

Version 1.0

# Mental Health and Psychosocial Support in Emergency Operations

**For Trainers of District and PHC 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

## **Mental Health Module for Psychosocial Care Givers**

### **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 form mild and moderate mental illness. In addition 30-50% of the population in is 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 form 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 sector 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:***

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

#### ***Module 2:***

6. Community Based Interventions
7. Individual Interventions  
*(Relaxation, problem solving, communication and counseling skills. Grief counseling and nonpharmacological interventions for Pain and sleep disturbances)*

#### ***Module 3***

8. Care For Special Groups

*(Children, women, elderly and Amputees)*

#### ***Module 4***

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

## **Mental Health Module for Psychosocial Care Givers**

### **Introduction and Rationale:**

Apart from widespread physical destruction earthquake has also resulted in major social and psychological impact on people. Psychological reactions to earthquake can be understood in the context of severe stress caused by death of dear ones, disabilities, injuries and amputations and loss of homes and livelihood, discontinuity in education for children, widows and orphans having to fend for themselves and uncertainty about future. Although there is no reliable data on number of people with mental health problems in the earthquake affected districts, the following rule-of-thumb provides estimates to the projected size of the problem. These estimates give a very rough indication what we can expect as the extent of morbidity and distress to be. We are likely to see 3 groups each requiring a different response:

#### **1. People with none or mild psychological stress or distress that resolves within a few days or weeks**

A very rough estimate would be that perhaps 20-40% of the quake -affected population falls in this group.

#### **2. People either with moderate or severe psychological distress that that may resolve with time or with mild distress that is chronic.**

This group is estimated to be 30-50% of the earthquake effected population. This group covers the people that tend to be wrongly labelled with psychiatric diagnoses by many non-professionals. This group would benefit from a range of mostly social and some basic psychological interventions that are considered helpful to reduce distress.

#### **3. People with mental disorders:**

**Mild and moderate mental disorder.** In general populations, 12-month prevalence rates of mild and moderate common mental disorders (e.g., mild and moderate depression and anxiety disorders, including PTSD) are on average about 10% in countries across the world (World Mental Health Survey 2000 data). This rate is likely to rise - possibly to 20% - after exposure to severe trauma and resource loss. Over a number of years, through natural recovery, rates may go down and settle at a lower rate, possibly at 15% in severely affected areas.

Thus, in short, as a result of disaster, the population rates of disorder are expected to go up about 5-10%.

#### **Severe Mental Disorders (Psychosis, Severe Depressive Illness)**

The rates for severe mental disorders would increase to 3-4% from the base line rates of 1-2%.

## Mental Health Module for Psychosocial Care Givers

### **Target Population:**

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

- Primary Care Physicians
- FLCF care providers

### **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 manage 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.

**Note of caution: skills to manage common mental disorders 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**

## Mental Health Module for Psychosocial Care Givers

### 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.

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

## Mental Health Module for Psychosocial Care Givers

### 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

## Mental Health Module for Psychosocial Care Givers

### **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.
- It 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

## Mental Health Module for Psychosocial Care Givers

### Differentiation Between Stress and Distress

If the body responses do not return 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

<b>Physical</b>	<b>Psychological</b>	<b>Social</b>
Headaches, Muscular Pains/aches, Tremors of Hands	Impaired Concentration, and decision making, anxiety, poor attention	Social withdrawal
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, Depressive illness	Misuse of Medicines or substances of abuse e.g.; smoking, cannabis etc.
Decreased appetite	Anger	
Gastrointestinal Problems	Guilt/Survivor Shame anxiety	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 the need for professional help, but if they persist, professional help may be needed. **TIME** is a great healer. Support from family and friends is 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 it is a 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 with them.
- 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.

## **Mental Health Module for Psychosocial Care Givers**

### **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 psychosocial 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.

## Mental Health Module for Psychosocial Care Givers

### Grief / Bereavement

The experience of grief after loss is common to all human beings. 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 are 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, 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.

## Mental Health Module for Psychosocial Care Givers

### MODULE 2: 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 Community based Psychosocial interventions  
Including formation of groups and running groups**
- **Familiarize the participants with Individual based Psychosocial interventions  
Including basic communication skills, Psycho education problem solving techniques, stress management techniques, like relaxation, Basic counseling skills 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 symptoms of distress and one of the participants acting as the care provider provides counseling using the communication, counseling and psycho educative techniques.
- 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 shelter.
- 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 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**

## Mental Health Module for Psychosocial Care Givers

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#### **Community Interventions- Promoting Community Self Help**

Disasters disrupt communities. Community trauma is often less "visible" to workers trained to work with individuals. Survivors are community members. People will find it very difficult to heal from the effects of individual trauma while the community around them remains in shreds and a supportive community setting does not exist.

Thus, community-based interventions are essential. These include outreach, support groups, community organization, consultation, and training of community caretakers.

#### **Promoting Community Participation**

**Identify community leaders-** These can be government officials, religious leaders, political/ social workers, or other well known people. These people need to be involved in helping heal the community. Involvement of local leaders is an essential part of community participation

- ❖ Identify leaders who:
  - i. Are locally accepted, trusted and respected
  - ii. Accurately represent their communities
  - iii. Will work towards helping the community to achieve its collective goals
  - iv. Have sufficient status to attract other members to be involved

#### **With their help organize:**

- Collective memorial services (Jumarat, chaliswan)
- Help keep people in their natural groups if they must be relocated.

**Identify community resources** especially human resources like adults and adolescents with special skills and help them in looking for opportunities to use their skills as much as possible for the wellbeing and functioning of the community and for earning their living. Masons, carpenters, teachers, and others should be helped in starting to utilize their areas of expertise.

## Mental Health Module for Psychosocial Care Givers

### In Camps or Temporary Shelter

- **Encourage camp administrators** to involve survivors in the running of the camp
  - Older children can be encouraged to help look after younger siblings and children, or help in the preparation of food.
  - Adults can help in preparing, cooking and distributing food, organizing and constructing shelter, documenting information, organizing family tracing, clearing and cleaning spaces for living, providing security for the camp, organizing or supporting health services and healthcare, caring for the sick or teaching children
- **Promote psychological well-being:**

**Educate** about the factors which can help like

- Maintaining a strong religious belief.
- For children having a caring adult to look after them and provide for them.

### On-Site Groups

Health Care workers can circulate in the camp and share information with people informally. This can happen through individual and group conversations.

**This is an informal, supportive, and educational group model.**

Locate a group of people and join their conversation. You are not here as an expert, but just someone who wants to listen and help

Tips:

- Allow people to speak as they wish- do not force anyone to speak
- Listen to stories without probing; don't interrupt while person is speaking.
- Allow people to speak to each other, respond to each other, like a normal group discussion
- Support: normalize and validate their experiences. Highlight universality:
  - When people describe similar experiences, point this out
- Educate about normal responses to disasters and extreme stress
- Encourage self care, especially about diet.
- Validate feelings of helplessness while encouraging activity

## Mental Health Module for Psychosocial Care Givers

### Individual Intervention:

#### 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. Structured problem solving often involves helping people find helpful ways of coping. You can help the people find solutions (or ways of coping) for their problems in a systematic manner. They may benefit from such help when the problems are:

- 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 crises 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. Don't give them directions just listen to them and help them out practically.*

- 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 let them “talk”. Try to put yourself in their shoes (empathy) then think about problem/solution.

##### **Step 2: List all possible solutions / ways of coping**

**Help the client to come up with as many solutions/ways of coping as possible (brainstorming)**

##### **Step 3: Discuss each possible solution / way of coping**

Go down the list of possible solutions and encourage the client to assess the main advantages and disadvantages of each one.

##### **Step 4: Choose the best or most practical solution / way of coping**

Support the client in choosing the solution that can be carried out with the present resources (time, money, skills, etc.). Decisions should be made according to reality.

##### **Step 5: Plan how to carry out the best solution/way of coping**

List the resources needed and the main problems that need to be overcome. Practice difficult steps. Always try to apply “empathic” approach. Take them in confidence.

##### **Step 6: Review how well the solution /way of coping was carried out and praise all efforts.**

*Continue the problem solving process until you have resolved the problem*

## Mental Health Module for Psychosocial Care Givers

### Basic Communication Skills;

The aim of communication skills training is to help you talk about very important and complicated issues without causing major arguments and hostility.

### How to Communicate Clearly

The basic rule is to keep messages *simple, clear, and positive*.

### When Listening be a good listener by

#### *Attentive listening*

- Establish (culturally appropriate) eye contact with the person while talking to him/her
- Listen attentively to everything a person says convey this by maintaining eye contact in a culturally acceptable manner, bending forward, nodding, etc.
- Respond by gestures and words (Hmmm...) to indicate that you are listening attentively
- Use short phrases (along with gestures) to indicate that you are listening, but do not interrupt frequently
- Try to encourage the person to talk more by repeating his/her words/phrases
- Think about what has been said and clarify wherever necessary
- Summarize the contents in between and at the end of the talk
- Empathize with the person by sharing the experience of others
- Reassure the person but do not make false promises

### When Talking:

- Look at the person (make eye contact)
- Be specific (e.g. Instead of saying, "I'd like you to try and help me" say, "I'd like you to help me with keeping record of people needing psychosocial support")
- Express your thought or request simply and positively
- Use an appropriate tone of voice and body posture. Remember that your tone of voice and your body language also give very strong messages. There is no point in asking someone to do something if you are standing with your hands on your hips and speaking in an angry or sarcastic manner.
- Ask one question or make one request at a time•
- Give praise for even small accomplishments, immediately after something pleasing has been said or done.
- Remember also that sometimes even clear and pleasant requests will be ignored. Perhaps the request was unreasonable. Or maybe the other person was feeling too troubled to help.

## Mental Health Module for Psychosocial Care Givers

### 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, diarrhea 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, then *relax*.

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

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

## Mental Health Module for Psychosocial Care Givers

### Slow Deep Breathing Exercise

1. Breathe in through nose and out slowly through your mouth 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. .

### Psycho Education

Education is one of the most important activities of health care providers after disaster. When people understand what is happening to them, and have some idea how to cope, they have more feelings of control. Education is a very important psychological intervention.

#### **All survivors should be given educational information to:**

- (1) help normalize common reactions to trauma,
- (2) improve coping,
- (3) enhance self-care,
- (4) facilitate recognition of significant problems, and
- (5) increase knowledge of and access to services.

Such information can be delivered in many ways, including through public media, community education activities, and written materials.

**First**, survivors and families should be reassured about common reactions to disasters and Information about social support and stress management is particularly important.

**Second**, opportunities to discuss emotional concerns in individual, family, or group meetings can enable survivors to reflect on what has happened.

**Finally**, survivors will need information about financial, mental-health, rehabilitation, legal, and other services available to them as well as education about common obstacles to pursuing needed services.

## Mental Health Module for Psychosocial Care Givers

### Basic Counseling Skills:

**Active Listening Skills: (see Communication skills)**

**Collaborative problem solving (see problem solving section )**

#### **Empathy:**

Share the experiences of the other person as if they are your own. You have to be sensitive and have the ability to recognize when the other person is going through certain feelings or emotional experiences. Give examples.

#### **The Difference Between Empathy and Sympathy**

<i>Empathy</i>	<i>Sympathy</i>
<ol style="list-style-type: none"><li><i>1. I try to understand what you are going through.</i></li><li><i>2. You are feeling angry at what has happened to you</i></li><li><i>3. I accept that you are very scared</i></li><li><i>4. Simply sitting in silence while the survivor expresses his/ her feelings or weeps.</i></li></ol>	<ol style="list-style-type: none"><li><i>1.Poor you, it is really bad that this happened to you.</i></li><li><i>2.It is horrible that this has happened to you</i></li><li><i>3.Don't be scared, I am here to help you however I can</i></li><li><i>4 .I am so sorry for you, don't worry everything will be all right.</i></li></ol>

#### **Genuineness/Sincerity:**

This refers to the ability to reduce / bridge the emotional distance between self and survivor. This can be achieved by

***Being friendly and open*** e.g. acknowledging that you may not be able to share/understand the enormity of their difficulties and sufferings but you are trying

***Being spontaneous*** rather than being rigid or overly formal e.g. sitting on the mattress or string bed rather than to keep standing or not expressing your emotions and sharing them with survivors for fear of causing distress or losing face.

***Action should be consistent*** with your intent of being there to help which includes not making promises you are not in a position to fulfill.

## Mental Health Module for Psychosocial Care Givers

### **Positive Regard for survivor;**

This is the ability to convey respect for the survivor by action like

***Seeking permission*** for visiting them at their convenience and setting meetings with their agreements.

Similarly **conveying your praise** and acknowledgement for their ability in handling a very difficult situation with dignity.

**Summarizing the messages from the survivors accurately and sharing it with them.**

### **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 may 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 family members and then talk about the deceased person.
- Encourage him/her 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 can be useful when these staff have some basic understanding of how to respond to a person grief.
- 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.

## **Mental Health Module for Psychosocial Care Givers**

### **Non Pharmacological Pain Management**

- Relaxation therapies  
As described earlier can be useful in pain reduction as well.
- 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
- 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.
- 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.

## **Mental Health Module for Psychosocial Care Givers**

### **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. Take Physical Exercise in the evening.

#### **Don'ts:**

1. Nap during the day.
2. Drink tea or coffee in the evening.
3. Leave lights or sound (radio) on when sleeping.

## **Mental Health Module for Psychosocial Care Givers**

### **Module 3: 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 3: Care of Special Groups**

### **Effects of Extreme Stressors on Children and Adolescents**

The impact of extreme stressors on children, including natural disasters, like the recent earthquake, is substantial. Aside from the hardships of daily living, the survivors may experience injuries and be exposed to other distressing events including witnessing someone dying or being injured, seeing dismembered bodies or body pieces, or being separated from family (UNICEF; 2004). Survivors of disasters often experience a range of losses, including loved ones, their home, neighbourhood, and place of worship. Although distressing for all, children may be particularly affected by the loss of their familiar environment (home, school, peers), as children tend to feel safe and secure when they have consistent and predictable routines in life. Disasters often disrupt this sense of well being by destroying normal life routines. Also, caregivers, during such times, are also often unable to give the care and comfort they provided before the disaster. This can cause anxiety, fear, and a great sense of insecurity among children. Their worries and fears manifest themselves through a range of reactions which generally vary by age.

## Mental Health Module for Psychosocial Care Givers

### Young children (ages 0-5) Reactions/Behaviors and Suggested Interventions

Reactions/Behaviours	Possible support/interventions <sup>1</sup>	Examples of how to implement the support/interventions
Helplessness and passivity	Encourage caregivers to provide support, rest, comfort, and opportunities to play. Check if child has eaten enough.	Establish a "child friendly space" - a simple and safe demarcation of an area with a rope or stones can preserve a place for children to play.
Generalized fear	Facilitate the presence of calm, supportive adult caregivers. Identify adult caregivers if child is without specific adult caregivers. Provide, where necessary, emotional support to adult caregivers provide verbal reassurance and physical comforting; give frequent attention; plan comforting; pre bedtime activities.	"Safety hand exercise" <sup>2</sup> Ask children to draw an outline of their hand and then think of at least five people they can talk to or approach for help. Have the children draw a picture of the identified people above each of the fingers of the drawing.
Confusion (e.g., child does not understand that the immediate danger is over, and may believe that death or illness is punishment for wrongdoing)	Give repeated, concrete clarifications.	Encourage parents, teachers, or trusted adults to provide children with information about the disaster in simple, plain language. Shield children from constant, extensive media coverage of the disaster which can contribute to their confusion.
The child has difficulties identifying what is bothering him or her	Provide emotional labels for any expressed feelings (e.g., anger, sadness, etc.).	Provide art and play materials for children. Young children will often express their feelings through play and art rather than through words.

<sup>1</sup> Adapted from Pynoos (1988)/WHO MSD (in press).

<sup>2</sup> Drawn from RIOTS Manual (2002),

## Mental Health Module for Psychosocial Care Givers

Reactions/Behaviours	Possible support/interventions <sup>1</sup>	Examples of how to implement the support/interventions
Withdrawal	Verbalize common feelings and complaints children may have after disasters (e.g., say something such as "children often feel sad that their home was destroyed").	As above. Do not force children to talk but provide them with opportunities to talk if they wish to do so.
Sleep disturbances (night terrors, nightmares, fear of being alone at night)	Give the child extra time and reassurance before going to sleep. Let him or her sleep closer to parents	Plan calming activities before going to sleep such as bedtime storytelling. Choose a story that has a comforting theme.
Anxious attachment (clinging, not wanting to be away from caretakers)	Provide consistent care and (realistic) re-assurance about the whereabouts of caretakers.	Encourage families to try to spend more time together or at least establish a specific time when the family members are together during the day (e.g., during meals).
Regressive behaviours (thumb-sucking, bed-wetting, baby-talk)	Encourage caretakers to tolerate these behaviors in a time-limited manner (up to a couple of weeks).	Avoid criticizing regressive behaviours or shaming the child by calling him or her a baby.
Anxieties related to an incomplete understanding about death (compared to adults)	Provide culturally and developmentally appropriate explanations about the physical reality of death. Very young children may have incomplete concepts of death and so consistent, culturally appropriate explanations must be given that do not lead to false hopes, but provide an explanation consistent with religious beliefs.	Encourage children to participate in cultural and religious grieving rituals (when this is culturally appropriate). When children are not able to participate in community rituals, help them to find their own way to symbolically say goodbye to someone they have lost (drawing a happy memory, prayer).

## Mental Health Module for Psychosocial Care Givers

### Children (ages 6-12)

Distress levels among children will also often depend on the response and level of distress of the parents and other adults around them. To the extent possible encourage caretakers to act with strength and calmness, which will provide children with a greater sense of security.

### Children (ages 6-12) Reactions/Behaviours and Support/Interventions

Reactions/ Behaviours	Support/Interventions <sup>3</sup>	Examples of how to implement the support/intervention
Pre-occupation with their own actions during event (feeling responsible)	Offer gentle re-assurance that it is not their fault.	Provide factual information about the disaster (provide handouts if available) to assure them that it is not their fault.
Specific fears triggered by reminders of the events	Help to identify and articulate reminders and anxieties; encourage them not to generalize.	Limit children's exposure to the media which can trigger reminders.
Retelling and replaying of the event (traumatic play); cognitive distortions (unrealistic beliefs): obsessive detailing	Permit children to talk and express emotional reactions. Address distortions, and acknowledge normality of feelings and reactions.	Provide art materials and paper for children to record their stories if they wish to do so.
Impaired concentration and learning	Encourage children to let parents and teachers know when thoughts are interfering with learning.	Hold in-school sessions with entire classes, with smaller groups of students, or with individual students as appropriate to provide them with factual and reliable information about the disaster and relief efforts. Also let students know that their fears and concerns are normal reactions.
Sleep disturbances (bad dreams, fear of sleeping alone)	Support children in reporting bad dreams; provide information about why they maybe having these dreams. Explain that this is natural under the circumstances.	Do not ask a child to describe a bad dream in detail but provide comfort. See sleep disturbances in previous table.

<sup>3</sup> Adapted from Pynoos (1998) /WHO MSD (in press).

## Mental Health Module for Psychosocial Care Givers

Reactions/ Behaviours	Support/Interventions <sup>3</sup>	Examples of how to implement the support/intervention
Concerns about their own and others safety	Help children to share their worries and reassure them with realistic information.	Create a "worry box" where children can write out their worries and place them in the box. Set a time when the box will be emptied and the questions or concerns answered.
Altered and inconsistent behaviour (unusually aggressive and restless behaviour)	Help children to cope with their own impulse control by providing emotional labels for feelings (e.g., "it must be hard to feel so angry") and suggesting appropriate outlets for those feelings.	Encourage children to engage in recreational activities and physical activity as an outlet for feelings and frustrations.
Somatic complaints - headaches, stomach-aches	Have a health professional determine whether there is a medical reason for the complaints. Provide support and comfort to the child and assure him/her that often children experience such complaints. Do not focus on the somatic complaints if satisfied that there is no medical reason for them.	Physical activity or breathing techniques can help relieve stress in the body. Example of a simple breathing exercise - take a deep breath and exhale to the count of five.  Also, ensure that the child is getting enough sleep, water, and nutritious food.
Children's close monitoring of parents responses and recovery; children's hesitation to disturb parent with their own anxieties	Provide emotional support for parents. Facilitate that there is an adult caregiver available to provide the child with opportunities to talk about their feelings and worries if parents are unavailable to do so.	Recognize when parents are having emotional difficulties and organize care for them if necessary, because children's responses often are a mirror of parents' difficulties.
Children's concern for other victims and their families	Encourage children to engage in constructive activities on behalf of the injured or deceased, but do not burden the child with undue responsibility in this regard.	Help children to form a club to help with the reconstructive efforts (Hart, 2002). Identify projects that are developmentally appropriate and meaningful (e.g., clearing rubble away from schools, etc.).

## Mental Health Module for Psychosocial Care Givers

### Adolescents (ages 13 and up)

Given the importance of the peer group to adolescents their reaction tends to be influenced by the response of their peers.

### Adolescents (ages 13 and up): Reactions/Behaviours and support/interventions

Reactions/ behaviours	Possible support/interventions <sup>4</sup>	Examples of how to implement the support/interventions
Detachment, shame and guilt	Provide adolescents with the opportunity to discuss the events, their feelings, and realistic expectations of what can be done.	If possible establish a private space where one can go to an "office" for discussion with a trained counselor. Provide realistic information.
Feeling self-consciousness about their fears, sense of vulnerability, and other emotional responses. Fear of being labeled abnormal	Help them understand the adult nature of these feelings, encourage peer understanding and support.	Encourage participation in group based activities (e.g., sports teams, social groups) in order to facilitate peer social networks and support.
Engaging in risky behaviour (e.g., using drugs, sexual promiscuity).	Help them consider that such behaviour maybe an effort to numb their emotions or, possibly, to voice their anger over the event.	Limit access to drugs. Explain clearly how drugs can distort perceptions.
Sudden shifts in interpersonal relationships	Discuss the expectable strain on relationships with family and peers.	Engage parents in a discussion about parental roles in a crisis situation. Educate adolescents explaining possible parental reactions (e.g., "your parent is upset, do not take it personally."
Pre-mature, culturally inappropriate, entrance into adulthood (e.g., suddenly leaving school or suddenly getting married).	Encourage the postponement of radical decisions. Also, explore other ways that the adolescent can feel more control over his or her life.	Use posters and talks by respected individuals to suggest by example ways to be mature without taking sudden actions that may be negative.

As in adults, in children of all ages healing is a process for most children, but some may need professional help.

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<sup>4</sup> Adapted from Pynoos (1988) /WHO MSD (in press).

## **Mental Health Module for Psychosocial Care Givers**

### **Older Adults**

Apart from symptoms described under sections on Stress/Distress following symptoms might be a sign of a response in the elderly to a traumatic event.

- Reluctance to talk about unpleasant events and sensations
- Embarrassment at admitting symptoms
- Difficulty in recalling events and remembering

Older people are often not totally in control of situations. It is important to take special care of them.

- They need to be near their loved ones, who can spend time with them.
- Ensure that their physical needs including health needs are looked after properly.
- Encourage family members to consult them in all decision making and establish their daily routines like praying with congregation.
- Keep them informed of the news, developments and activities taking place related to the disaster and their family members.

## **Mental Health Module for Psychosocial Care Givers**

### **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, and 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 neighbours to share in looking after their young children

## **Mental Health Module for Psychosocial Care Givers**

### **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 caregiver 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 are acknowledged in a supportive and compassionate manner.
- Encouragement and appreciation of his/her progress is important.
- Caregiver 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.

## **Mental Health Module for Psychosocial Care Givers**

### **Care & Self Care for Rescue and Relief Workers including Health Workers**

As a result of their work, relief workers and care providers can face enormous emotional challenges

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, shame and guilt.

#### **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
- Grandiose beliefs about own importance
- Heroic but reckless behavior
- Neglecting personal safety and physical needs
- Mistrusting colleagues and supervisors
- Changed values.

#### **On the Scene: 10 Self-Care Tips**

1. Get enough sleep
2. Get enough to eat and drink (drink water, juice, soda; avoid drugs)
3. Vary your work task and limit your hours to not more than 12 hours per day
4. Try and stay in touch with your family and friends
5. Do some light exercise
6. Focus on what you did well
7. Take daily some time to think about what you learned that day
8. Do not self medicate or take drugs
9. Pray, meditate or relax
10. Develop a Support system with a coworker, supporting him/her and being supported in turn

## **Mental Health Module for Psychosocial Care Givers**

### **With other colleagues**

- Listen to each other's feelings.
- Do not take anger too personally.
- Give each other comfort and care.
- Encourage and support co-workers.
- Reach out to others when you are feeling low as well as look around and support others if they are down.
- Develop a buddy system with a co-worker. Agree to keep an eye on each other's functioning. Check for fatigue and stress symptoms. Take a break when required.

### **SEEK HELP IF**

- You find it difficult to leave your work even for a short period.
- Your sleep, appetite is disturbed.
- You are unable to enjoy things.
- You want to avoid going to work.
- You are easily irritable.
- You cry easily.

### **REMEMBER**

- The work is going to be taxing on the mind and the body.
- It is important to build support systems to take care of one's personal well being.

### **When You Return Home**

- Catch up on your rest (this may take several days).
- Slow down - get back to a normal pace in your daily life.
- You may want to talk about what you saw or you may not want to talk about it both are normal
  - Remember: other people might not be interested in hearing all about it. Use caution in discussing with children
- Expect disappointment, frustration, and conflict
  - Daily life might seem unimportant or petty.
- Don't be surprised if you experience mood swings; they will diminish with time.
- If you don't want to talk, use other forms of expression or stress relief
  - Journal writing, hobbies, exercise, sports
  - Meditation, yoga, spiritual/religious activity

**DISASTER AFFECTS EVERYONE.**

**YOU CAN MAKE A DIFFERENCE TO REBUILD THE COMMUNITY.**

## **Mental Health Module for Psychosocial Care Givers**

### **MODULE 4: IDENTIFICATION, MANAGEMENT AND REFERRAL OF MENTAL DISORDERS**

#### **Session Aims**

On completion of the session trainees will:

Able to Identify, manage 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 and in an interactive manner explain the manifestations, management and referral guidelines for each of the disorders.
- Feedback, and question answer session follows.

## Mental Health Module for Psychosocial Care Givers

### 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. **REALISTIC FEAR SHOULD NOT BE DIAGNOSED AS A DISORDER.**

#### **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, fast or pounding heart, dry mouth, stomach pains, or chest pains)
- 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)
- Physical tension (e.g. restlessness, headaches, tremors, or an inability to relax).

## **Mental Health Module for Psychosocial Care Givers**

### **Management**

#### ***Psychosocial Management:***

- Encourage the patient to use relaxation methods daily to reduce physical symptoms of tension. (see module II)
- Advise avoidance of drugs 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.

## Mental Health Module for Psychosocial Care Givers

### Medication:

- Medication is a secondary treatment in the management of anxiety disorder.
- It may be used, however, if significant anxiety symptoms persists despite the measures suggested above.
- Benzodiazepines like diazepam 10 mg twice daily may be used for no longer than *two weeks*. Longer-term use may likely lead to dependence, and is likely to result in the return of symptoms when discontinued.
- Antidepressant drugs, for example Amitrytline or Fluoxetine, may be helpful. They do not lead to dependence or rebound symptoms, but can lead to withdrawal symptoms and so should be tapered gradually. (see section on Depression for guidelines on use of anti depressant medicines)
- Beta-blockers may help control physical symptoms such as tremor.

## Mental Health Module for Psychosocial Care Givers

### POST-TRAUMATIC STRESS DISORDER

#### Identification:

Post-traumatic stress disorder (PTSD) is characterised by the development of a **protracted response following a traumatic or catastrophic event like the recent earthquake.**

#### Diagnostic Criteria:

1. The individual has experienced an extremely traumatic event as the recent earthquake with human and material losses. And response includes intense fear, helplessness for horror.
2. The individual experiences repetitive and intrusive memories, daytime images and dreams of the traumatic event. Flashback (not simply remembering) and physiological reactivity to reminders.
3. The individual avoids cues associated with the traumatic event like shaking of the bed or table. Inability to recall important aspects of the traumatic event.
4. A. The individual does not have full memory recall of the traumatic event,  
OR  
B. The individual experiences increased psychological sensitivity and arousal indicated by at least 2 of the following:
  - sleep disturbance;
  - irritability or anger;
  - difficulty concentrating;
  - hypervigilance or being easily startled.

Substance abuse is commonly associated with this condition and there are difficulties in carrying out tasks of daily living. e.g.; the individual doesn't take part in rescue or relief work, just deeply thinking about something.

## **Mental Health Module for Psychosocial Care Givers**

### **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 no or minimal intervention.
- For those who continue to experience symptoms, effective treatments are available.
- 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".

## **Mental Health Module for Psychosocial Care Givers**

### **Medication**

- In cases of severe PTSD (usually co-occurring with depression), antidepressant medication, including tricyclics (Amitryptaline) and SSRIs (Fluoxetine) may be useful for the treatment of intrusion and avoidance symptoms (see section on Depressive Illness for use of the medicines). There may be a latent period of three weeks or more before the effects are seen.
- Arousal /Startle symptoms may be helped by beta-blockers.

## Mental Health Module for Psychosocial Care Givers

### DEPRESSIVE ILLNESS

#### Identification:

Depression is a mood state that is characterised 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, and duration*

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
- diurnal mood variation
- poor concentration
- suicidal thoughts or acts
- loss of self confidence
- fatigue or loss of energy
- agitation or slowing of movement or speech
- crying spells.

## Mental Health Module for Psychosocial Care Givers

### 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 (e.g. 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)
- 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 may have side effects but 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 (e.g. 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.

#### **Medication**

There are several antidepressant medications like:

Tricyclics (Amitryptaline )

SSRI (Fluoxetine)

#### Guideline: Treatment of Depression with Amitryptaline

Step 1: The initial dose of Amitryptaline is 50 or 75 mg/day in two divided doses.

Step 2: After one week, give 50 mg in the morning and 100 mg at night, or give 150 mg at night.

Step 3: Switch to Fluoxetine if:

- Amitryptaline did not work after 6 weeks;
- The patient has cardiac disease (e.g., irregular heartbeat or a murmur), epilepsy, or an enlarged prostate or
- The patient is older than 65 years. Side effects of Amitryptaline include:
  - tiredness

## Mental Health Module for Psychosocial Care Givers

### Guideline: Treatment of Depression with Amitryptaline

- dry mouth
- dizziness when the person changes position from lying or sitting to standing, s/he will feel dizzy due to a drop in blood pressure
- constipation
- blurring of vision

### Guideline: Treatment of Depression with Fluoxetine

Step 1: Give Fluoxetine capsules 20 mg/day. In case of sleep problems, add benzodiazepine for a period of 2 weeks (diazepam 5 mg/day maximum for 2 weeks).

Step 2: If the dose in step 1 does not work after four to six weeks consider referral

Side effects of Fluoxetine include:

- nausea
- loss of appetite
- diarrhea
- headache
- sleep problems

#### ***Explain to the patient that:***

- The medication must be taken every day
- Antidepressant medication is not addictive
- Improvement will build up over two to three weeks after starting the medication; mild side effects may occur but usually fade in seven to 10 days.
- Stress that the patient should consult the doctor before stopping the medication. All antidepressants should be withdrawn slowly, preferably over four weeks in weekly decrements.
- Continue full-dose antidepressant medication for at least four to six months after the condition improves to prevent relapse.
- Review regularly during this time.

***If sleep problems are very severe consider the use of diazepam 10 mg at night in the short term — no longer than two weeks — in addition to an antidepressant.***

### 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.

#### Management

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

*Provide an explanation and education about the disorder*

Let the woman know what is happening to her. It is often the 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.*"

*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.

**The Rest of the Treatment is same as discussed above under Depressive illness**

## Mental Health Module for Psychosocial Care Givers

### PSYCHOSIS

#### Identification:

Psychosis is a 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 more likely to occur after childbirth in women, in young adults abusing drugs (e.g. Cannabis, Amphetamines), and after sudden stress

#### Diagnostic Criteria:

- Delusions (Odd, false beliefs which are not shakable 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 talk.

## **Mental Health Module for Psychosocial Care Givers**

### **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
  - ensure that the patient's basic needs (e.g. 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.
- Advise patients and family about the importance of social support and of remaining part of society (through work and/or participation in community activities)
- Continued treatment may be needed for several months after symptoms resolve.

## Mental Health Module for Psychosocial Care Givers

### *Medication:*

For **ACUTE PSYCHOSIS**, i.e. psychotic symptoms of recent onset, give Haloperidol 5-15 mg/day oral or 1/M. Duration usually up to 3 months

For **CHRONIC or RECURRENT** psychotic symptoms,

Give Fluphenazine deconate 25-100mg fortnightly/Monthly 1/M. Duration usually a year or longer.

For **SIDE EFFECTS** like Parkinsonian features give Procyclidine 15 mg/day oral

ENSURE to:

- a. Involve family members, in treatment.
- b. Explain side effects like Parkinsonian features, dystonia, Akithesia, dryness of mouth, blurring of vision, orthostatic hypotension.
- c. Review frequently.
- d. Withdraw medicines gradually.
- e. Patient is not taking illicit drugs e.g. Charas.

## **Mental Health Module for Psychosocial Care Givers**

### **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), they will have 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 and psychotherapy, the woman will completely recover.

**FOR PSYCHOSOCIAL MEASURES SEE SECTION ON POST PARTUM  
DEPRESSION**

## Mental Health Module for Psychosocial Care Givers

### SUBSTANCE MISUSE DISORDERS — A disorder of repeated consumption of legal or 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. 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).
- Habitual drug use.
- Difficulty controlling drug use in terms of quantity and frequency of drug use.
- Strong desire to use drugs despite being aware of and experiencing the harmful consequences 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).

## Mental Health Module for Psychosocial Care Givers

### Management:

#### *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 (e.g. anaemia, chest problems) and nutritional deficiencies
- Consider options for problem solving, or targeted counseling, 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 (e.g. 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 (e.g. social situations or stressful events).
- Make specific plans to avoid drug use (e.g. how to respond to friends who still use drugs).
- Identify family or friends who will support stopping drug-use.
- 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 (e.g. use condoms, and do not share needles, syringes, spoons, water or any other injecting equipment).

## Mental Health Module for Psychosocial Care Givers

### 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 faeces
- Amnesia (inability to remember the event)
- Post fit confusion

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

## Mental Health Module for Psychosocial Care Givers

### Management:

#### *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 and live a normal life.
- Epilepsy is treatable and can be controlled effectively with regular medication.

##### *Essential information for patient and carer*

- Epilepsy can be treated successfully
- 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
- Disease is not contagious

## Mental Health Module for Psychosocial Care Givers

### **Medication:**

*Medicines should not be used in combination and dose should be gradually built up according to the response.*

Carbamazepine: dose not to exceed 1200 mg daily in divided doses. Side effect: drowsiness, dizziness, ataxia, blood dyscrasias.

Valproate: dose- 250-1500mg daily. Side effect- drowsiness, weight gain, Gastrointestinal upsets and hepatotoxicity .

### ***Status epilepticus:***

1. monitor pulse,
  - respiration
  - blood pressure.
2. Prevent aspiration, maintain clear airway.
3. Diazepam iv (very slowly, 1mg/min)
  - Children under 5 years: up to 5 mg
  - Children 5 to 10 years: 10 mg
  - Older children: 15 mg
  - Adults: 20 mg

## **Mental Health Module for Psychosocial Care Givers**

### **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 emphasizing 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. Emphasize 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.
- Advise the family to take relevant information with them to the psychiatrist/psychologist appointment (e.g. medical reports).
- Let the patient/family know that they are always welcome to come back

## Mental Health Module for Psychosocial Care Givers

### Criteria for Referral to Specialist Services at District Level

#### Depressive illness:

- Depression which does not respond to 4-6 weeks treatment with proper dosage of antidepressants and proper compliance is there.
- Persons talking about attempting Suicide or has recently attempted suicide.

#### Psychosis:

- psychosis associated with violence towards others
- Patient is a danger to himself, e.g. not eating, sleeping, constantly roaming about and not being controllable, persistently excited or Suicidal.
- psychosis complicated by substance abuse, or Physical illnesses Like fever, Diabetes, hypertension etc
- psychosis which does not respond to 2 weeks treatment with antipsychotics in adequate dosage.

#### Epilepsy:

- Fits not controlled in 6 weeks with adequate dose of antiepileptic medication and proper compliance.
- History of recent head injury, with memory impairments  
Epilepsy complicated by substance abuse, or Physical illnesses Like fever, Diabetes, hypertension etc
- Status Epilepticus

#### Substance Misuse disorders:

- Evidence of Physical complications like Frequent chest infections, Cardiac, liver or Kidney functions impairment and Psychological Complications like development of Psychosis and epileptic fits
- Patient is a danger to himself, e.g. not eating, sleeping, constantly roaming about and not being controllable, persistently excited or Suicidal.

#### Anxiety and stress related disorders:

- Patient experiencing persistent anxiety symptoms for more than six months despite the interventions mentioned in the manual and there remains marked functional disability.