

Mental Health and Psychosocial Support in Emergency Operations

For Facilitators of Lady Health Workers



Mental Health For All



Mental Health Module for Psychosocial Care Givers

Preface

The Ministry of Health gives priority to the psychosocial services involved in the earthquake affected areas

Form the very start I have taken a direct interest in the provision of mental health services in the affected areas

Under the umbrella of the Ministry the Personnel of mental health teams have given a good service to the needy which has to be enhanced.

Now I am pleased that the training manuals for different categories of health personnel have been finalized. This is a major achievement in terms of ensuring uniformity & standardization of training practices.

I am hope that these training manuals will be utilized effectively & will contribute to proper training of health professionals.

This in turn will ensure proper and consistent psychosocial support.

M. Naseer Khan
Federal Minister of Health

Dated: 11/03/2006

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Message

On Saturday, October 8, 2005, a massive earthquake of 7.6 on the Richter scale struck Azad Jammu and Kashmir and parts of the North Western Province of Pakistan. Estimates are of over 75,000 dead and more than 100,000 severely injured and are in excess of 4 million people affected by the earthquake in one way or the other. This has been one of the biggest disasters in Pakistan for over 100 years. It is estimated that 120,000-160,000 persons will be in need of treatment for severe mental disorders. Between 600,000 and 800,000 persons are expected to suffer from mild and moderate mental illness. In addition 30-50% of the population is in need of psychosocial support.

The Ministry of Health and WHO feel that it is imperative that the mental health and psychosocial needs of the population be fulfilled to help the people recover from this traumatic event, so that they can play a constructive role in the recovery and rehabilitation of their physical and social infrastructures.

This goal needs multipronged efforts involving cooperation not only between all the partners involved in the health sector but also across other sectors like education and social welfare in order to ensure that health services are provided in a holistic and integrated manner. Capacity building is an essential component of ensuring that we achieve this objective.

I am pleased to see that Ministry of Health, with active collaboration of WHO has developed the training materials for different cadres of Health personnel.

I sincerely hope that this would be the first step towards realization of the goal of providing mental health and psychosocial care in an integrated manner within the Primary care services.

Dr. Khalif Bile Mohammad
WR Paksitan

Mental Health Module for Psychosocial Care Givers

Programme

Module

1. Introduction
2. Normal Stress Response
3. Differentiation between stress and Distress
4. Differentiation between Distress and Disorder
5. Grief and Bereavement

Module

6. Individual Interventions
(Relaxation, problem solving, .Grief counseling and non-pharmacological interventions for Pain and sleep disturbances)

Module

7. Identification, and referral
of Common Mental disorders
(Post Traumatic stress disorder, Anxiety disorders, Depressive Illness, Psychosis, Substance Use disorders And Epilepsy)

Module

8. Care of Special Groups
(Children, Adolescents, Women , old people, Amputees and Relief workers)

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Introduction and Rationale

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On Saturday, October 8, 2005, a massive earthquake of 7.6 on the Richter scale struck Azad Jammu and Kashmir and parts of the North Western Province of Pakistan. So far, estimates are of over 75,000 dead and more than 100,000 severely injured. There are in excess of 4 million people affected by the earthquake in one way or the other. In addition to the physical distress the population has experienced severe psychological distress, because of loss of loved ones, loss of homes, valued possessions, having to survive in difficult conditions, having to look after injured family members, loss of livelihood, interrupted schooling and uncertainty about the future. As a result of disaster, the population rates of disorders are expected to go up by 5-10% from the pre earth quake rates of 10-12 % for mental disorders. Extrapolating from these to the Pakistan earthquake situation means 120,000-160,000 persons will be in need of treatment for severe mental disorders. Between 600,000 and 800,000 persons are expected to suffer from mild and moderate mental illness.

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Target Population:

This module is intended to train the following groups for helping earthquake affected population.

- Lady health workers.

Training Aims:

On completing the programme Trainees will:

- Have knowledge of Stress responses to earthquake and the process of grief following the human and material losses sustained by the survivors.
- Be familiar with the differentiating between distress and mental disorders.
- Be able to provide basic psychosocial support.
- Be able to identify common mental disorders seen amongst the survivors.
- Be able to identify those people who require referral for specialist assistance.
- Be able to educate the community about mental health and psychosocial issues commonly encountered by the surviving community members.

Normal Stress Response

Session Aims:

- Enable to understand the normal stress response following any traumatic event like disasters e.g. an earthquake.
- Help familiarize with the symptoms of the response.

Methods:

Facilitator explains concept of stress

- Facilitator encourages discussion by asking the participants to tell about their own personal experience of being in a stressful situation. Ask him/her to enumerate the signs/symptoms of stress.
- Invite the rest of the participants to fill any gaps left.
- Note all the signs/symptoms enumerated and add from the list, the missing ones.

Discussion by the whole group to ensure that all the participants understand the concept and symptomatology.

Normal Stress Response

At the time of earthquake anyone can experience stress. This Response of survivors is automatic and occurs as a reflex on involuntary basis.

Understanding Normal Stress Responses

Fight or Flight Response

Humans have a natural stress response. The stress response is called “fight or flight”.

1. A threat or potential threat is perceived
 - There is some perception of a threat to safety or potential threat. For example:
 - Driving in traffic
 - Conflict at work or home
 - Exam or test
 - Job interview
2. Body responds by mobilizing energy and resources so we can respond quickly.
 - Hearts beats faster and stronger
 - Breathing is fast and shallow
 - Feeling of tension in the arms and legs
 - Dryness of mouth and heightened Perceptions
3. Threat is dealt with or avoided (coping)
 - Once we have this “emergency” boost, we can deal with the threat. We might fight the threat or we might run away (flight) or we might find some other way to cope.
4. Body returns to relaxed condition
 - Once the threat has been removed, the body returns to its relaxed condition.

❖ **In a disaster, steps 3 and 4 may not occur!** Aftershocks and difficult conditions of living are resulting in a situation of sustained threat perception and fear, leading to Distress

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Differentiation between Stress and Distress

Session Aims:

Understanding the difference between a normal stress response and Distress

Methods:

- Facilitator discusses the differences between normal stress responses and Distress.
- Its is important for facilitator to emphasize that;
Distress does not mean that a person is mentally ill.
- Encourage one or two participants to share with the group narratives of survivors they might have seen /met highlighting the Difference between normal stress responses and distress being experienced by the Survivors

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Differentiation between Stress and Distress

If the body responses do not returns back to the usual level of functioning it can lead onto distress. This could manifest itself as experiencing for prolonged period of time as well as with increased intensity symptoms of normal stress response. This can also result in the following responses

Physical	Psychological	Social
Headaches, Muscular Pains/aches, Tremors of Hands	Impaired Concentration	Social with drawl
Palpitation	Forgetfulness	Inability to perform day to day tasks
Cold sweating	Irritability	Increased Conflict with family or community members
Tiredness	Worrying, Sadness or Crying and Loss of pleasure from regular activities	Inability/difficulty in going back to Work , school etc
Sleep disturbance	Fearfulness	Misuse of Medicines or substances of abuse
Decreased appetite	Anger	
Gastro Intestinal Problems	Guilt/Survivor Shame	Lack of interest in social life
Persistent pain without any apparent cause or in excess of what is warranted by the injury	Recurrent thoughts/memories about the disaster	

As a result ability to cope and general functioning is greatly compromised. Those who participate in rescue work are also at risk of this response. However, those who experience the disaster first hand and suffer losses directly are more likely to experience such Distress. The most common response however is **resiliency**. In most of the people having some of the reactions listed above these will diminish in intensity over time without of the need for professional help, but if they persist, professional help will be needed. **TIME** is a great healer. Support from family and friends are critical.

If person has impaired concentration, fatigue, irritability, crying, worrying, on several days for more than two weeks, this is a disorder not just distress! It is distress if you have only one or two of the above symptoms but if you have four or more of above symptoms then its disorder.

Differentiating Between Distress and Disorders

Facilitator's Note:

- Help understand the concept of Distress versus disorder.

Method:

- Ask the participants if any of them has seen a survivor whom He/She thought was suffering from a mental Disorder.
- Ask him/Her what were the disturbances in Behaviour/Talk which made him/her think of mental disorder.
- Introduce the features which are likely to indicate mental disorder which needs to be treated.

Differentiating Between Distress and Disorders

Warning Signs of Possible Mental Disorder

- Continuous distress without periods of relative calm or rest
- Impaired functioning; sad mood, crying spells.
- Four or more of the above distress symptoms for more than two weeks
- Severe depression; lack of pleasure in life, feelings of worthlessness, self-blame, dependency, sleep disruptions and suicidal ideations or attempts
- Person is not able to stop thinking about what happened, intense intrusive memories, thoughts and images that are fearfully avoided, deeply upsetting or interfere with sleep; nightmares about disasters.
- Disabling anxiety :persistent worry, paralyzing nervousness, fear of losing control/going crazy
- Severe hyper-arousal :Inability to relax, inability to sleep, panic episodes, terrifying nightmares, difficulty controlling violent impulses, rage, inability to concentrate
- Severe dissociation ;feeling as if the world is unreal, not feeling connected to one's own body, losing one's sense of identity or taking on a new identity, amnesia, feeling numb
- Excessive smoking , use of tranquilizers or drugs
- Problematic substance use: abuse or dependency, self-medication
- Unresponsive and /or disoriented, always seen in deep thinking.
- Extreme social withdrawal; always avoiding other people, doesn't want contact
- Psychotic symptoms: bizarre thoughts or images BUT be careful in your judgment.
- Suicidal action, plans, and thoughts

Individuals showing the above mentioned signs will require evaluation and treatment by a mental health professional (Psychiatrist or clinical psychologist). It is important to learn to identify the common signs and symptoms of mental disorders so that they can be referred to specialist Teams available in the area.

THE DIFFERENCE BETWEEN DISTRESS AND DISORDER RELATES TO THE INTENSITY OF THE SUFFERING AND/OR ASSOCIATED PROBLEMS IN FUNCTIONING.

Grief / Bereavement

Facilitator's Note:

- Facilitator gives a brief talk about normal grief process.
- Facilitator himself relates trauma story of a bereaved person he has encountered.

Method:

- Volunteers are asked to form small groups
- One member of a group becomes the psycho-social health worker and the other plays role of survivor who has lost a family member.
- Survivor relates his /her narrative of Loss of a close family member and the way she/he felt and is currently feeling.

Discussion: Feedback from other participants in the small group and discussion by all the group members on what they have learned about normal grief.

Grief / Bereavement

The experience of grief after loss is one common to human being. The most intense grief usually follows the death of a loved person, perhaps because death is so final and we feel a great sense of loss. Similar reactions occur in many different types of loss, e.g, Loss of a limb, home, belongings etc.

The intense feelings experienced after loss are a normal, healthy part of the healing process and will result eventually in learning to live with the loss.

What is normal grief?

The ways that we express grief are strongly influenced by social factors. In some cultures people are expected and encouraged to show their grief, but for men after a relatively brief period of time, people expect them to stop any display of emotion and 'get on with life'. Some people hold the belief that crying and grieving openly are religiously unacceptable. You may be said to be 'coping well' if you make little fuss, or said to be 'breaking down' and 'just not coping' if you continue to show emotion beyond the period others have set for you. In reality, the opposite may be true.

The length of time taken to get over a loss will vary from person to person, however, given the opportunity most people will work through the loss and resume a productive and satisfying life.

Children react differently to a traumatic event. They may show signs of grief at home and school. They become excessively jumpy or being startled easily. They start avoiding physical reminders of the traumatic death/events e.g. places or people related to the death etc. They also withdraw from important aspects of their environment. Also children may show preoccupation with the traumatic event happened.

- Immediately following bereavement, most people are in shock. Some people will throw themselves into practical tasks while others will flounder without assistance, finding it difficult to concentrate on tasks. Both reactions are normal.

Intense emotional reactions are common in the first weeks following bereavement and include: crying, irritability, anger, guilt, disturbed sleep and appetite, feelings of self-blame,

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related to things survivor may feel he/she should or should not have done in relation to loved one.

During the first month or so, such reactions would be acknowledged as being 'usual', but Health workers are advised to routinely assess that these symptoms are not becoming disabling. The time taken for complete recovery will vary from one individual to the next. Some individuals may recover rapidly from acute distress in a few weeks while others can show residual impairment in functioning for 4-5 years after their loss. Each individual will need to be assessed and treated individually. **If significant symptoms last more than 12 months, expert consultation is recommended.**

If a bereaved individual has a history of a mental disorder it would be wise to monitor for the early warning signs of that disorder on a weekly basis for as long as the health worker feels such monitoring is necessary.

MODULE: ORIENTATION ON BASIC PSYCHOSOCIAL SKILLS OF WORKING WITH POPULATIONS EFFECTED BY DISASTERS

Note of caution: these skills cannot be merely learned (a) by reading the materials solely or (b) a few days of training. Rather, learning these skills requires practice under regular supervision

Session Aims:

- Familiarize the participants with Individual based Psychosocial interventions Including basic problem solving techniques, stress management techniques, like relaxation, and grief counseling
- Provide opportunity to practice the communication, counseling and relaxation techniques under supervision

Method:

The facilitator should introduce the concepts outlined above one at a time (05-07 minutes each)

- Role play with the facilitator acting as the survivor presenting with having difficulty in finding a good tent for his /her family and one of the participants acting as the care provider using the problem solving approach to solve the problem of living.
- Role play with the facilitator acting as the survivor presenting with having persistent headache and difficulty in concentrating and one of the participants acting as the care provider taking him/her through the muscular relaxation and slow breathing exercise.
- Role play with the facilitator acting as the survivor having lost her/his son and husband and one of the participants acting as the care provider providing grief counseling.
- **Feedback from the group**

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Structured Problem Solving:

There are rarely perfect or ideal solutions to problems, however, the structured problem solving approach aims to identify the most effective plan of action available at the time. You can help the people find a solution to their problems in a systematic manner which can be because of the problem being:

- Too severe and novel in intensity e.g. Loss of number of family members, Loss of all the belongings during the earth quake.
- Too many crisis with compromised stress coping capabilities e.g. child going missing / physical illness / disability imposing additional stress.

You can help the person by being a concerned individual rather than by being an expert.

- Approach the person in a gentle and reassuring manner

THE SIX STEP METHOD OF STRUCTURED PROBLEM SOLVING:

Step 1: What is the problem?

Discuss the problem carefully

Step 2: List all possible solutions

Step 3: Discuss each possible solution

Quickly go down the list of possible solutions and assess the main advantages and disadvantages of each one.

Step 4: Choose the best or most practical solution

Choose the solution that can be carried out most easily with your present resources (time, money, skills, etc.)

Step 5: Plan how to carry out the best solution

List the resources needed and the main problems that need to be overcome. Practice difficult steps

Step 6: Review how well the solution was carried out and praise all efforts.

Continue the problem solving process until you have resolved the problem

Stress Management Strategies

Relaxation Training:

Relaxation is useful for reducing physical and mental tension. Relaxation helps people to reduce worry and anxiety, improve sleep, and relieve physical symptoms caused by stress (e.g., headaches, stomach pains, diarrhoea or constipation).

This exercise outlined below should take about 15-20 minutes.

Muscular Relaxation Exercise:

For each of the muscle groups in tense the muscles for 7-10 seconds, then relax for about 10 seconds. Tense and relax the muscles in the following order:

Hands - curl hands into fists, then *relax*.

Lower arms - bend hand down at the wrist, as though trying to touch the underside of arm, and then *relax*.

Upper arms - tighten biceps by bending arm at the elbow, and then *relax*.

Shoulders - lift shoulders up as if trying to touch ears with them, and then *relax*.

Neck - stretch neck gently to the left, then forward, then to the right, then to the back in a slow rolling motion, then *relax*.

Forehead and scalp - raise eyebrows, then *relax*.

Eyes - screw up eyes, and then *relax*.

Jaw - clench teeth (just to tighten the muscles), then *relax*.

Tongue - press tongue against the roof of mouth, then *relax*.

Chest - breathe in deeply to inflate lungs, then breathe out and *relax*.

Abdomen - Suck Abdomen in to tighten the muscle, and then *relax*.

Upper back - pull shoulders forward with arms at side, then *relax*.

Lower back - while sitting, lean head and upper back forward, rolling back into a smooth arc thus tensing the lower back, then *relax*.

Thighs - while sitting, push feet firmly into the floor, then *relax*.

Calves - lift toes off the ground towards shins, then *relax*.

Feet - gently curl toes down so that they are pressing into the floor, then *relax*.

This exercise should be **practiced once or twice every day for at least 8 weeks and whenever they are tense.**

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Slow Breathing Exercise:

1. Breathe in and out slowly through your nose in a six second cycle.
2. Breathe in for three seconds and out for three seconds. This will produce a breathing rate of 10 breaths per minute.
3. At the end of each minute (after 10 breaths) hold breath again for 5 seconds and then continue breathing using the six second cycle.
4. Continue breathing in this way until all the symptoms of tension have gone.

It is important to practice this exercise so that it becomes easy to use any time the survivors feel anxious.

Other relaxation methods:

Although progressive muscle relaxation is the most recognised and documented method of relaxation, there are other methods that can achieve similar results. Other methods include: **Praying, Meditation, Physical Exercise**, listening to music, reading books, and writing. These methods can be useful if they reduce tension for that individual and are used daily.

Grief Counseling

This is a technique which utilizes the above mentioned skills but modified to help bereaved survivors (i.e. those who have lost their close ones). The person is gently encouraged to talk about his relatives. This will hasten the process of mourning and its resolution. The following are to be done as a part of helping people grief:

- Approach the person in a gentle assuring manner; ask him about the overall welfare of his family members and then talk about the deceased person . Listen to them attentively.
- Encourage him to share information about the deceased family member. (e.g. to show and discuss the photo of a family member).
- Focus on pre-disaster relationship network, with the dead person and the personal meaning of the loss.
- Enquire about survivor guilt in this context and reassure survivors that it is a natural human reaction to feel guilty about being unable to save loved ones.
- Try to ensure that the bereaved person performs various mourning rituals.
- Ensure that survivor gets an opportunity to meet other survivors who know something more about the dead person.
- An opportunity to meet other people like nurses, doctors, or persons who extricated the body is also useful.
- One can use group approaches such as the group viewing the site of death and holding a public memorial service (Dua') to make the process of grieving easier.

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- Use the technique of “generalization”. eg “ everyone is effected you see, Aslam’s father died but he is still helping out his other family members. “

Non Pharmacological Pain Management

1. Relaxation therapies
As described earlier can be useful in pain reduction as well.
2. Medication reduction
 - Short term pain relief leads to a learned behaviour that leads to the excessive use of pain medication
 - Patients who start relying on their pain medication when not needed may suffer from the side effects of the drugs as well.
 - It is therefore important to help patients who need pain medication to take medication on fixed times instead of whenever needed
3. Activities training
 - Measure pre treatment levels of activity
 - Select targets that are achievable
 - Programme of step by step increase in activities
 - If a target is met then a new target is set.
4. Psychological Techniques :
 - Attention Diversion: attention is diverted to another task like Tasbih or reading Holy Quran.
 - Changing Context: Imagining pain occurring while saving a family member or friend thus linking it with a positive activity.
 - Imaginative Inattention: Imagining being in a calm and beautiful place with the family.

Non Pharmacological Management of Sleep Problems

Disturbed sleep can be a symptom of a mental illness. At times it is simply a complaint that can be dealt by following simple measures.

Dos:

1. Go to bed only when you are wanting to go to sleep
2. Develop a routine of going to and getting up at the same time every day.
3. Have a light meal at night
4. If possible have a hot drink of milk.
5. Take Physical Exercise in the evening.

Don'ts:

1. Use bed for anything other than sleeping.
2. Nap during the day.
3. Drink tea or coffee in the evening.
4. Leave lights or sound (radio) on when sleeping.

MODULE: IDENTIFICATION, REFERRAL OF COMMON MENTAL DISORDERS

Session Aims:

On completion of the session trainees will:

Able to Identify, and appropriately refer the common mental disorders:

- Post traumatic stress disorder
- Anxiety Disorders
- Depressive Illness
- Psychosis
- Substance use disorders
- Epilepsy

Method:

- The facilitator will introduce each of the common mental disorders
- In an interactive manner explain the manifestations, and referral for each of the disorders.
- Feedback, and Question answer session follows.

ANXIETY DISORDERS

Identification:

Anxiety Disorders are characterized by **persistent and excessive feelings of anxiety**. This may or may not be associated with a particular environmental circumstance. It may persist all the time or occur episodically.

Diagnostic Criteria:

The diagnosis of Anxiety Disorder should be made if the following signs and symptoms are present for most days of the week for a period of six months and are causing significant functional impairment.

- Physical arousal (e.g dizziness, sweating, a fast or pounding heart, a dry mouth, stomach pains, or chest pains lump in the throat, restlessness, headaches, tremors, or an inability to relax, sleep disturbance, **body aches, fatigue, diarrhea**).
- Mental tension (e.g. worry, feeling tense or nervous, poor concentration, fear that something dangerous will happen and the patient won't be able to cope)

Management

Psychosocial Management:

- Encourage the patient to use relaxation methods daily to reduce physical symptoms of tension. (see module II)
- Advise avoidance of drugs or cigarettes and reduction in caffeine consumption.(tea , coffee)to cope with anxiety.
- Encourage the patient to engage in pleasurable activities, Regular physical exercise and to resume activities that have been helpful in the past.
- Structured problem-solving methods can help patients to manage current life problems or stresses which contribute to anxiety symptoms. (see module on Basic helping skills)
- Set a date to review the plan. Identify and reinforce things that are working.

Essential information for patient and family:

- Stress and worry have both physical and mental effects. Use the Fight flight response model to explain the reason for physical complaints. (see Module I)
- Learning skills to reduce the effects of stress (not sedative medication) is the most effective relief.

POST-TRAUMATIC STRESS DISORDER

Identification:

Post-traumatic stress disorder (PTSD) is characterised by the development of a **long-lasting anxiety response following a traumatic or catastrophic event like the recent earthquake**. PTSD usually develops within 3-6 months of the traumatic event (although sometimes longer)

Diagnostic Criteria:

- The individual has experienced an extremely traumatic event as the recent earthquake with human and material losses.
 - The individual experiences repetitive and intrusive memories, daytime images and dreams of the traumatic event.
 - The individual has avoids cues associated with the traumatic event like shaking of the bed or table.
 - The individual does not have full memory recall of the traumatic event,
- OR
- The individual experiences increased psychological sensitivity and arousal indicated by at least 2 of the following:
 - sleep disturbance;
 - irritability or anger;
 - difficulty concentrating;
 - Hyper vigilance or being easily startled.

Substance abuse is commonly associated with this condition and there are difficulties in carrying out tasks of daily living.

Management

Psychosocial Management:

- Educate the patient and family about post-traumatic stress disorder, thus helping them understand the patient's changes in attitude and behaviour. (see below)
- Encourage the patient to talk about the event that triggered this condition. DO NOT FORCE the survivor and family to talk
- Explain the role of avoidance of cues associated with the trauma in increasing and maintaining fears and distress. Encourage the patient to face avoided activities and situations gradually.
- Avoid using drugs or cigarettes to cope with anxiety.

Essential information for the patient and family:

- Traumatic or life-threatening events often have psychological effects. For the majority, symptoms will subside with minimal intervention.
- For those who continue to experience symptoms, effective treatments are available.

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- Suffering from post-traumatic stress disorder is not a weakness and does not mean the patient has gone 'mad'. The patient needs support and understanding, not to be told to “BE strong or use your Will power”.

DEPRESSIVE ILLNESS

Identification:

Depression is a mood state that is characterized by significantly lowered mood and a loss of interest or pleasure in activities that are normally enjoyable. Such depressed mood is a common in the population which has experienced recent losses. *However, Depressive illness can be distinguished from this 'normal' depression by its severity, persistence, duration, and the presence of characteristic symptoms*

A wide range of presenting complaints may accompany or conceal depression. These include Unexplained somatic complaints, worries about social problems such as financial or marital difficulties, increased drug or cigarette use, or (in a new mother) constant worries about her baby or fear of harming the baby.

Diagnostic Criteria:

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

At least four of the following associated symptoms are present for at least two weeks most of the time:

- disturbed sleep
- disturbed appetite
- guilt or low self-worth
- pessimism or hopelessness about the future
- decreased libido
- crying spell
- poor concentration
- suicidal thoughts or acts
- loss of self confidence
- fatigue or loss of energy
- agitation or slowing of movement or speech
- diurnal mood variation

Management

Psychosocial Management:

- Identify current life problems or social stresses, including precipitating factors. Focus on small, specific steps patients might take towards reducing or improving management of these problems. Avoid major decisions or life changes.(see Module II for Problem solving Skills)
- Encourage the patient to resist pessimism and self-criticism and not to act on pessimistic ideas (eg ending life, leaving family or job), and not to concentrate on negative or guilty thoughts.
- Support the development of good sleep patterns and encourage a balanced diet.
- If physical symptoms are present, discuss the link between physical symptoms and mood (use the example of common cold to highlight the link between physical problems and low mood)

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- Plan short-term activities which give the patient enjoyment or build confidence. Exercise may be helpful.
- Advise reduction in caffeine intake and drug and cigarette use.
- Involve the patient in discussing the advantages and disadvantages of available treatments. Inform the patient that medication usually works more quickly than psychotherapies. Where a patient chooses not to take medication, respect their decision and arrange another appointment to monitor progress.
- Assess risk of suicide. Ask a series of questions about suicidal ideas, plans and intent (eg has the patient often thought of death or dying? Does the patient have a specific suicide plan? Has he/she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas?) Close supervision by family or friends, or hospitalization may be needed.

Essential information for patient and family:

- Depression is a common illness and effective treatments are available.
- Depression is not weakness or laziness.
- Depression can affect patients' ability to handle life problems.
- Patient needs support and help.

POSTNATAL DEPRESSION

Postnatal (or postpartum) depression is most appropriately described as depression that has its onset within 3 months, and possibly up to 6 months following childbirth. Depression that occurs after this time is best considered to be Depressive Illness and not postnatal depression.

The symptoms of postnatal depression are the same as those experienced in Depressive Illness

Postnatal depression is much less common than postnatal blues, affecting (respectively) approximately 10% versus 70% of new mothers. The depression usually lasts anywhere from a few weeks to a year or more. If untreated, postnatal depression may become a chronic disorder. With appropriate monitoring and intervention, it is possible to reduce the prevalence of such depression and perhaps even to prevent recurrence in the future.

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Management:

The management of postnatal depression can be broken down into the following steps:

1. *Provide an explanation and education about the disorder*

Let the woman know what is happening to her. It is often that case that women experience certain amount of relief just from having their disorder recognised and labeled. Women often worry that they are going crazy or that the depression signifies personal failure or that they are an unfit and incompetent mother. It may be helpful to say, *"You are suffering from postnatal depression."*

Explain what postnatal depression is. It is helpful for women to be informed that postnatal depression is not an uncommon disorder following childbirth and that this depression is not the result of personal shortcomings. It may be helpful to say, *"You are not alone"*, or *"You are not a bad/defective mother."*

2. *Organize practical help*

The Health worker/ staff can assist

- Helping the woman to recruit support from family and friends.
- Educate the husband/family about postnatal depression and the demands of being a mother.
- Point out to the husband/family that the woman is in need of practical and emotional support.

PSYCHOSIS

Identification:

It is severe disturbance of thoughts and behavior resulting in individual losing touch with reality. This leads to gross impairment of the individual's ability to carry out his responsibilities and day to day functions.

The individual being not aware of his illness refuses treatment and usually the relatives bring him/her for treatment.

Psychosis can be ACUTE, CHRONIC or RECURRENT. It is likely to occur after child birth in women, in young adults abusing drugs (e.g. Cannabis, Amphetamines), and after sudden stress

Diagnostic Criteria:

- Delusions (Odd, false beliefs which are not shake able with arguments.)
- Hallucination (Hearing/seeing in the absence of any sensory stimulus).
- Thoughts being controlled or tampered with by out side agencies, telepathy, magic etc.
- High mood, is unusually cheerful and boastful with excessive energy, overactive, over talkative with disturbed sleep, appetite and libido.
- Social withdrawal and lowering of social performance.
- Self neglect.
- Behaving against social norms like taking off clothes in public or being abusive towards parents, sisters, brothers, etc.
- Abnormally suspicious: claiming others are trying to harm him or have done black magic, taweez on him.
- Violent and aggressive.
- Irrelevant speech.

Management

Psychosocial Management:

- Minimize stress and stimulation.
- Do not argue with psychotic thinking (you may disagree with the patient's beliefs, but do not try to argue that they are wrong).
- Avoid confrontation or criticism, unless it is necessary to prevent harmful or disruptive behaviour.
- Ensure the safety of the patient and those caring for him/her:
 - family or friends should be available for the patient if possible

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- Ensure that the patient's basic needs (eg food and drink and accommodation) are met.

Encourage resumption of normal activities after symptoms improve.

Essential information for patient and family:

- Agitation and strange behaviour can be symptoms of a mental illness.
- Acute episodes often have a good prognosis, but long-term course of the illness is difficult to predict from an acute episode.
- Advise patient and family about the importance of medication, how it works and possible side-effects.
- Continued treatment may be needed for several months after symptoms resolve.

Psychosis after Childbirth:

After childbirth, a mother may develop an acute and serious psychotic disorder. The symptoms of psychosis become obvious in the first 2 weeks after the delivery. When alone, she may harm herself or the baby, or neglect the baby. A woman with post-partum psychosis and her baby require immediate attention. When the condition is severe (for example if she intends to harm herself or the baby), she has to be admitted to the hospital. In this case, family members should be instructed to remain with the patient at all times. If the patient stays home, she should not be left alone with the baby. Other people should stay with her, reassure her and help her take care of the baby. They should also ensure that she takes the medicines. With medication, the woman will completely recover.

FOR PSYCHOSOCIAL MEASURES SEE SECTION ON POST PARTUM DEPRESSION

SUBSTANCE MISUSE DISORDERS

A Disorder of Repeated Consumption of Illegal Drugs

Identification:

Family may request help before the patient (e.g. because the patient is irritable at home or missing work.) or the Patients may have depressed mood, nervousness or insomnia.

Patients may present with a direct request for prescriptions for narcotics or other drugs, a request for help to withdraw, or for help with stabilizing their drug use.

They may present in a state of intoxication or withdrawal or with physical complications of drug use, e.g. abscesses or thromboses.

Following drugs are known to be commonly abused

Heroin and Opium use shows decreased rate of breathing, lowered blood pressure, slowed heart rate, nausea, vomiting, coma and possibly death in intoxication.

In **withdrawal** from heroin strong desire to use the drug again, restlessness, muscle and bone pain, running nose and eyes, sweating, vomiting, abdominal cramps, diarrhea, dilated pupils and increased pulse rate can be seen within 8–12 hours (peak between 48 and 72 hours) after the last administration of heroin

Cannabis use give increased feeling of happiness, increased talking, laughing, increased self confidence, perception of being creative and smart loss of coordination and loss of concentration, sleepiness, increased appetite

Benzodiazepines (e.g., diazepam, alprazolam, bromazepam,) cause dependency if given for more than two weeks. Their effects of benzodiazepines include feeling relaxed, sleepiness and drowsiness along with dizziness.

Withdrawal from benzodiazepines may lead to anxiety, nervousness, irritability, sleep problems and headache.

Diagnostic features

- Drug use has caused physical harm (e.g. injuries while intoxicated), psychological harm (e.g. symptoms of mental disorder due to drug use), or has led to harmful social consequences (e.g. loss of job, severe family problems, or criminality). Strong desire to use drugs despite being aware of and experiencing the harmful consequences of drug use.
- Habitual drug use with primary focus on getting drug.
- Neglect of alternate sources of pleasure.
- Difficulty controlling drug use in terms of quantity and frequency of drug use.
- Tolerance (can use large amounts of drugs without appearing intoxicated).
- Withdrawal (e.g. anxiety, tremors or other withdrawal symptoms after stopping use).

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Psychosocial Management

For all patients:

- Discuss costs and benefits of drug-use from the patient's perspective
- Feedback information about health risks, including the results of investigations
- Emphasize personal responsibility for change
- Give clear advice to change
- Assess and manage physical health problems (eg anaemia, chest problems) and nutritional deficiencies
- Consider options for problem solving, or targeted counselling, to deal with life problems related to drug use.

For patients not willing to stop or change drug use now:

- Do not reject or blame.
- Advise on harm-reduction strategies (eg if the patient is injecting, advise on needle exchange, not injecting alone, not mixing alcohol, benzodiazepines and opiates).
- Clearly point out medical, psychological and social problems caused by drugs.
- Make a future appointment to reassess health

For patients willing to stop now:

- Set a definite day to quit
- Consider withdrawal symptoms and how to manage them
- Discuss strategies to avoid or cope with high-risk situations (eg social situations or stressful events)
- Make specific plans to avoid drug use (eg how to respond to friends who still use drugs)
- Identify family or friends who will support stopping drug-use
- consider options for counseling

For patients who do not succeed, or who relapse:

- Identify and give credit for any success
- Discuss situations which led to relapse

Essential information for patient and family

- Drug misuse is a chronic, relapsing problem, and controlling, or stopping, use often requires several attempts. Relapse is common.
- Abstinence should be seen as the long-term goal. Harm reduction (especially reducing intravenous drug use) may be a more realistic goal in the short- to medium term.
- Ceasing or reducing drug-use will bring psychological, social and physical benefits.
- Using some drugs during pregnancy risks harming the baby.
- For intravenous drug-users, there is a risk of transmitting HIV infection, hepatitis or other infections carried by body fluids. Discuss appropriate precautions (eg use condoms, and do not share needles, syringes, spoons, water or any other injecting equipment).

EPILEPSY

(Complex partial seizures/ Generalized Tonic Clonic)

Identification:

The diagnosis of epilepsy depends on a good and clear history. You may not have a chance to see an actual fit in many of your patient, so objective evidence from the family-member is absolutely crucial.

Diagnostic criteria:

Complex partial seizures:

- Changed perception (Seeing spot of light, Abnormal smell or taste, Tickling, burning sensation, Strange feeling in epigastrium)
- Automatic movements (lip smacking, chewing)
- Impaired consciousness but no complete loss
- Confusion
- Amnesia (inability to remember the event)

Generalized tonic clonic:

- Complete loss of consciousness
- Sudden onset
- Tonic and clonic movements (jerking movements)
- Tongue bite
- Incontinence for urine and sometimes feces
- Amnesia (inability to remember the event)
- Post fit confusion

Status epilepticus: seizure persists for at least 20 minutes. It is an Emergency!

Psychosocial Management

Advice the patient and/or family that

- Child should go to school and have normal life
- Do not over protect the child.
- Talk about epilepsy in the family and in the community
- Patient with epilepsy can marry.
- Epilepsy is treatable and can be controlled effectively with regular medication.

Essential information for patient and career

- Epilepsy can be treated successfully, Disease is not contagious
- Drugs have to be taken for many years
- Discontinuation of medication may result in recurrence of seizures
- Sudden discontinuation may result in life threatening status epilepticus
- It may take several days before the drugs show effect

Patient should not be close to fire, Do not combine with herbal drugs

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Pre Referral Interventions

An essential aspect of the referral process is preparing the family and patient:

- Demystify the referral process. Try to reduce the patient and family's anxiety by emphasising that a referral does not mean they are bad or that the patient is 'crazy'.
- Gain the family and patient's cooperation for the referral and for treatment, otherwise it is unlikely to be helpful. Emphasise the collaborative nature of psychological treatments.
- Ensure that family and patients have a realistic expectation of what might be achieved.
- Ensure that all family members requested to attend can actually attend. Some patients may wish not to involve the family. This should be respected.
- Give the family an idea of the time they will need to put aside for the consultation.
- Let the family know if there are any costs involved.
- Advise the family to take relevant information with them to the psychiatrist/psychologist appointment (e.g. medical reports).

Module: Care of Special Groups

Session Aims:

- Facilitator will help participants to understand that there are various vulnerable groups who can be affected by an earthquake.
- In particular following groups will be focused on
 - Children
 - Older adults
 - Women
 - Amputees
 - Rescue workers and their care
- Increased understanding of these responses and symptoms.
- Awareness in dealing with these issues.

Method:

- Initially the facilitator will discuss the issues related to various groups
- Small Group discussion and brain storming one for each of the vulnerable groups to generate the symptoms/presentation of the members of these groups.

Discussion:

By all the participants to ensure that there is a clear understanding of the issues involved specific to each group.

Module: Care of Special Groups

Children and adolescents in the family need special attention:

Children and adolescents do not have the mental or emotional maturity to understand adverse situations like adults. Often they cannot comprehend what has happened to them.

The impact of events like loud noises, shouting, running, panic and anxiety, separation from loved ones, loss of the comfortable environment, etc., affects them more than an adult.

Children Look At Adults:

- After a disaster, children and adolescents will look to adults as models for guidance and as role models
 - If parents are alarmed and distraught, children may also be alarmed and distraught
 - “If adults are upset, the danger is still REAL!”
 - Adult can reassure children by being:
 - Calm
 - Confident
 - Caring

Children and adolescents Need Structure and Play:

- Children depend on daily routines
 - Wake up
 - Eat meals
 - Go to school (if the child attends school)
 - Play with friends
 - Interact with family
 - Go to bed

Children and adolescents tend to show reactions to stress in the form of:

- (1) Irritable, crying excessively.
- (2) Clinging behavior.
- (3) Expressing intense fear and insecurity repeatedly, excessively dependent behavior.
- (4) Excessive quietness and withdrawn behavior, avoidance or passive behavior.
- (5) Reporting frightening dreams (nightmares and night terrors) waking up frequently from sleep and refusal to go to bed at times.

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- (6) Anger, rage and aggressive behavior.
- 7) Feeling nervous, unable to concentrate.
- (8) Recurrent memories or fantasies of the event.
- (9) Fantasies of playing 'rescuer'.
- (10) Intensely preoccupied with details of the event.
- (11) Dangerous, risk-taking behavior, rejecting social rules showing aggressive behavior, (in adolescents only).
- (12) Loss of interest in studies, refusal to go to school, significant drop in academic performance.
- (13) Psycho-somatic symptoms like stomachache, headache, giddiness, vomiting, heavy breathing and fainting attacks.
- (14) Possibility of developing different kinds of phobias.

You have to take measures to increase feelings of security and bonding. You need to understand that these changes are 'normal' for the situation and take measures to help the child/adolescent get over his/her stress. Some things you can Advise the family to do are:

- Re-establishing routines like eating, sleeping, going to school
- Giving security by actions like touching, hugging, reassuring them verbally (in culturally appropriate ways)
- Allowing them to talk about the event and listen to them without giving any advice
- Encouraging them to play or offering opportunities for painting and drawing where they can express their emotions. This is very healing
- Story telling, singing songs and games involving physical movement are other things that will help them feel better
- Giving lots of praise and love to them
- Pay more attention and spend time on their studies once they return to school.

When ever you come across children in the field,

- talk to them, reassuring them verbally, using culturally acceptable physical gestures, like patting on the head , *but be careful about physical contact that it should be misinterpreted*
- *Ask them what they would like and if they wish to talk , Listen attentively*

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Older people:

Some elderly people may face enormous difficulties.

- When confronted with the death of many young people in front of them they can become very depressed, they might withdraw and cry.
- They may find it difficult to sleep and lose their appetite and also fall ill.
- At times you may find them agitated
- At other times they would be feeling hopeless and having suicidal tendencies

It is important to take special care of them.

- They need to be near their loved ones and people who can spend time with them. Touching them and allowing them to cry when they feel like it is really beneficial because quite often they talk of their past life.
- Ensure that their physical needs including health needs are being looked after properly
- Keep them informed of the news, developments and activities taking place related to the disaster
- Re-establishing their daily routines, giving them responsibility that they can carry out without too much difficulty and
- Enabling them to pray are some things that can help them to feel better.

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Women

In addition to children and older persons women also need to be helped specifically. They are likely to experience the sign and symptoms of distress more intensely as compared to men .The situation may be compounded by the loss or separation from male members of the family and women having to fend for themselves and their families. They can be helped by adopting the following measures:

- Share their experience of loss as a group with other women in the community/camp.
- Helping to Contact relatives/ family members to mobilize support and facilitate recovery.
- Make time for recreation using what is available like the radio, visiting religious places, playing with children and engaging in activities like sewing.
- Resume normal activities of the pre-disaster days with family.
- Be together with family members. Do not send women, children and aged to far off places for the sake of safety.
- Restart activities that are special to family like having meals together, praying, playing games.
- It is important to ensure privacy for women in the temporary shelters for their physical needs.
- Take part in health and education related activities if possible.
- Arrange with neighbors to share in looking after their young children

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Traumatized Amputees

Amputation results in a loss of body function and is an insult to the patient's psychological sense of body integrity and competence. In dealing with such a patient, following guidelines should be kept in mind.

- The session should be conducted in a safe and private environment.
- The patient is encouraged to verbally recount the trauma experience but not forced to do so.
- The patient is allowed to relate memories, thoughts and feelings about the trauma, at his/ her own pace.
- The care giver tries to assure that the patient's responses and thoughts are normal.
- Focusing initially on concrete discussions related to the physical injuries treatments and the healing process is more beneficial.
- Patient's emotional conflict about his/her future role is acknowledged in a supportive and compassionate manner.
- Encouragement and appreciation of his/her progress is important.
- Care giver must be educated to tolerate and accept patient's anger, recognizing it as a normal expression.
- Patient must be allowed to find effective and healthy ways of communicating their own frustrations.
- Although uncommon, amputees can express suicidal ideation as a result of adjustment problems related to the amputation or actual depressive disorders. Such symptoms, when identified need to be carefully evaluated.

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Secondary Trauma & Self Care (Rescue and relief workers including Health workers)

As a result of their work, relief workers and care providers can enter a state of crisis. Often, there is a feeling of not having done enough or feeling overwhelmed by the needs. They need to cope with:

- Their own fears of death
- Their own feelings of helplessness and sadness, anger, self-blame guilt.

This is called “Secondary Trauma”

Sources of Stress for Helpers

- Being part of the crisis
- Repeated exposure to grim experiences and strong emotions
- Carrying out physically difficult or exhausting tasks
- Lacking sleep and feeling fatigued
- Facing the perceived inability ever to do enough
- Feeling guilt over access to food, shelter, etc.
- Being exposed to anger and lack of gratitude
- Being detached from personal support system
- Feeling frustrated by policies and decisions of superiors

Warning Signs:

- Cynicism or bitterness
- Feeling unappreciated or betrayed by the organization
- Loss of spirit. Nightmares. Increased sensitivity.
- Grandiose beliefs about own importance
- Heroic but reckless behavior
- Neglecting personal safety and physical needs
- Mistrusting colleagues and supervisors
- Mistrusting colleagues and supervisors
- Using drugs or self medication.

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On the Scene: 10 Self-Care Tips

1. Get enough sleep. Get enough to eat and drink (drink water, juice, soda; Avoid drugs)
2. Vary your work task and limit your hours to not more than 12 hours per day
3. Try and stay in touch with your family and friends
4. Do some light exercise including breathing exercises
5. Schedule pleasurable activities
6. Focus on what you did well
7. Take some time to think about what you learned today
8. Do not self medicate or take drugs
9. Pray, meditate or relax e.g. Practice expressive art as a healing medicine. Music, drawing, gardening
10. Avoid professional isolation. Develop a Support system with a coworker, supporting him/her and being supported in turn.