Guidance for mental health counselling

Médecins Sans Frontières

Mental Health International Working Group
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(First edition)

Index

INTRODUCTION

This first edition of the "guidance for mental health counselling" comes at the onset of the willingness to adopt amongst the MSF sections a common approach in addressing Mental Health needs in MSF settings (especially at primary health care level).

These counselling tips complete the "mental health chapter" of the international MSF medical clinical guidelines (latest revision).
It incorporates practical sheets to provide a proper psychological support/care to patients with specific psychological complaints/problems (12).

Each sheet addresses a specific condition that can be commonly encountered in a PHC consultation or counselling/ psychological consultation:
- explanation of the condition
- general principles
- how to deal with the patient
- recommendations for patient and family
- complementary information
- bibliographic references

It can be used by trained health staff, general practitioners, counsellors and mental health professionals in order to help them identify and care for people with psychological difficulties and mental health disorders.

A CD comes with this paper edition in which you will find the electronic version of the "guidance for Mental Health counselling" as well as a selection of references documents to use as complementary information.

Thank for your collaboration

This first edition can be gradually improved if you send us your comments while using it. Any doubt that arises, any error detected, any idea you may come up with or any missing points identified may contribute to periodically updating the document and improving the quality of our work.

Your comments will be most welcome. Please send them to the Mental Health Advisor of your section:

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THE ACUTELY PSYCHOTIC PATIENT

I- WHAT IS AN ACUTE PSYCHOTIC EPISODE?

⇨ The presence of one or more symptoms (for less than 1 month):

- Delusional thoughts (is convinced of things that are not real, etc.)
- Hallucinations (can see, hear, smell, feel or taste something that is not actually there, etc.)
- Agitation or bizarre behaviour (grossly disorganized or catatonic behaviour, etc.)
- Disorganized or strange speech (frequent derailment or incoherence, etc.)
- Extreme and labile emotional states

⇨ Psychosis seriously affects one's social and occupational functioning.

⇨ Physical disorders which can cause psychotic symptoms include:

- epilepsy
- intoxication or withdrawal from drugs and alcohol
- infections with febrile illness

II- GENERAL PRINCIPLES

⇨ Medical examination need to be carried out first to exclude organic confusional state, drug induced psychosis, delirium tremens... (please refer to the MD of the project and the MSF clinical guidelines)

⇨ Acute episodes often have a good prognosis, but the long-term course of the illness is difficult to predict from an acute episode.

⇨ Anti-psychotic medication is the mainstay of treatment.

⇨ Continued treatment may be needed for several months after symptoms resolve.

⇨ Agitation which is dangerous for the patient, his/her family and/or the community requires hospitalization (especially if the patient does not have a safe and caring environment) or close observation in a secure place. If the patient refuses treatment legal measures may be needed.

III- HOW TO DEAL WITH THE PATIENT?

⇨ Ensure the safety of the patient and those caring for him/her:

- Family or friends should stay with the patient.
- Ensure that the patient's basic needs (food and drink) are met.
- Take care not to harm the patient and not to let the patient harm himself or others.

⇨ Minimize stress and stimulation

- Do not argue with psychotic thinking (you may disagree with the patient's beliefs but do not try to argue that they are wrong).
- Avoid confrontation or criticism unless it is necessary to prevent harmful or disruptive behaviour.

⇨ Questions to ask the family or friends:

- When did it start? Have you noticed any odd behaviour? Has he/she been using drugs or alcohol recently? Has he/she been violent?
- Does anyone else in the family suffer from these sorts of problems?

⇨ Questions to ask the person:

- Have you been feeling stressed recently? Have you felt as if something odd was going on around you? Have you felt as if others were talking about you? That some people were trying to hurt you?

- Have you heard people talk about you behind your back? Have you heard people talk about you even when there is no one around?
- Have you been drinking or taking drugs recently?

⇨ Provide psychological education to the family

- The family/support network must be educated about the condition of the patient, the importance of adherence to medication for an extended period, and monitoring for side effects. If possible, CHW or counsellors should conduct home visits.
- Practical advice on how to attend to the patient and manage daily problems must be given to the family.
- Once the patient is stabilized, it is important to educate the family and the patient on how to recognize warning signs that could indicate a relapse.

⇨ Follow-up of the episode

- Discuss strategies which can minimize stressful relationships or life events.
- Help the person set realistic goals.
- Help the patient maintain educational, social, work and hobby activities to ensure his/her social integration.
- Strengthen coping mechanisms for managing conflict, tension and/or interpersonal problems.

⇨ Medical treatment:
See MSF Medical clinical guidelines

IV- RECOMMENDATIONS FOR PATIENT AND FAMILY

⇨ Minimize stress and stimulation:

- Do not argue with psychotic thinking (you may disagree with the patient's beliefs but do not try to argue that they are wrong).
- Avoid confrontation or criticism unless it is necessary to prevent harmful or disruptive behaviour.

⇨ The family needs to help in the follow up of the medical treatment: ensure that the patient takes his/her medication regularly, goes to medical appointments, etc.

⇨ Encourage resumption of normal activities once symptoms decrease.

- The family should ensure a structured and predictable living environment. They should be consistent with the person and maintain calm, safety, comprehension and understanding in the house.

V – COMPLEMENTARY INFORMATION

An agitated patient should not be physically restrained without a sedative medical treatment.
If it is necessary to restrain the patient, be careful and check the pulse and perfusion (blood circulation) of the extremities restrained (hands or feet).

THE ANXIOUS PATIENT

I- WHAT IS ANXIETY?

⇨ Anxiety is used to describe the mental and physical response to stressful, fearful and threatening situations. This reaction may include trembling, shaking, increased heart rate, sweating, excessive worry, feeling tense and nervous, poor concentration, inability to relax and so on.

⇨ Anxiety becomes a problem when:

- the anxiety reaction occurs frequently
- your fears are out of proportion to the situation
- you start to avoid feared situations
- it interferes with your work, social or family life.

⇨ Different forms of anxiety:

- generalized anxiety: persistent/excessive worry about normal events and the future.
- panic disorder: sudden/intense fear of certain situations.
- Social phobia
- Agoraphobia

⇨ Main triggers:

- It often starts during periods of psychological (relationship break-ups, death of someone close, work pressure, financial problems, etc.) or physical (physical illness, domestic violence, abuse of alcohol and drug, trauma) stress linked to worries and unrealistic or negative thinking.

II- GENERAL PRINCIPLES

⇨ Anxiety is a normal response experienced by everyone in response to stress.

⇨ Anxiety does not mean weakness, losing one's mind, or personality problems.

⇨ When people experience stress they have a natural tendency to breathe more quickly and deeply. This causes the physical symptoms of anxiety.

⇨ Always rule out physical causes first through medical examination before addressing the link between anxiety and symptoms with the patient.

⇨ The main goal of anxiety management is not to remove all the anxiety but rather to reduce it to manageable proportions.

III- HOW TO DEAL WITH THE PATIENT?

⇨ Questions to ask:

- Have there been any problems in your life recently?
- How long have you felt like this? How did this feeling begin? Are you using sleeping pills or alcohol? Have you been avoiding situations because of your fear? Does your fear ever get so bad that you feel you might collapse or die?

⇨ Psychological support strategies

- Explain that worry is the cause of the symptoms and that the symptoms can make the person even more worried.
- Identify and challenge exaggerated worries, unrealistic and negative thinking.
- Provide structured problem-solving methods to help the patient manage current life problems or stresses which contribute to anxiety symptoms:

- Identify events that trigger excessive worry
- Discuss what the patient is doing to manage the situation
- Identify and reinforce things that are working
- Identify some specific actions that the patient can take

‣ Teach the person breathing and relaxation exercises.

⇨ Medical treatment

‣ To be considered when:

- The anxiety is so great that the person is not able to listen to or understand your advice
- The person is so tense that he/she has not slept well for many days and he/she is very tired
- The anxiety causes suicidal ideas

See MSF Medical clinical guidelines

IV- RECOMMENDATIONS FOR PATIENT AND FAMILY

⇨ Regular physical exercise and daily relaxation methods reduce physical symptoms of tension.

⇨ Changing attitudes and ways of thinking are a very important part of treatment. It is necessary for the person to view his/her situation in a more positive manner.

⇨ In the event of a panic attack, the patient should remind him/herself that he/she is breathing too fast and take control of the breathing. He/she should reassure him/herself that the symptoms are due to breathing too fast and that nothing dangerous will happen (it is not a heart attack).

THE PATIENT WITH BEREAVEMENT ISSUES

I- WHAT IS BEREAVMENT?

⇨ Bereavement (or grief) is the experience someone goes through when a loved one dies. Bereavement is like a wound. It hurts. The patient will need time to recover and to allow the wound to heal. Like some wounds, bereavement can sometimes take longer to heal or become complicated.

⇨ The normal stages of the grief process

- the stage of denial: *"it cannot be true".* In the days just after the loss, the feeling that the news is false, that the loved one cannot be dead.
- the stage of sadness: *"I feel miserable".* This happens when the bereaved person is back to his own usual life, after the funeral. The absence of the loved person is now noticed and affects the mood in a depressive way or an angry way.
- the stage of reorganisation: *" it's time to move on".* This is the final stage of bereavement. Acceptation of the loss as part of life and getting on with the rest of their own life.
  Most people will always think of the lost person now and again, but the sadness does not interfere with the ability to enjoy happy moments in life and to make plans for the future.

II- WHAT IS AN ABNORMAL BEREAVEMENT?

⇨ Bereavement can be considered abnormal when**:**

- reactions last more than 6 months
- the bereaved person becomes very depressed or suicidal
- the person withdraws from social interactions with others
- the person avoids people and things linked to the lost relative or friend

⇨ Abnormal bereavement is more likely to happen in the following situations**:**

- if the person has suffered multiple losses
- if the person lacks adequate social support
- if the person has lost a child, especially an only child
- when an elderly person loses his/her spouse
- if the death is sudden, for example accident or suicide
- if the person denies (or ignores) the loss for a long time

III- HOW TO DEAL WITH THE BEREAVED PATIENT?

⇨ Questions to ask:

- What were the circumstances of the death? Talk about the deceased.
- With whom will the patient be spending the next few days?
- To whom can you talk when you need someone?
- How are you feeling?

⇨ Psychological support strategies

- Reassure the person that experiences such as imagining that the lost relative is still alive, or searching for the relative, are normal and are not signs that he/she is going "mad".
- Encourage free expression of feelings about the loss (including feelings of sadness, guilt or anger).
- Encourage him/her to share her feelings with friends and relatives.

‣ Encourage him/her to participate in rituals associated with death.

‣ If he/she has suicidal ideas, treat as described elsewhere (see “suicidal patient”). Special care must be taken with those who have been bereaved because of a suicide.

‣ Encourage a gradual return to daily life and work within 3 to 6 weeks. Work and other activities can themselves be helpful in raising spirits and helping people reorganise their lives for the future.

⇨ NB: If the bereavement is abnormal

‣ Consider a counselling session at least once a week. Counselling could include discussion about his/her relationship with the dead person (exploring both positive and negative feelings).

⇨ Medical treatment

‣ A decision about antidepressant medication should be delayed for three months or more after the loss. If significant depressive symptoms persist longer than three months, refer to treatment of severely depressed patient in the clinical guide.

See MSF Medical clinical guidelines

IV- INFORMATION FOR PATIENT AND FAMILY

⇨ Important losses are often followed by intense sadness, crying, anxiety, guilt or irritability

⇨ Bereavement typically includes preoccupation with the deceased (including hearing or seeing the person)

⇨ A desire to discuss the loss is normal

⇨ Intense grieving will fade slowly over several months but reminders of the loss may continue to provoke feelings of loss and sadness

⇨ Each family member can have a different way to overcome a loss: duration, styles

⇨ Do not neglect your own health

⇨ Do not make important decisions quickly, in a rush

⇨ Do look for and accept support from others

⇨ Avoid as much as possible the use of psychotropic drugs

⇨ Commemorate the deceased at certain key moments, by keeping some rituals

THE DELIRIOUS PATIENT

I- WHAT IS DELIRIUM?

⇨ A sudden disturbance of consciousness (inability to focus, sustain or shift attention), perception and/or change of cognition (disorientation, language disturbance, memory deficit).

⇨ Patient may present with: confusion, struggle to understand surroundings, clouded thinking or awareness, poor memory, emotional upset, wandering attention, withdrawal from others, suspicion, agitation, loss of orientation, disturbed sleep. May hear voices and have visions or delusions. Patient may appear uncooperative or fearful.

⇨ The disturbance fluctuates during the day, which is the biggest distinction with psychosis.

⇨ Common causes:

- Direct physiological consequences of a general medical or post-operative condition: severe infections, metabolic changes, hypoxia, etc.
- Brain illness, head trauma
- Side effects of some medicines
- Alcohol intoxication or withdrawal
- Drug intoxication or withdrawal
- Severe anxiety or stress, such as after a sudden shock

II- GENERAL PRINCIPLES

⇨ Delirium never has a psychological cause

⇨ Delirium generally means a neurological brain or other physiological disturbance . It is a medical emergency.

⇨ Treatment is focussed on the underlying cause as well as on the delirium.

⇨ Taking the medical, treatment, substance abuse and accident history is primordial.

⇨ Often hospitalisation or/and emergency care is necessary to treat the medical condition.

⇨ The elderly are at greater risk of becoming confused.

⇨ Some confused people can become aggressive or hurt themselves; temporary restraint may be needed.

III- HOW TO DEAL WITH THE PATIENT?

⇨ Psychological support strategies

- Adapt the patient's environment to reduce factors that may exacerbate delirium: adapt lights to indicate day and night, avoid overstimulation and reduce monotony, correct visual and auditory impairment, add familiar objects
- Reorient the patient to person, place, time and circumstances: inform the patient who you are; remind the person where he/she is, what day and time it is. Reassure the person that he/she is safe with you in the clinic.
- Reassure the patient that the deficits he/she they are is experiencing are common but usually temporary and reversible.
- Education regarding the current delirium, its aetiology and its course should be provided to the patient, and tailored to his ability to understand his condition, as well as to his family.

⇨ Medical treatment

See MSF Medical clinical guidelines

IV- RECOMMENDATIONS FOR PATIENT AND FAMILY

⇨ Take measures to prevent the patient from harming him/herself or others.

⇨ Supportive contact with familiar people can reduce confusion.

⇨ Provide frequent reminders of time and place to reduce confusion.

⇨ Hospitalization may be required because of agitation or because of the physical illness which is causing delirium.

V – COMPLEMENTARY INFORMATION

An agitated patient should not be physically restrained without a sedative medical treatment.
If it is necessary to restrain the patient, be careful and check the pulse and perfusion (blood circulation) of the extremities restrained (hands or feet).

THE SEVERELY DEPRESSED PATIENT

I- WHAT IS DEPRESSION?

⇨ Depression is not just sadness.

⇨ A person with depression will experience some of the following symptoms:

- Physical: tiredness, fatigue, weakness, nonspecific aches and pain all over the body
- Feelings: feeling sad and miserable, loss of interest in life (social interactions, work), guilty feelings
- Thinking: difficulty in concentrating, hopelessness about the future, difficulty making decisions, low self esteem, suicidal ideation
- Behaviour: disturbed sleep, poor appetite, reduced sex drive, etc.

⇨ Daily life functioning is affected.

⇨ It last for at least 2 weeks

II- GENERAL PRINCIPLES

⇨ Almost everyone suffers from a depressive mood episode at some time in his/her life. But when it starts to interfere with daily life (tiredness and difficulty in concentrating, working, taking care of the family, etc.) it becomes a pathological condition: depression.

⇨ Depression is a pathological condition that means more than just feeling temporarily low, sad, fed up or miserable.

⇨ Depression doesn't mean weakness or laziness. It is a common illness that can be treated.

⇨ Depression can be triggered by major life events, family history, illness, or medications.

⇨ Depression can appear at all ages: childhood, adolescence, adulthood, in the elderly.

⇨ A particular form of depression is *maternal* or *postpartum* depression. Symptoms are not different from those of major depression except that the mother also reports thoughts of inadequacy or incompetence in her maternal role. Feelings of aggression or impulses to harm the baby induce self-blame.

⇨ Important to exclude first medical conditions (refer to MD and MSF clinical guidelines)

III- HOW TO DEAL WITH THE PATIENT?

⇨ Psychological support strategies

- Take the history of the patient, symptoms and previous treatment.
- If physical symptoms are present, discuss the link between physical symptoms and mood.
- Assess risk of suicide (if risk is significant, hospitalisation should be considered).
- Evaluate and address functional impairments: deficits in interpersonal relationships, work, living conditions, and other health-related needs.
- Identify current life problems or social stresses. Focus on small, specific steps patients might take towards reducing or better managing these problems. Establish a problem-solving plan.
- Avoid major decisions or life changes.
- Plan short-term activities which give the patient enjoyment or build confidence.
- Work on changing attitudes and ways of thinking to promote a more positive vision of the world and self.
- After improvement, plan with patient the action to be taken if signs of relapse occur.

⇨ Medical treatment

- To be considered in case of:

- Major depression
- Severe impairment, little response to supportive therapy, family history of hereditary depression or attempted suicide.

See MSF Medical clinical guidelines

IV- RECOMMENDATIONS FOR PATIENT AND FAMILY

⇨ Don't be afraid to talk about the suicidal ideas of the patient. If you fear the patient could act it out, please contact the local doctor.

⇨ Don't force the patient to resume personal, social or work activities if he/she doesn't feel capable of it.

⇨ Stimulate the patient to set small and realistic objectives in daily life that he/she can reach.

⇨ Reinforce the patient's strategies of coping with daily life difficulties. Highlight the positive changes.

THE CHILD WITH ENURESIS

I- WHAT IS ENURESIS?

⇨ Definition

- ‣ Delay in the ability to control urination and/or reappearance of incontinence, not consistent with the normal developmental stage.
- ‣ May be continuous from birth – the child has never been continent (primary enuresis) - or may follow a period of continence (secondary enuresis).
- ‣ Urinating in clothing in the daytime is a problem only when a child repeatedly does it after the age of three.
- ‣ Bed-wetting when asleep is a problem only after the age of 5.

⇨ Main reasons

- ‣ Some children take longer to learn how to control their urine.
- ‣ Sometimes occurs with more general emotional or behavioural disorders: could be due to the child becoming upset about something, such as fights in the family or the arrival of a baby.
- ‣ May begin after stressful or traumatic events.
- ‣ Common reasons for daytime wetting are: not wanting to use the school toilets, urinary tract infections (especially girls) and problems related to school.
- ‣ Less common reasons include: child abuse, diabetes, physical problems in the urinary tract and some neurological problems.
- ‣ For many people, there is a hereditary factor in urinary control problems

II- GENERAL PRINCIPLES

⇨ The most common cause is a delay in this area of development of the child. It does not mean that the child is mentally retarded.

⇨ Enuresis could be caused by organic factors: always first conduct a medical assessment, including urine examination.

⇨ Check whether it is a primary (the child has never been continent) or secondary (the child has been continent before) enuresis.

⇨ Enuresis could be a very embarrassing topic for a child to talk about. He/she may feel ashamed and unhappy. Be sensitive to the feelings of the child.

⇨ Children never wet their bed purposely; showing them affection is an important part of helping to stop the problem.

III- HOW TO DEAL WITH THE CHILD?

⇨ Psychological support strategies

- ‣ Questions to ask the parents:
- ‣ Has the child ever learned to control his/her urine?
  - If not, then the problem is most likely due to a developmental delay.
  - If the child has learned to control his/her urine, when did you notice that he/she started bedwetting again? Were there any significant events in your family around that time?
- ‣ How do you feel about the bed-wetting? What have you said to the child? How has the problem been handled so far?
- ‣ Ask the parents at what age they themselves became continent. If there is a history of urine control delay, there is probably a hereditary factor. The child will get control of his urination probably at the same age as his parents.

- Questions to ask the child:
  - How have things been recently? At home? At school?
  - Have you been worried about anything?
  - Many children have difficulties with bed wetting. Has this been a problem for you recently?
  - Since when has this happened? Why do you feel it is happening?
  - How has this problem affected you? At home? At school?
- Stimulate self-esteem, self-perception and self–care.
- Propose some routines, such as: go to the toilet before going to sleep, don't take liquids after a certain hour, agree on alternative ways of calling attention to go to the toilet.
- Address with child and parents the family issues, schools issues or others that bother the child.
- Investigate carefully presence of abuse (physical or sexual) within or outside the family

IV- RECOMMENDATIONS FOR CHILD AND FAMILY

⇨ Make the child part of his/her own treatment. If possible, the child should take responsibility for the problem and its management (changing clothes, pyjamas and bedding). Stimulate autonomy and independence of the child in going to the toilet.

⇨ Do not use diapers.

⇨ Have the child keep a record of dry nights on a calendar.

⇨ Give praise and encouragement for success, but do not get angry on nights that he/she wets his/her bed.

⇨ Offer reassurance if the child is anxious about using toilets.

⇨ Get the child to go to the toilet regularly, say every 2 hours. This way the bladder is always empty. Once this controls daytime wetting, gradually increase the time between trips to the toilet.

⇨ Encourage the child to learn how to "hold" his/her urine with "pipi-stop": stop urinating before he/she has finished, hold it for few seconds, then continue urinating. This increases bladder control.

⇨ If there are any worries or stresses in the home, try to correct them.

⇨ Never scold a child who has wet his/her bed.

⇨ Avoid public comments on his/her incontinence.

V – COMPLEMENTARY INFORMATION

Be attentive to signs of abuse and negligence. The enuresis increases the risk of physical abuse and negligent behaviour by the parents or caretakers.

THE ACUTELY MANIC PATIENT

I- WHAT IS MANIA?

⇨ Mania is shown through an elevated mood state. Elevated affect may be irritable and labile. The manic person exhibits racing thoughts, rapid speech, grandiose thinking/planning, belief in being gifted with superhuman abilities, increased energy, increased psychomotor behaviour, hyper-sexuality, and decreased sleep. Insight is impaired.

⇨ In severe cases, patients may have hallucinations (hearing voices, seeing visions) or delusions (strange or illogical beliefs).

⇨ Mania is an essential diagnostic characteristic of bipolar disorders (going through manic phases and depressive episodes).

⇨ Bipolar disorder can cause serious psychosocial and interpersonal impairments for which medication and psychotherapy are indicated.

II- GENERAL PRINCIPLES

⇨ Exclude physical causes such as metabolic conditions, neurological diseases, infections, and substance abuse.

⇨ Provide a calm and highly structured environment.

⇨Inquire about the history of time periods with mood deregulation or lability accompanied by associated manic symptoms.

⇨ Evaluate the risky behaviours of the person: impulsiveness, violent ideas or intents and risk of suicide (when in the depressive period).

⇨ Consider hospitalisation for patients who pose a serious threat of harm to themselves or others, lack adequate social support and don't adhere to ambulatory treatment.

⇨ Always involve the family: educate them on the condition, explain what mania is and the impaired self-judgement it causes.

III- HOW TO DEAL WITH THE PATIENT?

⇨ Psychological support strategies

- rapidly control agitation, aggression and impulsivity.
- psycho-education sessions for the family and patient: diagnostic explanation and evolution of the sickness, de-stigmatization, long-term treatment plan, adherence management, side effects of medication.
- encourage the patient to avoid major life changes while in a manic state: decisions related to professional, economical and personal issues.
- set clear limits for the patient in a firm but non-provocative way.
- promote the maintenance of interpersonal and social rhythms, focusing on routine daily activities (sleep, eating, physical activities, etc.).
- suggest that the person keep a diary of daily activities, thoughts and beliefs to monitor the mood changes.
- group psychotherapy and family therapy may also help patients address issues such as adherence to a treatment plan, adaptation to a chronic illness, regulation of self-esteem, and management of marital and other psychosocial issues.
- As, usually, the maniac patient has already been on medical treatment, encourage the patient to follow up his treatment.

⇨ Medical treatment

To consider the full picture of the bipolar disorder (manic and depressive episodes); to set up the treatment plan.

See MSF Medical clinical guideline

IV- RECOMMENDATIONS FOR PATIENT AND FAMILY

⇨ If left untreated, manic episodes may become disruptive or dangerous. Manic episodes often lead to loss of job, legal problems, financial problems or high-risk sexual behaviour.

⇨ Consider limiting access to cars, credit cards, bank account, telephones and mobile phones because of the risk of reckless behaviour.

⇨ During manic periods: avoid confrontation unless necessary to prevent harmful or dangerous acts; advise caution about impulsive or dangerous behaviour. Close observation by family members is often needed; if agitation or disruptive behaviour are severe, consider hospitalisation.

⇨ Be aware that, over time, patients will vary in their ability to understand and retain information and accept and adapt to the need for long term treatment.

⇨ Be aware of the potential effect of sleep disruption in triggering a manic episode.

⇨ Help the patient and family members to recognise early signs and symptoms of a manic episode.

⇨Ask for the previous medical evaluation or history of previous episodes (mania and depression episodes). Contact the referent psychiatric system.

V – COMPLEMENTARY INFORMATION

An agitated patient should not be physically restrained without a sedative medical treatment
If it is necessary to restrain the patient, be careful and check the pulse and perfusion (blood circulation) of the extremities restrained (hands or feet).

THE SLEEPLESS PATIENT

I- WHAT ARE SLEEPING PROBLEMS?

⇨ Diagnostic features:

- Difficulty falling asleep
- Waking up early in the morning
- Restless or non-restful sleep
- Interrupted sleep: frequent or prolonged periods of being awake throughout the night

⇨ Patients are distressed and sometimes disabled by the daytime effects of poor sleep:

- Difficulties at work, social and family life
- Difficulties carrying out routine or desired tasks

II- GENERAL PRINCIPLES

⇨ Insomnia is one of the most common health complaints. Usually insomnia is not a diagnosis in itself; it is a symptom of another psychological or medical diagnosis.

⇨ As a result of the excessive use of sleeping pills, many people with insomnia become addicted to them!

⇨ The common causes of insomnia are: stressful life events, alcohol misuse, depression and anxiety, misuse of sleeping pills, medical problems (pain, breathing difficulties, urinary infections, etc.).

⇨ Insomnia leads to:

- Feeling drowsy during the day
- Tiredness
- Poor concentration
- Feeling irritable, frustrated and short-tempered
- Problems in thinking clearly and making decisions
- Increased risks of accident and injuries

III- HOW TO DEAL WITH THE PATIENT?

⇨ Psychological support strategies

- Questions to ask:
  - What is your sleep pattern? Do you take any medicine or alcohol to help you sleep? Do you suffer from any pain or other medical problem? Have you been feeling like you have lost interest in things recently? Have you been feeling tense, worried or scared recently?
- Promote the maintenance of a regular sleep routine by relaxing in the evening, going to bed at a fixed time , doing relaxation exercises, avoiding caffeine or alcohol before going to bed, and avoiding daytime naps.
- If the patient cannot fall asleep within 20 minutes, advise him/her to get up, do something else and try again later when feeling sleepy.
- Help the patient address worries and thoughts that keep him/her awake.

⇨ Medical treatment

Primary insomnia or sleeping disorder could be treated with some medications, but they are not common (less than 5% of sleep complaints are really sleep disorders in themselves).

It is important to note that medication alone won't cure the sleeping problem. Long-term use can lead to dependence, which means that when the medication is stopped the problem can become much worse.
Only short-term and intermittent use is recommended.

See MSF Medical Clinical Guidelines

IV- RECOMMENDATIONS FOR PATIENT AND FAMILY

⇨ Temporary sleep problems are common at times of stress or physical illness.

⇨ The normal amount of sleep varies widely and usually decreases with age.

⇨ Improvement of sleeping habits (not sedative medication) is the best treatment.

⇨ Worrying about not being able to sleep can worsen insomnia.

⇨ Alcohol may help a person fall asleep but can lead to restless sleep and early awakening.

⇨ Stimulants (including coffee and tea) can cause or worsen insomnia.

THE PATIENT WITH UNEXPLAINED SOMATIC COMPLAINTS

I- WHAT ARE UNEXPLAINED SOMATIC COMPLAINTS?

⇨ Physical complaints are the most common reason for seeking help from a health worker or doctor. However, some of those complaints don't always have a medical explanation and are rather a sign of emotional disturbances (mainly anxiety and depression).

⇨ Examples of such complaints: headaches, aches and pains all over the body, chest pain, heart beating fast, dizziness, low back pain, abdominal pain, difficulty in breathing, etc. Complaints may be single or multiple, and may change over time.

⇨ Symptoms may vary widely across cultures.

⇨ Patients are not imagining or lying about their symptoms, they are real; but no physical causes can be found

II- GENERAL PRINCIPLES

⇨ There is a strong relationship between mental illness and physical complaints.

⇨ You should think of mental illness particularly in a person who:

- has more than three complaints.
- has complaints that do not fit into any pattern which you associate with a physical disease.
- has consulted health workers many times for the same complaints.
- has been examined and has had tests that were normal.

⇨ Avoid referrals to a specialist. Patients are best managed in a primary health care setting.

III- HOW TO DEAL WITH THE PATIENT?

- First rule out a medical explanation. (by the MD of the project)
- Do not prescribe vitamins or pain killers unless there is clear evidence of malnutrition or a painful physical illness.

⇨ Psychological support strategies

- Acknowledge that the patient's physical symptoms are real.
- Try to avoid using labels such as "mental illness", since the person may resent this. Many people do not associate complaints such as headache with mental illness. Say rather: "Your symptoms are made worse by your worry and tension".
- Education and reassurance: explain to the patient the link between mental state (worry, sadness, stress, etc.) and physical experiences and complaints.
- Reassure the person that there is no life-threatening or serious physical illness.
- Ask about the patient's beliefs and fears.
- Discuss emotional stresses that were present when the symptoms began.
- Relaxation methods can help relieve symptoms related to tension.
- Develop a problem-solving approach in order to help the patient identify the various problems, face and try to solve those that are most important to him/her.
- Promote positive thinking: a different way of looking at life to prevent depression and anxiety.

IV- RECOMMENDATIONS FOR PATIENT AND FAMILY

⇨ Those symptoms, even if not medically explained, are real. They indicate that something is wrong but are not caused by physical problems.

⇨ Worrying is the cause of the symptoms and symptoms can make the person even more worried. The way to break this cycle is for the person to reassure him/herself when the symptoms start that they are only the result of worrying.

⇨ Changing attitudes and ways of thinking are a very important part of treatment. It is necessary for the person to view his/her situation in a more positive manner.

⇨ Encourage exercises and enjoyable activities: the patient need not wait until all symptoms are gone before returning to normal routines.

THE SUICIDAL PATIENT

I- WHAT IS SUICIDAL BEHAVIOUR?

⇨ Suicidal thoughts

- When a person contemplates ending his/her life when going through a difficult period

⇨ Suicidal plan

When the person has a structured arrangement to kill him/herself

⇨ "Self-harm act"

- Self inflicted injuries, without the objective of dying, aiming at:
  - Provoking a change within the social environment (support, attention, etc.)
  - Having the feeling of being alive and in control, pushing the limits further away
- When the person frequently risks killing him/herself, as with dangerous behaviours, frequent attempts or self-harm acts

⇨ Suicide attempt

- Any situation in which the person commits a self-destructive act, whatever the level of his/her intention to die:
  - Inflicts lesions on her/himself
  - Takes an overdose of drugs

II- GENERAL PRINCIPLES

⇨ Never take a suicide threat lightly.

⇨ Do not judge the behaviour of the person.

⇨ Do not minimize her/his situation by trying to reassure her/him.

⇨ Do not be afraid to ask the person about thoughts and suicidal conduct.

⇨ Try to address the patient's feelings about living.

⇨ Acknowledge the suffering of the person.

⇨ Evaluate the person's depression level.

⇨ Ensure that the person is out of immediate danger.

⇨ Assess the risk of the suicidal behaviour or repetition of attempt (reasons, means, planning, etc.).

III- HOW TO DEAL WITH THE PATIENT?

⇨ "First contact"

- Ensure privacy and allow time for the person to feel comfortable and to freely express her/his feelings
- Interview
  - the person who attempted suicide[1]: circumstances, willingness to die, reasons for wanting to die, triggering event, practical plan for suicide, feelings, perception of present and future, consumption of alcohol and/or drugs, presence of family and/or social support, etc.
  - family or friends: circumstances of AS, any previous AS, special event (recent loss or separation), history of illnesses, etc.
- Take into consideration the estimated suicide risk and the potential for danger to others.
- Assess the level of service/protection needed (hospitalization, ambulatory care, family care, etc.).
- Propose immediate/temporary protective measures needed.

[1] AS: attempted suicide

- Express clearly to the person your availability and your willingness to see her/him again.

⇨ Psychological support strategies

- Ensure a therapeutic alliance with the patient.
- Provide space for emotional discharge and expression of feeling.
- Assess risk factors.
- Stimulate self-esteem, self-care, flexibility and adaptation to change.
- Promote the search for coping resources within the couple, the family and the social environment.
- Work on the modification of any incorrect cognitive patterns concerning the self, the world and the personal future.
- Strengthen communication/social skills, problem- and conflict-solving abilities.
- Help her/him make decisions concerning personal, family and professional issues.
- Stimulate an internal locus of control.
- Address substance use disorders.
- Suggest hospitalization if necessary to safeguard the life of the patient.

⇨ Medical treatment

According to the diagnosis of MH disorder present, refer to the Clinical Guidelines for medication

IV- RECOMMENDATIONS FOR PATIENT AND FAMILY

⇨ Suicide attempts ARE NOT a psychological disorder in themselves BUT an expression of being emotionally overwhelmed that could be related to a psychological disorder (depression, psychosis, etc.), long-term health problems, alcohol and drug abuse, social factors, etc.

⇨ Do not avoid talking about the suicide attempt with the person.

⇨ In the acute phase, do not leave the person alone and take away any objects that could be used to harm oneself.

⇨ Encourage the person to openly express her/his feelings.

⇨ Try to improve communication within the family.

⇨ Do not take the following attitudes: jokes, criticism, reproach, ill-treatment, etc.

THE TRAUMATIZED PATIENT

I- WHAT IS TRAUMA?

⇨ A person who 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 the self or others.
- The person's response involved intense fear, helplessness, or horror.

⇨ Traumatic events can be of different natures:

- Personal trauma: being raped, a victim of crime, involved in a traffic accident, kidnapped, etc.
- War or terrorism: the horror of war can affect both soldiers and civilians.
- Disasters: airplane crashes, fires, natural disasters, etc., cause trauma to a large number of people at the same time.

⇨ Main symptoms:

- The traumatic event is persistently re-experienced through images of the incident, nightmares and flashbacks (feeling as if the traumatic incident is reoccurring in the present time).
- Persistent avoidance of stimuli associated with the trauma. The person avoids situations (places, activities, people, conversations, etc.) that remind him/her of the traumatic incident; he/she is unable to remember things related to the trauma and feels emotionally distant from people.
- Persistent symptoms of increased arousal; this means feeling more "awake". Sleep is disturbed; the person feels irritable, has difficulty concentrating and is easily startled or scared. Panic attacks can also occur.

⇨ Traumatized people experience difficulties in their working relationship with others. Children can experience difficulties in their studies.

⇨ Those symptoms last for more than a month

II- GENERAL PRINCIPLES

⇨ Many people who have been through a traumatic event may also present feelings of depression, loss of interest in daily life, tiredness, aches and pains and may have suicidal feelings.

⇨ The greater the loss of social support and community bonds, the greater the risk of developing traumatic disorders.

⇨ An important way of coping with traumatic events is sharing with others. Group discussions may be helpful, especially when the traumatic event has affected many people, such as refugees escaping a war.

III- HOW TO DEAL WITH THE PATIENT?

⇨ Questions to ask:

- What happened? What happened to you? What did you do immediately afterwards? Who else was present?
- How were you feeling at that moment? How are you feeling now?
- Who can you share your feelings with?

⇨ Psychological support strategies

- Encourage the person to talk about what happened but don't force her.
- Avoid overactive exploration of the patient's emotions; it is up to the patient to decide how much he/she wants to disclose/share.
- Avoid reassurance and denying guilt as it may devalue what the patient expresses.
- Reassure him/her that the emotional reactions are common and are not a sign of weakness or going crazy.
- Encourage him/her not to avoid situations that remind him/her of the event.

- Help the person integrate the traumatic event within his/her life and history.
- Help the person to develop positive coping strategies to manage the anxiety linked to the experience.
- Identify and address the cognitive and emotional distortions and perceptions of supposed threats.
- Make sure that he/she is staying with caring relatives or friends.
- Encourage the person to participate in social activities and peer support and do help him/her imagine objectives for the future.

⇨ Medical treatment

- If the person has severe sleep difficulties, please refer to the medical clinical guidelines.
- A course of antidepressants may also help some people who have experienced trauma.

See MSF Medical clinical guidelines

IV- RECOMMENDATIONS FOR PATIENT AND FAMILY

⇨ Explain to the person that symptoms such as flashbacks or dissociation are real psychobiological reactions and that they are not dangerous or life-threatening.

⇨ Stimulate the person to participate in routine daily activities, with the help of the family.

⇨ Suggest that the person get involved in activities that promote social interactions, avoiding isolation.

THE VIOLENT PATIENT

I- WHAT IS A VIOLENT PATIENT?

Aggression and violence are behaviours that can harm and hurt others. These include a variety of different behaviours. Verbal aggression through talking, such as shouting, abusing and using foul language, is hurtful. Physical aggression includes pinching, hitting, slapping, kicking and punching. More serious physical aggression can involve the use of weapons such as sticks, knives or guns.

II- GENERAL PRINCIPLES

⇨ The best predictor of violent behaviour is a prior episode of violence.

⇨ Some mental illnesses can lead to aggressive behaviours (paranoia, substance abuse, psychosis, delirium, confusion, etc.).

⇨ It is important to assess the patient to identify the cause of the violent behaviour:

- Organic reasons: neurological, medical
- Drug/alcohol intoxication
- Withdrawal reactions from alcohol or other drugs
- "Decompensation" of psychiatric disorders: schizophrenia, manic, anxiety disorder, "adaptive reactions", personality disorders, etc.

⇨ Protect yourself and those around you: ensure a safe physical environment by removing objects that can be used as weapons; also ensure a safe exit and always see the violent patient with another person in the room.

⇨ Like anyone else, those who have a mental illness usually have a reason for becoming aggressive. If you can find out why the person is angry, you are more likely to find a way to help.

⇨ Patients who do not respond to these basic measures and pose an imminent risk to themselves or others may need rapid chemical tranquillisation (temporarily). Refer to MSF Medical Clinical Guidelines.

III- HOW TO DEAL WITH THE PATIENT?

⇨ Contact/interaction with the patient

- Talk to the patient: introduce yourself clearly and show him/ her that you want to help.
- Try to calm the person by talking, reassuring and listening to him/her. Do not be in a hurry to get the situation under control. The aim is to encourage the person to take a sedative and calm down.
- Establish good/clear/calm communication. Call the person by his/her first name.
- Talk calmly but also with a firm voice.
- Do not move abruptly, do not show your back, and do not put your hands in your pockets. These are all movements that could be interpreted as provocative by the patient.
- Do offer the patient something to drink (plastic glass, non-alcoholic).
- Without sounding threatening, explain to the patient which behaviours will not be accepted/tolerated during the consultation, to clearly define a framework. Keep in mind that a violent patient is afraid to lose control of his/her actions, so setting limits will allow the patient to have some sense of control and remain calm.
- Be aware of :
  - signs of impending violence: talking louder, becoming abusive or threatening, fists opening and closing, breathing rapidly, fidgeting, tapping or punching or slapping tables
  - signs of intoxication or psychosis: look for signs in the person's speech. Listen to see if he/she is not making any sense or is speaking too fast.
  - signs of drug misuse: the smell of alcohol or the skin marks of injections

- Ask family or friends: *"What happened?", " How did it start?", "Has this ever happened before?", "Has the person suffered from a mental illness in the past?", "Is he/she on any medication?", "Whom does he/she trust?", "Does he/she have a drug or alcohol problem?", etc.*
- AVOID adopting aggressive discourse or behaviour, running away, shouting/screaming, giving a sedative medication before determining the underlying causes and before establishing good/clear communication.

⇨ Psychological support strategies

- Ask the aggressive person: *"What happened?", "Do you still feel angry?", "Have you been feeling under stress?", "Have you been feeling as if people around you were behaving strangely?", "Have you been feeling as if people are talking about you?", "Can you hear voices even when there is no one around?", etc.*
- Identify with the patient and address the triggering factors for violent behaviours.
- Teach non-violent communication skills, self-control techniques and problem-solving approaches.

⇨ Medical treatment

See MSF Medical clinical guidelines

If you need to restrain a patient:

- Make sure you have enough people and hold the person down firmly using hands. Always prepare the injection before you restrain someone.
- Once the person is sedated, explain to the family or friends what happened. When the person awakes, talk to him/her about what happened and explain the need to take oral medication. Offer him/her something to eat and drink.

IV- RECOMMENDATIONS FOR PATIENT AND FAMILY

An agitated patient should not be physically restrained without a sedative medical treatment
If it is necessary to restrain the patient, be careful and check the pulse and perfusion (blood circulation) of the extremities restrained (hands or feet).

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