicide, or are in the middle of major psychosocial difficulties, such as revelation of sexual abuse may need specialist consultation. In many cases crisis intervention is often appropriate. Problem solving therapy is often used with adolescents and has the advantage of being direct and easily understood. Using problem solving techniques and rehearsing coping strategies can help the adolescent when he or she is faced with future crises.

Suicidality

Many of us feel, at some time in our life, that we have had 'enough' of living. For most people thoughts of suicide pass quickly, and are often a reaction to a recent unhappy event. For some, however, suicidal thoughts or plans become more persistent and are associated with mental illnesses and severe life difficulties.

Suicide attempts are a part of self harm, but not all self harm is suicide attempts

- Suicide: ending one's own life.
- Suicide attempt: behaviour that was intended to die, but has not led to a fatal outcome
- Suicidal ideation: thoughts of killing onself
- Deliberate self-harm: willful self-inflicted acts that cause pain or injury without intent to die.

The following illnesses are associated with suicide:

- *Depression*. This is the most important cause of suicide. Depression can make a person feel miserable, lose interest in life and lose hope for the future.
- *Alcohol and drug misuse*. Although many people drink alcohol and take drugs to feel better, in fact these substances make people feel worse.
- *Long-term health problems*.
- *Severe mental disorders.* People with a psychosis and mania are also at a risk of ending their life through suicide.

Social and personal factors play an important role in the cause of the mental illness. Important social factors that can make a person unhappy and suicidal include:

- unhappy relationships, particularly an unhappy marriage;
- poverty and economic difficulties, particularly when these happen suddenly,
- losing a loved one,
- not having people with whom to share problems and feelings.

How to find out if a person is suicidal?

To find out if a person is suicidal, ask some questions directly but gently. Asking a person about suicide will not give him/her the idea or push them into doing something self-destructive. To the contrary the willingness of the health worker to ask can decrease the risk of suicide by giving them an opportunity to talk about their feelings..

You can ask the following questions:

- Do you think life is not worth living?
- Would you prefer to be dead?

- Have you thought of killing yourself?
- Have you thought about how you would do it?
- Have you tried to kill yourself or do you have plans to kill yourself?

Also, ask about previous suicide attempts (previous attempts increase the risk of further suicidal behavior and will give you an idea of what they will do).

How to deal with a person who is suicidal?

Questions to ask the family or friends

- What happened? Was it a dangerous attempt?
- Has it happened before? People with a history of suicide attempts are more likely to do it again
- Is there a history of a mental illness or a serious physical illness?
- Has he or she had a recent loss, for example separation from his spouse?

Questions to ask the person who has attempted suicide

- What happened? Did you want to end your life? Why?
- Did you have a plan? How long were you planning it? Did you tell anyone else about your plan?
- Attempts that have been carefully planned and kept secret from others are more serious.
- How do you feel now? Many people are relieved that their attempt did not lead to death.
- Those who are not relieved are more likely to try again.
- Have you been feeling depressed recently? Have you lost interest in life? (Ask these questions to detect depression)
- What reasons are there for you to continue living? This is an important way of trying to get the person to think of the good things in life. Some people are so depressed that they cannot see anything positive. This is a sign of how serious the illness is.

Judging the likelihood of further suicide attempts

It is difficult to predict whether a person will attempt suicide again. Factors that should make you concerned about the risk of repeated attempts are:

- a serious, planned attempt, where there was an effort to hide the attempt from others and a dangerous method was used;
- continued suicidal thoughts;
- hopelessness about the future;
- evidence of severe depression;
- evidence of severe life difficulties and losses;
- lack of social support;

- alcohol misuse or severe physical illness;
- previous suicide attempts;
- older age of the person attempting suicide.

What to do later

- Refer the person who has attempted suicide to the psychosocial counsellor
- Try to identify social issues that may be causing the person to feel depressed. Talk to important relatives or friends
- Treat an underlying mental illness such as a severe depression (see section on depression) Remember: The medication for depression takes two to four weeks to show effects; in the meantime counselling and family support are essential.
- If you feel he is at risk of harming himself again, ask relatives to spend time with him and ensure that he is not left alone.

Tips how to talk to a person who has suicidal ideas or has attempted suicide

- Consider to talk to the person in private. Suicide is a sensitive and personal matter. Give him/her enough time to feel comfortable and to share her reasons frankly.
- Listen attentively to what the person has to say. Let the person talk and try to learn as much as possible about what is causing the suicidal feelings.
- Comfort the person with words of encouragement. Use common sense to offer words of support.
- If the person is at a high risk of suicide, do not leave him or her alone.
- Ask openly about suicidal ideas, earlier attempts and future plans
- Don't be judgmental. Do not make judgements about the character of the person. Be supportive and caring. Let the person express his or her feelings and accept those feelings without judging or discounting them. Don't act shocked, lecture on the value of life, or tell the suicidal person that s/he is a bad person.
- Be careful of the statements that you make. You do not want to make the person feel any worse than he or she already does.
- Offer hope, but do not make reassuring statements without understanding the situation (this may make the person feel even more hopeless). Reassure the person that help is available and that the suicidal feelings are temporary. Don't dismiss the pain he or she feels, but talk about the alternatives to suicide and let the person know that his or her life is important.
- Help the person develop a "Plan for Life," a set of steps he or she or she promises to follow during a suicidal crisis. It should include who to go to in an emergency. One can also make a

contract in which the client promises not to attempt suicide for a specific period (for example one week)

What Doctors would do?

1. Assessment:

- Exploring symptoms of mental illnesses
- Exploring the severity of the symptoms.
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life.

Most importantly information about:

- Circumstances self harm happened
- Self-harm or suicide, depression or other mental disorder in the family
- Previous attempts and consequences
- Current physical diseases
- Use of substances or alcohol
- Person's personality before current problem
- Changes in the person's life before self harm
- Current psychosocial problems
- Attitude of family members

2. Referral to PSC or higher level

- There is a suicide attempt or high risk of suicide
- Mental disorder is present
- There is possible associated physical illness
- Initial counseling was not effective

3. Psychoeducation and psychosocial counseling:

- Educating patient and the family on the nature of self-harm and suicide, risk factors, psychosocial stressors, consequences, role of family members in prevention, follow up.

Some important tips:

- Self-harm should not be taken lightly
- Person should not be blamed for self harming
- There is a greater risk for self harm after first attempt
- Asking about suicidal thoughts or plans does not put the idea in the person's head
- Friends and family members can help to reduce the risk of self harm
- Self harm can be in response to stressful events

- Self harm often brought about by sudden, unexpected change in life
- Suicidal thoughts can be part a serious illness.

5. Follow up:

- Follow up is either for counseling or assessing improvement in self-harm thoughts, risk of repetition, assessing stressors, family involvement, and change in coping with stressors. Many self-harm patients have the tendency to default from follow-up appointments.

Epilepsy

Epilepsy is a brain disorder characterized by spontaneous, repetitive seizures. (at least 2 unprovoked seizures 24 hours apart.) Epilepsy is not a mental disorder, but a neurological disorder. During an epileptic seizure the normal pattern of neuronal activity becomes disturbed, resulting in muscle spasms, loss of consciousness, and additional symptoms. The clinical signs or symptoms of seizures depend on the location of the epileptic discharges and the extent and pattern of the spread of the epileptic discharge in the brain. International classification of epileptic seizures divides seizures into 2 major classes:

- Partial seizures. Partial-onset seizures begin in a focal area of the cerebral cortex; this includes simple partial seizure (SPS), complex partial seizures (CPS) also seizure with secondary generalization.
- Generalized seizures. They have an onset recorded simultaneously in both cerebral hemispheres.

Common causes of epileptic seizure:

- Prenatal, perinatal, or postnatal complications of pregnancy and delivery
- Cerebrovascular disease such as cerebral infarction, cerebral hemorrhage, and venous thrombosis
- Head trauma: It is more significant when it occurs with loss of consciousness lasting longer than 30 minutes, amnesia lasting longer than 30 minutes
- Infections in the central nervous system such as meningitis or encephalitis
- Brain neoplasm
- Drug intoxication, drug withdrawal, or alcohol withdrawal

1. **Clinical features**:

A. Generalized Seizures

Generalized seizures are a result of abnormal electric activity in many parts of the brain.

There are two forms:

A1) Tonic clonic seizures

These seizures may cause loss of consciousness, falls, or massive muscle spasms. The main characteristics of a generalized seizure are:

- Sudden fall with injury, tongue bite, frothing from mouth
- Jerky movements of limbs
- Blank stares during attack
- Incontinence of urine and feces
- Impaired consciousness during attack

The person may have a seizure when asleep or alone, and their body may shows signs of old injuries, burns, etc.

Generalized seizures have three phases: tonic, clonic and postictal.

I. Tonic phase

- The tonic phase begins with flexion of the trunk, elevation and abduction of the elbows with extension of the back and neck is followed by extension of arms and legs. This can be accompanied by apnea, which is secondary to laryngeal spasm.
- Autonomic signs are common during this phase and include increase in pulse rate and blood pressure, sweating, etc
- This stage lasts for 10-20 seconds.

II. Clonic phase

- The tonic stage gives way to clonic movements, in which the tonic muscles relax intermittently, lasting for a variable period of time.
- During the clonic stage, a generalized tremor occurs. This is because phases of atonia (muscle relaxation) alternate with repeated spasms (muscle contraction) Each spasm is accompanied by pupillary contraction and dilation.
- The atonic periods gradually become longer until the last spasm. Incontinence may occur at the end of the clonic phase as sphincter muscles relax. The atonic period lasts about 30 seconds and the patient can be apneic during this the atonic period (the breathing stops). The convulsion, including tonic and clonic phases, lasts for 1-2 minutes.

III. Postictal state

The postictal period includes a period of unconsciousness during which the patient becomes quiet and breathing resumes. Patient gradually awakens, often after a period of sleep, and is confused. Headache and muscular pain are common. The patient does not have memories about what happened during the seizure.

A 2) Absence Seizures

- Absence seizures are a special form of generalized seizures. They are often overlooked. Absences consist of short periods of loss of consciousness lasting only a few seconds (not more than 30 seconds). The person often shows a blank stare and a brief upward rotation of the eyes. The person does not respond when spoken to. The absence starts suddenly and then is suddenly over. After the absence the person continues what s/he was doing before the seizure. S/he has no memory of the seizure. Absence seizures happen mostly in

children and are often not diagnosed. The parents or teachers think that the child is inattentive and does not want to listen.

B Partial Seizures

- In partial seizures the abnormalities occur in just one part of the brain (see Figure 9.2). This makes the symptoms variable and dependent on where in the brain the abnormality is located. About half of the people with epilepsy have partial seizures. There are two types of partial seizures:

B1) Simple partial seizure

- In a simple partial seizure, the person will remain conscious. The attack is characterized by epileptic symptoms in only a part of the body. Most often the seizure leads to brief twitching of groups of muscles, often in the arm or face. A simple partial seizure can also manifest itself in sensory symptoms, for example seeing flashes or bright colored light.

B2) Complex partial seizure

- In a complex partial seizure, the person has a changed consciousness, but the consciousness is not impaired completely. During the period of the attack s/he does not react to normal talking and might look as if s/he is in a dreamlike state. People having a complex partial seizure may display strange, repetitious behaviors such as blinks, twitches, or mouth movements. These repetitious movements are called automatisms. During a complex partial seizure, some patients may make simple verbal responses, follow simple commands, or continue to perform simple gestures. Complex partial seizures typically arise from the temporal lobe but may arise from any region in the brain. These seizures usually are brief, from a few seconds to max two minutes. CPS often lasts up to 2 minutes.

- Some people with epilepsy may experience auras: unusual sensations that warn of an impending seizure. The feelings of an aura are often vague, such as strange sensations in the stomach, unpleasant smells, or a dreamlike feeling. These auras are actually simple partial seizures in which the person maintains consciousness.

2. **Possible risks and complications**

<u>Risk factors for recurrent seizures include the following:</u>

- Age younger than 16 years
- Remote symptomatic seizure
- Seizures occurring between midnight and 8:59 am
- Prior provoked seizures
- Remote symptomatic seizure in a patient whose sibling is affected with epilepsy

- Status epilepticus or multiple seizures within 24 hours as the initial remote symptomatic seizure
- Partial seizures
- History of neurologic deficit from birth such as cerebral palsy or mental retardation
- Abnormal EEG discharges

Complications can occur during attack or after:
- Trauma to head, tongue, lips, and cheeks
- Vertebral compression fractures
- Aspiration pneumonia

3. Diagnosis

A detailed history is likely to lead to an accurate diagnosis in up to 90% of patients. Diagnosing epilepsy is a multi-step process, usually involves the following evaluations:

- Confirmation through patient history, neurological exam, and supporting blood and other clinical tests if needed.
- Identification of the type of seizure involved.
- A clinical evaluation in search of the cause of the epilepsy.
- Based on all findings, selection of the most appropriate treatment.
- The main tool in diagnosing epilepsy is careful medical history
- Electroencephalography (EEG) can help to confirm the diagnosis in some case. But the absence of abnormality in the EEG does not exclude epilepsy.

Epilepsy has similar symptoms like Conversion disorder; following table helps to make differentiate them:

	Epilepsy	**Conversion**
Aura	**Abdominal discomfort, unusual smell or taste,**	**Upset after family discussion and change of mood, or argument**
Onset	**Sudden**	**Slow**
Location **Starting factor**	**Any where** **No factor**	**In presence of others** **Usually after arguments or other stressors**
Fall	**Sudden**	**Gradual**
Involuntary movement	**Tonic-clonic, symmetric**	**Irregular**

Frothing	Present	Absent
Incontinence	Present	Absent
Tongue bite	May be	Absent
Cyanosis during attack	Present	absent
Injury during attack	Present	May be
Memory of attack	No	Partial

2. Treatment

Pharmacotherapy is the first treatment approach for controlling seizure attacks. Approach to treatment is:

- To decide on the need for treatment on the basis of prognosis
- To select a single drug and increase the dosage slowly, giving the family clear information on how to manage status epilepticus
- To maximize the drug dosage if seizures continue
- To add a second drug if epilepsy is not controlled, with combined treatment lasting for sufficient time to assess the second drug as a possible line of treatment before withdrawal of the first
- To try further drugs and instigate detailed investigations if the epilepsy proves intractable to two drugs. If adverse factors are absent the diagnosis of epilepsy should be questioned
- Not to react to a brief cluster of seizures if the epilepsy is generally well controlled
- To investigate urgently deterioration in any domain of function.

Monotherapy or choosing a single drug is a first method in the pharmacotherapy of epilepsy.

Advantages of Monotherapy are:

- 70–80 percent controlled on monotherapy
- Fewer side effects
- Reduced teratogenicity
- No drug interactions
- Easier dosing, greater compliance
- Lower cost

Selecting a drug for epilepsy depends on many factors; some of the factors influencing drug selection are as follow:

Types of epilepsy and the frequency of seizures

- Side effects
- Achieving seizure control

A number of medications are used for the treatment of seizures; following drugs are included in essential medicine list of Afghanistan:

- Valproic acid is considered the drug of first choice since it treats a broad spectrum of seizure types. The dose of valproic acid is, 250-750mg/day, in divided doses. This is the drug of choice for primary generalized epilepsies, can be used for the treatment of partial seizures. A disadvantage is the relatively high price.
- Carbamazepine can be used for partial seizures. The dose is 200-400 mg; not to exceed 1000 mg/d.
-
- Phenobarbital can be used for epilepsy, though its adverse effects have led to a decline in its use. It is recommended by the World Health Organization as first-line for epilepsy in developing countries.The dose is 60-200 mg/day. It is effective in the treatment of partial and generalized seizures.

Summary table pharmacotherapy for epilepsy

Drug	Side Effects	Adult Dosage	Child Dosage
Phenobarbital (15 or 100 mg tablets; 15 mg/ml elixir)	Drowsiness Dizziness Ataxia	Start with 150 mg/day in two equal doses Increase 50 mg/week until seizures are controlled maximum dose in adults is 200 g	Starting dose: children up to 3 years: 15 mg/day as a single dose at bed time children 3–10 years: 30 m/day children older than 10 years: 60 or 100 mg, increase by 15 mg/week Maintenance dose: 5 mg/kg/day in two doses
Carbamazepine (200 mg tablets)	Dizziness Nausea Dry mouth Skin rash (if rash develops,	start with 100 mg twice daily gradually increase Not exceed 1000 mg/day	start with 50 mg twice daily increase up to 20 mg/kg in two divided doses

Drug	Side Effects	Adult Dosage	Child Dosage
	stop and choose another drug)		
Sodium valproate **Not to be used in first three months of pregnancy**	Nausea Tremor Weight gain	800 mg divided in two doses Increase in steps of 200 mg Usual dose is 1200 mg, but can be up to 3000 mg	Start with 15 mg/kg increase up to 40 mg/kg

The duration of treatment for epilepsy is 2-5 years free of attacks after last seizure.

Good and adverse prognostic features for outcome of epilepsy

Good outcome	Adverse outcome
• Single seizure type • No additional impairment • Late age of onset • Episode is related to illness with full recovery or was provoked • Short seizures • Low rate of seizures • Good response to antiepileptic drugs	• Multiple seizure types • Additional neurological impairment (especially in cognitive function) • Early age of onset (for the syndrome) Spontaneous seizures • Status epilepticus • High rate of seizures • Poor response to antiepileptic drugs

What to Do if Someone Has a Seizure

Roll the person on her/his side to prevent choking on any fluids or vomit.
Put a cushion under the person's head.
Loosen any tight clothing around the neck.
Keep the person's airway open. If necessary, grip the person's jaw gently and tilt her/his head back.

Do NOT restrict the person from moving unless s/he is in danger.

Do NOT put anything into the person's mouth, not even medicine or liquid. These can cause choking or damage to the person's jaw, tongue, or teeth. Contrary to widespread belief, people cannot swallow their tongues during a seizure or any other time.

Remove any sharp or solid objects that the person might hit during the seizure.

Note how long the seizure lasts and what symptoms occurred.

Stay with the person until the seizure ends.

Bring the person to a hospital if the:

- seizure lasts longer than 10 minutes
- person does not begin breathing again and return to consciousness after the seizure stops
- person injures her/himself during the seizure.

After the seizure ends, the person will probably be very tired. S/he also may have a headache and be confused or embarrassed. Be patient with the person and try to help her/him find a place to rest. If necessary, help the person get home safely.

Status Epilepticus

Status epilepticus is a severe, life-threatening condition in which a person either has prolonged seizures or does not fully regain consciousness between seizures.

While most seizures do not require emergency medical treatment, someone with a prolonged seizure lasting more than 10 minutes should be taken to a doctor immediately, if possible. In a health facility, intravenous (IV) injections with diazepam can be given. Give this slowly, over the course of a few minutes.

Give:

- 5 mg in children under 5 years
- 10 mg in children 5–10 years
- 20 mg in adults

Repeat this dose after half an hour if the seizure still has not stopped. If it is not possible to give diazepam IV, it can also be administered rectally via a plastic syringe. Diazepam can interrupt status epilepticus rapidly, but its effect is short-lived. As soon as the status epileptic is under control, give phenobarbital by intramuscular (IM) injection (3 mg/kg).

Pregnancy and Motherhood

Women with epilepsy are often concerned about whether they can become pregnant and have a healthy child. Most women with epilepsy can become pregnant and deliver a normal baby. Women with epilepsy have more than a 90% chance of having a normal, healthy baby.

There are several precautions women can take before and during pregnancy to reduce the risks associated with pregnancy and delivery. Women with epilepsy who want to become pregnant should talk with their doctors about their medications. Some anti-epileptic medications, particularly sodium valproate and phenytoin, are known to increase the risk of having a child with birth defects such as cleft palate, heart problems, or finger and toe defects.

Generally, the woman should continue taking anti-epileptic medication as prescribed to avoid preventable seizures. Seizures during pregnancy can harm the developing baby or lead to miscarriage, particularly if the seizures are severe. Nevertheless, many women who have seizures during pregnancy have normal, healthy babies. Labor and delivery usually proceed normally for women with epilepsy. Woman using epilepsy medications can breastfeed her baby. Only minor amounts of epilepsy medications are secreted in breast milk; usually not enough to harm the baby.

Prevention of epilepsy

Many cases of epilepsy can be prevented. Health workers can contribute to prevention of epilepsy by promoting the following:

- Adequate antenatal care (control of high blood pressure and infections during pregnancy can prevent brain damage in the developing baby that may lead to epilepsy and other neurological problems later).
- Safe delivery in the presence of a skilled provider to respond to problems during labor or the birth.
- Control of fever in children.
- Prevention of brain injury.
- Control of parasitic and infectious diseases.
- Wearing seat belts in cars and using helmets when riding a motorcycle.

What Doctors would do?

1. <u>Assessment:</u>

- Exploring symptoms before, during and after attack of epilepsy
- Exploring the severity of the symptoms
- Exploring frequency and duration, of attack

- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life.

Most importantly information about:

- Depression in the family
- Physical diseases
- Use of medication
- Use of substances or alcohol
- Change in person's personality after illness
- Risk of suicide or suicide attempts
- Use of traditional relief

2. Referral to higher level

- Attacks are frequent
- There is a risk of suicide
- There is possible associated physical illness
- Medication was not effective
- Mental disorder is present

3. Psychoeducation and psychosocial counseling:

- Educating patient and the family on the nature of symptoms, duration and frequency of attacks, changes over time, possible risk factors for attacks, psychosocial stressors, consequences, treatment issues, follow up, and prevention of new attacks.

Important tips:

- Epilepsy is not a mental illness
- Epilepsy patient can get mental illness
- Most cases start at childhood
- Discuss treatment plan with patient
- Medication controls attacks
- Coping with stress reduces number of attacks
- Counseling improves anxiety or depression and prevent attacks
- Attacks occur any time including during sleep
- Stigma and discrimination is high
- Treatment duration is about three years

4. Psychosocial intervention:

- Focuses on family support, psychosocial stressors and mental illness if present with epilepsy.

5. Follow up:

- Epilepsy patient needs a regular follow up till seizures are adequately controlled. The follow up will focus on improvement in seizure control, side effects of medication, compliance, psychosocial problems, and family support.

Way to lower risk of having a seizure:

- Getting enough sleep
- Avoiding substances or alcohol
- Taking medication as recommends by doctor —does not miss doses!
- Taking enough medicine when traveling
- Avoiding other medicine unless doctor has told to do so
- Fever may precipitate a new attack, take an antipyretic
- Sometime hunger may provoke a seizure

Appendix

I Crisis intervention in conflicts of domestic violence

Victims of violence often feel great shame about the violence and blame themselves. The society also judges victims often, believing that if a person (woman) is subjected to violence she must have done something to deserve it. Therefore it is crucial, that the counsellor does not in any way have a judgemental attitude or suggests that the victim could be responsible for the violence.

The importance to support for the victim of violence

- Work from an understanding that domestic violence includes physical, sexual and emotional abuse, and that all forms of violence can have extreme consequences (being traumatised, being injured)
- Be fearless and explicit about your position on domestic violence
  - ⇒ Name the violent behaviours
- Domestic violence is recognized as a pattern of behaviour used to dominate and control or out of complete helplessness
  - ⇒ Explore together with your client this pattern of control and violence!
  - ⇒ Do not focus on particular incidents of the violence
- Safety of your client is very important in your work as a counsellor
  - ⇒ Therefore you should express your concerns for safety:
    - ❖ Find out the level of risk and whether the violence has escalated over time
    - ❖ The client should be able to identify warning signs of up-coming violence
    - ❖ Develop strategies together with the client how to avoid the aggression or what to do to get immediately out of it once it has started
    - ❖ Give your client "contact-details" so that she can ask you for help as soon as it is escalating

⇓

If the life of your client is in danger you have to act immediately!

Resources

- Moreover you should search for resources the person has to cope with the situation
  - ⇒ Family and friends
  - ⇒ Does she have some skills that she could use to work somewhere

⇒ Does she have special talents

- Your patientneeds to be treated with respect and she has to be sure that she will be heard and understood!
- Never forget that it is your client's right to make her own decisions which should be encouraged and respected at all timed

The three guiding principles are: **Safety**; **confidentiality** and **respect**.

a) Safety

- Ensuring the safety and security of the victim should be the number one priority for all actors, at all times. Remember that the victim may be frightened and need assurance of her individual safety.

b) Confidentiality

- At all times, respect the confidentiality of the woman, and her family members and relatives.
- Share only necessary and relevant information (not all the details), with others involved in giving her help. This should ONLY be done if it is requested and agreed upon by the woman herself. Information about such cases should never be shared with others if it includes the individual's name or other identifying information. Information about the survivor should only be shared with third parties after seeking and obtaining the survivor's (or their parents,' in the case of children) explicit consent in writing.

c) Respect

- Conduct interviews in private settings and with same-gender workers, wherever possible.
- Be a good listener.
- Maintain a non-judgmental manner.
- Be patient; do not press for more information if the survivor is not ready to speak about her experience.
- Ask only relevant questions as it relates to the case.
- Avoid having the woman to repeat her story in multiple interviews.
- Non-discrimination principle: Do not laugh or show any disrespect for the individual or her culture, family or situation.

II Relaxation exercises

Relaxation helps to reduce physical and mental tension. It can help to reduce worries and anxiety, relieve physical stress symptoms and can help with sleeping problems.

1. Breathing exercise

- Choose a quiet room with little noise where you will have no interruptions
- Give your client the following instructions:
  - ⇒ Close you eyes or look at an object or on the wall. This will help you to concentrate
  - ⇒ After a moment, start concentrating of the rhythm of your breathing, observe your breath, especially the breathing out. Prolong gently the breathing out and wait till the breathing in comes all by itself
  - ⇒ Pay attention to how your body feels. Become aware of how your back feels, how you sit in your chair and in which way the bottom of your feet touch the ground
  - ⇒ Become aware of your breathing and inhale and exhale consciously
  - ⇒ Now concentrate on taking slow, deep, regular, steady breaths through the nose. Observe the rhythm of breathing in and out. Observe the pauses inbetween.
  - ⇒ When you exhale, imagine that you let go all tension in your body. If you feel while breathing somewhere is a barrier which disables you to breath through your whole body: then stay there! If you feel the pressure in your chest try to concentrate on it! Breath into this point and then let the pressure go in leaving the breath leave your body
  - ⇒ Imagine, that with every breath leaving your body: the worries, the pain, the thoughts also slowly leave you
  - ⇒ When you inhale, imagine that you take in new energy with each breath. You can take all this energy, as you own it!

- First explain the exercise, then instruct him in doing it, finally try to exercise together so that the client does not feel observed
- Explain that he can exercise this daily and after a while use it in a variety of situations, when she/he needs to relax!

2. Muscle Relaxation Exercise (Jacobson)

- Ask your client to sit in a comfortable position. And explain that you will put him in a state of deep relaxation. This will be achieved by teaching him how to tense and relax specific muscles in her body.
- Start by making him aware of his breathing (see breathing exercise)
- Ask the client to close his eyes and to concentrate fully on his breathing. Wait some moments!
- Then give her the following instructions:
  - ⇒ Wrinkle your forehead. Make your eyebrows touch your hairline and hold the tension for 10 seconds. Then relax and try to feel this relaxation in your whole body. Observe where you still are feeling tense. Observe also your breath as a result of this relaxation; take your time to feel those body sensations after each of the following exercises.
  - ⇒ Close your eyes as tightly as you can for 10 seconds. **Relax…**
  - ⇒ Lips, cheeks and jaw: Draw corners of your mouth back and grimace for 10 seconds. **Relax…**
  - ⇒ Extend arms in front of you and clench fists very tightly for 10 seconds. **Relax…**
  - ⇒ Extend arms out against an invisible wall and push forward with all your strength your hand for 10 seconds. **Relax….**
  - ⇒ Bend elbows. Tense biceps for 10 seconds or more with increasing strength. **Relax…**
  - ⇒ Shrug shoulders up to your ears for 10 seconds or more with increasing strength. **Relax…**
  - ⇒ Arch your back off the floor or bed. In a sitting position, arch your back away from the chair. Do this 10 seconds. **Relax…**
  - ⇒ Tighten your stomach muscles for 10 seconds or more with increasing strength. **Relax…**
  - ⇒ Tighten thigh muscles by pressing legs together as tightly as you can for 10 seconds or more with increasing strength. **Relax…**
  - ⇒ Bend ankles toward your body as far as you can for 10 seconds or more with increasing strength. **Relax…**
  - ⇒ Curl toes under as tightly as you can for 10 seconds or more with increasing strength. **Relax…**
  - ⇒ Do all the last exercises now at once, contract all muscles, make some faces hold you breath while increasing the tension, hold this for as long as you can with increasing strength and then relax….and feel how all muscles are relaxing and your whole body is sinking into the floor, your shoulders touch the floor and feel wide, open your mouth, the jaw falls down and start to yawn. Stay there and enjoy this feeling.

  ⇓

  Ask the client if he/she feels relaxed. Ask him/her if she liked the exercise and if she learned where in her body she felt any tensions. Propose to the client to do this exercise

at home.

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