

7 Behaviours causing concern

7.1 The person who is confused

People who are confused are not fully aware of their surroundings. The person doesn't make sense and cannot make sense of what you are saying. Confusion is also called **delirium**.

The main behaviours of a person who is confused are:

- she is not aware of her surroundings as you would expect her to be
- she is not able to remember things that happened recently
- she does not know the day, or where she is
- she does not sleep properly at night and may be drowsy during the day
- she may be uncooperative or fearful
- she may suffer hallucinations and be suspicious
- she may be restless and aggressive (⇨ flow chart 6.1).

Being confused is not the same as saying irrelevant or odd things or not making sense. When a person does not make sense, they can still be



Confusion is especially common in people who are physically sick.

aware of what is going on around them. Examples of unusual or odd thinking and speech are discussed later (⇨ 7.3). However, sometimes it is difficult to make out this difference. Careful questioning and observation are key to recognising when a person is confused.

7.1.1 What are the causes of confusion?

Acute confusion is a common condition in emergency settings and in medical and surgical wards in hospitals. The most common causes are:

- side-effects of some medications, for example, painkillers, especially in older people
- withdrawal from alcohol in someone who is dependent on drinking
- a brain illness, particularly strokes, head injury, epilepsy or infections such as malaria
- another medical illness, particularly high fevers, severe infections, dehydration, AIDS, severe breathing problems, severe kidney or liver disease
- being drunk or high on drugs
- severe anxiety or stress, for example, after a sudden shock.

7.1.2 How to deal with this problem

To decide on the emergency management of a person who is confused ☞ flow chart 6.2. In this section, we cover the detailed assessment of a person who is confused and longer-term care of a person who has needed emergency treatment for confusion.



Questions to ask the person

- Have you had any problems recently? (*The person's answer may give you a clue to whether they are aware of what has been happening recently.*)
- Are you feeling confused? Can you tell me what day it is? Can you tell me my name? Can you tell me where we are right now?
- Have you been drinking alcohol recently? When was your last drink? Have you been taking any other drugs recently?
- Have you hurt your head recently, for example, in an accident? Do you have pain anywhere in your body? Where? (*Pain may be a sign of an injury or medical illness.*)
- Do you feel worried for your safety? Are you hearing or seeing things that others cannot? (*Suspicious thoughts and hallucinations are typical features of confusion. Note that you should not diagnose psychosis if the person has these symptoms at the same time as being confused.*)
- How have you been sleeping recently? (*Confusion is almost always associated with disturbances of sleep.*)



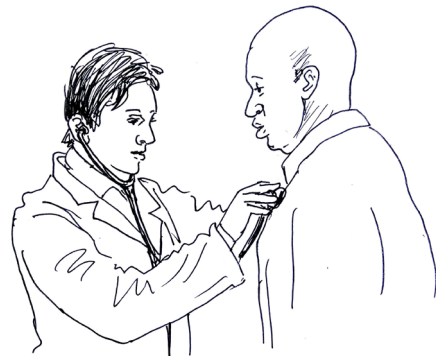
Things to look for during the interview

- The person's attention keeps wandering; for example, they do not seem to pay attention to your questions and may not answer them sensibly.
- The person may appear very drowsy and fall asleep during the interview.
- The person's orientation is poor; they may make mistakes about what time it is, where you are or what your name is.

- Their speech may be difficult to follow and may not make sense.
- The person may talk to himself or appear to be talking to an imaginary person.
- The person may make movements which suggest they are seeing imaginary things.
- They may be restless and fidgety. Agitation that occurs in the absence of confusion may be due to severe depression, mania, psychosis or depression, or side-effects of antipsychotic medication.
- The person's emotions may suddenly change from laughter to crying for no reason.

Always perform a basic physical examination. This must include:

- pulse
- temperature
- blood pressure
- be sensitive to the smell of alcohol
- look for signs of physical illnesses, particularly paralysis (due a to stroke), swelling of the feet, jaundice
- examine the head for any sign of injuries
- look for signs of poisoning (e.g. pesticide poisoning or overdose of tricyclic antidepressants, phenobarbitone or benzodiazepines)
- look for signs of brain infections (e.g. drowsiness or neck rigidity).





Questions to ask the family or friends

- How did it start? (*Typically, confusion starts suddenly and the person is brought to the clinic quickly because the family is worried.*)
- Has it happened before? (*If there is a history of similar episodes, the person may be suffering from repeated strokes, or from drug or alcohol abuse.*)
- Has the person been taking any new medications recently? Which medications?
- Has the person been suffering from any physical illness recently? Did they have a stroke or a heart problem? Has the person had a head injury or a seizure recently?
- Does the person have a drink or drug problem? If yes, when was the last time the person had a drink?



What to do immediately

- Place the person in a room on their own, if possible, with a health worker or relative to monitor them. The room should not be too dark or too brightly lit.
- Keep the family well informed about what is happening.
- Make sure the person is taking enough fluids. If there is any concern about dehydration, insert an intravenous line for fluids. This line can also be used for medication.

- Remind the person where they are, and what day and time it is. Reassure them that they are safe with you in the clinic.
- Some confused people can become aggressive or hurt themselves, for example, by pulling out their intravenous tubes. ☞ Flow chart 6.2 for guidance on managing disturbed behaviour in delirium.

When to refer

Confusion is often a sign of a medical emergency, particularly in elderly people or children. It is best, if you have reasonably quick access to a hospital, to refer any person with these symptoms to the hospital. If not possible, follow the steps described above and, once the person is stable, refer.

What to do later

- If the person was on multiple medications, reduce these to a reasonable number to reduce the chances of future drug-induced confusion.
- If the person has an alcohol or drug problem ☞ 9.1 and 9.2.
- If the person is elderly and memory problems persist after the confusion has reduced ☞ 7.8.



SECTION 7.1 SUMMARY BOX

THINGS TO REMEMBER IN DEALING WITH A PERSON WHO IS CONFUSED

- Confusion is when a person becomes unaware of their surroundings.
- The most common causes for confusion are strokes, medical illnesses, brain infections and injuries, side-effects of medications and alcohol or drug abuse.
- Confusion can be a medical emergency and often requires hospital admission.
- Elderly people are at greater risk of becoming confused.
- The key to treatment is to identify and treat the cause of the confusion, provide intensive nursing care and only consider medications if the person's behaviour is interfering with essential treatment or puts them at risk of harm.

7.2 The person who is aggressive

Aggression and violence are behaviours that hurt others. These terms include a variety of different behaviours. Verbal aggression is hurtful through talking, such as shouting, abusing and using foul language. Physical aggression includes pinching, hitting, slapping, kicking and punching. More serious physical aggression can involve the use of weapons such as sticks, rocks, knives or guns.

7.2.1 Why do people with mental disorders become aggressive?

A common belief is that people with mental health problems are 'dangerous' because they can suddenly become aggressive. It is true that, in some instances, the symptoms of a mental disorder can lead to aggressive behaviour, but this is rare. Let us consider some important examples of how mental disorder can lead to aggression.

- **Hearing voices and becoming angry:** imagine that you were hearing voices which said nasty things about you and made you feel that others were plotting to kill you. You would feel scared and would perhaps attack those who you believed were trying to harm you. This is what can sometimes happen in people who have psychosis (⇨7.3).
- **Being stopped from carrying out your plans and dreams:** imagine that you had great plans and dreams to do things which would change your life. If someone tried to stop you, or told you that you were 'ill', you would probably be quite angry. This is what can sometimes happen in a person with mania (⇨7.5).
- **Being unable to get a drink in time:** imagine that you were so dependent on alcohol (or a



drug) that you began to feel physically sick because of your desire for a drink (drug). You might become aggressive if someone tried to stop you from getting it (⇨9.1).

- **Suffering from confusion:** imagine that you have difficulty remembering things. You do not know where you are, what time or day it is, or who is speaking to you. You may become frightened and feel you need to defend yourself from these strangers. There are several causes for such states of confusion (⇨7.1).
- **Not able to express your feelings in words:** imagine that it is difficult for you to explain how you are feeling. A person, either a child or adult, whose development is delayed or who has brain damage may not be able to express themselves easily. If there is an important change in their life (e.g. a close family member leaves home) or if they are mistreated, they may become aggressive as a way of communicating that they are distressed or frustrated (⇨11.1 and 11.2).

Like anyone else, if a person with a mental health problem becomes aggressive, they usually have a reason. If you can find out why a person is angry, then you are more likely to find ways to help them.

7.2.2 How to deal with this problem?

The emergency management of a person who is aggressive or violent is given in flow chart 6.1. In this section we will cover the detailed assessment of a person who has been showing aggressive behaviour.

Special interview suggestions

- Make sure that both the person and you have access to the door.
- Speak in a clear, calm tone; do not shout in an attempt to calm the person down.
- Never threaten the person. This only worsens the situation.
- Ensure that another health worker is available during the interview. If this is not possible, get a trusted relative or friend to sit with you.





Make sure that the door to the clinic room is accessible to you and the person you are interviewing.

- Be sensitive to your own feelings; if you feel scared, then you should stop the interview.
- Be aware of the signs of impending violence. These include:
 - talking louder or becoming abusive or threatening
 - fists opening and closing
 - breathing rapidly
 - fidgeting
 - tapping, punching or slapping tables, walls or the floor.
- Listen for signs that the person's speech is not making any sense or is too fast; this is a sign of intoxication, mania or psychosis.
- Be aware of the smell of alcohol or skin marks from injections (for drug abuse).
- Look for signs that the person is losing balance or has slurred speech, which suggests intoxication.
- If the person becomes aggressive during the interview, use flow chart 6.1 to decide on the correct emergency management depending on the cause of the behaviour.



Questions to ask the person

- What happened? (*In particular, ask whether there were any reasons for becoming aggressive.*)
- Do you still feel angry? (*If yes, ask the person if they would prefer to spend some time alone before you ask any more questions.*)
- Have you been feeling under stress? Have you been feeling as if people around you were

behaving strangely? That they were talking about you? Or doing things which could hurt you? (*These questions help assess whether the person has psychosis.*)

- Have you heard people talking about you? Can you hear voices even when there is no one around? (*Hallucinations are an important sign of psychosis or mania.*)
- Do you feel full of energy? Do you feel you have special powers? (*These questions help assess for the presence of mania.*)
- Have you been drinking alcohol (*or, if appropriate, taking drugs*) recently? How much? When was your last drink? When did you last take drugs?
- Assess the person's level of awareness of their surroundings, for example, the date and place, to rule out delirium (see 7.1 and flow chart 6.2).

Questions to ask the family or friends



- What happened? (*One person's description of violence may be quite different from another's. Find out exactly what happened.*)
- How did it start? Has the person been irritable for several days? (*This may suggest mania or psychosis. Sudden onset suggests acute confusion.*)
- Has this ever happened before? (*If so, then the chances are that the person has a severe mental disorder and there is a risk of further violence.*)
- Has the person suffered from a mental health problem in the past? Is the person on any medication? (*This is of obvious importance since it may provide important clues for diagnosis and treatment.*)
- Who does the person trust? (*A trusted individual could be an important ally in helping the person to calm down.*)
- Does the person have a drug or alcohol problem?

What is the mental health problem?

When aggression is associated with a mental health problem, there are four major causes to remember.

1. A person can become aggressive either when they are intoxicated by a drug or alcohol, or when they are in a withdrawal state.
2. A person with psychosis or mania can become very agitated and, occasionally, aggressive.
3. A person who is acutely confused may become aggressive, for instance, soon after an epileptic seizure, a head injury or delirium.
4. A person with a brain disorder, for example, intellectual disability or dementia, may become aggressive.



What to do immediately

- Follow the guidelines for emergency management, depending on the cause (☞ flow chart 6.1).



What to do later

- If it was necessary for a person to be sedated, explain to the family or friends what happened.
- As the person may become agitated when the sedation wears off, ask someone who is familiar to the person to stay with them.
- When the person is able to talk to you, tell them about what happened and the reason.
- Advise family members to make a plan in case the person becomes aggressive again, for example, how they should react and who they can turn to for help. Tell them to return to see you immediately if this happens again.
- Use this manual to provide the correct treatment for any mental health problem which is contributing to the aggressive behaviour, such as psychosis (☞ 7.3), bipolar disorder (☞ 7.5), substance use (☞ 9.1–9.4), a developmental disability (☞ 11.1) or dementia (☞ 7.8).
- Offer an early follow-up appointment (within 1 week).
- If the person has an ongoing problem with managing their anger, consider the counselling strategy of ‘controlling anger’ (☞ 5.16).
- If the family had restrained the person at home, see Box 7.1 for advice on how to manage this situation.

BOX 7.1 THE PERSON RESTRAINED IN THE COMMUNITY

When a person with a mental health problem is restrained in the community (e.g. within their home or at a healing site), it is almost always done as a last resort. Families may have tried a number of remedies and healing approaches without success and do not know what else to do to prevent the person being a danger to themselves (e.g. through wandering off and being exploited or neglected) or a danger to others. As well as being a grave restriction of a person’s human rights and a traumatic experience for the person, restraint can lead to long-term problems such as contractures (not being able to straighten out arms and legs properly) and sores and infections at the site of restraint. The first step to addressing this situation

is to mobilise the community to support the family to bring the person to a health facility. The safest approach is likely to be referral for specialist assessment and possible hospital admission. In cases where this is not possible, assess the person and try to diagnose the underlying mental disorder and the reason for any aggressive behaviour (which may or may not be related to the mental health problem).



If the person is not currently aggressive, discuss with them and their family about the need for treatment for the mental disorder and negotiate release of the restraints. Families may need to be convinced that the person is responding to treatment before they feel confident to release them.

If the person is actively aggressive, consider the need for emergency treatment of the aggression (flow chart 1) before negotiating release from restraints with the family. Follow up closely, liaising with community-based health care colleagues if needed or even involve community leaders if the person remains restrained.

- Needing to restrain a person who is aggressive can be frightening and stressful for staff. Try to make time after the event to speak with the staff involved and discuss whether there are lessons that need to be learned about how to maximise the safety of all involved.



When to refer

If you suspect that the violence is associated with confusion and may be the result of a brain disease, or if the person remains aggressive despite your

efforts to follow the guidelines in this manual, they should be referred as an emergency to a general hospital, preferably accompanied by a health worker. Ideally, all people who are not known to have a mental health problem should be referred for a full mental health assessment after recovery from the acute episode of aggressive behaviour to identify whether they have a severe mental disorder or brain disorder. If that is not possible, take time to make a more full assessment and follow the guidance in this manual for starting the appropriate treatment.

SECTION 7.2 SUMMARY BOX

THINGS TO REMEMBER WHEN DEALING WITH A PERSON WHO IS AGGRESSIVE

- Aggressive behaviour is a rare feature of some mental health problems: psychosis, mania, intellectual disabilities, dementia, and alcohol and drug use are the important mental health problems which may be associated with violence.
- Aggressive behaviour almost always affects friends and relatives. Remember to counsel those affected and explain what you are doing and why.
- While you should be concerned about the safety of others, your primary goal must be to protect, understand and help the person.
- Use of sedative medications may be required to calm someone with a mental disorder who becomes aggressive.
- Restraint is only used in exceptional circumstances as a short-term intervention when the person is at immediate risk of harm or is putting others at risk.

7.3 The person who has odd beliefs or is hearing voices

7.3.1 What are ‘odd beliefs’?

Sometimes, people think that others are talking about them, trying to hurt them or plotting to harm them. Most often, the thought lasts for a short time, especially when people are under stress. Occasionally, this thought lasts for a long time and becomes a firm belief. No matter how much you try to reassure the person that there is nothing to worry about, the suspicious thoughts do not go away. Such thoughts are called delusions. People may try to protect themselves from the imagined people who are trying to harm them. Some people can also believe other sorts of odd things that make no sense either to you or to

their family. Examples include a man thinking that his thoughts are being interfered with by aliens, a woman convinced that people on the radio or television are making comments about her, or a man thinking that he possesses superhuman or special powers.

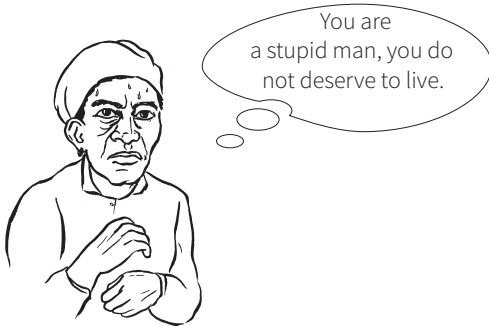
7.3.2 What is ‘hearing voices’?

‘Hearing voices’ is when someone hears people talking even when there is no one around. This experience is called a hallucination. Often, these voices have an unpleasant character. For example, they may say nasty things about the person. Occasionally, the voices may talk directly to the person and tell them to do things such as to hurt themselves or others.

7.3.3 Why do some people have these experiences?

These experiences are not common. They are typically associated with severe mental disorders:

- **psychosis:** there will often be a long history of illness, usually more than 6 months
- **bipolar disorder:** typically, there is a history of sudden onset, severe mood swings and similar episodes in the past (⇨7.5)



- **drug psychoses:** these occur after intoxication with certain drugs, such as stimulant tablets and cocaine (⇨9.2)
- **delirium** (⇨7.1) and **dementia** (⇨7.8): this is a condition where confused and agitated people also hear voices and become suspicious.

7.3.4 Can 'normal' people have these experiences?

Yes. In some communities, there are individuals who claim to have an ability to communicate with supernatural forces and spirits. These people may experience hearing of voices, particularly of spirits or God. They may also have beliefs which seem unusual, for example, that the spirits are angry or that there is witchcraft. These beliefs may be appropriate for that community. Examples of such people include the traditional healers in some societies and the charismatic priests in some evangelical churches. However, these people do not go to health workers for help since they are using their experiences in a manner which is beneficial to their own health and may help others in distress. It is important not to confuse these ex-

periences with a mental health problem. A mental health problem should be defined by its adverse effect on the person's life or the life of their family.

On rare occasions, it is not abnormal to hear the voice of a loved person who has died recently. Unless this experience leads to distress, do not consider this to be a mental disorder.



A priest who is speaking in tongues – it is important not to confuse such experiences with an illness.

7.3.5 How to deal with this problem?

Special interview suggestions

- A person who is already suspicious needs to be approached in a gentle manner; the aim must be to win their trust by asking general questions first.
- Never confront the person by challenging the beliefs. For example, do not say 'Don't be ridiculous. No one is talking about you'. The experiences which may appear 'ridiculous' to you are very real to the person.
- Never agree with the content of the beliefs; thus, even though you should not challenge them, you should not agree with them either.
- Never mock or laugh at the beliefs; the person will lose faith in you.

Questions to ask the person

- Have you been feeling under stress recently? (*Start with a general question instead of asking a direct question about delusions or hallucinations.*)
- Have you felt as if something odd was going on around you? Have you felt as if others were

talking about you? That some people were trying to hurt you? (These questions will help identify delusions.)

- Have you been hearing people talk about you behind your back? Have you been hearing people talk even when there is no one around? (These questions will help identify hallucinations.)
- Do you get thoughts of wanting to kill yourself? (Remember that the risk of suicide is higher in a person with a psychotic illness.)
- Have you been drinking or taking drugs recently? (If yes, ⇨ 9.1 and rule out an alcohol or drug use disorder.)
- Ask questions to assess whether the person is confused (⇨ 7.1).
- Ask questions to assess whether the person has had severe mood swings in the past (⇨ 7.5).



Things to look for during the interview

- Look for signs of confusion and, if present, assess for possible reasons for confusion (⇨ 7.1).
- The person's general appearance may indicate poor self-care.
- The person may be restrained, for example, their hands may be tied together.
- The person may do things which suggest that they are hearing voices, for example, suddenly looking in a different direction as if someone is speaking to them from there or talking to themselves.
- The person's speech may not make sense to you and answers to your questions may not be relevant.
- The person may talk far too much or may not talk at all.
- The person may laugh or cry or talk to themselves without reason.



Questions to ask the family or friends

- When did it start? (This will tell you whether the illness is sudden (mania or delirium) or long-standing (psychosis).)

BOX 7.2 EXPLAINING ABOUT PSYCHOSIS

Sometimes our minds can play tricks on us so that things seem real when that is not really the case. That is called psychosis.



- Being under stress and using drugs are reasons that psychosis can start.
- Psychosis can be treated.
- Treatment can help a person to get back to doing their usual activities and to make them feel better (e.g. calmer, less distressed, improved sleep).
- Medications are an important part of treatment and need to be taken regularly.
- It is also important to keep active: try to keep meeting with people and do as much work as you feel able.
- Avoid alcohol and drugs as they work against the treatments.
- Remember that recovery happens step by step.
- The support of family and friends is important for recovery.

- Have you noticed any odd behaviours? For example, appearing as if the person is talking to himself.
- Has the person been saying odd things? For example, accusing you of trying to harm them?
- Has the person been aggressive? (If so, ⇨ 7.2.)
- Does anyone else in the family suffer from these sorts of problems? (Psychosis sometimes runs in families.)

What to do immediately

- If the person is restrained or aggressive, follow emergency guidelines set out in flow chart 6.9.
- Prescribe antipsychotic medication (⇨ Box 5.3, p. 54). If prescribing typical antipsychotic drugs, you may consider giving medications





to prevent side-effects (e.g. procyclidine, benzhexol) if the person cannot easily come back to the facility (e.g. if they are restrained or live a long way away).

- Use basic counselling to provide an explanation about the illness and treatment (Box 7.2) and give realistic hope.



When to refer

- If you suspect delirium.
- If the person is suicidal. People who are suspicious and also have suicidal beliefs are at a high risk of harming themselves.
- If the person is violent; refer after taking steps to control the behaviour (☞ flow chart 6.9).
- If the person develops a high fever or severe side-effects of the medication they are taking.
- If the person's symptoms do not improve when they have been treated for at least 6 weeks at the proper dose.

What to do later

- Call the person back to the clinic in a week to assess their progress. You can increase the dose of the medication if symptoms are not under control.
- If possible, refer to a specialist mental health team. Many people with psychosis will need long-term care.
- If there is no mental health team, make a long-term plan to help the person and family cope with the illness. Psychosis can last several years and is often associated with considerable disability.
 - If possible, allocate a particular health worker to the person's care. In only a few cases will people with psychosis need long-term supervision.
 - Visit the person (or ask the person to visit the clinic) at least once every 2 months, both to support the person in the recovery process and to detect signs of a relapse.
 - Use the follow-up checklist in Chapter 4 (☞ 4.3, p. 43) to monitor the person properly during follow-up appointments.
 - Depending on the needs of the person and their family, consider interventions to improve functioning and independent skills for living (☞ 5.19), meet basic needs and promote livelihoods (☞ 5.21), improve skills for social situations (☞ 5.18), enable the person to respond to stigma, discrimination and abuse (☞ 5.23), equip and support families (☞ 5.24), consider befriending to overcome social isolation (☞ 5.25) and involvement in support groups (☞ 5.26).

SECTION 7.3 SUMMARY BOX

THINGS TO REMEMBER WHEN DEALING WITH A PERSON WHO HAS ODD BELIEFS OR IS HEARING VOICES

- Suspiciousness, odd beliefs and hearing voices are typical symptoms of psychosis.
- People with psychosis often suffer discrimination and stigma from others in the community.
- Antipsychotic medications combined with social interventions are the best treatment for these illnesses.
- If a family want to take the person to a traditional healer, encourage them to combine the traditional treatment with the medications you will give the person.
- If possible, refer people with these symptoms to a specialist mental health team.

7.4 The person who is miserable, thinking too much or withdrawn

Some people have periods of several weeks to months when they are miserable all of the time. During these periods, they may become hopeless about life, think too much, be tearful without reason or irritable about small things, lose their energy and drive, lack interest in everything around them, have unsatisfying sleep, feel worthless, withdraw from social occasions and have thoughts about ending their life.

We can all feel sad or worried when we are going through a difficult period in life, for example, owing to financial or relationship problems, and for some people this can lead to physical ailments (especially headaches and fatigue; [↗8.1](#) and [8.4](#)). But sometimes the person feels miserable and hopeless all of the time, regardless of what is happening around them. They cannot just ‘pull themselves out of it’. When this condition lasts for more than 2 weeks and is affecting the person’s daily life (e.g. ability to work), this is when sadness becomes the mental disorder called **depression**.



When depression becomes very severe, the person can start to believe that they are guilty of things they haven’t really done or that their body is rotting away or not working properly. They may give up eating or drinking and become weak. The person could also start to hear voices saying nasty things about them.

7.4.1 Why do some people get depression?

Depression is most often triggered by stressful events, for example, the break-up of a relationship, losing a job, money worries or poor physical health. People who have had traumatic experiences in childhood (e.g. abuse or loss of parents) are at increased risk of depression. Some medical conditions can cause depression, for example, hormonal abnormalities such as low thyroid hormone levels. Medications such as beta-blockers, oral contraceptive pills or antiretroviral therapy

(especially efavirenz) and excessive alcohol use are also known to cause depression in some people.

Some people get severe mood swings which include both depression and periods of high mood. This can happen in bipolar disorder ([↗7.5](#)).

7.4.2 How to deal with this problem

Questions to ask the person



- How have you been feeling in yourself? How is your mood? How is your level of interest in things recently? How are your energy levels? (*These ask about the core symptoms of depression.*)
- Are you thinking too much about things? What sort of things are on your mind? Have you been feeling tense, worried or scared recently? How is your sleep? How is your appetite?
- Have you felt that life is not worth living? Have you thought of doing something to harm yourself? Have you actually tried to harm yourself? (*Screening for suicide risk.*)
- Ask about anything that might have triggered the illness. In women, ask about domestic violence ([↗10.2](#)).
- Have you been hearing any voices that don’t seem to be really there? Have you been blaming yourself about things? (*Screening for psychosis.*)
- Ask whether the person has ever had episodes in the past when their mood was too high, they were full of energy, had little need to sleep and were more confident than usual? Was this associated with reckless behaviour? (*Detecting bipolar disorder; depression in someone with bipolar disorder needs a different approach to treatment* [↗7.5](#).)
- Screen for alcohol and drug use.
- Ask about any medical conditions and medications.

Things to look for during the interview



- Miserable look
- Poor eye contact

- Slow or subdued speech without any emotions
- Slow movements or restlessness (sign of more severe depression)



Questions to ask the family or friends

- Is the person drinking enough liquids and eating meals? Has the person spoken of wishes or plans to harm themselves? Has the person made any attempt to harm themselves? (*to identify people at high risk*)
- Does the person seem to be blaming themselves unnecessarily for past events? (*this may be due to psychosis with depression*)

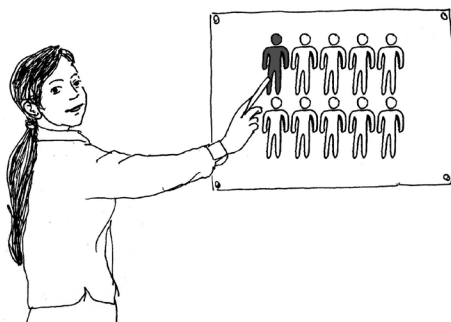


What to do immediately

- Follow the emergency guidelines if the person is suicidal (⇨ flow chart 6.3).
- Provide explanation about depression (Box 7.3).
- Give the person hope (⇨ 5.9.2); use approaches to enhance their social support (⇨ 5.18.1) and get them back into a routine (⇨ 5.18.2).

BOX 7.3 EXPLAINING ABOUT DEPRESSION

- Depression is the most common mental health problem in the world.
- When somebody has depression they can have unrealistic negative opinions about themselves, their life and their future.
- Depression is not because of laziness or weakness: it is an illness. A person who is ill with depression needs treatment and support.
- Most people with depression make a full recovery.



- Use the counselling strategy of ‘getting active’ (⇨ 5.13) and/or ‘problem-solving’ (⇨ 5.11) right from the beginning of treatment.
- Consider starting an antidepressant (⇨ Box 5.2), especially if you are worried about suicide risk (choose an SSRI antidepressant such as fluoxetine) or if the depression is severe. If the depression is in somebody who also has severe mood swings, follow the treatment advice below.
- If there is domestic violence ⇨ 10.2.
- Offer the person an appointment to see you after 1 week, but encourage them to return earlier if they feel worse.
- If the person has a severe depression, refer for specialist treatment. If that is not possible, make sure that the family are aware of the potential risk of suicide. If the person is not drinking an adequate amount of liquid, give intravenous fluids to rehydrate them and instruct the family on the importance of ensuring the person is drinking enough (sit with them and regularly offer small amounts of liquids).
- If the person has psychosis as well as depression, prescribe a low dose of antipsychotic medication until the mood improves (⇨ Box 5.3).

For depression in a person who also has severe mood swings

- Antidepressant treatment in a person who has previously had severe mood swings (⇨ 7.5 and Box 5.6) is complicated by the risk of triggering an episode of high mood (mania). Therefore, antidepressants should be avoided if possible. Consult with a mental health specialist. In the first instance, try to optimise mood stabiliser medication without an antidepressant and try counselling approaches. If that is not effective, only prescribe an antidepressant if the person is also taking a mood stabiliser or second-generation antipsychotic medication (⇨ Box 5.3). Monitor carefully for high mood and stop immediately if this occurs. Stop the antidepressant once the person is well (do not follow the usual recommendation to treat for 9 to 12 months) to reduce the risk of triggering more mood swings.



When to refer

- If the person develops a severe depression with suicidal features, psychosis or severe self-neglect (e.g. not drinking enough liquid). They may need hospital admission or specialist treatments. This may include electroconvulsive therapy (ECT), which can be life-saving for people who have given up eating and drinking.
- If the person does not respond to counselling and antidepressant treatment.
- Consult with a specialist if the person is pregnant or planning to start a family.



What to do later

- Choose the counselling strategy that best fits the person: for people with many social stressors consider problem-solving (↗5.11), for people who have become socially withdrawn consider 'getting active' (↗5.13), for

people with lots of negative thoughts or who are 'thinking too much' try 'thinking healthy' (↗5.14) and for those who need it, 'improving relationships' (↗5.15).

- Antidepressant medication needs to be continued for at least 9 to 12 months after the person recovers (↗Box 5.2). The dose should not be reduced during this period.
- After severe depression, the person may need support with recovering their previous level of functioning in a step-wise manner (↗5.18 and 5.19, social interventions).
- For people who are socially isolated, consider befriending (↗5.25). Some people who experience repeated depression episodes may need assistance with 'improving skills for social occasions' (↗5.22).
- Provide regular follow-up depending on need (↗4.9).

SECTION 7.4 SUMMARY BOX

THINGS TO REMEMBER WHEN DEALING WITH A PERSON WHO IS MISERABLE, THINKING TOO MUCH OR WITHDRAWN

- Misery and 'thinking too much' can be signs of the mental disorder called 'depression'.
- Social difficulties can cause both distress and depression. To diagnose depression, distress symptoms must persist for more than 2 weeks and have a negative impact on the person's life.
- Depression is an important cause of suicide.
- Depression is treatable with medication and/or counselling strategies and interventions to improve social support.
- Most depression is best treated in primary care.

7.5 The person who has severe mood swings

Some people get severe swings in their mood. They have periods of several weeks to months when they either have a 'high' mood or a 'low' mood. Usually they have normal mood in between these episodes. This happens in the condition called **bipolar disorder**.

When people with bipolar disorder have low mood (depression), it is similar to the depression seen in people who do not have bipolar disorder, but tends to be more severe with increased suicidal ideation (↗7.6). But during the high periods

(mania), the person can become full of joy and optimism, with boundless energy, no need for sleep, high levels of self-confidence and lots of new ideas and plans. Although this sounds like a pleasant experience, alongside these positive feelings can come negative feelings (irritability and being on an emotional rollercoaster) and risky behaviours, for example, spending money recklessly, becoming sexually promiscuous and getting into fights. When severe, the person can also start to lose touch with reality and believe that they are someone very important or on a special mission, or become suspicious that others are trying to harm them (↗7.3). The 'high' periods

may lead to the person being arrested, beaten up, admitted to hospital or restrained.

7.5.1 Why do some people have severe mood swings?

We all experience ups and downs in our mood. Usually these mood changes are in response to what is happening to us in our life and do not last longer than a few hours or days. They are also unlikely to interfere with work and relationships. When the mood swings are much more severe and protracted (at least 2 weeks for depression and at least 1 week for mania), then you should consider that the person has a bipolar disorder. Remember that having episodes only of depression does not indicate bipolar disorder: there must be an episode of mania for this disorder to be diagnosed. Bipolar disorder runs in families, which means it has a strong genetic basis. However, individual episodes of severe mood swings are often triggered by life events, including child-birth. A manic episode can also be caused by a medical condition (e.g. HIV infection of the brain), the side-effects of a medication (e.g. steroids or antidepressants) or use of stimulant drugs.

7.5.2 How to deal with this problem

Special interview suggestions

- A person with mania may become quickly irritable and aggressive. Ensure the environment where you are conducting the interview is safe, with a clear path to the exit and back-up from colleagues.



- The high mood of mania can be infectious. Take care not to get distracted from your assessment.

Questions to ask the person

- When and how did the mood swing start? Is this the first time it has happened? (*Remember to ask about previous episodes of depression.*)
- Does anyone in your family have this problem? (*For women, ask whether they have ever had an episode after giving birth.*)
- How have you been feeling emotionally? How are your energy levels? How is your sleep? (*A person with mania has increased energy and may not feel the need to sleep.*)
- Have you been thinking of harming yourself in any way? (*Even when in mania, a person may have impulsive suicidal thoughts.*)
- A person with mania usually does not realise that they are unwell. You can often get a clue to their thinking by asking, 'Do you think people treat you as they should do?' or 'Do you feel you may have special powers or gifts?' (*If the person has beliefs about their importance they may well be getting frustrated that the world does not appreciate their greatness.*)
- If the person appears low, follow the guide for questions for depression (⇐7.4).
- Screen for alcohol and drug use.
- Ask about any medical conditions and medications.

Things to look for during the interview

During an episode of mania, look for those signs in a person:

- unusual dress, with bright colours and ornaments
- flirtatious and inappropriate interactions (e.g. calling you by your first name or leaning too close)
- talking too fast, struggling to focus on the question, unable to sit still
- emotions changing very rapidly (tears, then laughter, then anger)
- the person is being restrained by others.



Questions to ask the family or friends

- Does anybody in the family have a problem with severe mood swings?
- Has the person been behaving in a way that is out of character for them (e.g. taking risks, spending too much money, gambling, increased sexual activity, getting into arguments)? Are they claiming to be someone special or gifted?



What to do immediately

- Follow the emergency guidelines if the person has acutely disturbed behaviour (↪ flow chart 6.1), is suicidal (↪ flow chart 6.3) or is restrained (↪ flow chart 6.9).
- Assess physical health. In mania, consider the need for a pregnancy test (urgent, before starting medications) or screening for sexually transmitted diseases, including HIV, if the person has been involved in risky sexual behaviour.
- Rule out drug intoxication (↪ flow chart 6.6).
- For the treatment of depression in bipolar disorder ↪ 7.4.
- For episodes of mania, medication treatment is required. Treat with an antipsychotic medication (either an atypical antipsychotic or a typical antipsychotic; ↪ Box 5.3) and/or a mood stabiliser (↪ Box 5.6).
- Before starting a mood stabiliser, exclude pregnancy.
- A short-term benzodiazepine may be used for some patients who have significant sleep disturbance (↪ Box 5.8).
- Provide explanation about bipolar disorder (Box 7.4) to the family and, when possible, to the person.



When to refer

- If possible, all people with a new diagnosis of bipolar disorder should be assessed by a specialist mental health worker. Be wary about starting a long-term mood stabiliser without guidance.

BOX 7.4 EXPLAINING ABOUT BIPOLAR DISORDER

- Bipolar disorder is when a person experiences severe mood swings.
- During mania, a person may act in a way that is not like their usual character: this behaviour is due to illness.
- Prevention of relapse is important – medications can help, but quick recognition of early symptoms (e.g. struggling to sleep, speaking fast, always on the move, seeming excited or easily irritable) is important.
- As mania stops a person realising that they are ill, the family have an important role in detecting relapse and seeking treatment promptly.

- Hospital admission may be needed for a person who has mania if their behaviour is putting them at risk of harm, for example, irresponsible spending or risky sexual behaviours.
- If the person has recurrence of symptoms while on medication.
- Consult with a specialist if the person is pregnant or planning to start a family.

What to do later



- After mania has resolved, take time to discuss with the person about what happened and why they needed treatment.
- 5. The person may benefit from a problem-solving counselling strategy.
- Many people with bipolar disorder can benefit from long-term medication treatment (Box 7.5). If possible, refer for a specialist assessment before starting long-term treatment.
- See Box 7.6 for relapse prevention tips. As severe mood swings can be very disruptive to the person's life, they may benefit from social interventions to improve functioning and skills for independent living (↪ 5.19), tackle economic difficulties (↪ 5.21), overcome social isolation (↪ 5.22) and helping the person to respond to stigma, discrimination and abuse (↪ 5.23). Interventions to equip and support the family can also be valuable (↪ 5.24).

- Provide regular follow-up, with the frequency depending on the need. Use the follow-up

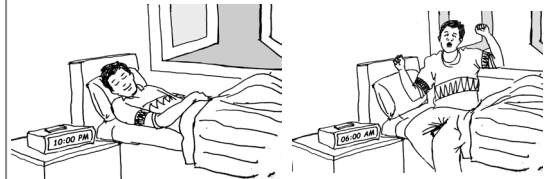
checklist to make sure that you review the person in a comprehensive way (☞4.9).

BOX 7.5 LONG-TERM MEDICATION TREATMENT FOR BIPOLAR DISORDER

- Medications help to reduce the chance of relapse.
- If the episodes occur at least once every 2 to 3 years and are severe then medication should be considered.
- If available, choose lithium (only if monitoring facilities are available and affordable), valproate (avoid in women of childbearing age), or risperidone, olanzapine or other second-generation antipsychotic medications (☞Box 5.3).
- If those medications are not available, first-generation antipsychotic medications (e.g. haloperidol) or carbamazepine may be used.
- If a woman of childbearing age is prescribed a mood stabiliser (lithium, valproate or carbamazepine), make sure she is fully informed about the risks if she becomes pregnant. Discuss with her about appropriate contraception and consider prescribing long-term folate if she is taking valproate or carbamazepine.
- Advise the person not to stop the medication suddenly, because this can sometimes trigger an episode.
- Often, people with bipolar disorder feel completely well in between episodes and find it difficult to be motivated to take medications on a long-term basis. Use the counselling strategy of ‘motivating for change’ to help (☞5.17).

BOX 7.6 PREVENTING RELAPSE IN BIPOLAR DISORDER – TIPS FOR THE PERSON

- Establish a regular sleep pattern.
- Plan a regular work or school schedule that avoids sleep deprivation.
- Seek support from family and friends after stressful events (e.g. bereavement).
- Use relaxation techniques (☞5.12) and problem-solving (☞5.11) as ways to cope with life’s difficulties.
- If you have any concerns about the medication, discuss with a health worker. Don’t stop them without advice (☞Box 5.6).
- Avoid excessive use of alcohol or drugs.
- Get into the habit of discussing and soliciting advice about major decisions (especially ones involving money or major commitments) with friends or family.
- Learn to recognise the early warning signs of relapse (e.g. difficulty with sleep) and know what to do (e.g. come to the clinic immediately).



Maintaining a regular sleep pattern is important in keeping well in bipolar disorder.

SECTION 7.5 SUMMARY BOX

THINGS TO REMEMBER WHEN DEALING WITH SEVERE MOOD SWINGS

- Episodes of severe mood swings can be caused by bipolar disorder.
- Medications can both treat and prevent episodes of severe mood swings.
- Learning about early signs of illness and family involvement are important for early identification of a relapse.
- The approach to treatment of episodes of low mood (depression) is different in someone with bipolar disorder compared with someone with depression: don’t prescribe an antidepressant on its own.
- Keeping a regular sleeping pattern is especially important to reduce relapse in bipolar disorder.

7.6 The person who wants to harm themselves

This chapter is about helping people who have been thinking about or have tried to harm themselves. This includes people who want to end their life (who are suicidal) and those who harm themselves but who do not want to die (people who self-harm). The role of a health worker is to understand why the person wanted to harm themselves and to support them in the difficult period soon after a suicide attempt.

7.6.1 Why do some people want to end their life?

Many of us feel, at some time in our lives, that we have had 'enough' of living. If you think of all the difficult situations in which you might not want to continue your life, you will find that the people who consult you when feeling suicidal give the same kinds of reasons. There is one big difference, of course. For most of us, thoughts of suicide pass quickly and are often a reaction to a recent unhappy event. Most of us will talk it over with friends or family or work out solutions to our problems and the thoughts will go away. For some, however, suicidal thoughts or plans become more persistent and may be associated with mental health problems and severe life difficulties. The following health problems are associated with suicide.

- **Depression.** This is the most important mental disorder linked to suicide. Depression can make a person feel miserable, lose interest in life and lose hope for the future.
- **Alcohol and drug abuse.** Although many people drink alcohol and take drugs to feel better, in fact these substances literally 'depress' the brain. The despair of not being able to stop the addiction and the resulting physical health and financial problems may make the person feel suicidal.
- **Long-term health problems.** Illnesses which cause pain or which are terminal.
- **Severe mental disorders** such as psychosis or bipolar disorder.

Social and personal factors play an important part in making a person feel unhappy and suicidal:

- unhappy relationships, such as an unhappy marriage or a broken love affair
- poverty and economic difficulties, particularly when these happen suddenly, such as when a person loses their job
- losing someone you love (e.g. when they die ☞ 10.4)
- not having friends with whom you can share your problems and feelings
- adolescents may become suicidal when they fail in school or have fights at home with their parents (☞ 11.8); many adolescent suicide attempts are impulsive (i.e. they are often triggered by sudden disappointments).

7.6.2 How to deal with this problem?

The emergency management of a person who wants to harm themselves is given in flow chart 6.3. In this section we cover the detailed assessment and longer-term care for self-harming behaviour.

BOX 7.7 GENDER, AGE AND SUICIDE

Women are more likely to suffer from depression and the social stresses that can make a person unhappy. Thus women are more likely to attempt suicide. However, the risk of death by suicide is usually higher in men. Similarly, young people are more likely to attempt suicide, but the risk of death is greater in older people. One reason for this difference is that men, particularly older men, may choose more dangerous methods of suicide (such as hanging or pesticide poisoning) and are, therefore, more likely to succeed in their attempt. The choice of a more dangerous method is also the reason that young women in some societies are more likely to die by suicide. Take all suicide attempts seriously, whether by men or women, young or old.



Questions to ask the person

- What happened?
- What did you think would happen when you did this to yourself? Were you trying to end your life? Why? What has happened recently?
- Did you have a plan? How long were you planning it? Did you tell anyone else about your plan?
- How do you feel now? Have you been feeling depressed recently? Have you lost interest in life? (*Ask questions to detect depression* ⇨ 3.9.)
- Do you think that you drink too much alcohol (or take drugs)? (*Ask questions about problem drinking* ⇨ 3.9.)
- What reasons are there for you to continue living? (*This is an important way of trying to get the person to think of the good things in life.*)



Questions to ask the family or friends

- What happened?
- Has the person ever attempted suicide before?
- Is there a history of a mental disorder or a serious physical illness?

BOX 7.8 SUICIDE AND THE LAW

In many societies, attempting suicide is an offence, and suicide becomes a legal or police case. Your first concern must be the person who made the attempt. If the person has a supportive family and the suicide attempt was because of a minor stressful event, you may decide not to inform the police. However, it is sometimes the case that the suicide attempt is the symptom of serious harassment or problems at home. Typically, women who are being beaten by their spouses or abused by their in-laws may try to end their lives. Informing the police about domestic violence, after discussing this with the woman first, may help. In more serious cases, an apparent suicide attempt may ultimately turn out to be an attempt to kill the woman. These are complex situations and you should discuss them with your colleagues. If you have a good link with the local police, you may be able to get their advice without registering a formal case.

- Has the person had a recent loss, for example, separation from the spouse?

Judging the seriousness and risk of further suicide attempts

Whenever a person harms themselves intentionally, it needs to be taken seriously, whether or not the life of the person has been threatened.

It is difficult to predict whether a person will attempt suicide again. Based on the responses to the questions asked above, the factors which should make you concerned about the risk of repeated attempts are:

- a method of suicide which is potentially lethal, for example, hanging or use of pesticides
- a carefully planned event, for example, one in which a note was left
- continued suicidal thoughts
- hopelessness about the future
- evidence of severe depression
- evidence of severe life difficulties and losses
- lack of social support
- alcohol abuse or severe physical illness
- previous suicide attempts
- older age of the person attempting suicide
- presence of psychotic symptoms.

Special interview suggestions



- Suicide is a sensitive and personal matter. Talk to the person in private. Give them enough time to feel comfortable and share their reasons frankly.
- Do not make judgements about the person's character.
- Do not make reassuring statements without fully understanding the person's situation, because this may make them feel even more hopeless.
- Talk to family or friends for their version of the person's recent life situation and health. You may need to form a trusting relationship with one individual who can help support the person at home.



| A woman in an unhappy relationship may feel her situation is hopeless and believe she would be better off dead.



What to do immediately

- Follow the emergency guidelines for the suicidal person (⇨ flow chart 6.3).

What to do once the person's life is not in danger anymore

- If the person has depression or abuses alcohol, treat accordingly (⇨ 7.4, 9.1). If you prescribe a medication for depression, choose an SSRI antidepressant rather than a tricyclic antidepressant because they are safer if overdosed. If only tricyclic antidepressants are available, reduce the chance of harm by prescribing small amounts at any one time (e.g. 1 week's supply) or entrusting the medications to a family member.
- Many suicidal people face difficulties in their lives which need to be tackled. Try to identify social issues which may have led the person to feel suicidal. Problem-solving can be helpful (⇨ 5.11).
- Make a crisis plan: think through with the person what they will do if they start to feel suicidal again. For example, they can keep a card listing all of the positive reasons to live and read it in moments of crisis, seek the company of others, do an activity to distract them from the negative thoughts, and come back to the clinic for an emergency appointment if the thoughts don't go away.

- Depressed people tend to view their life in a negative way. Counselling strategies that focus on 'thinking healthy' are helpful (⇨ 5.14).
- Make a plan to review the person in a week or two, and then regularly for a few months until they have been able to address their social difficulties or the suicide risk is very low.

When to refer

- If the suicide attempt is serious and life-threatening
- Persisting suicidal ideas despite counselling
- Serious mental disorder, such as a psychosis
- Repeated suicide attempts



What to do when the family is not interested

You will need to rely on the family for supporting the person, particularly during the period just after a suicide attempt. If, however, there is conflict or violence in the family or the family is not interested, you may need to think of alternatives. Remember that you should discuss these alternatives first with the person and then follow one or more of these actions:

- refer to a women's group or shelter: contact the local women's groups or shelters and ask them if they can arrange for temporary relief accommodation (⇨ 10.2)

- seek support from other people: for example, if a person is being harassed by work colleagues or family members, you could contact their relatives, friends or members of their religious group.

7.6.3 The person who threatens suicide or harms themselves again ... and again ... and again

Remember that such people are at higher risk of killing themselves. The best way of helping them is keeping in touch regularly and building up a trusting relationship so that, when upset or un-

happy, they can talk to you rather than try to kill themselves.

This is the type of person who is brought to an emergency unit repeatedly after threatening suicide or harming themselves. It is often easy to dislike such people, because the attempts are not usually dangerous and the person is seen as 'acting' and wasting the health workers' time. However, these people are not acting; their lives are unhappy and they need help. The most common example of such self-harming behaviour is cutting the skin superficially with a razor blade. The person may describe the experience of cutting as a 'release of tension' or making them feel as if they are 'real' or as a way to distract themselves from



a.



b.



a.



b.

| Inappropriate (a) and recommended (b) interview questions.

distress. Other harmful behaviours that might go along with cutting include burning oneself with cigarettes or swallowing a bottle of medicines. Self-harming behaviours can also be a sign of depression.

Often there is a trigger for the self-harming behaviour (e.g. an argument or other unhappy event). Support the person to react to unhappy events by means other than harming themselves. Identifying areas of strength, such as a supportive relationship or an occupational skill, may help the person in looking at the 'brighter side' of life.

Some of the counselling strategies may be helpful: try problem-solving (⇨5.11), relaxation training (⇨5.12) and thinking healthy (⇨5.14).

7.6.4 Loneliness and isolation



Loneliness is often a cause of a person feeling depressed and suicidal. This is particularly common among older people. Some solutions are to:

- make contact with old friends, neighbours or relatives with whom the person has not been in touch
- invite relatives or friends for a meal or social occasion

BOX 7.9 FOLLOWING A COMPLETED SUICIDE

Prevention of suicide is the goal. Nonetheless, despite our best efforts, some people will go on to complete suicide. This tragic event has consequences for those left behind. As well as experiencing distress following a suicide, family and friends may feel angry, ashamed, betrayed or guilty. Be aware of such reactions and offer people support if they need it. Visit family members who have survived the suicide, explore how they are feeling and coping with the loss, reassure them that they should not hold themselves responsible as many suicides are unpredictable, avoid making guesses about why the person died by suicide, and stress that they have the support of the health care team.

Health workers may also struggle to come to terms with the suicide of a person who they had been treating. They may feel responsible for the suicide and think they did something wrong. Take time to discuss the suicide of a patient of yours with your colleagues or your supervisor and reflect on what lessons this may have to help you provide care for other people who may be at risk, but never hold yourself responsible for the suicide.

- engage with community resources, for example, clubs to play card games
- do activities which involve social contact, for example, shopping in the market
- make the most of time when alone by doing enjoyable activities such as gardening or walking.

SECTION 7.6 SUMMARY BOX

THINGS TO REMEMBER WHEN DEALING WITH SUICIDAL AND SELF-HARMING BEHAVIOUR

- **Never take a suicide threat lightly.**
- Suicidal and self-harming behaviour is often associated with mental health problems such as depression and alcohol or drug abuse.
- Asking someone about suicidal thoughts does not make it more likely that they will end their life. On the contrary, most people feel relieved when they can talk about it with a health worker.
- Many persons who attempt suicide have a severe life problem such as marital or financial difficulties.
- Emergency treatment of the suicide attempt is a priority. Once the person is medically stable, treat any mental health problem, make a crisis plan for future suicidal thoughts and identify relatives or friends who can support the person.

7.7 The woman who develops problems in relation to pregnancy and childbirth



Pregnancy is, for the majority of women, a positive experience. The arrival of a newborn baby is greeted with pleasure and joy. However, some women develop mental health problems.

Women can develop mental health problems in relation to pregnancy, pregnancy loss (e.g. due to a miscarriage, induced abortion or stillbirth) and childbirth. Some mental health problems are triggered by pregnancy or childbirth (e.g. psychosis), but most of the mental health problems that develop at these times are just the same as at any other time in a woman's life. However, problems experienced around the time of pregnancy can have an enduring impact on the woman's sense of self and her confidence as a woman. In addition, untreated mental health problems in the woman can also have negative effects on the child and on the mother-child relationship.

7.7.1 Pregnancy

A woman may face a number of issues around her pregnancy, for instance, it may not be wanted. This is especially the case when a child is conceived as a result of sexual assault or out of wedlock, when the woman already has many children and the family would struggle to cope with another child, or when the pregnancy is unwanted. Be sensitive to the woman's response to her pregnancy. Even when a pregnancy is initially unwanted, many women adjust to the idea of pregnancy and do not have problems later on. However, for

some women an unwanted pregnancy can trigger depression or anxiety. This is also more likely to occur in women who have poor marital relationships or medical complications of the pregnancy, or who have previously had bad pregnancy outcomes (e.g. a traumatic labour or death of the baby).

Untreated mental health problems can be harmful to both the woman and her unborn child. Such women are more likely to neglect their health, to not put on enough weight, and to not attend antenatal care appointments or plan adequately for the birth, and they may start drinking alcohol or taking drugs to ease their mental distress. This underlines the importance of detecting and treating common mental health problems in pregnancy.

Pregnancy has long been considered to protect against suicide and self-harming behaviour, but this is not always the case. Particularly when a pregnancy is unwanted and when the woman does not have access to abortion services, the risk of suicide may be increased.



Most mothers will be happy and satisfied when the new baby arrives.

However, some mothers can become unhappy and distressed.

Severe mental disorders (psychosis and bipolar disorder) are rarely triggered by pregnancy; they are more common in the postpartum period. Women with pre-existing severe mental disorders or developmental disabilities can also become pregnant. These women have special needs, as discussed in Box 7.10.

Alcohol and drug use pose particular problems in pregnancy, as discussed in Box 7.11.

7.7.2 Pregnancy loss (abortion, miscarriage)

Losing a pregnancy owing to abortion or miscarriage can lead to depression. The woman may feel guilty about having had an abortion. In the case of a miscarriage, there may be a loss of self-esteem resulting from the woman's inability to rely on her body and give birth. Feelings of loss, sadness, emptiness, anger, inadequacy, blame and jealousy are sometimes experienced after the loss of a pregnancy.

7.7.3 After childbirth

- **The 'blues':** this is a common emotional state which occurs within the first week after the baby is born. Typically, the woman feels tearful and sad. This is a harmless condition which gets better by itself after a few days in a supportive environment.
- **Depression:** this is similar to depression in any other situation. It becomes obvious about a month after the baby is born. The woman may feel tired, have sleep problems and feel tearful. She may lose interest in herself and her baby.
- **Psychosis or manic episode:** this is the most severe postnatal mental health problem. Thankfully, it is also the rarest. However, if a woman has a pre-existing diagnosis of psychosis or bipolar disorder then she is at high risk of relapse (around 50%) in the post-partum period if she is not taking appropriate medication. Symptoms become obvious within 2 weeks of the birth. They worsen very quickly so that the woman may lose touch with reality, have bizarre ideas and hallucinate.

BOX 7.10 WHEN A WOMAN WITH A MENTAL HEALTH PROBLEM BECOMES PREGNANT

If a woman with existing mental health problems becomes pregnant, she needs additional support for both her obstetric and mental health care. Mental health problems can sometimes improve during pregnancy. However, pregnancy can also be stressful and lead to relapse. Mental health problems also increase the chance of pregnancy and obstetric complications.

One important issue is the effect of medications on the unborn baby. As a general rule, it is best to avoid any medication used to treat mental disorders in the first 3 months of pregnancy. In particular, mood stabilisers and benzodiazepines should be avoided, whereas antidepressants and antipsychotics are relatively safer. Try to avoid unnecessary medications when a woman is breastfeeding. If essential, monitor the baby's health more closely. In reality, however, there is only a tiny risk of medications being passed into the breast milk and, if the woman is very depressed or agitated, medications may help improve her mood. This, in turn, will help her bond with her baby, which is very important for both the woman and the baby.

When a woman who has a mental health problem becomes pregnant, she and her family may be concerned that the mental health problem could affect the unborn child. They may ask about the genetic risk of the disorder being passed to the baby. Health workers should say that, apart from severe mental disorders (psychosis and bipolar disorder), there is no risk. Even for women with severe mental disorders, the risk is extremely small and the baby is far more likely to be completely healthy than not. Women with a developmental disability may need more time for the health worker to explain what is happening to their bodies.

There are many reasons why some women experience a mental health problem after childbirth:

- the extra work of looking after a baby and associated sleep loss

BOX 7.11 ALCOHOL AND DRUG PROBLEMS IN PREGNANT WOMEN

Any alcohol or drug use during pregnancy can have serious effects on the unborn baby, including low birth weight, intellectual disability and birth defects. Pregnant women who are dependent on alcohol or drugs may be too absorbed in their drug use to look after their health in pregnancy or attend antenatal care. Harm can also come to the woman and her unborn child through exposure to chaotic or violent environments and risk of infectious diseases. Women with drug dependence are more likely to have an unplanned pregnancy or to have become pregnant following sexual assault. The ability of the woman to provide adequate parenting and a safe environment for the new baby can also be in question.

For all of these reasons, women who use alcohol or drugs during pregnancy are a high-risk group and need a lot of additional support and care. Given the complexity of the problems, it is best to refer the woman for specialist care if available. If you cannot refer, use counselling strategies such as 'motivating for change' (⇨ 5.17). Remember that becoming pregnant can itself be a motivator for the woman to quit using drugs. Try to involve family in supporting her and planning for the care of the new baby. Non-governmental organisations (NGOs) may be able to provide social or financial support.

- childbirth is an event of great emotional significance and such events can trigger depression
- the loss of independence for the woman
- the change in the relationship between the woman and the baby's father
- cultural factors (e.g. having a girl in some societies is a source of disappointment)
- women who have unhappy marriages or who had difficult deliveries are more likely to develop mental health problems postnatally
- during pregnancy and the postnatal period, a woman's body undergoes many physical and hormonal changes, which can lead to emotional disturbance.

7.7.4 Why is the woman's mental health important?



Women generally have less emotional support once their babies are born. All attention, particularly of families, is focused on the baby's needs and health. The woman may be too embarrassed to admit she is feeling unhappy because of fear of what others might think of her. Thus, the health worker needs to be especially sensitive to the woman's emotions and mood. Postnatal mental disorders can last up to a year and affect both the woman and the baby. Babies may show problems in growth and development and be more likely to develop health problems (e.g. diarrhoea), have accidents and not be taken for vaccination.

7.7.5 How to deal with this problem

Questions to ask the woman



To detect a depression

Physiological changes due to pregnancy can lead to fatigue, reduced appetite and interrupted sleep. Similarly, the period after childbirth is often associated with having to be up at different times of the night to nurse or change the baby, and this can interfere with sleep and make the woman tired. Many of the physical symptoms of depression, such as tiredness and sleep problems, are common in women who are not depressed. Therefore, it is the emotional and thinking symptoms which are often more important to identify the depression (⇨ 3.9). You should ask questions such as:

- Have you been feeling sad or unhappy?
- Do you feel hope for the future?

- How do you feel about becoming pregnant?
- (*If post-partum*) Are you able to enjoy the baby? Are you coping with looking after the baby? What support do you have with caring for the baby?
- Have you been feeling so bad that you have thought of harming yourself? (*If a post-partum woman has these feelings, ask whether she has felt so bad about things that she has also had thoughts of harming her baby.*)
- Does she seem to be out of touch with reality? Does she talk to herself or to imaginary voices? (*If so, then a psychosis is likely.*)
- Has this ever happened before? (*Severe post-natal depression is more likely in women who have had the illness at other times in their lives.*)
- Does she talk about killing herself? Does she talk about hurting the baby? (*These are signs that the illness is serious.*)

To detect a severe mental disorder

If you suspect psychosis or a manic episode, ask questions such as:

- Have you had difficulty controlling your thoughts?
- Have you been feeling as if people were talking about you or trying to harm you?
- Have you had unusual thoughts, such as feeling as if you have unusual powers?
- Have you had thoughts of harming your baby?
- Have you been hearing voices even when there is no one around?



Things to look for during the interview

- Take note of how the woman interacts with her baby. Does she respond appropriately when the baby cries? Does she seem interested in the baby? Does she seem anxious or frightened around the baby? Are there any concerns about the way she handles the baby? (*Such concerns may indicate the risk to the baby due to the mother's mental health problem.*)



Questions to ask the husband or family members

- When did you notice the problem? (*The different types of postnatal mental health problems begin at different times after the baby is born.*)
- Is she adjusting to pregnancy as you expect her to?
- Is she looking after herself/the baby as you would expect her to? (*In the most serious cases, the woman may lose interest in her baby.*)
- Has she been crying a lot? (*This is a typical feature of depression.*)

What to do immediately



For common mental disorders in pregnancy

- Reassure the woman and the family that the symptoms are the result of a common mental disorder (Box 7.3). The disorder is treatable and, with appropriate treatment, there is very little risk of harm to the woman or the unborn child.
- Try to address any factors contributing to the depression, such as domestic violence (↗10.2).
- Consider counselling strategies such as relaxation (↗5.12), getting active (↗5.13), thinking healthy (↗5.14 and Box 7.12) or improving relationships (↗5.15).
- If the depression does not improve within a week or if there are suicidal feelings, you can use an antidepressant medication. Ideally discuss this decision with a specialist. Tricyclic antidepressants (e.g. amitriptyline) or sertraline (an SSRI antidepressant) are the preferred medications in pregnancy. Sertraline also has advantages if a woman breastfeeds, as it is short-acting.

For the postnatal 'blues'

- Reassure the woman and family that the emotional distress following childbirth is very common and temporary.
- Encourage her to hold and play with her baby and to breastfeed if she is able to do so.
- Recommend that someone helps her take care of the baby during those few days.
- She should get adequate rest.
- Talk to her and let her share her concerns and worries.

- If she does not feel better in a week, keep a closer watch, because this may be a sign that her blues are becoming a more severe mental health problem.

For postnatal depression

- As with common mental disorders in pregnancy, give reassurance and explanations (as above).
- Ask the father or relatives to help the woman in caring for the baby.
- Talk to the woman regularly about her symptoms and worries.
- Ensure she gets adequate rest and food.
- Encourage her to hold and play with her baby and to breastfeed if she is able to do so.
- Consider counselling strategies such as relaxation (☞5.12), getting active, e.g. taking the

BOX 7.12 THINKING HEALTHY FOR MATERNAL DEPRESSION

- A programme of ‘thinking healthy’ for pregnant women delivered by community health workers has been developed in Pakistan and is recommended by the World Health Organization for other countries. A detailed manual explaining the ‘thinking healthy’ programme can be downloaded from www.who.int/mental_health/maternal-child/thinking_healthy/en/
- The manual uses pictures to explain the ideas behind ‘thinking healthy’ so that you can use this approach with women who cannot read and write. ‘Thinking healthy’ takes the same general approach as the counselling strategies of ‘thinking healthy’ and ‘getting active’ described in ☞Chapter 5. However, ‘thinking healthy’ for postnatal women is targeted much more closely to the needs of a new mother and emphasises the health and development of the infant too. ‘Thinking healthy’ focuses on the woman’s well-being, the mother–infant relationship and the woman’s relationship with her husband or other key family members. Many mothers seem to prefer this approach compared with just focusing on the woman’s mental health.

Fathers should help look after the baby.



baby out for fresh air with some other new mothers (☞5.13), thinking healthy (☞5.14 and Box 7.12) or improving relationships, e.g. with particular emphasis on the change in the woman’s role as mother and the changing relationship with her spouse or partner (☞5.15) as appropriate.

- If the depression does not improve within a week, or if there are suicidal feelings, you can use an antidepressant medication. For breastfeeding women, an SSRI antidepressant is preferable to a tricyclic antidepressant. Sertraline is short-acting and less likely to cause any symptoms in the baby compared with the more long-acting fluoxetine. Use the lowest therapeutic dose which is effective (e.g. sertraline 50 mg daily). Continue the medication for 9 to 12 months after full recovery.
- Be aware that women who become depressed after childbirth are may have bipolar disorder (☞7.5), so monitor the mood carefully for a change to a ‘high’ state.

For psychosis

- The woman may need to be admitted to hospital for a few days. Refer her to the nearest mental health or other appropriate hospital.
- Use antipsychotic medications to bring the illness under control. You can use any of the antipsychotic medications (☞Table 14.2). A benzodiazepine medication at night (e.g. diazepam 5 to 10 mg) will help the woman get adequate rest, but do not continue beyond 2 to 3 weeks.
- If the woman has a manic episode, she may benefit from a mood stabiliser (☞7.5), but avoid lithium if the woman is breastfeeding.

- In many cases, the baby needs to be cared for by a family member until the woman is fully well.
- Allow the woman as much time and contact with her baby as she wishes, as long as she is supervised carefully. As she improves, encourage her to gradually take over her role of mother.
- Continue the medications for at least 12 months after the symptoms have passed.



When to refer

- Refer women who show symptoms of psychosis or mania.
- Women who have tried to harm the baby.

- Women who have no family support and may be at risk of suicide or of harming the baby.

What to do later

- See the woman regularly until she is better. Always screen for suicidal thoughts and thoughts of harming the baby.
- Keep a close watch on the woman's mental health when she has another baby; postnatal mental health problems may recur with subsequent births.
- Chapter 12 for information about integrating mental health care into maternal health care.



SECTION 7.7 SUMMARY BOX

THINGS TO REMEMBER FOR THE WOMAN WHO DEVELOPS MENTAL HEALTH PROBLEMS IN RELATION TO PREGNANCY AND CHILDBIRTH

- Women can develop mental health problems after childbirth because of depression, psychosis or mania.
- Because women are expected to be happy and involved in baby care, they are less likely to share negative feelings and emotions with others.
- Postnatal depression is a common condition. It is more common in women whose marriages are unhappy or who have had a difficult delivery.
- The majority of women can be helped by counselling strategies and antidepressant medications given by the health worker.
- Postnatal psychosis is best treated in a specialist unit; if this is not available, treat the woman with antipsychotic medications and ensure that family members assist the woman in the baby's care.

7.8 The elderly person with disturbed behaviour

The most common disturbed behaviours in elderly people are aggression or confusion. Less often, family members may complain that the elderly person has become sexually inappropriate, or is constantly demanding to go out of the house because they are confused. Another type of disturbed behaviour is when a person simply withdraws from everyday life and appears to lose interest in things. This is less likely to be consid-

ered as 'disturbing' but is an important sign of a mental health problem.

7.8.1 What can make an elderly person behave like this?

There are four main reasons that an elderly person may change their behaviour.

- **Depression.** The common features of depression in elderly people are withdrawal from everyday life, loss of appetite, poor sleep and physical complaints. Some depressed elderly people can become agitated and suicidal.

- **Delirium or confusion.** The typical feature of delirium is that it is sudden in onset; the disturbed behaviour will have begun in the past few days. There is confusion, the person may be hallucinating and may be agitated.
- **Psychosis.** Severe mental disorders can cause suspicious thoughts and hallucinations. Psychosis can also occur in elderly people who have dementia.
- **Dementia.** This is a mental disorder which mainly affects older people, especially those who are more than 65 years of age. The earliest sign of the disorder is memory problems. The disorder usually comes to the notice of the health worker because of the disturbed behaviour. Dementia is a disease where the brain gradually degenerates. At present, there is no cure for this disease, and most people will gradually get worse and die within a few years. The most common causes of dementia are Alzheimer's disease and strokes.



BOX 7.13 THE STAGES OF DEMENTIA

Early stage

The person may appear confused and forgetful about things that have just happened. Concentration and making decisions become difficult. The person may lose interest in their usual activities. Most families (and health workers) consider this phase as a part of 'normal' ageing.

Middle stage

Confusion, forgetfulness and mood changes become more severe. Behavioural problems such as aggression and sexual problems may occur. The person may wander out of the house, their sleep becomes very disturbed and their ability to look after themselves becomes affected. Even simple things like dressing may become impossible. The person may have difficulties with talking and understanding everyday conversations.

Late stage

The person no longer recognises family or friends. Loss of weight, seizures and incontinence of urine and stool may occur. It is almost impossible to have any sensible conversation with the person. The person may appear confused all the time. Death usually happens due to pneumonia or other infections.

7.8.2 Memory problems in old age: when is this abnormal?

We associate growing old with becoming absent-minded. This is true in the sense that our mental abilities fade as we grow old. However, this does not mean that we forget who our family members are, where we live or other important facts of our daily lives. The memory loss of dementia is much more severe than in normal ageing. Thus, the person with dementia will not remember what they did the previous day, the names of close family members or their home address. As the disorder gets worse, the person may forget the day or time, what they have just said (so that they say the same thing again and again) or even who his wife or son is (Box 7.13).

7.8.3 When should you suspect dementia?

Suspect dementia in the following situations:

- an old person who is brought with complaints of disturbed behaviour
- an old person who is forgetting things more than usual
- an old person who is confused, agitated or aggressive for more than 1 month.

7.8.4 How does dementia affect the family?

The elderly are held with respect and love in most families. When an elderly person starts behaving in an unusual manner, it causes the family a great deal of distress. The person may forget who their

closest family are. Aggressive behaviour, agitation and confusion, and sexually inappropriate behaviour cause great difficulty to the family. As the disorder gets worse, the person gradually loses the ability to care for themselves. Soon, all daily activities such as feeding, bathing, dressing and toileting have to be done with help from others. In the final stages of the illness, the person is completely bedridden and needs constant care. You can well imagine how profound the impact of the disorder can be, given that dementia can last up to 7 or 8 years.

7.8.5 Why is diagnosis of dementia important?

As with any other disorder, knowing why a loved family member is behaving in a strange manner can make the burden less stressful. If the diagnosis is made during early dementia, the person themselves may benefit from knowing the diagnosis. The family (and the person, where possible) can be taught what to expect in the years ahead and plan for the future. It is also important to note that in a few people the dementia is caused by a treatable disease such as low thyroid function. Another important reason for accurate diagnosis is to make sure that the person is not suffering from depression, the other mental health problem seen in old age, which can be treated quite effectively.

7.8.6 How to deal with this problem

Dementia is a progressive and terminal disorder. It is essential that you should diagnose it only if there is clear evidence (as described below).



Caring for a loved one with dementia can be very distressing.

Special interview suggestions

Even if the person has poor memory and looks confused, introducing yourself is very important. The introduction serves to give the person some idea of where they are and who they are talking to. Interview the person with a family member who can help clarify the questions which the person cannot answer. Be sensitive to the person becoming distressed if they are aware that they cannot answer your questions.

Questions to ask the person

Assess for memory and cognitive problems.

- I would like you to remember the following three objects (e.g. ball, flag, tree). Can you repeat them back to me? After a few minutes I will ask you again. (*Note whether the person can immediately remember the objects.*)
- Can you tell me what year it is? What month? What day of the week? What time of day? (*This will help check for orientation to time.*)
- Can you tell me what this place is? (*For example, that this is a clinic.*) Where is this place? (*These will check for orientation to place.*)
- Now, can you remember the three objects that I told you earlier? Please tell me them now. (*Note whether or not the person is able to remember the objects.*)
- Please point to your elbow, your nose, your ear. (*These questions will help you to identify if the person has problems with language.*)

If the person appears to understand the questions reasonably well, you should now ask questions about feelings and emotions (⇨ 3.9).

Questions to ask the family or friends

- When did you first notice a problem? (*Often, a family member will recall symptoms starting several months or years before the person first sought help; if the onset is more recent, consider delirium.*)
- How did the illness start? Was there a stressful event? (*This history may suggest depression.*)
- Does the person have problems remembering things, such as names or which day it is?



(Memory problems are the classic symptoms of dementia, but can also occur in depression.)

- Does the person have difficulties with everyday activities such as eating and bathing? *(If yes, this would suggest dementia.)*
- Do the symptoms get worse at night? Is the person ever drowsy in the daytime? *(Consider delirium.)*
- Does the person have any difficult behaviour? For example, do they become aggressive or agitated? Wander out of the house? Accuse people of stealing their possessions? *(These symptoms are more typical of dementia.)*
- Has the person seemed sad or lost interest in daily life? *(These are typical symptoms of depression, but can also occur in dementia.)*
- Has the person suffered from a mental health problem in the past? *(If the person was depressed in the past, then there is a higher chance that they may be depressed again.)*
- Who is the main family member caring for the person? And how are you coping? *(The person who is providing care often needs counselling, and asking them about their experiences is a useful way of understanding their needs.)*

Things to observe

Notice the interaction between the older person and their family to detect whether the family is overwhelmed with the caring responsibility and needs more help. Does the person seem fearful? Is there any evidence of bruising or injury which might suggest abuse? Does the person's level of personal hygiene indicate that they are being cared for adequately?

Working out what's wrong

There are three important diagnostic decisions a health worker must make.

- First, it is important to tell the difference between the four conditions which can cause disturbed behaviour. Sometimes, two of these conditions can occur together. This is especially true for dementia and delirium (or confusion) and dementia and psychosis. The first priority is to ensure that the person

is not confused, because delirium can be life-threatening and is often treatable. Once this is excluded, or if you are in doubt, treat the person as if they are depressed. If the person is depressed, they will recover and, if not, you will not have harmed them. Only if the person is neither depressed nor confused should you consider the possibility of dementia. Sometimes, it is necessary for the person to be seen by a mental health specialist to make the correct diagnosis. Computed tomography (CT) scans of the head may also help in making the diagnosis of dementia.

- Second, a diagnosis of dementia can be made if (1) a family member reports that the problem has been present for at least 6 months, is getting worse and is causing difficulties in daily living, and (2) a health worker has assessed that the person has significant memory problems.
- Third, if it is a dementia, make sure that there is no treatable medical condition which is causing it. The main ones to think of are thyroid disease, head injuries which cause slow

BOX 7.14 DEMENTIA IN LOW- AND MIDDLE-INCOME COUNTRIES

Dementia is well recognised in high-income countries because these nations have a significant proportion of older people. Low-income countries, on the other hand, have had a relatively small proportion of older people and a much higher proportion of children. This balance is changing as birth rates fall and the expected life-span increases. This means that dementia will become more common in the future as more and more people live to older age. Most high-income countries have well-organised health and social care systems to support people and families through the long and difficult course of dementia. This is not the case in most low-income countries. Thus, societies will face growing numbers of people with dementia without much awareness or services for them. This is why dementia is an important problem for health workers in low-income countries.

bleeding inside the head, HIV (in younger people), vitamin B12 deficiency, chronic kidney or liver disease, and brain cancers. In addition, screen for high blood pressure, high cholesterol and lipids, and diabetes, and provide treatment or refer if need. This may help to slow down the progression of dementia.



What to do immediately

- If the person is psychotic or confused, follow the guidance in [☞ 7.1](#) and [7.3](#).
- Ask the person who is being assessed for possible dementia whether they wish to know the diagnosis and with whom it should be shared. Give information about dementia and what to expect ([Box 7.15](#)).
- If the person is suffering from advanced dementia, it is likely that the main person you will have to advise and support will be a family member.
- Make a realistic offer of ongoing help and support and inform the person and their family members about sources of support available in the community ([☞ 12.4.1, 15.2](#)).
- Always exclude physical causes of disturbed behaviour, for example, pain, urinary infection or constipation.
- In cases where the behaviour is very disturbed and the person poses an imminent risk to themselves or to others, and when non-medication approaches are not working, medications can be helpful to calm the person. A useful medication is haloperidol. Start with a small dose of 0.25 mg twice daily and increase slowly, if needed, up to 2 mg twice daily. Do not use benzodiazepines as they may make the problem worse.
- If the person with dementia also has depression, try counselling strategies first (for example, getting active). If that does not help, consider an antidepressant. SSRI antidepressants are preferred over tricyclic antidepressants.
- Some people with dementia lose a lot of weight and this may contribute to faster deterioration and poorer quality of life. Give the family advice on high-energy foods to try to

build up the person's weight. Monitor the person's weight. If needed, prescribe nutritional supplements to help the person to regain a normal weight.

- Caring for a person with dementia, like many other chronic and disabling diseases, can be a very stressful experience ([☞ 12.6](#) for advice to the family on how to deal with this stress).
- Refer the person providing care to a support group for families affected by dementia. Such support groups are increasingly available in many countries ([☞ Chapter 15](#)).

When to refer

- If you suspect delirium or a medical cause, refer for urgent hospital assessment.
- If the person is under 60 years of age, as treatable medical causes may be present.
- To confirm the diagnosis of dementia, if possible, and for assessment and treatment of cardiovascular disease.
- To see whether the person would benefit from a medication for dementia ([Box 7.17](#)).
- When the family member is unable to manage on their own.
- When physical health or behavioural problems become serious.



BOX 7.15 EXPLAINING ABOUT DEMENTIA

- Dementia is a disorder of the brain that gets worse over time.
- Although there is no cure for dementia, there is a lot that can be done to help with quality of life.
- Brain tonics (marketed as improving memory and brain function) are not effective and are a waste of money.
- Simple things can help to keep the person doing their usual activities for longer ([☞ practical hints in section 7.8 summary box](#)).
- For disturbed behaviour, medications are a last resort. [☞ section 7.8 summary box](#) for other approaches.
- Some new medications can slow down the progress of dementia, but they do not stop the illness ([☞ Box 7.17](#)).

BOX 7.16 PRACTICAL TIPS FOR CARING FOR A PERSON WITH DEMENTIA

General tips

- Never forget that the person has dignity. Do not talk negatively about them in their presence.
- Preserve their privacy during intimate activities such as bathing.
- Show love and affection whenever possible. A hug is worth a hundred pills.
- Laugh with the person (never at the person).
- Avoid confrontation and arguments.
- Establish a daily routine. This makes life a lot simpler because you know what is to be done, how often, when and so on.
- Safety is very important; if the person is wandering around, for example, put safety locks on the doors.
- Keep the floor free of clutter.
- Adapt the home with hand rails and ramps if possible.
- As far as possible, let the person be independent. For example, many people can feed themselves, even if they are slow and unsteady. Keep tasks simple. Help make the best of a person's abilities; simple tasks can be found for them to do, which could also provide some exercise.
- Make sure that the person's spectacles are correct or provide a magnifying glass. Also check that the person does not need hearing aids.
- Speak slowly and clearly. If the person has not understood, try to say things using simpler words and shorter sentences. Minimise background noise.
- Spend time looking over photo albums – old memories may not be affected as much as recent memory and this can bring the person pleasure.
- Use memory aids such as labelling doors to the bathroom or a writing board in the room on which today's day and date are written every day.
- Avoid unnecessary medications.



Bathing and personal hygiene

- Independence: let the person do as much as possible unaided.
- Dignity: bathe the person with underpants on.
- Safety: a chair to sit on while being bathed; a mat which does not slip on a wet floor.



Toileting

- Encourage a regular toilet routine.
- Use clothing which can be easily removed (and put back on).
- Limit drinks at bed time.
- Keep a vessel for urine during the nights.
- Special pads for incontinence in older people can be made or purchased (like diapers for children).

Feeding and eating

- Use finger foods.
- Cut up food into small bite-sized pieces.
- Do not serve food too hot.
- Remind the person how to eat (with hands or how to use cutlery).
- If the person has difficulty swallowing, refer to a specialist.
- Mix the food and serve it in a ready-to-eat state (e.g. mixing the rice and curry).



Suspiciousness and anger

- Do not argue back; keep your calm.
- Try and comfort; hold the person's hands firmly and talk gently.
- Distract the person by drawing attention to something in the room.
- Find ways to soothe the person, e.g. with music or a walk.
- Try and find out what made the person angry and try to avoid this in future.
- Consider medication such as haloperidol.

Wandering away from home

- Use an identification bracelet or necklace.
- Keep the doors of the house locked.
- When the person is found, don't show anger.



What to do later

Arrange to visit the family at their home. You will often understand their needs far better this way. If you have given a medication, check on side-effects and how much improvement has occurred. Increase the dose as needed, but always remember that elderly people are more sensitive to side-effects. As the dementia gets worse, you will need to provide more intensive nursing support and guidance.

BOX 7.17 MEDICATIONS TO TREAT DEMENTIA

There is no medication that can cure dementia. Some medications can slow down the deterioration seen in dementia, but only for a short period. These medications (such as donepezil and memantine) should be prescribed by a specialist mental health worker. The medication may not be available in your country or it may be costly. Discuss the cost of the medication before referring a person and be careful not to give the person and their family unrealistic expectation about what the medication can do.

SECTION 7.8 SUMMARY BOX

THINGS TO REMEMBER WITH THE ELDERLY PERSON WHO HAS DISTURBED BEHAVIOUR

- Disturbed behaviour in the elderly can be caused by dementia, psychosis, delirium or depression.
- There is no cure for dementia. However, practical advice, emotional support and medication for behaviour problems can improve quality of life and reduce the burden of care.
- In somebody with dementia it is important to try to identify depression, psychosis or delirium, since these disorders should be treated first.
- Try all other approaches before giving medications. If needed, the dose of most medications in the elderly is about one-third to one-half of what you would use in adults.

7.9 The person who repeats the same behaviour again and again

Some people have a mental disorder where they repeat the same thing again and again. Typically, the person will wash their hands or body several times a day. Other examples are when the person repeatedly checks whether they have done something, such as locked the door or turned off the oven. These behaviours are called **compulsions**. Some people also have thoughts which repeat again and again. These thoughts are distressing, such as sexual thoughts or thoughts of harming a loved relative. These are called **obsessions**. There is often a link between the compulsion and the obsession. For example, a person may have a repeated thought that they are dirty, especially when they touch an object. This leads to the behaviour of washing hands. A person may have

the repeated thought that they have not closed the door. This leads to the behaviour of checking whether the door is closed. If this happens once or twice, then it is probably normal. Only if it happens many times a day, and makes the person feel distressed, is it a sign of an illness.

Obsessions and compulsions are symptoms of a mental disorder called **obsessive-compulsive disorder** (OCD). In reality, few people will ever complain of these symptoms to a health worker, because they are embarrassed. Instead, many people with OCD become very unhappy because of their symptoms and may complain of tiredness, worry or depression. You might also notice a person who has red, raw hands due to over-washing or a person who comes for repeated HIV tests because of obsessional thoughts that they have become infected, even when they are at low risk for infection.

7.9.1 How to deal with this problem



Questions to ask the person

- Do you have thoughts which come into your mind again and again? What kind of thoughts? Do they make you feel tense? Do the thoughts make you have to do something to feel less tense? (*These are questions for identifying obsessions.*)
- Do you do things again and again? What kind of things? Does this make you feel tense? What happens if you don't do it? Does that make you feel more tense? (*These are questions for identifying compulsions.*)
- Do you feel unhappy or depressed? Have you felt as if you are losing interest in daily life? (*Ask about depression* ↗ 3.9.)



What to do immediately

- Ask the person about their illness and what it does to them. This will give them an opportunity to discuss their symptoms with confidence.

- Explain about OCD (Box 7.18).
- Teach the person relaxation and breathing exercises (↗ 5.12).
- Teach the person how to resist the obsessions and compulsions (Box 7.19).
- Try using medication:
 - an SSRI antidepressant, such as fluoxetine 20 mg daily for 6 weeks and, if there is no improvement, increase to 40 mg a day. Continue for at least 9 to 12 months after recovery;
 - if an SSRI antidepressant is not available or is not effective, clomipramine is a tricyclic antidepressant which is found to be quite useful in OCD. It is started in a small dose of 25 mg at night, increased by 25 mg every 3–4 days to a full dose of 150 mg at night.

When to refer

If the steps above do not help, refer.



a.



b.

| A common type of obsessive-compulsive behaviour.



c.



a. Some people feel that they become dirty whenever they touch something, such as when shaking someone's hand.
b. These thoughts make them want to wash their hands each time they touch someone.
c. This makes them feel unhappy and distressed because they know this is irrational.

BOX 7.18 EXPLAINING ABOUT OCD

- OCD is a mental disorder when repeated thoughts (e.g. ‘Did I lock the door?’) come into a person’s head, which then lead them to do something in response (e.g. go back and check the door multiple times).
- The symptoms of OCD can seem silly – the person knows that the thoughts are not realistic (‘I just checked the door so I know it can’t really be unlocked’) but if they try to ignore them it makes them feel tense and fearful.
- As well as being distressing, OCD can be very disabling – many hours can be spent on doing behaviours in response to the unwanted thoughts.
- People often try to hide OCD symptoms because they are worried what others will say. This makes the problem worse.
- OCD can be treated. Usually medications are required. Counselling approaches are also important to learn how not to act in response to the unwanted, repeated thoughts.

BOX 7.19 HELPING SOMEONE TO OVERCOME OBSESSIONS AND COMPULSIONS

Exposure and response prevention for compulsions

This counselling method is based on the principle of exposing the person to the thought or situation which triggers the obsessional thoughts but preventing them from carrying out the compulsive behaviour. The person will experience the anxiety associated with the thoughts, but by resisting the response they will overcome the anxiety and learn how to cope with the thoughts appropriately. Here is an example of a common compulsion of hand-washing, to illustrate how this treatment works in practice.

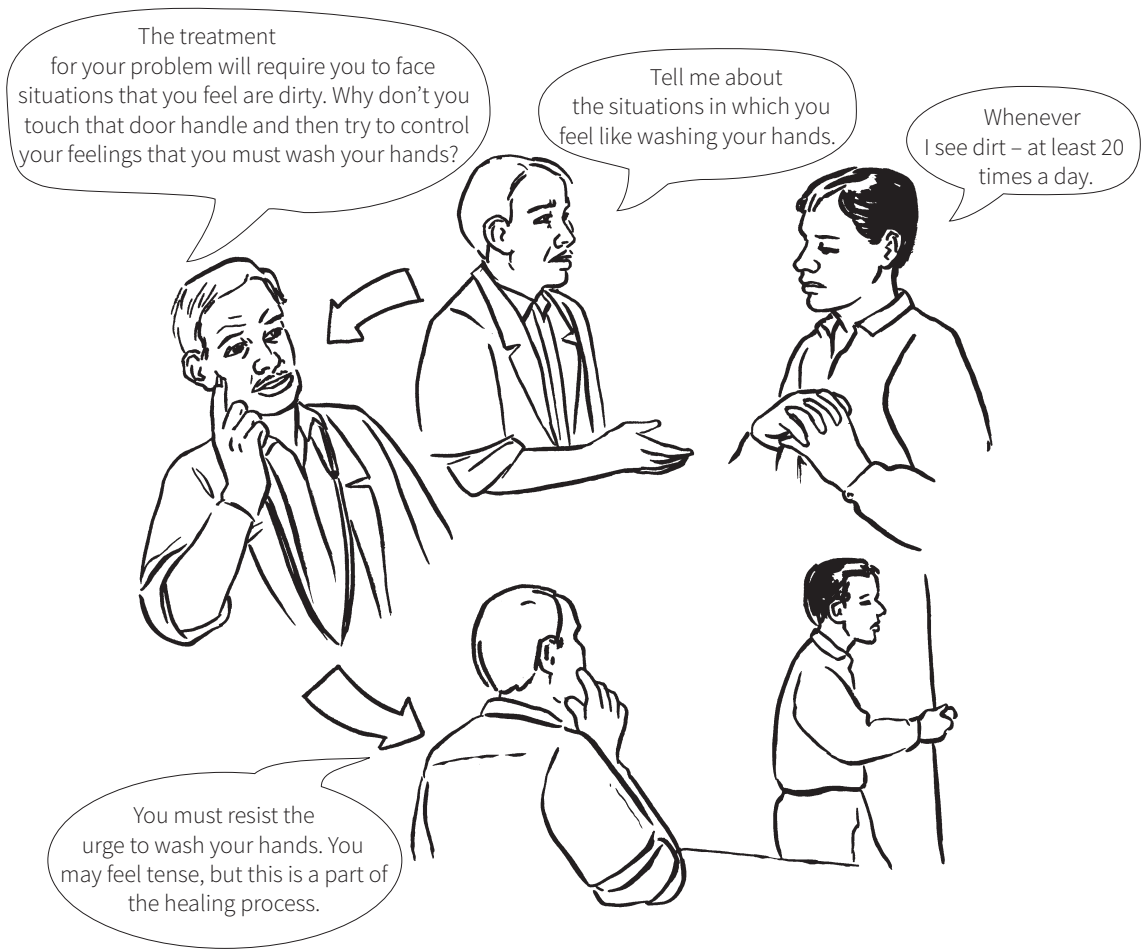
- Ask the person about the situations which lead to hand-washing. For example, she may say that whenever she sees any dirt in the house, she must wash her hands.
- Explain the treatment to her, especially that she will feel tense during the procedure. This is to be expected and is part of the process of getting better.
- Ask her to find some dirt in the clinic. When she does, ask her to resist the urge to wash her hands. She will feel tense, but this tension will always reduce with time. Relaxation exercises can help to reduce the tension (☞ 5.12).
- After she has done this, explain that this is how she should prevent her behaviour when at home.
- See her again in a week to check on how she is responding; if she has not been able to do it, find out why and try and get her to repeat it.

Treating obsessional thoughts alone

Some people with OCD only experience the distressing thoughts without any compulsive behaviour. Such persons often use mental techniques to distract themselves or avoid thinking the distressing thoughts. The principle of treatment remains the same, namely that the condition will gradually improve by repeated exposure to the feared thoughts and by resisting any mental rituals. The key, as before, is regular practice, particularly at home. The steps in treating these thoughts are:

- deliberately thinking the thoughts for pre-set time periods, for example 1 min, and then gradually increasing this time period
- writing down the thoughts repeatedly
- preventing any mental rituals or distraction from interfering with thoughts.

Thought-stopping is a technique where the person practices thinking the obsessional thought, and then firmly says ‘STOP’ in their mind. Instead, they think in detail of an alternative thought or scene which is interesting or relaxing. Before starting this treatment, the person should make a list of as many obsessional thoughts and alternative thoughts they can come up with. As with the other treatments, this should be practised first with the health worker and then for fixed periods of time at home until the person is able to stop the obsessional thoughts at any time.



SECTION 7.9 SUMMARY BOX

THINGS TO REMEMBER FOR SOMEONE WHO REPEATS THE SAME BEHAVIOUR

- Compulsions are behaviours that a person does repeatedly; obsessions are thoughts that a person thinks repeatedly. Both occur in obsessive-compulsive disorder (OCD).
- Repeated hand-washing and checking are the most common types of compulsion.
- Although OCD is not very common, it causes a lot of distress and disability.
- Both counselling methods and antidepressant medications can help most people suffering from OCD.

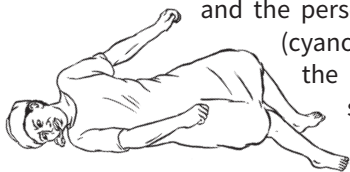
7.10 The person with seizures or fits[†]

Seizures or fits are when a person suddenly shows a change in his behaviour or consciousness lasting for a few minutes. In some seizures, there are shaking movements of the body (called convulsions) with loss of consciousness. There are also seizures in which the person may be fully awake or partly awake. The only changes may be short periods of losing touch with reality or repeated movements such as smacking lips. Epilepsy is an illness where seizures occur repeatedly. If a person had at least two seizures on different days within the past year, consider a diagnosis of epilepsy.

7.10.1 What are the types of seizures?

Seizures in adults are different from those in children. Childhood seizures are well described elsewhere (⇨ Chapter 18). In adults, three types of seizures are recognised.

- **Generalised seizures.** These are seizures in which the person loses consciousness for a couple of minutes. They become stiff and shake in a jerky manner. This seizure is associated with biting of the tongue, passing urine, and injury because of the sudden fall or movements. Observers may describe the person crying or screaming just before falling, the eyeballs rolling upwards, frothing at the mouth, and the person becoming blue



(cyanosis) or pale. During the seizure, the person is completely unconscious and will not respond to any verbal command. The seizure usually ends with the person being drowsy or falling asleep. Some people may develop a temporary weakness of their limbs.

- **Partial seizures.** These may occur in someone who is awake or in a person who is confused or has lost touch with their surroundings. The

seizures are very varied in their nature. Some seizures can be entirely localised to one area of the body, for example, jerky movements of the arm. Other seizures may involve complex behaviours such as smacking lips and buttoning shirts. Many persons experience a warning or 'aura' that the seizure is about to start. Examples of auras are an unusual feeling in the stomach area and hearing, seeing or smelling things which are unusual.

- **'Conversion' seizures.** In this type of seizure, there is no brain disease. Instead, the seizure is a physical expression of severe emotional distress. These seizures are more common in young women and are associated with psychological stress (⇨ 8.6 for more details on how to address conversion seizures).

7.10.2 Is epilepsy a mental health problem?

Epilepsy is caused by electrical changes in the brain. However, for many reasons, epilepsy is often considered a mental health problem.

Many cultures consider epilepsy as being caused by supernatural forces, such as witchcraft, similar to some types of mental disorders. In partial seizures, odd behaviours may be observed. Many persons with epilepsy develop mental health problems such as psychoses, depression and suicidal behaviour. Epilepsy can cause great stress to a person, for example, because of stigma and restrictions on daily life. Finally, one type of seizure in adults (the conversion seizure) is entirely psychological in origin. Thus, it is important not to ignore the mental health needs of people with epilepsy.

7.10.3 How to deal with this problem

This section focuses on the non-emergency assessment and management of seizures. ⇨ Flow chart 6.11 for emergency management if someone is having a seizure or if they have seizures that won't stop.

Getting a clear account of exactly what happened is essential because many conditions can

[†]With Manjari Tripathi.

look like seizures. The main information you need to make a correct diagnosis is what an observer tells you about what the seizure looks like, and what the person tells you about their experience of the seizure.

Proceed as follows in dealing with the problem of a seizure.

1. Check whether the characteristic features of a seizure were present (Box 7.20).
2. Check that the episode was not a faint (Box 7.21).
3. Make sure that the episode was not a conversion seizure (Box 7.22).
4. If it is a seizure, rule out possible medical causes (Box 7.23).

Remember that most people with epilepsy have their first seizure before the age of 30. If seizures start for the first time after the age of 30 (and especially after the age of 40), the chances are high that the person may have another illness causing the seizures. Most of these diseases will also have other symptoms such as fever and headache, but sometimes the seizures may be the only sign of the disease. If you detect another illness which is causing the seizure, treat that in the first instance. Do not start antiepileptic medications. Review after 3 months.

5. If the person has had a seizure and there is no underlying medical cause, find out whether it is the first seizure. A single seizure is not a rare event. For example, a seizure may occur during severe infections, but the person may never have another seizure again.

Determine the type of the seizure by interviewing both the person and someone who has observed the seizure in order to identify the type of epilepsy (generalised or partial). Sometimes, persons may have a partial seizure which then becomes generalised.

For a first seizure, there is no need to start antiepileptic medication. Review after 3 months. If the person has two seizures on different days within 12 months, start antiepileptic medication.

BOX 7.20 DIAGNOSING A SEIZURE

Two or more of the following characteristics should be present to diagnose a seizure:

- loss of or impaired consciousness
- stiffness, rigidity lasting longer than 1–2 min
- convulsive movements lasting longer than 1–2 min
- tongue bite or self-injury
- incontinence of urine and/or faeces
- after the abnormal movement: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache or muscle aches.

BOX 7.21 TELLING A SEIZURE FROM A FAINT

- A seizure starts suddenly, whereas a person usually complains of dizziness before a faint.
- The duration of unconsciousness is usually only seconds in a faint, but at least a few minutes in a seizure.
- Convulsions (i.e. jerky movements) are very rare in a faint but common in seizures.
- Biting one's tongue, frothing at the mouth, passing urine and cyanosis (going blue) are typical features only of seizures.
- People recover quickly after a faint, whereas they may be drowsy or complain of headaches and confusion after a seizure.

BOX 7.22 TELLING AN EPILEPTIC SEIZURE FROM A CONVERSION SEIZURE

- The epileptic seizure follows one of the patterns described in Box 7.20; the conversion seizure is usually bizarre or variable in its pattern.
- Cyanosis, tongue bite, frothing, self-injury and passing urine are typical features of epileptic seizures, but not of conversion seizures.
- People with conversion seizures never lose consciousness. Even when they may appear to be unconscious, they resist attempts to comfort them, showing that they are still awake.
- Sometimes, the same person may have both types of seizures; in such situations, extra care is needed before determining which type of seizure the person has had.



When to refer

Ideally, all people with seizures should be assessed at least once by a medically qualified physician and, if possible, by a specialist in neurology or psychiatry. This is especially important for people whose first seizure occurs after the age of 30. The main reason for this is to make sure the person does not suffer from a disease which is causing the epilepsy. Since the diagnosis of epilepsy often means that the person has to take medications for a long time, and may be restricted from doing some activities, it is important that the diagnosis is correct. Specialist doctors may do tests such as EEGs (electroencephalography, a method of examining the electrical activity of the brain) or CT or magnetic resonance imaging (MRI) scans. If the care worker has a mobile phone, ask them to make a video of the episode to show the specialist/health worker.



What to do later

The key areas in the treatment of epilepsy are education, ongoing adherence to medication and lifestyle changes (Box 7.25).

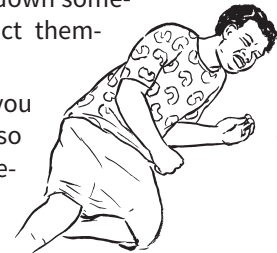
Explaining what the family should do when the person has a seizure

- Lay the person down on their side, head turned to the side, to help with breathing and to make sure they don't inhale vomit or saliva.
- Make sure they are breathing without any obstruction.

BOX 7.23 MEDICAL CAUSES OF SEIZURES IN ADULTS

- Head injuries leading to bleeding in the brain
- Alcohol or benzodiazepine withdrawal
- Infections in the brain (meningitis, tapeworm, malaria, tuberculosis and sleeping sickness)
- AIDS: either through direct infection by the virus or secondary infections such as fungal infections, or due to tumours
- Brain tumours
- Low blood sugar
- Severe liver or kidney disease
- Stimulant intoxication (e.g. cocaine)

- Do not try to restrain the person.
- Do not put anything in the person's mouth.
- Do not do things which are intended to stop the seizure but which can harm the person, for example, light a match near the person.
- Stay with the person until the seizure stops and they wake up.
- If the seizure lasts more than 5 minutes, seek emergency medical care.
- Sometimes people with epilepsy know or feel that the seizure is coming because of warning signals (e.g. suddenly becoming fearful, awareness of an unpleasant smell, a strange light or changes to the way things look). In that case they should lie down somewhere safe to protect themselves from falling.
- Remember that you can't catch epilepsy so it is OK to help someone who is having a seizure.



BOX 7.24 SEIZURES IN CHILDREN WHO HAVE A FEVER

For a child aged between 6 months and 6 years who has a seizure while they also had a fever, screen for the following.

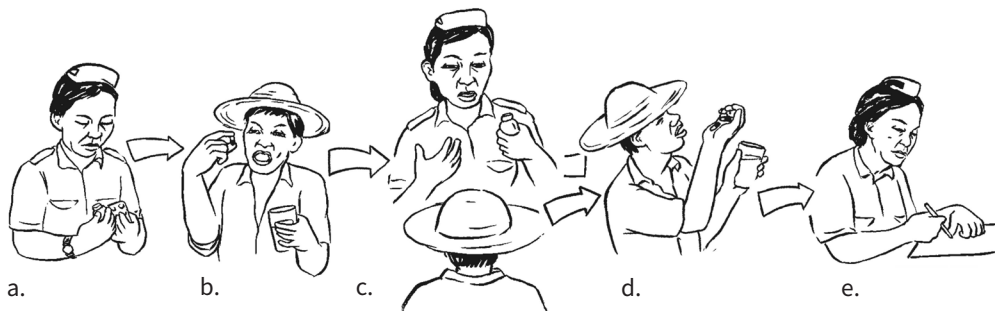
- Was the seizure focal? (starts in one part of the body)
- Was the seizure prolonged? (lasted more than 15 min)
- Did the child have repeated seizures? (more than one episode during the current illness)

If one or more of the above characteristics is present, the seizure is likely to be a **complex febrile seizure**. Refer for URGENT hospital admission. Screen for infection of the brain or meningitis. Follow up after recovery. If the child develops seizures in the absence of fever, consider antiepileptic medication.

- If none of these characteristics was present, the seizure is likely to be a **simple febrile seizure**. Manage the fever, treat the cause of the fever, observe for 24 h and review after 3 months.

Prescribing medications for epilepsy

- Select the medication of choice for the particular type of epilepsy. In general, carbamazepine is used for focal seizures; valproate is effective in generalised seizures. Phenytoin and phenobarbitone may also be used. When uncertain about seizure type, valproate is better.
- If cost is not a limitation, use carbamazepine or sodium valproate. If cost is a factor, consider phenobarbitone (⇨ Box 5.8).
- Refer to Chapter 5 (⇨ Box 5.7) for good practices on how to use antiepileptic medications.
- Ask the person to keep a record of the number of seizures. If there is less than a 50% reduction in seizure frequency, try increasing the dose to the maximum recommended dose; if side-effects appear, do not go any higher.



How to use drugs for epilepsy.

- a. Choose the right drug depending on type of epilepsy and cost.
- b. Start with a small dose; monitor response by counting how many seizures and side-effects.
- c. Change dose accordingly.
- d. If there is no response, increase dose to maximum of range.
- e. If there is still no response, add another drug or refer.

BOX 7.25 EXPLAINING ABOUT EPILEPSY

- A seizure or fit is a problem related to the brain. Epilepsy is the name of the illness when people have seizures.
- Epilepsy is not a contagious disease and is not caused by witchcraft or spirits.
- Epilepsy is a long-term illness and the person may need medication for many years. In three-quarters of cases the seizures can be fully controlled, and then it may be possible for the person to stop the medication.
- The key to treating epilepsy is regularly taking the prescribed medications.
- A person who has epilepsy can lead a normal life with some adjustments. They can marry, have children and work in most types of jobs.
- Women with epilepsy who are planning to become pregnant should discuss this with the health worker first as some medications for epilepsy should not be taken during pregnancy.
- A person with epilepsy should not drive, at least until they have had 1 year without a seizure and are continuing their medication – then follow the national laws guiding when a person is allowed to start driving again after a seizure. Similar caution should be exercised for swimming alone, cooking on open fires or working with or near heavy machinery.
- The person can try to modify their lifestyle in the following ways to reduce the risk of a seizure:
 - regular sleep
 - regular meals
 - strict limits on alcohol intake and avoiding other drugs
 - avoid extreme physical exercise
 - avoid situations which lead to tension or sudden excitement or stress.

- If available, use blood medication levels to help monitor the treatment.
- If seizures continue at an unacceptable frequency, switch to a different antiepileptic medication (don't stop the first medication until the new medication is at the minimum dose).
- If the seizures are still not controlled after trying the maximum tolerated dose of two different antiepileptic medications, check the diagnosis (Is it a conversion seizure? Is there an underlying medical cause that was missed? Is there undetected substance use?), and check that the person is taking the medication as prescribed. If this does not help, refer to a specialist. The specialist may combine different antiepileptic medications.
- Generally, do not consider stopping the medication unless the person has been free of seizures for at least 2 years. Discuss the pros and cons of stopping medication with the person. If the epilepsy was difficult to control or if there was an underlying cause (e.g. head injury or brain infection/meningitis) then longer-term treatment is likely to be needed. Never stop the medication suddenly; withdraw it slowly in small steps, such as a quarter of the total daily dose every month.
- Treat mental disorders such as depression and psychosis as with any other person, but try to choose medications that do not lower the seizure threshold (e.g. for depression it is preferable to use SSRI antidepressants rather than tricyclic antidepressants, and for psychosis use haloperidol rather than chlorpromazine).

SECTION 7.10 SUMMARY BOX

THINGS TO REMEMBER FOR THE PERSON WITH SEIZURES

- The most common cause of seizures in adults is epilepsy.
- Epilepsy most often starts before the age of 30; a first-ever seizure after the age of 30 may indicate a serious brain or medical disorder.
- Never try and restrain someone who is having a seizure; in most cases, the seizure will stop within minutes.
- People with epilepsy may develop mental health problems such as psychosis and depression.
- Educate the person about taking the medications regularly, avoiding driving or working with heavy machinery and avoiding alcohol.
- Where possible, refer the person to a specialist before starting antiepileptic drug treatment. If this is not possible, use the guidelines in this manual on how to diagnose epilepsy and use medication treatments.

7.11 The person with abnormal eating patterns[†]

Some people develop a persistent and severe disturbance of eating behaviour which significantly affects their mental or physical health, or both. There are two main types of eating disturbances which can be considered to be a 'disorder': **anorexia nervosa** ('anorexia') and **bulimia nervosa** ('bulimia'). A central feature of these

disorders is that body shape and weight take on excessive importance to the person. As a result, the person takes drastic measures to control their weight, including under-eating, over-exercising, self-induced vomiting and laxative misuse.

In anorexia, deliberate weight loss can lead to a very low body weight which can be life-threatening.



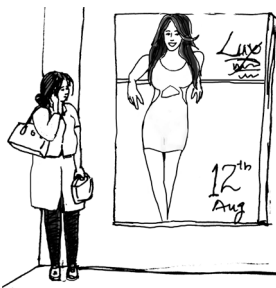
[†]With Christopher G. Fairburn.

In bulimia, episodes of undereating are interrupted by repeated bouts of uncontrolled overeating (binges) which are often followed by self-induced vomiting. The body weight of these persons is usually unremarkable owing to the effects of the undereating and overeating cancelling each other out.

Most people with an eating disorder also have features of other mental health problems. In anorexia, obsessive features are particularly common (⇨7.9) but these often go away when the person regains weight. In bulimia, depression is common and resolves if the eating disorder is treated successfully.



Eating disorders are mainly seen in adolescent girls and young women. Anorexia generally starts in adolescence and may get better by itself. If it persists it often evolves into bulimia, although anorexia can be lifelong in some people. Bulimia generally starts some years later. Untreated bulimia tends to run a chronic course.



Both anorexia and bulimia are mainly seen in societies in which there are strong social pressures to be slim; as a result, they are most common in Western countries.

However, globalisation means that many young women in other countries are now being exposed to Western norms and the desire to be thin, above all else.

7.11.1 How to deal with this problem

Special interview suggestions

People with anorexia often do not accept that they have an eating problem. Avoid confrontational approaches. Give value to the problems that concern the person, even if they are not related to the eating problem.



Questions to ask the person



- What problems are you facing at the moment?
- How do you feel about your current weight? What would your ideal weight be?
- Other people are concerned that you are losing too much weight. What do you think about this concern?
- Do you sometimes eat large amounts of food in a short time period? How often does this happen?
- Are you deliberately making yourself vomit to try to lose weight? How often do you do this?
- How much exercise do you do each day?
- Are you taking any tablets or drugs to lose weight (e.g. to reduce your appetite or to give yourself diarrhoea)?
- Have you been feeling low or lacking interest in things? Have you ever felt that life is not worth living? (*Screen for depression and suicidal behaviour* ⇨3.9.)

Questions to ask the family



- When did the problem start?
- How quickly has the person lost weight?
- How has the family tried to deal with the problem?



Things to look for during the interview

- Weigh the person and measure their height so that you can calculate their body mass index (BMI; a fraction which is made up of the weight in kilograms divided by the height in centimetres squared)
- Low weight can also be caused by physical health problems. Check for features of chronic physical health problems, such as undernutrition, problems with digestion, tuberculosis or HIV.
- Ask the person to crouch down and then stand up unaided. If they struggle to do this, it indicates that they have weak muscles due to weight loss and need urgent treatment.



What to do immediately

- Check whether or not the person needs referral for urgent medical intervention owing to dangerously low weight (e.g. BMI < 15) or the effects of repeated vomiting or laxative use (electrolyte abnormalities, especially low potassium).
- Explain about eating disorders (↪ Box 7.26).
- Give the person information to learn more about eating disorders and introduce them to self-help programmes (↪ resources in Chapter 15). Motivating for change (↪ 5.17) is an important counselling strategy in eating disorders. With this approach, the person is encouraged to think of the pros and cons of continuing with disturbed eating behaviour. While using this approach, encourage the person with anorexia to try to broaden the type of food that they eat and to try to regain some weight.
- There is no medication treatment for anorexia. Antidepressants can be helpful in people with bulimia, both to reduce the frequency of binge eating and to treat depressive symptoms. The SSRI antidepressants (e.g. fluoxetine) are preferred.

BOX 7.26 EXPLAINING ABOUT EATING DISORDERS

Sometimes the wish to become thinner can take over a person's life. This kind of problem is not uncommon in modern societies. The person may start to do harmful things to get thin (e.g. not eating enough, exercising too much, making themselves vomit or taking medications to lose weight). However, losing weight rarely makes the person satisfied with their appearance. They can also feel bad about themselves and ashamed because of the harmful behaviours. This in turn makes the eating problem worse. When a person has disturbed eating that is affecting their health, this needs treatment. Treatment can help with this mental health problem.

When to refer

- Refer if urgent medical intervention is needed.
- If possible, refer all people with eating disorders for specialist treatment.



What to do later

- Monitor the weight of a person with anorexia regularly.
- Counselling strategies, such as 'relaxation exercises', 'thinking healthy' or 'improving relationships' can help to deal with emotional problems that might be making the eating problem worse. In adolescents, involving the family is especially important.
- For persons with eating disorders with disturbed family communication ↪ 5.24.



SECTION 7.11 SUMMARY BOX

THINGS TO REMEMBER WITH THE PERSON WHO HAS DISTURBED EATING

- In eating disorders, there is an excessive preoccupation with body weight and shape, which leads to both mental and physical health problems.
- People with anorexia may develop a dangerously low weight.
- People with bulimia can develop blood chemical imbalances because of repeatedly inducing vomiting or using laxatives.
- Providing information, encouraging use of self-help resources and using counselling techniques to motivate for change can all help a person with an eating disorder.

NOTES
