Management of Mental Health Problems

A Guide for the Doctor in the Community

2nd Edition

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A compilation of the material used in the
Continuing Professional Development Programme
for Medical Officers in Mental Health

Organized by
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in collaboration with The Asia Foundation

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Foreword

The mental health of a patient is of vital importance to lead a fulfilling life. Thus the Ministry of Health gives priority to the improvement of the quality of mental health care as it not only benefits the individual but the nation at large.

To further this objective a Continuing Professional Development (CPD) programme has been organized by the Sri Lanka College Of Psychiatrists, for Medical Officers in Mental Health. This endeavour has proven to be successful in propagating knowledge amongst medical officers in mental health. *"Management of Mental Health Problems - A guide for the doctor in the community"* was published in 2012 to compliment this programme.

I am pleased that this publication was well received and was found to be immensely beneficial. As several new areas have been covered over the past year a second edition is being published with several new modules and updated information.

The Ministry of Health has been pleased to collaborate with the Sri Lanka College Of Psychiatrists and The Asia Foundation, to bring this opportunity to these medical officers in the Provinces. I hope that this programme which has already been successfully conducted in seven provinces up to date will be continued with equal success in the future.

Dr. Palitha G. Mahipala
Director General of Health Services
Ministry of Health

Introduction

It is with great pleasure that I write the introduction to the Second Edition of *"Management of Mental Health Problems- A guide for the doctor in the community"*.

The Sri Lanka College of Psychiatrists is committed to advancement in the field of psychiatry and mental health and holds regular educational activities throughout the country to improve knowledge, skills and to promote a healthy attitude.

One of the successful educational initiatives of the Sri Lanka College of Psychiatrists has been the continuing professional development (CPD) programme for medical officers of mental health scattered throughout the country, to improve their ability to provide services to the community. This programme commenced in 2012 with the aim of bridging the gaps in knowledge of the medical officers in mental health, as they had received a basic training which has not been updated since they started their work.

The Sri Lanka College of Psychiatrists has identified the significant contribution that these medical officers make with their basic training alone and commenced this programme to further improve mental health services. Three provinces were included in the first programme which was the Northern, Eastern and Sabaragamuwa Provinces. The first edition was published in 2012 and included the following topics covered by eminent Psychiatrists: (1)Psychiatry in Sri Lanka: the past, the present and the future, (2) Anxiety disorders, (3) Substance use disorders, (4) Suicide,(5) Child and adolescent mental health, (6) Dementia and (7) Psychopharmacology. This was well utilised by the medical officers in mental health and other primary care doctors.

The second round of training commenced in 2014 with the experience of the first programme. Following this, the second edition was compiled and contains new topics that were requested by the medical officers. I would like to congratulate the two editors Dr. Usha Gunawardhana and Dr. Lakmi Seneviratne for their untiring effort in producing this edition. I thank The Asia Foundation for its continued support for the continuing professional development programme and in publishing the second edition.

I am sure this book will be immensely useful for medical officers in mental health as well as other mental health professionals which will ultimately contribute to the improvement of mental health care in Sri Lanka.

Prof. Samudra Kathriarachchi
President
Sri Lanka College of Psychiatrists

Message

It's my pleasure to submit a message to the Second Edition of the publication *"Management of Mental Health Problems- A guide for the doctor in the community".*

The Sri Lanka College of Psychiatrists commenced a Continuing Professional Development (CPD) Program for medical officers working in the field of Psychiatry in 2012, in collaboration with The Asia Foundation, the Ministry of Health and Indigenous Medicine, the World Health Organization (WHO) and Volunteer Services Overseas (VSO). The program was aimed at strengthening the skills and knowledge of medical officers in mental health to work at the grassroots level. The original CPD publication was a success and was well received. This second edition, contains material used in the initial program, as well as new topics introduced in 2014. We believe that this second edition will be very useful as it addresses common issues faced by medical practitioners working in the field of mental health and is presented in an easy to read format.

The Asia Foundation is a nonprofit international development organization committed to improving lives across a dynamic and developing Asia. Informed by six decades of experience and deep local expertise, our programs address critical issues affecting Asia in the 21st century—governance and law, economic development, women's empowerment, environment, and regional cooperation. We are committed to Asia's continued development as a peaceful, just, and thriving region of the world.

During the past ten years, The Asia Foundation has been committed to helping Sri Lankan communities to overcome the lasting effects of conflict related violence through our Mental Health and Psychosocial Support Program, collaborating with both non-governmental and government organizations. The Asia Foundation is proud to be associated with this professional development program and to have been able to contribute to the growth and development of the mental health and psychosocial support sector in Sri Lanka.

Dinesha deSilva Wikramanayake
Country Representative
The Asia Foundation

MODULE 1

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1. PSYCHIATRY IN SRI LANKA: THE PAST, THE PRESENT AND THE FUTURE

The past:

In the era prior to British rule it is considered likely that people with mental illness would have been cared for within the community using the many forms of traditional healing.

It was during the British rule that formal mental health services commenced in Sri Lanka and came under the purview of the Lunacy Ordinance of 1839, which provided for the establishment of asylums in Sri Lanka for the mentally ill.

Initially patients with mental illness were treated at the Hendala Asylum and later transferred to the Borella Asylum (1846). The Cinnamon Gardens Asylum (1884) was built next to overcome the problem of overcrowding. However it too faced similar difficulties within a short period of time. The next major institution dedicated to the care of the mentally ill came about with the commissioning of the hospital at Angoda which also catered to the 'asylum' concept of treating the mentally ill. It was built to relieve the overcrowding at the other institutions, and had a bed strength of 1728.

Overcrowding which became a significant problem at the Angoda asylum as well resulted in the establishment of the 'noisy ward' in 1929, which housed the most disturbed patients. The overcrowding led to a significant number of deaths due to dysentery and tuberculosis. The Mapother report (1937) submitted to the Ceylon government by Professor Edward Mapother, on the state of mental health in Ceylon, compares the Angoda asylum to a run-down prison.

Newer forms of treatment were introduced to Angoda asylum by 1940. Prior to this sedation was the only form of treatment available. Antipsychotics were introduced to Sri Lanka in the 1950s, and the care of the mentally ill was revolutionized by these drugs. Lithium and depot neuroleptics were introduced in the 1970s.

An out-patient psychiatric clinic was established at the Colombo General Hospital in 1939 and clinics to provide psychotherapy and follow-up services were started in 1941.

The Mulleriyawa hospital which also housed the mentally ill was built in the late 1950s and currently serves as a Halfway Home for the mentally ill.

Although the hospital provided a centrally located treatment facility that catered exclusively to the mentally ill and offered in-patient treatment, it had many drawbacks. Standard of care was less than ideal and there was significant overcrowding after only a few years.

While the central location was convenient it also led to much stigma being attached to the hospital with 'Angoda' becoming synonymous with mental illness, a phenomenon that exists to this day. There was also a tendency to refer most patients to this hospital and the development of regional centres for treatment was not a priority. As the hospital was built on the 'asylum' model, there was also no provision for community based care.

The Lunacy Ordinance, enacted nearly a hundred and seventy five years ago has been amended on several occasions, most recently in 1956, over fifty years ago. As such, a comprehensive change to this archaic legislation is now long overdue.

The present:

Despite the lack of progress in mental health legislation, service provision in mental health care in Sri Lanka has kept pace and has seen remarkable developments over the past few decades.

The Mental Hospital at Angoda has undergone a phase of redevelopment and is now the National Institute of Mental Health (NIMH), a tertiary care centre for the mentally ill providing specialised services, post-graduate training and treatment for mentally ill offenders. The World Health Organisation (WHO) also contributed to the infrastructure (independence home) and service development of this institution after 2004.

Its capacity for service provision has been enhanced considerably, being better resourced with designated physicians and dental surgeons as well as over eighty medical officers. As its services expanded it has attracted staff from overseas as well.

Its specialised services include a peri-natal unit, a psycho-geriatric unit, a psychiatric intensive care unit, learning disability unit and a gender based violence unit, some of these services not being available elsewhere in Sri Lanka. The institute received the award for the best director and hospital in 2008-2009 and received the bronze medal for quality of services among the large scale institutions in Sri Lanka (2010-2011).

In more recent years, regional services in Sri Lanka have also made noteworthy progress. At present, in-patient units have been set up in twenty hospitals and include six professorial units in teaching hospitals as well as units in distant regional centres such as Anuradhapura, Badulla and Batticaloa. In addition, the country has 16 fully functional intermediate stay

rehabilitation units, compared to five units in 2004. Establishment of acute care units and intermediate care facilities has helped to expand the delivery of basic and specialized mental health services in the country. Meanwhile, mental health outreach clinics have been established in most parts of remote and rural areas of the country, enabling people with mental disorders to live and be treated close to their homes. This has contributed to the reduction in readmissions to acute care units.

WHO contributed to the development of mental health services - particularly in six districts, and played a catalytic role in convening health partners and donor agencies to support mental health reform. Other recent developments include the provision of services in child psychiatry in Colombo and Galle.

Although a significant percentage of psychiatrists trained in the country continue to migrate overseas in response to offers of better remuneration, at present there are 85 board certified psychiatrists in Sri Lanka. They work in conjunction with Diploma Holders in Psychiatry and Medical Officers of Mental Health (MOMH), two categories of doctors trained in Psychiatry to counter the dearth of specialists in remote areas.

With the increase in the number of psychiatrists in the country, research and professional development in the discipline have become a priority. A recently developed research tool has been the 'Peradeniya Depression Scale' at the University of Peradeniya while another research instrument for neuropsychological testing in the elderly is being developed at the University of Ruhuna in Karapitiya.

Meanwhile, the Sri Lanka Association of Psychiatrists was incorporated as the Sri Lanka College of Psychiatrists in 2003 and has become a focal institution for all aspects related to the specialty.

The College has also been responsible for an academic renaissance in the specialty, mostly through well attended Annual Academic Sessions which are held in collaboration with the Sri Lanka Psychiatric Association of the United Kingdom and WHO. It is also the publisher of the Sri Lanka Journal of Psychiatry, a publication aimed at fostering research and academic interest within the specialty.

The future:

While there has been an almost exponential increase in the provision of mental health care services, more remains to be done for the improvement of mental health services in the country.

It has been estimated that a total of 200 Diploma Holders in Psychiatry and MOMH would be required to provide satisfactory medical coverage of the entire island in Mental Health. Ongoing training programmes are working towards this target.

A complete revision of current Mental Health legislation has been undertaken for some years now but the draft legislation has yet to be passed into law. This has serious implications for the development of services and is arguably the top priority in Mental Health at present.

The development of a community based Mental Health Care Model is also a target. This remains an ambitious objective because of the costs involved but training of community psychiatric nurses has already commenced. When implemented, this will signal a landmark change in the provision of Mental Health Services in the country and will bring it on par with the community care model used in developed countries.

Notes

Notes

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2. ANXIETY & STRESS RELATED DISORDERS

Objectives

- To have an understanding of anxiety.
- To know the clinical features of anxiety disorders, obsessive compulsive disorder and post traumatic stress disorder.
- To be able to manage anxiety disorders, obsessive compulsive disorder and post traumatic stress disorder in the community.

What is anxiety?

It is an adaptive response to threat. It is a common psychiatric symptom. It consists of

- A set of psychic symptoms, which includes feeling apprehensive, pessimistic, feeling on edge and;
- A set of physical symptoms which includes dry mouth, tremor, sweaty palms and feet, feeling light headed, butterflies in the stomach and palpitations.

In anxiety there is activation of the sympathetic branch of the autonomic nervous system. It is considered maladaptive when there are symptoms present for a prolonged period, or when the symptoms are out of proportion to the threat.

Practice point

People with anxiety disorders may present to primary care doctors (OPD, GPs) complaining of various physical conditions and are commonly misdiagnosed and sometimes unnecessarily investigated.

Anxiety disorders

They are a group of illnesses where anxiety is the most prominent symptom. It consists of the following disorders;

- Generalized Anxiety Disorder (GAD)
- Phobic Anxiety Disorders
  - Specific Phobia
  - Agoraphobia with or without Panic Disorder
  - Social Phobia

Anxiety symptoms are also prominent in;

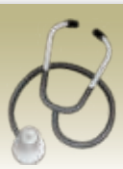
- Obsessive compulsive disorder

How common is anxiety?

It is very common, especially in the primary care setting. It is considered one of the most common mental health problems in the community setting. It is more common in females than males. **Except Social Phobia which is of similar incidence in both sexes.** It is more common in the young than in the elderly.

How to recognize anxiety?

Anxiety is the most prominent symptom. Anxiety may be persistent where the severity can wax and wane or it may be episodic. Depending on the way anxiety presents the Anxiety Disorders are classified.



Remember to exclude medical conditions that can give rise to symptoms that can mimic an Anxiety Disorder. E.g. Thyrotoxicosis, hypoglycemia, alcohol and drug withdrawal, drug side effects and vestibular disorders

Generalized Anxiety disorder (GAD)

There is free floating anxiety, i.e. anxiety is present all the time. There are no specific triggers. They are constantly worried and apprehensive. In addition there is also increased muscle tension, restlessness, trouble concentrating, irritability, and initial insomnia with unrefreshing sleep. Symptoms of autonomic hyperactivity (palpitations, dry mouth etc.) and hyperventilation can occur. These symptoms need to be present for more than 6 months.

Phobic Anxiety Disorders

Anxiety is present only in the presence of a certain object, situation or natural phenomena unlike in generalized anxiety disorder. Other characteristic features include avoidance of the anxiety provoking circumstance and anticipatory anxiety when faced with the possibility of facing the feared circumstance. Phobic anxiety disorders include specific phobia, agoraphobia and social phobia.

Specific phobia

The recognized types include those relating to animals, blood, injection and injury, natural environment (e.g. heights) and situations (e.g. airplane travel). People with specific phobias usually do not seek professional help.

Agoraphobia

Literally means fear of the market place. For the person who is experiencing agoraphobia, the fear is of being in a situation/place from which sudden escape is unlikely; or being in a place/situation where help is unlikely to come if experiencing a panic attack or symptoms of anxiety. Agoraphobic fears typically involve situations such as being outside the home alone, being in a crowd or standing in a queue, and travelling in a train, bus or car. In some patients, this results in an inability to leave his or her home (unless accompanied by someone). There is avoidance and anticipatory anxiety. May or may not be associated with panic attacks.

Practice point

Agoraphobia may be precipitated by a panic attack that took place in a public place, a sudden unexpected death of a friend or family member or as part of an established depression.

Social Phobia

There is a fear of being in situations in which the person may be negatively scrutinized by others. There is a recurring fear of social performance, situations that involve facing strangers or being observed by others. There is avoidance and anticipatory anxiety.

Practice point

Agoraphobia and social phobia are sometimes difficult to differentiate. It is important to inquire in to the reason as to why the person fears being in a particular situation, whether it is fear of negative scrutiny by others (social phobia) or if it is due to fear of not being able to escape if a panic attack occurs (agoraphobia).

Obsessive Compulsive Disorder

Anxiety occurs as result of obsessional thinking. Obsessions are recurrent, intrusive thoughts/doubts/images that are highly distressing to the person and considered to be senseless. They are unsuccessfully resisted. The compulsive acts or rituals are stereotyped behaviours that are repeated again and again. The patient tries to reduce anxiety by engaging in overt (rituals – hand washing, checking etc) or covert (counting, thinking neutralizing thoughts etc) compulsions.

Practice point

Even though compulsions such as hand washing may reduce anxiety associated with an obsession soon after the act, over time they tend to increase anxiety and increase the severity of obsessions.

How do you manage people with Anxiety?

General management principles

1. **Education of patient and the family members**

   In Sri Lanka, Mental Health literacy is low; there is a high risk of Anxiety Disorders being mismanaged. Education helps to relieve anxiety and makes it more likely that the patient engages in treatment.

2. **Always try to manage in primary care and refer only in the following situations**
   a. When diagnosis is in doubt
   b. When the patient is not responding to recommended treatment
   c. When complicated by comorbid mood disorder, substance use, personality disorder, or unstable medical illness
3. In almost all Anxiety Disorders the **treatment is long term** and requires pharmacological and non-pharmacological treatment
4. Regular exercise helps in managing Anxiety
5. Promote self help
6. Most patients have maladaptive coping mechanisms (e.g. psychoactive substance use, aggression) identify and address these issues separately
7. Range of medications are available including beta blockers, benzodiazepines, buspirone in addition to the main treatment of antidepressants
8. Despite treatment some patients with Anxiety Disorders will have a chronic debilitating illness

Pharmacology

Short term management

- Benzodiazepines (BDZ) may be used. Risks associated with use include abuse of benzodiazepines and benzodiazepine withdrawal which may make the Anxiety symptoms worse.
- For short term use only.
- Better to use long acting preparations (e.g. diazepam) instead of short acting preparations (e.g. lorazepam).

- Used in the initial period to relieve symptoms rapidly and to achieve symptom reduction until other medications start acting (e.g. antidepressants)

Long term management

Definitive treatment is with antidepressants. SSRIs, Low dose TCAs, and SNRIs can be used

Psychotherapy

- Relaxation exercises – Breathing exercises, progressive muscle relaxation, guided imagery
- Cognitive Behavioural Therapy

Other therapies

Peer support groups are useful when the illness is long term and showing poor response to treatment

Management Principles in Anxiety Disorders

Generalized Anxiety Disorder

- Drug treatment – SSRI
- Cognitive Behavioural Therapy
- Peer support groups
- Regular exercise
- Identify maladaptive coping strategies such as substance abuse and apply remedies

Specific Phobic Anxiety Disorders

- Graded exposure to feared object or situation
- Medication is unhelpful

Social phobia

- Medication is usually necessary.

  Antidepressants – e.g. SSRIs
- Cognitive Behavioural Therapy
  - Cognitive errors will be identified and challenged
  - Reduce safety behaviours
  - Graded exposure to situations being avoided
  - Modeling the feared behaviour with the patient

Agoraphobia

- Medication is necessary to control panic attacks. Usually higher doses of an antidepressant are necessary - E.g. SSRI
- Graded exposure to situations that are being avoided
- Modeling the feared behaviour with the patient also helps – accompanying the patient to public areas such as a shopping mall.
- Cognitive Behavioural Therapy – in which the patient's cognitive errors will be identified and challenged.
- Support group for people with Agoraphobia

Management of Obsessive Compulsive Disorder

- Medication is usually required
- Antidepressants – SSRIs (Eg. Fluoxetine usually at a higher dose of 40-60mg; Clomipramine – higher doses with caution)
- Antipsychotics – only useful as an augmenting agent – need to be used with care
- Benzodiazepines – do not have a place in the management
- Cognitive Therapy – challenging cognitions of inflated sense of responsibility and thought action fusion
- Behavioural Therapy – exposure and response prevention
- Education of the patient and the caregiver – sometimes the caregivers have become part of the compulsive behaviours of the patient and need to be educated on the management principles

Practice point

OCD symptoms may become worse during times of increased anxiety (e.g. close to exams, during the breakup of a relationship etc) and during times where the patient may be depressed.

How do you follow up people with anxiety disorders?

Need to continue antidepressants for a variable duration for the different illnesses.
Duration for each type of illness

- GAD – Lifelong
- Social Phobia – 6-8 months
- Agoraphobia with Panic Disorder – 1 – 2 years
- Panic Disorder – 1-2 years of treatment

Medication which has proven to be effective should be tailed off gradually. As relapses are common patients should be educated to obtain treatment at an early stage.

Cognitive Behavioural Therapy is efficacious in controlling symptoms as well as preventing recurrences thus should be tried in all relevant instances

Key points

- Anxiety Disorders are common but are frequently misdiagnosed and not properly managed
- Anxiety Disorders commonly overlap with depression
- Anxiety Disorders commonly present with physical symptoms
- Psychological Therapies and Antidepressants (SSRIs) are first line treatment
- Benzodiazepines should not be used as long term treatment
- Most illnesses are long term illnesses thus follow up is essential

Post Traumatic Stress Disorder (PTSD)

PTSD is considered a severe, prolonged reaction to an exceptionally traumatic experience (e.g. war, sexual assault etc.).

Anxiety occurs when exposed to cues and also spontaneously as a result of reliving experiences in the form of intrusive memories, flashbacks and /or nightmares of previous traumatic experiences. Other symptoms of hyperarousal include irritability and insomnia. Avoidance is another key feature

The onset often follows a latency period, which may range from a few weeks to months after the traumatic event. The course is fluctuating but recovery can be expected in the majority of cases.

Practice point

More common in ex-service personnel, victims of torture (refer presentation No. 7 in the CD for more details on torture), rape, kidnappings, in people who are subject to natural or man-made disasters and in those who reside in conflict areas.

Management principles in Post Traumatic Stress Disorder

- Trauma focused cognitive behavioural therapy
  - Educate on normal stress response
  - Self -monitoring for symptoms
  - Graded exposure to avoided situations
  - Recall and integrate images of the traumatic incident to rest of the experience
  - Cognitive restructuring of errors held by the patient
- Eye movement desensitization and reprocessing (EMDR) may help patients with PTSD
- Antidepressants (SSRIs) reduce the autonomic activation and the startle response seen in patients with PTSD
- Avoid benzodiazepines as long term use will lead to dependence.

Further reading

1. Cowen P, Harrison P, Burns T. Shorter Oxford Textbook of Psychiatry. 6th ed.Oxford : Oxford University Press; 2012.

2. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines in Psychiatry. 11th ed. West Sussex : Wiley- Blackwell; 2012.

Notes

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MODULE 3

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3. EARLY PSYCHOSIS

Learning Objectives

- To describe the clinical features of early psychosis
- To engage a patient with early psychosis
- To know the principles in management of early psychosis
- To know the principles in management of an acutely disturbed patient

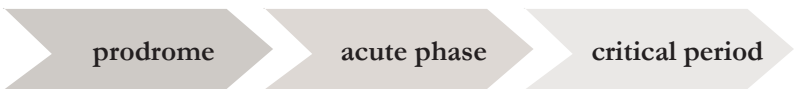
Early psychosis

The onset of psychotic illness occurs most commonly in late adolescence or early adulthood (McGorry *et al,* 2008). Acute psychotic symptoms are often an extremely disturbing experience for a young person, as well as their families.

Some conditions in which psychosis can occur in:

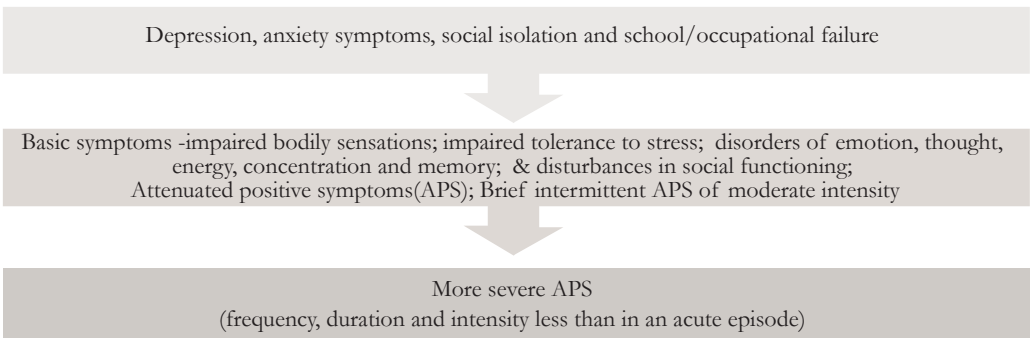
- Schizophrenia
- Drug intoxication
- Bipolar disorder
- Major depression
- Medical illness (eg. Epilepsy, encephalitis)

First episode psychosis



(Spencer *et al, 2001)*

Prodrome



(Larson *et al,* 2010)

First episode psychosis

A person may exhibit a cluster of symptoms which include the following.

- Delusions – e.g. persecutory, thought broadcasting
- Hallucinations – e.g. third person auditory hallucinations, thought echo
- Poor insight
- Negative symptoms
- Cognitive symptoms

Comorbidities may exist in the form of substance use, OCD, depression and anxiety, which must be actively sought out. Secondary comorbidities in the form of PTSD, fear & demoralization, disrupted personal development, low self-esteem and confidence may also be present.

Critical period

This is the initial phase following the acute psychotic episode, which is of approximately 3 years duration. Comprehensive treatment and management is required with close follow up as care during this period will affect the long term outcome of the illness.

Management of early psychosis

The duration of untreated psychosis can range from 1-2 years. This is associated with ineffective treatment seeking, high rate of involuntary admissions and traumatic events (Spencer *et al,* 2001). Thus early detection is vital. It is important to be aware of pathways to care in the community to prevent unnecessary delay and damage to the individual.

Integrated care

Integration of biological, psychological and social interventions is vital in achieving the best outcome in the first episode of psychosis (Kulkarni & Power, 1999).

Engagement

This is a critical step though barriers often exist in building a good therapeutic relationship. Engagement is more successful if the initial contact occurs prior to a major crisis.

Engagement techniques

- Recognize - the patient may be anxious or scared & may not want to see mental health professionals
- Be aware - psychosis might disturb the patient's interactions & ability to process information

- Listen carefully & take their views seriously
- Acknowledge & respect their point of view. Do not challenge their explanation to the current symptoms prematurely
- Gather information gradually fostering a close relationship
- Use appropriate body language
- Be helpful and active
- Explain procedures and try to be as flexible as possible when providing treatment
- Introduce key players
- Ensure good continuity of care & good communication between professionals

Remember

If a patient has poor adherence to treatment or defaults follow up, ensure increased contact by means of home visits, especially during the critical period.

Do not discharge the patient from the clinic.

Assessment

- History – patient & collateral
- Assess for comorbidities – substance abuse, depression
- Mental state examination
- Physical examination
- Risk assessment
  - Suicide
  - Violence
  - Physical illness & neglect
  - Victimisation by others
  - Non-adherence to treatment
  - Leaving hospital prematurely
- Assessment of needs & strengths of the individual
- Cognitive assessment
- Functional assessment
  - Current & best ever level of occupational functioning
- Strengths & needs of the family

Investigations

Recommended before commencing antipsychotic medications:

- Urine tests: drug screen
- Blood tests: Full blood count, Fasting blood glucose, Renal function tests, Liver function test.

- Body Mass Index (BMI)

If indicated:

- CT brain scan

Remember

About 4% of young patients with a first episode psychosis are found to have an organic cause for their illness

Setting

This should be the least restrictive environment in which the patient's illness can be managed. Home based care however can be feasible only if there is adequate family support and easy access to hospital care in an emergency.

In the presence of risk to self or others and risk of further deterioration due to poor treatment adherence consider admission to a psychiatric unit.

Psychological interventions during the acute phase

- Provide reassurance & emotional support
- Provide psycho-education to the family
- Engage through addressing issues of concern

Pharmacological treatment

The aim is to achieve a remission.

Consider an antipsychotic free period (if feasible),

- for at least 24 hours
- to clarify the diagnosis
- to exclude organic causes if suspected
- to provide time for symptoms of drug intoxication or withdrawal to diminish
- if symptoms of psychosis are vague/transient
- if symptoms are subtle or denied by the patient
- if the patient is very reluctant to accept medication

*Benzodiazepines can be used for sedation if needed.

Antipsychotics in the acute phase

- Educate the patient and family regarding the goals of treatment
- Educate about acute and long term adverse effects; efficacy and safety of the antipsychotic and provide an acceptable rationale for its use
- Commence at a low dose and titrate
- Monitor for side effects
- Use the minimum effective dose
- Avoid antipsychotic polypharmacy

Common fears about medication

- Loss of control by taking ' mind drugs' ; fear of medicine changing personality
- Fear of side effects of drugs
- Concern about stigma
- Fear of altered lifestyle
- Fear of emptiness
- Fear of lifelong medication
- Fear that medication will not work

Factors to consider when choosing antipsychotics

- The side effect profile & tolerability
  - Typicals – e.g. extra pyramidal side effects
  - Atypicals –e.g. metabolic side effects
- Availability & cost
- Patient preference

Antipsychotic dose rates

Start at a low dose- especially in those who are antipsychotic naive

Make dose adjustments in small increments

Optimal dose –maximum therapeutic benefits and minimal adverse effects

If a patient does not show any improvement within the first two weeks, it is less likely that he/she will do so later to the same drug and dose

If a patient does not respond to two adequate antipsychotic trials of different classes refer to a consultant psychiatrist for further management

Continue maintenance treatment for at least 2 years after remission of first episode

Management of an acutely disturbed patient

How to approach

- Ensure that adequate help is available in case the situation escalates
- Alert police or other security personnel if appropriate and if possible have them located unobtrusively close by
- If your safety or that of others is directly threatened then withdraw rather than persist
- Maintain as much privacy as possible while ensuring a safe environment
- If in a room, ensure you can reach the door but do not block the exit from the young person (Angry people may rather leave than resort to violence)
- Consider removing items of your clothing (such as ties or necklaces) which could be used to grasp you, or items such as pens or other objects which could be used as weapons
- Approach in a calm, confident manner
- Avoid sudden or violent gestures & adopt a relaxed, non-threatening posture
- Avoid prolonged eye contact (staring)
- Sit side-by-side rather than face-to-face
- Do not confront the person physically or "tower over them" (e.g. if they are seated)
- Allow the individual ample 'personal space'
- Use an empathetic non-confronting manner, emphasising your desire to help
- Do not turn your back
- Focus on the immediate situation- the 'here and now' – and the immediate needs of the individual, rather than dwelling on the past
- Try not to give ultimatums

Other aims in treatment

Achieve a level of functioning as close as possible to the premorbid state

Maintain social roles

Engage in competitive employment

Family therapy

Address their sense of trauma and loss

Practice point
Reduction in negative caregiving experiences during the initial stage may help to prevent a critical or hostile family environment at a later stage
(Spencer *et al,* 2001)

Potential benefits of effective intervention

- Effective intervention in the initial acute phase of psychosis – helps prevent biological, psychological and social deterioration (Birchwood & Macmillon,1993 ; Robinson *et al,* 1999)
- Reduces severity of illness
- More rapid recovery
- Better prognosis
- Preservation of psychosocial skills
- Preservation of family and social support
- Reduced need for hospitalisation

Further reading

1. Spencer E, Birchwood M, McGovern D. Management of first episode psychosis. Advances in Psychiatric treatment. 2001; 7:133-142

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MODULE 4 - Part I

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4.1. SUBSTANCE USE DISORDERS – PART I

Learning outcomes

At the end of this module you should be able to;

- List psychoactive substances according to ICD10
- List pharmacodynamic effects of psychoactive substances
- List learnt behaviours associated with psychoactive substances
- Appreciate difference between pharmacodynamic effects of and learnt beahviours of psychoactive substances
- Demonstrate how to help others appreciate above difference using appropriate examples
  - o Pharmacodynamics
- Substance use disorders
- Psychiatric conditions related to substance use
- Treatment in psychiatry setting
- Physical effects of substance use
- Describe what media literacy is
- Use media literacy as an effective tool in prevention of substance use
- Plan effective, scientifically designed substance use prevention campaigns
- Recognize the relevance of above techniques used in prevention in individual counselling of patients and their families.

Categories of psychoactive substances use as described in the ICD 10

1. Alcohol: Beer, arrack, toddy, kasippu, arishta, whiskey, wine, champagne
2. Opioids: Corex D, heroin, pethidine, tramadol
3. Cannabinoids: Cannabis, *modaka*
4. Hypnotics: diazepam, sleeping tablets
5. Stimulants: Cocaine, amphetamine, caffeine
6. Hallucinogens like LSD
7. Tobacco
8. Volatile solvents: Petrol, paint, thinner
9. Multiple drug use
10. Other psychoactive substances

Examples to be used to demonstrate the difference between pharmacodynamic effects and learnt behaviours related to substance use

1. The scientific analysis of the observation of the quicker occurrence of the effects of IV heroin compared to its inhalation using a diagram of the blood circulation of the body.
2. Comparing the popularly known effects of alcohol, which indicate a stimulated brain, to the actual biochemical effects of alcohol as a CNS depressant

Cigarette smoking may be just reducing the withdrawal symptoms of nicotine dependence, which could be interpreted as pleasure, in the dependent smoker rather than inducing actual pleasure or reducing stress.

Fig 1 Smoker's pleasure

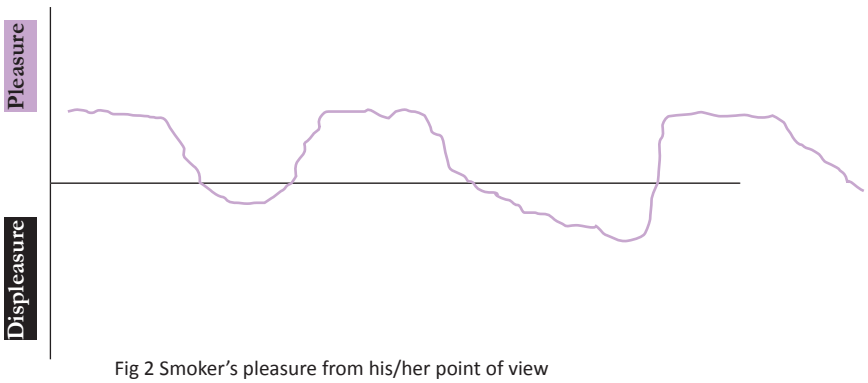

Fig 2 Smoker's pleasure from his/her point of view

Clinical presentations of major substance use disorders

1. Dependence syndrome
    a. Compulsion to take the substance.
    b. Impaired capacity to control substance-taking behaviour.
    c. A physiological withdrawal state.
    d. Tolerance to the effects of the substance.
    e. Preoccupation with substance use.
    f. Substance use despite clear evidence of harmful consequences.

2. Withdrawal state
    a. Cessation of substance use/ reduction of substance use.
    b. Characteristic symptoms develop after a certain period of time:
        i. E.g. Irritability 2 hours after last smoke in a nicotine dependent person.
        ii. E.g. Fits 4 days after the last drink in an alcohol dependent person.

3. Problem use
    a. Not meeting criteria for dependence.
    b. Substance use despite obvious harm.
        i. E.g. Drinking alcohol at parties despite causing great damage to social reputation in previous similar situations – Psychosocial harm.
        ii. E.g. Smoking despite chronic cough/ aged appearance – Physical health effect.

4. Acute intoxication. NB: Review 'learnt behaviour' due to substance use.
    a. How much is actual physiological phenomena?
    b. What proportion is learnt/ conditioned behaviour?

Clinical presentations of major psychiatric conditions related to substance use

- Psychosis: Notorious with cannabis in Sri Lanka.
- Depression: Commonly with alcohol.
    - Usually settles with abstinence.
- Dementia: With chronic alcohol use.
    - May not get better with abstinence.

Matrix to categorize disorders related to substance use

	Dependence syndrome	Withdrawal state	Problem use	Acute intoxication	Substance induced psychiatric disorder
Alcohol	**Alcohol dependence**	**Alcohol withdrawal**	**Problem drinking**	**Alcohol intoxication**	**Alcohol induced depression**
Opioids	**Opioid dependence**	**Opioid withdrawal**	**Harmful use of opioids**	**Opioid intoxication**	**Opioid induced psychiatric disorder**
Cannabinoids	**Cannabis dependence**	**Cannabis withdrawal**	**Harmful use of cannabis**		**Cannabis induced psychosis**
Hypnotics					
Stimulants					
Hallucinogens					
Tobacco	**Tobacco dependence**	**Tobacco/ nicotine withdrawal**	**Harmful use of tobacco**		
Volatile solvents					
Multiple drug use					
Other psychoactive substances					

Principles in treatment of above disorders in a clinical setting

- Withdrawal state: Medical management
- Substance induced psychiatric disorders: Management of specific disorder
- Abstinence therapy:
  - Pharmacotherapy
  - Non-pharmacological therapy
  - Approaches at specialised units/ services
- Harm reduction therapy

Treatment of alcohol withdrawal

- Admission in significant dependence: Fits may be fatal!
- Careful physical assessment.
- Careful motivational assessment.
- Delay diagnosis of a mental illness.

- Medication:
  - Chlordiazepoxide (or diazepam) as needed to control withdrawal symptoms.
    - If in acute withdrawal give 30mg stat and continue 20mg every one hour until settled.
    - 20 – 40 mg qds + 20 – 40 mg PRN
    - Can give 100 – 200 mg per 24 hours!
    - And you can give more, but you need some specialist input.
    - Start tailing off after 48 hours of reasonable stability in daily steps.
    - E.g. 30 mg qds → 20 mg qds → 10 mg qds → 10 mg tds …
  - Thiamine:
    - If dependent or withdrawal seem severe;
    - If in doubt;
    - Give IM 100 mg stat; 100 mg daily for three days.
    - Thiamine oral 100mg tds for four weeks.
    - Neurobion is available.
  - IV fluids if needed
  - Rarely domperidone/ metoclopramide

Treatment of a planned alcohol withdrawal

- Admission almost always.
  - Set a date and to drink till date – 1 day.
  - Admit on date.
  - Start regular chlordiazepoxide dose from evening.
- Careful physical assessment.
  - Liver disease
- Careful motivational assessment.
- Delay diagnosis of a mental illness.

Abstinence therapy

1. Pharmacotherapy
   a. Craving reduction
   b. Aversive therapy
      i. Disulfiram for alcohol
   c. Replacement therapy

2. Non-pharmacological therapy
    a. General measures and social interventions
    b. Group therapy: Alcohol groups
    c. Specific psychological therapy
    d. Motivational interview
    e. Relapse prevention
3. Approaches at specialised units/ services
    a. Alcoholics anonymous: Check with local church.
    b. Mel Madura, Sri Lanka Sumithrayo, No 60, Horton Place Colombo 07. Tel: 011 2693460. www.melmedura.org

Harm reduction therapy

- Examples of possible outcomes:
    - Man repeatedly beating wife while abusing alcohol →Abusing alcohol but no longer beats wife.
- Principles:
    - Accepting that many substance users do not initially wish to stop.
    - Engaging the active user in treatment is the primary goal: Relationship is the key.
    - Any reduction in the harms associated with substance use is seen as valuable.
    - Mobilizing the client's strengths towards change.
    - Usually guides, if given effectively, towards meaningful change in the end.

Harmful health effects of alcohol use not commonly found in popular literature

- Alcohol:
    - Acute sexual dysfunction

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Methods used by the tobacco and alcohol industry to promote substance use among children, adolescents and adults overtly and covertly

Addressing emotions in contrast to ideas		
Emotions		Ideas
Feelings		Information
Mood	Vs.	Thoughts
Motivation		Cognition
Impluse		Words

- By addressing emotions, one can manipulate the limbic system, which is more powerful than the neocortex, which is concerned with reason.

Role of hidden messages in concerned communications

- Hidden messages are the messages in a communication which are not readily visible at first glance.
  - E.g. "Alcohol became a panacea for Australian indigenous people's pain." – One hidden message is that alcohol can ease psychological pain.
  - E.g. "What a shame! Not even a beer? You're worse than a woman!" – One hidden message is that men are superior to women, and this particular man who refused beer, is inferior.
  - E.g. One hidden message is that alcohol is really fun, and you should drink it after reaching 21.

Awarding privileges in relation to substance use

- Intoxicated person is allowed to be violent: "He is a gem of a guy, you know, he only hits me when he is drunk."
- The intoxicated person is allowed to get away with offenses with none or minor punishment compared to a sober person committing the same offense.

Examples of methods used by the tobacco and alcohol industry to manipulate research findings and policy making related to substance use and control

International Centre for Alcohol Policies (ICAP) is a well-known "resource for all those interested in alcohol policy worldwide. ICAP promotes dialogue involving the drinks industry, the research and public health communities, government, and civil society, encouraging them to work together." But what is interesting is that it is a "not-for-profit organization, supported by major producers of beverage alcohol." http://www.icap.org/

- Many scientific communications stating substance-related 'facts' such as 'tobacco use reduces stress' without citations to back the statement.

Evidence based interventions in substance use prevention

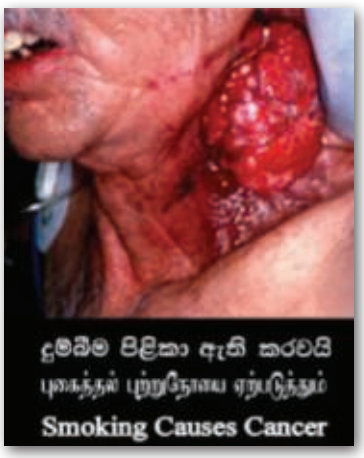
- Monitoring and improving tobacco/ alcohol/ drug use and prevention policies/ laws/ regulations. E.g. encouraging the Sri Lankan government to effect the inclusion of graphic pictorial warnings on cigarette packs.
- Offer effective help to quit substance use.
- Appropriately warn about the real dangers of tobacco/ alcohol/ drug use. NB: Pay attention to addressing emotions such as fear and shame.
- Enforce bans on tobacco/ alcohol advertising, promotion and sponsorship.
- Reduce accessibility to substances. E.g. raise taxes on tobacco.

Media literacy

- The ability to recognise the hidden motives of media messages.
- Media literacy is important to protect ourselves from the harmful messages coming through media as well as to teach our children to be vigilant about such messages.
- Important related sub-skills:
  - Ability to read hidden messages.
  - Ability to see how these messages create a positive/ attractive/ adventurous image about alcohol/ tobacco/ drug use.
  - Ability to detect product placement in media.

Some examples of scientifically designed media campaigns to prevent substance use.

Example of addressing emotions in daily patient clerking to motivate people to cease substance use



Doctor: Okay, it seems you need and urgent ECG to exclude a heart attack. Do you smoke?

Patient: Yes, doctor.

[Doctor stops writing, raises head, looks patient in the eye, appearing alarmed.]

D: You do?

P: … Yes… I know it is bad. Do you think I have a heart attack?

D: I don't until the ECG is done. But you certainly have a higher chance.

Further Reading

1. Cowen P, Harrison P, Burns T. Shorter Oxford Textbook of Psychiatry. 6th ed.Oxford : Oxford University Press; 2012.

2. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines in Psychiatry. 11th ed. West Sussex : Wiley- Blackwell; 2012.

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MODULE 4 - Part II

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4.2. SUBSTANCE USE DISORDERS – PART II

Objectives

- To explain the factors commonly influencing initiation and maintenance of substance use
- To describe common effects of heroin, cannabis and tobacco
- To be able to suspect and identify substance use in a clinic setting and community
- Carry out basic counselling for substance abuse in an effective manner
- To understand limitations of 'health education' model in addressing substance use disorders in the community
- Understand the pitfalls in dealing with patients and families who are affected by substance abuse problems
- Appreciate the available pharmacological treatment for substance abuse with special relevance to the Sri Lankan setting

Introduction

Substance use is a major problem encountered in day to day practice of any Medical Officer. The extent and the severity of the issue varies according to time and place. This module will provide a basic idea about dealing with such problems in your general practice (GP) clinic. The MOMH has a major role to play when it comes to prevention of substance abuse as well.

What are the commonly used substances?

Tobacco and alcohol are the most common substances that are used. When it comes to methods of use of tobacco, smoking cigarettes comes first and tobacco chewing next. Beer is the type of alcohol commonly used by young men in Sri Lanka. Cannabis and heroin are used frequently by people who seek treatment from us. There are other substances such as prescribed medications which contain psychoactive medications including opioids and sleeping tablets. Some knowledge of such substances is useful for Medical Officers who work in the community setting. The following discussion will be limited to tobacco, cannabis and opioids.

The deaths due to tobacco, in general, in Sri Lanka amount to 20,000- 40,000 per year. Similar numbers of people die due to alcohol related issues each year. However, the number

of deaths due to heroin and cannabis are almost zero. Even though the impact on life appears to be higher with heroin, greater harm is done by smoking and alcohol.

What is a 'gateway drug'?

A gateway drug is a substance that is known to lead to abuse of other substances. For example, almost all heroin users start with smoking cigarettes and addiction to alcohol starts with beer. Hence, these two substances are considered 'gateway drugs'. In other words, to prevent young children as well as adults abusing heroin, we have to prevent them smoking. This applies to alcohol in the form of beer as well.

Practice point
In order to prevent heroin addiction it is important to start with smoking as it is the gateway drug

What is the impact of substance abuse?

Death and chronic diseases due to substance abuse are uncommon among the young and otherwise healthy persons (except in smokers and patients who drink alcohol). However, there is always an impact on academic performances and social functioning. Peer relationships and relationships with teachers and parents will be affected, sometimes, to the extent where the child is marginalized and isolated.

Failure in examinations such as G.C.E. ordinary level and advanced level sometimes is traced to addictions in some situations. Absenteeism, engaging in petty crime and drug dealing also takes place. Drug dealing and recruitment of 'new members' for the club is usually carried out in order to finance one's own substance use.

Effects of commonly abused drugs on the human brain

Alcohol

In any form (beer or arrack) is known to cause brain damage. It is a cerebral depressant and will lead to general lowering of all the functions of the brain including attention, concentration and memory. Alcohol causes sexual dysfunction even among young adults.

Cigarettes

Tobacco causes the following; it leads to poor concentration, confusion, sensory disturbances. First time users and starters will experience nausea, vomiting, salivation, pallor, weakness,

abdominal pain, diarrhoea, dizziness, headache, increased blood pressure, tachycardia, tremor and sweating.

The myth that tobacco improves attention and memory is one major incentive for adolescents. These positive changes occur in adult and adolescent tobacco addicts, and only among addicts, as a result of alleviation of withdrawal syndrome; never in the tobacco naive individual. Most youngsters would not like the first few times they smoke or chew tobacco but would not disclose that to peers due to the substance abuse culture. Tobacco causes sexual dysfunction due to damage it causes to the nerves and small vessels.

Cannabis

Cannabis is more dangerous to the developing brain than we initially thought. It can give rise to Schizophrenia and other psychotic illnesses in 2- 6% of individuals. Being a very serious mental illness, Schizophrenia could lead to devastating academic and personal outcomes. Cannabis can cause sexual dysfunction and anxiety. It has similar effects to tobacco on the lung, when chronically smoked.

Heroin

Heroin causes drowsiness and impaired cognitive functions. The withdrawal syndrome causes irritability, poor sleep, pain, poor attention and concentration and impairment of memory due to distractibility in the acute withdrawal stage.

What is the most significant effect of addiction?

Addiction itself is the most significant effect. It is more destructive than any other physical or mental effects of the drugs as it causes the addict to be hooked on to the chemical, preventing them from enjoying any other activity in their life. Basically, they are "trapped" in 'something' and their whole life centers around it. The individual gives up all other alternative pleasures and joy. He associates with the same set of unpleasant individuals with whom he abuses drugs (and alcohol). Literally, he goes round and round, around the substance like the ox tied to the oil mill (Sekkuwa). For example, if someone were to be dependent on smoking cigarettes, he would be preoccupied throughout the day about the 'next smoke', as he develops withdrawal symptoms every 1 ½ to 2 hours. For many, this would be more unpleasant than death itself.

Why do people abuse substances?

The aetiology of substance abuse in children and adolescents differ somewhat from the adult. It is important to remember that the individual is just starting to take substances while they are in their teens.

The aetiology of initiation is different from dependence. Most young people would drink alcohol or smoke cigarettes due to peer pressure; they learn from peers. Then the imploring question would be 'from where do peers learn to drink and smoke?' The family, community and societal factors come into play and the most influential of all is the attraction to use substances.

Practice point

Most important factor leading to substance use is the 'attraction' created around the substance'

Attraction to tobacco and alcohol is maintained by fellow users in the school and the community that the adolescent lives in. The most important issue here would be the promotional activities carried out by the industry and their trade partners. Mass media plays a major role in creating and maintaining the image for alcohol and tobacco, and is much more powerful than parents', teachers' and peers' influence. These factors start operating very early in a child's life. The image that is maintained by the non-users including the adults that the child associates with also contributes to initiation.

Some other associated factors for substance abuse such as antisocial personality traits, genetic predisposition and urban drug ridden neighbourhoods are not easily amenable to activities carried out at the primary health care level. Genetic predisposition is a major aetiological factor among the long term drug addicts. However, most starters and experimenters will not have such a predisposition. The genetic factor is of secondary importance when it comes to teen substance use.

How to identify drug abuse?

Many children experiment with substances such as alcohol and give them up soon as they themselves experience the adverse effects then and there and they become disillusioned of the expected pleasant effects of those. It is difficult to identify occasional users. However, the following circumstances should lead to high index of suspicion regarding substance abuse, especially among the teenage males.

- Any significant recent change in behaviour
- Recent drop in school performance
- Frequent absenteeism at school and work

- Late comers
- Excessive drowsiness and other physical changes including weight loss
- Deterioration in self care
- Frequent quarrels
- Social withdrawal
- Notable injuries
- Suspected of criminal activities such as stealing
- Recent changes in personality including defiance and oppositional tendencies

Practice point

It is difficult to identify the occasional user.

Look out for recent behavioural changes and drop in performance.

Why is individual counselling not very effective?

Teens are more influenced by media and peers than adults. They would feel strongly about the acceptance by their peer group and would readily disregard advice. Inadvertently, the teachers/ parents and other adults would get into a tug of war around issues such as substance abuse and other disciplinary issues and would reinforce defiance. Hence, an unexpected result would emerge from some activities carried out in order to curb substance use among the school children.

Sometimes, the student who received advice or punishment would make it a point to feel proud of it and boost his image in the eye of his peers. This would add to the attractiveness of substance use among school children as it exhibits their defiance readily.

One other common reason for ineffectiveness of advice is that it is based on one of the two common models, namely fear arousing medical model and religious moral model. All the consequences that are usually listed, for example, lung cancer, cirrhosis and damnation to hell, are very distant repercussions that a young person would laugh at and forget. There is no point in educating someone on something that they are already aware of and disregard. The uselessness of such advice is enhanced in the presence of ready-made jokes and humorous stories that are deliberately circulated among school children and young adults.

Do we confuse ourselves when it comes to aetiology? Initiation vs. addiction

It is likely that most of the doctors do not attempt to address the factors related to initiation as they are taught the factors for the above two instances, namely initiation and addiction together. Most of the time, we see patients who are not addicted to substances but engages in some form of use. Hence it is important to be aware of the distinction of these aetiological factors.

Peer pressure and the role of parents, communities and the society at large

All the above factors could be addressed by the Community Mental Health staff. Yet the appropriate techniques have to be used as otherwise the efforts will be counterproductive. Peer pressure is one thing that we always need to discuss. Some settings create a culture of 'fear' in a subtle manner to facilitate propagation of substance abuse. The individual may not be aware of the ways that peer pressure is exerted as usually this is indirect, and needs to be educated on that line.

It is important to address parental influence as well. Apart from being role models, they exert a great deal of influence indirectly. For example, in chronic heroin users, it was found that the mother and the male child have a very dependent and enmeshed relationship. The responsibility of use and giving up is taken up by the mother making it difficult for the young adult to grow out of the addiction.

Do we promote drug use inadvertently?

Yes. We do promote the drug culture inadvertently. Depicting heroin as the devil is one such good example. These drugs and their users instead should be labeled as puppets and straw-men rather than devils that are feared by the community they live in. Hence, the power and the attraction towards them and the substance reduce.

In our daily lives, we do promote, for instance, by laughing at, telling and distributing jokes. This seemingly innocent act contributes to maintaining the positive image of alcohol and tobacco, and affects the way small children appreciate it. Associative learning which takes place with contributing to such 'jokes' maintain the positive image and attraction towards the substance in the society.

Likewise, allowing the children to watch cartoons (e.g. Tin Tin) and other programmes (e.g. Oshin); we allow them to be exposed to lot of alcohol and tobacco promotion through mainstream media. There is no necessity to elaborate on the internet and social media as anyone can learn by just switching on the computer.

What has been shown to be not so effective so far?

Some activities which are carried out in good faith have not yielded the desired outcome when it comes to substances of abuse. Among them, the haphazardly planned 'health education' activities top the list. Seemingly scientific interventions which appear to have a rational basis on paper and presentations could sometimes, lead to promotion rather than reduction of substance abuse in the society. Hence as MOMHs, you will have to be vigilant on evidence and what evidence to take seriously.

The effects of 'educational programmes'

Due to the high literacy rate in Sri Lanka, most people would get to know about harmful effects of drug and alcohol use early in their lives. The teachers teach them in health studies lessons; the priests preach on the topic all the time and doctors educate people via mass media. Hence, the harmful effects of drugs and alcohol are known by even the young school children in the country. What is not known are the 'real' effects?

The chemical effect of drugs and alcohol are heavily masked by the social and cultural factors and the promotional factors carried out by the industry. Educational programmes that are based on conventional teaching of for example the physical effects of alcohol are not going to change the use of it any more. Likewise, advice based on moral values has their limitations.

The new health education programme should rest on sound scientific principles. For example, it is known that *the messages that reduce attraction towards substance use* in fact reduce the tendency to use it.

The following points would be of some help in carrying out health education programmes:

- Try to focus on the things that are not generally touched by conventional health education programmes; for example, alcohol causes sexual dysfunction - but the users tend to lie due to social pressure. Tobacco causes sexual dysfunction and skin changes that makes one 'ugly' and unattractive.
- Addiction itself is the most undesirable 'effect'. It makes one's life centered around a substance to the exclusion of alternative pleasures. This happens without the knowledge of the user with time.
- Empowered attitude towards alcohol and other substances make them attractive to the user and furthermore, non-users also contribute to the perpetuation of the culture by subscribing in the way of jokes.
- Users have to be empowered as they have already become successful targets of the industry.

Counselling

If you are to counsel a child with substance use issues, you need to have some skills to do that. Just reading a book will not equip you to do that and the session might do more harm than not doing any counselling.

In a situation where you decide to do counselling use the following guidelines

- Ensure confidentiality.
- Do not argue, advice or scold and try to communicate a non-judgmental attitude.
- Take care not to appear as an agent of the parents/ teachers. Usually young people would not open up when they sense this.
- Do not use statements that would generalize substance use such as 'It's usual that boys of your age drink, so tell me the truth'. Use 'their' language when appropriate and discourage when not appropriate. Language communicates not only meaning but emotions and actions.
- Once substance use is acknowledged, education and advice could be provided accordingly. For example, sexual dysfunction and brain damage due to alcohol and smoking and psychosis due to cannabis may be new information for a student. There is no point reiterating facts about lung cancer and cirrhosis, unless you think that the patient is unaware of such.
- Help children to identify the real effects of the substances and reassess the situation. For instance, let them observe and learn that there is 'not even temporary relief' by using substances. For example, all young alcohol users experience distress, discomfort and distaste immediately with the use of alcohol, but are reluctant to admit due to the cultural factors that are created around alcohol use. Alcohol once isolated from the pleasant environment that it is used, gives rise to the opposite of what it is used for. Many people will feel depressed and nauseated.
- Teach how to be assertive as suggestion and coercion are two methods used by current users to compel their peers to take substances. Learning to say no and having reasons to do so empowers the users and helps them to come out of it.
- Discussing academic difficulties, worries and fears, and any psychological or social problem would be appropriate depending on the situation. This is addressing the life at large rather than restricting your discussion to the 'use'
- Be ready to give up some counselling theories that you studied (you have learnt that people are rational and counter- argument for a case would enable them to accept your point of view and change attitudes). For example, it would be counterproductive to argue against substance abuse with a teenager who claims that he enjoys alcohol. You will have to learn new ways of dealing with such problems. "Michael Jackson

used it so why shouldn't I?" and "I have heard the effects of drugs already; I don't mind dying at the age of 50 with an MI. I want to have fun before I die!"

- Remember that your moral values would be different from the person that you are counselling. Take care not to be paternalistic as the patient would become more and more defensive once he feels that you are similar to the other adults that he has to deal with (parents and teachers)
- Address life and not only the drugs
- Your emotions and the smoking kid – if you are angry, it is likely that you would fail in counselling. And you would appear to represent his /her parents. Hence learn to manage your own anger.

What is the place of 'rehabilitation' for individuals with a drug addiction?

Rehabilitation is a period of enforced abstinence, usually for an extended period of time in a protected environment. This option is used to treat patients with co-morbid mental illness and severe drug addiction. However, rehabilitation is rarely an option for a youngster who abuses substances. Consider the following reasons;

- There is no scientific evidence to suggest that rehabilitation carried out in protected environments over a long period of time improves abstinence, compared to short term treatment options carried out as out-patients. Results were shown to be better with short term interventions which enable the patient to live in the community
- Rehabilitation, if at all, is an option for long term drug addicts, who are dependent on substances; most school children and young adults would not qualify for this category
- Living in a rehabilitation unit where there are adults, and usually antisocial adults, would put a young person at risk of abuse as well as enable him to learn maladaptive and harmful behaviours
- Rather than rehabilitation, all persons with addiction should be helped to give up or cope with the habit while living in the community

Prevention is different from treatment

When it comes to youth, the following have been shown to be effective in preventing drug and alcohol use.

- Reduce attraction to drugs
- Reduce availability and accessibility

Remember, it is easier to prevent the whole community or a school from drinking rather than counselling one by one and 'saving them'. The attraction is not maintained only in the minds of the vulnerable children or users; it is actively propagated by non-users as well. As mentioned earlier, a contagious humorous story or a joke is a good example. Another example is to copy a frequent television advertisement or a social media post in order to have a laugh. Unless these phenomena are addressed effectively the use of alcohol and other substances will not come down.

Reducing availability and accessibility of drugs and alcohol seems less amenable to actions by MOMHs and primary health care doctors. Even though there is no direct way of dealing with availability, there are numerous examples where MOMHs and MoHs have dealt with the issue effectively. Community action assisted by the whole primary care staff and other community organizations have led to reduction in sales outlets and promotional activities in some parts of the country.

Reducing attraction towards substance use is easily addressed by MOMHs. For example, the school mental health education activity could be based on addressing the media influence on substance abuse. With a little bit of guidance, the children would easily identify the TV channels which promote drug abuse indirectly. Examples of such activities are found in various publications including booklets produced by the National Dangerous Drugs Control Board (NDDCB) and ADIC (Alcohol and drug information centre) - Sri Lanka.

Few examples are provided here:

Your creativity will take you a long way in dealing with this issue and it is always worthwhile to experiment and see. These activities can be carried out regularly at the classroom as well as on special days such as world tobacco prevention day.

- Ask children to draw – a tobacco face or an alcohol face
- Write essays on – industry influence on alcohol promotion
- Plan activities to identify non- advertising promotion in tele-dramas, television advertisements and news items and literary work
- Discuss methods of empowering both the 'deceived' user as well as non-users to say no to alcohol, tobacco and drugs
- Identify sales points and promoter shops and grocers and work towards boycotting such establishments
- Preparing for events – for example big matches and other similar events. They could be educated and empowered to observe how alcohol and tobacco are promoted and privileges being granted for the users

Things that would work both in individual counselling as well as community activities

Education about addiction itself

- Education about sexual effects
- Effects on appearance and attractiveness
- Education on how the individual has become a victim
- Education about industry strategies
- Education about real effects of alcohol
- Making the patient capable of challenging the myths of alcohol
- Empowering the user
- Allowing them to work for 'a smell free school'. Advocacy will help a user to come out of the habit
- Your attitude and language – keep an eye on the use of terms such as "pevenawa" as you would also be contributing to the culture
- Address self-fulfilling prophecies
- Address life in general

Know your limits

- Antisocial personality disorder traits
- Limitations in technical capacity
- Inadvertent promotion
- Being labeled – good, moral, religious etc.
- Your own ego and narcissism

What should not be done?

- Things which empower users and the industry
- Draw a lot of attention
- Labeling – as this would lead to a negative self-fulfilling prophecy
- Breaching confidentiality unless a criminal act is being carried out or a risk to life
- Take sides with parents, principals and other teachers
- Openly declare certain things

- Do not expel the child; this will worsen the problem
- Activities which have shown no obvious benefit and have become 'jokes'
- Rehabilitation has to be done in the community. Most children do not require it

Go by the science and when evidence is scarce, do some research and see

Research can be carried out in a small scale in order to verify the claims of the users. For example, close observation of alcohol users shows that they do not lose the capacity to take decisions and in fact will act with remarkable accuracy in their favour. However, they use this as an excuse in order to enjoy privileges that they would otherwise lose.

What next?

If you feel that the situation is beyond your capacity to handle, you must refer the patient for further help. Pay attention to the following conditions carefully and refer for appropriate interventions.

When to refer

- If you don't know what to do (limited technical skills)
- Severe addiction/ multiple substance use problems
- Concurrent mental illness
- Suicidal or homicidal attempts and intents which warrants a consultant psychiatrist's opinion
- Antisocial acts/ criminal behaviours need to be reported to the police
- If you are emotionally troubled and can't control it, for example, you have a child of similar age and you feel overwhelmed after listening to the story
- If you are angry and upset as the student has let you down and transgressed moral rules

Medications and therapeutic interventions for specific substances

The following discussion would help you to carry out medical treatment when appropriate. The specific advice on some substances is drawn from the generic models of substance abuse treatment such as stages of change model and Cognitive Behavioural Therapy (CBT).

Tobacco

1. Identify all smokers just by looking at their face. You will develop expertise of doing this soon. And take a short history.
2. Ask about smoking from all adult men who you come across. You need not do this with women as the rate of smoking is around 1% among Sri Lankan women. Hence, you should not generalize or normalize by asking about smoking from all women.
3. Just advice the men to STOP SMOKING. This advice works. Out of hundred, at least 10 will stop and this itself is a good enough intervention.
4. Follow up regarding this at each visit. Patients who did not stop would still reduce the number of cigarettes at least. Keep a record and try to help the patient to take the next step. Asking the patient to delay the next cigarette by half an hour, or persuading them to not buy cigarettes in large amounts or packets might work. Let them monitor their own habit in an objective manner.
5. Drug treatments,
    1. There is NO effective drug therapy for smoking
    2. Nicotine Replacement Therapy (NRT) in reality has very minimal effect. Given the cost and inconvenience, one may be better off without NRT. Try to resist prescribing in order to mask your own anxiety (as failing to help/ treat is something any doctor would not want to face). Moreover, NRT has become a way of keeping the patient hooked on the addiction. It has paved way for lot of smoking promotion by the industry (for example e-cigarettes).
    3. Bupropion – not officially available at present. Could be used in a dosage of 150 mg bd along with a behavioural programme
    4. Varenicline- not available. This drug can give rise to agitation and psychosis which could be severe. Hence use under supervision
6. Non-smokers: impart them with knowledge to identify their own contribution for promotion (tolerating jokes etc.) and help them to do something regarding passive smoking and exposing their children to promotion

Remember that the most important intervention for smoking is **ASKING** the patient to **STOP.**

You must ASK all your patients to STOP Smoking

Cannabis

1. Educate about psychosis (6%) and amotivational syndrome. The patient may have heard all the good things about cannabis and the above mentioned negative outcomes may be unknown to him.
2. Arguing is not useful. It would be helpful to invite the patient to appreciate the impact of cannabis on his life.
3. Motivational Enhancement Techniques are useful. The patient may take a long time to change and he might go through several cycles of 'stages of change'.
4. There is no antidote in the way of a chemical agent to help him.
5. May use medications to treat resultant psychosis, mood disorders and anxiety. For example, trifluoperazine is useful in dealing with psychosis.

Heroin

1. Heroin withdrawal lasts only for 5 days. The reason why most patients find it difficult to endure these five days is fear. They, more than anything else, fear the "sickness". Hence it is important to educate the patient regarding the anticipated duration of severe withdrawal. Tell them clearly that this lasts for just five days.
2. Patients do not die due to medical complications of heroin withdrawal. Unlike alcohol related delirium tremens, opioid withdrawal is safe. You can treat them in the community.
3. Common detoxification methods used in Sri Lanka:
    i. Cold turkey- do nothing. In fact a vast majority of patients will stop heroin themselves without any help. In such situations, just enhance self efficacy by encouraging the patient. Help them to learn to question the widely held distorted picture of being 'sick'.
    ii. Symptomatic treatment- the patient is prescribed a combination of medications to tackle symptoms. For example, a benzodiazepine such as diazepam for sleep problems; paracetamol and an NSAID for pain; and an antiemetic should suffice in majority of the cases.
    iii. DO NOT prescribe opioids. Patients who requests opioids must be educated about the nature of withdrawal and supported to go through it. Even in the western countries, now the treatment programmes are moving away from things such as methadone maintenance as they have resorted for a model free of opioids.

iv. When a patient reports that opioids are being prescribed by another doctor (mostly quacks and malpractice doctors), educate the patient about the possible underlying intention of him continuing the habit, by resorting to abuse of another opioid, rather than stopping it. It would be necessary to address the issue of patients being deceived by various doctors who do not in fact treat the addiction but make a living out of addicts by supplying a stock of cheap opioids and other medications. These quacks contribute to the perpetuation of the drug culture by creating and popularizing an image of heroin akin to a fierce 'devil'

v. If found to be an intravenous (IV) drug user, refer to appropriate places such as a psychiatry clinic and STD clinic

Conclusion

The commercial and cultural influences are more powerful than individual counselling. Hence do not get disheartened if you fail to do much. The little changes done in the environment will eventually bring some visible and useful results. It is always useful to focus on prevention as it brings forth change in many individuals' lives.

Do not give in to the desire for prescribing when it comes to substance abuse treatment. A short course of whatever the suitable medication that you decide useful could be prescribed. It is best to avoid making the patient feel that he stopped with the assistance of treatment as this hampers the development of self efficacy, which is the most important individual factor in giving up a habit.

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MODULE 5

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5. SEXUAL DISORDERS

Learning outcomes

At the end of this module you should be able to;

- describe the human sexual response.
- explain sexual dysfunctions.
- describe paraphilias.
- explain the role of relationship in sexual dysfunctions.
- describe differences between love and possession in relationships.
- show awareness of different attitudes in society towards sex.
- review roles of genders.
- describe performance anxiety.
- comparatively describe attitudes and science of the concept of virginity.
- list ways to promote sexual health.
- describe steps of sensate focus sex therapy.
- describe the basics of other behavioural therapy methods for sexual disorders.
- describe some pharmacological therapies in sexual disorders.
- describe assessment of a patient/ couple with a sexual issue.
- recognise possible diagnoses in a given case.
- suggest treatment methods for sexual disorders/ issues.

Normal Human Sexual Response

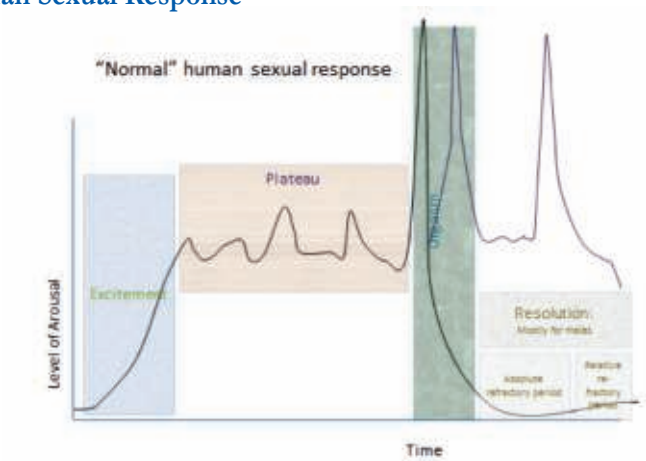

Figure 1: Human sexual response

Comprises of four stages, which include

- Excitement
- Plateau
- Orgasm
- Resolution

Excitement (arousal)

This is the first stage of the sexual response, which occurs following physical or mental stimulation.

Plateau

This stage of sexual excitement occurs prior to orgasm where many physiological changes take place

Orgasm

Orgasm is the third stage which occurs at the end of plateau. In males orgasm is associated with ejaculation.

Resolution

In the final stage of the human sexual response the physiological changes begin to reverse and the muscles relax. In males there is a refractory period which is subdivided as absolute and relative and during the absolute refractory period they are unable to achieve an orgasm.

Sexual dysfunction

Deviation from normal sexual response. E.g. in premature ejaculation the arousal is too high and orgasm is therefore too early

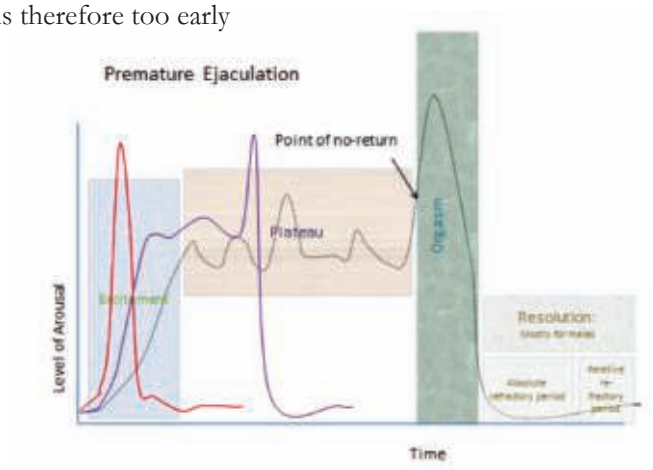

Figure 2: Human sexual response in premature ejaculation

	Examples of Presentation/ symptoms	Aetiology	Pathology	Treatment
Erectile dysfunction	Poor erections, loss of erection later, non-specific symptoms, refusal to have sexual intercourse, subfertility	Organic: Diabetes, other metabolic causes, vasculopathy, neuropathy, smoking, endocrine causes, medication side effects and many other factors. Psychological: Performance anxiety, depressive disorders, anxiety disorders, non-specific anxiety, relationship issues. Mixed: Common to have both factors.	Inability to have or maintain erection for sexual satisfaction.	Always try to treat aetiological cause. E.g. sex therapy for anxiety. Symptomatic treatments: Phosphodiesterase inhibitors. Other pharmacological and surgical methods are to be used in rare instances by experts.
Premature ejaculation	Poor sexual performance, erectile dysfunction	Anxiety may play a role. Mostly it is 'constitutional'	Inability to delay orgasm	Teach the man to control orgasm: Squeeze technique and other behavioural methods. SSRIs and condoms with topical benzocaine are effective, too
Vaginismus	Inability to have sexual intercourse, subfertility	Rarely physical causes. Mostly anxiety regarding penetration.	Inability to relax vaginal musculature during intercourse.	Behaviour therapy to reduce anxiety: Finger insertion method

Table 1: Common disorders of sexual dysfunction

Paraphilias (ICD 10)

Fetishism

Reliance on some non-living object as a stimulus for sexual arousal and sexual gratification. Many fetishes are extensions of the human body, such as articles of clothing or footwear. Other common examples are characterized by some particular texture such as rubber, plastic, or leather. Fetish objects vary in their importance to the individual: in some cases they serve simply to enhance sexual excitement achieved in ordinary ways (e.g. having the partner wear a particular garment).

Sadomasochism

A preference for sexual activity that involves bondage or the infliction of pain or humiliation. If the individual prefers to be the recipient of such stimulation this is called masochism; if the provider, sadism. Often an individual obtains sexual excitement from both sadistic and masochistic activities. Mild degrees of sadomasochistic stimulation are commonly used to enhance otherwise normal sexual activity. This category should be used only if sadomasochistic activity is the most important source of stimulation or if necessary for sexual gratification.

Exhibitionism

Either a recurrent or a persistent tendency to expose one's genitalia to unsuspecting strangers (usually of the opposite sex), almost invariably associated with sexual arousal and masturbation.

Voyeurism

Either a recurrent or a persistent tendency to look at people engaging in sexual or intimate behaviour such as undressing, associated with sexual excitement and masturbation. There is no intention to reveal one's presence. There is no intention to have a sexual involvement with the person(s) observed.

Paedophilia

A persistent or a predominant preference for sexual activity with a prepubescent child or children. The person is at least 16 years old and at least five years older than the child.

Multiple disorders in one person is common. Paraphilias almost always occur in men.

Remember
Paraphilias need expert treatment.
Giving insight on the negative outcomes including legal impact may be useful.

Performance anxiety

Masters & Johnson's (1970) introduced the construct "spectatoring". Spectatoring refers to focusing on and evaluating oneself from a third person perspective during sexual activity.

If sex is seen as a performance, a game/ a show, put up by the male on the female, then the male is going to have anxiety about his performance. This is known as performance anxiety.

Change of attitudes to sex is needed. Sex is not a competitive game; it is an intimate act of love. Relationship has to get better. The more you are in love, less anxiety you have.

Virginity

Virginity means sexual naivety, not intact hymen. Hymen could be reconstructed or one can have oral/ anal sex without damaging hymen and lose sexual naivety, i.e. virginity. The attitude towards virginity has to change.

Sexual Health Promotion

Sexual dialogue

Sexual dialogue/ communication is of primary importance for a better sex life. We do not have a sexual dialogue because we do not have appropriate words.

One important use of sexual dialogue is to indicate impending orgasm or otherwise.

We need to discuss sexual matters when in a non-sexual mood. Just invent one secret word (e.g. eating a banana for sexual activity) and improve sexual communication.

Optimising timing of orgasm

	Male	Female
Time to achieve	Generally shorter	Generally longer
Ability to achieve	Almost all	Probably almost all
Psychological influence • Love and affection • Mood and setting • Anxiety	Less	More
Ability to achieve mechanically	More	Less
Importance	High	High
Physiology	Ejaculation Rhythmic contractions	No similar phenomenon Rhythmic contractions

Table 2: Comparison of male and female orgasm

To give the female an orgasm, or even to have an orgasm at the same time, what is needed is to delay the man's orgasm and hasten the woman's orgasms, in most couples.

Understating clitoral stimulation is important in female orgasm. Changing the position may give time for the man to reduce his arousal and delay orgasm.

Further Reading

Supplementary Reading - Role of relationships on sexual dysfunction (See attachment in CD)

Notes

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MODULE 6

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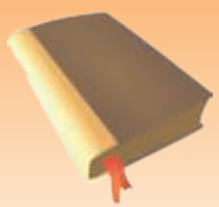
6. DEMENTIA

Learning Objectives

- To be able to identify dementia in clinical practice
- To be able to assess the severity of dementia
- To know the different types of dementia
- To know the reversible and irreversible causes of dementia
- To be aware of the general management principles in patients with dementia
- To be able to advice a care giver on the management of a patient with dementia

What is dementia?

It is the progressive deterioration of multiple cognitive functions, including memory in clear consciousness, leading to functional deterioration of day to day activities



ICD – 10 Definition

"A syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not clouded. Impairments of cognitive functions are commonly accompanied and occasionally preceded by deterioration in emotional control, social behaviour or motivation"

Causes of dementia

Main primary causes in later life:

- Alzheimer's disease
- Vascular (cortical, subcortical and mixed)
- Lewy body disease (Lewy body dementia & dementia in Parkinson's disease)

Potentially reversible:

- Hypothyroidism
- HIV, Neurosyphilis
- Alcoholic dementia
- Brain tumour
- Normal pressure hydrocephalus
- Vitamin B12 deficiency

Other, rarer causes:

- Fronto-temporal dementia (including Pick's disease)
- Huntington's disease, Wilson's disease

Commonest type of dementia is Alzheimer's disease followed by vascular and Lewy body dementias. A significant number of patients will have a mixture of Alzheimer's and vascular dementia.

Alzheimer's disease

Most cases of Alzheimer's disease are sporadic.
Familial cases of Alzheimer's disease with a defined inheritance pattern account for only 5 to 10%. They have an earlier age of onset.
Genetic defects on chromosomes 21, 14 and 1 have been identified.

Pathology

Macroscopy

Cerebral atrophy results in widening of sulci and narrowing of gyri mainly in frontal, temporal, and parietal regions. This results in compensatory ventricular dilatation.

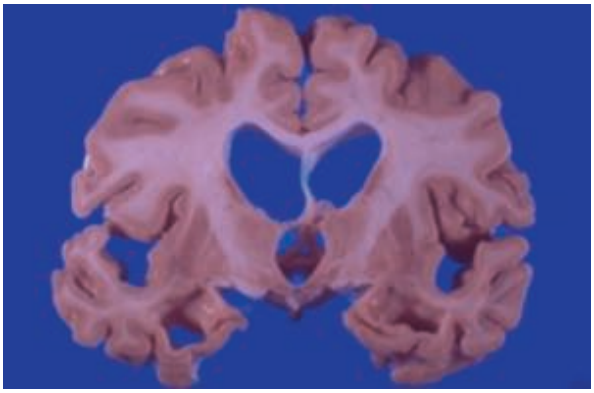


Fig.1 Cerebral atrophy with compensatory ventricular dilatation

Microscopy

Presence of;

1) Neuritic plaques
2) Diffuse plaques
3) Neurofibrillary tangles
4) Amyloid angiopathy
5) Granulovacuolar degeneration
6) Hirano Bodies

How common is dementia?

As the population is aging the prevalence of dementia is rising. It is estimated that the prevalence rate of dementia in those aged over 65 years is approximately 5%. At the age of 65 years it is postulated to be around 1% and this figure is supposed to double every 5 years. Therefore by the age of 90 years 30- 40% will suffer from Alzheimer's dementia.

At present Sri Lanka has an aging population. Prevalence of dementia is rising in Sri Lanka.

The prevelance of dementia in a suburban population in Sri Lanka was found to be 7.1% in a study conducted by Kathriarachchi *et al*, (2009)

How do you recognize dementia?

In dementia there is deterioration of multiple cognitive functions which would have an effect on the patient's activities of daily living (ADL). There is progressive memory loss, with memories of recent events affected more than remote events. There is progressive worsening of cognitive skills over time including difficulty in learning & manipulating new information, impairment of attention and concentration, disorientation, deterioration of language skills and difficulty in carrying out complex motor tasks.

Practice point

Be aware of the elderly patient who complains of memory loss with a depressed mood. The patient may be having depression instead of dementia and the apparent memory loss the patient complains may be due to reduced attention and concentration seen in depression, without having a primary problem in memory. This type of presentation is called a 'depressive pseudo-dementia'. These individuals should be treated with antidepressants and psychological therapies instead of anti-dementia drugs.

Behavioural and psychological symptoms of dementia (BPSD)

In addition to the cognitive symptoms there are other non-cognitive symptoms of dementia that are seen. These may be more troublesome and difficult to manage than the cognitive symptoms of dementia. These symptoms include poor sleep, inappropriate sexual behaviour, irritability, self neglect, incontinence, wandering, depression, delusions and hallucinations. These symptoms can be troublesome to the caregivers.

As these BPSD symptoms affect approximately 2/3 of the patients at some point in their illness they must be actively sought out and managed as it affects the quality of life of both the patient and their carers.

It is important to obtain a good history from the patient as well as collateral history from a caregiver.

Dementia affects day to day life

The doctor should also explore details of the patient's home circumstances, ability to cope with activities of daily living and to handle more complex tasks (e.g. handling money transactions, using a telephone, driving) and inquire about support from family. A home visit will enable assessment regarding safety and mobility.

Mild Cognitive Impairment (MCI)

As a person ages there is some deterioration of cognitive functions. There are certain illnesses such as Alzheimer's disease which cause the patient to lose his or her cognitive functions at an earlier age.

Before functional deterioration occurs patients may complain of mild forms of cognitive impairment. On screening they may have some cognitive deficits but would not be severe enough to be diagnosed as dementia. These individuals are considered to have **mild cognitive impairment.**

The present guidelines do not recommend use of AChEI in these individuals but recommend regular exercise, use of antioxidants, close monitoring of diabetes mellitus and blood pressure and to be monitored closely for development of dementia. It is an area in which a lot of research is taking place.

How do you manage people with dementia?

Broad management principles of dementia include;

1. Establishing a diagnosis of dementia and assessing severity
2. Ruling out potentially reversible causes of dementia
3. Use of medication and therapies to,
   a. stop or slow down the progression
   b. symptom alleviation
   c. management of behavioural and psychological symptoms (BPSD) of dementia
4. Supporting the primary caregiver and family
5. Education and support with regards to legal and financial matters

Establishing a diagnosis of dementia and assessing severity

- **History and mental state examination** – would reveal multiple cognitive deficits and associated functional deterioration as well as other behavioural and psychological symptoms of dementia.

- The physical examination focuses on physical risk factors (e.g. pulse, blood pressure, peripheral pulses). A thorough neurological examination should also be done in these patients.

- Use of screening tools such as the Mini Mental State Examination (MMSE) and the Montreal cognitive assessment (MoCA) for which there is a validated Sinhala translation, helps to identify the severity of dementia. These tools can also be used to measure the deterioration over time. The clock drawing test is another helpful screening tool that can be used in the primary care setting.

Ruling out potentially reversible causes of dementia

- A range of investigations need to be organized to identify potentially reversible causes of dementia, such as hypothyroidism, Vitamin B12 deficiency, normal pressure hydrocephalus (NPH), intracranial tumours, and other space occupying lesions.
- Full blood count (FBC), blood urea and serum electrolytes (BU & SE), liver function test (LFT), C-reactive protein(CRP), Thyroid function test (TFT), B12 and folate levels (can be replaced by blood picture in primary care setting), Fasting blood sugar (FBS); and HbA1C if diagnosed with diabetes),lipid profile, urine full report (UFR),chest x-ray (CXR) and VDRL
- If indicated CT Brain / MRI

Use of medication

Types of medication used in dementia of Alzheimer's disease

1. Acetylcholine esterase inhibitors (AChEI) - The three licensed drugs are all cholinesterase inhibitors: donepezil, rivastigmine and galantamine. They can be given only in patients with mild - moderate Alzheimer's disease, suggested by an MMSE score of 10–20. Their administration must be initiated by a specialist and monitored.
2. NMDA receptor antagonists – Memantine to be used in severe dementia (MMSE score of less than 10)

There should be optimal management of hypertension and diabetes with anti-hypertensive and oral hypoglycaemic drugs

Acetylcholine esterase inhibitors (AChE-I) in Dementia with Alzheimer's disease

- AChEIs are known to stop the progression of symptoms in 1/3 of patients, improve the clinical picture in another 1/3 and not to have any effect on rest. Serial measurement of MMSE scores will enable to identify those who benefit from AChEIs.
- AChEIs may also reduce the severity of non-cognitive symptoms of dementia such as behavioural and psychological symptoms.

- AChEIs are relatively safe drugs with fewer side effects. Side-effects include nausea, vomiting, insomnia, headaches and dizziness. These drugs aggravate cardiac conduction defects, and patients with pre-existing heart disease, dysrhythmias or a pulse rate below 60 beats/min need to have an ECG before treatment is commenced. To reduce side effects start with a low dose and gradually increase it. Advice the patient to take the medication with meals.
- Sometimes antidepressants and antipsychotics may need to be used with caution in patients with depression and psychosis. Antipsychotics are associated with increased side effects in patients with dementia. In addition they increase the risk of strokes.

Non pharmacological management

Education and support is a very important part of management

Psychological treatments

- **Reality orientation**
  This is used to help patients with dementia by reorienting them to details about themselves and their environment. It can be used as individual or group therapy. They are oriented to their environment using a range of materials and activities. Orientation devices such as signposts, notices and other memory aids such as calendars and clocks should be used consistently. Sensory stimuli such as distinctive sights, sounds, and smells are used to improve sensory awareness.
- **Validation therapy**
  It is based on the general principle of validation, the acceptance of the reality and personal truth of another's experience. The therapist attempts to communicate with individuals with dementia by empathizing with the feelings and meanings hidden behind their speech and behaviour, giving importance to the emotional content of what is being said. The benefits of this therapy include gratification and reduction in behavioural disturbance.
- **Reminiscence therapy**
  Reminiscence therapy helps the patient to re-live past experiences especially those that are positive and personally significant such as birthdays, holidays and weddings. This too can be done with individual patients or groups. Music, artwork and old photographs can be used to provide stimulation. It is said to improve the level of well-being and may give rise to reemergence of the pre-morbid personality.
- **Art therapy**
  This form of therapy provides stimulation, promotes self esteem by providing choice with regard to their creations and is also a form of self expression.

- **Music therapy**
  This could be in the form of singing, playing an instrument or listening to music / songs. This too can enhance the level of well-being, improve social interactions and autobiographical memory and reduce agitation in people with dementia.

- **Activity therapy**
  It involves activities such as dance, sport and drama. Physical exercise can improve mood, sleep, confidence and self esteem. Daytime exercise may also help to reduce agitation and night time restlessness. The non-sexual physical contact which occurs during this therapy is found to be soothing by many people with dementia.

- Specific stress management and coping skills training may also help caregivers

How do you manage behavioural and psychological symptoms of dementia?

- Assessment
  Identify the problem behaviours
  Duration & severity
  Causative factors

⬇

- Treat any underlying modifiable cause/s
  Eg: Pain – adequate analgesia
  Urinary tract infections – antibiotics

⬇

- Modify patient's environment

⬇

- Non pharmacological
  Structured activity programmes
  Exercise
  Behavioural management
  Eg: Differential reinforcement
  Sensory stimulation
  Eg: Music therapy
  Social contact

⬇

- Pharmacological
  Severe agitation / psychosis – quetiapine
  Depression – citalopram

Practice point

BPSD symptoms usually last for less than 3 months. Review & reassess the need for treatment, especially pharmacological treatment.

How do you follow up patients with dementia?

- Education and support for the patient and carer/s plays an important role
- If the disease is mild advice patients regarding the preparation of a will, about advance directives, appointment of a guardian and end of life discussions
- Titrate medication according to symptom relief and side effects
- Tightly control risk factors that would lead to further deterioration – diabetes, hypertension, cardiovascular diseases
- Carers may benefit in participation in local support groups
- Provide respite admissions to reduce carer burden & address their psychological distress

Key points

- Dementia is a progressive illness
- Dementia is on the rise worldwide and especially in Sri Lanka
- It is important to identify the cause of dementia as some causes may be reversible
- Screening tools play an important role in assessing the severity and treatment response
- AChEIs can reduce the rate of progression of the illness in some patients
- Non pharmacological management plays an important role
- Caregiver support is an integral part in dementia management

Further reading

1. Cowen P, Harrison P, Burns T. Shorter Oxford Textbook of Psychiatry. 6th ed.Oxford : Oxford University Press; 2012
2. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines inPsychiatry. 11th ed. West Sussex : Wiley- Blackwell; 2012.

Notes

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MODULE 7

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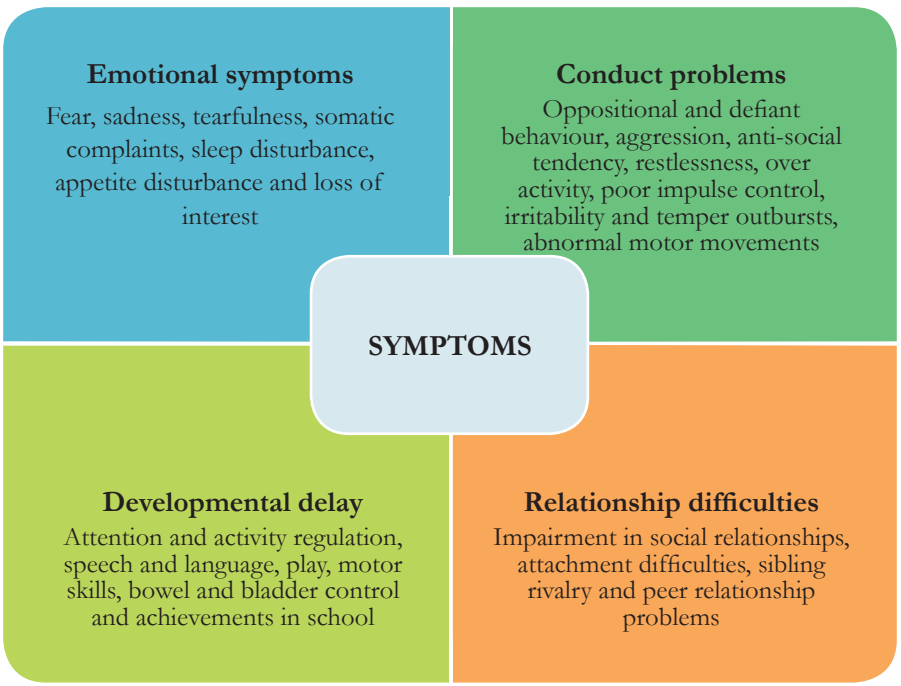
7. CHILD & ADOLESCENT MENTAL HEALTH

Core Knowledge

1. Common clinical presentations of mental health problems in children.
2. Differentiating between normal variations of behaviour, and psychiatric disorders.
3. Impact of mental health problems.
4. Risk factors and protective factors.
5. Basic concepts of management.
6. Prevention and health promotion.

Common Presentations



Most children who get referred for mental health problems show more than one type of symptoms.

Differentiation

Many of the symptoms are present in children who do not have any mental health problems. Other factors should be considered to differentiate a disorder from normal variation in behaviour.

- Age of the child
- Presence of multiple symptoms
- Persistence of symptom or symptoms
- Source of information about the child

Impact of symptoms

A disorder should be diagnosed only if the symptoms have a substantial impact.

Impact is judged from,

a. Social impairment
   - Family life
   - Classroom learning
   - Friendships
   - Leisure activities

b. Distress to the child

c. Disruption to others

Risk factors

I. Risk factors will increase the likelihood of the child developing a mental health problem.

II. Risk factors help to understand the reason/s for a child having particular combination of symptoms.

III. Single risk factors are not relevant unless severe.

IV. Risk factors are associated with individual child, family, school, community or a combination.

Risk factors can be grouped as;

Predisposing factors	• Pre-existing vulnerabilities
Precipitating factors	• Recent events
Perpetuating factors	• Maintaining factors
Absence of protective factors	

Some known risk factors associated with child mental health problems

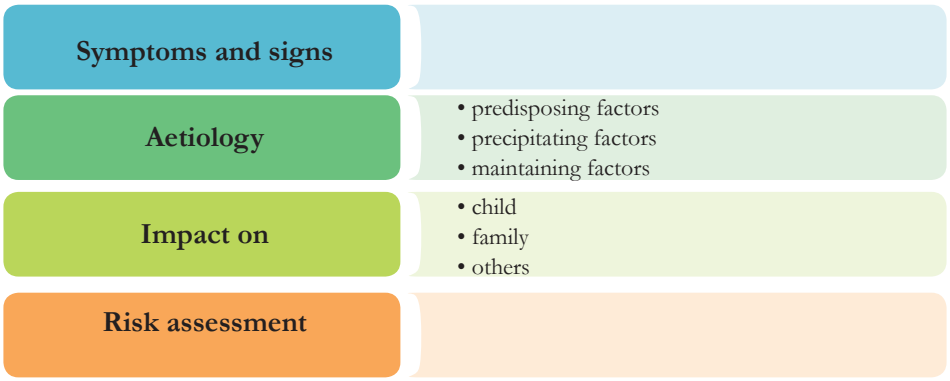
- Chronic physical illnesses
- Learning difficulties
- Brain disease
- Temperamental difficulties
- Adverse life events
- Persistent social disadvantage
- Chronic illness in parents
- Family conflicts and dysfunctions
- Child abuse

Protective factors

- Easy temperament
- Good self esteem
- Close supportive relationship with an adult
- Superior intellectual ability
- Good social skills
- Well-functioning parents

Protective factors will determine that the child has a mild rather than a severe disorder.

Diagnostic Formulation



Diagnosis

Types of disorders

Onset specific to childhood and adolescence – e.g. Attention deficit hyperactivity disorder (ADHD)

Disorders common with adults – e.g. depression, schizophrenia, anxiety

Basic concepts in management

- Understand how the family explains the problem in the child.
- Inform and educate the child and the family.
- Have a realistic and focused management plan.
- Aim at improving the level of functioning and quality of life of the child and the family.
- Use existing resources in child, family and the community.
- Monitor outcome of management.

Prevention and health promotion

Prevention is possible and cost effective

Knowledge of understanding risk and protective factors in the child mental health is important.

Types of preventive strategies

Indicated prevention	• Target individuals who are at risk or already showing early signs of having problems • eg. children of mentally ill mothers
Selective prevention	• Target populations at high risk • eg. Following disasters and displacement. Children living in deprived and disadvantaged communities.
Universal prevention	• Target entire population • eg. Prenatal care, anti-drug campaigns in schools

Prevention and mental health promotion

Network of services are needed to work together.

- Health services
- Educational services
- Social and welfare services
- Law enforcement and legal services
- Voluntary organizations working for the welfare of children and families

Autism

Core Knowledge

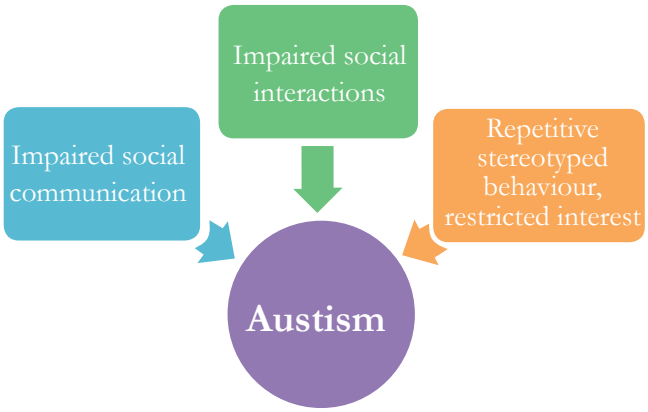
1. Clinical presentations of Autism
2. Diagnostic criteria and associated features
3. Differential diagnosis
4. Screening for Autism
5. Importance of early detection & intervention

Common Presentations

- Delay in speech development
- Hyperactivity
- Tantrums and temper-outbursts
- Rejection from preschool
- Does not work in class
- Ignore when spoken to

- On teacher's suggestion
- Does not mix with peers
- In their own world

Diagnosis



Austim Clinical Features

Speech / Language Problems	Social relationship Problems	Other Behaviours
Too few words or no speech	Does not share interests with parents	Watch rotating objects
Repeats what others say	Does not initiate interactions	Line up toys
Regression	Cannot be made to respond to an interaction	Lack of appropriate play
Jargon language	Avoids eye contact	Repetitive hand movements
Incomprehensible speech	Indifferent to presence of others	Toe walking
Receptive language problem	Does not recognize emotions	Mannerisms in gait/ speech
Use words in the wrong place (pragmatic language problem)		Insistence on routines

Atypical Presentations

- Common
- Good eye contact
- Points
- Talks a lot – repeated questioning
- Staring
- Sensory integration problems
- High-functioning autism
- Co-morbidities

Associated Features

1) *Spectrum of intellectual ability* - range from mental retardation to above average intelligence
2) *Seizures*
   Affect 40%
   Seizures often begins in adolescence
   Majority have abnormal EEGs

3) *Behaviour problems*
   Hyperactivity, self-injurious behavior, aggressive outbursts, food fads, fears and avoidance
4) *Oversensitivity and under-sensitivity to sensory stimulation*
5) *Medical conditions: well recognised associations are*
   - Tuberous sclerosis
   - Fragile X syndrome

Association is also known with

- Prader Willi syndrome
- Angelman's syndrome
- Congenital rubella
- Perinatal trauma and asphyxia
- Encephalopathies
- Prenatal exposure to antiepileptic medication

Differential Diagnosis

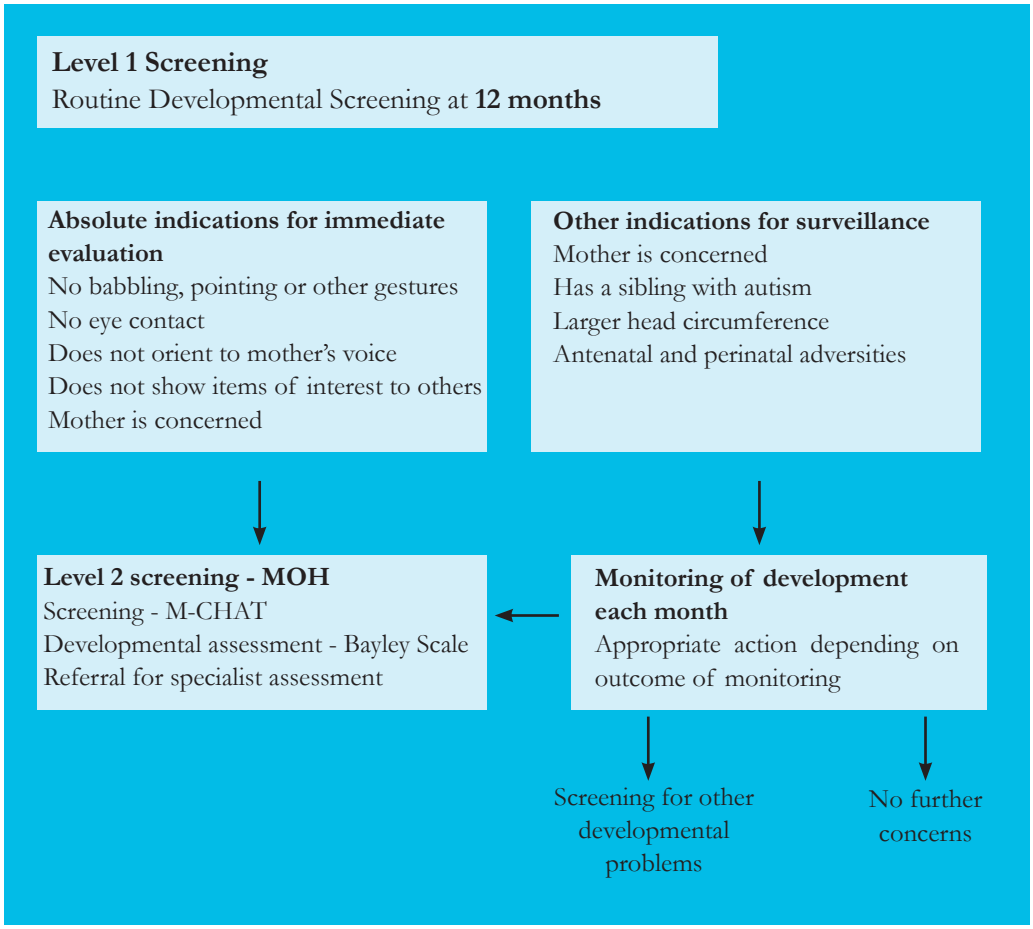
- Mental retardation
- Developmental language disorder
- Selective mutism

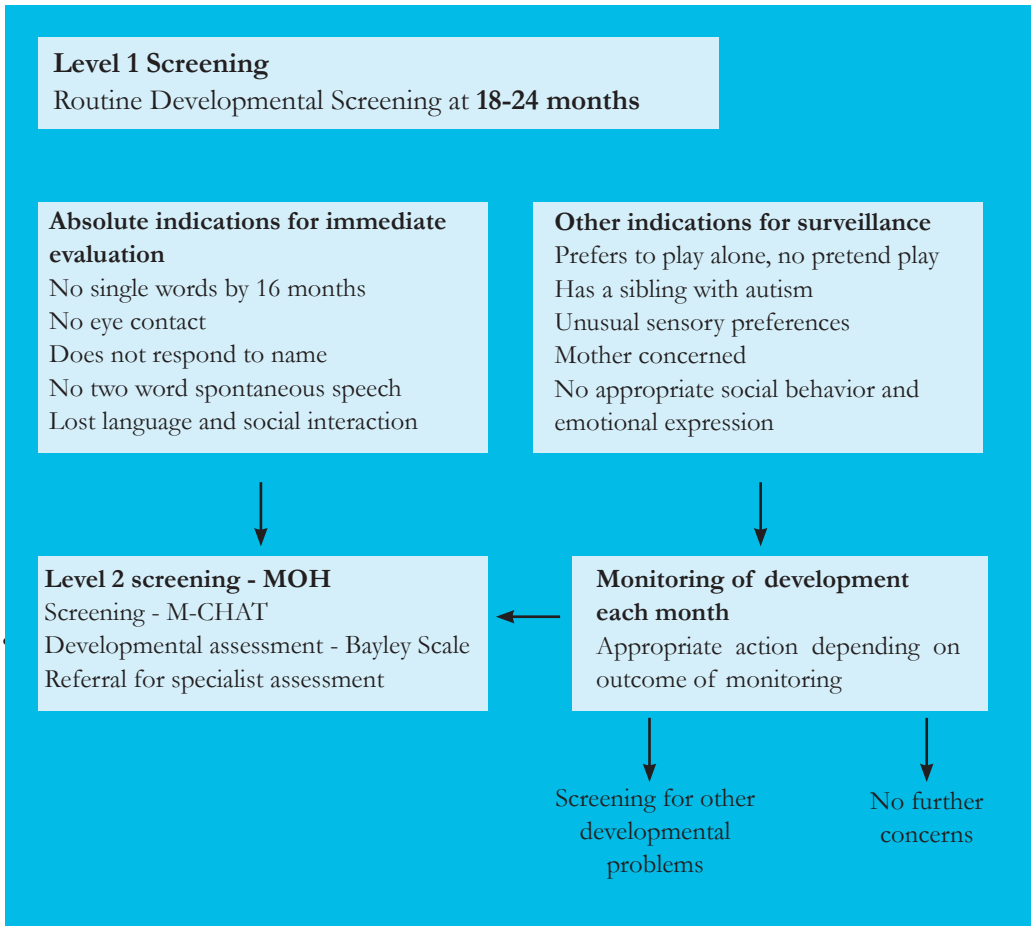
- Landau Kleffner syndrome
- Attachment disorder
- Severe emotional deprivation
- Temperamental shyness

It is widely accepted that….

- Autism need to be identified as early as possible
- Children & their families need to be referred on to appropriate services as soon as possible
- Early intervention in autism is necessary and beneficial
- The earlier the better for higher gains. Less favourable after 4 years.

Screening




Level 1 Screening
Routine Developmental Screening at 18-24 months
Absolute indications for immediate evaluation
No single words by 16 months
No eye contact
Does not respond to name
No two word spontaneous speech
Lost language and social interaction
Other indications for surveillance
Prefers to play alone, no pretend play
Has a sibling with autism
Unusual sensory preferences
Mother concerned
No appropriate social behavior and emotional expression
Level 2 screening - MOH
Screening - M-CHAT
Developmental assessment - Bayley Scale
Referral for specialist assessment
Monitoring of development each month
Appropriate action depending on outcome of monitoring
Screening for other developmental problems
No further concerns

Surveillance of Preschool Child

- Mother concerned
- Preschool teacher concerned
- Poor use of words to communicate
- Lacks appropriate gestures to request for things
- Ignores when mother calls the name or when mother attempts to engage child in play
- Does not seem to understand spoken language
- Lacks eye contact
- Prefers to play alone. Does not mix with peers
- Does not show pretend play – eg. Feed a doll
- Displays extreme distress when child does not get his own way or sometimes for no apparent reason
- Overactive and sometimes under-active
- Lacks emotional expressions
- Shows repetitive behaviours with toys or with own fingers and hands
- Smells everything including food

Preliminary assessment for autism using DSM IV criteria - by MOH

Referral for specialist assessment

Early detection

- Can be reliably assessed by 18 months (CHAT)
- Can be differentiated from non-autistic language delay
- Evidence from case studies, home videos, prospective follow up
- Early social, communication, behaviour and sensory abnormalities

Diagnostic tools

- Child Autism Rating Scale (CARS) - (Schopler et al 1980)
- Development Behaviour checklist (DBC) - (Einfeld & Tonge 1992)
- Autism Screening Questionnaire (ASQ) - (Berument et al 1999)
- Autism Diagnostic Observation Schedule (ADOS) - (Lord et al 1989)
- Developmental, dimensional and diagnostic interview (3Di) - (Skuse & Warrington 2004)

Early intervention –objectives

- Enhance development
- Minimise potential for delay
- Optimise special needs for health, education and social welfare
- Optimise opportunities for learning
- Enhance capacity of families as caregivers
- Improve quality of life

Special Needs

- Infant and preschool – facilitate development of Joint Attention
- Early school years – Joint Attention and academic learning
- Late childhood, adolescence – continue facilitation of development, treatment of co-morbidities, behaviour problems

Intervention in Autism

- Multidisciplinary – medical, speech and language therapist (SLT), occupational therapist (OT) psychologist, teachers
- Parent education / involvement. Implementation in the home by parents.
- Intense - 25 hrs per week 52 weeks per year
- Health, Education, Social Welfare collaboration

Attention Deficit Hyperactivity Disorder (ADHD)

Core Knowledge

1. Common presentations of Attention Deficit Hyperactivity Disorder (ADHD)
2. Diagnostic criteria & clinical features
3. Assessment of a child with features of ADHD
4. Management of a child with ADHD

How a child with ADHD may present

Common presentations

- "Always on the go"
- "Bright but not bothered"
- Always breaking or losing things
- Does not understand safety
- Noisy and disruptive
- Ignores when spoken to
- Leaves work incomplete

The child may present due to a more serious problem

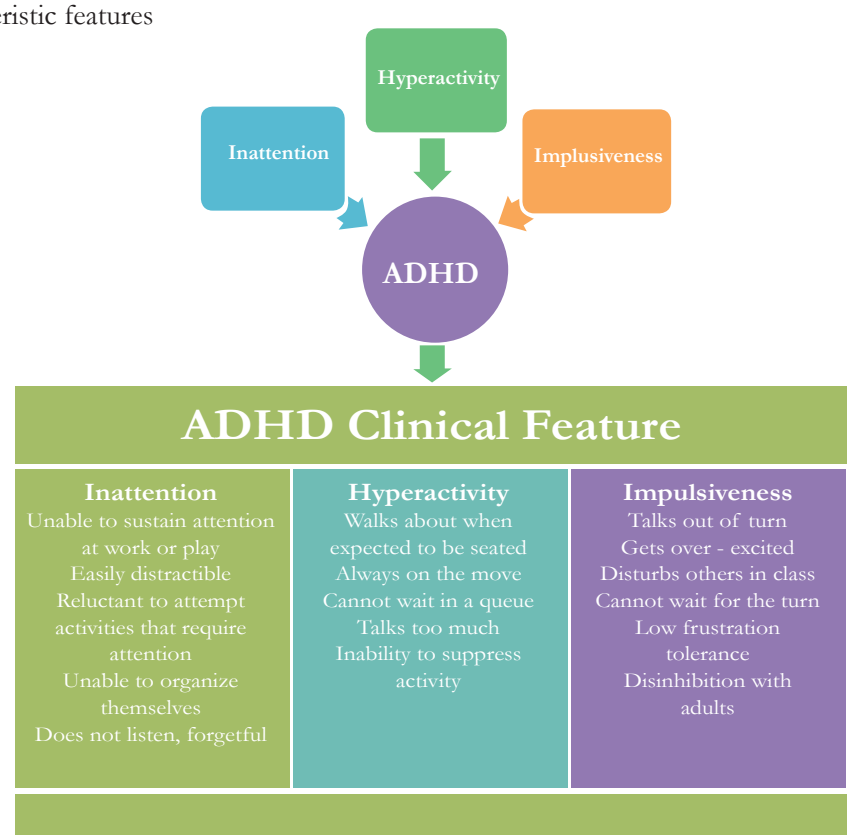
- About to be expelled from school
- Other children have got injured
- Work far below class average
- Exhausting to look after
- Temper outbursts and aggression
- Accident proneness

The problem behaviors

- Cannot be explained on the chronological age or mental age
- Are evident in multiple situations
- Has early onset and takes a chronic course
- Significant impairment of social and academic functioning

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

Characteristic features



Assessment

- History
  Developmental history
  Diagnostic criteria
  Impact on child, family and others
- Behaviour observation
  Can be misleading sometimes
- Rating scales
- Cognitive / intellectual / learning assessment
- Presence of co-morbid disorders

Co-morbid disorders

- Reading and spelling disability
- Motor coordination disability
- Delayed language development
- Obsessive compulsive disorder
- Tourette disorder
- Antisocial behaviour

Causes

- Genetic
- Monoamine under-activity
- Frontal cortical dysfunction
- Socio- environmental dysfunction

Treatment with Methylphenidate

- Effective and safe
- Only one aspect of treatment
- Aims to improve learning potential

Before starting treatment

- Check Past history, Family history of epilepsy, tics
- Neurological examination
- Check heart, blood pressure
- Check height, weight
- Get a baseline WBC, platelets
- Explain what Methylphenidate can do and can't; symptom reduction and not a cure

Starting treatment

- Age should be >6 years
- Starting dose preferably 5mg twice a day
- Doses per day 0.7-1.0mg/Kg body weight
- Desired outcome – improvement in all key clinical features
- Rebound effect may occur when effect wears off

Adverse effects

- Appetite suppression
- Headache
- Abdominal pain or discomfort
- Growth retardation
- Reduced seizure threshold
- Cardiovascular effects
- Tics
- Mood change
- Worsening of exfoliating skin condition

Special situations

There are no absolute contraindications but caution is needed.

- Child <6 years – effects are unpredictable
- Presence of epilepsy / tics
- Presence of exfoliating skin disease
- Presence of anxiety – mood changes may occur
- Addiction – a risk in older adolescents

Other drugs

The following can be used in the absence of methylphenidate but the effects are inconsistent

- Imipramine
- Haloperidol
- Risperidone
- Clonidine
- Fluoxetine

Other therapy

- Improving parent effectiveness
- Social skills training

- Improve cognitive / learning skills
- Improve organizational skills

Home intervention

- Predictable daily routines
- Avoid over-stimulating experiences
- Close guidance and monitoring on expected behaviour
- Immediate rewarding for cooperation and positive behaviour

Hyperactivity and inattention is common also in

- Post head injury
- Post encephalitic syndrome
- PANDAS
- Mental retardation / Autism
- Epilepsy
- Drug treatment
- Mood disorders
- Anxiety – often situational
- Disruptive and chaotic environments
- Inappropriate school placement

Points to note

- If features of ADHD is not evident at the time of consultation, it does not mean the diagnosis is wrong
- Avoid misdiagnosing an active and temperamentally difficult child as ADHD
- Never say that a child will "grow out of" difficult behaviour

Notes

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MODULE 8

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8. SUICIDE

Learning Objectives

- To be aware of the epidemiological data on suicide in Sri Lanka
- To be able to identify risk factors for suicide
- To be able to assess the degree of suicidal intent
- To be aware of and be able to apply the management principles to a person presenting following suicidal behaviour
- To be aware of the suicide prevention policy of Sri Lanka

What is Suicide and deliberate self-harm?

- Suicide – 'the act of deliberately killing oneself' (WHO, 2007).
  - o **Process which ends with death**
  - o **Process initiated & conducted by the person**
  - o **With the knowledge & expectation of death**
- Deliberate self-harm (DSH) – 'a non-fatal act in which an individual deliberately causes self – injury or ingests a substance in excess of any prescribed or generally recognized dosage' (Kreitman, 1977).

Practice point

Even though the intension was not to die there is always a risk of dying depending on the method employed. In rural areas in Sri Lanka DSH attempts following pesticide ingestion has resulted in death and thus has contributed to the suicide statistics.

How common is Suicide?

It is more common in certain countries. Sri Lanka continues to be a country with a very high rate of suicides (19.6 per 100,000 in 2009). In 2011 the male and female suicide rates in Sri Lanka was 34.8/100,000 and 9.24/100,000 respectively (de Silva et al, 2013). Suicide is one of the three leading causes of mortality in most countries between the age group of 15-45 years and the leading cause in the age group of 15 – 35 years.

There are many factors which affect the suicide rate in a country. These include socio-economic indicators as well as health related indicators.

How to recognize an individual with a high risk of suicide?

The prediction of suicide is a difficult and complicated exercise with poor results. However using risk factor profiles it is possible to identify individuals who are at a higher risk of suicide. These individuals need closer monitoring in clinical practice.

Risk factors

Demographic

- Male sex- There is about three male suicides for every female suicide. Females have higher rates of DSH
- Advancing age
- Those who have never been married, widowed and divorced
- Unemployment
- Unskilled workers and professionals (Veterinary surgeons, pharmacists, farmers, doctors etc.)

Psychiatric & medical factors

- Depression (15%) – more likely in the presence of hopelessness and past history of DSH
- Alcohol dependence or abuse (12%) – especially older males with a long history of alcohol abuse, history of depression and DSH
- Drug dependence or abuse
- Schizophrenia (10%)
- Personality disorders (7%)
- Current suicidal ideation, active plans and means for suicide
- Past history of DSH
- Long standing medical illnesses which compromise the person's independence or cause severe suffering – Epilepsy, persons with chronic pain, terminal illness, HIV infection

Biological factors

- Family history of suicide
- Reduced activity of brain 5-HT pathways

Psychological factors

- Hopelessness
- Impulsivity

- Problem solving difficulties
- On-going psychosocial stressors

Social factors

- Social isolation
- Poverty
- Attitude towards suicide and imitation

Absence of protective (resilience) factors

- Absence of a social support network
- Absence of strong religious views

Remember

The above risk factors have been identified after studying large populations. When assessing suicide risk, each patient must be regarded individually, as a unique person. An awareness of these risk factors, however, can alert health professionals in primary care to look at particular areas of people's lives.

How do you assess a person following a suicidal attempt?

Acts of deliberate self-harm can be done with various intentions. It may be a cry for help, to get relief, to change others behaviour or even to die. Therefore it is important to identify the intent and the current precipitant for the act. The Pierce Suicide intent scale can be used as an objective measure of suicide intent.

Information should be sought from the patient and the caregiver about the attempt itself and 48 hours preceding the attempt.

A detailed account of the incident

- The precipitant
- The planning involved
- The method employed to end life (Methods of higher lethality – hanging, walking in front of a moving train is supposed to reflect higher suicidal intention)
- The presence of a suicide note
- Attempts to put properties and belongings in order (e.g. making a will)
- Precautions taken to conceal discovery of the attempt
- Act done in isolation
- Act done at a time where discovery is unlikely

Expectation of outcome

- Lethality – death was likely with the method used
- Treatment and survival – survival was unlikely if treatment was not received

(Even if the means of harming oneself is trivial if the expected outcome is death it is considered as a serious attempt. E.g. a person who takes 5 tablets of Paracetamol who believes that the dose is lethal)

History and MSE

- Explore underlying mental illnesses (i.e. axis I disorders such as depression, schizophrenia or anxiety disorders and axis II disorders such as personality disorders)
- Presence of hopelessness, worthlessness and current suicidal ideas with active plans are also very important

Presence of substance use

- Current use and the severity of the problem are important in managing the risk

Practice point

Asking about suicide does not increase the suicide rate. It is unlikely that people will come out with suicidal ideas unless asked by the clinician. Most people find it helpful to talk about their despair with a non-judgmental professional

Assessing suicidal risk

(From www.medicine.manchester.ac.uk/storm)

1. Ask open ended questions
2. Pick up verbal and nonverbal cues
3. Identify current stressors
4. Specific questioning about suicide intent
    a. Explore hopelessness (e.g. 'how do you see your future?')
    b. Does the patient have any wishes to be dead (fleeting or persistent)?
    c. Specific plans for suicide (questions could include: 'Have you ever felt that you would prefer to get away from it all?', 'Have you ever felt that life isn't worth living?', 'Have you ever thought that you would do something to harm yourself?', 'What exactly would you do? Do you have plans?', 'What has stopped you from carrying that out so far?')
5. Measures to prevent detection
6. Background: past suicide attempts, coping mechanisms
7. Symptoms of mental disorder

Management of deliberate self-harm

- When deciding on the setting (inpatient vs. outpatient) to manage a person with suicidal ideation the degree of suicidal risk, availability of social support and access to potentially lethal means should be considered.
- If the suicidal risk is high or if there are inadequate support structures the person will require admission. High suicidal risk is considered an emergency and may even require the patient to be admitted against his will by invoking the mental health act (e.g. psychotic depression)
- If there is underlying axis I or II disorders they need to be managed and followed up by the psychiatric team
- *Medical / surgical management is required on presentation depending on the method employed by the patient*
- Those who attempt DSH without the intention of dying to change others behaviour etc. may have poor coping mechanisms or the stressor has overwhelmed the existing coping mechanisms. Identifying the stressor, possible support structures and also providing psychological support is important.

Psychological management of the patient

Supportive care

"The 2 E's & 2 I's of supportive care"

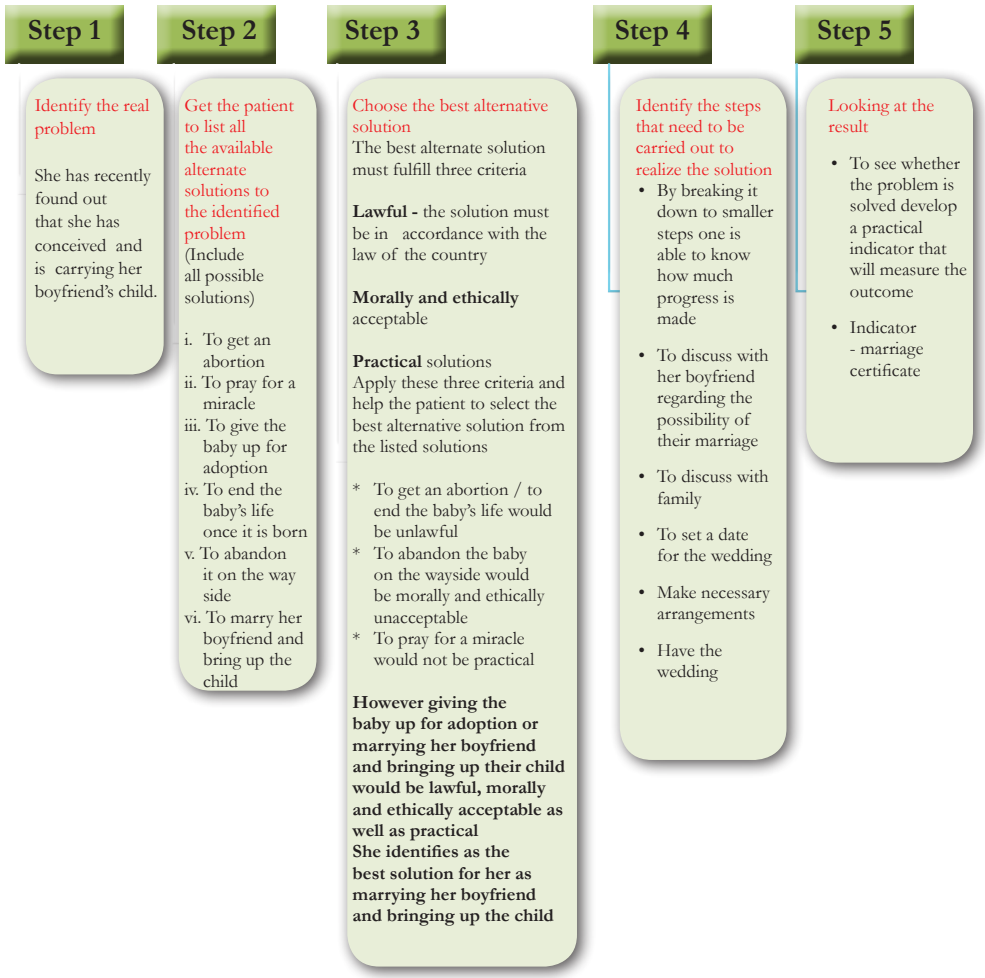
Emotional support – to provide love and care
Esteem support – highlight the value of the person and provide due respect
Raise his / her moral through praise and encouragement
Informational support
Information in factual knowledge – e.g. current status of his/her problem
Explanation – e.g. with regard to current issues he/she may have
Advice – e.g. what to do and what not to do
Instrumental support – to provide practical help

Problem solving counselling

The five step module of problem solving counseling is an essential component of the psychological management in patients presenting following suicidal behaviour.

It will be described with the aid of an example

E.g. A 19 year old girl presents after a drug overdose following a quarrel with her boyfriend.



Grief counselling

Useful in counselling persons presenting with a relationship breakdown (loss of a loved person)

The four principles of grief counselling

- Accept the reality of loss
- Acknowledge the pain associated with the loss
- Adjust to life to live despite the loss
- Internalize the loss in order to move on with life

The five strategies of grief counselling

- Talk about the loss & the circumstances of the loss
- Express the normal emotions triggered by the loss

- Make necessary adjustments to live despite the loss
- Sort out practical problems encountered
- Engage in routine activities

Practice point

Presidential Task Force for the Prevention of Suicide (1997) identified risk factors of suicide and made recommendations which led to the National policy and Action Plan for the Prevention of Suicide. The ensuing changes led to a reduction of the suicide rate in Sri Lanka.

The suicide prevention policy of Sri Lanka

i. Limiting the use of pesticides
   a. Limiting sale of pesticides – requiring a license to be able to sell pesticides
   b. Encouraging the use of biological control in cultivation

ii. Reducing the harmful effects of pesticides
   a. Selling pesticides in a crystal / powder form instead of liquid form
   b. Selling pesticides in a diluted form
   c. Adding an emetic to the pesticide

iii. Treating patients who present with deliberate self-harm in an effective way
   a. To supply equipment for artificial ventilation (ambu bag) to district and rural hospitals
   b. Train the staff to effectively manage such a patient (Ambu breathing, intubation)

* It is also important to change the attitudes of the staff – to treat the patient in a humane manner and understand that they have a psychological problem

iv. Changing the attitudes of the public about suicide
   a. Use religion to bring about an attitudinal change – suicide is not something to be glorified but should be regarded as a sin
   b. The survivors are not to be blamed

v. Media policy on reporting suicides
   a. Not to report suicides if possible
   b. If reporting a suicide do not give it a heroic status
      Avoid sensationalisation
      Investigate and find out the root cause and report it
      The message to the public should be that it is a life lost in vain, suicide is a foolish act
      Highlight the merits of living

vi. Promoting mental health
   a. To identify mental illness early and treat – especially depression

(Research indicates that the majority may have suffered from undetected depression)

b. Establishing counselling services and its promotion
c. Developing life skills

Key points

- Sri Lanka is still one of the countries with a high number of suicides
- Deliberate self-harm increases the risk of death by suicide
- It is important to identify high risk groups
- A majority of people who commit suicide have an underlying mental illness
- It is important to assess risk in individuals who present after an attempt of DSH
- Individual and community interventions are available that are known to reduce risk of suicide in the individual as well as in the community.

Further reading

1. Cowen P, Harrison P, Burns T. Shorter Oxford Textbook of Psychiatry. 6th ed.Oxford : Oxford University Press; 2012

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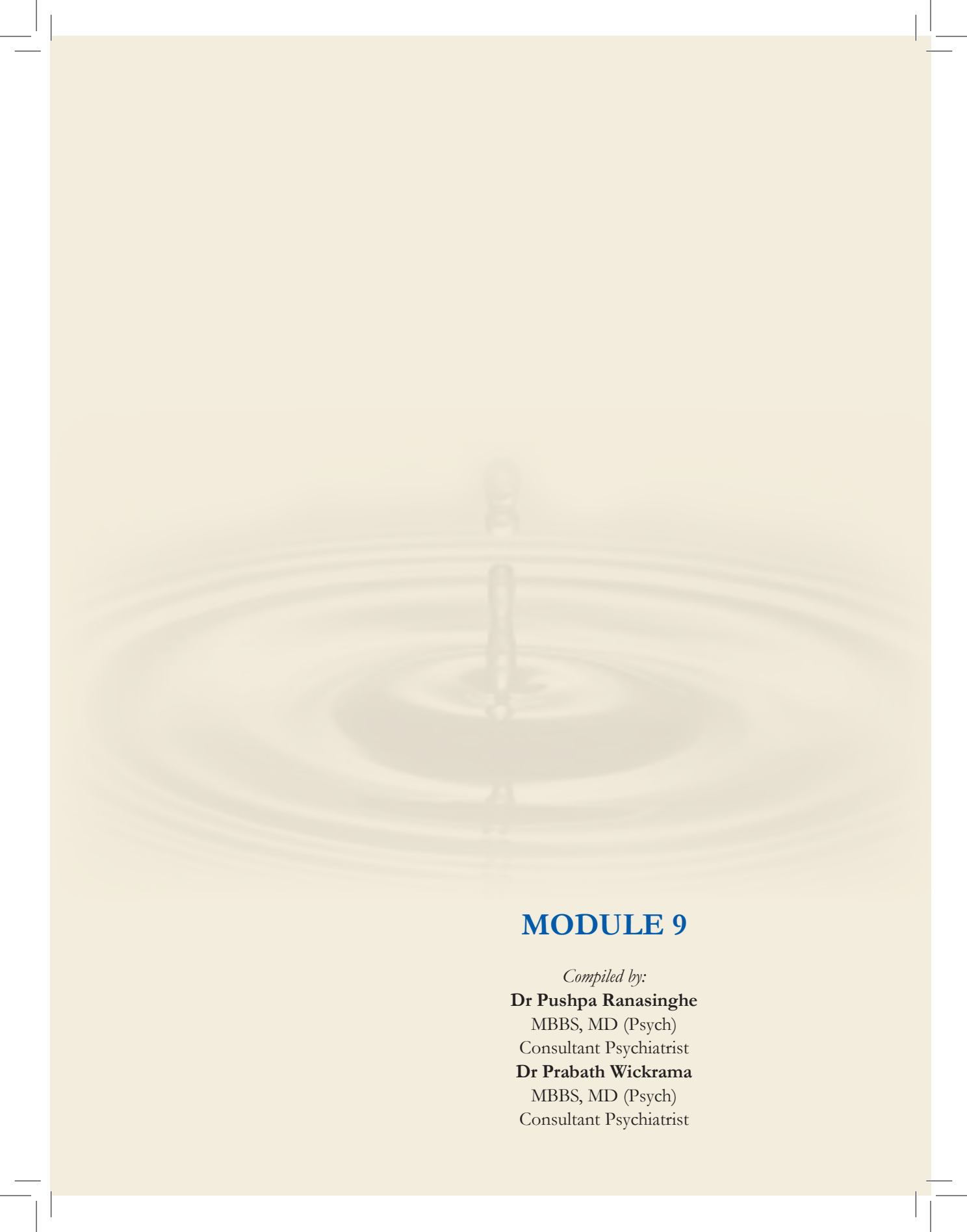

MODULE 9

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9. GENDER BASED VIOLENCE

Learning Objectives

- Understanding Gender Based Violence
- Domestic Violence in Sri Lanka
- Role of an MOMH

Gender Based Violence (GBV)

GBV is an umbrella term used for any harmful act that is perpetrated against a person's will, and is based on socially ascribed (gender) differences between males and females.

- It is a form of discrimination and a violation of human rights.
- It is a Public Health Problem.

It occurs commonly against women

It is helpful to consider this fact in the Sri Lankan context. The causes for gender discrimination against women can easily be written on paper. However to improve the mental health of our clients it may be more prudent as well as rewarding to contemplate on what we can do to resist this discrimination in our catchment areas. Assertively expressing ourselves against any form of GBV at forums and private discussions including social media may be one step forward.

Remember that GBV often occurs behind closed doors. The perpetrator is a known person and in many instances neither he nor the victim understands it as a crime. Such unnoticed crimes often occur within the family and the workplace (Figure 1).

Figure 1: Types of GBV

GBV is a public health problem. The outcome may be fatal as in the occurrence of suicides and homicides and increase in maternal and fetal mortality. It may lead to various injuries and varieties of reproductive complications. More importantly it may lead to psychiatric morbidity including Depression, Anxiety, Substance abuse and PTSD. Greater concern is the psychological trauma that leads to generalised unhappiness among the victims and loved ones.

Violence Against Women: An integrated, ecological framework

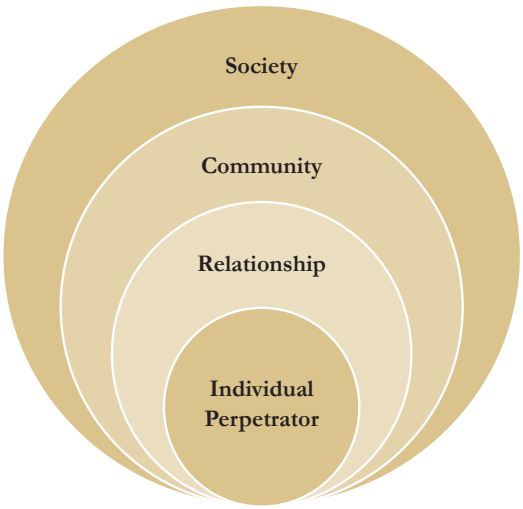

Figure 2: The integrated ecological framework of violence against women

This model can best be visualized as four concentric circles. The innermost circle represents the biological and personal history that affects an individual's behavior in his/her relationships. The second circle represents the immediate context in which gender-based violence takes place— frequently the family or other intimate or acquaintance relationship. The third circle represents the institutions and social structures, both formal and informal, in which relationships are embedded—neighbourhood, workplace, social networks, and peer groups. The fourth, outermost circle is the economic and social environment, including cultural norms.

A wide range of studies suggest that several factors at each of these levels, while not the sole cause, may increase the likelihood of gender-based violence occurring (studies cited in Population Reports/CHANGE, Volume XXVII, No. 4, December 1999):

- At the *individual level* these factors include the perpetrator being abused as a child or witnessing marital violence in the home, having an absent or rejecting father, and frequent use of alcohol.
- At the *level of the family and relationship,* cross-cultural studies have cited male control of wealth and decision-making within the family and marital conflict as strong predictors of abuse.
- At the *community level* women's isolation and lack of social support, together with male peer groups that condone and legitimize men's violence, predict higher rates of violence.
- At the *societal level* studies around the world have found that violence against women is most common where gender roles are rigidly defined and enforced and where the concept of masculinity is linked to toughness, male honour, or dominance. Other cultural norms associated with abuse include tolerance of physical punishment of women and children, acceptance of violence as a means to settle interpersonal disputes, and the perception that men have "ownership" of women.

An ecological approach to gender-based violence argues that no one factor alone "causes" violence but rather that a number of factors combine to raise the likelihood that a particular man in a particular setting may act violently towards a woman.

In the ecological framework, social and cultural norms-such as those that assert men's inherent superiority over women – combine with individual-level factors – such as whether a man was abused himself as a child – to determine the likelihood of gender-based violence. The more risk factors present, the higher the likelihood of violence.

It is important to remember that psychological explanations for gender-based violence (i.e. witnessing marital violence as a child, having an absent or rejecting father, or being abused as a child) often fail to appreciate the role of wider inequalities in the relations between women and men, and the need to transform these. It is not simply the case that if one sees or experiences violence as a child, one will in turn abuse others. Studies emphasize that girls are three to six times more likely to experience sexual abuse than boys, yet the vast majority of sexual abuse is perpetrated by male, not female, adults. At the other extreme, the explanation of violence against women solely as the result of men's experience of external factors (i.e. poverty, conflict, rapid economic or political change), fails to take into account that gender-based violence cuts across socio-economic boundaries.

While evidence from women themselves in many different contexts indicates that poverty and crisis exacerbate violence against women, in particular domestic violence, poverty is not in itself the cause of violence against women. Rather, it is one of main factors that

may aggravate or increase the violence that already exists. The fact that not all men in poor households are violent indicates that poverty is an insufficient explanation of violence. Exaggerating the role of poverty, in fact, negates people's agency in making choices about the way they react to factors outside of their control.

Likewise, conflict and rapid social or economic change affect the extent of gender-based violence in a society, but they do not cause it. Existing rates of violence against women do often increase during times of social instability, and new patterns of abuse can be triggered. Situations like men's unemployment and women's entry into the workforce during times of economic restructuring, or the lack of opportunities for demobilized soldiers after a war, may pose a challenge to men's sense of themselves as powerful. In contexts where individual men feel their sense of masculinity and power is threatened, and gender-based violence is condoned in law or in custom, such violence may increase in intensity and frequency, as men struggle to maintain a sense of power and control.

The gender perspective on violence against women shows us that the root cause of violence lies in the unequal power relations between women and men, which ensure male dominance over women, and are a characteristic of human societies throughout the world.

Domestic Violence in Sri Lanka: Extent of the problem

Domestic violence is the most prevalent form of GBV presenting to a MOMH. Domestic violence can be defined as all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim.

Practice point

Domestic violence occurs in 1/3 of married partners. However, most victims do not confide in others regarding the abuse. Therefore one must be vigilant to detect those who present to the primary care setting with other complaints.

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Rarely do victims present seeking help unless in a crisis. Crisis presentations to a hospital include DSH and physical injuries. It is questionable whether service providers including the Police and Health services are geared to identify and help these victims even when they present in a crisis. In many instances even close relatives choose to ignore the violence for the sake of continuation of the marriage.

Ensuing continuation of violence could lead to various mental health problems within the family (Table 1)

With Victims	With Perpetrators	Children
• Learned helplessness: Feelings of guilt, shame and isolation leading to low confidence and inability to make decisions • Traumatic bonding: Paradoxical emotional ties with the perpetrator • Depression and Suicidality • Post Traumatic stress disorder	• Alcohol and substance abuse • Personality disorder profiles : Borderline/ Emotionally dependent type, Antisocial/ Narcissistic type • Morbid jealousy	• Aggression as a child, adolescent or an adult • Childhood emotional problems including anxiety, depression and oppositional behaviour • Slow cognitive development

Table 1: Mental Health Problems associated with Domestic Violence

Prevention of Domestic Violence Act

This was enacted in 2005 and according to the Act;

- An aggrieved person or a police officer on behalf of that person can apply to the Magistrate Courts for a Protection Order to prevent domestic violence (In the case of a child : A parent, guardian, a person residing with the child or a person authorised by the National Child Protection Authority can make the application).
- The Magistrate Court shall review the application immediately and if deemed necessary issue an Interim Protection Order until the inquiry is completed.
- The Court will also Order a date for inquiry which will be no later than 14 days from the date of application.
- Following the inquiry court may issue a Protection order for a maximum period of 12 months.

Protection order or Interim order could prohibit the respondent from:

- any violence to aggrieved person or supporting party
- entering the residence, place of work or school
- preventing aggrieved person living in usual accommodation, or access to shared resources

- contact with a child
- contacting or following aggrieved person
- engaging in acts which may render aggrieved person destitute

Supplementary Orders

After the Court has made a Protection Order and deems it necessary to provide for immediate safety, health or welfare of the aggrieved party, the Court may order;

- police to seize any weapons
- police to accompany aggrieved person to collect children or property
- order mandatory counselling, psychotherapy or rehabilitation
- on request place in a safe home
- order social worker, counsellor, probation officer, family worker to observe and report to the court once in 3 months
- respondent to provide monitory assistance

Role of a MOMH in the issue:

Some helpful points

- Be on alert and do screening to identify survivors
- Beware that 10-20% of sufferers are males
- Remember that the client is already in a state of emotional and coping imbalance
- Understand the problem from the client's perspective through active listening
- Ensure the safety of the client
- Remember that the client may be scared to go home
- Action can be in a non directive or directive way
- Be patient; let the client make the decision
- Accept the client's decision to stay in the relationship or leave
- Let the client develop her skills and ability to change things
- Encourage and applaud small achievements

Crisis Intervention

One technique that would be helpful is crisis intervention. Basic points in crisis intervention include

- Stage one
  - Reduce arousal
  - Focus on current problems
  - Encourage self help

- Stage Two : Problem solving
  - Identify specific problem/s
  - Consider solutions
  - Test solutions

In some instances the question arises whether a female would be able to live in our society by herself. Many women do live alone in our cities and villages. Before the client decides on this issue the doctor should aid the client to weigh the pros and cons critically. Many government organisations mainly located at Divisional Secretariat offices are able to help single mothers. It is the duty of a MOMH to get familiarised and have a close relationship with these organisations. Police (Children and Women Bureau desk), Legal Aid Commission and other NGOs (e.g. Women in Need) are specifically assigned to help survivors.

Should we involve the husband?
This is a critical question. At times this could cause further harm. Common sense should prevail. Probably the wife is the best person to decide on this. Husband could be suffering from alcohol dependence or other psychiatric illnesses or entangled in a bad marriage. In these instances MOMH could help him. On the other hand he may be just a bad-tempered person.

Social Responses to Gender Based Violence

- health care services
- victim assistance services
- working with perpetrators
- exploring masculinities
- media information and awareness campaigns
- education
- legal responses
- community interventions
- faith-based programmes
- international conferences and conventions

Prevention of domestic violence

Best cost effective intervention to prevent domestic violence is conducting community programmes. It is rewarding as well. There are no rigid protocols to explain how to carry out a community programme. A good starting point would be to create a discussion within focal groups of villagers. Mostly this would be a learning exercise for doctors.

There are two points to remember before embarking on such programmes

- Any programme should aim at output, outcome and impact.
  - Output is what we gained directly from our intervention. It could be increased awareness, skills etc.
  - Outcome is the change we target in our population. This is what we should aim at when planning a programme.
  - Impact is the ultimate change that would happen with our intervention.
- We should always have a method to measure our output and more importantly outcome

Further Reading

- Prevention of Domestic Violence Act
  http://www.refworld.org/pdfid/4c03ba2f2.pdf

Notes

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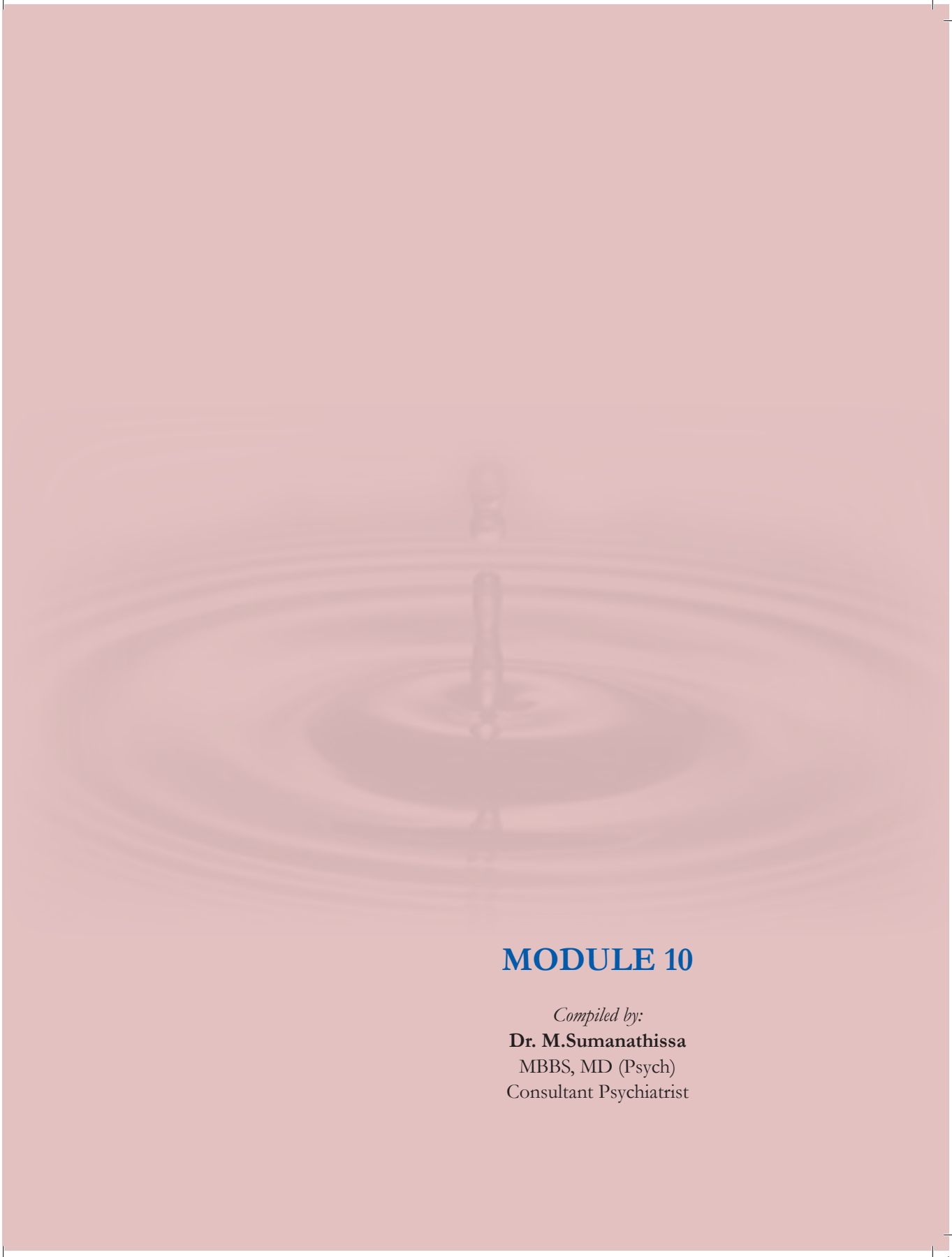

MODULE 10

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10. PSYCHOPHARMACOLOGY

Learning Objectives

- To know the minimum effective doses of antidepressants & antipsychotics
- To be able to manage common side effects of antipsychotics
- To identify Neuroleptic Malignant Syndrome
- To identify Serotonin syndrome
- To identify and manage discontinuation symptoms of antidepressants

Antipsychotics

Antipsychotics are drugs used in the treatment of schizophrenia and other psychotic disorders.

They can be classified as first generation antipsychotics (FGA) / typicals and second generation antipsychotics (SGA)/ atypicals.

What is the minimum effective daily dose of commonly used antipsychotics?

Antipsychotic	First Episode (mg/ d)	Relapse (mg/d)
Haloperidol	2	>4
Trifluoperazine	10	15
Risperidone	2	3
Olanzapine	5	10

(Source – The Maudsley Prescribing Guidelines in Psychiatry – 11th Ed)

Acute psychotic episode choice of antipsychotic

A drug with;

- Less Extra Pyramidal Side Effects (EPSE)
- Sedative properties- to control agitation
- Minimal drug interactions
- Olanzapine / Risperidone

What are the common adverse effects of antipsychotics?

The side effect profile of antipsychotics is variable, with extra pyramidal side effects being common with first generation antipsychotics & metabolic side effects with second generation antipsychotics.

Management of Extra Pyramidal Side Effects (EPSE)

Acute dystonic reactions

1. Anticholinergic drugs – benztropine, procyclidine
2. Route of administration – oral, IM, IV according to severity of symptoms

Parkinsonism

1. Reduce the drug dose (if clinically stable)
2. Switch over to a SGA - quetiapine
3. Add an anticholinergic – oral benzhexol (do not prescribe at night)

Akathisia

1. Reduce the drug dose (if clinically stable)
2. Switch over to a SGA – quetiapine , olanzapine
3. Consider oral propranolol (Exclude contraindications e.g. –asthma, bradyarrythmias)

Tardive dyskinesia

1. Omit anticholinergics
2. Reduce the drug dose (if clinically stable)
3. Switch over to a SGA – clozapine > quetiapine
4. Add on – tetrabenazine

Metabolic & other side effects

Weight gain

1. Monitor weight / BMI
2. Reduce dose if possible
3. Switch to another antipsychotic – aripiprazole
4. Add on aripiprazole – to clozapine / olanzapine
5. Behavioural methods
6. Calorie restriction/low glycaemic index diet
7. Regular exercise
8. Add oral metformin

Diabetes Mellitus

1. Monitor FBS- baseline and every 12 months

(Clozapine /olanzapine / risk factors for DM – baseline, 1 month, every 6 months)

2. Switch to aripiprazole/amisulpiride

Dyslipidaemia

1. Monitor Lipid Profile- baseline, 3months and every 12 months

(Clozapine / olanzapine- baseline, every 3months for 1year and every 12 months thereafter)

2. Life style modifications
3. Dietary advice
4. Regular exercise
5. Switch to another antipsychotic – aripiprazole
6. Increased cholesterol – consider statins
7. Increased triglycerides –consider fibrates

Sexual dysfunction

1. Assessment –identify likely cause/s

If drug induced;

2. Reduce dose if possible
3. Switch to – quetiapine, aripiprazole

Refer to consultant psychiatrist if side effects are persistent

What is Neuroleptic Malignant Syndrome?

Neuroleptic Malignant Syndrome (NMS) is a rare but potentially life threatening condition which occurs as a side effect of antipsychotics.

Clinical features include fever, rigidity, altered level of consciousness and confusion, while investigations reveal elevated creatinine phosphokinase (CPK) level, leukocytosis and abnormal liver function tests.

A patient on high potency FGA; recent dose increment; rapid dose titration would be at an increased risk as NMS occurs due to hyperactivity of sympathetic nervous system resulting from dopaminergic blockade.

Withdraw antipsychotic and refer patient for emergency admission to nearest hospital with ICU facilities.

Antidepressants

Antidepressants are used in the treatment of depression and anxiety disorders.

Main indications and doses

- Depression
  - SSRIs – Fluoxetine – 20 – 60 mg / d
  - SNRI - Venlafaxine – 75 – 375mg /d (with food)
  - TCA - Imipramine – 50 – 200mg / d

  Response takes close to 2-6 weeks to be seen
- Doses for anxiety disorders are usually similar to doses used in depression, except in OCD, and panic disorder where higher doses are used. Generally takes a longer time to show a response.

Practice point

Due to the slow onset of clinical response, the patient needs to be educated about this to prevent poor compliance. Even though the clinical response takes about 2-3 weeks the side effects are immediate.

What is the minimum effective dose of commonly used antidepressants?

Antidepressant	Minimum effective dose
Fluoxetine	20mg / d
Sertraline	50mg / d
Citalopram	20mg / d
Escitalopram	10mg / d
Mirtazapine	30mg / d
Venlafaxine	75mg / d

(Source – The Maudsley Prescribing Guidelines in Psychiatry – 11th Ed)

What is the duration of prophylaxis?

- Duration of prophylaxis depends on the episode
- First episode – treat for at least six to nine months after full remission

- Recurrent depression – two or more episodes (with functional impairment during the episode) continue for at least two years
- Maintenance beyond two years – patient requires re-evaluation by consultant psychiatrist

Drug interactions

Pharmacokinetic interactions –CYP 450 enzymes

- Fluoxetine increases risk of clozapine induced seizures (increases the clozapine level)
- Combination of paroxetine with tamoxifen can result in increased mortality due to treatment failure

Pharmacodynamic interactions

- Cardio-toxicity of tricyclic antidepressants can be increased by drugs which cause electrolyte imbalance such as diuretics.
- SSRI cause an increased risk of upper GI bleeds due to inhibition of platelet aggregation and can be exacerbated by aspirin/NSAIDs

Practice point

A patient treated with an SSRI for depression may already be on a TCA (Eg. Amitriptyline) for medical reasons.
This combination increases the risk of serotonin syndrome.
Therefore it is essential to go through clinic records, prescriptions etc. to ascertain the patient's current treatment.

What is Serotonin syndrome?

- Can occur as a result of overdose or when antidepressants are used in combination or when switching from one antidepressants to another.
- Clinical features - fever, diaphoresis, nausea, vomiting, diarrhoea, tremors, myoclonus, agitation, delirium, autonomic instability (changing blood pressure, tachycardia)
- Management - Stop antidepressant medication immediately. Urgently admit/transfer patient to a medical ward

How safe are antidepressants in an overdose?

- SSRIs – Safe; no major effects on the heart
- SNRIs – Venlafaxine – Generally safe; but there is a risk of cardiac effects
- TCAs – Very toxic; always require hospitalisation. May need ICU care.

What are discontinuation symptoms?

Symptoms which occur on stopping certain non-dependant drugs including antidepressants Symptoms are of six categories

- Affective – agitation , irritability
- Gastrointestinal - nausea
- Neuromotor- ataxia, movement disorder
- Vasomotor – excessive sweating
- Neurosensory - paraesthesia
- Other neurological symptoms – vivid dreams

Onset is within five days of stopping treatment. It may occur after a missed dose or during tapering of the drug

Practice point

Discontinuation symptoms may be mistaken as a relapse, or occurrence of a physical illness. Unnecessary investigations & treatment can be avoided through recognition & proper management of discontinuation symptoms

How do you avoid discontinuation symptoms?

Discontinue antidepressants over a four week period. This is not required with fluoxetine as it has a long half life. However patient may suffer from symptoms despite slow tapering off of the drug.

What information would you provide to the patient regarding antidepressants?

- Drug information- name, dose, dosing interval
- Duration of treatment
- Need for compliance – risk of relapse; discontinuation symptoms with abrupt withdrawal
- Onset of action – in clinical practice through observation is usually seen by 2 - 4 weeks
- Side effects – common & life threatening
  - o If intolerable side effects are present an alternative drug can be tried
  - o Antidepressants are effective & non addictive (despite discontinuation symptoms)

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- The Maudsley Prescribing Guidelines in Psychiatry (11th Edition)
- Shorter Oxford Textbook of Psychiatry (5th Edition)
- New Oxford Textbook of Psychiatry (02nd Edition)
- Oxford Hand book of Psychiatry (01st Edition)

MCQ

1. **Regarding Antipsychotics**
   - Haloperidol is more potent than trifluoperazine ( )
   - Metabolic side effects are more common with typical antipsychotics than atypical antipsychotics ( )
   - Management of tardive dyskinesia includes, switching over to clozapine ( )
   - The minimum effective daily dose of risperidone for the first episode is 2mg ( )
   - Akathisia is an extra pyramidal side effect caused by typical antipsychotics ( )
2. **Neuroleptic Malignant Syndrome**
   - Full blood count shows leucopenia ( )
   - Can be treated in a general psychiatric word ( )
   - Rapid dose titration of antipsychotics can increase the risk of NMS ( )
   - Antipsychotics can be given in reduced doses ( )
   - Occurs due to hyperactivity of sympathetic nervous system resulting from dopaminergic blockade ( )
3. **Serotonin Syndrome**
   - Can occur due to over dose of antidepressants ( )
   - Presents with autonomic instability ( )
   - Urgent transfer to a medical ward is essential ( )
   - Low doses of antidepressants can be given ( )
   - Switching from one antidepressant to another can be a precipitating factor ( )
4. **Treatment with Antidepressants,**
   - In OCD & panic disorder lower doses are needed than in depression & other anxiety disorders ( )
   - Minimum effective dose per day of citalopram is 20mg ( )
   - Clinical response takes 2-3 weeks to appear ( )
   - In first episode of depression antidepressant can be stopped after full remission ( )
   - Fluoxetine decreases the risk of seizures induced by clozapine ( )

5. Discontinuation symptoms of antidepressants,

- Occur due to dependency for antidepressants ( )
- Paraesthesia is a neurosensory symptom of it ( )
- May occur during tapering of the drug ( )
- Fluoxetine should be tapered over a four week period to avoid symptoms ( )
- Onset is within five days of stopping treatment ( )

Answers

1. a. (True)
   b. (False)
   c. (True)
   d. (True)
   e. (True)

2. a. (False)
   b. (False)
   c. (True)
   d. (False)
   e. (True)

3. a. (True)
   b. (True)
   c. (True)
   d. (False)
   e. (True)

4. a. (False)
   b. (True)
   c. (True)
   d. (False)
   e. (False)

5. a. (False)
   b. (True)
   c. (True)
   d. (False)
   e. (True)

Notes

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MODULE 11

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11. DEPRESSIVE DISORDER AND PSYCHOTHERAPY

Depression

Depressive disorder is a serious, recurrent mental illness associated with diminished role-functioning, quality of life and increased mortality. The Global Burden of Disease Study 2010 showed depression is the second leading cause of disability accounting for 63 million years lived with disability (YLDs) and 9.6% of all YLDs.[1,2] A Sri Lankan study conducted in 2007 showed that the life time prevalence of depression, 11.2%, was on par with global prevalence.[3,4] A more recent study reported much higher prevalence of depressive symptoms, 22.2% in post-war Sri Lanka.[5] Prevalence of depressive symptoms among Sri Lankan adolescents was 57.7% which is a considerably higher rate than that of rates reported in U.S. adolescents.[6] Those studies not only demonstrate that depression is a major health issue in Sri Lanka, but that it is also closely linked with several socioeconomic factors such as poverty - the single most important social problem, substance misuse, non-communicable medical problems - which are reaching epidemic proportions in Sri Lanka and suicides - with Sri Lanka having one of the highest rates in the world.[4,7]

Depression is a treatable illness. In spite of a wide range of well-established biological therapeutic interventions, relapse and recurrence rates of depression and the proportion of treatment resistance depression remain high suggesting that biological treatment options alone do not sufficiently address vulnerability or maintaining factors.[8-10] Therefore psychotherapy is an essential part of treatment either alone or in combination with other treatment. Psychotherapy not only supplements other treatment when used in conjunction but also complements those. Cognitive behaviour therapy (CBT) is the most effective and widely practiced psychotherapy for depression.

The core concept of CBT is an assumption that a person's mood is directly related to his or her patterns of thought. Negative, dysfunctional thinking affects a person's mood, sense of self, behaviour, and even physical state.

Cognitive techniques

Negative automatic thoughts

The premise of CBT is that there is an intricate connection between one's thoughts, behaviours, emotions and physiological sensations, and the way a person perceives and processes reality will influence his / her emotions and behaviour. Therefore, the major

focus of CBT has been to reframe and correct these distorted thoughts, and collaboratively explore pragmatic solutions to bring about behavioural change and improve mood. Automatic thoughts described in CBT are the thoughts at the fringe of awareness that occur spontaneously and rapidly, and are an immediate interpretation of any given situation. Those are different from the ordinary flow of thoughts observed in reflective thinking and free association, due to the speed of entry into awareness and the implicit truthfulness of automatic thoughts. The accuracy of these thoughts is taken for granted. Although we all experience automatic thoughts, in depression and other psychiatric disorders the thoughts are distinguished by their greater intensity and frequency. In depression, such automatic thoughts are distorted and negatively influence mood and behaviour and therefore are known as negative automatic thoughts. Beck coined the term negative cognitive triad to describe the content of automatic negative thoughts seen in depression which could be grouped by themes pertaining to self, world and future.

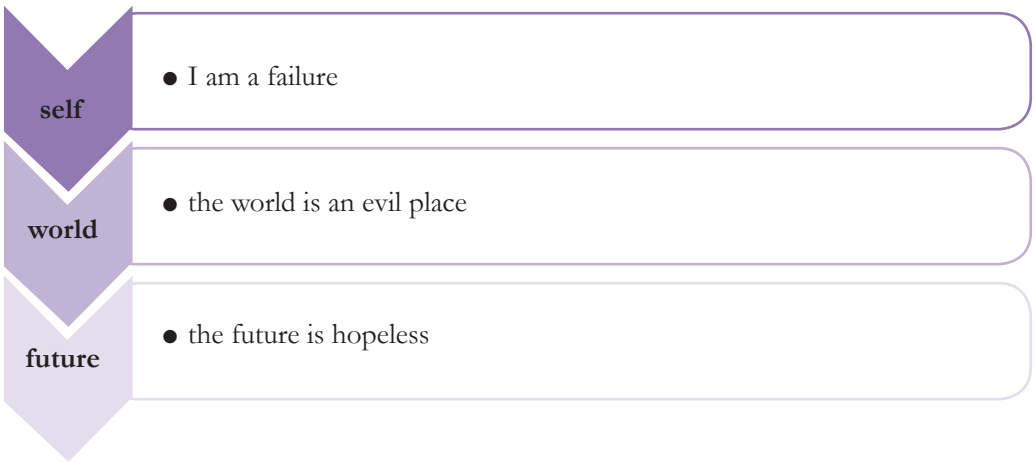

Figure 1: Beck's negative cognitive triad – themes of automatic negative thoughts in depression

Cognitive errors

Stereotypic errors in logic, known as cognitive errors or distortions, reinforce and shape the content of automatic thoughts. These thinking patterns affect information processing negatively and distort how reality is perceived. Examples and definitions of a number of common cognitive errors are included in Table 1.

Schema

At the root of these distorted interpretations are deeper dysfunctional thoughts called schemas or core beliefs. They have been described as 'relatively enduring internal cognitive structures of stored generic or prototypical features of stimuli, ideas, or experiences that

are used to organise new information in a meaningful way, thereby determining how phenomena are perceived and conceptualised'. These basic assumptions or unspoken rules which act as filters and templates for screening and decoding information from the environment shape one's thinking style. Schemas are formed early in the development through personal experiences and identification with significant others and the environment one grows up play a vital role in which type of schemas are acquired. The schemas of well adjusted individuals allow for realistic appraisals, while those of maladjusted individuals lead to distortions of reality, fostering, in turn, psychological disorder including depression. Schemas pertaining to one's lovability, and one's competence or self-efficacy are particularly relevant to the understanding of depression. Even though latent or inactive at given times, schemas are reactivated by triggers and precipitating factors.

Intermediate beliefs

Individuals with negative and maladaptive schemas may engage in tentative compensatory strategies to cope with and avoid getting in contact with their core beliefs. While these cognitive manoeuvres known as intermediate beliefs may alleviate the emotional suffering short term, in the long run these strategies may reinforce and worsen very dysfunctional beliefs they compensate for. Schemas influence the development of intermediate beliefs which are related attitudes, rules and assumptions that follow from core beliefs. For example, someone with a core belief of 'unlovability' might develop the attitude that, "It's terrible to be unloved". Similarly, the intermediate belief might include the following rule, "I must please everyone" and an assumption to the effect that, "If I please everyone then people will love me."

Cognitive restructuring

Many people are not immediately aware of the presence of automatic thoughts, unless they are trained to monitor and identify them. Most people do not examine automatic thoughts carefully for their validity and utility. Beck pointed out that it is just as possible to perceive a thought, focus on it, and evaluate it, as it is to identify and reflect on a sensation such as pain.

Cognitive restructuring starts with an explanation of the close connection between thoughts, behaviour, physiological sensations and emotions.

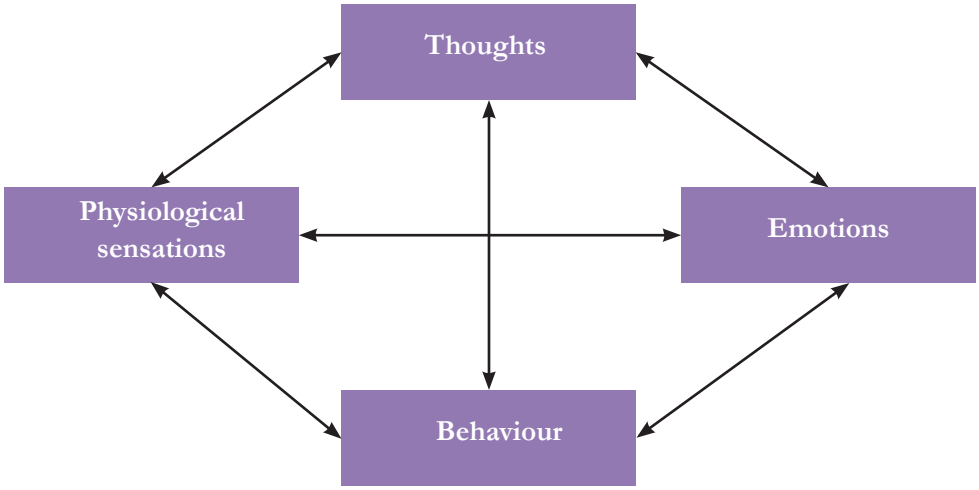

Figure 2: Interactions between thoughts, behaviour, physiological sensations and emotions

Further discussion on how negative automatic thoughts distort reality, how cognitive errors could misconstrue situations and how they in turn lead to behavioural choices that worsen distress and confirm misappraisals, contributing to a self-perpetuating cycle will demonstrate the benefits of cognitive restructuring. Recognition of thoughts as hypotheses that are open to evaluation and challenge rather than facts would follow.

Thought monitoring

Teaching patients to recognise their own negative automatic thoughts (NAT) is the first step in cognitive restructuring. Direct questioning of the client regarding the thoughts that occur in different situations is the simplest method of identifying NAT. Imagery techniques and role playing can be used when direct questioning does not help in eliciting NAT. When imagery is used, the therapist sets the scene by asking the client to vividly visualise the situation. Although some clients can readily imagine themselves in a previous scene, many need prompts or imagery induction to encourage their active participation in the exercise. In role-playing exercises, the therapist and client re-enact an interpersonal vignette to uncover automatic thoughts.

Beck described emotions as the royal road to cognitions as occurrence of NAT is associated with change in mood. Therefore the client is asked to pay attention to changes in their mood that occur following automatic thoughts to elicit NAT and to learn about the relationship between their automatic thoughts and their emotions.

To assist with eliciting thoughts, clients are asked to maintain a situation-thought-mood diary. A relatively simple two-column version can be tried initially. In this version clients are encouraged to record events in one column and mood /thoughts in the other. Alternatively, they can record events, thoughts, and emotions in three columns. Between therapy sessions, as home-work' clients are asked to record emotions and automatic thoughts that coincide with distressing situations or events and thoughts that occur with an associated clear change in mood, between therapy sessions. This thought record can then be reviewed at the next therapy session.

Challenging thoughts

When one is able to identify automatic thoughts as they occur, the next step is to challenge these NATs. Client is asked to look at the validity of NAT by evaluating evidence for and against each thought. The client is encouraged to write down evidence that either supports or refutes the negative cognition using a two column form (for and against). For example, examining the evidence for the automatic thought "I am a failure" may reveal information for and against the thought. The client may recall many occasions when he or she felt like a failure or was not successful. At the same time, it is very likely there were times the client was successful and did not feel in this way. Specific data on positive social relationships and successes in school, occupational or recreational activities may be used to counterbalance the patient's negative thought.

Challenging automatic thoughts can be also done by looking at the utility of the thought through cost-benefit analysis and identifying relevant cognitive errors or distortions, where appropriate. If the NAT proves to be distorted and maladaptive, the patient is encouraged to generate alternatives that are more accurate and adaptive.

The client is asked to complete additional columns on the thought record. The full thought record includes columns for describing distressing events, emotions and NATs that occur in these situations, strength of their initial belief in the NAT, alternative rational responses to the situation, strength of their belief in alternative thoughts and change of emotions they felt in response to generating alternative thoughts. Table 3 is an example of a thought record.

Schema modification

The cognitive emphasis in the early stages of CBT is usually on eliciting and modifying NAT and cognitive errors thereby reducing symptoms. However, as the client becomes more acclimatised to CBT and with resolution of acute symptoms, cognitive treatment could focus more on addressing maladaptive cognitions at deeper levels such as schemas and intermediate beliefs.

Most of the strategies used to elicit and change automatic thoughts are also used to recognise and modify schemas. It is often useful to demonstrate the connection between negative cognitions at superficial level such as NAT and those at deeper level like schemas and how it is relevant to the client. The 'downward arrow technique' is often used to move from surface cognitions to deeper cognitive structures. This technique describes asking the patient a question such as: "Suppose this thought was true, then what would that mean about you as a person?"

Behavioural strategies

Activity scheduling

Behavioural strategies are frequently used in the early stages of CBT for depression. Depression is often characterised by significant avoidance and reduction in activity level. It is not rare for individuals with depression to spend more time lying on bed and less time engaging in social activities, household chores and occupational or educational activities. While diminished activities may be secondary to depressed mood, reduction in activities worsens mood further creating a vicious cycle. Therefore behavioural strategies which decrease avoidance and increase engagement will help to improve the mood. Activities associated with pleasure and mastery or accomplishment have clearly been shown to reduce the mood symptoms. Patients are encouraged to engage in activities using a graded approach in which initial assigned activities are less complex and difficult, with more difficult activities being assigned gradually over the course of treatment as the patient becomes more active. Less difficult tasks such as watching TV for 10 minutes (pleasurable activity) and making the bed (accomplishment / mastery activity) are usually assigned at the beginning and relatively more complex tasks such as going to a family function (pleasurable activity) and completing a 30 minute work related assignment (accomplishment /mastery activity) assigned later, depending on the current level of functioning.

This behavioural strategy known as activity scheduling is particularly beneficial for clients presenting with marked anhedonia, social withdrawal and poor attention. To facilitate activity scheduling clients are encouraged to record their activities each day and rate them according to the pleasure and mastery they experienced with each activity.

Behavioural experiments

Behavioural experiments completed by the client are one of the most effective ways of evaluating negative cognitions. For this activity to be successful, the client must accept that cognitions are testable and can potentially be modified. Behavioural experiments follow the general principles of scientifically testing a hypothesis starting from generating the hypothesis, designing a method of testing the hypothesis, conducting the experiment and

finally checking whether the hypothesis has been proven or not. The client, under the guidance of the therapist, will pick a specific negative cognition to be tested and then design a behavioural method of testing whether that negative thought is actually true. The client will then practically carry out the test and finally analyse the results of the experiment with the therapist to identify whether the negative thought was actually true.

An example of a behavioural test would be a client with the negative cognition, "nobody likes me" agreeing to try calling 10 specific individuals to ask them to get together in the near future and record how many of the 10 agree. The therapist and client discuss what the patient should say on the phone, when to try calling, and other aspects of the assignment in order to increase chances of success. During the next session, the client and therapist review the results and discuss how the results relate to the hypothesis that "nobody wants to spend time with the client".

Cognitive–behavioural test is a treatment strategy that is particularly useful for preparing patients to practically use their experiences in CBT in real-life circumstances. After automatic thoughts have been elicited and modified through procedures described previously, the therapist guides the client through a series of rehearsal exercises to try out alternative cognitions in a variety of situations.

Style and Structure of CBT

CBT for depression has an explicit style and structure in addition to the specific treatment techniques and strategies mentioned before. CBT approaches are time-limited in nature. CBT for depression is designed to be delivered over a few sessions, depending on the severity of the depressive symptoms and other characteristics of the client. CBT treatment is focused and structured. The treatment will concentrate on achieving an agreed goal between the client and therapist and treatment will use and adhere to a clear structure making each session as efficient as possible. The structure of a CBT session is outlined in Table 2. Homework between sessions is an essential component of CBT. Homework assignments ensure that skills learnt during sessions are mastered and applied to practical situations. These assignments are decided collaboratively and depend on the stage of treatment.

CBT strategies stress the need for a collaborative therapist-client relationship in which the therapist and client work together and adopt a cooperative attitude where the therapist and client will jointly decide the goals for therapy in general and also before each particular session. Both the client and therapist will contribute towards deciding the goals which need to be focused on during therapy. An important aspect of this collaborative relationship is termed collaborative empiricism. Collaborative empiricism involves having the client and

therapist act as a team set out to investigate and evaluate hypotheses regarding the client's negative cognitions in a scientific manner.

Socratic questioning is a technique often used in CBT. This is useful in eliciting and challenging negative cognitions. It is said that Socrates asked his followers sequences of probing questions rather than handing out answers. In answering these questions, and analysing their answers, his followers were led through the process of constructing their knowledge and connecting it to their existing frameworks. Therefore Socratic questioning is based on use of rationality and inductive reasoning to ascertain whether what is thought or felt is actually true. The therapist models the use of Socratic questioning and encourages the client to start raising questions about the accuracy and validity of his or her thinking.

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Table 1- Cognitive biases

Cognitive bias	Explanation	Example
Selective abstraction (filtering)	One takes the negative details and magnifies them while filtering out all or most positive aspects of a situation.	An individual may pick out a single, unpleasant detail and dwell on it exclusively so that their vision of reality becomes darkened or distorted.
Dichotomous Thinking (Black & White / All or None Thinking)	One has to be perfect or he is a failure — there is no middle ground. One places people or situations in "either / or" categories, with no shades of gray or allowance for the complexity of most people and situations.	If one's performance falls short of perfect, an individual sees himself as a total failure.
Overgeneralisation	One tends to come to a general conclusion with a single piece of evidence	If something bad happens only once, one expects it to happen over and over again.
Personalisation	One believes that everything others do or say is some kind of direct, personal reaction to him / her.	A person may see themselves as the cause of some unhealthy external event that they were not responsible for
Fallacy of fairness	One feels resentful because they think they know what is fair, but other people won't agree with them. Because life isn't "fair" — things will not always work out in his/her favour, even when they think those should.	Individuals who evaluate every situation judging its "fairness" will often feel badly and negative because of it.
Blaming	One blames themselves for every problem.	"Stop making me feel bad about myself!" Nobody can "make" us feel any particular way — only we have control over our own emotions and emotional reactions.

Shoulds	One has a list of ironclad rules about how others and themselves should behave. People who break the rules make them angry, and they feel guilty when they themselves violate these rules. One may often believe they are trying to motivate themselves with shoulds and shouldn'ts, as if they have to be punished before they can do anything.	
Emotional reasoning	We believe that what we feel must be true automatically. If we feel stupid and boring, then we must be stupid and boring.	A person assumes that his / her unhealthy emotions reflect the way things really are — "I feel it, therefore it must be true."
Magnification and minimisation	Giving proportionally greater weight to a perceived failure, weakness or threat, or lesser weight to a perceived success, strength or opportunity, so the weight differs from that assigned to the event or thing by others.	This is common enough in the normal population to popularize idioms such as "make a mountain out of a molehill". In depressed clients, often the positive characteristics of other people are exaggerated and negative characteristics are understated.
Mind reading	Inferring a person's possible or probable (usually negative) thoughts from their behaviour and nonverbal communication; taking precautions against the worst reasonably suspected case or some other preliminary conclusion, without asking the person.	A student assumes the readers of their paper have already made up their mind concerning its topic, and therefore writing the paper is a pointless exercise.
Fortune telling	Predicting negative outcomes of events.	Being convinced of failure before a test, when the student is in fact prepared.

Table 2- Structure of a CBT Session

Steps	Description
Mood check	Briefly assess client's mood (e.g. degree of depression on a scale of 1-10)
Agenda setting	Propose issues to address, ask for any issues client wants to address
Bridge from prior session	What did the client learn? review homework
Body of the session	Address items on agenda in order of priority; teach new skills
Set homework	Jointly identify ways for client to apply what he or she has learnt
Closing	Summarise the main points and two-way feedback

Table 3- Example of a thought record

Situation	Mood	Thought
Monday a.m. Going for lectures	Anxious	I may not be able to understand
Tuesday p.m. Studying in the library	Sad	I am stupid, I don't remember
Wednesday p.m. Thinking about exam	Anxious	I am not able to pass
Thursday a.m. Talking to a friend (Dharshani) about an assignment	Sad	Dharshani is too busy for me Dharshani doesn't really want to help me

The following resource persons also contributed to the CPD programme carried out in 2014 in the Southern, Uva, North Central and North Western provinces and their presentations are available in the supplementary CD.

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