

5 Specific treatments for mental health problems

Section I: Medications[†]



5.1 When should I use medications?

Medications are essential for some mental health problems, but they are no use for others.

First, the health worker must decide whether or not to use a medication. As a principle, only use a medication when indicated for a specific type of mental disorder. Do not use a medication only because the person expects it. If a person expects medication, it is often because they are used to getting medications every time they consult the health worker. They may believe that the only way to help a sickness is with pills and injections. They may not be aware of the important roles of counselling, lifestyle changes and emotional support. If you do not take this chance to educate them and, instead, use unnecessary medications, the person's problem may take much longer to improve. In the long run, the person may come to see you more often and for much longer and take up more of your time.

On the other hand, there are some situations where people with mental health problems are very reluctant to take medications at all! This can happen when:

- the person is not adequately informed about the nature of their problem or why they should take the medication
- the person, and even the health worker, is afraid that medications for mental health problems are too dangerous
- the person prefers a counselling treatment
- the person experiences unpleasant side-effects of medications
- the person is too ill to make a decision.

Nowadays, there are different types of medications available for different mental health problems. Whenever you prescribe medications, there are some general rules which you should follow (Box 5.1). If these general rules are followed properly, then medications for mental health problems are as safe as any other medications. Do not make the error of avoiding medications when there is clear evidence that the person suffers from a mental health problem which will benefit from medications.

As a rule of thumb, the following mental health problems will benefit from medications:

- severe mental disorders such as psychosis, bipolar disorder and epilepsy
- common mental disorders that have lasted more than 2 weeks and are seriously affecting the person's day-to-day life or are associated with suicidal ideation or behaviour (⇨ 1.4.1)
- severe alcohol or drug use disorders, in particular when a person has a physical dependence
- some forms of child mental disorder, specifically attention-deficit hyperactivity disorder (ADHD) (⇨ 11.4).

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5.2 Which medication should I use?

The next step is deciding which medication to use. The major groups of medications for mental health problems that can be prescribed by general health workers are:

- **antipsychotic medications** (to treat psychosis, manage severe behavioural disturbance and control bipolar disorder)
- **antidepressant medications** (to treat moderate to severe depression or anxiety disorders)
- **mood stabilisers** (to control bipolar disorder)
- **antiepileptic medications** (to control epilepsy)
- **benzodiazepines** (as emergency sedation for someone who is agitated, for short-term management of anxiety disorders or sleep problems, to manage alcohol withdrawal, and in the emergency management of seizures)
- other medications used in mental health care in general health settings, including **sedating antihistamines** for sleep problems and

anticholinergic medications for managing side-effects of antipsychotics.

Boxes 5.2 to 5.8 contain the general guidelines on which medications to use for specific types of mental disorders. The availability of specific medications varies across countries, as does their cost. For that reason we have included a wide range of medications used for mental disorders (and given their generic names), but distinguished between those that are:

1. recommended by the World Health Organization in the Mental Health Gap Action Programme (mhGAP) *Intervention Guide* (**bold**);
2. other medications which may be more costly but can be prescribed by general health workers (no emphasis);
3. medications requiring specialist oversight (*italics*);
4. recommended in mhGAP and requiring specialist oversight (**bold italics**).

☞ Chapter 14 for dosages and side-effects.

BOX 5.1 GOOD PRACTICES IN USING MEDICATIONS FOR MENTAL HEALTH PROBLEMS

- Knowing the diagnosis can help make the choice of treatment much more accurate.
- Depending on the type of symptoms or diagnosis, and the severity of the mental health problem, decide whether medication is required.
- Medications for the same mental disorder differ in their side-effects; choose a medication which the patient is most likely to tolerate.
- Be aware that the safety of a medication may be different if a person is pregnant or breastfeeding, is a child or adolescent or above the age of 60, or has a medical condition.
- Explain to the person why they need the medication, how to take it and for how long.
- Begin with the recommended starting dose of the medication and increase it in steps until the recommended therapeutic dose is reached.
- Always keep a close watch for side-effects. Most medications for mental health problems are quite safe.
- Never exceed the maximum dose.
- Most people only need one medication at a time; try to avoid prescribing multiple medications, especially of the same type.
- Avoid using some medications for too short a period (e.g. antidepressants and antipsychotics) and be careful not to use other medications for too long a period (e.g. benzodiazepines).
- Most medications 'interact' with others and also with alcohol or drugs, so their side-effects may be worse. Reduce the dose accordingly.
- Combine medications with counselling and social interventions.
- Resist the temptation to continue medications 'as before' in follow-up clinics. If someone has been taking a medication for a long time, review whether they still need the medication.
- Advise the person/family members to store the medication safely and away from children.
- Be aware of the common trade names and costs of medications in your area. Space is provided for this information in Chapter 14.

BOX 5.2 ANTIDEPRESSANTS

Antidepressant medications can be used for depression and anxiety disorders which are persistent, associated with severe symptoms such as suicidal thoughts, and causing problems in the person's day-to-day life. They can also be used when depression occurs along with other mental health problems such as alcohol problems or psychosis.

Types of antidepressants

There are two main types of antidepressants which general health workers can use:

- tricyclic antidepressants: these include **amitriptyline**, clomipramine, dothiepin, doxepin, imipramine, lofepramine, nortriptyline and trimipramine
- SSRI antidepressants: these include **fluoxetine**, citalopram, escitalopram, fluvoxamine, paroxetine and sertraline

Other antidepressants: these include *agomelatine*, *bupropion*, *duloxetine*, *mianserin*, *mirtazapine*, *reboxetine*, *trazodone*, *venlafaxine* and *vortioxetine*.

There is another type of antidepressant which should only be prescribed by a mental health specialist:

- monoamine oxidase inhibitors (MAOIs): *isocarboxazid*, *phenelzine*, *tranylcypromine* and *moclobemide*.

Points to remember when prescribing antidepressants

- It is important that you still give counselling and provide social interventions, even if you are prescribing an antidepressant.
- Antidepressants may be associated with increased suicidal thoughts in adolescents. Monitor carefully.
- Do not prescribe antidepressants for children under 12.
- For adolescents (aged 12 and above), do not prescribe tricyclic antidepressants (they do not work well in this age group). If counselling has not helped the young person, consider fluoxetine (not the other SSRI antidepressants).
- Avoid prescribing antidepressants to a person who has bipolar disorder (☞ Box 5.6 for advice on how to treat depression in bipolar disorder).
- Take care before prescribing to a person who has just been bereaved (☞ 10.4). Unless the person has severe depression, it is better to provide support, counselling and 'watch and wait' rather than prescribing an antidepressant.
- Antidepressants are not addictive.
- All antidepressants are equally good overall at treating depression in adults, but they differ in their side-effect profiles, and individuals may respond differently to different types of antidepressant.
- Side-effects are often short-lived and resolve by themselves. However, if they persist, consider swapping to another antidepressant with better-tolerated side-effects.
- Most antidepressants take up to 2 to 4 weeks to start working. Thus, you should allow enough time to see an effect (4 to 6 weeks in working-age adults, 6 to 12 weeks in elderly people and adolescents).
- You must continue treatment at the recommended dose for at least 9 to 12 months after the person has recovered to avoid relapse.
- If the person has had more than one episode of depression or relapses, then antidepressants could be continued for at least 2 years.
- Prescribing two antidepressants at the same time can be dangerous and usually has no therapeutic benefit.
- When stopping antidepressants, do so gradually – inform the person that they may experience symptoms while stopping. If this happens, slow down the pace of reducing the dosage.

BOX 5.3 ANTIPSYCHOTIC MEDICATIONS

Antipsychotic medications are used to treat psychosis and mania and in the prevention of episodes of bipolar disorder. When all other non-medication approaches fail, they may be used to help calm people who are aggressive in the context of delirium or dementia.

Types of antipsychotic medications

There are many types of antipsychotic medications. A simple way of grouping them is into three types:

- ‘typical’ antipsychotics, which include **chlorpromazine**, **haloperidol**, *thioridazine*, flupentixol, pericyazine, perphenazine, pimozide, sulphiride, trifluoperazine and zuclopenthixol
- ‘atypical’ antipsychotics, which include olanzapine, **risperidone**, *amisulpride*, *aripiprazole*, *asenapine*, *iloperidone*, *lurasidone*, *paliperidone*, *quetiapine*, *sertindole*, *ziprasidone* and *clozapine*
- long-acting injectable (LAI) antipsychotics (depot), which include **fluphenazine**, *aripiprazole*, flupentixol, **haloperidol**, *paliperidone*, *olanzapine*, pipotiazine, **risperidone** and zuclopenthixol.

The typical antipsychotic medications are just as effective as the atypical antipsychotics with one important exception: *clozapine* can lead to improvements in people who have not got better with the other antipsychotics, but it is only used when other treatments have failed, because of rare but potentially life-threatening side-effects. Usually *clozapine* should be prescribed by mental health specialists.

Points to remember when prescribing

- Antipsychotic medications can be started by a general health worker. This will help to make sure that people get timely treatment, rather than delaying until they can see a mental health specialist.
- If possible, the person should be reviewed by a specialist after starting treatment and then periodically (e.g. at least once a year), while the general health worker continues to prescribe and provide ongoing care and monitoring.

Antipsychotics for psychosis

- It can take several weeks to see the full effect of antipsychotic medications.
- For any episode of psychosis, treat for at least 1 year after recovery to prevent relapse; many people will need treatment for longer.
- Antipsychotic medications can also be given in a LAI form (depot), which relieves the person from having to remember to take tablets daily (⇨ 5.7).
- Antipsychotic medications can also be used to treat mania or bipolar disorder (⇨ Box 5.6).

Side-effects

Make the initial choice of antipsychotic based on the preferred side-effect profile for the person. If side-effects are problematic, swap to a medication with a different side-effect profile.

Side-effects of typical antipsychotics

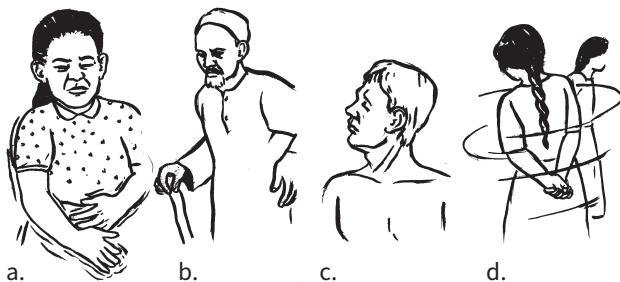
- The most common side-effects are tremor, rigidity and slow movement (‘pseudoparkinsonism’). Anticholinergic medications (procyclidine, **biperiden** or **benhexol**) may reduce these side-effects. It is not recommended that you routinely prescribe these medications alongside antipsychotics, but you may do so for first-episode psychosis in people who have difficulty in accessing the clinic if they have side-effects. This may help improve adherence.
- Severe side-effects which require urgent action are described in Box 5.5. Another severe side-effect can develop slowly (usually after years of treatment): the person develops movements that they cannot control (e.g. of the tongue or mouth) – ‘tardive dyskinesia’. Anybody with this problem should be seen by a specialist.

Side-effects of atypical antipsychotics

- Monitor blood glucose and lipids, blood pressure and weight regularly, as atypical antipsychotics are associated with increased risk of developing diabetes and cardiovascular disease. Give the person advice about healthy diet (low fat, low sugar) and lifestyle (e.g. exercise).

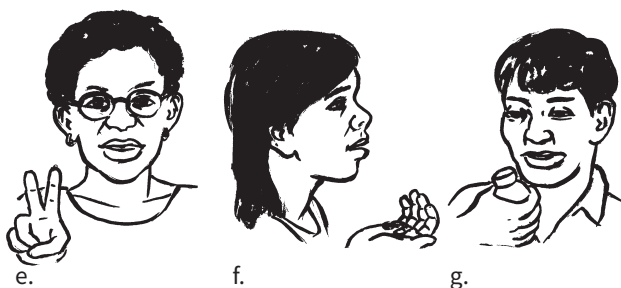
BOX 5.4 SIDE-EFFECTS OF ANTIPSYCHOTICS

The side effects of antipsychotics:



- a. Tremors (trembling movements, especially in the hands).
- b. Stiffness (the person may feel stiff all over, which can affect movements, e.g. walking).
- c. Dystonia (sudden movement of parts of the body, such as the head).
- d. Akathisia (feeling very restless and being unable to sit still).

The steps to take to stop or reduce these side-effects:



- e. Reduce the amount of medicine.
- f. Try a different medicine to reduce the side-effect.
- g. Change to another medicine for the mental disorder.

BOX 5.5 SEVERE SIDE-EFFECTS OF ANTIPSYCHOTICS REQUIRING URGENT ACTION

1. Sudden muscle spasm of the neck, tongue or eyes ('dystonia'). This is more common with typical antipsychotic medications, especially **haloperidol** and trifluoperazine, where it can affect one in ten people. It can be painful and frightening for the person.
 - Treat with **benzhexol** 4mg or **biperiden** 2mg. Depending on severity, use p.o., i.m. or i.v.
 - If possible, swap to a lower potency typical antipsychotic (e.g. **chlorpromazine**) or an atypical antipsychotic medication.
2. Severe inner restlessness causing distress ('akathisia'). Make sure the restlessness is not agitation due to psychotic or depressive symptoms. Screen for suicidal ideas or plans.
 - Reduce dose or swap to an atypical antipsychotic medication (olanzapine).
 - Consider propranolol up to 30mg to 80mg per day (starting at 10mg tds).
3. Fever, stiffness, fluctuating blood pressure and confusion ('neuroleptic malignant syndrome'). This rare reaction to antipsychotic medications is more likely when starting medications for the first time or when using typical antipsychotic medications such as **haloperidol**. This is a medical emergency.
 - Give intravenous fluids and resuscitation.
 - Stop the antipsychotic medication.
 - Refer for urgent hospital treatment.

i.m., intramuscular; i.v., intravenous; p.o., oral; tds, three times per day.



BOX 5.6 MOOD STABILISER MEDICATIONS

Mood stabiliser medications can be used to treat manic episodes and also to reduce the risk of relapse (with depression or mania) in a person who has bipolar disorder.

For prevention of relapse in bipolar disorder

- First-line treatments include mood stabiliser medications (**lithium** and **valproate**) and/or atypical antipsychotic medications (olanzapine, **risperidone** (depot or tablet), *quetiapine*, *aripiprazole*, *paliperidone extended release*).
- Second-line treatments include: the mood stabiliser **carbamazepine** and/or typical antipsychotic medications.

For treatment of mania

- Typical antipsychotics (e.g. **haloperidol** or **chlorpromazine**) or atypical antipsychotics (e.g. olanzapine or **risperidone**) or mood stabilisers (e.g. **lithium** or **valproate**).

For treatment of bipolar depression

- If the person is already taking a mood stabiliser, start by adjusting the dose. There is better evidence for **lithium**.
- Consider counselling.
- *Quetiapine* (an atypical antipsychotic) can be used as a sole treatment for depression in people with bipolar disorder.
- If none of the above is available or effective, consult with a specialist.
- Consider starting an antidepressant, but the person must also be prescribed a mood stabiliser or antipsychotic medication. Monitor carefully and stop the antidepressant straight away if the person develops high mood.

Points to remember when prescribing mood stabiliser medications

- Mood stabilisers can be started by a general health worker. If possible, the person should also be reviewed by a specialist as soon as possible to confirm that a mood stabiliser is needed, and then periodically after that (e.g. at least once per year), while the general health worker continues to prescribe and provide ongoing care and monitoring.
- **Lithium** must not be used unless laboratory and clinical monitoring is available.
- All mood stabilisers should be avoided in women who are pregnant or who are planning to have a baby. The risk to an unborn baby is highest with **valproate** and so this medication should not be prescribed to a woman of child-bearing potential unless recommended by a specialist.
- Check for cardiovascular, renal or hepatic disease before starting **valproate** or **carbamazepine**. Refer to a specialist if these conditions are present.
- Mood stabilisers have a number of important interactions with other medications (☞ Chapter 14). Make sure that the person is adequately informed.
- When switching from one mood stabiliser to another, start the new mood stabiliser while the person continues taking the old mood stabiliser. Treat with both mood stabilisers for at least 2 weeks before slowly stopping the old mood stabiliser.

Mood stabilisers need to be taken for long periods (a minimum of 2 years). If possible, consult with a specialist before stopping and be especially cautious if the person has a history of severe episodes or frequent relapses. Slowly reduce and stop over a period of at least a month. Sudden stopping of a mood stabiliser can trigger a relapse.

BOX 5.7 BENZODIAZEPINES

Benzodiazepines are sometimes called ‘anti-anxiety’ medications or ‘sleeping pills’, although they are not a good long-term treatment for anxiety or sleep problems, because it is easy to become dependent on them.

Benzodiazepines have a variety of uses:

- short-term treatment of acute and severe sleep problems, anxiety or distress
- behavioural disturbance in mania or psychosis (but not recommended for behavioural disturbance in people with delirium or dementia)
- managing detoxification for people who are physically dependent on alcohol
- emergency management of seizures.

Types of benzodiazepines

The following are common preparations of benzodiazepines: **diazepam**, lorazepam, nitrazepam, clonazepam, alprazolam and oxazepam. They differ in their duration of action.

Points to remember when prescribing benzodiazepines

- Avoid with alcohol.
- Avoid in pregnancy.
- Advise people to take care if driving and operating heavy machinery until they get used to the medication.
- Take care in the elderly as they may cause falls.
- Avoid in people with breathing problems.

Do not prescribe benzodiazepines for more than 2 to 3 weeks because the person can easily become dependent on them.

5.3 What other medications do I need to know about?

There are some medications used in mental health care which should only be started by specialists and which need ongoing monitoring by specialists. Nonetheless, the general health worker needs to have some knowledge about these medications and their side-effects in case people taking them require care in the general health care setting (☞ Chapter 14 for details of these medications and their side-effects).

5.3.1 Methylphenidate

Methylphenidate is a stimulant medication that is used to treat children who ADHD (☞ 11.4). The medication is only prescribed to children aged 6 years and above. Monitor children taking **methylphenidate** for growth retardation, low weight and sleep problems. Refer for specialist review if these problems develop.

5.3.2 Clozapine

Clozapine is an ‘atypical’ antipsychotic medication which is prescribed for people who have not responded to other antipsychotic medications. *Clozapine* has to be prescribed with guidance from specialists because of potentially life-threatening side-effects. You should know about the following.

- People who take *clozapine* need to have regular blood tests to check their white cell count. If the white cell count is low, speak with a specialist immediately. The medication may have to be stopped straight away to prevent fatal bone marrow suppression.
- *Clozapine* can also cause constipation which is so severe that it can even lead to bowel obstruction and death. If you see a person who is taking *clozapine*, always ask them about their bowel habit and advise them to eat plenty of fruit and vegetables. Take any complaint of constipation very seriously.
- More rarely, *clozapine* can cause inflammation of the heart (‘myocarditis’ – signs include

BOX 5.8 ANTIEPILEPTIC MEDICATIONS

Antiepileptic medications are used to prevent seizures in people who have epilepsy. Some antiepileptic medications are also effective as mood stabiliser medications.

Types of antiepileptic medications

- First-line antiepileptic medications for convulsive seizures include **phenobarbitone**, **phenytoin**, **carbamazepine** and **valproate**.
- For people with HIV, the following newer-generation antiepileptic medications may be preferred, if available and affordable: *levetiracetam*, *lacosamide*, *topiramate*, *gabapentin* and *pregabalin*.

Points to remember when prescribing antiepileptic medications

- If the woman is pregnant: avoid **valproate**.
- In a woman of child-bearing age, do not use **valproate** unless there is a good reason and in consultation with a specialist. If **valproate** is prescribed, prescribe folate 5 mg once daily (even if the woman has no plan to become pregnant) and ensure that the woman is using an effective contraception (the oral contraceptive pill may not work so well with some antiepileptic medications).
- If the person has an intellectual disability, try to avoid **phenobarbitone** and **phenytoin**.

- Be cautious about interactions between antiepileptic medications and any other medications that the person is taking.
- If an antiepileptic is not effective at the maximum dose, carefully swap over to another antiepileptic: start the new medication at a low dose while the person is still taking the previous medication, slowly increase the dose until it is effective (or the maximum dose). Only then reduce the first medication slowly and stop.
- If the person continues to have seizures, refer for specialist advice. The specialist may combine antiepileptic medications and/or try newer-generation medications: *lamotrigine*, *levetiracetam* and *topiramate*.
- Inform the person about the delay before the medication works and the risk of having a seizure if they stop the medication suddenly or miss doses.

Consider stopping antiepileptic medications if the person has been seizure-free for 2 years. However, long-term treatment might be needed if the seizures were difficult to control, if previous attempts to wean the person off led to renewed seizures, or if seizures occurred because of a head injury or infection of the brain. If the medication is to be reduced, do this slowly, over a period of at least 2 months.

fever and racing pulse) or clots in the lungs (breathing problems). Refer for urgent medical treatment.

- Other more common but less dangerous side-effects of *clozapine* include drooling of saliva at night (advise the person to put a towel over their pillow), sedation and weight gain.

5.3.3 Medications to manage opioid dependence

Methadone

Methadone is a long-acting opioid substitute that can be used to treat acute symptoms of opioid (e.g. heroin) withdrawal or can be taken on a long-term

basis to reduce the harmful use of opioid (e.g. injecting and illegal activities). *Methadone* comes in a syrup form. Misuse of *methadone* can be a problem, so it is necessary to observe the person drinking the *methadone* (on a daily basis) in the clinic or their homes. If people use street opiates at the same time as *methadone* then they can easily overdose. When treating overdose, don't forget that the effects of *methadone* take time to wear off (⇨ flow chart 6.5).

Buprenorphine

Buprenorphine is an opioid substitute used for both withdrawal and as a long-term substitution therapy. It is a tablet which is placed under the tongue. It is less dangerous than *methadone*.



However, it is still possible for people to overdose accidentally if they use street opioids at the same time as **buprenorphine**.

Clonidine, lofexidine

Clonidine or **lofexidine** can be used to reduce the symptoms of opiate withdrawal. They can cause light-headedness and sedation. Blood pressure monitoring is required.

5.3.4 Medications to prevent relapse of alcohol dependence

- **Acamprosate** helps to reduce craving for alcohol. It is taken for 12 months after a person stops drinking alcohol. Rarely, people who take **acamprosate** can get a skin reaction which needs urgent medical review.
- **Naltrexone** is another medication that helps to reduce cravings for alcohol. It is taken for 12 months after the person has stopped drinking. If a person taking **naltrexone** needs pain relief for some reason, do not give them an opioid type of pain relief (e.g. tramadol, pethidine, morphine) because it will not work – **naltrexone** blocks these kinds of painkillers.
- **Disulfiram** helps to deter a person from drinking alcohol by causing a very unpleasant reaction if it is taken with alcohol. The reaction can be dangerous. The person experiences flushing of the face, nausea, vomiting and fainting. Even if the person does not drink, **disulfiram** can cause serious side-effects, including psychosis.

5.4 What if the person doesn't take the medication as prescribed?

The most important thing a health worker can do to support a person to take medications is to build a trusting relationship with the person and to educate them about their illness and the medication. Some important points are listed below.

- Explain that the symptoms are caused by an illness and that, just as with physical disorders, medications can be of help.
- Explain that the medications need to be taken for a while after the person feels better so that the problem won't return.
- Explain that many medications for mental health problems take some time to act, so patience is needed. The most common example is antidepressants, which usually require at least 3 weeks before they start to work.
- Take steps to minimise the risk of side-effects by starting with a small dose and gradually increasing the dose to the required level.
- See the person at least once every 2 weeks (or more often if possible) until they show signs of recovery. Keep encouraging the person to persevere with treatment.
- If side-effects occur, follow the steps outlined in ☞ Box 5.4.
- Involve the family (with the person's permission) in encouraging the person to take the medications.
- Try strategies for improving motivation (☞ 5.17).



! Some people refuse medicines.

- Stick to simple dosage schedules; many psychiatric medications can be given once a day (e.g. most antipsychotics and antidepressants).
- Monitor whether the person is taking medications as prescribed; for example, you can check to see whether the expected number of pills has been taken by counting the number of pills left over in the medication bottle/strip.

Families may try to give the person medication secretly, for example, crushed up in food. It is important to be sympathetic to the family and their dilemma, but also to explain that there are potentially bad consequences of deceiving the person this way:

- it does not respect the person's right to know what is going on with their treatment
- the person may experience dangerous side-effects but not realise what is going on
- if the person finds out then they will lose their trust in family members
- if the person doesn't find out and gets better then they will not understand that medication helped them to recover.

Instead, try all of the suggestions to support the person to take the medication. If these fail and the person remains unwell or is at risk of harming themselves or others, consider injectable medication (⇨ 5.7) or admission to hospital.

5.5 What if the person does not improve?

Consider the following reasons.

1. **Poor adherence.** Poor adherence with medications may occur because the person feels better and decides that there is no more need for medications. Another reason is because the person is worried about becoming addicted to the medications. Side-effects can also make a person stop (⇨ 5.6).
2. **Not enough medication.** If a medication is not prescribed at the right dose, it may not work.
3. **Medications not taken for long enough.** Most medications take at least a few weeks at the recommended dose before a positive response is obtained.

4. **Wrong diagnosis.** Reconsider your diagnosis if the person has been taking the full recommended dose for enough time of at least two different types of medication for a mental health problem and shows no sign at all of recovery.
5. **Coexisting substance use.** If a person continues to use substances (e.g. alcohol) this may reduce the benefits of the medication.
6. **Ongoing social stressors.** Difficult social circumstances may get in the way of a person recovering from a mental disorder.

If, despite your efforts to identify and address the above factors, the person still fails to improve, you may need to consider a referral to a specialist. If that is not possible, try swapping to a different class of medication (e.g. from typical to atypical antipsychotic medication, or from tricyclic to SSRI antidepressants). In general, do not use two medications of the same type (e.g. two antidepressants or two antipsychotic medications) at the same time apart from when swapping from one to another.

5.6 What if there are side-effects?

First, make sure that the problem reported by the person is really a side-effect. To be a side-effect, the symptom should have started only after the medication was started. Often, the symptoms were present even before the medications were started and are due to the mental health problem. The person may misinterpret symptoms as side-effects. In such cases, reassure the person by pointing this out. Remember the common side-effects of medications for mental health problems; if a complaint does not fit with these side-effects, consider other reasons for them.

Once you are sure that the person does have side-effects, you have the following options.

- **Are the side-effects tolerable?** Most medications produce some side-effects, but most are minor and temporary. Ask the person how much distress the side-effect causes them. Often people will say that they can tolerate the symptoms, provided the benefit of the medications will also be evident in a short time.

BOX 5.9 LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS ('DEPOT')

Long-acting injectable antipsychotic medication is injected into muscle (usually the buttock) and is then released slowly into the bloodstream. The injection has to be given every few weeks (usually once per month).

Types of long-acting injectable antipsychotic medication

- The common examples of long-acting injectable antipsychotic medications are usually 'typical' antipsychotics. The most commonly encountered medications are: **fluphenazine decanoate**, flupentixol decanoate, **haloperidol decanoate**, pipothiazine palmitate, zuclopenthixol decanoate.
- New long-acting injectable antipsychotics are increasingly becoming available. There is no evidence that they work better, but the side-effects may be more acceptable to the person. These include: **injectable aripiprazole**, **olanzapine pamoate**, **paliperidone palmitate** and **risperidone microspheres**.

Points to remember when prescribing long-acting injectable antipsychotic medication:

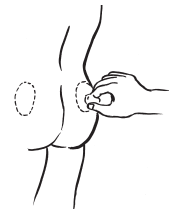
- Never give a long-acting injection to a person who has not previously been prescribed oral antipsychotic medication.
- Ideally, consult with a mental health specialist before initiating long-acting injections.
- Always start with a test dose in case the person has a bad reaction to the medication or to the oil preparation (e.g. 12.5 mg i.m. for fluphenazine) – wait for 5 to 7 days.
- Give the injections as far apart as possible (up to the maximum licensed interval).
- Remember that a depot takes time to work. Wait 2 to 3 months before increasing the dose and to evaluate the effect of any dose increase.
- Avoid prescribing depot to pregnant women.



a.



b.



c.



a. Give the injection in the upper arm or buttocks, into the muscle. If this is the first time the patient is receiving the medicine, always give a test dose of a quarter of the full dose you want to give.

b. Clean the injection site.

c. If there is no allergic reaction after 1 h, give the rest of the dose.

i.m., intramuscular.



Medications must be taken in the right dose.

- **Can the dose be reduced?** Sometimes, a small reduction in the dose may be tried and could lead to a reduction in side-effects without causing a worsening in the problem.
- **Can you switch to another medication?** Many types of medications can be used to treat the same mental health problem. If intolerable side-effects occur with one type of medication, try switching to another.
- **Is there an additional medication that you can give to reduce the side-effect?** For example, see Box 5.5 for the treatment of side-effects of typical antipsychotic medications.
- **Is there a non-medication intervention to help with the side-effect?** For example, weight gain can be managed by giving the person advice on a low-calorie diet, the need to avoid sugary drinks and the importance of exercise.

5.7 When are injections needed?

Injections have a very limited role in the treatment of mental health problems. Rarely, injections may be necessary as an emergency intervention if somebody is violent or agitated (see flow chart 6.1). Long-acting injectable 'depot' medications (Box 5.9) can be helpful in reducing the need for hospital admission. They are most commonly used for people with chronic psychosis who refuse to take oral antipsychotic medications but keep experiencing relapse when they are not taking medication. They are also sometimes used to prevent relapse in bipolar disorder when mood stabilisers are not available. Some people prefer long-acting injections because they are more convenient than daily medications. Besides these situations, it is advisable not to use injections to treat mental health problems. Avoid using unnecessary

injections such as vitamins for complaints of tiredness and weakness which may be the result of a common mental disorder rather than a vitamin deficiency.

5.8 Keeping the cost of medications down

Some new medications for mental health problems have advantages over older ones, mainly concerning the type of side-effects. However, a major limitation (as with new medications for other health problems) is their cost. In making a decision to use medications, this factor should always be considered, since the difference in side-effects may be less important to the patient than the difference in cost. Chapter 14 has space for you to note down the costs of different medications in your region so that you can choose the right medications for the people you are treating.

Section II: Counselling



Some health workers feel that 'proper' health care should involve something more than counselling, or 'just talking'. Many doubt that counselling can even be considered a treatment at all. This is why many health workers give medications every time a person comes to the clinic. The person, too, often expects medications. Some people may even tell the health worker that they need an injection! It is important to clear up a few doubts and myths about counselling.

The term 'counselling' is used in different ways and can mean different things to different people. Thus, a caring person with no formal training could 'counsel' friends who are distressed. In this

kind of counselling, the person is often following their own instincts and compassion. While this approach has its own strengths, counselling has some important differences from talking to a friend (Table 5.1).

In this manual, we use the term counselling to refer to all forms of psychological treatment. Counselling involves a set of skills and approaches which can be learned by any health worker who has an interest and an open mind.

5.9 General principles of counselling

5.9.1 Who is counselling for?

In the next section we will discuss some basic skills for counselling someone, such as giving hope. These are non-specific counselling skills that can be useful for every person you work with and will greatly improve the quality of the care you give and increase the person's satisfaction.

Some other types of counselling strategies, such as 'problem-solving', 'thinking healthy', 'getting active', 'improving motivation' and 'addressing relationship issues', have been shown to help people with particular types of mental health problems. These are called 'specific' counselling methods.

Counselling is not in competition with medications. For some people, counselling may be sufficient in itself, but others may also need medications.

5.9.2 Basic counselling for all people with mental health problems

We will now describe some simple basic counselling skills which should be used for any person with a mental health problem.

Give reassurance

Often, people suffering from mental health problems are dismissed by health workers as being 'mental' or 'neurotic'. These remarks suggest that the person does not have a 'real' health problem.

It is important for the health worker to avoid the mistake of saying 'there is nothing wrong with you'. Most people will be upset with this sort of remark. After all, there is something wrong with them. The person does not feel well: that is the reason that they have come to you for help. Many people are worried that they are suffering from a serious physical illness. This makes them even more tense and unhappy. Thus, the health worker should reassure the person that they do understand that the person is suffering from a number of distressing symptoms, but that these symptoms will not result in a life-threatening or dangerous illness. The health worker should reassure the person that such symptoms are common and that the cause and treatment of the problem will be explained to the person.

Provide an explanation

Explaining the nature of the problem helps to make the person aware of the reasons for their symptoms and to clear any doubts in their minds. First, explain the symptoms in general terms. Taking the example of Lucy in case 1.1 (⇨ p. 7), you could explain her symptoms in the following manner:

'After childbirth, many women feel pain and discomfort now and then. In fact, it is quite common to feel tired and have sleep problems. Some women may also become sad and lose interest in their babies.'



You can then move on to focusing on the specific symptoms the person has told you about. You can also put some further meaning on the nature of the symptoms if you know how they started. For example, you could say to Rita, the lady in case 1.2 (⇨ p. 7):

'When someone is feeling stressed, upset or unhappy about things, they often experience sleep problems, aches and pains, and worries.'

TABLE 5.1 DIFFERENCES BETWEEN PROFESSIONAL COUNSELLING AND A FRIENDLY CHAT

Counselling	Friendly chat
Professional ethics of confidentiality	Not bound by professional codes to keep information confidential
Focused, structured, goal targeted	Not focused on a specific goal
Helping patients find their own solutions	Advice-giving
Counsellor does not judge or take sides	Friends may be judgemental or take sides
Uses a specific method which is related to an understanding of why the person has a mental disorder	Not guided by theory

You have been feeling tired and unhappy in the past month. This is because you have been under stress ever since your husband died and your children have left the village. You have become depressed. This is not because you are lazy or are a “mental case”. This is a common problem which affects many people in our community. All the problems you described are because of this emotional illness.’



Or, taking the example of Ravi in case 1.3 (pp. 7–8):

‘Your symptoms of difficulty breathing, dizziness, heart beating fast and fear are because of attacks of anxiety. These are quite common problems and are not signs of a dangerous illness. In fact, they occur because you were tense or worried about something. When you are tense, this makes you breathe faster than normal. When you breathe faster, this produces changes in your body which make your heart beat fast and make you feel scared that something terrible may happen. Actually, if you had controlled your breathing, you could have stopped the attack quickly. You are probably suffering these attacks of anxiety because of the shock of the accident in which your friend died. This can happen to anyone.’

Or, consider Michael in case 1.4 (pp. 9–10):

‘Your complaints of sleep problems, sickness in the mornings and burning pain in the stomach are all related to your drinking too much. Alcohol is highly addictive so that now you are feeling like drinking all the time. This is why you wake up feeling sick: it is part of the withdrawal from alcohol which makes you sick. This is why you feel better when you have a drink in the morning. You have become depressed and unhappy because you feel you have lost control of your drinking and because you are feeling sick and unwell. If you stop drinking, these problems will go away and you will feel much better.’



It is more challenging to explain to the person what may be happening to them when they do not think they have a mental disorder, for example, in some people with psychosis, but it is still important to help the person understand your perspective without being confrontational. One approach could be:

‘You told me that someone is poisoning your food and that people are planning to harm you. I understand that this is causing you a lot of distress and I would like to help you. In my experience, this can happen because of a ‘trick

of the brain' which can make things seem real when they are not actually happening. I can't prove this to you but perhaps you could try the treatment I am suggesting? I think it will help you.'

It is important that you also ask the person what they think has caused the illness and what treatment they think might help. Understanding the person's views can help the health worker plan treatment much better. For example, consider a person who feels that their illness was caused by bad spirits. The health worker could suggest that, while the person may consult the priest for spiritual guidance, their symptoms were also caused by stress and for this the person should take treatment as directed by the health worker. Do not dismiss the person's views, even if they appear non-scientific. By listening to and appreciating the person's understanding of the problem, you will achieve a better outcome. After you give your explanation, always give the person a chance to clarify doubts or concerns.

Give hope

Make sure the person understands that their problem is likely to get better with treatment. For example, in a person diagnosed as having depression you might say:

'Even though right now you feel as if nothing can ever help you, in my experience, people with this kind of problem can, and do, get well again.'

Don't underestimate the influence that health workers can have in giving people hope for the future. Indeed, feeling hopeful can increase a person's motivation to follow through with the advice you give and to enhance the chances of healing themselves. At the same time, you should be realistic and honest. A person with long-standing psychosis may not recover fully; however, they can almost certainly be helped. Knowing that possibility can give a person hope.

Identify and address current problems

Social problems commonly contribute to mental health problems. Sometimes you may be able to

identify somebody known to the person who can help them to solve the problem, or you may know of organisations who can help (e.g. for women affected by domestic violence). Even when that is not possible, just allowing people to talk about the difficulties they are facing and listening sympathetically can be beneficial. Try to ask the person about the problems each time they come to visit. This will show the person that you are listening and that you are concerned.

Giving a person direct advice about how to solve their problems may help in the short term, but it doesn't help them to learn better ways of coping with their difficulties (which would be better in the longer term). Therefore, if you have the time, try to provide more in-depth support with a 'problem-solving' strategy (⇨ 5.11).

Review, encourage and support

For all counselling approaches, it is important to review the person's progress, and provide encouragement and support. Give plenty of encouragement to help the person gain confidence that they can succeed. The person may have a week when they are not able to make as much progress. Explain that this is expected, but not to give up.

When assessing progress, be specific. It is not helpful to ask 'How did you get on?' and accept a shrug of the shoulder or a vague answer like 'OK'. You should ask for details of exactly how the person did.

- What did you do towards achieving what we agreed in the last session?
- Was it easy or difficult?
- How did it affect your feelings and emotions?
- If the task was done, congratulate the person and ask whether they want to practise the same task again or move on to another goal.
- If the task was not done, what went wrong? How will the person address the difficulties which got in the way of carrying out what was agreed before?

5.9.3 What are the different ways to deliver counselling?

Counselling strategies can be delivered in various different ways, including individually or in groups

(Table 5.2), face-to-face, over the internet or over the telephone. People can also teach themselves counselling strategies with the help of internet or book resources. There are some pros and cons to these different approaches.

Individual v. group counselling



There does not appear to be a difference in how well individual counselling works compared with group counselling. Therefore, choose the approach that best suits the setting within which you work.

Self-help or face-to-face

Self-help is when the person accesses materials (e.g. books, leaflets or websites) which provide simple advice or a structured counselling strategy,

and then the person follows this advice or strategy by themselves. The big advantages of the self-help approach are: the person can easily access the materials at their own convenience and with low cost, stigma does not get in the way, and the person will always have this resource available to them to keep well and deal with any future difficulties. However, self-help on its own may not be enough for some people. Combining self-help with some face-to-face or telephone-based advice from the health worker can make self-help work better. Familiarise yourself with web-based and book-based self-help materials to ensure they are based on sound evidence and consistent with the advice given in this manual. Also consider preparing self-help brochures and making them available in the place where you work.

5.9.4 How much counselling is needed?

The counselling strategies discussed in this manual are intended to be time-limited. However, the exact number and duration of sessions should be tailored to the needs of the person as much as possible. It is useful to think of counselling as having a beginning, a middle and an end.

TABLE 5.2 DIFFERENCES BETWEEN INDIVIDUAL AND GROUP COUNSELLING

Individual	Group
More flexible timing	Time has to be convenient for the whole group Need to wait until enough people are recruited
Can be done in small consulting room	Needs adequately sized room or private area
May be more feasible for clinic-based counselling	May be more feasible for community-based counselling
Content more tailored to the individual	Content depends on the needs of the group
Learning depends on the individual and the patient–health worker relationship	Learning can be faster in a group as the patient is exposed to more real-life examples
	Helps the patient to make connections with people who have similar problems
May be more acceptable because not required to talk about sensitive issues in front of others	May be more acceptable because the problem is not focused on the individual patient
Usually more resource-intensive: one health worker to one patient	Can be more efficient – one health worker can provide treatment for a number of patients
Health worker only needs skills in the counselling strategy	Health worker needs skills in handling groups

The 'beginning' is when you:

- assess the person's main difficulties and decide, together with the person, which of these difficulties to address
- decide which counselling strategy might help
- develop a trusting relationship with the person
- explain the specific counselling approach to the person and how it is expected to help them
- build motivation in the person to be an active participant in the counselling.

The 'middle' is when you:

- work with the person to put the specific strategy into practice
- review progress and provide encouragement and support
- consider alternative strategies if it is not working or new problems arise which require a different strategy.

The 'end' is when you:

- work on how the person can stay well by continuing to use the strategies that they have learned
- prepare for the ending of the relationship that has built up between you and the person.

Some people may also require 'booster' sessions from time to time even after they have completed a course of counselling. When you start using a counselling strategy with a person, make sure that you explain that more than one session is required to really get the benefit. Try to agree on the number of sessions that the person

can commit to attending. Ideally, a minimum of 3 sessions are recommended, so that there is a beginning, middle and end; 6–8 sessions are usually needed to effectively complete the treatment.

It is also helpful to be clear with the person about the expected duration of each session and their frequency. Aim for a minimum duration of 20 min (on average, you will need about 30 min) and not longer than 1 h. The frequency should usually be every 1 to 2 weeks. For people with psychosis or bipolar disorder, counselling needs to be less frequent (e.g. monthly) but delivered over a longer period (e.g. 1 to 2 years).

5.9.5 Challenges

Some potential issues that can arise during counselling are described in Table 5.3, with suggested approaches. Good supervision, preferably from a colleague with experience and expertise in counselling, can help with most of the problems described. If it is not possible for you to have formal supervision, try to develop informal links with specialists working in your area so that you can consult them when you are uncertain about what to do. Discussing with colleagues, even if they are not experts, can also be helpful. Try to make sure that case discussions happen regularly (e.g. once a month).

5.9.6 Counselling strategies for specific symptoms and problems

Counselling will be more effective if it is sensitive to the main problems and symptoms of the



a.



b.

Challenges in counselling:

- a. when the person gets distressed or expresses suicidal ideas
- b. when the health worker gets irritated with the person.

TABLE 5.3 ISSUES THAT MAY ARISE DURING COUNSELLING AND HOW TO APPROACH THEM

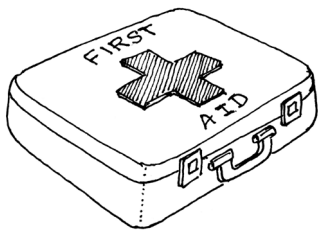
Issue	Approach
Person gets distressed and/or suicidal	<p>Sometimes people get worse before they get better.</p> <p>If the person is distressed, be supportive and keep calm. Allow them to express their distress. If the distress does not subside, suggest that you stop the session, assess for suicide risk or risk of harm to others (⇨ flow chart 6.3), try to arrange for a friend or family member to come to the health facility to collect the person, and arrange for a short follow-up appointment.</p>
Person misses lots of sessions or comes at the wrong time	<p>There may be a good reason for not attending, but sometimes this can be a clue that the person is not sure about the usefulness of counselling or is not benefitting from the counselling.</p> <p>Go back to the 'beginning' phase and check that you are focusing on the main problem. Also check that counselling is acceptable to the person. Make sure the person is well informed about the rationale for using that approach.</p>
Session overruns	<p>This could happen because of difficulties you have with time management. It may also be because the person is reluctant to end the session (e.g. they may keep telling you new things). At the beginning of each session, be clear about the time available. Remind the patient 5 min before the end that you will be ending shortly. If they start talking about a new problem, explain that you will tackle that problem the next time, unless you are concerned about the person's suicide risk or risk to others (⇨ 7.6).</p>
Person does not want to stop the course of counselling	<p>Planning ahead can help. Be clear about the number of sessions from the beginning and keep reminding the person about the number of sessions remaining. Focus the last session on how the person can stay well to give them confidence. Offer the possibility of booster sessions if they find that they are not managing well, but stress that it is important for the person to try out the approach on their own.</p>
Person and counsellor start an intimate relationship	<p>The counselling relationship can be close – the person may open up about areas of their life which are usually private and may feel great gratitude towards the counsellor. The counsellor may feel as if they are very important to the person. It is within this context that an intimate relationship may occur. Such a relationship is never the right thing. It is vital that you discuss any feelings you may have towards a person you care for with your colleagues or supervisor before you act on them. Stop the counselling but make sure that the person can continue to receive treatment and does not feel they are responsible for what has happened.</p>
Counsellor gets irritated or angry with the person	<p>Sometimes you might find yourself getting irritated by a person and their behaviour. Try to discuss your irritation in supervision or with colleagues and find ways to be more understanding of the person (and why they behave in a way that annoys you). Never express your anger or irritation to the person. If you cannot control your irritation, stop the counselling session but make sure that the person can continue to receive treatment.</p>
People contacting you when you are off-duty	<p>People who you care for may approach you when you are socialising, phone you or even come to your home. This can be exhausting and irritating. Instead of accepting the informal consultation, explain politely to the person that you will be happy to see them at the health facility. The only exception to this is if it seems to be an emergency, in which case do what is necessary to help the person to access emergency health services.</p>
Getting over-involved	<p>Some people get 'under our skin'. We can't stop thinking about their problems and their distress, even when we are away from work. If you find yourself taking your work home, speak with your supervisor or colleagues about the case and share the worry.</p>

person. In Table 5.4 we list various counselling methods alongside the specific symptoms and problems which they can address most effectively.

In the next section we will describe how to deliver these specific counselling strategies in detail.

TABLE 5.4 COUNSELLING STRATEGIES AND PROBLEMS THEY MAY ADDRESS	
Specific counselling strategy	When the strategy might be helpful
Psychological first aid	For the person who has been raped (☞ 10.3), who is overwhelmed by a personal crisis, who reacts severely to a traumatic event (☞ 10.1) or who has been bereaved (☞ 10.4).
Problem-solving	When the person is overwhelmed by many problems. This could occur in any person with a mental health problem, but especially so in people with common mental disorders (☞ 1.4.1).
Relaxation exercises	For any mental health problem which leads to a person feeling stressed, tense or anxious.
Getting active	For any mental health problem which has led to the person reducing their activity level and withdrawing from social life.
Thinking healthy	For the person who has negative thoughts about themselves or their life and is thinking too much.
Improving relationships	For any person who has difficulties with relationships, either as a cause or consequence of their mental health problems.
Controlling anger	For the person who is irritable or angry and for the partner of the person who is being beaten or abused.
Improving motivation	For anyone who needs to make a lifestyle change (for example, diet, physical exercise, use of substances) and for those who have difficulty taking medicines.

5.10 Psychological first aid



A crisis is a situation in which a person feels completely overwhelmed or defeated by the problems they are facing. What one person may see as a crisis is not the same as how another person might see it. Thus, the definition of a crisis is based on the person's view of their situation, and on how the situation has affected the person's ability to cope with the problems. In the same way that we

provide first aid for accidents that lead to physical injury, health workers can also provide 'psychological first aid' to people who have experienced a crisis. The idea behind psychological first aid is that sometimes people need brief support after a serious crisis in order to help them to find their own ways to cope with what has happened. Over time most people will recover.

5.10.1 When to use psychological first aid

Psychological first aid is useful when there has been a serious crisis event which has resulted in a person becoming very distressed, for example:

- a bad accident
- a violent assault (includes sexual assault)

- witnessing a violent death
- a major disaster, e.g. an earthquake (⇨13.1)
- a war or conflict (⇨13.1).

Psychological first aid is helpful in the period right after a serious crisis event, but not everybody will need psychological first aid. It is only for those people who are very emotionally distressed and who would like help. Do not use psychological first aid in situations when the person needs more specialist care, for instance:

- if the person has a life-threatening injury
- if the person is so distressed that they cannot care for themselves or their children
- when the person is suicidal and may hurt themselves (⇨7.6)
- when the person may hurt others (⇨7.2).

5.10.2 How to use psychological first aid

- Make sure the person gets treatment for physical consequences of the crisis, for example, injuries.
- Assess needs and concerns, such as understanding the person's priorities.
- Try to suggest solutions. These could include sharing the problems with others, making contact with the police or other helping agencies, and referring to a hospital for a short admission in severe situations.
- Listen, but never force the person to talk about what happened.
- Be calm and comforting even if the person is agitated and angry.
- Reassure the person that emotional reactions are normal.
- Help to connect the person with information, services and support.
- Protect the person from further harm.
- If the person is very agitated and has not slept well, you can prescribe a few days' supply of benzodiazepine medication (⇨Box 5.7).
- Always ask to see the person again in a day or two to review. Many will be much calmer on review and more in control of their situation.

At that time, a more detailed mental health assessment should be made.

5.10.3 Challenges

Hearing distressing stories can be upsetting for the health worker and trigger an impulse to try to make everything better. Remember that you cannot remove the trauma and that the best way to help the person is to assist them to find their own ways to cope.

5.11 Problem-solving

Problem-solving is a counselling strategy which teaches how problems in a person's life can make them feel anxious or depressed, and how these emotions can then make it harder to solve the problems. The aim is not that the health worker should try to solve a particular problem. Instead, you should teach the person problem-solving skills so that they can effectively overcome the problems themselves.

5.11.1 When to use problem-solving

Problem-solving can be seen as the basic structure of any counselling treatment, especially if the 'problem' is thought of as including both social problems (such as domestic violence) and mental health problems (such as feeling depressed or anxious). Thus problem-solving could be used for virtually all mental health problems, but is most valuable for common mental health disorders.

5.11.2 How to use problem-solving

In counselling, approaching a problem may be done in several steps, as outlined in this section.

Step 1. Explain the counselling strategy

The first step is to explain the counselling strategy by pointing out the links between problems a person faces in life and the emotional symptoms that they are experiencing, which in turn affect the ability of the person to solve problems. You could explain like this:

‘People with difficulties like yours can be helped by looking at the way in which they handle stress and deal with problems. I would like to discuss some of your problems and think of ways in which you can try and deal with them.’

Step 2. Define the problems

Ask the person a question about which problems they have been experiencing in their life. It is a good general principle to go from relatively ‘safe’ information (e.g. about work) before tackling the most personal problems (e.g. those about sex). Remember to ask questions about personal problems – they are often the most upsetting and important. A useful method of asking personal questions is to say something like:

‘Sometimes when people feel unhappy they have less interest in sex; has this happened to you?’

‘It is quite common for people who are worried to drink more alcohol than usual; how much are you drinking?’

This method of introducing a personal subject demonstrates you are not going to be shocked if they say ‘yes’ (Box 5.10).

Step 3. Summarise the problems

Once you have collected information about the person’s problems, summarise the key problems by saying something like this:

‘You have told me that your baby’s arrival has changed a lot of things in your life. You are not working now, you’re up half the night and you see less of your friends, and it has affected your relationship with your husband.’

Doing this serves several functions. It confirms to the person that you have been listening. It shows that there is some structure to the problems. It is also a useful means of getting more personal information.

BOX 5.10 THE KINDS OF LIFE PROBLEMS WHICH CAN AFFECT MENTAL HEALTH

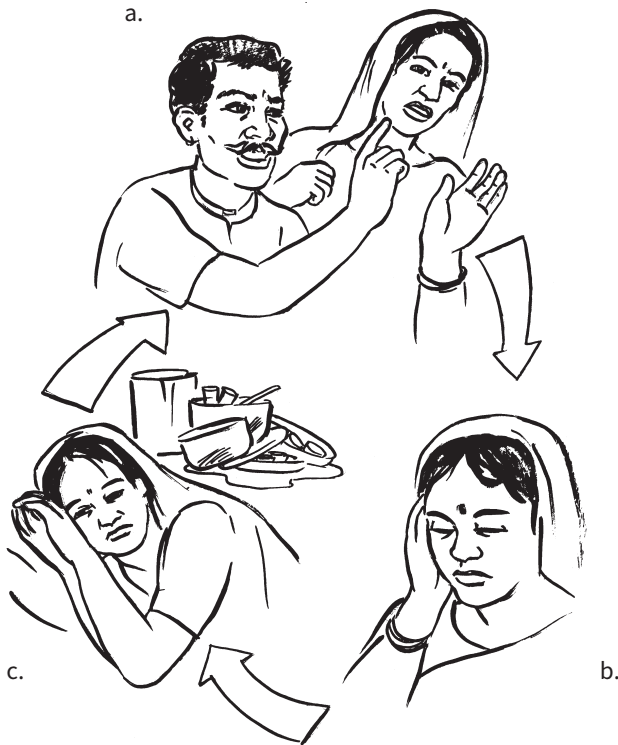
- Relationship problems with a spouse/partner, such as lack of communication, arguments, violence in the family and poor sex life
- Relationship problems with others, such as in-laws, children, relatives or friends
- Employment problems, such as not having a job or feeling overworked
- Financial problems, such as not having enough money, being in debt
- Housing problems, such as living in a noisy or violent neighbourhood
- Social isolation, such as being alone in a new place or not having friends
- Physical health problems, especially when painful and long-standing
- Sexual problems, such as loss of interest in sex
- Bereavement or losing someone you love
- Legal problems

Step 4. Select a problem and choose a goal

The next step involves selecting a specific problem worth tackling and choosing the goals the person would like to set. Here are some hints on how to select an appropriate problem.

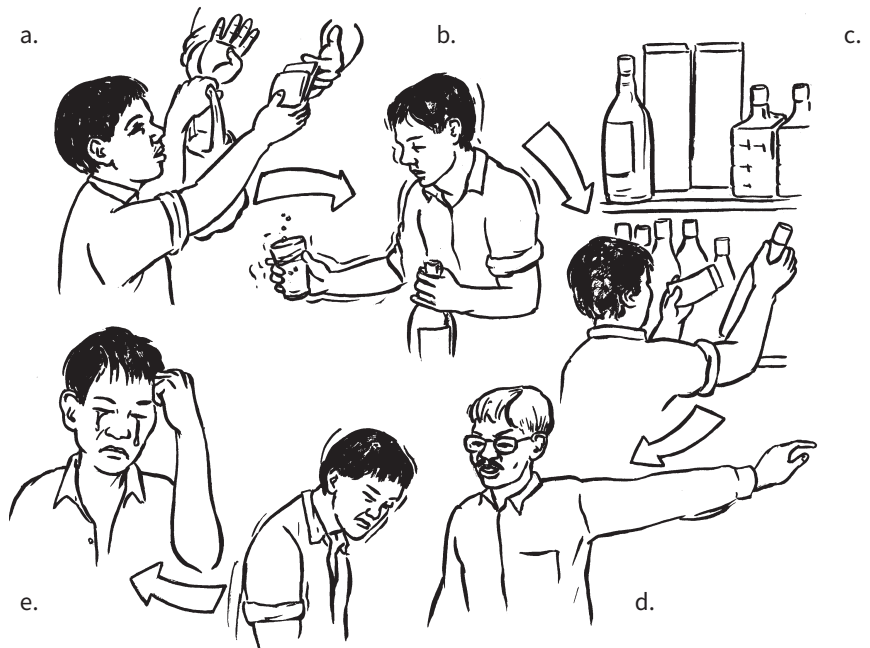
- Ask the person to make a list of all their problems. Identify those which are of most concern to the person.
- Target a problem which has a potential solution in the short term. For example, if the problem is related to a long-standing difficulty in the relationship with the spouse, it is not a good problem to tackle first. On the other hand, a recent problem in coping at work or feeling socially isolated may be a useful one to start with.
- Once a problem area is selected, confirm with the person that this is indeed the problem they wish to tackle during therapy.

Remember that the aim of the treatment is to teach the person problem-solving skills, not to solve all their problems.



a. A common problem people face in their life is unhappiness in their relationships.
 b. This makes the person unhappy.
 c. This can lead to tiredness and poor concentration. This is in turn likely to worsen the relationship.

a. A common problem is not having enough money to meet daily needs.
 b. This could make someone turn to alcohol.
 c. The person becomes even poorer, because they spend their money on alcohol.
 d. Their work suffers and they lose their job.
 e. This makes the person sad and desperate, and worsens the drinking and financial problems.





After 2 weeks...



Step 5. Define solutions

This consists of the following steps.

1. Generate solutions: think out various solutions with the person.
2. Narrow solutions: if many options are available, focus on those which are most practical given the person's social situation.
3. Identify consequences: consider what might happen as a result of implementing the solutions.
4. Choose the best solution.
5. Plan how to implement the solution.
6. Set specific targets which are achievable within the time before the next meeting with you.
7. Consider what might happen in the worst-case scenario, for example, if the solution fails completely.

Encourage the person to come up with the solutions to their problems. In this way, you will help improve their self-confidence. For example, if the person has said that being lonely was a major problem, do not say:

'I think you should sort this out by visiting some friends'

even if this is a perfectly logical and sensible solution to the problem. Instead, say:

'Now we've identified an area you want to tackle: how do you want to go about it?'

Often, it is difficult to identify solutions and you may need to assist the person either through more questions, or through more direct advice.

- Identify key social supports so that the person can be made aware of the people who care about them.
- Identify individual strengths, such as examples from the person's past which illustrate their coping skills.
- It is important that you are familiar with all the helping agencies in the area so that practical advice for specific problems may be given (a list of all helping agencies in your area can be entered in the resources section at the end of this manual (☞ Chapter 15).

- You may need to take a more direct role with some people, for example, by writing letters to other agencies on behalf of a person who is unable to read and write.
- You may need to provide ideas for solutions to the person's problems, especially at the beginning of the treatment. However, efforts should be made to get the person to take a leading role in problem-solving at some stage.

Briefly review all that has been covered during the meeting with the person. In particular, review the target and plan for problem-solving.

Step 6. Review, encourage and support

The main aims of the subsequent sessions are:

- to evaluate how well the person managed in trying to solve the target problem
- if progress has been made, to apply new solutions to the same problem or look at solutions to a new problem
- if progress has not been made, to identify what went wrong, discuss ways to address that (☞ 5.11.3) and set new goals for problem-solving.

5.11.3 Challenges

There are some problem areas which may seem especially difficult to deal with, and you may need to provide specific advice in case the steps listed above do not lead to a successful outcome. You can find suggested solutions in other parts of the manual in relation to specific problems such as:

- violence in the family (☞ 10.1, 10.2)
- loneliness and isolation (☞ 7.6.4)
- bereavement (☞ 10.4)
- relationship problems (☞ 5.15)
- alcohol and drug problems (☞ 3.5, 9.1, 13.8)
- caring for a family member who is ill (☞ 12.6).

5.12 Relaxation exercises

Relaxation is a useful way of reducing the effects of stress on the human mind, in particular, helping reduce anxiety and tension. There are two

main approaches to relaxation: muscle relaxation and breathing exercises. Before you teach these exercises to anyone else, try them yourself. You will feel relaxed and calm. It is one treatment which the health worker can take without feeling they have a sickness!

5.12.1 When to use relaxation exercises

Relaxation exercises are recommended for people who feel tense, irritable, distressed or worried, or who are suffering from multiple physical complaints. Both approaches are effective, but some people prefer one over the other. For a person who is panicky and anxious, breathing exercises

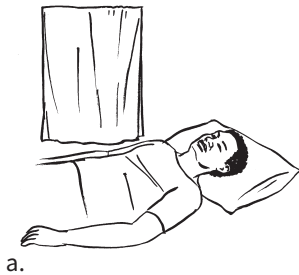
may be most helpful. For a person with multiple physical complaints (especially headache) and muscle tension, muscle relaxation may be most helpful.

5.12.2 How to use relaxation exercises

Box 5.11 contains advice on the two most popular relaxation methods. The diagram on the following page illustrates how to do breathing exercises.

5.12.3 Challenges

Relaxation exercises need to be practised every day if they are to be effective.



- Lie down in a room that is quiet and where you will not be disturbed.
- Close your eyes. Concentrate your mind on your breathing rhythm.
- Now, concentrate on breathing slow, regular, steady breaths through the nose, taking a deep breath in.
- Then let go of the breath slowly.

Try to spend at least 10 min a day doing this exercise.

BOX 5.11 RELAXATION EXERCISES

- These exercises can be done at any time of the day.
- They are best done in a room which is quiet and where the person will not be disturbed. The person must try to devote at least 10 min a day to the relaxation.
- Explain to the person that if they practise daily, they will begin to feel the benefits of relaxation within 2 weeks. With adequate experience, they may even be able to relax in a variety of situations, for example, while sitting on a bus.
- Begin the exercise by sitting in a comfortable position. There is no special position; any position which the person finds comfortable is the right one.
- The person should close their eyes.

Breathing exercises

- After about 10 seconds, the person should start concentrating their mind on their breathing rhythm.
- Now, the person should concentrate on breathing slow, regular, steady breaths through the nose.
- If a person asks how 'slow' the rhythm should be, you can suggest that they should breathe in until they can count slowly to three, then breathe out to the count of three, and then pause for the count of three until they breathe in again.
- You can suggest that each time the person breathes out, they could say in their mind the thought 'relax' or an equivalent thought in the local language. A person who is religious can use a word which has some importance to their faith. For example, a Hindu could say 'Om'.

- Demonstrate to the person how to breathe steady, deep breaths.

Muscle relaxation

- Start by asking the person to clench their toes as tightly as possible. Ask the person to count to three while keeping the toes clenched and then slowly relax.
- Ask the person to pay attention to how the muscles feel as they are unclenched.
- You can ask the person to breathe in deeply as they clench their muscles and then exhale slowly as they relax the muscles. Some people may struggle to do both at the same time. If that is the case, focus on the muscle clenching and relaxing.
- Next, ask the person to pull their toes towards them as tightly as possible so that the calf muscle is stretched, hold for a count of three and then relax.
- This process should be repeated for different muscle groups, slowly working up the body (thighs, buttocks, abdomen, chest, back, shoulders, neck, mouth and jaw, eyes and cheeks, forehead, upper arms, hands), with particular focus on muscles which become tense when a person is stressed, including the face muscles (screw up the face, then raise eyebrows as high as you can), the neck (bend the head forwards with chin on chest), the arms (bend at the elbow), the back (hunch forwards), the legs and then the feet.

5.13 Getting active

5.13.1 When to use ‘getting active’

Mental health problems commonly lead to a person withdrawing from social contact and stopping activities that they used to find enjoyable. This is particularly a problem in people with depression. The ‘getting active’ strategy can work for anyone who seems to have got stuck in a cycle of inactivity.



Getting active by meeting friends can improve mental health.

5.13.2 How to use ‘getting active’

Step 1. Explain about ‘getting active’

For a person who is feeling demoralised and lacking energy, the effort of continuing activities may be too much and it is easier to just stay at home all day. The problem with this is that people get stuck in a vicious circle. They don’t go out and so they miss out on the experience of doing activities that might make them feel better. Imagine how you would feel if you just stayed at home all day and didn’t speak with other people – even if you were not depressed, it would make you feel sad. This is exactly what happens. People also tend to lose self-confidence as they get out of the habit of being active. The ‘getting active’ strategy is about supporting people to restart rewarding or pleasurable activities so that they have some good feelings and slowly start to enjoy life again.

The goals of ‘getting active’ are to help treat depression and depressive symptoms (for example, low mood and low self-esteem) by:

- increasing the person’s involvement in activities that make them feel rewarded and satisfied, and
- supporting people not to avoid essential activities.

Step 2. Identify rewarding activities

Ask the person about activities that they used to find enjoyable or rewarding but no longer do because of their mental health problems. If somebody is very depressed they may find it difficult to remember anything positive and say ‘I never enjoyed anything’. Understand that this is probably the depression talking. You may need to prompt

the person with the types of activities that usually give people some pleasure or sense of reward, for example:

- going for a walk
- playing with children/grandchildren
- meeting with friends for a coffee
- going to see a film
- going to a religious meeting
- listening to music.

Once you have a list of activities, ask the person how many times they did any of the activities in the past week. Identify which activities they avoided.

Step 3. Plan activities

The next step is to make a plan with the person for them to do some activities in the next week. The person should start with activities that they find easier to do. In a very depressed person, going out for a 10 min walk every day may be the most that they can manage. You need to ask the person exactly when they plan to do the activity (e.g. Monday afternoon meet a friend for coffee and a chat). Make it clear to the person that they need to do the activity even if they don’t feel like it. The idea is that they will start to feel better after they start doing the activity.

It is important to motivate the person to really try to do the activities. When people feel depressed they may struggle to cope with the planning required for the activity. You can help the person by breaking the plan down into smaller steps. For example, making contact with the friend to arrange to meet, deciding where to go,

deciding what to wear, planning to get ready to go out at the right time, and so on.

Step 4. Link activities to feelings

Ask the person to keep a record of which activities they did (whether they did them fully, partially or not at all). Also, ask the person to take notice of how they felt before and after the activity. One way is to ask the person to rate their mood on a ten-point scale, where 1 represents feeling very sad, 5 represents feeling all right and 10 represents feeling very happy. If the person is unable to read and write, this could still be done using pictures.

Every week that you review the person, look at how the activities have affected their mood. Give the person clear feedback about the pattern of improving mood. Identify activities that seem to be having the most positive impact and encourage the person to increase the frequency of these activities.

Step 5. Tackle avoidance

Take note of any specific activities which the person seems to be avoiding, for instance, socialising with people they don't know very well. These avoided activities are usually the more difficult ones, so it may just be a case of building up to doing them when the person has got a bit more confidence. On the other hand, it may be necessary to discuss with the person about the barriers to doing these activities. You may find it helpful to use a 'problem-solving' strategy (5.11).

Here is an example of how a therapist might approach avoidance in a young student who is depressed.

Counsellor I understand that you tried a lot of activities that we agreed on. I am curious what happened to your walk in the park?

Person I didn't go.

Counsellor Could you tell me more about that?

Person I was struggling with my maths homework and did not find the time to go in the morning. And, when I start studying, I don't feel like leaving my room.

Counsellor So, do I understand that you also didn't have time in the evening?

Person It is too dark.

Counsellor When do you get up in the morning?

Person Around 8 a.m.

Counsellor When do you start studying?

Person Not before 11 a.m.

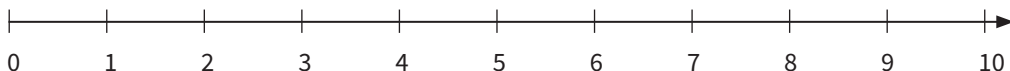
Counsellor I was wondering if you can possibly go before you start studying?

Person Hmm... yeah, that's possible.

Counsellor Great! So can I put that in the plan we have worked out?

Step 6. Use these steps for other situations

Once the person has started to do more rewarding activities and is experiencing improvements in their mood, talk about how this approach can be useful for them in other situations and in the future. Jointly list situations which could possibly trigger them to avoid or withdraw from activities and then list the skills practised in 'getting active' that would help them to make sure that they keep active. For example, a student could tell you that one of the situations that could trigger a decrease in enjoyable activities (e.g. exercise) is worrying about preparing for exams. In this case, you could talk about how stopping exercise could be the worst thing to do at a time of stress. Instead, planning to exercise every day, even when the student is worrying about exams, is necessary and will make the stress less.



| Measuring feelings.

Step 7. Review, encourage and support

Follow the general advice given in 5.9.2. If the person was not able to try ‘getting active’, check for the reason (⇨ 5.13.3) and support them to work out a more realistic plan.

5.13.3 Challenges

- **Trouble understanding the method.** To address this, you need to communicate the method specifically and clearly. For example, instead of generally telling the person to ‘enjoy yourself more’, you should take time to explain how withdrawing from activities affects the person’s mental health, identifying specific activities that the person enjoys and the specific steps that make up the activity.
- **Lack of skills.** A person may have difficulty completing an activity not only owing to avoidance but because they lack a required skill (e.g. the person may not engage socially because they lack communication skills). In such situations, consider another appropriate strategy (e.g. improving their social skills ⇨ 5.22) before giving them the task of socialising.
- **The activity is too difficult.** A common route to failure is missing the rule of thumb of ‘starting small’. A realistic assessment of how difficult the activity is prior to setting it as a goal will maximise the likelihood of success.

5.14 Thinking healthy

People with mental health problems can sometimes have the problem of ‘thinking too much’, for example, worrying constantly about something or having repeated negative thoughts. ‘Thinking healthy’ is a strategy which helps the person to spend less time thinking too much and helps them to think in a more positive way. This, in turn, helps them to feel better and get back to doing their usual activities.

5.14.1 When to use ‘thinking healthy’

This strategy is useful for people who have the

following types of thoughts:

- negative thoughts, for example, ‘I am a failure’, ‘Nobody likes me’, ‘There is no future for me’, ‘I have messed up my life’
- worried thoughts, for example, ‘What would happen to my family if I die?’, ‘What will happen if I don’t pass this exam?’, ‘Will I ever find a husband/wife?’ (general worries); ‘This tiredness means that I have cancer’, ‘There is something wrong with me that the doctors are missing’ (health worries).

People who ‘think too much’ cannot get the negative or worrying thoughts out of their head. The thoughts just go round and round, making them feel worse and stopping them from doing things that might otherwise make them feel better (e.g. spending time with family or friends). It can be frustrating as a health worker or as a family member. But just telling people to ‘Stop thinking too much’ or ‘Stop worrying about nothing’ or saying ‘Why do you always dwell on the negative side of things?’ does not help. We need a structured approach so that we can help people to be ‘thinking healthy’.

For people who have terrifying worries that happen in a moment of panic (e.g. ‘I’m having a heart attack’, ‘I’m going to die’, ‘I’m going crazy’); for people who have fearful thoughts about specific situations or things; and for people who have the same distressing thoughts again and again (e.g. that their hands are dirty), often accompanied by the urge to repeat a particular behaviour (hand-washing), use the method in ⇨ 8.2.

5.14.2 How to use ‘thinking healthy’

Step 1. Identify the effects of thinking too much

First, it is important to identify and highlight the effects of thinking too much.

- Thinking too much may be such an automatic experience that the person may do it without realising how negatively it is affecting their life. We can help the person see the effects of thinking too much on how they feel.

We may say:



I Thinking too much.

‘Anjana, when you are in bed thinking again and again about the pains in your back and the demands at your job, how do you feel? What about when you get up to prepare dinner for the family? Do you feel more or less tired?’

Or we may say:

‘Anjana, when you think all of the time about the mistakes you think you have made in your life, how do you feel? Does it make you feel more or less happy about yourself?’

In these ways, we can begin to help people to understand the impact of thinking too much about how they feel.

- The person may also believe that thinking too much is helpful in overcoming their problems. We can help the person to see the effects of thinking too much on the problems in their lives. We may say:

‘Anjana, we have talked about how you stay on your own and think again and again about your husband. It does not appear that this is helping you to solve the problems you and he face. Would you agree with that? I know it is hard to change the habit of thinking too much, but one of the first steps is noticing that it does not often solve your problems – even though it seems like it will.’

- It may be important to help the person to learn to ‘catch’ themselves when thinking too much and notice its effects at that moment in time. We may say:

‘Anjana, the first step in changing the problem of thinking too much is realising when it is happening. This week, I would like to suggest that you notice one time each afternoon when you are thinking too much and how you feel in that moment. Would you be willing to practise this?’

Step 2. Guide the person to learn actions to take to stop thinking too much

Second, it is important to guide the person to carry out some alternative actions when they notice that they are thinking too much. There are three main options in dealing with thinking too much.

A man was not selected for a job and had these thoughts:

- ‘I’m useless. I will never get a job.’
- ‘I will always be unemployed and poor. No one will marry me if I’m jobless.’
- ‘I may as well end my life.’



a.



b.



c.

The resulting emotions are those of unhappiness and depression.

Now, look at alternative ways of seeing this situation:



a.



b.



c.

- ‘There is a recession on and many people are finding it hard to get a job.’
- ‘I can see that my application was not well written and I should get some help before applying again.’
- ‘Well, I didn’t get the job, but there will be many more opportunities. I have held jobs in the past and done well.’

The resulting emotions may be more hopeful.

Problem-solving

It is often valuable to help define the problem that the person is thinking too much about and then outline steps towards active problem-solving (☞ 5.11). For example, we may teach Anjana to define the problems that she thinks about over and over and work on solving these problems in our sessions, focusing on how to talk with her husband in more useful ways, how to get support from her neighbour, and how to reduce demands at work.

Taking note of our senses

Thinking too much automatically shifts the person's focus from the present moment (what we are doing, what is going on, who we are with) to the negative or worrying thoughts that are going round and round in their head. Sometimes a person who thinks too much can even seem selfish or self-absorbed, as if they are only interested in what is going on in their head.

We can teach the person to refocus attention on what is happening outside their head by helping them to pay more attention to what their senses are telling them about the immediate environment, for example, sounds, smells, sights, tastes or touch. To teach this strategy to the person, do the following.

1. First, explain the purpose of this strategy:

'We will be learning a technique today that can be helpful when thinking too much is a problem. It is a way you can practise keeping your



mind focused away from your thoughts and on what is happening outside by directing your attention to what you feel, see, smell, hear, etc...'

2. Second, ask the person to focus on one of their senses as you guide them in practising the strategy in the session. For example, we may ask the person to take note of the room in which we are sitting, and to describe all of the colours that they see in the room.
3. Third, ask the person about what they experienced when carrying out the exercise. What were they thinking about when they described the colours? How did it make them feel? Practise with another example, such as getting them to focus on what their body is touching (e.g. the chair) and describe the texture and surface. Highlight to the person how this technique breaks the cycle of only being able to focus on thoughts.

Distracting

Distraction from thinking too much can help to shift the person's focus so that they can notice something new or different in the environment. Some helpful activities to explore with the person include: physical activities (brisk walking,

fast-paced household chores), activities that shift location (visit a neighbour, take a walk) and activities that are engaging (watching a funny movie, talking with a close person). This kind of approach can also be combined with the strategy of 'getting active' (☞ 5.13).

It is possible to plan such activities in advance by identifying the situations in which the person commonly thinks too much and thinking of something they can do to distract themselves when in that situation.

Step 3. Learn how to challenge thoughts that are negative or worrying

Thinking worrying thoughts makes us more worried, and thinking negative thoughts makes us feel

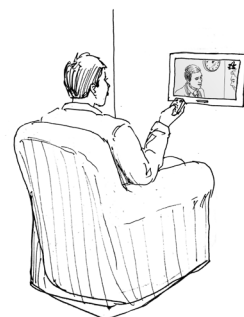


TABLE 5.5 EXAMPLE THOUGHT DIARY

Day	Time	What am I doing?	What am I thinking?	How do I feel?
Monday	8am	Having breakfast	I'm lonely	Mood 2 out of 10
Tuesday	----	-----	-----	-----

more sad and negative about life. But people with mental health problems can get into the habit of thinking negative or worrying thoughts without even realising it. We can help people to get out of unhealthy thinking habits in the following ways.

1. Get the person to notice when they are slipping into unhealthy thinking

Ask the person to keep a diary of the thoughts that are going around in their head and the way they made them feel on a score of 1 to 10 (1 is worst) using the scale from p. 78. Also ask the person to note what was happening at that time (to try and identify triggers for unhealthy thoughts). For example:

Wednesday afternoon: Thinking about what a failure I am as a mother
 Mood: very sad (crying) 1 out of 10
 Situation: Son came back from school and mentioned that he had been told off for being disruptive in class.

2. Get the person to challenge the unhealthy thoughts

Ask the person to consider how realistic or accurate the worrying or negative thought is. Try this approach:

‘How convinced are you that your negative thought that you are a bad mother is true? Tell me on a scale of 1 to 10 (1 not true at all, 10 definitely true).’

‘OK, let’s think of it another way. If your friend told you that she was thinking she was a bad mother because her son was naughty at school, what would you say to her?’

‘You have assumed that you are the reason for your son getting told off. Can you think of other reasons that he got told off? Perhaps it was

his own fault? Perhaps his friends got him into trouble? Perhaps the teacher was having a bad day and shouted for no reason? Could these be possible explanations?’

‘OK, now that we have tried to think of different explanations for why your son might have been told off at school, how convinced are you now that the negative thought that you are a bad mother is true? Tell me on a scale of 1 to 10 (1 not true at all, 10 definitely true).’

Usually, by going through this process, the person is able to see that there are other ways of seeing the situation that are more positive or less worrying. This, in turn, means that the thoughts have a less negative effect on the way that they are feeling (don’t make them feel so sad or anxious).

Step 4. Practise and learn

Progress is much faster if the person practises trying out these techniques at home. Ask the person to practise at home by developing a plan for when and how long they will practise. The time and place can be linked to the settings in which the person is most likely to be thinking too much, but it can also be helpful if the person starts to practise at times that are not the most challenging in order to build their basic skills. Also, remember to ask about what might get in the way of practising and solutions that might help.

Step 5. Review, encourage and support

Follow the general advice about how to review, encourage and provide support ↗5.9.2.

5.14.3 Challenges

When a person is very low in mood or worried, or when the thoughts are extremely distressing, they may struggle to use this type of counselling. In

such cases, it may be better to try a medication first and come back to ‘thinking healthy’ when the person has improved.

‘Thinking healthy’ may be difficult for some people to understand. Other counselling strategies, such as ‘problem-solving’ or ‘getting active’, may be more suitable for such people.

Keeping a diary of thoughts and feelings is not possible if the person cannot read or write. However, you can still try to get them to identify patterns between the situation that they are in, the thoughts going around in their head and how they feel (their mood). A visual chart can also be used (☞ p. 78).

5.15 Improving relationships[†]

Problems in relationships can act as triggers for many mental health problems. For example, the ways people interact and communicate with others can affect their mental health. Some depressed people have difficulty asking others for help, and this makes them feel isolated or overwhelmed by their problems. Others have difficulty saying ‘no’ to other people’s demands or requests and thus find themselves doing things they do not want to do, feeling pressured and becoming ‘cranky’.

5.15.1 When to use ‘improving relationships’

When counselling a person who is distressed, if you identify that the person’s distress is related to relationships with significant people in their life, you can use this strategy to help the person find better ways of dealing with their relationship problems. These relationship issues usually fit within one or more of the following categories:

- serious disagreement with someone important in the family, or in a social or work setting
- grief – death of a loved one
- any life change, bad or good, that has led to relationship stresses (e.g. change of residence, marriage, loss of job, birth of a new baby)
- loneliness and social isolation that results in feeling cut off from others.

[†]With Neerja Chowdhary.

5.15.2 How to use ‘improving relationships’

You can identify which area of the person’s relationships is acting as a trigger for their mental health problem by asking:

‘Please tell me about these problems you have been having with the relationship with your... (husband, mother, boss, etc.).’

Then try to identify which of the four categories the person’s relationship problem fits into. It is important to note that people may have problems in one or more category, in which case you, along with the person, need to decide which area to focus on first. You can say:

‘Based on what you have told me, it seems that your health problems are related to what has been going on in your life, in particular, the grief you are experiencing following the death of your mother. What I suggest is that over the next few weeks we focus on this problem and identify ways you can cope with it better. As we do this, you will find your health problems improving.’

Or:

‘Your health problems seem to be related to the stress you are experiencing due to the frequent quarrels with your husband over your wanting to find a job. We will, over the next few weeks, discuss how you can deal with this better so that the situation improves and you feel better.’

The techniques to deal with each category of relationship problem are described below.

Disagreements

One source of stress for many people is the challenge of communicating effectively with other people in their lives. You can teach the person some simple communication methods in the session and then ask if they are willing to practise these at home. There are three steps.

1. Problem solve

The first step is helping the person to identify clearly what they want or do not want. For

a.

Your mother is NOT welcome in this house!



Can we discuss about your mother coming to stay?

b.



I Finding the right words for better relationships.

example, a woman who is feeling hopeless about a conflict with her daughter may be encouraged to identify what exactly she would like from her daughter (e.g. wanting her to visit more often). The steps described in the section on problem-solving (⇨ 5.11) can be used here.

2. Communicate

The second step is teaching the person how to communicate clearly and effectively. Often, it is helpful to:

- focus on the current quarrel and not talk about all the mistakes the other person has made in the past;
- separate the other person from her behaviour – using the words ‘Your words were very hurtful’ leads to more constructive discussion than using the words ‘You are an unkind person’;
- acknowledge the other party’s expectations; the daughter could say: ‘I know you feel like I am not paying attention to you’;
- use ‘I’ statements about how the mother feels and what she wants; for example, she could say ‘I feel angry when you behave like this’ rather than ‘You make me angry’;

- avoid using words such as ‘always’ and ‘never’, for example, ‘You never listen to me’ or ‘You always shout when things don’t go your way’.

3. Practise

The third step is creating opportunities to practise these skills in action. You can do this in the session by acting out the situation with the person. For example, say, ‘I will be your daughter. I am calling you on the phone now. Hello mother, I can’t visit you this weekend. We are really busy. Maybe I will come next weekend... OK?’ The person is then asked to respond using the communication skills described above. If the person doesn’t respond, she may require more coaching; you could say, ‘So, what if you were to say...’ and then continue acting out the scene with the person so she has an opportunity to practise saying those words.

Grief

Some people struggle to cope with the loss of their loved one to the extent that it affects their mental health (⇨ 10.4). You can help the person who is in mourning by helping them to come to terms with their loss and re-establish interest in everyday life and activities. It is helpful for you to:

- encourage the person to talk and express their sadness about the loss
- ask the person to describe the events just prior to, during, and after the death
- discuss their relationship with the person who died
- discuss both positive and negative feelings that the person had about the loved one who died (‘Every relationship has rough times. What was your rough time?’)
- discuss how the future looks without the deceased, including the unrealised plans and the change in the person’s social/family status after the death
- encourage reaching out to other people who are supportive and encourage the person to get involved in activities that are pleasurable or relaxing (⇨ 10.4.3).

Life change

Changes in a person’s life may increase stress

owing to the effects they have on important relationships. For example, a promotion at the workplace, while a positive event, can mean a change in interactions with colleagues and less time with friends and family owing to increased work pressures. More commonly, the life change is due to negative events such as becoming unemployed. You can help the person who is going through such a life change in the following ways.

- Discussing positive and negative aspects of the old role. People may exaggerate the positive aspects of the old role and minimise the unpleasant aspects. It is important to draw their attention to both to help them to be more realistic.
- Express their feelings about the change, such as guilt, anger and fear at the loss.
- Discuss the positive and negative aspects of the new role. Explore opportunities that exist in the new role.
- If no positive aspects can be identified, help the person determine what is within their control. Even in the most negative circumstances, people will be able to identify something that they can do to feel better, for example, learning to make the most of their time when faced with a serious medical illness.
- Help the person develop new skills that they will need in the new role, for example, helping them to manage the change effectively by finding a new job, meeting new people.
- Help the person identify supportive people to help them manage the new role.

Loneliness and social isolation

Sometimes, distress can occur when the person experiences loneliness due to difficulty in making friends, or in sustaining friendships, owing to poor social skills or feeling depressed. Your role is to encourage the person to form new relationships (⇨ 5.18.1). This can be done by:

- Exploring current social interactions by asking about family and friends, e.g.
‘How often do you see them?’ ‘What do you enjoy about seeing them?’
- Finding out the problems in social interactions.



Does the person have trouble starting and/or maintaining relationships?

‘What are the problems that come up in your interactions with...?’

- Act out the social situation that the person finds difficult and give feedback and advice.
- Encourage social interaction, and have the person describe how the experiments from the previous week went.

‘This is a good time to try and work on your relationships. We can talk about what goes right or wrong when we meet next week.’

- If the person contacted an old friend and arranged to see them, you can ask:

‘Describe how it went. How did you feel? What did you say?’

Each such description provides an opportunity for you to refresh in the person’s mind the positive steps they have taken, provide encouragement and try acting out interactions that have not gone well.

5.15.3 Challenges

Some relationship problems may not respond to attempts by the person to improve communication. In such circumstances, it is necessary to work with the person to help them accept this and use the problem-solving strategy (⇨ 5.11) to define what changes need to be made in the relationship. Some people may have problems with

their social skills which make it difficult to carry out some of the interactions with other people to address relationship difficulties; try social skills training with such people (⇨ 5.22).

5.16 Controlling anger

5.16.1 When to use ‘controlling anger’

Anger can be justifiable and an important emotion for action against an injustice. But some people find it difficult to control their anger. They get angry for no good reason, or with only the slightest reason (too quick to anger) or to an excessive degree. A person may seek help for anger when it affects their relationships or leads to problems at work, or even gets them into trouble with the police.

Anger and irritability can be a sign of depression, especially in men, adolescents and the elderly. In that case, treat the depression first.

Anger has a two-way relationship with drug use, especially with alcohol. A person who has difficulty controlling their anger may drink alcohol to try to calm themselves down, but alcohol can also make people more likely to react with excessive anger. If a person has both anger problems and a drug use problem, try to tackle both at the same time (⇨ 9.2).

A person who is experiencing psychosis and believes that people are trying to harm them may get angry, although the anger is understandable in relation to the person’s beliefs. A person who is manic may also be irritable and quick to anger. In both of these cases, treat the underlying mental disorder first.

5.16.2 How to use ‘controlling anger’

Step 1. Educate the person about anger

The goals of controlling anger are to:

- identify the person’s difficulties managing anger
- increase the person’s understanding of the factors that trigger anger



- equip the person to be able to cope better with anger-arousing situations.

Start by explaining that anger is a normal emotion and that there are socially acceptable and unacceptable ways of expressing anger. Ask the person to tell you about a recent angry episode. What was the cause? How did they feel when they were angry? What did they do when they were angry? What were the consequences of the anger for them?

Help the person to identify how angry feelings make their body react. The most important step in controlling anger is recognising the first signs of anger. These may be feeling hot in the head, angry thoughts, heart beating fast, fists clenching and feeling tense all over the body.

Ask the person for examples of when someone used an angry tone with them, and compare these episodes with how the person felt when someone used a calm tone with them. Explain to the person about the ‘cycle of anger’. With the cycle of anger, a person is already experiencing anger before any provocation comes along. They are tense and ‘looking for a fight’. Even a neutral comment can be quickly misinterpreted, the person’s anger gets out of control and leads to an angry outburst (an ‘explosion’). The consequences of the angry outburst make the person feel worse and more likely to continue in an angry frame of mind.

Step 2. Motivate the person to control their anger

A person may have mixed feelings about trying to control their anger better. It may have become a habit that they no longer notice. They may feel



justified in their anger and blame everybody else. They may have the idea that anger is not something that can be controlled. Approaches described in ‘motivating people to change’ (⇨5.17) may be a necessary first step. Some helpful messages that might encourage a person to work on controlling their anger are as follows.

- Anger is damaging to your health and to your life. Learning how to control it is an important way of improving your life.
- Anger can be controlled. Some people say ‘I just cannot control what I do when I get angry’ or ‘I just see red’, but this is not true. You can learn to control your anger better.

Step 3. Teach techniques to delay or avoid an angry response

Discuss with the person the different techniques they could use as a way to either delay their angry response or avoid it altogether.

- Ignore or walk away from the provoking situation (e.g. if you become angry while talking to your wife, leave the room she is in).
- Attempt breathing exercises (pp. 75, 76).
- Count backwards.
- Replace aggressive responses (staring, making demands, threatening gestures, using harsh tones) with alternatives (non-threatening eye contact, appropriate gestures, a calm tone of voice, gently requesting a change in the other person’s behaviour).
- Using ‘positive self-talk’ during a conflict situation (e.g. ‘keep cool’, ‘don’t get too angry, it isn’t worth it’).

- Wait until your mind feels calm and only then continue what you were doing.
- After the anger has passed, plan to tell the person your thoughts to try to reduce the conflict.

Step 4. Keep a record of angry episodes

Ask the person to keep a record of angry episodes before the next appointment. Ask them to take note of what caused the episode, the angry behaviours they expressed and the consequences.

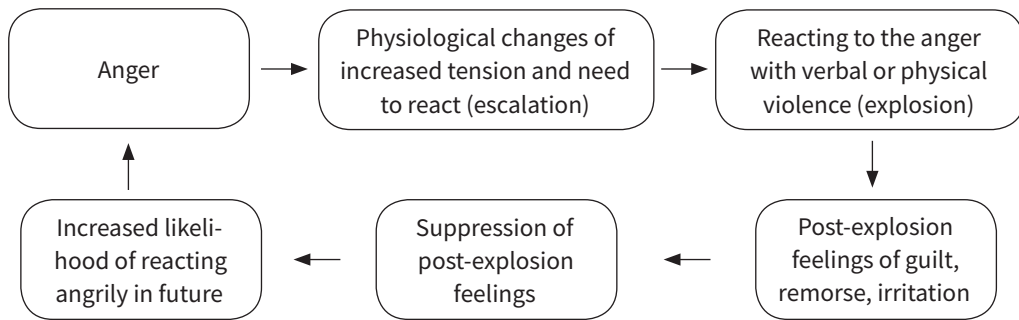
CASE 5.1

Rafael describes an episode in the past week when he was at work. His boss came into the room and looked across at what he was doing. Rafael immediately felt angry that his boss seemed to be singling him out. ‘Why should he look at me?’ In response, he shouted across the room ‘What are you looking at?’ in a hostile voice. When the boss said nothing Rafael got up from the seat, walked over to his boss and stared into his eyes, threatening ‘What is your problem?’ He could feel his heart pounding and felt like striking the boss, but his co-workers pulled him away from the confrontation. He has now been given a warning from his boss and is in danger of losing his job.

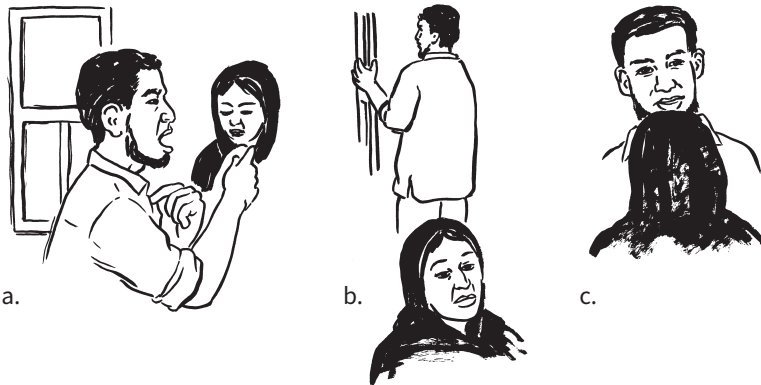
Step 5. Review, encourage and support

Review the episodes with the person and use a problem-solving strategy (⇨5.11) to find alternative, more socially acceptable ways of reacting to these triggers. It is very helpful for the person to role-play different ways of reacting. It helps them to get the feel of how to do it. You can also identify potential problems and find ways around them.

For example, you could ask the person ‘Looking back, how do you think you could have behaved differently?’ If the person cannot think of any alternative behaviours, go through the techniques described in step 3 and ask them which one they would feel comfortable trying. In case 5.1, Rafael says he could have counted backwards when he first noticed his boss looking at him. He could then tell himself, ‘He is not just looking at me’. If he still felt angry, he could leave the room to cool off for a few minutes (he could make the



I Cycle of anger.



Managing anger:

- a. Be aware of your feelings of anger.
- b. Leave the room or place where you are beginning to feel angry.
- c. Return only when you feel calm and able to solve your difficulty without losing your temper.

excuse that he needs to use the toilet) or he could try finding out what the boss wants without being confrontational, for example, saying ‘Good morning, is everything OK? Do you need anything from me?’

Now practise this with the person. Ask the person how he feels as he does the role play. Does he feel in control of his anger? Try to find ways to stop the anger building up in the first place. That means helping the person notice the signs that he is starting to get angry.

At the next appointment, don’t forget to ask the person ‘Did it work?’ and, if so, ‘Why did it work?’ If it did not work, ask ‘Why not?’ If the person’s approach to anger management did not work, try to generate new solutions together. Keep encouraging the person by acknowledging successes with positive feedback. If the person’s efforts to manage his anger have failed, reassure them that they have at least tried and that together you will come up with alternative solutions, practise them through role play and review their efforts.

5.16.3 Challenges

Other people may think the person has an anger problem, but the person themselves may believe that the real problem lies with others. This may make them hostile towards you and reluctant to work at controlling their anger. Always take care of your own safety (☞2.2.1). Try techniques to motivate the person to change (☞5.17). If that doesn’t work, just make the person aware that you are available to help them if and when they are interested to try to control their anger.

5.17 Motivating for change

People commonly have mixed feelings about changing their behaviour in the ways that doctors would like them to do, for example, reducing alcohol intake, taking more exercise, stopping smoking, taking their medication as prescribed or cutting back on fatty foods. It is not because people

are stupid or because they are deliberately defying medical advice. On the contrary, people often continue to behave in a certain way because, as well as the downsides, there are some benefits to them of continuing with the behaviour. People may also have given up thinking that they can do anything to change their behaviour. A counselling approach that can be very helpful in this situation is ‘motivating for change’.

5.17.1 When to use ‘motivating for change’

This is especially useful for people with an alcohol or drug use habit, but also for those who have other unhealthy behaviours or lifestyles affecting their health, such as poor diet and lack of exercise, or when a person does not wish to take medications which are needed for a mental health problem.

5.17.2 How to use ‘motivating for change’

Step 1. Express empathy

Use your communication skills of warmth, active listening and a non-judgemental attitude. This is necessary so that the person can trust you and feel comfortable to speak openly.

Step 2. Support the person to make their own arguments for changing

Instead of trying to convince the person of why they should change, try to get the person to convince themselves. Ask the person to tell you all of the reasons that they continue with the behaviour and the things that they like about it. Then ask

them whether there are any negative sides to the behaviour. For example:

‘Can you tell me what you like about drinking? What are the good things about drinking for you? Now can you tell me about any downsides of your drinking?’

If the person cannot tell you any downsides to drinking, you might need to prompt them about common areas affected by drinking. Make a list of all of the reasons that the person gives you.

Then ask the person to weigh up the benefits and disadvantages to continuing drinking. Listen for examples where the person’s values and what they care about most in life are affected by their ongoing drinking and try to highlight this inconsistency in a non-judgemental way:

‘So, it is really important to you to be involved in your children’s upbringing, but drinking alcohol all the time interferes with that.’

Step 3. Don’t get into conflict. Be prepared to let the person change at their own pace

Don’t get into conflict when the person resists changing their behaviour. It is not easy to change our habits. Trying to force people to change or trying to make them feel guilty is almost always counterproductive. Change can only happen if the person decides to change. This can be difficult for health workers to understand. To us it might seem obvious that a man who has breathing difficulties should stop smoking cigarettes. We may mistakenly believe that this is a simple decision and we just need to tell the person strongly. But this does not work.

Step 4. Help the person to believe that they can change

Talking positively about change can help to bring change about. So, when a person says ‘I have managed to lose weight in the past, so maybe I can do it again’, make sure you give them encouragement. ‘Yes, you have done it before’. If the person does not talk about change, try to ask a

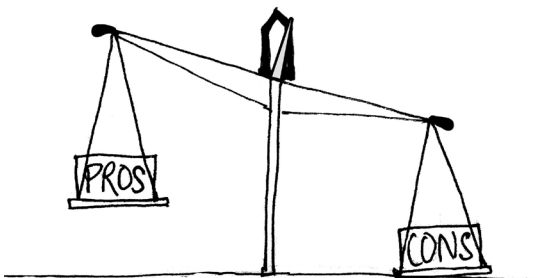


TABLE 5.6 EXAMPLE OF THE PROS AND CONS OF CONTINUING TO DRINK ALCOHOL

Pros	Cons
I just like the feeling	My wife is threatening to leave me unless I stop drinking
It gives me the confidence to socialise with people	I am missing out on bringing up my children
It helps me to forget about my problems	It is affecting my physical health
All my friends drink	I don't like the feeling of having to have a drink to feel normal
	It makes me get into fights
	My grades are going down and I may get thrown out of university
	If I get caught for drink-driving one more time I will lose my licence

question that will get them talking about change. For example:

‘You have told me while we have been discussing your drinking that your liver is being affected, and that your drinking is causing you some problems both at home and at work. Has that made you think about changing your drinking at all?’

‘Is there anything that you have tried in the past, on your own, to change your drinking?’

‘Is there anything about your drinking that you want to change?’

Then follow up by asking whether the person has any ideas about how they could change. The purpose of this is to convince them that they are the best person to know what could work for them. Help the person to think through their plans for change to make them sure that the goals are SMART (⇨4.5).

Step 5. Review, encourage and support

Meet with them regularly to review progress and continue working in partnership. Setbacks are inevitable and your role is to help the person to learn from their mistakes and be encouraged to keep trying.

5.17.3 Challenges

The most common challenge is that, despite your efforts to use this method, the person does not want to change. They are simply not ready for this, in which case you should not be judgemental. Instead, reassure the person that your door is always open for them to return at any time should they wish to restart the process. If a person is depressed, they may struggle to have enough self-belief and hope to try and change. In that case, it may be necessary to treat the depression first or tackle their negative thoughts (⇨5.14). Similarly, if a person fails to change an unhealthy behaviour, or if they relapse, despite having tried hard to stop it, they may lose hope in their ability to change. It



is important to reassure the person that such an experience of 'failure' is very common and that most people who persist with the effort will ultimately succeed.

Section III: Social interventions

5.18 General principles of social interventions

5.18.1 Increase social support

Mental health problems frequently disrupt a person's social activities and their support networks. Our social contacts, including with our families, friends and neighbours, are vital for mental health, for example, giving us opportunities to be distracted from difficulties, to feel part of our community, to be able to draw support to solve problems, and to have the chance to enjoy being with other people. For some people, religious institutions can be an important source of support.

Ask the person who they usually go to when they need support. If they say that there is no one to support them, then ask about who has supported them in the past. It is unusual for a person to have never had anyone to turn to.

Encourage the person to slowly start to increase their contact with people who support them. Remember that mental health problems can be a barrier to seeking the very support that a person needs. The person may be feeling demoralised, fearful of negative attitudes, or worried about burdening others with their problems, or they just might not feel like speaking to others. The steps used in problem-solving can be applied to address this challenge (⇨5.11). For example, start with something small and manageable, such as asking a trusted friend whether they can come around for a chat and a cup of coffee.

Explain to the person that increasing their contact with other people may be tiring for them at first and may not immediately make them feel better. The important thing is to keep doing it. Gradually, they will notice that it is helping them and, as their mental health improves, the social contact becomes easier and more enjoyable.

5.18.2 Get back into a routine

When a person develops a mental health problem, they may withdraw from the world and stop following the normal routines of day-to-day life. This is not the person's fault. It is a result of the mental health problem. Even so, withdrawing usually has the effect of making the problem worse. Explain this to the person. Encourage the person to start following personal and household routines, such as getting up at the same time as other people, maintaining personal hygiene, eating with other people, and spending some time outside the house every day. Physical exercise and getting some fresh air may also help the person to feel mentally better. Try to get the person to start doing activities that they used to enjoy, even if they don't feel like doing anything. If you have more time, you can use a 'getting active' strategy (⇨5.13), but even if you only have a few minutes, explaining the value of these simple things can help.

5.19 Specific social interventions

Most social interventions aim to support the person to realise their potential in a way that is defined by their values and priorities. Recovery, for many people, may include improving functioning and skills for independent living, meeting basic needs for food and shelter, promoting livelihoods, improving social skills, addressing stigma, discrimination and abuse, and supporting the person to integrate back into society (befriending). These specific social interventions are discussed in the next section. Support groups can promote recovery for individuals, but also serve as a force to mobilise and strengthen groups of people with mental health problems and their family members to advocate for a better deal.

5.20 Improving functioning and skills for independent living

5.20.1 When to use ‘improving functioning and skills’

Mental disorders and disabilities can undermine the person’s ability to care for themselves independently. They may not do anything useful with their day, either sitting doing nothing or wandering around aimlessly. This lack of productive activities is not good for recovery. When the mental disability is long-standing, the person may have lost their job and not adapted to new roles, or may be isolated from society owing to stigma, or may be overprotected by the family so that they are not encouraged to do anything with their time. Even when acute symptoms subside, the person may have got out of the habit of doing things for themselves or have lost confidence in their abilities. A process of re-learning and refreshing of daily living skills may be needed. In all cases, it is important to work with the person and, wherever possible, with the family to re-establish some routine to each day and to get the person doing things again.

5.20.2 How to use ‘improving functioning and skills’

If the person is willing, work with family members as well. Family members are your co-therapists. They can play a critical part in supporting and encouraging the person to move towards more independent living.

Step 1. Make an activity schedule

Explain the benefits of having the day structured with activities. This approach helps to give the person something to do, improves their self-confidence, enables them to contribute to the life of the household, distracts them from unpleasant symptoms, helps to improve concentration and memory, improves problem-solving skills and promotes greater independence.

With the person and family, make a structured plan for how the person will spend the day. Start from the time that they will get up. Try to agree



on a combination of work, rest, leisure, self-care and sleep. Focus on activities that the person and family value, as well as those which are pleasurable to the person. The activities also need to be graded appropriately for the person’s current level of functioning and should not be too long in duration.

The person’s preferences form the focus of the activities in this step, but the family plays a critical part in encouraging and supporting them to be able to achieve the plans.

Step 2. Set recovery goals

In ‘principles of treatment’ (⇨5.9, 5.18) we discussed how to set recovery goals with the person. The key is to identify goals that are valued by the person and which can be worked towards in a step-wise fashion.

A person’s recovery goals might be in the area of personal hygiene, education, work and livelihoods (⇨5.21), relationships, managing money, using public transport, living independently, dealing with stigma (⇨5.23), social skills (⇨5.22) or coping with symptoms.

Step 3. Work towards recovery goals

For the selected recovery goal, follow the steps used in problem-solving (⇨5.11). Thus, the first step is to break down the activities leading to achieving the goal into smaller steps. See the following examples of steps towards greater independence:

- improving hygiene: e.g. being washed by family, being helped to wash, washing with verbal prompting, washing independently without prompting
- managing money: being given the exact amount, being given more money and

accompanied to buy something, being given a monthly allowance to manage expenses independently

- using public transport: short trip with family, longer trip with family, family only buys ticket, person buys ticket and travels independently.

Discuss potential challenges and how they will be overcome. Agree on a specific (SMART; ↗4.5) target to achieve before the next appointment. Tell the family to support the person's motivation by providing them with positive feedback whenever they make an effort to do a step of the task, even if it is not successful.

Step 4. Review, encourage and support

When you review the person, always ask about progress towards the goal, give encouragement, trouble-shoot problems and set new goals in a spirit of positive expectation that they will be achieved.

5.20.3 Challenges

In psychosis, the person may experience problems of motivation, concentration and reduced capacity to carry out activities. Check that all symptoms are treated as well as possible. Also ensure that side-effects of a medication are not interfering with functioning (e.g. owing to over-sedation). Expectations from family members (and from the person themselves) may also be low, which can be a barrier to progress; this is why you should make efforts to engage family members as early as possible.

5.21 Meeting basic needs and promoting livelihoods

There is a two-way relationship between poverty and mental health (↗13.11). One way is through mental disorders and disability putting people at risk of falling into poverty (or worsening poverty) for a variety of reasons: the mental health

TABLE 5.7 TACKLING UNDERLYING CAUSES OF POVERTY

Problem	Solution
Too acutely unwell to work	Good clinical care to maximise symptom control
Lost opportunities for family members to work	Good clinical care to maximise symptom control
Expense of treatment	Good clinical care to maximise symptom control Drawing on community resources, social welfare funds, charity, other community-based organisations
Residual disability from mental health problems	Improve functioning and skills for independent living (↗5.20)
Poor social skills	Improving skills for social situations (↗5.22)
Stigma and discrimination	Interventions for stigma/discrimination at the individual (↗5.23) and societal (↗13.8) levels Support groups (↗5.26)
Low education and poor skills for work	Find out opportunities for training and refer the person Make links with employers who are open to the idea of vocational training Support groups (↗5.26)
Limited employment opportunities	Make links with employers and community-based organisations who may be able to assist people who need extra support to stay in work



problem may prevent a person from working and cause their family members to miss work opportunities, stigma and discrimination may exclude the person from livelihood opportunities, and out-of-pocket costs of treatment may be crippling for household finances. This is why interventions for mental health problems also need to consider the person's economic circumstances. This is particularly necessary for a person with long-term mental disability.

The first thing to do is to try to understand the main cause of the person's poor financial circumstances and use the relevant sections of this book to address the issue (☞ Table 5.7).

For a person who is facing serious economic hardship, refer to government social welfare agencies or non-governmental organisations for emergency support, for instance, in terms of food, support with housing, and other forms of material support. Ideally, you should keep a list of all such agencies and organisations in your area in the directory of providers in the manual (☞ Chapter 15).

5.22 Improving skills for social situations

5.22.1 When to use 'improving skills for social situations'

Mental health problems can affect a person's social skills. Poor social skills can also lead to mental health problems in the first place or make mental health problems worse. The most common difficulties with social skills are:

- not expressing feelings in a socially acceptable way

- not being able to recognise other people's emotions, for example, from their facial expressions or the tone of their voice
- struggling to 'read' a social situation, such as understanding social rules and the aims of those involved in a social interaction.

The goals of social skills training are to become more assertive, establish more satisfying relationships, and reduce isolation and loneliness. Social skills training focuses on improving core social skills such as:

- improving communication, for example, engaging in a conversation about interesting things, talking assertively without being aggressive, maintaining eye contact when listening and talking;
- following the accepted ways of social interaction, for example, taking turns in a conversation rather than interrupting a person who is talking;
- improving the person's ability to be supportive, encouraging and friendly towards others.

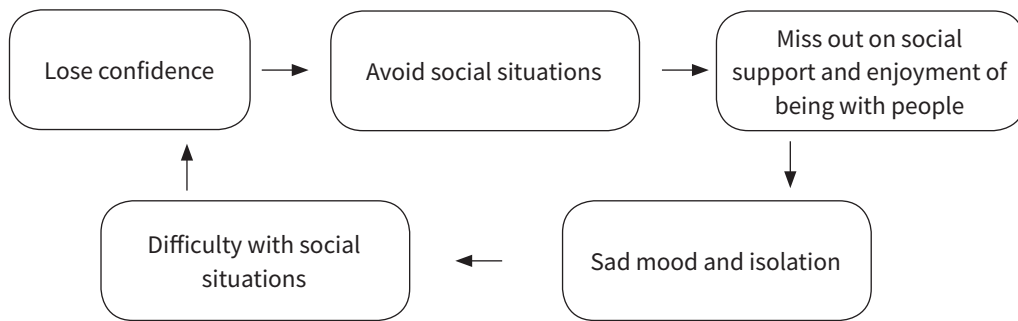
5.22.2 How to use 'improving skills for social situations'

Step 1. Explain the method

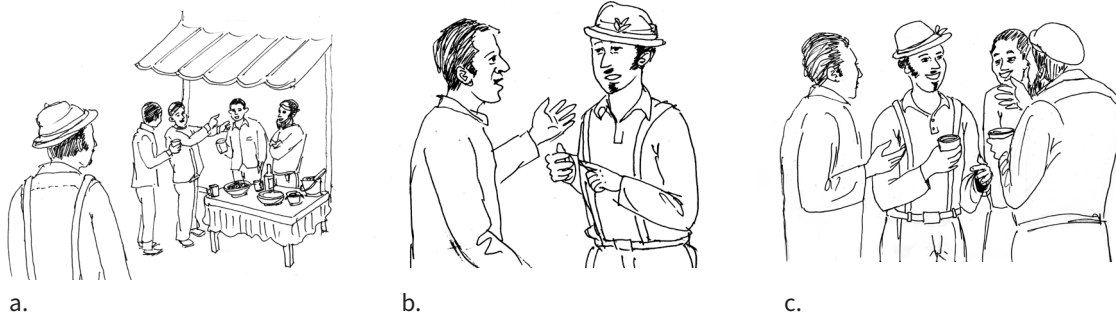
Describe the vicious circle that links social skills problems to worse mental health (☞ chart on the next page). Explain that social skills training involves learning about the skills needed for effective and rewarding communication in social situations, working out which skills the person needs, practising the skills, testing them out in a real-life situation and then learning from the experience.

Step 2. Assess the social skills problems

Together with the person, make a list of the problems they encounter in social situations. For each situation, ask the person to explain why the situation is difficult for them and to write this down next to the description of the situation. Then ask the person to rank the social problems in terms of how difficult they find them (from least to most difficult). For example, a man with depression



| A vicious circle of social skills problems and mental health problems.



| Strengthen social skills by (a) identifying a social event, (b) taking the first step of speaking with one person, and then (c) building up to joining a group.

who has always felt socially awkward may identify the following social difficulties:

1. knowing what to say in different situations (*least difficult*)
 - buying something in the local shop
 - family coming round to my home
 - friends coming round to my home
 - attending a group meeting
 - attending a wedding
2. putting across my view in a group meeting without getting angry
3. making new friends
4. starting a conversation with a woman who I like (*most difficult*).

Step 3. Practise a specific social skill

Choose one of the least difficult social problems that the person identified. Then act out that situation with the person so that you can try to

understand what some of the social skills problems might be. Following the example of the man with depression, start by acting out the situation where the man is buying something in the local shop. While you are acting out the social interaction, take note of the positive aspects of communication and also the difficulties which are revealed. For example, you might notice that the man has overly intense eye contact, tends to mumble and doesn't use any 'small talk' (e.g. greetings, routine questions and comments). Instead, he starts telling the shopkeeper straight away about his physical ailments in great detail. But, on the other hand, you notice that he was polite and respectful. Gently tell him what you noticed, starting with the positive aspects. Find out whether he agrees or does not agree with your observations and ask which of the weak areas he would like to work on first.

In this case, the man selects 'small talk'. Give him some examples of 'small talk' that would be

appropriate in this situation. For example, first greet the shopkeeper ‘Good morning’, then ask ‘How are you today?’ Advise the man not to start talking about his physical health concerns if the shopkeeper responds ‘Fine thank you, how are you?’ Explain that the question is not meant to be answered literally but is just a way to greet someone. Once the shopkeeper has responded, the man can ask for the item that he wants to buy. He could consider asking a general question: ‘How is business these days?’ He could also comment on something that has happened in the news or in the local community. Practise with the man so that he can try out some of these ideas.

Step 4. Set goals for that skill

Ask the person to set a goal for trying out the new skill, for example, to test out small talk at least twice in the next week.

Step 5. Review, encourage and support

See the general advice in ¶5.9.2. For improving skills, review with the person how the test of the new skill went. Try to obtain specific details of the interaction and the extent to which the person felt that it was successful. The person’s family members may also be able to give useful feedback if they accompanied him. When asking the family to give feedback, make sure they also consider positive aspects as well as anything that didn’t go so well. If the person faced challenges, try acting out the scenario again and find ways to overcome the challenge. If it went well, select a more difficult social situation and set a new goal.

5.22.3 Challenges

This approach to improving social skills works better with people who have an awareness of the social problems that they are facing and are motivated to change. For a person who has less appreciation of their social difficulties, the method will need to involve the family and focus on skills that bring some clear benefits for the person so that they may become more motivated to persevere.

5.23 Enabling people to respond to stigma and discrimination

During your assessment of the person you may identify that they are experiencing stigma (negative attitudes towards them due to their mental health problems), discrimination (unfair actions taken against the person) or abuse (actions that violate the person’s human rights). The role of the health worker in advocating for the human rights of people with mental health problems is discussed in Part 4 (¶13.8). In this section we are concerned with actions that the health worker can take to help the individual person.

The impact of stigma, discrimination and abuse on a person may be profound, for example:

- undermining self-confidence, leading to isolation and withdrawal, making the person fearful of rejection from others
- being denied equal opportunities, such as for jobs or education
- living in fear of harm, such as shouting insults, being restrained
- being denied fundamental rights, for example, of freedom of choice regarding how to lead one’s life
- being emotionally, physically or sexually abused.

The goal of the approach in this section is to help the person to consider how these negative experiences affect their life and how they can respond so that their quality of life is improved.

How to deal with stigma?

Step 1. Discuss experiences of negative comments, discrimination and abuse

Ask the person about experiences of stigma, discrimination and abuse. Discuss what happened and how it made them feel about themselves. Show empathy for the impact of negative experiences.

Step 2. Encourage the person to think about themselves in a positive way

Explain to the person that even if it is not possible

to control the way that other people see them, they should still see themselves as valuable. Tell the person that the mental health problems are not the only important thing about them, and that they can recover and have a meaningful life. Ask them to list all the valuable things they contribute to their family and community.

Step 3. Deal with negative comments, discrimination and abuse

- Discuss how the person dealt with the situation at the time. For example, what they did when someone called them an insulting name. Discuss whether the way they responded was helpful or not.
- Discuss other ways the person could respond. For example, it may be useful to practise explaining the mental health problem to others. You could suggest that the person tries saying, 'I have an illness like other illnesses. I am taking medication which makes me better'.
- Getting into a fight or trading insults is not a good way to respond to abuse. If needed, teach strategies to control anger (⇨5.16).
- When the person has experienced discrimination, for example, being excluded from livelihood opportunities in the community, use a problem-solving strategy (⇨5.11) and encourage the person to involve the family and relevant community members in addressing the issue.
- For criminal acts, for example, physical or sexual assault, speak with the person about involving the family and the police.



Step 4. Overcome the isolation resulting from stigma, discrimination and abuse

- Help the person to weigh up the advantages and disadvantages of isolating themselves from society. On the one hand they may minimise exposure to stigma, but on the other hand this means that they are missing out on the benefits of living in a community and not living life to the full.
- Address difficulties in social skills (⇨5.22). Occasional symptoms should not be a block to social interactions. If the person is more unwell, a priority is for them to receive effective treatment. When community members see the person doing usual activities again, this will help to reduce their ignorance and prejudice towards people with mental health problems.
- Explain that people may notice at first if the person starts going out more, but they soon stop noticing as everyone gets used to them being around. Not only that, people's fears about a person with mental health problems decrease as they get to know someone who has recovered.
- Concealing mental health problem because of fear of the consequences may be a burden on the person. Discuss with them about where and when they might consider telling others about their mental health problems without feeling shame or facing discrimination. Remember that it needs to be the right people, right place and right time. The person should feel and understand that whether to disclose their mental health problems is their choice.

5.24 Supporting families

5.24.1 When to use 'supporting families'

Family interventions are helpful for people with long-term mental disability, such as psychosis, dementia or developmental disorders, who are living with their family. They could also be used for non-family members who have ongoing, close, day-to-day involvement with the person.

There are three main aims with this method:

1. to equip the family to address problems constructively
2. to involve the family in supporting recovery of the person
3. to promote more healthy communication within the family (to improve quality of life and reduce symptoms and relapse).

Supporting families is also important, and is covered in Chapter 12 (⇨ 12.6).

5.24.2 How to use ‘supporting families’

Step 1. Assess the situation

When assessing the family, remember that different family members may differ in their attitudes and communication, and that the family may vary over time with respect to their strengths and problems. Families are dynamic, so it is not helpful to label a family as ‘a problem family’. Your role is to draw on the strengths of the family and help to address the current weaknesses in a supportive way.

If you ask family members directly about their attitudes towards the person and their communication styles, you are not likely to get a very realistic understanding. The family member may want to paint a rosy picture and may feel defensive about expressing negative feelings. Therefore, start the assessment with indirect questions that will allow the family members to feel more comfortable and will still give you the information that you need. By demonstrating empathy and good listening skills (⇨ 2.1.1) you can also encourage the family to speak frankly about the issues. This is a necessary first step in order to help the family and the person.

Ask the family:

- What problems are you facing because of your family member’s problems?
- What is the person’s daily routine?
- What level of duties and responsibilities is the person given?
- What are your hopes/expectations of the person?



Try to obtain detailed and specific information (e.g. about the daily routine) and observe how the family talks about (and to) the person as well as what the family says. When assessing communication, look out for the following unhealthy communication patterns:

- not allowing the person to speak
- family members not expressing their needs and expectations clearly or contradicting each other
- negative remarks about the person’s behaviour, e.g. ‘He just *sits* in his room *all day long*’ (*critical tone*)
- negative evaluations of the person which are not linked to a specific behaviour, e.g. ‘I don’t want to be with her anymore’ or ‘He is not good at anything’
- over-concern, indicated by self-sacrificing behaviour, exaggerated emotional responses or extreme overprotectiveness, e.g. ‘I am the only one who understands him’ or ‘I can’t leave her alone even for a minute’.

Healthy family communication typically comprises warm and positive remarks, showing appropriate levels of sympathy, concern, empathy and enjoyment of the person’s company, e.g. ‘He is very loving towards his sister’ or ‘She tries to help to the best of her ability’ or ‘I know he finds it difficult to cope with the side-effects’.

By the end of the assessment you should have a clear understanding of:

- any knowledge gaps, misunderstandings or negative attitudes regarding the cause of the

mental health problem and its effect on the person

- the degree to which family members have realistic expectations about recovery
- the problems facing the family and the highest priority problems to solve
- the family's strengths (e.g. coping strategies, attitudes, understanding)
- healthy and unhealthy communication within the family.

Step 2. Problem-solving

Some of the common problems experienced by families who have a member with a long-term mental disorder or disability are: financial hardship, handling suicidal behaviour or violence, the person refusing medications, coping with the person's sexuality, substance use, marital difficulties (when the spouse is the person with the mental disorder), and missed opportunities due to need to provide care. Use a problem-solving strategy (⇨ 5.11) to support the family in identifying the main problems; focus on one priority problem, identify potential strategies to overcome it and then test out the strategies (Table 5.8).

Step 3. Supporting recovery

Provide information

- Give the family information to address gaps

and misconceptions about the impact of the mental disorder or disability on functioning and realistic expectations for recovery. For example, for the family who comment that the person is 'lazy', it is necessary to explain that this behaviour could be related to the mental disability (e.g. a person with chronic psychosis may lack motivation and drive to do tasks) or a side-effect of medication (e.g. sedating effects of antipsychotic medications), or because the person does not have any routine to their day or meaningful activities to do.

- For the family who are impatient with the person's lack of progress in resuming work or other activities, it might be helpful to compare mental disorder and disability to a physical illness. If someone breaks a leg, even after it has healed, they still have to slowly regain their strength and ability to use their leg fully. Similarly, even when the obvious signs of mental disorder have gone, the person still needs time to get well. With a broken leg there can sometimes be permanent disability; this can also be the case with mental disorder. In that case, the person has to have time and support to learn a new way of living with the disability.
- For the family who are excessively negative about the person's chance of recovery, a different approach is needed. You can explain that mental disorder does not mean the person will never be able to function again, although

TABLE 5.8 EXAMPLE OF A PROBLEM-SOLVING STRATEGY IN PRACTICE

Define the problem	'Son's threatening behaviour towards mother'
Summarise	Worse when her son is unwell but also triggered whenever she asks him to do anything.
Define solutions	How can her son's mental health be optimised? Can he be brought in for review more regularly? How has the mother handled this behaviour in the past? What helped? Who else is available to support her? Can she involve community elders to speak with her son? Can she call on the police if needed? What would stop her getting help? Has she explained to her son that she is sometimes frightened? How does the mother communicate with her son (⇨ Step 1)?
Agree on solution to be tested	Mother decides to ask community elders to speak with her son, as well as to agree a way that neighbours can help if she is in trouble.
Test it out and review	Son respected community elders and has not been threatening since they spoke to him.



they may not get back to their previous level of functioning. The family may also worry that giving the person tasks and responsibilities might make them unwell again. You can explain that gradually giving the person tasks and involving them in activities is actually important for their mental health. It is also the only way that the person can start to regain skills and become more functional.

Get the family involved

Work with the family to find concrete ways in which they can support the person to recover. Be guided by the recovery goals set by the person (5.20) and the steps to achieving recovery (5.20).

- Start by asking the person how they would like the family to support them to recover. If the person refuses family involvement, explain to the family that they need to be

understanding and should continue to be loving and supportive.

- For one of the priority recovery goals, talk through how the family can help and how the family might get in the way. For example, if a person would like to make more friends, the family can facilitate by supporting them to attend social occasions in the community. But it might not be so helpful for a family member to interfere with choosing who the person should be friends with.

Step 4. Communication

Provide information

- If the family appears to have communication problems, explain to them about the link between the family's way of communicating and the mental health of the person (and the rest of the family too). Start by giving information about healthy forms of communication and noting which of these strengths you have observed in the particular family. Then explain about unhealthy forms of communication. Describing the 'do's and don'ts' of communication may be helpful (Table 5.9).
- Discuss with the family about the specific unhealthy communication patterns that seem to be present in the family.






Practise positive communication

- Agree with the family on how to improve their

TABLE 5.9 THE DO'S AND DON'TS OF COMMUNICATION

Do	Don't
Speak one at a time	All talk at the same time
Address comments about the person to them directly	Talk about the person but not to them
Make sure that everyone in the family has an equal chance to speak. Give the person time to speak	Leave out the person so that they have no opportunity to speak
Listen to what other family members have to say	Ignore others and assume that they have nothing to contribute
Express feelings honestly	Make rejecting comments
Be specific when expressing unhappiness or anger about a behaviour	Make general negative comments about the person
Express positive feelings when the person makes progress, however small	Focus only on the negative

TABLE 5.10 UNHELPFUL AND CONSTRUCTIVE WAYS OF COMMUNICATION

Unhelpful ways to communicate	Constructive communication	Message
‘Why are you so lazy and slow?’	<p data-bbox="546 264 889 291">‘Don’t worry how long it takes.’</p> 	The person’s difficulty with functioning is not their fault.
‘You’re a mental patient, you can’t do anything.’	<p data-bbox="546 550 889 643">‘Can you help me with the weeding? But let me know if you need a rest.’</p> 	Mental disorder doesn’t mean a person will never work again, but they may need to start slowly and with support.
‘Yes, yes, I’ll get your food straight away.’	<p data-bbox="546 855 889 883">‘We’ll all eat together in an hour.’</p> 	Try not to make the whole family routine revolve around the person with mental health problems.
‘How many times do I have to tell you? There is nobody trying to harm you. It’s all in your head.’	<p data-bbox="546 1105 889 1197">‘It’s hard for me to understand the things you say, but I am worried about how upset you are.’</p> 	It is not helpful to confront delusions. Express loving concern without colluding with the false belief.
‘He will have some of the meat stew and some potato.’	<p data-bbox="546 1456 889 1483">‘What would you like to eat?’</p> 	Allow the person to speak for themselves and make any choices that they can for themselves.

communication. See Table 5.10 for examples of unhealthy communication and alternative (healthier) ways of communicating, together with the justification for the new approach. Identify challenges to changing the way the family communicates and try to work out ways around these challenges.

- Ask the family members to test out the new ways of communicating. Agree on specific targets, such as stopping hostile comments altogether, or expressing at least one positive comment every day.

Step 5. Review, encourage and support

Review progress with the family and person at the next appointment. Identify difficulties and support the family and person to find a way forward.

5.24.3 Challenges

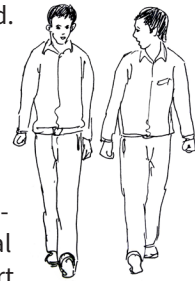
It may not be possible to get the key members of the family to attend the clinic (e.g. because they are at work) or to cooperate with your efforts. Some family members may be against the idea of a medical approach to treatment for mental disorders, while others may actively discriminate against the person. For uncooperative families, try to use counselling strategies to improve their motivation to change (⇨5.17). If you are concerned about a family acting in an abusive way towards the person and not being receptive to advice and support, speak with your seniors and try to involve other members of the family who are more receptive or respected members of the community who could try to engage the family.

5.25 Befriending

5.25.1 When to use befriending

Befriending is most useful for people with mental disability who have become isolated from society and have no social support networks. The person should be stable and not behave in a way that might put others at risk if meeting one-to-one. The befriender could be a community volunteer or a community-based worker (not necessarily a health worker), or a person with a mental disorder

or disability who has recovered. The unique aspect about this method is that a recovered person can be both the provider of the intervention and its beneficiary at the same time; thus, this is a good example of how people with mental health problems can support each other in a mutually rewarding way.



5.25.2 How to use befriending

The befriender meets with a person with a mental disability on a regular basis. The purpose of these visits is to provide the person with social support and friendship.

Step 1. Train the befriender

The befriender needs to have a clear understanding of their role. They are expected to:

- provide emotional support by being friendly and warm
- provide the person with any information they might need, for example, about community events
- support the person with activities, including support with their health care such as accompanying to the clinic or reminders to take medications
- give the person company, for example, to go for a walk.

Befrienders also need to be trained in recognising the early signs of a relapse or worsening of the mental health problem so that they can take appropriate steps to refer the person if needed.

Step 2. Introduce the person to the idea of befriending

It is important that the person understands that ‘befriending’ is not the same as a ‘friendship’. Befriending is usually time-limited, although the length of time varies and needs to be agreed for each individual befriender–person pair. It is possible for the relationship with the befriender to evolve into a lifelong friendship. It is also very

important to obtain agreement from the person for this method, as it does involve sharing information about their health problem with a stranger.

Step 3. Plan and carry out the befriending

Careful selection of the befriender is important, as well as careful matching of befriender to the person. The befriending relationship is not so protected by professional boundaries as the relationship between a health worker and the person they care for. For example, the befriender may share details of their personal life with the person. Try to minimise any possibility of exploitation by either side.

The befriender is not a counsellor. They are expected to meet up with the person in a community location, for instance, in a tea shop, and converse with them on neutral topics, such as sports, news stories or television programmes, depending on their common interests. If the person discusses symptoms (e.g. expresses distress about something), the befriender should listen attentively and ask if the person has been taking their treatment (and, if not, encourage them to do so) and suggest that the person goes to the clinic for a review. The frequency of contact will depend on the person. Weekly is good at the beginning while the befriender and person are getting to know one another. The meetings can be as short as 20 min or as long as is comfortable for both.

Step 4. Review, encourage and support

Ask the person how the befriending is going when you review them; congratulate them on their success and help trouble-shoot where necessary. For example, some people struggle to maintain a conversation; the health worker may suggest that they might do an activity with the befriender that does not involve conversation, for instance, go to a movie together. The person will still have some social contact but without any pressure to talk more than is comfortable for them.

5.25.3 Challenges

Finding community-based workers or volunteers who can befriend over an extended period of time may be challenging. The person with a mental health problem may express symptoms which are distressing to the befriender (e.g. accusations or resentment), or they may have unrealistic expectations (e.g. of being given money). Befrienders may suffer mental health problems themselves from time to time and you should pay close attention to this relationship in these circumstances. A further challenge is to handle the person's expectations that this is a new friendship, rather than a time-limited period of friend-like support.

5.26 Support groups for mental health



5.26.1 What are support groups and when to use them?

Support groups are groups of people who meet regularly to share and discuss issues of common interest. Members of a support group share some characteristic with each other. In dealing with mental health problems, there are two types of support groups.

1. Groups consisting of persons suffering from the same type of mental health problem. The best example of such groups are Alcoholics Anonymous groups where individuals with drinking problems meet regularly.

2. Groups consisting of persons who care for those who suffer from a particular type of mental health problem. Examples include groups of family members caring for relatives with dementia, psychoses and developmental disability.

5.26.2 How do support groups work?

Support groups provide an opportunity for participants to share their feelings, problems, ideas and information with others who have a similar experience. There are many ways in which groups work.

- **By providing practical hints.** For example, a mother of a child with developmental disability sharing how she manages her child's temper tantrums; or a man with a drinking problem sharing how he resists the urge to drink whenever he passes by the local bar.
- **By providing information.** For example, a brother of a person with schizophrenia sharing some news he has read about new medical treatments for the illness; or the daughter of someone with dementia sharing information about a new day care home for elderly people.
- **By providing an opportunity to help each other.** For example, when two parents of

children with developmental disabilities decide to baby-sit each other's children for a day each week, allowing both parents a day to get on to do other chores. Or when two individuals with psychosis who feel lonely decide to get together and go to the cinema.

- **By providing the sense that 'I am not alone' in my suffering.**
- **By providing space to share.** A space to share sensitive and distressing feelings about the mental disorder in a group of people who can understand the reasons for such feelings.

Ultimately, a support group works by providing mutual support. This means each member of the group is both being supported by others and providing support to others. This is an empowering feeling, quite unlike that of being a patient in a medical clinic.

5.26.3 Setting up a support group

Support groups are not easy to get going. They need, first and foremost, a group of people who are interested and committed to the idea. Not everyone is interested in support groups. Some people are not comfortable sharing personal feelings. They may not see the point of regularly meeting others with a similar problem.

The health worker can play three important parts in helping to set up support groups in their community.

1. **Putting people who share a common problem in touch with one another.** Many families facing a mental health problem are embarrassed and keep it quiet from others. The health worker may know of a number of families with, for instance, a child with a developmental disability in the community. She could introduce one family to another and thus help in setting up an informal, small support group. It is important that the health worker discusses this with each family before informing any outsider about their problem. Another way of putting people together is displaying information on the proposed group in a public place, for example, a poster in the health centre. Alternatively, you can arrange a meeting and simply tell all the people who



may be eligible to participate in the group to attend that meeting to find out more about the group.

- 2. Helping provide a space for meetings.** Ideally, support groups should meet in the homes of the members. However, this may not always be possible. In these situations, the health worker may offer a room in the clinic during hours when it is not too busy. This way, members can meet in a safe place and combine their participation in the support group with a consultation with the health worker if they so wish.
- 3. Facilitating the group.** The notion of self-help groups is unfamiliar to many people. The health worker can have a guiding role in helping getting a group going by participating in the first few meetings.

The first meeting

The first meeting is an important time to set the agenda for the group. What sorts of activities will the group get involved in? How often would it meet? (⇨ Box 5.11, Box 5.12) The next important issue is selecting a group leader who can encourage participation by other members. Often, the person who took the lead role in helping set up the group becomes the group leader and, sometimes, the health worker can play the part of group leader for the first few meetings. Once members are comfortable in running the group themselves, one of the members can be selected by the group to be the leader. The leadership position may change with time.

BOX 5.11 GROUP RULES

There are some basic rules in every group.

- What goes on must be kept confidential.
- You should be prepared to listen to others and, when you feel comfortable, share your own experiences.
- Do not make judgements or criticise others.
- Respect every other member's situation. What is right for one person does not have to be right for the others.

The group leader can conduct meetings in the following ways.

1. Welcoming all members and asking each person to introduce themselves and what they hope will be achieved in the group.
2. Stating the purpose of the group, by bringing together what each member has suggested.
3. Sharing information which is relevant to the members of the group.
4. Asking members to share their concerns on any issue which is relevant to the group. Members may respond by providing information, sharing their own experiences and expressing support. The discussion between members forms the core activity of the group.
5. Summing up at the end is a way of ensuring that the group discussions come to some kind of sensible conclusion. The date and time of the next meeting is agreed.

Keeping the group going

Group members should regularly review how the group is getting on. A health worker may attend occasional meetings of the group to provide information and advice on how to keep the group going.

5.26.4 Challenges

Common difficulties which may occur in keeping groups going are the convenience of the meeting place, difficulty in finding time to attend the groups, finding the discussions unhelpful and feeling marginalised in the group. Identifying these difficulties is important if solutions are to help the support group work properly.

BOX 5.12 SUPPORT GROUP FAQs

Q: How many members can take part?

A: There is no perfect number. Most groups start off very small. If the group gets too large, then it is obviously helping many people. Smaller groups can then be worked out based on factors such as area of residence or age of the participants.

Q: Where should the group meet?

A: Anywhere convenient with enough space and privacy. Ideally, the meeting place should be the same each time. Some groups may move around by taking place in the homes of different members on different occasions.

Q: How often should the group meet?

A: The group itself should decide on how frequently they will meet. To make it easy to remember, it helps to have a specific way of remembering the day of the meeting, for example, the first Saturday of every month.

Q: How much will it cost?

A: It should not cost anything to be a member of a support group. The only expenses may be those required to host the group (e.g. snacks and drinks) and all members can contribute towards the cost of these.

Q: How long will the group last?

A: As long as its members feel that it should go on. Successful groups have no time limit at all. For example, Alcoholics Anonymous run for an indefinite period of time. Participants may change over time; some may stop attending, while new members may join.

5.27 Putting it all together to plan care

In this chapter we have introduced you to a wide range of medications, counselling methods and social interventions. In the rest of the manual, you will see how different combinations (or ‘packages’) of these treatments can be used to treat different kinds of mental health problems. Each

person with a mental health problem who you see in your practice may need a different combination of these treatments, depending on the specific factors that have led to them developing a problem, their preferences and the availability of treatments in your particular facility. See below for a quick summary of principles when helping someone with a mental health problem.

CHAPTER 5 SUMMARY BOX

THINGS TO REMEMBER WHEN TREATING SOMEONE WITH A MENTAL HEALTH PROBLEM

- Medications, counselling and social interventions need to be combined for each person with a mental health problem, depending on their particular needs
- Treatment often needs to be given over a period of a few months, sometimes longer. It is critical, therefore, that the person becomes an active partner in their own care in order to get the best results.
- Families can be important for ensuring the success of treatment, but always respect the wishes of the person with mental health problems in terms of how much family involvement they want.

NOTES

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