MENTAL HEALTH IN PRIMARY HEALTH CARE

DIAGNOSIS AND TREATMENT OF PRIORITY MENTAL HEALTH CONDITIONS IN AFGHANISTAN’S BASIC PACKAGE OF HEALTH SERVICES

Human Resources Department
Ministry of Health
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This supplementary Mental Health Book was developed by Peter Ventevogel and the HealthNet International (HNI) Mental Health Team in Jalalabad—Ruhullah Nassery, Nasratullah Rasa, and Hafizullah Faiz.

This supplementary material is intended to accompany the reference manual and the trainer’s and participant’s guide for a 7-day clinically-oriented introductory course on mental health for doctors, midwives, and nurses. This material reflects the priority conditions of the Basic Package of Health Services in Afghanistan, and the content is intended more for physicians and mental health trainers than allied health providers. These materials were prepared for a National Refresher Training Program and can be freely used by all those organizations implementing a Refresher Training Program. Eventually, these materials will be integrated by the Ministry of Public Health Mental Health Task Force as standardized, national training materials. This version is a first draft.

Sources consulted in the preparation of this document include:

- *Mental Health in the Tamil Community*. Chapter 3. TPO, Jaffna.
- *Community Mental Health in Cambodia*. TPO, Cambodia.
- *Mental Health in Primary Care*. Prof. Mubbashar, Institute of Psychiatry, Rawalpindi Pakistan.
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INTRODUCTION

INTRODUCTION FOR TRAINERS

These materials are prepared for the training course, *Mental Health in Primary Health Care*, organized by HealthNet International (HNI) and the Ministry of Public Health in Jalalabad. The materials have been translated into Pashtu by Dr. Hafizullah Faiz, Dr. Nasratullah Rasa, and Dr. Ruhullah Nassery, who work in HNI’s Mental Health Program.

This book does not constitute the curriculum itself, and is by itself only one of a variety of educational tools to be used in this course.

The first part of the book is an introduction to mental health and why it is important for all doctors to have basic knowledge and skills in this field.

The second part of this book contains an overview of the most prevalent mental and neuro-psychiatric conditions in the primary health care level in Afghanistan. Each chapter contains an overview of the typical presenting symptoms, a brief description of the causes, and the treatment options. In these descriptions, the bio-psycho-social model is used as an organizing concept. The place of psychopharmacological treatment in this course, for paramedics, is limited to general information and side effects. Prescription of medicine is the realm of the doctors. The teaching methodology consists of interactive lectures, role plays, exercises, case studies, field visits, and group work.

Jalalabad, February 2003 (revised April 2005)

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INTRODUCTION FOR PARTICIPANTS

This information is part of a two-week training (4-5 hours per day), *Mental Health in Primary Health Care*. This book is not a replacement for the actual training, which consists of interactive lectures, role plays, exercises, case studies, field visits, and group work lectures.

After successful completion of the course the participant will have achieved the following objectives:

- Have an understanding of the importance of mental health for primary health care.
- Have a good understanding of the professional tasks and responsibilities of the different categories of health care providers (doctors, nurses, midwives, and community health workers) concerning mental health problems of their patients.
- Be able to use the Self Reporting Questionnaire as a screening instrument to identify primary care patients who are highly likely to have mental problems.
- Know the presenting symptoms of the six priority conditions:
  - Psychosis
  - Depression
  - Anxiety disorders
  - Epilepsy
  - Mental retardation
  - Substance abuse
- Have general knowledge about the causes of these conditions.
- Have a general knowledge about the treatment of these conditions, including biological, psychological, and social treatment methods.
- Know the principles of good communication and be able to use them in daily work with patients.
- Be able to give advice and educate patients and families regarding mental disorders.
CHAPTER 1: INTRODUCTION TO MENTAL HEALTH

WHAT IS HEALTH?

According to World Health Organization (WHO), health is the complete physical, mental, and social well-being, not merely the absence of disease. This means that health is not confined to only the body, but should also include the mind and behavior of a person.

WHAT IS MENTAL HEALTH?

As mentioned in WHO’s health definition, mental health is an important component of general health, which is mainly concerned with the mental functions of a person, that is the way the person: thinks, feels, behaves, and perceives the world around her/him.

Mental health is not the same as “absence of craziness.” In fact, mental health is a large part of health. Many people at a certain moment in their lifetime will suffer from a mental problem.

There are several reasons why mental disorders should be a priority for the healthcare system.

1. Many people have mental problems.
   In all countries of the world, many people have mental health problems. These can range from very severe disorders, such as psychosis, to less severe ones such as depression and anxiety disorders. In countries like Afghanistan that are ravaged by war and conflict, the numbers of mental problems are even higher. Many of the patients who visit a basic health facility have mental problems. Research in several Western and non-Western countries has found that about 30% of the patients visiting a general health facility have mental problems. A recent survey by HealthNet International (HNI) among the general population in Nangarhar Province indicated that many people, in particular women, have some symptoms of mental problems.

2. Mental disorders are a heavy burden for the patient and the family.
   Because of mental problems, a person: is less productive in their work than they could be; is less able to be a good family member and support the family; and causes financial burden to the family because of the cost of medical care and loss of income for the family members.
WHO has done worldwide research to estimate which diseases cause the highest burden for the society. Among the 10 most disabling diseases were mental disorders such as depression and chronic psychosis. WHO has also estimated the total burden of disease. Mental health problems are 11% of the “global burden of disease.” This figure is expected to rise. By the year 2020, WHO expects that 15% of the global burden of disease will be attributed to mental disorders.

3. Cheap and effective treatment options for mental disorders exist.
   Sometimes people think that mental disorders cannot be treated. This is not true. There are effective treatment options, which consist of:
   - affordable and effective medication;
   - advice and education to patients and their family;
   - counseling and psychotherapy; and
   - awareness-raising about mental health in communities.

4. Training in mental health is relatively easy.
   Sometimes people think that only specialists can treat mental disorders. This is not true. The majority of the cases can be treated in the primary health care system, if the health workers:
   - are able to identify the patients;
   - have been trained in treatment methods; and
   - have effective medication and other treatment methods available.

   It is possible to train health workers about the basic principles of mental health care. Experience in several other countries shows this. For example, in countries surrounding Afghanistan (Iran, Pakistan, India) training programs have been conducted to train primary health care workers (doctors, nurses, midwives, health volunteers) in basic mental health care.

MENTAL HEALTH CARE AND THE AFGHAN GOVERNMENT POLICY

The Afghan Ministry of Public Health has recognized the importance of mental health and realizes that mental health problems need to be addressed as an integrated part of health care, and not as a separate issue. Mental health is one of the seven priorities of the Basic Package of Health Services (BPHS), which describes the minimal health services to be delivered at every government health facility in Afghanistan.

The official MOPH policy is to include mental health as one of the elements of primary health care. Mental health in primary health care means that in each health post, basic health center, comprehensive health center, and district hospital in Afghanistan, the health workers should have basic knowledge and skills in the field of mental health.

HNI MENTAL HEALTH PROGRAM

HNI was one of the first organizations to start a mental health program, which is aimed at improving the knowledge and skills of health workers in the rural districts.
Refresher Training Program

Mental Health In Primary Care

Health program started in late 2002 in three districts of Shinwar Cluster in Nangarhar Province, and is gradually expanding. Eventually, it will cover all districts of Nangarhar Province. The project for the integration of mental health in primary health care is based on three elements:

1. Training for health workers.
   HNI developed two-week training modules (4-5 hours per day) for primary health care doctors that include essential information about the diagnosis and treatment of mental disorders. The course is limited to priority conditions such as schizophrenia, depression, anxiety disorders, epilepsy, mental retardation, and substance abuse. Similar courses are developed for nurses and midwives.

2. Community awareness raising.
   Two-day training courses were organized for village health volunteers, traditional birth attendants, and community health workers (CHWs). This enabled them to identify and refer typical cases of mental disorders to the health centers. HNI also organized one-day awareness-raising workshops for community leaders and influential women. Bridging the gap between the local communities and the newly introduced services is an essential ingredient for successful implementation of a mental health scheme.

3. Integration of activities in the logistical, monitoring, and supervision structures.
   After the doctors and nurses in a clinic have been trained, essential psychiatric drugs are included in the monthly kits to the clinic. The drugs consisted of those recommended by WHO with some additions. The mental health activities are included in the general supervision system, and the existing health information system was adapted.

HNI deliberately chose not to implement a vertical mental health care component, but to integrate the mental health activities fully in the existing structures. This gives the best guarantees for sustainability.

Most activities of HNI’s mental health program are aimed at integrating mental health in primary health care. Recently, HNI has also developed supportive activities at other levels of the mental health pyramid:

Activities to support and modernize specialized mental health facilities. The vast majority of mental patients can be treated at primary care level. They can continue to live with their families, who can support and encourage them. A small group of chronic mental patients needs more support. Jalalabad’s Provincial MOPH Hospital has a ward for chronic mental patients. A donation by a private Dutch foundation has enabled HNI to support this ward with regular medication supply and the development of resocialization activities for chronic mental patients.

Psychosocial activities. The onset of mental disorders can be provoked by problems in the social environment, such as family problems, marital problems, worries about the financial situation, grief, etc. These problems are called psychosocial problems. Psychosocial problems are different from mental disorders, but they can lead to
mental disorders. The reverse is also true: medical disorders (including mental
disorders) can lead to psychosocial problems (worry, tension in the family, financial
problems).

Psychosocial problems should preferably be dealt with in the communities. This can
be done by key figures in the community such as family-elders, community leaders,
or religious leaders. The health care system can also contribute, in particular the
CHWs, who have a good knowledge of their communities and the problems in their
communities.

More about this can be found in the chapter about psychosocial problems. HNI, with
financial support of Caritas Austria, has started a pilot project to train a small group
of Community Psychosocial Workers who can help the CHWs and communities to
deal better with psychosocial problems. The activities of the community psychosocial
workers will consist of: 1) health-education about mental health and psychosocial
problems, 2) support groups for people with similar psychosocial problems, and 3)
individual counseling when needed. Community Psychosocial Workers are not
included in the BPHS. HNI will evaluate the effects of the work of the Community
Psychosocial Workers and share the results with the MOPH and other NGOs.
CHAPTER 2: INTER-RELATIONSHIP BETWEEN PHYSICAL AND MENTAL PROBLEMS

Patients who visit a health facility usually present with physical symptoms for which they are seeking treatment. As health professionals, it is our task to list the symptoms and to make a proper diagnosis. Sometimes it is not easy to make a correct diagnosis if the person presents with a variety of symptoms. For example, headache can be a symptom of malaria, in particular if other symptoms of malaria are present. A stomach ache can be a symptom of an ulcer, if present with several other typical symptoms of ulcer. Likewise, diarrhea can be a symptom of intestinal infection, but not always.

But these physical symptoms can also indicate that the person is suffering from a mental problem or a psycho-social problem. Many times these problems present with other symptoms such as tiredness, sleeping problems, and dizziness. When carefully looked at, many of these patients suffer from a mental problem such as a depression or an anxiety disorder. But often the patient will only tell the health provider about this if s/he is specifically asked.

It is very important for health workers to identify those patients who present physical symptoms and have a mental problem. One way to identify these patients is by using the Self Reporting Questionnaire, developed by WHO.

TREATMENT OF HEALTH PROBLEMS WITH THE BIO-PSYCHO-SOCIAL MODEL

Patients who visit a basic health center almost always present a physical problem to the doctor. This can vary from headache to skin infection of the foot. Sometimes the doctor can easily relate the physical symptoms to a physical illness, but sometimes s/he needs to investigate further to make a diagnosis. But physical symptoms cannot always be fully explained by physical factors. Often, psychological or social factors also contribute to the creation or continuation of the disease. In all cases, doctors should investigate these three aspects before making a diagnosis. When the doctor routinely checks these three aspects—biological, psychological, and social—it will be easier to make a correct diagnosis.

Example:
A 28-year-old female patient feels tired, has lost her appetite, and cannot sleep well.
Biological: Are there signs of a physical disease causing tiredness, e.g., anemia, hepatitis, or other infections?
Psychological: Does the patient worry a lot? Does she feel incompetent? Does she feel sad and depressed?
Social: How is the support of the patient? Is she helped by her family? Are there any problems with her in-laws? Are there marital or financial problems?
In this example it is possible that the patient suffers from a chronic infection (biological), worries a lot about her condition (psychological), and has conflicts with her mother-in-law because she is not able to work like did in the past. It is also possible that she is suffering from a depressive disorder related to family problems (social), and that this depressive disorder makes her feel tired and sleepless and without appetite (biological).

Whatever the correct diagnosis may be, the treatment should consider the three aspects contributing to the disease. This can be done for all diseases, but is especially important for psychiatric diseases such as depression and anxiety disorders.

The treatment plan for the patient in the example should cover several aspects:

*Biological*: Medication, nutritional advice

*Psychological*: Counseling—let the patient talk about her worries. Let her express her feelings, and even cry if she wants. Investigate together with the patient what she can do to feel better.

*Social*: Give advice to the family and patient, e.g., getting enough rest, family relations.
CHAPTER 3: STRESS AND COPING

1. What is stress?
Stress is a mentally or emotionally upsetting condition occurring in response to adverse external influences. Our body responds instinctively to immediate danger by preparing us both physically and mentally for a reaction to the danger. When people feel threatened, they have a positive and natural tendency to defend and protect themselves, or to escape. As soon as we perceive danger, chemical messengers and hormones are released that increase our alertness and give us energy. Our heart and respiratory rates increase so that we have more oxygen available.

These reactions can be observed as an increase in muscle tension, quicker breathing, or a faster heartbeat than usual. When people feel or think that the threat is over, a relaxation occurs. During this relaxation, the muscles become soft again, the heartbeat slows down, and the respiratory rate becomes regular and slow. The person will feel calm and can rest and restore energy. For most people, these reactions of activation and relaxation are in balance.

Stress is part of life. A little bit of stress is normal and even good. It only becomes a problem when it is too much or too long. Persistent or regular stress can impact seriously on physical and psychological health because sustained high levels of the stress hormones can have many effects on the body. Stress is capable of affecting physical and mental health.

Signs of stress
Stress will lead to signs in the body, in the mind, and in the behavior. The most frequently reported signs of stress are listed below.

**Physical Complaints**
Tiredness, which can be caused by many physical diseases, such as malaria and tuberculosis, but it can also be a sign of stress.
Tense muscles leading to pain
Headache
Excessive sweating (e.g., cold sweaty hands)
Poor appetite
Vague pains in legs, arms, or chest
Disturbed menstruation

**Mental Complaints**
Feelings of anxiety.
Feeling insecure.
Poor concentration. During stress, activity in certain areas at the front of the brain is suppressed, and this impairs short-term memory, concentration, and learning ability. This will normalize when the stress goes away.
Thinking about the same things again and again.
**Changed Behavior**
- Reduced activity and energy, or over-activity and restlessness
- Being easily irritated
- Being quarrelsome
- Sleep problems such as reduced or disturbed sleep

**Effects of long term stress**
- When stress lasts a long time and the person is not able to decrease the amount of stress or to “cope” with the stress, it can affect all areas of a person’s life and contribute to the development of diseases and family problems.

**Physical Diseases**
- Continuously high heart rate and blood pressure causes headaches and increases the risk of abnormal heartbeats, heart attacks, and strokes.
- When a person is continually stressed, the immune system is suppressed and the body’s natural defenses are less effective. This increases the susceptibility to infections. Being stressed also slows the rate at which you can recover from illnesses.
- Prolonged stress can disrupt the digestive system causing diarrhea, constipation, cramping, or bloating.
- Stress is known to aggravate skin problems such as acne, psoriasis, and eczema. It has also been linked to unexplained itchy skin rashes.
- Continued stimulation of muscles through prolonged stress can lead to muscular pain such as backache.
- Stressful situations can lead to temporary sexual problems in both men and women.
- Levels of reproductive hormones can also be affected, so women who are under too much stress can stop having their menstrual periods, and both sexes can experience a drop in fertility.
- The tension of unresolved stress can cause sleep problems. A person under too much stress will find it hard to sleep at normal times and may feel tired and lack energy during the day.

**Mental Disorders**
- The onset of depression is often linked with the inability to cope with stress. When stress makes a person feel overwhelmed and out of control, s/he may become depressed. The person no longer enjoys things and lacks energy, a desire to do things, and an interest in the outside world. See the chapter about depression for additional information.
- Anxiety disorders, in particular generalized anxiety disorder, can be caused by too much stress. See the chapter about anxiety disorders for additional information.

**Social Problems**
- When people are stressed, they often do not think sensibly, and may over-react to situations or behave totally out of character. This in turn can generate more stress because they start to worry about their behavior.
- Stress makes it more difficult to handle complex social or intellectual tasks. This can lead to underperformance in school or at work.
Irritability due to stress can easily lead to arguments, disagreements, and misunderstandings. This can lead to parents beating children, husbands beating their wives, and children fighting with each other.

**Causes of Stress**
Any problem or situation that a person finds difficult to face and cope with can cause stress. All people experience stress. Some suffer more than others from its effects. Many people encounter stress in many different circumstances.

**Economic Difficulties**
As we all know, a lack of resources and poverty can make life difficult. A major burden may be the lack of male members of a family. Men are frequently abroad or killed, and women are not always allowed to work. Female-headed households are among the most vulnerable in the country. Without mobility or means to provide their families with basic necessities, they depend on their children for the day to day running of the household. Women may have a lot of tasks, including the education of the children. This can be the cause of huge distress.

**Family Problems**
A family situation in which there are more women for one husband or the relation of women with their mother-in-laws can frequently lead to stress. Infertility or not having sons can cause a woman to lose her place in the household as the first wife. Domestic violence is a frequent cause of stress for women.

**Social Difficulties**
The system of purdah separates the male from the female. This is part of Pashtun culture. It can give a woman protection and security, in particular in instable circumstances in the country. Purdah also includes the obligation of men to take care of the women. It is an important part of men’s honor to protect a woman from outside influences and dangers. The purdah system results in restriction on female movements, and can limit their ways of coping with stress. In some situations, girls after their marriage will experience a lot of stress in the new environment of their husband’s family.

**Disease**
Disease or physical disability can cause a lot of stress for the patient and family. This is particularly so when a disease is chronic and requires frequent visits to doctors, e.g., tuberculosis, paralysis, infertility, or schizophrenia.

**Coping with Stress**
Every human experiences stress. Fortunately, every person also has ways to deal with stress. This is called “coping.” There are many different ways of coping with stress. They are not the same for all people and all cultures. Every person has her/his own ways to cope with stress.

Examples of coping effectively with stress are:
Sharing the problem with others
Trying to find ways to eliminate the cause of stress
Setting positive goals by making a step-by-step plan to reach a goal
Asking others for advice
Praying
Ensuring a regular pattern of activities
Engaging in physical activity
Finding distractions, e.g., listening to music, playing with children

In many cases, these coping mechanisms are helpful. There are also coping mechanisms that can sometimes be helpful and sometimes not. In some cases, a coping mechanism can even have negative effects and make the person worse. Examples of coping that can sometimes be effective but sometimes not are:
Accepting the situation (“we will get used to it”)
Expressing emotions (crying, telling that you are angry)
Behaving as a patient (visiting doctors all the time)
Withdrawning from society

There are also ways of coping with stress that are harmful. The person might initially feel relieved, but eventually these ways of coping make the problems worse:
Acting aggressively or beating a wife or child
Sexually abusing children
Neglecting children or family
Acting in a self-destructive manner, such as burning or hitting oneself
Abusing substances like opium, heroine, cannabis, or benzodiazepines
Attempting suicide

Helping a Person Cope with Stress
Reducing or preventing the causes of stress will improve a person’s mental and physical health. The health system can help persons to cope more effectively with stress by:
Providing general information about stress. Patients who visit a doctor because of physical symptoms are often not aware that these symptoms are related to the stress they experience. An explanation can relieve the patient and help her/him to stop worrying.
Listening empathically and giving emotional support. A health worker is often trusted by the patient. A health worker can help a patient with stress by listening to her/him and providing the opportunity to talk about their problems.
Encouraging the person to use healthy coping mechanisms. It is important that people find their own ways to cope with stress. A doctor or nurse is often not able to solve all problems but can encourage the person to use more healthy coping mechanisms, such as:
• encouraging the person to do things that make her/him relax, such as lying down, taking a bath, stretching, or prayer;
• encouraging the establishment of friendships;
• encouraging the person to talk to individuals such as elders, female volunteers, traditional birth attendants, or other people they trust;
• trying to find and encourage others in the family or community who can help provide relief by caring for children, or providing proper food and rest; and
• strongly advising the patient to avoid drugs or alcohol.
Teaching relaxation exercises. These exercises can help break the cycle of tension and symptoms. People will feel more relaxed and can rest better.

Giving tips that can help the patient cope with stress:

- Meditating—10 to 20 minutes of quiet reflection may bring relief from chronic stress, as well as increase tolerance to stress. During meditation, the patient may use the time to listen to music, relax and try to think of pleasant things, or do nothing at all.

- Visualizing—The patient can use their imagination to picture how they can manage a stressful situation more successfully. Whether it’s a business presentation or moving to a new place, many people feel that visual rehearsals boost self-confidence and enables them to take a more positive approach to a difficult task.

- Sharing feelings—A conversation with a friend can let the patient know that they are not the only one having a bad day, caring for a sick child, or working in a busy office. By staying in touch with friends and family, these people can help provide love, support, and guidance to the patient.
CHAPTER 4: COMMUNICATION AND COUNSELING

INTRODUCTION

Diagnosis and treatment of a patient involves more than conducting a physical examination and prescribing medication. Communication between a health worker and patient is also very important. Health workers rely on what their patients tell them to be able to provide the best care possible. Therefore, the health worker should make it easy for the patient to provide the information required to make an accurate diagnosis and provide appropriate treatment. A patient will be more comfortable sharing his thoughts and feelings with the doctor, nurse or midwife if he/she is treated in a kind and respectful manner. Health workers should thus try to maintain a good attitude when speaking with patients.

PRINCIPLES OF GOOD COMMUNICATION

In good communication, certain principles or rules are consistently applied:
Show empathy. Show that you understand and accept the feelings of the patient. The empathetic health worker is “together with” the person, and tries to imagine what he/she would feel in his place. Empathy involves being sensitive, listening carefully to everything the patient says, and putting aside his/her own concerns. Empathy is different from feeling pity for a patient. Feeling pity means that one person feels “above” what that person is going through, or even “better” than the other. Empathy, on the other hand, has a more equal basis.
Respect privacy. Respect the individuality of the patient, and ensure that the conversation is not disturbed by other persons or things. Some private feelings or problems ought not to be heard by other people who have nothing to do with it. Respecting privacy might involve asking other people (even family members) in the consultation room to leave.
Keep things confidential. People fear gossiping and may feel afraid that by talking to you, all of their problems will be known by the entire community. Therefore, the health worker should assure the patient that he/she will keep secret all that is told. When discussing a case history with colleagues, omit the name of the patient to ensure confidentiality.
Be professional. A health worker is a professional helper. The task of a health worker who talks with a patient about his/her problems is very different from the task of a family member or close friend who talks with the same person about his/her problems. Differences between the role of a family member or friend and a professional health worker are shown below.

<table>
<thead>
<tr>
<th>Professional</th>
<th>Friend or Relative</th>
</tr>
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<tbody>
<tr>
<td>Is not personally involved in the problem of the patient</td>
<td>Is often personally involved in the problem</td>
</tr>
</tbody>
</table>
Not too close emotionally | Can be very close emotionally
---|---
Uses communication skills in a conscious, deliberate, professional manner | Is often not aware of the communication skills used
Can compare the symptoms of the patient with those of many other patients | Cannot compare with many other cases

**SKILLS NEEDED FOR COMMUNICATION**

For a doctor, nurse or midwife, it is very important to communicate effectively with the patient. Having good communication skills is as important as having good technical skills, like being able to measure blood pressure or listen to the heart sounds with a stethoscope. Good communication is a skills that can be learned—just like other skills a health worker needs to have. Examples of good communication are:

- **Listening.** Listening is the basis of good communication. Unfortunately, we as health professionals often do not listen very well. Too soon we start to ask questions, give advice or prescribe medication. Listening to the concerns of the patient is often helpful in itself. Patients feel helped when they can explain their problems and worries to a health worker who is trying to understand them. One needs to take time for listening, and patients need to feel that they have the health workers undivided attention and have been understood.

- **Attending behavior.** Effective communication also involves many non-verbal behaviors. Without saying a word, a health worker can express so much, and can also focus more on observing the patient. Some examples:
  - **Eye contact.** When a doctor is not looking at the patient, he/she might feel ignored. Having eye contact is like “talking with the eyes”—it helps maintain rapport and keeps the conversation going. A health worker who is trying to maintain eye contact will also notice when the patient is avoiding it. The reason may be that he/she feels shy, embarrassed, or depressed, all of which may be significant in the patient’s situation.
  - **Body language.** The body language of the health worker is very important. The health worker should sit in a position that enables listening and eye contact. He/she can show interest in what the patient is saying by leaning slightly forward and nodding as appropriate. Observation of the body language of the patient can also give much information. For example, a depressed patient may sit with bended shoulders, move little and have little facial expression. Tension, anger, sadness and shame are often visible in the body language of the patient. Sometimes, the health worker may notice that the words of the patient do not match his/her body language. For example, a patient is asked how he feels, he answers “fine,” but his tired gestures and sad facial expression show his unhappiness.
  - **Vocal qualities.** The health worker should use his/her voice in a kind and gentle manner. Shouting at a patient, or even talking loudly or in a commanding tone, can make the patient feel afraid to share his/her problems.
  - **Verbal following.** When a health worker listens, he/she can encourage the patient to continue by sounds or small words, such as “Ga, ga,” or “hm, hm.”
Silence. Silence can be a very good thing. We should give the patient time to think and to formulate an answer. When a patient keeps silent for a while, we can encourage him/her without pressure, by saying, “It is difficult to answer this question, isn’t it?”

Questioning. There are many ways to ask questions. Open questions, for example, invite the patient to answer with more than a “yes” or “no,” to share his/her opinion or to give his/her version of what happened.

Paraphrasing. Paraphrasing is saying what the patient said again, but using different words. This shows that the health worker is listening attentively and has understood what the patient said. The patient often feels encouraged to continue talking about his/her problem.

Reflecting feelings. A health worker can encourage patients to discuss their feelings by sharing his/her observations of emotions that a patient may be feeling but not talking about. It is often good for the patient to talk about his/her feelings. The expression of strong emotions is often followed by a sense of relief. Sometimes, however, patients find it difficult to express their feelings. They discuss facts or physical symptoms that they have, but find it difficult to talk about their emotions. A health worker can help the patient by stating what he observes. For example: A patient tells the doctor about the pains and sleep problems she is experiencing. The doctor asks her when this started. She says it started one year ago when her youngest child suddenly died. The doctor asks her to talk more about this. She continues by plainly stating the facts of the death of the child, but it is obvious from her face that she is feeling a lot of sadness. The doctor invites her to talk more about this by reflecting her feelings: “It makes you very sad to talk about these things, doesn’t it? When talking about feelings of the patient, the health worker should not tell the patient that his feelings are wrong (for example, “There is no need to be sad; you should feel happy because you survived!”). Feelings of the patients are real, even if the health worker cannot immediately understand them.

Summarization. During a conversation with a patient, it is often helpful to summarize what information has been collected so far. For example: “You have told me that for two months, you have felt tired, are having problems falling asleep, have not had a good appetite, and cannot enjoy your children. Are there other things that have changed as well?” A summarization shows the patient that the health worker has listened. It also structures the conversation, and encourages the patient to provide additional information, or to correct things that have been misunderstood.

**TALKING IS PART OF TREATMENT**

An important aspect of helping patients is to communicate with them in a kind, respectful manner. Unfortunately, some health workers think that health care involves nothing more than providing a patient with medication or other treatment, and do not consider talking as part of care. This is why many health workers give medicine to everyone who visits them. Many patients also expect to be given medicine whenever they visit the clinic. Some may even tell the doctor that they need an injection.
‘Talking treatment’ is sometimes called “counseling.” There is evidence that counseling can help people with mental illness, although it is not a substitute for medication when needed. For some mental illnesses, counseling is greatly effective. Such illnesses include depression, anxiety and substance abuse.

When a health worker talks to a patient with any of these diseases, it is important that he/she gives the patient reassurance. Often, people suffering from depression and anxiety are dismissed by health workers as being “crazy.” Or they may be told, “There is nothing wrong with you.” Remarks such as these suggest that the patient does not have a real medical problem. This can be very upsetting people suffering from actual symptoms. Many are worried that they are suffering from a serious physical illness. Feeling dismissed adds to their anxiety and unhappiness.

A health worker should, therefore, reassure such patients by telling them that their symptoms, although distressing, are the result of very common illness; and that the illness will not result in a life-threatening or dangerous condition. First, explain in general terms that everyone experiences symptoms of bodily discomforts at some time or other. Take the following example: “When a person feeling stressed or upset or unhappy about things, he/she will often experience sleep problems, pains and worries. You have been feeling tired and unhappy in the past month. This is because you have been under stress ever since your husband died and your children left the village. You have become depressed. This is not because you are lazy. This is a common problem that affects many people in our community. All the problems you described are because of this emotional illness.” The health worker can also discuss causes and treatments.
CHAPTER 5: PSYCHOSIS

Definitions and symptoms
Psychosis
A person with psychosis loses contact with the reality. This condition will manifest through a variety of symptoms, such as delusions, disturbed thinking, hallucinations, and chaotic behavior. A person with a psychosis is often called “crazy.”

Delusions
Delusions are false thoughts that are not shared by anyone else in the affected person’s environment. The person with delusions is convinced that her/his ideas are the truth, even if there are signs that prove that s/he is mistaken. The person persists with these ideas. Examples:
Believing that people are trying to poison or kill him/her, even when there is no evidence in support of this notion
Suspecting that everyone is talking about him/her in the village or on the radio
Being convinced that persons have implanted radio equipment in her/his body so that the American army can keep track of her/his actions
Being certain that s/he has a lethal disease such as cancer or AIDS, while all medical tests show that s/he does not have one
Thinking that s/he is very famous or rich, when this is known not to be true

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

Hallucinations
When a person hallucinates, s/he is seeing or hearing things that are not real, and is convinced that they are real. Examples:
Hearing things that no one else can hear
• Voices talking to him/her, commenting on him/her
• Voices in her/his head
• Strange sounds or music coming from unknown places
Seeing things or persons that no one else can see
The person sometimes keeps silent about these things because s/he realizes that other people do not believe him. Often, however, s/he reacts to the hallucinations as if they are real. For example, s/he may talk or shout in response to someone that is not actually there.

Chaotic Behavior
A psychotic person may also display chaotic behavior, or behavior that is disorganized. When s/he starts an activity, it become a mess or is not completed. Examples:
Wearing clothes in a strange or inappropriate way
Collecting or keeping things that have no value
Destroying things without realizing what is happening
Sitting motionless, without moving, for a very long time
Laughing suddenly when nothing funny has happened
Crying without a clear reason
Showing indifference toward things that are generally relevant (for example, food, clothing, money)

When a person has more than two of these symptoms, a doctor can make a diagnosis of psychosis. This diagnosis may be further supported by the nurse/midwife’s observations of the patient’s behavior or reports made by the patient’s family.

**Onset and Development**
A psychosis can happen suddenly, which is known as an “acute psychosis.” Often, an acute psychosis is caused by an external factor. For example, the affected person has:
- Used certain medications (like corticosteroids)
- Used drugs (like hashish)
- Experienced a very stressful situation

Usually, however, the psychosis develops slowly. In the beginning, the family does not realize that something is wrong with the person. It starts with mild symptoms and gradually develops into a chronic disease. When the symptoms trouble the person for longer than 1 month and s/he is unable to function normally for longer than 6 months, we call the disease schizophrenia.

In the beginning, the symptoms may not reach a psychotic state. For example, the person starts to talk about certain things all the time, and is obsessed by them but is still able to behave normally. Gradually, the person stops going to work or school, and remains at home, behaving in an odd way. Her/his sleep may be disturbed, and s/he stops practicing good hygiene. After some time, the full range of symptoms of the disease manifest (hallucinations, delusions).

**Negative Symptoms**
A person with chronic schizophrenia often develops negative symptoms in addition to the symptoms we have already described. By “negative symptom,” we are referring to the absence of certain normal or characteristic behaviors. For example:
- Absence of emotions: the person feels indifferent, nothing seems to make him/her happy, sad or angry
- Absence of initiative: the person does not feel inclined to take action; s/he is not motivated to accomplish anything
- Absence of interest: the things that interested the person before s/he became sick do not interest him/her anymore, such as listening to the radio, hearing news about relatives, discussing politics or economics
- Absence of movement: the person can sit quietly and motionless for a long time

**Causes of Psychosis**
In some cases, it is clear what causes the psychosis. This is often the case with acute psychoses. For example, a psychosis develops after the affect person:
Starts to use hashish
Begins a new medication, such as corticosteroids
Gives birth to a child (post-partum psychosis)

In most cases, however, it is not clear what causes the psychosis; a combination of many factors contributes to its development. Some factors make a person vulnerable to developing a psychosis. Other factors can protect a person against developing a psychosis, or against worsening psychosis.

<table>
<thead>
<tr>
<th>Factors that Make a Person Vulnerable to Psychosis</th>
<th>Factors that Protect a Person Against Psychosis</th>
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</thead>
<tbody>
<tr>
<td>Biological</td>
<td></td>
</tr>
<tr>
<td>Changes in certain substances in the brain: research has showed that in persons with psychosis, some substances, called “neurotransmitters,” have changed in quantity</td>
<td>Not using any illegal drugs, like hashish</td>
</tr>
<tr>
<td>Heredity: when a person has relatives with schizophrenia, s/he has an increased risk of getting the disease</td>
<td>Sleeping regularly</td>
</tr>
<tr>
<td>Developmental changes in the brain</td>
<td>Avoiding medications like corticosteroids</td>
</tr>
<tr>
<td>Psychological</td>
<td></td>
</tr>
<tr>
<td>Stress caused by tension in the family, and by extreme worry about things: normal people can deal with common stressors, but for a person who is already vulnerable, they may be too much</td>
<td>Good support and encouragement of person</td>
</tr>
<tr>
<td></td>
<td>No excessive criticism or blame placed on him/her; relatives should have a good understanding of the disease and that it decreases her/his abilities to function</td>
</tr>
<tr>
<td>Social</td>
<td></td>
</tr>
<tr>
<td>Change of environment: often a person is able to behave normally in her/his own environment where everything is known, but starts to get more symptoms when brought to a new environment where everything is different</td>
<td>A stable environment, in which s/he is able to work and live quietly</td>
</tr>
<tr>
<td>Social pressure: when the relatives press the person to be more active, and want him/her to do things that are beyond her/his capacity</td>
<td>Clear rules for the person about what is acceptable and what is not; this gives the person a feeling of security</td>
</tr>
<tr>
<td>Stigma: a person with psychosis is often laughed at, and not taken seriously; s/he is sometimes not</td>
<td></td>
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</tbody>
</table>
allowed to go out of the house and is even kept isolated, which can increase the problem

**Identification of psychosis**

**Acute Psychosis**
It is often easy to identify a person with an acute psychosis. The history of strange behavior began suddenly and is of short duration. Family, friends and members of the community are worried about the person’s strange behavior or the risk of violence to the affected person him/herself, themselves and others.
Ask the relatives if the person has had a sudden change in behavior and what might have caused this change? Strange behavior can also be caused by acute infections such as cerebral malaria, brain fever (encephalitis), vitamin B deficiency, withdrawal from alcohol or drugs, head injury and epileptic convulsion.

**Schizophrenia**
Ask when the symptoms first started. Has the person ever been treated by traditional or modern methods for psychosis? What events made the symptoms worse?
Involve the family. Normally, the patient is not able to provide reliable information on her/his own.
Record the treatment the patient has had so far (kinds of treatments, including traditional or modern treatments; and dates of treatments). What treatments helped relieve the patient’s symptoms?
Ask the person directly about possible dangerous hallucinations, as follows. If the patient is having any such hallucinations, try to determine how dangerous this situation is for the patient and others.
“Do you hear voices when there is no one there?”
“Do these voices ever tell you to harm yourself or others?”
“Have they ever told you to kill yourself or anyone else?”
“Do they speak directly to you or among themselves (referring to you as s/he)?”
“Do you do what they ask you to do?”
In elderly people, the symptoms of chronic psychosis can be caused by a disease called dementia, which is characterized by loss of memory and slow deterioration in intellectual functions.

**Management of psychosis**

**Acute Psychosis**
Treat the patient gently and calmly and offer comforting words of support.
Put the person in a quiet, calm, private room at home or in the clinic. The situation can be made worse by a lot of noise or commotion, or if many others are watching. In general, patients will be much less disturbed in the familiar surroundings of their own homes, where family can help to take care of them.
There should be nothing dangerous that the person can grab to hurt him/herself or others. Restrain a person who is out of control, but do so gently. Sedation with drugs by a medical staff member is the best way. Using a cloth to tie the legs and arms to the body is
another gentle and easy method of restraint. **Do not restrain a psychotic patient with chains.**

Once the person has been secured in a safe environment, ask a few people, preferably family or friends, to watch over the person until there is no longer a risk of harm to anyone.

**Chronic Psychosis (Schizophrenia)**

**Biological Treatment**

Most patients with psychosis will benefit from medication especially designed to treat psychosis. Choosing the appropriate medication is the doctor’s responsibility. There are several types of anti-psychotic medications, such as:

- Chlorpromazine (Largactil)
- Haloperidol (Haldol)
- Flufenazine Decanoate injections
- Risperdal
- Biperiden (for side effects of antipsychotics)

The treatment of choice is chlorpromazine tablets (see below) or haloperidol tablets (see below). If these do not work properly given in an appropriate dosage for an appropriate duration, it is important find out why. If the treatment does not work because the patient refuses to take tablets by mouth, then switch to injections of flufenazine. If the patient suffers from side effects, change to risperdal.

**Side Effects of Antipsychotics**

Chlorpromazine, haloperidol and flufenazine can all cause side effects. One example is acute muscle spasm, sometimes of the jaw and neck. Often this happens within 1–2 days of the start of the treatment or an increase in dose. These spasms are very frightening for the patient. Such a patient should be seen by a doctor immediately. In severe cases, biperiden can be injected, which will decrease the spasm. Other examples:

- Sexual disturbances
- Restlessness of legs
- Parkinsonism
- Biperiden can also counteract these side effects.

**Duration of Treatment**

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

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

In chronic psychosis, the medication has to be taken for a long time—usually for more than 6 months. The patient should continue even when the symptoms of psychosis seem to have disappeared. Complete instructions should be given to patients and their family members.
Medication must be taken according to prescription:
The tablets have to be taken daily.
The injections are often only given once in every 3 to 4 weeks.
When a patient refuses to take pills, the underlying reason should be investigated. The nurse, midwife or community health workers should advise the patient to see a doctor who can, for example, give another kind of tablet, or an injection.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Indications</th>
<th>Contraindications</th>
<th>Side Effects</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine (100 mg tablets; 25 mg/ml injection)</td>
<td>Psychosis, Severe agitation and violent behavior in patient with organic disorders (delirium dementia), Mania, Severe agitation and violent behavior</td>
<td>Pregnancy, especially first trimester, Severe hypertension, Liver damage, Young age (not for use in children),</td>
<td>Sleepiness (sedation), Dizziness (orthostatic hypotension), Sexual disturbances, Acute muscle spasm (dystonia), Restlessness of legs, Parkinsonism</td>
<td>Start with 300 mg in two divided doses two times/day, Increase up to 600 mg in two divided doses/day, Maximum dosage is 900 mg in three doses (Use this with caution, because there is a high risk of side effects.) Note: Stop the drug or reduce the dose if the patient’s blood pressure drops, particularly when standing up.</td>
</tr>
<tr>
<td>Haloperidol (5 mg tablets)</td>
<td>Psychosis, Severe agitation and violent behavior in patient with delirium and dementia, Mania</td>
<td></td>
<td>Sleepiness (sedation), Sexual disturbances, Acute muscle spasm (dystonia), Restlessness of legs, Parkinsonism</td>
<td>Start with half tablet of 5 mg/day, Increase to 5 mg/day or, if needed, 10 mg/day, Usual maintenance dosage is 5–10 mg/day</td>
</tr>
<tr>
<td>Flufenazine</td>
<td>Chronic, Severe acute</td>
<td></td>
<td></td>
<td>Start with half tablet of 5 mg/day, Increase to 5 mg/day or, if needed, 10 mg/day, Usual maintenance dosage is 5–10 mg/day</td>
</tr>
</tbody>
</table>
### Drug Indications Contraindications Side Effects Dosage

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>decanoate (25 mg/ml ampules for intramuscular injection)</td>
<td>psychotic disorders</td>
<td>muscle stiffness with chlorpromazine or haloperidol</td>
<td></td>
<td>ampule of 25 mg intramuscular injection After 14 days, give 25 mg intramuscular injection Maintenance dosage is 25–50 mg/month</td>
</tr>
<tr>
<td>Risperdal (2 mg tablets)</td>
<td>Side effects from other anti-psychotic medications</td>
<td>Increased weight Nausea Sexual disturbances At doses higher than 6 mg, all side effects listed for chlorpromazine and haloperidol</td>
<td>Start with 2 mg per day (evening) Increase to 4 mg after 3 days (evening) Usual maintenance dosage is 4 mg/day</td>
<td></td>
</tr>
<tr>
<td>Biperiden (2 mg tablets; 5 mg/ml ampules for injection)</td>
<td>Side effects from other anti-psychotic medications</td>
<td></td>
<td>For Parkinsonism caused by an anti-psychotic, 2 mg twice daily For severe, acute dystonia, 5 mg IM injection</td>
<td></td>
</tr>
</tbody>
</table>

**Psychosocial Management**

**Education of Patient**

It is very important that the patient realizes that s/he has a disease. Often patients with psychosis do not accept this. The health worker should realize that the patient is often extremely fearful and perceives the world as hostile and dangerous. A health worker has to adopt a friendly approach, and explain things in a kind and understanding manner. For example:

“The voices that trouble you are caused by the disease. These medicines will make your brain stronger so that the voices cannot trouble you so much.”
“It is difficult for you to do your work and your activities. This is because of the disease that you have. I see that you are not a bad person.”
“It will be very difficult for you when people around you and even your family do not believe your ideas. This may cause problems for you and make you feel lonely.”
Try to motivate the patient to go back to work and think of himself/herself as part of the community.

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

Education of Community
Basic information about the disease can be helpful for neighbors and community leaders. This can be provided by the community health worker.

Psychosis after Childbirth
Symptoms
After childbirth, a mother may develop an acute and dangerous kind of acute psychosis. The symptoms of psychosis become obvious in the first 2 weeks after the delivery. The behavior of the woman changes very quickly and she starts to develop strange ideas, for example that other people are trying to harm her and her baby. She mistrusts people, including her family, and tries to isolate herself. When alone, she may harm herself or the baby, or neglect the baby. A woman with post-partum psychosis and her baby require immediate medical attention. When the condition is severe (for example, if she intends to harm herself or the baby), they will probably have to be admitted to the hospital. In this case, family members should be instructed to remain with the patient at all times.

If the patient stays home, she should not be left alone with the baby. Other people should stay with her, reassure her and help her take care of the baby. They should also ensure that she takes the medicines. With medication, the woman will completely recover from this disease in a few weeks.

Management
Biological: Haloperidol 5 mg per day. The woman can continue to breastfeed the baby/
Psychosocial:
Clear instruction to the family not to leave the patient alone.
Reassurance of patient and family
Definition and symptoms
From time to time every person feels sad or unhappy, particularly when a person experiences an important loss (e.g., the death of a loved one). This is a normal part of life.

Sometimes a person can develop an illness that is characterized by sadness and loss of pleasure. This is called depression. A depression is a mental illness that involves the body, mood, and thoughts. It affects the way the person eats and sleeps, the way one feels about oneself, and the way one thinks about oneself and things.

A depression is not the same as feeling unhappy or sad. It is a real disease that can make the person suffer, just as any other disease. It is not a sign of personal weakness. A depression is a period of at least two weeks or longer, in which the person has:
- persistent low mood (feeling sad, empty, anxious) and/or
- lack of enjoyment, plus
- other symptoms:
  - tiredness
  - sleep problems (in particular early morning wakefulness, but some people have oversleeping)
  - loss of appetite (but some depressed people have overeating)
  - weight loss
  - difficulty concentrating
  - difficulty making decisions
  - loss of sexual desire
  - restlessness/irritability
  - persistent physical symptoms that do not respond to treatment, such as headache, stomach pain, constipation/diarrhea, chronic pain
  - thoughts that of worthlessness and uselessness
  - thoughts about death or suicide

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

Depression in women
Depression is more common in women than in men. This can be attributed to:
- biological differences, such as menstrual cycle changes and pregnancy (after the birth of a baby, a woman is more vulnerable to developing a depression)
- increased stress for women due to social and cultural restrictions
Depression in men
Men are less likely to develop a depression than women. But many men do still develop a depression. Often the disease is not recognized. Sometimes depression in a man leads to drug or alcohol abuse. Sometimes the depression in a man looks more like irritability and anger, and the feelings of sadness and helplessness are hidden because the man does not want to show them.

Causes of Depression
Several factors play a role in the development of a depression.

Biological Causes
People with a depression have changes in substances in the brain. Research has found that some substances in the brain are overactive while others are under-active during a depression. But these changes are most likely not the cause of the depression, but the result of the depression.
Heredity plays a role. Persons who have family members who had a depression are more likely to develop a depression.
Some physical illnesses can play a role in the development of depression, e.g., hormonal disorders, Parkinson disease.
Some medication can cause depressive feelings, e.g., hormones like corticosteroids, or medications used for high blood pressure.
Some illegal drugs (hashish or opium) or alcohol can contribute to the development of depression.

Psychological Causes
Some people are more likely to develop a depression. For example, persons who are very dependent on others (who only feel good about themselves if they are praised by others), or who are very strict and punctual (who become anxious and stressed when things do not go as they should go) are more likely to get a depression when they are under stress.
People who in general think in a negative way about themselves (evaluate their own accomplishments as negative) and who perceive the world in a pessimistic way, are more likely to develop a depression.

Social Causes
Depressive episodes are often provoked by a change in the life of a person. For example:
When a person moves to a different district where s/he does not know the environment or the people.
When a person loses a job.
When a person has long-term financial problems.
When there are family problems or marital problems.

Very often a combination of biological, psychological, and social factors are involved in the onset of a depression. This means that the health worker has to investigate carefully in each depressed person what factors could have played a role:
Biological:
ask about depression in the family
ask about physical diseases
ask about use of medication
ask about use of illegal drugs (hashish, opium)
Psychological:
ask about the person’s personality before s/he developed a depression
Social:
ask about the changes in the person’s life before the depression started—changes in the family situation, changes in economic situation, death of family members, etc.

**Identification of depression**
The most important way to identify a person with a depression is to talk to the person and take a careful history. Guidelines on how to talk to a person who possibly has a depression include:

- Find out if the person has symptoms of depression. How long have the symptoms occurred? Ask the patient and her/his family if the symptoms interfere with daily functioning (at home, school, or work) or the person’s capacity to earn a living.
- Ask the patient and her/his family about what events they think are responsible for causing the depression.
- Some depressed people will deny that they are sad or hopeless. They may say they are all right even if something bad has just happened. Often these people complain about physical problems instead. Other patients may be so depressed that they have few complaints and they stay quiet. They are seriously in great danger of killing themselves at some time.
- Find out in your first interview if the person is suicidal. Ask directly, as follows:
  - Do you think life is not worth living?
  - Would you prefer to be dead?
  - Have you thought of killing yourself?
  - Have you tried to kill yourself or do you have plans to kill yourself?
  - Also, ask about previous suicide attempts (previous attempts increase the risk of further suicidal behavior and will give you an idea of what they will do).
  - Patients who are very depressed may hear, see, or smell things that aren’t really there (hallucinations). This is called psychotic depression. This a depression plus additional symptoms of psychosis. Ask direct questions that test for this, such as “Do you sometimes hear voices when there is no one there?”
  - Ask people who are hearing voices if the voices are ordering them to kill themselves or others. If they say “Yes” ask, “Do you feel you are able to resist these voices?” Some depressed people will also say that they are having upsetting feelings often associated with death. For example, they smell dead bodies or feel they are infested with snakes or worms. Ask family members if the patient has any unusual or false beliefs (delusions), for example that they are the cause of all the misfortune befalling the family or country, or that their children are going to be taken away from them and killed. Sometimes the beliefs have to do with their body, such as that they have cancer. If the patients say they hear voices or have false beliefs, consider this as a possible psychosis.

**Management of Depression**
When a person has a depression the treatment should cover the three domains: biological, psychological, and social.

**Biological Treatment**

Medication for depression can be very effective. It is for the doctor to decide if a patient should use the antidepressant medication. There are several antidepressant medications:
- Tricyclic drugs (amitriptyline)
- SSRI (fluoxetine)
- Tranquillizers (e.g., valium or alprazolam) are sometimes given for a short period. These medications can cause dependency and should be used with caution.

All antidepressants are equally effective but the differences are in the side effects and their costs. Tricyclic antidepressant were discovered first. They have more side effects than the newer antidepressants. They are the drug of choice in severe depression and their price is low. Remember the following points:

- It usually takes a few weeks before the medication has its effect on the depression. If the patient’s condition has not improved after a few weeks, the doctor can increase the dose.
- It is important to be aware that initially the patient feels only effects in the body, while the mood is unchanged. The health worker should inform the family that these effects on the body are not harmful. They are a sign that the medication is working in the person. It should not be a reason to stop taking the medication. The effects on the body become less after time, but some of them remain as long as the persons use the medication. When the person stops the medication, these effects will also stop.
- The medication should be taken for a long period of time, often for six months or longer.

The first line medication recommended in the Basic Health Center is amitriptyline (see guidelines, below) or in some cases fluoxetine (see guidelines, below).

### Guideline: Treatment of Depression with Amitriptyline

| Step 1: | The initial dose of amitriptyline is 50 or 75 mg/day in two divided doses. |
| Step 2: | After one week, give 50 mg in the morning and 100 mg at night, or give 150 mg at night. |
| Step 3: | If the dose in step 2 does not work after one month from the start of treatment, give 225 mg/day. |
| Step 4: | Switch to fluoxetine if: amitriptyline did not work after 6 weeks; the patient has cardiac disease (e.g., irregular heartbeat or a murmur), epilepsy, or an enlarged prostate; or the patient is older than 65 years. |

Side effects of amitriptyline include:
- tiredness
- dry mouth
- dizziness when the person changes position from lying or sitting to standing, s/he will feel dizzy due to a drop in blood pressure
- constipation
Guideline: Treatment of Depression with Fluoxetine

Step 1: Give fluoxetine capsules 20 mg/day. In case of sleep problems, add benzodiazepine for a period of 2 weeks (diazepam 5 mg/day maximum for 2 weeks).

Step 2: If the dose in step 1 does not work after three weeks, increase dose 40 mg.

Side effects of fluoxetine include:
- nausea
- anorexia
- diarrhea
- headache
- diminished sexual libido
- sleep problems

Guideline: Treatment of Psychotic Depression

Step 1: Give amitriptyline plus haloperidol 5 mg plus biperiden.

Psychological Treatment

Talking can be very helpful for a person who has a depression. When a health worker is using talking as a treatment method it is called counseling. For more information about counseling, see Chapter 4.

The person who is depressed thinks that her/his mood and situation will never change. It is important to remember that this belief of the person with depression is one of the symptoms of the illness.

Some guidelines when talking with a depressed person:
- Make the person feel comfortable to talk about her/his feelings.
- Emphasize that you will keep secret what s/he tells you.
- Listen attentively and sympathetically.
- Explain that the person has a depression, and tell her/him something about the treatment.
- Emphasize positive aspects during the conversation.
- Explore with the person how to think in a different way.
- Give the person hope that this condition will change.

Some things should be avoided when talking to a depressed patient:
- Do not judge, such as saying that s/he is not a good husband/wife/parent.
- Do not tell the person to be happy.
- Do not remind her/him all the time how wonderful life is.
- Do not tell the person that the depression is caused by her/his own failures.
Do not immediately give advice to the person. Listen first, see what the person comes up with, and emphasize the good things.

**Social Treatment**
Depressed people feel extremely lonely, even when there are other people around. It is important to lessen the isolation of a depressed person. It is helpful for a depressed person to have signs that people are supportive. This means that it is necessary to involve the family:
- Explain the disease to the family.
- Talk to the depressed person about what activities s/he enjoys. Plan at least one enjoyable activity for each day.
- Make a plan for activities the patient can do. For example ask the patient what goals s/he would like to achieve, and make a plan with small, realistic steps for how to reach that goal.
- Make a plan with the patient for daily activities, in which there is a balance between enough rest and activities. Discuss this plan with the family and the patient.
- Encourage the family to do some physical activities with the patient, in particular in the morning. For example, getting water from the well or going to the market early morning. In Western countries people with depression are advised to run for a few kilometers every morning. Alternative sport activities can be done inside the house, such as push-ups, jumping rope, etc.
CHAPTER 7: ANXIETY AND TRAUMA

DEFINITIONS AND SYMPTOMS

Anxiety is normal. All humans experience anxiety or fear at some time in their life. Anxiety is a signal that alerts us to danger and it enables us to take measures against a threat. Example: A man walks in the street and suddenly a car comes with high speed right in front of him. He will feel fear. This reaction of fear prompts an emergency reaction to run quickly, and to save his life. If he feels no fear at all, he would look at the car and do nothing and be the victim of a serious car accident.

Anxiety refers to emotional and physical disturbances due to intense fear and worry. Often people face threats in their lives. People have to cope with many problems such as lack of food and shelter, unemployment, robberies and other incidents. There are also other problems like family conflicts, marital problems, poor living conditions, or many responsibilities. Many people also worry about things they have lost or they worry about their future, and especially about the future of their children.

Sometimes people become overwhelmed by these fears and worries. Stress may happen repeatedly or may become too severe for people to cope with. These worries and fears may cause physical disease and mental difficulties. Family and friends may not be able to help them cope with stress.

Mild depression can occur in combination with mental illness caused by fears and worries. In general, the person may look healthy and carry on with normal activities at work or at school.

Symptoms of Anxiety

A person who experiences anxiety will have several physical and mental reactions.

Physical Reactions

Anxiety can manifest itself in many parts of the body, including the following:

Gastrointestinal system:
- dry mouth
- upset stomach
- diarrhea

Cardiovascular system:
- increased heart rate
- high blood pressure
- sweating

Respiratory system:
- increased respiratory rate
- chest tightness
- chest pain

Urinary system:
increased urinary frequency
Sensory-motor system:
  tingling sensation in fingers or toes
  trembling
  dizziness/lightheadedness
  headaches

**Mental Reactions**

Anxiety will also affect the mental state of the person. This can manifest in different symptoms such as:
overwhelming fears and worries
tension, feeling shaky
restlessness, feeling tired
feeling keyed-up, on edge, or jittery
easily startled by sudden sounds
insomnia
always complaining
unable to concentrate on work or play

**Normal Versus Abnormal Anxiety**

Anxiety is usually a normal thing, but sometimes the anxiety can become a problem. in this case, it is called an anxiety disorder. Anxiety becomes abnormal if, for example:
the anxiety lasts too long;
the anxiety is too severe; or
the person fears things that are not fearful.

When anxiety becomes chronic this could lead to chronic physical symptoms, and a patient can visit a doctor with presenting symptoms of stomach problems, intestinal problems, problems in breathing, or pain. A person with chronic anxiety may experience pain due to chronic tension in the muscles, such as shoulder pain, neck pain, or headache.

**Types of Anxiety Disorders**

**Chronic Inner Fear (Generalized Anxiety Disorder)**

Sometimes people have a fear of many things. They worry about everything. The fear is not so much related to something outside (as in fear of specific situations) but is inside the person. S/he feels a constant anxiety inside, and often does not even know why s/he worries. Whenever something might go wrong s/he starts to think about it. They cannot control the worrying. This can exhaust the person and s/he can feel tired, does not sleep well, and has muscle pains.

Many times this condition goes together with depression, but sometimes it is separate. This condition is somewhat similar to the Pashtu word *waswasi*. 
**Panic Disorder**

Another type of anxiety disorder is when the person experiences sudden attacks of extreme fear without reason. These episodes last for a few minutes, and are called panic attacks. A panic attack is characterized by:
- sudden onset;
- many physical symptoms (e.g., hyperventilation, increased heart rate, sweating, trembling, etc.);
- terrible, fearful thoughts (e.g., fear to faint, vomit, have a heart attack, choke, die, etc.).

As a result, people with recurrent panic attacks may start to avoid situation where such an attack could happen without help being available. They might fear leaving the house out of fear of having an attack. They might avoid travel, being alone in a room, or going outside their home. One incidental panic attack can be normal, but if the attacks recur, or are accompanied with avoidance and social disability, then it is abnormal and is referred to as panic disorder.

**Fear of Specific Situations (Specific Phobia)**

A person can have an exaggerated fear of specific things or situations that other persons do not fear so much, such as a fear of:
- high places
- certain animals (spiders, snakes, dogs)
- blood
- social situations where the person feels s/he can be criticized, like speaking in public or participating in a party

By themselves, these fears are not abnormal. To a certain extent every person has some of these fears. It can become a problem when:
- the fear is exaggerated
- the person starts to avoid the situation and is less able to function normally.

Example: A person has a fear of blood. This is not a problem when the person is a farmer. But it is a problem when the person is a health care provider and tries to avoid seeing blood all the time.

**MANAGEMENT OF ANXIETY**

**Biological Management**

The best solution for anxiety is to help the person solve his problem. Often there may be help from relatives and friends of the patient. If it is not possible to solve the problem, we can persuade her/him to adjust to the problem. Medicine can be of help to reduce the symptoms but should be accompanied by advice to change something in the behavior or way of thinking of the patients. Medicine cannot solve an underlying problem that causes anxiety.
The symptoms of anxiety disorder may also develop in many physical diseases. Think about a physical cause when there is no obvious psychosocial problem, the person loses weight, or has fever.

Medication that can be used to treat anxiety disorders includes:

Benzodiazepines—These are medicines that relax the muscles and give a feeling of calmness. They give immediate relief of symptoms but should be prescribed with caution. They should be used for a short period (not longer than two weeks) because of the risk of developing drug dependency. Example: diazepam 10 mg twice daily.

Fluoxetine or amitriptyline—Fluoxetine capsules can be used to control the symptoms of generalized anxiety disorder. The average dose of fluoxetine for anxiety disorders is 20–60 mg. Amitriptyline can be effectively used for panic disorder.

Beta blockers (propranolol)—In some cases a patient can benefit from addition of propranolol, which is used for high blood pressure. One of the effects of propranolol is reduction of the heart rate. It should be given in a low dose of 10 mg 3 times/day.

**Psychological Management**

**Behavior Therapy**

In behavior therapy, the health worker tries to shape a desired behavior by rewarding or positively reinforcing the desired behavior and negatively reinforcing the unwanted behavior. The best rewards are attention, praise, sympathy, or a small prize. Negative reinforcing can include ignoring the person, not giving sympathy, or simply removing the person from that place. For example, when a child misbehaves you can ignore the child, and praise the child when s/he behaves properly.

An effective behavior therapy for fear of objects or situations (phobias) is desensitization, where the person is helped to get over the fear by becoming gradually habituated to the feared object or situation.

Behavior therapy can be used in the primary health care level, but the health care provider needs some experience to use it.

**Social Management**

Find out the life events, personal situation, and other social problems that make the person feel frightened and worried. Talk also with family, so that you could persuade them to help with the patient’s problem. Do not make any promise that you may not be able to keep. Sometimes, nobody can tackle a person’s problem. In these cases help the person to adjust and make the best of the situation. As a last resort, for example in a war situation, you may have to consider that the person with intense fears may need to move to a safer and quieter environment.

Explain to the patient about the relationship between anxiety and bodily symptoms. It is often necessary to repeat this information several times, because a patient who is anxious has problems concentrating, and might forget what s/he has been told. Techniques that
lead to greater mental tranquility, such as relaxation exercises or mindful breathing, are very helpful to reduce anxiety.

It is often helpful to explain to the family as well about the symptoms, so that they will be better able to reassure the patient.

**ANXIETY DISORDERS CAUSED BY EXTREME EVENTS**

When a person experiences an event that is extremely stressful, s/he can develop a strong fear reaction. This reaction can last some days or weeks. This is normal. For example, a person who escapes from a burning house, will have a fear reaction in the next days that may include sleeping difficulties, dreaming about the event, being fearful of noise, crying. This is a normal reaction. But sometimes the fear reaction persists. The person can develop symptoms of post-traumatic stress disorder (PTSD). Because of this fear reaction the person is unable to function normally.

It is estimated that up to 15% of the persons who experienced a terrible event will develop PTSD. The diagnosis of PTSD is made if the person has all four of the following:

1. Experienced an event that caused extreme fear or horror. It can be an event that threatened the life of the person, or an event that involved violence to other persons while the patient felt extremely powerless. Examples of such events could be:
   - nearly being killed
   - seeing relatives killed
   - being tortured
   - being in house that is bombarded
   - being raped
   - being in a burning house
   - being in a severe car accident
   - being forced to watch someone be tortured or raped.

2. Re-experiencing the event:
   - continually re-experiencing the event through images, thoughts that come involuntarily to the person’s mind, daydreams, or nightmares
   - acting and feeling as if the event is still happening in the present (the person knows that it is the past, but it feels as if it is the present)
   - fear in the presence of things that remind the person of the event

3. Avoidance:
   - avoiding places and thoughts that might remind the person of the event

4. Arousal:
   - hyper-alertness
   - strong fear reactions in the body when hearing loud sounds, or someone touching the person
   - difficulty concentrating
   - irritability and being angered easily
Management of PTSD

**Biological Management**

Medication is not very helpful for a person with PTSD. Sometimes sleeping tablets and tranquillizers (such as diazepam) are prescribed, but this often helps only temporarily. The danger with these medication is that they can lead to a drug dependency. Sometimes a doctor can prescribe fluoxetine for a patient with PTSD.

**Psycho-Social Management**

It is very important that the person and the family are aware of the symptoms. Sometimes the family is angry with the patient because s/he is so irritable. Sometimes the patient thinks that her/his lack of concentration will increase over time. When a person understands that the symptoms are part of a disease that can improve over time s/he will feel reassured.

**Creating a Safe Place**

A person with a PTSD feels unsafe and in danger. The symptoms can decrease if the person has a place where s/he can feel relaxed or safe, such as:
- a certain place for praying
- a garden with beautiful flowers

**Activities that Distract the Mind**

It is often helpful to do activities that distract the mind from the terrible event. Some activities such as knitting, gardening, carpentry, or drawing can be helpful because they:
- are not too difficult
- have some element of repetition
- can be done for a short time, and be resumed easily at a later time
- give the person the feeling that s/he is able to master something or to create something that is good and new

Activities such as reading or making calculations are often difficult because the concentration of the person is not very good.

**Counseling**

It can be helpful to talk with a person about what has happened. This is often a very painful thing for the patient, because s/he often tries to forget about the event. A few points to keep in mind when counseling a person with PTSD include:
- The person has experienced an event that was threatening and very painful to her/him.
- This means the counselor should never force the patient to continue. It is the patient who decides if s/he is willing to continue talking about what happened.
- The role of the healthcare provider is to encourage in such a way that it is not threatening to the patient and gives the patient a feeling that s/he is safe now.
CHAPTER 8: MENTAL RETARDATION

Definition and symptoms
Mental retardation is characterized by:
a low intelligence and
limitations in daily life such as:
communicating
taking care of her/himself
social skills

These limitations will cause a child to learn and develop more slowly than a normal child. Children with mental retardation may take longer to learn to speak, walk, and take care of their personal needs such as dressing or eating. They are likely to have trouble learning in school. They will learn, but it will take them longer.

Mental retardation is a permanent condition. A person who is temporarily confused and not able to function does not have mental retardation.

Diagnosing Mental Retardation
There are many signs of mental retardation. For example, children with mental retardation may:
sit up, crawl, or walk later than other children
learn to talk later, or have trouble speaking
find it hard to remember things
not understand how to pay for things
have trouble understanding social rules
have trouble seeing the consequences of their actions
have trouble solving problems
have trouble thinking logically

To diagnose mental retardation we have to assess the intelligence and the adaptive behavior

**Intelligence.** Intellectual functioning can be measured by a test called an IQ (intelligent quotient) test. The average score is 100. People scoring below 70 to 75 are thought to have mental retardation. Most of these tests are developed in Western countries and cannot easily be used in a non-Western country. It is easier to assess intelligence by:
- Asking questions of the child and assessing the answers (Does the child understand questions? Can s/he make simple calculations? Does the child use only simple language or also more difficult words?). Judge the use of language and the appropriateness of words.
- Asking questions of the caretakers (parents or teachers) (How quickly can the child understand new things? Is s/he able to attend school? Is the child slower in understanding than other children of her/his age? How are the child’s abilities in comparison with younger children in the family?).

**Adaptive behavior.** Adaptive behavior indicates whether the person has the skills s/he needs to live independently. To measure adaptive behavior, a health worker should look
at what a child can do in comparison to other children of his or her age. Certain skills are important to adaptive behavior. These are:

daily living skills, such as getting dressed, going to the bathroom, and eating on their own
communication skills, such as understanding what is said and being able to answer
social skills, such as how the person acts with other children, with peers, family
members, adults, etc.

A health worker in a basic health center can diagnose mental retardation by:
carefully observing the behavior of the child
observing the child’s physical appearance (e.g., small or large head, moon shaped face, slanting eyes, etc.)
talking to the mother in detail about the milestones of development, and checking if the child was delayed in reaching these milestones:
holding neck erect: 3 months
sitting with support: 6 months
walking: 9–12 months
speaking a few words: 18 months

There are different degrees of mental retardation, ranging from mild to profound. A person’s level of mental retardation can be defined by her/his intelligence and by the amount of support s/he needs. More than 3 out of every 100 people have mental retardation; most of these cases are only mild.

After the diagnosis of mental retardation is made, the person’s strengths and weaknesses should be assessed. Look at how much support or help the person needs to get along at home, in school, and in the community. This approach gives a realistic picture of each individual. As the person grows and learns, her/his ability to get along in the world grows as well.

Most of the people with mental retardation will only be a little slower than average in learning new information and skills. When they are children, their limitations may not be obvious. They may not even be diagnosed as having mental retardation until they get to school. As they become adults, many people with mild retardation can live independently. Other people may not even consider them as having mental retardation.

**Mild Mental Retardation (IQ 50–70)**
People with mild mental retardation develop more slowly than other children but are eventually able to use speech for everyday purposes and to have conversations with people. Most of them achieve full independence in self-care (eating, washing, dressing, self care, bowel and bladder control) and in practical and domestic skills.

The main difficulties are seen in school performance, where they often have problems in learning reading and writing. They are often able to do unskilled labor or domestic work. There is emotional and social immaturity, and this can lead to inability to cope with the demands of marriage and child rearing.
Moderate Mental Retardation (IQ 35–50)
People with moderate mental retardation are slow in developing their language skills, and even at adult age have only limited use of language. They can often take part in only very simple conversations, and understand clear instructions. They have great difficulties at school, but some can learn some very basic writing and counting. Achievement of self-care is limited. They need supervision throughout life. They often can do simple, practical work, if the tasks are carefully structured and supervision is available.

Severe Mental Retardation (IQ 20–35)
People with severe mental retardation usually never learn to speak, but may understand simple instructions. They often also have physical disabilities and often cannot walk without assistance (indicating severe damage to the brain).

Profound Mental Retardation (IQ < 20)
People with profound mental retardation are severely restricted in their ability to understand or comply with even simple instructions. Most individuals are severely restricted in their mobility (they cannot walk), are incontinent, and only use extremely simple forms of non-verbal communication. They need constant help and supervision.

Causes of Mental Retardation
Doctors have found many causes of mental retardation. The most common are:
Genetic conditions. Sometimes mental retardation is caused by abnormal genes inherited from parents, errors when genes combine, or other reasons. An examples of a genetic conditions is Down syndrome (see below).
Problems during pregnancy. Mental retardation can result when the fetus does not develop properly. A woman who drinks alcohol, is malnourished, or gets an infection like Rubella during pregnancy may also have a baby with mental retardation. In some parts of Afghanistan, limited availability of iodine in the food of the mother during pregnancy can cause malnutrition in the baby.
Problem around birth:
If problems occur during labor and birth, such as not getting enough oxygen, or head damage during the delivery, the baby may have mental retardation.
Mental retardation can also be caused by kernicterus, a kind of brain damage that happens when the liver of the newborn baby is not yet functioning well. The liver is not able to deal with bilirubin (caused by destruction of old red blood cells). If too much bilirubin builds up in a new baby’s body, the skin and whites of the eyes turn yellow, which is called jaundice. A little jaundice is not a problem, and is very common in newborn babies. When the jaundice does not go away after the first week it can be dangerous. If not treated, high levels of bilirubin can damage the brain and cause cerebral palsy or mental retardation. A child with prolonged jaundice should be referred to specialized centers to be treated with special lights (phototherapy).
Health problems in the early years. Diseases like whooping cough, measles, meningitis, or cerebral malaria can cause mental retardation. Mental retardation can also be caused by extreme malnutrition (not eating right, or too little). Head injuries (accidents or beating) can also disrupt the development or functioning of the brain, leading to mental retardation.
Down Syndrome

Down syndrome consists of some recognizable physical characteristics and limited intellectual endowments. Children with Down syndrome are usually smaller, and their physical and mental developments are slower, than children without Down syndrome. Most children with Down syndrome have mild or moderate mental retardation. There is a wide variation in mental abilities and developmental progress in children with Down syndrome. Also, their motor development is slow; children with Down syndrome usually learn to walk between 15 and 36 months. Language development is also delayed.

Children with Down syndrome have distinct physical characteristics, which can be useful to the physician in making the clinical diagnosis, but no emphasis should be put on those characteristics otherwise. Some of the physical features in children with Down syndrome include:
- flattening of the back of the head
- slanting of the eyelids
- small skin folds at the inner corner of the eyes
- decreased muscle tone
- loose ligaments
- small hands and feet
- one line across the palm of the hand, instead of two lines (found in about half of children with Down syndrome)
- gap between the first and second toes

Down syndrome is caused by the presence of an extra chromosome 21. Instead of 46 chromosomes in each cell, a person with Down syndrome has 47 chromosomes. This condition is called trisomy 21. The estimated incidence of Down syndrome is about 1 in 1,000 live births. The risk of having a child with Down syndrome increases with advancing age of the mother. The older the mother, the greater the possibility that she may have a child with Down syndrome. However, most babies with Down syndrome are born to mothers younger than 35 years.

The child with Down syndrome has more risks for physical disorders. Most children with Down syndrome have hearing deficits, and half of the children with Down syndrome have congenital heart disease.

There is no effective medical treatment for Down syndrome. Assistance to the families will result in better development of the child. A caring and enriching home environment will have a positive influence on the child’s development. Children with Down syndrome, like all children, benefit from sensory stimulation and specific exercises involving gross and fine motor activities. The family and community can help the child in obtaining a feeling of self-respect and enjoyment. Contrary to some views, all children can learn, and they will benefit from placement in a normalized setting with support as needed. When a person with Down Syndrome works, s/he needs help in order to learn good work habits and to engage in proper relationships with co-workers.
Mental Retardation in Combination with Other Problems
Mental retardation can be accompanied by other problems such as:
Epilepsy—About one in four of the children with mental retardation also have epilepsy. A health worker should ask whether a mentally retarded child also suffers from epilepsy because it can be treated.
Cerebral palsy—When there is damage to motor areas in the newborn’s brain, the child’s ability to control movement and posture is disturbed. This is called cerebral palsy. A child with cerebral palsy often also has mental retardation. Early signs of cerebral palsy appear before 3 years of age. Infants with cerebral palsy are slow to reach developmental milestones such as learning to roll over, sit, crawl, smile, or walk. There is no cure for cerebral palsy, but mechanical aids may to help overcome impairments, and counseling will help the patients and parents to cope with emotional and psychological needs.
Abuse—Persons with mental retardation are vulnerable to people who want to take advantage of them. The incidence of physical and sexual abuse among them is much higher than among others.

Management of mental retardation
The health worker can educate the parents about the following things:
Mental retardation is not a disease and cannot be cured.
Mental retardation of the child is not their fault or a punishment for their sins.
A mentally retarded child can learn many things (see the list of target activities). It just takes them more time and effort than other children.
Teaching the child requires a lot of patience and encouragement. It is better to praise the child when s/he is doing something well than to punish her/him when a mistake is made.
Repetitions are extremely helpful in training a mentally retarded child. Break down jobs into smaller steps. Show the child what to do, step by step, until the job is done.
Parents can encourage independence in their child by teaching daily care skills, such as dressing, feeding, using the bathroom, and grooming.
It helps to talk to other parents whose children have mental retardation. Parents can share practical advice and emotional support.

Teaching a Mentally Retarded Child

It is important to have goals for teaching a mentally retarded child.

<table>
<thead>
<tr>
<th>Age</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–2 years</td>
<td>Recognize familiar people</td>
</tr>
<tr>
<td></td>
<td>Walk</td>
</tr>
<tr>
<td></td>
<td>Talk in short sentences</td>
</tr>
<tr>
<td></td>
<td>Does not drool</td>
</tr>
<tr>
<td></td>
<td>Follow simple instructions</td>
</tr>
<tr>
<td></td>
<td>Drink from a glass unassisted</td>
</tr>
<tr>
<td></td>
<td>Differentiate between edible substances</td>
</tr>
<tr>
<td>2–4 years</td>
<td>Chew food</td>
</tr>
<tr>
<td></td>
<td>Toilet trained</td>
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<tr>
<td>----------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Help with simple household activities</td>
</tr>
<tr>
<td></td>
<td>Avoid simple dangers like fire</td>
</tr>
<tr>
<td>4–7 years</td>
<td>Bathe and dress</td>
</tr>
<tr>
<td></td>
<td>Play with other children</td>
</tr>
<tr>
<td></td>
<td>Write a few words</td>
</tr>
</tbody>
</table>
Decide target activities, starting from easy to more difficult ones.
Divide the activities into steps, e.g., bathing is not one single activity—teach the child to hold the jug of water, then to pour water on her/himself, then to rub the soap, then to wash it off.
Teach each step one at a time.
Parents should repeat the same activity every day for 2–3 weeks.
Perform each activity with the child rather than instructing her/him to do it on her/his own.
Each activity can be taught as a game.
Reward the child with a candy or praise every time s/he performs the desired activity.
Advise the health worker in the area to follow the progress of the child for at least one month.
CHAPTER 9: EPILEPSY

Definition and symptoms
Epilepsy is a brain disorder characterized by spontaneous, repetitive seizures. A normal brain gives electric signals all the time. This is called neuronal activity. During an epileptic seizure the normal pattern of neuronal activity becomes disturbed, resulting in muscle spasms, loss of consciousness, and additional symptoms. In some epileptic patients, this happens only occasionally; for others, it may happen many times a day. The prevalence of epilepsy worldwide is about 5 per 1,000 people. In Pakistan, a prevalence of 10/1000 was found. No figure is known for Afghanistan.

Types of Seizures

Generalized Seizures
Generalized seizures are a result of abnormal electric activity in many parts of the brain. See Figure 9.1. These seizures may cause loss of consciousness, falls, or massive muscle spasms. The main characteristics of a generalized seizure are:
- Sudden fall with injury, tongue bite, frothing from mouth
- Jerky movements of limbs
- Blank stares during attack
- Incontinence of urine and feces
- Impaired consciousness during attack

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

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

Figure 9.1. Generalized seizure (copied from Dekker 2002)
Absence Seizures

Absence seizures are short periods of loss of consciousness lasting only a few seconds (not more than 30 seconds). The person often shows a blank stare and a brief upward rotation of the eyes. The person does not respond when spoken to. The absence starts suddenly and then is suddenly over. After the absence the person continues what s/he was doing before the seizure. S/he has no memory of the seizure. Absence seizures happen mostly in children and are often not diagnosed. The parents or teachers think that the child is inattentive and does not want to listen.

Partial Seizures

In partial seizures the abnormalities occur in just one part of the brain (see Figure 9.2). This makes the symptoms variable and dependent on where in the brain the abnormality is located. About half of the people with epilepsy have partial seizures. There are two types of partial seizures:
In a simple partial seizure, the person will remain conscious. The attack is characterized by epileptic symptoms in only a part of the body. Most often the seizure leads to brief twitching of groups of muscles, often in the arm or face. A simple partial seizure can also manifest itself in sensory symptoms, for example seeing flashes or bright colored light.
In a complex partial seizure, the person has a changed consciousness. During the period of the attack s/he does not react to normal talking and might look as if s/he is in a dreamlike state. People having a complex partial seizure may display strange, repetitious behaviors such as blinks, twitches, or mouth movements. These repetitious movements are called automatisms. These seizures usually last just a few seconds.

The symptoms an individual person has, and the progression of those symptoms, tends to be stereotyped, or similar every time.

Figure 9.2. Partial seizure (copied from Dekker 2002)
When Are Seizures Called Epilepsy?
Having a seizure does not necessarily mean that a person has epilepsy. Only when a person has had two or more seizures is it considered epilepsy. Epilepsy is not contagious and is not caused by mental illness or mental retardation. Some people with mental retardation may experience seizures, but seizures do not necessarily mean the person has or will develop mental impairment. Many people with epilepsy have normal or above-average intelligence.

Seizures sometimes cause brain damage, particularly if they are severe. However, most seizures do not seem to have a detrimental effect on the brain. Any changes that do occur are usually subtle, and it is often unclear whether these changes are caused by the seizures themselves or by the underlying problem that caused the seizures.

Causes of epilepsy
Epilepsy is a disorder with many possible causes. Anything that disturbs the normal pattern of neuronal activity in the brain can lead to epileptic seizures. About half of all seizures have no known cause. Some known causes of epilepsy include:
Genetic factors. Some types of epilepsy tend to run in families, which suggests that genes influence epilepsy. For many forms of epilepsy, genetic abnormalities play only a partial role, perhaps by increasing a person’s susceptibility to seizures that are triggered by an environmental factor.
Problems during pregnancy. The developing brain is susceptible to many kinds of injury. Maternal infections, poor nutrition, and oxygen deficiencies can damage the brain of a developing fetus. These conditions may cause epilepsy and/or cerebral palsy (which goes together with epilepsy). About 20% of seizures in children are due to cerebral palsy.
Problems around birth. Complications at birth such as coiling of the umbilical cord or prolonged labor leading to lack of oxygen during delivery can cause brain damage and epilepsy.
Cerebral infections. Various factors that cause brain damage in children and adults can lead to epilepsy. When an infectious disease such as measles, herpes simplex, or malaria reach the brain and causes meningitis or encephalitis the patient risks permanent brain damage resulting in epilepsy. Cerebral malaria is one of the most common causes of encephalitis in Afghanistan. It is characterized by a coma (loss of consciousness) in a patient with a malaria falciparum infection and no other cause for the coma. About 10% of the survivors of cerebral malaria develop epilepsy.
Other external factors and diseases can cause brain damage. External causes of epilepsy include head injury due to a traffic accident or being hit by a heavy object. Epilepsy can also develop as a result of brain damage from other disorders, such as brain tumors, alcoholism, and dementia.

Seizures can be provoked by factors such as lack of sleep, alcohol consumption, or stress. These things do not cause epilepsy but can provoke seizures in people who otherwise experience good seizure control with their medication. For this reason, people with epilepsy should make sure to get enough sleep and should try to stay on a regular sleep schedule as much as possible. For some people, light flashing at a certain speed or the
flicker of a computer monitor can trigger a seizure; this problem is called photosensitive epilepsy.

**Identification of epilepsy**

To determine whether a person has epilepsy, the following things should be taken into consideration:

Medical history—Taking a detailed medical history, including symptoms and duration of the seizures, is the best method available to determine if a person has epilepsy and what kind of seizures they have. The doctor should ask detailed questions about the seizures and any past illnesses. Since people who have suffered a seizure often do not remember what happened, the family members’ accounts of the seizure are important.

Blood tests—Blood samples can be taken to check for underlying problems such as infections, anemia, and diabetes that may be causing or triggering the seizures.

EEG monitoring—An EEG records brain waves using electrodes placed on the scalp. This can detect abnormalities in the brain’s electrical activity. People with epilepsy frequently have changes in their normal pattern of brain waves during the epileptic attacks. When they are not experiencing a seizure the EEG can be normal or abnormal. When an EEG shows abnormal brain waves the diagnosis epilepsy is confirmed. When the test results in between the attack are normal this does NOT prove that the person does not have epilepsy. EEG is not yet available in Afghanistan.

**Single Seizures**

Not all seizures are epilepsy. A single seizure can be triggered by a reaction to anesthesia or a strong drug. These single seizures usually are not followed by additional seizures, and should not be called epilepsy.

**Febrile Seizures**

Sometimes a child will have a seizure during the course of an illness with a high fever. These seizures are called febrile seizures and can be very alarming to the family. Most febrile seizures occur between the ages of 6 months and 4 years. Nearly 5% of all children have at least one febrile seizure in their life. Most children who have a febrile seizure do not develop epilepsy; only 2% will develop true epilepsy. Use of anticonvulsant drugs is not needed unless certain other conditions are present, such as a family history of epilepsy, or a relatively prolonged or complicated seizure.

**Non-Epileptic Seizures**

Sometimes people appear to have seizures, even though their brains show no seizure activity. This type of phenomenon has various names, including non-epileptic seizures. They will be described at the end of this chapter.

**Eclampsia**

Eclampsia is a life-threatening condition that can develop in pregnant women. Its symptoms include sudden elevations of blood pressure and seizures. Pregnant women who develop unexpected seizures should be rushed to a hospital immediately. Eclampsia can be treated in a hospital setting and usually does not result in additional seizures or epilepsy once the pregnancy is over.
Co-Morbid Conditions
Epilepsy is frequently accompanied by other conditions such as mental retardation or cerebral palsy, due to the same factors that cause these conditions. But most people with epilepsy have a normal intelligence. About 15% of people with epilepsy also have mental retardation.

Management of epilepsy
Biological Treatment
The most important part of the treatment of a person with epilepsy is medication. For about 80% of those diagnosed with epilepsy, seizures can be controlled with medicines. However, about 20% of people with epilepsy will continue to have seizures even with the best available treatment. Once epilepsy is diagnosed, it is important to begin treatment as soon as possible and continue the medication for a long time.

The drugs should be chosen based on:
- availability of drugs and price
- type of seizures
- side effects
- individual response of the patient

Anti-Epileptic Drugs in Basic Package of Health Services (BPHS)
Doctors seeing a patient with newly developed epilepsy often prescribe phenobarbital, carbamazepine, or sodium valproate. Phenytoin is not included in the BPHS. When the other drugs do not work it may be necessary to prescribe it.

Some drugs, such as phenobarbital, only need to be taken once a day, while others such as valproate must be taken more frequently.

Type of Seizures
It is difficult to predict which patient will react best on which medication. To give some general guidelines:
- For generalized seizures in children, start with phenobarbital.
- For generalized seizures in adults, start with sodium valproate or phenobarbital.
- For absences, start with sodium valproate.
- For partial seizures, start with carbamazepine.

Side Effects
Most side effects of anti-epileptic drugs are relatively minor, such as fatigue, dizziness, or weight gain. However, severe side effects such as allergic reactions can occur. People with epilepsy should consult a doctor immediately if they develop any kind of rash while on medication. Other danger signs are extreme fatigue, staggering or other movement problems, and slurring of words. In these cases stop the medication and switch to another type of anti-epileptic.
Be aware that epilepsy medication can interact with many other drugs in potentially harmful ways. For this reason, people with epilepsy should always tell doctors who treat them which medications they are taking.

**Individual Response of Patient**
When a person starts a new epilepsy drug, it is important to tailor the dosage to achieve the best results. People’s bodies react to medications in different ways. It may take some time to find the right drug at the right dose to provide optimal control of seizures while minimizing side effects. A drug that has no effect or very bad side effects at one dose may work very well at another dose.

**Starting and Stopping Anti-Epileptic Drugs**
In general it is best to start with a low dose of a new medication and increase the dosage after a few weeks based on the number and severity of attacks. A good tool to evaluate the effect of medication is to ask the patient to indicate each attack with a cross in a small notebook with a page for each week. In this way the doctor can evaluate the effect of certain dosage of medications on the epileptic symptoms.

Anti-epileptic medication should be taken for a long time. It is important to explain to the patient and family that the medication will control the disease, but will not cure it. Usually the medication can be discontinued after two years have passed without a seizure. The medication should be reduced stepwise and this should be done slowly (e.g., one tablet less each month). Suddenly stopping medication can lead to return of very serious epileptic attacks.

Many people want to reduce the medication after they have been seizure free. In particular in children this is often successful. More than half of children in whom epilepsy is controlled can eventually stop their medication without having new seizures.

**Prescribing Anti-Epileptic Medication**
Explain duration of therapy.
Only use long term treatment when person has more than two epileptics seizures.
Continue treatment until patient has had no seizures for two years.
Never stop abruptly, but gradually decrease the dosage.
Avoid use in pregnancy, especially in first three months of pregnancy.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Indications</th>
<th>Side Effects</th>
<th>Adult Dosage</th>
<th>Child Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenobarbital (15 or 100 mg tablets; 15 mg/ml elixir)</td>
<td>Epilepsy</td>
<td>Drowsiness</td>
<td>Start with 150 mg/day in two equal doses Increase 50 mg/week until seizures are controlled maximum dose</td>
<td>Starting dose: children up to 3 years: 15 mg/day as a single dose at bed time children 3–10 years: 30 mg/day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dizziness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ataxia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>Indications</td>
<td>Side Effects</td>
<td>Adult Dosage</td>
<td>Child Dosage</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Carbamazepine (200 mg tablets)</td>
<td>Epilepsy if phenobarbital does not control the seizures. Particularly effective in partial seizures Bipolar disorder</td>
<td>Dizziness Nausea Dry mouth Skin rash (if rash develops, stop and choose another drug)</td>
<td>start with 100 mg twice daily gradually increase up to 1200 mg/day in two doses</td>
<td>start with 50 mg twice daily increase up to 20 mg/kg in two divided doses</td>
</tr>
<tr>
<td>Sodium valproate</td>
<td>Epilepsy Bipolar disorder</td>
<td>Nausea Tremor Weight gain</td>
<td>800 mg divided in two doses Increase in steps of 200 mg Usual dose is 1200 mg, but can be up to 3000 mg</td>
<td>Start with 15 mg/kg increase up to 40 mg/kg</td>
</tr>
</tbody>
</table>

**Psychosocial Management**
Most people with epilepsy can live normal lives. Approximately 80% can be significantly helped by medication, and the seizures can be effectively controlled. However, epilepsy can affect daily life for people with epilepsy, their families, and their friends. Many people with epilepsy live with the constant fear that they will have another seizure.

It is not uncommon for people with epilepsy, especially children, to develop behavioral and emotional problems. Sometimes these problems are caused by embarrassment or frustration. People with epilepsy have an increased risk of poor self-esteem and depression. These problems may be a reaction to a lack of understanding or discomfort about epilepsy that may result in cruelty or avoidance by other people.

Epilepsy can cause tensions in the family. Families must learn to accept and live with the seizures without blaming or resenting the affected person. Counseling can help families cope with epilepsy in a positive manner.
Society’s lack of understanding about the many different types of seizures is one of the biggest problems for people with epilepsy. In some cases epileptic attacks have led to the affected person being arrested or placed in a mental institution. Parents and teachers with little knowledge about epilepsy sometimes prevent children from attending school because they think it is dangerous for the other children. Problems may result from being teased by other children. These problems can be minimized if parents encourage positive thinking and independence and if teachers have a better understanding about epilepsy. Parents should inform the teacher that their child has epilepsy and teachers should be told what to do if a child in their classroom has a seizure.

An important part of treatment of epilepsy is a good explanation of the disease and its management to the patient and the family. The therapy compliance will be much higher when the doctor, nurse, or midwife takes some time for explanation and discussion. Community health workers can encourage the patient and family to continue the treatment according to the prescription by the doctor. Where psychosocial workers and counselors are available they can give health education and counseling to the patient and family. It can also be very helpful to bring people with epilepsy together in a support group in which they can discuss the problems they face, share solutions, and encourage each other.

Advise people with epilepsy not to drive a car, walk alone in remote places, or swim unless they have had no seizure during the last year.

### What to Do if Someone Has a Seizure

<table>
<thead>
<tr>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roll the person on her/his side to prevent choking on any fluids or vomit.</td>
<td>protect the airway from aspirating fluids or vomit</td>
</tr>
<tr>
<td>Put a cushion under the person’s head.</td>
<td>prevent the head from hitting the ground</td>
</tr>
<tr>
<td>Loosen any tight clothing around the neck.</td>
<td>prevent strangulation of clothing</td>
</tr>
<tr>
<td>Keep the person’s airway open. If necessary, grip the person’s jaw gently and tilt her/his head back.</td>
<td>prevent aspiration and maintain airway</td>
</tr>
<tr>
<td>Do NOT restrict the person from moving unless s/he is in danger.</td>
<td>prevent unnecessary physical restraint on the person</td>
</tr>
<tr>
<td>Do NOT put anything into the person’s mouth, not even medicine or liquid.</td>
<td>prevent choking or damage to the person’s mouth</td>
</tr>
<tr>
<td>Remove any sharp or solid objects that the person might hit during the seizure.</td>
<td>prevent injury from hitting objects</td>
</tr>
<tr>
<td>Note how long the seizure lasts and what symptoms occurred.</td>
<td>record the severity of the seizure for future reference</td>
</tr>
<tr>
<td>Stay with the person until the seizure ends.</td>
<td>provide continuous support during the seizure</td>
</tr>
<tr>
<td>Bring the person to a hospital if the:</td>
<td>ensure medical assistance is available</td>
</tr>
<tr>
<td>seizure lasts longer than 10 minutes</td>
<td></td>
</tr>
<tr>
<td>person does not begin breathing again and return to consciousness after the seizure stops</td>
<td>protect the airway from aspiration</td>
</tr>
<tr>
<td>person injures her/himself during the seizure.</td>
<td>protect the integrity of the person</td>
</tr>
</tbody>
</table>

After the seizure ends, the person will probably be very tired. S/he also may have a headache and be confused or embarrassed. Be patient with the person and try to help her/him find a place to rest. If necessary, help the person get home safely.
Status Epilepticus
Status epilepticus is a severe, life-threatening condition in which a person either has prolonged seizures or does not fully regain consciousness between seizures.

While most seizures do not require emergency medical treatment, someone with a prolonged seizure lasting more than 10 minutes should be taken to a doctor immediately, if possible. In a health facility, intravenous (IV) injections with diazepam can be given. Give this slowly, over the course of a few minutes. Give:
- 5 mg in children under 5 years
- 10 mg in children 5–10 years
- 20 mg in adults

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

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

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

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

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

Non-epileptic seizures
Sometimes people experience seizures that somehow resemble epilepsy, but are different. These attacks are called non-epileptic seizures or psychogenic seizures. “Psychogenic” means “beginning in the mind.” These are episodes in which the behavior and consciousness of the person is briefly changed. Non-epileptic seizures are not caused by electrical disruptions in the brain, like in epilepsy, but are often caused by stressful psychological experiences. Non-epileptic seizures are a way that the body indicates excessive stress. The stress that can result in people having non-epileptic seizures varies with each individual. For some people it may result from experiences of abuse (sexual or physical) in the past, especially in their childhood. Others may have experienced a major life event such as the death of someone close to them or a difficult family situation.

It is important to recognize that these seizures are real events, although they are different from epileptic seizures. In the past, they were sometimes called “hysterical seizures” and people having them were thought to be faking them or trying to get attention. There is nothing false or insincere about these seizures. It is important to diagnose them correctly so that people who have non-epileptic seizures can get appropriate treatment, and they will be prevented from getting the wrong treatment. Many Afghans consider non-epileptic attacks as a form of mergi caused by perian. This belief is very strong among people in rural areas.

Differences between epileptic seizures and non-epileptic seizures are shown in the table below. In epileptic seizures consciousness is lost, while in non-epileptic attacks the consciousness is often not completely lost. In non-epileptic seizures often the person is able to hear the relatives talking or is able to see the environment. In epileptic seizures often (but not always) tongue bite and urine incontinence is seen. In non-epileptic seizures this is rare.

Epileptic seizures can happen everywhere, at any time, and in any social setting. They can also happen when the person is alone or when in dangerous circumstances. A person with epilepsy often has the scars of injuries and burns. Non-epileptic seizures mostly always happen in social situations in which tension occurs. They rarely happen when the person is alone.

During a seizure one can do the flailing hand test while the patient is lying on her/his back on the floor. The investigator brings the hand about 40–50 cm above the head of the patient and lets it drop. In epilepsy the hand will fall vertically and hit the face. In non-epileptic seizures the patient is able to control the movement of the hand so that it does not hit the face.
Epileptic seizures often have a short duration (usually less than 15 minutes) after which the person wakes up in a state of confusion. Non-epileptic attacks can have a duration of several hours.

<table>
<thead>
<tr>
<th>Precipitating factor before attack</th>
<th><strong>Epileptic Seizure</strong></th>
<th><strong>Non-Epileptic Seizure</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>Often (emotion)</td>
<td></td>
</tr>
<tr>
<td>Circumstances</td>
<td>Can be everywhere, while asleep, or when alone</td>
<td>In social situations</td>
</tr>
<tr>
<td>Motor signs</td>
<td>Stereotyped</td>
<td>Variable</td>
</tr>
<tr>
<td>Consciousness</td>
<td>Lost</td>
<td>Not lost</td>
</tr>
<tr>
<td>Injury or burns</td>
<td>Present</td>
<td>Not present</td>
</tr>
<tr>
<td>Tongue bite</td>
<td>Common</td>
<td>Rare</td>
</tr>
<tr>
<td>Incontinence</td>
<td>Common</td>
<td>Rare</td>
</tr>
<tr>
<td>Time</td>
<td>1–10 minutes</td>
<td>Many minutes (up to hours)</td>
</tr>
<tr>
<td>Confusion after seizure</td>
<td>Present</td>
<td>Not present</td>
</tr>
<tr>
<td>Flailing of hand test</td>
<td>Positive</td>
<td>Negative</td>
</tr>
</tbody>
</table>

**Management of Non-Epileptic Seizures**

It is important to remember that the person with non-epileptic seizures does not benefit from anti-epileptic drugs. A second point is to give information about the condition to the patient and the family. Do not tell them that the complaints are not real. One could tell for example that the brain of the person sometimes has difficulties because of overwhelming stress. This can lead to the symptoms of non-epileptic seizures that are not dangerous in itself. The family should not be afraid that the person will die from the attacks. If the health care worker is trained, s/he can offer supportive counseling to identify and treat the underlying stress or trauma. If depression or anxiety is a part of the cause of the non-epileptic seizures, medications may be used to eliminate these symptoms. Persons suffering from non-epileptic attacks sometimes seek help from religious healers. They often pray with the patient and give them amulets. A health worker should not criticize the patient for seeking help in the non-medical sector. Some religious healers are very skillful in reducing the underlying anxiety of the patient and can really offer help. The best attitude of a health care worker is to be respectful but neutral.

The goal is to eliminate these episodes and restore the person to a satisfactory level of everyday activity. The outcome of treatment is usually better than that for individuals with epileptic seizures, especially when the episodes have only recently started.
CHAPTER 10: SUBSTANCE DEPENDENCY

DEFINITIONS

In every society there are people with a strong desire to use certain substances that is harmful to their health or their lives. These substance are sometimes called psychotropic drugs. These are drugs that act in the human brain to alter the person’s mood, way of thinking, and behavior. People use these substances because of their direct effects, e.g., feeling happy or brave, not feeling pain, forgetting about their problems. But use of the substance may lead to financial, social, mental, or health problems. These problems are due to:

Intoxication—The physical and psychological consequences of taking a high dose of the substance. The effects disappear when the substance is eliminated from the body.

Withdrawal—Specific physical symptoms that follow the ending of heavy use of a substance.

Tolerance—The need to use more and more of the substance to experience its desired effects.

Substance dependency—When a person uses a psychotropic drug s/he can become dependent on it. The person continues the substance despite clear evidence of harm. In scientific terms, substance dependency is a state of physical or psychological need to continue taking the substance, leading to a compulsion to take the drug in order to experience its effects, and to avoid the consequences of its absence. There are two aspects to dependency: 1) psychological dependency, which is a continuous desire to take the substance, and 2) physical dependency, which is the physical need to take the substance to prevent symptoms of withdrawal.

EFFECTS OF SUBSTANCES OF ABUSE

Heroin/Opium

Both heroin and opium are opioids. Opium is made from the dried juice of unripe capsules of the poppy plant. In Asia and the Middle East it has been used for centuries as an analgesic or to improve sleep. It can be eaten or smoked. Heroin is made from opium and is much stronger. It can be smoked or injected.

Farmers in Afghanistan grow poppy, or did so in the past, for economic reasons. The vast majority of the production is for export to other countries. There are no good statistics of heroin use in Afghanistan. It is estimated that about 0.6% of adults use heroin. The figures for heroin use are higher in Pakistan (0.9%) and Iran (2.8%). It is believed that the use of heroin in Afghanistan is increasing, and that the way of using it is also increasing, with intravenous heroin use rising. From a health perspective, this is a dangerous development. While it is not the task of the health worker to control or reduce the growth of poppies, it is part of their job to deal with the health-related aspects of the use of opium and heroin by the people in her/his coverage area. Substance dependency is a serious behavior disorder that needs attention from the health care system.
**Heroin/Opium Effects**
The effects of heroin and opium are:
Feelings of happiness (especially with heroin)
Decreased pain
Sleepiness
Constipation

The short-term effects of heroin abuse appear soon after taking the drug. Intravenous injection of heroin provides the greatest intensity and most rapid onset of these effects. After the initial feelings of happiness the user experiences an alternately wakeful and drowsy state, often feeling drowsy for several hours. Additionally, the rate of breathing may be slowed.

Effects of chronic use are lowered sexual desire and impotence in men. Injecting heroin can cause infections of the blood. In communities of heroin users HIV/AIDS can be rapidly spread.

An intoxication with a high dose of opium or heroin can cause:
decreased rate of breathing
lowered blood pressure
slowed heart rate
nausea, vomiting
coma and possibly death

**Heroin Withdrawal**
Within a few hours after the last administration of heroin, withdrawal may occur. This withdrawal can produce effects such as:
strong desire to use the drug again
restlessness
muscle and bone pain
running nose and eyes
sweating
vomiting, abdominal cramps, diarrhea
dilated pupils
increased pulse rate

The first withdrawal symptoms can start 8–12 hours after the last dose, and they reach their peak between 48 and 72 hours. The withdrawal symptoms subside after about one week. When withdrawal is done under controlled circumstances (detoxification), it is sometimes necessary to give symptomatic treatment for withdrawal reactions. Diazepam, antidiarrheals, pain killers, and vitamin supplements can be used for this.

**Tolerance**
Although some people are able to take heroin intermittently without becoming dependent, in most case tolerance develops very quickly in heroin users, in particular in those who use it intravenously.
Cannabis
Psychotropic drugs called marihuana, hashish, or “bhang” can be made from the dried cannabis plant. It is usually smoked as a cigarette or in a pipe. Worldwide, cannabis is the most commonly used illegal drug.

The effects of cannabis include:
increased feeling of happiness
increased talking and laughing
increased self confidence
perception of being creative and smart (in reality the person under influence of cannabis has difficulties in logical thinking and problem solving)
loss of coordination and loss of concentration
sleepiness
increased appetite
anxiety (rare)
psychosis (rare)

Withdrawal
There is no withdrawal syndrome with cannabis.

Dependence
Psychological dependence on cannabis develops quickly.

Benzodiazepines
Benzodiazepines (e.g., diazepam, alprazolam, bromazepam, clorazepate)are medications used for sleep problems and anxiety. When prescribed by a doctor who controls the use and makes sure that the patients uses it for only a few weeks, it can be beneficial. These medications can, however, cause dependency. Sometimes people continue to use it in high doses for many years.

The effects of benzodiazepines includes:
feeling relaxed
sleepiness and drowsiness
dizziness

Withdrawal
When a person has used benzodiazepines for a long time and s/he suddenly stops the person can experience several withdrawal symptoms, including:
anxiety, nervousness
irritability
sleep problems
headache

When benzodiazepines are used for a short period (a few weeks), they usually cause no tolerance, dependency, or withdrawal effects. When a person has used benzodiazepines for a long time and in high doses, and wants to stop, s/he should gradually reduce the dose over a period of at least 6 weeks (or 10% in every two weeks). Withdrawal
symptoms are less pronounced with long-acting benzodiazepines than with short-acting benzodiazepines. Therefore, short-acting benzodiazepines (alprazolam) can be replaced with long-acting benzodiazepines (diazepam) in an equivalent dose before starting withdrawal.

**Alcohol**
It is not known how many people in Afghanistan use alcohol regularly. In recent years the (illegal) availability of alcohol has increased, particularly in larger cities. Due to the illegality and the religious restrictions, most alcohol users do not easily admit the use of alcohol.

**Effects of Alcohol**
The short-term effects are loss of inhibition (leading to talkativeness), feeling happy and relaxed, lack of coordination, and slower reaction time. When consumed in large quantities, alcohol may cause aggressive behavior and sedation.

When alcohol is used regularly in high quantities (more than six bottles of wine per week) it can cause many diseases including peptic ulcer, liver diseases, infection of the pancreas, memory problems, and depression. Most users of alcohol do this moderately, but the minority of problem-users make alcohol abuse one of the major health problems in the world.

**Withdrawal**
Symptoms of alcohol withdrawal include:
- trembling, sweating
- nausea
- feeling anxious
- acute confusion with disorientation, extreme fear, or hallucinations (after 48 hours, in severe cases)

**Dependence**
Dependence on alcohol can develop in people who drink heavily. In moderate use, alcohol no dependence does not develop.

**Inhalants**
There are many chemicals that can be inhaled to become “high,” such as shoe glue, cleaning fluids, or petrol. These substances are called inhalants. The effects are variable and not much is know about them. Inhalants are used mostly by children who live or work on streets in large cities and who use it to make them forget hunger and pain. Chronic use might lead to memory problems and depression.

**CAUSES OF SUBSTANCE ABUSE**
People use substances because they want to feel better, to alleviate pain, or to forget sadness. Not everyone becomes addicted to the substances. Substance dependency is a complex problem that has biological, psychological, and social aspects. There is no single factor that can explain why a person becomes an addict. Factors that play a role are:
Biological factors:

Substance use can induce changes in the neurotransmitters in the brain. Dependency develops quickly with certain substances. Heroin, for example, changes the receptors in the brain so that after just a few times using heroin the brain can become dependent.

There are indications that genetic factors make certain persons more vulnerable to become dependent on substances than others in the same circumstances.

The “positive” effects of a substance (such as feeling happy, not feeling pain, improved sleep) are initially stronger than the negative effects that develop in the course of addiction.

Psychological factors:

People who feel lonely or depressed are more likely to become dependent on substances than others.

Social factors:

Peer pressure: Another influence is pressure from the group to which the person belongs or wants to belong. For example, friends may encourage a person to use a certain substance with them.

Family factors: When a young person who might abuse drugs is not properly corrected by the family, the incidental use of drugs can develop into drug-dependency.

Environmental factors increase the chance that a person will abuse substances. These include factors such as economic problems, family conflicts, and unemployment.

Often, so many factors influence the addictive behavior that is impossible to identify the real cause. In many cases, substance addiction develops as a vicious cycle.

<table>
<thead>
<tr>
<th>- The Vicious Cycle of Drug Dependency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initially a person is able to control the use of the substance. When a person moves into a regular pattern of substance use the substance starts to become the center of the person’s life. S/he spends less and less time in drug-free activities and loses interest in anything that is not related to the substance. Gradually, the person encounters social, emotional, and physical problems. Due to the use of the substance the family and non-drug friends become disillusioned. The person can start to feel bad about himself (sadness, guilt) and is only able to deal with these feelings by “escaping” them through the renewed use of the substance.</td>
</tr>
</tbody>
</table>

IDENTIFYING SUBSTANCE ABUSE IN PRIMARY CARE

It is important for health workers in primary health care to identify substance abuse. Substance abuse is an important cause for related health problems and disability. People who are dependent on a substance mostly consult a doctor for different reasons. A primary care worker should suspect substance dependence based on:

Physical signs of substance use such as very narrow pupils in heroin dependents, or sweating and dilated pupils during heroin withdrawal, scars of injections in the elbow pits, enlarged liver in alcohol abusers, etc.

Psychological and behavioral symptoms such as depressed mood (in alcohol abuse) or the effects of early withdrawal such as anxiety and agitation.

Signs and symptoms of secondary diseases that can be due substance abuse such as...
infections of the veins due to injections, anemia in alcohol dependency, or sleep problems due to withdrawal of opium or benzodiazepines.
Socio-economical signs such as self neglect, losing a job, or family problems.

If a health worker suspects substance dependency this should be asked in a non-judgmental way, so that the patient can feel free to answer honestly. If a person admits to the use of illegal substances the doctor can discuss the effects on health and to ask whether the person would like to stop or continue. If the person really wants to stop s/he can be referred to a treatment center.

**MANAGEMENT OF SUBSTANCE ABUSE**

The management of substance abuse involves biological interventions (such as substituting the drug of abuse with other less harmful drugs, or to gradually decrease the amount of substance taken), psychological interventions (such as counseling), and social interventions (such as involvement of the family and community members). For effective management these interventions have to be done in coordination.

Detection of patients. Through primary health-care settings substance abusers can be detected early and referred for treatment. The community health worker can play an important role in early detection. Outreach activities by specialized drug abuse treatment centers try to detect drug abusers who might want to stop. This involves close contact with and education of drug abusers who sit together in the bazaar or in other places.

Motivation for treatment. It is often difficult to convince a person to stop abusing drugs. Sometimes, a person says that they want to stop to satisfy the health worker or relatives. It is important for any further treatment that the person really wishes to stop the addiction. A technique that is often used to motivate substance abusers for treatment is to let them list the positive and negative effects of drug use. The health worker needs to be very careful that her/his attitude is non-judgmental; it is important to avoid becoming angry or disappointed.

Detoxification. When a drug abuser want to stop, this is called detoxification. For heroin abuse, this is mostly done through a short-term admission of a few weeks. Sometimes detoxification is done in a community-setting (with the client being at home and regularly visiting an out-patient department) provided that there is a basic medical service available and good social support. Detoxification is not the final answer to the problem and is only one step in a process. Detoxification without good follow up and social rehabilitation often has only a short-term effect.

Counseling is a very important component of treatment. It is also the first step towards rehabilitation and eventual social reintegration. Involvement of the family and mobilization of the community contribute significantly to the outcome of any treatment effort.

Support groups and self-help groups are groups of substance abuser who support each other in efforts to stop using drugs or to continue abstinence.

Social reintegration requires work with individuals, their families, and communities. It can include skills training (including vocation skills and social skills) and facilitating
the re-entry of former substance abusers into work.

Primary health care can play a significant role in the substance abuse management, in particular through detection, referral, and providing follow up. Community health workers could be very useful in helping the ex-abuser to abstain from using the substance.

SUBSTANCE ABUSE TREATMENT CENTERS

Substance abuse treatment centers in Afghanistan (Kabul) include:
Nejat Center, Darulaman Main Road, near Habibi High School. Tel: 070-290-868. The program consists of a motivation phase, a detoxification phase, and a follow-up phase.
Mental Hospital Kabul, Detoxification Unit, Karte Seh.

Substance abuse treatment centers in Pakistan (Peshawar) include:
Caritas Pakistan. Drug Abuse Treatment Program. Chamkani Road (near GT road, Kohat turning). Tel: 0092-91-261181. This program has outreach activities in the Eastern provinces of Afghanistan.
DOST Foundation No. 8, Sector B-2, Phase V, Hayatabad, Peshawar, Pakistan. Tel: 0092-91-814181-811529. Email: dost@netzone.net.pk
Horizon Agency. EE 32 Nishterabad, Peshawar, Pakistan. Tel: 0092-91-9216928