I. Mental Health Care as part of General Health Care

Health is wealth. All of us want to be healthy. However mere absence of illness is not health. A healthy person, has a sound body. Healthy individuals are happy and contented. They have the ability to face difficulties, losses and frustrations. They are capable of living in harmony with others. Not only they are happy but also are able to do their best to keep others happy. They see that others are not put into trouble because of them. They also have certain moral and spiritual values. Such persons who are physically, mentally, socially and spiritually well can be considered to be healthy.

People become physically ill due to many reasons. Under-nourishment, disease causing organisms invading the body, fluctuations in the environment, wear and tear of bodily organs, injury to the body, defective blood supply to specific organs of the body etc., can lead to illness. When an individual is ill, it is usual to consult the doctor and take treatment.

Like the body, the ‘mind’ too can become ill. The mentally ill person’s sense of wellbeing and emotional equilibrium are disturbed. The various mental functions like thinking, emotions, memory, intelligence, decision making etc., can get disturbed. Talk and behaviour can become abnormal. As a result the ability to work satisfactorily can be impaired.

It is easy to imagine and share the experiences with the various difficulties caused by damage or dysfunction to any part of the body. For e.g., all of us know what it is to have high fever, blindness or a broken leg. So we usually react and sympathise with a person who is physically ill or disabled. However, most of us do not understand what it is to be mentally ill. We often fail to sympathise with a mentally disabled person. We often neglect such individuals. When a person becomes mentally ill, such a person is usually not taken to a hospital immediately for proper treatment. To add to the problem,
currently most of the mental health care facilities are available only in cities and towns.

As a primary health care doctor, you are already aware of the goal ‘Health For All by the year 2000 A.D.’ Our country had accepted this goal. Provision and Promotion of mental health care is one of the 8 components of primary health care. Alma Ata Recommendation outlines this as follows:

“Education concerning prevailing problems, and the method of identifying, preventing and controlling them; promotion of food supply and proper nutrition and adequate supply of safe water and basic sanitation, maternal and child health care including family planning; immunisation against major infectious diseases; prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries; Promotion of Mental Health (emphasis added) and provision of essential drugs.”

Therefore the medical officers, multipurpose workers and other health staff of primary health centres have the primary responsibility of delivering basic mental health care to the community along with general health care. Integrating mental health into the existing health care system is accepted as the most important step for extending mental health care to the individuals in the community

MENTALLY ILL AND MENTAL HEALTH FACILITIES IN OUR COUNTRY

House to house surveys to estimate the number of mentally ill in a given community, have been conducted in our country as elsewhere in the world. According to World Health Organisation figures, in any country including ours, One per cent of the population suffers from severly incapacitating severe mental disorders and ten per cent from minor mental disorders. If we project these figures in our country, there would be about 9 million severely mentally
ill and ten times that number of mildly ill persons. Majority of Indian people live in rural areas. Most of the mentally ill persons too live in rural areas. It is also found that nearly 15 to 20% of people who seek medical help in primary health centres, general hospitals or private clinics, suffer from minor mental disorders. But most of them are not aware of it. They think and believe that they have some physical illness. They take various drugs and treatment methods to get relief, often in vain.

While there are millions of people suffering from various types of mental illnesses, the mental health care facilities available for them are very meagre. There are only 46 mental hospitals in the country with about 20,000 beds. More than 50% beds are occupied by chronic patients. In the state of Karnataka, there are two mental hospitals one in Bangalore with 800 beds, and the other in Dharwad with 300 beds. The number of mental health specialists, also is less. There is only about two to three psychiatrists for one million population, whereas in developed countries there are 50-150 psychiatrists for every million of population. Recently, psychiatric units have been established in Medical College hospitals and a few general hospitals. But it is very important to recognise that most of these facilities available in the country are situated in cities, and such facilities are not available in the rural areas.

**MENTAL HEALTH FACILITIES ARE AWAY FROM PEOPLE**

Most people do not make use of the available limited facilities. It is estimated that less than ten percent of patients who need help, take modern treatment. Majority of the patients remain without getting help because of ignorance, fear, stigma, misconceptions and wrong attitudes regarding mental illnesses, their causes and treatment. General public often consider that mental illnesses are caused by evil spirits, black magic, with craft, bad stars and bad deeds in the present or past life. Therefore ill persons seek the help of faith healers, (mantravadis) and magicians who perform puja, counter-magic, exorcism, or
offer prayers to Gods and give native / herbal medicines. Most often they do not know that modern doctors can treat mental illnesses similar to the treatment of physical illnesses.

People have their own fears about mental hospitals. It is often felt that mental hospitals are places where dangerous mental patients are locked up. Families would not like their relative to be kept in such a dangerous set up. An ex-patient of a mental hospital and his family members are at times socially isolated and stigmatised. Therefore people seek help from mental hospitals as a last resort. Delays in treatment decreases the chances of recovery.

**Distance**: There are only one to two mental hospitals in most states, which often are very far away for majority of the needy persons and their families to take treatment on a regular basis.

**Poverty and lack of social welfare support**: In our country large numbers are poor and do not have money or other help to take the patient to the hospital or buy medicines for regular and complete treatment.

**Long duration of treatment and follow up**: Some patients need medications for a long time. This is especially true for those who are ill for long periods and those not receiving care early in the illness. They have to consult the doctor periodically. For example, almost all the epileptic patients need drugs for 3-5 years. Most rural patients find it difficult to come even for the first consultation and treatment. They often become irregular and even stop the follow up visits to the hospital. They seek help again, when there is a relapse. They often lose faith in hospital treatment and become victims of quacks who claim instantaneous, quick relief or cure with their treatment. When patients do not improve, the attempts to treat the ill persons are given up with frustration and helplessness. These failed attempts also contribute to the myth of mental disorders are being untreatable.
II. Brain and Behaviour

Every organ in our body has a specific function. Brain is the organ, which carries out all the functions of the mind. Brain of an average man weighs about 1250 gms. It is made up of millions of nerve cells and connective tissue.

Brain

The brain, consists of cerebrum, cerebellum and brainstem. Cerebrum is responsible for higher mental functions like thinking, memory and intelligence. Cerebellum is responsible for coordinated movements of the body. Brainstem contains both sensory and motor pathways. The vital centres controlling respiration, heart rate, consciousness are also located in brainstem. The
cerebral hemispheres are further divided into frontal lobes (responsible for thinking and social behaviour) Parietal lobes (sensory and motor functions), occipital lobes (interpretation of the visual stimuli) and temporal lobes (interpretation of auditory, olfactory and gustatory stimuli).

Limbic system, also known as visceral brain, is composed of several structures like amygdala, septal nuclei, hypothalamus, thalamus etc. Limbic system exerts a restraining force on the cerebral cortex. It plays a role in the controlled expressions of various emotions, eating, sleeping and sexual behaviour of the individual. The hippocampus plays a major role in memory functions. Bilateral hippocampal damage can lead to recent memory loss and amnesias. Destruction of mamillary bodies leads to Korsakoff’s psychosis (recent memory loss, confabulation, indifference are the features). Hypothalamus, the highest centre controlling sympathetic and parasympathetic nervous system as well as endocrinal functions and moderates the expression of different emotions.

**Working Units of the Brain**

Brain consists of a large number of units called the nerve cells. Each nerve cell is connected to many other nerve cells. These nerve cells are always active whether an individual is wide awake or asleep; whether resting or working. Their activity is of a chemical and electrical type. By placing electrodes on the scalp, these electrical activities can be recorded on paper by a special technique. This recording is known as electroencephalogram (EEG). By studying the EEG in states of health and illness, it is possible to get an understanding of the functioning of the brain in various conditions.

The space between nerve cells, where one nerve cell connects to another cell is known as ‘synapse’. When a ‘message’ reaches the end of the nerve cell, it stimulates pockets of chemical substances and releases it into the synapse. These chemical substances are called ‘Neurotransmitters’. They act as messenger and help the messages to reach the other cell. When an
individual thinks, talks, or does anything, many such neurotransmitters are actively involved. The important neurotransmitters are acetylcholine, norepinephrine, GABA, serotonin, dopamine.

As long as these neurotransmitters are produced, released and function adequately, the brain functions normally. If there are alterations in these substances, the functioning of the mind gets disturbed. For example, decreased amount of noradrenaline or serotonin can lead to depression. Hypersensitive dopamine system is believed to result in psychotic symptoms. These types of biochemical changes are an important factor for some of the severe types of mental illnesses.

Poor blood supply, haemorrhage or use of toxic substances and intoxicating drugs can produce damage to the nerve cells. In old age, nerve cells gradually degenerate. In all these conditions, the functioning of the brain be diminished or altered.

**Development of Brain**

Nerve cells appear in the foetus by 4 weeks in the form of a tube. One of the end of this tube (towards the head) enlarges and develops into the brain. The brain of a newborn baby is more advanced in development as compared to other organs, and by two years, it is almost equivalent to the brain of an adult in its structure and weight. Protein is very essential for the growth of the brain during the developmental period. If there is undernourishment and protein deficiency during the intrauterine life and first two years of life, the development of brain suffers and this can lead to mental retardation. Enough care and attention has to be paid for providing nutritious food to the pregnant mother and the child to facilitate optimum development of the brain. The development of brain is more sensitive during these age periods than other organ systems.
The brain of the new born child is ‘functionally’ immature. The child can express a few emotions like fear and react to frustrations by crying. Except for basic skills like sucking, swallowing, bowel-bladder movement, reflex actions, the new born child is dependent on the adults for survival. As part of the child’s growth, the various mental functions develop. The child gradually learns to think, to remember, to understand the environment, to talk, to behave appropriately in different situations, to take decisions and acquire various skills like dressing, reading, writing, solving problems and control over biological functions.

**PARENTAL ROLE**

During the early stages of development children observe the parental and other adult’s activities and try to imitate them. Children retain and repeat the activities which are appreciated and encouraged by the elders and decrease those activities which are not appreciated by them. Thus parents, and the family environment shape the mental development and behaviour of the child. A child who gets proper love and affection, encouragement and guidance from the elders grows well and develops skills which are essential for successful living. Children learn to control the desires and to respect social and moral restrictions. On the other hand, a child who is overprotected or severely punished or not cared for or has inadequate role models can not learn the essential skills of life. Such children can develop faulty attitudes and behaviour. In later life he/she is may not be able to face day to day problems of living. He/she can become dependent on others or experience distress. Such persons are more prone to develop different mental disorders, when confronted with significant problems.

The process of learning appropriate behavioural skills and modifying the wrong ones, continues throughout the life of an individual. The process is dependent on the abilities and needs of the individual, expectations and reactions of the people and socio-cultural factors.
Human Behaviour

Different people behave differently. The same individual can behave differently in similar situations. Some of these behaviours may be normal and some may be abnormal. What controls behaviour? The nature of the stimulus (Eg: hunger, thirst, sex, loss, gain, separation, insult, a happy or a sad event, etc), the meaning of this stimulus as perceived by the individual, his personality and environment appear to decide the outward behaviour. For example, hunger is a basic need. However, an individual who is on a religious fasting can remain happy inspite of experiencing hunger. The person who controls anger in work situation, may act out at home and hit the family members. Many times, even in provoking situations every one of us try to control, but we may not succeed all the time. Some of the factors which influence behaviour are:

1. **Personality:** Attitudes, values, ability to develop and maintain relationships, energy level, concern for others, observing social and religious norms, ambitions and goals are all part of personality. Genetic factors, parental attitudes, child rearing practices, amount of love, discipline, punishment received, the models available to develop various actions and reactions shape the development of personality. Some are introvert personalities. They are hard working, less social, do not share their emotions with others and may be rigid in their attitudes and beliefs. Some are extrovert personalities. They are very jovial, make superficial friendship with many, but may not be consistent in their commitments. Some may remain suspicious. Some may do anything so seek attention. Some can have inadequate personality and remain excessively dependent on others. Some can have aggressive personality. Some can have anti-social personality and are selfish, do not learn from their past and indulge in unethical and anti-social activities. Thus the actions and reactions of people with different personality types differ.
2. **Physical Deficits and Physical Illness:** People who have physical deficits (handicapped, sensory deficits etc.) or physical illness (like anemia, arthritis, asthma, fits, skin diseases, etc.) can behave differently than people who do not have any deficits or illness. Most often these individuals are sensitive. Physical exhaustion, chronic pain make a person short tempered and can lead to inter-personal problems.

3. **Stress:** Stress is an individual phenomenon. It is a subjective unpleasant experience of the person who perceives his needs and/or environmental demands are beyond his abilities. An event or a situation which is said to be stressful to one, need not be stressful to the others.

**Types of Stress**

There are three types of stresses namely i) frustration, ii) conflicts and iii) pressures. Severe or frequent failures and disappointments lead to frustration.

Conflicts may be i) to do or not to do or ii) to make a choice between two good things or among many or iii) to chose between devil and deep sea! Pressures can come from within the individual or from without (from others/circumstances) to achieve certain goals and to perform better.

When an individual perceives a situation or an issue as stressful, a series of changes are seen in the body. Hypothalmus and pituitary glands in the brain send messages to the adrenal glands to secrete more adrenaline and prepare the person for either fight or flight. The following changes are seen in the body and mind.

1. **Redistribution of blood circulation:** In the normal state, 40% of the blood which is pumped out of the heart goes preferentially to the brain as nerve cells are always active and require glucose and oxygen all the time. In times of stress, more blood is rushed to the muscles in the limbs.
2. There is increased heart rate. Blood pressure increases. The person feels the ‘heat’ inside the body.

3. Since the body requires more and more oxygen, rate of breathing increases. Liver glycogen is converted into glucose and released into the blood which is now available to the muscles.

4. Person experiences either fear or anger. Once the stress is removed or the person learns to cope with the stress, these changes are reversed to the normal level.

5. The external behaviour of a person under stress is different than when he is not under stress.

In the last two decades, research has demonstrated the strong association between life stresses and emotional disorders. Stresses can be of varying intensity, ranging from the problems at work, personal misunderstandings, movement from one place to another or severe ones like death, divorce or loss of job. In addition, there can also be experiences like natural disasters like floods, earthquake or man made disasters like accidental fires, collapse of a building or a dam or leakage of toxic material from factories. These stresses can affect the mental health of the individuals. Individuals going through a stressful period, experience enhanced feelings of sadness, anxiety, irritability, hopelessness. These individuals seek help from doctors for physical complaints like poor appetite, weakness, sleeplessness, decreased sexual interest or bodily pains. These complaints can be the starting point of physical diseases if stress is prolonged (eg: hypertension, peptic ulcer, myocardial infarction).

Behaviour of an individual is the net result of his body constitution (genetic, growth and development of the brain) his psychological make up (experiences, knowledge, attitude etc.) and environmental factors (family, social and cultural norms). All behaviours can be understood against the
background of these factors. For Example: (i) Hyperactivity or underactivity of a mentally retarded child is related to the poor development of the brain, (ii) temper tantrums of a child can be due to improper attention given by the parents, (iii) shouting of a person towards is subordinates can be the result of anger and frustrations, (iv) expression of socially not accepted ideas, behaviour and beliefs by individuals can be the result of changes in the frontal lobe or other parts of the brain, (v) antisocial behaviour of an individual can be the result of brain damage or reactions to problems in personal life or a reaction to social stresses, (vi) severe emotional reaction in an individual can be the result of past experiences or poor social supports in a crisis.

Thus when individuals are seen with complaints or abnormal and unwanted behaviour, it is necessary to understand their behaviour against the background of different factors in the individual, namely, the biological factors, early life experiences, current life situation, social and cultural factors.
III. Mental Disorders
(Features, Types, Causes and Treatment)

WHAT ARE MENTAL DISORDERS

All individuals get emotionally disturbed at some time or the other, due to a variety of reasons. Sometimes we feel sad while at other times behave indifferently, in response to certain situations. Often, these responses do not last very long. The routine day to day functioning does not get disturbed and others are generally not affected in any significant way. These day to day changes are not considered to be abnormal. They would be considered as ‘off moods’ ‘emotional upsets’, ‘losing temper’, etc.

What is mental disorder? When can a person be considered mentally ill?

THREE CHARACTERISTICS OF MENTAL DISORDERS

1. Changes in one’s thinking, feeling, memory, perceptions and judgements resulting in changes in talk and behaviour which appear to be deviant from precious personality or from the norms of community.

2. Changes in behaviour cause distress and suffering to the individual or others, or both.

3. Changes and the consequent distress cause disturbance in day to day activities, work, and relationship with important others (social and vocational dysfunctioning).

For example: Most students become anxious at the time of examination. They are worried whether they would pass and are afraid of the consequences of failure. But majority of them take the examination. Only a few become so anxious that they cannot study. They complain that they forget whatever they read and stay back from the examination. They do not get
satisfactory sleep. They become more and more worried about their difficulties.

It is but natural for parents to feel sad when their child dies. They may not eat properly, sleep well or show interest in anything. They gradually reconcile and start attending to day to day work within 3 to 4 weeks. But if they continue to feel sad about the death, weep, neglect the other children, and the household responsibilities for months, sadness can be considered as abnormal.

Sometimes each one of us don’t get sleep and may not be able to eat properly due to poor appetite. When we strain ourselves or think too much, we can experience headache and feel exhausted. Since these last only for short periods of time they are not abnormal. But if they recur often and last for longer periods of time they can become disturbing. They could be considered as manifestation of ‘illness’.

Therefore, for a person to be considered mentally ill, individual should have (i) mental symptoms, (ii) which bother self and/or others around, and (iii) disturb daily routine and work.

FEATURES OF MENTAL DISORDERS:

1. Disturbances in bodily functions

   a) **Sleep**: Patients find it difficult to get sleep. This can be in the form of lying on the bed or sitting and worrying for not getting sleep, or waking up in the middle of the night and fail to get sleep again. There can be a disturbed sleep throughout the night, or no sleep at all. In addition there can be no freshness in the morning. Any of these types of sleep disturbances can be present.

   b) **Appetite and food intake**: Patient does not have appetite and eats less or although he has appetite he does not relish what he eats. He loses weight too. Sometimes there can be excessive appetite.
c) **Bowel and bladder movements:** Patient passes urine more frequently than before, or have loose-motions or become constipated. Some patients soil their clothes and remain unaware of it.

d) **Sexual desire and activity:** Patient loses interest in sex and report sexual inadequacies like premature ejaculation, impotence, lack of sexual satisfaction. In some conditions there can be excessive sexual desire or lack of social inhibitions.

2. **Changes in mental functions:**

a) **Behaviour:** Patient behaves peculiarly in a bizarre way and the behaviour irritates the family members and others or put them into very awkward situations. Behaviour can be dangerous to self or others. Alternatively, it can be overactivity, restlessness, abusive to others for trivial or no reason (EXCITEMENT). Or patient may become dull, withdrawn and stop responding to either internal or external cues.

b) **Talk:** Patient talks excessively and unnecessarily or talks very little or stays mute. The talk becomes irrelevant and ununderstandable (incoherent) or expresses peculiar and wrong beliefs which others do not share. For example, patient can say that somebody is pumping poisonous gas into eyes, thousands of worms are crawling under his skin or every food article served is mixed with poison (delusions).

c) **Emotions** (Feelings): Patient can exhibit excessive emotion (elation, sadness, anger, fear) inappropriate emotions to situations or can not express any emotion at all, laugh and/or weep to self, without any reason.
d) **Perception:** Patient can have disturbances in understanding various stimuli reaching him through the five senses. There can be misinterpretation or hear sounds that others do not hear and say that enemies are coming to kill, sees figures on the wall and says that it is a devil (illusions).

A mentally ill persons can see things which do not exist or which are not seen by others. They can hear voices from nowhere. They have spurious sensations of the skin. Thus without any external stimulus, they perceive things and react to them. This is known as “hallucination”. For example, when the patient hears abusing voices, patient can in turn start abusing or threatening the imaginary persons. On seeing some people with dangerous weapons, he may run or attack people. A patient, who is hallucinating, is seen talking to self, laughing or weeping to self, wandering in the streets, and arguing or behaving abnormally.

e) **Attention and Concentration:** Patient can have decreased attention and concentration.

f) **Memory:** Patient can lose his memory and start forgetting important matters. They forget what they see, hear, or experience a few minutes earlier. They cannot remember where they have kept a pen, spectacles, umbrella etc. They cannot remember the transactions made a few days age and people they met a week earlier. They can lose past memory and find it impossible to recollect the names of children, where brothers and sisters live etc. They can lose their way in a familiar place.

g) **Intelligence and judgement:** In some mental illnesses, intelligence and the ability to take decisions deteriorate. Patient loses reasoning skills and abilities, and makes mistakes in routine work. Patient may not able to do simple arithmatic and reacts like a ‘dull’ person.
h) Level of consciousness: In some mental illnesses, due to possible brain damage there can be changes in the level of consciousness. Patients fail to identify their relatives. They can be disoriented to time and place. (Disorientation). They may remain confused or may become unconscious.

3. Changes in individual and social activities:

**Individual:** Patients can neglect their bodily needs and personal hygiene. They may not take a wash, comb hairs, shave, take bath, change clothes etc. They can remain unclean. They may not bother even when things cause pain and discomfort. They can soil clothes and bed in severe illness states.

**Social:** They can behave strangely with their family members, friends, colleagues and others. They can insult them, abuse/assault them. They can behave in an inappropriate manner in social situations and embarass others. Patients can behave rudely so that others get annoyed with them or make fun of them. (Loss of social sense). To begin with, patients keep themself away from people, later on people keep them away.

4. Somatic complaints: Aches and pains in different parts of the body, fatigue, weakness, involuntary movements, unpleasant sensations and many symptoms related to heart, lungs, kidney, digestive organs without any disease in those organs.

Types of Mental Disorders

I. Psychosis: It is a severe type of mental disorder in which patients talk and behave abnormally. The functions of the body and mind are severely disturbed resulting in gross impairment of individual and social activities. The important features are:

1) Loss of touch with reality

2) Symptoms like hallucinations, delusions
3) Neglect of body needs and personal hygiene

4) Socially disruptive behaviour like aggression and violence

5) Neglect of work and responsibilities.

II. Minor Mental Disorders: Patients show either excessive or prolonged emotional reaction to a stress situation. They have symptoms like anxiety, fear, sadness, vague aches and pains and other bodily symptoms. They are aware of their problems and seek help. They do not have psychotic symptoms.

III. Alcohol and substance dependence.

IV. Childhood behaviour problems: These are mostly disturbances of behaviour and conduct occurring in stressful family situations or as part of development, manifesting as abnormal behaviour not appropriate to the age of the child.

Mental Retardation: These persons have decreased mental abilities and cannot adjust to usual demands of living like normal persons.

V. Epilepsy: It comes in attacks in which the patient loses consciousness, falls down and has rhythmic movements of the body. Children and young adults are more often affected.

CAUSES OF MENTAL DISORDERS:

1) Changes in the brain: Any changes either in the structure or functioning of the brain can give rise to a mental disorder. Biochemical changes at the level of nerve cells are the cause in majority of the severe type of mental disorders (psychoses). Damage to the structure of the brain by any of the following reasons, can also cause mental disorders. a) Infections, b) Injury, c) Poor blood supply, d) Haemorrhage, e)
Tumors, f) Alcohol intake for long periods, g) Nutritional deficiencies, h) Untreated fits, i) Degenerative diseases.

2) **Hereditary factors:** In few cases of mental disorders, there can be someone in the family suffering from a similar illness. But in most cases, there would not be anybody in the family who has mental disorder. The proneness for developing mental disorder is genetically transmitted to an individual but whether an individual would actually manifest the illness depends on many other factors.

3) **Childhood experiences:** Proper love, affection, suitable guidance, encouragement and discipline are necessary for healthy growth of a person. If they are not available and there are repeated unhappy experiences in the childhood, they can lead to mental disorders in childhood as well as in adult life.

4) **Home atmosphere:** Frequent quarrels, misunderstanding among family members, lack of warmth and trust among them can have untoward effects on the person. Such a person when faced with stress and strain can develop mental symptoms due to the limited skills to adjust and control emotions.

5) **Social factors:** An individual not getting fair opportunities and facilities to live in a society, can suffer and can develop mental disorder. Poverty, unemployment, injustice, insecurity and severe competitions, disaster experiences can result in mental disorders.

6) **Individual factors:** Poor self image, severe conflicts in life, perception of a big gap between ambition and actual achievements, disorganised life style, perceiving life events and environment as stressful, poor moral and ethical standards, severe guilt can also predispose to mental disorders.
TREATMENT OF MENTAL DISORDERS

As noted above mental disorders are of various types. They affect the individual to varying extent. They can be of short duration or of longer duration. The treatments available are varied. Lay people believe that there are no effective treatment for mental disorders.

This wrong notion arises as people generally think of the situation in the past when in mental hospitals people stayed for life. The general image was of chronically ill persons only. **In the past 40 years there have been specific treatments for chosen mental disorders which are as effective as treatments for physical illnesses like tuberculosis, leprosy, malaria, typhoid fever, pneumonia or hypertension.**

The different types of treatments available are

1. **Medicines:** These are most suitable for the treatment of acute cases of severe mental disorders, commonly called psychoses, and epilepsy. With starting of treatment early in the illness and regular use, a complete cure can be obtained.

2. **Electro-convulsive therapy (ECT):** Commonly thought of as the main treatment for all mental disorders is another method of treatment for severe depression and psychosis. When used in
selected patients, it can bring about dramatic improvement as in severe depression.

(3) **Psychotherapy:** Persons in situations of stress experience psychological distress. Such persons can be helped by simple methods like listening to their difficulties, talking to the family as a group, bringing about changes in the living situation to bring about greater harmony in their life.

(4) **Rehabilitation:** Persons with (chronic) long standing illnesses cannot be completely cured and continue to behave and live differently from others. Such persons also benefit by simple measures like involving them in recreational activities, teaching them simple repetitive type of jobs (basket making, gardening etc.) and not excluding them from ordinary life. With love and training much improvement can be brought about in these cases.

(5) **Social and cultural therapies:** Traditional, cultural and creative activities can help the individual to have the required diversion, recreation and improve his psychological wellbeing. The examples of such activities are: 1) music, 2) arts, 3) yoga and meditation, 4) spiritual activities, 5) reading and 6) group work. The above methods may be used in different combinations to treat the different mental disorders.
Establishing a satisfactory doctor-patient relationship is essential for successful assessment, diagnosis and management of patients with emotional problems. The quality of the doctor-patient relationship is important in all disciplines of medical practice, it is perhaps most crucial in primary health care and care of the mentally ill persons. The ultimate success of this relationship is determined by what occurs between the doctor and the patient. This largely depends on the doctor’s ability and skill to convey their interest and warmth to their patients as they listen to the patients’ problems, thus building up rapport and a relationship of trust. Most of primary care doctors are trained to investigate, diagnose and treat ‘diseases’ in organ systems of the body. Doctors are less trained to listen to and provide help for persons with emotional problems.

**General reactions to mentally ill persons**

As a first step, it will be worthwhile to consider your own emotional reactions to the mentally ill as these reactions will directly or indirectly reflect on your approach to these patients. In the previous chapter it was noted that mental illnesses are broadly divided into two groups, namely, psychoses which are the more severe disturbances and neuroses which are minor psychiatric problems.

When a doctor sees a **severely disturbed mentally ill** patient, the emotional reaction is likely to be one of the following; (1) Fear and apprehension that the patient may be harmful, (2) dislike because patient is not clean, (3) anger and rejection because patient arrogant and annoys, (4) sympathy and pity as patient is suffering, (5) amusement and laughter due to some of the
childish/funny behaviour, (6) distrust and disinterest as patient may behave in an unreliable manner.

A primary care doctor may try to keep himself away from such patients. Even if he is interested in helping the patient, he may not know how to talk to the patient and manage him. Either disinterest or ignorance can make the doctor to develop an attitude of ‘why should I bother, patient is after all a mad-man, let me refer him to the mental hospital/mental health specialist’.

With patients of **minor mental disorders (Neuroses)**, the reactions are likely to be different. In the first place there can be difficulty in diagnosing them. Next there can be dissatisfaction with the treatment response. Patients, persistent somatic complaints, repeated visits to the clinic and their tendency to cling or linger on may make the doctor to dislike them. Some of their complaints may puzzle the doctor because they are multiple, apparently vague and diffuse. Detailed physical examination and investigations may not reveal any abnormality. Sometimes even when the doctor knows that a patient with a somatic complaints has psychological problems, the doctor may have difficulty to change the approach from precise and concrete physical signs and symptoms to understanding psychosocial factors and manifestations.

**Approach to mentally ill persons**

Most patients, including the severely disturbed are capable of understanding their doctors' reactions and responding to them accordingly. The doctor's effort, initially, should be to establish a good doctor - patient relationship. All patients need to experience that their doctor is genuinely interested and concerned about them and is willing to listen to their problems attentively and carefully. It is important to develop a genuine desire to help the patients and communicate this interest to them.

How can the doctor's interest and concern for the patient be communicated? Listening carefully to the patient and by giving him an opportunity to express
problems as spontaneously and fully as possible with least interruptions. Maintaining eye contact with the patient as much as possible. Acknowledge and respond to what the patient says verbally and/or non-verbally (gestures like nodding). By not conveying the constraints of time and appearing to be in a hurry. Doctor has to be, sensitive to the emotional distress/needs of the patient.

The treating doctor has to be very careful about his own emotional reactions, while approaching a **severely disturbed patient**. Doctor should recognize ones own reactions and make every effort to moderate them. Show of trust, respect and concern for the severely disturbed patients, in turn will give trust and acceptance of the doctor by them.

Mentally ill persons are human beings with their own feelings, thoughts, likes, dislikes and self respect. Doctors should remember that patients expect to be treated as a responsible and respectable individual. It is essential to treat patients as one who is suffering and needing understanding and help. Doctors should not do anything to degrade the self respect. Doctors should not comment, confront, criticise or laugh at the patient. It is important to try to understand what the patient has to say. At no time should the doctor deny the reality of the patient’s experiences, though it is not needed to agree to all the statements. An attitude of neutrality is best. By direct verbal reassurance doctor can inform the patient of commitment to care. It is unwise to consider the patient ‘mad and unreliable’ and listen to only other members. Use these general methods,

- Get a detailed account of the onset, nature and course of the symptoms.

- Ask open ended questions: Instead of asking ‘Do you cry when you are upset?’, ask, “when you are upset, what do you do?”
➢ Find out the situations in which patient gets the symptoms. “Can you recall and tell me, when and where you get the headache?”

➢ Pick up clues to elicit the areas of stress Eg: Patient: “I get headache when I am alone:

   Doctor : “Do you feel lonely, Do you feel that you are not cared by others”.

   Patient : Yes, doctor.

   Doctor : Who are the ones you think are not caring for you.

   Patient : ..... My parents did not care for me.... now, my husband also does the same.

If the person is hesitating to talk, give a paper and a pen, and encourage to write about the problems.

After the patient’s description of the problems, talk to the close relatives who stay with him and collect details of other problems. If there are discrepancies in the information given by the patient and relatives, do not get alarmed but draw their attention to this and request them to clarify. While interviewing patients or their family members, ask only what is necessary and do not ask unnecessary details. Never ask for information just to satisfy your curiosity. Do not ask very personal questions or questions regarding sexual matters in front of others. When this information is required, try to obtain them when the patient is alone. Assure the patient that these details will be kept confidential and total confidentiality will be maintained.

HISTORY TAKING

The general principles of history taking with mentally ill patients are in many respects similar to that in general medical practice. The patients’ own description of current problems have to be heard first. Patients illness has to
be understood in the context of the family, job, social and cultural environment. Open ended general questions only should be asked initially. More specific questions can be asked later on, after the patient has completed the description of his complaints in own words. The details of how the patient’s symptoms started and progressed, (i.e. onset and course) in a chronological order are important. Patients should be encouraged to go back to the time when they were completely symptom free and to relate any possible precipitating or perpetuating stress factors. The degree of severity of the symptoms, their effects on patient’s daily activities and bodily functions like sleep, appetite and bowel/bladder functions must be enquired. It would be important to know what explanation patient gives to the symptoms and complaints.

The family history and personal history have, special relevance in the assessment of mentally ill patients. The causation and manifestation of several types of emotional disturbances can be understood by knowing the socio-cultural background of the family of the patient. Certain resources in the family could also be made use of in the management of the patient’s problems. History of mental illness in the family and any inter-personal problems should be enquired. The personal history ideally should be a biographical account of the patient indicating significant events from the time of birth till the present date. It should include early development, childhood, schooling (and educational attainments) work (occupation) and marriage. The nature of work and the effect of illness on work should be assessed. The completed history should contain information about any past physical or mental illness. An attempt must be made to know what kind of a person the patient was before the onset of the illness. In short, the history taking should be an effort to understand the patient as a whole, and not just aimed at obtaining the details of his symptoms.
CASE HISTORY PROFORMA

OPD NO. ..........................  Registration No. & Time ..........................

Name............................................. Age.................... Date..................

Sex: Male/Female  Education.................................. Marital Status..........................

Address ................................................................................................................................

Occupation............................................................... Family Type: Nuclear/Joint
Socio-economic Status: Lower/Middle/Upper. Religion: .............................................

Informant.............................................................................................................................

Information: Reliable/Unreliable. Adequate/Inadequate

Previous psychiatric Consultation......................................................................................

I Presenting complaints with duration:

<table>
<thead>
<tr>
<th>According to patient</th>
<th>According to informant</th>
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</tbody>
</table>
II History of present illness:

(a) Onset: Acute/Gradual

(b) Precipitating Factors: Present/absent. If Present, details .........................

......................................................................................................................

(c) Preceding the onset of the illness, whether there is history of

(i) Fever (ii) Head Injury (iii) Drug use/abuse (iv) Diabetes Mellitus/Hypertension/TB/Syphilis. (v). Transient Neurological deficits/Details:

......................................................................................................................

(d) Course of the illness: Continuous/Episodic.

(e) Description of symptoms:

(f) Disturbances in biological and psycho-social functions:

<table>
<thead>
<tr>
<th>Function</th>
<th>No Disturbance</th>
<th>Mild</th>
<th>Severe Disturbance</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Sleep</td>
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<tr>
<td>* Appetite</td>
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<td>* Bowel-bladder</td>
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<td>* Sexual function</td>
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<tr>
<td>* Personal Hygiene</td>
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<td></td>
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<tr>
<td>* Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Observing social norms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
III Past History: Physical/Mental illness: Description

IV Details of family including history of mental illness in the family

V Personal history:
(a) Birth & Childhood
(b) Educational level and performance
(c) Occupational history
(d) Sexual & Marital history
(e) Habits

DEPARTMENT OF PSYCHIATRY & DE-ADDICTION CENTRE J.L.N.
MEDICAL COLLEGE & HOSPITAL, AJMER
Mental State Examination

Name .................................................. S/o ....................................................

Age .................................................. Reg. No.............................................

1. GENERAL APPEARANCE / ATTITUDE / BEHAVIOUR

1. Personal Hygiene : Poor I Fair

2. Psychomotor Activity : Increased / Decreased / Normal / Others.

4. Movements: Normal / Abnormal / Ticks / Mannerism / Choreoathetoid / others.

2. SPEECH : Spontaneous / Induced / Mutism / Relevant / Irrelevant, Coherent / Incoherent / Pressure + Increased / Others. SAMPLE OF TALKS

3. THOUGHT DISORDERS :

1. Process : Illogical thinking / Loosening of association / Autistic or Magical thinking.

2. Disorder of Form : Neologism / Word Salad / Circumstantiality / Tangentiality / Taught Block / Others.

3. Contents of taught : Poverty/ Overvalued ideas / others.

(a) Delusions : Bizarre / Nihilistic / Somatic / Paranoid / Guilt / Infidelity / Grandiosity / Persecutony etc.

(b) Obsession & Compulsions / Phobia / Others.

4. (A) MOOD :- Anxious / Irritable / Elated / Euphoric / Other/ Depressed / Grief / Suicidal / Others.

(B) AFFECT :-Appropriate / Inappropriate / Blunt / Labile / Others. S.

PERCEPTUAL DISORDERS:


6. SENSORIUM & INTELLIGENCE :

1. Level of Consciousness - (gr-0) -fully alert (gr-1) - confused (gr-2) drowsy (gr-3) stupoursed (gr-4) coma.

2. Attention & concentration : Maintained / Not maintained / Attentive / Not Attentive / Aroused / Not aroused / Others.
3. Orientation: Time / Place / Person.

4. Memory:
   (a) Immediate - Intact / Impaired.
   (b) Recent - Intact / Impaired.
   (c) Remote - Intact / Impaired.

5. Intelligence: Clinically Average / below Average / Above Average.


7. Insight: Present / Partially Present / Absent.

7. OTHERS: H/O

1. Head Injury / Bony Injuries / Others.
2. Convulsion / Seizures.
4. Fever.
5. Unconscious.
7. L.M.P / Pregnancy.
8. Previous Hospitalisation.
9. Loose tooth & Old Fractures.
10. Others.

8. NEUROLOGICAL EXAM: HMFS
2. CRANIAL NS
3. SPEECH
4. MOTOR SYSTEM
5. SENSORY SYSTEM

6. SIGNS OF MENINGEAL IRRITATION

9. PROVISIONAL DIAGNOSIS :-

10 Final Diagnosis

Consultant signature         Resident Signature
V. Major Mental Disorders
(Psychoses)

Each of us is very individual in our own way. Every individual has different interests and methods of dealing with different situations in life. Similarly behaviour of individuals to life situations is also not uniform. However, most of the people in one community have fairly similar ways of thinking (mentally reacting), feeling and behaving. In all communities there are agreed norms as to what should be considered normal and what should be considered ‘ABNORMAL’. For example, nobody will consider the wearing of colourful dress to a village get together or a fair as abnormal, but anyone coming with similar dress to sad occasion will be immediately considered as being abnormal, by almost all persons.

In the medical sense, any persistent and severe disturbance of thinking, feeling and behaviour is considered abnormal. In the past such conditions were called ‘insanity or melancholia’. Modern science classifies them as PSYCHOSES. In popular language sufferers from such illnesses are often wrongly referred to as ‘mad’ or ‘insane’.

Till recent times, persons with severe mental illnesses were feared and managed harshly by tying up, chaining or locking them in a room. Some also considered mentally ill persons as holymen and cared for them with respect.

**In the last 40 years medical treatment has become available which can make these ill persons normal so that they lead a normal life.** The following section deals with persons having PSYCHOSES - their recognition and care. It is estimated that 5-6 persons in 1000 population suffer from one or other form of psychoses at any point of time and every year about 5-6 people develop this illness per 10,000 population.
POPULAR VIEWS ABOUT PSYCHOSES

It is a common belief among general population that psychoses are not illnesses. They are thought to be due to religious and supernatural causes. Illness is attributed to phenomenon like ‘ill will of Gods’ and ‘visitation of evil spirits and souls of dead persons’. As a result of these beliefs persons with psychoses are usually taken initially to religious healers, magicians, temples instead of medical facilities. It is also thought that there are no medical methods of treating psychoses.

It is very important to recognise and remember that psychoses are similar to other physical problems in that persons can recover from them as much as from other physical problems. As in the case of all disorders the outcome with treatment varies with the severity and type of the problem and the time of starting treatment. Early treatment gives the best results.

IMPORTANCE OF CORRECT TREATMENT

The importance of treating and caring for those with psychoses arises from the problems that such persons can experience for themselves and have effect on others. Excited persons can destroy property and hurt family and friends. As a reaction to their altered thinking and feeling they can harm themselves as well as stop taking care of their responsibilities at home and work. The additional factor of social embarrassment and loss of productivity is also important. When not treated early, small proportion of them can become chronically ill and may need to be taken care of for long periods of their life. It has also been noted that many marriages break up due to an acute attack of psychosis. For these reasons it is important to RECOGNISE PSYCHOSES EARLY AND GIVE CORRECT TREATMENT.

There are two main types of psychoses:

1. **Functional Psychoses** are forms of psychoses where there are no detectable abnormalities in the structure of the brain or other organ systems of the body. In **organic psychoses**, symptoms are the result of disturbances in the brain (infection, trauma, tumour etc.) or disturbances in the other body systems (congestive failure, pneumonia, uraemia, hepatic failure etc).

The different types of Psychoses and their management is considered in the following section.

1. **FUNCTIONAL PSYCHOSES**

There are three major types of functional psychoses namely:

1.1 Schizophrenia

1.2 Affective Psychoses

1.3. Acute Psychosis

1.1. **SCHIZOPHRENIA**

*Some case histories will illustrate the schizophrenic illness:*

PAPU is a 21 years old man from a rural area who completed his primary school and started assisting in the agricultural work of his family. He was a quiet and calm person with only few friends. His relationship with others in the family and village and his work was considered satisfactory. Since the last few weeks, he has been quiet and withdrawn, not talking to others, and even to family members. He has not been working well too. He looks different, as if he is in his own world, not aware of what is going on around him. He is irritable, sleepless and doesn't take his food regularly. On enquiry, the relatives mention that, he mutters and smiles to himself. His answers to questions put to him are not understandable (inappropriate). At times he acts in a very strange manner. He looks at the roof and gesticulates, sometimes he looks scared. He has been neglecting
his personal hygiene. On talking to him, he reveals that his thoughts and actions are controlled by some external force. He hears commanding voices ordering him to do certain things. Parents report that there have been no life changes preceding the onset of illness.

Satish, is a 24 year old male. He has been reported to be talking and behaving strangely since last several days. He is restless and hostile to people around him. He abuses them and even attempts to assault them when he gets irritated. He does not sleep at night. He keeps talking to himself and shouts at times. He has stopped working. On enquiry the relatives mention that he is unduly suspicious of everybody and everything around him. He says others are talking about him. He believes that people stare at him and watch his actions. He suspects that few of them are plotting to harm him and destroy him. He hears the conversations of these people who are against him. Some of them are people known to him while others are strangers. Sometimes he hears his own thoughts as if somebody is shouting from somewhere. At other times he can hear a running commentary of his own actions. Because of these experiences, he is scared to move around.

Poonam, is a 34 year old married female who has been separated from her husband and presently living with her old parents and brother. She has been ill for the last 5 years, with periodic episodes of exacerbation symptoms. She has never been completely well at any time during this period. Her illness started few years after her marriage. Her relatives are unable to give details of the onset and development of her symptoms. Presently she does not do any work regularly. She eats and sleeps as she likes. She stays at home and in her village for few days of the month while at other times wanders and begs around in the near and far off villages. She is known as a ‘mad woman’ by everybody including the children of these villages. After she became sick, her husband had taken her to various popular
healers but she continued to be ill. He sent her to her people who now believe
that there is no treatment for her ‘madness’.

The above three examples are of a mental illness called ‘SCHIZOPHRENIA’.
The choice of sexes in the examples do not indicate any specific type of
association with the type of illness and sex of patient.

Schizophrenia is the commonest of the psychoses and the symptoms of this
illness closely correspond to the layman’s concept of madness. It is an illness
which interferes with individual’s personal and social functioning and if
untreated, can run a chronic cause. Schizophrenia usually starts in the age
group 15-25 yrs. The onset can be acute or insidious. Sometimes the onset
may be precipitated by a stressful event. The illness affects both sexes
equally and occurs in all social groups.

The illness is characterised by abnormalities of thinking; perceptions, and
emotions resulting in abnormal behaviour, action and talk. An individual with
schizophrenia has abnormal ideas and thoughts of various kinds which the
individual believes and are unshakable (delusions). Ill persons perceive
things which really do not exist (i.e. hears voices and sees visions which are
non-existent - hallucinations). Ill persons misinterpret the environment and
give special meanings for normal events. The individual can be inappropriately
happy or sad or apathetic and unconcerned. Because of these, talk and
actions might become understandable and irrelevant. They can either talk
too much or too little (or not talk at all). They can be found talking and
laughing to self. (this can be responding to the hearing of voices). They can be
withdrawn and inactive or restless, and hyperactive. At times they can become
suddenly hostile, abusive and assaultive in response to an unpleasant thought
or hearing of voices. Phases of excitement may be followed by phases of
extreme withdrawal when patient may remain in uncomfortable and bizarre
postures for long periods of time. Varying degrees of sleep disturbance will
always be present. The illness is characterised by changes in personal, social and occupational functioning.

It is very essential to remember that in actual clinical practice, **only some of the above features may be present in any given patient.** Diagnostically one of the most important finding is that the examining doctor usually cannot share or understand the patient’s experiences, and meaningfully communicate with the patient.

Both genetic and environmental factors are important. Factors like family relationships, socio-cultural factors, severe psychological stresses of any kind are important in the occurrence of schizophrenia. These factors operate in different combinations and degrees to predispose, precipitate or perpetuate schizophrenic illness in an individual. Although the etiology is not definitely known, what is certain is that the causation is **multifactorial.** It is currently understood that hyper sensitive Dopamine system’ (Neurotransmitter) is responsible for the symptoms of schizophrenia.

**MANAGEMENT**

**RECOGNITION:** The most important guideline (indicator) for recognition is a rapid (recent) CHANGE in personal functioning. The family members and neighbours report that the individual has become ‘a different person’. They no longer understand or share the behaviour and thinking of the ill person.

The more severe cases of acute psychosis are easy to recognise as their behaviour will be very different from others, that is, those with excitement, slowness, suspiciousness, sadness or abnormal behaviour. However, less severe cases can be initially missed if not carefully looked for as part of routine work in the clinic.
Consider the possibility of psychosis under the following situations:

- When someone is mentioned to have excitement, violent behaviour or socially unacceptable behaviour;
- When someone is talking excessively or does not talk to anyone at all;
- When someone expresses repeatedly bizarre somatic symptoms; *Ex*: My inter stems are rotting, my brain is burnt, my liver is missing.
- When someone has stopped working without any clear reason;
- When someone talks of taking one’s life;
- When someone complains repeatedly that others are trying to harm him or planning to kill or doing black magic;
- When someone has sleep disturbance for few weeks;
- When a person has stopped taking interest in personal dress and appearance.

**WHAT TO DO AFTER THE DIAGNOSIS?**

Having identified a person with schizophrenia the next step is to evaluate whether he can be managed by you or referred to a psychiatric centre.

**Referral is advised in the following situations**

(i) **Suicidal risk:** Here the person, because of disturbed thinking and feeling, has shown a tendency to end life by talking about it or attempting it. This patient should be treated at a centre with hospitalisation facility.

(ii) **Danger to others:** This is mostly seen in those with acute disturbance in the form of excitement or in those with severe degree of suspiciousness, persons carrying weapons to protect self or when there is a danger of losing
control and harming others. Treatment is to be carried out in a HOSPITAL after giving initial treatment.

**MANAGEMENT**

In most families and communities, the initial response to a person with psychosis is fear and apprehension. This leads often to over reaction. The commonest way of reaction it restraining the person by physical restraint in the form of tying to the bed by rope or chains. This step aggravates the patient’s behaviour as the individual feels more threatened and a vicious circle of excitement-control-excitement results.

**GENERAL MEASURES**

In view of these reactions of patient and the family the steps that need to be taken by the primary care doctor, as the main source of help, is to (i) talk to the patient sympathetically to understand the reasons for the behaviour (ii) listen to the family members and allay their misgivings, (iii) remove restraints (if the excitement is not severe and the danger of immediate harm to others or patient is not there - in all cases restraining should be avoided unless the person is very violent), (iv) taking adequate care of nutrition of the ill person (excitement can easily exhaust a person), (v) keeping harmful weapons, drugs out of reach of the ill person, and (vi) meeting the patient and the family frequently for assessment, treatment and support.

**SPECIFIC MEASURES**

A. **Acute Schizophrenia** (less than 6 months)

Drug treatment can effectively control the disturbances of psychosis. The drug to be used is CHLORPROMAZINE. Chlorpromazine (CPZ) is available as tablets of 25 mg, 50 mg and 100 mg. and 200 mg. 100 mg tablet is most economical for use.
The initial dose of CPZ should be dependent on the degree of disturbance. For example, for persons with acute excitement requiring restraint a dosage of 300 mg per day (in three divided doses) is most appropriate. For those with disturbance of lesser intensity, dosage of 150 mg to 300 mg is used (in three divided doses).

Initially the response to the drug is often dramatic in that the symptoms subside with drug administration. However, after a few days there may be a need to increase the drug up to 600 mg per day. If 600 mg per day does not control the disturbance with 2 weeks, please consult a psychiatrist. Similarly, if there is no improvement after 4 weeks of treatment the person should be seen by a psychiatrist.

Most patients respond to 300 mg daily dosage. The improvement is seen in decrease of abnormal symptoms and gradual return to normal routine activities. As the treatment progresses the ill person sleeps better, talks more relevantly and takes interest in the family and friends, express less of the abnormal ideas and does not show ununderstandable behaviour.

The same dosage is also indicated for patients who are brought with extreme degree of withdrawal and other symptoms associated with it. In such patients, while chlorpromazine ensures adequate sleep at night, it can also cause excessive and unwanted drowsiness during the day. Another type of phenothiazine namely Trifluperazine (Chapter X) in doses ranging from 10 mg to 15 mg can be given instead of chlorpromazine. This will overcome the side effect of excessive drowsiness during the day. However if this phenothiazine drug is not available, Chlorpromazine in the above doses should be given.

The commonest cause of recurrence of symptoms or failure to respond sufficiently to treatment is the failure on the part of the patient (and his relatives) to take the medicines regularly due to various reasons and family reaction to the ill person. One of the commonest reasons is the mistaken
belief that they are ‘sleeping medicines’ and are habits forming. This belief needs correction. The phenothiazine drugs do not cause dependence irrespective of the duration of its use. Similarly, the family members should avoid either overprotection or rejection. They should understand the nature of illness and learn to react to the behaviour of the patient in a healthy manner.

It is advisable to follow up the patient initially, once weekly and later on when the symptoms have remitted, either once fortnightly or monthly. From the time of beginning of improvement the drug needs to be continued for another 4 - 8 weeks at the same dosage. Following this the dosage of the drug can be gradually reduced by 50 mg every 2 weeks to stop the drug after a total treatment of about 6 months. Some patients need longer period of treatment with medicines.

While decreasing the drug if there is reappearance of symptom, the dosage should be maintained and the help of specialist taken for further management.

Patients Refusing Oral Medication

Chlorpromazine is available as a parenteral preparation. In an acutely excited patient CPZ 50 mg can be given intramuscularly. It is best given in the gluteal (buttocks) are as deep IM injection. If following CPZ 50 mg IM, patient is not controlled, it can be repeated after an another half hour and later every two hours to a maximum of 200 mg.

If parentaral medication is used in the first few days as primary treatment, because patient refuses oral medication, injection CPZ 50-100 mg can be given every 6 hours. It is best to switch over to oral drugs as soon as patient is cooperative.

Side effects
Chlorpromazine and other phenothiazines are safe drugs but can produce hypotension. It is advisable to record the blood pressure of all patients on
Chlorpromazine. Evidence of liver damage is the only contraindication for use of chlorpromazine.

It is important to be aware of and look for side effects of the drug when a patient is started on phenothiazines (Chlorpromazine, Trifluperazine). The commonest side effects and their management is considered under Chapter X.

Doctor can refer an acute schizophrenic under treatment to a psychiatrist if i) excitement is not controlled within 48 - 96 hours in spite of using 600 mg of Chlorpromazine per day, ii) if the main symptoms in a non-excited patient have not come down after 4-6 weeks of treatment with adequate dosage, iii) if recurrent and severe side effects (dystonic reactions) occur in spite of taking appropriate measures.

Regular drug administration is only one aspect of the management of schizophrenia. All efforts should be taken to rehabilitate the patient as the symptoms start disappearing in response to treatment by engaging the individual to do some work regularly. The family members involvement is very important.

MANAGEMENT OF LONG STANDING CASES OF SCHIZOPHRENIA

There will be in the community some persons who have had an acute episode of psychosis a few years back but are currently having other symptoms. These persons usually do not have the acute symptoms that disturb others, but have other problems like extreme slowness in activities, disinterest in work, lack of emotional feelings for family and friends and inability to take responsibilities. They seem to live in a world of their own. Often such patients may have disrupted family life in the form of divorce, separation etc. They also find it difficult to hold on to regular jobs.

These persons can also be helped by treatment. The usual drug is chlorpromazine and the dosage is 150-300 mg per day in divided doses.
length of treatment is longer than 6 months. Some persons need to take them all their life to remain well. Along with drugs these persons should be helped to become accepted by the family and society. Finding them simple jobs to rehabilitate them goes a long way in the treatment. (Chapter X).

In situations where long-term medication is needed, another phenothiazine FLUPHENAZINE DECANOATE is useful. This is an INJECTABLE drug. It comes as 25 mg per one ml. This drug needs to be given only once in 2 or 4 weeks. This is a long-acting drug.

In chronic schizophrenia, after use of 6-9 months of drugs the dosage of the drug (oral) or the frequency of the injectable drug can be reduced gradually. In some the drugs can be discontinued while in others it has to be continued for many years.

1.2 MANIC DEPRESSIVE PSYCHOSES

This type of mental illness is also called ‘Affective psychosis ‘ because the primary abnormality in this illness is one of ‘affect’ (affect = emotion, mood). The disturbances in mood occurs both in quality and quantity and ranges from extreme sadness to extreme happiness. The mood disturbances occurs in episodes of either happiness (mania) or sadness (depression). These episodes can also occur alternatingly when the illness is called manic depressive psychosis (M.D.P). In between episodes the person remains normal. Each episode lasts for few days to few months and the period of normalcy lasts for few months to several years. A person may get only attacks of mania or only attacks of depression or both alternatingly. By and large recurrent attacks of depression is the commonest manifestation of affective illness and only a quarter of all affective psychoses occur as alternating attacks of mania and depression (M.D.P).

Kamal, a 28 year old clerk in an office, has been talking excessively, for the last 2 months concentrating less and less on his work. He is cheerful, jovial
and unduly happy for no obvious reasons. He has become boastful these days and claims that he can do any type of job quite easily without any training. He is friendly and helpful even with people whom he does not know. He talks about various subjects very confidently. He has very ambitious plans for future.

On enquiry his relatives report that he is disturbing everyone at home. He doesn’t sleep at night and keeps doing something or the other. He talks endlessly and gets easily irritated- if he is advised or if things don’t go the way he wants. He is impatient and restless. He has been spending money excessively. On talking to the patient is noted that he shifts from topic to topic very soon and cannot concentrate on any one topic. He gets easily distracted and is irritable. He says that he has special abilities and talents and he can perform various tasks better than others.

This is a typical example of a person with a diagnosis of ‘mania’. The ‘important clinical features are extreme happiness, increased talk and motor activity and high degree of irritability. These symptoms may be very much increased in severe cases of mania. In such cases the talk may become irrelevant and ununderstandable, the person may become impulsive and violent and the condition may be indistinguishable from a schizophrenic excitement. He can be a danger to himself and others. Untreated, a manic episode generally lasts about 3 months after which there can be spontaneous recovery. The frequency of episodes is highly variable - a person can have several episodes during a year or he may have only one or two episodes throughout the life time.

Rani, aged 38 years, married housewife has 3 children. She is found to be slow and withdrawn for 3 months. She was a very efficient housewife but now she gets tired very easily and finds it difficult to complete the routine household tasks. She is disinterested in keeping the house neat, looking after guests and visiting friends and prefers to be alone. She is disinterested in her
own appearance and looks dull and dejected. She has reduced her eating and
does not like any food. Most of the time she is found to be worrying. She
occasionally cries. She complains of generalized weakness and fears that she
is suffering from some incurable illness. On talking to her, she tells that the
future is really hopeless. She feels her current situation is due to the bad
deeds done in the past. She wakes up quite early, by 3 to 4 a.m. and finds it
difficult to go off to sleep again. She feels most miserable at this time and has
entertained the idea of leaving the house, or committing suicide. Many days
she feels better as the day progresses. She believes that death is the only
solution to her problems.

Rani, is suffering from ‘Depression’. The important clinical features are,
sadness without any reason, disinterest in everything, sleeplessness, (early
morning awakening) and changes in social functioning. In may cases, in
addition to some of the above symptoms multiple bodily complaints will be
present. In fact, the bodily complaints may be the only presenting complaints.
Such persons go from doctor to doctor undergoing repeated investigations
without any lasting relief. Some depressives hear voices telling them that they
are bad and useless and the future is hopeless. They may also firmly believe
that ‘curse of god’ is the reason for their illness or death is the only solution for
their problems. While most depressives are withdrawn and retarded, some
especially women in their menopausal age, may be agitated and restless in
addition to being depressed. They may also have extreme degree of anxiety.
This is called ‘agitated depression’.

The other common area of complaints is the biological changes in the body.
These are reported as poor appetite, constipation, lethargy, tired feelings
throughout the day. PERSONS WITH THE ABOVE TYPE OF DEPRESSION
NEED TO BE TREATED ON AN EMERGENCY BASIS. IT IS ESTIMATED
THAT ONE IN TEN SUCH PERSONS END THEIR LIFE BY SUICIDE
WITHOUT PROPER TREATMENT.
MANAGEMENT OF MANIA

The treatment is chiefly by the use of drugs, namely use of antipsychotic drugs (Chapter X).

When the patient is brought in a disturbed and excited state requiring to be restrained, patient can be brought under control with injection of CHLORPROMAZINE 50 mg. intramuscularly. This can be repeated every half an hour till the patient is sedated or to a maximum of 200 mg. Once the patient is sedated and under control oral drugs can be started.

The basic drug for treatment of MANIA is CHLORPROMAZINE. Initial oral dose is 300-400 mg daily in divided doses. The clinical condition is reviewed after three days. If there is no improvement with the above dosage, dosage is increased upto 600 mg daily in divided dosage. With this dosage most patients show improvement. At times, if there are short periods of excitement, injection Chlorpromazine 50 mg i.m. can be used.

With the above treatment, initially (FIRST WEEK) patient’s sleep improves and the activity level decreases. Gradually in the following weeks the grandiose ideas and other features of mania disappear.

The daily dosage is maintained for at least 4-6 weeks after adequate response has been noticed. Following this the daily dosage is gradually decreased by 100 mg every week over 4 to 6 weeks. During this period of decreasing the drug dosage, if there is a relapse of symptoms the preceding dose is restarted and maintained for another 2-4 weeks and then reduction attempted. Sudden stopping of the drugs is not advisable except when the daily maintenance dosage is less then 100 mg per day. After the initial week, major part of the drug can be given as a single night dosage, which decreases the side effects.

The commonest side effects complained of are drowsiness and extra pyramidal symptoms. Drowsiness decreases with suitably decreasing the
dosage of the drug or choosing a drug with less sedative effect. Management of extra pyramidal symptoms is given Chapter X.

**Referral** to a specialist is advisable under the following conditions (i) excitement is not controlled with the above dosage in 48 to 96 hours (ii) side effects are severe and disturbing to the patient, and (iii) main symptoms of mania have not shown significant change after 6 weeks of continuous treatment.

As in the case of schizophrenia, patient should be encouraged to return to work and assume gradually a normal routine.

**TREATMENT OF M.D.P - DEPRESSION**

Antidepressant drugs are the drugs of choice for the treatment of depression. There are a number of antidepressants available in the market (Chapter X). **There are no differences in the effectiveness of the different drugs.** They differ in the occurrence of side effects and sedative properties. Generally, it is best to become familiar with any one or two antidepressant drugs and be well experienced in dosage adjustment and management of side effects. The basic drug of choice is **Imipramine.** This comes as 25 mg and 75 mg tablets.

The starting dosage of the drug is 75 mg per day given in single bed time dose. All antidepressants take about 14-21 days to provide relief. It is best to tell the patient this aspect or the patient may stop drugs prematurely. At the initial stages, Imipramine can produce mild and short lasting side effects like dryness of mouth, constipation and blurring of vision. These should not lead to stopping of the drug. Doctor should review the clinical condition at the end of **TWO WEEKS** and if the side effects are not disturbing, should increase the dosage to 100 mg per day. (Maximum dose is 150 mg/day.)
With the above treatment, patients will gradually show improvement. The initial change will be in sleep, appetite, decreased feelings of sadness. Doctor should continue the treatment in full dosage at least for 4 weeks after complete improvement of all symptoms has been noticed. Following this, the drug can be gradually reduced by 25 mg per week over 6-8 weeks. If there is a recurrence of the symptoms when decreasing the dosage, the earlier dosage is given and maintained for 4 weeks prior to initiating reduction. The total duration of treatment is 3-6 months. Some people recommend at least 6 months maintenance following recovery from an episode of depression.

Referral to a specialist is indicated (i) when at the initial evaluation suicidal risk is considered high (such patients respond to ECT quickly), (ii) when there is no improvement in depression with 4-6 weeks of full dosage of antidepressants (iii) there is recurrent attacks of depression with or without mania (these can benefit from lithium), (iv) depression is associated with other physical problems like hypertension, neurological, cardiovascular problems, and (v) when there are multiple psychosocial problems associated with depressive episodes. All these situations require more detailed evaluation as well as management plans.

1.3. Acute Psychosis:

In India, a number of studies have shown that about 10% of all persons with psychoses belong to the category of Acute Psychosis. This condition is characterised by (i) an acute onset (within 2 weeks), (ii) presence of associated stress, and (iii) a typical syndrome characterised by rapidly changing and variable clinical picture. Complete recovery usually occurs within 2 to 3 months and most often within a few weeks or even days. In view of these features, the treatment of these disorders is very effective and the duration of treatment is not as long as in schizophrenia.
ORGANIC MENTAL DISORDERS

These disorders are caused directly by damage to the structures of brain. The underlying disease may be in the brain itself or may be in the other parts of the body.

The important symptoms and signs of organic brain disorders are:

1. **Disorientation** to time, place and person. Patient is unable to identify a place, to recognise relatives, cannot tell the time of day, day of week or month.

2. **Poor comprehension:** Patient is not able to understand the spoken or written language, cannot follow simple instructions like "open your mouth", "show your tongue", "touch the left ear."

3. **Poor calculation:** A person who was good in calculation and money matters loses the ability and may start making simple mistakes.

4. **Memory deficits:** Initially the person may have difficulty in recalling the immediate events, later on recent events and still later on in the illness the past events. Patients forget personal things like pen, footwear or purse, and keep searching for them. They can forget the conversations they had with friends, forget the article which they wanted to buy in a shop. They may not be able to recollect the names of friends, family members. They may forget the way in a familiar surroundings and get lost.

5. **Changes in personality:** There may be a change in the manner in which the person reacts to a situation or in the life-style. A person who was careful with money matters may become a spendthrift. A person who used to be calm and even tempered, becomes irritable and quarrels with everybody. A person who had hardly any friends, now tries to socialise with many. Persons may start talking about sex openly without bothering about
who are present, or show decreased control over sexual or aggressive behaviour.

6. Emotional liability: The affected person can show severe emotions like crying, laughing, intense fear for a short period and rapid changes in emotions.

7. In addition to the changes in higher mental functions like concentration, orientation, memory, intelligence, the affected person may have other symptoms like excess anxiety, depression, shame, suspicion, apathy, and exhibit socially embarrassing behaviours.

8. Self-neglect and absence of awareness of the same: Affected person can forget to button the trousers and remain unaware of it. They may put the shirt inside out. They may soil the clothes but not he aware of it.

Some of the patients can develop neurological symptoms or deficits like fits, paresis, paralysis, ataxia, in coordination, involuntary movements of the limbs etc.

Causes of organic mental disorders are already mentioned.

The following section covers two of the most common syndromes.

DELIRIUM

It is an acute organic mental disorder, often seen in primary health care setting and general hospitals. The important clinical features are acute onset of confusion and disturbances of higher mental functions due to diffuse brain dysfunction. It has a brief but fluctuating course. It is usually reversible. Rajendra, aged 35 years, known to be dependent on alcohol presents with behaving very strangely since morning. On examination, he is not recognising his wife and mother and say that they are strangers probably the agents of his enemies, who want to kill him. He is extremely fearful, tries to hide himself in a corner. He pleads for protection. Often he shouts and screams. His hands are
trembling. He sways from side to side unable and to stand erect. On enquiry the family gives the story that he had his last drink only yesterday. He is suffering from 'Delirium Tremens'.

Sita aged 30 years, who is a known diabetic, takes insulin injection by herself. she is brought to emergency with a complaint since morning, she is talking irre relevantly. She says that she is being haunted by devils who are abusing her. She is trying to chase them away. She is restless and attempts to runaway. Her daughter can hold her with difficulty. On inquiry, she took the insulin injection that day and did not have her breakfast. She is having auditory hallucinations to which she is referring to as 'devils'. This is an another form of delirium.

**Delirium is commonly associated with**

1. Withdrawal state in individuals who are dependent on alcohol, opium, and other substances.

2. Hyperpyrexia: High fever associated with viral fevers, urinary tract or respiratory tract infections, sepsis etc;

3. Electrolyte imbalance: Sudden fluid/ blood loss due to diarrhoeas, dysenteries, vomiting, bleeding, leading to electrolyte imbalance;

4. Post-epileptic attack period: When a person has an epileptic attack, following the cessation of convulsions, there can be confusion, automatic behaviour or aggression which last for a few minutes to an hour;

5. Head injury: Following head injury, the victim may have the features of delirium;

6. Hypo- or hyper-glycemia.

7. Hepatic, renal, cardiac insufficiency states.
8. Vit B1, B6, B12 deficiency.


Person before developing delirium, may have prodromal symptoms like daytime restlessness, fearfulness, hypersensitivity to light and sound. Disorientation to time is the first clinical symptom. Illusions and hallucinations in all sensory modalities and fleeting (quickly changing) delusions are commonly present. The clinical picture fluctuates, becomes more and more severe night or early morning. Autonomic instability in terms of pallor, flushing, sweating, irregular heartbeats, nausea, vomiting may be present. The affected person may become either suicidal or homicidal in response to the psychotic experiences.

Delirium usually remits in one to two weeks. In a few cases, it may lead to dementia. Depending on the underlying cause, if not treated, some cases may die (10 to 30%).

Management:

In the management of delirium, identification of the cause becomes a vital step. A good physical examination and basic investigations like blood, urine, x-ray skull and chest can lead to the diagnosis. If there are no facilities in PHC, the doctor has to immediately refer the patient to a nearby bigger hospital, and provide symptomatic management.

1. Evaluate signs of dehydration and if they are present give 1.V fluids and make the patient to take fluids orally unless the patient is semi/unconscious when you have to put Ryle’s tube and feed him.

2. Examine for a full bladder, if full, facilitate emptying.

3. Record the temperature and if the patient is having high temperature take a decision regarding prescribing antibiotics and/or antipyretics. Advice the attendants regarding the use of tepid sponging and giving adequate fluids.
4. If the person is semi or unconscious see that airway is maintained free.

5. If the patient is restless and exhibiting psychiatric symptoms the drug of choice is Haloperidol 5 mg to 20 mg. a day either IM or orally in 2 or 3 divided doses. If you do not have Haloperidol, use small doses of chlorpromazine 100 to 200 mg in 2 or 3 doses.

**Do not sedate the patient in case of delirium following head injury.**

6. Keep the patient in a properly lighted (room should not be either too bright or too dark), well ventilated room. Avoid crowding of relatives. Introduce your/anybody’s arrival and what you are going to do to the patient to avoid fear in the patient. Do not carry instruments in hand which may be dangerously misinterpreted by the patient.

7. Allow one familiar person to nurse the patient. Avoid frequent changes in nursing and other hospital staff.

**Dementia:**

Raju, who is 65 years old now, is becoming a problem to his family members. He insists on sitting in the cash counter of the departmental store which he owns but his children have observed him making mistakes in calculations. When he gives less money to the customers, they protest and Raju, argues that he is correct in his calculations. He keeps repeating certain statements without remembering that he has narrated the same, a few minutes earlier to the same person. He makes very childish jokes and laughs loudly. People make fun of him and say that he is becoming mad. If the children request him to stay back at home, he loses his temper and accuses them that they are trying to snatch away his property and desert him. Of late, they have noticed him losing his way and reaching wrong places. He is suffering from Dementia.

Dementia usually starts gradually and is progressive. It is generally irreversible. It is more common in people who are 50 years and above.
The clinical picture consists mainly of progressive deterioration of intellectual functions like memory, intelligence and judgement, changes in the personality (behaviour pattern), quick fluctuations in emotional responses (liability) and stereotyped repetition of words or actions. As the illness progresses, patient will not be unable to take care of his personal needs and hygiene, He may develop symptoms like restlessness, sleeplessness, wandering tendencies and suspiciousness.

Patient may also develop neurological symptoms like fits, weakness or paralysis of the limbs or body, difficulty in speech, vision and difficulty with coordinated movements.

**Common causes of dementia:**

1. Diseases of central nervous system like Alzheimers disease, Huntington's disease, Parkinson's disease etc.
2. Infections like tuberculosis, syphilis, cryptococcal memengitis.
3. Repeated injuries to brain (eg. boxers)
4. Cardiovascular; Cerebral hypoxia and anoxia, multi infarct dementia which is seen in the cases of diabetes mellitus, hypertension.
5. Encephalopathy as a result of organ failure(liver, kidney)
6. Endocrine and metabolic diseases (eg. thyroid)
7. Chronic abuse of alcohol or other toxic substances
8. Brain tumors

About 10% of dementias are treatable and reversible. Example are Syphilis/ Tuberculosis of brain, Hypothyrodism, Deficiency states, Normal pressure hydrocephalus and Slow growing brain tumors.
Management:

These patients often need investigations and should be referred to a hospital. Treatable conditions have to be treated after full investigations.

Counselling the family members regarding the nature of the illness is essential. Looking after patients nutritional and hygienic needs are very important. Tablets of chlorpromazine in smaller dose, 25 mg to 100 mg or Diazepam 5-10 mg can be given when sleeplessness, agitation are seen. Ant epileptic drug has to be given if the patient is having epilepsy. Any person who develops psychosis for the first time after the age of 50 years, should be examined in details for the possible evidence of organic psychosis.
VI. Minor Mental Disorders
(Neuroses)

Neuroses are a group of minor mental disorders, which are not easily defined. Unlike in psychoses, persons suffering from neurosis do not lose touch with reality and they are able to meet the ordinary demands of everyday living. They generally have a good understanding of their problems. While they do not cause much of distress to others (in the family, neighbourhood etc.) they themselves experience varying degrees of personal distress and suffering. Their ability to cope with routine household responsibilities, work and other usual social situations though disturbed to varying extent, usually does not disable the person completely. The disability caused is generally related to the degree of personal suffering the patient experiences.

The basic and predominant features of neuroses are mental tension and worry. All people get tense or worried from time to time especially when faced with difficult problems. However, they are able to cope with the situations and overcome their tensions or worry with passage of time. If the tension, worry is too much in intensity or prolonged in duration, they tend to interfere with the person’s sense of wellbeing and disturb the normal functioning. Many persons with neurosis, basically have feelings of inadequacy and inferiority (lack of confidence) which lead them to perceive common everyday problems as difficult and threatening. This constantly produces tension and worry and these individuals prefer to avoid facing these problems, ultimately resulting in a multiplicity of physical or psychological complaints (symptoms).

Majority of individuals with neuroses, there can be a stressful factor either precipitating or perpetuating the symptoms. The stress can be in the form of a disturbance in relationship with a person, a family quarrel, an unhappy marriage, difficulties at work, persistent financial problems, serious illnesses in family or a death in the family or a social setback.
It would be easy to recognise that all individuals cannot escape from suffering, from some degree of mental tension, unhappiness. They experience symptoms in the presence of problems of every day life, at one time or the other. However in the case of the persons with neuroses, these tensions, worries, unhappiness and the consequent symptomatology become part of their life style, leading to constant feelings of insecurity and a need for support from others. The exact clinical presentation of neuroses can markedly vary from one person to another. Some examples will illustrate these problems.

Lakshmi, 30, is married for the last 8 years but has not given birth to a child. Since two and half years she has difficulty in breathing complaints and chest pain. She constantly has burning sensation in the chest and abdomen. At times she is distressed by feeling of a ‘fast thumping’ in the chest. At such times she has intense fear, cannot sit in a place and wants somebody to be with her. She has consulted a heart specialist, who after careful examination and investigation reassured her that her heart is perfectly healthy. In spite of this, Lakshmi continues to have problems and often visits her family doctor, seeking good medicines to free her from the complaints.

Raju, 22 years is a tailor by occupation. He has general weakness, easy fatigability and pain in the legs for over a year. The tonics and injections given by various doctors whom he has visited during the past several months have not helped him. He thinks that his nerves have become weak and doctors have not been able to find out the reasons for it. He has a difficult family situation. He is not able to meet all the needs of the family members. He is worried that he will become weak and disabled.

Savitri, is a 30 years old housewife. Since last few months she is unable to do any household work, feels weak and tired most of the time and complains of heaviness of head, pulling sensation in the neck, back and
limbs. She is unable to eat properly and has difficulty to get sleep. She, as well as others in her family, believes that the cause for all her problems is the tubectomy operation she underwent 6 months back. She has been repeatedly requesting the health workers, who persuaded her to undergo the operation and the PHC doctor, for good' tonic injections`.

**Lakshmi, Raju and Savitri** suffer from Neurosis. Their neurosis is associated with problem of childlessness and family situation, and family planning operation respectively. Some types of neuroses fall into definite clinical pattern while the complaints of others may not be very specific.

**Aetiology**: Generally, biological, psychological and socio-cultural factors are considered to be relevant in the causation of neurosis. While it is believed that hereditary and constitutional factors can play a role in the causation of neurosis, their exact role has not been clearly delineated. Different theoretical models exist for the description of the psychological causation of neuroses,

Childhood experiences in the form of faulty learning, improper personality development due to pathological family and interpersonal relationships and faulty parental models have been associated with the development of neuroses in adult life. According to the theories of a very eminent psychiatrist, Sigmund Freud, who developed a treatment method called 'Psychoanalysis' the basic cause of neurosis is the individual’s failure to hormonise inner desires, impulses and reality situation; causing pressures and conflicts. These conflicts are generally resolved in the mind by certain mechanisms known as **defence mechanisms**. When these defence mechanisms either fail or inappropriate, neurosis results. It has been known that, in addition to the above psychological factors, socio-cultural factors like socio-economic status, race, religion, and rapid social changes due technological advances and value systems influence not only the prevalence of neurosis but also its presentation.
Depressive Disorder:

Depressive disorder is the most common disorder, affecting about 5% of the adult population at any given point of time. One of ten cases in a general hospital outpatient clinic or general practitioner’s clinic can be this disorder. Depressed mood, loss of interest, fatigability and diminished activity are the important and common symptoms. Other common symptoms are:

a) Reduced concentration and attention
b) Reduced self-confidence and feelings of inferiority
c) Feelings of guilt and worthlessness
d) Pessimistic views of the future
e) Disturbed sleep
f) Diminished appetite and sexual functioning
g) Death wish, suicidal ideas/ attempts

Most of the patients present to the doctor with somatic symptoms and biological function disturbances like headache, backache, chest pain, weakness, easy fatigability, insomnia, lack of appetite or sexual inadequacies. Thus there is a need to look for the depressive features by asking direct questions like ‘How is your mood? Are you happy? Are there worries which bother you?’

Assessing the Severity of Depression:

1) Enquire for psychotic symptoms: Find out whether the patient is having delusions (of guilt, suspicion, hallucination (blaming voices)

2) Check whether the patient had similar episodes of depression or mania in the past.
3) Evaluate the risk of suicide: Check whether the patient is serious about his death wish or suicidal ideas. Has he planned to commit suicide and how? If he has already made an attempt to commit suicide, check the severity of the method used.

4) Check how much the patient has neglected his basic needs and daily routines. Based on this, you can decide whether the given patient is suffering from severe depression, moderate depression or mild depression.

An individual with a **mild depressive episode** is usually distressed by the symptoms and some difficulty in continuing with ordinary work and social activities, but will probably not cease to function completely.

An individual with a **moderately depressive episode** will usually have considerable difficulty in continuing with social work or domestic activities.

In **severe depressive episode** the sufferer usually shows considerable distress or agitation, unless retardation is a marked feature. Loss of self-esteem or feelings of uselessness or guilt are likely to be prominent and suicide is a distinct danger.

**Management**

1) **Severe depression with high suicidal risk:** Patients with these problems are an emergency. Refer the patient to a psychiatric centre. Prescribe required sedation (Diazepam 10 to 20 mg/day) as an initial measure.

2) **Depression with a few psychotic features:** Suicidal risk is low. Put the patient on Amitryptaline or Imipramine 75 mg at bed time. Chlorpromazine 100 to 200 mg at bed time. Build up the dose to the therapeutic level and continue the meditation for 6 months.
3) **Mild Depression**: Patient needs psychological management. (See section on Treatment of Mental Disorder).

Management of Suicidal Risk: The following measures should be taken.

i) Inform all the family members and others regarding the risk.

ii) Tell them that Suicidal ideas are part of the disease and they should not blame the patient.

iii) The relatives should keep a vigil on the patient all through the day and night.

iv) Patient should not be left alone even for a few minutes.

v) Materials which can be used to commit suicide should be kept away from the patient (weapons, poison, medicines etc.)

vi) Patient should be engaged in activities which make him comfortable and involve him with others.

vii) Arrange for urgent psychiatric help.

**Generalised Anxiety Disorder**

The predominant features of this disorder is a constant feeling of uneasiness, vague tension and apprehension with anxious anticipation of danger (when there is no real threat or danger). This anxiety state is often associated with various symptoms like tightness and beating in the chest, empty feeling in the stomach, shortness of breath, inability to concentrate, difficulty in making decisions, forgetfulness, disturbed sleep, nightmares, poor appetite, chronic mild diarrhoea, giddiness, weakness, excessive sweating, sustained muscle tension causing aches and pains. These symptoms sometimes appear in episodes. They may appear suddenly (any where, any time without any precipitating factor) or may appear in specific situations or in relation to specific objects.
1) **Panic Disorder:** Sudden, unexplained attacks of anxiety / fear (fear of losing control, going mad, heart attack, sudden death etc.). Symptoms suddenly builds rapidly and lasts for a few minutes.

2) **Phobic Disorder:** The sufferer develops intense irrational fear of a specific object or situation, that normally presents no real danger, and actively avoids the object or situation. The sufferer would know that his fear is absolutely silly and there is no reason for fear but still he cannot help avoiding the object or situation. Symptoms and signs of acute anxiety appear, if they ever attempt to approach the feared object or situation. The common feared situations or objects include leaving home, crowds, public places, pet animals, speaking in public, entering small places like lift etc.

Symptoms of anxiety can be present continuously for months. The patient may present with various bodily symptoms like headache, chest pain etc. on enquiry patient reports having nervousness, worrying, poor concentration and memory, restlessness and other features of anxiety.

On examination, patient shows signs like restlessness inability to sit without moving, anxious look, tremors of the extremities, tachycardia, increased blood pressure, and cold clammy extremities. In chronic anxiety states, the above symptoms and signs fluctuate in their intensity causing remission and exacerbations.

The pharmacological management of anxiety is by the use of a minor tranquilizer like Diazepam. The dosage range of 5 mg to 15 mg per day is given in divided doses. Reassurance and counselling about the situation. along with minor tranquilizers relieve most of the symptoms of anxiety. In patients with panic attacks use of anti-depressant drug like imipramine 75 mg to 150 mg/day can give relief. Refer the patient to a psychiatrist, if he is not improving in 6 to 8 weeks of continuous treatment. (see chapter X for further details)
Dissociative (Conversion Disorder)

In this condition, patients develop typical symptoms of known physical illnesses without an evidence of any organic pathology. The illness usually helps the individual to escape or avoid a threatening or stressful situation. The stress or threat need not always be external. It may arise from the individual’s inner conflicts, impulses and desires. The symptoms, in addition to avoiding stress, may also help the individual to fulfil certain needs. They help the person to draw attention of significant others in the family and community and gain their support. These symptoms can be seen as a way of communicating distress, expressing problems or recording protests in a helpless situation.

In majority of the patients the symptoms are physical, either motor, sensory or visceral. In a few cases, the symptoms could be purely psychological. These symptoms can mimic any known physical illness but detailed examination would show no signs of the physical illness. The commonest sensory symptoms are, anaesthesia, parasthesia, (either absence or abnormalities in sensation) blindness or deafness, either partial or complete. The commonest motor symptoms are paralysis of various parts of the body, fits of various types and other involuntary movements. The usual visceral symptoms are vomiting, belching spells, hiccoughs, coughing spells, difficulty in breathing. In many cases, the anxiety and concern which the patient has for his symptoms or illness are less than with the actual or apparent seriousness of the symptomatology. Very often, more than the patient, it is the relatives who express excessive concern. The psychological manifestations of Dissociative disorder are: being possessed by evil spirits, God or Goddess; unexplained loss of memory for specific events (Amnesia, Fugue); Attacks of unresponsive spells.

The following points help you to make a diagnosis of Dissociative disorder

a) Acute, dramatic on set of symptoms which appear in front of people. They never occur when the patient is alone or during sleep.
b) In spite of the so-called disabling symptoms, the patient does take care of his basic needs (like food) and does not injure self.

c) There is always a threatening life event (like examination, marriage, quarrel, loss etc) or a situation which is perceived as stressful by the patient.

d) The symptoms can be precipitated by strong suggestion.

Management involves removal of the hysterical symptoms with suggestion and psychological support. Minimal attention should be given to the symptoms. Identify the problem by talking to the patient and family members. Improve the communication among the family members and patient. A physical examination should always be carried out to rule out the possibility of any physical illnesses.

To prevent the relapse of a dissociative symptoms, it is important to identify the stress and help the patient to discuss the same and help the patient to cope with the situation. (See chapter on Treatment of Mental Disorders, for psychotherapy)

**Somatoform Disorders**

Both in rural and urban areas a sizeable number of patients of all age groups, present with multiple physical symptoms which include vague aches and pains in different parts of the body, sensory symptoms, dizziness, weakness, easy fatigability. On examination there will be no medical basis for the complaints even after detailed physical examination and basic investigations. There may be mild symptoms of anxiety and/or depression. There will be history of more than three consultations or investigations in the previous one year. Previous examinations show that the patient is physically normal. Patients usually refuse to accept that the symptoms might be psychological and emphasises that there could be a physical illness. Some may believe that they may have diseases like cancer, heart disease, etc. They often demand drugs or other
forms of treatment. They deny having any stress in their recent past. They are said to be suffering form ‘Somatoform Disorders’. There is greater occurrence of this disorder in females as compared to males.

**Management**

Focus on managing the symptoms and not on discovering their cause. Accept the symptoms as real (Do not call them as malingerers). Discourage them to get pre-occupied with what could be their symptoms due to. Encourage them to talk about their life style and how they manage their needs. Divert their attention on to relaxation, recreational activities. Avoid experimenting with new drugs. Imipramine 25 to 75 mg/day may be helpful.

**Sexual Dysfunction**

Sex is one of the basic needs of human beings. But because of lack of sex-education, majority of our people have many misconceptions and fears about normal sexual activities. They hesitate to take help from doctors as talking about sex is a taboo in our culture. Persons who have problems in the sexual area may present to the doctor with symptoms of anxiety, depression or vague physical symptoms. Only after developing good rapport patient may accept the presence of sexual problems.

1. ‘Sexual Neurosis’ arising out of ‘Masturbation and / or loss of semen’:

Many young men consult their doctors with symptoms like weakness, inability to concentrate, poor memory, becoming sad, lack of interest, sleep disturbance etc., and request for a good tonic. On examination, doctors find them physically normal. When the doctor asks these individuals what is bothering them, they hesitatingly tell that they are in the habit of masturbation, or they have nocturnal emission and they are losing semen. They attribute all their symptoms to this and request for some powerful medicine either to stop the act of masturbation or to restore the ‘damage’ done by the ‘loss of semen.’ There is a belief among people that masturbation is bad for health and loss of
semen leads to loss of potency. The practice of masturbation leads to guilt feelings and also a fear that it may cause impotence. Any natural change in the health due to other psycho-social or environmental causes are erroneously attributed to masturbation. Often these young persons do not feel like consulting the doctor and ‘expose’ their ‘weakness’. They fall prey to self-styled ‘sex healers’ who thrive by exploiting and perpetuating the ignorance. This situation is also contributed by the unwillingness or hesitation of doctors to care for people with sex problems. **Many do not know that nocturnal emission is a natural phenomenon and is harmless.** Masturbation by itself does not have any deleterious effects either on the body or the mind. Masturbation can however, cause a problem indirectly. An individual burdened with misconceptions, excessively worries over it as the cause of his symptoms (which are due to some other causes) and suffers because of the excessive worry. Masturbation can also be an expression of some other problem like excessive boredom or doubt in one’s own sexual potency. Though by themselves, masturbation and loss of semen are harmless, the associated fear and guilt can cause damage not only by worrying about them, but also by leaving the real psycho-social causes of the presenting symptoms unattended.

**Ramesh**, an adolescent boy of slightly below average academic potential appearing for 2nd PUC, comes from a family with very high and strict expectations of his parents to score high marks. He developed somatic symptoms and features of depression like weakness all over the body, fatiguability, lack of interest, forgetfulness, poor concentration. But, he does not know them to be related to his fear of the possible outcome and consequences of the forthcoming examination. Incidentally, he has been masturbating, feeling guilty about it and fears on terrible consequences. He then conveniently (not consciously or deliberately) connects his bodily symptoms to masturbation, and believes them to be related, because of popular lay literature he has read or heard.
These cases can be provided help by the following measures. First, identify the clinical syndrome (viz., depression, anxiety) by detailed enquiry for other clinical features. Secondly enquire and identify the basic psychosocial stressors in the life of the individual. Thirdly, educate, and reassure the patient about the symptoms being unrelated to masturbation. Finally, counsel the patient and his family about the basic causal factors for eg, namely high expectations in studies in the case of Ramesh. Symptomatically if indicated, minor tranquillisers can be used.

2. Sexual Inadequacies:

Some patients can present with premature ejaculation, partial or total impotency, lack of sexual desire, lack of sexual satisfaction. They would have sought help from self-styled quacks and got exploited by them. In many cases the underlying anxiety disorder or depressive disorder may be the cause of sexual inadequacies. Ignorance, misconceptions, guilt complicate the picture. They have to be reassured and properly educated. Treatment is required for the underlying anxiety or depression.

In married patients, the couple have to be counselled initially individually and later on together. The drugs which are sold in the market for these problems are not better than placebo. Therefore it is better not to prescribe them and focus on education and teaching proper skills and social functioning.

3. Psychiatric aspects of contraception:

Reproduction is one of the important and basic functions of life. Naturally any attempt to control or stop this function can generate some amount of apprehension in an individual. Sometimes there may be some complications (both organic and psychogenic) with the use of family planning methods. Individuals can get into conflicts between the age old beliefs and the advantages of a limited family. If a family planning method is forced on individuals without preparing them well to accept it, it can lead to problems.
It is common experience of many doctors that several individuals after undergoing permanent family planning operations tubectomy or vasectomy report a wide range of symptoms starting from vague aches and pains to impotence. They may blame the doctors or the method and become chronic complainers with one or more complaints.

Sexual symptoms are the most commonly reported complaints following vasectomy. It is estimated that in our country, on an average 10% men reported various degrees of sexual inadequacies like poor erection, decrease in desire and sexual frequency. The psychological symptoms reported are irritability, depression, nervousness, lack of concentration, vague aches and pains, discomfort and inability to do hard work. Similarly, a large number of women report to development of menstrual, sexual and psychological symptoms following tubectomy operation.

As a Secretary sequelae of induced abortion, it is observed that women present with symptoms of guilt, regret, depression and anxiety. About 20 - 30% of subjects complain of various kinds of physical, sexual and psychological symptoms after contraceptive methods. These symptoms may arise out of

(i) personality factors

(ii) a form of social protest when decisions are taken not by the individual but by others

(iii) the family planning method becoming a very easily available reason to attribute for a lot of other problems in their life.

With oral pills, it is estimated that 8 to 30% of women report psychological symptoms like nausea, giddiness, vomiting, general malaise, burning sensation, headache, insomnia, decreased sex desire etc, as a result of the effect of the hormones. In all these situations, doctors have a vital role to play. Providing education, removal of the misconceptions, giving emotional support
and being available to understand their needs are important. Good motivation, more effective and simpler contraceptive methods, prompt and timely attention to side effects, regular follow-up, will be of help. A good doctor - individual relationship is important to help these individuals.
VII. Childhood Mental Disorders

‘A healthy child is a happy child’ is a commonly heard saying. Health not only means physical wellbeing, but also psychological wellbeing. As the child grows in age, physical and mental developments also occur.

There are two aspects of behaviour of children. Firstly, they gradually, with increasing age, show increased physical and mental capacities to interact with others in the environment. This is seen in the form of play activity, creativity, learning new tasks and questioning elders about activities around them. Secondly, the presence of some types of behaviours like naughtiness, telling lies, stubbornness and other behaviours considered normal for short periods at different age levels. The striking aspect of childhood behaviour is the acceptance of some types of behaviour as normal, at some age levels, while they would be considered ‘not normal’ at another age. This brings up the issue of how to recognise a child with a mental disorder?

Recognition of children with mental disorders.

Most of the children with mental disorders do not have any physical abnormalities. The following three characteristics of behaviour can help identify children needing mental health care.

(1) A child’s behaviour is not appropriate to age. For eg: when a 10 year old continues to wet the bed, it is considered a problem. When a 14 year old tells lies and doesn’t go to school; but plays with friends, this is a situation needing help.

(2) A child’s behaviour leads to disability: For eg: when a 9 year old does not sit in one place even for a short while, keeps running around, does not attend to simple activities, breaks the toys and other articles in the house and because of this behaviour can not learn anything in the class and fails repeatedly, the child is considered hyperactive and needs help.
(3) A child’s **behaviour is against the social expectations**. For eg: A 13 year old steals a plate from the hotel, or biscuits from the shop, or money from father’s pocket, is considered as a child needing help.

**How common are childhood mental disorders?** Children with abnormal or problem behaviour are about 5-10%. Very often they are not recognised early because people are not aware of this as a health problem. Why do children behave abnormally? There is no single reason to explain a child’s abnormal behaviour. Very often a number of reasons together contribute to the disturbance of the child. Mental disorders in children are caused by (1) psychological factors (2) social factors and (3) biological factors.

1. **Psychological factors**

**Parent-child relationship:** Just as protein and vitamins are necessary for a healthy physical development, so also a healthy parent-child relationship is essential for healthy mental growth. Faulty parent-child relationship can occur when parents neglect the child, or reject the child or overprotect. This makes the child emotionally insecure, or more dependent and lack self-confidence.

**Quarrels between parents:** Homes that have parents who frequently quarrel, beat or abuse one another, make the child insecure. Such a child may start hating one parent of the other and feel that the parents do not care for him.

**Broken homes:** When a parent dies, separates from the family or a step-parent is brought in, children may not be able to adjust to this new situation and manifest this in the form of abnormal behaviour. About 3 out of 4 children with delinquency come from single parent homes or broken homes.

**Discipline:** Excessive disciplining is as bad as no disciplining at all. Both can lead to problem behaviour. Inconsistency in discipline occurs when parents differ in their attitude towards the child. The child’s training suffers and is left to wonder whom to obey. In some instance a child may learn to take advantage of this situation by manipulating one parent over the other.
**Jealousy among the children:** Frequently, because of partiality shown to a sibling or a large age difference between the first and the second child, jealousy can occur. As a result of which, the child might behave in an abnormal manner.

2. **Social factors**

**Poverty:** Poverty is one of the important problems in India. This may occur due to low income, or misuse of the income, as in case of alcohol consumption by a parent. Poverty can prevent the child from going to school, having adequate clothes, toys etc., It prevents the child from getting sufficient to eat. In some situations poverty forces the child to take up a job even when only 8 or 10 years of age. Some children leave home and become street children.

**Unhealthy social environment:** A child living in an overcrowded place with socially undesirable activities around has a higher risk of developing abnormal behaviour.

3. **Biological factors**

**Heredity:** When a child has a family history of mental disorder in the family, the chances of the abnormality occurring in the child are higher. A child with a family history of epilepsy runs a higher risk of getting epilepsy. Anyway most children born to parents with mental disorder do not develop mental disorders.

**Physical problems:** A child who has physical problems like blindness or deafness or other problems may develop other behavioural problems too, because of the physical problem or due to ill treatment by others.

**Illnesses:** Certain diseases of the brain can be associated with behavioural problems. Encephalitis can make the child hyperactive following recovery.
**Low intelligence:** A child who is mentally retarded can develop behavioural problems, because of inability to learn in school or inability to learn personal and social skills or cope with social expectations appropriate to the age.

**Common Mental disorders in children (upto 6 years)**

(1) **Dull and withdrawn** children may be brought by parents with complaints of being dull, withdrawn, less active compared to other children or in comparison to earlier behaviour. This can be due to: (i) mental retardation (ii) physical illnesses or deformity, and (iii) emotional problems. Obtain details regarding milestones of development to rule out mental retardation (see section on mental retardation). Carry out a thorough physical examination to rule out any physical illness or deformity like partial blindness, deafness, etc. Then get details regarding the living situation regarding parents, family and other psychosocial problems. Depending on the cause, management should be planned. If the child is mentally retarded, advise training (see section on Mental Retardation). If there is any physical illness or deformity, plan appropriate intervention. If there are psychosocial problems, try to understand them and help the parents to find solutions for the same. Meanwhile child should be encouraged to get involved in activities with the help of parents and other family members. In difficult cases, specialists' help should be sought, especially when the problem is long standing, occurring in severe circumstances and not responding to therapy.

(2) **Hyperactivity:** Children can be brought for over activity or inability to concentrate and learn specific skills. Over activity may become a problem for others. Such a child may not keep quiet even for a minute. The common causes are mental retardation, minimum brain damage and emotional problems.

Obtain details regarding milestones of development, history suggesting brain damage like difficult labour and birth trauma, meningitis or encephalitis, head injury etc. Get details of any psychosocial problems as in some cases over
activity may be a method of drawing attention of the elders to the needs of the children.

If the hyperactivity is severe, small amounts of tranquillisers can be prescribed, i.e. 25 mg - 100 mg of chlorpromazine or 5-10 mg. of Diazepam. In addition to this, child has to be engaged in doing some attractive and purposeful activity, like making dolls from clay or wet flour, playing with wet sand, drawing or painting, cutting pictures, gardening. Drugs should not be used for longer than 3-4 months. Simultaneously, the psychosocial factors should receive attention.

**Mental disorders of children: (6 to 15 yrs)**

1. **Bed wetting (Enuresis):** Bed wetting is a disturbance of the voluntary control of the urethral sphincter. By about 3 years of age, an average child learns to control the bladder sphincter. However, in some children this control may not been adequately mastered and hence they wet their beds even after 3 years of age. Bed wetting can occur because of other reasons (eg. lack of adequate training because parents are over-indulgent or careless and indifferent). It can also occur as an attention-seeking behaviour or symptom of emotional insecurity in a child.

In all children with bedwetting, any biological or medical reason present should be treated, after a thorough physical examination and routine investigations.

If no medical reasons are found, the following guidelines will help. Clarify to the parents their doubts regarding the reasons for bed wetting. Reduce the quantity of fluids after 8 PM, and give the child dinner earlier. Train the child to visit the toilet before going to bed. And make sure that the child is not frightened by having to go out alone in the dark or to sleep alone in a dark room. Reassure the child before putting to bed. Reward the child in the morning following dry nights. Do not scold, beat or punish the child if he/she
wets the bed. Talk to the child and teach patiently. Attend to the problems of
the child. Imipramine 25 mg at bed time can be of benefit in some cases. This
should not be used for more than 4 weeks at any one time on a continuous
basis. Always review the situation periodically. Refer if not amenable to
treatment in 6 months.

2. Scholastic backwardness: This is one of the commonest problems that
teachers and parents report. A scholastically backward child is one who has
difficulty in coping with the studies in school. This can occur due to (1) mental
retardation (2) some physical illness because of which the child is frequently
absent from school, (3) some specific problems such as difficulty in reading, or
learning to write, or misidentifying letters or the alphabets eg. b for d (4)
sensory deficits like partial blindness or deafness. (5) psychological reasons
such as unhealthy teacher- student relationship, shyness, a critical parental
attitude, constant forcing of the child to study, comparison with other children
etc. You can help these children by assessing the main reason for poor
performance. Attend to the emotional problems and help the child to get
support from parents and teachers. These children may need help of a
specialist initially to identify the specific problem and approach to care.

3. Conversion (Hysteria): Hysteria is a common disorder among children. It
can present with headache, tremors or fits. In conversion reaction there is a
situation that the child finds difficult to cope with and develops symptom. Eg. A
13 year old girl complained of continuous headache for one year. On
interviewing the child and her parents, it was found that the child was being
forced to work in a silk factory because of monetary problems at home, in
spite of the fact the child wanted to continue education. After a hard day’s
work child was expected to do the household work. After about 6 months of
this strain, child developed headache. Following the onset of symptoms
parents were much more considerate, would not force the child to go to work
and gave more attention.
You can help such children by: (1) finding out details of the background situation (2) explaining to the concerned people and thereby reducing the problem, (3) reassuring the parents, about the treatability of the problem, (4) telling the parents not to give the child undue attention, when the child is complaining (5) talk to the child and help to understand the reason as to why the symptom occurs and assist to find different ways of handling the situation.

Other problems seen in childhood are frequent lying, stealing running away from home, refusing to go to school, truancy and stammering. If any of these are present, such children should be referred to a psychiatrist as they require more intensive help.

**MENTAL RETARDATION**

Vidya is a 10 year old girl. She is short. She cannot speak clearly. She cannot put on her clothes, or take bath herself. She does not understand much and has been in the same class for 2 years. Other children think that Vidya is ‘dull’. They do not want to play with her. They at times make fun of her. On talking to Vidya’s mother we find that Vidya is different from her other children. Her development, especially mental, has been rather slow. Her mother says that she behaves like a 4 years old child. Vidya’s brothers and sisters help her to finish her work. Vidya spends most of the time playing outside the house. People in Vidya’s house got worried when she was unable to learn or remember simple things. So they took her to healers, temples and doctors. Medicines given did not help. Nothing has been of use, to make her function as a girl of 10 years.

**What is her problem?**

As we can see, the child is not like her brothers, sisters or other children of same age. The child is one of those children who have low intelligence and are called mentally retarded or of low intelligence. In the common language they are called 'dull' children.
What is intelligence? Let us look at our hands. We can see that all our fingers are not of the same length or even the same shape. Similarly brains of different persons differ in their capacity to solve problems, to learn new things, to remember past experiences or understand new situations. All these functions of the brain, grouped together is called intelligence. Mental retardation is a subnormal state of intelligence. It is not an illness but a condition of poor development of the brain. Children who have this condition are 'mentally retarded'.

About three percent (3%) of the general population are mentally retarded. Mental retardation occurs among every caste, creed and amongst the rich as well as poor.

Normally, a child of a certain physical or chronological age, should have a mental age that corresponds to the physical age. When we find that the mental age is lesser than the physical age, such children are considered to be mentally retarded. Most of the parents of mentally retarded children are able to approximately estimate the mental age of the child. Intelligence of a person is referred to in terms of intelligence quotient (IQ). It is calculated from mental age (MA) and chronological age (CA) as follows:

\[ IQ = \frac{M.A.}{C.A.} \times 100 \]

For example, an 8 year old child with a mental age of 4 years has an IQ of 50. A person of average intelligence has an IQ of 90-110. **Less than 70 IQ is considered as mental retardation.** An IQ more than 110 indicates superior intelligence. 95% of the general population are of average intelligence.

Degrees of mental retardation?

Mental retardation can be classified as mild, moderate and severe degrees.
**Mild retardation:** If the mental growth of the child is more than 1/2 but less than 3/4 of what is expected at that age, then the child is mildly retarded.

**Moderate retardation:** When the mental development is more than 1/4 but less than 1/2 of what is expected for the age the child is moderately retarded.

**Severe retardation:** When the mental growth is less than 1/4 of the age the child is severely retarded.

**Recognition of Mental Retardation**

There are two ways through which a mentally retarded can be recognised.

1. By talking to the parents in detail about the growth of the child.
2. By observing the child’s behaviour and physical appearance.

**Details of growth**

In the case of Vidya, her mother is able to tell that her daughter’s mental growth has been slower than her physical one. Her milestones of development i.e. sitting, walking, talking have been delayed too. Vidya has also been failing in school. Children of Vidya’s age are able to dress up, take bath, avoid dangers like fire or traffic, but Vidya being retarded is unable to do so.

* Mental Retardation (MR) can be recognized from a history of delayed developmental milestones. Following are 4 important normal milestones of development.

<table>
<thead>
<tr>
<th>Holding neck erect</th>
<th>Sitting with Support</th>
<th>Walking</th>
<th>Speaking few words or phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months</td>
<td>6 months</td>
<td>9 months - 1 year</td>
<td>1-1/2 year</td>
</tr>
</tbody>
</table>

* MR can be identified at different stages of growth through the following features.
**Below 5 years** through history of delayed milestones.

**Above 5 years** through history of school failures, behaviour problems, and behaviour not keeping with social expectations.

**Physical appearance**

Children with MR sometimes have certain physical features which make them easily identifiable. These characteristic features appear more in the severely retarded. Mildly/moderately retarded individuals needs not have any physical abnormalities and look like normal children. The commonly seen physical characteristics are: small/large head, light coloured or soft hair, rough skin, slanting eyes, thick protruding tongue. Remember that most mentally retarded children look like other children. One of the easily recognised condition with physical abnormalities is DOWN’s SYNDROME (Mongolism). This condition is due to an extra chromosome. They have features like moon shaped face, slanting eyes and simian crease in the palm. These children are also very pleasant and friendly. The average head circumference is 51 cms. When the head is very small, the condition is called microcephaly. Very large head can be due to hydrocephalus.

**Need to identify mental retardation early:**

Early detection of mentally retarded children is important because: 1) early guidance to parents will result in early training for the child; 2) it can prevent further deterioration, if the mental retardation is associated with epilepsy or any other treatable medical condition, and 3) finally professionals can help parents accept their child’s condition and thus prevent them from spending further on ‘magical solutions’ or looking for medical cures.

**Causes of mental retardation:**

Mental retardation can be caused by a number of factors which occur before birth, at the time of birth, or after birth. A number of these factors can be controlled and in this way we can prevent mental retardation.
Factors before birth: Poor nutrition in the mother, taking medicines without consulting a doctor, infectious illnesses in the mother such as, measles/syphilis, drinking alcohol or smoking are causes which can be prevented. Proper health education to pregnant mothers, telling them about the irreversible nature of the condition and how they can prevent it by taking nutritious food, having check ups from time to time and having the delivery under medical supervision. Children born to mothers above the age of 35 years have a greater risk for Down’s syndrome. Exposure to x-rays in the first trimester can cause foetal abnormalities and mental retardation.

Factors at the time of birth: Complications at the time of delivery can damage the brain. For eg. delayed or prolonged labour, wrong use of forceps, excessive bleeding and the child being unable to breath immediately after birth, history of pre-eclamptic toxaemia/antepartem haemorrhage also increases the risk of the baby being retarded.

Factors after birth: In certain children, the baby may have been normal, at birth but some factors occurring later on in life lead to mental retardation. For eg. poor nutrition in the first 2 years, illnesses such as severe jaundice, high fevers with fits, untreated epilepsy and brain fever can damage the brain cells.

In some families, there can be more than one mentally retarded person. In such situations hereditary factors can play an important role. One of them is cousin marriages.

In many parts of India, like the hilly areas, iodine deficiency causes goitre and Cretinism. Adequate precaution by using iodised salt and early recognition and treatment minimise the brain damage.

Management

Primary care doctors have an important role to play in the prevention and management of mental retardation. Mental retardation cannot be cured by
medicines or any other method. A mentally retarded child or individual can be trained to utilise the available mental capacities to the full.

To help a mentally retarded child, use the following guidelines:

1. Obtain information from the parents regarding what the child can and cannot do.
2. Find out what the parents would like the child to be trained in.
3. Assess the level of mental development of the child.
4. According to the mental age, decide on the target activities ranging from the easiest to the more difficult ones.
5. Divide the identified target activity into sub groups (steps). For eg. If bathing is an activity, first teach the child to hold the mug, then to pour the water on the body, then to use the soap, and finally wash it off. Teach each step at a time and proceed from one step to the next after the mastery of each step.
6. Advice the parents to repeat the same activity every day for 2-3 weeks. or longer till the skill is mastered.
7. Perform each activity with the child rather than instructing to do it on own.
8. Think of ways of teaching each activity as a game.
9. Reward the child, with a sweet or verbal praise every time the child performs the desired activity.
10. Teach the health worker of the area these skills of training and advice them to follow-up these children at least once a month.

It is important to keep a longitudinal and regular contact with these families.
In children with epilepsy or other medical conditions there would be need for medication. Families with multiple persons with mental retardation, refer them to a specialist for genetic counselling.

In certain states (like Karnataka, Andhra Pradesh), aid from the Government is available for severely retarded individuals. You can help the family to obtain this by arranging certification and other procedures from the Department of Social Welfare of the state.

**Referral:** Mentally retarded child need not be referred routinely to a specialist except when the doctor: (1) suspects a physical condition causing mental retardation for diagnosis with investigation. (2) Sees a child with multiple handicaps. (3) has a family with reaction which is not healthy and the family needs detailed counselling and training and, (4) finds the need to carry out genetic counselling.

### SIMPLE GUIDELINES FOR CHOOSING ACTIVITIES FOR A RETARDED CHILD

<table>
<thead>
<tr>
<th>Age Levels</th>
<th>Normal development</th>
<th>Training</th>
</tr>
</thead>
</table>
| 0-2 yrs    | * Recognizing familiar people  
* Walking  
* talking in short sentences  
* Does not drool  
* Can follow simple instructions  
* Can drink from a glass unassisted  
* Can differentiate between edible and none  
* Recognizing & identifying simple objects | I. Provide sensory stimulation.  
* Different colours  
* Different smells  
* Different sounds  
* Different touch  
II. If weakness of limbs provide  
* Massage to the limbs  
* Use wooden cart for walking  
* Follow general guidelines of training and train in different activities |
* Can chew his food.
* Can be toilet trained.

2-4 yrs
* Can help with simple household activities.
* Can avoid simple dangers example: fire.

4-7 yrs
* Can bathe & dress himself.
* Starts playing with other children same as above
* Can write a few words.
* Can do simple calculations.
VIII. Alcohol and Drug Dependence

During the last two decades, alcohol and drug use and abuse have increased in the community because of easy availability and changes in life styles and values. Young people, skilled as well as unskilled workers, people who are in business, administrative jobs use alcohol for pleasure or to forget their worries, to get relief from tensions and pains and as a way of social interaction.

Doctors come across many alcohol related health problems like acid/peptic disease, liver diseases, peripheral neuropathy, accidents and injuries, intoxicated behaviour, memory deficits and alcohol related abnormal behaviour. Recognising the alcohol, abuse or dependence, you would have advised these individuals to reduce or stop taking alcohol. However, most of the persons would have continued drinking. The family members, often request for some treatment so that the individual gives up the habit. It is often thought referral to a psychiatric centre for detoxification and further management is the best help. There are very few such centres and cannot be easily reached by all. In addition the currently available knowledge about use and abuse of these drugs makes it possible for the primary health care doctors to provide the needed care.

Features of abuse/dependence.

Taking small quantities of alcohol beverages at infrequent intervals and taking care not to get intoxicated or lose control of behaviour in public under the influence of alcohol can be considered to be 'normal drinking'. Individuals who abuse or who have become dependent on alcohol also report that they drink limited amount and alcohol is not a problem to them. The following features can identify those with drug dependence:
1. TOLERANCE: The routine amount of alcohol/drug intake fails to give the required effects and the person increases the amount or switches to stronger beverages. Heavy alcohol users can take 300 cc to 2000 cc of liquor per day.

2. PROGRESSIVE NEGLECT OF FAMILY, WORK AND SOCIAL RESPONSIBILITIES: Individuals who were taking good care of the family, working well gradually neglect them. They become irregular to work. The efficiency is decreased. The relationship with spouse, children, colleagues, friends deteriorates. They may shift the social or family commitments to others.

3. DETERIORATION OF HIS MORAL AND ETHICAL STANDARDS: Individuals do not mind telling lies, stealing or cheating others to get money so that they could buy alcohol or drugs.

4. NEGLECT OF ALTERNATIVE METHODS OF RECREATION: Alcohol use or drug use becomes the main method of enjoyment and spending free time.

5. HEALTH PROBLEMS: Individuals develop using drugs various symptoms related to GI system, nervous system and cardiac and other body systems. They can sustain injuries and fractures. They can have angular stomatitis and soar tongue. Memory deficits, suspicious ideas towards spouse and colleagues, irritability, depression, hallucinations are some of the psychiatric symptoms seen among those using alcohol and drugs for a long time.

6. PROBLEMS WITH LAW: They can get arrested for drinking and driving, physical fights with others or such other law-breaking activities.

7. WITHDRAWAL SYMPTOMS: On stopping use or delay in intake symptoms like craving, tremors of hands, sleeplessness, aches and pains, restlessness, sweating, are reported. Most of these experiences are relieved by drinking alcohol or taking drugs for a temporary period.
At the end of this chapter a simple tool namely Alcohol use Disorder Identification Test (AUDIT) to help identify problem persons with hazardous use of alcohol. A score of 5 or more is significant and require help.

**Aetiology**

Many factors play a role in leading individuals to abuse or to become dependent on drugs.

1. Genetic factors
2. Personality disorders (psychopathic/anti-social personality disorder are more prone to drug dependence)
3. Easy availability and social acceptance of use
4. Recurrent or chronic anxiety or depressive disorders
5. Recurrent or chronic physical problems
6. Other underlying psychiatric disorders like Schizophrenia, Manic-Depressive psychosis.
7. Family and occupational stresses.

**Management**

1. **Identification:** Early identification is most important. Individuals (who present with recurrent gastritis, jaundice, deficiency states, repeated injuries or husbands of women who are depressed or known individuals who accept that they drink, it is important to find out the amount and frequency of drinking, its effect on family, finance, work and social status. Enquire for tolerance, craving, withdrawal symptoms and to look for physical and mental health complications. (use AUDIT for screening).

2. Check for motivation of the person to give up drugs. If the individual is willing for treatment, understands the hazards of drug use and if the
withdrawal symptoms are not very severe, or there are no severe physical problems, you can start DETOXIFICATION on an outpatient basis. For detoxification of alcohol dependence,

a) Give Diazepam or Chlordiazepoxide 60 to 100 mg in divided doses. Reduce by 10 to 20 mg a day and stop at the end of the week.

b) Start him on injectable Vitamin B1, 100 mg IM every day for 10 days.

c) Give oral vitamin B1, B6, B12 Tab or Capsule every day for a month.

Treatment of other physical problems like dehydration, gastritis is also important. Advice the patient and family members to avoid situations and people who encourage the individual to take drugs. Alternatively, engage the individual in useful activities and healthy recreation.

Psycho-education: Education of the patient, family members and the significant others (friends, colleagues) regarding (1) how alcohol and drugs are not necessary and their harmful effects, (2) how to avoid factors which promote drug abuse, (3) how to say no to alcohol and drugs in those situations, (4) developing healthy methods of recreation and (5) how to mobilise social support to the patient to reduce or solve the life problems in the areas of family, finance, occupation and relationships.

The involvement of the spouse and other family members to understand the ill individuals and to reorganise family life to lead a drug free life is very important. Most drug dependent persons require long term follow up support.

**Referral:** Referral to be made when the withdrawal symptoms are severe, if the patient is not confident of controlling drug taking behaviour, if physical or mental health problems are of serious nature, such patients need inpatient-detoxification. Refer him to a psychiatric centre closed to you. In addition to detoxification, you have to look into psychiatric co-morbidity like depression,
anxiety. Depending on the clinical condition anti-depressant drugs can be given for 2 to 3 months (see chapter on Depression).

In addition refer the patient to a psychiatric centre if the person is having the following psychiatric complications:

1. Severe delirium tremens (severe withdrawal symptoms with alcohol)
2. Korsakoff’s Wernicke’s Encephalopathy (Confusion, ataxia, cranial nerve palsy (III, IV & VI) Peripheral neuropathy, hallucinations, memory loss etc)
3. Associated paranoid state and dementia
4. Neurological complications

**Prevention**

All medical doctors can play a vital role in the prevention of alcohol and drug abuse by educating the target groups like students, teachers, young adults, workers, members of voluntary agencies, about the harmful effects of alcohol and drugs.

In addition to alcohol dependence, at the level of the primary health centre, you can come across individuals who abuse cannabis (ganja, bhang) sedatives and tranquillisers (Diazepam, phenobarbitone) pain killers (aspirin, ibubrufen) and opiates (Fortwin, Tidigesic injection).

Many features described earlier hold good for these substances. Management of these dependence situations follow the principles outlined namely (i) recognition of the need to live a drug free life, (ii) detoxification, (iii) assessment of individuals personal, social and occupational life, (iv) support to individual, (v) involvement of family, (vi) rehabilitation and (vii) long-term follow up.
Common misconceptions about alcohol:

- Alcohol is a tonic, improves the muscle power.
- Alcohol is a medicine, cures cough, cold, prevents paralysis etc.
- Alcohol improves sexual power.
- Alcohol improves creativity.
- Alcohol is the best sedative.
- It is possible to have controlled drinking.
- Taking good food (meat) takes away the ill-effects of alcohol on the body.
- Alcohol is the best pain killer.

Please discuss these issues with patients and others and educate them.
IX. Epilepsy

Epilepsy is a disorder of the nervous system in which altered level of consciousness occurs whenever there is disturbance in the well ordered functioning of the neurons in the brain most often due to electrical disturbances. The most characteristic aspects of epilepsy are the repetitiveness and recovery after an attack. Epilepsy can start at any age. In majority of the cases, it starts in childhood or adolescence. The common causes of epilepsy, in India are: (i) birth injury, (ii) difficult labour, (iii) brain infections and (iv) head injuries. In many cases it occurs without any clearly identifiable cause. It is estimated that in the general population about 8 to 10 persons in 1000 have this problem at any one time.

TYPE OF EPILEPSY: There are 3 common types of epilepsy:

1. Grandmal or Generalised epilepsy
2. Focal epilepsy (including temporal lobe epilepsy)
3. Focal epilepsy becoming generalised.

Grandmal Epilepsy

Recognition of epilepsy: The most important aspect of diagnosis is the need for a very good and clear history. It is not always possible for the doctor to have an opportunity to see an actual ‘fit’ in a given patient. In view of this, it is important to talk to the family members of the patient who have seen one or more ‘fits’. It is not adequate to depend on the information given by the patient as patients do not always have memory for details of the ‘fit’. On talking to a relative; the history provided would include a description, as follows:

“The attack or the fit occurs suddenly. The attack occurs at home, school or place of work. Patient falls down and loses awareness of surroundings (unconsciousness). This is often associated with a loud cry. During the attack
face is noted to be red and the eyeballs are rolled up. This is followed by a short period of few seconds when the whole body becomes stiff. Soon the hands, legs and rest of the body move in a rhythmic manner (jerky movements). At this stage frothing in the mouth is also noted. At times the wetting of clothes with urine is seen. Patient does not respond to what others are saying or doing during this time. Gradually the jerky movements become less and the patient becomes completely still and goes off to sleep. On waking up patient is not aware of what happened to during the attack. Patient complains of bodyaches, fatigue, headache and prefers to take rest. Sometimes, after an attack patient remains confused and behaves abnormally for a short period”.

In some patients, before the fits there are some clear changes like becoming dull, irritable, complaining of headache, smacking of lips and staring at blank spaces. These changes suggest that patient is likely to get an attack. If a definite pattern is noted then patient can prevent harm during attack, by reaching a safe place on experiencing these symptoms.

**Focal epilepsy:** The convulsions (jerky movements) start in one small part of the body like the hand or leg, or a side of the face and they either remain confined to that part only or are followed by a generalised epileptic attack.

**Temporal lobe epilepsy (TLE):** Unlike in grandmal epilepsy, loss of consciousness is not the striking feature. Patient behaves in an abnormal manner for a few minutes in which the patient appears to be angry, apprehensive and carries out repetitive purposeless activities for which the patient has no memory. In between the attacks patient is completely free of any disturbance. Patient may also experience hearing of voices, see visions or smell foul odours. It is often mistaken for psychosis but can be recognised as TLE by its very short duration, normalcy in between the attacks and repetitive nature of the attacks. It is because of the behaviour changes that predominate the presentation, it is also known as psychomotor epilepsy.
It is important to talk to a relative who has seen the fit to arrive at a diagnosis. Following questions help in arriving at a diagnosis:

1. What is the duration of each attack of fits?
2. What is the frequency? When and where it occurs?
3. Any injury occur during the attack?
4. Description of the attack step by step and post-fit-symptoms.

**Differentiation from hysterical fits:** Primary care doctors will be seeing other patients having attacks of fainting or anxiety which can be mistaken for epilepsy. These fits occur due to emotional problems. In these patients the characteristics of the fits are different.

<table>
<thead>
<tr>
<th></th>
<th>Epilepsy</th>
<th>Conversion Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precipitating factor</td>
<td>Usually absent</td>
<td>Emotional precipitating factor almost invariably present.</td>
</tr>
<tr>
<td>Nature of attack</td>
<td>Conforms to a specific pattern</td>
<td>Attacks are bizarre and do not usually conform to a pattern.</td>
</tr>
<tr>
<td>Place of attack</td>
<td>Anywhere</td>
<td>At specific places like at home or school.</td>
</tr>
<tr>
<td>Duration of attack</td>
<td>Usually lost for 2-3 minutes</td>
<td>Variable: often prolonged beyond 15 minutes.</td>
</tr>
<tr>
<td>Tongue bite</td>
<td>Present</td>
<td>Absent</td>
</tr>
<tr>
<td>Injury</td>
<td>Present</td>
<td>Absent</td>
</tr>
<tr>
<td>Incontinence</td>
<td>Present</td>
<td>Absent</td>
</tr>
<tr>
<td>Post-fit symptoms</td>
<td>Present</td>
<td>Absent</td>
</tr>
<tr>
<td>Consciousness during attack</td>
<td>Absent</td>
<td>Patient can recall events</td>
</tr>
<tr>
<td>Attacks during sleep</td>
<td>Present</td>
<td>Absent</td>
</tr>
<tr>
<td>Attacks when alone</td>
<td>Present</td>
<td>Absent</td>
</tr>
</tbody>
</table>
Neurological deficits may be Present Absent
Effect of suggestion Suggestion fails to induce an attack Suggestion can often precipitate an attack

### Differentiation from Syncopal attacks

<table>
<thead>
<tr>
<th></th>
<th>Epileptic seizure</th>
<th>Syncope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precipitant</td>
<td>Unusual</td>
<td>Usual</td>
</tr>
<tr>
<td>Circumstances</td>
<td>Variable</td>
<td>Usually upright posture: in crowded hot surrounding or emotionally stressful situation.</td>
</tr>
<tr>
<td>Onset</td>
<td>Usually abrupt</td>
<td>May be gradual with faintness</td>
</tr>
<tr>
<td>Motor phenomenon</td>
<td>Tonic or tonic-clonic</td>
<td>Usually placid without Movement</td>
</tr>
<tr>
<td>Skin Colour</td>
<td>May be pale or flushed</td>
<td>Usually pale</td>
</tr>
<tr>
<td>Respiration</td>
<td>Stertorous/foaming</td>
<td>Shallow slow</td>
</tr>
<tr>
<td>Incontinence</td>
<td>Common</td>
<td>Rare</td>
</tr>
<tr>
<td>Tongue biting</td>
<td>Common</td>
<td>Rare</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Unusual</td>
<td>Often</td>
</tr>
<tr>
<td>Injury</td>
<td>Common</td>
<td>Rare</td>
</tr>
<tr>
<td>Postical</td>
<td>Often drowniness/confusion/sleep</td>
<td>Rapid recovery without confusion</td>
</tr>
<tr>
<td>Duration</td>
<td>2 to 3 minutes</td>
<td>Usually 10 seconds</td>
</tr>
</tbody>
</table>

**Diagnosis of epilepsy is made from a reliable and good history**

There are no diagnostic laboratory tests to arrive at a diagnosis. X-ray skull, EEG, C.T. Scan etc., can help to find out associated brain-pathology which is found in some cases only. These investigations are indicated in patients of focal fits, late onset (above 20 years age) epilepsy, and epilepsy with neurological findings on physical examination.
**Presentation of patients:** It is possible that the doctors are not seeing these patients at present. This is for two reasons - (i) people do not think of it as a health problem and (ii) the hospital pharmacy may not contain the needed medicines for treatment. Once the treatment is available and public is educated, they will start coming to for the control of epilepsy. In addition, the doctor should think of underlying epilepsy when seeing patients of i) repeated burns and injuries, ii) children with mental retardation, iii) abnormal behaviour lasting for a few minutes only, either with or following fits, iv) poor school performance. In addition you may hear of a person who is taking treatment from traditional healers for being ‘possessed by evil spirits’. These persons can be having epilepsy.

**Help in acute attack - First Aid:** It is important to teach everyone in the community to provide first aid, when they see a person having an attack. It is important to make the person comfortable. No crowds should gather around the person. Sharp and dangerous objects, if they are near the patient should be removed. Loosening the clothes is another way of making the person comfortable. Turn the face to one side (this will bring out the secretion from the mouth). Do not pour water or put anything else into the mouth during the fits. Similarly do not try to hold arms or legs when they are showing jerky movements. The attack will usually last for 2 to 3 minutes only and then the person will go to sleep. Patient may become confused for about 30 minutes. Stay with the patient during this time and on recovery help him to reach home. Both these conditions will improve by themselves in a short time, usually within one hour. There is no need to place an iron object in the hands of the patient.

**Management:**

The following regime is to be followed for the treatment.

**Only one attack:** Wait to start treatment. Ask the patient to report if there are further attacks.
At least two attacks in 6 months: start treatment.

Start the treatment with one drug like - Phenobarbitone which is effective and least expensive. Start with a small dose depending on the age. For example:

- 3 years - 15 mg single bed time dose.
- 3-10 years - 30 mg single bed time dose.
- Above 10 years - 60 mg single bed time dose.

It is important to give the following instructions to the patient and family, taking care to see that they are fully understood by the patient and family members. (i) Take the prescribed medicines at bed time, regularly, not missing even a single dose, (ii) patient can feel drowsy in the beginning of the treatment. This should not lead to any change in drugs dosage without discussing with the doctor, (iii) missing of dose can result in an attack. Keep stock of medicines for at least two weeks at any time, (iv) keep medicines in a safe plastic container to avoid misuse or accidental use by others especially children, (v) keep a small book and record all the attacks, (vi) regular follow-up is essential for the adjustment of dosage and assessment of any side effects, (vii) visit the doctor in the beginning once a fortnight, later on once a month, (viii) till the attacks are fully under control do not work near fire, water, moving wheels, do not climb trees and do not drive vehicles, (ix) there are no food restrictions as part of treatment, (x) patients can continue all routine work (going to school, work etc.) and lead a normal life.

Drugs have to be taken for a minimum period of 3-5 years after the last attack of ‘fits’.

Follow-up

If the patient reports that there has been attack while on regular treatment, during the follow-up visit, (1) Check whether taking of medicines in the required dosage has been regular; (2) Enquire about any precipitating factors
like fever, alcohol intake, sleepless nights, missing a meal, and advise about maintaining regular habits; and (3) Rule out hysterical attacks by enquiring about the reaction of the family and life situation. **(It is good to remember some individuals can have a situation of both genuine and hysterical fits.)** Provide support to the patient and family.

Following clarification that the patient is really getting epileptic attacks in spite of regular medication, step up the dose by 30 mg. You can go up to 180 mg a day in an adult. If attacks are not controlled in 4-8 weeks, add **Diphenyl Hydantoin 100 mg/day.** Increase it to 300 mg if necessary, in adults. Another drug that can be used in epilepsy is Carbamazepine. It is comparatively expensive.

When the patient is attack free for **3 to 5 years** continuously, (that is 3-5 years from the last attack) then gradually taper the dose and stop the medication over 6 months period. In case of relapse, drugs are to be restarted and continued for another 3 to 5 years. In some patients, especially with brain damage drugs may need to be continued lifelong.

**Refer the patient to a specialist** if attacks are not controlled in spite of the above treatment for 6 months and if the patient develops some neurological signs like paresis, ataxia, nystagmus, confusion or forgetfulness.

**Long term complications with drug:** In majority of the cases there are no major side effects, no serious complications with long-term use of Phenobarbitone. With Diphenyl Hydantoin some can develop hypertrophy of gums, excessive hair growth after long term medication. A few can develop ataxia and nystagmus, which disappear after reducing or stopping the drug.

**Status epilepticus:** Sometimes patients can “have repeated attacks continuously without regaining consciousness in between the attacks. They will be brought to you as an urgent problem. **This is a medical emergency.** Give Diazepam 5 to 10 mg i.v. slowly. Following the Inj. Diazepam i.v, patient
will also have to be given Phenobarbitone 200 mg. intramuscularly. In most cases, these steps will stop the attacks. In case the attacks are not stopped, patient should be referred to a specialist. It is advisable to hospitalise a patient of status epilepticus and keep him under close observation. Adequate attention should be given to his nursing needs especially during the period of unconsciousness. Once the fits are controlled, the parenteral antiepileptics will have to be replaced by regular oral antiepileptic medication.

**Febrile convulsions:** At times children of age group 6 months to 5 years are brought with a history of fever and fits. If the child has status epilepticus, has family history of epilepsy and frequent attacks of fits with mild fever, start anti-epileptic treatment. Otherwise do not put the child on that treatment. Reassure the parents. Treat the cause of fever. Advise them to bring down the temperature in future episodes of fever by antipyretics, tepid sponging. If the child gets an attack without fever, start treatment, as per earlier guidelines.

**Psychiatric problems associated with epilepsy:** Compared to general population, patients with epilepsy, suffer more often from psychiatric morbidity like mental retardation, behavioural problems, depression, anxiety, hysteria, organic psychosis. They have to be identified and managed. (See relevant chapters in the manual).

**Individual and community consequences:** Epilepsy can affect persons of all ages. The epileptic attacks of an individual can make him look different to others and this can create difficulties and inferiority feelings. In addition, the general beliefs in the community about the disease being infectious or hereditary can create problems at work and marriage. During the fit individuals get hurt and this may result in disabilities. If the fit occurs in the middle of the road, or near water or fire, or while working near moving machines, or heights, it can be at times fatal. **The importance of controlling fits lies in decreasing harm to the individual, preventing social stigma, improving his social functioning, and minimising the damage to the brain.**
Helping families to live with epilepsy: When a person is suffering from epilepsy, parents and family members become panicky and they look for a reason for the illness. Sometimes parents get too anxious and overprotect to the extent the child is made an invalid. In these situations there is a need for guidance and counselling to the parents in the management and rehabilitation of the person with epilepsy. In the beginning, parents of the patient may not be willing to accept the treatment for want of information. At this stage, talk to them, not once or twice but many times, and try to make them realize that it is a disease and with treatment patient will get better, stop having the attacks and work properly. It is important to convey that the disease is not infectious or contagious. In all cases, an optimistic picture can be shared. These persons can lead the life of a normal person after getting better with the control of illness through regular medication.
X. Treatment of Mental Disorders

In an earlier section, it was noted that mental disorders are caused by a variety of factors. Hereditary factors, changes in the brain chemistry, unhappy childhood experiences, conflict in the family, various real life stresses and strains, social problems and many other factors interact to produce the symptoms of mental disorders and the various clearly defined syndromes.

It is often widely thought that mental disorders cannot be treated and no specific methods exist for the management of mentally ill persons. People are reminded of the situation in the past when in mental hospitals mentally ill persons stayed for very long periods of time, sometimes for life. As a result all types of mental disorders were equated with chronic psychoses. But during past few decades, major advances have taken place in the understanding and management of different types of mental disorders. These significant developments have contributed to more satisfactory and effective treatment for many of the mental disorders. For example, prior to the availability of specific treatment only 13% remitted after a schizophrenic episode while now less than 15% become ‘chronic’ and the rest recover to varying degrees.

There are mainly two basic approaches to the management of mental disorders; namely the psychosocial and the physical or biological or pharmacological. Both these methods may be used either separately or jointly. In each patient a careful understanding of the factors involved in the illness will help the doctor decide the specific approach required for satisfactory treatment.

The following section covers the different treatment approaches.

A. Psychological management.

B. Drug management
C. Family and mental health care

D. Rehabilitation.

E. Psychiatric emergencies and hospitalisation.

F. Legal aspects of psychiatric care.

A. PSYCHOLOGICAL MANAGEMENT (PSYCHOTHERAPY)

As part of general medical practice doctors come across patients who relate their life problems. Very often patients who come with vague bodily complaints have the tendency to talk about their various concerns and worries to their doctor. Most doctors are generally not very comfortable in providing care to these groups of patients with ‘real- life stresses’. Doctors have difficulty in taking the role of a counsellor or the psychotherapeutic aspect of their role as a doctor. This is largely because, undergraduate and post-graduate medical training does not prepare the future doctors or specialists to recognise and care for the emotional needs of their patients.

Psychotherapy essentially attempts to restore the emotional equilibrium of a person in distress by psychological means. It involves very simple measures like listening to a person in distress about his difficulties, understanding the nature of the problems and talking to the person. An authority in this field has said ‘Psychotherapy to a large degree is nothing but a systematic conscious application of methods by which we influence our fellow men in our daily life. The most important difference is that intuitive knowledge is replaced by the well established general principles of psychodynamics’. There are different major schools of psychotherapy which have developed specific techniques for specific types of mental illnesses with specific goals. While the various psychotherapeutic techniques and methods are important for a specialist in the field of mental health, all doctors can become familiar with the basic principles involved in counselling and psychotherapy. A separate Manual of Psychotherapy for medical officers by Sriram T.G., Chandrasekhar, C.R.,
Isaac, M.K. and Srinivasa Murthy, R. (1990) has been published by NIMHANS, Bangalore.

The type of psychotherapy useful in general medical practice is the ‘brief supportive psychotherapy’. The fundamental prerequisite for a successful therapy is a relationship between the doctor and patient of trust and confidence. All doctors must always be conscious of their therapeutic capability and for making changes in the patient. Doctor should give ample chance for the patients to ventilate their problems and unburden their anxieties, worries and complaints. In general medical practice, though the drugs play an important role, counselling the patients about various diet, relaxation and other preventive measures is useful. In medical problems, the nature of counselling is obviously one of telling the patient precisely what to do and what not to do. But with psychiatric patients, the nature of counselling is considerably different, because (i) though medicines have a definite role in few psychiatric conditions like psychoses, for the large majority of patients and their psychiatric conditions the cause will be related to psychosocial situations which vary with each individual. Therefore, generalised formulation of simple and precise do's and don'ts is not possible; (ii) in general medical practice, an individual suffering from, say a fracture, is assumed to have an adequate and well functioning mental framework with which to carry out the doctors advise. In psychiatric patients, the mental framework which has to carry out the doctor’s instructions / advice can be disturbed; like lack of will to live or to struggle or to face reality; (iii) most psychiatric patients may have been unable to adequately perceive and understand what the real cause of their suffering is, and how to go about solving it. Most often patients will not be in a ready frame of mind to understand it even if told what the doctor thinks of it. In such instances, it would become necessary for the doctor to proceed in simpler steps by gradually preparing the patient at each stage to understand the next step.
THERE ARE A FEW POINTS WHICH THE DOCTOR SHOULD ALWAYS REMEMBER:

Though **reassurance** is a very useful method, and has a definite role in counselling, most often it does not work, because, what is really important in reassurance is what and what not to reassure, and how to reassure. What not to reassure? About what the doctor has no control like,

i) the **course of the illness** that is not known, or not predictable. For example, if the patient has an anxiety state due to various factors related to difficult interpersonal problems in the family, neither the patient nor the doctor has any real or direct control over what might happen; ii) **Efficacy of drugs**, especially when the problems are psychosocial. E.g. in the above, though the anxiolytics may reduce the anxiety temporarily now and then, the family interpersonal problems may continuously keep the patient’s anxiety high; iii) **Philosophical statements / consolations**. Almost all patients will have already known them and will usually have used it themselves for self-consolation. Their relatives and friends will usually have also used similar statements without relief. **What to reassure?** About what the doctor and patient have control like i) Doctor’s best and sincere efforts, availability, concern and help; ii) patient’s ability to get over the difficulties. Every patient’s life history will contain instances of some successful struggle or other, however modest. These instances can be feedback to the patient to boost up his self-confidence and morale; iii) when the doctor is certain, in any given case, what and what not to reassure, and iv) after the patient has unburdened all his problems (when the patient has not yet completed saying all he wants to say, reassurance is useless because he is not yet ready to listen).

**How to reassure?** Methods to convey the message of reassurance.

This has to be learnt by practice and experience. Most often, doctor is the only person the patient can possibly talk to about the problems (the doctor is generally believed by patients to be a person who will listen to their difficulties
without making a judgement). If this need is satisfied with sympathy, patience, and tolerance, more than half the treatment can be considered completed.

Effective counselling has three stages or phases:

i) **Identifying the problem.** Symptoms are not problems, they are only manifestations of some other problem,

ii) **Feeding back to the patient** about the relationship between the problem and symptoms. Enquiring further about the problem.

iii) **Helping to deal with the problem.**

**Identifying the problem**

First, clue to the problem is related to the stress before the onset of symptoms. But generally patients do not, remember that stress, but will only remember the symptoms. Therefore, first elicit the date (or period) of onset of the symptoms to as much a degree of accuracy as possible. Then, separately enquire about patient’s life history, important events around that time and their dates.

Doctor should relate possible immediate relationship between any event and the onset of symptoms. Once a possible stress event is elicited, further enquiries should be made to confirm it. E.g. if the headache had started during summer 2 years previously, and if the doctor finds during the enquiry that the patient conducted daughter’s marriage 2 years ago, then enquiries along the following line will confirm the presence or absence of the stress factor: “When you conducted your daughter’s marriage, did you have headache at that time? How many days/weeks before marriage, or how many days/weeks after that marriage did your headache start?”
Feeding back to the patient

Feeding back to the patient the symptom-stress relationship is the next step. This feed back in the form of questions are better than statements namely; “it is important that your headache started the day after your daughter’s marriage”, or “have you observed how your headache started the day after your daughter’s wedding? and have you thought about it?” Many times, patients deny such a relationship when doctor mentions it to them. Doctor should not worry, or feel hurt that an important discovery is not accepted. Such denial only means that the patient is not yet ready to perceive and understand the implications of such a relationship. However, by continuing the enquiry about the ‘identified stress’ can eventually lead the doctor and the patient to the underlying problem. E.g. in the above example of the daughter’s marriage. “How was the marriage arranged? How did you manage the finance? Was everybody happy with the alliance? Did the marriage go on successfully?”

Helping the patient to deal with the problem

Enquire from patient what steps patient has already taken to deal with it, and what the outcome was. Enquire from patient what alternative steps have been considered. What the advantages and disadvantages of those alternatives are? If appropriate, doctor can suggest alternatives that are consider appropriate. Reinforce patient’s inherent abilities to cope with problems, to boost confidence and morale.

Family problems: Frequently, the doctor during his management of a psychiatric patient will come to know that some family problems are operative in a given case. The principles of counselling outlined above should be used, but the following points must be kept in mind. Avoid becoming a messenger among family members. If the patient complains to you about the spouse, then do not see the spouse separately. The other partner may complain to you
about the patient or other family members eg: mother-in-law. This approach will in no way solve the problem.

**Preferably**, see the concerned family members together. Avoid taking sides. Maintain strict, yet sympathetic neutrality. Also, avoid becoming a judge and passing judgements like wrong or right. The aim of counselling the family will be to make all the concerned family members understand the relationship between the nature of problem, its stress and the manifest symptoms, and the help the family members make joint efforts to get over the problem.

In helping individuals with psychological methods of treatment, it is important to remember that it takes time to see results. It is best to plan to see the patient and his family members on a regular basis for a few weeks. If at any time, counselling the patient or family seems difficult or you do not feel comfortable, or no improvement occurs after 12 weeks of therapy refer to a psychiatrist. In addition, refer patients to a specialist when you find that (i) it is not possible to identify stresses, or there are too many stresses, (ii) the support from the family members is difficult to obtain, (iii) the complaints have been present for many years, (iv) there are associated significant physical illnesses, and (v) your efforts are not providing relief even after seeing the patient for 8-12 weeks.

**DRUG MANAGEMENT**

Drug treatment for mentally ill persons is available only of about forty years. Chlorpromazine, the pharmacological agent for the treatment of severe types of mental disorders was the first drug to be discovered for use in psychiatric practice, in 1952. The discovery revolutionized the treatment for chronic and severe mental disorders and facilitated the discharge of large number of mentally ill persons from the custodial mental hospitals in Europe and America. Subsequent to the discovery and large scale use of chlorpromazine, the late fifties and the sixties saw the discovery of a series of new pharmacological agents. Many of them are presently in use. The experience
of last four decades has clearly demonstrated their usefulness and their relative safety.

The most commonly used drugs fall into three major categories; 1) Antianxiety drugs - Anxiolytics or Minor Tranquilizers 2) Antidepressants and 3) Antipsychotics - Major Tranquilizers. These drugs may sometimes be used in combinations too. This section deals with the various pharmacological agents, their strengths, dosage ranges, side effects and management of side effects. The list is restricted to suit primary health care level of work.

1. Anxiolytics (Minor Tranquilizers)

Anxiolytics are effective for symptomatic relief of neurotic conditions wherever symptoms of anxiety are present; like sweating, tremors, palpitations; they also facilitate sleep. Their effectiveness as sole curative agents is however very restricted to those conditions where the anxiety symptoms are of a) very recent origin, b) the patient has in the past shown ability to cope adequately with stress, and c) there are no severe and prolonged interpersonal / familial problems. In all other cases, the role of anxiolytics is limited, and the management must necessarily include psychotherapy and family counselling. In such cases if symptoms of anxiety are severe, anxiolytics can be used only as adjuncts to other modes of managements.

<table>
<thead>
<tr>
<th>Pharmacologic Name</th>
<th>Tablet Strength</th>
<th>Some (Proprietary) Trade names*</th>
<th>Daily Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diazepam</td>
<td>5 mg</td>
<td>Diazecalm</td>
<td>5 mg to 15 mg</td>
</tr>
<tr>
<td></td>
<td>2 mg</td>
<td>Calmose</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Valium</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paxum</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Calmod</td>
<td></td>
</tr>
<tr>
<td>2. Nitrazepam</td>
<td>5 mg</td>
<td>Nitravet</td>
<td>5 mg to 15 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nitrosun</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypnoris</td>
<td></td>
</tr>
</tbody>
</table>
### Table: Benzodiazepines

<table>
<thead>
<tr>
<th>Drug</th>
<th>Strength</th>
<th>Trade Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam</td>
<td>1 mg, 2 mg</td>
<td>Larpose, Ativan, Trapex, Lorel, Calmese</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlordiazepoxide</td>
<td>10 mg</td>
<td>Librium, Equibrom</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alprazolam</td>
<td>0.25 mg, 0.5 mg, 1.0 mg</td>
<td>Alzolam, Anxit, Alprax, Zoldac, Zolax</td>
</tr>
</tbody>
</table>

*Some trade names are given for the convenience of doctors. This does not mean that these preparations are better than others. Doctors should get familiarised with local trade names of the drug which are less expensive. The same applies to other trade names given elsewhere.*

Usually more than 15 mg per day of diazepam should not given as it can cause drowsiness, lethargy and ataxia.

*(Intravenous diazepam is very effective in cases of status epilepticus. The injection must be given slowly.)*

Hypnotics should be used **sparingly**. They facilitate sleep in conjunction with antidepressants in cases of severe insomnia. The word ‘sparingly’ is deliberately emphasised because (a) prescription merely of a hypnotic to an insomnic person will do nothing to his problems which are causing insomnia and there is danger of the individual **learning the habit of taking hypnotics** instead of dealing with the problems. If this happens doctors will be contributing to the individual's escape from healthy and legitimate responsibilities, (b) in majority of instances, insomnia will automatically set itself right either when the underlying problem is adequately dealt with or when anxiety or depression is treated.
Pharmacological name of a useful hypnotic is Nitrazepam. Concomitant use of alcohol and hypnotics will cause excessive drowsiness and should be avoided.

II. Antipsyhotics (‘Major Tranquilizers’)

Antipsyhotics are effective in the treatment of psychoses like schizophrenia and mania. It is also useful in those cases of depression are also present, when psychotic symptoms also in alcoholic psychoses, and in organic and epileptic psychoses.

<table>
<thead>
<tr>
<th>Pharmacological Names</th>
<th>Strength</th>
<th>Some Trade Name</th>
<th>Equipment Dose</th>
<th>Daily Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine</td>
<td>25 mg</td>
<td>Largactil</td>
<td>100 mg</td>
<td>100-300 mg</td>
</tr>
<tr>
<td></td>
<td>50 mg</td>
<td>Emetil</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100 mg</td>
<td>Sunprazin</td>
<td></td>
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<tr>
<td></td>
<td>200 mg</td>
<td>CPZ (Micro)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>5 mg</td>
<td>Espazine</td>
<td>5 mg</td>
<td>5-15 mg</td>
</tr>
<tr>
<td></td>
<td>10 mg</td>
<td>T.F.P</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neocalm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relicalm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td>1.5 mg</td>
<td>Larnase</td>
<td>1.5 mg</td>
<td>5-15 mg</td>
</tr>
<tr>
<td></td>
<td>5.0 mg</td>
<td>Tividol</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10.0 mg</td>
<td>Relinase</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Serenace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluphenazine Deconate</td>
<td>25 mg</td>
<td>Anatensoldeconate</td>
<td>25 mg 1M</td>
<td>25 mg 1M given once in 2 to 4 weeks</td>
</tr>
<tr>
<td></td>
<td>per 1 ml</td>
<td>Fludecan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prolionate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The maximum therapeutic doses mentioned above should not be given in the out-patient setting. In case of Depot Phenothiiazone: (a) it is used general as a maintenance medication for schizophrenic psychoses-chronic type, (b) the dose is adjusted by altering the interval, and between 0.5 ml and 1 ml.

The different antipsyhotics are equally effective when used in equivalent dosages. It is best to become familiar with one antipsyhotic (Chlorpromazine) and use it as first level drug.
These antipsychotic drugs have differing degrees of sedative effects, and this can be made use of to meet special clinical requirements like (a) when severe insomnia is a predominant problem and (b) the patient has to attend work during daytime. The sedative effect of the drugs is mentioned in decreasing order.

- Chlorpromazine  - Most sedation  
- Thioridazine  
- Trifluoperazine  
- Haloperidol  - Least sedation

It is to be noted that no important differences in effectiveness have been demonstrated among the various antipsychotic drugs mentioned above. The differences are related to sedation and the variation in the incidence of side-effects. Some patients whose symptoms fail to respond to one of the drugs will respond to another. The reasons for this are obscure.

**SIDE EFFECTS**

The following are the side effects of the antipsychotic drugs:

(i) **Minor and transient;** They usually disappear spontaneously after 2-3 days of treatment. These are dryness of mouth, blurring of vision and drowsiness.

(ii) (a) **Extrapyramidal side effects**

**Acute dystonic reaction:** Sudden muscular contraction, most often in neck, tongue, and pharynx, presenting as occulogyric crisis, laryngeal spasm or as protrusion of tongue against clenched teeth. One of the commonly used drugs in general practice, Triflupromazine, (Siquil) frequently causes this reaction. Acute dystonic reactions can be quickly relieved by 50 mg of intramuscular promethazine or I.V. diazepam given slowly.
Drug induced parkinsonism: The features are, excessive salivation, tremors, rigidity, and mask-like face.

Akathisia: It is a condition of motor restlessness, often accompanied by mental restlessness, namely, the patient cannot sit or stand at one place quietly for more than a few seconds, and is distressed. Though this picture may be seen as part of agitated depression, there will be history of phenothiazine medication in the last 24 or 48 hours in case of akathisia.

All the three above conditions can be treated with antiparkinsonian drugs. If the patient already happens to be on antiparkinsonian drug, the dose will have to be increased. Antiparkinsonian drugs should be continued till the extrapyramidal symptoms disappear. Thioridazine is known to cause less of these extrapyramidal symptoms.

(b) Tardive dyskinesia (TD): The clinical feature is one of Bucco-orofacio-lingual movements, almost continuously seen in wakeful state. There can be classical ‘fly-catching’ movements of the tongue, and grinding of the teeth. This usually follows after 5 to 6 years. This most troublesome iatrogenic condition is difficult to treat. Refer to a psychiatrist. The occurrence of TD can be decreased by careful and limited use of antipsychotics.

(c) Jaundice: Commonly seen with chlorpromazine. Stop drugs and immediately refer to a psychiatrist.

(d) Postural hypotension: If this is severe, the patient should be hospitalised and the drug has to be stopped. Foot end of the bed has to be raised. If necessary noradrenaline or Isoprenaline drip to be started. Adrenaline is contra-indicated. Earliest symptom is giddiness on standing. If so, check B.P., both standing and lying. This problem is commonest with chlorpromazine but rarely problematic.
(e) **Skin sensitivity and** rarely bone marrow depression can take place. When these occur, drugs should be stopped and patient should be referred to a specialist without delay.

Thioradazine has high anti- cholinergic side effects, and therefore, should be used with caution when prescribing to elderly patients.

**III. Antiparkinsonian agents**

**This group of drugs are effective for treatment of major tranquilizer induced extrapyramidal side effects. They should not be routinely used.**

<table>
<thead>
<tr>
<th>Pharmacological names</th>
<th>Strength</th>
<th>Some trade names</th>
<th>Daily dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trihexyphenidyl</td>
<td>2 mg</td>
<td>Pacitane</td>
<td>2 to 6 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parkin</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lahexy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relihexy</td>
<td></td>
</tr>
<tr>
<td>Procyclidine HCL</td>
<td>5 mg</td>
<td>Kemadrine</td>
<td>5 to 15 mg</td>
</tr>
</tbody>
</table>

**IV Antidepressant drugs (tricyclic compounds)**

**These drugs are effective against depression of arty cause.**

<table>
<thead>
<tr>
<th>Pharmacological names</th>
<th>Strength</th>
<th>Some trade names</th>
<th>Daily dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imipramine HCL</td>
<td>25 mg</td>
<td>Depsol</td>
<td>75-150 mg</td>
</tr>
<tr>
<td></td>
<td>75 mg</td>
<td>Impranil</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Antidep</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Imipramine (Micro)</td>
<td></td>
</tr>
<tr>
<td>Amitryptaline</td>
<td>25 mg</td>
<td>Sarotena</td>
<td>75-150 mg</td>
</tr>
<tr>
<td></td>
<td>50 mg</td>
<td>Latilin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>75 mg</td>
<td>Relidep</td>
<td></td>
</tr>
</tbody>
</table>
### Newer antidepressant drugs: Same potency but less side effects.

<table>
<thead>
<tr>
<th>Pharmacological names</th>
<th>Strength</th>
<th>Some trade names</th>
<th>Daily dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dothiepin HCl</td>
<td>25 mg</td>
<td>Prothiaden</td>
<td>75-150 mg</td>
</tr>
<tr>
<td></td>
<td>75 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trazadone HCl</td>
<td>25 mg</td>
<td>Sedodep</td>
<td>75-150 mg</td>
</tr>
<tr>
<td></td>
<td>50 mg</td>
<td>Trazalone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlomipramine HCL</td>
<td>10 mg</td>
<td>Anafranil</td>
<td>75-150 mg</td>
</tr>
<tr>
<td></td>
<td>25 mg</td>
<td>Clonil</td>
<td></td>
</tr>
<tr>
<td>Fluoxetine HCl</td>
<td>20 mg</td>
<td>Dawnex</td>
<td>20-100 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Flunat</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fludac</td>
<td></td>
</tr>
<tr>
<td>Mianserin HCl</td>
<td>10 mg</td>
<td>Depnon</td>
<td>30-60 mg</td>
</tr>
<tr>
<td></td>
<td>30 mg</td>
<td>Tetradep</td>
<td></td>
</tr>
</tbody>
</table>

Note: A higher or single night dose is preferable, and equally effective when the patient can tolerate without side effects.

The therapeutic benefit becomes obvious on an average 10-14 days of starting of treatment. Therefore, it is essential to advise the patient to take the drug for a minimum period of at least 3 weeks before considering any change.
Imipramine causes least sedation. The following are the common side effects - dryness of mouth, blurring of vision, constipation. Rarely, retention of urine and paralytic ileus when drugs have to be stopped immediately.

It is essential to advise the patients about these possible transient side effects so that they are prepared if they experience them and do not stop the medication.

Antidepressants are to be used with extreme caution and in consultation with the psychiatrist in patients with glaucoma, recent myocardial ischaemia and enlarged prostate.

V. Prophylactic Lithium and Carbamazepine

Lithium carbonate is effective in treating cases of mania, and it is widely used in preventing recurrent manic depressive psychoses. The initiation of prophylactic use of the drug is best left to the decision of a psychiatrist. The primary care doctor can effectively provide the maintenance care. The commonly used dose in 900-1200 mg per day in three divided doses. Because the therapeutic level and toxic serum levels are close, and because the serum lithium level tends to build up cumulatively, it is essential to regularly and periodically monitor the required dose by periodic serum lithium estimations. The therapeutically effective serum lithium level is 0.6 to 1.2 mEq/L (or milli mols\1). Beyond 1.5 mEq\L toxic effects manifest in the form of abdominal discomfort, nausea, vomiting, diarrhoea, tremors of hand, drowsiness. If they occur, the drugs must be immediately stopped and the patient referred to a psychiatrist. Lithium toxicity is an Emergency situation. Carbamazapine (Tegretol) in the dose range of 400 to 300 mg is also useful as a preventive drug in M.D.P.

**DRUG INTERACTION**

Patients with psychiatric problems may need to take other drugs for other health problems. The following are some of the guidelines about drug
interactions. However, if there is difficulty in regard to management of associated physical problem, it is appropriate to take the help of a psychiatrist.

<table>
<thead>
<tr>
<th>Drug group</th>
<th>Interaction</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tricyclic antioxidants</td>
<td>Adrenaline &amp; noradrenaline Alcohol Antihypertensive agents</td>
<td>Hypertension depressant Antagonism to antihypertensive effect</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Alcohol, anaesthetics and antihistamines</td>
<td>Depressant effect on CNS</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Anticoagulants</td>
<td>Antagonism of anticoagulant effect. In case of Phenothiazine increased toxicity of phenytoin.</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Griseofulvin</td>
<td>Reduced antifungal activity</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Phenothiazines Tranquilizers Buterophenos</td>
<td>Depressant effect on CNS</td>
</tr>
<tr>
<td>Phenothiazines</td>
<td>Anaesthetics, alcohol Barbiturates</td>
<td>Depressant effect on CNS</td>
</tr>
<tr>
<td>Phenothiazines</td>
<td>Antihypertensive agent</td>
<td>Hypotensive effect Methyl Dopa may cause Central excitation</td>
</tr>
<tr>
<td>Phenothiazines</td>
<td>Atropine like drugs and antihistamines</td>
<td>Decreased anticholinergic activity</td>
</tr>
<tr>
<td>Hypnotics</td>
<td>Alcohol Anaesthetics, Antihistamines Phenothiazines Minor tranquilizers</td>
<td>Increased depressant effect on CNS</td>
</tr>
</tbody>
</table>

In addition, antacids when taken together, delay absorption of the phenothiazines. Both anitdepresants and chlorpromazine are liable to precipitate epilepsy in known epileptics. All the commonly used antihypertensive drugs can cause depression, particularly reserpine containing drugs. Oral contraceptives are known to cause depressive symptomatology in some women. Alcohol when taken with most drugs described in this chapter enhances the depressant effect on CNS. In view of
this, a person on psychiatric drugs should be advised to avoid taking alcohol.

FAMILY AND MENTAL HEALTH CARE

Family is important in mental health care at many levels. In the healthy development of the child, a protective and nurturing family is vital for healthy development. In times of crises, family members form the first level of care providers and social support. In majority of the mental disorders, the involvement of the family contributes to better outcome. In recent times, special efforts to educate and support the families with mental disorders is part of the total treatment. Doctors should take time to understand the strengths of the family, needs of the different family members, educate them about the illness and make them partners in care. In condition where the illness is due to family situation (eg: conversion reaction) therapy should be directed to the total family.

D. REHABILITATION

The management of mentally ill persons can be considered complete and satisfactory, only when the patient is helped to successfully reintegrate into the family, work and the community. In addition to psychological and pharmacological management, certain additional steps will have to be taken to help the patient to attain competence in personal, social and occupational activities. These approaches are often referred to as social therapy and rehabilitation. It may involve attempts to modify patient's life situations, working with patients family members and other institutions in the community. Activity may be physical, mental, social, recreational or job oriented. For example, physical activities like doing some work, engaging in exercise and carrying out daily routine; mental activities like making plans and taking decision for the future, controlling behaviour, thinking and reasoning; social activities like talking to friends, relatives, attending religious functions, visiting religious places and taking' part in group
activities, job oriented activities like office work, agricultural and other manual work and recreational activities like engaging in singing, going for picnics, cinema, taking part in games.

Most of these activities are part and parcel of day to day living of an individual. These activities generally go on without much effort on the part of the individual. **In the case of mentally ill persons due to various reasons, these activities are disturbed or hampered to a varying extent.** Patients can be disabled to carry out the physical activities, mentally may not be able to take decisions and become incapable of proper thinking and reasoning. The social and recreational activities are very much affected and patients can exhibit socially undesirable behaviour. Thus most of the time, patients become more dependent on the family and thus a responsibility on the family members and on the community to make these persons as independent as possible.

It is an important task of medical team and other care giving persons to understand the importance of helping the patient to **re-establish or regain the interests to do useful activity** and there by modifying behaviour from useless to useful activity, non productive to productive activity, destructive to constructive activity and asocial to social activities. These activities help the patient to become a useful member of the family and society, thus rehabilitating to lead an independent life to the best extent.

The word **rehabilitation means re-building of the activities like physical, mental and social**, which prepare patients to take their place in the community to the fullest extent compared to the level of their functioning before the onset of the illness, and become an asset rather than a liability to themselves and to their families. Proper supervision, constant reinforcement and encouragement, are very essential in the initial stages. Persons involved in caring for such patients need patience, self- awareness and devotion to work. Family and neighbours need to understand the patient's potentialities
and capabilities before involving the patients for any type of activity. Interest can not be forced but interest can be instilled. Choices have to be given to the patients in selection of the activity or task. Patient needs to be respected as an individual. Continuous support and encouragement to the patients is very essential to increase their morale and self-esteem. Gradually, when the patients develop or acquire the skills or art of doing the work or activity assigned, they should be allowed to do their work independently. In the long run efforts need to be made to shift the patients for alternative work in private and public sectors like industries and other vocations which will be of great use to the patients to lead independent lives in the society.

The goal of any treatment plan should be rehabilitation and reintegration of the patients to active community life. For successful rehabilitation, cooperation and collaboration of health care personnel, patients and their family members, opinion leaders and various agencies are valuable.

E. PSYCHIATRIC EMERGENCES AND HOSPITALISATION

Psychiatric emergencies are any psychiatric conditions or circumstances of a patient which call for immediate action. Here, the decision as to what is to be done to the patient, has to be taken. A psychiatric condition will present as an emergency, usually due to one or more of the following reasons: i) patient may be a source of danger to himself or others because of the mental state, ii) patient’s relatives may be extremely anxious and worried regarding the patient’s conditions, iii) patient may create disturbance in the community to an intolerable or unmanageable degree and iv) patient may be in extreme and unbearable distress.

Approach to a psychiatric emergency

History taking, however brief it may be, is very essential. Inquiry should be made regarding the possibility of any probable precipitating factors. A
thorough examination of the patient including measurement of blood pressure should be done. Examination of the patient should preferably be in privately, except in cases of excited patients, in order to give the patient a chance to talk about any distressing issues. Avoiding restraints as far as possible will be useful. Doctors should not deny the reality to the patient’s experiences. Doctor must try to express respect for the patient and by direct verbal reassurances, inform the patient of doctor’s interest in the patient’s welfare. Doctor should reveal the identity and try to avoid pretending to be otherwise. The following are psychiatric situations that can be considered as emergencies;

1. Suicidal attempt
2. Excitement
3. Stupor
4. Dystonic reaction
5. Lithium toxicity
6. Hysteria

1. **Suicidal threats, gestures, attempts and risks:**

No suicidal threat, gestures, or attempts should be taken lightly. The assurances of the patients should not be taken for granted. There are no definite and fixed criteria to differentiate between serious and not serious attempts. An overdosage of drugs or intake of poisonous substance is seldom accidental and almost always suicidal. Frank admission of suicidal intent by the patient can be relied upon, but never the denials. It is desirable (and not harmful) to discuss openly about the risk of suicide \ suicidal attempt, with the patient and the relatives. The following suicidal situations, namely a) suicidal attempts with farewell or other notes, b) many suicidal attempts, c) suicidal
attempts with more lethal methods, when alone and pre-planning into the execution of the attempt, d) past history of suicidal ideas and e) elderly patients should be considered as real suicidal attempts.

**Management:** It is not safe to leave the patient alone and the co-operation of the family members should be sought to ensure sympathetic supervision and support to the patient. Referral to a psychiatrist and admission is indicated, if family members are not confident of looking after the patient. When psychiatric help is not easily available, treat the underlying psychiatric disorder either with drugs or psychosocial intervention or both.

2. **Excitement:** Excitement may be due to a) functional psychiatric illness like schizophrenia or mania, or sometimes postpartum psychosis, b) organic brain disorders caused by various CNS or systemic illnesses. When the excitement is due to either schizophrenia or mania, it is rarely the first evidence of these illnesses. Often there will be history dating back to at least few days prior to the onset of excitement, of some behavioural abnormalities and sleep disturbances. Usually there will be no confusion or other alterations in the state of consciousness. The clinical picture of **acute brain syndrome** would consist of fluctuations in the level in consciousness, disorientation, inability to concentrate, impairment of memory in addition to other features like restlessness, agitation, disturbances of sleep, slurred speech, irritability and unexplained fear.

**Management:** Excited patients generally carry the risk of self-neglect, exhaustion and nutrition problems. If the patient is too excited to be without an escort, it is always advisable to choose an escort who has not physically restrained the patient before, because excited patients generally tend to be uncooperative with those who have physically and forcefully restrained them earlier. However, one should not hesitate to take whatever precautions a situations may demand. For example, when dealing with a physically violent patient, it is safe to be out of his arms reach except while giving injections, and
be always facing him. If the patient expresses hallucinations or delusions, respect it and do not argue.

The Primary task in any excitement (except head injury) is sedation. Chlorpromazine 50 mg as in injection or Haloperidol 10 mg. IN. would be an ideal choice and should be given immediately. It can be repeated as injection of 50 mg up to a maximum 200 mg at half hourly intervals if necessary to control the patient. Later the injection should be substituted by tablets of 100 mg. Chlorpromazine given orally (300 to 400 mg per 24 hours can be sufficient). Fall of BP as a side effect of Chlorpromazine should always be kept in mind.

**Following head injuries, do not give any sedative drug to the patient.** Always admit for observation or refer to a hospital. In treating the patient with acute brain syndrome, the underlying physical condition should be determined and energetic treatment for the same should be started as promptly as possible. Chlorpromazine in dosage of 50-150 mg orally can control the behavioural disturbances.

3. **Stupor**

This can be either a schizophrenic stupor or a depressive stupor. Though the patient is conscious, there is non-responsive to the surroundings, total absence of self-care, neglecting physiological needs like food, fluids and almost total motor inactivity. These two conditions are emergencies because there is a risk of neglect of nutritional needs of the body. Referral to a psychiatrist and in patient care is essential.

4. **Dystonic reaction (as side effects of major tranquilizers)**

The commonest side effect is extrapyramidal symptoms in the form of acute reactions like spasm of the muscles, especially of neck and face with difficulty in swallow-mg, manifesting as torticollis and / or occulogyric crisis which is very distressing to the individual.
Management: For immediate relief, Promethazine (phenergan) 50 mg intramuscularly (IM) is given. Add antiparkinsonian agents orally, like trihexyphenidyl hydrochloride 2 mg twice or thrice daily. If the symptoms do not subside, refer to a psychiatrist.

5. Lithium toxicity

In those patients who are on maintenance treatment with prophylactic lithium, and consulting you, be on the look out for toxic effects, and keep a watch. If the patient develops coarse tremors, severe vomiting, diarrhoea, drowsiness, ataxia, altered sensorium, immediately refer the patient to the psychiatrist after stopping the drugs.

6. Conversion reaction:

Though not an emergency in itself, may present as an emergency. Relatives of patient may bring the patient as an emergency believing it to be so, due to dramatic onset of the symptoms and disability. A thorough examination of the patient, to make sure of the diagnosis, and also to alleviate the anxieties of the relatives is essential. Reassure the patient and the relatives that there is no danger to life and then proceed according to the clinical needs using the guidelines given.

7. Drug withdrawal states:

Among users of regular drugs like alcohol, cannabis, stopping of the drug can cause an emergency. Refer to chapter on Alcohol Abuse for recognition and management.

HOSPITALISATION In the primary health care setting in INDIA, there are only limited facilities for providing in-patient care. Usually the number of beds available is 6-12 at the primary health centres. These are utilised for acute physical problems like severe dehydration, or delivery of women. Hospitalisation of psychiatric patients is thought not possible at this level.
However, experience of training medical officers have shown that there are many situations that the PHC doctor comes across when hospitalisation for short periods becomes essential and feasible. This section deals with these situations and how to provide care and organise the services in the hospital.

There are THREE TYPES of clinical situations where hospitalisation is appropriate, namely;

(i) **Psychiatric Emergencies:** Conditions like status epilepticus, severe degree of extrapyramidal symptoms, severe excitement and acute conversion symptoms. In these situations the stay in the hospital will vary from a few hours to 24 hours. It is essentially to provide more intensive care under supervision, to be followed by referral to a bigger health facility or home treatment. Management of these conditions is considered in the earlier section. The general approach in these situations would be to see the patient every half to one hour and assess the progress, ensure that a relative is always staying with the patient and to maintain records. (The records should be sent to the referral hospital) and ensure adequate nursing care.

(ii) **To initiate Intensive treatment:** In patients where hospitalisation would be ideal (acute organic psychosis, mania, depressive stupor, suicidal patient, past epileptic psychoses, psychosis following childbirth, psychosis with physical problems like diabetes or hypertension, often doctors will find that relatives do not want to go to a bigger hospital or they would like the doctor to treat the patient locally. Initially a PHC doctor may feel that it is not possible to do anything.

However, experience has shown that primary care doctors can admit such patients for **few days** in the PHC facility and provide treatment. The purpose of this hospitalisation is to administer the drugs under supervision, to adjust the dosage from day to day, to monitor the side effects or any adverse reaction, to prevent harm to patient or others. When hospitalised, patients can get parenteral medicine (Chlorpromazine) to control psychotic symptoms. In
any hospital facility use of chlorpromazine 50 mg im every four to six hours will be possible. With this regime most acutely disturbed patients can be controlled in 2-4 days. In addition, the few days in the hospital setting will also convince relatives the usefulness of medical help and they would be more willing to take and follow the advice of the doctor. The safety precautions under psychiatric emergencies apply here. It also been noted that with experience there is very little need for referral to a psychiatric centre for most patients seen at primary health care.

iii) Hospitalisation for Diagnosis: This becomes important in situations where the information available at the OPD level both from relatives and an examination is not adequate for arriving at a diagnosis. Some such situations are the differentiation between conversion fits and epileptic fits, depression and schizophrenia, doubts about organic psychosis, occurrence of side effects which are unusual. In these situations short admissions and observations will clarify the problem. Such efforts from the doctor will save the patient’s visit to a specialised psychiatric centre.

The above experiences are given to share the wider role medical officer can play to meet the total needs of the rural population. As a doctor starts utilising fully all the facilities that are available, it will be found that more complete care can be provided at the PHC itself. It is best to have an active referral link with the nearest psychiatrist.

LEGAL ASPECTS OF PSYCHIATRIC PATIENT CARE

Unlike persons with other medical problems, persons who have mental disorders come under some special legal provisions. The current law is Mental Health Act, 1987 (MHA, 1987) regulates the admissions and discharge to psychiatric hospitals. In addition there are civil rights and criminal responsibilities related to mentally ill persons.
In regard to admission to a psychiatric hospital, patients can be admitted in 3 ways, namely:

i) **Voluntary admission** where an adult patient gives in writing his desire to be admitted and treated for mental illness. The medical officer in charge of the psychiatric hospital admits such patients and they can be discharged at any time and within 24 hours of request form the patient.

ii) **Admission under special circumstances:** Any mentally ill person who does not, or is unable to, express his willingness for admission as a voluntary patient, may be admitted and kept as an inpatient in a psychiatric hospital or psychiatric nursing home on an application made in that behalf by a relative or a friend of the mentally ill person if the medical officer in charge is satisfied that in the interests of the mentally ill person it is necessary to do so, provided that no person so admitted as an inpatient shall be kept in the psychiatric nursing home as an inpatient for a period exceeding **ninety days.** Every application shall be in the prescribed form and be accompanied by two medical certificates, from two medical practitioners of whom one shall be a medical practitioner in the service of Government, to the effect that the condition of such mentally ill person is such that he should be kept under observation and treatment as an inpatient in a psychiatric hospital or psychiatric nursing home.

iii) **Admission by reception order:** Under this procedure a relative of ill person makes a petition to the magistrate for a reception order. This request has to be in a specific form, which also includes a certified photograph of the patient, supported by to medical certificates, of which one of them is by a gazetted medical officer. The medical officers independently certify that they have examined the patient and given reasons why it is opined that the person is a mentally ill person fit to be admitted to a psychiatric hospital. The magistrate after receiving the request, medical officers certificates and seeing the patient can issue a reception order for admission to a psychiatric hospital.
These patients are discharged by the medical officer in charge when a relative gives in writing his willingness to look after him once discharged or on recovery.

iv) Admission of wandering mentally ill: Police personnel can initiate action on identifying this category of persons and through the magistrate admit them to a psychiatric hospital.

Mentally ill persons involvement in civil and criminal situations are covered by some special provisions. Issues of marriage, divorce, sale-purchase of property, ability to contest an election, involvement in a crime are considered differently.

In view of the special situation regarding persons of mental disorders, three aspects are important, Firstly, to maintain detailed and regular records of all contacts and observations. Secondly, to maintain total confidentiality of the information obtained as part of therapy contact. At no point should personal details be provided to other persons not involved in the patients problems and treatment. One of the aspects of confidentiality, is to keep the records in a safe place and not to discuss illness details in front of others. Thirdly, to be careful in assessing persons when legal reasons are the chief reason for contacting you. In such cases it will be best to refer them to a specialist.
XI. Implementation of Mental Health Care at Primary Health Care

As outlined in the National Mental Health Programme for India (1982) the approach to organise services for the mentally ill by:

(1) Diffusion of mental health skills to the periphery of the health service system
(2) Appropriate appointment of tasks in mental health care
(3) Equitable and balanced territorial distribution of resources
(4) Integration of basic mental health care into general health services and
(5) Linkage to community development

The implementation of the mental health care programme requires the leadership of the medical officer as the leader of the primary health care team. It is important that every person in PHC gets involved in the care of the mentally ill persons. As different categories and levels of personnel are involved it is the medical officer who is the coordinating person.

The role of the MEDICAL OFFICER is to provide skills to the team members, ensure supplies, support and supervise their work and initiate community involvement. To be more specific, the medical officers will be providing treatment for the ill persons, monitor the work of the health personnel, becomes a link with more specialised services.

The responsibilities of the different categories of health personnel in mental health care are as follows:
**Community health guides** i) identification of cases, ii) referral and iii) mental health education.

**Multipurpose health workers** i) identification of cases, ii) first aid, iii) referral, iv) follow up and v) mental health education.

**Health assistants** (Health inspectors and lady health visitors) i) first aid, ii) mental health education and iii) supervising the health workers.

**Pharmacist** i) mental health education and ii) compiling the data regarding drugs.

**Staff Nurses** i) first aid, ii) ‘Nursing care of out patients and in-patients and iii) mental health education.

**1. Training of non-medical staff in mental health care**

The medical officer should train all the non-medical workers so that they become part of the management of mentally ill. This can be done easily during the monthly conference (or if possible, special classes can be arranged). Basic information about causes, presentation and treatment of mental illness, mental retardation and epilepsy should be given. More emphasis should be on early identification, referral and follow-up. Medical officer should demonstrate a few cases to health workers periodically. Manuals for the different categories of the health personnel are available.

For your convenience, the section on responsibilities of health workers is included as Appendix I in this manual. You can adopt this to suit your local needs and as a teaching aid. Possibility to translate this in local language and distribute them could be most considered. (Kannada and Hindi versions are available from NIMHANS)

**2. Review of the programme in monthly meetings**
Medical officer should enquire about each worker’s contribution regarding identification, referral, follow up of psychiatric patients and mental health education. If there are problems, appropriate measures should be taken to solve them with the help of supervisory staff. The common problems are:

a) **An identified patient does not come to the clinic in spite of health workers effort**: After enquiring the details of the efforts made by the workers, doctor can ask the supervisory staff to visit the patient’s family or if needed doctor himself can do that and show them how the patient and family can be convinced to come to the clinic. Often the support of community leaders will be of great help in such situations.

b) **An irregular patient or a patient who has dropped out from treatment**: In every meeting, the medical officer should enquire about patients who are irregular or dropped out from treatment and initiate specific efforts to see that all ill persons get full treatment.

**SUPPORT AND SUPERVISION**

**Patient is referred to the clinic by the field worker**: When the patient or his family members report that the health worker has referred them to the clinic, immediately the medical officer should appreciate it and express that he is happy about the work done by the worker. He should give credit to the worker so that the credibility of the worker is increased in the community. Medical officer should check the referral slip sent by the worker. After examining and initiation of the treatment, doctor should tell the patient and family of the treatment and to contact the health workers for additional help and guidance regarding the management of the patient. Information regarding the patient’s illness and management should be given to the health workers at an early date through their supervisors.

**Irregularity of treatment by a patient**: Health workers are asked to find out the reasons for the same. The reasons may be side effects of the drugs, fits
not being controlled in spite of medication and family members losing faith in the drug, patient not willing to take drugs, difficulties to come to the hospital like distance, poverty, etc., family members trying traditional methods of treatment. The health workers and supervisory staff should be instructed to make a few more attempts to convince the patient and the family members to come regularly for follow up. Medical officer should take appropriate measures to overcome these difficulties as outlined earlier mobilising community resources.

Medical officer should recognise the good work done by health worker and encourage everybody to contribute to the care of mentally ill. If necessary and wherever possible medical officer should make home visits and demonstrate to the health workers how to convince them to accept the treatment.

**Records and reporting:** The medical officer will be maintaining simple case records of patients whom he treats. He will collect data regarding the work of health workers with the help of supervisory staff. He should prepare a monthly report regarding new cases identified, number of patients on treatment, number of cases dropped out, drug position and submit to District Health Officer (DHO, CMO) during the monthly conference at district headquarters. He should discuss the achievements and difficulties of implementing the programme.

**MENTAL HEALTH EDUCATION**

It has been already noted that there are large number of misconceptions in the community. Of all the health problems, mental illnesses are poorly understood by the general public. This has been the reason for people to seek non-medical help from healers, priests, mantravadis and seek refuge in places of pilgrimage.

Change in the community awareness is central to the success of the health programmes. With this in view all efforts should be made to enhance the
knowledge of all members of the community and not only the ill persons. As a medical officer you can carry out mental health education by: (i) providing correct information and correcting wrong beliefs and practices in the patient-family-doctor contacts in the clinics. (ii) Utilising the mental health education material in this manual as a topic in your community meetings. For example as an additional topic in the orientation training camps (OTC) along with family welfare information (iii) Reviewing mental health education activities along with other health activities in the monthly meetings of the PHC team.

In addition you would be receiving pamphlets, charts, films for distribution among the public. As the leader of the health team you have both the responsibility and opportunity to bring about changes in the community and health personnel and bring new hope for the long neglected mentally ill individuals in the rural areas.
RESPONSIBILITY OF HEALTH PROFESSIONALS

How Can You Help the Mentally ill and Disabled in Your Community?
Please note that there are several mentally ill and disabled in the community. Most of them do not get any meaningful treatment, with the result that they as well as their family members suffer. You will come in contact with them, while carrying out your routine health care activities. If you can assist in delivering mental health care to those in need of it most of them can improve and become useful members in their families and community.

Along with your regular health care responsibilities, you can do the following:

i. Identify all the persons with mental illness and epilepsy in the population covered by you.

ii. Provide first aid in emergencies.

iii. Refer the identified patients to the PHC \ PHU doctor.

iv. Follow up these patients regularly.

v. Educate the family and community in taking care of these patients.

1. IDENTIFICATION OF PATIENTS IN THE COMMUNITY

You will already know of some patients in the villages you work. You are likely to see some of them in future during your work. In addition, you must actively enquire about similar patients who may not be known to you. This can be done in the following ways;

(i) When you go to a village for your routine work, talk to important people like village panchayat members, local leaders, teachers, educated youth, members of service agencies like anganwadi, mahila mandals, youth clubs and shop keepers or hotel owners. Request them to tell you about individuals.
1. Who talk nonsense and act in a strange manner considered abnormal.

2. Who have become very quite and do not talk or mix with people.

3. Who claim to hear voices or see things others cannot hear or see.

4. Who are very suspicious and claim that some people are trying to harm them.

5. Who have become unusually cheerful, crack jokes and say that they are very wealthy, and superior to others when it is not really so.

6. Who have become very sad lately and cry without reason.

7. Who talk about suicide or have made an attempt at suicide.

8. Who get possessed by God or spirit or who is said to be the victim of black magic or evil power.

9. Who suffer from fits or loss of consciousness and fall down.

10. Who are dull, not mentally grown up like others of their age and slow since birth.

Tell them that these conditions can be helped and now such help is available at near by PHU or PHC. Request them to refer such patients to you or to the hospital. Every time you meet them, remind them to do this.

(ii) When you visit homes enquire about people who are suffering from mental illnesses. Ask the above questions tactfully without offending the members and obtain, information about the existence of a patient in that family, neighbourhood or among their relatives.

(iii) When you go to a school to carry out immunisation and other school health programmes, enquire, from the teachers and students about children
who get fits, who have behavioural or learning problems. Identify them, get
details and refer them to a doctor.

(iv) When you carry out immunisation of the children in the village, enquire
from mothers about children who have limited mental abilities and have poor
development. Thus you can easily identify mentally retarded children.

(v) When you do the follow up of persons, who have undergone family
planning operations look for those who have multiple bodily symptoms and
who feel very unhappy. These can be due to emotional problems. You can
identify depressive illness in this manner.

As noted above you can identify mental patients during your routine work with
little extra effort and be sensitive to those who contact you for other problems.
When you identify a patient, do the following:

(1) Talk to the family members and encourage the patient and family
members to give a detailed account of the symptoms, their duration
and severity. Get details about patient’s talk and behaviour and how
it has affected others in the family and community.

(2) Find out how the illness started - whether sudden or gradual - was
there any precipitating event like fever, fits, head injury, quarrel loss
or any other problem?

Find out the duration of the illness.

(3) Check specially whether the following symptoms are present

a) Sleep disturbance

b) Poor appetite \ irregular food intake

c) Not doing any work

d) Not attending \ maintaining personal hygiene
e) Disturbed relationship with family members and others

f) Exhibiting behaviour which is harmful or troublesome to others like being abusive, assaultive, suicidal, or homicidal.

g) Any bizarre or socially unacceptable behaviour like undressing in public, collecting rubbish, wandering away from home.

(4) What have the family members done? What treatment has been given and what is the result? What do they think about the illness and the patient.

Fill up the simple record and follow up form.

Identify whether the patient is suffering from epilepsy, psychosis or mental retardation. **Decide whether it is an emergency or not** (Details of the type of problems which should be referred immediately to the doctor are given later on in this chapter).

**Presentation of mentally ill**

Mentally ill people can present in the following ways:

1. Noisy and excited

2. Dull and withdrawn

3. Suspicious (paranoid)

4. Confused

5. Apparently normal

* Excited patient

**What can you do when you see an excited and restless patient?**

1. Advise others not to talk or behave in a way that irritates or provokes the patient. Keep away individuals whom the patient does not like.
2. Do not confront (argue, scold) the patient or provoke him.

3. Try to gain his confidence by enquiring ‘What are your problems? Why are you so angry? Who is troubling you? I am here to help you’.

4. When he calms down, see that he takes some fluids and food.

5. Try to convince him that he needs some medicines and it is better if he can come and see the doctor.

* Withdrawn patient

When you see a patient who is dull, withdrawn

1. Take time to talk to the patient

2. Persue him to eat something

3. Find out whether he feels like ending his life

4. Convince him to take treatment from the health centre and take medicines.

* Suspicious patient

You must be careful when you have to approach a suspicious patient who does not trust any one.

1. Be fair and honest. Do not tell lies or hide facts.

2. Do not question his beliefs or suspicions. Do not tell that his beliefs are wrong, baseless or false.

3. Allow him to talk about his suspicions. Collect more information. Do not pass any judgement.
4. Draw his attention towards his other problems like sleeplessness, decreased appetite etc., and convince him to see the doctor and take medicines.

* Patient with confusion

Confused persons do not recognise others, make errors in calculation and have poor memory.

1. Find out whether he had jerky movement (fits) of the limbs. Confusion could be following an epileptic fit.

2. Find out whether he is a known case of diabetes or high blood pressure.

3. Enquire whether he has had a recent head injury or has consumed alcohol or taken ganja or opium.

4. Tactfully find out whether he has consumed some drugs with an intention to commit suicide.

5. Examine to see if he is having high fever. All confused patients should be referred to the health centre as soon as possible.

It is better to avoid giving anything to the patient by mouth (to drink /eat). Presence of strangers, and unwanted disturbances around the patient are also better avoided.

**REMEMBER**

- Do not over promise the patient or his people.
- Do not say that you will do everything. Do not make all the decisions for the patient’s family.
- Do not criticize others. Do not blame anybody
See that family members make the important decisions.

If you are a male, do not interview a female patient alone.

See that they develop confidence in their abilities. Do not make people totally dependent on you.

Reassure that you would do your best to help them. Let them not think that you are a superman.

Avoid half hearted attempts. Hard work gives good results.

II. FIRST AID

First aid in psychiatric emergencies

You may be in situations where patients will be in need of urgent help but the PHC doctor is too far away or not available. Under these circumstances, you must offer immediate help. The following are the circumstances in which you can offer help.

* When you see a violent or very excited patient

1. Keep some distance from the patient and try to find out from him the reasons for his anger and who are troubling him.

2. Take the help of a person in whom the patient has confidence.

3. If the patient is not in a position to listen you, throw a blank( I on the patient and hold him with help of others. Take him immediately to the hospital.

4. Do not use thread, rope or chain to restrain him. If necessary, use only a towel or long cloth to tie his hands.

* Suicidal patient
Whenever a patient threatens that he wants to kill himself, take his words seriously. See to it that someone is always with the patient till he is taken to a doctor.

1. Quickly, find out the problem which made the patient to decide to commit suicide.

2. Talk to the patient so that he looks at you as a well wisher. Tell the patient that you will assist him\her to solve the problems.

3. Listen to the patient with sympathy and encourage him\her to talk about the problems in details.

4. Take the patient to the doctor yourself or refer him to the doctor immediately, along with a relative.

* Patient with continuous fits

Sometimes, patients, usually children, get fits, continuously, one after the other and in between they remain unconscious. This is an emergency and fits have to be stopped immediately, otherwise it can lead to brain damage or even death.

Therefore if a child \ person gets a second fit in a few minutes after the first, arrange for doctor’s help immediately.

III. REFERRAL

Following the identification of the patient and giving first aid whenever necessary, you will refer the patient to the PI-IC as early as possible. Find out the head of the family who can take decisions and entrust the responsibility of the patient to this person. You can accompany the patient to the hospital when possible. **Send a referral note to the doctor giving details that you have noted.** Provide all details of the place of treatment, to the family like name of the place, and the person to be contacted and working hours of the centre.
During your next visit to that family, find out whether they consulted the doctor. If they have not done it, find out the reasons and encourage them to do so.

**Refer the patient immediately to the doctor in following conditions:**

1. The patient is severely ill, violent or unmanageable at home.
2. There is history of recent head injury.
3. The patient has fever, severe headache, vomiting or fits.
4. The patient has attempted suicide and is still threatening to commit suicide.
5. The patient is getting fits repeatedly (more than 3 times a day or continuously)
6. Disturbed behaviour has occurred following child birth.
7. Disturbed behaviour occurring for the first time, after the age of 40 years.
8. Disturbed behaviour in persons with known diabetes or high blood pressure.
9. Persons who show abnormal behaviour after taking alcohol or any other intoxicating substance.

**IV. FOLLOW UP**

As part of the total management patient will be examined by the doctor. The nature of the illness is diagnosed and treatment is started. Due to any reason if the patient discontinues the treatment, all your efforts and the efforts of the doctor and family members becomes fruitless. Therefore during every visit you should meet the patient and the family members and enquire:

1. Whether the patient is taking medicines regularly as prescribed.
2. How much improvement has he made.

3. Has he developed any side effects with drug use.

4. Whether the patient has started working again.

5. Whether the patient has seen the doctor for follow up and review.

Collect the above information in these areas. The following section deals with handling of problems that can come up during follow up.

1. Side effects

Different types of drugs are used for the treatment of mental disorders. Sometimes these may have side-effects which are unpleasant to the patient and he may give up the drugs. You already know about the kind of side effects these drugs are likely to produce. First things to do is to reassure the patient if the side effects are mild. However, remember to refer him to the doctor immediately if they are severe. **All the changes in the drug dosage should be carried out by the doctor.**

Drugs given to the mentally ill can have mild side effects which are temporary, examples of this are, dryness of mouth, light headed feelings and constipation. When the patient complains of above, reassure him that it is temporary. Dryness of mouth can be helped by taking more water or keeping a piece of lemon or dry grapes in the mouth.

However, **severe side effects** can also occur. Examples of these are continuous light headedness, unsteadiness, stiffness of limbs, limbs getting pulled in different directions, twitching of tongue, mouth, neck or hand and legs. At times he can have unclear speech, drooling of saliva. If any of the above are present send the patient to the doctor immediately.

Another problem is **drowsiness**. When a patient is very excited he is put on higher doses, if not reduced, he can have drowsiness. However the drugs
should not be stopped. The patient should be taken to the doctor to reduce the medications suitably.

Patients who are **very sad and depressed** are given drugs which must not be stopped suddenly. If they are stopped suddenly they will get back the symptoms. These drugs should always be stopped gradually over a few weeks. These drugs take time to show the effects. Usually, patients report improvement after a week of starting the drugs.

**An epileptic patient** is given a medicine which can have the following side effects. Excessive sleep or unsteadiness and slurring of speech. Ask him to see the doctor immediately.

**REMEMBER**

- Tell the patient to take drugs as prescribed by the doctor.

- Patient should not make any changes in the dose without consulting the doctor.

- If patient has any difficulty or doubt regarding the drugs, he should consult the doctor.
MENTAL HEALTH EDUCATION

Of the many health problems (illnesses) mental illnesses are poorly understood by the general public. This has been the reason for people to seek non-medical help from healers, priests, mantrawadis and to go to places of pilgrimage. People using these methods do harm to the patient by delaying treatment. In all illnesses early recognition and treatment gives the best relief.

As the belief and practices in the community have been there for many years, they will not disappear in a short time. In addition, these ideas are firmly held by even the educated and the leaders of the community. There is no quick way to make people believe in what is known to modern science, as the right method of dealing with these problems. Repeated efforts to give the correct information can lead to change.

As an example, about 20 years, back if someone got an attack of malaria fever, the shivering was thought to be due to possession of spirits. General public did not believe it was due to malaria parasite in the blood. However, now, most of the people know malaria fever can be treated by chloroquine and ask for ‘malaria tablet’ as soon a person has fever. Continued efforts and willingness to hear their beliefs and be with them during their times of trouble will lead to changes of belief, their attitude to the illness and to give up the old practices and accept medical treatment.

Following are some of the common questions asked by the public about the mental disorders. As a doctor also use these questions as points to build up a health talk. The answers are guidelines and they can be developed according to the local needs. It is important that in providing new information, it is best to avoid giving the new ideas in a matter of fact manner and be patient and make enough time to clarify the doubts and fears.
I. Questions & Answers about Mental Illnesses

1. Are mental illnesses hereditary?

Children of mentally ill persons do not necessarily become mentally ill. Children of most ill persons remain healthy and lead a normal life.

2. Is mental illness contagious? By living with the patient, do others become ill?

Mental illnesses are not contagious and do not spread from one person to the other.

3. Do ghosts, black magic evil powers, curse cause mental illness?

In olden days people did not know that changes in the brain are the cause of mental illnesses, they believed that ghosts, black magic, evil powers are responsible for the illnesses. Similarly in olden days diseases like cholera, malaria, small-pox were believed to be caused by these super-natural powers. Today we know that there are other causes for these diseases. Changes and diseases of the brain, severe stress and strain in the family, unhealthy social environment cause mental illnesses.

4. Does masturbation, night discharge, loss of semen cause mental illness?

Masturbation and night discharge are normal events in our sexual life. They are harmless. Loss of semen does not cause any weakness on bad effects.

5. Does drinking alcohol cause mental illness?

Alcohol is harmful to the brain cells and other bodily organs. Taking alcohol regularly for long periods leads to various types of severe mental illnesses.
6. **Is mental illness treatable? Do drugs help?**

Drugs are an important way of treating different mental illnesses. Mental illnesses are treatable. Drugs when taken, correct the imbalances in the brain and symptoms become less and disappear. Like physical illnesses, mental illnesses respond to treatment.

7. **Is it always necessary to admit mental patients to a mental hospital?**

It is not necessary. Majority of the mentally ill persons can take medicines at home and with the help of family members can recover fast. In some cases admission to a hospital can delay recovery. Therefore managing the patient in his own home / village is best. In some cases mental hospital / psychiatric ward general hospitals is useful when the person has special needs like treatment of associated physical problems, use of treatments like ECT or for rehabilitation.

8. **Can marriage cure mental illnesses?**

A mentally ill person can get worse if he gets married when he is ill. Marriage can become an additional stress. A patient who has recovered can get married and live a normal family life like any other person.

9. **Can improved patients take responsibilities, like working?**

Mentally ill persons can work and take responsibilities. When they are ill, somebody has to supervise them. After recovery, they can lead a life, like any other person. Only a few patients have to work under supervision.

II. **Questions & Answer about Epilepsy (Fits)**

1. **Are ‘fits’ contagious?**
They are not contagious. By seeing a fit or by touching the froth, one does not gets a fit.

2. **Are fits caused by evil spirits entering the body?**

Fits are the result of abnormal electrical activities in the brain.

3. **Does branding cure or stop the fits?**

Branding does not help. It causes a lot of pain and suffering to the patient.

4. **Are there drugs for fit?**

Very effective drugs are available. Patient has to take them regularly as told by the doctor. Fits are controllable.

5. **Should we go to a specialist to get this treatment?**

It is not always necessary. Majority of the patients can be treated by the doctor at the nearest health centre.

6. **What should we do when we see a person getting a fit? Does placing an iron-object in the hand stop the fits?**

You can help a person with a fit as follows:

Turn the patient to a side so that the mouth secretions will not choke him to death. Make some space for the patient and remove harmful objects present near him. Do not place any hard object between his teeth. Do not hold limbs. As soon as the movement stops, see that he starts breathing.

Keeping an iron object in the hand does not help in any way. Always advise patient to take medical help without delay.

7. **Can the patient work? Can a child with fits go to school?**
Persons with epilepsy should work like other people. Children should go to school. Once fits are controlled with drugs they can live like others. Initially they should not work near fire, water, moving machinery or drive any vehicle.

8. **Should we give special kind of diet to the patient? Are there any food restrictions?**

Patients can eat what they like normally, prepared at home. There are no special diets for persons with epilepsy. They should take food at regular intervals. Starving can precipitate an attack.

9. **Can the patient marry? Can he/she have children?**

If fits are controlled, the patient can marry and have children. Women should seek the advice of their doctor when taking drugs before having a child.
III. Questions about Mental Retardation

1. Why are some children retarded? Are patients responsible? Is it their fate or bad luck?

Poor development of the brain or damage to the brain results in mental retardation. 2-3 out of 100 children are retarded. It is a medical problem and not due to fate, ones misdeeds or bad luck.

2. Are there medicines- tablets \ tonics \ injections or operation or other treatment methods to ‘cure’ mental retardation?

Medicines do not help a retarded person ‘L-o become normal. There is no treatment method which can make the brain grow again. If there are associated problems like epilepsy drugs will be useful.

3. Is it possible to make the child better?

It is possible to improve the retarded child. By training and making them learn various skills, they can function better.

4. Can a retarded become independent? Can the individual look after self?

This depends on how parents train the individual and how learning occurs. Our goals should be to make the individual as independent as possible. It also depends on the degree of damage of the brain and degree of retardation.

5. Does marriage cure mental retardation?

Marriage is not a cure for mental retardation. Moderate to severely retarded persons cannot take the responsibilities of marital life. It is better that they do not get married.