

The MANAS Model

For Health Counsellors



Manashanti Sudhar Shodh

A Program To Improve The Care
For Patients With Common Mental Disorders
In Primary Health Care



Managing Common Mental Disorders in Primary Care

The MANAS Model
for Health Counselors

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Introduction

Common mental health problems like depression and anxiety, collectively referred to as “Common Mental Disorders” (CMD), are a major public health concern in the world today. Those who suffer from CMD are often so distressed, that it prevents them from leading productive lives, worsens coexisting physical health problems, and in some instances can even lead to suicide. While there are a range of simple and effective treatments that can be provided to patients suffering from CMD, unfortunately, most patients do not receive these treatments.

The MANAS Program

The MANAS program was set up in Goa, India, between 2005 and 2010, to develop and evaluate a model for delivering these treatments in primary care settings. The guiding philosophy of MANAS is that the care for CMD requires a team approach involving three key players: the primary care doctor, a visiting mental health specialist and a health counselor (HC). The HC is a person who need not have previous experience in mental health treatment but is trained to provide psychosocial treatments described in this manual and the HC is a member of the primary health care team.

The essence of the MANAS model is to facilitate the shift for mental health care from specialists to lay people such as the HC (who would be similar to other more widely available health workers) within a primary care team, and thus improve the coverage and efficiency of treatments for CMD.

This manual is a resource for HCs working in Primary Care Clinics. The first version of this manual was developed as part of the MANAS trial. The goal of the MANAS program was to integrate the treatment of CMD into routine primary health care. In the MANAS program, a range of effective treatments (for example, psycho-education and anti-depressant medicines) and engagement styles (for example, continuing support and monitoring until recovery) were provided to patients with CMD. These treatments were tailored to individual requirements to improve the effectiveness of the treatments and to use the limited resources efficiently.

This version of the manual is based on the experiences of the HCs during the MANAS program, in which they provided care to over 1,400 patients with CMD in 12 primary health care facilities in Goa.

Role of the HC

The HC is the “front-line” person in the mental health care team and is expected to perform a number of important tasks. These include:

- i. screening patients who attend the primary health care clinics with the symptoms of CMD

- ii. providing specific psychosocial treatments to patients; referring patients with complex or severe problems to a specialist
- iii. facilitating follow up and supporting adherence with medications; referring patients to other agencies for specific social problems
- iv. maintaining the required standards of documentation

The HC needs to work very closely with the primary care team, in particular the primary care doctor. The activities of the HC should be supported by a visiting mental health specialist (preferably a psychiatrist) with whom he/she can discuss any difficulties in patients with complex problems or need of specialist assessment.

To be an effective practitioner, the HC will need to acquire a set of essential theoretical and practical skills that are described in this manual.

Manual for Health Counselors

The manual is organised as a series of chapters that describe these skills in a stepwise manner:

- **Chapter 1** introduces the essential theoretical basis for understanding CMD in relation to stress, detection and diagnosis.
- **Chapter 2** describes the principles and the structure of the program and introduces some essential cross cutting sections that are important to the program.
- **Chapter 3** describes the different individual treatments that are part of the overall intervention in detail.
- **Chapter 4** discusses the actual delivery of the intervention and describes the operational details of the program including the structure of the primary care team, recommended supervision, documentation requirements and strategies to enable integration within the clinic.
- **Chapter 5** consists of the Appendices relevant to the program for patients with CMD.

The manual also has a glossary of some technical terms and an appendix of the types of organisations that address social needs which should be mapped for a particular area.

This manual is intended for front line, non-specialist personnel (including community health workers, nurses and other cadres of non-specialist health workers) working in primary care clinics.

Some of these health workers may not have had any previous experience or training in providing care for persons with mental health problems. Accordingly, the manual uses non-technical language and day to day examples to make the manual user friendly.

Furthermore, the term “Common Mental Disorders” or CMD is used in this manual to collectively describe the International Classification of Disease (ICD)-10 diagnostic categories of depressive and anxiety disorders since these disorders have overlapping symptoms, similar course of the illness and treatments.

This version of the manual builds upon the previous drafts shaped by the rich experiences gained through the entire course of the MANAS program and the findings of the evaluation. These experiences and evidence have added value to the manual by making it relevant to the challenges and opportunities that exist in the real world and reflect on the benefits of the intervention in the trial.

This manual is also intended to be a resource for those involved in the training of the HC to deliver mental health treatments for patients with CMD.

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Glossary of Terms

Acute Stress Reactions	The immediate response of the body to a sudden stress. Consists of physical changes such as increase in the rate of heart beat that enables us to deal with the stress
Adherence	Compliance with the intervention such as taking medication, following advice and returning for regular follow up appointments
Adrenaline	Chemical released in the body in the face of stress, which causes the physical changes that make up the stress reaction
Alcoholics Anonymous	A self-help group of people who desire to stop drinking and maintain abstinence while helping others to do so too. They hold regular meetings of their members and aim to bring about recovery from alcoholism by abstaining from alcohol one day at a time.
Ambivalence	Having mixed feelings or contradictory ideas about something or someone
Attempted Suicide	An act of harming oneself that does not lead to death
Attending Behaviour	The counselor's behaviour that indicates she is listening attentively to the patient. For example, leaning forward in her chair, nodding attentively, etc.
Biopsychosocial	Having biological, social and psychological characteristics. The Idea that the body, the mind and one's social environment are closely connected.
Black Magic	Cultural belief related to the supernatural, magical and most often evil practices such as casting of spells
Mental Health Specialist	The Psychiatrist or Clinical Psychologist who trains, supports and supervises other members of the primary care team
Clinical Status	The health condition of the patient, who visits the clinic as observed by the doctor/health counselor

Collaborative Stepped Care	The MANAS intervention follows a <i>stepped</i> care approach i.e. a range of simple to complex treatments in a step by step fashion depending upon the severity of the illness. The intervention is provided in close collaboration with members of the clinic team and the Mental Health Specialist (MHS).
Community Agencies	Government or Non Governmental Organisations (NGO) that provide specific social assistance to people in the community. For example, financial support for widows, the elderly, women's groups for women affected by domestic violence, etc.
Completed Suicide	The act of knowingly and intentionally harming oneself that results in death
Confidentiality	Making sure that information provided by the patient is not known publicly and kept restricted to the small circle of persons involved in providing care
Counseling	Assistance from a professional to help in the resolution of personal difficulties and/or health problems
Detoxification Centre	A specialised facility that deals with treatment of alcohol and drug dependence. Besides treatment of withdrawal states, some centers provide rehabilitation and long stay facilities as well.
Disability	The combination of a physical impairment such as loss of vision and the social attitudes and environment that prevents a person from living a full, normal life or from performing his/her normal job
Distress	The experience of emotional pain and anguish
Genes	Unit of heredity that is transferred from parent to child and determines some characteristic of the child, for example, colour of hair and eyes, or even susceptibility to some illnesses.
Gynaecologist	A medical specialist who deals with women's reproductive health problems

Health Counselor (HC)	The member of the primary clinic team who coordinates the MANAS intervention, facilitates the detection of Common Mental Disorders (CMD), provides psychological treatment for CMD and maintains clinical records
Homosexuality	Sexual attraction to members of the same sex
Hysterectomy	Surgical removal of the uterus
Impasse	A situation that is so difficult that no progress can be made
Impotency	A complete inability to have sexual intercourse in men
Insomnia	The inability to fall asleep or remain asleep for an adequate length of time
Interpersonal Deficit	An interpersonal problem area described in Interpersonal Psychotherapy that denotes difficulty in establishing intimate and long standing relationships resulting in loneliness and social isolation
Interpersonal Dispute	An interpersonal problem area described in Interpersonal Psychotherapy that denotes serious disagreement with a significant person in your life
Interpersonal Psychotherapy	A form of psychotherapy in which emphasis is placed on enhancing the patient's ability to cope with stresses, improving communication with other persons, increasing morale and helping the patient deal with the effects of the Common Mental Disorders (CMD). It identifies four problem areas viz. interpersonal dispute, grief, role transition and interpersonal deficits as important factors contributing to CMD
Intervention	An approach to help a person with a health problem recover
Menopause	The period during which a woman's menstrual cycle ceases, normally occurring at an age of 45-50
Mental Health Specialist	The Psychiatrist or Clinical Psychologist who trains, supports and supervises other members of the primary care team

Mental Illness	Any illness which affects a person's emotions, thoughts or behavior, which is out of keeping with their cultural beliefs and personality, and is producing a negative effect on their lives or the lives of their families
Metabolism	The chemical processes occurring within a living cell or organism that are necessary for the maintenance of life
Mood Ladder	A way of rating someone's mood in the form of the steps of a ladder
Motivation	A desire or interest to do something
Perception	The conscious experience of things that involve our senses of hearing, seeing, touching, etc.
Phobia	A persistent, abnormal and irrational fear of a specific thing or situation that compels one to avoid it, despite the awareness and reassurance that it is not dangerous
Predictor	Information that anticipates the occurrence of a future event
Procedure	A set of guidelines or rules to achieve a task
Psychoeducation	The process by which the patient is given an explanation about what her illness is and is provided with practical advice to deal with her problems. It is the first step in the collaborative stepped care model and offered to all depressed patients irrespective of illness severity.
Psychological Treatment	"Talking" treatments given to improve the psychological health of a person. For example: Interpersonal therapy, Psychoeducation, etc.
Reassurance	Acts of helping a person regain their confidence
Resilience	The positive capacity of a person to cope with stress. It is also used to indicate the resistance to future negative events that can cause stress.

Role Transition	When a person's role changes due to changed life circumstances. This may be positive, e.g. job promotion, or negative e.g. loss of job. It is one of the IPT problem areas.
Self Esteem	Personal feelings or opinions of oneself
Sense of Mastery	An individual's perceived ability to handle a task
Sick Role	Identifying oneself to have an illness that then allows the adoption of appropriate behaviors such as rest, reduced responsibilities, going to the doctor for treatment, etc.
Somatic Complaints	Complaints related to the body, for example, aches and pains, tiredness, etc.
Stigma	Negative attitudes towards someone having problems like mental illness
Stressor	An event, situation or condition that causes stress
Suicidal Risk	The chance that a person will intentionally cause harm to him/herself
Symptom	A physical or mental feature that is regarded as indicating a condition of diseases, for example, stomach pain is a symptom of stomach ulcer or, in the case, of mental health, tiredness is a symptom of depression
Symptomatic Treatment	Symptomatic treatment is any intervention targeting the signs and symptoms of an illness, but not necessarily their cause. Examples: pain killers and sleeping medicines
Ventilation	Freely talking or sharing personal information about a problem
Vulnerability	The predisposition of experiencing negative events like physical injury or emotional distress
Withdrawal Symptoms	Any physical or psychological distress (such as sweating or CMD) experienced by a person who is addicted to alcohol or drugs when deprived of the alcohol or drug

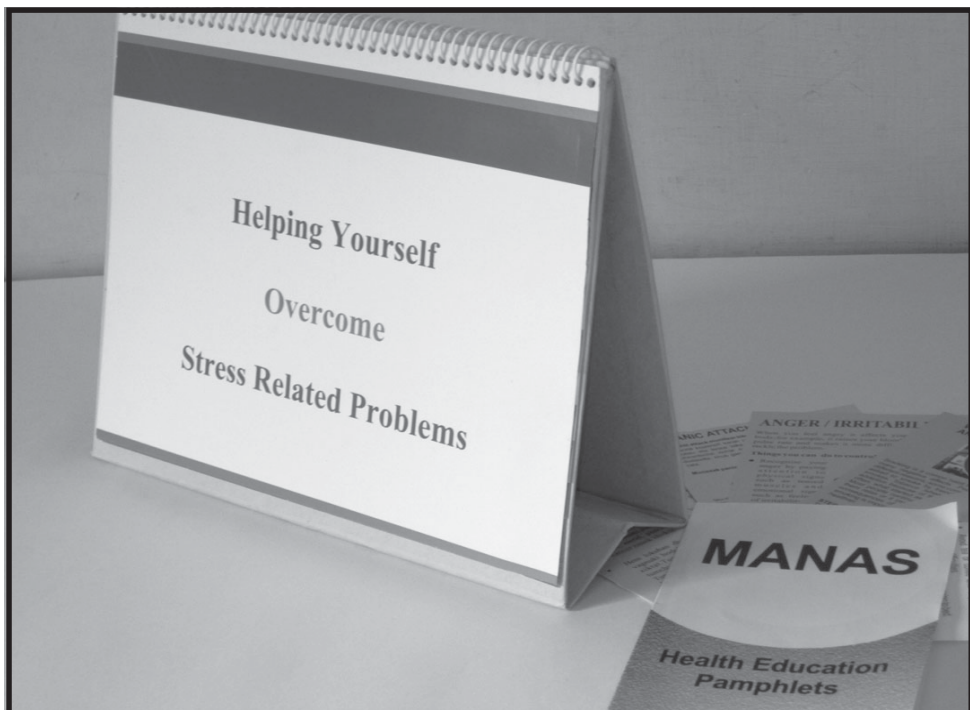
List Of Abbreviations

ADT	Antidepressant
AIDS	Acquired Immune Deficiency Syndrome
CSC	Collaborative Stepped Care
CMD	Common Mental Disorder
GHQ	General Health Questionnaire
HC	Health Counselor
HIV	Human Immunodeficiency Virus
IP	Interpersonal
IPT	Interpersonal Psychotherapy
MHS	Mental Health Specialist
NGO	Non-Governmental Organisation
OP	Out Patient
PE	Psychoeducation
PHC	Primary Health Centre
SSRI	Selective Serotonin Reuptake Inhibitor
SMS	Short Message Service
TCA	Tricyclic Antidepressant
WHO	World Health Organisation

Chapter 1

Stress and Common Mental Disorders

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Flip chart used during psychoeducation

Introduction to Stress

In this chapter we will answer five important questions about stress and explain the meaning of Biopsychosocial Model. By the end of the chapter, we will know:

- What is Stress?
- What are the common types of stress?
- What are the different reactions to stress?
- How do we understand stress and its consequences from the point of view of the Biopsychosocial Model?
- What is the relation between stress and CMD?

1.1a What is stress?

In the recent years, more and more people are getting to know about stress and the stress related problems. Why this increase in awareness has happened is that the busy lives of people and the pressures at work have increased reporting of stress in the TV and newspapers. The words “stress” and “tension” have, therefore, become part of our everyday language.

A simple way to understand stress is to think about it in mechanical terms. You can think of stress as being caused by an excessive physical load being placed on a person. While some stress is bearable, beyond a certain limit, stress results in ‘breakdown’, and a person cannot deal with daily tasks. Therefore, the inability to deal with stress can result in problems in various areas of a person’s life. For example, stress can make a person’s health worse, create difficulties in close relationships and cause poor performance in studies or in work.

And now, let us define stress. For our purpose, **stress can be defined as any event or experience that disturbs the balance or the ability of a person to function smoothly.**

1.1b What are the common types of stress?

Now that we know what stress is, let us look into the different types of stress. There are three common ways in which stress can be described:

i) Stress that is caused by changes ‘inside or outside us’:

This first way to describe stress is the stress that is due to the many changes that keep occurring during our lifetimes, both ‘inside us’ i.e. in our bodies, and ‘outside us’ i.e. in our environment. Some examples of changes that happen ‘inside us’ are serious health problems like the diagnosis of heart disease, cancer or mental illness.

The examples of changes that occur 'outside us' are changes or break up of valued relationships, the death of a loved one, etc. When these kind of changes take place, it results in stress.

ii) Stress that is sudden (acute) or long term

The second way to describe stress is by how it happened: whether the event that caused the stress happened all of a sudden (acute or sudden stress) or whether the event that caused the stress had been going on for a long period of time (long term stress).

Examples of the cause of acute or sudden stress include death of a family member, serious accidents and natural or manmade disasters. Examples of cause of long term stress include disadvantages of being a woman in society and in earning an income, disadvantages of belonging to a particular social class, problems of poverty, problems in marriage and disabling illnesses, all of which reduces the quality of people's lives. Both sudden and long-term stresses affect a person biologically, socially and psychologically in different ways.

iii) Stress that is mild or severe

Stress can be less serious or mild, and it can be more serious or severe. This third way to describe stress is defined by the mildness or severity of the stress and the event that causes the stress. Of course, it goes without saying that if the problem is more serious, the stress to the person is also more serious and the person's life is more affected. Research has shown consistently that as the problem becomes more difficult to handle or severe, the health of the person becomes worse. Examples of mild stress are changes in vacation or travel plans, or dealing with unexpected visitors. Examples of severe stress are the death of a loved one or being the victim of a serious accident.

1.1c What are the different reactions to stress?

Everybody does not react to stress in the same manner. Different people deal with stress in different ways and some people are more likely than others to develop problems after experiencing stress. How do we explain this?

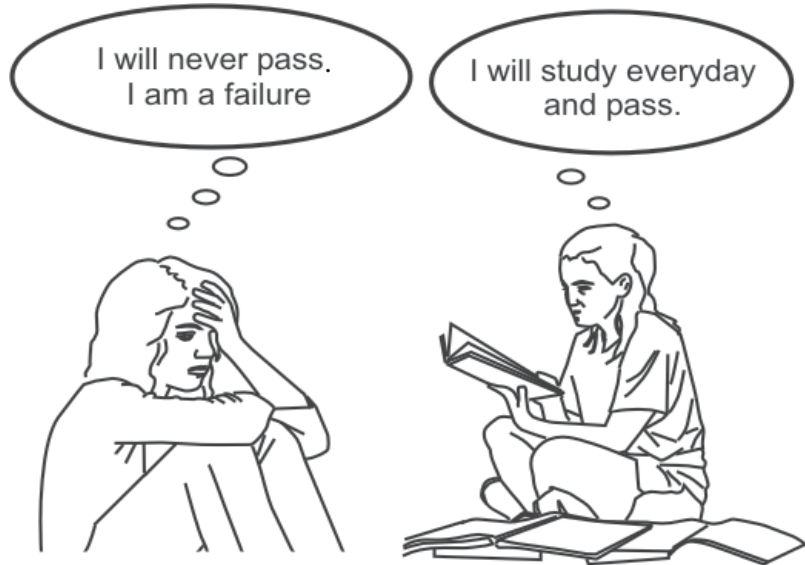
As we learnt earlier, stress is produced by events or problems in our physical or social environment. First, we experience that particular stressful event or problem, and then, we react to that problem by giving it some emotional importance. **The reason why different people react differently to a similar stressful problem is that no two persons are the alike in terms of their biological make-up, personality or social environment.**

Failing in examinations is a good illustration of the above. While some of us are very seriously affected to the point of contemplating suicide, others deal with failure by

taking it in their stride, or seeing it as a challenge to excel the next time around. **The manner in which a person reacts to the events and deals with difficulties is also different at different points in a person's life.**

It must be mentioned that **not all stress is bad.** We are more

alert, focused and oriented to the task when we are stressed and therefore, stress can, sometimes, help improve our functioning. Stress can also help us to see things from a different point of view. It can also enhance our personal growth by improving our self esteem and giving us a feeling of being in control of our lives.



1.1d How do we understand stress in the context of the Biopsychosocial Model?

First let us learn what is the Biopsychosocial model. It is a model that is used to consider the biological, social and psychological aspects of a person's life to understand the stress that a person is facing.

Not only can we understand stress better if we consider its biological, social and psychological aspects, but we can also better understand the causes or the consequences of stress i.e. what happens after stress occurs.

i. Using the Biopsychosocial model to understand stress

First let us understand stress by using the Biopsychosocial model. What makes an event or a problem stressful is the meaning we attach to it. The meaning we attach to it is, in turn, influenced by the social, physical and psychological aspects like the social environment, cultural beliefs and attitudes, past experience and personality type of the individual.

The psychology or the mental make-up of a person affects a person's ability to deal with stress. For example, someone who has a naturally anxious psychological make-up will tend to get upset more easily when compared to another person who is more relaxed and easy going.

The social environment in which a person lives, also influences a person's ability to deal with stress. For example, after the death of her husband, the widow could lose family support and face economic difficulties and, therefore, feel stressed more easily.

Finally the biological aspect of person's life also matters in his or her ability to deal with stress. A person suffering a chronic illness can find it more difficult to deal with stress.

In this manner, if we are to understand a stress completely it is important to consider the biological, social and psychological aspects of the event and the person.

ii. **Using the Biopsychosocial model to understand the consequences of stress**

Now let us use the Biopsychosocial model to understand the consequences, the results or how a person is affected when he or she experiences stress.

The physical consequences of stress

The first consequence deals with the physical body of the person. How does stress affect a person physically? To understand this we need to know what changes occur in the body.

In a stressful situation, the human body is designed to react to stress in a particular manner. **Acute stress reactions** is the term given to these immediate responses of the body to a certain stressful situation.

To explain acute stress reactions further, let us see the sequence of events that occur as soon as a person experiences a stressful situation. The brain and body go on an alert mode. This releases certain chemicals in the brain that cause certain changes in the body to help cope with the stress. The attention improves, the heart and respiration rate increases and the blood supply to the muscles increases. In other words, the body gets ready for a 'fight or flight' response to the stressful situation.

For example, if we suddenly see a snake, our heart starts beating quickly. We start breathing faster and our muscles get tense. These are the automatic preparations that the body makes to escape from the situation.

Similarly, when we get angry, we experience the same physical changes that help us fight, if necessary. Chemicals involved in stress reactions also affect the body by increasing metabolism and making more energy available to deal with the problem.

However, there is a negative side to the acute stress reactions, and that is if the stress continues for a long time, the alert mode of functioning also continues for a long time. By then the body has used up much energy and is finding it difficult to keep the body and mind at high alert. That is when fatigue sets in. The brain and body are now too tired and 'give up'. The weakness makes the person more vulnerable

to physical and/or mental problems like fatigue, sleeping difficulties, and aches and pains.

The emotional consequences of stress:

Now let us move on to the second consequence which is psychological, which involves the emotional life of a person. How does stress affect a person emotionally? The emotional consequences or results of acute and chronic stress are similar in nature to the physical responses described above. In the short term, stress energises the mental functions like attention span, concentration and memory. These mental functions perform at their best, which then helps to solve the immediate problem. On a short term, this heightened state of the mind is usually quite successful and useful in dealing with most daily problems. For example, the heightened/aroused state of readiness helps individuals cope with the strains of work, caring for the family and sorting out interpersonal disputes.

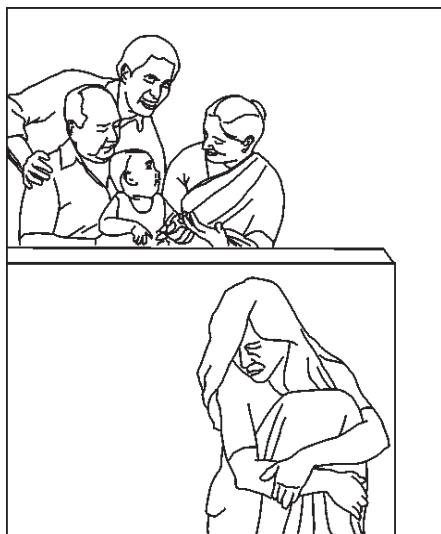
However, when the stress is too much or too severe like the loss of employment and social status, being physically or sexually assaulted, loss of home during disasters, etc., or when the stress goes on for a long term with little possibility of being resolved, like domestic violence, poverty, infection with HIV/AIDS, etc., the psychological ability to cope may get exhausted and person experiences a lot of distress. The exhaustion and distress then result in depression, anxious mood, lack of concentration and feelings of hopelessness, etc.

The social consequences of stress:

The third and final consequence of stress is social. How does a person get affected socially when he/she faces a certain stress? This is concerned with the social life of a person. The social networks, like friends and family, exist in a person's life in a supportive and protective role to help an individual deal with stress. They can be thought of as a **safety net**. For example, when we are upset about something, we talk to parents, friends and family members who provide us support and help in resolving difficulties.

On the other hand, **social networks can also be a cause of distress** and can make a person feel trapped and humiliated. A good example is the trauma faced by some women after marriage, when they are subjected to domestic violence and neglect because of dispute over dowry.

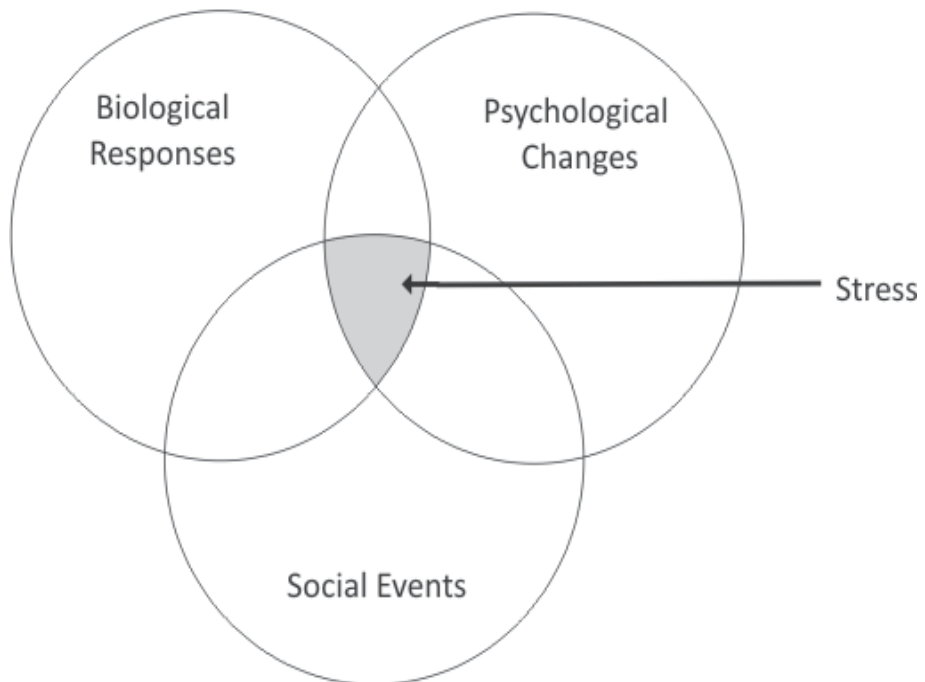
If the stress is ongoing and long term, its effects can be seen in the social context also when a person withdraws from previous social interactions with friends, colleagues or family.



The Biopsychosocial model of stress:

Although we have discussed the biological, psychological and social consequences of stress separately for the sake of convenience, you must understand that they are not independent of each other. In reality, there is a **continuous interaction** between the biological, psychological and social elements that together results in the stressful experience and its consequences. **We therefore see that stress is best understood as a Biopsychosocial experience.** Refer to the figure below:

The Biopsychosocial Causes Of Stress



1.1e What is the relation between stress and Common Mental Disorders?

Common mental disorders (CMDs) are common mental health problems like depression and anxiety. Stress and CMDs share a close relationship. A person who experiences a stressful situation is more likely to develop CMDs. If a person is exposed to certain types of stress that are born out of long term and difficult to change life experiences, then he or she is especially prone to CMD.

A person, who develops CMD like depression or anxiety, will find dealing with stress more difficult. And the inability to deal with stress further causes a lack of confidence which in turn further aggravates the CMD.

The following figure shows that they mutually reinforce each other, i.e. stress causes CMD and CMD causes stress, and this makes it more difficult for the person to recover.

The Relationship Between Stress and CMD



Understanding stress: the relationship between stress and CMD

As an HC, you will be dealing with people who experience stress. Helping the person to identify and deal with stressful experiences is an essential part of your work. You will need to break the mutually reinforcing link between the two, the stress and the CMD, and this will help the person to recover. Therefore it is important for you to understand stress properly and also the relationship between stress and CMD.

In this chapter we learnt that:

- ⊙ Stress is a part of everyday life.
- ⊙ Stress can be caused by changes inside or outside us; can be sudden or acute; and can be mild or severe.
- ⊙ Different people have different ways of perceiving and reacting to stress.
- ⊙ Stress is best understood as a Biopsychosocial experience, in which biological, psychological and social elements together result in the stressful experience and its effects.
- ⊙ Stress and CMDs are closely linked and mutually reinforce each other making it difficult for the person to break the cycle and recover.
- ⊙ As an HC, you need to understand the link between stress and CMDs.

Vulnerability and Resilience

After looking into the meaning of stress, let us move on to the topics of vulnerability and resilience. In this chapter, you will learn:

- What is mental health?
- What is resilience?
- What are protective factors?
- What is vulnerability?
- What are risk factors?
- What is the importance of vulnerability and resilience?

1.2a What is Mental Health?

The World Health Organisation (WHO) defines health as being a complete state of physical, psychological and social well-being.

Mental health may be considered to have three aspects:

- Firstly, mental health involves the ability of a person to function to the best of his or her ability and to achieve goals to the best of his or her capacity.
- Secondly, it includes a sense of control over the environment. This means learning to overcome obstacles or problems that are 'outside us' by using the strength that is 'inside us'.
- And thirdly, positive mental health also means being able to identify, face and solve problems. This is possible by finding positive ways and methods to deal with everyday problems.

1.2b What is resilience?

All of us face some kind of difficulty or the other in our daily lives. The capacity to deal with difficulties and to avoid health problems is different from person to person. Sometimes, even with the most severe stress and difficulties, many people do not suffer from CMD. This is because of their resilience.

What is resilience? **Resilience refers to the ability of a person to deal successfully with difficulties and not to 'breakdown' or develop health problems when faced with stressors which are events, situations or conditions that cause stress.**

The development of resilience is dependent on a number of factors which are inter-related. For example, we know that losing parents early in life makes a person get CMDs more easily than others.

However, this does not happen to everyone. If a person after losing his /her parents, faces inadequate care and deals with the lack of emotional stability in the family then he or she will get CMDs more easily. If a person, when a child, has loving supportive relatives, then he or she can deal with the loss of parents and still build up resistance to developing CMD in adulthood.

The person with supportive relatives will have a better ability to deal with difficulties than the person who does not have supportive and loving relations.

1.2c What are protective factors?

Therefore there are certain factors that can increase a person's resilience. The term given to them is "protective factors". Protective factors are the things that help a person to deal with a stressor in such a way that the person can prevent the stressor from becoming a CMD.

Examples of protective factors are:

- having strong and trusting relationships with relatives (such as spouse), friends, or colleagues at work
- having a 'positive' self image, for example, feeling that one is a good mother
- having faced and overcome difficulties successfully in the past
- having a happy childhood with caring parents and relatives
- living in a safe community with strong social networks
- having good physical health

1.2d What is vulnerability?

And now let us move on to "vulnerability". Vulnerability is the opposite of resilience. **Vulnerability refers to the inability of a person to deal successfully with difficulties and to the 'breakdown' or development of health problems when faced with stressors.**

Some people can successfully deal with stress while some cannot. This inability to deal with difficulties is termed as "vulnerability". People who do not have the capacity to deal with difficulties are more likely to fall ill.

Why one person has resilience and another has vulnerability to CMDs is because of multiple and interacting biological, psychological and social reasons. Just as certain

factors increase our resilience, there are many factors that also increase our vulnerability. Examples of vulnerability factors are the absence of a strong, affectionate relationship during childhood and being a woman in societies where women are undervalued. This makes a person less able to deal with stressors, and therefore more likely to experience CMD.

Another important factor that determines vulnerability is what we inherit from our parents: characteristics determined by our genes. Genes determine many things about us, such as our gender and the color of our eyes and hair. Our genes also determine which illnesses we may be vulnerable to at some point in our lives.

Some people have a genetic vulnerability for developing CMD. This means that if we have close relatives who suffer from depression, we may inherit a tendency to develop the same illness.

Stress-Vulnerability model of CMD

There is a definite relationship between the inability to deal with stress and falling ill. If a person is more vulnerable to stress, then he or she is more likely to fall ill with a CMD when faced with a stressor. This is called the **Stress-Vulnerability model of CMD**.

The idea is that when the stress a person faces in life becomes unbearable, then the person becomes ill. Also, do not forget that people's ability to deal with stress differs, and a particular problem which one person may take in her stride might be enough to cause another person to become depressed.

This relationship between the inability to face stress and getting a CMD is most clearly seen amongst people who are socially and economically not very well off. The factors that make them more vulnerable to mental illnesses are: being unable to acquire wealth and social happiness; the insecurity that arises from this; the feelings of hopelessness; the realisation that everyone else is going ahead in their lives; the risks of violence from within the family; and physical ill health due to inadequate nutrition, etc. All these factors make a person vulnerable to CMDs.

1.2 e What are risk factors?

Just as protective factors are factors that increase a person's resilience, the factors that increase a person's vulnerability to developing mental health problems are called risk factors. In addition to the risk factors that have been discussed above, other risk factors that lead to CMD can be listed as follows:

- **Physical health risk factors:**
 - i. suffering from a chronic physical illness or disability (e.g. heart disease or cancer)

- ii. suffering from gynaecological complaints – for women
 - iii. addiction to alcohol
 - iv. addiction to tobacco (smoking or chewing)
- **Socioeconomic risk factors:**
 - i. indebtedness
 - ii. unemployment
 - iii. overwork (e.g. looking after many children for women)
- **Relationship risk factors:**
 - i. lacking trusting relationships (e.g. with friends or spouse)
 - ii. living in a violent relationship
 - iii. experiencing child abuse
 - iv. losing parents in early life
- **Difficult life events that are risk factors:**
 - i. bereavement (i.e. death of a loved one)
 - ii. break-up of a relationship
 - iii. transition of a relationship (for e.g. retiring from work or children leaving home)
 - iv. care for a loved person who is severely ill
 - v. experience of a violent incident or accident

1.2 f How are protective and risk factors important to you as the HC?

As the HC, you will be providing counseling to people, who already suffer from CMD. It is important for you to identify the risk and protective factors that affect the person so that you can understand the vulnerability and resilience to the stress that the person is facing.

This is important because it has a direct influence on what advice you might give to a patient.



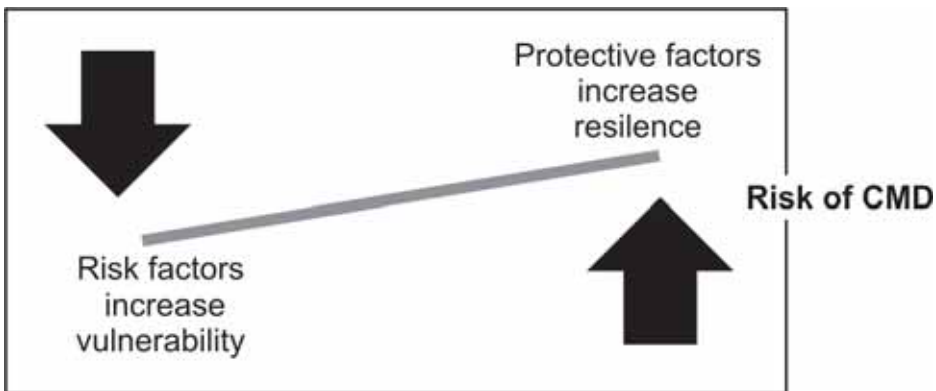
By identifying risk and protective factors, you can decide on what advice to give.

This is the way this works:

Protective factors make a person more able to deal with stress. By identifying protective factors, you can build on these factors to help the person recover and then remain in good mental health. For example, a woman with a supportive family can be encouraged to seek help from her family in times of stress.

Alternatively, risk factors determine the person's inability to deal with stress. By identifying risk factors, you can encourage the person to reduce these, or reduce their impact and thus help the person to recover and then to remain in good mental health. For example, a patient who drinks excessively is educated about the harmful effects of alcohol and encouraged to cut down/stop drinking.

Relationship of vulnerability and resilience to the risk of CMD



In this chapter we learnt that:

- ⊙ Resilience is a person's ability to deal with stressors.
- ⊙ Protective factors are factors that increase the resilience of a person to deal with stressors.
- ⊙ Vulnerability is the inability of a person to deal with stressors and the greater risk of developing CMD.
- ⊙ Risk factors are factors that increase vulnerability and lead to development of health problems.
- ⊙ As an HC, while counseling patients with CMD, you have to increase protective factors and reduce risk factors.

Common Mental Disorders: An overview of symptoms

In this chapter we will learn the following:

- What is depression and anxiety?
- How is CMD presented in Primary Care?
- What are conditions that may mimic CMD or co-exist with them?

1.3a What is depression and anxiety?

We all know what depression is. At one point of time or the other, we have all felt depressed. Depression refers to the experience of feeling unhappy, 'low', sad, fed-up or miserable. Depression is part of our lives. It comes and goes. However, when depression lasts for more than a month it results in tiredness and difficulty in concentration.

These disabling symptoms then make it more difficult to work or look after small children at home. If depression starts to get in the way of life and continues for a certain length of time without any let up, then we say that the patient is suffering from an illness called 'depressive disorder'.

Similarly, we also know what anxiety is! We have all felt anxious at some point in our lives. Anxiety is feeling tense, fearful and nervous. Like depression, this is normal in certain situations. For example, most students feel anxious and tense before examinations.

However, anxiety can cross the line from being a normal experience to becoming an illness when it lasts for a prolonged period (i.e. over 2 weeks), starts interfering with the person's life and consists of persistent symptoms like headaches, palpitations and worrying that something terrible is going to happen.

Even though we talk about depression and anxiety as different emotional states, in reality, they are the two sides



of the same coin. When a person is feeling sad, she may also worry a lot. When a person is feeling tense, she may also lose interest in meeting friends and feel sad and unhappy.

In fact, in primary health care settings you will see that the vast majority of people with anxiety and depression have mixed symptoms of both emotional states. In this manual, when we refer to the term CMD (Common Mental Disorders), we include patients who suffer from either depression or anxiety disorders or more commonly from a combination of symptoms.

CMD is the most common type of mental disorder in primary health care settings. Research from Goa and other parts of India has shown that CMD is a critical health problem because:

- It affects between 10-20% of all adults attending primary care clinics.
- It is known to result in high levels of disability and utilisation of medical services.
- It worsens any co-existing physical health problem.
- In mothers, it can affect the growth and development of children.
- In severe cases, if untreated, it may lead to suicide.



1.3b How is CMD presented in Primary Care?

It is important to know that in the primary health care setting, people with CMD rarely complain of emotional difficulties or symptoms. They complain about physical symptoms of depression and anxiety e.g. tiredness, sleep problems, palpitations (heart beating fast), headache, stomach upset, dizziness, and other aches and pains.

Most of these symptoms cannot be connected to any particular physical health problem and often these unexplained or multiple physical symptoms are the result of depression or anxiety from which the person suffers, but is unaware of the fact.

Symptoms of Depressive Disorders

Presenting Complaints

- aches and pains all over the body
- tiredness, fatigue and weakness
- disturbed sleep (usually worse, but occasionally too much sleep)
- poor appetite (sometimes markedly increased appetite)

Complaints on inquiry

- feeling sad and miserable
- feeling a loss of interest in life, social interactions, work etc
- feeling guilty
- feeling hopeless about the future
- having difficulty in making decisions
- thoughts that one is not as good as others (low self-esteem)
- thoughts that it would be better if one was not alive
- persistent suicidal ideas and plans to end life

Symptoms of f Anxiety Disorders

Presenting Complaints

- palpitations
- a feeling of suffocation
- chest pain
- dizziness
- trembling, shaking all over
- headaches
- pins and needles (or sensation of ants crawling) on limbs or face
- poor sleep

Complaints on inquiry

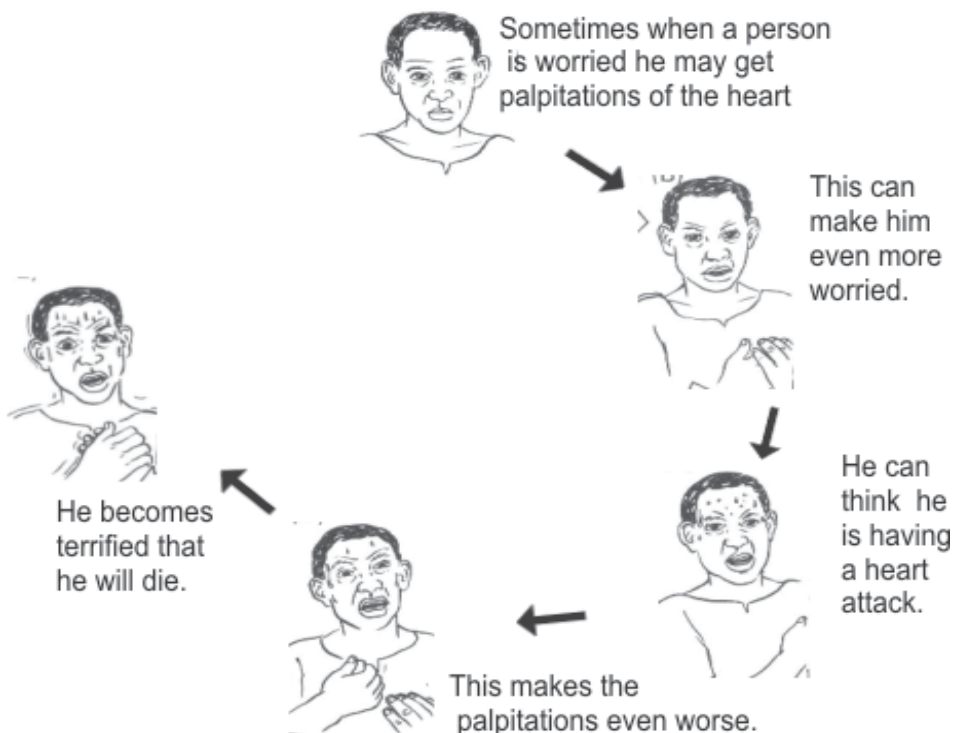
- feeling as if something terrible is going to happen
- feeling scared of things that most people do not usually worry about
- worrying too much about one's problems or one's health
- thoughts that one is going to die or lose control

What are panic attacks and phobias?

Panic attacks are episodes of extreme anxiety and fear. They consist of some specific kinds of anxiety symptoms which commonly tend to occur together to form recognisable patterns of illness. These illnesses are panic attacks and phobias.

This is the description of a typical panic attack:

- It occurs suddenly without any warning.
- It is so extreme with such severe physical symptoms such as palpitations (i.e. feeling one's heart beating fast) or difficulty in breathing, that the person is terrified that he may die or collapse or lose control of his mind.
- These symptoms last from a few minutes upto half an hour.
- The symptoms disappear as suddenly as they appear.



Panic attacks are quite common. Most persons will have one or two panic attacks at some point during their lives. However, when panic attacks become more frequent, regular and prevent the person from carrying out their daily activities (like going to work using public transport), then this is called **Panic Disorder**.

Some people experience panic attacks only in specific situations or as a reaction to certain objects. These fears are not reasonable because the situations or objects are not themselves dangerous and the person would, under normal circumstances, have faced them without feeling scared. Typically, the person with these fears of specific situations will try and prevent experiencing panic attacks by avoiding the situations. These fears linked to specific situations or objects are called **phobias**.

Many of us suffer from one phobia or another, for example, of dogs, spiders or snakes. However, some people have phobias of every day situations, such as:

- crowded places such as public buses, elevators or markets
- open places such as anywhere out of the house where there is no one to ask for help readily
- social situations such as meeting people or speaking in public

When a person becomes unreasonably fearful of these situations and starts avoiding them, it affects their life by stopping them from going out of the house alone for work or going to the market. This is why some phobias become health problems.



One must not forget that most patients with CMD never complain of psychological or emotional symptoms as their main problem. Their main complaints often will be physical symptoms.

1.3c Conditions that may mimic CMD or co-exist with them

It is important to remember that CMDs can often co-exist with other conditions. Hence, in the primary care setting you need to check whether these signs or conditions are also present in a person who is depressed.

A person who is depressed or suffers from anxiety could also:

- have an alcohol addiction

- have a medical illness especially chronic illness like arthritis, diabetes or heart disease
- have personality problems, a long-standing pattern of behavior that makes it difficult for him or her to deal with difficulties and solve problems. For e.g. those who feel inferior to others very easily on a regular basis could find it difficult to deal with stress at work or in the family

As you will learn later, as an HC you will have to refer some of these patients to the Mental Health Specialist for further management.

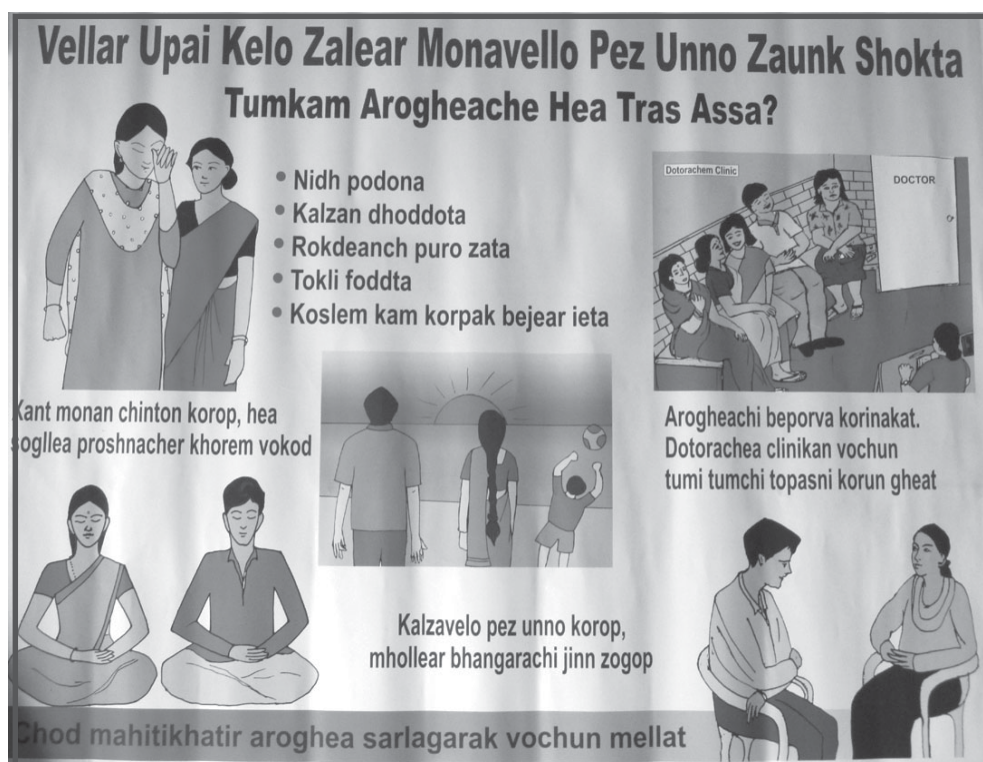
In this chapter we learnt that:

- ⊙ CMDs are common in primary care, affecting up to 20% of the patients.
- ⊙ People with CMD often have a mixture of symptoms of depression and anxiety.
- ⊙ In primary care settings, people with CMD will complain of physical problems rather than mental or emotional problems.
- ⊙ You should be familiar with the various symptoms both physical and mental that a person with CMD may experience.
- ⊙ CMD often occurs together with other conditions like alcohol abuse or personality problems.
- ⊙ As an HC, you will have to check whether these signs are also present in a person who is depressed.

Chapter 2

The Structure And Essential Building Blocks of the Program

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MANAS program poster displayed in the Primary Health Center in the local language.

The Collaborative Stepped Care Intervention

After learning about stress and Common Mental Disorders, let us move ahead to learn how these illnesses can be treated. In this chapter you will learn:

- What are the key principles of the intervention?
- What treatments are provided as part of the intervention?
- Who are the key personnel or people involved in providing the treatments?
- What are the detailed steps of the Collaborative Stepped Care model?

The meanings of the terms “treatment” and “intervention”

First, let us become familiar with two words that we will be using repeatedly in this manual and later on as an HC. We need to understand how the terms “treatment” and “intervention” differ from each other.

Treatment: This word refers to a single or specific method of treating an illness. To treat a CMD, for example, using antidepressant medicines would be one type of treatment, whereas using psychological treatment would be another type of treatment.

Intervention: This word refers to the way a package of treatments or a combination of medical, social and psychological treatments is delivered to the patient. For example, to treat a CMD, an intervention would be to use antidepressant medicines together with using psychological treatments and addressing the patient’s social problems.

2.1a What are the key principles of the intervention?

While treating a person with CMD, the intervention or overall approach of treatment that you decide to use is guided by certain rules.

Before we learn in depth about interventions and treatments, it is necessary to know what are the rules or principles that guide the intervention that we will give to the person.



These principles are described below:

1. We will use acceptable labels or words for mental health problems:

When we treat a person it is important to remember that we are interacting with people. Therefore, the use of certain words like “mental” or “mental illness” might be upsetting to them. During treatment, it is important to use words which will not upset anyone.

Research clearly shows that social factors, such as poverty and domestic violence, are the main causes of CMD. These views are also shared by patients. However while talking about them with people we must be sensitive to their feelings. Using terms such as “mental illness” is not acceptable to many patients.

Thus, we use locally acceptable words reflecting social difficulties, stress and tension in daily life.

However, we can use terms like CMD when communicating with doctors and other primary health workers.



2. We will give interventions for CMD in primary care facilities

It is recommended by the WHO that the Primary Health Care facility is the best place to deliver interventions for CMD. This WHO recommendation is based on four key reasons:

- There is a high burden of CMD in primary care, and therefore, there is most need for CMD interventions in the primary care.
- There is a severe shortage of specialist mental health providers such as psychiatrists or psychologists in the primary care.
- There is a stigma associated with seeing a mental health specialist, and a person, if treated at the primary care, will get privacy.
- The treatments for CMD that the doctor and you, the HC, can provide to the person are relatively simple and effective.

3. We will follow the principles for Chronic Health Care

We will give chronic (i.e. long term) disease interventions through team work. Many illnesses, which primary care focuses on, are acute (sudden) diseases, such as malaria that respond to a simple treatment like a single course of medicines. Chronic diseases, on the other hand, typically need a combination of medical, social and psychological

treatments (i.e. an intervention), and also follow up of the treatments over longer period of time. In chronic disease interventions it is necessary for the health care approach to be based on team work, the combined work of many professionals. The team you will be a part of is the Primary Health Care Team.

The primary health care team consists of three key players: the Health Counselor (HC), the Primary Care Doctor and the Mental Health Specialist (MHS). Several other clinic staff may also play important roles (see below).

Principles for chronic (i.e. long term) disease intervention:

The principles of **chronic disease management** are similar for any chronic disease (such as CMD, HIV/AIDS, diabetes or heart disease). The four key principles are:

1. We will adopt a Stepped Care Model:

What is a stepped care model? Imagine a series of steps. To go to the second step, you must first land on the first step. To go to the third step, you go via the first and second steps and so on. Unless, of course, you are in a hurry in which case you may skip a step!

In the case of MANAS model, the stepped care treatment helps provide for the treatments according to different needs. To start off with, we would use the first step for everyone. On this step would be a relatively simple and risk-free treatment, which could be, for example, psycho-education, which involves explaining the nature of his or her illness to the person, or giving advice about the symptoms.

However, not everyone will get better with this simple treatment, because not everyone who suffers from CMD will be cured by the same treatment. Some people need more intensive treatments, which would then be moving onto the next treatment steps on which would be, for example, antidepressants and psychological treatments, which would form the second and third steps. In this manner, the intervention, tailored to the needs of the individual person, is delivered in 'steps' of specific treatments, depending on the severity of the illness and the response of the patient to the treatment. (See figure 2.1 A below.)

2. We will adopt collaborative care:

The next principle of the chronic disease intervention is to provide collaborative care. The word "collaboration" is a big word with a simple message that is "to work as a team". The MHS is the Psychiatrist or Clinical Psychologist who trains, supports and supervises other members of the primary care team, and also works collaboratively with the primary care team to ensure that the quality of the intervention is adequate.

Within the PHC (primary health care centre), the primary care team members will work as a team to ensure that each patient receives the best care. For

example, you, the HC, and the doctor will work collaboratively to discuss clinical issues around individual patient care.

3. We will combine health promotion with medical treatments:

The intervention will combine both health promotions (such as education about diet, lifestyle changes, etc) and specific medical treatments (e.g. antidepressants and psychological treatments). All the treatments we will use have been proved to be effective in the management of CMD. However, some patients may need additional treatment (medication/structured psychotherapy) not included in the intervention. The Mental Health Specialist will provide these treatments.

4. We will enable adherence management: Adherence management is to ensure that the treatment is being followed regularly by people and they are completing their course of treatments. Adherence management is a major challenge in the management of chronic diseases.

2.1b What are the treatments provided as part of the intervention?

After getting to know about stepped care intervention, let us now consider the specific treatments that are included in the Collaborative Stepped Care Intervention. These treatments have been chosen on the basis of the best scientific evidence available and after careful consultation with national and international experts. An introduction to the treatments is given here. The treatments are described in detail in the following chapters of the manual.

1. Detection of Common Mental Disorders (CMD):

This is the first and most important treatment. After all, if you don't detect CMD, you can't treat it! This treatment was discussed earlier in the manual. Do go back and refresh your memory on what we learnt about CMDs. The detection of a CMD will be the responsibility of the clinic secretary, registration clerk or you, the HC. (see the table of 'Detailed steps' below)

2. Psycho-education:

In this treatment you will combine the following: explanation about the nature of health problems and complaints, practical advice for managing symptoms of CMD (such as tiredness and sleep problems), advice on managing tension (such as breathing exercises) and referral to other agencies for problems which can be better handled by them (e.g. social welfare).

3. Yoga:

This ancient Indian practice is highly effective for promoting physical and mental health. Yoga is not an essential part of the intervention but it is an optional treatment that can be provided in places where it is feasible and culturally accepted. Since this is not routinely used in the MANAS program, details of the yoga methods are given in the Appendix 5.6.

4. Interpersonal Psychotherapy (IPT):

This is a specialised type of psychological treatment in which you will require at least 6 sessions with the person. IPT used in the MANAS model has been modified in order to improve its feasibility and acceptability.

5. Antidepressants:

Antidepressants are medicines that are given to treat CMDs and are prescribed by the clinic doctor.

6. Adherence management:

It is essential to become thoroughly familiar with the word 'adherence'. This is one of the biggest challenges of delivering the Collaborative Stepped Care Intervention. It literally means 'sticking to'. Practically, it means ensuring that the patient "sticks to" the intervention and takes the treatments as advised, for example, that he or she continues with the antidepressant medicine or comes for follow up sessions as required. The ultimate goal is to ensure that all patients recover fully from their symptoms and are able to live normal lives.

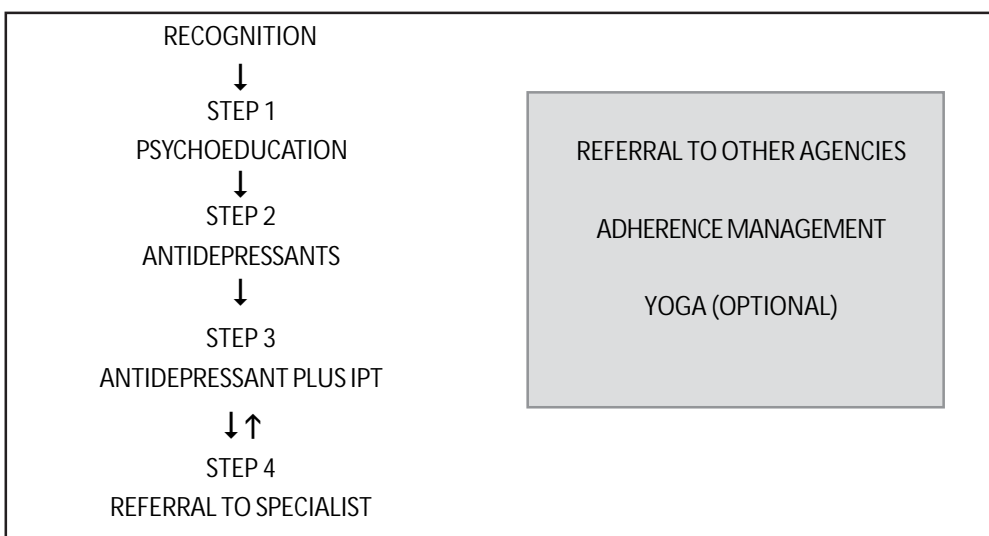
7. Referral to the Mental Health Specialist:

Despite your best efforts, there will be a small number of patients with CMD who need to see the MHS. So such cases you will refer to the MHS.

Note:

While most patients with CMD who attend primary care will improve with these treatments, there is a subgroup of patients with moderate/severe depressive disorders who may need further intervention such as different medications or specialised psychological treatments. The MANAS intervention does not specifically provide this and such patients are referred to the MHS for further management.

A simple flow chart of the steps of care



2.1c Who are the key personnel for the Stepped Care Intervention?

The doctor: the doctor is in charge of the entire program in the clinic. The doctor has two major roles. The first is to encourage patients who have been screened to be suffering from CMD to take the treatment as advised. The second role is to prescribe antidepressants.

The Health Counselor (HC): this person is you! You will be trained to provide all the non-drug treatments. You will report, on a day to day basis, to the doctor. In addition, you will also report to the Mental Health Specialist (MHS) for supervision.

The Mental Health Specialist (MHS): this is a visiting psychiatrist or clinical psychologist who has two key roles. The first role is to support the entire clinic team for difficult clinical cases. The second role is to monitor the quality of the program.

Other PHC team members: such as the registration clerk may also play a crucial role, including screening for CMD and supporting adherence.

2.1d What are the detailed steps of the Collaborative Stepped Care model?

See below and refer Appendix 5.7

Step	For whom	Timing	Treatment	By whom
Recognition	Adult patients attending primary care clinics	Before consultation with doctor	GHQ Screening questionnaire; report for doctor	Secretary/ registration clerk/HC
1	Patients screened with CMD (GHQ >5)	At first consultation	Advice regarding screening questionnaire results; advice regarding seeing HC Psychoeducation and follow up appointment as appropriate Information about Yoga sessions (where appropriate)	Doctor HC HC
2	Patients who are severely ill at first consultation (GHQ >7) or whose symptoms persist at follow-up	At first consultation or at first follow up at 2-4 weeks	Antidepressants Psychoeducation Adherence Management	Doctor HC HC
3	For patients who remain unwell or are not adherent	Patients who do not respond to Step 2 despite taking the treatment	Antidepressants & IPT Adherence Management	Doctor HC HC
4	For participants who do not respond despite good adherence	Patients who do not respond to Step 3 despite taking the treatment & Patients expressing suicidal ideas at any time	Continue all existing treatments Refer to Mental Health Specialist	HC & Doctor Mental Health Specialist

In this chapter we learnt that:

- ⊙ A treatment is a single or specific method of treating an illness
- ⊙ An intervention is a combination of medical, social and psychological treatments.
- ⊙ The MANAS model uses the Collaborative Stepped Care intervention to treat CMDs.
- ⊙ In the Collaborative Stepped Care intervention the treatments are provided in a graded fashion with simpler treatments provided to all patients, and the more sophisticated, resource intensive treatments reserved for those with a more severe illness.
- ⊙ The stepped care model is collaborative. The Doctor, HC, other primary care team members and MHS all work together to ensure the patient receives the best care.

General Principles of Counseling

It is important that if you are to help patients with CMD, you need to establish a rapport, a feeling of trust and build a strong and positive professional relationship with the person. This will make it easier for the patient to discuss her problems with you, and for her and you to benefit from the process of counseling. To build a good professional relationship, you need certain skills and attributes. So let us learn about the skills and attributes you need to be a good counselor:

In this chapter you will learn:

- What is counseling?
- Why is self awareness a prerequisite to counseling?
- What are the characteristics of a good counselor?
- What are the basic counseling and interviewing skills?
- What is telephone counseling?

2.2a What is Counseling?

Counseling is a two-way interaction between two people: the counselor, who is the trained person, and the patient. Counseling is a treatment that involves a trained person “talking” to a patient to assist and guide him or her to resolve personal, social or psychological problems and difficulties.

By talking to the trained person, the patient becomes more self-aware, accepts her weaknesses and identifies her strengths. The person gets a clearer picture of her problems and also gets to know how to work out various options to improve the situation. Counseling is also helpful to the counselor to decide upon a suitable course of action or intervention to take up to treat the person. Through counseling and treatment, the patient regains some control and mastery over her problems and feels less helpless.

What does counseling NOT include?

- i. It is not telling patients what to do.
- ii. It is not making decisions for patients.
- iii. It does not mean judging patients as good or bad people.
- iv. It does not involve interrogating or forcefully questioning the patients.
- v. It does not involve blaming patients.
- vi. It does not mean preaching or lecturing to the patients.

- vii. It does not mean making promises that you cannot keep.
- viii. It does not involve imposing your own beliefs on the patients.

Your husband is beating you !
It is wrong, go and
complain to the police

2.2b Why is self awareness a prerequisite to counseling?

Before you begin counseling, it is necessary that you are aware of yourself or that you know yourself well. Self awareness is needed for good counseling. Let us find out why.

What is self awareness?

First let us learn what self awareness is. For you, as a counselor, as indeed for everyone, self awareness is being aware of or knowing your own attitudes, values and beliefs. It involves understanding the manner in which your own attitudes, values and beliefs affect or influence your interactions with other people.

Why does one need to be self-aware to be a good counselor?

For a counselor, self-awareness is important for a number of reasons:

- It helps you to identify your own values, beliefs and attitudes. Each of us has a very set way of thinking. For example, a particular male counselor could believe that all women are weak. This can create problems in the counseling process. So self-awareness helps you to identify any stereotyped or set way of thinking, as well as prejudices or biases that could create problems in the way you treat certain patients. For example, you may have a negative attitude towards people who drink alcohol or people who are of a particular religion; this could influence the counseling process if you are not aware of this bias.

You told me that your husband is beating you when he comes home drunk .Can you think of ways by which you can avoid such situation?

- Self awareness helps to make a clear distinction between you and your patient. It helps differentiate between your own thoughts, feelings and problems from those of the person whom you are treating. If you do not do this, you can end up in forcing thoughts or way of seeing things, or solutions that work for you on your patient. What you should do instead is understand how the patient sees his problem and find solutions that work for the patient and not for you.

An example of imposing your own thoughts is: *You might think it unacceptable to live with a violent spouse; whereas the person you are treating who is living with a violent husband might continue to want to do so, but in a happier manner. In this case you will not help her achieve what she wants, but unknowingly force her to do what you want.*

- Another use of self awareness is it helps you to get to know yourself better. If you are aware of your own reactions during the counseling session, you can get to know your own beliefs that you did not know earlier. It will open up opportunities for your own growth and development. For example, if you feel uncomfortable when a patient is describing her tendency to pamper her child excessively, it makes you wonder whether your idea of parenting is too harsh.
- Self awareness also helps you to take care of yourself. It helps to make a separation or boundary between your thoughts, feelings or problems and those of the patient. It helps to create a boundary between yourself and the person. You need to make sure that this boundary remains clear. If you find it difficult to separate the patient's situation from your own, or find yourself preoccupied with a patient's problem, it is a sign that you have taken on the patient's problems as if they are your own. This can make you as a counselor feel emotionally tired and deal with high levels of stress.

2.2c What skills do you need to be a good counselor?

Counseling skills can be learned by anyone who has an interest in the subject and an open mind. You can too become a good counselor by learning what it takes. Let us first look into what are some of the important characteristics of a good counselor:

- You must be a good listener.
- You must be empathic.
- You must be non-judgmental.
- You must generate trust.
- You must be patient.
- You must be observant.

- You must have respect and be accepting of the other person.

Now let us take up each of these points separately:

You must be a good listener:

There is a difference between listening to the words the other person says and understanding the person's feelings and meaning behind those words. We are always 'hearing others out'. However, our listening process is selective and we often hear 'what we want to hear'. In counseling, you have to listen very carefully and with an open mind to the feelings being expressed by the patient as well as to the words used to express the feelings. Sometimes the words can be different from what the person really feels. To be a good listener you have to go beyond just the words and listen also to the feelings and thoughts of a person.

You must be empathic:

To have empathy for a person is different from sympathy. Sympathy is to feel "sorry for the person", whereas empathy is to put yourself in the place of the patient and feel what he or she could be feeling at the moment. Empathy is essential to be a good counselor. Sympathy is not. If you have empathy, you can then feel the frustration, anger, and the fears of the person. The process helps you to understand the person and her situation better. A patient needs to feel that he or she is being understood by you. To have sympathy does not, in anyway, make the patient feel that she is being genuinely understood.

What words express empathy?

Now let us learn a bit more about empathy. You must be wondering, "How can I express empathy?" "How can I tell the person that I understand what he or she feels?" There are certain ways to do this:

If you want to express to the patient that you have understood his or her feelings, you could say:

"You seem to feel ... (discouraged.)"

When the patient has conflicting feelings, you could say:

"You seem to have mixed feelings about this."

When you are unsure as to what the person is feeling, you could say:

"It seems to me ... (that you feel angry with your daughter.)"

"It sounds as if ... (you have had a very difficult time.)"

"You seem to ... (be disappointed.)"

"If I understood you correctly,... (you are feeling hurt at the way he spoke to you.)"

"I wonder if you mean that ... (you are feeling anxious.)"

You must remember to use the un-bracketed part of the sentence and then link it to the context or the situation as it may be in different cases, which has been bracketed. (*"You seem to feel angry /hurt because ... (he spoke to you rudely)"*)

You must express empathy without being over-confident and forceful. You can never be too certain of how a person is actually feeling. You must express this doubt until you have checked with the patient. (*"Am I right when I say that his behaviour made you feel sad?"*)

In what ways can you compromise empathy?

If you can use certain words to express empathy, you can also do certain things to unknowingly show less empathy in certain situations. What are the things that you must watch out for to ensure that you do not express to the patient that you have actually not understood his or her feelings at all?

- You must not pretend to understand what the person feels unless you are sure. It is always better to ask for clarification.
- If you do not respond or you give a superficial response, the person to whom you are talking feels that she was not 'heard' or she feels that you do not think what she said was worth responding. An example of this is that a lady expresses that she just lost her job and your response is *"How sad!"*, or you do not say anything at all.
- If you give a long response to anything that a person says, you end up saying more about your feelings rather than expressing the patient's feelings.
- On the other hand, if you just repeat word-for-word what the patient said when he or she was expressing intense emotion, it could convey that you were not listening.
- If you sympathise with the person, you do not empathise. An example of sympathy is *"I feel so bad for you. You are stuck at home since you have been ill"*.
- If you ask a question or give advice instead of responding to a feeling that is expressed, you do not show empathy. For e.g. *"Don't cry, be strong. You have to look after your children now that your husband is no more."*



- Plain words are of no use until you actually mean them. If you use words like *"I understand"* when you don't understand, it does not show empathy.
- If you share with the patient a personal experience that you think is similar to the patient's experience, it is not empathy, because your experience may not actually be anything like the patient's experience. *For e.g. If you say to a physically disabled person, "I know how you feel, I broke my leg once."*
- Preaching or bringing in your personal sense of what is right or wrong is also not empathy. *For e.g. "That's not the way to treat your partner."*
- Also when you interpret or generalise, it is as though you are personally judging the person or blaming him. *For e.g. "It seems you tend to lose your temper easily".*

We have covered two points needed to be a good counselor: i.e. you must be a good listener and you must be empathic. Now let us move onto the third.

You must be non-judgmental:

If you learn to be empathic, then you will automatically be non-judgmental. You must not judge a person according to religion, sex, caste, creed, etc. As a counselor, it is important for you to accept the patient for who she is. The patient is entitled to his/her own views and feelings. Even when these views and feelings are the complete opposite of your own views and feelings, you must not judge the patient negatively. It is not easy. You might find it difficult to maintain this non-judgmental attitude with a particular patient. In such a case, you should refer the patient to another counselor. For e.g., if you are uncomfortable interacting with a man who has sex with men you should be aware of your problem and discuss this with the MHS.

You must be trustworthy:

Trust is an important factor in a good counselor. You have to establish trust and assure the patient that whatever is spoken between the two of you will remain private and confidential. You have to maintain this confidentiality. If a need arises wherein you feel you have to reveal something spoken during the counseling session to a third person, for example the MHS, you must take permission from the patient before sharing information with the MHS or any other member of the team. This makes the patient feel that he/she can trust you and feels free to open up to you.

You must be patient:

Counseling requires patience. You may not get results immediately. The patient may take a lot of time to understand herself and her strengths and weaknesses. If you are impatient and if you want things to happen fast, you will feel tempted to give advice and be forceful, but this is not counseling.

You must be observant:

You need to be very observant. You must watch not just what the patient says, but also watch the body language of the patient. A person might be speaking with a

smile on her face, but her fists might be clenched, or she might be fidgeting a lot. If you are aware of this, then you will realise that although her words say she is happy, she is feeling tense about something.

You must be respectful and accepting

This is a very important factor. Always remember that the very basis of counseling is built upon respect. It is important that you respect patients as people in their own right. You must accept people as they are. You must recognise that people are capable of making their own decisions and managing their lives in general. This means that you will accept that a person has a right to think and feel differently from you. When you show respect, you create an atmosphere of acceptance in which the person feels understood, cared for and valued without having to meet any pre-conditions.



We have discussed the skills you need to have to be a good counselor. Now as a counselor you will be conducting counseling sessions or interviews. There are certain skills that you need to learn to conduct these sessions in an effective manner. Let us now learn what these skills are.

2.2d What are the skills you need to conduct a good counseling session?

What you must aim for in a successful counseling session is to encourage people to talk about their problems without influencing them with your own views.

How can you learn the skill of Attending Behaviour?

This is the most basic and a very important skill in counseling. What is attending behaviour? It is the manner in which you, as a counselor, conduct yourself when you are 'attending' a counseling session or an interview. The proper attending skill is to convey interest in what is being said by the patient, and yet to ensure that the person sticks to the point, and does not talk needlessly. What are the four things you need to do achieve proper attending behaviour?

- **You need to maintain eye contact with the patient at all times.**

While conducting a counseling session and facing the person while you are talking to him/her, it is necessary meet the eye of the other person.

- **You need to adopt an attentive body language**

When you talk to a person, you communicate not only with language but also through other aspects like the way you sit, etc. Body language means what

you tell the patient by the way you sit, speak etc. Therefore, it is important to watch what signals you are sending to the other person. It is important not to look bored, or yawn, or fidget while the person is speaking. While talking to the person, it is necessary to make encouraging gestures or signs to show that you are interested in what the patient is saying. (See the case narrative for more details).

Some examples of attentive body language are to sit facing the patient with arms opened out rather than folded against your chest, because this conveys interest and an open attitude. Do not keep checking your watch. Focus on listening to what the patient is saying.

- **You need to be aware of the tone of your voice.** Another important factor is how you speak. It is necessary to remember that a person during an interview session is vulnerable and perhaps scared. Your words and your tone of voice need to be encouraging. Remember to keep your tone gentle, speak slowly and clearly.
- **You need to track the session verbally (verbal tracking).** Verbal tracking means to keep the patient to the subject. A particular topic will be initiated by the patient. Then he or she might wander and move on to subjects that might not help you or the person in the treatment. In such a situation it is necessary to bring the person back to the subject. If the patient continues talking without sticking to the topic at hand, gently draw the patient's attention to the problem.

How can you learn the skill of questioning?

During the counseling session, you will be both asking and answering questions. Therefore, an essential skill to conducting a good counseling session is to know how to deal with questions. Proper answering and asking of questions helps the person to talk more freely.

If the patient is talkative, it may not be necessary to ask many questions. Even so, effectively used questions can help to explore the patient's mind. How can you learn the art of questioning? Let us start with the two types of questions: Open ended questions and close ended questions.

What are Open Ended Questions?

Some questions can be answered with just one word or a few words. For e.g., *"Who are the people you live with?"* Other questions need more than one word to answer. For e.g. *"How did you feel when that happened?"* The questions that need more than one word to answer are called "open ended questions." They need to be answered in a few words or sentences. Open ended questions encourage the patient to talk and give maximum information. Another example of an open ended question is *"Could you tell me more about that?"*

What are Closed Questions?

These are questions that can be answered in a few words. They are also useful when you do not want the patient to wander from the subject and when you want to help focus a conversation and get specific details, e.g., *"Where do you live?"*

What is a general framework of collecting information?

Questions are a method for collecting information. In the first part of counseling, a general framework for collecting the required information would be the following:

- Who is the patient? What are the key personal background factors? Who else is involved in the patient's daily life?
- What is the problem? What are the specific details of the situation?
- When does the problem occur? What happens immediately before or after the situation?
- Where does the problem occur, in what environment and situation?
- Why does the problem occur? What triggers it? What makes it better?
- How does the patient react? How does she or he feel about it?

When can questioning become a problem?

To learn the skill of proper questioning, you need to know what NOT to do:

- Do not bombard or grill: Bombarding or grilling is asking too many questions too quickly, without listening to the other person's words or giving him time to answer. This can put people on the defensive. Too many questions can also confuse a patient.
- Do not disguise statements as questions: Sometimes a question is used to tell a person something or suggest something to the person instead of asking. For example, when you ask *"Don't you think it would be helpful if you found a job?"* You are actually telling her that she should get a job. It is using a question to put your own view across and this can put the patient off.
- Do not use "Why Questions". You must exercise caution when using "Why" questions or questions that begin with the word "Why". The reason for this is it can cause discomfort and sound threatening and judgmental. For example, *"Why did you not go to work?"* To avoid using a why question you could frame the question differently. For e.g., *"Do you think you could have gone to work at the time?"*
- Keep the questions short and simple. Long questions can confuse a patient.

How can you learn the skill of Observation?

A person communicates not only through words but also through other ways like through the eyes or the body, which is termed as non-verbal communication.

As good counselor, you need to be observant or you will miss this communication. The three areas of non-verbal behavior you need to watch out for are:

i. What are the patient's eye contact patterns?

When a patient breaks eye contact or shifts her gaze constantly, it could mean that she is distracted or uncomfortable talking about a particular issue.

ii. What is the body language?

Leaning forward while talking means that the patient is interested and involved in what she is saying. Leaning back and crossing arms could mean the patient is disinterested, defensive or 'closing off'.

iii. What are the facial expressions?

Frowning, biting lips, flushing and tearfulness can indicate tension and distress.

How can you learn the skill of using Encouragers and Paraphrases?

It is necessary to convey to the patient that you are interested in what she has been saying. You must convey to her that you have been listening; you have seen her point of view; and you are able to experience her world view as she experiences it. You can do this by using encouragers and paraphrases.

What are Encouragers?

Encouragers are words that are used in between the conversation, like "*Um*", "*Is it?*" "*Really?*" "*Ah ha*". You use these to show that you are with the patient. Along with these words, you can also use physical gestures like nodding your head, keeping your palms open, looking interested and other friendly non-verbal gestures.

Sometimes, just the repetition of a keyword could become an encourager. For example, when a patient says that her life is terrible, you could say, "*Terrible?*".

This encourages the patient to elaborate on why she thinks that her life is terrible, or tell a bit more about her feelings. Therefore, words and actions, which are used as encouragers, encourage the patient to continue talking once she knows that she is being heard.

What are Paraphrases?

Paraphrases are the feedback that you give to the patient by shortening and clarifying the person's comments. For e.g. a paraphrase could be, "*You seem to be saying ... (you were not happy with what he said.)*"

However, paraphrasing is not just repetition of the person's "words". It is more a repetition of the meaning of the person's words. You repeat some of her words, and use some of your own to convey that you have understood or you want to understand what the person is trying to say.

Paraphrases help the process of counseling by:

- clarifying for the patient what he or she has said, e.g., *"You appear to be saying...(that you are unhappy)"*, *"You sound like...(you do not like him)"*
- clarifying for yourself what the patient has said by feeding back what you have heard. You can check on the accuracy of what you have heard e.g. *"Did I get you correctly?"*, *"Am I hearing you correctly?"*
- helping patients to talk in more detail about issues of concern to them
- helping a talkative patient to stop repeating the same facts or story

How can you learn the skill of Noting and Reflecting feelings?

The next skill of conducting a good counseling session focuses on the emotions of the patient and her subjective or personal experiences in dealing with a situation. The skill of noting and reflecting feelings is a very useful skill that helps the patient talk and makes her feel understood. It also helps to identify and sort out the patient's feelings. To be able to note and reflect feelings one needs to pay attention both to what is said, and what is not said.

How does one note feelings?

- You could repeat the emotional words used by the patient e.g. *"I was so angry that I felt like hitting her"* to which you could respond, *"You must have been really angry"*
- You could note the non-verbally expressed emotional words, e.g. a patient biting her lips - *"You seem very anxious today"*
- You could ask questions and directly observe emotions: *"How do you feel about that? Do you feel angry?"*


How does one reflect feelings?

Once you have noted the emotions of the patient you then reflect it back by repeating it to the person for further clarification or to show the person that you have understood.

You can create a sentence to reflect a feeling in these following five steps:

1. Begin with words like *"You feel"* or *"Sounds like you feel"* or *"Could it be that you feel?"*
2. To the above introductory phrase or words, you then add a "feeling" word. You can use *sad, happy, glad, puzzled, uncertain and confused*. Remember to

- use the patient's name whenever possible. For e.g. *"Could it be that you feel confused, Mr. A?"*
3. The context may be added through a paraphrase or a repetition of key content. For e.g., *"Could it be that you feel confused about getting a job, Mr. A?"*
 4. A present tense reflection is more powerful than a past or future tense. If the person felt a particular way about something in the past then to reflect it will be less effective. Only reflect back the present feelings that you can gather. For e.g., *'It seems to me you feel happy about getting a job'* rather than *'It seems to me you felt happy about getting the job then.'*
 5. After identifying a feeling, you can confirm this with the patient to make sure you have understood correctly, *"Could it be that you feel confused about going back to work." "Did I understand you correctly?"*
 6. You can sometimes gather specific information after reflection e.g.: *"You seem angry with your father. Could you give me an example of a specific situation when you feel this way?"*



You say you feel tired all the time. Despite this you still do all the household work. This is very good.

How do you acquire the skill of clarifying?

Next, we come to the skill of clarification. When the patient talks of anything that is not clear or contradictory to what she

said earlier you can check with the person rather than draw your own conclusions.

Sometimes, when the person is anxious she will keep talking in an unfocused way or keep shifting from one topic to another. In such circumstances,

it is better to stop her gently and discuss with her what you have not understood or what she has been unclear about or left half said.

How do you acquire the skill of focusing on positive strengths of the patient?

One useful technique to employ while counseling a patient is to identify his or her positive assets or strengths, and reflect them back. This raises the self-esteem of the person. Following are the ways in which you can use this skill:

This case narrative illustrates different counseling skills:

REFLECTING FEELINGS AND OBSERVED NON-VERBAL BEHAVIOUR

I am fed up. My husband has been beating me everyday. I feel like running away.

You seem to be so anxious and you sound so fed up of the situation that you want to run away from home.

CLOSED QUESTION

Yes, it is really humiliating. Two years back my husband lost his job, since then he has been drinking.

Has your husband been beating you too since then?

ENCOURAGER

He used to shout and use bad words earlier but now, since my daughter has been born, he beats me everyday.

Hmm...

After he lost his job I have been managing the household but since my daughter was born I have to look after her as well and have not been able to work as much. He used to take money from me for his drinks, now I try to hide the money so he beats me.

How do you feel about the situation?

I feel very angry, it is so difficult to manage the household with what I earn I have to leave my small child with my mother and go to work and then I have to suffer this harassment from her. On top of it his family blames me.

It must be very upsetting for you.

OPEN ENDED QUESTION AND CLARIFICATION

REFLECTING

Yes, I tried to talk to my brothers but they say I have to bear up with the beating. But why should I keep quiet? I am not going to take this beating anymore.

You appear to be very upset by your husband and family and don't want to keep quiet and now you feel like doing something about it.

PARAPHRASING

- You can begin the session by asking the person what has happened recently that the person feels good about.
- You can use the answer that the person gives during the session to remind her about something positive.
- If your patient constantly repeats negative statements, these can *be paraphrased (summarised and then reflected back to the patient) and then followed by positive feedback*. Fore.g., "Yes, being insulted by your daughter-in-law really hurts. At the same time, I see a number of positive points. You have a good sense of humor, you seem to have very caring neighbours, and your daughter too seems to care for you a lot."

2.2e What is telephone counseling?

It might be the case that some patients find it difficult to travel to the health centre for various reasons. Problems such as costs involved in traveling to the health center, work hours, care responsibilities at home and their own health factors could prevent a face to face counseling session with the counselor. In such cases, the telephone or cell phone can also be used for counseling.

Telephone counseling can include various aspects of clinical care including diagnosis/assessment, intervention and follow up.

What are the steps that are involved in telephone counseling? A telephone counseling session can be divided into the following steps: before initiating the call, initiating the call, during the call, concluding the call and record keeping.

What are the things one must keep in mind during each step of the telephone counseling session?

What do you do before initiating the call? Before initiating the call, consent and privacy are the things to look into:

Consent: When you meet the person face to face is the time that you must get the patient's willingness to be contacted at home and to participate in a telephone counseling session. This consent should be documented.

Privacy and confidentiality: Privacy and confidentiality should be assured and maintained at all times. Find out whether the patient has privacy at the place from where he or she is making the call. And ensure that there is privacy at the place from where you are speaking and that you will not be disturbed during the length of the call. Also discuss with the patient other issues of privacy; for example, if the patient is not available when you call, it may be inappropriate to leave your name or information about yourself with someone else. All these matters need to be discussed with the patient in advance. Also ensure that you are alone and unlikely to be disturbed when making the call.

What do you do while initiating the call?

These are the things to do while initiating the call:

- Introduce yourself and remind the patient of her visit to the clinic and your mentioning that you may call.
- Give the introduction enough time. Don't rush!
- Move smoothly from the introduction to the reason for calling.
- Remember, this is most likely to be a new experience for the patient so encourage participation and make an effort to reassure hesitant speakers.



What do you do during the call?

First review the clinical state of the patient. Then, depending on the stage of intervention, proceed with psychoeducation or IPT as the case might be. (The details of these are given in the following chapters).

During the call at all times, what must you keep in mind? You must, remember to:

- Be focused, sit up straight in your chair and talk directly into the mouthpiece.
- Be courteous, pleasant and friendly.
- Speak as clearly as possible in a natural conversational manner. A proper tone of voice, attentiveness and manner can make all the difference to the patient's comfort during the call.
- Pay close attention to what the patient is saying and how they are saying it. Listen for hesitation or pauses that may indicate uncertainty and may need you to probe or verify.
- Take it slowly: give the patient time to talk without interruption and without hurrying the patient.
- Answer all the questions, complaints and objections politely as a general principle.
- Remain respectful and maintain an even tone of voice.

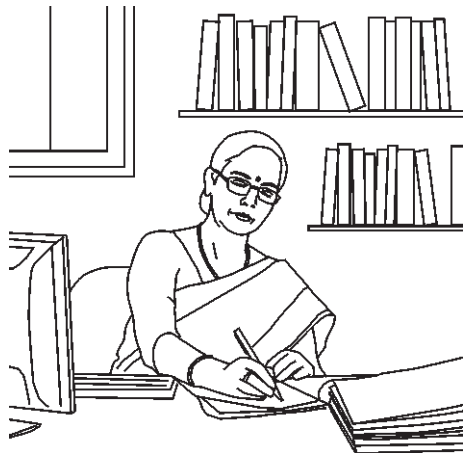
What do you do while concluding the call?

While concluding the call, summarise all that has been discussed. Ask the patient if she has any questions or wants to add anything to the discussion. Make an appointment for the next call or clinic visit.

How do you keep records?

After the call, document the details of the call including the duration, content and your impressions of the patient's current state and future intervention plan.

If the patient is not available when you call, ask when you can call back. Also ask the name of the person who answers the phone and his/her relationship to the patient (if possible). Leave a message and your telephone number. If no one answers the phone, call back at three different times of the day.



What must one be prepared for to be able to deal with problem situations that may arise?

You must be able to deal with the problems that might arise during a telephone counseling session:

- The patient could be rushed or in a hurry and just wants to get this over with. If this happens, ask if there is a better time to call when the patient is not busy. You may also convey to the patient that you have set aside time to speak with her and are in no hurry so she can take her time in speaking to you.
- The patient could be overly chatty and gives an overly long account of her problems. If this happens, interrupt her gently and try to get her to focus on important information.
- You could ask open, direct or closed questions.
- The patient could be confused or unable to focus. You could try and get information about health problems and suggest a visit to the PHC.
- The patient could be argumentative. If so, stay calm and do not engage in an argument. Repeat the reason for your call and if the patient continues to be argumentative, terminate the conversation gently.
- The patient could be distraught and emotional. Allow the patient time to ventilate her feelings. Do not interrupt. Encourage her to express her feelings

and be non-judgmental and supportive. Encourage her to make a visit to the clinic.

If the patient is suicidal, assess the risk of suicide, ask her to come to the PHC as soon as possible, get help from a family member and make a no-suicide agreement.

In this section we learnt that:

- ⊙ Counseling is a two way interaction between the counselor and the patient that provides assistance and guidance in resolving personal, social or psychological problems.
- ⊙ To be a good counselor, you should be a good listener, empathic, non-judgmental, patient, observant, respectful, accepting and trustworthy.
- ⊙ To conduct a good interview, you need to learn skills of attending behaviour, questioning, observation, using encouragers and paraphrases, noting and reflecting feelings and clarifying and focusing on the positive.
- ⊙ You could conduct a counseling session on the telephone.

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Detecting Common Mental Disorders in the Clinic

In the previous sections, you learnt about the impact of stress on a person's mental health. You also learnt that some people develop a mental disorder when faced with stressful life situations. In this chapter, let us learn how to detect CMDs in the clinic.

In this section we will learn:

- What is screening for CMD in the clinic?
- How to use the General Health Questionnaire (GHQ) as a screening tool?
- Who can do the screening in the clinic?

What are the types of Mental disorders?

There are three types of mental disorders that are the focus of this training program:

1. Depressive disorders
2. Anxiety disorders
3. Mixed anxiety and Depressive disorders.

These three disorders typically occur together, and we will refer to them as Common Mental Disorders or "CMD."

A person suffering from CMD experiences symptoms that can affect a person's thinking, emotions, physical health and behaviour. Although the symptoms of CMD are unmistakable, in reality, very few patients with CMD are correctly identified in the primary health care clinics (PHC). The reasons for this are many.

Some of the reasons are:

- Most patients with CMD complain about physical complaints such as tiredness and sleep problems and so on. The doctors treat them for these physical complaints (for example, by giving tonics or vitamins for tiredness). Instead of screening or testing the patient to see if they have CMD, they are treated only for the presenting symptoms. Thus the underlying cause, i.e., CMD is neglected.
- Unless specifically asked, few patients will openly discuss emotional problems or their stressors because they do not expect the clinic staff to be interested in their personal problems.
- There is considerable stigma (i.e. shame and embarrassment) attached to mental illness and not many patients will want to be told that they are suffering from a mental illness.

- Most primary care health workers have had little training or experience in the detection and treatment of CMD.
- Many primary care health workers fear that discussion about mental health may take a lot of time and so avoid it altogether.

In the MANAS Program, as HCs, you will overcome each of these problems in the following ways:

- You will use words such as 'tension' and 'stress' that do not upset people.
- You will work in the PHCs so that the clinics will be provided with additional staff. You as the HC will give dedicated time to treat people with CMDs. You will be trained and therefore in a position to provide psychological and social treatments.
- You will use a particular method or strategy to question patients about their mental health so that you can detect the person who has CMD. You will be specifically trained for this.
- To detect people with CMDs, you will use a process of routinely asking questions, which we call "screening". This is described in more detail below.



2.3a What is screening for CMD in the clinic?

Screening is a process in which a group of people are put through a specific procedure in order to detect common health problems. Here are some typical examples of screening in health care facilities:

- weighing a child regularly to detect malnutrition
- asking women to self-examine their breasts regularly to detect breast cancer
- doing blood sugar tests every year after the age of 40 to detect diabetes

2.3b How to use the General Health Questionnaire (GHQ) as a screening tool?

The method of screening that we use in the MANAS programme to detect the people who have CMD is the General Health Questionnaire (GHQ). The GHQ was first

developed in the United Kingdom (UK) and is one of the most widely used screening questionnaires in the world, including in India.

At the MANAS Program, we compared five internationally used screening questionnaires and found that the GHQ was the best for detecting CMD¹. The GHQ was able to correctly identify 80% of people with CMD during the MANAS program; this is a very high rate of detection of a problem through screening. Therefore, we recommend the use of the GHQ for future programs dealing with persons with CMD.

What is the GHQ?

The GHQ consists of questions covering about 12 emotional experiences over the *previous two weeks*. Some questions ask about the *presence of distress*, i.e. they ask about the *presence of symptoms* (such as 'losing sleep over worry') while others ask about *well-being*, i.e. they ask about the *absence of symptoms* or how well the person is feeling (such as 'Have you been able to concentrate'). Each question is given a score of about 0 (if the symptom is absent) or 1 (if the symptom is present). If the patient does not understand the question being asked, approved alternative probes are listed in the Appendix 5.1.

Once the questionnaire is completed, the total score of all 12 questions are added up to give a single, summary score for each person. This score is then used as a measure of the person's likelihood of suffering from CMD. The higher the score, it is more likely that the person is experiencing CMD. To know more about the GHQ questions and scoring the responses, refer to Appendix 5.1.

How to use the GHQ?

GHQ can be used in two ways in programs in primary care clinics.

1. The first use is to detect CMD in the clinic:

Adult patients attending the clinic can be screened by having them answer the GHQ-12. Their answers are then scored and they are given a rating. The rating then helps to find out whether the person suffers from CMD.

The other use is that by studying the score we can find out the severity of the CMD and then decide how the treatment should be given. If the total score is 5 or less, it is unlikely that a patient suffers from CMD and therefore, needs no further action; on the other hand, anyone scoring 6 or more needs to be treated.

A score of 6 or 7 indicates a **mild** CMD while a score of 8 to 12 indicates a **moderate to severe** CMD. This classification is important since it determines the choice of treatment.

We recommend that all adult patients who attend the PHCs and who do not need emergency care should be screened for CMD because mental diseases are relatively common and the screening takes just a few minutes. However, if this is not acceptable, you can also screen only those patients whom you suspect may suffer from CMD, e.g., those with multiple physical complaints.

In the MANAS program, between 10-15% of all adults attending the clinics were detected suffering from CMD and in need of specific treatment.

GHQ score	Interpretation
<6	No CMD
6-7	Mild CMD
>7	Moderate/severe CMD

How to use the GHQ to evaluate progress?

To find out how the person with CMD is progressing with the treatment, you could just ask how she is feeling since her previous appointment. Sometimes, the patient may not be sure of whether her mental health has improved or worsened. In this case you could use the GHQ to find out.

Have the person fill the GHQ again and compare with their previous score. For example, if the patient's score at the time of detection was 9, and two months later the score decreased to 7, you would say she had improved 'a little' (i.e. improved by 2 points on a scale of 12). Alternatively, if the patient's score after two months was 4, you might say she has improved 'a lot'. An increase in score of a patient would indicate that his/her stress-related illness has worsened since the time of detection. This change in mental health is very important for deciding what the next treatment should be.

2.3c Who can do the screening in the clinic?

In the Primary Health Centers, where CMD is to be treated, if there is no person dedicated specifically for detecting CMD, the detection procedure can be done in many ways that do not require an additional person. Some of these options are:

- Detection can be done by the registration clerk when the patients are being registered in the clinic.
- Patients who know how to read and write can answer the GHQ themselves.
- As the Health Counselor, you can complete the GHQ in the clinic.
- The PHC doctor can sometimes complete the screening using the GHQ if time permits.

However, it is important to ensure privacy so the patient can understand and respond to the questions undisturbed. In the MANAS program, we ensure that room is created within the clinics, where the person can work on the GHQ.

We recommend creating some private space in clinics by using a curtain or a booth so that the person gets privacy and the screening is useful.

In this section we learnt that:

- ⊙ To improve the detection of CMD in the primary health care setting, all adult patients who attend the clinic can be screened with a questionnaire.
- ⊙ The screening instrument of choice is the GHQ that consists of 12 questions exploring different symptoms of CMD.
- ⊙ Screening for CMD by using the GHQ is a simple procedure and can be completed in many ways in the clinic without having a dedicated person.
- ⊙ In addition to the detection of CMD, the GHQ can also be used to assess the effectiveness of treatment over a period of time.

(Footnotes)

¹ Patel V., Araya R., Chowdhary N., King M., Kirkwood B., Nayak S., et al. *Detecting common mental disorders in primary care in India: a comparison of five screening questionnaires*. Psychological medicine. 2008 Feb;38(2):221-8

The Assessment of Suicidal Risk

Suicide is a major public health problem in the world that can easily be prevented. One of the key tasks for you is to identify whether a person has a chance of committing suicide and how high is this risk in the patients you will be counseling. This will help you plan interventions that can reduce the possibility of suicide and save precious lives. In this chapter, we will learn about the method of carefully assessing the risk of suicide.

In this section you will learn:

- How do we define suicidal behaviors?
- What is the global and Indian burden of suicide?
- How does one detect the risk of suicide?
- What are the socio demographic, clinical, and immediate risk factors?
- What are protective factors?
- How do you assess the degree of risk?

2.4a How do we define suicidal behaviours?

Suicidal behaviours can be defined in two ways: attempted suicide and completed suicide. **Attempted suicide is an act of harming oneself that does not lead to death.** These are most common in young women. There are 10-20 times more attempted suicides than completed suicides.

Completed suicide is an act of knowingly and intentionally harming oneself that results in death. Different methods are employed by people who complete suicide. These methods are dependent on local factors like easy availability of guns, pesticides or cooking gas. Drowning, hanging, and eating or drinking poisonous substances are the most common methods. In many parts of India, jumping into wells and burning are also commonly used methods to commit suicide. If a person attempts suicide, the possibility that he or she might commit completed suicide in his or her life is significantly larger. This is the reason that attempted suicides should be taken very seriously when assessing risk.

2.4b What is the global and Indian burden of suicide?

It is estimated that suicide claims more than one million lives in the world every year. Although this sounds like a lot, the actual figures are even more, because many deaths by suicide are not reported in most parts of the world, including in India because of the stigma associated with suicide. In India, young people are particularly vulnerable. Elderly

men are another high risk group. Some of the reasons why so many suicides occur are rapid changes in society like urbanisation, agricultural distress, poverty, the breakdown of traditional family support systems, loss of shared cultural values and the increasing use of alcohol and drugs.

Suicide is an important health problem that needs urgent action. For example, in a rural block in Tamil Nadu, it is estimated that suicide is responsible for a quarter of all deaths in young men and up to half of all deaths in young women. If this figure is applied to the rest of India, the number of deaths due to suicide would be very large.

2.4c How does one detect the risk of suicide?

As a counselor, you will work with patients who are depressed and/or anxious. Depression and anxiety are amongst the most important reasons for people attempting suicide. **To assess whether the person is at the risk of committing suicide will be an important part of your work and must be integrated within the first session of psychoeducation** (i.e. during the initial assessment of the person's mental condition about which you will learn in detail in the following chapter).

How can one find out whether a person is at a risk of committing suicide? The most important points to remember are:

- During the counseling sessions, you must routinely ask whether the patient thinks a lot about committing suicide.
- It is a wrongly felt that asking the person if he/she has ideas of suicide will introduce the idea in the patient's mind. Quite the opposite is true. Asking the patient whether he or she has thoughts of suicide is the only way to identify risk and enable the person prevent suicidal acts.
- Risk may change over time. Therefore, it is not enough to only ask for suicidal ideas in the first session. It is necessary to ask the same person many times during the course of the treatment about his or her suicidal thoughts.
- The patient may feel guilty or embarrassed about sharing this since it is a very private experience. It is important to question the patient and ask him or her about his thoughts on committing suicide in a gentle and non-judgmental manner.
- A good relationship with the patient makes it easier to assess risk.

Some of the ways that the question may be framed include:

- *"Have you felt in the last few weeks that it would be better if you did not wake up in the morning?"*
- *"I can see that you are going through a very difficult period. In your situation, many people feel that carrying on with life is not worth it. Have you ever felt this way in the last few weeks?"*

- *"Have you ever felt that the problems in your life are too difficult to be solved and that you are better off dead?"*

2.4d What are the socio demographic, clinical, and immediate risk factors?

It makes it easier to detect the risk of suicide if we know what are factors that contribute to this risk. This way if your patient has any of these risk factors, you might need to be more watchful or change your treatment accordingly.

The risk factors can be broadly classified as socio-demographic, clinical and immediate risk factor. Let us take up each of these:

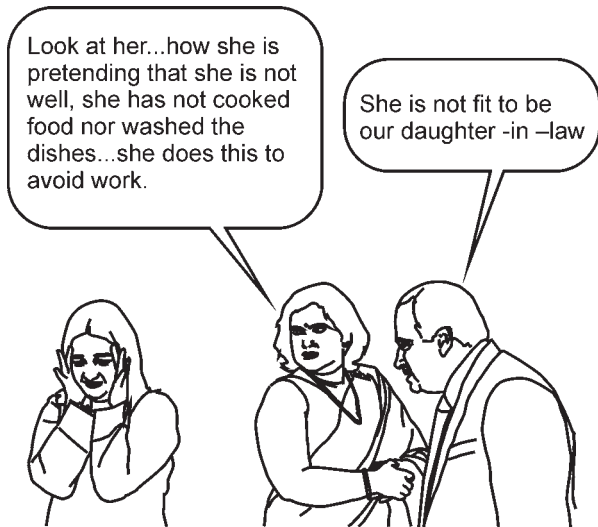
Socio demographic risk factors: These are chronic, relatively long-standing factors that apply to the entire population rather than just the individual. These factors are also hard to modify or change. If your patient belongs to any of these factors you have to be more watchful. Socio demographic risk factors are:

- **Age:** The risk of suicide is the greatest in young adults and in old age.
- **Sex:** In youth, women are at higher risk; in middle and older age, men are at higher risk.
- **Socio-economic status:** Lower socio-economic status has a strong relationship with suicide.
- **Marital status:** Single persons or persons who have recently lost their spouses or recently separated persons are at a greater risk of suicide.
- **Employment:** Being unemployed or recent loss of job is a very important risk factor.
- **Social isolation and lack of social support:** Being alone with no close friends or relatives is an important risk factor.

Clinical risk factors: These are the risks related to the clinical problems of the patient. Some of these risk factors can be modified and should, therefore, be part of the treatment regime. Clinical risk factors are:

- **Presence of mental illness or chronic, serious physical illness:** If a person has current or past mental or physical illness, we can take these illnesses to be a strong sign that the person could be at the highest risk of committing suicide. Many people who commit suicide have diagnosable mental illnesses like CMD.
- **Family history of suicide:** This is another important risk factor since having a family member who has committed suicide increases the risk many times.
- **Previous history of suicide attempt:** The risk of completed suicide is 10 times greater in persons who have attempted suicide earlier.

- **Use of alcohol:** The current and past use of alcohol, which is more common in men, is a very important predictor of suicidal risk.
- **Unsupportive family:** This is an understandable risk factor which is especially important to consider in young adults, women who have married recently, and in elderly persons.
- **History of past or current abuse:** Physical and sexual abuse are very important risk factors. In our context, ongoing domestic violence from an alcoholic husband is a common and a serious risk factor that needs immediate attention.

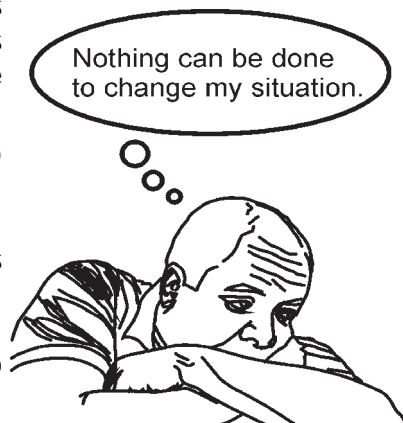


Immediate risk factors: These are the risks that are closely linked to current social and psychological situation of the patient and need immediate attention to reduce the risk of suicidal acts. Immediate risks are:

Ongoing and severe social stresses: Social stresses where a person feels trapped (large debts), humiliated, or loses status (sudden loss of employment, failure in examinations) are often the immediate factor for attempting suicide.

Hopelessness: The feeling of hopelessness is the final common pathway to suicidal acts and is the single best predictor of risk in the immediate term.

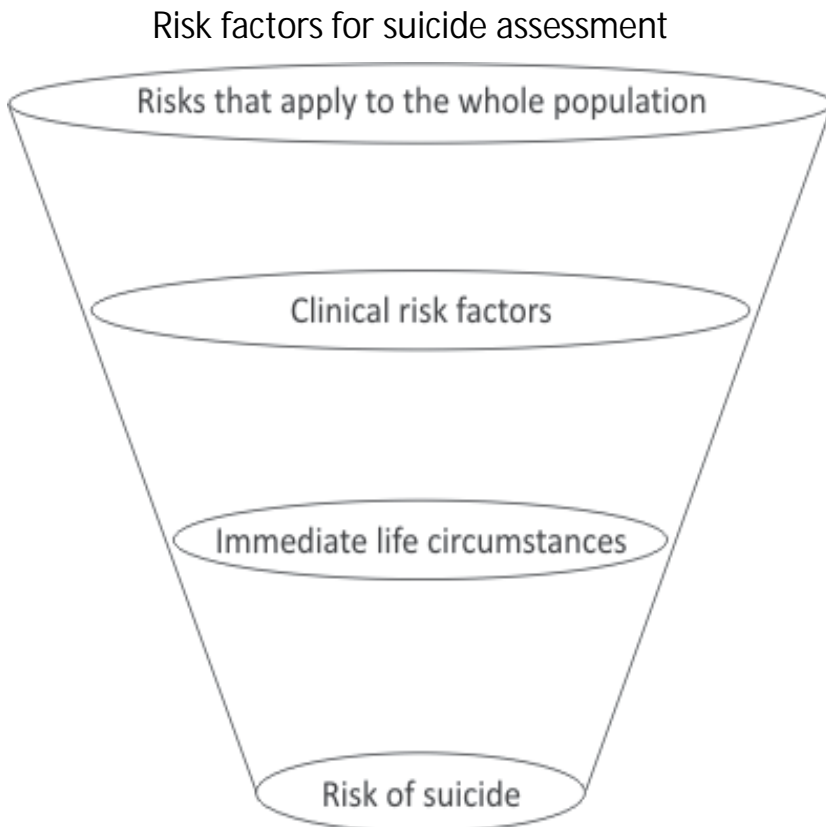
Loss of interest: Another important clue to the risk of immediate suicide is when a person loses interest and withdraws from his/her usual social interactions with friends or family members or does not feel motivated to work any longer. In these circumstances the lack of appetite and sleep are common and lead to the person dropping out of treatment as well.



Conveying the intention to attempt suicide: Suicidal acts can be sudden or impulsive, or planned in advance. In the case of planned suicide, very often, a person would have communicated his/her intention through clues like suddenly giving away personal possessions and drawing up a legal will.

Sometimes people make attempts to get the methods or means of committing suicides like buying pesticides or stocking large amounts of medicines. This is an extremely serious situation that signals high suicidal risk and needs immediate interventions.

The **Checklist for assessment of suicide risk** (see clinical case record in Appendix 5.3) will help you understand the degree of risk. Risk factors for suicide can be understood as being multi-layered and in the form of a cone (see Figure 2.4 A).



2.4e What are Protective factors?

Now that we know what are the risk factors that increase the possibility of suicide, let us find out what are the protective factors that reduce the risk of suicide. The act of taking one's own life is a very difficult decision to make since life is the most precious thing we possess.

Often those who contemplate suicide are torn between whether to continue to live or to die. The desire to live is partly due to the influence of protective factors.

Protective factors refer to those reasons that minimize the risk of suicide and are therefore, the opposite of risk factors. An understanding of these factors is essential in

planning interventions to reduce suicidal risk. Increasing the protective factors in the patient's life will reduce the risk of suicide.

Some of the most common protective factors are:

- **Social support** from family, friends and other significant relationships like children who offer support.
- **Religious and cultural beliefs** that consider suicide as morally wrong can be a very important factor in preventing suicide.
- **Community involvement** and integration through employment and membership of groups can be powerful factors to reduce risks.
- **Access to help** like priests, counselors and telephone hotlines where the person can discuss her problems in a confidential manner.



- **The patient's perception of the consequences** of the suicidal act and how it will affect the lives of their children and family are frequently important factors that prevent suicide.

- **Individual personality differences** like an optimistic view of life, sense of control, positive coping styles and problem solving abilities are personal assets that can reduce the risk of suicide.



2.4f How do you assess the degree of risk?

Once you have asked the person whether he or she has thoughts of suicide, it is important to make an estimate of how high the risk is of committing suicide. It is possible that some patients may not feel comfortable about disclosing their suicidal

thoughts in the first meeting. Whether the person does or does not disclose his or her suicidal thoughts, you need to be aware of whether the person is in a high risk factor (i.e. age, history, economic status, etc.) or not and make an informed judgment that will guide your interventions.

It is equally important to understand that it is not possible to predict suicide accurately, and it is better to be overly careful about the possibility of the patient committing suicide rather than ignore important clues.

If the patient does mention that she is experiencing suicidal ideas, it is very important that you do not over-react. It is natural to feel anxious in such situations, but, as the HC, you must be able to manage your personal anxiety and remain calm and emotionally supportive. Remember, you can always discuss such cases with the MHS.



An understanding of the risk and protective factors should enable you to judge the seriousness and immediacy of the risk (see box below). After estimating the risk, you must confirm the degree of the risk. If you think the patient you have just seen is at possible risk of attempting suicide, you should ask some specific questions that will confirm the degree of the risk. These include:

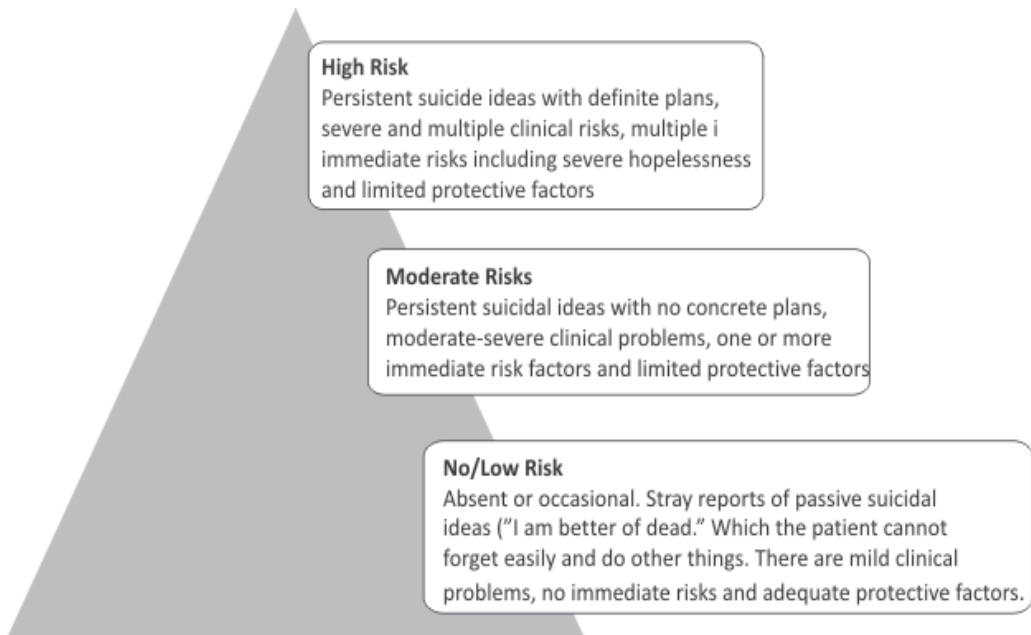
- *"Have you been having thoughts of harming or killing yourself?"*
- *"Have you made any plans for harming yourself?"*
- *"Have you been having these thoughts repeatedly and cannot distract yourself from them?"*
- *"Have you been feeling hopeless and that nothing can help you?"*
- *"Have you been thinking about what will happen to your family after you die?"*

After you have confirmed the degree of the risk, you will need to specify or categorise the degree of risk for that patient.

In MANAS, we have identified three possible categories of risks and you will need to choose the most appropriate one based on the guidelines given in the box below.

After you have assessed the risk of suicide, you will treat the patients of high and medium risks with proper interventions. The management of these patients is discussed in Chapter 3.1

Levels of Risk of Suicide.



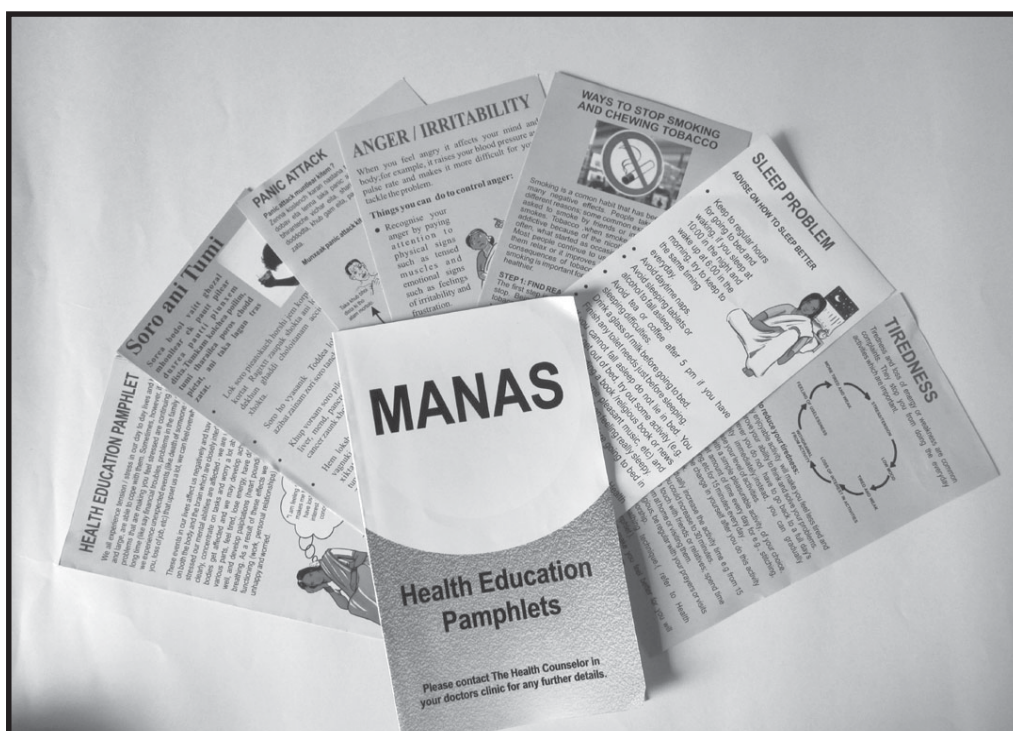
In this section we learnt that:

- ⊙ Assessment of suicide risk is an integral part of your role as Health Counselor and must be addressed in the first psychoeducation session.
- ⊙ A good rapport with the patient makes it easier to assess suicide risk.
- ⊙ Risk factors for suicide can include socio demographic, clinical and immediate factors.
- ⊙ Protective factors that reduce the suicide risk must also be identified as they are important in planning risk management strategies.
- ⊙ You assess the degree of risk by questioning the patient about suicidal thoughts, assessing the risk and protective factors and then categorizing the degree as high, medium or low.

Chapter 3

Treatments for Common Mental Disorders

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3.2	Anti Depressants (ADT) And Other Drug Treatments For CMDs used In Primary Care	91
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Support literature used in the MANAS program

Psychoeducation¹

3.1 Psychoeducation¹

Now that we have learnt the essential building blocks of the treatment and are familiar with common mental disorders, let us go ahead and learn what are the treatments for CMDs. The first of the treatments is psychoeducation.

In this section, you will learn:

- What is psychoeducation?
- How do you reassure and explain the link between the stress and the symptom?
- How do you explain the diagnosis and give hope?
- How do you help people affirm their role as a sick person?
- How do you teach relaxation through a breathing exercise?
- How do you manage suicidal risk?
- How do you give advice for managing specific symptoms of CMD?

3.1a What is psychoeducation?

Psychoeducation, as the name suggests, is the process in which you give the patient with CMD an explanation about her/his illness and practical advice to deal with her/his problems.

This is a process of learning and it helps the patient understand the reasons for her problems. Psychoeducation can be a very powerful way to treat a patient with CMD.

The reasons why brief counseling can be so effective are possibly because the patient feels that the cause for her health problems is identifiable. The person understands her illness and knows that there are simple but effective ways of dealing with it.

This understanding of the illness can give the person a sense of mastery and control over her problems, which directly addresses the problems of helplessness, tiredness and lack of sleep which are the core symptoms of CMD.

The treatment is most successful when the sessions are a two-way collaborative process between you and the patient. You need to know what is involved to conduct a successful psychoeducation session.

¹ The MANAS psychoeducation DVD that accompanies this manual illustrates how each component of psychoeducation can be delivered in the clinic setting.

Therefore, let us look what are the things that you must do:

- You must give reassurance and explain the link between patient's stress and the symptoms by explaining the mind and body link.
- You must explain the diagnosis and give hope.
- You must affirm the person's role as a sick person.
- You must teach the patient to relax through the breathing exercise.
- You must manage suicidal risk.
- And, you must give advice for managing specific symptoms of CMD.

Let us take up each of these points.

3.1 b How do you reassure and explain the link between the stress and the symptom?

What does the patient attribute his/her illness to?

It is necessary to know whether the patient has an explanation for his/her symptoms and to find out what they think is causing their illness. The person might not think or believe that the symptom is due to anxiety or depression. For example, some patients may believe that their symptoms are a result of stressful life events, while others may attribute their symptoms to black magic, ill luck, etc. In such cases, what do you do?

It is important to make the person understand what the cause of his or her symptom is, because if the patient does not believe that psychological treatments or medication are necessary for the symptoms, then s/he is less likely to adhere or stick to these treatments.

The following are some specific examples of common explanations that patients have about their illness and how you could handle each situation.

What do you do when patients attribute their problem to something else?

1. If the patient says that their illness is due to black magic/fate/past bad deed:
 - Without disagreeing with the patient's view or agreeing with it, explain to them that an important reason for their symptoms is the mind-body link and elaborate upon this. (The mind body link is explained just after this section).
 - If the patient disagrees with your explanation, without arguing with her, tell her to try out the advice you have given her and see if it is of benefit.
2. If the patient attributes her symptoms to a physical illness or to a minor accident/menopause/sterilisation operation/hysterectomy:
 - Agree that this may be one of the reasons and at the same time present her with another reason i.e. the mind - body link.

- If the patient keeps complaining about physical problems, ask her to speak to the doctor (for specialised treatment if necessary or to clarify doubts).
 - Ask the patient to follow the advice given and note the difference.
3. If the patient attributes the stress in her life as a reason for the symptoms:
- Agree with the patient that this is so and prove to them their thought is right by explaining the mind-body link through the stress cycle.
4. If patient relates his problem to the similar problems that someone else in the family:
- Follow the same steps as given in point 1 above.

It is also important to pay attention to what the patient believes is causing their symptoms and incorporate this into your explanation of the mind body link.

The link between stress and the symptom is best explained with the mind and body link.

What is the mind body link?

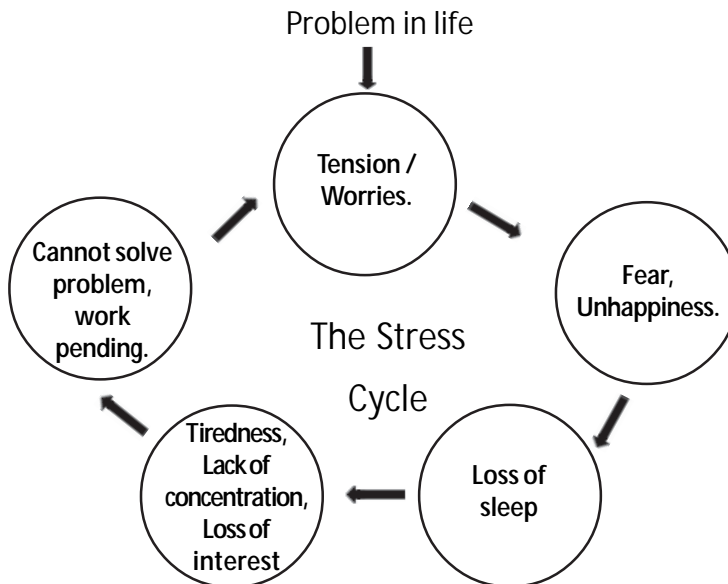
If the mind is stressed it affects the body. A stress in the mind will result in problems like “fatigue, tiredness and lack of sleep”. It can also result in the symptoms that the patient is experiencing. However these problems are not because of a problem in the body but because of a problem in the mind or the stress that the person is experiencing.

It is necessary to explain this mind and body link to the patient. You could do so in the following words:

“So whenever we are tense, our body shows the effect of this tension and we experience symptoms like sleep problems, tiredness, palpitations, aches and pains, lack of concentration and interest, etc. Many people experience these types of complaints.”

Then you must explain the stress cycle. You could use the following words:

“The problem in your daily life results in tension and worry. This worry makes you afraid and unhappy and at night you cannot sleep. When you do not get enough sleep, you feel tired, you cannot concentrate and you lose interest in life. There is no interest or energy to solve that problem which has caused all this. And so that problem remains, further causing more tension and making you more tired. This is a cycle. It will continue until you break it.



3.1b How do you reassure a patient regarding his or her problem and symptoms?

Tell the patient that some of the symptoms, particularly those of sleeplessness, tiredness, other physical complaints and psychological symptoms must be making it very difficult to handle his/her every day activities/work. Then, explain how ordinary tension is different from stress related tension and fatigue and that their fatigue is from the stress in their lives rather than a physical reason. You could use these following words:

"All of us feel pain and discomfort now and then. We feel tired, suffer headaches or sleep problems now and then. However, when there is tension or stress in our lives, many people become sad and worry. This often puts more pressure on the body and the body feels ill. This is why you are feeling tired and having problems sleeping."

Tell the patient that symptoms that arise from stress will not result in a life-threatening or dangerous illness. For example, to patients whose main symptoms are panic and anxiety, you could say:

"Your symptoms of dizziness, palpitations, fear, difficulty in breathing, and fear are because of attacks of anxiety. These are common problems and are not signs of a dangerous illness. In fact, they occur because you are tense or worried about something and this makes you breathe faster than normal. When you breathe faster, this produces changes in your body which makes your heart beat fast and makes you feel scared that something terrible is about to happen. There are ways by which you could stop your attack by controlling your breathing."

After this, give the patient a chance to ask questions. You can do this by telling asking the person:

"Do you feel you have understood why you are suffering from these symptoms? (e.g. disturbed sleep, loss of appetite, loss of interest in work, etc.) If you would like to ask any questions, please do so."

3.1c How do you explain the diagnosis and give hope?

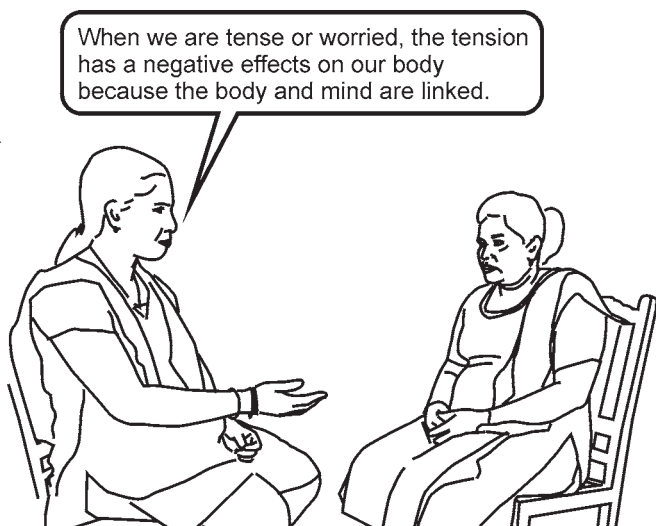
You could explain the diagnosis to the patient in such a way that it is acceptable to the patient and will not lead to embarrassment or stigma, e.g., avoid saying that the patient has a mental illness and avoid using technical terms such as phobia or panic, unless there are locally acceptable words to describe these conditions. You may explain the diagnosis in the following manner: :

"From what you have told me, you seem to be suffering from an illness resulting from stress. Your complaints/symptoms are the result of this illness. This is very common; many people attending this clinic suffer from a similar illness. This illness is treatable and in this clinic we are providing all the effective treatments for it".

Remember! There is no need to use the label of 'mental illness'; this often means something quite different to the people and because of this they may stop coming for counseling.

3.1d How do you help people affirm their role as a sick person?

Many people when they suffer from a CMD are unable to lead normal lives and are unable to deal with the routine work as they did before the start of their illness. This makes them feel guilty and inadequate. In addition, sometimes their family and friends accuse them of being lazy or stubborn. Hence, it is important to explain to them that because they have a "stress-related illness" it is normal for them to feel tired and unable to do



their work. You could use these following words to affirm the role of the patient as a sick person:

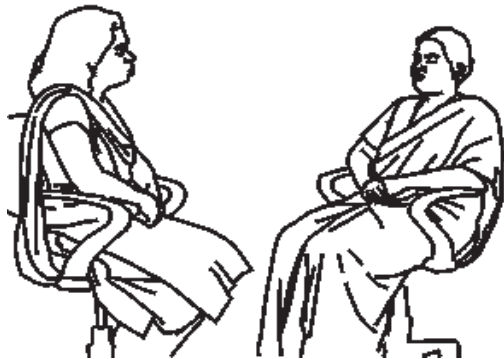
"For example, if you had a broken leg, you wouldn't expect yourself to be able to run. You may not be able to do the things you have to do or want to do in the same way as before your stress symptoms started. The treatment we are offering you will help you get better. When you feel better, you will see that you will be able to do many more things as before."

3.1e How do you teach relaxation through a breathing exercise?

Now we come to a very important part of the psychoeducation session – the breathing exercise. This is important because many patients with CMD feel better when they practice the exercise regularly.

Focus your mind on breathing... take slow deep breaths through the nose... breathe out, while breathing out you use the word "relax"

- First, explain to the person that you will be teaching him/her a practical and useful technique for relaxing the body and mind by controlling the breath. Explain that this technique is used not only in medical clinics, but also in yoga and meditation.
- Demonstrate the exercise after explaining the steps outlined below - show him or her the correct manner of breathing.
- Then, ask the patient to do the exercise. For the first time, it is helpful if you yourself take the patient through the steps.
- Then, let the patient continue the breathing exercise in silence for about 3-5 minutes.
- Confirm that the patient has learnt the technique correctly and encourage her to practice it regularly at home.



What are the steps in the breathing exercise?

- There is no special position; any position that the patient finds comfortable is the right one. The patient can therefore sit or lie down (if there is space in your office). Give the patient a choice of doing the exercise either with eyes open or shut. Generally, the exercise is more rewarding if the eyes are closed but some patients may feel uncomfortable.

- After about 10 seconds, the patient should start concentrating her mind on the rhythm of her breathing. Tell her to concentrate on breathing slow, regular, steady breaths through the nose. If a patient asks how “slow” the rhythm should be, you can suggest that she should breathe in until she can count slowly to 3, then breathe out to the count of 3 and then pause for the count of 3 till she breathes in again. As the exercise progresses, the rhythm can be slowed even further according to the comfort level of the patient.
- You can suggest that each time the patient breathes out, she could say in her mind, “relax” or an equivalent thought in the local language. Patients who are religious can use a word which has some importance to their faith e.g., a Hindu could say “Om” while a Christian may say “Praise the Lord”. Continue the breathing for at least 10 minutes until the anxiety has completely subsided.
- If a patient complains of palpitations, tingling-numbness in fingers or mouth, chest pain or any other physical discomfort during the exercise, it may mean that she is breathing too fast; slow down the rhythm to a rhythm that she finds more comfortable.

3.1f How to manage suicidal risk?

Now we come to the next and also very important part of psychoeducation – management of suicidal risk. We have learnt about suicide in the last chapter. In this session let us see how to further handle situations where the person might be suicidal.

The management of suicidal risk will depend on how serious the problem is. However there are some basic things that you could do with the patient in regards to suicidal risk before the patient leaves the psychoeducation session with you. This is what you must do in every situation:

i. You must establish a trusting relationship with the patient:

This is the most crucial part of the interventions and is the foundation on which everything else rests. Your aim should be to make the patient feel that his/her problems are being understood in an empathic manner and that you are not judging anything that he/she reveals to you. To achieve this, you must consciously utilise your counseling skills of verbal and non-verbal communication in an appropriate manner.

ii. You must encourage the patient to talk about his/her problems (ventilation):

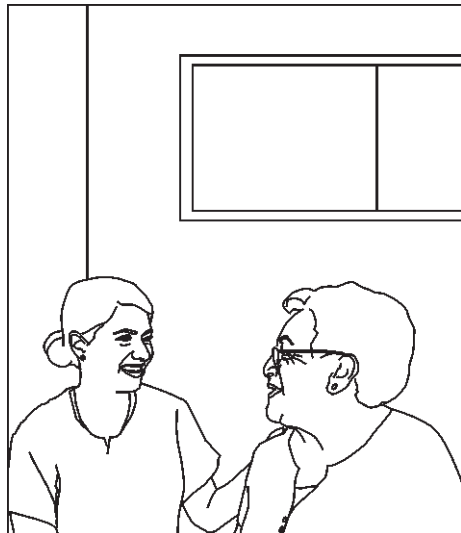
The aim of engagement is to facilitate the patient to talk freely about her concerns and distress with you. Remember that suicidal ideas cause a lot of distress to patients because of the associated guilt and interpretation of it being a sign of ‘weakness’.

Ventilation, or talking freely about such ideas, can be a very powerful tool in decreasing the intensity of suicidal thoughts. Frequently, patients will become emotional and tearful during this time and you need to be supportive without encouraging the idea of self-harm.

iii. You must give patients hope:

The feeling of hopelessness is a commonly associated state of the mind and when hopelessness is combined with suicidal ideas there is a strong chance that it can lead to suicide. The patient should feel free to first acknowledge suicidal ideas and then she must be helped to manage hopelessness. This is a very important part of the initial interview, psychoeducation, and should be done without fail.

One of the ways to do this is to tell the patient that you have understood her problems and are concerned about her well-being, but you must also stress that you do not share her lack of optimism or her feelings that there is no use living any more. It may also be useful if you point out to the patient that hopelessness is a key symptom of her illness, which is CMD, and when she continues treatment, feelings of hopelessness will reduce.



iv. You must increase protective factors:

This is another key task to be accomplished during the interview. You would need to understand what are the reasons that have stopped the patient from actually carrying out her plans for her life. In the Chapter 2.4, you had asked the patient to list out her reasons for continuing to live. You could go back to that list and ask why the patient does not want to live despite these reasons. You have to get her attention to these points during the discussion so that the patient leaves with the feeling that there are things in her life which make it worth her making an effort to live.

v. You must ensure safety:

Especially if the risk of suicide is either moderate or severe, you must carry out this basic intervention with the patient in the psychoeducation session. The first principle is to involve immediate family members of the patient: inform them your concerns about her safety so that she can be observed at home.

Remember so as not to break trust with the patient, you could contact the family members after a discussion with the patient and obtaining her consent. However, in some circumstances it may be necessary to breach confidentiality as saving a patient's life is more important than anything else. Secondly, you would have to talk to the

patient about whether they have access to means of suicide like pesticides, medicines, ropes, sharp weapons, etc. and how to limit this access. You could explain that this is part of your professional obligation.

Do not let the patient leave the interview room, until you are satisfied that you have taken the necessary precautions around ensuring safety.

vi. You must ask for advice and directions:

In any situation where you are unsure about what you should be doing, you must ask for necessary advice from the MHS without any hesitation. Always discuss your concerns with the clinic doctor or the MHS. Remember that you should have continuous access to the MHS, who is experienced in dealing with the management of suicidal risk.

vii. You must increase the frequency of contact with the patient:

If you increase the frequency of contact with the patient, you can ensure that the suicidal patient is engaged adequately and feel that you are making an effort to meet her needs.

This is an important intervention. It is useful to make telephone calls, whenever possible, in between and in addition to the face-to-face meetings to enquire about the well-being of the patient.

Finally, in case the risk is high, you may need to make a home visit and make sure that the plans to ensure safety like access to poisonous substances etc. are being adequately monitored. Make an agreement with the patient that he/she will call you (or someone else) if she is feeling suicidal.



viii. You must document:

Documentation is a vital part of the suicide risk management. Adequate documentation of the risk assessment procedure, the plans and their implementation must be done on an ongoing basis.

For example, documenting that you met with family members and consulted appropriately with the MHS is important for quality assurance and clinical purposes.

What must you do for the different categories of risks?

Once you have detected the level of the suicidal risk of the patient you must vary your intervention according to how severe the risk is. The risk can be low, medium or severe. The steps to be taken in each case is listed in the table below:

Summary of Suicide Risk Identification and Management

Level of Risk	Action to be taken
Low: Absent or very occasional reports of passive suicidal ideas. Clinical problems are mild, no immediate risks, and protective factors adequate.	Encourage continuation of treatment and specific advice. Enhance protective factors. Ensure follow up within 2 weeks.
Moderate: Persistent suicidal ideas without concrete plans Clinical problems are mod-severe, few immediate risk factors, and limited protective factors.	Provide appropriate step of treatment Provide hope that things will get better. Ensure safety; talk to family with patient's consent. Ensure follow up and contact within 7 days. Enhance protective factors. Share concerns with Doctor. Consult with MHS on phone or during supervision.
High: Persistent suicidal ideas with definite plans Clinical problems are severe, multiple immediate risk factors, hopelessness, and very limited protective factors	Contact MHS immediately for advice! Ensure safety and observation by enlisting family. Provide support and hope. If out-patient care continues, contact daily on phone and have a face-to-face meeting within 3 days (home visit) for risk reassessment.

3.1g How do you give advice for managing specific symptoms of CMD?

Patients will come to you with different problems. Some will complain of tiredness and others of dizzy spells. It will help you to conduct a useful psychoeducation session if you know what are the ways to handle these individual symptoms. We will learn to manage problems of sleep, tiredness, fatigue, physical health, irritability, giddiness, panic attacks, phobias, smoking and alcohol abuse, and give advice on healthy eating.

1. How to manage sleep problems?

Many people come to the primary care facilities with sleep problems. This is a very common complaint. This can occur as part of a CMD or as a separate problem altogether.

This is what you should tell the patient:

- Keep to regular hours for going to bed and waking, even if you have slept well or poorly the previous night.
- Avoid daytime naps. If the patient must nap in the afternoon, they should restrict it to no more than 45 minutes.
- Avoid taking sleeping tablets or alcohol to fall asleep.
- Avoid tea or coffee after 5 pm.
- Try relaxation exercises to help fall asleep.
- Drink a glass of warm milk before bed.
- If the patient cannot fall asleep within 20 minutes or so, she/he should get out of bed and try out some activity (e.g. walking,, etc).

2. How do you manage tiredness and fatigue?

These are typical features of CMD and are again very commonly seen in primary care settings. A patient loses interest in activities, and begins to feel tired and weak. This leads to further withdrawal from activities, and adds to the feeling of tiredness and low mood. These are some steps to break this cycle:

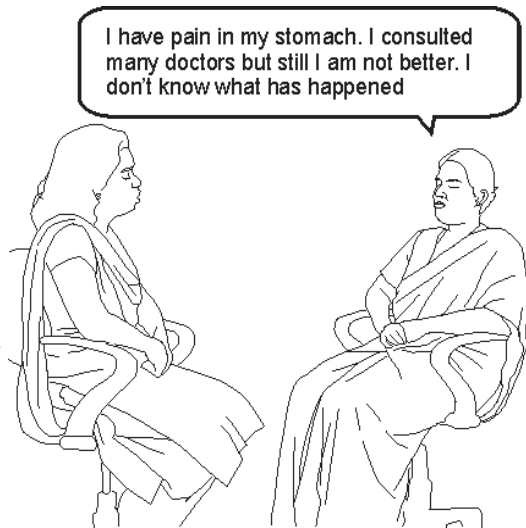
- Explain to the patient how stress is making her feel tired and weak. You could explain the mind-body link.
- The less involved the patient becomes in activity, the more tired she will feel. It is important for the patient to understand that a graded activity will make her feel less tired and improve her ability to think and solve problems.
- What is a graded activity? A graded activity is a gradual increase in physical activity according to the needs and capabilities of the patient. Encourage the patient to start with a simple activity of choice that she/he enjoys doing. choice, for a set amount of time every day. For e.g. she/he could do stitching, gardening, for 15 minutes every day in the morning. The 15 minutes could then be increased to half-hour gradually. Ask the patient to notice the changes within herself after she does the activity. You should not advise the person to go back to a full day's activity immediately.

3. How do you manage worries about physical health?

If a person is overly worried about her health, this is what you do:

Let her talk about her physical complaints, if need be even look at her prescriptions and medications. Although you know her symptoms are not physical, do not ignore or dismiss her worries about her physical health. Tell her that the doctor is dealing with some of her problems; others may be related to worrying or stress.

- Make her realise the close connection between physical health and stress. Let her know that learning to cope with the problems she is facing in life could reduce the intensity of the physical symptoms.
- Reinforce that if there is a need for more physical investigations such as X-rays, the medical doctor will carry them out.
- Explain that counseling is not an alternative to the standard medical treatment.



4. How do you manage problems about irritability?

Some people might come to the health care centre with problems of irritability and anger. These are the ways that you manage irritability:

- Explain the effect anger has on a person's mind and body. For example, it raises blood pressure and pulse rate and makes solving problems more difficult.
- The first step in anger control is to be aware of the signs of one's own anger such as tensed muscles, feelings of irritability and frustration. By recognising one's own anger by paying attention to signs, one can control it.
- It is then necessary to identify what is making the person angry. Once you know the cause of the feelings of anger, the patient can try to take positive steps to resolve the problem.
- Suggest to the person that she/he tries to calm down the moment she/he recognise the first signs of anger. If they try to calm down when they find themselves getting tense then they can prevent feelings of anger increasing into verbal or physical aggression. A person can calm down by breathing exercises, by trying to relax alone till anger subsides or by expressing the reasons for anger to a close friend or relative.
- The patient should leave the anger-provoking situation and return when the anger has reduced to diffuse the situation and also to help calm down.
- As a rule, the patient should never act or make a decision when angry. Afterwards, these actions or deeds will most often be regretted.

5. How to manage symptoms of giddiness?

Another common symptom of CMD is giddiness. When a patient comes to you complaining of giddiness or dizziness, explain to the patient that there are simple methods which can help cure this:

- If experiencing giddiness while standing or walking, she/he should sit down until the feeling passes.
- If she/he experiences giddiness when getting up from bed, she/he should rise slowly from the lying position, sit on the edge of the bed for some time with legs dangling over the edge of the bed and then stand up slowly.
- Missed meals may also be a cause for giddiness. This will improve if she/he eats something.
- Breathing too rapidly (hyperventilation) may also result in giddiness. Explain this to the patient and teach him/her the breathing exercise.

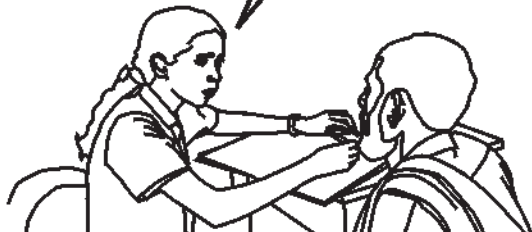
6. How to manage symptoms of panic attacks?

Panic attacks are episodes of intense fear or apprehension that come suddenly and last for a short while.

Explain to the patient that her feelings of fear and tension are linked to rapid breathing and is a normal reaction when someone becomes anxious.

The patient should recognize that when the fear begins, physical symptoms start.

When you are tense, you breathe faster than normal. When you breathe faster, this produces changes in your body which makes your heart beat faster and make you feel scared that something terrible may happen.



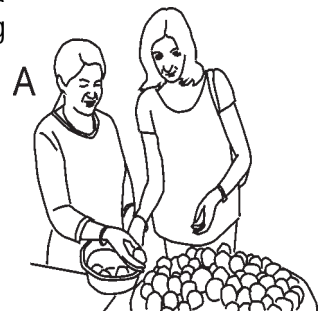
- Explain that you will be teaching the patient a practical and useful technique for relaxing the body and mind by controlling the breathing. Explain that this technique is used not only in medical clinics but also in yoga and meditation.
- Teach the patient the breathing exercise.
- As soon as the fearful thought starts or symptoms begin, the breathing exercise should be started.
- The patient should remind herself that there is nothing to fear until she gains control over her breathing.

7. How do you manage Phobias:

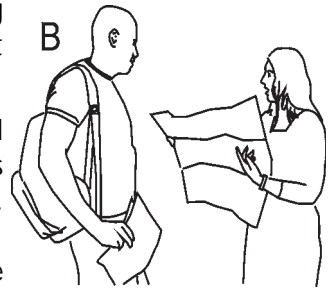
What is a phobia? A phobia is an irrational, intense and persistent fear of certain situations, activities, things, animals or people. Agoraphobia and social phobia are the two common phobias that afflict patients. Agoraphobia is the fear of crowded places such as markets or public transport, or going out of the house. Such persons often become house-bound. Social phobia is the fear of meeting people and interacting socially.

If the patient is suffering from a phobia, it would be helpful to teach her breathing exercises and give advice on any of the other specific symptoms such as sleep problems in the first session. Fix an appointment for the next session indicating to her that the next task will be to work on her fears through the graded method explained below. Some ways to help overcome phobias are:

- Explain to the patient what a phobia is. Tell her that her symptoms are related to a fear of the situation, which is irrational, or which does not have basis in fact.
- Explain that the only way of overcoming this fear is by exposing herself to this situation until the fear subsides. This way, she can “unlearn” that there is something to be fearful about in the situation and can face it the next time with confidence.
- Explain to the patient that she could expose herself to the fearful situation in a graded manner.
- Grade the fearful situations of the person in a list from the least fearful to the most fearful. For e.g., for a person fearful of talking to strangers, the least fearful situation would be to have a friend with her when she is speaking to someone and the most would be to talk to strangers alone.
- Then help the person in actually exposing himself/ herself to the fearful situation in steps starting from the less fearful situation. Once the patient has mastered this situation and can face it without fear, encourage them to move to the next situation on the hierarchy. In this manner, move on to the most fearful situation.
- You could give advice of step by step exposure to a person fearful of social situations in the following manner: **A)** “First try going with a friend to a shop and asking for an item. **B)** Once you can do this without feeling anxious, when with a friend, try asking a stranger for directions. **C)** When you feel comfortable doing that, try going to a shop and asking for an item by yourself. **D)** Once you can do that, try going to a restaurant and have tea all by yourself.”



- Make sure that each step results in a corresponding increase in the person's confidence. The consistent build up will then help overcome the phobia.
- A house-bound patient could be first encouraged to take a short walk to the neighbour's home. This should be practiced daily until the fear goes away. The patient must persist and not give up under any circumstances. After overcoming this fear, she should move on to the next step up.
- Emphasise to the patient that not facing a situation only worsens fear.
- She can be taught to deal with fear by breathing exercises (as with Panic attacks) and by reassuring herself in her mind that the fear is temporary and it is there because of her phobia.



8. How to help manage alcohol and tobacco abuse

You will have patients come to you in the primary health care center who have problems of alcohol and tobacco abuse. Let us first find out how to manage problems of excessive drinking. To such a person you could say:

"The problem with alcohol is that sometimes one drink can easily lead to another. Before you know it, you might have had more to drink than you had planned and then you will experience some of these problems".



How does drink affect a person's life?

- When people get drunk they do things that they usually would not do. For example, they can become either aggressive or they may drive recklessly.
- Alcohol is highly addictive. Some people are often unable to stop drinking even though alcohol is harming them.
- Moderate to heavy drinking over many years damages the liver, brain, heart and pancreas, and can cause cancer.
- Children learn about behaviour largely from



their parents; it is more likely that children of parents who drink heavily will themselves take up the habit later.

- For pregnant women, it is not at all safe to drink.
- It is unsafe to drive/drive a vehicle when drunk.

How to give tips on being a safe drinker?

These are some suggestions that you should give your patient in order to encourage safer drinking habits:

- *"Have a maximum limit of 2 small pegs of alcohol, for example, a maximum of 2 small pegs of Feni or spirits or 2 small bottles of beer in a day."*
- *"Decide how many pegs (bottles of beer) you have allowed yourself for that evening and stick with it."*
- *"Reduce pegs by choosing drinks that are not so strong.(e.g. beer instead of whisky)."*
- *"Drink a full glass of water before drinking alcohol."*
- *"Drink either water or a soft drink between each alcoholic drink."*
- *"Eat before going out drinking."*
- *"Set aside specific days in the week when drinking is not allowed."*
- *"Try not to go out too often with friends who drink heavily."*

Remember that for most people who are trying to stop drinking, it is hard to do so in one attempt. Even people who want to stop drinking, might start again, usually when feeling bored or unhappy or in the company of friends.

If this happens, it is important that patients do not feel guilty as they may restart the use of heavy and regular drinking. Instead, you must help the patient understand that this has happened in spite of the patient wanting to stop drinking, that she must learn from the experience and to think of ways of stopping this from happening again.

Patients who have alcohol dependence and develop severe withdrawal symptoms when they reduce or stop drinking should be advised to seek help from the MHS.

ii. How to stop tobacco use:

Smoking or chewing tobacco is a common habit that has many negative effects. The nicotine content in tobacco is highly addictive. Tobacco causes heart disease, breathing difficulties and many types of cancers. Tobacco use can also worsen CMD. Stopping tobacco improves physical and mental health.

How to enable a patient to follow a stepped approach to stop smoking?

Step 1: Find reasons to stop

Tell the patient that, *"You should think carefully about reasons why you may want to stop smoking."* If you help the patient to find reasons for stopping tobacco use, it will have a powerful impact on the process of quitting. Some reasons could be:

- use of tobacco smoking or chewing kills
- cigarettes and chewing tobacco are full of poisons
- tobacco causes cancer, heart attacks, breathing problems and CMD
- tobacco use affects fertility, babies and children
- tobacco is expensive

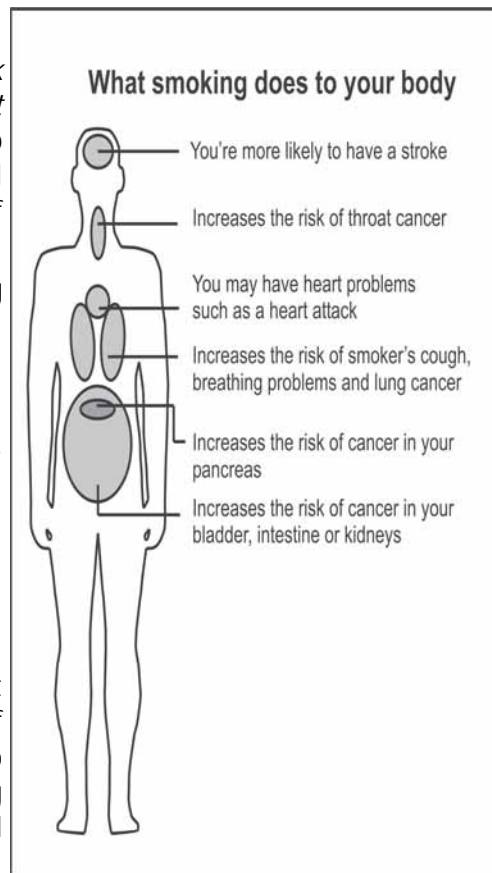
Step 2: Make a plan

The next thing to do is to help the patient make a plan to increase the chances of quitting successfully. Help the patient to make a plan to stop smoking by identifying what the patient feels are the most useful ways to stop.

- Discuss reasons for using tobacco and situations in which the patient uses it regularly. Make a record of the times and situations of frequent use to help the patient develop quitting strategies.
- Decide on an approach that is best for the patient whether it should be stopped completely and suddenly, cut down, or gradually reduced.
- Plan ways to cope with stopping, such as incorporating alternative activities into the daily routine to avoid smoking since tobacco is available everywhere.
- Set a date to stop.
- Have the patient create reminders of the steps that must be taken to stop using tobacco.

Step 3: Put the plan into action

Remind the patient, *"When you begin the process to stop smoking you may experience withdrawal symptoms, urges, and difficulty in social situations where smoking is the norm."*



The following are some suggestions:

- Withdrawal: Irritability and anxiety are common in the first few days after quitting. Suggest that the patient informs family and friends so they will understand and be supportive at this difficult time.
- Urges: Have the patient think of ways in which to resist urges and also make suggestions like breathing exercises for relaxation, or taking up an activity that will distract them from thinking about smoking (eg. going for a walk).
- Difficult social situations: Advise the patient to avoid situations that are associated with tobacco use, for example, drinking alcohol and going out for tea with friends who smoke. Remind the patient that to stop smoking and to show a commitment to stop using tobacco products can serve as an example to friends.
- More strategies: With the money saved from stopping smoking, the patient can use it as a self reward by taking the family out for a meal or a movie, or invest in a new shirt.
- Review your plan: Ask the patient whether the plan is working and to remind oneself of the reasons why the patient wants to stop in the first place.

Step 4: Staying on track

After putting the plan in action, the patient will feel the urge to smoke less and less, but staying off tobacco takes long term effort and commitment to the plan.

The patient should develop strategies that help with commitment to quitting, such as daily reminders of reasons for quitting or rewards. This will be good for the patient. The person can buy a reward with the money saved. You must review the plan with the patient and make sure that this plan is still working each time you meet.

While some people are able to stop in their first attempt, most of those who stop will need to make several attempts before they finally succeed. In other words, even with the best intentions, most people go back to smoking because of craving or boredom.

It is very important that you make the patient aware that feelings of guilt or disheartenment should not come if the plan fails as this will only make quitting more difficult. The patient should try again, refocus on the reasons to stop smoking and go through the steps again.

9. How to give healthy eating advice?

Finally it is necessary to give the people who come to the primary health care centre advice on how to eat healthy. A healthful diet goes a long way in keeping the mind healthy. This advice should be given to all patients and remember to tailor the advice according to the patient's economic status and current eating patterns.

Chapter 3.1: Psychoeducation

Explain to the patient that what we eat has a profound effect on our body as well as on our mind.

Explain to the patient, in the following words, what she/he can do to eat a healthy diet:

- *"Eat meals at regular intervals. Ignoring meal timings can lead to negative effects on health, like stomach problems such as increased acidity."*
- *"Eat meals in a relaxed atmosphere and not in a hurry."*
- *"Your diet should have a large amount of fiber. This can be done by regular consumption of whole grain cereals, chapatis, fruits and green leafy vegetables."*
- *"Limit fat from dairy and meat sources like pork and mutton."*
- *"Avoid overly spicy food and deep fried foods on a regular basis."*
- *"Steamed, boiled, baked and roasted foods are better than fried foods."*
- *"Avoid munching in between on snacks or fast foods that give a lot of unhealthy calories and are responsible for weight gain."*
- *"Take a brisk walk every day and do yoga to help maintain a healthful weight."*
- *"Drink plenty of water, especially in the summer months."*

In this section we learnt that:

- ⊙ Psychoeducation is the process by which the patient with CMD is given an explanation about her illness and practical advice to deal with her problems.
- ⊙ The person should understand the cause of her symptom is psychological so that she will adhere or stick to the treatments.
- ⊙ The stress cycle and the mind and body link help understand the need for treatment.
- ⊙ The treatment will help the patient get better. Until then it is normal for the patient to feel tired and unable to do things as before.
- ⊙ Breathing exercise helps relaxation.
- ⊙ Managing suicidal risks is an important part of psychoeducation.
- ⊙ Giving advice for specific symptoms that the patient experiences are an important component of psychoeducation.
- ⊙ Following this advice frequently leads to relief in symptoms for those with mild CMD.

Antidepressants (ADT) and other Drug Treatments for CMD used in Primary Care

In the last chapter, we learnt about psychoeducation. Now let us know about the drug treatments that you will prescribe to the patients who need them. In this chapter you will learn:

- What are antidepressants?
- How do antidepressants work?
- What are the common antidepressants used in the clinics?
- When will the Doctor start antidepressants?
- What is your role when a patient is taking antidepressant treatment?
- What are the symptomatic treatments that are sometimes used in the clinic?

3.2a What are antidepressants?

The term antidepressant refers to a group of medicines that are used in the treatment of CMD that is of a **moderate to severe** intensity. The first antidepressant medicines were discovered by chance about 50 years ago; since then, these have been used extensively. Though referred to as antidepressants, these medicines have been found to be effective for a number of other disorders like anxiety and for chronic pain.

As the name suggests, antidepressant medicines are specific and effective drug treatment for CMD. However, most patients with CMD in primary care clinics are not treated with these specific medicines. Instead, many patients with CMD are prescribed a number of non-specific treatments like vitamins, tonics, pain killers and sedatives (medicines which cause sleepiness), which are both costly and do not provide lasting relief from the symptoms.

The non-specific treatments like vitamins, tonics, pain killers and sedatives as a group are referred to as 'symptomatic drug treatments'.

One of the key objectives of the MANAS program is to encourage doctors to prescribe antidepressants for severe CMD rather than the symptomatic treatments. Treatment with antidepressants is more effective in reducing the symptoms of CMD than prescribing symptomatic drugs, and the overall costs of treatment are also lower for the patient.

In this chapter, you will be introduced to the various antidepressant medicines that are likely to be used by the doctors; your specific role in ensuring that patients get the maximum benefit from the treatment; and a brief outline of the common 'symptomatic' treatments that you will encounter during your work in the clinic.

3.2b How do antidepressants work?

Although the exact manner in which antidepressants actually work is not yet clear, there is enough evidence to suggest that they work by altering the chemical profile of the brain. Antidepressant medicines are carried in the blood to the brain where they attach themselves to particular parts of the nerve cells. Once attached (like a key fitting a lock), these medicines generally increase the available levels of chemicals like serotonin, which in turn gradually improves the symptoms of CMD.

Understanding how the antidepressants work is important for two reasons:

When a person begins to take antidepressants, she/he will not start getting better immediately. There will be a slight delay in starting to feel better. The other thing is the patient on antidepressants will experience certain side effects initially, like stomach pain and nausea.

Let us see why this happens. After beginning the antidepressant treatment, it takes a few days, around two weeks, for the patient to start feeling better because it takes time for the medicines to bring about the chemical changes in the brain that lead to improvement of symptoms. Thus, there is a 'lag period' or time period before the antidepressants begin to show results.

Secondly, the patient experiences side effects because the chemicals that are altered by antidepressants are present in the brain and also in other areas of the body. The levels of these chemicals change quickly after the medicines are started, whether they are elsewhere or in the brain. This leads to side effects like headache, nausea, and diarrhea and other stomach complaints, dry mouth and blurred vision.

It is necessary to explain to the patient the reasons why the patient is feeling ill instead of feeling better after taking the antidepressants. Otherwise she/he will be encouraged to discontinue the treatment.

3.2c What are the common antidepressants used in clinics?

There are several different antidepressant drugs currently available. These medicines can be conveniently categorised into three broad groups based on their chemical structure and mechanism of action. Broadly, antidepressants can be classified as Tricyclic Antidepressants (TCAs), Selective Serotonin Reuptake Inhibitors (SSRIs), and newer medications with mixed actions (see Appendix 5.4).

Antidepressants are only recommended for **moderate-severe CMD treatment**. In some instances, patients with mild CMD who do not respond to other treatments may also benefit from them.

Choosing and prescribing a particular antidepressant is the doctor's responsibility, you will also have a very important and unique role to play for patients on ADT. Appendix 5.4 summarises the commonly used antidepressants with their doses and side effects

The doctors can choose which antidepressant to use in the treatment of CMD. However, it is important to understand that no single antidepressant is clearly superior to others; in other words, they are all of equal effectiveness.

Therefore, the most important factors that we encourage doctors to consider before starting antidepressants are the side effects that the particular antidepressant will cause, the convenience of a single dosage and the cost to the patient.

All these factors are important to reduce the initial difficulties that the patient faces when he starts using antidepressants and will help the patient continue the treatment despite the "time lag" and side effects.

So what are the important things to know and to tell the patient regarding antidepressant use in treating common mental disorders?

- *"Antidepressants are used to treat moderate to severe CMD."*
- *"Although called antidepressants, these medicines are equally effective for the management of anxiety disorders as well as depression."*
- *"All antidepressants have equal overall effectiveness."*
- *"Antidepressants have different side effects and costs."*
- *"Antidepressants are not addictive."*
- *"Antidepressants are most effective if they are taken regularly at the right dose and for an appropriate time - usually for 6 months."*

These are called antidepressants and are used for the treatment of stress related illness such as your and taking your medicines regularly as the doctor has advised, will help you feel better.

3.2d When will the Doctor start antidepressants?

Patients can be started on antidepressant treatment (ADT) at the initial visit when they score above the limit for moderate to severe CMD on the



GHQ, or on subsequent visits when the Step 1 treatments are not effective.

The decision to start the medicine is, of course, one that the doctor will make based on screening the score of the GHQ and her clinical judgment.

Once the doctor has started treatment with ADT, she will indicate the same to you on the Patient Card (refer Appendix 5.2).

3.2e What is your role when a patient is taking antidepressant treatment?

When a patient is on ADT, your role as an HC, is very important.

As we have learnt earlier, to achieve a successful treatment of CMD you have to accomplish all that we learnt in principles of chronic disease management. For this to be done, the patients have to be encouraged to continue with the recommended treatments for an adequate length of time.

I have prescribed tablets, which you need to take regularly for at least six months.



If the patient who is on ADT discontinues treatment, then the efforts stop half way. Discontinuation of treatment or non-adherence is the single biggest barrier to recovery. Your central role when ADT has been started will be to use all possible strategies to encourage the patient to continue with the ADT and also the counseling.

How long should ADT be continued?

The treatment of CMD with ADT can be conveniently divided into 3 phases. The initial, acute phase lasts for about 4-6 weeks. During this time, the aim of the treatment is to reduce the symptoms and enable the patient to resume his/her life before the onset of the illness.

Since CMD can relapse in some patients after a while, it is recommended that, patients need to continue the medicine for a period of time even when they are better, after the completion of the initial phase, to prevent a relapse of the problems. This is the second or the continuation phase of treatment which lasts usually up to 6 months, but can be longer (for example upto two years) especially if the patient has had more than one episode of CMD.

Finally after a period of about 6 months of the treatment when the patient has recovered, a decision needs to be made about stopping the medicine; this is the planned discontinuation of treatment. You must remember these different stages since your inputs will vary depending on the stage of treatment.

Now let us look into each of the stages in detail:

i. Starting ADT (Initial, acute phase that lasts 4-6 weeks)

Your role is to encourage and monitor the use of antidepressant treatment from the very first session when the doctor prescribes the medicine. At this point, you will be expected to provide information to the patient about, "why the antidepressants are necessary", and "how the patient will benefit if she/he starts and then continues with medication." It is important for you to inform the patient about the time lag between starting ADT and the health benefits becoming evident and possible side effects which may occur. You need to reassure the patient that the side effects are temporary and only occur in the initial stages of ADT. This message should be conveyed in a manner that the patient understands that the initial side effects are not unexpected and can be managed easily; and the side effects should not be a reason to discontinue the medicine.

What to tell the patient who has started antidepressants:

- *"The medicines are safe and can be taken along with other medicines."*
- *"They are widely used and many people have benefited from these tablets. They will help to reduce symptoms and improve overall health."*
- *"They are not addictive."*
- *"They may occasionally produce side effects like headache, churning in the stomach, dryness of mouth, etc. If these do occur, they are mild and short-lived."*
- *"The medicines will start showing a positive effect on health in a few days, around 2 weeks."*
- *"The medicines must be taken regularly for maximum benefit."*
- *"Some ADT are taken at night as they are sedative; others are taken in the morning."*
- *"They must be taken for at least six months, or as prescribed by your doctor, to ensure complete recovery."*
- *"It is important to take the medicines, even if you feel better, for complete recovery. If you stop the treatment too soon, symptoms may return."*
- *"If the side effects are unbearable, you must inform me (as the HC) and doctor."*
- *"If you want to discontinue the treatment, you must consult me (as the HC) and doctor."*
- *"Remember to come back and meet the doctor regularly while on ADT."*

When the patient returns for the first time after being prescribed ADT, you should compliment her/him for having come back as planned. Then you should do a review of the symptoms and find out whether the side effects are present or not. You should then give this information to the doctor. At this point, the doctor may either continue the medicine at the same dose or increase the dose and ask the patient to come back after a month. You will need to encourage the patient to take the medicine as prescribed. You must find out from the patient whether it will be possible to contact her to enquire about her progress and adherence before the planned review which is scheduled after four weeks.

At the third review, most patients would be expected to have improved and you will need to do a brief review of 5-10 minutes when you enquire about the patient's health and tell her that the medicine should be continued. You should discuss the benefits of the treatment and inform her about the danger of a relapse if medicines are stopped prematurely.

ii. Continuation Phase (6 weeks-6 months)

From here on, the treatment enters the continuation phase where the doctor may review the patient once every 2 months when she can also meet you. This can be supplemented by telephone counseling to encourage adherence. If, during this review, you find that the patient is not better then discuss this with the doctor who can increase the dose or, if necessary, consult the MHS.

iii. Stopping ADT (6 months)

Finally, at the end of 6 months of treatment, you will need to alert the doctor about the need to make a decision to either continue or stop the medicine. If the decision is to stop the treatment, you must follow the discharge procedure described in Chapter 4.1.

These are the three phases of ADT treatment. Now let us take a look at what are symptomatic treatments.

3.2f What are the symptomatic treatments that are sometimes used in the clinic?

When patients with CMDs come to the primary care clinics, they are frequently prescribed with 'symptomatic treatments' like vitamins, tonics, sleeping pills, painkillers, food supplements and injections that are mostly unnecessary and costly. In some cases, the use of medicines like sleeping tablets for long periods can lead to an addiction to the medicine.

Why do doctors prescribe symptomatic drugs? Doctors prescribe these treatments for a number of reasons. Many patients with mild CMD do respond to these treatments and improve. This commonly observed fact of the patient improving

even without specific treatment is known as the 'placebo effect' and occurs for reasons that are not clear. The placebo response of some patients reinforces the doctor's belief that the particular symptomatic treatment is indeed effective and he may decide to use it for all patients with suspected CMD.

However, the more important reasons for the use of these treatments include the non-detection of CMD and the lack of time to provide even brief counseling. Finally, even when the doctor is aware that this is not necessary, there is the pressure to prescribe the patient something after the consultation as patients expect to be given something.

There is also widespread perception among doctors that 'talking treatments' are not accepted by patients and that if they do not prescribe anything the patients will either stop all treatment or shop around for another doctor who does prescribe vitamins or tonics.



How can you reduce the dependence on symptomatic drugs?

One of the key aims of the MANAS program is to reduce inappropriate use of symptomatic treatments by creating the necessary conditions for providing treatments that are both effective and appropriate. Improved detection of CMD through screening, provision of psychosocial treatments by the HC, encouragement and support of the MHS to boost the doctor's confidence to use antidepressants appropriately and to reduce the use of symptomatic treatments should reduce the prescription of unnecessary medicines.

What do you do if the patient demands medicines?

It is not unusual for patients to demand injections or vitamins/sleeping pills and to feel dissatisfied if the doctor does not prescribe these. At such times, it is important to explain to the patient that:

"Your symptoms of fatigue/insomnia are a part of their stress related illness and will get better if you follow the advice given by me (or take the antidepressants prescribed by the doctor)."

"Unnecessary injections can be harmful as they can increase the chances of infection. Likewise, vitamins are costly and sleeping pills can cause dependence and be difficult to discontinue when they are no longer required. Further, none of these medications are useful for stress related problems."

If patients still insist on receiving these medications, urge them to try out your advice about your taking the antidepressant medication for a while and see how they feel.

In this section we learnt that:

- ⊙ Antidepressants should be used for all patients with a moderate/severe CMD or those with mild CMD who fail to improve with psychoeducation.
- ⊙ The choice of antidepressant is governed by the doctor's familiarity with the use of a particular ADT, the side effect profile and the cost of treatment.
- ⊙ Your role as HC is to explain the benefits of ADT to all patients who are prescribed these and to encourage them to adhere to the full course of treatment.
- ⊙ While the MANAS model encourages the use of ADT for patients who need it, it also recommends that the doctor reduce the use of symptomatic treatments such as vitamins, tonics, sleeping pills and injections which have no benefit in the treatment of CMD and in fact may prove harmful.
- ⊙ ADTs are not recommended as the initial treatment for mild CMD.

Interpersonal Psychotherapy For Common Mental Disorders

So far we have learnt two treatments for patients with CMD, let us now move to the third which is called Interpersonal Psychotherapy (IPT). Interpersonal Psychotherapy (IPT) is a treatment that was initially developed by mental health professionals to treat adults with moderate to severe depressive disorders. It has been adapted for different disorders and ages (from adolescents to the elderly) and its effectiveness has been demonstrated in numerous scientific trials.

In this section, you will learn:

- What is Interpersonal Psychotherapy (IPT)?
- What are the three phases of IPT?
- What does the initial phase of IPT involve?
- What does the middle phase of IPT involve?
- What are the treatment techniques used in the middle phase of IPT?
- What does the termination phase of IPT involve?

3.3a What is Interpersonal Psychotherapy (IPT)?

Depression and anxiety occur most often because of social and interpersonal reasons. Interpersonal Psychotherapy Treatment (IPT) is a treatment in which the patient learns to understand the relationship between his/her symptoms and interpersonal triggers, which are events or reasons that sets off these symptoms. The patient is helped to reduce depressive symptoms by finding better ways of dealing with the interpersonal problems that have been contributing to his/her CMD.

In IPT, depressive symptoms are closely linked to events in a patient's life. These events fit within one or more of the following categories: role dispute, role transition, grief or interpersonal deficits.

1. What are the key features of IPT?

- CMD is understood as a medical disorder.
- The patient is given the 'sick role'.
- It is a time-limited, focused, "here and now" treatment for CMD.
- It makes clear the diagnosis of CMD and the treatment plan.

- It considers CMD as not being anyone's fault and looks at what was happening in a person's life when the problems began (trigger for developing the CMD).
- It looks at current rather than past interpersonal relationships.
- It focuses on helping the patient decide what she wants and what skills she will need to develop to achieve what she wants.
- The therapist plays an active role, but is not an 'advice giver' or guru.

2. What are four problem areas categorised by IPT?

IPT categorises interpersonal problems under four broad problem areas and considers that the start of the CMD is associated with one or more of these problem areas (but the focus of the treatment is never on more than two problem areas). These problem areas are:

- **Grief** - death of a loved one
- **Interpersonal Disputes** - serious disagreement with someone important
- **Role Transitions** - any life change, bad or good
- **Interpersonal Deficits** - loneliness and social isolation that results in feeling lonely, bored and /or cut off from the others

3. What are the factors of CMD considered important in IPT?

IPT is based on certain characteristics of CMD. These are:

- CMD is a common disorder
- CMD is a medical condition
- CMD may run in families
- CMD commonly occurs due to major life changes, serious disagreements with others, death of a loved one or loneliness
- CMD makes normal work and family life difficult
- CMD is treatable

4. What has MANAS's experience been with IPT?

In the MANAS program, IPT was used in two ways. Firstly, most of the initial phases of IPT were incorporated into the psychoeducation sessions, e.g.:

- **Session 1** gave the patient the sick role and hope
- **Session 2** identified the most likely problem area and instituted basic coping skills based on this

Secondly, for some patients, for whom both Step 1 (psychoeducation) and Step 2 (antidepressant) treatments may not be effective, IPT is offered as a formal psychological treatment (Step 3) in addition to continue Step 2 treatments.

Most patients with CMD improved with the use of 'IPT informed psychoeducation' used in the MANAS program. Our experience during MANAS programme led us to modify how IPT is delivered to make the treatment acceptable and feasible in the primary care setting.

5. Who would require IPT?

Patients with moderate or severe CMD who do not improve or worsen despite receiving adequate treatment with ADT, are offered IPT in addition to ADT as a Step 3 treatment. You could explain this to the person in the following words:

"As I told you previously there is another treatment to help you manage your problem. For this treatment you will be required to come to the clinic to meet me for 6 sessions over 2-3 months or longer depending on your improvement. Each session will be for approximately 45 minutes each. This treatment will help you deal with the issues that are related to your tension, we will talk about the problems that are causing you stress in greater detail and see how you can cope better."

6. What must you do if the patient is reluctant?

You need to emphasise to patients that this treatment is for their benefit and because they have not responded to ADT enough, IPT is necessary. You may need to emphasize that many other patients have shown improvement with this form of '*talking treatment*'.

However, the patient must also be assured that if she/he refuses to agree to the treatment, she will continue to get other form of help/treatment from the clinic and that will not stop. Also give her time to think about it. She is also free to stop at any stage of the treatment if she changes their mind.

If at this point, the patient agrees to accept IPT, then you must follow the detailed process of IPT.

3.3b What are the three phases of the IPT treatment?

So now that you know all the basic information regarding Interpersonal Psychotherapy, let us learn about the detailed process of IPT. IPT in the MANAS programme consists of reduced number of minimum sessions (6 rather than 8-12) and flexibility in frequency of session (every 2 weeks rather than weekly).

The three phases of IPT are:

- Initial Phase (Sessions 1-2)
- Middle phase (Sessions 2-5)
- Termination phase (Session 6)

Now let us learn in detail about the different strategies for each of these phases. We shall also learn the techniques used in the middle phase. Let us start with the Initial phase.

3.3c What does the initial phase (Session 1-2) involve?

The initial phase is when you create the interpersonal inventory and interpersonal formulation. These are large words but the process is quite simple. We shall find out what they mean.

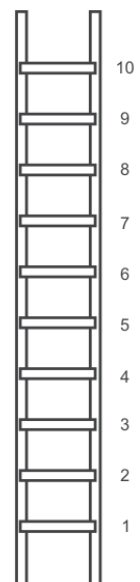
How do you start the initial session?

Be sure to start and end this, and each subsequent session on time. Session should last for about 45 minutes. All the sessions begin the same way:

- Welcome the patient.
- Explain to the patient how the sessions of the IPT will be carried out. Reassure the patient about confidentiality. Encourage regular attendance of the patient. Also address dropping out. You could say, *"If you feel that if you want to stop coming, it's important to come and discuss this, maybe we can find what the problem is and deal with it."*
- Review stress symptoms, i.e. go over the problems of the patient like dizziness, fatigue, etc. Ask whether the symptoms have increased or decreased or remained the same.
- Rate stress symptoms using the "mood ladder". A mood ladder is a way of rating someone's mood in the form of a ladder of steps. This exercise has been described in detail in Chapter 3.4. It involves showing the patient a picture of a ladder and telling him/her *"If lowest rung is the worst you have felt and the top rung the best you have felt, at which rung would you place your current mood?"*
- Give the patient hope. The person will probably be feeling especially hopeless and unhappy since their treatment with ADT has not worked. You can reassure the patient with the following words:

"Not every treatment works for everybody. It takes time, and we have to find the right treatment. We are now going to try a

MOOD RATING



new treatment that has been shown to help a lot of people who have stress related illness. It is called Interpersonal Psychotherapy (you may call this “a counseling treatment” or a “talking treatment” in the local language), and it has been used around the world to help people who have similar problems to those that you have. We are going to spend time today looking at the situations in your life that trigger and maintain your stress. We want to spend time today looking at the people in your life that are connected to your stress and who are affected by it.”

How do you conduct an Interpersonal (IP) Inventory?

First, let us get to know what an interpersonal inventory is. The interpersonal inventory is an attempt to collect information about the important relationships in the person's life that would help you understand interpersonal factors that may be contributing to her CMD.

What do you keep in mind while conducting the inventory?

- When conducting the inventory, remember to ask only about the important people in the patient's life that are associated with the stressors that you have already identified. For example, you might start the inventory in this way: *“I want to spend some time today understanding a little further how some of the important people in your life may be contributing to your stress related illness. Let's start with...(your daughter in law)”* (Fill in the name of the person you know from the patient's life who seems to be at the center of the stress).
- Remember to keep the focus of the Interpersonal Inventory on the problem area that you've already identified. This should not be a time for the patient to ramble. Keep a tight focus. Begin by explaining to the patient, *“In order to help you deal with your stress further, I need to understand about the relationships in your life that may be contributing to your stress.”*

What are the questions you could ask to get information?

You could ask these following question:

- *Do you have any problems with(your daughter in law)?*
- *Has anything changed in your relationship with(your daughter in law)?.? When did this happen?*
- *What would you like to change about this relationship?*
- *How often do you see(your daughter in law)?*
- *What do you like about(your daughter in law)?*
- *How often do you argue with(your daughter in law)? Describe a typical argument.*

- *How do you get along with friends? Do you have friendships from long ago?*
- *Has anyone important to you died? When? How has this affected your stress related illness?*

These are only suggestions. You don't need to ask all of these. Choose those which seem relevant. Add questions that you think are important. Change the details in the brackets as per the case.

How will you benefit from conducting an interpersonal inventory?

- You will get a better insight into the triggers of the patient's stress.
- Remember to have the patient describe when she first noticed the symptoms and see if you can determine what was happening or not happening in her life at that time.
- You will get a better sense of the intervening triggers and current interpersonal stressors that sustains the patient's stress.
- Since you already know the patient, you probably have some knowledge about the about the relevant problem area(s).

Note: The IP inventory is also useful to identify those people who are supportive to the patient in his/her life and this can be a protective factor.

How do you create an Interpersonal (IP) Formulation?

Interpersonal formulation is the summary of the information that you have gathered during the interpersonal inventory, to present to the person for clarification and to identify the problem area(s). What must you do to create an interpersonal formulation?

i. You must identify major problem area(s):

After you have spoken to the patient about his/her relationships or the events at the time the CMD began, you must tell the patient what you think is the focus of his/her problem.

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

The details in the brackets will change as per the case.

Thus based on the information gathered, you will determine the problem area(s) related to the current stress. You can choose 1 - 2 of the following:

- **Grief** - death of a loved one

- **Interpersonal Disputes** - serious disagreement with someone important
- **Role Transitions** - any life change, bad or good
- **Interpersonal Deficits** - loneliness and social isolation that results in feeling lonely, bored and/or cut off from the others

Sometimes the patient may have more than one problem area. For example, the patient may have changed her job and have difficulty in adjusting to this change (role transition). The same person may be having frequent conflict with her junior at work who resents her appointment (interpersonal dispute).

ii. Get agreement from the patient:

You must get agreement from the patient that this is the problem area(s) that she believes is causing stress and that she would like to change. You could say: *"Your health problems seem to be related to the stress you are experiencing due to ... (the frequent quarrels with your husband over your wanting to find a job). Do you agree with this?"*

iii. Find out how the patient would like the situation to be different:

You could say: *"We will, over the next few weeks, discuss how you can deal with this better so that the situation improves and you feel better. How would you like your relationship with your husband to be different?"*

iv. Do not argue if the patient disagrees with the chosen problem area, but re-suggest it at a later stage:

If the patient does not think it is the important issue, do not disagree. Focus on the issue she chooses for the moment. Then in the next session during the middle phase, you can try to link it to the one you have in mind, if possible.

For example, if a patient developed CMD after the death of her aunt (problem area - grief) who was like a parent to her, but felt that the problem was a relationship with her boyfriend (dispute), you can agree to this in the initial sessions.

During the middle phase, you can say to her in the following words *"How does it feel not to have your aunt around during this difficult time?"* This may be effective in getting the patient to focus on the grief she is experiencing.

3.3 d. What does the Middle Phase (Sessions 2-5) involve?

In this second session of IPT, depending on which areas her problem lies, you will adopt different strategies. We will learn the four different strategies for the four problem areas. You will learn:

- How to deal with the problem area of Grief?
- How to deal with the problem area of Interpersonal Disputes?

- How to deal with the problem area of Role Transitions—life changes?
- How to deal with the problem area of Interpersonal Deficits—loneliness and social isolation?
- We will then come to know about the different techniques to be used in the middle phase.

How do you start the middle session?

- As with the earlier sessions, start and end this session on time.
- Welcome the patient.
- Check patient's stress by using the "mood ladder" (Ref: Chapter 3.4)
- When the patient reviews his/her stress, link the stress to events from the previous week and events from previous week to stress. For example, if patient says, *"I had a lot of headaches and stress during the week"*, find out what happened in the interpersonal events linked to her problem area. For example, if the problem area is grief; check if in the previous week there was an event like an anniversary related to the close relative who had died when her symptoms began.
- Focus on identifiable problem area(s). Make the focus of your conversations the identified problem area.
- Encourage the patient to practice outside the clinic some of the skills that have been learned in these sessions. We will discuss these skills in the following part of this session.
- Continue educating her about symptoms of stress and the mind body link
- Continue making and encourage the patient to make links between stress symptoms and what is happening or not happening in her life.
- Remind the patient about the number of remaining sessions and prepare her for the next phase i.e. the termination phase



Now you will address the problem through the identified problem area. Let us take up the first problem area.

i. How to deal with the problem area of grief?

Grief occurs when there is the loss of an important person in the patient's life.

Example: A 45 year-old woman whose husband died suddenly of a stroke was unable to mourn his death as she had to deal with the responsibility of providing for their

three children and running the family business. One year later she suffered from loss of sleep and appetite, irritability and disinterest in work suggesting CMD.

How do you work with this patient?

- You must facilitate the mourning process. You must give her the time and space to feel unhappy and cry over the passing of her husband to deal with the unhappiness locked inside her.
- You must help the patient re-establish interest and develop relationships to help her come to terms with the loss of her husband

What must you do in this session?

- Review stress symptoms. Ask the patient how s/he is feeling.
- Relate the beginning of symptoms to the death of a person who is important to the patient (worsening of symptoms at anniversaries).
- Encourage her to talk and express her sadness about the loss.
- Describe the events just prior to, during and after the death. Talk about the death scene.
- Discuss the patient's relationship with the deceased (reconstruct the relationship).
- Discuss the patient's positive and negative feelings about the deceased. You could say, "*Every relationship has rough times. What was your rough time?*"
- Discuss how the future looks without the deceased, including the unrealised plans and the change in the patient's social/family status after the death).
- Encourage relationships, old and new and encourage the development of interests.

ii. How to deal with the problem area of Interpersonal Disputes?

Interpersonal dispute is when there is an ongoing disagreement with a person in the patient's life.

Example: A woman has CMD, the start of which coincides with her discovering her husband's extra marital relationship. This has led to frequent, bitter quarrels over several months between her and her husband. She feels burdened and does not know how to handle this situation.

How do you work with this patient?

- Identify the dispute, including the stage of the dispute - renegotiation, impasse and dissolution (these terms are explained below).
- Choose a plan of action.
- Modify expectations or faulty communication so that the difference of opinion is resolved.

What must you do in this session?

- Review stress symptoms. Have the patient tell you whether she feels better or worse.
- Relate the start of the symptom to the interpersonal dispute.
- Identify stage of dispute: When a relationship with a person develops a problem there are three different stages that the relationship goes through.

Let us learn about these three stages:

What is renegotiation? A renegotiation exists when the parties are in active contact about their differences as in the example above, where there are arguments but the two are still talking. If the dispute is at the renegotiation stage, you must plan on helping the patient develop better communication skills so that the discussions and arguments can result in improving the relationship.

What is impasse? An impasse exists when discussions have stopped about the disputed issue. There is no discussion or argument anymore. Both parties want to continue the relationship, but feel hopeless and stuck. If the dispute is in the impasse stage, you must ask the patient what she tried to resolve when the relationship was at a renegotiation stage. You must try to help her develop other approaches by talking and experimenting.

What is dissolution? When one or both parties want to end the relationship, assist mourning and help the patient to move on. Make sure that this is not really an impasse:

- Ask the patient if she is willing to try to get back with the other person one last time.
- To achieve the goals of interpersonal disputes, you should encourage the patient to talk about her feelings.
- Help the patient understand the dispute as a difference in expectations of the people involved.
- Help the patient understand her expectations.
- Help the patient understand, but not necessarily accept, the other person's expectations. The technique you can use here is Communication Analysis*. You could ask the patient to describe what happened in detail as if she was filming it with a video camera; focus on a specific incident; also ask her describe thoughts and feelings.
- Find out what the patient wants from this relationship and choose a plan of action. The technique you can use here will be Decision Analysis*. With patients who have trouble finding options, you could start by making suggestions, then ask the patient to think of some more options and suggestions for solving the problem.

- Help the patient change communication patterns to improve the situation. The technique you can use here is Role-Play*. Rehearse what the patient plans to communicate. Switch roles so that the patient has the opportunity to play both roles in the dispute. The therapist should not make the role-play too easy. It should be a realistic example of what may happen in real life.
- Help the person improve his/her communication skills.

****Techniques are discussed in detail at the end of this section on the middle phase.***

How do you help patient improve his/her communication skills?

- Tell the patient to find a good time to talk when the other person is more receptive to the conversation. You must strike while the iron is cold!
- The patient should focus on the current dispute and not talk about all the mistakes the other person has made in the past.
- The patient should separate the other person from his/her behavior. Using the words "*Your words were very hurtful*" lead to more constructive discussion than using the words "*You are an unkind person*".
- The patient should acknowledge the other party's expectations. He/she could say: "*I know you feel like I am not paying attention to you*".
- The patient should use "*I*" statements about how s/he feels and what s/he wants. For e.g. you could say "*I feel angry when you behave like this*" rather than "*You make me angry*".
- The patient should avoid using words such as "*always*" and "*never*."
- The patient should find advocates or helpers to help if s/he cannot directly communicate with the other party.

iii. How to deal with the problem area of Role Transitions—life changes?

Example: A middle aged man sustained a hip fracture following a road accident. Since then, he walks with a limp and has frequent radiating pain down one leg. This has led to his having to stop working (he was a farm laborer), frequent visits to the doctor and increasing dependence on his wife and sons. His depressive symptoms coincide with these life changes.

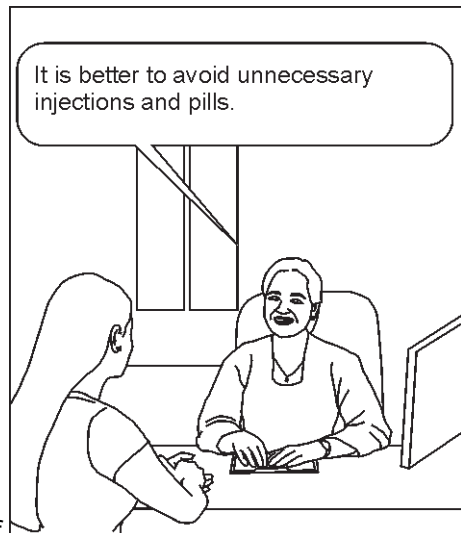
How do you work with this patient?

- Mourn the loss of the old role.
- See the positive aspects of the new role.
- Develop any new skills necessary to gain mastery of the new role.

What must you do in this session?

- Review stress symptoms with the patient.

- Relate stress symptoms to difficulty in coping with the new life situation.
- Discuss positive and negative aspects of the old role. Patients may exaggerate the positive aspects of the old role and minimise the unpleasant aspects. It is important to draw their attention to both.
- Mourn the loss of the old role – express guilt, anger, fear at the loss.
- Discuss the positive and negative aspects of the new role.
- Explore opportunities in the new role.
- If no positive aspects exist, help the patient determine what is within his control. Even in the most negative circumstances, patients will be able to identify something that they can do to feel better, for example, learning to make the most of their time when faced with a serious medical illness.
- Encourage the patient to talk about feelings.
- Help the patient develop new skills that he will need in the new role. E.g., it may mean helping the patient to manage the transition effectively by finding a new job, finding a new home, meeting new people, etc.
- Help the patient find advocates/ supportive figures to help her/him manage the new role. In the example above, the patient can be helped to identify a reliable doctor who can provide advice about pain relief and guide the patient about further treatment.



How to deal with the problem area of Interpersonal Deficits—loneliness and social isolation?

Example: A 35 year-old depressed man lives alone, has very few friends and would like to get married. He is unable to make friends with women as he feels socially awkward and does not know how to sustain a conversation with them. He has low self esteem and believes that women find him uninteresting.

How do you work with this patient?

- Reduce the patient's social isolation.
- Encourage the patient to form new relationships and to look for new opportunities to develop social contacts and supports.

What must you do in this session?

- Review stress symptoms. Ask the patient how she/he feels.

- Relate stress symptoms to isolation.
- Explore current social interactions by asking about family and friends, e.g., "*How often do you see them?*" "*What do you enjoy about seeing them?*"
- Find out the problems in social interactions. Does the patient have trouble starting and/or maintaining relationships? You could ask: "*What are the problems that come up in your interactions with...(your husband).?*"
- Use extensive role-play and feedback.
- If the patient contacted an old friend and arranged to see that person, you can ask: "*Describe how it went. How did you feel? What did you say?*"
- Encourage social interaction outside the therapy and have the patient talk during the sessions about how the experiments from the previous week went. You could say, "*This is a good time to try and work on your relationships. We can talk about what goes right or wrong when we meet for our next session.*"
- Each description provides an opportunity for you to reinforce the positive steps the patient has taken, provide encouragement and use role play for interactions that have not gone well.

Remember: Regardless of the problem area, complete the middle phase tasks for every session.

3.3 e. What are the treatment techniques used in the Middle Phase of IPT?

What is Communication Analysis? Communication Analysis is a technique or a tool where a single communication event is examined in detail. The event is discussed with the patient and ways are found to improve the communication between the parties.

What are the goals of Communication Analysis?

Communication analysis helps the patient to understand:

- the feelings he/she conveys with verbal and nonverbal communications
- the impact of these communications on others
- the impact of others' communications on him/her
- that he/she has the ability to change these interactions and that as a result, experience a change in his/her feelings associated with the relationship

What are the guidelines of Communications Analysis?

- Identify an interpersonal communication to examine in detail (*Let's talk about the worst fight of the week*", "*Tell me how was the visit to your sister's house.*")

- Encourage the patient to explain what was said in the communication. Ask questions such as: *"What did you say? What did she say? How did it make you feel? Is that the message you wanted to send? What else could you have said? How could you have said it differently? How did you feel when she said ____ back to you? What do you think she meant?"*
- Here you could convey to the patient the manner of improving his/her communication by the points given above in the section **"How do you help patient improve his/her communication skills?"**
- Illustrate the cyclical nature of the communication. Cyclical communication is a statement by one person that leads to a response by the other, which then leads to a response by the first person, and so forth. We can change another's response by changing what and how we communicate.

What is Decision Analysis?

Decision analysis is an attempt to help the patient consider all options she has in a situation, to enable her to choose the option she would like to exert and help her plan the action. Following exploration of the situation through communication analysis, action is encouraged. You could say: *"What are you going to do about the situation?"*

What are the guidelines of Decision Analysis?

- Select an interpersonal situation that is causing a problem.
- Encourage the patient to generate possible solutions to the conflict. Brainstorm, don't evaluate any of the ideas yet.
- Evaluate the pros and cons of each solution.
- Select one solution or a combination of a number of them to try first.
- Rehearse the interaction for the first solution.
- Encourage the patient to try the solution out of the office during the week.
- Remember to reinforce that this is an experiment and that it may or may not work, but that it is important to come back the next week to discuss the outcome.
- Start with smaller problems first to help the patient build confidence.
- Review the interaction the following week, examining either its success or where it didn't work and possible reasons why.

What is Role-Play?

Role play involves the patient and counselor assuming the roles of the two parties in the conflict and enacting the conversation as if in a play. This allows the patient to rehearse how and what she may say in a real situation.

What are the goals of Role Play?

- To give the patient a SAFE place to practice new interpersonal skills (e.g. expression of emotions).
- To give the patient the opportunity for rehearsal and to receive feedback on skills and strategies prior to trying to apply them outside the therapy.
- To improve the person's social confidence.

What are the guidelines of Role Play?

- Role-playing is an active technique (act it out).
- Be prepared to initially gently push some patients to do it. They may feel self-conscious.
- Do not make the role-play too easy (remember that in reality the other person may be rough or confrontational).
- You have the option to play the patient role first so that the patient gives you a flavor for how the other person really is. You can also start by being the other person, it's up to you and the patient. You can then switch roles.
- At the end of the role-play, ask the patient how she felt about it, does she feel ready to try this at home?
- For anxious patients—lead them to it gently.
- Talk through the role-play first.
- Structure it for them.

This is the middle phase. When you end the middle phase you would have finished around 5 sessions with the patient. Let us look into what you must do in the final phase.

3.3 e. What does the Termination Phase (Session 6) involve?

Therapy is a tool to equip the patient to handle her stress beyond the duration of the therapy sessions. Termination is explicitly discussed throughout the therapy. By doing this you ensure that the patient is aware the counseling is time bound, and she is not unprepared when it ends.

How do you begin this session?

- Welcome the patient and remind her that there are two sessions remaining after this one.
- Check on the patients' stress symptoms.

- Review changes in the symptoms and interpersonal problem area(s).

What do you do to during this session?

Explore the patient's feelings about termination—fear, excitement, pride and sadness.

- Discuss possible sources of problems in the future and skills the patient might use to prevent stress based on strategies learnt in the sessions.
- Ask the patient to describe how she would know that the stress is returning, i.e. what symptoms will she notice.
- Make an action plan (For example, when to contact the doctor or HC in future)
- Deal with non-response or partial response, and discuss the possibility of continuation or maintenance treatment.

Do you plan extra sessions?

Some patients who have long-standing interpersonal problems and lingering symptoms may need additional booster sessions to reinforce the skills learnt during therapy. These sessions are spaced at intervals of one month and the tasks are the same as that of middle phase sessions described above. On discussion with your supervisor, these sessions are continued until as long as they are necessary.

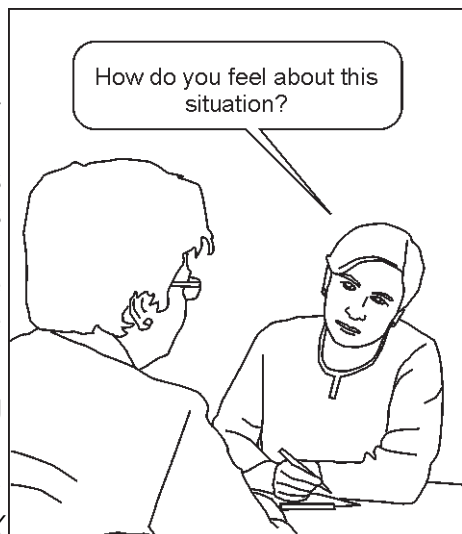
How to encourage the Patient to keep working at home?

Remind the patient frequently about termination, but not every week: *"We have X more meetings until we end."* This encourages the therapist and patient to keep the momentum going. Also after every week and during the final session, encourage the patient to keep the work at home:

- Explain to the patient that he/she will be experimenting with new skills from what has developed from communication analysis, decision analysis, and role-play.
- Work at home is developed as a result of work within a particular problem area.
- Work at home is tailored to the individual patient and is not strictly prescribed.

Maintaining clinical records:

You will be keeping records for each session. You will fill in a prescribed form IPT Clinical Record, see Appendix 5.3.



In this section we learnt that:

- ⊙ Interpersonal Psychotherapy Treatment (IPT) is a treatment in which the patient learns to understand the relationship between his/her symptoms and interpersonal triggers, which are events or reasons that sets off these symptoms.
- ⊙ Patients with moderate or severe CMD who do not improve or worsen despite receiving adequate treatment with ADT, are offered IPT in addition to ADT as a step 3 treatment.
- ⊙ The three phases of IPT are: Initial Phase(Sessions 1-2) Middle Phase (Sessions 2-5) Termination phase (Session 6)
- ⊙ An interpersonal inventory is to find information regarding the events in the person's life during the time the CMD began and also the interpersonal relations in the person's life
- ⊙ Interpersonal formulation is the summary of the information that you have gathered during the interpersonal inventory.
- ⊙ Strategies used are tailored to deal with problem areas of grief, interpersonal disputes, role transitions and interpersonal deficits.
- ⊙ Some patients who have long-standing interpersonal problems and lingering symptoms may need additional booster sessions to reinforce the skills learnt during therapy.

Adherence Management

CMD is a chronic disease. Even though there are effective treatments available for most chronic diseases, to motivate patients to continue with their recommended treatments for the necessary period of time is the single greatest challenge facing health providers worldwide. This is called the problem of adherence, which we shall now look into in greater detail.

In this chapter, you will learn:

- What is adherence?
- Why is adherence so important?
- How widespread is non-adherence and what are its health consequences?
- What are the factors that influence adherence?
- How can we improve adherence?
- What are adherence management strategies in the MANAS program?
- What are the major problems affecting adherence and their potential solutions?
- What are the different roles of the team members in the MANAS program?

3.4a What is adherence?

Adherence can be understood as ‘the act or quality of sticking (adhering) to something’. Can the patient follow a treatment plan, take medications at prescribed times and frequencies and sustain positive lifestyle changes right up to the end of the required time? The ability of the patient to do this is adherence.

3.4b Why is adherence so important?

Some diseases need a long time to be treated. To get the best outcomes from the treatments of chronic diseases, whether infectious (such as HIV/AIDS) or non-infectious (such as CMD), long-term treatments are needed. This applies both to medicines that need to be taken on a daily basis, even when there are no obvious symptoms, and also specific lifestyle changes that the patient needs to commit to and continue with.

For example, the treatment of heart diseases involves doing regular exercise, stopping smoking, avoiding excessive alcohol consumption, modifying diet to decrease fat and salt intake as well taking medicines 2-3 times daily. In chronic

infectious diseases like HIV/AIDS, it is similarly important that patients take a complex treatment regime at least 95% of the time for the rest of their lives as well as substantially change their lifestyle and sexual behavior to achieve the best effects of the treatments.

CMD also needs a long time to be treated. CMD is often a chronic disease. The treatments that produce the greatest benefits, like antidepressants, lifestyle changes and IPT need to be continued for a length of time (six months of treatment with antidepressant), for the patient to recover and to maintain good health.

Some people find taking treatment a challenge even when it needs to be taken only for a few days (like antibiotics for chest infections). Many patients start to miss the doses of medicines once the acute symptoms subside. To stick to treatment of a chronic disease is, therefore, a greater challenge for a patient.

If the patient does not follow through with the necessary treatment, even if we give the best treatments, it will be of limited benefit. In technical terms, this is called non-adherence to treatments.

3.4c How widespread is non- adherence and what are its health consequences?

The problem of non-adherence is a huge public health problem globally and especially in countries, like India, where the resources for healthcare are limited. Non-adherence to treatments can cause the relapse of the illness or it can cause the illness to recur.

Subsequent treatment becomes even more difficult when the person develops drug resistance due to non-adherence. The loss of productivity due to continued sickness can place a high health and economic cost on the individual and society.

CMD are a kind of a disorder where patients are most likely to drop out of treatment. When the person discontinues the treatment, the chance of recovery reduces, the chance of the illness relapsing increases, attendance at work gets affected, and the risks of suicide increase. Moreover, the effectiveness of the treatment is wasted.

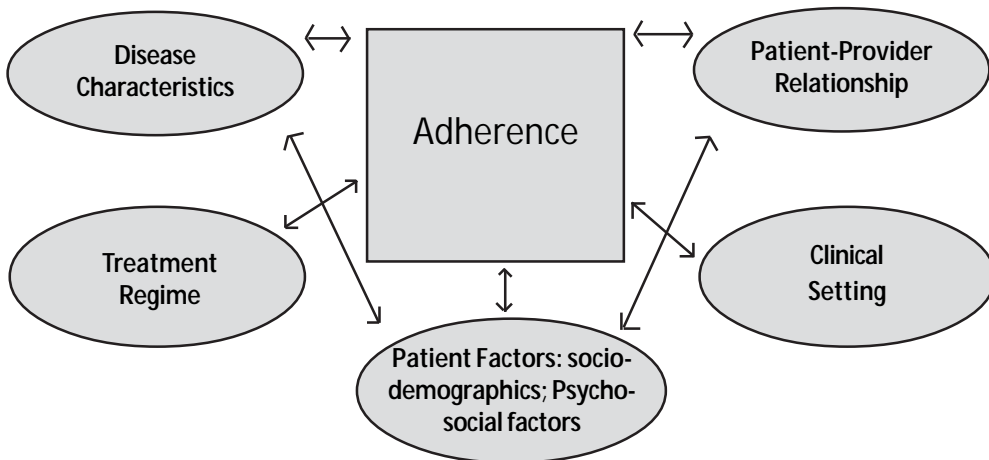
In a previous study done in Goa, it was found that although antidepressants produced most significant clinical benefits in the first couple of months, the effects of the treatment were lost at 12 months because by then most patients had discontinued their medications.

3.4d What are the factors that influence adherence?

So in order to solve this problem and ensure proper adherence, we need to know a bit more about it. What are the factors that affect adherence?

These factors are represented in the figure below:

The interaction of factors that influence adherence



How do patient factors affect adherence?

Let us look at the patient factors that affect adherence. Factors such as gender, ethnicity, age, employment, income, education and literacy, which are socio-demographic factors, are the patient factors that you have to consider.

Although for men, older age, higher income levels, higher education and literacy correlate with better adherence, in general, some studies have found that whether a person will continue with the treatment or not is not influenced by socio-demographic factors too much.

On the other hand, a number of psychosocial factors have been found to strongly influence adherence. Since most of them can be changed it is important to identify these factors. What are these psychosocial factors? They are:

- a good social support like an understanding family which encourages the patient to adhere with treatment recommendations
- the knowledge and understanding of a patient of her medication regimen
- a good understanding of the relationship between non-adherence and poor outcomes
- a patient's belief and confidence in treatments being provided, and his/her self-efficacy, i.e. confidence in herself to be able to adhere
- finally, the common understanding of the illness of the patient and the health provider

All these psychosocial factors go a long way in affecting the adherence of the patient to treatment.

How do treatment related factors affect adherence?

Now let us look at the treatment related factors that affect adherence. In general, the more complex the treatment requirements become, the lower is the adherence. In chronic diseases, frequently the treatment regimen involves use of multiple drugs several times a day. For example, in the treatment of CMD, sometimes doctors can prescribe many pills per day which need to be taken at different times. These are often difficult to follow for patients and contribute to poor adherence.

Another very important reason for non-adherence is the side effects of the treatment. In the treatment of CMD, antidepressant medications, for example, may have unpleasant immediate and long term side effects. It is obvious that if the patient experiences these side-effects, she/he tends to stop treatment or takes it irregularly; in both scenarios, the outcomes are poor adherence. One way to overcome this challenge is to educate the patient about these side-effects and their management.

How does patient – healthcare provider relationship affect adherence?

The importance of a positive therapeutic relationship cannot be exaggerated as this is possibly the single most important factor that predicts long term adherence. The quality of the relationship between the patient and health care provider (the doctor and you, the HC, in the primary care clinic) determines adherence. If the care providers inspire trust and confidence, the adherence is affected positively.

How do the disease characteristics affect adherence?

It is very important to remember that CMD itself is a commonly observed reason that results in poor adherence. To suffer from a CMD means to experience symptoms like lack of motivation, helplessness and hopelessness. This can discourage a patient to continue with treatments. Also, the poor concentration and memory problems that many depressed patients experience can result in them forgetting to take medicines or to keep appointments with the counselor. Similarly, continued use of alcohol and drugs generally results in poor adherence to treatments.

How do clinical setting related factors affect adherence?

It matters as to where you are delivering the CMD treatment. For example, if patients go to the treatment facility and feel that the staff is rude or uncaring, it is more likely that they would not return for their treatment. On the other hand, if there is a sympathetic staff, availability of basic physical amenities like clean toilets, drinking water and privacy during physical examinations or counseling sessions, a patient is encouraged to adhere to the treatment and to be regular.

Another factor that influences adherence is the assured availability of the treatment and staff. For example, if patients attend the health centre to find that the doctor or their medicines are not available regularly, they are more likely to stop the treatment.

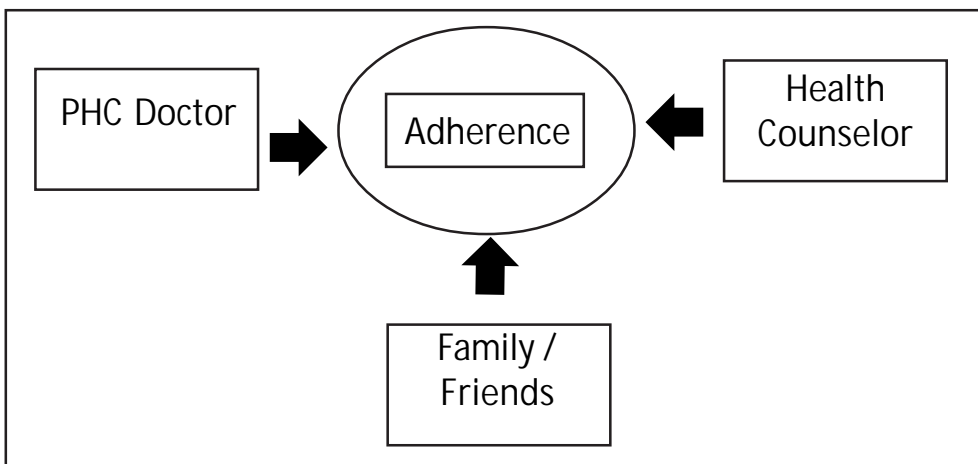
Finally, if treatment facilities are easily accessible and nearby, i.e. patients do not have to travel long distances to reach them, then this is strongly associated with better adherence.

3.4e How can we improve adherence?

So now that we know what factors affect adherence, how do we improve adherence?

Figure 3.4B below provides the methods that can be employed in health programs to improve adherence of patients to their treatments.

The Multiple Players Involved In Improving Adherence



Now let us look into the factors that help improve adherence.

There is no single method of improving adherence. The general principles of a good adherence management program are broadly based on the following principles, which need to be applied at multiple levels of the program:

Make the care accessible: If patients live very far from the clinic, they are likely not to return. Telephone consultations may be the best way to continue counseling treatments.

Make the care equitable: The care should not systematically exclude any section of the population (e.g. women, those living in great poverty, migrant workers, etc.).

Make the treatments simple and acceptable: The patient should feel that the treatments are easy to follow and meet their expectations.

Make the treatment affordable: Patients need to pay for the cost of the antidepressant and any other medicines that the doctor prescribes. They also need to pay the travel cost, time taken off from work, as well as costs to return to the clinic regularly to

receive treatment. We address the first issue by recommending cheaper antidepressants and the second one by coordinating follow-up sessions at the patient's convenience (e.g. when she has an appointment to see the doctor, or is coming to the area of the clinic for some other reason).

Make the treatments effective: This is done by making sure that the treatments are based on good scientific evidence. We use the stepped care model to deliver a range of treatments that match the different needs of the patient.

3.4f What are the adherence management strategies in the MANAS program?

Only if the challenge of non-adherence is dealt with systematically, the treatment for CMD can be delivered best. Keeping this in mind, we have made an intensive effort to understand the possible reasons why patients do not follow through with treatment recommendations and have changed the delivery of the program accordingly. To ensure better adherence let us look into the major problems and identify the potential solutions.

3.4g What are the major problems with adherence, and their potential solutions?

Lack of information in the clinics about the program: If the people know about the program and the benefits of adherence they will be better able to continue with the treatment. It is important that everybody who is a part of the clinic is able to provide the patient with information about the program available in the clinic. It is especially important that all the clinic staff are co-opted and briefed about the program and the role that they are expected to play to ensure adherence amongst the patients.

Lack of time for the patients to return as they work as daily wage labourers: It is very important to find out about the employment status of the patient during the first visit so that you can judge whether the patient is likely to have difficulties in follow up visits to the clinic. Some of the ways you can encourage the patient to adhere are:

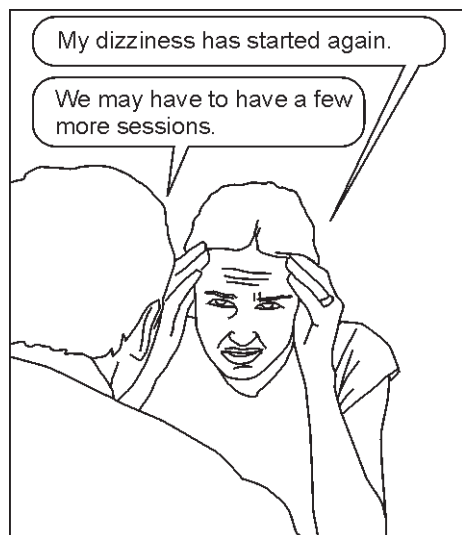
- You can explain to the patient that you are available for consultation later in the day, for e.g., in the afternoons as well, and that the patient can come at a convenient time before the clinic closes or come in on Saturday mornings.
- You can plan follow-up sessions according to patient's convenience (e.g. when she has an appointment to see the doctor, or is coming to the area of the clinic for some other reason).
- You can provide telephone counseling if telephones are available. Home visits may be used very rarely for selected patients who have unique risks and after consultation with the MHS.

Lack of punctuality of patients in keeping the follow up appointments: Although you, as the HC, will write down the date for the follow up visit, only a small number of patients actually come on the designated date. The majority of patients come back a week or even later for the appointment. Some people forget the appointment, and some patients say they feel embarrassed going back after having missed the date. You should clearly tell the patient that they are still welcome to drop in for the appointment on some other date that is convenient for them if for some reason they cannot make it on the date that has been fixed for the follow-up.

Lack of doctor's briefing the patients regarding the importance of regular treatments over a period of time to recover: Doctors have a very important role in motivating patients to return for follow up appointments. Sometimes, a doctor's words carry more weight.

Therefore both you and the MHS, who will interact with the doctors in the clinic regularly, can remind the doctors about their role in ensuring adherence. Also, doctors should be encouraged to prescribe one dose per day treatments, which are more convenient than multiple doses per day if they forget the importance of this in ensuring adherence.

Non-adherence of patients when they start feeling better: For the best results, you should clearly explain to the patient the importance of following through with treatments even after the patient starts feeling better during the initial psychoeducation session itself. It is important to say that if the patient does not complete the 'course', they will experience a relapse of the illness.



You may give an example that the patients understand, i.e. the example of Malaria. Although, the course of tablets of Malaria be for a week, for most patients the fever subsides in just two days, but if the patient stops the course at that time the malarial fever will return and the same treatment may not work again. This same thing can happen with a CMD.

Lack of patients' comfort with some of the psychoeducation techniques for the management of CMD: Some patients report feeling uncomfortable with certain psychoeducation techniques like the breathing technique which they may find unfamiliar. You should always ask patients specifically about their comfort level during this exercise. If they feel uncomfortable, ask them to try the exercise with their eyes open or slow the breathing rate. If patients reject this technique, tell them that this is perfectly all right and proceed with the rest of the session.

Denial of the nature of illness: Some patients deny that they have any 'mental health' problem and will insist that their problems are related to physical health problems like lack of sleep or tiredness. A useful method is to avoid using the term 'mental' while explaining the nature of the problem to patients. It is best to use the term 'stress or tension related' when explaining the nature of the problem to patients as this is something that patients can identify with easily and do not feel a personal stigma attached to it.

Existence of social problems that trigger CMD: During the health education session, you would need to explore if the patient has problems like poverty, domestic violence, etc. that is the reason of the CMD. In the MANAS program, we have developed a checklist for this purpose (see Appendix 5.3). If any social problem is identified, you will need to consider possible solutions together with the patient. It is possible that the social problems like poverty or legal problems cannot be solved by you or the primary health care clinic staff. In this case, you need to refer the patient to the appropriate agency to help in resolving her problems.

In the MANAS program, each HC has a list of such resource agencies in order to identify and refer to patients. It is preferable that you write a small note to the agency or make a telephone call and introduce the patient to a particular person in the agency. Showing concern for social difficulties can enhance the patient's trust in you and improve adherence.

To ensure you identify the possible risk factors that can compromise adherence in the initial session, you will complete a checklist (Appendix 5.3). This summarises the risk factors for the individual patient and helps you to take specific steps to minimise the risk factors as far as possible. At MANAS, we found "risk of non-adherence checklist" a useful method to ensure that HCs ask about these as a matter of routine and we recommend it for other programs.

3.4g What are the different roles of the team members in the MANAS program?

As we mentioned earlier, improving adherence is a team effort. Everyone involved in providing the intervention plays multiple roles in improving the adherence of patients to medications and in promoting engagement with the program. However, as the HC, you will have a critical role to play in coordinating efforts of the various members to improve adherence. We briefly describe the specific actions that team members can play in this regard, evolved from our experience during the MANAS program, and have since been implemented successfully.

What is your role, as the HC, in improving adherence?

During the session of psychoeducation, you will impart an important message to the patient, which is the need for adherence for the best results.

You will also:

- complete an adherence checklist in initial session and plan solutions for identified risks with the patient
- enable flexible follow-up dates and timings which are arranged with patients to maximize chances of follow-up
- match the follow-up dates whenever possible with doctor's appointment for the convenience of patient
- meet the doctor regularly to provide feedback about patients, especially those who have missed appointments
- provide, at monthly intervals, a list of those who have missed follow-ups to the other PHC team members and the doctor so that they can refer those patients to you
- provide mobile phone number to patients of those who can fix new appointments, if necessary
- ensure that the postal address and other crucial contact details in the clinical case record are filled out accurately
- record contact telephone number whenever possible; also clarify if the telephone is in the home or if patient has to be called to a different location.
- enable brief contact and basic counseling on the phone whenever possible
- discuss new strategies for improving adherence with MHS and other HCs during supervision meetings
- use every opportunity to reinforce the need for adherence even if you meet the patients unexpectedly in the clinic or during yoga sessions, if the sessions are being conducted at the clinic
- be familiar with all the other treatments and physical health problems the patient is suffering from; this will help the patient feel that you are concerned about all health aspects
- be sensitive to the patient's social problems; listen to these problems, advise patients about what to do, write referral letters to relevant community



agencies and follow-up. This will help improve your engagement and credibility

- monitor the use of antidepressants closely - this is a key treatment for patients with more serious problems. It is very important that these patients with the more serious problems are given more than usual inputs to continue with treatments
- make concerted efforts and establish an excellent rapport with the doctor and other clinic staff. For all practical purposes, you are a member of the clinic with a clear line of accountability to the doctor
- make sure you update your community resources directory to include all local agencies in the area. Once you have this information, it is useful to contact them and introduce yourself, explain your role in the clinic and that you might be making referrals to the agency, if the need arises
- make sure you have a good idea of the socio-demographic profile, such as gender, ethnicity, age, employment, income, education and literacy of patients who come to the clinic in discussion with the doctor and other PHC staff. This information can be very helpful in helping the patient to accept the intervention in that clinic.
- ensure minimum standards of space allocation and privacy are met prior to starting intervention; the ideal location for the HC is in close proximity to doctor's consulting room
- improve the knowledge of the availability of the program for all patients who attend the clinic through well-located posters and other creative methods that can be implemented in the clinic
- enhance visibility of boards, signs and the room where the people can meet you
- give handouts that emphasise need for adherence to all patients during the first psychoeducation session; also ensure that your contact phone number is printed in the handout



What is the role of the PHC doctor in improving adherence?

The doctor should:

- educate patients briefly about the nature of problems emphasising the role of stress
- encourage clients to meet you after consultation with the doctor
- emphasise need for regular follow-up for best outcomes
- choose an antidepressant that is cheap and convenient for the patient to take once a day
- if prescribing antidepressants, explain the need for continuation and advise briefly regarding side effect profile
- meet you and the MHS to discuss any ideas to improve follow-up rates while specifically discussing patients who have dropped out or stopped using medicines
- ensure that adequate stocks of medicines are available in the clinic at all times
- personally advocate improving adherence of CMD patients in the clinic during routine staff meetings

What is the role of the MHS in improving adherence?

The MHS will:

- ensure that there is adequate training for doctors, and then during ongoing supervision, will focus on the appropriate use of adherence management strategies in the clinic
- during supervision visits, review the status of adherence of patients who have been prescribed medicines and recommend strategies to address possible reasons for non-adherence in individual patients
- encourage the doctor to use antidepressant medicines that are convenient for the patient
- discuss any bottlenecks or problems to the continued supply of medicines with the doctor and, if necessary, with the head of the clinic
- personally review patients who have stopped medication due to complex problems, serious side effects or due to non response to the medicines prescribed by the PHC doctor

What are the roles of other clinic staff in improving adherence?

The PHC team also consists of staff within the center like the registration clerk, pharmacist, nurses, clinic attendants as well as field based staff, who are responsible for coordinating community based activities. You need to see all of them as valuable resources and integrate the issue of adherence in the course of their work. During

the MANAS program in PHC settings, we found that most of the PHC staff members were very helpful in improving adherence management. Some specific examples of such collaborative efforts are listed below:

- **The Pharmacist** who dispenses the medicines can be an extremely useful partner in improving adherence of individual patients prescribed antidepressants by telling patients to be regular with the use of medicines.
- **Nursing staff** in the PHC are also important allies in promoting adherence as they interact with patients across a wide spectrum of needs and have credibility; if they reinforce the message of adherence, this can have a positive impact.
- **The registration staff** is another resource for you in the PHC. They have a list of patients who have attended the facility and can assist by making the patients aware of the program, reminding patients to meet the HC when they visit the clinic and ensure that they have left with adequate stocks of the medicine.
- **Field based staff** of the PHC are in close and regular contact with a range of persons in the community and have a good knowledge of where patients with CMD live in their areas. They can be an extremely valuable resource, which you should use by asking them to contact patients who have stopped treatments by contacting them at home and persuading them to come back to the clinic for a review.

In this session we learnt that:

- ⊙ A major challenge in the management of CMD is to ensure that patients adhere to their recommended treatment.
- ⊙ Adherence is important to ensure full recovery.
- ⊙ Factors that influence adherence should be understood as they help identify barriers to adherence which can then be overcome by using effective adherence management strategies.
- ⊙ Effective adherence management is based on the principles of providing care that is accessible, equitable, acceptable, affordable and effective.
- ⊙ The MANAS model has used these principles to formulate an adherence management procedure that you can follow in the clinic to ensure that most patients complete the full course of treatment.
- ⊙ All the PHC team members have a role to play in improving adherence.

Chapter 4

The Delivery of the Collaborative Stepped Care Intervention

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HC cabin at Marcaim PHC, Goa.

A Guide to Delivering Psychoeducation to Patients with CMD¹.

In Chapter 3.1, we took our first look and went through the main features of psychoeducation. In this section, we shall take this further. We shall come to know how psychoeducation is delivered through a stepped care intervention. To recollect, stepped care intervention is a range of simple to complex treatments carried out in a step by step fashion, depending upon the severity of the illness.

In this section you will learn:

- What is the detailed procedure for each session of psychoeducation?
- What do you do in the assessment session: session 1?
- What do you do in the review session: session 2?
- What should you do in subsequent follow-up sessions?
- What do you do in the termination session: session 3?
- What are the summary points: Steps of Psychoeducation?

4.1a What is the detailed procedure for each session of psychoeducation?

The psychoeducation therapy is divided into 3 sessions:

- i) The assessment session which is the 1st session;
- ii) The review session, which makes up the 2nd session, and
- iii) The termination session the 3rd session.

Let us proceed from the, beginning with Session 1: Assessment Session.

4.1b What do you do in Session 1: Assessment session?

To recollect, once the patient has been diagnosed to be suffering from CMD, based on the results of the screening procedure and the doctor's assessment, she will be referred to you, the HC, for initiating the psychoeducation process.

This initial session is critical as it helps the patient understand his/her problems and give a specific set of information to help deal with them.

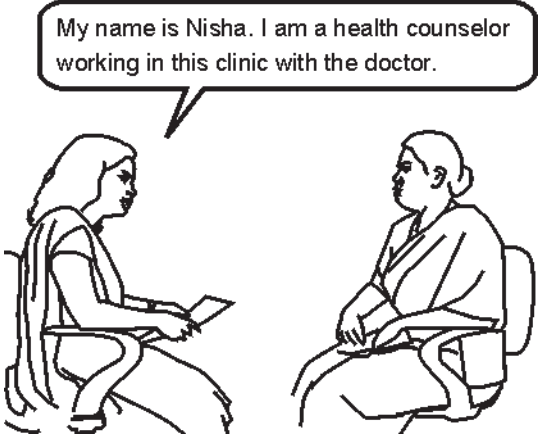
(Footnotes)

¹ Refer to the MANAS psychoeducation video which accompanies this manual for a step by step illustration of the psychoeducation process.

What are the important steps to keep in mind during this first contact with the patient?

- **How do you greet the patient?**

In this very important part of the treatment, greet the patient, introduce yourself, confirm the patient's name, and build a rapport with the patient. You can introduce yourself by saying, *"My name is ... (your name). I am a health counselor working in this clinic with the doctor. Your name is ... (the patient's name)?"*



My name is Nisha. I am a health counselor working in this clinic with the doctor.

- **How do you build a rapport with the patient?**

Building rapport with the patient becomes easier if you spend some time asking why she had come to the doctor. She may speak about her physical complaints and how she has been taking medications for the complaints, etc. Ask the patient what the doctor has prescribed and whether she has been coming to the health center for long time.

Check the doctor's notes/prescription and inquire with the patient if antidepressants have been prescribed. (Refer to Appendix 5.4 for information on antidepressants).

Once the patient is comfortable, build a rapport with the patient by explaining your role to her. You could say, *"The doctor has asked you to see me because I will be talking to you about your stress-related health problems and giving advice to help you get better. This treatment is being offered in addition to the doctor's treatment which will continue as usual".*

How do you emphasise confidentiality?

You need to reassure the patient that he/she need not worry about confidentiality.

You could say, *"Whatever we speak about will be entirely between us. If the need arises for me to share any of this with the doctor/someone close to you, I will do so only with your permission".*

- **How to discuss the benefits of the treatment?**

After you have reassured the patient regarding her fears of exposure, you must tell her about the benefits of the talking treatment.

The patient will recover faster: You could say, *"Both the treatments provided by the doctor and provided by me as the HC will help you handle your stress and tension better and may allow you to get better sooner."*

The treatment will have a positive effect on the patient's health: If the patient also suffers from a physical illness (which is likely), you could say, *"You are receiving treatment for this illness from the doctor. The treatment of the stress-related illness with the talking treatment may help improve the physical illness outcome as well."*

The patient will be able to make fewer visits to the doctor: You could say, *"These treatments will help you to handle stress and tension more effectively and make you feel better. Many people who have done this treatment have felt better and have had to visit the doctor less often."*

- **How do you convey the key points of treatment to the patient?**

You tell the patient that the crucial parts of the treatment are follow up and medication adherence. You could say, *"It is very important that we follow up our appointment with meetings at intervals of two weeks. This treatment is most effective if you will come to the clinic regularly, as well as take the medication prescribed by the doctor."*

You need not specify the exact number of sessions at this stage. Instead, you could tell the patient that *"Most people will show considerable long-term benefit, usually after a few weeks of treatment"*

- **How to begin the psychoeducation session?**

Now with this you will have had your first interaction with the patient. You can now start the psychoeducation session by telling the patient the basic information about his or her complaints, an understanding about causes of the symptoms and advice on how to promote mental health. This session comprises a number of specific components, all of which must be delivered in about 30 minutes. Therefore you have to learn to talk with ease to the patient. This can be best achieved through practice

Let us now look at the key steps in the first session. These are:

1. getting information about symptoms, inquiry into suicidal ideas, obtaining a baseline mood rating (You will learn what this is later in the chapter.)
2. getting information about the psychosocial stressors in the patient's life especially those that are closely related to onset of stress symptoms
3. reassuring the patient and explaining to him or her about the link between patient's stress and complaints
4. explaining the diagnosis and giving hope
5. giving the patient a sick role
6. management of suicide risk
7. teaching the breathing exercise

8. advising the patient on specific symptoms
9. advising the patient on using alcohol or tobacco
10. advising the patient on ADT
11. adherence management
12. referring the patient to community agencies
13. concluding the session

Most of these steps have been described in Chapter 3.1. In this chapter, we will demonstrate how you will deliver these during a clinical session.

One skill you will be using while conducting these sessions is using flip charts as a visual aid. Let us learn how to do this:

How to use the flip charts

What is a flip chart? Flip charts consist of illustrations and abbreviated text, which you will show the patient when you are explaining to him/her about the various matters. The charts provide visual information and make the talk more interesting. Flip charts help you to communicate information to the patient in a more interesting and informative manner. Using a flip chart also ensures that you cover all the important issues. When using the flip chart during the psychoeducation session, keep the following points in mind:



- Place the flip chart on the table so that both you and the patient can see the pages.
- Maintain eye contact while speaking to the patient - do not read from the chart.
- The text that accompanies the charts is provided in the manual. You should be fluent with this.
- Point to the relevant text/pictures from time to time to draw the patient's attention to the contents of the chart.
- You might need to use only some of the pages depending on the patient's symptoms.
- Pause between subsequent pages and confirm that the patient has understood the information provided. Also, give the patient time to ask questions.
- Link the information on the flip charts to the handouts that you will give the patients later in the session.

And now let us look at each of the key steps of the **first psychoeducation** session that were mentioned earlier.

1. Get information about the key symptoms:

You will have with you a key symptoms checklist. This checklist will include the following points.

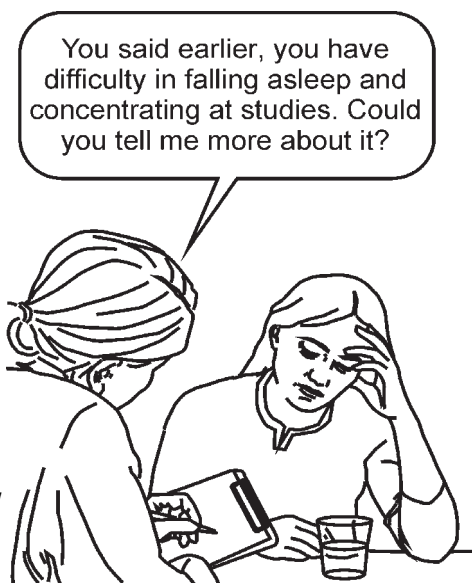
Symptoms Checklist:

- Sleep difficulties
- Appetite problems
- Tiredness
- Feeling miserable
- Feeling worried all the time
- Aches and pains
- Palpitations
- Irritability
- Loss of interest
- Lack of concentration
- Suicidal thoughts

You will refer to the checklist of key symptoms and go over each of these with the patient in a structured manner. The patient may have mentioned some of them already to you, e.g., the patient might have already told you that she/he has poor sleep and poor appetite. There are some symptoms you may have to ask the patient about directly.

While asking for symptoms, make sure you use acceptable language. Do not use technical terms. Instead, focus on the symptoms. For e.g., do not say "*You have a phobia*". Instead, you could say, "*Do you feel your heart beating very fast when you are in a crowd?*"

Once you have found which of the symptoms in the checklist the person suffers from, get more information regarding the symptoms, get her to briefly tell you, the following:



- **Timing:** Since when has she been suffering from these symptoms?
- **Severity:** How severe are the symptoms? What is the personal distress caused by the symptoms?
- **Impact:** What is their impact on the patient's work and social functioning? For example, the patient may be unable to do her daily household tasks or may withdraw from her friends as a result of the CMD.
- **Previous Occurrences:** Has the patient had these symptoms before?
- **Previous Treatment:** Did the patient receive any treatment for these symptoms? If yes, which treatment? Enquire what methods the patient is employing to cope with the symptoms, e.g., sleeping pills, tonics, injections.
- **Substance Use:** Does the patient use alcohol, tobacco, etc.?

Key point to remember!

Allow the patient to speak freely in response to the questions: be attentive, show concern and empathy while listening.

How do you do a baseline mood rating?

After finding out about the symptoms of the patient you will find out about her "mood" or her psychological condition. You will do this with a mood ladder. Let us learn what baseline mood rating is and how to use a mood ladder to find out the patient's psychological status.



i. How will you do a baseline mood rating using a mood ladder?

A baseline mood rating is a way of rating someone's mood in the first session which you can then use as a baseline and see if this changes in subsequent sessions. A mood ladder is a tool you will use to do this rating.

To do a **baseline mood rating** using the mood ladder, show the patient a picture of ladder and ask: *"On this ladder, if the bottom rung, zero, is the worst you have ever felt and the top rung ten is the best you have ever felt. Where would you currently place yourself?"* Make a note of the mood as rated by the patient. You will have the person rate his or her mood at regular intervals in follow up sessions to judge if the patient is better or not. It is also useful as a tool to provide feedback to patients about their improvement (or lack of it).

After you have rated the person's mood, ensure that every patient is asked about ideas of self-harm/suicidal ideas.

ii. **How do you ask the patient about self harm/suicidal thoughts?** Asking about such ideas does not increase the risk of suicide. You could say, *"Sometimes, people who have stress in their lives feel hopeless about their future. They may feel life isn't worth living anymore. Have you felt this way recently?"* Other examples on suicide risk assessment have been described in Chapter 2.4.

If the patient expresses suicidal ideas, carry out a suicide risk assessment. You can get the method to do this from the section on "Assessment of degree of suicide" (Refer chapter 2.4). On the basis of your assessment, follow the suicide management procedure given in Chapter 3.1.

Sometimes, people who have stress in their lives feel hopeless about their future. They may feel life isn't worth living anymore. Have you felt this way recently?



These are the things that you would do to get the initial information about the person's symptoms, mood and suicidal ideas. Now let us move on to getting information about the events or factors that caused stress, especially related to onset of stress symptoms.

2. Get information about the psychosocial stressors in the patient's life:

The social difficulties in the patient's life that you will inquire about may have had a direct relationship to the onset of the symptoms and they may be either sudden or long standing. These can be got from the patient by saying to him/her: *"When your symptoms of ...(tiredness/sleeplessness) began, was there any stressful event that occurred in your life?"* Or, you could say: *"In your life, is there something that has been causing you great worry and tension?"*

Based on the patient's response to these questions, you will systematically record the presence or absence of some common social problems faced by patients.

For this you can use the **Social Difficulty Checklist** (refer to Appendix 5.3). This checklist includes most of the common stressors that patients experience, e.g., financial difficulties, domestic violence and interpersonal conflicts.

Describe in some detail the exact nature of the stressor, i.e. the extent, its impact etc., as this is the basis upon which you will provide practical advice. If necessary, refer the patient to the appropriate social agency (described later in this chapter).

3. Reassure and explain the link between patient's stress and complaints:

This has already been explained in Chapter 3.1. If the mind is stressed, it affects the body. A stress in the mind will result in problems like 'fatigue, tiredness and lack of sleep'. You will convey this mind and body connection to the patient. This is a critical step in making the patients appreciate the link between stress and their problems and getting patients to feel that their problems are being listened to with concern.

4. Explain the diagnosis and give hope:

This is another key step in the PE (psychoeducation) process in helping patients understand they have a recognisable illness for which there is effective treatment. The details of conducting this component have been given in Chapter 3.1. Tell the patient that symptoms that arise from stress will not result in a life-threatening or dangerous illness in a manner that does not make the patient embarrassed or feel stigmatised.

5. Give the patient a sick role:

This is based on the principles of IPT discussed in Chapter 3.3. You could read the details on this in Chapter 3.1. Tell the patient that she has an illness which is like any physical illness for where there is a definite treatment and from which she can be cured.

6. Management of suicide risks:

As mentioned in Chapter 2.4, assessing suicide risk is your essential task. If you feel that the patient is currently having a significant suicide risk, follow the guidelines suggested in Chapter 3.1 in managing the risk appropriately like increasing protective factors, making the patient find reasons to live, etc.

7. Teach the breathing exercise:

A well accepted and useful method for reducing stress and anxiety symptoms in the MANAS program was found to be the breathing exercise that is described in Chapter 3.1, which you can easily implement in the first PE session with good results.

8. Give advice on specific symptoms:

Depending on the symptoms that the patient describes as being troublesome, you can provide the specific management as detailed in Chapter 3.1. At this time, use the flipchart and then give the relevant handouts to the patient specific to her symptoms, for example, on diet, anger/irritability, panic attack, phobia, tiredness/fatigue or sleep problems. Inform the patient that the handouts will be helpful since it may be difficult for the patient to remember all that has been explained in the session and can be used as a guide to follow instructions at home. If the patient is not able to read the contents of the handouts, you can advise her to request any of her family members or neighbours to read them to her. Also mention that if she has any difficulties understanding the contents of the handout, she can clarify these with you at the next meeting.

9. Give advice on using alcohol or tobacco:

This information is described in detail in Chapter 3.1. It involves helping the patient find reasons and ways to stop amongst other methods. Do refer to Chapter 3.1. You should use the relevant pages of the flipchart and provide the patient with the specific handouts as described earlier.

10. Give advice on ADT:

You should check with every patient whether the doctor has prescribed antidepressant medicines. If so, provide the necessary information about antidepressant medicines as outlined in Chapter 3.1.

11. Ensure adherence management:

As mentioned in Chapter 3.4, promoting adherence with medicines is a key part of the intervention. You should make all possible efforts to understand the potential risk of non-adherence for the patient and use relevant strategies to minimize the risks.

12. Refer to community agencies:

Patients with CMD who attend the clinic often are faced with difficult social circumstances. Failure to address these and provide practical assistance, when required, can alienate the patient who will then not be able to benefit from the program. For e.g., not addressing the problem of the patient regarding unemployment may make him feel that you are ignoring something that is uppermost in his mind. This may make him less receptive to the rest of the psychoeducation session.

Guiding patients and providing information to them about the various agencies/schemes that exist and which they can approach (with your help), makes them feel that their immediate social concerns are being addressed. This will make them accept the other treatments and advice more readily.

It is useful if you prepare a list of such community agencies and welfare schemes available in your region as soon as possible. The template for this is provided in Appendix 5.5. You must keep this list handy at all times and familiarise yourself with the information provided.

Establishing prior contact with the agencies in the locality and providing a referral letter or making a telephone call to the agency when referring a patient will be of immense value in ensuring that the patient gets the help she needs.

You should also keep copies of relevant forms (for example, application for social welfare schemes) and assist the patient to complete these when applicable. It is also important during follow up to ask the patient about the results of the referral, so that further action may be taken if needed.

What are other examples of community referrals:

- A patient with a drinking problem will benefit from information about the local Alcoholics Anonymous group and a referral letter to them.
- If unemployment is a problem for either the patient or a family member, information can be given about employment agencies.
- A woman who seeks help to deal with a violent spouse can be referred to the women's support group.
- An elderly patient with financial problems can be referred for the Senior Citizen's Scheme.
- Women who are widowed or separated can benefit from the widow pension scheme.
- For children from backward classes or families with financial problems, educational schemes can be availed of to provide scholarships, books, etc.

13. Conclude the session:

To conclude the session, summarise all that has been covered during the first session, emphasising once more that the patient is suffering from an illness and that the patient will get better with the intervention.

Emphasise that she/he needs to review her/his progress and learn new techniques at the next session. It is important to highlight that there are additional coping strategies that will be taught in future sessions. *"Depending on how you feel, we have other treatments which might help you and which we will teach when you come back".*

Introduce the availability of yoga in the clinic (where applicable) and explain its benefits. Inform the patient about the day, timing and venue of the yoga sessions.

Give an appointment for follow-up, keeping it flexible so that it suits the patient's convenience.



Ideally, follow up appointments should be at a time when the clinic is relatively quiet (which is usually when the doctor's clinic is closed).

Give the patient an appointment card after agreeing on a time for the review and also your clinic phone number.

Ensure you have the postal address of the patient with landmarks and contact phone number.

How to end the assessment - session 1?

At the end of session 1 you will:

- complete the patient intervention card to record the details of the session
- enter the patient's next appointment date in your diary
- record your overall understanding of the patient's problems based on the information available to you and think of the specific points you would like to discuss in the next session

Why you should also pay attention to your personal safety.

At all times, it is important for you to take steps to ensure you are safe from any kind of threat. For example, a patient or a relative may be angry or disturbed and may attempt to physically harm you. These simple measures will help you stay safe:

- If you sense any kind of threat, keep the room door ajar, and place your chair closer to the exit.
- Always ensure you can call out to someone for help if necessary.
- If the patient is agitated, speak in a calm and firm manner. Terminate the session and ask the patient to return with a relative or when she feels calmer.

Now let us look at Session 2: Review Session

4.1c What do you do in Session 2: Review Session?

The review session usually lasts for 30 minutes. During this session, you will:

- Review the clinical status of the patient
- Reinforce the information provided in the assessment session : session 1
- Introduce specific techniques based on the psychosocial problem area identified
- Plan further intervention in patients who have not improved or have worsened since previous visit.

Let us take up these steps one by one:

1. Review of the clinical status of the Patient

This is a crucial first step for each follow-up session. The clinical status of the patient can be reviewed in the following ways:

- By inquiring how the patient has been feeling since she came to the clinic the last time, e.g., *"How have you been since we last met?"* If the patient does not volunteer descriptions of mood or events since the previous meeting, ask a more specific question such as *"Previously you were suffering from stress problems like tiredness, difficulty with sleep, etc. How have these problems been in the past few days?"* and *"Do you think your conditions/symptoms have improved, are they same, or are you feeling worse since we last met?"*
- By repeating the mood rating. Show the patient the mood ladder and ask: *"As I had asked you to rate your mood in the last session, if zero is the worst you have ever felt and 10 is the best you have ever felt, can you tell me how you have been feeling since we last met? Where would you place yourself on the ladder now?"*

In case you or the patient are not clear about the difference in the way the patient is feeling since the last visit, you can repeat the GHQ questionnaire and compare the score with the one available during the initial assessment.

Note the difference in the rating or GHQ and provide feedback to the patient. If the patient reports not feeling any change or feels she/he has worsened, always ask about thoughts of self-harm.

2. Reinforcement of information provided in session 1.

Ask the patient if she was able to follow the advice given by you in the last session and if not, ask what are the reasons for this. For example, if she may not have been clear about how to do the breathing technique, you can ask her to do this in your presence with your guidance.

For patients who are improving:

- Explain the specific techniques of coping with stress based on the problem area you have identified in session 1 – elaborated on the following page.
- Emphasise the need to continue practicing the techniques that have been taught and to be optimistic that they are on the road to recovery.
- Let the doctor know that there is an improvement in the patient's condition.
- Advise the patient to come back for a review in about 4 weeks.
- Advise the patient that if the symptoms should worsen, to come back for a review earlier.

3. Introduction of specific techniques based on psychosocial problem area identified

At the end of the first session, you identified the problem area based on information obtained from the patient about psychosocial stressors. You then introduced specific techniques to the patient to help her deal with problems (the IPT module describes these techniques in detail). In the second session, you will provide basic focused advice. A recap of the management of the problems as per their problem area is given below:

For grief (loss of a significant person in the patient's life): Facilitate the mourning process by encouraging the patient to talk about events surrounding the death and express his feelings of sadness and loss.

For interpersonal disputes (ongoing disagreements): Where faulty communication triggers dispute, educate the patient about effective communication strategies and modifying expectations. Where the patient cannot think of possible options available, use decision analysis to assist patients in making a choice between different possible coping strategies.

For role transition (life changes): Discuss positive and negative aspects of the new role (this will include talking about what he misses of the old role) and identify simple strategies of coping with the new role, e.g., identifying supportive persons and developing new skills.

For loneliness and social isolation: Encourage the patient to form new relationships and draw on already existing ones to reduce loneliness.

4. Planning of further intervention in patients who have not improved

For patients who have not shown improvement till now, you will:

- Ask about the worries and stressors that are associated with the complaints. (For example in a patient who is extremely concerned about his health, ask: *"Are you thinking about your health all the time? Does this affect your work?"*) You will need to ask whether the worries and stressors have become worse and how is the patient coping with the stressors.
- If the patient has not been able to adhere to the advice given in the first session, review the reasons for this. For example, if the patient had complained of fatigue and was supposed to do one activity every day for 15 minutes like sweeping one room or feeding the cows, but says she couldn't do it, review the reasons why and try to get her to come up with another activity which could be easily accomplished. If she found it difficult to do the breathing exercises, review it in the clinic. Let her do the exercise once more under guidance.
- If the patient has moderate/high suicidal risk, discuss with the doctor and consider referral to the Mental Health Specialist (MHS).

- Inform the doctor about the continuing symptoms; the doctor may prescribe antidepressants.
- If the doctor gives antidepressants, it is essential you provide information regarding their use as elaborated in Chapter 2.5.
- Ask the patient to come back to the clinic for a review in 2 weeks.

When should you refer patients to the Mental Health Specialist (MHS)?

- when patients have a high suicide risk
- when unusual symptoms exist, which indicate that the patient may have symptoms of mental illness other than CMD such as hearing imaginary voices, unreasonable suspiciousness or severe behavioral disturbances
- when there are significant memory problems and confused behavior especially in elderly persons
- when patients have moderate to severe depression and need have more specialist care to recover
- when treatment fails, e.g., having used antidepressants in adequate dosage and duration without significant improvement in symptoms
- when patients have a combination of problems (dual diagnoses) i.e. moderate/severe CMD with alcohol dependence

4.1d What should you do in subsequent follow-up sessions?

In subsequent follow-up sessions, you should cover the following steps:

- Review the clinical state of the patient (including mood rating) as described above.
- Review the patient's use of specific skills to tackle the problem area.
- Link any change in mood to the skills used. You can do this by saying: *"The effort you have made to communicate more effectively with ...(your husband) has probably resulted in your feeling better."*
- Reinforce the need to follow the advice for specific symptoms as well as strategies to deal with problem areas.
- Educate her/him about 'early warning signs' and discuss what steps she/he could take in case symptoms reappear. This is described below.
- Monitor and reinforce ADT if these are being prescribed.

In addition, to the these points:

1. For patients who are improving, but not fully recovered:

- Emphasise the need to continue practicing the techniques you have taught and tell them to be optimistic that they are on the road to recovery.
- Let the doctor know that there is an improvement in the patient's condition.
- Offer a review appointment in 4 to 8 weeks and advise the patients that if the symptoms should worsen again, to come back for a review earlier.

2. For patients who are not improving / feeling worse:

Consider moving to the next step in the intervention. However before doing this, cover the following steps:

- Recap which symptoms have worsened.
- Check adherence with treatments: if not adherent, then reinforce the need for the treatment. If adherent, then increase the frequency or intensity of treatments. For example, if the patient is on antidepressant treatment, discuss with the doctor the possibility of increasing the dose of the medication. If the patient has received adequate dose of ADT for 4 weeks, move to step 3 (i.e. IPT).
- If the patient has not been able to adhere to the advice given, review the reasons why this has happened. (Refer adherence improvement guidelines).
- Ask about the worries and stressors which are associated with the complaints. (e.g. Has there been any additional stressful event since the last visit?). Make appropriate referrals to other helping agencies.
- If the patient focuses more on the physical complaints, repeat the explanation of the mind and body link and why it is necessary to follow the advice.
- Ask about suicidal thoughts. If these are serious, discuss with the doctor and consider referral to the MHS.
- Review the strategies for all the relevant specific symptoms and techniques of dealing with problem areas that were covered during the previous sessions.
- If patient has new symptoms, record these and give appropriate advice.
- Arrange a review in 2 to 4 weeks.



3. For patients who have remained well since the previous session and are not on a treatment such as ADT or IPT or have completed this course:

You can start planning for the discharge of such patients (see below for details).

4. For patients who are well and on a treatment such as ADT or IPT:

Review as per the requirements of the treatment.

Each time the patient comes to the clinic to meet the doctor for a follow up for ADT, you will conduct a brief session (10-15 mins). During this session, you should cover the following:

- Review the symptoms and the overall mood status of the patients.
- Give advice about ADT (refer Chapter 3.1), emphasise the need for adherence and give explanation of side effects, if any.
- Reinforce coping techniques depending on the problem area that have been taught.

Session 3: Termination Session

4.1e What do you do in the Termination Session: Session 3?

Now let us know how to conduct the termination session of PE. The end of the treatment is reached under the following circumstances:

- The patient has stayed well for 2-3 consecutive follow-up sessions.
or
- The course of antidepressant treatment or IPT is completed and the patient has recovered.

In addition to these situations, a patient in the program may be discharged in accordance with the procedure below.

Procedure for patients who have missed scheduled appointment:

In the MANAS program, we used certain guidelines in responding to patients who had missed their scheduled appointment and were at a high risk of becoming non-adherent. These are described below but you may choose to alter the number and frequency of reminder letters depending on your setting.

For patients on Step 1:

- Wait for 1 week after the scheduled date of follow up for the patient on Step 1 to return for an appointment.
- Contact the patient over the phone whenever possible and ask her to return for the new appointment on a convenient date.

- If no phone is available, send a reminder letter after one week asking the patient to attend on a new date and timings.
- If no response to the first reminder letter in the next 3 weeks, send a second reminder letter with another date for the follow up.
- If there is no response to the second reminder letter for the next 12 months, send final letter before instituting discharge procedures as per the procedure detailed below.

For patients on Step 2 and above:

- Send a letter to the patient one week before her scheduled appointment to remind her to visit the clinic. This is important since you want to ensure that the patient does not interrupt her course of ADT.
- If the patient misses her appointment, wait for 2 days after the patient was scheduled to follow up, and if the phone number is available, contact immediately and remind the patient to continue with the prescribed treatment and arrange a date for making a visit to the clinic.
- If there is no phone number, send the first reminder letter with a specific mention of the need to continue with the antidepressants and to return for a follow up visit with the doctor and the HC.
- If there is no response to the reminder letter within the next 6 weeks, send a second reminder letter.
- If there is no response to the second reminder letter for the next 12 weeks, send final letter before instituting discharge procedures.

Discharge from the intervention

In any health intervention, it is necessary to discharge patients so that the limited resources and capacity of the system are not wasted. There can be many reasons why patients are discharged from the program:

1. When patient recovers and does not need any further intervention:

For example, the patient has followed your advice given during the psychoeducation sessions and reports that she is feeling much better and has gone back to her normal life. When the improvement is maintained and confirmed in 2 successive follow-up visits, you can prepare to discharge the patient.

For the patient who is receiving IPT and has completed the required IPT sessions, discharge the patient after consultation with the concerned IPT supervisor. If the patient has completed 6 months of ADT, remember to consult with the doctor who would then take the decision about how to proceed and if the ADT needs to be stopped before discharging the patient.

2. Failure to engage or refusal to participate:

- A patient may refuse the offer for treatment either in the initial session, when she is referred to you, or subsequently due to a number of reasons like 'cannot attend', 'do not feel advice is useful', 'do not want to take ADT', 'cannot deal with side effects', 'do not feel she has any mental health problem', etc. In this situation you try to understand the reasons for the refusal and try to convince the patient about the benefits of the intervention. If, after making these efforts, the patient is still adamant about not continuing with the intervention, discharge her from the program and inform the referring doctor about it. However, always let the patient know that she can return anytime.
- A patient may miss her scheduled follow up appointments and you would have then instituted the adherence management procedure as described earlier (See Chapter 3.4 Adherence Management). If, in spite of all possible efforts, the patient does not return for follow up within 3 months of the last attempt to contact her, she is considered to have dropped out of the program.
- A patient may indicate her inability to attend follow up counseling as she would be going elsewhere for work or would return to her original place of residence. In such a case, reinforce the advice to continue with the recommended treatment for an appropriate period of time. If the patient has started on ADT, discuss the need to continue with the medicine wherever she is for 6 months and, if necessary, provide a brief referral letter to a doctor that she might consult in her new place of residence.

3. Referral to MHS:

- A patient may not be suitable for the program because of other psychiatric problems like psychosis, or severe alcohol dependence as a primary problem with CMD being a secondary diagnosis. This patient is to be referred to the MHS who will determine whether the discharge from the program is to be given after reviewing the problems of the patient. The MHS may take over the management of the patient or after initial intervention, may refer the patient back into the program.
- A small number of patients may have a high suicidal risk, where in-patient treatment is necessary to manage their risk (in all such scenarios, contact the MHS who will make the judgment); these patients have a threshold of risk that cannot be safely managed in the program and would be recommended to specialist care.

4. Important points to remember when discharging the patient:

Termination of treatment is something to discuss with the patient right from the start. Being explicit about how much time the intervention will take is important in

order to prevent dependence on you and give hope to the patient of recovery within a reasonable time frame. Many of the techniques used in the intervention, e.g., anger management, breathing exercise and yoga are life skills that the patient should be able to continue using beyond the treatment setting.

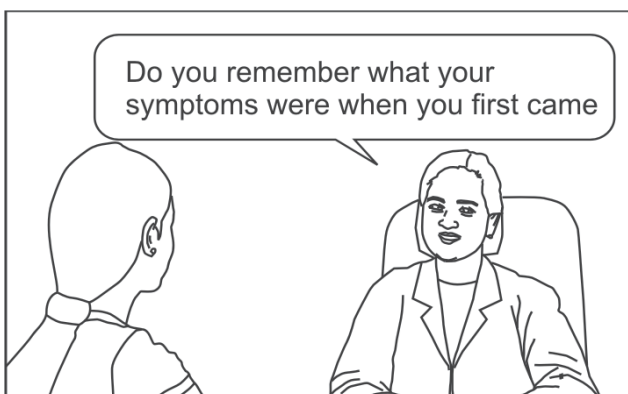
You should focus on the patient's success in coping with her stress symptoms and thus increase her confidence in her ability to deal with her problems without your assistance.

Particularly important is the patient's ability to recognize when she needs help in future. For this, she should be able to identify the early warning signs of stress-related symptoms (such as insomnia, fatigue, etc).

What are "early warning signs"?

Even when a patient does her best to avoid it, her symptoms may return and she may have a relapse. Some relapses may occur over short periods of time, such as a few days, with very little or no warning at all. However, most relapses develop gradually over longer periods of time, over several weeks.

There are often changes in the person's inner experience and changes in her behaviour when a relapse is starting. For some people, the changes may be so minor at first that they may not be noticeable. For others, the changes are more pronounced and distressing. When people look back after a relapse, they often realise that these early changes, even the minor ones, were signs that they were starting to have a relapse. These changes are called "early warning signs".



Early warning signs are the changes in a person's inner experience and behaviours that signal that a relapse may be starting. Common early warning signs include:

- Feeling tense or nervous
- Eating less or eating more
- Sleeping too much or too little
- Feeling depressed or low
- Feeling like not being around people
- Losing interest in things that were previously enjoyable
- Feeling irritable

- Feeling tiredness and fatigued
- Having trouble concentrating

What can a patient do in case her symptoms reappear?

When a patient notices early warning signs, she should consider visiting the clinic to see you or the doctor and asking family members/friends for support.

Advise her to assess her current situation:

- Is the stress level high? What can be done to reduce it?
- Are the treatments/suggestions given by you being followed?
- Are breathing exercises being done regularly?
- If prescribed antidepressant medication, is the dose being taken regularly?

4.1f What are the summary points: Steps of Psychoeducation?

Now that we have gone through the entire psychoeducation, to summarise what we have learnt would be a good idea. This is the point-wise summary of the various sessions of psychoeducation:

1. Assessment Session

- Elicit symptoms.
- Elicit psychosocial stressors.
- Inquiry for suicidal ideas.
- Reassurance and explanation about the link between patient's stress and complaints.
- Explain the diagnosis and giving hope.
- Give the sick role.
- Teach breathing exercise.
- Advise on specific symptoms including suicide risk management.
- Advise on ADT (if prescribed).
- Advise on using alcohol or tobacco.
- Refer to community agencies.
- Conclude the session.

2. Follow up sessions

- Review the clinical status of the patient.

- Confirm adherence to treatments and employing adherence management strategies as applicable.
- Link change in mood to efforts made by the patient to change things and reinforcing information provided in previous sessions.
- Introduce specific techniques to deal with the problem area of grief/ interpersonal dispute/role transition/social isolation.
- Step up the intervention in patients who have not improved or have worsened since the previous visit.

3. Termination Session

- Review the use of techniques learnt in previous sessions.
- Link recovery with skills used by the patient.
- Educate about “early warning signs”.
- Discuss with the patient what steps to take incase symptoms reappear.

How to manage difficult case scenarios?

There may be difficult case scenarios or circumstances that you may encounter in the clinic. Some of these scenarios with suggestions on how to deal with the problems should you face them, are described below. While these scenarios are not comprehensive, they are collated from the experience of HCs during the MANAS program.

1. Inappropriate referral to program (patient with severe mental disorder):

“A 40 year- old lady referred by the doctor is suffering from a psychotic illness(charactersed by unusual symptoms such as aggressiveness, suspiciousness and sometimes muttering/gesticulating to self). She was angry, restless and abusive towards the HC. She tried snatching the mobile phone from the HC”

What should you do?

- Take safety precautions
- Meanwhile, speak to the patient firmly but gently and try to calm her.
- Inform the doctor and the MHS about the patient’s behavior.
- Discuss with the MHS the immediate management plans for the patient; if the MHS recommends that the patient be referred to a hospital for treatment, speak to relatives and write a referral note accordingly. If the MHS recommends an assessment either with the MHS or some other Psychiatrist, make suitable arrangements for getting her there with her relatives. If unaccompanied, try and contact a relative or send a letter with the patient for a relative to meet or call you immediately.

- Follow up with the patient/relative about her current status and whether they have followed your advice.

2. The intoxicated patient:

"A 25 year -old man visits the clinic in an intoxicated state. He is suffering from mild CMD. He is verbally abusive towards his mother who accompanies him. He is also crying and insists that the HC should listen to him. He is becoming increasingly aggressive and demanding."

What should you do?

- Take safety precautions.
- Speak to the patient in a calm and firm manner.
- Do not attempt to interview a patient who is intoxicated. Cut the session short and ask the patient/relative to return when he is not under the influence of alcohol.
- Refer the patient to the doctor and inform her why you cannot provide services at this time.
- Provide information of where the patient can seek help for his drinking problem - for example, Alcoholics Anonymous, or a psychiatry hospital.
- Offer a follow up appointment and insist that the patient must be sober.

3. Discussion of personally sensitive issues:

i. "A 29 year-old man is accompanied by his mother. The doctor refers him for counseling for mild CMD. Before his mother comes into the room, the patient tells you he is HIV +. He is taking treatment from the Medical College for this. His family is not aware of his illness."

What should you do?

- Speak to the patient alone; ask his mother to leave the room.
- Give psychoeducation.
- Give him information about NGOs associated with AIDS and Care Homes.
- Take consent from him to speak to the clinic doctor about his HIV status (if the doctor is unaware of this) and explain the importance of the information for his overall treatment.
- Adherence management for psychoeducation as well as for his treatment at the antiretroviral treatment (ART) centre.
- Speak to the MHS for further management. Offer a follow up appointment.

ii. "A 20 year-old man was initially reluctant to talk about his problem. On probing, he says that he has frequent night fall (i.e. the nocturnal emission of semen). He is worried

that this will cause impotence. (This is a culture specific belief held by young men who have night fall. They think that it indicates loss of energy and virility and will eventually lead to impotence)."

What should you do?

- Be comfortable about discussing the problem in a professional manner.
- Give psychoeducation. Give simple advice – night fall is normal, does not lead to weakness or impotence.
- Talk to the doctor about the symptoms and ask her to provide further advice to the patient.
- Offer a follow up appointment.

iii. *"A 27 year old pregnant woman has two daughters. She has an alcoholic husband who is physically abusive at times. She is worried about her children and is contemplating an abortion. She asks the HC's opinion about whether she should have an abortion."*

What should you do?

- Give psychoeducation.
- Give referral to gynaecologist.
- Provide information about Alcoholics Anonymous and Detoxification Centre.
- Refrain from giving advice to the patient about the abortion – help her make her own decision after considering pros and cons of various options.
- If she decides to have an abortion, provide referral to necessary agency for legal and safe abortions.

4. Violation of professional relationship boundaries:

"A 30 year-old man with mild CMD was given psychoeducation. He was regular at each follow up. He began to call the HC on the telephone at out-of-office hours, sent personal SMS and sought personal information about the HC. When asked to follow up after a month, he insisted on meeting the HC sooner. When he was informed about discharge from the program, he refused to accept it."

What should you do?

- Firmly inform the patient that you will not answer calls out of working hours and for anything other than an emergency.
- Explain to the patient that you are there to help him and other patients deal with stress related problems and will not give any personal information about yourself as it is not relevant to the patient's treatment.
- Inform the doctor about the patient's attitude and seek advice from the MHS about how to deal with this problem.

5. Complex clinical problems:

i. *"A 35 year-old man with moderate to severe CMD, alcohol dependence and high suicidal risk is separated from his wife and children due to domestic violence. He is currently living with his mother. He showed a photograph of his children to the HC and started crying, insisting that the HC should inform his wife about his illness and that he needs to be admitted in the hospital. When informed about the possibility of meeting the MHS for further management, he asked for financial help to travel there."*

What should you do?

- Give psychoeducation.
- Inform the doctor and MHS.
- Urgently refer to the MHS. If the patient gives consent, inform the patient's mother about his condition.
- Give advice for a follow up appointment immediately after psychiatric assessment and/or treatment is completed.
- Keep check on the patient's health – through telephone calls and home visits (accompanied by another person, if possible) if you have not been able to establish contact with a family member.
- When any patient requests financial assistance, politely inform them that your role is to help them deal with their stress related problem. Inform them about financial schemes that they can avail of or refer them to employment agencies depending on their problem.

ii. *"An 18 year-old boy accompanied by his mother has mild CMD. He is worried about his future but did not want to disclose any details. He refused to follow advice given by the HCs, showed disinterest, was inattentive and restless during the psychoeducation."*

What should you do?

- Firstly, build a rapport with the patient and make him feel at ease.
- Acknowledge his feelings and emphasise confidentiality.
- Give handouts related to advice on symptoms and encourage him to read them at home.
- Offer follow-up appointment.
- If the patient is willing, discuss with his mother/person closest to him.

6. Dealing with social difficulties:

i. *"A 50 year-old woman suffers from moderate CMD. Her main stressor is her husband's drinking habit. He is verbally abusive and not ready for referrals to detoxification centers. The patient cannot follow advice on sleep, which is her main health complaint."*

What should you do?

- Emphasise the link between her stress, symptoms and the stressor (husband's drinking habit).
- Ensure that she receives ADT and emphasise the need for adherence.
- If both the patient and her husband are willing, request him to meet you and explore reasons for refusing help for his drinking problem.
- If the patient's husband is willing, give further information about referral agencies and provide information about Alcoholics Anonymous and Detoxification Centers.

ii. *"A 26 year-old woman with mild CMD has interpersonal problem with her in - laws. Her husband refuses to send her to the clinic and she seeks your help to convince him."*

What should you do?

- Offer to speak to the husband. If he is unable to come to the clinic, contact him over the telephone after discussing this with the patient.
 - Explain to the husband your role in the clinic and the treatment you are offering.
 - If the stress the woman is experiencing is also due to her relationship with her husband, do not state this explicitly. Instead say that your aim is to help her deal with the effects that stress is having on her health.
- If the husband insists on knowing more, gently refuse to divulge confidential information. If the husband asks for help too, discuss with your MHS and proceed accordingly.

7. Patients who are unconvinced about the benefits of 'talking':

i. *"A 45 year-old woman with moderate CMD insists on receiving injections for her various aches and pains as she believes that it is the only thing which will help her."*

What should you do?

- Ensure that the doctor has prescribed ADT.
- Explain to the patient the benefits of ADT for her stress related symptoms and the lack of benefit as well as additional risks of injections.
- If she continues to insist, ask her to take ADT regularly for 4 weeks to see if it helps before she resorts to injections.

ii. *"A 50 year-old widow with mild CMD is preoccupied with financial problems and her son's inability to find a suitable job. She is inattentive to the psychoeducation and instead repeatedly asks for help to deal with her financial difficulties."*

What should you do?

- First address her financial concerns. Inform her about the government schemes available for widows and for those with financial problems.
- Guide her about the procedure involved and provide her with the address of the nearest government office where she will get further information.
- Provide her with information about employment agencies and write a referral letter to the official there if necessary.
- Then, when she has been reassured about your willingness to help her with her social problems, proceed with psycho-education.
- Ask her to let you know the outcome of the referral.

Structure And Function Of The Primary Health Care Team

This section describes the overall structure of the program and the specific roles of HCs and other staff members. This will help you understand the way in which you should be working and interacting with the rest of the team. In this section, you will learn:

- What constitutes a good team?
- What is the structure of the team?
- What are the roles and responsibilities of the team members?

4.2a What constitutes a good team?

All health care interventions are delivered by skilled people, who are the most important part of the program. Having a team of people who are well trained, confident about their work and satisfied with their specific roles makes the program successful. A good comparison would be a car, which to run smoothly needs all the individual parts to perform efficiently. Similarly, for the program for patients with CMD to be effective, the team needs to function as a whole in a harmonious manner.

What makes a good team?

A good team is one that has the following features:

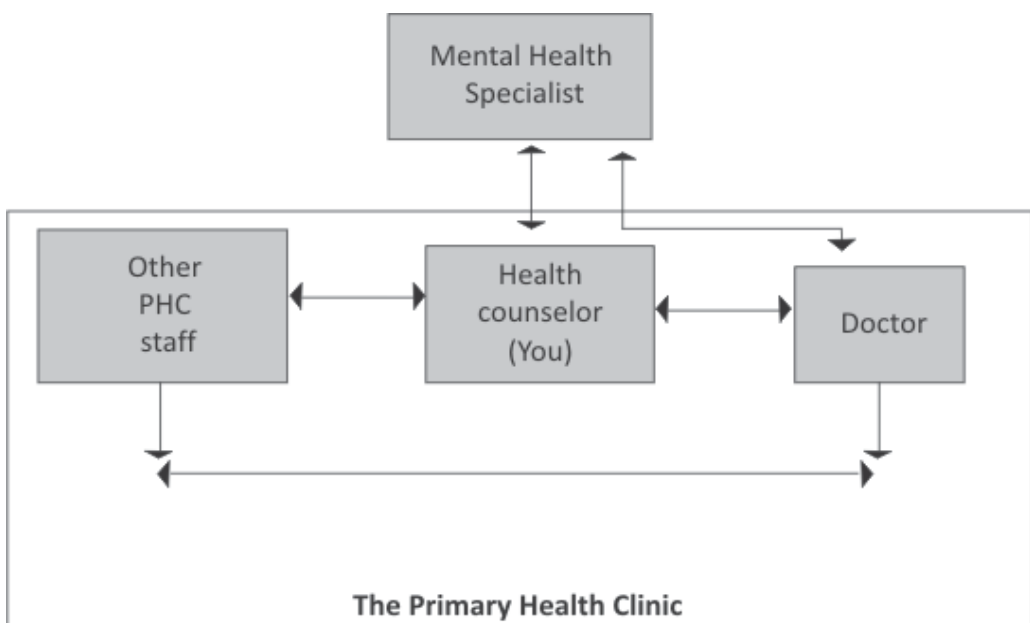
- **Shared goals and values:** The whole team has shared goals and values, which means that all team members agree that the primary focus will be on providing the best treatments to the patients being treated in the clinics. In addition, the team believes all their patients will be treated with dignity and helped to reach their maximum potential.
- **Respect for all team members:** The members should have respect for other team members and value the work that the others do.
- **Sense of ownership:** Every member of the team has to feel that she/he owns the program and is responsible personally for maintaining the quality of her/his individual work.
- **Free and open communication:** All team members should feel free to communicate openly and to learn from each other.
- **Improving the quality:** The members should focus on ways to improve the quality of the program continuously so that the team delivers the best care possible to patients.

- **Agreement on management procedures, lines of clinical responsibility:** The team members should also have clear ideas about the boundaries of each other's roles to reduce the possibility of disagreements.
- **Supportive atmosphere:** A supportive atmosphere within the team helps the team members to learn from and support each other.
- **Open and democratic decisions:** The decisions that affect the team are made through consultations and in an open manner.

4.2b What is the structure of the team?

A number of members performing different roles in the clinic makes up the intervention team. The figure 4.2A below shows the structure of the team that delivers the intervention during the program. This may need some modifications to match individual clinic requirements and any changes would be guided by your experiences.

Please note that the doctor in whose clinic you are based is the designated head of the clinic. Since you will be expected to integrate your work within the clinic structure, the doctor will be the person that you will be reporting to on a regular basis. The other members of the team provide supervisory support and would not be expected to involve themselves in the day to day functioning of the program.



The Primary Care Clinic

From the figure, in each clinic you will notice that you, the HC, will work closely with the other PHC staff as a team and will report to the PHC doctor for any immediate issues that need attention. Each clinic will have a designated Mental Health Specialist who will also be visiting the clinic for supervision and can be contacted on the phone as required.

The MHS will have the overall responsibility for the smooth implementation of the program in the clinic. The roles and responsibilities of the team members are described below.

4.2c What are the roles and responsibilities of team members?

1. Health Counselor (HC), your role and responsibility:

- to be the front-line coordinator of the intervention program in the clinic
- inform other PHC team members about your role in the program
- to deliver the treatments following the stepped care model
- to monitor each patient to recovery
- to meet the quality and safety standards of the program
- to maintain clinical and recording standards as set out in this manual
- to contact the MHS in all situations requiring referral or consultation
- to report regularly to the doctor in your clinic about individual cases and the progress of the overall program.

2. The PHC doctor's role and responsibility:

- to provide antidepressant treatment for patients who need it
- to maintain patient records
- to encourage patients to meet the HC and follow up regularly
- to discuss clinical problems with the MHS when the need arises
- to discuss clinical cases with the HC on a regular basis
- to assist in adherence management

3. Mental Health Specialist's role and responsibility:

- to train doctors, HCs and other program staff as relevant
- to provide on-site supervision to HCs
- to provide support for doctors, when necessary through phone contact and clinic visits

- to provide overall assurance in maintaining quality standards and safe practices
- to ensure that standards of documentation are adequate and meet the needs of the program

4. Other PHC team members' roles and responsibility:

- to conduct screening of patients in assigned clinics and complete the report (this task may also be done by the HC)
- to inform patients who attend the clinic about the program
- to encourage patients with CMD, in particular those who are not adherent, about seeing the HC

In this section we learnt that:

- ⊙ The primary care team consists of individual members working in harmony to ensure that the program runs in a smooth and efficient manner.
- ⊙ Key members for the program are the Health Counselor, the PHC Doctor and the Mental Health Specialist.
- ⊙ The roles and responsibilities of each team member are clearly defined.

Supervision And Documentation

In this chapter we shall learn the following:

- What is supervision?
- Why is supervision important?
- What you need to do to make supervision useful?
- Why is documentation important?

4.3a What is supervision?

Supervision is a process by which the HC is guided by an expert (usually the Mental Health Specialist) to ensure that her/his skills are continuously refreshed and improved. This process of learning allows you, as the HC, to discharge your duties competently to meet the quality standards of the program. The supervisor, i.e. the MHS, will provide support, technical inputs and guide you in your clinical work. The supervision process encourages you to treat the patients confidently and efficiently.

What are the two important functions of supervision?

- **Professional support:** The supervisor discusses with you the patients you have seen, the quality of the assessments with the clinical records and the management plans that have been made. The supervision process makes suggestions about additional strategies you can use for the assessment and treatments of a particular patient. The short term and long term goals of management of the patient will also be discussed and recorded for further review.
- **Personal support:** It can be quite a stressful experience, working with patients with CMD who might have suicidal risk and multiple social problems on an ongoing basis. This can manifest in various ways like you and other health workers losing motivation to work, feeling anxious or depressed and becoming easily irritable with patients or friends. This problem is called 'burnout'.

An important part of supervision is to identify any personal problems related to work or issues in your personal life that are affecting your well-being. The supervision process allows you to deal with them in a confidential, supportive and enabling manner. In addition, during supervision, you might wish to discuss any personal goals you have set for yourself and enlist the supervisor's support to make them happen so that the quality of your life improves.

In short, supervision is a positive learning experience for the supervisor and you, the HC. Through the process of supervision, you should feel supported personally and continuously gain technical skills to help you provide the best possible quality of services to your patients.

4.3b Why is supervision important?

Any health program is delivered by a trained staff. While the training provides them with the necessary theoretical and practical skills to start working, no training can capture entirely the variety of problems that the person will face in real life settings. Supervision allows the HCs to practice and implement what they have learnt in the most appropriate manner and provide the maximum benefits to their patients. Some of the more important reasons why supervision is essential for you are:



- **Supervision helps to manage difficult cases appropriately:**
Supervision allows you to discuss patients with complex or difficult problems and helps you to manage them in the best possible manner by taking the advice of an experienced supervisor who would have dealt with similar problems before.
- **Supervision ensures that the quality of your work is good:**
Since you will be working with patients who have significant life problems, it is very important that the treatment you are offering is effective and appropriate. Supervision allows you to maintain the standards of care by ensuring that the intervention is rational and well thought out.
- **Supervision helps manage suicide risk appropriately:**
At times, you will be seeing patients who have significant risk factors that increase their chances of self-harm. In these situations, it is essential that the best possible interventions be provided to minimize the risks involved and that the safety issues are addressed in an appropriate manner. Supervision then becomes an essential element through which safety standards of the program are met and to ensure that you feel supported in your work.
- **Other reasons that make supervision important:**
Supervision also allows you to learn continuously while you are working and to facilitate your personal and professional growth. This experience

should make you a competent practitioner and also help you identify professional and personal development goals for which your supervisor can help you plan.

Research has identified that supervision is an essential element of any successful health program and is especially important when CMD is being treated in primary care settings. Previously, it was thought that training alone would be enough to make program staff into effective practitioners, but this has repeatedly been shown to be false. Without ongoing supervision, staff gradually tends to lose the skills that were taught and go back to practicing in a manner similar to before the training program. Supervision, therefore, provides staff with the opportunity to upgrade and refresh their new skills in a continuous manner and makes the investment in training worthwhile.

As an HC, you will be working in a health clinic that has an established system of work culture. Some staff may be resistant to change for reasons that may be beyond your control. In such situations where there are problems in your work environment, discussing the problem(s) with your supervisor can be a very useful way of getting fresh ideas of how to resolve them so that you may work in the most effective manner.

4.3c What will you need to do to make the supervision most useful?

Supervision is an active and dynamic process that is most useful if you take a proactive role in planning the sessions. This means that you would have to record and document the details of the interventions with your patients and identify any difficulties that you face.

You need to make a list of these problem cases or other difficulties you might have faced, detail the strategies that you used to overcome these problems and record why you thought these did not work in the way you had hoped. This will help both you and the supervisor to focus on the problem and find possible ways to solve them within the limited time available.

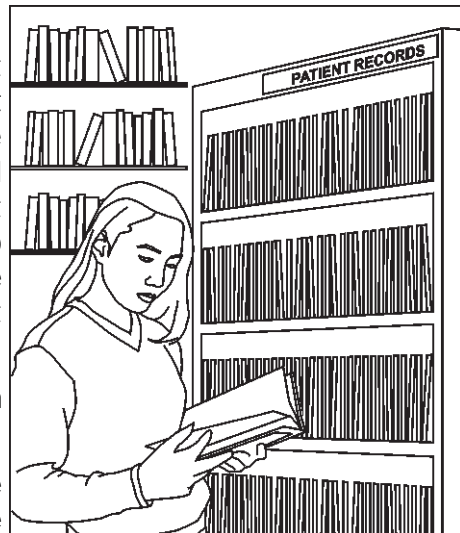
Another vital part of supervision is to record the discussions you had in the case record of the patient so that the suggestions that were made in the session are followed up. It is important to remember that supervision is not a mechanism to only monitor the person being supervised.

It is a two-way process and the supervisor also benefits from the process through learning from you about difficult situations and trying to solve problems in a logical manner.

It is important that you are diligent in completing the supporting documentation or the recording of information related to your patient encounters. This captures the

essential details of what occurred during the meeting, i.e. the clinical and social problems that the patient is presented with and the advice that you provided.

The nature of the documentation is different depending on whether it's the patient's first visit or follow-up and the Clinical Case Record (see Appendix 5.3 for a sample record form) will enable you to record the relevant information. It is important for you to understand the importance of adequate documentation; some of the more important reasons are given below:



4.3d Why is adequate documentation important?

1. Documentation helps keep track of the clinical process for each patient in the program:

- The clinical record is useful for you to refer to when the patient returns for follow up. When the records are maintained properly, they enable you and the patient to focus on the relevant details and make the best use of your limited time.
- Since you will be seeing a large number of patients, it is impossible for you to remember their individual problems and personal details. A good quality clinical record will tell you what were the symptoms that the patient had presented what was the nature of interventions that you had carried out and the tasks that both had agreed on during subsequent sessions. This baseline information allows you to monitor the progress of the patient accurately and will also make the patient feel that her concerns are being addressed in a systematic manner.
- The clinical case record is also an indicator of the process of treatment, i.e. it provides a summary of the type and details of the interventions provided. This will help you evaluate whether the program goals are being met.

2. Documentation helps make supervision effective:

- The quality of the clinical record has a direct relationship with the quality and agenda of the supervision process by making it very focused.
- Correct documentation will ensure that the stepped care treatments are being followed in a systematic and rational manner. For example, if a patient is being 'stepped up' to receive antidepressants, the reasons for that decision

need to be detailed so that your supervisor can judge whether the decision is appropriate.

- Clinical records are a very useful way of monitoring the overall quality of any health program.

Suggested documentation to be completed by the HC

No.	Type of document/ record	Purpose
1.	Clinical case record	Details of the clinical interventions provided to patients in the program
2.	Appointment diary	To record patients' appointments for adherence management
3.	Individual IPT clinical record	To record details of patient's symptoms, problem area and plan for the next session (for IPT patients only)
4.	Yoga assessment and physical evaluation forms (where implemented)	To assess the performance of participants during the yoga sessions and record information about their health

In this section we learnt that:

- ⊙ Regular structured supervision by the MHS is an essential component of the intervention.
- ⊙ This will help to monitor the quality of your work, provide assistance with difficult cases and provide you with personal support, if needed.
- ⊙ Meticulous documentation is very important both for providing patient care and monitoring quality of the intervention.

Integrating Services In Primary Care Clinics

Let us look at the role you will play in integrating the program into the primary health clinics.

In this section, you will learn:

- What does integrating services in the primary health care mean?
- What are the tasks for integration in the initial period?
- How to continue efforts to integrate the program?

4.4a What does integrating services in the primary health care mean?

As a Health Counselor (HC), you will be expected to be an integral part of the primary care clinic and will work with the doctor and other staff members who are already a part of the clinic. If you are already part of the PHC team, some of the issues we will discuss in this chapter may not be relevant for you. If you are a new person introduced into the system, there are special challenges to the integration of the program in the clinic that you need to be aware of.

Since you may be a new addition to the staff, there can be challenges in developing a close working arrangement with the existing staff members. In addition, the structure and functioning of clinics can be quite varied and you will need to orient yourself properly and identify any challenges to the implementation of the program and deal with them appropriately.

For this purpose, there are some activities that should be conducted in the initial period to ensure the CMD program is well integrated into the primary care setting to ensure that the collaborations among the team members are further strengthened as the program is implemented.

4.4b What are the tasks for integration in the initial period?

- In the initial phase, you and the PHC team members who carry out screening, the doctor and the MHS and any other key staff in the clinic will need to meet and review the arrangements and the process of conducting the program smoothly. As the HC, you should conduct a seminar for the PHC team using audio-visual aids where you will explain the purpose of the program and the manner in which others in the primary care clinic need to contribute to the process to make it work best for patients with CMD.

Frame work for the introductory meeting with the PHC staff

- What are stress related health problems and how do they present in the clinic?
- The relationship between stress and health.
- Why are these important? Magnitude of the program and its consequences.
- What treatments work? Pharmacological and non-pharmacological treatments.
- Description of the intervention model. Roles of the clinic staff.
- It is useful to undertake the mapping exercise of the clinic with the help of the tool designed for the purpose (Appendix 5.9). This will help you to get to know the other members of the clinic and develop the terms of your work relationship while giving you a detailed understanding of the facility.
- It is also useful, in the initial days, to observe the process that a patient goes through when she/he visits the clinic. This would include observing the registration process, observing the order in which patients are asked to see the doctor and sitting in with the doctor and patient while an interview is conducted. This period of observation helps you to work out the exact manner in which you will locate the program within the clinic and identify any problems that might come in the way of your work. This will also help you to build rapport and trust with the clinic staff.
- Ensure that your workspace provides you with adequate privacy for patient consultation.
- Take some time to set up posters in the clinic informing patients about the program
- In the MANAS program, we found that this initial systematic way of understanding the physical and human resources of the clinic helps the HC to plan integration of the program within the working of the clinic effectively.

4.4c How to continue efforts to integrate the program?

Your work of integrating the program continues throughout the time that you will be working in the clinic. The list of activities that we found useful are given below. These are by no means the only activities that can be done and you should be creative in designing other methods to ensure that you are accepted as a valuable member of the PHC.

- **Continue to liaise closely with the doctors in the clinic:** It is an essential requirement for you to be accepted in the clinic. Make it a point to provide

some feedback about the patients you have seen every day to the concerned doctor and proactively seek his advice for any problems. This is also a good opportunity for you to update the doctor about the progress made by the patients you are seeing in common. These daily meetings can also be an opportunity to learn a few things about the treatments in the program, especially around the use of antidepressant medicines. This can also be the forum for you to inform the doctor that a particular patient is non-adherent with treatment so that the doctors can advise the patient to resume medicines when she comes back for a follow-up.

- **Meet with other staff in the clinic regularly:** Once a fortnight or so, it is very useful to schedule some time to meet with other staff in the clinic like the pharmacist, nursing staff, registration staff who might be doing the screening, to discuss the progress of the intervention and any problems that you might be facing, which the staff can help you with. Remember, these staff members have been in the system for a long period and play an important role in making the program a success if they are also made stakeholders in the process.
- **Meet with field staff:** The field staff are an important resource for you as we mentioned in the chapter on adherence management. In all PHCs, there is a designated meeting day (usually on a monthly basis) where all field staff come to the PHC for an update on the activities for the next month. This is an ideal forum for you to present the details of the program, conduct some brief training and thank the field staff for their cooperation.
- **Conduct yoga for the clinic staff:** This can be a useful 'icebreaker' and help you get to know the staff well. In the MANAS program, we found this activity was taken up enthusiastically by the staff and greatly helped the HC become a valued member of the team. It also served the purpose of de-stigmatising the intervention by getting the staff to understand that stress management is not only for those with mental illness but is a health promotional activity that has benefits for everyone.
- **Help out with other tasks in the PHC:** One of the most effective ways of being accepted as a valuable colleague by the PHC staff is for you to help out others in conducting the routine work of the PHC. Many of the HCs in the MANAS program helped with field surveys, immunisation programs, organising awareness meetings in schools or the community, with registration procedures in the clinic and in other small tasks to help doctors and nurses. These are well appreciated by staff, who are then more likely to reciprocate positively when you ask them for help.

Table displaying potential risks to integration of the program in PHCs and possible solutions.

Risk to integration	Solution
1. Lack of space for privacy to conduct counseling	<ul style="list-style-type: none"> Initially map the clinic to indentify adequate space. Construct a small cabin in an identified area in the clinic. Shield the designated area with a curtain to conduct counseling.
2. Lack of awareness about mental health issues by staff and patients	<ul style="list-style-type: none"> Have introductory talks at the start of the program in the clinic and community (see below). Exhibit posters of the program in clinic. Prepare brochures about the program that can be distributed to patients when they visit the clinic Conduct regular (monthly) program update with staff during their scheduled meeting.
3. Staff uncooperative with the program	<ul style="list-style-type: none"> Interact regularly with staff and address their concerns about the program. For example, reassure them that the program will not add to their work load. Conduct yoga sessions or relaxation sessions for the staff as an ice breaker.
4. Irregular supplies of ADT	<ul style="list-style-type: none"> Regularly monitor ADT supply along with the PHC Pharmacist. Prepare ADT requirements list in advance.
5. Staff turnover: trained staff leave the program	<ul style="list-style-type: none"> Ensure additional staff trained to provide backup if necessary Retain additional staff in clinics with heavy work load.
6. Patient is uncooperative and refusing treatment	<ul style="list-style-type: none"> Provide information on the program and benefits of treatment. Have doctor and other PHC staff reinforce importance of seeing you.

In this section we learnt that:

- ⊙ Integrating the intervention in the primary care clinic will require active engagement with clinic staff to share with them the purpose and activities of the program and to understand the roles of each staff member.
- ⊙ Presentations and posters in the clinic can help in raising awareness about the program amongst clinic staff and patients.
- ⊙ Mapping the clinic facilities and staff can help in planning how to integrate the program smoothly in the clinic.
- ⊙ Continue to make efforts to interact with a wide range of staff members in the PHC to ensure their cooperation in the smooth running of the program.

Chapter 5

Appendix

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Pockets used to keep health education material at clinics.

Appendix 5.1: General Health Questionnaire (GHQ) with examples:

This consists of the 12 item questionnaire used for the purpose of screening. There are some questions that patient's may not understand easily and for these we have provided examples that you can use to illustrate the meaning of the questions to the patients.

Screening Questionnaire (GHQ 12)

We would like to know if you have had any medical complaints and how your health has been in general over the past two weeks.

- Instructions:
- Shaded questions if answered as **No** code 1 and If **Yes** code 0
 - Unshaded questions if answered as **Yes** code 1 and if **No** code 0

<i>HAVE YOU RECENTLY :-</i>		
GHQ 1	been able to concentrate on whatever you're doing?	
GHQ 2	lost much sleep over worry?	
GHQ 3	felt that you are playing a useful part in things?	
GHQ 4	felt capable of making decisions about things?	
GHQ 5	felt constantly under strain ?	
GHQ 6	felt you could overcome your difficulties?	
GHQ 7	been able to enjoy your normal day-to-day activities?	
GHQ 8	been able to face up to your problems ?	
GHQ 9	been feeling unhappy and depressed?	
GHQ 10	been losing confidence in yourself?	
GHQ 11	been thinking of yourself as a worthless person?	
GHQ 12	been feeling reasonably happy, all things considered ?	
Total Score		

GHQ Probes

In the MANAS program, we found that sometimes it was difficult for patients to understand the question being asked and that they needed some additional prompts to help them understand and respond to the GHQ questions appropriately. Based on the experience of the persons conducting the screening, we give you a list of additional probe questions for specific items of the GHQ that you might find to be useful.

For Q 1.

Example 1

While watching a TV Program, are you able to concentrate?

Example 2

While cooking, do you remember to put salt and other spices in the food?

Example 3

While studying, are you able to concentrate on what you are reading?

For Q3

Example 1

Whatever work you do (for eg. work at home, fieldwork, job), do you feel it is useful?

For Q4

Example 1

If you have to go somewhere, for example, visit the doctor, are you able to make a decision about this?

For Q6

Example 1

If you have visitors at home and have run out of ingredients to make tea, will you be able to deal with this?

For Q7

Example 1

Whatever you do, example housework, job, are you able to enjoy these activities?

For Q8

Example 1

Whatever problems you have in your life, for eg., illness in family, are you able to face these confidently? If patients respond with somatic complaints, then say "these are physical symptoms you are describing". I am asking you about your emotional problems?

For Q12

Example 1

After all that you have told me, do you still remain reasonably happy?

Appendix 5.2: Patient Card

This is the patient card that is completed for every patient that is screened for Common Mental Disorders. The doctor then fills the 'doctor section' at the bottom of the card.

Patient Health Card			
PATIENT ID:-			<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
Clinic Name: _____			
Date of Registration:			<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
			d d m m y y
Full Name: _____			
Sex:	<input type="checkbox"/> (M / F)	Age:	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>
GHQ Score (Tick appropriate box)			<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>
(0 5)	(6 7)	(8 12)	
<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	<input style="width: 30px; height: 20px; background-color: #cccccc; border: 1px solid black;" type="checkbox"/>	<input style="width: 30px; height: 20px; background-color: #333333; border: 1px solid black;" type="checkbox"/>	Score ()
Nil	Mild	Moderate/Severe	
TO BE COMPLETED BY THE DOCTOR FOR PATIENTS WHO SCORE 6 OR MORE			
			Tick if the answer is yes
1	Have you advised the patient to see the Health Counselor?	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	
2	Have you prescribed any vitamins or tonics or injections?	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	
3	Have you prescribed alprazolam or diazepam or similar medicine?	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	
4	Have you prescribed antidepressants for the patient?	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	
5	Can you write the name of the antidepressant you have prescribed?	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	
6	What dose of the antidepressant have you prescribed?	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	
7	When have you asked the patient to return for a follow-up	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	

Appendix 5.3: The Clinical Case Record

This is the form used in the clinic to record the details of each patient who receives the intervention.

Clinical Case Record Form			
		Patient ID: <table border="1" style="display: inline-table; width: 100px; height: 30px; vertical-align: middle;"></table>	
Date of Registration: _____			
Name : _____			
Age: _____ Sex : _____			
Marital Status: _____			
Address:			

If necessary, can I contact you through:			
Letter	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Telephone call	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Home visit	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Convenient Day/ Time : _____			
Spouse / Closest person's name: _____			
Patient's occupation: _____			
Telephone No/Mobile: _____			
(If neighbor's contact) Neighbor's Name: _____			
Doctor's Name: _____ Clinic Location: _____			

First Consultation Details

Patient ID:

--	--	--	--	--

Date:	
Attended	<input type="checkbox"/> alone <input type="checkbox"/> accompanied
Screening GHQ score	
Any other medical diagnosis	
Main health complaints	1 2 3 4
Mood rating	
Summary of risk assessment	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High
Substance abuse	<input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> None
Any barrier(s) to adherence identified	
Specific adherence management strategies used	
Antidepressant (drug, dose, duration)	
Other medication (apart from vitamins and sleeping pills)	
Advice given	
Follow up appointment (date/time)	
Remarks	
Plan for session 2	

Checklist for Suicide Risk Assessment

Patient ID:

--	--	--	--	--

Demographic risks:

- ☐ Poverty
- ☐ Unemployed
- ☐ Separated, widowed
- ☐ Age

Clinical risks:

- ☐ Moderate or severe Common mental disorders
- ☐ Previous suicide attempt
- ☐ Family history of suicide
- ☐ Misuse of alcohol or other drinks
- ☐ Physical illness and disability

Immediate risks:

- ☐ Ongoing severe social stress
- ☐ Lack of social support
- ☐ Hopelessness
- ☐ Loss of interest
- ☐ Frequent suicidal ideas
- ☐ Plan to commit suicide and access to means

Summary risk:

- ☐ No risk / Low risk
- ☐ Moderate risk
- ☐ High risk

Additional comments: _____

Intervention/ action taken: _____

Checklist for Social Difficulties

Patient ID:

--	--	--	--	--	--

Social Difficulties	Brief description	Action taken
<input type="checkbox"/> Financial difficulties		
<input type="checkbox"/> Domestic violence		
<input type="checkbox"/> Unemployment		
<input type="checkbox"/> Legal disputes		
<input type="checkbox"/> Interpersonal conflicts		
<input type="checkbox"/> Problems at work		
<input type="checkbox"/> Health problems in self		
<input type="checkbox"/> Illness/disability in family		
<input type="checkbox"/> Substance abuse in family		
<input type="checkbox"/> Problem with parenting		
<input type="checkbox"/> Bereavement		
<input type="checkbox"/> Lack of support/isolation		
<input type="checkbox"/> Childlessness		
<input type="checkbox"/> Family member leaving home		
<input type="checkbox"/> Others, describe		

Adherence Management

Patient ID:

--	--	--	--	--

Barriers to adherence	Action taken to improve adherence
<input type="checkbox"/> Time constraints <input type="checkbox"/> Travel distance <input type="checkbox"/> Travel expense <input type="checkbox"/> Health problem <input type="checkbox"/> Dependent family member <input type="checkbox"/> Uncooperative spouse/relatives <input type="checkbox"/> Unconvinced about need or appropriateness of treatment <input type="checkbox"/> Pressing social difficulties <input type="checkbox"/> Other, specify	<input type="checkbox"/> Give flexible appointment <input type="checkbox"/> Address and telephone number carefully recorded so that patient can be reached by phone call, letter or home visit. <input type="checkbox"/> Offer telephone consultation <input type="checkbox"/> Brief counseling when yoga session attended <input type="checkbox"/> Offer to speak to relative to explain about the treatment <input type="checkbox"/> Reinforce mind body link <input type="checkbox"/> Referral letter to community agency / information about welfare schemes, etc <input type="checkbox"/> Telephone call to remind patient of missed appointment <input type="checkbox"/> Letter sent to remind patient about need to visit the clinic <input type="checkbox"/> Home visit for counseling <input type="checkbox"/> Any Other. Specify.

Intervention SummaryPatient ID:

--	--	--	--	--

Step of Intervention	Date	Reason for Starting
1. Psychoeducation		
2. Antidepressant		
3. IPT + Antidepressant		
4. Referral to specialist		

Medication RecordsPatient ID:

--	--	--	--	--

Name	Dose	When started
Sleeping pills: Eg. Benzodiazepines Alprazolam/diazepam	X	
Vitamins, Nutritional supplement	X	
Injections	X	
Antidepressant		

Reasons for starting Antidepressants: Tick the box (only one).

- ☐ Severity of Common mental disorders
- ☐ Patient not better with PE
- ☐ Other reason. Specify: _____

Reasons for stopping Antidepressants: Tick the box.**PLANNED STOPPAGE – specify reason**

- ☐ On completion of treatment
- ☐ Improved with treatment but course incomplete (doctor stops med or patient refuses)
- ☐ Referred out of the program ie. MHS, other treatment centre
- ☐ Patient already on Psychiatric treatment, hence referred back to treating Psychiatrist
- ☐ Patient from another town/village
- ☐ Other reason, specify _____

UNPLANNED STOPPAGE – specify reason

- ☐ Refuses to continue despite no improvement
- ☐ Medication side-effects
- ☐ Not convinced medication will help/ are needed
- ☐ Failure to keep appointments.
- ☐ Other reason. Specify _____

Subsequent Consultation Form

Patient ID:

--	--	--	--	--

Date:	
Attended	<input type="checkbox"/> alone <input type="checkbox"/> accompanied
Type of contact:	<input type="checkbox"/> telephone <input type="checkbox"/> face-to-face
Change in Main Health Complaints described in first contact	<div style="text-align: center;"> 1 2 3 4 </div>
Overall status	<input type="checkbox"/> Better <input type="checkbox"/> No change <input type="checkbox"/> Worse
Mood rating	
Summary of current risk assessment	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High
Current social difficulties	
Antidepressant (drug, dose, duration)	
Other medication	
IPT Session No.	
Yoga	
Adherence management	
Advice given	
Consultation with Mental Health Specialist	
Follow up appointment	
Remarks	

Appendix 5.4: Antidepressant table

This consists of a list of commonly used antidepressant medication in primary care with their recommended doses and common side effects. Brand names and costs may vary according to the setting and hence these have been left blank.

Name of anti-depressant	Commonly available brand names and strengths	Monthly cost of maintenance dose	Starting dose	Maintenance dose (usually in 2 weeks)	Maximum recommended dose if no response at 4 weeks	Common side effects	Specific clinical indications/ relative contra indications
Serotonin specific reuptake inhibitor (SSRI)							
Fluoxetine	Available as 10, 20 and 40mg capsules		10-20 mg in the morning on full stomach	40 mg	20 mg	GI disturbances Headache Sweating Sexual problems	Convenient once daily dose; Generally tend to increase the availability of concurrent medications like warfarin
Sertraline	Available as 25, 50 and 100 mg tablets		50 mg in the morning on full stomach	100 mg	200 mg		Non sedating and generally well tolerated; Use in lower doses for patients with hepatic or renal problems; Taper and withdraw
Citalopram	Available as 10, 20 30 and 40 mg tablets		10 mg in the morning on full stomach	20 mg	30 mg		

Guidelines for Antidepressant Use

Name of anti-depressant	Commonly available brand names and strengths	Monthly cost of maintenance dose	Starting dose	Maintenance dose (usually in 2 weeks)	Maximum recommended dose if no response at 4 weeks	Common side effects	Specific clinical indications/ relative contra indications
Tricyclic Antidepressant (TCA)							
Dothiepin (TCA)	Available as 25, 50, 100 and 150 mg tablets		50 mg at night	100mgs	150 mg	Dryness of mouth Constipation Postural hypotension Sedation Tachycardia	Useful when sedation is required Weight gain Avoid in patients with cardiac problems and elderly Avoid in patients with high suicidal risk Taper and withdraw
Imipramine (TCA)	Available as 25 and 75 mg tablets		50 mg at night	100 mg	150 mg		
Amitryptiline	Available as 10, 25, 50 & 75 mg tablets		50 mg at night	100 mg	150 mg		

Appendix 5.5: Community Referral Agencies

You can enter a list of resources in the table below of various social agencies in your region along with their contact details to which you should refer patients for their social problems.

Sr. No	Name of organisation	TEL	Contact person	Services offered
RESOURCES FOR PEOPLE WITH HIV/AIDS				
This may include counseling /health centres dispensing antiretroviral treatment				
RESOURCES FOR DRUG AND ALCOHOL PROBLEMS				
This may include detoxification centres, drug rehabilitation centres, self help groups				
RESOURCES FOR WOMEN WITH DOMESTIC VIOLENCE				
This may include women's organisations, short stay shelter homes, lawyers, social workers, counsellors				
RESOURCES FOR THE ELDERLY				
This may include shelters, dementia associations, agencies providing financial assistance to the elderly				
RESOURCES FOR SEVERE MENTAL ILLNESSES				
This may include health centres with specialist facilities, rehabilitation centres, family support organisations				
RESOURCES FOR CHILDREN				
This may include children's homes, orphanages, child protection agencies, special schools for children with mental retardation				
LEGAL AID: This may include assistance for domestic violence, child rights, employment benefit claims				

Appendix 5.6: Yoga for Common Mental Disorders

This chapter is covered under the following sections:

- What is yoga?
- What are the types of yoga?
- Understanding stress - a yogic perspective
- Concept of disease in yoga
- Basis and application of yoga as therapy
- Yoga therapy module for anxiety and CMD
- Basic instructions to practice yoga
- Important points for yoga teachers
- Essential requirements for practicing yoga

Important Note About the MANAS Yoga Therapy Module:

Yoga is not an essential component of the MANAS collaborative stepped care model but rather an optional treatment offered to patients with CMD.

Yoga is introduced in three sessions and practiced with a weekly review session. The practices are listed and described separately for each session with illustrations wherever possible. Although a common yoga therapy program is adopted for anxiety and CMD, after the completion of the three sessions the yoga instructor would emphasize the importance of focusing on specific techniques separately for anxiety and depressive symptoms.

A general rule of thumb is that patients with symptoms of anxiety are instructed to focus on slow breathing techniques, relaxing yoga postures, *pranayama*, guided relaxation and meditation.

Patients with signs of CMD would be asked to focus on repeated rounds of breathing exercises practiced briskly, all *asanas* [physical postures], repeated rounds of a high-frequency breathing *kriya* [cleansing techniques] called *kapalabhati* & balancing *pranayama*, i.e., *nadisudhi pranayama* also popularly known as *anuloma-viloma pranayama* – alternate nostril breathing.

5.6a What is yoga?

Yoga is an ancient Indian science and a way of life. Yoga is one of the six philosophies of India which is regarded as a secular spiritual discipline. Classically, the word Yoga is derived from the Sanskrit root 'Yuj' which means union.

Hence, yoga is considered as the path to unite the individual being with that of the cosmic one. In recent times, the term has been used in the context of union of the mind with the body [soma].

Three classical yoga texts define yoga as:

1. '*Yogah citta vritti nirodhaha*' , [*Patanjali Yoga Sutras*]

Yoga is a path to reach a mental state devoid of very strong positive or negative feelings, without sudden flashes of memory, this very difficult to reach state is described as a 'mental state devoid of modifications' which leads to a state of equilibrium and enlightenment.

Considering a 'no thought state' as a reference state, there are five mental modifications viz., right knowledge [*pramana*], wrong knowledge [*viparyaya*], illusion [*vikalpa*], sleep [*nidra*] and memory [*smriti*].

2. '*Samatvam Yoga Uchayate*'....

From yoga one attains equilibrium, balance and harmony within and around.

3. '*Manah prashmana upayaha yogah ityabidiyathe*'

Yoga is a skill to calm the mind [the agitated-stressed mind].

Patanjali's Yoga Sutras (circa 900 B.C.), the most respected yoga text, recommends eight practices to attain the state of equilibrium called '*ashtanga yoga*'. The eight practices are:

- *Yama* - Recommended code of conduct- five personal observances viz., *ahersa* [non-violence], *satya* [truthfulness], *astheya* [abstinence from stealing and misappropriation], *bramacharya* [celibacy] and *aparigraha* [non-possessiveness]
- *Niyama* - Recommended code of conduct: five social observances viz., *soucha* [purity (external & internal)], *santhosa* [contentment], *tapa* [the practice of austerity], *svadyaya* [the self study of spiritual literature] and *iswarapranidana* [living in tune with cosmic consciousness]
- *Asanas* - Physical postures
- *Pranayama* - Voluntarily regulated yoga breathing
- *Prathyhara* - Sensory withdrawal
- *Dharana* - Meditative focusing
- *Dhyana* - Meditative defocussing
- *Samadhi* - Experience of transcendence

5.7b What are the types of yoga?

Classically there are four types of yoga viz., (i) *Jnana yoga* - the path of knowledge, (ii) *Bhakti yoga* - the path of surrender/devotion, (iii) *Karma yoga* - the path of selfless work and (iv) *Raja yoga* - the path of self control. In the present day context, it is the *Raja yoga* which is referred to as yoga.

In recent times, *Raja yoga* –the king of yoga - is practiced in a number of styles based on the founding teacher, i.e., the *yoga guru*. These styles emphasize at least one of the three most popular practices of yoga, i.e., *asanas*-physical postures, *pranayamas*-voluntarily regulated yoga breathing and *dhyana*-meditation. Some of the well known styles are:

- Styles which focus on *asanas* or physical postures:
 - ♦ *Sivananada yoga* – based on the teachings of Swami Sivananda.
 - ♦ *Iyengar yoga* – based on the teachings of Sri BKS Iyengar.
 - ♦ Yoga as taught by Swami Dharendra Brahmachari.
 - ♦ *Vinyasa yoga* – of Sri Patlabhi Jois.
 - ♦ *The yoga* of Sri Deshikachar.
 - ♦ *Bikram yoga* of Bikram Chowdhary.
- Styles which focus on *pranayama* - voluntarily regulated yoga breathing:
 - ♦ *Patanjali yoga* as taught by Swami Ramdev.
 - ♦ *Sudarshan Kriya yoga* [SKY] of Sri Sri Ravishankar, The Art of Living Foundation.
- Styles which focus on *dhyana* - meditation:
 - ♦ Transcendental Meditation [TM] as taught by Maharishi Mahesh Yogi.
 - ♦ Self realization meditation of Paramahansa Sri Yogananda.
 - ♦ *Vipassana meditation* as taught by Sri Goenka.
 - ♦ Meditation as taught by Osho.
 - ♦ *Brahmakumari raja yoga meditation* of Brahmakumari Raja Yoga University.
 - ♦ Life bliss program of Swami Sukhabodananda.
 - ♦ *Nityananda yoga* of Swami Nityananda.

Apart from these specific yoga styles which are practiced as taught by popular yoga gurus there are well established institutions which teach yoga, based on the original teachings of *Patanjali* (circa 900 B.C.). These schools have evolved yoga programs which give equal importance to all the eight steps of *Patanjalis yoga*

sutras viz., (i) *Yama* - Recommended code of conduct - five personal observances, (ii) *Niyama* - Recommended code of conduct- five social observances, (iii) *Asanas* - Physical postures, (iv) *Pranayama* - Voluntarily regulated yoga breathing (v) *Prathyhara* - Sensory withdrawal, (vi) *Dharana* - Meditative focusing, (vii) *Dhyana* - Meditative defocusing and (viii) *Samadhi* - Experience of transcendence

These are:

- ♦ Integrated Approach of Yoga Therapy [IAYT] rarely called as *Vivekananda yoga* – of Swami Vivekananda Yoga Research Foundation [a Yoga University], Bengaluru.
- ♦ Yoga of Bihar School of Yoga, Munger, Bihar.
- ♦ Integral yoga of Sri Aurobindo, Pondicherry.
- ♦ Yoga as taught by Swami Kuvalyananda of Kaivalyadham, Lonavla.

5.6c Understanding stress - a yogic perspective

Yoga texts consider everything that disturbs the inner balance and causes mental distractions as sources of stress. Patanjali's *yoga sutras* describe specific factors that are identified as stress producing factors and *astanga yoga* as its remedy. These are called '*kleshas*' viz.

- *Avidya* [Ignorance] – lack of knowledge to distinguish mortal & immortal; auspicious & inauspicious and freedom & bondage.
- *Asmita* [Strong sense of 'self'] – a sense of glorified self identity and self centered living.
- *Raga* [intense liking] – strong affinity, liking and attachment.
- *Dvesha* [intense hatred] - strong repulsion, dislike, and hatred, and
- *Abhinivesha* [fear of death] – fear ranging from known phobias to fear of losing self identity and ultimately of death.

It is prescribed that one has to resort to practicing yoga [*abhyasa*] and have a holistic outlook of life [*vairagya*] to attain mental stability and equilibrium.

5.6d Concept of disease in yoga

Yoga Vasista, one of the comprehensive classical yoga texts classifies disease [*vyadhi*] as (i) *adhija vyadhi* [inherited disease] and (ii) *anadhija vyadhi* [acquired disease]. *Anadhija vyadhi* are those diseases that are caused by infections and trauma. Everything else is regarded as *adhija vyadhi*, i.e., inherited. Stress related/lifestyle related or psychosomatic diseases are classified as inherited. This is in the context of

personality, vulnerability and lifestyle. Hence, *Yoga Vasista* recommends yoga as an ancient and potent mind-body intervention to treat *adhija vyadhi*, in the context of stress related diseases, viz., anxiety and CMD.

5.6e Basis and application of yoga as therapy

Yoga is an ancient Indian science, which includes the practice of loosening exercises (*sithilikarana vyayama*), purifying practices (*shatkriyas*), specific postures (*asanas*), cleansing practices (*kriyas*), voluntarily regulated breathing (*pranayamas*), yoga-based guided relaxation and meditation (*dhyana*). Yoga training has been reported to decrease heart rate and breath rate which are signs of increased arousal in normal volunteers. For example, significant reductions were shown for CMD, anger, anxiety, neurotic symptoms and low frequency heart rate variability in 17 patients with CMD following training in *Iyengar yoga*.

The classical yoga therapy is an integrated yoga program combining practices intended to act at physical, emotional, intellectual and even at spiritual levels. This yoga program is derived from principles in ancient texts (*Patanjali's Yoga Sutras and the Taittreyia Upanisad*), which emphasize that yoga should promote health at all levels. Another ancient Indian text (*the Mandukya Upanisad*) considers the 'body' as three parts namely, the physical part (*sthula sharira*), a subtle or inner part (*sukshma sharira*) and the causal body (*kaarana sarira*). These three parts are represented as five levels of existence (*pancha koshas*).

These are the physical level (*annamaya kosha*), the level of subtle life energy (*pranayama kosha*), the level of emotional thinking (*manomaya kosha*), the level of rational thinking and judgment (*vijnanamaya kosha*) and the level of complete health and happiness (*anandamaya kosha*). In this description the physical level and physical part (of the body) (*sthula sharira*) are the same. The levels of subtle energy, emotional and rational thinking form the 'subtle inner part' (*sukshma sharira*) and the level of complete health and happiness is the causal body (*kaarana sharira*). A balance between these three parts (*shariras*) is believed to be necessary for complete health.

The 'eight limbed yoga' (*astanga yoga*) of *Sage Patanjali* acts at different levels of existence, i.e., (i) *yama and niyama* [rules for social conduct] act at the level of rational thinking and judgment; (ii) *asanas* [physical postures] at the physical level; (iii) *pranayama* [voluntarily regulated yoga breathing] at the level of subtle life energy; (iv) *prathyahara* and *dharana* at the level of emotional and rational thinking (vii) *dhyana* and *samadhi* at the level of complete health and happiness. This traditional style of yoga has come to be known as an 'Integrated Approach of Yoga Therapy [IAYT]' also popularly referred to as '*Patanjala Yoga* or *Vivekananda Yoga*'.

5.6f Yoga therapy module for CMD

With a large number of yoga techniques to choose from it is important to select the most suitable techniques to treat a specific disease. This selection is based on (i) the traditional prescription [based on the described effect of each practice], (ii) research evidence on physiological effects of yoga and (iii) unpublished clinical observations.

5.6g General description of the sessions and the prescribed techniques:

The yoga sessions should be conducted in small groups with one teacher for a maximum of ten participants. The yoga teacher should have adequate training and experience in dealing with patients suffering from CMD. Typically each session would be for 60 min and this would include: loosening exercises (*shithilikarana vyayama*, 10 min), physical postures (*asanas*, 20 min), voluntarily regulated breathing (*pranayama*, 15 min) and yoga-based guided relaxation (15 min).

Loosening exercises (*Sithilikarana Vyayama*, in Sanskrit) are a set of practices intended to increase mobility of joints and to prepare for the practice of yoga postures. The techniques involve repetitive movements of all the joints from the toes up to the neck (the detailed list of *sithilikarana vyayama* is given in the 'MANAS module' below).

For example, complex joints such as the shoulder could have movements such as rotation, flexion, extension, abduction and adduction.

For the practice of yoga postures (*asanas*) participants were asked to be in a posture as long as they could with comfort and normal breathing. The following yoga postures will be taught as part of this module: mountain posture (*tadasana*), lateral arc posture (*ardha-kati-chakrasana*), comfortable posture while seated on the floor [*sukhasana*] or half lotus posture (*ardha-padmasana*), cobra posture (*bhujangasana*), crocodile posture (*makarasana*), leg lock posture (*pavanamuktasana*), diamond posture (*vajrasana*), butterfly posture/bound angle posture/cobbler's posture and movement (*badha konasana*) and corpse posture (*shavasana*).

While seated with eyes closed keeping the neck and back as straight as possible, voluntarily regulated breathing techniques (*pranayamas*) will be practiced where the nostrils are manipulated by adopting a specific hand gesture (*mudra*) where the index finger and middle fingers will be flexed against the palm keeping the thumb and other fingers extended. This *mudra* is illustrated in the figure 1. The ring and little finger will be used to regulate the breathing through the left nostril while the thumb was similarly used for the right nostril.

The practice of alternate nostril breathing (*nadishudhi* or *anuloma-viloma pranyama*) would begin with exhalation through the left nostril, inhalation through the same side followed by exhalation and then inhalation on the right side.

This will be considered as one round and practiced for nine rounds. Bumble bee practice (*brahmari*) involves exhalation with a humming sound with the mouth closed and the index fingers on either side in the ears. This practice will be performed for five rounds.

Guided relaxation involves lying in the corpse posture (*shavasana*) and relaxing parts of the body beginning with the toes and moving upwards according to instructions.

5.6h Session by session guide for conducting yoga for patients with CMD

The yoga course consists of three sessions – 1 ½ hr. each on consecutive days followed by an open session once a week.

Each session consists of: Theory + Practical + Revision + New Techniques.

SESSION 1

This session begins with an introduction to yoga and the theory behind this ancient practice. This is followed by general instructions to participants (see section 2.8g) and then demonstration of the specific yoga techniques. The introduction and theory should include the following points:

- **Symptoms of stress are a result of today's life style**
(Contents may vary for rural/urban areas)
 - ♦ A sedentary existence
 - ♦ Over eating
 - ♦ An unbalanced diet – “Nutritionally deficient” / “junk food”
 - ♦ Over-work

Yoga is an age-old Indian science which could be a useful adjunct, a complimentary science to medicines.


- **Principles of Yoga which address these lifestyle issues**
 - ♦ Relaxation and movements of all groups of muscles.
 - ♦ Full movement of all joints and spine
 - ♦ Deep, slow breathing



All of these results in several benefits like:


- ♦ Improved circulation of blood throughout the body



- ♦ Better oxygenation of blood.
 - ♦ Reduction in joints pains & body aches.
 - ♦ Calming down of mind, good sleep.
 - ♦ Feeling of well-being and energetic in work and otherwise.
-
- **Types of yoga – different classifications**
 - **Definition of yoga**

SESSION 1

Technique	Description
Training single syllable chanting in <i>Tadasana</i>	<p>Single syllable chants which are known to facilitate deep breathing, enhance awareness and induce mental calmness viz., A [pronounced as aa-produces resonance in the abdomen region], U [pronounced as vu-produces resonance in the chest region], M [pronounced as mm-produces resonance in the head region] while in <i>tadasana</i> [is a starting pose for standing series of yoga postures]. These chants are done with eyes closed to enhance internalization of one's awareness.</p>
Breathing techniques (these are preparatory breathing practices to sensitize the practitioner about breathing and movement) 	<p>HANDS IN AND OUT BREATHING</p> <p>STARTING POSITION [<i>Sthiti</i>]: <i>Tadasana</i></p> <p>Practice:</p> <ul style="list-style-type: none"> • Stretch out your arms in front, in level with your shoulders & bring the palms together. While inhaling spread your arms sideways in the horizontal plane. • While exhaling bring the arms forward with palms touching each other. • Repeat five times, making your arm movements continuous, breath flowing in and out rhythmically. Synchronize breathing with arm movements. • Relax in <i>Tadasana</i>. Feel the changes in the breath and the body, especially the arms, shoulders and the back of the neck.
Loosening techniques	<p><i>PADA SANCALANA</i> (Cycling) in standing posture with forward-backward movement.</p> <p>STARTING POSITION [<i>Sthiti</i>] in <i>Tadasana</i>.</p> <p>Practice:</p> <ul style="list-style-type: none"> • Bring the right leg upwards and forwards and at the same time stretch the foot forward. Then move the leg backwards, now stretching the foot backward.

Technique	Description
<p>Twisting should be done above the waist level.....Keep the body below the waist straight and firmDo not bend your knees.</p> 	<p>Eventually making a circular movement as done while cycling.</p> <ul style="list-style-type: none"> • This makes it one round. Practice ten such rounds. • Repeat the same practice with the left leg. <p>NOTE:</p> <ul style="list-style-type: none"> • Do not bend the knee at any stage of the practice. • You can keep your hands on the waist, or can have wall support for proper balance. • The leg movement should be continuous. • Gradually increase the speed and mobility, within your limit • Raise the leg forward / backward as much as you can. <p>Specific precaution: Patients with neck & back pain, spondylitis, prolapsed intervertebral disc, high blood pressure, heart disease, glaucoma [increased pressure in the eyes] and retinal detachment should practice this technique with care and learn the comforting pace under the supervision of a trained yoga instructor.</p>
<p>Asanas: Physical postures</p> 	<p>1. ARDA-KATI-CHAKRASANA (Lateral Arc Posture): practiced separately from right and left side STARTING POSITION: <i>Tadasana</i>. Practice:</p> <ul style="list-style-type: none"> • While inhaling, slowly raise the right arm side ways up above the head until the biceps touch the ear, palm facing left. • Bend slowly on the left side; slide the left palm down as far as possible along the left leg.

Technique	Description
	<ul style="list-style-type: none"> • Exhale as you bend. Raised hand should not bend at the elbow. Knees straight. Breathe normally. Maintain the position for about a minute. • Inhaling completely slowly stretch up the trunk and the arm to vertical position. • Bring the hand down to <i>Sthiti</i> position on exhale. • Repeat on the left side, by bending towards the right.
	<p>2. SUKHASANA (Comfortable posture while seated on the floor)</p> <p>This is a posture where one sits on the floor in a cross legged position with the palms placed on the knees. If required, in the initial stages one can sit with support by placing the palms on the ground on either side.</p>
	<p>3. BADDHA-KONASANA (Butterfly posture and movement): <i>Sthiti: Dandasana</i> / leg stretched position while seated on the floor - this is a starting posture for sitting series.</p> <ul style="list-style-type: none"> • Bend the knees and bring the soles of the feet together. • Then pull them as close to the body as possible. The heels may touch the perineum, • If possible, completely relax the inner thigh muscles. <p>Practicing Butterfly Movement: STAGE - I (Clasping the feet with both hands).</p> <ul style="list-style-type: none"> • Clasp the feet with both hands.

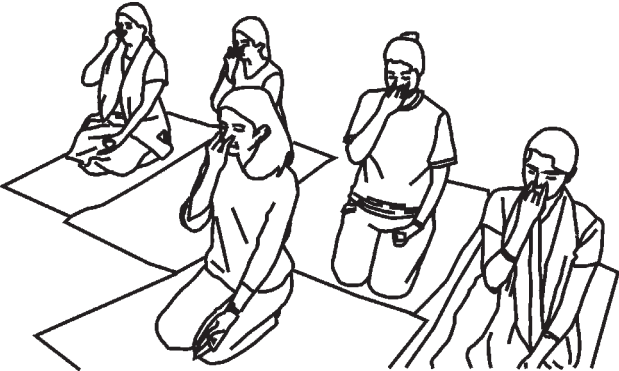
Technique	Description
	<ul style="list-style-type: none"> Now gently bounce the knees up and down, if required, using the elbows as levers to press the legs down. Try to touch the knees to the ground on the downward stroke. Practice 30 to 50 up and down movements. <p>STAGE - II (Hands on the knees).</p> <ul style="list-style-type: none"> Place the hands on the knees. Using the palms, gently push the knees down towards the floor, allowing them to spring up again. Repeat 20 to 30 times. Straighten the legs and relax in <i>dandasana</i>. <p>NOTE:</p> <ul style="list-style-type: none"> Do not force the movements. Try to keep the back, neck and head straight. Also keep the trunk still during the practice.
	<p>4. VAJRASANA (Diamond Posture)</p> <p><i>Sthiti: Dandasana</i> [leg stretched position]</p> <ul style="list-style-type: none"> By placing the left palm by the left side of the body, gently fold the right leg and place the right foot under the right buttocks. Similarly, gently fold the leg and place the left foot under the left buttocks. Now, firmly be seated on the ankles and feet fanning backwards. Place the palms on the knees and sit straight looking forward and then close the eyes.

Technique	Description
	<ul style="list-style-type: none"> • Maintain this posture with normal breath for a while. • Then slowly release the right foot and the right leg and then the left leg and the left foot. • Relax in the leg stretched position.
	<p>KAPALABHATHI KRIYA (High Frequency Yoga Breathing)</p> <p>STARTING POSITION: Sit in any meditative posture. Keep your spine, neck erect and perfectly vertical to the ground and keeping your eyes closed, shoulders collapsed and sit with the sense of complete relaxation.</p> <p>Practice:</p> <ul style="list-style-type: none"> • In this practice, exhalations will be very active and forceful whereas the inhalations will be totally passive and happening on its own. • In fact, it is done by blasting out the air and is accomplished by vigorous flapping movement of the abdomen in quick succession. • Inhale passively by relaxing the abdominal muscles at the end of each expulsion. • Repeat the expulsion as quickly as possible starting with 60 strokes or expulsions per minute and increasing with practice up to 120 expulsions per minute. • At the end of one minute, stop the practice. Now you will observe an automatic suspension of breath. In fact, there will be no urge for breathing.

Technique	Description
	<p>Simultaneously the mind achieves a state of silence. Enjoy this state of silence.</p> <ul style="list-style-type: none"> Then gradually, breathing resumes when you start breathing in and out slowly and then after few rounds breathing becomes normal. <p>NOTE:</p> <ul style="list-style-type: none"> Throughout the entire practice the spine must be kept erect. Otherwise, there is a possibility of hurting the spine because of the vigorous flapping of the abdomen. In the beginning it may not be possible for one to do the practice continuously for one minute and for so many expulsions or strokes. Therefore, one can start with 10 to 20 strokes or expulsions in one round without bothering for the time it takes and do it for 2 to 3 rounds. Once you get the technique of doing it properly, you can do it rapidly meeting the prescribed number of strokes. People with High BP, IHD, vertigo, epilepsy, Hernia, Gastric Ulcer, Slipped disc, Spondylosis should practice this with not more than 20 strokes. Also it is advised that women during menstruation and in pregnancy avoid this practice.

Technique	Description
	<p>1. Demonstration of hand gestures [<i>mudras</i>] used in the <i>pranayama</i> practice: While practicing pranayama the nostrils are manipulated by adopting a specific hand gesture called <i>mudra</i> where the index finger and middle fingers will be flexed against the palm keeping the thumb and other fingers extended. This <i>mudra</i> is illustrated in the figure. The ring and little finger will be used to regulate the breathing through the left nostril while the thumb is similarly used for the right nostril.</p>
	<p>2. SUKHA PRANAYAMA (Full Yogic Breathing) STARTING POSITION: Sit in any meditative posture viz., <i>sukhasana</i>, <i>padmasana</i> [lotus posture] or <i>vajrasana</i> [diamond posture]. Practice: There are three parts to the full yogic breathing : a) abdominal [where, lower portion of the lungs are filled with air-this is evident by bulging the abdomen forward]; b) thoracic [where the middle portion of the lungs are filled-this is evident by complete chest expansion] and c) clavicular [in this case the upper lobes are filled with the air-this is evident by the gentle elevation of the shoulder blades and collar bones] a) ABDOMINAL BREATHING OR DIAPHRAGMATIC BREATHING STARTING POSITION: Sit in any meditative posture. Practice:</p> <ul style="list-style-type: none"> Inhale deeply, slowly and continuously. This is called <i>puraka</i>, the abdomen is made to bulge continuously with the air entering specially in the lower section of the lungs.

Technique	Description
	<ul style="list-style-type: none"> • Before exhaling stop the breath (<i>antarya kumbhaka</i>) for a second. • While exhaling (<i>recaka</i>) the abdomen is drawn inwards continuously and slowly. • Before the breath is reversed, stop the breath (<i>bahya kumbhaka</i>) for a second and then inhale. • Repeat the breathing cycle. There should be no jerks in the whole process. It should be smooth, continuous and relaxing. • The diaphragm separating the thorax from the abdomen descends during inhalation with the bulging of the abdomen. This increases the airflow into the lower sections of the lungs. The rhythmic movement of the diaphragm massages the contents of the abdomen gently, and helps the organs to function normally. <p>b) THORACIC (CHEST) BREATHING OR INTERCOSTAL BREATHING)</p> <p>STARTING POSITION: Sit in any meditative posture.</p> <p>PRACTICE:</p> <ul style="list-style-type: none"> • In this practice perform inhalation and exhalation by expanding and contracting the chest. • The middle portion of the lungs is opened up fully by this type of breathing. <p>c) CLAVICULAR BREATHING</p> <p>STARTING POSITION: Sit in any meditative posture.</p> <p>Practice:</p> <ul style="list-style-type: none"> • Raise the collarbones while inhaling. Keep the abdominal muscles contracted. • The air is forced into the upper most regions of the lungs thus ventilating the upper lobes. The sparingly used upper

Technique	Description
	<p>lobes of the lungs will be properly aerated by this breathing.</p> <ul style="list-style-type: none"> • In full yogic breathing technique all the three types will be combined. • During inhalation, and exhalation the breathing sequence is combined i.e., abdominal thoracic and clavicular. • The whole process should be relaxing and comfortable with deep, slow and rhythmic breathing.
	<p>3) NADI SHUDHI/ANULOMA - VILOMA PRNAYAMA (Alternate Nostril Breathing)</p> <p>STARTING POSITION: Sit in any meditative posture</p>  <p>Practice:</p> <ul style="list-style-type: none"> • Close the right nostril with the right thumb by adopting <i>Nasika mudra</i> and exhale completely through the left nostril, then inhale deeply through the same left nostril. • Close the left nostril with your ring & small fingers of the right hand, then open the right nostril and exhale through the right

Technique	Description
	<p>nostril, again inhale through the right nostril.</p> <ul style="list-style-type: none"> • Then close the right nostril and exhale through the left nostril. This is one round of <i>Nadisuddhi pranayama</i>. • Repeat the practice for nine rounds. This practice also helps to maintain balance between <i>nadis</i>-the energy channels where the subtle energy [<i>prana</i>] flows and has shown to bring about autonomic balance.
	<p>4.) BHRAMARI PRANAYAMA (Humming Bee)</p> <p>Practice:</p> <ul style="list-style-type: none"> • Understand the M-kara [a sanskrit syllable known to produce resonance in the head region] and chant 'M kara [pronounced as mmm...]' a few times with closed lips, jaws gently open. • Place the index finger on the tragus-a pointed eminence of the external ear and press. • Then, take a deep breath and while exhaling start chanting 'M – kara'. • Longer the exhalation - longer the chanting. • Listen to the resonance after every chant and then repeat the 'M-kara' chanting. • Repeat for 5-10 times.
Guided relaxation in <i>Shavasana</i> (Corpse Posture)	<p>1. INSTANT RELAXATION TECHNIQUE</p> <p>STARTING POSITION: <i>Sthiti: Shavasana</i>.</p> <p>Practice:</p> <ul style="list-style-type: none"> • This is one of the guided relaxation techniques in which systematic stimulation and relaxation of each and every group of muscles of the body results in deeper relaxation to that part.

Technique	Description
	<p>Practice:</p> <ul style="list-style-type: none"> • Lie flat on your back keeping the heels and toes together, palms by the sides of your thighs, head and neck in one line with the spine. • Inhale and tighten your toes, ankles, feet and calves one after the other. Pull up the kneecaps, tighten thighs & squeeze the buttocks. • Exhale and the suck in the abdomen. Make a fist of your hands and tighten the arms. • Inhaling, expand your chest. Tighten your shoulders, neck and face. Tighten your whole body. Tighten ... Tighten ... Tighten. Release your breath and relax. <p>Note: <i>The above instruction should be completed within a minute</i></p>
	<p>2. DEEP RELAXATION TECHNIQUE:- STARTING POSITION: <i>Sthiti: Shavasana.</i> · Practice:</p> <p>Phase-I Bring your awareness to the tip of the toes, gently move your toes and relax. Sensitize [awareness through visualization] the soles of your feet, loosen the ankle joints, relax the calf muscles, pull up the knee caps, relax your thigh muscles, buttock muscles, loosen hip joints, relax pelvic region and the waist region. Totally relax your lower part of the body. R...e...l...a...x. Chant 'A' kara and feel the vibration in your lower parts of the body.</p> <p>Phase-II Gently bring your awareness to the abdominal region and observe the abdominal movement for a while, relax your abdominal muscles, relax the chest muscles. Gently bring your awareness on your lower back, relax your lower back, loosen all the vertebral joints one by one. Relax the muscles</p>



Technique	Description
	<p>and nerves around the back bones. Relax your middle back, shoulder blades and upper back muscles...totally relax. Shift your awareness to the tip of the fingers, gently move them a little and sensitize. Relax your fingers one by one. Relax your palms, loosen the wrist joints, relax the forearms, loosen the elbow joints, relax the hind arms- triceps, biceps and relax your shoulders. Shift your awareness to your neck, slowly turn your head to the right and left, again bring back to the center. Relax the muscles and nerves of the neck. Relax your middle part of the body totally relax. R...e...l...a...x. Chant 'U' kara and feel the vibration in your lower parts of the body.</p> <p>Phase-III</p> <p>Gently bring your awareness to your head region. Relax your lower jaw and upper jaw, lower and upper gums, lower and upper teeth and relax your tongue. Relax your palates-hard and soft, relax your throat and vocal chords.</p> <p>Gently shift your awareness to your lips, relax your lower and upper lips. Shift your awareness to your nose, observe your nostrils, and feel the warm air touching the walls of the nostrils as you exhale and fee: the cool air touching the walls of the nostrils as you inhale.</p> <p>Observe for a few seconds and relax your nostrils. Relax your cheek muscles, feel the heaviness of the checks and have a beautiful smile on your cheeks. Relax your eye balls muscles, feel the heaviness of eye balls, relax your eye lids, eye brows and in between the eye brows. Relax your forehead, temple muscles, ears the sides of the head, back of the head and crown of the head. Relax your head region totally relax. R...e...l...a...x. Chant 'M' kara and feel the vibration in your lower parts of the body.</p>



Technique	Description
	<p>Phase-IV Observe your whole body from toes to head and relax, chant A-U-M-kara together. Feel the resonance throughout the body.</p> <p>Phase-V Slowly come out of the body consciousness and visualize your body lying on the ground completely collapsed.</p> <p>Phase-VI Imagine the vast beautiful blue sky. The limitless blue sky. Expand your awareness as vast as the blue sky. Merge yourself into the blue sky. You are becoming the blue sky. You are the blue sky. Enjoy the infinite bliss. E .. N .. J .. O .. Y ... the blissful state of silence and all pervasive awareness.</p> <p>Phase-VII Slowly come back to body consciousness. Inhale deeply. Chant 'A-U-M-kara". Feel the resonance throughout the body. The soothing and massaging effect from toes to head.</p> <p>Phase-VIII Gently move your whole body a little. Feel the lightness, alertness and energy throughout the body. Slowly bring your legs together and the hands by the side of the body. Turn over to the left or the right side and come up when your are ready.</p> <p>Note: Shorter periods for patients with CMD</p>

Session 1 ends by addressing the participants' queries and instructions to them to return the next day when new techniques will be taught.

SESSION 2

Note: Practice one round of each of the techniques learnt in the first session and then move on to learn new techniques for the session.

Technique	Description
<p>Asanas Physical postures</p> 	<p>1) MAKARASANA (Crocodile Posture)</p> <p>STARTING POSITION: Lie down on the abdomen with the legs apart and toes pointing outwards. Arms stretched over the head and chin touching the floor.</p> <p>Practice:</p> <ul style="list-style-type: none"> • Bend the right arm and place the right palm on the shoulder. • Then, bend the left arm and place the left palm on the right shoulder. • Now allow the head to relax on to the folded arms so that the neck is supported at the point where the two arms cross. • Lie down and relax in this position for sometime.
	<p>2) BHUJANGASANA (Cobra Posture)</p> <p>STARTING POSITION: <i>Sthiti: Makarasana</i> -</p> <p>Practice:</p> <ul style="list-style-type: none"> • Bring the palms to the level of the last rib bone and place them on the ground. Keep the hands bent at elbows; least pressure to be exerted on the hands. Maintain the elbows touching the body and let it not spread out. • Raise the head first and then the upper portion of the trunk slowly, till the navel portion, just as the cobra raises its hood. Arch the dorsal spine well. Keep the body below the navel straight and in touch with the ground. Maintain this position for a minute. • Come back to <i>Sthiti</i> position & relax in <i>Makarasana</i>.

Technique	Description
	<p>3) PAVANAMUKTASANA (Leg Lock Posture)</p> <p>STARTING POSITION [<i>Sthiti</i>]: <i>shavasana</i>.</p> <p>Practice:</p> <ul style="list-style-type: none"> • Raise the right leg keeping it straight about 45° from the ground. Keep the left leg firmly on the ground. Inhale partially. • Place the right leg perpendicular to the ground with inhalation. • Bend the right leg and press the knees over the chest by holding the legs by interlocked fingers of the hand. Exhale and bring the knee to touch the chin. • Maintain this position for one minute with normal breathing • Return to <i>Sthiti</i> position. • Repeat with the left leg.
A preparatory <i>kriya</i> [internal cleansing and activating breathing practice]	<p>KAPALABHATHI KRIYA (High Frequency Yoga Breathing):</p> <p>As described in the session 1.</p>
<i>Pranayama</i> – Voluntarily regulated breathing practices	<p>SUKHA PRANAYAMA (Full Yoga Breathing):</p> <p>As described in the session 1.</p> <p>NADI SHUDHI/ANULOMA-VILOMA PRNAYAMA (Alternate Nostril Breathing)</p>
<p>Guided relaxation in <i>Shavasana</i></p> 	<p>BHRAMARI PRANAYAMA (Humming Bee)</p> <ol style="list-style-type: none"> 1. Instant relaxation technique: 2. Deep relaxation technique: <p>Note: Shorter periods for patients with CMD</p>
At the end of session 2, participants' queries are addressed and they are asked to return the next day.	

SESSION 3:

In this session patients would practice techniques learnt in the first two sessions. Hence this session is a complete session of yoga therapy program for anxiety and depression. In this session the focus would be to check the accuracy of practice, understanding the sequence and completing the session within the time allotted for the session.

Technique	Description
<i>Tadasana</i>	
Breathing techniques	Hands in and out (sideways) As described in session 1.
Loosening techniques	<i>PADA SANCALANA</i> []
<i>Asanas: Physical postures</i>	<ol style="list-style-type: none"> 1. <i>Arda-kati-chakrasana:</i> (Practiced separately from right and left side) 2. <i>Bhujangasana</i> 3. <i>Makarasana</i> 4. <i>Pavanamuktasana</i> 5. <i>Sukhasana</i> 6. <i>Baddha-konasana</i> 7. <i>Vajrasana</i>
<i>Kriya-Internal cleansing technique</i>	<i>Kapalabhathi kriya</i>
<i>Pranayama-Voluntarily regulated yoga breathing</i>	<ol style="list-style-type: none"> 1. <i>Sukha pranayama/:</i> 2. <i>Nadi shudhi/Anuloma-viloma prnayama</i> [alternate nostril breathing] 3. <i>Bhramari pranayama</i> [humming bee practice]
<i>Guided relaxation in Shavasana</i>	<ol style="list-style-type: none"> 1. Instant relaxation technique 2. Deep relaxation technique
Note: <i>Shorter periods for patients with CMD</i>	

At the end of session 3, the importance of regular practice is emphasised and patients are offered weekly review sessions if they wish to avail of these.

Weekly review session

Weekly review session is meant to monitor the quality of practice, provide clarifications [if required], discuss the compliance [preferably through daily diary], deal with the difficulties encountered, and provide solutions for any side effects [if any].

Sr. No.	Common difficulties	Recommended solutions
1	First day syndrome: painful muscles	Giving a break here aggravates the pain. Hence low intensity session is recommended.
2	Forgetting the name of the practice	Working with the chart helps.
3	Forgetting the sequence of practice	Sequence is important as it gives the session a smooth flow viz., standing series; prone series; supine series; sitting series; <i>pranayama</i> practice in sitting position and finally <i>shavasana</i> in the supine position. This sequence ensures complementary postures are practiced which is essential in preventing injuries.
4	Forgetting the final posture	All the postures are taught by counts. This helps to keep track of the posture
5	Breathing pattern while practicing the postures	Inhalation is done while bending backwards and exhalation while bending forward. In the final posture normal breathing is maintained. This has to be ensured during the review session.
	Flexibility	On a given day, the practitioner should listen to body signals and skip those practices which hurt.
6	Practicing pranayama	While practicing <i>pranayama</i> one has maintained 1:2 ratios for inhalation and exhalation. This should be ensured and at no point the practitioner should hold the breath unless it is part of the practice
7	Guided relaxation	The sequence and the instructions decide the quality of the relaxation. Hence in the review session the familiarity to the instructions has to be checked.
8	Guidelines during the menstrual period	Patients should be encouraged to be flexible with the time of the practice rather than missing a session for the day. The basic rule of practicing 2 hours after the last meal should be followed.
9	Flexibility in the time of the practice	During this period the emphasis should be to practice breathing exercise, <i>pranayama</i> [except <i>kapalbhati kriya</i>] and guided relaxation

5.6i Basic instructions to practice yoga

- Yoga is best practiced on an empty stomach (*except Sukhasan /Vajrasan*), i.e., 90 min to 120 min after a meal.
- Yoga is to be practiced regularly, preferably once daily.
- Early hours of the day are the recommended time for yoga.
- Immediate beneficial results should not be expected. With regular practice one can experience the proven health benefits. Ladies are instructed to not to practice certain techniques during menstrual period / pregnancy. These include: generally those practices which compress abdominal cavity viz., *kapalabhati kriya*, forward bending postures, *bhujangasana*, *pavanamuktasana* and *badha konasana*. Yoga should be practiced with utmost relaxation with a sense of self awareness.
- Do not force yourself to carry out any technique; note body signals such as pain which tells you not to continue or complete the technique
- Avoid comparing yourself with others since each person is different considering various factors like age, body flexibility, medical history, pain – threshold etc.
- It is described that yoga when practiced properly results in health benefits and can produce side effects when practiced wrongly. Hence yoga should be learnt in two phases, i.e., learning phase and self-observation phase. This ensures the quality of the practice and prevents the harmful effects [if any].

5.6j Important points for yoga teachers

- Follow the prescribed style, school and the method.
- Use an elevated space for demonstration.
- Use charts showing body structure (anatomy) to explain the techniques.
- Use a white / black board and yoga charts and illustrations of techniques.
- Follow the same dress code as for participants
- Practice yoga regularly to experience health benefits. Then, you can confidently motivate patients to comply with the yoga intervention.
- Study / prepare well before each session. Avoid looking into notes / the manual while conducting sessions.
- Practice giving lessons / instructions.
- Contact the consultant for any clarifications.

5.6k Essential requirements for practicing yoga

- A well ventilated space.
- Preferably quiet.
- People should not walk through the hall during a session, i.e., it cannot be a thoroughfare.
- The temperature should be comfortable.
- Soft mats made of cotton or professional yoga mats
- Loose clothing to practice at ease.
- Course materials viz., posters, illustrations and books.

Summary :

- ✧ Yoga is an ancient Indian science and a way of life.
- ✧ Practicing yoga is shown to have stress reducing effects.
- ✧ There is evidence supporting the use of yoga in the management of anxiety and CMD.
- ✧ Of all the styles, an integrated approach where a combination of asanas, kriyas, pranayamas, relaxation and meditation are used, is expected to produce best results.
- ✧ Regular practice and attendance at review sessions is necessary to ensure maximum benefit.
- ✧ Yoga is not a core element of the MANAS model but can be a useful adjunct therapy in the management of CMD.

Appendix 5.7 Collaborative Stepped Care Intervention Quick Reference

Step	For whom	Timing	Treatment	By
Recognition	Adult patients attending primary care clinics	Before consultation with doctor	GHQ Screening questionnaire; report for doctor	Secretary/ registration clerk/HC
1	Patients screened with CMD (GHQ >5)	At first consultation	Advice regarding screening questionnaire results; advice regarding seeing HC Psychoeducation and follow up appointment as appropriate Information about Yoga sessions	Doctor HC HC
2	Patients who are severely ill at first consultation (GHQ>7) or whose symptoms persist at follow-up	At first consultation or at first follow up at 2-4 weeks	Antidepressants Psychoeducation Adherence Management	Doctor HC HC
3	For patients who remain unwell or are not adherent	Patients who do not respond to Step 2 despite taking the treatment	Antidepressants & IPT Adherence Management	Doctor HC HC
4	For participants who do not respond despite good adherence	Patients who do not respond to Step 3 despite taking the treatment & patients who are expressing suicidal ideas at any time	Continue all existing treatments Refer to Mental Health Specialist	HC & Doctor Mental Health Specialist

Appendix 5.8: IPT Clinical Record

Individual IPT Clinical Record				
Individual Sessions				
Patient Name _____ Patient ID: _____				
Session No ____ Date: _____ Health Counsellor : _____				
Symptoms: (Tick ones applicable)				
Symptoms	Tick	Improved	Same	Worst
Sleep problems				
Aches and pains/ Worry about physical health				
Poor Concentration/ Memory				
Fatigue/ Lack of interest				
Panic attacks/ Phobias				
Suicidal ideas				

List Problem area(s) identified: _____

Interpersonal inventory: _____

(Notes on relationships): _____

Goals : _____

Brief description on what was covered during session: _____

Plan for next session: _____

Appendix 5.9: Mapping Tool for the Clinics

CLINIC DETAIL SHEET

1. Clinic Details:

Clinic Name: _____ Tel No: _____

Clinic Address: _____

2. Staff in the Clinic:

Staff designation	Number
PHC Director	
PHC doctors	
PHC nurses	
Pharmacist	
Registration person	
Other support staff in the PHC	
Field staff: ANM's Education officer MPHW's	
Other community health workers ASHA workers	

3. Other Details:

- No. of patients attending the clinic per month : _____
- No. of adult patients attending clinic per month: _____
- No. of new patients registered per month: _____
- Transport facility available to reach clinic: Bus ☐ Taxi ☐
- Availability of space:
 - a) For storing files
 - b) For displaying posters
 - c) For Yoga sessions
 - d) Who will conduct screening and where
 - e) For Health Counselor
- Nearest post office details: _____

4 Registration Procedure:

- Case papers are given to patients or kept in clinic.
- In case of key person's absence, who is responsible his/her duty?

Common mental health problems like depression and anxiety (collectively referred to as "Common Mental Disorders", or CMD in short) are a major public health concern in all countries. The MANAS program was set up in Goa, India, to develop and evaluate a model for delivering treatments for CMD in primary care settings where most patients go for help.

The essence of the MANAS model is to facilitate mental health care tasks to be shifted from specialists to lay Health Counselors (who would be similar to other more widely available health workers) within a primary care team and thus improve the coverage and efficiency of treatments for CMD.

To be an effective practitioner, the HC will need to acquire the set of essential theoretical and practical skills that are described in this manual. The manual is organized as a series of chapters:

Chapter 1 introduces the essential theoretical basis for understanding CMD, including its relation to stress, detection and diagnosis.

Chapter 2 describes the principles and the structure of the program and introduces some essential cross cutting sections that are of importance to the program.

Chapter 3 describes the different individual treatments that are part of the overall intervention, in detail.

Chapter 4 discusses the actual delivery of the intervention and describes the operational details of the program, including the structure of the primary care team, recommended supervision, documentation requirements and strategies to enable integration within the clinics.

Chapter 5 consists of the Appendices that are relevant to the program for persons with CMD.

This manual and its accompanying material is also intended as a resource for those involved in the training of Health Counselors to deliver mental health treatments for patients with CMD.



Managing Common Mental Disorders in Primary Care

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