

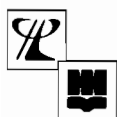
# **Diagnostic and Management Guidelines for Mental Disorders in Primary Care**

**ICD-10 Chapter V Primary Care Version**

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# Foreword

Mental and behavioural disorders are a major public health problem. These disorders are frequent in societies and cultures, they cause a great amount of disability and suffering among those affected, as well as considerable distress among friends and family members. Yet while all societies extend sympathy and some degree of assistance to those who are physically ill, attitudes to the mentally ill all too often include rejection and stigma.

The many millions who suffer mental and behavioural disorders deserve both our respect and our assistance. The World Health Organization has consistently encouraged research into the treatment of mentally ill persons and has stressed that approaches to mental ill-health should be fundamentally the same as approaches to physical ill-health. Our knowledge of mental illness and its causes is now such that the treatment of mentally ill persons has become routine in many parts of the world. Different disorders can be diagnosed with accuracy and treated with reliable and effective methods. Nevertheless, in many places such treatment is not available and negative attitudes to the mentally ill still persist.

The World Health Organization is developing a range of clinical tools to assist primary care practitioners (even without psychiatric training) and community health workers (even without advanced medical training) to deal appropriately with the mentally ill persons with whom they come into contact. The first of those tools is this book – a classification of mental and behavioural disorders that guides diagnosis, advises on counselling, recommends treatment and indicates when referral is likely to be necessary. It uses the primary care approach which has been so successfully used in the treatment of physical ill-health around the world.

The secrecy that attends mental and behavioural disorders frequently conceals the size of the problem. We must be honest enough to face up to mental illness, informed enough to recognize it for what it is, and open enough to enlist the help of family and community members in its treatment. Mental illness is, after all, only illness, and in most cases, with the right kind of help, it can be overcome. We owe it to those who have this type of illness to provide the help they need before their illness develops to a more serious state.

*Professor Jorge Alberto Costa e Silva  
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and Prevention of Substance Abuse  
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# Preface

Primary care encompasses both a philosophy of health development as well as a health service level. The philosophy stresses the need for comprehensive coverage of health problems in communities, providing promotive, preventive, curative and rehabilitative services. At the service level this means that primary care should cover all basic aspects of health. This book has been written to ensure that, at the level of service provision, mental health becomes an integral part of the primary care practice.

Mental disorders are common in the primary care settings. They are more disabling than many chronic and severe diseases; they do not easily get better or limit themselves without treatment. Although simple, effective and acceptable treatments are available, they are not utilized sufficiently. There is therefore a need to improve the identification and management of mental disorders at the primary care level.

Today there is ample scientific evidence that mental disorders are medical illnesses. Work on the criteria for mental disorders has enabled us to define these illnesses with accuracy and reliability. Many mental disorders such as depression, panic disorder and bipolar disorder can be treated more effectively than hypertension and coronary heart disease. This treatment must become an integral part of the work of primary care physicians.

The World Health Organization (WHO) has developed a state-of-the-art classification of mental disorders for use in clinical practice and research. The *Tenth Revision of the International Classification of Diseases (ICD-10)* has many features that improve the diagnosis of mental disorders. To extend this development to primary care settings, where most patients with mental disorders are seen, diagnostic and management guidelines have been combined in the present book, *Diagnostic and Management Guidelines for Mental Disorders in Primary Care (ICD-10 Chapter V, Primary Care Version)*, referred to here as ICD-10 PC Chapter V.

ICD-10 PC Chapter V has been prepared in the light of the experience of primary care physicians and takes into account their needs. It is short, user-friendly and oriented towards management. The book contains essential information on how to help patients with mental disorders. It gives guidelines for diagnosis in cases where the primary care physician has to do this task alone. It also gives guidelines on what to say to patients and their families, how to give them counselling, what medication to prescribe, and when to consult a specialist. In short ICD-10 PC Chapter V presents the knowledge of mental health science in an easily understandable form for the practitioner at the primary care level.

The primary care version of the mental disorders classification was designed by an international group of general practitioners, family physicians, mental health workers, public health experts, social workers, psychiatrists and psychologists with a special interest in mental health problems in primary care. Drafts were reviewed by mental health care providers and primary care providers. After two rounds of revision, the classification system was field-tested in more than 40 countries by over 500 primary care physicians to assess its relevance, ease of use and reliability.

This primary care classification system provides a model for national adaptation and allows for other changes as appropriate. WHO is currently developing methods for improving the diagnostic assessment of mental disorders (e.g., brief screening tools), as well as educational programmes for training workers at the primary care level in the fields of mental health and substance use (e.g., training kits for individual use or group-learning). WHO and the network of Collaborating Centres that developed the classification system are making efforts to get it disseminated more widely and adapted to local needs in different countries. These efforts are being

accompanied by a research strategy to evaluate whether this classification system actually improves identification and management.

WHO would be pleased to see the primary care version of the mental disorders classification become part of all medical curricula, since it sets out precisely what a general practitioner should know in diagnosing and treating mental health problems. WHO is ready to assist users in adapting the classification to their national needs, incorporating it into computer systems, and improving consultation and assessment. This book has been prepared as a practical response to the need to improve the diagnosis and management of mental disorders by primary care physicians. Continuing efforts are being made to improve this response, and it is hoped that users of the book will provide feedback to help in this. Please send us your comments and suggestions to improve ICD-10 primary care version of the mental disorders classification.

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# Introduction

This primary care version of the mental disorders classification (ICD-10 PC Chapter V) deals with conditions which are frequently seen in primary care and which can be managed effectively by general practitioners. For each condition, diagnostic and management guidelines are given on facing pages. The management guidelines include information for the patient, advice on counselling, descriptions of treatment methods, and indications for specialist referral. They are supported by a set of flow charts to aid diagnostic decision-making. National adaptations of the guidelines may include the production of medication cards for physicians and information leaflets for patients. The primary care version of the classification of mental disorders is tailored to the needs of general practitioners worldwide and corresponds to Chapter V of the Tenth Revision of the International Classification of Diseases (ICD-10). The primary care version has been designed to be:

- brief and easy to understand
- user friendly
- a source of advice on management (including treatment)
- compatible with ICD-10 Chapter V
- reliable for assessment in primary care settings (i.e., so that different users may reach the same diagnosis).

Use of the classification in education and training was also regarded as important. The system can be learned easily by primary care personnel in different parts of the world.

## The categories

The book contains a list of categories of mental disorders from the ICD-10 classification.

This is the result of a selection process that reflects:

- the public health importance of disorders (i.e., prevalence, morbidity or mortality, disability resulting from the condition, burdens imposed on the family or community, health care resources need);
- availability of effective and acceptable management (i.e., interventions with a high probability of benefit to the patient or her/his family are readily available within primary care and are acceptable to the patient and the community);
- consensus regarding classification and management (i.e., a reasonable consensus exists among primary care physicians and psychiatrists regarding the diagnosis and management of the condition);
- cross-cultural applicability (i.e., suggestions for identification and management are applicable in different cultural settings and health care systems);
- consistency with the main ICD-10 classification scheme (i.e., each diagnosis and diagnostic category corresponds to those in ICD-10).

All diagnoses included in this book are fairly common in primary care settings and a management plan can be written for each of them. The list of categories is standard and is used internationally, although categories of disorder that are reported infrequently in a particular country (such as eating disorders in India or dissociative disorders in the United Kingdom) may be omitted from the lists normally used in those places. The management guidelines may, how-

ever, vary according to the country, the health care system and the training of health care workers.

## The guidelines

The headings for diagnostic information on each category of disorder are:

- *Presenting complaints* – problems typically seen in primary care patients (to avoid repetition, those presented as diagnostic features are not restated);
- *Diagnostic features* – a concise version of ICD-10 diagnostic guidelines;
- *Differential diagnosis* – other physical or mental conditions that should be considered when making a diagnosis.

The management plan that follows each diagnosis can be modified to suit local conditions. The general headings for the management guidelines are:

- *Essential information for patient and family* – general information about the disorder, such as its nature or cause;
- *Specific counselling for patient and family* – advice and psychotherapeutic strategies concerning the particular condition (how to cope, what to do, etc.);
- *Medication* – advice on the use of drugs (how to use, effects, side-effects, ways to increase compliance);
- *Specialist consultation* – indications on when and how to refer to a specialist.

The guidelines contain information that is considered essential for all patients. In addition, leaflets are being prepared to help patients understand the management strategies (e.g., a guide to sensible drinking or learning to relax)

## The symptom index and flow charts

A “symptom index” (see pages 92–93) provides different entry points to the classification system (e.g., differential diagnostic indexes for key symptoms such as appetite loss, tiredness, insomnia, anxiety, fears, inattention, etc.).

Flow charts (see pages 94–95) that accompany the primary care classification are intended to facilitate learning and assist general practitioners in their everyday decision-making. The flow charts show the sequence of diagnostic decisions that a general practitioner makes in the identification of mental disorders.

In view of the increasing role of computers in primary care settings in some parts of the world, WHO is also exploring possibilities of developing a simple computerized system to guide primary care physicians in making diagnoses.

## Two versions of the primary care classification

There are at least two major groups of primary care practitioners: (1) those with medical training and prescription responsibility; (2) others with limited medical training. Usually these work as “primary care teams” as a desirable way of work. Therefore, the ICD-10 PC Chapter V contains two versions:

- a concise version (containing 25 conditions) for those with medical training (1),
- a brief version (containing 6 conditions) for other primary care workers (2).

## Crosswalks to ICD-10 Chapter V

The ICD-10 PC Chapter V mental disorders classification, primary care version, is a “user-friendly” version of the Tenth Revision of the International Classification of Diseases (ICD-10) Chapter V. For practical reasons, the ICD-10 PC is a condensed version of ICD-10 Chapter V for easy application in busy primary care settings. It has 25 categories instead of 457 in the main ICD-10 Chapter V. The ICD-10 PC Chapter V intends to cover the universe of mental disorders seen in primary care settings. As a classification, it is “jointly exhaustive and mutually exclusive”. It may seem simplistic; however, it corresponds to the ICD-10 main volume. Appendix 1 is a crosswalk that shows the “lumping” of the detailed specialty-adaptation categories into ICD-10 PC categories.

## Field trials

Field trials of the primary care classification of mental disorders were conducted in 40 countries with more than 500 primary care physicians. The field trials assessed the adequacy, ease of use and consistency of the classification in different settings and tested the appropriateness of the management guidelines in different cultures and health care systems. Modifications were made in the light of this experience, resulting in the present publication.

## Acknowledgements

The primary care classification of mental disorders would not have been possible without the advice, support and collaboration of primary care workers, researchers, WHO Collaborating Centres and other agencies. WHO wishes to express its particular thanks to the following for their valuable collaboration:

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## **World Psychiatric Association**

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A full list of participating investigators is provided in Appendix 2 on pages 86–88.

Ms G. Covino carried out the secretarial and administrative work. Mr M. Privett and Ms M. Lotfy carried out the data collection and analyses for the field trials.

The overall management and coordination of the project was made by Dr. T.B. Üstün.

# **Concise Version for Primary Care Physicians**



## Categories of mental and behavioural disorders

Code	Disorder
F00#	Dementia
F05	Delirium
F10	Alcohol use disorders
F11#	Drug use disorders
F17.1	Tobacco use disorders
F20#	Chronic psychotic disorders
F23	Acute psychotic disorders
F31	Bipolar disorder
F32#	Depression
F40	Phobic disorders
F41.0	Panic disorder
F41.1	Generalized anxiety
F41.2	Mixed anxiety and depression
F43.2	Adjustment disorder
F44	Dissociative (conversion) disorder
F45	Unexplained somatic complaints
F48.0	Neurasthenia
F50	Eating disorders
F51	Sleep problems
F52	Sexual disorders
F70	Mental retardation
F90	Hyperkinetic (attention deficit) disorder
F91#	Conduct disorder
F98.0	Enuresis
Z63	Bereavement disorders
F99	Mental Disorder, Not Otherwise Specified
U50#	Unused/temporarily unassigned to any category

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

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

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

# Dementia – F00#

## Presenting complaints

Patients may complain of forgetfulness or feeling depressed, but may be unaware of memory loss. Patients and family may sometimes deny severity of memory loss.

Families ask for help initially because of failing memory, change in personality or behaviour. In the later stages of the illness they seek help because of confusion, wandering or incontinence.

Poor personal hygiene in an older patient may indicate memory loss.

## Diagnostic features

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

Tests of memory and thinking may include:

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

## Differential diagnosis

**Examine for other illnesses causing memory loss.** Examples include:

depression (F32#)	anaemia
urinary infection	B12 or folate deficiency
subdural haematoma	syphilis
other infectious illnesses	HIV infection
normal pressure hydrocephalus	

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



# Dementia F00# – management guidelines

## Essential information for patient and family

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

## Counselling of patient and family

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

## Medication

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

## Specialist consultation

Consider consultation for:

- uncontrollable agitation
- sudden onset or worsening of memory loss
- physical causes of dementia requiring specialist treatment (e. g., syphilis, subdural haematoma).

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

# Delirium – F05

## Presenting complaints

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

## Diagnostic features

### Acute onset of:

- **confusion** (patient appears confused, struggles to understand surroundings)
- **clouded thinking or awareness**.

### Often accompanied by:

Poor memory	agitation
emotional upset	loss of orientation
wandering attention	hearing voices
withdrawal from others	visions or illusions
suspiciousness	disturbed sleep
	(reversal of sleep pattern)

Symptoms often develop rapidly and may change from hour to hour.

May occur in patients with previously normal mental function or in those with dementia. Milder stresses (medication, mild infections) may cause delirium in older patients or in those with dementia.

## Differential diagnosis

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

- alcohol intoxication or withdrawal
- drug intoxication or withdrawal (including prescribed drugs)
- severe infections
- metabolic changes (e. g., liver disease, dehydration, hypoglycaemia)
- head trauma
- hypoxia

If symptoms persists, delusions and disordered thinking predominate, and no physical cause is identified, see *Acute psychotic disorders – F23*.

## Delirium F05 – management guidelines

### Essential information for patient and family

- Strange behaviour or speech are symptoms of an illness.

### Counselling of patient and family

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

### Medication

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

### Specialist consultation

Consider specialist consultation for:

- physical illness requiring specialist treatment
- uncontrollable agitation.

# Alcohol use disorders – F10

## Presenting complaints

Patient may present with:

- depressed mood
- nervousness
- insomnia
- physical complications of alcohol use (ulcer, gastritis, liver disease)
- accidents or injuries due to alcohol use
- poor memory or concentration

There may also be:

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

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

## Diagnostic features

**Harmful alcohol use:**

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

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

**Alcohol dependence:**

- **continued alcohol use despite harm**
- **difficulty controlling** alcohol use
- **strong desire to use** alcohol
- **tolerance** (drinks large amounts of alcohol without appearing intoxicated)
- **withdrawal** (anxiety, tremors, sweating after stopping drinking).

## Differential diagnosis

- Reducing alcohol use may be desirable for some patients who do not fit the above guidelines.
- Symptoms of anxiety or depression may occur with heavy alcohol use. If these continue after a period of abstinence, see *Depression – F32#*, and *Generalized anxiety – F41.1*.

# Alcohol use disorders F10 – management guidelines

## Essential information for patient and family

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

## Counselling of patient and family

For patients **willing to stop now**

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

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

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

For patients **not willing to stop or reduce use now**

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

For patients who do not succeed or relapse

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

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

## Medication

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

## Specialist consultation

Specialized counselling programmes for alcohol dependence should be considered, if available.

# Drug use disorders – F11#

## Presenting complaints

Patients may have:

- depressed mood
- nervousness
- insomnia
- physical complications of drug use
- accidents or injuries due to drug use.

There may also be:

- unexplained change in behaviour, appearance, or functioning
- denial of drug use
- complaints of pain or direct request for prescriptions for narcotics or other drugs
- legal and social problems due to drug use (marital problems, missed work).

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

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

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

## Diagnostic features

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

## Differential diagnosis

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

## Drug use disorders F11# – management guidelines

### Essential information for patient and family

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

### Counselling of patient and family

For patients **willing to stop now**

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

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

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

For patients **not willing to stop or reduce use now**

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

For patients who do not succeed or relapse

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

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

### Medication

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

### Specialist Consultation

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

## Chronic psychotic disorders – F20#

### Presenting complaints

Patients may present with:

- difficulties with thinking or concentration
- reports of hearing voices
- strange beliefs (e. g., having supernatural powers, being persecuted)
- extraordinary physical complaints (e. g., having animal or unusual objects inside one's body)
- problems or questions related to antipsychotic medication.

There may be problems in managing work or studies.

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

### Diagnostic features

Chronic problems with the following features:

- **social withdrawal**
- **low motivation or interest, self-neglect**
- **disordered thinking** (exhibited by strange or disjointed speech).

Periodic episodes of:

- **agitation or restlessness**
- **bizarre behaviour**
- **hallucinations** (false or imagined perceptions, e. g., hearing voices)
- **delusions** (firm beliefs that are plainly false, e. g., patient is related to royalty, receiving messages from television, being followed or persecuted).

### Differential diagnosis

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

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

Chronic intoxication or withdrawal from alcohol or other substances (stimulants, hallucinogens) can cause psychotic symptoms. See *Alcohol use disorders – F10* and *Drug use disorders – F11#*.



# Chronic psychotic disorders F20# – management guidelines

## Essential information for patient and family

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

## Counselling to patient and family

- **Discuss treatment plan with family members** and obtain their support for it.
- **Explain that drugs will prevent relapse** and inform patient of side-effects.
- **Encourage patient to function at the highest reasonable level in work and other daily activities.**
- Encourage patient to respect community standards and expectations (dress, appearance, behaviour).
- **Minimize stress** and stimulation:
  - **do not argue with psychotic thinking**
  - **avoid confrontation** or criticism
  - during periods when symptoms are more severe, rest and withdrawal from stress may be helpful.
- Refer to *Acute Psychosis – F23* for advice on the management of agitated or excited states.

## Medication

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

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

Inform patient of potential side-effects. Common motor side-effects include:

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

## Specialist consultation

If facilities exist, consider consultation for all new cases of psychotic disorder.

Depression or mania with psychotic symptoms may need other treatment. Consider consultation to clarify diagnosis and ensure most appropriate treatment.

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

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

## Acute psychotic disorders – F23

### Presenting complaints

Patients may experience:

- hearing voices
- strange beliefs or fears
- confusion
- apprehension.

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

### Diagnostic features

**Recent onset of:**

- **hallucinations** (false or imagined sensations, e. g., hearing voices when no one is around)
- **delusions** (firmly held ideas that are plainly false and not shared by others in the patient's social group, e. g., patients believe they are being poisoned by neighbours, receiving messages from television, or being looked at by others in some special way)
- **agitation or bizarre behaviour**
- **disorganized or strange speech**
- **extreme and labile emotional states.**

### Differential diagnosis

Physical disorders which can cause psychotic symptoms include:

- epilepsy
- intoxication or withdrawal from drugs or alcohol
- infectious or febrile illness.

Refer to card on *Delirium – F05* for other potential causes

If psychotic symptoms are recurrent or chronic, also see *Chronic psychotic disorders – F20#*.

If symptoms of mania (elevated mood, racing speech or thoughts, exaggerated self-worth) are prominent, the patient may be experiencing a manic episode. See *Bipolar disorder – F31*.

If low or sad mood is prominent, also see *Depression F32#*.

## Acute psychotic disorders F23 – management guidelines

### Essential information for patient and family

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

*Advise family about legal issues related to mental health treatment.*

### Counselling of patient and family

- Ensure the **safety** of the patient and those caring for him/her:
  - family or friends should stay with the patient
  - ensure that the patient's basic needs (e.g., food and drink) are met
  - take care not to harm the patient.
- **Minimize stress** and stimulation.
  - **do not argue with psychotic thinking** (you may disagree with the patient's beliefs, but do not try to argue that they are wrong).
  - **avoid confrontation** or criticism unless it is necessary to prevent harmful or disruptive behaviour.
- Agitation which is dangerous to the patient, the family or the community requires hospitalization or close observation in a secure place. If patients refuse treatment, legal measures may be needed
- Encourage resumption of normal activities after symptoms improve.

### Medication

**Antipsychotic medication will reduce psychotic symptoms** (e.g., haloperidol 2–5 mg up to three times a day or chlorpromazine 100–200 mg up to three times a day). The dose should be the lowest possible for the relief of symptoms, though some patients may require higher doses.

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

Continue antipsychotic medication for at least three months after symptoms resolve.

Monitor for side-effects of medication:

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

### Specialist consultation

If possible, consider consultation for all new cases of psychotic disorder.

In cases of severe motor side-effects or the appearance of fever, rigidity, hypertension, stop antipsychotic medication and consider consultation.

## Bipolar disorder – F31

### Presenting complaints

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

### Diagnostic features

**Periods of mania with:**

- |                                      |                                      |
|--------------------------------------|--------------------------------------|
| <b>increased energy and activity</b> | <b>elevated mood or irritability</b> |
| rapid speech                         | loss of inhibitions.                 |
| decreased need for sleep             | increased importance of self         |

The patient may be easily distracted.

The patient may also have **periods of depression with:**

- **low or sad mood**
- **loss of interest or pleasure.**

The following associated symptoms are frequently present:

- |                                  |                                   |
|----------------------------------|-----------------------------------|
| disturbed <b>sleep</b>           | poor <b>concentration</b>         |
| <b>guilt</b> or low self-worth   | disturbed <b>appetite</b>         |
| <b>Fatigue</b> or loss of energy | <b>suicidal</b> thoughts or acts. |

Either type of episode may predominate.

Episodes may be frequent or may be separated by periods of normal mood.

In severe cases, patients may have hallucinations (hearing voices, seeing visions) or delusions (strange or illogical beliefs) during periods of mania or depression.

### Differential diagnosis

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

## Bipolar disorder F31 – management guidelines

### Essential information for patient and family

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

### Counselling to patient and family

- **During depression, ask about risk of suicide.** (Has the patient frequently thought of death or dying? Does the patient have a specific suicide plan? Has he/she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas?) Close supervision by family or friends may be needed. Ask about risk of harm to others (see *Depression – F32#*).
- During manic periods:
  - avoid confrontation unless necessary to prevent harmful or dangerous acts
  - advise caution about impulsive or dangerous behaviour
  - close observation by family members is often needed
  - if agitation or disruptive behaviour are severe, consider hospitalization.
- During depressed periods, consult management guidelines for depression (see *Depression – F32#*).

### Medication

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

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

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

Lithium will help relieve mania and depression and can prevent episodes from recurring. Alternative medications include carbamazepine and valproate. If lithium is prescribed:

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

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

### Specialist consultation

Consider consultation:

- if risk of **suicide or disruptive behaviour** is severe
- if **significant depression or mania** continues.

## Depression – F32#

### Presenting complaints

The patient may present initially with one or more physical symptoms (fatigue, pain). Further enquiry will reveal depression or loss of interest.

Irritability is sometimes the presenting problem.

Some groups are at higher risk (e.g., those who have recently given birth or had a stroke, those with Parkinson's disease or multiple sclerosis).

### Diagnostic features

- **Low or sad mood**
- **Loss of interest or pleasure**

The following associated symptoms are frequently present:

disturbed **sleep**

**guilt** or loss of self-confidence

**fatigue** or loss of energy or decreased libido

**agitation** or **slowing** of movement or speech

disturbed **appetite**

suicidal thoughts or acts.

**poor concentration**

Symptoms of anxiety or nervousness are also frequently present.

### Differential diagnosis

If hallucinations (hearing voices, seeing visions) or delusions (strange or unusual beliefs) are present, see *Acute psychotic disorders – F23* for management of these problems. Consider consultation about management.

If the patient has a history of manic episodes (excitement, elevated mood, rapid speech), see *Bipolar disorder – F31*.

If heavy alcohol or drug use is present, see *Alcohol use disorders – F10* and *Drug use disorders – F11#*.

Some medications may produce symptoms of depression (e.g., beta-blockers, other antihypertensives, H2 blockers, oral contraceptives, corticosteroids).

## Depression F32# – management guidelines

### Essential information for patient and family

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

### Counselling of patient and family

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

### Medication

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

fatigue or loss of energy	disturbed sleep	guilt or self-reproach
poor concentration	thoughts of death or suicide	disturbed appetite
agitation OR slowing of movement and speech.		

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

Choice of medication:

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

**Build up to the effective dose.** Antidepressants (e.g., imipramine) should start at 25–50 mg each night and increase to 100–150 mg by 10 days. Lower doses should be given if the patient is older or physically ill.

**Explain to the patient that the medication must be taken every day, that improvement will build up over two to three weeks after starting the medication, and that mild side-effects may occur but usually fade in 7–10 days. Stress that the patient should consult the physician before stopping the medication.**

**Continue antidepressant medication for at least three months after the condition improves.**

### Specialist consultation

Consider consultation if the patient shows:

- significant risk of suicide or danger to others
- psychotic symptoms
- persistence of significant depression following the above treatment.

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

## Phobic disorders – F40

(includes agoraphobia, social phobia)

### Presenting complaints

Patients may avoid or restrict activities because of fear.

They may have difficulty travelling to the doctor's office, going shopping, visiting others.

Patients sometimes present with physical symptoms (palpitations, shortness of breath, "asthma"). Questioning will reveal specific fears.

### Diagnostic features

- **Unreasonably strong fear of specific places or events.** Patients often **avoid** these situations altogether.

Commonly feared situations include:

leaving home	crowds or public places
open spaces	travelling in buses, cars, trains, or planes
speaking in public	social events.

Patients may be **unable to leave home** or unable to stay alone because of fear.

### Differential diagnosis

- If anxiety attacks are prominent see *Panic disorder – F41.0*.
- If low or sad mood is prominent, see *Depression – F32#*.
- Many of the management guidelines opposite may also be helpful for specific phobias (e.g., fear of water, fear of heights).



## Phobic disorders F40 – management guidelines

### Essential information for patient and family

- Phobias can be treated.
- **Avoiding feared situations allows the fear to grow stronger.**
- **Following a set of specific steps can help a person overcome fear.**

### Counselling of patient and family

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

### Medication

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

### Specialist consultation

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

## Panic disorder – F41.0

### Presenting complaints

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

### Diagnostic features

**Unexplained attacks of anxiety or fear** that begin suddenly, develop rapidly and may last only a few minutes.

The attacks often occur with **physical symptoms** such as palpitation, chest pain, sensations of choking, churning stomach, dizziness, feelings of unreality, or fear of personal disaster (losing control or going mad, heart attack, sudden death).

An attack often leads to fear of another attack and avoidance of places where attacks have occurred. Patients may avoid exercise or other activities that may produce physical sensations similar to those of a panic attack.

### Differential diagnosis

Many medical conditions may cause symptoms similar to panic attacks (arrhythmia, cerebral ischemia, coronary disease, thyrotoxicosis). History and physical examination should be sufficient to exclude many of these.

If attacks occur only in specific feared situations, see *Phobic disorders – F40*.

If low or sad mood is also present, see *Depression – F32#*.

## Panic disorder F41.0 – management guidelines

### Essential information for patient and family

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

### Counselling of patient and family

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

### Medication

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

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

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

**Avoid unnecessary tests or medications.**

### Specialist consultation

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

## Generalized anxiety – F41.1

### Presenting complaints

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

### Diagnostic features

**Multiple symptoms of anxiety or tension:**

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

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

### Differential diagnosis

- If low or sad mood is prominent, see *Depression – F32#*.
- If sudden attacks of unprovoked anxiety are present, see *Panic disorder – F41.0*.
- If fear and avoidance of specific situations are present, see *Phobic disorders – F40*.
- If heavy alcohol or drug use is present, see *Alcohol use disorders – F10* and *Drug use disorders – F11#*.
- Certain physical conditions (thyrotoxicosis) or medications (methyl xanthines, beta agonists) may cause anxiety symptoms.

# Generalized anxiety F41.1 – management guidelines

## Essential information for patient and family

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

## Counselling of patient and family

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

## Medication

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

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

## Specialist consultation

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

## Mixed anxiety and depression – F41.2

### Presenting complaints

The patient presents with variety of symptoms of anxiety and depression.

There may initially be one or more physical symptoms (e.g., fatigue, pain). Further enquiry will reveal depressed mood and/or anxiety.

### Diagnostic features

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

The following associated symptoms are frequently present:

disturbed sleep	tremor
fatigue or loss of energy	palpitations
poor concentration	dizziness
disturbed appetite	suicidal thoughts or acts
dry mouth	loss of libido
tension and restlessness	

### Differential diagnosis

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

## Mixed anxiety and depression F41.2 – management guidelines

### Essential information for patient and family

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

### Counselling of patient and family

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

### Medication

In mild cases:

- Medication is a secondary component of management. If more severe symptoms of depression are present, however, antidepressant drugs may be used. See *Depression – F32#* for guidance on use of antidepressant drugs.

### Specialist consultation

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

## Adjustment disorder – F43.2

### Presenting complaints

Patients feel overwhelmed or unable to cope.

There may be stress-related physical symptoms such as insomnia, headache, abdominal pain, chest pain, palpitations.

### Diagnostic features

- **Acute reaction to recent stressful or traumatic event.**
- Extreme distress resulting from a recent event, or preoccupation with the event.
- Symptoms may be primarily somatic.
- Other symptoms may include:
  - low or sad mood
  - anxiety
  - worry
  - feeling unable to cope.

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

### Differential diagnosis

If dissociative symptoms (sudden onset of unusual or dramatic somatic symptoms) are present, see *Dissociative (conversion) disorder – F45*.

Acute symptoms may persist or evolve over time. If significant symptoms persist longer than one month, consider an alternative diagnosis:

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



## Adjustment disorder F43.2 – management guidelines

### Essential information for patient and family

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

### Counselling of patient and family

- Encourage the patient to **acknowledge the personal significance** of the stressful event.

**Review and reinforce positive steps the patient has taken** to deal with the stress.

- Identify **steps the patient can take** to modify the situation that produced the stress. If the situation cannot be changed, discuss problem-solving strategies.
- Identify relatives, friends and community resources able to offer support.
- **Short-term rest and relief** from stress may help the patient.
- Encourage **a return to usual activities within a few weeks**.

### Medication

Most acute stress reactions will resolve without use of medication. However, If **severe anxiety symptoms occur, use antianxiety drugs for up to three days** (e.g., benzodiazepines such as lorazepam 0.5–1.0 mg up to three times a day).

If the patient has severe insomnia, use hypnotic drugs for up to three days (e.g., temazepam 15 mg each night).

### Specialist consultation

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

## Dissociative (conversion) disorder – F44

### Presenting complaints

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

### Diagnostic features

Physical symptoms that are:

- **unusual in presentation**
- **not consistent with known disease**

Onset is often **sudden and** related to **psychological stress or difficult personal circumstances**.

In acute cases, symptoms may:

- be dramatic and unusual
- change from time to time
- be related to attention from others.

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

### Differential diagnosis

Carefully consider physical conditions which may cause symptoms. A full history and physical (including neurological) examination are essential. Early symptoms of neurological disorders (e.g., multiple sclerosis) may resemble conversion symptoms.

If other unexplained physical symptoms are present, see *Unexplained somatic complaints – F45*.

If pronounced depressive symptoms are present, see *Depression – F32#*.

## Dissociative (conversion) disorder F44 – management guidelines

### Essential information for patient and family

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

### Counselling of patient and family

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

### Medication

Avoid anxiolytics or sedatives.

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

### Specialist consultation

Consider consultation:

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

# Unexplained somatic complaints – F45

## Presenting complaints

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

## Diagnostic features

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

## Differential diagnosis

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

- If low or sad mood is prominent, see *Depression – F32#*.
- If strange beliefs about symptoms are present (e.g., belief that organs are decaying), see *Acute psychotic disorders – F23*.
- If anxiety symptoms are prominent, see *Panic disorder – F41.0* and *Generalized anxiety disorder – F41.1*.

## Unexplained somatic complaints F45 – management guidelines

### Essential information for patient and family

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

### Counselling of patient and family

- **Acknowledge that the patient's physical symptoms are real.** They are not lies or inventions.
- **Ask about the patient's beliefs** (what is causing the symptoms?) and **fears** (what does he/she fear may happen?).
- Offer **appropriate reassurance** (e. g., abdominal pain does not indicate cancer). Advise patients not to focus on medical worries.
- Discuss **emotional stresses** that were present when the symptoms began.
- **Relaxation methods** can help relieve symptoms related to tension (headache, neck or back pain).
- Encourage **exercise and enjoyable activities**. The patient need not wait until all symptoms are gone before returning to normal routines.
- For patients with more chronic complaints, time-limited appointments that are regularly scheduled can prevent more frequent urgent visits.

### Medication

Avoid unnecessary diagnostic testing or prescription of new medication for each new symptom.

Antidepressant medication (e. g., amitriptyline 50–100 mg a day) may be helpful in some cases (e. g., headache, irritable bowel syndrome, atypical chest pain).

### Specialist consultation

Avoid referrals to specialists. Patients are best managed in primary care settings.

Patients may be offended by psychiatric referral and seek additional medical consultation elsewhere.

## Neurasthenia – F48.0

(includes chronic fatigue)

### Presenting complaints

Patients may report:

- lack of energy
- aches and pains
- feeling tired easily
- inability to complete tasks.

Patients may request certification for medical leave or disability.

### Diagnostic features

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

Other common symptoms include:

dizziness	headache
disturbed sleep	inability to relax
irritability	aches and pains
decreased libido	poor memory and concentration

The disorder may occur after infection or other physical illness

### Differential diagnosis

Many physical disorders can cause fatigue. A full history and physical examination is necessary.

- If low or sad mood is prominent, see *Depression – F32#*.
- If anxiety attacks are prominent, see *Panic disorder – F41.1*.
- If unexplained physical symptoms are prominent, see *Unexplained somatic complaints – F45*.

## Neurasthenia F48.0 – management guidelines

### Essential information for patient and family

- Periods of fatigue or exhaustion are common and are usually temporary.
- Treatment is possible and usually has good results.

### Counselling of patient and family

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

### Medication

No physical treatment has been established. If other mental or physical disorders are present, they may require physical treatment.

Activating antidepressants (e.g., fluoxetine, amineptine, desipramine) are sometimes helpful.

### Specialist consultation

Consider consultation if severe symptoms continue longer than three months.

## Eating disorders – F50

### Presenting complaints

The patient may present because of binge eating or extreme weight control measures such as self-induced vomiting, excessive use of diet pills, and laxative abuse.

The family may ask for help because of the patient's loss of weight, refusal to eat, vomiting or amenorrhea.

### Diagnostic features

Common features

- unreasonable fear of being fat or gaining weight
- extensive efforts to control weight (strict dieting, vomiting, use of purgatives, excessive exercise)
- denial that weight or eating habits are a problem.

Patients with anorexia nervosa typically show:

- severe dieting despite very low weight
- distorted body image (unreasonable belief that one is overweight)
- amenorrhea.

Patients with bulimia typically show:

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

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

### Differential diagnosis

Depression may occur along with bulimia or anorexia. See *Depression – F32#*.

Both anorexia and bulimia may cause physical disorders (amenorrhea, hypokalemia, seizures, cardiac arrhythmias) that require monitoring or treatment.



## Eating disorders F50 – management guidelines

### Essential information for patient and family

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

### Specific counselling of patient and family

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

### Medication

Antidepressant drugs have sometimes been effective in controlling binge eating.

### Specialist consultation

Consider consultation if severe or physically dangerous symptoms continue after the above measures.

Family conflicts may cause eating problems or result from them. Consider referral for family counselling, if available.

## Sleep problems (insomnia) – F51

### Presenting complaints

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

### Diagnostic features

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

### Differential diagnosis

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

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

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

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

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

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

## Sleep problems F51 – management guidelines

### Essential information for patient and family

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

### Counselling of patient and family

**Maintain a regular sleep routine by:**

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

### Medication

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

### Specialist consultation

Consider consultation:

- if more complex sleep disorders (e.g., narcolepsy, sleep apnoea) are suspected
- if significant insomnia continues despite the measures above.

## Sexual disorders (male) – F52

### Presenting complaints

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

Special problems may occur in cultural minorities.

### Diagnostic features

Common sexual disorders presenting in the male are:

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

### Differential diagnosis

If low or sad mood is prominent, see *Depression – F32#*.

Problems in marital relationships often contribute to sexual disorders, especially those of desire.

Ejaculatory problems may be circumstantial (e.g., performance anxiety, overexcitement, ambivalence about partner) or may be caused by medication, but specific organic pathology is rare.

Physical factors which may contribute to impotence include diabetes, hypertension, multiple sclerosis, alcohol abuse and medication.

## Sexual disorders (male) F52 – management guidelines

### • Erectile dysfunction (failure of genital response, impotence)

#### Essential information for patient and spouse

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

#### Counselling of patient and spouse

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

### • Premature ejaculation

#### Essential information for patient and spouse

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

#### Counselling of patient and spouse

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

### • Orgasmic dysfunction

#### Essential information for patient and spouse

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

#### Counselling of patient and spouse

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

### • Low sexual desire

#### Essential information for patient and spouse

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

#### Counselling of patient and spouse

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

#### Specialist consultation

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

## Sexual disorders (female) – F52

### Presenting complaints

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

Special problems may occur in cultural minorities.

### Diagnostic features

Common sexual disorders presenting in the male are:

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

### Differential diagnosis

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

## Sexual disorders (female) F52 – management guidelines

- **Low sexual desire**

### Essential information for patient and spouse

Low sexual desire has many causes, including marital problems, earlier traumas, physical and psychiatric illnesses and stress. The problem is often temporary.

### Counselling of patient and spouse

Discuss patient's beliefs about sexual realtions. Ask about traumatic sexual experiences and negative attitudes to sex. See couple together to try to lower husband's sexual expectations. Suggest planning sexual activity for specific days.

- **Vaginismus**

### Essential information for patient and spouse

Vaginismus is simply a form of muscle spasm and can be overcome by relaxation exercises.

### Counselling of patient and spouse

Digital examination of vagina will confirm diagnosis. Recommend exercises for husband and patient with graded dilators or finger dilation, accompanied by relaxation.

- **Dyspareunia**

### Essential information for patient and spouse

There are many physical causes, but in some cases poor lubrication and muscle tension are the main factors.

### Counselling of patient and spouse

Relaxation, prolonged foreplay and careful penetration may overcome psychogenic problems. Referral to a gynaecologist is advisable if simple measures are unsuccessful.

- **Anorgasmia**

### Essential information for patient and spouse

Many women are unable to experience orgasm during intercourse but can usually achieve it by clitoral stimulation.

### Counselling of patient and spouse

Discuss patient's beliefs and attitudes. Encourage manual self-exploration (e.g., genital stimulation). The couple should be helped to communicate openly and to reduce any unrealistic expectations.

### Specialist Consultation

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

# Mental retardation – F70

## Presenting complaints

In children:

- delay in usual development (walking, speaking, toilet training)
- difficulties with school work, as well as with other children, because of learning disabilities
- problems of behaviour.

In adolescents:

- difficulties with peers
- inappropriate sexual behaviour.

In adults:

- difficulties in everyday functioning (e.g., cooking, cleaning)
- problems with normal social development, (e.g., finding work, marriage, child-rearing).

## Diagnostic features

Slow or incomplete mental development resulting in:

- learning difficulties
- social adjustment problems.

The range of severity includes:

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

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

## Differential diagnosis

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

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



## Mental retardation F70 – management guidelines

### Essential information for patient and family

- Early training can help a mentally retarded person towards independence and self-care.
- Retarded children are capable of loving relationships.

### Specific counselling of patient and family

- Reward effort. Allow retarded children and adults to function at the highest level of their ability in school, work and family.
- Families may feel great loss or feel overwhelmed by the burden of caring for a retarded child. Offer sympathy and reassurance.
- Advise families that training will be helpful but that miracle cures do not exist.

### Medication

Except in the case of certain physical or psychiatric disorders, medical treatment cannot improve mental function.

Retardation may occur with other disorders that require medical treatment (e. g., seizures, spasticity, psychiatric illness such as depression).

### Specialist consultation

When retardation is first identified, consider specialist consultation to help plan education and training.

# Hyperkinetic (attention deficit) disorder – F90

## Presenting complaints

Patients:

- can't sit still
- are always moving
- cannot wait for others
- will not listen to what others say
- have poor concentration.

Younger ones are likely to be failing in school work.

## Diagnostic features

Usually there is:

- severe difficulty in maintaining attention (short attention span, frequent changes of activity)
- abnormal physical restlessness (most evident in classroom or at mealtimes)
- impulsiveness (the patient cannot wait his or her turn, or acts without thinking).

Sometimes there may be discipline problems, underachievement in school, proneness to accidents.

This pattern occurs in all situations (home, school, play).

Avoid premature diagnosis. High levels of physical activity are not necessarily abnormal.

## Differential diagnosis

Also consider presence of:

- a specific physical disorder (e.g., epilepsy, fetal alcohol syndrome, thyroid disease)
- general emotional disorders (patient exhibits anxiety depression)
- autism (social/language impairment and stereotyped behaviours are present)
- conduct disorder (patient exhibits disruptive behaviour without inattentiveness, see *Conduct disorder – F91#*)
- mild mental retardation or learning disability.

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

# Hyperkinetic (attention deficit) disorder F90 – management guidelines

## Essential information for patient and family

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

## Counselling of patient and family

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

## Medication

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

## Specialist consultation

If available, consider consultation before starting drug treatment or if the above measures are unsuccessful.

Referral for behavioural treatment, if available, can improve attention and self-control.

## Conduct disorder – F91#

### Presenting complaints

Parents or schoolteachers may request help in managing disruptive behaviour.

### Diagnostic features

A consistent pattern of abnormally aggressive or defiant behaviour such as:

fighting	bullying	truancy
cruelty	stealing	
lying	vandalism.	

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

### Differential diagnosis

Some rebellious behaviour may be within the normal range.

Inconsistent discipline or conflict in the family, or inadequate supervision at school, may contribute to disruptive behavior.

Disruptive behaviour can also be caused by a depressive state, learning disability, situational problems or parent-child problems.

May occur together with hyperkinetic disorder. If overactivity and inattention are prominent, see *Hyperkinetic disorder – F90*.

## Conduct disorder F91# – management guidelines

### Essential information for patient and family

- Effective discipline should be clear and consistent, but not harsh.
- Avoid punishment. It is more helpful to reward positive behaviour.

### Counselling to patient and family

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

### Medication

No physical treatment has been established

### Specialist consultation

Consider consultation if severe behaviour problems persist following the above measures.

## Enuresis – F98.0

### Presenting complaints

Repeated urination into clothes or bed.

### Diagnostic features

**Delay in ability to control urination** (Note: wetting at night is normal until the mental age of 5 years).

The urination

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

### Differential diagnosis

Most enuresis has no physical cause (primary enuresis), but enuresis may be secondary to:

- neurological disorder (spina bifida) where urination is also abnormal during the day
- diabetes or diuretic drugs that may cause polyuria and urgency
- seizure disorder
- structural urinary tract abnormality
- acute urinary tract infection
- generalized emotional disturbance.

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

## Enuresis F98.0 – management guidelines

### Essential information for patient and family

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

### Counselling of patient or family

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

### Medication

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

### Specialist consultation

Consider psychiatric/psychological consultation:

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

## Bereavement disorder – Z63

### Presenting complaints

The patient

- feels overwhelmed by loss
- is preoccupied with the lost loved one
- may present with somatic symptoms following loss.

### Diagnostic features

Normal grief includes preoccupation with loss of loved one.

However, this may be accompanied by **symptoms resembling depression**, such as:

- low or sad mood
- disturbed sleep
- loss of interest
- guilt or self-criticism
- restlessness.

The patient may

- withdraw from usual activities and social contacts
- find it difficult to think of the future.

### Differential diagnosis

If a full picture of depression is still present 2 months after the loss, consider depression. See *Depression – F32#*.

Symptoms that cannot be related to the loss of a loved one are inappropriate guilt and feelings of worthlessness. Marked psychomotor slowing may directly indicate depression.

Symptoms resembling depression may not, however, be indicative of depression (e.g., **guilt** about actions not taken by the person before the death of the loved one; **thoughts of death** reflected in statements such as “I should die and join the beloved one” or “I should have died instead”; some **hallucinations** such as seeing the deceased person or hearing his or her voice.



## Bereavement disorder Z63 – management guidelines

### Essential information for patient and family

- Important losses are often followed by intense sadness, crying, anxiety, guilt or irritability.
- Bereavement typically includes preoccupation with the deceased (including hearing or seeing the person)
- A desire to discuss the loss is normal.

### Counselling of patient and family

- Allow the bereaved person to talk about the deceased and the circumstances of the death.
- Encourage free expression of feelings about the loss (including feelings of sadness, guilt or anger)
- Offer reassurance that recovery will take time. Some reduction in burdens (work, social commitments) may be necessary.
- Explain that intense grieving will fade slowly over several months but that reminders of the loss may continue to provoke feelings of loss and sadness.

### Medication

Decisions about antidepressant medication should be delayed for three months or more. If significant depressive symptoms persist longer than three months, see *Depression – F32* for advice on use of antidepressants.

If severe insomnia occurs, short-term use of hypnotic drugs may be helpful (e.g., temazepam 15 mg each night) but use should be limited to two weeks.

### Specialist consultation

Consider consultation if severe symptoms of grief persist for longer than six months, and in any case before prescribing antidepressant medication.

Bereaved children may benefit from family counselling.



**Brief Version  
for Primary Care Workers**

## F0<sup>s</sup> – Cognitive disorders

### Presenting complaints

In chronic (long-term) cases, patients may complain of forgetfulness or feeling depressed but may be unaware of memory loss. Patients and family may sometimes deny severity of memory loss.

In acute (new) cases, patients may appear agitated, uncooperative or fearful.

Families ask for help in milder cases because of failing memory, change in personality or behaviour. In more acute or advanced cases families seek help because of confusion, wandering or incontinence.

Poor hygiene in an older patient may indicate memory loss.

### Diagnostic features

**In acute (new or short-term) cases, patients will be confused with clouded thinking or awareness.** This is often accompanied by agitation, wandering attention, loss of orientation, hallucinations, suspiciousness and disturbed sleep.

**In chronic (old or long-term) cases, patients will have decline in recent memory, thinking and judgement,** orientation and language. Patients often appear apathetic or disinterested, but may appear alert and appropriate despite poor memory.

Cognitive disorders are common in older patients but very rare in youth or middle age.

Loss of emotional control is common; patients may easily become tearful or irritable.

Tests of memory and thinking may include:

- remembering the names of three common objects immediately and after three minutes
- naming the days of the week in reverse order
- recalling details of the previous day's meals.

### Differential diagnosis

Sudden increases in confusion may indicate a physical illness. Examine for **physical causes** of confusion or memory loss, including:

- alcohol, drugs, prescribed medication
- infection (urinary infection, syphilis, HIV)
- metabolic changes (hypoxia, hypoglycemia, dehydration)
- head trauma.

Depression may interfere with memory and concentration, especially in older patients. If sad mood is prominent, see *Depression – F3<sup>s</sup>*.

# Cognitive disorders – management guidelines

## Essential information for patient and family

- Memory problems are common in old age.
- Memory loss or confusion may cause behaviour problems (e.g., agitation, suspiciousness, emotional outbursts).
- Physical illness or mental stress can increase confusion.

## Counselling of patient and family

- In acute cases:
  - take measures to **prevent the patient from harming him/herself or others** (e.g., remove unsafe objects, restrain if necessary)
  - ensure that basic needs (food and drink) are met
  - hospitalization may be necessary to treat a physical condition or to control agitation.
- Assess the patient's ability to perform daily tasks safely
- **Supportive contact with familiar people can reduce confusion.**
- Avoid placing the patient in unfamiliar surroundings or situations. Prepare the patient for any changes in daily routine.
- Consider ways to reduce stress on those caring for the patient. Support from other families with similar difficulties may be helpful.
- As appropriate, discuss arrangements for support in the home, community or day care programmes, or residential placement.
- In chronic cases, discuss planning of legal and financial affairs.

## Medication

Use **sedative or hypnotic medications** (e.g., **benzodiazepines**) cautiously. They may increase confusion.

**Antipsychotic medication** in low doses (e.g., haloperidol 0.5 mg to 1.0 mg once or twice a day) may sometimes be needed to control agitation, psychotic symptoms or aggression. Beware of drug side-effects (Parkinsonism, anticholinergic effects).

## Specialist consultation

Seek consultation for medical conditions requiring specialist treatment (e.g., syphilis, subdural haematoma).

## F1<sup>s</sup> – Alcohol and drug use disorders

### Presenting complaints

Patients may present with:

- depressed mood
- nervousness
- insomnia
- physical complications of alcohol or drug use (ulcer, gastritis, liver disease, blood infections)
- legal and social problems due to alcohol or drug use (marital problems, missed work)
- accidents or injuries due to alcohol or drug use.

Patients may sometimes deny alcohol or drug use.

There may also be signs of alcohol or drug withdrawal (sweating, tremors, morning sickness, hallucinations, muscle cramps, watering of eyes or nose).

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

### Diagnostic features

**Harmful alcohol or drug use:**

- **heavy alcohol or drug use** (quantity defined by local standards, e.g., over 21 drinks per week for men, 14 drinks per week for women)
- **use of alcohol or drugs has caused physical or mental harm** (e. g., liver disease, depression) or **social consequences** (e.g., loss of job).

**Alcohol or drug dependence:**

- **continued alcohol or drug use despite harmful consequences**
- **difficulty controlling** alcohol or drug use
- **strong desire to use** alcohol or drugs
- **tolerance** (uses large amounts of alcohol or drugs without appearing intoxicated)
- **withdrawal** (anxiety, tremors, sweating after stopping use).

### Differential diagnosis

Reducing alcohol or drug use may be desirable for some patients who do not fit the above guidelines.

Symptoms of anxiety or depression may occur with heavy alcohol or drug use. If these continue after a period of abstinence, see *Depression – F3<sup>s</sup>* and *Anxiety disorders – F4<sup>s</sup>*.

# Alcohol and drug use disorders – management guidelines

## Essential information for patient and family

- Alcohol and drug disorders are illnesses with serious consequences. Stopping or reducing alcohol and drug use will bring mental and physical benefits.
- Drinking or using drugs during pregnancy can harm the baby.
- Intravenous drug use can cause serious infection (e.g., HIV, hepatitis).
- In some cases of harmful alcohol use without dependence, controlled or reduced drinking is a reasonable goal. **In other cases, abstinence from alcohol and drugs is the goal.**
- For those with alcohol or drug dependence, abstinence is the goal. Because abrupt discontinuation can cause withdrawal symptoms, medical supervision is necessary.
- Relapses are common after stopping or reducing use.

## Counselling of patient and family

For patients **willing to stop now**

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

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

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

For patients **not willing to stop or reduce use now**

- **Do not reject or blame.**
- Clearly **point out problems** caused by alcohol or drugs.
- Make a **future appointment** to discuss patient's drinking.

For patients who do not succeed or relapse

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

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

## Medication

Withdrawal from alcohol or sedatives may require short-term antianxiety drugs. Severe alcohol or sedative withdrawal may require hospitalization and use of higher dose antianxiety drugs. Withdrawal from stimulants, cocaine or opiates is distressing and may require medical supervision.

## Specialist consultation

Specialized counselling programmes should be considered, if available.

## F2<sup>s</sup> – Psychotic disorders

### Presenting complaints

Patients may present with:

- reports of hearing voices
- extraordinary physical complaints (e.g., having animals or unusual objects inside one's body)
- difficulties with thinking or concentration
- confusion.

The family or community may ask for help with the patient's strange or frightening behaviour (e.g., shouting, agitation, threatening) or because of withdrawal and apathy.

### Diagnostic features

In acute cases:

- **agitation or disturbed behaviour**
- **hallucinations** (false or imagined perceptions such as hearing voices)
- **delusions** (firm beliefs that are plainly false, e.g., food is poisoned, patient is being followed or persecuted).
- **disordered thinking, disorganized or strange speech**
- **extreme and labile emotional states.**

In **chronic cases**, the acute symptoms above may occur only occasionally. Between these acute spells, patients often show:

- **social withdrawal**
- **low motivation or interest**
- **disordered thinking or difficulty concentrating.**

### Differential diagnosis

Consider treatable causes of psychotic symptoms, including:

- infectious or febrile illness
- intoxication or withdrawal from alcohol or drugs
- epilepsy
- head injury.

If symptoms of depression are prominent (low or sad mood, pessimism, ideas of guilt) see *Depression – F3<sup>s</sup>*.

If symptoms of mania (excitement, elevated mood, exaggerated self-worth) are prominent, the patient may have bipolar disorder. If possible, seek consultation regarding management.



# Psychotic disorders – management guidelines

## Essential information for patient and family

- Agitation and strange behaviour are symptoms of a mental illness. Effective treatment is available.
- Acute episodes often resolve though they may recur. The long-term course of the illness is difficult to predict.
- Medication is a central component of treatment; it will both reduce current symptoms and prevent relapse. Continued treatment may be necessary for several months after symptoms resolve.
- Family support is essential for compliance with treatment and effective rehabilitation.

## Counselling of patient and family

- Discuss treatment plan with family members and obtain their support.
- During acute episodes of agitation or excitement:
  - assess and secure the safety of the patient and those caring for him/her
  - ensure that the patient's basic needs (food and drink) are met
  - do not argue with abnormal beliefs
  - dangerous behaviour or severe agitation will require close supervision or hospitalization
  - families may need help managing disruptive or threatening behaviour
  - if patients refuse treatment, legal measures may be needed
  - encourage resumption of normal activities after symptoms improve.
- **Avoid confrontation or criticism** unless necessary to prevent harmful or disruptive behaviour.
- Unreasonably high expectations by patients or others may be harmful. However, patients should be allowed to function at the highest level of their ability in work or other daily activities.

## Medication

**Antipsychotic medication will reduce agitation, hallucinations and delusions** (e.g., haloperidol 2–5 mg up to three times a day or chlorpromazine 100–200 mg up to three times a day). The dose should be the lowest possible for the relief of symptoms, though some patients may require higher doses.

Continue antipsychotic medication for at least three months after symptoms resolve (longer in the case of a recurrent episode).

If available, injectable long-acting antipsychotic medication may ensure continuity of treatment and reduce risk of relapse.

Inform patient and family of potential side-effects. Common motor side-effects include:

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

## Specialist consultation

If facilities exist, seek consultation for all new cases of psychotic disorder.

Depression or mania with psychotic symptoms may need other treatment. If possible, seek consultation to clarify diagnosis and begin appropriate treatment.

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

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

## F3<sup>s</sup> – Depression

### Presenting complaints

The patient may present initially with one or more physical symptoms (fatigue, headache, pain). Further enquiry will reveal depression or loss of interest.

Irritability is sometimes the presenting problem.

May present after suicide attempt.

Some groups are at higher risk (e.g., those who have recently given birth or had a stroke, those with Parkinson's disease or multiple sclerosis).

### Diagnostic features

**Low or sad mood.**

**Loss of interest in usual activities** (withdrawal or inactivity).

The following associated symptoms are frequently present:

- disturbed sleep
- poor concentration
- guilt or low self-worth
- disturbed appetite (or fatigue or loss of energy)
- change in weight)
- suicidal thoughts or acts
- decreased libido
- agitation or slowing of activity.

Symptoms of anxiety or nervousness are also frequently present.

### Differential diagnosis

Some medications may produce symptoms of depression (e.g., beta-blockers, other antihypertensives, H2 blockers, oral contraceptives, corticosteroids).

If hallucinations (hearing voices, seeing visions) or delusions (strange or unusual beliefs) are present, see also Psychotic disorders for management of these problems. If possible, seek consultation about management.

If the patient has a history of manic episodes (excitement, elevated mood, rapid speech), he/she may have bipolar disorder. If possible, seek consultation on diagnosis and management.

If heavy alcohol use is present, see *Alcohol and drug use disorders – F1<sup>s</sup>*.

# Depression – management guidelines

## Essential information for patient and family

- Depression is common and effective treatments are available.
- **Depression is not weakness or laziness**; patients are trying hard to cope.

## Counselling of patient and family

- **Ask about risk of suicide and risk of harm to others.** Has the patient often thought of death or dying? Does the patient have a specific suicide plan? Has he/she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas? Close supervision by family or friends, or hospitalization, may be needed.
- **Plan short-term activities which give the patient enjoyment or build confidence.**
- **Encourage the patient to resist pessimism and self-criticism**, not to act on pessimistic ideas (e.g., ending marriage, leaving job), and not to concentrate on negative or guilty thoughts.
- Identify current life problems or social stresses. Focus on small, specific steps patients might take towards managing these problems.
- If physical symptoms are present, **discuss link between physical symptoms and mood** (see *Unexplained somatic complaints – F53*).
- After improvement, discuss action to be taken if signs of relapse occur.

## Medication

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

fatigue or loss of energy	disturbed sleep
guilt or self-reproach	poor concentration
thoughts of death or suicide	disturbed appetite
agitation or slowing of movement and speech.	

In severe cases, consider medication at the first visit. In moderate cases, consider medication if counselling is not sufficiently helpful.

Build up to the effective dose (e.g., imipramine starting at 25–50 mg each night and increasing to 100–150 mg by 10 days). Lower doses should be given if the patient is older or physically ill.

Explain to patient that the medication must be taken every day, that improvement will build up over two to three weeks, and that mild side-effects may occur but usually fade in 7–10 days.

Advise the patient always to check with health care worker before stopping the medication.

Continue antidepressant medication for at least 3 months after the condition improves.

## Specialist consultation

Consider consultation if the patient shows significant risk of harm to self or others, or if psychotic symptoms are present.

If **significant depression persists**, consider consultation about other therapies. More **intensive psychotherapies** (e.g., cognitive therapy, interpersonal therapy) may be useful for treatment of acute cases and prevention of relapse.

## F4<sup>s</sup> – Anxiety disorders

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

### Diagnostic features

**Fear, anxiety or worry** (exaggerated worry, inability to relax), often accompanied by:

poor concentration	fast or pounding heart
restlessness	headaches
tremors	churning stomach or nausea
dizziness	sweating.

Disorders may occur as sudden attacks of anxiety or fear.

Some patients may have extreme fear of specific situations. Common feared situations include leaving home, crowds, social events, buses or trains. Patients may be unable to be alone in these situations or may avoid them altogether.

### Differential diagnosis

If low or sad mood is prominent, see *Depression – F3<sup>s</sup>*.

If heavy alcohol or drug use is present, see *Alcohol and drug disorders – F1<sup>s</sup>*.

# Anxiety disorders – management guidelines

## Essential information for patient and family

- Stress and worry have both physical and mental effects.
- Learning skills to reduce the effects of stress (not sedative medication) is the most effective relief.
- **Anxiety often produces frightening physical symptoms.** Chest pain, dizziness, or shortness of breath are not necessarily signs of a physical illness.
- Avoiding feared situations allows the fear to grow stronger; confronting these situations will reduce the fear.

## Counselling of patient and family

- Encourage the patient to practise **relaxation methods** (such as slow, relaxed breathing) to reduce physical symptoms of anxiety.
- Identify exaggerated fears which occur with anxiety (e. g., patient feels a pounding heart and fears he/she is having a heart attack).
- **Discuss ways to challenge these fears** when they occur (e. g., patient reminds him/herself, “I am not having a heart attack. This is a panic attack, and it will pass in a few minutes”).
- For phobias (anxiety related to specific situations), plan a **series of steps to enable the patient to confront and get used to** feared situations. For example:
  - 1) Identify a small first step towards the feared situation (e. g., take a short walk away from home with a family member).
  - 2) This step should be practised over and over until it is no longer frightening.
  - 3) If the feared situation still causes anxiety, the patient should not leave the situation until the fear subsides (this will always occur after a few minutes).
  - 4) Move on to a slightly more difficult step and repeat the procedure (e. g., spend a longer time away from home).
  - 5) Do not use alcohol or drugs to help cope with feared situations.
- Identify current life problems or social stresses. Focus on small, specific steps patients might take towards managing these problems.
- Regular exercise is often helpful.

## Medication

With the above counselling, many patients will be able to deal with anxiety without medication.

If panic attacks are frequent or if the patient is also depressed, antidepressants may be helpful (e. g., imipramine 25 mg at night increasing to 75–100 mg at night after two weeks).

For patients with more severe anxiety, short-term use of antianxiety medication may be helpful (e. g., lorazepam 0.5 mg up to three times a day). Regular use may lead to dependence with symptoms returning when the medication is discontinued.

## Specialist consultation

**Avoid unnecessary tests or medications.**

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

## F5\$ – Unexplained somatic complaints

### Presenting complaints

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

### Diagnostic features

**Various physical complaints without a physical explanation** (a full history and physical examination are necessary to determine this).

**Symptoms of depression and anxiety are common.**

**In acute cases, patients may have:**

- **dramatic presentations** with exaggerated, attention-seeking behaviour
- unusual symptoms not consistent with known disease
- symptoms that vary from minute to minute
- symptoms that may be related to attention from others

**In chronic cases, patients may:**

- visit health services repeatedly although medical examinations show no physical problem
- seek only relief from symptoms
- be convinced of the presence of physical illness and unable to believe that no medical condition is present (hypochondriasis).

### Differential diagnosis

If low or sad mood is prominent, see *Depression – F3\$*.

If strange physical symptoms are present (e.g., belief that organs are decaying) see Psychotic disorders.

If anxiety symptoms are prominent, see *Anxiety disorders – F4\$*.

# Unexplained somatic complaints – management guidelines

## Essential information for patient and family

- Stress often produces physical symptoms.
- **The focus should be on managing the symptoms, not on discovering their cause.**
- Cure may not be possible; the goal should be to live the best life possible even if symptoms continue.

## Counselling of patient and family

- **Acknowledge that the patient's physical symptoms are real.** They are not lies or inventions.
- **Reinforce improvement in the patient. Try not to reinforce symptoms.**
- **Ask the patient what he/she thinks is causing the symptoms.** Offer appropriate reassurance (e. g., abdominal pain does not indicate cancer). Advise patients not to focus on medical worries.
- Discuss **emotional stresses** that were present when the symptoms began.
- **Relaxation methods** can help relieve symptoms related to tension (headache, neck or back pain).
- Acute cases may need brief rest and relief from stress. After the acute period, encourage **exercise and enjoyable activities**. The patient need not wait until all symptoms are gone before returning to normal routines.
- For patients with more chronic complaints, regular time-limited appointments with the same doctor may prevent more frequent urgent visits.

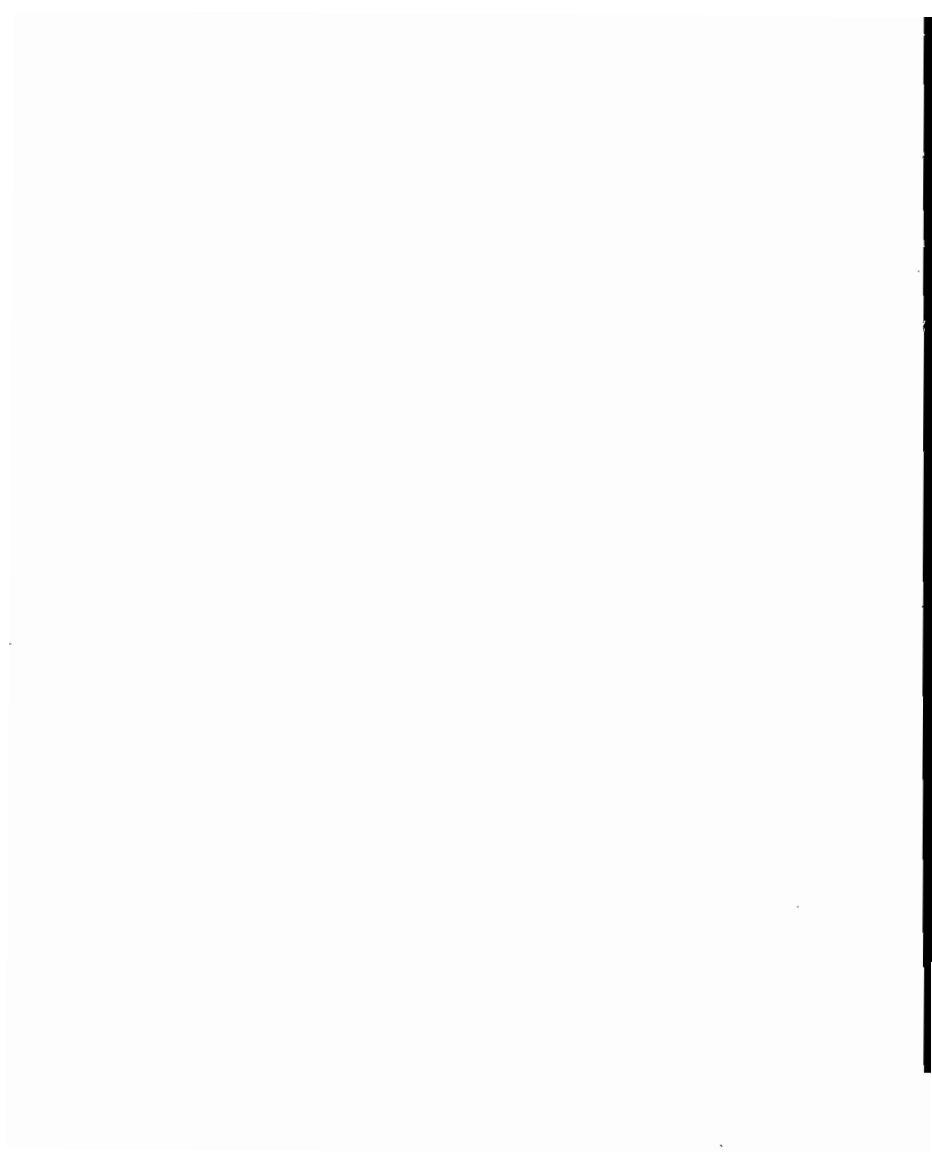
## Medication

Avoid unnecessary diagnostic testing or prescription of new medication for each new symptom.

Antidepressant medication (e. g., imipramine 25–75 mg a day) may be helpful in some cases (e. g., headache, irritable bowel syndrome, atypical chest pain).

## Specialist consultation

Avoid referrals to specialists. Patients are best managed by one primary health care physician. Patients may be offended by psychiatric referral and seek additional medical consultation elsewhere.





# Appendix 1

## Crosswalks between ICD-10 PC Chapter V & ICD-10 Chapter V

The ICD-10 PC codes refer to the corresponding ICD-10 three character codes and their relevant subcodes (e.g., fourth and fifth character codes). Detailed codes have been taken from *The International Classification of Mental and Behavioural Disorders* (WHO, 1992).

ICD-10 PC Chapter V	ICD-10 Chapter V Main Volume
F00#      Dementia	<i>F00    Dementia in Alzheimer's disease</i> <i>F01    Vascular dementia</i> <i>F02    Dementia in diseases classified elsewhere</i> <i>F03    Unspecified dementia</i>
	includes subcodes for the above
	<b>F00    Dementia in Alzheimer's disease</b>
	F00.0   Dementia in Alzheimer's disease with early onset
	F00.1   Dementia in Alzheimer's disease with late onset
	F00.2   Dementia in Alzheimer's disease, atypical or mixed type
	F00.9   Dementia in Alzheimer's disease, unspecified
	<b>F01    Vascular dementia</b>
	F01.0   Vascular dementia of acute onset
	F01.1   Multi-infarct dementia
	F01.2   Subcortical vascular dementia
	F01.3   Mixed cortical and subcortical vascular dementia
	F01.8   Other vascular dementia
	F01.9   Vascular dementia, unspecified
	<b>F02    Dementia in other diseases classified elsewhere</b>
	F02.0   Dementia in Pick's disease
	F02.1   Dementia in Creutzfeldt-Jakob disease
	F02.2   Dementia in Huntington's disease
	F02.3   Dementia in Parkinson's disease
	F02.4   Dementia in human immunodeficiency virus [HIV] disease
	F02.8   Dementia in other specified diseases classified elsewhere
	<b>F03    Unspecified dementia</b>
	A fifth character may be added to specify dementia in F00–F03, as follows:
	.x0      Without additional symptoms
	.x1      Other symptoms, predominantly delusional

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F05 Delirium

- .x2 Other symptoms, predominantly hallucinatory
- .x3 Other symptoms, predominantly depressive
- .x4 Other mixed symptoms

*F05 Delirium, not induced by alcohol and other psychoactive substances*

includes subcodes (fourth character) for the above

- F05 Delirium, not induced by alcohol and other psychoactive substances
  - F05.0 Delirium, not superimposed on dementia, so described
  - F05.1 Delirium, superimposed on dementia
  - F05.8 Other delirium
  - F05.9 Delirium, unspecified

F10 Alcohol use disorders

*F10 Disorders resulting from use of alcohol*

includes subcodes (fourth, fifth and sixth character) for the above

- F10.0 Acute intoxication
- F10.1 Harmful use
- F10.2 Dependence syndrome
- F10.3 Withdrawal state
- F10.4 Withdrawal state with delirium
- F10.5 Psychotic disorder
- F10.6 Amnesic syndrome
- F10.7 Residual and late onset psychotic disorder

Four- and five-character categories may be used to specify the clinical conditions, as follows:

- F1x.0 Acute intoxication
  - .00 Uncomplicated
  - .01 With trauma or other bodily injury
  - .02 With other medical complications
  - .03 With delirium
  - .04 With perceptual distortions
  - .05 With coma
  - .06 With convulsions
  - .07 Pathological intoxication
- F1x.1 Harmful use
- F1x.2 Dependence syndrome
  - .20 Currently abstinent
  - .21 Currently abstinent, but in a protected environment
  - .22 Currently on a clinically supervised maintenance or replacement regime [controlled dependence]
  - .23 Currently abstinent, but receiving treatment with aversive or blocking drugs

			.24	Currently using the substance [active dependence]
			.25	Continuous use
			.26	Episodic use [dipsomania]
		F1x.3		Withdrawal state
			.30	Uncomplicated
			.31	With convulsions
		F1x.4		Withdrawal state with delirium
			.40	Without convulsions
			.41	With convulsions
		F1x.5		Psychotic disorder
			.50	Schizophrenia-like
			.51	Predominantly delusional
			.52	Predominantly hallucinatory
			.53	Predominantly polymorphic
			.54	Predominantly depressive symptoms
			.55	Predominantly manic symptoms
			.56	Mixed
		F1x.6		Amnesic syndrome
		F1x.7		Residual and late-onset psychotic disorder
			.70	Flashbacks
			.71	Personality or behaviour disorder
			.72	Residual affective disorder
			.73	Dementia
			.74	Other persisting cognitive impairment
			.75	Late-onset psychotic disorder
		F1x.8		Other mental and behavioural disorders
		F1x.9		Unspecified mental and behavioural disorder
F11#	Drug use disorders	F11		<i>Disorders resulting from use of opioids</i>
		F12		<i>Disorders resulting from use of cannabinoids</i>
		F13		<i>Disorders resulting from use of sedatives or hypnotics</i>
		F14		<i>Disorders resulting from use of cocaine</i>
		F15		<i>Disorders resulting from use of other stimulants, including caffeine</i>
		F16		<i>Disorders resulting from use of hallucinogens</i>
		F18		<i>Disorders resulting from use of volatile solvents</i>
		F19		<i>Disorders resulting from multiple drug use and use of other psychoactive substances</i>

includes subcodes (fourth, fifth and sixth character) for the above

- F1x.0 Acute intoxication
- F1x.1 Harmful use
- F1x.2 Dependence syndrome
- F1x.3 Withdrawal state
- F1x.4 Withdrawal state with delirium
- F1x.5 Psychotic disorder due to alcohol use
- F1x.6 Amnesic syndrome

**ICD-10 PC Chapter V****ICD-10 Chapter V Main Volume****F1x.7 Residual and late onset psychotic disorder**

Same four and five character codes listed for F10 apply to F11# (that is F11–F19)

**F17.1** Tobacco use disorders

**F17** *Disorders resulting from use of tobacco*

includes subcodes (fourth character) for the above F11#, e.g.,

F17.1 Harmful use

F17.2 Dependence syndrome

F17.3 Withdrawal state

**F20#** Chronic psychotic disorders

**F20** *Schizophrenia*

**F21** *Schizotypal disorder*

**F22** *Persistent delusional disorders*

**F24** *Induced delusional disorder*

**F28** *Other nonorganic psychotic disorders*

**F29** *Unspecified nonorganic psychosis*

includes subcodes (fourth and fifth character) for the above:

F20.0 Paranoid schizophrenia

F20.1 Hebephrenic schizophrenia

F20.2 Catatonic schizophrenia

F20.3 Undifferentiated schizophrenia

F20.5 Residual schizophrenia

F20.6 Simple schizophrenia

F20.8 Other schizophrenia

F20.9 Unspecified schizophrenia

A fifth character may be used to classify course:

.x0 Continuous

.x1 Episodic with progressive deficit

.x2 Episodic with stable deficit

.x3 Episodic remittent

.x4 Incomplete remission

.x5 Complete remission

.x6 Other

.x9 Course uncertain, period of observation too short

**F23** Acute psychotic disorders

**F23** *Acute and transient psychotic disorders*

includes subcodes (fourth and fifth character codes) for the above:

F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia

F23.1 Acute polymorphic psychotic disorder with symptoms of schizophrenia

F23.2 Acute schizophrenia-like psychotic disorder

F23.3 Other acute predominantly delusional psychotic disorders

F23.8 Other acute and transient psychotic disorders

## F23.9 Acute and transient psychotic disorders unspecified

A fifth character may be used to identify the presence or absence of associated acute stress:

- .x0 Without associated acute stress
- .x1 With associated acute stress

If acute episodes are a form of a recurrent or current psychotic disorder, they should be coded in F20#.

## F31 Bipolar disorder

F30 Manic episode

F31 Bipolar affective disorder

F30 Manic episode

includes subcodes (fourth and fifth character codes) for the above:

F30.0 Hypomania

F30.1 Mania without psychotic symptoms

F30.2 Mania with psychotic symptoms

F30.8 Other manic episodes

F30.9 Manic episode, unspecified

**F31 Bipolar affective disorder**

F31.0 Bipolar affective disorder, current episode hypomanic

F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms

F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms

F31.3 Bipolar affective disorder, current episode mild or moderate depression

.30 Without somatic syndrome

.31 With somatic syndrome

F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms

F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms

F31.6 Bipolar affective disorder, current episode mixed

F31.7 Bipolar affective disorder, currently in remission

F31.8 Other bipolar affective disorders

F31.9 Bipolar affective disorder, unspecified

## F32# Depression

F32 Depressive episodes

F33 Recurrent depressive disorder

F38 Other mood (affective) disorders

F39 Unspecified mood (affective) disorder

includes subcodes (fourth and fifth character codes) for the above:

**F32 Depressive episode**

F32.0 Mild depressive episode

.00 Without somatic syndrome

.01 With somatic syndrome

## ICD-10 PC Chapter V

## ICD-10 Chapter V Main Volume

		F32.1	Moderate depressive episode
		.10	Without somatic syndrome
		.11	With somatic syndrome
		F32.2	Severe depressive episode without psychotic symptoms
		F32.3	Severe depressive episode with psychotic symptoms
		F32.8	Other depressive episodes
		F32.9	Depressive episode, unspecified
		<b>F33</b>	<b>Recurrent depressive disorders</b>
		F33.0	Recurrent depressive disorder, current episode mild
		.00	Without somatic syndrome
		.01	With somatic syndrome
		F33.1	Recurrent depressive disorder, current episode moderate
		.10	Without somatic syndrome
		.11	With somatic syndrome
		F33.2	Recurrent depressive disorder, current episode severe without psychotic symptoms
		F33.3	Recurrent depressive disorder, current episode severe with psychotic symptoms
		F33.4	Recurrent depressive disorder, currently in remission
		F33.8	Other recurrent depressive disorders
		F33.9	Recurrent depressive disorder, unspecified
		<b>F38</b>	<b>Other mood [affective] disorders</b>
		F38.0	Other single mood [affective] disorders
		.00	Mixed affective episode
		F38.1	Other recurrent mood [affective] disorders
		.10	Recurrent brief depressive disorder
		F38.8	Other specified mood [affective] disorders
		<b>F39</b>	<b>Unspecified mood [affective] disorder</b>
<b>F40</b>	Phobic disorders	<b>F40</b>	<b>Phobic anxiety disorders</b>
		F40.0	Agoraphobia
		.00	Without panic disorder
		F40.1	Social phobias
<b>F41.0</b>	Panic disorder	[F41	Other anxiety disorders]
		F41.0	Panic disorder [episodic paroxysmal anxiety]
		F41.1	Agoraphobia with panic disorder
<b>F41.1</b>	Generalized anxiety	[F41	Other anxiety disorders]
		F41.1	Generalized anxiety disorder
		F41.3	Other mixed anxiety disorders
		F41.8	Other specified anxiety disorders
		F41.9	Anxiety disorder, unspecified
<b>F41.2</b>	Mixed anxiety and depression	[F41	Other anxiety disorders]
		F41.2	Mixed anxiety and depressive disorder
<b>F43.2</b>	Adjustment disorder	[F43	Reaction to severe stress, and adjustment disorders]

## ICD-10 PC Chapter V

## ICD-10 Chapter V Main Volume

		F43.2	Adjustment disorders
		.20	Brief depressive reaction
		.21	Prolonged depressive reaction
		.22	Mixed anxiety and depressive reaction
		.23	With predominant disturbance of other emotions
		.24	With predominant disturbance of conduct
		.25	With mixed disturbance of emotions and conduct
		.28	With other specified predominant symptoms
<b>F44#</b>	Dissociative (conversion) disorder	<b>F44</b>	<b>Dissociative (conversion) disorders</b>
		F44.0	Dissociative amnesia
		F44.1	Dissociative fugue
		F44.2	Dissociative stupor
		F44.3	Trance and possession disorders
		F44.4	Dissociative motor disorders
		F44.5	Dissociative convulsions
		F44.6	Dissociative anaesthesia and sensory loss
		F44.7	Mixed dissociative [conversion] disorders
		F44.8	Other dissociative [conversion] disorders
		.80	Ganser's syndrome
		.81	Multiple personality disorder
		.82	Transient dissociative [conversion] disorders occurring in childhood and adolescence
		.88	Other specified dissociative [conversion] disorders
		F44.9	Dissociative [conversion] disorder, unspecified
<b>F45</b>	Unexplained somatic complaints	<b>F45</b>	<b>Somatoform disorders</b>
		F45.0	Somatization disorder
		F45.1	Undifferentiated somatoform disorder
		F45.2	Hypochondrical disorder
		F45.3	Somatoform autonomic dysfunction
		.30	Heart and cardiovascular system
		.31	Upper gastrointestinal tract
		.32	Lower gastrointestinal tract
		.33	Respiratory system
		.34	Genitourinary system
		.38	Other organ or system
		F45.4	Persistent somatoform pain disorder
		F45.8	Other somatoform disorders
		F45.9	Somatoform disorder, unspecified
<b>F48.0</b>	Neurasthenia	[F48	Other neurotic disorders]
		F48.0	Neurasthenia
<b>F50</b>	Eating disorders	<b>F50</b>	<b>Eating disorders</b>
		F50.0	Anorexia nervosa
		F50.1	Atypical anorexia nervosa
		F50.2	Bulimia nervosa
		F50.3	Atypical bulimia nervosa

# Appendix 2

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Production of ICD-10 PC Chapter V involved researchers and practitioners in some 70 countries. Their efforts in compiling diagnostic and management guidelines were of great importance. Many others participated in the field trials which further helped to refine and improve the classification system.

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# **Appendix 3:**

## **Translations and adaptation to national standards**

The primary health care classification of mental and behavioural disorders is intended as a model system that will assist the identification and management of these disorders in primary health care settings. While diagnostic guidelines may be consistent across different health care systems, patients' presenting complaints and management guidelines may require adaptation to meet the needs of users in different countries. Diagnostic and management guidelines may be adapted to reflect different health service situations, especially in view of the following variations:

- presentation of mental disorders across cultures
- prevalence of physical disorders which may produce mental symptoms
- practice of primary health care
- availability of specialist treatments.

Persons and organizations who wish to undertake the translation, adaptation or any other application of this book should contact WHO's Division of Mental Health for permission and consultation. This procedure is required for coordination of translation rights and granting of copyright clearance, and will help avoid duplication of effort. Sample copies of adaptations should be sent to WHO.

Similar to the initial production of ICD-10 PC Chapter V., which encompassed various sources, it is recommended that national adaptations should be carried out by (or in consultation with) the following:

- organizations of general practitioners and family physicians (e.g., relevant bodies of the national medical association)
- organizations of psychiatrists (e.g., relevant bodies of the national psychiatric association)
- relevant government agencies (e.g., Ministry of Health)
- WHO and its Collaborating Centres.

WHO's Division of Mental Health is ready to provide as much assistance as is feasible in the adaptation process. For guidelines on translation and national adaptations please write to:

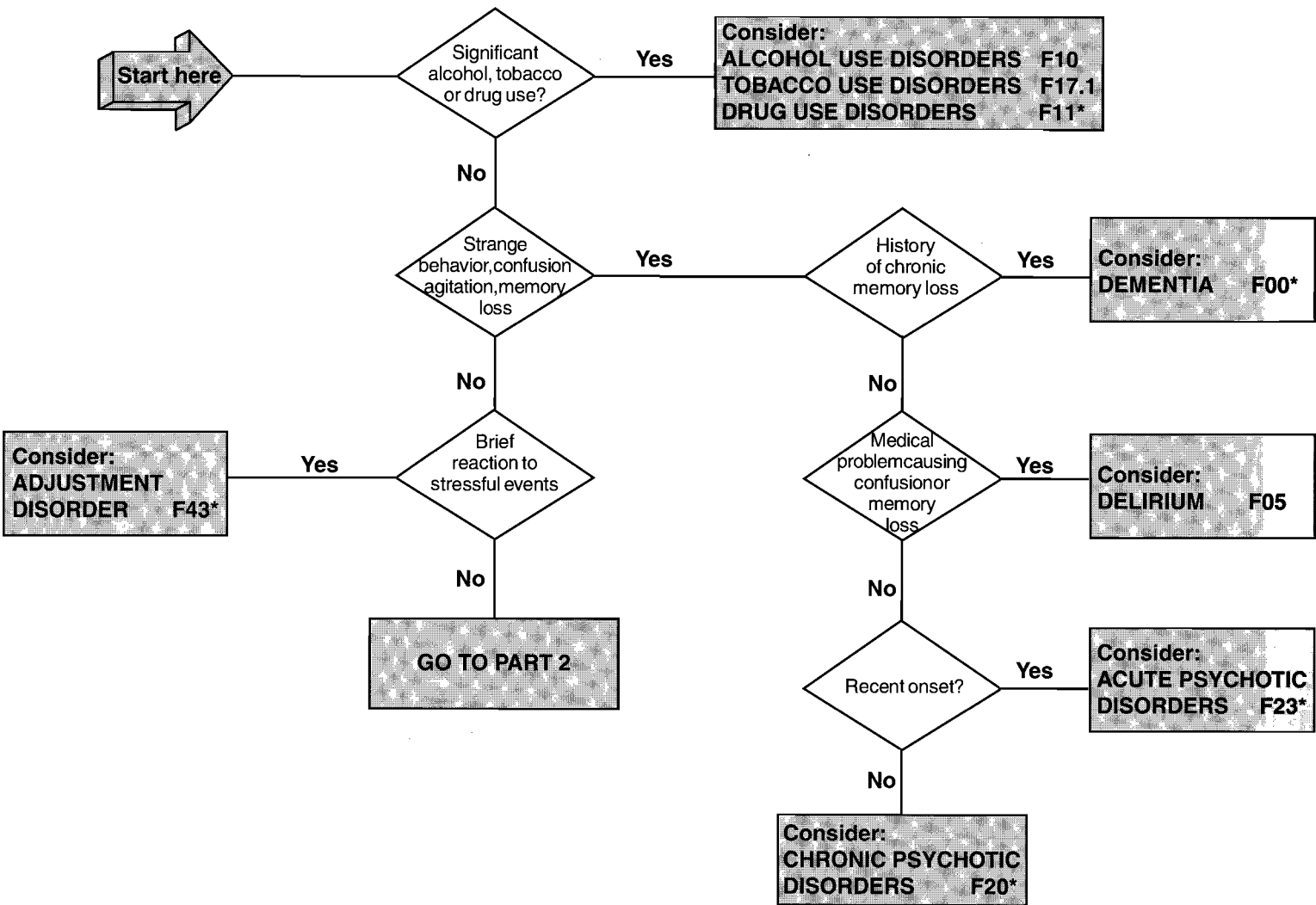
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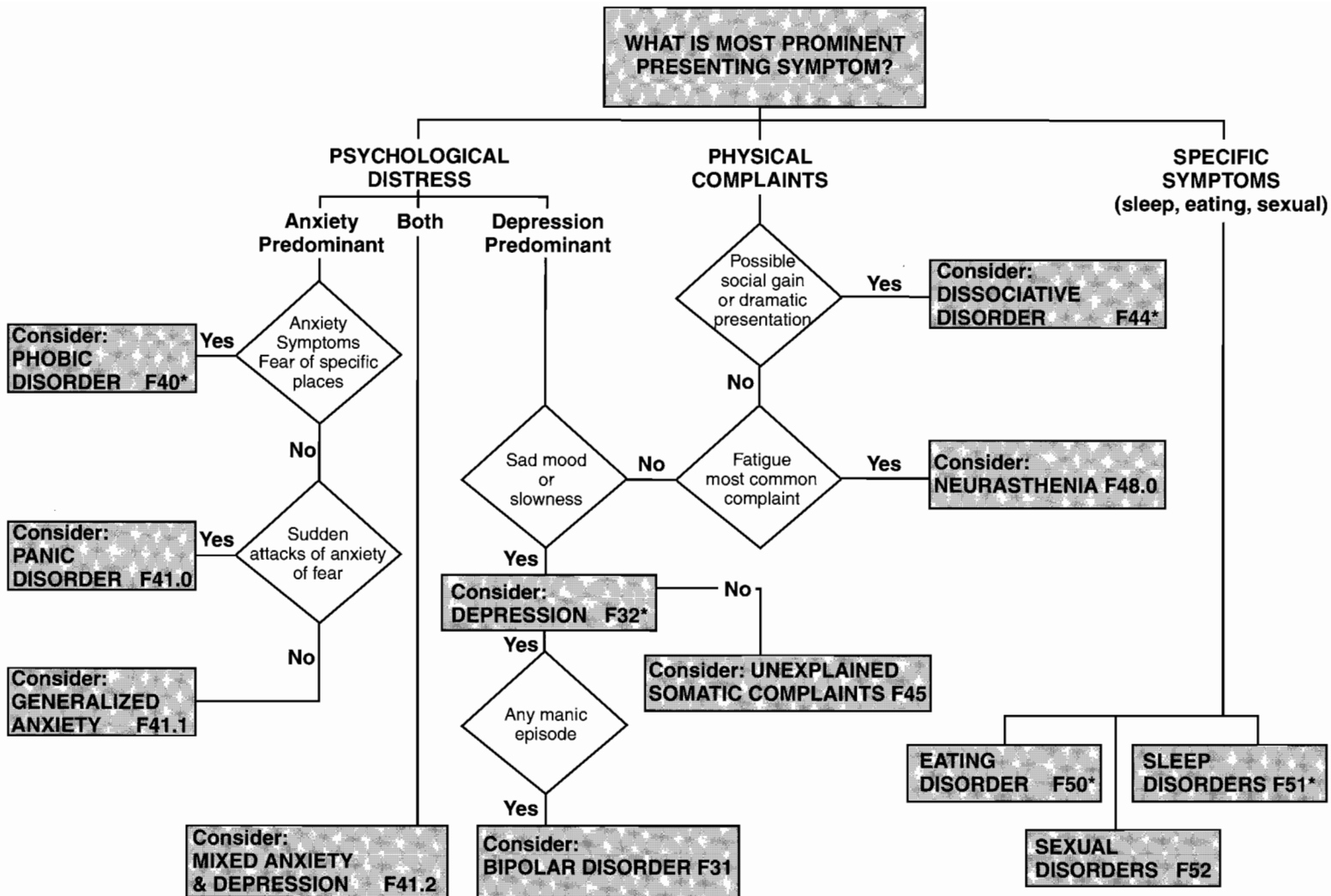
## Symptom Index for Adults

Agitation or excitement	<p>Acute psychotic disorders – F23</p> <p>Delirium – F05</p> <p>Chronic psychotic disorders – F20#</p>
Anxiety	<p>Generalized anxiety – F41.1</p> <p>Panic disorder – F41.0</p> <p>Phobic disorder – F40</p> <p>Adjustment disorder – F43.2</p> <p>Alcohol use disorders – F10</p> <p>Drug use disorders – F11#</p>
Confusion	<p>Delirium F05</p> <p>Dementia F00#</p>
Delusions or bizarre beliefs	<p>Acute psychotic disorders – F23</p> <p>Delirium – F05</p> <p>Chronic psychotic disorders – F20#</p> <p>Dementia – F00#</p> <p>Alcohol use disorders – F10</p> <p>Drug use disorders – F11#</p>
Fatigue	<p>Neurasthenia – F48.0</p> <p>Depression – F32#</p>
Hallucinations	<p>Acute psychotic disorders – F23</p> <p>Delirium – F05</p> <p>Chronic psychotic disorders – F20#</p> <p>Alcohol use disorders – F10</p> <p>Drug use disorders – F11#</p>
Poor hygiene/self-care	<p>Dementia – F00#</p> <p>Chronic psychotic disorders – F20#</p> <p>Alcohol use disorders – F10</p> <p>Drug use disorders – F11#</p>
Insomnia	<p>Sleep problems – F51</p> <p>Depression – F32#</p> <p>Alcohol use disorders – F10</p> <p>Drug use disorders – F11#</p>

## Symptom Index for Adults

Memory loss	Dementia – F00# Delirium – F05
Suspiciousness	Acute psychotic disorders – F23
Feeling persecuted	Delirium – F05 Chronic psychotic disorders – F20# Dementia – F00# Drug use disorders – F11#
Physical symptoms (without physical cause)	Unexplained somatic complaints – F45 Dissociative disorders (conversion hysteria) – F44 Panic disorder – F41.0 Generalized anxiety disorder – F41.1 Adjustment disorder – F43.2
Sad mood	Depression – F32# Adjustment disorder – F43.2 Alcohol use disorders – F10 Drug use disorders – F11#
Strange speech or behaviour	Acute psychotic disorders – F23 Delirium – F05 Chronic psychotic disorders – F20#
Suicidal thoughts or acts	Depression – F32# Alcohol use disorders – F10 Drug use disorders – F11#
Worry or fear	Generalized anxiety – F41.0 Phobic disorder – F40 Panic disorder – F41.1 Adjustment disorder – F43.2 Alcohol use disorders – F10 Drug use disorders – F11#
Violent behaviour	Acute psychotic disorders – F23 Delirium – F05 Chronic psychotic disorders – F20# Alcohol use disorders – F10 Drug use disorders – F11#





## The official WHO checklists for Mental and Behavioural Disorders

### ICD-10 Checklists

#### SCL-Symptom Checklist for Mental Disorders

#### IDCL-International Diagnostic Checklists

##### Contents of the Box:

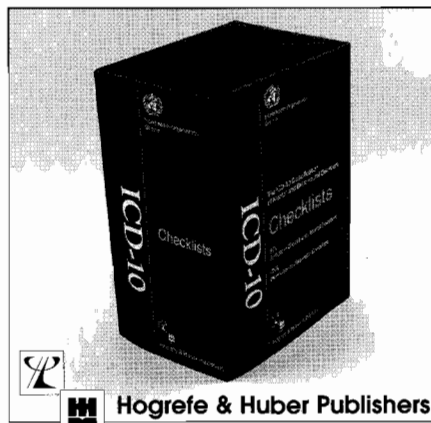
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(ISBN 0-88937-164-4)

The ICD-10 Symptom Checklist for Mental Disorders (SCL) is intended for use by clinicians in their assessment of the main psychiatric symptoms and syndromes. The Checklist can be used as a screening instrument to be followed by a more detailed psychiatric examination.

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**The book gives helpful guidelines on diagnosis for primary care physicians. It also provides guidelines on what to say to patients and their families, how to give them counselling, what medication to prescribe, and when to consult a specialist. In short, this volume presents the knowledge of mental health science in an easily understandable form for practitioners (both physicians and others) at the primary health care level.**

**Two versions of ICD-10 Chapter V Primary Care Version (ICD-10 PC) are presented here: (1) a concise version for those with medical training and prescription responsibility; (2) a brief version for primary care staff with other medical training. The primary care versions of the mental disorders classification were designed by an international group of general practitioners, family physicians, mental health workers, public health experts, social workers, psychiatrists and psychologists with a special interest in mental health problems in primary health care. Drafts were reviewed by both mental health and primary health care providers. After two rounds of revision, the classification system was field tested in more than 40 countries by over 500 primary care physicians to assess its relevance, ease of use and reliability.**

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