Diagnostic and Management Guidelines For Mental Disorders In Primary Care

ICD – 10 Chapter V Primary Care Version

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CATEGORIES OF MENTAL AND BEHAVIORAL DISORDERS

Code	Disorder
F00#	Dementia
F05	Delirium
F10	Alcohol use disorders
F11#	Drug use disorders
F17.1	Tobacco use disorders
F20#	Chronic psychotic disorders
F23	Acute psychotic disorders
F31	Bipolar disorder
F32#	Depression
F 40	Phobic disorders
F41.0	Panic disorder
F41.1	Generalized anxiety
F41.2	Mixed anxiety and depression
F43.2	Adjustment disorder
F44	Dissociative (conversion) disorder
F45	Unexplained somatic complaints
F48.0	Neurasthenia
F50	Eating disorders
F 51	Sleep problems
F52	Sexual disorders
F70	Mental retardation
F90	Hyper kinetic (attention deficit) disorder
F91#	Conduct disorder
F98.0	Enuresis
Z63	Bereavement disorders
F99	Mental disorder, Not other wise specified
U50#	Unused/temporarily unassigned to any category

ICD – 10 PC Chapter V used some selected – usually three character – codes from the main ICD – 10 volume. The # code is used in ICD – 10 PC Chapter V only. It refers to "condensed " codes. For example, F100# - Dementia refers to all different types of dementias listed in F00-F03 and their related fourth and fifth character codes (see the cross walks below)

F99 is a non-recommended residual category, when no other code from the list can be used. If there is a more definite diagnosis with ICD-10 chapter V codes users may with to retain it in full rather than using F99

U50# is to be used during assessment and if there is a diagnosis or coding is deferred.

DEMENTIA – F00#

Presenting Complaints

Patients may complain of forgetfulness or feeling depressed, but may be unaware of memory loss. Patients and family may sometimes deny severity of memory loss.
Families ask for help initially because of failing memory, change in personality or behavior. In the later stages of the illness they seek help because of confusion, wandering or incontinence.
Poor personal hygiene in an older patient may indicate memory loss.

Diagnostic Features

- Decline in recent memory, thinking and judgement, orientation, language.
- Patients often appear apathetic or disinterested, but may appear alert and appropriate despite poor memory.
- Decline in everyday functioning (dressing, washing, cooking)
- Loss of emotional control – patients may be easily upset, tearful or irritable.
- Common in older patients, very rare in youth or middle age.

Test of memory and thinking may include : -

- Ability to recall names of three common objects immediately and again after three minutes.
- Ability to name days of week in reverse order.

Differential Diagnosis

Examine for other illnesses causing memory loss. Examples include :

Depression (F32#)
Urinary tract infection
Subdural haematoma
Other infectious illnesses
Normal pressure hydrocephalus
anaemia
B12 or folate deficiency
syphilis
HIV infection

- Prescribed drugs or alcohol may affect memory and concentration.
- Sudden increase in confusion may indicate a physical illness (e. g., acute infectious illness) or toxicity from medication. If confusion, wandering attention or agitation are present, see Delirium – F05
- Depression may cause memory and concentration problems similar to those of dementia, especially in older patients. If low or sad mood is prominent, see Depression – F32#

DEMENTIA F00#

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Dementia is frequent in old age.
- Memory loss and confusion may cause behavior problems (e.g., agitation, suspiciousness, emotional outbursts)
- Memory loss usually proceeds slowly, but course is quite variable.
- Physical illness or metal stress can increase confusion.
- Provide available information and describe community resources.

Counseling of Patient and Family

- Monitor the patient's ability to perform daily tasks safely.
- If memory loss is mild, consider use of memory aids or reminders.
- Avoid placing patient in unfamiliar places or situations.
- Consider ways to reduce stress on those caring for the patient. (e.g., self-help groups). Support from other families caring for relatives with dementia may be helpful.
- Discuss planning of legal and financial affairs.
- As appropriate, discuss arrangements for support in the home, community or day care programmers, or residential placement.
- Uncontrollable agitation may require admission to a hospital or nursing home.

Medication

- Use sedative or hypnotic medications (e.g., benzodiazepines) cautiously; they may increase confusion.
- Antipsychotic medication in low doses (e.g., haloperidol 0.5-1.0mg once or twice a day) may sometimes be needed to control agitation, psychotic symptoms or aggression. Beware of drug side-effects (parkinsonian symptoms, anticholinergic effects) and drug interactions.

Specialist Consultation

Consider consultation for:

- Uncontrollable agitation
- Sudden onset or worsening of memory loss
- Physical causes of dementia requiring specialist treatment (e.g., syphilis, subdural haematoma)

Consider placement in a hospital or nursing home if intensive care is needed.

DELIRIUM – F05

Presenting complaints

- Families may request help because patient is confused or agitated.
- Delirium may occur in patients hospitalized for physical conditions.
- Patients may appear uncooperative or fearful.

Diagnostic Features

Acute onset of:

- Confusion (patient appears confused, struggles to understand surroundings)
- Clouded thinking or awareness.

Often accompanied by:

Poor memory	agitation
Emotional upset	loss of orientation
Wandering attention	hearing voices
Withdrawal from others	visions or illusions
Suspiciousness	disturbed sleep
	(Reversal of sleep pattern)

Symptoms often develop rapidly and may change from hour to hour.
May occur in patients with previously normal mental function or in those with dementia.
Milder stresses (medication, mild infarctions) may cause delirium in older patients or in those with dementia.

Differential Diagnosis

Identify and correct possible physical causes of confusion, such as :

- Alcohol intoxication or withdrawal
- Drug intoxication or withdrawal (including prescribed drugs)
- Severe infections
- Metabolic changes (e.g., liver disease, dehydration, hypoglycemia)
- Head trauma
- Hypoxia

If symptoms persist, delusions and disordered thinking predominate, and no physical cause is identified, see acute psychotic disorders – F23.

DELIRIUM F05

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Strange behavior or speech are symptoms of an illness.

Counseling of Patient and Family

- Take measure to prevent the patient from harming him/herself or others (e.g., remove unsafe objects, restrain if necessary)
- Supportive contact with familiar people can reduce confusion/
- Provide frequent reminders of time and place to reduce confusion.
- Hospitalization may be required because of agitation or because of physical illness, which is causing delirium.

Medication

- Avoid use of sedative or hypnotic medications (e.g., benzodiazepines) except for the treatment of alcohol or sedative withdrawal.
- Antipsychotic medication in low doses (e.g., haloperidol 0.5-1.0mg once or twice a day may sometimes be needed to control agitation, psychotic symptoms or aggression. Beware of drug side-effects (Parkinsonian symptoms, anticholinergic effects) and drug interactions.

Specialist consultation

Consider specialist consultation for:

- Physical illness requiring specialist treatment.
- Uncontrollable agitation.

ALCOHOL USE DISORDERS – F10

Presenting Complaints

Patient may present with:

- Depressed mood
- Nervousness
- Insomnia
- Physical complications of alcohol use (ulcer, gastritis, liver disease)
- Accidents or injuries due to alcohol use
- Poor memory or concentration

There may also be:

- Legal and social problems due to alcohol use (marital problems, missed work)
- Signs of alcohol withdrawal (sweating, tremors, morning sickness, hallucinations)

Patients may some times deny or be unaware of alcohol problems. Family may request help before patient does (e.g., because patient is irritable at home, missing work)

Diagnostic Features

Harmful alcohol use:

- Heavy alcohol use (quantity defined by local standards, e.g., over 21 drinks per week of men, over 14 drinks per week in women)
- Overuse of alcohol has caused physical harm (e.g., liver disease, gastrointestinal bleeding), psychological harm (e.g., depression or anxiety due to alcohol) of has led to harmful social consequences (e.g., loss of job).

Standard questionnaires (e.g., AUDIT) may help identify harmful use.

Alcohol dependence:

- Continued alcohol use despite harm
- Difficulty controlling alcohol use
- Strong desire to use alcohol
- Tolerance (drinks large amounts of alcohol without appearing intoxicated)
- Withdrawal (anxiety, tremors, sweating after stopping drinking)

Differential Diagnosis

- Symptoms of anxiety or anxiety or depression may occur with heavy alcohol use. If these continue after a period of abstinence, see Depression – F32#, and Generalized anxiety – F41.1

ALCOHOL USE DISORDERS F10

MANAGEMENT GUIDELINES

Essential Information for patient and Family

- Alcohol dependence is an illness with serious consequences.
- Stopping or reduce alcohol use will bring mental and physical benefits.
- Drinking during pregnancy can harm the baby
- In some cases of harmful alcohol use without dependence, controlled or reduced drinking is a reasonable goal.
- For patients with alcohol dependence, abstinence from alcohol is the goal. Because abrupt abstinence can cause withdrawal symptoms, medical supervision is necessary.
- Relapses are common. Controlling or stopping drinking often requires several attempts.

Counseling of Patient and Family

For patients willing to stop now:

- Set a definite day to quit.
- Discuss strategies to avoid or cope with high-risk situations (e.g., social situation, stress full events).
- Make specific plans to avoid drinking (e.g., way to face situation events without alcohol, ways to respond friends who still drink).
- Help patients to identify family members or friends who will support stopping alcohol use.
- Discuss symptoms and management of alcohol withdrawal.

If reducing drinking is a reasonable goal (or if patient is unwilling to quit)

- Negotiate a clear goal for decreased use (e.g., no more than two drinks per day with two alcohol – free days per week)
- Discuss strategies to avoid or cope with high-risk situations (e.g., social situations, stressful events).
- Introduce self-monitoring procedures and safer drinking behaviors (e.g., time restrictions, slowing down drinking)

For patients not willing to stop or reduce use now:

- Do not reject or blame.
- Clearly point out medical, psychological and social problems caused by alcohol.
- Make a future appointment to reassess health and alcohol use.

For patients who do not succeed or relapse

- Identify and give credit for any success.
- Discuss situations, which led to relapse.
- Return to earlier steps above.

Self – help organizations (e.g., alcoholics anonymous) are often helpful.

Medication

- Withdrawal from alcohol may require short–term use of benzodiazepines (e.g., chlordiazepoxide 25 – 100mg once or twice a day) but outpatient use should be closely monitored. Severe alcohol withdrawal (with hallucinations and autonomic instability) may require hospitalization and use of higher dose benzodiazepines.
- Disulfiram may help to maintain abstinence from alcohol in some cause, but routine use is not necessary.

Specialist Consultation

Specialized counseling programmes for alcohol dependence should be considered, if available

DRUG USE DISORDERS – F11#

Presenting Complaints

Patients may have

- Depressed mood
- Nervousness
- Insomnia
- Physical complications of drug use
- Accidents or injuries due to drug use.

There may also be:

- Unexplained change in behavior, appearance, or functioning
- Denial of drug use
- Complaints of pain or direct request for prescriptions for narcotics or other drugs.
- Legal and social problems due to drug use (marital problems, missed work).

Signs of drug withdrawal may be present, i.e.,

- Opiates: nausea, sweating, tremors
- Sedatives: anxiety, tremors, hallucinations
- Stimulants: depression, moodiness.

Family may request help before patient (e.g., irritable at home, missing work).

Diagnostic Features

- Heavy or frequent use
- Drug use has caused physical harm (e.g., injuries while intoxicated), psychological harm (e.g., psychiatric symptoms due to drug use) or has led to harmful social consequences (e.g., loss of job, severe family problems)
- Difficulty controlling drug use.
- Strong desire to use drugs
- Tolerance (can use large amounts of drugs without appearing intoxicated).
- Withdrawal (anxiety, tremors or other withdrawal symptoms after stopping use).

Different Diagnosis

- Drug use disorders commonly coexist with alcohol use disorders (see alcohol use disorders F10#)
- Symptoms of anxiety or depression may occur with heavy drug use. If these continue after a period of abstinence (e.g., about four weeks), see depression – F32# and generalized anxiety – F41.1

DRUG USE DISORDERS F11#

MANAGEMENT GUIDELINES

Essential information for Patient and Family

- Abstinence is the goal: the patient and family should concentrate on this.
- Stopping or reducing drug use will bring mental and physical benefits.
- Using drugs during pregnancy will harm the baby.
- For intravenous drug users, there is a risk of getting or giving HIV infection, hepatitis or other blood borne infections. Discuss appropriate precautions (use condoms, do not re-use needles)
- Relapse is common. Controlling or stopping drug use often requires several attempts.

Counseling of Patient and Family

For patients willing to stop now:

- Set a definite day to quit.
- Discuss strategies to avoid or cope with high-risk situations (e.g., social situation, stressful events).
- Make specific plans to avoid drug use (e.g., how to respond to friends who still use drugs).
- Identify family or friends who will support stopping drug use.

If reducing drug use is a reasonable goal (or if patient is unwilling to quit)

- Negotiate a clear goal for decreased use (e.g., no more than one marijuana cigarette per day with two drug-free per week).
- Discuss strategies to avoid or cope with high-risk situations (e.g., social situations, stressful events.).
- Introduce self-monitoring procedures and safer drug-use behaviors (e.g., time restrictions, slowing down rate of use).

For patients not willing to stop or reduce use now:

- Do not reject or blame.
- Clearly point out medical, psychological and social problems caused by drugs.
- Make a future appointment to reassess health and discuss drug use.

For patients who do not succeed or relapse

- Identify and give credit for any success.
- Discuss situations, which led to relapse.
- Return to earlier steps above.

Self-help organizations (e.g., Narcotics Anonymous) are often helpful.

Medication

- Withdrawal from sedatives may require use of benzodiazepines (e.g., chlordiazepoxide 25 – 50mg up to four times a day), but outpatient use should be closely monitored. Severe sedative withdrawal (with hallucinations and autonomic instability) may require hospitalization and use of higher dose anti anxiety drugs.
- Withdrawal from stimulants, cocaine or opiates is distressing and may require supervision.Withdrawal from opiates is sometimes managed with a 10-14 day tapering dose of methadone or naltrexone.

Specialist Consultation

Specialized counseling programmes for dependence should be considered, if available.

TOBACCO USE DISORDERS – F17.1

(Includes : harmful use, dependence syndrome, withdrawal state)

Presenting Complaints

Patients may complain of:

- An unpleasant smell in the mouth
- Coughing
- Sputum
- Frequent respiratory infections
- High blood pressure
- Chest pains
- Heart problems
- Fatigue, not being fit.

Many smokers would like to stop smoking and welcome assistance in doing so.

Diagnostic Features

Harmful use (tobacco use has caused physical or psychological harm)
Dependence:

- Continued use despite harm.
- Inability to discontinue or control use
- Withdrawal symptoms.

Some tobacco users may be dependent on tobacco (use of large quantities, difficulty controlling use), but all users will benefit from stopping.
Although any amount of tobacco use may be harmful, it is most important to reduce tobacco use among:

- Pregnant women
- Children and adolescents
- Parents of young children
- Patients with diseases strongly affected by tobacco use (respiratory disease, heart disease, vascular disease).

TOBACCO USE DISORDERS F17.1

MANAGEMENT GUIDELINES

Essential Information for Patient and Family.

- Any tobacco use may have harmful health effects.
- Using tobacco during pregnancy may harm the baby.
- Discontinuing tobacco use should improve health now and in the future.

Counseling of Patient and Family.

For patients willing to quit now:

- Set a definite date for quitting
- Discuss high-risk situations for resuming tobacco use (e.g., socializing with friends who use tobacco)
- Make specific plans to avoid resuming tobacco use (e.g., discuss how to responds to friends who offer cigarettes).
- Advise about managing the craving for tobacco (e.g., relaxation, physical exercise, distracting activities, other stress management techniques).
- Identify friends or family members who support stopping tobacco use.

For patients not willing to quit now:

- Do not reject or blame the person.
- Clearly point out current and future effects of continued tobacco use.
- Make a future appointment to discuss health status and tobacco use.

If reducing tobacco use is a reasonable goal (or if patient is unwilling to quit)

- Negotiate a clear goal for decreased use (e.g., no more than five cigarettes per day).
- Discuss strategies to avoid or cope with high-risk situations (e.g., social situations, stressful events).
- Introduce self-monitoring procedure and pattern of controlled tobacco use (e.g., time restrictions, slowing down rate of use).

Group counseling programmes may be helpful.

Medication

Nicotine preparations may help reduce nicotine withdrawal symptoms. These are significantly more effective when used with advice about quitting.

CHRONIC PSYCHOTIC DISORDERS – F20#

Presenting Complaints

Patients may present with :

- Difficulties with thinking or concentration
- Reports of hearing voices
- Strange beliefs (e.g., having supernatural powers, being persecuted)
- Extraordinary physical complaints (e.g., having animal or unusual objects inside one's body)
- Problems or questions related to antipsychotic medication

There may be problems in managing work or studies.

- Families may seek help because of apathy, withdrawal, poor hygiene or strange behavior.

Diagnostic Features

Chronic problems with the following features :

- Social withdrawal
- Low motivation or interest, self-neglect
- Disordered thinking (exhibited by strange or disjointed speech).

Periodic episodes of :

- Agitation or restlessness
- Bizarre behavior
- Hallucinations (false or imagined perceptions, e.g., hearing voices)
- Delusions (firm beliefs that are plainly false, e.g., patient is related to royalty, receiving messages from television, being followed or persecuted).

Differential Diagnosis

If symptoms of depression are prominent (low or sad mood, pessimism, feelings of guilt) see depression – F32#

If symptoms of mania (excitement, elevated mood, exaggerated self-worth) are prominent, see bipolar disorder – F31

Chronic intoxication or withdrawal from alcohol or other substance (stimulants, hallucinogens can cause psychotic symptoms. See alcohol use disorder – F10 and drug use disorder – F11#

CHRONIC PSYCHOTIC DISORDERS F20#

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Agitation and strange behavior are symptoms of a mental illness.
- Symptoms may come and go over time. Anticipate and prepare for relapses.
- Medication is a central component of treatment: it will both reduce current difficulties and prevent relapse
- Family support is essential for compliance with treatment and effective rehabilitation.
- Community organizations can provide valuable support to patient and family.

Counseling to Patient and Family

- Discuss treatment plan with family members and obtain their support for it.
- Explain that drugs will prevent relapse and inform patient of side – effects.
- Encourage patient to function at the highest reasonable level in work and other daily activities.
- Encourage patient to respect community standards and expectations (dress, appearance, behavior)
- Minimize stress and stimulation :
    - Do no argue with psychotic thinking
    - Avoid confrontation or criticism
    - During periods when symptoms are more severe, rest and withdrawal from stress may be helpful.

(Refer to acute psychosis – F23 for advice on the management of agitated or excited states).

Medication

Antipsychotic medication will reduce psychotic symptoms (e.g., haloperidol 2-5mg up to three times a day or chlorpromazine 100-200mg up to three times a day). The dose should be the lowest possible for the relief of symptoms, though some patients may require higher doses. Inform the patient that continued medication will reduce risk of relapse. In general, antipsychotic medication should be continued for at least three months following a first episode of illness and longer after a subsequent episode.

If the patient fails to take medication as requested, injectable long-acting antipsychotic medication may ensure continuity of treatment and reduce risk of relapse.

- Acute dystonias or spasms that can be managed with injectable benzodiazepines or antiparkinsonian drugs.
- Akathisia (severe motor restlessness) that can be managed with dosage reduction or betablockers.
- Parkinsonian symptoms (tremor, akinesia) that can be managed with oral antiparkinsonian drugs (e.g., biperiden 1mg up to three times a day)

Specialist Consultation

If facilities exist, consider consultation for all new cases of psychotic disorder. Depression or mania with psychotic symptoms may need other treatment. Consider consultation to clarify diagnosis and ensure most appropriate treatment.

Consultation with appropriate community services may reduce family burden and improve rehabilitation.

Also consider consultation in cases of severe motor side-effects.

ACUTE PSYCHOTIC DISORDERS – F23

Presenting Complaints

Patients may experience :

- Hearing voices
- Strange beliefs or fears
- Confusion
- Apprehension

Families may ask for help with behavior changes that cannot be explained, including strange or frightening behavior (withdrawal, suspiciousness, threats).

Diagnostic Features

Recent onset of :

- Hallucinations (false or imagined sensations, e.g., hearing voice when no one is around)
- Delusions (firmly held ideas that are plainly false and not shared by others in the patient's social group, e.g., patients believe they are being poisoned by neighbours, receiving messages from television, or being looked at by others in some special way)
- Agitation or bizarre behavior
- Disorganized or strange speech
- Extreme and labile emotional states

Differential Diagnosis

Physical disorders which can cause psychotic symptoms include :

- Epilepsy
- Intoxication or withdrawal from drugs or alcohol
- Infectious or febrile illness

Refer to card on delirium – F5 for other potential causes.
If psychotic symptoms are recurrent or chronic, also see chronic psychotic disorders – F20#.
If symptoms of mania (elevated modd, racing speech or thoughts, exaggerated self-worth) are prominent, the patient may be experiencing a manic episode. See bipolar disorder – F31.
If low or sad mood is prominent, also see depression F32#

ACUTE PSYCHOTIC DISORDERS F23

MANAGEMENT GUIDELINES

Essential information for Patient and Family

- Agitation and strange behavior are symptoms of a mental illness.
- Acute episodes often have a good prognosis, but long-term course of the illness is difficult to predict from an acute episode.
- Continued treatment may be needed for several months after symptoms resolve.

Advise family about legal issues related to mental health treatment.

Counseling of Patient and Family

Ensure the safety of the patient and those caring for him / her.

- Family or friends should stay with the patient
- Ensure that the patient's basic needs (e.g., food and drink) are met.
- Take care not to harm the patient.

Minimize stress and stimulation.

- Do not argue with psychotic thinking (you may disagree with the patient's beliefs, but do not try to argue that they are wrong).
- Avoid confrontation or criticism unless it is necessary to prevent harmful or disruptive behavior.

Agitation which is dangerous to the patient, the family or the community requires hospitalization or close observation in a secure place. If patients refuse treatment, legal measures may be needed.
Encourage resumption of normal activities after symptoms improve.

Medication

Antipsychotic medication will reduce psychotic symptoms (e.g., haloperidol 2 – 5mg up to three times a day or chlorpromazine 100-200mg up to three times a day). The dose should be the lowest possible for the relief of symptoms, through some patients may require higher doses.
Anti-anxiety medication may also be used in conjunction with neuroleptics to control acute agitation (e.g., lorazepam 1-2mg up to four times a day).
Continue antipsychotic medication for at least three months after symptoms resolve.
Monitor for side-effects of medication :

- Acute dystonias or spasms may be managed with injectable benzodiazepines or antiparkinsonian drugs.
- Akathisia (severe motor restlessness) may be managed with dosage reduction or beta-blockers.
- Parkinsonian symptoms (tremor, akinesia) may be managed with oral antiparkinsonian drugs (e.g., biperiden 1mg up to three times a day).

Specialist Consultation

If possible, consider consultation for all new cases of psychotic disorder.
In cases o severe motor side-effects or the appearance of fever, rigidity, hypertension, stop antipsychotic medication and consider consultation.

BIPOLAR DISORDER – F31

Presenting Complaints

Patients may have a period of depression, mania or excitement with pattern described bellow.

Diagnostic Features

Periods of mania with :

- Increased energy and activity
- Rapid speech
- Decreased need for sleep
- elevated mood or irritability
- loss of inhibitions
- increased importance of self

The patient may be easily distracted.

The patient may also have periods of depression with:

- Low or sad mood
- Loss of interest or pleasure

The following associated symptoms are frequently present :

- Disturbed sleep
- Guilt or low self-worth
- Fatigue or loss of energy
- poor concentration
- disturbed appetite
- suicidal thoughts or acts

Either type of episode may predominate.
Episodes, may be frequent or may be separated by periods of normal mood.
In severe cases, patients may have hallucinations (hearing voices, seeing visions) or delusions (strange or illogical beliefs) during period of mania or depression.

Differential Diagnosis

Alcohol or drug use may cause similar symptoms. If heavy alcohol or drug use is present, see alcohol use disorders – F10 and drug use disorders – F11#

BIPOLAR DISORDER F31

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Unexplained changes in mood and behavior are symptoms of an illness.
- Effective treatments are available. Long-term treatment can prevent future episodes.
- If left untreated, manic episodes may become disruptive or dangerous. Manic episodes often lead to loss of job, legal problems, financial problems or high-risk sexual behavior.

Counseling to Patient and Family

- During depression, ask about risk of suicide. (has the patient frequently throught of death or dying? Does the patient have a specific suicide plan? Has he / she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas?) close supervision by family or friends may be needed. Ask about risk of harm to others (see depression – F32#).

During manic periods :

- Avoid confrontation unless necessary to prevent harmful or dangerous acts
- Advise caution about impulsive or dangerous behavior
- Close observation by family members is often needed
- If agitation or disruptive behavior are severe, consider hospitalization.

During depressed periods, consult management guidelines for depression (see depression – F32#)

Medication

If patient displays agitation, excitement or disruptive behavior, antipsychotic medication may be needed initially (e.g., haloperidal 2-5mg up to three times a day or chlorpromazine 100-200mg up to three times a day).

The dose should be the lowest possible for the relief of symptoms, though some patients may require higher doses. If antipsychotic medication causes acute dystonic reactions (muscle spasms) or marked extra pyramidal symptoms (stiffness, tremors), antiparkinsonian medication (e.g., benztropine 0.5-1.0mg up to three times a day) may be helpful. Routine use is not necessary.

Benzodiazepines may also be used in conjunction with neuroleptics to control acute agitation (e.g., lorazepam 1-2mg up to four times a day).

Lithium will help relieve mania and drepression and can prevent episodes from recurring. Alternative medications include Carbamazepine and Valproate. If lithium is prescribed.

- The dose should start at 300mg twice daily and the average dose should be 600mg twice daily.
- The level of lithium in the blood should be measured frequently when adjusting the dose and every three to six months in stable patients (desired blood level is 0.6-1.0 meq per liter)
- Tremors, diarrhoea, nausea or confusion may indicate lithium intoxication so check blood level of lithium if possible and stop lithium until symptoms resolve.
- Lithium should be continued for at least six months after symptoms resolve (longer-term use is usually necessary to prevent recurrences).

Antidepressant medication is often needed during phases of depression but can precipitate mania when used alone (see depression – F32#)

Specialist Consultation

Consider consultation :

- If risk of suicide or disruptive behavior is severe.
- If significant depression or mania continues.

DEPRESSION – F32#

Presenting Complaints

- The patient may present initially with one or more physical symptoms (fatigue, pain). Further enquiry will reveal depression or loss of interest.
- Irritability is some times the presenting problems.
- Some groups are at higher risk (e.g., those who have recently given birth or had a stroke, those with Parkinson's disease or multiple sclerosis).

Diagnostic Features

- Low or sad mood
- Loss of interest or pleasure

The following associated symptoms are frequently present :

Disturbed sleep	disturbed appetite
Guilt of loss of self- confidence	suicidal thoughts or acts
Fatigue or loss of energy or decreased libido	poor concentration

Symptoms of anxiety or nervousness are also frequently present.

Differential Diagnosis

If hallucinations (hearing voices, seeing visions) or delusions (strange or unusual beliefs) are present, see Acute psychotic disorder – F23 for management of these problems. Consider consultation about management.
If the patient has a history of manic episodes (excitement, elevated moo, rapid speech), see Bipolar disorder – F31.
If heavy alcohol or drug use is present, see alcohol use disorders – F10 and drug use disorders-F11#
Some medications may produce symptoms of depression (e.g., beta-blockers, other antihypertensives, H2 blockers, oral contraceptives, corticosteroids).

DEPRESSION F32#

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Depression is a common illness and effective treatments are available.
- Depression is not weakness or laziness; patients are trying hard to copy.

Counseling of Patient and Family

- As about risk of suicide. Has the patient often thought of death or dying? Does the patient have a specific suicide plan? Has he / she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas? Close supervision by family or friends, or hospitalization, may be needed. Ask about risk of harm to others.
- Plan short-term activities which give the patient enjoyment or build confidence.
- Encourage the patient to resist pessimism and self-criticism, not to act on pessimistic ideas (e.g., ending marriage, leaving job), and not to concentrate on negative or guilty thoughts.
- Identify current life problems or social stress. Focus on small, specific steps patients might take towards reducing or better managing these problems. Avoid major decisions or life changes.
- If physical symptoms are present, discuss the link between physical symptoms and mood (see unexplained somatic complaints – F45).
- After improvement, plan with patient the action to be taken if signs of relapse occur.

Medication

Consider antidepressant drugs if sad mood or loss of interest are prominent for at least two weeks and four or more of these symptoms are present :

Fatigue or loss of energy	disturbed sleep	guilt or self-reproach
Poor concentration	thoughts of death or suicide	disturbed appetite

Agitation or slowing of movements and speech.

In severe cases, consider medication at the first visit. In moderate cases, consider medication at follow-up visit if counseling is not sufficiently helpful.

Choice of medication :

- If the patient has responded well to a particular drug in the past, use that drug again.
- If the patient is older or physically ill, use medication with fewer anticholingergic and cardiovascular side-effects.
- If the patient is anxious or unable to sleep, use a drug with more sedative effects.

Build up to the effective dose. Antidepressants (e.g., imipramine) should start at 25-50mg each night and increase to 100-150mg by 10 days. Lower doses should be given if the patient is older or physically ill.
Explain to the patient that the medication must be taken every day, that improvement will build up over two to three weeks after starting the medication, and that mild side-effects may occur but usually fade in 7-10days. Stress that the patient should consult the physician before stopping the medication.
Continue antidepressant medication for at least three months after the condition improves.

Specialist Consultation

Consider consultation if the patient shows :

- Significant risk of suicide or danger to others
- Psychotic symptoms
- Persistence of significant depression following the above treatment.

More intensive psychotherapies (e.g., cognitive therapy, interpersonal therapy) may be useful for initial treatment and prevention of relapse.

PHOBIC DISORDERS – F40
(Includes agoraphobia, social phobia)

Presenting complaints

Patients may avoid or restrict activities because of fear.
They may have difficulty traveling to the doctor's office, going shopping, visiting others.
Patients sometimes present with physical symptoms (palpitations, shortness of breath, "asthma"). Questioning will reveal specific fears.

Diagnostic Features

Unreasonably strong fear of specific places or events. Patients often avoid these situations altogether.
Commonly feared situations include :

Leaving home	crowds or public places
Open spaces	traveling in buses, cars, trains, or planes
Speaking in public	social events.

Differential Diagnosis

- If anxiety attacks are prominent see Panic disorder – F41#
- If low or sad mood in prominent, see Depression – F32#
- Many of the managements guidelines opposite may also be helpfull for specific phobias (e.g., fear of water, fear of heights).

PHOBIC DISORDERS F40

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Phobias can be treated.
- Avoiding feared situations allows the fear to grow stronger.
- Following a set of specific step can help a person over come fear.

Counseling of Patient and Family

- Encourage the patient to practice controlled breathing methods to reduce physical symptoms of fear.
- Ask the patient to make a list of all situations that he / she fears and avoid although other people do not.
- Discuss ways to challenge these exaggerated fears (e.g., patient reminds him / herself, "I am feeling a little anxious because there is a large crowd. The feeling will pass in a few minutes.")
- Plan a series of steps to enable the patient to confront and get used to feared situations :
  - Identify a small first step towards the feared situation (e.g., take a short walk away from the home with a family member).
  - This step should be practiced for one hour each day until it is no longer frightening.
  - If the feared situation still causes anxiety, the patient should practice slow and relaxed breathing, telling him / herself that the panic will pass within 30 minutes. The patient should not leave the feared situation until the fear subsides.
  - Move on to a slightly more difficult step and repeat the procedure (e.g., spend a longer time away from home)
  - Take no alcohol or anti-anxiety medicine for at least four hours before practicing these steps.
- Identify a friend or family member who will help in over coming the fear. Self-help groups can assist in confronting feared situation.
- The patient should avoid using alcohol or benzodiazepine drugs to cope with feared situations.

Medication

- With the use of these counseling methods, many patients will not need medication. How ever, if depression is also present, antidepressant medication may be helpful (e.g., imipramine 50-150mg a day)
- For patients with infrequent and limited symptoms, occasional use of antianxiety medication (e.g., benzodiazepines) may help. Regular use may lead to dependence, however, and is likely to result in return of symptoms when discontinued.
- For management of performance anxiety (e.g., fear of public speaking) beta-blockers may reduce physical symptoms.

Specialist Consultation

Consider consultation if disabling fears (e.g., patient is unable to leave home) persist. Referral for behavioural psychotherapy, if available, may be effective for patients who do not improve.

PANIC DISORDER – F41.0

Presenting Complaints

Patients may present with one or more physical symptoms (e.g., chest pain, dizziness, shortness of breath). Further enquiry shows the full pattern described below.

Diagnostic Features

Unexplained attacks of anxiety or fear that begin suddenly, develop rapidly and may last only a few minutes.
The attacks often occur with physical symptoms such a palpitation, chest pain, sensations of choking, churning stomach, dizziness, feelings of unreality, or fear of personal disaster (losing control or going mad, heart attack, sudden death).
An attack often leads to fear of another attack and avoidance of places where attacks have occurred. Patients may avoid exercise or other activities that may produce physical sensations similar to those of a panic attack.

Differential Diagnosis

Many medical conditions may cause symptoms similar to panic attacks (arrhythmia, cerebral ischemia, coronary disease, thyrotoxicosis). History and physical examination should be sufficient to exclude many of these.
If attacks occur only in specific feared situations, see Phobic disorders – F40
If low or sad mood is also present, see Depression – F32#

PANIC DISORDER F41.0

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Panic is common and can be treated.
- Anxiety often produces frightening physical sensations. Chest pain, dizziness or shortness of breath are not necessarily signs of a physical illness: they will pass when anxiety is controlled.
- Panic anxiety also causes frightening thoughts (fear of dying, a feeling that one is going mad or will lose control). These also pass when anxiety is controlled.
- Mental and physical anxiety reinforce each other. Concentrating on physical symptoms will increase fear.
- A person who withdraws from or avoids situations where attacks have occurred will only strengthen his/her anxiety.

Counseling of Patient and Family

- Advise the patient to take the following steps if a panic attack occurs :
- Stay where you are until the attack passes.
- Concentrate on controlling anxiety, not on physical symptoms.
- Practice slow, relaxed breathing. Breathing deeply or rapidly (hyperventilation) can cause some of the physical symptoms of panic. Controlled breathing will reduce physical symptoms.
- Tell yourself that this is a panic attack and the frightening thoughts and sensations will soon pass. Note the time passing on your watch. It may feel like a long time but it will be only a few minutes.
- Identify exaggerated fears which occur during panic (e.g., patient fears that he / she is having a heart attack)
- Discuss ways to challenge these fears during panic (e.g., patient reminds him / herself, " I am not having a heart attack. This is a panic attack, and it will pass in few minutes").
- Self-help groups my help the patient manage panic symptoms and over come fears.

Medication

Many patients will benefit from counseling and will not need medication.

If attacks are frequent and severe, or if the patient is significantly depressed, antidepressants may be helpful (e.g., imipramine 25mg at night increasing to 100-150mg at night after two weeks).

For patients with infrequent and limited attacks, short-term use of antianxiety medication may be helpful (lorazepam 0.5-1.0mg up to three times a day). Regular use may lead to dependence and is likely to result in the return of panic symptoms when discontinued.

Avoid unnecessary tests or medications.

Specialist Consultation

- Consider consultation if severe attacks continue after the above treatments.
- Referral for cognitive and behavioral psychotherapies, if available, may be effective for patients who do not improve.
- Panic commonly causes physical symptoms. Avoid unnecessary medical consultations

GENERALIZED ANXIETY – F41.1

Presenting Complaints

The patient may present initially with tension-related physical symptoms (e.g., headache, pounding heart) or with insomnia. Enquiry will reveal prominent anxiety.

Diagnostic Features

Multiple symptoms of anxiety or tension:

- Mental tension (worry, feeling tense or nervous, poor concentration)
- Physical tension (restlessness, headaches, tremors, inability to relax)
- Physical arousal (dizziness, sweating, fast or pounding heart, dry mouth, stomach pains)

Symptoms may last for months and recur often. They are often triggered by stressful events in those with a chronic tendency to worry.

Differential Diagnosis

- If low of sad mood is prominent, see depression – F32#
- If sudden attacks of unprovoked anxiety are present, see panic Disorder – F 41.0
- If fear and avoidance of specific situations are present, see Phobic disorders – F40
- If heavy alcohol or drug use Is present, see Alcohol use Disorders – R10 and Drug use disorders – F11#
- Certain physical conditions (thyrotoxicosis) or medications (methyl xanthenes, beta agonists) may cause anxiety symptoms.

GENERALIZED ANXIETY F41.12

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Stress and worry have both physical and mental effects.
- Learning skills to reduce the effects of stress (not sedative medication) is the most effective relief.

Counseling of Patient and Family

- Encourage the patient to practice daily relaxation methods to reduce physical symptoms of tension.
-
- Encourage the patient to engage in pleasurable activities and exercise, and to resume activities that have been helpful in the past.
- Identifying and challenging exaggerated worries can reduce anxiety symptoms.
    - Identify exaggerated worries or pessimistic thought (e.g., when daughter is five minutes late from school, patient worries that she may have had an accident)
    - Discuss ways to challenge these exaggerated worries when they occur (e.g., when the patient starts to worry about the daughter, the patient could tell him / herself, " I am starting to be caught up in a worry again. My daughter is only a few minutes late and should be home soon. I won't call the school to check unless she's an hour late")
- Structured problem – solving methods can help patients to manage current life problems or stress which contribute to anxiety symptoms
    - Identify events that trigger excessive worry (e.g., young woman present with worry, tension, nausea and insomnia. These symptoms began after her son was diagnosed with asthma. Her anxiety worsens when he has asthma episodes)
    - Discuss what the patient is doing to manage this situation. Identify and reinforce things that are working.
    - Identify some specific actions the patient can take in the next weeks such as :
        - Meet with nurse / doctor / health professionals to learn about the course and management of asthma.
        - Discuss concerns with parents of other asthmatic children.
        - Write down a plan for management of asthma episodes.
- Regular physical exercise is often helpful.

Medication

Medication is a secondary treatment in the management of generalized anxiety. It may be used, however, if significant anxiety symptoms persist despite counselling.

- Antianxiety medication (e.g., diazepam 5-10mg at night) may be used for no longer than two weeks. Longer term use may lead to dependence and is likely to result in the return of symptoms when discontinued.
- Beta-blockers may help control physical symptoms.
- Antidepressant drugs may be helpful (especially if symptoms of depression are present) and do not lead to dependence or rebound symptoms. For details see Depression – F32#

Specialist Consultation

Consultation my be helpful if severe anxiety lasts longer than three months.

MIXED ANXIETY AND DEPRESSION – F41.2

Presenting Complaints.

The patient presents with variety of symptoms of anxiety and depression.
There may initially be one or more physical symptoms (e.g., fatigue, pain). Further enquiry will reveal depressed mood and/ or anxiety.

Diagnostic Features

- Low or sad mood.
- Loss or interest or pleasure
- Prominent anxiety or worry

The following associated symptoms are frequently present :

Disturbed sleep	tremor
Fatigue or loss of energy	palpitations
Poor concentration	dizziness
Disturbed appetite	suicidal thoughts or acts
Tension and restlessness	loss of libido

Differential diagnosis

- If more severe symptoms of depression or anxiety are present, see management guidelines for Depression – F32# and Generalized anxiety – F41.1
- If somatic symptoms predominate, see Unexplained somatic symptoms – F45
- If the patient has a history of manic episodes (excitement, elevated mood, rapid speech). See Bipolar disorder – F31
- If heavy alcohol or drug use in present, see alcohol use disorders – F10 and drug use disorders – F11#

MIXED ANXIETY AND DEPRESSION F41.2

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Stress and worry have many physical and mental effects.
- These problems are not due to weakness or laziness; patients are trying to cope.

Counseling of Patient and Family

- Encourage the patient to practice relaxation methods to reduce physical symptoms of tension.
- Plan short-tem activities that are relaxing, enjoyable or help the patient to build confidence. Resume activities that have been helpful in the past.
- Discuss way to challenge negative thoughts or exaggerated worries.
- If physical symptoms are present, discuss link between physical symptoms and mental distress (see Unexplained somatic complaints – F45). If tension related symptoms are prominent, recommend relaxation methods to relieve physical symptoms.
- Structured problem solving methods can help patients to manage life problems or stresses which contribute to anxiety symptoms.
    - Identify events that trigger excessive worry and work out practical steps for coping with them (e.g., A young woman presents with worry, tension, nausea and insomnias. These symptoms began after her son was diagnosed with asthma. Her anxiety worsens when he has asthma episodes)
    - Discuss what the patient is doing to manage this situation. Identify and reinforce things that are working.
    - Identify some specific actions the patient can take in the next few weeks such as:
      - Meet with nurse / doctor to learn about the course and management of asthma.
      - Discuss concerns with parents of other asthma episodes.
      - Write down a plan for management of asthma episodes.
- Ask about risk of suicide. Has the patient thought frequently about death or dying? Does the patient have a specific suicide plan? Has he / she made serious suicide attempts in the past? can the patient be sure not to act on suicidal ideas? Close observation by family or hospitalization may be necessary.

Medication

In mind case

- Medication is a secondary component of management. If more severe symptoms of depression are present, however, antidepressant drugs may be used. See depression – 32# for guidance on use of antidepressant drugs.

Specialist Consultation

- If the risk of suicide is severe, consider consultation and / or hospitalization.
- If significant symptoms persist the above treatment, refer to the management advice given for depression – F32# and Generalized anxiety – F41.1 follow advice given there regarding consultation

ADJUSTMENT DISORDER – F43.2

Presenting Complaints

Patients feel overwhelmed or unable to cope.
There may be stress related physical symptoms such a insomnia, headache, abdominal pain, chest pain, palpitations.

Diagnostic Features

- Acute reaction to recent stressful or traumatic event.
- Extreme distress resulting from a recent event, or preoccupation with the event.
- Symptoms may be primarily somatic.
- Other symptoms may include :
  - Low or sad mood
  - Anxiety
  - Worry
  - Feelings unable to cope.

Acute reaction usually lasts from a few days to several weeks.

Differential Diagnosis

If dissociative symptoms (sudden onset of unusual or dramatic somatic symptoms) are present, see Dissociative (conversion) disorder – F45
Acute symptoms may persist or evolve over time. If significant symptoms persist longer than one month, consider an alternative diagnosis :

- If significant symptoms of depression persist, see Depression – F32#
- If significant symptoms of anxiety persist, see Generalized anxiety – F41.1
- If stress related somatic symptoms persists, see Unexplained somatic complaints – F45
- If symptoms are due to a loss of a loved one, see Bereavement disorder –Z63

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Stressful events often have mental and physical effects.
- Stress related symptoms usually last only a few days or weeks.

Counseling of Patient and Family

- Encourage the patient to acknowledge the personal significance of the stressful event.
- Review and reinforce positive steps the patient has taken to deal with the stress.
- Identify steps the patient can take to modify the situation that produced the Stress. If the situation cannot be changed, discuss problem solving strategies.
- Identify relatives, friends and community resources able to offer support.
- Short – term rest and relief from stress may help the patient.
- Encourage a return to usual activities with in a few weeks.

Medication

Most acute stress reactions will resolve without use of medication. How ever, if severe anxiety symptoms occur, use antiznxiety drugs for up to three days (e.g., benzodiazepines such as lorazepam 0.5 – 1.0mg up to three times a day).
If the patient has severe insomnia, use hypnotic drugs for up to three days (e.g., temazepam 15mg each night).

Specialist Consultation

If symptoms last longer than one month, consider a more specific diagnosis (see differential diagnosis). Follow advice regarding consultation for that diagnosis.

DISSOCIATIVE (CONVERSION) DISORDER – F44

Presenting Complaints

Patients exhibit unusual or dramatic physical symptoms such as seizures, amnesia, trance, loss of sensation, visual disturbances, paralysis, aphonia, identity confusion, "possession" states.

Diagnostic Features

Physical symptoms that are :

- Unusual in presentation
- Not consistent with known disease

Onset is often sudden and related to psychological stress or difficult personal circumstances.
In acute cases, symptoms may :

- Be dramatic and unusual
- Change from time to time
- Be related to attention from others.

In more chronic cases, patients may appear clam in view of the seriousness of the complaint.

Differential Diagnosis

Carefully consider physical conditions which may cause symptoms. A full history and physical (including neurological) examination are essential. Early symptoms of neurological disorders (e.g., multiple sclerosis) may resemble conversion symptoms.
If other unexplained physical symptoms are present, see Unexplained somatic complaints – F45.
If pronounced depressive symptoms are present, see Depression – F32#

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Physical or neurological symptoms often have no clear physical cause. Symptoms can be brought about by stress.
- Symptoms usually resolve rapidly (from hours to a few weeks) leaving no permanent damage.

Counseling of Patient and Family

- Encourage the patient to acknowledge recent stresses or difficulties (though it is not necessary for the patient to link the stress to current symptoms)
- Give positive reinforcement for improvement. Try not to reinforce symptoms.
- Advise the patient to take a brief rest and relief from stress, then return to usual activities.
- Advise against prolonged rest or withdrawal from activities.

Medication

Avoid anxiolytics or sedatives.
In more chronic cases with depressive symptoms, antidepressant medication may be helpful (e.g., amitriptyline 25-50mg each night increasing to 100-150mg each night after 10 days)

Specialist Consultation

Consider consultation :

- If symptoms persist longer than six months
- To prevent or treat physical complications of dissociative symptoms (e.g., contractures).

UNEXPLAINED SOMATIC COMPLAINTS – F45

Presenting Complaints

Any physical symptom may be present. Symptoms may vary widely across cultures. Complaints my be single or multiple, and may change over time

Diagnostic Features

- Various many physical symptoms without a physical explanation (a full history and physical examination are necessary to determine this)
- Frequent medical visits in spite of negative investigation.
- Some patients may be primarily concerned with obtaining relief from physical symptoms. Others may be worried about having a physical illness and be unable to believe that no physical condition is present (hypochondriasis)
- Symptoms of depression and anxiety are common.

Differential Diagnosis

Seeking narcotics for relief to pain may also be a sign of drug use disorder. See Drug use disorder – F11#

- If low or sad mood is prominent, see Depression – F32#
- If strange beliefs about symptoms are present (e.g., belief that organs are decaying), see Acute psychotic disorder – F23
- If anxiety symptoms are prominent, see Panic disorder – F41.0 and Generalized anxiety disorder – 41.1

UNEXPLAINED SOMATIC COMPLAINTS F45

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Stress often produces physical symptoms.
- Focus on managing the symptoms, not on discovering their cause.
- Cure may not always be possible: the goal is to live the best life possible even if symptoms continue.

Counseling of Patient and Family

- Acknowledge that the patient's physical symptoms are real. They are no lies or inventions.
- Ask about the patient's beliefs (what is causing the symptoms?) and fears (what does he/she fear may happen")
- Offer appropriate reassurance (e.g., abdominal pain does not indicate cancer). Advise patients not to focus on medical worries.
- Discuss emotional stress that were present when the symptoms began.
- Relaxation methods can help relieve symptoms related to tension (headache, neck or back pain).
- Encourage exercise and enjoyable activities. the patient need not wait until all symptoms are gone before returning to normal routine.
- For patients with more chronic complaints, time-limited appointments that are regularly scheduled can prevent more frequent urgent visits.

Medication

Avoid unnecessary diagnostic testing or prescription of new medication for each new symptoms.
Antidepressant medication (e.g., amitriptyline 50-100mg a day)may be helpful in some cases (e.g., headache, irritable bowel syndrome, atypical chest pain).

Specialist Consultation

Avoid referrals to specialists. Patients are best managed in primary care settings. Patients may be offended by psychiatric referral and seek additional medical consultation else where.

NEURASTHENIA – F48.0
(Includes chronic fatigue)

Presenting Complaints

Patients may report :
- Lack of energy
- Aches and pains
- Feeling tired easily
- Inability to complete tasks.

Patients may request certification for medical leave or disability.

Diagnostic Features
- Mental or physical fatigue.
- Tired after minimal effort, with rest bringing little relief.
- Lack of energy

Other common symptoms include :

Dizziness	headache
Disturbed sleep	inability or relax
Irritability	aches and pains
Decreased libido	poor memory and concentration

This disorder may occur after infection or other physical illness.

Differential Diagnosis
Many physical disorder can cause fatigue. A full history and physical examination is necessary.
- If low or sad mood is prominent, see Depression – F32#
- If anxiety attacks are prominent, see Panic disorder - F41.1
- In unexplained physical symptoms are prominent, see Unexplained somatic complaints – F41

MANAGEMENT GUIDELINES

Essential Information for Patient and Family
- Periods of fatigue or exhaustion are common and are usually temporary.
- Treatment is possible and usually has good results.

Counseling of Patient and Family
- Advise brief rest (less than two weeks) followed by a gradual return to usual activities.
- The patient can build endurance with a programme of gradually increasing physical activity. Start with manageable level and increase a little each week.
- Emphasize pleasant or enjoyable activities. encourage the patient to resume activities which have helped in the past

Medication
No physical treatment has been established. If other mental or physical disorders are present, they may require physical treatment.
Activating antidepressants (e.g., fluoxitine, amineptine, desipramine) are some times helpful.

Specialist Consultation
Consider consultation if severe symptoms continue longer than three months.

EATING DISORDERS – F50

Presenting Complaints

The patient may present because of binge eating or extreme weight control measures such as self induced vomiting, excessive use of diet pills, and laxative abuse.
The family may ask for help because of the patient's loss of weight, refusal to eat, vomiting or amenorrhea.

Diagnostic Features

Common features

- Unreasonable fear of being fat or gaining weight
- Extensive efforts to control weight (strict dieting, vomiting, use of purgatives, excessive exercise)
- Denial that weight or eating habits are a problems.

Patients with anorexia nervosa typically show:

- Severe dieting despite very low weight
- Distorted body image (unreasonable belief that one is over weight)
- Amenorrhea

Patients with bulimia typically show:

- Binge eating (eating large amounts of food in a few hours)
- Purging (attempts to eliminate food by self induced vomiting, diuretic or laxative use)

A patient may show both anorexic and bulimic patterns at different times.

Differential Diagnosis

Depression may occur along with bulimia or anorexia. See Depression – F32#
Both anorexia and bulimia may cause physical disorders (amenorrhea, hypokalemia, seizures, cardiac arrhythmaias) that require monitoring or treatment.

EATING DISORDERS F50

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Purging and severe dieting may cause serious physical harm. Anorexia nervosa can be life threatening.
- Adopting more normal eating habits will give patients a great sense of control over their eating habits and weight.
- Purging and severe dieting are ineffective ways of achieving lasting weight control.

Specific Counseling of Patient and Family

- Establish a collaborative relationsship and explore ambivalence about changing eating habits and gaining weights.
- Review concerns about job and about current and future health (e.g., childbearing) that arise from eating problems.
- Plan daily meals based on normal intake of calories and nutrients. Consultation with a dietitian will be helpful. Focus on establishing normal patterns of eating and help patients develop more realistic ideas about food.
- Challenge the patient's strong convictions about weight, shape and eating (e.g., carbohydrates are fattening) and challenge rigid views about body image (e.g., patients believe no one will like them unless they are very thin)
- In case of patients with bulimia, identify situations when binge eating occurs and make clear plans to cope more effectively with these trigger events.
- Hospitalization may be necessary if there are medical complications of dieting or vomiting.

Medication

Antidepressant drugs have some times been effective in controlling binge eating.

Specialist Consultation

Consider consultation if severe or physically dangerous symptoms continue after the above measures.
Family conflicts may cause eating problems or result from them. Consider referral for family counseling, if available.

SLEEP PROBLEM (INSOMNIA) – F51

Presenting Complaints

Patients are distressed and some times disabled by the daytime effects of poor sleep.

Diagnostic Features

- Difficulty falling asleep.
- Restless or unrefreshing sleep.
- Frequent or prolonged periods of awakeness.

Differential Diagnosis

Short term sleep problems may result from stressful life events, acute physical illnesses, or changes in schedule. Persistent sleep problems may indicate another cause :

- If low or sad mood, and loss of interest in activities are prominent, see Depression – F32#
- If daytime anxiety is prominent, see Generalized anxiety – F41.1

Sleep problems can be a presenting complaint of alcohol or substance abuse. Enquire about current substance use.

Consider medical conditions which may cause insomnia (e.g., heart failure, pulmonary disease, pain conditions).

Consider medications which may cause insomnia (e.g., steroids, theophylline, decongestants, some antidepressant drugs.)

If the patient snores loudly while asleep, consider sleep apnoea. It will be helpful to take a history from the bed partner. Patients with sleep apnoea often complain of day time sleepiness but are unaware of night-time awakenings.

SLEEP PROBLEM F51

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Temporary sleep problems are common at times of stress or physical illness.
- The normal amount of sleep varies widely and usually decreases with age.
- Improvement of sleeping habits (not sedative medication) is the best treatment.
- Worry about not being able to sleep can worsen insomnia.
- Alcohol may help a person to fall asleep but can lead to restless sleep and early awakening.
- Stimulants (including coffee and tea) can cause or worsen insomnia.

Counseling of Patient and Family

Maintain a regular sleep routine by :

- Relaxing in the evening.
- Keeping to regular hours for going to bed and getting up in the morning, trying not to vary schedule or "sleep in" on the weekend.
- Getting up at the regular time even if the previous night's sleep was poor.
- Avoiding daytime naps since they can disturb the next night's sleep.
- Recommend relaxation exercises to help the patient to fall asleep.
- Advise the patient to avoid caffeine and alcohol.
- If the patient cannot fall asleep within 20 minutes, advise him/her to get up and try again later when feeling sleepy.
- Daytime exercise can help the patient to sleep regularly, but evening exercise may contribute to insomnia.

Medication

- Treat underlying psychiatric or physical condition.
- Make change to medication, as appropriate.
- Hypnotic medication may be used intermittently (e.g., benzodiazepines such as temazepam 15-30mg at bed time.) risk of dependence increases significantly after 14 days of use. Avoid hypnotic medication in cases of chronic insomnia.

Specialist Consultation

Consider consultation :

- If more complex sleep disorder (e.g., narcolepsy, sleep apnoea) are suspected.
- If significant insomnia continue despite the measures above.

SEXUAL DISORDER (MALE) – F52

Presenting Complaints

Patients may be reluctant to discuss sexual matters they may instead complain of physical symptoms, depressed mood or marital problems.

Diagnostic Features

Common sexual disorders presenting in the male are :

- Erectile dysfunction or impotence (erection is absent or is lost before completion of satisfactory sexual relations)
- Premature ejaculation (ejaculation occurs too early for satisfactory sexual relations)
- Orgasmic dysfunctions or delayed ejaculation (ejaculation is greatly delayed or absent and may occur only after the person has gone to sleep)
- Low sexual desire (more of a problem if the couple want children or if the female partner has greater sexual need).

Differential Diagnosis

If low or sad mood is prominent, see Depression – F32#
Problems in martial relationsships often contribute to sexual disorders, especially those of desire.
Ejaculatory problems may be circumstantial (e.g., performance anxiety, overexicitement, ambivlanece about partner) or may be caused by medication, but specific organic pathology is rare.
Physical factors which may contribute to impotence include diabetes, hypertension, multiple sclerosis, alcohol abuse and medication.

SEXUAL DISORDERS (MALE) F52

MANAGEMENT GUIDELINES

- **ERECTILE DYSFUNCTION (Failure of Genital response, impotence)**

Essential Information for Patient and Spouse

Erectile dysfunction has many possible causes. It is often a temporary response to stress or loss of confidence and is treatable, especially if morning erections occur.

Counseling of Patient and Spouse

Advise patient and partner to refrain from attempting intercourse for one or two weeks. Encourage them to practice pleasurable physical contact without intercourse during that time with a gradual return to full intercourse. Inform them of the possibility of physical treatment by penile rings, vacuum devices and intracavernosal injections.

- **PREMATURE EJACULATION**

Essential Information for Patient and Spouse

Control of ejaculation is possible, and can enchance sexual pleasure for both partners.

Counseling of Patient and Spouse

Reassure the patient that ejaculation can be delayed by learning new approaches (the squeeze or stop-start tequnique). Delay can also be achieved with clomipramine or seratonin reuptake inhibitors (e.g., fluoxetine).

- **ORGASMIC DYSFUNCTION**

Essential Information for Patient and Spouse

This is a more difficult condition to treat. However, if ejaculation can be brought about in some way (e.g., masturbation) the prognosis is better.

Counseling of Patient and Spouse

Recommend exercises such as penile stimulation with body oil. For fertility, consider artificial insemination by husband.

- **LOW SEXUAL DESIRE**

Essential Information for Patient and Spouse

Low sexual desire has many causes, including hormonal deficiencies, physical and psychiatric illnesses, stress and relationship problems.

Counseling of Patient and Spouse

Encourage relaxation, stress reduction, open communication, appropriate assertiveness and cooperation between partners.

Specialist Consultation

Consider consultation if the sexual problem lasts more than three months despite the above measures.

SEXUAL DISORDERS (FEMALE) – F52

Presenting Complaints

Patients may be reluctant to discuss sexual matters. They may instead complain of physical symptoms, depressed mood or marital problems.
Special problems may occur in cultural minorities.

Diagnostic Features

Common sexual disorders presenting in the male are :

- Low sexual desire (more of a problem if the couple want children or if the male partner has greater sexual need)
- Vaginismus or spasmodic contraction of vaginal muscles on attempted penetrations (often seen in nonconsummated marriages)
- Dyspareunia (pain in the vagina or pelvic region during intercourse)
- Anorgamia (orgasm or climax is not experienced).

Differential Diagnosis

- If low or sad mood is prominent, see Depression – F32#
- Problems in marital relationships often contribute to sexual disorders, especially those of desire.
- Vaginismus rarely has a physical cause.
- Factors that may contribute to dyspareunia include vaginal infections, pelvic infections (salpingitis) and other pelvic lesions (tumours or cysts)
- Anorgasmia in intercourse is very common. The etiology is unknown but in some cases medication my contribute.

SEXUAL DISORDERS (FEMALE) F52

MANAGEMENT GUIDELINES

- **LOW SEXUAL DESIRE**

Essential Information for Patient and Spouse
Low sexual desire has many cause, including marital problems, earlier traumas, physical and phychiatric illnesses and stress. The problem is often temporary.
Counseling of Patient and Spouse
Discuss patient's beliefs about sexual relations. Ask about traumatic sexual experiences and negative attitudes to sex. See couple together to try to lower husband's sexual expectations. Suggest planning sexual activity for specific days.

- **VAGINISMUS**

Essential Information for Patient and Spouse
Vaginismus is simply a form of muscle spasm and can be over come by relaxation exercises.
Counseling of Patient and Spouse
Digital examination of vagina will confirm diagnosis. Recommend exercises for husband and patient with graded dilators or fingers dilation, accompanied by relaxation.

- **DYSPAREUNIA**

Essential Information for Patient and Spouse
There are many physical causes, but in some cases poor lubrication and muscle tension are the main factors.
Counseling of Patient and Spouse
Relaxation, prolonged foreplay and careful penetration may over come psychogenic problem. Referral to a gynaecologist is advisable if simple measures are unsuccessful.

- **ANORGASMIA**

Essential Information for Patient and Spouse
Many women are unable to experience orgasm during intercourse but can usually achieve it by clitoral stimulation.
Counseling of Patient and Spouse
Discuss patient's beliefs and attitude. Encourage manual self-exploration (e.g., genital stimulation). The couple should be helped to communicate openly and to reduce any unrealistic expectations.
Specialist Consultation
Consider consultation if the sexual problem lasts longer than three months despite the above measures.

MENTAL RETARDATION – F70

Presenting Complaints

In Children :

- Delay in usual development (walking, speaking, toilet training)
- Difficulties with school work, as well as with other children, because of learning disabilities.
- Problems of behavior.

In adolescents :

- Difficulties with peers
- Inappropriate sexual behavior.

In adults :

- Difficulties in every day functioning (e.g., cooking, cleaning)
- Problems with normal social development, (e.g., finding work, marriage, chil-rearing)

Diagnostic Features

Slow or incomplete mental development resulting in :

- Learning difficulties
- Social adjustment problems

The range of severity includes :

- Severely retarded (usually identified by age before age 2, requires help with daily tasks, capable of only simple speech)
- Moderately retarded (usually identified by age 3-5, able to do simple work in supervision, needs guidance or supervision in daily activities)
- Mildly retarded (usually identified during school years, limited in school work, but able to live alone and work at simple jobs)

If possible, evaluation should include consultation about appropriate training and rehabilitation.

Differential Diagnosis

Specific learning difficulties, attention deficit disorder (see Hyperkinetic disorder – F90), motor disorders (e.g., cerebral palsy) and sensory problems (e.g., deafness) may also interfere with school performance.

Malnutrition or chronic medical illness may cause developmental delays. Most causes of mental retardation cannot be treated. The more common treatable cause of retardation include hypothyroidism, lead poisoning and some inborn errors of metabolism (e.g., phenylketonuria).

HYPERKINETIC (ATTENTION DEFICIT) DISORDER – F90

Presenting Complaints

Patients:

- Can't sit still.
- Are always moving
- Cannot wait for others
- Will not listen to what others say
- Have poor concentration.

Younger ones are likely to be failing in school work.

Diagnostic Features

Usually there is :

- Severe difficulty in maintaining attention (short attention span, frequent changes of activity)
- Abnormal physical restlessness (most evident in class room or at mealtimes)
- Impulsiveness (the patient cannot wait his or her turn or acts without thinking)

Some times there may be discipline problems, underachievement in school, proneness to accidents.
This pattern occurs in all situations (home, school, play)
Avoid premature diagnosis. High levels of physical activity are not necessarily abnormal.

Differential Diagnosis

Also consider presence of :

- A specific physical disorder (e.g., epilepsy, fetal alcohol syndrome, thyroid disease)
- General emotional disorders (patient exhibits anxiety depression)
- Autism (social / language impairment and stereotyped behaviors are present)
- Conduct disorder (patient exhibits disruptive behavior without inattentiveness, see Conduct disorder – F91#)
- Mild mental retardation or learning disability.

Hyperkinetic behavior can either cause or result from parent–child problems. Assessment of family relationships may be important.

HYPERKINETIC (ATTENTION DEFICIT) DISORDER F90

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Hyperkinetic behavior is not the child's fault, it is cause by an impairment of attention and self-control that is often inborn.
- The outcome is better if parents can be calm and accepting.
- Hyperactive children need extra help to remain clam and attentive at home and school.
- Some hyperactive children continue to have difficulties into adulthood, but more make a satisfactory adjustment.

Counseling of Patient and Family

- Encourage parents to give positive feedback or recognition when the child is able to pay attention.
- Avoid punishment. Disciplinary control must be immediate (within seconds) to be effective.
- Advise parents to discuss the problem with the child's school teacher (to explain that learning will be in short bursts, immediate rewards will encourage attention, and periods of individual attention in class may be beneficial)
- Stress the need to minimize distractions (e.g., have child sit at front of class)
- Sport or other physical activity may help release excess energy.
- Encourage parents to meet with the school psychologist or counselor.

Medication

For more severe cases, stimulant medication may improve attention and reduce over activity (e.g., methylphenidate 15-45mg a day or dextroamphetamine 10-30mg a day). Pemoline 60-120mg a day is preferred if substance abuse is possible (adolescents) and clonidine 25-50mg a day is preferred if motor tics are also present.

Specialist consultation

If available, consider consultation before starting drug treatment or if the above measure are unsuccessful.
Referral for behavioral treatment, if available, can improve attention and self-control.

CONDUCT DISORDER – F91#

Presenting Complaints
Parents or school teachers may request help in managing disruptive behavior.

Diagnostic Features
A consistent pattern of abnormally aggressive or defiant behavior such as :

Fighting	bullying	truancy
Cruelty	stealing	
Lying	vandalism.	

- Conduct must be judged by what is normal for age and culture.
- Conduct disorder may be associated with stress at home or school.

Differential Diagnosis
Some rebellious behavior may be within the normal range.
Inconsistent discipline or conflict in the family, or inadequate supervision at school, may contribute to disruptive behavior.
Disruptive behavior can also be caused by a depressive state, learning disability, situational problems or parent–child problems.
May occur together with hyperkinetic disorder. If over activity and inattention are prominent, see Hyperkinetic disorder- F 90

MANAGEMENT GUIDELINES

Essential Information for Patient and Family
- Effective discipline should be clear and consistent, but not harsh.
- Avoid punishment. It is more helpful to reward positive behavior.

Counseling of Patient and Family
- Ask about the reasons for disruptive behavior. Alter the child's circumstances accordingly, as far as is possible.
- Encourage parents to give positive feedback or recognition for good behavior.
- Parents should make discipline consistent. They should set clear and firm limits on bad behavior and should inform the child in advance of the consequences of exceeding those limits. Parents should enforce the consequences immediately and without fail.
- Advise parents to discuss this approach to discipline with teachers.
- Relatives, friends or community resources can support parents in providing consistent discipline.

Medication
No physical treatment has been established

Specialist Consultation
Consider consultation if severe behavior problems persist following the above measures.

ENURESIS – F98.0

Presenting Complaints
Repeated urination into clothes or bed

Diagnostic Features
Delay in ability to control urination (Note : wetting at night is normal until the metal age of 5 years)
The urination

- is usually involuntary, though occasionally intentional.
- may be continuous from birth, or may follow a period of continence.
- some times occurs with more general emotional or behavior disorder
- may begin after stressful or traumatic events.

Differential Diagnosis
Most enuresis has no physical cause (primary enuresis), but enuresis may be secondary to ;

- Neurological disorder (spina bifida) where urination is also abnormal during the day.
- Diabetes or diuretic drugs that may cause polyuria and urgency
- Seizure disorder
- Structural urinary tract abnormality
- Acute urinary tract infection
- Generalized emotional disturbance.

Initial evaluation should include urine examination. If daytime urination is normal and enuresis is the only problem, further testing is usually not necessary.

MANAGEMENT GUIDELINES

Essential Information for Patient and Family

- Enuresis is usually part of a specific delay in development. It is often hereditary.
- The out look is good. Treatment is usually effective.
- Enuresis is not within a child's voluntary control. Night-time wetting occurs while the child is asleep.
- Punishment and scolding are unlikely to help and may increase emotional distress.

Counseling of Patient and Family

- Make the child a part of his/her own treatment. If possible, the child should take responsibility for the problem and its management (e.g., changing cloths, pyjamas and bedding).
- Have the child keep a record of dry nights on a calendar.
- Give praise and encouragement for success
- Offer reassurance if the child is anxious about using toilets e.g., at night, away from home
- If available, simple alarm system will warn the child of night time wetting and can improve bladder control. Ensure that the child wakes and urinates in the toilet when the alarm sounds. Up to 12 weeks of use may be needed.
- Exercise to increase bladder control while awake may be helpful (resisting urge to urinate for longer and longer periods, stopping urination in mid-stream).

Medication
Regular use of medication is usually not required though it can help when children have a special need to be dry. Effective medications include imipramine (25-50mg two hours before bed time), desmopressin (20-40 micrograms intranasally) or urinary antispasmodic agents (e.g., genurine)

Specialist Consultation
Consider psychiatric / psychological consultation :

- If enuresis occurs in association with severe family conflict or more severe emotional disturbance.
- In case of urinary infection, persistent daytime incontinence, or an abnormal urinary stream.
- If problem persists beyond age 10

ಸೆಲ್ಫ್ ರಿಪೋರ್ಟಿಂಗ್ ಕ್ವೆಶ್ಚನೀರ್ (SRQ)

FOR PRIVATE CIRCULATION

ಸೂಚನೆ : ಈ ಕೆಲಕಂಡ ಪ್ರಶ್ನಾವಳಿಗಳಲ್ಲಿ ನಿಮ್ಮ ನೋವು ನಲಿವುಗಳ ಸಂಬಂಧ ಪಟ್ಟಂಥಹ ಅನುಭವಗಳು. ಹಿಂದಿನ ಮುವತ್ತು (30) ದಿವಸಗಳ ಒಳಗಾಗಿ ನೀವು ಅನುಭವಿಸಿದ್ದರೆ ಹೌದು ಎಂದು ನಿಮ್ಮ ಉತ್ತರ ಮತ್ತು ಈ ಅನುಭವಗಳನ್ನು ನೀವು ಗುರುತಿಸದಿದ್ದರೆ ಇಲ್ಲ ಎಂದು ನಿಮ್ಮ ಉತ್ತರ ಎಂದು ಈ ಕೆಳಗಿನ ಪ್ರತ್ನೆಗಳಿಗೆ ಉತ್ತರಿಸಿ. ಈ ಪ್ರಶ್ನಾವಳಿಗೆ ಉತ್ತರಿಸುವಾಗ ಬೇರೆಯವರ ಸಹಾಯವನ್ನು ಪಡೆಯಬೇಡಿರಿ. (ಏಕೆಂದರೆ ಇವು ನಿಮ್ಮ ಸ್ವಂತ ಅನುಭವಗಳು) ಈ ನಿಮ್ಮ ಉತ್ತರಗಳನ್ನು ಬೇರೆಯವರಿಗೆ ತಿಳಿಸದಂತೆ ಅಭಯ ಕೊಡುವೆವು.

1. ನಿಮಗೆ ಆಗಾಗ್ಗೆ ತಲೆನೋವು ಬರುತ್ತಾ?	ಹೌದು / ಇಲ್ಲ
2. ಹಸಿವು ಕಡಿಮೆ ಆಗಿದೆಯಾ?	ಹೌದು / ಇಲ್ಲ
3. ನಿದ್ರೆ ಸರಿಯಾಗಿ ಮಾಡುವುದಿಲ್ಲವೇ?	ಹೌದು / ಇಲ್ಲ
4. ನೀವು ಸ್ವಲ್ಪಕ್ಕೇ ಹೆದರಿಕೊಳ್ಳುತ್ತೀರಾ?	ಹೌದು / ಇಲ್ಲ
5. ನಿಮ್ಮ ಕೈಗಳು ನಡುಗುತ್ತವೆಯೇ?	ಹೌದು / ಇಲ್ಲ
6. ನಿಮಗೆ ಗಾಬರಿ, ಏನಾಗುವುದೋ ಎಂಬ ಭಯ, ಚಿಂತೆ ಇದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
7. ನಿಮ್ಮ ಜೀರ್ಣಶಕ್ತಿ ಕಡಿಮೆಯಾಗಿದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
8. ಸ್ಪಷ್ಟವಾಗಿ ಯೋಚಿಸಲು ನಿಮಗೆ ಕಷ್ಟವಾಗುತ್ತದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
9. ಮನಸ್ಸಿಗೆ ದುಃಖವಾಗುತ್ತದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
10. ಮಾಮೂಲಿಗಿಂತ ಹೆಚ್ಚಾಗಿ ಅಳು ಬರುತ್ತದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
11. ದಿನನಿತ್ಯದ ಕೆಲಸ ಕಾರ್ಯಗಳನ್ನು ಸಂತೋಷವಾಗಿ ಮಾಡಲು ಕಷ್ಟವಾಗುತ್ತಿದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
12. ನಿರ್ಧಾರವನ್ನು ಮಾಡಲು ಕಷ್ಟವಾಗುತ್ತಿದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
13. ನಿಮ್ಮ ದಿನನಿತ್ಯದ ಕೆಲಸ ಮುಗಿಯದೆ ತೊಂದರೆಯಾಗುತ್ತಿದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
14. ಜೀವನದಲ್ಲಿ ಉಪಯುಕ್ತ ಪಾತ್ರ ವಹಿಸಲು ನಿಮಗೆ ಆಗುತ್ತಿಲ್ಲವೆ?	ಹೌದು / ಇಲ್ಲ
15. ಎಲ್ಲಾ ವಿಚಾರಗಳಲ್ಲಿ ನೀವು ಆಸಕ್ತಿಯನ್ನು ಕಳೆದುಕೊಂಡಿದ್ದೀರಾ?	ಹೌದು / ಇಲ್ಲ
16. ನೀವು ಯಾವುದಕ್ಕೂ ಪ್ರಯೋಜನವಿಲ್ಲದವರು (ಬೆಲೆ ಇಲ್ಲದವರು) ಏನಿಸುತ್ತದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
17. ಪ್ರಾಣ ಕಳೆದುಕೊಳ್ಳಬೇಕು ಎಂಬ ಆಲೋಚನೆ ನಿಮ್ಮ ಮನಸ್ಸಿನಲ್ಲಿದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
18. ಎಲ್ಲಾ ಸಮಯದಲ್ಲೂ ನಿಮಗೆ ಆಯಾಸ ಸುಸ್ತು ಆಗುತ್ತದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
19. ಹೊಟ್ಟೆಯಲ್ಲಿ ಏನೋ ಸಂಕಟವಾದಂತೆ ಆಗುತ್ತದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
20. ನಿಮಗೆ ಸುಲಭವಾಗಿ ಆಯಾಸವಾಗುತ್ತದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
21. ಯಾರಾದರೂ ನಿಮಗೆ ಯಾವುದೇ ರೀತಿಯಲ್ಲಿ ತೊಂದರೆ ಕೊಡಲು ಪ್ರಯತ್ನಿಸುತ್ತಿದ್ದಾರೆ ಎಂದು ಅನಿಸುತ್ತಿದ್ದೆಯೆ?	ಹೌದು / ಇಲ್ಲ
22. ಇತರರು ತಿಳಿದಿರುವುದಕ್ಕಿಂತಲೂ ನೀವು ವಿಶೇಷ ವ್ಯಕ್ತಿ ಯೆಂದು ತಿಳಿದಿರುವಿರಾ?	ಹೌದು / ಇಲ್ಲ
23. ನಿಮ್ಮ ಆಲೊಚನೆಗಳಲ್ಲಿ ಏನಾದರೂ ಅಸಹಜವಾಗಿರುವುದು / ಆಡ್ಡಿಯಾಗಿರುವುದನ್ನು ಗಮನಿಸಿದ್ದಿರಾ?	ಹೌದು / ಇಲ್ಲ
24. ನಿಮಗೆ ಯಾವಾಗಲಾದರೂ ಇತರರಿಗೆ ಕೇಳಿಸದೆ ಇರುವ ಮತ್ತು ಅದು ಎಲ್ಲಿಂದ ಬರುತ್ತಿದೆ ಎಂಬುದು ತಿಳಿಯದೆ ಇರುವಂತಹ ಶಬ್ದ / ಮಾತುಗಳು ಕೇಳಿಸಿವೆಯೆ?	ಹೌದು / ಇಲ್ಲ
25. ನಿಮಗೆ ಯಾವಾಗಲಾದರೂ ಮೂರ್ಛೆರೋಗದಿಂದ ಅಥವಾ ಪ್ರಜ್ಞೆ ತಪ್ಪಿ ಬೀಳುವ ತೊಂದರೆ ಇದೆಯೆ?	ಹೌದು / ಇಲ್ಲ

Note : If the respondent say YES to 7 or more items from question no. 1 to 20 or / and a respondent says YES to any 1 question from question no. 21 to 25 then he / she might be having a psychiatric problem which requires detailed evaluation and treatment or referral to a psychiatrist.

11595
MH-100

ಈ ಕೆಳಗಿನ ಪ್ರಶ್ನೆಗಳಿಗೆ ಯಾವುದಾದರೂ ಒಂದಕ್ಕೆ **ಹೌದು** *ಎಂದು ಬಂದಲ್ಲಿ ಮಾನಸಿಕ ತೊಂದರೆ ಇದೆ ಎಂದು ಅರ್ಥ. ಕಾರಣ ಕೂಡಲೇ ಮನೋಶಾಸ್ತ್ರಜ್ಞರ ಬಳಿ ಚಿಕಿತ್ಸೆಗಾಗಿ ಕಳುಹಿಸಿ.*

1. ಯಾರಾದರೂ, ಹುಚ್ಚು ಹಿಡಿದು, ಅರ್ಥವಿಲ್ಲದೆ ಮಾತಾಡುವುದು ಅಥವಾ ವಿಚಿತ್ರವಾಗಿ ವರ್ತಿಸುವುದು ಮಾಡುತ್ತಾರೆಯೆ? ಹೌದು / ಇಲ್ಲ
2. ಯಾರಾದರೂ, ಮೂರ್ಛೆ ರೋಗದಿಂದ ಅಥವಾ ಪ್ರಜ್ಞೆತಪ್ಪಿ ಬೀಳುವ ತೊಂದರೆಯಿಂದ ಬಳಲುತ್ತಾರೆಯೆ? ಹೌದು / ಇಲ್ಲ
3. ಯಾರಾದರೂ, ಜನರ ಜೊತೆ ಮಾತಾಡದೆ, ಬಹಳ ಮಂಕಾಗಿರುವುದುಂಟೆ?
4. ಯಾರಾದರೂ, ಬೇರೆಯವರಿಗೆ ಕಾಣಿಸದ ದೃಶ್ಯ ತನಗೆ ಕಾಣುತ್ತದೆ ಅಥವಾ ಬೇರೆಯವರಿಗೆ ಕೇಳಿಸದ ಧ್ವನಿ ತನಗೆ ಕೇಳಿಸುತ್ತದೆ ಎನ್ನುತ್ತಾರೆಯೆ? ಹೌದು / ಇಲ್ಲ
5. ಯಾರಾದರೂ, ಎಲ್ಲರ ಬಗ್ಗೆ ಬಹಳ ಸಂಶಯ ಪಡುವುದು ಅಥವಾ ತನಗೆ ಎಲ್ಲರೂ ತೊಂದರೆ ಕೊಡುತ್ತಾರೆ ಎಂದು ಹೇಳುತ್ತಾರೆಯೆ? ಹೌದು / ಇಲ್ಲ
6. ಯಾರಾದರೂ, ವಿಪರೀತ ಖುಷಿಯಲ್ಲಿದ್ದು, ಆತ ಸಾಧಾರಣ ವ್ಯಕ್ತಿಯಾದರೂ, ತಾನು ಬಹಳ ದೊಡ್ಡ ಮನುಷ್ಯ ಎಂದು ಜಂಬಕೊಚ್ಚುತ್ತಾರೆಯೆ? ಹೌದು / ಇಲ್ಲ
7. ಯಾರಾದರೂ, ಇತ್ತೀಚೆಗೆ ಬಹಳ ದುಃಖಪಟ್ಟುಕೊಂಡು ಕಾರಣವಿಲ್ಲದೆ ಅಳುತ್ತಾರೆಯೆ? ಹೌದು / ಇಲ್ಲ
8. ಯಾರಾದರೂ, ತನ್ನ ಜ್ಞಾಪಕಶಕ್ತಿಯನ್ನು ಕಳೆದುಕೊಂಡಿದ್ದಾರೆಯೆ ಅಥವಾ ಕಳೆದುಕೊಳ್ಳುತ್ತಿದ್ದಾರೆಯೆ? ಹೌದು / ಇಲ್ಲ
9. ಯಾರಾದರೂ ಹುಟ್ಟಿದಂದಿನಿಂದ ಮಂದ ಬುದ್ಧಿ ಇದ್ದು, ದೊಡ್ಡವರಾದರೂ ಸಣ್ಣ ಮಗುವಿನಂತಿದ್ದಾರೆಯೆ? ಹೌದು / ಇಲ್ಲ
10. ಯಾರಾದರೂ ತುಂಬಾ ಕುಡಿಯುವುದು ಅಥವಾ ಅಮಲು ವ್ಯಸನಿಗಳು ಇದ್ದಾರೆಯೆ? ಹೌದು / ಇಲ್ಲ

A sample page from the SRQ

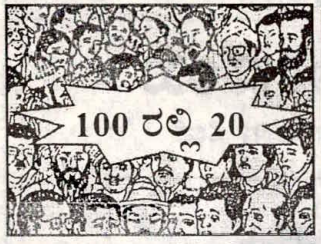
SRQ-20

A copy of the English version of the Self Reporting Questionnaire-20 is shown below.

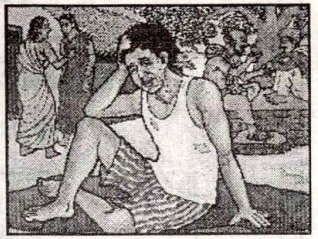
1.	Do you often have headaches?	yes/no
2.	Is your appetite poor?	yes/no
3.	Do you sleep badly?	yes/no
4.	Are you easily frightened?	yes/no
5.	Do your hands shake?	yes/no
6.	Do you feel nervous, tense or worried?	yes/no
7.	Is your digestion poor?	yes/no
8.	Do you have trouble thinking clearly?	yes/no
9.	Do you feel unhappy?	yes/no
10.	Do you cry more than usual?	yes/no
11.	Do you find it difficult to enjoy your daily activities?	yes/no
12.	Do you find it difficult to make decisions?	yes/no
13.	Is your daily work suffering?	yes/no
14.	Are you unable to play a useful part in life?	yes/no
15.	Have you lost interest in things?	yes/no
16.	Do you feel that you are a worthless person?	yes/no
17.	Has the thought of ending your life been on your mind?	yes/no
18.	Do you feel tired all the time?	yes/no
19.	Do you have uncomfortable feelings in your stomach?	yes/no
20.	Are you easily tired?	yes/no

ಮಾನಸಿಕ ರೋಗಿಗಳೆಂದರೆ ಯಾರು?

ಅವರ ಲಕ್ಷಣಗಳೇನು?



ಇದು ನಿಮಗೆ ಗೊತ್ತೇ



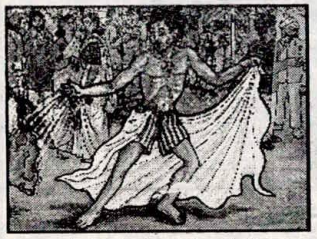
ನನಗೇನೋ ಆಗಿದೆ ಗೊತ್ತೇ

ನನಗೆ ಏನೂ ಬೇಡಾ,
ಯಾರೂ ಬೇಡಾ

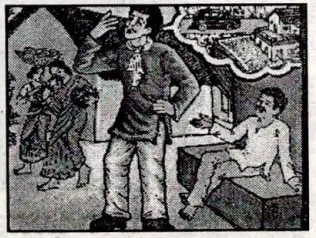
ಜೀವನವೇ ಬೇಡಾ

ವಿಚಿತ್ರ ಸದ್ದು ಕೇಳಿಸುತ್ತದೆ

ಕೊಲ್ಲಲು ಸಂಚು ಹಾಕುತ್ತಿದ್ದಾರೆ



ನನ್ನ ಪ್ರಪಂಚವೇ ಬೇರೆ

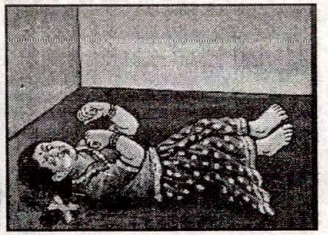


ನಾನು ಸದಾ ಸುಖಿ

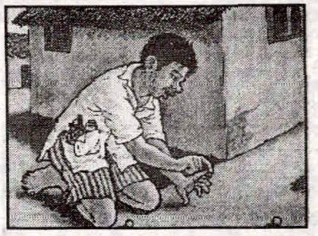
ಅಯ್ಯಯ್ಯೋ ಏನಾಗುತ್ತೋ !

ಭಯ ! ಭಯ !! ಭಯ !!!

ನನ್ನನ್ನು ಬಿಟ್ಟು ಬಿಡಿ



ವಾಯು ಕಾಯಿಲೆ

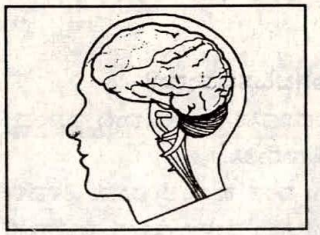


ಬುದ್ಧಿ ಮಾಂದ್ಯತೆ

ಸಮಸ್ಯೆಗಳಿಗೆ ಸರಾಯಿ ಪರಿಹಾರವೇ ?

ಸರಾಯಿ ಇಲ್ಲದೆ ಉಸಿರಿಲ್ಲ

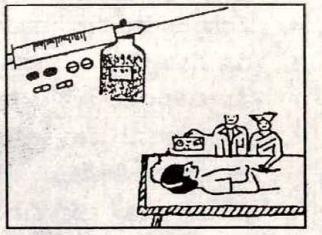
ಇವೆಲ್ಲ ಮಾಮೂಲು



ಮೆದುಳು ....!.... ?

ಮಾನಸಿಕ ಕಾಯಿಲೆ,
ಮನೋವೈದ್ಯರ ಸಲಹೆ ಅಗತ್ಯ.

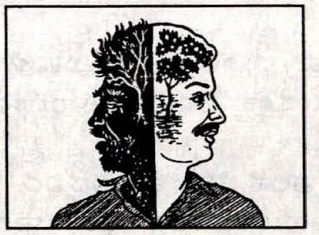
ಹೌದು, ಇದು ಮಾನಸಿಕ ಕಾಯಿಲೆ,
ಚಿಕಿತ್ಸೆಗೆ ಸಹಕಾರ ಬೇಕು



ಔಷಧೋಪಚಾರ /
ಎಲೆಕ್ಟ್ರಿಕ್ ಕಂಪನ ಚಿಕಿತ್ಸೆ

ಮಾನಸಿಕ ಆರೋಗ್ಯಕ್ಕೆ
ಇವುಗಳು ಕೂಡಾ ಬೇಕು

ಔಷಧಿಗಳನ್ನು ಮುಂದುವರೆಸು ...



ಅಸ್ವಸ್ಥತೆಯಿಂದ ಸ್ವಸ್ಥತೆಯ ಕಡೆಗೆ

ಮಾನಸಿಕ ಆರೋಗ್ಯ :
ಭೇದ ಭಾವನೆ ಅಳಿಸಿ ಸೇವಾ
ಮನೋಭಾವನೆ ಬೆಳೆಸಿ

ನೀವೇನು ಮಾಡಬಹುದು?

ಈ ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಹೇಗೆ ಭಾಗಬಹಿಸಬಹುದು?

1. ನಿಮ್ಮ ಸುತ್ತಮುತ್ತ ಯಾರಿಗಾ ಮಾನಸಿಕ ಕಾಯಿಲೆ/ಬುದ್ಧಿ ಮಾಂದ್ಯ/ಮೂರ್ಛೆರೋಗ ಇದೆ ಎಂದು ಗುರುತಿಸಿ.
2. ಅವರಿಗೆ ಇದು ಚಿಕಿತ್ಸೆ ಗೆಬಗ್ಗುವಂತ ಕಾಯಿಲೆ ಎಂದು ತಿಳಿವಳಿಕೆ ಹೇಳಿ, ಹತ್ತಿರದ ಆಸ್ಪತ್ರೆಗೆ ಹೋಗಲು ಹೇಳಿ ಆರೋಗ್ಯ ಸಹಾಯಕ/ವೈದ್ಯರ ಸಲಹೆ ಪಡೆಯಲು ಸೂಚಿಸಿ.
3. ವೈದ್ಯರು ಸೂಚಿಸಿದ ಔಷಧೋಪಚಾರವನ್ನು ಕ್ರಮವಾಗಿ ಮಾಡಲು ಪ್ರೋತ್ಸಾಹಿಸಿ.
4. ಎರಡು ಅಥವಾ ನಾಲ್ಕು ವಾರಗಳಿಗೊಮ್ಮೆ ವೈದ್ಯರನ್ನು ಕಾಣಲು ಹೇಳಿ.
5. ರೋಗಿಯ ಬೇಕು - ಬೇಡಗಳನ್ನು ಗಮನಿಸಿ, ಪ್ರೀತಿ ವಿಶ್ವಾಸದಿಂದ ನೋಡಿಕೊಳ್ಳಲು ಉತ್ತೇಜಿಸಿ.
6. ರೋಗಿ ಆದಷ್ಟು ಬೇಗ ಕೆಲಸ ಮಾಡಲು, ಸ್ವಾಲಂಬಿಯಾಗಿ ಬದುಕಲು ಅವಕಾಶ ಮಾಡಿಕೊಡಿ.
7. ರೋಗಿಗೆ ಮತ್ತು ಮನೆಯವರಿಗೆ ಸಮಾಧಾನ, ಆಸರೆ ನೀಡಿ.

ನೀವು ಮಾನಸಿಕ ಆರೋಗ್ಯ ಶಿಕ್ಷಣದಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳಿ.

1. ಮಾನಸಿಕ ಕಾಯಿಲೆ/ಬುದ್ಧಿ ಮಾಂದ್ಯ/ಮೂರ್ಛೆರೋಗ ಮಿದುಳಿಗೆ ಸಂಬಂಧಿಸಿದ ಕಾಯಿಲೆಗಳು ಎಂದು ಹೇಳಿ.
2. ದೆವ್ವ/ಮದ್ದು/ಮಾಟ/ಅತೃಪ್ತಕಾಮ/ಪಾಪದ ಫಲದಿಂದ ಈ ಕಾಯಿಲೆಗಳು ಬರುತ್ತವೆ ಎಂಬ ತಪ್ಪು ನಂಬಿಕೆಯನ್ನು ಹೋಗಲಾಡಿಸಿ.
3. ರೋಗಿಗೆ ಹೊಡೆದರೆ, ಉಪವಾಸವಿಟ್ಟರೆ, ರೂಮಿನಲ್ಲಿ ಕೂಡಿ ಹಾಕಿದರೆ, ಬರೆ ಹಾಕಿದರೆ, ಹೆದರಿಸಿದರೆ ಕಾಯಿಲೆ ಕಡಿಮೆ ಯಾಗುತ್ತದೆ ಎಂಬ ಕಂದಾಚಾರವನ್ನು ನಿಲ್ಲಿಸಿ.
4. ಉದಾಸೀನ ಮಾಡುವುದು, ಅಪಹಾಸ್ಯ ಮಾಡುವುದು, ತಿರಸ್ಕಾರ ಮಾಡುವುದು ಬಿಟ್ಟು, ರೋಗಿಗೆ ಪ್ರೀತಿ ಪ್ರೋತ್ಸಾಹ- ಸ್ವಾಲಂಬಿಯಾಗಿ ಬದುಕಲು ಅವಕಾಶ ಮಾಡಿಕೊಡಲು ಪ್ರಯತ್ನಿಸಿ.

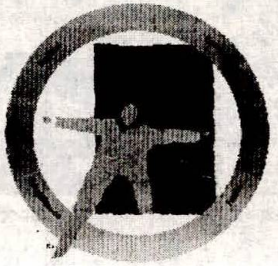
ನೆನಪಿಡಿ:

- ಮಾನಸಿಕ ಕಾಯಿಲೆ ಮತ್ತು ಮೂರ್ಛೆರೋಗ ಮಿದುಳಿಗೆ ಸಂಬಂಧಿಸಿ ಕಾಯಿಲೆಗಳು. ಸೂಕ್ತ ಔಷಧೋಪಚಾರದಿಂದ ಹತೋಟಿಗೆ ಬರುತ್ತವೆ.
- ಈ ಕಾಯಿಲೆಗಳಿಗೆ ಸೂಕ್ತ ಸಲಹೆ ಚಿಕಿತ್ಸೆ ಈಗ ಲಭ್ಯವಿದೆ.
- ಪ್ರತಿಯೊಬ್ಬರೂ ಈ ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಭಾಗಿಗಳಾಗ ಬಹುದು. ರೋಗಿಗಳಿಗೆ ತಮ್ಮ ಕೈಲಾದ ನೆರವು ಮತ್ತು ಆಸರೆಯನ್ನು ನೀಡಬಹುದು.

ಮನವಿ

ಇಂದು ಮಿಲಿಯಗಟ್ಟಲೆ ಜನ ಮಾನಸಿಕ ಅನಾರೋಗ್ಯದಿಂದ ಬಳಲುತ್ತಿದ್ದಾರೆ, ಸಮಾಜವು ಇವರನ್ನು ಕಡೆಗಣಿಸಿದೆ. ಇಂತ ವ್ಯಕ್ತಿಗಳ ಸೇವೆ ಮಾಡಿ ಸಮಾಜದಲ್ಲಿ ಅವರಿಗೆ ಸ್ಥಾನ ದೊರೆಯುವಂತೆ ಮಾಡುವ ಪ್ರಯತ್ನದಲ್ಲಿ ಪುಣ್ಯಕೋಟಿ ಫೌಂಡೇಶನ್ ತಮ್ಮಿಂದ ಸಹಾಯ ಸಹಕಾರವನ್ನು ಬಯಸುತ್ತದೆ.

ಆರೈಕೆಯ ವರ್ತುಲ



(Courtesy: WHO, Geneva)

ಮಾನಸಿಕ ಆರೋಗ್ಯ ಚಿಕಿತ್ಸಾ ಶಿಬಿರಗಳನ್ನು ಈ ಕೆಳಕಂಡ ಊರುಗಳಲ್ಲಿ ಪ್ರತಿ ತಿಂಗಳು ನಡೆಸುತ್ತಿದ್ದೇವೆ.

1. ಪ್ರತಿ ತಿಂಗಳು ಮೊದಲನೇ ಬುಧವಾರ - ಕನಕಗಿರಿ
2. ಪ್ರತಿ ತಿಂಗಳು ಎರಡನೇ ಬುಧವಾರ - ಕುಕ್ಕನೂರು
3. ಪ್ರತಿ ತಿಂಗಳು ಮೂರನೇ ಬುಧವಾರ - ಇರಕಲಗಡ
4. ಪ್ರತಿ ತಿಂಗಳು ನಾಲ್ಕನೇ ಬುಧವಾರ - ಹಗರಿಬೊಮ್ಮನಹಳ್ಳಿ
5. ಪ್ರತಿ ತಿಂಗಳು ಮೊದಲನೇ ಭಾನುವಾರ - ಗಂಗಾವತಿ
6. ಪ್ರತಿ ತಿಂಗಳು ಎರಡನೇ ಭಾನುವಾರ - ಕುಷ್ಟಗಿ
7. ಪ್ರತಿ ತಿಂಗಳು ಮೂರನೇ ಭಾನುವಾರ - ಕೊಟ್ಟೂರು
8. ಪ್ರತಿ ಶನಿವಾರ - ಮಾದಕ ವಸ್ತುಗಳ ದುಶ್ಚಟಗಳ ನಿವಾರಣ ಶಿಬಿರಗಳು

ಸಂಪರ್ಕಿಸಿ

ಮನೋದಯ ಮಾನಸಿಕ ಆರೋಗ್ಯ ಸೇವೆ

ಪುಣ್ಯಕೋಟಿ ಫೌಂಡೇಶನ್ (ರಿ), ಹೊಸಪೇಟೆ.

1ನೇ ಮಹಡಿ, ಅಮರೇಶ್ವರ ಆಸ್ಪತ್ರೆ, 4/334,
ಪಟೇಲ್ ನಗರ, ಹೊಸಪೇಟೆ.

ದೂ. 08394 - 223599 ಮೊ. 98453 00708

ಪುಣ್ಯಕೋಟಿ ಫೌಂಡೇಶನ್ (ರಿ), ಹೊಸಪೇಟೆ.

PUNYAKOTI FOUNDATION (R)

ಮನೋದಯ

ಮಾನಸಿಕ ಆರೋಗ್ಯ ಸೇವೆ

ಭೇದ ಭಾವನೆ ಅಳಿಸೋಣ;
ಸೇವಾ ಮನೋಭಾವ ಬೆಳೆಸೋಣ.