

# FAMILY PHYSICIAN GUIDE

FOR DEPRESSION,  
ANXIETY DISORDERS,  
EARLY PSYCHOSIS  
AND SUBSTANCE  
USE DISORDERS

NOVEMBER 2008



**CARMHA** Centre for Applied Research in  
Mental Health and Addiction  
Faculty of Health Sciences  
Simon Fraser University



**BRITISH  
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# Background and Purpose

In British Columbia data suggests that direct services for mental illness, including problematic substance use and addiction, make up at least 10% of a family physician's workload. The demand for indirect services may be even higher. Additionally, the number of patients receiving services for mental health and substance-related problems is increasing at a rate faster than the growth in BC population (BC Ministry of Health data).

Recent improvements in the collaboration between mental health and primary care physicians has led to the development of a model of Shared Mental Health Care in some regions. This rejuvenated approach to mental health care stresses the importance of integration of mental health services within existing primary care practices in order to care for under-served populations. The importance of continuing medical education provided by psychiatrists and mental health services to family physicians is also critical. These specialized services encompass a range of both professional and community groups.

In order to support best practices in mental health and addictions services, accurate and up-to-date information is required by family physicians who are frequently involved in assessment, support, and treatment of these problems. Additionally, clinicians need to be able to direct affected individuals and families to credible and accurate sources of information geared to supporting self-management activities. In particular, such information is needed in regard to depression, anxiety disorder, early psychosis, and substance use disorder, in view of the large burden of disease associated with these problems.

Given the large volume of information that is developed through research and practice, it is a challenging task for clinicians to compile accurate and up-to-date information that will be useful in providing treatment and support. It is equally challenging for the individual and family to obtain access to accurate resources and tools needed for self-management.

Guidelines and publications have been developed by many groups and organizations relevant to depression, anxiety disorders, early psychosis, and substance use disorders. However, the existing documents have been issued through a wide variety of sources and consequently it is difficult for clinicians to have a clear, easily accessible source of information that addresses these areas of clinical care.

The purpose of this *Family Physician Guide for Depression, Anxiety Disorders, Early Psychosis, and Substance Use Disorders* is to provide a practical, office-based tool for dealing with these conditions in day-to-day practice. It is not meant to be all inclusive, but is to serve as an overview and rapid reference in the office setting. This guide will also be accessible to individuals, families, and consumer groups to encourage collaborative involvement in support of self-management.





# Background and Purpose

Following the recommendation of expert stakeholders in British Columbia, this guide does not address the specific needs of either British Columbia's Aboriginal people or of individuals outside the age range of 18 – 65. It is clear that depression, anxiety disorders, early psychosis, and substance use disorders are identified as a significant problem among these groups. The unique strengths and historical, cultural, experiential, and spiritual traditions of Aboriginal people, however, warrant a distinct physician guide built upon a thorough knowledge of their particular needs and circumstances. The approach and timing will be determined through Aboriginal leadership in the province. Likewise, there are numerous issues specific to either adolescents or the elderly (spanning the topics of comorbidity, diagnosis, pharmacotherapy, non-pharmacological interventions, and self-care) that tailored information for both age groups is also necessary.



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# 1 INTRODUCTION



# Shared Mental Health Care

The concept of shared mental health care is an increasingly successful approach that attempts to address the problems of access and co-ordination/continuity of care. In this approach, mental health and primary care providers work together as part of a well co-ordinated mental health care delivery system that spans both primary and specialized care.

Shared care promotes collaboration between providers from different services or disciplines who share responsibility for the care an individual receives. Working together, they will be able to pool their resources according to the needs of an individual client, service availability, and their respective skills. In doing so, they will attempt to:

- ensure patients receive the services they need when they need them
- improve communication and personal contacts between providers from different sectors
- enhance continuity of care
- provide mutual support.

Shared care models also have the potential to address resource shortages, build system capacity, and deal with mental health emergencies, as the provision of backup and support for primary care providers can enable them to handle a broader range of cases.

Such an approach recognizes that no single service or provider can deliver every service that an individual needs. While an individual may require greater involvement with a specific service at particular times or during certain stages of illness, other providers or services will remain involved and will be able to reactivate care quickly when required.

### Goals of Shared Care

The overall goal of collaborative projects is to improve the outcomes for individuals with mental health problems. This can be achieved by developing new models of service delivery/training that aim to:

- increase access to mental health services
- support and enhance the role of primary care providers in delivering mental health care
- strengthen personal contacts between providers from different specialties
- strengthen links between the two sectors
- increase the skills and comfort of primary care providers in managing the mental health problems of their patients
- increase understanding of the demands and needs of primary care among mental health providers and learners
- integrate mental health services within primary care settings.

### Models of Shared Care

Models of shared care need to be adapted to local resource availability (i.e., availability of particular types of care providers) and be based upon key principles. The key to successful collaborative partnerships is personal contact among providers involved who are in regular communication, treat each other with respect, and take advantage of opportunities to support each other and share resources when appropriate. These foster the sharing of care by:

- **strengthening personal contacts**, leading to improved communication and more collaborative/less fragmented care
- **creating opportunities to discuss problems/cases** that may not need a specialist consultation but where advice may have a significant impact on the outcome
- **creating personal relationships** that reduce the likelihood that territorial issues will affect service delivery.

There are many possible ways in which care can be shared. Examples include:

- making intake processes more user friendly
- improving written communication between the sectors
- developing rapid access consultation services
- holding joint clinic or educational rounds
- educational programs for primary care providers in managing mental health problems
- integrating mental health services in primary care settings.

### Potential Benefits

Evidence within Canadian programs over the last five years suggest that better integrated services are effective and well received by patients, family members, and providers alike, and lead to:

- an increase in access
- decreased waiting time for services
- decreases in hospitalization rates
- decreases in the number of prescriptions being written for individuals being seen
- decreased outpatient utilization rate
- more efficient use of secondary and tertiary resources.

## SHARED MENTAL HEALTH CARE

The College of Family Physicians in Canada and the Canadian Psychiatric Association Collaborative Working Group has worked diligently over the last eight years to find ways to bridge this gap and promote the concept and practice of shared mental health care across Canada. Also, the BC Medical Association and the BC College of Family Physicians have strongly supported the development of Mental Health Shared Care in British Columbia.

For more information, we encourage you to contact the regional director of mental health and addiction services within your local health authority (listed under General Resources for Patients and Families in this Guide) and access the national website on Shared Care: [www.shared-care.ca](http://www.shared-care.ca)





# Diversity Issues

Canadian family physicians face the challenge of providing health care services to a diverse population of patients. The expression of psychopathology, risk for mental illness, symptoms of mental illness, utilization of mental health services, and responses to treatments or interventions vary depending on the individual, their gender, age, country of origin, circumstances of migration, sexual orientation, marital status, socioeconomic class, religion, and place of residence.

According to the American Psychiatric Association Position Statement on Diversity (May, 1999), awareness of cultural diversity includes awareness of issues of race, sex, language, age, country of origin, sexual orientation, religious/spiritual beliefs, social class, and physical disability. Awareness of cultural diversity also includes knowledge about cultural factors in the delivery of mental health care and in the patient's health-related behaviour. Cultural diversity is a challenge to the diagnosis and treatment of mental illness, as it can affect the experience and communication of symptoms.

The establishment of a therapeutic alliance between patient and physician is determined as much by the patient's cultural background as by the physician's values, ideas, and understanding of cultural diversity. This concept is particularly important in British Columbia. For instance, visible minorities in Vancouver in 2001 accounted for 49% of the total population.

**Women's Mental Health**

Women suffer higher rates of certain mental disorders than do men. Women are more often diagnosed with affective disorders (major depression and rapid cycling bipolar illness), eating disorders, post-traumatic stress disorder (PTSD), social anxiety, somatization disorder, and borderline and histrionic personality disorders. Women are more likely to be exposed to traumatic events, domestic violence, physical and sexual abuse, discrimination, inferior social class, and lack of educational/economic opportunities. Women are also more likely than men to attempt suicide. Elderly, ethnic, immigrant, incarcerated, lesbian or bisexual women, and single mothers are more likely than other women to live in poverty, experience discrimination, and have problems accessing health care services.

All aspects of a women's world, including complex biological, psychological, and social factors must be considered in understanding health care needs from a women's perspective.

**Gay, Lesbian, and Bisexual Community**

From January to December of 2003, 135,000 Canadians over age 12 were surveyed through the Canadian Community Health Survey Cycle 2.1. For the first time, a question about sexual orientation was included in the survey. This information was needed to understand differences in health-related issues within the homosexual, bisexual, and heterosexual populations. Among Canadians aged 18 to 59, 1% reported that they considered themselves to be homosexual and 0.7% considered themselves to be bisexual. 1.3% of men consider themselves to be homosexual, almost twice as much as women do (0.7%). The results of the survey also indicated that there were important health differences between heterosexual, bisexual, and homosexual populations. For instance, among individuals 18 to 59, 21.8% reported unmet health care needs in 2003, which is nearly double of the proportion of heterosexuals with unmet health care needs (12.7%) for the same year. Also, individuals who identified themselves as either homosexual or bisexual reported increased levels of stress in their lives when compared to heterosexual individuals. British Columbia reported the number of homosexual or bisexual people in 2003 to be 47,700 or 1.9% of the total population.

**Visible Minorities**

The 2004 report by Canadian Heritage ("Canadian Diversity: Respecting our Differences") states that by the year 2006, one of six Canadians will be a member of a visible minority.

The largest visible minorities groups are Chinese, South Asian, Filipino, Japanese, South East Asian, Latin American, Arab, West Asian and Korean. The most commonly spoken languages in British Columbia, other than the official languages, are Chinese (Cantonese and Mandarin), Punjabi, Vietnamese, Korean, Tagalog, Spanish, Persian, and Japanese.

**Aboriginal People's Mental Health**

As indicated in the Background and Purpose of this document, issues specific to the Aboriginal People's are out of scope for this Guide. However, a brief summary of epidemiology is included in this section. In addition, an Aboriginal Health Services resource list is available in the section titled Information and Supports for Individuals and Families, under Cross Cultural Resources.

First Nations, Inuit, and Métis represent about 1 million people, or 4% of the total Canadian population. There are 11 major languages with more than 58 dialects in 596 bands residing on 2284 reserves, or in cities and rural communities.

Historically, Canadian Aboriginal people have suffered rapid cultural change and dislocation of their communities, causing them to live in isolated areas and under conditions of poverty. This poses challenges for the delivery of health care to these small and isolated communities.

Epidemiological studies have documented higher levels of mental health problems in many Canadian Aboriginal communities than in the population at large, including higher rates of suicide, alcoholism, and violence. Depression, anxiety, and PTSD are more prevalent in Aboriginal communities. Aboriginal people have increased rates of death among the youth caused by accidents and suicide.

### **Immigrant and Refugee Populations**

#### *Barriers to Accessing Services for Refugees in British Columbia*

Access to Mental Health services can be a significant challenge for immigrants and refugees. Barriers to consider include:

- language/culture
  - absence of or poor English skills
  - issues regarding interpreters (e.g., availability, discomfort)
- access issues
  - finding service providers
- difficulty identifying mental health issues, especially differentiating between acculturation stress and mental illness.
- lack of transportation
- lack of childcare.

Perception of what constitutes a health issue can also be very different for immigrant or refugee groups. A BC 2004 study titled 'Chinese and South Asian Immigrant Women — Experiences of Postpartum Depression' revealed that these women understood their emotional difficulties as being related to their personal relationships and social networks rather than as a health issue. Therefore, they are unlikely to speak to their GPs about 'depression'. Based on this information, it is recommended that health care providers ask women questions about the practical and emotional support they are receiving. Consider referral to community organizations and other less formal sources of support as possible avenues of treatment. For more information on this study and further recommendations, go to [www.bcwomens.ca](http://www.bcwomens.ca).

Cross-cultural assessment is challenging. Physicians need to be culturally sensitive and aware of variations in phenomenology from culture to culture. Cultural sensitivity is the ability to appreciate that patients may have different lifestyles, divergent views, experience different types of stress, and have unique coping skills.

### **Formulating Cross-cultural Patients**

When formulating culturally diverse patients, consider the following:

- the cultural identity of the individual.
  - Note the individual's ethnic or cultural reference group.
  - For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture.
  - Note language abilities, use, and preferences (including multilingualism).
- cultural explanations of the individual's illness.
  - Note the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., "nerves", possessing spirits, somatic complaints, inexplicable misfortune).
  - Understand the meaning and perceived severity of the illness in relation to the norms of the cultural reference group.
  - Explore the explanatory models of the illness used by the reference culture.
  - Inquire about current preferences for, and past experience with, health professionals and Western medicine.
- cultural factors related to psycho-social environment and level of functioning.
  - Note culturally relevant interpretations of social stressors.
  - Clarify available social supports and the role of religion and kin networks in providing emotional, instrumental, and informational support.
- cultural elements of the relationship between the individual and the clinician.
  - Identify cultural differences and potential pitfalls (e.g., difficulty with communication, eliciting symptoms, determining whether a behaviour is normative or pathological).
  - Understand and discuss how cultural considerations specifically influence comprehensive diagnosis and care.

### **Mental Health History — Taking in Immigrant and Refugee Populations**

When screening immigrants or refugees for mental illness, it is critical to consider certain issues which may contribute to mental illness. Certain specific questions may be useful in screening for anxiety disorders including PTSD, adjustment disorders, depression, and suicidal ideation/behaviours:

- Where were you born?
- When did you come to Canada?
- How did you arrive?
- Who came with you? Did you come on your own or with your family?  
Were they left behind?
- Were you sponsored?
- Are you currently going through an immigration process?
- What was your profession before coming to Canada?
- Were you persecuted in your country?
- Was there violence or war?
- Did you witness or were you a victim of sexual and/or physical abuse in your country or on your immigration journey?
- Were you detained or imprisoned?

- Were you tortured?
- Have you had personal losses? How did you grieve the loss?
- Describe the adjustment to Canada? Financial? Shelter? Employment?

### **Mood Disorders**

In the specific case of depression, culture can affect the experience and communication of symptoms. Complaints of “nerves” or headaches (in Latino and Mediterranean cultures), weakness, tiredness, or “imbalance” (in Chinese and Asian cultures), and problems of the “heart” (in Middle Eastern culture) may be communications of depressive symptomatology.

Most cross-cultural studies have found a higher rate of somatization associated with depression in non-Western groups of countries; however, most research has focused on unipolar depression indicating extensive cultural patterns but also extensive similarities. According to the World Health Organization Collaborative Study of Depression, the differences beyond the core depressive syndrome are in symptom presentation, conceptualization of affect, level of severity and influence of acculturation.

### **Anxiety Disorders**

The World Health Organization study on mental disorders found significant variation in the prevalence of anxiety disorders across countries. For example, the prevalence rate of anxiety disorders is high in Brazil (22.6%) and Chile (18.7%), compared to Shanghai, China (1.9%). These prevalence rates are difficult to interpret and they may or may not reflect the actual incidence of these disorders. For example the rates are often based on self-reports which in turn may be influenced by cultural differences in beliefs, perceptions, and willingness to report. However, at the same time, some cultural elements may contribute to stress, influence the perception of stress, and influence the ability to cope. For example, anxiety can be caused by cultural beliefs, such as breaking taboos or cultural demands in the family, intergenerational conflict between children and parents, rapid change, family separation due to war or other sociocultural situation. Anxiety often manifests itself as a mixture of anxiety, depression, and somatization.

### **Psychosis**

Research into cross-cultural presentations and course of schizophrenia shows significant differences as well as similarities. While the core positive and negative symptoms are universal, the content of hallucinations and delusions varies significantly. Phenomenology also varies with cultural settings: catatonia is more frequent in India and agitation more frequent in Japan when compared to Western cultures. Ideas that may appear delusional, such as witchcraft or sorcery may be culturally appropriate. Certain mental status observations like disorganized speech may be difficult to assess if using an interpreter.

**Substance Use Disorders**

Cultural factors influence problematic substance use and prevalence varies greatly amongst cultures. The definition of substance abuse or dependence and the perception of impairment and intoxication may be specific to the local culture. The availability of alcohol, its use in religious ceremonies and social activities, and family values regarding alcohol consumption by children are all cultural factors that may influence problematic alcohol use.



# Natural History of Mental Illness Trajectories

- While some individuals may only experience a single episode of the disorder, many will have a chronic illness trajectory.
- Each new episode may occur sooner, last longer and become more severe and more difficult to treat.
- Terms such as prodrome, acute presentation, remission, residual symptoms and relapse describe the various stages of the trajectory.

### Prodrome

- A period marked by numerous subtle changes that precede the acute presentation of the illness
- Common changes include:
  - sleep and appetite changes
  - increased substance use
  - withdrawal from family and friends
  - feelings of irritability, anxiety or depression.

### Acute Presentation

- During this period the type of illness manifests itself more clearly.
- The individual may experience distress and will usually have impaired function at work, school or home.

### Remission

- A period of reduced symptom severity with a return of function and remission of impairment
- Remission is the primary goal of treatment.
- Illness which is resistant to remission after a full treatment course is considered to be *refractory*.

### Residual Symptoms

- Even with effective treatment, some people may continue to experience symptoms.
- The presence of residual symptoms demands more active treatment efforts in an effort to attain remission.
- In some situations the presence of residual symptoms may increase the likelihood of relapse.
- The use of self-management strategies may lead to better control of residual symptoms for many individuals.

### Relapse

- Relapse is a return of acute presentation after a period of remission.
- Relapse rates for many of the disorders are high.
- The goal of maintenance treatments is to prevent relapse.

### Comorbidity

- Comorbidity is defined as the simultaneous presence of two or more physical or psychiatric disorders.
- There is a high rate of comorbidity between the disorders presented in this guide. These disorders are often comorbid with physical disorders and other mental disorders (including eating disorders and personality disorders). Comorbidity is associated with significant diagnostic and treatment challenges.
- Assess comorbid conditions (both mental and physical) initially and throughout the course of illness.
- Treatment ideally is integrated but at times must be prioritized.
- Comorbidity influences the clinical presentation and is not always easily detected. For example,
  - psychosis may obscure the presence of a co-occurring anxiety disorder
  - alcohol abuse may obscure the presence of a co-occurring depression
  - heart disease may co-occur with major depression.



- Comorbidity tends to be associated with:
  - delayed detection and diagnosis
  - incomplete treatment
  - less complete recovery
  - more chronic course
  - greater problems with functioning
  - higher rates of suicide.
- Chronic pain and chronic illness commonly present with a comorbid psychiatric illness (depression, anxiety or substance use disorders). Chronic pain itself and analgesics such as opiate medications can mask symptoms of mental illness.

### **Comorbidity and Trauma**

- Lifetime prevalence rates for exposure to traumatic events ranges from 50% to 98% across studies.
- The experience of trauma may lead to significant comorbidity in the areas of physical and mental health.
- Individuals with a mental illness are also more likely to be exposed to traumatic events including childhood sexual or physical abuse and adulthood traumatic victimization.
- Children exposed to early traumatic experiences are at increased risk for the development of depression, anxiety disorders, personality disorders, substance use disorders and psychotic disorders later in life.
- In some cases, individuals may develop problems with substance use as they use alcohol or other drugs as method to cope with the trauma and resultant symptoms of over-arousal or avoidance.
- The lifetime prevalence of posttraumatic stress disorder (PTSD) is about 8% – 14% in the general population. Rates of comorbid PTSD in individuals with a mental illness are estimated to be as high as 43%.



# Overview of Disorders

Annual rates for Major Depressive Disorder, Mania, Social Phobia, Panic Disorder and Agoraphobia as well as those for Problematic Alcohol and Substance Use are provided by the 2002 Canadian Community Health Survey: Mental health and well-being [www.statcan.ca/Daily/English/030903/d030903a.htm](http://www.statcan.ca/Daily/English/030903/d030903a.htm).

*“One out of every 10 Canadians aged 15 and over, about 2.6 million people, reported symptoms consistent with alcohol or illicit drug dependence, or one of the five mental disorders covered in the survey, at some time during the 12 months prior to the interview”*

– 2002 Canadian Community Health Survey: Mental health and well-being

## MAJOR DEPRESSIVE DISORDER

\* For a complete review on issues regarding Major Depressive Disorder, please see the Guidelines and Protocol Advisory Committee: Diagnosis and Management of Major Depressive Disorder [monograph]. *BC Medical Association and BC Ministry of Health Services, Victoria, 2004, 18 pages.* [www.healthservices.gov.bc.ca/msp/protoguides/gps/title.html](http://www.healthservices.gov.bc.ca/msp/protoguides/gps/title.html)

- A clinical depression occurs when a person experiences a major depressive episode as defined by the DSM-IV or DSM-IV-TR.
- Other mood disorders or conditions with mood components include:
  - dysthymic disorder
  - bipolar disorders 1 and 2 and cyclothymic disorder
  - bereavement
  - substance-induced mood disorder
  - adjustment disorder with depressed mood
- Subtypes of major depressive disorder include:
  - seasonal affective disorder
  - postpartum depression
  - psychotic depression
  - atypical depression
  - melancholic depression

### Epidemiology

The implications of depression for both the individual and society are significant:

- In 2002, 4.5% of Canadians reported suffering from Major Depression in the previous 12 months; 4.9% reported “any mood” disorder.
- Lifetime risk of Major Depressive Disorder varies from 10 – 25% for women and 5 – 12% for men.
- About 2% of people with depression will commit suicide.
- Depression is the second leading cause of long-term disability and the fourth leading cause of global burden of disease.
- 50 – 60% of individuals with a first episode can expect to have a second while 70% of those with two episodes can expect to have a third; 90% of those with a third will go on to have a fourth.
- 5 – 10% of individuals diagnosed with MDD go on to develop bipolar disorder.
- In 2002, 0.8% of Canadians reported suffering a manic episode in the previous 12 months.
- ‘Bipolar spectrum disorders’ affect up to 8% of the population “Bipolar spectrum disorders” include bipolar disorder type 2, cyclothymia and “ultra-rapid cyclers”.
- Postpartum depression occurs in up to 10 – 20% of women.

### Comorbidity

- Medical illnesses commonly presenting with comorbid depression include:
  - coronary artery disease
  - HIV/AIDS
  - cancer
  - arthritis
  - stroke
  - metabolic and endocrine disorders such as hypo or hyperthyroidism
  - diabetes
  - neurodegenerative disorders
  - e.g., Alzheimer’s and Parkinson’s disease
- Most psychiatric disorders, including anxiety and psychotic disorders, problematic alcohol and substance use and personality disorders have high rates of comorbid depression.

### Overview of Treatment

- Between 70% and 80% of depressed people get better with various forms of evidence-based therapy.
- The evidence indicates that antidepressant medication and various psychotherapies are effective treatments for many people.
- Depression is a time-limited disorder and many recover over time in the absence of treatment.

## ANXIETY DISORDERS

While anxiety can be a normal and adaptive emotion, chronic and excessive anxiety can lead to significant personal suffering and substantial interference in daily functioning.

Anxiety disorders (approximate prevalence rates) include:

- panic disorder (2.4%)
- social anxiety disorder (2 – 13%)
- agoraphobia (1 – 5%)
- generalized anxiety disorder (3 – 7%)
- post-traumatic stress disorder (1 – 14%)
- specific phobias (9 – 11%)
- obsessive-compulsive disorder (1 – 2%)
- substance-induced anxiety disorder.

Note: Prevalence rates are approximate and often vary substantially across studies.

### Epidemiology

- About 1 in 10 Canadians reported suffering from an anxiety disorder in the previous 12 months.
- PTSD has a prevalence rate of 9 – 10% in Western countries.
- Panic disorder, agoraphobia, post-traumatic stress disorder, generalized anxiety disorder and specific phobias occur more frequently in women.
- There are no significant gender differences for social anxiety disorder and obsessive-compulsive disorder.

### Comorbidity

- More than half of individuals with an anxiety disorder receive at least one additional psychiatric diagnosis.
- Common comorbid medical conditions include:
  - osteoarthritis
  - diabetes
  - heart disease
  - obesity
  - elevated lipid levels
  - fibromyalgia
  - irritable bowel syndrome.
- Common comorbid psychiatric illness include:
  - another additional anxiety disorder
  - depression and other mood disorders
  - substance use disorders
  - personality disorders.
- Comorbidity is often associated with more severe anxiety disorder symptoms.

### Overview of Treatment

- Approximately 80% of patients benefit from cognitive-behavioural therapy, medications or a combination of both.
- Cognitive-behavioural therapy and medication treatment (when appropriate) are roughly equivalent after approximately 8 to 20 weeks of treatment.
- Cognitive-behavioural therapy may be superior to medication treatments in the long-term (i.e., months and years following treatment) most likely due to the high relapse rates often associated with medication cessation.

## EARLY PSYCHOSIS

- Psychosis is a state characterized by an individual's loss of contact with reality. It may involve abnormal perceptions (hallucinations in any sensory modality), delusions, disorganized speech or disorganized or catatonic behaviour.
- Psychotic Disorders include:
  - schizophrenia
  - schizophreniform disorder
  - schizoaffective disorder
  - delusional disorder
  - brief psychotic disorder
  - psychotic disorder due to a general medical condition
  - psychotic disorder not otherwise specified
  - substance-induced psychotic disorder.
- Subtypes include: paranoid, disorganized, catatonic, undifferentiated, and residual types.
- Mood disorders such as Bipolar disorder and Depression may present with psychotic features. Bipolar disorder in adolescents is often misdiagnosed as Schizophrenia and should be revisited as a possible diagnosis when mood symptoms present.
- Dementia may be accompanied by psychosis.

### Epidemiology

- Psychosis has a lifetime prevalence of about 3%. Schizophrenia is the most prevalent psychotic disorder with a lifetime prevalence rate reported to be between 0.4% and 1.5%.
- The median age at onset for the first psychotic episode of schizophrenia for men is early to mid 20's and for women, late 20's.
- First-degree biological relatives of individuals with schizophrenia have a risk of schizophrenia that is 10 times that of the general population.
- Both genetic and environmental factors have been implicated in the etiology of schizophrenia.
- The rate of completed suicide in persons with schizophrenia is about 10%, a rate more than 25 times higher than in the general population. The risk of suicide is highest during the first five years of the illness.
- According to the World Health Organization, active psychosis ranks as the third most disabling condition — higher than paraplegia and blindness.

### Comorbidity

- Comorbid substance abuse occurs in 20 – 30% of individuals with rates for substance misuse above 50%.
- 15% of individuals with psychosis have post-traumatic stress disorder.
- 40% of individuals with psychosis have significant depression.
- Many individuals with a psychotic disorder develop serious medical conditions leading to shortened life expectancy:
  - Diabetes and obesity
  - Conditions related to chronic tobacco/substance use
  - Nutritional deficiencies and self-neglect
  - Victimization and violence.

### *Methamphetamine-related Psychotic Symptoms*

The use of methamphetamine has increased in recent years leading to a higher number of individuals seen with comorbid psychosis. Further research is needed to understand the association between methamphetamine use and psychosis.

Three theories have been proposed to account for the high rate of comorbid methamphetamine use and psychosis:

1. People with psychosis use methamphetamine – this causes a relapse and gives the appearance that the drug caused the psychosis.
2. Methamphetamine use may be a kind of stressor that unmasks a person's vulnerability to develop psychosis (e.g., someone with a high genetic risk may have developed schizophrenia given one of many possible physical or social stresses).
3. Methamphetamine may cause psychosis — there are increasing reports of persons with no psychiatric history whose psychosis fails to go away after the drug is out of their system.

### **Overview of Treatment**

- With appropriate treatment up to 85% of people with a diagnosis of schizophrenia will symptomatically recover within a year.
- For schizophrenia and bipolar disorder with psychosis, the one-year relapse rates are reduced by half with appropriate medication treatment (from about 60% to 30%).

## SUBSTANCE USE DISORDERS

Substance related disorders include:

- substance use disorders:
  - abuse
  - dependence
- substance-induced disorders:
  - withdrawal
  - intoxication
  - substance-induced delirium
  - substance-induced psychotic disorder
  - substance-induced mood disorder
  - substance-induced anxiety disorder
  - substance-induced sleep disorder

### Epidemiology

- In the “2002 Canadian Community Health Survey: Mental health and well-being”, in the previous 12 months
  - 2.6% of Canadians reported alcohol dependence
  - 0.7% reported an illicit substance dependence
- Lifetime prevalence of alcohol dependence may be as high as 15%

### Comorbidity

- Medical comorbidity may include liver disease, lung disease, emphysema, STDs, HIV, head injuries.
- There is significant overlap between substance use disorders and concurrent mental disorders.
- Substances may be used as a form of self medication for mental health problems (eg. depression, anxiety).
- Substance use may also trigger, worsen, or mask mental health problems.
- Trauma contributes to both mental health and substance use problems.
- Comorbidity of substance use disorder with a mental disorder is associated with an overall higher disease burden and higher mortality.
- **People experiencing multiple diagnoses are more likely to develop substance dependencies and less likely to benefit from stand-alone addictions services.** Such complex cases require an integrated approach that addresses substance use and mental health issues concurrently.

### Overview of Treatment

- The annual rate of remission in patients completing intensive treatment is estimated to be between 45 – 60%.
- About 2% of alcohol dependent individuals achieve stable abstinence each year, with or without treatment.
- Similar figures exist for heroin and tobacco dependence.



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# 2 DIAGNOSTIC ISSUES

# Diagnosis

## THE PSYCHIATRIC INTERVIEW

Diagnoses should be made with direct reference to the DSM-IV or DSM-IV-TR. Typically, a psychiatric interview would have the following structure:

- identifying information: age, marital status, occupation/financial support, living conditions, family
- chief complaint
- history of presenting illness
  - based on the early information, is this a psychotic, anxiety, mood or substance disorder
  - thoroughly review the symptoms of the disorder
  - screen for the three other categories of disorder
- substances of abuse — route, frequency, quantity, last use:
  - alcohol, rubbing alcohol, Listerine
  - stimulants: cocaine, crystal methamphetamine
  - marijuana
  - opiates — heroin, methadone, morphine, codeine, oxycodone (Oxycontin)
  - benzodiazepines
  - tobacco (chew, cigarettes)
  - caffeine
  - OTC and prescription (especially anticholinergics)
- past psychiatric history
  - hospitalizations
  - suicide attempts (severity; parasuicidal nature — overdoses, wrist slashing; how they survived, were substances involved?)
  - medication trials (whether trial was completed; whether remission was achieved — partial, full, duration; reasons for discontinuation)
  - psychotherapy, counselling (age when first saw professional and for what reason)
- past medical history
  - hospitalizations
  - history of injection drug use
  - surgeries
  - chronic illness
  - head trauma, MVAs, loss of consciousness
  - endocrine disorders — thyroid +/- medical or surgical intervention
  - seizures
  - risk/presence of HIV/HCV/HBV/TB
- current and recent medications
- family history
  - psychiatric (suicides, substance use, hospitalizations, odd or estranged family members)
  - medical/surgical

- social
  - place of birth, labour and delivery, growth and development
  - early, middle and high school performance
  - family relations — parents, foster care, siblings
  - abuse — sexual or physical
  - relationships — “coming out” experiences
  - post-secondary education, employment, vocational training
- mental status exam
  - appearance, behaviour, speech, rapport, reliability, mood and affect, thought form and content, insight, judgment, cognitive ability, suicidal ideation
- physical exam — evidence of intoxication/withdrawal, track marks, conjunctival injection (THC users), stigmata of chronic liver disease, etc
- impression
- Multi-Axial Diagnosis
  - Axis I: psychiatric disorders
  - Axis II: personality disorders, coping styles/defences
  - Axis III: comorbid medical conditions which may contribute to psychiatric presentation
  - Axis IV: social stressors/circumstances which may contribute
  - Axis V: GAF score

### Suicide Risk Assessment

— adapted from Rubenstein, Unutzer, Miranda et al, 1996

- Ask all patients at risk (including depression, anxiety disorders, psychosis, substance use disorders, personality disorders, etc.) if they have thoughts of death or suicide, or if they feel hopeless and feel that life is not worth living. Also ask if they have previously attempted suicide.
- If the answer is yes, ask about plans for suicide. How much have they thought about suicide? Have they thought about a method? Do they have access to material required for suicide? Have they said goodbyes, written a note or given away things? What specific conditions would precipitate suicide? What is stopping them from suicide?
- Assess risk factors for suicide.
- Warn the patient that agitation and suicide risk may increase early in treatment.
- Obtain collateral information from family or friends.
- Consider emergency psychiatric consultation and treatment if:
  - suicidal thoughts are persistent
  - the patient has a prior history of a suicide attempt or a current plan
  - the patient has several risk factors for suicide.

## DIAGNOSING MAJOR DEPRESSIVE DISORDER

The symptoms of depression can be divided into 2 categories:

- cognitive, behavioural or emotional (low mood, loss of interest or enjoyment, trouble concentrating, feelings of guilt or self-blame, low self-esteem, thoughts of death and suicide)
- physical or neurovegetative (fatigue, psychomotor changes, disturbances of sleep and appetite/weight).

The symptom criteria for MDD can be recalled using the **SIG E CAPS** mnemonic:

- S** — Sleep disturbance (too much or too little)
- I** — Interest reduced (reduced pleasure or enjoyment)
- G** — Guilt (excess) and self-blame or feelings of worthlessness
- E** — Energy loss and tiredness
- C** — Concentration problems
- A** — Appetite changes (low appetite/weight loss or increased appetite/weight gain)
- P** — Psychomotor changes (slowed down or speeded up)
- S** — Suicidal thoughts.

The individual must have depressed mood (or loss of interest) and at least 4 other symptoms, most of the time, most days, for at least two weeks.

### DSM-IV or DSM-IV-TR Criteria: Major Depressive Episode

Five or more of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure:

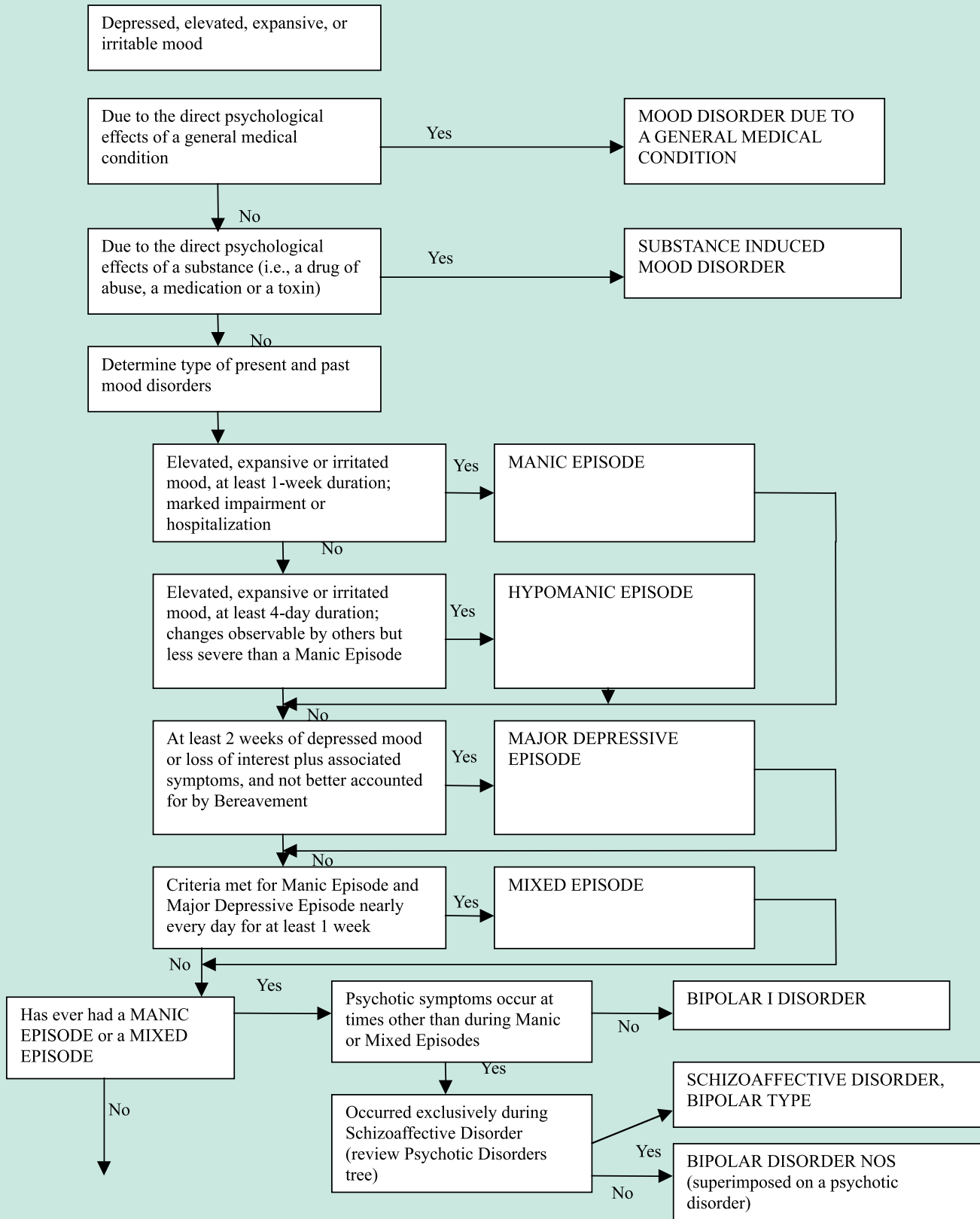
1. depressed mood, as described by the patient (e.g., feels sad or empty) or by observation (e.g., appears tearful)
2. markedly reduced interest or pleasure in all, or almost all, activities nearly every day
3. significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite
4. insomnia or hypersomnia (or increased need for sleep).
5. psychomotor agitation or retardation (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. fatigue or loss of energy.
7. feelings of worthlessness or excessive or inappropriate guilt
8. reduced ability to think or concentrate, or indecisiveness
9. recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

### Bipolar Disorder

- Bipolar disorder is often misdiagnosed as unipolar depression largely because mania and hypomania often go unrecognized.
    - In adolescents/youth, psychotic mania can be mistaken for schizophrenia.
  - When a patient appears depressed, probe extensively for hypomania. Ask
    - Do they ever have periods when they need less sleep or go to bed later for even only a few days (sleep pattern changes can be as subtle as a couple hours)?
    - Do they ever feel the “opposite of depressed”?
    - Do they have periods of taking on more responsibility or plans that they ultimately are unable to fulfill?
    - Do they ever feel overconfident or “grandiose”?
    - Do their thoughts ever feel “sped up” or feel like they can’t speak quickly enough to get their words out or have friends tell them that they are speaking quickly?
    - Do they act impulsively — for instance with spending sprees, casual sex, or gambling?
  - On history, bankruptcies, changes in sexual behavior, legal involvement, or sudden dismissals from employment may reflect a history of hypomania.
  - On past psychiatric history, they may have been diagnosed early as having personality disorders, or have had multiple trials of antidepressants with similar outcomes: early mood improvement (in the first 1 – 2 weeks) with eventual treatment failure.
  - Rule out or identify comorbid substance use, especially cocaine, crystal methamphetamine and alcohol.
  - Depressive episodes in bipolar disorder may be indistinguishable from major depressive disorder. Alternatively, there is a tendency towards atypical symptoms:
    - hypersomnia
    - hyperphagia
    - leaden paralysis (a subjective feeling of heaviness in the limbs).
- (See the DSM-IV or DSM-IV-TR Criteria.)

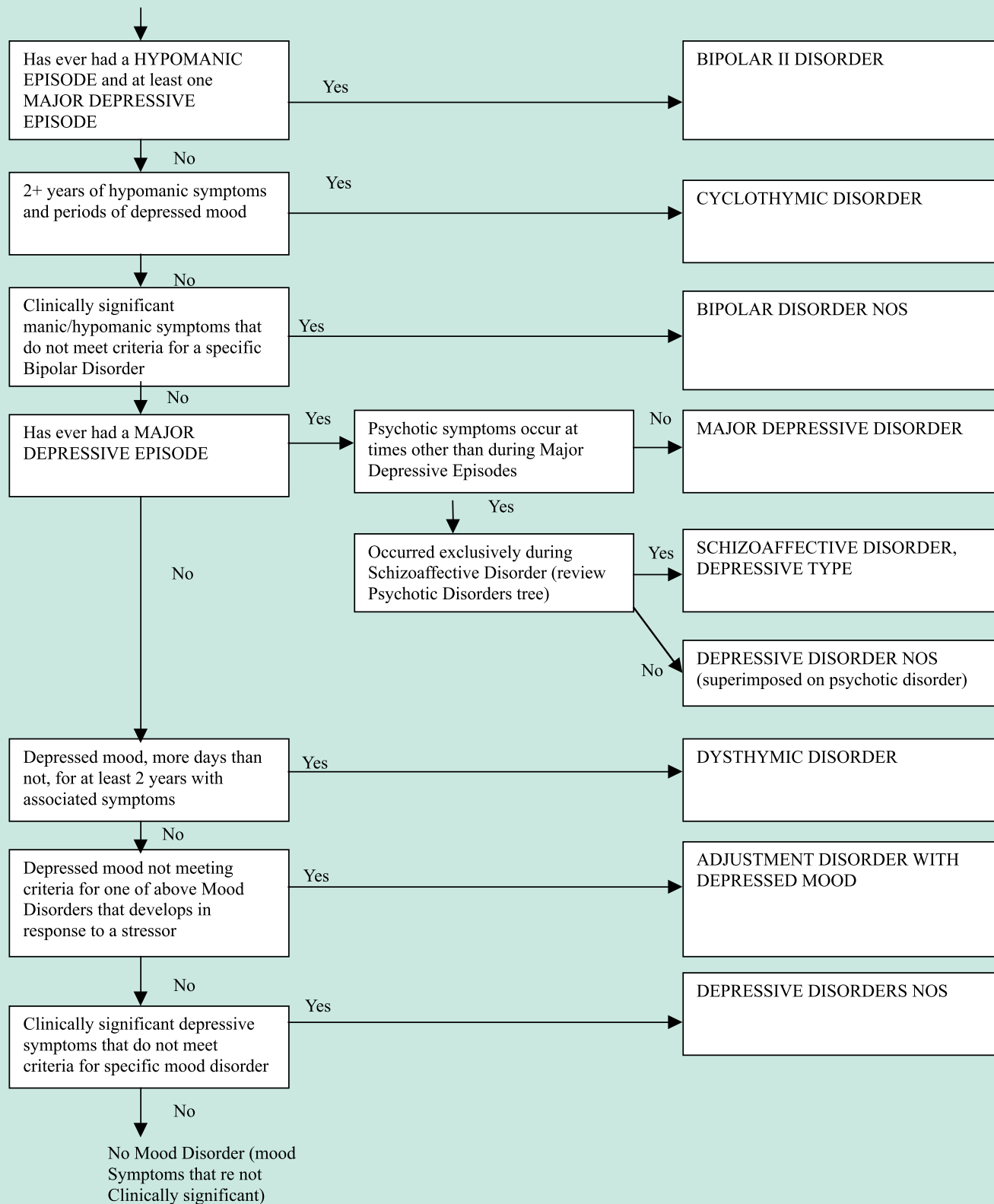
## DIAGNOSING MAJOR DEPRESSIVE DISORDER

### Mood Disorders — Diagnostic Decision Tree (adapted from DSM-IV or DSM-IV-TR)





## DIAGNOSING MAJOR DEPRESSIVE DISORDER



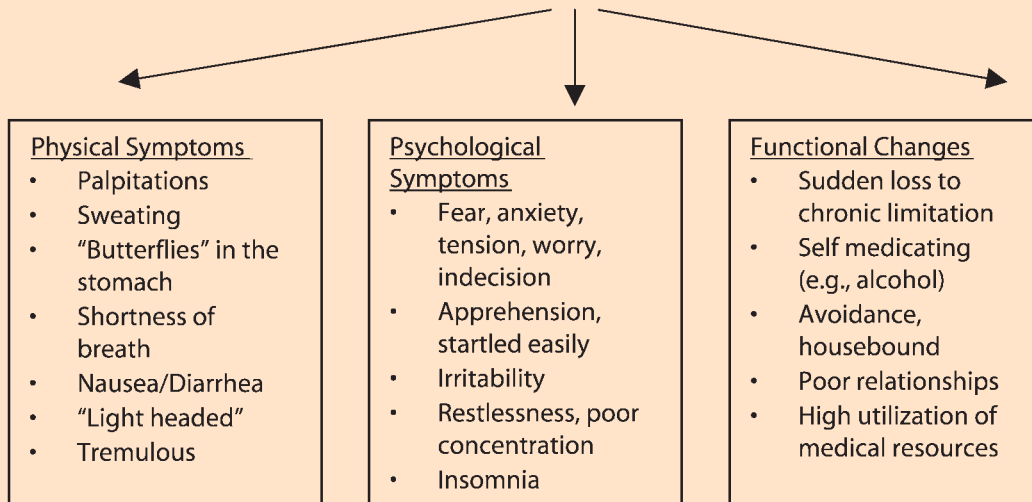
## DIAGNOSING ANXIETY DISORDERS

- All anxiety disorders share basic symptoms of anxiety, fear, and avoidance.
- Panic attacks can occur across all anxiety disorders. Panic attack is defined as a sudden episodic rush of intense fear or terror along with physiological symptoms (e.g., rapid heart rate, shortness of breath) and concern about losing control, going crazy, having a heart attack, etc.

FEATURES OF THE MAIN ANXIETY DISORDERS adapted from DSM-IV or DSM-IV-TR	
TYPE OF ANXIETY DISORDER	MAIN FEATURES
<b>Obsessive Compulsive Disorder</b>	repeated, unwanted, intrusive thoughts/images/urges (obsessions) accompanied by repetitive behaviours or mental acts (compulsions) in attempts to neutralize anxiety
<b>Social Anxiety Disorder</b>	excessive fear of social or performance situations (e.g., being judged negatively by other people)
<b>Generalized Anxiety Disorder</b>	at least 6 months of chronic, uncontrollable and excessive worry about a broad number of issues in daily life
<b>Post Traumatic Stress Disorder &amp; Acute Stress Disorder</b>	re-experiencing the traumatic event along with physiological arousal and avoidance of reminders that does not resolve within 1 month (less than one month is diagnosed as Acute Stress Disorder)
<b>Panic Disorder (with or without agoraphobia)</b>	recurrent panic attacks that are initially unexpected <b>and</b> excessive fear of future panic attacks
<b>Agoraphobia without history of panic disorder</b>	excessive fear and avoidance of situations in which help may be unavailable or escape impossible when experiencing anxiety or panic symptoms
<b>Specific Phobias</b>	Excessive fear and avoidance of specific situations, objects or things
<b>Anxiety Disorder due to a General Medical Condition</b>	prominent symptoms of anxiety that are the direct physiological consequence of a medical condition (e.g., thyroid problems, hypoglycemia, congestive heart failure, arrhythmia)

**Anxiety Disorders — Diagnostic Decision Tree**  
(adapted from The Ontario Anxiety Disorder Primary Care Guidelines 2000)

Step 1: Does the patient have the symptoms and signs of Anxiety?

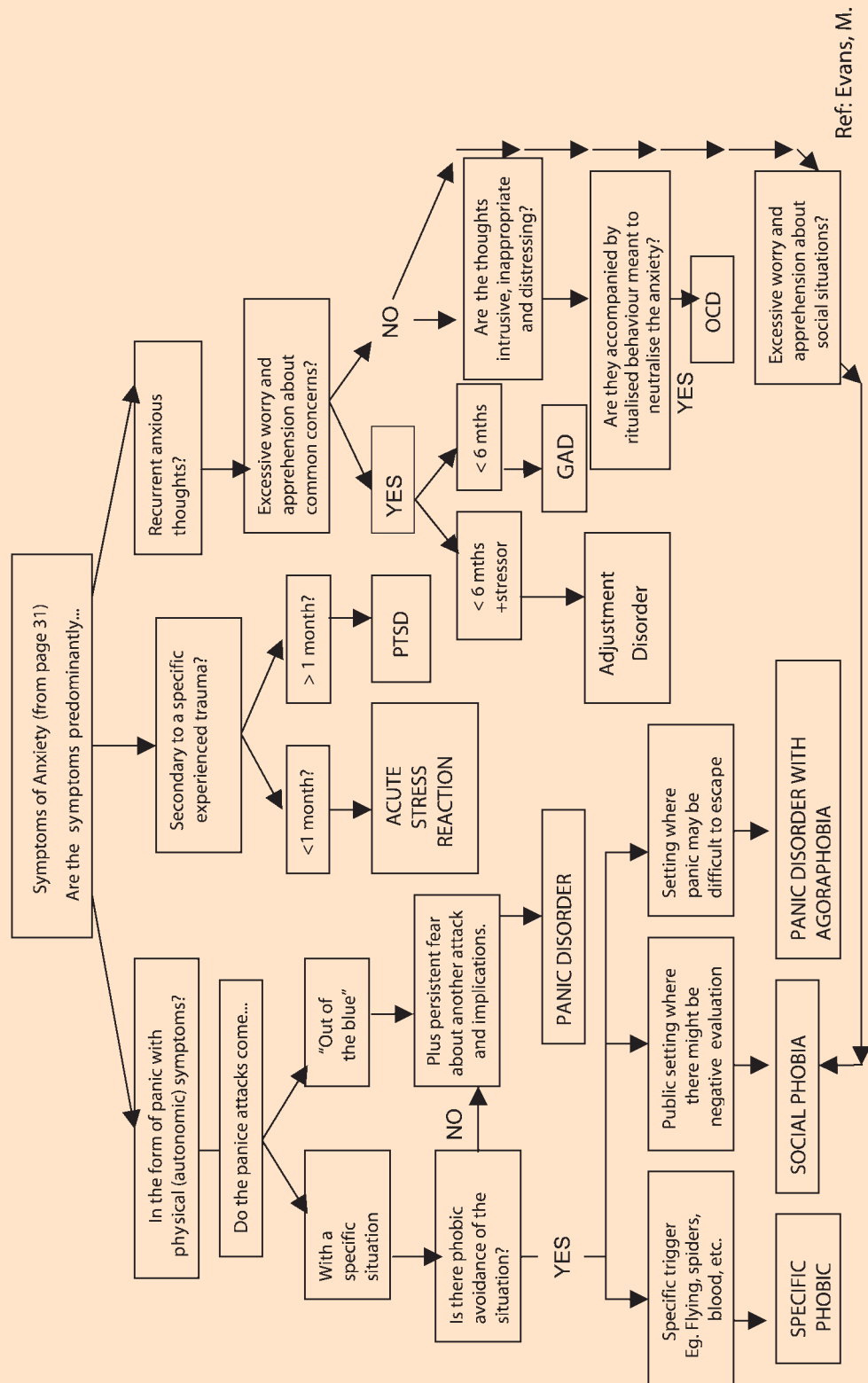


Step 2: Consider and Treat other Causes of Anxiety or Co-morbidities

Diagnosis To Consider	Depression	Substance Abuse
<ul style="list-style-type: none"> <li>• Hyperthyroidism</li> <li>• Temporal lobe epilepsy</li> <li>• Endocrine dysfunction</li> <li>• Pheochromocytoma</li> <li>• Caffeine abuse</li> <li>• Other stimulants</li> <li>• Cardiac illness</li> </ul>	<ul style="list-style-type: none"> <li>• Considerable overlap in symptoms</li> <li>• Consider isolated depression symptoms such as anhedonia and weight changes</li> <li>• Assess severity and suicidal ideation</li> </ul>	<ul style="list-style-type: none"> <li>• Identify if abusing alcohol and/or drugs</li> <li>• Identify dependence and/or harmful/hazardous use</li> <li>• Educate regarding relationships between substance abuse and anxiety</li> <li>• Initiate treatment plan (ARF phone number for anxiety substance abuse program)</li> </ul>

Reference: Evans, M. (2000)

# Anxiety Disorders — Diagnostic Decision Tree



## DIAGNOSING EARLY PSYCHOSIS

The most common psychotic and manic symptoms are listed in the tables below. In early psychosis, the diagnosis may change over time (e.g., from schizophrenia to bipolar disorder, or from bipolar disorder to schizoaffective disorder) so re-assessments are needed regularly.

DSM-IV or DSM-IV-TR DIAGNOSIS	MAIN SYMPTOMS
<b>Schizophrenia A criteria</b> <b>Psychotic symptoms</b>	At least two of <ul style="list-style-type: none"> <li>• delusions</li> <li>• hallucinations</li> <li>• disorganized speech</li> <li>• grossly disorganized or catatonic behaviour</li> <li>• negative symptoms, including flat affect, lack of speech or lack of motivation.</li> </ul> OR one of <ul style="list-style-type: none"> <li>• bizarre delusions (i.e. totally impossible and implausible)</li> <li>• voices keeping a running commentary (i.e. voices commenting on the person's behaviour) or two or more voices conversing with each other.</li> </ul>
<b>Bipolar I Disorder with Psychosis</b> <b>Manic symptoms</b>	Distinct period of abnormally elevated, expansive or irritable mood plus at least three of: <ul style="list-style-type: none"> <li>• decreased need for sleep</li> <li>• inflated self-esteem or grandiosity</li> <li>• racing thoughts</li> <li>• rapid speech</li> <li>• easily distracted</li> <li>• dangerous pursuit of pleasure with large risks</li> <li>• increase in social, work or sexual pursuits or agitation</li> </ul> plus psychotic features (mentioned above).

### *Positive Symptoms*

"Positive symptoms" are usually dramatic and are the first 4 of the 5 criteria listed above:

- delusions — fixed, false beliefs even in the face of contradictory evidence
- hallucinations — which may occur in any modality
- disorganized speech (e.g., tangentiality and loose associations)
- disorganized behaviour.

### *Negative Symptoms*

"Negative" symptoms are less dramatic and are so called because they are a decrease in normal experiences. They often precede the appearance of positive symptoms.

"Negative" symptoms are not synonymous with symptoms of depression.

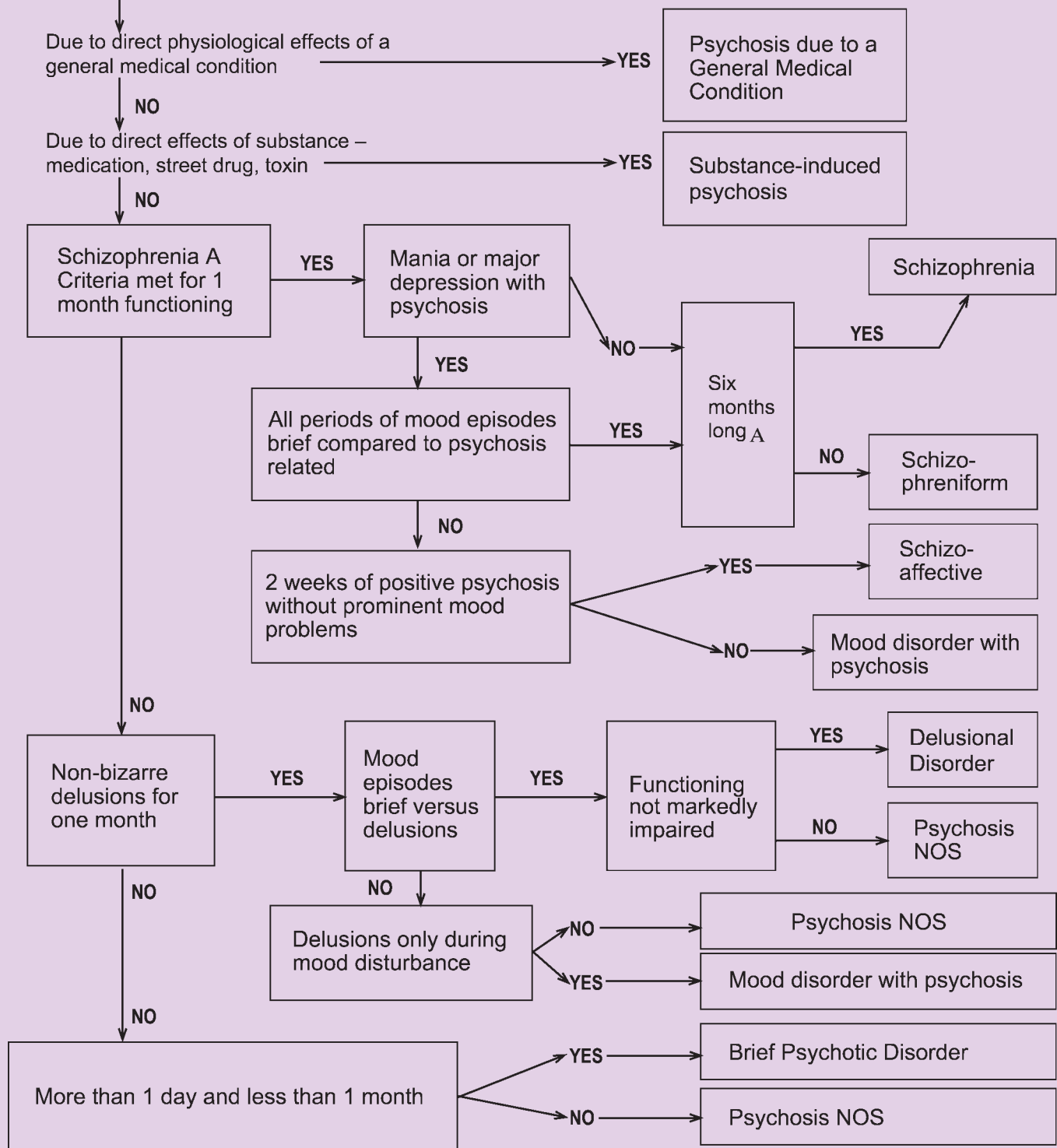
They include:

- avolition — lack of motivation, apathy
- affective flattening in either range or intensity
- alogia — decreased output of speech that reflects poverty of inner thought  
e.g., blocking
- anhedonia — absence of pleasure, asociality.

## DIAGNOSING EARLY PSYCHOSIS

### Psychosis – Diagnostic Decision Tree (adapted from DSM-IV or DSM-IV-TR)

Delusions, hallucinations, disorganized speech, grossly disorganized behaviour, Negative Symptoms



## DIAGNOSING SUBSTANCE USE DISORDERS

### *Problems with Substance Use*

- Substance use disorders (SUD) (substance abuse and substance dependence as defined in the DSM-IV or DSM-IV-TR) are a subset of substance related disorders.
- SUDs are further classified into substance abuse and substance dependence disorders depending on the number and type of associated problems.
- A patient exhibiting some but not all the criteria for a substance use disorder may still be experiencing problems related to their substance use, and require treatment.

### **Assessment**

- Obtain full alcohol and drug histories including frequency, amount and route of use.
- Establish a diagnosis, either problematic use (not meeting criteria for abuse or dependence), abuse or dependence.
- Questions which cover the symptoms of dependence are useful in establishing either abuse or dependence but may also uncover negative consequences of use.
- Explore areas such as impulsive or high risk behaviours (e.g., rash driving, promiscuous behaviours) while intoxicated.
- A full physical examination, mindful of biological red flags, is the standard of care.
- Order blood work — including CBC, electrolytes, liver function tests as well as tests for renal function.
- Consider screening for HIV, Hepatitis B and C and STDs including syphilis, especially if there is suspicion of high-risk behaviours.
- Consider TB skin testing.
- Consider ordering urine drug screens to confirm the history.
  - Patients may believe that they have used one substance only to find that they have used another (e.g., methamphetamine is commonly substituted for, or is a major ingredient in, ecstasy and crack cocaine).
  - Non-disclosure of certain drugs may complicate treatment.

### *Pitfalls of Urine Drug Screens*

- Depending on the methodology and cut offs used by the lab, there are both false positives and false negative tests.
- May be used for non-medical reasons — occupational safety, child protection/custody; therefore carefully consider the benefit/risk of drug screens, and discuss with patient when able.
- Opiates with codeine or morphine metabolites are detected more readily than meperidine in EMIT tests.
- Fentanyl and Methadone may not be detected and must be requested specifically.
- Heroin only detected if within 8 hours of last use — otherwise detected as morphine.
- Clonazepam and Lorazepam are poorly detected.
- Approximate windows of detection:
  - amphetamine/methamphetamine: 1 – 2 days
  - benzodiazepines: 3 – 5 days; up to 3 weeks or longer for prolonged use
  - cocaine: 2 – 4 days; up to 7 days or longer for prolonged use
  - ethanol: 2 – 14 hours
  - methadone: 3 days (single use only) 5 – 7 days if chronic use
  - opiates (codeine, morphine, heroin): 1 – 3 days
  - THC: 5 days (moderate use); 10 days (heavy); up to 2 months (heavy, chronic)
  - LSD: 1 day
  - barbiturates: 1 day (short acting); 2 – 3 weeks (long).

### **DSM-IV or DSM-IV-TR Criteria: Substance Abuse and Dependence**

The DSM-IV or DSM-IV-TR recognizes substance abuse and dependence as two presentations of substance use disorders. Withdrawal and Intoxication reflect more acute states and are not exclusive of the disorders.

#### *Substance Abuse*

#### **Substance Abuse DSM-IV or DSM-IV-TR Criteria:**

- A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:
  - 1. recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home
  - 2. recurrent substance use in situations in which it is physically hazardous
  - 3. recurrent substance-related legal problems
  - 4. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
- B. The symptoms have never met the criteria for substance dependence for the substance in question.

#### *Substance Dependence*

Substance dependence reflects a progression from abuse and reflects physiological, behavioural or psychological consequences.

#### **Substance Dependence DSM-IV or DSM-IV-TR Criteria:**

- A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:
  - 1. tolerance, as defined by either
    - a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect or
    - b) markedly diminished effect with continued use of the same amount of the substance
  - 2. withdrawal, as manifested by either
    - a) the characteristic withdrawal syndrome for the substance or
    - b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
  - 3. the substance is often taken in larger amounts or over a longer period than was intended
  - 4. there is a persistent desire or unsuccessful efforts to cut down or control use
  - 5. a great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects
  - 6. important social, occupational, or recreational activities are given up or reduced because of use
  - 7. the use is continued despite knowledge of having persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance



### Glossary of Substance Use Terms

— (adapted from the Substance Abuse Mental Health Services Administration website [www.samhsa.gov](http://www.samhsa.gov))

**Blackouts:** A type of memory impairment that occurs when a person is conscious but cannot remember the blackout period. In general, blackouts consist of periods of amnesia or memory loss, typically caused by chronic, high-dose problematic alcohol or substance use. Blackouts are most often caused by sedative-hypnotics, such as alcohol and the benzodiazepines.

**Coke bugs:** Tactile hallucinations (also called formications) that feel like bugs crawling on or under the skin. Chronic and high-dose stimulant abuse can cause various types of hallucinations.

**Crack:** Cocaine (cocaine hydrochloride) that has been chemically modified so that it will become a gas vapour when heated at relatively low temperatures; also called “rock” cocaine.

**Downers:** Slang term for drugs that exert a depressant effect on the central nervous system. In general, downers are sedative-hypnotic drugs, such as benzodiazepines and barbiturates.

**DTs:** Delirium tremens; a state of confusion accompanied by trembling and vivid hallucinations. Symptoms may include restlessness, agitation, trembling, sleeplessness, rapid heartbeat, and possibly convulsions. Delirium tremens often occurs in chronic alcoholics after withdrawal or abstinence from alcohol.

**Ecstasy:** Slang term for methylenedioxymethamphetamine (MDMA), a member of the amphetamine family. At lower doses, MDMA causes distortions of emotional perceptions. At higher doses, it causes potent stimulation typical of the amphetamines.

**Eight (8) Ball:** 3.6g or 1/8th ounce.

**Hallucinogens:** A broad group of drugs that cause distortions of sensory perception. The prototype hallucinogen is lysergic acid diethylamide (LSD). LSD can cause potent sensory perceptions, such as visual, auditory, and tactile hallucinations. Related hallucinogens include peyote and mescaline.

**Ice:** Slang term for smokeable methamphetamine. Much as cocaine can be modified into a smokeable state (crack cocaine), methamphetamine can be prepared so that it will produce a gas vapour when heated at relatively low temperatures. When smoked, ice methamphetamine produces an extremely potent and long-lasting euphoria, an extended period of high energy and possible agitation, followed by an extended period of deep depression.

**Marijuana:** The dried leaves and flowering tops of the Indian hemp plant *cannabis sativa*; also called “pot” and “weed.” It can be smoked or prepared in a tea or food. Marijuana has two significant effects. In the non-tolerant user, marijuana can produce distortions of sensory perception, sometimes including hallucinations. Marijuana also has depressant effects and is partially cross-tolerant with

## DIAGNOSING SUBSTANCE USE DISORDERS

sedative-hypnotic drugs such as alcohol. Hashish (or hash) is a combination of the dried resins and compressed flowers from the female plant.

**Nodding out:** Slang term for the early stages of depressant-induced sleep. Opioids and sedative-hypnotics induce depression of the central nervous system, causing mental and behavioural activity to become sluggish. As the nervous system becomes profoundly depressed, symptoms may range from sleepiness to coma and death. Typically, “nodding out” refers to fading in and out of a sleepy state.

**Opiates:** A type of depressant drug that diminishes pain and central nervous system activity. Prescription opiates include morphine, meperidine (Demerol), methadone, codeine, and various opioid drugs for coughing and pain. Illicit opioids include heroin, also called “smack,” “horse,” and “boy.”

**Paraphernalia:** A broad term that describes objects used during the chemical preparation or use of drugs. These include syringes, syringe needles, roach clips, and marijuana or crack pipes.

**Point:** 1/10th gram. A measurement of drug quantity.

**Uppers:** Slang term used to describe drugs that have a stimulating effect on the central nervous system. Examples include cocaine, caffeine, and amphetamines.

# Early Detection

As with all disorders, the Early Detection of mental illness helps prevent short-term complications, initiate recovery and minimize negative long-term consequences of the disorder. Programs such as Early Psychosis Intervention (E.P.I.) have been internationally embraced as a standard of care because of their intended impact on outcomes.

Early Detection requires an awareness of Risk Factors, the observation of Warning Signs and the application of Screening Tools.

## **The Family Physician's Role in Early Detection**

- Screen and assess any patient with symptoms of a psychiatric disorder.
- Encourage patients and family to openly discuss psychological problems.
- Note that many patients frame their distress somatically or report only physical symptoms because of a reluctance to express psychiatric symptoms.
- Keep in mind that patients' personal beliefs and symptoms (e.g., avoidance, fear of negative evaluation, delusions, hallucinations) can interfere with disclosure and help-seeking behaviours.
- Provide educational materials in the waiting area to help patients recognize their own problems and encourage disclosure of symptoms during office visits (*see section on self-management and information for families for free and easily accessible sources of educational materials*).

## RISK FACTORS

Risk factors can be inherent or acquired and may interact with each other to result in illness expression.

### General Risk Factors

- past history of any psychiatric disorder
- family history of any psychiatric disorders
- co-morbid medical illnesses
- history of physical or sexual abuse
- recent major negative life events
- pregnancy and post-partum periods
- presence of any psychiatric disorder increases risk of a secondary psychiatric disorders
- substance use including early onset tobacco use

### Disorder-Specific Risk Factors

#### *Major Depressive Disorder*

- long term pain or chronic illness (e.g., diabetes, arthritis)
- cardiovascular disease
- family history of mood disorder
- pregnancy or postpartum
- long-term sleep problems
- substance use disorders
- female gender
- tobacco dependence

#### *Anxiety Disorders*

- higher incidence in adolescents/youth and the elderly
- stressful periods
- postpartum period
- chronic physical illness including chronic pain conditions
- substance use disorders

#### *Early Psychosis*

- family history of psychosis/psychiatric disorder
- history of head injury
- history of poor growth and development
- history of academic and social difficulties
- history of pregnancy and birth complications
- psychological trauma/ongoing stress
- substance use disorders (especially stimulants, cocaine)
- higher incidence in adolescence/youth

### *Substance Use Disorders*

- family history of SUD
- past history of substance use disorder
- trauma and/or violence
- mental illness

### *Some additional factors that influence substance use are*

- availability of substance (e.g. easy availability for tobacco, alcohol, and marijuana)
- occupation (e.g. health care workers, bartenders, truck drivers, etc.)
- social instability
- low cost
- speed of drug effect onset
- peer group
- culture (acceptability of certain substances in some cultures)
- chronic physical pain



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# Screening Tools





# Screening Tools

## **General Screening Suggestions**

- Screen adolescent populations at all visits, as they are infrequent and inconsistent users of health care.
- Screen adult populations if considered to be in at-risk population.
- Screen women at antepartum and post-partum visit (screen at 2 months with first infant immunization).
- Set reminders to screen on office charting systems.
- Build screens into social histories when discussing other high-risk behaviours such as unprotected sex or extreme sports.
- In order to ease apprehension with screening tools, especially teenagers, try “This questionnaire is like taking your emotional temperature — it is part of a normal visit”.
- If a screen is positive, complete a full history and physical, in an attempt to clarify the diagnosis, over the next 1 or 2 appointments.

## SCREENING FOR MAJOR DEPRESSIVE DISORDER

There are a number of brief, valid, easy-to-administer assessment scales that can be used to detect depression in primary care. Two approaches are described here:

- the “two-quick-question” screening method
- use of the Patient Health Questionnaire 9 (PHQ 9).

### *The ‘Two-quick-question’ screening method*

- Use during routine visits with high-risk individuals.
- Ask whether, in the last month, they have
  1. “lost interest or pleasure in things you usually like to do?”
  2. “felt sad, low, down, depressed or hopeless?”

An answer of ‘yes’ to either question triggers a more detailed assessment of other symptoms of depression such as sleep disturbance, appetite change or lack of energy.

### *Use of the Patient Health Questionnaire 9 (PHQ 9)*

Having patients complete a PHQ 9 Questionnaire (see sample provided here) yields a wealth of information that can be used for both assessment and follow-up action. When reviewing the completed, questionnaire, major depressive disorder is suggested if

- of the 9 items, 5 or more are checked as at least ‘more than half the days’
- either item a. or b. is positive, that is, at least ‘more than half the days.’

Other depressive syndrome is suggested if

- of the 9 items, a., b., or c., are checked as at least ‘more than half the days’
- either item a., or b. is positive, that is, at least ‘more than half the days.’

Also, PHQ 9 scores can be used to plan and monitor treatment. To score the instrument, tally each response by the number value under the answer headings, (not at all = 0, several days = 1, more than half the days = 2, and nearly every day = 3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the following guide.

GUIDE FOR INTERPRETING PHQ-9 SCORES	
SCORE	ACTION
0-4	The score suggests the patient may not need depression treatment
5-14	Mild to major depressive disorder. Physician uses clinical judgment about treatment, based on patient’s duration of symptoms and functional impairment.
15-19	Moderate to major depressive disorder. Warrants treatment for depression, using antidepressant, psychotherapy or a combination of treatment.
20 OR HIGHER	Severe major depressive disorder. Warrants treatment with antidepressant, with or without psychotherapy, follow frequently.

The PHQ 9 instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, things at home, or relationships with other people. Patient responses can be one of four: Not difficult at all, Somewhat difficult, Very difficult, Extremely difficult. The last two responses suggest that the patient’s functionality is impaired. After treatment begins, functional status and number score can be used to assess patient improvement.

## SCREENING FOR MAJOR DEPRESSIVE DISORDER

### Patient Health Questionnaire — PHQ 9

( [www.primary-care.org](http://www.primary-care.org) )

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
 ☐ Somewhat difficult
 ☐ Very difficult
 ☐ Extremely difficult

**TOTAL SCORE** \_\_\_\_\_

## SCREENING FOR ANXIETY DISORDERS

Valid standardized scales for assessment of anxiety disorders in the primary care setting are not widely available or easily accessible. Two scales that may be used are

- ***the Hospital Anxiety and Depression Scale (HADS)***

- a self-report scale that helps to quickly identify cases with anxiety or depression
- 14 easy to answer questions with 7 each related to anxiety and depression
- Can be self-administered in the waiting area of the family physician

- ***the Anxiety Disorders Screening Tool: Mini International Neuropsychiatric Interview (MINI)***

The screening questionnaire used in the National Anxiety Disorders Screening Day is the Mini-International Neuropsychiatric Interview (M.I.N.I.). It is a short, structured, diagnostic interview that was developed by a group of psychiatrists and clinicians in the United States and Europe. the MINI was designed for DSM-IV or DSM-IV-TR and ICD-10 psychiatric disorders. The version in the screening program is designed to explore five Axis I psychiatric disorders (panic disorder, social phobia, post-traumatic stress disorder, generalized anxiety disorder, and obsessive-compulsive disorder) according to DSM-IV or DSM-IV-TR diagnostic criteria. Validated against both the SCID and ICD-10 diagnostic criteria, the MINI is a sensitive, valid and reliable instrument. See [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) for free on-line version with printable results. A copy of the MINI screening tool has also been provided here for immediate reference.

## Anxiety Disorders Screening Tool

### Mini International Neuropsychiatry Interview (MINI)

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE CIRCLE COMPLETELY Y (YES)  
OR N (NO)

persistent fear of having another attack?  
..... Y N

#### Section 1 \_\_\_\_\_

1. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? (If yes to either, please mark YES.) .....Y N

**If your answer to question 1 above is no, please proceed to Section 2**

2. At any time in the past, did any of these spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner? ..... Y N

3. Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack? ..... Y N

4. During the worst attacks that you can remember: Did you have skipping, racing or pounding of your heart? ..... Y N  
Did you have sweating or clammy hands? .....Y N  
Were you trembling or shaking? .....Y N  
Did you have shortness of breath or difficulty breathing? .....Y N  
Did you have a choking sensation or a lump in your throat? .....Y N

Did you have chest pain, pressure or discomfort? .....Y N  
Did you have nausea, stomach problems or sudden diarrhoea? .....Y N  
Did you feel dizzy, unsteady, light-headed or faint? .....Y N  
Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from, part or all of your body? .....Y N  
Did you feel that you were losing control or going crazy? .....Y N  
Did you fear that you were dying? .....Y N  
Did you have tingling or numbness .....Y N  
in parts of your body? .....Y N  
Did you have hot flushes or chills? .....Y N

5. In the past month, did you have such attacks repeatedly (2 or more) followed by

#### Section 2 \_\_\_\_\_

1. In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations? .....Y N

**If your answer to question 1 above is no, please proceed to Section 3**

2. Is this fear excessive or unreasonable? .....Y N

3. Do you fear these situations so much that you avoid them or suffer through them? .....Y N

4. Does this fear disrupt your normal work or social functioning or cause you significant distress? .....Y N

#### Section 3 \_\_\_\_\_

1. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? .....Y N

**If your answer to question 1 above is no, please proceed to Section 4**

2. During the past month, have you re-experienced the event in a distressing way (such as dreams, intense recollections, flashbacks or physical reactions)? .....Y N

3. In the past month: Have you avoided thinking about the event, or have you avoided things that remind you of the event? .....Y N

Have you had trouble recalling some important part of what happened? .....Y N

Have you become less interested in hobbies or social activities? .....Y N

Have you felt detached or estranged from others? .....Y N

Have you noticed that your feelings are numbed? .....Y N

Have you felt that your life would be shortened because of this trauma? .....Y N

## SCREENING FOR ANXIETY DISORDERS

4. In the past month: Have you had difficulty sleeping? ..... Y N  
Were you especially irritable or did you have outbursts of anger? ..... Y N  
Have you had difficulty concentrating?.... Y N  
Were you nervous or constantly on your guard? Were you easily startled? ..... Y N  
5. During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress? ..... Y N

### Section 4\_\_\_\_\_

1. Have you worried excessively or been anxious about 2 or more things (e.g., finances, children's well-being, misfortune) over the past 6 months? More than most others would? Are these worries present most days? ..... Y N

**If your answer to question 1 above is no, please proceed to Section 5**

2. Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing? ..... Y N  
3. When you were anxious over the past 6 months, did you, most of the time: Feel restless, keyed up or on edge? ..... Y N  
Feel tense? ..... Y N  
Feel tired, weak or exhausted easily? ..... Y N  
Have difficulty concentrating or find your mind going blank? ..... Y N  
Feel irritable? ..... Y N  
Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning waking or sleeping excessively)? ..... Y N

### Section 5\_\_\_\_\_

1. In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive or distressing? (For example, the idea that you were dirty, contaminated or had germs, fear of contaminating others, or fear of harming someone even though you didn't want to, or fearing that you would act on some impulse, or fear or superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting or religious obsessions)..... Y N

**If your answer to question 1 above is no, please proceed to Question #4**

2. Did they keep coming back into your mind even when you tried to ignore or get rid of them? .....Y N  
3. Do you think these obsessions are the product of your own mind and that they are not imposed from the outside? .....Y N  
4. In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals? .....Y N  
5. Did you recognize that either these obsessive thoughts or these compulsive behaviours were excessive or unreasonable? .....Y N  
6. Did these obsessive thoughts and/or compulsive behaviours significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour? .....Y N

### Section 6\_\_\_\_\_

1. Have you EVER...  
Discussed an emotional problem with your medical doctor? .....Y N  
Received care from a psychiatrist? .....Y N  
Received care from a psychologist, psychotherapist, social worker, family therapist, or other mental health professional? .....Y N  
Been to Alcoholics Anonymous? .....Y N  
Talked to a drug counsellor? .....Y N

### Section 7\_\_\_\_\_

Please fill ONE circle for each of the following 3 scales.

To what extent have emotional symptoms disrupted...

1. ... your work in the last month:  
not at all mildly moderately mostly extremely  
0 1 2 3 4 5 6 7 8 9 10  
2. ... your social life in the last month:  
not at all mildly moderately mostly extremely  
0 1 2 3 4 5 6 7 8 9 10  
3. ... your family life/home responsibilities in the last month:  
not at all mildly moderately mostly extremely  
0 1 2 3 4 5 6 7 8 9 1

## SCREENING FOR ANXIETY DISORDERS

### ***Interpreting the Results of the Anxiety Disorders Screening Tool: Mini International Neuropsychiatric Interview (MINI)***

Question 1 must be answered positively to meet criteria

#### Section 1 – Panic Disorder \_\_\_\_\_

Rule out Panic Disorder if NO to Question 1

Panic Disorder lifetime if Y to Questions 1, 2 & 3 + (4 or more Y responses in Q4)

Panic Disorder current if Y to Questions 1, 2 & 3 + (4 or more Y responses in Q4) + Q5

---

#### Section 2 – Social Anxiety Disorder \_\_\_\_\_

Rule out Social Phobia if NO to Question 1

Social Anxiety Disorder if Y to Questions 1, 2, 3 & 4

---

#### Section 3 – Post Traumatic Stress Disorder \_\_\_\_\_

Rule out PTSD if NO to Question 1

Rule out PTSD if YES to Question 1 + NO to Question 2

PTSD if Y to Questions 1 & 2 + (3 or more Y responses in Q3) +  
(2 or more Y responses in Q4) + Q5

---

#### Section 4 – Generalized Anxiety Disorder \_\_\_\_\_

Rule out GAD if NO to Question 1

GAD if Y to Questions 1 & 2 + (3 or more Y responses in Q3)

---

#### Section 5 – Obsessive Compulsive Disorder \_\_\_\_\_

Rule out OCD (obsessions) if NO to Question 1

OCD obsessions if Y to Questions 1, 2, 3, & 6

Rule out OCD (compulsions) if NO to Question 1

OCD compulsions if Y to Questions 4, 5, & 6

**CAUTION – If there are several YES answers in any section even though the screening participant does not meet criteria, check the impairment scale (section 7). If substantial impairment is evident, it is recommended that the screening participant be referred for a complete clinical evaluation.**

## SCREENING FOR EARLY PSYCHOSIS

- There are no self-report screening instruments for early psychosis that can be easily implemented.
- Most young people are either reluctant to admit having psychotic experiences or they lack the vocabulary to easily describe their extraordinary experiences.
- Observation of changes in appearance and activity should raise the index of suspicion.
- Inquire about the presence of hallucinations (e.g., "when a person gets really stressed out their mind can play tricks on them — like hearing a whisper or even a voice saying things — has that ever happened to you?")



## SCREENING FOR SUBSTANCE USE DISORDERS

Various screening tools are available that enable the family physician to quickly identify individuals who may have a substance use problem (*see ensuing samples provided*).

When taking a substance use history, inquire

1. about the following classes
  - marijuana
  - cocaine/crack
  - “party drugs” — ecstasy, GHB, ketamine
  - prescription drugs — benzodiazepines especially Lorazepam, Diazepam and Clonazepam (readily available on the street)
  - solvents — gasoline, aerosols, glue
  - opioids — heroin, morphine, methadone, codeine, oxycodone
  - crystal methamphetamine, amphetamine, prescription stimulants (dexamphetamine, methylphenidate)
  - hallucinogens — LSD, “magic” mushrooms
  - alcohol — classify using standard drinks; also inquire re: the use of rubbing alcohol, mouthwash
2. (if affirmative) about route of administration of the specific substance
  - sniffing/snorting, injection, oral, smoking or inhalational
  - sharing of needles or paraphernalia (high-risk behaviours)
3. about quantity and frequency of use
  - # of Standard Drinks (Canadian)
  - Point = 1/10th g
  - Rock = variable amount usually 3 – 4 points
  - “Mickey” = 13 fl. ounces
  - “8 Ball” or an 1/8th of an ounce = 3.6g
4. about concerns related to drug use
  - consider modifying the CAGE by substituting the substance of concern for “alcohol” or “drinking” (e.g., “Have you ever felt bad or Guilty about your cocaine use?”); although it is not evidence based, it may serve as an initial point of discussion.

The staff/clinician administered CAGE and self-administered AUDIT (Alcohol Use Disorders Inventory Test) are questionnaires that require less than 15 minutes in a primary care setting.

- The CAGE Questionnaire
  - There are 4 questions scored 0 or 1.
  - A score of 2 or greater is significant.
  - The combination of CAGE questionnaire, MCV and GGT activity will detect about 75% of people with an alcohol problem.
  - During pregnancy or adolescence, a score of 1 may signal problematic drinking. However, CAGE is not specific to pregnancy and consider using the TWEAK. (*see Women’s Mental Health Appendix*)
- The AUDIT Questionnaire
  - This 10-question survey of alcohol use is sensitive across cultures.
  - Scores for each question range from 0 to 4, with the first response for each question (e.g., never) scoring 0, the second (e.g., less than monthly) scoring 1, the third (e.g., monthly) scoring 2, the fourth (e.g., weekly) scoring 3, and the last response (e.g., daily or almost daily) scoring 4.
  - For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).
  - A score of 8 or more is associated with harmful or hazardous drinking,
  - score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

(Source: Saunders JB, Aasland OG, Babor TF *et al.* Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption II. *Addiction* 1993, 88: 791 – 803).
- Also available is the DAST.

### CAGE Questionnaire — Screen for Problematic Alcohol Use

*Alcohol dependence is likely if the patient gives two or more positive answers to the following questions:*

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?

The combination of CAGE questionnaire, MCV and GGT activity will detect about 75% of people with an alcohol problem.

## AUDIT (Alcohol Use Disorders Inventory Test) Questionnaire: Screen for Problematic Alcohol Use

**Please circle the answer that is correct for you**

1. How often do you have a drink containing alcohol?
  - Never
  - Monthly or less
  - 2 – 4 times a month
  - 2 – 3 times a week
  - 4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day when drinking?
  - 1 or 2
  - 3 or 4
  - 5 or 6
  - 7 to 9
  - 10 or more
3. How often do you have six or more drinks on one occasion?
  - Never
  - Less than monthly
  - Monthly
  - Weekly
  - Daily or almost daily
4. During the past year, how often have you found that you were not able to stop drinking once you had started?
  - Never
  - Less than monthly
  - Monthly
  - Weekly
  - Daily or almost daily
5. During the past year, how often have you failed to do what was normally expected of you because of drinking?
  - Never
  - Less than monthly
  - Monthly
  - Weekly
  - Daily or almost daily
6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?
  - Never
  - Less than monthly
  - Monthly
  - Weekly
  - Daily or almost daily
7. During the past year, how often have you had a feeling of guilt or remorse after drinking?
  - Never
  - Less than monthly
  - Monthly
  - Weekly
  - Daily or almost daily
8. During the past year, have you been unable to remember what happened the night before because you had been drinking?
  - Never
  - Less than monthly
  - Monthly
  - Weekly
  - Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?
  - No
  - Yes, but not in the past year
  - Yes, during the past year
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?
  - No
  - Yes, but not in the past year
  - Yes, during the past year

## SCREENING FOR SUBSTANCE USE DISORDERS

### Drug Abuse Screening Test (DAST)

The following questions concern information about your possible involvement with **drugs** (*not including alcoholic beverages*) during the past 12 months. Carefully read each statement and choose the response that is true (or mostly true) for you.

1. Have you used drugs other than those required for medical reasons? \_\_\_\_ Yes \_\_\_\_ No
2. Do you abuse more than one drug at a time? \_\_\_\_ Yes \_\_\_\_ No
3. Are you unable to stop using drugs when you want to? \_\_\_\_ Yes \_\_\_\_ No
4. Have you ever had blackouts or flashbacks as a result of drug use? \_\_\_\_ Yes \_\_\_\_ No
5. Do you ever feel bad or guilty about your drug use? \_\_\_\_ Yes \_\_\_\_ No
6. Does your spouse (or parents) ever complain about your involvement with drugs?  
\_\_\_\_ Yes \_\_\_\_ No
7. Have you neglected your family because of your use of drugs? \_\_\_\_ Yes \_\_\_\_ No
8. Have you engaged in illegal activities in order to obtain drugs? \_\_\_\_ Yes \_\_\_\_ No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? \_\_\_\_ Yes \_\_\_\_ No
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)? \_\_\_\_ Yes \_\_\_\_ No

### Results for DAST

SCORE EACH YES RESPONSE WITH 1 POINT.

Score	Degree of addiction	Suggested Action
0	No Problem	None at this time
1 – 2	Low Level	Contact an outpatient programme in your area
3 – 5	Moderate Level	Contact a detox (if necessary) or an outpatient programme.
6 – 10	Substantial Level	Contact a detox or Emergency Room

Source: Gavin DR; Ross HE; Skinner HA. Diagnostic validity of the Drug Abuse Screening Test in the assessment of DSM-III drug disorders. *British Journal of Addiction* 84(3): 301 – 307, 1989. (23 refs.)

## SCREENING FOR SUBSTANCE USE DISORDERS

### Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol — Revised CIWA-Ar

Patient: _____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)	
Pulse or heart rate, taken for one minute: _____ Blood pressure: _____	
<b>NAUSEA AND VOMITING</b> -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation. 0 no nausea and no vomiting 1 mild nausea with no vomiting 2 3 4 intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves and vomiting	<b>TACTILE DISTURBANCES</b> -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation. 0 none 1 very mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
<b>TREMOR</b> -- Arms extended and fingers spread apart. Observation. 0 no tremor 1 not visible, but can be felt fingertip to fingertip 2 3 4 moderate, with patient's arms extended 5 6 7 severe, even with arms not extended	<b>AUDITORY DISTURBANCES</b> -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation. 0 not present 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
<b>PAROXYSMAL SWEATS</b> -- Observation. 0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats	<b>VISUAL DISTURBANCES</b> -- Ask "Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation. 0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
<b>ANXIETY</b> -- Ask "Do you feel nervous?" Observation. 0 no anxiety, at ease 1 mild anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions	<b>HEADACHE, FULLNESS IN HEAD</b> -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or light-headedness. Otherwise, rate severity. 0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe
<b>AGITATION</b> -- Observation. 0 normal activity 1 somewhat more than normal activity 2 3 4 moderately fidgety and restless 5 6 7 paces back and forth during most of the interview, or constantly thrashes about	<b>ORIENTATION AND CLOUDING OF SENSORIUM</b> -- Ask "What day is this? Where are you? Who am I?" 0 oriented and can do serial additions 1 cannot do serial additions or is uncertain about date 2 disoriented for date by no more than 2 calendar days 3 disoriented for date by more than 2 calendar days 4 disoriented for place/or person
<div style="text-align: right;">             Total <b>CIWA-Ar</b> Score _____              Rater's Initials _____              Maximum Possible Score 67           </div>	

The **CIWA-Ar** is not copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357.



# Warning Signs for Onset or Relapse

## **General Warning Signs and Symptoms**

- sleep disturbances
- appetite changes
- social withdrawal
- irritability
- indecisiveness
- absences from school or work
- loss of energy or agitation
- feelings of anxiety and depression
- multiple or unexplained physical complaints
- reports from others of out-of-character behaviour

### Disorder-Specific Warning Signs and Symptoms

#### *Major Depressive Disorder*

In addition to the general warnings the person may experience

- loss of interest or pleasure in activities or relationships
- guilt
- complaints of decreased memory and concentration
- decline in functioning in primary roles (e.g., poor work performance, delayed bonding with baby)
- dangerous behaviour/impulsivity.

#### *Anxiety Disorders*

In addition to the general warnings the person may exhibit

- chronic symptoms of anxiety, worry, panic and stress
- sleep disturbance
- somatic symptoms (e.g., headache, gastrointestinal upset or stomach ache)
- frequent distressing thoughts, images, memories or urges
- difficulty concentrating or making decisions
- high rates of health care utilization (family physician visits, medical specialists, emergency room visits, ambulance service use, etc)
- excessive avoidance or use of safety behaviours (e.g., compulsions, reassurance seeking).

#### *Early Psychosis*

Collateral reports may be especially pertinent to detecting psychotic disorders. Vague changes in mood and behaviour are often noticed quite early by family and friends.

In addition to the general warnings the person may exhibit

- shifts in social circle or markedly reduced social activity
- decreased concentration
- decreased hygiene
- over-concern with physical functions and appearance or significant change in dress or appearance
- increased interest in metaphysics and spirituality
- inappropriate emotional expression
- reduced speech output or speech that is difficult to follow
- suspiciousness, paranoia or even delusional beliefs
- attending to internal stimuli or “talking/laughing to themselves”
- impulsivity
- irritability.

### Substance Use Disorders

Alcohol and substance abuse disorders may present with any of the general warning signs and symptoms. In addition, potential warnings include those identified in the following table:

<b>SUMMARY OF BIOPSYCHOSOCIAL COMPLAINTS AND PRESENTATION OF PROBLEMATIC ALCOHOL AND SUBSTANCE USE</b>		
<b>COMPLAINT OR PRESENTATION</b>	<b>ALCOHOL</b>	<b>OTHER SUBSTANCES</b>
<b>Physical</b>		
GENERAL	Smell of alcohol, trauma	Trauma, weight loss (cocaine, methamphetamine and heroin)
CNS	Tremors, headaches, ataxia	Headaches, choreic movements, fluctuating level of consciousness
CVS	Hypertension, tachycardia	Hypertension, tachycardia, stroke, MI in young people
RESP		Asthma, Nasal septum perforation
GI	Gastritis, dyspepsia, pancreatitis, recurrent diarrhoea, signs of liver disease (jaundice, gynecomastia, testicular atrophy, telangectasia, spider nevi, palmar erythema), blood tainted stool	Hepatitis, signs of liver disease
REPRODUCTIVE	Impotence, menstrual irregularities or infertility	Menstrual irregularities
HEENT	Scleral Icterus, Parotid Gland enlargement	Injected conjunctiva (cannabis), pinpoint pupils (opioids), nasal complaints
DERM	Liver Signs	Track marks (IDUs), cellulitis, abscesses, excoriations
Lab Markers		
	Anemia with ↓ MCV	Unexplained ALT elevations (IDUs)
	↑ GGT	HIV, HCV, HBV
<b>Psychological Complaints</b>		
	Depression, anxiety, fatigue, low energy, insomnia	Depression, anxiety insomnia, fatigue,
		Paranoia and psychosis (methamphetamine, Gamma Hydroxy Butyrate and benzo withdrawal, cocaine and hallucinogens), Flat affect (Benzo, marijuana and stimulant withdrawal)
Social Complaints	Changes in school or work performance, marital discord, impaired driving, criminal charges including domestic violence, financial concerns	Changes in school or work performance, marital discord, impaired driving, criminal charges including domestic violence, financial concerns



# 3 MANAGEMENT ISSUES

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# 3 MANAGEMENT ISSUES

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# 3 MANAGEMENT ISSUES

## GENERAL TREATMENT RECOMMENDATIONS

Provide treatment as soon as possible in order to:

- reduce symptoms and suffering
- prevent secondary problems from occurring such as
  - loss of job
  - physical health problems
  - mental health problems
  - social isolation
- lower risk of relapse.

With inappropriate treatments or no treatment at all, many of these disorders have a high rate of relapse and worsen over time.

Treatment options of psychiatric disorders consist of non-pharmacological as well as pharmacological interventions.



# Psychotherapies and Other Non-pharmacological Interventions

Non-Rx





# Psychotherapies and Other Non-pharmacological Interventions

Psychotherapy, lifestyle modifications, stress management strategies, relapse prevention, and brief interventions are all important aspects in the management of the disorders listed in this Guide. For some conditions (mild depression or anxiety), they can be as effective as medication for remission. For more severe conditions (severe depression, acute psychosis), non-pharmacological interventions provide as essential component in obtaining and maintaining health.

## **Psychotherapies, including Cognitive Behavioural Therapies (CBT)**

- **Cognitive Behavioral Therapy (CBT)**
  - A time limited psychotherapy which teaches the patient to identify automatic, dysfunctional thoughts and distorted beliefs and to develop positive new behaviours and coping strategies
  - Focuses on current problems and uses a process of teaching, coaching, and reinforcing positive behaviours to address the interactions between how we think, feel and behave
  - Follows a structured style of intervention, including the use of ‘homework’, or between-session practice
  - Key elements include:
    - psychoeducation
    - relaxation training (e.g. controlled breathing, progressive muscle relaxation)
    - cognitive skills training (e.g. challenging cognitions that are maladaptive)
    - overcoming avoidance via gradual exposure to feared situations
    - planning for relapse prevention and maintaining gains.
  - Administered individually or in groups, and also incorporated in self-directed resources
  - Evidence supports the effectiveness of CBT for many common mental disorders
  - Visit [www.healthservices.gov.bc.ca/mhd/publications.html](http://www.healthservices.gov.bc.ca/mhd/publications.html) to access the Core Information Document on Cognitive Behavioural Therapy developed by the Centre for Applied Research in Mental Health and Addictions, Simon Fraser University.

Other schools of Psychotherapy include the following:

- **Interpersonal Psychotherapy (IPT):** is a time limited individual or group therapy which examines 2 of 4 interpersonal areas: grief, role transition, role dispute and interpersonal conflicts. Core principles include that the illness is not the patient's fault, and that by understanding the connection between the illness and life events, the patient can use this to solve their current difficulties.

- **Psychodynamic Psychotherapy:** Both brief and long term, focus on the transference, countertransference and resistance between patient and therapist.
- **Supportive Therapy:** Is focused on problem solving and advice giving.

### Lifestyle Issues

There are several basic but important healthy lifestyle choices which should be stressed regardless of the illness:

- personal hygiene (encourage laundry, showering and personal grooming)
- regular exercise (provide guidelines for regular exercise and target heart rates)
- healthy, regular meals (provide guidelines; refer to a dietician)
- sleep hygiene (discuss regulation of sleep hours, encourage a reduction in evening stimulation)
- substance use (discuss caffeine and alcohol intake, and recreational drug use)
- housing (safe, supported, drug free).

### Stress Management Strategies

- relaxation training using specific techniques such as imagery or progressive muscle relaxation
- problem solving techniques that involve learning to analyze problems, brainstorm and evaluate solutions and then carry out the solutions in small steps
- resources for stress management are listed in the sections on 'Information for Families' and 'Information for Self-Management'.

### Relapse Prevention

Preventing relapse of the mental illness is a key goal of treatment.

- Prior to a relapse there are usually early warning signs — it is important that patients learn to recognize their own early warning signs.
- Develop a 'Relapse Prevention Plan' with all patients.
- Outline steps to be taken if early warning signs are detected.
- Actions in the plan might include:
  - making an appointment to come in
  - stress management techniques
  - "Rescue medications"
- Share the plan with the patient's family or close friends so they may help identify warning signs.

### Resources for Psychological Treatment in BC

1. Private psychiatrists by referral.
2. For a province-wide list of private psychologists contact the British Columbia Psychological Association at [www.psychologists.bc.ca](http://www.psychologists.bc.ca) or toll free: 1-800-730-0522
3. Ambulatory Psychiatric Clinics or Day Programs at hospitals, or community Mental Health Centres (call the BC Partners Mental Health Information Line at 1-800-661-2121 or (604) 669-7600 for listings in your community)
4. Changeways: A best-practice, group-based psychoeducational program for depression, offered in a number of hospitals and community health centres throughout the province ([www.changeways.com](http://www.changeways.com))
5. Many people may be able to access a psychologist through an Employee Assistance Programs (EAP) if they or their spouse are working.

### Major Depressive Disorder

- In patients with mild to moderate depression, evidence-based psychological treatments are as effective as antidepressant medications.
- First-line psychotherapies include Cognitive Behavioural Therapy (CBT), Interpersonal Psychotherapy (IPT) and Problem-Solving Therapy (PST).
- Although less stringent evidence exists, Brief Psychodynamic Psychotherapy has been shown to be effective in certain suitable populations.
  - Poor response has been predicted by low motivation, severe ego weaknesses such as impulse-control problems and poor reality testing, a tendency toward concrete thinking, poor object-relatedness and unstable family/home environment. (“Synopsis of Treatments of Psychiatric Disorders” Gabbard 1996.)
- For most patients, combined treatment with pharmacotherapy and psychological treatment is no more effective than either therapy alone. Combined treatment should be considered for patients with:
  - chronic or severe depressive episodes
  - comorbidity
  - poor clinical response to either antidepressant or psychological treatment alone
- Effective psychological treatments for depression include:
  - cognitive behavioural therapy
  - interpersonal psychotherapy
  - brief psychodynamic psychotherapy
  - supportive therapy
  - group therapy
- Consider patient preferences and availability of resources when considering options.
- Patients can benefit from supportive management by family physicians, especially when combined with medication treatment.
- Good evidence exists to support the use of light therapy for Seasonal Affective Disorder (SAD)
  - SAD treatment guidelines and Lightbox retailers can be found at: [www.ubcsad.ca](http://www.ubcsad.ca)

### ■ Bipolar Disorder

- CBT has shown early, promising results as an adjunct to pharmacological interventions.

#### *Brief Intervention for Depression*

This section describes a brief problem-solving intervention for depressed patients that is evidence-based and practical to implement in a typical primary care practice.

The research literature shows **Cognitive Behavioural Therapy (CBT)** is an effective intervention for depression of mild to moderate severity, whether combined with antidepressant medication or not. But the amount of advanced training and treatment time required for effective CBT is not feasible for most general practitioners. The Brief Intervention is based on CBT principles, but uses recent research on self-care methodology to provide a form of intervention that is feasible in a real-world primary care practice.

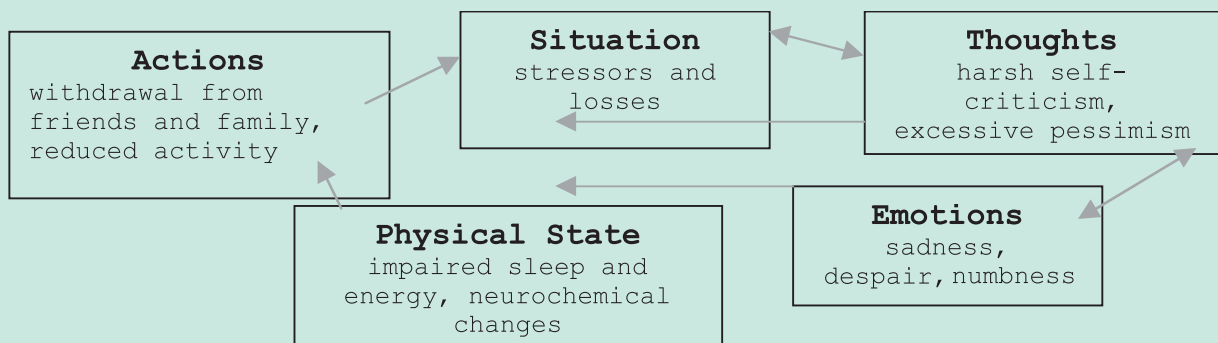
#### **Evidence shows:**

- Distribution of self-care material based on CBT principles leads to substantial improvement in mild to moderate severity depression. A high proportion of patients find self-care material acceptable and use it to achieve significant and lasting improvement in mood symptoms. Many feel empowered by knowing that they are actively participating in their recovery.
- For relatively mild depression, effective intervention focuses on encouragement of self-care and problem-solving. For relatively severe depression, intervention focuses on standard evidence-based treatments such as antidepressant medication or CBT, while self-care can serve as an adjunct.

The general practitioner is in an excellent position to support and coach self-care, given the frequency of visits, high level of established trust and professional credibility. Self-care manuals have been developed by Mheccu, UBC for this purpose. An **Antidepressant Skills Workbook** for adults is available for free download and unlimited copying at [www.carmha.ca](http://www.carmha.ca), under Self Care. Translations of this workbook are available in French, Chinese (Traditional and Simplified) and Punjabi. A version for adolescents, **Dealing with Depression: Antidepressant Skills for Teens**, is also available.

#### Five steps of brief intervention for depression

1. Explain the biopsychosocial model of depression:



The acronym **STEP-A** (Situation, Thoughts, Emotions, Physical State and Actions) can serve as a mnemonic for this model.

- a. Each of these areas can affect the others, so a person can spiral down into a depression that feels overwhelming and out-of-control.
  - b. Medication works on Physical State, but important changes also can be made in Thoughts and Actions.
2. Distribute CBT-based self-care book (e.g. the SCDP), whether giving a copy or information about how to access it.
    - a. Inform the patient that research evidence shows depressed individuals can use the skills taught in this book to recover from depression, and it works along with medication (where this has been prescribed)
    - b. Briefly describe the skills taught in the material: e.g. for SCDP, skills are Activation, Change of Depressive Thinking and Problem Solving.
    - c. Encourage the patient to **Give It a Try**. Ask the patient to look it over before the next visit and offer to answer questions then.
  3. Help the patient to get started.
    - a. Discuss with the patient which of the skills to focus on initially.
    - b. Assist the patient to set a first goal. For example, if there is a clear precipitating situational problem, begin with problem-solving and help the patient to identify a few possible actions; then assign the patient to write out the pros and cons of each action and identify the best or least bad one. Another example would be a physically inactive patient for whom a program of exercise would be beneficial for mood: help the patient to set a modest (but gradually increasing) exercise goal.
  4. Check on how it went, ask about new goals or another skill to try.
    - a. Praise the patient generously for any attempts made.
    - b. Don't tie achievement of a goal or new learning to any short-term mood changes — point out that mood changes happen gradually as a person practices new skills and achieves small goals.
  5. Encourage continued practice of skills and goal setting.
    - a. Praise generously. Remember that behavioural or cognitive change is very difficult, especially for depressed individuals, so be impressed when changes are made.
    - b. Check how the person is doing with practicing skills and setting goals, even in the context of a quick office visit.

Note: This Brief Intervention, though based on CBT principles, is not equivalent to CBT provided by a mental health professional with specialized training in this method. The next step to a more intensive level of CBT intervention might involve referral to a cognitive behavioural group program. In British Columbia the Changeways group depression treatment program operates at outpatient mental health facilities in many regions of the province. Alternatively, consider referral to individual CBT (generally, 8 – 15 sessions).

### Anxiety Disorders

- Psychological treatments are roughly equivalent to pharmacotherapy in the short-term and may lower relapse rates long-term.
- Combined pharmacotherapy and psychological approaches do not appear to be more effective than either therapy alone. However, a combination of treatments may be considered for patients with
  - chronic and severe anxiety symptoms
  - comorbidity (e.g., major depression)
  - poor clinical response to either antidepressant or psychological treatment alone.
- Psychological treatments for anxiety disorders include:
  - CBT — significant benefits are experienced by approximately 80% of people with anxiety disorders who complete CBT programs.
  - Eye Movement Desensitization and Reprocessing (EMDR) is effective for PTSD only
  - A wide variety of evidence based handbooks, clinician manuals and client work books provide detailed information about developing and implementing cognitive behavioural management plans for each of the different types of anxiety disorders. (*See the self-management and information for families sections for more information or [www.anxietybc.com](http://www.anxietybc.com) for reading lists.*)

### Early Psychosis

- Psychological and social interventions for patients with psychosis are adjuncts to medication — they are not substitutes for pharmacotherapy.
- The addition of these psychosocial intervention leads to better short and long-term outcomes.
- All patients with psychosis should receive:
  - patient and family education
  - stress management
  - relapse prevention
  - problem solving
  - supportive counselling
  - assistance with housing, finances, and school and work opportunities.
- Certain early psychosis patients may also benefit from CBT in particular for treating secondary problems that can co-occur with psychosis, such as depression and anxiety, and persistent psychotic symptoms that do not respond to medication.

### Substance Use Disorders

#### *Stages of Change Model*

- Originally developed to understand the experiences a person has when reducing substance use by DiClemente & Prochaska (1982).
- The model has since been applied to understanding a person's experience and readiness for change for a variety of other behaviours, including mental health problems.

- The model has not been validated for all disorders — it may be most useful in the treatment of substance misuse or other harmful behaviours, eating disorders, or in addressing adherence issues.
- Progression through these stages is not always linear; people tend to move back and forth between stages, and relapse to a prior stage is always possible.
- Understanding the stages of change can guide the tailoring of therapy to meet a person's needs and further encourage change at his or her particular point in the change process.

Stage of Change	What the Patient is Experiencing	Strategies for Working with the Patient
<b>Precontemplation</b>	<ul style="list-style-type: none"> <li>unaware or denies there is a problem</li> <li>may be feeling angry, anxious or embarrassed about having the “problem” discussed</li> </ul>	<ul style="list-style-type: none"> <li>develop a therapeutic relationship</li> <li>offer compassion, empathy and hope</li> <li>reassure the individual about choices and next steps</li> </ul>
<b>Contemplation</b>	<ul style="list-style-type: none"> <li>aware that there is a problem and is seriously thinking about overcoming the problem</li> <li>not yet made any commitment to take action to overcome the problem</li> <li>may be feeling ambivalent, apprehensive or relieved at discussing the problem</li> </ul>	<ul style="list-style-type: none"> <li>provide support</li> <li>encourage self-evaluation of the pros and cons of overcoming the problem or not</li> <li>share examples of people who have successfully overcome a similar problem</li> <li>offer information about the problem, the range of treatment options and the success of treatment</li> <li>assist in making a plan and setting timelines</li> </ul>
<b>Action</b>	<ul style="list-style-type: none"> <li>working on the problem to overcome it</li> <li>engagement in treatment and making significant efforts to succeed</li> <li>may be on an emotional “roller coaster” grieving old behaviours but enthusiastic about change</li> </ul>	<ul style="list-style-type: none"> <li>work on treatment plan</li> <li>affirm positive changes and provide support for difficult changes to behaviour or lifestyle</li> <li>refer to community and professional programs to ensure a full range of care and support is provided</li> <li>work with the person to develop a relapse prevention plan</li> </ul>
<b>Maintenance</b>	<ul style="list-style-type: none"> <li>maintain success in having overcome the problem</li> <li>focus on lifestyle changes and self-management skills</li> <li>may be feeling greater comfort but have concerns about continuing success</li> </ul>	<ul style="list-style-type: none"> <li>continue with relapse prevention work</li> <li>watch out for new emerging issues and treat or refer as appropriate</li> <li>discuss and normalize lifestyle changes.</li> <li>reinforce self-management efforts</li> </ul>
<b>Relapse</b>	<ul style="list-style-type: none"> <li>relapse may or may not occur</li> <li>when relapse does occur, may be feeling like a “failure” and may have reduced motivation to continue to work on overcoming the problem</li> </ul>	<ul style="list-style-type: none"> <li>give hope</li> <li>re-affirm accomplishments and review and revise treatment plan</li> <li>normalize relapse and move forward with new plans</li> <li>explore triggers for relapse and revise relapse prevention plans</li> </ul>



### *Brief Interventions for Substance Use Disorders*

- Evidence suggests that simply asking a patient about alcohol use can reduce consumption.
- After completing an initial screen followed by a detailed assessment with lab work and a urine screen, carry out a “Brief Intervention.”
- The “Brief Intervention” is an evidence-based, five step, time limited intervention focused on changing behaviour and increasing compliance for alcohol use disorders.
- While there are numerous models of “Brief Intervention” with no consensus on number of visits, try 2 – 3 10 – 15 minute visits over a 6 – 8 week period.
- The “Brief Intervention” is well established as a counselling tool for such medical issues as hypertension, diabetes and obesity.
- An increasingly large body of evidence supports the expansion to effective interventions, including “Brief Interventions” by physicians.
- The Five Steps include:
  1. providing feedback about screening results, impairment and risks while clarifying the findings
  2. assessing the patient’s readiness to change based on the “Stages of Change” (see *previous page*)
  3. informing the patient about safe consumption limits and offering harm reduction strategies
  4. negotiating goals and strategies for change
  5. arranging for follow-up treatment.
- Typically, candidates for brief intervention will be in one of the first three stages of change and are ambivalent. The brief intervention is meant to reduce the level of ambivalence and guide the patient further along the stages.

#### **1. Provide feedback about screening results, impairment and risks while clarifying the findings**

- What often moves someone from the precontemplative to contemplative stage is convincing, personal, and timely information.
  - “As your family physician, I am concerned about how much you are drinking and how this is impacting your health/you socially.”
  - “Your unborn child could develop a birth defect called Fetal Alcohol Syndrome — there are no safe levels of alcohol consumption while you’re pregnant.”
- It is essential that the information be intimately tied to the individual’s addictive behaviour, and runs contrary to their expectancies.

#### **2. Assess the patient’s readiness to change based on the stages of change**

- Be clear about the stage of change. Matching stage specific interventions is critical to the successful outcome.
  - “What do you think about your alcohol/consumption?”
  - “Do you believe that your alcohol/consumption has had negative consequences? What are they?”



- “What have been the physical consequences?”  
e.g., trauma, liver, abscesses, teeth
- “What have been the social consequences?”  
e.g., loss of friends or work, family estrangement
- “What are the psychological consequences?”  
e.g., depression, psychosis, anxiety

### 3. Inform the patient about safe consumption limits and offer harm reduction strategies

- Harm reduction (HR) strategies are evidence based measures aimed at reducing the harm to the patient while continuing to use. It is not the goal of therapy but a highly effective way to engage a user in the discussion of treatment.
- While abstinence remains the traditional way to reduce harm associated with use, patients may not be prepared for this.
- HR strategies can be offered at all stages of change.
  - For the pre-contemplative user these may be broader strategies to address overall health, as there is simultaneously an acceptance of the person’s ambivalence and communication of concern for their overall health.
  - Safe consumption limits are useful and may be more specific to the contemplative user. (Men: 14 drinks/week; no more than 2/day; Women: 9 drinks/week; no more than 2/day)
  - Aim to reduce the incidence of common co-morbid illness, such as HIV, Hep C and STD’s while using. Encourage the use of clean needles and safe injection techniques. Suggest switching to lower potency substances or reducing use as other ways to reduce harm (e.g., “Rubbing alcohol is very dangerous. While you think about cutting back, would you consider switching to beer or wine?”; “Sharing needles can put you at high risk for getting HIV or Hepatitis C. Do you have a source of clean needles? Do you use bleach and clean water?”; “Have you thought of smoking instead of injecting?”)

### 4. Negotiate goals and strategies for change

- When negotiating goals, successful outcomes are most likely if goals specific to the stage of change are generated.
- Use the BC Partners Problem Substance Use Workbook when developing short-term goals. Email [bcpartners@heretohelp.bc.ca](mailto:bcpartners@heretohelp.bc.ca) or call 1-800-661-2121 or (604) 669-7600 for further information on workbooks
- Goals might include (with Stage of Change noted):
  - Harm reduction strategies (precontemplative)
  - Attending a meeting (contemplative) or schedule an appointment with an AD counsellor (e.g., “Have you thought of going to a meeting — you might find others who understand your situation.”)
  - Reducing quantity or frequency of use (contemplative: e.g., “You need to reduce your drinking — can you cut down to 2 or 3 drinks three times per week?”)

- Entering detox or applying for treatment (action: “With the amount you’re consuming, it would be wise to stop in a supportive medical environment like detox.”; “You’ve tried to quit on your own. I think it is worth trying a treatment centre.”)
- Strategies for Change
  - Behavioural Modification Techniques (e.g., “What are some triggers for use? When you have relapsed in the past, what kind of things triggered you.”; “Let’s talk about ways to avoid these situations.”; “What are other ways you have coped with triggers in the past?” e.g., exercise, calling a friend)
  - Self-help Directed Bibliography (e.g., “Here is some information on substance use. I would like you to review it so that we may discuss it at the next visit”; “Try this website for some information”)

### 5. Arrange for follow-up treatment

Patient preference is an important determinant of treatment outcomes. A 3 month engagement in treatment has been shown to be a key threshold, as positive, long-term outcomes increase significantly after this stage.

“Let’s schedule a follow-up appointment to discuss your use” or “to discuss detox/treatment options”.

- Positive evidence exists for numerous treatment modalities, but no one treatment has been identified above the rest.
- Early treatment is often pharmacologically based and requires a withdrawal management period either at home, in a “daytox” programme, a residential detox or a medical detox.
- A broad range of treatment services are available and are highly patient specific.
- Post detox, inpatient treatment settings include Residential Treatment and Support Recovery Homes.
- Outpatient programmes range from intensive day programmes to AD counselling or group work.
- Modalities may include any one or more of pharmacotherapy, psychological or behavioural interventions or self-help groups.

### INTRODUCTION

- Mental disorders are major contributors to occupational impairment, absence, and disability. This is particularly true for depression, the primary source of disability in many occupational sectors. The World Health Organization projects that, by 2020, depression will be the second leading cause of disability in the developed world. Depression raises the risk for secondary physical and psychiatric illness, as well as for injuries and accidents. Lessons learned from appropriate management of depression-related impairment are often relevant for other psychiatric disorders, including adjustment and anxiety disorders.
- The family physician plays a major role in the clinical management of mental disorders. As in other areas of medicine, the role of the family physician is to restore health; optimize social, psychological, physical, and functional capabilities; and, minimize the negative impact of injury/illness.
- The tasks of the family physician are to: provide a clinical diagnosis; establish appropriate clinical goals; recommend/implement evidence-based treatment, in line with existing standards; and monitor clinical response.
- The family physician can make a significant contribution toward the prevention and mitigation of occupational disability, with support from the psychiatrist, psychologist and/or other mental health professional for more severe or treatment resistant patients.
- Management of workplace mental health issues can be challenging, as the family physician:
  - a) is trained to focus on symptomatology and diagnosis, rather than functioning (including occupational functioning);
  - b) may not be informed about the particular job or job requirements held by the patient and the degree to which the individual is able to meet those requirements;
  - c) is interacting with unfamiliar systems (e.g., employers; insurers); and
  - d) may feel torn between the concerns of patient/worker, the employer, and the insurer.
- Nevertheless, this is a critical issue for the patient and all concerned parties. Failure to provide appropriate, timely and specific information can lead to exacerbation and increased complexity of mental health conditions; increased risk of injury, accident or incident; and/or delayed financial compensation for disabled patients.

#### STEPS:

- I. Assess Impairment and Functioning
- II. Communicate Effectively with the Employer and/or Insurer
- III. Collaborate with Patient on Decision-making around Accommodation and Work Absence
- IV. Maximize Recovery of Occupational Function



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## I. Assess Impairment and Functioning

The role of the physician is to evaluate **Impairment** (diagnosis, symptomatology, functional deficits) rather than **Disability** (patient's incapacity to carry out a particular job, which is determined by the employer or insurance adjudicator).

**Impairment** is defined by the World Health Organization as “any loss or abnormality of psychological, physiological or anatomical structure or function”. Delineation of impairment requires a statement of diagnosis and detailed description of symptomatology.

- Family physicians have expertise in assessing and documenting degree of impairment, including:

diagnosis:

- Be specific as possible, preferably using DSM-IV-TR diagnosis (e.g., “stress” is not a psychiatric diagnosis).
- Include information on expected course and prognosis.
- Include information on evidence-based treatment.

symptomatology:

- Provide sufficient details, particularly with respect to symptoms that may impact occupational functioning.
- Because symptom constellations within a diagnosis vary from patient to patient, specify a patient's particular symptoms, their severity, and how they impact work performance.
- When describing impairments, provide details such as their frequency, intensity, and duration, as well as any ameliorating factors or supports that may assist the patient in maintaining a greater functional level.

functional impairment:

There are four areas in which deficits may occur<sup>1</sup>:

- (b) activities of daily living (e.g., patterns of eating and sleep, activities outside the home)
- (b) social functioning;
- (c) concentration, persistence, and pace;
- (d) deterioration or decompensation in complex or work like settings (e.g., how a patient's symptoms might cause problems in work function)

The GAF (Global Assessment of Functioning) index has questionable reliability and validity<sup>2</sup>, but nevertheless remains the standard index of functional status.

Careful determination of the GAF with respect to consistency with stated symptomatology and evident functional limitations will greatly assist with determination of a patient's insurance eligibility (e.g., a claimant separately describing a reasonable family life, some volunteer work, and a relaxing trip to Hawaii, does not have a GAF of 40-45).

- Provide information on functional impairments specific to a patient's particular occupation. In complex patients, a job analysis may be of value.
- Be cognizant of appropriate language for describing functional deficits (e.g., it is not meaningful to state that a patient “can't concentrate” and “can't sleep”; it is most unlikely that a patient is, for example, so depressed that he is entirely unable to concentrate or sleep to any extent for any period of time). It is more appropriate to describe some degree of impairment, whether in terms of reduced capacity, time limits of sustained concentration, or specific difficulty with concentrating on several tasks at the same time.

<sup>1</sup> The American Medical Association's Guides to the Evaluation of Permanent Impairment (5th Ed.)

<sup>2</sup> Söderberg P, Tungström S, Armelius BA. Special section on the GAF: Reliability of Global Assessment of Functioning ratings made by clinical psychiatric staff. *Psychiatr Serv* 2005;56:434-438.



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- Although **disability** requires the presence of significant impairment in ability to perform daily activities, including occupational activities, impairment alone does not determine disability. Factors such as age, general health, social supports, motivation, satisfaction with job and supervisor/manager are important determinants.<sup>3</sup>

Impairment does not necessitate disability. A patient may be able to remain at work with significant impairments, if appropriate accommodations can be provided by the employer. Consider the contributing role of factors such as age, general health, social supports, motivation, and job satisfaction.

### II. Communicate Effectively with the Employer and/or Insurer

- A unique aspect of management of workplace mental health issues is the need to communicate with unfamiliar systems, such as employers and/or insurers
- Employers may require clinical information from the family physician to make necessary accommodations in the workplace; similarly, the family physician may need information from the employer to address the impact of symptoms on occupational function
- Insurers require information from the family physician on clinical diagnosis, functional impairments, prognosis, recommended treatment, and duration of treatment to (a) adjudicate claims for eligibility for benefits and (b) ensure the patient has access to appropriate treatment
  - Complete forms in a timely and thorough manner. Although extra paperwork can be frustrating, disability evaluation forms are the primary way for insurance case managers to obtain the information needed to perform their job effectively
  - Discuss billing for additional paperwork with the patient in situations where this is not reimbursed by the insurer.
- Obtain specific consent to communicate with the insurer and/or employer, including informing patients of what information will be released

In complex patients (e.g., those that are treatment-refractory or require workplace accommodation) it may be helpful to directly communicate with the employer or insurer (as well as other treatment providers).

### III. Collaborate with Patient on Decision-making around Accommodation and Work Absence

- Encourage patients to be actively involved in decision-making with respect to their care, rehabilitation and work plan (e.g., decisions around modifying duties at work, taking leave from work, and returning to work). Failure to do so may encourage hopelessness and helplessness, which can impede compliance and recovery. It is helpful to elicit information on the patient's expectations for recovery.

Prolonged absence from one's usual roles – including prolonged absence from work – has negative impact on an individual's mental, social, and physical well-being and health.

#### Accommodation

- Consider appropriateness of accommodation in the workplace, as an alternative to complete work absence.

<sup>3</sup> Rael EG, Stansfeld SA, Shipley M, Head J, Feeney A, & Maemot M. Sickness absence in the Whitehall II study, London: The role of social support and material problems. J Epidemiol Community Health 1995; 49: 474-81.



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- In cases where accommodation in the workplace is being considered, encourage the patient to communicate with the employer.

### Work Absence

- Collaboratively consider the advantages and disadvantages of work absence. If an absence from work is suggested, it should be a part of an overall treatment plan with specific recommendations and goals in mind for the time away from work.

Develop a definable treatment plan, including a plan for treatment if a work absence is recommended. Do not put an open-ended return to work date.

- Set a definite duration for the work absence.
  - In recommending leave duration, consider norms of treatment response (e.g., it is realistic to expect substantial recovery from uncomplicated treated depression and anxiety disorders in 6-8 weeks).

### *Benefits & Costs of Absence from Work*

Benefits	Costs
Patient removed from occupational stresses, allowing stabilization in a protected environment.	Patient may become inactive and socially isolated, a behavioural pattern likely to worsen depression and reinforce anxiety.
Less risk of work incidents, especially in safety-sensitive positions.	Patient may develop a secondary anxiety pattern after extended work absence in which they become more apprehensive about work return.
Patient has more time for activities conducive to recovery such as psychotherapy or exercise programs.	Prolonged absence from work is a negative prognostic factor with regard to whether an individual ever returns to work. <sup>4</sup>

## IV. Maximize Recovery of Occupational Function

- Although it was previously believed that restoration of occupational function lags behind symptomatic recovery in depression, current research indicates that symptom remission and recovery of function are typically synchronous<sup>5</sup>.

Symptomatic and functional recovery should be evident within the first few months of treatment. Failure to achieve functional recovery within 6-8 weeks for common mental disorders, such as depression and anxiety disorders, indicates the need for a change in treatment strategy or involvement of other mental health treatment providers.

<sup>4</sup> Shrey DE, Lacerte M. Principles and practices of disability management in industry. Winter Park, Florida:GR Press, Inc; 1995.

<sup>5</sup> Simon GE, Revicki DA, Heiligenstein J, et al.. Recovery from depression, work productivity, and health care costs among primary care patients. General Hospital Psychiatry 2000;22(2): 153-162



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- Pharmacologic treatment for depression and anxiety disorders can lead to significant improvement in function, but still leaves a significant gap in functional recovery for many individuals. Psychopharmacology can be augmented with referral for cognitive behavioural therapy, which has been shown to have specific benefit in promoting functional recovery<sup>6,7</sup>.
- Assess capacity for activity. Encourage early, graduated functional activation. Consider prescription of activity.
- Take an active role in encouraging self-management efforts, focused on helping patients understand their diagnosis and ways to manage their symptoms. One way to augment standard treatment to support individual coping and promote functional recovery is dissemination of Self-Care material, for example the **Antidepressant Skills Workbook**, available at no cost from [www.carmha.ca/publications](http://www.carmha.ca/publications) or the depression and anxiety toolkits and wellness modules, available at no cost from [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca).
- If appropriate, the patient should be encouraged to investigate opportunities for assistance through the employer, for example Employee and Family Assistance Programs or extended health coverage for care by a psychologist.
- For severe mental disorders such as schizophrenia, referral to rehabilitation/supported employment program should be considered.

Early intervention efforts targeted at assisting patients to regain function are effective in decreasing subsequent disability, and in reducing secondary illness reinforcers (e.g., reduction of responsibility; avoidance of stressors work and personal life; family sympathy)<sup>8,9</sup>.

### Further Reading

Bilsker D, Wiseman, S, Gilbert M. Managing depression-related occupational disability: A pragmatic approach. *Can J Psychiatry* 2006; 51: 76-83.

Canadian Medical Association. CMA policy. The physician's role in helping patients return to work after an illness or injury. *Can Med Assoc J* 1997;156(5):680A-680F. 2000 Update located at [www.cma.ca/staticContent/HTML/N0/I2/where\\_we\\_stand/return\\_to\\_work.pdf](http://www.cma.ca/staticContent/HTML/N0/I2/where_we_stand/return_to_work.pdf).

Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision (DSM-IV-TR). American Psychiatric Association, Washington DC, 2000.

*Includes:* Global Assessment of Functioning (GAF) Scale; Social and Occupational Functioning Assessment Scale (SOFAS)

<sup>6</sup> Sherbourne CD, Wells KB, Duan N, et al.. Long-term effectiveness of disseminating quality improvement for depression in primary care. *Archives of General Psychiatry* 2001;58(7):696-703.

<sup>7</sup> Hirschfeld RM, Dunner DL, Keitner G. Does psychosocial functioning improve independent of depressive symptoms? A comparison of nefazodone, psychotherapy, and their combination. *Biological Psychiatry* 2002;51(2):123-133.

<sup>8</sup> Bjorndal A. Follow-up of persons on long-term sick leave. A cohort study in the city of Moss. *Tidsskr Nor Lægeforen* 1994; 114: 2857-62.

<sup>9</sup> Crook J, Moldofsky H. The probability of recovery and return to work from work disability as a function of time. *Qual Life Res* 1994; 3(suppl 1): S97-109.



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- Electroconvulsive therapy (ECT) is a safe and effective treatment for a variety of psychiatric and some medical conditions.
- It has proven superiority in prospective studies comparing ECT with “sham” ECT and with standard antidepressant treatment in “medication-resistant” patients.
- Especially when patients are identified early in the course of hospitalization and offered ECT as a treatment option, there can be a reduction in the length of stay and hospitalization cost, owing to both efficacy and rapidity of response.
- Despite generally higher seizure thresholds in the elderly, evidence suggests that response rates are higher in both the “young” elderly (65 – 74), and “old” elderly (75 or greater), with fewer complications compared to certain antidepressants.
- Nevertheless, ECT can induce side effects and may be physically risky for certain individuals.
- Relapse rates after an acute course of ECT can be high without continuation or maintenance pharmacotherapy and/or ECT.

### ECT Indications

#### *Primary Indications for Use*

As stated in the APA guidelines, there is “compelling data . . . or strong consensus” supporting the use of ECT in the following conditions:

- Major Depressive Episode (arising from unipolar depression, as part of bipolar depression, or concomitant manic symptoms during “mixed states”) — ECT should be strongly considered, especially when associated with one of the following features:
    - acute suicidality with high risk of acting out suicidal thoughts
    - psychotic features
    - rapidly deteriorating physical status due to complications from the depression, such as poor oral intake
    - history of poor response to medications
    - history of good response to ECT
    - patient preference
    - risks of standard antidepressant treatment outweigh the risks of ECT, particularly in medically frail or elderly patients
    - catatonia.
  - Mania — ECT should be particularly considered if there is:
    - extreme and sustained agitation
    - “manic delirium”.
  - Schizophrenia\* (According to the APA guidelines, the following associated features predict a favourable response to ECT):
    - positive symptoms with abrupt or recent onset
    - catatonia
    - history of good response to ECT.
- \* Studies demonstrating a favourable response to ECT in regard to psychotic symptoms have generally used a combination of ECT and standard antipsychotics.

*Secondary Indications for Use*

- Catatonia (unrelated to the primary conditions described above)
- Parkinson's Disease
- Neuroleptic Malignant Syndrome
- Delirium (rarely considered for patients who require urgent treatment)
- Intractable Seizure Disorder
- Mood Disorder secondary to physical conditions

*Cultural Considerations*

- There may be specific beliefs in certain cultures surrounding electricity and touching of the head that can prevent patients from accepting ECT as a form of treatment.
- Another barrier occurs in refugees and immigrants who may have experienced incarceration for political reasons in psychiatric institutions and who have been subjected to ECT involuntarily without psychiatric indication.
- Survivors of torture who have been subjected to electrical shocks may also resist the notion of ECT.
- The reluctance to proceed with ECT is unfortunate in these circumstances, since these individuals may benefit significantly from ECT in treating mood and psychotic disorders that have developed as a complication of trauma or migration.

**Selection and Risk**

- Patient selection is critical in ensuring a high degree of confidence that ECT will be more effective than other treatments considered, while minimizing risk.
- ECT evaluation also addresses the presence of concurrent medical conditions that can increase risk, as well as the concurrent use of medical or psychiatric medications that can alter risk.
- The risk is defined as serious morbidity and mortality, which is most likely cardiopulmonary in nature if occurring, and is considered in line with the risk associated with other low-risk procedures under a general anesthetic.
- A widely-quoted risk figure is 1.6 deaths per 10,000 in a (typical) course of 8 ECTs.

**Contraindications for ECT**

- **There are no absolute contraindications for ECT.** ECT may be deemed necessary even when such "relative contraindications" identified by the APA guidelines are present:
  - unstable or severe cardiovascular conditions, such as recent myocardial infarction
  - unstable angina, poorly-compensated heart failure, and severe valvular cardiac disease including critical aortic stenosis
  - aneurysm or vascular malformation that might be susceptible to rupture with increased blood pressure
  - increased intracranial pressure, as may occur with some brain tumours or other space-occupying cerebral lesions
  - recent cerebral infarction
  - pulmonary conditions such as severe chronic obstructive pulmonary disease, asthma, or pneumonia
  - patient status rated as ASA (American Society of Anesthesiologists) level 4 or 5
- Conditions having substantially higher risk with ECT include:
  - Pheochromocytoma

- retinal detachment
- acute narrow angle glaucoma.

Those with cardiac pacemakers and implanted automatic defibrillators warrant some caution. (It is unlikely ECT would disrupt the functioning of a modern cardiac pacemaker)

### **ECT Providers**

- Community psychiatrists provide ECT.
- The ECT is carried out using general anaesthetic — an induction agent and a muscle relaxant, and the patient is managed by an anaesthesiologist.
- ECT is done in hospital/surgical day care ORs or PARs.
- ECT is safe on an outpatient basis, appropriate for maintenance ECT.

### **ECT Resources**

Visit [www.hlth.gov.bc.ca/mhd/publications.html](http://www.hlth.gov.bc.ca/mhd/publications.html) for ECT Guidelines for Health Authorities in BC, available on the BC Ministry of Health web page. An ECT information video for families is available at mental health and addictions centres across BC, and ECT information for families is available also in Chinese and Punjabi on the above website.



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# Pharmacological Intervention

Rx



# Pharmacological Intervention

## GENERAL PRINCIPLES OF PHARMACOLOGICAL INTERVENTION

Consider these clinical factors when choosing a medication:

- previous response
- side effects
- remission rates
- cost
- comorbid conditions
- drug-drug interactions
- dosing regimen

Educate the patients about treatment

- Review with patients and families
  - Goals and benefits of treatment 1) Full Remission 2) Return to premorbid function
  - Side effects of various medication choices
  - Warn patients about suddenly discontinuing a medication and rebound symptoms which may occur
- Discuss medication onset timelines with patients
  - Antidepressants for depression: 4 – 6 weeks (if sooner, consider hypomania induction). Routine follow up within the first 2 weeks of prescribing an SSRI is prudent and always warn patients/families to monitor for increased suicidal ideation.
  - Antidepressants for anxiety: 2 – 3 weeks
  - Benzodiazepines: acute relief NOT advised to use for longer than 2 weeks
  - Antipsychotics: some reduction in psychotic symptoms within 1 week of starting therapeutic dose but longer time needed for fixed, delusional beliefs and negative symptoms

Common problems faced by many patients:

- stigma of being on medications
- cost
- dosing schedule adherence — time at which patient is most likely to take medication is in evening
- belief that the medication may not be helpful or appropriate
- side effects even at very low doses
- excessive use of benzodiazepines
- problems with adjusting to taper when decreasing or eliminating medications
- return of symptoms when medications are no longer taken.

Precautions when using Psychotropic medications:

- start low, go slow, keep going!
- psychotropic medications should be tapered prior to discontinuation.

Pharmacological information in this Guide was last updated in March 2006, based on input from PharmaCare.

### Benzodiazepine Use in Primary Care

- British Columbia and Canada has no official guidelines for prescription use of Benzodiazepines.
- The College of Physicians and Surgeons of British Columbia has posted Benzodiazepines and Other Targeted Substances Regulations: Guidance Document for Practitioners and Questions and Answers on their website [www.cpsbc.ca/cps](http://www.cpsbc.ca/cps). This is published by Health Canada and discusses issues of theft, storage, destruction, etc. of targeted substances.
- The College of Physicians and Surgeons of British Columbia has endorsed the UK protocol for BDZ withdrawal management entitled Benzodiazepines: How they work and how to withdraw (The Ashton Manual) [benzo.org.uk](http://benzo.org.uk).

In the United Kingdom, the Committee on Safety of Medicines and the Royal College of Psychiatrists have made some recommendations for BDZ use.

- BDZs can clearly provide critical and wide-ranging symptom relief for a variety of medical conditions and procedures.
  - BDZs should typically be used intermittently or in the short term (two weeks duration).
  - Chronic BDZ therapy should be used in exceptional cases with a clear medical indication, individualized treatment planning, close monitoring, and frequent evaluation.
  - In general, BDZ use is best avoided in pregnancy, breast-feeding, the elderly, and those with a history of addiction.
    - There is a risk of significant cognitive impairment, falls and trauma in the elderly
  - If needed in these populations for acute substance withdrawal or for symptoms refractory to other treatments, BDZ therapy should be carefully administered.

## MAJOR DEPRESSIVE DISORDER

- Antidepressant medication is indicated for moderate to severe depression. Most studies show a considerable placebo effect in cases of mild depression.
- Encourage open, honest discussions with the patient about their beliefs and concerns surrounding antidepressant medications.
- After 1 medication
  - 65 – 75% of treated patients have clinically significant improvement
  - 50 – 60% have complete recovery
  - 15% have improvement with residual symptoms
  - 25% have minimal improvement
- Responder definition \*
  - Partial Responder: 25 – 50% decrease in HAM-D scale
  - Non-Responder: <25% decrease in HAM-D scale
  - Responder: >50% decrease in HAM-D scale

\* The definition of Responder is based on the HAM-D or “Hamilton Rating Scale for Depression” — a 24 item, clinician administered scale introduced in 1960 and used to standardize research
- Refractory: non-responder to >2 medications from different classes
- Current evidence does not indicate that any one class of antidepressant is significantly superior in treating depression. First line agents are selected for their overall tolerability and effectiveness.
- Use antidepressants with caution where there is a concurrent substance use problem
  - There is no evidence for the prescription of antidepressants in the context of ongoing substance abuse or dependence

## MAJOR DEPRESSIVE DISORDER

### Principles of Pharmacological Treatment of Depression

- If treating with antidepressants, initial response should occur within 3 – 4 weeks of treatment with a therapeutic dose.
- If there is no response (or no further improvement after partial response) after 3 – 4 weeks, increase medication every 2 – 4 weeks until remission of symptoms, maximum suggested dose is reached, or limiting side effects are experienced.
- If remission is achieved, maintain patient on medication for at least 6 months if first episode, and at least 2 years if:
  - second episode
  - suicidal/psychotic/severe
  - episode > two years
  - resistant or difficult to treat.
- Partial response Strategies (*See below, “Levels of Evidence”*)
  - Level 1 evidence: Augmentation
    - Proven Effective with TCAs (not SSRIs) — Lithium (target blood level 0.6 – 0.9; 600 – 900mg)
    - Probably Effective — Liothyronine Sodium (T3-Cytomel®) more centrally acting than Levothyroxine Sodium (T4-Synthroid®) 25 – 75mcg; low-dose atypical antipsychotic
    - Possibly Effective — Amphetamines (e.g., Dextroamphetamine: 5 – 10mg); Modafinil; Buspar, Tryptophan may be effective if target symptoms remain (e.g., poor sleep, low energy, poor concentration)
  - Level 2 evidence: Switching (*see Table: Washout Recommendations for Switching Antidepressants*)
    - Benefit of simplicity with better compliance
    - Switch within class once, then switch out
  - Level 3 evidence: Combination
    - e.g., SSRI + SNRI + Mirtazapine or Bupropion
- Non responder strategies
  - If there is no response, within 4 weeks of a therapeutic dose, switch within the same or out of class
  - If after two medications within a class there is no response, switch class
- Refractory patient strategies
  - Re-evaluate diagnosis (for example, mania/hypomania, subtype of depression)
  - Reassess treatment issues (for example, adherence, side-effects)
  - Reassess comorbidity
    - Axis I: Panic, OCD, PTSD, Substances, Psychosis etc
    - Axis II: Personality Disorder especially Cluster B, Dependent
    - Axis III: General medical conditions
  - Consider adding psychotherapy
  - Refer to a specialist, community health centre or rural outreach team

### Levels of Evidence

- |                  |   |
|------------------|---|
| <b>Level 1</b>   | at least one randomized controlled study  |
| <b>Level 2.1</b> | well-defined controlled trial without randomization   |
| <b>Level 2.2</b> | well-designed cohort or case-controlled studies, preferably multicentre or more than one research group                       |
| <b>Level 2.3</b> | very significant results from uncontrolled trials from more than one centre comparing results with and without intervention   |
| <b>Level 3</b>   | opinions of respected clinical authorities based on clinical experience, descriptive studies, or reports of expert committees |

## MAJOR DEPRESSIVE DISORDER

THERAPEUTIC DOSES AND COSTS OF COMMONLY PRESCRIBED ANTIDEPRESSANTS

ANTIDEPRESSANT	USUAL STARTING AND (DAILY DOSE) (MG)	SIDE EFFECTS (KEY BELOW)					COST PER DAY (\$)
FIRST LINE ANTIDEPRESSANTS		A	B	C	D	E	
<b>SSRI</b>							
Citalopram (Celexa)	10 qd (20-40)	0	0	0	4	2	0.94-1.88
Fluoxetine (Prozac)	10 qd (20-40)	0	0	0	4	3	1.08-2.16
Fluvoxamine (Luvox)	25 qd (100-200)	0	0	0	4	3	0.95-1.90
Paroxetine (Paxil)	10 qd (20-40)	0	0	0	4	3	1.18-2.36
Sertraline (Zoloft)	25 qd (50-150)	0	0	0	4	3	1.07-3.21
<b>SNRI</b>							
Venlafaxine (EffexorXR)	37.5 qd (75-300)	0	0	0	4	2	1.73-5.19
SECOND LINE ANTIDEPRESSANTS							
<b>Novel action</b>							
Bupropion-SR (Wellbutrin)	100 qam(150-300)	0	0	0	0	2	0.88-1.54
Mirtazapine (Remeron)	15 qd (30-60)						1.33-2.66
Trazodone (Desyrel)	50 bid(200-400)	0	1	3	3	2	0.84-1.68
<b>TCA</b>							
Amitriptyline (Elavil)	25 bid (100-250)	5	5	4	2	2	0.32-0.80
Clomipramine (Anafranil)	25 bid (100-250)	2	3	3	3	3	0.86-2.15
Desipramine (Norpramin)	25 bid (100-250)	1	2	1	1	3	0.92-2.28
Imipramine (Tofranil)	25 bid (100-250)	2	4	1	3	3	0.66-1.65
Nortriptyline (Aventyl)	25 qd (75-150)	1	4	2	1	2	0.77-1.63
<b>RIMA</b>							
Moclobemide (Manerix)	150bid(450-600)	2	1	3	2	2	
THIRD LINE ANTIDEPRESSANTS							
<b>MAOI*</b>							
Phenelzine (Nardil)	15qam (30-75)	3	3	3	3	3	0.74-1.86
Tranlycypromine (Parnate)	10 bid (20-60)	2	2	3	2	3	0.73-2.20

Data adapted from the BC Drug Formulary and the Manufacturers' list (2001)

RIMA :Reversible monoamine oxidase inhibitor; TCA = Tricyclic antidepressant; SNRI =Serotonin and norepinephrine reuptake inhibitor MAOI =Monoamine oxidase inhibitor ;SSRI = Selective serotonin reuptake inhibitor

\* Use with caution because of dietary restrictions and drug-drug interactions

Side Effect information from "The Canadian Psychotropic Handbook First Edition" 2000 Sudler and Hennessey

Side Effects= 0=none; 1=very low; 2=low; 3=moderate; 4=high; 5=very high

A= Anticholinergic (dry mouth, blurred vision, constipation, urinary retention, sweating, tachycardia, confusion)

B= Antihistaminic (drowsiness, weight gain)

C= Anti- alpha- adrenergic (orthostatic hypotension, dizziness, reflex tachycardia, sedation)

D= Serotonergic (GI distress, headache, nervousness, akathisia, EPS, sweating, sexual dysfunction, anorexia)

E= Adrenergic (tremors, tachycardia, sweating, insomnia, sexual dysfunction)

Not all medications listed are eligible for coverage under the No-Charge Psychiatric Medication Program (Plan G).

Coverage information is provided on the BC PharmaCare website at [www.health.gov.bc.ca/pharme/outgoing/plangtable.html](http://www.health.gov.bc.ca/pharme/outgoing/plangtable.html).

## MAJOR DEPRESSIVE DISORDER

### WASHOUT RECOMMENDATIONS FOR SWITCHING ANTIDEPRESSANTS

Adapted from Guidelines for the Diagnosis and Pharmacological Treatment of Depression. Toronto, ON, Canadian Network for Mood and Anxiety Treatments, 1998.

Switch to →	SSRI	Novel	TCA	RIMA	MAOI
Switch from ↓					
<b>SSRI</b> citalopram fluoxetine fluvoxamine paroxetine sertraline	No washout  May have additive serotonergic side effects for 1 week (5 weeks for fluoxetine)	No washout  May have additive serotonergic side effects for 1 week (5 weeks for fluoxetine)	No washout  Start TCA at a lower dose  Some SSRIs can increase serum TCA levels for 1 week (5 weeks for fluoxetine)	1 week  (5 weeks for fluoxetine)	1 week  (5 weeks for fluoxetine)
<b>NOVEL</b> bupropion-SR mirtazapine venlafaxine-XR	No washout  May have additive serotonergic side effects for 1 week	No washout  May have additive serotonergic side effects for 1 week	No washout	1 week	1 week
<b>TCA</b> desipramine nortriptyline amitriptyline imipramine others	No washout  Serum TCA levels may be increased by some SSRIs for 1 week	No washout	No washout	1 week	1 week
<b>RIMA</b> moclobemide	3 days	3 days	3 days	N/A	3 days
<b>MAOI*</b> phenelzine tranylcypromine	2 weeks	2 weeks	2 weeks	2 weeks	2 weeks



## MAJOR DEPRESSIVE DISORDER

### Bipolar Disorder

Generally, initiate a mood stabilizer on admission with mania, hypomania, or bipolar depression.

PRESCRIBING MOOD STABILIZERS			
MOOD STABILIZER	USUAL STARTING AND (DAILY DOSE) (MG)		PLASMA LEVELS
FIRST LINE MOOD STABILIZER			
Lithium Carbonate	300 bid (900-1800)	Nausea, vomiting, diarrhoea, dry mouth, weight gain, fatigue, dizziness, fine hand tremor, polyuria, hypothyroidism, cognitive blunting, psoriasis, acne, alopecia, edema, teratogen; Toxicity: ataxia, vertigo, dysarthria, confusion, nystagmus	0.8-1.0 mmol/L
Valproate (Epival)	250 bid (750-1750)	Nausea, vomiting, diarrhoea, rash, indigestion, sedation, tremor, alopecia, weight gain, menstrual disturbances, thrombocytopenia, leucopenia, teratogen Toxicity: ataxia, nystagmus, diplopia, dysarthria	350-700 umol/L
Carbamazepine (Tegretol)	100 bid (600-1200)	Allergic skin reactions, drowsiness, headache, diplopia, blurred vision, ataxia, dizziness, nausea, vomiting, tremor, dry mouth, confusion, sedation, low WBC, weight gain	17-50 umol/L
Lamotrigine	25qd (75-250)	Skin rash, dizziness, diplopia, headache, somnolence, ataxia, nausea, vomiting, blurred vision, sedation	Nil
SECOND LINE MOOD STABILIZER			
Gabapentin	300 qd (900-1800+)	Somnolence, dizziness, ataxia, fatigue, nystagmus, tremor, diplopia	Nil
ANTI-MANIC ADJUNCTS			
Clonazepam (Rivotril)	2 bid (6-12 acute)		Nil
Atypical Antipsychotics	See below		Nil

- Discontinue antipsychotic typically six months after there has been a good response.
- Maintain on a mood stabilizer.
- A combination of a mood stabilizer and a very low dose of an antipsychotic is an option for treating refractory bipolar disorder.

## ANXIETY DISORDERS

There are a variety of evidence-based medications for most but not all of the anxiety disorders.

*Note on Benzodiazepines (see General Principles of Pharmacologic Treatments — Benzodiazepines in Primary Care)*

- Consider Benzodiazepines under some circumstances for short term management of anxiety symptoms until benefits from other longer-acting treatments are apparent.
- Prescribe Benzodiazepines for periods of no longer than 2 weeks.
- Do not use Benzodiazepines as the first line of treatment as they
  - are subject to abuse, dependence, and/or diversion
  - have risk of sedation
  - can cause dangerous interactions with other drugs or alcohol, and
  - often create rebound anxiety that promotes increased use.

TABLE OF MEDICATIONS INDICATED FOR SELECTED ANXIETY DISORDERS

TYPE OF ANXIETY DISORDER	SRI (INCLUDING SSRIs)	TCAs AND RELATED ANTI-DEPRESSANTS	BENZOS*	OTHERS
Obsessive Compulsive Disorder	✓	✓ clomipramine only		Some evidence for augmentation of SRIs with clonazepam or buspirone Or atypical antipsychotics
Social Anxiety Disorder	✓		✓	
Generalized Anxiety Disorder	SSRIs and Venlafaxine	✓	✓	Buspirone
Post Traumatic Stress Disorder	✓	✓		
Panic Disorder with or without Agoraphobia	✓	✓	✓	
Agoraphobia only	No evidence based medications for Agoraphobia without Panic Disorder			
Specific Phobias	No evidence based medications for specific phobias			

### Guidelines for Anxiety Disorders

Andrews, G., Creamer, M., Crino, R., Hunt, C., Lampe, L., & Page, A. (2003). *The treatment of anxiety disorders: Clinician Guides and Patient Manuals (2nd edition)*. United Kingdom: Cambridge University Press.

Andrews, G., Goldner, E.M., Parikh, S.V., & Bilsker, D. (2000). *Management of Mental Disorders: Volume I* (Canadian Edition). Vancouver: Bond Reproductions Inc.

Anxiety Review Panel. (2000). *Ontario Guidelines for the Management of Anxiety Disorders in Primary Care*, 1st Edition. Ontario Program for Optimal Therapeutics. Queen's Printer of Ontario.

**General Principles of Starting Antipsychotic Medication**

- The treatment of choice is a single atypical antipsychotic medication.
- The use of several antipsychotics at once is not recommended.
- The newer atypical antipsychotics (e.g., risperidone, olanzapine, clozapine and quetiapine) are preferred over the older typical antipsychotics (e.g., haloperidol).

Advantages of the class of atypical antipsychotics include:

- As effective as “typicals” in treating psychosis
- Favourable side effect profile
  - Low risk of serious side effect like tardive dyskinesia
  - Lower incidence of EPS
- Target negative symptoms as well as positive symptoms
- Are effective at resolving acute mania.

Disadvantages include:

- Significant risk of weight gain/diabetes/hyperprolactinemia.

**Initial Dosing**

- First-episode patients are more sensitive than other patients to the effects of antipsychotic medications, and therefore much lower doses are needed.
- For example, after a low starting dose, first-episode patients often respond to 2 mg of risperidone or 5 – 10 mg of olanzapine.
- Side effects should be closely monitored, especially at the beginning of treatment.

Medication	Starting Daily Dose In mg. Per Day	Expected Lowest Effective Dose	Typical Higher Effective Dose
Risperidone	0.5 – 1 mg	1 – 2 mg	4 – 5 mg
Olanzapine	2.5 – 5 mg	5 mg	15 mg
Quetiapine	50 – 100 mg	300 – 400 mg	600 – 800 mg

**Use of Other Medications**

- If mood symptoms are also present, a mood stabilizer or antidepressant should be started as well.
- Benzodiazepines are helpful for managing sleep disturbance, agitation and anxiety in the acutely psychotic/manic patients.

**Side Effects**

- Significant weight gain is a common side effect, especially with clozapine, olanzapine and quetiapine.
  - Weight gain may lead to discontinuation.
  - Weight gain increase risk for obesity-related disorders such as diabetes.
  - Diet and exercise are the main treatments for overcoming the weight gain.
- Sedation is common with the newer atypicals, although not with risperidone.
- Overdose from antipsychotics is rare and unlikely to cause death.

## EARLY PSYCHOSIS

- Extrapyramidal side effects such as akathisia, and Parkinsonism can occur even with olanzapine and risperidone.
  - Benztropine is effective against Parkinsonism (start with 0.5mg qd-BID — caution: may cause increased cognitive slowing).
  - Lorazepam is an effective first line agent against akathisia (a subjective sense of internal restlessness which may be exhibited behaviourally and misdiagnosed as agitation).
- Sexual side effects are common and need to be openly discussed.

### Evaluating Medication Response

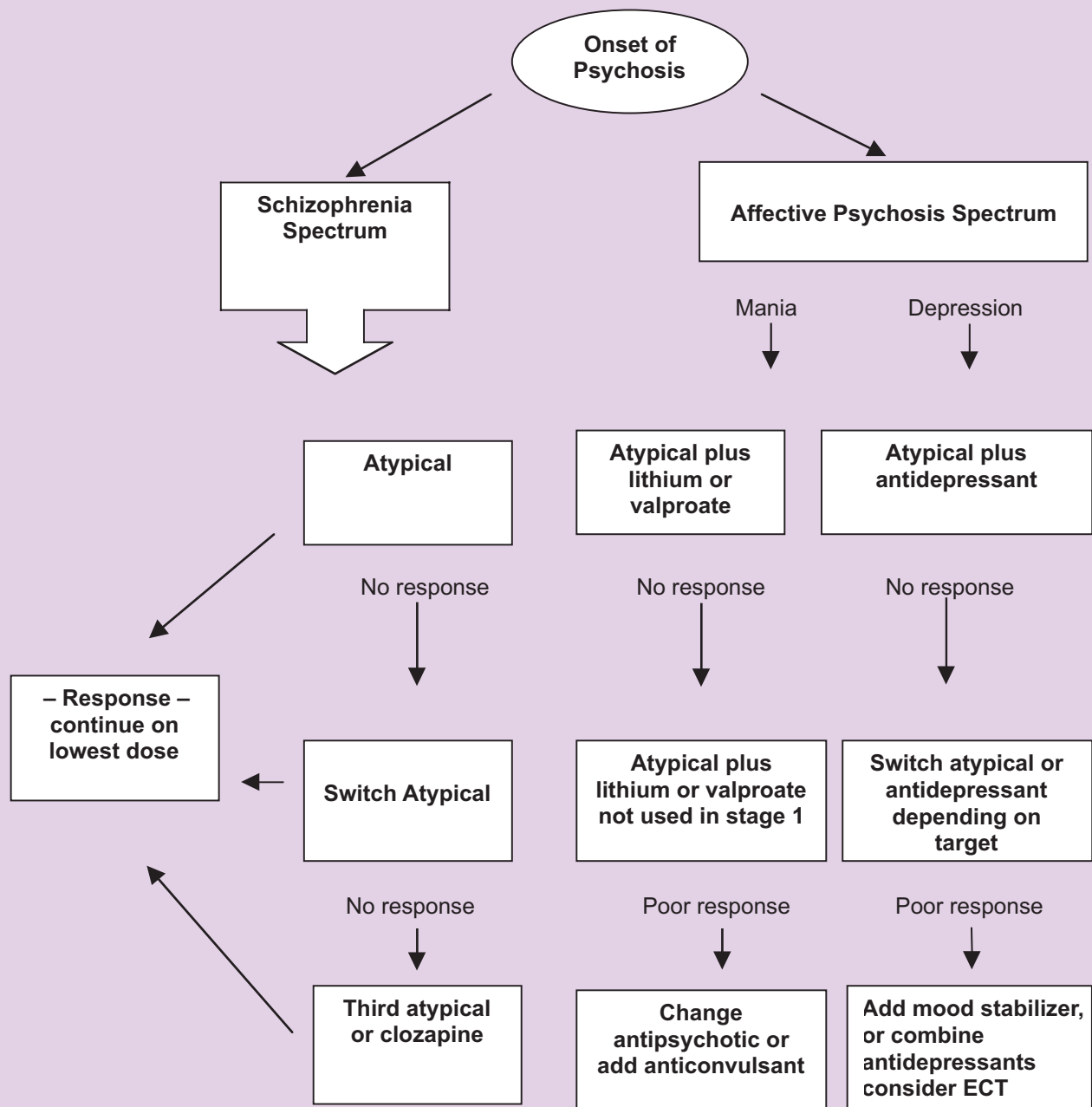
- Most patients will show a good response within the first six weeks of treatment, and an almost complete response in the first six months. Delusions may persist in an attenuated form, however.
- Responders are more likely to be
  - female
  - have less severe symptoms
  - older at age of onset
  - well-adjusted beforehand
  - free of movement disorders.

### Switching Medications

- Consider switching if there is a poor response after two months on a reasonable dose.
- Tapering one while titrating another is an effective approach.
- Clozapine is reserved for use when at least two other antipsychotics have been unsuccessful. It is a restricted medication due to the 1% risk of agranulocytosis.

### Duration of Treatment

- Maintain the antipsychotic at least one year if the diagnosis is first break psychosis.
- In schizophrenia, approximately 20% never have a second episode.
- Continue medication indefinitely if this is a relapse.
- Monitor with frequent follow-ups if the medication is discontinued at the patient's request.

*Pharmacotherapy Flow Chart for Psychosis*

**\* Note —** If history suggests schizoaffective bipolar type and patient presents in depressive phase, use antipsychotic and mood stabilizer and follow bipolar manic stream

## EARLY PSYCHOSIS

### *Early-Psychosis-Specific Guidelines*

Early Psychosis: A Care Guide (2002). This is a made in BC document that summarizes all treatments. Available on-line at:  
[www.carmha.ca](http://www.carmha.ca)

Lambert M, Conus P, Lambert T, McGorry PD. Pharmacotherapy of first-episode psychosis. *Expert Opin Pharmacother* 2003;4(5):717 – 50.

The Australian Clinical Guidelines for Early Psychosis (1999/2000) available at:  
[www.eppic.org.au/](http://www.eppic.org.au/)

The following documents are available on-line at:  
[www.healthservices.gov.bc.ca/mhd/publications.html](http://www.healthservices.gov.bc.ca/mhd/publications.html).

- [Early Psychosis — A Care Guide \(PDF 3.2MB\)](#)
- [Early Psychosis — A Care Guide Summary \(PDF 2.8MB\)](#)
- [Early Psychosis: A Guide for Physicians \(PDF 0.8MB\)](#)
- [Early Psychosis: A Guide for Mental Health Clinicians \(PDF 0.9MB\)](#)
- [Early Identification of Psychosis: A Primer \(PDF 83KB\)](#)
- [Minimizing Damage — Maximizing Outcomes: The Importance of Early and Effective Treatment for Psychosis \(PDF 69KB\)](#)

### *Disorder-Specific Guidelines*

Canadian clinical practice guidelines for the treatment of schizophrenia.  
The Canadian Psychiatric Association [see comments]. *Can J Psychiatry* 1998;43 Suppl 2:25S-40S.

The Treatment of Bipolar Disorder: Review of the Literature, Guidelines.  
The Canadian Network for Mood and Anxiety Treatments (CANMAT)

Goodwin GM. Evidence-based guidelines for treating bipolar disorder: recommendations from the British Association for Psychopharmacology. *J Psychopharmacol* 2003;17(2):149 – 73; discussion 147

Treatment of depression in primary care — Part 1: Principles of acute treatment.  
*BC Medical Journal* Volume 44, Number 9, November 2002, page 473 – 478.  
Agnes To, MD, Heidi Oetter, MD, and Raymond W. Lam, MD, FRCPC

Treatment of depression in primary care — Part 2: Principles of maintenance treatment  
*BC Medical Journal* Volume 44, Number 8, November 2002, pages 479 – 484  
Agnes To, MD, Heidi Oetter, MD, and Raymond W. Lam, MD, FRCPC

Practice Guidelines for the Treatment of Patients with Bipolar Disorder (Revision).  
Arlington: American Psychiatric Association; 2002.

## SUBSTANCE USE DISORDERS

A full review of possible pharmacological interventions is beyond the scope of this Guide. Generally, interventions are categorized based on the phase of treatment.

- *Withdrawal management*: medications may be used to facilitate the process of withdrawal and to treat the symptoms of withdrawal.
- *Relapse prevention*: relapse is discouraged through use of medications that block the desired effects of problematic substances or cause negative effects when problematic substances are used.
- *Maintenance*: a medication (only methadone in BC) is prescribed for regular use to block withdrawal symptoms and reduce cravings.
- *Treatment of concurrent psychiatric disorders*: medications are used to treat a concurrent psychiatric disorder.

### Available Pharmacotherapy Medications

- Withdrawal Agents — long-acting, cross-tolerant agents:
  - Benzodiazepines: clonazepam, phenobarbital
  - Opioids: methadone
  - Alcohol: diazepam, phenobarbital
- Replacement Therapies
  - Nicotine replacement therapy
  - Methadone
- Anti-craving
  - Alcohol: naltrexone
  - Nicotine: bupropion
- Agents for Concomitant Psychiatric Symptoms

Important considerations in choosing medication include:

- effectiveness
- indications
- safety profile — overdose, drug interactions
- impact on concurrent disorders (physical and psychiatric)
- cost
- abuse, dependence, and diversion potential
- Substance use can interfere with medication pharmacodynamics & exacerbate symptoms.

### Principles of Substance Withdrawal Management (by Substance Type)

- The experience of detoxification, or the reversal of physical dependence, is a treatable syndrome which may cause significant distress or impairment.
- Withdrawal is specific to:
  - the individual — variable in onset, duration, and intensity
  - the problematic substance (usually the opposite of the direct pharmacological effects of a drug)
  - the amount, route, duration and frequency of use (generally worse in heavy or prolonged substance use).
- Not due to general medical condition or another mental disorder
- The plan of care should be individualized & frequently reassessed.
- Generally, prescribe medications used in withdrawal management for no longer than two weeks.

## SUBSTANCE USE DISORDERS

- Use medications to minimize the risk of harm (e.g., to prevent or manage seizures or hypertensive crisis while assuaging signs and symptoms of withdrawal).
- Review medical and psychiatric comorbidity in order to determine the level of care required for withdrawal management (outpatient vs inpatient)
  - High-risk withdrawals should be done as inpatients where close medical monitoring is available
- Potential high-risk withdrawal:
  - physical illness — CAD, HTN, HIV
  - prior seizure history with withdrawal
  - elderly
  - brain injured
  - psychiatric illness
  - pregnancy
  - withdrawal from prolonged CNS depressants (Alcohol, Benzos, Barbituates).

### *Alcohol*

- Withdrawal begins within 6 to 24 hours of consumption and tends to persist for up to 4 – 7 days. Disruption in sleep may last up to 1.5 years.
- Indications for receiving withdrawal meds include: dependence, past seizures, delirium tremens, underlying conditions which make tolerance to withdrawal difficult e.g., anxiety, psychosis and those with concurrent medical condition such as coronary artery disease, hypertension, and pregnancy.
- Strong evidence exists for the use of benzodiazepines, and Phenobarbital in withdrawal management. Carbamazepine, Phenytoin and Valproic Acid are also used in hospital settings but while preventing seizures, do not prevent Delirium Tremens.
- Withdrawal management may be in the form of a symptom-based protocol, a loading protocol or a gradual taper. The CIWA-AR (the Clinical Institute Withdrawal Assessment — Alcohol) is a 10 item withdrawal symptom list used in both symptom-triggered and fixed-dose protocols. It can be used with benzodiazepines (commonly diazepam) or Phenobarbital.
- Pharmacological intervention is indicated for scores of 10 or greater.

### *Benzodiazepines*

- Regardless of how benzodiazepines are used, either as prescribed or problematically, withdrawal syndrome is highly likely with regular use.
- **The College of Physicians and Surgeons of British Columbia has endorsed the UK protocol for BDZ withdrawal management entitled Benzodiazepines: How they work and how to withdraw (The Ashton Manual) [benzo.org.uk/manual/index.htm](http://benzo.org.uk/manual/index.htm). This is also linked on the CPSBC website [www.cpsbc.bc.ca/physician/documents/index.htm](http://www.cpsbc.bc.ca/physician/documents/index.htm).**
- Withdrawal symptoms present within 1 – 2 days of discontinuation with short acting benzodiazepines and may take up to 4 days with longer acting benzodiazepines.
- Symptoms of withdrawal include: anxiety, restlessness, irritability, insomnia and depression. Seizures and delirium can occur with benzodiazepine withdrawal.
- The discomfort associated with withdrawal tends to peak by day 7 – 10 but may take several weeks or longer to clear depending on the benzodiazepine.
- Withdrawal is often managed by substituting the problem drug with a longer acting benzodiazepine such as diazepam, clonazepam, or chlordiazepoxide and taper over weeks to months.
- Use caution when tapering from alprazolam due to the risk of withdrawal seizures.



TABLE OF ORAL BENZODIAZEPINE EQUIVALENCE (APPROXIMATE)		
DRUG	CANADIAN TRADE NAME	EQUIVALENCE TO DIAZEPAM (VALIUM) 10 MG
Alprazolam	Xanax	0.5
Chlordiazepoxide	Librium	25
Clonazepam	Rivotril	0.5
Flurazepam	Dalmane	30
Lorazepam	Ativan	1
Nitrazepam	Mogadon	10
Oxazepam	Serax	30
Temazepam	Restoril	30
Triazolam	Halcion	0.5

### *Opioids*

- For heroin, morphine, codeine and oxycodone withdrawal begins within hours of discontinuation and peaks within 2 – 4 days.
- For methadone, withdrawal begins 24 – 36 hours after the last dose.
- Patients will often detoxify themselves safely at home.
- For others, management of withdrawal can be attained either with a Clonidine protocol or with a rapid methadone taper. Methadone, usually used as a maintenance therapy, can also be used as a substitution medication and be tapered over several weeks to months.

### *Stimulants*

- Physical symptoms of withdrawal are unpleasant but not life threatening. Patients usually complain of hyperphagia and hypersomnia.
- Dysphoria and suicidal ideation may occur.
- Use low dose atypical antipsychotics to manage psychosis, paranoia, anxiety and insomnia.

### *Marijuana*

- Physical signs may include mild increases in heart rate, blood pressure, and body temperature and anorexia.
- Psychological symptoms may include anxiety, depression, irritability, insomnia, tremors, and chills.
- Withdrawal usually last several days (6 – 10), although subtle symptoms may persist for weeks.
- Treatment is mainly education and support.

### *Polysubstance Use*

- There is a hierarchy of withdrawal management priority based on risk of harm to the patient
  - Prioritize as follows: Alcohol/benzos > opiates > cocaine and stimulants > marijuana
- Consider referral for inpatient detox.

### **Relapse Prevention (by Substance Type)**

Once detoxification is completed, medications which block pleasurable effects of drugs, modulate cravings, or trigger significant physical adverse effects with relapse have had limited albeit documented success in preventing relapse.

### **for Nicotine**

Agonist substitution therapy or nicotine replacement therapy is effective:

- proven efficacy in helping cigarette smokers quit smoking when used as part of a comprehensive behavioural smoking cessation program
  - increase quit rates by 1.5 – 2x
  - success independent of additional support or treatment setting
- nicotine polacrilex (nicotine gum)
- transdermally delivered nicotine (nicotine patch)
- nicotine inhaler (Nicorette inhaler) puffed and delivered orally (not really inhaled)
- contraindicated if vascular compromise or arrhythmia
  - immediate post-myocardial infarction period
  - life-threatening arrhythmias
  - worsening angina pectoris
- Bupropion (Zyban) — indicated for smoking cessation at a dose of 150mg/day po q daily for 3 days and then 150mg po bid
  - used to reduce cravings but not for nicotine withdrawal per se
  - can be used safely with nicotine replacement therapy
  - should be started at least one week prior to the target quit date.

### **for Alcohol**

**Naltrexone** can be used:

- a competitive opioid antagonist.
- cost is approximately \$200/month
- indicated for alcohol intake reduction and relapse prevention
- most thoroughly scientifically established adjunct in alcoholism treatment (Sinclair, 2000)
  - in several randomized trials, patients engaged in counselling and treated with adjunctive Naltrexone were shown to decrease the intensity and severity of their binge drinking; success of treatment evaluated in terms of health and patient satisfaction
  - less effective with abstinence based supportive therapy
  - can be used safely without prior detox
  - effective even when taken only on days when drinking is expected
  - intermittent use can continue indefinitely
- optimal treatment
  - initial dose of 12.5 – 25mg/day and titrate to effect, as high as 150mg; a standard dose is 50mg
  - combined with psychosocial therapy > 3 months
- use with caution in patients with liver disease and pancreatitis and contraindicated if in liver failure
  - obtain baseline function prior to initiation.

**Disulfiram** (Antabuse) remains an option:

- Antabuse removed from the Canadian market in 2004, but still available via the federal Special Access Program (must be ordered under special physician request)
- Disulfiram is commonly available in compounded capsules made by a number of pharmacies in BC. These are a PharmaCare benefit in lieu of the now discontinued Antabuse.
- interferes with the metabolism of the intermediary product of alcohol oxidation, acetaldehyde which triggers an unpleasant reaction: throbbing headache, sweating, flushing, nausea, and vomiting; the reaction can last up to 3 hours and,

## SUBSTANCE USE DISORDERS

- while a deterrent to alcohol consumption, it may be avoided by simply not taking the medication on the day in question; however, alcohol consumption should not occur for about 36 hours after the last pill
- use should be limited to highly motivated patients with a spouse or partner able to supervise daily ingestion
- obtain EKG and liver enzymes/function prior to initiation

### Maintenance Therapy for Opioids

#### *Methadone*

- The College of Physicians and Surgeons of British Columbia have released a *Methadone Maintenance Manual 2004* that is available through their member website or can be ordered.  
[www.cpsbc.ca/cps](http://www.cpsbc.ca/cps) ( First Login -> College Programs -> Methadone ).
- For complete information on Methadone Treatment or to obtain Methadone licensing, refer to the College of Physicians and Surgeons website:  
[www.cpsbc.ca](http://www.cpsbc.ca).
- Synthetic opioid agonist
- Currently the only evidence-based maintenance treatment available for opioid dependence approved for use in British Columbia.
- It is a controlled substance and requires duplicate prescriptions in BC. Its use is administered by the College of Physicians and Surgeons of BC and requires a Health Canada exemption.
- Best researched treatment for opioids
  - Better treatment retention rates
  - Reduces morbidity and mortality
  - Curbs spread of infectious disease
  - Work best if program is numerous, accessible, and flexible (Mattick et al, 2003)
- Methadone is well absorbed through the gastrointestinal tract. It reduces or eliminates withdrawal symptoms and reduces craving.
- If dosed appropriately, the person is able to work or perform tasks unimpaired and without the rush or risks associated with heroin.
- Before beginning methadone maintenance treatment (MMT), there must be “evidence of extensive past opioid use and/or failed treatment”.
- It is generally a once daily dosed medication and initially, MMT requires daily dispensation and witnessed ingestion. Frequent urine drug screens are required.
- Although persons on MMT may not discontinue illicit drug use completely, they can still experience benefit from maintenance therapy, e.g., reduced frequency of injection, reduced needle sharing, reduced crime.

#### *Precautions in management of Concurrent Mental Health and Substance Use Disorders*

- As there are high levels of comorbidity, screening for concurrent disorders is important
- Some patients may be predisposed to a protracted withdrawal syndrome difficult to distinguish from a comorbid psychiatric illness.
  - Protracted withdrawal syndrome is subject of considerable controversy (Geller, 1994).
  - Not as predictable as those of acute withdrawal.

## SUBSTANCE USE DISORDERS

- Use caution when prescribing medications for managing a mental illness in patients with a concurrent substance use problem
- For all,
  - avoid benzodiazepines if possible.
- For anxiety,
  - consider low dose antipsychotics for short term relief of anxiety.
- For mood disorders,
  - use anti-depressants with caution as aggressive treatment may lead to the induction of hypomania
  - the early remission phase of most substance dependence can present with a self-limited period of depression marked by dysphoria and/or atypical depression
  - approximately 60% of bipolar patients have an SUD — keep a high index of suspicion for this illness.
- For insomnia,
  - low potency medications such as Trazodone 25 – 100mg (best for middle and late insomnia)
  - consider short term atypical antipsychotics in low dose (quetiapine 12.5 – 50 mg)
- For psychosis,
  - treat aggressively and hospitalize if indicated
  - crystal methamphetamine induced psychoses can take weeks to months to clear.

### Serotonin Specific Reuptake Inhibitor (SSRI) Discontinuation Syndrome

- Effects are generally mild, short-lived, and self-limiting but can be distressing and may lead to missed work days and decreased productivity.
- “SSRI discontinuation syndrome” is now widely accepted.
- Symptoms are most likely to occur 24 – 48 hours after discontinuation or after a large dose decrease.
- Symptoms may last up to weeks after interruption of treatment, and may be relieved by restarting antidepressant therapy.
- SSRIs with shorter half lives, such as paroxetine, sertraline, citalopram, produce discontinuation symptoms that persist for up to 1 – 2 weeks after treatment cessation.
- Due to its longer half life, Fluoxetine may cause symptoms beginning as late as 25 days and up to 56 days after discontinuation.

#### *Clinical features*

- Physical or Somatic complaints
  - dizziness and light-headedness
  - nausea and vomiting
  - fatigue, lethargy
  - myalgia, chills and other flu-like symptoms
  - sensory and sleep disturbances
- Psychological manifestations
  - changes in mood, affect, crying spells, irritability
  - neurovegetative changes in appetite or sleep
  - anxiety and/or agitation

- SSRI specific observations
  - skin disorders with abrupt cessation of sertraline
  - flu-like withdrawal syndrome with paroxetine
  - extra-pyramidal symptoms have been reported with fluoxetine.

### *Clinical Notes*

- Symptoms of discontinuation may be mistaken for relapse into depression or physical illness.
- Misdiagnosing these symptoms may lead to unnecessary investigations and/or treatment.
- Rebound depression can occur in patients treated with an SSRI for other disorders e.g., Obsessive Compulsive Disorder.
- Paradoxical mood changes have been reported on abrupt withdrawal, including mania or hypomania.
- The syndrome is distinct from the classic withdrawal syndrome associated with alcohol and barbiturates — there is no craving or med seeking distinguishing it from abusive or addictive behaviour.

### *Diagnostic Criteria*

- 2 or more of the following symptoms, developing within 1 to 7 days of discontinuation or reduction in dosage of an SSRI, after at least 1 month's use, when these symptoms cause clinically significant distress or impairment and are not due to a general medical condition or recurrence of a mental disorder.
  - dizziness
  - vertigo or feeling faint
  - paresthesia
  - diarrhoea
  - gait instability
  - insomnia
  - nausea or emesis
  - visual disturbances
  - light-headedness
  - shock-like sensations
  - anxiety
  - fatigue
  - headache
  - irritability
  - tremor

### *Precautions when discontinuing SSRIs*

- Taper SSRIs before discontinuation.
- The syndrome is more likely to occur when
  - medication has been taken for longer than 2 months
  - the SSRI has a short half life (e.g., paroxetine)
  - higher doses are used.
- Neonatal SSRI Discontinuation Syndrome can follow maternal use of antidepressants during pregnancy and possibly breast-feeding. Consider this when making treatment decisions.
- Educate patients not to stop therapy without a consultation.
- For most SSRIs, taper over a period of 2 weeks or more to reduce/minimize symptoms.
- Fluoxetine has a longer half-life and may be discontinued more abruptly.
- Consider tapering high doses of paroxetine more gradually, over 4 weeks or longer.
- Treat mild symptoms by simply reassuring the patient that they are usually transient.
- For more severe symptoms, reinstitute the original dosage and slow the rate of taper or switch to a longer acting medication like fluoxetine.
- In cases in which the SSRI is restarted, symptoms generally resolve within 72 hours.



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**This section is under development. When the content for this section is complete, it will be posted on the Ministry of Health Services, Mental Health and Addictions website at: [http://www.health.gov.bc.ca/mhd/physicians\\_guide.html](http://www.health.gov.bc.ca/mhd/physicians_guide.html).**



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## **PHARMACARE NO-CHARGE PSYCHIATRIC MEDICATION PROGRAM (PLAN G)**

The No-Charge Psychiatric Medication Program (Plan G) is available to individuals of any age who are registered with a mental health and addictions centre and who are in clinical and financial need. The program provides 100% coverage of the eligible costs of certain psychiatric medications.

Patients who are eligible for subsidy for the MSP program are also eligible for Plan G. Individual patient eligibility is determined by the patient's physician and the local mental health centre. Registration is required.

The drugs eligible for coverage under the No-Charge Psychiatric Medication Program are listed in the Plan G formulary on the BC PharmaCare website at [www.health.gov.bc.ca/pharme/outgoing/plangtable.html](http://www.health.gov.bc.ca/pharme/outgoing/plangtable.html) by both brand and chemical name. Drugs in the formulary identified as "Limited Coverage" require prior Special Authority approval from PharmaCare. For these medications, the patient's physician must submit a Special Authority Request to PharmaCare. For more information on Special Authorities, visit [www.health.gov.bc.ca/pharme/sa/saindex.html](http://www.health.gov.bc.ca/pharme/sa/saindex.html).

For more information on the program, or to request Plan G application forms, physician's offices can contact their local mental health centre. Plan G application forms can also be downloaded from the BC Pharmacare website at [www.health.gov.bc.ca/exforms/mhdforms/3497.pdf](http://www.health.gov.bc.ca/exforms/mhdforms/3497.pdf).



**A. TO BE SIGNED AS TRUE BY THE APPLICANT**

Name: \_\_\_\_\_ Gender: ☐ M ☐ F

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: | | | | | | | | | | | |  
YYYY MM DD

Personal Health Number (PHN) 

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 Mandatory

1. The cost of the prescribed psychiatric medication is a significant barrier to me taking my medication. I have no other financial coverage, and I believe I qualify for Premium Assistance (\$28,000 family adjusted net income plus \$3,000 per dependent).
2. I consent to the release of financial and clinical information about me to the mental health centre and the Ministry of Health for the sole purpose of verifying my eligibility for this program.
3. I understand that the personal information collected on this form relates directly to and is necessary for program operations. The information will be handled in accordance with the *Freedom of Information and Protection of Privacy Act*. If I have any questions about the collection and use of this information, I will contact my Health Authority.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**B. TO BE SIGNED BY THE PRESCRIBING PHYSICIAN - Send to local Mental Health Centre/Authority. (Do NOT send to MSP/PharmaCare or Mental Health & Addictions Headquarters.)**

*Check a, b or c*

I certify that the patient:

a. ☐ has been hospitalized for a psychiatric condition,

OR without the medication

b. ☐ is likely to require hospitalization,

OR

c. ☐ other serious consequences are very likely (e.g. unemployment, child neglect, etc.)

\_\_\_\_\_  
Name of prescribing physician (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**C. APPROVAL BY MENTAL HEALTH CENTRE / AUTHORITY**

\_\_\_\_\_  
Signature of Director or Designate

\_\_\_\_\_  
Date

**Note:** This authorization will expire in ☐ 1 year Date: \_\_\_\_\_

☐ or earlier Date: \_\_\_\_\_



# Crisis Management



# Crisis Management

- Crises are common when treating patients with a psychiatric disorder. Crises may include a relapse of symptoms, disruptive behaviour, or risk of harm to self or others.
- Crises offer a time-limited window of opportunity to encourage the patient to make positive steps towards treatment and ongoing recovery.
  - Several provincial mental health crises intervention units are built on this principle.
  - The window for positive change is often limited to 24 – 48 hours.
- Potential crisis situations include:
  - risk of suicide
  - overdose or self-harm behaviours such as cutting or burning (most typically used in an attempt to relieve distress and tension)
  - inability to perform regular tasks of daily living or self-care
  - refusal of management or support options despite acute symptoms, significant interference, ongoing distress, or risk of self-harm.

### *Strategies Prior to Onset of a Crisis:*

- Ensure families have access to information about how to ensure safety and provide support before crises occur.
- Work with patient and family to develop management plan before crises occur (e.g., coping options, lists of useful contact numbers, when to seek professional help).

### *Crisis Management in the Office*

- Ensure the physical safety of you and your staff, other patients and the patient in crisis.
  - Consult with another staff member if crisis or conflict is anticipated
  - Provide panic alarms or emergency signals
  - Use a critical incident book/database to record all threats or episodes of violence
  - Provide de-escalation training to all staff
  - Ensure that the entire waiting area can be seen from the reception desk
  - Provide a means of exit for you and your staff that doesn't involve crossing the patient's path
  - Call the police if situation seems likely to become violent
- Problem-solve with patient and supportive family or friends.
  - Identify the trigger or triggers, if there is one
  - Generate concerns from the patient
  - Identify options or alternative coping strategies
  - Reassure that the crisis will pass
  - Review supports and options should the crisis return
- Assess whether this crisis can be managed in the community.
  - Outreach resources (e.g., housing, social services) for community treatment may be available to help avoid hospitalization.
- If hospitalization is necessary, assess whether the patient is certifiable
  - Stock "Form 4's" in your office
  - Consider contacting Police, EHS or Mental Health Team
  - Stock prn medications such as Lorazepam (1 – 2mg po, sl, im), Diazepam (10 – 20mg po, im), Olanzapine (5 – 10mg po/rapid dissolve — Zydys), Seroquel (25 – 50mg po)
- Consider referral to specialist for on-going management and treatment options.
- De-escalation of the patient in crisis:
  - The ability to 'de-escalate' an upset or unreasonable patient and avoid confrontation and conflict is an important crisis management skill.
  - The approach, although useful with a wide variety of upset patients, may be ineffective with an acutely psychotic or intoxicated patient.
  - Escalation can best be avoided by having consistent rules which might be posted in the lobby of the Waiting Area (e.g., "We do not prescribe Benzodiazepines on intake interviews")
  - Stages involved in de-escalation:
    1. Allow the patient an opportunity for self-expression.
    2. Acknowledge the patient's voiced concern without being apologetic.
    3. Empathize with the situation to help defuse tension.
    4. Explain why a particular demand cannot be met.
    5. Negotiate a compromise if necessary.

# Addressing Suicidal Risk

**Two new documents are provided below on pages 3.65 and 3.71**

- *Working with the Suicidal Patient: A Guide for Health Care Professionals.* This document outlines steps in assessing the client, providing advice, support, and information, including development of safety plans.
- *Coping with Suicidal Thoughts.* This document is a brief guide to help individuals decrease thoughts of suicide, connect with helpful resources, make their homes safe, and develop safety plans. It is a supplement to professional care and it is not intended to replace professional care.

Two other very helpful documents are available and can be down loaded without cost from the MoH Mental Health & Addictions website:

[www.healthservices.gov.bc.ca/mhd/publications.html](http://www.healthservices.gov.bc.ca/mhd/publications.html)

and from the CARMHA website: [www.carmha.ca](http://www.carmha.ca).

- *Working with the Client who is Suicidal: A Tool for Adult Mental Health & Addiction Services.* This is a best practice guide for clinicians to improve assessment and intervention with adults presenting in crisis with suicidal ideation and plans.
- *Hope & Healing: A Practical Guide for Survivors of Suicide.* This document was designed to help survivors through difficult times. It focuses on practical matters that survivors need to deal with after a suicide, including help, resources, and information for them to access.



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# Working with the Suicidal Patient

## A Guide for Health Care Professionals

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### Task One: ASSESS

#### 1. Assess current suicidal ideation

##### Is suicidal ideation present now?

*Have you gotten to the point where you did not want to go on? Have you had thoughts of not wanting to be alive? What about right now?*

**Passive Ideation:** The patient would rather not be alive, but does not indicate a plan that involves an act of initiation = **LOWER RISK** (e.g., *I'd rather not wake up in the morning; I wouldn't mind if a car hit me when I was crossing the road*)

**Active Ideation:** The patient has acute thoughts of completing suicide = **HIGHER RISK** (e.g., *I do think about killing myself; I feel like throwing myself into traffic*)

*Intense, continuous ideation* = **HIGHER RISK**

##### Is there a plan?

*Do you have a plan as to how you would end your life?*

*Detailed, carefully thought-out plan* = **HIGHER RISK**

##### Is there intent?

*You talk about wanting to die, and have even considered [taking pills] but are you intending to do this?*

**Low Intent:** Suicidal thoughts and fantasies about plans, with absolutely no intent to put these plans into action. Fantasizing about suicide can provide some comfort to those in distress to know there is always a way out = **LOWER RISK** (e.g., *Oh no, I could never do that, I have children*)

**High Intent:** Expression of specific intent to end life = **HIGHER RISK** (e.g., *I intend to do this as soon as my daughter's graduation is over*)

**Ambivalent or Unclear Intent:** Ask about what has helped in past. *What has stopped you from ending your life to this point? What has helped in the past when/if you've had these thoughts?*

#### 2. Obtain details if there is a suicide plan

##### How lethal is the plan?

How lethal does the patient believe the method(s) to be?

##### Is there access to means?

Obtain specific details. (*What pills do you have or would you take to overdose?*)

##### Has patient chosen a time and/or place?

How isolated is the patient? What preparations have been made (e.g., buying rope)?

##### Has patient made final arrangements?

Has patient prepared a suicide note, settled their affairs or communicated to others?

*Higher lethality, access to means, preparations and arrangements* = **HIGHER RISK**

#### 3. Gather details on current and previous attempts

*Previous attempts, especially in past year* = **HIGHER RISK**

##### Triggers of Present Attempt

*Walk me through the last 24 hours. At what point did you consider suicide?*

##### Triggers of Past Attempts

*Tell me about other times you have seriously considered suicide or made an attempt. What chain of events led up to attempts you've made in the past?*

##### Lethality

*Assess the lethality of the method(s). What was the likelihood that the patient would be found after they made the attempt?*

##### Impulsivity

*Was attempt carried out in the heat of anger (impulsive) or was it carefully thought-out (planned), with day and time picked in advance? What was the direction of hostility (goal to hurt self or others)?*

##### Intoxication

Was patient intoxicated at time of attempt (substance use can lead to disinhibition and can contribute to individuals acting in atypical ways)?

##### Expectations of Dying

*What did you think would happen to you when you [cut your wrists/took an overdose]? How did you think others would respond? Did you truly think you would die?*

##### Outcome

Was medical intervention required? How was this accessed (e.g., patient called for help vs. being found unresponsive by others)?



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### Feelings About Survival

Guilt, remorse, embarrassment = **LOWER RISK**

Disappointment, self-blame = **HIGHER RISK** (e.g. *I couldn't even get this right and kill myself properly*)

## **4. Obtain information on psychiatric and other history**

Obtain information on psychiatric history (e.g., depression, psychosis), including symptoms that may suggest undiagnosed mental illness; substance use/abuse (alcohol, drugs); and past/current mental health treatment, including all current and past psychiatric medications.

Obtain information on other chronic and acute stressors (e.g., loss of relationship, loved one, job; gambling/financial stressors; trauma/abuse; struggle with sexual identity issues; changes/discontinuation of medications).

Assess for protective factors, such as family, friends, pets, religion, and therapist.

Ask about any other relevant and contributory factors.  
(*Is there anything else I should know about?*)

## **5. Conduct mental status examination**

### Emotional State

What is the patient's self-reported mood vs. their observed affect?

*Extremes in emotional state/mood (no vitality, emotionally numb or unbearable emotional pain/turmoil) = HIGHER RISK*

### Behaviour & Appearance

How is the patient behaving (agitated, alert, cooperative)?  
How do they appear (hygiene, speech)?

### Thought Process

Is the patient oriented? Are attention, concentration and memory intact? Assess thought process (logical, organized), thought content (paranoid, delusional), and judgment and reasoning.

### Problem-Solving Capacity

Can the patient generate strategies and options for problem-solving through their difficulties?

### Reasons for Living & Level of Hope

*What reasons do you have for living? How hopeful do you feel that your current situation could change? What is needed to change to help you feel not so hopeless?*

*Feelings of hopelessness, helplessness, and view of future as empty or meaningless = HIGHER RISK*

## **6. Communicate with families/ significant other(s)**

Obtain contact information for, and consent to speak with, family/significant other(s). Connecting with family and friends demystifies what's happening, and allows the patient's support system to develop confidence in the assessment and treatment process.

Inform next of kin/emergency contact if patient has made suicide attempt.

**Note:** In an emergency, consent is not required to release information to family/significant other(s), although it is a courtesy to inform the patient of disclosure of information.

Solicit input from family or significant others, as this is helpful for risk assessment and safety planning. Inquire about changes in behaviour, signs of depression, hopelessness, past attempts, any communication of intent, difficulties adhering to treatment, and examples of risky behaviour (important when decisions are made about certification).

Include family/significant other(s) in discussions regarding safety and treatment planning (discuss ways family/friends can implement support in the patient's home environment).

Acknowledge feelings of family/friends (e.g. fear, anger). Guide them to seek psycho-educational and emotional supports for themselves. Provide referrals for support agencies.

## **7. When to make a specialist referral**

Refer patients with a psychiatric history to mental health/psychiatry.

The high-risk patient should be admitted to hospital or provided a high-priority referral for a mental health or psychiatric assessment to provide recommendations about management.

**SAD PERSONS** provides a useful screening acronym to identify the high risk patient:

**S**ex (male)

**A**ge (adolescent or elderly)

**D**epression

**P**revious attempt

**E**thanol abuse

**R**ational thinking loss (psychosis)

**S**ocial supports lacking

**O**rganized plan

**N**o spouse/partner

**S**ickness – especially chronic/uncontrolled pain



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Other factors suggesting high risk are: multiple risk factors; profound hopelessness; lack of protective factors; high lethality; premeditation of present attempt; and/or family history of suicide, depression or substance abuse.

## 8. Communicate with primary care provider(s)

Obtain information from patient and/or their family about the patient's current health and mental health care provider(s). Communicate with patient's primary care provider(s) to ensure continuity of care.

# Task Two: ADVISE

## 1. Provide meaning and support

### Explain a Model of Suicide

Provide a model to help the patient understand their suicidality, and to normalize their feelings. People think seriously about suicide when they experience the 3 I's in their life situation: **Intolerable** (meaning their life situation is so painful that it seems unbearable), **Interminable** (it seems like it's going to go on like this forever), and **Inescapable** (it seems like nothing they've tried has changed or will change their experience).

### Provide Coping Strategies

Provide *Coping with Suicidal Thought*, a document to help individuals decrease thoughts of suicide, develop a safety plan and connect with helpful resources.

### Reinforce the Value of Treatment

Treatment (both therapy and medication) can help to reduce your suffering. Therapy can help you to identify and address underlying issues that are contributing to you feeling this way, and provide you new ways of dealing with your life problems. Medication can help you with difficulties you are having with (depressed mood, anxiety, sleep, appetite).

### Address Ambivalence in Order to Instill Hope

Many people have mixed feelings about suicide, and are just looking for some way to get out of the pain they are feeling. There are ways you can find support to help with that pain that don't include ending your life.

### Reinforce Positive Coping Used in the Past

*What has helped in the past when you've had these thoughts?*

## 2. Develop a safety plan

Develop an interim, written safety plan with the patient to help them stay safe until they secure longer-term professional supports.

Discuss with the patient how to make their environment safe (remove risky means of self-harm; have friend or family on-site for the short-term).

Generate with the patient adaptive means of self-soothing and coping with distress (calling a friend, going for a walk).

Generate with the patient reasons they have for living, and methods they have used to cope in the past. Work with the patient on completing the Safety Plan provided in the patient handout, *Coping with Suicidal Thoughts*.

Indicate to patient that if they try these steps and still do not feel safe, they should go to a hospital emergency room or call 911.

## 3. Provide information

Provide a written copy of a treatment plan, including details of medications (if applicable) and dates of follow-up appointments.

If the patient is prescribed antidepressants, explain that there may be temporary increased risk as symptoms of depression resolve at different rates, and improvement of mood may be delayed in comparison to improvement in physical symptoms such as energy or sleep.

Provide contact numbers of primary care providers (family physician, psychiatrist, psychologist), local crisis lines (1-800-SUICIDE) and mental health centres.

Instill hope. Most importantly, let the patient and their family/friends know that there is help available. Indicate that although you cannot guarantee that there will be no further attempts or difficult feelings, prognosis will be much better if the patient adheres to the treatment plan. Indicate that it may take time to find the right diagnosis and treatment, and time for patient to make accompanying changes.

## 4. Follow-up

Follow-up with the patient and/or family or significant other(s) within 48 hours to answer any questions they have, and to offer further information, including providing referrals.

**Note:** This document is intended to be a guide to working with the suicidal adult, and should not replace a psychiatric consultation. When suicide risk exists, an expert opinion should be sought to determine the need for hospitalization and clarification of diagnosis.



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# Coping with Suicidal Thoughts

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## I'm seriously thinking about suicide. What should I do?

If you are thinking about suicide, you are not alone. Many people have thoughts of suicide, for a number of reasons. Thoughts of suicide can be very scary. You probably feel hurt, confused, overwhelmed and hopeless about your future. You may feel sadness, grief, anger, guilt, shame, or emptiness. You may think that nothing can be done to change your situation. Your feelings may seem like they are just too much to handle right now. It is important to know that thinking about suicide does not mean that you will lose control or act on these thoughts. Having thoughts of suicide does not mean you are weak, or 'crazy'. Many people think about suicide because they are looking for a way to escape the pain they are feeling.

Even though your situation seems hopeless and you wonder if you can stand another minute of feeling this bad, there are ways to get through this and feel better. You don't have to face this situation alone. Help is available. Here are a few ideas that you can use right now.

- **Connect with others:** If you are worried that you may lose control or do something to hurt yourself, tell someone. Make sure you are around someone you trust. If you live alone, ask a friend or family member to stay with you. If you don't know anyone or can't reach friends or family members, call 1-800-SUICIDE (1-800-784-2433).
- **Keep your home safe by getting rid of ways to hurt yourself:** It is important to get rid of things that could be used to hurt or kill yourself, such as pills, razor blades, or guns. If you are unable to do so, go to a place you can feel safe.
- **Develop a safety plan:** It is very helpful to have a written safety plan when you have thoughts of hurting yourself. Have a trusted family member, friend, or professional help you to complete this safety plan. Keep this plan somewhere you can see or find easily. Write down the steps you will take to keep yourself safe (see the following example). Follow the steps. If you follow these steps and still do not feel safe, call a crisis line, get yourself to a hospital emergency room or call 911.

*This document is not intended to replace professional care with a therapist or physician.*

1-800-SUICIDE (1-800-784-2433)



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## Safety Plan

If you have thoughts of hurting yourself, start at Step 1. Go through each step until you are safe. Remember: Suicidal thoughts can be very strong. It may seem they will last forever. With support and time, these thoughts will usually pass. When they pass, you can put energy into sorting out problems that have contributed to you feeling so badly. The hopelessness you may feel now will not last forever. It is important to reach out for help and support. You can get through this difficult time. Since it can be hard to focus and think clearly when you feel suicidal, please copy this and put in places where you can easily use it, such as your purse, wallet or by the phone.

---

1. Do the following activities to calm/comfort myself:
  
  
  
  
  
  
  
  
  
  
2. Remind myself of my reasons for living:
  
  
  
  
  
  
  
  
  
  
3. Call a friend or family member:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_
  
4. Call a backup person if person above is not available:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_
  
5. Call a care provider (psychologist, psychiatrist, therapist):  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_
  
6. Call my local crisis line:  
Phone: \_\_\_\_\_
  
7. Go somewhere I am safe:
  
  
  
  
  
8. Go to the Emergency Room at the nearest hospital.
  
9. If I feel that I can't get to the hospital safely, call 911 and request transportation to the hospital. They will send someone to transport me safely.

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## How can I better understand my suicidal thoughts and feelings?

Some problems and experiences, especially those that have been around for a long time, can leave you feeling hopeless and overwhelmed. At these times, you may think that you have no options left. You may think about suicide as a way to escape intense emotional pain.

People who kill themselves often think that their problems are unbearable and can't be fixed. They feel like nothing they have tried has or will change their situation. Their emotional pain can distort thinking so it becomes harder to trust, or to see possible solutions to problems, or to connect with available love and support. Even if it seems that you can't stand another minute, it is important to remember that feelings (e.g., grief, anger, sadness, loneliness, shame), especially at this intense level, don't last forever. Sometimes thoughts of suicide can become very strong, especially if you have taken drugs or alcohol. It is important to not use non-prescription drugs or alcohol, particularly when you feel hopeless or are thinking about suicide.

Some of the thoughts you may be having are:

- believing there are no other options;
- sensing your family or friends would be better off without you;
- thinking you've done something so horrible that suicide is the only option;
- experiencing unbearable pain that feels like it will go on forever;
- wanting to escape your suffering;
- wanting to let your loved ones know how much you hurt; and
- wanting to hurt or get revenge on others.

Your feelings of pain are very real. However, it is important to know that there is hope. With the help of professionals and the support of family and friends, you can learn about what is causing your suffering and how you can change or manage it. Hurting or killing yourself are not your only options. Professionals can help you learn new skills for dealing with your pain. These might include: developing new skills to cope; seeing your problems in a new light; improving your ability to handle intense and painful emotions; improving your relationships; increasing your social supports; or medications.

Some other things that may lead you to think of suicide are:

**Mental health problems:** Some mental health problems, such as depression or anxiety, can increase feelings of suicide. Mental health problems are treatable. It is important to talk to your doctor if you feel low, depressed, or anxious. Counseling or medication may help. There are also free resources that can help (e.g., the Antidepressant Skills Workbook, at [www.carmha.ca](http://www.carmha.ca)).

**Conflict with loved ones:** You may feel that your family or friends would be better off without you. It is important to remember that conflict with others doesn't last forever. Ending your life is not a way to solve that conflict. We know that people who lose a loved one to suicide say that their lives are not better off.

**Loss:** Many different types of loss can increase the chances you may feel suicidal. Some examples that may set off feelings of suicide include: a break-up; losing a job; losing social status; or losing a loved one or friend. Knowing someone who has died by suicide can increase the chance that you think of suicide as an option. As difficult as your loss may seem, there are people and services that can help you get through difficult times, such as Griefworks BC (1-877-234-3322).

**Financial/legal problems:** Financial or legal problems, such as overwhelming debt, gambling problems, or problems with the law, can be very stressful. It is important to know that there may be free services that can help you deal with financial or legal problems. These include the Credit Counselling Society (1-888-527-8999), the Problem Gambling Help Line (1-888-795-6111), or the Legal Services Society (1-866-577-2525).

**Lack of connection to friends and others:** Thoughts of suicide can increase if you spend a lot of time alone, or don't feel you can tell anyone your problems. Talk to someone, like a professional, about ways that you can increase social supports in your life. You may feel that the people that are in your life don't understand the pain you are feeling. Talk to a professional about ways that you can let others know of the pain and unhappiness you are

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feeling. The Social Supports wellness module at [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) gives ideas for how to improve your social supports.

**Drug and alcohol problems:** Using alcohol or drugs can make feelings of depression, anxiety, and thoughts about suicide worse. Drugs and alcohol can change the way you think about problems in your life. If drugs or alcohol are causing your problems, you can get information on treatment from the BC Alcohol and Drug Information and Referral Service (1-800-663-1441).

**Medical problems:** Medical problems such as diabetes, thyroid problems, chronic pain, or multiple sclerosis can increase chances that you may think about suicide. Make sure you have proper medical care for health problems. Some medications can increase feelings of suicide. It is important to speak to your doctor about this. You can also get information by calling the BC NurseLine (1-866-215-4700) or the Living a Healthy Life with Chronic Conditions programs (1-866-902-3767).

**Sexual identity issues:** People who are lesbian, gay, bisexual, or transgender may have a higher risk of suicide. Confusion about sexual identity and fears of possible or real rejection from family or friends can make things worse. There is support available. Prideline (1-800-566-1170) is a peer support and information phone line. Prideline is open 7 days a week, from 7:00 p.m. to 10:00 p.m.

## What else can I do to decrease thoughts of suicide?

**Problem-solve:** It is always helpful to think of ways other than suicide that you can solve your problems. First, make a list of all the problems you are dealing with in your life. Second, make a list of all the solutions you can think of to those problems. You can ask someone you trust to help you with this. Dealing with 1 or 2 small problems can help to put an end to immediate feelings of suicide. Once you are thinking more clearly, you can tackle other bigger problems. You can find worksheets on Problem-Solving and Healthy Thinking in the

Antidepressant Skills Workbook ([www.carmha.ca](http://www.carmha.ca)) or at [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca).

Some examples of common problems and ideas for solutions are:

### **Problem: Depressed mood**

#### **Possible Solution:**

- Call 1-800-SUICIDE for emotional support, short-term problem-solving and referrals for longer term help.
- See your family doctor to discuss options for treatment (e.g., medications, changes in medications, undiagnosed illnesses).
- Take care of yourself by resting, exercising regularly, eating regularly and spending time with friends.

### **Problem: End of a relationship**

#### **Possible Solution:**

- Talk to friends about the pain you feel.
- Get help from a crisis line or counselor.
- Join a social group.

**Think of reasons for living:** Most people who think about suicide want to escape their pain, but they do not always want to die. When you feel low, it's easy to stay focused on things that are negative and upsetting in your life. This makes it easy to think of suicide as the only option. Start thinking about some reasons you have for living. For example, many people have relationships with loved ones, pets they love, religion, goals and dreams, or responsibilities to others in their life that give them reasons to live and prevent them from acting on their suicidal thoughts. Think of all of the reasons you have for living. Write them down. Remind yourself of them when you are feeling low.

### **Remember things that have helped in the past:**

Many people have had thoughts of suicide before. Think of some of the things that helped you feel better when you faced the same types of problems in the past. Some examples are: having faith and trust that time always helps; reaching out to friends and family; seeing a professional; going to a support group; following a safety plan; doing something you enjoy; not being alone; keeping a journal; or not drinking or using drugs.

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**Talk to a trusted friend, family member, or professional:** It's important to speak to someone you trust about how you feel. Sometimes just talking about how you feel can help. It is important to be open about all of your thoughts. If you have a suicide plan, it is important to tell someone what your plan is. People often say they are relieved that they shared how they felt with someone. Talking can help you feel less alone.

**Get treatment for mental health problems:** It is important to get treatment for depression, anxiety, and alcohol and drug problems. Just seeing your family doctor may not be enough. It can help to see a mental health specialist, such as a psychologist or a psychiatrist. You can get referrals from your doctor or learn how to find a specialist from one of the referral lines listed on the following page. If you are already receiving treatment, speak up if your treatment plan is not working.

**Do the opposite of how you feel:** When you have thoughts of suicide, it can be helpful to do the opposite of how you feel. For example, when people feel depressed they usually want to be alone. Doing the opposite, for example getting in touch with others, can help with feelings of depression.

## How can I decrease chances that I will feel suicidal in the future?

**Get professional support:** You can get help and referrals from your doctor or from referral lines listed on the following page. If the first referral doesn't work for you, ask for another.

**Identify high-risk triggers or situations:** Think about the situations or factors that increase your feelings of despair and thoughts of suicide. Work to avoid those situations. For example, going to a bar and drinking with friends may increase feelings of depression. If this is a trigger for you, avoid going to a bar or seeing friends who drink.

**Self-care:** Taking good care of yourself is important to feel better. It is important to do the following:

- eat a healthy diet;
- get some exercise every day;
- get a good night's sleep; and
- decrease or stop using alcohol or drugs, as these can make feelings of depression and suicide worse.

**Follow through with prescribed medications:** If you take prescription medications, it is important to make sure you take them as your doctor directed. Speak to your doctor if medications aren't working, or if side effects are causing you problems. If you have just begun taking antidepressants, it is important to know that symptoms of depression resolve at different rates. Physical symptoms such as energy or sleep may improve first. Improvement in mood may be delayed. Speak to your doctor if you are feeling worse.

**Structure and routine:** Keep a regular routine as much as possible, even when your feelings seem out of control. Here are some tips for creating structure in your life:

- wake up at a regular time;
- have a regular bed time;
- have planned activities in your day, such as going for a walk or going to the gym; and
- continue to go to work or school.

**Do things you enjoy:** When you are feeling very low, do an activity you enjoy. You may find that very few things bring you pleasure. Think of things you used to enjoy doing at times you didn't feel so depressed or suicidal. Do these things, even if they don't bring you enjoyment right now. Giving yourself a break from suicide thoughts can help, even if it is for a short time.

**Think of personal goals:** Think of personal goals you have for yourself, or that you've had in the past. Some examples are: to read a particular book; travel; get a pet; move to another place; learn a new hobby; volunteer; go back to school; or start a family.

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# What can I do to learn more?

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## Useful Phone Numbers (24 hrs/day, 7 days/week)

1-800-SUICIDE (1-800-784-2433)

BC Nurse Line: 1-866-215-4700 (TTY deaf/hearing impaired number: 1-866-889-4700)

BC Mental Health Information Line: 1-800-661-2121

BC Alcohol and Drug Information and Referral Service: 1-800-663-1441

Problem Gambling Help Line: 1-888-795-6111

## Other Useful Phone Numbers

Credit Counselling Society: 1-888-527-8999

Mood Disorders Association of BC: 604-873-0103

Early Psychosis Intervention Program: 1-866-870-7847

Griefworks BC: 1-877-234-3322

Legal Services Society: 1-866-577-2525

SAFER (Suicide Attempt Follow-up, Education and Research): 604-879-9251

Vancouver Crisis Centre: 1-866-661-3311

## Useful Websites

Anxiety Disorders Association of BC: [www.anxietybc.com](http://www.anxietybc.com)

BC Schizophrenia Society: [www.bcscs.org](http://www.bcscs.org)

Canadian Mental Health Association – BC Division: [www.cmha.bc.ca](http://www.cmha.bc.ca)

Early Psychosis Intervention Program: [www.psychosissucks.ca](http://www.psychosissucks.ca)

BC Partners for Mental Health and Addictions Information: [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)

Mood Disorders Association of BC: [www.mdabc.ca](http://www.mdabc.ca)

Youth Support: [www.youthinbc.com](http://www.youthinbc.com)

## Books

Arena, J. (1995). *Step Back From the Exit: 45 Reasons to Say No to Suicide*. Milwaukee, WI: Zebulon Press.

Bilsker, D., & Paterson, R. (2005). *Antidepressant Skills Workbook*. Vancouver, B.C.: Centre for Applied Research in Mental Health and Addiction. Free download at [www.carmha.ca](http://www.carmha.ca).

Blauner, S. R. (2002). *How I Stayed Alive When My Brain Was Trying to Kill Me: One Person's Guide to Suicide Prevention*. New York, NY: William Morrow.

Chabot, J. A. (1997). *A New Lease on Life: Facing the World After a Suicide Attempt*. Minneapolis, MN: Fairview Press.

Cobain, B. (1998). *When Nothing Matters Anymore: a Survival Guide for Depressed Teens*. Minneapolis, MN: Free Spirit Publishing Inc.

Conroy, D. L. (1991). *Out of the Nightmare: Recovery From Depression and Suicidal Pain*. New York, NY: New Liberty Press.

Quinnett, P. G. (1995). *Suicide: the Forever Decision. For Those Thinking About Suicide, and For Those Who Know, Love, or Counsel Them*. New York, NY: The Crossroad Publishing Company.

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Admission to hospital may be indicated when the patient poses potential harm to themselves or other people, for example, when the patient is demonstrating

- active suicidal thoughts or plans
- homicidal thoughts or plans
- psychotic symptoms
- risky behaviour or inability to care for self or others.

Admission to the hospital can be either voluntary or involuntary.

### **Voluntary Admission to Hospital:**

- Whenever possible, admission should occur with the patient's consent.
- Generally the patient is not an AWOL risk and may have insight to their illness and need for treatment.
- If the patient were to AWOL, they are considered low risk for self harm, very low risk to harm others.
- Adults are defined as persons 16 years of age and older for purposes of the *Mental Health Act*.
- An adult may voluntarily seek admission to a designated facility for treatment of a mental disorder under either the *Hospital Act* or the *Mental Health Act*.
- Voluntary admissions under the *Mental Health Act* require the person to request admission. Voluntary patients may discharge themselves at any time — just like non-psychiatric patients admitted to a hospital under the *Hospital Act*.
- Most hospitals admit and treat voluntary psychiatric patients in the same way that they deal with any other patients.

### **Involuntary Admission to Hospital:**

- Involuntary admission and treatment (also known as certification) is considered when a person is in need of psychiatric treatment and either lacks insight to this need or refuses. Certification must clearly list one of three conditions:
  - risk of harm to self
  - risk of harm to others
  - risk of further deterioration without treatment is imminent.

The patient must meet the *Mental Health Act* definition of “person with a mental disorder”, a disorder of the mind that requires treatment and seriously impairs the person's ability to react appropriately to the person's environment, or to associate with others.

In British Columbia the rules and procedures regarding involuntary admission and treatment are contained in the *Mental Health Act and the Guide to the Mental Health Act* at [www.healthservices.gov.bc.ca/mhd/publications.html](http://www.healthservices.gov.bc.ca/mhd/publications.html). A list of designated provincial and regional facilities is available at [www.healthservices.gov.bc.ca/mhd/publications.html](http://www.healthservices.gov.bc.ca/mhd/publications.html)

### *Medical Certification (Involuntary Admission) Through a Physician's Medical Certificate*

- One Medical Certificate completed by a physician who examines a person and finds that the person meets the involuntary admission criteria of the *Mental Health Act* (section 22) provides
  - legal authority for an involuntary admission for a 48-hour period.

- authority for anyone, including ambulance personnel, police or, if the physician believes it is safe, relatives or others, to take the person to a designated facility (See the Guide to the Mental Health Act for a list of designated facilities).
- A second Medical Certificate must be
  - completed by a different physician
  - completed within 48 hours of initial admission, otherwise the patient must be discharged or admitted as a voluntary patient.
- Once the second medical certificate is completed, the person may be admitted as an involuntary patient for up to one month from the day of initial admission.
- To extend involuntary hospitalization beyond the first month, a physician must examine the person and complete a Renewal Certificate (Form 6), before each certificate period expires.

### *Criteria for Involuntary Admission*

- In order for a physician to fill out a Medical Certificate, the physician must have examined the patient and be of the opinion the patient meets ALL four of the criteria, which are described below. The opinion must be based upon information from the examination and preferably includes information received from family members, health care providers, or others involved with the person.
- The FOUR criteria for involuntary admission must include that the person
  - is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others
  - requires psychiatric treatment in or through a designated facility
  - requires care, supervision, and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others and
  - is not suitable as a voluntary patient.
- The words "in or through" a designated facility mean that a patient initially requires inpatient treatment as an involuntary patient, but may subsequently be placed on leave and continue to receive psychiatric treatment on an outpatient basis, while [legally] remaining under the care, supervision, or control of the designated facility.

### *Validity of the Medical Certificates*

- Unless the person is admitted, a Medical Certificate is valid for only 14 days following the date of the examination. If the person is not admitted during this 14-day period, the certificate becomes invalid.
- Only a physician licensed to practice medicine in British Columbia may complete a Medical Certificate. An educational license is not sufficient. The physician does not have to be a psychiatrist.

Additional questions and issues related to involuntary admissions are discussed in the *Guide to the Mental Health Act*.

## Mental Health Certification

FORM 4

### MEDICAL CERTIFICATE MENTAL HEALTH ACT

(INVOLUNTARY ADMISSION)

[Sections 22, 28, 29 and 42, R.S.B.C. 1996, c. 288]

I, \_\_\_\_\_, MD., certify that I examined  
*physician's name (please print)*

\_\_\_\_\_ on \_\_\_\_\_  
*first and last name of person examined (please print) dd / mm / yyyy*

In summary form, the reasons for my opinion are:  
(information may be obtained through interviews,  
observations and collateral sources)

1. In my opinion, this person

has a disorder of the mind that requires  
treatment and which seriously impairs the  
person's ability to react appropriately to  
his/her environment or to associate with  
others (section 1 of the *Mental Health Act*);  
**and**

2. In my opinion, this person

(a) requires treatment in or through a  
designated facility; **and**

(b) requires care, supervision and control  
in or through a designated facility to  
prevent his/her substantial mental or  
physical deterioration or for the  
protection of the person or for the  
protection of others; **and**

(c) cannot suitably be admitted as a  
voluntary patient

*This person ☐ was ☐ was not  
brought to me by a police officer or  
constable under section 28 of the Act.*

*Note: if above space is insufficient, continue on back of form*

Signed \_\_\_\_\_  
*physician's signature date of signature (dd / mm / yyyy)*

\_\_\_\_\_ *physician's address (please print) telephone*

*Note: This medical certificate, when duly signed, is authority for anyone to apprehend the person who is the subject of this certificate and to transport the person to a designated facility for admission and detention for a 48 hour period. If a second medical certificate is completed within that period, it provides authority to detain the person for one month from the date of admission under the first certificate.*

*If this is a first medical certificate, it becomes invalid on the 15th day after the date upon which the physician examined the person who is the subject of the certificate unless the person has been admitted on the basis of it. HL TH 3504 Rev. 2003/01/23 (PINK)*

### Discharge Planning

- Discharge planning is critical for maintaining gains and preventing future lapses/relapses following inpatient or outpatient psychiatric care.
- Proper discharge planning is generally a result of consensus decision-making between the inpatient/outpatient physician, the family physician, the outpatient psychiatrist (if relevant), and allied professionals (psychotherapist, counsellor, outreach nurse, etc).
- A discharge planning meeting, whenever possible, is recommended to ensure comprehensive care.

### *Elements of Successful Discharge Planning*

- Complete referrals and schedule follow-up appointments before discharge.
- Apply for Pharmacare Special Authority coverage for medications that require it (e.g. olanzapine) before discharge  
(see website at [www.health.gov.bc.ca/pharme/sa/saindex.html](http://www.health.gov.bc.ca/pharme/sa/saindex.html) for details).
- **All individuals discharged from acute care should schedule a family physician follow-up appointment within 15 days and no later than 30 days of discharge.**
  - Review symptoms, monitor medications and track effectiveness of management plan at follow-up.
  - Consider keeping a registry of patients with mental illness in order to ensure and monitor regular follow-up.
- Consider other resources:
  - specialists (i.e., community psychiatrist for medication management or ongoing care)
  - psychotherapist or counsellor for talk therapy, further support, or booster CBT
  - outreach (e.g., home care)
  - support groups (e.g., AA).
- Distribute self-management information (books, websites, etc — see information on self-management and information for families section for options).
- Plan for how to respond to crises, lapses and relapses.
- Include supportive family and friends, as they play a critical role in assuring successful planning.
  - Review concerns about the future.
  - Mediate and encourage the collaborative resolution of problems between patients and families.

# Evaluation of Progress

Psychiatric disorders tend to follow a Chronic Disease Model, with partial and complete remissions, recurrences and relapses as part of the natural course of illness. Some symptoms may wax and wane, while others may resolve completely. Monitoring progress is critical to maximize treatment successes and minimize failures.

## *Office Management*

- The frequency of office visits to evaluate progress can be increased or decreased depending on status.
- Early follow-up should occur at least weekly or biweekly, depending on severity, until the patient begins to show clear improvement.
- Visits can then be reduced to monthly or less often, depending on individual circumstances.
- Consider “Shared-Care” approaches, where referred specialists complete more detailed evaluations of progress.
- Assess symptoms specific to the diagnosed psychiatric disorder(s) rather than general symptoms.

## **Goals of the Evaluation**

The goals of the evaluation should be to

1. identify progress
2. review treatment — both pharmacological and non-pharmacological interventions, and modify as needed
3. respond to lapses or relapses early
4. ensure patient safety when there is a risk of suicide, self-harm, or harm to others
5. identify patient’s plan for ongoing recovery
6. identify barriers to progress.

## *Identifying Progress*

Reviewing progress reinforces the patient’s efforts and communicates a clear interest by the family physician in the care of the patient.

- Review overall quality of life using the “Global Assessment of Functioning Scale (GAF)”.
  - the GAF is from the DSM-IV or DSM-IV-TR and is an overall rating of the patient’s psychological, social and occupational functioning on a scale ranging from 1 to 100.
  - this is the rating listed on “Axis V” of most psychiatric consultations.
  - use the GAF at specific time intervals (e.g., every 3 months) to track overall progress.

(See 3.65 for a GAF)
- Discuss symptom severity (mental health and any other co-morbid health problems) using scales wherever possible.
  - simple symptom rating scales such as “On a scale of 1 to 10, 1 being the worst, 10 being the best” work very well if answers are documented and scales are used consistently.
  - questions such as “what would it take to go from a 4 to a 6?” often yield helpful and insightful answers.

- Assess ability to function independently and effectively in a variety of settings (home, work/school, social)
  - symptom scales should be used in different settings and can help identify stressful situations.
- Collect collateral information from key family or friends as they should be involved in the evaluation process and are often the best of observers of progress.

### *Reviewing Treatment Effects*

#### Pharmacological

- Review medications:
  - side effects
  - adherence
  - dosing schedule — simple schedules have higher adherence rates.
- Review indications for prescribed medications:
  - frequently upon initiation
  - at minimum every 3 months if on maintenance therapy.
- Taper or titrate to effect.
- Early side effects may be as a result of starting at too high a dose. Lower the dose and re-titrate if necessary.

#### Non-pharmacological

- Review adherence with psychotherapist or group or sponsor.
- Encourage discussion of concerns and identify misconceptions regarding therapy.
- Explore the effect of therapy on the patient—triggers, flashbacks, withdrawal, mood, etc.
  - The family physician may be viewed as objective or neutral by the patient.
  - Patients sometimes withhold from their therapist uncomfortable feelings or experiences.
- Encourage completion of therapy including formal termination with therapists or groups.

### *Responding to Lapses or Relapses Early*

- Normalize relapses and lapses as part of the chronic disease model.
- Discuss events leading to the episode. Review
  - recent discontinuation or change in meds
  - recent physical health
  - recent social stressors or losses.
- Review self-management strategies.
- Encourage patient to re-connect with support groups.
- Use medications as needed for a brief period to restore health and resolve target symptoms.

### *Ensuring Patient Safety*

Generally, there is an increased risk of suicide and self-harm behaviour in the mentally ill.

- Assess suicidal ideation, self-harm behaviour or homicidal ideation frequently, especially with relapses.
- Identify acute stressors and problem solve.



- Increase frequency of visits if necessary.
- Encourage involvement of family and friends in the self-management discussion.
- Send the patient to a local ER or certify if necessary.
- Contact police if there is specifically stated homicidal ideation.

### *Identifying the patient's plan for ongoing recovery*

Engage the patient in a discussion of their plan to maintain or establish responsibilities and roles. This includes:

- return to employment or vocational training
- school strategies
- safe and affordable housing
- stable relationships
- healthy lifestyles
- stress management strategies.

### *Identifying barriers to progress*

As with any medical illness, progress may be slowed by unaddressed concerns of the patient. Reinforce that the family physician cares about the outcome and is committed to being an integral part of the treatment team. If the evaluation of progress shows limited advancement, consider the following:

- intolerance of medication side effects
- difficulty tolerating psychotherapy (e.g., distress associated with exposure component of CBT)
- fears and concerns about the aftermath of making progress that may lead to ambivalence or problems with treatment adherence (e.g., fears of returning to work or living independently)
- patients, family, and friends may require time to adjust to positive changes in patient (e.g., reduced need for assistance, desire to move out into own home, forming new relationships with others, trying new things, being more assertive)
- pushing too fast and too soon (e.g., premature return to work or school, taking on too many new responsibilities).

## EVALUATION OF PROGRESS

Addressing these issues may help bring the treatment back on track.

<b>CUES FOR EVALUATING PROGRESS</b> areas to explore when monitoring progress — assessing both negative and positive elements				
	<b>Depression</b>	<b>Anxiety</b>	<b>Psychosis</b>	<b>Substance Use</b>
Biological	<ul style="list-style-type: none"> <li>constipation</li> <li>weight gain or loss</li> </ul>	<ul style="list-style-type: none"> <li>sympathetic symptoms (e.g., rapid heart rate, GI upset, diarrhoea, SOB, chest pain)</li> </ul>	<ul style="list-style-type: none"> <li>Weight gain</li> <li>Extrapyramidal symptoms- cogwheeling, decreased arm swing, rigidity, shuffling gait</li> </ul>	<ul style="list-style-type: none"> <li>comorbid medical conditions, e.g., cellulitis, liver stigmata, abscesses or active tract marks.</li> </ul>
Medication side effects	<ul style="list-style-type: none"> <li>weight gain</li> <li>sexual dysfunction</li> <li>insomnia</li> </ul>	<ul style="list-style-type: none"> <li>weight gain</li> <li>sexual dysfunction</li> <li>insomnia</li> </ul>	<ul style="list-style-type: none"> <li>weight gain</li> <li>sexual dysfunction</li> <li>increased cholesterol</li> <li>akathisia — subjective feeling of restlessness</li> <li>QTc prolongation</li> </ul>	<ul style="list-style-type: none"> <li>nodding off, constipation (methadone)</li> </ul>
Laboratory	<ul style="list-style-type: none"> <li>mood stabilizer levels</li> <li>TSH</li> </ul>	<ul style="list-style-type: none"> <li>TSH</li> </ul>	<ul style="list-style-type: none"> <li>cholesterol changes, increased blood glucose</li> <li>ECG</li> </ul>	<ul style="list-style-type: none"> <li>changes in GGT, MCV, liver enzymes or reversal of biological red flags</li> </ul>
Psychological	<ul style="list-style-type: none"> <li>sleep, appetite, libido</li> <li>concentration, feelings of guilt or worthlessness</li> <li>interests, hobbies</li> <li>anxiety and substance use</li> </ul>	<ul style="list-style-type: none"> <li>overall anxiety</li> <li>avoidance of activities</li> <li>cognitive symptoms such as: fear of dying, fear of negative evaluation, phobias</li> <li>lack of energy</li> <li>need to escape fearful situations</li> <li>panic attack frequency, intensity</li> <li>coping responses</li> </ul>	<ul style="list-style-type: none"> <li>psychotic symptoms: positive and negative</li> <li>self harm risk to self or others</li> <li>mood, anxiety and substance use</li> <li>stress management</li> <li>level of insight</li> </ul>	<ul style="list-style-type: none"> <li>cravings, mood or anxiety symptoms, psychotic features</li> <li>boredom,</li> <li>pessimism</li> <li>stage of change</li> </ul>
Social	<ul style="list-style-type: none"> <li>relationships</li> <li>attendance to therapy or groups</li> <li>return to work or school</li> <li>hospitalizations</li> </ul>	<ul style="list-style-type: none"> <li>relationships</li> <li>attendance to therapy or groups</li> <li>return to work or school</li> <li>hospitalizations</li> </ul>	<ul style="list-style-type: none"> <li>extent and quality of relationships.</li> <li>community involvement</li> <li>caregiver burden</li> <li>grooming and hygiene</li> <li>status of main role functions (e.g., work, school)</li> </ul>	<ul style="list-style-type: none"> <li>relationships, presence of sponsors, meeting participation, hospitalizations</li> <li>loss of “using” peers, academic performance, employment</li> </ul>
Scale	<ul style="list-style-type: none"> <li>PHQ-9</li> <li>GAF</li> </ul>	<ul style="list-style-type: none"> <li>GAF</li> </ul>	<ul style="list-style-type: none"> <li>-AIMS (abnormal involuntary movement scale)</li> <li>-GAF</li> </ul>	<ul style="list-style-type: none"> <li>AUDIT or CAGE</li> <li>GAF</li> </ul>
Self Management	<ul style="list-style-type: none"> <li>ability to gain access to, understand, and use information to promote and maintain good health</li> </ul>	<ul style="list-style-type: none"> <li>ability to gain access to, understand, and use information to promote and maintain good health</li> </ul>	<ul style="list-style-type: none"> <li>ability to gain access to, understand, and use information to promote and maintain good health</li> </ul>	<ul style="list-style-type: none"> <li>ability to gain access to, understand, and use information to promote and maintain good health</li> </ul>

## Global Assessment of Functioning (GAF) Scale \*

<b>Psychopathology</b> Consider psychopathology on a hypothetical continuum of mental health to illness. Do not include impairment due to physical or environmental limitations.		<b>Social and Occupational Functioning (SOFAS)</b> Consider social and occupational functioning on a continuum from excellent to grossly impaired. Include impairments in functioning due to physical limitations, as well as those due to mental impairments. Impairment must be a direct consequence of mental and physical health problems. The effects of lack of opportunity and environmental limitations are not to be considered.	
100	Life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.	Superior functioning in a wide range of activities.	100
91			91
90	Absent or minimal symptoms (e.g., mild anxiety before an exam), generally satisfied with life, no more than everyday problems or concerns (e.g., occasional argument with family members)	Good functioning in all areas. Occupationally and socially effective.	90
81			81
80	If symptoms are present, they are transient and expected reactions to psychosocial stressors (e.g., difficulty concentrating after a family argument)	No more than slight impairment in social, occupational, or school functioning (e.g., infrequent interpersonal conflict, temporarily falling behind in schoolwork).	80
71			71
70	Some mild symptoms (e.g., depressed mood, mild insomnia).	Some difficulty in social, occupational, or school functioning but generally functioning well. Has some meaningful interpersonal relationships.	70
61			61
60	Moderate symptoms (e.g., flat affect, circumstantial speech, occasional panic attacks).	Moderate difficulty in social, occupational or school functioning (few friends, conflict with peers or co-workers).	60
51			51
50	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting).	Serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).	50
41			41
40	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in judgement, thinking, or mood.	Major impairment in several areas, such as work, school, or family relations (e.g., depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).	40
31			31
30	Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgement (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation)	Inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).	30
21			21
20	Some danger of hurting self or others (e.g., suicidal attempts without clear expectation of death; frequently violent; manic excitement) OR gross impairment in communication (e.g., largely incoherent or mute)	Occasionally fails to meet minimal personal hygiene (e.g., smears feces); unable to function independently.	20
11			11
10	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR serious suicidal act with clear expectation of death	Persistent inability to maintain personal hygiene. Unable to function without harming self or others or without considerable external support (nursing care and supervision).	10
1			1

1) \_\_\_\_\_ Psychopathology Score

2) SOFAS score \_\_\_\_\_

- Starting at the top of the scale, ask yourself "is EITHER the patient's symptom severity OR the patient's level of functioning WORSE than what is indicated in the range?"
- Move down the scale until you find a range which matches the patient's symptom severity OR level of functioning, WHICHEVER IS THE WORST.
- Double check your selection of a range by referring to the range immediately below the one chosen: it should have examples which are too severe on BOTH symptom severity and level of functioning. IF NOT BOTH — keep moving down the scale.

\* Table from DSM-IV, American Psychiatric Association, Washington, 1994.



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# Management Plan Worksheet (for Patients)



## Management Plan Worksheet

This plan will help you manage any lapses, relapses or crises. Keep this in an easy to access place and make sure your family and other important support providers have a copy. This way everyone can work together towards the shared goals of wellness and recovery.

Your Family Doctor's Name and Contact Information is:

### When I am well and my symptoms are stable, I am able to do the following:

Check off those that apply to you. Use blank spaces to add your own personal signs of wellness.

<input type="checkbox"/>	take care of my appearance and shower regularly
<input type="checkbox"/>	attend work or school regularly
<input type="checkbox"/>	keep up with work or schoolwork
<input type="checkbox"/>	keep up with household chores
<input type="checkbox"/>	keep up with paying bills
<input type="checkbox"/>	get together with family or friends to do social activities _____ times per week
<input type="checkbox"/>	exercise regularly
<input type="checkbox"/>	eat healthy meals regularly
<input type="checkbox"/>	take medications as prescribed
<input type="checkbox"/>	keep regular sleeping hours (go to bed and get up at roughly same time each day)
<input type="checkbox"/>	socialize with other people without getting extremely irritable or starting arguments

### In the past my symptoms have included:

Check off those that apply to you. Use blank spaces to add other symptoms that have bothered you in the past.

<input type="checkbox"/>	problems sleeping (too much/ too little)	<p>It can be overwhelming to complete this worksheet on your own.</p> <p>Ask your spouse, family, close friends or physician to help you fill it out and brainstorm ideas.</p>
<input type="checkbox"/>	feeling anxious or tense or panicky	
<input type="checkbox"/>	not feeling as hungry as normal or unusual increases in appetite	
<input type="checkbox"/>	problems with thinking, concentrating or making decisions	
<input type="checkbox"/>	unwanted or upsetting thoughts you can't easily get rid of	
<input type="checkbox"/>	feeling down or sad	
<input type="checkbox"/>	increases in bodily aches or pains	
<input type="checkbox"/>	missing work or school	
<input type="checkbox"/>	using drugs or alcohol even though it leads to harm	
<input type="checkbox"/>	not enjoying hobbies or other usual fun activities	
<input type="checkbox"/>	not wanting to go out or spend time with family or friends	
<input type="checkbox"/>	becoming easily annoyed at others	
<input type="checkbox"/>	avoiding things you need to do	



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**Past triggers for my symptoms have included:**

Check off those that apply to you. Use blank spaces to add additional triggers you have experienced.

<input type="checkbox"/>	break-up of relationship or family conflict
<input type="checkbox"/>	losing a job or hours cut back
<input type="checkbox"/>	bad life event (describe):
<input type="checkbox"/>	good life event (describe):
<input type="checkbox"/>	drug or alcohol use
<input type="checkbox"/>	substantial changes in health behaviours (e.g., smoking, exercise)
<input type="checkbox"/>	physical illness
<input type="checkbox"/>	changes in medications

**Early warning signs**

When any of these occur I will increase my use of self-management skills. I will follow the plans outlined below as needed with the support of my family, friends and family physician.

My early warning signs include:

*Remember: sometimes warning signs will be the same as they were before the first episode; however, sometimes these warning signs can be completely different. Therefore, be alert to all early warning signs.*



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**With your family physician and family develop a plan outlining what to do if warning signs are present**

*Example: What to do if you experience an increase in panic attacks and urge to avoid things*

*Example: What to do if you begin to hear voices or see things that are not actually there.*

**If these early warning signs appear — follow this relapse prevention plan:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Consider including in this relapse prevention plan:

- making an appointment to see your doctor
- ways to reduce your level of stress or helpful coping behaviours
- changes to medication approved by your doctor

**With your family physician and family develop an emergency plan in case things suddenly become much worse.**

*Example: What to do if you overdose during a relapse in your problematic drug or alcohol use*

*Example: What to do if you become extremely depressed and suicidal*

**If things become suddenly become much worse — follow this emergency plan:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Consider including in this emergency plan:

- address for nearest hospital
- contact information for other emergency resources
- contact information for family or other people who can help provide

Successful self-management skills take time to develop. You, your family and your family physician will most likely need to revise this management plan from time to time based on your own experiences. With a good management plan in place, patients and families live full and rewarding lives despite the presence of mental health or substance use problems.

As you progress in your recovery it can help to begin thinking about or working towards some of your life goals. Be realistic, break goals down into manageable tasks and don't take on too much too soon. Use the back page to begin brainstorming ideas about your future goals and dreams.




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# 4 INFORMATION & SUPPORTS

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# 4 INFORMATION AND SUPPORTS FOR INDIVIDUALS AND FAMILIES



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# Self-Management & Primary Care



Self-management is a key goal for physicians, patients and their families when coping with depression, anxiety disorders, early psychosis or substance use disorders.

***Self-management*** is when a person develops the knowledge and skills needed to take an active role in successfully managing their mental or substance use disorder with the support of their family, friends, physician and other service or support providers as appropriate and if available.

Self-management skills take time to develop and need to be reviewed by physicians with patients and families coping with mental health or substance use problems. Patients and families with strong self-management skills tend to experience much better outcomes including lower symptoms, fewer relapses, and higher quality of life for everyone involved.

This section has been developed to support physicians' efforts to facilitate the development of self-management skills in the patients they work with and their families. Many of the resources listed are reliable sources of free, easy-to-access information relevant to physicians practicing in the primary care setting — especially those who wish to remain up to date and evidence based in their approach to mental health and substance use problems. Physicians are encouraged to become familiar with the various resources available in BC as outlined in this guide so they can direct patients and families to the appropriate resources effectively and efficiently. Resources for specific types of problems are listed together for quick and easy reference.

Physicians, patients, and families can use the following checklist to help ensure key aspects of self-management and associated supports have been included in each patient's management plan. Missing components need to be covered in upcoming visits between the physician, patient, and family.

SELF-MANAGEMENT PLAN CHECKLIST		
	Yes	No
Is there a positive working relationship between the patient, physician, and family?		
Is there a positive working relationship with other service or support providers?		
Is the patient actively involved in the treatment and management process?		
Are family actively involved in the treatment and management process?		
Do the patient and family have access to high quality information about		
• the nature of diagnosed disorders, symptoms and expected course?		
• effective treatment and management options?		
• additional resources and supports?		
Do the patient and family have a good understanding of the diagnosed disorder(s)?		
Have effective treatment and management options been reviewed with patient and family?		
Have an effective management plan that includes relapse prevention and crisis management been developed in consultation with patient and family?		
Do the patient and family know how to monitor symptoms and progress over time?		
Is some time saved during visits to review patient and family concerns with the physician?		
Are visits scheduled with the patient and family to review and modify the management plan as needed?		
Are patient and family learning and practicing how to		
• use daily management skills to maintain and increase gains?		
• identify lapses and relapses in symptoms?		
• prevent or respond to lapses, relapses and crises?		
• engage in self-care behaviours and healthy life style choices?		
Have family members been screened for their own health problems including mental health or substance use problems?		
Have the patient and family been referred to additional community supports, services or agencies that match their information and management needs?		

The remainder of this section addresses how to meet these goals including providing access to high quality information, self-management skills, and other evidence based supports for patients and families coping with anxiety disorders, depression, substance use disorders or early psychosis.

A good working relationship is characterized by clear communication and a collaborative approach that helps the patient, family and physician work towards common goals. A positive alliance between the physician, the patient and the family is important for several reasons:

- 3 out of every 4 people receiving mental health care obtain services from the primary care setting.
- a poor working relationship can interfere with patients' ability to manage their illness and may even lead them to drop out of treatment.

Evidence has shown the first contact between the physician, patient and family is especially important in building a good working relationship. It may be more important to work on building a positive alliance during the first few visits, even if treatment is delayed for a short period of time.

### **Quick Tips: Building Alliances**

- If the patient is referred from hospital, arrange to see the patient and family prior to discharge
- If the patient is referred by another professional or a friend, engage that individual in the initial contacts with the patient and the patient's family.
- Provide accurate information about confidentiality, rights, and how information is shared with family and other health professionals or agencies.
- Encourage regular and open exchange of information.
- Include time during visits for review of patient and family concerns, even if not deemed a clinical priority.
- Share with patients and families the evidence that shows they can effectively manage the symptoms of mental health or substance use problems with the appropriate resources and supports.
- Connect the patient and family to other agencies for practical assistance or resources as needed (e.g., finances, housing, educational, vocational, respite).
- Provide outreach if the patient is unwilling or unable to attend office appointments.
- Use visits as opportunities for ongoing education about the illness and effective management.

### *Active Involvement Improves Outcomes*

To maximize positive outcomes, both the patient and family need to be directly involved in the process of identifying and managing the problem. Active involvement is associated with better outcomes for patients and families coping with these common problems.

### *Involve the Family*

There is growing evidence that active family involvement in the treatment process can have specific beneficial effects on health outcomes including

- greater treatment adherence
- improved patient functioning
- improved family well-being

## WORKING RELATIONSHIPS

- fewer relapses
- better overall prognosis.

Effective management plans usually include some form of ongoing supports for the patient in their daily lives. Families need to be directly involved as they are typically the main providers of these types of supports including

- emotional support and help with problem solving
- assistance with activities in daily living (e.g., grocery shopping, filling prescriptions)
- providing stable and safe place to stay if needed
- encouraging basic self-care (eating regularly, basic hygiene, etc.)
- encouraging patient to engage in helpful self-management skills
- being a contact person to call in high-risk situations or times of stress
- being positive about managing the ups and downs of recovery, so a slip doesn't have to be a relapse.

Note: If a patient prefers to speak with the physician or health professional without a family or friend being present, this decision should be respected.

Access to quality information is an essential component of effective management for both patients and families.

### **Benefits of Education**

Initiate education during the first visit. Benefits, with time, include:

- improved knowledge of the disorder and its symptoms
- improved interpersonal skills
- decreased relapse rates
- shorter hospital stays for those patients requiring inpatient treatment
- better communication among all involved.

Education and access to information can also help patients and families with

- maintaining self-esteem and a sense of control over the direction of their lives
- lowering sense of stigma or shame, given how common these problems are
- making sense of difficult symptoms or experiences
- managing emotions around receiving diagnosis, treatment options and the impact on one's life
- identifying and modifying well-intended but unhelpful coping responses.

Example: Understanding the complex nature of substance use and addiction can alleviate the guilt that some families, particularly parents, may experience.

Example: When coping with anxiety disorders, family members often encourage avoidance of feared situations and provide excessive reassurance. These common, well-intended responses often reduce anxiety in the short-term but typically increase symptoms of anxiety disorders in the long-term.

### **Information Needs of Patients and Families**

Patients and their families typically need to know

- the name and symptoms of diagnosed disorder(s)
- the prognosis and expected course of disorder(s)
- the effective treatment options including pros and cons, cost, rates of success, etc.
- self-management skills
- what family and friends can do to help
- how to prevent lapses or relapses
- how to respond to lapses and relapses
- how to respond to a crises
- stress management skills
- understanding how self-care and lifestyle choices are associated with health and well-being (e.g., diet, exercise, drugs and alcohol).

Example: When managing a substance use disorder, family members may benefit from information on the specific substances being used and the range of possible intoxication and withdrawal symptoms.

Example: Individuals who have persistent psychotic symptoms may benefit from learning some simple coping strategies until symptoms can be better controlled by medication. For example, some patients report that humming or listening to music through headphones helps them cope when they hear voices.

Patients and families will typically have information needs around specific problems and require practical advice and problem solving tips. Common examples include:

- psychotic behaviours
- panic attacks
- substance use urges
- substance use lapses or relapses
- suicidal thoughts and behaviours
- difficulties leaving the house or getting out of bed
- risky or dangerous behaviours
- how to preserve or regain the patient's social, home, educational and/or vocational functioning
- how to preserve or regain daily structure and routines
- what to do while on waiting list for treatment and additional resources
- how to get prompt assistance during difficult periods, crises and emergencies.

### Using Multiple Sources of Information

Physicians can draw upon additional sources of information by using:

- referrals to evidence based organizations or agencies that provide access to free educational information and resources
- directed reading or 'bibliotherapy' between visits
- readily available print materials in office or waiting room areas, including culturally sensitive information in languages other than English; these are especially important for patients and families who are unsure if mental or substance use disorders are real health problems or do not wish to discuss mental health or substance use problems with the physician.

### Public Education Events

**During the weeks surrounding these events there are often increased physician visits around issues pertaining to mental health, mental illness, and substance use.**

Mental Illness Awareness Week	1st full week in October
Beyond the Blues: Depression Anxiety Screening and Education Day	Thursday of 1st full week in October
World Mental Health Day	October 10
Addictions Awareness Week	3rd full week in November
Eating Disorders Awareness Week	1st full week in February
Mental Health Week	1st full week in May

Visit [www.heretohelp.bc.ca/events](http://www.heretohelp.bc.ca/events) for more information about these events in BC





# General Resources for Patients & Families



# General Resources for Patients and Families

## RESOURCES BY PHONE

### **BC Partners Mental Health Information Line:**

To get information 24 hours a day and referrals to local agencies in your community just call 1-800-661-2121 or (604) 669-7600 or email [bcpartners@heretohelp.bc.ca](mailto:bcpartners@heretohelp.bc.ca). Listings include contact information for local mental health teams.

### **BC Nurse Line:**

To get information 24 hours a day call toll free 1-866-215-4700, (604) 215-4700 or toll free for deaf/hearing-impaired at 1-866-889-4700 or visit [www.bchealthguide.org](http://www.bchealthguide.org). Translation services are available in 130 languages.

### **BC Alcohol and Drug Information and Referral Service:**

Call (604) 660-9382 or, outside the Lower Mainland, 1-800-663-1441.

### **BC Housing:**

Call (604) 433-1711 or visit [www.bchousing.org](http://www.bchousing.org).

### **Crisis Centres:**

Check inside the front page of the phone book for resources to help get through a crisis or emergency including suicidal urges or intent to harm self in some other way.

### **Provincial Language Service:**

Professional health care interpretation and translation services are provided by the Provincial Health Services Authority (PHSA) to PHSA agencies and other health organizations in BC using qualified health care interpreters, call-centre technology and web-enabled software. Individuals and families with limited English proficiency can access these services throughout BC for about 60 languages. For more information please call (604) 875-2553 or visit [www.phsa.ca](http://www.phsa.ca)

### **Ministry of Health Information Line:**

Call 1-800-465-4911 for general information about the Ministry of Health's programs, services and initiatives. The line operates from 8:30 a.m. – 4:30 p.m., Monday to Friday.

**Health Authorities**

**Northern Health Authority**

Phone: (250) 565-2649

Fax: (250) 565-2640

[www.northernhealth.ca/](http://www.northernhealth.ca/)

**Interior Health Authority**

Phone: (250) 862-4200

Fax: (250) 862-4201

[www.interiorhealth.ca](http://www.interiorhealth.ca)

**Vancouver Island Health Authority**

Phone: (250) 370-8699

Fax: (250) 370-8750

[www.viha.ca/](http://www.viha.ca/)

**Vancouver Coastal Health Authority**

Phone: Toll Free 1-866-884-0888

Local: (604) 736-2033

Fax: (604) 874-7661

[www.vch.ca/](http://www.vch.ca/)

**Fraser Health Authority**

Phone: (604) 587-4600

Fax: (604) 587-4666

[www.fraserhealth.ca](http://www.fraserhealth.ca)

**Provincial Health Services Authority**

Phone: (604) 675-7400

Fax: (604) 708-2700

[www.phsa.ca/default.htm](http://www.phsa.ca/default.htm)

**Mental Health Support Teams**

**Island:**

Island Mental Health Support Team

Vancouver Island Health Authority

#203 - 3939 Quadra, Victoria, BC V8X 1J5

Phone (250) 479-7005 Fax (250) 479-2275

**Vancouver and Fraser:**

Fraser Valley & West Coast Mental Health Support Teams

#207 - 2248 Elgin Avenue

Port Coquitlam, BC V3C 2B2

Phone (604) 777-8476 Fax (604) 461-2189

**Fraser Health:**

#300 - 5238 Joyce Street

Vancouver, BC V5R 6C9,

Phone (604) 660-0786 Fax (604) 660-0815

### Interior:

Developmental Disability Mental Health Services,  
Interior Health Authority  
#309 - 1664 Richter Street  
Kelowna BC V1Y 8N3  
Phone (250) 860-5183 Fax (250) 860-9146

### North:

Northern Mental Health Support Team  
2nd Floor, 1308 Alward Street  
Prince George, BC V2M 7B1  
Phone (250) 565-7393 Fax (250) 649-7219

## OTHER HELPFUL RESOURCES

### Association for Awareness & Networking Around Disordered Eating (ANAD)

Visit [www.anad.bc.ca](http://www.anad.bc.ca) or call 1-877-228-0877 or (604) 739-2070 for information around disordered eating including community resources, links and more. ADAD is a member agency of the BC Partners.

### BC Partners for Mental Health and Addictions Information

Visit [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) or call 1-800-661-2121

Free evidence-based information and tools for individuals, families and professionals including toolkits, screening tools, stress management tips, facts sheets, personal stories and more.

Examples:

**BC Partners Family Toolkit.** This guide includes resources and tools for family members coping with a loved one who has mental health or substance use problems. This resource was prepared by the BC Schizophrenia Society for the BC Partners and provides information and tools for communication skills, problem solving, self-care and more.

**BC Partners Mental Disorders Toolkit.** This self-management guide was prepared by the BC Canadian Mental Health Association for the BC Partners. Tips and tools to help manage the symptoms of mental illness are emphasized including treatment plans, preventing relapses and resources for a range of mental health problems.

**Wellness Modules.** Strategies for basic self-care and stress management.

**Fact Sheets.** Basic information on common mental health and substance use topics.

**Family Toolkit.** Key information for family and friends.

### Canadian Mental Health Association — BC Division

Visit [www.cmha-bc.org](http://www.cmha-bc.org) or call 1-800-555-8222 or (604) 688-3234 for a wide range of resources on mental health, mental illness and substance use. Links to local CMHA branches who can offer further information and supports for individuals, families and professionals are also provided. CMHA-BC is a member agency of the BC Partners.

### Centre for Addiction and Mental Health

Visit [www.camh.net](http://www.camh.net) for evidence based information on mental health and substance use topics including answers to frequently asked questions and select materials in multiple languages.

### F.O.R.C.E. Society

Visit [www.bckidsmentalhealth.org](http://www.bckidsmentalhealth.org) or call (604) 878-3400 for information and resources for parents of children with mental illness. F.O.R.C.E. is a member agency of the BC Partners.

### PSYCHOLOGICAL TREATMENT REFERRAL SERVICES

#### **BC Psychological Association Referral Line**

Visit [www.psychologists.bc.ca](http://www.psychologists.bc.ca) or call (604) 730-0522 or 1-800-730-0522 for information about private psychologists in your community who charge a fee for service.

#### **BC Association of Clinical Counsellors**

Visit [www.bc-counsellors.org](http://www.bc-counsellors.org) or call 1-800-909-6303 for information about private clinical counsellors in your community who charge a fee for service.

### RESOURCES FOR DEPRESSION

#### **Mood Disorders Association (MDA)**

Visit [www.mdabc.ca](http://www.mdabc.ca) or call (604) 873-0103 for a range of resources for individuals, families and professionals including recommended readings for patients and families, newsletters and a network of support groups throughout the province. MDA is a member agency of the BC Partners.

#### **The Antidepressant Skills Workbook**

Visit [www.carmha.ca](http://www.carmha.ca) for this step-by-step guide to changing patterns that trigger depression. It gives an overview of depression and explains how it can be effectively managed according to the best available research. Translations of the original Depression Guide are available in French, Chinese and Punjabi. A workbook for teens titled: **Dealing with Depression: Antidepressant Skills for Teens** is also available.

#### **BC Partners Depression Toolkit**

Visit [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) or call 1-800-661-2121 for this self-management guide prepared by the BC Canadian Mental Health Association for the BC Partners. Includes information about the symptoms of mood disorders, effective treatment options, self-management skills, links to other useful resources and more.

#### **Free Web-Based Programs**

Visit [www.moodgym.anu.edu.au](http://www.moodgym.anu.edu.au) for an evidence based self-management program for depression based on cognitive-behavioural therapy.

Recommended strategies for addressing substance use, depression, and related disorders during pregnancy and in the postpartum period are discussed in the B.C. Ministry of Health Mental Health & Addictions publication *Addressing Perinatal Depression: A Framework for BC's Health Authorities* (2006), available at: [www.healthservices.gov.bc.ca/mhd/publications.html](http://www.healthservices.gov.bc.ca/mhd/publications.html).

#### **Depression and Bipolar Support Alliance**

Visit [www.dbsalliance.org](http://www.dbsalliance.org) for a variety of helpful resources including a series of brochures such as *'Helping a Friend or Family Member with a Mood Disorder'*.

**RESOURCES FOR ANXIETY DISORDERS****Anxiety Disorders Association of BC (ADABC)**

Visit [www.anxietybc.com](http://www.anxietybc.com) or call (604) 681-3400 for a range of resources for individuals, families and professionals including recommended reading lists, information about ADABC programs, links to other useful websites and more. ADABC is a member agency of the BC Partners.

**BC Partners Anxiety Disorders Toolkit**

Visit [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) or call 1-800-661-2121 for this self-management guide prepared by the Anxiety Disorders Association of BC for the BC Partners. Includes information about the symptoms of anxiety disorders, a self-test, treatment options, self-management skills and more.

**Free Web-based Programs**

Visit [www.paniccenter.net](http://www.paniccenter.net) or [www.anxieties.com](http://www.anxieties.com) for evidence based self-management programs for anxiety disorders that are based on cognitive-behavioural therapy. Visit the Knowledge Network ([www.knowledgenetwork.ca/takingcare/index.html](http://www.knowledgenetwork.ca/takingcare/index.html)) for child and youth mental health documentaries on anxiety.

**RESOURCES FOR EARLY PSYCHOSIS****BC Partners Schizophrenia and Psychosis Disorders Toolkit**

Visit [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) or 1-800-661-2121 for this self-management guide providing the symptoms of schizophrenia, treatment options and more.

**British Columbia Schizophrenia Society (BCSS)**

Visit [www.bcscs.org](http://www.bcscs.org) or call 1-888-888-0029 or (604) 270-7841 for a range of resources for individuals, families and professionals including *'Early Psychosis: What Families and Friends need to Know'*. Links to a provincial wide network of family support and education groups are also provided. BCSS is a member agency of the BC Partners.

**Schizophrenia Society of Canada**

Visit [www.schizophrenia.ca](http://www.schizophrenia.ca) for a range of resources for individuals or families including the comprehensive and practical manual "Rays of Hope".

**Specialized Programs**

Specialized Early Psychosis Intervention services are available in every health region in BC. Contact your local mental health centre for information.

Examples

**Fraser South Early Psychosis Intervention Program**

Visit [www.earlypsychosisintervention.ca](http://www.earlypsychosisintervention.ca) for more information and on-line resources for individuals and families. For more information about their support group for parents visit [www.psychosissupport.com](http://www.psychosissupport.com).

**Help Overcome Psychosis Early (HOPE)**

Visit [www.hopevancouver.com/](http://www.hopevancouver.com/) for more information about this specialized early psychosis program serving Vancouver/Richmond. Check with your local mental health centre to see what special resources exist in your community.

**National Canadian Mental Health Association (CMHA National)**

Visit [www.cmha.ca](http://www.cmha.ca) for "Family to Family" — a free newsletter for families coping with early psychosis.

### RESOURCES FOR EARLY PSYCHOSIS (continued)

#### **Mood Disorders Association (MDA)**

For families whose relative has a diagnosis of a mood disorder with psychosis the MDA organizes individual and family support groups and education across the province. *See resource listings for depression for more information.*

### RESOURCES FOR SUBSTANCE USE

#### **Centre for Addictions Research of BC (CARBC)**

Visit [www.carbc.uvic.ca/index.htm](http://www.carbc.uvic.ca/index.htm) for information on substance use problems including effective prevention and treatment. Links to useful resources for individuals, families and professionals are listed including [www.silink.ca](http://www.silink.ca). CARBC is a member agency of the BC Partners.

#### **Kaiser Foundation**

Visit [www.kaiserfoundation.ca](http://www.kaiserfoundation.ca) for a free searchable directory of resources and services for individuals and families coping with substance use problems.

#### **BC Partners Problem Substance Use Workbook**

Visit [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) or call 1-800-661-2121 for this self-management guide prepared by the Kaiser Foundation for the BC Partners. Includes worksheets and exercises to support recovery for individuals experiencing problems managing their substance use.

#### **From Grief to Action**

Visit [www.fromgriefftoaction.org](http://www.fromgriefftoaction.org) for resources for individuals, families and professionals coping with drug use. The free '*Coping Kit*' for families includes strategies for living with substance users on a day-to-day basis, information about substance use and addiction, and fact sheets on various drugs and their effects.

#### **BC Alcohol and Drug Information and Referral Service (1-800-663-1441)**

Provides information and referral services for people needing assistance related to any kind of substance use disorder. Information and referrals provided on education, prevention, treatment and regulatory agencies.

#### **Problem Gambling Help Line (1-888-795-6111)**

A province-wide, toll-free, multilingual telephone information and referral service to community resources, including counseling, prevention and self-help resources. The service is for anyone who is adversely affected by their own, or another's gambling habits.

#### **Credit Counseling Society (1-888-527-8999)**

A non-profit service offering fee credit and budget counseling, and workable strategies for reducing or eliminating debt. Services are open to anyone in Western Canada and there are no restrictions on age or income level.



### PROFESSIONAL ORGANIZATIONS

**BC Association of Social Workers**

(604) 730-9111 or 1-800-665-4747

**BC Association of Clinical Counsellors**

(250) 595-4448 (Victoria) or 1-800-909-6303

**BC Medical Association & BC Psychiatric Association**

(604) 736-5551 or [www.bcma.org](http://www.bcma.org)

**BC Psychological Association**

(604) 730-0522 or [www.psychologists.bc.ca](http://www.psychologists.bc.ca)

**College of Pharmacists of BC**

(604) 733-2440 or 1-800-663-1940 or [www.bcpharmacists.org/](http://www.bcpharmacists.org/)

**College of Physicians and Surgeons of BC**

(604) 733-7758 or 1-800-461-3008 or [www.cpsbc.ca/cps](http://www.cpsbc.ca/cps)

**College of Psychologists of BC**

(604) 736-6164 or 1-800-665-0979 or [www.collegeofpsychologists.bc.ca](http://www.collegeofpsychologists.bc.ca)

**Registered Nurses Association of BC**

(604) 736-7331 or 1-800-565-6505 or [www.crnbc.ca/](http://www.crnbc.ca/)

**College of Registered Psychiatric Nurses of BC**

(604) 931-5200 or 1-800-565-2505 or [www.crpnb.ca/](http://www.crpnb.ca/)

### PATIENT AND FAMILY SELF-CARE

Self-care, healthy life style choices and other helpful coping strategies are a basic component of effective management of mental health and substance use problems. Both patients and families can benefit when the following are explicitly built into the management plan: healthy eating, satisfying sleep, regular exercise, leisure activities, fun with friends, how to cope with negative emotion, getting social support and other general stress management techniques (e.g., muscle relaxation, yoga, meditation, etc). For more information on basic self-care, healthy life style choices and stress management tips see the BC Partners Wellness Modules and other resources at [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca).

### ADDITIONAL SUPPORTS FOR PATIENTS AND FAMILIES

When a person is diagnosed with an anxiety disorder, depression, early psychosis or a substance use disorder it is common for everyone closely involved to experience a range of emotions including grief, guilt, anger, fear, and even relief. Often patients and families become socially isolated. It is also normal for patients and families to feel overwhelmed by the wide range of stressors they must face.

### ADDITIONAL SUPPORTS FOR PATIENTS AND FAMILIES (continued)

A variety of community based resources can provide important support and coping resources for patients and families around these types of issues. Physicians should actively refer patients and families to the following types of supports as appropriate:

- non-profit mental health or substance use agencies
- local mental health centres or teams
- early psychosis programs
- evidence based self-help or support groups
- family support organizations
- other community based resources that provide high quality information and support.

For listings of these types of additional supports and community based resources see the Redbook at: [www2.vpl.vancouver.bc.ca/DBs/Redbook/htmlPgs/home.html](http://www2.vpl.vancouver.bc.ca/DBs/Redbook/htmlPgs/home.html) or check the local listings in your area

Families often benefit from skills training programs that include overview and practice of evidence based coping skills. For example, cognitive and behavioural strategies have been shown to be effective in managing a wide range of mental health and substance use problems including anxiety disorders, depression, substance use disorders and psychotic disorders. Physicians should attempt to refer patients and families to professionals and programs that provide training in these types of skills.

Example: Patients with anxiety disorders often experience significant reductions in anxiety symptoms after a course of gradual exposure to a feared situation. Family members who receive training in cognitive behavioural management skills can accompany the patient during early stages of exposures. Training can also help family provide effective emotional support to the patient during prescribed daily exposures.

Family members are also at risk for developing their own mental health or substance use problems or may already have undiagnosed disorders of varying severity. Family members should be screened for their own mental health or substance use problems. Patients and families can benefit significantly from connecting with other people who have had similar experiences. Consider referrals to evidence based self-management groups run by recovered consumers (e.g., Living Effectively with Anxiety & Fear program provided by Anxiety Disorders Association of BC in select communities).

It is often beneficial for physician, patient, and family to involve other expert professionals who can assist with assessment, differential diagnosis, treatment planning, general management issues, monitoring of progress, training and support for family, and education or information needs. Patients and families need to be familiar with the different types of experts. Referrals to evidence based practitioners including psychiatrists, psychologists, counsellors, psychiatric nurses and other trained experts should be made as needed.



# Cross-cultural Resources



**MENTAL HEALTH SERVICES AVAILABLE TO REFUGEES IN BRITISH COLUMBIA**■ **Vancouver General Hospital Cross Cultural Outpatient Psychiatry Program**

Tel: (604) 875-4115

This program was established in 1988 and its mandate is to provide sensitive and language specific comprehensive psychiatric assessment for psychotic and non-psychotic individuals. Psychiatrists from major ethnic groups in the city provide diagnosis, recommendations for treatment and referrals to other resources in both hospital and the community.

■ **Vancouver Association for the Survivors of Torture (VAST)**

Tel: (604) 299-3539 or 1-866-393-3133 Web: [www.vast-vancouver.ca](http://www.vast-vancouver.ca)

VAST is a private, non-profitable, multicultural, association that provides support to victims of torture and their families. This resource is unique in that it provides services for refugees that include settlement counselling and health and mental health services.

■ **Multicultural Mental Health Liaison Program**

Tel: (604) 874-7626

The goal of this program is to increase the accessibility and acceptability of mental health services to members of four target communities: South Asians (Indo-Pakistanis), Chinese, Latin Americans and First Nations. Staff provide education, consultation, service brokerage and clinical services.

■ **PTSD clinic at Vancouver General Hospital**

Tel: (604) 875-4115

■ **Bridge Community Health Clinic**

Tel: (604) 709-6540

■ **Mosaic**

Tel: (604) 254-9626

Settlement services

■ **S.O.S (Storefront Orientation Services)**

Tel: (604) 255-4611

Settlement services

■ **MCC Refugee Office**

Tel: (604) 325-5524

Settlement services

**ABORIGINAL HEALTH SERVICES**■ **Aboriginal Health Services**

Tel: (604) 708-5248, 200-520 West 6th Avenue Vancouver, BC

*Regional resources*■ **Vancouver Aboriginal Council (regional Aboriginal Resource Directory available)**

[www.vac-bc.ca/default.html](http://www.vac-bc.ca/default.html)

■ **Vancouver Native Health Society**

[www.vnhs.net](http://www.vnhs.net)

*Provincial resources*■ **Association of BC First Nations Treatment Programs**

[www.firstnationstreatment.org](http://www.firstnationstreatment.org)

### ABORIGINAL HEALTH SERVICES (continued)

- **BC Aboriginal Network on Disability Society**  
[www.bcands.bc.ca](http://www.bcands.bc.ca)
- **Community Health Associates of BC**  
[www.cha-bc.org](http://www.cha-bc.org)
- **A Guide to Aboriginal Organizations and Services in BC**  
[www.mcaaws.gov.bc.ca/aboriginal\\_dir/aboriginal\\_guide.pdf](http://www.mcaaws.gov.bc.ca/aboriginal_dir/aboriginal_guide.pdf)
- **Ministry of Health Planning, Office of the Special Advisor on Aboriginal Health**  
[www.healthservices.gov.bc.ca/aboriginal](http://www.healthservices.gov.bc.ca/aboriginal)
- **Provincial Health Officer Report 2001 Feature Report**  
The Health and Well-being of Aboriginal People in BC  
[www.healthplanning.gov.bc.ca/pho/pdf/phoannual2001.pdf](http://www.healthplanning.gov.bc.ca/pho/pdf/phoannual2001.pdf)
- **The Red Road: Pathways to Wholeness. An Aboriginal Strategy for HIV and AIDS in BC**  
[www.healthservices.gov.bc.ca/cpa/publications/red-road.pdf](http://www.healthservices.gov.bc.ca/cpa/publications/red-road.pdf)

#### *Federal resources*

- **Government of Canada, Aboriginal Canada Portal**  
[www.aboriginalcanada.gc.ca/abdt/interface/interface2.nsf/](http://www.aboriginalcanada.gc.ca/abdt/interface/interface2.nsf/)
- **A Guide to Federal Initiatives for Urban Aboriginal People**  
[www.pco-bcp.gc.ca/docs/Publications/aborguide/cover\\_e.htm](http://www.pco-bcp.gc.ca/docs/Publications/aborguide/cover_e.htm)
- **Health Canada, First Nations and Inuit Health Branch**  
(on-reserve First Nations health services)  
[www.hc-sc.gc.ca/fnihb/](http://www.hc-sc.gc.ca/fnihb/)
- **Health Canada, First Nations and Inuit Health Branch, Non-Insured Health Benefits** (available for Status First Nations on and off reserve)  
[www.hc-sc.gc.ca/fnihb/nihb/](http://www.hc-sc.gc.ca/fnihb/nihb/)
- **National Aboriginal Health Organization**  
[www.naho.ca/english/](http://www.naho.ca/english/)

### MULTICULTURAL SERVICES

- **Broadway Youth Resource Centre**  
Tel: (604) 709-5724  
Counselling for youth and their families.
- **Family Services of Greater Vancouver**  
Tel: (604) 874-2938  
Provides individual and family counselling: services for children affected by family violence and sexual abuse, alcohol and drugs day treatment program
- **Hispanic Community Centre Society**  
Tel: (604) 872-4431  
Legal Clinic, employment services, ESL classes, translation and interpretation services
- **Multicultural Family Centre**  
Tel: (604) 254-6468  
Conversation classes, seniors group, etc
- **Multicultural Family Support Services**  
Tel: (604) 436-1025  
Services for women faced with domestic violence.

**MULTICULTURAL SERVICES (continued)**

- **Project Parent**  
Tel: (604) 875-0387  
Services to improve parenting skills
- **South Vancouver Neighbourhood House**  
Tel: (604) 324-6212  
Groups for women, ESL classes and crafts.
- **Watari**  
Tel: (604) 293-7914  
Alcohol and drug counselling services.

**MENTAL HEALTH RESOURCES FOR THE CHINESE COMMUNITY**

- **BC Psychological Association**  
Tel: (604) 730-0522  
[www.psychologists.bc.ca](http://www.psychologists.bc.ca)
- **CHIMO Crisis Services**  
Tel: (604) 279-7077  
Services for Richmond residents over 13 in suicidal crisis
- **CMHA-MDA Mandarin Emotional Health Support Group**  
Tel: (604) 872-4902  
175 West Broadway, Vancouver
- **The Canadian Chinese Autism Association of BC**  
Tel: (604) 649-2810  
Neurological Centre, 2805 Kingsway, Vancouver
- **Cantonese Mutual Sharing and Support Group of Family Members who have relatives with Schizophrenia**  
Tel: (604) 251-2264 or (604) 253-5353  
2610 Victoria Drive, Vancouver
- **Chinese Hope Line, Taiwanese Canadian Cultural Society**
- **Chinese Mental Health Promotion Program, Canadian Mental Health Association, Vancouver-Burnaby Branch**  
Tel: (604) 872-4902  
175 West Broadway, Vancouver
- **Chinese Speaking Single Mother's Group, Richmond Women's Resource Centre**  
Tel: (604) 279-7060
- **Chinese Support Group for Women and Families who are facing family violence, Vancouver and Lower Mainland Multicultural Family Support Services Society**  
Tel: (604) 436-1025
- **MDA Cantonese-speaking Support Group**  
Tel: (604) 232-4025  
5836 Fraser St. Vancouver
- **Mandarin Family Psycho-Education and Support Group for Family Members who have relatives with mental illness**  
Tel: (604) 251-2264 or (604) 253-5353  
2610 Victoria Drive, Vancouver
- **SUCCESS's Chinese Help Lines**  
Tel: (604) 270-8222 or (604) 270-8233

**MENTAL HEALTH RESOURCES FOR THE CHINESE COMMUNITY (continued)**■ **SUCCESS's Family and Young Counselling Services**

Tel: (604) 408-7266

**MENTAL HEALTH SERVICES FOR GAY, LESBIAN, BISEXUAL, AND TRANSGENDERED INDIVIDUALS**■ **Bute Street Clinic at The Centre**

Tel: (604) 660-7949, 1170 Bute Street, Vancouver, BC

HIV/STD outreach clinic for the lesbian and gay communities. Free, confidential testing. Hep A & B immunization, and STD treatments. Needle exchange. Weekdays, 11 am – 6:30 pm.

■ **Gay & Lesbian Centre Vancouver Counselling & Information**

Tel: (604) 684-6869

■ **Three Bridges Community Health Centre**

Tel: (604) 736-9844, 1292 Hornby Street, Vancouver, BC

Provides full health care services including **Pride Health Services** [(604) 633-4201] offers confidential health services for lesbian, gay, bisexual, and transgendered individuals; drop-in hours are 3 pm to 6 pm Thursdays. Serves the City Centre Community Health Area, which includes the West End, Yaletown, Downtown Vancouver Business District, Downtown South, False Creek, Kitsilano, Fairview Slopes, and South Granville.

The centre also houses **Boys R Us** [(604) 633-4200], a drop-in centre for male and transgendered sex trade workers in Vancouver, particularly the downtown south area. Open 7 pm to 9 pm Tuesday to Thursday, offers a safe and confidential place for connecting with others, including social activities such as dinner and movies. Helps individuals access resources such as health care, housing, and other community services. A joint project of VCHA and AIDS Vancouver.

■ **The Centre for Lesbian, Gay, or Lesbian, Gay, Bisexual and Transgendered — Gab Youth Services**

Tel: (604) 684-6869, 1170 Bute Street, Vancouver, BC

Drop-in for lesbian, gay, bisexual and transgendered youth.

■ **St. Paul's Domestic Violence Intervention Program (pgr)**

Tel: (604) 645-1714

■ **Vancouver Women's Health Collective**

([www.womenshealthcollective.ca](http://www.womenshealthcollective.ca))

Tel: (604) 736-5262, 1 - 175 East 15th Avenue, Vancouver, BC

email: [vwhc@vcn.bc.ca](mailto:vwhc@vcn.bc.ca)

Provides information, resources and other support for women to empower themselves to take charge of their own health care.

■ **Youthquest! Lesbian and Gay Youth Society of BC**

Tel: (604) 944-6293 or (604) 460-9115 (Pitt Meadows BC) [www.youthquest.bc.ca](http://www.youthquest.bc.ca)

Provides support, advocacy, peer counselling, referrals and telephone support to lesbian, gay, bisexual and transgendered youth up to 21 years of age.

Drop-in programs are available in the Lower Mainland and educational outreach to youth service providers.



# 5 PATIENT/FAMILY INFORMATION SHEETS

<b>Depression — Information for Patients and their Families</b>	<b>ENGLISH</b>	<b>5.3</b>
<b>Depression — Information for Patients and their Families</b>	<b>CHINESE</b>	<b>5.7</b>
<b>Depression — Information for Patients and their Families</b>	<b>KOREAN</b>	<b>5.13</b>
<b>Depression — Information for Patients and their Families</b>	<b>PUNJABI</b>	<b>5.17</b>
<b>Depression — Information for Patients and their Families</b>	<b>SPANISH</b>	<b>5.23</b>
<b>Depression — Information for Patients and their Families</b>	<b>VIETNAMESE</b>	<b>5.27</b>
<b>Anxiety Disorders — Information for Patients and their Families</b>	<b>ENGLISH</b>	<b>5.31</b>
<b>Anxiety Disorders — Information for Patients and their Families</b>	<b>CHINESE</b>	<b>5.37</b>
<b>Anxiety Disorders — Information for Patients and their Families</b>	<b>KOREAN</b>	<b>5.43</b>
<b>Anxiety Disorders — Information for Patients and their Families</b>	<b>PUNJABI</b>	<b>5.47</b>
<b>Anxiety Disorders — Information for Patients and their Families</b>	<b>SPANISH</b>	<b>5.53</b>
<b>Anxiety Disorders — Information for Patients and their Families</b>	<b>VIETNAMESE</b>	<b>5.59</b>
<b>Early Psychosis — Information for Patients and their Families</b>	<b>ENGLISH</b>	<b>5.63</b>
<b>Early Psychosis — Information for Patients and their Families</b>	<b>CHINESE</b>	<b>5.69</b>
<b>Early Psychosis — Information for Patients and their Families</b>	<b>KOREAN</b>	<b>5.75</b>
<b>Early Psychosis — Information for Patients and their Families</b>	<b>PUNJABI</b>	<b>5.81</b>
<b>Early Psychosis — Information for Patients and their Families</b>	<b>SPANISH</b>	<b>5.89</b>
<b>Early Psychosis — Information for Patients and their Families</b>	<b>VIETNAMESE</b>	<b>5.95</b>
<b>Substance Use — Information for Patients and their Families</b>	<b>ENGLISH</b>	<b>5.101</b>
<b>Substance Use — Information for Patients and their Families</b>	<b>CHINESE</b>	<b>5.105</b>
<b>Substance Use — Information for Patients and their Families</b>	<b>KOREAN</b>	<b>5.111</b>
<b>Substance Use — Information for Patients and their Families</b>	<b>PUNJABI</b>	<b>5.115</b>
<b>Substance Use — Information for Patients and their Families</b>	<b>SPANISH</b>	<b>5.121</b>
<b>Substance Use — Information for Patients and their Families</b>	<b>VIETNAMESE</b>	<b>5.125</b>
<b>Coping with Suicidal Thoughts — Information for Patients and their Families</b>		<b>5.129</b>





# 5 PATIENT/FAMILY MEMBER INFORMATION SHEETS

**Please note that the Chinese, Korean, Punjabi, Spanish and Vietnamese versions of the Patient/Family Member Information Sheets on Depression, Anxiety Disorders, Early Psychosis and Substance Use are not exact, up-to-date translations of the English versions.**



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# DEPRESSION: Information for Patients & their Families



# Depression

## Information for Patients and their Families

### ***What is depression?***

#### ***Depression is not...***

Most times when you feel down, you're not depressed. Feeling sad or low is a big part of life and can't be avoided. Low mood will typically go away in a week or two, especially if there's an improvement in the situation that started it.

#### ***Depression is...***

But suppose it doesn't go away and just gets worse. You might be depressed:

1. if you feel in a very low mood or have almost no interest in your life, almost every day, and this feeling goes on for weeks; **and**
2. if you have other problems like: big changes in weight or appetite; not being able to sleep enough or sleeping too much; feeling that you are always restless or slowed-down; thinking that you are worthless or guilty; feeling really tired much of the time; feeling numb or empty; having a lot of trouble concentrating or making decisions; or thinking about death or suicide.

### ***Who gets depression?***

If you have depression, you are not alone. More than 4% of people are depressed at any given time, and about 15% of people will have depression at some point in their lives.

### ***What type of depression do I have?***

There are two main forms of depression: *mild depression* and *major depression*. Each of these includes the same kinds of problems (the ones listed above) but major depression is more severe. Usually, when a person gets depressed, it's the mild kind. Your family physician, a psychiatrist or a psychologist can tell you whether you have depression.

Certain types of depression can occur during particular times in people's lives. For example, *postpartum depression* sometimes occurs in women after they have given birth. There are also several other conditions that are similar to depression, such as *dysthymia* - a long-lasting, usually milder (but still serious) form of depression or *bipolar disorder* (sometimes referred to as 'manic depression') – where there are extreme highs and lows of mood.

### ***What are my treatment options?***

#### ***Mild Depression***

- Talking to family and trusted friends about how you've been feeling is usually a good thing to do. They can help you to figure out solutions to some of the problems you've been dealing with; besides, just knowing that people care about you is helpful. If your employer provides an Employee and Family Assistance Program, talking to a counsellor there can help you to better understand what's going on and do some problem-solving
- Write about problems you're facing, your feelings and thoughts, and possible solutions. This can help you to understand what you're going through and what choices you have.
- Speak to a family physician, psychiatrist or psychologist. A professional can help you figure out what's been going on and can make useful suggestions.
- In some cases, antidepressant medications can be helpful in overcoming mild depression.
- **A useful tool is the *Antidepressant Skills Workbook*, a self-help guide to dealing with depression. This guide is available for free download at [www.carmha.ca](http://www.carmha.ca).**

#### ***Major Depression***

- Definitely see your family physician if you think you might have major depression. Major depression is a serious problem and should be diagnosed by a family physician, psychiatrist or psychologist.
- Antidepressant medications are the most commonly prescribed treatments for major depression and are usually effective. Some people experience negative side effects from antidepressants, including problems with sexual functioning. Discuss your medication treatment options with your health care provider.

**Please note that the Chinese, Korean, Punjabi, Spanish and Vietnamese versions of the Patient/Family Member Information Sheets on Depression, Anxiety Disorders, Early Psychosis and Substance Use are not exact, up-to-date translations of the English versions.**



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- Another effective treatment is **Cognitive Behavioural Therapy (CBT)**. CBT is a talking therapy that teaches new skills for thinking and acting more effectively. In some parts of BC, a free or inexpensive CBT group program called *Changeways* is provided (ask your physician or local mental health team).
- Yet another effective treatment is **Interpersonal Therapy (IPT)**, a talking therapy that teaches new skills for dealing with partners, friends and family.
- The *Antidepressant Skills Workbook* can be used along with these treatments for depression.

### ***What can I do to help myself?***

Three self-management skills, based on research, are explained in the *Antidepressant Skills Workbook*. These are:

**Reactivating Your Life.** During depression, people often stop doing the activities that normally keep their mood positive. This can keep the depression going and make it worse. Schedule *small* achievable goals like: more involvement with friends and family; short scheduled walks; or slightly more nutritious eating.

**Realistic Thinking.** During depression, people often think about themselves and their situation in ways that are unfair and unrealistic. Learning to spot these kinds of depressive thoughts and replacing them with fair and realistic thoughts helps people emerge from depression.

**Effective Problem-Solving.** During depression, it becomes more difficult to solve problems in your life – they seem overwhelming and you may feel helpless. A step by step approach to problem-solving will help you to figure out the best way of starting to deal with problems.

### ***How can I help a loved one who is experiencing depression?***

Family members of people with depression can help in number of ways, including:

- providing emotional support and help with problem-solving
- helping with activities in daily living (e.g., grocery shopping, filling prescriptions)
- providing a stable and safe place to stay if needed
- encouraging self-care (e.g., eating regularly, basic hygiene)
- encouraging their loved one to learn and apply self-management skills
- being a contact person to call in high-risk situations or times of stress

### ***Where can I get more information?***

- **BC Partners for Mental Health and Addictions Information ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) or 1-800-661-2121)**  
Free resources include:
  - **Depression Toolkit:** symptoms of depression, self-management strategies and more
  - **Mental Disorders Toolkit:** options for living well in the face of mental illness
  - **Wellness Modules:** strategies for basic self-care and stress management
  - **Fact sheets:** basic information on common mental health and substance use topics
  - **Family Toolkit:** key information for family and friends.
- **Self-Management Guides** (available for free download at [www.carmha.ca](http://www.carmha.ca))
  - **Antidepressant Skills Workbook, 2<sup>nd</sup> Edition**
  - **Dealing with Depression: Antidepressant Skills for Teens**
- **Chronic Disease Self-Management Program ([www.coag.uvic.ca/cdsmp](http://www.coag.uvic.ca/cdsmp))**  
A patient education program offered in communities throughout British Columbia, which teaches practical skills on managing chronic health problems.
- **Evidence-Based Books**
  - *Feeling Good: The New Mood Therapy* (1999) by David Burns (Plume Books)
  - *Mind over Mood* (1995) by Dennis Greenberger & Christine Padesky (Guilford Books)
  - *Postpartum Depression and Anxiety: A self help guide for mothers* (Pacific Post Partum Support Society, Vancouver BC)
- **Consumer and Self-Help Organizations**
  - Canadian Mental Health Association (Tel: 1-800-555-8222; [www.cmha-bc.org](http://www.cmha-bc.org))
  - Mood Disorders Association of BC (Tel: 604-873-0103; [www.mdabc.ca](http://www.mdabc.ca))
  - Pacific Post Partum Support Society (Tel: 604-255-7999; [www.postpartum.org](http://www.postpartum.org))

**Remember:** Depression is a highly treatable condition. Most people recover from it well, going on to lead productive, enjoyable lives.



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# 憂鬱症

## Depression

### 患者與家屬須知

#### 何謂憂鬱症？

憂鬱症是可以治療的一種病症，由一種叫做神經傳遞介質的腦中化學物質不平衡造成的症狀，並非人格上有缺陷，也不表示個性軟弱。憂鬱症和正常的情緒低落或悲傷不同，臨床上所謂的憂鬱症是指患者有過發作的經驗。憂鬱症發作時，患者情緒抑鬱、對週遭事物失去興趣、悶悶不樂，至少持續兩星期，還伴隨好幾種其他症狀，這些症狀會對工作或家庭造成壓力或問題。憂鬱症的常見症狀包括：

- 悲傷或沒來由的好哭
- 失去生活的樂趣
- 體重增加或減輕
- 失眠或嗜睡
- 特別易怒、氣憤、擔憂、緊張、焦慮
- 疲倦異常
- 罪惡感，無價值感
- 注意力不集中，無法做決定
- 社交上感到孤立
- 有尋死或自殺的念頭

#### 誰會罹患憂鬱症？

如果得了憂鬱症，你並不孤單。百分之四以上的人有過抑鬱的經驗，約有百分之十五的人一生中會得憂鬱症。

#### 如果我有憂鬱症，我的孩子也會有憂鬱症嗎？

某些類型的憂鬱症，特別是躁鬱症，似乎有家族遺傳因素。然而，即使同卵雙生的雙胞胎，得憂鬱症的機率也不完全相同。憂鬱症似乎是綜合下列三種因素而衍生的結果：抑鬱（部分是遺傳，但不一定）、生命中的重大事故和腦中生化學物質變化。

#### 我得的是哪一種憂鬱症？

憂鬱症有好幾種，重度憂鬱症患者至少有過一次嚴重發作的病史--五種或五種以上的憂鬱症狀，至少持續兩週。有些人的憂鬱症狀會復發，也就是每隔一段時間會再發，如一個月一次，一年一次，有時終其一生會發作好幾次。憂鬱症達兩年以上，就是慢性憂鬱症。

某些類型的憂鬱症，會在一生中的某些特定時間發生。例如，產後憂鬱症是婦女在生產後發生的，季節性憂鬱症只在冬季幾個月發生，還有其他幾種類似憂



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鬱症的症狀，例如輕鬱症，一種長期性、通常症狀較輕微（但仍算嚴重）的憂鬱症，或是躁鬱症，這種憂鬱症情緒很極端，有時高亢，有時很低落。

### 有哪些治療方法？

治療憂鬱症有許多不同的好方法，主要是藥物和心理治療。抗鬱劑是治療憂鬱症的一種有效方法，要知道抗鬱劑不會使人上癮，但是有些人可能會因藥物而有副作用，這時要跟醫生討論你的用藥處方。憂鬱症也可以採用好幾種不同的心理治療，包括認知行為治療、人際關係治療、以及加強有關憂鬱症的知識。研究證實，認知行為治療對治療憂鬱症特別有效，只是要找到受過認知行為治療訓練的心理衛生專業人員很困難。卑詩省有些地方提供一種免費或收取少許費用的小組團體課程，叫做改變行為模式 (*Changeways*) 的認知行為治療課程 (參閱 [www.changeways.com](http://www.changeways.com))。

### 我該如何幫助自己？

盡量保持健康的生活方式，以下是維持均衡生活方式的幾個基本要點：

- 每天要梳妝打點，輕鬆地沐浴洗澡，將自己打理整潔
- 規律地運動
- 三餐定時，吃健康有營養的食物
- 夜晚睡眠充足
- 避免攝取過量咖啡因、藥物和酒精

### 如何幫助有憂鬱症的親人？

憂鬱症患者的家屬可以下列方式協助患者

- 提供情感上的支援，協助其解決問題
- 提供日常生活上的協助 (例如，購物、領取藥方等)
- 必要時，提供安全固定的居所
- 鼓勵其照料自己 (定時進餐，基本的個人衛生等等)
- 鼓勵患者學習自我管理的技能
- 患者遇有危急狀況或困難發生時，做患者的聯繫支援後盾
- 在患者療癒過程遇有情緒起伏時，保持正向態度，以免其憂鬱症復發

### 如何取得更多資訊？

- 有許多有關憂鬱症的自助書籍，包括卑詩大學 (UBC) 編撰的《憂鬱症患者自我照護指南》(*Self-Care Depression Patient Guide*)，可免費從 [www.carmha.ca](http://www.carmha.ca) 網站下載；David D. Burns 著，Plume Books 1999 年出版的《情緒健康手冊》(*Feeling Good Handbook*)，以及 Zipper Books 出版，Dennis Greenberger 和 Christine A. Padesky 合著的《理智戰勝情緒》(*Mind Over Mood*) 也有幫助。有關產後憂鬱症，可參閱 Shaila Misri 醫生所寫的“我不該快樂嗎？婦女懷孕期間與產後的情緒問題”
- 『卑詩省心理衛生與成癮資訊合作夥伴』(BC Partners for Mental Health and Addictions Information) 提供有精神病、憂鬱症及焦慮症百寶箱 (Mental



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Disorders, Depression and Anxiety Disorders Toolkits) 。 可 查 詢 [www.mentalhealthaddictions.bc.ca](http://www.mentalhealthaddictions.bc.ca)

- 卑詩省各社區提供有教育患者的『慢性病自我管理課程』(The Chronic Disease Self-Management Program)，教導患者照料各種慢性疾病問題的實際技能。請查閱 [www.coag.uvic.ca/cdsmp](http://www.coag.uvic.ca/cdsmp)
- 以下各消費者和自助組織提供資訊和協助：  
加拿大心理衛生協會 (Canadian Mental Health Association)，電話 1-800-555-8222; [www.cmha-bc.org](http://www.cmha-bc.org)；卑詩省情緒障礙協會 (the Mood Disorders Association of BC)，電話 604-873-0103; 網址 [www.mdabc.ca](http://www.mdabc.ca) 以及太平洋產後支援社團 (Pacific Post Partum Support Society)，電話：604 255-7999; 網址 <http://www.postpartum.org/> 等特定障礙支援團體
- 製作一張紀錄每天情緒的圖表，觀察自己的症狀，可參閱憂鬱症與躁鬱症支援聯盟( Depression and Bipolar Support Alliance) 的網址 <http://www.dbsalliance.org>.

憂鬱症的治癒率極高，許多人康復狀況極佳，可繼續工作，生活愉快。



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# 우울증

## 환자와 가족들을 위한 정보

### Depression

Information for Patients and their Families

#### 우울증이란 무엇인가?

대부분의 우울증은 뇌에 있는 신경전달 화학물질인 신경전달물질의 불균형에 의한 것이다. 이는 개인적인 약점이나 성격 결함이 아니며 충분히 치유가 가능하다. 우울증은 사람들이 평소 겪는 기분이 안좋은 상태나 슬픔에 빠진 상태와는 구별되어야 만 하는데 병으로 구별되는 우울병은 특정한 상태인 “증(episode)” 라고 구별지어 진다. 2주 이상이 지속되며 기분이 가라앉는하거나 즐거움에 대한 흥미를 잃거나 하는 증세들이 2주 이상 그 외 다른 증세들과 함께 지속된다면 이것이 “우울증”이다. 그리고 이 모든 증세들은 집이나 직장등에서의 상황들에 대처할때 스트레스나 문제들을 유발한다. 우울증의 대표적인 증세들은 다음과 같다.

- 슬픔 또는 이유 없는 울음 발작
- 삶에 대한 기쁨이나 즐거움들을 느낄 수 없음
- 체중 감소 또는 증가
- 너무 적거나 너무 많은 수면시간
- 화남, 노여움, 걱정, 병에 걸렸다는 망상 또는 불안감
- 평소보다 더 피로함
- 죄책감 또는 자신이 쓸모 없다는 생각
- 집중력이나 판단력이 흐려짐
- 자신이 사회적으로 고립되어 있다는 감정
- 죽음이나 자살에 관한 생각을 하게 됨

#### 누가 우울증에 걸리는가?

만일 귀하가 우울증에 걸렸다는 생각이 든다면 지금 현재 귀하는 혼자가 아니다. 전체인구의 약 4%의 인구가 현재 우울증에 걸려있고 15%의 인구가 앞으로 우울증에 걸릴것이다.

#### 만일 내가 우울증이라면 나의 아이도 우울증에 걸리나?

조울증(Bipolar Disorder) 와 같은 특정 종류의 우울증 같은 경우에는 가족 전체에게도 영향을 미치는 듯 보인다. 하지만 일란성 쌍둥이 같은 경우도 우울증이 발전되는데 있어서는 노출 되는 위험수위가 똑같지는 않다. 그리고 우울증에 걸리기 쉬운 상태(유전적일 수 있음), 힘든 상황, 그리고 뇌의 생화학적인 변화가 함께 복합적으로 일어날 수도 있다.

#### 나는 어떤 종류의 우울증을 가지고 있나?

우울증의 종류는 각각 다르다. 심각한 우울증을 앓고 있다고 구분되어지는 사람은 적어도 한 가지 이상의 심각한 우울 증세 겪는 사람이다. - 우울증 증세이라고 생각되어는 증세를 다섯가지 이상, 그리고 2 주가 넘는 시간동안 겪는다. 어떤 사람들에게는 이런 증세가 계속적으로 되풀이 되어 일어 날 수도 있다. 다시 말하면 그런 증세들이 한달에 한번, 일년에 한번 또는 일생 동안 몇번이나 일어날 수 있는 것이다. 이런 우울증 증세를 2년 넘게 지니고 있는 것을 만성 우울증이라고 한다.

특정 종류의 우울증은 한 사람의 일생 중 특별한 기간에 나타나게 된다. 예를들면 산후 우울증은 산모가 아이를 출산한 후에 나타나며 계절성 정서 장애는 겨울에만 나타나는 우울병이다. 감정부전증(dysthymia) (약하지만 오랫동안 지속되는 우울증세) 또는 감정이 극도로 좋아졌다 나빠졌다 함이 반복되는 조울증(Bipolar disorder - manic depression 이라고도 불림)등도 우울증과 비슷한 종류이다.

#### 치료 방법에는 어떤것이 있나?

우울증을 위한 치료방법에는 효과적인 다양한 종류의 치료법들이 있다. 주요 타입에는 약물치료와 심리치료가 있다. 항울제 같은 경우는 매우 효과적인 우울증 치료방법이다. 영두해야할 점은 이 항울제에는 중독성이 없다. 하지만 부작용은 특정 사람들에게 나타날 수도 있으며 치료방법은 담당의사와 상의하여야 한다. 다양한 종류의 심리학적인 치료방법들도 우울증을 치료하는데 도움이 된다. 인지 행동 치료요법 (CBT), 대인관계 치료요법 (IPT), 그리고 우울증에 관한 특수 교육등이 이에 포함된다. CBT를 할 수 있는 정신건강의 전문인이 부족하건 사실이지만 CBT가 특별히 우울증 치료에 많은 도움이 된다는 것이 연구 결과이다. BC주에서는 Changeways라고 불리는 CBT 프로그램이 준비 되어 있다. (관련 웹사이트 [www.changeways.com](http://www.changeways.com))



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### 나 스스로를 위해 무엇을 할 수 있을까?

건강한 생활습관을 위해 노력하라. 기본적인지만 중요한 균형적인 생활습관을 유지하는 방법들은 다음과 같다.

- 매일 신경써서 옷을 입고 샤워하고 방을 정돈하는데 시간을 투자하라.
- 규칙적인 운동을 하라.
- 건강하고 영양가 있는 음식을 규칙적으로 섭취하라.
- 밤에 숙면을 취하라.
- 다량의 카페인과 음주, 또는 약품 복용을 피하라.

### 우울증을 앓고 있는 내 주위 사람을 도울 수 있는 방법은?

가족들은 이러한 방법으로 우울증에 걸린 사람을 도울 수 있다.

- 문제를 해결하는데 있어서 정신적인 도움을 주어라.
- 매일 하는 평범한 일과를 도와주어라 (예, 시장보기, 처방전 쓰기)
- 필요하다면 안정적이며 안전한 장소를 제공하여 주어라.
- 기본적인 자기관리를 권장하라. (규칙적인 식사, 그리고 기본적 위생관리 등)
- 스트레스가 극도로 위험해 질 때 전화걸 수 있는 사람이 되어라.
- 긍정적으로 감정 기록을 조절하도록 하라. 따라서 한번의 실수가 재발로 이어지지 않게 도와주어라.

### 더 많은 정보를 얻을 수 있는 곳은?

- 우울증에 관련된 좋은 자기 도움 책들이 많이 나와있다. (우울증 환자들을 위한 자기 도움 가이드 (Self-Care Depression Patient Guide), UBC, 무료 다운로드 [www.carmha.ca](http://www.carmha.ca). 좋은 기분을 위한 핸드북(The feeling Good Handbook) by David D. Burns, Plume Books (1999) and 기분을 극복하는 마음가짐 (Mind Over Mood) by Dennis Greenberger and Christine A. Padesky, Zipper Books are also useful. For postpartum depression, see 'Shouldn't I Be Happy? 임신기간과 출산후 여성의 감정적 문제들(Emotional Problems of Pregnant and Postpartum Women) by Shaila Misri MD.
- BC partners for Mental Health and Addictions information provides Mental Disorders, Depression and Anxiety Disorders Toolkits. (관련 웹사이트 [www.mentalhealthaddictions.bc.ca](http://www.mentalhealthaddictions.bc.ca))
- 만성 질병을 위한 자기 관리 프로그램(The Chronic Disease Self-Management Program)은 BC주 내에서 제공되는 만성 질병들로 오는 문제점에 대한 실용적인 기술을 가르쳐 주는 환자들을 위한 교육 프로그램이다 (관련 웹사이트 [www.coag.uvic.ca/cdsmp](http://www.coag.uvic.ca/cdsmp))
- Consumer and self-help organizations, including the Canadian Mental Health Association (전화: 1-800-555-8222; [www.cmha-bc.org/](http://www.cmha-bc.org/)) 는 정보와 도움을 제공하고 있다.
- 자신의 증세를 알아보기 위하여 매일의 감정 차트를 기록한다. 우울증과 조울증 도움 협회 웹사이트 : [www.dbsalliance.org](http://www.dbsalliance.org).

우울증은 충분히 치료될 수 있는 병임을 명심하십시오.

많은 사람들이 회복되었고 현재 즐겁고 생산적인 삶을 살고 있습니다.



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## ਡਿਪਰੈਸ਼ਨ

### ਮਰੀਜ਼ਾਂ ਅਤੇ ਉਹਨਾਂ ਦੇ ਪਰਿਵਾਰਾਂ ਲਈ ਜਾਣਕਾਰੀ

#### ਡਿਪਰੈਸ਼ਨ ਕੀ ਹੈ?

ਗੰਭੀਰ ਡਿਪਰੈਸ਼ਨ ਇੱਕ ਅਜਿਹੀ ਕੰਡੀਸ਼ਨ ਹੈ ਜਿਸਦਾ ਇਲਾਜ ਹੋ ਸਕਦਾ ਹੈ, ਇਹ ਦਿਮਾਗ ਦੇ ਰਸਾਇਣਕ ਅਣੂਆਂ, ਜਿਨ੍ਹਾਂ ਨੂੰ ਨਿਊਰੋਟ੍ਰਾਂਸਮਿਟਰ ਕਿਹਾ ਜਾਂਦਾ ਹੈ, ਵਿਚ ਅਸੰਤੁਲਨ ਪੈਦਾ ਹੋਣ ਨਾਲ ਹੋ ਜਾਂਦਾ ਹੈ। ਇਹ ਕੋਈ ਤੁਹਾਡੇ ਸੁਭਾਅ ਵਿਚ ਨੁਕਸ ਨਹੀਂ, ਨਾਂ ਹੀ ਕੋਈ ਨਿੱਜੀ ਕਮਜ਼ੋਰੀ ਹੈ। ਅਤੇ ਡਿਪਰੈਸ਼ਨ ਦਾ ਉਹਨਾਂ ਸਥਿਤੀਆਂ ਨਾਲੋਂ ਵੀ ਅੰਤਰ ਸਮਝ ਲੈਣਾ ਚਾਹੀਦਾ ਹੈ ਜਦੋਂ ਕੋਈ ਵਿਅਕਤੀ ਉਂਜ ਹੀ ਢਾਹੂ ਮੂਡ ਜਾਂ ਉਦਾਸੀ ਵਿਚ ਹੁੰਦਾ/ਹੁੰਦੀ ਹੈ। ਕਲਿਨੀਕਲ (ਚਕਿਤਸ਼ਾਲੀ) ਡਿਪਰੈਸ਼ਨ ਓਦੋਂ ਹੁੰਦਾ ਹੈ ਜਦੋਂ ਵਿਅਕਤੀ ਇੱਕ ਘਟਨਾ ਜਾਂ “ਐਪੀਸੋਡ” ਵਿਚੋਂ ਗੁਜ਼ਰਦਾ ਹੈ। ਡਿਪਰੈਸ਼ਨ ਵਾਲਾ ਐਪੀਸੋਡ ਓਦੋਂ ਵਾਪਰਦਾ ਹੈ ਜਦੋਂ ਇੱਕ ਵਿਅਕਤੀ ਦੋ ਹਫ਼ਤਿਆਂ ਤੱਕ ਢਾਹੂ ਮੂਡ ਵਿਚ ਰਹਿੰਦਾ/ਰਹਿੰਦੀ ਹੈ ਜਾਂ ਉਸਨੂੰ ਕੋਈ ਦਿਲਚਸਪੀ ਜਾਂ ਖੁਸ਼ੀ ਨਹੀਂ ਰਹਿੰਦੀ ਅਤੇ ਇਸਦੇ ਨਾਲ ਹੀ ਕਈ ਹੋਰ ਲੱਛਣ ਵੀ ਉਭਰ ਆਉਂਦੇ ਹਨ ਜਿਹਨਾ ਨਾਲ ਕਸ਼ਟ ਹੁੰਦਾ ਹੈ, ਜਾਂ ਕੰਮ ਜਾਂ ਘਰ ਵਿਚ ਸਮੱਸਿਆਵਾਂ ਖੜ੍ਹੀਆਂ ਹੋ ਜਾਂਦੀਆਂ ਹਨ। ਡਿਪਰੈਸ਼ਨ ਦੇ ਆਮ ਲੱਛਣ ਇਹ ਹਨ:

- ਉਦਾਸੀ ਜਾਂ ਬਿਨ ਕਾਰਨ ਰੋਣ ਆਉਣਾ
- ਜੀਵਨ ਵਿਚੋਂ ਖੁਸ਼ੀ ਜਾਂ ਮਨੋਰੰਜਨ ਦਾ ਖਤਮ ਹੋਣਾ
- ਭਾਰ ਵਧ ਜਾਣਾ ਜਾਂ ਘਟ ਜਾਣਾ
- ਨੀਂਦ ਜਾਂ ਜ਼ਿਆਦਾ ਆਉਣੀ ਜਾਂ ਘੱਟ ਆਉਣੀ
- ਅਸਧਾਰਨ ਹੱਦ ਤੱਕ ਖਿਝ, ਗੁੱਸਾ, ਚਿੰਤਾ, ਗੁੰਮਸ਼ੁਮ ਜਾਂ ਘਬਰਾਹਟ ਮਹਿਸੂਸ ਕਰਨਾ
- ਸਾਧਾਰਨ ਨਾਲੋਂ ਵੱਧ ਥਕੇਵਾਂ ਮਹਿਸੂਸ ਕਰਨਾ
- ਦੇਸ਼ੀ ਜਾਂ ਨਿਕੰਮਾ ਮਹਿਸੂਸ ਕਰਨਾ
- ਧਿਆਨ ਲਾਉਣ ਵਿਚ ਜਾਂ ਫੈਸਲਾ ਕਰਨ ਵਿਚ ਸਮੱਸਿਆਵਾਂ ਮਹਿਸੂਸ ਕਰਨੀਆਂ
- ਸਮਾਜਕ ਤੌਰ ਤੇ ਤਨਹਾ ਮਹਿਸੂਸ ਕਰਨਾ ਜਾਂ ਤਨਹਾ ਹੋ ਜਾਣਾ
- ਮੌਤ ਜਾਂ ਆਤਮ ਹੱਤਿਆ ਦੇ ਖਿਆਲ ਆਉਣੇ

#### ਡਿਪਰੈਸ਼ਨ ਕਿਸ ਨੂੰ ਹੁੰਦਾ ਹੈ?

ਜੇ ਤੁਹਾਨੂੰ ਡਿਪਰੈਸ਼ਨ ਹੈ ਤਾਂ ਤੁਸੀਂ ਇਕੱਲੇ ਨਹੀਂ। ਹਰ ਸਮੇਂ 4% ਲੋਕਾਂ ਨੂੰ ਡਿਪਰੈਸ਼ਨ ਰਹਿੰਦਾ ਹੈ, ਅਤੇ 15% ਲੋਕ ਅਜਿਹੇ ਹਨ ਜਿਹਨਾ ਨੂੰ ਜੀਵਨ ਵਿਚ ਕਿਸੇ ਨਾ ਕਿਸੇ ਸਮੇਂ ਡਿਪਰੈਸ਼ਨ ਅਨੁਭਵ ਹੁੰਦਾ ਹੈ।

#### ਜੇ ਮੈਨੂੰ ਡਿਪਰੈਸ਼ਨ ਹੈ, ਕੀ ਮੇਰੇ ਬੱਚਿਆਂ ਨੂੰ ਵੀ ਹੋਵੇਗਾ?

ਕੁਝ ਵਿਸ਼ੇਸ਼ ਕਿਸਮ ਦੇ ਡਿਪਰੈਸ਼ਨ, ਵਿਸ਼ੇਸ਼ ਕਰਕੇ ਬਾਇਪੋਲਰ ਡਿਸਆਰਡਰ, ਪਰਿਵਾਰਾਂ ਵਿਚ ਪੀੜ੍ਹੀ ਦਰ ਪੀੜ੍ਹੀ ਹੁੰਦੇ ਜਾਪਦੇ ਹਨ। ਪਰ ਸਮਰੂਪੀ ਜੋੜਿਆਂ ਨੂੰ ਵੀ ਡਿਪਰੈਸ਼ਨ ਹੋਣ ਦਾ ਖਤਰਾ ਇਕੋ ਜਿਹਾ ਨਹੀਂ ਹੁੰਦਾ, ਅਤੇ ਜਾਪਦਾ ਹੈ ਡਿਪਰੈਸ਼ਨ ਕਈ ਗੱਲਾਂ ਦਾ ਸੰਜੋਗ ਹੈ, ਜਿਵੇਂ ਡਿਪਰੈਸ਼ਨ ਵੱਲ ਕੁਦਰਤੀ ਰੁਝਾਨ ਹੋਣਾ (ਇਹ ਕਿਸੇ ਹੱਦ ਤੱਕ ਜਮਾਂਦਰੂ ਵੀ ਹੋ ਸਕਦਾ ਹੈ ਪਰ ਜ਼ਰੂਰੀ ਨਹੀਂ), ਜੀਵਨ ਵਿਚ ਔਕੜਾਂ ਆਉਣੀਆਂ, ਅਤੇ ਦਿਮਾਗ ਵਿਚ ਰਸਾਇਣਕ ਤਬਦੀਲੀਆਂ ਦਾ ਹੋ ਜਾਣਾ।

#### ਮੇਰਾ ਡਿਪਰੈਸ਼ਨ ਕਿਸ ਕਿਸਮ ਦਾ ਹੈ?

ਡਿਪਰੈਸ਼ਨ ਕਈ ਕਿਸਮ ਦੇ ਹਨ। ਜਿਹਨਾ ਲੋਕਾਂ ਨੂੰ ਮੇਜਰ ਡਿਪਰੈਸ਼ਨ ਡਿਸਆਰਡਰ (ਗੰਭੀਰ ਡਿਪਰੈਸ਼ਨ ਦਾ ਰੋਗ) ਹੁੰਦਾ ਹੈ ਉਨ੍ਹਾਂ ਨਾਲ ਵੱਡੇ ਡਿਪਰੈਸ਼ਨ ਦਾ ਘੱਟੋ ਘੱਟ ਇੱਕ ਐਪੀਸੋਡ ਵਾਪਰਿਆ ਹੁੰਦਾ ਹੈ – ਡਿਪਰੈਸ਼ਨ ਦੇ ਪੰਜ ਜਾਂ ਇਸ ਤੋਂ ਵੱਧ ਲੱਛਣ ਘੱਟੋ ਘੱਟ ਦੋ ਹਫ਼ਤੇ ਰਹਿੰਦੇ ਹਨ। ਕਈ ਲੋਕਾਂ ਨੂੰ ਇਹ ਰੋਗ ਬਾਰਬਾਰ ਹੁੰਦਾ ਹੈ, ਜਿਸਦਾ ਭਾਵ ਹੈ ਉਹਨਾਂ ਨੂੰ ਇਹ ਐਪੀਸੋਡ ਅਕਸਰ ਹੁੰਦੇ ਰਹਿੰਦੇ ਹਨ – ਮਿਸਾਲ ਵਜੋਂ ਮਹੀਨੇ ਚ ਇੱਕ ਵਾਰ, ਸਾਲ ਵਿਚ ਇੱਕ ਵਾਰ, ਜਾਂ ਜੀਵਨ ਭਰ ਵਿਚ ਕਈ ਵਾਰ। ਜਿਨ੍ਹਾਂ ਲੋਕਾਂ ਨੂੰ ਡਿਪਰੈਸ਼ਨ ਦੇ ਸਾਲ ਤੋਂ ਵੱਧ ਰਹੇ ਉਹਨਾ ਨੂੰ ਜੀਰਨ (ਕਰੋਨਿਕ) ਡਿਪਰੈਸ਼ਨ ਹੋਇਆ ਸਮਝਿਆ ਜਾਂਦਾ ਹੈ।

ਕੁਝ ਕਿਸਮ ਦੇ ਡਿਪਰੈਸ਼ਨ ਲੋਕਾਂ ਦੀ ਜ਼ਿੰਦਗੀ ਵਿਚ ਖਾਸ ਖਾਸ ਸਮਿਆਂ ਤੇ ਵਾਪਰਦੇ ਹਨ। ਮਿਸਾਲ ਵਜੋਂ ਪੋਸਟਪਾਰਟਮ ਡਿਪਰੈਸ਼ਨ ਔਰਤਾਂ ਨੂੰ ਕਈ ਵਾਰ ਜਣੇਪੇ ਤੋਂ ਪਿਛੋਂ ਹੋ ਜਾਂਦਾ ਹੈ। ਸੀਜ਼ਨਲ ਅਫੈਕਟਿਵ ਡਿਸਆਰਡਰ (ਮੌਸਮੀ ਰੋਗ), ਡਿਪਰੈਸ਼ਨ ਇੱਕ ਅਜਿਹੀ



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ਕਿਸਮ ਦਾ ਹੈ ਜੋ ਕੇਵਲ ਸਰਦੀ ਦੇ ਮਹੀਨਿਆਂ ਵਿਚ ਹੁੰਦਾ ਹੈ। ਹੋਰ ਵੀ ਕਿੰਨੀਆਂ ਹੀ ਕੰਡੀਸ਼ਨਾਂ ਹਨ ਜੋ ਡਿਪਰੈਸ਼ਨ ਵਰਗੀਆਂ ਹਨ, ਜਿਵੇਂ ਡਿਸਬਾਇਮੀਆ ਜੋ ਇਕ ਲੰਮਾ ਸਮਾਂ ਰਹਿਣ ਵਾਲੀ, ਨਰਮ (ਪਰ ਫੇਰ ਵੀ ਗੰਭੀਰ), ਡਿਪਰੈਸ਼ਨ ਦੀ ਕਿਸਮ ਹੈ, ਇਸੇ ਤਰ੍ਹਾਂ ਬਾਇਪੋਲਰ ਰੋਗ ਹੈ (ਜਿਸਨੂੰ ਕਈ ਵਾਰ 'ਮੈਨਿਕ ਡਿਪਰੈਸ਼ਨ' ਵੀ ਕਿਹਾ ਜਾਂਦਾ ਹੈ) ਜਿਸ ਵਿਚ ਮੂਡ ਦੇ ਉਤਰਾ ਚੜ੍ਹਾ ਅਤਿਅੰਤ ਹੱਦ ਤੱਕ ਪਹੁੰਚ ਜਾਂਦੇ ਹਨ।

### ਮੇਰੇ ਕੋਲ ਇਲਾਜ ਲਈ ਕੀ ਚੋਣਾਂ ਹਨ?

ਡਿਪਰੈਸ਼ਨ ਲਈ ਔਡ ਔਡ ਕਿਸਮ ਦੇ ਕਿੰਨੇ ਹੀ ਵਧੀਆ ਇਲਾਜ ਹਨ। ਮੁੱਖ ਕਿਸਮਾਂ ਵਿਚ ਜਾਂ ਤਾਂ ਦਵਾਈਆਂ ਆਉਂਦੀਆਂ ਹਨ ਜਾਂ ਮਨੋਵਿਗਿਆਨਕ ਇਲਾਜ। ਐਂਟੀਡਿਪਰੈਸੈਂਟ ਦਵਾਈਆਂ (ਮੈਡੀਕੇਸ਼ਨਜ਼) ਡਿਪਰੈਸ਼ਨ ਲਈ ਬਹੁਤ ਅਸਰਦਾਰ ਕਿਸਮ ਦਾ ਇਲਾਜ ਹਨ। ਇਹ ਗੱਲ ਨੋਟ ਕਰਨ ਵਾਲੀ ਹੈ ਕਿ ਐਂਟੀਡਿਪਰੈਸੈਂਟ ਦਵਾਈਆਂ ਅਮਲ ਲਾਉਣ ਵਾਲੀਆਂ (ਅਡਿਕਟਵ) ਨਹੀਂ ਹੁੰਦੀਆਂ। ਪਰ ਕੁਝ ਲੋਕਾਂ ਨੂੰ ਆਪਣੀਆਂ ਦਵਾਈਆਂ ਨਾਲ ਗੌਣ ਪ੍ਰਭਾਵ (ਸਾਇਡ-ਅਫੈਕਟ) ਹੋ ਸਕਦੇ ਹਨ -ਦਵਾਈਆਂ ਨਾਲ ਇਲਾਜ ਕਰਨ ਲਈ ਆਪਣੇ ਡਾਕਟਰ ਨਾਲ ਦਵਾਈ-ਚੋਣ ਲਈ ਸਲਾਹ ਮਸ਼ਵਰਾ ਕਰੋ। ਕਈ ਕਿਸਮ ਦੀਆਂ ਮਨੋਵਿਗਿਆਨਕ ਥੈਰਪੀਆਂ (ਇਲਾਜ) ਵੀ ਡਿਪਰੈਸ਼ਨ ਦੇ ਇਲਾਜ ਲਈ ਵਰਤੀਆਂ ਜਾ ਸਕਦੀਆਂ ਹਨ। ਇਨ੍ਹਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ ਕਾਗਨੀਟਿਵ ਬਹੇਵੀਅਰਲ ਥੈਰਪੀ (ਸੀ.ਬੀ.ਟੀ), ਇੰਟਰਪਰਸਨਲ ਥੈਰਪੀ (ਆਈ.ਪੀ.ਟੀ), ਅਤੇ ਡਿਪਰੈਸ਼ਨ ਬਾਬਤ ਵਿਦਿਆ। ਖੋਜ ਤੋਂ ਪਤਾ ਲਗਦਾ ਹੈ ਕਿ ਡਿਪਰੈਸ਼ਨ ਲਈ ਸੀ.ਬੀ.ਟੀ ਵਿਸ਼ੇਸ਼ ਕਰਕੇ ਅਸਰਦਾਰ ਇਲਾਜ ਹੈ, ਭਾਵੇਂ ਕਿ ਮਾਨਸਿਕ ਸਿਹਤ ਦਾ ਅਜਿਹਾ ਮਾਹਰ ਲਭਣਾ ਮੁਸ਼ਕਿਲ ਹੈ ਜਿਸਨੇ ਸੀ.ਬੀ.ਟੀ ਵਿਚ ਟ੍ਰੇਨਿੰਗ ਲਈ ਹੋਵੇ। ਬ੍ਰਿਟਿਸ਼ ਕੁਲੰਬੀਆ ਦੇ ਕੁਝ ਭਾਗਾਂ ਵਿਚ, ਇਕ ਸੀ.ਬੀ.ਟੀ ਗਰੁੱਪ ਪ੍ਰੋਗਰਾਮ, ਜਿਸਦਾ ਨਾਮ ਚੇਂਜਵੇਜ਼ ਹੈ, ਮੁਫਤ ਜਾਂ ਬਹੁਤ ਘੱਟ ਕੀਮਤ ਤੇ ਪ੍ਰਦਾਨ ਕੀਤਾ ਜਾਂਦਾ ਹੈ (ਦੇਖੋ [www.changeways.com](http://www.changeways.com))

### ਮੈਂ ਆਪਣੀ ਸਹਾਇਤਾ ਆਪ ਕਰਨ ਲਈ ਕੀ ਕਰ ਸਕਦਾ ਹਾਂ?

ਸਿਹਤਮੰਦ ਜੀਵਨ-ਢੰਗ ਕਾਇਮ ਰੱਖਣ ਦੀ ਕੋਸ਼ਿਸ਼ ਕਰੋ। ਅਜਿਹੇ ਕਈ ਸਾਥੇ ਪਰ ਮਹੱਤਵ ਪੂਰਣ ਢੰਗ ਹਨ ਜਿਹਨਾ ਨਾਲ ਤੁਸੀਂ ਆਪਣੀ ਜਿੰਦਗੀ ਨੂੰ ਸੰਤੁਲਤ ਰਖਣਾ ਯਕੀਨੀ ਬਣਾ ਸਕਦੇ ਹੋ, ਜਿਵੇਂ

- ਰੋਜ਼ਾਨਾ ਡਰੈੱਸ ਪਹਿਨਣੀ, ਅਤੇ ਸ਼ਾਵਰ ਲਈ ਅਤੇ ਸਫਾਈ ਲਈ ਸਮਾਂ ਕਢਣਾ
- ਬਾਕਾਇਦਾ ਕਸਰਤ ਕਰਨੀ
- ਸਿਹਤਮੰਦ ਖੁਰਾਕ ਅਤੇ ਬਾਕਾਇਦਾ ਪੌਸ਼ਟਿਕ ਭੋਜਨ ਖਾਣੇ
- ਰਾਤ ਨੂੰ ਵਧੀਆ ਨੀਂਦ ਲੈਣੀ
- ਹੱਦੋਂ ਵੱਧ ਕੈਫੀਨ, ਡਰੱਗ, ਜਾਂ ਸ਼ਰਾਬ ਵਰਤਣ ਤੋਂ ਗੁਰੇਜ਼ ਕਰਨਾ

### ਜੇ ਮੇਰੇ ਕਿਸੇ ਸਨੇਹੀ ਨੂੰ ਡਿਪਰੈਸ਼ਨ ਹੈ ਤਾਂ ਮੈਂ ਉਸਦੀ ਸਹਾਇਤਾ ਕਿਵੇਂ ਕਰ ਸਕਦਾ/ਸਕਦੀ ਹਾਂ?

ਪਰਿਵਾਰ ਦੇ ਮੈਂਬਰ ਡਿਪਰੈਸ਼ਨ ਵਾਲੇ ਲੋਕਾਂ ਦੀ ਕਈ ਢੰਗਾਂ ਨਾਲ ਸਹਾਇਤਾ ਕਰ ਸਕਦੇ ਹਨ, ਜਿਨ੍ਹਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ,

- ਭਾਵਕ ਸਹਾਰਾ ਦੇਣਾ ਅਤੇ ਸਮੱਸਿਆਵਾਂ ਹੱਲ ਕਰਨ ਵਿਚ ਸਹਾਇਤਾ ਕਰਨੀ
- ਰੋਜ਼ਾਨਾ ਜੀਵਨ ਦੀਆਂ ਸਰਗਰਮੀਆਂ ਵਿਚ ਸਹਾਇਤਾ ਕਰਨੀ (ਜਿਵੇਂ ਗਰੋਸਰੀ ਸ਼ਾਪਿੰਗ, ਦਵਾਈਆਂ ਲਈ ਫਾਰਮ ਭਰਨੇ, ਆਦਿ)
- ਜੇ ਲੋੜ ਪਵੇ ਤਾਂ ਰਹਿਣ ਲਈ ਮਹਿਫੂਜ਼ ਅਤੇ ਪੱਕੀ ਥਾਂ ਪ੍ਰਦਾਨ ਕਰਨੀ
- ਮੁਢਲੀ ਸਵੈ-ਸੰਭਾਲ ਨੂੰ ਉਤਸ਼ਾਹਿਤ ਕਰਨਾ (ਬਾਕਾਇਦਾ ਖਾਣਾ, ਮੁਢਲੀ ਸਿਹਤ-ਰੱਖਿਆ, ਆਦਿ)
- ਆਪਣੇ ਸਨੇਹੀ ਨੂੰ ਲਾਭਕਾਰੀ ਸਵੈ-ਅਨੁਸ਼ਾਸਨੀ ਹੁਨਰ ਸਿੱਖਣ ਲਈ ਉਤਸ਼ਾਹਿਤ ਕਰਨਾ
- ਉਸਦੇ ਸੰਪਰਕ ਵਿਅਕਤੀ ਹੋਣ ਦੇ ਨਾਤੇ ਖਤਰੇ ਵਾਲੀਆਂ ਸਥਿਤੀਆਂ ਜਾਂ ਮਾਨਸਿਕ ਦਬਾਓ (ਸਟਰੈੱਸ) ਸਮੇਂ ਕਾਲ ਕਰਨਾ
- ਰੋਗ-ਮੁਕਤੀ ਦੇ ਦੌਰਾਨ ਉਤਰਾਵਾਂ ਚੜ੍ਹਾਵਾਂ ਪ੍ਰਤਿ ਹਾਂ-ਪੱਖੀ ਵਤੀਰਾ ਰੱਖਣਾ, ਤਾਂ ਕਿ ਕਿਸੇ ਨਿੱਕੀ ਜਿਹੀ ਗਲਤੀ ਤੋਂ ਡਿਪਰੈਸ਼ਨ ਮੁੜ ਕੇ ਵਾਪਸ ਨਾ ਆ ਜਾਵੇ।

### ਮੈਂ ਹੋਰ ਜਾਣਕਾਰੀ ਕਿੱਥੋਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦਾ/ਸਕਦੀ ਹਾਂ?

- ਡਿਪਰੈਸ਼ਨ ਉਤੇ ਕਿੰਨੀਆਂ ਹੀ ਉਤਮ, ਸਵੈ-ਸਹਾਇਤਾ ਲਈ ਪੁਸਤਕਾਂ ਉਪਲਬਧ ਹਨ, ਜਿਹਨਾ ਵਿਚ ਸੈਲਫ-ਕੇਅਰ ਡਿਪਰੈਸ਼ਨ ਪੇਸ਼ੈਂਟ ਗਾਈਡ ਵੀ ਸ਼ਾਮਲ ਹੈ ਜਿਸਨੂੰ ਯੂ.ਬੀ.ਸੀ ਵਿਚ ਤਿਆਰ ਕੀਤਾ ਗਿਆ ਅਤੇ ਜੋ [www.carmha.ca](http://www.carmha.ca) ਤੋਂ ਡਾਊਨਲੋਡ ਵੀ ਕੀਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਡੇਵਡ ਡੀ. ਬਰਨਜ਼ ਵਲੋਂ ਲਿਖੀ ਅਤੇ ਪਲੂਮ ਬੁਕਸ ਵਲੋਂ ਪ੍ਰਕਾਸ਼ਿਤ (1999) ਕੀਤੀ ਗਈ ਪੁਸਤਕ, ਫੀਲਿੰਗ ਗੁੱਡ ਹੈਂਡਬੁੱਕ, ਅਤੇ ਡੈਨਸ ਗਰੈਨਬਰਜਰ



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ਅਤੇ ਕ੍ਰਿਸਟੀਨ ਏ. ਪਡੈਸਕੀ ਵਲੋਂ ਲਿਖੀ ਤੇ ਜਿਪਰ ਬੁਕਸ ਵੱਲੋਂ ਪ੍ਰਕਾਸ਼ਿਤ ਪੁਸਤਕ, *ਮਾਈਡ ਓਵਰ ਮੂਡ*, ਵੀ ਲਾਭਦਾਇਕ ਹਨ। ਜਣੇਪੇ ਪਿਛਲੇ ਡਿਪਰੈਸ਼ਨ ਲਈ ਦੇਖੋ ਸ਼ੈਲਾ ਮਿਸਰੀ ਐਮ.ਡੀ. ਦੀ ਲਿਖੀ, ‘ਸੁਡਾਈਟ ਆਈ ਬੀ ਹੈਪੀ? ਇਮੋਸ਼ਨਲ ਪ੍ਰੋਬਲਮਜ਼ ਔਫ ਪਰੈਗਨੈਂਟ ਅਤੇ ਪੋਸਟਪਾਰਟਮ ਵਿੱਮਨ’

- ਬੀ.ਸੀ ਪਾਰਟਨਰਜ਼ ਫਾਰ ਮੈਂਟਲ ਹੈਲਥ ਐਂਡ ਅਡਿਕਸ਼ਨਜ਼, ਮਾਨਸਿਕ ਰੋਗਾਂ, ਡਿਪਰੈਸ਼ਨ ਅਤੇ ਐਂਗਜ਼ਾਇਟੀ ਵਾਸਤੇ ਟੂਲ ਕਿੱਟਾਂ ਮੁਹੱਈਆ ਕਰਦੇ ਹਨ। ਦੇਖੋ [www.mentalhealthaddictions.bc.ca](http://www.mentalhealthaddictions.bc.ca).
- ਕਰੋਨਿਕ ਡੀਪਰੈਸ਼ਨ ਸੈਲਫ-ਮੈਨੇਜਮੈਂਟ ਪ੍ਰੋਗਰਾਮ, ਮਰੀਜ਼ਾਂ ਨੂੰ ਇਕ ਵਿਦਿਆ ਦੇਣ ਵਾਲਾ ਪ੍ਰੋਗਰਾਮ ਹੈ, ਜੋ ਸਾਰੇ ਬ੍ਰਿਟਿਸ਼ ਕੁਲੰਬੀਆ ਵਿਚ ਮੁਹੱਈਆ ਕੀਤਾ ਜਾਂਦਾ ਹੈ, ਜਿਹੜਾ ਸਿਹਤ ਦੀਆਂ ਜੀਰਣ ਸਮੱਸਿਆਵਾਂ ਲਈ ਅਮਲੀ ਹੁਨਰ ਸਿਖਾਉਂਦਾ ਹੈ। ਦੇਖੋ [www.coag.uvic.ca/cdsmp](http://www.coag.uvic.ca/cdsmp).
- ਖਪਤਕਾਰੀ ਅਤੇ ਸਵੈ-ਸਹਾਇਤਾ ਜੱਥੇਬੰਦੀਆਂ ਜਿਹਨਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ ਕਨੇਡੀਅਨ ਮੈਂਟਲ ਹੈਲਥ ਐਸੋਸੀਏਸ਼ਨ (ਟੈਲੀਫੋਨ: 1-800-555-8222; [www.cmha-bc.org](http://www.cmha-bc.org)), ਮੂਡ ਡਿਸਆਰਡਰਜ਼ ਐਸੋਸੀਏਸ਼ਨ ਔਫ ਬੀ.ਸੀ (ਟੈਲੀਫੋਨ: 604-873-0103; [www.mdabc.ca](http://www.mdabc.ca)) ਜਾਂ ਵਿਸ਼ੇਸ਼-ਰੋਗਾਂ ਦੇ ਸਹਾਇਤਾ ਗਰੁਪ, ਜਿਸਤਰਾਂ ਪੈਸਟਰਿਕ ਪੋਸਟ ਪਾਰਟਮ ਸਪੋਰਟ ਸੁਸਾਇਟੀ (ਟੈਲੀਫੋਨ: 604-255-7999; <http://www.postpartum.org/>) , ਇਹ ਜੱਥੇਬੰਦੀਆਂ ਜਾਣਕਾਰੀ ਅਤੇ ਸਹਾਇਤਾ ਪ੍ਰਦਾਨ ਕਰ ਸਕਦੀਆਂ ਹਨ।
- ਆਪਣੇ ਰੋਗ-ਲੱਛਣਾਂ ਦਾ ਹਿਸਾਬ ਰੱਖਣ ਲਈ ਇਕ ਰੋਜ਼ਾਨਾ ਮੂਡ ਚਾਰਟ ਰੱਖੋ। ਦੇਖੋ ਡਿਪਰੈਸ਼ਨ ਅਤੇ ਬਾਇਪੋਲਰ ਸਪੋਰਟ ਅਲਾਇੰਸ: <http://www.dbsalliance.org>.

ਯਾਦ ਰੱਖੋ, ਡਿਪਰੈਸ਼ਨ ਅਜਿਹੀ ਕੰਡੀਸ਼ਨ ਹੈ ਜਿਸਦਾ ਇਲਾਜ ਹੋਣ ਦੀ ਬਹੁਤ ਸੰਭਾਵਨਾ ਹੈ। ਬਹੁਤ ਲੋਕ ਇਸਤੋਂ ਚੰਗੀ ਤਰਾਂ ਮੁਕਤ ਹੋ ਜਾਂਦੇ ਹਨ ਅਤੇ ਸਾਰਥਕ ਤੇ ਖੁਸ਼ੀ ਭਰਿਆ ਜੀਵਨ ਬਤੀਤ ਕਰਦੇ ਹਨ।



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# Depresión

## Información para los pacientes y sus familias

(Depression - Information for Patients and their Families)

### ¿Qué es la depresión?

La depresión grave es una enfermedad tratable que involucra un desequilibrio de los químicos del cerebro llamados neurotransmisores. No es un trastorno de la personalidad o un signo de debilidad personal. La depresión debe distinguirse de las ocasiones en que una persona se siente triste o con estado anímico normal bajo. Una depresión “clínica” sucede cuando una persona sufre un “episodio”. Un episodio de depresión involucra por lo menos dos semanas de estado anímico depresivo o de pérdida de interés o placer, junto con varios otros síntomas, todo lo cual puede causar angustia o problemas para sobrellevar el trabajo o el hogar. Los síntomas más comunes de la depresión incluyen:

- tristeza o episodios en los cuales se llora sin explicación
- pérdida del placer o del disfrute de la vida
- subir o bajar de peso
- dormir mucho o muy poco
- sentirse inusualmente más irritable, enojado, preocupado, agitado, o ansioso
- más cansancio del usual
- sentimientos de culpabilidad o inutilidad
- tener problemas de concentración o para tomar decisiones
- sentirse o aislarse socialmente
- pensar en la muerte o en el suicidio.

### ¿A quién le da la depresión?

Si tiene depresión, no está solo. Más del 4% de las personas sufren de depresión en algún momento dado y alrededor del 15% de las personas tendrán depresión en algún momento de sus vidas.

### ¿Si tengo depresión, mis hijos sufrirán de depresión?

Ciertos tipos de depresión, especialmente el trastorno bipolar, parecen venir de familia. Sin embargo, ni siquiera los gemelos tienen el mismo riesgo de desarrollar la depresión. La depresión parece ser una combinación de vulnerabilidad a la depresión (parte de la cual puede heredarse pero no necesariamente), eventos difíciles en la vida y cambios bioquímicos en el cerebro.

### ¿Qué tipo de depresión tengo?

Hay varios tipos diferentes de depresión. Las personas que sufren de *trastornos de depresión graves* han tenido por lo menos un episodio de depresión grave – cinco o más síntomas de depresión que duren por lo menos dos semanas. Para algunas personas, este trastorno es *recurrente*, lo cual quiere decir que experimentan episodios de vez en cuando, una vez al mes, una vez al año o varias veces durante sus vidas. A las personas que han tenido depresión por más de dos años se les dice que sufren de depresión *crónica*.

Ciertos tipos de depresión pueden suceder durante algunos acontecimientos particulares en las vidas de las personas. Por ejemplo, la *depresión de posparto* sucede a veces en las mujeres después de dar a luz. El *trastorno afectivo estacional* es un tipo de depresión que sólo sucede durante los meses de invierno. También hay otras enfermedades diversas similares a la depresión, tales como la *distimia*, una forma de depresión generalmente leve, de larga duración (pero de todas formas grave) o el *trastorno bipolar* (algunas veces denominado como “el síndrome maniático depresivo”), donde hay estados de ánimo extremadamente altos y bajos.

### ¿Cuáles son mis opciones de tratamiento?

Hay muchos tipos diferentes de tratamientos para la depresión. Los principales tipos de tratamientos son ya sea los medicamentos o el tratamiento psicológico. Los medicamentos antidepresivos son una forma muy efectiva de tratamiento para la depresión. Es importante notar que los antidepresivos *no* son adictivos. Algunas personas, sin embargo, pueden experimentar efectos secundarios debido a los medicamentos; hable con su doctor acerca de las opciones de tratamiento con medicamentos. También pueden usarse diversos tipos de terapia psicológica para ayudar



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a tratar la depresión. Estos incluyen la “Terapia de comportamiento cognitiva” (*Cognitive Behavioural Therapy*; CBT, por sus siglas en inglés), “Terapia interpersonal” (*Interpersonal Therapy*; IPT, por sus siglas en inglés) y educación acerca de la depresión. La evidencia producto de la investigación muestra que la CBT es una forma especialmente efectiva de tratamiento para la depresión, si bien puede que sea difícil encontrar a un profesional de la salud mental capacitado en la CBT. En algunas partes de Columbia Británica, existe un programa de la CBT gratuito o muy económico llamado *Changeways* (refiérase a [www.changeways.com](http://www.changeways.com))

### **¿Cómo me puedo ayudar a mi mismo?**

Esfuércese en mantener un estilo de vida saludable. Hay diversas formas importantes, si bien básicas que le ayudarán a asegurar un estilo de vida balanceado, como por ejemplo:

- vestirse todos los días y darse el tiempo para ducharse y arreglarse
- ejercitar en forma regular
- comer alimentos saludables y nutritivos en forma regular
- dormir bien durante la noche
- evitar ingerir cafeína, droga o alcohol en exceso

### **¿Cómo puedo ayudar a un ser querido que está con depresión?**

Las familias que tienen un familiar con depresión pueden ayudar en diversas formas, incluyendo:

- proporcionar apoyo emocional y ayudar a solucionar problemas
- ayudar con las actividades del diario vivir (por ejemplo: hacer las compras de supermercado, ir a buscar recetas médicas, etc.)
- proporcionar un lugar seguro y estable para hospedarse si fuera necesario
- estimular el cuidado personal básico (comer en forma regular, higiene básica, etc.)
- estimular a los seres queridos a involucrarse en técnicas útiles de manejo autónomo
- ser una persona de contacto a quien llamar en situaciones de alto riesgo o tiempo de estrés
- ser positivo acerca del manejo de los altos y bajos de la recuperación, de forma que un decaimiento no tenga que ser una recaída.

### **¿Dónde puedo obtener más información?**

- Hay muchos libros excelentes de auto ayuda acerca de la depresión, incluyendo la “Guía de cuidado personal del paciente deprimido” (*Self-Care Depression Patient Guide*) realizada en UBC, la cual se puede descargar gratuitamente de [www.carmha.ca](http://www.carmha.ca). El “Manual sintiéndose bien” (*Feeling Good Handbook*) de David D. Burns, Plume Books (1999) y “La mente por sobre los estados de ánimo” (*Mind Over Mood*) de Dennis Greenberger y Christine A. Padesky, Zipper Books también son útiles. Para depresión de posparto, refiérase a “¿No debiera estar feliz?” (*Shouldn't I Be Happy?*) “Problemas emocionales de la mujer embarazada y en posparto” (*Emotional Problems of Pregnant and Postpartum Women*) de Shaila Misri, Doctora en medicina.
- La “Sociedad de Columbia Británica de información sobre la salud mental y las adicciones” (*Partners for Mental Health and Addictions Information of BC*) proporciona herramientas para enfermedades mentales, depresión y trastornos de ansiedad. Refiérase a [www.mentalhealthaddictions.bc.ca](http://www.mentalhealthaddictions.bc.ca).
- El “Programa de control autónomo de enfermedades crónicas” (*Chronic Disease Self-Management Program*) es un programa de educación de pacientes ofrecido en las comunidades en Columbia Británica, que enseña técnicas básicas acerca de cómo manejar problemas crónicos de salud. Refiérase a [www.coag.uvic.ca/cdsmp](http://www.coag.uvic.ca/cdsmp).
- Las organizaciones de auto ayuda y de ayuda al consumidor incluyen a la “Asociación canadiense de la salud mental” *Canadian Mental Health Association* (teléfono: 1-800-555-8222; [www.cmha-bc.org](http://www.cmha-bc.org)), la “Asociación de Columbia Británica de trastornos emocionales” (*Mood Disorders Association of BC*), Teléfono: 604-873-0103; [www.mdabc.ca](http://www.mdabc.ca) o grupos de apoyo específico del trastorno, tales como la “Sociedad del Pacífico de apoyo durante el posparto” (*Pacific Post Partum Support Society*), teléfono: 604 255-7999; [www.postpartum.org](http://www.postpartum.org) pueden proporcionar información y apoyo.
- Mantenga un gráfico diario de sus estados de ánimo para registrar sus síntomas. Refiérase a la “Alianza de apoyo bipolar y depresión” (*Depression and Bipolar Support Alliance*): [www.dbsalliance.org](http://www.dbsalliance.org).

**Recuerde, la depresión es una enfermedad altamente tratable. Muchas personas se recuperan bien de la enfermedad y llegan a tener vidas productivas y a disfrutar de la vida.**



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## BỆNH TRẦM CẢM hay SUY-NHUỘC TÂM-THẦN Thông-tin Cho Bệnh-nhân và Gia-đình của Họ

### **Bệnh Trầm-cảm hay Suy-nhuộc Tâm-thần là gì ?**

Bệnh Trầm-cảm hay Suy-nhuộc Tâm-thần là một tình-trạng có thể điều-trị được liên-quan đến sự bất-quân-bình của các chất hóa-học của bộ não, còn được gọi là chất dẫn-truyền thần-kinh. Đây không phải là sự hư-hại về cá-tính, và cũng không phải là dấu-hiệu của sự yếu-kém cá-nhân. Chúng ta nên phân-biệt bệnh suy-nhuộc tâm-thần với những lần mà một người trải qua những cảm-xúc xuống thấp hay buồn-bã một cách bình-thường. Bệnh suy-nhuộc tâm-thần “theo bệnh-lý” xảy ra khi một người trải qua một “biến-cổ”. Một biến-cổ suy-nhuộc tâm-thần liên-quan đến ít nhất là hai tuần-lễ mà cảm-xúc bị xuống thấp, hay bị mất hứng-thú, mất niềm vui, cùng những triệu-chứng khác, mà tất-cả những điều ấy gây sự phiền-não và khó-khăn cho sự đáp-ứng tại sở làm hay tại nhà. Những triệu-chứng thông-thường của bệnh suy-nhuộc tâm-thần gồm có:

- Những lần đột-ngột buồn-bã hay khóc-lóc không giải-thích được lý-do
- mất sự khoan-khoái hay lạc-thú đời-sống
- bị lên cân hay bị sút cân
- bị ngủ ít quá hay nhiều quá
- có cảm-giác bức-bội, giận-dữ, lo-lắng, căng-thẳng hay bồn-chồn một cách bất-thường
- cảm thấy mệt-mỏi hơn bình-thường
- cảm thấy mình tội-lỗi hay không có giá-trị
- khó lòng tập-trung tư-tưởng hay khi phải quyết-định việc gì
- có cảm-giác, hoặc trở nên cô-lập về mặt xã-hội
- có những ý-tưởng chết-chóc, hay có ý-định tự-tử

### **Ai là người có thể mắc bệnh Suy-nhuộc Tâm-thần ?**

Nếu bạn bị bệnh suy-nhuộc tâm-thần, hãy nhớ là không phải chỉ có mình bạn mà thôi. Lúc nào cũng có hơn 4% tổng-số dân-chúng bị suy-nhuộc tâm-thần, và có đến 15% dân-chúng sẽ bị suy-nhuộc tâm-thần vào một thời-điểm nào đó trong cuộc đời của họ.

### **Nếu tôi mắc bệnh suy-nhuộc tâm-thần, thì con cái tôi có bị mắc bệnh không ?**

Một vài loại bệnh suy-nhuộc tâm-thần, nhất là bệnh rối-loạn lưỡng-cực thần-kinh, có vẻ như là di-truyền trong gia-đình. Tuy vậy, ngay cả những người sinh đôi giống hệt nhau cũng không có mức-độ rủi-ro mắc phải bệnh suy-nhuộc tâm-thần ngang nhau, và bệnh này có vẻ như là sự tổng-hợp của mức-độ dễ mắc phải bệnh (mà một phần có thể là do di-truyền, nhưng không nhất-thiết phải là như vậy) và những biến-cổ khó-khăn của đời-sống, cùng những sự thay-đổi sinh-hóa-học trong bộ não.

### **Tôi mắc phải loại bệnh suy-nhuộc tâm-thần nào ?**

Có nhiều loại bệnh suy-nhuộc tâm-thần khác nhau. Những người bị **rối-loạn tâm-thần trầm-trọng** thì đã từng có ít nhất là một lần phát bệnh **suy-nhuộc tâm-thần trầm-trọng** - gồm có 5 triệu-chứng hay nhiều hơn, kéo dài ít nhất là 5 tuần-lễ. Đối với một số người, thì sự rối-loạn này có thể thuộc loại **tái-phát**, tức là họ sẽ trải qua những biến-cổ này rất thường - một tháng một lần, một năm một lần, hay có thể nhiều lần trong suốt cuộc đời của họ. Người nào bị bệnh suy-nhuộc tâm-thần kéo dài lâu hơn hai năm thì được xem là mắc bệnh suy-nhuộc tâm-thần **kinh-niên**.

Một số loại bệnh suy-nhuộc tâm-thần có thể xảy ra vào giai-đoạn đặc-biệt nào đó của đời-sống con người. Lấy thí-dụ như, **bệnh suy-nhuộc tâm-thần hậu-sản** đôi khi xảy ra cho phụ-nữ sau khi họ sanh con. **Bệnh rối-loạn ảnh-hưởng theo mùa** là một loại bệnh suy-nhuộc tâm-thần chỉ xảy ra vào những tháng mùa đông. Và cũng có nhiều tình-trạng khác tương-tự như bệnh suy-nhuộc tâm-thần, chẳng hạn như bệnh **khó-khăn tâm-thần (dysthymia)** – là một dạng bệnh suy-nhuộc tâm-thần thường là nhẹ hơn (nhưng vẫn là nghiêm-trọng), và có tác-dụng lâu dài hơn, hoặc **bệnh rối-loạn lưỡng-cực thần-kinh** (đôi khi còn được gọi là “bệnh suy-nhuộc tâm-thần thao cuống”), mà có cả hai loại cảm-xúc buồn vui lên xuống quá đáng.

### **Tôi có những cách điều-trị nào ?**

Có nhiều phương-cách khác nhau điều-trị rất tốt cho bệnh suy-nhuộc tâm-thần. Những cách điều-trị chính là điều-trị bằng thuốc, hay là bằng tâm-lý. Sử-dụng loại thuốc chống suy-nhuộc tâm-thần là một dạng điều-trị bệnh suy-nhuộc tâm-thần rất hiệu-nghiệm. Điều quan-trọng cần chú-ý ở đây là các loại thuốc chống suy-nhuộc tâm-thần **không** làm người ta ghiền. Tuy vậy, một số người có thể phải chịu những phản-ứng phụ từ thuốc của họ - xin bạn hãy thảo-luận các cách điều-trị bằng thuốc khác với bác-sĩ của bạn. Bác-sĩ cũng có thể dùng nhiều loại trị-liệu tâm-lý khác nhau để giúp việc điều-trị bệnh suy-nhuộc tâm-thần. Những cách này bao gồm Trị-liệu Cư-xử Trực-giác (Cognitive Behavioural Therapy) gọi tắt là CBT, Trị-liệu hỗ-tương (Interpersonal Therapy), và phương-cách giáo-dục về bệnh Suy-nhuộc Tâm-thần. Bằng-chứng nghiên-cứu cho thấy rằng CBT là một dạng điều-trị đặc-biệt rất là hữu-hiệu cho bệnh suy-nhuộc tâm-thần, mặc dù rất khó tìm được một chuyên-gia y-tế tâm-thần đã được huấn-luyện về phương-pháp CBT. Tại một số nơi



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trong tỉnh BC, người ta có cung-cấp một chương-trình nhóm CBT miễn-phí hoặc với giá rẻ gọi là *Changeways* (xin xem trang mạng lưới ([www.changeways.com](http://www.changeways.com)))

### ***Tôi có thể làm gì để tự giúp mình ?***

Bạn hãy nỗ-lực duy-trì một lối sống lành-mạnh. Có nhiều cách đơn-giản nhưng quan-trọng giúp bạn bảo-đảm có một lối sống quân-bình, chẳng hạn như

- thay quần-áo mỗi ngày, và dành thì-giờ để tắm rửa và làm gọn-ghế
- tập thể-dục đều-đặn
- ăn những thức ăn lành-mạnh, và ăn những bữa ăn đều-đặn, bổ-dưỡng
- đi ngủ đầy-đủ
- tránh dùng quá nhiều chất cà-phê, thuốc hay rượu

### ***Tôi làm thế nào để có thể giúp một người thân đang bị bệnh suy-nhược tâm-thần ?***

Những thành-viên trong gia-đình của người bị bệnh suy-nhược tâm-thần có thể giúp bằng nhiều cách, bao gồm cả việc

- cung-cấp sự hỗ-trợ về mặt tình-cảm, và giúp-đỡ họ khi giải-quyết vấn-đề
- giúp-đỡ họ trong những hoạt-động đời-sống thường ngày (chẳng hạn như mua tạp-hóa, điền đơn mua thuốc, vân vân..)
- cung-cấp cho họ một chỗ để ở an-toàn và ổn-định khi cần
- khuyến-khích họ trong sự chăm-sóc những việc đơn-giản cho chính mình (ăn-uống đều-đặn, vệ-sinh cá-nhân..vân vân..)
- khuyến-khích người thân của họ tham-gia vào những kỹ-năng tự điều-hành có ích-lợi
- đóng vai-trò là người liên-lạc cho họ trong những trường-hợp nhiều rủi-ro, hay trong những dịp nhiều căng-thẳng
- có thái-độ tích-cực khi phải đối-phó với tình-trạng lên xuống thất-thường trong thời-kỳ hồi-phục của họ, để những lần họ làm-lỡ không trở thành lần bệnh bị tái-phát

### ***Tôi có thể lấy thêm tin-tức ở đâu ?***

- Có nhiều sách tự học rất tốt về bệnh Suy-nhược Tâm-thần, kể cả tập sách *Hướng-dẫn Tự Chăm-sóc dành cho Bệnh-nhân bệnh Suy-nhược Tâm-thần* (*Self-Care Depression Patient Guide*) do trường đại-học UBC soạn ra, mà bạn có thể chuyển xuống máy điện-toán của bạn không mất tiền từ trang mạng lưới [www.carmha.ca](http://www.carmha.ca). Những quyển sách như *Cảm-Nang Cảm Thấy Khỏe* (*Feeling Good Handbook*) do David D. Burns viết, sách Plum Books (1999) và quyển *Lý-trí thắng Cảm-xúc* (*Mind Over Mood*) do Dennis Greenberger và Christine A. Padesky viết, và bộ sách Zipper Books cũng rất có ích. Đối với bệnh Suy-nhược Tâm-thần Hậu-sản, xin bạn xem quyển "Tôi không nên cảm thấy vui hay sao?" (*Shouldn't I Feel Happy?*), "Những vấn-đề tình-cảm của phụ-nữ đang có mang và sau khi sanh" (*Emotional Problems of Pregnant and Postpartum Women*) do Bác-sĩ Shaila Misri viết
- Cơ-quan Thông-tin về các Sự nghiê-n-gập và Sức-khỏe Tâm-thần của Nhóm Bằng-hữu tỉnh BC cung-cấp Túi Điều-trị các bệnh Rối-loạn Tâm-thần, bệnh Suy-nhược Tâm-thần và bệnh Rối-loạn Lo-lắng. Xin bạn xem trang mạng lưới [www.mentalhealthaddictions.bc.ca](http://www.mentalhealthaddictions.bc.ca) .
- Chương-trình Tự-quản-trị Bệnh Kinh-niên là một chương-trình giáo-dục dành cho bệnh-nhân được mở ra trong các cộng-đồng ở khắp tỉnh British Columbia, và chương-trình này dạy những kỹ-năng thực-dụng về việc quản-trị những trở-ngại sức-khỏe kinh-niên. Xin bạn xem trang mạng lưới [www.coag.uvic.ca/cdsmp](http://www.coag.uvic.ca/cdsmp)
- Các Tổ-chức Tự-trợ và Tiêu-thụ, bao gồm cả Hiệp-hội Y-tế Tâm-thần Gia-nã-đại (điện-thoai số 1-800-555 8222) tại trang mạng lưới [www.cmha-bc.org](http://www.cmha-bc.org) , Hiệp-hội bệnh Rối-loạn Cảm-xúc của BC (điện-thoai số 604-873-0103; [www.mdabc.ca](http://www.mdabc.ca) ), hay những Nhóm Hỗ-trợ chuyên-biệt về Bệnh rối-loạn, chẳng hạn như Hiệp-hội Hỗ-trợ Hậu-sản vùng Thái-bình-Dương (điện-thoai số 604-255-7999; trang mạng lưới <http://www.postpartum.org>) có thể cung-cấp những thông-tin và sự hỗ-trợ.
- Bạn hãy giữ một biểu-đồ cảm-xúc hàng ngày để theo-đổi những triệu-chứng của bạn. Xin bạn xem qua trang mạng lưới của Liên-hữu hỗ-trợ bệnh Suy-nhược Tâm-thần và bệnh Suy-nhược lưỡng-cực thần-kinh tại trang mạng lưới <http://www.dbsalliance.org> .

**Bạn nên nhớ rằng, bệnh trầm-cảm hay suy-nhược tâm-thần là một tình-trạng rất dễ điều-trị. Đã có nhiều người hồi-phục lại rất tốt sau khi bị bệnh, và tiếp-tục sống một cuộc sống có kết-quả và vui-thú.**



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# ANXIETY DISORDER: Information for Patients & their Families



# Anxiety Disorders

## Information for Patients and their Families

### ***What is anxiety?***

Anxiety is a normal and adaptive emotion that is important to our survival. Anxiety can help keep us away from situations that are perceived as being dangerous. Anxiety is associated with a *fight-flight-freeze* response, which is an alarm reaction - it causes physiological changes that increase our ability to fight against a source of danger, run away from something dangerous, or remain still enough to avoid being detected by a source of danger.

The following are common symptoms of anxiety:

- **Emotions:** anxiety, fear, worry, or other unpleasant emotions such as irritability, anger, and sadness
- **Body Reactions:** difficulty breathing, rapid heartbeat, nausea, dizziness, or other signs of the fight-flight-freeze response
- **Behaviours:** avoiding things, excessively seeking reassurance, distraction, safety rituals, compulsive behaviours, or other acts used to counteract anxiety
- **Thoughts:** unwanted and distressing thoughts, urges, memories, or images ("what if something really bad happens") as well as memories of past traumatic experiences or unwanted thoughts of harming someone.

Anxiety can become problematic if it occurs persistently, if there is no objective source of danger, and if it keeps us from entering non-dangerous situations (e.g., going to the mall, using public washrooms, talking to others).

### ***What are panic attacks?***

Panic attacks are a sudden rush of intense anxiety, fear, or terror along with physical symptoms (e.g., rapid heart rate, shortness of breath) and concern about losing control, dying, or losing one's mind. Panic attacks can be a symptom of any of the anxiety disorders. Although symptoms of a panic attack may be extremely uncomfortable, they are part of the body's natural response to perceived danger and are not harmful.

### ***Normal Anxiety vs. Anxiety Disorders: How do I tell the difference?***

Just because we have anxiety symptoms does not mean we have an anxiety disorder. The diagnosis of an anxiety disorder is considered only when the anxiety symptoms: are excessive and do not go away with time; interfere with quality of life and personal happiness; or interfere with functioning in work, school, home, or social settings.

Anxiety disorders are more than just problems coping with stress. Anxiety disorders are real health problems. Anxiety disorders tend to become chronic or even worsen over time if they are not identified and well-managed.

### ***What type of anxiety disorder do I have?***

There are several different anxiety disorders that have unique features, including:

- **panic disorder:** recurrent, unexpected panic attacks and/or excessive concern about having a panic attack
- **agoraphobia:** anxiety about being in a place or situation from which escape would be difficult or embarrassing and/or where help might not be available
- **obsessive-compulsive disorder:** recurrent obsessions (intrusive thoughts, impulses, or images) and compulsions (repetitive behaviours)
- **social phobia:** marked and persistent fear of social or performance situations in which embarrassment might occur
- **generalized anxiety disorder:** excessive and ongoing anxiety and worry about a number of events or activities
- **post-traumatic stress disorder:** the development of traumatic symptoms following exposure to an extreme trauma involving threat of death or serious injury
- **specific phobias:** persistent fear of a specific object or situation

For more information about anxiety disorders and symptoms see the Anxiety Disorders Toolkit at [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)

**Please note that the Chinese, Korean, Punjabi, Spanish and Vietnamese versions of the Patient/Family Member Information Sheets on Depression, Anxiety Disorders, Early Psychosis and Substance Use are not exact, up-to-date translations of the English versions.**



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### ***What causes anxiety disorders?***

There is no single cause of anxiety disorders. For most people, anxiety disorders result from a combination of several risk factors. Risk factors include family history of anxiety or depression, negative life experiences, substance use, presence of another mental health problem, medical conditions, lack of social support, the tendency to see things as dangerous, and using avoidance as a way of coping. Adults with lower socioeconomic status (i.e., lower incomes) and women are also more likely to develop certain anxiety disorders.

**You are not alone.** If you are coping with an anxiety disorder, over 400,000 adults in BC can relate to what you and your family are going through. Anxiety disorders are the most common type of mental health problem. Over one in four people will experience an anxiety disorder at some point in their lives. At least one in ten people are currently suffering from at least one anxiety disorder. At least half of these people are also coping with depression or some other kind of mental health or substance use problem such as alcohol abuse.

### ***Are there effective treatment options?***

The good news is that anxiety disorders are highly treatable. Approximately eight out of every ten people with anxiety disorders experience benefits from treatments involving cognitive-behavioural therapy, medications, or a combination of both.

**Cognitive Behavioural Treatments (CBT)** emphasize new skills that are also highly effective in lowering anxiety (whether taking medications or not). CBT includes learning about symptoms and triggers, relaxation training, cognitive skills training (identifying and challenging anxiety-provoking thoughts), building tolerance (via gradual exposure to fears), and relapse prevention planning.

**Medication** treatment usually involves taking an antidepressant medication (e.g., serotonin reuptake inhibitor). Even though symptoms often return when medications are stopped, many people find one of the antidepressants to be an effective treatment option for managing anxiety disorders. It usually takes several weeks for the benefits to be felt, and some people experience negative side effects including problems with sexual functioning. Sometimes fast-acting benzodiazepines are prescribed for short-term anxiety management, but they are not recommended for long-term use as they can be addictive and the withdrawal symptoms include anxiety.

### ***What steps do I need to take next?***

- Increase your knowledge about anxiety. Get more information about anxiety disorders, including finding out about the other types of mental health and substance use problems that often occur along with anxiety (e.g., depression).
- Take the anonymous screening test at [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca). Print out the results and discuss with your family physician or health professional.
- Talk to your family physician or health professional about your symptoms and how they are affecting your life.
- Ask for a full assessment of the mental health or substance use issues you are facing.
- Ask for evidence-based treatment options that have been shown to work (e.g., CBT and/or medications).
- Talk to your family physician about getting a referral to a specialist who can provide more intensive training in daily self-management skills.
- Talk to trusted family or friends to get added support during your recovery and maintenance plan.
- Take care of the basics in self-care including regular exercise, healthy eating, getting enough sleep and reducing excessive use of substances such as caffeine, alcohol, and benzodiazepines.



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### ***Where can I get more information?***

- **BC Partners for Mental Health and Addictions Information ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) or 1-800-661-2121)**
  - Free resources include:
    - **Anxiety Disorders Toolkit:** self-test, symptoms of anxiety disorders, treatment options and more
    - **Mental Disorders Toolkit:** options for living well in the face of mental illness
    - **Wellness Modules:** strategies for basic self-care and stress management
    - **Fact Sheets:** basic information on common mental health and substance use topics
    - **Family Toolkit:** key information for family and friends.
- **Anxiety Disorders Association of BC ([www.anxietybc.com](http://www.anxietybc.com))**
  - Free resources include self-help reading lists, links to other anxiety websites, and personal stories.
- **The Panic Centre ([www.paniccenter.net](http://www.paniccenter.net)) or Anxieties.com ([www.anxieties.com](http://www.anxieties.com))**
  - Free web-based self-management programs you can follow in the comfort and privacy of your own home.
- **Knowledge Network ([www.knowledgenetwork.ca/takingcare/index.html](http://www.knowledgenetwork.ca/takingcare/index.html))**
  - Child and youth mental health documentaries on anxiety.
- **Evidence based books, videos, and audiotapes**
  - Check out bookstores, libraries, and the web for evidence-based self-management resources (ask them to add resources they don't have to their catalogue). Examples include:
    - **The Anxiety & Phobia Workbook** (2000), by E.J. Bourne (New Harbinger Publications). See additional books and audiotapes by the same author.
    - **Mastery of Your Anxiety and Panic** (2000) by M.G. Craske & D.H. Barlow (Graywind Publications, [www.graywindpublications.com](http://www.graywindpublications.com)). See additional titles in this Mastery series for other anxiety disorders including specific phobias and obsessive-compulsive disorder.

***Remember: People with anxiety disorders can manage their symptoms and live rewarding and productive lives.***



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# 焦慮症

## Anxiety

### 患者與家屬須知

#### 何謂焦慮？

焦慮是正常的情緒反應，焦慮使我們遠離危險的情境，沒有焦慮人無法生存。以下是常見的焦慮症狀：

- 情緒反應：焦慮、害怕，及其他負面的情緒，如躁怒、氣憤和悲傷
- 身體反應：呼吸困難、心跳加速、噁心、暈眩和其他調節緊張狀態及反應
- 行為上：逃避、再三要求保證、容易分心、重複強調安全的異常行徑、強迫性行為，以及其他刻意淡化焦慮的行徑
- 思想上：揮之不去的惱人念頭、衝動、記憶和影像（“如果真的發生怎麼辦”），以及過去心理受創的記憶，或有傷害他人的妄念

#### 何謂恐慌症？

恐慌症是突如其來的一陣強烈焦慮、害怕或恐懼，伴隨有身體的症狀（如心跳加速、呼吸困難），擔心失控、死亡或發狂。每三個成人就有一人有這種經驗（包括許多沒有焦慮症的人都有過），恐慌症也可能併隨有各種焦慮症狀。

#### 如何區分正常的焦慮與真正的焦慮症？

有焦慮症狀並不表示有焦慮症，出現下列症狀時，才需考慮就診：

- 焦慮症狀頻繁，且持續未見好轉
- 影響生活品質和個人幸福
- 影響工作、求學、家庭、社交

如果沒有發現並予治療，久而久之，焦慮症會變成慢性病，甚至惡化。焦慮症不只是在調適壓力上有困難，而是真正的疾病。

#### 我罹患的是哪一種焦慮症？

焦慮症有好幾種，各有不同的症狀，包括恐慌症、廣場恐懼症、強迫症、社交焦慮症、一般性的焦慮症、心理受創後壓力症、以及特定的恐懼症。有關焦慮症及其症狀，請上 [www.hcrctohelp.bc.ca](http://www.hcrctohelp.bc.ca) 網站，查詢『焦慮症百寶箱』（Anxiety Disorders Toolkit）。

#### 焦慮症的成因？

焦慮症沒有單一的特定成因，大多數的人都是綜合好幾個因素形成的，包括有焦慮或憂鬱症的家族史、負面的生活經驗、藥物濫用、有其他精神問題、其他疾病、缺乏社會支援、對事情多採負面觀點、處理事情多採逃避方式；社經地位較低（意即收入較低）的成年人與婦女，也較容易罹患某些焦慮症。

你並不孤單。如果你正為焦慮症所苦，在卑詩省有超過四十萬成年人對你 and 家



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人所經歷的都能感同身受。焦慮症是最常見的心理健康問題，有四分之一以上的人一生中會有焦慮症狀出現，至少有十分之一的人目前正為至少一種焦慮症狀所苦，這些人中至少有一半有憂鬱症、或其他種類的精神問題、或是藥物濫用如酗酒之類的問題。

### 有有效的治療方法嗎？

好在焦慮症的治癒率很高，治療的方法有藥物治療、認知行為治療、或者雙管齊下的綜合療法。大約十分之八的焦慮症患者，接受治療後都見成效。

藥物治療有多種不同的抗鬱劑，通常是服用其中的一種（例如：血清素再吸收抑制劑）。雖然停藥後，症狀常會復發，許多人發現總有一種抗鬱劑對控制焦慮症非常有效，通常需幾週時間才見藥效，有些人會有負面的副作用，如性功能障礙。有時醫生會開療效快速的 benzodiazepines 安眠鎮靜劑，以便在短期內控制焦慮，但不建議長期使用，因為會造成對藥物依賴，而且會有包括焦慮症狀的畏縮症狀出現。

認知行為治療強調能有效降低焦慮的新技能（無論是否服藥），認知行為治療包含了解症狀和誘因、放鬆訓練、認知技能訓練（辨識與正視導致焦慮的思維方式），強化包容性（經由漸進式地面對恐懼），以及預防病症復發的訓練，但並不是每一個社區都有提供認知行為治療。

### 接下來該做什麼？

- 獲得更多有關焦慮症的資訊，加強自己這方面的知識，同時也蒐集常伴隨焦慮問題出現的其他心理健康問題（如憂鬱症）或藥物濫用的資料
- 上 [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) 網站做匿名檢測，將結果印出來，拿給家庭醫生或醫療專業人員看
- 將症狀及其對生活的影響，告訴家庭醫生或醫療專業人員
- 要求對自己正面臨的心理健康問題或濫用藥物問題，作全面性的評估。
- 要求接受已證實具有成效的治療（例如藥物和認知行為治療）
- 要求家庭醫生轉介能提供日常自我管理技能密集訓練的專科醫師
- 和可信靠的家人或朋友談，以便在療愈期間獲得更多支援
- 自行打理基本的自我照護工作，包括規律的運動、吃的健康、睡眠充足和減少過量使用咖啡因、酒精和安眠鎮靜劑

### 何處取得更多資訊？

- 『卑詩省心理衛生與成癮資訊合作夥伴』（Partners for Mental Health and Addictions Information）([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) 或致電 1-800-661-2121)
  - 免費資源有
    - **焦慮症百寶箱 (Anxiety Disorders Toolkit):** 自我測試、焦慮症症狀、治療方法及更多資料
    - **精神障礙百寶箱 (Mental Disorders Toolkit):** 面對精神疾病自在生活妙方
    - **健康法寶 (Wellness Modules):** 基本自我照護與壓力處理策略
    - **真相釋疑 (Fact sheets):** 有關常見心理健康話題與濫用藥物話題的



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#### 基本資訊

- 家庭百寶箱 (*Family Toolkit*): 家人與朋友須知
- 卑詩省焦慮症協會 (**Anxiety Disorders Association of BC**) ([www.anxietybc.com](http://www.anxietybc.com))  
免費資源包括自助書單、與其他焦慮症相關網站連結、及患者切身經驗
- 恐慌症中心 (**The Panic Center**) ([www.paniccenter.net](http://www.paniccenter.net)) 或是 **Anxieties.com** ([www.anxieties.com](http://www.anxieties.com))  
網路上有免費的自我管理課程，可在家裡上網。
- 有實證經驗的書籍、錄影帶和錄音帶  
查詢書店、圖書館和有實際經驗根據的自我管理資源 (可要求這些單位將其沒有的資源加入其目錄中)，例如：
  - 《焦慮症與恐懼症手冊》 (**The Anxiety & Phobia Workbook**) (2000 年出版) E.J. Bourne 著. New Harbinger Publications 出版 (參閱作者出版的其他書籍和錄音帶)。
  - 《克服焦慮與恐慌》 (**Mastery of Your Anxiety and Panic**) (2000 年出版) M.G. Craske 與 D.H. Barlow 合著 D.H. Graywind Publications 出版 [www.graywindpublications.com](http://www.graywindpublications.com) (參閱該系列叢書其他有關焦慮症的書籍，包括特定恐懼症和強迫症)。

你會發現，焦慮症患者可以控制其症狀，過著有生產力與有意義的生活。



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# 불안장애

## 환자와 가족들을 위한 정보

### Anxiety

Information for Patients and their Families

#### 불안이란 무엇인가?

불안감은 정상적인 감정이다. 불안감은 우리가 위험한 상황으로부터 피할 수 있도록 도와주며 만일 불안감이 없다면 아마 우리 인간은 살아남지 못할것이다.

다음은 일반적인 불안감의 증세이다.

- 감정: 불안함, 두려움과 노여움, 화남, 그리고 슬픔등과 같은 다른 부정적인 감정들
- 신체적 반응: 호흡곤란, 빠른 심장박동, 메스꺼움, 어지러움, 그리고 flight-flight-freeze 반응
- 행동: 회피행동, 지나친 재확인을 요구함, 주의산만, 안전을 위한 의식, 강박적인 행동, 그리고 그 외 불안감을 완하시킬 수 있는 행동들.
- 생각: 원치않거나 고민되는 생각들, 급히 서두름, 기억들, 망상(정말로 나쁜일이 일어나면 어쩌지), 그리고 크게 상처를 받았거나 원치 않던 다른사람에게 해를 끼쳤던 과거경험들을 떠올린다.

#### 초조감 발작이란 무엇인가?

초조감 발작 (panic attacks) 은 신체적인 반응을 동반하는 갑작스러운 극도의 불안감, 두려움, 또는 초조감이다. (예, 빠른 심장 박동수, 호흡곤란) 그리고 자제력 상실, 그리고 이성의 상실 또는 완전한 사라짐이다. 초조감 발작은 어른 세명중 한명이 겪는 증세이며(불안장애를 겪지 않는 사람들도 포함) 모든 불안장애의 증세가 될 수 있다.

#### 보통 불안증과 불안장애는 어떻게 다른가?

어떤이가 불안증을 가지고 있다고 해서 모두 불안장애는 아니다. 불안장애로 진단되는 증세들은 다음의 증세들 뿐이다.

- 증세들이 극심하며 시간이 지나도 사라지지 않을 때.
- 삶의 질과 행복에 방해 될 때.
- 학교나, 직장, 집, 또는 사회적 생활에 방해가 될 때.

불안장애는 밝혀지지 않거나 제대로 관리가 되지 않는 상황에서 증세가 더 심해지거나 만성으로 발전될 수 있다. 불안장애는 스트레스에 대해서 대처 할 수 없는것 뿐만이 아니라 심각한 건강상의 문제인 것이다.

#### 나는 어떤 종류의 불안장애를 앓고 있나?

불안장애에는 각자의 독특한 증세에 따라 다양한 종류로 나뉜다. 초조감 장애(panic disorder), 광장 공포증(agoraphobia), 강박장애(obsessive compulsive disorder), 사회적 불안장애 (social anxiety disorder), 일반 불안장애 (generalized anxiety diorder), 충격 후의 스트레스 장애 (post traumatic stress disorder), 그리고 특정 초조감 등이 그것이다. 불안장애와 이의 증세들에 대한 더 많은 정보는 불안장애 가이드 라인(Anxiety Disorders Toolkit) 사이트 [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)에서 얻을 수 있다.

#### 불안장애의 원인은 무엇인가?

불안장애의 원인은 한가지 뿐만이 아니다. 거의 모든 사람들이 한가지 이상의 복합적인 위험요소들을 갖고 있다. 이의 위험 요소들에는 집안에 불안증이나 우울증을 겪고 있거나, 부정적인 삶의 경험에 있거나, 약물치료, 또 다른 정신적인 문제, 질병, 사회로부터의 도움의 결핍, 사물을 위험하게 보는 경향, 대처상황때 회피함 등이 있다. 경제적으로 낮은 위치에 있는 성인들과 여성들이 불안장애를 더 많이 갖게 된다.

귀하는 혼자가 아니다. 만일 귀하가 불안장애를 겪고 있다면, BC주에서도 400,000명이 넘는 사람들이 귀하와 귀하의 가족들이 경험하고 있는것을 똑같이 겪고 있다. 불안장애는 가장 흔히 나타나는 정신적 문제이다. 전체 인구중 네명중 한명꼴이 그들의 일생에서 한번쯤은 이런 불안장애를 경험할 것이며적어도 10명 중 1명이 현재 불안장애를 겪고 있다. 적어도 이중 반이상은 우울증과 또 다른 정신적 문제나 약물 복용, 알콜 남용 등의 문제들을 경험하게 된다.

#### 효과적인 치료방법들이 있는가?

다행히도 불안장애는 쉽게 치료가 가능하다. 정신 불안장애를 겪고 있는 사람들중 약 10명중 8명이 약물치료와, 인지 행동 치료, 그리고 이 두가지를 합한 치료방법등으로 효과를 보았다.



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약물치료는 다양한 종류의 항울제 (예 Serotonin Reuptake Inhibitors) 등의 치료제가 포함된다. 약물치료를 중단하게 되면 증세들이 다시 나타나기도 하지만 많은 사람들에게 이런 항울제는 매우 효과적인 불안장애 치료법으로 사용되어 지고 있다. 치료가 시작된 후 호전 기미를 보이기까지는 약 몇주가 소요되며 특정 사람들에게서는 성기능면에서의 부작용등이 보이기도 한다. 때때로 빠른 시간내에 효과를 보이는 신경 안정제인 벤조디아제핀등이 짧은 시간내에 불안장애를 없애기 위하여 처방되기도 하지만 이 처방은 중독성이 강하고 투여를 멈추었을때 불안감을 더 고조시키는 허탈증세가 나타날 수 있으므로 보통 긴 치료를 갖게 되는 상황에서는 추천하지 않는다.

인지 행동 치료 (CBT)는 (약물치료를 병행 하거나 하지 않던 간에)불안감을 감소시키는데 매우 효과적으로 사용되는 기법이다. CBT 는 불안장애의 원인과 증세들을 배우고, 마음을 편안하게 할 수 있는 기술, 인식 기술(불안증을 없애는 생각을 알아차리고 극복하는), 견뎌낼 수 있는 능력 (지속적인 초조감에 대한 노출을 통하여) 그리고 재발 예방 계획 등을 익혀가는 과정이다. CBT 과정은 모든곳에서는 준비되어 있지 않다.

### 다음에는 무엇을 해야 하나?

- 감정 장애에 대한 더 많은 정보를 얻어서 극복할 수 있는 능력을 지닌다. 또한 감정 장애와 함께 나타날 수 있는 다른 정신적 질환들(예, 우울증)과 약물치료에 대한 정보를 찾는다.
- 웹사이트 [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) 에서 자주치료 스크리닝 테스트를 받는다. 그리고 결과물을 뽑아서 가족이나 의사, 또는 건강 전문가들에게 보여준다.
- 가족이나 의사, 또는 건강 전문가들에게 자신의 증세들과 이런 증세들이 귀하의 삶에 어떤 영향을 끼치는지에 대해서 이야기를 나눈다.
- 귀하가 겪고있는 정신적 문제와 약물치료등에 대하여 충분한 평가를 부탁한다.
- 충분한 증거가 있는 치료방법들을 택하고 빠짐없이 치료에 참여한다. (예 약물치료 그리고/또는 CBT)
- 가정의에게 좀 더 강한 매일 자기 관리법 기술을 트레이닝 받을 수 있는 스페셜리스트를 소개 받는다.
- 회복, 유지 기간에는 믿을 수 있는 가족이나 친구의 도움을 받을 수 있도록 이야기 한다.
- 자기관리에 신경쓴다. 규칙적인 운동, 건강한 음식, 충분한 수면, 그리고 카페인과, 알콜 그리고 신경안정제등의 지나친 약물 복용을 줄인다.

### 보다 자세한 정보를 어디서 얻을 수 있나?

- BC주 정신 건강과 중독 정보 파트너 ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) 또는 1-800-661-2121) 무료 공급
  - 불안장애 자료집: 자기진단, 불안장애의 증세들, 치료방법 등
  - 정신장애 자료집: 정신 질환을 앓고 있는 경우를 위한 방법들
  - 건강관리 기본: 기본적인 자기 관리와 스트레스 조절을 위한 해결책
  - 안내서: 정신 건강과 약물치료에 관한 기본적인 정보
  - 가족 자료집: 가족과 친구들을 위한 중요 정보
- BC주 불안장애 협회 ([www.anxietybc.com](http://www.anxietybc.com)) 자기 도움에 관한 읽을거리, 다른 불안증에 관한 웹사이트들의 링크, 그리고 개인적인 사례등의 무료 공급
- 초조감 관리 센터 ([www.paniccenter.net](http://www.paniccenter.net)) 또는 불안증닷컴 ([www.anxieties.com](http://www.anxieties.com)) 집에서 편안하게 사용할 수 있는 무료 인터넷 자기관리 프로그램 제공
- 입증된 책, 비디오, 오디오 테이프
  - 입증된 자기 관리에 관한 정보를 서점이나 도서관, 또는 인터넷에서 얻을 수 있다. (보기)
    - 불안증과 공포증 워크북 (The Anxiety & Phobia Workbook) (2000) by E. J Bourne. New Harbinger Publications (같은 저자가 지은 또 다른 책과 테이프도 있음)
    - 귀하의 불안과 공포를 정복하기 (Mastery of Your Anxiety and Panic) (2000) by M.G. Craske & D. H. Barlow, D.H Graywind Publications. [www.graywindpublications.com](http://www.graywindpublications.com) ( 특정 공포증과 강박장애 같은 다른 종류의 불안장애들에 관한 이 Mastery 시리즈도 있음)

**불안장애를 가진사람들이 어떻게 자신의 증세들을 이겨내고 즐겁고 생산적인 삶을 살 수 있는지에 대해 배울 수 있게 될 것입니다.**



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## ਐਂਗਜ਼ਾਇਟੀ ਦੇ ਰੋਗ ਮਰੀਜ਼ਾਂ ਅਤੇ ਉਹਨਾਂ ਦੇ ਪਰਿਵਾਰਾਂ ਲਈ ਜਾਣਕਾਰੀ

### ਐਂਗਜ਼ਾਇਟੀ ਕੀ ਹੈ?

ਐਂਗਜ਼ਾਇਟੀ (ਘਬਰਾਹਟ) ਇੱਕ ਸਾਧਾਰਨ ਮਨੋਵੇਗ ਹੈ। ਐਂਗਜ਼ਾਇਟੀ ਸਾਨੂੰ ਖਤਰਨਾਕ ਸਥਿਤੀਆਂ ਤੋਂ ਦੂਰ ਰਖਦੀ ਹੈ। ਬੇੜੀ ਬਹੁਤ ਐਂਗਜ਼ਾਇਟੀ ਤੋਂ ਬਿਨਾਂ ਅਸੀਂ ਬਚੇ ਨਹੀਂ ਰਹਿ ਸਕਦੇ। ਐਂਗਜ਼ਾਇਟੀ ਦੇ ਆਮ ਲੱਛਣ ਹੇਠਾਂ ਲਿਖੇ ਹਨ:

- **ਮਨੋਵੇਗ:** ਐਂਗਜ਼ਾਇਟੀ, ਡਰ ਅਤੇ ਹੋਰ ਨਾਂਹ ਪੱਖੀ ਮਨੋਵੇਗ ਜਿਵੇਂ ਖਿੜ, ਗੁੱਸਾ, ਅਤੇ ਉਦਾਸੀ।
- **ਸਰੀਰਕ ਪ੍ਰਤੀਕਰਮ:** ਸਾਹ ਲੈਣ ਵਿੱਚ ਦਿੱਕਤ, ਦਿਲ ਦੀ ਧੜਕਣ ਤੇਜ਼, ਕਚਿਆਹਣ, ਚੱਕਰ ਅਤੇ ਫਲਾਈਟ-ਫਲਾਈਟ-ਫਰੀਜ਼ ਦੇ ਹੋਰ ਚਿੰਨ੍ਹ।
- **ਵਿਵਹਾਰ:** ਕੰਮ ਕਰਨ ਤੋਂ ਕਤਰਾਉਣਾ, ਲੋੜ ਤੋਂ ਵੱਧ ਸਹਾਰਾ ਭਾਲਣਾ, ਧਿਆਨ-ਭੰਗ ਹੋਣਾ, ਬਚਾ ਦੀਆਂ ਰਹੁਰੀਤਾਂ, ਜ਼ੋਰਾਵਰ ਵਿਵਹਾਰ, ਅਤੇ ਹੋਰ ਕੋਈ ਵੀ ਕਰਮ ਜੋ ਐਂਗਜ਼ਾਇਟੀ ਤੋਂ ਬਚਾ ਸਕੇ।
- **ਵਿਚਾਰ:** ਅਣਚਾਹੇ ਅਤੇ ਦੁਖਦਾਈ ਵਿਚਾਰ, ਉਕਸਾਊ ਪ੍ਰੇਰਣਾਵਾਂ, ਯਾਦਾਂ, ਜਾਂ ਦ੍ਰਿਸ਼ (“ਜੇ ਸਚਮੁਚ ਹੀ ਕੁਝ ਭੈੜਾ ਵਾਪਰ ਗਿਆ”) ਅਤੇ ਬੀਤੇ ਦੀਆਂ ਸਦਮਾਜਨਕ ਘਟਨਾਵਾਂ ਦੀਆਂ ਯਾਦਾਂ ਜਾਂ ਕਿਸੇ ਨੂੰ ਨੁਕਸਾਨ ਪਹੁੰਚਾਣ ਦੇ ਅਣਚਾਹੇ ਖਿਆਲ।

### ਪੈਨਿਕ ਅਟੈਕ (ਹੌਲਨਾਕ ਹਮਲੇ) ਕੀ ਹਨ?

ਪੈਨਿਕ ਅਟੈਕ ਅਚਾਨਕ ਅਤਿਅੰਤ ਘਬਰਾਹਟ, ਭੈਅ, ਜਾਂ ਦਹਿਸ਼ਤ ਦਾ ਨਾਮ ਹੈ ਜਿਸ ਦੇ ਨਾਲ ਸਰੀਰਕ ਲੱਛਣ (ਜਿਵੇਂ: ਦਿਲ ਦੀ ਤੇਜ਼ ਧੜਕਣ, ਸਾਹ ਦਾ ਚੜ੍ਹਨਾ) ਵੀ ਪਰਗਟ ਹੁੰਦੇ ਹਨ; ਚਿੰਤਾ ਹੁੰਦੀ ਹੈ, ਕੰਟਰੋਲ ਨਾ ਰਹਿਣ ਦੀ, ਮਰਨ ਦੀ, ਜਾਂ ਦਿਮਾਗ ਹਿੱਲ ਜਾਣ ਦੀ। ਪੈਨਿਕ ਅਟੈਕ, ਤਿੰਨਾਂ ਪਿਛੇ ਇੱਕ ਬਾਲਗ ਵਿਅਕਤੀ ਨੂੰ ਹੋ ਜਾਂਦੇ ਹਨ (ਇਨ੍ਹਾਂ ‘ਚ ਉਹ ਲੋਕ ਵੀ ਸ਼ਾਮਲ ਹਨ ਜਿਨ੍ਹਾਂ ਨੂੰ ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ ਨਹੀਂ ਹੁੰਦਾ)। ਪੈਨਿਕ ਅਟੈਕ, ਐਂਗਜ਼ਾਇਟੀ ਦੇ ਸਾਰੇ ਰੋਗਾਂ ਦੇ ਸੂਚਕ ਹੋ ਸਕਦੇ ਹਨ।

### ਸਾਧਾਰਨ ਘਬਰਾਹਟ ਦੇ ਮੁਕਾਬਲੇ ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ: ਮੈਨੂੰ ਇਹਨਾਂ ਦੇ ਅੰਤਰ ਦਾ ਪਤਾ ਕਿਵੇਂ ਲੱਗੇ?

ਕੇਵਲ ਇਸ ਕਰਕੇ ਕਿ ਸਾਡੇ ਵਿੱਚ ਐਂਗਜ਼ਾਇਟੀ ਦੇ ਲੱਛਣ ਹਨ, ਇਸਦਾ ਭਾਵ ਇਹ ਨਹੀਂ ਕਿ ਸਾਨੂੰ ਐਂਗਜ਼ਾਇਟੀ ਦਾ ਰੋਗ ਹੈ। ਐਂਗਜ਼ਾਇਟੀ ਡਿਸਆਰਡਰ ਦਾ ਰੋਗ-ਪਛਾਣ ਉਦੋਂ ਹੀ ਸਮਝਿਆ ਜਾਂਦਾ ਹੈ ਜਦੋਂ ਐਂਗਜ਼ਾਇਟੀ ਦੇ ਲੱਛਣ:

- ਹੱਦੋਂ ਵੱਧ ਹੋਣ ਅਤੇ ਸਮੇਂ ਨਾਲ ਚਲੇ ਨਾ ਜਾਣ
- ਜੀਵਨ ਦੇ ਨਰੋਏਪਣ ਅਤੇ ਨਿੱਜੀ ਖੁਸ਼ੀ ਵਿੱਚ ਵਿਘਨ ਪਾਉਣ।
- ਕੰਮ, ਸਕੂਲ, ਘਰ, ਜਾਂ ਸਮਾਜਕ ਵਾਤਾਵਰਣਾਂ ਵਿੱਚ ਵਿਘਨ ਪਾਉਣ।

ਜੇ ਐਂਗਜ਼ਾਇਟੀ ਰੋਗਾਂ ਦੀ ਸ਼ਨਾਖਤ ਨਾ ਕੀਤੀ ਜਾਵੇ ਅਤੇ ਉਹਨਾਂ ਨੂੰ ਕਾਬੂ ਨਾ ਕੀਤਾ ਜਾਵੇ ਤਾਂ ਸਮੇਂ ਨਾਲ ਉਹ ਜੀਰਣ ਰੋਗ ਬਣਦੇ ਜਾਂਦੇ ਹਨ ਜਾਂ ਪਹਿਲਾਂ ਨਾਲੋਂ ਵੀ ਵਧ ਜਾਂਦੇ ਹਨ। ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ ਕੇਵਲ ਮਾਨਸਿਕ ਦਬਾਓ (ਸਟਰੈੱਸ) ਨਾਲ ਨਜਿੱਠਣ ਨਾਲੋਂ ਅੱਗੇ ਦੀ ਗੱਲ ਹੈ। ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ ਸਿਹਤ ਦੀਆਂ ਯਥਾਰਥਕ ਸਮੱਸਿਆਵਾਂ ਹਨ।

### ਮੈਨੂੰ ਕਿਸ ਕਿਸਮ ਦਾ ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ ਹੈ?

ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ ਦੇ ਵਖਰੇ ਵਖਰੇ ਕਿੰਨੇ ਹੀ ਰੂਪ ਹਨ ਅਤੇ ਹਰ ਇੱਕ ਦੇ ਆਪਣੇ ਵਿਲੱਖਣ ਗੁਣ ਹਨ, ਜਿਹਨਾਂ ਵਿੱਚ ਪੈਨਿਕ ਡਿਸਆਰਡਰ (ਹੌਲਨਾਕ ਹਮਲਿਆਂ ਦਾ ਰੋਗ), ਐਗਰਫੋਬੀਆ (ਖੁਲੀਆਂ ਥਾਵਾਂ ਦਾ ਭੈਅ), ਅਬਸੈਸਿਵ-ਕੰਪਲਸਿਵ ਡਿਸਆਰਡਰ (ਖਬਤੀ-ਅਵਸ਼ਕਾਰੀ ਰੋਗ) ਸੋਸ਼ਲ ਐਂਗਜ਼ਾਇਟੀ ਡਿਸਆਰਡਰ (ਸਮਾਜਕ ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ), ਆਮ ਐਂਗਜ਼ਾਇਟੀ ਡਿਸਆਰਡਰ, ਪੋਸਟ ਟਰਮੈਟਿਕ ਸਟਰੈੱਸ ਡਿਸਆਰਡਰ (ਪੁਨਰਜਨਮ ਦੀ ਸਟਰੈੱਸ ਦਾ ਰੋਗ), ਅਤੇ ਹੋਰ ਵਿਸ਼ੇਸ਼ ਫੋਬੀਆ (ਭੈਅ) ਸ਼ਾਮਲ ਹਨ। ਐਂਗਜ਼ਾਇਟੀ ਰੋਗਾਂ ਅਤੇ ਉਹਨਾਂ ਦੇ ਲੱਛਣਾਂ ਲਈ ਹੋਰ ਜਾਣਕਾਰੀ ਐਂਗਜ਼ਾਇਟੀ ਡਿਸਆਰਡਰ ਟੂਲਕਿੱਟ [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) ਉੱਤੇ ਦੇਖੋ।



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### **ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ ਕਿਸਤਰਾਂ ਉਤਪੰਨ ਹੁੰਦੇ ਹਨ?**

ਐਂਗਜ਼ਾਇਟੀ ਦੇ ਰੋਗਾਂ ਦਾ ਕੋਈ ਇਕ ਕਾਰਨ ਨਹੀਂ। ਬਹੁਤੇ ਲੋਕਾਂ ਲਈ ਇਹ ਕਈ ਖਤਰਾ-ਜੁਜ਼ਾਂ (ਰਿਸਕ ਫੈਕਟਰਜ਼) ਦਾ ਜੋੜ ਹੁੰਦਾ ਹੈ। ਖਤਰਾ-ਜੁਜ਼ਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ ਐਂਗਜ਼ਾਇਟੀ ਜਾਂ ਡਿਪਰੈਸ਼ਨ ਦਾ ਪਰਿਵਾਰਕ ਇਤਿਹਾਸ, ਜੀਵਨ ਵਿਚ ਨਾਕਾਰਾਤਮਿਕ (ਨੈਗਟਿਵ) ਅਨੁਭਵ, ਪਦਾਰਥ ਦੁਰਵਰਤੋਂ, ਕਿਸੇ ਹੋਰ ਮਾਨਸਿਕ ਸਿਹਤ ਦੀ ਸਮੱਸਿਆ ਦਾ ਹੋਣਾ, ਮੈਡੀਕਲ ਕੰਡੀਸ਼ਨਾਂ (ਬਿਮਾਰੀਆਂ), ਸਮਾਜਕ ਸਹਾਰੇ ਦੀ ਘਾਟ, ਚੀਜ਼ਾਂ ਨੂੰ ਖਤਰਨਾਕ ਸਮਝਣ ਦੀ ਰੁਚੀ, ਅਤੇ ਉਹਨਾਂ ਨੂੰ ਨਜ਼ਿਠਣ ਲਈ ਉਹਨਾਂ ਤੋਂ ਕਤਰੋਣ ਦਾ ਢੰਗ ਵਰਤਣਾ। ਉਹ ਬਾਲਗ ਜਿਹਨਾਂ ਦਾ ਸਮਾਜਕ-ਆਰਥਕ ਰੁਤਬਾ ਘੱਟ (ਭਾਵ ਘੱਟ ਆਮਦਨ) ਹੁੰਦਾ ਹੈ ਉਨ੍ਹਾਂ ਵਿਚ ਅਤੇ ਔਰਤਾਂ ਵਿਚ ਵੀ ਕੁਝ ਵਿਸ਼ੇਸ਼ ਕਿਸਮ ਦੇ ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ ਹੋਣ ਦੀ ਸੰਭਾਵਨਾ ਵੱਧ ਹੁੰਦੀ ਹੈ।

**ਤੁਸੀਂ ਇਕੱਲੇ ਨਹੀਂ।** ਜੇ ਤੁਸੀਂ ਐਂਗਜ਼ਾਇਟੀ ਦੇ ਰੋਗ ਨਾਲ ਸਿੱਝ ਰਹੇ ਹੋ ਤਾਂ ਬ੍ਰਿਟਿਸ਼ ਕੁਲੰਬੀਆ ਦੇ 400,000 ਲੋਕ ਸਮਝ ਸਮਕਦੇ ਹਨ ਕਿ ਤੁਹਾਡੇ ਅਤੇ ਤੁਹਾਡੇ ਪਰਿਵਾਰ ਨਾਲ ਕੀ ਬੀਤ ਰਹੀ ਹੈ। ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ ਮਾਨਸਿਕ ਸਿਹਤ ਸਮੱਸਿਆਵਾਂ ਵਿਚੋਂ ਸਭ ਤੋਂ ਆਮ ਹੈ। ਚਾਰਾਂ ਵਿਚੋਂ ਇਕ ਤੋਂ ਵਧੀਕ ਲੋਕ ਆਪਣੇ ਜੀਵਨ ਵਿਚ ਕਦੇ ਨਾ ਕਦੇ ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ ਦਾ ਸ਼ਿਕਾਰ ਹੋਣਗੇ। ਵਰਤਮਾਨ ਵਿਚ ਘੱਟੋ ਘੱਟ ਦਸਾਂ ਵਿਚੋਂ ਇਕ ਲੋਕ ਕਿਸੇ ਨਾ ਕਿਸੇ ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ ਦਾ ਸ਼ਿਕਾਰ ਹਨ। ਇਹਨਾਂ ਵਿਚੋਂ ਘੱਟੋ ਘੱਟ ਅੱਧੇ ਲੋਕ ਡਿਪਰੈਸ਼ਨ ਦੇ ਰੋਗ ਨਾਲ ਸਿੱਝ ਰਹੇ ਹਨ ਜਾਂ ਕਿਸੇ ਹੋਰ ਮਾਨਸਿਕ ਸਿਹਤ ਦੀ ਸਮੱਸਿਆ ਨਾਲ ਜਾਂ ਸ਼ਰਾਬ ਵਰਗੇ ਪਦਾਰਥ ਦੀ ਦੁਰਵਰਤੋਂ ਨਾਲ।

### **ਕੀ ਇਲਾਜ ਲਈ ਅਸਰਭਰਪੂਰ ਚੋਣਾਂ ਮੌਜੂਦ ਹਨ?**

ਚੰਗੀ ਖਬਰ ਇਹ ਹੈ ਕਿ ਐਂਗਜ਼ਾਇਟੀ ਦੇ ਰੋਗਾਂ ਦਾ ਇਲਾਜ ਬਹੁਤ ਹੱਦ ਤੱਕ ਹੋ ਸਕਦਾ ਹੈ। ਐਂਗਜ਼ਾਇਟੀ ਰੋਗਾਂ ਵਾਲੇ ਤਕਰੀਬਨ ਦਸਾਂ ਵਿਚੋਂ ਅੱਠ ਲੋਕ ਐਂਗਜ਼ਾਇਟੀ ਦੇ ਇਲਾਜ ਤੋਂ ਲਾਭ ਉਠਾ ਸਕਦੇ ਹਨ, ਇਹਨਾਂ ਇਲਾਜਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ ਦਵਾਈਆਂ, ਕਾਗਨੀਟਿਵ-ਬਹੇਵੀਅਰਲ ਟਰੀਟਮੈਂਟ (ਸੰਗਿਆਨ-ਵਿਵਹਾਰੀ ਇਲਾਜ), ਜਾਂ ਦੋਹਾਂ ਦਾ ਸੁਮੇਲ।

ਦਵਾਈਆਂ ਵਾਲੇ ਇਲਾਜ ਵਿਚ ਅਕਸਰ ਬਹੁਤ ਸਾਰੀਆਂ ਐਂਟੀ ਡਿਪਰੈਸੈਂਟ ਦਵਾਈਆਂ ਵਿਚੋਂ ਇਕ ਦੀ ਵਰਤੋਂ ਕੀਤੀ ਜਾਂਦੀ ਹੈ (ਮਿਸਾਲ ਵਜੋਂ ਸੈਰਨਟੋਨਨ ਰੋਪਟੇਕ ਇਨਹਿਬਿਟਰਜ਼)। ਭਾਵੇਂ ਦਵਾਈ ਬੰਦ ਕਰਨ ਪਿਛੋਂ ਰੋਗ ਦੇ ਲੱਛਣ ਅਕਸਰ ਪਰਤ ਆਉਂਦੇ ਹਨ ਫੇਰ ਵੀ ਐਂਗਜ਼ਾਇਟੀ ਰੋਗਾਂ ਨੂੰ ਕਾਬੂ ਰੱਖਣ ਲਈ ਬਹੁਤੇ ਲੋਕਾਂ ਲਈ ਕੋਈ ਨਾ ਕੋਈ ਡਿਪਰੈਸੈਂਟ ਅਤਿ ਅਸਰਦਾਰ ਇਲਾਜ ਹੋ ਨਿਬੜਦਾ ਹੈ। ਇਸ ਦੇ ਲਾਭਾਂ ਦਾ ਪਤਾ ਲੱਗਣ ਨੂੰ ਅਕਸਰ ਕਈ ਹਫ਼ਤੇ ਲੱਗ ਜਾਂਦੇ ਹਨ, ਅਤੇ ਕੁਝ ਲੋਕਾਂ ਨੂੰ ਇਸਦੇ ਨਾਕਾਰਾਤਮਿਕ ਗੌਣ ਪ੍ਰਭਾਵਾਂ (ਨੈਗਟਿਵ ਸਾਇਡ ਇਫੈਕਟਸ) ਦਾ ਵੀ ਅਨੁਭਵ ਹੁੰਦਾ ਹੈ ਜਿਹਨਾਂ ਵਿਚ ਲਿੰਗਕ (ਸੈਕਸੁਅਲ) ਸਮੱਸਿਆਵਾਂ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਕਦੇ ਕਦੇ ਬੋੜ-ਚਿਰੀ ਐਂਗਜ਼ਾਇਟੀ ਨੂੰ ਠੀਕ ਕਰਨ ਲਈ ਤੇਜ਼ੀ ਨਾਲ ਅਸਰ ਕਰਨ ਵਾਲੇ ਬੈਂਜ਼ੋਡਾਇਆਜ਼ੋਪੀਨਜ਼ ਵੀ ਇਲਾਜ ਲਈ ਦਿੱਤੇ ਜਾਂਦੇ ਹਨ ਪਰ ਉਹਨਾਂ ਦਾ ਲੰਬੇ ਸਮੇਂ ਦੀ ਵਰਤੋਂ ਲਈ ਮਸ਼ਮਰਾ ਨਹੀਂ ਦਿੱਤਾ ਜਾਂਦਾ ਕਿਉਂਕਿ ਉਹਨਾਂ ਦਾ ਅਮਲ ਲੱਗ ਸਕਦਾ ਹੈ ਅਤੇ ਉਹਨਾਂ ਦੇ ਛੱਡਣ ਉਪਰੰਤ ਜੋ ਲੱਛਣ (ਵਿਦਭਰਾਅਲ ਸਿੰਪਟਮਜ਼) ਉਜਾਗਰ ਹੁੰਦੇ ਹਨ ਐਂਗਜ਼ਾਇਟੀ ਉਨ੍ਹਾਂ ਵਿਚੋਂ ਇਕ ਹੈ।

ਕਾਗਨੀਟਿਵ ਬਹੇਵੀਅਰਲ ਟਰੀਟਮੈਂਟਸ (ਸੀ.ਬੀ.ਟੀ) ਨਵੇਂ ਹੁਨਰਾਂ ਤੇ ਜ਼ੋਰ ਦਿੰਦੀਆਂ ਹਨ ਜੋ ਐਂਗਜ਼ਾਇਟੀ ਨੂੰ ਘਟਾਉਣ ਵਿਚ ਬਹੁਤ ਅਸਰ ਭਰਪੂਰ ਹਨ (ਭਾਵੇਂ ਤੁਸੀਂ ਦਵਾਈਆਂ ਲੈ ਰਹੇ ਹੋ ਜਾਂ ਨਹੀਂ)। ਸੀ.ਬੀ.ਟੀ ਵਿਚ ਸ਼ਾਮਲ ਹਨ ਐਂਗਜ਼ਾਇਟੀ ਦੇ ਲੱਛਣਾਂ ਅਤੇ ਪ੍ਰੇਰਕਾਂ (ਟ੍ਰਿਗਰਜ਼) ਬਾਰੇ ਸਿੱਖਿਆ, ਵਿਸ਼੍ਰਾਂਤੀ (ਰਿਲੈਕਸੇਸ਼ਨ) ਦੇ ਹੁਨਰ, ਸੰਗਿਆਨ (ਕਾਗਨੀਟਿਵ) ਦੇ ਹੁਨਰਾਂ ਦੀ ਟ੍ਰੇਨਿੰਗ (ਐਂਗਜ਼ਾਇਟੀ ਉਤਪੰਨ ਕਰਨ ਵਾਲੇ ਵਿਚਾਰਾਂ ਦੀ ਸ਼ਨਾਖਤ ਅਤੇ ਉਹਨਾਂ ਦਾ ਮੁਕਾਬਲਾ), ਸਹਿਣਸ਼ੀਲਤਾ ਪੈਦਾ ਕਰਨੀ (ਡਰਾਂ ਦਾ ਸਹਿਜੇ ਸਹਿਜੇ ਸਾਹਮਣਾ ਕਰਕੇ) ਅਤੇ ਐਂਗਜ਼ਾਇਟੀ ਦੇ ਪਰਤਣ ਨੂੰ ਰੋਕਣ ਲਈ ਪਲੈਨ ਕਰਨਾ। ਸੀ.ਬੀ.ਟੀ ਹਰ ਕਮਿਊਨਿਟੀ ਵਿਚ ਹਰ ਸਮੇਂ ਉਪਲਬਧ ਨਹੀਂ ਹੁੰਦੀ।

### **ਮੈਨੂੰ ਅੱਗੇ ਕਿਹੜੇ ਕਦਮ ਉਠਾਉਣੇ ਚਾਹੀਦੇ ਹਨ?**

- ਐਂਗਜ਼ਾਇਟੀ ਰੋਗਾਂ ਬਾਰੇ ਹੋਰ ਗਿਆਨ ਪ੍ਰਾਪਤ ਕਰਕੇ ਆਪਣੇ ਆਪ ਨੂੰ ਸਮਰੱਥ ਬਣਾਓ। ਇਸਦੇ ਨਾਲ ਹੀ ਮਾਨਸਿਕ ਸਿਹਤ ਜਾਂ ਪਦਾਰਥ ਵਰਤੋਂ ਦੀਆਂ ਸਮੱਸਿਆਵਾਂ, ਜੋ ਅਕਸਰ ਐਂਗਜ਼ਾਇਟੀ ਸਮੱਸਿਆਵਾਂ ਦੇ ਨਾਲ ਹੋ ਜਾਂਦੀਆਂ ਹਨ (ਜਿਵੇਂ ਡਿਪਰੈਸ਼ਨ), ਬਾਰੇ ਵੀ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰੋ।
- [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) ਉੱਤੇ ਜਾ ਕੇ ਗੁੰਮਨਾਮ ਸਕਰੀਨਿੰਗ ਟੈਸਟ ਲਵੋ। ਨਤੀਜੇ ਪ੍ਰਿੰਟ ਕਰੋ ਅਤੇ ਆਪਣੇ ਫੈਮਲੀ ਡਾਕਟਰ ਜਾਂ ਸਿਹਤ ਮਾਹਰ (ਹੈਲਥ ਪ੍ਰੋਫੈਸ਼ਨਲ) ਨੂੰ ਦਿਖਾਓ।
- ਆਪਣੇ ਫੈਮਲੀ ਡਾਕਟਰ ਜਾਂ ਸਿਹਤ ਮਾਹਰ ਨਾਲ ਆਪਣੇ ਲੱਛਣਾਂ ਬਾਰੇ ਗੱਲਬਾਤ ਕਰੋ ਅਤੇ ਦੱਸੋ ਕਿ ਇਹ ਲੱਛਣ ਤੁਹਾਡੀ ਜ਼ਿੰਦਗੀ ਉੱਤੇ ਕਿਹੋ ਜਿਹਾ ਅਸਰ ਪਾ ਰਹੇ ਹਨ।



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- ਮਾਨਸਿਕ ਸਿਹਤ ਜਾਂ ਪਦਾਰਥ ਵਰਤੋਂ ਦੇ ਮੁੱਦਿਆਂ ਬਾਰੇ ਜਿਨ੍ਹਾਂ ਦਾ ਤੁਸੀਂ ਸਾਹਮਣਾ ਕਰ ਰਹੇ ਹੋ, ਪੂਰੇ ਮੁਲਾਂਕਣ ਬਾਰੇ ਕਹੋ।
- ਸਬੂਤ ਆਧਾਰਤ ਇਲਾਜਾਂ ਬਾਰੇ ਪੁਛੋ ਜੋ ਕਾਰਗਰ ਸਿੱਧ ਹੋ ਚੁੱਕੇ ਹੋਣ (ਮਿਸਾਲ ਵਜੋਂ ਦਵਾਈਆਂ ਅਤੇ ਜਾਂ ਸੀ.ਬੀ.ਟੀ)
- ਆਪਣੇ ਫੈਮਲੀ ਡਾਕਟਰ ਕੋਲੋਂ ਕਿਸੇ ਮਾਹਰ (ਸਪੈਸ਼ਲਿਸਟ) ਕੋਲ ਜਾਣ ਲਈ ਰੈਫਰਲ ਲਵੋ ਜੋ ਤੁਹਾਨੂੰ ਰੋਜ਼ਾਨਾ ਸਵੈ-ਅਨੁਸ਼ਾਸਨ (ਸੈਲਫ-ਮੈਨੇਜਮੈਂਟ) ਹੁਨਰਾਂ ਵਿਚ ਵਧੇਰੇ ਡੂੰਘੇਰੀ ਟ੍ਰੇਨਿੰਗ ਦੇ ਸਕੇ।
- ਆਪਣੀ ਰੋਗ-ਮੁਕਤੀ ਸਮੇਂ ਅਤੇ ਉਸਨੂੰ ਕਾਇਮ ਰੱਖਣ ਲਈ ਆਪਣੇ ਭਰੋਸੇਯੋਗ ਪਰਿਵਾਰਕ ਮੈਂਬਰਾਂ ਜਾਂ ਦੋਸਤਾਂ ਨਾਲ ਗੱਲ ਕਰੋ
- ਸਵੈ-ਸੰਭਾਲ ਦੀਆਂ ਮੁਢਲੀਆਂ ਗੱਲਾਂ ਨੂੰ ਧਿਆਨ ਵਿਚ ਰੱਖੋ; ਇਹਨਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ, ਬਾਕਾਇਦਾ ਕਸਰਤ, ਸਿਹਤਮੰਦ ਖੁਰਾਕ, ਲੋੜੀਂਦੀ ਨੀਂਦਰ ਅਤੇ ਪਦਾਰਥਾਂ ਜਿਵੇਂ ਕੈਫੀਨ, ਸ਼ਰਾਬ, ਅਤੇ ਬੈਂਜ਼ੋਡਾਇਆਜ਼ੈਪੀਨ ਦੀ ਵਰਤੋਂ ਨੂੰ ਘਟਾਉਣਾ।

### ਮੈਂ ਹੋਰ ਜਾਣਕਾਰੀ ਕਿੱਥੋਂ ਲੈ ਸਕਦਾ/ਸਕਦੀ ਹਾਂ?

- ਮੈਂਟਲ ਹੈਲਥ ਅਤੇ ਅਡਿਕਸ਼ਨਜ਼ ਇਨਫਰਮੇਸ਼ਨ ਦੇ ਭਾਗੀਦਾਰ ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) ਜਾਂ 1-800-661-2121)  
ਮੁਫਤ ਸਾਧਨਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ
  - ਐਂਗਜ਼ਾਇਟੀ ਡਿਸਆਰਡਰ ਟੂਲਕਿੱਟ: ਸਵੈ-ਨਿਰੀਖਣ, ਐਂਗਜ਼ਾਇਟੀ ਰੋਗਾਂ ਦੇ ਲੱਛਣ, ਇਲਾਜ ਚੋਣਾਂ ਅਤੇ ਹੋਰ ਜਾਣਕਾਰੀ
  - ਮੈਂਟਲ ਡਿਸਆਰਡਰ ਟੂਲਕਿੱਟ: ਮਾਨਸਿਕ ਰੋਗ ਦੇ ਹੁੰਦਿਆਂ ਠੀਕ ਜੀਵਨ ਬਿਤਾਉਣ ਲਈ ਤਰੀਕੇ (ਐਪਸ਼ਨਜ਼)
  - ਵੈਲਨੈੱਸ ਮਾਜੂਅਲਜ਼: ਮੁਢਲੀ ਸਵੈ-ਸੰਭਾਲ ਅਤੇ ਮਾਨਸਿਕ ਦਬਾਓ ਲਈ ਵਿਧੀਆਂ
  - ਫੈਕਟ ਸ਼ੀਟਸ: ਮਾਨਸਿਕ ਸਿਹਤ ਅਤੇ ਪਦਾਰਥ ਵਰਤੋਂ ਦੇ ਵਿਸ਼ਿਆਂ ਤੇ ਮੁਢਲੀ ਜਾਣਕਾਰੀ
  - ਫੈਮਲੀ ਟੂਲਕਿੱਟ: ਪਰਿਵਾਰ ਅਤੇ ਦੋਸਤਾਂ ਵਾਸਤੇ ਕੁੰਜੀਵਤ ਜਾਣਕਾਰੀ
- ਐਂਗਜ਼ਾਇਟੀ ਡਿਸਆਰਡਰਜ਼ ਐਸੋਸੀਏਸ਼ਨ ਐਂਡ ਬੀ.ਸੀ ([www.anxietybc.com](http://www.anxietybc.com))  
ਮੁਫਤ ਸਾਧਨਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ ਸਵੈ-ਸਹਾਇਤਾ ਉਤੇ ਪਾਠਾਂ ਦੀ ਲਿਸਟ, ਦੂਸਰੇ ਐਂਗਜ਼ਾਇਟੀ ਵੈੱਬ ਸਾਇਟਾਂ ਨੂੰ ਲਿੰਕ, ਅਤੇ ਜਾਤੀ ਕਹਾਣੀਆਂ
- ਦਾ ਪੈਨਿਕ ਸੈਂਟਰ ([www.paniccenter.net](http://www.paniccenter.net)) ਜਾਂ [Anxieties.com](http://Anxieties.com) ([www.anxieties.com](http://www.anxieties.com))  
ਵੈੱਬ ਉਤੇ ਆਧਾਰਿਤ ਅਜਿਹੇ ਸਵੈ-ਅਨੁਸ਼ਾਸਨ ਦੇ ਪ੍ਰੋਗਰਾਮ ਉਪਲਬਧ ਹਨ ਜਿਹਨਾਂ ਨੂੰ ਤੁਸੀਂ ਘਰੇ ਆਰਾਮ ਨਾਲ ਅਤੇ ਪਰਦੇ ਵਿਚ ਬੈਠ ਕੇ ਪੜ੍ਹ ਸਕਦੇ ਹੋ
- ਸਬੂਤਾਂ ਤੇ ਆਧਾਰਿਤ ਪੁਸਤਕਾਂ, ਵਿਡੀਓ, ਅਤੇ ਸੁਣਨ ਵਾਲੀਆਂ ਟੇਪਾਂ  
ਸਵੈ-ਅਨੁਸ਼ਾਸਨ ਦੇ ਸਬੂਤ-ਆਧਾਰਿਤ ਸਾਧਨਾਂ ਲਈ ਬੁੱਕਸਟੋਰ, ਲਾਇਬ੍ਰੇਰੀਆਂ, ਅਤੇ ਵੈੱਬ ਨੂੰ ਚੈੱਕ ਕਰੋ (ਉਹਨਾਂ ਨੂੰ ਉਹ ਸਾਧਨ ਵੀ ਸ਼ਾਮਲ ਕਰਨ ਲਈ ਕਹੋ ਜੋ ਉਹਨਾਂ ਦੀ ਲਿਸਟ ਵਿਚ ਨਹੀਂ ਮਿਲਦੇ) ਕੁਝ ਮਿਸਾਲਾਂ:
  - ਦੀ ਐਂਗਜ਼ਾਇਟੀ ਐਂਡ ਫੋਬੀਆ ਵਰਕਬੁੱਕ (2000), ਲੇਖਕ: ਈ.ਜੇ. ਬੋਰਨ, ਨਿਊ ਹਾਰਬਿੰਜਰ ਪਬਲੀਕੇਸ਼ਨਜ਼ (ਇਸੇ ਲੇਖਕ ਦੀਆਂ ਹੋਰ ਪੁਸਤਕਾਂ ਅਤੇ ਆਡੀਓਟੇਪਾਂ ਵੀ ਦੇਖੋ)
  - ਮਾਸਟਰੀ ਐਂਡ ਯੂਅਰ ਐਂਗਜ਼ਾਇਟੀ ਐਂਡ ਪੈਨਿਕ (2000) ਲੇਖਕ: ਐਮ.ਜੀ. ਕਰੈਸਕ ਅਤੇ ਡੀ.ਐੱਚ ਬਾਰਲੋਅ, ਡੀ.ਐੱਚ ਗਰੇਅਵਿੰਡ ਪਬਲੀਕੇਸ਼ਨਜ਼  
[www.graywindpublications.com](http://www.graywindpublications.com) (ਇਸ ਮਾਸਟਰੀ ਸੀਰੀਜ਼ ਵਿਚ ਐਂਗਜ਼ਾਇਟੀ ਰੋਗ, ਸਮੇਤ ਵਿਸ਼ੇਸ਼ ਫੋਬੀਆ ਅਤੇ ਅਬਸੈਸਿਵ-ਕੰਪਲਸਿਵ ਰੋਗ ਦੇ, ਉਤੇ ਹੋਰ ਪੁਸਤਕਾਂ ਵੀ ਦੇਖੋ)

ਜੋ ਤੁਸੀਂ ਸਿਖੋਗੇ ਉਹ ਇਹ ਹੈ ਕਿ ਐਂਗਜ਼ਾਇਟੀ ਰੋਗਾਂ ਵਾਲੇ ਲੋਕ ਆਪਣੇ ਲੱਛਣਾਂ ਦੀ ਦੇਖਭਾਲ ਕਰ ਸਕਦੇ ਹਨ ਅਤੇ ਲਾਹੇਵੰਦ ਅਤੇ ਸਿਰਜਣਾਤਮਿਕ ਜ਼ਿੰਦਗੀ ਬਸਰ ਕਰ ਸਕਦੇ ਹਨ।



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# Trastornos de ansiedad

## Información para los pacientes y sus familias

(Anxiety Disorders - Information for Patients and their Families)

### ¿Qué es la ansiedad?

La ansiedad es una emoción normal. La ansiedad nos ayuda a alejarnos de situaciones peligrosas. No sobreviviríamos sin algo de ansiedad. Los siguientes son síntomas comunes de ansiedad:

- **Emociones:** ansiedad, temor y otras emociones negativas tales como la irritabilidad, el enojo o la tristeza
- **Reacciones del cuerpo:** dificultad para respirar, latido rápido del corazón, náusea, mareo y otros signos de la respuesta de lucha-huida-parálisis
- **Comportamientos:** evitar cosas, buscar la seguridad excesiva, distracción, rituales de seguridad, comportamientos compulsivos y otros actos que neutralizan la ansiedad
- **Pensamientos:** pensamientos no deseados o perturbadores, impulsos, recuerdos o imágenes (“qué si algo realmente malo sucede”) así como también recuerdos de experiencias traumáticas pasadas o pensamientos no deseados con respecto a causarle daño a alguien.

### ¿Qué son los ataques de pánico?

Los ataques de pánico son impulsos repentinos de ansiedad intensa, temor o terror junto con síntomas físicos (por ejemplo: latido cardíaco rápido, falta de aliento) y preocupación acerca de perder el control, morirse o volverse loco. Uno de cada tres adultos experimenta ataques de pánico (incluyendo muchas personas que no tienen trastornos de ansiedad). Los ataques de pánico pueden ser un síntoma de todos los trastornos de ansiedad.

### Ansiedad normal contra los trastornos de ansiedad: ¿Cómo puedo diferenciarlos?

Sólo porque tengamos síntomas de ansiedad no quiere decir que tengamos trastornos de ansiedad. El diagnóstico de un trastorno de ansiedad se considera sólo cuando los síntomas de ansiedad:

- son excesivos y no se van con el tiempo
- interfieren con la calidad de vida y la felicidad personal
- interfieren con el funcionamiento laboral, del hogar o del ambiente social.

Los trastornos de ansiedad tienden a hacerse crónicos o incluso a empeorar a través del tiempo si no se manejan e identifican bien. Los trastornos de ansiedad son más que problemas para sobrellevar el estrés. Los trastornos de ansiedad son problemas reales de salud.

### ¿Qué tipo de trastorno de ansiedad tengo?

Hay diversos trastornos de ansiedad con características propias únicas, incluyendo trastornos de pánico, agorafobia, trastorno de obsesión compulsiva, trastorno de ansiedad social, trastorno de ansiedad generalizada, trastorno de estrés post traumático y otras fobias específicas. Para más información acerca de los trastornos de ansiedad y de los síntomas refiérase a “Herramientas para trastornos de ansiedad” (*Anxiety Disorders Toolkit*) [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca).

### ¿Cuál es la causa de los trastornos de ansiedad?

No hay una causa única para los trastornos de ansiedad. Para la mayoría de las personas es una combinación de varios factores de riesgo. Los factores de riesgo incluyen los antecedentes familiares de ansiedad o depresión, las experiencias de vida negativas, el uso de sustancias, la presencia de otro problema mental, las enfermedades médicas, la carencia de apoyo social, la tendencia a ver las cosas como peligrosas y evitarlas como un medio de sobrellevarlas. Los adultos de estrato socioeconómico bajo (es decir, de ingresos más bajos) y las mujeres también son más susceptibles de contraer trastornos de ansiedad.

**Usted no está solo.** Si está tratando de sobrellevar un trastorno de ansiedad, más de 400.000 adultos en Columbia Británica pueden asociar lo que usted y su familia están pasando. Los trastornos de ansiedad son el tipo más común de problema de salud mental. Más de una en cuatro personas experimentará un trastorno de ansiedad en algún momento de sus vidas. Al menos una de cada diez personas está sufriendo actualmente al menos un trastorno de ansiedad. Al menos la mitad de estas personas están tratando de sobrellevar la depresión o algún otro tipo de problema de salud mental o uso de sustancia como por ejemplo el alcohol.



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## ¿Hay opciones de tratamiento efectivo?

Las buenas noticias son que los trastornos de ansiedad son altamente tratables. Aproximadamente ocho de cada diez personas con trastornos de ansiedad experimentan beneficios al tratarse con medicamentos, tratamientos de comportamiento cognitivo o una combinación de los dos.

Los tratamientos con **medicamentos** generalmente implican tomar uno de los muchos tipos diferentes de anti depresivos (por ejemplo, inhibidores de la gestión de la serotonina). Aún cuando los síntomas vuelven con frecuencia cuando se dejan de tomar los medicamentos, muchas personas encuentran que los antidepresivos son una opción de tratamiento altamente efectiva para manejar los trastornos de ansiedad. Generalmente el beneficio demora varias semanas para sentirse y algunas personas experimentan efectos secundarios negativos que incluyen problemas con el funcionamiento sexual. Algunas veces las benzodiacepinas de acción rápida se recetan para el manejo de la ansiedad a corto plazo, pero no se recomiendan para uso prolongado ya que pueden ser adictivas y el síndrome de la abstinencia incluye ansiedad.

Los **Tratamientos de comportamiento cognitivo** (*Cognitive Behavioural Treatments*, CBT por su sigla en inglés) enfatizan las nuevas técnicas que son altamente efectivas para reducir la ansiedad (ya sea tomando los medicamentos o no). Los CBT incluyen el aprendizaje de los síntomas y los desencadenantes, la relajación, las técnicas cognitivas (identificando y desafiando los pensamientos que desencadenan la ansiedad), el fortalecimiento de la tolerancia (a través de exposición gradual a los miedos) y el plan de prevención de recaída. Los CBT no siempre están disponibles en todas las comunidades.

## ¿Qué pasos debo tomar después?

- Hágase cargo al informarse más acerca de los trastornos de ansiedad. También investigue acerca de otros tipos de enfermedades mentales o problemas de uso de sustancias que suceden a menudo junto con problemas de ansiedad (es decir, depresión).
- Haga la prueba anónima en [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca). Imprima los resultados y muéstreselos a su médico de cabecera o profesional de la salud.
- Hable con su médico de cabecera o profesional de la salud acerca de sus síntomas y cómo le están afectando en su vida.
- Solicite una evaluación completa acerca del uso de sustancia o salud mental que está enfrentando.
- Pida opciones de tratamiento basados en la evidencia que se ha comprobado que funcionan (por ejemplo: medicamentos y/o los CBT).
- Hable con su médico de cabecera para que lo derive a un especialista quien le pueda proporcionar capacitación más intensiva en técnicas de manejo autónomo diario.
- Hable con familiares o amigos de confianza para obtener apoyo adicional durante su plan de recuperación y mantenimiento.
- Preocúpese de los elementos básicos del cuidado personal que incluyen: ejercicio regular, comer en forma saludable, dormir en forma suficiente y reducir el uso excesivo de sustancias tales como la cafeína, el alcohol y las benzodiacepinas.

## ¿Dónde puedo obtener más información?

- **Asociación de Columbia Británica de información sobre la salud mental y adicciones** “BC Partners for Mental Health and Addictions Information” ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) o 1-800-661-2121)  
Los recursos gratuitos incluyen:
  - **Herramientas para los trastornos de ansiedad:** auto evaluaciones, síntomas de trastornos de ansiedad, opciones de tratamiento y más
  - **Herramientas para los trastornos mentales:** opciones para vivir bien cuando se enfrentan enfermedades mentales
  - **Módulos de bienestar:** estrategias para el manejo del estrés y cuidado personal básico
  - **Hojas de datos:** información básica acerca del uso de sustancias y problemas mentales comunes
  - **Herramientas para la familia:** información clave para la familia y amigos.
- **Asociación de Columbia Británica de trastornos de ansiedad** (*Anxiety Disorders Association of BC*) ([www.anxietybc.com](http://www.anxietybc.com))  
Los recursos gratuitos incluyen listas de lecturas de ayuda personal, enlaces a otras páginas Web acerca de la ansiedad e historias personales.
- **El Centro de pánico** (*The Panic Center*) ([www.paniccenter.net](http://www.paniccenter.net)) o **Anxieties.com** ([www.anxieties.com](http://www.anxieties.com))



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Hay programas gratis disponibles de manejo autónomo basados en la Web que puede seguir en la comodidad y privacidad de su propio hogar.

- **Libros , videos y casetes de audio basados en la evidencia**

Consulte en las librerías, bibliotecas y recursos de manejo personal basados en la evidencia (pídales a ellos que añadan los recursos que no aparecen en su catálogo). Los ejemplos incluyen:

- **Libro de instrucciones sobre la ansiedad y las fobias** (*The Anxiety & Phobia Workbook*), 2000 de E.J. Bourne. New Harbinger Publications (ver libros adicionales y casetes del mismo autor).
- **Tomar el control de su propia ansiedad y pánico** (*Mastery of Your Anxiety and Panic*) (2000) de M.G. Craske & D.H. Barlow, D.H. Graywind Publications. ([www.graywindpublications.com](http://www.graywindpublications.com)), ver títulos adicionales en esta serie llamada *Mastery* para otros trastornos de ansiedad que incluyan fobias específicas y otros trastornos de obsesión compulsiva).

***Lo que aprenderá es que las personas con trastornos de ansiedad pueden manejar sus síntomas y llevar vidas provechosas y productivas.***



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## **Bệnh Rối-loạn Lo-lắng**

### **Thông-tin cho bệnh-nhân và gia-đình của họ**

Lo-lắng là một cảm-xúc bình-thường. Sự lo-lắng giữ giúp cho chúng ta tránh xa những hoàn-cảnh nguy-hiểm. Chúng ta không thể sống còn nếu không có lo-lắng. Sau đây là những triệu-chứng thông-thường của bệnh lo-lắng.

- **cảm-xúc** : lo-lắng, sợ-sệt, và những cảm-xúc bất-lợi khác, chẳng hạn như bức-bội, giận-dữ và buồn-bã
- **các phản-ứng của cơ-thể**: bị khó thở, nhịp tim đập nhanh, buồn nôn, choáng-váng và những dấu-hiệu khác của cách phản-ứng loại sợ-trốn-hay-chết-đúng
- **cách cư-xử**: trốn-tránh sự việc, tìm kiếm sự bảo-đảm một cách quá đáng, bị phân-tâm, những lễ-nghi an-toàn, cách cư-xử đột-hứng, và bất-kỳ hành-động nào khác dùng để trấn-áp sự lo-lắng
- **ý-tưởng**: những ý-tưởng khó-khăn bạn không muốn có, những sự thúc-dục, những kỷ-niệm hay suy-tưởng ("nếu giả-sử có điều thật xấu xảy ra thì sao"), cũng như là những kỷ-niệm của kinh-nghiệm đau-thương trong quá-khứ, hoặc những ý-tưởng không muốn có, nhằm ý-định làm hại người khác

### **Những cơn hốt-hoảng là gì ?**

Những cơn hốt-hoảng là những lần đột-nhiên có sự lo-âu hay sợ-hãi hoặc kinh-khiếp rất lớn ào đến, cùng với những triệu-chứng thể-chất khác (chẳng hạn như nhịp tim đập nhanh, bị hụt hơi), và sự quan-tâm về tình-trạng mất quyền kiểm-soát, chết-chóc, hoặc mất trí. Một trong số ba người trưởng-thành trải qua những cơn hốt-hoảng (kể cả nhiều người khác không bị bệnh rối-loạn lo-lắng). Các cơn hốt-hoảng có thể là triệu-chứng của tất-cả các loại bệnh rối-loạn lo-lắng.

### **Sự lo-lắng bình-thường so với bệnh rối-loạn lo-lắng: Làm sao tôi có thể phân-biệt được chúng ?**

Nếu chỉ vì chúng ta có những triệu-chứng lo-lắng không thôi thì điều ấy không có nghĩa là chúng ta bị bệnh rối-loạn lo-lắng. Bác-sĩ chỉ có thể xét đến việc định-bệnh bệnh rối-loạn lo-lắng khi những triệu-chứng lo-lắng :

- là quá-đáng và không mất đi theo thời-gian
- ảnh-hưởng đến phẩm-chất đời-sống và hạnh-phúc cá-nhân
- ảnh-hưởng đến hoạt-động tại sở làm, tại trường học, tại nhà, hay tại các nơi giao-tế

Bệnh rối-loạn lo-lắng có khuynh-hướng trở thành bệnh kinh-niên, và có khi trở thành trầm-trọng hơn theo thời-gian nếu không được nhận ra và chế-ngự kỹ-lưỡng. Bệnh rối-loạn lo-lắng là những gì lớn hơn chứ không đơn-giản chỉ là sự khó-khăn khi phải đối-diện với sự căng-thẳng. Bệnh rối-loạn lo-lắng là một vấn-đề y-tế thực-sự.

### **Tôi mắc bệnh rối-loạn lo-lắng loại nào ?**

Có nhiều loại bệnh rối-loạn lo-lắng khác nhau, và chúng có những nét đặc-thù riêng, bao gồm cả bệnh rối-loạn hốt-hoảng, bệnh sợ khoảng rộng, bệnh rối-loạn đột-hứng ám-ảnh, bệnh rối-loạn lo-lắng khi giao-tế, bệnh rối-loạn lo-lắng tổng-quát, bệnh rối-loạn lo-lắng sau khi có căng-thẳng đau-thương, và những loại bệnh sợ-sệt riêng-biệt khác. Nếu bạn muốn biết thêm chi-tiết về những triệu-chứng và các loại bệnh rối-loạn lo-lắng, xin xem tập sách Túi Điều-trị Bệnh Rối-loạn Lo-lắng tại trang mạng lưới [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) .

### **Điều gì gây ra bệnh Rối-loạn lo-lắng ?**

Không phải chỉ có một nguyên-cớ duy-nhất là có thể gây ra bệnh rối-loạn lo-lắng. Đối với nhiều người, đây là sự tổng-hợp của nhiều yếu-tố rủi-ro mà thành. Những yếu-tố rủi-ro bao gồm trong bệnh-sử gia-đình có sự lo-lắng, hay có bị bệnh suy-nhược tâm-thần, có những kinh-nghiệm đời-sống bất-lợi, sự xử-dụng hóa-chất, hay có sự hiện-diện của vấn-đề sức-khỏe tâm-thần khác, những trở-ngại y-tế, thiếu-sót sự hỗ-trợ về mặt xã-hội, khuynh-hướng nhìn mọi sự việc đều là nguy-hiểm, và dùng sự tránh-né như là cách để đối-phó với sự việc. Những người đã thành-nhân nhưng có một vị-trí thấp về mặt kinh-tế xã-hội (có nghĩa là có lợi-tức thấp) và các phụ-nữ là rất dễ phát ra một số bệnh rối-loạn lo-lắng nào đó.

**Không phải chỉ có mình bạn mắc phải.** Nếu bạn đang phải đối-phó với bệnh rối-loạn lo-lắng thì bạn nên biết là có đến hơn 400,000 người trưởng-thành khác trong tỉnh BC có thể đồng-cảm với những gì mà chính bạn và gia-đình bạn đang phải trải qua. Bệnh rối-loạn lo-lắng là loại vấn-đề bệnh tâm-thần thông-thường nhất. Cứ 1 trong số 4 người sẽ phải trải qua sự rối-loạn lo-lắng vào một thời-điểm nào đó trong cuộc đời của họ. Và có ít nhất là 1 trong số 10 người hiện đang bị khổ-sở vì một loại bệnh rối-loạn lo-lắng. Và ít nhất là phân nửa số người này đang phải đối-phó với bệnh suy-nhược tâm-thần hay một số loại bệnh tâm-thần khác, hoặc với những rắc-rối về việc xử-dụng hóa-chất chẳng hạn như việc lạm-dụng rượu.

### **Có những phương-cách điều-trị hữu-hiệu nào không ?**

Tin mừng cho bạn là những bệnh rối-loạn lo-lắng rất dễ điều-trị. Có độ chừng 8 trong số 10 người mắc bệnh rối-loạn lo-lắng có dịp kinh-nghiệm được sự lợi-ích từ những cách điều-trị, bao gồm sự dùng thuốc men, và sự điều-trị cách cư-xử bằng trực-giác, hoặc tổng-hợp cả hai cách.



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**Sự điều-trị bằng thuốc men** thường liên-quan đến việc dùng một hay nhiều loại thuốc chống suy-nhuộc tâm-thần khác nhau (chẳng hạn như hóa-chất ngăn-cản việc tái dây hợp-chất serotonin kích-thích chất dẫn-truyền thần-kinh ở trong huyết tương). Mặc dù các triệu-chứng trở lại một khi bệnh-nhân ngưng dùng thuốc, nhiều người thấy rằng một trong số những loại thuốc chống suy-nhuộc tâm-thần là một cách điều-trị rất hữu-hiệu trong việc chế-ngự các bệnh rối-loạn lo-lắng. Thường chúng ta phải mất nhiều tuần-lễ mới có thể cảm thấy được những sự ích-lợi, và một số người phải trải qua những phản-ứng phụ bất-lợi kể cả những trục-trắc trong việc giao-hợp tình-dục. Đôi khi bác-sĩ kê toa thuốc loại an-thần cấp-tốc cho việc chế-ngự ngắn hạn bệnh lo-lắng, nhưng chúng tôi không khuyến-khích việc sử-dụng chúng dài hạn vì chúng có thể làm người ta ghiền, và chúng có những triệu-chứng bị thuốc hành bao gồm cả bệnh lo-lắng.

**Phương-pháp điều-trị cách cư-xử trực-giác ( cognitive behavioural treatments)** gọi tắt là CBT, nhấn mạnh đến những kỹ-năng mới vốn rất có hiệu-quả trong việc làm giảm bớt sự lo-lắng (cho dù bạn có đang uống thuốc hay không). Phương-pháp CBT bao gồm việc học-hỏi về những triệu-chứng và những sự khởi-động căn-bệnh, huấn-luyện về cách thư-giãn, huấn-luyện về những kỹ-năng trực-giác (nhận-diện và thử-thách những ý-tưởng kích-động sự lo-lắng), bồi-đắp mức-độ chịu-đựng (qua sự tiếp-xúc càng gia-tăng với sự sợ-hãi) , và kế-hoạch để ngăn-ngừa sự tái-phát của bệnh. Phương-pháp CBT không phải lúc nào cũng có sẵn trong mọi cộng-đồng.

### ***Tôi cần làm những bước kế tiếp nào ?***

- thêm sức cho chính bạn bằng cách thu-lượm thêm tin-tức về bệnh rối-loạn lo-lắng. Và bạn cũng nên tìm biết về những vấn-đề sức-khỏe tâm-thần và những trở-ngại của việc sử-dụng hóa-chất khác mà thường xảy ra đồng lúc với vấn-đề lo-lắng (chẳng hạn như bệnh suy-nhuộc tâm-thần)
- bạn hãy làm cuộc thử-nghiệm gạn-lọc không nêu tên tạiI trang mạng lưới [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) . Bạn hãy in kết-quả này ra và cho bác-sĩ gia-đình hay vị chuyên-gia y-tế của bạn xem qua
- bạn hãy nói chuyện với bác-sĩ gia-đình hay chuyên-gia y-tế của bạn về những triệu-chứng mà bạn có, và về vệc chúng ảnh-hưởng đời-sống bạn ra sao
- bạn hãy yêu-cầu sự thăm-định đầy-đủ về những vấn-đề sức-khỏe tâm-thần hay các vấn-đề trong việc sử-dụng hóa-chất mà bạn đang phải đối-diện
- Xin bạn hỏi thăm về những cách điều-trị có trưng-dẫn mà người ta đã chỉ cho bạn thấy là chúng thực có hiệu-quả (chẳng hạn như việc dùng thuốc men và / hay là phương-pháp CBT)
- Xin bạn nói chuyện với bác-sĩ gia-đình của bạn về việc giới-thiệu bạn đến một bác-sĩ chuyên-môn, là người có thể cung-cấp sự huấn-luyện cấp-tốc hơn trong những kỹ-năng tự-quản-trị hàng ngày
- Xin bạn nói chuyện với gia-đình và bạn-bè đáng tin-cậy để có thêm sự hỗ-trợ trong dự-tính hồi-phục và bảo-trì của bạn
- Xin bạn quan-tâm đến những điều cần-bản về tự chăm-sóc, kể cả việc tập thể-dục đều-đặn, ăn-uống lành-mạnh, ngủ đủ giấc, và giảm bớt sự sử-dụng quá độ các hóa-chất chẳng hạn như chất cà-phê, rượu và các loại thuốc an-thần và giảm đau


### ***Tôi có thể lấy thêm tin-tức ở đâu ?***

- **Cơ-quan Thông-tin về các bệnh Ghiền và Sức-khỏe Tâm-thần của Nhóm Bằng-hữu tinh BC** ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) hay số điện-thoại miễn-phí **1-800-661-2121**)  
Những tài-liệu miễn-phí bao gồm
  - **Túi điều-trị bệnh Rối-loạn lo-lắng:** bài thử-nghiệm, những triệu-chứng của bệnh rối-loạn lo-lắng, các cách điều-trị và nhiều thứ khác
  - **Túi điều-trị bệnh Rối-loạn tâm-thần:** những cách để sống tốt trong khi đang bị bệnh tâm-thần
  - **Kiểu-mẫu an-sinh:** những đường-lối phương-thức để tự chăm-sóc và chế-ngự sự căng-thẳng căn-bản
  - **Bảng dữ-kiện:** những thông-tin cần-bản về sức-khỏe tâm-thần thông-thường và những đề-tài về sử-dụng hóa-chất
  - **Túi điều-trị cho gia-đình:** những thông-tin chính-yếu cho gia-đình và bạn-bè.
- **Hiệp-hội bệnh Rối-loạn lo-lắng tỉnh BC** ([www.anxietybc.com](http://www.anxietybc.com))  
Những tài-liệu miễn-phí bao gồm danh-sách tự chọn những điều cần đọc, những kết-nối với các trang mạng lưới khác về bệnh lo-lắng, và những câu chuyện cá-nhân.
- **Trung-tâm về Hốt-hoàng** ([www.paniccenter.com](http://www.paniccenter.com)) hay nhóm **Anxieties.com** ([www.anxieties.com](http://www.anxieties.com))  
Có những chương-trình tự-quản-tri miễn-phí có sẵn dựa trên mạng lưới thông-tin mà bạn có thể theo dõi một cách thoải-mái và riêng-tư tại nhà
- **Những sách, phim chiếu và băng nói dựa trên bằng-chứng**  
Xin các bạn duyệt qua các nhà sách, thư-viện, và các trang mạng lưới về những nguồn tài-liệu tự quản-trị trên mạng lưới dựa theo bằng-chứng (xin bạn nhớ hỏi họ bỏ thêm vào những nguồn tin mà họ không có trong danh-mục của họ). Những thí-dụ bao gồm :
  - **Sách bài tập về Sự lo-lắng và những bệnh sợ-sệt (The Anxiety & Phobia Workbook)** (2000) do E. J. Bourne viết. nhà xuất-bản New Harbinger Publications (xin bạn xem thêm những sách và băng nói khác của cùng một tác-giả).
  - **Làm chủ được nỗi lo-lắng và sự hốt-hoàng của bạn (Mastery of Your Anxiety and Panic)** (2000), do M. G. Craske & D. H. Barlow viết, xuất-bản bởi D. H. Graywind Publications. Xin xem trang mạng lưới [www.graywindpublications.com](http://www.graywindpublications.com) ( xin xem những quyển sách khác cùng trong chuỗi đề-tài này nói về những bệnh rối-loạn lo-lắng khác kể cả những bệnh sợ-hãi và bệnh rối-loạn đột-hứng ám-ảnh).

***Điều bạn sẽ học-hỏi được là những người có bệnh rối-loạn lo-lắng có thể chế-ngự được những triệu-chứng của họ và sống một đời-sống có kết-quả tốt phước-hạnh.***



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# EARLY PSYCHOSIS: Information for Patients & their Families



# Early Psychosis

## Information for Patients and their Families

### ***What is psychosis?***

The word “psychosis” means loss of touch with reality. A person with psychosis may have severe problems with thinking, behaviour, and emotions. Also, the person may hear voices or other sounds that are not really there. Sometimes the person may see, smell, feel or taste things, or have other sensations that are not real. The term “early psychosis” simply means that a person is experiencing psychosis for the first time.

### ***Who gets psychosis?***

- About 3% of all people will develop psychosis at some time in their life.
- Psychosis usually starts in the late teens or twenties.
- Psychosis can run in families but it is hard to predict who might get it. The chances are about 10-15% that someone may get schizophrenia or bipolar disorder if the illness is found in a parent, brother or sister. The other way of looking at it is that there is 85-90% chance of not developing the disorder.
- Most theories suggest that - like other types of mental illness - the majority of cases of psychosis arise from a combination of genetics and environmental events. Early environmental events (problems during pregnancy, viral infection or head injury) are believed to act as forms of stress that can trigger psychosis.
- Alcohol or drugs may be a trigger for individuals who have a genetic leaning toward psychosis. However, heavy use of alcohol or certain drugs may alone cause psychosis. Sometimes a person may remain psychotic for days (or even longer) after the drug is supposed to have worn off.

### ***What are the symptoms of psychosis?***

#### **Positive Symptoms**

The most dramatic symptoms of psychosis are called positive symptoms. They are called “positive” since the person’s thoughts, beliefs or sensations seem to be expanded or greater than normal. Positive symptoms always suggest that the person has lost contact with reality in some way. Positive symptoms include:

- hallucinations (hearing or seeing things that are not there);
- delusions (false beliefs such as being followed, persecuted by other people, having special powers, or other more bizarre beliefs); and
- thought disorder (trouble thinking clearly or disorganized behaviour, which becomes evident when others can’t understand the meaning of what a person is doing or saying).

#### **Negative Symptoms**

In some disorders, people experience negative symptoms. These symptoms are called “negative” because they involve a decrease in normal experiences. Negative symptoms include:

- little drive to do things;
- lack of energy and interest;
- little display of feelings (this is believed to reflect a loss in the ability to feel things as strongly as before); and
- not speaking very much (this may indicate that the person’s inner world is not as rich as it used to be).

### ***Do People Recover from Psychosis?***

Most people recover from early psychosis, especially if they get prompt and proper treatment. Some people recover quickly and can return to their normal lives very soon. Others need much more time to recover. Although most people recover from a first episode of psychosis, some will experience future episodes. The chances of further episodes depend on the diagnosis, the treatment, and how long treatment is given. Continuing with treatment often prevents future episodes.

**Please note that the Chinese, Korean, Punjabi, Spanish and Vietnamese versions of the Patient/Family Member Information Sheets on Depression, Anxiety Disorders, Early Psychosis and Substance Use are not exact, up-to-date translations of the English versions.**



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Psychosis can have devastating consequences for both the person and their family. It is essential that the entire family be involved in treatment to ensure that all members get the facts and learn how to cope with the impact of psychosis. Through continuing support and education, the entire family is well positioned to work together toward recovery and prevention of future episodes.

### ***How is Psychosis Diagnosed?***

Psychosis occurs in many different mental and physical disorders. Two of the more common diagnoses are schizophrenia and bipolar disorder. A complete assessment is needed to diagnose psychosis. It can take many months to confirm a diagnosis.

### ***How is Psychosis Treated?***

#### **Medication**

Treatment for psychosis usually begins with a type of medication called an atypical antipsychotic. There are many different atypical antipsychotics. The goal of medication is to decrease symptoms of psychosis and prevent future episodes. The lowest possible amount of medication will be used. This helps reduce any possible side effects. It may take many weeks to several months for the medication to have its full effect. Medication should be continued even after the symptoms of psychosis are gone. This is because there is a high risk of having another episode if the medication is stopped too soon.

There are other medications that might be used as well. For example, antidepressants or mood stabilizing medications may be added if there are also problems with mood.

#### **Other Treatments**

In addition to medication, several other types of treatment are very helpful in improving recovery and lowering the risk of future episodes. Treatments should address all the problems caused by the disorder. The positive symptoms of psychosis are usually only the first target for treatment. Other targets could be depression, social problems, poor physical health, or substance use.

Both the person and their family need support and education about psychosis and how to manage it. Learning how to manage stress is one form of education. Coping with stress can make a person feel better and help reduce chances of a future episode. Also, people need to make a plan about what to do if there are signs that psychosis might be starting again.

### ***What Resources are Available for People with Psychosis and their Families?***

Many of the treatments can be provided by your family physician or through your local mental health centre. Listed below are some other resources that will help provide information and support to individuals and their families.

- **BC Schizophrenia Society ([www.bcscs.org](http://www.bcscs.org))**  
Organizes family support and education groups across the province and provides many information resources, including “Early Psychosis: What Families and Friends need to Know,” and “Basic Facts About Schizophrenia”.
- **Early Psychosis Intervention Program ([www.earlypsychosisintervention.ca](http://www.earlypsychosisintervention.ca))**  
Specialized early psychosis intervention services are available in every health region in BC. You can get information about these programs by contacting your local mental health centre. The Fraser South Early Psychosis Intervention Program is one example, which services the Fraser South Region, and provides many online information resources for patients and families.
- **BC Partners for Mental Health and Addictions Information ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) or 1-800-661-2121)**  
Free resources include:
  - **Schizophrenia and Psychosis Disorders Toolkit:** symptoms of schizophrenia, treatment options and more
  - **Mental Disorders Toolkit:** options for living well in the face of mental illness
  - **Wellness Modules:** strategies for basic self-care and stress management
  - **Fact sheets:** basic information on common mental health and substance use topics
  - **Family Toolkit:** key information for family and friends



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### ***Resources (Continued)***

- **Psychosis Support for Parents ([www.psychosissupport.com](http://www.psychosissupport.com))**  
A support group for parents based in the Fraser South Region.
- **Help Overcome Psychosis Early (HOPE) ([www.hope.vancouver.bc.ca](http://www.hope.vancouver.bc.ca))**  
A specialized early psychosis program serving Vancouver/Richmond.
- **Family to Family Newsletter ([www.cmha.ca/english/intrvent](http://www.cmha.ca/english/intrvent))**
- **Schizophrenia Society of Canada ([www.schizophrenia.ca](http://www.schizophrenia.ca))**  
The online manual “Rays of Hope” provides comprehensive and practical information.
- **Knowledge Network ([www.knowledgenetwork.ca/takingcare/index.html](http://www.knowledgenetwork.ca/takingcare/index.html))**  
Child and youth mental health documentaries on psychosis.
- **Dealing with Psychosis: A workbook for learning antipsychotic skills**

**Remember: Psychosis is a treatable condition, and many people recover, going on to lead productive, enjoyable lives.**



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# 初發型精神病

## Early Psychosis

### 患者與家屬須知

#### 何謂精神病?

精神病意指與現實脫節，患者的思想、行為與情感可能出現嚴重問題，同時也可能有幻聽的現象 (聽到其實並不存在的聲音)，有時會看到、聞到或感受到並不存在的現象、氣味或感覺。初發型精神病，是指患者第一次罹患精神病。

#### 誰會得精神病?

- 約有百分之三的人一生中會得精神病
- 精神病通常在十幾、二十歲左右開始發作
- 各種文化的人都會發生精神病
- 精神病可能具有家族遺傳性，但很難預測誰會罹患。如果兄弟姊妹或父母親罹患此症，家中成員罹患精神分裂症或躁鬱症的可能性，是百分之十到十五。或者換個角度看，家人不會得病的機率是百分之八十五到九十。
- 大多數的理論認為，精神病大多是綜合遺傳和環境因素所致。心理創傷、或懷孕時出現的問題、或早年頭部受傷等環境因素，會形成壓力而引發精神病。
- 先天上有精神病傾向的人，也可能因藥物引發此病。某些藥物可使處於亢奮狀態的人精神異常，有時精神異常狀態在藥效減退後，仍會持續數天 (甚至更久)。

#### 精神病有哪些症狀?

##### 正向症狀

精神病最戲劇化的症狀稱為正向症狀，有此一稱是因為患者的思想、信念、或感覺似乎超乎常情，在某些方面與現實脫節，包括：

- 幻覺 (例如，聽到或看到並不存在的聲音與影像)
- 妄想 (覺得被跟蹤、受迫害或具有特殊能力及其他怪誕念頭的妄想)
- 思考混亂 (無法清楚思考，當不了解他人談話內容時，這種情形尤其明顯)

##### 負向症狀

有些病患呈現負向症狀，之所以稱為負向症狀，是因為與正常的情況背離，包括：

- 沒有驅動力
- 沒有精力，興趣缺缺
- 感受力遲鈍 (顯示患者對事物的感受力不如以往敏銳)
- 寡言 (顯示患者的內在世界不如以往豐富)

##### 其他症狀

伴隨精神病症狀出現的其他常見問題有：



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- 抑鬱
- 焦慮
- 濫用藥物成癮
- 睡眠障礙
- 健康障礙
- 社會功能失調
- 工作表現或課業成績失常

### **精神病會痊癒嗎？**

多數精神病患會痊癒，尤其是即時給予正確治療的患者。有些人復元迅速，可以很快恢復正常生活，有些需要較長時間康復。大多數人在第一次發病後即康復，但是有些人日後還會病發。再發的機率端視診斷、治療和治療時間長短而定。持續治療，往往可預防日後病情復發。

精神病會給病患及家屬帶來極大的困擾，有一點很重要的是，全家人都要參與治療，使所有家人都能從精神病所帶來的衝擊中迅速完全恢復。透過持續的支持與教育，全家人才能站穩腳步，攜手合作，預防患者日後再度發病。

### **如何診斷精神病？**

精神病有許多不同的身心障礙症狀，最常見的兩種是精神分裂症和躁鬱症。要診

斷精神病必需做全面性的評估，可能需要好幾個月的時間才能確證罹患精神病。

### **如何治療精神病？**

#### **藥物**

治療精神病通常都先用一種叫做非典型抗精神病的藥物，這種藥有很多種。用藥的目的在減緩精神病症狀，防止日後再發。

爲了防止發生副作用，都投以最低劑量，可能要好幾星期到數月，藥效才能完全發揮。即使在症狀消失後，仍須持續服藥。如果很快就停止服藥，再發的比率很高。

可能也會使用其他藥物，例如，若有情緒問題，也會投以抗憂鬱或穩定情緒的藥物。

#### **其他治療方法**

除了藥物，還有幾種其他療法，對促進康復與降低日後再發率都很有幫助，務須針對精神病引發的所有問題予以治療。精神病患所呈現的正向症狀，通常是治療的首要目標，其他還有憂鬱症、社交障礙、身體健康問題、或藥物濫用問題。

病患與家屬在面對精神病以及如何應對自處這方面，都需要支援與教育。學習如何處理壓力是其中的一環，懂得處理壓力可以令人心情舒暢，有助於降低日後發病機率。同時，如果患者又出現發病徵兆，家人也需要擬定計劃以便因應。



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### 精神病患與家屬有哪些可用資源?

家庭醫生或透過地方性的精神病中心可提供許多治療，以下所列是可協助提供病患和家屬資訊與支援的其他資源

#### 對家屬有用的資源:

- 卑詩省精神分裂症協會 (British Columbia Schizophrenia Society) ，網址是 [www.bcscs.org](http://www.bcscs.org) ，在全省設有家庭支援與教育團體，提供許多資訊資源，包括《初發型精神病：家人與朋友須知事項》和《精神分裂症初探》，網址是 [http://www.bcscs.org/information\\_centre/schizophrenia/early\\_psychosis.html](http://www.bcscs.org/information_centre/schizophrenia/early_psychosis.html)
- 菲沙南區精神病防治計劃 (Fraser South Early Psychosis Intervention Program) <http://www.earlypsychosisintervention.ca> 是服務菲沙南區專門針對初發型精神病的計劃，上面有許多提供給病患與家屬的資訊資源
- 精神病支援家長團體 (Psychosis Support for Parents) <http://www.psychosissupport.com/> 是設在菲沙南區提供給家長的支援團體
- 克服初發型精神病協助會 (Help Overcome Psychosis Early) (HOPE) <http://www.hope.vancouver.bc.ca/> 是服務溫哥華/列治文區，專門針對初發型精神病的計劃
- 家戶簡訊 (Family to Family Newsletter) – [www.cmha.ca/english/intrvent/](http://www.cmha.ca/english/intrvent/)
- 卑詩合作夥伴 (BC Partners) <http://www.heretohelp.bc.ca/> 的線上百寶箱與其他資源，可協助病患面對精神病
- 加拿大精神分裂症協會 (Schizophrenia Society of Canada) 的《一線希望》手冊，提供完整實際的資訊，可上 <http://www.schizophrenia.ca/> 網站取得

若有親人經診斷有精神病的情緒障礙，情緒障礙協會 (Mood Disorders Association) <http://www.mdabc.ca/index.htm> 在全省設有病患與家屬支援團體

卑詩省各醫療區域都有初發型精神病專治計劃服務，目前已推出課程活動或正在籌畫的有下列地區：

- 維多利亞、溫哥華島中部地區
- 溫哥華、素里、本那比、及低陸平原各地
- 科隆那、潘提頓 (Penticton)、維儂 (Vernon)、奈爾森 (Nelson) 和庫特尼 (Kootenays)
- 坎路普斯(Kamloops)、喬治王子(Prince George)

通常成人精神病醫療單位及青少年與孩童精神病醫療單位，都共同參與這些活動；兒童及家庭發展廳 (Ministry of Children and Family Development )(MCFD) 在全省各地，大力推展初發型精神病的服務；有些小社區也對此展現高度興趣，以加強這方面的服務；洽詢各地精神病防治中心，以了解社區內有何特殊資源。

精神病是可治癒的疾病，許多人康復後，繼續工作，生活愉快。



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# 초기 정신질환

## 환자와 가족들을 위한 정보

### Early Psychosis

Information for Patients and their Families

#### 정신질환이란 무엇인가?

"정신질환"이란 단어는 한 사람이 실제 현실과의 단절을 의미한다. 이 같은 경우 사고와 행동, 그리고 감정등에 문제가 생기게 된다. 또한 정신질환을 앓고 있는 사람은 스스로의 목소리를 듣거나 아니면 환청을 듣게 되는데 때때로 실제로 존재 하지 않는 것을 보거나 냄새를 맡거나 다른 감각을 인식하기도 한다. "초기 정신질환"은 정신질환을 처음으로 앓고 있는 사람들을 가리키는 말이다.

#### 누가 정신질환에 걸리는가?

- 3%의 인구가 인생에서 한번은 정신질환을 앓게 된다.
- 정신질환은 대체로 십대나 이십대에 처음 발생하게 된다.
- 정신질환은 모든 문화권에서 발생한다.
- 정신질환은 유전적인 요인으로 집안 내력으로 발생할 수도 있지만 누가 정신질환을 앓게 될런지는 예상할 수 없다. 형제나 부모 등 직계가족중 한명이 정신질환을 앓고 있는 경우 당사자가 정신 분열증이나 조울증등의 정신질환을 앓게 될 가능성은 약 10-15%이다. 반대로 말한다면 정신질환을 앓고 있는 가족이 있다 해도 85-90%는 정신 장애를 앓지 않을 수 있다는 것이다.
- 거의 모든 학설들이 거의 모든 정신질환 케이스들은 유전적인 영향과 환경적인 영향이 합해져서 발달된다고 믿고 있다. 정신적 충격이나 임신기간중 문제 또는 몇년전의 뇌 부상등의 환경적인 요소들이 정신질환을 시작하는 스트레스의 요인으로 작용한다.
- 유전적으로 정신질환 발생인자를 가지고 있는 사람에게는 특정 약물치료 등이 정신질환을 유발 할 수도 있다. 하지만 특정 약물이 정신질환을 유발하는 경우는 그 사람이 예민할때 이다. 때때로 그 사람은 약기운이 떨어지고 난 뒤 며칠 후(더 길어질 수도 있음) 동안 정신이상 상태로 남아 있을 수 있다.

#### 정신질환의 증세에는 어떤것들이 있는가?

##### 양성적 증세

- 정신질환의 가장 두드러진 증세들을 양성적 증세이라고 부른다. 양성적이라고 불리우는 이유는 환자의 생각과 믿음 또는 감각등이 평소보다 확대되거나 확산되는 것 처럼 보이기 때문이다. 적극적 증세들은 언제나 환자의 현실세계와의 단절을 나타내며 그 증세들은 다음과 같다.
- 환각증세 (예,실존 하지 않는 소리를 듣는다.)
- 망상 (쫓기고 있다거나 다른이에게 박해를 당한다거나, 자신이 특별한 능력을 지니고 있다거나 더 심각한 생각등의 틀린 믿음들을 갖게 된다.)
- 사고 장애 (분명한 생각을 하는데 있어서 문제가 있는 경우: 사람이 이야기 하는 것에 대해서 확실하게 이해하지 못하는 경우이다.)

##### 음성적 증세

특정 장애를 갖고 있는 사람들은 음성적 증세들을 보인다. 음성적이라고 불리우는 이유는 평소 경험들의 저하와 관련이 있기 때문이다. 그 증세들은 다음과 같다.

- 사물에 대한 의욕 저하
- 에너지와 흥미 부족
- 감정을 느끼지 못함 (어떤것에 대한 느낌이 예전보다 많이 감퇴되었음을 의미한다)
- 말수가 줄 (이것은 그 사람의 내면세계가 예전보다 덜 풍부하다는 것을 의미한다)

##### 그 외 다른 증세들

정신질환 증세와 함께 아래와 같은 증세들이 나타나는것이 보통이다.

- 우울증
- 불안감
- 약물 남용
- 수면 장애



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- 건강 문제
- 사회적 기능 악화
- 학교나 직장에서의 기능 악화

### 정신질환에서 회복될 수 있는가?

심한 자극을 받거나 적당한 치료를 한다면 거의 모든 사람들이 정신질환에서 회복될 수 있다. 어떤 사람들은 광범히 빨리 회복될 수 있으며 평범한 일상생활로 곧 돌아올 수 있으며 어떤 사람들은 이 보다 훨씬 더 많은 시간을 필요로 하기도 한다. 정신질환의 첫번째 기간에서 회복 되었다 하더라도 어떤 사람들은 후에 이런 정신증들을 다시 겪을 수 있다. 차후 증세들은 진단, 치료, 그리고 치료기간에 따라서 달라진다. 지속적인 치료는 이런 차후 재발을 막아준다.

정신질환은 환자와 가족 모두에게 망연자실케 하는 결과를 초래할 수 있다. 정신질환의 영양해서 최대한 빨리 그리고 완전하게 회복되기 위해서는 가족 모두가 치료에 함께 참여하는것이 중요하다. 그리고 지속적인 도움과 교육을 통해서 가족 전체가 차후 재발을 막기 위해 노력해야 할 것이다.

### 정신질환은 어떻게 진단되는가?

정신질환은 다양한 정신적 신체적 장애에서 나타난다. 가장 보편적인 진단중 두가지는 정신분열증과 조울증이다. 정신질환 진단을 위해서는 완벽한 판단이 필요하며 확실히 병으로 판명되기 위해서는 수개월이 걸린다.

### 정신질환은 어떻게 치료 되는가?

#### 약물 치료

대체로 정신질환 치료는 비전형 항정신약(atypical antipsychotic) 이란 약물로 시작된다. 이런 비전형 항정신약에는 많은 종류가 있는데 이 약물치료의 목적은 정신질환 증세의 감소와 차후 재발을 막기 위함이다.

약물치료시에는 최소한의 양만이 사용되는데 이는 다른 부작용들의 발생을 줄이기 위함이다. 약물치료가 완전히 효과를 보이기 까지는 몇주에서 몇달이 걸리는데 이런 치료는 정신질환 증세들이 사라지고 난 후에도 계속되어야만 한다. 이유는 약물치료가 너무 빨리 중단 된다면 차후 재발 가능성이 높아지기 때문이다.

비전형 항정신약외에 치료에 쓰는 약물들이 더 있다. 예를들면 항울제나, 감정 안정제등이 감정등에 문제가 있을때 함께 쓰이기도 한다.

#### 다른 치료

약물치료외에도 다른 치료 방법들이 정신질환에서 회복하고 차후 재발 가능성을 줄이기 위해 사용되고 있다. 이런 치료들은 장애로 부터 오는 문제점들에게 정확히 다가가야 한다. 정신질환의 퍼지티브 증세들이 대개 이런 치료의 첫번째 대상이 된다. 다른 대상들은 우울증이나, 사회적 문제, 신체적 건강문제, 또는 약물 남용들이 된다.

당사자나 가족 모두 정신질환과 이를 관리하는 방법에 대한 교육과 도움이 필요하다. 스트레스를 관리하는 방법도 교육의 한가지이다. 스트레스에 대한 대처능력은 당사자가 기분을 좋게 하고 차후 재발의 가능성을 줄이는데 도움이 된다. 또한, 사람들은 정신질환 증세들이 다시 보이기 시작했을때 무엇을 해야할지에 대한 계획도 세워 놓아야 한다.

### 정신질환을 앓고 있는 환자와 그의 가족들을 위한 관련 정보에는 어떤것이 있을까?

많은 치료들이 당사자의 가족이나 의사, 또는 지역 정신건강센터등에서 행해지고 있다. 아래에 나열된 정보들은 당사자와 가족들에게 더 많은 정보와 도움이 될 것이다.

가족들에게 도움이 되는 정보들:

- 비씨주 정신분열증 협회(British Columbia Schizophrenia Society) [www.bcscs.org](http://www.bcscs.org)  
BC주 내의 가족의 도움과 교육을 위한 그룹 개설. "초기 정신질환:가족과 친구들이 무엇을 알아야 하나" 와 "정신분열증에 관한 기본적인 사실들 ([www.bcscs.org/information\\_center/schizophrenia/early\\_psychosis.html](http://www.bcscs.org/information_center/schizophrenia/early_psychosis.html))
- 프레이저 사우스 초기 정신질환 중재 프로그램 (Fraser South Early Psychosis Intervention Program) <http://www.earlypsychosisintervention.ca>  
프레이저 사우스 지역의 차별화된 초기 정신질환 프로그램; 가족과 친구들을 위한 많은 정보들이 인터넷상에 준비되어 있다.



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- 부모를 위한 정신질환 후원 <http://www.psychosissupport.com/>  
프레이저 싸우스 지역의 부모들을 위한 후원그룹
- Help Overcome Psychosis Early(HOPE) <http://hope.vancouver.bc.ca/>  
밴쿠버와 리치몬드 지역의 차별화된 초기 정신질환 프로그램
- Family to Family Newspaper - [www.cmha.ca/english/intrvent/](http://www.cmha.ca/english/intrvent/)
- BC Partners <http://www.heretohelp.bc.ca/>  
당사자들이 그들의 병을 관리할 수 있는 온라인 툴킷과 다른 정보들.
- 캐나다 정신분열증 협회 (Schizophrenia Society of Canada)  
"희망의 빛(Rays of Hope) 이란 문서는 포괄적이며 실용적인 정보들을 담고 있다.  
온라인상에서도 볼 수 있다. [www.schizophrenia.ca/](http://www.schizophrenia.ca/)

가족중 누군가가 감정장애 진단을 받은 사람들을 위하여 감정 장애 협회  
<http://www.mdabc.ca/index.htm> 가 환자와 가족을 위한 서포트 그룹과 교육프로그램을 구성하였다.

전문적인 초기 정신질환 중재 서비스는 BC주 모든 건강지역에서 입수할 수 있다. 현재 프로그램이  
진행되고 있는 지역은

- 빅토리아, 밴쿠버 아일랜드 중심부
- 밴쿠버, 씨리, 버나비를 포함한 로워 메인랜드지역
- 켈로나, 펜틱톤, 버논, 벨슨과 쿠틀네이스
- 캄프스, 프린스 조지

성인과 아이, 그리고 청소년들을 위한 정신 건강 서비스는 다음의 팀으로 이루어 진다. 가족과 어린이  
개발부(Ministry of Child and Family Development) 는 BC주 내의 초기 정신질환에 관한 서비스의 폭을  
넓혀왔다. 규모가 작은 커뮤니티들도 또한 초기 정신질환에 관한 관심을 보이고 있다. 귀하가 거주하고  
있는 커뮤니티내에서 어떤 지원이 이루어지고 있는지 지역 정신 건강 센터를 확인 바란다.

정신질환은 치료 가능한 병입니다. 그리고 병으로부터 회복할 수 있으며  
생산적이고 즐거운 생활로 되돌아 갈 수 있음을 기억해야 할 것입니다.



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## ਆਰੰਭਕ ਮਨੋਰੋਗ ਮਰੀਜ਼ਾਂ ਅਤੇ ਪਰਿਵਾਰਾਂ ਲਈ ਜਾਣਕਾਰੀ

### ਮਨੋਰੋਗ ਕੀ ਹੈ?

ਸ਼ਬਦ ਮਨੋਰੋਗ (ਸਾਇਕੋਸਿਸ) ਦਾ ਭਾਵ ਹੈ ਕਿ ਵਿਅਕਤੀ ਯਥਾਰਥ ਨਾਲੋਂ ਟੁੱਟ ਜਾਂਦਾ/ਜਾਂਦੀ ਹੈ। ਸੋਚ ਪ੍ਰਕਿਰਿਆ, ਵਿਵਹਾਰ ਅਤੇ ਭਾਵਾਂ ਵਿਚ ਗੰਭੀਰ ਸਮੱਸਿਆਵਾਂ ਪੈਦਾ ਹੋ ਸਕਦੀਆਂ ਹਨ। ਵਿਅਕਤੀ ਨੂੰ ਬੋਲ ਜਾਂ ਹੋਰ ਅਜਿਹੀਆਂ ਅਵਾਜ਼ਾਂ ਸੁਣ ਸਕਦੀਆਂ ਹਨ ਜੋ ਅਸਲ ਵਿਚ ਮੌਜੂਦ ਨਾ ਹੋਣ। ਕਦੇ ਕਦੇ ਵਿਅਕਤੀ ਅਜਿਹੀਆਂ ਵਸਤਾਂ ਸੁੰਘ ਸਕਦਾ/ਸਕਦੀ ਹੈ, ਜਾਂ ਹੋਰ ਅਜਿਹੀਆਂ ਸੰਵੇਦਨਾਵਾਂ ਮਹਿਸੂਸ ਕਰ ਸਕਦਾ/ਸਕਦੀ ਹੈ ਜੋ ਸੱਚ ਨਾ ਹੋਣ। “ਆਰੰਭਕ ਮਨੋਰੋਗ” ਦਾ ਸਿਧਾ ਜਿਹਾ ਭਾਵ ਹੈ ਕਿ ਵਿਅਕਤੀ ਪਹਿਲੀ ਵਾਰ ਮਨੋਰੋਗ ਅਨੁਭਵ ਕਰ ਰਿਹਾ/ਰਹੀ ਹੈ।

### ਮਨੋਰੋਗ ਕਿਸਨੂੰ ਹੁੰਦਾ ਹੈ?

- ਤਕਰੀਬਨ 3 ਪ੍ਰਤਿਸ਼ਤ ਲੋਕ ਜ਼ਿੰਦਗੀ ਵਿਚ ਕਿਸੇ ਨਾ ਕਿਸੇ ਸਮੇਂ ਮਨੋਰੋਗ ਦਾ ਸ਼ਿਕਾਰ ਹੋ ਜਾਂਦੇ ਹਨ
- ਮਨੋਰੋਗ ਆਮ ਕਰਕੇ ਵਿਅਕਤੀ ਦੇ 13 ਸਾਲ ਤੋਂ ਪਿਛਲੇ ਅਤੇ ਵੀਹਵਿਆਂ ਦੇ ਮੁਢਲੇ ਸਾਲਾਂ ਵਿਚ ਆਰੰਭ ਹੁੰਦਾ ਹੈ
- ਮਨੋਰੋਗ ਸਾਰੇ ਸਭਿਆਚਾਰਾਂ ਦੇ ਲੋਕਾਂ ਨੂੰ ਹੁੰਦਾ ਹੈ
- ਮਨੋਰੋਗ ਪਰਿਵਾਰ ਵਿਚ ਪੀੜ੍ਹੀ ਦਰ ਪੀੜ੍ਹੀ ਹੋ ਸਕਦਾ ਹੈ ਪਰ ਇਹ ਅੰਦਾਜ਼ਾ ਲਾਉਣਾ ਕਠਿਨ ਹੈ ਕਿ ਇਹ ਕਿਸਨੂੰ ਹੋਵੇਗਾ। ਜੇ ਪਰਿਵਾਰ ਵਿਚ ਭਰਾ ਜਾਂ ਭੈਣ ਜਾਂ ਇਕ ਮਾਪੇ ਨੂੰ ਮਨੋਰੋਗ ਹੋਵੇ ਤਾਂ 10-15 ਪ੍ਰਤਿਸ਼ਤ ਸੰਭਾਵਨਾ ਹੈ ਕਿ ਵਿਅਕਤੀ ਨੂੰ ਕੋਈ ਸਕਿਟਸਫਰੀਨੀਅ(ਮਨੋਭਾਜਨ) ਜਾਂ ਬਾਇਪੋਲਰ(ਦੋ-ਧੁਰਾ) ਵਰਗਾ ਰੋਗ ਲੱਗ ਜਾਵੇ
- ਵਧੇਰੇ ਸਿਧਾਂਤ ਇਸ ਗੱਲ ‘ਚ ਯਕੀਨ ਰਖਦੇ ਹਨ ਕਿ ਮਨੋਰੋਗ ਦੇ ਬਹੁਤੇ ਕੇਸ ਜਨੈਟਿਕਸ (ਉਤਪਤੀ-ਵਿਗਿਆਨ) ਅਤੇ ਵਾਤਾਵਰਣ ਦੀਆਂ ਘਟਨਾਵਾਂ ਦੇ ਸੁਮੇਲ ਤੋਂ ਪੈਦਾ ਹੁੰਦੇ ਹਨ। ਯਕੀਨ ਕੀਤਾ ਜਾਂਦਾ ਹੈ ਕਿ ਵਾਤਾਵਰਣਿਕ ਘਟਨਾਵਾਂ ਜਿਵੇਂ ਸਦਮਾ, ਜਾਂ ਜਣੇਪੇ ਵੇਲੇ ਦੀਆਂ ਸਮੱਸਿਆਵਾਂ, ਜਾਂ ਬਹੁਤ ਸਾਲ ਪਹਿਲਾਂ ਲੱਗੀ ਸਿਰ ਦੀ ਸੱਟ, ਅਜਿਹੇ ਮਾਨਸਿਕ ਦਬਾਓ ਪੈਦਾ ਕਰ ਸਕਦੇ ਹਨ ਜਿਹਨਾਂ ਨਾਲ ਮਨੋਰੋਗ ਉਤਪੰਨ ਹੋ ਜਾਵੇ।
- ਜਿਨ੍ਹਾਂ ਵਿਅਕਤੀਆਂ ਦੀ ਜਨੈਟਿਕ ਤੌਰ ਤੇ ਮਨੋਰੋਗ ਵੱਲ ਰੁਚੀ ਹੋਵੇ ਉਹਨਾਂ ਨੂੰ ਡਰੱਗਾਂ ਨਾਲ ਵੀ ਮਨੋਰੋਗ ਆਰੰਭ ਹੋ ਸਕਦਾ ਹੈ, ਕੁਝ ਡਰੱਗਾਂ ਵਿਅਕਤੀ ਨੂੰ ਜਦੋਂ ਉਹ ਬਹੁਤ ਨਸ਼ੇ ਵਿਚ ਹੋਵੇ ਮਨੋਰੋਗੀ ਬਣਾ ਸਕਦੀਆਂ। ਕਈ ਵਾਰ ਜਦੋਂ ਖਿਆਲ ਕੀਤਾ ਜਾਂਦਾ ਹੈ ਕਿ ਡਰੱਗ ਦਾ ਅਸਰ ਲਹਿ ਗਿਆ ਹੈ ਫੇਰ ਵੀ ਵਿਅਕਤੀ ਕਈ ਦਿਨ (ਜਾਂ ਇਸਤੋਂ ਵੀ ਲੰਬਾ ਸਮਾਂ) ਮਨੋਰੋਗੀ ਰਹਿ ਸਕਦਾ ਹੈ।

### ਮਨੋਰੋਗ ਦੇ ਲੱਛਣ ਕੀ ਹਨ?

#### ਹਾਂ-ਪੱਖੀ ਲੱਛਣ

ਮਨੋਰੋਗ ਦੇ ਸਭ ਤੋਂ ਬਹੁਤੇ ਨਾਟਕੀ ਲੱਛਣਾਂ ਨੂੰ ਹਾਂ-ਪੱਖੀ (ਪਾਜ਼ਟਿਵ) ਕਿਹਾ ਜਾਂਦਾ ਹੈ। ਇਹਨਾਂ ਨੂੰ ਹਾਂ-ਪੱਖੀ ਇਸ ਲਈ ਕਿਹਾ ਜਾਂਦਾ ਹੈ ਕਿਉਂਕਿ ਵਿਅਕਤੀ ਦੇ ਖਿਆਲ, ਵਿਸ਼ਵਾਸ, ਜਾਂ ਸੰਵੇਦਨਾਵਾਂ ਦਾ ਫੈਲਾਅ ਹੋ ਜਾਂਦਾ ਹੈ ਜਾਂ ਉਹ ਆਮ ਨਾਲੋਂ ਵੱਡੀਆਂ ਹੋ ਜਾਂਦੀਆਂ ਹਨ। ਹਾਂ-ਪੱਖੀ ਲੱਛਣ ਹਮੇਸ਼ਾਂ ਇਹ ਸੁਝਾਉਂਦੇ ਹਨ ਕਿ ਵਿਅਕਤੀ ਕਿਸੇ ਨਾ ਕਿਸੇ ਤਰੀਕੇ ਨਾਲ ਯਥਾਰਥ ਤੋਂ ਟੁੱਟ ਗਿਆ ਹੈ। ਇਨ੍ਹਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ

- ਮਨੋ-ਭ੍ਰਾਂਤੀ ਜਾਂ ਹਲੂਸੀਨੇਸ਼ਨਜ਼ (ਮਿਸਾਲ ਵਜੋਂ ਅਜਿਹੀਆਂ ਗੱਲਾਂ ਸੁਣਨੀਆਂ ਜਾਂ ਵਸਤਾਂ ਦਿਸਣੀਆਂ ਜੋ ਅਸਲ ਵਿਚ ਨਾ ਹੋਣ)
- ਵਹਿਮ ਜਾਂ ਡਲੂਯਨਜ਼ (ਬੁਠੇ ਯਕੀਨ ਜਿਵੇਂ ਕੋਈ ਮਗਰ ਮਗਰ ਆ ਰਿਹਾ ਹੈ, ਦੂਸਰਿਆਂ ਵੱਲੋਂ ਜ਼ੁਲਮ, ਵਿਸ਼ੇਸ਼ ਤਾਕਤਾਂ ਦਾ ਮਾਲਕ ਹੋਣਾ, ਜਾਂ ਹੋਰ ਬੇਤੁਕੇ ਵਿਸ਼ਵਾਸ)
- ਵਿਚਾਰ-ਰੋਗ ਜਾਂ ਬਾਟ ਡਿਸਆਰਡਰ (ਸਪਸ਼ਟ ਨਾ ਸੋਚ ਸਕਣਾ, ਇਸ ਦਾ ਉਸ ਸਮੇਂ ਪਤਾ ਲਗਦਾ ਹੈ ਜਦੋਂ ਤੁਸੀਂ ਸਮਝ ਨਾ ਸਕੋ ਕਿ ਵਿਅਕਤੀ ਕੀ ਕਹਿ ਰਿਹਾ ਹੈ)



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### **ਨਾ-ਪੱਖੀ ਲੱਛਣ**

ਕਈ ਰੋਗਾਂ ਵਿਚ ਲੋਕ ਨਾ-ਪੱਖੀ ਲੱਛਣ ਅਨੁਭਵ ਕਰਦੇ ਹਨ। ਇਹਨਾਂ ਲੱਛਣਾਂ ਨੂੰ ਨਾ-ਪੱਖੀ ਇਸ ਲਈ ਕਿਹਾ ਜਾਂਦਾ ਹੈ ਕਿਉਂਕਿ ਇਨ੍ਹਾਂ ਸਮੇਂ ਅਨੁਭਵ ਵਿਚ ਆਮ ਸਥਿਤੀ ਨਾਲੋਂ ਘਾਟ ਆ ਜਾਂਦੀ ਹੈ। ਇਹਨਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ

- ਕੰਮ ਕਰਨ ਲਈ ਰੁਚੀ ਨਾ ਹੋਣੀ
- ਬਲ ਅਤੇ ਦਿਲਚਸਪੀ ਦੀ ਘਾਟ
- ਭਾਵਨਾਵਾਂ ਦਾ ਪ੍ਰਗਟਾ ਨਾ ਕਰਨਾ (ਇਸ ਬਾਰੇ ਯਕੀਨ ਕੀਤਾ ਜਾਂਦਾ ਹੈ ਕਿ ਚੀਜ਼ਾਂ ਨੂੰ ਪਹਿਲਾਂ ਵਾਂਗ ਸ਼ਿਦਤ ਨਾਲ ਮਹਿਸੂਸ ਕਰਨ ਦੀ ਯੋਗਤਾ ਘਟ ਜਾਂਦੀ ਹੈ)
- ਬਹੁਤਾ ਨਾ ਬੋਲਣਾ (ਇਹ ਇਸ ਗੱਲ ਦਾ ਸੂਚਕ ਹੋ ਸਕਦਾ ਹੈ ਕਿ ਵਿਅਕਤੀ ਦਾ ਅੰਤਰੀਵ ਸੰਸਾਰ ਪਹਿਲਾਂ ਵਾਂਗ ਅਮੀਰ ਨਹੀਂ ਰਿਹਾ)

### **ਦੂਜੇ ਲੱਛਣ**

ਇਹ ਆਮ ਗੱਲ ਹੈ ਕਿ ਮਨੋਰੋਗ ਲੱਛਣਾਂ ਦੇ ਨਾਲ ਨਾਲ ਦੂਸਰੇ ਲੱਛਣ ਵੀ ਪ੍ਰਗਟ ਹੁੰਦੇ ਹਨ, ਜਿਨ੍ਹਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ

- ਡਿਪਰੈਸ਼ਨ
- ਐਂਗਜ਼ਾਇਟੀ
- ਡਰੱਗ ਦੁਰਵਰਤੋਂ
- ਨੀਂਦ ਦੀਆਂ ਸਮੱਸਿਆਵਾਂ
- ਸਿਹਤ ਦੀਆਂ ਸਮੱਸਿਆਵਾਂ
- ਸਮਾਜ ਵਿਚ ਚੰਗੀ ਤਰਾਂ ਨਾ ਵਿਚਰਨਾ
- ਸਕੂਲ ਵਿਚ ਜਾਂ ਕੰਮ ਉੱਤੇ ਚੰਗੀ ਤਰਾਂ ਨਾ ਵਿਚਰਨਾ

### **ਕੀ ਲੋਕ ਮਨੋਰੋਗ ਤੋਂ ਰਾਜੀ ਹੋ ਜਾਂਦੇ ਹਨ?**

ਬਹੁਤੇ ਲੋਕ ਮਨੋਰੋਗ ਤੋਂ ਮੁਕਤ ਹੋ ਜਾਂਦੇ ਹਨ, ਵਿਸ਼ੇਸ਼ ਕਰਕੇ ਜੇ ਉਹਨਾਂ ਨੂੰ ਸਹੀ ਅਤੇ ਤੁਰੰਤ ਇਲਾਜ ਮਿਲ ਜਾਵੇ। ਕੁਝ ਲੋਕ ਛੇਤੀ ਰਾਜੀ ਹੋ ਜਾਂਦੇ ਹਨ ਅਤੇ ਆਪਣੀਆਂ ਆਮ ਜ਼ਿੰਦਗੀਆਂ ਵਿਚ ਬਹੁਤ ਛੋਟੀ ਵਾਪਸ ਆ ਜਾਂਦੇ ਹਨ। ਦੂਸਰਿਆਂ ਨੂੰ ਰਾਜੀ ਹੋਣ ਲਈ ਬਹੁਤ ਸਮੇਂ ਦੀ ਲੋੜ ਹੁੰਦੀ ਹੈ। ਭਾਵੇਂ ਬਹੁਤੇ ਲੋਕ ਮਨੋਰੋਗ ਦੇ ਪਹਿਲੇ ਐਪੀਸੋਡ (ਘਟਨਾ) ਪਿਛੋਂ ਰਾਜੀ ਹੋ ਜਾਂਦੇ ਹਨ, ਕਈ ਅੱਗੋਂ ਭਵਿੱਖ ਵਿਚ ਹੋਰ ਐਪੀਸੋਡਾਂ ਦਾ ਅਨੁਭਵ ਵੀ ਕਰਦੇ ਹਨ। ਅਗਲੇ ਐਪੀਸੋਡਾਂ ਦਾ ਆਉਣਾ ਰੋਗ-ਪਛਾਣ, ਇਲਾਜ, ਅਤੇ ਇਲਾਜ ਦੀ ਲੰਬਾਈ ਤੇ ਨਿਰਭਰ ਕਰਦਾ ਹੈ। ਜੇ ਇਲਾਜ ਜਾਰੀ ਰਹੇ ਤਾਂ ਇਸ ਨਾਲ ਅਕਸਰ ਭਵਿੱਖ ਦੇ ਐਪੀਸੋਡ ਰੁਕ ਜਾਂਦੇ ਹਨ।

ਮਨੋਰੋਗ ਦੇ ਅਸਰ ਵਿਅਕਤੀ ਲਈ ਅਤੇ ਉਸਦੇ ਪਰਿਵਾਰ ਦੋਹਾਂ ਲਈ ਤਬਾਹਕੂਨ ਹੋ ਸਕਦੇ ਹਨ। ਇਹ ਜ਼ਰੂਰੀ ਹੈ ਕਿ ਪਰਿਵਾਰ ਦੇ ਸਾਰੇ ਮੈਂਬਰ ਹੀ ਇਲਾਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਤਾਂ ਕਿ ਸਾਰੇ ਮੈਂਬਰ ਹੀ ਮਨੋਰੋਗ ਦੀਆਂ ਸੱਟਾਂ ਦੇ ਅਸਰ ਤੋਂ ਛੇਤੀ ਅਤੇ ਪੂਰੀ ਤਰਾਂ ਮੁਕਤ ਹੋ ਸਕਣ। ਨਿਰੰਤਰ ਵਿਦਿਆ ਅਤੇ ਸਹਾਰੇ ਰਾਹੀਂ ਸਾਰਾ ਪਰਿਵਾਰ ਹੀ ਭਵਿੱਖ ਵਿਚ ਹੋਣ ਵਾਲੇ ਐਪੀਸੋਡਾਂ ਨੂੰ ਰੋਕਣ ਲਈ ਤਿਆਰ ਬਰ ਤਿਆਰ ਰਹਿੰਦਾ ਹੈ

### **ਮਨੋਰੋਗ ਦੀ ਰੋਗ-ਪਛਾਣ ਕਿਵੇਂ ਕੀਤੀ ਜਾਂਦੀ ਹੈ**

ਮਨੋਰੋਗ ਵਖਰੇ ਵਖਰੇ ਬਹੁਤ ਮਾਨਸਿਕ ਅਤੇ ਸਰੀਰਕ ਰੋਗਾਂ ਦੇ ਨਾਲ ਨਾਲ ਹੋ ਜਾਂਦਾ ਹੈ। ਬਹੁਤੇ ਪਾਏ ਜਾਂਦੇ ਆਮ ਰੋਗ-ਪਛਾਣਾਂ (ਡਾਇਗਨੋਸਿਸ) ਵਿਚੋਂ ਦੋ ਹਨ: ਸਕਿਟਸਫਰੀਨੀਆ ਅਤੇ ਬਾਇਪੋਲਰ ਰੋਗ। ਮਨੋਰੋਗ ਦਾ ਮੁਲਾਂਕਣ ਕਰਨ ਲਈ ਪੂਰੀ ਪੂਰੀ ਰੋਗ-ਪਛਾਣ ਕਰਨੀ ਜ਼ਰੂਰੀ ਹੈ। ਕਿਸੇ ਰੋਗ-ਪਛਾਣ ਦੀ ਪੁਸ਼ਟੀ ਕਰਨ ਲਈ ਕਈ ਮਹੀਨੇ ਲੱਗ ਸਕਦੇ ਹਨ।

### **ਮਨੋਰੋਗ ਦਾ ਇਲਾਜ ਕਿਵੇਂ ਕੀਤਾ ਜਾਂਦਾ ਹੈ?**

#### **ਦਵਾਈਆਂ (ਮੈਡੀਕੇਸ਼ਨ)**

ਮਨੋਰੋਗ ਦਾ ਇਲਾਜ ਆਮ ਤੌਰ ਤੇ ਇਕ ਕਿਸਮ ਦੀ ਦਵਾਈ ਨਾਲ ਆਰੰਭ ਹੁੰਦਾ ਹੈ ਜਿਸਨੂੰ ਏਟਿਪਕਲ ਐਂਟੀਸਾਇਕਾਟਿਕ ਕਿਹਾ ਜਾਂਦਾ ਹੈ। ਏਟਿਪਕਲ ਐਂਟੀਸਾਇਕਾਟਿਕ ਦਵਾਈਆਂ ਕਈ ਕਿਸਮ ਦੀਆਂ ਉਪਲਬਧ ਹਨ। ਦਵਾਈਆਂ ਦਾ ਉਦੇਸ਼ ਮਨੋਰੋਗ ਦੇ ਲੱਛਣਾਂ ਨੂੰ ਘਟਾਉਣਾ ਅਤੇ ਭਵਿੱਖ ਵਿਚ ਹੋਣ ਵਾਲੇ ਐਪੀਸੋਡਾਂ ਨੂੰ ਰੋਕਣਾ ਹੈ।

ਘੱਟ ਤੋਂ ਘੱਟ ਦਵਾਈਆਂ ਦੀ ਵਰਤੋਂ ਕੀਤੀ ਜਾਂਦੀ ਹੈ। ਇਸਤਰਾਂ ਹੋਣ ਵਾਲੇ ਸੰਭਾਵੀ ਗੌਣ ਪ੍ਰਭਾਵ ਘਟਾਉਣ ਵਿਚ ਸਹਾਇਤਾ ਹੁੰਦੀ ਹੈ। ਦਵਾਈਆਂ ਦਾ ਪੂਰਾ ਅਸਰ ਹੋਣ ਵਿਚ ਕਈ ਹਫ਼ਤਿਆਂ ਤੋਂ ਲੈਕੇ ਮਹੀਨੇ ਲੱਗ ਸਕਦੇ ਹਨ। ਇਹ ਦਵਾਈਆਂ ਮਨੋਰੋਗ ਦੇ ਲੱਛਣ



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ਹਟ ਜਾਣ ਤੋਂ ਪਿਛੋਂ ਵੀ ਜਾਰੀ ਰਖਣੀਆਂ ਚਾਹੀਦੀਆਂ ਹਨ। ਇਹ ਇਸ ਲਈ ਕਿ ਜੇ ਦਵਾਈਆਂ ਛੇਤੀ ਬੰਦ ਕਰ ਦਿਤੀਆਂ ਜਾਣ ਤਾਂ ਇਕ ਹੋਰ ਐਪੀਸੋਡ ਹੋ ਜਾਣ ਦਾ ਬਹੁਤ ਖਤਰਾ ਵਧ ਜਾਂਦਾ ਹੈ।

ਹੋਰ ਵੀ ਦਵਾਈਆਂ ਹਨ ਜੋ ਵਰਤੀਆਂ ਜਾ ਸਕਦੀਆਂ ਹਨ। ਮਿਸਾਲ ਵਜੋਂ, ਜੇ ਮੂਡ ਦੀਆਂ ਸਮੱਸਿਆਵਾਂ ਵੀ ਹੋਣ ਤਾਂ ਐਂਟੀ ਡਿਪਰੈਸੈਂਟ ਜਾਂ ਮੂਡ ਨੂੰ ਸੰਤੁਲਤ ਕਰਨ ਵਾਲੀਆਂ ਦਵਾਈਆਂ ਵੀ ਨਾਲ ਲਈਆਂ ਜਾ ਸਕਦੀਆਂ ਹਨ।

### ਹੋਰ ਇਲਾਜ

ਦਵਾਈਆਂ ਤੋਂ ਇਲਾਵਾ ਹੋਰ ਕਈ ਕਿਸਮ ਦੇ ਇਲਾਜ ਹਨ ਜੋ ਰਾਜੀ ਹੋਣ ਅਤੇ ਭਵਿੱਖ ਵਿਚ ਹੋਣ ਵਾਲੇ ਐਪੀਸੋਡਾਂ ਦਾ ਖਤਰਾ ਘੱਟ ਕਰਨ ਲਈ ਬਹੁਤ ਸਹਾਇਕ ਹੋ ਸਕਦੇ ਹਨ। ਇਲਾਜ ਲਈ ਜ਼ਰੂਰੀ ਹੈ ਕਿ ਇਹ ਰੋਗ ਨਾਲ ਪੈਦਾ ਹੋਈਆਂ ਸਾਰੀਆਂ ਸਮੱਸਿਆਵਾਂ ਤੇ ਲਾਗੂ ਹੋਵੇ। ਮਨੋਰੋਗ ਦੇ ਹਾਂ-ਪੱਖੀ ਲੱਛਣ ਆਮ ਤੌਰ ਤੇ ਇਲਾਜ ਦਾ ਕੇਵਲ ਪਹਿਲਾ ਨਿਸ਼ਾਨਾ ਹੁੰਦੇ ਹਨ। ਦੂਸਰੇ ਨਿਸ਼ਾਨੇ, ਡਿਪਰੈਸ਼ਨ, ਸਮਾਜਿਕ ਸਮੱਸਿਆਵਾਂ, ਕਮਜ਼ੋਰ ਸਰੀਰਕ ਸਿਹਤ, ਜਾਂ ਪਦਾਰਥ ਦੁਰਵਰਤੋਂ।

ਵਿਅਕਤੀ ਅਤੇ ਪਰਿਵਾਰ ਦੋਹਾਂ ਨੂੰ ਹੀ ਮਨੋਰੋਗ ਅਤੇ ਇਸਨੂੰ ਕਾਬੂ ਵਿਚ ਰੱਖਣ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਵਿਦਿਆ ਦੀ ਲੋੜ ਹੈ। ਵਿਦਿਆ ਦਾ ਇਕ ਭਾਗ ਹੈ ਕਿ ਮਾਨਸਿਕ ਦਬਾਓ ਨੂੰ ਕਿਵੇਂ ਮੈਨੇਜ ਕਰਨਾ ਹੈ। ਮਾਨਸਿਕ ਦਬਾਓ ਨਾਲ ਸਿੱਝਣਾ ਇਕ ਵਿਅਕਤੀ ਨੂੰ ਚੰਗਾ ਮਹਿਸੂਸ ਕਰਵਾ ਸਕਦਾ ਹੈ ਅਤੇ ਭਵਿੱਖ ਵਿਚ ਹੋਣ ਵਾਲੇ ਐਪੀਸੋਡ ਦੀ ਸੰਭਾਵਨਾ ਘਟਾ ਸਕਦਾ ਹੈ। ਲੋਕਾਂ ਨੂੰ ਇਹ ਵੀ ਪਤਾ ਹੋਣਾ ਚਾਹੀਦਾ ਹੈ ਕਿ ਜੇ ਵਿਅਕਤੀ ਇਹ ਦਰਸਾਵੇ ਕਿ ਉਸਨੂੰ ਮਨੋਰੋਗ ਫੇਰ ਸ਼ੁਰੂ ਹੋ ਸਕਦਾ ਹੈ, ਤਾਂ ਕੀ ਕਦਮ ਪੁਟਣੇ ਹਨ।

### ਮਨੋਰੋਗੀਆਂ ਅਤੇ ਉਹਨਾਂ ਦੇ ਪਰਿਵਾਰਾਂ ਵਾਸਤੇ ਕੀ ਵਸੀਲੇ ਉਪਲਬਧ ਹਨ?

ਬਹੁਤ ਸਾਰੇ ਇਲਾਜ ਤੁਹਾਡਾ ਫੈਮਲੀ ਡਾਕਟਰ ਪ੍ਰਦਾਨ ਕਰ ਸਕਦਾ ਹੈ, ਜਾਂ ਸਥਾਨਕ ਸਿਹਤ ਕੇਂਦਰ ਤੋਂ ਉਪਲਬਧ ਹੋ ਸਕਦੇ ਹਨ। ਹੇਠਾਂ ਕੁਝ ਹੋਰ ਵਸੀਲਿਆਂ ਦੀ ਲਿਸਟ ਦਿਤੀ ਜਾਂਦੀ ਹੈ ਜਿਹੜੇ ਵਿਅਕਤੀ ਅਤੇ ਉਸਦੇ ਪਰਿਵਾਰ ਨੂੰ ਜਾਣਕਾਰੀ ਅਤੇ ਸਹਾਇਤਾ ਪ੍ਰਦਾਨ ਕਰ ਸਕਦੇ ਹਨ।

### ਪਰਿਵਾਰ ਦੇ ਮੈਂਬਰਾਂ ਵਾਸਤੇ ਲਾਭਵੰਦ ਸੋਮੇ:

- ਬ੍ਰਿਟਿਸ਼ ਕੁਲੰਬੀਆ ਸਕਿਟਸਫਰੈਨਕ ਸੁਸਾਇਟੀ [www.bcass.org](http://www.bcass.org)  
ਇਹ ਸੂਬੇ ਭਰ ਵਿਚ ਪਰਿਵਾਰਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਵਿਦਿਆ ਦੇ ਗਰੁੱਪ ਜੱਥੇਬੰਦ ਕਰਦੀ ਹੈ ਅਤੇ ਜਾਣਕਾਰੀ ਦੇ ਕਈ ਵਸੀਲੇ ਪ੍ਰਦਾਨ ਕਰਦੀ ਹੈ ਜਿਹਨਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ, “ਅਰਲੀ ਸਾਇਕੋਸਿਸ: ਵੱਡੇ ਫੈਮਲੀ ਐਂਡ ਫਰੈਂਡਜ਼ ਨੀਡ ਟੂ ਨੋਅ,” ਅਤੇ “ਬੇਸਿਕ ਫੈਕਟਸ ਅਬਾਊਟ ਸਕਿਟਸਫਰੈਨੀਆ”  
[http://www.bcass.org/information\\_centre/schizophrenia/early\\_psychosis.html](http://www.bcass.org/information_centre/schizophrenia/early_psychosis.html)
- ਫਰੇਜ਼ਰ ਸਾਊਥ ਅਰਲੀ ਸਾਇਕੋਸਿਸ ਇੰਟਰਵੈਨਸ਼ਨ ਪਰੋਗਰਾਮ:  
<http://www.earlypsychosisintervention.ca>  
ਇਹ ਇਕ ਵਿਸ਼ੇਸ਼ ਆਰੰਭਕ ਮਨੋਰੋਗ ਲਈ ਪ੍ਰੋਗਰਾਮ ਹੈ ਜੋ ਫਰੇਜ਼ਰ ਸਾਊਥ ਦੇ ਇਲਾਕੇ ਨੂੰ ਸੇਵਾਵਾਂ ਪ੍ਰਦਾਨ ਕਰਦਾ ਹੈ: ਮਰੀਜ਼ਾਂ ਅਤੇ ਪਰਿਵਾਰਾਂ ਵਾਸਤੇ ਜਾਣਕਾਰੀ ਦੇ ਕਈ ਸੋਮੇ ਔਨਲਾਈਨ ਉਪਲਬਧ ਹਨ।
- ਸਾਇਕੋਸਿਸ ਸਪੋਰਟ ਫਾਰ ਪੈਰੈਂਟਸ: <http://www.psychosissupport.com/>  
ਫਰੇਜ਼ਰ ਸਾਊਥ ਇਲਾਕੇ ਵਿਚ ਸਥਿਤ ਮਾਪਿਆਂ ਲਈ ਇਕ ਸਹਾਰਾ ਗਰੁੱਪ
- ਹੈਲਪ ਓਵਰਕਮ ਸਾਇਕੋਸਿਸ ਅਰਲੀ (ਐਚ.ਓ.ਪੀ.ਈ): <http://www.hope.vancouver.bc.ca/>  
ਵੈਨਕੂਵਰ/ਰਿਚਮੰਡ ਨੂੰ ਸੇਵਾਵਾਂ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਇਕ ਵਿਸ਼ੇਸ਼ ਆਰੰਭਕ ਮਨੋਰੋਗ ਗਰੁੱਪ
- ਫੈਮਲੀ ਟੂ ਫੈਮਲੀ ਨਿਊਜ਼ਲੈਟਰ - [www.cmha.ca/english/intrvent/](http://www.cmha.ca/english/intrvent/)
- ਬੀ.ਸੀ ਪਾਰਟਨਰਜ਼ <http://www.heretohelp.bc.ca/>  
ਵਿਅਕਤੀਆਂ ਨੂੰ ਆਪਣੇ ਰੋਗ ਨੂੰ ਕਾਬੂ ਕਰਨ ਵਿਚ ਸਹਾਇਤਾ ਦੇਣ ਲਈ ਔਨਲਾਈਨ (ਇੰਟਰਨੈਟ ਉੱਤੇ) ਟੂਲਕਿੱਟਾਂ ਅਤੇ ਹੋਰ ਵਸੀਲੇ
- ਸਕਿਟਸਫਰੈਨੀਆ ਸੁਸਾਇਟੀ ਔਫ ਕੈਨੇਡਾ  
“ਰੇਜ਼ ਔਫ ਹੋਪ” ਕਿਤਾਬਚਾ ਅਮਲੀ ਅਤੇ ਵਿਸਤਰਿਤ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਦਾ ਹੈ, ਇਹ ਔਨਲਾਈਨ ਇਸ ਥਾਂ ਤੇ ਉਪਲਬਧ ਹੈ: <http://www.schizophrenia.ca/>

ਉਹਨਾਂ ਪਰਿਵਾਰਾਂ ਲਈ ਜਿਹਨਾਂ ਦੇ ਸੰਬੰਧੀਆਂ ਦੀ ਮਨੋਰੋਗ ਦੇ ਨਾਲ ਨਾਲ ਮੂਡ ਦੇ ਰੋਗ ਦੀ ਵੀ ਰੋਗ-ਪਛਾਣ ਹੋਈ ਹੋਵੇ, ਦਾ ਮੂਡ ਡਿਸਆਰਡਰ ਐਸੋਸੀਏਸ਼ਨ, <http://www.mdabc.ca/index.htm>, ਸੂਬੇ ਭਰ ਵਿਚ ਮਰੀਜ਼ ਅਤੇ ਪਰਿਵਾਰ ਦੋਹਾਂ ਲਈ ਸਹਾਰਾ ਅਤੇ ਵਿਦਿਆ ਗਰੁੱਪ ਜੱਥੇਬੰਦ ਕਰਦੀ ਹੈ।



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ਵਿਸ਼ੇਸ਼, ਅਰਲੀ ਸਾਇਕੋਸੋਸ਼ਿਅਲ ਇੰਟਰਵੈਨਸ਼ਨ, ਸੇਵਾਵਾਂ ਬ੍ਰਿਟਿਸ਼ ਕੁਲੰਬੀਆ ਦੇ ਹਰ ਇਲਾਕੇ ਵਿਚ ਉਪਲਬਧ ਹਨ। ਇਸ ਸਮੇਂ ਪ੍ਰੋਗਰਾਮ ਇਨ੍ਹਾਂ ਇਲਾਕਿਆਂ ਵਿਚ ਚੱਲ ਰਹੇ ਹਨ ਜਾਂ ਪ੍ਰਫੁੱਲਤ ਕੀਤੇ ਜਾ ਰਹੇ ਹਨ:

- ਵਿਕਟੋਰੀਆ, ਸੈਂਟਰਲ ਵੈਨਕੂਵਰ ਆਇਲੈਂਡ
- ਵੈਨਕੂਵਰ, ਸਰੂੀ, ਬਰਨਬੀ ਅਤੇ ਸਾਰੇ ਲੋਅਰ ਮੇਨਲੈਂਡ ਵਾਸਤੇ
- ਕਲੋਨਾ, ਪੈਟਿਕਟਨ, ਵਰਨਨ, ਨੈਲਸਨ, ਅਤੇ ਕੂਟਨੀ ਦੇ ਇਲਾਕਿਆਂ ਵਿਚ
- ਕੈਮਲੂਪਸ, ਪ੍ਰਿੰਸ ਜੌਰਜ਼।

ਇਹਨਾਂ ਟੀਮਾਂ ਵਿਚ ਆਮ ਤੌਰ ਤੇ ਦੋਨੋਂ ਹੀ, ਅਡਲਟ ਐਂਡ ਚਾਇਲਡ ਐਂਡ ਯੂਥ ਮੈਂਟਲ ਹੈਲਥ ਸਰਵਿਸਿਜ਼, ਭਾਗ ਲੈਂਦੀਆਂ ਹਨ। ਦਾ ਮਨਿਸਟਰੀ ਔਫ ਚਾਇਲਡ ਐਂਡ ਫੈਮਲੀ ਡਵੈਲਪਮੈਂਟ (ਐਮ.ਸੀ.ਐਫ.ਡੀ) ਸਾਰੇ ਸੂਬੇ ਵਿਚ ਆਰੰਭਕ ਮਨੋਰੋਗ ਲਈ ਸੇਵਾਵਾਂ ਦਾ ਬਹੁਤ ਪਰਸਾਰ ਕਰ ਰਹੀ ਹੈ। ਕਈ ਛੋਟੀਆਂ ਕਮਿਊਨਿਟੀਆਂ ਨੇ ਵੀ ਆਰੰਭਕ ਮਨੋਰੋਗ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦੇ ਸੁਧਾਰ ਵਿਚ ਤਿੱਖੀ ਦਿਲਚਸਪੀ ਪ੍ਰਗਟ ਕੀਤੀ ਹੈ। ਆਪਣੇ ਸਥਾਨਕ ਮਾਨਸਿਕ ਸਿਹਤ ਕੇਂਦਰ ਤੋਂ ਪਤਾ ਕਰੋ ਕਿ ਤੁਹਾਡੀ ਕਮਿਊਨਿਟੀ ਵਿਚ ਕਿਹੜੇ ਵਿਸ਼ੇਸ਼ ਵਸੀਲੇ ਉਪਲਬਧ ਹਨ।

ਯਾਦ ਰੱਖੋ, ਕਿ ਮਨੋਰੋਗ ਇਕ ਇਲਾਜ ਹੋ ਸਕਣ ਵਾਲੀ ਕੰਡੀਸ਼ਨ ਹੈ, ਅਤੇ ਬਹੁਤ ਲੋਕ ਰਾਜੀ ਹੋ ਕੇ ਖੁਸ਼ੀ ਭਰਿਆ ਅਤੇ ਸਿਰਜਣਾਤਮਿਕ ਜੀਵਨ ਬਤੀਤ ਕਰਨ ਲੱਗ ਜਾਂਦੇ ਹਨ।



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# Psicosis precoz

## Información para los pacientes y sus familias

(Early Psychosis - Information for Patients and their Families)

### ***¿Qué es la psicosis?***

La palabra “psicosis” quiere decir que una persona pierde el contacto con la realidad. Puede que haya problemas graves de pensamiento, comportamiento y emocionales. También, puede que la persona escuche voces o sonidos que realmente no existen. Algunas veces puede que una persona vea o huela cosas o tenga sensaciones que no son reales. El término “psicosis precoz” simplemente quiere decir que una persona está sufriendo psicosis por primera vez.

### ***¿A quién le da la psicosis?***

- Alrededor del 3% de las personas desarrollarán psicosis en algún momento de sus vidas
- La psicosis generalmente comienza al término de la adolescencia o en el segundo decenio
- La psicosis sucede en todas las culturas
- La psicosis puede venir de familia pero es difícil predecir a quien le dará. Las posibilidades son de alrededor de 10 a 15% que una persona pueda tener un trastorno como esquizofrenia o trastorno bipolar si uno de los hermanos o padres lo tiene. La otra forma de ver esto es que hay de 85 a 90% de posibilidad de no desarrollar el trastorno.
- La mayoría de las teorías creen que la generalidad de los casos de psicosis pueden surgir por una combinación de acontecimientos genéticos y medioambientales. Los acontecimientos medioambientales tales como trauma o problemas durante el embarazo o una lesión en la cabeza muchos años atrás se cree que actúan como formas de estrés que puedan detonar la psicosis.
- Las drogas pueden ser una forma de detonante para personas que tienen una inclinación genética hacia la psicosis. Sin embargo, ciertas drogas pueden hacer que una persona se vuelva psicótica cuando está muy eufórica. Algunas veces la persona puede permanecer psicótica por días (o incluso por más tiempo) después que se supone se le ha pasado el efecto de la droga.

### ***¿Cuáles son los síntomas de la psicosis?***

#### **Síntomas positivos**

Los síntomas más evidentes de la psicosis se denominan síntomas positivos. Se llaman “positivos” dado que los pensamientos, creencias o sensaciones de la persona parecen expandirse o ser mayores que lo normal. Los síntomas positivos siempre sugieren que la persona ha perdido de alguna forma el contacto con la realidad. Ellos incluyen:

- alucinaciones (por ejemplo: ver o escuchar cosas que realmente no están ahí)
- delirios (creencias falsas tales como que se siente seguido, perseguido por otras personas, que tiene poderes especiales u otras creencias aún más extrañas)
- trastorno del pensamiento (problema para pensar claramente, esto es evidente cuando no se puede entender el significado de lo que la persona está diciendo)

#### **Síntomas negativos**

En algunos trastornos, las personas experimentan síntomas negativos. Estos síntomas se llaman “negativos” porque involucran una disminución en las experiencias normales. Ellos incluyen:

- poco vigor para hacer las cosas
- carencia de energía e interés
- poca demostración de sentimientos (se cree que esto refleja la pérdida de la habilidad para sentir las cosas con la misma fuerza que antes)
- no hablar mucho (esto puede indicar que el mundo interno de la persona no es tan rico como solía ser)

#### **Otros síntomas:**

Junto con los síntomas sicóticos, es común que ocurran otros problemas, incluyendo:

- depresión
- ansiedad
- abuso de drogas
- problemas para dormir
- problemas de salud
- funcionamiento social inadecuado



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- funcionamiento inadecuado en la escuela o el trabajo.

### ***¿Se recuperan las personas de la psicosis?***

La mayoría de las personas se recuperarán de la psicosis, especialmente, si reciben el tratamiento adecuado y a tiempo. Algunas personas se recuperan rápidamente y pueden volver a sus vidas normales muy pronto. Otros necesitan mucho más tiempo para recuperarse. Si bien la mayoría de las personas se recuperan de un primer episodio de psicosis, algunos experimentarán episodios futuros. Los riesgos de episodios futuros dependerán del diagnóstico, del tratamiento y de la duración del tratamiento. La continuación del tratamiento con frecuencia evita episodios futuros.

La psicosis puede tener consecuencias devastadoras tanto para la familia como para la persona. Es esencial que toda la familia se involucre en el tratamiento para asegurar que todos los miembros se recuperen con más rapidez y completamente de los impactos de la psicosis. A través del apoyo continuo y de la educación, la familia completa también está bien posicionada para trabajar juntos en la prevención de episodios futuros.

### ***¿Cómo se diagnostica la psicosis?***

La psicosis se presenta en muchos trastornos físicos y mentales diferentes. Dos de los diagnósticos más comunes son la esquizofrenia y el trastorno bipolar. Para diagnosticar la psicosis se necesita una evaluación completa. La confirmación del diagnóstico puede tomar muchos meses.

### ***¿Cómo se trata la psicosis?***

#### **Medicamentos**

El tratamiento para la psicosis generalmente comienza con un tipo de medicamento llamado antipsicótico atípico. Hay muchos antipsicóticos atípicos diferentes. El objetivo del medicamento es disminuir los síntomas de la psicosis y prevenir episodios futuros.

Se usará la menor cantidad posible de medicamento. Esto ayuda a reducir cualquier efecto secundario. Puede que tome de muchas semanas a varios meses para que los medicamentos surtan completamente su efecto. Este medicamento debe continuarse aún después que hayan desaparecido los síntomas de la psicosis. Esto se debe a que existe un alto riesgo de tener otro episodio si se deja de tomar el medicamento demasiado pronto.

También se pueden usar otros medicamentos. Por ejemplo, se pueden añadir medicamentos estabilizadores del estado de ánimo o antidepresivos si hay problemas con el estado de ánimo.

#### **Otros tratamientos**

Además de medicamentos, hay varios tipos de medicamentos muy útiles que ayudan a mejorar la recuperación y disminuir el riesgo de episodios futuros. Los tratamientos debieran tratar todos los problemas causados por el trastorno. Los síntomas positivos de la psicosis son generalmente sólo el primer objetivo a tratar. Otros objetivos pueden ser la depresión, los problemas sociales, la salud física deficiente o el abuso de sustancias.

Tanto la persona como la familia necesitan apoyo y educación acerca de la psicosis y cómo manejarla. Aprender cómo manejar el estrés es una forma de educación. El sobrellevar el estrés puede hacer que una persona se sienta mejor y ayuda a reducir los riesgos de un episodio futuro. También las personas necesitan tener un plan acerca de qué hacer si una persona comienza a mostrar signos que la psicosis pueda estar comenzando nuevamente.

### ***¿Cuáles son los recursos disponibles para las personas con psicosis y sus familias?***

Muchos de los tratamientos pueden ser proporcionados por su médico de cabecera o a través de su centro de salud mental. A continuación se enumeran otros recursos que le proporcionarán información y apoyo a los individuos y a sus familias.

#### **Recursos útiles para familiares:**

- “Sociedad de esquizofrenia de Columbia Británica” (*British Columbia Schizophrenia Society*), [www.bcscs.org](http://www.bcscs.org) organiza los grupos de apoyo familiar y de educación en la provincia, y proporciona muchos recursos informativos, incluyendo “Psicosis precoz”: “Lo que las familias y amigos tienen que saber” (“*What Families and Friends need to Know*”) y “Asuntos puntuales acerca de la esquizofrenia” (“*Basic Facts About Schizophrenia*”), [www.bcscs.org/information\\_centre/schizophrenia/early\\_psychosis.html](http://www.bcscs.org/information_centre/schizophrenia/early_psychosis.html)
- “Programa de intervención de psicosis precoz de South Fraser” (*Fraser South Early Psychosis Intervention Program*) [www.earlypsychosisintervention.ca](http://www.earlypsychosisintervention.ca)



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un programa de psicosis precoz especializado que atiende la región de South Fraser; hay muchos recursos informativos disponibles en línea para pacientes y familiares

- “Apoyo para padres que enfrentan la psicosis” (*Psychosis Support for Parents*) [www.psychosissupport.com](http://www.psychosissupport.com)  
un grupo de apoyo para padres ubicado en la región de Fraser South
- “Ayuda a superar la psicosis temprana” (*Help Overcome Psychosis Early*), HOPE , [www.hope.vancouver.bc.ca/](http://www.hope.vancouver.bc.ca/)  
un programa de psicosis precoz especializado que atiende Vancouver/Richmond
- “Boletín Familia a Familia” (*Family to Family Newsletter*) – [www.cmha.ca/english/intrvent/](http://www.cmha.ca/english/intrvent/)
- “Asociación de Columbia Británica” (BC Partners) [www.cmha.ca/](http://www.cmha.ca/)  
herramientas en línea y otros recursos para ayudar a los individuos a manejar su enfermedad
- “Sociedad de esquizofrenia del Canadá” (*Schizophrenia Society of Canada*)  
el manual “Rayos de esperanza” (*“Rays of Hope”*) proporciona información exhaustiva y práctica; está disponible en línea en el [www.schizophrenia.ca/](http://www.schizophrenia.ca/)

Para las familias cuyos parientes han sido diagnosticados con un trastorno del estado de humor con psicosis, la “Asociación de trastornos del estado anímico” (*Mood Disorders Association*) [www.mdabc.ca/index.htm](http://www.mdabc.ca/index.htm) organiza grupos de apoyo para pacientes y familiares en toda la provincia.

Los “Servicios de intervención de psicosis precoz especializados” (*Specialized Early Psychosis Intervention Services*) se encuentran disponibles en cada región de salud de Columbia Británica. Hay programas actualmente funcionando o siendo desarrollados en:

- Victoria, Centro de la isla de Vancouver
- Vancouver, Surrey, Burnaby y todo el Lower Mainland
- Kelowna, Penticton, Vernon, Nelson y Kootenays
- Kamloops, Prince George.

En estos equipos generalmente están involucrados los servicios de salud mental de adultos, niños y jóvenes. El “Ministerio de Desarrollo de la Familia y la Infancia” (*Ministry of Child and Family Development*, MCFD, por sus siglas en inglés) ha estado expandiendo los servicios para la psicosis precoz en de la provincia. Algunas comunidades pequeñas también han mostrado un gran interés en mejorar los servicios para la psicosis precoz. Consulte con su centro local de salud mental para ver que recursos especiales existen en su comunidad.

**Recuerde, la psicosis es una enfermedad tratable y muchas personas se recuperan y llevan vidas productivas, disfrutando de la vida.**



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## Loạn Tâm-thần mới phát Thông-tin cho bệnh-nhân và gia-đình của họ

### Loạn tâm-thần là gì ?

Từ-ngữ "loạn tâm-thần" có nghĩa là một người bị mất sự tiếp-xúc với thực-tế. Có thể là họ có những vấn-đề nghiêm-trọng đối với sự suy-nghĩ, về cách cư-xử, và về tình-cảm. Và cũng có thể là người đó nghe được tiếng nói hay những âm-thanh mà thực-sự là không có. Đôi khi một người có thể thấy, có thể ngửi được, hay có những cảm-nhận được những gì không có thực. Từ-ngữ "loạn tâm-thần mới phát" chỉ có nghĩa đơn-giản là người bệnh mới bị loạn tâm-thần lần đầu-tiên.

### Ai là người có thể mắc bệnh loạn tâm-thần ?

- Có khoảng 3% tổng-số dân-chúng sẽ phát ra bệnh loạn tâm-thần vào một thời-điểm nào đó trong đời-sống của họ
- bệnh loạn tâm-thần thường bắt đầu khoảng cuối thời thiếu-niên hay tuổi hai mươi của một người
- bệnh loạn tâm-thần xảy ra cho tất-cả mọi nền văn-hóa
- bệnh loạn tâm-thần có thể di-truyền trong một gia-đình nhưng rất khó đoán trước được ai sẽ là người mắc bệnh. Độ may rủi là khoảng từ 10 đến 15% một người sẽ có thể bị một bệnh rối-loạn chẳng hạn như bệnh tâm-thần phân-liệt hay bệnh rối-loạn lưỡng-cực thần-kinh nếu người ta tìm thấy bệnh loạn tâm-thần ở nơi một người anh em, người chị em hoặc cha hay mẹ. Bạn có thể nhìn vấn-đề một cách khác là bạn có từ 85 đến 90 phần trăm may-mắn là không mắc bệnh rối loạn.
- đa-số các lý-thuyết tin rằng phần lớn những trường-hợp loạn tâm-thần sanh ra từ sự tổng-hợp của sự di-truyền và của những biến-cổ của môi-trường. Người ta tin rằng những biến-cổ môi-trường chẳng hạn như sự đau-đớn hay rắc-rối trong thời-gian mang thai, hoặc một vết thương trên đầu nhiều năm trước đây đã hành-động như là một dạng căng-thẳng mà có thể châm ngòi cho bệnh loạn tâm-thần phát ra.
- thuốc có thể là một dạng ngòi châm cho những người nào có tính di-truyền nghiêng về phía bị loạn tâm-thần. Tuy-nhiên, một số thuốc có thể khiến cho một người trở nên bị loạn tâm-thần khi người đó đang "phê". Đôi khi một người có thể giữ nguyên tình-trạng bị loạn nhiều ngày (nhiều khi lâu hơn) sau khi thuốc được xem là đã phải giã đi rồi.

### Những triệu-chứng của bệnh loạn tâm-thần là như thế nào ?

#### Triệu-chứng tăng

Những triệu-chứng sôi-nổi nhất của bệnh loạn tâm-thần được gọi là những triệu-chứng tăng. Chúng được gọi là "tăng" bởi vì những ý-tưởng, niềm-tin và cảm-nhận của người bệnh có vẻ như mở rộng ra hay nhiều hơn bình-thường. Những triệu-chứng tăng luôn-luôn đề ra việc người bệnh đã mất sự liên-kết với thực-tế phần nào. Chúng bao gồm

- ảo-giác (chẳng hạn như nghe hay thấy một điều gì không có thực)
- hoang-tưởng (những sự tin-tưởng sai-lầm chẳng hạn như đang bị theo dõi, đang bị người khác bắt-bớ, có quyền-năng đặc-biệt, hay nhiều niềm tin kỳ-quặc khác)
- rối-loạn về tư-tưởng (bị khó-khăn khi muốn suy-nghĩ rõ-ràng; điều này thật dễ thấy khi bạn không thể hiểu những gì mà người khác đang nói).

#### Triệu-chứng giảm

Trong một vài bệnh rối loạn, bệnh-nhân có trải qua những triệu-chứng giảm. Những triệu-chứng này được gọi là triệu-chứng "giảm" vì chúng liên-quan đến sự giảm xuống của những kinh-nghiệm bình-thường. Chúng bao gồm

- ít có hứng-khởi để làm chuyện này nọ
- thiếu-sót sức-lực và thích-thú
- ít khi bày-tò cảm-xúc (người ta tin rằng điều này phản-ảnh sự mất đi khả-năng cảm-nhận sự việc mạnh-mẽ giống như trước đây)
- ít nói (điều này có thể cho thấy là thế-giới bên trong của một người không còn phong-phú như trước đây).

#### Những triệu-chứng khác

Cùng lúc với những triệu-chứng loạn tâm-thần, thường chúng ta thấy những trở-ngại khác xảy ra, kể cả

- bệnh suy-nhuộc tâm-thần
- bệnh lo-lắng
- lạm-dụng thuốc
- trở-ngại với giấc ngủ
- trở-ngại về sức khỏe
- sinh-hoạt xã-hội kém
- sinh-hoạt kém tại trường học hay tại chỗ làm.



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## ***Bệnh-nhân có hồi-phục sau khi bị bệnh loạn tâm-thần không ?***

Phần lớn bệnh-nhân sẽ hồi-phục sau cơn loạn tâm-thần, nhất là khi họ nhận được sự điều-trị tức-thời và đúng cách. Một số người hồi-phục nhanh-chóng và có thể trở lại đời sống bình-thường của họ rất sớm. Những người khác cần nhiều thời-gian hơn để hồi-phục. Mặc dù phần lớn bệnh-nhân sẽ hồi-phục sau lần phát loạn tâm-thần đầu-tiên, một số người sẽ trải qua những lần phát bệnh trong tương-lai. Cơ-may xảy ra những lần phát bệnh thêm tùy-thuộc vào sự định-bệnh, cách điều-trị, và thời-gian điều-trị dài bao lâu. Khi tiếp-tục điều-trị, thì điều này thường ngăn-ngừa được những lần phát bệnh trong tương-lai.

Bệnh loạn tâm-thần có thể có hậu-quả tang-thương cho cả người bệnh lẫn gia-đình của họ. Điều cần-yếu là toàn-thể gia-đình nên can-dự vào việc điều-trị để bảo-đảm rằng tất-cả mọi thành-viên trong gia-đình hồi-phục nhanh-chóng hơn và hoàn-toàn hơn sau những tác-động của bệnh loạn tâm-thần. Qua sự hỗ-trợ và giáo-dục liên-tục, toàn-thể gia-đình sẽ ở trong một vị-trí tốt để làm việc chung với nhau trong chiều-hướng ngăn-ngừa những lần phát bệnh trong tương-lai.

## ***Bệnh loạn tâm-thần được định-bệnh như thế nào ?***

Bệnh loạn tâm-thần xảy ra trong nhiều bệnh rối-loạn thể-chất và tâm-thần. Hai loại bệnh được chẩn thông-thường nhất là bệnh tâm-thần phân-liệt và bệnh rối-loạn lưỡng-cực thần-kinh. Chúng ta cần có cuộc thăm-định hoàn-toàn để định-bệnh loạn tâm-thần. Có khi cần mất nhiều tháng để xác-nhận việc định-bệnh.

## ***Bệnh loạn tâm-thần được điều-trị như thế nào ?***

### **Thuốc men**

Sự điều-trị bệnh loạn tâm-thần thường bắt đầu bằng một loại thuốc gọi là thuốc kháng-loạn bất tiêu-chuẩn (atypical antipsychotic). Có nhiều loại thuốc kháng-loạn bất tiêu-chuẩn. Mục-đích của thuốc là giảm những triệu-chứng loạn tâm-thần và ngăn-ngừa những lần phát bệnh trong tương-lai.

Bác-sĩ sẽ dùng liều thuốc nào thấp nhất mà ông có thể dùng được. Điều này giúp giảm đi những phản-ứng phụ có thể xảy ra. Có khi mất đến nhiều tuần hay nhiều tháng để cho thuốc hoàn-toàn có hiệu-lực đầy-đủ. Bệnh-nhân nên tiếp-tục dùng thuốc ngay cả khi những triệu-chứng về bệnh loạn tâm-thần đã biến mất. Bởi vì nếu ngưng thuốc quá sớm thì sẽ có mực-độ rủi-ro lớn là khiến cho một lần phát bệnh khác xảy ra.

Bệnh-nhân cũng có thể dùng những loại thuốc khác. Chẳng hạn như, bệnh-nhân có thể dùng thêm những thuốc chống suy-nhuộc tâm-thần hay điều-hòa cảm-xúc nếu có vấn-đề về cảm-xúc.

### **Những cách điều-trị khác**

Thêm vào việc dùng thuốc, có nhiều loại điều-trị khác rất có ích-lợi trong việc cải-tiến sự phục-hồi và giảm bớt độ rủi-ro có những lần phát bệnh trong tương-lai. Sự điều-trị nên đề-cập đến tất-cả những vấn-đề do bệnh rối-loạn gây ra. Thường thì những triệu-chứng tăng của bệnh loạn tâm-thần chỉ là mục-tiêu đầu-tiên của việc điều-trị. Những mục-tiêu khác có thể là bệnh suy-nhuộc tâm-thần, rắc-rối về xã-hội, sức-khỏe thể-chất kém, hay sự lạm-dụng hóa-chất.

Cả bệnh-nhân lẫn gia-đình cần có sự hỗ-trợ và giáo-dục về bệnh loạn tâm-thần cùng phương-cách để chế-ngự bệnh. Học biết cách để quản-trị sự căng-thẳng là một hình-thức giáo-dục. Khi phải đối-phó với sự căng-thẳng thì điều này sẽ khiến bệnh-nhân cảm thấy mạnh hơn và giúp họ giảm mực-độ xảy ra của lần phát bệnh trong tương-lai. Cũng vậy, gia-đình cần phải có sự kế-hoạch để biết họ phải làm gì nếu một người bắt đầu có dấu-hiệu cho thấy rằng bệnh loạn tâm-thần có thể sẽ phát ra lần nữa.

## ***Những nguồn dữ-liệu nào là có sẵn cho người mắc bệnh loạn tâm-thần và gia-đình của họ ?***

Bác-sĩ gia-đình của bạn, hay trung-tâm y-tế tâm-thần địa-phương của bạn có thể cung-cấp nhiều loại điều-trị. Trong danh-sách kê-khai dưới đây, có vài nguồn dữ-liệu có thể cung-cấp thông-tin và sự hỗ-trợ cho cá-nhân và gia-đình của họ.

### **Các nguồn dữ-liệu có ích cho thành-viên của gia-đình:**

- Hiệp-hội bệnh tâm-thần phân-liệt của British Columbia (British Columbia Schizophrenia Society) tại trang mạng lưới [www.bcscs.org](http://www.bcscs.org) tổ-chức nhóm hỗ-trợ và giáo-dục gia-đình khắp tỉnh và cung-cấp nhiều nguồn dữ-liệu thông-tin, kể cả tập sách "Những gì mà gia-đình và bạn-bè cần biết về bệnh loạn tâm-thần khi gặp lần đầu" (Early Psychosis: What Families and Friends Need to Know) và sách "Những dữ-kiện căn-bản về bệnh tâm-thần phân-liệt" ("Basic Facts About Schizophrenia") tại trang mạng lưới [http://www.bcscs.org/information\\_centre/schizophrenia/early\\_psychosis.html](http://www.bcscs.org/information_centre/schizophrenia/early_psychosis.html)
- Chương-trình ngăn-ngừa bệnh loạn tâm-thần lần đầu của nhóm phía nam sông Fraser (Fraser South Psychosis Intervention Program) tại trang mạng lưới <http://www.earlypsychosisintervention.ca>, là một chương-trình chuyên-biệt về bệnh loạn tâm-thần lần đầu nhằm phục-vụ cho vùng Nam Fraser; và có nhiều nguồn dữ-liệu thông-tin có sẵn cho bệnh-nhân và gia-đình của họ trên mạng lưới thông-tin
- Sự hỗ-trợ về bệnh loạn tâm-thần cho cha mẹ (Psychosis Support for Parents) tại trang mạng lưới <http://www.psychosissupport.com/>, là một nhóm hỗ-trợ cho cha mẹ có cơ-sở trong vùng Nam Fraser
- Nhóm Giúp Vượt Qua Bệnh Loạn Tâm-thần lần đầu-tiên (Help Overcome Psychosis Early) gọi tắt là HOPE tại trang mạng lưới <http://www.hope.vancouver.bc.ca/>, là một chương-trình chuyên-biệt về bệnh loạn tâm-thần lần đầu-tiên phục-vụ cho vùng Vancouver/ Richmond



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- Thư liên-lạc từ gia-đình này sang gia-đình khác (Family to Family Newsletter) tại trang mạng lưới [www.cmha.ca/english/intervent/](http://www.cmha.ca/english/intervent/)
- Bạn đồng-sự tại BC (BC Partners) tại trang mạng lưới <http://www.heretohelp.bc.ca/> , có những túi điều-trị và những nguồn dữ-liệu khác trên mạng lưới để giúp những cá-nhân quản-trị được bệnh-trạng của họ
- Hiệp-hội bệnh Tâm-thần phân-liệt của Gia-nã-đại (Schizophrenia Society of Canada), mà cầm-nang "Tia Hy-vọng" (Rays of Hope) cung-cấp những thông-tin đầy-đủ và thực-dụng; và thông-tin này có sẵn ở trang mạng lưới <http://www.schizophrenia.ca>

Đối với những gia-đình nào có người thân được định-bệnh là rối-loạn cảm-nhận cùng với bệnh loạn tâm-thần, thì Hội bệnh Rối-loạn cảm-nhận tại trang mạng lưới <http://www.mdabc.ca/index.htm> tổ-chức những nhóm hỗ-trợ và giáo-dục bệnh-nhân và gia-đình trên toàn tỉnh

Những dịch-vụ chuyên-biệt ngăn-ngừa bệnh loạn tâm-thần lần đầu tiên đều có sẵn trong mỗi vùng y-tế của tỉnh BC. Những chương-trình hiện-hành hay đang được thiết-lập trong


- Victoria, vùng trung-tâm đảo Vancouver
- Vancouver, Surrey, Burnaby và cho tất-cả những vùng Lower Mainland
- Kelowna, Penticton, Vernon, Nelson và vùng Kootenays
- Kamloops, Prince George.

Cả hai Dịch-vụ Y-tế Tâm-thần cho Thanh-thiếu-niên, Trẻ-em và Dịch-vụ cho Người lớn thường có can-dự trong các nhóm này. Bộ Phát-triển Gia-đình và Trẻ-em (MCFD) đã và đang mở thật rộng-rãi những dịch-vụ cho những bệnh loạn tâm-thần đầu-tiên trên khắp toàn tỉnh. Một vài cộng-đồng nhỏ cũng cho thấy là họ chú-ý đặc-biệt vào việc cải-tiến những dịch-vụ cho các trường-hợp bệnh loạn tâm-thần lần đầu-tiên. Xin bạn phối-kiểm lại với trung-tâm y-tế tâm-thần tại địa-phương của bạn để biết được những nguồn phương-tiện đặc-biệt nào có ở trong cộng-đồng của bạn.

**Xin bạn nhớ cho rằng, bệnh loạn tâm-thần là một tình-trạng có thể điều-trị được, và có nhiều người hồi-phục , rồi tiếp-tục sống một đời-sống vui và có kết-quả.**



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# SUBSTANCE USE: Information for Patients & their Families



# Substance Use

## Information for Patients and their Families

### ***Is my substance use a problem?***

People use substances such as alcohol and other drugs because they like the way these substances make them think or feel. While some substance use may have few harmful consequences, regular substance use can often lead to serious problems.

There are different ways that substance use could cause you problems:

- if it prevents you from doing your job properly
- if it impacts on your health
- if you are pregnant, trying to become pregnant, or breastfeeding, any alcohol or other substance use could be harming your baby
- if it causes you financial or legal problems
- if it causes conflict or disagreement with your family or friends.

If your substance use is causing problems in your life, help is available. Your family physician is one of the people who can help you, by suggesting existing community resources and specialist help.

### ***What can lead to problematic substance use?***

It is recognized that many **risk factors** can affect the likelihood of someone developing problems with substances. Risk factors include:

- a family history of substance use problems
- substance use among a person's primary social group
- a history of trauma or abuse
- poverty
- mental illness (e.g., depression, anxiety)
- chronic pain
- other stressful life situations.

Substance use problems are recognized as a health issue, rather than as a criminal issue or moral failing. There is help and support available through the health system.

### ***What can I expect from my family physician?***

To assess your substance use accurately, your family physician or other health care provider may

- ask you questions to determine how your substance use is affecting your life
- ask about your substance use history and behaviour
- perform a physical examination
- order laboratory tests.

### ***What sort of help is available in British Columbia?***

After assessing your substance use, your health care provider may refer you to addiction services, or prescribe medications. You may require some or all of the following:

- ***Brief Intervention***  
Your doctor may offer some short-term counselling to help you understand how your substance use is affecting your life. The doctor may identify strategies to help you minimize the harm associated with your substance use, and discuss why or how you might want to change your substance use behaviour. This type of counselling will be tailored to your readiness to make changes.
- ***Referral to other Services***  
Your doctor may discuss other treatment options with you, including residential or intensive outpatient (non-residential) treatment, counselling, or participation in group meetings in your area. If you are pregnant, you may be referred to special services that will help you to minimize the harm to your baby.
- ***Withdrawal Management***  
This involves medical supervision (on a live-in, at-home, or outpatient basis) as you withdraw from the substance(s) you're using. Usually medications will be prescribed to make you more comfortable, and other support services such as counselling are also provided.

**Please note that the Chinese, Korean, Punjabi, Spanish and Vietnamese versions of the Patient/Family Member Information Sheets on Depression, Anxiety Disorders, Early Psychosis and Substance Use are not exact, up-to-date translations of the English versions.**



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- **Treatment for Concurrent Disorders**  
If you have a concurrent mental disorder (e.g. depression, bipolar, or anxiety disorder), you may be offered medication or other treatment to address these issues as well.
- **Methadone Maintenance Therapy**  
If you are dependent on opioids (e.g., heroin, morphine, oxycodone) and have had several unsuccessful attempts at treatment in the past, methadone can be used as a substitute therapy. This therapy will block withdrawal symptoms and reduce cravings, allowing you to function without using the substance that has been causing you problems. Only certain doctors can prescribe methadone.
- **Relapse Prevention Medications**  
After withdrawal (detox), you may be prescribed medications designed to help you maintain abstinence. These medications should be provided in conjunction with counselling.
- **Follow Up**  
Even after completing a treatment program, it is important for medical professionals to follow up on your progress. Your family physician or another health care provider may be the one to do follow up with you. This involves ongoing assessment of your health and well-being, and is of critical importance. If you are experiencing difficulties or have had a slip or a relapse, the person doing your follow up can provide the support you need or refer you to other services as required.

### **What are other kinds of support?**

- **Family and Friends**  
Family and friends can play a critical role in supporting you through treatment and recovery. Your health care provider may suggest you bring a family member or close friend to your appointments. This person can take an active role in your recovery by understanding the issues and being available to discuss experiences or feelings, being a contact person to call in high-risk situations or times of stress, and being positive about managing the ups and downs of recovery. For instance, a friend or family member can help you remember that a slip doesn't have to be a relapse, or can join you in taking up a new hobby.
- **BC Partners for Mental Health and Addictions Information ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) or 1-800-661-2121)**  
Free resources include:
  - **Problem Substance Use Workbook:** contains modules that you can work through at your own pace
  - **Mental Disorders Toolkit:** options for living well in the face of mental illness
  - **Wellness Modules:** strategies for basic self-care and stress management
  - **Fact sheets:** basic information on common mental health and substance use topics
  - **Family Toolkit:** key information for family and friends.
- **Substance Information Link ([www.silink.ca](http://www.silink.ca))**  
A site of the Centre for Addictions Research of BC, which has useful information about substances and substance use.
- **BC Alcohol and Drug Information and Referral Service (1-800-663-1441)**  
Provides information and referral services for people needing assistance related to any kind of substance use disorder. Information and referrals provided on education, prevention, treatment, and regulatory agencies.
- **Problem Gambling Help Line (1-888-795-6111)**  
A province-wide, toll-free, multilingual telephone information and referral service to community resources, including counseling, prevention and self-help resources. The service is for anyone who is adversely affected by their own, or another's gambling habits.
- **Credit Counselling Society (1-888-527-8999)**  
A non-profit service offering free credit and budget counseling, and workable strategies for reducing or eliminating debt. Services are open to anyone in Western Canada and there are no restrictions on age or income level.

**Remember: Although substance use disorders can be devastating, many people recover and live a fulfilling life without the influence of harmful substances. Help is available.**



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## 藥物濫用

### Substance Use

#### 患者與家屬須知

#### *服用藥物會構成問題嗎？*

自古以來，人類就有使用藥物改變自身想法和感受的傳統。有些物質的貽害不大，但有些卻會導致嚴重問題。

濫用藥物造成的問題不一而足：

- 無法正常工作
- 影響健康
- 妊娠期、想要懷孕或哺乳期、任何酒精或其他藥物都可能傷害嬰兒
- 引發財務或法律問題
- 與家人朋友發生衝突或不和

濫用藥物造成困擾，可以尋求協助，家庭醫生就是可以幫助你的其中一人。

#### *濫用藥物成癮的成因？*

現在已了解，許多危險因子會引發濫用藥物的問題，包括：

- 家族有濫用藥物的問題
- 同儕團體影響力
- 有精神受創或受虐的經歷
- 貧窮
- 精神異常
- 慢性病痛
- 各種社會因素

藥物濫用問題，在卑詩省視為是醫療而非犯罪或道德低落問題，因此醫療體系提供有協助和支援。

#### *家庭醫師如何處置？*

為正確評估藥物濫用狀況，家庭醫師會：

- 提出問題，據以判斷是否影響你的生活
- 詢問濫用藥物的情況和行為
- 為你進行身體檢查
- 做各種檢測

#### *卑詩省提供哪些協助？*

醫師評估後會開處方或轉介其他戒治的服務單位，你可能需要：



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- **暫時性的介入**  
醫師可能要求你進行短期諮商，幫助你了解自己受影響的程度，告訴你如何減少藥物濫用造成的傷害，討論何以需要或如何改變濫用行為，這類諮商會配合你的情況而有所調整。
- **轉介其他單位**  
醫師會跟你討論其他治療方法，如住院治療、密集門診治療、心理諮商、參加附近小組團體。如果你已懷孕，會將你轉介至特定單位，協助降低對胎兒的傷害。
- **戒癮治療**  
當你進行戒癮治療時，需以藥物控制，有住院、居家和門診三種方式。通常醫師會開藥讓你比較好受，並提供諸如心理諮商等其他支援服務。
- **治療其他精神病症**  
戒癮期間，如同時有其他精神病症，醫師會開藥或採其他方式予以治療。
- **methadone 防止戒斷症狀**  
如果你有毒癮 (海洛因、嗎啡、oxycodone 等毒品)，以往做過幾次戒治都不成功，可改以美沙冬(methadone)治療，防止戒斷症狀出現，降低毒癮，讓你不必仰賴那些毒品。只有某些醫師可以開立此一處方。
- **預防復發的藥物**  
戒癮之後，醫師可能會開藥給你，幫助你戒癮，這些處方藥應該和心理諮商同時進行。
- **後續治療**  
即便在完成治療後，醫療專業人員必須繼續觀察你的情況，可能是你的家庭醫生或其他個案工作人員持續評估你的身心狀況，這點極為重要。若是遇到困難或毒癮復發，負責你個案的工作人員可提供你所需的支援，或將你轉介至其他單位。

#### **還有其他支援嗎？**

- **家人與朋友**在你治療和復元期間扮演重要的角色，家庭醫生可能建議你在就診時與家人或好友一同前往，此人在整個過程裡肩負起重要的角色：了解問題；討論經驗和感受；遇有危急情況或困境時，肩負後援任務；當你治療過程時好時壞時，能以正向態度面對；例如，安慰你情況不好時，並不表示就是毒癮復發，和你一起培養新嗜好。
- **卑詩省心理衛生與戒癮資訊合作夥伴 (BC Partners for Mental Health and Addictions Information)** ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)) 有免費資源 (也可致電 (604) 669-7600 或 1-800-661-2121)。除了真相釋疑和一般性的資料外，還有免費的《戒癮手冊》*Problem Substance Use Workbook*，裡面有許多指導課程，可依自己的進度自行研讀([www.heretohelp.bc.ca/helpmewith/psuworkbook.shtml](http://www.heretohelp.bc.ca/helpmewith/psuworkbook.shtml))。



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- **毒品資訊連結網 (Substance Information Link)** ([www.silink.ca](http://www.silink.ca)) 是卑詩省戒癮研究中心 (the Centre for Addiction Research of BC) 的網站，裡面有許多有關這方面的有用資訊。

濫用藥物成癮會有致命性的不良後果，然而大多數的人都可復元，過著充實的生活，不受藥物危害，這個問題是可以獲得協助的。



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# 약물사용중독

## 환자와 가족들을 위한 정보

### Substance Abuse

Information for Patients and their Families

#### 약물사용 중독은 문제가 될까?

사람들은 이제껏 자신들의 생각이나 감정의 변화를 위해서 약물을 사용해 왔다. 하지만 특정 약물사용 중독은 해로운 결과를 미치므로 약물사용은 심각한 문제를 초래할 수 있다.

약물사용 중독이 다음과 같은 문제를 초래할 수 있다.

- 귀하의 일을 제대로 하는것을 막음.
- 건강에 영향을 미침.
- 임신을 했거나 임신을 원하고 있을 경우, 또는 수유를 하고 있을 경우, 음주나 다른 약물사용 중독은 아기에게 해를 끼칠 수 있음.
- 약물사용 중독으로 인해 법적으로나 경제적으로 문제가 될 수 있음.
- 가족이나 친구의 반대에 부딪치는 경우.

약물사용 중독이 귀하의 생활에 문제를 일으키는 경우, 도움을 받을 수 있으며 귀하의 가정의가 도움을 줄 수 있는 사람들 중 한명이 될 수 있습니다.

#### 약물사용 중독은 어떤 문제를 일으킬 수 있나?

약물사용 중독이 많은 문제를 일으킬 수 있는 요소로 작용한다는 것이 인식되었다.

위험 요소들:

- 가족 역사에 남는 약물사용 중독의 문제들
- 동료들의 비난
- 정신적 충격이나 폭력의 지난 과거
- 가난
- 정신 장애
- 만성 통증
- 다양한 사회적 사실들

BC 주에서는 약물사용 중독 사실이 드러나게 되면 범죄문제나 비도덕적인 것으로 취급하기 보다는 건강 문제로 분류됩니다. 따라서 건강제도를 통해 도움을 받을 수 있습니다.

#### 가정들에게서는 어떤 도움을 받을 수 있나?

귀하의 약물사용 중독을 정확하게 판단하기 위해서 귀하의 가정의는 다음과 같은 절차를 밟을 것이다.

- 약물사용 중독이 귀하의 일상생활에 어떤 영향을 끼치는지 물어봄.
- 과거 약물사용 중독의 전례와 행동을 물어봄.
- 신체적 검사.
- 실험 테스트 요청.

#### BC 주에서는 어떤 도움을 받을 수가 있나?

약물사용 중독의 평가가 끝난후 귀하의 의사는 약을 처방해 주거나 추가 서비스를 권할 것이다. 귀하는 다음과 같이 요구할 수 있다.

- **단순 조정**  
귀하의 의사는 귀하의 약물사용 중독이 귀하의 삶에 어떤 영향을 끼치는지에 대한 단기간의 상담을 해 줄것이다. 귀하의 약물사용 중독과 관계된 악영향을 줄이는 방법에 대해서 알려주며 귀하가 왜 그리고 어떻게 약물사용 중독에 대한 생각을 변화시켜야 하는지를 의논할 것이다. 이런 종류의 상담은 귀하가 변화를 만들기 위한 준비를 하는데 도움을 줄 것이다.
- **다른 치료 서비스 시도**  
귀하의 의사는 통원치료나 좀 더 강한 외래환자 치료, 상담, 또는 지역의 그룹미팅등의 참여등 다른 치료방법에 대해서 귀하와 의논할 것이다. 만일 귀하가 임신중이라면 아기에게 최소한 해를 덜 끼칠 수 있는 다른 특별한 관리를 받게 될 것이다.



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- **투여중지 관리**  
이것은 귀하가 약물사용을 중지함에 따른 의사의 차후 관리이다. (입원이나 외래진료, 또는 집에서) 대개 기분을 좀 더 편안하게 만들기 위한 약이 처방되며 그 외에 상담 같은 다른 도움 서비스를 받을 수 있다.
- **현재 진행중인 장애에 대한 치료**  
귀하가 동시에 정신적 장애를 가지고 있을 경우, 약물사용 중지에 대한 치료와 함께 이에 합당한 약물사용이나 다른 치료 방법들이 시도될 것이다.
- **메타돈 유지 치료요법**  
만일 귀하가 합성 진통 마취제인 오피오이드 (헤로인, 모르핀, 옥시코돈, 등)에 의존하고 있고 과거 치료에 실패한 경험이 있다면 메타돈의 치료요법을 사용할 수 있다. 이 치료요법은 약물사용 중지 증세를 막고 약물사용에 대한 갈망을 감소시키며, 문제가 되어왔던 해당 약물사용 없이도 귀하의 기능을 활성화할 수 있게 도와줄 것이다. 다만 특정 의사들만이 이 메타돈을 처방 할 수 있다.
- **재발 방지 약물치료**  
약물사용을 중지한 후 귀하는 약물사용에 대한 절제를 유지하기 위해서 약을 처방 받을 수 있다. 이 약들은 의료상담과 함께 병행되어야 한다.
- **차후 관리**  
치료 프로그램이 끝난 후에도 의료 전문가가 귀하의 진행과정에 대해 차후 관리를 하는것이 중요하다. 귀하의 가정이나 다른 관계 중사자들이 차후 문제들을 위해 함께 해야 만 한다. 지속적인 건강과 복지 생활의 체크로 이루어 지며 이는 매우 중요하다. 만일 귀하가 회복하는데에 있어서 어려움을 겪거나 실수가 있다면 이 차후 관리를 하는 사람은 귀하에게 도움을 주어야 하며 다른 조치 방법을 제시할 수 있다.  
**다른 종류의 도움들에는 어떤것이 있나?**
- 가족과 친구들은 귀하가 치료를 받고 회복하는 기간동안 곁에서 도움을 주는 매우 중요한 역할을 하게 된다. 귀하의 가정의는 귀하의 진료를 받을때 가족 중 한명이나 가까운 친구와 동행할 것을 권유할 지도 모른다. 이 사람은 회복기간 동안 매우 중요한 역할을 하게 되는데, 귀하가 겪을 감정과 상황을 이해하고 의논할 수 있어야 하며 위험한 상황에 처했을때 연락할 수 있는 사람이어야 하며, 회복기간동안 오는 감정의 기복을 잘 다룰 수 있는 사람이어야 한다. 예를들어, 친구나 가족은 귀하가 실수를 했을 때 이것이 다시 치료의 원점으로 돌아가는 것이 아님을 상기시켜 줄 수 있어야 하며 새로운 취미생활을 함께 할 수 있도록 도와야 한다.
- BC Partners for Mental Health and Addictions Information ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)) 는 이에 관련된 무료 정보들을 제공하고 있다. (전화로도 가능 (604) 669-7600 또는 1-800-661-2121). 이 문서와 웰네스 모듈들 등과 같이 "약물치료 문제 워크북" (Problem Substance Use Workbook)은 귀하 스스로에 맞게 사용할 수 있는 모듈들을 갖추고 있다. (이곳에서 받을 수 있음 [www.heretohelp.bc.ca/helpmewith/psuworkbook.shtml](http://www.heretohelp.bc.ca/helpmewith/psuworkbook.shtml))
- BC 주 약물중독 연구 센터의 약물 정보 링크 ([www.silink.ca](http://www.silink.ca)) 에는 약물과 약물사용 중독에 관한 유용한 정보들이 있다.

약물사용 중독은 사람을 황폐시키는 결과를 가져 올 수 있다. 하지만 많은 사람들이 이런 상황에서 회복하고 약물의 악영향 없이 만족하는 삶을 살고 있습니다. 도움 받으실 수 있습니다.



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## ਪਦਾਰਥ ਵਰਤੋਂ ਮਰੀਜ਼ਾਂ ਅਤੇ ਉਹਨਾਂ ਦੇ ਪਰਿਵਾਰਾਂ ਲਈ ਜਾਣਕਾਰੀ

### ਕੀ ਮੇਰੀ ਪਦਾਰਥ ਵਰਤੋਂ (ਸਬਸਟੈਂਸ ਯੂਜ਼) ਇਕ ਸਮੱਸਿਆ ਹੈ?

ਲੋਕ ਆਪਣੇ ਸੋਚਣ ਜਾਂ ਮਹਿਸੂਸ ਕਰਨ ਵਿਚ ਪਰਿਵਰਤਨ ਲਿਆਉਣ ਲਈ ਰਵਾਇਤੀ ਤੌਰ ਤੇ ਪਦਾਰਥਾਂ ਦੀ ਵਰਤੋਂ ਕਰਦੇ ਆਏ ਹਨ। ਭਾਵੇਂ ਪਦਾਰਥਾਂ ਦੀ ਕੁਝ ਹੱਦ ਤੱਕ ਵਰਤੋਂ ਦੇ ਨੁਕਸਾਨਦੇਹ ਨਤੀਜੇ ਨਾਂਹ ਵਰਗੇ ਹੀ ਹੁੰਦੇ ਹਨ ਫੇਰ ਵੀ ਪਦਾਰਥਾਂ ਦੀ ਵਰਤੋਂ ਅਕਸਰ ਗੰਭੀਰ ਸਮੱਸਿਆਵਾਂ ਖੜ੍ਹੀਆਂ ਕਰ ਸਕਦੀ ਹੈ।

ਵਖਰੇ ਵਖਰੇ ਕਈ ਰਸਤੇ ਹਨ ਜਿਹਨਾਂ ਰਾਹੀਂ ਪਦਾਰਥ ਵਰਤੋਂ ਤੁਹਾਡੇ ਲਈ ਸਮੱਸਿਆਵਾਂ ਖੜ੍ਹੀਆਂ ਕਰ ਸਕਦੀ ਹੈ:

- ਜੇ ਇਹ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਜੌਬ ਉਚਿਤ ਢੰਗ ਨਾਲ ਕਰਨੇ ਰੋਕਦੀ ਹੈ
- ਜੇ ਇਹ ਤੁਹਾਡੀ ਸਿਹਤ ਉਤੇ ਅਸਰ ਪਾਉਂਦੀ ਹੈ
- ਜੇ ਤੁਸੀਂ ਗਰਭਵਤੀ ਹੋ, ਜਾਂ ਗਰਭਵਤੀ ਹੋਣ ਦੀ ਕੋਸ਼ਿਸ਼ ਕਰ ਰਹੇ ਹੋ, ਜਾਂ ਛਾਤੀਆਂ ਚੌਂ ਦੁਧ ਚੁੰਘਾਉਂਦੇ ਹੋ ਤਾਂ ਹੋ ਸਕਦੇ ਸ਼ਰਾਬ ਜਾਂ ਕਿਸੇ ਹੋਰ ਪਦਾਰਥ ਦੀ ਵਰਤੋਂ ਤੁਹਾਡੇ ਬੇਬੀ ਨੂੰ ਨੁਕਸਾਨ ਪਹੁੰਚਾ ਰਹੀ ਹੋਵੇ।
- ਜੇ ਪਦਾਰਥ ਵਰਤੋਂ ਨਾਲ ਤੁਹਾਨੂੰ ਆਰਥਕ ਜਾਂ ਕਾਨੂੰਨੀ ਸਮੱਸਿਆਵਾਂ ਦਾ ਸਾਹਮਣਾ ਕਰਨਾ ਪੈ ਰਿਹਾ ਹੈ
- ਜੇ ਇਹ ਤੁਹਾਡੇ ਪਰਿਵਾਰ ਜਾਂ ਦੋਸਤਾਂ ਨਾਲ ਝਗੜਾ ਜਾਂ ਅਸਹਿਮਤੀ ਪੈਦਾ ਕਰ ਰਹੀ ਹੈ

ਜੇ ਪਦਾਰਥ ਵਰਤੋਂ ਤੁਹਾਡੇ ਜੀਵਨ ਵਿਚ ਸਮੱਸਿਆਵਾਂ ਖੜ੍ਹੀਆਂ ਕਰ ਰਹੀ ਹੈ, ਤਾਂ ਸਹਾਇਤਾ ਉਪਲਬਧ ਹੈ। ਤੁਹਾਡਾ ਫੈਮਲੀ ਡਾਕਟਰ ਉਹਨਾਂ ਲੋਕਾਂ ਵਿਚੋਂ ਹੈ ਜੋ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰ ਸਕਦਾ/ਸਕਦੀ ਹੈ।

### ਪਦਾਰਥਾਂ ਦੀ ਸਮੱਸਿਆ-ਗੁਸਤ ਵਰਤੋਂ ਕਿਸ ਢੰਗ ਤੋਂ ਹੋ ਸਕਦੀ ਹੈ?

ਇਹ ਗੱਲ ਹੁਣ ਮੰਨੀ ਜਾ ਚੁੱਕੀ ਹੈ ਕਿ ਅਜਿਹੇ ਬਹੁਤ ਖਤਰੇ ਵਾਲੇ ਜੁਸ ਹਨ ਜੋ ਕਿਸੇ ਲਈ ਪਦਾਰਥ ਵਰਤੋਂ ਦੇ ਫਲਸਰੂਪ ਪੈਦਾ ਹੋਣ ਵਾਲੀਆਂ ਸਮੱਸਿਆਵਾਂ ਤੇ ਅਸਰ ਪਾ ਸਕਦੇ ਹਨ। ਖਤਰੇ ਵਾਲੇ ਜੁਸਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ:

- ਪਦਾਰਥ ਵਰਤੋਂ ਨਾਲ ਸੰਬੰਧਿਤ ਸਮੱਸਿਆਵਾਂ ਦਾ ਪਰਿਵਾਰਕ ਇਤਿਹਾਸ
- ਪੀਅਰ ਗਰੁੱਪ ਦੇ ਵਿਅਕਤੀਆਂ ਦੀਆਂ ਵਿਸ਼ੇਸ਼ਤਾਈਆਂ
- ਕਿਸੇ ਸੱਟ ਜਾਂ ਦੁਰ ਵਿਵਹਾਰ ਦਾ ਭੂਤਕਾਲੀ ਇਤਿਹਾਸ
- ਗਰੀਬੀ
- ਕੋਈ ਮਾਨਸਿਕ ਰੋਗ
- ਜੀਰਣ ਦਰਦ
- ਕਈ ਕਿਸਮ ਦੇ ਕਮਿਊਨਿਟੀ ਜੁਸ

ਜਦੋਂ ਪਦਾਰਥ ਵਰਤੋਂ ਦੀਆਂ ਸਮੱਸਿਆਵਾਂ ਹੋਂਦ ਵਿਚ ਆ ਜਾਣ ਤਾਂ ਬ੍ਰਿਟਿਸ਼ ਕੁਲੰਬੀਆ ਵਿਚ ਉਹਨਾਂ ਨੂੰ ਇਕ ਸਿਹਤ ਦਾ ਇਸ਼ੂ ਕਰਾਰ ਦਿਤਾ ਜਾਂਦਾ ਹੈ ਨਾ ਕਿ ਇਕ ਮੁਜਰਮਾਨਾ ਇਸ਼ੂ ਜਾਂ ਆਚਰਣਕ ਗਿਰਾਵਟ। ਸੋ ਸਿਹਤ ਸਿਸਟਮ ਰਾਹੀਂ ਸਹਾਇਤਾ ਅਤੇ ਸਹਾਰਾ ਉਪਲਬਧ ਹਨ।

### ਮੈਂ ਆਪਣੇ ਫੈਮਲੀ ਡਾਕਟਰ ਤੋਂ ਕਿਹੋ ਜਿਹੀ ਉਮੀਦ ਰੱਖ ਸਕਦਾ/ਸਕਦੀ ਹਾਂ ?

ਤੁਹਾਡੀ ਪਦਾਰਥ ਵਰਤੋਂ ਦੇ ਸਹੀ ਮੁਲਾਂਕਣ ਲਈ ਤੁਹਾਡਾ/ਤੁਹਾਡੀ ਫੈਮਲੀ ਡਾਕਟਰ ਹੋ ਸਕਦੇ:

- ਤੁਹਾਥੋਂ ਪ੍ਰਸ਼ਨ ਪੁਛੇ ਕਿ ਪਦਾਰਥ ਵਰਤੋਂ ਤੁਹਾਡੇ ਜੀਵਨ ਨੂੰ ਕਿਸਤਰਾਂ ਪ੍ਰਭਾਵਤ ਕਰ ਰਹੀ ਹੈ
- ਤੁਹਾਥੋਂ ਪਦਾਰਥ ਵਰਤੋਂ ਦਾ ਇਤਿਹਾਸ ਅਤੇ ਉਸ ਨਾਲ ਸੰਬੰਧਿਤ ਵਿਵਹਾਰ ਬਾਰੇ ਪੁਛੇ
- ਤੁਹਾਡਾ ਸਰੀਰਕ ਮੁਆਇਨਾ ਕਰੇ
- ਪ੍ਰਯੋਗਸ਼ਾਲਾ ਵਿਚ ਟੈਸਟਾਂ ਦਾ ਹੁਕਮ ਦੇਵੇ



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## ਬ੍ਰਿਟਿਸ਼ ਕੁਲੰਬੀਆ ਵਿਚ ਕਿਸ ਕਿਸਮ ਦੀ ਸਹਾਇਤਾ ਉਪਲਬਧ ਹੈ?

ਤੁਹਾਡੀ ਪਦਾਰਥ ਵਰਤੋਂ ਦਾ ਮੁਲਾਂਕਣ ਕਰਨ ਪਿਛੋਂ ਡਾਕਟਰ ਤੁਹਾਡੇ ਲਈ ਦਵਾਈਆਂ ਲਿਖ ਸਕਦਾ/ਸਕਦੀ ਹੈ ਜਾਂ ਤੁਹਾਨੂੰ ਹੋਰ ਕਿਸੇ ਅਡਿਕਸ਼ਨ ਸੇਵਾਵਾਂ ਵਾਲੇ ਸਥਾਨ ਉੱਤੇ ਜਾਣ ਲਈ ਸਿਫਾਰਸ਼ ਕਰ ਸਕਦਾ/ਸਕਦੀ ਹੈ। ਤੁਹਾਨੂੰ ਇਨ੍ਹਾਂ ਦੀ ਲੋੜ ਪੈ ਸਕਦੀ ਹੈ:

- **ਸੰਖੇਪ ਦਖਲਅੰਦਾਜ਼ੀ**

ਤੁਹਾਡਾ/ਤੁਹਾਡੀ ਡਾਕਟਰ ਤੁਹਾਨੂੰ ਇਹ ਸਮਝਣ ਲਈ ਇੱਕ ਕਮ ਵਕਤੀ ਮਸ਼ਵਰਾ ਦੇ ਸਕਦਾ/ਸਕਦੀ ਹੈ ਕਿ ਪਦਾਰਥ ਵਰਤੋਂ ਕਿਸ ਤਰ੍ਹਾਂ ਤੁਹਾਡੇ ਜੀਵਨ ਤੇ ਅਸਰ ਪਾ ਰਹੀ ਹੈ। ਹੋ ਸਕਦਾ ਹੈ ਡਾਕਟਰ ਉਹਨਾਂ ਵਿਧੀਆਂ ਦੀ ਸੁਨਾਖਤ ਕਰਕੇ ਦੱਸੇ ਜੋ ਤੁਹਾਡੇ ਪਦਾਰਥ ਵਰਤੋਂ ਨਾਲ ਸੰਬੰਧਤ ਨੁਕਸਾਨ ਨੂੰ ਘੱਟ ਕਰਨ ਵਿਚ ਸਹਾਇਤਾ ਕਰਨ, ਅਤੇ ਤੁਹਾਡੇ ਨਾਲ ਇਹ ਵਿਚਾਰ ਵਟਾਂਦਰਾ ਕਰੇ ਕਿ ਕਿਉਂ ਜਾਂ ਕਿਵੇਂ ਤੁਸੀਂ ਆਪਣੇ ਪਦਾਰਥ ਵਰਤੋਂ ਦੇ ਵਿਵਹਾਰ ਨੂੰ ਬਦਲ ਸਕਦੇ ਹੋ। ਇਸ ਕਿਸਮ ਦਾ ਮਸ਼ਵਰਾ ਇਸ ਗੱਲ ਦੇ ਅਨੁਸਾਰ ਦਿਤਾ ਜਾਵੇਗਾ ਕਿ ਤੁਸੀਂ ਤਬਦੀਲੀਆਂ ਕਰਨ ਲਈ ਕਿੰਨੇ ਕੁ ਤਿਆਰ ਹੋ।

- **ਹੋਰ ਸੇਵਾਵਾਂ ਲਈ ਰੈਫਰਲ**

ਤੁਹਾਡਾ/ਤੁਹਾਡੀ ਡਾਕਟਰ ਤੁਹਾਡੇ ਨਾਲ ਹੋਰ ਇਲਾਜਾਂ ਦੀ ਚੋਣ ਕਰਨ ਲਈ ਵੀ ਵਿਚਾਰ ਵਟਾਂਦਰਾ ਕਰ ਸਕਦਾ/ਸਕਦੀ ਹੈ ਜਿਹਨਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ ਰਿਹਾਇਸ਼ੀ ਜਾਂ ਇਨਟੈਨਸਿਵ ਆਉਟ ਪੇਸ਼ੈਂਟ (ਰਿਹਾਇਸ਼ੀ ਨਹੀਂ) ਇਲਾਜ, ਸਲਾਹ ਮਸ਼ਵਰਾ, ਜਾਂ ਤੁਹਾਡੇ ਇਲਾਕੇ ਵਿਚ ਹੋਣ ਵਾਲੀਆਂ ਗਰੁਪ ਮੀਟਿੰਗਾਂ ਵਿਚ ਭਾਗ ਲੈਣਾ। ਜੇ ਤੁਸੀਂ ਗਰਭਵਤੀ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਵਿਸ਼ੇਸ਼ ਸੇਵਾਵਾਂ ਲਈ ਰੈਫਰ ਕੀਤਾ ਜਾ ਸਕਦਾ ਹੈ ਜੋ ਤੁਹਾਡੇ ਬੇਬੀ ਨੂੰ ਹੋ ਸਕਣ ਵਾਲੇ ਨੁਕਸਾਨ ਨੂੰ ਘੱਟ ਤੋਂ ਘੱਟ ਕਰਨ ਵਿਚ ਸਹਾਇਤਾ ਦੇਣ।

- **ਨਸ਼ਾ ਛੱਡਣ ਪਿਛੋਂ ਅਨੁਸ਼ਾਸਨ**

ਇਸ ਦਾ ਭਾਵ ਹੈ ਉਸ ਸਮੇਂ ਵਿਚ ਮੈਡੀਕਲ ਨਿਗਰਾਨੀ (ਲਿਵ-ਇਨ, ਐਟ-ਹੋਮ, ਜਾਂ ਆਉਟ ਪੇਸ਼ੈਂਟ ਦੇ ਆਧਾਰ ਤੇ) ਜਦੋਂ ਤੁਸੀਂ ਪਦਾਰਥ ਦੀ ਵਰਤੋਂ ਨੂੰ ਛੱਡਦੇ ਜਾਂਦੇ ਹੋ। ਆਮ ਤੌਰ ਤੇ ਤੁਹਾਨੂੰ ਸੁਖਾਵਾਂ ਮਹਿਸੂਸ ਕਰਵਾਉਣ ਲਈ ਦਵਾਈਆਂ ਲਿਖ ਕੇ ਦਿਤੀਆਂ ਜਾਣਗੀਆਂ, ਅਤੇ ਹੋਰ ਸਹਾਇਕ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਸਲਾਹ ਮਸ਼ਵਰਾ, ਵੀ ਪ੍ਰਦਾਨ ਕੀਤੀਆਂ ਜਾਣਗੀਆਂ।

- **ਸਮਾਂਨਾਂਤਰ ਰੋਗਾਂ ਲਈ ਇਲਾਜ**

ਜੇ ਤੁਹਾਨੂੰ ਕੋਈ ਸਮਾਂਨਾਂਤਰ ਮਾਨਸਿਕ ਰੋਗ ਹੈ ਤਾਂ ਤੁਹਾਨੂੰ ਇਸ ਲਈ ਵੀ ਦਵਾਈਆਂ ਜਾਂ ਹੋਰ ਇਲਾਜ ਦੀ ਪੇਸ਼ਕਸ਼ ਕੀਤੀ ਜਾ ਸਕਦੀ ਹੈ ਜਦੋਂ ਕਿ ਤੁਹਾਡੀ ਪਦਾਰਥ ਵਰਤੋਂ ਵੱਲ ਧਿਆਨ ਦਿਤਾ ਜਾ ਰਿਹਾ ਹੈ।

- **ਮੈਥਡੋਨ ਮੇਨਟਿਨੈਂਸ ਥੈਰਪੀ**

ਜੇ ਤੁਸੀਂ ਅਫੀਮਦਾਰ ਨਸ਼ਿਆਂ (ਹੈਰੋਇਨ, ਮਾਰਫੀਨ, ਆਕਸੀਕੋਡੋਨ, ਆਦਿ) ਉੱਤੇ ਨਿਰਭਰ ਹੋ ਅਤੇ ਭੂਤ ਵਿਚ ਇਲਾਜ ਦੀਆਂ ਕਈ ਅਸਫਲ ਕੋਸ਼ਿਸ਼ਾਂ ਕਰ ਚੁੱਕੇ ਹੋ ਤਾਂ ਮੈਥਡੋਨ ਨੂੰ ਉਨ੍ਹਾਂ ਦੇ ਬਦਲ ਵਜੋਂ ਇਲਾਜ ਲਈ ਵਰਤਿਆ ਜਾ ਸਕਦਾ ਹੈ। ਇਹ ਇਲਾਜ ਨਸ਼ਾ-ਛੱਡਣ-ਉਪਰੰਤ (ਵਿਦਫਰਾਅਲ) ਦੇ ਲੱਛਣਾਂ ਨੂੰ ਰੋਕ ਦੇਵੇਗਾ ਅਤੇ ਨਸ਼ੇ ਲਈ ਲਾਲਸਾ ਵੀ ਘਟਾ ਦੇਵੇਗਾ, ਤੇ ਇਸਦੇ ਨਾਲ ਹੀ ਤੁਹਾਨੂੰ ਉਸ ਪਦਾਰਥ ਦੀ ਵਰਤੋਂ ਤੋਂ ਬਗੈਰ ਜੋ ਤੁਹਾਡੇ ਲਈ ਸਮੱਸਿਆਵਾਂ ਖੜ੍ਹੀਆਂ ਕਰ ਰਹੀ ਸੀ, ਰਹਿਣ ਸਹਿਣ ਦੇ ਯੋਗ ਬਣਾ ਦੇਵੇਗਾ। ਕੇਵਲ ਕੁਝ ਡਾਕਟਰ ਹੀ ਮੈਥਡੋਨ ਲਈ ਆਦੇਸ਼ ਦੇ ਸਕਦੇ ਹਨ।

- **ਮੁੜ-ਰੋਗੀ ਹੋਣ ਤੋਂ ਬਚਾ ਲਈ ਦਵਾਈਆਂ**

ਨਸ਼ਾ ਛੱਡਣ ਉਪਰੰਤ (ਡੀਟਾਕਸ), ਤੁਹਾਨੂੰ ਅਜਿਹੀਆਂ ਦਵਾਈਆਂ ਦਾ ਆਦੇਸ਼ ਦਿਤਾ ਜਾ ਸਕਦਾ ਹੈ ਜੋ ਤੁਹਾਨੂੰ ਸਵੈਕਾਬੂ ਰੱਖਣ ਲਈ ਸਹਾਇਤਾ ਕਰਨ। ਇਹ ਦਵਾਈਆਂ ਸਲਾਹ ਮਸ਼ਵਰੇ ਦੇ ਨਾਲ ਨਾਲ ਹੀ ਪ੍ਰਦਾਨ ਕੀਤੀਆਂ ਜਾਣੀਆਂ ਚਾਹੀਦੀਆਂ ਹਨ।

- **ਪੈਰਵੀ**

ਇਲਾਜ ਸੰਪੂਰਨ ਹੋ ਜਾਣ ਪਿਛੋਂ ਵੀ ਇਹ ਗੱਲ ਮਹੱਤਵ ਪੂਰਨ ਹੈ ਕਿ ਡਾਕਟਰੀ ਮਾਹਰ ਤੁਹਾਡੀ ਉਨਤੀ ਦੀ ਪੈਰਵੀ ਕਰਦੇ ਰਹਿਣ। ਪੈਰਵੀ ਤੁਹਾਡਾ ਫੈਮਿਲੀ ਡਾਕਟਰ ਜਾਂ ਕੋਈ ਹੋਰ ਕੇਸ ਵਰਕਰ ਕਰ ਸਕਦਾ/ਸਕਦੀ ਹੈ। ਇਸ ਪੈਰਵੀ ਦਾ ਭਾਵ ਹੈ ਤੁਹਾਡੀ ਸਿਹਤ ਅਤੇ ਭਲਾਈ ਦਾ ਨਿਰੰਤਰ ਮੁਲਾਂਕਣ ਹੁੰਦੇ ਰਹਿਣਾ, ਅਤੇ ਇਹ ਮੁਲਾਂਕਣ ਅਤਿ-ਲੋੜੀਂਦਾ (ਕ੍ਰੀਟੀਕਲ) ਹੈ। ਜੇ ਤੁਸੀਂ ਹੁਣ ਔਖ ਮਹਿਸੂਸ ਕਰ ਰਹੇ ਹੋ ਜਾਂ ਫੇਰ ਬਿੜਕ ਗਏ ਸੀ ਤਾਂ ਤੁਹਾਡੀ ਪੈਰਵੀ ਕਰਨ ਵਾਲਾ/ਵਾਲੀ ਤੁਹਾਨੂੰ ਲੋੜੀਂਦੀ ਸਹਾਇਤਾ ਪ੍ਰਦਾਨ ਕਰ ਸਕਦਾ/ਸਕਦੀ ਹੈ ਜਾਂ ਲੋੜ ਅਨੁਸਾਰ ਹੋਰ ਸੇਵਾਵਾਂ ਲਈ ਭੇਜ ਸਕਦਾ/ਸਕਦੀ ਹੈ।



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### ਹੋਰ ਕਿਹੜੀਆਂ ਕਿਸਮਾਂ ਦੀ ਸਹਾਇਤਾ ਉਪਲਬਧ ਹੈ?

- ਪਰਿਵਾਰ ਅਤੇ ਦੋਸਤ ਤੁਹਾਡੇ ਲਈ ਇਲਾਜ ਅਤੇ ਰਾਜੀ ਹੋਣ ਦੌਰਾਨ ਅਤਿ-ਲੋੜੀਂਦਾ (ਕ੍ਰੀਟੀਕਲ) ਰੋਲ ਅਦਾ ਕਰ ਸਕਦੇ ਹਨ। ਤੁਹਾਡਾ ਫੈਮਿਲੀ ਡਾਕਟਰ ਤੁਹਾਨੂੰ ਇਹ ਸਲਾਹ ਵੀ ਦੇ ਸਕਦਾ/ਸਕਦੀ ਹੈ ਕਿ ਅਪੋਇਟਮੈਂਟ ਸਮੇਂ ਤੁਸੀਂ ਆਪਣੇ ਕਿਸੇ ਪਰਿਵਾਰ ਦੇ ਜੀਅ ਜਾਂ ਨਜ਼ਦੀਕੀ ਦੋਸਤ ਨੂੰ ਨਾਲ ਲੈ ਕੇ ਆਓ। ਇਹ ਵਿਅਕਤੀ, ਤੁਹਾਡੀਆਂ ਸਮੱਸਿਆਵਾਂ ਸਮਝਦਾ ਹੋਇਆ, ਅਨੁਭਵਾਂ ਅਤੇ ਭਾਵਨਾਵਾਂ ਉਤੇ ਵਿਚਾਰ ਵਟਾਂਦਰੇ ਲਈ ਹਾਜ਼ਰ ਹੁੰਦਾ ਹੋਇਆ, ਖਤਰਾ-ਭਰਪੂਰ ਸਥਿਤੀਆਂ ਜਾਂ ਮਾਨਸਿਕ ਦਬਾਉ ਦੇ ਸਮਿਆਂ ਵਿਚ ਸੰਪਰਕ ਵਿਅਕਤੀ ਦੇ ਤੌਰ ਤੇ ਵਿਚਰਦਾ ਹੋਇਆ, ਅਤੇ ਰਾਜੀ ਹੋਣ ਦੀ ਪ੍ਰਕਿਰਿਆ ਵਿਚ ਤੁਹਾਡੇ ਉਤਾਰ ਚੜ੍ਹਾਵਾਂ ਪ੍ਰਤਿ ਹਾਂ-ਪੱਖੀ ਰਹਿੰਦਾ ਹੋਇਆ, ਤੁਹਾਡੀ ਰੋਗ-ਮੁਕਤੀ ਵਿਚ ਇਕ ਸਰਗਰਮ ਰੋਲ ਨਿਭਾ ਸਕਦਾ ਹੈ। ਮਿਸਾਲ ਵਜੋਂ, ਇਕ ਦੋਸਤ ਜਾਂ ਪਰਿਵਾਰਕ ਮੈਂਬਰ ਤੁਹਾਨੂੰ ਇਹ ਯਾਦ ਰੱਖਣ ਵਿਚ ਸਹਾਇਤਾ ਕਰ ਸਕਦਾ/ਸਕਦੀ ਹੈ ਕਿ ਕਿਸੇ ਸਮੇਂ ਬਿੜਕ ਜਾਣ ਦਾ ਭਾਵ ਜ਼ਰੂਰੀ ਨਹੀਂ ਕਿ ਤੁਸੀਂ ਦੁਬਾਰਾ ਰੋਗ ਗ੍ਰਸਤ ਹੋ ਗਏ ਹੋ, ਅਤੇ ਉਹ ਤੁਹਾਡੇ ਨਾਲ ਕੋਈ ਨਵੀਂ ਹੋਬੀ ਸ਼ੁਰੂ ਕਰਨ ਲਈ ਰਲ ਸਕਦਾ/ਸਕਦੀ ਹੈ।
- ਬੀ.ਸੀ ਪਾਰਟਨਰਜ਼ ਫਾਰ ਮੈਂਟਲ ਹੈਲਥ ਐਂਡ ਅਡਿਕਸ਼ਨਜ਼ ਇਨਫਰਮੇਸ਼ਨ ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)) ਕੋਲ ਮੁਫਤ ਵਸੀਲਿਆਂ ਦੀ ਇਕ ਲੜੀ ਹੈ; (ਇਹ (604) 669-7600 ਜਾਂ 1-800-661-2121 ਨੰਬਰਾਂ ਉਤੇ ਕਾਲ ਕਰਕੇ ਵੀ ਉਪਲਬਧ ਹੋ ਸਕਦੀ ਹੈ)। ਫੈਕਟ ਸ਼ੀਟਸ ਅਤੇ ਸਹਾਇਤਾ ਪੂਰਵਕ ਆਮ ਸਾਮੱਗਰੀ ਜਿਵੇਂ ਵੈੱਲਨੈੱਸ ਮਾਜ਼ੂਅਲਜ਼ ਦੇ ਨਾਲ ਨਾਲ ਇਕ ਪ੍ਰੋਬਲਮ ਸਬਸਟੈਂਸ ਯੂਜ਼ ਵਰਕਬੁੱਕ ਜਿਸ ਵਿਚ ਕਈ ਮਾਜ਼ੂਅਲ ਸ਼ਾਮਲ ਹਨ ਅਤੇ ਜਿਨ੍ਹਾਂ ਤੇ ਤੁਸੀਂ ਆਪਣੀ ਗਤੀ ਅਨੁਸਾਰ ਕੰਮ ਕਰ ਸਕਦੇ ਹੋ, ਵੀ ਉਪਲਬਧ ਹੈ (ਇਹ [www.heretohelp.bc.ca/helpmewith/psuworkbook.shtml](http://www.heretohelp.bc.ca/helpmewith/psuworkbook.shtml) ਉਤੇ ਮਿਲ ਸਕਦੀ ਹੈ)
- ਸਬਸਟੈਂਸ ਇਮਫਰਮੇਸ਼ਨ ਲਿੰਕ ([www.silink.ca](http://www.silink.ca)) ਜਿਹੜੀ ਸੈਂਟਰ ਫਾਰ ਅਡਿਕਸ਼ਨਜ਼ ਐਂਡ ਬੀ.ਸੀ ਉਤੇ ਮੌਜੂਦ ਹੈ, ਵਿਚ ਵੀ ਪਦਾਰਥਾਂ ਅਤੇ ਪਦਾਰਥ ਵਰਤੋਂ ਉਤੇ ਲਾਭਦਾਇਕ ਜਾਣਕਾਰੀ ਦੀ ਲੜੀ ਉਪਲਬਧ ਹੈ।

ਪਦਾਰਥ ਵਰਤੋਂ ਦੇ ਰੋਗ ਤਬਾਹਕੁਨ ਹੋ ਸਕਦੇ ਹਨ। ਪਰ ਬਹੁਤੇ ਲੋਕ ਇਹਨਾਂ ਤੋਂ ਰਾਜੀ ਹੋ ਜਾਂਦੇ ਹਨ ਅਤੇ ਨੁਕਸਾਨ ਦੇਹ ਪਦਾਰਥਾਂ ਦੇ ਅਸਰਾਂ ਤੋਂ ਮੁਕਤ ਭਰਪੂਰ ਜ਼ਿੰਦਗੀ ਜਿਉਂਦੇ ਹਨ। ਸਹਾਇਤਾ ਉਪਲਬਧ ਹੈ।



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# Uso de sustancias

## Información para los pacientes y sus familias

(Substance Use -Information for Patients and their Families)

### ***¿Es mi uso de sustancia un problema?***

Tradicionalmente las personas han usado sustancias para cambiar la forma en que se sienten o piensan. Si bien el uso de ciertas sustancias tiene pocas consecuencias dañinas, el uso de sustancias con frecuencia puede conducir a problemas graves.

Hay formas diferentes en que el uso de sustancias puede causarle problemas:

- si le impide hacer su trabajo en forma adecuada
- si impacta su salud
- si está embarazada, tratando de embarazarse, o amamantando, el alcohol o el uso de otra sustancia puede ser dañina para su bebé
- si tiene problemas financieros o legales debido a su uso de sustancia
- si causa conflicto o desacuerdo con sus familiares o amigos.

Si el uso de sustancia le está causando problemas en su vida, hay ayuda disponible. Su médico de cabecera es una de las personas que le puede ayudar.

### ***¿Qué puede conducir a tener problemas con el uso de sustancia?***

Se reconoce ahora que muchos **factores de riesgo** pueden afectar la posibilidad de que alguien desarrolle problemas con sustancias. Los factores de riesgo incluyen:

- historial familiar de problemas de uso de sustancias
- características del grupo de pares
- historial pasado de trauma o abuso
- pobreza
- trastorno mental
- dolor crónico
- varios factores de la comunidad.

En Columbia Británica cuando existen problemas por el uso de sustancias se les reconoce como un problema de salud más que como un asunto criminal o falla moral, de forma que hay ayuda de parte del sistema de salud.

### ***¿Qué puedo esperar de mi médico de cabecera?***

Para evaluar su uso de sustancia con precisión, su médico de cabecera puede:

- hacerle preguntas para determinar cómo su uso de sustancia está afectando su vida
- preguntarle acerca de su historial de uso de sustancia y comportamiento
- realizar un examen físico
- ordenar pruebas de laboratorio.

### ***¿Qué tipo de ayuda hay disponible en Columbia Británica?***

Después de evaluar su uso de sustancia, su médico puede recetar medicamentos o derivarlo a otros servicios de adicción. Puede que necesite:

- ***Una intervención breve***

Su doctor puede ofrecerle asesoramiento psicológico a corto plazo para ayudarle a entender cómo su uso de sustancia está afectando su vida. El doctor puede identificar estrategias para ayudarle a minimizar el daño asociado con su uso de sustancia y discutir por qué o cómo podría desear cambiar su comportamiento al usar sustancias. Este tipo de asesoramiento psicológico se diseñará según su disposición para cambiar.

- ***derivación a otros servicios***

Su doctor puede discutir otras opciones de tratamiento con usted, que incluyan tratamiento en residencia o ambulatorio intensivo (no residencial), asesoramiento psicológico o participación en reuniones de grupo en su área. Si está embarazada, puede que sea derivada a servicios especiales que le ayudarán a minimizar el daño a su bebé.



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- **manejo de la abstinencia**  
Esto involucra supervisión médica (ya sea como paciente interno o externo) ya que usted se está absteniendo de la sustancia(s) que está usando. Generalmente se recetarán medicamentos para hacerlo sentir más cómodo y se proporcionan otros servicios de apoyo tales como asesoramiento psicológico .
- **tratamiento para trastornos simultáneos**  
Si tiene un trastorno mental simultáneo, puede que se le ofrezcan medicamentos u algún otro tratamiento para tratar su caso mientras se trata su uso de sustancia.
- **terapia de mantenimiento con metadona**  
Si depende de los opiáceos (heroína, morfina, oxicodona, etc.) y ha tenido varios intentos infructuosos de tratamiento en el pasado, se puede usar la metadona como una terapia sustituta. Esta terapia bloqueará los síntomas de abstinencia y reducirá los antojos, permitiéndole funcionar sin usar la sustancia que le está causando problemas. Sólo ciertos doctores pueden recetar metadona.
- **medicamentos para prevenir una recaída**  
Después de la abstinencia (desintoxicación), puede que se le receten medicamentos diseñados para ayudarlo a mantener la abstinencia. Estos medicamentos deberían proporcionarse junto con el asesoramiento psicológico.
- **seguimiento**  
Aún después de completar un programa de tratamiento, es importante que los profesionales médicos le hagan un seguimiento de su progreso. Su médico de cabecera u otro trabajador involucrado en su caso puede que sea quien le hace el seguimiento. Esto involucra una evaluación continua de su salud y bienestar y es de suma importancia. Si está experimentando dificultades o tiene una recaída, la persona que está haciendo su seguimiento le puede proporcionar el apoyo que necesita o derivarlo a otros servicios según se requiera.

### **¿Cuáles son los otros tipos de apoyo?**

- Familiares y amigos pueden jugar un papel crítico para apoyarlo a través del tratamiento y la recuperación. Su médico de cabecera puede sugerirle que traiga a un familiar o amigo cercano a sus citas. Esta persona puede tener un rol activo en su recuperación al entender sus asuntos y estar disponible para conversar experiencias o sentimientos, ser una persona de contacto a quien llamar en situaciones de alto riesgo o en momentos de estrés y permanecer positivo en el manejo de los altos y bajos de la recuperación. Por ejemplo, un amigo o familiar le puede ayudar a recordar que una recaída no significa una reincidencia y puede acompañarlo a tomar un pasatiempo nuevo.
- **“Sociedad de Columbia Británica de información sobre la salud mental y adicciones”** (*Partners for Mental Health and Addictions Information*), [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca), tiene una amplia gama de recursos gratuitos (también disponibles llamando al (604) 669-7600 o 1-800-661-2121). Así como también hojas de datos y material general de ayuda tal como módulos, también puede obtenerse gratis un “Libro de trabajo” acerca del problema por el uso de sustancias (*Problem Substance Use Workbook*) que contiene numerosos módulos con los cuales puede trabajar a su propio paso (disponible en [www.heretohelp.bc.ca/helpmewith/psuworkbook.shtml](http://www.heretohelp.bc.ca/helpmewith/psuworkbook.shtml)).
- **“Enlace con información sobre sustancias”** (*Substance Information Link*), [www.silink.ca](http://www.silink.ca), en el “Centro de Columbia Británica de investigación de adicciones” (*Centre for Addictions Research of BC*) tiene amplia información acerca de las sustancias y su uso.

**Los trastornos por el uso de sustancias pueden ser devastadores. Sin embargo, la mayoría de las personas se recuperan y llevan una vida plena sin la influencia de sustancias dañinas. Hay ayuda disponible.**



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## Sự sử-dụng hoá-chất

### Thông-tin dành cho bệnh-nhân và gia-đình của họ

#### ***Sự sử-dụng hóa-chất của tôi có là một vấn-đề không ?***

Người ta thường theo thói quen dùng hóa-chất để thay-đổi cảm-giác hay sự suy-nghĩ của họ. Trong khi một vài hóa-chất có một đôi hậu-quả có hại, sự sử-dụng hóa-chất thường dẫn đến những trở-ngại rất nghiêm-trọng.

Có nhiều cách khác nhau mà sự sử-dụng hóa-chất có thể gây trở-ngại cho bạn:

- khi việc ấy cản-trở bạn làm việc đúng cách
- khi việc ấy có tác-động trên sức-khỏe của bạn
- nếu bạn đang mang thai, hay dự-định sẽ mang thai, hay cho con bú, thì bất-kỳ sự uống rượu hay dùng các hóa-chất khác có thể làm hại em bé của bạn
- khi bạn có trở-ngại trong vấn-đề tài-chánh hay pháp-lý vì việc sử-dụng hóa-chất của bạn
- khi việc ấy gây ra đụng-chạm hay bất-đồng với gia-đình hay bạn-bè của bạn

Nếu sự sử-dụng hóa-chất đang gây ra trở-ngại trong cuộc sống của bạn, xin bạn nhớ rằng chúng ta có sẵn sự giúp-đỡ. Bác-sĩ gia-đình của bạn là một trong những người có thể giúp-đỡ bạn.

#### ***Điều gì có thể dẫn đến sự sử-dụng hóa-chất gây phiền-phức ?***

Bây giờ người ta nhận biết rằng có nhiều **yếu-tố rủi-ro** có thể dễ ảnh-hưởng một người trở nên có vấn-đề đối với hóa-chất.

Những yếu-tố rủi-ro bao gồm:

- quá-khứ gia-đình có vấn-đề sử-dụng hóa-chất
- ảnh-hưởng của những người chung quanh trong cùng một nhóm
- quá-khứ có sự đau-thương hay lạm-dụng
- nghèo-khó
- rối-loạn tâm-thần
- bị đau-đớn kinh-niên
- những yếu-tố khác nhau của cộng-đồng

Một khi nhận-biết được là có trở-ngại về sử-dụng hóa-chất, thì tỉnh BC này xem đây là một nan-đề về y-tế hơn là một nan-đề hình-tội hoặc sự thất-bại đạo-đức, vì thế chúng ta có sẵn những sự-giúp-đỡ và hỗ-trợ trên suốt toàn-thể hệ-thống y-tế.

#### ***Tôi có thể mong-mỏi điều gì nơi bác-sĩ gia-đình của tôi ?***

Để thẩm-định chính-xác việc sử-dụng hóa-chất của bạn, bác-sĩ gia-đình của bạn có thể:

- hỏi bạn những câu hỏi để xác-định sự sử-dụng hóa-chất của bạn đang ảnh-hưởng đời-sống của bạn như thế nào
- hỏi bạn về lịch-sử sử-dụng hóa-chất và cách cư-xử của bạn trong quá-khứ
- làm một cuộc khám bệnh
- đặt những cuộc thử-nghiệm tại phòng thí-nghiệm.

#### ***Những sự giúp-đỡ nào là có sẵn trong tỉnh British Columbia ?***

Sau khi đã thẩm-định sự sử-dụng hóa-chất của bạn, bác-sĩ gia-đình của bạn có thể kê toa thuốc hay giới-thiệu bạn đến những dịch-vụ lo về sự nghiện-ngập. Bạn có thể cần đến

- ***sự can-thiệp ngắn hạn***

Bác-sĩ gia-đình của bạn có thể gợi ý ra sự tư-vấn ngắn hạn để giúp bạn hiểu rõ sự sử-dụng hóa-chất của bạn đang ảnh-hưởng đến đời-sống của bạn như thế nào. Bác-sĩ có thể nhận-diện những phương-pháp nào giúp bạn giảm-thiểu sự nguy-hại đi kèm với sự sử-dụng hóa-chất của bạn, và thảo-luận về lý-do tại sao, hay làm cách nào bạn có thể muốn thay-đổi thái-độ muốn sử-dụng hóa-chất của mình. Loại tư-vấn này sẽ được linh-động để thích-hợp với sự sẵn lòng muốn thay-đổi của bạn.

- ***giới-thiệu đến các dịch-vụ khác***

Bác-sĩ gia-đình của bạn có thể thảo-luận với bạn về những phương-cách điều-trị khác, kể cả việc điều-trị khi bạn là bệnh-nhân còn ở trong bệnh-viện hay ở ngoài bệnh-viện, về tư-vấn, hay về sự tham-gia vào các nhóm thảo-luận trong khu-vực nơi ở của bạn. Nếu bạn đang mang thai, bác-sĩ có thể giới-thiệu bạn đến những dịch-vụ đặc-biệt giúp bạn giảm-thiểu sự nguy-hại đối với em bé của bạn.



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- **quản-trị sự bị thuốc hành**

Điều này liên-quan đến sự giám-thị về y-tế (trên căn-bản sống chung, tại-gia, hay bệnh-nhân ở ngoài bệnh-viện) khi bạn rút lại không dùng các loại hóa-chất nữa. Thường bác-sĩ sẽ cho toa thuốc để bạn có thể cảm thấy thoải-mái hơn, và cũng sẽ cung-cấp cho bạn những dịch-vụ hỗ-trợ khác chẳng hạn như tư-vấn.

- **điều-trị cho những bệnh rối-loạn xảy ra cùng lúc**

Nếu bạn có một bệnh rối-loạn tâm-thần đồng một lúc, bác-sĩ có thể cho bạn dùng thuốc hay cách điều-trị khác để giải-quyết vấn-đề này trong khi vẫn đang giải-quyết vấn-đề dùng hóa-chất của bạn.

- **Trị-liệu bảo-trì dùng thuốc giảm đau methadone**

Nếu bạn đang nhờ-cậy các loại thuốc gốc á-phiện (như bạch-phiến, thuốc mọt-phin, hay thuốc oxycodone, vân vân..) và đã có thử qua nhiều lần trong quá-khứ mà không thành-công, thì bạn có thể dùng thuốc giảm đau methodone như là một cách trị-liệu thế vào. Cách trị-liệu này sẽ chặn đứng những triệu-chứng bị thuốc hành và giảm những sự thèm thuốc, và cho phép bạn có thể sinh-động được mà không cần dùng đến loại hóa-chất đã gây ra trở-ngại cho bạn. Chỉ có một số bác-sĩ nào đó mới có thể kê toa thuốc giảm đau methodone.

- **những thuốc ngăn-ngừa bệnh tái-phát**

Sau giai-đoạn bị thuốc hành (giã thuốc), bác-sĩ có thể kê toa những loại thuốc cho bạn theo dự-tính là sẽ giúp bạn giữ được tình-trạng không cần hóa-chất. Những loại thuốc này nên được cung-cấp chung với sự tư-vấn.

- **theo-dõi tiếp**

Ngay cả sau khi đã hoàn-tất một chương-trình điều-trị, điều quan-trọng cho các chuyên-gia y-tế là phải theo-dõi tình-trạng và diễn-tiến của bạn. Bác-sĩ gia-đình hay một viên-chức khác lo về vụ của bạn có thể là người sẽ lo việc theo-dõi tiếp tình-trạng của bạn. Điều này liên-can đến việc thăm-định tình-trạng sức-khỏe và an-sinh bạn hiện đang có, và ấy là điều quan-trọng cần-yếu. Nếu bạn đang trải qua sự khó-khăn hay đã có lầm-lỡ, thì người đang lo phần theo-dõi tình-trạng của bạn có thể cung-cấp những sự hỗ-trợ mà bạn cần, hoặc họ có thể giới-thiệu bạn cho những dịch-vụ khác khi cần.

### **Những sự hỗ-trợ khác là gì ?**

- **Gia-đình và bạn-bè** có thể đóng một vai-trò khẩn-yếu trong việc hỗ-trợ bạn khi điều-trị và cho việc hồi-phục. Bác-sĩ gia-đình của bạn có thể đề-nghị bạn đem theo một người trong gia-đình hay một người bạn thân đến những buổi hẹn gặp của bạn. Người này có thể đóng một vai-trò tích-cực trong việc hồi-phục của bạn qua sự thông-hiểu vấn-đề và qua sự sẵn-sàng có mặt để thảo-luận những kinh-nghiệm hay cảm-xúc, và qua việc làm người để liên-lạc khi gọi cho người khác trong những hoàn-cảnh nhiều rủi-ro, hay trong những lần căng-thẳng, và giữ thái-độ tích-cực khi quản-trị những lần lên xuống trong lúc bạn hồi-phục. Chẳng hạn như, một người bạn hay người thân trong gia-đình có thể giúp bạn nhớ rằng một lần lầm-lỡ không nhất-thiết phải trở thành một lần bệnh tái-phát, và còn có thể là cùng với bạn học một thú tiêu-khiển mới.


- **Cơ-quan Thông-tin về Sức-khỏe tâm-thần và Nghiện-ngập của nhóm bằng-hữu tại BC** ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)) có một số lớn những nguồn tin-tức miễn-phí (có sẵn-sàng khi bạn gọi cho số (604) 669-7600 hay số điện-thoại miễn-phí 1-800-661-2121). Và chỗ này cũng có những bảng dữ-kiện cùng những tài-liệu hữu-ích tổng-quát cũng như những khuôn-mẫu về an-sinh, ngoài ra, tại đây cũng còn có tập *Bài Tập về Sự Lạm Dụng Hóa Chất (Problem Substance Use Workbook)* trong đó có chứa một số những khuôn-mẫu mà bạn có thể tự xây-dựng tùy-tiện theo tốc-độ của bạn (tập này có sẵn tại trang mạng lưới [www.heretohelp.bc.ca/helpmewith/psuworkbook.shtml](http://www.heretohelp.bc.ca/helpmewith/psuworkbook.shtml)).

- **Những kết-nối thông-tin mạng lưới về hoá-chất** ([www.silink.ca](http://www.silink.ca)) có tại Trung-tâm Nghiên-cứ về Nghiện-ngập tại BC (Centre for Addictions Research of BC) có một số lớn thông-tin hữu-ích về hóa-chất và sự xử-dụng hóa-chất.

**Bệnh rối-loạn về xử-dụng hóa-chất có thể rất là tàn-hại. Tuy-nhiên, một số lớn người bệnh đã hồi-phục và sống một đời-sống sung-mãn mà không bị ảnh-hưởng của những hóa-chất có hại. Bạn nhớ rằng lúc nào cũng có sẵn sự giúp-đỡ cho bạn**



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# COPING WITH SUICIDAL THOUGHTS: Information for Patients & their Families



# Coping with Suicidal Thoughts

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## I'm seriously thinking about suicide. What should I do?

If you are thinking about suicide, you are not alone. Many people have thoughts of suicide, for a number of reasons. Thoughts of suicide can be very scary. You probably feel hurt, confused, overwhelmed and hopeless about your future. You may feel sadness, grief, anger, guilt, shame, or emptiness. You may think that nothing can be done to change your situation. Your feelings may seem like they are just too much to handle right now. It is important to know that thinking about suicide does not mean that you will lose control or act on these thoughts. Having thoughts of suicide does not mean you are weak, or 'crazy'. Many people think about suicide because they are looking for a way to escape the pain they are feeling.

Even though your situation seems hopeless and you wonder if you can stand another minute of feeling this bad, there are ways to get through this and feel better. You don't have to face this situation alone. Help is available. Here are a few ideas that you can use right now.

- **Connect with others:** If you are worried that you may lose control or do something to hurt yourself, tell someone. Make sure you are around someone you trust. If you live alone, ask a friend or family member to stay with you. If you don't know anyone or can't reach friends or family members, call 1-800-SUICIDE (1-800-784-2433).
- **Keep your home safe by getting rid of ways to hurt yourself:** It is important to get rid of things that could be used to hurt or kill yourself, such as pills, razor blades, or guns. If you are unable to do so, go to a place you can feel safe.
- **Develop a safety plan:** It is very helpful to have a written safety plan when you have thoughts of hurting yourself. Have a trusted family member, friend, or professional help you to complete this safety plan. Keep this plan somewhere you can see or find easily. Write down the steps you will take to keep yourself safe (see the following example). Follow the steps. If you follow these steps and still do not feel safe, call a crisis line, get yourself to a hospital emergency room or call 911.

*This document is not intended to replace professional care with a therapist or physician.*

1-800-SUICIDE (1-800-784-2433)



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## Safety Plan

If you have thoughts of hurting yourself, start at Step 1. Go through each step until you are safe. Remember: Suicidal thoughts can be very strong. It may seem they will last forever. With support and time, these thoughts will usually pass. When they pass, you can put energy into sorting out problems that have contributed to you feeling so badly. The hopelessness you may feel now will not last forever. It is important to reach out for help and support. You can get through this difficult time. Since it can be hard to focus and think clearly when you feel suicidal, please copy this and put in places where you can easily use it, such as your purse, wallet or by the phone.

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1. Do the following activities to calm/comfort myself:

2. Remind myself of my reasons for living:

3. Call a friend or family member:

Name:

Phone:

4. Call a backup person if person above is not available:

Name:

Phone:

5. Call a care provider (psychologist, psychiatrist, therapist):

Name:

Phone:

6. Call my local crisis line:

Phone:

7. Go somewhere I am safe:

8. Go to the Emergency Room at the nearest hospital.

9. If I feel that I can't get to the hospital safely, call 911 and request transportation to the hospital. They will send someone to transport me safely.

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## How can I better understand my suicidal thoughts and feelings?

Some problems and experiences, especially those that have been around for a long time, can leave you feeling hopeless and overwhelmed. At these times, you may think that you have no options left. You may think about suicide as a way to escape intense emotional pain.

People who kill themselves often think that their problems are unbearable and can't be fixed. They feel like nothing they have tried has or will change their situation. Their emotional pain can distort thinking so it becomes harder to trust, or to see possible solutions to problems, or to connect with available love and support. Even if it seems that you can't stand another minute, it is important to remember that feelings (e.g., grief, anger, sadness, loneliness, shame), especially at this intense level, don't last forever. Sometimes thoughts of suicide can become very strong, especially if you have taken drugs or alcohol. It is important to not use non-prescription drugs or alcohol, particularly when you feel hopeless or are thinking about suicide.

Some of the thoughts you may be having are:

- believing there are no other options;
- sensing your family or friends would be better off without you;
- thinking you've done something so horrible that suicide is the only option;
- experiencing unbearable pain that feels like it will go on forever;
- wanting to escape your suffering;
- wanting to let your loved ones know how much you hurt; and
- wanting to hurt or get revenge on others.

Your feelings of pain are very real. However, it is important to know that there is hope. With the help of professionals and the support of family and friends, you can learn about what is causing your suffering and how you can change or manage it. Hurting or killing yourself are not your only options. Professionals can help you learn new skills for dealing with your pain. These might include: developing new skills to cope; seeing your problems in a new light; improving your ability to handle intense and painful emotions; improving your relationships; increasing your social supports; or medications.

Some other things that may lead you to think of suicide are:

**Mental health problems:** Some mental health problems, such as depression or anxiety, can increase feelings of suicide. Mental health problems are treatable. It is important to talk to your doctor if you feel low, depressed, or anxious. Counseling or medication may help. There are also free resources that can help (e.g., the Antidepressant Skills Workbook, at [www.carmha.ca](http://www.carmha.ca)).

**Conflict with loved ones:** You may feel that your family or friends would be better off without you. It is important to remember that conflict with others doesn't last forever. Ending your life is not a way to solve that conflict. We know that people who lose a loved one to suicide say that their lives are not better off.

**Loss:** Many different types of loss can increase the chances you may feel suicidal. Some examples that may set off feelings of suicide include: a break-up; losing a job; losing social status; or losing a loved one or friend. Knowing someone who has died by suicide can increase the chance that you think of suicide as an option. As difficult as your loss may seem, there are people and services that can help you get through difficult times, such as Griefworks BC (1-877-234-3322).

**Financial/legal problems:** Financial or legal problems, such as overwhelming debt, gambling problems, or problems with the law, can be very stressful. It is important to know that there may be free services that can help you deal with financial or legal problems. These include the Credit Counselling Society (1-888-527-8999), the Problem Gambling Help Line (1-888-795-6111), or the Legal Services Society (1-866-577-2525).

**Lack of connection to friends and others:** Thoughts of suicide can increase if you spend a lot of time alone, or don't feel you can tell anyone your problems. Talk to someone, like a professional, about ways that you can increase social supports in your life. You may feel that the people that are in your life don't understand the pain you are feeling. Talk to a professional about ways that you can let others know of the pain and unhappiness you are

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feeling. The Social Supports wellness module at [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) gives ideas for how to improve your social supports.

**Drug and alcohol problems:** Using alcohol or drugs can make feelings of depression, anxiety, and thoughts about suicide worse. Drugs and alcohol can change the way you think about problems in your life. If drugs or alcohol are causing your problems, you can get information on treatment from the BC Alcohol and Drug Information and Referral Service (1-800-663-1441).

**Medical problems:** Medical problems such as diabetes, thyroid problems, chronic pain, or multiple sclerosis can increase chances that you may think about suicide. Make sure you have proper medical care for health problems. Some medications can increase feelings of suicide. It is important to speak to your doctor about this. You can also get information by calling the BC NurseLine (1-866-215-4700) or the Living a Healthy Life with Chronic Conditions programs (1-866-902-3767).

**Sexual identity issues:** People who are lesbian, gay, bisexual, or transgender may have a higher risk of suicide. Confusion about sexual identity and fears of possible or real rejection from family or friends can make things worse. There is support available. Prideline (1-800-566-1170) is a peer support and information phone line. Prideline is open 7 days a week, from 7:00 p.m. to 10:00 p.m.

## What else can I do to decrease thoughts of suicide?

**Problem-solve:** It is always helpful to think of ways other than suicide that you can solve your problems. First, make a list of all the problems you are dealing with in your life. Second, make a list of all the solutions you can think of to those problems. You can ask someone you trust to help you with this. Dealing with 1 or 2 small problems can help to put an end to immediate feelings of suicide. Once you are thinking more clearly, you can tackle other bigger problems. You can find worksheets on Problem-Solving and Healthy Thinking in the

Antidepressant Skills Workbook ([www.carmha.ca](http://www.carmha.ca)) or at [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca).

Some examples of common problems and ideas for solutions are:

### **Problem: Depressed mood**

#### **Possible Solution:**

- Call 1-800-SUICIDE for emotional support, short-term problem-solving and referrals for longer term help.
- See your family doctor to discuss options for treatment (e.g., medications, changes in medications, undiagnosed illnesses).
- Take care of yourself by resting, exercising regularly, eating regularly and spending time with friends.

### **Problem: End of a relationship**

#### **Possible Solution:**

- Talk to friends about the pain you feel.
- Get help from a crisis line or counselor.
- Join a social group.

**Think of reasons for living:** Most people who think about suicide want to escape their pain, but they do not always want to die. When you feel low, it's easy to stay focused on things that are negative and upsetting in your life. This makes it easy to think of suicide as the only option. Start thinking about some reasons you have for living. For example, many people have relationships with loved ones, pets they love, religion, goals and dreams, or responsibilities to others in their life that give them reasons to live and prevent them from acting on their suicidal thoughts. Think of all of the reasons you have for living. Write them down. Remind yourself of them when you are feeling low.

### **Remember things that have helped in the past:**

Many people have had thoughts of suicide before. Think of some of the things that helped you feel better when you faced the same types of problems in the past. Some examples are: having faith and trust that time always helps; reaching out to friends and family; seeing a professional; going to a support group; following a safety plan; doing something you enjoy; not being alone; keeping a journal; or not drinking or using drugs.

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**Talk to a trusted friend, family member, or professional:** It's important to speak to someone you trust about how you feel. Sometimes just talking about how you feel can help. It is important to be open about all of your thoughts. If you have a suicide plan, it is important to tell someone what your plan is. People often say they are relieved that they shared how they felt with someone. Talking can help you feel less alone.

**Get treatment for mental health problems:** It is important to get treatment for depression, anxiety, and alcohol and drug problems. Just seeing your family doctor may not be enough. It can help to see a mental health specialist, such as a psychologist or a psychiatrist. You can get referrals from your doctor or learn how to find a specialist from one of the referral lines listed on the following page. If you are already receiving treatment, speak up if your treatment plan is not working.

**Do the opposite of how you feel:** When you have thoughts of suicide, it can be helpful to do the opposite of how you feel. For example, when people feel depressed they usually want to be alone. Doing the opposite, for example getting in touch with others, can help with feelings of depression.

## How can I decrease chances that I will feel suicidal in the future?

**Get professional support:** You can get help and referrals from your doctor or from referral lines listed on the following page. If the first referral doesn't work for you, ask for another.

**Identify high-risk triggers or situations:** Think about the situations or factors that increase your feelings of despair and thoughts of suicide. Work to avoid those situations. For example, going to a bar and drinking with friends may increase feelings of depression. If this is a trigger for you, avoid going to a bar or seeing friends who drink.

**Self-care:** Taking good care of yourself is important to feel better. It is important to do the following:

- eat a healthy diet;
- get some exercise every day;
- get a good night's sleep; and
- decrease or stop using alcohol or drugs, as these can make feelings of depression and suicide worse.

**Follow through with prescribed medications:** If you take prescription medications, it is important to make sure you take them as your doctor directed. Speak to your doctor if medications aren't working, or if side effects are causing you problems. If you have just begun taking antidepressants, it is important to know that symptoms of depression resolve at different rates. Physical symptoms such as energy or sleep may improve first. Improvement in mood may be delayed. Speak to your doctor if you are feeling worse.

**Structure and routine:** Keep a regular routine as much as possible, even when your feelings seem out of control. Here are some tips for creating structure in your life:

- wake up at a regular time;
- have a regular bed time;
- have planned activities in your day, such as going for a walk or going to the gym; and
- continue to go to work or school.

**Do things you enjoy:** When you are feeling very low, do an activity you enjoy. You may find that very few things bring you pleasure. Think of things you used to enjoy doing at times you didn't feel so depressed or suicidal. Do these things, even if they don't bring you enjoyment right now. Giving yourself a break from suicide thoughts can help, even if it is for a short time.

**Think of personal goals:** Think of personal goals you have for yourself, or that you've had in the past. Some examples are: to read a particular book; travel; get a pet; move to another place; learn a new hobby; volunteer; go back to school; or start a family.

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# What can I do to learn more?

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## Useful Phone Numbers (24 hrs/day, 7 days/week)

1-800-SUICIDE (1-800-784-2433)

BC Nurse Line: 1-866-215-4700 (TTY deaf/hearing impaired number: 1-866-889-4700)

BC Mental Health Information Line: 1-800-661-2121

BC Alcohol and Drug Information and Referral Service: 1-800-663-1441

Problem Gambling Help Line: 1-888-795-6111

## Other Useful Phone Numbers

Credit Counselling Society: 1-888-527-8999

Mood Disorders Association of BC: 604-873-0103

Early Psychosis Intervention Program: 1-866-870-7847

Griefworks BC: 1-877-234-3322

Legal Services Society: 1-866-577-2525

SAFER (Suicide Attempt Follow-up, Education and Research): 604-879-9251

Vancouver Crisis Centre: 1-866-661-3311

## Useful Websites

Anxiety Disorders Association of BC: [www.anxietybc.com](http://www.anxietybc.com)

BC Schizophrenia Society: [www.bcscs.org](http://www.bcscs.org)

Canadian Mental Health Association – BC Division: [www.cmha.bc.ca](http://www.cmha.bc.ca)

Early Psychosis Intervention Program: [www.psychosissucks.ca](http://www.psychosissucks.ca)

BC Partners for Mental Health and Addictions Information: [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)

Mood Disorders Association of BC: [www.mdabc.ca](http://www.mdabc.ca)

Youth Support: [www.youthinbc.com](http://www.youthinbc.com)

## Books

Arena, J. (1995). *Step Back From the Exit: 45 Reasons to Say No to Suicide*. Milwaukee, WI: Zebulon Press.

Bilsker, D., & Paterson, R. (2005). *Antidepressant Skills Workbook*. Vancouver, B.C.: Centre for Applied Research in Mental Health and Addiction. Free download at [www.carmha.ca](http://www.carmha.ca).

Blauner, S. R. (2002). *How I Stayed Alive When My Brain Was Trying to Kill Me: One Person's Guide to Suicide Prevention*. New York, NY: William Morrow.

Chabot, J. A. (1997). *A New Lease on Life: Facing the World After a Suicide Attempt*. Minneapolis, MN: Fairview Press.

Cobain, B. (1998). *When Nothing Matters Anymore: a Survival Guide for Depressed Teens*. Minneapolis, MN: Free Spirit Publishing Inc.

Conroy, D. L. (1991). *Out of the Nightmare: Recovery From Depression and Suicidal Pain*. New York, NY: New Liberty Press.

Quinnett, P. G. (1995). *Suicide: the Forever Decision. For Those Thinking About Suicide, and For Those Who Know, Love, or Counsel Them*. New York, NY: The Crossroad Publishing Company.

1-800-SUICIDE (1-800-784-2433)



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# APPENDIX 1 DEVELOPMENTAL DISABILITIES

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# 6 APPENDIX 1: DEVELOPMENTAL DISABILITIES

### DEPRESSION, EARLY PSYCHOSIS, ANXIETY AND SUBSTANCE USE DISORDERS IN PEOPLE WITH DEVELOPMENTAL DISABILITIES

- In BC, long-stay institutions for people with DD have been closed since 1996.
- A *developmental disability* means sub-average intellectual functioning equivalent to an IQ of 70 or below, as well as impaired adaptive skills, and occurrence prior to age 18. (definition of *mental retardation* in DSM-IV or DSM-IV-TR)
- Those who meet the full criteria for developmental disability are probably about 1% of the population.
- The diagnosis of *mental retardation* in the DSM-IV or DSM-IV-TR classification system is coded on AXIS II.
- Services to people with DD are provided by Community Living Services MCFD

### BASIC PRINCIPLES OF MENTAL HEALTH IN DEVELOPMENTAL DISABILITY

- People with DD can develop the full range of psychiatric disorders.
- IQ does not predict prognosis or response to treatment.
- The presentation of psychiatric illness in people with DD may range from typical to atypical.
- People with DD experience a very significant rate (30 – 40%) of mental health disorders based on estimated prevalence rates, yet many are typically underdiagnosed, misdiagnosed, and underserved
- The most frequent reason for a request for psychiatric assessment is aggression or self injury for people with DD, but aggression or self-injury are often the outward symptoms of common mental health disorders, or a physical cause or environmental change.
- The most commonly occurring disorders, similar to the general population, include major depressive disorder, bipolar disorder and anxiety disorders.
- Higher rates of physical, emotional, and sexual abuse may also be responsible for a higher rate of mental illness.
- Medical conditions may present with psychiatric symptoms more frequently than in the general population.
  - Undiagnosed or improperly treated physical problems can affect a person's behaviour and may lead to over-diagnosing of 'behaviour' problems, misdiagnosis of personality disorder and/or psychotic disorders resulting in over-prescribing of psychotropic medications, especially antipsychotic medications.
- Ensure that informed and valid consent is obtained for health care for people with DD
  - Be aware of British Columbia's Adult Guardianship Legislation when working with people with DD ([www.trustee.bc.ca](http://www.trustee.bc.ca) for information).

### TREATMENT PRINCIPLES FOR MENTAL HEALTH IN DEVELOPMENTAL DISABILITY

- People with DD have the same requirement for treatment as others in a health authority but care and sensitivity must be taken to accommodate to their disability.
- Consider and seek out reports of family, third party caregivers, or associated support staff and make adaptations to accommodate to the individual's communication needs.
- The language of the interview must be significantly altered.
  - Use plain language, short sentences, speak slowly and avoid leading questions.
- Allow for adequate time for physical examinations, mental health and addiction assessments.

## FREQUENT PSYCHIATRIC DISORDERS IN PEOPLE WITH DEVELOPMENTAL DISABILITIES

### *Depression*

- Common presentations include:
  - tearfulness, sad, irritable or angry affect
  - social withdrawal or increased dependency, regression in self-care skills or loss of learned skills
  - aggression or self-injurious behaviour
  - decreased energy or psychomotor retardation
  - appetite change or sleep disturbance
  - hypochondriasis or tantrums
  - reduced speech or mutism.
- Reporting of suicidal ideation, self-depreciation, and guilt may be difficult for many.
  - Individuals with DD may never meet full DSM-IV or DSM-IV-TR criteria.
- Although thought to be serious by the individual, suicidal behaviour may not always be lethal (e.g., self-strangling) or risk taking behaviour may occur (e.g., riding bike with eyes closed).
- Symptoms of hallucinations or delusions may occur more frequently with depression.

### *Anxiety Disorders*

- Frequent in the DD population, but difficult to diagnose as identification of anxiety can be difficult for someone with DD.
- Significant anxiety may be reflected as a somatic illness, e.g., a stomach ache. In addition, severe anxiety can lead to behavioural problems.
- **Obsessive-compulsive disorder** is also identified frequently. Some individuals are able to articulate the anxiety associated with performing a compulsion, and others are not. There is a consensus that these conditions should be treated as they typically would even if the person appears to not be bothered by performing a compulsion.
- **Posttraumatic Stress Disorder (PTSD)** It is likely that individuals who have DD are at greater than average risk for experiencing repeated traumatization (Sobsey, et al., 1992). People with DD live, to varying degrees, in a state of dependency on others.
- The symptoms of PTSD may be quite different from those seen among the general population.
  - articulating the event may be difficult.
  - flashbacks and memories may be more vague or distorted.
  - increased anxiety and hyperarousal may present as a 'behavioural problem'.
  - brief psychotic episodes may occur (Martorana, 1985).

*Psychotic Disorders*

- Because of verbal difficulties it is not thought possible to reliably diagnose psychosis in those with an IQ of less than 50.
- The rate of actual psychotic disorders may be similar to that in the general population, though this is still controversial as some studies suggest an increased prevalence.
- Onset of schizophrenia before adolescence is rare but tends to be somewhat earlier in people with DD than in the general population (Meadows et al, 1991).
- Imaginary friends, self-talk, dramatic fantasy play are usually not signs of psychosis.
  - Many fantasies *may* appear to be a delusional system, but when questioned carefully, the individual can indicate awareness that the subject of discussion is not real.
- People with DD may experience a higher rate of psychotic symptoms when under severe stress.
- As with other psychiatric disorders, aggression may also be a presenting problem.

*Overuse and Misuse of Anti-Psychotic Medications*

- Due to the frequent presence of aggression and self-injury, there has been a historical trend for overuse and misuse of antipsychotic medications for people with developmental disabilities.
- The use of anti-psychotics in this population is associated with greater risk of developing movement disorders (especially tardive dyskinesia and tardive akathisia) and cognitive impairment.
- Anti-psychotics are often prescribed for 'behaviour' without understanding what is behind the behaviour.
- Withdrawing someone from an antipsychotic medication after they have been on for many years must be done very slowly (5% – 10 % every 2 months) in order to minimize potentially very serious withdrawal effects (agitation, insomnia, confusion or aggression).
- If anti-psychotics must be used, start low and go slow.

*Substance Use Disorders*

- Incidence of substance use disorders appear to be low compared to the general population. It is likely to be underestimated and under diagnosed.
- Caffeine and nicotine-related disorders are the most frequently found disorders in this population. Alcohol or illicit drugs tend to be consumed in lower amounts as compared to the general population. Stavrakaki (2002)
- Enquire about *all* substance use (including cigarettes, caffeine, and over-the-counter medicine)
- Treatment tips:
  - make materials easy to read/comprehend
  - avoid abstract written and spoken material
  - keep sessions short (15 – 30 minutes)
  - supplement group with individual treatment
  - use modeling, rehearsal and feedback to teach skills

- enhance family/other support
- monitor impact of drug/alcohol use on concurrent medications
- use more concrete and short term goals.
- encourage a support person to attend sessions with the client to provide reinforcement of the concepts after discharge from treatment.
- treatment interventions that support reduction in stress and drugs craving, such as yoga and acupuncture, over cognitive based therapies common in the substance use field may be helpful with people with developmental disabilities (Sturmey et al., 2003)

## SYNDROMES ASSOCIATED WITH A HIGH INCIDENCE OF MENTAL HEALTH DISORDERS

### Fetal Alcohol Spectrum Disorder

- FASD refers to the range of birth defects caused by prenatal exposure to alcohol, including Fetal Alcohol Syndrome (FAS), Partial FAS and Alcohol Related Neurodevelopmental Disorder (ARND).
- It is estimated that 1 – 3 of every 1,000 live births in North America are affected by FAS, and rates of Partial FAS and ARND are likely to be much higher.
- It is the leading cause of preventable mental retardation.
- Recommend abstinence. There is no known safe level of alcohol consumption while pregnant.
  - Binge drinking is thought to be more harmful than consistent lower levels of drinking, since it raises the blood alcohol content to a higher level.
- *Primary disability:* The permanent neurodevelopmental deficits of Fetal Alcohol Spectrum Disorders ('brain damage') growth impairment and other birth defects.
  - facial changes including epicanthal eye folds
  - poorly formed concha
  - small teeth with faulty enamel
  - cardiac atrial or ventricular septal defects
  - aberrant palmar crease and limitation in joint movement
  - microcephaly
  - kidney, liver, hearing and sight may also be affected
- *Secondary disabilities:* (many of which can be mediated by proper interventions and support) include:
  - a very high rate of mental health/addiction problems and disorders (90%) such as suicide and suicide attempts, depression, anxiety, attention-deficit hyperactivity disorder; disrupted school experience;
  - trouble with the law (60%)
  - confinement in inpatient units for mental illness/substance use disorders or incarceration for a crime (50%)
  - inappropriate sexual behaviour (50%)
  - alcohol or drug use problems (30%)
  - dependent living (80%)
  - problems with employment (80%), (Streissguth & Kanter, 1997).
- Lack of a proper diagnosis results in higher concurrent disorders and can also lead to misdiagnosis of mental health/addiction disorders or over-diagnosis of personality disorders.

- Mental retardation (IQ less than 70) may or may not be present but most tend to have a marked discrepancy between IQ and adaptive functioning, with adaptive functioning almost always being lower than the IQ and adaptive function often falling below 70.
- For women with an alcohol or other substance use problem, consider referral to the BC Women's Hospital program at Fir Square which provides care for substance using women and their children, and also operates an outpatient clinic.
- When someone is diagnosed with FASD, it is important to consider the needs of two patients (mother and child). The highest predictor of having a child with FASD is already having a child with FASD

### **Autism Spectrum Disorder (ASD)/ Pervasive Developmental Disorder**

- Most have associated anxiety including panic attacks, compulsions and perseverative rituals that may result in challenging behaviours.
- Some have a severe form that includes relentless hyperactivity and severe sleep disturbance. In addition, there is a significant association with bipolar disorder in this population.

### **Down Syndrome**

- High rate of depression and anxiety disorders, with obsessive compulsive disorders frequently occurring.
- Individuals with Down Syndrome are also more prone to develop Alzheimer-like dementia at an earlier age, associated with accelerated aging problems.

### **Fragile X Syndrome**

- Most common inherited genetic disorder. In its full form it affects only males, but lesser forms of the condition are found in female family members as well.
- Associated with hyperactivity and some autistic features.
- Usually results in moderate to mild DD, and is also associated with (ADHD), hyperarousal, anxiety and aggression related to mood lability.

## **DEDICATED HEALTH AND MENTAL HEALTH SERVICES AVAILABLE**

### **Health Services for Community Living (HSCL) and Mental Health Support Teams (MHST)**

- Operated and managed by the Health Authorities.
- HSCL provides consultation in the areas of home nursing, physiotherapy and occupational therapy as well as nutrition and dental care.
- MHST provide assessment, treatment and consultation (to Family Physicians) for those individuals with DD and mental health needs who need special attention through Mental Health and Addiction Services.
- MCFD continues to provide some health services: specifically tertiary inpatient services (Willow Clinic) and professional behavioural support contractors for high need individuals throughout BC.
- Health Authorities provide the services of a Medical Consultant in Developmental Disability to Family Physicians. *(Find contact information under Resources at end of document)*
- See 4.10 for a listing of mental health support teams



### REFERENCES AND RESOURCES

The information in this appendix is excerpted from a much larger document: *Mental Health Services for People with Developmental Disability: Planning Guidelines for Health Authorities in BC* 2004. Ministry of Health Services, MHAS. The following references are specifically cited in this appendix:

- Martorana, G.R. (1985). Schizophreniform disorder in a mentally retarded adolescent boy following sexual victimization. *American Journal of Psychiatry*, 142, 784 – 786.
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- Streissguth, A. & Kanter, J. (Eds.) (1997). *The Challenge of Fetal Alcohol Syndrome: overcoming secondary disabilities*. Seattle Washington: University of Washington Press.
- Sturmey, P. Reyer, H., Lee, R., & Robek, A. (2003). *Substance-related disorders in persons with mental retardation*. Kingston, New York: NADD Press.

#### Resources

The Advocate for Service Quality in British Columbia-assists adults with developmental disabilities and their families in obtaining high quality service from MCFD, from other ministries and service agencies Office: 1-604-775-1238 [www.mcf.gov.bc.ca/getting\\_help/advocate\\_service\\_quality.htm](http://www.mcf.gov.bc.ca/getting_help/advocate_service_quality.htm)

Bradley, E.A., Burke, L., Drummond, C., Korossy, M., Lunskey, Y. L., & Morris, S. (2002). *Guidelines for managing the client with intellectual disability in the emergency room*. Toronto: Centre for Addiction and Mental Health, University of Toronto, Surrey Place Centre. 1-800-661-1111 [www.camh.net/](http://www.camh.net/)

The Provincial Medical Consultant in Developmental Disability for BC: Dr. Brian Plain, Saanich Health Unit, #303-3995 Quadra St Victoria BC V8X 1J8 Telephone 1-250-744-5174; Fax 1-250-479-5836; [brian.plain@caphealth.org](mailto:brian.plain@caphealth.org)

#### FASD Resources

The FASD Fact Sheet includes information and where to find more help: [www.heretohelp.bc.ca/publications/factsheets/fetalalcohol.shtml](http://www.heretohelp.bc.ca/publications/factsheets/fetalalcohol.shtml)

The Fir Square program at BC Women's Hospital: call (604) 875-2424, local 2160 on weekdays.

The FAS/E Support Network provides support for families with an affected child: [www.fetalalcohol.com](http://www.fetalalcohol.com)

*Fetal Alcohol Spectrum Disorder: A Strategic Plan for British Columbia*: available at [www.healthservices.gov.bc.ca/mhd/fasd.html](http://www.healthservices.gov.bc.ca/mhd/fasd.html)



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# APPENDIX 2: WOMEN'S MENTAL HEALTH ISSUES

### MENTAL HEALTH & THE FEMALE LIFECYCLE

In the realm of mental health, women are recognized by the World Health Organization as more commonly experiencing specific conditions such as anxiety disorders, depression and somatic complaints as compared with men. Although women may experience psychiatric illness at any point in their lives, times of heightened vulnerability occur during pregnancy, the postpartum, and the peri-menopausal period. Women may also experience mood changes related to their menstrual cycle such as PMS or PMDD.

When considering the mental health of women over the reproductive lifecycle, it is essential to view women within their psychosocial context. This context is one of complex gender-specific issues, economic circumstances, and variable levels of stigma and support within both the family and the community as a whole. For example, women have comparatively fewer resources and more often provide primary child-care. Beyond these challenges are the societal expectations attached to different points in the reproductive lifecycle. For example, pregnancy and the postpartum are expected to be times of happiness, when in fact disorders of mood and anxiety are common in this period. Myths of this nature are fundamental barriers which prevent not only women from seeking help, but also healthcare providers from recognizing the need for intervention.

### PRE-MENSTRUAL SYNDROME (PMS) & PRE-MENSTRUAL DYSPHORIC DISORDER (PMDD)

- Between 30 – 70% of women experience pre-menstrual symptoms.
- Approximately 4 – 9% of women suffer from PMDD.
- PMS/PMDD may start any time after puberty, often worsen over time, and remit during pregnancy and at menopause.
- PMDD unlike PMS is classified as a mood disorder by DSM-IV or DSM-IV-TR.
- Symptoms of PMDD overlap with symptoms of depression, but include irritability and feelings of loss of emotional control.
- Symptoms of PMDD can markedly interfere with daily functioning.
- PMDD is experienced in the luteal phase of the menstrual cycle with remission of symptoms within a few days of the onset of menses.
- Women with PMDD are often misdiagnosed with bipolar disorder or unipolar depression. Symptoms of PMDD are always linked to the menstrual cycle whereas other mood disorders may not be.
- Women who first experience PMDD in their late thirties and early forties often have a history of depression, sometimes related to the postpartum period.
- Although some women who are depressed will notice worsening during the luteal phase of the menstrual cycle this is not PMDD. This is sometimes referred to as premenstrual magnification.
- Women with PMS/PMDD are at an increased risk of concurrent mood disorders, particularly depressive and anxiety disorders.
- Women with a history of addictions seem to have more cravings in the premenstrual phase of the cycle.



**Overview of Treatment for PMDD**

Non-pharmacologic treatment:

- education and support
- exercise
- healthy lifestyle — regular sleep and balanced diet
- psychotherapy — focus on life stresses and how to reduce them
- self-help groups.

Pharmacotherapy:

- Some women with PMDD may find non-pharmacologic measures inadequate.
- The latest research suggests that serotonin dysregulation is involved in PMDD.
- Women with symptoms of PMDD can be treated with serotonin-reuptake inhibitors (SSRIs) or serotonin and noradrenalin reuptake inhibitors — SNRIs (Venlafaxine).
- Intermittent dosing (14 days before menses) appears to be as effective as continuous dosing and withdrawal symptoms are not usually problematic.
- Low-dose therapy is usually adequate.
- At present, hormonal therapy is not commonly recommended as first-line treatment.

**PERI-MENOPAUSE/MENOPAUSE**

- There is no evidence that natural menopause causes depression.
- This can be an unstable time for women with mood disorders.
- Women with a history of psychiatric illness (including postpartum depression or PMDD) are at a greater risk of experiencing depression/depressive symptoms during peri-menopause or menopause.
- Depression is more likely during peri-menopause than at menopause.
- Diagnosis of depression can be difficult, because many symptoms of depression overlap with symptoms of peri-menopause (e.g., change in appetite and energy levels).
- The peri-menopausal years are a time of endocrine changes; thus an important clinical concern is whether mood complaints reflect endocrine changes or the psychosocial stressors in women's lives.

**Overview of Treatment**

- Lifestyle changes are essential components of treatment, particularly diet and exercise.
- Women experiencing major depression during menopause can be successfully treated with psychotherapy and/or anti-depressants.
- Vasomotor symptoms and sleep may be helped by hormone replacement therapy (HRT), but the risks and benefits must be carefully assessed for each individual. HRT alone should not be used for the treatment of Major Depression.

## PSYCHIATRIC ILLNESS DURING PREGNANCY AND THE POSTPARTUM PERIOD (THE PERINATAL PERIOD)

### Depression in the Perinatal Period

#### *Pregnancy*

- Pregnancy does not protect against mental illness.
- Up to 70% of women report experiencing depressive symptoms during pregnancy, while the prevalence of Major Depression in pregnant women is between 10% and 16%.
- Diagnosing depression during pregnancy can be difficult, as symptoms of depression such as changes in sleep and appetite can be difficult to distinguish from the normal signs of pregnancy.
- Many women diagnosed with postpartum depression are symptomatic antenatally; therefore the primary caregiver should be aware of the opportunity for early detection and treatment.
- Women with untreated depression in pregnancy may be less likely to see their physician and may thus receive poor prenatal care, increasing their risk of medical/obstetric complications. These women are also at higher risk for self-medicating, substance use, suicidal/homicidal thoughts and the continuation or worsening of symptoms in the postpartum.
- Long term follow-up is essential.

#### *Postpartum Blues*

- The “Postpartum Blues” occurs in up to 50 – 80% of women.
- It generally occurs between 3 and 5 days postpartum.
- It is self-limited, and in most cases recovery occurs spontaneously within two weeks.
- It is characterized by tearfulness, fatigue, anxiety, and irritability.
- A small percentage of cases progress to postpartum depression. Any woman experiencing “blues” symptoms for over 24 hours should be monitored carefully.

#### *Overview of Treatment*

- Support and reassurance for the individual and family is essential.
- Maximize healthy lifestyle — nutrition, exercise, sleep.
- If ongoing sleep deprivation is a problem, sleep medication may be beneficial on a short-term basis.

#### *Postpartum Depression (PPD)*

- PPD occurs in up to 10 – 20% of women.
- Up to 26% of adolescent mothers experience PPD.
- PPD can present at anytime in the 12 months after delivery.
- PPD can pose significant risks to both mother and infant.
- Signs and symptoms of PPD are the same as for a major depressive disorder at other times, but there are often additional issues concerning the baby.  
For example,
  - Is there impaired or delayed bonding with the baby?
  - Is the mother experiencing difficulty caring for her baby?

- PPD is also often associated with symptoms of anxiety (e.g., excessive worry about the baby or guilty ruminations about not being a good mother) and may be associated with obsessive thoughts (e.g., fears of harming the baby) without compulsions.
- Women may have difficulty disclosing negative feelings to their doctors at a time when they're "supposed to be happy."
- Routine screening of postpartum women (e.g., with the EPDS — Edinburgh Postpartum Depression Scale) is recommended. The EPDS is found later in this appendix.
- Untreated women have an increased risk of chronic relapsing depressive illness as well as suicide and/or infanticide. Mother-infant bonding can be impaired by PPD, and other adverse infant outcomes have been reported.
- PPD with superimposed psychosis occurs in a small percentage of women (0.1 – 2% of pregnancies). Often these women had untreated illness and were depressed in pregnancy and the postpartum.
- It is **essential** to check for psychotic symptoms and thoughts of harming the baby in patients with postpartum depression.
- Depression is evident in greater than 70% of patients who commit infanticide.
- A major concern for nursing women surrounds the possible effects of medications upon their baby.
- *Canadian Network for Mood and Anxiety Treatments CANMAT Guidelines 2001* and the *Reproductive Mental Health Program Best Practices Practice Guidelines relating to Reproductive Mental Health (see Resources)* are useful in prescribing medications.
- Long-term follow-up is essential.

#### Overview of Treatment

TABLE 1: TREATMENT MODALITIES FOR POSTPARTUM DEPRESSION VERSUS SYMPTOM SEVERITY (from <i>Best Practice Guidelines relating to Reproductive Mental Health</i> , January 2003)	
SYMPTOMS	TREATMENT
Mild to Moderate	I. Psychosocial Therapies A. Cognitive Behavioural Therapy B. Interpersonal Psychotherapy C. Group Therapy D. Family and Marital Therapy E. Psychoeducation F. Supportive Psychotherapy II. Light Therapy
Moderate to Severe or At High Risk of Relapse	III. Pharmacotherapy (used in conjunction with Psychosocial Therapies)
Suicide Risk or Cannot Tolerate/ does Not Respond to Medication	IV. Electroconvulsive Therapy (ECT)

### Anxiety Disorders in the Perinatal Period

#### *Anxiety Disorders in General*

- Are relatively common in the perinatal period.
- Often manifest as Panic Disorder, Generalized Anxiety Disorder (GAD) or Obsessive Compulsive Disorder (OCD).
- Often coexist with depression in the perinatal period.
- Long-term treatment is essential, especially for those with GAD or OCD.

#### *GAD*

- Excessive anxiety and worry about numerous events/activities on more days than not for 6mths.
- Worry is difficult for the woman to control and usually centers around either the pregnancy or the welfare of the baby/infant.

#### *Panic Disorder*

- The prevalence in the perinatal period is unknown but is likely to follow that in the general population (2%).
- New onset of panic disorder may occur in pregnancy or postpartum.
- Pre-existing panic disorder often remains the same or worsens during pregnancy and the postpartum.
- Women with a past history are at a particularly high risk of postpartum relapse.

#### *Obsessive Compulsive Disorder (OCD)*

- Patients symptomatic with OCD in pregnancy may have a prior history and become worse in pregnancy and postpartum. However, new onset of OCD in pregnancy or postpartum is relatively common.
- Comorbid depression occurs in about 1/3 of women with postpartum OCD.
- In pregnancy and the postpartum, obsessional thoughts may focus on fetal or infant harm such as images of stabbing, drowning, or otherwise abusing the infant.
- Thoughts cause marked distress.
- Thoughts are not always associated with compulsive behaviours.
- Thoughts are often associated with avoidance, specifically avoiding the infant.
- The mother who avoids being alone with her infant should always be questioned about thoughts, images, or plans of harming her infant.

### Bipolar Affective Disorder and Psychoses in the Perinatal Period

#### *Bipolar Disorder*

- New onset of psychotic illness postpartum is most often bipolar mood disorder.
- In women with a past history of bipolar disorder, preconception counselling as well as close follow-up during pregnancy and the postpartum is essential.
- Medication changes in pregnancy and/or the postpartum period may be required to avoid adverse fetal or infant effects.
- There are high rates of postpartum relapse (30 – 90%).
- Relapse is likely to occur if medication is stopped, and may result in higher doses of multiple medications in order to achieve symptom control.

- Arrangements for adequate sleep for the mother in immediate postpartum period may help lessen risk of relapse.
- Treatment with an anti-psychotic or mood-stabilizing medication is the essential starting point to reduce psychotic symptoms.
- Long-term follow-up is essential.

### *Schizophrenia*

- New onset in pregnancy is uncommon.
- In the postpartum, schizoaffective disorder is usually the subtype of illness seen.
- Women with schizophrenia are more likely to have an unplanned pregnancy. The older anti-psychotics reduce fertility via hyperprolactinemia. Although all atypical anti-psychotics have less effect on prolactin they still may affect prolactin and fertility. Quetiapine may be the only prolactin sparing antipsychotic.
- The presence of a psychotic disorder may interfere with a woman obtaining proper prenatal care.
- Untreated patients have a much higher risk of decompensating during and after pregnancy.
- It is advisable to continue antipsychotic medications during pregnancy and the postpartum in patients with past history.
- Long-term follow-up is essential.

**For both Schizophrenia and Bipolar Disorder, medical consultation and treatment by a multidisciplinary team — preferably before starting a pregnancy and throughout the pregnancy and postpartum period is ideal and may be particularly important if medications need to be changed to avoid fetal risks.**

### **Substance Use in the Perinatal Period**

- Some psychoactive substances effect the menstrual cycle and can thus influence fertility (i.e. cocaine and heroin can disrupt the menstrual cycle).
- **Substance use in pregnancy is common.** In the year 1992 – 3, a reported 5.5% of US women used illicit drugs and 18.8% used alcohol while pregnant.
- Risk factors for substance use in pregnancy may include:
  - Past history of Substance Use Disorder (SUD)
  - Unstable mental illness
  - Trauma history
- Concurrent substance use & psychiatric disorders are **common** & need specialized treatment.
- Perinatal consequences of substance use in general may include:
  - low birth weight
  - prematurity
  - small head circumference
  - poor nutritional status
  - infections (HIV, HepC)
  - withdrawal issues

- Substance specific conditions may include:
  - Alcohol: Fetal Alcohol Syndrome/Effects
  - Marijuana: behavioural problems, impaired decision-making, memory, attentiveness, tremors and altered visual responsiveness
  - Stimulants: malignant hypertension & cardiac ischemia, stroke, sudden death, premature rupture of membranes, placenta previa. Some teratogenic effects reported.
- **The prenatal period is a time when women are more likely to engage with the healthcare system and abstain or reduce their substance use.** Without treatment many will relapse BUT almost 90% of individuals who remain abstinent for 2 years will be relatively substance free at 10 years.
- The stigma associated with a SUD is even greater for women who are childbearing
- As women may be reluctant to disclose a SUD, warning signs for clinicians may include:
  - Missed or inadequate prenatal care
  - Recurrent somatic complaints (sleep)
  - Psychiatric history or condition which is unstable or under-treated
  - Nicotine and/or alcohol use
  - Failure to gain adequate weight
  - Intra-uterine growth delay/retardation
  - Withdrawal signs at delivery

#### *Management*

- Women specific services improve retention, substance use outcomes, psychosocial function, and one study showed that **children are five times less likely to be placed in foster care.**
- **Pharmacotherapy is useful for harm reduction & the treatment of psychiatric symptoms.**
  - e.g. Methadone conversion in pregnancy improves:
    - prenatal care
    - nutrition
    - engagement into addiction treatment programs
    - birthweight
    - head circumference
  - Methadone conversion in pregnancy decreases:
    - maternal opioid withdrawal
    - criminality
    - sex trade work
    - IV drug use & infections
    - prematurity & infant mortality

However methadone conversion is not appropriate for everyone and treatment decisions should be made on a case-by-case basis.

#### *Child Protection*

- The clinician has a responsibility to intervene when the child is at risk of:
  - Physical harm, emotional harm, sexual abuse or exploitation
  - Deprivation of required health care
  - Parental refusal of needed treatment

- Death, abandonment, or inadequate provision for care
- Parent's prolonged absence from home in dangerous situation

It is preferable to encourage women and/or their families to self refer.

#### *Psychosocial context*

The management of a woman with a substance use disorder in the perinatal period (or at any other time) requires management of the gender-specific problems which may surround a woman with a SUD. A report by the United Nations entitled "*Substance Abuse treatment and care for women: Case studies and lessons learned*" (2004) identified differences between men and women with substance use problems.

- Compared with men, women generally:
  - are less likely to use illicit substances
  - are more likely to use pharmaceutical drugs (medically & non-medically)
  - may become dependent on some illicit substances faster
  - have greater rates of concurrent mental health problems
  - are more likely to have suffered from sexual and/or physical abuse
  - IVDUs (intravenous drug users) may engage in more HIV-risk behaviors, have higher mortality rates, and progress to AIDS from HIV faster
  - are more stigmatized & less likely to have their problem acknowledged
  - have more severe problems at the start of treatment
  - are more likely to be introduced to & carry on using substances with their partner
  - have less resources (education, employment, income)
  - care for dependent children
  - have difficulty entering and staying in treatment because of lack of support, financial resources, childcare or transport

## TREATMENT OF PSYCHIATRIC ILLNESS IN THE PERINATAL PERIOD

### **Barriers to Care**

There are many factors which may adversely affect the ability of a woman with a mental health and/or substance use problem to receive care. General barriers women may face include:

- Stigma (guilt, shame, judgment) associated with mental illness and/or substance use (e.g. shame about not being happy) and thus failure to disclose symptoms to a professional
- Reluctance to see a mental health professional
- Concerns child will be removed into custody
- Lack of child care and transportation
- Caretaker role for dependent family
- Untreated anxiety may prevent attendance of medical appointment
- Women with a SUD may also face greater opposition for treatment from family & friends than men

#### *Barriers to successful non-pharmacotherapy*

- Lack of available services (eg. CBT trained therapists, PPD groups in person's area)

- Lack of resources (finances to pay for therapy, child care)
- Non-compliance with treatment (eg CBT homework, using light therapy, attendance at groups) is a significant barrier to treatment success. However it is important to remember that:
  - symptoms of depression may encourage non-compliance
  - women face time constraints because of demands of caring for infant. If child care and food are provided, attendance at Postpartum Group improves

Barriers to successful pharmacotherapy

- Fear of harm to unborn child.
- Lack of knowledge that mental illness can occur in pregnancy by patient or significant others.
- Negative comments from family/friends about taking medication in pregnancy/lactation.
- Discontinuation of medication with diagnosis of pregnancy (particularly in the context of a past history of chronic, relapsing illness).
- Partial or non-compliance with medication.
- Limited data on long-term neurobehavioral teratogenicity of certain pharmacotherapies.
- Misinformation (internet, lay press, healthcare providers, etc . . . ).

The behavior of healthcare providers may also be a barrier, for example:

- Perceived or real gender and cultural insensitivity
- Failure to screen for or diagnose psychiatric illness in pregnancy and postpartum.
- Women with SUDs face lower rates of identification & referral by doctors & social workers than men.

### Early Detection

Early identification of perinatal mental illness is imperative to minimize the impact of the illness on the mother, her infant and family. For example, many women diagnosed with postpartum depression are symptomatic antenatally; therefore the opportunity for early detection and treatment exists. During the initial contact with a woman, the service provider should ask about **her family and/or personal history of mental illness**. For example, a woman with a family history of depression or previous history of depression/postpartum depression is at a high risk of developing a mood disorder(s) in the perinatal period.

The Early Identification Guide (*see Table 2*) provides a summary of the educational, screening, and general assessment tools utilized in the *Best Practices Guidelines relating to Reproductive Mental Health* (*see resource list*), and the time periods when they should be used.



**TABLE 2: EARLY IDENTIFICATION GUIDE**

(from *Best Practice Guidelines relating to Reproductive Mental Health*. January 2003 – see [www.bcrmh.com](http://www.bcrmh.com))

TIMING	CONTACT PERSON	ACTION
Preconception <b>*Target</b> <b>Initial Contact</b>	<ul style="list-style-type: none"> <li>GP, OB/GYN</li> <li>Midwife</li> <li>Community Health Nurse</li> <li>Multicultural worker</li> <li>Mental Health worker- if appropriate</li> </ul>	<ul style="list-style-type: none"> <li>Educate with the Fact Sheet “Emotional Wellness during Pregnancy and the Postpartum Period: Information for Women and their Families” (included with this Appendix)</li> <li>Educate with the web site: <a href="http://www.bcrmh.com">www.bcrmh.com</a> and <a href="http://www.postpartum.ca">www.postpartum.ca</a> .</li> <li>Ask if the woman has a family and/or personal <i>history</i> of mental illness’ (e.g., depression, anxiety, psychosis).</li> <li>Use the General Perinatal Mental Health Assessment Tool.</li> </ul>
Prenatal <b>*Target</b> <b>Initial Contact</b> <b>Third Trimester</b> <b>Every Contact if Family/Personal History of Mental Illness</b>	<ul style="list-style-type: none"> <li>GP, OB/GYN</li> <li>Midwife</li> <li>Community Health Nurse</li> <li>Childbirth Educator, Doula</li> <li>Pregnancy Outreach Program</li> <li>Nurses in Offices &amp; Hospitals</li> <li>Social Workers</li> <li>Educators in Pregnant Teen Programs</li> <li>Mental Health worker- if appropriate</li> <li>Ministry of Child &amp; Family Development- if appropriate</li> </ul>	<ul style="list-style-type: none"> <li>Educate with the Fact Sheet “Emotional Wellness during Pregnancy and the Postpartum Period: Information for Women and their Families” (included with this Appendix).</li> <li>Educate with the web sites: <a href="http://www.bcrmh.com">www.bcrmh.com</a> and <a href="http://www.postpartum.ca">www.postpartum.ca</a> .</li> <li>Use the Pacific Postpartum Support Society pamphlet.</li> <li>Use the Perinatal Mental Health Risk Assessment Questionnaire.</li> <li>Use the Postpartum Depression Predictors Inventory (PDPI) Revised, Beck, 2002.</li> <li>Use the Edinburgh Postnatal Depression Inventory (EPDS) (included with this Appendix).</li> <li>Use the General Perinatal Mental Health Assessment Tool.</li> <li>Use the Antenatal Psychosocial Health Assessment (ALPHA) to investigate woman abuse, child abuse, depression, marital/couple dysfunction.</li> </ul>
Labour & Delivery <b>*Target</b> <b>Initial Contact</b>	<ul style="list-style-type: none"> <li>GP, OB/GYN</li> <li>Midwife</li> <li>Labour &amp; Delivery Nurses</li> <li>Doula</li> <li>Social Workers (S.W)</li> <li>Paediatrician</li> <li>Mental Health worker- if appropriate</li> <li>Ministry of Child &amp; Family Development- if appropriate</li> </ul>	<ul style="list-style-type: none"> <li>Educate with the Fact Sheet “Emotional Wellness during Pregnancy and the Postpartum Period: Information for Women and their Families” (included with this Appendix).</li> <li>Educate with the web sites: <a href="http://www.bcrmh.com">www.bcrmh.com</a> and <a href="http://www.postpartum.ca">www.postpartum.ca</a> .</li> <li>Use the Pacific Postpartum Support Society pamphlet.</li> <li>Use the Postpartum Depression Predictors Inventory (PDPI) Revised, Beck, 2002.</li> <li>Use the Edinburgh Postnatal Depression Inventory (EPDS) (included with this Appendix).</li> <li>Use the Perinatal Mental Health Risk Assessment Questionnaire.</li> </ul>
Postpartum <b>*Target</b> <b>1-2 days</b> <b>1-2 weeks</b> <b>6-8 weeks</b> <b>4 &amp; 6 months</b> <b>Every contact if family/personal history of mental illness</b>	<ul style="list-style-type: none"> <li>GP, OB/GYN</li> <li>Midwife</li> <li>Endocrinologist</li> <li>Paediatrician</li> <li>Community Health Nurse</li> <li>Hospital Nurses, S.W.</li> <li>Doula, Lactation Consultants</li> <li>Pregnancy Outreach Program, Educators in Pregnant Teen Programs</li> <li>Support group leaders: new moms, etc.</li> <li>Mental Health worker if appropriate</li> <li>Ministry of Child &amp; Family Development if appropriate</li> </ul>	<ul style="list-style-type: none"> <li>Educate with the Fact Sheet “Emotional Wellness during Pregnancy and the Postpartum Period: Information for Women and their Families” (included with this Appendix).</li> <li>Educate with the web sites: <a href="http://www.bcrmh.com">www.bcrmh.com</a> and <a href="http://www.postpartum.ca">www.postpartum.ca</a> .</li> <li>Use the Pacific Postpartum Support Society pamphlet and the book <i>Postpartum Depression &amp; Anxiety: A Self-Help Guide for Mother</i></li> <li>Use the videos: <i>Postpartum Emotions: The Blues &amp; Beyond</i> and <i>Heartache and Hope</i></li> <li>Use the Perinatal Mental Health Risk Assessment Questionnaire.</li> <li>Use the Postpartum Depression Predictors Inventory (PDPI) Revised, every 2 months, Beck, 2002.</li> <li>Use the Edinburgh Postnatal Depression Inventory (EPDS) &gt; 1 week (included with this Appendix).</li> <li>Use the General Perinatal Mental Health Assessment Tool.</li> <li>Use the Postpartum Depression Screening Scale &gt; 2 weeks.</li> </ul>

### Screening Tools

The **Edinburgh Postpartum Depression Scale (EPDS)**: The Provincial Reproductive Mental Health Program is recommending **universal screening of all women at the two month postpartum visit** using the EPDS. This scale can be readministered at any time within the first 12 months following the birth of a baby. The EPDS may also be used in pregnancy to screen for suspected depression. (the EPDS is included as part of this Appendix).

### Educational Tools

- Perinatal Mental Health Fact Sheet, "Emotional Wellness during Pregnancy and the Postpartum Period: Information for Women and their Families." This is included in this Appendix.
- Pacific Post Partum Support Society Pamphlet *in English, Punjabi and Chinese*. This is an excellent source of information that can be given to women and their partners during the perinatal period.
- The Provincial Reproductive Mental Health Program Website: [www.bcrmh.com](http://www.bcrmh.com) or [www.bcwomens.ca](http://www.bcwomens.ca)
- Video: *Heartache and Hope: Living through Postpartum Depression*. In this video, women and their partners give a retrospective account of their experience of living through postpartum depression. (To order contact Families Matter, 206-12th Ave., South East, Calgary, Alberta, T2G 1A1 Tel: (403) 205-5178 Fax: (403) 205-5191 E-Mail: [info@familiesmatter.ca](mailto:info@familiesmatter.ca))

### TREATMENT ISSUES

The treatment of psychiatric illness in the perinatal period is a clinical challenge. Treatment by a multidisciplinary team that includes a family doctor, psychiatrist and OBGYN is not only ideal but also essential for complex cases, to ensure the best outcome for mother and child. The use of pharmacotherapy must be decided on a case-by-case basis, after weighing the risks and the benefits. When using pharmacotherapy in the perinatal period, the goal is to limit pharmacologic exposure to both the mother and fetus/infant by using the minimum effective dosage of medication and limiting the total number of medications used while maintaining maternal mental health. There are many non-pharmacologic therapies that can be used alone or in conjunction with medications depending on case severity.

#### Non-Pharmacological Therapies in the Perinatal Period

Non-pharmacological therapies that may be appropriately used in the perinatal period include:

- Self-Care & Lifestyle
- Psychoeducation & Support
- Supportive Psychotherapy
- Cognitive Behavioural Therapy (CBT)
- Interpersonal Psychotherapy
- Group Psychotherapy
- Marital/Couples/Family Psychotherapy

Detailed information on the specific application of these treatment modalities in the perinatal period is in the (1) *Best Practices Guidelines relating to Reproductive Mental Health*, and (2) *Self-Care Program for Women with postpartum depression & anxiety (see Resources)*. See also the section on non-pharmacological therapies in the Guide.

### Pharmacotherapy in the Perinatal Period

#### *Practice Issues: Antidepressants in Pregnancy and Postpartum*

- Sustaining maternal mental health throughout pregnancy is the key to ensuring an optimum outcome for the baby.
- As yet, there is little evidence for the efficacy of psychotherapy in the treatment of moderate to severe depression in pregnant, depressed women.
- Resolution of symptoms for women in this category is best achieved, at present, with antidepressant medications.
- Women with severe depression and with a prior history of depression can be treated with a combination of antidepressant medication and psychotherapy.
- To date, existing evidence suggests that the most commonly used antidepressant medications, such as SSRIs (e.g., Prozac, Paxil, Zoloft, Luvox and Celexa) and SNRIs (e.g., Effexor), have not been associated with major birth defects.
- There is increasing concern regarding transient neonatal adaptation symptoms following prenatal exposure.
- This has led the Health Canada (see Health Canada Advisory below) and the US Food and Drug Administration (FDA) to issue warnings regarding third-trimester SSRI and SNRI use for treating depression during pregnancy.
- The recent concern over the warnings by Health Canada and the US FDA regarding infants exposed to antidepressants in the third trimester, has lead to a clinical dilemma for treating physicians. The evidence for these warnings is:
  - based on case reports and retrospective data.
  - the number of cases studied tends to be small, particularly with newer anti-depressants
- In addition, the presence/absence of symptoms observed in neonates are governed by a complex set of factors including:
  - prematurity
  - maternal mental and physical health
  - use of concomitant substances (e.g., alcohol, cigarettes)
  - polypharmacy
- Characteristics of this Neonatal Poor Adaptation Syndrome include:
  - transient course in the infant
  - resolution within the first few days of life
  - no evidence of long-term consequences in the children.
  - the use of multiple psychotropic medications during pregnancy with an SSRI appears to increase the risk of these symptoms

### Neonatal Management Issues

- An infant can be identified as being at risk for transient Neonatal Poor Adaptation Syndrome if the mother is:
  - taking a high dose of any antidepressant medication
  - on more than one medication
  - if the woman is mentally ill and/or under-treated

- The infant's behaviour should be monitored closely :
  - by nursing and medical staff
  - if there are signs of abnormal Central Nervous System (CNS) behaviour, avoid early discharge and consider a differential diagnosis
  - obtain infant drug levels if possible where a diagnosis remains unclear
- Supportive neonatal care of symptomatic infants can be provided by using the following approach:
  - provide low level stimulation
  - support breastfeeding
  - provide supportive measures where appropriate
  - follow symptoms closely
- Ensure long-term follow-up for mother and infant.

### Health Canada Advisory

Health Canada advises of potential adverse effects of SSRIs and other anti-depressants on newborns  
[http://www.hc-sc.gc.ca/english/protection/warnings/2004/2004\\_44.htm](http://www.hc-sc.gc.ca/english/protection/warnings/2004/2004_44.htm)

**OTTAWA** — Health Canada is advising Canadians that newborns may be adversely affected when pregnant women take Selective Serotonin Re-uptake Inhibitors (SSRIs) and other newer anti-depressants during the third trimester of pregnancy. This advisory is intended to increase awareness among mothers and physicians of the possible symptoms that may occur in the newborn, so that symptoms can be recognized and addressed quickly.

**This advisory applies to the following anti-depressants: bupropion (whether used for depression or for smoking cessation), citalopram, fluoxetine, fluvoxamine, mirtazapine, paroxetine, sertraline and venlafaxine.**

International and Canadian reports reveal that some newborns whose mothers took these medications during pregnancy have developed complications at birth requiring prolonged hospitalization, breathing support and tube feeding. Reported symptoms include: feeding and/or breathing difficulties, seizures, muscle rigidity, jitteriness and constant crying. In most cases, the newer anti-depressant was taken during the third trimester of pregnancy. These symptoms are consistent with either a direct adverse effect of the anti-depressant on the baby, or possibly a discontinuation syndrome caused by sudden withdrawal from the drug.

**When treating depression in pregnant women, physicians and patients should carefully consider the potential risks and benefits of the various treatment options for both the mother and the unborn baby. To date, there is little evidence-based information on how best to treat depression during pregnancy. If a woman is pregnant and is taking an SSRI, or other newer anti-depressant, she should discuss the risks and benefits of the various treatment options with her health care professional. It is very important that patients do NOT stop taking these medications without first consulting with their doctor.**

The frequency of symptoms may vary with each drug. In the case of two of the newer anti-depressants — bupropion and mirtazapine — discontinuation problems appear to be less than with the other drugs. In the case of mirtazapine, there are only two reports. Health Canada is issuing this advisory to encompass all newer anti-depressants in order to alert Canadians to the potential risk. Health Canada has also worked with the manufacturers of these medications to update their labelling with new precaution information.

Any suspected adverse reactions can be reported directly to the product manufacturer or to Canadian Adverse Drug Reaction Monitoring Program (CADRMP) Marketed Health Products Directorate  
HEALTH CANADA  
Address Locator: 0701C  
OTTAWA, Ontario, K1A 0K9  
Tel: (613) 957-0337 or Fax: (613) 957-0335

To report an Adverse Reaction, consumers and health professionals may call toll free: Tel: 866 234-2345, Fax: 866 678-6789 [http://www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/adr\\_guideline\\_e.html](http://www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/adr_guideline_e.html)

## Pharmacotherapy in the Perinatal Period: Specific Medications

**TABLE 3: AMERICAN FOOD AND DRUG ADMINISTRATION RISK CATEGORIES**

<b>a) Pregnancy Risk Categories</b>	
<b>A</b>	Adequate, well-controlled studies in pregnant women have failed to demonstrate a risk to the developing fetus.
<b>B</b>	Either animal studies show a risk, but human studies do not; or, if no adequate studies have been conducted in pregnant women, then animal studies have not demonstrated a risk.
<b>C</b>	Human studies are lacking, and animal studies have either produced adverse effects or are also lacking. Therefore, the risk of medication exposure in the fetus cannot be ruled out. Medications should be used in pregnancy only when potential benefits outweigh potential risk.
<b>D</b>	Positive evidence of fetal risk has been demonstrated in humans. However, the potential benefits of use in pregnant women may outweigh the potential risks, thus decisions must be made on an individual basis.
<b>X</b>	The medication is contraindicated in women who are or may become pregnant. The fetal risk of medication exposure clearly outweighs any potential benefits to the mother.
<b>b) Lactation Risk Categories</b>	
The lactation risk classification system has been developed by Hale, and is described in detail in his publication <i>Medications in Mothers' Milk</i> , 9 <sup>th</sup> edition (2000). The 5 categories closely follow the pregnancy risk categories of the FDA, and they outline the infants' risk of medication exposure through breast milk.	
<b>L1</b>	The medication has been taken by a large number of breastfeeding mothers without any documented adverse effects in their nursing infants. Controlled studies have been conducted and have not identified an increased risk to infants.
<b>L2</b>	The medication has been studied in a limited number of breastfeeding women, and no adverse effects have been documented in their infants.
<b>L3</b>	No controlled studies of the medication have been conducted in breastfeeding women. The medication should be used only when the potential benefits to the mother outweigh the potential risks of infant exposure.
<b>L4</b>	There is documented evidence of risk to infants exposed to this medication through breast milk. However, the potential benefits of use of the medication in women may outweigh the potential risk to the nursing infants, so the decision must be made on an individual basis.
<b>L5</b>	This medication is contraindicated in mothers who are breastfeeding. Human studies have clearly demonstrated risk to exposed infants, and this risk outweighs any potential benefits.

## Pharmacotherapy in the Perinatal Period: Specific Medications

**TABLE 4: SSRIs (SELECTIVE SEROTONIN REUPTAKE INHIBITORS) IN THE PERINATAL PERIOD**

(from Best Practice Guidelines relating to Reproductive Mental Health. January 2003).

DRUG CLASS	START DAILY DOSE AT (MG) <sup>a</sup>	MAX DAILY DOSE AT (MG)	FDA PREGNANCY RISK CATEGORY <sup>b</sup>	FETAL RISKS <sup>c</sup>	HALE'S LACTATION RISK CATEGORY <sup>d</sup>	BREASTFEEDING <sup>e</sup>
Fluoxetine (Prozac®)	10	80	B	Fluoxetine exposure in pregnancy is not associated with increased teratogenic effects in humans, but perinatal effects of 3 <sup>rd</sup> trimester exposure have been reported. A study of 55 preschool children exposed to fluoxetine <i>in utero</i> reported no long-term adverse effects with respect to IQ, language, or behaviour.	L3 for neonates L2 for older infants	Norfluoxetine, the active metabolite of fluoxetine, has a very long half-life that predisposes to accumulation in the infant, particularly neonates. Adverse effects (colic, fussiness, crying, seizure activity, lower weight gain) have been documented.
fluvoxamine (Luvox®)	50	300	C	Use of these SSRIs during pregnancy does not appear to have teratogenic effects, but data is limited. One prospective case series reported 26 exposures to fluvoxamine, 97 to paroxetine, and 147 sertraline in pregnancy. The rates of malformations were similar between all 3 groups, and were not higher than those reported for the control group.	L2	Two small case studies of fluvoxamine exposure through breast milk have reported very low levels in the breast milk, and no adverse events in the infants.
citalopram (Celexa®)	10	60	C	A review of 375 cases of citalopram exposure in early pregnancy found that the rate of congenital anomalies was not higher than that for SSRI exposure or for the general population	L3	20 cases reported. 1 case report of uneasy sleep in the infant, correlated to high serum concentration of citalopram. Symptoms were short-lasting and disappeared after a dose decrease. Data is limited.
Paroxetine (Paxil®)	10	60	B	Transient neonatal withdrawal (?) symptoms have been reported	L2	Paroxetine does not have an active metabolite. It is excreted into breast milk but with generally undetectable serum levels in infants; no adverse effects have been reported.
sertraline (Zoloft®)	50	225	B		L2	Milk levels have been reported for sertraline and its weak metabolite desmethylsertraline, but with low or undetectable serum levels in the infant. There is one report of a nursing infant with 50% of maternal serum levels, but no adverse effects noted.

<sup>a</sup> monograph doses are guidelines only. Doses must be individualized for each patient.

<sup>b</sup> adapted from the Food and Drug Administration (FDA, 1979). See Table 3a.

<sup>c</sup> comments adapted from GG Briggs et al., (1998), *Drugs in Pregnancy and Lactation*, 5th edition, as well as TW Hale (2000), *Medications in Mothers' Milk*, 9th edition.

<sup>d</sup> adapted from TW Hale (2000). *Medications in Mothers' Milk*, 9th edition. See Table 3b.

<sup>e</sup> comments adapted from GG Briggs et al., (1998), *Drugs in Pregnancy and Lactation*, 5<sup>th</sup> edition, as well as TW Hale (2000), *Medications in Mothers' Milk*, 9<sup>th</sup> edition.



## Pharmacotherapy in the Perinatal Period: Specific Medications

**TABLE 5: ATYPICAL ANTIDEPRESSANTS IN THE PERINATAL PERIOD**

(from *Best Practice Guidelines relating to Reproductive Mental Health*. January 2003)

DRUG CLASS	START DAILY DOSE AT (MG) <sup>a</sup>	MAX DAILY DOSE AT (MG)	FDA PREGNANCY RISK CATEGORY <sup>b</sup>	FETAL RISKS <sup>c</sup>	HALE'S LACTATION RISK CATEGORY <sup>d</sup>	BREASTFEEDING <sup>e</sup>
bupropion (Wellbutrin SR®)	100	300	B	Insufficient human data available to ascertain the teratogenicity of these agents. Caution is recommended, and when possible, use an alternate medication with better known effects.	L3	Bupropion and its two metabolites have been measured in milk with reported milk: plasma ratios of up to 8.7, however no adverse effects have been reported.
trazodone (Desyrel®)	75	600	C	No documented teratogenic effects	L2	Trazodone is excreted in milk with peak levels at 2 hours.
venlafaxine (Effexor®)	75	225	C	No documented teratogenic effects.	L3	One case report of high infant venlafaxine levels transferred through breastmilk. No adverse effects reported.

**TABLE 6: TRICYCLIC ANTIDEPRESSANTS IN THE PERINATAL PERIOD<sup>f</sup>**

(from *Best Practice Guidelines relating to Reproductive Mental Health*. January 2003)

DRUG CLASS	START DAILY DOSE AT (MG) <sup>a</sup>	MAX DAILY DOSE AT (MG)	FDA PREGNANCY RISK CATEGORY <sup>b</sup>	FETAL RISKS <sup>c</sup>	HALE'S LACTATION RISK CATEGORY <sup>d</sup>	BREASTFEEDING <sup>e</sup>
Amitriptyline (Elavil®)	25-75	300	D	Data analysis has shown that TCA exposure in pregnancy does not increase the incidence of teratogenic effect in humans.	L2	All TCAs are excreted into human breast milk in low concentrations. The active metabolite of doxepin has a long half-life (37 hrs) and can be hazardous due to documented high accumulations in nursing infants.
imipramine (Tofranil®)	25-75	300	D	As above	L2	As Above
Clomipramine (Anafranil®)	25-75	300	C	Neonatal withdrawal symptoms have been associated with high doses of clomipramine	L2	As Above

For tables 5 & 6

<sup>a</sup> monograph doses are guidelines only. Doses must be individualized for each patient.

<sup>b</sup> adapted from the Food and Drug Administration (FDA, 1979). See Table 3a.

<sup>c</sup> comments adapted from GG Briggs et al., (1998), *Drugs in Pregnancy and Lactation*, 5th edition, as well as TW Hale (2000), *Medications in Mothers' Milk*, 9th edition. .

<sup>d</sup> adapted from TW Hale (2000). *Medications in Mothers' Milk*, 9th edition. See Table 3b.

<sup>e</sup> comments adapted from GG Briggs et al., (1998), *Drugs in Pregnancy and Lactation*, 5th edition, as well as TW Hale (2000), *Medications in Mothers' Milk*, 9th edition .

<sup>f</sup> doses adapted from the *Clinical Handbook of Psychotropic Drugs*, 10th revised edition (2000). Starting doses of medications are lower for pregnant and postpartum women than for the general adult population. Bezchlibnyk-Butler KZ, Jeffries JJ, Editors. Toronto, Hogrefe & Huber Publishers, 2000.



## Pharmacotherapy in the Perinatal Period: Specific Medications

**TABLE 7: BENZODIAZEPINES IN THE PERINATAL PERIOD**

(from *Best Practice Guidelines relating to Reproductive Mental Health*. January 2003).

	START DAILY DOSE AT (MG) <sup>a</sup>	MAX DAILY DOSE AT (MG)	FDA PREGNANCY RISK CATEGORY <sup>b</sup>	FETAL RISK <sup>c</sup>	HALE'S LACTATION RISK CATEGORY <sup>d</sup>	BREASTFEEDING <sup>e</sup>
Alprazolam (Xanax®)	0.5	4	D	Exposure to benzodiazepines <i>in utero</i> has been associated with withdrawal symptoms, including irritability and restlessness. Alprazolam has not been associated with congenital anomalies during human pregnancies, however, caution is urged, as data is limited.	L3	Benzodiazepines are excreted into breast milk. These medications are not ideal during breastfeeding due to relatively long half-lives; chronic exposure may therefore be of concern. Monitor infants closely for sedation. Withdrawal symptoms have been reported in infants exposed to alprazolam through breast milk.
clonazepam (Rivotril®)	0.25	8	C	Clonazepam exposure during pregnancy has been associated with symptoms of newborn toxicity, including apnea, cyanosis, lethargy, and hypotonia. No long-term effects have been reported for clonazepam, although data is limited.	L3	Is preferred by the Reproductive Mental Health program due to intermediate length of action.
Diazepam (Valium®)	5	30	D	Diazepam use in pregnancy has been associated with oral clefts, though the data is conflicting.	L3-acute L4-chronic	Diazepam and its metabolite have long half-lives and tend to accumulate when used for chronic treatment. Diazepam treatment has been associated with withdrawal, lethargy, sedation, and poor suckling in nursing infants.
Lorazepam (Ativan®)	1	6	D	Placental transfer of lorazepam is lower than that of other benzodiazepines, but high doses in pregnancy have been associated with “floppy infant syndrome”.	L3	When benzodiazepines are indicated, lorazepam may be preferred over the others, due to its shorter half-life and absence of active metabolites.

<sup>a</sup> monograph doses are guidelines only. Doses must be individualized for each patient.

<sup>b</sup> adapted from the Food and Drug Administration (FDA, 1979). See Table 3a.

<sup>c</sup> comments adapted from GG Briggs et al., (1998), *Drugs in Pregnancy and Lactation*, 5<sup>th</sup> Edition, as well as TW Hale (2000), *Medications in Mothers' Milk*, 9<sup>th</sup> edition.

<sup>d</sup> adapted from TW Hale (2000). *Medications in Mothers' Milk*, 9<sup>th</sup> edition. See Table 3b.

<sup>e</sup> comments adapted from GG Briggs et al., (1998), *Drugs in Pregnancy and Lactation*, 5<sup>th</sup> Edition, as well as TW Hale (2000), *Medications in Mothers' Milk*, 9<sup>th</sup> edition.

## Pharmacotherapy in the Perinatal Period: Specific Medications

**TABLE 8: MOOD STABILIZERS AND NEUROLEPTICS IN THE PERINATAL PERIOD<sup>a</sup>**  
(from *Best Practice Guidelines relating to Reproductive Mental Health*. January 2003)

DRUG CLASS	START DAILY DOSE AT (MG) <sup>b</sup>	MAX DAILY DOSE AT (MG)	PREGNANCY RISK CATEGORY <sup>c</sup>	FETAL RISK <sup>d</sup>	LACTATION RISK CATEGORY <sup>e</sup>	BREASTFEEDING <sup>f</sup>
carbamazepine (Tegretol®)	200	1600	C	Estimated risk of neural tube defects with carbamazepine (CBZ) during pregnancy is 1%. Facial dysmorphism has also been associated with CBZ and VP during pregnancy. Women of childbearing age taking CBZ or VP should take folic acid supplements prior to conception and throughout the pregnancy.	L2	Both carbamazepine and valproate are approved by the American Academy of Pediatrics for use in breastfeeding mothers. Small amounts are secreted into breastmilk and have been measured in infant serum, but neither of these medications have been found to be associated with adverse events in infants.
Valproate (Epival®)	750	3000	D	Estimated risk of neural tube defects 3-8%. Other risks see above (CBZ).	L2	As above.
Lithium carbonate (Lithane®, Carbolith®)	<b>maint.:</b> 400 <b>acute:</b> 900	1200 2400 <sup>g</sup>	D	First trimester exposure to lithium has been associated with a increased risk of fetal cardiovascular anomalies, particularly Ebstein's anomaly (1:1000). Use near term may produce neonatal toxicity.	L4	Lithium is excreted into breastmilk at 30 – 40% of maternal serum concentrations, and therefore is contraindicated during breastfeeding.
Haloperidol (Haldol®)	1.5	6	C	Haloperidol does not have known teratogenic effects based on animal data and limited case reports in humans.	L2	Caution advised, observe infant for sedation.
Loxapine (Loxapine®)	15	250	C	There are no published studies on the use of loxapine in pregnant women. Animal studies with loxapine have shown retarded fetal development.	L4	Loxapine is a potent tranquilizer, and may produce adverse effects in the developing fetus or nursing infant.
Olanzapine (Zyprexa®)	2.5	10	C	A report from the Lilly Worldwide Safety Database on 23 pregnancy outcomes found no increased risk of adverse fetal outcomes.	L3	There is very limited data available on the use of olanzapine during breastfeeding. Caution is advised.
Quetiapine (Seroquel®)	50	600	C	There are no published studies on the use of quetiapine in pregnant women.	L4	No information is available on the use of quetiapine during breastfeeding.
Risperidone (Risperdal®)	1	8	C	There are no published studies on the use of risperidone in pregnant women.	L3	One case report of a nursing infant exposed to risperidone did not indicate any adverse effects.

<sup>a</sup> doses adapted from the *Clinical Handbook of Psychotropic Drugs*, 10<sup>th</sup> revised edition. Starting doses of medications are lower for pregnant and postpartum women than for the general adult population.

<sup>b</sup> monograph doses are guidelines only. Doses must be individualized for each patient.

<sup>c</sup> adapted from the Food and Drug Administration (FDA, 1979). See Table 3a.

<sup>d</sup> comments adapted from GG Briggs et al., (1998), *Drugs in Pregnancy and Lactation*, 5<sup>th</sup> edition, as well as TW Hale (2000), *Medications in Mothers' Milk*, 9<sup>th</sup> edition.

<sup>e</sup> adapted from TW Hale (2000). *Medications in Mothers' Milk*, 9<sup>th</sup> edition. See Table 3b.

<sup>f</sup> comments adapted from GG Briggs et al., (1998), *Drugs in Pregnancy and Lactation*, 5<sup>th</sup> edition, as well as TW Hale (2000), *Medications in Mothers' Milk*, 9<sup>th</sup> edition.

<sup>g</sup> starting and high doses are higher for mania and adjunct psychotic states than for panic disorder and anxiety.

**SCREENING FOR POST-PARTUM DEPRESSION**

The BC Reproductive Mental Health Program is recommending *universal screening of all women at the 2 month postpartum visit* using the Edinburgh Postnatal Depression Scale (EPDS). This scale can be re-administered at any time within the first 12 months following birth of a baby. The EPDS may also be used in pregnancy to screen for suspected depression.

**How to Use the Edinburgh Postnatal Depression Scale**

Ask the woman to underline the response that comes closest to how she has felt during the previous 7 days. Ensure that all 10 items are completed. The woman should complete the EPDS herself, unless she has difficulty with reading.

The following are guidelines for scoring, discussing, and interpreting the Edinburgh Postnatal Depression Scale:

1. EPDS items are scored from 0 to 3; the normal response scores 0 and the 'severe' response scores 3. Total the individual item scores.
2. *A positive score on item #10* should be taken seriously. Safety of the mother needs to be discussed.
3. *A positive screening result is an EPDS score of 12 or more.*
4. *A marginal screening result is an EPDS score of 10 or 11*, readministered in 2 weeks.
5. *A negative screening result is an EPDS score of 9 or less.* A low score does not always mean that a woman does not have depression: she may be unwilling or afraid to reveal her true feelings. Mothers with puerperal psychosis may also score low on the EPDS.
6. Discuss women's responses, being alert to a mismatch with your clinical impression. The EPDS should never be used in isolation, it should form part of a full and systematic mood assessment of the mother, supporting professional judgment and a clinical interview.

### Edinburgh Postnatal Depression Scale (EPDS)

Source: Cox, J. L., Holden, J.M. & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782 – 786.

#### How are you feeling?

As you have recently had a baby, we would like to know how you are feeling. Please underline the answer which comes closest to how you have felt **in the past 7 days**, not just how you feel today. Here is an example, already completed:

I have felt happy:	Yes, most of the time
	<u>Yes, some of the time</u>
	No, not very often
	No, not at all

This would mean: 'I have felt happy some of the time during the past week'. Please complete the other questions in the same way.

#### In the past 7 days:

- |  |   |
|--|---|
| 1. I have been able to laugh and see the funny side of things: |   |
| As much as I always could                                      | 0 |
| Not quite so much now  | 1 |
| Definitely not so much now                                     | 2 |
| Not at all   | 3 |
| 2. I have looked forward with enjoyment to things:             |   |
| As much as I ever did  | 0 |
| Rather less than I used to                                     | 1 |
| Definitely less than I used to                                 | 2 |
| Hardly at all  | 3 |
| 3. I have blamed myself unnecessarily when things went wrong:  |   |
| Yes, most of the time  | 3 |
| Yes, some of the time  | 2 |
| Not very often   | 1 |
| No, never  | 0 |
| 4. I have been anxious or worried for no good reason:          |   |
| No, not at all   | 0 |
| Hardly ever  | 1 |
| Yes, sometimes   | 2 |
| Yes, very often  | 3 |
| 5. I have felt scared or panicky for no very good reason:      |   |
| Yes, quite a lot   | 3 |
| Yes, sometimes   | 2 |
| No, not much   | 1 |
| No, not at all   | 0 |
| 6. Things have been getting on top of me:                      |   |
| Yes, most of the time I haven't been able to cope at all       | 3 |
| Yes, sometimes I haven't been coping as well as usual          | 2 |
| No, most of the time I have coped quite well                   | 1 |
| No, I have been coping as well as ever                         | 0 |

7. I have been so unhappy that I have had difficulty sleeping:	
Yes, most of the time	3
Yes, sometimes	2
Not very often	1
No, not at all	0
8. I have felt sad or miserable:	
Yes, most of the time	3
Yes, quite often	2
Not very often	1
No, not at all	0
9. I have been so unhappy that I have been crying:	
Yes, most of the time	3
Yes, quite often	2
Only occasionally	1
No, never	0
10. The thought of harming myself has occurred to me:	
Yes, quite often	3
Sometimes	2
Hardly ever	1
Never	0

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Translations of the scale, and guidance as to its use, may be found in Cox, J.L. & Holden, J. (2003) *Perinatal Mental Health: A Guide to the Edinburgh Postnatal Depression Scale*. London: Gaskell.



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# Information for Women & their Families





# Emotional Wellness during Pregnancy and the Postpartum Period

## Information for Women and their Families

### ***Before Birth***

During pregnancy a women's body, mind, and spirit undergo monumental changes. Some pregnant women have difficulty coping with pregnancy and find support from friends, health nurses, neighbourhood groups, and family doctors. However, other women may encounter a range of mood disturbances, such as anxiety, depressive, and obsessive compulsive disorder.

10%- 16% of pregnant women experience depression.  
2% to 4% of pregnant women experience anxiety or have a Panic Disorder

These mood and anxiety disturbances are more difficult to recognize in the first and third trimester of pregnancy, because many of the symptoms are similar to those experienced by most women during pregnancy. In the second trimester they may be more easily noticed, because most women enjoy this period as they start to feel the baby move. Women who are depressed though, may experience pervasive sadness, a sense of hopelessness, crying spells, and in severe cases suicidal ideation. Women who have mood disturbances during the third trimester of their pregnancy are at high risk of having mood disorders during the postpartum period.

Approximately 30% of women with a history of depression prior to conceiving will develop postpartum depression.

### ***Anxiety***

The most frequently cited difficulties include

- nervousness, anxiety
- sleep and appetite disturbances
- over concern for the baby
- poor concentration, confusion & memory loss
- uncontrollable crying & irritability.

Panic attacks may also occur.

### ***Depression***

These may include some of the symptoms listed with anxiety along with

- sluggishness, fatigue, exhaustion
- sadness, hopelessness, and/or uncontrollable crying
- over concern or lack of interest in the baby
- sense of guilt, inadequacy, or worthlessness
- lack of interest in sex.

### ***Obsessive/Compulsive Disorder***

This occurs in approximately 2-3% of the new mothers and may include anxiety and depression reactions along with a deep fear of losing control and harming their babies. Women typically have intrusive thoughts about things which could hurt the baby. Studies indicate that as long as the woman is repulsed by the thought of harming her baby, she is extremely unlikely to act on her thoughts. Her fears may however limit her interactions with the baby and could cause problems with bonding.



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## ***After Birth***

After birth, the mother often feels a combination of feelings. Joy and relief that the birth is over may be combined with uncertainty, frustration, and anxiety. Her body's changes include hormonal fluctuations that are part of her emotional adjustment. Taking care of a new baby is hard work, and mothers sometimes experience 'ups' and 'downs' during the first year. Having the continued support of family members and friends is extremely helpful while the mother becomes accustomed to her new and very important role. New mothers especially need other mothers to help them to adjust to their new lives. Sometimes, however, the mother experiences bewildering emotions that can cause considerable concern. These feelings can be grouped into two main categories:

- baby blues
- postpartum mood disturbances.

### ***Baby Blues***

The 'blues' occurs in approximately 70 to 80 percent of all mothers. It usually appears suddenly during the first few days after delivery and usually resolves itself within a week or two; it is generally not treated. Symptoms include: weepiness, irritability, restlessness, and anxiety.

### ***Postpartum Mood Disturbances***

The term 'postpartum depression' has been used for many years to describe a variety of problems that are now referred to by several names, such as mood disturbances, adjustment problems, or specific reactions such as anxiety reactions, depressive reactions, obsessive/compulsive reactions, or postpartum psychosis. Each woman's symptoms are unique, as she may be experiencing a combination of reactions.

12-16% of women experience postpartum depression  
Up to 26% of adolescent mothers experience postpartum depression

### ***Postpartum Psychosis***

This is the least common and most severe postpartum disturbance. One in 1,000 women experience a postpartum psychosis, usually within the first two weeks following the birth of their baby. Symptoms are severe and may include insomnia, agitation, hallucinations, bizarre perceptions and behaviour which indicates a disconnection with reality. Women experiencing these symptoms are at risk of harming themselves or their babies. This is a psychiatric emergency, and the woman needs to be hospitalized immediately.

## **Women experiencing mood disturbances need to know that they are not alone**

### **Reasons why women with mood disturbances should seek treatment in pregnancy or postpartum:**

- A woman with untreated depression or anxiety in pregnancy is at a higher risk of developing postpartum depression.
- Treating women with mental illness in pregnancy increases their coping skills during pregnancy and in the post partum period.
- Untreated mood disturbances may affect the mother-child relationship and the woman's ability to parent in the postpartum period.
- A woman with untreated mental illness in the post partum period may minimize her interactions with her baby for fears she may harm him/her. Treating the woman promptly may help her normalize her fears, increase her interactions with the child, and therefore promote the bonding between mother and child.

### **Reaching Out**

Sometimes it is difficult for women to ask for help because they fear being misunderstood. Most of the time, it is a lack of education and understanding about emotional distress during pregnancy and the postpartum period that causes misunderstandings.



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In recent years emotional problems during pregnancy and postpartum mood disorders have been studied in more depth. This fact sheet is part of a document informing physicians, nurses, midwives, social workers, and mental health providers about early identification, assessment, treatment options, and follow-up of pregnant and postpartum women with mood disorders.

*Access the BC Reproductive Mental Health Program website for more information about mood disorder and treatment options such as light therapy, and the latest on medication use during pregnancy and while breastfeeding.* [www.bcrmh.com](http://www.bcrmh.com) / [www.bcwomens.ca](http://www.bcwomens.ca)

**Self-Care Program for women with Postpartum Depression and Anxiety** is available on line at [www.bcrmh.com](http://www.bcrmh.com) / [www.bcwomens.ca](http://www.bcwomens.ca) or call 604-875-2424 Local 7644 for a hard copy, purchased at cost.



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# 產前產後心理健康

## Emotional Wellness during Pregnancy and the Postpartum Period

### 婦女與家人須知

#### 產前

婦女在懷孕期間，身心靈都經歷巨變。有些孕婦因調適困難，向朋友、保健護士、社區團體及家庭醫師尋求支援；有些婦女會產生各種情緒障礙，如焦慮、憂鬱和強迫症。

百分之十到十六的孕婦有憂鬱症  
百分之二到四的孕婦出現焦慮症狀或有恐慌感

這些情緒起伏和焦慮的症狀，在懷孕第一和第三期較難察覺，因為許多症狀和大多數婦女懷孕期間所經歷的很類似。在懷孕的第二期就比較容易發覺，因為此時大多數孕婦開始感覺胎動，初嘗懷孕的喜悅。可是，有憂鬱症狀的孕婦可能會有悲傷、絕望、易哭的現象，情況嚴重的還會有自殺的念頭。在懷孕第三期仍有情緒障礙的婦女，是產後出現情緒障礙的高危險群。

懷孕前有憂鬱症病史的婦女大約百分之三十會有產後憂鬱症

#### 焦慮

最常見的症狀有

- 精神緊張、焦慮不安
- 失眠和食慾下降
- 過度擔憂嬰兒
- 注意力不集中、混亂和記憶力減退
- 不由自主地好哭和易怒

也可能會有恐慌感



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## 憂鬱

這些症狀可能與上列焦慮症狀中的部分重複，還伴隨有

- 提不起勁、疲倦、困乏
- 悲傷，絕望，易哭
- 過度擔憂嬰兒或是對嬰兒沒有興趣
- 罪疚感、自覺無能、或無價值感
- 缺乏性慾

### 強迫症

約有百分之二到三的初產婦有此現象，感到焦慮憂鬱，深恐無力照顧嬰兒，擔心傷害嬰兒。婦女特別會有擔憂嬰兒受傷害的念頭，研究指出，婦女一旦有此念頭，極不可能有傷害嬰兒的行為；但是，內心的恐懼會妨礙母親與嬰兒的互動，造成親子關係的障礙。

### 產後

產婦在產後常會有錯綜複雜的情緒，一方面感到既高興又安慰，生產結束；一方面又感到惶惑、挫折和焦慮。身體的變化包括荷爾蒙的劇烈變化，這在情緒上也需要調適。照顧新生兒的工作繁重，初為人母者在第一年裡時有情緒起伏不定的經驗，在逐漸適應這項非常重要的新角色時，家人和朋友持續的支持會有極大的幫助。初為人母的婦女，尤其需要其他的媽媽們協助其適應新生活。然而，有時仍不免會經歷令人困惑的情緒，引發極大的憂慮，這些情緒主要有兩大類：

- 產後憂愁
- 產後情緒障礙

### 產後憂愁

百分之七十到八十的母親有此現象，通常在產後頭幾天突然出現，一到兩週內會緩解，大體不需要治療，症狀包括哭泣、易怒、不安和焦慮。

### 產後情緒障礙

「產後情緒障礙」一詞已行之有年，是形容不一而足的症狀。這些症狀現在已分別有了各自的名稱，例如情緒障礙、調適困難、或是諸如焦慮反應、抑鬱反應、強迫性反應、或產後精神病等特定反應。由於有些人可能綜合有數種症狀，因此每個婦女的症狀都是具有獨一無二的個別性的。

百分之十二到十六的婦女有產後憂鬱症的現象  
高達百分之二十六的少年婦女有產後憂鬱症的現象

### 產後精神病

這是最少見但最嚴重的產後情緒障礙，有千分之一的婦女出現產後精神病，通常在



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嬰兒出生後頭兩週發生，會有嚴重的症狀，可能包括失眠、悸動、幻覺以及與現實脫節的怪誕想法和行爲。有這些症狀的婦女，可能會傷害自己或者傷害嬰兒，這是需要緊急處理的精神病症狀，需要立刻住院治療。

出現情緒障礙的婦女要了解，她們不是唯一有此現象的人

有情緒障礙的婦女在懷孕期間與產後應尋求治療的原因

- 婦女在懷孕期間有憂鬱或焦慮症狀而不予治療，出現產後憂鬱症的可能性較高。
- 懷孕期間有精神疾病的婦女，若予以治療，可加強其懷孕期間和產後的適應力。
- 情緒障礙未予治療，會影響產後母子關係以及婦女育兒的能力。
- 婦女產後有精神疾病而未予治療，會因擔憂傷害嬰兒，而影響其與嬰兒的互動。即時治療可緩解其憂慮，加強其與嬰兒的互動，增進母子關係。

## 求援

有時婦女擔心被誤解而不願尋求協助，大多數時候，這是因為對懷孕期間和產後的情緒困擾缺少教育和了解，才生此誤解。

近年來，對於懷孕期間和產後的情緒問題，已有較深刻的研究，本文就是從一份文件選取其中一部份而成。這份文件是要告知醫生、護士、助產士、社工人員和心理衛生醫護人員，針對懷孕期間及產後有情緒障礙的婦女，如何早期發現、評估、進行治療及其跟進療法。

『卑詩省生育心理衛生計劃』網址是 [www.bcrmh.com](http://www.bcrmh.com)

『生育心理衛生』，有關情緒障礙和諸如光照治療等治療選擇的資訊，以及懷孕和哺乳期間用藥的最新資訊，網址是 [www.bcrmh.com/www.bcwomens.ca](http://www.bcrmh.com/www.bcwomens.ca)

有產後憂鬱和焦慮症的婦女『自我照護計劃』的網址是 [www.bcrmh.com/www.bcwomens.ca](http://www.bcrmh.com/www.bcwomens.ca)

或致電 604-875-2424 分機號碼 7644

可付費購買付印的文件資料



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# 임신 기간과 출산 후 산모의 정신건강

## 산모와 가족을 위한 정보

### Emotional Wellness during Pregnancy and the Postpartum Period

#### Information for Women and their Families

#### 출산 전

임신 기간 중 여성은 몸과 마음, 그리고 정신적으로 커다란 변화를 겪게 된다. 일부의 임신 여성들은 임신에 대처하는 데 어려움을 겪으며, 친구, 간호사, 주변 단체와 가정으로부터 도움을 찾는다. 하지만 다른 부류의 여성들은 불안증, 우울증, 그리고 강박관념 등의 감정이복을 겪게 된다.

10%-16 퍼센트의 임신여성이  
우울증을 경험한다.  
2%-4%의 임신여성이 불안감이나  
초조감의 정신적 장애를 경험한다.

이런 기분과 불안증의 감정이복에서 오는 증세들은 거의 모든 여성이 임신 기간에 겪는 현상과 비슷하기 때문에 임신 첫 달과 셋째 달에서는 더욱 인식하기가 어렵다. 임신 기간 둘째 달에서는 이런 증세들을 인식하기가 쉬워지는데 이는 거의 모든 여성들이 아기의 움직임을 느끼기 시작하는 이 시기를 즐거이 받아들이고 있기 때문이다. 하지만 우울증을 앓고 있는 여성은 슬픔과 좌절, 울음, 그리고 심한 경우에 자살을 상상할 수 있다. 셋째 달에서 이와 같은 감정이복을 경험하는 여성은 출산 후에도 이런 감정장애를 겪을 위험이 높다.

임신전 우울증을 경험한 여성중 약  
30%가 출산 후에도 우울증을  
경험한다.

#### 불안증

가장 자주 나타나는 증세들

- 신경과민, 불안
- 수면장애 및 식욕 부진
- 아기에 대한 지나친 걱정
- 집중력 저하, 혼돈과 기억력 상실
- 억제불능한 울음 및 과민반응

초조감 발작도 발생할 수 있음.

#### 우울증

아래의 증세들은 불안증에 나타난 증세들과 함께 나타날 수 있음.

- 나른함, 피로, 기진맥진
- 슬픔, 좌절, 또는 억제불능한 울음
- 아기에 대한 지나친 걱정
- 죄책감, 무능, 무가치한 느낌
- 성적 관심 저하

#### 강박 장애

이 강박장애는 초임신부 2-3%에게서 나타나는데 증세로서 근심걱정과 우울증의 반응이 아이를 잃거나 아이에게 해가 끼칠지도 모른다는 심한 두려움이 함께 찾아오는 것이다. 이러한 여성들은 대개 아이에게 해를 끼칠것 같은 생각에 사로 잡히게 된다. 연구에 따르면 이러한 여성은 자신의



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생각을 극단적으로 행동할 가능성은 드문 것으로 나타난다. 하지만 그녀의 두려움은 아이와의 상호교류를 제한하게 되며 교감 상에 문제를 야기시킬 수 있다.

### 출산 후

출산 후 산모는 종종 여러가지 복잡한 감정을 겪게 된다. 출산에 대한 기쁨과 안도감은 불확실성, 좌절과 불안감이 뒤섞일 수 있다. 산모 몸은 감정을 조절하는 호르몬에 대한 변화를 체험한다. 아이를 돌보는 일은 어려운 일이며, 산모는 출산 후 일년동안 심한 감정의 기복을 겪게 된다. 이때에 가족이나 친구들이 산모가 새롭고도 매우 중요한 역할에 적응하도록 하는데 많은 도움이 된다. 새 엄마가 된 여성은 특히 새로운 생활 적응에 다른 여성의 도움이 필요하다. 그렇지만 때때로 산모는 심각한 고민에 빠지게 되는 엉뚱한 감정을 겪게 되는데, 이러한 감정들은 두 가지 주요종류로 분류될 수 있다.

- 산후 우울증
- 산후 감정기복

### 산후 우울증

이 우울증은 모든 산모 중 약 70-80%에게서 나타난다. 이 우울증은 출산 며칠후 갑작스럽게 나타나게 되며 대개 1, 2 주 후면 자연적으로 사라지고 보통 특별한 치료가 필요없다. 증세는 울음, 흥분과 분노, 피로함, 불안감이다.

### 산후 감정기복

“산후 우울증”이란 용어는 출산 후 나타나는 다양한 증세들을 표현하는데 오랫동안 사용되어 왔던 단어이며 현재는 감정기복, 감정 조절능력 감퇴, 또는 불안 반응, 우울 반응, 강박 반응과 같은 산후 정신질환 등의 특수 반응들로 표현되기도 한다. 각 산모의 증세들은 모두 독특하며, 위의 반응들을 동시에 여러개 겪기도 한다.

12-16%의 산모가 출산 후 우울증을 경험한다.

어린 산모들이 많게는 26%가 출산후 우울증을 경험한다.

### 산후 정신질환

가장 드물지만 가장 위중한 산후 감정기복이다. 1000 명중에 한명이 이 정신질환을 경험하는데 이 중에 아기의 출생 이후 1, 2 주 안에 나타난다. 증세는 심한 불면증, 초조감, 환각, 괴이한 생각과 행동으로 현실세계와의 동떨어진 증세를 나타낸다. 이런 증세를 겪고 있는 여성들은 자기 자신이나 아기에게 해를 끼칠 위험이 크다. 이것은 정신적 치료가 필요한 비상 사태이며 해당 여성은 즉시 병원에 입원해야만 한다.

감정 기복을 겪고 있는 여성은 자신들이 혼자가 아님을 인식해야 한다.

임신 중이나 출산 후에 감정기복을 겪고 있는 여성이 치료를 받아야 하는 이유:

- 임신 중 치료되지 않은 우울증이나 불안증을 갖은 여성은 산후 우울증에 걸릴 위험이 높다.
- 임신 기간 정신적 치료를 받은 여성은 출산 후 문제에서 잘 극복해 낼 수 있는 능력을 지니게 된다.
- 치료되지 않는 감정기복은 엄마와 아기 사이의 관계와 출산 후 여성의 육아에 영향을 미칠 수 있다.
- 정신적 치료를 받지 않은 여성은 출산 후 자신이 아기에게 해가 될 수 있다는 두려움에 아이와의 교감이 떨어진다. 이런 여성들은 치료 후에는 이런 현상을 정상으로 되돌릴 수 있고 따라서 아이와의 교감도 높일 수 있다.



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### 해결책

때때로 여성들은 자신들이 남들에게 잘못 비추어질까봐 도움 요청을 꺼리는 경우가 있다. 대부분 그것은 임신과 출산 후 기간 중 감정적 고뇌에 대한 교육부족과 몰이해 탓이다.

최근 수년 간 임신 기간 또는 출산 후의 감정장애 문제에 대해 더욱 깊이 연구해왔다. 이 사례보고서는 의사, 변호사, 조산원, 사회복지직원 및 정신보건원 직원들에게 감정장애를 겪고 있는 임산부의 조기 식별, 판단, 치료 선택, 그리고 지속적 조사에 대해 설명하고 있다.

BC 출산 정신건강 프로그램 웹사이트: [www.bcrmh.com](http://www.bcrmh.com)

임신 중 감정장애와 이에 대한 치료, 임신과 수유 기간을 위한 빛 치료와 최신 약물 치료 방법에 관한 자세한 정보는 출산 정신건강 프로그램 웹사이트를 방문하여 주십시오. [www.bcrmh.com](http://www.bcrmh.com) / [www.bcwomens.ca](http://www.bcwomens.ca)

산후 우울증과 불안증을 갖고 있는 여성들을 위한 자기 관리 프로그램이 인터넷상에 준비되어 있습니다.

[www.bcrmh.com](http://www.bcrmh.com) / [www.bcwomens.ca](http://www.bcwomens.ca)

전화: 604-875-2424 또는 7644

인쇄물을 원하실 경우에는 돈을 지불하셔야 합니다.



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## ਗਰਭ-ਅਵਸਥਾ ਅਤੇ ਜਣੇਪੇ-ਉਪਰੰਤ ਦੇ ਸਮੇਂ ਦੌਰਾਨ ਭਾਵਾਤਮਕ ਭਲਾਈ

### ਔਰਤਾਂ ਅਤੇ ਉਹਨਾਂ ਦੇ ਪਰਿਵਾਰਾਂ ਲਈ ਜਾਣਕਾਰੀ

#### ਜਣੇਪੇ ਤੋਂ ਪਹਿਲਾਂ

ਗਰਭ-ਅਵਸਥਾ ਦੌਰਾਨ ਔਰਤ ਦਾ ਸਰੀਰ, ਮਨ ਅਤੇ ਆਤਮਾ ਭਾਰੀ ਪਰਿਵਰਤਨਾਂ ਵਿਚੋਂ ਲੰਘਦੇ ਹਨ। ਕੁਝ ਔਰਤਾਂ ਨੂੰ ਗਰਭ-ਅਵਸਥਾ ਦਾ ਮੁਕਾਬਲਾ ਕਰਨਾ ਕਠਨ ਹੋ ਜਾਂਦਾ ਹੈ ਤੇ ਉਹ ਦੋਸਤਾਂ, ਸਿਹਤ ਨਰਸਾਂ, ਪੜ੍ਹੇ-ਲਿਖੇ ਗਰੁਪਾਂ, ਅਤੇ ਫੈਮਲੀ ਡਾਕਟਰਾਂ ਦਾ ਸਹਾਰਾ ਲੈਂਦੀਆਂ ਹਨ। ਪਰ ਕੁਝ ਔਰਤਾਂ ਨੂੰ ਮੂਡ ਦੀਆਂ ਕਈ ਪਰੇਸ਼ਾਨੀਆਂ ਦਾ ਸਾਹਮਣਾ ਕਰਨਾ ਪੈ ਸਕਦਾ ਹੈ, ਜਿਵੇਂ ਐਂਗਜ਼ਾਇਟੀ, ਡਿਪਰੈਸ਼ਨ ਅਤੇ ਅਬਸੈਸਿਵ ਕੰਪਲਸਿਵ ਦਾ ਰੋਗ।

10% - 16% ਗਰਭਵਤੀ ਔਰਤਾਂ ਡਿਪਰੈਸ਼ਨ ਅਨੁਭਵ ਕਰਦੀਆਂ ਹਨ  
2% ਤੋਂ 4% ਗਰਭਵਤੀ ਔਰਤਾਂ ਐਂਗਜ਼ਾਇਟੀ ਜਾਂ ਪੈਨਿਕ ਦੇ ਰੋਗ ਭੋਗਦੀਆਂ ਹਨ।

ਇਹ ਮੂਡ ਅਤੇ ਐਂਗਜ਼ਾਇਟੀ ਦੀਆਂ ਪਰੇਸ਼ਾਨੀਆਂ ਨੂੰ ਗਰਭ ਦੀ ਪਹਿਲੀ ਅਤੇ ਤੀਸਰੀ ਤਿਹਾਈ ਵਿਚ ਪਛਾਨਣਾ ਜ਼ਿਆਦਾ ਔਖਾ ਹੁੰਦਾ ਹੈ, ਕਿਉਂਕਿ ਬਹੁਤੇ ਲੱਛਣ ਉਸੇ ਤਰ੍ਹਾਂ ਦੇ ਹੁੰਦੇ ਹਨ ਜੋ ਆਮ ਕਰਕੇ ਔਰਤਾਂ ਗਰਭ ਦੇ ਦੌਰਾਨ ਅਨੁਭਵ ਕਰਦੀਆਂ ਹਨ। ਦੂਸਰੀ ਤਿਹਾਈ ਵਿਚ ਉਹ ਜ਼ਿਆਦਾ ਸੌਖੀ ਤਰ੍ਹਾਂ ਪਛਾਣੇ ਜਾ ਸਕਦੇ ਹਨ, ਕਿਉਂਕਿ ਬਹੁਤੀਆਂ ਔਰਤਾਂ ਇਸ ਸਮੇਂ ਵਿਚ ਅਨੰਦ ਦਾ ਅਨੁਭਵ ਕਰਦੀਆਂ ਹਨ ਜਦੋਂ ਉਹ ਬੇਬੀ ਨੂੰ ਹਿਲਦਾ ਜੁਲਦਾ ਮਹਿਸੂਸ ਕਰਦੀਆਂ ਹਨ। ਪਰ ਜਿਹੜੀਆਂ ਔਰਤਾਂ ਨੂੰ ਡਿਪਰੈਸ਼ਨ ਹੋਵੇ ਉਹ ਵਿਆਪਕ ਉਦਾਸੀ ਅਨੁਭਵ ਕਰਦੀਆਂ ਹਨ, ਇਕ ਬੇਆਸ ਅਵਸਥਾ ਭੋਗਦੀਆਂ ਹਨ, ਰੋਣ ਦੇ ਦੌਰੇ ਪੈਂਦੇ ਹਨ, ਤੇ ਇੰਤਹਾ ਕੇਸਾਂ ਵਿਚ ਆਤਮਘਾਤ ਦੇ ਖਿਆਲ ਆਉਂਦੇ ਹਨ। ਜਿਨ੍ਹਾਂ ਔਰਤਾਂ ਨੂੰ ਗਰਭ ਦੀ ਤੀਸਰੀ ਤਿਹਾਈ ਵਿਚ ਮੂਡ ਦੀਆਂ ਪਰੇਸ਼ਾਨੀਆਂ ਪੇਸ਼ ਆਉਂਦੀਆਂ ਹਨ ਉਹਨਾਂ ਨੂੰ ਜਣੇਪੇ-ਉਪਰੰਤ ਦੇ ਸਮੇਂ ਵਿਚ ਮੂਡ ਨਾਲ ਸੰਬੰਧਤ ਰੋਗਾਂ ਦਾ ਵਡਾ ਖਤਰਾ ਹੁੰਦਾ ਹੈ।

ਤਕਰੀਬਨ 30% ਔਰਤਾਂ ਜਿਹਨਾਂ ਦਾ ਗਰਭ ਧਾਰਨ ਤੋਂ ਪਹਿਲਾਂ ਡਿਪਰੈਸ਼ਨ ਦਾ ਇਤਿਹਾਸ ਹੋਵੇ, ਜਣੇਪੇ-ਉਪਰੰਤ ਵੀ ਡਿਪਰੈਸ਼ਨ ਦਾ ਸ਼ਿਕਾਰ ਹੋ ਜਾਣਗੀਆਂ

#### ਐਂਗਜ਼ਾਇਟੀ

ਸਭ ਤੋਂ ਵੱਧ ਦੱਸੀਆਂ ਜਾਂਦੀਆਂ ਮੁਸ਼ਕਲਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ

- ਘਬਰਾਹਟ, ਐਂਗਜ਼ਾਇਟੀ
- ਨੀਂਦਰ ਅਤੇ ਭੁੱਖ ਦੀਆਂ ਪਰੇਸ਼ਾਨੀਆਂ
- ਬੇਬੀ ਲਈ ਲੋੜੀਂਦੇ ਵੱਧ ਚਿੰਤਾ
- ਧਿਆਨ ਲਾਉਣ ਵਿਚ ਔਖ, ਉਲਝਣ, ਅਤੇ ਯਾਦਾਸ਼ਤ ਦਾ ਘਾਟਾ
- ਬੇਕਾਬੂ ਰੋਣਾ ਅਤੇ ਖਿੜਣਾ

ਪੈਨਿਕ ਅਟੈਕ ਵੀ ਹੋ ਸਕਦੇ ਹਨ।

#### ਡਿਪਰੈਸ਼ਨ

ਇਨ੍ਹਾਂ ਵਿਚ ਐਂਗਜ਼ਾਇਟੀ ਬੱਲੇ ਲਿਸਟ ਕੀਤੇ ਗਏ ਕੁਝ ਲੱਛਣ ਵੀ ਹੋ ਸਕਦੇ ਹਨ, ਤੇ ਹੇਠਾਂ ਲਿਖੇ ਵੀ ਹਨ

- ਸੁਸਤੀ, ਥਕੇਵਾਂ, ਹੰਭਣਾ
- ਉਦਾਸੀ, ਨਿਰਾਸ਼ਾ, ਅਤੇ/ਜਾਂ ਬੇਕਾਬੂ ਰੋਣ



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- ਬੇਬੀ ਲਈ ਲੋੜੇਂ ਵੱਧ ਚਿੰਤਾ ਜਾਂ ਕੋਈ ਦਿਲਚਸਪੀ ਨਾ ਹੋਣਾ
- ਦੋਸ਼ ਦਾ ਅਹਿਸਾਸ, ਕਮੀ, ਜਾਂ ਨਿਕੰਮੇ ਹੋਣ ਦੀ ਸੋਚ
- ਸੈਕਸ ਵਿਚ ਦਿਲਚਸਪੀ ਦੀ ਘਾਟ

### ਅਬਸੈਸਵ/ਕੰਪਲਸਿਵ ਰੋਗ

ਇਹ ਤਕਰੀਬਨ 2-3% ਨਵੀਆਂ ਮਾਵਾਂ ਨੂੰ ਹੋ ਜਾਂਦਾ ਹੈ ਅਤੇ ਇਸ ਵਿਚ ਸ਼ਾਮਲ ਹੋ ਸਕਦੇ ਹਨ ਐਂਗਜ਼ਾਇਟੀ ਅਤੇ ਡਿਪਰੈਸ਼ਨ ਦੇ ਪ੍ਰਤੀਕਰਮ, ਤੇ ਨਾਲ ਹੀ ਕਾਬੂ ਖੋਅ ਜਾਣ ਅਤੇ ਬੇਬੀ ਨੂੰ ਨੁਕਸਾਨ ਪਹੁੰਚਾਉਣ ਦਾ ਡੂੰਘਾ ਡਰ ਪੈਦਾ ਹੋ ਸਕਦਾ ਹੈ। ਆਮ ਤੌਰ ਤੇ ਮਾਵਾਂ ਨੂੰ ਜ਼ਬਰਨ ਅਜਿਹੀਆਂ ਗੱਲਾਂ ਦੇ ਖਿਆਲ ਆਉਂਦੇ ਹਨ ਜਿਨ੍ਹਾਂ ਨਾਲ ਉਹਨਾਂ ਦੇ ਬੇਬੀ ਦਾ ਨੁਕਸਾਨ ਹੁੰਦਾ ਹੋਵੇ। ਅਧਿਕਾਨ ਇਹ ਦਰਸਾਉਂਦੇ ਹਨ ਕਿ ਜਿੰਨਾ ਚਿਰ ਔਰਤ ਨੂੰ ਬੇਬੀ ਨੂੰ ਨੁਕਸਾਨ ਕਰਨ ਵਾਲੇ ਖਿਆਲਾਂ ਤੋਂ ਨਫਰਤ ਰਹਿੰਦੀ ਹੈ, ਉਨ੍ਹਾਂ ਚਿਰ ਇਸ ਗੱਲ ਦੀ ਬਹੁਤ ਹੀ ਘੱਟ ਸੰਭਾਵਨਾ ਹੈ ਕਿ ਉਹ ਆਪਣੇ ਖਿਆਲਾਂ ਤੇ ਅਮਲ ਕਰੇ। ਪਰ ਇਹ ਡਰ ਉਸਦੇ ਬੇਬੀ ਨਾਲ ਪਰਸਪਰ ਪ੍ਰਤੀਕਰਮ ਸੀਮਤ ਕਰ ਸਕਦੇ ਹਨ ਅਤੇ ਬੇਬੀ ਨਾਲ ਉਸਦੇ ਸੰਬੰਧਾਂ ਤੇ ਅਸਰ ਪਾ ਸਕਦੇ ਹਨ।

### ਜਣੇਪੇ ਤੋਂ ਪਿਛੋਂ

ਜਣੇਪੇ ਪਿਛੋਂ ਮਾਂ ਅਕਸਰ ਕਈ ਤਰ੍ਹਾਂ ਦੀਆਂ ਭਾਵਨਾਵਾਂ ਦਾ ਮਿਲਗੋਭਾ ਮਹਿਸੂਸ ਕਰਦੀ ਹੈ। ਆਨੰਦ ਅਤੇ ਚੈਨ ਜੋ ਜਣੇਪਾ ਹੋਣ ਤੋਂ ਪਿਛੋਂ ਮਿਲਦੇ ਹਨ ਉਹਨਾਂ ਵਿਚ ਅਨਿਸ਼ਚਿਤਤਾ, ਉਪਰਾਮਤਾ, ਅਤੇ ਘਬਰਾਹਟ ਦਾ ਰਲਾ ਵੀ ਹੋ ਸਕਦਾ ਹੈ। ਉਸਦੇ ਸਰੀਰ ਦੀਆਂ ਤਬਦੀਲੀਆਂ ਵਿਚ ਹਾਰਮੋਨਾਂ ਦਾ ਉਤਰਾ ਚੜ੍ਹਾ ਵੀ ਸ਼ਾਮਲ ਹੈ ਜੋ ਉਸਦੇ ਭਾਵਾਂ ਦੇ ਸਮਾਧਾਨ ਦਾ ਹਿੱਸਾ ਹੈ। ਨਵੇਂ ਬੇਬੀ ਦੀ ਦੇਖਭਾਲ ਕਰਨਾ ਕਠਿਨ ਕੰਮ ਹੈ, ਅਤੇ ਮਾਵਾਂ ਕਈ ਵਾਰ ਪਹਿਲੇ ਸਾਲ ਵਿਚ “ਉਤਰਾ” ਅਤੇ “ਚੜ੍ਹਾ” ਵੀ ਅਨੁਭਵ ਕਰਦੀਆਂ ਹਨ। ਮਾਂ ਨੂੰ ਆਪਣੇ ਨਵੇਂ ਅਤੇ ਬਹੁਤ ਮਹੱਤਵ ਪੂਰਨ ਰੋਲ ਵਿਚ ਢਲਣ ਵਾਸਤੇ ਪਰਿਵਾਰ ਅਤੇ ਦੋਸਤਾਂ ਦੀ ਸਹਾਇਤਾ ਅਤਿਅੰਤ ਸਹਾਈ ਹੁੰਦੀ ਹੈ। ਵਿਸ਼ੇਸ਼ ਕਰਕੇ ਨਵੀਆਂ ਮਾਵਾਂ ਨੂੰ ਆਪਣੀਆਂ ਨਵੀਆਂ ਜ਼ਿੰਦਗੀਆਂ ਵਿਚ ਢਲਣ ਲਈ ਦੂਸਰੀਆਂ ਮਾਵਾਂ ਦੀ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਪੈਂਦੀ ਹੈ। ਪਰ ਕਦੇ ਕਦੇ ਮਾਂ ਚਕਰਾ ਦੇਣ ਵਾਲੇ ਭਾਵਾਂ ਵਿਚੋਂ ਗੁਜ਼ਰਦੀ ਹੈ ਜੋ ਕਾਫੀ ਚਿੰਤਾ ਦਾ ਕਾਰਨ ਬਣ ਸਕਦੇ ਹਨ। ਇਹ ਭਾਵਨਾਵਾਂ ਦੇ ਸ਼੍ਰੇਣੀਆਂ ਵਿਚ ਵੰਡੀਆਂ ਜਾ ਸਕਦੀਆਂ ਹਨ:

- ਬੇਬੀ ਬਲੂਜ਼ (ਜਣੇਪੇ ਪਿਛੋਂ ਉਦਾਸੀ)
- ਜਣੇਪੇ ਉਪਰੰਤ ਮੂਡ ਦੀਆਂ ਪਰੇਸ਼ਾਨੀਆਂ (ਪੋਸਟਪਾਰਟਮ ਮੂਡ ਡਿਸਟਰਬੈਂਸਜ਼)

### ਬੇਬੀ ਬਲੂਜ਼

“ਬਲੂਜ਼” ਜਾਂ ਉਦਾਸੀ ਤਕਰੀਬਨ 70 ਤੋਂ 80 ਪਰਿਸ਼ਤ ਮਾਵਾਂ ਨੂੰ ਅਨੁਭਵ ਹੁੰਦੀ ਹੈ। ਇਹ ਬੱਚਾ ਜੰਮਣ ਪਿਛੋਂ ਪਹਿਲੇ ਦਿਨਾਂ ਵਿਚ ਅਚਾਨਕ ਹੀ ਪ੍ਰਗਟ ਹੋ ਜਾਂਦੀ ਹੈ ਅਤੇ ਇਕ ਦੋ ਹਫ਼ਤਿਆਂ ਵਿਚ ਆਪੇ ਹੀ ਚਲੀ ਜਾਂਦੀ ਹੈ; ਆਮ ਤੌਰ ਤੇ ਇਸਦਾ ਕੋਈ ਇਲਾਜ ਨਹੀਂ ਕੀਤਾ ਜਾਂਦਾ। ਇਸਦੇ ਲੱਛਣਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹਨ: ਰੋਣਾ, ਖਿੜ, ਅਤੇ ਘਬਰਾਹਟ।

### ਜਣੇਪੇ-ਉਪਰੰਤ ਮੂਡ ਦੀਆਂ ਪਰੇਸ਼ਾਨੀਆਂ

ਕਈ ਸਾਲਾਂ ਤੋਂ ਸ਼ਬਦ, “ਪੋਸਟਪਾਰਟਮ ਡਿਪਰੈਸ਼ਨ” ਕਈ ਕਿਸਮ ਦੀਆਂ ਸਮੱਸਿਆਵਾਂ ਨੂੰ ਬਿਆਨ ਕਰਨ ਲਈ ਵਰਤਿਆ ਜਾ ਰਿਹਾ ਹੈ, ਇਹ ਸਮੱਸਿਆਵਾਂ ਹੁਣ ਕਈ ਨਵਾਂ ਨਾਲ ਜਾਣੀਆਂ ਜਾਂਦੀਆਂ ਹਨ ਜਿਵੇਂ ਮੂਡ ਦੀਆਂ ਪਰੇਸ਼ਾਨੀਆਂ, ਅਜਸਟ (ਸਮਾਧਾਨ) ਕਰਨ ਦੀਆਂ ਸਮੱਸਿਆਵਾਂ; ਜਾਂ ਵਿਸ਼ੇਸ਼ ਕਿਸਮ ਦੇ ਪ੍ਰਤੀਕਰਮ ਜਿਵੇਂ ਘਬਰਾਹਟ ਦੇ ਪ੍ਰਤੀਕਰਮ, ਡਿਪਰੈਸ਼ਨ ਦੇ ਪ੍ਰਤੀਕਰਮ, ਅਬਸੈਸਵ/ਕੰਪਲਸਿਵ ਪ੍ਰਤੀਕਰਮ, ਜਾਂ ਜਣੇਪੇ ਤੋਂ ਉਪਰੰਤ ਦਾ ਮਨੋਰੋਗ। ਹਰ ਔਰਤ ਦੇ ਲੱਛਣ ਵਿਲੱਖਣ ਹਨ ਕਿਉਂਕਿ ਹੋ ਸਕਦਾ ਹੈ ਉਹ ਕਈ ਪ੍ਰਤੀਕਰਮਾਂ ਦਾ ਮੇਲ ਅਨੁਭਵ ਕਰ ਰਹੀ ਹੋਵੇ।

12-16% ਔਰਤਾਂ ਜਣੇਪੇ-ਉਪਰੰਤ ਡਿਪਰੈਸ਼ਨ ਅਨੁਭਵ ਕਰਦੀਆਂ ਹਨ

ਕਿਸ਼ੋਰ-ਅਵਸਥਾ ਵਾਲੀਆਂ ਮਾਵਾਂ 26% ਤੱਕ ਜਣੇਪੇ-ਉਪਰੰਤ ਡਿਪਰੈਸ਼ਨ ਅਨੁਭਵ ਕਰਦੀਆਂ ਹਨ

### ਜਣੇਪੇ-ਉਪਰੰਤ ਮਨੋਰੋਗ

### ਜਣੇਪੇ-ਉਪਰੰਤ ਮਨੋਰੋਗ

ਇਹ ਸਭ ਤੋਂ ਘੱਟ ਹੋਣ ਵਾਲਾ ਪਰ ਸਭ ਤੋਂ ਵੱਧ ਗੰਭੀਰ ਜਣੇਪੇ-ਉਪਰੰਤ ਪੈਣ ਵਾਲਾ ਵਿਘਨ ਹੈ। ਇਕ ਹਜ਼ਾਰ ਮਗਰ ਇਕ ਔਰਤ ਜਣੇਪੇ-ਉਪਰੰਤ ਰੋਗ ਦਾ ਸ਼ਿਕਾਰ ਹੋ ਜਾਂਦੀ ਹੈ, ਬੇਬੀ ਦੇ ਜਨਮ ਪਿਛੋਂ ਅਕਸਰ ਪਹਿਲੇ ਦੋ ਸਪਤਾਹਾਂ ਦੇ ਵਿਚ ਵਿਚ। ਇਸਦੇ ਲੱਛਣ ਗੰਭੀਰ ਹੁੰਦੇ ਹਨ ਅਤੇ ਇਨ੍ਹਾਂ ਵਿਚ ਸ਼ਾਮਲ ਹੋ ਸਕਦੇ ਹਨ ਉਨੀਂਦਰਾ-ਰੋਗ, ਬੇਚੈਨੀ, ਮਨੋ-ਭ੍ਰਾਂਤੀ, ਬੇਤੁਕੇ ਪ੍ਰਤੱਖਣ ਅਤੇ ਅਜਿਹਾ ਵਿਵਹਾਰ ਜੋ ਯਥਾਰਥ ਤੋਂ ਟੁਟਿਆ ਹੋਵੇ। ਜਿਨ੍ਹਾਂ ਔਰਤਾਂ ਨੂੰ ਅਜਿਹੇ ਲੱਛਣਾਂ ਦਾ ਅਨੁਭਵ ਹੁੰਦਾ ਹੈ ਉਹ ਆਪਣੇ ਆਪ ਦਾ ਜਾਂ ਬੇਬੀ ਦਾ



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ਨੁਕਸਾਨ ਕਰ ਸਕਦੀਆਂ ਹਨ। ਇਹ ਇਕ ਮਨੋ-ਚਿਕਿਤਸਕ (ਸਾਇਕਿਆਟ੍ਰਕ) ਇਮਰਜੰਸੀ ਹੈ ਅਤੇ ਔਰਤ ਨੂੰ ਤੁਰੰਤ ਹਸਪਤਾਲ ਵਿਚ ਲਿਜਾਣ ਦੀ ਲੋੜ ਹੈ।

ਔਰਤਾਂ ਜੋ ਮੂਡ ਦੇ ਵਿਘਨਾਂ ਦਾ ਅਨੁਭਵ ਕਰਦੀਆਂ ਹਨ ਉਹਨਾਂ ਨੂੰ ਦੱਸਣ ਦੀ ਲੋੜ ਹੈ ਕਿ ਉਹ ਇਕੱਲੀਆਂ ਨਹੀਂ।

ਉਹ ਕਾਰਨ ਜਿਨ੍ਹਾਂ ਕਰਕੇ ਮੂਡ ਵਿਚ ਵਿਘਨ ਪੈਣ ਵਾਲੀਆਂ ਔਰਤਾਂ ਨੂੰ ਗਰਭ ਦੌਰਾਨ ਜਾਂ ਜਣੇਪੇ-ਉਪਰੰਤ ਇਲਾਜ ਦੀ ਲੋੜ ਹੈ:

- ਉਸ ਔਰਤ ਨੂੰ, ਜਿਸਦੇ ਡਿਪਰੈਸ਼ਨ ਜਾਂ ਐਂਗਜ਼ਾਇਟੀ ਦਾ ਗਰਭ ਦੌਰਾਨ ਇਲਾਜ ਨਹੀਂ ਕੀਤਾ ਗਿਆ, ਜਣੇਪੇ ਪਿਛੋਂ ਡਿਪਰੈਸ਼ਨ ਹੋਣ ਦਾ ਜ਼ਿਆਦਾ ਖਤਰਾ ਹੈ।
- ਮਾਨਸਿਕ ਰੋਗੀ ਔਰਤਾਂ ਦਾ ਗਰਭ ਦੌਰਾਨ ਇਲਾਜ ਕਰਨ ਨਾਲ ਉਹਨਾਂ ਦੇ ਗਰਭ ਦੌਰਾਨ ਅਤੇ ਜਣੇਪੇ ਉਪਰੰਤ ਹਾਲਾਤ ਨੂੰ ਝੱਲਣ ਦੇ ਹੁਨਰ ਵਧ ਜਾਂਦੇ ਹਨ।
- ਬਿਨਾਂ ਇਲਾਜ ਤੋਂ ਛੱਡੀਆਂ ਮੂਡ ਦੀਆਂ ਪਰੇਸ਼ਾਨੀਆਂ ਮਾਂ-ਬੱਚੇ ਦੇ ਸੰਬੰਧਾਂ ਤੇ ਅਸਰ ਪਾ ਸਕਦੀਆਂ ਹਨ ਅਤੇ ਜਣੇਪੇ ਉਪਰੰਤ ਔਰਤ ਦੀ ਮਾਪਾ ਬਣਨ ਦੀ ਯੋਗਤਾ ਤੇ ਅਸਰ ਪਾ ਸਕਦੀਆਂ ਹਨ।
- ਜਿਸ ਔਰਤ ਦੇ ਮਾਨਸਿਕ ਰੋਗ ਦਾ ਇਲਾਜ ਨਾ ਕੀਤਾ ਜਾਵੇ ਉਹ ਜਣੇਪੇ ਉਪਰੰਤ ਆਪਣੇ ਬੱਚੇ ਨਾਲ ਘੱਟ ਤੋਂ ਘੱਟ ਰਿਸ਼ਤਾ ਜੋੜ ਸਕਦੀ ਹੈ ਇਸ ਡਰੋਂ ਕਿ ਉਹ ਬੱਚੇ ਨੂੰ ਨੁਕਸਾਨ ਨਾ ਪਹੁੰਚਾ ਦੇਵੇ। ਜੇ ਔਰਤ ਦਾ ਤੁਰੰਤ ਇਲਾਜ ਕਰ ਦਿਤਾ ਜਾਵੇ ਤਾਂ ਉਸਦੇ ਡਰ ਦੂਰ ਹੋ ਸਕਦੇ ਹਨ, ਉਸਦਾ ਬੱਚੇ ਨਾਲ ਪਰਸਪਰ ਮੇਲਜੋਲ ਵਧ ਸਕਦਾ ਹੈ, ਅਤੇ ਇਸ ਲਈ ਮਾਂ ਬੱਚੇ ਵਿਚਕਾਰ ਰਿਸ਼ਤਾ ਵਧੇਰੇ ਖੱਕਾ ਹੋ ਸਕਦਾ ਹੈ।

ਪਹੁੰਚ ਕਰਨੀ

ਕਈ ਵਾਰ ਔਰਤਾਂ ਨੂੰ ਸਹਾਇਤਾ ਦੀ ਮੰਗ ਕਰਨੀ ਮੁਸ਼ਕਲ ਹੋ ਜਾਂਦੀ ਹੈ, ਇਸ ਡਰੋਂ ਕਿ ਉਹਨਾਂ ਨੂੰ ਗਲਤ ਨਾ ਸਮਝ ਲਿਆ ਜਾਵੇ। ਬਹੁਤ ਵਾਰੀ ਇਹ ਗਰਭ ਦੌਰਾਨ ਅਤੇ ਜਣੇਪੇ ਉਪਰੰਤ ਭਾਵਕ ਸੰਕਟ ਬਾਰੇ ਵਿਦਿਆ ਅਤੇ ਸਮਝਦਾਰੀ ਦੀ ਘਾਟ ਹੁੰਦੀ ਹੈ ਜੋ ਗਲਤਫਹਿਮੀ ਪਾ ਦਿੰਦੀ ਹੈ।

ਪਿਛਲੇ ਸਾਲਾਂ ਵਿਚ ਗਰਭ ਦੌਰਾਨ ਭਾਵਕ ਸਮੱਸਿਆਵਾਂ ਦਾ ਅਤੇ ਜਣੇਪੇ ਉਪਰੰਤ ਮੂਡ ਦੇ ਰੋਗਾਂ ਦਾ ਡੂੰਘਾਈ ਵਿਚ ਅਧਿਐਨ ਕੀਤਾ ਗਿਆ ਹੈ। ਇਹ ਫੈਕਟ ਸ਼ੀਟ (ਤੱਥ ਪੰਨਾ) ਉਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਭਾਗ ਹੈ ਜੋ ਡਾਕਟਰਾਂ, ਨਰਸਾਂ, ਦਾਈਆਂ, ਸੋਸ਼ਲ ਵਰਕਰਾਂ, ਅਤੇ ਮਾਨਸਿਕ ਸਿਹਤ ਪ੍ਰਦਾਨ ਕਰਨ ਵਾਲੀਆਂ ਲਈ ਹੈ, ਅਤੇ ਮੂਡ ਦੇ ਰੋਗਾਂ ਵਾਲੀਆਂ ਗਰਭਵਤੀ ਅਤੇ ਜਣੇਪੇ-ਉਪਰੰਤ ਔਰਤਾਂ ਦੀ ਅਗਾਊਂ ਸਨਾਖਤ, ਉਹਨਾਂ ਦੇ ਮੁਲਾਂਕਣ, ਇਲਾਜ-ਚੋਣਾਂ, ਅਤੇ ਪੈਰਵੀ ਬਾਬਤ ਹੈ।

ਬੀ.ਸੀ ਰੀਪ੍ਰਡਕਟਿਵ ਮੈਂਟਲ ਹੈਲਥ ਪ੍ਰੋਗਰਾਮ ਵੈਬਸਾਈਟ: [www.bcrmh.com](http://www.bcrmh.com) .

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# Bienestar emocional durante el embarazo y el período de posparto

## Información para las mujeres y sus familias

(Emotional Wellness during Pregnancy and the Postpartum Period - Information for Women and their Families)

### **Antes del nacimiento**

Durante el embarazo el cuerpo, la mente y el espíritu de una mujer experimentan cambios monumentales. Algunas mujeres embarazadas tienen dificultades para sobrellevar el embarazo y encuentran apoyo en amistades, enfermeras, grupos del barrio y médicos de cabecera. Sin embargo, otras mujeres enfrentan una gama de trastornos del estado del humor, tales como ansiedad, depresión y trastorno de obsesión compulsiva.

**10%- 16% de las mujeres embarazadas experimentan depresión. 2% a 4% de las mujeres embarazadas experimentan ansiedad o tienen trastornos de ataques de pánico.**

Estos trastornos del estado de ánimo y de ansiedad son más difíciles de reconocer en el primer y tercer trimestre del embarazo, dado que muchos de estos síntomas son similares a aquellos experimentados por la mayoría de las mujeres durante el embarazo. En el segundo trimestre puede notarse con más facilidad, ya que la mayoría de las mujeres disfrutan de este período cuando empiezan a sentir moverse al bebé. Sin embargo, las mujeres que están deprimidas, puede que experimente tristeza pervasiva, un sentimiento de desesperación, ataques de llanto y en los casos graves la idea del suicidio. Las mujeres que tienen trastornos del estado de ánimo durante el primer trimestre de su embarazo corren un alto riesgo de tener trastornos del estado de ánimo durante el período de posparto.

Approximadamente 30% de las mujeres con una historia de depresión antes de concebir tendrán depresión de posparto.

### **Ansiedad**

Las dificultades mencionada con más frecuencia incluyen:

- nerviosismo, ansiedad
- alteración del apetito y el dormir
- sobre preocupación por el bebé
- mala concentración, confusión y pérdida de la memoria
- llanto incontrolable e irritabilidad.

También pueden suceder ataques de pánico.

### **Depresión**

Estos pueden incluir algunos de los síntomas listados junto con ansiedad

- pereza, fatiga, agotamiento
- tristeza, desesperanza y/o llanto incontrolable
- sobre preocupación o carencia de interés en el bebé
- sentimiento de culpabilidad, insuficiencia o inutilidad
- carencia de interés sexual.

### **Trastorno obsesivo - compulsivo**

Esto ocurre en aproximadamente 2-3% de las nuevas madres y puede incluir reacciones de depresión y ansiedad junto con un miedo profundo de perder el control y dañar a sus bebés. Las mujeres típicamente tienen pensamientos intrusivos acerca de las cosas que le pueden causar daño al bebé. Los estudios indican



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que siempre y cuando la mujer sienta repulsión de pensar en causarle a daño a su bebé, es extremadamente poco probable que ella haga lo que está pensando. Sin embargo, sus temores pueden limitar sus interacciones con el bebé y causar problemas con la creación de lazos afectivos.

### ***Después del nacimiento***

Después del nacimiento, la madre con frecuencia siente una combinación de sentimientos. Alegría y alivio al dar a luz pueden combinarse con inseguridad, frustración y ansiedad. Los cambios corporales incluyen las fluctuaciones hormonales que son parte de su ajuste emocional. Cuidar de un bebé es una tarea ardua y las madres, en ocasiones, durante el primer año experimentan los “altos” y “bajos”. Tener el apoyo continuo de familiares y amigos es de suma ayuda mientras la madre se acostumbra a su nuevo y sumamente importante rol. Las nuevas madres necesitan especialmente de otras madres para ayudarles a ajustarse a sus nuevas vidas. Algunas veces, sin embargo, la madre experimenta emociones de desconcierto que le pueden causar daño considerable. Estos sentimientos se pueden agrupar en dos categorías principales:

- Etapa melancólica
- trastornos del estado de ánimo después del parto

#### ***Etapa melancólica***

La “etapa melancólica” le sucede a aproximadamente 70 a 80% de las madres. Generalmente aparecen repentinamente durante los primeros días después de dar a luz y generalmente se resuelven por sí solos en una semana o dos, generalmente no requiere tratamiento. Los síntomas incluyen: llanto, irritabilidad, incapacidad de relajarse y ansiedad

#### ***Trastornos emocionales de post parto***

El término “depresión de posparto” se ha usado durante muchos años para describir una variedad de problemas para los cuales ahora se usan nombres diversos, tales como trastornos del estado de ánimo, problemas de ajuste o reacciones específicas tales como ansiedad, reacciones de depresión, reacciones de obsesión compulsiva o psicosis de posparto. Los síntomas de cada mujer son únicos ya que ella puede estar experimentando una combinación de reacciones.

12-16% de mujeres experimentan depresión de posparto

Hasta un 26% de madres adolescente experimentan depresión de posparto

#### ***Psicosis de posparto***

Este es el trastorno menos común y más grave de la depresión de posparto. Una de cada 1.000 mujeres experimenta una psicosis de posparto, generalmente dentro de las dos primeras semanas después del nacimiento de su bebé. Los síntomas son graves y pueden incluir insomnio, agitación, alucinaciones, percepciones extrañas y comportamiento indicativo de una desconexión con la realidad. Las mujeres que experimentan estos síntomas corren el riesgo de dañarse a sí mismas y a sus bebés. Esta es una emergencia psiquiátrica y la mujer necesita ser hospitalizada de inmediato.

**Las mujeres que sufren de trastornos del estado de ánimo necesitan saber que no están solas.**

**Las razones por las cuales las mujeres con trastornos del estado de ánimo deben buscar tratamiento durante el embarazo o posparto son:**

- Una mujer con depresión no tratada o ansiedad en el embarazo corre un mayor riesgo de contraer la depresión de posparto.
- Tratar a las mujeres con enfermedades mentales durante el embarazo aumenta sus habilidades para sobrellevar el embarazo y el período de posparto.
- Los trastornos del estado de ánimo no tratados pueden afectar la relación entre la madre e hijo y la capacidad de la madre como padre durante el período de posparto.



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- Una mujer con enfermedades mentales no tratadas durante el período de posparto puede minimizar sus interacciones con su bebé por temor a dañar al bebé. El tratar a la mujer lo antes posible puede ayudar a normalizar sus temores, aumentar sus interacciones con el niño y por lo tanto promover la creación de lazos entre la madre e hijo.

### **Alcance**

Algunas veces es difícil para las mujeres pedir ayuda porque les da miedo ser malinterpretadas. La mayoría del tiempo, es la falta de educación y de comprensión acerca de la angustia emocional del embarazo y del período de posparto que puede causar malos entendidos.

En los últimos años se han estudiado más los problemas emocionales durante el embarazo y los trastornos emocionales del posparto. Esta hoja de datos es parte de un documento que informa a doctores, enfermeras, parteras, trabajadoras sociales y personal relacionado con la salud mental acerca de la identificación temprana, evaluación, opciones de tratamiento y seguimiento de mujeres embarazadas y con posparto que tienen trastornos del estado de ánimo.

La páginas Web del Programa de salud mental reproductiva de Columbia Británica (*BC Reproductive Mental Health Program*) es : [www.bcrmh.com](http://www.bcrmh.com) .

**Diríjase a la página Web de Salud mental reproductiva (*Reproductive Mental Health*) para más información acerca de los trastornos del estado ánimo y opciones de tratamiento tales como terapia de luz y lo último en medicamentos durante el embarazo y durante el amamantamiento.**  
[www.bcwomens.ca](http://www.bcwomens.ca) .

**El Programa de cuidado autónomo para mujeres con depresión de posparto y ansiedad (*Self-Care Program for women with Postpartum Depression and Anxiety*)** está disponible en línea en [www.bcrmh.com](http://www.bcrmh.com) / [www.bcwomens.ca](http://www.bcwomens.ca)  
o llame al 604-875-2424 Local 7644  
Puede comprar una copia impresa al costo.



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# Sự lành-mạnh về tình-cảm trong thời-gian mang thai và thời-gian sau khi sanh

## Thông-tin cho các phụ-nữ và gia-đình của họ

### **Trước khi sanh**

Trong giai-đoạn đang mang thai thì thân-thể, tâm-trí và tâm-linh của một phụ-nữ trải qua những sự thay-đổi lớn-lao. Một vài phụ-nữ đang mang thai gặp khó-khăn trong việc đối-phó với sự mang thai, và họ tìm-kiếm những sự hỗ-trợ từ bạn-bè, các y-tá, những nhóm trong láng-giềng, và từ các bác-sĩ gia-đình. Tuy-nhiên, nhiều phụ-nữ khác có thể gặp phải một số những sự rối-loạn cảm-xúc khác nhau, chẳng hạn như bệnh rối-loạn lo-lắng, suy-nhuộc tâm-thần, và bệnh rối-loạn đột-hứng ám-ảnh.

**Có 10% đến 16% số phụ nữ mang thai bị bệnh suy-nhuộc tâm-thần.  
Có 2% đến 4% phụ-nữ mang thai kinh-nghiệm bệnh rối-loạn lo-lắng hay mắc phải bệnh rối loạn hốt-hoảng.**

Những sự rối-loạn cảm-xúc và lo-lắng này khó nhận-diện được hơn khi chúng đang ở trong giai-đoạn tam-cá-nguyệt thứ nhất và thứ ba của thời-kỳ mang thai, bởi vì một số lớn chúng rất giống như những triệu-chứng mà đa-số phụ-nữ mang thai trải qua. Trong giai-đoạn tam-cá-nguyệt thứ nhì thì những triệu-chứng này dễ nhận biết hơn, vì phần lớn các phụ-nữ vui hưởng giai-đoạn này khi họ bắt đầu cảm thấy em bé cử-động. Dầu vậy, những phụ-nữ nào bị suy-nhuộc tâm-thần có thể trải qua sự buồn-bã mệnh-mang, có cảm-giác tuyệt-vọng, có những lần bất khốc, và đôi-khi có những ý-tưởng tự-tử trong những trường-hợp nặng. Những phụ-nữ nào có sự rối-loạn cảm-xúc trong thời-kỳ tam-cá-nguyệt thứ ba khi mang thai thì có độ rủi-ro cao là sẽ có bệnh rối-loạn cảm-xúc trong giai-đoạn hậu-sản.

**Có độ khoảng 30% phụ-nữ mà trong quá-khứ có bệnh suy-nhuộc tâm-thần trước khi thụ thai thì sẽ phát ra bệnh suy-nhuộc tâm-thần hậu-sản.**

### **Bệnh lo-lắng**

Những sự khó-khăn được kể ra thường thấy nhất gồm

- bồn-chồn, lo-lắng
- rối-loạn giấc ngủ và khẩu-vị
- lo-lắng quá-đáng cho em bé
- kém tập-trung, bi lộn-xộn & mất trí-nhớ
- khóc-lóc không kèm-chế được & bực-bội.

Những cơn hoảng-hốt có thể xảy ra.

### **Suy-nhuộc tâm-thần (trầm-cảm)**

Những điều này có thể bao gồm một số những triệu-chứng đã được kể ra trong bệnh lo-lắng và cùng với

- sự dờ-đẫn, mệt-mỏi, kiệt-sức
- buồn-bã, tuyệt-vọng, và/hoặc là khóc-lóc không kèm-chế được
- quan-tâm quá-đáng hoặc thiếu sự chú-ý đến em bé
- có cảm-giác có tội, kém-cỏi, hoặc không có giá-trị
- thiếu sự thích-thú về tình-dục.



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### *Bệnh rối-loạn đột-hứng ám-ảnh*

Bệnh này xảy ra trong vòng từ 2 đến 3% tổng-số phụ nữ mới làm mẹ, và có thể bao gồm những phản-ứng lo-lắng và suy-nhuộc tâm-thần kèm theo một nỗi sợ-hãi sâu-xa là họ sẽ mất sự kiểm-soát, và cảm-giác làm hại em bé của họ. Tiêu-biểu là phụ-nữ thường có những ý-nghĩ không mong-đợi về những điều gì có thể làm hại em bé. Các cuộc nghiên-cứu cho thấy rằng cho đến chừng nào mà người mẹ còn bị ý-tưởng muốn hại con của bà xua đuổi, thì bà tuyệt-đối không để gì làm theo những tư-tưởng của mình. Tuy vậy, sự sợ-hãi của người mẹ có thể giới-hạn sự giao-tiếp của bà với em bé, và có thể gây trở-ngại trong sự gắn-bó.

### *Sau khi sanh*

Sau khi sanh-nở, người mẹ thường có một số cảm-giác lẫn-lộn. Cảm-giác hân-hoan nhẹ-nhõm vì sự sanh nở đã xong-xuôi có thể pha trộn với sự bất-an, bất-măn, và lo-lắng. Những sự thay-đổi trong cơ-thể người mẹ bao gồm cả sự lên xuống của các chất kính-thích-tổ là một phần của sự điều-chỉnh tinh-cảm của bà. Công-việc chăm-sóc cho em bé là một công-việc nặng-nhọc, và các bà đôi khi kinh-nghiệm những sự "lên xuống" trong năm thứ nhất. Nếu người mẹ có sự hỗ-trợ liên-tục của người trong gia-đình và của bạn-bè thì điều ấy thật là có ích trong khi người mẹ tập làm quen với vai trò mới và là một vai-trò rất quan-trọng của mình. Những phụ-nữ mới làm mẹ đặc-biệt là cần những bà mẹ khác để giúp họ thích-hợp với cuộc sống mới. Tuy-nhiên, đôi khi người mẹ trải qua những cảm-xúc kỳ-quặc đến độ gây ra những sự quan-tâm đáng kể. Những cảm-xúc này có thể phân hạng thành hai loại chính:

- "những cơn buồn em bé"
- những sự rối-loạn cảm-xúc hậu-sản

### *"Những cơn buồn em bé"*

Những "cơn buồn" xảy ra cho khoảng từ 70 đến 80 phần trăm tổng-số các bà mẹ. Sự việc này thường xuất-hiện đột-ngột trong thời-gian vài ngày đầu sau khi sanh, và thường tự biến mất đi trong vòng từ một đến hai tuần-lẽ; và thường bác-sĩ không điều-trị việc này. Những triệu-chứng bao gồm: khóc-lóc luôn, bực-dộc, bồn-chồn, và lo-lắng.

### *Những sự rối-loạn cảm-xúc hậu-sản*

Từ-ngữ "suy-nhuộc tâm-thần hậu-sản" đã được dùng trong nhiều năm qua để mô-tả một số những vấn-đề khó-khăn khác nhau, mà hiện-tại người ta dùng nhiều tên khác để gọi, chẳng hạn như sự rối-loạn cảm-xúc, trở-ngại về thích-ứng, hay là những phản-ứng chuyên-biệt như phản-ứng lo-lắng, phản-ứng suy-nhuộc tâm-thần, phản-ứng ám-ảnh/đột-hứng, hay loạn tâm-thần hậu-sản. Những phản-ứng của mỗi phụ-nữ đều có nét đặc-thù riêng, bởi vì có thể bà ta đang trải qua sự tổng-hợp của nhiều phản-ứng.

Có khoảng từ 12 đến 16% phụ-nữ trải qua sự suy-nhuộc tâm-thần hậu-sản

Có đến 26% số người mẹ tuổi thiếu-niên trải qua sự suy-nhuộc tâm-thần hậu-sản

### *Loạn tâm-thần hậu-sản*

Bệnh này là sự xáo-trộn hậu-sản ít thấy nhất, và trầm-trọng nhất. Có một trong số 1,000 phụ-nữ trải qua sự loạn tâm-thần hậu-sản, thường là trong khoảng thời-gian hai tuần lễ đầu-tiên sau khi sanh em bé của họ. Các triệu-chứng đều nặng và có thể bao gồm chứng mất ngủ, bực-bội, ảo-giác, những sự cảm-nhận và cư-xử kỳ-quặc cho thấy có sự mất liên-lạc với thực-tế. Những phụ-nữ đang trải qua những triệu-chứng này thì ở trong sự rủi-ro làm hại chính họ, hay hại em bé của họ. Đây là chuyện khẩn-cấp về tâm-thần, và người mẹ cần được cho nhập bệnh-viện ngay tức thì.

**Những phụ-nữ đang trải qua sự rối-loạn cảm-xúc cần được cho biết là không phải chỉ có mình họ mắc phải**

**Những lý-do tại sao phụ-nữ bị rối-loạn cảm-xúc nên tìm-kiếm sự điều-trị trong khi mang thai hay sau khi sanh:**

- Một phụ-nữ khi mang thai, có bệnh suy-nhuộc tâm-thần hay bệnh lo-lắng mà không chữa-trị thì độ rủi-ro cao hơn là họ sẽ phát ra bệnh suy-nhuộc tâm-thần hậu-sản.
- Điều-trị những phụ-nữ có bệnh tâm-thần trong lúc họ mang thai gia-tăng kỹ-năng đối-phó của họ trong giai-đoạn mang thai và trong giai-đoạn hậu-sản.
- Những sự xáo-trộn cảm-xúc mà không được chữa-trị có thể ảnh-hưởng đến mối liên-hệ mẹ con, và đến khả-năng làm mẹ của người phụ-nữ trong giai-đoạn hậu-sản.
- Một phụ-nữ có bệnh tâm-thần trong thời-gian hậu-sản mà không được điều-trị có thể giảm-thiểu sự giao-tiếp của bà với em bé vì sợ rằng sẽ có thể làm hại em. Khi điều-trị người mẹ tức-thời thì có thể giúp bà bình-thường-hóa sự sợ-hãi của mình, gia-tăng sự giao-tiếp với em bé, và nhờ thế cổ-động cho sự gắn-bó giữa mẹ và con.



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## **Đến với họ**

Đôi khi thật là khó cho phụ-nữ để cầu xin sự giúp-đỡ bởi vì họ sợ bị hiểu lầm. Trong phần lớn các lần thì chính sự thiếu giáo-dục và hiểu-biết về những khó-khẩn tình-cảm trong thời-gian mang thai và trong thời-gian hậu-sản đã gây ra những sự hiểu lầm.

Trong những năm gần đây những vấn-đề tình-cảm trong thời-gian mang thai và những sự rối-loạn cảm-xúc hậu-sản đã và đang được nghiên-cứu kỹ-lưỡng hơn. Bản dữ-kiện này là một phần trong tập tài-liệu thông-báo cho bác-sĩ, y-tá, các bà mẹ, viện-chức xã-hội và những người chăm-sóc y-tế về sự sớm nhận-diện, thăm-định, và những phương-cách điều-trị cùng sự tiếp-tục theo-dõi tình-trạng của những phụ-nữ có bệnh rối-loạn cảm-xúc khi họ mang thai và sau khi sanh.

Trang mạng-lưới của Chương-trình Y-tế Tâm-thần để tái kết-quả của tỉnh BC: [www.bcrmh.com](http://www.bcrmh.com)

***Xin bạn móc nối vào trang mạng lưới Y-tế tâm-thần tái-kết-quả để biết thêm chi-tiết về bệnh rối-loạn cảm-xúc cùng những phương-cách điều-trị chẳng hạn như trị-liệu ánh-sáng, và để biết những tin mới nhất về sự xử-dụng thuốc trong thời-gian mang thai và trong lúc cho con bú sữa mẹ. [www.bcrmh.com/www.bcwomens.ca](http://www.bcrmh.com/www.bcwomens.ca).***

**Chương-trình tự chăm-sóc dành cho phụ-nữ có bệnh suy-nhược tâm-thần và bệnh lo-lắng trong thời-gian sau khi sanh** thì có sẵn trên mạng lưới tại trang [www.bcrmh.com/www.womens.ca](http://www.bcrmh.com/www.womens.ca), hay bạn có thể gọi điện-thoại số 604-875-2424, dây nhánh số 7644

Nếu bạn muốn có bản in, xin bạn đặt mua.



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### RESOURCES AND REFERENCES: WOMEN'S MENTAL HEALTH

Provincial Reproductive Mental Health Program

BC Women's Hospital & St. Paul's Hospital,  
H214 - 4500 Oak St, Vancouver, BC, V6H 3N1  
Tel: 1-604-875-2025 or 1-604-806-8589 Fax: 1-604-875-3115

Best Practice Guidelines relating to Reproductive Mental Health: Principles for Early Identification, Assessment, Treatment and Follow-up of Women with Mental Illness during the Perinatal Period. January 2003. Available on line at [www.bcrmh.com](http://www.bcrmh.com)

Self-Care Program for Women with postpartum depression and anxiety September 2004. D. Bodnar, Dr. Ryan & Jules Smith from the BC Reproductive Mental Health Program. Available online @ [www.bcrmh.com](http://www.bcrmh.com) or a hard copy can be purchased at cost through the Family Resource Library call (604) 875-2424 Local 7644.

Postpartum Depression and Anxiety: A self-help guide for mothers available through the Pacific Post Partum Support Society, Tel: (604) 255-7999 Fax: (604) 255-7588.

SRI Use in Pregnancy: A Guide for the Care of Women and their Infants. Available from the Provincial Reproductive Mental Health Program. BC Women's Hospital & St. Paul's Hospital, H214 - 4500 Oak St, Vancouver, BC, V6H 3N1.  
Tel: 1-604-875-2025 or 1-604-806-8589 Fax: 1-604-875-3115

#### Web

[www.bcrmh.com](http://www.bcrmh.com) / [www.bcwomens.ca](http://www.bcwomens.ca): Provincial Reproductive Mental Health Program  
[www.postpartum.org](http://www.postpartum.org): Pacific Postpartum Support Society  
[www.crisiscentre.bc.ca](http://www.crisiscentre.bc.ca): Crisis Centre for Greater Vancouver  
[www.camh.net/](http://www.camh.net/) Centre for Addiction and Mental Health  
[www.nida.nih.gov/](http://www.nida.nih.gov/) National Institute of Drug Abuse (NIDA)  
[www.niaaa.nih.gov/](http://www.niaaa.nih.gov/) National Institute on Alcohol Abuse and Alcoholism

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# APPENDIX 3 MEDICAL SERVICE PLAN (MSP) DIAGNOSTIC CODES





# APPENDIX 3: MEDICAL SERVICE PLAN (MSP) DIAGNOSTIC CODES

## MSP Diagnostic Codes

	DESCRIPTION	ICD 9 CODE
<b>PSYCHOSIS</b>		
	Paranoia	2971
	Acute paranoid reaction	2983
	Psychogenic paranoid psychosis	2984
	Simple type	2950
	Hebephrenic type	2951
	Catatonic type	2952
	Paranoid type	2953
	Acute schizophrenic episode	2954
	Latent schizophrenia	2955
	Residual schizophrenia	2956
	Schizoaffective type	2957
	Other	2958
	Unspecified	2959
	Induced psychosis	2973
	Other	2978
	Unspecified	2979
	Depressive type	2980
	Other and unspecified reactive psychosis	2988
	Unspecified psychosis	2989
	Disintegrative psychosis	2991
	Other	2998
<b>ANXIETY</b>		
	Neurotic disorders	3000
	Blindness, hysterical	3001
	Hysteria	3001
	Phobic state	3002
	Obsessive-compulsive disorders	3003
	Neurotic depression	3004
	Neurasthenia	3005
	Depersonalization syndrome	3006
	Hypochondriasis	3007
	Other neurotic disorders	3008
	Unspecified	3009
	Gastrointestinal	3064
	Genitourinary	3065
	Other	3068
	Unspecified	3069

## MSP Diagnostic Codes

	DESCRIPTION	ICD 9 CODE
<b>DEPRESSION</b>		
	Depressive disorder not otherwise classified	311
<b>SUBSTANCE USE DISORDER</b>		
	Alcohol dependence syndrome	303
	Alcohol dependence syndrome	3040
	Barbiturate type	3041
	Cocaine	3042
	Cannabis	3043
	Amphetamine type and other Psychostimulants	3044
	Hallucinogens	3045
	Other	3046
	Unspecified	3049
	Alcohol	3050
	Tobacco	3051
	Cannabis	3052
	Hallucinogens	3053
	Barbiturates and tranquilizers	3054
	Morphine type	3055
	Cocaine type	3056
	Amphetamine type	3057
	Other, mixed or unspecified	3059



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