The Health Counsellor's Trainer's Manual

The MANAS Model

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Introduction

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

MANAS Program

The MANAS program was implemented in Goa, India, between 2005 and 2010 to develop and evaluate a model for delivering CMD treatment in the primary care setting. The guiding philosophy of MANAS is that the care for CMD requires a **team approach** involving three key players: **the primary care doctor**, **a visiting mental health specialist** and a **health counsellor** (HC). The HC is a person who may not have previous experience in mental health care but is trained to provide psychosocial treatment. The HC is a member of the primary health care team.

The essence of the MANAS model is to facilitate the shift for mental health care from specialists to lay people such as the HC (similar to health worker) within a primary care team, and thus improving the coverage and efficiency of management of CMD.

The course has been designed to train HCs who have little or no prior experience in health or mental health issues. It may also be used to assist health or mental health administrators and planners as they develop a training component for mental health interventions at the Primary Health Centre (PHC) level. Follow-up mentoring and supervision of participants is necessary to complement this course. Without follow-up, the participants may find themselves confronting difficulties for which their they are not prepared.

It is assumed that the trainers are professionals in the fields of medicine, mental health and community-based work. It is necessary to emphasise that, in order to be able to move smoothly between the different kinds of activities (inputs, discussions, discussion of scripts, examples of cases and role-plays), trainers will need to spend time familiarising themselves with the content and flow of each session as well as the course.

This is approximately a 4 weeks program that comprises several modules that focus on particular skills that the HC needs to acquire for optimal service delivery.

An overview of the modules and a suggested training schedule giving approximate times per activity is provided. The training content does not include the daily agenda because it is assumed that the trainer's preference and the needs of the participants will dictate this level of specificity. At the beginning of each section of this course, an outline of its purpose, objectives, content and methods, duration of each activity, and the materials necessary is provided.

Training Objectives

The course aims to train Health Counsellors in the MANAS Project to deliver services to persons with Common Mental Disorders (CMD) in the primary care setting. The objectives are to:

- Understand the important concepts of CMD and recognise them
- Understand the Collaborative Stepped Care model and their role
- Understand the general principles of counselling
- Provide appropriate psychosocial treatments to people with CMD who attend the primary care clinic, specifically psychoeducation and health promotion
- Monitor clinical progress and improve adherence, and
- Provide information about resources and procedures for onward referral of or consultation about cases which cannot be managed adequately at the primary care level.

Learning Approach

The manual adopts an **adult learning approach**. It assumes that participants are adults, who bring to the training relevant prior knowledge and skills, whether formally or informally acquired, and who can be expected to take some responsibility for their own learning.

The training is carried out in a participatory manner. This implies that training must allow for participants to engage with the materials and for dialogue and interaction between facilitator(s) and participants and amongst participants themselves. It would be useful to have the participants prepare for the course by reading the training material (see below) ahead of time.

Specific methods used:

- *didactic lectures* supported by *slides* to highlight key points
- small and large *group discussions*, with the trainer giving supplementary input, commenting or elaborating where necessary
- discussion of scripts or *case material* to allow participants to learn and apply skills to typical patient situations
- *role play* to allow participants to observe and practice relevant skills.

This manual is designed to be used by trainers along with the MANAS Health Counsellor Training Kit that should be provided to all trainees as esential training material. Time is also provided for specified assignments relevant to the module being taught.

Equipment and materials required

1 Venue with sufficient space to allow breakaway discussions and activities
2 Laptop computer and data projector
3 Overhead projector and transparencies or chart paper for feedback
4 Whiteboard and pens for recording feedback from exercises
5 Name-tags for participants and trainers
6 Powerpoint presentation and copies of slides in handout form
7 The MANAS Manual for Health Counsellors with training videos
8 Copies of worksheets for participants
9 Note-pads and pens for participants

Evaluation

At the end of each module participants are assessed on the course content to enable quality control of the program. This should consist of a written assessment consisting of multiple choice questions or short answers and role plays.

The participants should be assessed using a pre-designed structured assessment sheet. In addition, there should be a final evaluation at the end of the training course that consists of a written test and practical.

Acknowledgements

We acknowledge the important contribution of four organizations in implementing MANAS: Sangath, an NGO which led the program in Goa; the London School of Hygiene & Tropical Medicine which provided technical support on intervention development and evaluation; the Directorate of Health Services (Government of Goa) which collaborated in the phase involving primary health care centers; the general practitioners who participated in program implementation and the Voluntary Health Association of Goa, an NGO which was responsible for the field work related to evaluation of the intervention.

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The Health Counsellor's Training Plan

Trainees are updated through a power point presentation about the training plan objectives, modules, assessment, trainers and the role of the trainee during training.

Reading materials: Trainees are provided a copy of the Health Counsellors manual and the power point slide handouts as reading material.
Each training day begins with a feedback session (see below) by the trainees, followed by the lectures and group work exercises. At the end of the day, trainees fill in and submit feedback forms (refer appendix 1) reflecting their perceptions of the training content and methods.

Selection of trainee for feedback session: All trainees have to write their names on a small slip of paper and put in a box. Two names are randomly drawn out for each training day. These two trainees are then expected to make a brief presentation on the next day of the training, summarizing the contents of the day's module. These selected names of the trainees may be put up on the chart paper as a reference.

Feedback session: Every day training will start with a feedback from the trainees.

Objectives:

- Trainees have the opportunity to review the module discussed during the previous day, clarify doubts and queries.

Duration: approximately half an hour.

Method:

- Power point slides / charts
- Group discussions
- Feedback

Procedure:

1. **Presentation:** (duration: 10 minutes for both trainees)
   The randomly selected trainees make their presentations that recap key elements of the previous day's training.
2. **Group discussion and clarification:** (duration: 20 minutes)
   The whole group is then encouraged to contribute to the discussion and clarify doubts if any with the trainers.

Assessment: During this training, the trainer should rate the trainees on their participation, communication abilities and interpersonal skills using the ongoing assessment form (refer appendix 3)

Written test: There should be a structured assessment at the end of the every week /module (refer appendix 4).

Training Schedule

Topic	Key Points	Duration
Introduction to Training		½ hour
Module I: Stress and Common Mental Disorders		10 hrs. 40 min.
A. Stress	• What is stress? • What are the common types of stress? • What are the different reactions to stress? • How do we understand stress and it's consequences from the Biopsychosocial Model?	2 ½ hours
B. Vulnerability and Resilience	• What is mental health? • What is vulnerability and resilience? • What are risk and protective factors? • What is the importance of vulnerability and resilience?	2 ½ hours
C. Common Mental Disorders (CMD): An overview of symptoms	• What is CMD? • Why do some people develop depression and anxiety? • How does CMD present in primary care?	5 hours
Written Test		40 minutes
Module 2: Structure & Essential Building Blocks of Program		30 hrs.10 min
A. Treatments of common mental disorders and the collaborative stepped care intervention	• What are the principles of MANAS intervention? • What treatments are provided as part of the intervention? • Understanding how the collaborative stepped care model works in practice	5 ½ hours
B. Detecting common mental disorders in primary care	• Use of screening questionnaires for detection of CMD in primary care • How to use the (GHQ), General Health Questionnaire as a screening tool?	3 hours
C. Assessment of suicidal risk and its management	• What is the definition of suicidal behavior? • How to detect the risk of suicide? • What are the socio - demographic, clinical and immediate risk factors? • What are protective factors? • How to assess degree of suicidal risk?	7 hours

Topic	Key Learnings	Duration
D. General principles of counselling	• What is couselling ? • Why is self awareness a prerequisite to couselling? • What are the characteristics of a good counsellor? • What are the basic counselling and interviewing skills?	14 hours
Written Test		40 minutes
Module 3 : Treatments of Common Mental Disorders		84 hrs. 20 min.
A. Psychoeducation	• What is psychoeducation? • How to reassure and explain the link between patient's stress and symptoms? • How to explain the diagnosis and give hope? • How to help patients affirm their role as a sick person? • How to teach relaxation through a breathing exercise? • How to manage suicidal risk? • How to give advice for managing specific symptoms of CMD?	40 hours
Written Test		40 minutes
B. Antidepressants (ADT) and other drug treatments of common mental disorders used in primary care	• What are antidepressants? • How do antidepressants work? • What are the common types of antidepressants used in the clinic? • When will the doctor start administering antidepressants? • What is the role of the HC when a patient is on antidepressant treatment? • What are the other medicines used in the clinic?	3 ½ hours
Written Test		15 minutes

C. Interpersonal psychotherapy	• What is Interpersonal Psychotherapy (IPT)?
	• What are the three phases of IPT?
	  • Initial phase
	  • Middle phase
	  • Termination phase
		36 hours

Written Test		40 minutes

Topic	Key Points	Duration
D. Adherence management	• What is adherence management? • Why is adherence important? • What are the major problems affecting adherence ? • How to improve adherence? • What are the adherence management strategies in the MANAS program?	3 hours
Written Test		15 minutes
Module 4: Delivery of collaborative stepped care intervention		6 hrs. 10 min.
A. Integrating services in primary care clinics	• What is the structure of the team? • What are the roles and responsibilities of the team members? • What are the tasks for integrating mental health services in primary care clinics in the initial period? • How to continue efforts to integrate the program?	2 hours
B. Supervision and Documentation	• What is supervision? • Why is supervision important? • What HC need to do to make supervision useful? • Why is documentation important?	3 hours 30 minutes
Written Test		40 minutes
Final review of the training program, focusing on implementation		6 hours
Final assessment:	Written and practical	6 hours
Certification		

Grand Total: 144 hours

Module 1 : Stress and Common Mental Disorders

A. Stress

Objectives:

1. Trainees have an understanding of the nature of stress, the typology of stress and the possible effects on bodily and mental functions.
2. Trainees are aware of the models of stress (the stress vulnerability and the bio psychosocial models) and development of psychological problems through clear examples drawn from plausible, real life situations.

Duration: approximate 2 ½ hours

Method:

- Lecture using power point slides
- Group discussions
- Role plays

Procedure:

1. Group discussion: (duration: 10 minutes).

A group discussion that elicits the trainee's understanding of stress and how it affects the mental and physical health of individuals. The major themes expressed during this discussion are placed on a whiteboard for reference during the rest of the session.

2. Presentation and lecture: (duration 20 minutes)
Didactic lecture, using power point slides, will explain the contents of the module. During the lecture, there is a an emphasis on making sure the contents are understood through interactive discussion and by providing time for clarification.

3. Group discussion: (duration: 20 minutes)
At the end of the presentation, there is another group discussion, where the key points are revised and reinforced.

4. Role play: (duration: 100 minutes)
Participants are divided into two groups. Each group will enact all four case vignettes which briefly describe stress related health problems drawn from real life experiences in primary health care clinics. Each role play lasts for 15 minutes. Role plays can be done using the local language as the medium of communication.

One trainee will play the counsellor while the other will play the patient. The rest of the trainees will observe and record the stressors and its effects on the patient's - physical, emotional and social state, for each case vignette (refer to the tasks and case vignettes below). The next 10 minutes will allow trainees to discuss their observations and clarifications with the group.

At the end of the session, both groups will reassemble .One person from each group presents the discussion to the entire group, followed by a large group discussion (duration: 30 minutes).

Material related to the lecture is found in the *HC Manual – The MANAS Model for Health Counsellors* on pages 14 -21.

Worksheet

Tasks:

1. Identify the stressors in the cases below.
2. Identify the effects of stress and categorise as physical, emotional and social effects of stress

Case vignettes

Narrative A:

Seema is a 45 year old woman living with three children. Her husband expired two years ago. She sells vegetables in the market to make a living and manages to look after her children but very often finds it difficult to make ends meet. Her mother-in law verbally abuses her for not doing her house hold work. She has been feeling tired, has headaches and does not get sleep .She is scared that her illness will make it impossible for her to go to the market and that her children may go hungry.

Narrative B:

Amit is a 37 year old married man living with his wife, two children, and his mother. He comes to the clinic complainting of chest pain, palpitation, headache and lack of sleep.He also feels life is not worth living. He has recently lost his job because of his drinking habit. He said he tried to give up alcohol but was not successful. He feels that his friends and relatives avoid interacting with him.

Narrative C:

Sunita is a 30 year old woman who recently had her second girl child. Her husband and in-laws are very upset since her first child too is a girl. She complains that her mother-in-law keeps taunting her and praises her sister-in-law who has a son. After her delivery, no one has been supportive and they make her do most of the house hold work. Her husband too is not supportive of Sunita and has been coming home late in the evenings. She feels irritated, gets palpitation, does not get sleep, is unable to concentrate on work and sometimes she gets thoughts of harming herself, but does not do so as she thinks of the welfare of her children.

Narrative D:

Narayan is a 65 years old and a widower. His daughter lives in the neighbouring state and is part of a joint family. He lives alone and till recently has been working in the fields and managing on his own. Since the past six months he has been finding it difficult to work and make ends meet. He does not like to visit his daughter and cannot live with her since she has 3 children and is part of a big joint family. He has been feeling very tired recently, finding it difficult to sleep and has been getting palpitations.

Introduction to Stress

Introduction to stress related disorders

- Stress & tension are now recognized as part of everyday life.
- Commonly understood in mechanical terms like a load on a machine.
- Any event / experience that affects the balance / ability to function smoothly.

1

Common Types of Stress

- Stress can be because of changes inside (developing physical illness) or outside of us (loss of job).
- Can be sudden (death in family) or long standing-e.g. poverty, domestic violence, gender discrimination.
- Can be of different grade of severity- mild to severe.

2

Stress and the individual

- Not everyone reacts to the same stress in the same manner.
- Individuals give different meanings to stressful events
- Individuals react to stress based on their personality, culture and life experiences
- Not all stress is harmful.

3

Stress- Immediate physical effects

- The physical changes- the acute stress reaction is universal.
- It has a common chemistry- the release of adrenaline and hormones like cortisol.
- These mediate the physical and mental consequences of 'fight or flight'.

4

Stress- long term physical effects

- The acute stress reaction is energy intensive and cannot be continued for long
- Body and mind become exhausted with continued stress
- Long term stress has negative results
- In chronic health problems like heart disease, diabetes and cancer- high stress causes earlier death.

5

Stress- Emotional Consequences

- In the short-term improves mental functions like attention, concentration, memory, problem solving.
- However, stress when very severe can cause problems like Depression.
- When long standing with little possibility of being resolved;('being trapped') can cause Depression.

6

Stress- Social Consequences

- Social networks are a safety net, making it easier to deal with stress.
- Can also be a cause of the problem, e.g. problems faced by bride over dowry.
- Stress causes problems in social roles.

7

Stress is due to dynamic Interactions

- The physical, emotional and social dimensions of stress interact closely.
- Stress is a biopsychosocial experience.
- This gives meaning to, produces unique effects and influences outcomes of stress.

8

B. Vulnerability and Resilience

Objectives:

1. Trainees get an understanding of the concepts of vulnerability and resilience, risk and protective factors and the stress- vulnerability model
2. Trainees learn to identify risk and protective factors
3. Trainees understand factors which promote resilience
4. Trainees understand how strengthening such factors are an important part of the counselling process

Duration: approximately 2 ½ hours

Method:

- Lecture using power point slides
- Group work
- Group discussions

Procedure:

1. Presentation and lecture: (duration: 60 minutes).

Didactic lecture using power-point slides that explains the content of the module for 40 minutes, followed by 20 minutes of discussion and clarification.

2. Group work: (duration: 120 minutes).

The trainees are divided into groups of 6 to 8 participants. Each group tackles one of the following cases, and aims to generate ideas on the following themes:

- What factors may increase the risk of the person getting CMD? (What information would you collect to determine risk factors?)
- What factors may help the person cope with the problems he or she is facing? (What information would you collect to determine protective factors?)
- If the person was depressed and you were his/her counsellor, what would you advise the person to do to reduce the risk factors and promote protective factors?

Narrative A
A 36 year old married woman lives with her husband and mother-in-law. They have been married for ten years, but have not been able to have a child.

Narrative B
A 24 year old man has recently completed an electrical engineering diploma from a regional engineering college. Since finishing college, however, he has not been able to get a job for six months.

Narrative C
A 60 year old woman has recently lost her husband to a sudden illness. Her two children are married and live in cities in other parts of India.

The session has two parts: group work (30 minutes) and feedback (60 minutes). Group work will follow the usual guidelines, viz., one member will be the reporter and one is the chair person. The chair person guides the group work while the reporter takes notes and will present the group's findings to the entire group during the feedback. The use of transparencies / chart paper is recommended for the feedback. Each group is given 20 minutes which includes no more than 5 minutes for the report and 15 minutes for the discussion guided by a tutor.

The objective of the discussion is to illustrate how, for the person in each narrative, a combination of factors may help explain why the person may, or may not, become depressed. Strengthening the protective factors or minimising the risk factors is counselling strategy to promote recovery from CMD.

Additional exercise: This exercise can be completed after the class and submitted the following morning to the tutor which can be the basis of the feedback discussion. Imagine two people facing very similar social difficulties; both are women of the same age, and live in the same village. Both have been married for 10 years and have two children. Both have husbands who drink heavily and, sometimes, beat them. One becomes very depressed and suicidal, the other does not.

List at least five possible reasons why the first woman has become depressed, and five possible reasons why the second has not. List five things you could advise the depressed woman to do which can reduce the risk factors, or promote protective factors.

Material related to the lecture can be found in the HC Manual – The MANAS Model for Health Counsellors on pages 22-26.

Resilience and Vulnerability

Resilience

and

Vulnerability

1

What is Mental Health?

- Self-realization- achieving one's potential
- Sense of mastery-having some control over one's life
- Autonomy- face and overcome problems
- Social integration

2

Vulnerability and Resilience

- Vulnerability
  Why some people are more prone to suffer from Common Mental Disorders (CMD)
- Resilience
  Why some people remain in good mental health even in the face of difficulties

3

Risk and Protective Factors

- Risk factors: factors which increase the chance of suffering from common mental disorders
- Protective factors: factors which act as a buffer and prevent a person from suffering from common mental disorders

4

The Stress- Vulnerability Model

- Useful model to understand why someone is likely to develop common mental disorders
- Vulnerability is the inherent possibility of becoming depressed
- Biological, psychological or social factors
- Stress in persons who are more vulnerable can lead to depression more easily

5

Risk Factors that lead to CMD

- Physical health
- Social and economic disadvantages
- Relationships
- Life Events
- Biological factors

6

Physical Health

- Suffering from a chronic physical illness or disability
- Women-suffering from gynaecological complaints
- Heavy alcohol consumption • Tobacco use (smoking or chewed)
- Caring for a loved person who is severely ill
- Physical and mental health problems typically occur together

7

Socio-economic Factors

- Living in conditions of extreme financial disadvantage
- Being in debt
- Unemployment
- Heavy work load

8

Relationship Factors

- Lack of trusting relationships
- Living in an unhappy relationship
- Living in a violent relationship
- Experiencing child abuse
- Loss of parents in early life
- Sickness in a family member

9

Life Events

- Bereavement
- Break-up of a relationship
- Transition of a relationship

10

"Biological" Factors

- Genetic risk
- Some medical problems can cause depression (e.g. thyroid problems)
- Some medicines can cause depression (e.g. steroids)

11

Women are at Risk

- Exposure to domestic violence
- Gender-based oppression
- Gynecological and reproductive health issues
- Face greater burden of poverty
- Work load; lack of time for self

12

Women are at Risk

- But most people living even in the most difficult circumstances do not become depressed.
- Most women who live in violent relationships do not become depressed

13

Protective Factors

- Factors which help protect people from depression by strengthening their ability to cope with difficulties
- Resilience is the individual's capacity to cope with adversity and to avoid breakdown or mental health problems when confronted with stressors.

14

What are Protective Factors?

- Strong, trusting relationships with relatives (such as spouse), friends, colleagues at work
- Having a 'positive' view of oneself, for example, that one is good at being a mother
- Living in a community with strong social networks and which is safe

15

What are Protective Factors?

- Past experience of having faced difficulties successfully
- Having experienced a childhood with caring parents and relatives
- Financial security
- Religious affiliation

16

Why do some people become depressed?

- Due to an interplay between risk and protective factors
- Differs between one person and the next
- Can differ from one time to the next
- Health Counsellor aims to minimise risk factors and promote protective factors

17

C. Common Mental Disorders (CMD): An Overview of Symptoms

Objectives:

1. To understand the association of CMD and physical illness
2. To learn the common presentations of CMD
3. To learn how to elicit the symptoms of CMD including identifying co-morbid conditions and ruling out other conditions that mimic depression

Duration: approximately 5 hours

Method:

- Lecture using power point slides
- Group discussions
- Role plays

Procedure:

1. *Small group discussion:* (duration: 60 minutes).
Trainees are divided into groups of 3-4. Each group discusses one case vignette (refer to the worksheet below) for 20 minutes. One person from each group presents the discussion to the entire group, followed by a large group discussion for 40 minutes.
Note: On the whiteboard, note depressive symptoms classified as feelings, behaviour or thoughts. Emphasise the difference between everyday sadness and CMD.

2. *Presentation and lecture:* (duration: 70 minutes)
Lecture which covers the following topics:

- What is CMD?
- Scope of the problem
- Symptoms of CMD and questions to elicit these symptoms
- Identifying co-morbid conditions
- Ruling out other conditions that may mimic CMD

3. Small group work: (duration: 20 minutes)
Participants in pairs discuss what they have learnt in the above session and clarify doubts.

4. Role plays: (duration: 120 minutes)
Participants are divided into groups of 4/5. Each group is assisted by one co-facilitator. The co-facilitator first demonstrates through role-play how to elicit CMD symptoms.

Then each participant in turn practices this through role-play. By the end of this, the participants should be comfortable asking for CMD symptoms.
The groups will reassemble and provide their feedback to the entire group (duration: 20 minutes).

5. Group discussion and clarifications: (duration: 30 minutes)
Trainees will get the opportunity to discuss and clarify any issue that arises from the exercise.

Material related to the lecture can be found in the HC Manual – *The MANAS Model for Health Counsellors* on pages 27-32.

Additional Resources:

- ICD 10 Classification of Mental Disorders, Primary Care Version
- Where there is no Psychiatrist (Author: Dr. Vikram Patel)

Worksheet

Read the cases below and answer these two questions.

1. What do you think are the feelings, behaviour or thoughts that the person has?
2. What do you think is her/his problem?

Case1 :

Mona, a 23 years old college student had had a quarrel with her boyfriend two days ago. When you see her, she is tearful, saying she does not want to go to college anymore, nor does not want to eat anything. She says she can't study because her mind is preoccupied with thoughts about her boyfriend.

Case 2:

Radha, a 35 year old housewife is brought to the centre by her husband. She has become withdrawn, since two months does not interact with her family and friends, avoids social functions (something she would enjoy earlier), and cannot sleep at night. Her sister died suddenly in an accident six months ago. Radha recalls that the last time she met her sister they had a bitter quarrel. This makes Radha feel that she is not a nice person and does not deserve to live.

Case 3:

Krishna, a 40 year old man has to appear for an important job interview. Since two days his sleep is disturbed. He feels his heart pounding and starts sweating whenever he thinks about the interview. He cannot eat properly and is worried about failing the interview.

Case 4:

Beena, a 26 year old working girl had a minor accident two months ago while crossing the road. Since then, she feels her heart beating fast,cannot concentrate at work, and has disturbed sleep with nightmares. She is afraid to travel to work as she is worried about meeting with an accident. She thinks that some harm might befall her or her family and this makes her very restless.

Common Mental Disorders (CMD): An Overview of Symptoms

Common Mental Disorders:
An Overview
of Symptoms

1

Objectives

- What is a Common Mental Disorder?
- Why are CMD common in primary care?
- What are the symptoms of CMD?

2

Common Mental Disorder

- Conditions included in this group
- Depression and Generalized anxiety
- Other Anxiety Disorders: Panic Disorder, Phobias, Post-Traumatic Stress Disorder
- Somatoform disorders

3

Depression is NOT:

- a sign of weakness, failure, laziness
- a possession by spirit forces, a spell
- a contagious disease
- does not mean losing one's mind
- untreatable, unspeakable
- a major handicap in life events
- associated with a poor outlook
- always hereditary

4

What is depression

Origin: Latin deprimere = "to press down"

- disturbance in an individual's emotions and feelings, referred to as mood

Ancient texts:

- Papyrus (1550 BC)
- Old Testament
- Hippocratic writing (4th century) "melancholy"

5

How does the experience feel like?

- We all feel sad or depressed
- We all feel anxious or fearful some of the time
- We all have sleep problems some of the time
- 90% of the general population has had suicidal ideas at least once in their lifetime
- But we don't say we have a Depressive Disorder

6

Depression is a disorder, not just an experience!

- People with depression/ anxiety have these experiences most of the time
- It is so persistent that it interferes with their normal functioning
- Untreated episodes of depression will last for 6 to 9 months
- The *constancy of symptoms* and *effects on functioning* describes a Disorder

7

Scope of the problem

- 1 in 5 of us will have depression in our lifetime
- Every year one in ten of us suffers from a depressive episode
- Depression is the fourth largest cause of disability, but by 2020 it will be the second after Heart Disease (WHO)

8

Depression and primary care

Association between depression & physical illness

- Life threatening or chronic physical illness
- Unpleasant and demanding treatment
- Low social support and other adverse social circumstances
- Personal or family history of depression or other psychological vulnerability

9

Depression and primary care

Association between depression & physical illness

- Alcoholism and substance misuse
- Drug treatments that cause depression as a side effect, such as anti-hypertensives, corticosteroids, and chemotherapy agents.

10

Depression and primary care

Reasons why depression is missed in primary care:

- Difficulty distinguishing psychological symptoms of depression, such as sadness and loss of interest, from a "realistic" response to stressful physical illness
- Negative attitudes to diagnosis of depression

11

Depression and primary care

Reasons why depression is missed in primary care:

- Confusion over whether physical symptoms of depression are due to an underlying medical condition
- Unsuitability of clinical setting for discussion of personal and emotional matters
- Patients' unwillingness to report symptoms of depression

12

Patients present with physical rather than psychological symptoms

- Acceptability of medical illness over psychological illness (self & society)
- Patients more accustomed to physical idioms of distress

13

Summary

"if you wake up feeling no pain, you know you are dead".

It is like trying to define hunger - it affects us several times in a day but when severe can be fatal.

14

Summary

- Continuous, intense, interferes with functioning
- "internal stress state"
- On the outside seen as agitation/ withdrawal, internal experience differs
- Described in different ways by different people - hence important to have some specific symptoms to look for

15

How will you diagnose depression?

- Blood test?
- Cardiogram?
- X-ray?
- Brain scan?

16

General points while asking about any symptom

- Make sure it is truly *a change from the baseline*
- Make sure that the symptom has occurred *almost every day* for 2 weeks
- Make sure you are *not asking a leading question*

17

Core symptoms of depression

- Feeling sad or irritable most of the time
- Fatigue or decrease in energy
- Inability to enjoy pleasurable activities

18

Depressive thoughts

- Lack of confidence or feelings of inferiority
- Helplessness/Hopelessness/ Worthlessness
- Undue guilt
- Suicidal ideas/plans

19

Depressive symptoms

- Forgetfulness
- Lack of concentration/ distractibility
- Affects functioning

20

Sleep and weight problems

- Does not feel fresh from sleep
- Takes time to fall asleep
- Awakens repeatedly in the night
- Early morning awakening
- Excess sleep
- Lost or gained weight in past month; three kilos or more
- Loss or increase in appetite
- Affects functioning

21

Depression and anxiety

- Often depression incorporates anxiety symptoms
- "They are fraternal twins"
- Depression with anxiety - higher suicide rate

22

Anxiety

Core symptoms:

- Feeling as if something terrible is going to happen
- Feeling scared
- Worrying too much about one's problems/health
- Thoughts that one is going to die, lose control or go mad

23

Anxiety

Other symptoms:

- Palpitations
- Feeling of suffocation
- Chest pain
- Dizziness
- Trembling, shaking all over
- Headaches
- Pins & needles on limbs or face
- Poor sleep

24

Panic disorder

Greek God Pan:
Because of his striking appearance, he would sometimes cause sudden fear in people - "panic".

25

Panic disorder

Attacks of extreme anxiety and fear:
- Comes out of the blue, without warning
- Person fears he may die or lose his mind
- Last from few mins up to half an hour
- Disappear as suddenly as they started

26

Panic disorder

- Panic: An anxiety attack is a sudden rush of fear with heart pounding, shortness of breath and fear that one is going to lose control and die

27

Specific phobia

- Fear of specific objects or situations
- Unreasonable, excessive, recurrent
- Leads to avoidance behavior

26

Specific phobia

Objects,Activities,Situations:
- Crowds, buses, rail stations, social situations
- Anxiety in such situations so intolerable that it leads to avoidance of those situations

29

Generalized anxiety disorder

Excessive worry about everyday problems causing significant functional impairment
- Worrying thoughts
- Physical symptoms

30

Further information about each symptom

- When did the symptoms start?
- Was there a stressful event or series of events that occurred around the time the depressive symptoms began?
- Has the patient had these symptoms before?

31

Further information about each symptom

- Did the patient receive treatment?
- What treatment was given?
- Have other family members had a depressive illness?
- **Has the patient had thoughts about death or suicide?**

32

Additional Information

How do the symptoms affect functioning?

- Difficulties carrying out routine activities
- Difficulties performing at work
- Difficulties with home life
- Withdrawal from friends and social activities

33

Remember

- Ask open-ended questions
- Understand & acknowledge patient's responses
- Allow patients to talk freely and express their emotions
- Be sensitive to patients' emotions
- Pay attention to patient's body language and tone of voice

34

Conditions that mimic depression

Other psychiatric problems:

- psychosis (unusual symptoms such as odd behaviour, talking to oneself, odd beliefs/suspiciousness)
- memory disorders or confusional states

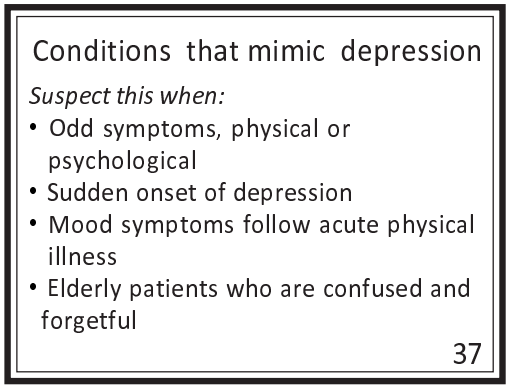
35

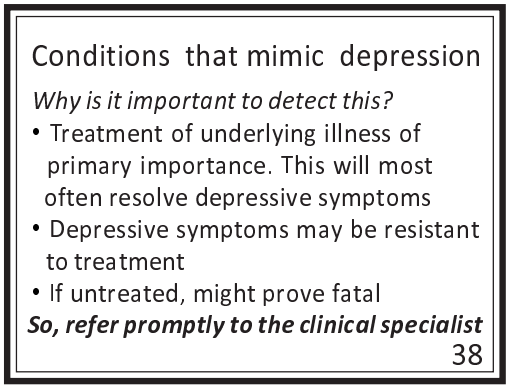
Conditions that mimic depression

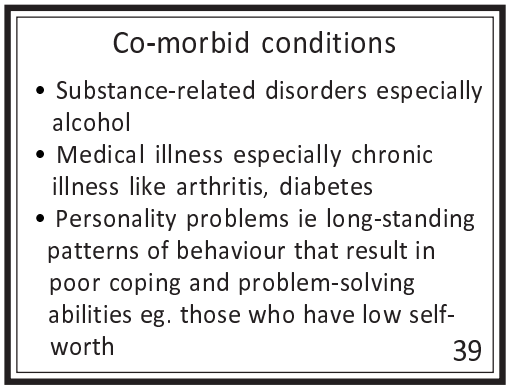
Medical illnesses:

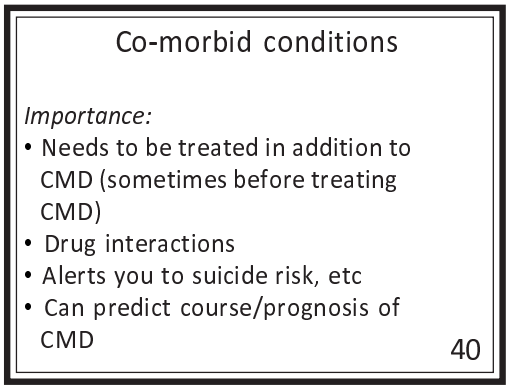
- hormonal problems: symptoms that occur around menstruation and at the time of menopause
- medication-related symptoms. Ie. some drugs used to treat high blood pressure can lead to depressive symptoms

36









Written test: (duration: 40 minutes)

Module 1: Stress and Common Mental Disorders: refer appendix 4

Module 2 : The Structure and Essential Building Blocks of the Program

A. Treatment for Common Mental Disorders and the Collaborative Stepped Care Intervention

Objective:

1. To acquire necessary knowledge about the treatment for Common Mental Disorders (CMD)
2. To acquire necessary knowledge about the principles of the MANAS Intervention
3. To acquire necessary knowledge and skill in implementing the collaborative stepped care intervention

Duration: approximately 5 ½ hours

Method:

- Lecture using power point slides.
- Group discussions.
- Role-plays

Procedure:

a) The treatment for CMD: (duration: 140 minutes)

1. Presentation, lecture and group work: (duration: 60 minutes)

The tutor will introduce the topic on treatment for CMD. The trainees are then divided into two groups and asked to brain-storm the following questions (show slide)

- What treatments do they think may help a person suffering from CMD?
- What are the various types of treatment for CMD?
- What factors determine choice of treatment for CMD?

Each group will nominate one person to make the presentation to the entire group.

2. Discussion and clarifications: (duration: 30 minutes).
The entire group will interact and clarify issues that arise.

3. Presentations and lecture: (duration: 20 minutes). The lecture will cover types of treatments for common mental disorders.

4. Discussion and clarifications: (duration: 30 minutes). The entire group will discuss further and clarify their doubts.

b) The MANAS Interventions: (duration: 90 minutes)

5. **Presentation, lecture and group work:** (duration: 60 minutes). The lecture on The MANAS Intervention will be for 10 minutes followed by group work in pairs for 20 minutes (show slide):
    - Discuss the last time you saw your family doctor /or visited the Primary Health Centre (PHC) and describe exactly what happened. The trainees then share their experience with the entire group for 30 minutes. The aim is for the tutor to demonstrate how much of primary care experiences is around acute care models with emphasis on short courses of medicines, and using this to contrast how chronic diseases management should be planned, and hence the design of the MANAS intervention.

6. **Discussion and clarifications:** (duration: 30 minutes). The entire group will discuss further and clarify their doubts.

c) Principles of stepped care intervention: (duration: 100 minutes)

7. **Presentation and lecture:** (duration: 10 minutes). The lecture on principles of collaborative stepped care intervention

8. **Group work:** (duration: 60 minutes). Trainees work in small groups- each group will consider the two scenarios given below, and describe how the stepped care approach would be used.
    a) Person has mild CMD at first visit
    b) Person has severe CMD at first visit
    c) For each scenario, consider what would be your approach if, at the review visit, the person has 'improved', or there is 'no change/it is worse'. Each group will nominate one person from their respective group to make the presentation to the entire group.

9. **Discussion and clarifications:** (duration: 30 minutes). The entire group will interact and clarify their doubts.

Material related to the lecture can be found in the HC Manual – The MANAS Model for Health Counsellors on pages 34 -40.

Treatments for CMD

Treatments
for
CMD

1

Two Terms

- Treatment: this word refers to a specific method of treating common mental disorders
- Intervention: this word refers to the way a package of treatments is delivered to the patient

2

Treatments for Common Mental Disorders

- *Aim of treatment*

a) Control of symptoms

b) Improvement of psychosocial functioning

c) Prevention of relapse

3

What Treatment?

- Common mental disorders are caused by many factors
- In two groups, brain-storm what treatments you think may help a person suffering from common mental disorders;
- the various types of treatment in common mental disorders;
- what factors determine treatment choice in common mental disorders

4

Choice of Treatment

- *Three major types of treatment:*
  a) Medicines (antidepressants)
  b) Psychological treatments ('talking treatments')
  c) Social treatments
- *Best results in combination of the above*

5

Antidepressants

- Medicines to treat depression
- Effective for moderate/severe depression and anxiety
- About 2 out of 3 depressed persons will recovery completely with these medicines

6

Which Antidepressant?

- Two major classes of antidepressants
- Many types of antidepressants in each class
- In Manas, we choose Fluoxetine

7

Some facts about Fluoxetine

- More than 15 years old
- Many brands
- Fluoxetine works by changing the way some chemicals in the brain (serotonin) work
- Dose is 20 mgs (one capsule) a day, usually taken in morning
- Cost is about Rs 1.20 per day or, Rs 36/ month

8

Some More Facts

- It is not a sleeping pill
- It is not addictive
- It works only if it is taken regularly for 6 months
- It does not work immediately-usually the first signs of benefit take two weeks

9

Psychological Treatment

- Psycho-education: counselling about symptoms
- Interpersonal Therapy: structured psychological treatment over 6 to 12 sessions
- Yoga (optional)

10

Social Treatment

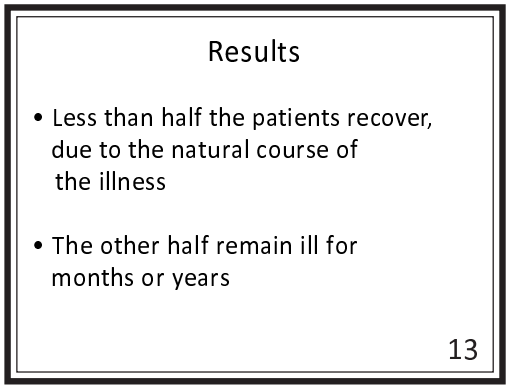
- Advice about practical problems
- Referral to community agencies

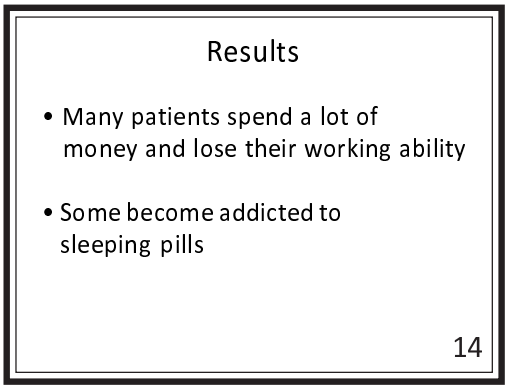
11

What do patients with CMD get currently?

- Most (?>75%) are not diagnosed
- If they get medicines, these are either of no value (e.g. tonics) or produce only temporary benefit (e.g. sleeping pills)
- No psychological or social treatments

12


Results
• Less than half the patients recover, due to the natural course of the illness
• The other half remain ill for months or years
13


Results
• Many patients spend a lot of money and lose their working ability
• Some become addicted to sleeping pills
14

The MANAS Intervention

The
MANAS
Intervention

1

What Treatments

- Antidepressants
- Psychoeducation (including social treatments)
- Interpersonal therapy (IPT)
- Yoga (optional)
- Detection of Common Mental Disorders
- Adherence Management
- Referral to Mental Health Specialist

2

Why MANAS?

- Why not simply give these treatments in the existing PHC?
- In pairs, discuss the last time you visited your family doctor/attended the PHC and describe exactly what happened

3

The Real World of Primary Care

- Focused mainly on 'acute' diseases of a short duration
  e.g. malaria, diarrhoea, fever etc
- "Chronic" diseases such as diabetes, heart disease, depression need a different approach

4

Principles of MANAS Intervention

- Provide acceptable and effective intervention based on best scientific information
- Use acceptable, non stigmatizing terms
- Most effective treatments can be delivered by non specialists with training and supervision
- Intervention delivered as a team using chronic disease management principles

5

The Approach for Chronic Diseases

- Treatment needed for many months, sometimes years
- Both medicines and psychosocial treatment important: thus we need an intervention
- More than just the doctor
- Treatments only work if taken regularly- adherence is essential

6

The Approach for Chronic Diseases

- Linking the PHC with specialist support is very valuable to ensure PHC staff skills are enhanced and supervised
- Collaborative stepped care intervention is needed: tailor the intervention to suit the individual patient

7

The Collaborative Stepped Care Intervention in MANAS

8

Principles of Collaborative Stepped Care

- Not everyone with CMD needs the same treatment
  a) Mild CMD may only need psychoeducation
  b) Severe CMD may need psychoeducation and other treatments
- In steps, give simpler treatments to all, and reserve other treatments for those who are severely ill or not responding to simpler treatments

9

Steps of Care Flow Chart

RECOGNITION

STEP 1
Psychoeducation

- Referral to other agencies
- Adherence Management
- Yoga

STEP 2
Antidepressants

STEP 3
Antidepressant plus IPT

STEP 4
Referral to mental health specialist

10

The Key Personnel for Collaborative Stepped Care Intervention

- Primary Care Doctor
- Health Counsellor
- Mental Health Specialist
- Other Primary Care team members

11

B. Detecting Common Mental Disorders in Primary Care

Objectives:

1. To acquire necessary knowledge base and skills to use the screening tool General Health questionnaire (GHQ) - for detecting common mental disorders in patients seen in their clinical practice.

Duration: approximately 3 hours.

Method:

- Lecture using power point slides.
- Role plays
- Group discussions

Procedure:

1. Presentation, lecture and group work : (duration: 60 minutes).
Didactic lecture, using power point slides, on the CMD of depression in the clinic.

2. Small Group work: (duration: 30 minutes)
Each trainee is given a copy of the GHQ without the scoring pattern (refer below). The trainees are required to independently identify negative and positive questions, and then compare their ratings with their partner and discuss with the entire group.

3. Role Play: (duration: 60 minutes)
The tutor will play the role of a patient and one trainee will conduct the interview with the GHQ; other trainees will rate them independently and then the ratings are compared and discussed. Next, one of the trainees plays the patient and the role play is repeated. This exercise continues until all trainees have had the opportunity to participate.

4. Discussion and clarifications: (duration: 30 minutes)
Trainees are allowed to discuss their observations and clarifications with the training group.

Material related to the lecture can be found in the HC Manual – The MANAS Model for Health Counsellors on pages 58-62

The Screening Questionnaire (GHQ 12)

We would like to know if you have had any medical complaints and how your health has been in general over the past two weeks.
Instructions :
Shaded Questions if answered as 'No' code 1 and if 'Yes' code 0
Unshaded Questions if answered as 'Yes' code 1 and if 'No' code 0

HAVE YOU RECENTLY :-

GHQ 1	been able to concentrate on whatever you're doing?	
GHQ 2	lost much sleep over worry?	
GHQ 3	felt that you are playing a useful part in things?	
GHQ 4	felt capable of making decisions about things?	
GHQ 5	felt constantly under strain ?	
GHQ 6	felt you could overcome your difficulties?	
GHQ 7	been able to enjoy your normal day-to-day activities?	
GHQ 8	been able to face up to your problems ?	
GHQ 9	been feeling unhappy and depressed?	
GHQ 10	been losing confidence in yourself?	
GHQ 11	been thinking of yourself as a worthless person?	
GHQ 12	been feeling reasonably happy, all things considered ?	
	Total Score	

Detecting CMD

Detecting
CMD

1

How does CMD present in the clinic

- Tiredness; weakness
- Headaches; aches and pains all over the body
- Palpitations;
- Trembling all over; sweating a lot
- Dizziness
- Difficulty in sleeping well
- Losing appetite
- Chest pain, feeling of suffocation

2

But
how is
CMD
'diagnosed'?

3

ICD-10

- International Classification of Diseases
- 10th revision of the ICD
- Published in 1993 after 10 years of consensus and field work
- Aimed to be a universal, culturally appropriate classification system
- Around 100 major types of mental disorders

4

F32: Depressive Episode

- Should last at least two weeks (duration)
- No co-existing hypomanic/manic episode in lifetime (obligatory exclusion)
- No substance abuse or organic brain disease (hierarchical)
- At least 2 of these 3 symptoms: depressed mood; loss of interest; fatigue (obligatory inclusion)
- Minimum 4 of a list of 7 other symptoms

5

…and there are other diagnoses

- Generalized Anxiety Disorder
- Mixed Anxiety-Depressive Disorder
- Panic Disorder
- Phobic Disorders
- Etc.

6

The gap between burden and diagnosis

- Studies from many parts of India, including Goa, show that at least 1 in 5 adults attending PHCs suffer from CMD
- But in practice, CMD is rarely diagnosed.
- Why?

7

Explaining the gap

- Stigma
- Lack of training or experience - ICD10 too complicated
- Most primary health workers fear that the discussion may be time-consuming, so avoid it altogether
- Most patients present with physical complaintswhich are treated bydoctors

8

Explaining the gap

- Unless asked, few patients will openly discuss emotional complaints or complaints about their stressors because they do not expect that the clinic staff are interested in their personal problems.

9

How does MANAS address these obstacles?

- Not using the words 'mental illness' as far as possible-instead use ?
- A full-time Health Counsellor to provide psychological and social interventions
- Screening for CMD

10

Screening

- To detect 'probable' cases of a health problem
- Why screen?

a) When diagnosis is complex or difficult
b)When a condition is very common
c) When the condition has a treatment

- For e.g. screening for breast cancer?

a)Breast examination

- For e.g. screening for heart disease?

a) Stress ECG

11

Screening for CMD

- Questionnaires asking about symptoms or complaints associated with CMD
- MANAS evaluated five different questionnaires which are in wide use internationally
- Best questionnaire was the 12 item GHQ

12

General Health Questionnaire (GHQ)

- "General"- to avoid stigma
- "Health"- both 'positive' and 'negative' items
- "Questionnaire" –originally developed as a self-report

13

History

- Developed in the UK in 1970s by David Goldberg
- Originally 60 questions
- Later reduced to 12 key questions
- Most widely used screening questionnaire in primary care settings in the world
- Widely used in India, including Goa

14

Using the GHQ in Manas

- To detect cases of CMD
- To monitor the progress of a patient with CMD

15

Detecting cases

- As a screening tool to detect patients who are suffering from CMD
- Who can carry out screening? (Registration clerk, health counsellor, doctor , patient)
- All adult attenders (18 years and older) will be screened
- Patients who score 6 or more are 'cases' of CMD

16

How to use

- 12 questions
- Some are 'positive', some are 'negative'
- Each question has a score of 0 or 1
- Score of 1 means that a symptom is present
- Add the scores; a score of 6 or more indicates that the person is possibly depressed

17

Monitoring progress

- Most often, all you need to do is to ask how the patient is feeling since the last meeting ('better'; 'no change'; 'worse')
- Sometimes, its not so clear-then you can use GHQ12 and compare the present score with the previous score

18

Activity

- Read the GHQ12
- Mark out which are 'Positive' and which are 'Negative' questions.
- Compare and discuss the rating with your partner.

19

Interpreting scores

- At my first meeting with the HC my score was 9. *What does this mean?*
- At my second meeting, my score was 3. *What does this mean?*
- At my third meeting, my score is 8. *What does this mean?*

20

Interpreting scores

- At my first meeting with the HC my score was 6. *What does this mean?*
- At my first meeting, my score was 11. *What does this mean?*
- At my second meeting, my score is 12 *What does this mean?*
- At my third meeting, my score is 6 *What does this mean?*

21

Group work

- Role play exercise
- One person plays patient
- One person asks GHQ12
- All rate and discuss scores

22

C. The Assessment and Management of Suicidal Risk

Objectives:

1. To acquire necessary knowledge base and the skills for the assessment of risk of suicide in patients seen in the clinic
2. Awareness of the principles of managing suicidal risk in patients
3. To acquire the interview skills to elicit information for an accurate estimation of suicidal risk
4. Have the skills for intervening and managing suicidal risk, once identified, in an appropriate manner

Duration: approximately 7 hours

Method:

- Lecture using power point slides.
- Group discussions.
- Role-plays

Procedure:

a) Assessments of suicidal risk: (duration: 180 minutes)

1. Group discussion: (duration : 20 minutes)
The topic on Suicide is introduced through group discussion, where the trainees existing knowledge and attitudes are recorded.

2. Presentations and lecture: (duration: 40 minutes)
Where the theoretical basis of risk assessment is explained, using the Health Counsellor's manual as the framework.

3. Group discussion and clarifications: (duration: 30 minutes)
Where issues around risk assessment is discussed and clarified till the trainees and the trainer are satisfied that key learning skills have been acquired.

4. Group work: (duration: 60 minutes)
The trainees are asked to form smaller groups of four persons each with a facilitator. Each group is provided with a clinical vignette (refer below) that details the information necessary to make a judgement on the degree of suicidal risk. The group and the facilitator have 30 minutes to discuss the scenario and come to a conclusion of the degree of risk in the particular clinical scenario. Each group will nominate one person from their respective group to make a 5 minute presentation of the case scenario and justification for the risk assessment.

5. Discussion and clarification: (duration: 30 minutes)
The entire group will interact and clarify any necessary issues.

b) Management of suicidal risk: (duration: 240 minutes)

6. Presentations and lecture: (duration: 30 minutes)
Lecture will cover:

- The principles of risk management
- The MANAS project protocol for risk management.

7. Group work: (duration: 60 minutes)
As before, the trainees are divided into smaller groups and deal with the clinical scenario (refer below) that they have worked with in the previous session. They have 30 minutes to decide on the management of risk in their hypothetical patient and make a summary of the same. Each group will nominate one person from their respective group to make a 5 minute presentation to the larger group and justify their approach.

8. Discussion and clarifications: (duration: 30 minutes)
The trainees further discuss and clarify doubts after the exercise.

9. Role plays : (duration: 60 minutes)
The trainees are asked to enact a number of clinical scenarios where they have to identify and manage the suicidal risk of the patient.
In addition, they would be expected to role play discussing the case with the clinic doctor and the Mental Health Specialist over the telephone and putting the recommendations into practice. These role play scenarios are facilitated and closely monitored by the training staff.

10. Discussion and clarifications: (duration: 30 minutes)
The whole group will have the opportunity to discuss and clarify any issues that arise from the exercises.

11. Discussion and clarification: (duration: 30 minutes)
Trainees will get the opportunity to discuss and clarify any issues from the reading materials provided to them.

Material related to the lecture can be found in the HC Manual – *The MANAS Model for Health Counsellors* on pages 63-70.

Additional resources:

- WHO Manual for Trainees
- Suicide First Aid Guidelines for India - Colucci, E., Kelly, C., Minas, H.K. and Jorm, A.F.,Melbourne: Centre for International Mental Health & ORYGEN Youth Health Research Centre, The University of Melbourne; 2009.

CASE VIGNETTES

Case 1

Kamini is a 26 year old, married for 6 months, whose husband and mother- in-law verbally abuse her. She has to do all the household work. She was working before her marriage and now she wants to continue her job but her husband and mother-in-law do not give her permission to do so. She had lost interest in life, cannot concentrate on work, feels hopeless, and thinks of ending her life by consuming poison. At the same time she thinks that doing so will bring disgrace to her family.

Case 2.

Manish is a 54 year old widower with two children both in college. He works as a clerk in the government office. He feels that he has heart problem and spends lots of money on medical examinations. He also has financial problems. His children do not listen to him. Since one year he has been having palpitations, disturbed sleep, inability to concentrate on his work and feels hopeless. He attempted suicide two months ago by taking sleeping pills. He still has two bottles of sleeping pills with him.

Case 3.

Nisha, a 53 year old, unmarried female lives with her married brother. He is separated from his wife, is an alcoholic, beats her, and calls her names. She is financially supported by her two married sisters. She is unable to concentrate on her work, feels tired and does not get good sleep. She feels hopeless and worthless and has lost interest in life. She has attempted suicide two months ago.

Case 4

Vandana, a 27 year old spinster lives with her elderly parents. She works in a factory. Her brother committed suicide one year ago after break-up with his girl friend. Presently patient has symptoms like lack of sleep, irritability, feeling suffocated and often feels there is no hope in life. She has bought rat poison and kept it in her table drawer. Every night she opens the drawer looks at it and goes back to sleep. She has the responsibility of her old parents.

Assessment and Management of Suicidal Risk

Assessment of Suicidal Risk and management in Primary Health Care

1

Definitions

- Suicide- an act of intentional self harm causing death.
- Common means- hanging, pesticides, drowning, firearms, prescription medicine.
- Suicide attempt- intentional self harm with non fatal outcome
- Cutting, prescription medicines, physical injury.

2

Rate of suicide

- WHO estimate: 1 million people die every year due to suicide worldwide.
- Global health problem.
- Rates vary across countries for a number of reasons.
- Suicide rates in India are difficult to estimate due to inadequate reporting.
- South India has high rates- the evidence from TamilNadu.

3

Why assess suicide risk

- Suicide is a global public health problem
- Assessing risk is a key role of HC's
- Risk assessment can save lives and reduce distress to the individual and the social network

4

Principles of risk assessment

- Asking patients for suicidal ideas routinely is mandatory
- Risk is not static and can change due to changing life circumstances; risk assessment needs to be repeated.
- Essential requirement for reliable assessment is having a trusting relationship with the patient.

5

Key questions for detection

- Ask without getting anxious.
- Normalize the context.
- Be empathetic.
- Ask for active thoughts and passive death wish.

6

Assessing degree of risk

- After detection, need to assess the degree of risk.
- Risk assessment is imperfect- better to overestimate.
- There is existing knowledge about the factors that contribute to suicidal risk.

7

Risk factors

- Socio demographic factors
- Clinical factors
- Immediate risk factors
- Multiple layers that interact

8

Socio demographic factors

- Age- adolescence, early adulthood, old age are high risk periods.
- Gender- commoner in females; males complete suicide due to means chosen.
- SES- low SES carries greater risk.
- Marital status- separated, recently bereaved at higher risk.
- Unemployment/ recent job loss.
- Social isolation/ lack of support.

9

Clinical factors

- Presence of any mental illness or chronic, serious physical illness.
- Personality- impulsive, difficulty in handling stress
- Previous attempt.
- Family history.
- Current use of alcohol or drugs.
- Hostile or critical family.
- Past or current abuse

10

Immediate risk factors

- Ongoing severe social stress.
- Recent loss or humiliation
- Hopelessness- single most accurate predictive factor.
- Loss of interest- withdrawn, isolated, dropout from treatment.
- Communicating intent- making will, letter to family.

11

Protective factors

- Social support.
- Religious, cultural, ethnic beliefs.
- Community involvement, membership of groups.
- Resilience.
- Access to help.

12

Key questions

- Have you been having thoughts of harming yourself?
- Have you made any plans to do it?
- Are these thoughts coming in to your mind repeatedly?
- Have you been feeling that nothing can be done to make things better?

13

Degree of risk

- Absent/ Low- Very occasional thoughts/ passive death wish, social support, stable life circumstances.
- Moderate- Persistent ideas, moderate – severe clinical problems, limited protective factors, 1 or more immediate risks.
- Severe- Active plans, severe/ multiple clinical risks, multiple current problems, severe hopelessness, limited protective factors.

14

Conclusion

- Suicidal behaviours are common and need to be responded to with empathy
- Routinely assessing risk in any clinical interaction is necessary
- Risks can be estimated and appropriate management plans used to minimize risk
- There should be specific protocols of management including counselling

15

Management of suicidal risk in general health care settings

16

Principles of management of suicidal risk

- Management needs to be matched to the degree of risk.
- Engagement is crucial to encourage the person to discuss his/her problems.
- Provision of hope.
- Enhancing protective factors
- Ensuring safety- remove access to means and continue observation.

17

Management….

- Increase the frequency of contact including phone contact.
- Meet any immediate social needs.
- Discussion with family.

18

Management.....

- When in doubt, discuss immediately
- Document the problem and the steps you have undertaken to manage the situation.
- Taking care of yourself!

19

Management protocols

- Mild risk: Ensure treatment plan is appropriate, enhance protective factors, increase frequency of contact, reassess risk
- Moderate: Address safety needs, enhance protective factors, meet social needs, ensure adequate treatment - REFER

20

Management protocols

- Severe risk: Discuss immediately and follow suggested management plan.
- Inpatient treatment maybe required in the short term for safety- provide family with details and referral.
- Discuss with family and ensure safety; ensure continuous observation.
- Aggressive follow up including home visit.

21

Suicide prevention

- Education efforts to alert students and parents of the problem of suicide and recognition of common triggers.
- Being aware of the warning signs and taking prompt action in their presence
- Ensuring appropriate help in the presence of depressive symptoms and providing support during stressful situations eg. around exam time

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Suicide prevention

- Universal means:
  - Reducing access to means
  - Reducing alcohol sales
  - Awareness campaigns
  - Responsible media reporting

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Suicide prevention

Targeted strategies:

A) Special attention to vulnerable groups

- Having current mental illness
- Youth during important exams
- Young men in rural areas
- Women who suffer domestic violence
- Agricultural communities in distress
- Elderly living alone

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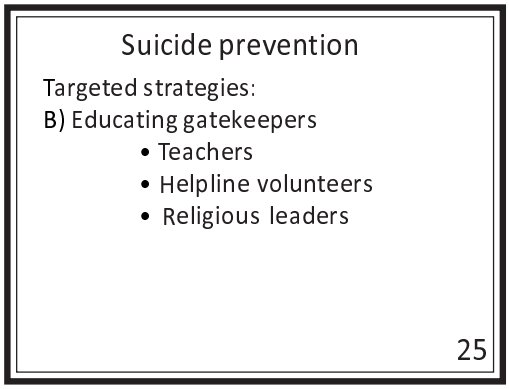
Suicide prevention
Targeted strategies:
B) Educating gatekeepers
• Teachers
• Helpline volunteers
• Religious leaders
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D. General Principles of Counselling

Objective:

1. To understand what is meant by counselling
2. To learn the attributes that are required to be an effective counsellor
3. To learn basic counselling skills

Duration: approximately 14 hours.

Method:

- Lecture using power point slides.
- Group discussions.
- Role-plays

Procedure:

1. Activity 1:
Definitions of counselling: (duration: 30 minutes)

Discuss the following questions with your partner:

a) *"What is counselling?"*
b) *"In what ways is talking to a counsellor different from talking to a friend?"*

- People work in pairs – (10 minutes)
- 2 pairs join and share their definitions – (5 minutes).
- 4 pairs join and share definitions- (5 minutes).
- Groups write the definitions on chart papers, and nominate one person to do the presentation of the definitions to the entire group (10 minutes).

2. Presentation and lecture on the definitions of counselling: (duration: 30 minutes)

3. Activity 2:
What is not counselling, refer to the worksheet 1 (responses that a counsellor should not make) below : (duration: 30 minutes)

Worksheet 1

Instructions: These are statements made by a counsellor in response to what a patient may say during a couselling session.

- Are the responses what a counsellor should say? and if not what kind of responses are these?
- Why are the statements that a counsellor should not make? (Reasons given at end of statement in brackets)

1. **Sheela:** *I am very upset, I lost my job last week.*
Response: I think you should stop worrying and start looking for a job. (e.g. of telling her what to do)

2. **Meena:** *I am not sure what to do, I want to buy a new house but am scared about taking a loan.*
Response: It is not difficult to get a loan, I will get you the forms, and you should take the loan and buy the house. (e.g. making decisions for patient)

3. **Hamid:** *My neighbour, is always quarrelling with us about our boundary wall encroaching on to his property.*
Response: I wonder when you people will stop fighting with each other and learn to live in harmony. (e.g. judgment)

4. **Sara:** *I am worried about my daughter, she is two years old and she still does not speak clearly.*
Response: Have you taken her to a doctor? What does your mother say about it? Your mother-in law must be troubling you too? What did you tell them? (e.g. Interrogating)

5. **Ganesh:** *My wife is pregnant; we already have two children and never planned for a third. Now we don't know what to do.*
Response: I am sure you never took any precautions. You must have neglected using contraceptives in a responsible manner. (e.g. Blaming)

6. **Mary**: *The shop keeper gave me a five hundred rupee note instead of a hundred; I realized it only when I came home. I just kept quiet and spent it instead of returning it. Now I am feeling very guilty.*
Response: That is against our Christian values. One of the commandments says thou shall not lie, you have committed a sin, you should go and confess and ask God for pardon. (e.g. Preaching)

7. **Saraswati:** *I am finding it difficult to get admission for my son in 'The new English High School. I don't know what to do; I want the best for him.*
Response: I think you will get admission if I speak to the principal. I will make sure your son goes to that school. (e.g. Making promises)

8. **Manoj:** *I have been having problems with my children; they don't tell us anything that happens in school. I try to be strict because I feel that fathers should be strict and I do it for their good.*
Response: I think parents should not be strict at all, they should give children freedom. In this modern age you cannot behave like how our parents behaved with us. (e.g. Imposing own beliefs)

4. Activity 3: Attitude and Values for effective counselling. (duration: 45 minutes)

Worksheet 2

Instructions: Read each of the statements given below and imagine that you are hearing this from a friend: (15 minutes)

- 28-year-old unmarried woman wants to terminate her first pregnancy
- 25-year-old woman, with 2 young children, unemployed, talks of committing suicide
- 30 -year-old man who reveals that he is a homosexual
- 48-year-old married woman having an extra-marital relationship
- A 40-year-old woman confesses to getting thoughts of wanting to kill her daughter

a) What is your own immediate reaction (what do you think and feel) on hearing this?
b) What would others in your family think of this person's behaviour?
c) What would your friends think about this person's behaviour?
d) What would most people think about this person's behaviour?

Discussion after activity 3:
After trainees complete the written assignment give them 15 minutes to share their answers with their partners.
This will be followed by discussions where each pair can share their attitudes about one situation each and the facilitator makes notes of general attitudes against each specific situation. (15 minutes)

Notes for facilitator: After eliciting feedback from trainees, ask these follow-up questions:

- If you had heard about the situation while counselling the person, would your reaction have been any different?

Elicit comments on:

- Differences/ similarity between social and counselling situation
- Possibility of own attitudes, values, etc. affecting counselling

5. Presentation and lecture: Why self awareness is important (duration: 15 minutes)

6. Activity 4: Attributes of a good counsellor: (duration: 30 minutes)
Each participant thinks about this individually and shares with a partner :
"*Think about a time when you went to someone for help with a personal problem; if the experience was helpful, what was it about the experience that made you feel helped? If not helpful, what was it that was not helpful?*"

Feedback: Have some (not necessarily all) trainees share with the group one specific attribute of the counsellor that made the experience good/bad; record key points on the white board.

7. Activity 5: Judgements: (duration: 40 minutes).

Worksheet 3

Worksheet 3 ***Instructions:*** *Read each of the following statements and write down as many assumptions about each character that comes to your mind. E.g. in the first one you may make assumptions such as "her husband must have a drinking problem" or "she must have had another lover", etc.*

1. A 30 year old woman says that she is not happy with her husband, since the sexual experiences that she has is not gratifying to her. The woman must be_____ (make as many assumptions as possible about this case)

2. A 25 year old unmarried woman is having an affair with a 45 year old married man. The woman must be_____ The man must be_____

3.A 56-year-old man admits to forging documents at work for financial gain He must be_____

4. A 35 year old commercial sex worker has just discovered she is HIV+. She has 2 regular partners and has not been insisting on condom use when she has a sexual relationship with her regular partners. She is _____

5. A 30 year old woman reveals having been sexually abused by her cousin when she was 14. Later she had a boyfriend who had sex with her and then left her. Now she is having a difficult relationship with her husband. She must be _____ must have been _____

Instructions to the facilitator:
After they do this on their own, the trainees ask participants to share the assumptions that they have made. Make a point of how, at times when we encounter people with a problem, we do put them into stereotypes that we have in our mind. But as a counsellor one has to be aware of our one's biases and not let that influence the counselling process. (15 minutes)

8. Activity 6: listening skills (duration: 45 minutes)
Facilitator takes one participant into another room and reads out to him a passage from a newspaper. After that the participant has to inform another participant what he heard. Each trainee informs the next one what he heard and the last participant informs the whole group what he heard.

After the exercise facilitator gets trainees to discuss on:

- What struck them about what they heard?
- How people hear some things and don't hear others?
- The importance of listening while you are counselling.

9. Activity 7: Video* and discussion on listening skills / attending behaviour
(duration: 30 minutes).
Show the video – first section on listening skills/attending behaviour followed by discussion on the following:

- What did you observe that was unhelpful to the clients?
- What did you observe that was helpful to the clients?
- In both scenarios what did you observe about the client's reaction to the counsellor?

10. Presentation and lecture on core attributes of an effective Counsellor :
(duration: 30 minutes)

11. Activity 8: Empathy : (duration: 30 minutes)
Explain that the statements that you are going to read *(show slide)* are examples of empathy and sympathy to a patient expressing a difficulty.

- Ask the trainees to identify empathy from sympathy responses in the given examples.

Patient A: *I have been told I have a heart problem and I don't know what to do.*
Response A1: It sounds as if you are having a hard time. It is good
you have come here because maybe talking it through will help.
Response (empathetic)

Response A2: Oh, You poor thing. Yes, it is terrible to have a heart condition. I don't know what you should do but at least I am here for you.
Response (sympathetic)

Patient B: *My mother is going to be so angry with me. I don't think I can tell her about my relationship with ……*

**Basic Skills in Counselling DVD - – Sangath REACH*

Response B1: That sounds very frightening. You must be feeling awful. I'm so sorry. It is probably better not to tell her.
Response (sympathetic)

Response B 2: That sounds hard. A lot of people find it difficult to talk to their parents about this. Is there anything you think that might help?
Response (empathetic)

Patient C: *I've been feeling sick all week and have vomited several times. I think it might be connected to my drugs.*
Response C 1: How awful for you, being sick is so terrible.
Response (sympathetic)

Response C 2: That doesn't sound good. It might be connected to your drugs or it might not be, but it is worth checking it out with the doctor.
Response (empathetic)

12. Presentation and lecture on counselling skills. (duration: 15 minutes)

13. Show video – section on asking questions followed by discussion on open and closed ended questions (duration: 15 minutes)

14. Activity 9 on questioning skills. (duration: 60 minutes)

Divide the class into groups of 3 (A, B, C). Ask A to talk about an interesting incident in her/his life. The second person 'B' should ask questions and 'A' should answer only questions asked of her/him. 'C' is the observer who makes notes on which were the appropriate questions, and which ones could be asked differently. After 10 minutes they stop and 'C' gives feedback to them. After that they reverse roles till every one plays the various roles. (45 minutes)

The group reassembles, and thefacilitator generates responses on on how every one felt, and how closed and open ended questions can be useful.

15. Activity 10 on priorities in life (duration: 30 minutes)

Instructions:

- Ask trainees to think of their lives and what is important for them.
- Ask them to list the points given below in order of priority starting with 1 as the top priority and10 as the lowest.
    - A comfortable life
    - An exciting life
    - Freedom
    - Happiness
    - Health
    - Inner harmony
    - Affection from immediate family and friends
    - Self respect
    - A sense of accomplishment
    - Social recognition and leadership.
- Allow 5 minutes and ask them to share them with a partner for 2 - 3 minutes.
- Ask: what can we learn?

Notes for facilitator:

Emphasize the following:

"All these issues are important to all of us. We may rank them differently at different times in our lives. What I value is not necessarily the same as what you value. Our patients may have different priorities from us. It is important not to make assumptions or to impose our own values on our patients".

16. Activity 11 on looking at our own weak spots (duration: 30 minutes)

* Work Sheet 5

Thoughts and events of our own lives can easily get in the way of us helping someone else. This is another exercise to help you spot your "accident black spots" - the areas that you need to be aware of and may be work on if you are going to help someone else, whether this is as a friend, a helper, a boss or a counsellor.

Go through the following list and tick those items that have aspects that worry, upset or frighten you or could do so under certain circumstances. All the topics included below are the kinds of issues a patient may raise and have a problem with.

You should know that you will not be asked to share what you tick or what you write for question 1, but you may be asked to answer questions 2 - 6.

_____	Your marital status	____	Anticipated experiences
_____	Past experience with death	_____	Qualifications or lack of them
_____	Your relationship with your children	_____	Your lack of children
		_____	Your sexuality
_____	Sexual behaviour of others	_____	Religious beliefs
_____	Suicidal thoughts	_____	Social status
_____	Financial security	_____	Anger
_____	Your fears	_____	Relationships - present and past
_____	Relationship with your partner		
_____	Relationship you have/had with your mother	_____	Your personal feelings about what happens when life ends
_____	Particular ethnic/religious groups	_____	Child abuse
		_____	Feelings about what you have to offer other people
_____	Feelings about certain types of death - e.g. drowning, , AIDS, murder, suicide	_____	Other weak spots

Consider:

1. Why does a particular item threaten you?
2. What do you fear would happen if others were to learn of your secret(s)?
3. How might your efforts to keep your secret be affecting the way you relate to other people?
4. How will you be affected if one of the items you ticked comes up in a counselling session?
5. How easily will you be able to help a client with his problem if it is similar to one that upsets you?
6. How do you cope with thoughts, feelings or events that disturb you?

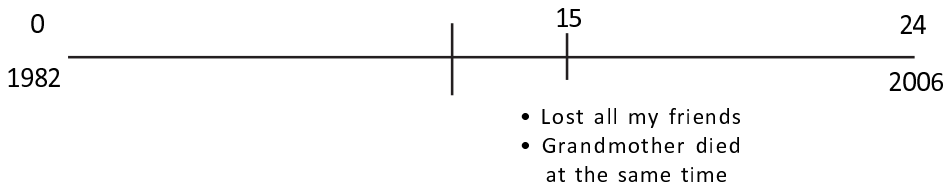
* *Adapted from "Counselling and Support" by Lyn Franchino*

17. Activity 12 on making your own time line (duration: 45 minutes)

Work Sheet 6

Using lining paper cut off between 1.5 metres - 2 metres (depending on how long or complex you think your life may be!) Draw a line through the middle (as in the diagram below) and mark out your current age at the right hand end (and 0 at the left hand end) of the line. Above the line mark out major life events, both good and bad. Below the line mark out any losses you may have had together with what effect this had on you.

Major Life Events



Please note: ***Although you may share some of this (if you wish) with members of your group, this exercise is primarily for you.***

18. Activity 13 on time line – continuation (duration: 45 minutes)
Having worked on your Timeline you will realise that there have been many positive and negative events in your life - all of which, together with your innate temperament and personality have helped you to become the person you are.

When we help others it is important that we understand ourselves, and how events in our life have affected us. If we do not deal with our own problems and fears first, we are in danger of muddling our problems with that of the person we are trying to help - and that won't help them.

Using your time line as a start point, think about the following questions with a partner. Only share what it is safe to share. This work is for you. No one else.

1. How have the positive and negative events shaped your life?

2. Consider some of the events that have left you troubled: angry, sad or feeling fearful .

3. How have the feelings that have come from these difficult events affected the way you coped with your life?

4. Are any of these feelings still affecting you?

5. If questions 3 and 4 have evoked some answers for you is there any thing you would like to do to deal with your feelings?

19. Paraphrase and reflecting feelings – show video and followed by discussion (duration: 20 minutes)

20. Activity 14 on Paraphrase and reflecting feelings (duration: 30minutes)

Work sheet 7

***Instructions*:** trainees have to read each statement and note how they would paraphrase and reflect feelings. Can work in pairs (30 minutes) each pair shares one response, interspersed with discussions**.**

Paraphrasing and Reflecting Skills

1. "I really wanted to meet my sister yesterday but I had too much housework to do and so could not go."
2. I have failed in the job interview again. I don't think I will ever find work. I don't think it is worth even trying.
3. My sister-in-law always gets better treatment at home. It is not fair.
4. I told my best friend about my problems and she was so kind and supportive.
5. My husband expects me to be cheerful all the time. Doesn't he understand I have a lot on my mind?
6. I have been told I have to take my anti-diabetic medicines all my life. This will be so difficult.
7. Today my friends came home to see me and we had a nice time together, talking about old times.
8. Mala and me were such good friends, but now I feel very distant from her. I don't know what's wrong with me.
9. I got home late yesterday and the minute I entered, my wife started screaming at me. I just couldn't bear it.
10. All my friends are working, but I don't have a job. They are more successful than I am.

21. Activity 15 on Positive asset search (duration: 45 minutes)

Work Sheet 8

Read the following situations and discuss with your partner on how you would find positive aspects in the patients life and reflect the same to him or her.

1. Gaurav had a very bad experience at his work place. He made a major error that cost the company X amount. His manager fired him and threatened to throw him out of his job, but the union has been supporting him and he still has a job. However, he has become very anxious and finds it difficult to concentrate. Every morning he has to make a great effort to get ready for work . Yet he has not missed a single day at work. He has offered his apologies and asked his manager to cut the amount from his salary in instalments. This would create financial problems for him. He is the only bread winner in his family.

2. Sita has lost her husband; she has three children and has never held a job before. She approached the village head and asked for his assistance to start her own enterprise. Under a rural scheme the village head gave her money to start a tea stall next to the village temple. She has started the venture and is very anxious about managing it, though she has managed to do so thus far.

3. Sangeeta is a school teacher, who has a disabled child. The rest of her family is always insulting her and she is constantly blaming her for bearing a disabled child. Sangeeta feels very bad but never makes the child feel any different from her other children. She has managed to convince the head-master of her school to admit her child in the same school and she patiently teaches her child every day.

4. Manish stammers and feels very embarrassed about it. Sometimes his class mates imitate him and make fun of him. His class teacher is very supportive and so are his parents. His teacher wants him to speak publicly on the occasion of Independence Day. He is very nervous but has agreed to do so.

5. Sara has been an orphan. She lived with nuns in a convent for several years. One day she ran off from the convent to make a living and got involved in sex work, drinking alcohol and using drugs too. Now she wants to stop using drugs as well as the sex work and is trying to find a job. It has been very difficult for her but she is determined to change her life style.

Instructions to the facilitator:
After the exercise is done, let trainees share their answers with the whole group. Follow by discussions on how important it is to find positive assets in the patient, to encourage him to look at his efforts and continue them.

22. Activity 16 on Clarifying (duration: 20 minutes)
Show the whole video and discuss each component including the need to clarify.

23. Practice of all counselling skills (duration: 120 minutes)
First demonstrate a full case and than get groups of 3 to practice cases
(duration: 30 minutes)

Case study for demonstration:
A 30 year old woman is feeling depressed since she lost her mother a year ago and has a daughter who is very sickly. Her husband is supportive but very busy. He leaves home at 8 am and gets back at 8 pm in the night.

While a co-facilitator will play the role of the patient, facilitator will demonstrate use of the following skills in a wrong manner interspersed with the right use of skills:

- Listening
- Attending
- Questioning
- Clarifying
- Positive asset search
- Paraphrasing
- Reflecting feelings
- Summarising

Trainees have to note when each skill is used correctly and when it is used wrongly. Facilitator will stop at intervals and discuss.

Cases vignettes for practice of counselling skills (duration: 90 minutes)

Work Sheet 9

Case 1:

Meena, a 53 year old widow, primary school teacher by profession has been bereaved of her husband since the last two years. Living in an extended family with her married eldest son in Santa Cruz, a semi-urban area of Goa, she has presented with a five month history of CMD characterized by poor sleep, depressed mood, and loss of interest in usually pleasurable activities. She has become extremely anxious over the last two years, that running small errands outside the house precipitates an anxiety attack. As she is mostly at home, she has taken leave from the school and contemplates early retirement. The above problems are of acute onset starting during a difficult period of illness of her eldest son. The financial difficulties that the family faced was a big worry for her, especially as she was the only other breadwinner besides her son. She would usually cope with stress by addressing her concerns to her husband, but since her bereavement, she has not been able to develop new social contacts. She occasionally thinks about ending her life but has no plans / intent to do so and the strong protective factor is her children (low suicide risk).

Case 2:

Sunita is married for the past five years with two children- a three year old and the other is just six months old. She stays in a joint family with her brother-in law and his family. She has health problems like backache and vaginal discharge since her baby was born. Her husband is presently unemployed and this worries her a lot. She cannot get sleep, feels tired and frequently gets migraines. She feels that her bother-in-law's family is happy and enjoys life and this makes her even more depressed. She had got married to this man against her parent's wishes, so she has no support from them and she feels very lonely. Her husband is frantically looking for a job and has no time to listen or even to take her to the doctor.

Case 3:

Namrata is a 30 years old married, working woman with one girl child aged six years, she lives in an extended family in rural Goa. Recently her husband has started coming home late and neglecting his family and has financial difficulties in the form of loans and debts. When she questions him she is always told that she needs to take a loan to help him with his debts. She usually copes with the stress by talking to her mother and some office colleagues about her problems but feels shy to discuss her current concerns as she feels it's a family matter

and stigmatizing. She has had thoughts about ending her life but has no plans / intent to do so and feels that she has to live because of her daughter.

Case 4:
Dimesh a 20 year old man living in a nuclear family in rural Goa has been having problems with sleep and concentration.The above problems are of a gradual onset but are being maintained by embarrassment while talking with others, since he has a soft voice which appears to be slightly feminine. He usually copes with the stress by talking to his mother and sister about his problems but it is not of much help. He avoids interacting with new people and is usually absent from social functions. He worries about his future. He has a close friend (girl) who is very positive about him and supports him, but has moved to Mumbai for further studies. He feels attracted to her but has not expressed his feelings to her since he is not sure about the exact nature of her feelings.

Case 5:
Sheela is a 25 year old who is an orphan. She lived with nuns in a convent for several years. One day she ran off from the convent to make a living, got involved in sex work, drinking alcohol and using drugs too. Now she wants to stop using drugs as well as sex work and is trying to find a job. She has been looking for a job for the past two months and hasn't managed to get one. She is very worried and is wondering if she will have to go back to sex work.

24. Evaluation: (duration: 30 minutes)

Role play: The facilitators play the patient while the trainees, each in turn, do a counselling session. They are evaluated by the trainers/facilitators.

Material related to the lecture can be found in the HC Manual – *The MANAS Model for Health Counsellors* on pages 41-57

Additional resource: *Basic Skills in Counselling* DVD – Sangath REACH

Counselling

Counselling

Aim:

- To understand what is meant by counselling
- To learn what makes an effective counsellor
- To learn basic counselling skills
- To handle special HIV/ART issues

1

Counselling Vs. Advice

Counselling	Advice
1. Primary Purpose	
Empower client to cope better	Persuade
2. Role	
Facilitate	Advice
3. Control	
Client	Advisor

2

Counselling Vs. Advice

Counselling	Advice
4. Focus	
Process & outcome	Outcome
5. Process	
Explores (views, options)	Imposes (opinions, beliefs)
6. Communication Flow	
Two-way, partners	Mainly one-way, top-down

3

Counselling Vs. Advice

Counselling	Advice
7. Building Relationship	
Essential (working relationship)	Secondary
8. Feelings	
Critical (empathy)	Distract from goal (side-issue)
9. Time Frame	
Longer term	Short Term

4

Counselling (Contd)

Counselling includes:

1. Establishing helpful relationships with patients
2. Having conversations with a purpose
3. Listening attentively to patients
4. Helping patients tell their story
5. Giving patients correct and appropriate information

5

Counselling (Contd)

Counselling includes:

6. Helping patients make informed decisions
7. Helping patients recognize and build on their strengths
8. Helping patients develop a positive attitude to life.

6

Counselling (Contd)

Counselling does not include:

1. Telling patients what to do
2. Making decisions on behalf of patients
3. Judging patients
4. Interrogating patients
5. Blaming patients
6. Preaching or lecturing patients
7. Making promises that you cannot keep
8. Imposing your beliefs on patients

7

Attitudes, Values, Beliefs

- Counsellor attitudes, values, beliefs can influence counselling
- Counselling values: not imposing own attitudes, values, beliefs i.e.
- Take client's perspective (seeing things as this individual does)
- Accept client as he or she is (strengths/ weaknesses, positive/negative qualities, feelings, behaviours)
- Be non-judgmental (not your task to assign blame)

8

Attitudes, Values, Beliefs

- Help client to make own decisions (client self-determination)

Implications:

1. Identify & be aware of your own attitudes, values, beliefs
2. Be aware of pressures from social & communal values

9

Attitudes, Values, Beliefs

Implications:

3. Need to suspend (not give up) own attitudes, values, beliefs in order to able to show respect, empathy, etc.
4. If unable to do so, refer client to colleague or another service.

10

Why is Empathy Important ?

- Emphasis on feelings & reflection of *feelings* (rather than content)
- *Recognise* feelings of another person & *communicate* understanding in verbal or non-verbal ways
- Validates client's feelings, reduces defensiveness
- Shows respect for client's ability to cope with feelings
- Provides emotional support to client

11

Why is Empathy Important ?

- Builds rapport, encourages dialogue, builds relationship with client
- Helps counsellor to identify underlying concerns (rather than only the most obvious concerns)
- Different from sympathy - feel and express pity (sympathy emphasises helplessness of client)

12

Empathy (Contd.)

Patient A: *I have been told I am HIV+ and I don't know what to do.*

- **Response A1:** It sounds as if you are having a hard time. It is good you have come here because maybe talking it through will help.
- **Response A2:** Oh, You poor thing. Yes, it is terrible to be HIV+. I don't know what you should do but at least I am here for you.

13

Empathy (Contd.)

Patient B: *My husband is going to be so angry with me. I don't think I can tell him my results.*

- **Response B1**: That sounds very frightening. You must be feeling awful. I'm so sorry. It is better not to tell him.
- **Response B 2:** That sounds hard. A lot of people find telling their partner is difficult. Is there anything you think might help?

14

Empathy (Contd.)

Patient C: *I've been feeling sick all week and have vomited several times. I think it might be connected to my drugs.*

- **Response C1:** How awful for you, being sick is so terrible.
- **Response C2:** That doesn't sound good. It might be connected to your drugs or it might not be, but it is worth checking it out with the nurse.

15

Showing Empathy

- Listen to complete message (verbal, non-verbal, in context)
- Try to identify core emotional message
- Try to understand link between feelings & source of feelings (client's situation, context)
- Communicate/check understanding
- Use words that encourage client to confirm or correct the way you understand things

16

Counselling Skills

- Building a relationship ('joining')
- Active listening
- Paraphrasing, mirroring
- Reflecting feelings
- Questioning, probing
- Summarising

17

Building a Relationship

- Building relationship is a continuous process
- Initial meeting with client - critical in setting tone, conveying nature of counselling
- Convey warmth, interest, concern
- Clarify roles & expectations (agreement)

18

Building a Relationship

- Key points - introductions, purpose of counselling, counsellor role, confidentiality, expectations of client
- Keep this particular client & his/her needs & situation in mind
- Revisit agreement when necessary

19

Active Listening

- Active listening (listening in order to understand) involves:
  a) Attending
  b) Verbal & non-verbal behaviour of counsellor
  c) Helps counsellor to listen properly & to let client know that he/she is listening

20

Active Listening

- **Listening:**

a) Verbal messages
(what is said in words)
b) Non-verbal messages
(what is conveyed by non-verbal signs)
c) Message in context (meaning of what is said in client's context)

21

Active Listening

- **Allowing time:**

a) Don't rush, allow silence
b) Give client time to express him/herself. Give yourself time to digest, before responding

22

Active Listening

- What is the client saying ?
- How is he/she saying it ?
- Does the client's non-verbal communication agree with what he/she is saying in words ? If not, what does that mean ?

23

Active Listening

- Is there a gap in what the client is saying ? What is that ? Why is he/she leaving it out ?
- What are my (counsellor's) own reactions (physical, emotional, values, attitude) to what the client is saying in all these ways ?

24

Paraphrasing & Mirroring

Repeating in one's own words what the client has said to show one's understanding

25

Paraphrasing & Mirroring

It helps the process of counselling by:

a) Clarifying for the client what he/she has said

b) Clarifying for the interviewer what the client has said – by feeding back what you have heard, you can check on the accuracy of your listening

c) Helping client talk in more detail about issues of concern to him/her

d) Helping a talkative client to stop repeating the same facts or story

26

Reflecting Feelings

- To pick up the client' s feelings & letting him/her know you have understood how & what he/she is feeling
- To do this one needs to observe:
  - a) Emotional words used by the client
  - b) Non-verbally expressed emotional words

27

Reflecting Feelings

1. Begin with words such as:
   eg. "you feel…", "sounds like you feel…", "could it be you feel…?"
2. Feeling words may be added:
   eg. Sad, happy, glad
3. The context may be added through a paraphrase or repetition of key content.
   eg. *"looks like you feel happy about getting a job"*

28

Reflecting Feelings

4. A present tense reflection is more effective
   eg. *"you feel.."* rather than *"you felt…"*
5. After identifying a feeling, you can clarify so that the client can correct you if needed
   eg. *"am I hearing correctly ?"*

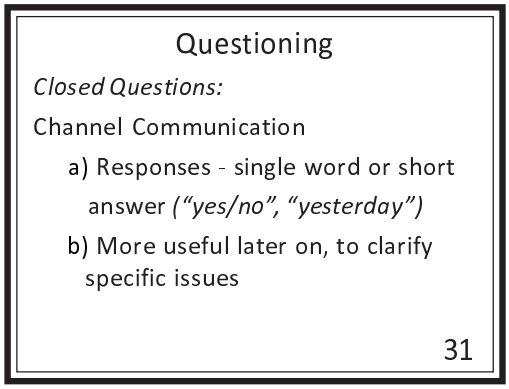
29

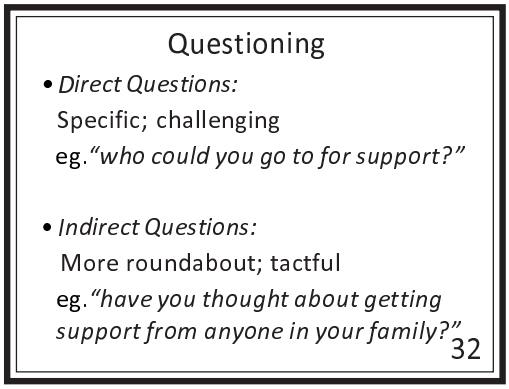
Questioning

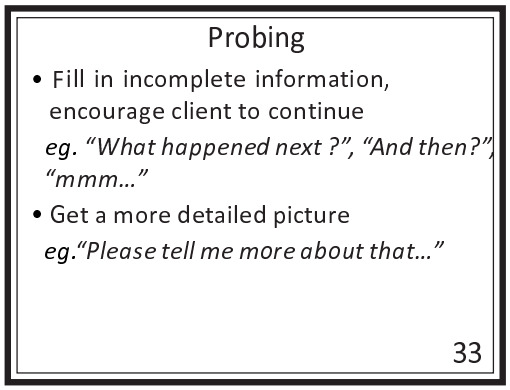
Includes questions, statements (with questioning intonation), requests, non-verbal prompts:

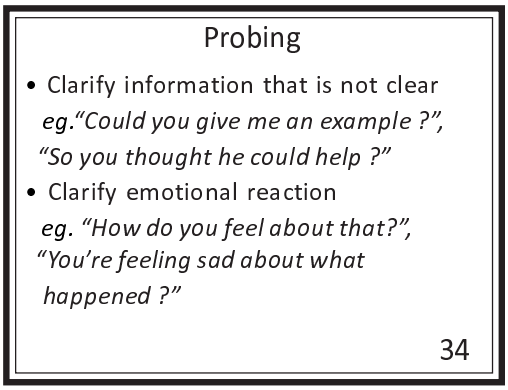
- *Open Questions*
  - a) open up communication
  - b) Responses - more detailed
  - c) Used more often early in counselling, to get a broad overview

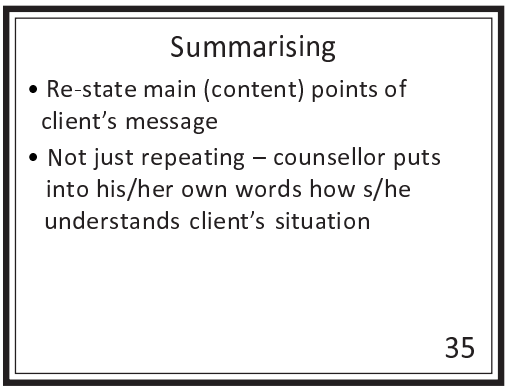
30

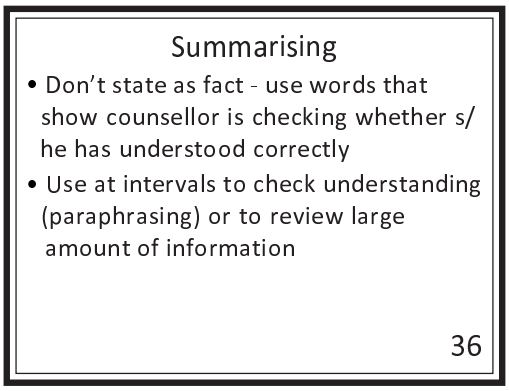












Written test: (duration: 40 minutes)
Module 2: The structure and essential building blocks of the program: refer to appendix 4

Module 3 : Treatment for Common Mental Disorders

A. Psychoeducation

Objectives

1. To learn the various components of psychoeducation session I, II and III.
2. To practice delivering psychoeducation session I, II and III through role-play and observation

Duration: approximately 40 hours

Method:

- Lecture using power point slides.
- Role-play
- Group discussions.

Procedure:

1. Presentation with didactic lecture and group discussions : (duration: 10 minutes)

- What is psychoeducation?
- How does psychoeducation help?
- Why is it important?

PSYCHOEDUCATION SESSION – I: (duration: 19 hours)

2. Presentation and lecture of psychoeducation steps 1and 2 of session I (duration: 5 minutes)

- Greeting the patient
- Emphasizing confidentiality

3. Demonstration and practice: (duration: 40 minutes)

The facilitator acts as the patient and invites one trainee from the group to demonstrate how the two above steps can be done. Change role to very depressed and slow patient to irritated patient and get group members to demonstrate the above steps to the whole group. Follow each demonstration with discussions/ clarifications.

4. Presentation and lecture of psychoeducation steps 3 - 5 of session I: (duration: 15 minutes)

- Elicit key symptoms
- Enquiring about suicide (emphasize importance)
- Obtain base line mood rating

5. Case demonstration of the steps 3 - 5 of session I (duration: 20 minutes)
The co-facilitator acts as the patient with the following symptoms: sleep difficulty, fatigue, irritability, panic attacks and suicidal ideation. The facilitator demonstrates each of the above steps to the group followed by a discussion.

6. Practice (duration: 45 minutes)
Trainees practice each of the above steps in pairs with each other.

7. Discussion and clarification on the above steps (duration: 30 minutes)

8. Presentation and lecture of psychoeducation steps 6 - 9 session I
(duration: 20 minutes)

- Eliciting psychosocial stressors related to onset of symptoms
- Reassurance and linking stress and symptoms (with flip chart)
- Explaining the diagnoses and giving hope
- Giving the sick role

9. Self Study: (duration: 20 minutes)
Trainees are asked to read the sections explained in the Health Counsellors manual (pages: 73-76 and 129-136)

10. Practice: (duration: 60 minutes)
Health counsellors pair up (*preferably experienced HC's with new ones*). The following psychosocial stressors have to be elicited – death in the family or/and loss of job and financial difficulties. After eliciting the stressors each one practices the next 3 steps of psychoeducation.

11. Discussions and clarifications: (duration: 30 minutes)
HC's are randomly asked to demonstrate to the whole group each of the steps followed by discussions, feed back on difficult parts and clarifications.

12. Review psychoeducation steps 1 - 9 of session I : (duration: 30 minutes)

13. Presentation ,lecture and demonstration of psychoeducation steps 10 -12 session I: (duration: 45 minutes)

- Advice on specific symptoms (with flip chart)
- Demonstration of breathing exercise
- Advice on antidepressant medication (ADT)

Presentation will follow demonstration of the steps by a facilitator

14. Self study and practice in small groups (duration: 45 minutes)
Refer to Health counsellors manual (pages77- 90,136-137) and practice in pairs – give advice on specific symptoms, breathing exercise and advice on antidepressant medicines (ADT)

15. Case demonstration of the above steps (duration: 40 minutes)
Each trainee has to demonstrate to the group how she will give advice.Trainees are alternately asked to demonstrate each symptom. These are followed by discussions.

16. Presentation, lecture and demonstration of psychoeducation steps 13 – 15 session I (duration: 60 minutes)

- Describing the interventions and adherence management
- Referral to community agencies
- Concluding the session
- How to end the assessment - session I

Presentation will follow discussion on adherence management and referral to community agencies which would include the agencies listed, method of referring and obtaining feed back – *Experienced HC's could be asked to demonstrate their experiences by enacting how they speak to referral agencies over the phone.*

17. Self study and practice in small groups : (duration: 60 minutes).
Refer to the Health Counsellors manual for the steps of psychoeducation session 1 (pages: 137-139)and practice in pairs the steps 13 – 15 also role play making phone calls to contact agencies and discuss patients problems.

18. Case demonstration of the above steps (duration: 45 minutes)
Trainees to alternately demonstrate to the group how the intervention will be described, how to refer to various community agencies and concluding the session. Follow this with discussions on the different steps in adherence management

19. Review steps of psychoeducation session 1, discussions and clarification (duration: 60 minutes).
Facilitator reviews each of the 15 steps of psychoeducation session I. Discuss difficulties faced in each of the steps and ensure clarifications.

20. Case demonstration of psychoeducation session I (duration: 80 minutes).
The group reviews each of the steps of psychoeducation I – trainees alternately demonstrate each of the steps while facilitator acts as patient. Facilitator changes role to a talkative patient, to a very slow patient, some one who cannot do the breathing exercises properly and tends to breathe fast, some one who is in a hurry, etc.

21. Practice in small groups: (duration: 90 minutes)
Trainees work in groups of three - Each group is given a case. Each member of each group alternately plays the role of a patient, counsellor and observer and practice steps 1 - 9 steps.

22. Discussions and clarification: (duration: 30 minutes).
Discussions in the whole group on difficulties faced/ clarifications and feed back given by facilitators on what needs improvement.

23. Practice in small groups: (duration: 90 minutes)
Trainees work in groups of three - Each group practices with the same cases as above. Each member of each group alternately plays the role of a patient, counsellor and observer and practices steps 10 - 15 steps.

24. Discussions and clarifications: (duration: 40 minutes).
Discussions in the whole group on difficulties faced,clarifications and feed back given by facilitators on what needs improvement.

25. Practice in small groups: (duration: 120 minutes)
Trainees work in groups of three and practice the full psychoeducation session I (all 15 steps) using various cases.Each trainee gets to play the role of the counsellor and at the end identifyies the problem area and devises a plan.

26. Discussions and clarifications: (duration: 40 minutes).
Discussions in the whole group on difficulties faced, clarifications and feed back given by facilitators on what needs improvement to the trainees

PSYCHOEDUCATION SESSION- II AND III: (duration: 20 hours, 40 miniutes)

1. Presentation and lecture on psychoeducation steps 1 and 2 session II
(duration: 20 minutes).

- Reviewing the clinical status of the patient
- Reviewing strategies and advice given in session I and
- Reinforcing information provided in session I

2. **Self study and practice in small groups:** (duration: 60 minutes).
Trainees to refer to manual (pages: 139-141) and practice in pairs the above 2 steps in pairs

3. Presentation, lecture and demonstration (duration: 45 minutes)

- introducing specific techniques based on the interpersonal problem area i.e. grief, interpersonal disputes, role transitions, deficits.
- Presentation will follow demonstration by a facilitator

4. Practice in small groups (duration: 60 minutes)

Trainees in pairs practise the above steps of introducing specific techniques in case of specific problem areas.

5. Demonstration, discussions and clarifications (duration: 45 minutes)

Trainees to alternately demonstrate to the group how they would introduce specific techniques in case of each problem area followed by discussions and clarifications

6. Presentations and lecture (duration: 30 minutes)

On steps mentioned below of psychoeducation session II:

- Specific techniques for patients who are improving
- Specific techniques for patients who are not improving

7. Demonstrations and discussions (duration: 60 minutes)

Facilitator to review all steps of psychoeducation-II with the group; discussions and demonstrations where ever required can be made.

8. Self study and practice in small groups (duration: 30 minutes)

Trainees refer to the Health Counsellor's Manual (page: 143) and practice in pairs the steps for patients who are improving.

9. Demonstrations, discussions and clarifications (duration: 45 minutes)

Trainees are randomly asked to demonstrate to the group the steps to be followed for patients who are improving followed by discussion and clarification.

10. Self study and practice in small groups (duration: 30 minutes).

Trainees refer to the Health counsellor's manual (pages: 143-144) and practice in pairs the steps for patients who are not improving.

11. Demonstrations, discussions and clarifications (duration: 45 minutes).

Trainees are randomly asked to demonstrate to the group the steps to be followed for patients who are not improving followed by discussions and clarification.

12. Practice in small groups (duration: 90 minutes).

Trainees are given case vignettes and divided into groups of three each. Each group practices the steps of psychoeducation session II for patients showing improvement and for patients showing no improvement. Each trainee get a chance to play the role of a counsellor.

13. Demonstrations, discussions and clarifications (duration: 45 minutes).
The whole group discusses difficulties encountered. Clarifications made with demonstration by facilitator.

14. Self-study (duration: 30 minutes)
Trainees read the relevant sections in the Health Counsellor's manual.

15. Trainees review the steps covered in psychoeducation session II
(duration: 30 minutes).

16. Presentation, lecture and demonstration of psychoeducation
Session III (duration: 45 minutes):

- Reviewing the clinical status
- Steps for patients who have remained well
- Steps for patients who are not improving
- Ending the intervention

17 Self study and practice in small groups (duration: 45 minutes).
Trainees refer to the Health Counsellor's manual and practice each of the steps in session III in pairs.

18. Demonstrations, discussions and clarifications (duration: 45 minutes).
Trainees are randomly asked to demonstrate to the group the steps to be followed in psychoeducation session III followed by discussion and clarification.

19. Self study (duration: 20 minutes)
Trainees read the relevant section of the Health Counsellor's manual related to psychoeducation session III.

20. Practice in small groups: (duration: 90 minutes).
Trainees practice the given case vignettes (refer below) in small groups-psychoeduction session III.

21. Review steps of psychoeducation sessions II and III (duration: 45 minutes).

22. Practice in small groups (duration: 240 minutes).
Trainees practice the given case vignettes (refer below) in small groups - psychoeducation session I, II and III.

23. Clarifications / discussions of difficulties and summarising (duration: 45 minutes).

Case vignettes for practice

Case 1

Thomas , a 65 year old baker, has always been very active. For the last one year his sons who have got into other businesses have been urging him to stop running the bakery and stop working so hard. He has reduced the work but has been finding it difficult to cope with the change in his life style. Two months back he noticed a small lump on his back.He thinks it is cancer and has been having panic attacks, difficulty falling asleep and loss of appetite.

Clinical scenario: Thomas is detected to have CMD on screening.The doctor had advised him to take an X-ray and has asked him to meet the new person in the clinic i.e. HC to discuss his problem.

Psychoeducation session 1.

Task

1. Allow the patient to talk about his physical complaints.
2. Elicit other key symptoms.
3. Explain how stress worsens physical problem.
4. Explain the close connection between the mind and body to explain his symptoms.
5. Describe the intervention.
6. Provide advice on specific symptoms
    - Change in his life style
    - Sleep problem
    - Panic attack
    - Breathing exercise
7. Conclude the session

Psychoeducation session 2

He is feeling worse as doctor said that he needs to do some more tests. He is sure that it is a cancer and that the doctor is not telling him about it. He has sleep problems, is unable to concentrate, feels tired,and does not feel like doing anything. He also has palpitations. He felt better when he did breathing exercise especially during the panic attack.

Task:

1. Review the symptoms: How have you been feeling since we last met?
2. Enquire about the investigation. Reassure, encourage to do suggested investigations.

3. Reinforce information provided in session one (encourage and praise)
4. Explain mind body link.
5. Advice on new symptoms:
    - Feeling tired (activity schedule)
    - Breathing exercise
6. Conclude the session

Psychoeducation session 3

He is feeling better as his reports are normal. All his symptoms have improved.

Task:

1. Review the symptoms
2. Reinforce information provided in session two.
3. Conclude the session.

Case 2

Jenny, a 45 year old widower who has three children, sells vegetables in the market to make a living and look after her children. Her elder son is alcoholic,and beats her up for money. Other children are studying. She says she has had poor sleep, fatigue and loss of appetite for a long time. But for the last 2 months she has back pain, headaches, poor sleep and working has become very difficult. Her business is also not going on well. Making ends meet has been very difficult. Sometime she feels that life is not worth living.

Clinical scenario: Jenny is detected to have CMD on screening .She has seen the doctor who has asked her to meet the HC for talking about her problem.

Psychoeducation session 1

Task:

1. Elicit key symptoms
2. Reassure and explain about the link between patient's stress and complaints
3. Explain diagnosis.
4. Describe the intervention.
5. Breathing exercise
6. Advice on specific symptoms
    - Tiredness
    - Sleep problem
7. Conclude the session.

Psychoeducation session 2

Patient's symptoms has worsened. Doctor had prescribed ADT. She has severe body ache as her alcoholic son had physically abused her. She is feeling weak and tired, now she does the house hold work with her daughter's help.She also gets angry easily. She does not feel like eating and feels worthless and has suicidal thoughts. She did not follow the advice given to her as she did not get enough time to do so.

Task:

1. Review the symptoms: How have you been feeling since we last met?
2. Review the strategies. (Review reasons, Reinforce)
3. Advice on new symptoms and ADT.
4. Conclude the session.

Psychoeducation session 3

Patient's symptoms have improved. Doctor has given medicine for one more week. She feels little better but has headache, backache and sleep problems. She doesn't have suicidal ideas as there are no fights in the house because her brother took her son with him to Mumbai. She had vomiting so she did not take the medicine for two days. No side effects appeared later when continued the medication.

Task:

1. Review the symptoms: How have you been feeling since we last met?
2. Review the strategies. (Reinforce)
3. Advice on ADT.
4. Conclude the session.

Case 3

Dora, a 25 year old married lady has three children. The youngest child is two years old .Her husband is an alcoholic who sometimes goes to work. She finds it difficult to make ends meets. Her mother-in law harasses and verbally abuses her. Often there are quarrels in the house and her husband beats her. Sometimes she has suicidal thoughts. She has once attempted suicide along with her three children but was stopped by the neighbours.For the past six months she has had severe headaches, backache, is unable to concentrate, feels angry and has difficulty in sleeping. Her in-laws have given her a plot of land to build a house and told her to shift to the new house as soon as possible. Now she is worried as her children do not have proper food to eat and does not know how she will build a house. She is fed up about the quarrels in the house and the husbands beatings and feels that life is not worth living. She lives because of her children.

Clinical scenario: Dora is screened to have CMD. Doctor has given her medicines (not ADT) and asked her to meet the HC to talk about her problems.

Psychoeducation session 1

Task:

1. Elicit key symptoms. (Suicidal risk)
2. Elicit psychosocial stressors (Identify the problem area and make a note)
3. Reassure and explain about the link between patient's stress and complaints
4. Explain diagnosis.
5. Describe the intervention.
6. Advice on specific symptoms
    a. Anger
    b. Sleep problem
    c. Breathing exercise
7. Conclude the session.

Psychoeducation session 2

Patient feels a little better. Headaches have stopped but she still feels tired and weak and also has back pain , she is unable to sleep well, do her house work and take proper care of the children. She did the breathing exercise when she had headache. She does not have help from any one. She has suicidal thoughts, but no plans.

Task:

1. Review the symptoms: How have you been feeling since we last met?
2. Review the strategies. (Review reasons, Reinforce)
3. Introduce specific technique based on identified problem area.
4. Conclude the session.

- Ending the intervention

Case 4

Raj a 27 year old man presents with severe headache, unable to concentrate on the work as a result of which he has stopped going to work. He also has palpitations and sleeping difficulty. Four months ago,he had a break up with his girlfriend.

Clinical scenario: Raj is screened to have CMD. Doctor has asked him to meet the HC to talk about his problem.

Psychoeducation session 1

Task:
1. Elicit key symptoms.
2. Reassure and explain close connection between mind and body in explaining his symptoms.
3. Description of intervention.
4. Breathing exercise
5. Advice on specific symptoms
    - Sleep problem
6. Conclude the session

Psychoeducation session 2

He is feeling better, his headache has improved and he sleeps well. But he is unable to concentrate on his work,feels tired and does not feel like doing anything. When he had palpitations he did breathing exercise and it helped him. He spoke to his friend about his problem on the phone and he felt better after that.

Task:
1. Review the symptoms: How have you been feeling since we last met?
2. Reinforce information provided in session one (encourage and praise)
3. Advice on new symptoms:
    - Feeling tired (activity schedule)
4. Conclude the session

Psychoeducation session 3

He is feeling better. All his symptoms have been improved. He has joined work.

Task:
1. Review the symptoms
2. Reinforce information provided in session two.
3. Conclude the session.

- Ending the intervention

Case 5

Tara, a 35 year old lady, recently lost her husband three months ago. Her presenting complaints are severe aches and pains, tiredness, loss of appetite, palpitations and poor sleep. Twice she had attempted suicide but was saved by the neighbour. She does not talk to anybody. She has suicidal thoughts but no plans. Now she is staying with her mother and brother who take good care of her.

Clinical scenario: Tara has been screened positive for CMD. She has seen the doctor who prescribed antidepressants (ADT) and has asked her to meet the HC to talk about her problem.

Psychoeducation Session 1.

Task:
1. Elicit key symptoms
2. Elicit psychosocial stressors (Identify the problem area and make a note)
3. Reassure and explain about the link between patient's stress and complaints
4. Explain diagnosis.
5. Describe the intervention.
6. Breathing exercise
7. Advice on specific symptoms: • Tiredness • Sleep problem • Antidepressants (ADT)
8. Conclude the session.

Psychoeducation Session 2

Patient's symptoms have worsened. Doctor has prescribed ADT. She has suicidal thoughts but no plans. She did not follow the advice as she did not feel like doing it. She spoke to her aunt on the phone.

Task:
1. Review the symptoms: How have you been feeling since we last met?
2. Review the strategies. (Review reasons, Reinforce)
3. Introduce specific technique based on identified problem area
4. Conclude the session.

Psychoeducation session 3

Patient's symptoms improved, doctor prescribed ADT. He felt little better but she has headache, backache and sleep problems. She has suicidal ideas but no plans

Task:
1. Review the symptoms: How have you been feeling since we last met?
2. Review the strategies. (Reinforce)
3. Advice on ADT.
4. Conclude the session.

Case 6

Neha, a 25 year old lady, married for six months is being harassed by her in-laws and husband for dowry. Her presenting complaints are aches and pains, tiredness, loss of appetite, poor sleep and palpitations. She comes from a poor family and her parents are unable to meet her in-laws expectations. She feels worthless and has suicidal ideas but no plans.

Clinical scenario: Neha has been screened positive for CMD. The doctor has prescribed medicines (not ADT) and has asked her to meet the HC to talk about her problem.

Psychoeducation session 1

Task:

1. Elicit key symptoms. (suicidal risk)
2. Elicit psychosocial stressors (Identify the problem area and make a note)
3. Reassure and explain about the link between patient's stress and complaints
4. Explain diagnosis.
5. Describe the intervention.
6. Breathing exercise
7. Advice on specific symptoms
    - Sleep problem
    - Tiredness
8. Conclude the session.

Psychoeducation session 2

Patient's symptom worsens.She still feels tired and weak and also has back pain and is unable to sleep well. She is unable to do her house work and her in-laws verbally abuse her. She gets angry and also has palpitations. She did the breathing exercise when she had palpitations. She has suicidal thoughts but no plans.

Task:

1. Review the symptoms: How have you been feeling since we last met?
2. Review the strategies. (Review reasons, Reinforce)
3. Introduce specific techniques based on identified problem area.
4. Conclude the session.

Case 7

Mario, a 45 year old man, presents with severe headache, palpitations, and poor sleep for three months while his son had to undergo heart surgery and also has financial problems.

Clinical scenario: Mario is detected to have CMD. Doctor has asked him to meet the HC to talk about his problem.

Psychoeducation session 1

Task:
1. Elicit key symptoms.
2. Reassurance and explain close connection between mind and body in explaining his symptoms.
3. Description of intervention.
4. Breathing exercise
5. Advice on specific symptoms
    - Sleep problem
6. Conclude the session

Psychoeducation session 2

Patient's symptoms are the same. He has aches and pains and also feels tired and weak. He tried the breathing exercise but he felt suffocated as a result of which he did not do it. He has suicidal ideas but no plans. He could not make enought money for his son's heart surgery.

Task:
1. Review the symptoms: How have you been feeling since we last met?
2. Reinforce information provided in session one (reasons for non adherence)
3. Advice on new symptoms:
    - Feeling tired (activity schedule)
    - ADT
4. Introduce specific techniques based on identified problem area
5. Conclude the session

Psychoeducation session 3

Patient complaints of side effects. He has stopped the tablets. His symptoms are the same, has suicidal ideas but no plans.

Task:
1. Review the symptoms
2. Reinforce information provided in session two.
3. Conclude the session.

Case 8

Saira is a 35 year old, living with her husband and three children. Her presenting complaints are severe headache, anger, panic attack and poor sleep. Her husband has had an extra marital affair. There are often quarrels in the house and sometimes he beats her. She has suicidal ideas but no plans as she has to look after her children.

Clinical scenario: Saira has been screened positive for CMD, has seen the doctor and been prescribed ADT. She was asked to meet the HC to talk about her problem.

Psychoeducation session 1

Task:
1. Elicit key symptoms
2. Elicit psychosocial stressors (Identify the problem area and make a note)
3. Reassure and explain about the link between patient's stress and complaints
4. Explain diagnosis.
5. Describe the intervention.
6. Breathing exercise
7. Advice on specific symptoms
    - Anger
    - Panic attack.
    - Sleep problem
8. Conclude the session.

Psychoeducation session 2

Patient's symptoms have worsened. Doctor has prescribed ADT. She has suicidal thoughts but no plans. She did not follow the advice as she did not feel like doing it.

Task:
1. Review the symptoms: How have you been feeling since we last met?
2. Review the strategies. (Review reasons, Reinforce)
3. Introduce specific technique based on identified problem area
4. Conclude the session.

Psychoeducation session 3

Patient's symptoms have improved. The doctor has prescribed ADT. She feels a little better but has headache, backache and sleep problems. She has suicidal ideas but no plans

Task:
1. Review the symptoms: How have you been feeling since we last met?
2. Review the strategies. (Reinforce)
3. Advice on ADT.
4. Conclude the session.

Psychoeducation-I

Psychoeducation-I

1

What is Psychoeducation?

First step in MANAS:

- Educational process
- Explanation about illness
- Practical advice to deal with problems
- Interactive session
- 2 - 3 sessions, approx 30 minutes each

2

How does it work?

- Therapeutic relationship
- De-mystifying symptoms/illness
- Treatable
- Sense of mastery and control

3

Enhanced Psychoeducation

Session 1:

- Give hope
- Sick role
- Use of mood ladder

Session 2:

- Specific basic techniques to deal with problems based on problem area

4

Enhanced Psychoeducation

- Use of flip charts
- Why?
- How?
- When?

5

Steps in Psychoeducation Session 1

- *Greet the patient:* Introduce yourself, confirm patient's name, build rapport, briefly explain your role
- *Emphasize confidentiality:* Information may need to be shared but this will be done with patient's consent

6

Key steps in the first session

- Eliciting symptoms and inquiry for suicidal ideas
- Obtaining a baseline mood rating
- Eliciting psychosocial stressors
- Reassurance and explanation about the link between patient's stress and complaints.
- Explaining the diagnosis and giving hope.
- Giving the sick role

7

Psychoeducation (contd.)

- Advise on specific symptoms.
- Advice on ADT (if prescribed).
- Advice to patients using alcohol or tobacco.
- Describing the interventions and adherence management.
- Referral to community agencies (if required).
- Concluding the session.

8

Psychoeducation (contd.)

1. Eliciting symptoms and inquiry for suicidal ideas
   - *Ask* for substance use: alcohol and tobacco
2. Enquiring about suicide
3. Obtaining base line mood rating

9

Psychoeducation (contd.)

- Eliciting psycho social stressors related to onset of symptoms

  Fill the social difficulty checklist
- Elicit patient's perceptions of the problem. Based on this, explain the diagnosis (stress cycle)
- Give hope (reassurance)
- Giving the sick role

10

Psychoeducation (contd.)

Teach the breathing exercise:

- Explain using flip chart
- Demonstrate
- Ask patient to try it. Emphasise need to continue practicing it at home

Advise about diet:

- Eg. stopping drinking, smoking
- Tailor diet advice to patient's situation

11

Psychoeducation (contd.)

Advise on specific symptoms:

- Sleep
- Tiredness
- Irritability/anger
- Panic attacks
- Phobia
- Giddiness

Any other symptoms?

Do not give advice that you are unsure about or that has not been discussed in training

12

Psychoeducation (contd.)

Advice on ADT

The medicines are safe and can be taken along with other medicines. (Don't say tablets are powerful/strong)

- Widely used and many people have benefited from these tablets. - will help in reducing your stress related symptoms and improve your overall health.

13

Psychoeducation (contd.)

Advice on ADT

- They are not addictive
- They may occasionally produce some side effects like headache etc - But these are uncommon, mild and short-lived.
- They start showing a positive effect on health in a few days

14

Psychoeducation (contd.)

Advice on ADT:

- They must be taken regularly for maximum benefit and for at least six months to ensure complete recovery or as prescribed by your doctor.
- Take them after you have eaten something, not on an empty stomach
- Superiority over injections

15

Psychoeducation (contd.)

Referral to Community Agencies:

- Familiarise yourself with list
- Establish prior contact, referral letter
- Follow-up

16

Psychoeducation (contd.)

Describing the interventions & adherence management:

- treatments mainly help the person handle stress and tension more effectively and make them better
- treatment of the stress-related illness would help improve the physical illness outcome as well.
- no additional cost
- emphasise need for adherence
- availability of yoga classes

17

Psychoeducation (contd.)

Concluding the session:

- Revise information. Need to follow ` advice at home
- Next appointment - flexible timing, additional information will be provided
- Check contact details
- Handouts
- Ask patient for questions /clarifications

18

How to end the assessment

- Complete the patient intervention card
- Enter patient next appointment date on diary
- Record pateint's problem
- Devise a plan for session II

19

Psychoeducation -2

Psychoeducation -2

1

Steps to be covered in Session-2

- Reviewing the clinical status of the patient
- Reinforcement of information provided in session 1
- Introduction of specific techniques based on problem area identified
- Planning further intervention for those who have not improved or have worsened

2

Step by Step…

Reviewing the clinical status:

1. **Inquire***: "How have you been feeling since we last met?"* ...then refer to specific symptoms…

" Last time you said you had difficulty sleeping, lack of appetite …how have these problems been in the last few days"

2. **Repeat mood rating** – note the difference and provide feed back

3

Step by Step…

- Review advice for specific symptoms: *"Were you able to follow the advice for ___"*
- Ask patient to do breathing exercises once again.
- Reinforce information provided in Session - 1

4

Identifying Problem Areas

- **Grief**: Loss of a significant person in the patient's life

Eg. death of a parent, death of spouse

- **Interpersonal Dispute:** is an ongoing disagreement with someone important. It occurs when there is a difference in expectations of the people involved.

Eg. Between siblings, husband and wife

5

Identifying Problem Areas

- **Interpersonal Deficits** - problems are around initiating and maintaining relationships. The patient is socially isolated.

Eg. Loneliness or not having friends

- **Role Transition**- any life changes bad or good that the person has difficulty adjusting to

Eg. Marriage, divorce, motherhood, promotion, etc.

6

Specific techniques
based on problem areas

- **For Grief** : Encourage the patient to talk about events surrounding the death and express her feelings of sadness and loss.

Eg. "*You told me that your symptoms started after the death of your husband. Can you tell me more about this?"*

7

Specific techniques
based on problem areas

- **If patient is reluctant to talk:**

"*Talking about your husband's death is difficult, but talking about it and understanding how you feel about his death will help you to manage your stress better."*

- Allow the patient to speak, prompting if required and reflect feelings and empathise

8

Specific techniques
based on problem areas

- For interpersonal disputes: Where faulty communication triggers dispute, educate the patient about effective communication strategies
- Find a good time/day when the other person will be receptive to conversation
- Use "I" statements about how u feel and what u want. avoid using words such as" always" , "never" and "you"

9

Specific techniques
based on problem areas

- Talk about behavior not the person (What you said the other day was really hurting, Do not say you are insensitive)
- Strike while the fire is cold——not in the middle of an argument
- Have a little note in front of you
- Help the patient understand the feelings he conveys with the verbal and non-verbal communication.

10

Specific techniques
based on problem areas
OR

- Use decision analysis to assist patients in making a choice between different possible coping strategies.
- What does she want to do? What options does she have? Encourage the person to generate many possible solutions to the problem and select one solution or a combination that looks the most appropriate.

11

Specific techniques
based on problem areas

- **For Role Transition**
- Discuss positive and negative aspects of the new role.

"Is there anything you like about the new role?"

"What is it that you find difficult to adjust to?"

12

Specific techniques based on problem areas

- Identify **strategies of coping** with the new role.

Eg. *identify supportive figures*

- Help the patient find supports- identify supportive figures to help him manage the new role.

13

Specific techniques based on problem areas

Loneliness and Social Isolation

- Encourage the patient to form new relationships and draw on already existing ones to reduce loneliness.
- "who are the people close to you?
- To look for new opportunities for socialization (attending functions, social gatherings, small visits to friends or neighbour's house, etc).

14

Specific Scenarios

15

For Patients Who Are Improving

- Explain specific techniques - based on problem area identified in session 1
- Emphasize need to continue practicing the techniques that have been taught
- Letting the doctor know – of improvement in patient's condition
- Advise the patient to come back for a review in 4 weeks
- Advise that if symptoms worsen, to come back for a review earlier

16

For patients who are the same - not improving or worsened

- Ask about worries and stressors associated with the complaints.

Eg. Patient is worried because her child is unwell, - ask: "*are you thinking about your sick child all the time? Does this affect your work?*"

17

For patients who are the same - not improving or worsened

- If the patient has not been able to adhere to the advice given in the first session, review the reasons for this.

Eg. Not being able to do activity prescribed for complaint of fatigue – change the activity OR If he/ she found it difficult to do the breathing exercises, review it during the session

- Teach specific techniques as per problem area

18

Specific techniques based on problem areas

- If the patient has serious suicidal thoughts, discuss with the GP and consider referral to the Clinical Specialist
- Inform the doctor about the continuing symptoms; the doctor may initiate antidepressants
- If the doctor gives antidepressants, - Provide information regarding ADT
- Review in 2 weeks

19

Concluding the session

- Important to summarize the session
- Ask if the patient has understood and has clarifications to make
- Emphasize adherence to non-pharmacological treatment
- Give flexible appointment
- Inform about yoga

20

Psychoeducation Session - 3

21

Psychoeducation Session - 3

- Review clinical state of the patient (including mood rating)
- Review patient's use of specific skills to tackle the problem area
- Link change in mood to the skills used
- Reinforce the need to follow the advice for specific symptoms as well as strategies to deal with problem area
- Educate about 'early warning signs' - and discuss steps to be taken if symptoms reappear

22

Specific Scenarios

- For patients who have remained well: DISCHARGE

23

For patients who are improving but not fully recovered

- Emphasize need to continue practicing techniques - taught to them
- Inform the doctor there is an improvement in the patient's condition
- Advise patient to come back if condition worsens / in case of relapse
- Discharge the patient

24

For patients who are not improving or feeling worse

- Recap - which symptoms have worsened
- Check regarding adherence with treatments:
  a) if not adhered, to reinforce need for the treatment.
  b) If adhered, to increase the frequency or intensity of treatments. For eg. if on ADT discuss with the doctor possibility of increasing medication dose

25

For patients who are not improving or feeling worse

- If the patient has not been able to adhere to the advice given, review the reasons for the same.
- If patient has new symptoms, record these and give appropriate advice
- Ask about the worries and stressors which are associated with the complaints. – review use of specific strategies according to problem area

26

For patients who are Not Improving or Feeling Worse

- Review any additional stressful event ?
- If the patient focuses more on the physical complaints repeat the explanation of the mind and body link and why it is necessary to follow the advice.

27

For patients who are Not Improving or Feeling Worse

- Ask about suicidal thoughts. If these are serious, discuss with the GP and refer to the Mental Health Specialist.
- Inform the doctor about the continuing symptoms; the doctor may add or increase the dose of antidepressants.
- Review in 2 to 4 weeks.

28

Follow up session for patients on ADT

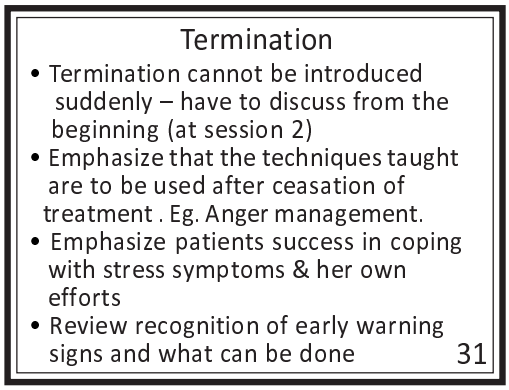
- Each time the patient comes for ADT:
  1. Review of symptoms and patients overall mood state
  2. Advise about ADT (refer session 1)
  3. Reinforce coping techniques taught depending on problem area
  4. Emphasize on adherence

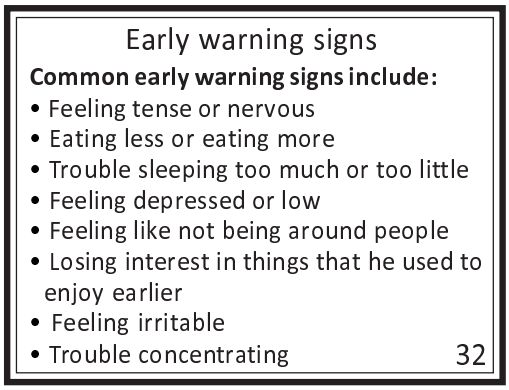
29

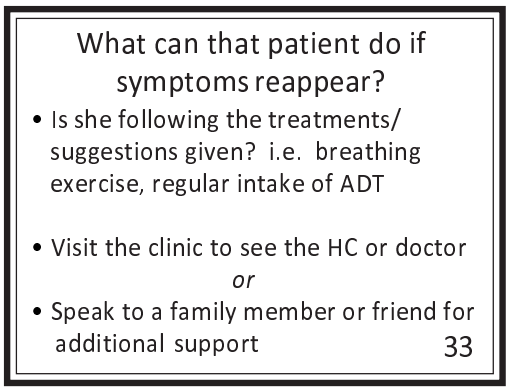
Ending the intervention

- When do you terminate?
  a)The patient has stayed well for 2 consecutive follow-up sessions of psychoeducation
  b) Course of ADT is completed and patient has recovered

30







Written test: Psychoeducation (duration: 40 minutes) - refer appendix 4

B. Antidepressants and Other Medication-related Issues

Objectives:

1. To acquire the necessary knowledge base about the principles of antidepressant (ADT) use.
2. To get an understanding of the 'symptomatic' treatments commonly used in primary care for depression and the potential problems of this approach.
3. To understand the content of the education to be given to patients prior to starting antidepressants and methods to promote adherence as part of their work.

Duration: approximately 3 ½ hours

Method:

- Lecture using power point slides.
- Role-play
- Group discussions.

Procedure:

1. Presentation and lecture: (duration: 60 minutes)
Didactic lecture that explains the rationale of antidepressant use, the specific issues around the use of antidepressants, the essential advice that health cousellor's need to provide patients at different stages of the use of antidepressant and the principles of enhancing adherence during treatment with antidepressants.

2. Group work: (duration: 40 minutes)
Trainees are divided into groups of 3/4. Each group will discuss and write on the given chart paper the information they will provide to the patient in the given scenarios (refer worksheet below). One person from each group will be nominated to make a presentation to the entire group.

3. Group discussion and clarifications: (duration: 20 minutes)
Trainees will get the opportunity to discuss further and clarify any issue that arises from the exercise.

4. Group work: (duration: 60 minutes)
Trainees will be divided into groups of 3/4. Each group will discuss and come up with various ways to educate and promote adherence to ADT. Each group will nominate one person to make a presentation to the entire group.

5. Group discussion and clarifications: (duration: 30 minutes)
Trainees will discuss further and clarify any doubts.

Material related to the lecture can be found in the HC Manual – The MANAS Model for Health Counsellors on pages 91-98

Worksheet

What information would you provide to the patient or what would you do in the following scenarios?

1. a) On the first visit to the doctors' clinic the patient was prescribed 15 capsules of fluoxetine (ADT) and she came to meet you.

   b) She came for the follow-up visit after 2 weeks and complained of side effects.

2. Patient has been started on ADT on his first visit. He continued taking ADT as prescribed by the doctor for one month but complains that he is not feeling better.

3. Patient started on ADT came for the follow-up visit after one month and was feeling better.

Antidepressants

Antidepressant and other Drug Treatments For CMD used In Primary Care

1

Introduction

- Antidepressants- group of medicines that are used to treat moderate-severe CMD
- Also used in a number of other conditions
- Discovered by chance around 50 years ago
- Specific, effective and widely used treatment

2

Other treatments of CMD in primary care

- Various medicines like vitamins, tonics, pain killers, sleeping pills are widely used to treat CMD
- Since they target individual symptoms and not the disorder, they are called symptomatic drug treatments.
- In MANAS, we would like to change this pattern of prescription

3

How do antidepressants work?

- ADT attach themselves to particular areas of nerve cells and alter levels of specific brain chemicals.
- Do not work immediately- lag period of 1-2 weeks before feeling starting to feel better Same dose not effective for everyone.
- Antidepressants have side effects which happen before positive effects.

4

Important facts about antidepressants

- Best results when used in moderate-severe CMD
- There are different classes of ADT
- SSRI, TCA, Mixed action
- Do not differ in terms of effectiveness
- Side effect profiles and costs are different
- Most effective when taken for the right duration

5

Antidepressant use in MANAS

- Doctor will prescribe ADT for patients with severe CMD - Step 2
- Can be started on 1st visit or in later consultations
- The patient card and the prescription given will inform you about the use of ADT

6

Role of HC during ADT treatment

- Ensure adherence with ADT
- What you do will depend on the phases of treatment:
  - Initial, acute phase (4-6 weeks) - symptom control
  - Continuation phase (6 months) - continue at same dose regularly to maintain well being
  - Planned discontinuation / stopping

7

Initial phase roles

Before starting:

- Educate about why it has been started and the benefits of treatment
- Inform about time lag for improvement- few days-2 weeks
- Inform about chance of side effects- emphasize these are mild and disappear after a few days
- Record best possible contact details
- Motivate to come for followup session to meet you and the doctor.

8

Subsequent sessions

- Session 2- compliment for having come back
- Review symptoms, side effects and interact with doctor with relevant information
- If tolerating ADT well, doctor will increase dose for better effect
- Encourage to continue and come back in 4-6 weeks

9

Subsequent contacts

- By now, patient is feeling better
- Brief, 5-10 minute contact
- Review improvement in symptoms and functioning
- Encourage to continue
- Ask to come back every 1-2 months
- Supplement with brief telephone contact

10

Treatmentreview at 6 months

- Alert doctor that 6 months of treatment is complete
- Decision to continue or stop will be made by doctor
- If stopping ADT, plan discharge after planned set of steps (discharge planning)

11

Role of the HC

- Once started, monitor and encourage adherence
- Monitor progress as in stepped care protocol
- Advice about when and how to stop in consultation with doctor

12

Other treatments used for depression

- Most common treatments for C MD are 'symptomatic' i.e. symptoms and not the disease is treated
- Common treatments include vitamins, tonics, injections, pain killers and sleeping pills.

13

Symptomatic treatments

- These are not effective and delay recovery
- These are expensive as well
- Can create new problems
- Encourage doctor shopping

14

Why are they used?

- The placebo response
- Poor recognition
- Practice conditions in primary care
- Patient expectations and doctors' compulsions

15

How do we change things

- Educate doctors about rational use of medicines
- Promote recognition
- Monitor use of symptomatic treatments
- Mental health specialist supervision to change practices.
- Important outcome measure for MANAS

16

Written Test: (duration: 15 minutes)

Antidepressant - refer Appendix 4

C. Interpersonal Psychotherapy

Trainers Credentials
To become a trainer you must have:

- A degree in a mental health profession
- Psychotherapy experience (individual and/or group)
- Completed at least three supervised individual IPT cases, and the approval of the IPT senior trainers, Lena Verdeli and Kathleen Clougherty, University of Columbia, New York, USA.

Objectives

- To learn the various components of Inter-personal psychotherapy (IPT).
- To practice delivering Interpersonal Psychotherapy through role-play/ observation

Duration: approximately 36 hours

Method:

- Lecture using power point slides
- Role-play
- Group discussions

Schedule:
Presentations and lectures on the following topics:

Day 1: Overview of IPT: (principles, triggers of depression and stress, role of the therapist role, structure of IPT - phases, treatment techniques in IPT - all phases).

Day 2: Initial Phase: (Introduction to the patient, explanation of IPT aims and procedures; Interpersonal Inventory)

Day 3: Middle phase; Dealing with grief; IPT techniques (group exercises and role-play)

Day 4: Interpersonal disputes; Role transitions (group exercises and role-play)

Day 5: Interpersonal deficits; Termination (group exercises and role-play)

Day 6: Practice the four problem areas; Special problems in group IPT: Dealing with partial-response and non-response; suicidal patients; shy/non-communicative patients; patients who dominate the session; domestic abuse; anxiety; medical conditions, etc .

Procedures

IPT training uses an apprenticeship model, through:

- Experiential components:
    1. Start training with warm-up exercises as you would in the therapy group (Introduce neighbour; ask each trainee "what do you always carry with you")?
    2. Refer to trainers and trainees personal experiences while covering the problem areas (encourage the discussion of personal losses when you cover grief, personal/professional arguments when you cover disputes, etc).
    3. Identify feelings surrounding termination of training and draw parallel to feelings about termination in therapy

- Practice: A number of exercises will be used during training to increase skill level in trainees during simulation of components of real sessions. These exercises will progress from something very safe to one that has more risk (like in IPT itself): for example, trainers can start with role-playing the interpersonal inventory taking turns being therapist and patient. Then move to role-play with one trainer as patient while the other trainer helps the trainee group (not any trainee in particular) to come up with appropriate ways of asking questions (like "How do you think you should respond to that?", "What do you think the patient understands when you say that?", etc). Finally, ask trainees to role play the therapist and patient.

- Peer modelling : Weaker trainees will be paired with stronger ones during training exercises

- Supervision during/following training:
    1. During training, while pairs practice, trainers listen in to what happens with each pair. Ask people to evaluate themselves, stating strengths and weaknesses as well as that of the other trainee.
    2. Notice that you use IPT techniques like communication analysis, role play, decision making, clarifications, etc, throughout the training
    3. Following training: Supervise taking into consideration the trainee's stage of training: you have fewer expectations for the first case than for the third. Model how to give positive feedback, don't just criticize. Tentative plan: meet with them weekly, have a supervisors conference call including senior supervisors, initially weekly for 3 months and then biweekly.

Interpersonal Psychtherapy (IPT)

Interpersonal
Psychtherapy
(IPT)

1

Principles of IPT

- Assumes that stress is triggered by interpersonal difficulties in one or more of the following problem areas:
- Grief
- Death of a person significant to the patient
- Interpersonal Disputes

2

Principles of IPT

- Disagreements
- Role Transitions
- Life changes—negative or positive
- Interpersonal Deficits
- Loneliness, social isolation

3

Principles of IPT

- By understanding the relationship between interpersonal events and stress, and by helping the patient improve his skills to handle these interpersonal events, we can help the patient recover.
- IPT aims to decrease of stress symptoms and improve functioning.

4

Examples of triggers of stress

- Death of an important person in patient's life
- Local disaster
- Rejection by someone
- Conflict with someone at work or home
- Unrequited love
- Loneliness/not having friends
- Unemployment/loss of job
- Difficulty getting pregnant

5

Examples of triggers of stress

- Poor school performance
- Illness of self or loved one
- Move
- Birth
- Financial problems
- Retirement
- Promotion
- Betrayal
- Marriage
- Abuse/domestic violence

6

Therapists's role in IPT

- Active
- Makes suggestions, **but does not tell the patient what to do**
- Asks questions
- Helps the patient consider options for managing the interpersonal problem ("*What are you going to do about this*?" or "*What would you like to do about this*?")

7

Therapists's role in IPT

- Empathetic
- Hopeful/optimistic
- Non-judgmental
- Works with the patient ("*We're in this together*").
- Focused on interpersonal problem area

8

Structure of IPT phases

- Initial Phase — Sessions 1-2
- Middle Phase — Sessions 2-5
- Termination Phase — Session 6

9

Structure of IPT number of sessions

- 6-8 sessions (6 sessions minimum), each lasting approximately 45 minutes
- All sessions held weekly
- If patient does well in symptoms/mood by the 5th session terminate, continue biweekly or monthly (depending on the patient's ability to come to the clinic)

10

Structure of IPT number of sessions

- If patient has not improved, may need to extend for a couple of additional sessions following discussion with your supervisor

11

Treatment techniques (all phases)

Start all sessions in the same way:

- Review stress related symptoms of last week: "How have your stress symptoms been since we last met?"
- Rate mood (use ladder scale)
- If patient begins relating event associated with stress, gently refocus on stress related symptoms.
- After rating, you link stress to events. Ask for details.

12

Tasks of the initial phase (Session 1)

- Introduce IPT to the patient and explain the need for this additional treatment
- Rate Mood
- Conduct the Interpersonal inventory related to the problem area (this will be completed in session 1)

13

Introducing IPT to the patient

- *"As I told you previously that there is going to be another form of treatment to help you manage your problem.*
- *For this treatment you will be required to come to the clinic to meet me for 6 sessions over 2-3 months or longer depending up on your improvement.*
- *Each session will last for approximately 40 miniutes.*

14

Introducing IPT to the patient

- *This treatment will help you deal with the issues that are related to your tension, we will talk about the problems that are causing you stress in greater detail and see how you can cope better."*

15

Patients who ask if it is important

HC needs to emphasize:

- *" It is for your benefit and because your response to ADT has been inadequate"*
- *"It is a free treatment, you do not have to pay".*

16

Interpersonal inventory

- Gather information about the important people, alive or dead, associated with the problem in the person's life whether it is grief, interpersonal dispute , interpersonal deficit or role transition.
- This helps to get a better understanding about what sustains the patient's stress.

17

You can start by saying...

- *In order to help you deal with your stress further, I need to understand the relationships in your life that may be contributing to your stress."*

18

You can start by saying...

- *"I' want to spend some time today understanding a little more how some of the important people in your life may be contributing to your stress related illness. Let's start with....."*

(Fill in the name of the person you know from the patient's life who seems to be at the center of the stress.)

19

You can start by saying...

- Remember to keep the focus of the Interpersonal Inventory on the problem area that you've already identified. This should not be a time for the patient to ramble.

20

Ask questions that you think are relevant

- *Do you have any problems with ……?*
- *Has anything changed in your relationship with ……? When did this happen?*
- *What would you like to change about this relationship?*
- *How often do you see …..?*
- *What do you like about ……?*

21

Ask questions that you think are relevant

- *How often do you argue with ….? Describe a typical argument.*
- *How do you get along with friends? Do you have friendships from long ago?*
- *Has anyone important to you died? When? How has this affected your depression?*

22

Tasks of Middle Phase (Session 2)

Working on the problem area:

Steps:
- Greet the patient.
- Ask how he has been since you last met.
- Do a mood rating.
- Present the **interpersonal formulation** and discuss this with the patient
- Therapist and patient agree to goals that will be the focus of treatment

11

Grief

- Goals:

1. Facilitate the mourning process.
2. Help the patient reestablish interest and develop new relationships to help manage the loss.

24

Grief: Techniques used

Get details about:

- How the patient learned of the death
- Conversations patient had with the deceased prior to death
- Conversations patient had with others about the deceased
- What the patient wished he had said to the deceased prior to death

25

Grief: Techniques used

Get details about:

- How did patient mourn the deceased
- Discuss the patient's positive and negative feelings about the deceased (*"Every relationship has rough times. What was your rough time"?)*

26

Grief

Strategies: What you do in sessions

- Review stress symptoms.
- Rate mood.
- Discuss the patient's relationship with the deceased (reconstruct the relationship).
- Discuss with the patient how the future feels without the deceased—the unrealized plans.
- Encourage relationships old and new and develop other interests.

27

Techniques used with other problem areas

Communication Analysis

- Goals are to help the patient understand:
- The feelings he conveys with verbal and nonverbal communication
- The impact of this communication on others

28

Techniques used with other problem areas

Communication Analysis

- The impact of the other's communication on him
- His ability to change these interactions and as a result change the feeling associated with the relationship

29

Grief

- Goals:

1. Facilitate the mourning process.
2. Help the patient reestablish interest and develop new relationships to help manage the loss.

30

Communication Analysis Guidelines

- Identify an interpersonal communication to examine in detail.
  ("*let's talk about the worst fight of the week")*
  Say, "*If I had a video camera, what would I have seen*?"

31

Communication Analysis Guidelines

- What did you say? What did she say? **How did it make you feel?** Is that the message you wanted to send? What else could you have said? How could you have said it differently? How did you feel when she said ___ back to you? What do you think she meant?
- Illustrate the cyclical nature of the communication.

32

Decision analysis: Looking at options

- Encourage the patient to generate possible solutions to the conflict-don't evaluate yet (brain storm)." What *are you going to do about the situation?"*
- Evaluate the pros and cons of each solution.
- Select one solution or a combination of a number of them to try first.
- Rehearse the interaction for the first solution.

33

Decision analysis: looking at options

- Encourage the patient to try the solution as home work during the week.
- Reinforce that this is an experiment and that it may or not work, but that it is important to come back the next week to discuss the outcome.

34

Decision Analysis: looking at options

- Start with smaller problems first to help patient build confidence.
- Review the interaction of the pervious week examining either its success or where it doesn't work and possible reasons why.

35

Role-play goals:

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

36

Role Play: Acting it out guidelines

- Be prepared to initially have to gently push some patients to do it.
- Do not make the role play too easy.
- You have the option to play the patient role first so that the patient gives you a flavor for how the other person really is. You can also start by being the other person, it's up to you and the patient. You can the switch roles.

37

Role Play: Acting it out guidelines

- At the end of the role play, ask the patient how he felt, was he comfortable with any part of the role play, does he feel he could carry out the conversation at home?

38

Work at home

- Explain to the patient that he will be experimenting with new skills from what was developed in communication analysis, decision analysis and role play

39

Interpersonal disputes

- Goals:
  a) Choose a plan of action.
  b) Modify expectations or faulty communication to bring about a satisfactory resolution.

40

Interpersonal disputes

- Review stress symptoms.
- Mood rating
- Identify stage of dispute:
- Renegotiation (Clarify situation to facilitate resolution)

41

Interpersonal disputes

- Impasse : Discussions have stopped about the disputed issue, both parties want to continue the relationship but feel hopeless and stuck
- Dissolution :One or both parties want to end the relationship: assist mourning and help people move on

42

Interpersonal Disputes

- **Strategies: What you do in sessions**
- Help patient understand the dispute as a difference in expectations of the people involved.
- Help patient understand his own expectations.
- Help patient understand (but not necessarily accept) the other's expectations.
- **Techniques: Communication Analysis**

43

Interpersonal Disputes

- Find out what the patient wants and choose a plan of action.
- **TECHNIQUE: Decision Analysis.** Help patient change communication patterns to improve the situation.
- **TECHNIQUE: Role play.** Rehearse what the patient plans to communicate.

44

Guidelines to Improve Communication

- Find a good time (when the other person will be receptive to conversations).
- Focus on the current dispute.
- Strike while the fire is cold.
- Separate the person from this behavior.
- Acknowledge the other party's expectations.

45

Guidelines to Improve Communication

- Use "I" statements about how you feel and what you want.
- Avoid using words such as "always: and "never."
- Find advocates to help you if you cannot directly communicate with the other party.

46

Role Transitions

Goals:

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

47

Role Transitions

Strategies: What you do in sessions

- Review stress symptoms.
- Discuss positive and negative aspects of the old role.
- Mourn the loss of the old role
- Discuss positive and negative aspects of new role.
- Explore opportunities in new role.

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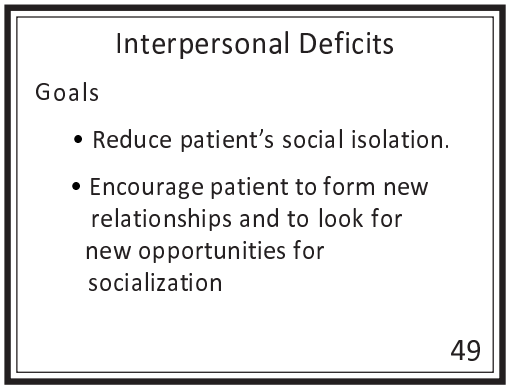
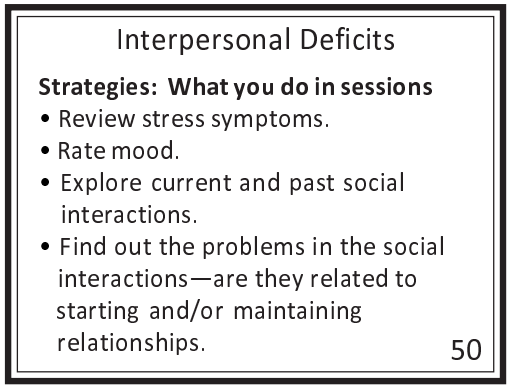
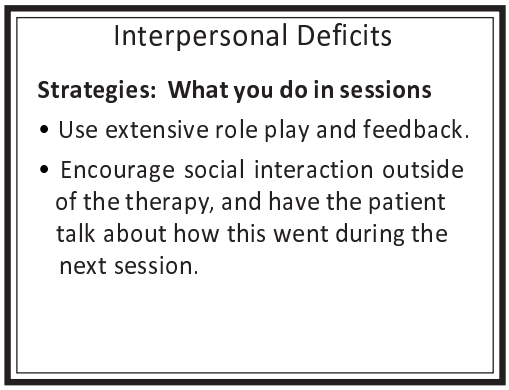
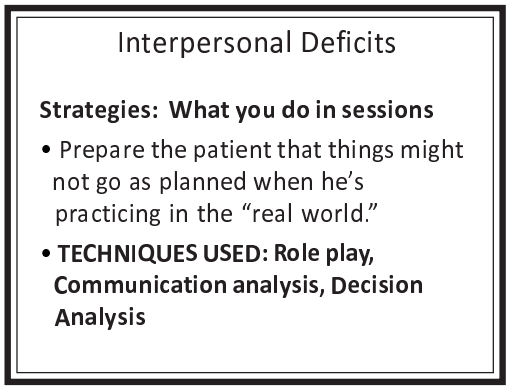
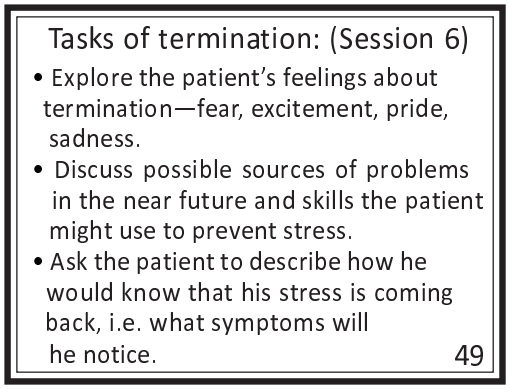
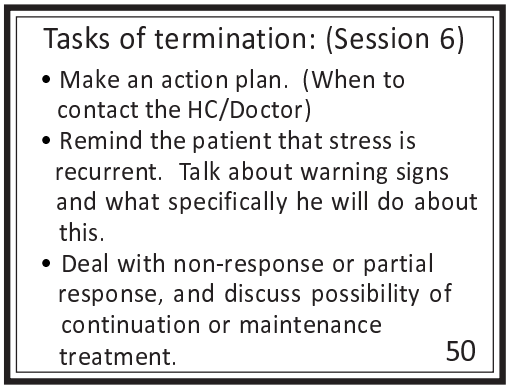












Written Test: (duration 40 minutes) On Interpersonal psychotherapy refer Appendix 4

D. Adherence Management

Objectives:

- To get an understanding of the key concepts of adherence management in generic health programs.
- To get a clear understanding of the principles and procedures related to adherence management in the MANAS program.

Duration: approximately 3 hours.

Method:

- Lecture using power point slides.
- Role-play
- Group discussions.

Procedure:

1. Presentation and lecture: (duration: 50 minutes)
Didactic lecture explains:

- The concept of adherence.
- The public health importance of adherence management
- Exploration of factors that contributes to adherence.
- How adherence management is built into the MANAS program with the specific roles of the HC and other members of the intervention team.

2. Group work: (duration: 30 minutes)
Trainees will discuss in small groups and generate a checklist of atleast five most important risk factors for non adherence patients who will be seen in the program. A person nominated from each group will make a presentation to the entire group

3. Group discussion and clarifications: (duration: 20 minutes)
Trainees will discuss further and clarify for 30 minutes.

2. Group work: (duration: 60 minutes)
Trainees will discuss for 30 minutes in small groups about the roles of the health cousellor in adherence management. Nominated person from the group will make a presentation to the entire group.

3. Group discussion and clarifications: (duration: 20 minutes)
Trainees will discuss further and clarify any doubts.

Material related to the lecture can be found in the HC Manual – *The MANAS Model for Health Counsellors* on pages 116-127.

Adherence

Adherence management in the MANAS Program

- Chronic diseases need long term management involving medicines and lifestyle changes.
- The single greatest challenge in chronic disease management is to get patients to continue with suggested treatments.

1

Adherence - definition

- Adherence 'sticking with' is that part of treatment which refers to the patient's ability to:
- Follow a treatment plan
- Take medicines at prescribed times and frequencies
- Sustain lifestyle changes for best outcomes.

2

Consequences of Non-adherence

- Non adherence causes relapse of the illness being treated
- Contributes to drug resistance
- Has major economic and social costs due to disability and loss of productivity

3

Non-adherence: examples of consequences

- Heart disease and diabetes
- Tuberculosis
- HIV/AIDS
- Depression

4

Factors Influencing Adherence

Patient related factors:

a) Socio demographic factors do not seem to have strong predictive validity
b) Psychosocial factors strongly predict adherence:
c) Good social supports, having good knowledge and understanding of treatments and sharing common explanatory models

5

Understanding Adherence

Treatment related factors:

a) The more complex the treatment requirements, the greater is the risk of non adherence
b) Treatments with more side effects cause more non adherence

6

Understanding Adherence

- The patient -care provider relationship: a positive and friendly relationship improves adherence
- Nature of the disease: depression is a risk factor for non adherence- lack of motivation, hopelessness and memory problems

7

Understanding Adherence

Systemic factors:

- Physical environment
- Staff attitudes
- Availability of treatment providers and medicines
- Distance and travel requirements

8

Improving Adherence

- No single method is the best- a combination of means has the best chance of improving adherence
- Accessible
- Equitable
- Affordable
- Simple and effective
- Matched to needs of patient.

9

Improving Adherence In The MANAS Program

- Adherence was a major challenge in the formative phase; problems and solutions based on research
- Lack of information about the program in the primary health center
- Patients being daily wage earners
- Patients forget date of follow up
- Doctors forget to remind patients about having to come back

10

Improving Adherence

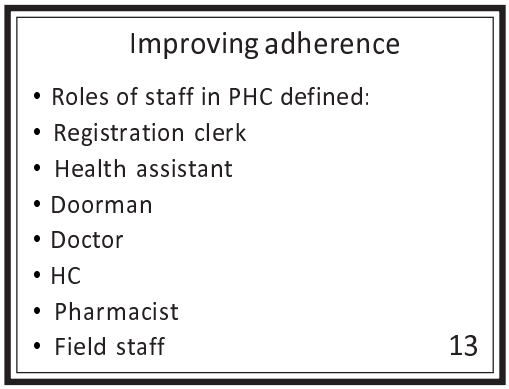
- Patients do not come back when they start to feel better
- Patients do not feel comfortable with psychoeducation procedures and do not think it will be useful
- Have social problems that maintain their problems
- Were not reminded to come back by HC

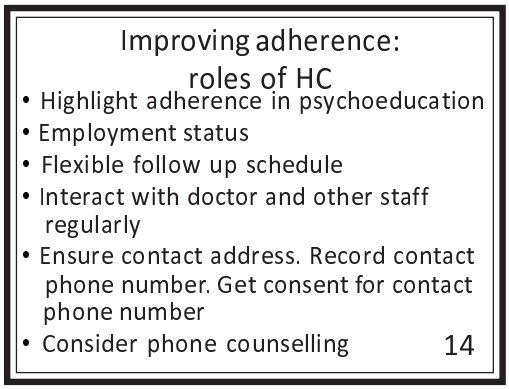
11

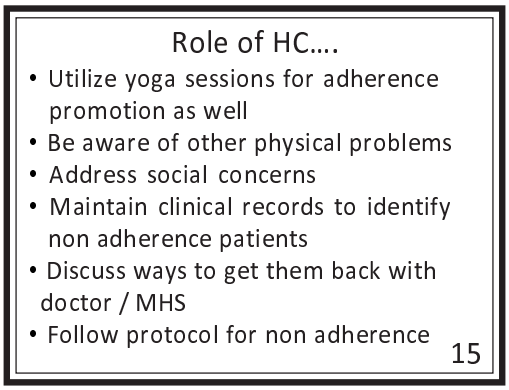
Improving Adherence

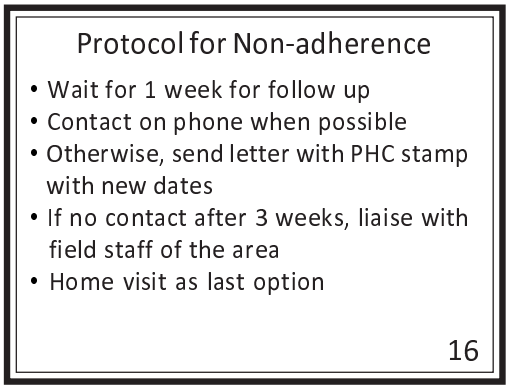
- Revised adherence management guidelines based on mapping of persons involved in care during primary health center visit.
- Improving procedures and physical changes to enhance awareness

12









Written Test: (duration: 15 minutes)
Adherence management-refer Appendix 4

Module 4 : The Delivery of the Collaborative Stepped Care Intervention

A. Integrating Services in Primary Health Care Clinics: Working in Teams

Objectives:

1. To acquire the necessary knowledge about the role of the team members in delivering the intervention in the primary care clinics.
2. To acquire information about necessary tasks to integrate services in primary health care clinics.
3. To acquire information about the challenges of working in a team and the various ways to address them while working in a team.

Duration: approximately 2 hours

Method:

- Lecture using power point slides
- Group discussions

Procedure:

1. **Presentation and lecture:** (duration: 30 minutes)

The lecture will cover the following topics:

- The role of the team members in delivering the intervention.
- Integrating services in primary care clinics.

2. **Group work**: (duration: 60 minutes).

Trainees are divided into small groups. Each group will discuss the following activity (show slide) :

Imagine you are working as a member of a team.

- *What are the key things you need to do to make yourself a part of the team, with the aim of carrying out your work successfully?*
- *Describe the common challenges of working in teams.*
- *How can you prevent, or address common challenges of working in a team?*

3. **Discussion and clarifications:** (duration: 30 minutes).

Each group will make presentations to the entire group followed by discussion and clarifications.

Material related to the lecture can be found in the HC Manual – *The MANAS Model for Health Counsellors* on pages 155- 158 and 164 -168.

Structure and Function of the Primary Health Care Team

The Stepped Care Intervention

- Detection of Common Mental Disorders
- Psychoeducation, IPT, adherence management and yoga (optional)
- Referral to Mental Health Specialist

1

Who is involved

For Stepped Care intervention:

a) Primary Care Doctor

b) Health Counsellor (HC)

c) Mental Health Specialist (MHS)

2

Roles Of The Team Members In Delivering The Intervention

3

Primary Care Doctor

- Head of Primary Care
- Overall leader of the intervention
- Mainly responsible for prescribing antidepressants
- Referral to HC
- Emphasize adherence

4

Health Counsellor

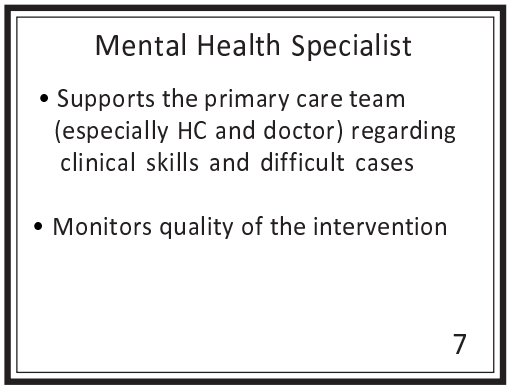
- Detection of probable cases of common mental disorders
- Reports to primary care doctor

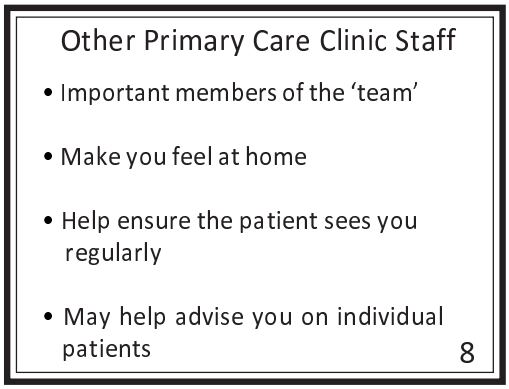
5

Health Counsellor

- All psychological and social treatment
- Adherence
- Managing the overall intervention for each patient
- Reports to primary care doctor and Mental Health Specialist

6


Mental Health Specialist
• Supports the primary care team (especially HC and doctor) regarding clinical skills and difficult cases
• Monitors quality of the intervention
7


Other Primary Care Clinic Staff
• Important members of the 'team'
• Make you feel at home
• Help ensure the patient sees you regularly
• May help advise you on individual patients
8

Integrating Services in Primary Care Clinics

The tasks for integration

Tasks during initial period:

- Introductory meeting with the primary care staff
- Mapping exercise of the clinic
- Observation of clinic process (e.g. registration procedures)
- Ensure adequate privacy for patients at work place
- Set up posters about the program

1

The tasks for integration

Work of integration continues:

- Liaise closely with the primary care doctor
- Meet regularly with other clinic staff
- Meet with field staff
- Help with other tasks in the primary care clinic

2

Group Work

- Imagine you are working as a member of a team.
- What are the key things you need to do to make yourself part of the team, with the aim of carrying out your work successfully?
- Describe the common challenges of working in teams and how you can prevent, or address them?

3

B. Supervision and Documentation

Objective:

1. Understanding how the supervision process will work over the duration of the project including the various components of individual and group supervision.
2. To understand how to complete the various documents for each patient who has been offered the intervention
3. To learn the method of maintaining records - the filing and reporting system

Duration: approximately 3 ½ hours.

Method:

- Lecture using power point slides
- Group discussions

Procedure:

1. **Presentation and lecture:** (duration: 15 minutes).
Didactic lecture on supervision process

2. **Group discussion:** (duration: 90 minutes).
Trainees will be divided into two groups. Group 1 discusses important components of individual supervision including goals, frequency and specific areas that need to be supervised. Group 2 does the same for group supervision (duration: 60 minutes). One person from each group provides feedback to the entire group followed by a summarizing of the key points by the co-facilitator.

3. **Presentation and lecture:** (duration: 5 minutes).
Documentation in MANAS.

4. **Explanation and demonstration:** (duration: 30 minutes)
The entire set of documents that need to be completed for each patient is presented to the trainees. How the various details need to be collected with specific instructions where necessary will be explained and demonstrated to the trainees.

4. **Group exercise:** (duration: 70 minutes)
The trainees will practice completed the various documents in groups of 4/5 and discuss difficulties with the facilitator

Material related to the lecture can be found in the HC Manual – *The MANAS Model for Health Counsellors* on pages 159-163 and Appendix Section 5.3.

Supervision

What is Supervision?

- Guidance by an expert to continuously refresh & improve skills
- Continuation of the learning process
- Provision of feedback on the quality of service provided

1

What is Supervision?

Two components:

- Professional support:
  - a) Administrative
  - b) Teaching
  - c) Evaluation
  - d) Consultant
- Personal support:
  - Mistakes are a presupposition
  - Personal problems, stress, goals, etc

2

Why is supervision important?

- Maintain standards of care
- Discuss difficult cases, minimise risk
- Continuous training/learning opportunity
- Resolve professional/personal issues

3

How was supervision arranged in MANAS?

- Individual supervision in clinics
- Group supervision
  - a) Structured approach with regular scheduled meetings
  - b) In addition, emergency or need based meetings
  - c) Preparation of an agenda

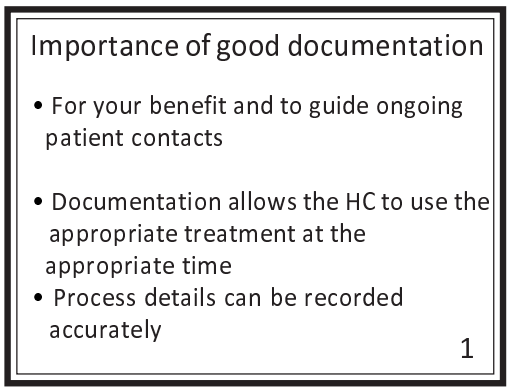
4

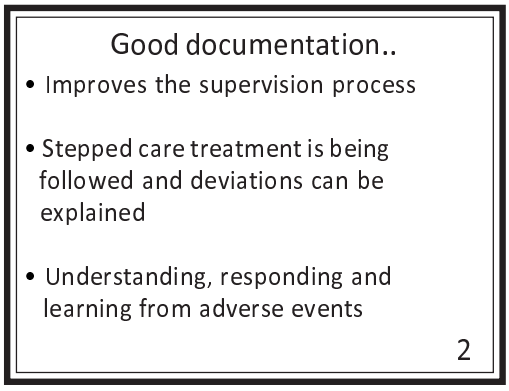
What do you need to do?

- Documentation of intervention given with specific difficulties faced
- List of problem cases
- Record discussions in the patient record

5

Documentation In MANAS





Written test: (duration: 40 minutes)
The delivery of the collaborative stepped care intervention: refer Appendix 4

Appendix

Appendix 1. Feedback Form

Your feedback of the training is important to us. We would like to incorporate your suggestions in the on going training sessions.

Session title: _____

What did you like about this session?

What did you not like in this session*?*

Rate this session on the following parameters (tick in the box below) and provide reasons for your rating:

	Poor	Average	Good	Very Good	Comments
Information					
Clarity					
Methods used					
Practical Applicability					
Time spent					

Additional comments/suggestions: _____

Appendix 2. Planned Assessment of Health Counsellors (HCs)

Objective:

1. To assess the skills, knowledge and competence of the HC in implementing various components of the intervention.

Structure of assessments:

A. Ongoing assessment - oral evaluations: During the training, two observers will rate the HC's on their participation, communication abilities and interpersonal skills using ongoing assessment form.

B. Written tests: Comprises of objective type questions and brief essay type questions. Written test is given to the HC's at the end of each module and also during the final assessment.

C. Practical: The practical assessment is carried out during the final assessment. It is based on simulated clinical scenarios that HC's will experience during their real life work in the clinic. During this assessment HC's are expected to conduct interviews with an actor who will play the role of a patient. The actor is provided a script outlining his /her role during the assessment. The HC's task is to conduct an interview based on a brief note provided to the HC five minutes prior to the start of the test, explaining the outline of the clinical scenario and their expected roles during the time limited exercise of 15 minutes. Two observers will rate the individual HC based on a predetermined marking scheme.

This simulated exercise is an innovative way to assess the skills of HC's which also provides them with a practical learning experience.

Framing of clinical scenarios:

The following steps were undertaken while framing clinical scenarios:

a) The exact nature of the interview's defined (e.g. psycho education, initiation / middle phase / termination of IPT or compliance enhancing interventions) as well as the tasks (or domains) that the HC should complete.

b) The script for the actor explains his/her socio – demographic details/ clinical status,current problems and reason for consultation. The script includes a guide for the actor to follow during the interview.

c) Assessment sheets are made using the various domains and listing out a marking system.

Plan of assessment:

- Prior to conducting the assessment, the team of trainers need to meet to standardize the testing procedure, clarify any doubts about the marking scheme and set appropriate benchmarks.

- Six stations / scenarios are provided :
  - Two stations - psychoeducation,
  - Two stations - IPT stages,
  - One station - assess and manage suicidal risk , use of antidepressant
  - One station - challenges faced while working with teams and their solutions.

The adherence management and knowledge of the stepped care protocol is built into each of the stations as cross cutting themes.

Appendix 3. Ongoing Assessment Form

No	Attributes	Trainee 1	Trainee 2	Trainee 3
1	Punctuality			
2	Overall participation*			
3	Verbal communication ability			
4	Flexible thinking			
5	Leadership ability			
6	Team integration			
7	Creativity / Innovation			

Grade: 1 = below average; 2 = average; 3= above average

Note: *The first four are essential attributes while the last three are desirable.*

** Here one needs to assess how the participant is willing to participate, take part in discussions actively, asks questions, etc.*

Appendix 4. Written Test - 1

Module 1: Stress and Common Mental Disorders

Duration **:** 40 minutes.
Marks : 50

A. There are 20 statements given below. Each correct answer carries 1 mark.
Please tick (✓) the box that you think is appropriate (20 marks)

1. Long – term physical illness can cause stress
   - ☐ True
   - ☐ False
2. The same stress causes the same reaction in everyone
   - ☐ True
   - ☐ False
3. There are some common physical changes that all of us experience with acute stress.
   - ☐ True
   - ☐ False
4. Stress can improve recovery from heart disease.
   - ☐ True
   - ☐ False
5. Social networking can help us deal with stress.
   - ☐ True
   - ☐ False
6. Protective factors can increase resilience.
   - ☐ True
   - ☐ False
7. Living in a safe and supportive community increases the chance of developing stress related problems.
   - ☐ True
   - ☐ False
8. Persons from lower socio-economic sections are more likely to develop depression.
   - ☐ True
   - ☐ False
9. Alcohol and tobacco use decreases the risk of depression.
   - ☐ True
   - ☐ False

10. Domestic violence increases the chances of mental health problems.
    - ☐ True
    - ☐ False
11. Men are more likely to develop depression
    - ☐ True
    - ☐ False
12. Depression and anxiety are both present together most of the time.
    - ☐ True
    - ☐ False
13. Any sadness is the same as depression
    - ☐ True
    - ☐ False
14. Most patients with depression present to doctors with unexplained physical symptoms.
    - ☐ True
    - ☐ False
15. When depressed, a person feels more confident and can concentrate better.
    - ☐ True
    - ☐ False
16. Panic attacks can sometimes be mistaken for a heart attack.
    - ☐ True
    - ☐ False
17. In phobias, patients try to avoid situations where they feel anxious.
    - ☐ True
    - ☐ False
18. Depression makes a person feel more energetic.
    - ☐ True
    - ☐ False
19. Some people can sleep more than usual when they are depressed.
    - ☐ True
    - ☐ False
20. Most patients with depression are correctly diagnosed by doctors in primary care.
    - ☐ True
    - ☐ False

B. Answer briefly. Five marks for each correct answer (30 marks)

1. What do you understand by the term Depression? How is it different from sadness?
2. Why is it important to recognise common mental disorders in the primary health care settings?
3. How will someone with common mental disorders present in the primary health care setting ?
4. What is the acute stress reaction?
5. Why does lower socio-economic status increase the chances of having common mental disorders?
6. Explain the relationship between stress and common mental disorders.

Appendix 4. Written Tests -2

Module 2: The Structure and Essential Building Blocks of the Program

Duration : 40 minutes.
Marks : 50

A. Answer the questions below following the stepped-care approach. One mark for each correct answer. (6 marks)

1. A 35 year old woman has a score of 7 on the GHQ at her first visit. What will you do?

2. On her second visit, she says she is feeling worse (GHQ 10) and reports suicidal ideas. What will you do?

3. A 60 year old man has a GHQ score of 8. His wife says that he is forgetful, loses his way when he goes outdoors alone and has had one episode of loss of consciousness. What will you do?

4. A 45 year old lady has an initial GHQ score of 8. She is not better ever after sessions 2 of psychoeducation. What will you do?

5. If the same lady is better after one session of psychoeducation, what will you do?

6. A 25 year old lady is unreasonably suspicious about her in-laws and hears imaginary voices. What will you do?

B. Circle the appropriate answer below. One mark for each correct answer. (20 marks)

1. Counselling involves giving a person advice and telling him how to solve his problem
   True/False

2. As a counsellor one should not separate between your own thoughts, feelings or problems and those of the patient.
   True/False

3. "I feel so bad for you, you have to work so hard" is a good example of empathy.
   True/False

4. One good way of empathizing is to share your own personal experience that you feel is similar to the counselee's experience.
   True/False

5. A past tense reflection is more powerful than a present tense reflection of feelings
   True/False

6. After identifying a feeling you can always clarify with the patient if you are correct
   True/False

7. Counseling includes:
a) Making decisions on behalf of the patient
   True/False
b) Explaining to the patient on what you believe is the right way
   True/False

8. Most patients with depression are correctly diagnosed by doctors in primary care
   True/False

9. On the GHQ, a lower score indicates worse mental health
   True/False

10. Deliberate self harm is more common in young men
    True/False

11. Demographic factors are the least specific in predicting the risk of suicide
    True/False

12. Social isolation can increase the risk of suicide
    True/False

13. Use of alcohol decreases the risk of suicide
    True/False

14. Hopelessness is the most specific risk factor for suicide
    True/False

15. Contacting the clinical specialist is not necessary when treating someone with a high risk of attempting suicide
    True/False

16. The GHQ is useful in monitoring the progress of treatment for depression
    True/False

17. A score of nine on the GHQ indicates that the person has a high chance of being depressed
True/False

18. Asking for suicidal ideas increases the possibility of the patient attempting suicide.
True/False

19. Protective factors refer to those reasons that minimize the risk of suicide.
True/False

20. Understanding of the risk and protective factors enables one to judge the seriousness and immediacy of the suicidal risk
True/False

C. Answer briefly. Two marks for each correct answer. (24 marks)

1. Enumerate the various treatment of the stepped care intervention

2. Name the persons in the team responsible for providing intervention at the primary care.

3. Why should we use acceptable labels or words for mental health problems?

4. Name 4 attributes of an effective counsellor.

5. Sheela says: " I am very upset with my boss"
   a)Give an example of a closed ended question you can ask her.
   b) Give an example of an open ended question you can ask her.

6. " I have to leave my job. My husband feels I am not able to look after the children."
   a) How will you paraphrase and reflect this person's feelings?

7. What is the attending behaviour that you need to consciously use during counselling?

8. Mention two kinds of questions can be a problem during couselling.

9. Give two reasons why self awareness is important to a counsellor.

10. What are the 4 most important things you can do as a HC to manage suicida risk?

11. List the uses of the GHQ 12 in the MANAS program.

12. How will you find out whether a person is at a risk of committing suicide?

Appendix 4. Written Tests - 3

Module 3: Treatment for Common Mental Disorders

A. Psychoeducation

Duration: 40 minutes.

Marks: 50

I . Fill in the blanks by choosing the most appropriate word from within the brackets. One mark for each correct answer. (10 marks)

1. Psycho education is a process by which the patient is given an explanation about her illness and provided practical _____ to deal with her problems (solutions/ advice / medications)

2. In the first session need to to be taken consent from the patient for _____ (the second visit / a home visit)

3. It is necessary to explain the link between the mind and the body the patient _____
(True/False)

4. If the patient has been prescribed medication you have to tell her or him that they must be taken for at least ____months to ensure complete recovery (three/four/six)

5. The first step of Psycho education 2 is_____ (planning further interventions with the patient/ getting a detailed history of symptoms/ reviewing the clinical status of the patient)

6. It is not necessary to ask about self harm at all after the first session (True/False)

7. If the patient has been prescribed antidepressants you need to tell the patient that the medicines are ____(addictive /not addictive)

8. For advice on sleep the patient is told to drink a glass of tea or coffee before bed time_____ (True/False)

9. While explaining the diagnoses to the patient needs to know that “his /her stress related illness is very _____ (rare/common)

10. Early warning signs are the changes in a person's inner experience and behaviour that signal the onset of a relapse _____(True/ False)

II. Answer briefly .Four marks for each correct answer. (40 marks)

1. Four questions that need to be asked to get a complete history of symptoms.

2. While reassuring the patient in psycho education 1, after you acknowledge that some of their symptoms may make it difficult for them to handle their every day activities, what would you say next?

3. What would you do in the following situations?
    a. When patients attribute their problems to black magic
    b. When patients attribute their problems to physical illness – menopause.

4. If antidepressants are prescribed what should the health counsellor do in the first psycho education session?

5. Mention four specific advices that you would give to a patient suffering from fatigue?

6. How will you explain the diagnosis to the patient?

7. What action would you take if the person is at moderate suicidal risk?

8. Mention four points that you would emphases while concluding the first psychoeducation session.

9. Under what circumstances would you say that the end point of the treatment is reached?

10. What are the steps to follow while referring the patient to a community agency?

B. Antidepressants and other medication-related issues

Duration: 15 minutes.

Marks: 15

I. Please indicate whether the statements below are True or False: One marks for each correct answer. (5 marks)

1. The course of treatment with antidepressants should be of 6 weeks duration to achieve maximum benefit.
2. The majority of patients taking antidepressants tend to present with thier side effects.
3. Symptomatic treatments for depression are never effective.
4. Symptomatic treatment for depression is more expensive than treatment with antidepressants.
5. Discontinuation of treatment is the single biggest barrier to recovery.

II. Answer briefly. 5 marks for each correct answer. (10 marks)

1. What is the advice that you will give to a patient before starting antidepressants?
2. What would you do if the patient demands medicines like injections or vitamins?

C. Interpersonal Psychotherapy

Duration: 40 minutes.

Marks: 50

I. One mark for each correct answer. Circle the appropriate answer. (10 marks)

1. In IPT, the therapist assumes a passive role
   True/False
2. In decision analysis, it is better for you to choose which option the patient should implement
   True/False
3. Termination of IPT should always begin in the 8th session.
   True/False

4. Communication analysis should explore the most recent argument
True/False

5. The therapist allows the patient to choose the person he/she want to begin the IP inventory with.
True/False

6. IP inventory should include no more than 4 people
True/False

7. It is not necessary to carry out a symptom check and mood rating in every session.
True/False

8. In the IP inventory, it is necessary to include significant people who have died.
True/False

9. A patient can never have more than 2 problem areas.
True/False

10. For effective communication, statements that begin with "you" are preferable to those that begin with "I".
True/False

II. **Answer Briefly. Five marks for each correct answer.** (40 marks)

1. Name the four problem areas in IPT .Describe each one in a sentence.

2. Describe the Therapist's role in IPT

3. What are the three phases in IPT? Describe the tasks in the first session.

4. How do you create an interpersonal formulation?

5. Describe the strategies used in the middle phase of IPT for a patient who has been recently bereaved.

6. Describe two techniques used in IPT to solve interpersonal disputes.

7. a) Who would require IPT?
   b) What must you do if the patient is reluctant?

8. How will you benefit from conducting an interpersonal inventory?

D. Adherence Management

Duration: 15 minutes.

Marks: 15

A. Please indicate whether the statements below are True or False. One mark for each correct answer. (5 marks)

1. Addressing the social problems associated with depression does not improve adherence
2. Having information about the program in the form of attractive posters improves adherence
3. Telephone counselling is not recommended for patients who miss appointments
4. A positive therapeutic relationship is possibly the single most important factor that predicts long term adherence.
5. Adherence is important to ensure full recovery.

B. Answer Briefly. Five marks for each correct answer. (10 marks)

1. Describe the five most importanr risk factors for non adhereence in the MANAS program
2. Describe five important activities that you should be doing to improve adherence in the primary health center.

Appendix 4 Written Tests - 4

Module 4: The Delivery of the Collaborative
Stepped Care Intervention

Duration: 40 minutes.

Marks: 50

A. Please indicate whether the statements below are True or False: One mark for each correct answer (10 marks)

1. The doctor's role is to monitor each patient till recovery.

2. The mental health specialist's role is to provide overall assurance in maintaining quality of standard and safe practices.

3. You should not be taking any active role in supervision during the program

4. The only person who will you be supervising you in the clinic will be the intervention facilitator.

5. Documentation helps make supervision effective.

6. Clinical records are a very useful way of monitoring the overall quality of any health program.

7. Identifying any personal problem related to work that is affecting the health counsellor's wellbeing is not the function of supervisor.
8. Team members should focus on ways to improve the quality of the program.
9. Supervisor should encourage the patient to meet the HC.
10. Documentation helps to evaluate the program goals.

B. Answer briefly .Five marks for each correct answer. (40 marks)

1. What are the features of a good team?

2. State five responsibilities of the Health counsellor.

3. State five responsibilities of the Mental Health Specialist.

4. What are the most important reasons for supervision?

5. List the tasks that you must complete at the end of each day, having finished seeing your patients.

6. What will you need to do to make the supervision most useful?

7. Why is documentation important?

8. Describe the steps involved in referring a patient with drinking problems to an agency for help.

Appendix 5: Final Assessment: Written

Duration: 30 minutes.

Marks: 50

You have been given 5 different clinical scenarios to read carefully. Each scenario has 5 questions that you must answer briefly in points. Please be very specific in your answers. 10 marks for each correct answer.

1. Shiva is a 30 year old man who, since his father died 3 months ago, has developed depression. He is screened and found to have moderate- severe CMD.The doctor sees him and sends him to you.

A) What will you do on the first visit?

B) When he returns for a follow-up a week later, he says he feels worse. What is the next step?

C) He fails to come for his next appointment despite a phone call. What will you do?

D) When he finally comes to see you he says that he cannot keep regular appointments as his work timings are unpredictable. He works day /night shifts as a watchman. What will you do?

E) He responds to treatment and is symptom free for 2 consecutive visits. What will you do?

2. Janet, a 60 year old lady comes to you feeling anxious, experiencing palpitations, sweating and tremors. This interferes with her sleep.

A) What specific advice will you give her?

B) She returns after a week feeling better. What will you do?

C) She does not keep her next appointment and does not respond to a letter you send. What will you do?

D) When she comes back, she says her symptoms have worsened as her son is unable to find a job despite many attempts and this is causing her financial stress. What will you do?

E) She reports suicidal ideas and has begun to give away her personal possessions. What will you do?

3. Radha, a 33 year old lady presents with moderate depression. The doctor has prescribed antidepressants for her.

A) What specific advice will you give her?

B) On follow up 2 weeks later, she reports side-effects like nausea, bloating of the stomach and tremors. What will you tell her?

C) The side-effects persist and are troublesome after a month of treatment. What will you do?

D) She refuses IPT when offered to her. What will you do?

E) She does not come for her next appointment despite a visit by the PHC staff. What will you do?

4: Michael is a 40 year married man who has suffered a recent loss in his business and has a large debt which he is having difficulty in repaying. He has become anxious and sad and is also not sleeping or eating well. He comes to the PHC for 'heart problems' and has been screened to have mild depression.

A) What will be the specific psychoeducation advice you will give him?

B) He comes back after a week and says he is feeling better. What will you do in this meeting?

C) However, he is back next week saying that he is feeling very anxious as the bank has sent him a letter warning him that his payments are overdue. What will you do now?

D) After 4 weeks he continues to feel tense and has now says that he has bought a large amount of medicines. What will you do now?

E) Michael fails to attend his scheduled appointment after1 week. What will you do now?

5. Sarita is a 35 year old female who has been feeling very irritable and has been having regular quarrels with her husband and mother-in-law about her husband's regular drinking. She is also having multiple aches and pains and sometimes feels anxious and breathless. She is screened as having moderate-severe depression and the doctor has asked her to meet you. He has not prescribed antidepressants for Sarita and has asked her to speak to you.

A) What will you do in this session?

B) She does not attend her scheduled follow up appointment in 2 weeks. What will you do?

C) She attends the PHC after 4 weeks and wants to speak to you. What will you do?

D) Sarita wants some help with her husband's drinking. What will you do to help her?

E) She has been coming regularly and has completed 6 sessions of IPT. She is much better and asks you how long does she have to come back for treatment. What will you tell her?

Appendix 5: Final Assessment - Practical

Station 1

John is a 45 year old man who has 3 children. He used to work in a factory and recently met with an accident that has caused slight damage to his spinal cord.He has to wear a belt and the doctor has told him there is nothing to worry about. However, he does not believe his doctor entirely and is very worried that he has a major problem with his back and will lose his job eventually. He is the only earning member in his family

Hir presenting symptoms are poor sleep, panic attacks, loss of appetite, lack of concentration and irritability.

He says he always to worries about his family and the fact that they all depend on him completely. He often wondered what would happen to his family if his conditions worsened. He used to share this with his wife and she would get angry. His accident has now made her very anxious too. She gets very scared when he gets these panic attacks and is worried that he might be having a heart problem. She accompanied him to the PHC and the doctor once again told him that he is 'simply getting worried' and has asked him to meet the Health Counsellor.

The man has been diagnosed to have CMD, and been prescribed medicines for it (pain killers).He has been asked to meet the new person in the clinic i.e. HC, to talk about his problem.

Task 1: HC should be able to demonstrate necessary skills to engage the patient and complete the seven steps of psycho education.

Task 2: HC should specifically demonstrate and teach him breathing exercises.

Station1: Marking sheet

Sr. No.	Domain	Grade achieved	Comments
1)	**Engagement**: Greeting patient, eye contact, Smile, Introducing self.	10	
2)	**Psycho education -1 : Steps** 1. Eliciting symptoms and inquiry for suicidal ideas 2. Reassurance and explanation about link between patient's stress and complaints 3. Explaining the diagnosis 4. Describing the interventions 5. Advice on specific symptoms 6. Referral to community agencies 7. Concluding the session	 10 10 5 5 25 5 5	
3)	**Counselling Skills:** Empathy Body language Questioning style Clarifying Reflecting Feelings Paraphrasing	25	

Overall Rating: Total 100 Grade_____

Station 2

Mrs. G is a 30 year old married, working woman with one girl child aged 6yrs, living in an extended family in rural Goa. She presents with a 3 month history of depression characterized by poor sleep, lack of appetite, worry, poor concentration and depressed mood with loss of energy and interest in usually pleasurable activities. These problems have caused her much distress and disability in her interpersonal and working roles as the home maker prompting her to seek help at the local Primary Health Centre. The above problems are of a sudden onset with clear precipitating problems since her husband has started coming home late , neglecting his family. Mrs. G's problems are being maintained by her husband's financial difficulties in the form of loans and debts; when she questions her husband, she is always told that she needs to take loans to help him with his debts. She usually copes with the stress by talking to her mother and some office colleagues about her problems but feels shy to discuss her current concerns as she feels it's a family matter and stigmatizing. She has had thoughts about ending her life but has no plans or intent to do so.She feels that she has to live only because of her daughter as her husband does not show any concern for her and is only wants her salary. She feels her problems are due to her physical health and says that 'all women go through this'.

This lady had been screened positive for CMD, has been seen by the Health Counsellor two weeks ago when she was psycho education-1 which included breathing exercises. On her second visit, she reports feeling the same way and has seen the doctor who asks her to see the HC again. She has briefly told the HC about her problems in the first session. She has tried to follow the advice given to her by the HC.She found the breathing exercises helpful but is still feeling sick. She is not keen on taking medicines and would prefer to discuss her problems and solve them.

Tasks for the HC:

HC should be able to demonstrate necessary skills to engage the patient and complete the 3 steps of psycho education- II :

- **Review the clinical status**
- **Reinforce information provided in session 1**
- **Plan further intervention – introduce IPT**
- **End the session**

Station 2: Marking sheet

Sr. No.	Domain	Grade achieved	Comments
1)	**Engagement**: Greeting patient, eye contact, Smile, Introducing self.	10	
2)	**Psycho education -2 : Steps** 1.Review of clinical status 2. Reinforcing information of session 1 3. Introducing IPT 4. End the session	 15 20 20 10	
3)	**Counseling Skills:** Empathy Body language Questioning style Clarifying Reflecting Feelings Paraphrasing	25	

Overall Rating: Total 100 Grade _____

Station 3

Shanta is a 45 year old married lady who presented with tiredness and inability to carry out her household responsibilities she has loss of interest in doing things she would earlier enjoy such as watching television and chatting with her neighbours. She also complains of disturbed sleep and reduced appetite. These symptoms have been present for the last two months and recently she also has thoughts about wishing that she did not have to go on. However she denies active suicidal ideation or plans.

On further probing, you have learnt that Shanta's husband had a vehicular accident 6 months ago following which he has been unwell, having to visit the doctor frequently. This has led to his absenteeism from work ,loss in daily wages and subsequent financial difficulties. She worries about his health and wonders what she would do if he failed to recover. She feels inadequate and believes she is not doing enough to help him.

This patient Shanta has not improved despite 2 psychoeducation sessions and has been practicing the advice given at home.

Tasks for HC :

Part 1:
- Introduce IPT
- Do a symptom checklist
- Rate her mood
- Give her the sick role

Part 2

The patient fails to come for a follow up session and you have decided to make a phone call. What will you say to her when you make the call?

Part 3

The patient has attended 4 IPT sessions and has not improved. What will you do when she comes and sees you in the 5th session?

Station 3: Marking Sheet

Sr. No	Domain	Expected tasks	Grade achieved	Comments
1)	**Engagement**:	Greeting patient, Eye contact, Smile, Introducing Self.	10	
	Content Part 1 • Introduction of IPT • Review of symptoms • Assessing current symptoms including suicidal ideas. • Mood rating • Assigning the sick role	• Giving the patient hope. • Emphasizing the medical model and that it is not the patient's fault.	50	
	Content Part 2 Adherence Management	Inquiry about patient's health, reason for missed appointment. flexibility in arranging next appointment.	30	
	Content Part 3 Planning Stepped Care Intervention	• Making a plan • Conveying this to the patient	10	

Overall Rating: Total 100 Grade_____

Station 4

Seema is a 50 year old home maker who reports a three week history of bodyache, tiredness and palpitations. She is more tearful than usual and avoids company, preferring solitude. She has difficulty falling asleep at night and wakes up feeling unrefreshed. This has led to her neglecting household tasks and she feels guilty about this.

Seema has 2 children. The older, a daughter aged 22 years, works as a secretary in an office. Seema disapproves of her working late, going out at night for parties and speaking to men friends. They have frequent quarrels about this and her daughter accuses her of being old-fashioned and suspicious.

You have done the interpersonal inventory where Seema speaks about her relationship with her daughter. You think this is the source of her stress.

Tasks :

Part 1:
- Present the formulation to the patient
- Do a decision analysis - to explore how she can communicate her disapproval to her daughter

Part 2 : The patient is better at the end of 6 sessions - almost symptom-free. What will you do? How will you convey your plan to the patient?

Part 3: What are the various documents you will fill at the end of the session?

Station 4: Marking Sheet

Sr. No	Domain	Expected tasks	Grade achieved	Comments
Part 1	• Formulation • Decision analysis	• Identifying problem area correctly • Seeking patient's agreement • Guiding patient in making and choosing options	10 10 20	
Part 2	• Decision re-termination • Conveying this to patient • Summarising work done • Detecting early warning signs • Use of skills acquired in future situations	• Making a treatment decision • Ability to address the patient's concerns • Covering steps in termination	10 10 20	
Part 3	• Documentation	• Patient intervention ` card • Post session note • Detailed case notes	20	

Overall Rating: Total 100 Grade_____

Station 5:

Sawant is a 40 year old, married man who lives in a house close to the primary health center HC with his wife and two children. He has been coming to the clinic for some time now for 'heart' and 'stomach' problems. He has told the doctor that he sometimes has chest pain and breathlessness like a heart attack. These happen 2-3 times every week and he has become very afraid of going to his work as a driver as he is worried he will have a heart attack and die without getting medical attention.

Sawant has also been having stomach problems in the last three months and cannot eat properly as he has nausea and pain in the stomach. He has had several investigations at various hospitals but no problem has been found. In the last three months he has stopped going to work, does not mix with his friends and is also having sleep problems. The doctor has prescribed him Alprazolam and some vitamin injections.

He came to the clinic and was screened by the HA and found to have CMD. He met the doctor who advised him to start Fluoxetine and has told him about the HC who will talk to him about his problems'. He comes in to meet you with a thick bundle of previous prescriptions and the patient card.

Your Tasks are:

1. Brief review of symptoms and assessment of suicidal risk within 5 minutes.
2. Explaining about fluoxetine.
3. Deal with any other important issue briefly.

Station 5: Marking Sheet

Sr. No	Domain	Expected Tasks	Grade Achieved	Comments
1	Engagement	Greeting patient, Eye contact, Smile, Introducing self and Purpose of interview.	10	
2	• Review of symptoms to generate symptoms of CMD - panic disorder and alcohol abuse • Assessing current problems (no work, financial worries, stress at home) including suicidal ideas. • Explaining the stress related nature of the problem		20 20 20	
3	Introducing Antidepressant Treatment	• What is the reason for starting this capsule • side effects and their management, especially nausea and headaches.• lag period before getting better • need to continue for 6 months • best not to use with alcohol; otherwise safe• need to come back in 2 weeks	10	
4	Other Tasks	• feedback re: alcohol and ways to control / stop using it • Organizing medical certificate • Feedback re: sleep problems • Documentation	20	

Overall Rating: Total 100 Grade_____

Station 6

You are working in the Primary Health Centre (PHC) and have noticed that the doctor in the clinic is not very cooperative. You have noticed while filling in your weekly statistics that he has not been referring all the patients screened as having CMD to you. On a couple of occasions, you have tried to raise the matter of not referring patients to you but each time he has brushed it off saying that he was 'too busy to talk' and that 'anyway, there is nothing to talk about'.

You are now feeling concerned about this problem and want to resolve it as this is affecting the program in the PHC.

Tasks:

1. Please describe the problem as you understand it and why you think it is affecting the program negatively.
2. Please discuss what you think are possible reasons for the doctor to act like this.
3. Please explain the way in which you want to solve the problem.

Station 6: Marking Sheet

Sr. No	Domain	Expected tasks	Grade achieved	Comments
1	Framing the problem	Ability to describe the problem and identify how it is affecting the program: • this will include non referral • the value the doctor attaches to the work of the HC • doctor not willing to talk about the problem	20	
2	Discussing possible reasons for the doctor's actions	• Personality of the doctor. • Power equations and not being valued as useful • Not trained in MANAS • Having personal problems with stress and at work	40	
3	Logical framework of problem solving	• Discussion with supervisor, Mental Health Specialist (MHS) and superior • Discussion with MHSin weekly supervision meeting and drawing up of strategy • Joint meetings and MHS personally having discussions with doctor • Managing personal sense of self esteem	20	
4	Overall impressions	• Confidence • Communication skills	20	

Overall Rating: Total 100 Grade_____