

**Guideline for Assessment, Diagnosis and Management of persons  
with mental disorders in Primary Medical Care Institutions**



**Ministry of Health, Nutrition and Indigenous Medicine**

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Guideline for Assessment, Diagnosis and Management of persons with mental disorders in  
Primary Medical Care Institutions

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## **Preface**

Preparation of guidelines on Mental Health constitutes a major role in the mandate of Directorate of Mental Health. Mental Health is an important thing to talk about but it can sometimes feel uncomfortable for people to start discussing.

This book lays out an intuitive and practical approach to management of common Mental Health illnesses that any professional can find useful.

I wish to acknowledge all the contributors in this endeavour.

**Dr Rohan Rathnayake**  
**Director /Mental Health**

## **Message from the Deputy Director General/Non Communicable Diseases**

The Ministry of Health, Nutrition and Indigenous Medicine is currently undergoing re-strengthening of Primary Medical Care institutions (PMCI) empowering those to provide comprehensive care appropriate for that level of institution with the objective of ensuring Universal Health Care to all citizens of the country. For that, we need to improve the facilities in PMCIs and should build up the trust of the citizens by providing better care. Mental health care is one service that needs to be provided by every institution as the need for mental health services is rising.

Preparation of a guideline for Mental Health Care in Primary Medical Care Institutions constitutes an important need which should be fulfilled by the Ministry of Health. This Guideline will be an immense help to the Medical Officers in PMCI in managing the persons with mental health problems. I like to thank all the contributors from College of Psychiatrists and the Directorate of Mental Health in developing this guideline and also for training Medical Officers at Primary Care Institutions based on the guideline.

**Dr. Champika Wickramasinghe**  
**Deputy Director General/Non Communicable Diseases**

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# Chapter 1- Child presenting with possible abuse

## 1. Recognition of the issue

The most important first step in the management of child abuse & neglect is a high degree of suspicion and prompt recognition. There are warning signs in the history and examination of such victims. All professionals dealing with children should be conversant in detecting these signs.

### Warning signs in the history

<b>Nature of presentation</b>		<ul style="list-style-type: none"> <li>a) Delayed presentation for medical treatment.</li> <li>b) History incompatible with the injuries seen.</li> <li>c) History incompatible with the developmental age of the child.</li> <li>d) Changing history from time to time.</li> </ul>
<b>Symptom pattern</b>	<b>Somatic</b>	<ul style="list-style-type: none"> <li>a) Vaginal discharge especially if blood stained or purulent.</li> <li>b) Assumed menarche without secondary sexual characteristics.</li> <li>c) Painful defecation with or without bleeding per rectum.</li> <li>d) Skin lesions in the perineum and or peri-anal region.</li> <li>e) Somatization phenomena such as headache, abdominal pain, pseudo- seizures etc.</li> </ul>
	<b>Behavioural/ psychological</b>	<ul style="list-style-type: none"> <li>a) Deteriorating school performance or school refusal.</li> <li>b) Sudden onset unusual behaviours.</li> <li>c) Attempted suicide or deliberate self-harm.</li> <li>d) Sexualized behaviour.</li> <li>e) Avoiding certain places and / or persons.</li> <li>f) Children with sexually inappropriate behaviours e.g. being unusually friendly with certain adults.</li> </ul>

### Social issues

- a) Dysfunctional home environment
  - e.g.* Fractured families, parent/s employed abroad, substance abuse among family members
- b) Children without adult supervision

### Warning signs in the examination

<b>Physical</b>	<ul style="list-style-type: none"> <li>a) Evidence of neglect                             <ul style="list-style-type: none"> <li><i>e.g.</i> Poor grooming, unkempt, malnutrition etc.</li> </ul> </li> <li>b) Multiple injuries of different stages of healing</li> <li>c) Unusual skeletal injuries*                             <ul style="list-style-type: none"> <li>i. Long bone fractures in infants (spiral fractures are very suspicious)</li> <li>ii. Metaphyseal fractures – chip and bucket handle fracture</li> <li>iii. Posterior rib fractures</li> </ul> </li> <li>d) Bite marks.*</li> <li>e) Burns and scalds eg. Cigarette and fire brand injuries, incense stick burns, peri-oral scalds, immersion injuries due to hot water</li> <li>f) Association of retinal haemorrhages and finger-tip bruises on the chest in. shaken baby syndrome*</li> <li>g) Foreign body in the vagina</li> <li>h) Multiple anal fissures or patulous anus, skin lesions in perineum/ peri-anal region e.g. viral warts due to genital Herpes Simplex</li> <li>i) Ulcerations in oral cavity and torn frenulum*</li> </ul>
<b>Psychological</b>	<ul style="list-style-type: none"> <li>a) Depressed mood and other unusual emotional responses</li> <li>b) Poor eye to eye contact</li> <li>c) Aggressive behaviour</li> <li>d) Unusual or unexplainable attachment patterns with carers</li> </ul>
Any other physical or psychological findings which may arouse suspicion	

## **2. Initial encounter by medical personnel**

At the first encounter when a child presents with suspected abuse, it is very important for the doctor to establish a trusting relationship with the child and caregivers. The following steps would help in establishing such relationship.

1. Indicate your willingness to listen and help
2. Listen and show you understand their concerns
3. Clearly communicate with them about your suspicions of abuse in a gentle and subtle way
4. Emphasize the need to provide absolute protection from further abuse
5. Discuss options for providing safety

## **3. Reasons for admission to a hospital**

1. To provide medical/surgical/psychological treatment that cannot be provided as an outpatient.
2. To provide a place of safety e.g. Alleged/ suspected perpetrator living in the same environment as the child victim

All admissions should be to the Paediatric Wards. A victim with a surgical problem should be managed in a surgical ward initially and transferred to a Paediatric Ward for further management. A pregnant teenager should be managed in the Obstetrics and Gynaecology ward. Once wards for victims of child abuse and neglect (Lama Piyasa) are established in health institutions child victims should be admitted to these wards (closest paediatric unit after discussing with the Paediatrician).

If parents/guardians refuse admission, Medical Officer OPD should inform the Medico-legal team immediately to obtain a court order through the police irrespective of the time of day.

*Adapted from: National Guideline for the Management of Child Abuse and Neglect, a Multi-Sectorial Approach 2014*



## Chapter 2- Child with developmental delay

*A 2 year old child is brought to your clinic with a history of speech delay and mild motor delay. Currently the child does not speak any words with meaning and the parents compliant that he does not respond to his name, and engages in solitary play.*

### Differential Diagnosis

This presentation can have a wide range of differential diagnoses; they are presented in broad categories here.

1. Autism Spectrum Disorders
2. Early signs of a Generalized Learning disability
3. A hearing related issue
4. A Sign of another neurological or medical syndrome
5. A Manifestation of environmental factors such as lack of stimulation and opportunities for interactions.

As the above presentation warrants early assessment and intervention, it is important that they are referred to pediatric, and specialized psychiatric and neurological services. In most cases of developmental delay (Autism spectrum Disorders will be further discussed below).

### Autism Spectrum Disorders (ASD)

ASD is characterised by difficulties in *social communication* and, *social interactions* and also the presences of persistent and repetitive activities (*stereotyped behaviours*). ASD being on a spectrum can be categorised as mild moderate or severe, depending on symptom severity. However in earlier categorisations some forms of ASD like the milder Asperger's disorder was categorised as a separate category. This is around four times more common in males than in females.

Features of difficulties with social communication and social interactions

- Failure of normal back and forth conversation
- Reduced sharing of interests
- Reduced sharing of emotions
- Lack of initiation and social interaction
- Poor social imitation
- Impairment in social use of eye contact and body gestures
- Lack of coordination of verbal and non-verbal communication

Examples of Stereotyped or repetitive behaviours

- Repetitive hand movements
- Lining up toys
- Turning wheels of toys excessively
- Rotating around one self

The red flag signs that alert us to the possibility of ASD

- Does not babble or coo by 12 months
- Does not gesture ( point ,wave) by 12 months
- Does not say a single word by 16 months
- Does not say 2 word sentences on his own by 2 years
- Has a loss of language or social skills at any age.

Causes

Although autism was once considered a rare disorder, recent data from the United States (From the Centre for Disease Control and Prevention) estimates the prevalence of ASD as 1 in 68. Although the heritability of autism (i.e. the genetic contribution to its causation) has been estimated to be as high as 90%, these factors are heterogeneous and complex).

Meanwhile, neuro imaging studies suggest that there is an increase in the brain size in those with autism. Autistic children on average have been found to have slightly smaller brains at birth but by 2 to 3 years of age their brains have been found to be around 10 per cent larger than that of a child of equivalent age.

Treatment

Treatment for ASD mostly uses a behavioural approach. These approaches try to develop social communication and interaction. Interventions are also used to remove undesirable behaviours and to promote desirable behaviours. The management usually requires a multidisciplinary team, including speech and occupational therapists). Medication is use at times to treat comorbidities and to treat sleep and behavioural disturbances in the short term.

## CHAPTER 3- Child with Behavioral problems

*A six year old child is brought to your clinic with the complaints of not being able to stay in one place at school, and getting into frequent fights at school. It was also reported that at home he engages in activities such as climbing on to the roof and also being disobedient.*

### Differential Diagnosis

1. Attention Deficit Hyperactivity Disorder  
(Also called Hyperkinetic Disorder in the ICD- 10 classification)
2. Conduct Disorder.
3. Oppositional Defiant Disorder
4. Conditions such as Attachment Disorders, Psychological trauma related conditions and depression can also present in this way.
5. Associated Autism Spectrum Disorders and Learning disability
6. Other environment factors such as lack of time and space to play, parenting etc.

Attention Deficit Hyperactivity Disorder and Conduct Disorder will be discussed further.

### **Attention Deficit Hyperactivity Disorder (ADHD)**

#### Introduction

Also called hyperkinetic disorder in the ICD 10 classification, this is a heterogeneous syndrome characterised by the core symptoms of

- hyperactivity
- impulsivity
- inattention

While these symptoms usually cluster together, some people are predominantly hyperactive and impulsive, while others are principally inattentive. ADHD is usually diagnosed when the symptoms of hyperactivity/impulsivity and/or inattention, or all three, occur together, and are associated with impairment. This should be present in multiple settings (for example, home and school or a healthcare setting).

Those with Inattentive symptoms of ADHD can

- Be easily distracted, miss details, forget things, and frequently switch from one activity to another
- Have difficulty maintaining focus on one task
- Become bored with a task after only a few minutes, unless doing something enjoyable
- Have difficulty focusing attention on organizing and completing a task or learning something new
- Have trouble completing or turning in homework assignments, often losing things (e.g., pencils, toys, assignments) needed to complete tasks or activities
- Not seem to listen when spoken to
- Daydream, become easily confused, and move slowly
- Have difficulty processing information as quickly and accurately as others
- Struggle to follow instructions

- Have trouble understanding minute details

Meanwhile hyperactive and impulsive individuals

- Fidget and squirm in their seats
- Talk nonstop
- Dash around, touching or playing with anything and everything in sight
- Have trouble sitting still during dinner, school, doing homework, and story time
- Be constantly in motion
- Have difficulty doing quiet tasks or activities
- Be very impatient
- Blur out inappropriate comments, show their emotions without restraint, and act without regard for consequences
- Have difficulty waiting for things they want or waiting their turns in games
- Often interrupt conversations or others' activities

Classification

ADHD has been classified into a predominantly

- Hyperactive/impulsive type
- Inattentive type
- And a Combined type depending on the predominant symptoms they present with.

Although useful, the latest classifications tend not to use these sub categories.

Epidemiology

International studies suggest that around 8% of children suffer from ADHD. Although hyperactivity and impulsivity tend to abate with age inattentive symptoms tend to persist. Male are two to three times likely to have ADHD symptoms than females. What symptoms they present with will also depend on their developmental age.

The exact cause of ADHD is unknown, but the condition has been shown to run in families. Research has also identified a number of possible differences in the brains of people with ADHD compared to those who don't have the condition.

Other factors that have been suggested as potentially having a role in ADHD include:

- being born prematurely (before the 37th week of pregnancy)
- having a low birth weight
- smoking, alcohol or drug abuse during pregnancy

The symptoms of ADHD usually improve with age, but many adults who are diagnosed with the condition at a young age continue to experience problems.

Treatment

As ADHD can affect multiple areas of functioning (e.g. school work, play with other, interactions with siblings) a treatment plan should ideally take in to consideration all these areas.

- Education
- Treatment of comorbidities
- Behaviour therapy
- Pharmacotherapy
- Follow up

## **Conduct disorder and Oppositional Defiant Disorder**

### Introduction

Conduct disorders present through a repetitive and persistent pattern of behavioural issues, in which the basic rights of others, or major age-appropriate norms are violated.

Examples of the behaviours on which the diagnosis is based include:

excessive levels of fighting or bullying, cruelty to animals or other people, severe destructiveness to property, fire-setting, stealing, repeated lying, truancy from school and running away from home. Any one of these categories, if marked, is sufficient for the diagnosis, but isolated dissocial acts are not enough to make a diagnosis. Unusually frequent and severe temper tantrums, defiant provocative behaviour, and persistent severe disobedience can also be present. However unlike in Oppositional Defiant Disorder (see below), these are more severe and usually lead to the violation of the rights of others. E.g. hitting and injuring others during a temper tantrum.

Meanwhile Oppositional Defiant Disorder (ODD) is characteristically seen in children below the age of 9 or 10 years. It is defined by the presence of markedly defiant, disobedient, provocative behaviour and by the absence of the more severe dissocial or aggressive acts that violate the rights of others.

Children with this disorder, tend to frequently and actively to defy adult requests or rules. They also tend to deliberately annoy other people. Usually they tend to be angry, resentful, and easily annoyed by other people whom they blame for their own mistakes and difficulties. They generally have a low frustration tolerance and easily lose their temper. Typically, their defiance has a provocative quality, so that they initiate confrontations. They can also be uncooperativeness, excessively rude and resistance to authority.

### Classification

Currently, two possible developmental courses are discussed in relation to conduct disorders. The "childhood-onset type" presents early in life usually before the age of 10 years of age. The course of this variation is more persistent. The "adolescent onset" group starts in the adolescent period and has a more likelihood of resolving with time.

### Epidemiology

The lifetime prevalence of conduct disorder is around 10% with more males affected than females. The aetiology of conduct disorder is thought to relate to both biological and environmental factors. It is reported that around one half of those diagnosed with a conduct disorder will go on to develop antisocial personalities in adulthood. Meanwhile,

some others may go on to develop other disorders like depression and anxiety. Thus this is a condition that can greatly benefit from early intervention.

### Treatment

The most important aspect of treatment would be to establish a good rapport with the child/adolescent. If this is not established it is usually difficult to implement the other management strategies.

- Assessing for comorbidities
- Family based interventions and liaison with other services
- Behavioural management
- Cognitive Behaviour therapy
- Medication
- Follow up

## Chapter 4- Child with internet and screen addiction

Similar to other addictions, those suffering from Internet and screen addiction use the virtual fantasy world to connect with real people through the Internet/ screen, as a substitution for real-life human connection, which they are unable to achieve normally.

Presenting complaints

- Preoccupation with the Internet/ screen. (Thoughts about previous on-line activity or anticipation of the next on-line session.)
- Use of the Internet in increasing amounts of time in order to achieve satisfaction.
- Repeated, unsuccessful efforts to control, cut back or stop Internet use.
- Feelings of restlessness, moodiness, depression, or irritability when attempting to cut down use of the Internet.
- On-line longer than originally intended.
- Risked loss of significant relationships, job, educational or career opportunities because of Internet use.
- Lies to family members or others to conceal the extent of involvement with the Internet.
- Use of the Internet is a way to escape from problems or to relieve a low mood. (E.g. Feelings of hopelessness, guilt, anxiety, depression.)

Being addicted to the Internet can also cause physical discomfort or medical problems such as:

- Carpal Tunnel Syndrome
- dry eyes, backaches
- severe headaches
- eating irregularities, (such as skipping meals)
- failure to attend to personal hygiene
- sleep disturbance

Differential diagnoses

If the patient is having the above features, it is likely that it is internet addiction rather than any Other disorder. However, exclude depression and anxiety disorders as co-occurring disorders.

Management plan

It is ideal to cut down excessive use of the internet in order to reduce the symptoms mentioned above by behavioural management, skill development. Co-occurring anxiety depression if present, needs to be treated.

Essential information for family

Internet addiction is a serious problem. If the family notices symptoms of depression or anxiety, and a general drop in other activities of daily living, they should make efforts to bring the patient to the doctor.

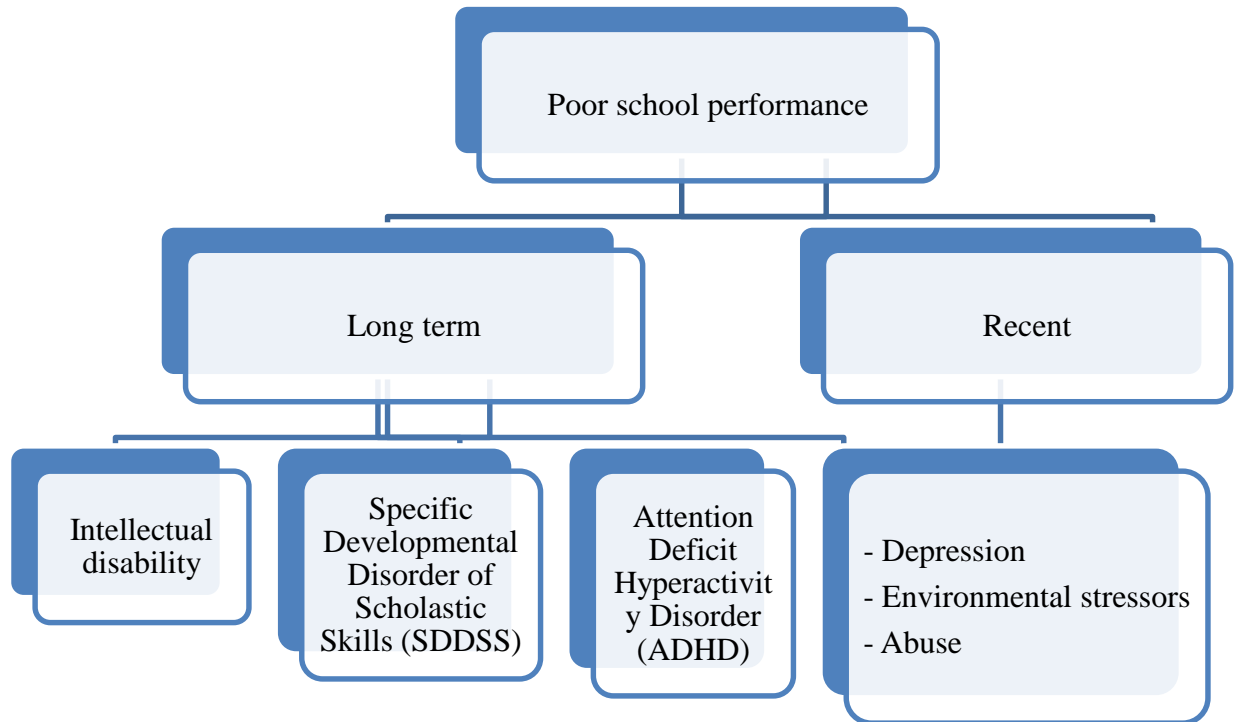
Specialist consultation Management will need liaising with the mental health team

## Chapter 5-Child presenting with academic difficulties

Case scenario:

An 8 year old child is referred to you by the class teacher due to poor school performance.

### 1. Differential diagnosis



### 2. Assessment

- Find out the duration of poor school performance – whether long term or recent
- If long term, look for features suggestive of intellectual disability, SDDSS or ADHD
- Get feedback from the teacher about the nature of academic difficulties and any associated behavioural problems
- Get the screening tool for ADHD (SNAP-IV) filled by the parents and the teacher
- If recent onset poor school performance/deteriorating school performance
  - Look for any environmental stressors at home or at school
  - Look for depressive symptoms



### **Intellectual Disability**

- There is often a history of global developmental delay
- Activities of daily living (e.g. self-care, self-help skills, household skills) are usually delayed
- Social interactions immature
- Usually below average in all aspects of learning
- IQ < 70

### **SDDSS**

- There is no history of global developmental delay
- Activities of daily living are age appropriate
- Has normal social interactions and friendships
- Maybe performing well in subjects like music, arts, sports etc..
- IQ usually normal; maybe above average (may sometimes be below average). There is a disparity in IQ and academic performance

### **ADHD**

- Inattention
  - Easily distracted
  - Often forgets things
  - Does not convey messages
  - Has difficulty in carrying out instructions
- Hyperactivity
  - Always “on the go”, difficulty in staying still
  - Walks about when needs to be seated
  - Fidgety
  - Often climbs things
- Impulsivity
  - Difficulty in waiting for his turn
  - Difficulty in waiting in a queue
  - Often interrupts others

## 3. Management

### 3.1 Refer to psychiatrist

- If intellectual disability or SDDSS is suspected, refer to a psychiatrist, as these conditions require multi-disciplinary management
- If ADHD is suspected, refer to a psychiatrist for further management
- If depression is suspected, refer to a psychiatrist for further management

### 3.2 Advice to parents

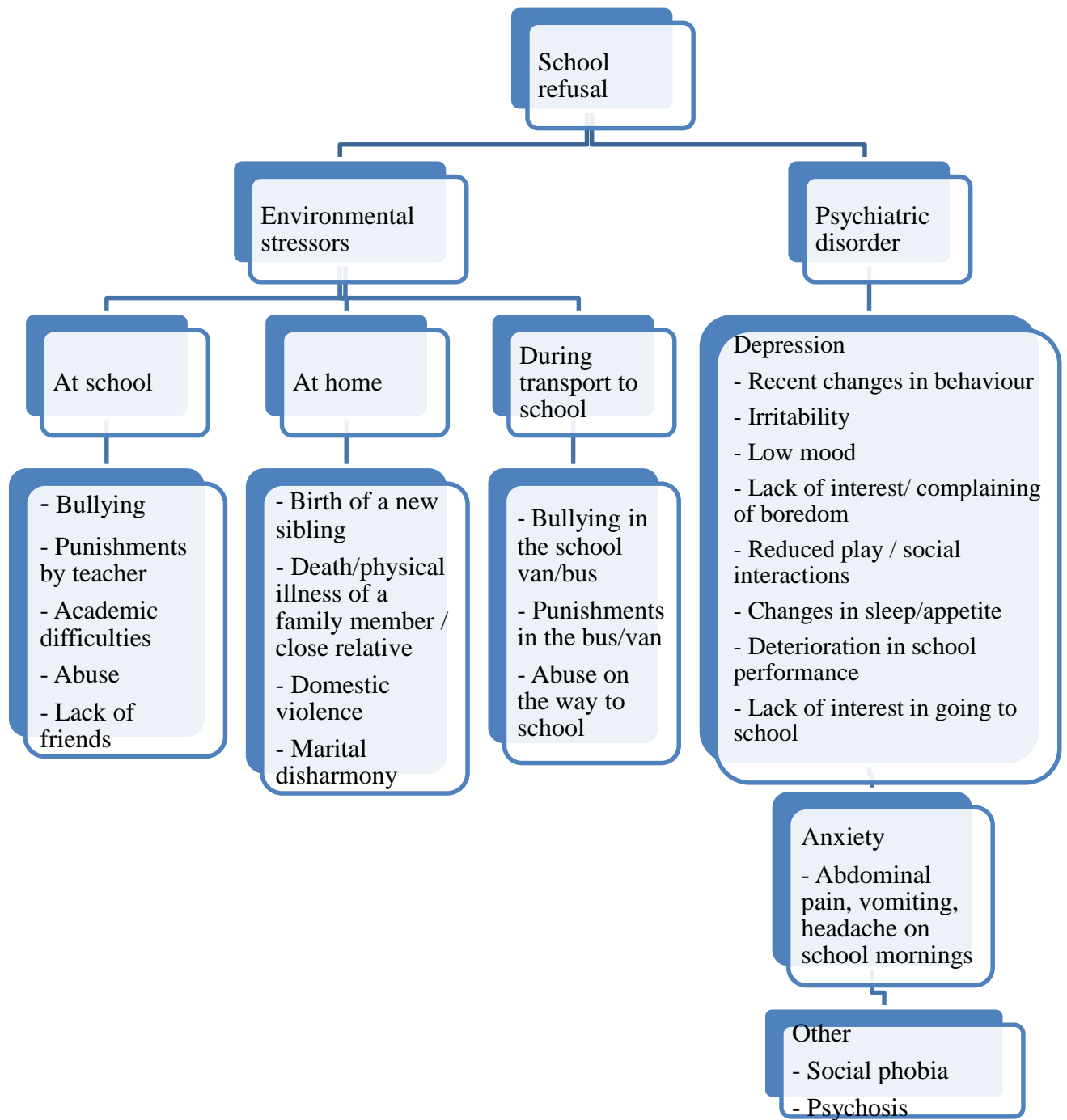
- If there is deterioration of school performance secondary to an environmental stressor, help the parents resolve these stressors
- Educate the parents not to punish the child for academic difficulties

## Chapter 6-Child presenting with school refusal

Case scenario:

A 9 year old child is brought to you by his parents complaining that he is refusing to go to school and has missed 12 days of school for the past month.

### 1. Differential diagnosis



## 2. Assessment

### History

- History should be taken from the parents and the child separately
- Obtain information from the teacher about any problems at school recent changes in behaviour, wherever possible
- Look for any environmental stressors at school, at home or on the way to school
- Look for symptoms of depression, anxiety, social phobia, psychosis
- Child's usual academic performance
- Find out what the parents have done so far to send the child to school
  - whether the parents have allowed the child to be at home without trying to send him/her to school
  - whether the child has been punished by parents for not attending school
  - whether parents have spoken to the teacher
- Find out any reinforcers for staying at home
  - Child allowed to play/ watch TV all day when staying home
- What the parents believe as the cause for school refusal

### Mental state examination

- Appearance: whether fidgety/hyperactive, eye contact, facial expressions, rapport
- Speech: Rate, amount, volume
- Mood: whether depressed/anxious
- Thoughts: anxious preoccupations
- Perceptual abnormalities

## 4. Management

### Advice to parents

- If there are any environmental stressors, educate the parents how these may lead to school refusal
- Assist the parents to resolve any environmental stressors
- Send the child back to school as soon as possible. Educate the parents that the longer the child stays at home, the harder it will be to send him/her back to school. Educate that when the child stays at home, he/she misses school work, which will add extra stress when sending back to school. In addition, friendships may change during the time the child stays at home, making going back to school difficult
- Do not make staying at home rewarding – if the child stays at home, he needs to do schoolwork according to the time tables
- Do not change schools (unless there is a very significant reason such as abuse)
- Do not punish the child for not going to school
- Reward the child on days that he goes to school – e.g. use star charts. i.e. give a star on every day the child goes to school. When the child gets 5 stars, give a small reward
- Graded exposure to school – initially the child can be kept in school for short durations and gradually increase the time spent at school till the child is able to spend the whole day in school

### Liaison with the school teacher

- Talk/write to the school teacher if there are any ongoing stressors at school and get the teachers help to resolve such issues

#### 5. When to refer to a psychiatrist

- Features suggestive of depression, anxiety disorder or other psychiatric illness
- Suspicion of any type of abuse
- Severe environmental stressor requiring multidisciplinary management
- Suspicion of learning disorders

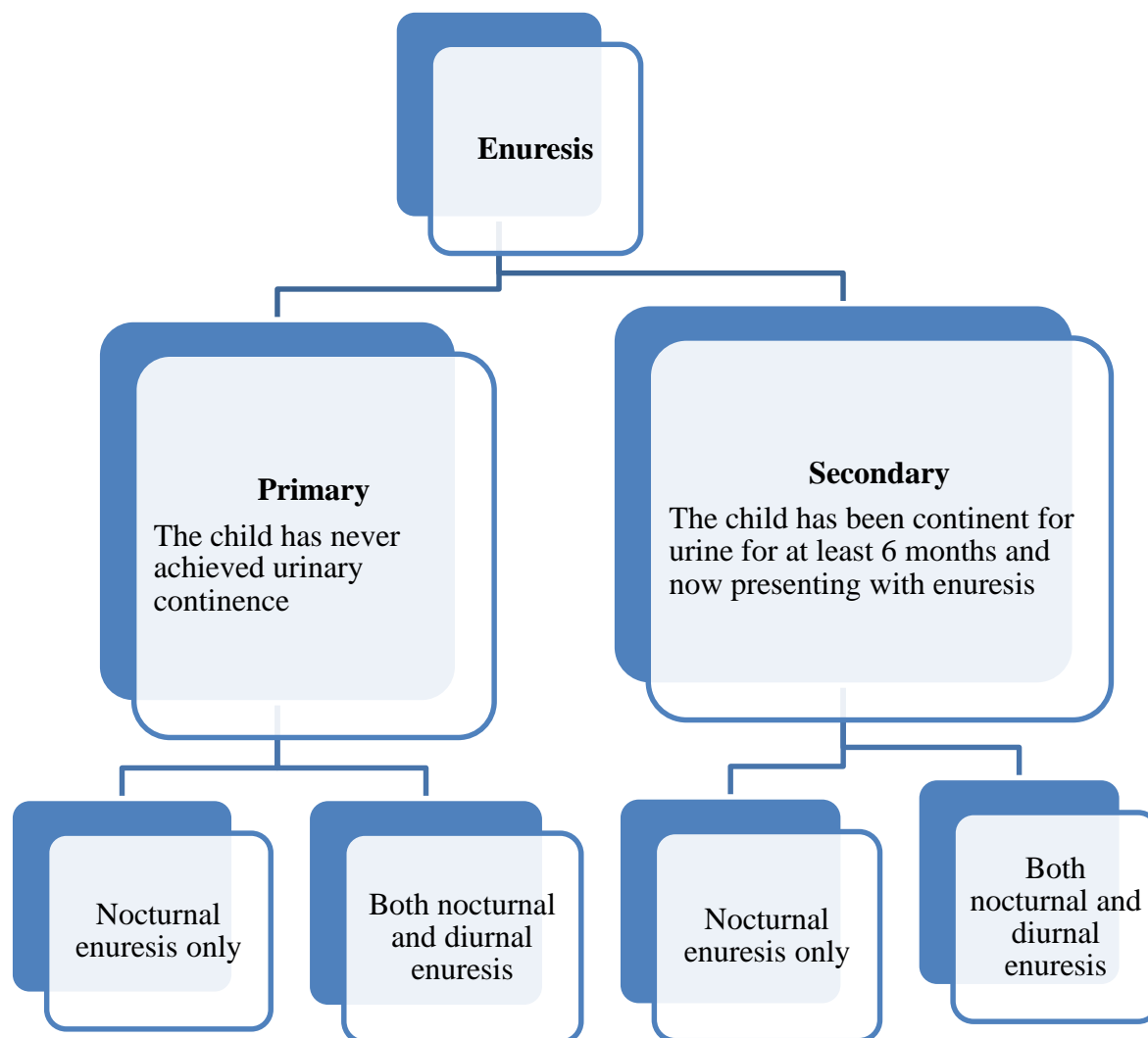
## Chapter 7- Child presenting with problems with elimination

### Enuresis

Case scenario:

An 8 year old child is brought to you by his mother complaining of bed wetting.

#### 1. Differential diagnosis



#### 2. Assessment

- Whether primary or secondary enuresis
- Whether only nocturnal enuresis or both nocturnal and diurnal enuresis
- Look for associated encoporesis
- If diurnal enuresis is present
  - Find out whether diurnal enuresis is present at school and home or both
  - Fear/ disgust in using the school toilet
  - Fear of asking the teacher permission to go to the toilet

- Pattern of urination – i.e. whether the child uses the toilet regularly or goes to the toilet the last moment
- In secondary enuresis
  - Duration
  - Assess for any environmental stressors preceding the onset of enuresis
  - Look for other changes in behaviour since the onset of enuresis – any symptoms of anxiety or depression
  - Assess for any history suggestive of abuse
  - Any urinary symptoms indicating UTI
- Assess the impact of enuresis to the child in all children presenting with enuresis
  - Punishments
  - Teasing / bullying at home or at school
  - Unable to have sleepovers/go on overnight trips
- Find out how the parents have managed the enuresis so far
  - Whether the child is being punished
  - Whether the parents are limiting water close to bedtime
  - Whether the parents are waking the child prior to enuresis occurs and takes to the toilet

### 3. Management

#### 3.1 Primary nocturnal enuresis

##### 3.1.1 Investigations

- Do a Urine Full Report

##### 3.1.2 Advice to parents on behavioural management

- Explain that nocturnal enuresis is a common problem among children and that it will spontaneously resolve with time. Explain that the child is not intentionally wetting the bed
- Advise that punishing the child will not help
- If there is any teasing from siblings about enuresis, advise parents to take measures to minimize it
- Advise parents not to compare the child to younger siblings who maybe continent
- Encourage regular daytime voiding
- Make sure that the child empties the bladder before going to bed
- Reward dry nights – advise the parents to maintain a star chart and to give a star on every morning the child has not wet the bed. When the child gets 5 stars, give him a small reward. However, educate parents not to give black stars on nights that the child wets the bed
- Advise the parents to involve the child in cleaning the bed sheets/bed/cloths etc.. (in an age appropriate manner)

##### 3.1.3 Pharmacological management

- Medications may be used
  - if the nocturnal enuresis has not improved despite behavioural management
  - if the child is older
  - if there is marked psychosocial impact due to the enuresis
- Medications that can be used
  - Imipramine 12.5mg-25mg

#### 3.2 Diurnal enuresis

##### 3.2.1 Investigations

- Do a Urine Full Report

### 3.2.2 Advise the parents on behavioural management

- If the child has diurnal enuresis due to obvious stressors (e.g. too scared to ask the teacher permission to go to the toilet) advise the parents on how to resolve these stressors
- Reward the child on days that she/he is dry during daytime – advise the parents to maintain a star chart and to give a star on every day the child is dry. When the child gets 5 stars, give him/her a small reward. However, educate parents not to give black stars on days that the child wets themselves
- Encourage regular daytime voiding (every 2 hours)
- Advise not to punish the child for wetting themselves

### 3.2.3 Liaise with the teacher if needed

- To assist the child with maintaining regular voiding during school hours (every 2 hours)
- Reward the child on days that she/he is dry during school – advise the teacher to maintain a star chart and to give a star on every day the child is dry. When the child gets 5 stars, give him/her a small reward. However, educate the teacher not to give black stars on days that the child wets themselves
- Advise that punishment, teasing or ridiculing the child at school for wetting themselves is not helpful and could worsen the condition

### 3.2.4 Refer to a psychiatrist

- If the enuresis does not improve with behavioural management

### 3.3 Secondary diurnal/nocturnal enuresis

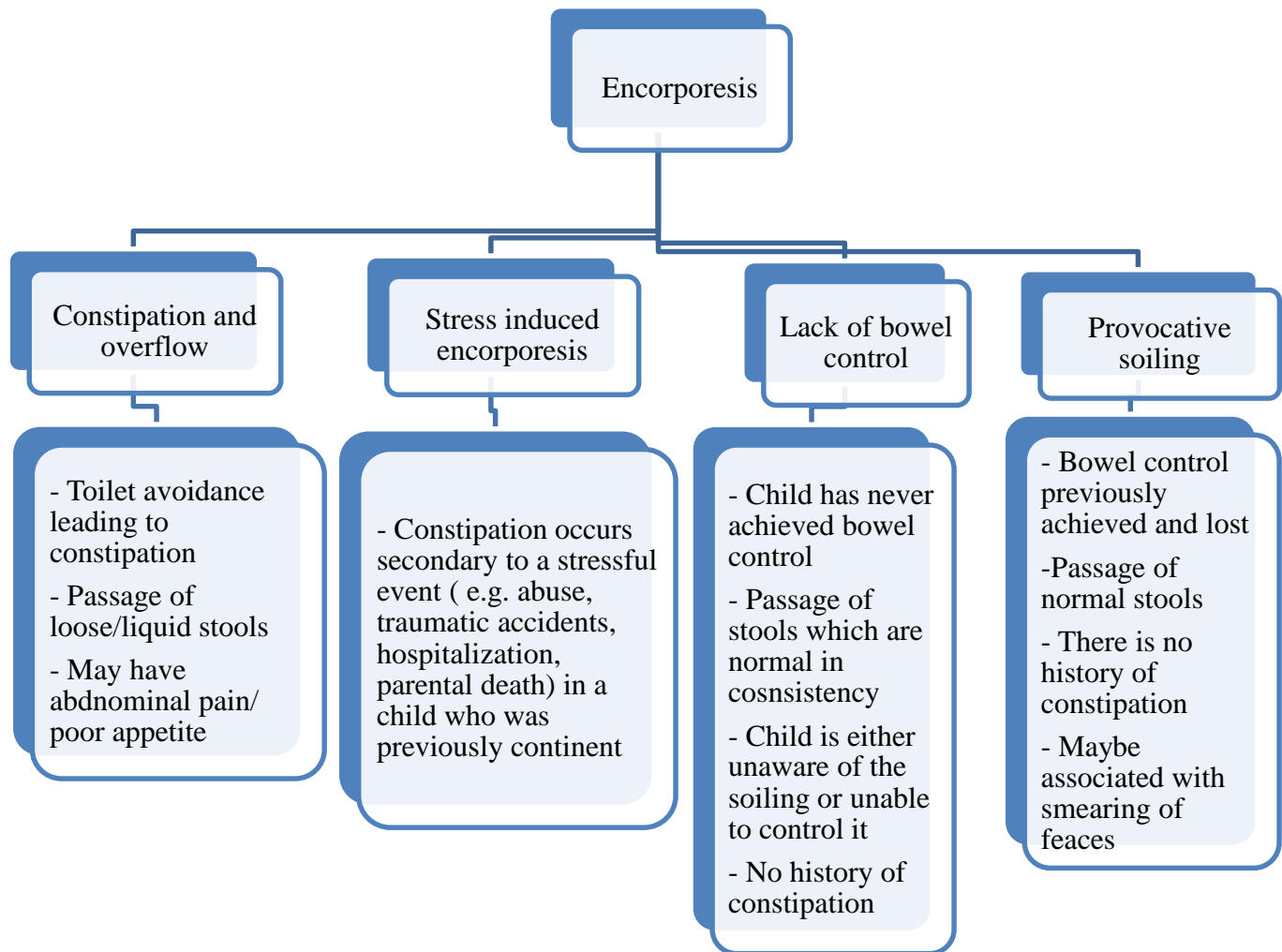
- Do a Urine Full Report
- Secondary enuresis occurring secondary to a stressful event indicates psychological distress and should be referred to a psychiatrist.

## **Encopresis**

Case scenario:

A 7 year old child is brought to you by parents, complaining of passing stools in his cloths, several times a week.

### 1. Differential diagnosis



## 2. Assessment

- Assess whether the child has ever achieved bowel control
- Find out the
  - age of onset of soiling
  - pattern (whether daily/how many times a week)
  - where soiling occurs – at school or at home
- History of toilet training – what age was toilet training started and whether any harsh punishments were used in the process
- Normal toileting pattern – look for any history of constipation
- Find out whether the soiling has started secondary to an environmental stressor
- Look for any history suggestive of abuse



- Assess the child's understanding of the problem, the psychological impact (e.g. whether he is distressed by it or unconcerned) and his level of motivation to change
- Assess the impact of the soiling on the child
  - Punishments
  - Bullying / teasing
- Assess the impact of soiling on the family

### 3. Management

#### 3.1 Referral to secondary care centre

- If soiling has started secondary to an environmental stressor, it indicates severe psychological distress. Therefore, the child should be referred to a psychiatrist
- If the child has never achieved bowel control it may suggest a neurological problem or intellectual disability. Refer to a paediatrician if neurological cause is suspected.
- Provocative soiling indicates poor family functioning and usually needs long term family work. Thus, needs to be referred to a psychiatrist

#### 3.2 Advice to parents

- Do not punish the child for soiling
- Reward the child on days that she/he does not soil— advise the parents to maintain a star chart and to give a star on every day the child does not soil himself. When the child gets 5 stars, give him/her a small reward. However, educate parents not to give black stars on days that the child soil themselves
- Bowel training - Regular toilet sitting some 15 min after meals to coincide with the gastro colic reflex. The length of sitting should be a maximum of 5 min

#### 3.3 If constipation and overflow is suspected

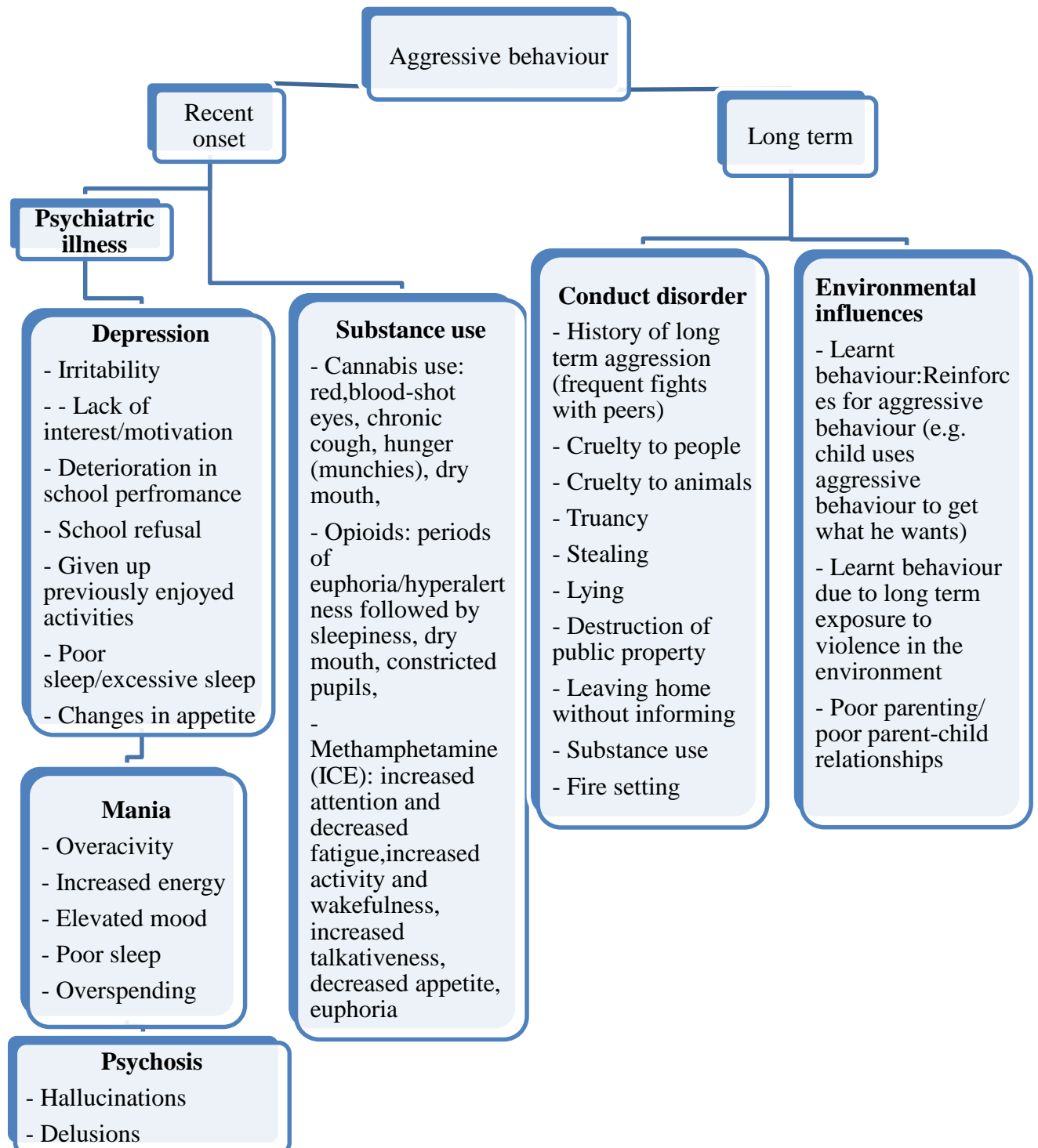
- Laxatives or stool softeners can be used short term
- Encourage good dietary habits – increased intake of fruits, vegetable, fiber

## Chapter 8-An adolescent presenting with aggressive behaviour

Case scenario:

A 16 year old boy is brought to you by his parents, complaining of aggressive behaviour.

### 1. Differential diagnosis



## 2. Assessment

- If recent onset, look for
  - Other behavioural changes during the same period
  - Symptoms of depression
  - Signs or symptoms suggestive of mania or psychosis
  - Past history of psychiatric illness
- If aggressive behaviour is a long term problem, look for
  - Symptoms suggestive of conduct disorder
  - Any environmental influences
    - Aggressive behaviour only occurs at home, only when the adolescents demands are not met
    - How the parents respond to the aggressive behaviour: are there any reinforces
    - Is the child exposed to long term violence (domestic violence, living in a violent neighbourhood)
- Impact of aggressive behaviour on others - find out whether anyone has been injured/required hospital admissions due to the adolescents aggression

## 3. Management

3.1 If the adolescent is aggressive on presentation (e.g verbally abusive towards staff, irritable, threatening etc.)

- Verbal de-escalation: calm environment, avoid confrontations
- Oral medication: olanzapine 5mg; lorazepam
- IM medications

Promethazine IM	<12 years: 5–25 mg (max 50 mg/day)  >12 years: 25–50 mg (max 100 mg/day)	Useful if the cause of behavioural disturbance is unknown and especially in an anti-psychotic naïve patient
Haloperidol IM	<12 years: 0.025–0.075 mg/kg/dose (max 2.5 mg)  Adolescents >12 years : 2.5–5 mg	Must have parenteral anticholinergics present in case of laryngeal spasm or other dystonia (young people more vulnerable to severe dystonia)
Midazolam IM	0.1–0.15 mg/kg	

Once the aggression is under control, transfer to the nearest hospital with psychiatric services.

### 3.2 Refer to a psychiatrist

Any aggressive behaviour (recent or long term) needs further assessment for diagnostic clarification, risk assessment and specialized management and should be referred to a psychiatrist

## Chapter 9- Person with Neurological symptoms

### Case Vignette

A 22-year-old single female presents with acute onset limb weakness of five days duration. This occurs in the context of impending first year university exams. She has had no preceding medical or psychiatric history.

### Differential diagnosis

- 1) Dissociative motor disorders (conversion)
- 2) Neurological causes
- 3) Factitious disorder
- 4) Malingering

### Assessment

- Presenting complaint
  - Onset and progression of symptoms
  - Current psychosocial stressors
- Degree and impact of disability
- Psychiatric symptoms
- Past history of similar symptoms
- Personal history
- Premorbid personality
  - Predominant coping style

### Dissociation

- Symptoms cannot be explained by a physical disorder
  - E.g. signs and symptoms of left lower limb weakness is not in keeping with a physical disorder

The onset of symptoms must be associated in time with stressors faced by the individual

- E.g. occurrence of limb weakness resulting in inability to attend school, in the context of bullying by peers
- Symptoms include
  - Complete or partial loss of voluntary movements
    - Weakness in a limb
    - Inability to speak or;
  - Incoordination, ataxia or inability to stand

### Factitious disorder

- Persistent pattern of intentionally feigning symptoms
- No external motivation such as obtaining compensation
- Engages in sick role

### Malingering

- Intentional production of symptoms due to external motivation
  - E.g. to obtain financial compensation or avoid criminal prosecution

#### Examination

- On observation note *la belle indifférence*, the apparent lack of concern about symptoms or disability
  - Not always present
- Neurological examination
  - Findings are NOT compatible with a neurological disorder

#### Specific tests for dissociative motor disorders (conversion)

- Limb weakness
  - Assess for inconsistencies (their gait when walking towards the examination bed and back)
  - Hoover's sign (examiner keeps his hand on the heel of the affected limb – e.g. left foot in left leg weakness)
    - Voluntary hip extension – command 'push down with your left heel' – weak
    - Involuntary hip extension- command 'raise your right leg' (against resistance applied by the examiner on to the right leg) – left hip extends
  - Collapsing weakness
    - On light touch by the examiner the limb collapses from instructed position
    - E.g. right arm weakness – command to extend right arm, then apply light pressure, resulting in the arm to collapse
  - Arm drop – slow and jerky descent of arm from extended position

#### False positive test results

- Pain in the affected joint resulting in improved function with distraction
- General weakness
- Inability to understand or follow instructions

- Tremor
  - Significant variability in amplitude, frequency and distribution of the tremor
  - Improvement with distraction
  - Entrainment
    - Command to carry out a specified rhythmical movement with the normal hand
    - Normal hand entrains to same rhythm as the abnormal side or rhythm becomes irregular or incomplete
  - Co-activation
    - Add weights to affected limb
    - Organic tremor – amplitude reduces
    - Conversion symptom – amplitude increases

- Gait
  - Characteristic gait
    - Drags the affected leg behind the body like a log
    - External / internal rotation of the hip with the foot pointing inwards / outwards
  - Excessive slowness
  - Uneconomic postures
    - E.g. Walking with flexion of hips and knees
  - Falling towards or away from the examiner

## Management

- Address the diagnosis in a sensitive manner (see below)
- Non-specific, supportive interventions
  - Reassuring statements – with an element of suggestion
  - Relaxation
- General advice
  - Lifestyle modification
  - Gradual increase in level of activity
- Physiotherapy
  - Face saving mechanism
  - E.g. physiotherapy for limb weakness
- Address psychosocial stressors
- Improve coping mechanisms
- Specific psychological interventions
  - Problem solving counselling
- If secondary gains present
  - Manipulate the environment that reinforces symptoms
  - Family work – educate family to reward autonomy and independence vs. sick role
- Refer to psychiatric services for further interventions

## Chapter 10- Person with Obsessive-compulsive disorder

### Dos and don'ts in explaining the diagnosis of conversion

- Acknowledge symptoms
  - 'Your nervous system is intact, but something's preventing it from working properly'
- Use of metaphors
  - E.g. It's like a car that's out of tune, there's nothing wrong with the parts but it's not working as it's supposed to
- Address patient's fears
  - Reassure them that you don't think that they're making up their symptoms or imaging them
- Let them know that it's common and that you have seen it before
- Explain the reversible nature of the symptoms

*A 17-year-old girl presents to your practice with her mother. Her mother states that her daughter repeatedly engages in hand washing and counting rituals and this has resulted in a marked decline in her level of functioning. She has no other past psychiatric or medical history. There is a family history of depression in a first degree relative.*

### How do you recognize an obsession?

The following are key features of an obsession

- Repetitive
- Intrusive
- Unpleasant
- Resisted by the patient
- Recognized as own thoughts
- Senseless

### Types of obsessions and compulsions

- Obsessional thoughts
  - Single words, phrases, ideas and beliefs
  - Can be obscene and blasphemous
    - E.g. Thoughts of contamination or blasphemous thoughts
- Obsessional images
  - Vividly imagined scenes
  - Can be violent or repulsive
    - E.g. Images of his / her family being murdered
- Obsessional ruminations
  - Internal debates, where the individual argues for and against a topic
- Obsessional doubts
  - Concern that an action was not completed
  - Concern that an action has caused harm to another

- E.g. Doubts whether the door was locked properly, which often leads to compulsive checking behaviours
- Obsessional impulses
  - Urge to perform acts that are either violent or embarrassing
    - E.g. To shout out blasphemies at the temple
- Obsessional rituals
  - Mental activities
    - E.g. Counting rituals
  - Repetitive senseless behaviours
    - E.g. Hand washing
- Obsessional slowness
  - Extreme slowness, which is out of proportion to other symptoms

#### Differential diagnosis

- Obsessive compulsive disorder (OCD)
- Depression
- Schizophrenia

#### In children also consider

- Tourette's syndrome
- Autism

#### Assessment

- Symptoms list
  - Obsessions and compulsions
- Onset and course
- Impact on activities of daily living and function
- Symptoms of other anxiety disorders
- Symptoms of depression
  - Low mood, loss of energy, loss of interest in pleasurable activities
  - Depressive cognitions
  - Poor sleep and appetite
- Symptoms of psychosis
  - Patients with schizophrenia may have OCD symptoms
  - Some obsessions may resemble delusions
    - If the content is unusual
    - Initial internal resistance mounted against the obsessions have become weak
- In childhood onset assess for Tourette's syndrome and Autism Spectrum Disorders (ASD)
  - In Tourette's syndrome more than 50% will suffer from OCD
  - Other symptoms of Tourette's syndrome are;
    - Motor and vocal tics -E.g. Jerking of the head, snarling and grunting
    - Coprolalia - obscenities that are uttered involuntarily
  - Routines and rituals seen in ASD need to be differentiated from OCD
    - There's an associated social and communication impairment in ASD
    - These rituals are not distressing to the child and are ego syntonic
    - They're often more simple than what is seen in OCD



## OCD and depression

- symptoms, which will diminish with treatment of depression
- OCD itself can give rise to depressive symptoms
- Assess chronological order of depressive and obsessional symptoms to differentiate which preceded

## Management

- Provide psycho education to patient and family
  - Educate about the nature of the disease and availability of effective treatment
  - Advice family members against being drawn in to rituals or providing reassurance
  - Explain how reassurance can perpetuate symptoms and how to decline requests for reassurance in a kind but firm manner
- Refer to psychiatric services for specialist input
- Commence pharmacological treatment
  - SSRI
  - Clomipramine
- Short term use of benzodiazepines
  - Benzodiazepines should not be prescribed for more than two to four weeks
  - Use of benzodiazepines is counter-productive in a patient undergoing CBT
- Psychological interventions
  - Cognitive Behaviour Therapy
    - Exposure and response prevention – compulsions
    - Cognitive therapy - obsessions
- Combination of pharmacological and psychological interventions is more effective than either alone
- Relapse is common soon after discontinuation and thus long term maintenance treatment is advised

## Treatment with medication

- Selective serotonin reuptake inhibitors (SSRIs) are often first line treatment
  - E.g. fluoxetine
- They do not cause dependence
- May need higher doses than what is prescribed for depression
  - E.g. fluoxetine 20 – 60mg / day
- May take longer to see an improvement than with depression
- Monitor for side effects
  - GI – nausea – often resolves with continued treatment
  - Neuropsychiatric – insomnia, agitation, tremor, headache
  - Sexual side effects – sexual dysfunction

## Chapter 11- Person with Somatic symptoms

### Case Vignette

A 47-year-old, unemployed male married with two children, presents to your practice with abdominal pain with nausea and bloating. His symptoms have not responded to treatment. He reports that he has seen several doctors over the past two years due to his illness and undergone several investigations including endoscopy.

### Differential diagnosis

- 1) Somatization disorder
- 2) Hypochondriasis
- 3) Depression

### Assessment

- Assess the patient's presenting somatic complaints
  - List out all somatic symptoms
  - Provides the patient an opportunity to ventilate
  - Gives you the opportunity to understand the overall picture
- Impact on daily life and disability
  - Inquire about a typical day
  - Beliefs contributing to disability e.g. fear of falling resulting in greater disability than the reported weakness
- Onset and course
  - For chronic symptoms a timeline or graph will be useful

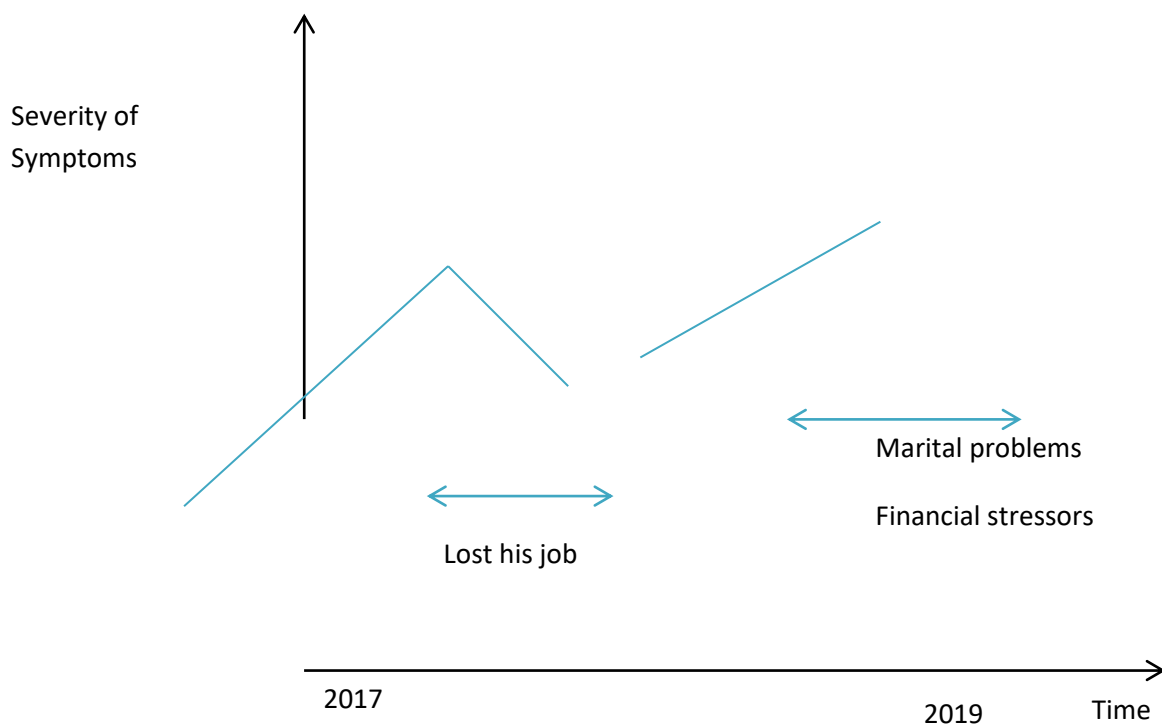


Fig 01 – Course of illness plotted against time

- Current illness beliefs and expectations
  - Cause of symptoms

- Their expectations – e.g. further investigations
- Previous treatment and investigations
  - Number of consultations
  - Investigations - e.g. x-ray, scans, MRI
- Current psychosocial stressors
  - Relationship conflicts
  - Financial difficulties
    - Recipient of benefits / compensation
- Medical history of patient and family
  - Chronic medical illnesses
  - Illness behaviour
- Personal history
- Mental state examination

### Practice Point

A patient presenting with multiple somatic symptoms is a red flag for an underlying psychological disorder

Further assessment to explore differential diagnosis

### Somatization disorder

- Assess for other physical symptoms
  - Preoccupation with multiple and variable physical symptoms, not explained by a physical disorder for at least 02 years
    - GI – nausea, vomiting, frequent bowel movement
    - CVS – chest pain, shortness of breath without exertion
    - GU – frequency, dysuria, vaginal discharge
    - Skin and pain – skin discolouration; pain in limbs and joints
- Assess past medical history
  - Refusal to accept medical advice regarding absence of a physical cause, except for brief periods
    - Multiple consultations (3 or more) with primary care or specialist doctors
      - Or if the patient is unable to access or afford such doctors, to persistently engage in self-medication or consultations with indigenous healers
    - Repeated investigations – e.g. repeated ultrasound scans, endoscopy

### Hypochondriasis

- Assess underlying beliefs regarding physical symptoms
  - Belief of serious underlying physical disease for at least 06 months duration
    - E.g. Patient believes that abdominal pain indicates bowel cancer
- Persistent refusal to accept medical advice

- Results in doctor shopping and repeated investigations

## Depression

- Somatic symptoms are often the presenting complaint of patients who are depressed
- Assess for other clinical features of depression
  - Pervasive low mood
  - Loss of energy, lethargy
  - Anhedonia – loss of interest in previously pleasurable activities
  - Biological symptoms
    - Reduced sleep and appetite
  - Depressive cognitions

## Management

Carry out a comprehensive assessment

- Understand the patient's expectations
- Exclude organic causes

Acknowledge patient's symptoms

- Emphasize that you know the symptoms are real
- Express that you're familiar with them
- Validate distress due to symptoms

Educate patient on the role of psychosocial factors in medical illness

- Provide the patient with an alternative psychosocial explanation to his symptoms
- Ensure that there's adequate time in the consultation to address any concerns or queries

Review previous records and investigations

- Avoid duplicating investigations
- Avoid unnecessary medical / surgical referrals

Agree on a treatment plan

- If new symptoms occur that you would investigate as needed
- Consider a treatment contract

Prevent doctor shopping

- Set regular pre-arranged appointments
- Patient to reduce demands in between sessions

General

- Lifestyle modification
- Gradual increase in exercise / activity

Referral to psychiatric services in a sensitive and timely manner

- Psychological interventions
  - Cognitive Behaviour Therapy

## Chapter 12 –Person with Alcohol use disorder with morbid jealousy

Patients with alcohol use disorders- harmful use or dependence, may have doubts about their partner's faithfulness (fidelity)

Patients presenting with jealousy made worse during

- Acute intoxication with alcohol - this is temporary, as part of the intoxication symptoms
- During withdrawal if it is an alcohol dependent person- this again, can be temporarily present during the withdrawal symptom phase
- As a longer term symptoms since the commencement of alcohol use

They have doubts about their partner with one/many other partners with no proof to support their claim

The differential diagnoses

1. Delusional disorder-jealous type
2. Severe depression with psychotic symptoms
3. Depression with obsessional jealousy
4. Personality disorders
5. Depression with overvalued ideas
6. Dementia ( behavioral and psychological symptoms associated with dementia)

Management plan

1. Risk assessment ( Homicide/ Suicide/ Intimate partner violence)
2. It is essential to consider the alcohol use pattern- is the patient a social drinker?Is he having harmful use? Or is he dependent on alcohol?
3. Is the patient presenting during acute intoxication ( will have other features of intoxication), during withdrawal ( will have other features of withdrawal) or is it a more long standing doubt the partner
4. Is the doubt about the partner a temporary, fleeting and can be argued against when interviewing the patient? (i.e. not delusional) or is he fully convinces about it with no solid basis to his belief? ( i.e. delusional)
5. Does the patient have any plans to harm the partner to the alleged lover/lovers or any plans or attempts to harm himself
6. As mentioned above, delusional disorder, depression and dementia need to be excluded( see care guidelines )
7. If the patient is intoxicated or in a withdrawal state, please reassess once settled
8. Medication will depend on the underlying disorders

Essential information for patient and family

Suspiciousness toward the partner's fidelity is on a spectrum

There are those who have fleeting, temporary suspiciousness and those who have long standing convictions

When jealousy is combined with alcohol use, it can be risky for the partner, the alleged lover or the patient himself

Specialist consultation

Specialist consultation will be necessary in this case, as there are risks involved, as well as co morbidity between alcohol and other psychiatric disorders

## Chapter 13 -Alcohol use disorders

Prevalence of alcohol use disorders have a clear positive linear relationship with per capita alcohol consumption (i.e. average overall alcohol consumption in a country). Alcohol industry is the vector that drives the epidemic of alcohol use disorders by promoting overall alcohol consumption. Their primary tactic is to make alcohol use a highly attractive, fashionable behaviour.

Alcohol is a depressant of the central nervous system, and some of the acute effects of alcohol appear to be learnt responses. Some inexperienced users getting “drunk” even before blood alcohol concentration reaches a significant level, evidence revealing dopamine surge in the reward centre due to alcohol ingestion only in veteran drinkers, and sudden sober behaviour in some intoxicated people when confronted by authority such as police are powerful observations that point toward the role of psychological learning in explaining some acute effects of alcohol.

Although alcohol use might be protective against having myocardial infarctions, alcohol use, even at very low amounts, increases chances of early death. No recommendations should be made on initiation or continuation of alcohol use based on the so-called health benefits, which is an out-dated myth.

Effective management of alcohol use disorders warrants an understanding of the alcohol industry and their tactics to promote alcohol use, negative health effects of long-term alcohol use and possible psychological mechanisms in explaining some of the acute effects of alcohol.

### Diagnostic categories and presentation

All patients that present to primary care for all reasons are from one of the categories shown in table 1.

Category of alcohol use	Diagnosis	Description
Pathological alcohol user	Alcohol dependence	More severe form of alcohol use disorder
Pathological alcohol user	Harmful use of alcohol	Less severe form of alcohol use disorder
Non-pathological alcohol user	None	User without an alcohol use disorder
Non-user of alcohol or abstainer or teetotaler	None	User who has not taken alcohol for a considerable period of time (usually six to 12 months or lifetime)

You need to be able to recognise which category a patient belongs to, even the presentation is not directly related to alcohol use, in order to make your response a more effective one. Your clinical skills, better informed and enhanced by reading this chapter, will help you to do that.

### Approach to assessment:

It is not only the alcohol use, but its impact, too, needs to be assessed. There can be factors that promote and demote alcohol use, which are useful to be recognised as well. People who use alcohol in a clinically significant way, usually have multiple other issues and co-morbidities in life. Let us first examine the relationship between all such issues in the life of the alcohol user and his alcohol use, irrespective of the fact that they “results” or “causes” of his alcohol use.

## Complex relationship between alcohol use and issues in the life of the user

Many people, including health professionals seem to believe that all problematic issues, health or otherwise, seen in a person with alcohol use disorders, are due to alcohol use. The relationship between such issues and alcohol use is complex:

- Some issues are directly caused by alcohol use while some aggravated by alcohol use  
E.g. A man developing alcoholic hepatitis after an episode of heavy alcohol use
- Certain other issues may have a contribution from alcohol. E.g. A man's diabetic status is aggravated as his alcohol use increases
- Certain conditions may induce or worsen alcohol use. E.g. A man who believes frequent alcohol use is a sign of wealth, develops mania with grandiosity, and starts throwing frequent alcohol parties at home.
- Some issues may be worsened by alcohol use while the same issue makes alcohol use worse in return. E.g. Chronic pancreatitis due to alcohol use making a carpenter non-functional, who now spends his entire day at illicit alcohol sale point drinking alcohol
- Many psychological and social issues have a dual and complex relationship with alcohol use. E.g. the relationship in a couple deteriorating as the man uses alcohol in an increasingly irresponsible way. As the sexual relationship stops, the man starts to drink even at home late into night.
- Sometimes, even non-pathological use may cause harm. E.g. A young man without an alcohol use disorder encountering traffic accident following a drinking session at a party.
- Hence, in summary, it is very complex to understand the exact relationships between many issues seen in the life of people engaging in alcohol use.

## Assessment template

The assessment may happen across many sessions. However, areas 1, 2 and 7 need to happen as early as possible. The assessment may begin even if you see the patient. E.g. Family coming to see you without the patient first.

Table 2: Areas to inquire in assessment to detect all health-related issues

<b>Area</b>	<b>Examples</b>
1. Substance use/ other psychiatric disorders a. Alcohol b. Tobacco c. Others	Harmful use of alcohol Occasional use of cigarettes Cannabis used once two years ago
2. Medical conditions a. Secondary to alcohol/ other substance b. General medical conditions	Fatty liver with mildly elevated liver enzymes None
3. Personality a. Assertiveness, other major issues b. Significant deterioration in personality	Poor assertiveness in saying no to friends No deterioration
4. Motivation to change alcohol use and related behaviour a. Actual genuine intrinsic motivation b. Family's perception of patients real intrinsic motivation c. Factors inducing extrinsic motivation	High motivation – determination stage Fiancé believes he is motivated  Nothing of significance
5. Family / occupational function a. Intimate partner relationship b. Other relationships c. Occupational function	Healthy relationship with fiancé No major issues No major issues
6. Sexual health a. Sexual function b. Sexual problems in partner	No major issues No major issues
7. Risk and legal issues a. Risks of obvious physical harm to self and/ or to family/ others b. Law enforcement issues c. Risk of STI d. Risk of neglect of physical health e. Sexual abuse of/ by patient f. Social/ psychological exploitation of/ by patient	None
8. Substance use promotion by client a. Directly b. Indirectly	He used to make novices drink at office parties He still argues for benefits of alcohol use with friends
9. Unhelpful behaviours/ beliefs a. In client  b. In spouse c. In other family members d. In any relevant others	“Alcohol is a symbol of sophistication” “Alcohol industry is a decent ethical industry; not involved in making people drink more”  “Alcohol is a symbol of sophistication and modernity”
10. Any other issue	

#### Application of assessment template

This is done through the usual history and examination pathway. Once the list of issue is made after assessing a real patient, it will look like as follows:

Mr.TP, 46 y, a banker, married with two school going children, presenting seeking medical help to discontinue his daily heave alcohol use. His last drink was this morning, and has no signs of alcohol withdrawal.



Issues/ problems/ diagnoses identified as a full assessment (or over several sessions of assessment):

1. Substance use/ other psychiatric disorders
  - 1.1. Alcohol dependence + Impending alcohol withdrawal once he stops alcohol use
  - 1.2. Harmful use of tobacco
  - 1.3. ? Current moderate depression
2. Medical disorders/ conditions/ symptoms
  - 2.1. Poorly managed diabetes and hypercholesterolemia
  - 2.2. Fatty liver; not-assessed for the last one year
3. Personality
  - 3.1. Aggression
4. Motivation to change alcohol use and related behaviour
  - 4.1. Moderately motivated (contemplation/ determination stage)
  - 4.2. Family believes he is well motivated
  - 4.3. Wife's expression of divorce as an outcome prompted him to seek treatment
5. Family / occupational function
  - 5.1. Poor intimate partner relationship from the beginning; overt marital discord for two/ three years
  - 5.2. Somewhat estranged from kids
  - 5.3. Erratic occupational function
6. Sexual function
  - 6.1. No sex life for six or more months
7. Risk of obvious harm and legal issues
  - 7.1. Escaped getting caught driving drunk few times
  - 7.2. Dangerous driving even when with family members at times
  - 7.3. Occasional physical assault on wife
  - 7.4. No overt risks of self-harm
8. Substance use promotion by client
  - 8.1. Pressurises novice banker to drink alcohol at bank parties
9. Unhelpful behaviours/ beliefs
  - 9.1. In client: Bankers can/ should tolerate high amounts of alcohol/ Alcohol is essential to celebrate/ Alcohol is toxic to children not adults/ If you eat well, alcohol causes no physical harm/ Behaviour: Repeated attempts to drive car when under influence of alcohol
  - 9.2. In spouse: Alcohol is toxic to children not adults/ If you eat well, alcohol can cause little physical harm / Heavy drinking is the only problem in my husband/ Behaviour:
  - 9.3. Other family members: His mother believes that a good wife should be able to stop the alcohol use in her husband
10. Any other issues: --

Assessment for alcohol withdrawal state

Suspect alcohol withdrawal in any adult patient with unexplained delirium or generalized tonic-clonic seizures. Alcohol withdrawal state with delirium (two to four days after last alcohol intake) or seizures (developing in the first two days after last alcohol intake) is known as complicated alcohol withdrawal state.

Some dependent patients may present with alcohol withdrawal state (e.g. patient brought to ED due to generalised tonic-clonic seizures), or they may develop it while taking treatment for some other issue (delirium in a patient two days after admission to hospital following a traffic accident trauma). The diagnosis of alcohol withdrawal state needs to be considered in all male patients who are agitated due to unknown reasons with tremors and those with unexplained

generalised tonic clonic seizures. See table 3 for symptoms, signs and complications of alcohol withdrawal.

Table 3: Symptoms, signs and complications of alcohol withdrawal state

<i>Acute alcohol withdrawal state</i>		
Time frame	Features	Complications
Usually develops 12 to 24 hours from last drink. In heavy chronic users may develop earlier, even in 12 hours or less. Symptoms are most severe in 24 to 48 hours from last drink.	Anxiety, agitation and insomnia Tachycardia, sweating Tremor of hands, legs and trunk Nausea, vomiting Insomnia Illusions and paranoia – less prominent than in delirium tremens Transient hallucinations, mainly frightening visual hallucinations. e.g. of serpents – less prominent than in delirium tremens	Alcohol withdrawal seizures Delirium tremens
<i>Alcohol withdrawal seizures</i>		
Time frame	Features	Complications
Seizures may occur within first 48 hours from last drink, even without features of acute alcohol withdrawal state.	Generalised tonic clonic seizures NB: May occur without any warnings or any features of acute alcohol withdrawal state	Death
<i>Delirium tremens</i>		
Time frame	Features	Complications
Around 48 after last drink as the acute withdrawal symptoms peak	Confused thinking and disorientation Agitation Tachycardia and hypertension Fever Large increases in blood pressure, respiratory rate and heart rate Prominent illusions and paranoia Frightening visual hallucinations. e.g. of serpents	Death

The features of alcohol withdrawal are due to a hyper excitatory state of the brain since the CNS depressant effect of alcohol is acutely removed.

### Assessment of alcohol use

People with pathological alcohol use may present with a direct issue related to the alcohol use disorder (such as withdrawal state, wanting to stop alcohol use) or with other issues (such as road traffic accident, liver disease) without mentioning alcohol use in the first place. It is always imperative to ask all adult patients if they use alcohol and tobacco.

A quick practical, although not perfect, way to diagnose alcohol dependence and to differentiate it from harmful use of alcohol, is to follow the algorithm shown in figure 1.

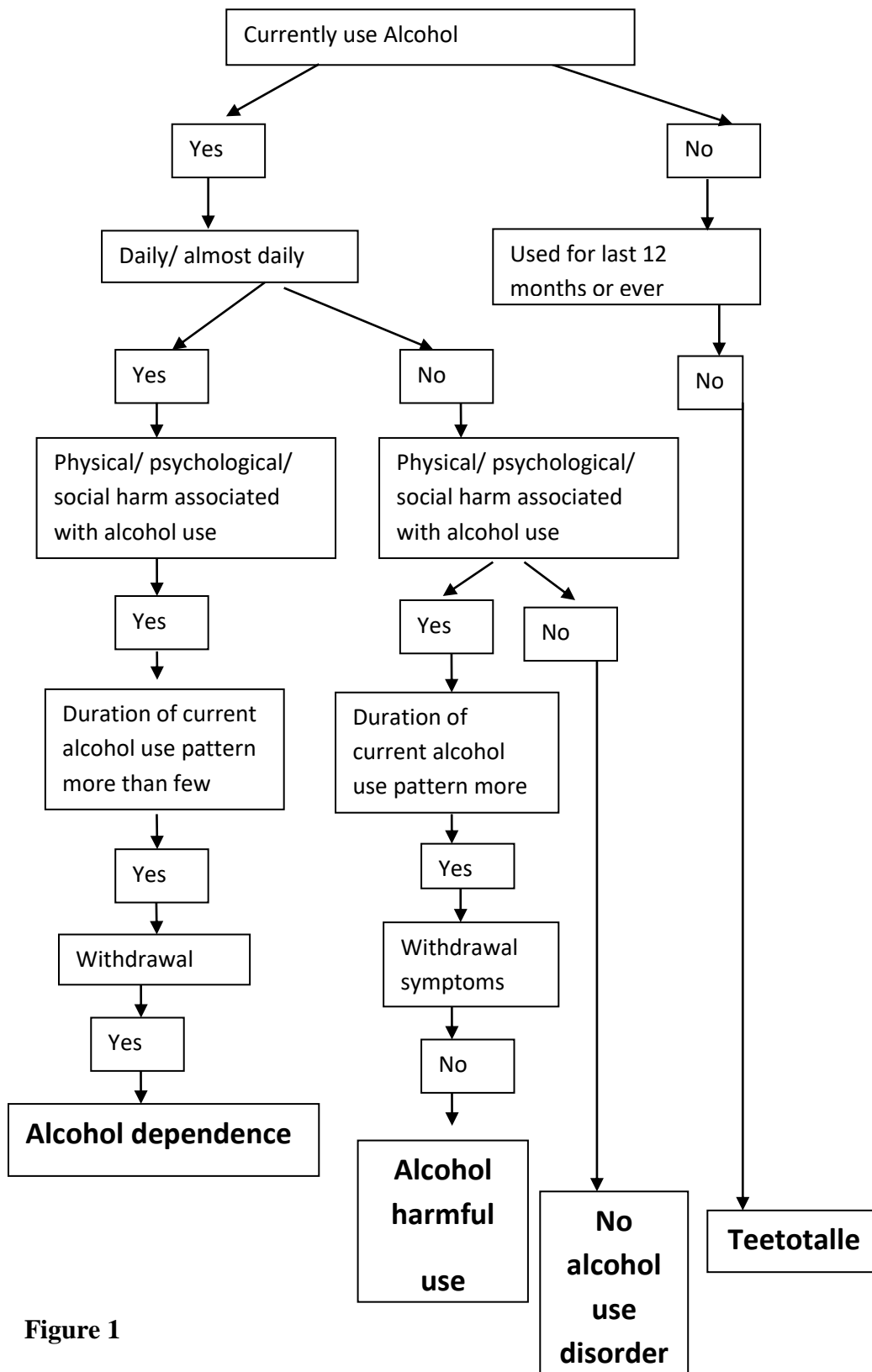


Figure 1

## Approach to management

The holistic management of a patient with pathological alcohol use is four-fold:

1. Assessment of alcohol use and other clinically significant issues
2. Treatment for alcohol withdrawal if applicable
3. Treatment for discontinuation of alcohol use pattern
4. Treatment/ interventions for issues detected in the user and the family

The specific management steps the primary care physician may plan once it is recognised which category the patient belongs to, are given in table 4.

Table 4: Summary of management according to types of alcohol use

Category of alcohol use	Diagnosis	Summary of management
Pathological alcohol user	Alcohol dependence	<ol style="list-style-type: none"> <li>1. Do full assessment using assessment template (table 2)</li> <li>2. Plan for detoxification after deciding the setting, i.e. inpatient or outpatient</li> <li>3. Select one or more from effective treatments to achieve discontinuation of pathological alcohol</li> <li>4. Give basic education on alcohol as a chemical, value given to alcohol, effects and harms of alcohol, and role of alcohol industry in promoting alcohol use (see “Mandatory messages to be included in health education” below).</li> <li>5. Plan specific management steps including referral to specialists guided by the issues detected in step 1 (see “Management plan of Mr.TP).</li> </ol>
Pathological alcohol user	Harmful use of alcohol	<ol style="list-style-type: none"> <li>1. Do full assessment using assessment template (table 2)</li> <li>2. Select one or more from effective treatments to achieve discontinuation of pathological alcohol</li> <li>3. Give basic education on alcohol as a chemical, value given to alcohol, effects and harms of alcohol, and role of alcohol industry in promoting alcohol use (see “Mandatory messages to be included in health education” below).</li> <li>4. Plan specific management steps including referral to specialists guided by the issues detected in step 1(see “Management plan of Mr.TP).</li> </ol>
Non-pathological alcohol user	None	Give basic education on alcohol as a chemical, value given to alcohol, effects and harms of alcohol, and role of alcohol industry in promoting alcohol use (see “Mandatory messages to be included in health education” below).
Non-user of alcohol or abstainer or teetotaler	None	<b>Optional</b> - Give basic education on alcohol as a chemical, value given to alcohol, effects and harms of alcohol, and role of alcohol industry in promoting alcohol use (see “Mandatory messages to be included in health education” below).

Now, what is needed is to plan treatment interventions. Following principles will guide preparing a good treatment plan:

Principle 1: All issues/ problems in the user of alcohol are not only and entirely due to alcohol use. Hence, all issues/ problems/ conditions have to be looked at, not only the alcohol use.

Principle 2: Discontinuation or reduction of alcohol use is an important and integral part of clinical improvement, although it is not the only treatment outcome.

Principle 3: There are effective evidence based interventions indicated for discontinuation/reduction of alcohol use, although all these interventions are not equally effective.

Principle 4: Effective treatments indicated to help patients to stop or reduce their alcohol intake (such as motivation enhancement therapy or disulfiram) are not necessarily interventions indicated for other issues related or unrelated to alcohol use (such as marital discord or hypertension).

Principle 5: The treatment team has a duty of care to the patient who uses alcohol irrespective of the level of motivation, respect shown to or engagement with the treating team.

Principle 6: The treatment team has an equal duty of care to all the actually and potentially affected persons, such as spouse or children, negatively affected by the issues recognised in the patient, such as aggression or irresponsible behaviour. Even the pedestrians on the road that could potentially be affected by reckless driving need to be taken into account.

Principle 7: Patients with chronic alcohol use are at a higher risk of developing serious medical complications including death. This should be remembered by the treating team and conveyed appropriately to patient and the family.

Principle 8: Patients who are dependent need a plan to treat impending alcohol withdrawal state, or if they are already in a withdrawal state, it has to be treated urgently.

Principle 9: Patients benefit from simple, sometimes one-off sessions of, proper tailored effective health education, especially when administration of specialised treatments such as anti-craving or aversive medications or CBT, is unavailable or impractical. However, a mere list of popular harms of alcohol use, or a moral lecture on the demerits of 'bad behaviour', are very unlikely to have any meaningful effect. To further understand this, please read the next section titled "Mandatory messages to be included in health education".

Mandatory messages to be included in health education:

- The main responsibility to seek treatment and make behaviour changes lie within the patient, not others.
- Alcohol is a CNS depressant not a stimulant. The pleasure and other emotions, and most behaviours following alcohol use are learnt responses.
- Therefore alcohol users should not be given undue privileges or permissions such as excusing them for behaviour in an indecent manner in a party.
- More than if one drinks alcohol or not, the value one gives alcohol is more important and relevant. For an example the teetotaler wife of the pathological drinker may insist that they serve free alcohol at the wedding reception of their daughter although her husband is just recovering from alcohol dependence.
- Alcohol, even at very low doses such as one drink a day, causes health harms. Safest level of regular alcohol use is zero.
- Alcohol use is a major risk factor for development of cancer, especially breast cancer.
- Alcohol industry wants to recruit new customers as their customers die prematurely. They target young people more for obvious reasons.
- Product placement coupled with powerful messages in mass media and creative media is a well-known tactic of the alcohol industry. E.g. the hero of the movie starts to drink alcohol as the girl leaves her, who returns hearing that he drinks alcohol because she left him.

- The industry also manipulates role models in society such as doctors and lawyers to promote alcohol among lay people and youth.

Treatments to achieve discontinuation of pathological alcohol use in alcohol dependence and harmful use:

Pharmacological treatments:

1. Aversive treatments: Disulfiram
2. Anti-craving treatments: Naltrexone and accamprosate

Non-pharmacological treatments:

3. Effective health education, if possible with CBT and motivation enhancement elements (see “Mandatory messages to be included in health education” above.)
4. Motivation enhancement therapy
5. Behaviour therapy
6. CBT
7. Input targeting patient’s family and friends, especially health education (see “Mandatory messages to be included in health education” and \*\*\*).

Provision of information necessary to administer above treatments is outside the scope of this book. Doctors are encouraged to get training in above treatments. The Multi-sector Alcohol Prevention (MAP) programme run by the Mental Health Directorate together with World Health Organisation Country Office and National Authority on Tobacco and Alcohol conducts a three day training programme for doctors covering each district in Sri Lanka.

Treatment of alcohol withdrawal state (i.e. alcohol detoxification):

Unless patient is in alcohol withdrawal at presentation, always plan for the date of discontinuation of alcohol use in a dependent patient; never do it in an ad hoc manner or solely on the wishes of the family or the treating doctor.

Treatment setting

Inpatient if symptoms are severe or withdrawal is complicated. Otherwise, especially if tolerance is lower and past withdrawals were milder, outpatient treatment is advisable. If in doubt, guide patient for admission or specialist opinion. **Delirium tremens and withdrawal seizures carry a high mortality rate if not managed properly.** If there are complications, severe withdrawal symptoms, or diazepam doses are needed in excess of 30- 40mg a day, it is advisable to have a consultant (internal medicine or psychiatry) cover. Inpatients in alcohol withdrawal are generally managed in internal medicine wards or psychiatry wards.

If you decide the patient could be managed as an outpatient or as an inpatient under your care in a hospital without consultant cover, after first or second day, start reducing the medication in order to tail off in five to seven days. E.g. 15mg tds in first two days, 10mg tds on third day, 5mg tds on fourth day, 5mg bd on fifth day and 5mg nocte on sixth day. However, some patients may need extra doses at night to sleep.

Pharmacological agents

Benzodiazepines are effective in fully controlling all withdrawals symptoms. Diazepam (10 to 20 mg tds) or chlordiazepoxide (20 to 40 mg tds) are frequently used with higher doses for inpatients. From day 2 or 3, the dose should be gradually tapered off in 3 to 5 days.

Thiamine (Neurobion not Polybion) 100mg per day or more is needed in first few days to prevent development of Wernicke’s encephalopathy in patients with heavier longer

consumption of alcohol. Intramuscular route is preferred in inpatients, which may be supplemented by oral administration.

A patient you have selected to be managed by yourself, probably as an outpatient, usually needs oral thiamine 100 mg (Neurobion one tablet) tds for few weeks.

Treatments for other issues recognised using assessment template

Most of the issues commonly recognised need interventions based on common sense. E.g. educating patient and family firmly on surrendering car keys before any drinking session in a patient with reckless driving following intoxication. Some issues may need specialised therapy, such as couples therapy for marital discord, but we may be able to deliver only psycho education due to lack of availability of qualified therapists.

Mr.TP, described above under “Application of assessment template”, had many issues. To help Mr.TP and his family, following interventions are planned according to the management plan reproduced below.

### Management plan of Mr.TP

Mr.TP, 46 y, a banker, married with two school going children, presenting seeking medical help to discontinue his daily heavy alcohol use. His last drink was this morning, and has no signs of alcohol withdrawal.

Issue/ diagnosis/ clinical problem	Intervention planned
1. Substance use/ other psychiatric disorders 1.1. Alcohol dependence + Impending alcohol withdrawal once he stops alcohol use 1.2. Harmful use of tobacco ? Current moderate depression	<ul style="list-style-type: none"> <li>• Admit to medical ward for detoxification under supervision of Internal Medicine Physician</li> <li>• Simple advice on health harms of tobacco and need to quit</li> <li>• Review if psychiatric referral is needed after detoxification</li> </ul>
2. Medical disorders/ conditions/ symptoms 2.1. Poorly managed diabetes and hypercholesterolemia 2.2. Fatty liver; not-assessed for the last one year	<ul style="list-style-type: none"> <li>• Full assessment and management plan from medical ward (during detoxification admission)</li> </ul>
3. Personality 3.1. Aggression	<ul style="list-style-type: none"> <li>• Family meeting to discuss his behaviour.</li> <li>• Education on not giving permission by others for aggression when drunk (see “Mandatory messages to be included in health education”)</li> </ul>
4. Motivation to change alcohol use and related behaviour 4.1. Moderately motivated (contemplation/ determination stage) 4.2. Family believes he is well motivated 4.3. Wife’s expression of divorce as an outcome prompted him to seek treatment	<ul style="list-style-type: none"> <li>• Education on need of motivation and commitment to change if change is desired.</li> <li>• Apply motivation enhancement principles if possible.</li> <li>• Point out to family that his motivation is moderate.</li> <li>• Point out to wife that her divorce threat is a major factor behind his motivation; it may be useful for her to know that children benefit more from a single parent home rather than a home where parents fight all the time.</li> </ul>
5. Family / occupational function 5.1. Poor intimate partner relationship from the beginning; overt marital discord for two/ three years 5.2. Somewhat estranged from kids 5.3. Erratic occupational function	<ul style="list-style-type: none"> <li>• Educate them that they need marital therapy – ask if a referral is needed to a psychiatrist or psychotherapist.</li> <li>• Point out that estrangement from kids and poor functional level are probably secondary to alcohol use and associated behaviour.</li> </ul>

<p>6. Sexual function 6.1. No sex life for six or more months</p>	<ul style="list-style-type: none"> <li>• Educate them that they need marital therapy – ask if a referral is needed to a psychiatrist or psychotherapist.</li> <li>• Ask again of any possibility of a sexual dysfunction.</li> </ul>
<p>7. Risk of obvious harm and legal issues 7.1. Escaped getting caught driving drunk few times 7.2. Dangerous driving even when with family members at times 7.3. Occasional physical assault on wife 7.4. No overt risks of self-harm</p>	<ul style="list-style-type: none"> <li>• Educate the potential harm to others, including children, on the road due to his driving</li> <li>• A family meeting to firmly agree that reckless driving/ driving when drunk is not going to be allowed hereafter – the family will take a taxi in such situations.</li> <li>• Educate that alcohol should not be used as an excuse for erratic behaviour (see “Mandatory messages to be included in health education”).</li> <li>• Discussion with patient and wife to agree on a firm no-physical violence at home status</li> </ul>
<p>8. Substance use promotion by client 8.1. Pressurises novice banker to drink alcohol at bank parties</p>	<ul style="list-style-type: none"> <li>• Point out that he is working for the alcohol industry unknowingly (see “Mandatory messages to be included in health education”).</li> </ul>
<p>9. Unhelpful behaviours/ beliefs 9.1. In client: Bankers can/ should tolerate high amounts of alcohol/ Alcohol is essential to celebrate/ Alcohol is toxic to children not adults/ If you eat well, alcohol causes no physical harm / Behaviour: Repeated attempts to drive car when under influence of alcohol 9.2. In spouse: Alcohol is toxic to children not adults/ If you eat well, alcohol can cause little physical harm / Heavy drinking is the only problem in my husband/ Behaviour: 9.3. Other family members: His mother believes that a good wife should be able to stop the alcohol use in her husband</p>	<ul style="list-style-type: none"> <li>• Appropriate health education (see “Mandatory messages to be included in health education”).</li> </ul>
<p>10. Any other issues: --</p>	<ul style="list-style-type: none"> <li>• No intervention</li> </ul>

### Selecting treatment setting

Treatment should always be outpatient unless indicated otherwise. Residential treatment is not shown to be superior to outpatient treatment except for alcohol detoxification. Rehabilitation is needed by only a handful of alcohol users who have suffered serious irreversible damage such as Wernicke-Korsakoff syndrome. Therefore naming residential alcohol treatment centres as ‘rehabilitation centres’ are technically wrong and induces stigma.

Inpatient treatment should be reserved for following indications:

- Recognition of serious multiple issues, especially risk issues, during assessment. E.g. Man with harmful use of alcohol showing serious aggression at home with some recent sexual advance towards his young daughter
- Recognition of comorbid psychiatric or general medical or other condition potentially involving risks to patient and/ or others. E.g. Man with harmful use of alcohol and delusional morbid jealousy. E.g. Alcohol using man with poorly controlled diabetes. E.g. Alcohol using pregnant woman.
- Current or impending alcohol withdrawal state with:



- Previous severe withdrawal symptoms
- Previous complicated withdrawal state: seizures, delirium tremens
- Multiple past detoxifications
- Comorbid medical or psychiatric condition – relative indication
- Recent high levels of alcohol consumption
- Lack of reliable support network

If you are working in a small peripheral hospital, you may admit patients that need inpatient care under supervision from specialists, and then transfer them to the appropriate hospital. This may be needed especially if the risks are significant and the intrinsic motivation of the patient is low. It is always advisable to communicate with the specialist or his/ her team first. You may justify the admission to the patient citing the physical harm, which is not untrue.

#### Follow up

Proper effective management happens over multiple sessions of follow up. One major session with hours of assessment, advice and treatment with little follow up plan is as almost good as not seeing the patient at all. Follow up allows the treating team to recognize issues in the life of the patient and the family previously unrecognized, and, more importantly, to get to know the patient, his family and their beliefs. You need to evaluate the effectiveness of your interventions by assessing the change in relation to the issues recognised in assessment.

## Chapter 14- Person with substance abuse

Apart from alcohol, there are a number of other substances that are abused by people

They can present in many different ways according to the substance

### **Cannabis**

The effects experienced by the cannabis user are variable and will depend upon the dose, method of administration, prior experience, any concurrent drug use, personal expectations, mood state and the social environment in which the drug is used.

- Effects of cannabis include:
  - An altered state of consciousness. The user may feel "high", very happy, euphoric, relaxed, sociable and uninhibited.
  - distorted perceptions of time and space. The user may feel more sensitive to things around them, and may also experience a more vivid sense of taste, sight, smell and hearing.
  - increased pulse and heart rate, bloodshot eyes, dilated pupils, and often increased appetite.
  - impaired coordination and concentration, making activities such as driving a car or operating machinery difficult and dangerous.
  - Negative experiences, such as anxiousness, panic, self-consciousness and paranoid thoughts.
- People who use large quantities of cannabis may become sedated or disoriented and may experience toxic psychosis - not knowing who they are, where they are, or what time it is. High doses may also cause fluctuating emotions, fragmentary thoughts, paranoia, panic attacks, hallucinations and feelings of unreality.
- The effects of cannabis are felt within minutes, reach their peak in 10 to 30 minutes, and may linger for two or three hours. THC is highly lipid soluble and can be stored in fat cells potentially for several months. The stored THC is released very slowly, and unevenly, back into the bloodstream.

### **Cocaine**

Cocaine's effects appear almost immediately after a single dose and disappear within a few minutes to an hour. Small amounts of cocaine usually make the user feel euphoric, energetic, talkative, mentally alert, and hypersensitive to sight, sound, and touch. The drug can also temporarily decrease the need for food and sleep.

Some users find that cocaine helps them perform simple physical and intellectual tasks more quickly, although others experience the opposite effect.

The duration of cocaine's euphoric effects depend upon the route of administration. The faster the drug is absorbed, the more intense the resulting high, but also the shorter its duration. Snorting cocaine produces a relatively slow onset of the high, but it may last from 15 to 30 minutes. In contrast, the high from smoking is more immediate but may last only 5 to 10 minutes

Short-term physiological effects of cocaine use include constricted blood vessels; dilated pupils; and increased body temperature, heart rate, and blood pressure

## **Heroin**

People who use heroin typically report feeling a surge of pleasurable sensation—a "rush." The intensity of the rush is a function of how much drug is taken and how rapidly the drug enters the brain and binds to the opioid receptors. With heroin, the rush is usually accompanied by a warm flushing of the skin, dry mouth, and a heavy feeling in the extremities. Nausea, vomiting, and severe itching may also occur. After the initial effects, users usually will be drowsy for several hours; mental function is clouded; heart function slows; and breathing is also severely slowed, sometimes enough to be life-threatening. Slowed breathing can also lead to coma and permanent brain damage

Heroin also produces profound degrees of tolerance and physical dependence. Tolerance occurs when more and more of the drug is required to achieve the same effects. With physical dependence, the body adapts to the presence of the drug, and withdrawal symptoms occur if use is reduced abruptly.

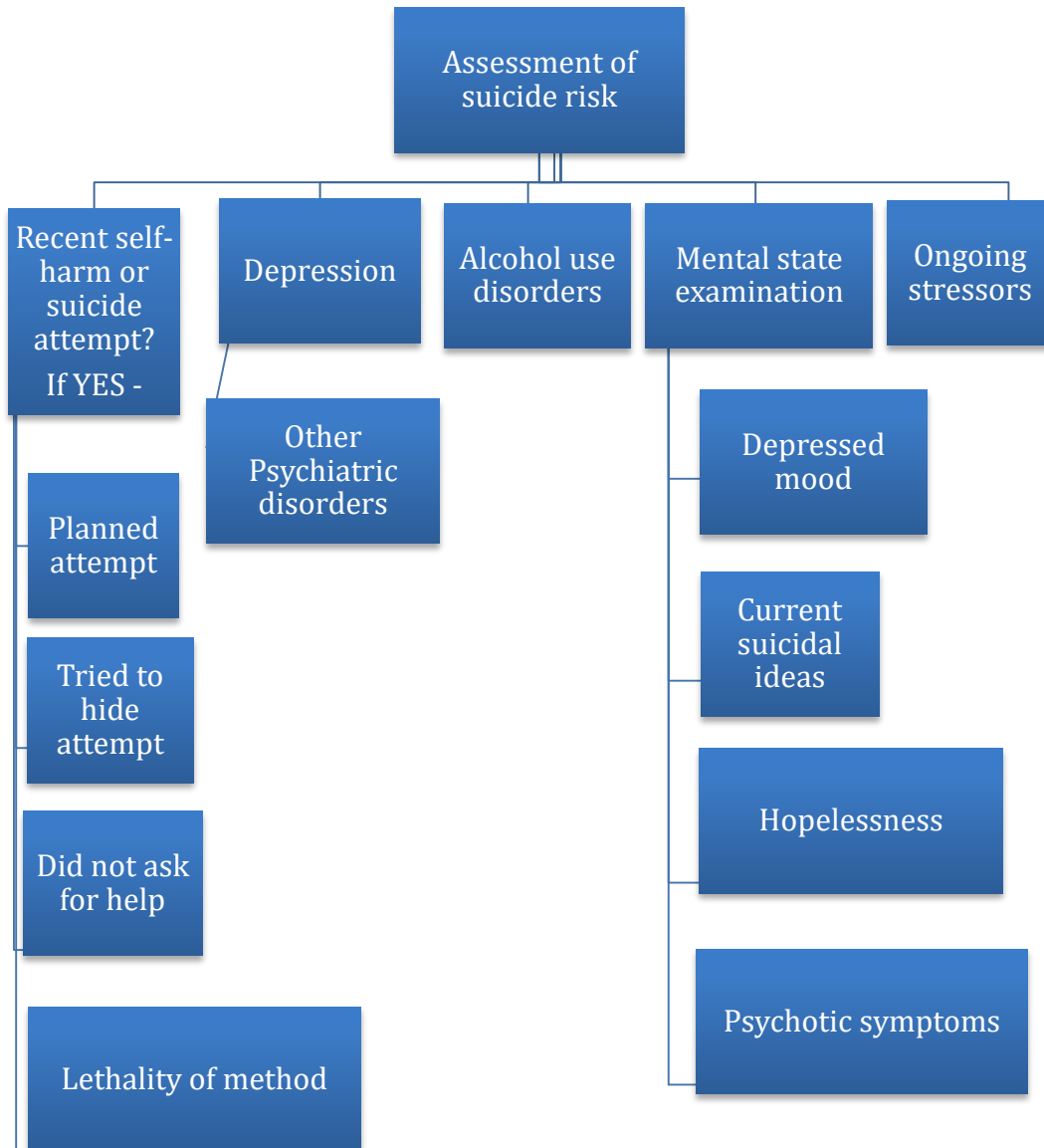
## **Management**

If you have any suspicion of a person abusing these substances, please refer to the closest consultant psychiatrist for further management

## Chapter 15- Person with deliberate self-harm and attempted suicide

- Deliberate self-harm is defined as a non-fatal act, in which an individual deliberately causes self-injury or ingests a substance in excess of prescribed dosage. The degree of suicidal intent is not directly specified when using the term deliberate self-harm, and can vary.
- Attempted suicide is defined as a non-fatal act, in which an individual deliberately causes self-injury, or ingests a substance in excess of prescribed dosage, with some degree of suicidal intent. The term, attempted suicide implies that the person had an intent to die when he/she harmed himself (the degree of this intent may vary).
- Self-harm often occurs after an acute ‘crisis’ – most often an interpersonal conflict. The person who attempts self-harm is often very emotionally distressed at that time. He /she may have a mixture of motives associated with the act – for example to escape distress, to communicate distress, to make something change, anger, shame, to die etc.
- The degree of suicidal risk associated with an act of self-harm can vary – from high risk to low risk.
- A proportion of people (but not all) who attempt self-harm will have a psychiatric illness – most often depression or alcohol use disorder.
- Older people who attempt self- harm are more likely to have a higher suicidal intent, and a psychiatric disorder.
- But this is not an invariable rule, and all people who attempt self-harm should be screened for the associated suicidal risk.
- The flow chart on the next page demonstrates an outline of how to assess for suicidal risk (figure 1).

**Figure 1. Suicidal risk assessment, after an attempt of self-harm**



**Suicidal risk assessment, following an attempt of self-harm.**

- It is important to assess the risk of suicide, if somebody has recently attempted self-harm.
- The risk of suicide can vary. It can be described as mild, moderate or severe and should be assessed clinically (Figure 1).
- Consider the following two examples. Example A and B describes two patients who have presented to the OPD after attempted self-poisoning. Whom do you think has the higher suicide risk and why?

### Example A

A 65-year-old man is brought to hospital after ingesting pesticide.

He bought a bottle of pesticide 2 weeks previously, and had kept it hidden under his bed.

The day prior to admission, after an argument with his son, he had gone to his room, locked his room door, ingested the pesticide, and gone to sleep.

The next morning when he did not come out, the family broke the door and found him semi-conscious and brought him to hospital.

He has a history of alcohol dependency, and in the recent two months has been more irritable and drinking more.

On mental state examination he appears depressed, but he refused to talk about the suicide attempt or how he feels now.

### Example B

A 16-year-old girl is brought to hospital after ingesting 10 tablets of paracetamol.

Her mother had scolded and slapped her for texting a boy in her tuition class. The girl got upset and soon after ingested paracetamol tablets (that were being used by her grandmother).

She then told her mother what she had done, and was brought to hospital.

Prior to the incident the family had not noticed any change in behaviour in the girl. She had been going to school and tuition as usual.

On mental state examination she is not depressed, but is upset about the conflict with the mother. She regrets the overdose now, because she had to come to hospital and 'suffer'. No suicidal ideas now.

- If you read the two examples, it is fairly obvious that the patient in Example A has a high suicide risk, and the girl in Example B has a low suicide risk.
- The manner in which we came to that conclusion, is the process of suicide risk assessment.
- Another way to approach suicidal risk assessment is to ask yourself: "Am I comfortable to send this person home? Am I worried that they will go home and hurt themselves again?"
- To make it easier, we can break the process down to steps; suicidal risk can be assessed clinically as follows (Figure 1):

Suicide risk can be assessed clinically as follows (Figure 1):

- **Recent past history of self-harm or attempted suicide?**
  - If YES – risk increases; the degree of risk can be assessed based on the nature of the self-harm attempt:
  - **If YES - Nature of suicide attempt? The following point to a higher risk:**
    - *Planning* the attempt,
    - Making attempts to *prevent* being found out,
    - Using a more *lethal method*,
    - *Not* asking for help
- **Depression?**
  - If the person is suffering from depression, this will increase the risk
- **Comorbid alcohol dependence, or drug dependency?**
  - If YES – increases risk
  - Other psychiatric disorders will also increase the risk

- **Current mental state examination (MSE)? The presence of the following point to increased risk of suicide:**
  - Depressed mood on MSE
  - Still expressing suicidal ideas
  - Plans of suicide
  - Presence of hopelessness
  - Psychotic symptoms
- **Other factors**
  - Ongoing stressors – for example if a woman attempts suicide in the context of domestic violence at home, and if this problem is ongoing – then the risk of suicide may increase.
  - Medical comorbidities – for example chronic illnesses, such as epilepsy, are associated with increased risk
  - Other

**The assessment of suicide risk is not a black and white absolute measure. It is an estimate, based on clinical assessment as described above.**

### **Management**

- A person with a high suicide risk should be offered inpatient treatment and should be referred for further psychiatric assessment as soon as possible. Depending on the presentation, relevant treatment can also be started. But ensuring the safety of the patient, and early psychiatric assessment, is important.
- Patients with a low risk of suicide can usually be managed in the community, on an outpatient basis. Some people may not need any further support, but many people may need relevant psychological support. For instance, in Example B above, although the suicidal risk is low, counselling to the young girl and her parents, on how to deal with issues like this, would be useful.
- If you think the suicide risk is moderate, assess each patient individually and decide how best to ensure the safety of the patient, on whether admission is needed, and the need for a psychiatric referral.
- Persons with repeated self-harm should be referred for assessment by a psychiatrist.

### **Persons who present with repeated attempts of deliberate self-harm:**

- A small proportion of people will carry out repeated attempts of self-harm.
- This repeat attempts of self-harm may be repeated *low-intent* attempts of self-harm, such as repeated superficial self-cutting, or repeated non-lethal overdoses (such as repeated overdoses of a few tablets of paracetamol). OR the repeat attempts of self-harm could be repeated *high-intent* attempts of suicide.
- Repeated self-harm indicates an increased risk of suicide, and each patient must be assessed on a **case-by-case basis**. The suicide risk assessment should be done based on the same principles as described above.
- Persons with repeated self-harm should be referred for assessment by a psychiatrist.
- Repeated attempts of self-harm, especially high-intent repeated self-harm, is more likely in people with a psychiatric disorder such as depression, or a substance use disorder.
- Repeated attempts of self-harm can also occur in the context of certain personality disorders - for example, borderline personality disorder.

- The diagnosis of a personality disorder should be only made after careful assessment and taking a collaborative history. If you suspect that a person is struggling with repeated self-harm in context of a personality disorder, referral to a psychiatrist for further assessment is recommended.

**In conclusion, each person who presents with attempted self-harm is different; and each person should be assessed on an individual basis, based on the above principles, to assess risk and decide future management.**



## Chapter 16- Person presenting with Domestic Violence

Routine Screening: All clients should be routinely inquired into domestic violence. Routine inquiring, either written or verbal by health care providers to patients about personal history with domestic violence – universal screening should include

- Questions about behaviors as well as the patient's perception of fear and safety
- Observe signs and symptoms, both direct and indirect of possible abuse
- Ongoing screening as a patient's abuse status can change over time
- Statistics of numbers of victims identified

### Assessment

1. The pattern and history of abuse
2. Immediate safety needs
3. Client's state of mind
4. Chief complaint and present illnesses
5. Effects of abuse on client's health
6. Effects on children and families
7. Client's mental health issues (Depression, Homicide risk, Suicide risk, Substance abuse)
8. Abuser's danger and lethality assessment
9. Past safety strategies used by clients
10. Victim's current access to advocacy and support resources

### Interventions

All clients suspected or known to be victims of domestic violence should receive interventions

Appropriate intervention may include

1. Verbal reassurance that they are not alone
2. Convincing of the fact that no one deserves to be abused
3. Verbal reassurance that violence is not their fault
4. Verbal reassurance that they can talk to someone privately for information and support
5. Written information about domestic violence and resources for help in their geographical area
6. Written information available in patient's primary languages
7. Written information that is culturally appropriate
8. Assistance in making safety plan which respects the integrity and autonomy of the victim
9. Advocacy and assistance in accessing the service agencies Eg: WIN, 1938, 1926 and 119
10. Information about legal options and protection orders
11. Information regarding confidentiality
12. Information about the requirement to report child abuse Eg: 1929
13. Information about the requirement to report vulnerable adult abuse
14. Reassurance that they will continue to be offered assistance whenever they seek help

### Vulnerable elderly abuse

Health care professionals who have reasons to believe there is abuse, neglect, self-abuse or exploitation of a vulnerable elder in the community must report it to elderly protection services (Divisional Secretary office, police, elderly secretariat)

Referral options when intimate partner violence is disclosed and child(ren) are present at home

Intimate partner violence disclosed, Health and Risk assessment completed

Option 1  
No child protection concerns identified and no active referral

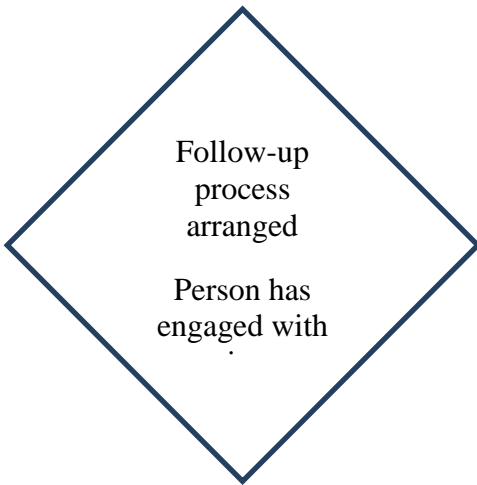
Option 2  
No child protection concerns

Option 3  
Child protection concerns



Information provided regarding local family support services and contact details

Person provided with information regarding local family support services and appointment arranged, and person understands the plan for follow up



NO



Consult with multidisciplinary team (Annex 1)



- Annex 1
- Multidisciplinary team
- Local Mental health team
- Divisional secretariat
- Women and child desk police
- Legal aid
- Zonal education

Child probation

Mithuru piyasa

NCPA

CSC

MOH Office

NGOs

## Chapter 17- Person with acute aggression

Acute aggressive person should be ideally managed at ETU. Priority should be given to ensure staff, community and patient safety. Always contact the MOMH attached to the area.

Step 1

De-escalation/time out/ placement

Step 2

Oral medication

Olanzapine 10 mg / Risperidone 1- 2mg / Haloperidol 6mg

Step 3

Intramuscular medication

Haloperidol 5mg

Promethazine 50mg

Midazolam 5mg IM

Notes.

\*Antipsychotics and benzodiazepines should be administered using separate syringes

\*Promethazine 50mg IM can be used in patients who are unable to tolerate benzodiazepines

\*Emergency trays should be readily available when administering IM

Arrangements should be made to transfer person to the nearest mental health in patient unit as soon as possible

## Chapter 18- Person with Sexual dysfunctions

### Classification and diagnosis

The current classification offered in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) links dysfunctions to the phases of the sexual response cycle.

Sexual dysfunctions that are commonly seen are;

Sexual desire disorders

### **Female sexual arousal/interest disorder (earlier Hypoactive sexual desire disorder)**

-Low desire and a persistent inability to attain or maintain adequate vaginal lubrication and vaginal expansion in response to sexual excitement.

### **Male hypoactive Desire disorders (low libido/reduced libido)**

-An absence or deficiency of sexual fantasies and desire for sexual activity.

### **Sexual arousal disorder**

#### **Erectile disorder**

-Persistent or recurrent inability to attain or sustain an adequate penile erection.

Variabilities: Some attain very strong erections without being able to sustain them, while some have sustainable erections which are not strong enough for penetration. Loss of erection during thrusting is also reported by some.

#### **Orgasmic disorders**

#### **Female orgasmic disorder (Inhibited female orgasm/anorgasmia/ Inorgasmia)**

- Persistent delay or absence of orgasm following a normal sexual excitement.

#### **Male orgasmic disorder (inhibited male orgasm)**

-Difficulty in reaching orgasm following a normal sexual stimulation.

#### **Delayed Ejaculation (Retarded ejaculation)**

-Focuses on ejaculation rather than orgasm. In some conditions, a male can reach an orgasm without discharging any semen. Some are capable of orgasm through super stimulation, the new term refers specifically to the orgasmic experience.

#### **Premature ejaculation**

-Persistent onset of orgasm with minimal sexual stimulation. Men with premature ejaculation reach an orgasm before their partner is sexually gratified.

#### **Genito-pelvic pain/penetration disorders**

#### **Dyspareunia**

-Genital pain is associated with sexual intercourse.

-Most commonly experienced during coitus, but it can also occur before or after coitus.

-Can happen in both men and women. However, at clinical settings it is much more common in females

## **Vaginismus**

-Persistent involuntary contraction of the muscles surrounding the outer third of the vagina when penetration is attempted. When severe, it makes penetration impossible.

Specifiers;

Lifelong dysfunction - The problem has been present since the beginning of sexual functioning; Ex. a man who has never had an erection as an adult.

Acquired dysfunction-The dysfunction develops only after a period of normal functioning.

Generalized sexual dysfunctions - The dysfunction occurs in all situations, and is not linked to certain types of partner, situations, or stimulation.

Situational sexual dysfunctions - The dysfunction occurs in certain situations. Ex: a man may have an erectile difficulty when attempting sex with a partner, but not when masturbating.

Co-morbidities- Co-occurrence of several disorders/dysfunctions at the same time. Ex: co-occurrence of erectile dysfunction and premature ejaculation is not uncommonly seen in clinics.

### **Assessment**

- Diagnostic evaluation is based on an in-depth sexual history, including sexual and gender identity, orientation, sexual activities, current level of sexual functioning, overall health and comorbidities, partner relationship and interpersonal factors, and the role of cultural and personal expectations and attitudes.

### **Interviewer Guide**

- The history of the problem, its beginnings and course, and present sexual activity;
- The partner's reactions to the problem;
- The person's sexual knowledge, beliefs and attitudes, including those determined by his or her religion and culture;
- The person's sexual likes, dislikes, and preferences and fantasies;
- Past sexual history including relevant early experiences;
- Psychiatric and medical factors, including drugs, alcohol, etc.
- Menstrual history and relation of the problem to the menstrual cycle;
- Contraception and past pregnancies, and attitude towards the possibility of conception;
- General relationships.
- Background factors, such as job, income, accommodation, and so on, which can be sources of stress;
- Previous treatment, if any. In a given case more details may be needed in some of the areas than in others, and this is a matter of clinical judgement as the interview proceeds.

## Individual and couple interviews

Better is to see the couple jointly to start with, and then conducting separate assessment interviews.

It is important that individual interview sessions are undertaken in all the cases. This provides an opportunity for each partner to give his or her version of the problem, and discuss with the therapist various matters, including feelings about the partner, without inhibition. It also gives an opportunity for him or her to divulge information, which might have been kept from the partner, such as an extramarital relationship, or a particular aspect of the individual's past history.

## Physical examination

- Not compulsory in all cases
- General examination and a genital examination
  - When the person complains of pain or discomfort during sex;
  - Recent history of ill health or physical symptoms other than the sexual problem;
  - Recent onset of loss of sex drive with no apparent cause;
  - When the patient believes that a physical cause is most likely, or is concerned about the genitalia;
  - History of abnormal puberty or other endocrine disorder, in men over 50 years of age;
  - In women, being in the pre- or postmenopausal age group, and history of marked menstrual irregularities or infertility

## Investigations

- For all persons- FBC, Renal functions, Liver functions and TSH.
- Among hypo sexual men- serum free testosterone level.
- 

## Psychological treatment

- Behavioural therapy
  - Reduction of anxiety and modified sex therapy

Stage 1; *Non-genital sensate focus*- touching and caressing, excluding the genital area and the woman's breasts

Stage 2; *Genital sensate focus*- touching and caressing, including the genital area and the woman's breasts

- Cognitive approaches

-Applicable for those without partners, who tend to avoid developing relationships because of fear of repeated failure.

- Cognitive - behavioural therapy- behavioural and cognitive elements are used in conjunction
- Systemic interventions- The therapist takes into account the relationship factors such as jealousy, resentment and dominance often contribute to the sexual problems and intervenes appropriately

## Physical treatments

### ➤ Oral medications

First-line therapy-For erectile dysfunction oral phosphodiesterase type 5 (PDE5) inhibitors (Sildenafil, Vardenafil, Tadalafil and Avanafil)

When oral medication fails IM Injections- Smooth muscle relaxants (papaverine and prostaglandin E into one of the corpora cavernosa of the penis) can be given by an expert practitioner.

It is important to remember, even in cases where a physical treatment is used because there are physical aetiological factors, additional psychological work is useful and often necessary.

### Referral to a specialist Service

- When assessments are difficult
- When service user has complex issues or co-morbidity



## Chapter 19- A person presenting with suspiciousness

Suspiciousness can be an underlying symptom of many psychiatric disorders. Therefore, there can be a wide range of symptoms.

- Suspiciousness can be directed towards one's spouse without any firm evidence ( morbid jealousy)
- Suspiciousness can be a symptoms of paranoid schizophrenia. In this case there will be other symptoms of schizophrenia like a conviction that  
Thought echo, thought insertion or withdrawal, or thought broadcasting.

Delusions of control, influence or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception

Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing him between themselves, or other types of hallucinatory voices coming from some part of the body

Persistent delusions of other kinds that are culturally inappropriate and completely impossible (e.g. being able to control the weather, or being in communication with aliens from another world).

Persistent hallucinations in any modality, when occurring every day for at least one month

Neologisms, breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech.

Catatonic behaviour, such as excitement, posturing or waxy flexibility, negativism, mutism and stupor.

"Negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses

- Suspiciousness can be a symptom of underlying substance abuse-particularly cannabis
- It can be a symptom of an underlying personality disorder
- Some patients can present with aggression towards others due to the underlying suspiciousness

### Differential Diagnoses

- Paranoid schizophrenia
- Delusional disorder (jealous type/morbid jealousy)-if the suspiciousness is directed towards one's partner
- Drug induced -particularly cannabis
- Personality disorder
- Cognitive defects (Dementia, Head injury, other brain disorders)

### Management

- All patients need to be evaluated for the risk of harm to others
- They may be carrying weapons with them, which needs to be inquired about
- The underlying cause for the suspiciousness should be looked for and treated

### Essential information for family

Suspiciousness can have a variety of causes but most likely it is due to a serious underlying disorder which need treatment, particularly if it is causing a problem for the day to day functioning of the patient and his/her family

### Specialist consultation

Please refer to the mental health team should you detect any of the symptoms seen above.

## Chapter 20- Person with elevated mood

Nature:

- ❖ Mood is grossly and persistently elevated–
  - Subjective: Feeling ‘high’, ‘on top of the world’.
  - Objective: Noticeable by those who know the patient as clear deviation from normal
- ❖ May take an infectious quality (Elation) or become labile or irritable

Associated features

- ❖ Increased energy – over activity, physical restlessness
- ❖ Increased talkativeness
- ❖ Difficulty in concentration or distractibility
- ❖ Decreased need for sleep
- ❖ Increased sexual energy and sexual indiscretions
- ❖ Increased sociability - over-familiarity
- ❖ Subjective experience of thoughts racing- Flight of ideas /
- ❖ Distractibility or constant changes in activity or plans
- ❖ Inflated self-esteem / grandiosity
- ❖ Loss of normal social inhibitions resulting in inappropriate behaviour
- ❖ Risk taking/ Reckless behaviour whose risks the subject does not recognize (spending sprees, foolish enterprises, reckless driving)
- ❖ Impaired judgement and insight
- ❖ Psychotic symptoms-
  - Disorders of thought form – flight of ideas
  - Disorders of thought content – Grandiose delusions, Persecutory delusions
  - Disorders of perception – Hallucinations, *heightened senses*

Management Plan

1. Assessing patients with elevated mood can be made difficult by their distractibility and disinhibition. Adopt a polite but firm approach.
2. Look for risks- harming others / self – harm (risk taking behaviours)
3. Manage agitation or aggression, if its severe – benzodiazepines or antipsychotics or a combination
4. Look for physical consequences – injuries/fracture, unwanted pregnancy
5. Always screen for psychotic symptoms in patients with elevated mood
6. Rule out organic causes for the elevated mood –
  - ❖ Medical disorders- Cerebral neoplasms, infarcts, trauma, infection (including HIV) Cushing’s disease, Huntington’s disease, Hyperthyroidism, Multiple sclerosis, Renal failure, Systemic lupus erythematosus, Temporal lobe epilepsy, Vitamin B12 and niacin (pellagra) deficiency
  - ❖ Psychoactive substances- Cannabis, Amphetamines, Cocaine, Hallucinogens
  - ❖ Prescribed medications- Anabolic steroids, Antidepressants, Corticosteroids, Dopaminergic agents (e.g. L-dopa, selegiline, bromocriptine)
7. Consider possible differential diagnoses of psychiatric disorders
  - ❖ Mood disorders- Hypomania, mania, mixed affective episode
  - ❖ Schizo-affective disorders
  - ❖ Schizophrenia
  - ❖ Substance related disorders

- ❖ Acute and transient psychotic disorder
- ❖ *Delirium / Dementia*
- ❖ *Personality disorders*
- ❖ *Neurodevelopmental disorders*

#### Essential information for patient and family

- ❖ Elevated mood is a feature of illness
- ❖ Take measures to prevent the patient from harming him/herself or others (e. g.remove unsafe objects, restrain if necessary).
- ❖ Avoid entering arguments with the patients
- ❖ Supervise whether the patient has been taking the medications if prescribed.

#### Specialist Consultation

Patients with elevated mood should be referred to specialist consultation for complex interventions that includes

- ❖ Needs of inpatient assessment when there are risks of self-harm and harming others
- ❖ Specialized investigation to rule out organic causes

## Chapter 21- Person with Anxiety

### Presenting complaints

Anxiety presents with psychological and physical problems. Patients may come to you with one, many or possibly most of the following symptoms in combination

#### Physical symptoms

- Dizziness
- Sweating
- Pounding/Fast beating heart
- Dry mouth
- Feeling breathless/difficulty breathing/choking-like feeling

#### Psychological symptoms

- Worrying excessively
- Feeling 'tense'
- Unnecessary/Excessive fear
- Irritability

#### Depressive symptoms

Anxiety and depression frequently exist together

It is important to remember that each makes the other worse.

Therefore, patients presenting with anxiety will also have symptoms of depression (see section on depression)

#### Substance related symptoms

Anxious persons also have substance related issues. The most common substances are nicotine and alcohol

Therefore please remember that they may present with worsening of their substance related issue with the onset of their anxiety

Be aware that acute intoxication with cannabis can cause immediate anxiety like symptoms

#### Physical causes for anxiety

Physical illnesses-especially thyroid problems and certain medication eg salbutamol, theophylline can mimic symptoms of anxiety

Therefore please take a careful medical and drug history

#### Differential Diagnosis

- Anxiety disorders
- Depression
- Adjustment disorder
- Substance related - acute/long term
- Physical disorders
- Medication side effects

### Management plan

Mild levels of anxiety, if other causes are excluded can be reassured and reviewed at a later date (two to four weeks)

Relaxation (PMR, life skills)

Management of moderate to severe anxiety needs a combination of mediation, Behaviour therapy and cognitive behavioral therapy

You may need to refer for specialist care at this point, in the best interest of the patient

### Essential information for family

Symptoms of anxiety are easily mistaken for physical illnesses and this can make the anxiety worse

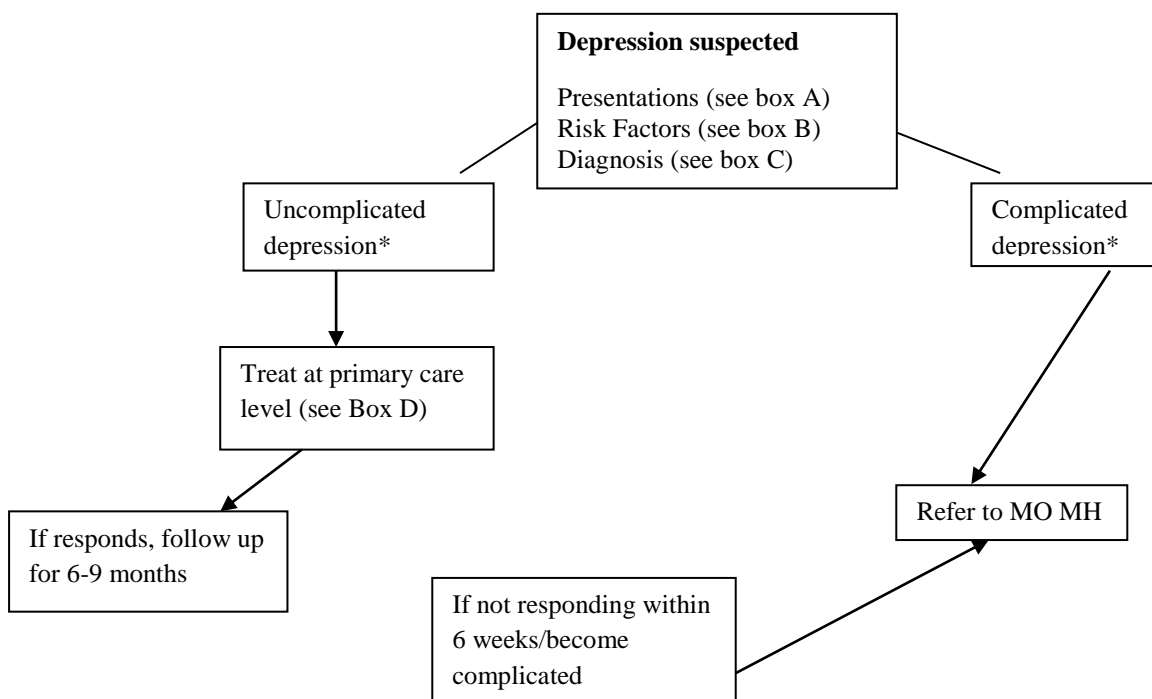
Anxiety symptoms don't go away immediately following treatment, but will get better with the continuation of treatment as prescribed by the doctor

Specialist consultation

See above

# Chapter 22- Adult with Depression

## Algorithm



**BOX A -Common presentations**  
 Multiple medical visits, multiple unexplained symptoms  
 Work/ relationship dysfunction  
 Reduced affect  
 Changes in interpersonal relationships  
 Sleep issues & weight changes  
 Fatigue  
 Stress/ mood changes  
 Memory issues/ reduced concentration

**BOX B- Risk factors for depression**  
 Personal &/ Family history of depression  
 Substance misuse  
 Recent loss  
 Chronic medical illness  
 Stressful life events (loss events)  
 Major life changes (e.g.: job change)  
 Traumatic events  
 Domestic violence

**Box D- Management of uncomplicated depression**  
 Comprehensive management plan  
 Collaborative care; educate and engage patient & family Management-  
 Pharmacotherapy (for moderate depression) \*\*,  
 Counselling,  
 Lifestyle changes,  
 Treat co-morbidities (refer relevant guideline)  
 Refer to other services where appropriate  
 (Medical clinics, counsellors, social services etc  
 Pharmacotherapy\*\*

- First line treatment- SSRI: Fluoxetine 20mg increased to max 60mg  
 Sertraline 50mg increased to max 200mg
- Titrate to recognized therapeutic dose. Assess efficacy after 2 weeks.
- If not effective assess weekly for further 1-2 weeks.  
 If still no response increase dose.  
 If still no effect switch to different antidepressant.  
 Titrate to therapeutic dose.  
 Assess over 2 weeks. Increase dose as necessary.  
 If no effect refer to MOMH.
- Antidepressant prophylaxis.  
 Single episode- treat for 6-9 months after full remission.  
 Use same dose as for acute treatment.

\*For the purpose of this guideline uncomplicated and complicated depression is identified as follows-

Uncomplicated Depression- mild & moderate depression

Complicated Depression- Severe depression including with psychotic symptoms; with suicidal thoughts and or thoughts of harming others; resistant depression (not responding to 2 antidepressants); depression with risk to physical health; recurrent depression (2 or more episodes)



## Chapter 23 –Person who is socially withdrawn

A person can be socially withdrawn due to a variety of reasons/disorders. Therefore it is important to take a detailed history according to each of the differentials described below

### **Social phobia-**

Significant amount of fear in one or more **social** situations, causing considerable distress and impaired ability to function in at least some parts of daily life.

### **Depression**

Look for other depressive symptoms

### **Schizophrenia**

Look for other associated symptoms. Usually the withdrawal is either due to developing negative symptoms or due to the suspiciousness and paranoia associated with the positive symptoms

### **Lack of social skills**

Management

Please refer to the mental health team

## Chapter 24- Maternal Mental Disorders

### Perinatal period

The perinatal period refers to the pregnancy and the first 12 months following child birth.

### Mental disorders in the perinatal period

One of the main reasons for relapse of mental disorders in pregnancy is discontinuation of psychotropic medications with the fear of harming the fetus. The patients who discontinue medications are 5 times more likely to relapse compared to those who continued medication.

### Management of maternal mental health issues in the primary health care setting

#### Preconception advice

Women with a complex or severe mental health problem (current or past) who are planning a pregnancy should be referred to psychiatrist receive timely preconception advice regarding the care plan which includes changing medications, optimizing treatment, follow up, monitoring of mental state and physical parameters

#### Screening in the perinatal period

The screening for maternal mental health problems is important

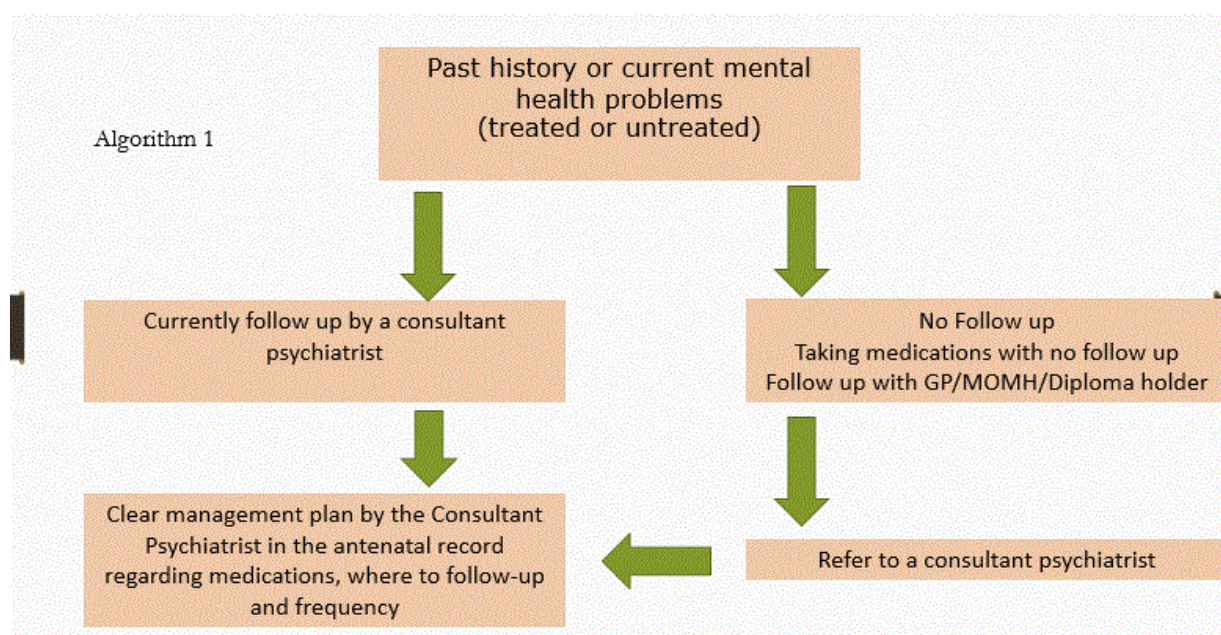
- To identify and manage normal anxieties that the mother and family members may have
- To detect early relapse
- To detect new cases early
- To carry out appropriate management strategies on patients who have a history of mental disorders or currently on treatment

All mothers registered with a MOH office should undergo bio-psycho-social risk factor screening and the protocol for each category is mentioned below.

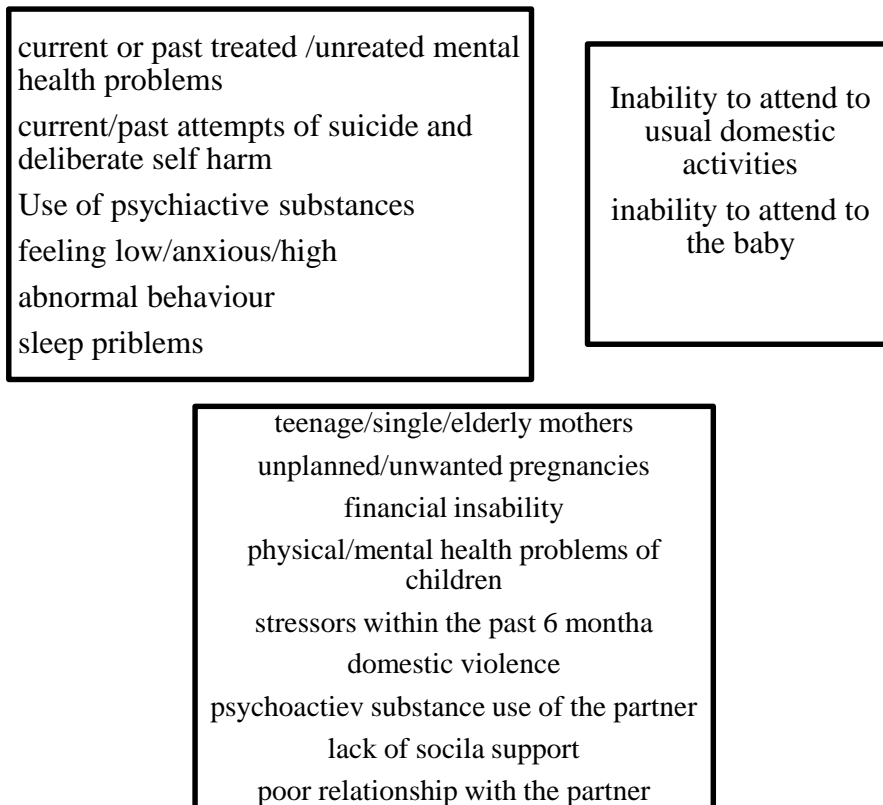
#### Protocol for maternal mental health care

##### Algorithm 1

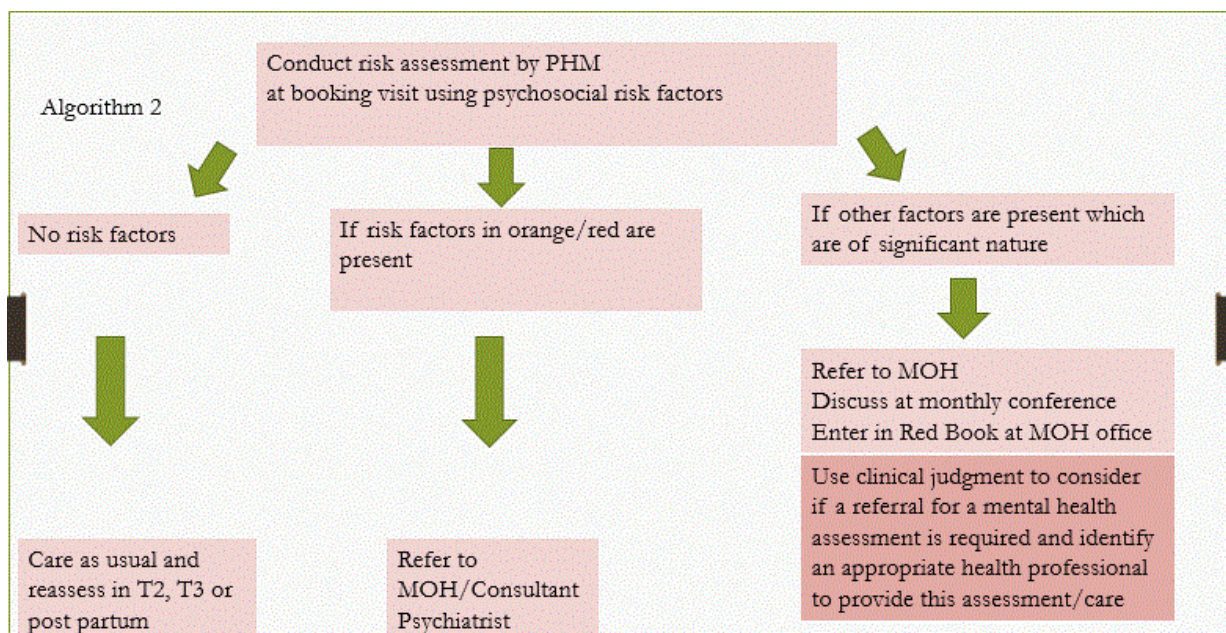
For mothers with a past/current mental health issues



## Bio-psychosocial risk factors



## Algorithm 2 – For all mothers registered in an MOH area



## Chapter 25- Confused elderly person (Delirium, dementia)

- Confusion is a common problem in persons over 65 years of age.
- Confusion is defined as disorientation ( not being properly oriented) in
  - Time**- patient is unable to recognize time, day, date, month or year
  - Place**-patient is unable to recognize the place where he is at. eg while at hospital, some may believe that they are at home or vice versa
  - Person**- patient is unable to recognize his own identity

Often accompanied by:

- Poor memory
- Emotional disturbances (Anger/irritability/crying/elevated mood)
- Muteness
- Retardation
- Fluctuating attention
- Wandering
- Withdrawal from others/ Isolation
- Suspiciousness
- Agitation
- Hearing voices/ noises
- Visions or illusions
- Infestation
- Disturbed sleep

In older persons, confusion is most likely to be a symptom of delirium or dementia, although it can also be associated with affective disorders, specifically major depression

Differential diagnoses

- Delirium
- Dementia
- Depression
- Psychosis
- Substance use disorder

Until proved otherwise, the patient should be assumed to have delirium.

Management plan

The main part of the management is to rule out the causes for the delirium.

Therefore identify and correct possible physical causes of confusion, such as: -

- alcohol intoxication or withdrawal
- Infection
- Vascular events
- drug intoxication or withdrawal (including prescribed drugs) severe infections
- Drug interaction
- metabolic changes (e. g., liver disease, dehydration, hypoglycaemia, electrolyte imbalances) head trauma

- hypoxia

This will include

- full blood count
- urine full report
- serum electrolytes
- blood urea
- serum creatinine
- liver functions
- Pulse oximetry
- ECG
- CXR

Correctable/reversible causes should be attended to immediately

If the problem is caused by one or more specific medications, the patient should be switched to other drugs that are less likely to cause confusion in the elderly.

Treatment of delirium improves cognitive functioning even in patients with underlying dementia

Only after delirium and psychiatric disorders have been ruled out can dementia be diagnosed in an elderly patient

The management guidelines and diagnostic features of dementia and depression are listed in the care guidelines

Essential information for patient and family

- Strange behaviour or speech are symptoms of an illness
- Take measures to prevent the patient from harming him/herself or others (e. g., remove unsafe objects, restrain if necessary).
- Supportive contact with familiar people can reduce confusion.
- Provide frequent reminders of time and place to reduce confusion.

Specialist consultation

Confused persons should be referred to specialist consultation as certain cases may need complex interventions and radiographic interventions if the delirium



## Chapter 26 - Adult with memory problems

### Presenting complaints

Patients will either present with

Subjective problems of memory- patient themselves will complain of problems with memory

Objective problems of memory-most often family, and primary caregivers will bring the patient to you saying that he/she seems to be having problems with memory

Depending on the underlying disorder, there will often be other symptoms

Problems with recent rather than long term memory, difficulty with recognizing people, objects and places, with difficulties in speech and tasks are likely to be due to an underlying dementia

If the patient himself says that he has problems with memory and answers "I don't know" or "I can't remember" to questions you ask, then it is very likely that it is due to an underlying depression which can present with symptoms mimicking dementia (depressive pseudo dementia)

Please look for other symptoms of intracranial pressures well because space occupying lesions can present initially with memory problems

### Differential Diagnoses

Depression (with features of pseudo dementia)

Dementia

### Management

On suspicion of memory problems refer to mental health team

MMSE score on initial assessment (score out of 30)

The maximum **MMSE score** is 30 points. A **score** of 20 to 24 suggests mild dementia, 13 to 20 suggests moderate dementia, and less than 12 indicates severe dementia.

## Chapter 27- Bereavement

Grief is the response to bereavement, which is the situation in which a loved one has died. Natural acute grief reactions are often painful and impairing with emotional and somatic distress, but should not be diagnosed as a mental disorder.

However, bereavement is a stressor that can precipitate or worsen mental disorders (eg, depression).

In addition, complications (maladaptive thoughts, feelings, or behaviors) may occur, so that acute grief becomes intense, prolonged, and debilitating. This condition is then called complicated grief, which is viewed as a unique and recognizable disorder that requires specific treatment.

### Presenting complaints

During the first few months after a loss, many signs and symptoms of normal grief are the same as those of complicated grief.

However, while normal grief symptoms gradually start to fade over time, those of complicated grief linger or get worse.

- Intense sorrow, pain and rumination over the loss of the loved one
- Focus on little else but the loved one's death
- Extreme focus on reminders of the loved one or excessive avoidance of reminders
- Intense and persistent longing or pining for the deceased
- Problems accepting the death
- Numbness or detachment
- Anger about the loss
- Feeling that life holds no meaning or purpose
- Lack of trust in others
- Inability to enjoy life or think back on positive experiences with loved one

### Differential Diagnosis

Normal Grief  
Adjustment disorder  
Depression

### Management plan

Grief without complications will resolve naturally with some reappearance of symptoms during the time of the death anniversary

### Essential information for patient and family

Grief is an entirely normal condition.

It is not pathological unless it progresses towards signs and symptoms of pathological grief (Adjustment disorder)

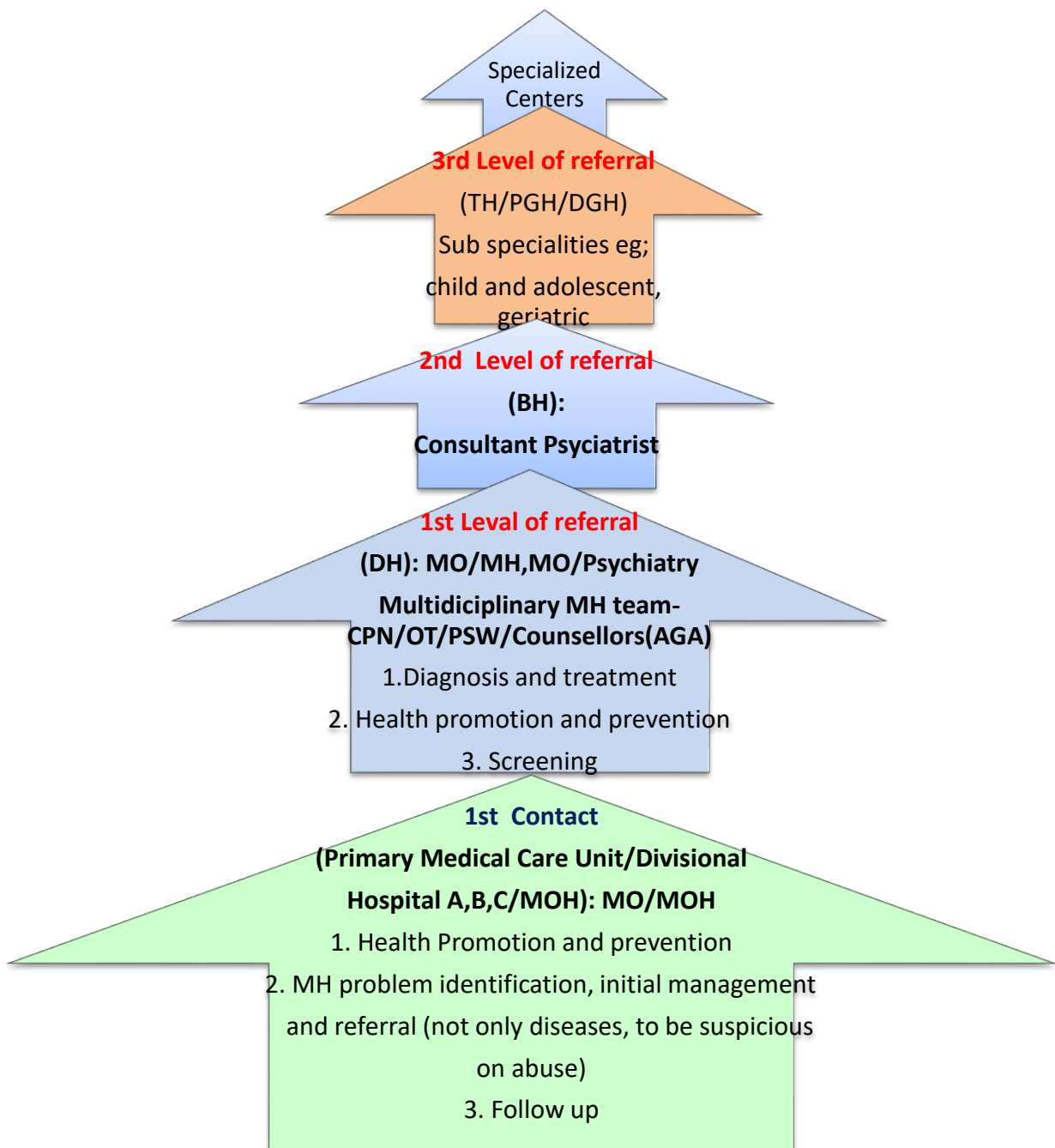
## Specialist consultation

This will be required if the patient is developing complications like

- Depression
- Denial
- Aggression, irritability
- Suicidal thoughts or behaviours
- Anxiety, including PTSD
- Significant sleep disturbances
- Increased risk of physical illness, such as heart disease, cancer or high blood pressure
- Long-term difficulty with daily living, relationships or work activities
- Alcohol, nicotine use or substance misuse



## Care Pathway for Mental Health Service Provision



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