



Psychosocial Support to Wenchuan Earthquake Survivors Project Core Information Cards

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Project of Psychosocial Support to
Survivors of the Wenchuan
Earthquake
Core Information Card 1
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An Introduction to China MOH/UNFPA's Project of Psychosocial Support to Survivors of the Wenchuan Earthquake An Introduction to China MOH/ UNFPA's Psychosocial Support to Wenchuan Earthquake Survivors Project



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The China Ministry of Health (MOH) and United Nations Population Fund's (UNFPA) Project of Psychosocial Support to Survivors of the Wenchuan Earthquake lasted for one year from the 1st of January till the 31st of December, 2009.

With financial support from the Government of Finland, the project was managed by the UNFPA and implemented by the MOH/Peking University Institute of Mental Health (PKUIMH), the All China Women's Federation (ACWF) and the China National Committee on Ageing (CNCA).

As a part of the Project, core information cards were developed through a series of community trainings and were pre-tested by a team of national experts. The end-users of the core information cards are trained community and village managers working in health, the Women's Federation, civil affairs, ageing and other areas.

The core information cards cover eight areas including:

- i) An overview of communication skills specifically for youth, women, and the elderly,
- ii) Cognition and treatment of common psychological problems,
- iii) Psychological counseling and intervention skills,
- iv) Post-disaster and public health education
- v) Self-protection strategies for those assisting in post-disaster situations,
- vi) Responsible and safe sexual behaviors for young people,
- vii) Interventions against gender based violence.

Natural disasters cause significant psychological and social suffering to affected populations. The Wenchuan earthquake on the 12th of May, 2008 affected approximately 46 million people.

In response to the Government of China's request for assistance following the earthquake, the UNFPA's initial response was to provide support to national counterparts in a multitude of areas including the provision of emergency reproductive health kits to those in affected areas and the distribution of personal hygiene kits to women. In the subsequent three months, UNFPA focused its efforts on capacity building in the areas of reproductive health and psychosocial support through a series of trainings with national partners. In October 2008, UNFPA, in collaboration with the World Health Organization (WHO) and national partners including China's MOH and the CNCA, organized two training workshops on psychosocial support and mental health in Beijing and Sichuan.

This Project was the first time that the UNFPA had responded to an emergency crisis in China by providing both reproductive health and psychosocial support. Global experience in emergencies has shown that psychosocial support is critical for the long-term recovery of communities, and as such protecting and improving people's mental health and psychosocial well-being has become a priority in such emergencies.

In 2009, through a timely donation from the Government of Finland and in line with the State Council's September 2008 circulation on the 'Overall Planning for Post-Wenchuan Earthquake Restoration and Reconstruction', the UNFPA maintained close partnerships with the MOH/PKUIMH, the ACWF and the CNCA to facilitate the provision of psychosocial support to earthquake survivors. Vulnerable groups such as the elderly, women and youths were a specific focus of the project. The project was conducted in six counties of Sichuan province - Beichuan, An, Shi Fang, Qing Chuan, Mian Zhu and Du Jiang Yan counties. The scope of the project included: i) joint community training in sectoral clusters; ii) provision of psychosocial support to vulnerable groups in a sectoral cluster approach; iii) identification, management and referral of common mental disorders; and, iv) joint assessment of mental health and psychosocial issues. As a demonstration project, this Project endeavored, through community mobilization to formulate an inter-agency psychosocial support network.

the information
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United Nations Population Fund
China Ministry of health

Source: United Nations Population Fund, China Ministry of health

Self-Protection Strategies for those Assisting in Post- disaster Situations



Helpers:

Those assisting in recovery efforts after the earthquake (i.e. emergency workers etc.). This population is also at high risk of suffering from psychological trauma.

People who assist in relief efforts following earthquakes and other such mass disasters may witness tragic and horrific events which can lead to shock. In addition, the combination of insufficient resources and difficulties during disaster relief, and the intense emotional burden encompassing grief, sympathy, and empathy with other survivors, can result in physiological and psychological reactions. One such reaction is a state of psychological exhaustion resulting from excessive consumption of emotional and mental energy over an extended period of time. The predominant syndrome of psychological exhaustion is extreme mental, physical and emotional fatigue which can manifest through symptoms including: an aversion to

work, anxiety, depression, loss of sympathy and a feeling of inferiority. In order to better help the victims of the disasters, relief workers must be aware of their own psychological status and be equipped with certain skills and knowledge which will enable them to protect their own mental and physical health.

Self-evaluation Scale for Relief workers with Psychological Discomfort

- Extreme fatigue, lack of rest and sleep, resulting in physical discomfort (such as nightmares, dizziness, difficult or laboured breathing, gastrointestinal discomfort, etc.)
- An inability to concentrate and/or memory loss
- Feeling numb or unable to feel emotion in daily life
- Worry and fear that you may break down or exhibit a lack of self-control
- Feelings of sadness, exhaustion, or even anger and rage at the limitations of the relief work
- Feeling unduly sad and depressed for the painful experience of the victims
- Thinking that you are not doing the relief work well, leading to feelings of guilt and remorse towards the victims
- Increased consumption, or reliance on alcohol, tobacco or prescription medicines.

**Do not forget to take care
of yourself while helping
others!**

Solutions

1. Self-isolation techniques

We all know that vehicles cannot drive continuously without stopping to refuel. Isolation strategies are like gas-stations in that they allow relief workers breaks where they can recharge and refuel from their stressful work. Relief workers should ensure that they do not use all of their time and energy focusing on helping others, but also reserve time for their own mental and physical health.

A. General methods of isolation

- Arranging work schedules into shifts, with mandatory rest breaks if possible
- Ensuring that relief workers take regular rests and leave the workplace when doing so. Also while working, relief workers should not spend all of their time working together with those who have been rescued
- Separating rest areas from the rescued people as much as possible
- Ensuring that workers maintain contact with their own family and friends
- Encouraging participation in appropriate relaxation and entertainment activities
- It is important for relief workers to remember that when they are listening to and empathizing with what happened to the affected people, they should not forget that they are a rescuer and not the same as the people who were rescued.

B. Special Isolation Techniques

This is an imaginary exercise with which you can temporarily "pack away" unpleasant emotions and feelings by following these instructions:

1. Firstly, find a comfortable position and close your eyes; imaging that there is a safe or box in front of you, which is impregnable,
2. Now open the safe and put inside all the things that are causing you to feel stressed and pressured such as sensory and physical discomforts, thoughts and sounds that repeatedly discomfort or entangling you, bad smells, tastes and sights,
3. Now lock the door of the safe and put it in a place of your choice where it is not too close but still within your reach.
4. Now, has the burden been lifted? Enjoy the sense of relaxation.

2. Relaxation Technique

This exercise can help you to temporarily break away from noisy and stressful surroundings. Firstly select a comfortable position, close your eyes or look up or at a comfortable place around you. Now picture a place or scene that has made you feel relaxed, warm and happy before. Recall with whom you were at that time, and once again allow yourself to experience the good feelings you had then.



3. Team Support

Another strategy is to organize a group sharing session after a work-shift or rescue effort. This can allow team members to talk spontaneously about their experiences in the disaster. You should allow at least 30-45 minutes for each session, following the format below.

- Team members should greet each other and talk about the results achieved in their work. They should listen to each other's experiences and offer encouragement and praise to their peers for their hard work and the good job that they are doing.
- They should discuss "what is the worst part" of the tasks that they have each been involved in, allowing catharsis and sharing of feelings. It is important to ensure that no rescue team members are criticized for how they feel or how their work has been performed.
- The aim of the group is to offer support and comfort to members who are suffering from psychological stress and to assure them that their reaction is normal and can happen to anyone. Supportive gestures such as patting each other on the back or hugging are also an appropriate way of supporting those who are suffering from mental anguish and stress.
- The team leader should affirm the efforts in the rescue work of all of the relief workers and stress that their contribution is very valuable. Presenting relief workers with a small present or souvenir may make them feel appreciated.
- When members leave the team for various reasons, they could exchange photos and contact information so that they may keep in touch in the future. Another good idea is to give members who are leaving a memorial card or photo and to write on the back of it some of the specific achievements or contributions of the team member.

4. Self-decompression

Self-decompression means to remove pressure/stress from yourself. The following techniques and strategies are helpful in doing so:

- Using positive "self-dialogue". For example, you can say positive affirmations such as "I'm pretty good", "I am doing a good job", or "I am achieving good results" as a means of assuring yourself of your own achievements.
- Self-protection is an innate human mechanism that should have been learned when you burnt your finger or hurt yourself in the past. Try to avoid excessive self-criticism and eliminate guilt by telling yourself that "I have worked hard and done my best" and "No man is omnipotent".
- Stay with a trusted colleague and pay attention to each other's function, fatigue levels and stress symptoms. When necessary, remind each other that a break is needed.
- At the end of a day's work, spend a few minutes talking with colleagues about your thoughts and feelings of the day so as to prevent a bad mood that night.
- It is beneficial to participate in group sharing sessions or workers' support groups on a regular basis to talk about the emotional impact of your work on yourself and your colleagues. Learning some stress management exercises or attending a course is also a good idea.
- Ensure that you get adequate sleep and learn some relaxation techniques to help fall asleep if needed.
- Eat as regularly as possible and drink enough water. Avoid consuming too much sugar, fat, tea, coffee and alcohol. Try not to increase the amount you smoke.
- Limit work to 12 hour shifts and take a rest every four hours unless in special circumstances. When you are sick or unwell do not force yourself to continue working.
- If you feel that the pressure is becoming suffocating or making it hard to breathe, a good exercise which will gently stretch and release tension from the muscles associated with breathing is to take a deep breath and to hold it for as long as you can and then allow the breath to be forcibly exhaled.
- When conditions permit, make a conscious effort to treat yourself. For example, taking a shower, having a good meal and enjoying leisure activities can help you to lift the emotional and physical burden of your work. Also try to find and nourish some activities which will support your mental and physical health such as having quiet time alone, reading a good book, listening to beautiful music, playing chess with friends and doing some form of physical exercise.
- Put pictures of your loved ones close-by when you are away from home. Keep in close contact with your family and keep them updated on your safety and whereabouts so that they can also support you. When you have the chance, return home and spend time with your friends and family. Try to make new friends who are working or living in the disaster zone with you. Do activities that normally make you feel relaxed. Record your experiences in a diary or by video.

Sources:

"Theory and Practice of Psychotherapy"
"Disaster: From occurrence to recovery -
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Overview and Summary of Communication Skills



The basic skills of clinical communication are:

- Observation, listening, questioning
- Affirmation and clarification
- Non-verbal communication

Comprehensive skills of clinical communication include:

- Discussing the diagnosis with patients and their families, encouraging them to accept treatment and communicating with them on their prognosis
- Treating and talking with the patient and patient's family differently
- Communicating bad news with patients and their families

Basic skills

Observation

1. The principles of observation

- A. Observation with reflection – collection of information via observation as well as through the consideration and analysis of observed behaviours, actions, symptoms or speech
- B. Responsive observation – giving appropriate verbal and non-verbal responses to the observed information to ensure effective communication
- C. Observing through conversation – giving feedback and making adjustments
- D. Observation combined with listening – carefully watching what is done and said

2. The contents of observation

- A. Expression, attitude, action
- B. Gait, posture, clothing
- C. Mode of talk and contact
- D. Methods of response
- E. General state and consciousness

Listening

1. The principle of listening - listen carefully with the heart and head and not just with your ears

- A. Listening with reflection- considering implications of actions and looking for clues or things that may reveal other symptoms
- B. Listening with observation – considering the speaker's emotion and any other psychological and social factors which may be of importance
- C. Combining the findings with the visual observations

2. The contents of listening

- A. Tone
- B. Intonation
- C. The actual contents of the conversation

Questions and answers

The role of asking questions is to clarify issues, to guide and control the conversation, to exchange thoughts and to give feedback. Some points to remember when asking questions are:

1. Questions can be used to control the conversation through the asking of ordered questions or through asking questions after conclusions have been made
2. It can be useful to combine open-ended and closed questions
3. Questions should have a strong focus and a clear meaning
4. Only one question should be asked at a time.
5. Instead of asking "why?" it is better to ask more questions that ask about concrete details such as "where?", "who", "when".

Communication process

The communication process includes three stages, the introduction/beginning, in-depth questions in the middle of the interview, and the conclusion/ending

The initial stage of communication

1.Objectives:

- A. Establishing trust in the relationship
- B. Looking for and gathering clues which may help to determine symptoms
- C. Deciding the way in which to conduct the interview (i.e. style of speech etc)
- D. Dealing with the emotion of topics of conversation

2.The main techniques which are utilized

- A. Observation
- B. Listening

3.Specific strategies

- A. Doctors should prepare themselves psychologically and make an appropriate space/environment available
- B. When the doctor meets the patient they should shake their hand and start the conversation by introducing themselves and preparing the seating arrangements. They should also observe the patient while doing this.
- C. Based on their observed findings, the doctor should then determine the best way in which to start the communications including beginning with:
 - Greetings and general questions, e.g. about everyday life
 - Discussion about the patient's current environment or situation
 - Discussion about the patient's chief complaints and pressing concerns
 - Discussing the patient's daily functions such as sleep, eating status etc.
 - Other conversation starters
- D. Doctors should attempt to deal with emotional problems that they observed at all times through-out the consultation
- E. A doctor should observe the patient's personality, characteristics, communication style, emotional and behavioral impulses and background in order to decide on the best way in which to facilitate continuous and open conversation.

F. Doctors should deal with the earthquake survivors with feeling and emotional sensitivity.

G. Doctors should attempt to find verbal, physical and behavioural clues that will alert them to the patient's symptoms and lead to more in-depth conversation.

Second, in-depth phase of communication

1.Objectives:

- A. To clarify and verify the problem
- B. To approach the conclusion
- C. To continue to build relationships

2.The main techniques utilized

- A. Observation - listening - response
- B. Asking question – asking for clarification – providing feedback

3.Specific strategies

- A. Control - guidance
- B. Define core clinical problems accurately
- C. Decide the way in which to continue the conversation

Third, the final stage of communication

1.Objectives:

- A. To summarize and verify the problems
- B. To provide necessary explanations and encouragement for facilitating future communications

2.The main techniques utilized

- A. Summary and conclusion
- B. Control
- C. Guidance techniques

3.Specific strategies

- A. Symbolic questions: "Do you have anything to say?"
- B. Arrange the next meeting when making conclusions.
- C. "Method of time limit"
- D. Giving the patient assignments and offering them encouragement at all times.

Communication Skills with Adolescents

Characteristics of Adolescents

- Immaturity
- Lack of ability to protect and support themselves
- Lack of effective problem-solving methods and resources
- Lack of competence in autonomy and independence
- Unable or unwilling to directly express their emotions and needs
- Their emotions and needs can easily be overlooked

How to better communicate with adolescents

1. Building a warm, trusting, understanding and respectful relationship with adolescents and deciding upon appropriate treatment objectives using the following strategies:
 - Saying hello to the young people first when they come with their parents
 - Allowing the young people to talk about their motivation for coming to the consultation (i.e. their ideas about changing themselves, their home and school)
 - Patiently treating a variety of negative emotions in young people and attempting to understand the causes, and express a desire to help them
 - Not forcing the young people to talk when they are nervous or not willing to talk, and allowing them to say when they want to talk
2. Understanding and eliminating the sense of shame and fear from young people's families when they receive psychological help. The support for young people can be increased with attention to the following points:
 - Concern about the worries of parents, as well as their aspirations and goals of treatment for their children
 - Understanding the various negative emotions and concerns of the parents when they see doctors
 - Limiting parents negative evaluation of young people and encouraging them to comment and support their children in a positive fashion.
3. Determining who to interview and in which sequences - recommendations and the principle of flexibility
 - Arrange an individual interviews with the young person and their parents separately and then conduct a group discussion with the whole family
 - Interview the young person first, then their parents, and then everyone together, but allowing the young person to choose the conversation topics
 - Structuring interviews and sessions as described above will not only assist parents to understand their children but will also maintain a young person's privacy
4. Give supportive feedback at the end of the conversation to facilitate:
 - Understanding of the adolescent's emotions, thoughts and behavior, and their difficulties
 - Giving optimistic and positive recommendations in line with the issues to be resolved.

The principles of communicating with young people

- Sincerely express concern for the youth, and show regard for him/her as a human being, making him/her feel liked and that they are being taken seriously and respected
- Respect the wishes and concerns of the young people's families
- Conversations with young people should be conducted in an objective, clear, explicit and direct way
- Use communication methods suitable for young people
- Help young people to gradually build their capacity to make their own decisions
- Protect young people's right to privacy, except when they are taking undue risks, or self-harming actions

Communication and management steps for adolescents attending psychosocial or counseling clinics:

- Let the young person know the reasons for attending the counseling clinics
- Understand the reasons for the initial diagnosis
- Focus on the young person's difficulties or problems rather than focusing on the diagnosis
- Take into account the young person's desire to contribute to their own treatment plan, and also consult their parents.

Adolescent mental health emergencies - Identification of risk factors

1. The first priority should be to ensure the physical health and safety of the adolescent
2. Next, rapidly assess the nature of the problem and define first-aid measures including:
 - Whether to contact a Pediatrician to give treatment
 - Whether to contact a Psychiatrist to give treatment
 - Whether there is a need to refer the young person to hospital for observation to prevent suicide or self-harm etc.
 - Whether the young person presents a risk of running away from home, and if so, what restrictions should be taken
 - Whether there is the possibility of the young person being mistreated, and if so, what protective measures should be provided
3. Thirdly, conduct a comprehensive psychiatric examination including:
 - The current issue
 - Present discomfort and predisposing factors
 - Family history, family stressors and response
 - Developmental and growth history
 - Past history of disease and similar problems
 - While interviewing the youth and their family, make detailed observations
4. Physical examination

Especially when young people have been abused or abuse is suspected or when they exhibit behaviours or there is suspicion that they are involved in substance abuse, suicide attempts or sudden behaviour changes
5. Take into account different sources of information related to the young person including:
 - History of medical treatment
 - The information provided by family members
 - The information provided by teachers

Common psychological problems or disorders in adolescent psychiatric emergencies

1. Suicide or self-harm

A. signs:

 - Complaining that they feel like they are dying or they wish to die
 - Reveal the idea of "wanting to leave the world" verbally
 - Making preparations for the end of their life such as preparations for their funeral
 - A sudden light-hearted change of emotions

B. Strategies to help:

 - Ask the adolescent directly if they are depressed and have thoughts of committing suicide
 - Present solutions to suicide-related problems
 - Help the adolescent find positive and optimistic resources in their daily life that will offer them support if they experience extreme or sudden changes in their family, negative life events or the negative attitudes of others
 - Family members can stay with young people to avoid them being left alone
 - Refer youth who are at risk of suicide to a Psychiatrist for further treatment
2. Aggressive behavior

A. signs:

 - Aggressive behavior in the past
 - Tension
 - Threatening speech and actions

B. Strategies to help:

 - Remove environmental stimuli and maintain a calm and firm manner so that the young person calms down
 - Listen to the young person's ideas and be aware of their emotional changes
 - Avoid threatening or blaming them, and help young people to control their emotions
 - Protect the safety of the youth and others
 - Refer them to a Psychiatrist
3. Sexual abuse

A. Signs:

 - Suspicious physical signs such as bruises and abrasions
 - Depression, withdrawal from interaction with others including those they are close/familiar with
 - Agitated or short tempered
 - Avoidance of a person or situation
 - Obvious changes in their attitude to and interest in sex
 - Suicidal thoughts or behaviours

B. Strategies to help young victims:

 - Encourage the discussion of matters related to sexual abuse
 - Reaffirm the adolescent's value and integrity as a human being
 - Immediately contact the relevant departments to prevent them from further injury
 - Arrange for a medical and psychological examination
4. Anorexia Nervosa

A. Signs:

 - Weight loss in the range of 25-30% of their initial body weight
 - Acts of vomiting, binge-eating or excessive exercise
 - Amenorrhea (cessation of menstrual periods) in girls
 - Chest pain, arrhythmia (irregular heart beats) and other physical discomfort

B. Strategies to help:

 - Refer the adolescent for hospitalization for the length of time required to improve their physical health condition
 - Contact a Psychiatrist to provide further treatment
5. Refusal to go to school: young people can refuse to go to school because of psychological problems or disorders which will be aggravated if there is no timely assistance.

A. Strategies to help

 - Determine the time of onset, predisposing factors and possible psychiatric diagnoses
 - Refer to a Psychiatrist for treatment
 - Ensure the young person and their family receives timely help to return to school as soon as possible because it is conducive to their healthy growth
 - Cooperate with the family and the school to make a detailed plan to urge the youth to attend school

Communication Skills with Women and Men

Principles for effective communication with women

1. Respect and trust is centered on:

- Acceptance of women and recognition and respect for women with diverse and unique life experiences.
- Acceptance and respect for women to express different views and opinions.
- A. Encourage women to express themselves and their ideas, for example, by asking them, "What do you think?", "What do you want to say?"
- B. Try to understand things from a women's point of view and try to use a variety of methods to encourage them to express themselves. For example, allow women to take photographs as a way of expressing their views and life experiences through the camera.
- C. Encourage women's participation in the decision-making of their community and home affairs through:
 - Regard the experience of women as a resource, share their knowledge and experience with others in an equitable manner and learn from them.
 - Women have means and experiences to solve their own problems
 - Address and appreciate the common experience of women, and establish mutual support between them.

2. Avoid the negative impacts of certain social stereotypes of women

- Do not use the same standards to judge men and women;
- Do not explain women's emotions and behaviour as a factor of their biological characteristics.
- To avoid negative impressions of women, people should attempt to view situations from a woman's point of view.

3. Build women's capacity and improve their ability to solve problems

- Uncover women's strengths and potential – from what perspectives could they be used to their advantage?
- Utilize women's resources to solve problems
- Encouraging help-seeking when required

4. Women-centered/oriented approaches

- A. When providing psychological support, service providers together with women can help women to reflect on their own status as a vulnerable social group through the use of social gender and culture analysis. This will assist women to see the emergence of the problem that is not their fault and thus remove self-blame.
- B. The services should meet the needs of women, such as arranging female gynecologists who can provide women's physical check-ups, and by increasing the number of female doctors in the rescue team.
- C. Promote measures to enable women's equal access to health care resources: women are often the care-givers for other family members which can make it difficult for them to find time to attend health services.
- D. When distributing food and nutrition in disaster-affected areas, special attention should be given to prioritize females as they often take the primary responsibility for the health and nutrition of their children and other family members.
- E. Women's family decisions, especially regarding pregnancy and birth control should be respected, as should her other decision-making powers. It should be noted however, that women may define family issues and responsibilities as personal issues. Community services should be provided to counter-act oppression of women and gender inequality.
- F. Awareness of women's participation in various activities should be increased and education regarding gender equality should be provided to both men and women.

Post-disaster supportive counseling for women

Supportive psychological counseling for women can occur at the following different stages:

A. Pre-disaster preparedness

- To enable women to participate in disaster mitigation and the preparedness process and to master corresponding skills to reduce the anxiety of the disaster.
- To enable women to maintain a healthy body and to learn methods of self health care
- To enable women to maintain and improve their mental health status.
- Remembering that women's health is the guarantee of family stability and community development.

B. After the a disaster occurs

- Determine the mental health status of various groups through individual cases, group work and community work, etc. Crises should be responded to immediately.
- Focus on maintaining long-term psychological care and support for specific high-risk groups, such as bereaved families, aged women, widows and orphans.
- In addition to women, men's psychological status also needs attention because men's mental health status can affect family and marital relations.

C. Post-disaster reconstruction

- Promoting women's employment, including participation in the social reconstruction which will also assist them to access economic income and a certain social status.
- The reconstruction of relationships: these include establishing relationships between women and the family, women and the community, women and society.
- Disasters can to some extent provide opportunities for role-remodeling: through encouraging women to actively participate in disaster relief and post-disaster reconstruction, this can present an opportunity for them to change their original stereotyped role. This will also enable them to develop new skills, enter the job market, and also minimize women's dependence on men.

Communication skills with women

1. The use of symbols to communicate

- A. The use of linguistic cues: the staff should strive to speak in a clear, accurate, appropriate and easily understood manner when communicating with clients
- B. The use of physical cues: staff can add to the meaning of what they are saying verbally by using body language and non-verbal cues such as facial expressions, body posture, gestures and their appearance to make their meaning more clear
- C. The use of environmental symbols: during conversation elements such as the sense of timing, the appropriate moment to start talking, the environment where the conversation takes place, physical distance during the conversation, etc. should be considered.

2. The specific communication skills

- A. Good at listening: Helpers must try to be good at listening to women, not only listening to what a woman says, but also trying to understand her needs and feelings which she has not communicated through words.
- B. Good at responding: Let a woman know that you understand her. Communication is a two-way process whereby you must not only listen, but should also express and re-iterate what you have heard which will enable a woman to feel that you understand and respect them.
- C. Good at clarifying: To avoid misunderstandings during communication it is important to use clarification techniques. Clarification techniques should target statements that the client made which were unclear or contradictory. Staff should attempt to assist the client in filling in gaps in information and in resolving any contradictions.
The objective is to reduce any unclear or uncertain behaviours and thoughts that they client has so that the conversation is more precise. You could seek clarification by asking, "You mean.....?" "What did you mean in the conversation a moment ago?"
- D. Good at accepting: Learn to accept others beyond your own understanding and show respect and understanding for the client regardless of who she is. Provide a safe, comfortable and open environment for female clients so that they understand that they can be frank in revealing their weaknesses, failures and discomfort, without hesitation and embarrassment.
- E. Expressing sincerity: Helpers that are very open, frank and willing to share their own personal experiences will build a clients trust. Sincerity is also a key to building trust in relationships.

Communication Skills with the Elderly

Make an effort to provide a suitable environment for the elderly taking into account their requirements due to their physiological aging and limited capacity for physical exercise. An ideal environment for the elderly should focus on the following:

- The living environment should be relatively fixed for the elderly
- Outdoor space where the elderly can perform activities should be relatively convenient
- Elderly people should not be restricted from socializing with other age groups and peoples.

- Respect is the most important feature when communicating with the elderly
- Language expression should be appropriate
- Enthusiasm and sincerity are essential
- Acceptance and patience are also very important elements

- Show respect for personality differences among the elderly
- Adopt different communication methods according to each elderly person's personality traits

- Show respect for the habits of the elderly
- Show respect for different ethnic groups' customs
- Show respect for different regional cultures

Adopting a progressive approach to effective communication

1. The image of staff and self-introduction

- Staff should be well dressed in a respectful manner.
- Self-introduction should be brief
- Do not stare, use a friendly expression, and use slow speech and a higher tone of voice

2. The establishment of relationships with unfamiliar elderly citizens

- When staff want to establish a relationship with an unfamiliar elderly person, they should get consent from the elderly person, e.g. staff could ask the elderly person whether they prefer to be called "Sir" or "Uncle".
- When speaking, the staff could lean forward in order to be close to the elderly person and to make eye contact with them.
- The staff should repeat what they said with more clarifications and explanation if the elderly person did not understand something.
- Show respect for the habits and ethnic (geographical) customs of the elderly

3. What to talk about with the elderly and how to express yourself?

- First of all, listen to what the elderly person say, then conclude and reconfirm the issues raised by the elderly person.
- When there are sensitive issues, such as security, you can give an overview of the security policies, and then inquire about the elderly person's conditions. If necessary, indicate if something needs further confirmation or follow-up and express your concern to the elderly person.
- If an elderly person becomes angry and wants to immediately resolve a problem, firstly arrange for the elderly person to sit down and bring them a drink. Once the elderly person has calmed down and they are not so emotional, ask them about their concerns and try to find a solution to the problem.

4. Speech application

- Take full advantage of body language when communicating with the elderly, such as holding hands and sitting together.
- Staff should slow down their walking pace and say hello to the elderly when they approach
- When communicating with the elderly, firstly, offer them encouragement and then help them to analyze the problem. For example, you could say something like, "You have done it very well, but it might be better if you could do in this way....".

Sources:

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Dr. Ma Ning, Peking University Institute of Mental Health
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Insomnia and Sleep Management

Definition: Insomnia is a condition in which the patient is subjectively unsatisfied with the time and/or the quality of hi/her sleep, which results in impairment of his/ her usual functions.

Criteria for “normal” sleep time—depends on age.

- Newborn infants need at least 20 hours of sleep per day. Infants needs to sleep for 14-15 hours per day;
- Preschool children need 12 hours, elementary school students need 10 hours and middle school students need 9 hours per day;
- University students and adults need 8 hours of sleep per day. The elderly usually only require between 6-7 hours of sleep per day because their metabolisms are slowing down.

Clinical Features

During the night:

1. Difficulty in falling asleep: it takes longer than 30 minutes to fall asleep;
2. Difficulty in remaining asleep: waking during the night more than twice, or waking early in the morning;
3. Poor quality sleep: shallow sleep disturbed with dreams or nightmares, a subjective experience of “poor sleep”;
4. Insufficient duration of sleep: less than 6 hours of sleep, or less than the usual sleep time.

In the daytime:

Drowsiness, low energy, dizziness, sensitivity or intolerance of bright lights, puffy eyes, lack of concentration, yawning, fatigue.

Note: Insomniacs often present itself as a mixture of several symptoms mentioned above in different ways.

Diagnostic criteria and classification

1. Sleep disturbance is almost the only symptom of the patient. Other symptoms are all secondary to, or caused by the insomnia.
2. The sleep disturbance has been occurring at least three times per week, and has lasted for more than one month.
3. The insomnia has produced significant distress to the patient, impaired social function or low mental efficiency in everyday activities.
4. The sleep disturbance is not any part of a general physical condition or mental disorder.

Acute insomnia: Lasting less than four weeks, it is often evoked by sudden stress or environmental changes. The most common precipitating factors include a general medical condition, noise, jet-lag, high environmental temperatures, etc. Sub-acute insomnia: Lasts more than four weeks but less than six months.

Chronic insomnia: Lasting longer than six months. It is often associated with a medical condition or mental disorder but can also be produced by alcohol or substance abuse.

Treatment of insomnia

Principles of therapy

Eliminate the precipitating factors:

1. This is the principal method for treating insomnia which is caused by identifiable factors such as:
 - Environmental factors, e.g. noise, mosquito bites etc.
 - Medical conditions
 - Physiological effects of certain substances, e.g. hormones, illegal drugs, respiration inhibitors etc.
2. **Sleep hygienic and cognitive-behavioural guidance:** Are adapted for all insomnia patients.
3. **Psycho-behavioural therapy,** e.g. relaxation training is adapted for patients who have psychological factors and/or psychotic problems/ disorders.
4. **Pharmacotherapy:** is an option for patients who have severe insomnia and impairments in their mood, work and normal life-style.

Sleep hygiene

1. Establish regular times for going to bed and getting up, ensuring that time for sleep is prioritised.
2. Create an environment conducive for sleep.
3. Practice good sleep habits: i.e. going to bed and getting up at appropriate times, sleeping on the side of the bed that is most comfortable, having the preferred style of pillow, mattress and pyjamas.
4. Reduce or abstain from psycho-stimulating substances, such tobacco, alcohol, tea and coffee.
5. Don't eat too much in the evening.
6. Play sports or do some form of physical exercise regularly.
7. If you have a nap time, restrict it to 30 minutes or less.
8. Avoid intense physical or stressful activities immediately before sleep, e.g. playing soccer, running, watching horror film etc.
9. Activities that may help you to sleep include: taking a warm shower about 10-20 minutes before bed and practicing relaxation exercises.

Pharmacotherapy

1. Benzodiazepines:

- **Diazepam:** 2.5-5mg oral, or 10-20mg muscular injection
- **Lorazepam:** 0.5-4mg oral, or 1-2mg muscular injection
- **Alprazolam:** 0.4-0.8mg oral
- **Estazolam:** 1-2mg oral

2. Non-benzodiazepine sedatives:

- **Zolpidem:** 5-10mg oral before sleep
- **Zopiclone:** 7.5-15mg oral before sleep

Note: Non-benzodiazepine sedatives can produce a rapid curative effect. They should be taken 20 minutes before sleep. To prevent accidents, activities such as taking a bath or driving should not be conducted after taking the drug.

3. Important safety messages:

- Benzodiazepines are not suitable for patients who have severe sleep apnoea (temporary absence or cessation of breathing).
- Benzodiazepines should not be administered to patients who have severe respiratory disease, chronic obstructive pulmonary disease (COPD), hypercapnia (too much carbon dioxide in the blood), or decompensate

restrictive pulmonary disease. Benzodiazepines are also contraindication for patients with dyspnea (shortness of breath).

- Benzodiazepines have a residual effect which can lead to dizziness, drowsiness and lethargy the following day. Patients should not drive a vehicle, operate heavy machinery or work in high or potentially dangerous places.

- Individuals who take benzodiazepines should not consume alcohol.

- Dosages should be tailored to the individual, commencing with a low starting dose, especially for the elderly.

- Sedative drugs such as benzodiazepines and non-benzodiazepines have the potential for tolerance and abuse. They should not be prescribed for long-term use.

4. Specific strategies for pharmacotherapy use:

- When anticipating difficulty in falling asleep, sleeping tablets can be taken 15 minutes before going to bed or patients can choose when to take the pills according to their experience.

- Patients can also take the sleeping tablets according to their sleep patterns each night, for example if it takes them longer

than 30 minutes to get to sleep or if they wake up five hours before they intended to wake up and cannot get back to sleep again, they may self-administer sleeping tablets as appropriate.

- Patients can take sleeping tablets based on their activities the next day, i.e. if they have an important work task the next day.

5. Changing prescriptions:

Changes in prescriptions should be considered in the following circumstances:

- The recommended dose is not effective;
- Developing tolerance;
- Drug interactions with medicines being used to treat other comorbid disease/s;
- Severe adverse effects;
- Overdose; long-term (more than 6 months) use ;
- Ageing patients;
- Patients who have high risk factors such as alcohol or drug abuse and/or a history of drug addiction.

6. Prescription change strategy:

- Switch from benzodiazepines to non-benzodiazepine sedatives: It should take about two weeks for the switch-over.
- Patients should be gradually withdrawn from benzodiazepines, while using non-benzodiazepines to make up the treatment dosage.

7. Indicators for drug discontinuation:

- It is time to consider gradually withdrawing from using sleeping tablets when the patient feels that they can control their sleep themselves;
- Patients should be gradually withdrawn over several weeks, even several months, depending on each individual.
- The most common drug discontinuation strategy is to gradually withdraw from using the drug at night. Patients can then take sleeping tablets intermittently after the regular treatment has been stopped.

Relaxation training

Relaxation training is a set of exercises and procedures through which patients learn how to consciously control and regulate their own psycho-physiological activity. It can regulate disturbed mental and physical functions which are produced by tension or stress and reduce the level of arousal.

1. Deep breathing: Inhale deeply, hold the breath for several seconds, then exhale.

2. Gradual relaxation: Sit in a chair in a comfortable position - breathe slowly and deeply (2-3 times). Hold on to the breath for several seconds and contract or tense the muscles of each part of the body gradually, continuing until your muscles are tired and cannot tense for much longer. Then exhale and relax all of the muscles of your body quickly and completely. Repeat the exercise twice.

3. Self-hypnosis

Using verbal suggestions and affirmations to deepen the state of relaxation:

My breath is getting deeper and deeper. My heart is beating slowly and strongly. I feel very calm. I can feel that the sun is shining on the top of my head. A warm stream is flowing through all parts of my body. I feel the top of my head is warm and heavy. The warm stream is flowing over my face. I feel my face is warm and heavy. My breath is getting deeper and deeper. I feel my heart is very calm and comfortable. I will be in high spirits and a good mood after I awaken (self-suggestion).

4. Several routes for self-hypnosis

- Top of head--face--neck--breast--heart--stomach--lower abdomen--left thigh--left knee--left leg--left foot--toes on the left side--right thigh--right knee--right leg--right foot--toes on the right side.
- Top of head--back of head--neck--back--lower back--buttocks
- Left shoulder--left upper arm--left elbow--left forearm--left wrist--left hand--all fingers on the left side--right shoulder--right upper arm--right elbow--right forearm--right hand--fingers on the right side.

Referral of patients with insomnia for psychiatric or medical evaluation

- Patients, who have persistent insomnia which impairs the routine of their study, work and life should be referred to a psychiatrist earlier rather than later.
- Patients, who have persistent insomnia associated with depression, anxiety, psychotic symptoms or behaviours relating to deliberate self-harm and/or suicide, should be referred to a psychiatrist as early as possible.
- Insomnia may be the symptom of a mental illness, e.g. schizophrenia, depression, anxiety, post-traumatic stress disorder (PTSD) etc. If the patient has suspected psychotic symptoms, he/she should be referred immediately to a psychiatrist.
- Insomnia may also be a symptom of a respiratory or nervous system disease. If the patient has suspected medical conditions, he/she should be referred to a doctor or their advice should be sought.

Depression

Definition: Depression is a common mood disorder, whose primary clinical feature is persistent and significant depressed mood, ranging from unhappiness to total despair, which is not consistent with a person's situation in life. Depression tends to be a recurrent disorder with most episodes ceasing automatically after a period of time. For some people however, although episodes may be alleviated the patient may suffer from residual symptoms. Other patients may suffer from a progression of the disorder whereby it the episodes enter into a chronic, ongoing phase. Depression can also be accompanied by psychotic symptoms such as hallucinations or delusions.

Clinical features and diagnostic criteria

Clinical Features

1. Core symptoms

- Depressed mood — which is not relieved by self-regulation, consolation by others or by changes of environment.
- Diminished interest and pleasure — Loss of interest in almost all activities or hobbies that patients would normally enjoy; the patient does not feel happy in everyday life, when he/she participates in activities he/she does so passively and reluctantly; the patient avoids friends and their family and withdraws from social activities; the patient feels that he/she "does not want to do anything".
- Reduced energy — subjective experience of reduced energy or a feeling of restlessness without any apparent reason.

2. Biological symptoms

- Sleep disturbance — characteristic feature is early morning waking.
- Lack of appetite — changes in weight
- Loss of sexual desire
- Gastrointestinal symptoms (No organic pathological change occurred)
- Circadian features — the depression is regularly worse in the morning
- Psychomotor retardation — stupor or sub-stupor state (poverty of speech and slowing of movement/motionless and mutism, rejecting food in severe cases)

3. Concomitant symptoms

- Slowing of thought, poor memory and concentration
- The three 's' - self-reproach, self-guilt and suicide
- The three 'less' - hopeless, helpless, worthless
- Anxiety — prominent in aged depressive patients

Diagnostic criteria [International classification of diagnosis (ICD-10)]

1. Criteria of depression symptoms:

- At least two of the above-mentioned core symptoms
- At least two other of the above-mentioned biological and concomitant symptoms

2. Duration criteria: symptoms have been present most of the time, almost every day and have persisted two weeks or longer.

3. Criteria of severity: the symptoms result in impairment of normal social functioning and/or produce significant distress.

4. Criteria of exclusion: diagnosis can only be made once organic disorders, psychotropic substance induced disorder, schizophrenia etc. have been excluded.

Patients and families

Health education

1. Depression is a common disorder. It can be treated effectively.
2. A person does not suffer from depression because they are weak or idle. Patients try to respond to it.
3. Some medicines can induce depression symptoms (e.g. β -blockers, other anti-hypertensive agents, histamine H₂ antagonists, oral contraceptive agents, corticosteroids).
4. Excessive and prolonged alcohol use can induce depressive symptoms.

The risk of suicide may be increased in those suffering from depression if these pre-existing conditions are present: the person is a female or elderly; there is a family history of suicide; they have intense feelings of hopelessness, self-reproach and guilt; there is a history of attempted suicide or a pre-determined suicide plan; there are concomitant psychotic symptoms and disturbed psychological problems; medical comorbidities; and a lack of support from family members/High risk populations include patients who have recently undergone childbirth, experienced a stroke, or those who have been diagnosed with Parkinson's disease or multiple sclerosis or have a family history of depression.

How can families help the patient to recover from depression?

1. Ask about the possibility of suicide (i.e. Does the patient often think of death or dying? Has the patient created a suicide plan? Have they attempted suicide? Can patients guarantee not to act on thoughts or plans of suicide?) Patients may need their families and friends to provide close, at-home care and around the clock supervision or this may need to be done in a hospital. Patients should also be asked about the possibility they deliberately or otherwise hurting others.
2. Make a short term plan for patients to obtain happiness and self-confidence.
3. Encourage patients to give up pessimistic ideas and self-reproach, not to make negative or destructive decisions and actions (e.g. ending their marriage, quitting their job), and to rid themselves of guilty thoughts and passive behaviours.
4. Uncover and discuss the current problems and social stresses in the life of the patient. Help the patient to adopt accepted, suitable ways to reduce or resolve those problems and stresses. Encourage them not to make any great life changing decisions without taking time and careful consideration of the implications, and perhaps not until they recover from their depressed episode.
5. Try to identify any correlation between their mood and medical symptoms especially if they have apparent physical symptoms.
6. If the patient feels better make a plan with them to help them cope with the possibility of recurrence.

Pharmacotherapy for depression

1. If the symptoms of low mood or loss of interest have persisted at least two weeks and at least four of the symptoms listed below are present, antidepressant pharmacotherapy should be considered:

- Fatigue or reduced energy
- Poor concentration
- Movement and speech retardation or agitation
- Sleep disturbance
- Suicidal thoughts, plans or attempts
- Remorse, guilt or self-depreciation
- Loss of appetite

2. The initiation of pharmacotherapy should be considered from the first clinical visit for patients suffering severe depression.

For moderately depressed patients pharmacotherapy should be considered from the follow-up visit or when it is apparent that counselling alone has not improved the patient's mental health status.

3. Antidepressant drugs:

A. Tri-cyclic antidepressants (TCAs):

Drug Name	Dosage
Imipramine	50-300mg/day
Amitriptyline	50-300mg/day
Doxepin	75-300mg/day

● **Contraindication:** Do not use in those patients with severe heart problems, hepatic or renal disease/disorders, epilepsy or glaucoma. Do not use in children under the age of 14, pregnant women and patients with prostatic hypertrophy (enlarged prostate gland).

● **Adverse effects:** (1) anti-cholinergic effects; (2) cardiovascular effects; (3) other effects.

B. Selective Serotonin Reuptake Inhibitors (SSRIs)

Drug Name	Dosage
Fluoxetine	10-40mg/day
Paroxetine	20-40mg/day
Sertraline	100-200mg/day
Fluvoxamine	50-150mg/day
Citalopram	20-60mg/day

● **Advantages:** Less side effects than TCAs, especially less anti-cholinergic and cardiovascular effects.

● **Common side effects:**

Gastrointestinal and urinary: nausea, vomiting, poor appetite, incontinence.

Neurological: headache, dizziness, tension, insomnia, fatigue, dry mouth, increased sweating.

Sexual dysfunction: impotence, delayed ejaculation, anhedonia (a lack of pleasure or the capacity to experience it).

4. Antidepressant selection criteria

● An antidepressant could be used again at subsequent episodes if it has previously shown previous a positive response for a patient.

● If patients are elderly or have concomitant diseases/disorders, it may be beneficial for them to be prescribed antidepressants with less anti-cholinergic and cardiovascular effects.

● If patients have symptoms of anxiety and sleep disorder, it may be beneficial for them to be prescribed antidepressants with a sedative effect.

5. The initial dosage of an antidepressant, for example imipramine should start out low, i.e. 25-50mg/night and be titrated to 100-150mg/day within about 10 days. It should be used in a single dosage as far as possible, and gradually titrated to the therapeutic dose. If patients are elderly or have concomitant medical conditions, the dosage should be reduced.

6. It is important to explain to the patients that they must take their medicine everyday and that it will take 2-3 weeks of treatment before the symptoms will be reduced. Patients should also be informed that the medicine may produce some mild side effects which often diminished after the first 7-10 days. The patients should be consulted before withdrawal of the medicine.

7. Antidepressant treatment should be continued for at least 3 months after the depressive symptoms have reduced. Recurrent depression should receive ongoing pharmacotherapy for maintenance for a much longer duration.

Notice to the patients:

The Zung questionnaire is a useful tool to complement the diagnosis of depression but it is in no way a substitute for a consultation with a doctor. Please ask the patients to carefully read the 20 descriptions below and tick(✓)the relevant square according to their actual situation and experiences in the past week.

SELF-RATING SCALE FOR DEPRESSION

	Rarely	Sometimes	Often	Most of the time
1. I feel down and blue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*2. I feel that morning is the best time of one day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I want to cry or feel like crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I have trouble sleeping at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*5. I eat as much as I used to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*6. I still enjoy sex with partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I notice that I am losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I have trouble with constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. My heart beats faster than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I get tired for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*11. My mind is as clear as it used to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*12. I find it easy to do the things I used to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I am restless and can't keep still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*14. I feel hopeful about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I am more irritable than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*16. I find it easy to make decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*17. I feel that I am useful and needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*18. My life is pretty full	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I feel that others would be better off if I were dead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*20. I still enjoy the things I used to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notice for the doctors:

1. How to mark the score:

The forward questions: give "1, 2, 3, 4" in turn to "Rarely, sometimes, often, most of the time". The backward questions: (there is a * before the question) give "4, 3, 2, 1" in turn to "Rarely, sometimes, often, most of the time".

2. How to calculate standard score:

Add the score of every question and we will get the total primary score. Standard score = primary score x 1.25. If the total primary is higher than 41 or the standard score is higher than 53, we could consider there is a depressive emotion needing treatment.

3. If the subject's level of the education is poor, the doctor could read to him by sentence, but let the subject evaluate himself.

Post-Traumatic Stress Disorder (PTSD)

DSM-IV-TR¹ Criteria for PTSD

1. The person has been exposed to a traumatic event in which both of the following were present:
The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of them self or others.
The person's response involved intense fear, helplessness or horror (children may also respond with behaviour disorders or agitation).
 2. The traumatic event is persistently re-experienced in one or more of the following ways:
Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
Recurrent distressing dreams of the event
Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (e.g. trembling, chills, and rapid heartbeats)
Persistent symptoms of increased arousal, as indicated by the following two (or more) symptoms:
Difficulty in falling or staying asleep
Irritability or outbursts of anger
difficulty in concentrating
Hyper-vigilance
Exaggerated startle response
Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by the following three (or more) symptoms:
Attempts to try to avoid thoughts, feelings, or conversations associated with the trauma
Attempts to try to avoid activities, places, or people that arouse recollections of the trauma
Inability to recall an important aspect of the trauma
Rare participation in significant activities or no interest in participation
Feeling of detachment or estrangement from others
Restriction in affection/emotion (e.g. difficulty in having loving feelings). No long-term vision for the future.
Duration of the disturbance (symptoms in above criteria 2-4) lasts more than 1 month.
The disturbance causes clinically significant distress or impairment in social, occupational, or other important functions.
- Clinical manifestation**
PTSD is a delayed anxiety response to significant psychological trauma, which persists more than one month and is distressing or causes impairment to the social function of the subject.

Clinical manifestation

PTSD is a delayed anxiety response to significant psychological trauma, which persists more than one month and is distressing or causes impairment to the social function of the subject.

Main features:

- Recurrent re-experiencing of the traumatic event.
- Avoidance of stimuli related to the traumatic events, a feel of numbness to normal environment changes.
- Hyper-vigilance

Clinical Interview with Patients

- Ask the patient: "Have you ever experienced or witnessed any events associated with severe injury to you or others? Have you had to deal with this kind of event? Such as the situation in the Wenchuan earthquake?" "Did you feel frightened, helpless or horror at that time?" "Could you tell me something about it?"
- Inquire about if the patient re-experienced the event in at least one of the ways mentioned above. Children may have frightening dreams in association with the themes of the trauma and may conduct some trauma-specific re-enactment.
- After the traumatic event, there are at least two of the hyper-vigilant symptoms.
- Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the symptoms listed in the diagnostic criteria.
- Acute: If duration of symptoms is less than three months
Chronic: If duration of symptoms is three months or more
Specify if: With delayed onset: If onset of symptoms is at least six months after the stressor

PTSD Screening

Screening questions:

After it has been established that the patient has experienced traumatic events that have continued to make him/her feel frightened, helpless or to have a sense of horror in the month following the event, the following questions should be asked:

- | | |
|---|---------|
| 1. Have you ever re-experienced the event in your dreams or in your mind when you do not want to recall it? | Yes /No |
| 2. Do you try to avoid recalling that event, or avoid situations that will remind you of that event? | Yes /No |
| 3. Do you keep vigilant all the time? Or do you have poor sleep, or feel frightened? | Yes /No |
| 4. Do you feel indifferent or alienated from others, all activities, or your environment? | Yes /No |

The Population with High Risk Factors

1. chronic insomnia;
2. low mood;
3. inappropriate worry;
4. panic or irritable;
5. social withdrawal;
6. physical weakness;
7. bad temper;
8. excessive alcohol use for a long time;
9. pessimistic;
10. disabled individuals;
11. those who have lost their spouse and/or children;
12. feeling alone and without any help from others;
13. those with mental illness;

I. Treatment flow chart

1. Intervention as early as possible	The medicine should be used once the patient is diagnosed for PTSD. If the medicine is un-effective after 6-12 weeks systematic treatment, it should be changed to another drug.
2. single antidepressant	TCAs: imipramine or amitriptyline (initial dosage range 6.25-12.5mg/day, should be titrated slowly) Or new typical antidepressants: fluoxetine, sertraline, paroxetine, venlafaxine, mirtazapine
3. Titrated to the effective dose to be tolerable	If there is a partial effect after adequate TCA use (e.g. imipramine or amitriptyline 150mg/day), they can be gradually titrated to the maximal recommended dosage (i.e. imipramine/amitriptyline 250 mg/day, or sertraline 200mg/day, paroxetine 50mg, fluoxetine 60mg).
4. Enhancement therapy for partial effect	If there is a partial effect after 6-12 weeks of adequate TCA use (e.g. imipramine or amitriptyline 150mg/day), the remaining symptoms should be evaluated, and another lower dosage antidepressant drug should co-administrated to enhance the therapy, e.g. trazodone, nefazodone, sertraline, fluoxetine.
5. Change therapy for non-effect	If it is a non-effect (i.e. the improvement rate of the symptoms is <25%) after 6-12 weeks of adequate TCA use (e.g. imipramine or amitriptyline 150mg/day), and the core symptoms (i.e. re-experiencing the trauma, avoidance and numbing, hyper-arousal) and sleep disturbance still persist, the patient should be changed to a different antidepressant or coadminstrated with another antidepressants, e.g. fluoxetine, sertraline, paroxetine, venlafaxine, midazolam.
6. continue the effective therapy	Therapy should be continued for at least one year. If the therapy has been effective, the patients can then be gradually withdrawn from the drugs over a period of time until they are stopped and therapy is discontinued.
7. compounding therapy for other co-existent symptoms.	If there is a partial effect after the enhancement therapy or changed therapy of 6-12 weeks, the diagnoses of the patient should be re-assessed and compounding therapy should used with two of three kinds of psychotropic drugs and social-psycho therapy should be considered as well.
Hyper-arousal	Co-administration with anti-adrenergic drugs (i.e. clonidine, guanfacine, or propranolol dinitrate)
Aggressive, impulsive behaviours and thoughts	Co-administration with anticonvulsants or mood stabilizers (i.e. sodium valproate, risperidone)
Fear, paranoia	Co-administration with atypical antipsychotics
Insomnia, nightmares	Co-administration with trazodone, α -1 adrenergic antagonists, low dosage of TCAs or other sedative drugs.
Anxiety, restlessness	Risperidone, olanzapine, quetiapine, buspirone, propranolol dinitrate
Phobia	Cautiously use benzodiazepines in patients without a history of substance abuse.
obsessive-compulsive disorder	Co-administration with chlorimipramine or atypical antipsychotics (risperidone, quetiapine, olanzapine etc)
Generalized anxiety disorder	Co- administration with buspirone, trazodone, or benzodiazepines
Social anxiety disorder	Co-administration with clonazepam, olanzapine etc.
Psychotic disorder	inhibitive effect

II. Profile of drug side effects

Drug	Side effect	Important information
TCAs	Convulsions, anti-cholinergic side effects etc.	Contraindication: heart disease, e.g. angina, myocardial infarction, heart failure; depression of central nervous system or coma, glaucoma, pregnant women. Should be used with caution in patients suffering from the following comorbidities: epilepsy, severe hepatic or renal disease, prostatic hypertrophy, the elderly, cardiovascular disease, history of uroschisis, and thyroid disease. Patients should be prevented from suicide by overdose with TCAs. TCAs must not be co-administrated with MAOIs (monoamine oxidase Inhibitors). If a patient complains of having a dry mouth, they should be advised to drink more water to remedy it and to prevent constipation.
Atypical antipsychotics	Weight gain, deterioration of diabetes mellitus, Metabolism syndrome, hyperlipemia, hyperprolactinemia	The patients health should be observed and examined periodically.
Benzodiazepines	Addiction can result from prolonged use.	Contraindication: glaucoma and myasthenia gravis. Benzodiazepines should be used with caution with infants, the aged and physical weak persons.
Propranolol	Inhibitive effect	Contraindication: bronchial asthma, heart failure, conduction block.

III. Treatment of co-morbid disorders

The most common psychiatric disorders that accompany PTSD are depressive disorder, generalized anxiety disorder, drug addiction, somatoform disorder, panic disorder, bipolar disorder, phobias and dissociative disorder. All of these co-morbidities should be treated together with PTSD.

Consultation or referral

- Patients should be consulted by a psychiatrist or sent to a psychiatric hospital if they have the following problems:
 - Risk of self-harm, suicide, or doing harm to others
 - Severe psychotic symptoms
 - Severe physical diseases
 - Questionable diagnosis of PTSD or co-morbidity
 - Incapable of living independently and refusal of treatment
 - Severe symptoms and no caregiver
 - Persisting significant core symptoms of PTSD, depression, social withdrawal after receiving the treatment mentioned above
 - Severe side effects.
- Psychotherapy for trauma (e.g. cognitive-behaviour therapy, eye movement desensitisation therapy-EMDR, interpersonal therapy).
- Alternative treatment and prevention of recurrence.

Acute and Chronic Psychoses

The necessity and importance of identifying psychotic disorders

- Psychotic disorders are the most severe mental illness in many societies and cultures. Psychotic disorders bring about intensive distress to the patient, produce functional impairment and suffering for the patient's family and friends.
- Society tends to express sympathy and the wish to help those who have a physical disease or condition but the general attitude to psychotic diseases is one of fear and discrimination.
- The features of psychotic diseases are often subjective, mysterious or hard to define when compared to medical conditions such as fever, stomach-ache, fractures, or cough. Because many people think that the cause of psychotic disorders are associated with moral problems, therapy is often delayed or inappropriate.
- Psychotic disorders are also a kind of disease, the same as other medical diseases and in most cases they can be clinically relieved through appropriate therapy. Every physician is obligated and responsible for providing help to patients with psychotic disorders, and to attempt to prevent the patients from a recurrence.
- Knowledge about psychotic disorders, their etiology and treatment has become a wide-spread knowledge in many areas all over the world. Various psychotic disorders can be accurately diagnosed and effectively treated by physicians.
- People's negative attitude towards psychotic disorders interferes with a patient's treatment and re-integration into society.
- Patients who have psychotic disorders are commonly encountered in community health work. Compared with many chronic and severe medical diseases, psychotic disorders are more difficult to understand and accept. Assessment and diagnosis of psychotic disorders are different from those of medical diseases as they depend on a physician's interview and the diagnostic instruments and classification system (i.e. ICD-10) they apply.
- The treatment of psychotic disorders is a relatively long-term and comprehensive treatment process. Ongoing prevention efforts should also be continuous and systematic to guarantee a comprehensive service for the patients. In summary, treatment and prevention of psychotic disorders in the community is one of the most important therapies.

Acute psychotic disorder

Common complaints of psychotic patients:

- Hearing voices when there is nobody around
- Strange ideas or fear
- Mental aberration
- Scared, fearful

Family members should ask for help for those weird or scared behaviours from the patients (e.g. withdrawal, suspiciousness, threatening behaviours).

Diagnostic criteria

Other symptoms:

- Hallucination (a perception without objective stimulants, e.g. hearing voices where there is nobody)
- Delusion (a visibly false belief that is firmly held by the patient, e.g. a patient believes that he was poisoned by his neighbour, or that he can receive radio signal information, or that someone stared at him in a special way.)
- Agitation and weird behaviours
- Incoherent or strange speech
- Extreme and unstable mood state

Differential diagnosis

The medical diseases listed below may produce psychotic symptoms:

- Epilepsy
- Drug or alcohol intoxication/addiction
- Infectious or febrile diseases

Guideline for acute psychoses

Health education

- Agitation (obvious restlessness and excessive body activity accompanied by anxiety) and bizarre behaviour are symptoms of psychotic disorders.
- Acute episodes of psychosis often have a good prognosis, but it is difficult to predict the long-term prognosis from one acute episode.
- Patients may need to continue treatment for several months after the symptoms improve.

How families can help the patients to recover from psychotic illness

- Ensure the safety of patients and caregivers.
- ◆ Patients should be accompanied by their family and friends.
- ◆ Ensure the basic needs (food, drink) of the patient are met.
- ◆ Be careful not to hurt the patients.
- Reduced stress and irritants.
- ◆ Do not argue with patients about their psychotic thoughts (you can disagree with their thoughts, but do not try to argue with them).
- ◆ Do not be opposed to or criticize the patients, but at the same time still try to prevent the patients from hurting themselves or performing destructive behaviours.
- Agitation is very dangerous for the patient. They should be sent to the hospital or a secure place where they can be closely monitored. In cases where patients refuse to receive treatment, there may be a need to seek law enforcement action.

- Encourage patients to join in normal activities after their symptoms have improved.
- Provide suggestions about mental rehabilitation to the families.

Consultation by Experts

- All patients with a new onset of a psychotic disorder should be referred to a psychiatrist if possible.
- If the patient has severe side-effects in the loco-motor system or symptoms including fever, stupor or hypertension, antipsychotic drugs should be withdrawn, and the patients should be examined.

Principles and guidelines for pharmacotherapy

1. Standard treatment, especially after the first episode should be provided under the guidance of specialists; drugs should be gradually titrated, dosage could differ on an individual basis, and the lowest tolerance dosage should be adopted to alleviate symptoms. The side-effects should be closely monitored.
2. Psychotic symptoms can be reduced by antipsychotic drugs (typical drugs, e.g. haloperidol, chlorpromazine and perphenazine and atypical drugs, e.g. risperidone and sulpiride). Some long acting injections are also available for easy use.
3. Acute agitation should sometimes be co-administrated with anti-anxiety agents, e.g. benzodiazepines.
4. Antipsychotic therapy should be continued and strengthened for at least 4-6 months and maintenance therapy should continue for more than six months after the symptoms are alleviated.
5. Side-effects of drug treatment:
 - Acute dystonia or convulsions which can be treated by benzodiazepines and intramuscular injection of anti-cholinergic agents.
 - Akathisia (marked loco-motor restlessness - patients keep on walking and cannot sit down) can be treated by reducing the dosage or by administering β -blockers.
 - Parkinsonism symptoms (tremor, akinesia), can be treated by antiparkinsonian drugs (e.g. trihexyphenidyl, promethazine).

Chronic psychoses

Complaints:

Patients may have the following symptoms:

- Difficulties in thinking and concentration
- Hearing voices when there is nobody around
- Bizarre ideas (e.g. supernatural powers, thoughts of persecution)
- Unusual somatic complaints (e.g. patients think that there are animals or that they have unusual things in their bodies)
- Problems or trouble related to the pharmacotherapy
- Troubles in their work or daily life
- Families may ask for help for the patient's apathy, withdrawal, poor hygiene, or bizarre behaviour.

Diagnostic criteria

The features of chronic psychoses are list below:

- Social withdrawal
- Loss of motivation or interest, self-ignorance
- Disturbed thought (strange and incoherent speech)

The features of periodic episodes:

Agitation or restlessness

- Hallucination (sensory perceptions which do not really occur, e.g. hearing voices when nobody is present)
- Delusions (an obviously false belief that is firmly held by the patients, e.g. the patient believes that he/she has a relationship with the royal family, that he/she can receive wireless information, or that he/she is being tracked or persecuted by someone).

Differential diagnosis

- When the patient's dominant symptoms are a low mood or feeling blue, pessimism and self-guilt, the diagnosis should be distinguished from depression.
- Bipolar disorder should be considered when patient have dominant symptoms of depression and mania (excited, high mood, grandiose ideas).
- Psychotic symptoms can be produced by chronic alcohol/substance (stimulants, hallucinogens) intoxication or withdrawal. The history of alcohol or substance use should be cautiously asked.

Guideline for chronic psychoses

Health education

- Agitation and bizarre behaviour are symptoms of psychotic disorders.
- The symptoms may come and go and the possibility of recurrence should be noted.
- Pharmacotherapy is in the core part of treatment; it can alleviate the current episode and prevent patient from recurrence.
- Family support is important for a patient's compliance with treatment and effective recovery.
- It is important to maintain patients' social life and daily functions, especially if the community and family can provide practical help for the patients.

How can families help patient recover from chronic psychoses

- Discuss with patients and their families about the plan for therapy as much as possible and obtain their input.
- Explain to patients and their family members that drugs can prevent the recurrence, also inform them about the side-effects of the drugs.
- Encourage patients to work and do daily activities as much as they can.
- Encourage patients to follow the community rules and other's expectations regarding their appearance, the way they dress and behave etc.
- Reduce stress and irritants:
 - ◇ Do not argue with patients about their psychotic thoughts;
 - ◇ Do not criticize patients for their bizarre behaviours;
 - ◇ Patients should take rest and avoid stress while they have severely active symptoms.
- The treatment of agitation/excited state should follow the same guidelines as per treating acute psychotic disorders.

Consultation of experts

- All patients with psychotic disorders should be referred to a psychiatrist if possible.
- Additional treatment and therapy may be needed for patients with psychotic depression or mania. Experts should conduct further consultations and diagnosis in order to adopt the optimal mode of therapy.
- Community services can reduce the burden on family members and improve the patient's rehabilitation.
- If patients have severe side-effects in the loco-motor system, physicians should consult a psychiatrist's advice.

Principles and guidelines of pharmacotherapy

- The pharmacotherapy guidelines for chronic psychoses is the same as the one for acute psychoses. The patients should be informed that recurrence could be reduced by continual drug therapy. The patients should be treated with antipsychotic therapy continuously for at least 4-6 months following the first episode and therapy should be continued for a longer time after subsequent episodes.
- Intramuscular antipsychotic depot forms can be used to ensure the continuity of therapy and to reduce the risk of recurrence, especially if the compliance of patient is poor.
- The patient should be informed about the possibility of side-effects. The common loco-motor system side-effects include:
 - ◇ Acute dystonia or convulsions which can be treated by intramuscular benzodiazepines and anti-cholinergic drugs.
 - ◇ Akathisia (marked motor restlessness) which can be treated by reducing the dosage or by administering β -blockers.
 - ◇ Parkinson's symptoms (tremor, akinesia) which can be treated with antiparkinsonal drugs.

Information sources:

WHO (the 5th Chapter of ICD-10)
Series for Guidance of Prevention
and Control of Mental Illness in
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All the drug therapy must be practiced and guided by registered physicians/psychiatrists.

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Psychological First Aid and Bereavement Treatment

Psychological First Aid

When?

- Before a disaster:** to provide human resource building, planning of psychological first aid, disaster exercises, rapid assessment tools and health education for the public, especially special training for children, as well as investigations on shelters, food and water;
- Emergency phase:** to establish organizations for coordination, recruit volunteers, save lives, provide social support and reliable information;
- Restoration phase:** to increase sense of safety, hopes and enhance relationships, and to conduct assessment of depression and suicide prevention;

Where?

- Before a disaster:** schools, community and workplaces;
- Emergency phase:** hospitals, accommodation sites for disaster affected persons and community;
- Restoration phase:** hospitals, community, schools and administrative departments;

Psychological First Aid ABC

- Arouse:** calm down and relax
- Behavior:** conduct psychological health assessment and direct health behavior
- Cognition:** effective communication, environment-oriented and face to reality

What are the principles?

- Not to be intrusive, conveying compassion to establish interpersonal relationships
- Increase immediate and on-going sense of safety
- Comfort and guide survivors with disturbed emotions or breaking down
- To be harmless, respect privacy and autonomy of people
- To be equal, not provide different services to the same group of people
- Participation, to maximally promote people in disaster affected areas to play a part in rescue
- Integration, to reduce psychological stress through various activities
- Accessibility, to build local capacity and reinforce existing resources as early as possible
- Multiple hierarchical support— including non-professional support such as community and family support and professional support for psychological restoration which is systematic and hierarchical

What is the content?

- Non-medical treatment as main component
- Prevent secondary distress
- Provide chances to discuss without pressure and avoid things that people are reluctant to talk
- Listen to patiently and convey real compassion
- Make sure the basic needs of disaster affected persons and try to help them to solve it
- Prevent negative coping styles (alcoholism)
- If possible, encourage disaster affected persons to play a part in daily affairs or be accompanied
- Recommend local supportive agencies to the ones who needs further treatment

Information transmission

- Reliable
- On-going providing
- Information released by specific person
- Constructive, practical and specific actions
- Consistent information—the information provided to all staffs should be the same
- Focus on community information

8 key behaviors in psychological first aid

- Contact and interaction
- Safety and comfort
- Stable (if necessary)
- Information collection: current needs and concerns
- Practical aid
- Establish a connection with social support
- Provide information of coping skills, and promote adaptability
- Establish connections with cooperative service

Common psychological responses

- Fear, helplessness
- Distress, anger
- Arousal, tension
- Numbness, suspicion
- Difficult to concentration
- Infatuated, worried
- Problems in decision-making
- Social backwards
- Conflicts
- Interpersonal relationship disorder



A sense of hope is the first step on the road to recovery
"Man can live about 40 days without food, about 3 days without water, about 8 minutes without air, but only for 1 second without hope."



Bereavement disorders

Earthquakes made thousands of people die, which was a heavy loss even an unacceptable fact for the relatives alive. Loss of family members is a heavy loss which can cause changes on emotion, thinking and actions, also on interpersonal relationships and social function, even may develop into chronic disorders and bring immeasurable loss to the person itself or his (her) family.

Complaints

Patients

- yearn for lost person profoundly
- distress that person is not here
- show somatic symptoms after sense of loss



Diagnostic points

Sadness can be shown as preoccupying with distress for lost family members, accompanied with symptoms similar to depression, such as:

- Depressed mood or sadness
- Disturbed sleep
- Loss of interest
- Self-blame or preoccupation with guilt
- Anxiety

Patients may also have

- Withdrawal of daily and social activities
- Hard to think about the future

Differential diagnosis

If the symptoms of depression still exist after two month, it should be considered to diagnose as depression.

- Inappropriate self-blame and feeling of worthlessness is unrelated to loss of family members. Obvious psychomotor retardation (less talk and movement, even no talk and movement) directs to depression.
- But symptoms similar to depression are not prognosis to depression. (For example, feel guilty that did nothing for lost family members before they died; have thoughts of death such as "I should die with him/her together", or "Better to die"; have illusions such as see the lost persons or hear their voice).

Treatment guidelines of bereavement disorder

Health education

- Heavy loss often is followed by intense sadness, crying, anxiety, self-blame or agitation.
- Typical bereavement involves yearning for lost persons (hear or see the lost persons)
- It is normal to talk about the lost persons

What family members can do to help patients to recover?

- Allow the patients to talk about the lost persons and dying moment
- Encourage patients to let out their feelings to lost persons (including sadness, shame and anger)
- It will cost some time to recover, and some measures to reduce the burden is necessary such as work and social activities
- Understand that excessive sadness will gradually disappear after several months, but it can be back when recall lost persons

Medication

- Antidepressant should not be given within 3 months after bereavement. If apparent symptoms of depression last for more than 3 months, please see treatment of depression.
- In case of severe insomnia, should give oxazepam 15mg/day for two weeks.



Why we provide intervention to bereaved persons:

*Help them go through normal sadness reaction;
Help them face distress, demonstrate feelings of lost persons
and get new life goal;
The original live was broken down, but our live will go on;
Human society struggles through disasters and continue;*

Expert consultation

*If serious symptoms relevant to grief last for more than 6 months and the patient has not get any antidepressant, an expert consultation should be arranged.
Bereaved children may get benefits from family therapy.*

Mental health of women being pregnant again

Advocacy and support of policy

"Decision on giving birth again in the family with family members victims in the Wenchuan earthquake"

- Age, contraceptive measures, mental stress caused by the earthquake, lack of medical inspection equipments and so on add difficulty in giving birth again.
- Provide three-phase free service of pre-pregnancy, pregnancy and childbirth to the family which complies with the provisions and proposes to re-birth children.
- Based on principles of voluntary selection, informed consent and respect for scientific, to provide psychological counseling and scientific fertility guide, health check-up, the termination of contraception, pregnancy care, safe delivery and other full technical services free of charge.

Physiological and psychological characteristics in pregnancy and coping strategies

1. The physiological characteristics during pregnancy

- Physiological changes during pregnancy may give rise to psychological changes
- Suspicion and fear
- Stress caused by gender of newborn babies in the future
- Over-emphasis of family on pregnancy will make pregnant women suffer from psychological changes similarly
- Effects of past adverse experience of reproduction
- Thoughts of the previous child will bring great expectations to the child in belly
- Psychological effects of pseudo-pregnancy

2. How to active physical and mental health during pregnancy

- Actively guide the psychological state of health of pregnant women
- Family harmony and mutual understanding and support between husband and wife are the important conditions for pregnant women to maintain good mental health
- Pregnant women themselves should also regulate psychologically. Various physiological changes are normal during pregnancy which should be calmly treated. Calm, cheerful, and lively mental state should be remained well.

Postpartum Depression

1. How to identify postpartum depression:

- Many women experienced some psychological concerns after giving birth
- There is the feeling of repression within a few post-natal weeks which change is called postpartum depression
- Features: anxiety or unexplained shouting; losing interest in daily life; despair; producing the feeling of unworthiness and guilt; drowsiness; being restless easily; fatigue; difficulty concentrating; wanting to hurt the baby and so on
- Some women experience postpartum mental illness; even appear mental anxiety and hallucinations.

2. Influencing Factors

- History of mental illness, previous depression, marital difficulties and some life events, etc.
- Post-natal levels of progesterone and estrogen drop sharply.
- Reducing of social support is an important reason in the risks of postpartum depression.

Abortion

1. Factors affecting abortion

- Physiological Factors
- The environment (radiation, pollution)
- Psychological stress (tension, anxiety, fear)
- Bad habits (eating habits, lifestyle, etc.)
- The role of external forces
- Having a history of abortion
- Dysembryoplasia

2. Note the following points

- Take it easy, maintaining normal mental state.
- Generally, more than 3 months of pregnancy is less likely to miscarriage.
- Note rest, not too tired, and to avoid heavy work or intense activity.
- To avoid sex life at early stage of pregnancy.
- Taking folic acid after consulting a doctor.
- To be able to conduct inspections during pregnancy regularly.
- In case of anomaly, you must promptly go to obstetrics and gynecology in regular hospital for examination and treatment.
- To childbirth, you must go to the regular hospital for delivery in order to avoid accidents.

Infertility

- Infertility is the inability to conceive after a year of efforts.
- The proportion of infertility increases with growth of age.
- Women, men, or both have the problem account for one-third respectively.
- Female infertility includes cervical obstruction, anovulation (tubal blockage) and endometriosis.
- Infertility is a special kind of disease, which affects the patient's psychological state, in the meanwhile a negative mental state also affects the patient's reproductive capacity and effect of treatment.
- In face of infertility, both spouses should fully communicate with and support and understand each other. In particular, her husband should know the problem of infertility belongs not just to his wife, and the husband also needs for timely examination and treatment.

Support and counseling in the family of reconstruction

Support and counseling in the family of reconstruction

- The rapid restructuring of families plays an important role for post-earthquake recovery and stability of social life.
- The functions of the family are gradually restored, and people's feelings have gradually been comforted and satisfied.
- As the cell of society, stability of the family is the foundation of recovery and stability of the whole society.

The characteristics of the reorganization family after the earthquake

- Sudden
- Concentration
- Rapidity



The main reason for restructuring of the family - in order to survive

- Spiritually lonely feeling needs consolation
- Support is needed economically
- Taking care is needed in life
- Emotional and physiological needs call for being met
- Need to have children and the generations to come
- Support of the elderly and offspring, persuasion of relatives and friends and colleagues
- Being driven by those of remarriage around
- Sympathy for each other's experiences
- The two sides establish emotion and combine

Particularity of the reorganization family

- The relatively rapid decision of marriage has the color of marriage encounter
- Need for a process of feeling-transfer and adaptation
- Many "role expectations" is not easy to meet
- Special family structure
- An increase in parent-child conflict
- Prevalence of trial marriage
- Main reasons of disintegration of restructuring family are: economic disputes and child issues; too short feelings-transfer period and inability to accept the new feelings; the sudden death of a spouse and difficult to cut prior feelings and difficult to accept new life style, and so on. After the Tangshan earthquake, disintegration peak of the re-organization family appeared in the third year after the earthquake.

Learning to live in the new family

- Recognizing that adaptation for the new family life will take time.
- Going into the family life of multi-surname and multi-origin as soon as possible
- To pinpoint roles of yourself and to meet role expectations of other family members
- Making overall arrangements, coordinating with various contradictions, giving and taking mutually and understanding peer.
- Nurturing a new life
- Positive and optimistic attitude towards life

Concerning about women of reorganization families

- The relevant departments solve the difficult problem of middle-aged women's remarriage.
- Appreciating and preventing domestic violence in the reorganization family.
- To provide women with resources to help their employment.
- Balancing relationship between men and women of the family.
- Establishment of a social support network for women.

Remarriage needs to consider carefully

- Before re-marriage, both sides should have a certain amount of in love time, mutual understanding and mutual accommodation and lay a solid emotional foundation for the married life.
- To know each other through normal channels, to guard against marriage fraud and to prevent secondary injury from occurring.

Model of supportive psychological counseling for the elderly

1. A. Story → B. Blind fulcrum → C. Pivot → Action
2. A. Possibilities → B. Agenda → C. Commitments → led to
3. A. Strategies → B. The most appropriate → C. Plan → value-reflection

In this model, psychological counselors mainly provide supports including five elements: explanation, encouragement, guarantee, guide and promotion for the improvement of the environment.

Mental protection mode for the elderly

To change the environment	To change attitudes	To change target and standard	To change priorities	To enhance life satisfaction of other aspects
Basic strategies:	Basic strategies:	Basic strategies:	Basic strategies:	Basic strategies:
problems needed to be solved for changing the environment	To find what in the world had happened, and what does this mean for you and your future	Set realistic goals and try to raise or lower the standard. Can you think of any new goals or standards	To re-evaluate the priority of life, and to highlight what is most important and can be controlled	Improving life satisfaction in any aspect of life you care about, improve the overall well-being

Developing supportive psychological counseling for the elderly and skills of psychological protection

1. The effective way of mental health work for the elderly is group discussion. To counsel people with same or similar living environment and conditions. To look for resources in the older age groups to promote the mutual influence and support of older persons.
2. To forward a positive reason to the elderly. For example, we want to carry out psychological counseling, but the older age groups do not want to participate due to their own reasons, so we can interpret this work like this "Your participation will enable us to learn the experience of providing services for the elderly. Thank you very much for your help".
3. In carrying out the work, to find an entry point for the care of older persons. For example, how to establish a good relationship with grandchildren is a common concern of the elderly, so we can begin guidance with establishing a good relationship not with just indulgence. A good relationship between grandparent and grandchild is a cornerstone of taking part in some activities together, and then let grandchildren get to learn and grow.
4. Most causes of the elderly's problem is from the family, but the elderly are basically "washing your dirty linen at home". This requires us to establish a relationship of trust with the elderly-entering their family, understanding the situation and giving support and to carry out family counseling in an open state.
5. Regardless of what way to support the elderly, the most fundamental is to understand. Understanding of its own for the elderly is a strong support.
6. To providing opportunities to participate in social and recreational activities as much as possible for the elderly. To establish good social support systems and to provide effective community resources have a positive role for psychological support for the elderly.
7. To carry out the mental health work for the elderly, the most important is to build a relationship of trust, which may lead the elderly to say their demands. We have the possibility to solve the problem only when it exists and may provide support so as to play the role of psychological counseling.

Psychological protection for Adolescents

	Early adolescence (10-13 years old)	Medium adolescence (14-16 years old)	Late adolescents (17-24 years old)
Developmental stages	<ul style="list-style-type: none"> ● Transition to adolescence ● Adolescent characteristics appear 	<ul style="list-style-type: none"> ● The performance of typical adolescent ● Great impact on their peers 	<ul style="list-style-type: none"> ● Transition to adulthood ● Behaviors of adult role
Independence	<ul style="list-style-type: none"> ● To challenge authority, parents and other adults ● Do not like something under-age child 	<ul style="list-style-type: none"> ● To leave their parents enjoying interaction with their peers ● Begin to form their own values 	<ul style="list-style-type: none"> ● Begin to seek higher academic opportunity and to consider future work ● Into adult life
Cognition	<ul style="list-style-type: none"> ● Finding difficulties in abstract thinking ● Seek more possibilities and methods ● Volatile mood 	<ul style="list-style-type: none"> ● Begin to develop abstract thinking ● Begin to analyze potential possibilities and to respond 	<ul style="list-style-type: none"> ● To build up abstract thinking stably ● Gradually developing problem-solving ability ● A strong ability to resolve conflicts
Peer group relationships	<ul style="list-style-type: none"> ● Establishing stronger friendship with the same sex partners in the group ● Interacting with opposite sex partners in the group 	<ul style="list-style-type: none"> ● To form loyalty relationships with their peers ● Start to try methods to attract their peers 	<ul style="list-style-type: none"> ● Peers influence their decision-making and values weakened ● Individual interaction with their peers is paid more attention rather than groups'
Self-image	<ul style="list-style-type: none"> ● Concerned about the physical changes ● Harsh on the appearance ● Anxious about menstruation, nocturnal emission, masturbation, breast or penis size 	<ul style="list-style-type: none"> ● Weakening of the body image concerns ● More concerned about whether they have the attraction 	<ul style="list-style-type: none"> ● Acceptance of body image ● Accept their appearance
sex	<ul style="list-style-type: none"> ● Finding themselves attractive to others ● Appearing masturbation ● Experience of sex game ● Comparing the body's development with their 	<ul style="list-style-type: none"> ● Increasing interest in sex ● Confusion appears in the formation of gender identity ● Acts of sexual intimacy occur 	<ul style="list-style-type: none"> ● Starting to form truly intimate relationships between individuals, which becomes the main relationships rather than satisfying with group relationship

Sources:

WHO Community Health Care (ICD-10 Chapter 5)
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MOH Post Disaster Self and Mutual Medical Aid Manual
Female and Social Work – From Practice to Policy

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Responsible and safe sexual behavior for young people



Consequences of risky sexual behaviours:

Adolescence usually begins at 12 years of age but may commence as early as 10 years of age. Teens sexual risk behaviour is increased because they have insufficient ability to protect themselves, boldness, easy access to information from the TV and internet and they face delays in marriage and child-bearing. Sexual risk behaviours include:

- Unprotected sexual behaviour
- Involuntary sexual behaviour (sexual abuse, rape, incest)
- Sexual behaviour with multiple sexual partners

Physically:

- Unintended pregnancy: unprotected sexual activities may cause unintended pregnancy, even delivery.
- Induced abortion: populations of young women who undergo induced abortion are often lacking awareness of how to protect themselves and when they become pregnant they do not tell their families or even take time to rest after an abortion for fear that their family may find out. They are also unlikely to take a proper course of antibiotics and their nutrition may not be adequate. These factors increase their risk of abortion related side-effects including inflammation, sterility and infertility.
- Sexually transmitted infections: increase the risk of reproductive tract infections such as herpes, gonorrhea, chlamydia, syphilis and human papillomavirus (HPV) which is strongly related to cervical cancer.
- HIV: adolescents are sexually active and therefore they are a vulnerable group of HIV.

Psychologically:

- Fear, anxiety and withdrawal from social interactions.
- Feelings of self-abasement, a loss of confidence, thoughts of killing oneself.
- Disruptions in school performance, not wanting to go to or avoiding school.
- Delayed consequences later in adulthood when they may have difficulties in choosing a life-mate and in finding happiness in family life.

Ways to advocate safer sex amongst adolescents:

- Personally: teenagers should learn about sex, the ability to love, how to make friends through normal approaches, and how to be responsible for their own personal psychosomatic health.
- Families: should talk about sex with adolescents and help them to deal with any problems or confusion they have regarding sex. This will also assist adolescents to learn how to properly use different resources to help deal with their problems.
- Peer education: offer peer education to adolescents to help them to develop a good attitude towards love and sex, to educate them on the importance of delaying their first sexual activity and to educate them about sexual risk behaviour and advocate for safe sex. Youth should develop the ability to be responsible for their sexual relationships.
- In schools: offer well targeted sex education to adolescent students, advocate for safe sexual behaviour, offer counseling to students with problems or confusions regarding sex and refer them to associated institutions or departments as required.
- In the community: offer adolescents lectures, education and training about healthy and safe sexual practices, actively plan for regular education sessions in local policy and help adolescents with problems and confusion about sex through a range of different resources.
- Socially: advocate for a healthy life-style and safe sexual behaviour, build a pure and favorable social environment.

Safe sex education for adolescents

Objectives:

To reduce risky behaviours:

- To postpone the first sexual activity or to avoid premarital sexual behaviour;
- To avoid high risk sexual behaviours.

Contents:

- It is impossible to tell whether someone is HIV positive from their appearance, so avoid unprotected sexual behaviour.

Note: unprotected sexual behaviour means sexual behaviour without the proper use of a condom.

- You can refuse to participate in sexual activity with someone at anytime you choose. You are not the only one, many other people also choose not to participate in sexual activity.
- If you do decide to have sex, be sure to use high quality condoms;
- Refuse to be involved in sexual activities without the use of a condom;
- Have sex with only one fixed sexual partner.
- Avoid unprotected sexual behaviour with multiple sexual partners
- Protect yourself from being in a situation where you are alone with someone who may try to pressure or force you to participate in unwanted sexual activity. Be aware that this situation can also occur with acquaintances or with someone who you are dating;
- If you are raped, are the victim of unwanted sexual activity, or have unprotected sex, have a physical and psychological examination as soon as possible after the event;
- For those who are sexually active, you should have a physical examination once a year. Men should practice safe sex by having only one fixed sexual partner and using condoms correctly and consistently

Source:

Ministry of Health
United Nations Population Fund

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Unfortunately, in many countries, when there is a complicated, emergency situation such as a natural disaster, violence associated with social gender, especially sexual violence may result. This form of violence is a severe, life-threatening problem which mainly affects women and children. Although reports of sexual violence after disasters are rare. But due to a variety of reasons, such as the community destruction and migration caused by disaster, we should pay attention to the sexual violence.

The topic of gender based violence is somewhat new to China, but all post-disaster helpers should be aware of it and should act to prevent violence at the earliest stage of the disaster. They should offer proper support to survivors and victims.

Emotional support and/or counseling includes confidential and sympathetic listening and offering tenderness and comfort to reassure the survivor that they are in no way responsible and should not feel guilt or shame for the fact that they were the victim of gender based violence. It is also normal for victims to feel emotional and psychological responses to extreme events they have experienced. Family members can effectively offer support to the victims.

Not all survivors/victims need emotional support, psychological counseling or help to feel integrated into society but all victims require psychological and social support at the initial stages of the emergency/disaster situation.



According to Inter-Agency Standing Committee of United Nations (IASC), the main preventive actions against gender based violence are described in the table below.

Basic prevention and action (Also relevant for urgent and emergency situations)	Comprehensive prevention and action (for the ongoing response)
Distribute information and inform all the cooperative departments about the list of behaviours that constitute gender based violence Implement a confidential complaint system	
Carry out water security and environmental hygiene projects	Do continuous evaluation to define water and hygiene supply problems associated with gender Make sure there are women representatives in water and hygiene committee
Ensure food safety and nutrition requirements are fulfilled	Monitor nutritional levels to determine food safety and nutrition problems associated with gender
Arrange shelters and allocations safely Make sure that violence survivors/victims get safe shelters Use a safe fuel collection strategy Offer hygienic products to women and children	Continuously supervise all shelter and allocation arrangements and re-design any areas where there are shown to be problems associated with gender
Make sure that women can get basic health services Offer sexual-violence associated health services Offer community-based psychological and social support to survivors/victims	Expand medical and psychological health services for survivors/victims Establish or improve medicine-law evidence collection rules Bring gender based violence associated health care management into the current health system, national policy, programming and curriculum structure Organize ongoing training and supportive supervision for medical staff Organize regular evaluation of the quality of health services Support community-based supportive projects for survivors/victims and their children Actively lead men to participate in activities preventing gender based violence
Make sure children receive safe education	Offer life skills training including preventing gender based violence to teachers and children in various educational activities.

Source:

"http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp" / "_blank" Guidelines on Gender-Based Violence Interventions – IASC

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CPR-Cardiopulmonary Resuscitation

Preparation

- 1. Response (R:Response):** Make sure field security quickly and get the response of patients. Pat the cheeks lightly or shake the shoulders gently and ask the patients "Are you OK?"
- 2. Activate the EMS system(A:Activate):** Call 120 to activate emergency medical service system.
- 3. Position:** Let the patient lie on flat ground, face up, with two arms on two sides of the body. Take care of the body to prevent spinal injuries when move.

Open the Airway(A:Airway)

Methods:

- (1) Head tilt-chin lift maneuver.
- (2) Jaw thrust maneuver: (recommended on a victim with or suspected with cervical spinal injury)



General medications

Pathways: Establish a near-cardiac venous pathway immediately, and drugs may be given through airways after an advanced airway is in place.

- **Adrenaline:** First choice.
1mg or 0.01~0.02mg/kg intravenous injection every 3~5 minutes.
- **Atropine:**
1mg every 3~5 minutes should be injected in victims with asystole and pulseless electrical activity.
A dose of 0.5mg every 5 minutes for bradycardia.
- **Vasopressin:**
Recommended when routine resuscitation, defibrillation and adrenalin are not effective.
Intravenous injection of 40U (0.8U/kg) of vasopressin diluted in 20ml normal saline should be repeated once after 5 minutes if there is no sign of circulation.
- **Amiodarone:**
Recommended in continuous ventricular fibrillation victims when adrenaline injection and defibrillation don't work.
IV injection of 5mg/kg amiodarone diluted in normal saline should be followed by defibrillation. If there is no sign of effectiveness after two defibrillations, another half dose may be tried.
- **Lidocaine:** seldom used now.
IV injection of 50~100mg diluted in normal saline is followed by IV drop of 1~4mg/min (100mg in 100ml saline, 15~60 drops/min).
- **Dopamine:** recommended in hypotension post resuscitation.
IV drop of 5~20µg/kg/min (20~40mg in 100ml saline, 19~75 drops/min) is recommended.

Breathing(B:Breathing)

Evaluation: to determine if there is no or poor breathing.

- The rescuer should put his ear near the mouth and nose of the victim whose airway was kept open and
 - To see if there is fluctuation of the chest;
 - To hear if there is air breathed in and out;
 - To feel if there is air movement.

The evaluation should take no more than 10 seconds.

- Techniques of rescue breathing
 - Mouth-to-mouth rescue breathing
 - Mouth-to-nose rescue breathing
 - Mouth-to-barrier device breathing
 - Ventilation With Bag and Mask

The ventilation rate of 10~12 breaths per minute (4-5 seconds each) should be maintained when only rescue breathing is available.



Circulation (C:Circulation)

1.Evaluation:

Rescuers should check the circulation signs of breathing and coughing. Healthcare providers should check the carotid pulse.

2.Chest compression

Place: Joint of the upper 2/3 and lower 1/3 of the sternum;

Frequency: 100 compressions per minute; The sternum should be depressed 4~5 cm in a normal figured adult;

Caution: Place the heel of the second hand on top of the first so that the hands are overlapped and parallel to the sternum; Fingers should be straight out or over-crossed so that they don't attach to the chest; The elbow, arm and shoulders should be in a line and depressed vertically; Compression and chest recoil/relaxation times should be approximately equal.

A compression-ventilation ratio of 30:2 is recommended for one or two rescuers' resuscitation. After an advanced airway is in place, chest compression at a rate of 100 per minute and ventilation at a rate of 10~12 per minute should be given, but not necessarily synchronous.

3.Re-evaluation: The victim should be reevaluated after 5 circle of compression-ventilation(30:2) within no more than 10 seconds. If there is no sign of circulation, chest compression should be continued and electrical defibrillation and advanced airway should be prepared.



Defibrillation (D:defibrillation)

Automated external defibrillators (AEDs)

1. AEDs should be used only in three clinical conditions as below:

- No response; ● No effective breathing; ● No signs of circulation.

2. AEDs procedures:

- Turn on the power
- Electrode placement: One pad is placed on the victim's right superior-anterior (infraclavicular) chest and the other one is placed on the victim's inferior-lateral left chest, lateral to the left breast, 4~5 cm below axilla.
- Analyze the cardiac rhythm: Don't touch the victim and the automated analyzer will detect ventricular tachycardia or ventricular fibrillation within 5~15 seconds and indicates that defibrillation should be started.
- Press the button: Make sure no one is touching the victim before you press down the defibrillation button.

Acute Intoxication

Essentials in diagnosis

Inquisition, examination, and resuscitation at the same time.

1. History: Careful history collection may lead us to the diagnosis straight forward although it may take a little more time.

- Pay attention to: initiation symptoms of the victim; history of contacting any toxics, drugs, or toxic animals or plants; similar symptoms of other persons in the same working, living, or eating environment; emotional behavior of the victim in the past few days; history of diagnosis and treatments;
- Acute poisoning should be considered if a patient developed manifestations of vomiting, diarrhea, dyspnea, cyanosis, convulsions, coma and shock with no apparent reasons.
- The rescuer in the scene should check the circumstance immediately looking for containers of possible poisons and any signs of poison residuals, vomit, and correspondences.

2. Manifestations: performing a comprehensive and quick physical check

- Vital signs: sensation, respiratory, blood pressure, heart rate and heart sounds are vital. If there is any signs of dying, resuscitation should be initiated before poisoning treatment.
- Type of poisons and degree of poisoning may be hinted by the following: color, humidity and temperature of the victim's skin, wideness of the pupil, odor of the mouth, rales of the lungs, abdominal pain, muscle extension strength, and physical or pathological reflex.

3. Laboratory test and poison identification: It is useful for diagnosis.

- (1) If necessary, the following tests should be conducted: routine tests of blood, urine, and feces, serum cholinesterase activity, determination of serum carbon monoxide, liver function, renal function, X-ray check, and electrocardiography.
- (2) Other than the specimen on the scene, samples of the stomach washout, waste product, and blood should be preserved for further examination.

Treatments

Emergency rescue, close observation, and careful nursing should be conducted.

First to stabilize the vital signs, and then to treat the poisoning according to the following procedures:

1. Termination of contacting with the poison: The victims poisoned by inhalation or contacting should be moved to a place with fresh air stripped of contaminated clothes and washed by warm water if possible.

2. Elimination of unabsorbed poisons in the gastrointestinal tract

(1) Vomiting induction: Recommended in conscious and collaborative patients. After drinking 300~500ml water, the patient should be induced vomiting with stimulation of the root of tongue and retropharyngeal. This action should be repeated until the vomit is clear.

▲ Caution: Vomiting induction should not be used in the following situations: coma, convulsions, recent bleeding or surgery of the gastrointestinal tract, pregnancy, portal hypertension, swallowing of corrosives and quick reacting drugs on CNS.

(2) Gastric lavage: A relatively thick tube should be inserted to the stomach. The location of the tube is normally determined by auscultation when air was injected to the stomach. Samples drained from the stomach should be kept for further examination. 200~400ml warm water should be injected into the stomach followed by draining. This should be repeated until the stomach washout is clear. The total water used should be about 5~10L. Preservatives, antidotes, and cathartic agents should be injected into the stomach before the tube was pulled out. Gastric lavage is preferred for swallowed poisons within 6 hours.

▲ Contraindications: esophageal varices, recent surgery or bleeding of the GI tract, convulsions, shock, corrosive swallower. Gastric lavage can be used for a coma patient only after an advanced airway was in place.

(3) Catharsis: 20~30g of magnesium sulfate or sodium sulfate should be admitted after vomit induction or gastric lavage.

▲ Contraindications: catharsis should not be used in corrosive swallowers. Magnesium sulfate should not be used in renal failure or CNS poisoning patients. Fluid infusion should be conducted before catharsis in a severely dehydrated patient.

3. Excretion of poisons absorbed

(1) Diuresis: This can be achieved by drinking a lot of water, intravenous fluid injection, injection of 200~250ml 20% mannitol or 20mg furosemide, with the aim to maintain the urine at 200~300ml/hour. Attention should be paid to the functions of the heart, lungs, and kidneys.

(2) Blood purification: hemodialysis, hemoperfusion

(3) Plasma exchange.

4. Specific antidotes:

(1) Organophosphorus: Atropine, cholinesterase reactive agents (pralidoxime, pralidoxime chloride)

(2) Heavy metal: calcium disodium edentate (CaNa₂-EDTA), Diethylenetriamine pentaacetic acid (CaNa₅-DTPA), sodium dimercaptosuccinate (DMS), sodium dimercaptosulphonate (DMPS), dimercaprol (BAL), penicillamine, prussian blue.

(3) Nitrite: methylene blue (small dose is recommended), toluidine blue

(4) Cyanide (bitter almond): nitrite + sodium thiosulfate

(5) Fluoroacetamide: Acetamide

(6) Morphine, ethanol (alcohol): naloxone

(7) Benzodiazepine: flumazenil

(8) Tricyclic antidepressants: Bicarbonate + physostigmine

5. Symptomatic treatment:

● Emergency rescue should be given to victims with airway obstruction, respiratory depression, lung edema, acute heart failure, cardiac arrest, shock, cerebral edema, convulsions, coma, or acute renal failure.

● Intensive care should be performed to keep the airway open and maintain the normal function of the lungs and heart. Great efforts also need to be used to prevent infection, maintain the balance of nutrition, acid-base, and water and electrolyte.

● Psychological interventions should be given immediately after sanity restored of a suicide who must be referred to a mental health specialty hospital after he or she returned to a stable condition to avoid another suicide.

● Severely ill patients must be transferred to a hospital when appropriate.



1 Mental health is one indispensable part for a healthy person. One person without mental disorders does not mean he/she is mental healthy. We need not only physical health ,but also mental health.

- Health not only means no illness or weakness, but also means a good condition with bio-psychosocial adjustment.
- Mental health means one condition that one person can evaluate oneself correctly, cope with the pressure of the daily life, study and work efficiently, and do good to the society and family. It includes normal intelligent, stable emotion, happiness, well self-awareness, harmony between the thought and behaviors, good social relationship and adjustment.
- Mental health problems exist commonly. Lots of people have mental health problems which may not be aware of.
- Mental disorder is one disease state that the psychological activities are abnormal, and mental symptoms occur, which are severe enough and last for a period of time that result in upset or the social function impaired
- There are approximate 400 kinds of mental disorders which can be classified into 10 main categories and 72 sub-classes according to the International Classification of Mental and Behavioral Disorders (ICD-10). The ten main categories include:
 - 1.Organic mental disorders. e.g. senile dementia
 - 2.mental and behavioral disorders due to psychoactive substances use. e.g. alcoholic dependence syndrome
 - 3.Schizophrenia, schizotypal disorder and delusional disorders
 - 4.Mood disorders. e.g. depression and mania
 - 5.Neurotic , stress-related disorders and somatoform disorders. e.g. anxiety disorder
 - 6.Behavioral syndromes associated with physiological disturbances and physical factors e.g. insomnia.
 - 7.disorders of adult personality and behavioral disorders. e.g. paranoid personality disorder.
 - 8.mental retardation.
 - 9.disorders of psychological development e.g. autism
 - 10.behavioral and emotional disorders with onset usually occurring in childhood and adolescence e.g. ADHD



2 Mental health and mental disorders are determined by the biological, psychological and social factors and their interactions, which is the same as the physical health and physical disorders

- The biological factors include age, gender, heredity, the development level around the birth, physical illness and addictive substances and etc..
- The psychological factors include personality trait, opinions on things, coping style and emotional characteristics and etc..
- The social factors include great events in daily life, accidents, adverse events, the support from society and family, culture and circumstance and etc.
- The biological, psychological and social factors and their interactions influence all the periods in one life. The benign interactions are the protective factors for the mental health, while the adverse interactions are the risk factors.



3 Everyone will face various mental health problems in one's life. It is necessary to pay much attention to and protect one's mental health.

- Infants (0-3 years old): The common mental health problems in infants are mainly resulted from the inappropriate education style. For example, the language development is limited and the interpersonal skills and the ability to control the emotion and behaviors is poor. It is the viable method to avoid these problems to develop their good habits and to increase the communication with them on mood, language and body.
- Pre-school children (4-6 years old): The common problems in preschool children include the difficulties to separate from parents, and to get along with others children. If these problems were not dealt with in a purposeful way, children would refuse to go to school, or be unsociable and eccentric. It is the viable method to avoid these problems to encourage them to play with other children and share their experience with each other, and to develop their independent and cooperative abilities.
- School children (7- 12 years old) and adolescents (13-18 years old) The common problems in school children and adolescents include learning problems(e.g. test anxiety and learning difficulties), interpersonal problems(e.g. school mal-adaptation and playing truancy), emotional problems, psychosexual development problems, behavioral problems(e.g. bully, self-harm, and recklessness), internet addiction, smoking, drinking, drug misuse, and excessive diet, anorexia and gluttony. It is the viable method to avoid these problems to adjust their learning pressure, communicate with others, strengthen their social adaptation, and to cultivate hobbies.
- Adults (19-55 years old): The common problems in adults are related to their work, such as working circumstance mal-adaptation, interpersonal problems, employment and working pressure. Another common problems are related to their family, such as marriage crisis, tensions within families, and the education problems on children. It is the viable method to avoid these problems to build the interpersonal support network, seek helps actively, live loose and tight, and to cultivate hobbies.
- Middle aged and elderly (Over 55 years old) The common problems in middle-aged and elderly are related to retirement, relationship with sons and daughters, empty net, family accident, and physical illness. It is the viable method to avoid these problems to receive the physiological change resulted from ages, establish new social circle, participate more social activities, study new knowledge and to develop hobbies.
- All the natural disasters, human accidents, traffic accidents and violence incident will not only influence our daily life, but also result in psychological upset, even mental disorders. It is the viable method to avoid these problems to understand the psychological changes resulted from sudden and tragic incidents, and to seek helps and psychological support.



4 The mental disorders needed priority prevention and treatment are schizophrenia, depression, behavior disorders in children and adolescents and senile dementia.

- Schizophrenia often occurs in young adulthood. Hallucination, delusion and thinking disturbance will be present in acute period. Some cases will turn to chronic course, in which poverty of thought, apathy, abulia and social interaction avoidance will be present. And they will be mental disability finally.
- Depression can occur in persons of almost any age, and it is characterized by marked and persistent lowered mood, thought retardation, and fatigue. Anxiety, uselessness, helplessness, hopelessness often occur together. In severe cases self harm and suicide may be present. Somatic discomfort is often accompanied with depression, so it is often misdiagnosed. If features above last for 2 weeks, it should be paid much attention to.
- Behavioral disorders in children and adolescence include attention deficit hyperactivity disorder(ADHD), oppositional defiant disorder, conduct disorders, tic disorders, and other behavioral disorders. ADHD is more common than other behavioral disorder among children under 6 years old, and it is characterized by marked inattention, lack of perseverance in task performance, over activity or impulse, which result in marked impairment in academic performance and interpersonal relationship.
- Dementia is characterized by pervasive impairment in memory, intelligence and personality in elderly. Alzheimer's Dementia and Vascular Dementia are common. The memory, understanding, judgment and calculation ability are pervasively declined, which result in the impairment in work ability and social adoption. In some severe cases they can not take care of themselves with the disease deterioration.



5 If some one was suspected to suffer from mental disorder or psychological and behavioral problems, it is best to go to the medical institution to receive the consultation and the regular diagnosis and treatment as soon as possible.

- If someone was suspected to suffer from mental disorder or psychological and behavioral problems, it is best to go to the psychiatric hospital or the department of the psychiatry or psychology in general hospital to receive the consultation and the diagnosis and treatment as soon as possible.
- If people around you such as your families, neighbors, colleagues, classmates manifest obviously eccentric language and behaviors, it suggests that he/she might suffer from psychological and behavioral problems or mental disorder, and you'd better suggest him/her to go to medical institution to receive examine.
- The main treatment method to psychological and behavioral problems is psychological consultation and psychotherapy, and the social support and the medication is supplementary.
- There have been effective medication, psychotherapy and social rehabilitation methods to mental disorders.
- If some one is diagnosed with mental disorder, regular treatment should be carried out, that means medicine should be taken by description uninterruptedly so as to get the best effect. If some one with mental disorder would be reluctant to take medicine, or take medicine incorrectly or irregularly, it would lead to the disease relapse or to be difficulty to be healed.
- After the standardized treatment, most patients can be healed, and live, study and work normally.



6 Mental disorders can be prevented and treated

- The prevention and treatment of mental disorders can be divided into three levels.
- The primary prevention is to strengthen the protective factors and decrease the risk factors. the measures that can be taken include improving the nutritional status and living condition, increasing the opportunities to education, improving the economic condition, fostering a stable and good family atmosphere, strengthening the community support network, decreasing the addictive substance misuse, preventing the violence, carrying out the psychological intervention after the disaster and health education, and developing the personal skills, and so forth.
- The secondary prevention is to discover, diagnose, and treat the disease early so as to control the disease and decrease the harm.
- The tertiary prevention is to carry out the self-care and social adaptation ability and the career skills training to patients so as to decrease the disability and the impairment of the social function, to promote rehabilitation and to prevent the recurrence.



7 Concern about and not discriminate against psychiatric patients, and helping them back to family, community and society.

- Like the physical disorders patients, the psychiatric patients are victims, and they should be understood and helped.
- The families should take care of and monitor them.
- They should not be discriminated against in the community, and should receive the help for rehabilitation.
- Their work unit or school should provide the appropriate opportunities to work or study after the rehabilitation.
- The mental disability is one of the six kinds of disabilities, so they are protected by the Law of the People's Republic of China on the Protection of Disabled Persons.
- The vagrants and beggars who suffer from mental disorder and endanger the public security and affect the social order and image severely should be treated.
- The eligible patients can apply for the medical assistance from the civil administration department in areas where medical assistance have been implemented.



8 The mental health is related to social harmony and development. It is the responsibility of the whole society to promote the mental health and to prevent the mental disorder.

- It is reported by WHO (2001 World Health Report) that about one quarter of the world population will suffer from mental or behavioral disorders. one fifth will suffer from developmental, emotional or behavioral problems, and one eighth will suffer from mental disorders among people under 18 years old.
- It is calculated that the total prevalence of the mental disorders is about 15% among people above 15 years old in China, according to the epidemiological survey in Zhejiang and Hebei Province.
- The guidelines on mental health work are prevention first, combining prevention and treatment, focusing on intervention, extensive coverage and management in accordance with laws. The working mechanism is government leading, sectors cooperation and community involvement. The mental health service network will be established and completed, and the priority of the prevention and treatment will be transferred to community and grass root step by step.

Sources:

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