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Psychosocial Care of
Tsunami-Affected Populations

Physician's Manual



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1. INTRODUCTION

The Tsunami disaster has imposed a huge burden on the community not only in physical terms but also in terms of the psychological trauma they have suffered. A major challenge that faces communities and their governments is to cope with adverse physical and psychological conditions effectively. Although disaster-affected individuals do need and benefit from the material assistance and physical healthcare provided to them as part of relief work, they also need appropriate psychosocial care to help them cope better with the psychological trauma they undergo during and after the disaster. Psychological support should be available from the acute phase immediately after the disaster, and extend till the community is rehabilitated both physically and psychologically.

It should be noted that EACH AND EVERY PERSON in the population is psychologically affected to some extent. Thus, in terms of numbers, the magnitude of the problem of psychological stress is as large as the size of the population affected by the disaster. It is imperative that psychosocial interventions are accessible to each person in the community.

Immediately after the disaster, there is an outpouring of concern, sympathy and the desire to assist the victims as much as possible. Money, material and personnel are mobilized to help the disaster victims. Unfortunately, such assistance, although well meaning, is sometimes lacking in professional standards and is often based on the belief that doing something is better than doing nothing. Psychological interventions provided by untrained or unsupervised workers can even be harmful.

The international community has witnessed several major disasters in recent decades and their response is getting better and more streamlined over time. However, there can be no one 'universal formula' for dealing with the needs of all Regions and for all type of disasters.

The term 'social intervention' is used for interventions that primarily aim to have social effects, and the term 'psychological intervention' is used for interventions that primarily aim to have psychological effects. It is acknowledged that social interventions have secondary psychological effects and that psychological interventions have secondary social effects as the term psychosocial suggests.

The term 'psychosocial interventions' in the context of disaster management does not refer only to highly specialized interventions by mental health experts. In fact most psychosocial interventions for disaster-affected people can be carried out effectively by community level relief workers, if they are trained and supervised to do so.

While psychosocial care to a majority of people can be provided by the community level workers (CLWs) engaged in relief work, physicians are required to deliver psychosocial interventions to those people either seeking help from physicians directly or referred to physicians by CLWs for treatment of psychological problems. Generally it is believed that a small percentage ranging from 5-10% should need medical treatment. The

physicians (specially general physicians) can provide effective treatment to these people for their psychosocial problems after they have been sensitized to psychosocial aspects of disaster.

The present manual is meant exclusively for physicians, to help them in providing treatment for psychological problems of Tsunami disaster victims in SEAR.

2. RESPECT FOR LOCAL CULTURE IN IMPLEMENTING PSYCHOSOCIAL INTERVENTIONS

In addressing the psychosocial needs of the community, the cultural foundations of the community must be kept in mind. All programmes being implemented must be culturally sensitive and appropriate to the local community. A deep appreciation of the culture, its historical roots, and the way it has shaped indigenous concepts of mental health and healing requires an ongoing commitment to learning.

Complete understanding of local cultures helps determine the appropriateness and feasibility of specific interventions. The culture of a community may affect the choice of interventions in many ways. Important considerations include:

- Help-seeking expectations (e.g., persons used to dealing with traditional healers may expect almost immediate relief);
- Duration of treatment (which may need to be short because of limited access to care);
- Attitudes toward intervention (e.g., preference for or dislike of medication);
- Cost-effectiveness of the intervention; and
- Family attitudes and involvement (many cultures emphasize the family over the individual).

Respecting the concerns, needs, resources, strengths and human rights of individuals, their families, communities, cultures and nations are extremely important.

3. SOCIAL SUPPORT

The psychological well-being of disaster-affected victims can be promoted by attention to some social issues which concern the victims. Strategies to improve social well-being include:

- Providing uncomplicated and accessible information on location of corpses.
- Discourage unceremonious disposal of corpses.
- Helping to trace the families of unaccompanied minors, the elderly and other vulnerable people.

- Encourage members of field teams to actively participate in grieving.
- Encourage recreational activities for children including opening schools.
- Widely disseminating uncomplicated, reassuring, empathic information on normal stress/trauma reaction to the community at large (religious leaders, teachers and other social leaders should be involved actively).
- Encourage the re-establishment of normal cultural and religious activities
- Involve adults and adolescents in concrete purposeful activities (e.g., repair of housing, distributing food, sanitation measures, etc.)
- Assist illiterate people to deal with official documentation required in order to obtain aid.
- Occupational rehabilitation for those who may have lost their means of livelihood.
- Please keep in mind that the local communities may be sensitive to the dress and demeanor of the workers especially if they happen to be from outside the community.

4. INTEGRATING TREATMENT FOR PSYCHOLOGICAL PROBLEMS WITH OTHER MEDICAL CONDITIONS

Some people affected by a disaster may develop stress related physical symptoms (e.g. headache) for which they will consult a physician. The course of many medical illnesses may become prolonged or complicated due to stress caused by the disaster.

It is necessary to integrate the delivery of treatment for psychological problems and physical problems because:

- It is usually not possible to have enough number of mental health specialists to serve all the people.
- Majority of the psychosocial problems can be treated adequately by appropriately trained physicians.
- Some people prefer to take treatment from a physician rather than from a psychiatrist, due to stigma, more so for minor psychological problems.
- People manifest their psychological problems in the form of physical symptoms and hence seek advice from a physician.
- Many people suffer from both physical and psychological problems simultaneously.
- It is cost effective and more practical to deliver services for psychological problems and physical problems in an integrated manner through single channel of service delivery rather than two parallel service delivery systems.

5. AIM OF THIS MANUAL

- To sensitize physicians to the psychosocial aspects of disaster in the affected population.
- To familiarize them with integrating medical interventions with psychosocial care to survivors.
- To enhance their capacity in evaluation and management of individuals with psychiatric disorders and make appropriate referral wherever necessary.

6. PSYCHOLOGICAL RESPONSES OF THE DISASTER AFFECTED POPULATION

The psychological impact of disaster varies from transient reactions like tension, anxiety, panic, confusion, fear, repeated 'flashbacks' etc.; to lifelong emotional scars. Some of the psychological symptoms which may disturb the disaster affected victims for several months after a disaster are sadness, pessimistic thoughts, inactivity, withdrawn behaviour and anxiety manifested as physical symptoms.

Majority of the people are able to cope well with these emotional reactions due to their innate coping mechanisms/resilience. However, some disaster survivors may develop psychiatric disorders such as depressive disorders, anxiety disorders, post traumatic stress disorder, adjustment disorder, abnormal grief, exacerbation/relapse of pre-existing psychiatric disorders, alcohol and drug abuse. This group requires appropriate identification, treatment or referral.

Some people undergoing psychosocial trauma may complain of certain physical symptoms like headache, pain abdomen etc. It is important to recognize the psychological nature of these symptoms and manage them accordingly. [For details of the various psychological responses, please refer to the CLWs manual – module 1)

7. PSYCHOLOGICAL INTERVENTIONS FOR DISASTER AFFECTED PEOPLE

A vast majority of disaster affected people need some form of psychosocial support and care. However the degree and nature of support needed depends upon the type and severity of the emotional reaction. Depending upon the type of psychological reactions to the disaster situation, disaster-affected people may need different psychosocial interventions. During the acute emergency phase, general psychosocial measures like providing uncomplicated and accessible information on location of corpses, encouraging organization of prayers and other socio-religious activities, involving healthy survivors in relief work etc. are undertaken to enhance the emotional well-being of the disaster affected people.

The levels of intervention required during the reconsolidation phase, also depends on the kinds of psychological reactions. General psychosocial measures may help people who are able to cope well with their emotional responses. Those who suffer from some psychological symptoms which are not severe enough to be called a disorder, may benefit from more specific interventions like emotional first aid, grief counseling etc. People who suffer from specific psychiatric disorders will need to be identified and treated by a physician or referred to a mental health specialist. Similarly physicians should be careful not to assume that all physical symptoms are due to psychological trauma. They should be able to differentiate between normal and transient reactions, which do not require intervention and cases that require medication.

Psychosocial interventions aim to restore the emotional equilibrium, of a person in distress by psychological means. It involves very simple measures like listening to a person in distress about his difficulties, understanding the nature of his problems and talking to him. Some simple psychotherapeutic techniques like brief supportive psychotherapy and building trusting and confiding relationships between physician and patient are very helpful. Some specific psychosocial intervention techniques like psychological/emotional first-aid, crisis counseling, crisis intervention and problem solving counseling are used to help the disaster affected individuals presenting to the physician. Physicians may refer to module-II of the CLWs manual for details of the counseling techniques.

8. PSYCHOSOCIAL INTERVENTIONS FOR SPECIAL GROUPS

Certain groups of people like children, women, elderly, disabled people and persons suffering from mental disorders are more vulnerable to the psychosocial effects of disaster.

The emotional reactions of pre-school children differ from that of the school-going age group and as such, the measures needed to be taken for them also differ. In general, measures should be taken to ensure that the child remains close to its family and that the child's routine activity like playing, games, drawing etc. are restored and encouraged. In case the child continues to show symptoms even after one month, the mother/teacher should be asked to report to a mental health specialist.

The elderly may show varied emotional reactions like anger, frustration, feeling lonely etc. and may be especially vulnerable if they are physically disabled, living alone and lacking help from other resources. They can be helped by ensuring that they are placed with their families, helping them establish their daily routine, keeping them informed about the happenings and referring them to a physician or a mental health specialist if needed.

Women also tend to be more vulnerable to the effects of a disaster and are more prone to depressive and anxiety symptoms. Some strategies to help them include involving them in community level activities, extending special care to pregnant and nursing mothers etc. For details of psychosocial intervention for special groups, please refer to module-III of the CLWs manual.

9. WAYS IN WHICH PATIENTS MAY PRESENT TO A PHYSICIAN

Patients requiring evaluation and treatment for psychological problems, which present in one of the following forms:

- (1) Patients with obvious psychological symptoms and indicative of a specific psychiatric disorder.
- (2) Individuals with obvious psychological symptoms but not amounting to a diagnosable psychiatric disorder.
- (3) Individuals with psychological symptoms associated with physical illness.
- (4) Individual with physical symptoms which are not explainable by physical illness and are part of a psychiatric illness or are physical manifestations of stress.

10. EVALUATION AND MANAGEMENT OF PSYCHIATRIC DISORDERS

Psychiatric disorders commonly seen in disaster affected people are depression, anxiety disorder, mixed anxiety-depressive disorder, abnormal grief, somatoform disorders, alcoholism and substance use disorders. In addition to these, known cases of psychoses, substance abuse or alcoholism may relapse after the disaster. The patients suffering from these disorders may either approach physicians directly for treatment or a CLW or any other health worker or relief provider may refer them to a physician. Physicians should be well aware of the common signs and symptoms of these disorders to be able to diagnose these patients correctly.

It is important to note that psychological symptoms should only be labeled as a disorder when they meet the following criteria:

- (1) The symptoms are intense leading to significant impairment in functioning – social and occupational of the affected person.
- (2) The symptoms persist for a few weeks (4 – 6 weeks) (except in psychoses where even one week symptoms are sufficient to make a diagnosis).
- (3) The symptoms should be present for most of the time rather than occasionally or sporadically.

Depressive Disorder

It is important to differentiate depressive symptoms which can also be called 'sadness' and requires no specific treatment from depressive disorder which requires specific medical treatment. Depressive disorder should be diagnosed only when the persons symptoms are severe, prolonged and functionally disable a person. Patients with depressive disorder will require pharmacological treatment along with psychosocial interventions.

Signs and symptoms

- Depressed mood: feeling sad, anguished, mournful, irritable or anxious
- Loss of interest and enjoyment
- Reduced energy, easy fatigability, decreased activity, marked tiredness on slight effort
- Reduced concentration and attention on a task
- Reduced confidence and low self-esteem
- Feelings of guilt and unworthiness
- Bleak and pessimistic view of the future
- Acts of self-harm or attempted suicide
- Disturbed sleep
- Diminished libido and appetite

Many patients with depression present to the doctor with physical symptoms such as headache, chest pain, loss of appetite, inability to sleep etc., thus every physician should consider if depressive disorder is the cause of physical symptoms in a patient. Physician should enquire about the patients worries, adverse situations or other causes which could be bothering the patient. However it is incorrect to presume that in a disaster situation all physical symptoms are due to depression.

Patients with depressive disorder are also at a high risk for committing suicide. If in doubt, ask the patient directly if they have considered committing suicide.

On examination the patient usually is very quiet and looks withdrawn with a blank face. They often refuse to talk or may reply with single words. Detailed history is often impossible to elicit.

Pharmacological treatment

Choice of antidepressant drugs will depend on anticipated side effects, safety and tolerability and presence of co-morbid physical illness.

Following medicines are likely to be optimal for most patients:

- Selective Serotonin Reuptake Inhibitor (SSRI) (Fluoxetine: 20 – 40 mg/ day)
- Imipramine (150 – 250 mg/ day). This is the most widely used antidepressant, however it is now less preferred because of side effects
- Start all medicines in lower doses and build up gradually over a period of 7- 10 days.
- Continue antidepressants in adequate doses for 6 – 8 weeks period

- If the response is partial increase the dose
- If patient has shown good response to treatment, continue for 6 – 9 months
- Taper off medications over 4 – 6 weeks after completion of treatment.

When to refer to a psychiatrist

The following patients should be referred to a psychiatrist:

- Patients of recurrent depression, severe depression, depression with psychotic symptoms, depression resistant to treatment as described above, bipolar disorders in the phase of depression and patients with co-morbid physical and other psychiatric disorders
- Patients with suicidal ideations and attempt.

Anxiety Disorders

Anxiety usually presents with somatic, cognitive or emotional symptoms. Anxiety disorders include generalized anxiety disorder (GAD), panic disorders, social and specific phobias and post traumatic stress disorder (PTSD). Symptoms could be episodic or continuous, they can appear suddenly without cause or be a response to a specific situation.

Signs and symptoms

- Prominent somatic symptoms: palpitation, muscle tremor, perspiration, abdominal discomfort, hyperventilation
- Prominent cognitive symptom such as poor concentration and memory
- Prominent emotional symptoms such as nervousness and fearfulness.

On examination, the patient shows signs of restlessness, is fidgety has a worried look. They often have tremors and sweaty palms with increased heart rate and blood pressure.

Pharmacological treatment

- Generalized anxiety disorder:
 - Diazepam 5mg twice daily in mild cases and 10mg thrice daily in severe cases ***or***
 - Alprazolam 0.75 – 1.5 mg/day ***or***
 - Buspirone 30 – 60 mg/day
 - Propranolol 40 – 80 mg/day in two divided doses

Because of abuse potential, benzodiazepines should not be given for more than 4 – 6 weeks.

- Panic disorder
 - Fluoxetine 20 – 40 mg/day *or*
 - Alprazolam 1.5 – 6 mg/day in two to three divided doses *or*
 - Imipramine 50mg/day in two divided doses to a maximum of 150 – 250 mg/day

Post-Traumatic Stress Disorder

This is a condition seen after disasters. When people face an overwhelming event that is perceived as dangerous and beyond the normal coping capacity, the ability to respond adequately gets hampered. PTSD is not a single symptom but a cluster of symptoms. Symptoms of PTSD include:

- Re-experiencing the event (e.g. in nightmares)
- Routine avoidance of reminders of the event
- General lack of responsiveness
- Diminished interest and engagement
- Increased sleep disturbance and poor concentration

Other symptoms such as depression and anxiety should not be considered as indicators of presence of PTSD. This condition is diagnosed only when the above symptoms have been present for longer than one month.

Management of PTSD

A person can recover from PTSD on his own over a period of time through the combined actions of education, support, anxiety management and lifestyle modification.

- Education, the first step, involves helping the person understand his/ her condition and reassuring them that the reactions are a result of stress due to the traumatic event.
- Support from family, friends and anyone working with the person by letting the person know that he/ she is not alone and is not responsible for the event, etc., helps in the recovery process.
- Teaching anxiety management strategies like relaxation, breathing techniques and diverting the individual's mind through involvement in activities.
- Changes in their lifestyle are very important. This means following a healthy diet, avoiding stimulants or intoxicants, regular exercise and adequate sleep. In certain cases medication may be recommended. All these help in the recovery process.
- Patients may need pharmacological treatment for anxiety.

When to refer to a psychiatrist

Patients with severe anxiety, recurrent panic attacks and severe PTSD not responding to treatment as described above after a trial of 4-6 weeks.

Mixed Anxiety Depressive Disorder

Sometimes anxiety disorder and depressive disorder can occur in the same person at the same time presenting with signs and symptoms of both disorders. Treatment may be necessary for both conditions.

Adjustment Disorder

This is a painful or maladaptive reaction to some specific stress and occurring within 3 months of onset of stressor(s). Once the stressor (or its consequences) has terminated, the symptoms usually subside in 6 months.

Signs and symptoms

- Depressed mood
- Tearfulness
- Hopelessness
- Anxiety manifested by palpitation, hyperventilation
- Disturbance of conduct such as: vandalism, reckless driving, fighting (rights of others are violated or age appropriate societal norms are disregarded)
- Work disturbance (academic inhibition manifested by difficulty functioning at work or in school)
- Withdrawal, manifested by socially withdrawn behaviour that is not typical for the person.

Pharmacological treatment

If severe anxiety symptoms occur, use anti-anxiety drugs for the first few days (e.g. Alprazolam 0.5 – 1 mg up to three times per day).

When to refer to a psychiatrist

Refer the patient to psychiatrist if significant symptoms last more than one month despite the above measures.

Somatoform Disorders

These represent a category in which the patient has a variety of physical complaints for which no specific etiology can be found. Previously this condition was called as hysteria. The symptoms usually help the individual to escape from the stressful situation or attract attention. The symptoms can mimic any medical illness. Thus a careful medical examination is necessary to exclude physical illness. The characteristic feature of somatoform disorders are that it does not fit into a characteristic pattern of medical illness.

Somatoform disorders include:

- Conversion disorder: unexplained paralysis, seizures
- Hypochondriasis
- Somatization disorder: a disorder characterized by multiple somatic complaints.

General principles of management

- Exclude disease but avoid unnecessary investigation
- Listen to patients sympathetically, the patient is seeking help
- Do not label them as hysterical or malingerers
- Focus on simple symptomatic relief and not on determining its cause
- Provide reassurance to the patient
- Encourage and focus on functioning rather than on symptoms and illness
- Psychotropic medications should be used judiciously.

Abnormal Grief

Grief refers to the psychological and emotional processes that accompany bereavement, which are expressed both internally and externally. Normal grief remits within 6 months.

Signs and symptoms

- Social avoidance
- Depressive ideation
- Lack of sleep
- Anorexia
- Somatic symptoms of pain or discomfort
- Impairment of performance

- Lack of energy
- Preoccupation with deceased
- Transient hallucinations
- Mummification (preservation of possessions)

Management

- Counseling for the bereaved
- Drug treatment can relieve severe anxiety or depression that is distressing. Initially a hypnotic or anxiolytic may be needed, but later antidepressant drugs may be beneficial.

Acute Psychotic Disorders (relapse or new onset)

Signs and symptoms

Recent onset of:

- Hallucinations (false or imagined sensations e.g. hearing voices when no one is around)
- Delusions (firmly held ideas which are plainly false and not shared by others in the patient's social group)
- Disordered thinking: exhibited by strange or disjointed speech.
- Abnormal behaviours like social withdrawal and social inhibition, suspiciousness, threatening.

Pharmacological treatment

- Give Inj. Haloperidol (5-10 mg) along with Inj. Promethazine (50mg) intramuscularly **or** give Inj. Lorazepam (4 mg) intravenously/intramuscularly
- Commence oral neuroleptics and refer the patient to a psychiatrist.

Acute Manic Episode

It can occur as an isolated episode or may precede or follow a depressive episode.

Signs and symptoms

- Increased energy and activity
- Elevated mood or activity

- Rapid speech
- Loss of inhibitions
- Decreased need for sleep
- Easily distracted
- In severe cases hallucinations and delusions may be present.

Pharmacological treatment

- Injection Haloperidol (5-10 mg) along with Injection Promethazine (50mg) intramuscularly **or** Injection Lorazepam (4 mg) intravenously/ intramuscularly
- Commence oral neuroleptics and refer to psychiatrist

Alcoholism

In situation of disasters there could be excessive consumption of alcohol leading to alcohol intoxication or if alcohol is not available to a dependent on alcohol there may be alcohol withdrawal symptoms.

- **Alcohol intoxication:** elated mood, disinhibition, impaired judgment, belligerence, mood lability, reduced attention span, slurred speech, motor incoordination, unsteady gait, nystagmus, stupor or coma.
- **Alcohol withdrawal:**
 - Autonomic hyperactivity (e.g. sweating or pulse rate > 100)
 - Increased hand tremor
 - Insomnia
 - Nausea or vomiting
 - Transient visual, tactile or auditory hallucinations
 - Psychomotor agitation
 - Anxiety
 - *Rum Fits:* Generalized tonic-clonic seizures
 - *Delirium Tremens:* typically begins 48–72 hours after the last drink and subsides within 2–5 days. The above symptoms are accompanied by reduced level of consciousness, disorientation to time and place, impairment in recent memory, insomnia and perceptual disturbances like visual and auditory hallucinations and illusion. The patient is restless, fearful and may become severely agitated. Symptoms are worse at night

Management of alcohol withdrawal

Uncomplicated withdrawal

- Benzodiazepines are the treatment of choice
 - Diazepam 20-60 mg or chlordiazepoxide 40-120 mg daily in divided doses orally.
 - Oxazepam 30-60 mg or Lorazepam 4-8 mg daily in divided doses by oral route in patients with hepatic impairment
- Alternatives- Carbamazepine 400-600 mg/day in 3 divided doses
- There is no need of antipsychotic medications
- Medications should be tapered off within 7-14 days.

Rum fits

- Diazepam 10-20 mg IV for prevention of further convulsions
- Refer the patient to a hospital for urgent treatment.

Delirium Tremens

- Parenteral Diazepam (10 mg) or Lorazepam (2mg) are the drugs of choice. The patient should be referred to a hospital for urgent treatment.

Other substance use disorders

Opioids

- **Opioid intoxication:** Initial euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgment, impaired social or occupational functioning, papillary constriction, slurred speech, drowsiness, impairment of memory.
- **Opioid withdrawal:** nausea, vomiting, muscle aches, joint pains, lacrimation, rhinorrhoea, dilated pupils, piloerection, sweating, diarrhoea, yawning, changes in body temperature, increased cardiac rate, cramp like abdominal pain.

Sedatives, hypnotics and anxiolytics

- **Intoxication:** Slurred speech, incoordination, unsteady gait, impaired attention or memory, disinhibition, mood lability, impaired judgment, impaired social functioning.
- **Withdrawal:** nausea, vomiting, malaise or weakness, tachycardia, sweating, anxiety, irritability, orthostatic hypotension, coarse tremor of the hands, tongue, eyelids,

insomnia, generalized tonic-clonic seizures, loss of appetite and body weight; delirium, hallucinations, delusions, agitation.

Management

If the patient is suffering from a overdose of either opioids or other drugs symptomatic relief should be started immediately for the presenting symptoms. For long-term management the patient should be referred to a detoxification centre.

Psychosocial Care of Tsunami-Affected Populations

Information for Physician's

WHO SEARO

Introduction

- **Magnitude**
 - ◆ **Everyone is affected in some way**
 - ◆ **Approximately 50% require some support**
 - ◆ **Approximately 5 – 10% require professional help**

- **Social intervention**
- **Psychological intervention**
- **Psychosocial intervention**

Introduction

- Health issue, but not necessarily medical
- Implement only appropriate interventions
- Appropriate training of CLWs extremely important
- Many methods are available
- Coordination is important

Psychosocial support

- Each affected person should be reached
- Government estimates of persons affected
- CLWs working in the community for psychosocial first aid

Respect for local culture

- Programmes must be culturally sensitive
- Culture affects response of the society
- Culture may affect the choice of interventions

Social support

- Attention to simple social issues
- Strategies to improve social well-being
 - ◆ Issues which are relevant immediately and locally
 - ◆ Social support should be culturally appropriate

Need for external psychosocial support

- Mutual social support built into community life
- Entire support system destroyed

Inter-agency collaboration

- Initial out pouring of humanitarian assistance
- Many people and agencies are concerned
- Doing something is better than doing nothing
- Too many people doing the same thing

Psychological responses of disaster-affected populations

Psychological reactions seen among victims

Responses of affected people can be divided into 3 broad categories

- ◆ **Normal psychosocial responses, requiring no specific intervention**
- ◆ **Psychological responses resulting in short duration distress or dysfunction, people will benefit from psychosocial first aid**
- ◆ **Severe distress or dysfunction needing help from a mental health professional**

Psychological reactions seen among victims

Immediate reactions (within 24 hours):

- ◆ Tension, anxiety, panic
- ◆ Stunned, dazed, shocked, disbelief
- ◆ Elation or euphoria among survivors (in people suffering lesser losses)
- ◆ Restlessness, confusion
- ◆ Agitation, crying and withdrawal
- ◆ Survivor's guilt

These reactions are seen in nearly everybody in the affected region and can be considered as a *Normal reactions to an abnormal situation.*

Needs no specific psychological intervention.

Psychological reactions seen among victims

Within days to weeks after the disaster

- ◆ Being fearful, vigilant, hyper-alert
- ◆ Irritable, angry, unable to sleep
- ◆ Worried, despondent
- ◆ Repeated 'flashbacks' (memories of the event coming to mind again and again)
- ◆ Weeping, guilt feeling (including survivors guilt)
- ◆ Sadness
- ◆ Positive reactions including: hoping / thinking of future, getting involved in relief and rescue work
- ◆ Acceptance of disaster as nature's doing

All these are normal responses and may need only minimal psychosocial intervention

Psychological reactions seen among victims

After about three weeks of disaster:

The previously noted reactions may persist and involve symptoms such as:

- Restlessness
- Panic feelings
- Continued deep sadness, unrealistic pessimistic thoughts
- Outward inactivity, isolated and withdrawn behavior
- Anxiety manifested as physical symptoms like palpitations, dizziness, restlessness, nausea, headache

These responses do not necessarily amount to a mental illness.

The individuals reporting the symptoms can likely be helped by the CLWs trained in providing some basic psychological intervention.

Common coping skills of disaster affected populations

Healthy Coping Skills

- ◆ Ability to orient oneself rapidly
- ◆ Planning and execution of decisive action
- ◆ Appropriate use of assistance resources
- ◆ Appropriate expression of painful emotions
- ◆ Tolerance of uncertainty without resorting to impulsive action

Not all emotional consequences of the disaster among the survivors are maladaptive.

A majority of people demonstrate healthy and mature coping responses to the situation.

Negative coping skills of disaster affected populations

Unhealthy Coping Skills

- ◆ Excessive denial and avoidance
- ◆ Impulsive behaviour
- ◆ Over-dependence
- ◆ Inability to evoke caring feelings from others
- ◆ Emotional suppression
- ◆ Substance abuse

Psychosocial interventions for disaster-affected people

Psychosocial interventions for disaster-affected people

During the acute emergency phase (first 3 weeks)

- ◆ **Provide uncomplicated and accessible information on location of corpses**
- ◆ **Discourage unceremonious disposal of corpses**
- ◆ **Provide family tracing for unaccompanied minors, elderly and other vulnerable people**
- ◆ **Encourage people to organize group activities like prayers, collective performance of rituals and other socio-religious activities**
- ◆ **Encourage members of field teams to actively participate in grieving**

Psychosocial interventions for disaster-affected people

During the acute emergency phase (first 3 weeks)

- ◆ **Encourage recreational activities for children**
- ◆ **Inform people about the normal psychological reactions that occur after disaster. Assure them that these are NORMAL, TRANSIENT, and SELF-LIMITING and UNIVERSAL.**
- ◆ **Religious leaders, teachers and other social leaders should be involved actively**

Psychosocial interventions for disaster-affected people

During the acute emergency phase (first 3 weeks)

- ◆ Encourage people to work together for looking after their needs
- ◆ Involve healthy survivors in relief work
- ◆ Motivate community leaders and other key persons to engage people in group discussions and share their feelings
- ◆ Ensure equitable distribution of the relief aid
- ◆ Deliver services in a 'healing manner' empathizing with the people and showing no callousness towards any section (e.g. weaker or minority) of the community

DO NOT FORCE VICTIMS TO TALK ABOUT THEIR EXPERIENCES

Psychosocial interventions for disaster-affected people

Summary of interventions during the acute emergency phase (first 3 weeks)

- ◆ Listen
- ◆ Convey compassion
- ◆ Assess needs
- ◆ Ensure basic physical needs are met
- ◆ Do not force talking
- ◆ Provide or mobilize company preferably from family members
- ◆ Encourage but do not force social support
- ◆ Protect from further harm

General suggestions to individuals for their own well-being

- ◆ Remain in familiar surroundings
- ◆ Begin reconstruction
- ◆ Avail of bonafide assistance
- ◆ Get back to daily routine
- ◆ Express your emotions
- ◆ Try to help others
- ◆ Take time to relax
- ◆ Eat right and sleep well
- ◆ Do not consume excessive alcohol or sedatives

Communicating with disaster-affected people: Important Do's and Don'ts

DO's

- ◆ Approach the people actively
- ◆ Listen attentively
- ◆ Be empathetic, avoid sympathy
- ◆ Respect people's dignity
- ◆ Accept and appreciate people's views on their problems
- ◆ Be aware of the need for privacy and confidentiality
- ◆ Ensure continuity of care

Communicating with disaster-affected people: Important Do's and Don'ts

DON'Ts

- ◆ Do not force your help/ support
- ◆ Do not interrupt people when they share their emotions
- ◆ Do not pity them
- ◆ Do not be judgmental
- ◆ Don't allow rumors to spread
- ◆ Do not label people with psychiatric diagnoses
(Rather refer to a medical doctor or mental health professional)

Communicating with disaster-affected people: Difference between Empathy and Sympathy

Empathy

- ◆ I can understand what you are going through.
- ◆ I can understand that you are feeling angry at what has happened to you.
- ◆ I accept that you are very scared, almost anyone can feel scared.

Sympathy

- ◆ Poor you, it is really bad that this happened to you.
- ◆ I am also angry and we will deal with it together.
- ◆ Don't be scared, I am here to help you, whatever it takes.
- ◆ I am so sorry for you, don't worry everything will be all right.

Effective communication with disaster-affected people

Active Listening

- ◆ Establish eye contact with the person while talking to him/her
- ◆ Listen attentively to everything the person says
- ◆ Respond by gestures and words (hmmm...) to indicate that you are listening attentively
- ◆ Do not interrupt as far as possible
- ◆ Reassure the person at the end

Effective communication with disaster-affected people

Reflective Listening

- ◆ Establish eye contact with the person while talking to him/her
- ◆ Listen attentively
- ◆ Use short phrases (along with gestures) but do not interrupt frequently
- ◆ Reflect upon the contents and clarify wherever necessary
- ◆ Summarize the contents in between and at the end of the talk
- ◆ Empathize with the person by sharing the experience of others
- ◆ Reassure the person but do not make false promises

Specific psychosocial interventions

Who will require help ?

- ◆ Individuals reporting symptoms of distress
- ◆ People who remain isolated
- ◆ Individuals who break into irritated outburst
- ◆ Individuals extremely reluctant to communicate
- ◆ People who have had significant losses
- ◆ Conduct a needs assessment

Specific psychosocial interventions

How to help these people ?

- ◆ General psychosocial measures
- ◆ Specific psychosocial measures
- ◆ When to refer to a specialist

How to help these people ?

◆ General psychosocial measures

- Pay special attention to these people during routine services
- Establish rapport with them
- Ask about their well-being and offer to help
- Encourage them to talk if they so wish to

Counselling techniques

- ◆ Psychosocial first aid
- ◆ Trauma counselling
- ◆ Grief counselling
- ◆ Anticipatory guidance
- ◆ Crisis counselling
- ◆ Problem solving counselling

Psychosocial interventions for special groups

Emotional responses seen in pre-school children

- ◆ Irritable, crying excessively
- ◆ Clinging behaviour
- ◆ Expressing intense fear and insecurity repeatedly
- ◆ Excessively dependent behaviour
- ◆ Fearful of water – even of water used for domestic purposes
- ◆ Excessive quietness and withdrawn behaviour
- ◆ Thumb-sucking, bedwetting, excessive temper tantrums
- ◆ Play activities may spontaneously involve aspects of the disaster event
- ◆ Reporting frightening dreams & waking up frequently in between sleep

Emotional responses seen in school-going children

- ◆ **Withdrawal**
- ◆ **Guilt**
- ◆ **Feelings of failure**
- ◆ **Anger, rage and aggressive behaviour**
- ◆ **Fearfulness, anxiety or suspiciousness**
- ◆ **Feeling of low mood, decreased activity and interaction level**
- ◆ **Feeling nervous, unable to concentrate**
- ◆ **Recurrent memories or fantasies of the event**
- ◆ **Fantasies of playing 'rescuer'**

Emotional responses seen in school-going children

- ◆ **Intensely pre-occupied with details of the event**
- ◆ **Dangerous, risk-taking behavior, rejecting social rules showing aggressive behaviour (in adolescents only)**
- ◆ **Loss of interest in studies, refusal to go to school, significant drop in academic performance**
- ◆ **Psycho-somatic symptoms like medically unexplained pain in abdomen, headache, giddiness, vomiting, rapid breathing or fainting attacks**

Measures to be taken for children

- ◆ **Ensure the infant/child remains close to its mother/family**
- ◆ **Ensure adequate nutrition and meeting of all physical needs**
- ◆ **Encourage and help the families to re-establish child's previous routine like eating, playing, studying, sleeping and interacting with others**
- ◆ **Engage children in activities: drawing, storytelling, drama, games (do not too strongly encourage children to express disaster-related feelings through these activities; allow children control over the decision whether or not to think about the trauma and to express feelings about it)**
- ◆ **Encourage the families (in groups) to facilitate the play activities specially the group games of the children**

Measures to be taken for children

- ◆ **Advise families/community leaders to start some kind of teaching activities (even non-formal) for the school going children till the children are able to go back to their usual schools. Mobilize the help of educated youth volunteers for this**
- ◆ **Advise parents and families not to discourage the children when they verbalize their feelings**

Referral of children to mental health specialists

Ask mothers/ teachers to report about the children who continue to show the symptoms even after one month and despite the appropriate measures listed above

These children may require specialist mental health care

Specific measures for adolescents

- ◆ **Ensure privacy and confidentiality while interviewing them about their problems**
- ◆ **Be cautious about gender sensitivity issues (interaction with and physical touch to the persons with opposite gender)**
- ◆ **Help them in deciding their future course of action**
- ◆ **Encourage continuation of formal education especially of secondary and higher-secondary students**
- ◆ **Involve them in formation of community groups**
- ◆ **Encourage participation of older adolescents in community humanitarian activities**

Psychosocial care of the elderly

Possible psychological reactions to disaster

- ◆ **Immediate fear response followed by anger and frustration**
- ◆ **Feel agitated, lonely and hopeless with a feeling of multiple losses**
- ◆ **Increased dependence on family & refusing assistance from authorities**
- ◆ **Withdrawn behaviour, crying repeatedly, feeling depressed**
- ◆ **Sleep disturbance**
- ◆ **Suicidal tendency**
- ◆ **Disoriented (as routine is interrupted)**
- ◆ **Concentration and communication difficulties**

Psychosocial care of the elderly

Elderly are especially vulnerable if

- ◆ **Physically disabled**
- ◆ **Living alone**
- ◆ **Lacking help from other resources**
- ◆ **Having to face the shock of losing all that they had attained in life**

Helping elderly people

Helping elderly people

- ◆ Ensure that they are not isolated
- ◆ Ensure their physical safety and day to day physical needs
- ◆ Facilitate easy access to aid & support services including health facilities
- ◆ Help them to reestablish their daily routine
- ◆ Help them maintain their sense of identity
- ◆ Keep them informed of the happenings
- ◆ Involve them in relief work by asking for their suggestions and guidance
- ◆ Interact with them about the tragedy and gently encourage them to express feelings (but do not too strongly encourage this); Allow them to cry.
- ◆ Provide opportunities to feel a sense of continuity, culture and history (e.g. through group discussion)

If the symptoms are causing gross dysfunction on almost a daily basis for two weeks then consider referral to a mental health professional (if available) or a physician.

Psychosocial care for women

Women tend to be more prone to depressive and anxiety symptoms as well as to psychosomatic symptoms.

Of course, they are also able to provide higher levels of strength and ability to support others.

Some strategies to help women

- ◆ Involve them in community level activities like in community kitchen, sanitation, group religious activities
- ◆ Involve them in ongoing relief activities like arranging group games or teaching activities for the children, identifying physically ill people in the community etc.
- ◆ Encourage them to form self help groups to find ways of coping with their feelings and the current situation
- ◆ Specific intervention techniques described in previous module may be more frequently required for women
- ◆ Extend special care to pregnant and nursing mothers by ensuring adequate nutrition, appropriate medical care, physical safety and privacy (e.g. screened area for nursing)

Evaluation and management of psychiatric disorders

Integrating treatment for psychological problems with other medical conditions

- ◆ Mental health specialists not available to serve all the people
- ◆ Majority of the psychosocial problems can be treated adequately by appropriately trained physicians
- ◆ Some people prefer to take treatment from a physician rather than from a psychiatrist due to stigma
- ◆ People manifest their psychological problems in the form of physical symptoms and hence seek advice from a physician
- ◆ Cost effective and practical to deliver services for psychological problems and physical problems through single channel of service delivery

Ways in which patient may present to a physician

- ◆ Patients with obvious psychological symptoms indicative of a specific psychiatric disorder
- ◆ Individuals with obvious psychological symptoms but not amounting to a diagnosable psychiatric disorder
- ◆ Individuals with psychological symptoms associated with physical illness
- ◆ Individual with physical symptoms which are not explainable by physical illness and are part of a psychiatric illness or are physical manifestations of stress

Frequently observed mental disorders after a disaster

- ◆ Acute stress reaction
- ◆ Bereavement and grief
- ◆ Diagnosable mental disorders
 - Depression (vs sadness)
 - Anxiety disorders (vs anxiety)
 - Adjustment disorders (vs adjustment difficulty)
 - Somatoform disorders
- ◆ Alcohol and drug abuse
- ◆ Post-traumatic stress disorder (PTSD)
- ◆ Exacerbation/ relapse of pre-existing mental disorders
- ◆ Psychosomatic illness

These mental disorders need specialist mental health intervention and require referral.

Emergence of major neuropsychiatric disorders

- ◆ Other than depression there is no evidence for increase in major neuropsychiatric disorders
- ◆ Some previously undiagnosed cases may be unable to handle the stress and so seek help
- ◆ Previously known cases on treatment may not have access to medications and thus symptoms may relapse

Criteria for psychiatric disorders

Psychological symptoms should only be labeled as a disorder when they meet the following criteria:

- ◆ Symptoms are intense and lead to significant impairment in social and occupational functioning
- ◆ Symptoms persist for a few weeks (4–6 weeks)
(except in psychoses where even one week of symptoms are sufficient to make a diagnosis)
- ◆ Symptoms should be present most of the time rather than occasionally or sporadically

Depressive Symptoms VS Depressive Disorder

- ◆ Depressive symptoms can also be called 'sadness' and requires no specific treatment
- ◆ Depressive disorder requires specific medical treatment
- ◆ Depressive disorder should be diagnosed only when the persons symptoms are severe, prolonged and functionally disable a person

Depressive Disorder

◆ Signs and Symptoms

- Depressed mood: feeling sad, anguished, mournful, irritable or anxious
- Loss of interest and enjoyment
- Reduced energy, easy fatigability, decreased activity, marked tiredness on slight effort
- Reduced concentration and attention on a task
- Reduced confidence and low self-esteem
- Feelings of guilt and unworthiness
- Bleak and pessimistic view of the future
- Acts of self-harm or attempted suicide
- Disturbed sleep
- Diminished libido and appetite

Depressive Disorder

◆ Pharmacological treatment

- Selective Serotonin Reuptake Inhibitor (SSRI)
(Fluoxetine: 20 – 40 mg/ day)
- Imipramine (150 – 250 mg/ day). Now less preferred because of side effects
- Start all medicines in lower doses and build up gradually over a period of 7- 10 days
- Continue antidepressants in adequate doses for 6–8 weeks
- If the response is partial increase the dose
- If patient has shown good response to treatment, continue for 6–9 months
- Taper off medications over 4–6 weeks after completion of treatment.

Depressive Disorder

◆ When to refer to a psychiatrist

- Recurrent depression
- Severe depression
- Depression with psychotic symptoms
- Depression resistant to treatment
- Bipolar disorders in the phase of depression
- Patients with co-morbid physical and other psychiatric disorders
- Patients with suicidal ideations and attempt

Anxiety Disorders

- ◆ Anxiety usually presents with somatic, cognitive or emotional symptoms
- ◆ Anxiety disorders include generalized anxiety disorder (GAD), panic disorders, social and specific phobias and post traumatic stress disorder (PTSD)
- ◆ Symptoms could be episodic or continuous, they can appear suddenly without cause or be a response to a specific situation.

Anxiety Disorders

◆ Signs and Symptoms

- Prominent somatic symptoms: palpitation, muscle tremor, perspiration, abdominal discomfort, hyperventilation
- Prominent cognitive symptom such as poor concentration and memory
- Prominent emotional symptoms such as nervousness and fearfulness
- On examination:
 - ◆ patient shows signs of restlessness
 - ◆ is fidgety has a worried look
 - ◆ often have tremors and sweaty palms with increased heart rate and blood pressure

Anxiety Disorders

◆ Pharmacological treatment

- Generalized Anxiety disorder:
 - ◆ Diazepam 5mg twice daily in mild cases and 10mg thrice daily in severe cases **or**
 - ◆ Alprazolam 0.75 – 1.5 mg/ day **or**
 - ◆ Buspirone 30 – 60 mg/ day

 - ◆ Propranolol 40 – 80 mg/ day in two divided doses
- Panic Disorder:
 - ◆ Fluoxetine 20 – 40 mg/ day **or**
 - ◆ Alprazolam 1.5 – 6 mg /day in two to three divided doses **or**
 - ◆ Imipramine 50mg/day in two divided doses to a maximum of 150 – 250 mg/ day

Post-Traumatic Stress Disorder

PTSD is a cluster of symptoms

◆ Symptoms include:

- Re-experiencing the event (e.g. in nightmares)
- Routine avoidance of reminders of the event
- General lack of responsiveness
- Diminished interest and engagement
- Increased sleep disturbance and poor concentration

◆ Diagnosed only when the above symptoms have been present for longer than one month

Post-Traumatic Stress Disorder

◆ Management

- Combined actions of education, support, anxiety management and lifestyle modification
- Education: helping the person understand his/her condition and reassuring them that the reactions are a result of stress due to the traumatic event
- Support from family, friends and anyone working with the person by letting the person know that he/she is not alone and is not responsible for the event, etc.
- Anxiety management strategies: relaxation, breathing techniques and diverting the individual's mind through involvement in activities
- Lifestyle changes: healthy diet, avoiding stimulants or intoxicants, regular exercise and adequate sleep
- Patients may need pharmacological treatment for anxiety.

Anxiety Disorders

◆ When to refer to a psychiatrist

- Patients with severe anxiety
- Recurrent panic attacks
- Severe PTSD not responding to treatment after a trial of 4-6 weeks.

Mixed anxiety-depressive disorder

- ◆ Sometimes anxiety disorder and depressive disorder can occur in the same person at the same time presenting with signs and symptoms of both disorders.
- ◆ Treatment may be necessary for both conditions.

Adjustment Disorder

- ◆ **Painful or maladaptive reaction to some specific stress and occurring within 3 months of onset of stressor(s).**

- ◆ **Once the stressor (or its consequences) has terminated, the symptoms usually subside in 6 months.**

Adjustment Disorder

- ◆ **Signs and Symptoms**
 - Depressed mood
 - Tearfulness
 - Hopelessness
 - Anxiety manifested by palpitation, hyperventilation
 - Disturbance of conduct such as: vandalism, reckless driving, fighting (rights of others are violated or age appropriate societal norms are disregarded)
 - Work disturbance (academic inhibition manifested by difficulty functioning at work or in school)
 - Withdrawal, manifested by socially withdrawn behaviour that is not typical for the person

Adjustment Disorder

◆ Pharmacological treatment

- If severe anxiety symptoms occur use anxiolytic drugs for the first few days
- Alprazolam 0.5 – 1 mg up to three times per day

Adjustment Disorder

◆ When to refer to a psychiatrist

- If significant symptoms last more than one month despite treatment

Somatoform Disorders

- ◆ Patient has a variety of physical complaints for which no specific etiology can be found
- ◆ Symptoms usually help the individual to escape from the stressful situation or attract attention
- ◆ Somatoform disorders include:
 - Conversion disorder: unexplained paralysis, seizures
 - Hypochondriasis
 - Somatization disorder: a disorder characterized by multiple somatic complaints.

Somatoform Disorders

- ◆ General principles of management
 - Exclude disease but avoid unnecessary investigation
 - Listen to patients sympathetically, the patient is seeking help
 - Do not label them as hysterical or malingerers
 - Focus on simple symptomatic relief and not on determining its cause
 - Provide reassurance to the patient
 - Encourage and focus on functioning rather than on symptoms and illness
 - Psychotropic medications should be used judiciously

Grief Reaction

- ◆ Refers to the psychological and emotional processes that accompany bereavement, which are expressed both internally and externally

- ◆ Normal grief remits within 6 months

Abnormal Grief

- ◆ Signs and Symptoms
 - Social avoidance
 - Depressive ideation
 - Lack of sleep
 - Anorexia
 - Somatic symptoms of pain or discomfort
 - Impairment of performance
 - Lack of energy
 - Preoccupation with deceased
 - Transient hallucinations
 - Mummification (preservation of possessions)

Abnormal Grief

◆ Management

- Counseling for the bereaved
- Drug treatment can relieve severe anxiety or depression that is distressing
- Initially a hypnotic or anxiolytic may be needed
- Later antidepressant drugs may be beneficial

Acute psychotic disorder

◆ Signs and Symptoms

Recent onset of:

- Hallucinations (false or imagined sensations e.g. hearing voices when no one is around)
- Delusions (firmly held ideas which are plainly false and not shared by others in the patient's social group)
- Disordered thinking: exhibited by strange or disjointed speech
- Abnormal behaviours like social withdrawal and social inhibition, suspiciousness, threatening.

Acute psychotic disorder

◆ Pharmacological treatment

- Give Inj. Haloperidol (5-10 mg) along with Inj. Promethazine (50mg) intramuscularly *or*
- give Inj. Lorazepam (4 mg) intravenously/intramuscularly
- Commence oral neuroleptics and refer the patient to a psychiatrist

Acute manic episode

◆ Signs and Symptoms

- Increased energy and activity
- Elevated mood or activity
- Rapid speech
- Loss of inhibitions
- Decreased need for sleep
- Easily distracted
- In severe cases hallucinations and delusions may be present

Acute manic episode

◆ Pharmacological treatment

- Injection Haloperidol (5-10 mg) along with Injection Promethazine (50mg) intramuscularly *or*
- Injection Lorazepam (4 mg) intravenously or intramuscularly
- Commence oral neuroleptics and refer to psychiatrist

Alcoholism

- ◆ Alcohol intoxication
 - elated mood, disinhibition, impaired judgment, belligerence, mood lability, reduced attention span, slurred speech, motor incoordination, unsteady gait, nystagmus, stupor or coma
- ◆ Alcohol withdrawal
 - Autonomic hyperactivity (e.g. sweating or pulse rate > 100)
 - Increased hand tremor
 - Insomnia
 - Nausea or vomiting
 - Transient visual, tactile or auditory hallucinations
 - Psychomotor agitation
 - Anxiety
 - *Rum Fits*: Generalized tonic-clonic seizures
 - *Delirium Tremens*

Alcohol Withdrawal

◆ Management

- Uncomplicated withdrawal
 - ◆ Benzodiazepines are the treatment of choice
 - Diazepam 20-60 mg or clordiazepoxide 40- 120 mg daily in divided doses orally.
 - Oxazepam 30-60 mg or Lorazepam 4-8 mg daily in divided doses by oral route in patients with hepatic impairment
 - Alternatives- Carbamazepine 400-600 mg/day in 3 divided doses
 - No need of antipsychotic medications
 - Medications should be tapered off within 7-14 days.
- Rum fits
 - ◆ Diazepam 10-20 mg IV for prevention of further convulsions
 - ◆ Refer the patient to a hospital for urgent treatment.
- Delirium Tremens
 - ◆ Parenteral Diazepam (10 mg) or Lorazepam (2mg) are the drugs of choice
 - ◆ Refer to a hospital for urgent treatment

Other substance use disorders

Opioids

- ◆ **Opioid intoxication:** Initial euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgment, impaired social or occupational functioning, papillary constriction, slurred speech, drowsiness, impairment of memory
- ◆ **Opioid withdrawal:** nausea, vomiting, muscle aches, joint pains, lacrimation, rhinorrhoea, dilated pupils, piloerection, sweating, diarrhoea, yawning, changes in body temperature, increased cardiac rate, cramp like abdominal pain.

Other substance use disorders

Sedatives, hypnotics and anxiolytics

- **Intoxication:** Slurred speech, incoordination, unsteady gait, impaired attention or memory, disinhibition, mood lability, impaired judgment, impaired social functioning.
- **Withdrawal:** nausea, vomiting, malaise or weakness, tachycardia, sweating, anxiety, irritability, orthostatic hypotension, coarse tremor of the hands, tongue, eyelids, insomnia, generalized tonic-clonic seizures, loss of appetite and body weight; delirium, hallucinations, delusions, agitation.

Other substance use disorders

Management

- **If the patient is suffering from a overdose of either opioids or other drugs, symptomatic relief should be started immediately for the presenting symptoms**
- **For long-term management the patient should be referred to a detoxification centre**