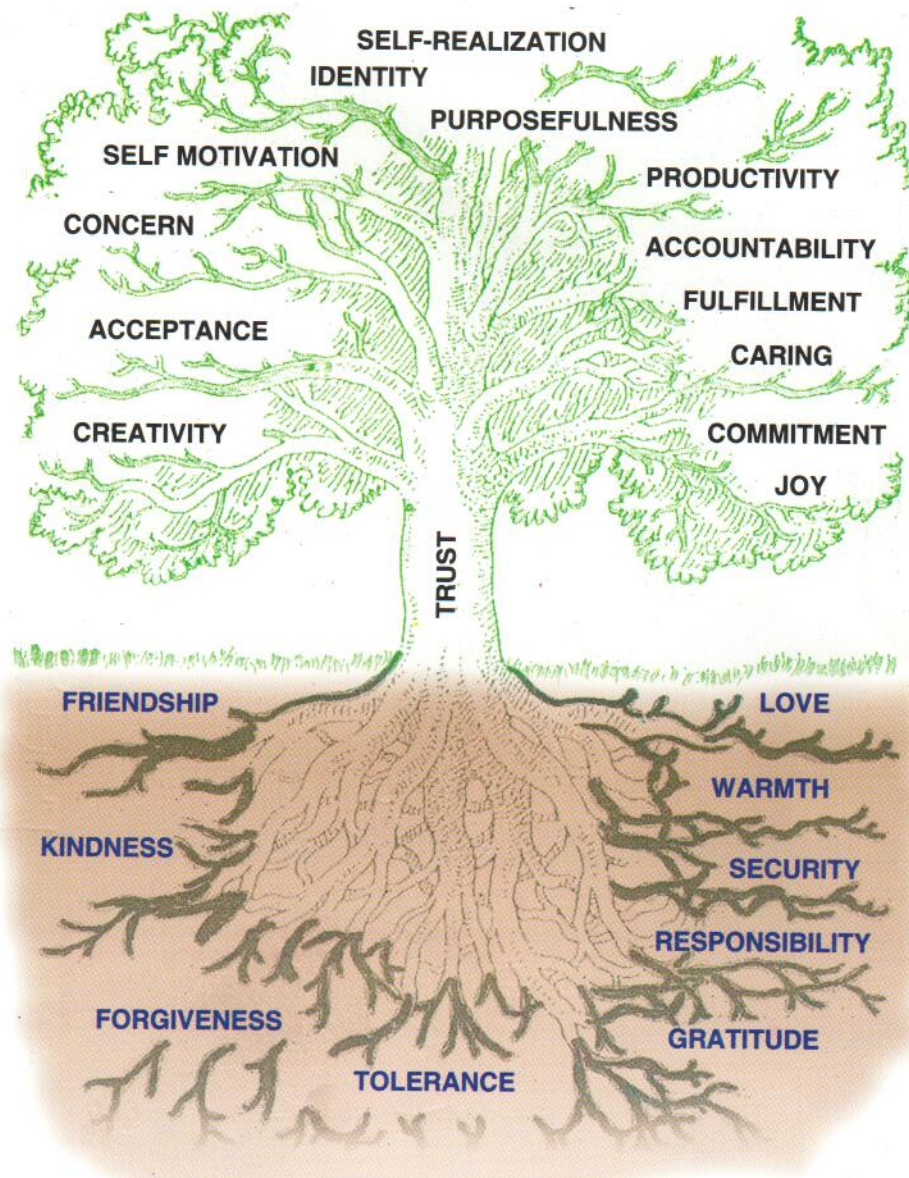


Guidelines and Treatment Protocols for the Management of Common Mental Health Disorders in Primary Care



MENTAL HEALTH TREE



Mental Health Services Dept.
Ministry of Health and Child Welfare



World Health Organisation

Foreword

In any Mental Health program appropriate case management is extremely important and includes early identification and detection of a mental health disorder, leading to prompt treatment of the patient to avoid complications that lead to chronic disorders.

This guideline is meant to empower health staff on the management of mentally disordered patients. In Zimbabwe, it is important to ensure that staff are empowered with knowledge on the management and treatment of common mental health disorders from the first contact, to the follow up management after discharge of the patient.

The need to disseminate information on standard management of common mental health disorders is paramount in boosting staff confidence and morale. This also assures positive management of the mentally disordered patient resulting in high quality care. This should be accompanied by availability of anti psychotic drugs at all levels of care.

These guidelines should be made available at all levels including at the primary care level, in order to provide uniformity in the care of these patients. Continuous dissemination of information should be done especially for the staff/new cadres from various institutions. This can be done as on-the-job training for the general qualified staff as well as being taught to students on basic training.

I expect that widespread use of this guideline will enhance positive management of the Mental Disordered Patients. My Ministry will ensure that these guidelines are available and are utilized effectively.

This guideline is designed for both pre-service training of medical officers, clinical officers and nurses involved in treatment and management of mentally disordered patients. It indicates how the client should be managed holistically from history taking, observation, assessment, psychological and physical examination leading to correct diagnosis and appropriate treatment and management of the client.

My gratitude goes to WHO Country Office for their support to the ministry of Health and Child Welfare in the production of this Guideline and subsequent printing of the document for widespread dissemination, and engagement of the consultant who produced the initial draft. I also thank all those who participated in the final drafting of this guideline. All health workers are encouraged to use this guideline as a daily reference in their work.



BRIGADIER GENERAL (DR) G. GWINJI
SECRETARY FOR HEALTH AND CHILD WELFARE

Acknowledgments

The effort to develop the treatment modalities for psychiatric disorders appropriate in Primary Care was a team effort. We are especially indebted to the tireless efforts of Dr S. Nhiwatiwa who did the lion's share.

We would also like to acknowledge the contributions from various work groups:—

College of Psychiatry

Department of Psychiatry

Department of Nursing Science (UZ)

Mental Health Department (MOH&CW)

Stakeholders who provided their inputs.

We are also grateful to the support from World Health Organization.

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Preamble

The overview objective of the Zimbabwean Government is to achieve optimal Health for all Zimbabweans. Mental Health disorders are ranked high among the top causes for mortality and morbidity. Mental Health contributes immensely to the achievement of the Millennium Development Goals (MDGs). Whilst mental health problems are ranked so high they are not accorded the priority that they deserve. There is a shortage of trained health personnel who have migrated to other countries, in particular the trained mental health care providers. This has created gaps in the identification, care and treatment of mental health problems with most mental health facilities being manned by skeletal, non trained and inexperienced staff. It is against this background that prompted the development of these guidelines and Treatment Protocols aimed at Primary Care service providers.

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Definition of Terms

AIDS	-	Acquired Immuno Deficiency Syndrome
AMT	-	Amytriptilline
ANC	-	Ante Natal Clinic
ARVs	-	Anti Retrovirals
B.P.	-	Blood Pressure
CPZ	-	Chlorpromazine
CNS	-	Central Nervous System
ECT	-	Electro Convulsive Therapy
EEG	-	Electroencephalogram
F.D	-	Fluphenazine Decanoate
HIV	-	Human Immunodeficiency Virus
IM	-	Intra Muscular Injection
Na+Cl	-	Sodium Chloride
TFPZ	-	Trifluoperazine
TPR	-	Temperature, Pulse, and Respiration

CHAPTER ONE: INTRODUCTION

Psychiatric conditions are different from medical and surgical conditions in that the patient can tell you where it hurts.

In Psychiatric conditions the patient usually knows that something is wrong. They experience unusual phenomena like hallucinations and delusions. They cannot explain how it came about. As a result in our culture they seek explanations from Traditional Healers who connect it to traditional beliefs like ancestral spirits or to Faith Healers who will associate it with Demonic Possession.

Hence it is important to take a systematic history and do a thorough mental state examination and a diagnostic formulation. It helps to keep good records in Psychiatry as some conditions are life- long. A personal health record book is suggested as with all chronic conditions. It is better than the loose cards.

HISTORY TAKING, PHYSICAL EXAMINATION, MENTAL STATE EXAMINATION AND DIAGNOSTIC FORMULATION.

History Taking

Demographic Data:

Name

Age /Sex

Occupation

Marital Status

Reasons for Referral

Informant

Presenting Complaints

History of presenting complaints

Past Psychiatric History

Past medical and surgical history.

Family History

Father: age, occupation. Substance use/abuse, relationship with patient

Mother: age, occupation, Substance use/abuse, relationship with patient

Siblings: in chronological order: age, occupation, marital status, relationship with patient.

Personal History

Pregnancy

Delivery

Milestones

Childhood illness (Inc. febrile convulsions), temperament

Schooling

Work record in chronological order and reasons for leaving.

Psychosexual History

Menarche

Relationships – reasons for breaking them

Marriages and level of functioning

Children

Forensic History

Substance use/abuse

Premorbid Personality

- Predominant mood
- Overt, covert behaviour
- Sociable
- Sociable with strangers
- Shams strangers
- Stealing and lying- persistent pattern

Physical Examination

There is need to do a thorough physical examination to rule out organic causes. One must also check for signs of recent or old injuries and other lesions like STIs and HIV stigmata.

Mental Status Examination

Appearance and Behaviour

- Grooming
- Cooperation
- Eye contact
- Rapport

Speech: Coherent, pressured, retarded, mute. Flight of ideas, loosening of associations. Word salad: neologisms.

Mood: Sad, elated

Affect: Appropriate, incongruent

Neurovegetative Symptoms

- Diurnal variation of mood
- Insomnia
- Appetite
- Energy
- Interest (severe lack is anhedonia)
- Reduced libido
- Reduced concentration
- Hopeless future
- Feeling of worthlessness
- Suicidal ideation

Abnormal Beliefs and Experiences

Hallucinations:

- ✓ Auditory
- ✓ Visual
- ✓ Olfactory
- ✓ Gustatory
- ✓ Tactile

Delusions:

- Persecutory
- Grandiose
- Poverty
- Paranoid
- Jealousy etc

Thought content

Possession of thought – patient denies thoughts as is own; thought insertion; thought withdrawal; thought broadcast

Depersonalization and Derealization

Cognitive State

Orientation: in time, place and person

Attention and Concentration: Memory

- Registration (Immediate)
- Short term; Long term

Abstract thinking:- ask to interpret proverbs or similarities between bus and train, orange and apple etc.

Judgment: e.g. What would patient do if they find a dumped baby in the street?

Intelligence: General fund of knowledge e.g. current affairs

Insight – a patient having an appreciation that they have a problem that needs external help.

Diagnostic Formulation

Statement of the Problem

Differential Diagnosis-Pros and cons for each

Aetiology

- Predisposing Factors
- Precipitating Factors
- Perpetuating Factors

Investigations

- ✓ Collaborate history from significant others
- ✓ Physical investigation depending on the patient-

Treatment

- Early physical treatment
- Long term physical treatment

Other forms of treatment:

- Psychoeducation
- Other forms of psychotherapy
- Occupational therapy

Prognosis

Good and bad prognostic factors which influence recovery.

CHAPTER TWO: MOOD DISORDERS

The main feature in this condition is mood disturbance.

Clinical Features: (Major Depression)

- Sad mood – Diurnal variation of mood
- Insomnia (early morning waking)
- Poor appetite (rarely increased appetite)
- Weight loss (rarely weight gain)
- Loss of energy
- Loss of interest
- Loss of libido
- Loss of concentration
- No hope for the future (Hopelessness)
- Helplessness
- Feelings of worthlessness and guilt
- Suicidal ideation – may progress to suicidal attempt

Sex- M : F - 2 : 1 (twice as common in females)
Age of onset -from late teens to 50s.

Treatment

Drug Treatment

Antidepressants

Tricyclics: In patients who have no heart problems and who are not obese.
Also in patients who have problems sleeping at night

Amitryptiline: 25mg increased to 75 mg nocte

Immipramine: Same dosage as AMT

Fluoexitene: 20 mg daily

Setraline: 20 mg daily

Fluvoxamine: 20 mg daily

Second Generation Antidepressants

Trazodone 100 mg nocte

Lopramine; Mianserine

These are less cardiotoxic

Each class of drug must be given for long enough e.g. 6 weeks in adequate dosage before being abandoned for another. Do not give 2 different classes concurrently (e.g. mixing AMT and Fluoexitene)

Side Effects to be looked for particularly with Tricyclics are;

- Drowsiness
- Dry mouth
- Tremor
- Double vision
- Weight gain

If the patient starts to improve on antidepressants – then continue.

Second Line Treatment

Psychosocial treatment

You need to address the problems the patient is facing. If they are divorced you need to use cognitive behavioural psychotherapy to help them accept their situation and move on.

You also want the individual psychotherapy to address the issues that arise from the assessment.

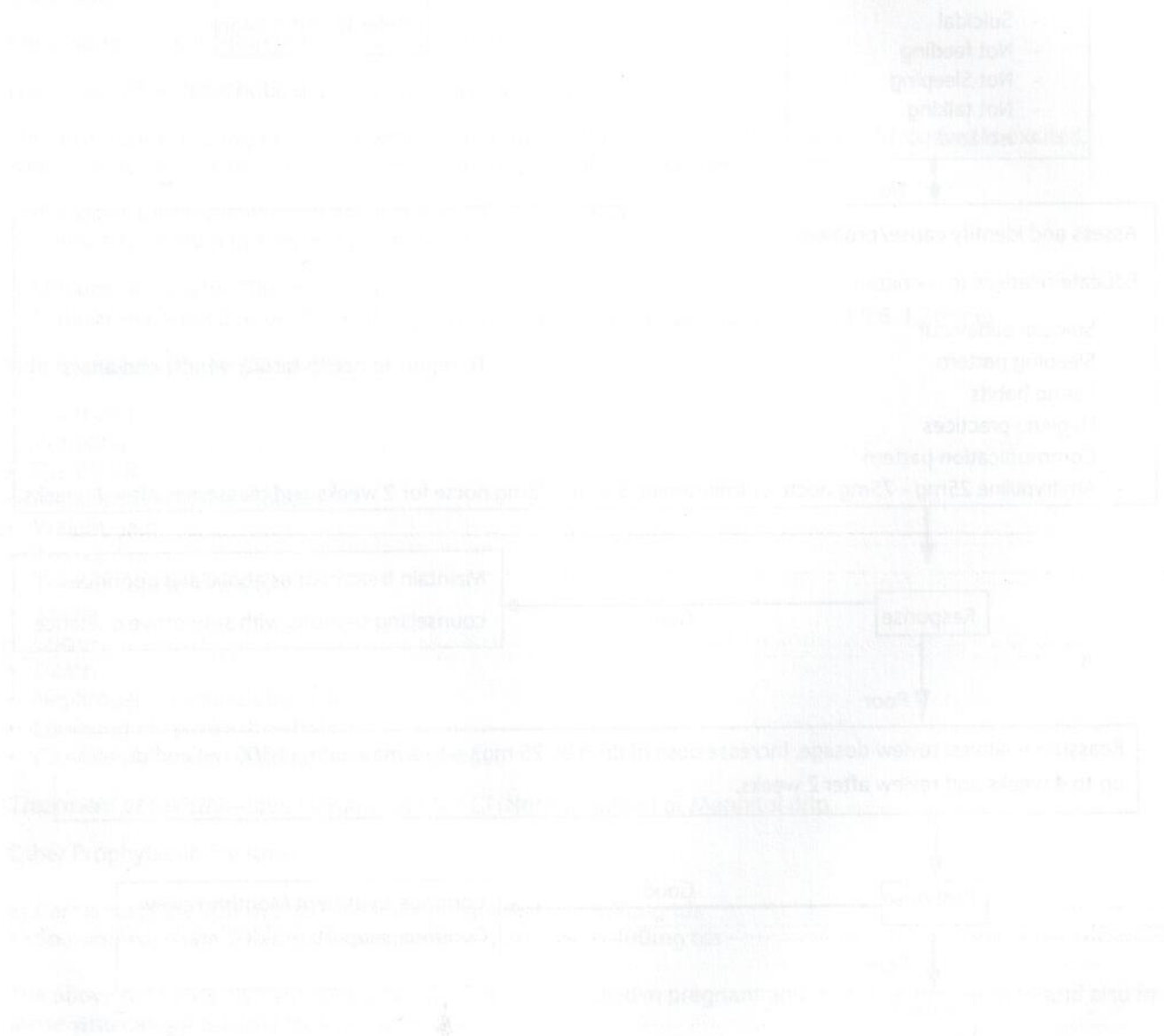
Social and spiritual aspects to be noted and incorporated into treatment.

Psycho education and Family work

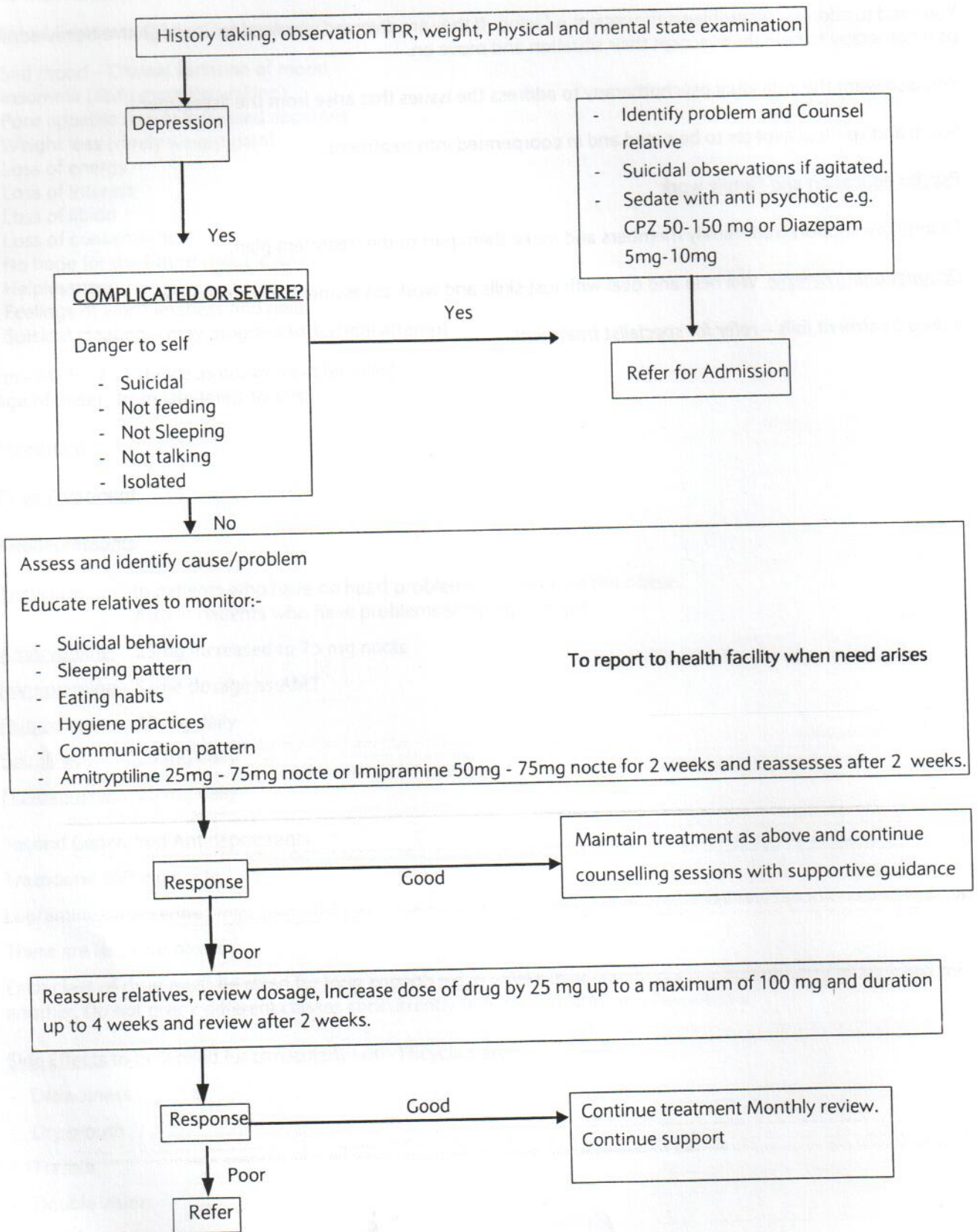
To improve support from family members and make them part of the treatment plan.

Occupational Therapy: Will help and deal with lost skills and work assessment and evaluation.

If drug treatment fails – refer for specialist treatment.



MANAGEMENT FLOW CHART FOR DEPRESSION



Bipolar Affective Disorder (Hypomania)

Clinical Features

- Hyperactivity
- Restlessness
- Bountiful energy
- Distractibility
- Pressured speech
- Flight of ideas
- Over-spending
- Starting of numerous projects and finishing none
- Grandiose ideas
- Grandiose delusion
- If frustrated can be violent

M : F equal incidence

Age of onset: Late teens to 50s

Treatment

Antipsychotic medication to treat florid symptoms.

The choice of antipsychotic depends on desired side effects

Chlorpromazine 100 mg bd - has a sedative and tranquilizing (calming) effect when the patient is excited. When the patient is calm – she/he is prepared for prophylaxis treatment.

- **Bloods:** – for Creatinine clearance; and for Thyroid function test
The patient is then put on lithium carbonate
- Lithium carbonate- 700 mg to 1000 mg nocte.
Lithium levels need to be checked regularly to maintain a therapeutic window of 0.6-1.2mmol

Side Effects of Lithium Carbonate

- Diarrhoea
- Vomiting
- Dry mouth
- Metallic taste in the mouth
- Weight gain
- Tremor fine
- Tremor coarse in toxicity
- Ataxia
- Coma
- Death
- Nephrogenic Diabetes insipidus
- Lowering of seizure threshold
- Can be fatal when combined with haloperidol

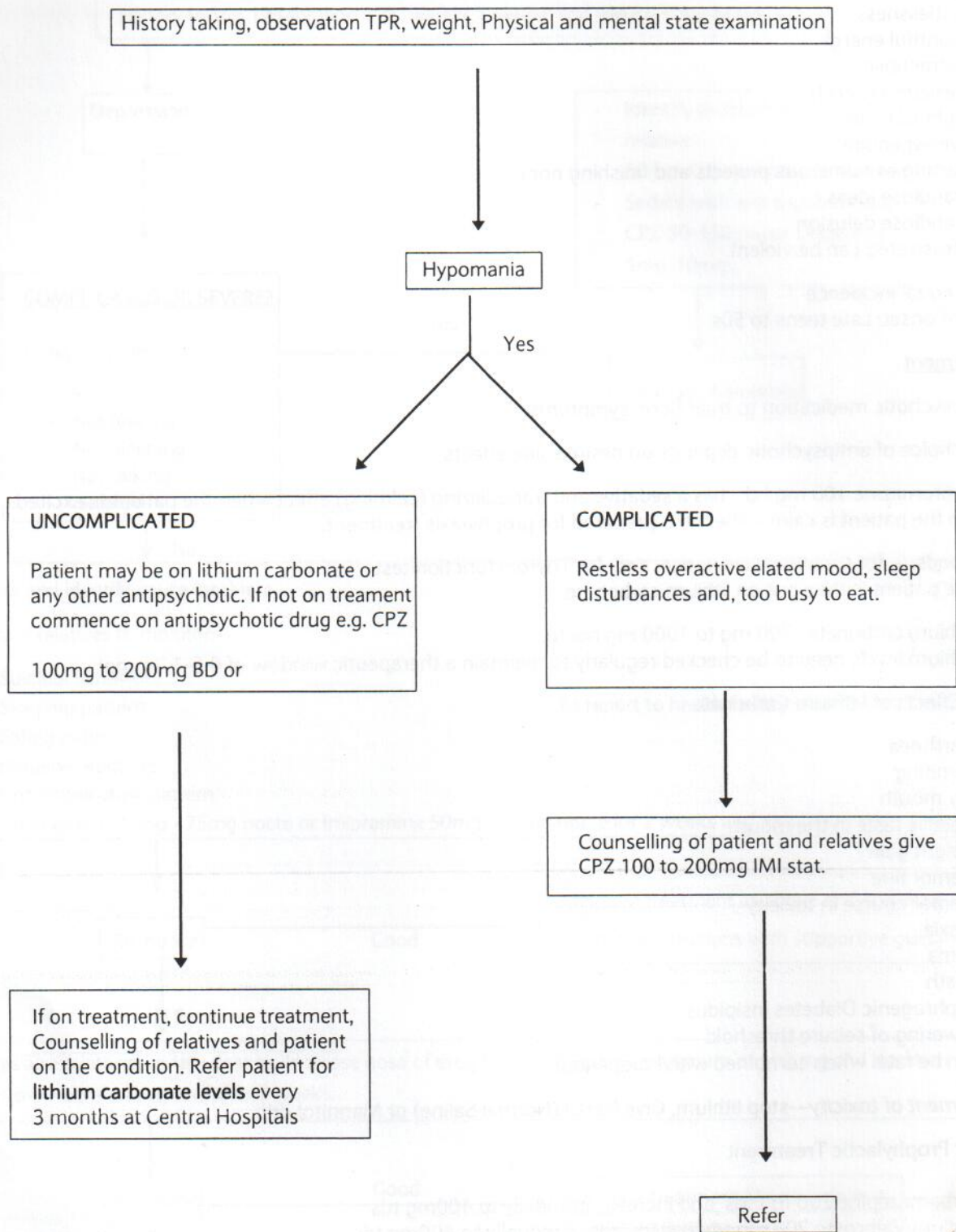
Treatment of toxicity—stop lithium, Give Na+Cl (Normal Saline) or Mannitol drip

Other Prophylactic Treatment

- a) Carbamazepine 200 mg tds and increase gradually to 400mg tds
- b) Sodium Valproate 200 mg tds and increase gradually to 400mg tds

The above drugs are also anticonvulsants. They may be used in pregnant and breastfeeding women and also in those who cannot tolerate lithium carbonate.

MANAGEMENT FLOW CHART FOR HYPOMANIA



CHAPTER THREE: SCHIZOPHRENIA

Schizophrenia is one of the most serious psychiatric conditions. It shows disturbances in four spheres:

- Affect
- Behaviour
- Perception
- Thinking

Clinical Features

Speech:

- Incoherence
- Loosening of association
- Word salad
- Neologism

Behaviour:

- Abnormal behaviour
- Dressing inappropriately (in sacks and plastics)

Hallucinations:

- Auditory in 3rd person
- Running commentary
- Somatic hallucinations
- Visual, olfactory, gustatory (tactile are rare)

Abnormal Experiences

Delusions

- Primary delusions
- Persecutory delusions
- Delusional jealousy
- Bizarre delusions
- Delusions of reference
- Depersonalization
- Derealization
- Obsessional thoughts

Other

- Reduced level of function – less than premorbid levels
- Apathy
- Lack of volition (goal directed activity)
- Lack of planning
- M:F ratio – equal
- Age of onset – 15 to 45 in men; 5 years late in women

Treatment

Antipsychotic medication is mainstay of treatment. Choice of treatment is targeted at the desired side effects, initial treatment is to target the positive symptoms (Hallucinations, speech problem, behaviour and delusions). Chlorpromazine 100 – 200 mg bd. When patient is becoming drowsy change to less sedative drugs like Haloperidol 10mg bd; Trifluoperazine 10mg bd; Fluphenazine Decanoate 25mg inj. Stat. Although the above drugs have less sedative side effects they are notorious for causing Extra Pyramidal Side Effects. Benzhexol 5mg daily may be added to counteract the extrapyramidal effects. Maintenance therapy is with the same drugs.

Second Line Management

Psycho-education to family/ Caregiver:

- To explain the patient's condition
- To assist with drug treatment
- To improve level of social support
- To bring the patient to hospital for regular follow up and reviews

Occupational Therapy

To assess lost skills e.g. living skills, social skills, and work skills and then strengthen them.

Psychotherapy

Individual or dynamic psychotherapy is not useful in schizophrenia.

Prognosis

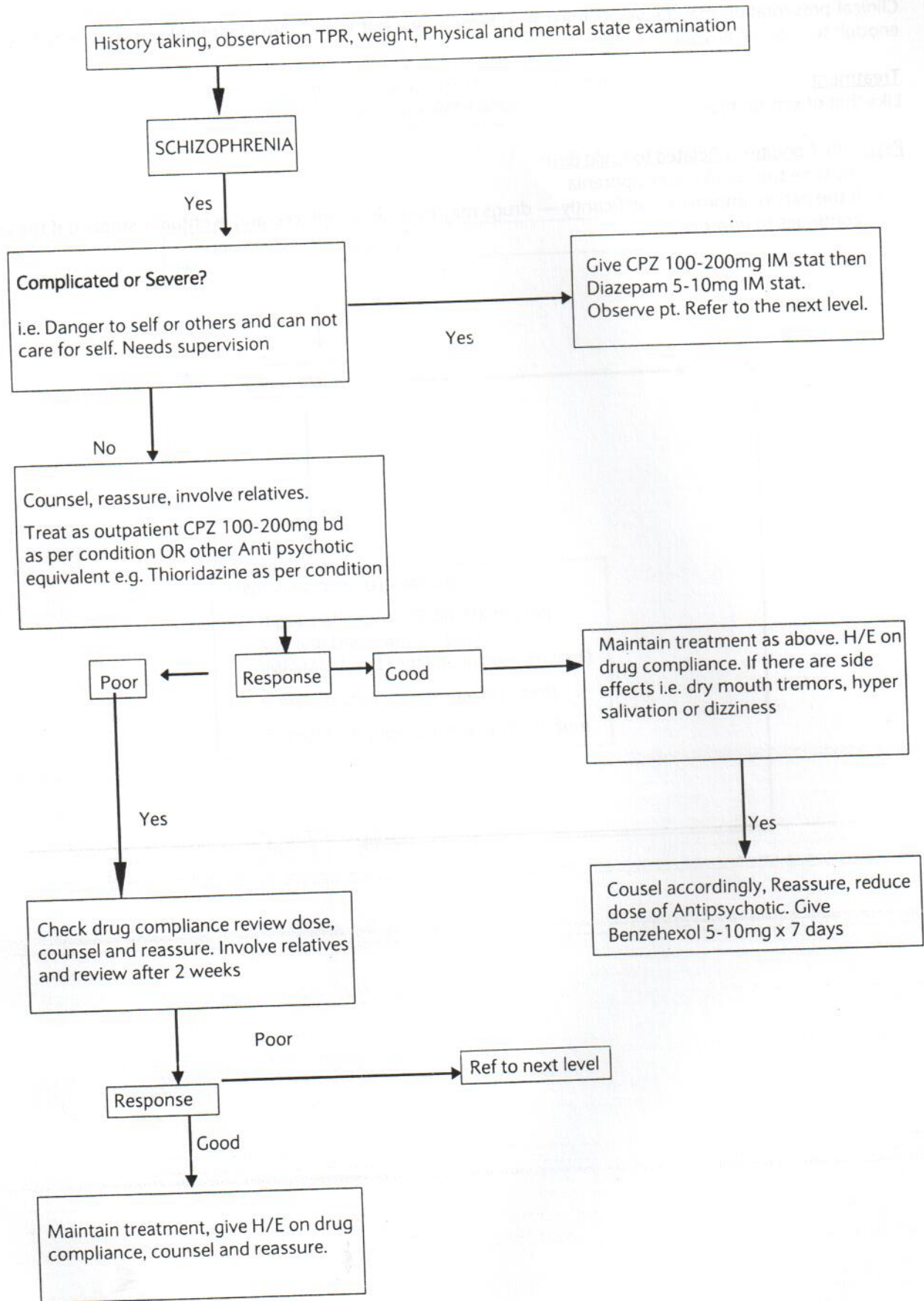
Good prognostic features

- Acute onset
- Identifiable life event
- Being married
- Being employed
- Good social support
- Good response to medication
- Good premorbid level of functioning

Other Psychotic Syndromes (Not Specified)

Treat as specified – emphasis may need to be paid to cause or identified cause.

MANAGEMENT FLOW CHART FOR SCHIZOPHRENIA



Brief Reactive Psychosis

Clinical presentation may be very similar to schizophrenia but there is an identifiable stressor which is severe enough to unsettle anyone.

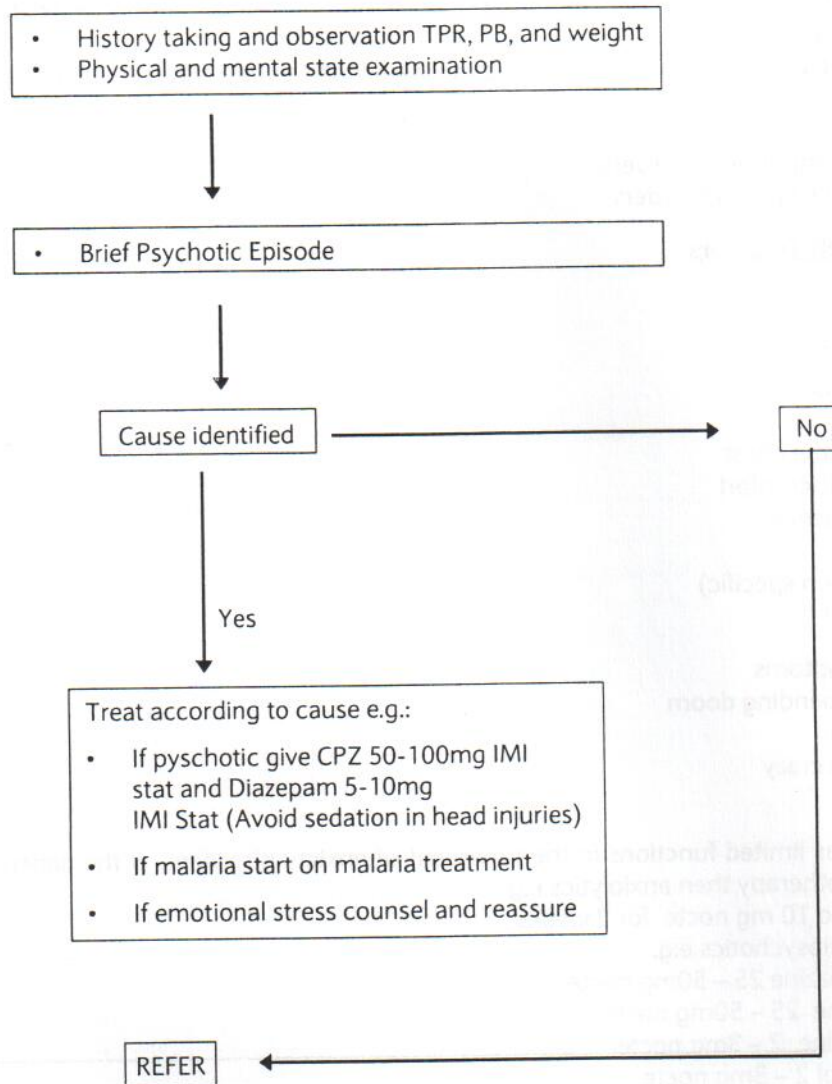
Treatment

Like that of schizophrenia

Psychotic Conditions Related to Child Birth

- Must be treated like schizophrenia
- If the patient improves significantly — drugs may need to be reduced and eventually stopped if the patient continues to improve.

MANAGEMENT FLOW CHART FOR: BRIEF PSYCHOTIC EPISODE



CHAPTER FOUR: ANXIETY DISORDERS

Anxiety Disorders are classified into:—

- Generalized anxiety Disorders
- Panic Disorders
- Agoraphobias
- Specific Phobias
 - Social
 - Simple
- Obsessive compulsive Disorders
- Post traumatic stress Disorders

Generalized Anxiety Disorders

Clinical features

Excessive worrying

Physical symptoms

- Palpitation
- Tightness in the chest
- Abdominal discomfort
- Urinary frequency
- Diarrhoea
- Headache (non specific)
- Sweaty palms

Psychological symptoms

- feeling of impending doom
- Fear of death
- Fear of going crazy

Treatment

Drug treatment has limited functions in the treatment of anxiety disorders. If the patient is too anxious to be engaged in psychotherapy then anxiolytics e.g

- Diazepam 5 to 10 mg nocte for 2 weeks
- Low dose antipsychotics e.g.
 - Chlorpromazine 25 – 50mg nocte
 - Thioridazine 25 – 50mg nocte
 - Trifluoperazine 2 – 3mg nocte
 - Haloperidol 2 – 3mg nocte
 - Sulpiride 100mg nocte

Main Stay of Treatment

1. Psychotherapy

Individual psychotherapy when one tries to address issues that result in the anxiety and work to correct and nullify its effect. This may take months or years.

2. Anxiety Management

3. These usually take the form of relaxation exercise particularly as the patient anticipates the anxious environment or situation. Breathing exercises also help.

Panic Disorders

If patient is too anxious – drugs as above for 2 weeks

Phobias

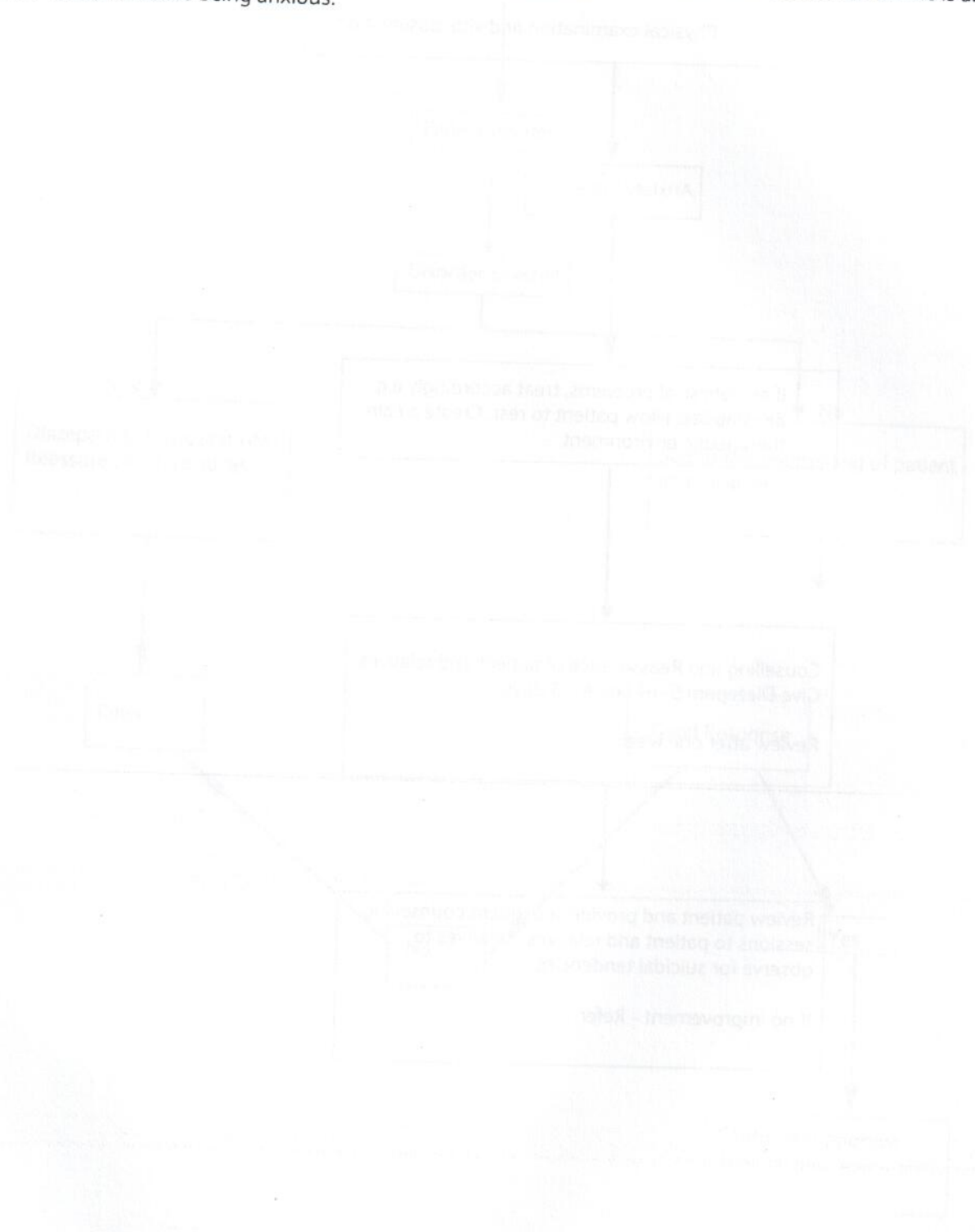
Intense fear of object or environment or situation which is out of keeping with stress experienced.

Mainstay of treatment is psychotherapy (Simple phobia)

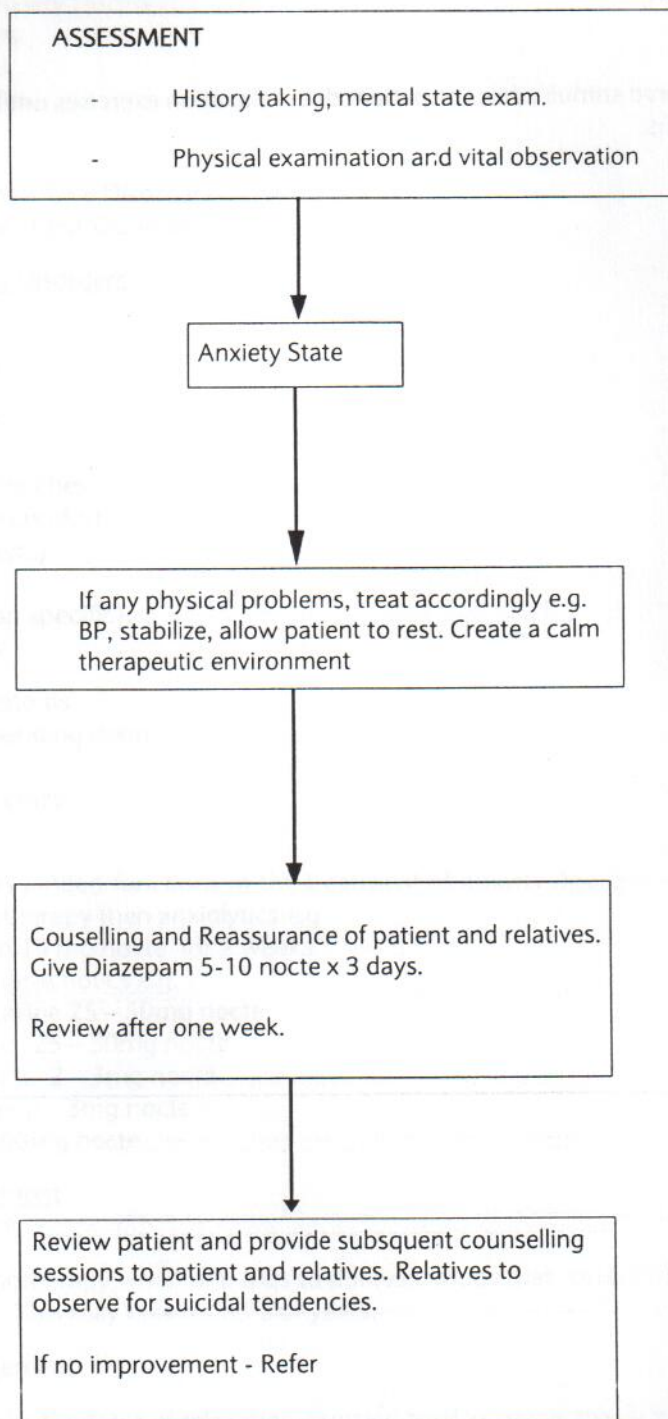
Anxiety management - relaxation exercises with:—

- Flooding
- Modeling
- Imitation
- Anxiety management (relaxation)
- Systematic desensitization

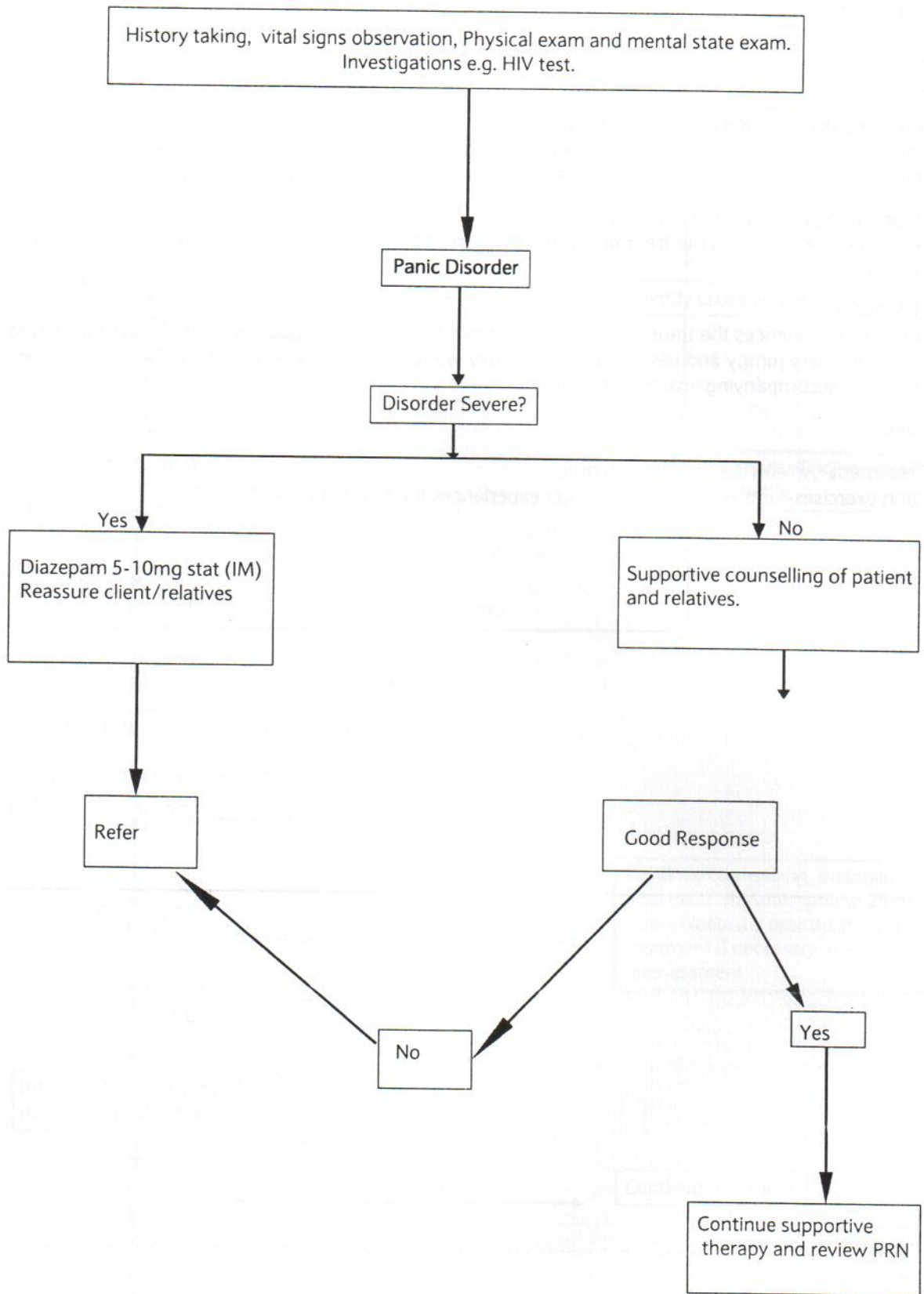
This involves gradual exposure to feared stimuli while the patient does relaxation exercises until he/she is able to face the feared stimulus being anxious.



MANAGEMENT FLOW CHART FOR ANXIETY STATE



MANAGEMENT FLOW CHART FOR PANIC DISORDER



Obsessive Compulsive Disorders

Clinical features

Recurrent thoughts of unacceptable thoughts but the patient recognizes thoughts as his own.

Rituals- repeated acts like rearranging furniture, checking whether doors are locked or not. Cordial washing of hands.

Mainstay of treatment is Behavioural Therapy.

The patient is taught to relax and they are prevented from doing the usual behaviour or thought stopping. If the patient is too anxious then give anxiolytics (Diazepam) or low dose antipsychotic for a limited period of time.

Post Traumatic Stress Disorders

The patient experiences extreme trauma e.g. torture, forced to witness torture, rape, mass killing, floods, displacement, etc.

Clinical features

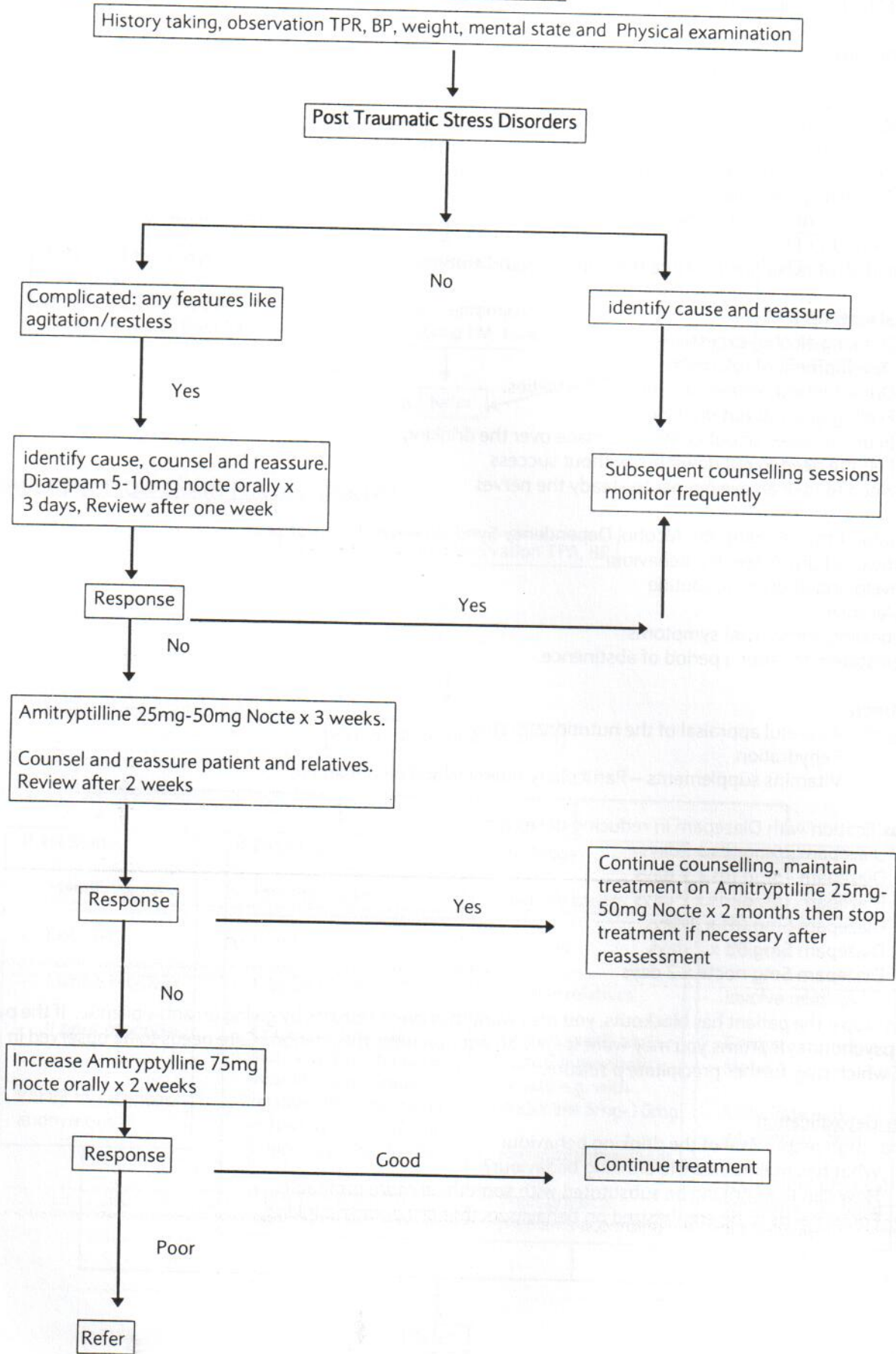
The patient re-experiences the trauma at any minor reminder of the traumatic event. They have flashbacks and nightmares; are very jumpy and easily startled and they want to avoid any reminders of the trauma. They also experience the accompanying anxiety symptoms.

Treatment

Drug Treatment- Anxiolytics for a limited time

Relaxation exercises- until the patient no longer experiences the traumatic event

MANAGEMENT FLOW CHART POST-TRAUMATIC STRESS DISORDER



CHAPTER FIVE: SUBSTANCE ABUSE

Alcohol abuse

Accepted levels

- Male 21 units a week.
- Female 14 units a week.
- 1 unit of alcohol = pint of beer.
 - = small glass wine.
 - = a tort of whisky, vodka.
 - = a tort of liquor, etc.

Abuse of alcohol is drinking more than the accepted amount per week.

Clinical features

- Drinking alcohol excessively
- Development of tolerance
- Drink seeking behaviour over other activities.
- Feeling guilty about drinking
- Being annoyed about comments made over the drinking.
- Felt the need to cut down but without success
- Need to take an eye opener to steady the nerves

The patient may develop the Alcohol Dependency Syndrome which comprises:

1. Privacy of drunk seeking behaviour
2. Developing of drinking routine
3. Tolerance
4. Repealing withdrawal symptoms
5. Reinstatement after a period of abstinence.

Treatment

General - A careful appraisal of the nutritional status.

- Rehydration
- Vitamins supplements – Particularly thiamine and nicotinamide

Detoxification with Diazepam in reducing doses e.g.

- Diazepam 20mg tds x 2 days
- Diazepam 15mg tds x 2 days
- Diazepam 10mg tds x 2 days
- Diazepam 5mg tds x 2 days
- Diazepam 5mg Bd x 2 days
- Diazepam 5mg nocte x 2 days

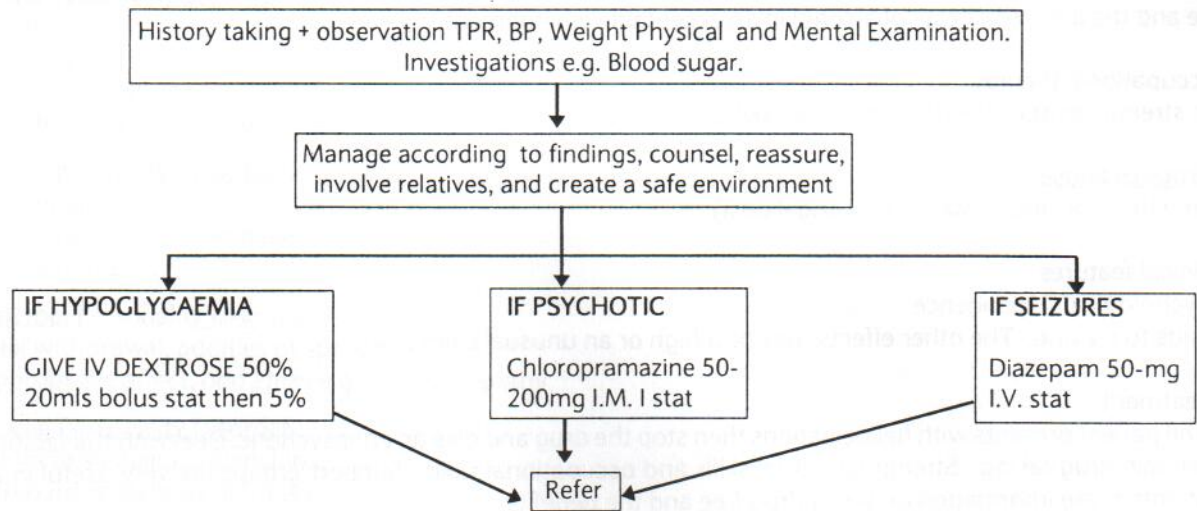
Then stop if the patient has blackouts, you may want to prevent seizures by giving an anti-epileptic. If the patient has psychotic symptoms you may want to give an antipsychotic medication. Care needs to be observed in using CPZ which may further precipitate a seizure.

After Detoxification

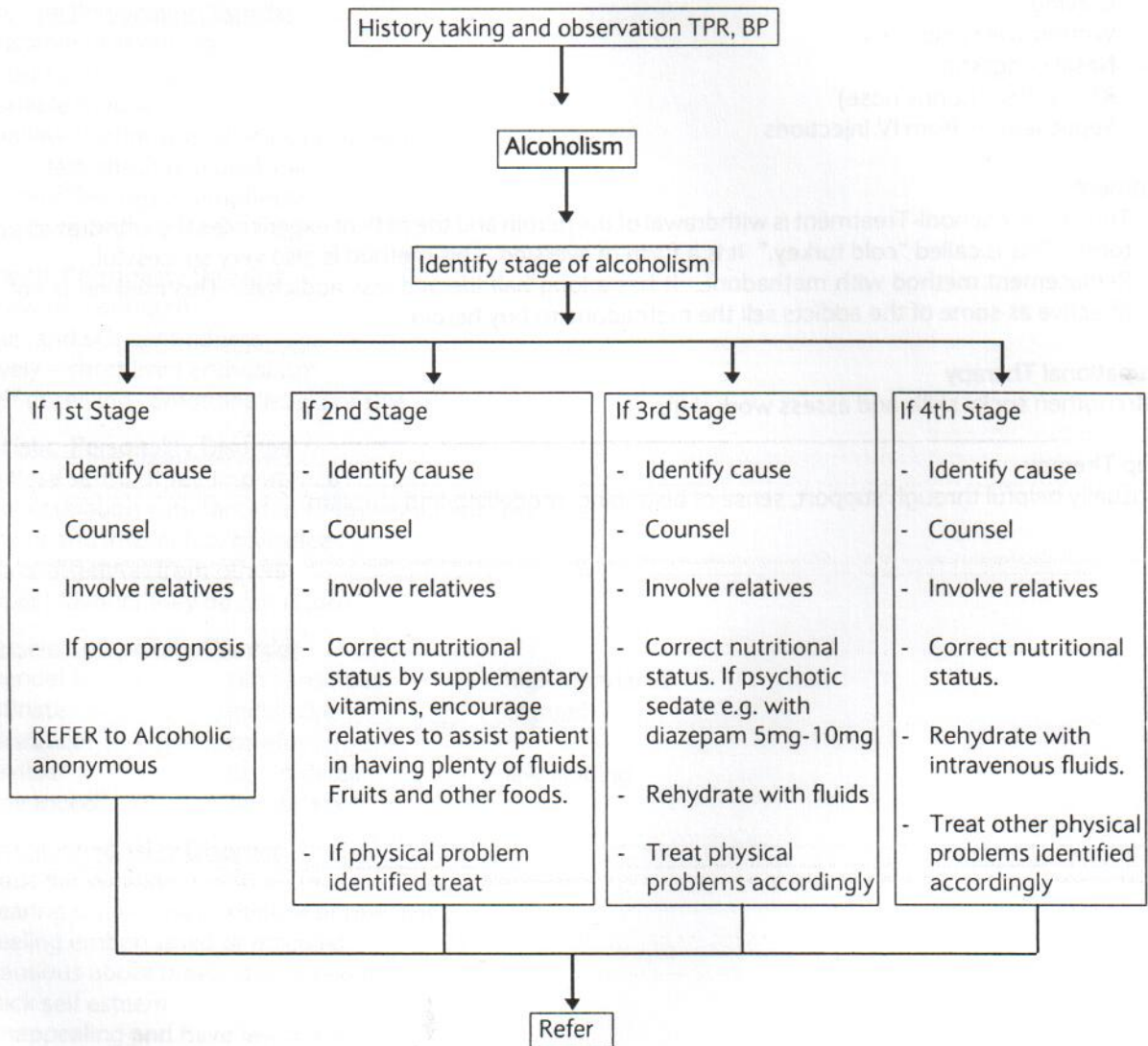
A thorough reappraisal of the drinking behaviour

- What has maintained the drinking behaviour?
- How can the drinking be substituted with something more profitable
- Focus needs to be emphasized on behaviours that discourage drinking.

MANAGEMENT FLOW CHART FOR ALCOHOL WITHDRAWAL



MANAGEMENT FLOW CHART FOR ALCOHOLISM



Support Groups

Alcoholic anonymous - emphasis is on total abstinence. Patients are given an opportunity to reflect on their past life and the adverse effects of alcohol in an acceptable environment.

Occupational therapy

To strengthen social and occupational skills.

Drugs of abuse

Cannabis, cocaine, ecstasy PCP (Angel dust).

Clinical features

Psychological Dependence

Leads to craving. The other effects may be a high or an unusual calm.

Treatment

If the patient presents with hallucinations then stop the drug and give an antipsychotic. Deal with the factors that maintain drug taking. Strengthen social skills and occupational skills. Support groups are very useful in which patients share information on being drug free and the benefits.

Heroin addiction

Clinical features

- Physical and psychological addiction
- Craving
- Withdrawal symptoms
- Nasal congestion
- Rhinorrhea (Runny nose)
- Septic lesions from IV injections

Treatment

- The Chinese school-Treatment is withdrawal of the heroin and the patient experiences the withdrawal symptoms. This is called "cold turkey." It is a form of aversion. This method is also very successful.
- Replacement method with methadone. It has a long half life and less addictive. This method is not very effective as some of the addicts sell the methadone to buy heroin.

Occupational Therapy

To strengthen social skills and assess work skills.

Group Therapy

Are usually helpful through support, sense of belonging, modelling and altruism.

CHAPTER SIX: PERSONALITY DISORDERS

Paranoid Personality Disorder

- Suspiciousness
- Paranoid ideation
- Sensitive, mistrustful of others
- Argumentation, stubborn

Schizoid Personality Disorder

- emotionally cold
- Detached, aloof, humourless
- Introspective

Schizotypal Personality Disorder

- o Social withdrawal, oddities of speech
- o Inappropriate affect, odd ideas e.g. about telepathy

Antisocial Personality Disorder

- Failure to sustain relationships
- Disregard of feelings of others
- Impulsive actions
- Low tolerance of frustration
- Tendency to violence, lack of guilt
- Failure to learn from experience

Borderline Personality Disorder

- ✓ Unstable relationship
- ✓ Impulsive behaviour
- ✓ Variable moods
- ✓ Shallow relationship, threats of suicide
- ✓ Uncertain about personal identity
- ✓ Chronic feelings of emptiness
- ✓ Efforts to avoid abandonment

Histrionic Personality Disorder

- ❖ Outward confident
- ❖ Vain and self centredness
- ❖ Lively – short lived enthusiasm
- ❖ Self deceiving. Emotionally responsive

Narcissistic Personality Disorder

- Grandiose sense of self importance
- ✓ Preoccupation with fantasies of unlimited Success
- ✓ Power and intellectual brilliance
- ✓ Crave attention from others
- ✓ Expect favours they do not return

Obsessive Compulsive Disorder

- | | | | | |
|--------------|---|----------------|---|----------------|
| -Dependable | - | self conscious | - | high standards |
| -Obstinate | - | indecisive | - | bigoted |
| -Persistence | - | careful | | |
| -Inflexible | - | lost in detail | - | law abiding |
| -Stable mood | - | humorless | | |

Avoidant Personality Disorder

- Anxious personality
- Fearing disapproval, criticism or rejection
- Feeling embarrassed or ridiculed
- Cautious about meeting new people
- Lack self esteem
- Unappealing and have few friends

Dependent Personality Disorder

- o Weak
- o Lack rigour and show little capacity for employment
- o Avoid responsibility, lack self-reliance

Aggressive Personality Disorder

- ❖ Response with passive aggression e.g. procrastination, dawdling, stubbornness, deliberate inefficiency
- ❖ Pretended forgetfulness
- ❖ Unreasonable criticism of people in authority

Affective Personality Disorder

Dysthymia: Persistently gloomy mood

Cyclothymia: up and down mood

Hyperthymia: Persistently elated

Treatment-

Personality Disorders are difficult to treat as they involve changing ingrained maladaptive ways of dealing with situations. Drugs have a limited role.

Mainstay of Treatment

Involve the therapeutic community. This may be a hospital setting or boarding house. Patients with Personality Disorders are admitted for long periods of time. Patients may benefit from non institutionalized care e.g. Day Care centers.

Treatment Modalities

- ◆ Challenging unwanted behaviour
- ◆ Rewarding good behaviour
- ◆ Keeping charts of each patient's progress.
- ◆ In our African setting many patients find it difficult to express distress in psychological terms
- ◆ For some patients one session is enough to make the link. For some it takes several sessions.

An important Diagnostic Feature- Is that the symptoms do not respond to physical treatment e.g. analgesics for headaches etc.

CHAPTER SEVEN: SOMATOFORM OR PSYCHOSOMATIC DISORDERS

These are psychological disorders which are expressed as physical disorders. Patients may go doctor shopping moving from health institution to another. They present with a heap of cards and may undergo numerous investigations which come out negative.

Clinical Features

- ❖ Multisystem or organ complaints
- ❖ Diagnosis comprises of at least 13 symptoms involving different systems

Common Systems – Affected

- ✓ Cardiovascular system
- ✓ Gastrointestinal system
- ✓ Genitor urinary system
- ✓ Nervous system

The symptoms are vague and difficult to describe and they do not follow any known anatomic or physiological patterns.

Cardiorespiratory Systems (Symptoms)

- Palpitations
- Left sided pain
- Feeling of constriction in the chest
- Pain in chest as if there is a raw wound
- Difficulty in breathing
- Sweaty palms
- Paraesthesia

Gastrointestinal Symptoms

- Nausea
- Abdominal pain – may be diarrhoea (irritable bowel)
- Epigastric pain
- Indigestion

Nervous Symptoms

- ◆ Headache – feeling of heaviness
 - Feeling of constriction
 - Fleeting headache
- ◆ Neck pain and tension
- ◆ Peripheral numbness

Musculoskeletal Symptoms

- Joint stiffness
- Generalized muscle tension

Psychological symptoms may involve

- Insomnia
- Appetite problems

Treatment

Drugs have limited role in treatment

Mainstay of Treatment is psychological

- Help the patient understand the way they are feeling in relation to the stresses or situations in their life. Success with this form of treatment is over 80%.

CHAPTER EIGHT: PSYCHOSEXUAL DISORDERS

These are male and female sexual disorders.

On history taking exclude use of drugs and substances that cause sexual dysfunction like alcohol, methyldopa, CPZ and diabetes mellitus.

Male Disorders

- Premature ejaculation
- Erectile dysfunction (impotence)
- Dyspareunia

Female Disorders

- ✓ Disorders of sexual arousal
- ✓ Dyspareunia
- ✓ Vaginismus
- ✓ Anorgasmic disorders

Management of psychosexual Disorders

Heavily depends on a thorough history and mental status examination.

- The usual history taking and mental status examination are essential.
- Then a detailed history of the psychosexual problem presenting with.
- The problem e.g. erectile dysfunction
- Onset of problem acute or gradual.
- Is problem confined to partner or is it generalized.
- Communication with partner.
- Is he still attracted to spouse or partner.
- Are there unresolved conflicts
- Are there physical symptoms of e.g.
 - urinary tract infection
 - hypertension
 - peripheral neuropathy
 - sexually transmitted disease

Deal with any physical condition or refer them to the urologist.

In 86 – 95% of cases of psychosexual dysfunction the psychological communication breakdown is the main culprit. This can be dealt with through honest discussion of resentments and other problems. Usually the problem reduces with improvement in communication.

Premature Ejaculation

Common in young male mainly due to inexperience.

Treatment

Is psychological (Master and Johnson Method). The couple is treated together through graded method.

Stage 1) The couple is taught to relax in each other's company.

Stage 2) They are taught to identify each other's sensate force.

Stage 3) They are to stimulate each other without intercourse

Stage 4) Stimulation and intercourse

Disorders of sexual arousal are very rare in males. If present deal with the problem that arises from the history taking and mental status examination.

Female Psychosexual Disorders

Disorders of sexual arousal

This may be due to abuse in early years or as a result of rape.

Treatment

Deal with the abuse or rape and also improve on communication.

Dyspareunia

- Painful ejaculation
- In females this may be due to
 - Vaginitis
 - Bartholin cyst
 - Pelvic inflammatory disease

Treatment

Is by tracking the cause.

Vaginismus

Involuntary contraction of the vaginal muscle at attempted penetration. Cause is usually early sexual abuse or rape.

Treatment

Is by graded dilatation while the patient is taught relaxation exercises simultaneously.

Unorgasmic Disorders

About 10% of females never experience orgasm.

Reasons (causes)

Reduced sexual arousal

Inadequate stimulation or foreplay.

Paraphilias (disorder of sexual object)

Voyeurism – peeping Toms

Transvestism – cross dressing

Zoophilia – having sex with animals

Paedophilia – fondling pre pubertal children (male and female)

Exhibition – exposing genitalia to unexpecting someone.

Assessment

- Find out reason for seeking treatment as some of these are offences which may include incarceration in prison.
- Treatment results are best if they present themselves for treatment not being forced because of a jail sentence.
- Detailed history of the problem.
- Treatment is by behavioural technique and relaxation excises.

CHAPTER NINE: ORGANIC PSYCHIATRY

Delirium

Clinical Features

- Impaired consciousness
- Disorientation in time and place
- Short term memory disturbance

Causes

- ❖ Drugs, illicit and prescribed
- ❖ Electrolyte imbalance
- ❖ CNS Infections
- ❖ Systemic Infections
- ❖ Hypertension
- ❖ Diabetes mellitus
- ❖ Severe stress reaction, etc.
- ❖ Epilepsy
- ❖ HIV

Treatment

Treat the cause that is identified.

Social support to help the patient deal with further episodes.

Epileptic patients with hallucinations and delusions should be referred to the psychiatrist

Patients with seizures to be referred to the physician.

Avoid drugs like CPZ and AMT, they lower seizure threshold.

Avoid Carbamazapine on patients on ARVS.

The drugs of choice are Haloperidol and TFPZ

Psycho-education

To involve and strengthen the family support network

Dementia

Clinical Features

- Clear consciousness
- Disorientation in time and place
- Short term memory problems
- General decline of cognitive faculties.

Types of Dementia

Alzheimers

Senile – under 65 years

Pre-senile

Clinical Features

- ✓ Disorientation in time and place
- ✓ Short term memory problems
- ✓ Nominal aphasia
- ✓ Constructional dyspraxia
- ✓ Discalculia
- ✓ Gertsman's Syndrome

Multi Infarct Dementia

- o Disorientation in time and place
- o Short term memory problems
- o Stepwise deterioration
- o This results from multi infarcts in the brain
- o The clinical picture is dependent on the number of infarcts in the brain
- o There may be psychotic features

Pick's Disease

Areas affected are frontal temporal areas. Symptoms as for other dementias.

Huntington's Chorea

- ✓ Characterized by choreic movements of face and trunk
- ✓ Childhood onset
- ✓ Presentation may be psychotic

Creutzfeld – Jacob Disease

This is caused by a virus related to the virus that affects the sheep. Transmission is by organ transplant.

Treatment of Dementias

Treat the cause found during assessment e.g.

- Stop drugs
- Treat infection
- Correct electrolyte imbalance
- Correct anaemia

Treat psychotic features with antipsychotic medication

- Thioridazine 25 – 50mg nocte
- Haloperidol 5 – 10 mg tds
- Add nutritional supplements like multivitamins

Psychotherapy

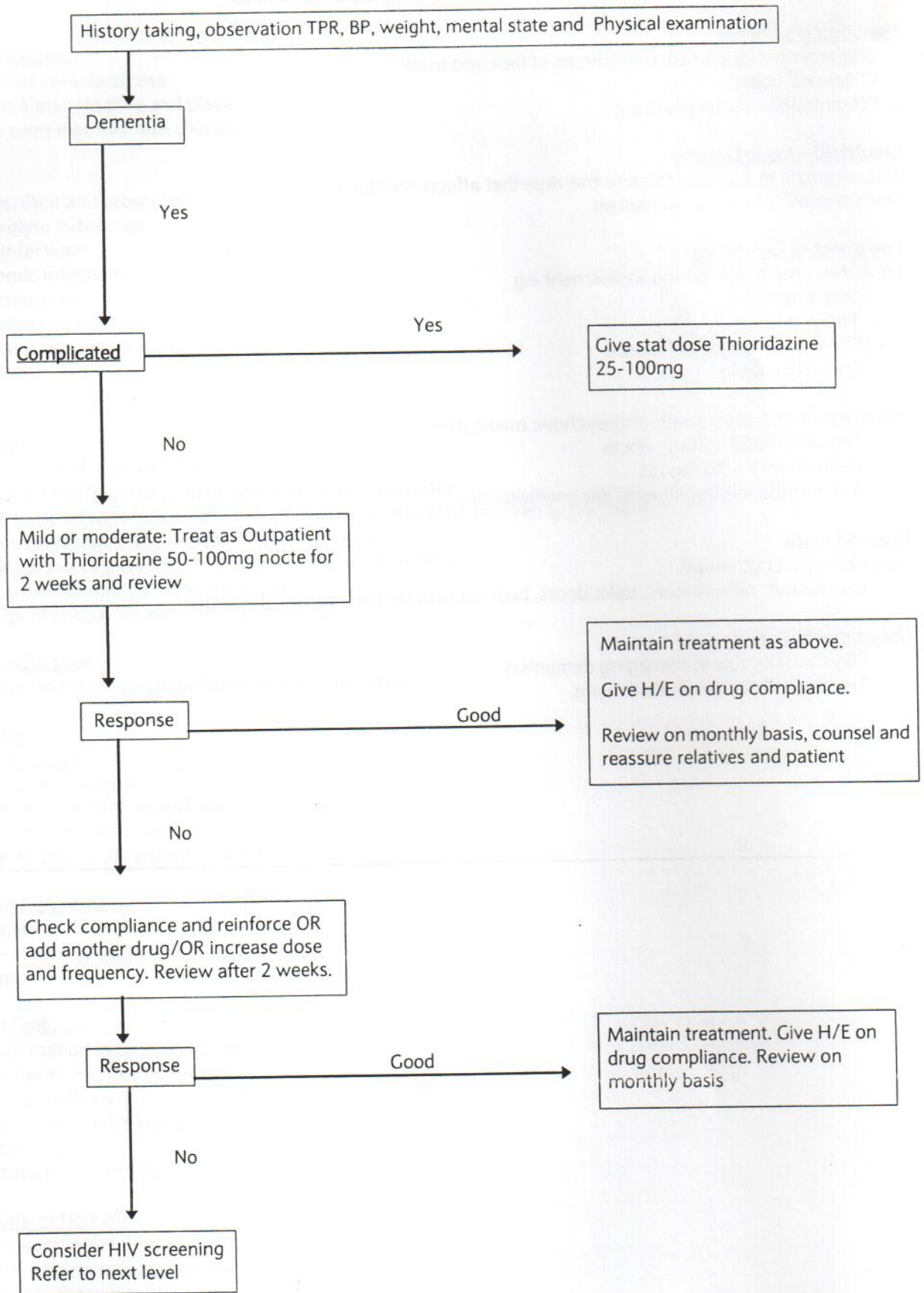
Supportive psychotherapy

- Label doors, refrigerators, toilet doors, bedrooms to try and reorient the patient

Occupational Therapy

- Plays a major role in managing dementias
- Training in activities of daily living.

MANAGEMENT FLOW CHART FOR DEMENTIA



CHAPTER TEN: OTHER ORGANIC CONDITIONS

Pellagra

Clinical Feature

- o Dementia
- o Diarrhoea
- o Dermatitis

Treatment Vitamin replacement

Vitamin B Deficiency

Treatment Vitamin B replacement

CHAPTER ELEVEN: PSYCHIATRIC CONDITIONS RELATED TO CHILD BIRTH

Psychiatric conditions during pregnancy are not very common. Problems start to surface in the third trimester are mainly anxiety about the birth process and the condition of the baby. Ascertain who are at risk e.g. those with family history of psychosis. Health Education and intervention to start during ANC visits.

Treatment

Usually reassurance is sufficient

Maternal Blues

Onset of symptoms:

Two weeks after birth

Tearfulness

Loss of appetite

Confusion

Poor sleep

Worry about the baby

Treatment

- No drug treatment is necessary
- Supportive psychotherapy and reassurance
- Symptoms are usually self limiting – treatment is necessary to enhance bonding between mother and baby.

Puerperal Depression

Onset up to six months after birth.

- Insidious onset
- Lack of self care
- May be neglect of baby
- Insomnia
- Appetite changes
- Lack of energy
- Loss of libido
- Lack of concentration
- Worries about baby's e.g.
 - a) Growth
 - b) Appearance, etc.

Treatment

Admission should be in a mother and baby unit to avoid separation.

- Special care should be given to monitoring the mother and baby to ensure breastfeeding
- Bathing of the baby, etc.

Psychotherapy

Psycho-education

- To mobilize social support for the mother
- Social skills and skills of daily living should be assessed and strengthened.
- Problems that arise during assessment should be addressed before discharge.

These may be affective in nature about - 75%

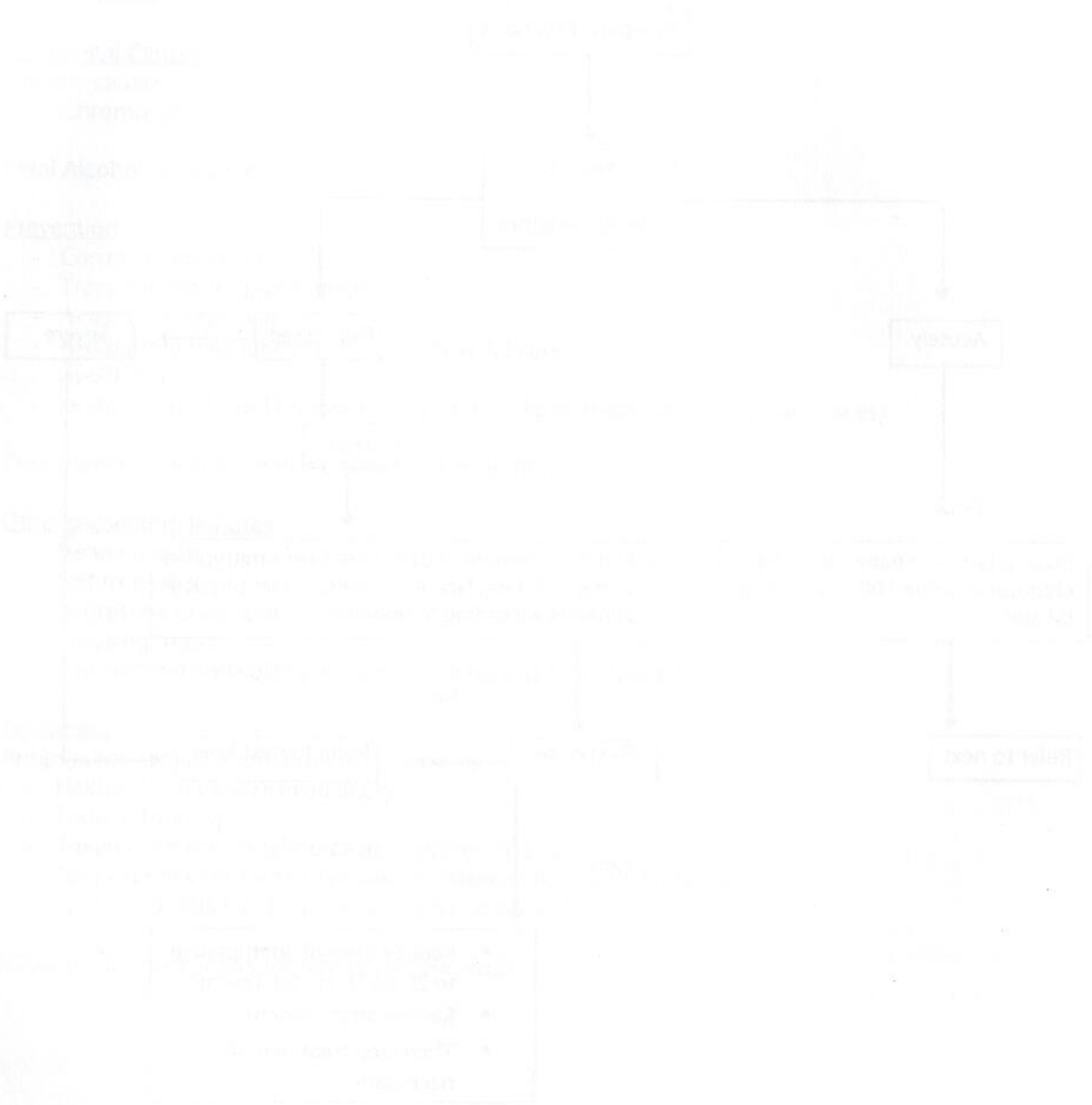
- Schizophrenic - 20%
- Organic - +5%

Clinical Features are described elsewhere under each syndrome except

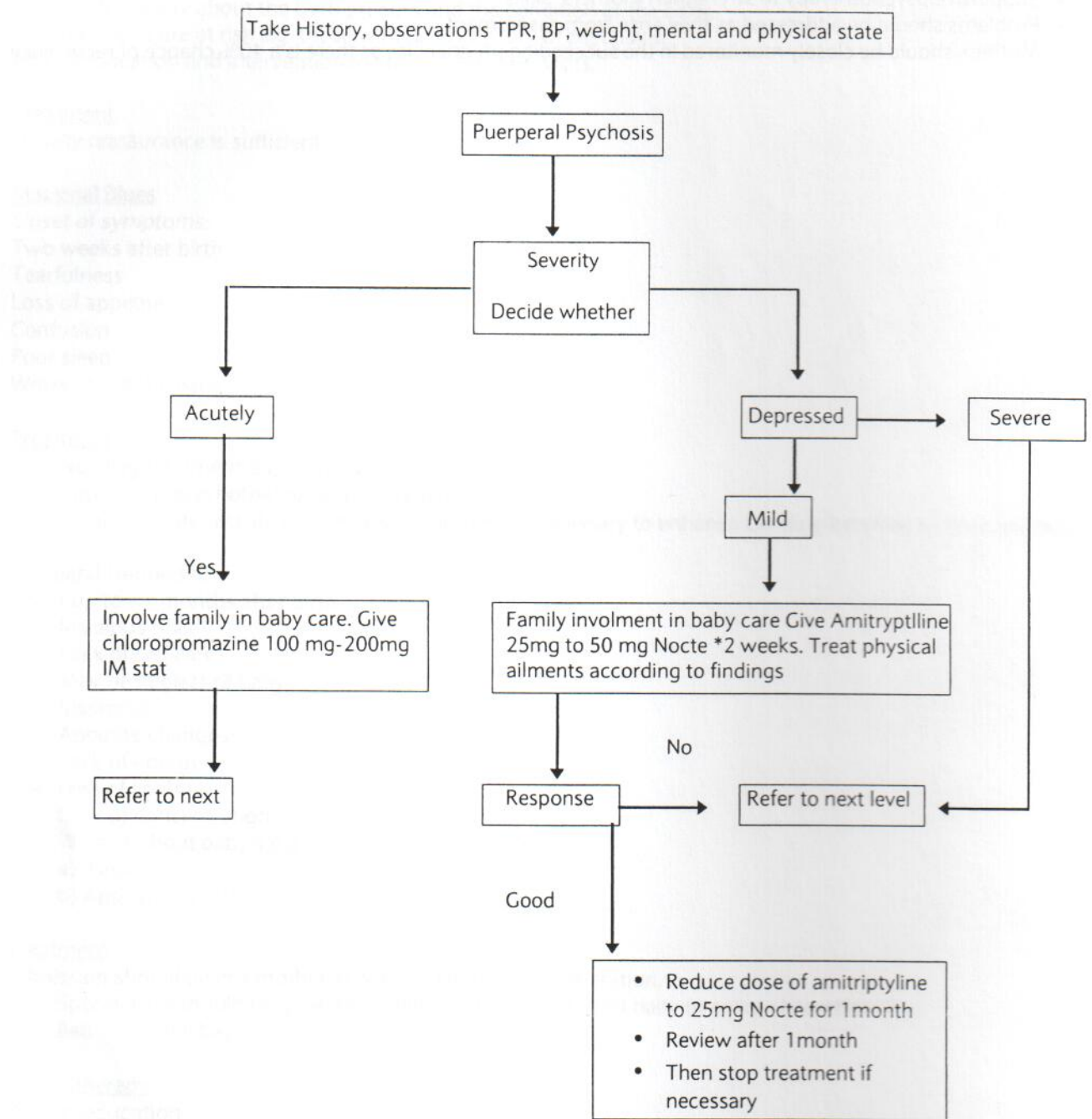
- There may be delusion about the baby's deformity
- Or failure to thrive
- Care need to be taken as the baby may be in danger of being killed.

Treatment

- Antipsychotic medication
- Electroconvulsive Therapy (ECT) for quick recovery
- Supportive psychotherapy to strengthen mothers' skills
- Problems should be addressed as they arise from assessment
- Mothers should be closely monitored in the succeeding pregnancies as there is a 40% chance of recurrence



MANAGEMENT FLOW CHART FOR PUERPERAL PSYCHOSIS



CHAPTER TWELVE: MENTAL RETARDATION

Definition is a state of incomplete development of the mind existing from birth or an early age whether from inherent causes, diseases or injury.

Causes can be:

- Congenital
- Acquired

Congenital Causes

Genetic causes

- Chromosomal

Fetal Alcohol Syndrome

Prevention

- Correct malnutrition
- Treat infections appropriately
- Avoid birth asphyxia
- Avoid prolonged labour by good ante natal care
- Avoid injuries
- Keeping pencils and batteries away from children (lead containing substances)

Treatment is aimed at reducing further deterioration

Other presenting features

- Head banging
- Self mutilation
- Regressive behaviour
- Refusing to eat
- Bed-wetting and soiling in someone who was toilet trained

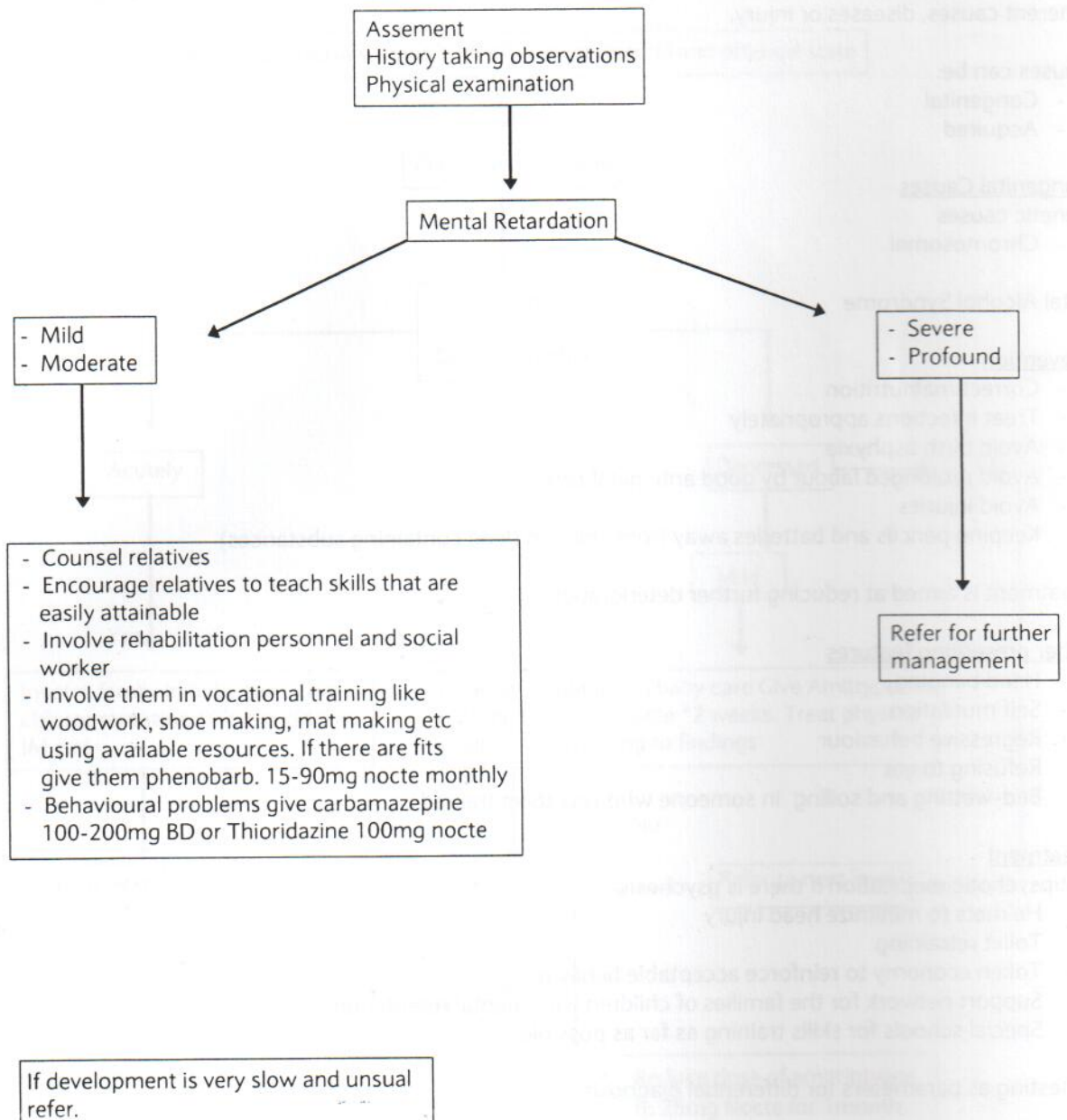
Treatment

Antipsychotic medication if there is psychosis

- Helmets to minimize head injury
- Toilet retraining
- Token economy to reinforce acceptable behaviour
- Support network for the families of children with mental retardation
- Special schools for skills training as far as possible.

IQ testing as parameters for differential diagnosis.

MANAGEMENT FLOW CHART FOR MENTAL RETARDATION



CHAPTER THIRTEEN: CHILD AND ADOLESCENT PSYCHIATRY

Child and Adolescents Psychiatry is a highly specialized area. Information gathering on assessment is very crucial. Usually during assessment it may be apparent the problem is not with the child but may be with the parents.

History Taking

Care should be taken as to who is referring the child. What is it that they want assistance with.

Personal History

- Mothers pregnancy with the child. Illness she suffered e.g. infections, hypertension, diabetes mellitus, etc.
- Delivery — prolonged, assisted or normal delivery.
- Developmental milestones delayed or normal.
- Temperament — easy child or difficult to please.
- Childhood easy going or difficult, temper tantrum, nail biting, etc.
- Preschool
- Schooling
- Relationship with other children – gets along, bully, etc.
- Its essential to do a family interview – observe sitting arrangements, who answers all the questions.
- The child may be asked to draw his family. A lot of information will be obtained this way.

Psychiatric Conditions in Children and Adolescents

Enuresis

Bedwetting at an age when toilet training is expected to be complete.

Primary – they were never dry

Secondary – the child was dry for a period and then starts bedwetting again

Boys to girls — 3:1

Treatment

Tricyclic Antidepressants are effective but bedwetting resumes as the medication is stopped.

Behavioural

- Star chart for each night the child is dry.
- Waking the child up several times a night
- Bell and pad – as soon as the child begins to wet the bed the bell rings and the child is taken to the toilet, the sheets are changed and the apparatus is reset until the child is able to wake up by himself.
- A thorough physical exam is crucial to rule out urinary tract infection or physical anomaly.

Encopresis

Soiling at an age toilet training expected to be complete.

Boys: Girls = 4:1

Treatment is mainly behavioural. Physical exam is also essential to rule out anomalies.

Conduct Disorders

Stealing

Truancy at school

Cruelty to others and animals

Drug abuse

Boys outnumber girls - 5:1

Treatment is mainly Behavioural

Token economy – by rewarding good behaviour until control is maintained

Pervasive Developmental Disorder

Autism

Onset before 36 months

More common in boys

May be mental retardation

There may be speech problems

- Main problem is lack of socialization
- Prefers isolated activities
- There may be pockets of highly developed areas e.g. mathematical calculations
- They have speech defects like pronominal reversal e.g. they say you like ice cream rather than saying I like ice cream
- They get upset when their routine is disturbed.

Treatment is by supportive psychotherapy.

Prognosis

- One third improve, if of average intelligence.
- One third improve a little bit
- In a third there is no improvement

Dyslexia

Problem in reading certain work. Problem may manifest during school years. Improvement is significant if picked up early. Some may get as far as university.

In adolescents adult psychiatric syndromes are beginning to appear. Treatment is as in adults and special attention should be paid to stresses in order to prevent chronicity

Treatment of childhood psychiatric condition is not expected at the Primary Care Level. These cases should be referred without delay.

May be mental retardation

There may be speech problems

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CHAPTER FOURTEEN: CHILD ABUSE

Physical Abuse

Clinical presentation

- Frozen watchfulness
- Multiple injuries in different stages of healing
- There may be fractures on X-ray examination

Treatment

- May involve removing the child to a place of safety
- Work with the parents to prevent further abuse

Child Sexual Abuse

Both male and female children are abused.

Clinical Features

- Fearful of opposite sex
- Being over sexualized for the age
- Promiscuity
- Genital tears
- Infections
- Pregnancy in adolescent girls
- Regressive behaviour
- Bedwetting in someone who was already dry
- Poor performance in school
- Socially withdrawn

Treatment

- Believe the child
- Need to be sensitive so that blame is not put on the child
- There are victim friendly courts that deal with the legal side of things
- Long term psychotherapy is necessary to develop self esteem and self acceptance in the child.
- Long term follow up is necessary
- Support groups for victim of sexual abuse
- Support groups for parents of sexually abused children

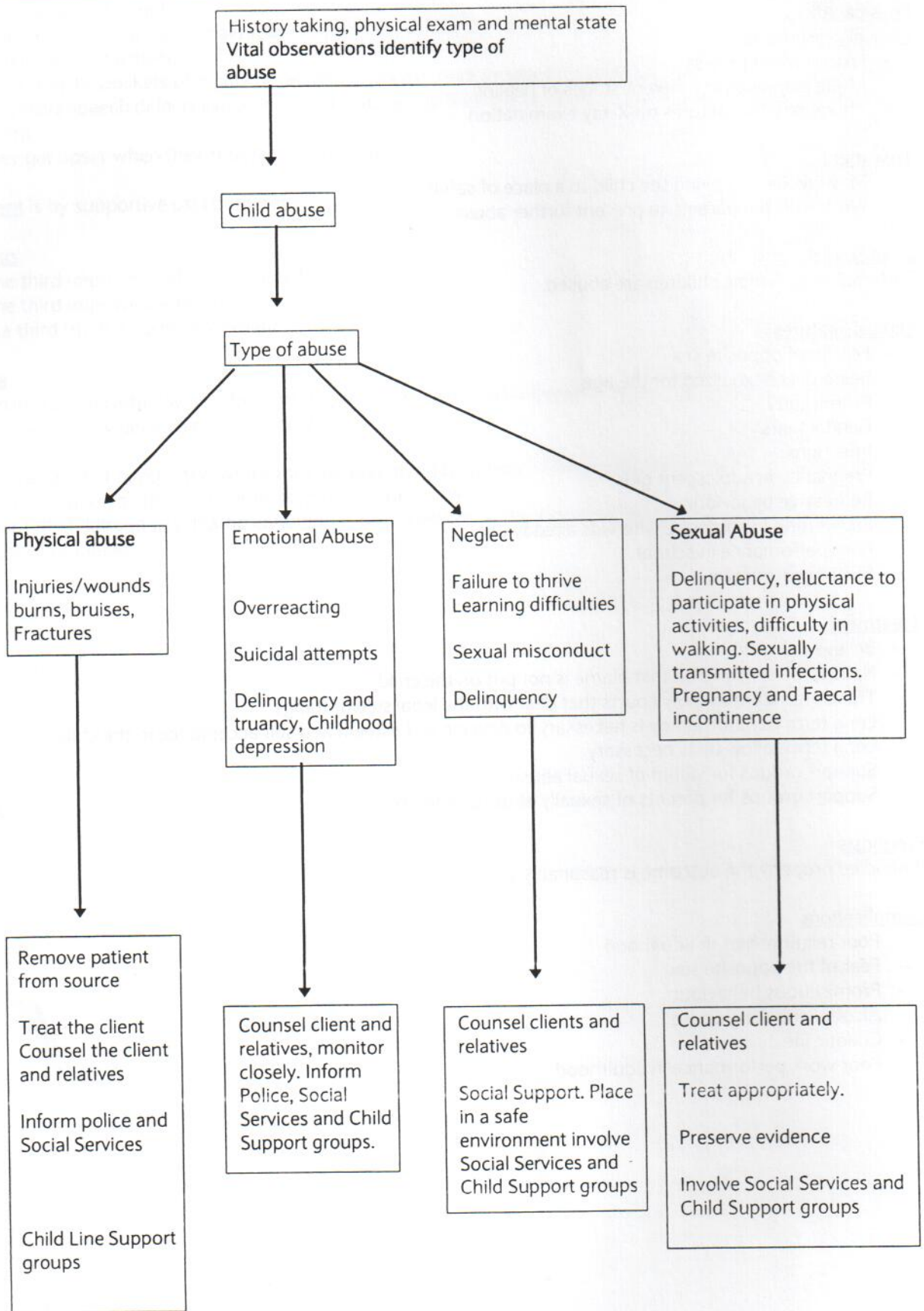
Prognosis

If handled properly the outcome is reasonably good.

Complications

- Poor relationships in adulthood
- Fear of the opposite sex
- Promiscuous behaviour
- Alcohol and drug abuse
- Chaotic life
- Poor work performance in adulthood

FLOW CHART FOR CHILD ABUSE



CHAPTER FIFTEEN: SUICIDAL AND PARASUICIDE

Suicide: The act of killing oneself

Risk Factors - Older age groups. More males, and those with the conditions below.

- Depression
- Alcohol abuse
- Drug abuse
- Personality Disorder

Chronic painful conditions e.g. Cancer, HIV/AIDS, Schizophrenia

People who are experiencing adverse effects e.g. those facing divorce, separation, conflicts within relationships, loss of jobs, isolation, etc.

Assessing Suicidal Risk

Is the patient serious –

Is death a welcome outcome

What plans have they made?

Have they written a suicidal note?

What plans is he/she making not to be discovered

Are there feelings of hopelessness, helplessness and worthlessness?

The suicidal patient usually tells someone about the intent.

Management of the suicidal patient

Decision as whether to admit or not depends on whether there are adequate social support networks. If the decision to admit is reached, the patient is to be stripped of all dangerous items like knives, razor blades, belts, etc.

Level I observation

The patient and the nurse must be together always. When the patient is in the toilet he should not lock the door.

Level II

The nurse must be able to see where the patient is at all times.

Level III

The nurse must know where the patient is e.g. in group therapy, or at occupational therapy. Care must be taken when the patient is recovering because the patient will be having enough energy to kill themselves.

The current condition must be treated accordingly.

Deliberate Self Harm or Parasuicide

Clinically

These are younger people

- More common in females
- Threats of committing suicide are common
- Sometimes occurs after a dispute
- May be used to manipulate others
- These may also be failed suicides
- Common in Borderline Personality disorders

Management

Treat the underlying cause e.g. addressing some relationships and other conflicts.

Building self esteem

Eating Disorders

Are not very common in Africa and developing countries.

Anorexia Nervosa

Excessive Dieting
Usually eating meager vegetables and fruits.
Loss of weight
Complaints about being overweight despite the evidence
Avoidance of eating with others
May go to great lengths to cook for others
Hypothermia.

Treatment

In group therapy
Monitor eating and weekly weighing
Prognosis: usually poor

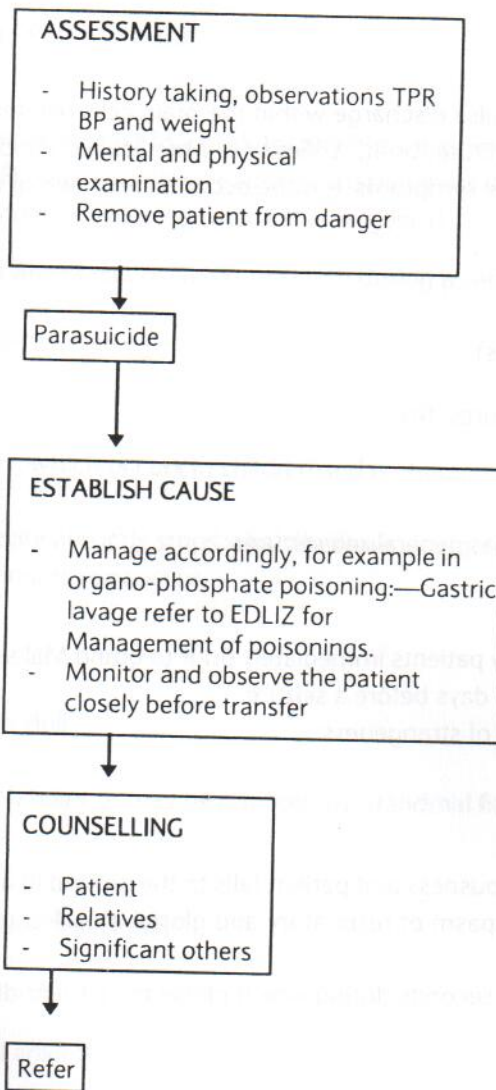
Bulimia Nervosa

Eating large volumes of food and then vomiting it to maintain weight
Feeling of disgust after vomiting

Treatment

In group – controlled feeding and monitoring weight
Psychotherapy to build self esteem.

MANAGEMENT FLOW CHART FOR PARASUICIDE



CHAPTER SIXTEEN: EPILEPSY

Definition

Epilepsy is an abnormal electrical impulse discharge within the brain cells resulting in altered mental and body functions always with some type of seizure or fit. Epilepsy is a medical condition but, only becomes a mental disorder if it manifests with behavioural symptoms. It is the occurrence of two or more unprovoked seizures in a 12 months period

Types of epilepsy

Grand Mal epilepsy (major seizures/fits)

Petit Mal epilepsy which is (minor seizures/fit)

Temporal Lobe epilepsy

Grand Mal Seizure has fit stages and has generalized seizures

Stage 1 Prodrome/Aura:-

- Aura is experienced by patients immediately prior to grand Mal seizure e.g. tingling sensation.
- This can take hours or days before a seizure
- There may be feelings of strangeness.

Stage 2-Tonic Stage

- Sudden loss of consciousness and patient falls to the ground in a state of good extension. There may be a cry due to spasm of respiratory and glottal muscles, cessation of respiration leads to cyanosis.
- This phase lasts 5-40 seconds during which phase the patient displays intense tonic spasms of face trunk and limbs

Stage 3- Clonic Stage

- The tonic spasms give way to a series of jerky pavements involving muscles of the face, trunk and limbs
- The tongue may be bitten. Patient frequently froths from the mouth.
- Incontinence of urine and faeces occur.
- This phase may last 40-60 seconds.

Stage 4 –Coma Stage

- Comatose stage follows the clonic stage.
- The clonic movements gradually subside and cease.
- Patient relaxes, breathes deeply and noisily, in a comatose stage. Muscles are quite relaxed.
- It may last 60 minutes or more.
- Consciousness gradually returns leaving patient with post fit symptoms e.g. headache, confusion or drowsiness. Patient may go into a natural sleep

Stage 5- Post ictal stage/Automatism

- It is a twilight state, in which a state of disturbed consciousness occurs lasting from a few minutes to several days.
- Patient can move around without being aware (figure) anxiety, paranoid ideas, hallucinations or aggressive behaviour may be present and can commit crimes unaware.

Management During a Seizure

- Remove patient from any source of danger
- Maintain a clear airway
- Loosen tight clothing
- Check body parts involved during the fit, check for any body injuries
- Should a second seizure/Fit follows without gaining consciousness this can be the start of status epilepticus and medical attention should be obtained (medical emergency).

NOTE: Do not put a spatula or any object between the teeth during a seizure.

One seizure is not epilepsy.

PETIT MAL EPILEPSY

- It is a mild form of epilepsy, which occurs in children and is characterized by short lapses of consciousness lasting 5-20 seconds.
- In an attack the sufferer quite abruptly stops what she/he is doing, may stare or roll his/her eyes upwards.
- Twitching of eyelids and fingers may occur.
- Confusion
- Poor concentration span.
- Slow thought process
- Individual appears mentally dull.

Condition may disappear in adolescent or may be replaced by grandmal fits.

TEMPORAL LOBE EPILEPSY

Originates from the temporal lobe of the brain

Signs and Symptoms

- Sudden attacks of fear and anxiety
- Changes in perception
- Presence of all Hallucinations except tactile
- Disorientation to familiar places/objects
- May feel that she/he foresee the future
- Disturbance in thinking
- Destructive and violent behaviour
- Dreamy state
- Affective disorders which may range from anxiety and terror to pleasure and happiness.

SOCIAL IMPLICATIONS OF EPILEPSY

1. Patients are stigmatized by the society
2. Experience difficulties in employment
3. Restrictions in sporting activities
4. The community associates it with witchcraft and (ngozi)
5. Rejection/overprotection by parents

Epilepsy is regarded as a family problem in so far as the importance of medications, the monitoring of fits and ensuring that the patient is not treated as different from other members of the family. All efforts should be made to ensure the child is not rejected from school because of fits.

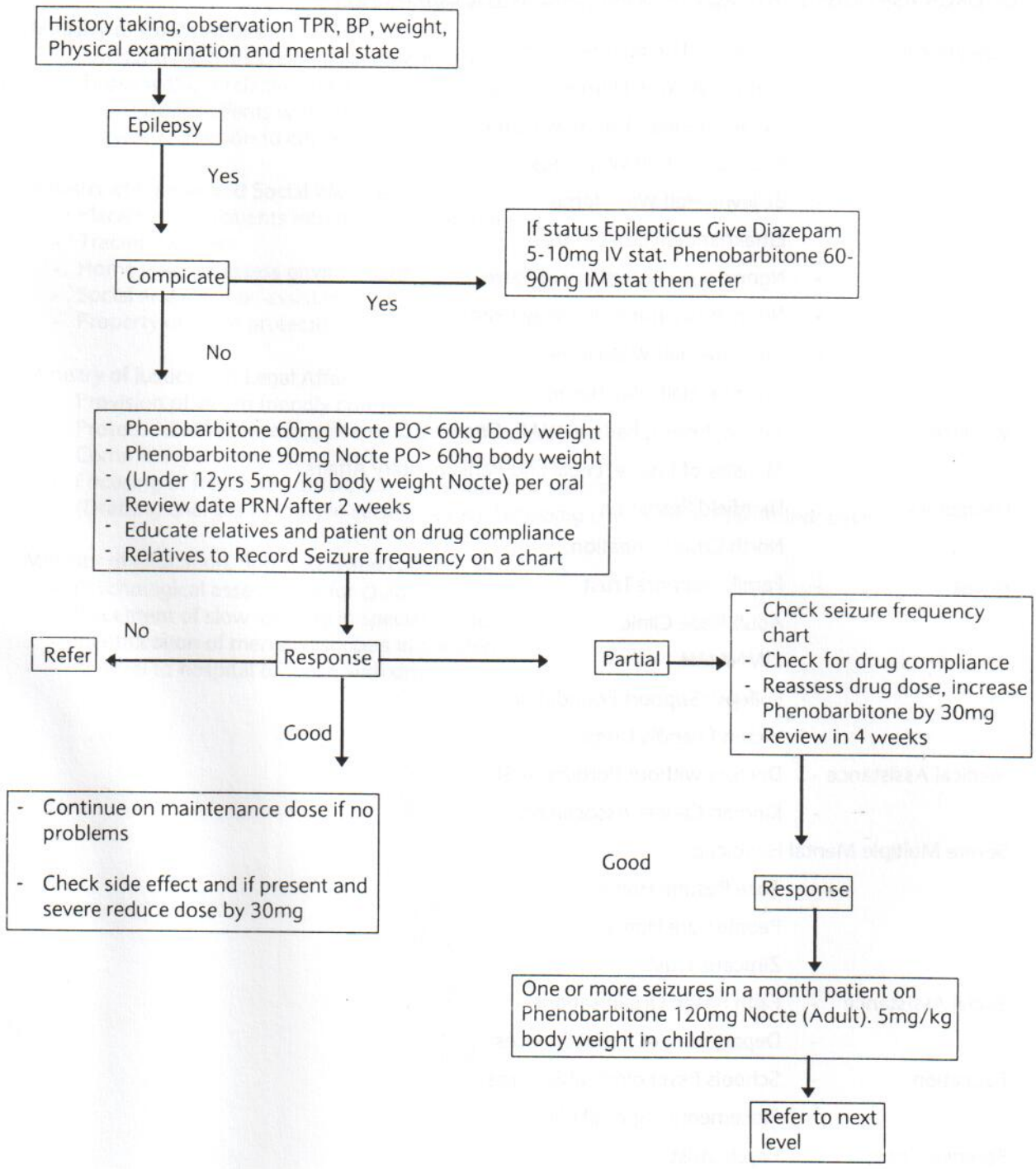
MANAGEMENT OF EPILEPSY

- Comprehensive history taking RPR. BP, weight, physical and mental state examinations.
- Exclude other causes of fits e.g. meningitis, cerebral malaria.
- Health Education on condition, seizure management, drug compliance, seizure precipitating factors and occupational and recreational safety.

DRUG MANAGEMENT

- Phenobarbitone 30 mg Nocte is a drug of choice for epilepsy and Carbamazepine 200mg TDS is a specific drug for temporal lobe epilepsy and those with behaviour problems.

MANAGEMENT FLOW CHART FOR EPILEPSY



LIST OF ORGANISATIONS THAT PROVIDE SOME CARE IN THE COMMUNITY

1. Rehabilitation
 - Tirivanhu Therapeutic Farm
 - Tariro Half-Way Homes
 - Queen of Peace Half Way Home
 - Southerton Half Way House
 - Bellevue Half Way Home
 - Emakhandeni Day Centre
 - Ngomahuru Resettlement Farm
 - Ngomahuru Rural Half Way Home
 - Chinhoyi Half Way Home
 - Rukariro Half Way Home
2. Violence
 - Msasa Project, Padare, WAG, Connect, Counselling Services Unit.
 - Ministry of Justice, Legal and Parliamentary Affairs
3. Delinquency
 - Highfield Probation
 - North Court Probation
4. Abuse
 - Family Support Trust
 - Adult Rape Clinic
 - ZIMNAMH
 - Epilepsy Support Foundation
 - Victim Friendly Units
5. Medical Assistance
 - Doctors without Borders (MSF)
 - Kioman Cancer Association
6. Severe Multiple Mental Handicap
 - Tose Respite Home
 - People Care Home
 - Zimcare Trust
7. Social Assistance
 - Faith Based Organisations
 - Department of Social Services
8. Education
 - Schools Psychological Services
 - Placement in Special Classes
9. Forensic Team
 - Psychiatrist
 - Psychiatric Nurse
 - Psychologist
 - Social Worker
 - Police Officer
 - Prison Officer
 - Attorney General
 - Judges
 - Magistrates

ANNEXE 2.

ROLES OF OTHER MINISTRIES OR SERVICE PROVIDERS

Ministry of Home Affairs

- Assisting relatives taking a client to hospital
- Those without relatives taking them to hospitals
- Arresting the clients who commit crimes
- Provide protection to children

Ministry of Labour and Social Welfare

- Placement of patients into homes/institutions
- Tracing relatives
- Home visits to assess environment
- Social and material assistance
- Property of client protection

Ministry of Justice and Legal Affairs

- Provision of victim friendly courts
- Protection of the property of the mental offenders
- Committing the mentally ill offenders to institutions
- Focusing of Reception orders for admission to hospitals
- (Drafting charges (minor) in certain cases). Dropping charges in certain minor cases.

Ministry of Education, Sport, Arts and Culture

- Psychological assessment for children
- Placement of slow learners in special classes
- Identification of mental disorders in children
- Referral to hospital of those with disorders.

ANNEXE 3

HUMAN RIGHTS CONVENTIONS

- UN Convention
- African Charter
- Child Protection/Adoption Act (ZIM)
- Mental Health Act (1996)
- Patient Charter
- SADC Protocol
- UN convention (equalization of opportunities)
- Disabled Persons Act

Ethical practices—

- Rights Based approach – reduce stigma
- Confidentiality
- Consent
- Freedom from discrimination
- Right to quality care/protection
- Safe hygiene—Personal and Communal hygiene
- Communication
- Privacy
- Social security rights— social assistances, etc.
- Rehabilitation and Social Integration
- Independent review
- Access to information
- Need for training and counselling