

Mental Health Care

1) Medical Abbreviations List

- **bid** – twice daily
- **po** – by mouth
- **BP** – blood pressure
- **prn** – as needed
- **cap** – capsule
- **q** – every
- **CBC** – complete blood (cell) count
- **qhs** – every bedtime
- **CNS** – central nervous system
- **qid** – 4 times daily
- **DSM** – Diagnostic Statistical Manual
- **SNRI** – selective norepinephrine reuptake inhibitor
- **dx** – diagnosis
- **SR** – slow release
- **EKG** – electrocardiogram
- **SSRI** – selective serotonin reuptake inhibitor
- **EPS** – extrapyramidal symptoms
- **sx** – symptoms
- **ESR** – erythrocyte sedimentation rate
- **TD** – tardive dyskinesia
- **HR** – heart rate
- **tid** – three times daily
- **ICD** – International Classification of Diseases
- **WHO** – World Health Organization
- **IM** – intramuscular
- **XL** – extended length

- **IV** – intravenous
 - **XR** – extended release
 - **MAOI** – monoamine oxidase inhibitor
 - **Meq/L** – milliequivalent/liter
 - **mg** – milligram
 - **ml** – milliliter
 - **MSE** – mental status examination
 - **ng** – nanogram
 - **NMS** – neuroleptic malignant syndrome
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PART I: Mental Health Worldwide

Definition of Mental Health

The **World Health Organization (WHO)** defines mental health as a:
"state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community."

Definition of Global Mental Health

Global mental health refers to the **international perspective** on mental health. It is defined as:

"the area of study, research, and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide" (Koplan et al, 2009).

- **Neuropsychiatric disorders** contribute to **13% of the global disease burden**, affecting every country worldwide.
- Assessing **mental health resources** worldwide helps in:
 - Understanding the availability of **mental health services**.
 - Identifying gaps in **mental health interventions and policies**.
 - Protecting **human rights** in mental health care.

Global Mental Health Assessments

The WHO evaluates mental health resources based on:

1. **Geographic region** – Helps classify and compare mental health systems globally.
 2. **Economic status** – Examines mental health disparities between **high-income and low-income countries**.
 - Some **countries lack mental health programs** and must **rely on regional support**.
 - **Regional partnerships** can be a **cost-effective** way to develop mental health infrastructure.
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Limitations of Global Studies & Reports

Challenges in Assessing Mental Health Care Worldwide

- **Data limitations:** Not all countries provide complete information on mental health services.
- **Regional classification issues:** WHO-defined "regions" do not always align with physical geography but may be based on **economic, historical, or cultural similarities**.
- **Differences in mental health definitions:** Concepts and services **vary between countries**, affecting data comparisons.
- **Inconsistencies in information sources:** Countries rely on **different reporting methods**, making standardization difficult.

WHO 2011 Report: Global Mental Health Findings

A recent WHO assessment (2011) analyzed **184 out of 196** WHO member states (covering **98% of the world's population**).

Findings include:

- **Mental health burden is higher in low-income countries.**
- **Global reduction in mental hospital beds**, indicating a shift to **community-based care**.

WHO Regional Classifications

- **Africa (AFR)**
- **The Americas (AMR)**
- **Eastern Mediterranean (EMR)**
- **Europe (EUR)**

- **South-East Asia (SEAR)**
- **Western Pacific (WPR)**

WHO Income Classification

- **High-income:** GNI per capita $\geq \$12,276$
 - **Upper-middle-income:** GNI per capita $\$3,976 - \$12,275$
 - **Lower-middle-income:** GNI per capita $\$1,006 - \$3,975$
 - **Low-income:** GNI per capita $\leq \$1,005$
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Indicators of Global Mental Health (WHO, 2011)

1) Governance

Mental Health Policy

- **60% of countries** have an official **mental health policy**.
- These policies cover **72% of the world's population**.
- More common in **EMR, EUR, SEAR**, less common in **AFR, AMR, WPR**.

Mental Health Plan

- **72% of WHO countries** have a **mental health plan**.
- **Highest adoption:** EMR (74%), SEAR (80%), EUR (81%).
- **Lowest adoption:** WPR (62%), AMR (66%), AFR (67%).
- **High-income countries** are more likely to have mental health plans than low-income countries.

Mental Health Legislation

- **59% of the global population** lives in a country with official **mental health legislation**.
 - **Most prevalent in:** EUR (80.8%), AMR (56.3%), EMR (57.9%), WPR (53.8%).
 - **Least prevalent in:** AFR (44.4%), SEAR (40%).
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2) Financing

- **Global median mental health expenditure per capita: \$1.63 USD.**
- **Disparities by income group:**

- **Low-income countries: \$0.20 USD**
 - **High-income countries: \$44.84 USD**
 - **Health budget allocated to mental health (by region):**
 - **EUR – 5.0%**
 - **EMR – 3.75%**
 - **WPR – 1.95%**
 - **AMR – 1.53%**
 - **AFR – 0.62%**
 - **SEAR – 0.44%**
 - **Mental health funding allocation:**
 - **67% directed toward mental hospitals**
 - **Only a small percentage for community-based facilities**
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3) Mental Health Care Delivery of Services

Primary Health Care (PHC)

- **Most countries allow PHC physicians to prescribe mental health medications.**
- **Restrictions:** Some countries allow prescriptions only in **emergencies** or for **certain drug types**.

Mental Health Facilities

- **Facility types:**
 - **Outpatient facilities** (most common)
 - **Day treatment facilities**
 - **Community residential facilities**
 - **Psychiatric beds in general hospitals**

Aspects of Service

- **Hospital stay duration:**
 - Most patients stay **less than a year**.
 - **23% of patients stay longer than a year.**

- **Follow-up care availability:**
 - **High-income:** 45%
 - **Upper-middle-income:** 39%
 - **Lower-middle-income:** 29%
 - **Low-income:** 7%

Psychosocial Interventions

- **Global availability:** 44% of countries provide these services.
- **Availability by income level:**
 - **High-income:** 59%
 - **Upper-middle-income:** 61%
 - **Lower-middle-income:** 34%
 - **Low-income:** 14%

Mental Health Worldwide

1) Primary Health Care (PHC) Mental Health Care Delivery

- The majority of countries allow PHC physicians to prescribe (or continue prescribing) medicines for mental and behavioral disorders, either **without restrictions (56%) or with some legal restrictions (40%)**.
- Restrictions include prescriptions only in emergency settings or for certain categories of medicines.
- **Only 3% of countries do not allow PHC physicians to prescribe any form of medication.**
- Regarding nurses, **71% of countries do not allow them to prescribe, 26% allow prescribing with restrictions, and 3% allow prescribing without restrictions.**

2) Mental Health Facilities

- **Outpatient facilities** outnumber **day treatment facilities, mental hospitals, community residential facilities, and psychiatric beds in general hospitals.**

- **Definitions of Facilities:**
 - **Outpatient facility:** Focuses on managing mental disorders on an outpatient basis.
 - **Day treatment facility:** Provides care during the day without overnight stays.
 - **Mental hospital:** Specialized hospital-based facility for inpatient and long-term residential care for people with severe mental disorders.
 - **Community residential facility:** Non-hospital, community-based facility providing overnight residence for people with mental disorders.

Global Median Number of Facilities (per 100,000 population):

- **Outpatient facilities:** 0.61
 - **Day treatment facilities:** 0.05
 - **Mental hospitals:** 0.04
 - **Community residential facilities:** 0.01
 - **Psychiatric beds in general hospitals:** 1.4
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3) Aspects of Mental Health Services

- **High-income countries** have **more mental health facilities** and **higher admission & utilization rates**.
- **Length of Stay in Mental Hospitals:**
 - The majority of patients stay **less than one year**.
 - **23% remain in hospitals for more than a year**.

Follow-up Care

- **Only 32% of countries have a majority of facilities providing follow-up care** (e.g., home visits for medication monitoring, relapse prevention, and rehabilitation support).
- Follow-up care is available in:
 - **45% of high-income countries**
 - **39% of upper-middle-income countries**
 - **29% of lower-middle-income countries**

- **7% of low-income countries**

Psychosocial Interventions

- **Only 44% of countries provide psychosocial interventions at most facilities.**
- **Availability by income level:**
 - **High-income countries:** 59%
 - **Upper-middle-income countries:** 61%
 - **Lower-middle-income countries:** 34%
 - **Low-income countries:** 14%

Global Median Bed Availability in Mental Health Facilities (per 100,000 population)

- **Total (including community residential facilities, mental hospitals, and psychiatric wards):** 3.2 beds
 - **Regional Disparities:**
 - **Lowest rates:** Africa (AFR: 0.60), Eastern Mediterranean (EMR: 0.62), Southeast Asia (SEAR: 0.23)
 - **Highest rates:** Europe (EUR: 7.09, more than double the world median)
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4) Human Resources in Mental Health

- **Most common mental health professionals worldwide:**
 - **Nurses:** 5.15 per 100,000 population
 - **Medical doctors:** 3.38 per 100,000 population

Psychiatrists per 100,000 population:

- **Africa (AFR):** 0.05
- **Europe (EUR):** 8.59

Other Health Personnel in the Mental Health Sector (per 100,000 population)

- **Other medical doctors:** 0.06 (AFR) to 1.14 (EUR)
- **Nurses:** 0.61 (AFR) to 21.93 (EUR)
- **Psychologists:** 0 (WPR) to 2.58 (EUR)
- **Social workers:** 0 (WPR) to 1.12 (EUR)
- **Occupational therapists:** 0 (SEAR/WPR) to 0.57 (EUR)

- **Other health workers:** 0.04 (SEAR) to 17.21 (EUR)

Income-Level Disparities in Human Resources

- **Psychologists:** Over 180 times more psychologists per capita in high-income countries than in low-income countries.
- **Psychiatrists per 100,000 population:**
 - **High-income countries:** 8.59
 - **Low-income countries:** 0.05

Training in Psychiatry & Mental Health

- **Doctors:** 2.8% of total training focuses on mental health.
 - **Lowest:** 2.2% (AMR)
 - **Highest:** 4.0% (SEAR)
- **Nurses:** 3.3% of total training focuses on mental health.
 - **Lowest:** 2.0% (SEAR)
 - **Highest:** 4.0% (AFR)

5) Medicines for Mental & Behavioral Disorders

- Worldwide median expenditure per person per year on psychiatric medicines: \$7 USD (\$6.81).
- **Data Collection Issues:**
 - Less than 30% of countries reported data.
 - Most data comes from high-income countries, meaning actual global expenditure may be lower.

6) Mental Health Information Systems

- **Mental health data is collected in:**
 - Mental hospitals, general hospitals, day treatment facilities, and outpatient facilities.
- **Less data is collected from:**
 - Primary care and community residential facilities.

PART II: MENTAL HEALTH CAPACITY BUILDING

Increasing Access to Care Through Integration & Collaboration

1) Integrating Mental Health Care into Existing Health Facilities

Integrating **mental health care** into **existing community facilities** is an effective way to provide services in **resource-limited areas**.

Key Components of Integration

- **Training Primary Healthcare Providers:**
 - General practitioners and healthcare workers are **trained** to:
 - Conduct **basic mental health assessments**.
 - Provide **basic therapeutic interventions**.
 - Refer severe cases to **specialized mental health services** (if available).
 - **Collaboration with Government Agencies:**
 - Develop **mental health policies**.
 - Promote **deinstitutionalization** (transition from mental hospitals to **community-based care**).
 - Incorporate **mental health training in medical, nursing, and graduate programs**.
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2) Telepsychiatry: Expanding Mental Health Services

Telepsychiatry uses **communication technologies** to provide **mental health services** **remotely**.

Benefits of Telepsychiatry

- **Access to Specialists:**
 - General practitioners in **remote areas** can consult **mental health specialists** via **video conferencing**.
- **Training & Supervision:**
 - Mental health professionals **train and supervise** primary healthcare providers **remotely**.
- **Cost-Effective:**

- Reduces the cost of **mental health training and service delivery** while ensuring **efficient care**.
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3) Mental Health Training: Curricula & Duties for Healthcare Workers

Mental Health Training Curriculum

The **mental health training curriculum** consists of three main sections:

1. Psychiatric History & Mental Status Examination:

- Training on how to conduct **patient assessments, mental health evaluations, and treatment planning**.

2. Symptoms, Diagnosis & Treatment of Major Psychiatric Disorders:

- **Schizophrenia & Other Psychotic Conditions**
- **Mood Disorders** (Depression, Bipolar Disorders)
- **Anxiety Disorders** (Panic Disorder, Generalized Anxiety Disorder, PTSD)
- **Somatic Symptom Disorders & Psychological Factors Affecting Other Conditions**
- **Neurocognitive Disorders** (Delirium, Dementia)
- **Alcohol & Drug Use Disorders**
- **Epilepsy & Seizure Disorders**
- **Maternal Mental Health and Child & Adolescent Psychiatric Conditions**
- **Loss & Bereavement**
- **Psychiatric Emergencies** (Suicide, Agitation, Self-Harm)

3. Other Key Mental Health Issues:

- **Community Mental Health Nursing**
 - **Institutionalization and Deinstitutionalization**
 - **Mental Health Care in Disaster Relief**
 - **Stigma, Discrimination, Legal & Ethical Issues in Mental Health**
 - **Mental Health Promotion, Education, and Advocacy**
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Duties of Healthcare Professionals in Mental Health

The responsibilities of different healthcare professionals in mental health care are as follows:

A) General Physicians & Psychiatrists

- Conduct **mental health evaluations** and diagnose psychiatric conditions.
- Prescribe and manage **psychotropic medications**.
- Provide **direct counseling** or refer patients for psychotherapy.
- Develop **treatment plans** based on **mental status examinations**.

B) Nurses & Midwives

- Perform **mental health evaluations** and **child development assessments**.
- Administer prescribed **medications** and monitor side effects.
- Recognize signs of **mental illness** and refer to physicians.
- Educate patients and communities about **mental health awareness**.

C) Social Workers

- Offer **counseling services** to individuals, families, and groups.
- Conduct **community education** on **stigma and mental wellness**.
- Help individuals access **mental health evaluations and services**.
- Support communities in **organizing psychosocial activities**.

D) Community Mental Health Workers

- Identify and refer individuals in need of **mental health evaluations**.
- Provide **basic psychological support** to individuals and families.
- Educate the community about **mental health and early warning signs**.
- Organize **support groups and awareness campaigns**.

4) Guidelines for Teaching Mental Health to Primary Healthcare Staff

A) Establishing Learning Goals & Objectives

- Trainers must **set clear objectives** that align with the **daily responsibilities** of healthcare staff.
- Example: For physicians, training should focus on:

1. Taking psychiatric histories.
2. Recognizing symptoms of mental disorders.
3. Learning treatment methods for various psychiatric conditions.

B) Theoretical Training & On-the-Job Supervision

1) Lecture-Based Training

- Use **clear and interactive lectures** instead of passive presentations.
- Ensure content is **concise** and **directly relevant** to healthcare workers' roles.
- Training should include **case discussions and role-playing exercises**.

2) Practical Training (On-the-Job Supervision)

- Trainees work directly with patients under the supervision of a **mental health specialist**.
 - Supervisors ensure **practical application of theoretical knowledge**.
 - Patients should be informed that a **supervisor is present for training purposes**.
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5) Evaluating Mental Health Training Effectiveness

A) Evaluating Trainees

- Record details of **trainee education level, completed courses, and examination scores**.
- Track **repeated courses and practical training completion rates**.

B) Evaluating Trainers & Course Content

- Collect feedback from trainees about:
 - **Trainer communication skills and teaching effectiveness**.
 - **Course content relevance and clarity**.
 - **Quality of training materials and exams**.

C) Evaluating the Overall Training Program

- Track **enrollment, dropout rates, and course completion percentages**.
- Assess **clinical outcomes** by comparing patient conditions **before and after treatment** by trained staff.

- Conduct **community surveys** to measure the impact of trained healthcare workers.
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Key Takeaways

- ✓ Mental health services should be integrated into primary healthcare to increase accessibility.
- ✓ Telepsychiatry provides remote access to mental health professionals, particularly in rural and underserved areas.
- ✓ Training different types of healthcare professionals ensures a comprehensive and effective mental health system.
- ✓ Evaluating training programs helps improve mental health service delivery and patient outcomes.

PART II: MENTAL HEALTH CAPACITY BUILDING

Developing Collaborations in Mental Health Care

Understanding the Need for Collaboration

Throughout history, societies have developed various ways to **understand and manage human emotions and behavior**. Some cultures have formalized mental health care systems, while others use alternative approaches.

Collaboration in mental health care allows different **systems and approaches** to coexist, contributing **unique treatment methods** and improving **patient outcomes**. By working together, **more treatment options become available**, increasing the effectiveness of mental health services.

1) Methods for Developing Collaborations

Mental health professionals from different healthcare systems can collaborate in the following ways:

Ways to Collaborate:

- **Consultation Invitations:** Experts from different systems can invite one another for discussions and shared learning.
- **Cross-Referral System:**
 - Some conditions may be **better treated by one system** over another.

- **Example:** Stress, anxiety, bereavement, and conversion disorders may benefit from **traditional healing methods**, while **allopathic medicine** is more effective for **severe mental disorders and epilepsy**.
 - **Joint Assessments:** Mental health professionals can work together to evaluate patients from **different medical perspectives**.
 - **Joint Training Sessions:** Mental health practitioners can **train one another** to improve the **range of treatment options**.
 - **Joint Clinics:** Establishing **multi-disciplinary clinics** where professionals from different healthcare backgrounds work **side by side**.
 - **Shared Care Approach:**
 - Non-allopathic practitioners can **monitor psychotic patients** receiving long-term allopathic treatments.
 - They can also **provide support facilities** where patients can stay while undergoing psychiatric treatment.
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2) Benefits of Collaboration in Mental Health

Collaborating across healthcare systems has multiple advantages:

- **Greater Understanding:**
 - Helps professionals understand **how emotional distress and psychiatric illnesses are expressed in different cultural contexts**.
 - Provides a **comprehensive picture** of mental health challenges within a community.
- **Improved Referral System:**
 - Easier patient referrals between **traditional healers, community health workers, and medical doctors**.
- **Stronger Relationships with Community Healers:**
 - Many people seek **alternative healers** for emotional and mental health support.
 - Collaboration ensures these **healers are connected to modern mental health services**.
- **Better Cultural Integration:**

- Understanding **spiritual, psychological, and social beliefs** of a community improves acceptance of mental health services.
 - **Increased Acceptance of New Services:**
 - When different healing traditions work together, **community members are more likely to trust modern mental health treatments.**
 - **More Treatment Options for Patients:**
 - Combining **scientific psychiatric care with traditional mental health approaches** increases the number of available **treatment choices.**
 - **Culturally Appropriate Services:**
 - Mental health services that **align with cultural traditions** are **more likely to be effective.**
 - **Monitoring Human Rights Practices:**
 - Collaboration provides opportunities to **identify and eliminate harmful practices** in traditional healing systems.
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3) Steps to Take Before Establishing Collaborations

Before engaging in collaboration, **healthcare providers must understand:**

- **National policies** on traditional healers and non-allopathic practitioners.
 - Some governments **ban or discourage collaboration** with traditional healers.
 - Other governments **encourage collaboration**, offering **formal training, research, and regulation** of traditional medicine.
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4) Organizing Effective Collaborations

How to Assess Existing Mental Health Systems in a Community

Before initiating collaboration, mental health providers should assess **other care systems** within the community. This may be difficult for **outsiders**, so building **trust and respect** is essential.

Steps to Identify Existing Mental Health Systems:

1. **Engage with Community Members:**
 - Speak with **diverse groups** (men, women, elderly, youth, different ethnicities).

- Ask them **where they seek help for emotional and mental health issues.**
- 2. **Consult Primary Healthcare Providers:**
 - Ask local **doctors, nurses, midwives, and pharmacists** about **existing mental health services.**
- 3. **Interview Patients & Healthcare Users:**
 - Ask individuals in **health facilities** how they perceive their mental health issues.
 - Inquire about **other sources of help they have sought in the past.**
- 4. **Engage Religious Leaders:**
 - Ask if they provide **spiritual or mental health support.**
 - Identify **other community members offering healing services.**
- 5. **Organize Community Meetings:**
 - Work with local representatives to **arrange discussions with traditional healers.**
- 6. **Recognize Multiple Systems of Care:**
 - Different healing traditions **may coexist but not acknowledge** one another.
 - Some traditional practitioners may **compete for patients** or disagree on treatment methods.

5) Establishing Trust and Communication with Traditional Practitioners

To **successfully collaborate**, mental health professionals should:

- Build **ongoing relationships** with traditional healers.
- Organize **forums for discussion and knowledge exchange.**
- Encourage **joint training programs** involving different healing traditions.
- Address **practical issues** such as **referral systems and shared care models.**

Once a **trusting relationship** is developed, mental health practitioners can:

- Provide **cross-training** for traditional healers and community health workers.
- Introduce **modern psychiatric care** while **respecting traditional practices.**

- Establish **joint mental health services**, where possible.
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6) Caution: Identifying Harmful Traditional Practices

Not all traditional healing methods are **safe or beneficial**. Some involve **harmful practices**, including:

- **Beatings** as a form of "spiritual cleansing".
- **Prolonged fasting** as a means of healing.
- **Cutting or burning** the body to remove "bad spirits".
- **Physical restraint** of mentally ill individuals.
- **Expelling individuals accused of "witchcraft" from communities.**

Addressing Harmful Practices:

- Mental health providers should **assess traditional healing methods** before collaborating.
 - Determine whether the **practices are beneficial, neutral, or harmful**.
 - If practices are harmful, maintain a **respectful distance** rather than seeking collaboration.
 - Work **constructively to educate communities** about **safe and ethical mental health treatments**.
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Key Takeaways

- ✓ **Mental health collaboration improves service delivery** by combining **modern psychiatry with traditional healing methods**.
 - ✓ **Effective cross-referrals** allow patients to access **the best treatment available** for their condition.
 - ✓ **Cultural awareness and respect** are critical when integrating **different healing traditions** into mental healthcare.
 - ✓ **Identifying and addressing harmful traditional practices** is essential before collaboration.
 - ✓ **Building trust with community healers** and **establishing clear referral systems** enhances mental health outcomes.
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PART III: MENTAL HEALTH CONDITIONS & ISSUES

Identification and Interventions

Overview

The **allopathic (Western) medical system** is one approach to managing mental health conditions. It is based on **medical and behavioral sciences, formal psychotherapy, and structured care in hospitals, clinics, and community facilities**. This system is commonly used in **high-income societies**.

In contrast, **non-allopathic care** includes **traditional, indigenous, complementary, alternative, informal, and local medicine**. These systems may rely on **natural remedies, religious or spiritual interventions, and manual healing techniques**.

This section presents an **allopathic approach** to managing **various mental health conditions**, including **theoretical concepts, counseling strategies, and medication therapies**.

HOW TO IDENTIFY PSYCHOLOGICAL SYMPTOMS

Mental Health and Illness

A **healthy mind** is characterized by **clear thinking, problem-solving abilities, good relationships, emotional well-being, and the capacity to bring happiness to others** (V. Patel, 2002).

Mental illness is defined as any condition affecting **emotions, thoughts, or behavior** that is **inconsistent with cultural beliefs and personality and negatively impacts a person's life and social function**.

Symptoms of mental illness may include **persistent mood changes, distorted reality perception, and difficulties in organizing or maintaining thoughts**, which interfere with **personal beliefs, personality, and social function**.

THE PSYCHIATRIC HISTORY & MENTAL STATUS EXAMINATION (MSE)

Psychiatric History

Psychological distress and mental illness are influenced by a person's **past and present experiences**. A **psychiatric history** provides insight into **personal habits, activities, relationships, and medical conditions** that may contribute to mental health symptoms.

Elements of the Psychiatric History

- 1. Identifying Data:** Name, age, race, sex.

2. **Chief Complaint:** The patient's psychiatric concerns in their own words.
 3. **History of Present Illness:** Circumstances surrounding the onset of symptoms.
 4. **Previous Psychiatric History:** Past psychiatric symptoms, treatments, and hospitalizations.
 5. **Medical History:** Significant medical conditions, treatments, allergies, surgeries, history of head injuries, seizures, or neurological disorders.
 6. **Family Psychiatric History:** Family members with psychiatric conditions or hospitalizations.
 7. **Substance Use History:** Drug/alcohol use, length of use, treatment history.
 8. **Social History:** Place of birth, family background, marital status, education, employment history.
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Mental Status Examination (MSE)

The **MSE** is a structured evaluation of a person's **emotional state and cognitive function**. It categorizes **observations made during a psychiatric interview** based on **behavior, appearance, emotions, thought patterns, perception, judgment, and insight**.

Elements of the MSE

1. **General Appearance:** Physical presentation, grooming, posture.
2. **Motor Behavior:** Movements, agitation, tremors, anxiety.
3. **Speech:** Rate, volume, clarity (e.g., slow, rapid, loud, stuttering, slurred).
4. **Attitude:** Cooperative, irritable, angry, defensive, apathetic.
5. **Mood:** Emotional state (e.g., sad, happy, irritable, angry, elevated).
6. **Affect:** Facial expressions (e.g., flat, blunted, fluctuating, congruent/incongruent with mood).
7. **Thought Content:** Presence of **delusions, paranoia, suicidal/homicidal thoughts**.
8. **Thought Process:** Logical/illogical, repetitive, disorganized, tangential, slow, or racing thoughts.
9. **Perception:** Presence of **hallucinations (auditory, visual, tactile, olfactory)**.
10. **Judgment:** Ability to assess situations and make appropriate decisions.

11. Insight: Awareness and understanding of one's own condition.

12. Cognition:

- **Level of consciousness** (alert, confused, clouded).
 - **Orientation** (awareness of self, place, date, and time).
 - **Memory** (long-term, recent, and short-term recall).
 - **Attention** (ability to concentrate, e.g., Serial 7 Test – counting backward by 7s from 100).
 - **Executive Function** (reasoning and abstract thinking).
 - **Visual-Motor Coordination** (ability to draw figures and copy shapes).
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PSYCHOTIC CONDITIONS: SCHIZOPHRENIA & OTHER DISORDERS

Definition of Psychosis

Psychosis describes a **misinterpretation of reality** leading to **distorted perceptions, thoughts, and emotions**. It often results in **disruptions in relationships, work, and daily life**.

Schizophrenia

Schizophrenia is a **chronic psychiatric disorder** affecting **motivation, social function, emotional expression, and perception of reality**. The worldwide prevalence is estimated between **0.5% and 1%**. The exact cause is **unknown**, but genetic, biological, psychosocial, and infectious factors have been suggested.

Symptoms of Schizophrenia

- **Social withdrawal** (isolation, aggression).
- **Disorganized thinking** (incoherence, lapses in thought, fragmented speech).
- **Delusions** (fixed false beliefs).
- **Hallucinations** (most commonly auditory, less commonly visual, olfactory, or tactile).
- **Blunted or incongruent emotions** (lack of expression, inappropriate emotional responses).
- **Abnormal motor behavior** (e.g., catatonia).
- **Loss of motivation** (ambivalence toward activities).

- **Symptoms persist for at least 6 months** and are not due to medical or substance-related conditions.
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Other Psychotic Conditions

- **Delusional Disorder:** Persistent delusions without other psychotic symptoms.
 - **Schizophreniform Disorder:** Schizophrenia-like symptoms lasting **less than 6 months**.
 - **Schizoaffective Disorder:** Combination of **mood disorder symptoms** (e.g., depression, mania) and **psychotic symptoms**.
 - **Brief Psychotic Disorder:** Symptoms lasting **less than one month**.
 - **Postpartum Psychosis:** Psychotic symptoms occurring after childbirth.
 - **Substance-Induced Psychosis:** Caused by drugs, alcohol, or medical conditions.
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Counseling Interventions for Schizophrenia & Psychotic Disorders

1. **Create a structured daily schedule** to reduce stress and anxiety.
 2. **Encourage positive behaviors** through a **reward system**.
 3. **Identify stressors** and **develop coping strategies** to prevent relapse.
 4. **Promote medication adherence** and discuss treatment options.
 5. **Educate caregivers** about schizophrenia, potential relapses, and warning signs.
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MOOD-RELATED CONDITIONS: MAJOR DEPRESSION & BIPOLAR DISORDER

Major Depression

Depression is characterized by **a persistent decline in mood, loss of pleasure, and impairment in daily function**. It affects an estimated **350 million people worldwide**.

Symptoms of Depression

- **Persistent low mood and loss of interest in pleasurable activities.**
- **Changes in weight** (loss or gain).
- **Insomnia or excessive sleep.**
- **Fatigue and low energy.**

- **Feelings of worthlessness or guilt.**
- **Difficulty concentrating and making decisions.**
- **Suicidal thoughts or intentions.**
- **Symptoms must last for at least two weeks** and not be due to medical or substance-related causes.

Causes of Depression

- **Biological:** Neurotransmitter imbalances, immune system dysfunction, hormonal changes.
- **Genetic:** Family history of depression.
- **Psychosocial:** Environmental stressors, traumatic life events.

Treatment

- **Counseling & Psychotherapy:** Cognitive Behavioral Therapy (CBT), support groups.
- **Medication:** Antidepressants (SSRIs, SNRIs, MAOIs, tricyclic antidepressants).
- **PART III: MENTAL HEALTH CONDITIONS & ISSUES**
- **Mood-Related Conditions: Bipolar Disorder**
- **Bipolar Disorder Overview**
- Bipolar disorder is a **mood disorder characterized by alternating episodes of depression and abnormally elevated, expansive, or irritable moods.** Psychosis may be present in either phase. The **World Health Organization (WHO)** reports that **bipolar spectrum disorder (BPS) is prevalent worldwide**, although its severity and patterns of co-morbidity are similar across regions.
- ---
- **Types of Bipolar Disorder**
- **1) Bipolar I Disorder**
- **Causes:** Evidence suggests genetic, biological, and environmental factors contribute to the disorder.
- **Manic Phase Symptoms:**
 - Elevated or irritable mood
 - Excessive energy or agitation
 - Grandiosity (inflated self-esteem)

- Rapid thoughts and pressured speech
- Decreased need for sleep
- Impulsive, potentially harmful behavior
- **Depressive Phase Symptoms:**
- Symptoms resemble those of major depressive disorder, including persistent sadness, loss of interest, fatigue, and feelings of hopelessness.
- **Diagnosis:**
- Symptoms are identified through **Mental Status Examination (MSE)**.
- Medical tests (e.g., **toxicology screens, thyroid function tests, brain imaging**) are used to rule out other conditions.
- **2) Bipolar II Disorder**
- Characterized by at least **one major depressive episode and one hypomanic episode**.
- Unlike Bipolar I, hypomania does **not cause significant impairment** in social or occupational function.
- Psychosis may occur in some cases.
- **3) Substance/Medication-Induced Bipolar Disorder**
- Characterized by **persistent mood disturbances** triggered by substance or medication use.
- Symptoms cause significant distress or impairment but are **not associated with delirium**.
- _____
- **Counseling Interventions for Bipolar Disorder**
- **Educate the Family and Caregivers**
- Explain that mood fluctuations, agitation, and impulsivity are **common symptoms and not intentional**.
- Teach family members to recognize **early warning signs of relapse**.
- **Emphasize Medication Adherence**
- Discuss **pill organizers** and explore **once-a-day dosing** options with a doctor.
- Educate on **medication side effects** to improve adherence.

- **Reward Constructive Behavior**
- Encourage positive actions by **offering small rewards** when impulsive behaviors are controlled.
- **Encourage a Structured Daily Routine**
- Help create a **weekly schedule** to reduce stress and anxiety.
- Incorporate **self-care activities, social interactions, and relaxation techniques**.
- **Identify and Avoid Stress Triggers**
- Work on **problem-solving strategies** for stressful situations.
- Teach **breathing and relaxation exercises** to manage anxiety.
- **Ensure Regular Follow-Up Appointments**
- Missing appointments and medication doses increases **relapse risk**.
- **Medication Therapy**
- See the "**Medication Guide**" section of the manual for details.
- _____
- **Anxiety-Related Conditions, OCD, and PTSD**
- **Understanding Anxiety Disorders**
- Anxiety is a **state of heightened neurological arousal** that presents with **both physical and psychological symptoms**. It is a **normal response to stress**, but when prolonged, it can **disrupt normal function**.
- **Physical Symptoms of Anxiety**
 - Headache
 - Muscle tension
 - Trembling or "shakiness"
 - Fatigue
 - Shortness of breath
 - Rapid heartbeat (palpitations)
 - Sweating
- **Psychological Symptoms of Anxiety**

- Feeling of dread
 - Poor concentration
 - Impaired sleep
 - Reduced sexual desire
-

- **Types of Anxiety Disorders**

- **Generalized Anxiety Disorder (GAD)**
 - Persistent anxiety throughout the day for **at least one month**.
 - **Panic Disorder**
 - Sudden and overwhelming onset of anxiety symptoms.
 - **Agoraphobia**
 - Fear of **open spaces, enclosed spaces, crowds, or being alone outside**.
 - **Phobia**
 - **Irrational fears** of objects or situations that cause severe distress.
 - **Social Phobia (Social Anxiety Disorder)**
 - Intense fear of **social interactions or public situations**.
-

- **Obsessive-Compulsive Disorder (OCD)**

- OCD is characterized by:
 - **Obsessions:** Persistent and intrusive thoughts causing anxiety.
 - **Compulsions:** Repetitive behaviors aimed at reducing anxiety.
-

- **Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder**

- Anxiety occurs following a **traumatic event**.
 - Symptoms include **flashbacks, nightmares, hyperarousal, and avoidance behaviors**.
 - **PTSD** is diagnosed if symptoms persist **for more than one month**; otherwise, it is classified as **acute stress disorder**.
-

- **Counseling Strategies for Anxiety, OCD, and PTSD**
- **1) Breathing Exercise (for panic attacks and phobias)**
 - Breathe **slowly for 3 seconds**, hold, and exhale slowly for 3 seconds.
 - Repeat for **five minutes** twice daily.
- **2) Progressive Muscle Relaxation (for generalized anxiety)**
 - Tense and relax each muscle group **from head to toe** for **5–10 seconds each**.
- **3) Problem-Solving Strategy (for GAD and social anxiety)**
 - Identify **stressors**.
 - List **possible solutions**.
 - Evaluate pros and cons.
 - Select and implement the best solution.
- **4) Managing Negative Thinking (for OCD and anxiety)**
 - Identify **negative thoughts**.
 - Replace them with **realistic, positive alternatives**.
- **5) Gradual Exposure Therapy (for phobias)**
 - Slowly introduce the feared object or situation **in small steps**.
 - _____
- **Somatic Symptom Disorder and Psychological Factors in Medical Conditions**
- **Understanding Somatic Symptom Disorder**
 - Somatic symptom disorder occurs when a person **excessively focuses on physical symptoms** (e.g., pain, fatigue) in a way that significantly affects daily life.
- **Signs of Somatic Symptom Disorder**
 - Persistent worry about physical symptoms.
 - Exaggeration of symptoms despite medical reassurance.
 - Repeated visits to healthcare providers.
 - Symptoms **not explained by a medical condition**.
- **Counseling Interventions for Somatic Symptom Disorder**

- Acknowledge symptoms but avoid excessive medical tests or new medications.
- Encourage wellness over focusing on illness.
- Identify stressors that might contribute to symptoms.
- Suggest relaxation techniques for stress-related symptoms.
- Provide regular follow-ups with the same clinician.
- Exercise for Identifying Emotional Triggers
- List physical complaints and their severity.
- Identify what the person was doing when symptoms appeared.
- Note emotions linked to the physical symptoms.
- Discuss how to adjust activities to reduce distress.
- Example:
 - Physical Complaint: Headache
 - Severity: 8/10
 - Activity: Shopping at a crowded market
 - Emotion: Irritability
- Medication Therapy for Somatic Symptom Disorder
- Treat underlying depression and anxiety with antidepressants or anti-anxiety medication.
- See the "Medication Guide" for details.
- PART III: MENTAL HEALTH CONDITIONS & ISSUES
- Psychological Factors Affecting Other Medical Conditions
- Signs & Characteristics
 - Psychological factors can influence medical conditions by:
 - Precipitating or worsening symptoms (e.g., increased asthma symptoms after stress).
 - Exacerbating illness severity.
 - Altering disease progression.
 - These factors can include:

- **Depression and anxiety.**
- **Stressful life events.**
- **Maladaptive coping strategies or personality traits.**
- **Strained interpersonal relationships.**
- **Counseling Interventions & Medication Therapy**
- **Medical Symptom Stabilization** – Treat any underlying medical condition.
- **Medication for Co-existing Conditions** – Prescribe **antidepressants or anti-anxiety medication** for patients with depression or anxiety.
- **Counseling & Psychotherapy** – Help patients recognize and manage psychological stressors affecting their health.
-  See the "**Medication Guide**" section for detailed drug therapy recommendations.
- ---
- **Substance Use Disorders**
- **Key Definitions Related to Psychoactive Substances**
- **Intoxication** – A maladaptive behavior pattern following recent substance ingestion.
- **Withdrawal** – Negative physical and psychological symptoms occurring after stopping a drug.
- **Tolerance** – The need for higher doses of a substance to achieve the same effect.
- **Abuse or Misuse** – The use of a substance despite **legal, social, or occupational consequences**.
- **Dependence (Addiction)** – The compulsive use of a substance for pleasure or to avoid withdrawal symptoms.
- ---
- **Psychological vs. Physical Dependence**
- **Psychological Dependence**
- Continued substance use despite knowing its **harmful effects**.
- Difficulty in controlling drug consumption.
- Neglect of personal interests or social obligations.

- The need for increasing doses (**tolerance**).
 - Craving and compulsive drug-seeking behavior.
 - Mood disturbances if the drug is not used.
 - **Physical Dependence**
 - Withdrawal symptoms such as **headache, digestive distress, high blood pressure, sweating, tremors, and muscular pain**.
 - The body's **physiological reliance** on a substance.
-

- **Effects of Common Psychoactive Substances**

- **Alcohol**

- **Global Impact:**

- Alcohol is the **third leading cause of disease and disability worldwide** (after high blood pressure and smoking).
- Middle-income countries experience **the highest alcohol-related risks**.

- **Intoxication Symptoms:**

- Slurred speech, unstable walking, mood swings, aggression, anxiety, psychosis, sleep disturbances, and delirium.
 - **Withdrawal Symptoms** (appear within hours to days after stopping heavy use):
 - Nausea, headaches, **rapid eye movement (nystagmus)**, irregular heart rate or blood pressure, psychosis, anxiety, mood swings, seizures, and delirium.
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- **Cannabis**

- **Global Impact:**

- Cannabis is the **most widely used illicit drug globally** (annual prevalence: 2.6% to 5%).

- **Intoxication Symptoms:**

- **Mood alterations** (euphoria or depression), **anxiety, paranoia, hallucinations, red eyes, increased appetite, dry mouth, and increased heart rate**.
- **High doses** can cause **delirium, panic, or persistent psychosis**.
- **Long-term use** is linked to **anxiety, depression, and loss of motivation**.

- **Withdrawal Symptoms** (appear about **one week after stopping prolonged heavy use**):
- **Depression, irritability, anxiety, restlessness, sleep disturbances, poor appetite, and weight loss.**
- _____
- **Interventions for Substance Use Disorders**
- **1) Medical & Psychological Assessment**
- Refer for **medical evaluation and stabilization**.
- Screen for **underlying psychiatric conditions** (e.g., depression, anxiety, bipolar disorder).
- **2) Referral to Treatment**
- **Drug counseling programs or psychotherapy** for substance dependence.
- **3) Psychological Support & Counseling**
- **Address underlying mental health issues:**
- Some people use **drugs or alcohol to self-medicate** for anxiety, mood disorders, or psychotic symptoms.
- Treating **co-existing depression, anxiety, or mood disturbances** can reduce substance use.
- **Teach Breathing & Relaxation Techniques:**
- Techniques such as **deep breathing and progressive muscle relaxation** help manage cravings and anxiety.
- **Build a Support System:**
- Encourage individuals to **identify supportive friends or family members**.
- Having a **sober friend or sponsor** can help during moments of **craving or distress**.

PART III: MENTAL HEALTH CONDITIONS & ISSUES

Neurocognitive Disorders: Delirium & Dementia

Definition of Neurocognitive Disorders

Neurocognitive disorders involve a significant **decline from a previous level of cognitive function** in areas such as:

- **Awareness** (orientation, consciousness).
- **Complex attention** (sustained, selective, and divided attention).
- **Executive function** (planning, decision-making, mental flexibility).
- **Learning and memory.**
- **Language skills.**
- **Perceptual-motor coordination** (visual perception, movement integration).
- **Social cognition** (understanding emotions, recognizing others' mental states).

Types of neurocognitive disorders include:

1. **Delirium.**
2. **Major & Mild Neurocognitive Disorders (Dementia).**

1) Delirium

- Delirium is **characterized by a disturbance in attention** (difficulty focusing, shifting, or sustaining attention).
 - **Symptoms:** Memory loss, perception issues, **sudden onset**, fluctuating course, agitation, irritability, and psychosis.
 - **Causes:** Brain disease, systemic illnesses (e.g., heart disease), medications, toxins, and substance use.
 - **Diagnosis:** Mental status examination and, if resources allow, **blood tests, brain imaging (CT/MRI), urinalysis, EKG.**
-

2) Major/Mild Neurocognitive Disorder (Dementia)

- Dementia is distinguished from **delirium** by its **gradual onset, progressive course, and lack of fluctuation.**
- **Characteristics:**
 - **Pervasive cognitive decline** without a lack of awareness.
 - **Slow progression.**
 - **Irreversible deterioration** in memory, reasoning, and daily function.
 - **Agitation, irritability, depression, and possible psychosis.**
- **Causes:**

- **Alzheimer's disease, vascular disease, Lewy body disease, brain trauma, alcoholism, drug use, HIV/AIDS, tumors, and medication side effects.**
 - **Diagnosis:**
 - **Mental status exam & cognitive function tests.**
 - **Blood tests & brain imaging (MRI, CT scan) to determine causes.**
-

Interventions for Delirium & Dementia

A) Delirium

- **Adjust sensory stimulation:**
 - **Reduce noise and distractions** for agitated individuals.
 - **Increase sensory input** if the person is unresponsive or under-stimulated.
- **Ensure a safe environment:** Keep the person in a **hazard-free, supervised space**.

B) Major/Mild Neurocognitive Disorders (Dementia)

- **Improve orientation:** Use **calendars, clocks, labeled rooms, and familiar objects** to help with disorientation.
- **Encourage mental stimulation:** Activities such as **puzzles, storytelling, music, board games, and group interactions** help maintain cognitive abilities.
- **Support caregivers and family members:** Offer **education, support groups, and counseling**.

Aids for Daily Functioning

- **Memory aids:** Calendars, organizers, checklists, pill boxes, and alarms.
- **Physical aids:** Walking canes, wrist weights for balance.
- **Stimulation aids:** Exercise, arts & crafts, talking with social companions.

Medication Considerations

- **Caution with benzodiazepines and antipsychotics** (used only for severe agitation).
- **Antidepressants** may help **dementia-related depression**.
- **Antiretroviral therapy** may reverse HIV-related dementia.

Epilepsy

- Epilepsy is a **neurological disorder** affecting **50 million people worldwide** (80% in developing countries).
- Characterized by **recurrent seizures** caused by excessive electrical discharges in the brain.
- Seizures may be **partial (localized)** or **generalized (affecting the entire brain)**.

Types of Seizures

1) Partial (Focal) Seizures

- Originate in a **specific brain region** and remain localized.
 - **Simple Partial:** No loss of consciousness (e.g., muscle twitching).
 - **Complex Partial:** Altered consciousness, possible hallucinations or déjà vu sensations.
 - **Secondarily Generalized:** Starts in one region and spreads to the entire brain.

2) Generalized Seizures

- Originate in the **entire brain** at once.
 - **Absence Seizures (Petit Mal):** Brief staring episodes.
 - **Tonic-Clonic Seizures (Grand Mal):** Loss of consciousness, shaking, incontinence, confusion.
 - **Myoclonic Seizures:** Muscle jerks.
 - **Atonic Seizures:** Sudden loss of muscle tone, causing falls.

Psychiatric Manifestations

- Mood instability, **changes in personality** (common in **temporal lobe epilepsy**).

Counseling & Treatment for Epilepsy

1. **Educate caregivers** on how to handle seizures safely.
 2. **Identify triggers** (stress, flashing lights, irregular sleep).
 3. **Promote medication adherence** (use reminders like pill organizers).
 4. **Teach relaxation techniques** (deep breathing, meditation).
-

Sleep Disturbances

Signs & Characteristics

- **Insomnia** (difficulty sleeping) is one of the most common psychiatric symptoms.
- Can be **primary (no underlying cause)** or **secondary (due to medical or psychiatric conditions, medications, drugs, or stress)**.

Counseling Interventions for Sleep Issues

Sleep Hygiene Guidelines

1. **Set a fixed bedtime and wake-up time**, even on weekends.
2. **Avoid naps** during the day.
3. **Exercise daily** but not right before bedtime.
4. **Create a comfortable sleep environment** (cool, dark, and quiet room).
5. **Limit caffeine, alcohol, and nicotine**, especially in the evening.
6. **Address underlying medical or psychological issues** contributing to sleep problems.

PART III: MENTAL HEALTH CONDITIONS & ISSUES

Loss & Bereavement

Signs & Characteristics

Grief refers to the emotional response to the loss of a **loved person, place, or object**.

Examples include:

- Loss of a **home**.
- Loss of **health** (e.g., chronic illness, amputation).
- Loss of **culture/country** (e.g., refugees).

Kubler-Ross' Five Stages of Grief:

1. **Denial** – Inability to accept the loss, feeling of **shock, numbness, disbelief**.
2. **Anger** – Blaming others or oneself, **hostility, frustration**.
3. **Bargaining** – Attempting to regain the lost entity, **guilt, self-blame**.
4. **Depression** – Realization of loss leading to **sadness, isolation, fatigue, sleep/appetite disturbances**.
5. **Acceptance** – Coming to terms with the loss and **moving forward**.

 **Grief does not follow a strict order;** stages may **overlap or repeat**.

Factors Influencing Grief Response

1. **Age & Emotional Maturity.**
 2. **Personality Traits** (resilience, patience, adaptability).
 3. **Belief Systems** (spiritual perspectives on loss, death, and afterlife).
 4. **Defense Mechanisms** (e.g., humor, humanitarian actions).
 5. **Expectations of Recovery.**
 6. **Support System** (family, friends, healthcare workers).
-

Counseling Interventions

 **People grieve differently.** Those with prolonged distress should be evaluated for **depression or anxiety disorders**.

1. Allow the person to **express grief in their own way**.
 2. **Culturally appropriate mourning rituals** should be encouraged.
 3. **Normalize grief**—Reassure that sadness, anger, or withdrawal is a **natural** reaction.
 4. **Encourage reminiscence**—Using photos, memories, and storytelling.
 5. **Reassure that pain decreases with time.**
 6. Promote **physical well-being** (adequate sleep, nutrition, exercise).
 7. Prepare for **grief triggers** (birthdays, anniversaries, holidays).
 8. **Avoid major life decisions** immediately after loss.
 9. **Encourage new relationships & activities** when the individual is ready.
-

Loss & Bereavement in Children

Children's Understanding of Death by Age

Ages 0–5

- Do not understand death's **finality**.
- Engage in "**magical thinking**" (e.g., believing they caused the death).

- **Reactions:** Confusion, detachment, increased dependence.

Ages 5–10

- Understand that **death is permanent** but may not apply it to themselves.
- May show **curiosity** about death's causes.
- **Common reactions:** Seeking **connection with deceased**, guilt, fear.

Ages 10–Adolescence

- Recognize **death is universal and inevitable**.
- Experience conflicts such as **justice vs. injustice, independence vs. attachment**.
- **Common reactions:**
 - Shock & disbelief.
 - Anxiety, sadness, isolation.
 - Acting out (anger, aggression).
 - Sleep disturbances, school issues.
 - Personality changes, pessimism about the future.

Guidelines for Managing Loss in Children

1. **Be honest**—Avoid misleading terms like “asleep” or “gone away.”
2. **Correct magical thinking**—Children may blame themselves for the death.
3. **Create a safe space for emotional expression**—Allow open conversations.
4. **Provide consistency**—Children need **stable caregivers** and routines.
5. **Avoid abrupt changes**—Familiar environments and caregivers **reduce stress**.
6. **Encourage healthy remembrance**—Photos, storytelling, rituals.

Loss & Bereavement in Disasters & Catastrophes

A **disaster** (natural or human-caused) can lead to:

- **Sudden, overwhelming loss** (lives, homes, security).
- **Severe emotional distress** in survivors.

- **Long-term psychological trauma.**

Psychosocial Interventions in Disaster Settings

The **Inter-Agency Standing Committee (IASC)** has created guidelines to:

1. **Provide immediate crisis support** (food, shelter, safety).
 2. **Address psychological trauma** through counseling.
 3. **Help survivors rebuild social support networks.**
 4. **Prevent mental health conditions** (PTSD, depression, anxiety).
-

Maternal Mental Health

Prevalence & Risk Factors

- **Depression & anxiety** are **twice as common in women** as in men.
- **Highest risk occurs during pregnancy and the first postpartum year.**
- **Suicide** is a leading cause of maternal death in developed countries.

Risk Factors for Maternal Mental Disorders

1. **Poverty & extreme stress.**
 2. **Domestic/gender-based violence.**
 3. **Lack of social support.**
 4. **Migration, natural disasters, or conflict situations.**
-

Pregnancy & Mental Health

Most women adjust well, but some experience **significant distress**.

Potential Effects of Poor Maternal Mental Health

- **Poor prenatal care** (due to lack of motivation, fear, or financial barriers).
- **Increased risk of pre-eclampsia, premature birth, or low birth weight.**
- **Substance use (alcohol, tobacco, drugs)** as a coping mechanism.
- **Higher risk of postpartum depression or anxiety.**

Medication is used with caution during pregnancy—treatment should prioritize **counseling and social support**.

Postpartum Mental Health Conditions

1) Postpartum Sadness ("Baby Blues")

- **Common**, affecting **50–80% of new mothers**.
- Symptoms: **Irritability, tearfulness, anxiety, mood swings** (1–10 days postpartum).
- **Management:** Support, reassurance, and education—symptoms **resolve naturally**.

2) Postpartum Depression (PPD)

- **Symptoms:**
 - **Persistent sadness, fatigue, sleep/appetite disturbance.**
 - **Loss of interest in baby, feelings of guilt or worthlessness.**
 - **Suicidal thoughts (in severe cases).**
- **Management:**
 - **Support system** (family, friends, community).
 - **Counseling & psychotherapy.**
 - **Antidepressants (for severe cases, with caution if breastfeeding).**

3) Postpartum Psychosis

- **Rare but severe.**
- **Symptoms:**
 - **Delusions or hallucinations** (e.g., belief that the baby is evil or in danger).
 - **Severe confusion, disorganized behavior.**
 - **Risk of harming self or baby.**
- **Management:**
 - **Immediate hospitalization & psychiatric care.**
 - **Antipsychotic medications (if severe and persistent)**

PART III: MENTAL HEALTH ISSUES IN CHILDREN

1. Neurodevelopmental Disorders

Neurodevelopmental disorders emerge **early in a child's development** and may impact:

- **Cognitive abilities** (intelligence, problem-solving).
- **Social skills** (communication, interaction).
- **Learning abilities** (academic performance).
- **Executive function** (planning, organization).

The **DSM-5** classifies these disorders into:

- **Intellectual disabilities.**
- **Communication disorders.**
- **Autism Spectrum Disorder (ASD).**
- **Attention-Deficit/Hyperactivity Disorder (ADHD).**
- **Specific learning disorders.**
- **Motor disorders (e.g., Tourette's Syndrome).**

A) Intellectual Disability (Intellectual Developmental Disorder)

- Intellectual disability is characterized by **significantly impaired intellectual and adaptive functioning**.
- The **global prevalence is about 2% of the population**.
- **Causes** include:
 - **Prenatal:** Genetic disorders (Down syndrome), metabolic disorders, infections, toxic exposures.
 - **Perinatal & Postnatal:** Birth complications, oxygen deprivation, traumatic brain injury, infections, extreme social deprivation.

Treatment includes:

- **Early behavioral interventions.**
- **Special education programs.**
- **Adaptive skills training.**
- **Support services to improve independence.**

B) Autism Spectrum Disorder (ASD)

- ASD is characterized by **deficits in social communication** and **repetitive behaviors or restricted interests**.
- **Prevalence:** ~1% globally.
- **Risk Factors:**
 - Advanced parental age.
 - Low birth weight/prematurity.
 - Genetic mutations (heritability estimates: 37–90%).
- **Diagnosis:**
 - **Deficits in social interactions.**
 - **Repetitive behaviors and restricted interests.**
 - **Symptoms start early and impair daily life.**

Treatment:

- **Early intervention services.**
- **Applied Behavioral Analysis (ABA).**

General Guidelines for Managing Intellectual Disability & ASD

1. **Evaluate psychiatric history** (developmental history is key).
2. **Educate families** about strengths and challenges.
3. **Seek specialist evaluation** (if available).
4. **Provide structured routines** to reduce anxiety.
5. **Encourage participation in daily activities** (hygiene, chores).
6. **Support socialization** through structured interactions.
7. **Identify & address comorbid conditions** (e.g., epilepsy, hyperactivity, depression).

C) Attention Deficit/Hyperactivity Disorder (ADHD)

- ADHD is a **persistent pattern of inattention, hyperactivity, or impulsivity** affecting daily function.

- **Prevalence:** ~5% in children, 2.5% in adults.
- **Risk Factors:**
 - **Hereditary** (strong genetic link).
 - **Environmental:** Low birth weight, premature birth, prenatal exposure to smoking/alcohol, brain injury.

Symptoms of ADHD

- **Inattention:**
 - Fails to pay attention to details.
 - Easily distracted.
 - Forgetful, disorganized.
 - Avoids tasks requiring focus.
- **Hyperactivity/Impulsivity:**
 - Fidgeting, difficulty staying seated.
 - Running/climbing in inappropriate settings.
 - Talking excessively, interrupting others.

ADHD Management

1. **Avoid physical punishment** – Positive reinforcement works better.
 2. **Provide structured daily routines.**
 3. **Educate families** about ADHD – Encourage patience while setting firm boundaries.
 4. **Use behavior management strategies** – One task at a time, consistent praise.
 5. **Consider stimulant medications** (e.g., methylphenidate) only if behavioral strategies fail.
-

D) Tourette's Disorder

- **Characterized by multiple motor and vocal tics** lasting over a year.
- **Prevalence:** 1–30 per 1,000 persons worldwide.
- **Causes:**
 - **Genetic factors** (heritability, identified genes).

- **Risk factors:** Birth complications, older paternal age, low birth weight, maternal smoking/alcohol use.

Symptoms

- **Motor tics:** Eye blinking, head jerking, facial grimacing.
- **Vocal tics:** Repetitive throat clearing, grunting, or shouting.

Management

- **Behavioral therapy** for symptom management.
 - **Medication** for severe tics interfering with daily life.
 - **No treatment necessary** for mild cases with no impairment.
-

2. Emotional & Behavioral Problems

A) Depression & Anxiety in Children

- Children express depression **differently from adults.**
- **Signs of childhood depression/anxiety:**
 - Sadness, anger, or agitation.
 - Social withdrawal.
 - Sleep disturbances.
 - School performance decline.

Management

- **Provide emotional support** – Allow children to express feelings.
 - **Educate families** about children's emotions.
 - **Encourage healthy coping strategies.**
 - **Avoid antidepressants in children unless prescribed by a specialist.**
-

B) Elimination Disorders

1) Enuresis (Bed-Wetting)

- Defined as **lack of bladder control past age 5** (without a medical cause).
- **Causes:** Delayed bladder control, psychological stress.

- **Management:**
 - **Medical evaluation** to rule out physical conditions.
 - **Behavioral interventions:** Limit evening fluids, toilet routine.
 - **Address psychological factors** (e.g., nightmares, school stress).
-

Structuring a Child's Day for ADHD & Other Behavioral Issues

1. **Set a Daily Routine**
 - Fixed times for **waking, meals, school, play, bedtime**.
 - Homework & playtime included.
2. **Stay Organized**
 - **Designated places** for school supplies, clothing, and toys.
 - **Use planners & notebooks** for schoolwork.
3. **Consistent Rules**
 - **Clear, simple, and fair** rules.
 - **Praise good behavior** (children with ADHD receive frequent criticism).

PART III: MENTAL HEALTH ISSUES IN CHILDREN

Helpful Techniques for Enuresis (Bedwetting)

1. **Avoid bedtime fluid intake.**
2. **Reduce diuretic foods/drinks** (those that stimulate urination).
3. **Train bladder muscles:**
 - Instruct the child to **start urinating, then stop** for 5 seconds before continuing.
 - Repeating this technique strengthens bladder control.
4. **Ensure the child empties the bladder before sleep.**
5. **Encourage self-esteem and self-worth:**
 - Have the child **help wash wet sheets/clothes** (if old enough).
 - This **reduces guilt** and makes them feel more in control.
6. **Use a bed-wetting progress chart:**

- **Mark dry days with a check (✓) and wet days with an (X).**
 - Encourage the child to **color dry days green and wet days red.**
 - Offer **small rewards** when improvements occur (e.g., fewer wet nights than the previous week).
7. **If no improvement after one month**, reconsider potential causes and consult a doctor.
-

Conduct Disorder in Children

Definition: A persistent pattern of behavior involving:

- **Aggression** toward people or animals.
- **Destruction of property.**
- **Deceitfulness or theft.**
- **Violations of established rules or social norms.**

Risk Factors:

- **Difficult infant temperament.**
- **Lower-than-average intelligence.**
- **Family instability.**
- **History of violence, abuse, or parental substance abuse.**

Management:

1. **Assess the child's environment** (family, school, and peer influences).
 2. **Teach emotional regulation** (help the child express emotions in a constructive way).
 3. **Address substance abuse** (if present in the child or household).
 4. **Report safety threats** to the proper authorities.
-

ADOLESCENT PSYCHOSOCIAL ISSUES

Substance Abuse in Adolescents

Risk Factors:

- **Gender (higher in males).**

- **Mental health disorders.**
- **Low self-esteem.**
- **Family dysfunction.**
- **Peer pressure and social environment.**

Protective Factors:

- **Supportive family.**
- **High self-esteem.**
- **Educational and occupational opportunities.**

Intervention:

1. **Assess mental and medical health.**
 2. **Provide accurate information** about substance risks.
 3. **Refer to counseling services.**
-

Youth Violence & Risk Factors

1. Individual Factors:

- Gender (higher in males).
- Gang involvement.
- Exposure to violence.
- Drug use.

2. Community Factors:

- Social & economic inequality.
- Poor neighborhood conditions.

3. Intervention Strategies:

- **Life skills education** for children.
 - **Stricter policies on alcohol/drug availability.**
 - **Reducing access to weapons.**
 - **Protecting vulnerable youth** (especially adolescent girls).
-

Unsafe Sexual Behavior

Contributing Factors:

- **Lack of knowledge about safe sex practices.**
- **Peer pressure.**
- **Limited access to condoms/contraceptives.**
- **Cultural and societal norms.**

Interventions:

1. **Educate adolescents** on reproductive health and safe sex.
 2. **Improve access to contraceptives.**
 3. **Encourage parental and school involvement in awareness programs.**
-

CRISIS SITUATIONS

1. Agitation & Aggressive Behavior

Potential Causes:

- **Uncontrolled psychiatric conditions** (e.g., psychosis, mania).
- **Medical conditions affecting the brain** (e.g., infections, metabolic disorders).
- **Drug/alcohol intoxication or withdrawal.**
- **Medication overdose/toxicity.**

Intervention:

1. **Alert healthcare staff or authorities.**
 2. **Ensure safety** by removing hazardous objects.
 3. **Remain calm and avoid physical confrontation.**
 4. **Use a soft tone, reassure, and minimize sudden movements.**
 5. **Seek medical or psychiatric intervention immediately.**
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2. Suicide Risk & Intervention

Risk Factors:

- **Young age (15-24 years) or elderly.**

- **Male gender.**
- **Prolonged suicidal thinking.**
- **Previous suicide attempts.**

Questions to Assess Suicide Risk:

- **Do you feel very sad or hopeless?**
- **Have you thought about ending your life?**
- **Do you have a specific plan?**

High-Risk Suicide Intervention

- **Never leave the person alone.**
 - **Remove access to harmful objects** (pills, weapons, poison).
 - **Seek emergency medical help immediately.**
 - **Involve family and close support systems.**
 - **Arrange follow-up mental health care.**
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DISASTER/EMERGENCY MENTAL HEALTH CARE

Phases of Disaster Mental Health Response

1. **Emergency Phase**
 - Address **basic needs first** (food, shelter, safety).
 - **Psychological first aid** (calm survivors, reduce distress).
 - Provide medical and psychiatric treatment for **severe cases** (suicidal individuals, psychosis, severe depression).
 2. **Post-Emergency Phase**
 - **Long-term emotional support.**
 - **Community rebuilding.**
 - **Social reintegration programs** for trauma survivors.
-

Elements of Psychological First Aid

- **Listen actively** and allow survivors to express feelings.

- **Provide reassurance** and reduce feelings of isolation.
- **Assess & address basic needs** (shelter, food, safety).
- **Encourage healthy coping strategies** (avoid alcohol, drugs).
- **Refer to professional support if symptoms persist.**

PART III: CRISIS SITUATIONS & GENDER-BASED VIOLENCE

Post-Emergency or Reconsolidation Phase

Once basic needs have been **restored to pre-emergency levels** or a **stable condition**, interventions continue:

- **Social outreach and education** efforts increase.
 - **Psychological and psychiatric care** is further integrated into **primary healthcare services**.
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GENDER-BASED VIOLENCE (GBV) IN INSECURE SETTINGS

Overview

GBV is often linked to **humanitarian crises**, including:

- **War and displacement.**
- **Natural disasters.**
- **Collapsed societal structures.**

Underreporting of GBV

Survivors often do not report GBV due to:

- **Fear of retaliation.**
- **Self-blame and stigma.**
- **Lack of trust in authorities.**

While **both men and women** may experience GBV, studies show **women and girls are the most frequent victims**.

Types & Causes of GBV in Crisis Settings

Common Forms of GBV

1. **Domestic violence.**
2. **Forced or early marriage.**
3. **Harmful traditional practices** (e.g., female genital mutilation, honor killings).
4. **Human trafficking.**
5. **Sexual violence** (e.g., rape, sexual assault, verbal sexual harassment).

Common Perpetrators in Crisis Situations

- **Fellow displaced persons** (e.g., in refugee camps).
- **Relief workers.**
- **Military personnel.**
- **Family members.**

Contributing Factors to GBV in Crisis Situations

A) Displacement & social collapse:

- Loss of **family and community protection** makes women and children vulnerable.

B) Violence as a weapon in conflict:

- Sexual violence is used to **terrorize and control** communities.

C) Resentment toward refugees:

- Local populations may **attack refugees** who receive aid.

D) Unequal access to resources:

- Women may be denied access to food, shelter, and security.

E) Survival-based exploitation:

- Women may **exchange sex for food, water, and shelter.**

Effects of GBV

Medical Effects

- **Sexually transmitted infections** (STIs) including HIV.
- **Reproductive tract injuries.**
- **Unwanted pregnancies and unsafe abortions.**

- **Chronic pelvic infections.**

Psychological Effects

- **Depression, PTSD, and suicidal thoughts.**
- **Fear, guilt, and self-blame.**
- **Loss of self-esteem and confidence.**

Social & Economic Effects

- **Survivors may be rejected by family/community.**
 - **Economic dependency and homelessness.**
 - **Loss of children or property** due to stigma.
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INTERVENTIONS FOR GBV INCIDENTS

1) Protection & Confidentiality

- **Keep information private** to avoid stigma and retaliation.
- **Provide a safe space** for survivors to share their experiences.
- **Allow family/friends to accompany the survivor** (if desired).
- **Contact authorities** (only if survivor agrees).

2) Medical Care for Sexual Assault Survivors

- **Immediate medical attention** is crucial.
- **Collect forensic evidence** if laws permit.
- **Perform pregnancy, STI, and HIV tests.**
- **Offer treatments, including emergency contraception and PEP (post-exposure prophylaxis).**

3) Psychological & Emotional Support

Counseling Goals:

- **Reduce self-blame** (remind survivor they are not responsible).
- **Empower survivors** to regain a sense of control.
- **Help them build a safety plan** to prevent further abuse.
- **Encourage healthy coping strategies** (avoid alcohol or drugs).

4) Community Support

- **Train community members as support workers.**
 - **Create safe spaces and women's support groups.**
 - **Ensure survivors and children are not stigmatized.**
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SPECIAL CASES IN GBV RESPONSE

1) Domestic Violence in Crisis Settings

- **Survivors of spousal or family violence** may face **retaliation**.
- **Healthcare providers must assess risk** and provide **discreet safety options**.

2) Children Born from Rape

- **Risk of abuse and abandonment** is high.
 - **Monitor children's well-being** and ensure social acceptance.
 - **Consider foster placement or adoption if necessary.**
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HIV/AIDS & MENTAL HEALTH

Global Summary of HIV/AIDS

Key Statistics (2010 Data)

- **34 million people living with HIV worldwide.**
 - **2.7 million new infections annually.**
 - **1.8 million AIDS-related deaths** (declining from 2.2 million in 2005).
 - **Sub-Saharan Africa remains most affected.**
 - **HIV-related deaths rising in Eastern Europe, the Middle East, and Central Asia.**
 - **350,000+ children have avoided HIV due to antiretroviral prevention.**
-

HIV/AIDS & Mental Health

HIV impacts:

1. **Physical health** (immune deficiency, neurological problems).

2. **Emotional well-being** (fear, depression, anger).
3. **Social stability** (stigma, loss of income, family breakdown).

Mental Health Interventions

- **Support groups and counseling** for coping with stigma and emotional distress.
 - **HIV education and prevention counseling** to prevent transmission.
 - **Adherence counseling** to ensure patients take their medication consistently.
-

PART III: HIV/AIDS & MENTAL HEALTH

Community Psychosocial Development

Examples of Psychosocial Activities for Community Development

Communities affected by social stressors (e.g., war, poverty, natural disasters) benefit from activities that foster social bonding and mental well-being. These include:

1. **Recreational Activities** – Sports, games, and hobbies.
 2. **Cultural Events** – Music concerts, artistic performances, art exhibits.
 3. **Educational Projects** – Lectures, mobile libraries, school competitions.
 4. **Work-Related Projects** – Job training seminars, business development programs.
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MEDICATION GUIDE

General Prescribing Principles

1. Ensure clarity on the **psychiatric diagnosis** and target symptoms.
2. Be aware of **underlying medical conditions** and possible **drug interactions**.
3. Monitor **side effects** and potential for dependence.
4. Advise patients to **avoid self-medication** or combining drugs without medical advice.
5. Follow **full medication trials** before discontinuing due to inefficacy.
6. **Simplify regimens** to encourage adherence.
7. **Avoid polypharmacy** (unnecessary multiple medications).

8. Adjust doses for **special populations** (children, elderly, malnourished individuals).
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Essential Psychotropic Medications (WHO Model List, 2011)

1. Medications for Psychotic Conditions

- **Chlorpromazine**
- **Fluphenazine (Decanoate/Enantate)**
- **Haloperidol**

2. Medications for Depression

- **Amitriptyline**
- **Fluoxetine**

3. Medications for Bipolar Disorder

- **Carbamazepine**
- **Lithium Carbonate**
- **Valproic Acid**

4. Medications for Generalized Anxiety & Insomnia

- **Diazepam**

5. Medications for Obsessive-Compulsive Disorder (OCD)

- **Clomipramine**

6. Medications for Substance Dependence

- **Methadone**
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Medication Therapy for Schizophrenia & Psychotic Conditions

Chlorpromazine

- **Dosing:** 10mg tid-qid, increasing to **200-600mg daily**.
- **Side Effects:** Sedation, constipation, urinary retention, dizziness, tardive dyskinesia.
- **Comment:** Low risk of EPS; may be used for agitation.

Fluphenazine

- **Dosing:** 2.5mg-10mg/day (oral); 12.5mg-25mg IM every 2-4 weeks.
- **Side Effects:** Sedation, EPS, tardive dyskinesia.
- **Comment:** High EPS risk; for chronic psychosis patients with poor adherence to oral meds.

Haloperidol

- **Dosing:** 0.5mg-5mg bid-tid (oral); 5mg q30-60 min (IM for acute agitation).
 - **Side Effects:** Sedation, EPS, tardive dyskinesia.
 - **Comment:** High EPS risk; used for **acute psychosis or severe agitation**.
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Medication Therapy for Depression

Amitriptyline (Tricyclic Antidepressant - TCA)

- **Dosing:** 50-150mg/day (max: **300mg/day**).
- **Side Effects:** Sedation, constipation, urinary retention, arrhythmia.
- **Comment:** Requires **therapeutic blood monitoring**.

Fluoxetine (SSRI)

- **Dosing:** 20mg/day; may increase in **20mg increments** to a **max of 80mg/day**.
 - **Side Effects:** Insomnia, agitation.
 - **Comment:** Useful for **depression with low energy**.
-

Medication Therapy for Bipolar Disorder

Lithium Carbonate

- **Dosing:** **600mg tid** for acute mania, maintenance: **300mg tid-qid**.
- **Side Effects:** Tremors, excessive thirst, weight gain.
- **Comment:** Requires **serum monitoring** (1-1.5 mEq/L).

Carbamazepine

- **Dosing:** 400mg/day, max: **1600mg/day**.
- **Side Effects:** Dizziness, ataxia, liver issues, anemia.
- **Comment:** Requires **blood monitoring**.

Valproic Acid

- **Dosing:** 750mg/day, max: **60mg/kg/day**.
 - **Side Effects:** Tremors, liver toxicity, GI distress.
 - **Comment:** Effective for **manic phases of bipolar disorder**.
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Medication Therapy for Anxiety Disorders, PTSD, & OCD

Clomipramine (OCD Treatment - TCA)

- **Dosing:** 25mg/day, max: **250mg/day**.
- **Side Effects:** Dry mouth, constipation, dizziness, weight gain.
- **Comment:** No risk of addiction.

Diazepam (Anxiety & Insomnia - Benzodiazepine)

- **Dosing:** 2-10mg bid-tid.
 - **Side Effects:** Sedation, dizziness, risk of dependence.
 - **Comment:** Use for **short-term relief** only due to addiction potential.
-

Managing Extra-Pyramidal Symptoms (EPS) Caused by Antipsychotics

1. Amantadine

- **Dosing:** 100mg bid, max: **300mg/day**.
- **Side Effects:** Insomnia, hallucinations, depression.

2. Benztropine

- **Dosing:** 1-2mg bid-tid.
- **Side Effects:** Dry mouth, constipation, delirium.

3. Diphenhydramine

- **Dosing:** 25-100mg/day.
 - **Side Effects:** Sedation, dry mouth.
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Special Notes for Prescribers

1. EPS (Extra-Pyramidal Symptoms)

- Risk is **higher with high-potency antipsychotics** (e.g., Haloperidol).
- Symptoms include tremors, restlessness, muscle stiffness.
- **Manage with anticholinergics** (e.g., **Benztropine**).

2. Tardive Dyskinesia (TD)

- Involuntary, repetitive movements.
- **Irreversible; stop antipsychotic immediately.**

3. Neuroleptic Malignant Syndrome (NMS)

- Symptoms: Muscle rigidity, fever, unstable blood pressure.
- **Medical emergency—stop medication & seek urgent care.**

4. Metabolic Syndrome Risk

- Common with **Atypical Antipsychotics** (e.g., Risperidone, Olanzapine).
- Monitor **glucose, lipids, and body weight.**

This structured format ensures **clarity and accessibility** of information while maintaining **accuracy and completeness**.