Detecting and managing common child and adult mental health problems in HIV care

Participants’ Manual
November 2011

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Communication Skills and Assessment

Module 2
Thought, perception, and memory problems

Module 3
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FOREWORD

As a concerted effort to improve the healthcare provision to all, the Federal Ministry of Health has also given particular attention regarding the issue of mental health. FMOH is currently working on scaling-up mental health services by integrating it into the primary health care delivery system.

As many literature points out mental health problems are more than twice as common among people living with HIV/AIDS compared to the general population. Having a mental health problem is one of the risk factors for becoming infected with HIV. People with mental health problems are also more likely to be exploited by others and less able to negotiate safe sexual relationships with partners. They may be less likely to stay in the kind of steady, long-term relationships in which partners can protect each other from getting HIV.

The stresses of living with HIV have also been known to cause mental health problems, aggravated by poor nutrition, sleep, chronic pain that are caused by, or made worse by, the illness. In addition to the trauma of learning about their diagnosis, people living with HIV/AIDS face ongoing stigma, the burdens of ongoing medical treatment, and worry about their own health and that of friends and family members. In addition, some of the medicines used to treat HIV/AIDS and the infections that come with it have been known to have side effects related to mental health.

This resource material entitled “Detecting and Managing Common Child and Adult Mental Health Problems in HIV Care” is intended to be a resource for healthcare professionals for the treatment of mental health issues, including treatment, care and support of HIV/AIDS clients. The training package is developed based on in-country experience and international standards.

The training package is also designed to provide practical information about the recognition and management of mental health problems, including addressing psychiatric emergencies and the use of basic psychotropics medications.

The effective utilization of this training package will enable the non-specialist to be an effective partner with mental health specialists, pharmacists, adherence supporters, and site supporters in the provision of treatment, care and support for HIV/AIDS clients.

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An introduction to mental health and HIV care

The overall goals of this training are:
1. To enable primary health providers to work together in teams to recognize mental health problems among individuals receiving HIV care, and to deliver brief, first-line interventions.
2. To enable primary health providers to collaborate with mental health specialists (nurses, psychologists, social workers and psychiatrists) in the evaluation and treatment of mental health problems among individuals receiving HIV care.
3. To be familiar with the many different ways in which people with mental health problems can be helped, and to be familiar with “stepped” approaches based on response to initial treatment and follow-up.

What the training is meant to do:
1. Provide practical information about recognition of mental health problems, how to recognize and manage emergencies, how to give brief advice, and how to use basic medications.
2. Enable the generalist to be an effective partner with mental health specialists, pharmacists, adherence supporters, and site supporters in providing care for mental health problems among individuals receiving HIV care.

In this introductory module we will cover
1. What we mean by “mental health”
2. Why mental health is important in caring for people living with HIV/AIDS
3. What we mean by mental health treatment
4. What the training teaches you to do

What do we mean by “mental health?”

What are mental health problems? These words mean many things to many people. It is not always easy to say someone has a mental health problem because there are no tests that confirm the diagnosis.

One way to look at it is to say that when people have good “mental health” they feel a certain way about life: they feel good about themselves, they get along well with others, and they feel capable of meeting the challenges that face them. Many people go through brief periods in their lives where they don’t feel this way. During those times they can still go about most of their business as normal, and with some support they soon return to feeling good.

But there are other sorts of mental health problems that can last longer, that get in the way of day-to-day life, and that often do not get better without help.

One group of these problems goes by the name of “common mental disorders” – because they are so common – 10% or more of people will experience one of them in the course of their life. It
includes problems with low mood, excessive worry, or difficult behaviors that do get in the way of daily function. These problems can go on for months or years, and even though people with them can usually still work, or live with their families, the problems can cause a lot of misery and disability.

A second group is often called “severe mental disorders.” They are much less common, but much more serious. They include problems with thinking that severely limit function and may make the person a danger to themselves or others. People with these problems may behave very strangely. They may see and hear things that others don’t perceive and develop strange beliefs about themselves and others. They can seem frightening when they are ill, though most of the time they are dangerous only to themselves. Without treatment, people with these problems can not work or live at home.

In this manual we will also include seizure disorders (epilepsy). In Ethiopia, seizures are usually treated by psychiatrists. Seizures are often mistakenly seen as a form of mental illness, which they are not, but they can be very disabiling and there is a high rate of co-occurrence of seizures and depression.

**Why is mental health important to caring for people with HIV/AIDS**

In general around the world, mental health problems are more than twice as common among people living with HIV/AIDS compared to the general population. One study conducted in Ethiopia (Deribew 2010) found that nearly half of the people living with HIV/AIDS were depressed or anxious, and the proportion increased to two-thirds among people co-infected with HIV and TB. Other studies have found that 30-40% of HIV+ pregnant women and new mothers in Ethiopia report symptoms of depression (Hanlon 2007).

HIV infects the brain, and it can directly cause some mental health problems. When HIV infection results in compromised immunity it can lead to brain infections (toxoplasmosis, cryptococcus, cytomegalovirus, and others) and tumors. The stresses of living with HIV/AIDS can also cause mental health problems, as can problems with poor nutrition, sleep, and chronic pain that are caused by, or made worse by, the illness. In addition to the trauma of learning about their diagnosis, people living with HIV face ongoing stigma, the burdens of ongoing medical treatment, and worry about their own health and that of friends and family members. In addition, some of the medicines used to treat HIV and the infections that come with it have mental health side effects.

Another reason why mental health problems are more common among people with HIV/AIDS is that having a mental health problem is one of the risk factors for becoming infected with HIV. People with mental health problems are more likely to be exploited by others and less able to negotiate safe sexual relationships with partners. They may be less likely to stay in the kind of steady, long-term relationships in which partners can protect each other from getting HIV. Some kinds of mental health problems (in particular substance abuse) make it less likely that people will take precautions (using condoms, avoiding impulsive sexual activity) to avoid getting infected.
Mental health problems also impact HIV treatment in many ways:

- Mental health problems are a major reason for decisions to decline or stop taking ART, and they are a major reason for poor adherence among those who don’t completely stop.
- Side effects and interactions of drugs used in HIV treatment limit the choices available to people who already have mental health problems.
- Changes in mental health can be early signs of poorly controlled HIV infection or its medical complications. Overall, people living with HIV have their illness progress faster to more serious levels if they also have mental health problems.
- Patients with poor mental health are a cause of stress and suffering among HIV treatment personnel, and contribute to burn-out.

**Mental health treatment**

For many people, mental health treatment means medicines or visits to a psychiatrist. But there are many other ways people with mental health problems can be helped, and most people with mental health problems need a combination of treatments. We will talk about all of these forms of treatment in the modules that follow.

- Routine interactions in clinic help people feel cared for, understood, and respected. A study conducted in Addis Ababa (Biadgilin 2009) found that having a steady health care provider, and feeling that the clinic was a friendly place for adults and children, was related to greater HIV medication adherence.

- Help with practical issues including support to get adequate food, housing, education and employment can reduce stress, improve mood, and reduce worry. The same study in Addis Ababa found that lack of stable housing and food supply were the biggest barriers to taking medication consistently.

- Helping people with their social relationships can reduce stress and improve mood, in addition to helping people get other forms of treatment and support that they need. This can happen through counseling the person himself, or through counseling and educating family members and even friends.

- Giving brief advice about how to deal with specific problems.

- Teaching people about mental health problems and what to expect from them.

- Treating an underlying medical problem that is causing the person to feel different or that may be causing changes to their brain.

So, if you have read the list just above, you might have noticed that many of the treatments don’t have to be given by a mental health specialist, though having one around for help with diagnosis and deciding on treatment is always helpful! In fact, general medical facilities can be good places to care for mental health problems because they are a lot like other chronic conditions –
they come and go, and often treatment needs to be adjusted or boosted. And you might also have noticed that treatment likely requires a team – no one person can usually supply all that might be needed.

Finally, you might have noticed that treatment of mental health problems requires an “attitude” as well as skills and knowledge – your caring and willingness to listen is an essential part of treatment.

**What will the training teach you to do?**

If you look at Figure 1, you can see that the approach to mental health you will learn is based on hearing patient and family concerns. You will learn to use methods of interaction with patients that build trust and willingness to disclose concerns. In this sense, mental health treatment starts right away, because, as we’ve said before, there is therapeutic value in the way that clinicians interact with patients, even while simply trying to understand their needs.

The next step is to match the patient’s concerns with one of the diagnostic and treatment modules that we will introduce. You do this in part by using a short, focused mental health interview that we will teach in the first module. It is very possible that the concerns will match more than one module – in that case, start with the one that seems most important to the patient or most serious to you as the clinician. You will also find that the modules sometimes refer to each other.

Each module includes a step where you assess the need for emergency medical or mental health intervention. If that is not needed, you move to a consideration of the possible medical and mental health reasons for the patient’s concerns. You work out a treatment plan with the patient, including brief advice delivered in the comprehensive HIV care, medical care, and referrals. There is always a follow-up visit, where you re-assess the concerns, checking for progress and the need for additional treatment.

In the final module of the training, we will go into more depth about how this model can be applied in the comprehensive HIV care, treatment and support clinic, looking at roles for team members and how new and follow-up visits might differ.
Figure 0.1: Generic classification plan

- Family and patient concerns
  - Methods of interaction: empathy, optimism, agreement, listening, respect
  - Routine MH questions at intake/as needed
  - Focused diagnostic interview

- Strange behavior or loss of insight
  - Thought, perception and memory problems module

- Low mood, loss of pleasure/interest
  - Depression module

- Worry, tension, or preoccupation
  - Anxiety and psycho trauma module

- Alcohol, khat, or tobacco use
  - Substance abuse module

- Fits, uncontrolled body movements
  - Epilepsy module

- Child behavior or family problem
  - Behavior and developmental issues in children and adolescents module

- Difficulty living with HIV
  - Behavior and developmental issues in children and adolescents module
Exercises for Introduction

**Purpose:** To review the links between mental health problems and HIV/AIDS; to keep in mind the range of interventions that can be of help.

**Instructions:** Read the following case stories, answer the questions and discuss.

**Case 1**
W/t Tsehay is a 25-year-old woman, a secretary, who has a 5-year history of recurrent psychotic illness - schizophrenia. She periodically stopped taking her psychotropic medication, but it was effective while she was taking it. When she relapses after stopping medication, she stops going to work and disappears from home for days. About a year ago, she started experiencing body aches and she was easily fatigued and had low energy with occasional fever. Evaluation by the General Practitioner at the health center, which included various lab tests, showed no abnormality. A detailed personal history revealed that Tsehay had, during her relapses, frequent unprotected sex with strangers. HIV serology subsequently revealed that she was HIV seropositive. Now her family has brought her to see you because neighbors found her wandering late at night, and though they were old friends she did not seem to recognize them.

1. What are the similarities and differences between HIV and schizophrenia treatment?

2. Can you think of any ways to try to protect people like Tsehay from exposure to HIV both when her mental illness is in control and when she relapses?

**Case 2**
Ato Tollosa is a 34-year-old divorced businessman from Ambo. He found out two years ago that he was HIV positive, but kept it a secret. Just one month ago his CD4 count became very low and his doctor recommended that he start ART. Since then his behavior has changed. He says that he cannot concentrate on his business. He has isolated himself from any social interaction, and felt so sad that he has contemplated killing himself.

1. What do you think Tollosa is experiencing and why do think it is happening now?

2. Can you think of any way that Tollosa’s doctor could have prevented his response to the fall in his CD4 count, or perhaps made it less severe?
Module 1

Communication Skills and Assessment
Module Objectives

1. To be able to use core communication skills to:
   - Build a therapeutic connection with families
   - Help families disclose concerns in actionable and efficient ways
   - Give advice that is likely to be accepted

2. To know a few screening questions that can be asked of every patient at intake and periodically during follow-up to open discussion of mental health issues

3. To be able to do a focused “mental status” interview that helps decide which assessment/treatment module to use first when it is not obvious

A. Introduction to communication skills

As we said in the introduction, we want to start by doing all we can to encourage patients to tell us their mental health concerns, and to do this in a way that already starts to help the patient feel better. So in talking with patients we want to:

   - Make sure we identify and start to treat medical, social, or mental health emergencies.
   - Provide immediate relief in the form of a therapeutic encounter.
   - Come to some agreement on the main problem and offer some brief advice, or start treatment that seems to be needed now.
   - Make a plan for what other evaluation or treatment might be needed, or for a return visit to check on progress.
   - Stay in control of the visit and balance the needs of this patient with the needs of other patients who require care.

B. Communication skills

1. Basic interviewing technique

There are some basic skills that will be helpful:

Knowing how to ask questions that are “open-ended” rather than “closed-ended.” An open-ended question is one that can’t be answered with simply “yes” or “no” or a single fact. Open-ended questions encourage people to tell you more about what they are thinking and feeling.
2. Starting a visit

Efficiently getting all the concerns. Many patients don’t give their full list of concerns when first asked. In Ethiopia, it is very common for people to say they are “OK” the first time you ask them how they feel. This is especially true for sensitive or embarrassing subjects. Sometimes patients don’t get a chance because the clinician interrupts and takes over the discussion before the main concern is divulged. Sometimes patients give lead-ins or hints, but clinicians ignore them and move on to other topics. But a lot of the time, patients are simply afraid of what the clinician will say. For example, some people don’t tell doctors they are depressed because they are afraid they will be pressured into taking a medication or told that they are crazy.

It’s possible to overcome these barriers, even when you are busy. You can show your interest and attention through good eye contact, not fussing with papers, sitting down, and closing the door. Try through your manner to show that you have the time to listen. Here’s a sequence of things to try:

- Start the visit with an open-ended greeting -- “How have things been since the last time?” “How can I be of help?” rather than, “So I see we are here for your blood test today.”
- Then, try not to interrupt the patient’s initial answer by asking specific questions or giving information. Show your interest in having them continue: either nonverbally, by briefly summarizing what they have said so far, or by asking if they can tell you more about what they have noticed about the problem. Often all that is needed is a pause of a few seconds and people will begin to elaborate on what they have been saying.
- Try not to ignore “hints.” Consider this exchange:
• Health professional: “How have you been since last time?”
• Patient: “Well, I guess OK.”
• Health professional: “You don’t sound too enthusiastic. What has been happening?”
• Ask if there is “anything else?” until there are no additions to the list. Important concerns -- or more information about what came earlier -- often comes at the end.

**Setting the agenda.** Sometimes it seems obvious that all of someone’s concerns are really about a single issue. You can speculate on this, check for the patient’s agreement, and ask them if it’s something they’d like to talk about.

• “You’ve said a lot of different things about how hard it is take all of the medicines and how you still don’t feel that good or have that much energy. I’m wondering if you are having some trouble keeping up hope? If that’s right, is it something you’d like to talk more about?”

If there are several concerns and their relationship is not clear, play back the list and your impression of what seems to be the most important:

• “You’ve mentioned several things but it seems that your worry about his anger is what concerns you the most, is that right? Maybe that is what we should focus on today.”
• Or, if a priority is not clear, “You’ve mentioned several concerns -- which ones did you want to make sure we talked about today?”

**What if people go on and on?** Gently interrupt, paraphrase, and ask for additional concerns: “I’m sorry to interrupt, but, so that we don’t run out of time, let me see if I understand your concern.... [paraphrase, get confirmation]. OK, good, now was there anything else that concerned you?” Or, gently interrupt, paraphrase, and refocus: “I think I understand what you are talking about. You started by talking about [some original issue]. So we don’t run out of time, do you want to get back to that, or do you want to talk about [the new/tangential issue] now?”

**What if a child, spouse, or relative is there, too?** Make a connection with each person present: a specific greeting for each, a handshake if appropriate; while talking, shift eye contact and body position to address everyone; get everyone’s name if you are not sure; use their name when you address them.

Think about whether this is a visit where it would be important to develop the visit agenda from talking to all parties, not just the patient (or parent, if it is a pediatric visit). If that is appropriate, invite each to add to the list or validate the priorities. “Is that what is most important to you, too?” “Do you have anything else that you want to bring up?”

If there is disagreement:
• Reassure that ultimately you can make opportunities for discussion of everyone’s concerns. “We might only be able to get at one of those things today, but I want to make sure that I write down what you are saying so that we can be sure to talk about it the next time we meet.”
3. When people seem to be asking for advice

Even when people seem to be clearly stating a concern or even directly asking for advice, it is not always the case that they are likely to accept suggestions made in response. People may not be ready to take action, even when they are quite concerned about something. They may see equally strong reasons not to act, or they may have little confidence in their ability to make a change. Even patients who are very ready to change may feel suddenly reluctant if they think that the doctor has not thought enough about their case or if the doctor doesn’t seem friendly or concerned.

So when people ask you for advice, or when you are ready to give it, consider asking:

- What sorts of ideas have you had yourself about what to do?
- What kinds of things would get in the way of your doing this?
- Is there anything about this plan that you don’t understand? I’m happy to go over it again.

*If people seem reluctant to take your advice.* The most important thing to remember is not to insist or just try to persuade. Sometimes a three-step approach works well:

- You look worried. I know these can be hard choices. Can you tell me more about what worries you about this plan?
- Is it OK if I tell you some more about the plan?
- So what do you think? Was I able to answer your concerns?

It can also be all right to gently point out problems that the patient seems to be avoiding. You do not want to scold or be judgmental, but you can point out that you both know there is a problem and that you are willing to help find a solution.

- We both know that all the money you are spending on what is causing a problem for your family. I hope that some time we’ll be able to find a way for you to cut back on your chewing.

C. Routine questions

In many forms of health care we are familiar with the idea of screening – giving some kind of a test (sometimes a laboratory test, sometimes a questionnaire) to every patient to detect an important condition. When we do this we have two main goals: to make sure that no patient misses the opportunity to have the condition detected and treated, and to try to find the condition as early as possible, when it is easier to treat.

We do not have any good screening tests that cover the whole range of mental health problems that can occur, especially when people speak many different languages and have many different ways of talking about their moods and worries. The questions here were developed by doctors at Addis Ababa University as a way to open up discussion about mental health problems. We think that when you combine these questions with the communication skills we have already discussed that they will help you decide if you need to go on to ask the more specific questions we outline below in Section D.
For adults and adolescents, ask the patient and partner, if they are accompanied by one and the patient gives permission:

Have you (or has the patient) been having problems sleeping at night?
Have you (or has the patient) been feeling unhappy or more irritable?
Have you (or has the patient) lost interest in things or not felt like being with other people?
Have you (or has the patient) been feeling worried, nervous, or frightened?
Have you (or has the patient) been having trouble remembering things or doing things you (or he/she) used to do?
Do you (or has the patient) worry or have you been told that you smoke too much, use too much alcohol, or any other drug?

For children, ask the child and the parent/guardian:

Have you (or has the patient) been having problems sleeping at night?
Have you (or has the patient) been feeling unhappy or more irritable?
Have you (or has the patient) lost interest in things or not felt like being with other people?
Have you (or has the patient) been feeling worried, nervous, or frightened?
Have you (or has the patient) been having trouble remembering things or doing things you (or he/she) used to do?
Have you (or has the patient) been having problems at school with behavior or learning?

D. Assessment

Before moving on to the clinical modules, we want to introduce the way that mental health specialists think about assessing someone who has emotional or behavioral concerns. Mental health specialists have their own way of thinking about taking a history and doing an examination. In many ways it is similar to the format used by generalists, but includes some different elements and places extra emphasis on others.

There are times when a patient’s problems will seem to obviously fit into one of the clinical modules, and you can go directly from the patient’s concerns to the further evaluation and treatment described in the module. But there may be other times, especially early in your work with mental health problems, when you will want to go briefly through this assessment to help you decide which module might best apply. You will see that some of the sections include questions you can ask; in others you will just be recalling things that the patient or family may already have told you.

The assessment outline below is included in your “pocket manual” for easy reference in those situations, and for use during role plays and other exercises during the training.
1. History/background

Because there are few or no diagnostic tests for many mental health problems, we look to a patient’s past to see if there’s an increased chance he or she may have one. Though it’s not known why (there are many possibilities), having relatives with a mental health problem increases the chances you will have one. So we try to ask about family history, knowing that people may be reluctant to tell you, or that it may have been a secret and they don’t know.

We also want to know about current stresses and recent losses. It’s well known that these sorts of things can trigger mental health problems or make existing ones worse; knowing what they are may lead to specific kinds of help that either relieve the stress or help cope with the loss.

Ask about drinking (alcohol) or the use of other drugs or medications, now or in the past.

It is always important to ask if anything like this has ever happened before, and, if so, if anything helped at that time.

Finally, it is good to get an account of the patient’s problems from family or other people who know the patient; it is particularly difficult for people to describe their own mental health problems.

2. How does the patient look?

Most people, even the most disadvantaged, will do their best to look as good as they can when they come to see you. Is someone dressed very oddly, or does it seem that they have been neglecting to care for themselves? These could be signs of low mood or of thought problems.

Mental health specialists also talk about what they call “affect” – the mood that it looks like someone is feeling, just from observing them. Does the person look sad, frightened, threatening, or agitated? This may give you more information than the patient’s words.

3. How is the patient interacting with you?

It’s normal for people to be somewhat anxious or even shy when they see you, and sometimes they are angry for having to wait or because they feel other staff were rude. But is all of this more or less within the range of normal for your patients, or is it different? Odd behavior is often a sign of a thought problem or intoxication.

- Are they moving around more or less than usual? Can they sit still, or are they too still?
- What is their talking like? Can you hear and understand the words they are saying? Do they talk to themselves or mumble? Do they talk very quickly or hardly at all?
- Do they seem to be following the usual patterns of social interaction – as if they know who you are – and the usual sort of exchange between a patient and clinician?
4. How do they describe their mood?

Do they say that they are sad, anxious, worried, indifferent, irritable, or something else?

5. What is their thinking like?

Sometimes you can easily understand what someone is saying, but the more you listen the more you feel that the person is not making sense. Perhaps they are convinced that unknown people are trying to harm them; perhaps they are so focused on one event in their life, or one thing that they must see happen, that they can’t talk about anything else. Mental health experts recognize some particular patterns of talking that suggest people are having trouble thinking:

- **Circumstantial speech**: people seem very long-winded and only get to their point after many remarks that are only a little related and don’t seem to be needed; sometimes they don’t get to their point at all.
- **Flight of ideas and loose associations**: people change subjects suddenly and to subjects that don’t seem to be related at all.
- **Perseveration**: people keep repeating the same thought or answer over and over, even when you ask a completely different question. Sometimes they will just echo back what you are saying.
- **Thought blocking**: people just suddenly stop talking in the middle of a sentence.

Sometimes what someone is saying is very clear, but it seems very unlikely to be true. Delusions, strongly held but false beliefs, are another sign of serious thought problems. The most common delusions are about conspiracies to harm the person, that there are hidden messages for the person on the radio or elsewhere, or that there is something foreign inside someone’s body. Men or women can also have delusions that their partner is not faithful – but of course it is not always possible to know immediately if these are delusions or not.

How is the patient’s judgment? Sometimes this is obvious – they say they can walk somewhere that it is impossible to go on foot, or they clearly over-estimate their ability in other ways. Poor judgment can be a sign of intoxication or thought or memory problems.

Can someone do harder kinds of thinking – such as telling you the meaning of something subtle, such as a proverb? (This is called “abstract thinking.”) Or can they tell you what is alike and different about a banana and an orange?

6. Perceptions

A fairly common symptom of serious mental illness is seeing or hearing things that other people don’t see or hear. Does the patient report any of this? Do they seem to be experiencing it now?

- Auditory (hearing) and visual hallucinations are the most common in serious mental health problems. Particularly worrisome are voices that seem to be talking directly to or about the person, or that are telling them what to do.
- Tactile hallucinations are more common in medical illnesses that affect the brain and in alcohol withdrawal.
7. Alertness and awareness

Does the patient seem fully awake and alert? Are they aware of where they are and do they know who you are? There are many questions to ask (see the thought problem module). If you have doubts, for starters you can ask:

- Can you tell me the day and date?
- Can you tell me the name of the place we are now and what we do here?
- Can you count the days of the week backwards?

8. The neurologic exam

In addition, when thinking about mental health problems in the context of HIV, one usually wants to know something about the patient’s neurologic examination (gait, vision, abnormal body movement, motor and sensory function). Is it basically normal? Abnormalities make one think immediately of serious brain infections, tumors, or strokes.

9. Functioning

Though it’s not part of the classic mental status exam, how well a person functions (or if their function has changed) is often the most important sign that there is a problem, or that treatment is working or failing. Some of these changes could be just because of mood, but others could be caused by damage to the brain from HIV or other infections or conditions. It is hard to come up with ways of measuring changes in function that cut across all cultures, but some categories include (Antinori 2007):

- Does the person need any more help than usual with things like taking medicine, using money, shopping, chores around the house, cooking, getting to places, or taking care of their children?
- Do they have trouble doing a job that they used to be able to do? Did they have to quit, cut back on responsibilities, or do they just work more slowly or make more mistakes?
- Does the person feel that they are having more trouble remembering things that happened to them recently, or concentrating on what they have to do, or interacting with or getting along with friends and family members?

Summary

- Through a skilled interview, clinicians can gather data necessary to understand and treat patients, and in the process, increase the patients’ understanding of, and compliance with, the clinicians’ advice.

- There are specific techniques which make the information exchange between the clinician and the patient easy, open and constructive. The major ones include:
  - Open-ended vs. close-ended questions
  - Reflective listening techniques
  - Empathic comments with appropriate reassurance
• Getting a full list of concerns and helping the patient prioritize their agenda
• Giving advice thoughtfully

• It is good to have a short list of questions that you can ask every patient at intake or periodically during their care to help open up discussion of mental health concerns.

• If a concern is raised by the patient or family, the brief mental status exam allows a rapid but systematic way of gathering history, observations, and symptoms that can help decide what category of mental health problem may need to be addressed.
Exercises for Module 1

1. Communication skills role plays

Instructions: Take turns being the patient, clinician, and an accompanying family member.

Scenario 1
A mother is concerned that tension between her and her husband is having an impact on her child’s mood and behavior. She initially tells the health care worker about the child’s behavior (clingy, won’t play alone as much, waking up a lot at night and wanting comfort from the parents) without telling what she believes is the underlying reason. The health care worker’s job is to use good communication skills to elicit this underlying concern, which she is reluctant to disclose because she is ashamed and not sure that this is the place to talk about it.

- Use active listening
- Use open-ended questions
- Ask if there is “anything else” that might be of concern

Scenario 2
The patient is a factory worker who has been abusing alcohol for the last many years and who was diagnosed with HIV three weeks ago. He was divorced 3 years ago; his heavy drinking was a factor. His sleep is poor. Now he is not able to work as much as before because of frequent uncontrollable worry. He is nervous, cannot concentrate, and easily becomes irritable. He often gets into quarrels with his boss as well as his co-workers. He is afraid of being dismissed from work. He asks you if maybe he should just sell his few possessions and move back to the village where he grew up so that he can start his life over again.

- The health care worker’s job is to use good communication skills to elicit his underlying concerns.
- Think about how you would respond to his request for advice.

2. The brief mental status evaluation

Refer to the outline of the brief mental status evaluation in this manual or in your pocket guide. Read each of the following cases (the same two cases as in the introductory module) and, referring to the evaluation outline, think of questions you might ask each patient or their family, and think of observations you might make in order to decide what sort of treatment they need. Don’t worry that you can’t yet do this in a lot of detail – as you go through the modules you will learn more about each category of questions. When you get to the end of the evaluation, take out Figure 0.1, the flow chart of all the modules, and talk about which module you think would be the best place to start for each patient.

Case 1
W/t Tsehay is a 25-year-old woman, a secretary, who has a 5-year history of recurrent psychotic illness - schizophrenia. She periodically stopped taking her psychotropic medication, but it was effective while she was taking it. When she relapses after stopping medication, she stops go-
ing to work and disappears from home for days. About a year ago, she started experiencing body aches and she was easily fatigued and had low energy with occasional fever. Evaluation by the General Practitioner at the health center, which included various lab tests, showed no abnormality. A detailed personal history revealed that Tsehay had, during her relapses, frequent unprotected sex with strangers. HIV serology subsequently revealed that she was HIV seropositive. Now her family has brought her to see you because neighbors found her wandering late at night, and though they were old friends she did not seem to recognize them.

**Case 2**

Ato Tollosa is a 34-year-old divorced businessman from Ambo. He found out two years ago that he was HIV positive, but kept it a secret. Just one month ago his CD4 count became very low and his doctor recommended that he start ART. Since then his behavior has changed. He says that he cannot concentrate on his business. He has isolated himself from any social interaction, and says that at times he has felt so sad that he has contemplated killing himself.
Thought, perception, and memory problems
Module objectives

1. To be able to recognize individuals who have:
   a) Hallucinations and delusions
   b) Dementia
   c) Delerium
2. To be able to assess and manage safety issues (for patient, staff, family members, and other clinic patients)
3. To be able to recognize when a treatable medical illness may be the cause of the patient’s problems and either initiate treatment or refer the patient for treatment
4. To be able to recognize dementia associated with HIV and initiate appropriate treatment
5. To be able to initiate antipsychotic treatment for individuals with abnormal thought symptoms in the absence of medical illness or when symptom control is needed
6. To be able to provide basic education to the patient and family members about the nature of thought symptoms and how to cope with them
7. To know when to refer to mental health specialists for additional diagnostic or treatment advice

Introduction

This module addresses a group of problems that are characterized overall by problems with thinking, perception and memory. These problems go beyond simple confusion, being indecisive, or forgetful. They include hearing voices not heard by others or seeing things that are not seen by others. They can involve truly not being able to tell what is real from what is not real, not knowing where one is or even who one is, or not being able to remember even the most basic things e.g. fasting days or holidays.

NB: These are not the most common mental health problems encountered (and are even less common among children), but they are among the most frightening and difficult for families and general medical personnel. In addition, some of these problems can be signs of serious medical illness in people with HIV – and thus they are important place to start talking about mental health problems seen in ART clinics. In the final module of the manual we will talk about milder (but still serious) thinking problems that occur for many people living with HIV, even when they are doing well on treatment.
Case to start off discussion

Bogale is a 22-year-old young man with a 2-month history of strange behavior characterized by talking to the television, accusing local police of bugging his room, and carrying on conversations with himself. His mother also says that he has shown progressive withdrawal from social activities and dropped out of college.

- Have you ever met or heard about someone like Bogale?
- What do people think about people with problems like Bogale’s?
- What do people assume are the causes of these sorts of problems?
- If people try to help people like Bogale, what do they do or suggest?
- What gets in the way of getting help for people like Bogale?

A. Types of thought problems

There are three main kinds of thought problems that can occur individually or all at the same time:

- Those that are primarily caused by a mental illness,
- Those that occur because of a medical condition, drugs or alcohol, or a medication that has affected how someone’s brain is working.
- Those caused by a brain problem that mostly affects memory – where people have trouble remembering names, how to do things, and even important things about themselves.

The reason for telling these apart is that the treatments are different, even though sometimes the symptoms may look a lot alike at first.

B. How these patients are noticed in ART care

Patients with thought, perception and memory problems are often brought by family members or noticed by staff because they are acting strangely, or because there has been a change in the way they care for themselves.

What you or the family might notice (think back to the mental status exam in Module 1):

Changes in speech

- Uses recognizable words but does not make sense
- May be very animated and talk very quickly
- May not answer questions – is silent or gives answers that don’t really relate to the question you asked
- Shows a lack of connection between ideas
- Says the same things over and over again
Changes in mood

- Is irritable, suspicious, or angry in a way they have not been before
- Seems inappropriately happy, energized, thinks they are famous or very powerful, or is doing things very quickly (or just taking on too many tasks at once)
- Very changeable mood without apparent provocation

Changes in appearance and behavior

- Has poor self care, improper clothing
- Friends and family cannot predict what the person will do next
- Roams aimlessly, may collect garbage or other odd items that don’t seem to be of use
- Becomes aggressive and destructive
- Might give things away or spend all resources without thought
- May be sexually promiscuous or inappropriate
- Can’t seem to do or figure out things that were previously easy

Changes in thoughts and perceptions

If you talk to people who exhibit these behaviors, they may or may not be willing to tell you about unusual thoughts. If they will tell you, it can be important to both deciding that they have a thought problem and also to understanding their distress.

It is important to realize that these strange thoughts and behaviors may seem real to the person who is ill, but at the same time the person may realize that you will think them strange if they tell you, so they will not talk about their experiences or how much they are troubled.

What the person may describe if they do talk with you:

Hallucinations are things seen, heard, felt, smelled, or tasted that can’t be perceived by another person; the person perceives them as real:
- Hearing a voice constantly commenting on oneself, or hearing voices of two people talking about you; voices telling you to do something (often violent)
- Seeing things that others do not see
- Feeling that bugs are crawling on the skin

You can ask, “Do you see or hear things that other people don’t see or hear?”

Delusions are strongly held, false beliefs or convictions that cannot be changed by rational arguments or evidence and are not shared by people from the same social, cultural and religious background and experience.

- The most common tend to be “persecutory” – that people, or the government, are trying to harm them, are following them, or constantly spying on them.
- Delusions can be “grandiose” – feeling that one is great or powerful or can do things that would be unusual for them – this often occurs when people also seem inappropriately happy or energetic.
• Delusions of jealousy/infidelity: belief that the spouse or partner is being unfaithful.
• Delusion of reference: belief that objects, events or the actions of other people have special significance for the person; e.g. the announcer on the radio is talking directly to the person as if they know that the person is listening.
• Somatic delusions – beliefs that there is something foreign inside the body, or that a part of the body is not working correctly.

You can sometimes hear about these thoughts by asking people to explain their behavior, or to tell you why they are feeling upset. Often, the best way to hear about them is to just give the person some time to talk while only showing interest in what they are saying, but not commenting.

Delusions can be very hard to separate from the truth or from strongly held religious beliefs. It can be helpful to talk to family members or a religious leader from the patient’s faith before deciding if what the patient believes is a sign of a thought problem. The more time the patient spends thinking about the belief, and the more the belief has a harmful impact on their life, the more likely it is to be a delusion.

_Somatic delusions can sometimes be hard to separate from medical symptoms such as pain and fatigue for which there isn’t a ready medical explanation, but which are not symptoms of a thought problem. When symptoms or concerns are odd (“my inner body parts have been replaced by plastic”) they are more likely to be delusions. See the low mood module for information on somatic presentations of mental health problems and for an approach to medically unexplained symptoms that are not delusional._

_Problems_ with memory can be hard to detect. People have to lose a lot of their ability to remember before they have trouble answering simple questions about familiar things (even though sometimes they are making up the answers). But if you ask, the family may have already noticed that the person is having some trouble with new tasks, or with things that seem complicated – like remembering to take medicines or forgetting fasting days, holidays or other important appointments. We will talk more about that below.

**C. Approach to treatment for thought, perception and memory disorder in primary care/HIV care**

[For this section, it can be helpful to look at the flow chart for the module while reading the text]

1. Is there an urgent need for treatment? We start by not worrying about the cause, but whether the patient is (or seems like they could become) aggressive or do something impulsively to harm themselves (for example, run out into traffic).
   • Stay safe yourself – keep your distance, never let the patient get between you and an escape route, call for help quickly, involve family members
   • Keep the environment calm and avoid confrontations
   • Trust your instincts if you are frightened
   • Having multiple team members can be calming to the patient if you are all calm and firm
• Consider use of a medication to treat the disorder
  o Low dose of haloperidol 2-5 mg orally or intramuscularly followed by maintenance dose once the cause seems clearer
  o If haloperidol is not available, consider chlorpromazine 25-50mg IM
  o Be ready to treat dystonic symptoms – see below
  o Diazepam 10mg IM alone or can be given along with haloperidol

2. Does the patient seem to have recently become medically ill?
   Thought disorders caused by medical illness usually come on relatively suddenly (over a few hours to days). Though there are exceptions, this is a handy rule to guide decision-making.

   **Delerium** is a special kind of thought disorder that occurs as part of serious medical illness and with alcohol withdrawal. It is characterized by thought problems that come and go and also by varying states of alertness – the patient is intermittently confused and disoriented, not recognizing where they are, the time or day, and often not recognizing familiar people.

   *Thought problems that are part of medical illness (and especially delirium) are potential emergencies – they usually mean that a person is very sick.*

   In persons with HIV infection, a number of infections can cause changes in behavior, personality, and level of consciousness. They are all, to one extent or another, accompanied by other neurologic or medical symptoms, but some can be hard to diagnose even when laboratory tests and brain scanning are readily available. The following table [Table 2.1] lists the most common possibilities. We don’t expect that you will memorize the list, but consulting it may then make it easier to find diagnostic and treatment information in other manuals. In working with the table, we will assume that you already have some concern for a change in the person’s behavior or thinking. So the next step will be based on whether you believe the person has an abnormal neurologic exam, or if there is concern that the patient has had a seizure (when they had not had seizures before).

   Other acute medical issues to consider, besides the infections in the table, include:
   • Recent head injury
   • Brain tumor
   • Substance abuse
     o Alcohol withdrawal
     o Stimulant use or overdose (khat may be the most common)
   • Medication side effects or overdose (see also module on low mood and agents associated with suicide attempts)
     o Steroids
     o Stimulants
     o INH
     o Digoxin
     o In HIV care, the side effects of medications, especially AZT, 3TC, efavirenz, abacavir, and nevirapine
### Table 2.1: Opportunistic infections and tumors in HIV

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mental status changes</th>
<th>Onset</th>
<th>Other Physical Findings</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focal neurologic signs present and/or new seizures</td>
<td>Toxoplasmosis</td>
<td>Decreased alertness</td>
<td>Rapid, less than 2 weeks</td>
<td>Fever and headache</td>
</tr>
<tr>
<td>PML (JC virus)</td>
<td>Impaired speech, vision, motor function</td>
<td>Slow, over weeks or months</td>
<td>No fever or headache</td>
<td></td>
</tr>
<tr>
<td>Primary CNS lymphoma (EBV)</td>
<td>Personality and behavior change</td>
<td>Moderate, over 2-8 weeks</td>
<td>Headache but no fever</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Decreased alertness</td>
<td>Rapid-moderate – days to weeks</td>
<td>Fever, headache</td>
<td></td>
</tr>
<tr>
<td>Variable neurologic signs</td>
<td>Neurosyphilis</td>
<td>Memory loss, personality changes, dementia</td>
<td>Insidious</td>
<td>“Argyll Robertson” pupil (small, accommodates but no reaction to light); may be loss of DTR’s or other neuro signs; headache, but may be few signs.</td>
</tr>
<tr>
<td>Few/no focal signs</td>
<td>CMV</td>
<td>Delerium, lethargy</td>
<td>Rapid, under two weeks</td>
<td>Headache, stiff neck, photosphobia</td>
</tr>
<tr>
<td>Cryptococcal meningitis</td>
<td>Usually alert, not usually associated with behavior change</td>
<td>Rapid, under two weeks</td>
<td>Cranial nerve palsies, fever and headache but not stiff neck</td>
<td></td>
</tr>
</tbody>
</table>

Table adapted from Bartlett et al. Medical management of HIV infection, 2009-2010, and WHO IMAI District Clinician manual.
If you think the thought problem is caused by a medical problem, follow the national guideline for the management of opportunistic infections and other conditions, though in some cases the kind of treatment described above for emergencies may also be needed to control agitation and still be warranted in the short term.

*See the substance module for what to do about alcohol withdrawal.*

3. If the person is not medically ill, consider whether they have a primary mental health problem. In this case, the onset will usually have been more gradual, and the most common symptoms will be hallucinations and delusions. Again, though it’s not 100% reliable, the hallucinations in primary mental health problems are most often visual and auditory, while those in thought problems caused by medical conditions can also be visual or auditory but additionally involve tactile hallucinations – often that there are things crawling on the skin or inside the body.

- Primary mental disorders e.g. schizophrenia causing thought problems can occur at most any stage of adulthood, but the peak age of first symptoms is in the late teens/early 20’s; sudden onset at older ages raises more concern for medical causes
- First onset is often gradual, over a period of weeks; early symptoms are often attributed to a change in mood or stress.

Mental illness causing thought problems:
- Schizophrenia (a chronic condition involving episodes of thought, mood, and behavioral disturbance along with more persistent problems with slowed thinking and changed personality)
- Mania (increased energy, elevated mood, rapid speech, often evolving into delusions and sometimes hallucinations; when it alternates with depression is called “bipolar disorder”)
- Psychotic depression (the development of delusions and sometimes hallucinations among those who are very depressed)
- Delusional disorder (just strong delusions –usually persecutory or suspicious – without hallucinations)

Some people develop what is called “brief psychotic disorder.” They experience hallucinations and change their behavior, usually after a serious loss or traumatic event. There is no evidence of any change prior to the trauma, and no sign of medical illness. Sometimes the patient or the family will make a link between the onset of the symptoms and the trauma. With this type of presentation, it may be reasonable not to give antipsychotic medication if the patient appears safe and can be supported. The symptoms, by definition, should resolve within 4 weeks. If antipsychotic medication has been started and the patient has stabilized rapidly, it is reasonable to try to taper off the medicine. Despite the presentation, if symptoms linger longer, another cause should be investigated (primary e.g schizophrenia or secondary, caused by a medical condition).
It is also important to remember that healthy people can have experiences that sound like psychotic symptoms but are not. Most commonly, these are seeing, talking with, or hearing from close relatives who have passed away. Most of the time these non-psychotic symptoms are benign, but they may also be sources of distress depending on the patient’s belief about what they mean or what the relative is communicating.

While the long-term treatment of the primary mental illnesses is different from the treatment of thought problems caused by medical illness, the initial treatment is often the same.

4. Start with an assessment of severity: we’ll assume that you have already decided that the person is not a threat to themselves or others, and is not medically ill. But we want to know how much their life is impaired by the problems and how much of an impact there is on their family. This will give you an idea of whether you feel you need to offer medication right away and/or get a mental health consultation.

5. Start with “psychoeducation” – explaining the condition to patients and their families is often the single most effective thing you can do at the outset:
   - The agitation and strange behavior are symptoms of an illness, not something that the person is choosing to do, not the result of something done by the person or a family member
   - Treatment is effective, with better results than confinement or non-treatment
     - The sooner initiated after onset and the more consistently the treatment is taken, the better the results will be
   - Treatment response takes time
     - Hallucinations often go away rapidly
     - Delusional beliefs may go away more gradually and can persist at low levels for a long time, but seem to be less troubling
     - It may take several weeks until mood and thinking return to normal
     - The longer someone has been ill, the longer recovery usually takes

Families can help – their collaboration increases the effectiveness of medications (and thus helps minimize the dose needed)

- Minimize stress on the patient
- Try to avoid directly confronting odd beliefs; let them fade away and the patient gets better
- Support the patient to gradually return to regular roles but try to avoid frustration by keeping demands simple
- Provide reassurance that recovery is taking place; be encouraging
- If medication seems to be working, watch for signs of relapse – what are the earliest signs that unusual thinking or behavior is taking place?
- Help make sure that psychotropic medication is consistently available
- Avoid substance use – e.g. khat, marijuana, alcohol – since they may trigger psychosis or alter effects of medications
6. Medications are very effective for many people with primary thought problems (schizophrenia, bipolar disorder, etc.)
   - Will often help severe agitation within minutes to hours
   - Clearing of other thought problems can take days or weeks – allow at least 2 and up to 4 weeks at a recommended dose before declaring a medication to have failed (up to 30% may fail one medicine but respond to another)
   - It can be up to 6 months to show a full response – avoid temptation to escalate dose since it can take time to respond and you won’t know if the higher dose was really needed. See Table 2.3 for dosing guidelines.
   - Some episodes may get better on their own, but chronic treatment may cut the one-year relapse rate from 80-90% to 25%

Use of antipsychotics
   - There are three main antipsychotics available in Ethiopia at this time: chlorpromazine (sometimes called CPZ – but that is a dangerous abbreviation because it can be confused with carbamazepine, which is sometimes referred to as CBZ); haloperidol and risperidone. Chlorpromazine and haloperidol are among the “typical” antipsychotics. They share the chance of producing a type of side effect known as EPS (extrapyramidal symptoms). EPS involves movements and sensations that can range from annoying to dangerous. Risperidone is among the “atypical” antipsychotics – it has a much lower rate of side effects. Table 2.2 summarizes the choice among the different antipsychotics.
   - No effective dose is too low, especially in people who may have an underlying illness like HIV (regardless of whether or not you think that HIV is a cause of the thought problems). There is little likelihood of increased beneficial effects for doses that are higher than recommended. Table 2.3 gives doses, side effects, and possible interactions with other medications.
<table>
<thead>
<tr>
<th>Medication</th>
<th>Availability</th>
<th>Medical issues</th>
<th>Side effects</th>
<th>Risk of EPS</th>
<th>ART interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine</td>
<td>Good oral and IM</td>
<td>Many side effects and toxicities – avoid in seriously ill or debilitated; avoid chronic use in dementia</td>
<td>Many, including sedation, hypotension, urinary retention, dry mouth</td>
<td>Moderate</td>
<td>No good data available</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Good oral and IM</td>
<td>Generally OK but use lowest possible dose; avoid chronic use in dementia</td>
<td>Hypotension, lowered threshold for seizures, prolonged Q-T interval (avoid if prior history of heart disease), sedation</td>
<td>Highest risk, especially in young males treated for the first time</td>
<td>PIs can increase haloperidol level so start at lowest dose of haloperidol. NNRTIs can decrease haloperidol level. Level reduced by carbamazepine and phenobarbital</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Sometimes limited, more expensive</td>
<td>Avoid chronic use in dementia; watch for weight gain</td>
<td>In higher doses (over 6 mg a day in adults) has similar side effects to typical antipsychotics</td>
<td>Very low at doses less than 6mg a day</td>
<td>Some PI’s may increase risperidone levels. Avoid use with ritonavir.</td>
</tr>
</tbody>
</table>
### Table 2.3: Antipsychotic drugs, side effects, and interactions

<table>
<thead>
<tr>
<th>Medication</th>
<th>General dosing guidelines</th>
<th>HIV-specific dosing</th>
<th>Common side effects</th>
<th>Medication interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>Adults: Starting dose 1.5 – 3mg/day Increase by 0.5 or 1 mg at a time Usual daily dose: 3-15mg; dose over 10mg rarely needed Child 3-12 yrs: Agitation: 0.01 to 0.03 mg/kg/day divided into two or three doses Psychosis: 0.05 to 0.15 mg/kg /day, divided into two or three doses Child &gt; 12 yrs: Starting dose: 1-5 mg/ dose Usual daily dose: 1-15 mg/day divided bid or tid. Raise dose slowly and use minimally effective dose</td>
<td>Generally half usual dosing with slow progression. Adults: Starting dose: 0.75mg a day. If no response after one week, increase by 0.75 every week to the maximum dose of 3 mg/d. If inadequate response at 6 weeks, change to risperidone</td>
<td>Extra-pyramidal side effects (tremor, stiffness), feeling of restlessness, irregular periods in women, weight gain, enlarged breasts or discharge of milk in men or women when not breastfeeding, sexual problems such as decreased sexual desire</td>
<td>Pls can increase haloperidol level; NNRTIs except DLV can decrease haloperidol level. Level reduced by carbamazepine and phenobarbital.</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>Adults: Starting dose 75mg/day Usual daily dose: 75-300mg/day Child &gt; 6 months: 2.5-6mg/kg/day orally divided into three or four doses</td>
<td>Generally, half usual dosing with slow progression. Adults:start with 25mg a day. Increase by 25mg every week till max. dose of 150mg. if inadequate response in 6 weeks, change to risperidone.</td>
<td>Drowsiness, jaundice, lowered threshold for seizures, hypotension (measure the patient’s BP after IM dose, keep the patient in supine position), prolonged PR interval. Avoid in weak/debilitated patients and delirium.</td>
<td>Potentiates effects of sedatives. Data not available on ART interactions.</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Adults: Starting dose: 0.5 to 1mg twice a day Increase by 1-2 mg per day at intervals of 2-3 weeks Usual daily dose 4-6mg/day divided into two doses Child &gt; 20kg: 0.5 - 1 mg a day to start; after 4 days increase by 0.5 mg every two weeks; 2-3 mg a day maximum.</td>
<td>Start with 0.5 mg/d. Increase by 0.5mg every week till the maximum dose of 4 mg. if inadequate response, refer to specialist.</td>
<td>In higher doses (over 6 mg a day in adults) has similar side effects to typical antipsychotics e.g. haloperidol</td>
<td>Some Pls may increase risperidone levels. Avoid use with ritonavir.</td>
</tr>
<tr>
<td>Medication</td>
<td>General dosing guidelines</td>
<td>HIV-specific dosing</td>
<td>Common side effects</td>
<td>Medication interactions</td>
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<td>------------------</td>
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<td>-------------------------------------------------------------------------------------</td>
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<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Trihexyphenidyl</td>
<td>Adult: Initial dose 1 mg a day; if not sufficient, increase by 2mg/day at a time; usual</td>
<td>Lowest possible dose; can cause confusion and agitation</td>
<td>Dryness of mouth, blurred vision, dizziness, mild nausea or nervousness common</td>
<td>Potentiates sedative effects of other medications. Increase the anticholinergic side effects of chlorpromazine and haloperidol: more dry mouth, blurring of vision, constipation and urine retention</td>
</tr>
<tr>
<td>(for EPS)</td>
<td>dose range is 5-15 mg a day divided into two or three doses at mealtime. Child: dose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ranges not established</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: suggested doses from WHO mhGAP; APA Textbook of Psychiatry; Harriet Lane Handbook (child doses); note that dosing may be lower in Ethiopia – *good rules include giving the medication time to take effect (once agitation has improved, days to weeks for psychotic symptoms to resolve) and using the lowest possible dose that seems effective.*

Common antipsychotic side effects

1. Acute dystonia (grimacing, difficulty swallowing – can be very uncomfortable and sometimes interfere with breathing). These need to be treated:
   - Diphenhydramine 25-50 mg orally or IM
   - Diazepam: 5-10mg IV slowly or IM

2. Stiffness of the arms and legs or feelings of restlessness. These can be prevented or treated with Trihexyphenidyl (see dosing in Table 2.3); sometimes they can be relieved by carefully lowering the antipsychotic dose by a small amount.

3. Somnolence sometimes goes away or gets a lot better as a person takes the medication for a longer time – giving the medication before bedtime can help with sleep and avoid daytime sleepiness.

4. Chlorpromazine especially can cause a form of fainting when someone stands rapidly (“orthostatic hypotension”) – this can be prevented by suggesting that the patient drink a lot of water and get up slowly from sitting or reclining.

5. In some cases, chlorpromazine can cause urinary retention (anticholinergic effects). Lowering the dose should help.

6. There is a rare and dangerous complication of antipsychotic medications called neuroleptic malignant syndrome, or NMS. Patients with NMS have fever, confusion, and muscle rigidity (which may help you figure out that the patient has NMS and not malaria or another infection. NMS is a serious medical condition that can be fatal. If it is suspected, stop the antipsychotic and refer the patient to a hospital for evaluation as quickly as possible.

7. If the person is not acutely ill, and has changed behavior but is not having hallucinations
or delusions, consider whether the person could have dementia, a loss of mental function that usually involves memory, the ability to understand what is going on or what people say, and changes in personality. In persons without HIV, dementia most commonly occurs in old age, or after many years of heavy alcohol use. Dementia can happen in advanced HIV infection, in which case it can strike at any age. Prior to HAART, it was very common among persons with AIDS. Since HAART, severe dementia is much less common, but milder forms of thinking problems have become more common and may occur in as many as a half of those on HAART (see the module on living with HIV).

- Patients may complain of forgetfulness, inability to figure things out, or of feeling depressed, but they may be unaware of memory loss.
- Families may ask for help initially because of failing memory, disorientation, and change in personality or behavior.
- In the later stages of the illness, they may seek help because of behavioral disturbance: wandering, incontinence, irritability and aggression, apparent carelessness that is dangerous (leaving a fire unattended, leaving gates unlocked)

If there is concern, a screen for memory and orientation may be helpful. You can ask some of the following questions.

- Ask the person to remember three words (for example, “ball,” “cat,” “table”) and repeat them back to you. Tell them you will ask them to recall the three things again in a few moments.
- Ask someone to:
  o Give their age (make sure you know whether they are correct).
  o Give the time to the nearest hour.
  o Give their address (woreda, kebele, house number).
  o Give the year and season.
  o Give the name of the place where the conversation is taking place.
- Ask the person to tell you the three things you asked them to remember.
- Ask the person to recognize and name two people who are present in the clinic.
- Ask for some facts that most people know (you can make it harder if you think the person is well-educated).
  o Give the year of the fall of the Derg regime.
  o Name the present head of the government.
- Count backwards from 20 or say the days of the week backwards.

If the person has difficulty with more than two or three of these tasks, and there is no other explanation (very anxious, hard of hearing, medically ill, known to be developmentally delayed) then there is concern for dementia.

The dementia associated with HIV differs from the kind that usually strikes in old age in that it also involves changes in the speed with which people can think and do things with their hands.

- Cognitive problems: difficulty with memory, concentration, and sustained attention, can
lead to difficulty doing routine things; tasks take longer; it takes longer to learn new things

- Motor problems: slowing of repetitive movement, trouble with balance
- Behavioral changes: “impoverished” thought and emotions – less spontaneous, less initiative, more quiet and passive
- More common with a low CD4 count (under 100) and high viral load
- If there is concern for dementia and the person has HIV, you can screen with the International HIV Dementia Scale (in the pocket manual)

Treatment for dementia depends on the cause. For HIV-related dementia, treatment of the HIV often can produce a lot of improvement. If the person is taking any kind medication, think about which ones could be responsible for changes in thinking (for example, too-high doses of antipsychotic medications or medications used to treat their side effects).

For the dementias associated with older age, there are no known therapies that will reverse the losses, but there are things that families can do to help:

- Help the person stay oriented by reminding them of the day and time
- Having family routines and simple, familiar tasks that the person can do or assist with
- If the person uses corrective glasses, remind them to use them and try to keep them from being lost
- Provide additional supervision, though this may have to be gentle if the patient comes to resent being watched or accompanied all the time. Help the patient avoid dangerous situations – don’t place them in charge of children; don’t let them be alone where they could be injured, lost, or victimized.
- Get a specialist consultation – sometimes what looks like dementia in old age is, in fact, very severe depression. In that case, treatment may be of help.

The family will have a lot of additional work caring for the patient, who will require more assistance and supervision over time. Help them think about how to organize this work so that no one person is worked too hard. Ideally, help them get a consultation from a specialist to confirm the diagnosis. Be on the alert for depression or other signs of strain among the patient’s caregivers.

Sometimes people with dementia have episodes or prolonged periods of time when they are agitated and might harm themselves or others. Unfortunately, there are not many good choices for medication. Haloperidol, in the smallest dose that seems effective (0.5 to 1 mg a day to start) may be the safest, but there is concern that long-term use of antipsychotics in demented patients leads to increased mortality. Benzodiazepenes are considered a second choice, but again in very low doses because they can have an effect opposite to the one desired (that is, cause increased confusion and distress).
D. Follow-up care

Patients with newly diagnosed thought and memory problems who are well enough to be treated as outpatients should be seen frequently until they seem stable. This initial frequency depends on the severity of their illness and the certainty of the diagnosis.

If the patient has good family support, then initially seeing them at one or two-week intervals will usually be enough. Once it is clear that they are improving, visits can usually be monthly until a long-term treatment regimen is established, so long as the patient and family are willing to come back sooner if they think that there has been a relapse. After that, visits every three months are usually sufficient.

At follow-up visits, assessments can focus on:
- Is the patient responding to whatever treatment has been started? Are they less agitated, getting more regular sleep, starting to return to some of their normal activities?
- Is the patient experiencing and, if so, tolerating side effects of medication?
- Are there any signs of an emerging underlying medical illness that wasn’t obvious when the patient was first assessed?
- Is family stress reduced, is the ability to tolerate and support the patient increased?

If there seems to be progress, no change in medications should be made. In primary mental disorders, improvement can take weeks to months and will not be hastened by using higher doses of medications so long as there already seems to be improvement. If there is only a little improvement or none, the dose can be raised a little, and questions can be asked (see below) to reconsider the initial diagnosis.

Long-term follow-up for any condition that has caused persistent psychotic symptoms:
- Treat for at least 6 months after symptoms seem to have cleared and the person is back to normal.
- After that time
  - If this is a first episode, symptoms were mild, and if close follow-up is possible, try a very gradual taper (cut dose by about 10% a month); stop the taper if symptoms start to return.
  - If the initial episode was severe or prolonged (or if there has been more than one episode, consider the need for long-term medication. In that case, the goal is to use the smallest effective dose of medication. Try a small taper (10%) and wait at that dose for several months before deciding if a further taper is possible.

E. Referral and consultation

Ideally, because of the severity of these problems, any time that a patient is thought to have a new thought or memory problem, the general health practitioner will have a chance to review the case with a mental health specialist. This review can include discussion of other observations to make or medical issues to consider, and making plans for clarifying the diagnosis during follow-up visits.
If routine review of all new thought and memory cases is not possible, then consultation or referral can be considered if:

- Symptoms have not clearly seemed to get better within four weeks.
- At the time of follow-up, the patient is suicidal or seems threatening to others.
- The thought problems initially were combined with low mood – to make sure that the patient does not also need treatment for depression.
- The thought problems initially were combined with elevated mood – to make sure that the person does not also need treatment with a “mood stabilizer” medication if one is available.
- The patient seems to be dementing but the case does not fit the pattern usually seen with HIV.
- Medications are helping but side effects are not tolerable.

If consultation is not readily available and progress is not good at the time of follow-up:

- Does the patient still have problems with low mood, sadness, or a lack of wanting to do anything? See the depression package and consider starting treatment for depression in addition to what you have already started for the thought problems.

- Before the patient had the thought problems, did they have problems with being too active? Did they have grandiose delusions? Were they not sleeping or eating enough (because they felt they did not need to)? This person may have bipolar disorder. If the person is taking a depression medicine, lower the dose or consider stopping it. Keep up efforts to get a consultation, and ask in particular about the availability of a “mood stabilizer” medicine (for example, lithium).

F. Summary

Thought problems

- In cases of psychosis you will find disturbances of thought, perception, and changes in speech, mood, or behavior. Psychotic individuals usually do not recognize that they are ill; however, they can be aware that something is wrong with what they are experiencing and fearful of disclosing their concerns.
- Schizophrenia, mania, psychotic depression, and delusional disorder are primary psychotic disorders.
- Psychotic states can also be caused by medical illnesses or in association with use of drugs – medications or drugs of abuse.
- Psychosis is more common among people with HIV/AIDS than in the general population.
- While drug treatment of psychosis with typical and atypical antipsychotic drugs is the mainstay of treatment, behavioral handling of an agitated psychotic patient and giving psychoeducation to the patient and family are important components of treatment.
- Among people taking ART, the administration of antipsychotic drugs could lead to unwanted effects and interactions and therefore precautions should be taken.
• Treating chronic psychotic disorders is similar to treating HIV in that adherence to
treatment is necessary for continued good functioning and to prevent worsening of the
condition.

Memory problems

• Cognition includes memory, language, orientation, judgment, conducting interpersonal
relationships, performing actions (praxis), and problem solving. Problems with cogni-
tion can be caused by medical conditions, substances, and commonly used medications.
• Delirium is characterized by the acute onset of fluctuating cognitive impairment with
disturbance of consciousness. It is more prominent at night.
• Delirium readily happens among people living with HIV. It can be caused by opportu-
nistic infections, tumors and different medications used in HIV treatment; the primary
means of treatment is to treat the underlying condition.
• Dementia is a condition in which there is a progressive impairment of cognitive func-
tions occurring in clear consciousness. It mainly affects memory, attention, thinking,
and comprehension, which leads to behavioral changes and impairment in social or oc-
cupational functioning.
• In HIV dementia, compared to the dementia that can happen in old age, there are more
problems with movement, including slowed rapid movements, abnormal gait, incoordi-
nation, hyperreflexia, hypertonia, or muscle weakness.
• HIV dementia is more common in the late stage of HIV illness or with anemia, low CD4
cell count, and high plasma viral load.
• Treatment in both delirium and dementia includes:
  o Identifying and treating the primary cause (though in non-HIV dementia there may
    be no treatment).
  o Pharmacologic treatment of insomnia, agitation/restlessness, delusions or halluci-
    nations, etc.
  o Supportive and educational psychotherapy to both the patient and the family/care
    takers.
• When giving pharmacotherapy in those with HIV, one should be cautious of the drug-
drug interaction between ART and psychotropic drugs and of the mental side effects of
ART and related drugs.
Exercises for Module 2

1. Thought problem terminology

Instructions: for each of these cases, give the mental health/psychiatric term that best corresponds.

1. A 45-year-old female with a chronic psychiatric disorder claims that wherever she goes people stare at her, make some indirect remarks about her and laugh at her. She even believes that the radio announcer said something about her, indirectly.

2. A 21-year-old woman hospitalized for severe toxoplasmosis awakens in the middle of the night and cries out that there is a “lion” in her room. She is relieved when a nurse turns on the light revealing that the “lion” was an armchair covered with a coat.

3. The nurses in the ward noted that from time to time the 40-year-old patient with AIDS “was not making any sense – he talks about unrelated things.” On closer evaluation, it was found that the patient could not even recognize his own children. He believes the nurse is his deceased sister and he does know where he is.

4. For the past 2 months, a 22-year-old college student has been increasingly convinced that a well-known music star, Dawit Melese, is in love with her. They have never met or talked to each other. She claims that people are preventing him from openly declaring his love for her. She is otherwise functioning well and attends her class regularly.

5. A patient’s family reports that he frequently seems to change what he is doing in the middle of it. In your interview with him, he tells you that he hears the voice of a man telling him that he is a sinful person.

2. Cases to think about to differentiate dementia and delerium

Ato Tolossa Gemechu, a 27-year-old merchant, is brought to a hospital by his wife. Two years ago he found out that he is HIV positive. Six months ago he was started on antiretroviral drug treatment. His overall health condition was in good shape until two weeks ago at which time he started to show intermittent restlessness, agitation, incoherent speech confusion, disorientation and at times vivid visual hallucination. Such periods alternate with periods of relative normalcy during which time Ato Tolossa becomes calm and coherent with no memory impairment, hallucination or delusion. Physical examination showed no abnormality except low-grade fever.

a. What is the most likely psychiatric diagnosis?
b. What will you check in physical examination?
c. What are the possible causative factors?
d. List the most important components of treatment in this case.
A 61-year-old male Ethiopian high school teacher, who was well experienced and an enthusiastic teacher, appeared to lose interest in his usual work and made gross errors in home financial management. On several occasions he became lost while he was driving in areas that were formerly familiar to him. On examination patient was alert and cooperative. He was disoriented to time and place, he could not recall the names of his sons and daughters, and he could not remember the name of his college from where he graduated. His speech was fluent, but he had difficulty finding words, and used many long, usually meaningless sentences.

- a. When you interview the relatives, what information would you check?
- b. In what components of the mental state examination you would expect to find abnormality?
- c. If this patient is HIV positive, would you consider ART treatment?
- d. Which of his symptoms respond to psychotropic drug administration?

3. Cases to practice using the brief mental status exam and the flow chart to guide diagnosis and treatment decisions

Instructions: For each case, go through the categories of the brief mental status exam noting which details are present in the case description and what other questions you might ask the patient or family. Then use the flow chart and the reference and pocket guide materials to reach a decision about what you might need to do for the patient.

Case 1
Bogale is a 22-year-old young man with a 2-month history of strange behavior characterized by talking to the television, accusing local police of bugging his room, and carrying on conversations with himself. His mother also says that he has shown progressive withdrawal from social activities and dropped out of college. Prior to this he was normal, and though he is HIV positive, his most recent laboratory tests show a moderate viral load and high CD4 count. He is not taking any medications.

Case 2
Taye is a 23-year-old factory worker, single, who has been taking ART for about a month. Last week he started to show behavioral changes. He claimed that, two weeks ago, one of his co-workers put something in his food during lunch. Since then he has not been his old self. He believes he is under the control of some spirit. This thing forces him to do things he does not like. For example, the thing tells him he may not wear red colored cloth. His sleep is disturbed with interruptions and nightmares. This morning he heard the voice of his co-worker, even though he was alone in the toilet. It said “Koy gena minun ayteh”. He is brought to the clinic by friends who caught him trying to stab his co-worker with a dagger. He has no fever, cough, or chest pain. He is fully conscious and his speech is coherent.
Case 3
Ato Ketema is a 42-year-old government employee with a 2-month history of behavioral changes. His wife stated that he has become suspicious of her. He checks her frequently; makes phone calls to her office many times a day, spies on her, and comes to her workplace unexpectedly. She once found him checking her pants for signs that she had been having sex. Lately he has become restless, talkative, sometimes carrying on conversations with himself. During your interview he is agitated and his speech is pressured. He is conscious and fully oriented.

Case 4
Senayt is a 35-year-old woman who has had HIV for several years. She was put out by her family when she revealed the diagnosis, and has lived with various friends and worked low-paying and difficult jobs. She will come for ART treatment and start but then vanish for months at a time; when she comes back she says she has run out of her medicine or had to leave it behind at a place she could no longer stay. Recently she has been getting confused about how to take the minibus from work to where she is now staying. She has had trouble remembering some of the things she needs to buy to cook, and also has had trouble sewing.

4. Role plays to practice interviewing, differential diagnosis, and psychoeducation

Instructions: Take turns being the patient, clinician, or accompanying family member. The clinician should use the brief mental status guide to interview the patient. The clinician can then consult with colleagues about a possible diagnosis and treatment plan, including what you would do for follow-up. The clinician should then explain the diagnosis and plan to the patient and accompanying family member. Use any tools mentioned in the reference manual that may be of help, for example, the International HIV Dementia Scale, or questions about memory or orientation.

Case 1
Kebede is a 21-year-old college student. He is currently living with his mother in Addis Ababa. He has three siblings and hasn’t had contact with his father since he was very young. College study becomes very difficult. In the last three months he stopped going to classes. He is being interviewed at the OPD; his older sister has come with him. He is very passive and never initiates conversation during the interview, but attempts to answer any questions from the interviewer. He becomes very confused about what to say in response to abstract questions. If asked, he admits to hearing voices during the interview. The voices tell him that he has to protect himself from evil people and that maybe the interviewer is evil.

Case 2
You are the spouse of Ato Mehari, a young man in his late 20’s who has been treated in the ART clinic for two years and has been adherent to his treatment. You’ve brought him in because, in the course of a few weeks, he started to act strangely. He has begun to talk in ways that don’t make sense. He seems to act as if you are plotting against him – when you come into a room where he is, he looks at you strangely and may even appear afraid or angry even though you don’t do anything. His sleep is disturbed; he seems to see things no one is seeing. Your mother has said that this has been caused by the medicine that he is taking for HIV and thinks that you should take it away from him and, instead, take him for more Holy Water.
Case 3
W/ro Askale really does not know what to do. Her husband Ato Mengasha is not his old self any more. He talks nonsense. He asks the same question again and again. He once got lost in the city. The police brought him home. His sleep is disturbed. He gets up in the middle of the night and tries to open the door and get out. These days he becomes so confused that he cannot even wear his clothes correctly. She is not sure, after 23 years of marriage and 5 children between them, whether he recognizes her or not. She cannot leave him alone lest he get lost or do something unexpected. Her life has become miserable.
Figure 2.1 Thought, perception and memory problems

New or return to strange behavior
- Hears voices
- Overly excited
- Disoriented, disheveled
- Bizarre speech
- Paranoid
- Trouble with memory and orientation, major loss of function

Agitated and frightening? No
- Yes
  - Remain safe (staff and other patients)
  - Summon help
  - Avoid provocation
  - Remove dangerous objects
  - Consider medication

Patient calm and help available

Classify problem
- Appears ill
- Recent head injury
- Known low CD4
- Child
- Very sudden onset (days)
- Disoriented

Assess for delirium
- Medical illness
- Intoxication
- Alcohol withdrawal
- Medication toxicity or interaction
- Severe dehydration

Consider dementia
- If CD4 low consider HIV dementia – treat with HAART
- Family education

Consider mania
- Start antipsychotic
- Family education
- Safety measures
- Assess for suicidality
- When better, review history and consider mood stabilizer.

Psychosis
- Treat with antipsychotic
- Family education
- Safety measures
- As thought problems clear, if mood stays low, add antidepressant
Depression
Module objectives

1. To be able to identify, evaluate, and respond to emergencies (in particular, suicidal ideation and psychotic symptoms) related to low mood
2. To identify medical conditions that may be contributing to low mood
3. To be able to assess overall severity of mood problems and decide on the level of intervention required
4. To be able to give psychoeducation about low mood
5. To use good advice-giving skills to give brief advice about depression self-management, including behavioral activation, stress management, and problem solving
6. To know when medication for low mood may be warranted, and to know how to choose and prescribe initial medications
7. To be able identify, assess, and provide initial advice to mothers of young children who may be depressed

Introduction

This module introduces detection and treatment of problems associated with low mood. These are among the most common mental health problems all over the world. By some estimates, as many as one in every 10 people will have an episode of depression during their lifetime. WHO predicts that major depression will become second only to ischemic heart disease as a cause of disability among adults.

Spells of depression range from mild and brief episodes where people feel a lack of joy, optimism, and energy but can carry on with their lives, to prolonged periods of incapacity marked by a total lack of desire to do anything and thoughts that life is not worth living. Depression is common in both children and adults, but its manifestations are different.

Depression in pregnant women and mothers is thought to be one of the most common causes of preventable problems with child health, development and mental health. A study in Ethiopia found that children of depressed mothers were more likely than children of non-depressed mothers to have diarrheal illnesses in early infancy, and more likely to have developmental delays (Ross 2010).

In addition, as we noted in the introductory module, studies in many parts of the world, including Ethiopia, found that rates of depression are many time higher among individuals with HIV com-
pared to similar individuals who are HIV negative.

Cases to start off discussion:
Munira is 35 years old, single, an accountant who had refused to marry several times but now finds herself wanting a partner but unable to find one. Recently, she has lost her appetite, has developed early morning awakening, lost all the drive and energy to go to work, and she gets easily irritable and frequently quarrels with her colleagues. Sometimes, she feels that she would prefer dying to living in this situation.

- Have you ever met or heard about someone like Munira?
- What do people think about people with problems like Munira’s?
- What do people assume are the causes of these sorts of problems?
- If people try to help people like Munira, what do they do or suggest?
- What gets in the way of getting help for people like Munira?

Etenesh is a 12-year-old girl who was recently forced to move to a new neighborhood because her grandmother died and the family’s economic situation changed. Before, she had been a cheerful girl who attended school and was helpful with her younger siblings. In the last month, she has been refusing to help or getting angry when her mother asks her; she also has frequently said that she is not hungry and does not want to eat with the rest of the family. Her mother is worried about her but also very annoyed that Etenesh is not being helpful in this time when the family must adapt to new surroundings. Etenesh’s mother does not understand the change in her daughter and thinks it might be because she is becoming an adolescent.

- Have you ever met or heard about someone like Etenesh?
- What do people think about people with problems like Etenesh’s?
- What do people assume are the causes of these sorts of problems?
- If people try to help children like Etenesh, what do they do or suggest?
- What gets in the way of getting help for children like Etenesh?

A. Types of disorders

Depression can be caused by many things. It seems to be more common in some families, suggesting that some vulnerability to depression may be inherited. Depression often follows major losses or stresses and is a frequent complication of some illnesses. For example, depression seems very common in adults after they have had a heart attack or if they have congestive heart failure. There are also many medications that seem to be able to cause or increase the risk of depression, including the thiazide anti-hypertensive medicines, steroids, and INH.

There are many variants of depression, but in primary care/HIV care you might want to consider starting with only two big categories:

- **Serious depression** accompanied by suicidal thoughts or extreme feelings of guilt or low self-worth. This form of depression can be so severe that it is accompanied by psychotic symptoms (often delusions).
- **Milder forms** of depression that clearly cause distress but allow the patient to continue to function at some level.
People often have depressive feelings after a major loss or set-back. While this is “normal” it may still require help. People often start to feel better after a few weeks, but relapses may occur and at that point treatment may be needed. Any time low feelings last more than two or three weeks it is worth looking for a cause and offering treatment of some kind.

Since depression can be caused or worsened by medical conditions and substance use, if one of these causes is suspected, treating them first may make most sense. The excess of depression among people with HIV may be caused by a number of factors: prior depression may make it more likely that someone will get HIV, the many stresses of the diagnosis and treatment may contribute to depression, and depressive symptoms can be caused by the many medical complications of HIV infection or the medications used to treat it. Fortunately, there is no evidence that treatment of depression among people with HIV is any less successful than treatment of depression among those who are HIV negative.

**B. Presentations and detection in primary care/HIV care**

Depression can be hard to detect and separate from other conditions. There are many different ways in which people express their feelings of depression; sometimes they directly talk about their mood, but a lot of the time they speak indirectly. Some people just consider it a fact of life and don’t talk about it at all. The feelings come and go, and they consider it normal to feel badly when there is a lot of stress in life. Often, their friends and family members tell them that they should just be strong and shake it off.

1. **Somatic symptoms**
   Around the world, somatic concerns (aches and pains, feeling that something is not right in the body) are the most common symptoms of depression. These include feeling tired or weak, difficulty sleeping (or sleeping too much), and aches and pains. In these cases, clinicians have to be thinking simultaneously about the possibility of a treatable physical condition and the possibility of depression. They have to balance how much they try to make a medical diagnosis with how much they are willing to ask the patient about their mood.

Some common bodily concerns in Amharic-speaking areas of Ethiopia that can be symptoms of depression include:

- **Head-related:**
  - *Yakatlema* – burning of head
  - *Makatol* – burning scalp, feeling as if bugs are crawling under skin (usually associated with anxiety)
  - *Yikebdegna* – heavy feeling in head
  - *Yakatilegnal* – burning sensation in head (but also could be in back, hands, legs, one side of the body or the other)
  - *Yiweregnal, yurania* – crawling sensation in or on head
  - *Wotiro yiiyizegal* – feeling tight in the head
Yikezekizegnal – feeling cold inside the head
Bado yihonibgnal – feeling empty inside the head
Wustus yimbochabichibignal – as if a fluid is sloshing around inside your head

Stomach-related:
Tsguarra – chronic stomach pain
Cheguara alebign – have gastritis, stomach ulcer
Hoden yinefagnal – feeling of fullness, distended

Other common ways that people in Ethiopia talk about what may be depression include:
• I am irritable with my children (erebischachewalehu) (“I disturb or worry my children”)
• I am easily irritable (yanechaniecgnal)
• I prefer to be lonely (bichegnnet): to be alone, loneliness
• I feel low (medebet)

2. Diagnostic criteria
So if people talk about some of these concerns, one can ask about symptoms that suggest depression. The “official” defining features of depression are:
• Low or sad mood
• Loss of interest or pleasure in life, often seen by others as pulling away from normal activities or interactions.

At least five of the following associated symptoms should be present:
• Disturbed sleep (trouble falling asleep, frequent awakening, awaking too early in the morning and not feeling rested)
• Poor concentration
• Disturbed appetite (greatly increased or decreased)
• Suicidal thoughts or acts
• Guilt or low self-worth
• Loss of self confidence
• Pessimism or hopelessness about the future
• Fatigue or loss of energy
• Agitation or slowing of movement or speech
• Decreased libido
• Mood variation during the day

Because of what we said above about how common brief periods of depression can be after stresses, to start considering if someone has medically-treatable depression, the official guideline is that the symptoms should have lasted for at least two weeks, and they should be causing a major change in what the person would normally be able to do.

How might depression be different in children and adolescents? Symptoms in children are very similar to those in adults, except that children and adolescents may have more irritability than sadness, and they are less able to describe their inner feelings. There are similar changes in behavior – lack of a desire to be with others, lack of interest in pleasurable activities, and impairment in ability to do important things (such as school work).
Some of the most important symptoms of depression are ones that can be the most taboo or stigmatizing to talk about in front of others. Asking about these things in a non-private setting risks getting bad information, and harming the trust that you are hopefully building with the patient. Some of these symptoms can also seem shocking to clinicians, too. It can take practice to be able to ask about them.
C. Assessing suicidality

Everyone who talks about low mood, or who is suspected of having low mood, should be asked if they are thinking about hurting themselves. This is a very difficult topic to talk about in any culture, and it is particularly sensitive in Ethiopia. You can start by asking some questions that get at whether someone may be having thoughts that death might be better than life, even if they are not thinking of deliberately harming themselves.

- Have you ever thought that life is not worth living?
- Have you been feeling badly about yourself, as if you are a failure?
- Is life getting darker? Tesfa mokuret – do you have periods of hopelessness?

Regardless of the answers to the above questions, you should also ask:

- Have you ever thought about harming yourself?

If the answer to this question is, “yes,” consider the following:

What else is happening in the person’s life? Suicide is more common at points of life crisis – a turning point in a serious illness like HIV, a major loss or rejection. In HIV treatment, suicidal thoughts seem to be particularly common when the diagnosis is first made, when the CD4 count first falls to the point where medication is started, when there are set-backs in treatment or new complications, and when there are chronic symptoms that make life difficult, especially pain.

What sort of mental health problems does the person have? Suicide is more common when depression or psychosis are severe, or when these conditions occur along with alcohol or drug use. The single biggest predictor of suicide is a prior attempt, especially if the person feels disappointed that the prior attempt failed.

So the most important three questions to check for serious suicidality are:

- Have you ever actually tried to hurt yourself in the past?
- Are you thinking of hurting yourself now?
- If so, do you have a plan to hurt yourself? (thought about what you would do, either started to or gathered what you might need, given away possessions or written a farewell letter)

If the answer to any of these questions is “yes” then the risk of suicide should be considered to be high.

Another method of assessing a patient’s risk for suicide is to use the “Sad Persons” scale. Although the scale was developed outside of Africa and the scoring may not be valid in Ethiopia, it can tell us some of the things that make a person more likely to attempt suicide. In other countries, having six or more of the factors below indicates substantial risk.

**SAD PERSONS Scale**

- **Sex** (available data in Ethiopia do not find that the rate of attempts is that different between men and women; in other countries being male puts one at more risk)
- **Age** (attempts in Ethiopia seem more common among older teens and young adults)
- **Depression**
D. Treatment of depression in primary care/HIV care

[For this section, it can be helpful to look at the flow chart for the module while reading the text]

1. What might lead you to think that the depression is serious?

   1. Evidence of thought problem
      a. People who are depressed can sometimes develop thought problems that involve delusions and sometimes hallucinations
      1. In this case, treat the thought problem first

   2. Suicidal thoughts
      a. Many depressed people have feelings that they might as well not live, and may have even thought briefly about harming themselves. Most, however, will not have ever made a plan to harm themselves or actually tried. These latter two characteristics are the ones considered to indicate high risk. So the most important three questions are:
      1. Are you thinking of hurting yourself now?
      2. Have you ever actually tried to hurt yourself?
      3. Have you ever developed a plan to hurt yourself? (thought about what you would do, either started to or gathered what you might need)

      If the answer to any of these questions is “yes” then the depression should be considered serious.

      Other factors that might make even lesser degrees of suicidal thinking seem dangerous include:
      1. The person is intoxicated
      2. The person is very upset or agitated
      3. Someone in the person’s family or a close friend (especially among adolescents) has attempted or completed suicide.

Special concern for suicidal individuals who may have taken an insecticide:
- They may say they are suicidal and appear intoxicated or agitated
- This is a medical emergency – start plans for transfer to a hospital
- Avoid any fluids by mouth except if less than an hour after ingestion and then give activated charcoal and atropine
- Treat seizures if present
b. If there is a concern that the person will harm themselves:
   1. Assess realistic possibilities for close support and supervision – if there are none, try to arrange it, even temporarily.
   2. Ask about and try to get others to remove things that could cause harm: weapons, insecticide, cleaning chemicals, or medications that might be harmful in overdose. In a study conducted at the Black Lion Hospital in Addis Ababa, the most common things taken in self-poisonings were bleach, household disinfectants, insecticides, tricyclic antidepressants (see below), phenobarbital, and antipsychotic medications (Desalew).
   3. If the suicidal thoughts seem to have been triggered by a shame, loss or shock (for example, getting the diagnosis of HIV, hearing that the CD4 count has fallen, rejection by partner or the death of someone close) talk specifically about different ways of thinking about this and keep emphasizing these alternative views until the patient seems to be calming down.
   4. If there is concern that a medical condition might be involved (see below), treat it.
   6. Make a plan for the patient to get some kind of help as rapidly as possible if suicidal thoughts return – this might be calling a hot line, coming to the clinic, or talking to a friend.
   7. Consider starting medication (see below).

2. For less severe depression:
   1. Many types of chronic illness and chronic malnutrition can cause symptoms that resemble depression
      a. In HIV, in initial stages of taking efavirenz, but also many other regimens are associated with weakness and fatigue
      b. Hypothyroidism
      c. Anemia
      d. Vitamin B12 deficiency
      e. Renal or cardiac failure
   2. Patients with chronic pain and limited mobility may also feel depressed; but their mood symptoms will improve if the pain and disability can be adequately treated.
      a. In HIV this can include individuals with oral candidiasis or chronic abdominal pain
   3. Disrupted sleep can worsen mood (and, as above, it can be a symptom of depression when there seems to be no other cause)
   4. Psychoeducation is often helpful in itself – for both the patient and for family members – and even when there are medical causes. Points that you can emphasize include:
      a. Depression is a common problem and effective treatments are available.
      b. Depression is not weakness or laziness.
      c. Depression can affect patients’ ability to cope – when they are not depressed they will be able to do more for themselves.
      d. It is normal to feel “down” or briefly hopeless when life is difficult, but that does not mean that there are no ways to try to feel better.
• If physical symptoms (headache, abdominal pain, aches and fatigue) are the main way the patient is experiencing their depression, discuss the link between physical symptoms and mood. Patients can be receptive to the idea that the physical symptoms are linked to stressful events. As an example, if someone has a headache you can say that it is reasonable that the stressor is causing you pain, or that a more serious stressor would cause you pain everywhere.
• If there are strong beliefs about the feelings being caused by Satan, hexing, or the consequence of some bad conduct, you can respect those beliefs without having to directly agree; suggest that what you are proposing may still be effective.

5. Brief advice can be helpful
• Identify current life problems or stresses. Focus on small, specific steps to take towards reducing or managing these problems, even if it’s only a little. Talk about ways to lighten the person’s load temporarily, if that is possible.
• Avoid major decisions or life changes – provide assurance that it is OK to put these off until feeling better. Encourage the patient to resist pessimism and self-criticism and not to act on pessimistic ideas (e.g., ending marriage, leaving job), and not to concentrate on negative or guilty thoughts.
• Plan short-term activities that give the patient enjoyment or build confidence.
• Exercise may be helpful both to lift spirits and prevent low mood.
• Advise reduction in caffeine intake and drug and alcohol use.
• Support the development of good sleep patterns and encourage good nutrition if possible.
• For teens and children, explore ways to reduce conflict with parents; see if teens can find other adults who would be acceptable sources of support (teachers, elders).

6. Be a good listener. Even in a very short interaction it can be helpful to:
• Give the patient time to explain their feelings
• Empathize with their difficulties
• Find something positive to say – at least, compliment them on their willingness to talk and to seek help

7. Community referrals. What organizations can help with practical matters including housing, work, transportation, food, HIV support?
• Worry about food and shelter is a major cause of depression and anxiety
• Encourage the family to think about other things they feel would be helpful including holy water or other traditional approaches, but assess with them whether there is a chance for harm (for example, use of herbal medications that might interact with current medications)

8. Make a definite plan for a follow-up visit, especially if this mood change is in response to a new stress (for example, new HIV diagnosis or change in status); try to differentiate acute mood change from depression)
3. When to consider medication:
   a. Function is severely impaired
   b. Concern that there might be some delusional thinking
   c. Persistent and severe suicidal thoughts
   d. There was a previous time when the person had low mood that lasted more than a few
days and that was hard to help and/or that resulted in problems in function

Medications for children and adolescents
   • There is very little evidence that any are effective for low mood for young children;
     there is better evidence if there are anxiety symptoms
   • The only evidence is for SSRI’s (for example, fluoxetine or sertraline), and this is only
     for older adolescents

Medication choices (see Table 3.1 and pocket guide for more information)
   All antidepressants can take time to have an effect; sometimes there is a partial response in
   a few days, most people need 10-14 days to see some change and longer to get the maxi-
   mal effect from any particular dose. Don’t consider the medication a failure until at least a
   month has gone by with insufficient improvement. At that point, check for adherence and
   side effects. If OK, consider a dose increase.

**Tricyclic antidepressants:** in general are effective in adults. There is no evidence for effective-
ness in children or adolescents. These medications tend to have many side effects (dry mouth,
sedation, hypotension) and can be fatal in overdose. Avoid using them in patients who have
current or past suicidal thoughts. Avoid in patients with known heart disease. Co-administra-
tion with ritonavir and other protease inhibitors can greatly increase tricyclic levels and thus
contribute to toxicity.
   • Amitriptyline: Starting dose is 25-50 mg daily in divided dose or as a single dose at bed
time and it can be increased gradually (by 25 or 50 mg at a time) as necessary up to
   150-200mg per day.
   • Imipramine: starting dose is 25mg 1-2 times/day, increase dose gradually, and the total
dose that may be given at bed time is 300mg

**Selective serotonin-uptake inhibitors (SSRI):** in general are all equally effective for adults.
The best evidence of effectiveness for adolescents is for fluoxetine, but evidence in younger
children for fluoxetine is only for anxiety. These medications are extremely safe except for
concerns about interactions with other medications. Common side effects (mostly early in
   treatment) include stomach distress, agitation, sedation, trouble sleeping. Adults may experi-
ence loss of sexual drive.
   • Fluoxetine: 10-20 mg a day starting dose. Has an extremely long half-life so waiting
   at least two weeks after starting or a dose change is reasonable to see effects; no need
to taper dose if discontinuing; little worry about occasional missed dose; check interac-
tions with other medications – in particular, giving at the same time as an tricyclic can
raise the tricyclic to toxic levels.
   • Sertraline has been shown to be effective for adults. The starting dose is 25mg a day
   and can be given up to 200mg a day, usually divided into two doses. The half-life is shorter
   than fluoxetine so when stopping taper by 25-50 mg a week to avoid unpleasant side
effects.
### Table 3.1- Antidepressant dosages and side effects

<table>
<thead>
<tr>
<th>Antidepressant Drug</th>
<th>Dosage</th>
<th>Common side effects</th>
<th>Interactions</th>
</tr>
</thead>
</table>
| Amitriptyline       | Adults:  
Starting dose: 25-50mg a day given at bedtime  
Increase by 25mg a week  
Usual maintenance dose: 100-150mg/day in single dose at night or divided into two doses; maximum 200mg a day  
Adolescents and children: Not recommended | Dry mouth, sedation, postural hypotension, weight gain; **can be fatal in overdose; avoid use in suicidal patients.** Do not use in men with prostate enlargement or in anyone with heart disease. | OK with NNRTIs and NRTIs  
OK with PIs except LPV/r, RTV, TPV/r where those medications can raise the level of the antidepressant so try to use fluoxetine.  
Steroids can increase the level of the antidepressants (including contraceptives)  
Phenobarbital and carbamazepine can decrease levels. |
| Imipramine          | Adults:  
Initial dose 25-50mg at night; can raise by 25mg a week  
Usual adult dose 100-150mg at night or divided into two or three doses; maximum 200mg a day  
Adolescents and children: Not recommended | | |
| Fluoxetine          | Adults:  
Starting dose: 10-20mg a day (morning or night depending on side effects); wait 4-6 weeks before deciding to increase  
Usual maintenance dose: 10-40mg/day  
Adolescents  
Starting dose 10mg a day; increase by 5 or 10mg in 1-2 weeks only if no response at all  
Usual maintenance dose: 20mg a day | Headache, restlessness, agitation, insomnia or sedation, GI symptoms, sexual dysfunction. | No specific problems for PIs or NNRTIs in HIV care; can be some variation in level of either medication.  
Never give along with amitriptyline or imipramine (can lead to overdose of those drugs)  
Interacts with many medications so check before using. |
E. Follow-up and monitoring

Several aspects of depression make follow-up care very important.

First, as we said before, response to treatment can be slow. Some people will feel better in a few days or a week, but most will take weeks or a month until they notice a lot of improvement. If the person is taking a medicine for the depression, this is a time when any problems with the medicine will seem to outweigh any possible benefits, and the person is likely to stop. So a return visit in one or two weeks is important. Early return visits are also important if there was worry about suicidal thoughts, or if the diagnosis didn’t seem clear.

Depression can get a lot better in a month or two, but stopping treatment at that point makes it very likely that the person will relapse. Ideally, continue treatment for at least six months after the person feels well before tapering down treatment – longer if this is not the first time the person has been depressed enough to need treatment.

Finally, people who have been depressed once may relapse, so even once they feel better, asking them about symptoms when they come back for other reasons is a good way to catch a relapse early before it becomes severe.

So, one possible plan for follow-up of someone who has been started on depression treatment would be to see them weekly for a month, then monthly for another five months, and then decide about plans based on how well they are doing. At each follow-up visit, assess for new stresses, suicidal thoughts, return to normal of sleep and appetite, and the side effects of any medications.

F. Referral criteria

When consultation is available, generalist clinicians may want to review with a specialist all cases of severe depression, including those where there was worry about suicidal thoughts but the patient was allowed to go home.

Referral to mental health consultant (or seeking general hospital admission for safety while awaiting mental health consultant) is warranted if there is:

1. Suicidal thought with a plan and likely means
2. Suicidal thought and a concern about recent ingestion
3. Suicidal thought and intoxication
4. Depression with catatonic features
5. Concern about serious acute medical illness

Referral at follow-up is warranted if there is:

1. Non response to treatment and the patient remains severely affected
2. Further worsening of depression or lack of clarity about diagnosis
3. Response to medication treatment but inability to tolerate side effects.
G. Summary – Depressive disorders

- Depression is highly prevalent in HIV/AIDS cases
- In depression one finds both somatic and psychologic symptoms.
- Many people with depression have somatic symptoms that raise concerns for medical illness – it is important to consider both causes at the same time.
- 90% of suicides occur within the context of a mental disorder, particularly depression and substance abuse.
- Untreated depression could lead to increased non-adherence to ART, increased suicide risk, decreased quality of life of the patient, and family emotional distress.
- Effective treatments are available for depression; antidepressant medications are effective, the SSRI’s are preferable
- Medical illnesses and substances causing depressive symptoms should always be identified and managed accordingly.
Exercises for Module 3

1. Major symptoms of depression and suicidality

Purpose: review major psychological and somatic symptoms; review questions to ask to elicit them.

Instruction: Individually list as many possible symptoms as you can in the two main categories. Highlight or put a mark next to the ones you think are the most common or most important to ask about. Then, go around the group each proposing a way to ask about each of the symptoms.

Take extra time to talk about assessing suicidal thoughts. What are some initial questions to ask everyone you are evaluating for possible depression? What additional questions would you ask if the person said they had some suicidal thoughts? Which responses would make you think that the person is at high risk of harming themselves?

2. Cases to practice using the brief mental status exam and the flow chart to guide diagnosis and treatment decisions

Instructions: For each case, go through the categories of the brief mental status exam noting which details are present in the case description and what other questions you might ask the patient or family. Then use the flow chart and the reference and pocket guide materials to reach a decision about what you might need to do for the patient.

Case 1
Almaz is 35 years old. She is divorced. Three weeks ago, she discovered that she has HIV. Since that time, she has developed loss of appetite, early morning awakening, and says that she has no desire or energy to go to work. She gets irritable easily and frequently quarrels with her colleagues, which she says is OK because she prefers to be alone. She says that she finds herself crying a lot, and sometimes she feels so sad that she would prefer dying to living in this situation.

Case 2
Solomon is a 30-year-old man who has been on ART for three years. When he first started treatment, soon after his HIV diagnosis, he had a small shop and seemed to be coping well. However, over the last year he has been using more khat and drinking more beer. He has been putting in less time at the shop and business has gotten bad. Recently, his wife said that if he was not able to pay more attention to the shop and his affairs that she would take their children and return to her family in another city. At this visit Solomon tells you that he ran out of HIV medicine two weeks ago and did not think of coming for more. He says that he is thinking of stopping the treatment, because he knows that he will die of HIV sooner or later.

Case 3
Tirunesh is a 24-year-old young woman who works in a bank. Her long-term boyfriend died two years earlier due to AIDS, but she has been afraid to go for testing herself. She’s come now
to her doctor with a number of symptoms, including backache, pains in the chest and abdomen and aches in the muscles. She is frequently tired and sleeps poorly. Though she tells you that her mood is not bad, she does say that she since the death of her boyfriend she has not felt much purpose in life; she says that her motto is just to live for today, because life can be so uncertain. Her physical examination is normal.

Case 4
Hirut was found unconscious in her bedroom with an empty bottle of an insecticide containing malathion. She was sent to a hospital and after 11 hours she regained consciousness, became communicative and her vital signs were stable. Her husband told the attending physician that they both are HIV positive; in talking to the doctor, he says that he believes he contracted HIV from her and blames her unfaithfulness for their present condition.

Case 5
Etenesh is a 12-year-old girl who was recently forced to move to a new neighborhood because her grandmother died and the family’s economic situation changed. Before, she had been a cheerful girl who attended school and was helpful with her younger siblings. In the last month, she has been refusing to help or getting angry when her mother asks her; she also has frequently said that she is not hungry and does not want to eat with the rest of the family. Her mother is worried about her but also very annoyed that Etenesh is not being helpful in this time when the family must adapt to new surroundings. Etenesh’s mother does not understand the change in her daughter and thinks it might be because she is becoming an adolescent.

Case 6
Ato Gebremariam is a 32-year-old male, married government employee, who was diagnosed with HIV a year back. He came to the clinic due to frequent diarrhea and weight loss. He has lost interest in work and isolates himself. He feels guilty about infecting his wife and is sad all the time. After lab test it was decided to start HAART.

Case 7
Abdella is a 35-year-old, single accountant who has been on HAART for the last 3 months. Four weeks ago he was started on anti-TB drugs. In the last two weeks, after the death of his former girl friend, he started to show behavioral changes. He stopped going to work. He is slow, spends most of his time in his bed, cries a lot, and his sleep is full of nightmares.

3. Role plays to practice interviewing, differential diagnosis, and psychoeducation

Instructions: Take turns being the patient, clinician, and an accompanying family member. The clinician should use the brief mental status guide to interview the patient. The clinician can then consult with colleagues about a possible diagnosis and treatment plan, including what you would do for follow-up. The clinician should then explain the diagnosis and plan to the patient and accompanying family member.
**Scenario 1**
Senait is 31, married, and has three children. When the interviewer begins to ask about what brought her to seek treatment, her voice wavers and she chokes up and has to clear her throat several times before answering. She admits that she finds herself crying several times a week, that the sad feelings seem to come out of the blue and overwhelm her when she least expects it, and that she worries a lot about her ability to be a good mother. She also admits that she has recently found herself getting irritable with her two-year-old son and that he seems to be more and more difficult to control as she seems to have less and less patience with him. She isn’t sleeping well and she feels tired all the time. Lately, she has trouble concentrating.

**Scenario 2**
Teklu is a 16-year-old student from Nazareth. The teenager has many aches and pains and is tired all the time. He says he has lost interest in going to school and he avoids any social interaction. He remains in his room for hours. The weekly premier-league football game he was crazy about does not give him any pleasure. The family has been through many adversities – the father has been imprisoned for a long time and his grandmother, who raised him, is very ill.
Figure 3.1- Low mood flow chart

New or recurring problem with low or sad mood, loss of interest in normal activities, loss of sense of pleasure.
- Trouble sleeping
- Change in appetite (markedly less or more than usual)
- Many aches and pains that are hard to explain
- Feeling always tired or low energy
- Guilty thoughts or low self-worth
- Pessimism and hopelessness
- Irritable (especially in children and adolescents)
- Frequent thoughts of death, thoughts about life not worth living

Suicidal thoughts?

Yes

Assess current suicide risk
- Suicidal thoughts now
- Has a plan
- Intoxicated or agitated
- History of attempt
- Acute loss/trauma

Make immediate safety plans
- Constant companionship until more calm and suicidal feelings pass
- Remove hazardous materials and weapons
- Treat any medical issue or withdrawal
- Supportive advice
- Consider depression medicine (not TCA)

No

Classify problems – may be more than one

Possible medical causes
- Anemia
- Malnutrition
- Hypothyroidism
- Medication side effects

Begin medical treatment but address low mood at the same time

Mild/moderate depression
- Still functional in most domains
- Some hope and energy to help self
- No or only vague suicidal thoughts

Psychoeducation
Self care
Address unhelpful beliefs
- Guilt
- Hexing
- Excessive demands or expectations

Severe depression
- Poor function
- Prior severe episode
- Severely disrupted sleep

Psycho education
Self care
Address unhelpful beliefs
- Guilt
- Hexing
- Excessive demands or expectations
Medication – SSRI only for teens or older.

Psychotic delusions or hallucinations

Treat with antipsychotic
Objectives for module 4

1. To be able to describe the range of symptoms that could indicate an underlying problem with anxiety, including manifestations related to psychotrauma
2. To know basic screening questions for anxiety, including the possibility of exposure to psychotrauma.
3. To be able to respond to possible emergency situations associated with anxiety symptoms
4. To identify possible medical and developmental causes of anxiety
5. To be able to give patients and families psychoeducation about anxiety problems
6. To give brief counseling for anxiety including stress reduction, active coping, and relaxation
7. To be able to identify panic attacks, and to provide psychoeducation and suggest treatment
8. To know when medication for anxiety may be warranted, and to know how to choose and prescribe initial medications
9. To make plans for reassessment and referral if needed

A. Introduction

Anxiety is known to affect all people regardless of culture, race, age, religion, gender, level of education or economic background. It is characterized by excessive fear and/or inappropriate feelings of nervousness that can be very general (applied to nearly all aspects of life) or very focused on a particular situation. Anxiety is frequently mixed with feelings of depression. It is often chronic, unremitting, and disabling. In many countries it goes undetected for many years after people first experience symptoms, even when mental health services are potentially available.

The mental health literature recognizes many distinct types of anxiety problems. They may sometime co-occur and some of their symptoms overlap. However, treatment principles are very similar across the range of different types. Rather than focusing on the different types, we will focus on assessment of three main decision points that will have an influence on treatment:

- Level of dysfunction – anxiety problems vary in the number and intensity of the things feared or avoided, but what matters most is the extent to which they have an impact on a person’s day-day-to-day activities and mood. Depression is a common part of anxiety. While suicidal thoughts are less common than in severe depression, they can occur. Another possible emergency is if the anxiety is occurring in relationship to trauma.
• Are there possible medical causes?
• Are there “panic attacks” which occur alone or with other anxiety symptoms?

Case to start off discussion

Abebaw is a 30-year-old man who has been in HIV care for some time and has been doing well medically. However, at his last follow-up visit, he told you that he has been out of work for a month, having been dismissed for poor attendance. He says that this has caused him many stresses, and he sometimes now forgets his ART medications. You ask him what might have changed in his life. He says that he had not told you, but about 6 months ago, the mini-bus he was riding in was hit by a speeding truck. He was thrown free and was shaken but unharmed. However, several people on the bus were killed, and he has vivid memories of seeing their bodies trapped in the wreck. Since that time he has found it difficult to get to work. He can only take the bus if he can go with a friend, and sometimes he cannot get himself to get on the bus at all.

• Have you ever met or heard about someone like Abebaw?
• What do people think about people with problems like Abebaw’s?
• What do people assume are the causes of these sorts of problems?
• If people try to help people like Abebaw, what do they do or suggest?
• What gets in the way of getting help for people like Abebaw?

B. Presentations and detection in primary care and ART

As with depression, some of the most common ways that people start to talk about anxiety involve difficulties with physical feelings or sleep. This is particularly true with children, who will often say that they have headaches or stomachaches when anticipating something that they fear. We can divide the symptoms of anxiety into physical symptoms, mental symptoms, and behaviors.

Physical symptoms

• Restlessness
• Headaches and stomach-aches
• Inability to relax or fall asleep
  o Too many thoughts in their head to fall asleep, or awaken and then worry
• Panic attacks
  o A fast or pounding heart, chest pains or tightness, sweating, trembling
  o Comes on suddenly, often without warning but sometimes triggered by a worry, lasts a few minutes
  o Often have several a day
  o Followed by worry about having an attack – often leads to unwillingness to leave home or go out alone for fear of having an attack in public or without help

Mental symptoms

• Worry, feeling tense or nervous, poor concentration, fear that something dangerous will happen and the patient won’t be able to cope
• Hyper-arousal: always monitoring what is going on, over-reactive to sudden changes or loud noises (may be manifested by irritability or sudden anger with changes of plans or
unforeseen events)

• Repetitive thoughts (worries about touching things for fear they are dirty) or actions (having to wash hands very often, having to pray) that are very much more than normal; the person gets very anxious if they try to resist having the thoughts or doing the actions

Behaviors

• Not wanting to leave home or a safe place
• In children, not wanting to separate from parent or guardian, refusing to go to school
• Avoidance of things that are reminders of feared objects or situations (for example, taking medications for HIV)
• Speaking only in front of certain people (usually close family members)
• Repetitive behaviors – frequent washing
• Irritability (and in children especially can be manifested as bad behavior)
• Unlikely explanations for injuries, or unwillingness to discuss an injury

As with many mental health problems, people often will not tell you that they are worried or reveal some of the causes. They may be ashamed of what has happened to them, or of their own response to the fears. Children, in particular, may not be able to tell you exactly what they are afraid of. Their symptoms can include:

• Having “bad dreams” but they can’t tell you what they are about
• Getting more upset than expected over routine challenges or separation from their parents (including leaving home in the morning to go to school)
• Showing changes in behavior similar to those in depression – less willingness to play, more clingy with adults
• Repetitive play that may relate to their fears – for example, “killing” a doll or crashing a toy car into a rock over and over.

Questions to ask

Often you have to ask if you suspect that there is an anxiety issue:

• Are there things that worry you or that you can’t get out of your mind?
• Are there things that you fear? You may have to suggest some examples to get the conversation started. Commonly feared situations include:
  o Crowds
  o Open spaces
  o Traveling in buses or cars, especially if they are crowded
  o Speaking in front of strangers
  o Social events
  o Heights
  o Being cursed/hexed (religious belief or witchcraft)
  o That others can tell by looking at them, or will discover, that they have a stigmatized condition/situation (like having HIV)
  o Fear of being contaminated (will not touch things they believe are dirty)

Anxiety can also be related to past psychotrauma — in some countries this seems to be a particularly common cause of unexplained worry about physical problems. Chronic lower abdominal or
genital pain is, for example, a common symptom of past sexual violence among women in some countries.

Studies in Ethiopia have found that as many as half of all women experience some form of violence during their lifetime. Gender-based violence may be even higher among women living with HIV/AIDS. Sexual assault may be the way that a woman becomes infected with HIV, and women with HIV may be more likely to be assaulted.

Most of the time, people will not say readily that they have been victims of violence.

- Physical or sexual violence between partners
- Sexual assault
- Physical violence by a parent
- Events during war or displacement
- Witnessing violence
- Being bullied or assaulted

People may also have been a witness to or involved in a traumatic event (for example, an automobile accident)

How would you ask about these things among your patients? Which patients might you think of asking? This is a sensitive issue that we will practice in role plays.

Since anxiety problems are so common, it is important to ask how much the problems interfere with function. In ART, it is common for patients to be so anxious that they cannot look at medicine bottles or come to clinic. Some will begin to gag or vomit if they know that a pill is related to HIV treatment. These are common causes of not following through with ART. Other ways to assess severity include asking if the symptoms get in the way of work, socializing, shopping, school, or relationships with family members. The more severe the interference, the higher priority it is that treatment be offered.

C. Approach to treatment in primary care

One way to think about anxiety problems is to divide them into four main groups. Although treatment has much in common, there can also be specific treatments for each kind

1. Anxieties and worries not related to psychotrauma
2. Anxieties and worries when there seems to be a link to psychotrauma
3. Panic attacks
4. Obsessions and compulsions

Thinking through anxiety treatment

1. Function/level of severity
   a. Are there real/immediate threats that need to be discussed?
   Anxiety problems do not often present as emergencies, but when they occur along with depression they may involve suicidal thoughts, so it is important to ask about. Suicidal thoughts may also occur when someone has suffered a very shameful traumatic event, such as a sexual assault.
Another potential emergency is if the anxiety is related to violence.
- Is there ongoing violence in the home or another form of threat from others?
- Again, this may not be disclosed readily, especially if the patient is not certain about confidentiality or has been threatened with harm if they disclose the trauma. So the approach may include:
  - Find a more private place for the discussion
  - Consider matching gender – in many countries women may not divulge marital or sexual trauma to male providers
  - Hearing the story in an empathetic way is often the most that can be done immediately
    - What are definitions of and responses to child or spouse abuse in your community?
  - Resist giving advice and ask the patient what they have thought of doing. People often tolerate ongoing violence because there is no obvious easy solution.
  - Offer opportunities to come back to the clinic (sometimes disguised as medical visits) to seek further support
  - Refer to community organizations that might be helpful if they are available

b. Impact on function.
Anxiety problems can be very disabling. Think about the main areas of people’s lives – home, social relationships, work, leisure. How do the problems create difficulties in these areas? How would the person’s life be different if they did not experience the anxiety symptoms. How do the problems interfere with caring for or living with HIV? Possibilities include:
- Fear of death or illness triggered by looking at ART medicine bottles, trying to swallow pills, or coming to clinic
- Fear of medications being discovered at home

2. Could there be a medical condition producing the symptoms?
Some symptoms that are experienced by patients as anxiety involve medical conditions or substance use.
- Hyperthyroidism
- Asthma or other conditions that make it hard to breathe
- Using too much coffee or khat
- Medication side effects
  - Theophylline or other medications given for asthma
  - “Akathesia” – a disturbing feeling of anxiousness and not being able to stay still that can be a side effect of medications (haldoperidol, chlorpromazine, others) used for thought problems

3. Are there panic attacks?
Panic attacks are sudden episodes that have both physical and emotional symptoms. Physically, there is usually a feeling of being short of breath, of a rapid heart-beat, and often sweating or shaking. Emotionally, there can be a feeling of intense fear, or even that the person is about to die. Panic attacks can be “triggered” by a thought or situation, or they can happen without any
apparent trigger. They usually last a few minutes and then fade away. One complication of panic attacks is that people may be afraid to leave home or some other safe place because they fear having an attack in public, where they may not be able to get support or where they will feel embarrassed.

Try to estimate the frequency of attacks and whether fear of having an attack is keeping the individual from going out or doing day-to-day activities. If not too severe:

- Describe the condition, re-assure that it is more like a medical problem, the body overreacting to a thought about harm, talk about the relationship with stress and worry.
- Identify current stresses and worries and how to approach them
- Teach relaxation and other self-care skills (see below)

If the attacks are frequent and especially if they are “un cued” – that is, the person doesn’t have an idea of what worries trigger the attacks, consider:

- Treat with a medication if available to try to suppress the attacks (see below)
- Consider referral for exploring how to treat the related anxiety problems

General treatment for most anxiety problems

1. Psychoeducation – this is a first and most important kind of treatment for all mental health problems – helping people realize that their condition is common, treatable, and not something to be ashamed of:
   - These sorts of problems are very common
   - It is not a form of weakness – our bodies are designed to have these sorts of reactions
   - Though most of these problems will not vanish, they almost always get better, though it can take time

2. Learning skills to reduce the effects of stress can provide relief. Help people become aware of when they are anxious and what seems to provoke it. This seems obvious but anxious behaviors can be a habit and not noticed.
   - Anxious people may always be trying to do things too fast or doing too many things at the same time.
   - Anxious people may always holding their body in a tense position, clenching their fists or jaw

So when the patient is aware of being anxious or of cues to anxiety, try a method of relaxation:

- Take a few slow, deep breaths
- Have a motto or something to think about that reminds them to be calm
- Count slowly to 10 and then continue with whatever they were doing

3. Try “active coping” - If there is a feared issue or thing, try to work on dealing with it rather than avoiding (but all the while acknowledging that it’s hard).
   - Think of who can be a role model or partner
   - Try gradual and supported exposure to the feared object or situation, coupled with relaxation. At each step, do the activity over and over until it’s comfortable.
For example, if someone is afraid to get on a bus, first spend some time looking at the bus go by, trying to stay calm. Next, talk to the driver or conductor without getting on. Then, if possible, get on the bus and get off before it moves on. Then, go for a short ride accompanied by a partner, and finally, a short ride alone.

- For children (or even adults), reward brave behavior

4. **Suggest a medication** if the symptoms seem severe (see below).

### Anxiety related to traumatic stress

In addition to the symptoms discussed above, patients may experience emotional numbing

- Loss of interest in activities
- Seem detached, can show less concern, less reaction to things
- These symptoms can overlap with depression

Treatment approaches for anxiety related to trauma

- Acknowledge and empathize with the trauma – you don’t need to say more than “I realize how difficult that was” or “I am so sorry you had to experience that.”
- Be ready for expressions of guilt and responsibility – again, empathize, remind that those are common feelings.
- Ask about thoughts of self-harm – this form of anxiety has the highest rate of suicidal thought among the anxiety problems
- Talk about relationship to physical symptoms
- Treat the patient with extra respect and patience, especially with regards to physical examination
- If routines are disrupted, talk about how to normalize them
- Do what is possible to assure basic needs for nutrition, shelter, support and general self-care
- Attend to the needs of supportive others (parents, partners)
- Where possible, link with community groups that have programs for that form of trauma
- Attempt to couple talking or thinking about the trauma with relaxation techniques; attempts to tolerate the thoughts
- Medications can be helpful if the symptoms are severe.

### Anxiety related to fear of HIV disclosure (or of other stigmatizing issues)

Many people with HIV, and other stigmatizing experiences or conditions (for example, experiences during the reign of the Derg) live with the fear of what would happen if others were to find out. It is not always clear what is the right thing for them to do in these situations. Sometimes it seems that disclosure, at least to partners and close friends, would be of comfort and reduce anxiety, but the consequences of disclosure can’t always be predicted.

In HIV care, fear that the doctor will insist on disclosure is one of the more common reasons patients don’t come back for care. As with other forms of trauma, this is a situation in which good
communication skills can help:

- listen to and empathize with the patient’s concerns, and especially the difficulty of deciding about disclosure
- get permission from the patient to give information – the risks of non-disclosure, the possible benefits – but give information in a neutral way, and don’t expect a decision right away

We will talk more about disclosure in Module 8, living with HIV.

**Obsessions and compulsions**

This category of anxiety problems can be among the most difficult to treat. It usually comes and goes over many years. People experience thoughts and impulses that they can’t control without a lot of effort and distress. One way to imagine what this is like is to think about having an itch and trying not to scratch it.

Impulsive behaviors include the need to wash the hands over and over (often until the skin is irritated), lining up objects and being disturbed if they are moved, always needing to check if a door is locked or a stove is turned off.

Recurrent thoughts include worry about contamination – not being willing to touch things because they may be dirty, or the need to wash immediately after touching anything; needing to count, repeat a saying, or say a prayer over and over.

Attending to these things limits normal activity – it either takes a lot of time or creates reasons why someone cannot carry out their usual activities. The symptoms will come and go, usually appearing at times of stress and then fading somewhat over time. It is not unusual for one symptom to go away to be replaced by another.

**Approach in primary care:**

1. Try to get an idea of the waxing and waning of severity over time. People often seek help when the condition is at its worst. If, over time, the symptoms are generally not too severe:
   a. Describe the condition, re-assure that this is more like a medical than mental illness, talk about relationship with stresses.
   b. Identify current stresses, think about how to try to reduce them.
   c. Teach relaxation and other self-care skills.

2. If relatively severe, consider referral for initiation of medication and specific cognitive treatment. If referral is not available:
   a. The medications noted below may be at least partially helpful.
   b. Trying the gradual exposure method described above may also work if there is a helpful partner and coach. The “target” of the method, this time, is the intrusive thought or impulse. For a brief time (a few seconds) and then longer periods, and with the help of the coach in trying to relax, the patient should try to resist the thought or impulse (for example, needing to clean the hands).
Medications for anxiety

SSRI’s (fluoxetine, sertraline) are the first choice and thought to be effective for general anxiety, obsessions/compulsions, symptoms related to trauma, and panic attacks in children, adolescents, and adults.

- Effectiveness varies and response is not usually 100%.
- Onset of anti-anxiety effect can be slow – similar to with depression or even slower.
- Remember to consider interactions with other medications.
- Start at low doses (10 mg of fluoxetine, 25 mg of sertraline a day) and be prepared for patients to worry about side effects or to tell you that they stopped the medicine because of them. Gradually increase the dose every few weeks to try to get symptom control. Doses higher than depression doses may be required to help with anxiety, but you may see some improvement on a low dose, especially if combined with counseling/advice.
- Once symptoms have been suppressed for a period of weeks to months, try a gradual taper.

Amitriptyline and imipramine have some evidence for effectiveness but patients are usually frightened by the side effects, so willingness to continue is diminished.

- There are more risks of side effects and risk in overdose, so the overall ratio of benefit to risk is not as good.

Benzodiazepines (diazepam, lorzepam) can be used for immediate relief (they act within minutes of being taken) but there can be problems with dependence and a worsening of symptoms when stopped. They can also impair judgment and alertness, and they have an additive sedative effect with alcohol (together they can be fatal). They are probably best used when anxiety is keeping someone from a single event (a visit to a specialist, undergoing an operation) so that use will be short term. Benzodiazepines can also interact with other medications – (lorazepam, oxazepam, and temazepam are the safest for use along with ART, though they are not generally available in Ethiopia at this time).

- Benzodiazepines are also sometimes purchased on the street (“Roche”); make sure that someone is not taking them already before prescribing.
<table>
<thead>
<tr>
<th>Drugs for anxiety</th>
<th>Dosage</th>
<th>Common side effects</th>
<th>Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diazepam</strong></td>
<td>Adults</td>
<td>Drowsiness, high risk for drug dependence and withdrawal symptoms; combined sedation and respiratory depression with alcohol.</td>
<td>All PI’s can increase levels of diazepam and bromazepam, as can delavirdine (NNRTI); efavirenz and nevirapine can decrease levels. If available, lorazepam, oxazepam, and temazepam are unaffected by ARVs.</td>
</tr>
<tr>
<td></td>
<td>5 mg at night for trouble sleeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 mg two or three times a day</td>
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</tr>
<tr>
<td></td>
<td>Usual maximum 20mg a day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.12-0.8 mg/kg/day divided into 3-4 doses; under 5 years old maximum 5 mg a day, over 5 years old maximum 10 mg a day</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bromazepam</strong></td>
<td>Adults</td>
<td>Bromazepam may have even higher potential to create dependence because of rapid onset of its effects.</td>
<td>INH, intraconazole, ketoconazole can all increase benzodiazepene levels.</td>
</tr>
<tr>
<td></td>
<td>1.5-3 mg/day (maximum 6 mg a day; maximum 3 mg a day for elderly or ill patients).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children: not recommended</td>
<td></td>
<td>Benzodiazepenes can increase digoxin levels.</td>
</tr>
<tr>
<td><strong>Amitryptiline</strong></td>
<td>Adults</td>
<td>Dry mouth, sedation, hypotension; risk of overdose</td>
<td>OK with NNRTIs and NRTIs</td>
</tr>
<tr>
<td></td>
<td>Starting dose: 25-50 mg a day at bedtime</td>
<td></td>
<td>OK with PIs except lopinavir/r, ritonavir, tipranavir/r where those medications can raise the level of the antidepressant; so try to use fluoxetine instead.</td>
</tr>
<tr>
<td></td>
<td>Increase by 25 mg a week</td>
<td></td>
<td>Steroids can increase the level of the antidepressants (including contraceptives)</td>
</tr>
<tr>
<td></td>
<td>Usual maintenance dose: 100-150mg/day in single dose at night or divided into two doses; maximum 200mg a day</td>
<td></td>
<td>Phenobarbital and carbamazepine can decrease levels.</td>
</tr>
<tr>
<td></td>
<td>Adolescents and children: Not recommended</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Imipramine</strong></td>
<td>Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Initial dose 25-50mg at night; can raise by 25mg a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Usual adult dose 100-150 mg at night or divided into two or three doses; maximum 200mg a day</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Adolescents and children: Not recommended</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 4.1 - Drugs for treating anxiety - dosages, side effects, and interactions (part 1)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Common side effects</th>
<th>Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>Adults: Starting dose: 10-20mg a day (morning or night depending on side effects); wait 4-6 weeks before deciding to increase. Usual maintenance dose: 10-40mg/day. Adolescents: Starting dose 10mg a day; increase by 5 or 10mg in 1-2 weeks only if no response at all. Usual maintenance dose: 20mg a day. Children over 5 years (for anxiety): 5-10 mg a day.</td>
<td>Headache, restlessness, agitation, Insomnia, GI symptoms, sexual dysfunction. Short half-life of sertraline makes it important in higher doses to divide into more than one dose a day or can get unpleasant withdrawal feelings; sertraline (but not fluoxetine) needs to be tapered rather than stopped suddenly.</td>
<td>No specific problems for PIs or NNRTIs in HIV care; can be some variation in level of either medication. Never give along with amitryptiline or imipramine (can lead to overdose of those drugs). Interacts with many medications so check before using.</td>
</tr>
<tr>
<td>Sertraline</td>
<td>Adults: 25-200mg/day. Adolescents (for anxiety): Starting dose 50mg a day. Children 6-12 (for anxiety): Starting dose 25mg a day. Increase slowly.</td>
<td>Dry mouth, sedation, hypotension; risk of overdose.</td>
<td>Generally no problems with PIs, NNRTIs, or NRTIs. Efavirenz and darunavir/r can reduce levels of sertraline;</td>
</tr>
</tbody>
</table>

### D. Follow-up and monitoring

Anxiety problems tend to be chronic. They get better and worse over time, often in response to general life stress or re-exposure to trauma. Thus, even after current symptoms are improved, it is important to anticipate upcoming challenges and expect that there will be relapses.

If the treatment provided is psychosocial, then frequent visits can be helpful to go over relaxation skills, to provide support, and to consider if medication would be helpful.

If the patient is taking a medication for anxiety, initially they can be seen every 2-3 weeks to adjust the dose. Once they are feeling better, they can be seen every few months. Tapering the medication can be attempted after a few months of reduced concern.

It can be important to keep up good, open communication during treatment for anxiety – it is likely that patients will share additional details and problems that they did not feel comfortable talking about initially.
E. Referral criteria:

- Severe, incapacitating anxiety symptoms persists after 6 weeks of treatment
- Suicidal ideation persists
- Side effects from medication are not tolerable
- The patient appears to be in immediate danger from someone else
- There is co-occurring drug or alcohol abuse

F. Summary- Anxiety and psychotrauma

- The main characteristic of anxiety disorders is excessive fear and/ or inappropriate feelings of nervousness; fear that something bad or dangerous will happen
- The psychological symptoms of anxiety include tension, fear of going crazy, worry, panic, fear of dying, feelings of unreality, fear of losing control
- The physical symptoms are trembling, breathlessness, light headedness, dizziness numbness, tingling sensation, nausea, stomach pains, heart pounding, muscle tension, and sweating
- Anxiety disorders are classified into many subtypes based on the various characteristics of anxiety response.
- A number of medical illnesses can cause anxiety symptoms. Anemia, endocrine dysfunctions, Vitamin B12 deficiency, chronic infections, cerebrovascular diseases, alcohol and drugs are some of the conditions.
- Anxiety disorders are common in HIV infection and there are certain periods in the course of the HIV/AIDS progression with increased risk of developing anxiety disorders.
- Effective treatments for anxiety include both pharmacologic and non-pharmacologic measures.
- Relaxation methods, graded exposure to feared situation, positive thinking approaches, structured problem-solving strategies, exposure and response prevention are some of the non pharmacologic treatments of anxiety.
- In those with HIV/AIDS, helping the patient in anticipating milestones often associated with anxiety is crucial to prevent anxiety.
- SSRIs, tricyclic antidepressants, and benzodiazepines are the drugs used in anxiety; in those with HIV/AIDS interaction between ART and these anxiolytics determines the choice and dosage of the drugs.
- Anxiety problems tend to be chronic and therefore long term follow-up and monitoring should be instituted
Exercises for Module 4

1. Major symptoms of anxiety problems

Purpose: review major psychological and somatic symptoms, review questions to ask to elicit them.

Instruction: Individually list as many possible symptoms as you can in the three main categories (mental, physical, behavioral). Highlight or put a mark next to the ones you think are the most common or most important to ask about. Then, go around the group each proposing a way to ask about each of the symptoms – are they being experienced and what is their impact on the patient’s function.

2. Major triggers of anxiety

Purpose: review common sources of anxiety and situations that may trigger anxiety (including traumatic experiences)

Instruction: Individually list as many possible sources and situations as you can. Then, go around the group each proposing a way to ask about each of the situations and sources you have listed.

3. Anxiety and living with HIV/AIDS

Purpose: Identify anxiety predisposing conditions and situations in HIV infected individuals

Instruction: List as many conditions and situations as you can think of, then share ways of either asking about these situations or trying to bring them up in advance so that the patient will not become so anxious or avoidant.

Exercise 4: Initial assessment of ongoing violence.

Purpose: practice initial response to a woman disclosing domestic violence.

Instruction: Read the following short case to the participants and ask what they would do next.

Senayt is a 28-year-old woman who has been coming to your clinic for regular care. She and her husband are HIV positive; they know of each other’s diagnosis but you are aware that this has been a source of tension between them. You saw Senayt today and she seemed subdued but otherwise well, and you sent her to the laboratory for blood work. The nurse in the laboratory sent Senayt back to you for re-assessment. When Senayt rolled up her sleeve for the blood draw, the nurse observed multiple bruises, some fresh and some old. The nurse asked Senayt what had happened, and Senayt began to cry.
4. Cases to practice using the brief mental status exam and the flow chart to guide diagnosis and treatment decisions

Instructions: For each case, go through the categories of the brief mental status exam noting which details are present in the case description and what other questions you might ask the patient or family. Then use the flow chart and the reference and pocket guide materials to reach a decision about what you might need to do for the patient.

Case 1
Almaz is a 45-year-old woman who presented for evaluation of her “nerves”. She described herself as a lifetime “worrier”. She worried about everything -- her health, physical appearance and her cooking skills. The problem had worsened in the last two years. She acknowledged feeling keyed up, sleeping poorly, experiencing daily headaches and tension in her muscles. Over the last three months her anxiety and irritability have had a negative effect on her marriage and her relationship with her two children.

Case 2
A 26-year-old woman presents to the emergency department in an acutely distressed, nervous state. The emergency department staff is unable to calm her down or gain an adequate history from the patient. She complains of terrible anxiety. She is sweating a lot, tachycardic, and her pupils are mildly dilated. She is on no medications.

Case 3
A 23-year-old school teacher started to experience episodes of excessive fear with tremulousness, sweating, dizziness, and tingling in his extremities. He reported that these episodes occur when he crosses the Kelebet Road Bridge. He is now becoming fearful of crossing bridges and has to take another, longer route to go to his work.

Case 4
Habtamu is an anesthetist working in a general hospital. He came for evaluation because of his obsession with dirt or germs. Whenever he has touched something, for example doorknobs, people’s hands, or telephones, he feels contaminated and has to wash his hands excessively with soap many times per day. If he cannot wash his hands immediately, he will develop anxiety symptoms. Lately he stopped shaking hands with people, and has stopped going to operating theatre due to the fear the air is full of germs. He said that, as a health professional he believes that his excessive washing is really unnecessary, but unless he washes his hands he could not control his fear and worry.

Case 5
Abeba was only 16 when she was attacked by three men on the way home from school. They took turns screaming abuse at her and then they each raped her. Finally, one of the men, who was holding knife, threatened to stab her. He would almost certainly have succeeded had a passer-by not intervened. Feeling frightened and humiliated, Abeba did not tell her family what had happened; she made up a story about why she was upset and late coming home. For three months
after this event, she was not herself. She felt irritable and depressed, withdrew from her friends and was unable to keep the memories of the attack out of her mind. During the day, she would recall all the unpleasant details while at night she would have terrible dreams of being attacked and would wake up screaming. She began taking a longer route back home from the school as the usual route took her past the site of the attack. She felt as though her emotions were numbed, and as though she had no real future. At home she was easily startled by a door banging or any loud noise and was always watchful of any person who walked down her street past the house.

3. Role plays to practice interviewing, differential diagnosis, and psychoeducation

Instructions: Take turns being the patient, clinician, and an accompanying family member. The clinician should use the brief mental status guide to interview the patient. The clinician can then consult with colleagues about a possible diagnosis and treatment plan, including what you would do for follow-up. The clinician should then explain the diagnosis and plan to the patient and accompanying family member.

Scenario 1
Mengistu is a 32-year-old engineer working as private contractor in Addis Ababa. His work takes him to different construction sites in the country. He is not married yet. He has been sick for the last six months. He admits to a growing problem with focusing his attention on his work and concentrating while he makes designs. His stomach has been the greatest source of consistent trouble to him. His symptoms include a lack of appetite, heartburn, frequent headache and stomach bloating. He worries too much for trivial things, and become easily irritable. About a year ago, in one of his field trips, he got drunk and had unprotected sex with a bar lady. Since then he is worrying about HIV.

Scenario 2
A teenager has headaches and stomach aches many mornings and does not want to go to school. She worries a lot about her schoolwork, and is afraid that she will not do well on her exams. Her parents are starting to get irritated with her because many mornings there is a “scene” before she is ready to go to school.
**Figure 4.1 Anxiety and psychotrauma flow chart**

New or recurring problem with worry, constant tension, preoccupations
Physical symptoms
- Restlessness
- Many aches and pains that are hard to explain
- Trouble relaxing or falling asleep
- Episodes of panic (racing heart, shortness of breath)
Mental tension
- Constant worry or fear for self or others
- Hyper-alertness: always monitoring what is going on, easily startled
- Repetitive, intrusive thoughts
Behaviors
- Avoiding separation or crowds
- Avoiding reminders of feared things (won’t take HIV medications)
- Irritability (and bad behavior in children)
- Unwillingness to discuss traumatic experiences

Suicidal thoughts? Yes No

Possibly related to recent trauma Yes No

Consider medical causes
- Hyperthyroidism
- Substances
- Asthma
- Medication side effects

See depression flow sheet and whether or not suicidal consider if patient could be depressed.

Find a private place to talk
- Assess for violence between partners
- Assess for violence to children
- Assess for past traumatic experiences

Consider present safety
- Treat patient as “expert” on their situation
- Avoid easy advice
- Help make safety plan for adults and children

Psychoeducation
Self care
- Address unhelpful beliefs
  - Guilt
  - Hexing
  - Excessive demands or expectations

Consider medication if anxiety is disabling, results in reluctance to leave home, or no response to psychoeducation and advice
- Avoid prolonged use of benzodiazepenes (more than 2 weeks)
- SSRI preferred starting at low dose and working up slowly (refer to pocket guide)

For child and spouse abuse
- Refer to specialized help when available
- Involve those who can support and protect the abused child/spouse
For past torture or political violence
- Refer to specialized help

Psychoeducation
Brief advice
- Awareness of tension followed by relaxation
- Gradual exposure to feared situations
- Empathetic listening
If many bodily concerns
- Acknowledge and link to stress
- Avoid excessive treatment
5

Substance use
Substance use

Objectives for module 5

1. To be able to ask screening questions about substance use when indicated
2. To recognize medical and mental health symptoms associated with substances that require urgent treatment (especially mild to moderate alcohol withdrawal)
3. To assess relative level of use/risk
4. To give brief counseling, including recommendation to quit or cut back, strategies to quit or cut back

A. Introduction - types of disorders and commonly used substances

Substance use problems are the most prevalent of mental health problems – even more prevalent than depression, especially if one considers nicotine (smoking). In this module we talk about five commonly used “substances” – alcohol, tobacco, marijuana, khat, and inhalants. Other substances are used in Ethiopia, but these are the most common.

Intravenous substance use is relatively uncommon in Ethiopia. It is important to note, however, that in other countries (such as the USA), use of intravenous drugs (such as heroin) is a major source of HIV transmission. HIV can be transmitted through sharing or re-use of needles and syringes, using contaminated equipment to prepare drugs for injection, or sexual activity with IV drug users who have become infected with HIV.

Addiction (or dependence) is a state where the brain and body have adapted to the use of the substance to the point where it is difficult to stop or even cut back on intake. When users try to stop or cut back, they experience strong feelings – and sometimes physical illnesses – that compel them to resume use. For many people, addiction also means that they need more and more of the substance to feel its effects or avoid the ill effects of stopping (this is called “tolerance”).

As an example, the nicotine in cigarettes is strongly addictive and that is one of the reasons that it is difficult to stop smoking once one decides to try. However, people can feel strong urges to keep using substances even when they are not physically addicted. For example, in some societies, having a drink or chewing khat is an important part of socializing and the urge and pressure to use those substances can be strong.

Substance use can be harmful even if someone does not become addicted. It can have an impact on physical health, change behaviours (including promoting risky sexual behaviour and HIV acquisition or transmission), and harm families financially and legally.
Case to start discussion

Demisse is a 40-year-old man who works driving a delivery truck. When you ask, he tells you that some nights after work he will leave the truck at the depot and stop on the way home to drink several beers with friends. Then he walks the rest of the way home. Once, he stumbled in the dark, fell, and had a bad cut on his head. His wife is angry that he spends money on beer that she feels they need to buy clothes and books so that their children can attend school. He told you that when he comes home after drinking he sometimes falls asleep without taking his evening dose of ART medications.

- Have you ever met or heard about someone like Demisse?
- What do people think about people with problems like Demisse’s?
- What do people assume are the causes of these sorts of problems?
- If people try to help people like Demisse, what do they do or suggest?
- What gets in the way of getting help for people like Demisse?

B. Background on the four substances

Alcohol
Alcohol is dangerous for several reasons. In the short term, it impairs judgment, increases risky and sometimes violent behavior, and often uses up money that would otherwise go to important household needs. In the long run, it can have many serious medical effects, the most serious of which is lethal damage to the liver.

Harm from drinking can occur in the absence of addiction/dependence

- Most of the people who are harmed by and who harm others through drinking are not “dependent”
- These people are frequently not recognized as having an alcohol problem

ICD definitions are useful in thinking about the level of treatment needed. Counseling is often sufficient to help people control hazardous use. Harmful use may require counseling plus intensive support over a long time. Dependence on alcohol requires careful detoxification and then long-term support to prevent a relapse (which is common).

- Hazardous use: creates risk to physical or mental health by making other conditions worse (perhaps through not taking medication), impairing judgment, making it more likely that someone will engage in high risk behaviors (sexual, driving, harmful social relationships)
- Harmful use: already see some damage to health (physical or mental) or to others.
- Dependence/addiction: strong desire to drink, difficulty controlling use, continued use despite harmful consequences, priority to drinking over other activities, increased tolerance, physical withdrawal.

“Early” detection and intervention seem to be effective ways of helping people before they get to the harmful or dependent stage. Again, you don’t have to be dependent to be harmed. For example, many young drinkers, especially in low-income communities but across the economic spectrum, do not drink constantly and thus don’t develop dependence. But they will drink very large quantities of alcohol periodically at social events (sometimes to quell anxieties about meet-
ing others). The resulting disinhibition can lead to risky behavior; the large amount they drink can lead to acute alcohol poisoning, with death resulting from passing out and not breathing, striking their head, or choking on their vomit.

**Cannabis/marijuana**
The marijuana that is smoked comes from the tops and leaves of the plant Cannabis sativa. Hashish is a more concentrated resinous form of the plant. Marijuana can also be brewed as a tea or mixed into food. The extent of its effects depend on the concentration of the main active ingredient, THC (delta-9-tetrahydrocannabinol), so that (like khat) marijuana from different sources will have greater or lesser effects. In some countries, the marijuana may be sprayed with other chemicals or drugs to enhance its effect (or make up for low-concentrations of THC).

After smoking, the onset of effects is within 1-3 hours. Users experience
- relaxation
- increased appetite and thirst
- difficulty concentrating
- problems with learning and memory
- loss of coordination
- poor judgment, inappropriate social behavior
- at higher doses there can be hallucinations

Many of these effects are mild or subtle, and regular users enjoy the feeling of relaxation and tolerate or partially compensate for the negative effects. It is not uncommon for users to smoke marijuana throughout the day nearly every day that they can get a supply.

There is a relatively mild withdrawal syndrome experienced by some after prolonged or frequent use. It is uncomfortable but not life-threatening. Individuals feel mildly ill and experience difficulty sleeping, irritability, low mood, and nervousness.

One of main risks of using marijuana seems to be a role in precipitating or exacerbating psychotic disorders. It’s thought that marijuana use may increase the risk of becoming schizophrenic in people with a family history or other risk factors. Use of marijuana also makes management of schizophrenia and bipolar illness more difficult because it contributes to mood changes and impairs the ability to take medication regularly.

**Khat/Chat**
Khat is derived from a plant that is widely grown in east Africa. It contains chemicals (cathinone and cathine) that are similar to the stimulant amphetamine. Cathinone, the main chemical thought to be behind its effects, breaks down quickly after the leaves are picked, so there is a premium on chewing fresh leaves. In many areas, khat is picked in the morning and then rushed to market for sale and use later in the morning or early in the afternoon. There is a synthetic version, methcathinone, sometimes called goob, crank, or CAT.

Khat is not illegal in Ethiopia and it is readily available and easily grown. It is widely used to try to maintain alertness and reduce fatigue or avoid falling asleep, and by some to increase concentration during prayer. Some people also think that it increases sexual potency, although the best evidence is that it increases sexual desire but actually impairs potency. One survey in rural Ethio-
pia estimated that about a third of adults used khat (and about 10% of pregnant women), other surveys have found rates among men at 50-75%. Chat is often chewed in social settings over the course of a few hours.

When khat is chewed there is a three-phase set of reactions. Initially, after about an hour, khat causes mild euphoria with feelings of alertness and excitability. In the second phase, there is increased talkativeness and sociability, but accompanied by impaired ability to concentrate and make decisions (gezbia). Sometimes there are poorly connected thoughts (“flight of ideas”). In the third phase there can be low mood, irritability, loss of appetite, and difficulty sleeping. Chewers typically will report being tired the next morning, and some feel a strong desire to start chewing right away (a yejebena – an “eye opener”). This suggest that there is a degree of dependence occurring. These users may experience withdrawal symptoms (dukak) that include nightmares, paranoia, intense fatigue, and difficulty sleeping. For most users, however, symptoms seem to fade a few days after stopping, and the motivation to keep chewing is largely social.

Problems with khat use, especially at higher doses:

- Subsequent use of alcohol, benzodiazepenes (“Roche”), or marijunana to self-treat the irritable, sleepless final phase (if there has been heavy use of benzodiazepenes consider tapering over 2-3 months if possible. If there is evidence of acute withdrawal from benzodiazepines or alcohol, seek a consultation and initiate treatment as for alcohol).
- Development of thought problems, including grandiose delusions, hallucinations, and paranoia. With prolonged use some people report experiencing a kind of waking but dreamlike state in which, as they go about their business, they see or hear things that others do not experience. This can happen even when they are not actually chewing.
- Constipation, poor sleep, loss of appetite, blurred vision, dry mouth, and poor sexual function. Khat is thought to be a cause of oral cancer, stomach ulcers, and can cause low birth weight or spontaneous abortion when used by pregnant women.
- Khat use is thought to be a contributor to road accidents because drivers who use it to stay alert develop impaired judgment and irritability.
- In some countries, use is so constant, especially among men, that it becomes a major drain on family income.

Important considerations for primary care/ART

- Consider khat as a cause of symptoms when evaluating someone for a thought disorder
- Consider khat as a contributor to poor sleep and next-day fatigue
- There do not seem to be any “treatment” programs designed specifically for khat; the general steps outlined below to help people overcome cravings or cut down on use may be effective
  - It may be easier to help reduce use among truck drivers and others for whom use is directed at maintaining alertness versus people whose use is predominantly social

**Tobacco**

People with mental health problems are more likely to smoke than the general population. Smoking is a health hazard to the smoker and to those around him or her. Risks to others come from smoke and, with cigarettes, the risk of fire if the person smoking falls asleep before a cigarette is put out.
Smoking increases the risk of developing a number of health problems including asthma, heart disease, and a number of different forms of cancer. Use of shisha is thought to be even more harmful than cigarette smoking because, despite the use of a water filter, the smoke inhaled is stronger than the smoke of cigarettes. Shisha is sometimes also mixed with marijuana.

There is both psychological dependence and physical nicotine dependence with an unpleasant (though not dangerous) withdrawal syndrome.

**Inhalants**

A range of readily available, volatile solvents and gases are used as inhalants including aerosol sprays, butane gas, petrol, glue, paint thinners, solvents, and amyl nitrite (“poppers”). In many parts of the world, these substances are widely used among children living on the street or not in families. They are inexpensive and easy to purchase (or to take from places of work), and produce powerful and rapid effects.

- They have a combination of sedative and hallucinogenic effects.
- They can be acutely fatal – for some of the chemicals, nearly any exposure would be considered an “overdose”
- Most are capable of causing irreversible brain and liver toxicity.

**C. Presentations in ART/primary care**

People who drink (or use other substances) often appear quite normal. One of the big difficulties helping substance users is that they minimize the extent to which it causes them problems, and they rarely spontaneously volunteer that they drink or smoke (tobacco or marijuana). This is especially the case in cultures where smoking or drinking are stigmatized or go against religious beliefs and culture or gender norms. Thus, asking patients about substance use seems to be the best way to find out about possible problems.

Depending on how often medical providers ask about substances, there may be worry that patients will take offense – especially patients that seem to be at little risk. It can be helpful to say something like, “we ask everyone these questions.”

**Being called a “drunkard” is a very serious and shameful thing in Ethiopia and many patients will not think that asking about drinking is something that should happen at a medical visit. So think about how you can approach this subject tactfully, and make a case that it is something important to discuss.**

- For alcohol, the “CAGE” questions have some record of being useful in Ethiopia. The letters CAGE stand for “cut down, annoyed, guilty, and ‘eye opener’,” the key concepts of the four questions when asked in English. The questions don’t have to be asked using exactly these words, and they can likely be used to refer to other forms of substance use, too, including khat:
  - Have you ever thought you should cut down on your drinking?
  - Have you ever been annoyed by other people’s criticism of your drinking?
  - Have you ever felt guilty about your drinking?
  - Do you drink alcohol as an eye opener e.g. “yejebena”?
Identifying level of harm/severity: ask about whether the substance use interferes with these aspects of the person’s life.

1. Social – does it disrupt relationships; has it caused embarrassing behavior? Has the individual engaged in violent behavior while drinking, or have they gotten into a sexual relationship while drinking?
2. Physical – has the person been injured while under the influence of a substance, or is there evidence of medical consequences (for example, medical problems from smoking or drinking, getting into a fight while drinking)? Have they ever driven a car while intoxicated (or been in a car driven by someone who was intoxicated)? Do they operate machinery or walk along a busy road after they have been drinking?
3. Economic – is the substance use diverting money needed for other causes, or interfering with work?
4. Legal – has there been involvement in illegal acts to obtain substances?
5. Withdrawal: do you have hand shaking when not taking alcohol?
6. Tolerance: have you increased the amount/strength of alcohol in order to get the desired effect?

It a patient has withdrawal and tolerance; he might be suffering from alcohol dependence and has to be managed accordingly.

Special considerations for adolescents

1. Experimentation is common and the majority of youth who try substances do not go on to use heavily or at all; non-punitive counseling about the risks of substance use is probably most helpful.
2. As noted above, adolescents are more likely to engage in “binge” use of alcohol: that is, they don’t necessarily use often but when they do, it is a lot and associated with high risk behaviors (in the case of alcohol there can be a risk of fatal alcohol poisoning – loss of consciousness and respiratory depression or aspiration – from rapidly drinking large quantities).
3. There is worry about the relationship of substance use and sexual exploitation of some kind – it’s not unusual for young people to exchange sex for a substance supply, or to be more vulnerable to exploitation after using substances.
4. Past inhalant use may be hard to detect, but youth who are examined for acute lethargy or changes in consciousness may smell like the material that they inhaled.

D. Approaches to treatment in primary care

1. Emergency situations
Perhaps with the exception of cigarettes, all substances can lead to behavioral “crises” where people become agitated, irrational, and sometimes violent or suicidal. See the “thought problem” module and the suicide section of the depression package for thoughts about management. In general, trying to keep the person safe and calm until the crisis passes is all that can be done.
The main exception to this approach to treatment is if you suspect that someone who has chronically used a lot of alcohol (probably on a daily basis) has suddenly stopped drinking. This may happen because they run out of money, have some social crisis that cuts them off from their supply or drink, or become ill and cannot drink (for example, because they have been admitted to a hospital). Alcohol withdrawal is a serious medical condition and can lead to fatal seizures.

**Emergency care for alcohol withdrawal**

Individuals who drink on a daily basis are at risk for dependence

- Signs of withdrawal include hands shaking, nausea, sweating, feelings of anxiety, increased heart rate and blood pressure, and can include visual and tactile hallucinations. Symptoms usually start within 24-48 hours of stopping drinking but can start as long as five days later. If you are already noticing these symptoms, ideally admit the patient to a hospital and treat the withdrawal as in Table 5.1. Seizures are an ominous sign and can be fatal. Watch pulse and blood pressure; if they remain elevated treat with additional benzodiazepene.

- If someone has been drinking heavily and continuously (nearly every day) consider that they are at risk for withdrawal symptoms. If they plan to stop suddenly, prescribe the regimen listed in Table 5.1.

- If the patient has liver disease they are at risk for becoming overly sedated by diazepam. Carbamazepine or valproic acid (see epilepsy module) can be used instead, with the choice dictated by interactions with other medications the patient may be taking. One possible tapering regimen for carbamazepine is to start with 200mg orally 4 times on the first day, 3 times on the second day, 2 times on the third day, and then once a day for two more days.
### Table 5.1- Treatment of alcohol withdrawal

<table>
<thead>
<tr>
<th>Day of treatment</th>
<th>Inpatient regimen</th>
<th>Outpatient regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 and 2</td>
<td>Diazepam 10mg orally every 8 hours and Thiamine 100 mg IM once and folate 1mg IM or orally BEFORE ANY IV fluids containing glucose</td>
<td>Diazepam 10mg orally twice a day and Vitamin B compound tablet (contains 200mg thiamine) and folate 1mg twice a day</td>
</tr>
<tr>
<td>Day 3 and 4</td>
<td>Diazepam 10 mg orally every 12 hours and Thiamine 100 mg IM once</td>
<td>Diazepam 5mg orally twice a day and Vitamin B compound tablet twice a day.</td>
</tr>
<tr>
<td>Day 5</td>
<td>Diazepam 5 mg orally every 12 hours and B-complex vitamins orally once</td>
<td>Diazepam 5 mg orally once and one Vitamin B compound tablet</td>
</tr>
<tr>
<td>Day 6</td>
<td>Diazepam 5 mg orally at bedtime and B-complex vitamins orally once</td>
<td>Diazepam 5 mg orally once and one Vitamin B compound tablet</td>
</tr>
<tr>
<td>Subsequent days</td>
<td>Continue B-complex vitamins for 3 months</td>
<td>Continue B-complex vitamins for 3 months</td>
</tr>
</tbody>
</table>

Source: Drs. Haddis and Teshome, Amanuel Hospital and Addis Ababa University

### 2. Care for hazardous or harmful substance use in primary care

It is important to ask about substance use routinely, at least at intake/initial evaluation. This is not just for detection – It helps to create the “norm” that it would be good to stop and makes it a reasonable topic for conversation in the medical setting. There is good evidence that brief counseling is effective for lesser severity substance use. Take an empathetic and non-judgmental but clear stand.

1. It would be better if you cut down or abstained from using these drugs
2. I understand the difficulty of doing it but I am optimistic that you can succeed
3. I am willing to help you make plans and provide some ideas on how to do it
4. I am willing to help you think about where this falls in relationship to other goals and priorities

Based on what you have found out when getting the history of use:

1. Give empathetic but clear feedback about the risk of harm to themselves or others.
2. Clearly state that the person should make a change in their use, but don’t be judgmental – that is, you should make a change, but not because you are a bad person, just because, given what you have told me about the consequences, it is the right thing to do.
3. Suggest a range of strategies that the person might use to change their behavior. Some examples include:
   - Identify the settings where someone is at high risk to drink or use the substance and plan to avoid them. Who is it with, where does it take place?
- When there is use, what kind of rules can the person make to limit their consumption?
- What alternatives to use might there be?
- Is there a family member or friend who will help you cut back?

4. Ask the person to set a goal for cutting back: when will it start, what will be goals for amount used at any one time or in a week?

5. Provide advice on reducing or ceasing use – all of the substances discussed (including smoking) have unpleasant physical and emotional sensations associated with quitting
- Recognition of withdrawal symptoms and advice for coping, such as using a toothpick for desire to smoke
- Try putting use off for even 10 minutes – sometimes a craving will pass
- Suggest other strategies for managing stress or for feeling comfortable in social interactions (frequent reasons cited for smoking, drinking, and use of marijuana)

**E. Follow-up and monitoring**

When people are actively using a substance, it is unlikely that you will convince them to stop with a single discussion. Again, using good communication skills to understand their motivation for using drugs or alcohol will help. There is good evidence that patient reminders about the desirability of quitting, and gentle but truthful information about harms, will help people stop.

Once someone has engaged in an attempt to quit, be prepared for relapses. Most people will make several attempts to quit or cut down before being successful. Relapse doesn’t mean that the prior plan was bad, but that it may need renewed support and commitment or analysis of new stressors or situations

**F. Referral criteria**

1. Severe alcohol dependence and withdrawal, or concern that the patient has been drinking heavily and steadily and could experience withdrawal
2. If the patient is suicidal
3. Substance use seems complicated by other mental health problem (anxiety, trauma, depression)
4. Multiple attempts to reduce use with brief counseling and community support have failed

**G. Summary – Substance related disorders**

- Psychoactive substances are chemicals which, when taken into the body, alter its function psychologically.
- Each psychoactive substance when taken can lead to acute disturbances, like intoxications, or to long term consequences like harmful use or “abuse”, or dependence which could be psychological and/or physical
- Alcohol is one of the commonest substance which can cause multiple forms of psychiatric manifestations including delirium, dementia and psychosis
- Early detection, through rapid screening tools (e.g. CAGE), intervention counseling and
drug treatment for specific condition like alcohol withdrawal, and alcohol induced psychosis are the major components of management of alcoholism

- Adolescents and young adults are more and more affected by cannabis use. Its use can lead to acute delusional symptoms as well as withdrawal symptoms.
- Khat is a milder psychostimulant widely used in Ethiopia. Khat is known, in susceptible individuals, to lead to psychotic states: transient psychotic disorders, manic symptoms, or paranoid reactions. It will also exacerbate or cause the relapse of preexisting psychotic disorders.
- Khat causes mainly psychological dependence rather than physical withdrawal symptoms.
- There is high comorbidity of substance use and HIV. There is high risk of acquiring HIV in substance users. Substance use can also complicate the course of HIV disease and adherence to ART treatment is negatively influenced by substance use.
- Apart from emergency management, like in the case of alcohol withdrawal, a long-term treatment approach is the mainstay of combating substance abuse and dependence. There are a range of strategies that the person might use to reduce or cease to use substances.
Exercises for Module 5

1. Major symptoms of substance problems

Purpose: review major indicators of harmful substance use and of substance dependence

Instruction: Individually list as many possible symptoms as you can in these two main categories. Highlight or put a mark next to the ones you think are the most common or most important to ask about. Then, go around the group each proposing a way to ask about each of the symptoms – are they being experienced and what is their impact on the patient’s function.

2. Asking patients about substance abuse

Purpose: review ways of systematically asking patients if they use substances

Instruction: Write down the “CAGE” questions for alcohol; ask them to a partner and then say what you would ask in addition if any of the answers were “yes.” Say how you would ask about other substance use a) for a patient you had just met; b) for a patient who has told you in the past that they drink or use khat.

3. Substance use and HIV

Purpose: To summarize the relationship of substance abuse/dependence and HIV

Instruction: Discuss how substance abuse can influence acquisition of HIV and adherence to treatment.

4. Cases to practice using the brief mental status exam and the flow chart to guide diagnosis and treatment decisions

Instructions: For each case, go through the categories of the brief mental status exam noting which details are present in the case description and what other questions you might ask the patient or family. Then use the flow chart and the reference and pocket guide materials to reach a decision about what you might need to do for the patient. Describe your treatment or counseling. Make sure you think not just about substance abuse but other conditions that can develop along with it or be complications.

Case 1
A 35-year-old taxi driver is brought to the clinic by his wife. She says that he has been acting oddly at home and claiming that he sees rats climbing the walls. He looks ill and worried. His pulse is 100 beats per minute, his blood pressure is 170/95 mm Hg, and he is shaking and sweating. He says he has not been able to sleep for two nights. He has been a daily drinker since age 19, but, after a near miss on the road where he came close to running down an old woman, he vowed not to drink and has not had any alcohol in the last 3 days.
Case 2
Mimi is a 17-year-old girl who has come for the evaluation of abdominal pain. The nurse thought that she was a little unsteady as they took her weight and signed her in to the clinic. She admitted to smoking marijuana and tobacco that she obtained from “friends.”

Case 3
Ato Bedru brought his nephew, Jemal, to the clinic because of a two-week period of unusual and frightening behavior. Jemal is a 25-year-old trader from Wolkitie who has been chewing khat since his early teens. In the last six months he has increased his consumption. He now chews every afternoon and evening. He lost property worth 5000.00 Birr six months ago. Two weeks ago he stopped going to his kiosk altogether. He is sleepless, restless, talks to himself, and shows suspicion towards his uncle. He is convinced that the property he lost was taken by the police because they were notified by his uncle.

5. Role plays to practice interviewing, differential diagnosis, and psychoeducation

Instructions: Take turns being the patient, clinician, and an accompanying family member. The clinician should use the brief mental status guide to interview the patient. The clinician can then consult with colleagues about a possible diagnosis and treatment plan, including what you would do for follow-up. The clinician should then explain the diagnosis and plan to the patient and accompanying family member.

Scenario 1
You’ve been talking to Ato Geremew, a patient in his 40’s. He is here with his wife. For the last 7 years he has been working as a steward in a local “Tej bet”. When he arrives, he is shabbily dressed, smells of alcohol, and he has a lot of bruises on his head. He responds vaguely to your question about whether he ever drinks alcohol, but does say that he’d like to cut back. Ask him some other questions that might get at his drinking history, and giving him some advice on how to do it.

Scenario 2
Demisse is a 40-year-old man who works driving a delivery truck. When you ask, he tells you that some nights after work he will leave the truck at the depot and stop on the way home to drink several beers with friends. Then he walks the rest of the way home. Once, he stumbled in the dark, fell, and had a bad cut on his head. His wife is angry that he spends money on beer that she feels they need to buy clothes and books so that their children can attend school. He told you that when he comes home after drinking he sometimes falls asleep without taking his evening dose of ART medications. But he also is firm with you that he doesn’t have a drinking problem – he says that many of his friends drink more, and his wife and children have everything that they need.
Figure 5.1- Substance use flow chart

Concern for use of tobacco, alcohol, khat, un-prescribed medications, or illegal drugs
Ask routinely at initial visit and periodically
  • If patient reports use, at routine visits ask about continued use and level

Possible emergencies
  • Alcohol or benzodiazepine withdrawal
  • Caused by sudden cessation or being cut off from supply
  • Psychotic symptoms: paranoia, hallucinations

Urgent treatment
  • Medical treatment for alcohol or benzodiazepine withdrawal
  • Safety precautions and possible treatment of psychotic symptoms

Assess level of harm/consequences
  • Social
  • Physical health and safety
  • Economic
  • Legal
  • Empathetic but clear feedback about risks

Treatment for severe, hazardous use
  • Refer to specialist if available
  • Consider how to counsel family to support intensive treatment
  • Outpatient alcohol detoxification

Is there another mental health problem?
  • Depression, anxiety, trauma
  • Chronic psychotic problems

Assess and treat underlying problem simultaneously
  • See corresponding flow charts
  • Chronic psychotic problems

Empathetic, clear feedback about recommendation to quit or cut back
  • Would be better for patient and family
  • Recognize difficulty personally and perhaps socially but confident it can be done given time
  • Willing to help when patient feels they are ready to try

Suggest strategies for cutting back or quitting
  • Identify settings and cues to use and possibility of avoiding or changing them
  • Identify alternatives to use
  • Anticipate withdrawal symptoms and ways to relieve them
  • Discuss ways to put off cravings

Make a plan to start
  • Set a date
  • Set goals for reduced use
  • Identify a supportive family member or friend to help
  • Anticipate set backs and make plans to continue trying or start again

Long-term follow-up
  • Monitor at regular visits
  • Anticipate relapses and re-assure that these happen
  • Trouble-shoot quitting plan and try again when needed
Module 6

Epilepsy
Objectives for Module 6

1. Be able to identify seizures by history and if directly observed
2. Be able to react appropriately when a seizure is witnessed
3. Understand situations in which some rapid medical intervention is needed for a seizure
4. Be able to prescribe an initial medication for seizure treatment and understand when treatment is appropriate
5. Be able to educate patients and families about the causes of seizures, their lack of relationship with mental health problems, their treatment, and prognosis

A. Types of disorders

Seizures are very common, affecting up to 1 in 100 people, half of whom are thought to have active seizures (had one in the last 2 years) (Berhanu 2004, 2009). Probably only 10% of Ethiopians with epilepsy ever get treatment. Seizures are even more common among people living with HIV because of the increased risk of infections and stroke associated with the illness.

Seizures are caused by abnormal impulses in a part of brain that change behavior, movements, and consciousness. In many countries, seizures are not considered mental health problems, but traditionally in Ethiopia they have been treated by psychiatrists. However, for reasons that are not understood, people with epilepsy do seem to have a higher prevalence of mental health problems than those in the general population.

Table 6.1. Causes and beliefs about seizures and epilepsy

<table>
<thead>
<tr>
<th>Cause of seizures and epilepsy</th>
<th>Traditional concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Brain tumor</td>
<td>• It is insanity</td>
</tr>
<tr>
<td>• Perinatal injury to brain</td>
<td>• Possession by evil spirits</td>
</tr>
<tr>
<td>• Head injury</td>
<td>• Bewitchment, sorcery</td>
</tr>
<tr>
<td>• Cerebrovascular disorder - stroke</td>
<td>• It is contagious (especially if you hold or are near someone with a seizure)</td>
</tr>
<tr>
<td>• Brain infections</td>
<td>• You can treat it by lighting a match or burning something, or by writing something and erasing it</td>
</tr>
<tr>
<td>• Alcohol - Chronic intoxication, withdrawal</td>
<td></td>
</tr>
<tr>
<td>• Genetics – familial</td>
<td></td>
</tr>
<tr>
<td>• Hypoglycemia</td>
<td></td>
</tr>
</tbody>
</table>
Case to start discussion

Ato Girma, a 51-year-old chauffeur from Addis Ababa, came with a 2-year history of repeatedly falling down, loss of consciousness and generalized convulsions. Just before falling down he develops a deviation of his head to the right side. When he regains consciousness, he develops a severe headache and transient weakness of the right side of the body. In the last 8 months he additionally has had headaches at other times and marked forgetfulness. He has neither diabetes nor hypertension. There is no family history of epilepsy.

- Have you ever met or heard about someone like Girma?
- What do people think about people with problems like Girma’s?
- What do people assume are the causes of these sorts of problems?
- If people try to help people like Girma, what do they do or suggest?
- What gets in the way of getting help for people like Girma?

Classifying seizures

Seizures are classified in many ways that can be quite complicated. For initial recognition and management in primary care, one can think first of three types:

1. Generalized seizures resulting in immediate loss of consciousness – once the seizure starts, the person is completely unaware of what is happening.
2. Partial seizures involving either no loss of consciousness or loss is delayed after the start of the seizure
3. Psychogenic seizures involving behavior that, to an observer, may look like a seizure but that don’t seem to be associated with abnormal brain impulses.

The main reason for differentiating seizures is that treatment may differ (either different medications or no medication at all). However, treatment also depends on what one thinks is the underlying cause of the seizure. Presentations and causes are discussed below.

B. Presentation/detection in primary care/ART

Occasionally someone will have a seizure in a clinic or office, but more often they will come or be brought in after having one or more seizures somewhere else. Although there are some tests (notably a brain wave recording -- EEG) that can help with the diagnosis, the most important step in diagnosis is getting an account from the patient and someone who saw the seizure. By asking, you are trying to fit the seizure into one of the three major patterns and also thinking about possible causes. These categories are summarized in Tables 6.2 and 6.3.

Questions include:

- Whether there was loss of consciousness or loss of awareness, body jerking all over (grand mal seizure).
- Whether there is absent-mindedness at other times (possible absence/petit mal episodes).
- Whether there is amnesia for the period that the seizure seems to have occurred (found in generalized seizures and partial seizures)
- Whether any other behavioral changes have been noticed (possible partial seizures or psychogenic seizures)
- Whether this is the first seizure or if there have been any in the past
  o New onset of a seizure disorder outside of the syndrome of a febrile seizure in children raises the concern for an identifiable underlying problem (though ultimately about half of all seizure problems go unexplained)
  o At least two seizures in the past year on different days and without a cause raises the concern for epilepsy (seizure disorder without a known cause)
- Are there neurologic changes, headache, fever, or history of head trauma? These might lead to the need for more medical evaluation.
- Could the patient have taken a poison or is the person taking any medication?

Epilepsy is another stigmatized condition – it is possible that family members who have seen someone have a seizure will not tell the person what happened. So asking for information from other family members is sensitive but often necessary. In Ethiopia, people frequently don’t come for care for seizures until they have had the problem for years.

1. Generalized seizures: the most common form of generalized seizure (and the one that most people think of when they hear the term “seizure” is the “grand mal.” These can have their onset at nearly any age of life. Grand mal seizures involve four phases; family members or observers can usually describe the last two:
   1. Prodromal subjective phenomena: for minutes, hours or days – often only the patient can talk about this. It may be manifested as a change in mood – irritability, depression, or being easily startled
   2. Aura: occur seconds to minutes – similarly, often only the patient can report about this – a feeling that the seizure is about to happen; may pass so quickly that the person isn’t aware of it. Sometimes it involves some twitching or numbness in a particular part of the body.
   3. The seizure: three phases that usually last a few minutes.
      a. Tonic phase- tonic contraction sudden cry, tongue biting may occur, urine incontinence
      b. Clonic phase - clonic jerks, frothing of saliva, generalized sweating
      c. Terminal phase - remain unconscious but still
   4. Post ictal phase - headache, drowsiness, confusion state – with no memory of the seizure itself

However, another form of generalized seizure is harder to detect. These are “absence” or “petit mal” seizures. They usually start in childhood (ages 5-9). In contrast to grand mal seizures, there are fewer visible movements and they last only a few seconds. They can be very difficult to detect. Also in contrast to grand mal seizures, people may remember what happened and they rarely will be incontinent or harm themselves. Clinically:
   1. No aura symptoms
   2. Sudden interruption of consciousness - patients become motionless, stop talking, stare blankly, cease to respond – but only for a few seconds
   3. May have some slight clonic movements- eyelids, facial muscles, fingers, but these are subtle and pass quickly. Sometimes they resemble “normal” actions such as licking the lips or chewing
2. Partial seizures: are sometimes considered as a cause of odd behavior because they can involve longer (2-3 minute) periods of what can look like “normal” behavior even though the person is not aware of what they are doing and will not remember it. Partial seizures can have three components

- An aura, often accompanied by hallucinations
- The seizure which can involve:
  1. Alterations in psychic function- perceptual distortions
  2. Motor disturbance – simple automatism like lip smacking, sucking or turning the head
  3. Complex automatic behavior – e.g. laughing, running, picking, undressing
- Postictal phase – amnesia for the seizure, deep sleep, headache

3. Psychogenic seizures: are behaviors that look like a seizure (at least a little) but do not seem to be related to abnormal electrical activity in the brain. Psychogenic seizures don’t fit any of the patterns of generalized or partial seizures described above. Patients with this form of seizure may report odd and often complicated sorts of feeling and hallucinations that go beyond the visual changes that are reported in auras of partial seizures. These may include feelings of floating or that everything that has happened has happened before. They will report jerking or other involuntary movements, but will rarely if ever fall in a way that they are injured or have incontinence. Psychogenic seizures often last longer than generalized or partial seizures. People with psychogenic seizures have often seen someone else have a seizure or have heard them described.

### Table 6.2 Characteristics of most common types of seizures

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Aura</th>
<th>Activity during seizure</th>
<th>Anmesia</th>
<th>Post-ictal phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalized</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand mal</td>
<td>Seconds to minutes, feeling or twitching in part of the body</td>
<td>Tonic-clonic followed by unconscious terminal phase</td>
<td>Yes</td>
<td>Headache, drowsiness, confused</td>
</tr>
<tr>
<td>Petit mal</td>
<td>None</td>
<td>Very briefly (only seconds) motionless, stare, stop responding</td>
<td>Variable</td>
<td>No</td>
</tr>
<tr>
<td>Partial</td>
<td>Can include hallucinations</td>
<td>2-3 minutes of behaviors ranging from small motions of head or face to complex activities</td>
<td>Yes</td>
<td>Headache, deep sleep</td>
</tr>
</tbody>
</table>
Table 6.3 Psychogenic versus generalized seizures

<table>
<thead>
<tr>
<th>Cause of seizures and epilepsy</th>
<th>Psychogenic seizure</th>
<th>Grand mal epilepsy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>gradual</td>
<td>Sudden</td>
</tr>
<tr>
<td>Tongue bite</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Incontinence</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Nocturnal occurrence</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Injuries</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Eyes</td>
<td>Closed</td>
<td>Open, turn upward, side ward</td>
</tr>
<tr>
<td>Postictal state</td>
<td>Alert</td>
<td>Confused</td>
</tr>
<tr>
<td>Recollecting events during the attack</td>
<td>Not impaired</td>
<td>Amnestic</td>
</tr>
</tbody>
</table>

C. Approach to treatment in primary care/ART

History of a first seizure. Several medical conditions can provoke a seizure, and for most of these some form of urgent treatment can be lifesaving. Causes to consider include:

- Hypoglycemia (especially if a diabetic has taken insulin and not been able to eat)
- Head injury that has caused delayed bleeding inside the head
- Stroke
- Meningitis or encephalitis (including cerebral malaria)
- Alcohol withdrawal
- Hypertension in pregnancy (pre-eclampsia)
- Some medications make it more likely that someone will experience a seizure spontaneously. These include some of the antipsychotics.
- In the setting of HIV and low CD4 count, consider opportunistic infections (see Table 2.1) including tuberculosis, toxoplasmosis.
- In children, febrile seizures

Emergencies and urgent issues

Management during acute grand mal seizure

Should do:

- Move patient away from water, fire, traffic, or any other hazard
- Take away any object that could harm the patient that he or she might be holding
- Loosen tight clothing, remove eye-glasses
- Put something soft under the head
- Turn patient to the side
- Remain with the patient until he regains consciousness, then begin evaluation; if it’s thought that the seizure could have resulted from alcohol withdrawal, begin the treatment protocol for that immediately.
Do not:
- Put anything (e.g. tongue plate) into the mouth
- Light matches
- Give anything to drink, including “tebel” (holy water), until the patient has completely regained consciousness
- Try to stop the convulsion by force or by holding tight
- Give diazepam or any other medication (except during status epilepticus or a series of seizure attacks)

**Prolonged seizures:** If a seizure lasts more than 5 minutes, prepare to try to stop it with medication: diazepam 10mg IV slowly or rectally, or lorazepam 4mg (adult doses), [child dose of diazepam is 1mg/year of age up to 10 or 0.2-0.5mg/kg] and then proceed with an evaluation. Again, if it’s thought that the seizure could have resulted from alcohol withdrawal, begin the treatment protocol for that immediately. If the seizure does not stop 10 minutes after the first dose of diazepam, give a second dose.

**Treatment of seizures if the cause can’t be determined or treated separately**
All of what is described below applies to generalized and partial seizures – see the particular section below if psychogenic seizures are suspected. In general, if a person experiences a second seizure, or if the condition that seems to be causing the seizures can’t be immediately resolved, the medical treatment is indicated.

**General non-drug measures**
Physical and mental hygiene seems to be able to reduce the frequency of seizures
- Regular hours of sleep
- Avoid substances – alcohol, hashish, cigarettes
- Avoid dangerous situations
- Moderate physical exercise

**Patient education/counseling**
- Not insanity or a curse
- Does not have to be disabling. Epileptics can have a fulfilling life in every aspect
- Not contagious
- Drug treatment does not contradict faith based treatment e.g. tebel, prayers
  - Antiepileptic drugs should not be discontinued during these religious treatments
  - Tebel should not be given during a seizure
- Long term treatment is usually required
- Some professions may not be suitable e.g. being a chauffeur
- For children with non-febrile seizures:
  - Except for some limitations, a child with epilepsy can participate in any activity
    - Most sports are safe
    - Should never swim alone (no one should, even if they don’t have epilepsy)
  - Should be educated, should be sent to school
  - Should not be spoiled “because of the illness”
Medication
- Select the appropriate medication for the type of seizure
- Use only one medication initially
- Start with the smallest suggested dose
- Gradually increase aiming for complete control of seizures at lowest possible dose. For example, for an adult with grand mal seizures who can come to the clinic fairly easily, start with phenobarbital (comes as 30mg and 100mg tablets) 60 mg a day for one month, then increase to 100mg a day if seizures persist. Increase by 30-40mg a day each month. If control is not achieved at 200mg a day, or there are intolerable side effects, start a different medication at the lowest possible dose while lowering the phenobarbital in corresponding steps (“cross tapering”)

In primary care, carbamazepine, phenytoin, or phenobarbital are reasonable first choices except when absence/petit mal is suspected, in which case sodium valproate is preferable. In HIV care, sodium valproate is preferred because it has minimal interactions with anti-retroviral medications.
- See Table 6.3 for doses, side effects, and interactions with other medications
- Generally treat for 2-4 years after last seizure and then attempt to discontinue

Treatment of psychogenic seizures
- Attempt to understand underlying issues
  - Often associated with anxiety – can be considered another somatic presentation of a mood problem
  - Despite “non-organic” cause, most patients will not be consciously aware that the fit is voluntary
  - Occasionally a form of malingering (conscious attempt to get out of something – for example, to avoid work or military service)
- Make linkage with the distress; avoid use of “pseudo” label as there is a risk of provoking resistance. The goal is to help the patient feel that the underlying cause of their problems is understood and being healed, so that the seizures are allowed to stop without the patient being forced to admit that they were not “real.”
- Encourage the patient to return to normal activity
# Table 6.4 Medications for seizures: doses, side effects, and interactions

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Dose range</th>
<th>Side effects</th>
<th>Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenobarbital</td>
<td>Adult dose 60-200 mg/day</td>
<td>Mental dullness, sedation, drowsiness, skin rash, hyperactivity in children</td>
<td>Can decrease PI and NNRTI levels (OK with NRTIs). Not recommended for use with LPV/r.</td>
</tr>
<tr>
<td></td>
<td>Child dose 2-3 mg/kg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phenytoin</td>
<td>Adult dose 100-400 mg/day</td>
<td>Gum hypertrophy, skin rash, hirsutism, neuropathy, ataxia,</td>
<td>Can decrease PI and NNRTI levels (OK with NRTIs). Not recommended with LPV/r. If have to use with LPV/r, may need higher dose of both LPV and phenytoin.</td>
</tr>
<tr>
<td></td>
<td>Child dose 4-7 mg/kg/day</td>
<td>slurred speech</td>
<td></td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Adult dose 400-1600 mg/day</td>
<td>Skin rash, leukopenia, elevated liver enzymes</td>
<td>Can decrease PI and NNRTI levels (OK with NRTIs). Not recommended with LPV/r. Carba-</td>
</tr>
<tr>
<td></td>
<td>Child dose 10-20 mg/kg/day</td>
<td></td>
<td>mazepine toxicity possible when used with RTV.</td>
</tr>
<tr>
<td>Sodium valproate</td>
<td>Adult dose 600-1200 mg/day</td>
<td>Liver toxicity, alopecia</td>
<td>Minimal or insignificant interaction with antiretrovirals.</td>
</tr>
<tr>
<td></td>
<td>Child dose 20-40 mg/kg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethosuximide</td>
<td>Adult dose 750-1500 mg/day</td>
<td>Nausea, vomiting, drowsiness</td>
<td>Ritonavir can increase ethosuximide levels; may need to reduce ethosuximide dose by more than half.</td>
</tr>
<tr>
<td></td>
<td>Child dose 20-30 mg/kg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam for prolonged seizure (over 5 minutes)</td>
<td>Adult dose 10 mg IV slowly or rectally</td>
<td>Sedation, respiratory depression</td>
<td>All PI’s can increase levels of diazepam and bromazepam; efavirenz and nevirapine can decrease levels. If available, lorazepam, oxazepam, and temazepam are unaffected by ARVs. In emergency situation use diazepam as needed but watch for respiratory depression.</td>
</tr>
<tr>
<td></td>
<td>Child dose 1mg/year of age up to 10 or 0.2-0.5mg/kg, IV slowly or rectally</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 6.4. Medications for different types of seizures**

<table>
<thead>
<tr>
<th>Type of seizure</th>
<th>Anmesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial seizure</td>
<td>Carbamazepine, phenytoin, phenobarbital</td>
</tr>
<tr>
<td>Grand mal epilepsy</td>
<td>Sodium valproate, carbamazepine, phenytoin, phenobarbital</td>
</tr>
<tr>
<td>Petit mal epilepsy</td>
<td>Sodium valproate, ethosuximide</td>
</tr>
<tr>
<td>Atypical Absence, Myoclonic, Atonic</td>
<td>Sodium valproate</td>
</tr>
<tr>
<td>Psychogenic seizures</td>
<td>Usually none, possibly medication for anxiety</td>
</tr>
</tbody>
</table>
D. Special conditions in epilepsy

1. Status epilepticus. Convulsive status epilepticus is diagnosed when two or more seizures occur in close succession without consciousness being regained, or if a seizure lasts more than 30 min. It is a serious medical emergency.
   A. General supportive measures for the unconscious
      - Side positioning
        - Institute IV line if possible and give 50% glucose 25-50 ml IV slowly with thiamine 100mg IV (2-5ml/kg of 10% glucose in children)
        - Control fluid input and urinary output.
        - Frequent check-up of vital signs – especially respiratory rate
   B. Drug treatment: another dose of diazepam 10 mg IV slowly or rectally. If no response, another 10 mg IV slowly; for children 0.2-0.5 mg/kg or 1mg/year of age.
   C. Ongoing monitoring respirations, heart rate, and blood glucose
   D. If not responding to second dose of diazepam, send to a hospital with an ICU unit.
   E. Start on a maintenance dose of anticonvulsant (see below the dose and preferred drugs for the various types of seizures)

2. Febrile seizures (young children)

Criteria
   - Most common from 6 months to about 5 years of age
   - Occurs while child is febrile – usually a high fever
   - Generalized seizure that lasts for less than 15 minutes
   - Afterwards the neurologic exam is normal
   - The child has not had some other neurologic problem (other than a previous febrile seizure)

Treatment
   - No specific treatment other than to try to reduce the fever, though this is not an emergency
   - Look for the cause of fever (including meningitis, CNS malaria) and treat it if possible

Prognosis for febrile seizures
   - 30% of those with one will have another with a subsequent episode of fever
   - Long term risk of epilepsy 2% compared to 1% in general population (so still very low)
   - An exception is when the “febrile seizure” occurred during an episode of cerebral malaria – these may occur outside the usual age range for febrile seizures and are different from the brief, generalized seizures that happen with other febrile illness (they may last longer, not fully generalize). The recurrence rate for children who have seizures in context of cerebral malaria seems to be much higher.
3. Epilepsy, contraception, and pregnancy

To prevent contraceptive failure among women taking an anticonvulsant
- Higher estradiol-containing contraceptive (50 ug) preferable since phenytoin, phenobarbital, carbamazepine, and some other medications reduce the effectiveness of the contraceptives; if possible use valproate or gabapentin, which don’t change the metabolism of the contraceptive
- Levonorgestrel implant not recommended

For seizures during pregnancy and immediately after
- For new onset of seizures in the second half of pregnancy or up to 1 week post partum, rule out eclampsia (take blood pressure). If elevated give magnesium sulfate 10 grams IM (5 grams = 10ml of 50% solution; give 5 grams in each buttock with 1ml of 2% lidocaine in the same syringe). Refer urgently to hospital.
- If a woman has had seizures prior to pregnancy, never stop medication during pregnancy, labor or breast-feeding if it has been effective in controlling seizures
- Avoid poly-drug seizure therapy during pregnancy – all the seizure medications probably have teratogenic effects, but combinations are worse
- Avoid carbamazepine and sodium valproate during pregnancy if possible (associated with neural tube defects) but may be indicated if warranted by the severity of the seizure disorder. Give fefol tab (4mg folic acid/day) during the whole pregnancy
- If family history of congenital malformation – ultrasound, alpha-fetoprotein testing from10-12th week of gestation onwards (if available)
- Delivery should be in a health institution for women with a history of seizures
- Give vitamin K for the mother – 10mg/day orally, from the 36th week of gestation until delivery
- Give vitamin K for the new born - 1mg IM stat at birth
- Weaning should be gradual to avoid withdrawal symptom from the seizure medication in the baby

4. Depression and epilepsy

Depression is the most common mental health complication of epilepsy. As many as half of people with epilepsy (reports say 20-60%) suffer from depression at some point in their lives, and the risk of suicide is five times that of the general population. The reason for the link between depression and epilepsy is not known, but it is important to ask patients with epilepsy about their mood.

5. HIV and epilepsy

- In the context of HIV, most new onset seizures will be grand mal and will be caused by CNS infections, aneurysms, and tumors.
- For unknown reasons, there seems to be a higher risk of seizure recurrence among individuals with HIV who have a first seizure.
  - Consider maintenance treatment after first-onset seizure, even if there seems to
have been a cause that was treated

- Be wary of drug-drug interactions
  - Between ART and anticonvulsants (see pocket guide)
  - Between anticonvulsants and other drugs
- Drug toxicity
  - Because HIV directly infects the brain, it may be more sensitive to drugs and their side effects. Start with low doses of medications.
- No anticonvulsant has absolute contraindication in HIV
  - Valproate – the fewest medication interactions
  - Carbamazepine – can cause bone marrow depression that may make HIV-related bone marrow issues worse
  - Phenobarbital – can cause over-sedation
  - Phenytoin – can be neurotoxic

**E. Case management and long-term follow-up**

Prognosis for adults with seizure disorders

- ~70% full control with medication
- 5-10% have refractory seizures – despite adequate doses of medication still have seizures

After starting anticonvulsants, see initially at monthly intervals to check on effectiveness and side effects. Even if there are no further seizures, if the patient is taking ART, see them more often than you might usually until certain that there are no emerging side effects.

If general maintenance of medication for many years is required

- Adherence is often a difficult problem because of side effects of medication
- After 2-4 years of seizure-free time consider a very gradual taper of medications

**F. Referral criteria**

1. Status epilepticus not responding to initial diazepam IV treatment (emergency transfer to hospital)
2. New onset of seizures with any localizing/focal neurologic signs (emergency transfer to hospital)
3. Seizures in pregnancy (emergency if elevated blood pressure)
4. Seizures that can not be controlled on a single anticonvulsant (or can only be controlled with side effects that are difficult to tolerate)
5. Seizures accompanied by loss of mental or physical abilities over time (seen in some childhood disorders)
6. Diagnostic challenge. Not clearly one type of seizure, or “intractable” but likely psychogenic seizures
7. Medication challenge. Combination of ART and other medications seems to make it impossible to use correct, available anticonvulsant.
G. Summary - Epilepsy

- Epilepsy has a higher prevalence rate in HIV/AIDS cases as compared to the general population
- There are different types of epilepsy, each with a different mode of clinical manifestation
- Detailed history-taking is the mainstay of diagnosis of epilepsy
- Effective treatments are available for epilepsy; specific anticonvulsant medications are effective for specific types of epilepsy
- Status epilepticus is a medical emergency requiring immediate measure
- Drug side effects and drug-drug interactions between ART and Anticonvulsant should be monitored closely when treating epilepsy in HIV/AIDS cases
- Psychoeducation is a very important component of management and should include: epilepsy is not insanity, or contagious; stigmatizing or overprotection could lead to additional mental disturbance; avoiding precipitating and dangerous situations
- Long-term drug treatment and case management is required
Exercises for Module 6

1. Causes of epilepsy

Purpose: review causes and also common beliefs about epilepsy, be able to explain causes to patients in a way that incorporates common beliefs when possible

Instruction: in pairs or groups, one person or group lists as many medical causes as they can think of, and the other person or group lists common beliefs. Go over both lists. Then, the first person or group tries to explain “idiopathic epilepsy” to someone in the other group.

2. Review types of seizures

Purpose: Solidify knowledge of major features in the history that can differentiate partial, grand mal, petit mal, and psychogenic seizures

Instruction: as a group, list the distinguishing features of each type and suggest a question to ask the patient or family member. Then, for each group, suggest a medication that might be appropriate, and talk about how you would decide if medication is indicated.

3. Epilepsy quiz

Purpose: Test on knowledge of epilepsy

Instruction: mark the following questions as “true” or “false.” Be ready to explain the correct answer. You can use the manual if you can’t remember the answer.
1. ________ Most children with febrile seizure develop epilepsy later.
2. ________ Sleep deprivation can precipitate seizure attacks in epileptic individuals.
3. ________ You should immediately put a tongue plate into the mouth of a convulsing patient.
4. ________ Phenobarbital is an anticonvulsant and is effective for both grand mal epilepsy and petit mal epilepsy.
5. ________ Pregnant women with epilepsy should not take any antiepileptic drug because of danger of congenital malformation in the fetus.
6. ________ Grand mal seizures could be a first symptom of HIV infection.
7. ________ A patient with HIV/AIDS developed his first seizure, and was diagnosed as having toxoplasmosis. Long-term anticonvulsant medication is indicated in this patient.
8. ________ Never stop medication during pregnancy, labor or breast-feeding
3. Cases to practice using the brief mental status exam and the flow chart to guide diagnosis and treatment decisions

Instructions: For each case, go through the categories of the brief mental status exam noting which details are present in the case description and what other questions you might ask the patient or family. Then use the flow chart and the reference and pocket guide materials to reach a decision about what you might need to do for the patient. Describe your treatment or counseling. Make sure you think not just about epilepsy but other conditions that can develop along with it or be complications.

Case 1:
Ato Chalachew Yehune, a 51-year-old man, is a widower. He works as a merchant in Addis Ababa. For the last two years he has had episodes of falling down, loss of consciousness and generalized convulsion. Just before the falling down he develops deviation of his head to the right side and when he regains consciousness, he develops severe headache and transient weakness of the right side of the body. In the last 8 months he additionally suffered from persistent headache, marked forgetfulness, and recurrent cough. He has neither diabetes nor hypertension. There is no family history of epilepsy.

Assume that he has had a few seizures like this before, but has never been treated. How would you talk with him about the possibility of getting treatment?

Case 2
Tamiru is 30 and has been coming to the ART clinic for some time. He is taking a three-drug combination antiretroviral drug. Today in the waiting area he had what appeared to be a grand mal seizure. He was unharmed but several of the other patients in the waiting area were frightened. He is now starting to wake up – you’ve gotten him to an examining table in one of the offices. For this case, think about what you will do and be thinking about as he awakens, then what you will tell him, and then what you will ask him and his wife, who was with him in the waiting area.

Case 3
Ato Wondimu is brought to the emergency OPD due to recurrent grand mal seizures; it appears that he has had several during the past night – maybe as many as 10, and most of the time he was not fully conscious. He was found to be HIV positive 5 years ago; a year ago he started taking ART and his CD4 count has been getting higher – last check a week ago was 310.

Case 4
A 25-year-old accountant for a commercial bank began noticing episodes of losing track of conversations and having difficulty with finding words. These episodes lasted 2-3 minutes. This is usually followed by severe headache. A colleague at her workplace told her that she sometimes appears totally absent and does not respond when talked to; they have seen her bow down to the floor and to pick something which is not there. There is no one in her close family who has a seizure disorder. She is in her third month of pregnancy.
**Figure 6.1. Epilepsy flow chart**

New or recurring problem with uncontrollable spells or fits that involve body movements with or without loss of consciousness.

- **Generalized seizures**
  - Grand mal seizure
    - Brief aura
    - Tonic-clonic seizure lasts minutes with final period of unconsciousness
    - Post-ictal confusion, fatigue
    - Amnesia
  - Attend to comfort and safety; nothing in mouth
  - Consider medication if seizures are frequent
  - Evaluate for underlying illness if first seizure

  * Petit mal seizure
    - No aura
    - Sudden brief (seconds) unconsciousness
    - Only subtle movements
    - Usually start in childhood

  * Seizure longer than 5 min. or Status epilepticus
    - Two or more grand mal seizures in a row or single seizure more than 30 min.
    - Position on side
    - Diazepam 10mg IV slowly (0.2-0.5mg/kg children)

- **Partial seizures**
  - Febrile seizure
    - Child 6mos to 5 with febrile illness
    - Brief grand mal seizure
    - No underlying neurologic condition
  - No treatment for seizure usually required
  - Treat underlying illness
  - Recurrence rate low except if occurs with CNS malaria

- **Psychogenic seizures**
  - Complex “hallucinations”
    - Floating or déjà vu
    - Jerking and falling but rare to injure self
    - Not incontinent
    - Often witnessed seizure
  - Consider medication if seizures are frequent
  - If new onset in adult consider medical conditions that may be responsible

  - Explore model and concern patient may have
  - Explore other concerns for anxiety
  - Reassurance without suggesting it’s “fake”
Behavior and developmental issues in children and adolescents
Objectives for module 7

1. To identify treatable underlying problems related to child behavior, including medical conditions, attention problems, developmental and learning problems, substance use, and mood/anxiety problems.
2. To identify emergencies (in particular child maltreatment) that may be related to behavior problems
3. To use good communication skills to identify specific behavioral targets that parents would like to work to achieve
4. To use good advice-giving skills to give parents instruction in basic child behavior strategies

A. Introduction

Behaviour problems are very common among children and adolescents, and they are often a cause of stress for parents. There are two big barriers to helping parents with these problems. The first is that families differ a great deal in what they consider to be bad behaviour, and the second is that they differ a great deal in what they believe are the best ways to change their child’s behaviour toward what they believe is proper. Thus, in this module, we try to outline an approach that can be adapted to the needs of many different families. This includes attention to:

1. Recognizing the parents’ own needs and issues that may make it harder for them to be the kind of parents they would like to be.
2. Recognizing when the child’s behaviour may be caused by some treatable problem, including developmental or learning problems, substance abuse, low mood, or trauma.
3. Collaborating with parents to develop plans to change behaviour that incorporate the parents’ values.
4. Finding ways to reduce parenting stress while the behaviour change plans are put into place.

See the depression and anxiety modules for information about treating those concerns in children and adolescents.

HIV creates many opportunities for children to develop behavioral or developmental problems.

- Depressed or chronically ill parents may be less nurturing or more irritable with their children; the secrecy that sometimes surrounds having HIV can lead to many difficult
parent-child interactions

- Foster caretakers may be less invested in the children they care for
- Ill children may be more irritable and harder to interact with
- Even well-controlled HIV infection in childhood is thought to be associated with learning problems – especially problems with reading and language that can have an impact on school abilities
- Children who are ill a lot may miss a lot of school and fall behind
- Severe HIV infection sometimes causes developmental delay either through its impact on nutrition, opportunistic infections, or direct HIV effects on the brain. For example, children with HIV are more likely to develop cerebral complications of malaria, and these are associated with subsequent developmental problems.

Cases to start off discussion

Aynalem is an 8-year-old girl, the middle child of 3. She has an older brother, 12, and a younger sister, 6. Recently she has been irritable and angry when her mother has asked her to get her younger sister ready for school in the morning, or to help prepare the family meal in the evening. The conflict in the evening has annoyed Aynalem’s father, who has scolded his wife for not being able to control Aynalem’s behavior.

- Have you ever met or heard about a child like Aynalem?
- What do people think about children with problems like Aynalem’s?
- What do people assume are the causes of these sorts of problems?
- If people try to help children like Aynalem and her parents, what do they do or suggest?
- What gets in the way of getting help for children like Aynalem?

Girma is a 15-year-old boy living with his parents. He attends school, though he says that he does not like it that much. Recently he has been coming home late from school, rather than returning home directly. He has been irritable with his parents, and when they ask him what is the matter or to be more respectful, he refuses to talk.

- Have you ever met or heard about a child like Girma?
- What do people think about children with problems like Girma’s?
- What do people assume are the causes of these sorts of problems?
- If people try to help children like Girma and his parents, what do they do or suggest?
- What gets in the way of getting help for children like Girma?

B. Presentation in primary care/ART treatment

In many parts of the world, parents do not consider primary medical care as a place to discuss or get information about child behavior problems. When parents do raise the issue, it may be in the context of a child not wanting to take a needed medicine, worry about whether the child is using drugs, or as a source of stress contributing to the parents’ own problems. Thus, if one wants to hear more from families about these problems, one can routinely (or at intake visits) ask about:

- How is the child getting along with other members of the family?
- How is the child getting along with friends?
Are there problems reported from school with behavior or learning?
For younger children, are there any problems with meal or bed-time behavior?

In Ethiopia and many other countries, children who are shy and quiet are seen as good, so their problems may be overlooked. Physical punishment is also seen as useful and acceptable. So think about how to tactfully bring these subjects up.

One of the more difficult situations in primary care can be when a parent and child are seeing the provider together and the parent says critical things about the child’s behavior, attitude, or character. It can be difficult to try to elicit details about the problem in a way that is respectful of the parent and also tries to reduce tension between the parent and child. Some techniques that may be useful:

- Empathizing with the parent’s frustration and the difficulties of parenting
- Praising the parent for being concerned and for wanting the best for his or her child
- If the parent is very upset, suggesting that the child be allowed to leave the room so that the provider and parent can speak privately for a few minutes.

Though time may be limited, it is always important to evaluate concerns about child behavior in the context of larger family issues. Even if this is a family that you have known previously, when ever possible ask for an update on major issues including:

- Food, financial, or housing uncertainty
- Illness or death of another family member
- Difficulties between the parents
- Difficulties in the neighborhood

Again, depending on the age of the child and what you feel is best for the parent, these questions may have to be asked privately, with the child and others out of the room.

The most difficult situation for the provider is when parents report problems in a way that is either vague or makes them seem overwhelming. It is easiest to offer advice when the problem is simple and easily understood. Even in very complicated situations, try to get parents to be able to name:

- A particular behavior that the child does that is a problem (for example, he hits his little sister), rather than “he is not nice to his little sister.”
- A particular alternative behavior they would like to see (for example, I would like to see him allow his sister to play with his toy sometimes).

If the parents have multiple concerns, try to get them to name the single most important behavior they would like to see changed first.
C. Treatment in primary care/ART setting

Urgent/emergency issues

1. Physical injury to the child: norms vary from family to family and in different countries about what separates acceptable from unacceptable harsh punishment of children. In general, punishment that leaves visible marks, or that might reasonably be considered to be life threatening (blows to the head, blows with heavy objects, refusal of food or water) would probably be considered unacceptable.
   - Ask to speak to the parent alone
   - Ask about other violence in the family
   - Seek the parent’s agreement to preventing further harm to the child
   - Explore with the parent ways of protecting the child in the short term; this might include recruiting relatives to help care for the child, or help for the family with some sort of emergency aid
   - Conduct a gentle but thorough physical examination of the child

2. Sexual injury to the child: if it is suspected or disclosed that a child has been a victim of sexual assault or has been engaged in sexual activity by an adult, proceed as with physical injury to the child.

3. Physical or emotional violence between parents: child behavior problems are common in households where there is physical violence between parents. See discussion of violence in the anxiety module.

4. Suicidal ideation: especially among adolescents, behavior problems can be a symptom of depression. In the other direction, the conflicts and crises provoked by behavior problems can be a trigger for suicidal thoughts and low mood. See discussion of suicidal thoughts in the depression module.

5. Especially in very young children, is the child’s nutritional state adequate?

6. Childhood psychotic symptoms: Psychosis and dementia are very uncommon in children, but can occur among those with serious illnesses (including HIV) There are times among well children when the concern for childhood thought symptoms may be raised:
   - “Normal” child behavior/symptoms
     - In many cultures, children have imaginary friends to whom they talk and play. This usually stops when children are in their early school years, and most of the time they will admit that their “friend” is imaginary (or that their doll can not really talk to them)
     - When the child is very frightened – these will mostly be visual and tactile sensations – especially in young children (2-7). What they believe will sometimes be consistent with things they have been taught by adults e.g. chirack. These do not require treatment with medication unless they are putting the child in danger (and then the treatment would be with medicines used for anxiety, not antipsychotics)
• When psychotic symptoms are caused by medications or substance abuse (especially prescribed or illicit stimulants) – these will most likely be in the form of tactile hallucinations or seeing crawling insects
• In severe illness
  o The same types of things can occur as in adults– children can become delirious
• Childhood onset schizophrenia is thought to be very rare, and usually occurs in children who already have been thought to have problems with social development
• Childhood bipolar disorder (mania) is also thought to be rare, and when it does occur there are less likely to be hallucinations and delusions but more irritability, increased activity, and increased sexual interest or behavior.
• After emotional trauma some anxiety symptoms can be mistaken for psychosis. Children will report fearful visions or worries that they can’t describe well.

**In children, with the exception of emotional trauma, consider severe psychotic-like symptoms to be most likely caused by a medical problem or intoxication.**

**Consider non-urgent treatable causes**

1. Problems with hearing or vision that have been undetected or untreated

2. Developmental problems that limit school performance or ability to understand and comply with parental norms for behavior
   • How does this child’s development compare to that of siblings? Was this child ahead of or behind relative to others in the age they first spoke or walked? (see the “Ten questions” for developmental screening, below and in the pocket manual. Also in the manual is the “Gesell” drawing test you can use to help determine if a school-aged child may have developmental problems).
   • You can learn a lot about how a school-aged child is developing just by asking him or her to make a drawing and talk to you about it. After introducing yourself to the parent and child, you can give the child a pen or marker and some paper and ask them to draw a picture while you start talking to their parent. When they are finished you can ask them to write their name on the paper, too.
     o While the child is drawing, notice if they have trouble seeing the paper or holding the pen. Does the drawing look like something a child of their age would do? Is it recognizable?
     o The ask the child to tell you about what they drew. Engage them in a conversation about it. Can you understand what they are saying? Again, does it seem to include what you would expect a child of this age to know?
   • Children who have low weight for their age are more likely than others to have developmental problems.
   • Does the child have friends of their own age?
   • If the child is in school, has he or she had difficulties all along or only recently?

3. Could there be a medical reason for the child being irritable?
   • Problems with nutrition or insufficient food?
• Could the child have a chronic illness that causes pain, fatigue, or problems with sleep?
• Could the child or adolescent be using substances of some kind?

4. Is there another mental health reason for the child being irritable or exhibiting difficult behavior?
   • Consider depression, anxiety, exposure to trauma

5. Is the parent depressed or physically ill?

Table 7.1. “Ten Questions” for detection of child developmental disability

A “yes” answer to any of the following questions for children 2-9 years is an indicator of possible disability

1. Compared to other children, does or did the child have any serious delay in sitting, walking, or standing
2. Compared to other children, does the child have any difficulty seeing either in the daytime or at night?
3. Does the child appear to have difficulty hearing (needs a hearing aid, hears with difficulty, is completely deaf)?
4. When you tell the child to do something, does he or she seem to understand what you are saying?
5. Does the child have difficulty in walking or moving his or her arms or does he or she have weakness and/or stiffness in the legs or arms?
6. Does the child sometimes have fits, become rigid, or lose consciousness?
7. Does the child learn to do things like other children?
8. Does the child speak at all? Can he or she make him or herself understood in words; can he or she say any recognizable words?
9. Speaking questions by age:
   1. For 2-year-olds: Can the child name at least one object (an animal, toy, cup, or spoon)?
   2. For children 3-9: Is the child’s speech in any way different from normal (not clear enough to be understood by anyone other than the immediate family)?
10. Compared to other children of the same age, does the child appear in any way mentally backward, dull, or slow?
Attention deficit-hyperactivity disorder (ADHD)

In many parts of the world, ADHD is considered to be the most common childhood mental health problem, but in Ethiopia it is not recognized as often. ADHD has both cognitive (thinking) and behavioral aspects. The thinking aspects involve difficulty being organized and sticking with one task. Children with ADHD can be very forgetful, lose things, and have a lot of trouble keeping their mind on one task, especially if it needs a lot of mental effort (such as school work). They can be easily distracted from their work by noises or the presence of others. Boys more than girls with ADHD can also have trouble sitting still, though this usually gets better by adolescence (the thinking problems may not). The behavioral counseling we talk about below can help children with ADHD, but in more severe cases medication – stimulants – seems more effective. These medications are not currently available in Ethiopia.

General interventions to suggest to parents

1. Consider the environment
   - Is the parent’s health status, low mood, or drinking creating greater-than-normal demands for the child to behave? Can these problems be addressed?
   - Are there ways for the parents to get more support for themselves in caring for what might be a more temperamentally difficult child?
   - Do the child’s caregivers have inconsistent or differing beliefs about parenting? Are these differences getting in the way of attempts to create rules, limits, or consequences?
   - Can caretakers agree on priority behavioral problems and how to address them?

2. Promote positive interactions with children
   - Praise the child for agreed on desired behavior
   - Praise frequently and consistently
   - Don’t mix praise with negatives – save the corrections for later
   - Make the praise strong and physical if appropriate – accompanied by hugs

3. Focus on priority areas. Try to temporarily ignore minor unwanted behaviors.

4. Set aside even a small time each day for child-parent activities, ideally at about the same time.

5. Promote positive behaviors
   - When possible, reorganize the child’s day to prevent trouble.
     - For example, ask someone to look after a child briefly if the parent has something to do that requires concentration or lack of interruption
     - Think of other antecedents to problem behavior and try to avoid them

6. Commands and requests
   - Set clear rules.
   - Give short specific commands about the desired behavior, not prohibitions about unde-
sired behaviors. For example, say “Please walk slowly” rather than “Don’t run!"
• Advance notice can be helpful. “We will need to go in 5 minutes.”

7. Punishment
• As infrequent as possible – save it for situations where the child has had a chance to do
tings correctly or has failed to respond to a request to behave
• Keep mild, even if it is firm – calmly and verbally
• Avoid long-standing consequences – children forget why they are being punished and
just get angry at the punisher. “You can not go out this afternoon, but if you are better
you can go out tomorrow.”
• Punishment should come quickly after the problem occurs, so the child knows what they
are being punished for, unless the parent is too upset to stay calm when giving the pun-
ishment.
• Avoid getting into arguments or explanations. This will merely give more attention for
the misbehavior. Put off negotiations and discussions until a later period of calm.

Things that may help with school behavior problems or possible ADHD
• Have the child sit in the front of the class. The goal is to have the child be easily seen by
the teacher and to have other children not be so visible to the child.
• Give the child extra time to stay organized. This may include giving the child extra time
to write down assignments or to repeat them back to the teacher to make sure they are
understood.
• Break longer assignments into smaller pieces, with opportunities for the child to check
with the teacher or parent (for homework) that they are doing the work correctly.
• Inquire about bullying or other social difficulties at school.
• When possible, make sure that the child has had enough sleep and enough to eat before
attending school.
• To the best of your ability, see if the school and family can provide extra help with mate-
rial that is difficult (but be careful in interacting with the school not to disclose the child’s
HIV status when that is not needed or appropriate)

Treatment for possible developmental and learning problems
The most important first treatment for possible developmental and learning problems is to help
parents understand that their child is likely not just lazy or “foolish.” This can be a good reason
to use the simple tests in the pocket manual as a way of showing what the child can and can’t do.

If the child’s delays or school problems seem mild, try to work out plans with the parents to get
the child as much help with school work as possible, and try to get any behavioral, emotional, or
medical issues taken care of.

If the delays seem more serious – especially if the child seems considerably behind others of his
or her age, see if a referral is possible for more of an evaluation.
When children with serious delays have behavior problems, it can be tempting to use medications, especially if the child’s parents are very upset or stressed. Very low doses of fluoxetine (1-2 mg a day) can sometimes be helpful. If possible avoid other antidepressants (especially tricyclics) and antipsychotics because of their many side effects and complications. If antipsychotics must be used, it should be for as short a period of time as possible until consultation and more support for the family can be obtained. Table 7.2 gives some dosing guidelines, side effects, and drug interactions.

Table 7.2 Antipsychotics medications for children

<table>
<thead>
<tr>
<th>Antipsychotic Drug</th>
<th>Dosage</th>
<th>Common side effects</th>
<th>Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>Child 3-12 yrs: 0.01 to 0.03 mg/kg/day up to 0.15 mg/kg/day; Child &gt; 12 yrs: 1-5 mg/dose initially and then 1-15 mg/day divided bid or tid. Raise dose slowly and use minimally effective dose.</td>
<td>Hypotension, lowered threshold for seizures, prolonged Q-T interval (avoid if prior history of heart disease)</td>
<td>PIs and DLV can increase haloperidol level; NNRTIs except DLV can decrease haloperidol level. Level reduced by carbamazepine and phenobarbital.</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>&gt; 6 yrs: 2.5-6mg/kg/day orally</td>
<td>Drowsiness (potentiates effects of sedatives), jaundice, lowered threshold for seizures, hypotension, prolonged PR interval</td>
<td>Potentiates effects of sedatives. Data not available on ART interactions.</td>
</tr>
<tr>
<td>Risperidone</td>
<td>&gt; 20kg: 0.5 -1 mg a day to start; after 4 days increase by 0.5 mg every two weeks; 2-3 mg a day thought to be maximum effective dose in children</td>
<td>In higher doses has similar side effects to typical antipsychotics</td>
<td>Some PIs may increase risperidone levels. Avoid use with ritonavir.</td>
</tr>
</tbody>
</table>

D. Follow-up and monitoring

Fortunately, many child and adolescent behavior problems get better over time. However, just saying this to parents is not reassuring – it can be taken as an indication that you (the provider) don’t really understand the parents’ concerns or the seriousness of the problem. It is more helpful to:

- Ask if the parent would like advice, and if so, give it
- Make arrangements to meet again later to talk about the results – usually in two or three weeks
- If problems persist at the follow-up visit, ask the parent to talk about what they tried and
why they thought it did not work. Ask if the parent has ideas about how to try the same things but in a more effective way.

- If problems are significantly worse, go back over the above lists of possible causes and re-evaluate the possibility that there are medical, mental health, or family violence issues playing a role. If the child seems to have a developmental problem, get the best evaluation possible, and then work to educate the family about the child’s strengths and limitations and how best to support growth
- When possible, refer to community support groups, especially if the child is identified as having a developmental problem

**E. Referral criteria**

- Evidence of child neglect, sexual or physical abuse with concern for serious harm
- If evidence of medical or neurologic diseases are causative of behavioral change, especially if there is a loss of developmental milestones
- Behavior problem seems complicated by a mood or anxiety problem and neither condition can be well controlled
- Diagnostic challenge – confirmation of diagnosis
- Symptoms persistence or worsening after treatment
- More than mild developmental problems

**F. Summary of child behavior and development problems**

- Delay in achieving key milestones, difficulty in school, difficulty playing with others, or inability to carry out instructions raise concerns for developmental or learning problems
- Addressing the whole family’s situation and concerns can help them understand and treat child behavior problems
- Parents can usually improve their child’s behavior by focusing on a few, consistent rules and applying them firmly but calmly
- Behavioral treatment in school and at home as well as psychostimulant drugs is important in the management of children with ADHD.
Exercises for module 7

Note that for these exercises you may also want to consult material in the communication, depression, and anxiety modules.

1. Asking about behavior problems in children

Purpose: to remember a few questions that can be asked of most parents

Instruction: Suggest:
- A few questions to routinely ask at all child/adolescent visits to get an idea if there are any problems with child behavior
- A few questions to ask to understand stresses the family may be experiencing
- How to get more details if a parent is upset with a child but can not seem to tell you the exact problem

2. Causes of behavior problems in children

Purpose: review common causes of behavior problems that could be related to the family, to the child’s physical health, to child development, and to the child’s emotional health.

Instruction: Make a list of causes in each of the four categories above; write down ways that you could tactfully explore these causes with the parent and child

3. Developmental assessment

Purpose: become familiar with simple tests of child development

Instruction: Pair up and administer to each other the Gesell figure drawing test (in the pocket guide). Practice scoring them. Imagine how you would explain to a parent results that were less than the child’s age.

4. Cases to practice using the brief mental status exam and the flow chart to guide diagnosis and treatment decisions

Instructions: For each case, go through the categories of the brief mental status exam noting which details are present in the case description and what other questions you might ask the patient or family. Then use the flow chart and the reference and pocket guide materials to reach a decision about what you might need to do for the patient. Describe your treatment or counseling.

Case 1
Basnael is a 5-year-old boy who refuses to go to school. He cries for hours if he is forced to go. His mother has to stay in the school with him. He often complains about headaches, stomachaches, and nausea. At home he cannot sleep without being near his mother.
**Case 2**
Eyoel is a 7-year-old child who has marked difficulty in school. Though he is in grade 1 he cannot read or write the alphabet. His mother stated that Eyoel is not like his older siblings. He is delayed in many ways - he was not able to walk by the age of 2 years, and he uttered his first words only when he was 18 months old.

**Case 3**
Ato Gemechu complains that his 6-year-old child Diriba is difficult to discipline. He attends school but mostly gets poor marks. In class he doesn’t pay attention, and when asked about the work he will give guesses or evasive answers.

**Case 4**
Berhanu is a 10-year-old boy whose father died from HIV about a year ago. He is living with his maternal grandparents, his mother, and his younger sister in his grandparents’ small home. Recently he has been frequently angry and refused to do any chores around the home. He insulted his grandfather and threatened to hit his sister. His mother has threatened to put him in an orphanage if he does not behave better.
**Figure 7.1. Child conduct flow sheet**

Parents or teachers complain that child or teen is oppositional, disrespectful, engages in activities that are risky for self or others, or has academic difficulties

Assess the situation:
- Does the child have a treatable medical or nutritional problem? (treat it)
- Is the child having trouble with parents, teachers, siblings, peers, or in all domains of function? (If only one domain, consider causes specific to that domain)
- Are there problems with illegal or violent behavior? (Consider if legal intervention is warranted)
- What other stressors does the family face? Is there violence or stress among adults in the home? (These may need to be addressed first)

<table>
<thead>
<tr>
<th><strong>Is there concern for risky behavior?</strong></th>
<th><strong>See flow charts for depression/anxiety</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Running away or self-injury?</td>
<td>• What hazards might be in the home?</td>
</tr>
<tr>
<td>• Is there a chance that the child might be depressed?</td>
<td>• Is there a way to increase supervision and support?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Is there concern for substance abuse?</strong></th>
<th><strong>See substance abuse module.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the child seem overactive?</td>
<td>• Treat any vision or hearing issues.</td>
</tr>
<tr>
<td>• Sloppy, loses things, distractible.</td>
<td>• Get help for areas of cognitive weakness.</td>
</tr>
<tr>
<td>• Never sits still</td>
<td></td>
</tr>
<tr>
<td>• Impatient, interrupts</td>
<td></td>
</tr>
<tr>
<td>• Has there ever been worry that the child was slow to develop or had trouble learning?</td>
<td><strong>School and home advice</strong></td>
</tr>
<tr>
<td>• Walked or talked late compared to siblings</td>
<td>• Sit in front of class</td>
</tr>
<tr>
<td>• Never able to keep up in school</td>
<td>• Extra time to understand assignments</td>
</tr>
<tr>
<td>• Trouble with vision or hearing</td>
<td>• Break long assignments into smaller pieces</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Is the child’s bad behavior a reaction to fear or trauma?</strong></th>
<th><strong>See anxiety/trauma flow chart</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the child fearful of many things?</td>
<td>• Consider the possibility that harsh parenting could contribute to bad behavior</td>
</tr>
<tr>
<td>• Is the child being bullied or harmed outside the home?</td>
<td>• Empathize with difficulty of parenting but assume that parent would really rather use more gentle means</td>
</tr>
<tr>
<td>• Is there any concern about injury or threat within the home?</td>
<td></td>
</tr>
</tbody>
</table>

**General parenting advice**
- Promote positive interactions by praising the child when possible and responding only to most important problems; find ways to avoid confrontations or foreseeable difficult situations
- Start behavior change by focusing on a few very observable behaviors that you think the child can do.
- Give clear, simple commands that emphasize what you want the child to do rather than not do.
- Make punishment mild and infrequent compared to praise
- Put off discussions with the child until you are calm
Living with HIV
Module 8: Living with HIV

Objectives for module 8

1. Be able to inquire about and respond to common adjustment problems experienced by people living with HIV infection
2. Know when to consider cognitive effects of HIV (HAND) when assessing individuals for problems or challenges related to everyday functioning.

A. Introduction

Some of the topics discussed in this module are covered in more depth in other trainings. The goal of repeating them here is to be able to think about them in the context of definable mental health conditions and mental health treatment. If there is one recurring theme in most of this module, it is a return to the discussion in the introductory module – care for “mental health” problems can involve care for all aspects of a person’s physical health and social environment.

Perhaps the biggest change in thinking over the past few years has been the realization of how much subtle changes in brain functioning caused by HIV can have an impact on day-to-day function even in people who are very careful to take their medications and have excellent health otherwise.

The issues discussed here can come up with or without a definable mental health problem that you might identify in one of the other modules. Some of the problems that might make you think of the considerations in this module include:

- Not wanting to or feeling able to return to school or work after a break or illness
- Difficulty sticking with a medication regimen, or coping with the need for a change in treatment
- Long-term feelings of fatigue for which no medical or frank mental health cause can be found

B. Reaction to the diagnosis

People have many different reactions to learning that they have HIV infection. They may react initially with anger, shock, or denial, and these reactions can change or recur over time. As a medical provider, you can:
• Ask what is feared most about HIV and offer information (when they are willing and able to hear)
• Encourage finding someone that they can disclose to and obtain support
• Encourage and accept venting, show empathy for the difficulty of adjusting

If people feel guilty for something that they feel led to their acquisition of HIV:
• Reassure that no one can foresee all the consequences of what they do
• Reassure that life offers many opportunities to do good and they will have many chances in the future feel better about themselves

For feelings of loneliness and isolation
• Note that there are millions of people living well with HIV, both in Ethiopia and other countries
• Note that they are right to be cautious about whom they tell, but that over time they will find many accepting people and develop many close relationships
• Remind them that the ART site and its many services will always be a place that they can turn to for support and care

For feelings of grief and loss
• Acknowledge that this is a big change, that life looks very different
• Be optimistic that the loss will heal with time
• Express your willingness to be of support
• Suggest self-care
• Remind them that this is a treatable problem, and that you and the ART staff will be here to evaluate their concerns.

C. Stigma and disclosure

Fear of telling others about their diagnosis is one of the greatest burdens faced by people living with HIV. HIV remains a very misunderstood condition, with many people still believing that it can only be acquired in immoral ways and that casual contact with sero-positive people can lead to fatal infection. Efforts to avoid disclosure can be very disruptive to normal life, and harmful to treatment adherence. People living with HIV often say they lead “double lives” in that they feel they are always hiding something (when they go for an appointment, why they don’t feel well, why they have a medicine to take), and always trying to guess if their friends have guessed the truth. Fear of needing to disclose can discourage people from seeking friends and partners, or it can lead to unprotected sexual activity. In contrast, individuals with HIV also often have false ideas of who they should tell – for example, others where they work. ART staff can help patients understand where disclosure would seem helpful, and where it is not required.

Even when people living with HIV have been able to tell some close friends and family members, they may be burdened by changes in their appearance caused by ART medications or HIV-related illnesses. Feeling that they have an additional source of shame – a seizure problem or mental health problem – may prove to be overwhelming.
One of the biggest difficulties faced by persons living with HIV is maintaining supportive and positive relationships with family members and others who help them with day-to-day needs. Even when patients are doing well medically, they may rely on family, friends, and neighbors for many things, including financial help (money for transportation, replacement of income lost when the patient can’t work), child care or other duties when the patient has medical visits, reading or interpreting instructions for care, and listening and helping with emotional concerns. When these relationships are strained patient functioning can decline in a number of ways.

As an ART clinician there may be little you can do directly about these problems. If the patient comes with family members, you can use some of the skills discussed in the communication module to make the family feel welcome, engaged, and appreciated. You can use the opportunity to empathize with their burdens and you can explicitly thank them for their efforts. It may also be an opportunity to “trouble shoot” problems, perhaps thinking of ways to limit burdens on the patient and family (for example, changing the frequency or timing of visits).

Where available, advice from adherence supporters may give patients ideas of how to best nurture relations with people on whom they depend.

One way to help people best function in light of attitudes toward HIV (and mental health issues) is to connect them with other people who have faced the same issues. The adherence supporters in HIV clinics can fill this role. Groups (for adults and youth) offer opportunities to relax and talk with people without fear of disclosure, as well as opportunities for sharing practical information and support. In some communities in Ethiopia, “Idirs” have expanded their role to provide more comprehensive support to persons living with chronic illness such as HIV. Support has included small loans, help with legal advocacy, and transportation in addition to in-home care in times of illness. Referral to these organizations may be beneficial for the patient and their family.

**Disclosure to HIV+ children:** Families often have many concerns about telling a child that he or she has HIV. They worry that the child will become depressed, or that the child will tell others and a family secret will become known. Telling a child who was perinatally infected also means that parents have to again face feelings of guilt or loss about their own illness.

Eventually, it becomes hard to keep children from knowing their diagnosis, especially when they start asking questions about the need for medication or frequent medical visits, or when they near the age where they may become sexually active. Long before this, though, many children sense that something is the matter, and the fear caused by that secret may be worse than knowing. They often guess their diagnosis from reading signs or overhearing conversations in the clinic, or seeing HIV-related messages on television (which may name medications that they know they are taking).

The degree of stigma and risk in the child’s community may determine, in part, when they are told. If disclosure to outsiders is a risk, telling the child may have to wait until he or she can truly understand the idea that this is not information to tell others.
Disclosure to children usually takes place over time – often over a period of months or even years as the child matures and asks more questions. One approach is to truthfully answer questions but only with just enough information for what the child might understand at that age. The following list of explanations might be started with a young child, with each additional point being added as the child is more curious:

- Medicines keep you healthy
- Blood tests can tell the doctors if the medicine is working
- Germs (virus, etc) can make you sick
- Your body has an immune system to fight germs
- Your have a virus that tries to hurt your immune system. Your medicine fights that virus to keep you healthy.
- The name of the virus is HIV. Have you heard of it?
- There are some things about ourselves and our bodies that are private – we don’t tell other people.

As with adults, once children know about their diagnosis, contact with other children in similar circumstances is often a tremendous help.

**C. Mild impairment of cognitive functioning**

With the advent of effective HIV treatment, the proportion of people living with HIV who develop very serious declines in mental capacity (dementia) has been greatly reduced. There is more awareness, however, that as many as half of those living with HIV, even when their illness is well-managed, have varying degrees of what has been called HAND (HIV-associated neuro-cognitive dysfunction). For most, the impact of HAND is relatively subtle and goes unnoticed by others. However, there is more and more evidence that even mild degrees of HAND can have an impact on day-to-day function.

HAND can have an impact on many areas of brain function, and there is not a lot of similarity from person to person in its effects. What seems most consistent, however, is an impact on the ability to organize one’s life – to keep a focus on what needs to be done, to make the kinds of day-to-day decisions that seem simple but do require remembering, prioritizing, deciding on the order in which to do tasks, and figuring out how to achieve goals. The impact of HAND can’t be explained by depression or other medical problems.

*One aspect of HAND that can be particularly troubling is that the combination of brain problems tends to make people unconsciously shy away from new situations and challenges. This can be a barrier to accessing new programs and treatments that may be helpful, and can be frustrating to both the patient and clinicians, neither of whom can really understand the source of the reluctance.*

When available, neuropsychological testing is the best way to diagnose HAND. However, these tests are not available in most of the world (including Ethiopia). Instead, clinicians can work with patients and families to explore the possibility that HAND could be problem. The approach
is to try to understand if there has been a change in the kinds of things that the patient can do. There are not yet any standard sets of questions to ask about this kind of functioning in Ethiopia, but examples of things to ask about include:

- For women, do they now have trouble remembering the ingredients and steps involved in making traditional dishes, especially if there is some change in what needs to be done (substituting an ingredient they don’t have, making food for fewer or more people than usual)?
- Does the person now have trouble organizing a shopping trip? – deciding what to buy, figuring out what to get at each shop, understanding the relationship of the price per item or kilo to the total cost?
- Does the person now have trouble figuring out how to make a trip using taxis or busses, especially if it involves figuring out how to get to a new place?
- Does the person now have trouble remembering when and how to take medicines?

None of these differences need be very marked, as they might be if the patient had dementia, but they could be enough that the patient takes more time to do the activity, finds it frustrating, or avoids it. At this point, treatment of these “mild” forms of HAND involves:

- Optimizing HIV treatment
- Looking for any untreated infections or medical conditions
- Looking for unrecognized medication side effects
- Inquiring about substance use that may be having an additional impairing effect
- Helping the patient to develop ways around the impairments – breaking tasks into smaller, manageable steps; getting help from family and friends; using pill boxes and calendars to stay organized for medications and other tasks
- Providing extra support at times of change or where new tasks must be accomplished – for example, escorting the patient to a visit with a new clinician at an unfamiliar hospital; arranging a meeting with a representative of a community support group at a place familiar to the patient

**Summary points for this module**

- Reactions to HIV diagnosis can resemble, precipitate, or exacerbate mental health problems
- Decisions about disclosure of HIV status can be major sources of stress
- Mild forms of cognitive problems can occur even among people who are doing well with HIV treatment and can cause a lot of functional problems
- Mental health problems can look like cognitive problems
Exercises for module 8

1. Cases to practice using the brief mental status exam and the flow chart to guide diagnosis and treatment decisions

Instructions: For each case, go through the categories of the brief mental status exam noting which details are present in the case description and what other questions you might ask the patient or family. Then use the flow chart and the reference and pocket guide materials to reach a decision about what you might need to do for the patient. Describe your treatment or counseling.

Case 1
Aman is 45 years old and a father of two children who are in their teens. Recently, he discovered that he is seropositive. He did not tell anyone and he is worried that his wife might have acquired the HIV infection from him. He feels very guilty and is blaming himself a lot. He came to you looking for some advice.

Case 2
Mihret is a 29-year-old, single woman being treated for HIV. She had a job in private company until recently but was dismissed from her work. She says that she has ceased to be interested in working or much else in life. She says that her memory is failing her and at times it is even difficult to say whether she really knows what her medical problem is. Her mother stated that she is uncertain about her daughter’s mental capacity and is getting tired of having to help her all the time.

3. Role plays to practice interviewing, differential diagnosis, and psychoeducation

Instructions: Take turns being the patient, clinician, and an accompanying family member. If needed, the clinician should use the brief mental status guide to interview the patient. The clinician can then consult with colleagues about a possible diagnosis and treatment plan, including what you would do for follow-up. Make sure that you ask questions that might get at whether there is a problem with HAND if that seems appropriate. The clinician should then explain the diagnosis and plan to the patient and accompanying family member. Scenario 3 is a good case to explore different possible causes of dysfunction in someone who seems to otherwise be doing well with HIV. For this case, have someone play the patient, but then have 3 clinicians: one to do a mental status exam, one to go through the HAND assessment, and one to go through the flow chart for possible low mood.

Scenario 1
Eyoel is a 9-year-old boy who had been losing some weight and saying to his mother that he was feeling tired all the time. She brought him to a clinic and after an examination and testing he was found to be HIV positive with a low CD4 count, presumably from perinatal infection. His mother told him that the doctor had prescribed some medicine that helps give him more energy and not be so tired. He took the medicine for a while, but then started to refuse, saying that he didn’t
feel any better and the medicine tasted bad. His mother is asking you whether she should tell him the real diagnosis so that he will understand why he needs to keep taking the medicine.

**Scenario 2**
W/rt Lidiya, a 21-year-old girl and a 3rd year university student, came to ART clinic. She is nervous and fidgety on her chair. Her voice is strained and her speech is frequently interrupted. She has known about her seropositivity for 12 months. Her CD4 count is 450 and she has no medical illness. In the last 4 weeks, she fell in love with a nice guy, her classmate, and he is head over heels about her. She has not been able to concentrate on her studies. She stays in her dormitory and cries a lot. She is uncertain of what to do next.

**Scenario 3**
Abraham is a 35-year-old man who was working at an office that prints a local tourist magazine. He wrote short articles for the magazine and solicited advertising from area businesses and hotels. About a year ago he started feeling poorly, and lost weight. He was diagnosed with HIV and, because his CD4 count was already low, he was started on ART. He has had a good response in terms of lowered viral load and higher CD4, and he has regained much of the weight he lost. However, he continues to feel that he’s not ready to go back to work. His former boss knows about his HIV and says that he is welcome to return whenever he wants, but Abraham continues to feel that he is not ready.
Figure 8.1 Living with HIV flow sheet

Problems with adjusting to living with HIV:
- Hesitant or unwilling to return to school or work
- Adherence issues
- Fatigue and demoralization without other explanation

Ask patient and family to elaborate on concerns
Listen for concerns that match other mental health modules

- Recent changes to HIV status or treatment and new or ongoing emotional reaction
- Stigma and disclosure issues
- Caregiver burden and relationship problems
- Food and housing insecurity
- Medication side effects and interactions
- “Asymptomatic” cognitive impairment related to HIV
- Untreated or inadequately controlled pain and other physical symptoms

Address underlying mental health issues

Reassess for underlying mental health issues and ongoing needs for support
Implementation issues and “putting it all together”
Implementation issues and “putting it all together”

Objectives for module 9

1. To be able to describe the roles of different individuals in the primary care setting with regard to detection and treatment of emotional, behavioral, and mental health problems
2. To be able to describe some of the ethical/privacy issues surrounding mental health care
3. To be able to describe the referral/consultation system as it exists or needs to be, and general criteria for referral of cases up and down the system
4. To be able to communicate information to a consultant
5. To be able to create a brief record of sample cases for supervision/team discussion

Introduction

The purpose of this module is to help participants think about how they will be working with each other and within the larger ART care system to provide mental health care to their patients. The main goal of the module is to help participants anticipate barriers and possible changes to how they work that might be needed to provide mental health care – it is a way to wrap up the training with participants thinking about practical next steps. You will want to review module 1 as well.

A. The work plan for integrating mental health into ART visits

The outline is divided into two parts – roles for front-lines clinicians (nurses and health officers), and roles for physicians who are acting as the next-up level of care.

Assessments by nurses and health officers

This process is illustrated in two diagrams, one for all patients, and the other for patients who have been identified at a prior visit as having a mental health problem.

For a new patient or patient not previously thought to have a mental health problem (Figure 9.1)

1. As described in Module 1, use a core set of questions and listening skills to elicit possible mental health issues (low mood, anxiety, substance use, thought problems, epilepsy, behavior problem)
   - For suspected mood and anxiety, consider using a screening instrument if one is available (the HSCL for Amharic-speaking patients) to assess severity; for suspected dementia, you may use the International HIV Dementia Scale and screening questions about change in function.
2. If the patient is suspected of having a thought disorder, new onset of seizures, or poorly
controlled seizures, suicidal thoughts, or severe inability to function, consider if this is something that the nurse/health officer has been trained to treat; if not, refer to physician for additional consultation and treatment.

3. Decide on the predominant problem or problems and use the treatment information in this guide to provide a first, brief response:
   - Use brief counseling techniques appropriate to each of the areas that might apply
   - Make referrals that might be indicated to adherence supporters or other support services
   - Consider if a medication may be helpful
   - Consider if further medical evaluation is needed
   - Give an appointment for a follow-up visit

---

**Figure 9.1. Flow chart for a patient newly thought to have a mental health problem**

New patient or in “regular” care and not know to have MH problem → Sees nurse, HANS nurse, or health officer

- Initial assessment using questions and instruments for every patient diagnosis
- Thought disorder, confusional state, suicidality, new seizure, poorly controlled seizure, medical conditions/drugs?
  - Yes → Physician assessment and treatment
  - No → Mild or moderate MH (anxiety, depression, etc) with out medical complication
    - Yes → Brief counseling referral for support and education re appointment, medication initiating dosage adjustment
    - No → To “know patient” flow chart

- Medical treatment
- Safety planning and urgent mental health treatment
- Mental health consultant? Medication and refer to nurse or HO
If this is a returning patient with a previously identified mental health problem (Figure 9.2):

1. Use core set of questions and listening skills to elicit current status of patient’s functioning
   - Main questions include whether problems are seen as same, better, or worse
   - If medication had been prescribed in past ask about adherence and supply
   - If the patient is better but not “recovered,” the same as before, or slightly worse
     - Review brief counseling provided previously, focusing on barriers to implementing that advice
     - Consider further referrals to adherence supporters or community supports
     - Consider adding a medicine if one was not used before; ask about adherence and side effects of medicine if one had been prescribed
     - Consider if additional medical evaluation is needed
     - Give an appointment for a follow-up visit
   - If the patient is significantly worse:
     - And appears medically stable and not suicidal: refer to mental health consultant (psychiatric nurse if available, psychiatrist if nurse not available)
     - And appears medically ill or is suicidal: refer immediately to physician
2. If the patient is “recovered”
   - Review ongoing “treatment” (medication, self-care, use of support services)
   - Continue seeing at regular intervals for at least 6 more months
     - If not on medication, discuss reasons for seeing mental health help again, discharge to “regular” ART care

If taking medication, discuss with physician indications for discontinuation or taper (will depend on medication and condition)

**Figure 9.2. Flow chart for returning patients known to have a mental health problem**
Patients referred to the physician at the ART site (second-level medical care)

1. If the patient is thought to have an acute or chronic medical illness that could be causing the mental health problem, then treatment is initiated for the problem. Make a safety plan if patient has thought or behavior problems related to the illness.

2. If the patient is thought to have either a new or poorly-controlled seizure disorder, evaluate and decide about the need for treatment or a change in treatment.

3. If the patient is thought disordered without an underlying medical condition, actively suicidal or homicidal, discuss options with patient and family and make plan for safety and mental health evaluation; consider emergency medical treatment (antipsychotic) for thought disorder; make return appointment.

4. If patient does not appear to be in danger but has relatively mild or moderate thought or mood problem, consider prescribing medication.

5. Refer back to nurse/health officer for brief counseling and scheduling follow-up visit.

B. Ethical/procedural issues for mental health

Caring for mental health problems brings out issues that actually apply to all visits. Think about your current practices, and the physical set-up of your clinical areas, and see how they fit with the need to create an atmosphere of trust and confidentiality that will promote good mental health care.

How private are interactions between patients and providers? Is more than one visit going on in a room at the same time? Can patients who are waiting to be seen hear what is going on in an office or examining room? Privacy can be very important to promote disclosure of sensitive information and to prevent that information from being heard by others.

Does your clinical site have policies (and training for staff) about:
- Sharing information among staff members
- What to document about visits in charts
- When confidentiality can be breached to protect a patient or someone else?
- Whether children are entitled to confidentiality?
- What other family members can be told about a patient’s condition or treatment?

Does your clinic have policies for treating patients who do not seem capable of understanding their condition or making decisions for themselves (including HIV testing for individuals who are acutely mentally ill with a thought or cognitive problem)?

Does your clinic have protocols (and stocks of emergency medication such as diazepam or haloperidol) for a patient who is seizing or agitated?
C. Monitoring and evaluation

Monitoring is an ongoing process. It is carried out routinely and is usually quite structured. It helps managers keep an eye on things in a simple way. Evaluation is ‘the process of determining the merit or worth or value of something; or the product of that process’ by systematically collecting and analyzing information to assess an organization’s effectiveness in achieving its goals. Monitoring and evaluation (M&E) are critical for ensuring that successful interventions become part of an integrated health service. Together they track performance, measure results, and report progress of service delivery.

Table 9.1. The monitoring and evaluation framework

<table>
<thead>
<tr>
<th>A Comprehensive M&amp;E Framework</th>
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<tr>
<td><strong>Types of Monitoring and Evaluation</strong></td>
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<table>
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<tr>
<th>Questions Addressed By the Different Types of M&amp;E</th>
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<tr>
<td>• Is an intervention needed, e.g., palliative care?</td>
<td>• To what extent are planned activities actually realised, e.g., has the palliative care service been set up?</td>
<td>• What outcomes are observed, e.g., is there better pain control?</td>
<td>• Should programme priorities be changed or expanded?</td>
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<td>• Who needs the intervention, e.g., people with HIV/AIDS or cancer?</td>
<td>• How well are the palliative care services provided?</td>
<td>• What does the outcome mean (e.g., what does it mean if pain is not controlled)?</td>
<td>• To what extent should resources be reallocated?</td>
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<tr>
<td>• How should the intervention be carried out, e.g., what model of palliative care delivery best suits the need?</td>
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<td>• Does the programme make a difference?</td>
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In order to address the issue of monitoring and evaluation we need to have indicators. There are five levels of indicators. Input indicators, process indicators, output indicators, outcome indicators and impact indicators. These indicators are usually collected from a register that collects information about each patient seen.
Draft register

Patient ID: ___________________ Patient name: ___________________
Patient date of birth: ______ Gender: ______
Date registry initiated: ____________
Treatment site where initiated: ____________ Provider initiating: ____________

Codes to use:

Severity: 0. Problems resolved. 1. Mild distress or interference with function; 2. Moderate distress or interference with function; 3. Severe chronic distress and interference with function; 4. Medical or psychiatric emergency.

Means of identification: 1. Patient or family raises concern; 2. Referral by someone in the community (non-medical); 3. Referral by other medical provider (including other ART provider); 4. Discovered in response to clinician question or exam; 5. Follow-up from prior visit.

<table>
<thead>
<tr>
<th>Date of visit</th>
<th>Conditions identified or treated</th>
<th>Overall severity</th>
<th>Means of identification</th>
<th>Counseling provided (yes or no)</th>
<th>Medications provided or continued (give names and doses)</th>
<th>Other treatment (describe)</th>
<th>Referral – non-emergent (give location)</th>
<th>Referral – emergent (give location)</th>
<th>Tests ordered or reviewed (give results)</th>
<th>Date of next visit</th>
<th>Provider</th>
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D. What else is needed to be able to increase attention to mental health in ART services?

Workforce issues
- In the course of usual clinical care, who is hearing about these issues now?
- Who do you want to be hearing about them or dealing with them?
- What training do these people have so far?
- What are their attitudes toward learning more about mental health? How might training need to be framed to not clash with these attitudes? Are there key opinion leaders at local or national levels who might endorse it?
- How much turnover is there – how often will you have to start over?

What other areas of care need to be involved?
- Pharmacy
- Access to community resources
- Consultation mechanisms
- Emergency protocols
- Ongoing education and support
- Links to other services and aspects of HIV care
  - Pharmacy
  - Psychiatric consultation and referral
  - Community resources
  - Adherence supporters
  - Case management services
  - Collaboration with traditional and religious healers

Visit issues
- Time
- Main competing demands
- Privacy
- Patient expectations
- Current availability of medications and diagnostic tools?

Training issues – as you return to your clinic and think about passing on the information in the training manual, how will you organize your teaching?
- What are opportunities for “optimal” teaching?
  - Multiple short sessions
  - Opportunities for peer-to-peer education
  - Modeling by trainers
  - Active learning (case studies, role plays)
  - Re-enforcement and support over time
- What are the incentives for generalists to learn these new things?
E. What follow-up training and refreshers should be offered?

- Opportunities for case review and discussion
- Training in “psychotherapeutic” communication skills
- Additional focus on issues with children and adolescents
- Focused training sessions on specific conditions
Exercises for module 9

1. Creating a patient flow/staff needs chart for your own clinic

**Purpose:** to help identify staffing needs and gaps at your own work site

**Instruction:** take the flow charts (Figures 9.1 and 9.2, describing how patients are evaluated)
- Modify them for your clinical site
- Fill in names of staff who might be in the various roles
- Think about what additional training or materials these staff members might need to carry out the roles
- Think about any other changes at the site that might have to be made
- When the site support teams come for a follow-up assessment, what information might they want to see to understand if the training has been effective

2. Creating an action plan for your own clinical site

**Purpose:** to make it possible to work systematically once you return to your own work site to put in place what is needed to provide mental health care

**Instruction:** thinking about the flow chart you created in Exercise 1, and going back through the contents of this module, make a table like the one below for your site.

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Current Gaps</th>
<th>Key Activities or Actions</th>
<th>Person(s) Responsible</th>
<th>Resources Needed</th>
<th>Time frame</th>
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Bibliography/selected readings from recent publications about mental health in Ethiopia


