

Training Module for Individuals Caring

for

Earth quake Survivors:

Section –I: Roles and responsibilities of Care providers

Introduction :

Although there are no reliable data on numbers of people with mental health problems in the earth quake affected districts , the following rule-of-thumb provides estimates to the likely size of the problem. These estimates give a very rough indication what we can expect as the extent of morbidity and distress to be. We are likely to see 3 groups each requiring a different response:

1. People with mild psychological distress that resolves within a few days or weeks

A very rough estimate would be that perhaps 20-40% of the quake -affected population falls in this group. These people only basic psychological first aid .

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

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

3. People with mental disorders

Mild and moderate mental disorder. In general populations, 12-month prevalence rates of mild and moderate common mental disorders (e.g., mild and moderate depression and anxiety disorders, including PTSD) are on average about 10% in countries across the world (World Mental Health Survey 2000 data). This rate is likely to rise - possibly to 20% - after exposure to severe trauma and resource loss.

Over a number of years, through natural recovery, rates may go down and settle at a lower rate, possibly at 15% in severely affected areas.

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

A misconception is that PTSD is the main or most important mental disorder resulting from disaster.

PTSD is only one of a range of (frequently co-morbid) common mental disorders (mood and anxiety disorders), which tend to make up the mild and moderate mental disorders, and which become more prevalent after disaster. The low-level of help-seeking behaviour for PTSD symptoms in many non-western cultures suggests that PTSD is not the focus of many trauma survivors. Consequently, we need to guard against over-emphasizing PTSD and creating narrowly defined, vertical (stand-alone) services that do not serve people with other mental problems. This way of working could waste precious resources.

Severe mental disorder. Severe mental disorder that tends to severely disable daily functioning (psychosis, severe depression, severely disabling anxiety, severe substance abuse, etc.) is approx. 2-3% in general populations of countries across the world (World Mental Health Survey 2000 data). People with these disorders may experience inability to undertake life-sustaining care (of self or of their children); incapacitating distress; or social unmanageability. The 2-3% rate may be expected to go-up (e.g. to roughly 3-4%) after exposure to severe trauma and loss. Trauma and loss (a) may exacerbate previous mental illness (e.g., it may turn moderate depression into severe depression), and (b) may cause a severe form of trauma-induced common mental disorder in some people. The destruction of the earthquake has caused distress (traumatic stress, loss-related stress, etc.) in the majority of the population. Yet, according to WHO estimates we can expect the increase in mental disorder to be about 5-10% across all mental disorders. This implies that:

We need to urgently make available mental health care interventions in the health sector. Social and basic psychological interventions should be made available to the population-at-large in the community through a variety of sectors in addition to the health sector. Such interventions may (a) address widespread psychological distress in people without disorders and (b) provide some support to those people with mental disorders who do not seek help within the health sector.

Examples of social intervention with significant psychological impact would be:

- (Re)starting schooling
- Family reunification programs
- Economic development initiatives, like reconstruction of infrastructure providing employment preferentially to the local population.

Summary table on psychosocial/mental health assistance to earthquake-affected populations: WHO projections and recommendations.

Description	BEFORE DISASTER: 12-month prevalence rates (median of World Mental Health Survey 2000 data across countries)	AFTER DISASTER: 12-month prevalence rates (projected)	Type of aid recommended	Sector/agency expertise
Severe disorder (e.g., psychosis, severe depression, severely disabling form of anxiety disorder, etc)	2-3%	3-4%	Make mental health care available through general health services and in community mental health services	Health sector (with WHO assistance)
Mild or moderate mental disorder (e.g., mild and moderate forms of depression and anxiety disorders, including of PTSD)	10%	20% (which over the years reduces to 15% through natural recovery without intervention)	1) Make mental health care available through general health services and in community mental health services. 2) Make social interventions and basic psychological support interventions available in the community	1) Health sector (with WHO assistance) 2) A variety of sectors
Moderate or severe psychological distress that does not meet criteria for disorder, that resolves over time or mild distress that does not resolve over time	No estimate	30-50% (which over the years will reduce to an unknown extent through natural recovery without intervention)	Make social interventions and basic psychological support interventions available in the community	A variety of sectors
Mild psychological distress, which resolves over time	No estimate	20-40% (which will over the years increase as people with severe problems recover)	Basic psychological support	A variety of sectors

Aims of the Manual:

- Enable you to understand the psychosocial aspects of recent earthquake in the effected population.
- To help train you in providing basic psychosocial support to the population effected
- To help train you in identifying and appropriately referring individuals requiring specialist care.

Learning Objectives:

By the end of the training sessions you should feel able to :

1. Provide Psychosocial intervention for individual survivors and families who require it
2. Identify people at risk to develop psychological disorders in the future
3. Support the rescue workers, relief personnel and volunteers
4. Educate the community and groups within the community
5. Promote resilience and recovery in individuals and the community by
 - a. Providing education and information
 - b. Using coping skills training
 - c. Group and family support
 - d. Help arrange spiritual support
6. Integrate mental health services into “the bigger picture
7. Educate government personnel, administrators and people responsible for making relief decisions about mental health considerations of the relief process.
8. Understand methods to take care of your own emotional well being

Roles And responsibilities

Preparation for starting work with the effected population:

Before commencing work you need to make some preparation to help you function effectively :

- **Establish contact** with the relief/ reconstruction coordinator in your area and explain the work you will be doing
- **Explain the work** you will be doing to the community leaders of the area
- **Collect from these sources the information** about the location of contact numbers and facilities available at the health facilities, the major relief agencies and help they can offer operating in your locality. **Establish and maintain regular contact with them**
- **Carry out psychosocial support activities integrated** within the broad framework of ongoing relief, reconstruction and rehabilitation efforts.
- **Maintain regular liaison** with your designated mental health relief centre.

Key Characteristics and Helping Behaviors

- Openness To Experience
 - Nonjudgmental acceptance of people & responses
 - Curiosity
 - Comfortable with lack of structure
- Sociability
 - Outgoing
 - Approachable- people feel comfortable approaching you
 - See the best in others during the worst situations
 - Tact and discretion
- Calmness
 - Can stay calm in very difficult situations
 - Can be patient and compassionate with people who are very angry, anxious, or depressed
- System Savvy
 - Have practical information and knowledge of the resources that are available
 - Understands the overall “system”
- Patience
- Caring, Kindness
- Basic counseling skills: (see module on Basic skills for More details)
 - Empathy
 - Genuineness/Sincerity
 - Positive Regard
 - Respect
 - Active Listening Skills
 - Attentive listening
 - Reflection of feelings
 - Summarizing
 - Reassurance
 - Collaborative problem solving

Remember

- Many emotional reactions of disaster survivors stem from *problems of living* caused by this earthquake. For example, n, They have lost family members ,they are not able to go to work, or they have lost their home. Most people do not see themselves as needing mental health services following disaster, and will not seek out such services.
- Survivors may reject assistance of all types.
- Most people do not know about stress and trauma. Educating people is an important mental health function
- Survivors respond to active interest and concern.
- Support systems are crucial to recovery. Helping to rebuild support systems is a vital mental health intervention

Core Guidelines For Care Providers

Guideline #1: Normalize

Assume the emotional responses you see are normal

Guideline #2: Practical Assistance

Disaster mental health assistance is often more "practical" than "psychological" in nature..

Guideline #3: Integrate & Cooperate

Integrate mental health assistance into overall relief programs.

Guideline #4: Community Approach

Mental health efforts must be guided by the principles of psychosocial rehabilitation (PSR). This has two components:

1. Each survivor needs
 - social networks
 - Engaging in meaningful activity
 - i. Work
 - ii. Other activities.
2. The community is in need as a whole.
 - a. In order to heal, people need social support which comes from their natural networks of family, friends, and neighbors. Therefore Care providers Need To:
 - ✓ Set Aside Traditional Methods,
 - ✓ Avoid The Use Of Mental Labels, And
 - ✓ Use An Active Outreach Approach.

The traditional, hospital-based or clinic-based approach is of little use in disaster.

Section –II: Psychological Reactions And Intervention For Earthquake Survivors

Psychological Responses of Disaster effected Population:

I. Emergency Phase :

The recent earthquake has not only caused wide spread physical destruction but has also resulted in a major psychological impact on the population . These reaction can be understood in the context of the following psychosocial factors :

- Severe stress experienced due to the earthquake;
- Sudden forced displacement.
- Difficulties of living in the tents and temporary often dangerous or extremely basic accommodations.
- Uncertainty about the future
- disorganization of the community
- Single parent families, Widows, parent les children
- Discontinuity in education.
- Loss of employment
- Loss of life routines,
- Homelessness,
- Process of rebuilding personal, family and community life

Normal Responses Seen In survivors of Earthquake

Emotional Effects

- ✓ Shock
- ✓ Anger
- ✓ Despair
- ✓ Emotional numbing**
- ✓ Terror, continuing fear
 - Guilt**
- ✓ Survivor Shame
- ✓ Grief or sadness
- ✓ Hopelessness
- ✓ Irritability
- ✓ Helplessness
- ✓ Loss of pleasure from regular activities
- ✓ Dissociation: person's experience does not seem real to them (e.g., "dreamlike,")

Cognitive Effects

- ✓ Impaired concentration
- ✓ Impaired decision-making ability
- ✓ Memory impairment
- ✓ Disbelief
- ✓ Confusion
- ✓ Distortion
- ✓ Decreased self-esteem
- ✓ Decreased self-efficacy
- ✓ Self-blame
- ✓ Worry
- ✓ Intrusive thoughts and memories**
 - "Flashbacks"
 - Nightmares
 - Recurring thoughts and memories

Physical Effects

- ✓ Fatigue
- ✓ Insomnia
- ✓ Sleep disturbance
- ✓ Hyperarousal**
- ✓ Somatic complaints ('aches and pains')
- ✓ Impaired immune response
- ✓ Headaches
- ✓ Gastrointestinal problems
- ✓ Decreased appetite
- ✓ Decreased libido
- ✓ Increased startle response ('jumpy')
- ✓

Interpersonal Effects

- ✓ Alienation
- ✓ Social withdrawal**
- ✓ Increased conflict within relationships
- ✓ Vocational impairment
- ✓ School impairment

Reaction Pattern and Duration

- The most common response is **resiliency**. Most people will have some of the responses listed above. **TIME** is a great healer and in a vast majority of people these reactions will diminish in intensity over time without the need for professional help, but if they persist, professional help will be needed. Support from family and friends is critical..
- your job is to promote this natural resiliency and NOT to give Medical/ Psychiatric labels.
- Stress and affirm that the **NORMALCY** and **UNIVERSALITY** of these reactions.

- **These emotional reactions are normal responses to an abnormal experience**
- **The reactions are common and experienced by everyone**
- **Everybody who experiences a disaster is touched by it**
- **The reactions manifest differently at different periods of time after the earthquake**

Some people will show responses that will not decrease over time. These people may be at risk to develop psychological disorder (such as Acute Stress Disorder, Post Traumatic Stress Disorder, Depression, Substance Abuse, Traumatic Grief, etc)

Some factors that can influence the resolution of emotional reactions are:

- Availability of support.
- Personal losses of the survivor (loss of kith and kin, property, source of livelihood, personal injury).
- Separation from family/primary support group.
- Age.
- Gender.
- Status of the person (single/widowed/married).
- Separation/displacement from locality.
- Pre-disaster mental functioning.

2. Immediate post emergency Phase :

This phase would last for a variable period generally extending from 03- 18 weeks post event. During this phase the above mentioned reactions might persist in a proportion of population and any of the following additional symptoms might appear:

Warning Signs

- Continuous distress without periods of relative calm or rest
- Person is not able to stop thinking about what happened, intense intrusive memories, thoughts and images that are fearfully avoided, deeply upsetting or interfere with sleep;
- numbing, flashbacks, disturbing thoughts/images
- unresponsive/disoriented
- Extreme social withdrawal; always avoiding other people, doesn't want contact
- Excessive smoking , use of tranquilizers or drugs
- Impaired functioning
- Severe hyper-arousal :Inability to relax, inability to sleep, panic episodes, terrifying nightmares, difficulty controlling violent impulses, rage, inability to concentrate
- Severe dissociation ;feeling as if the world is unreal, not feeling connected to one's own body, losing one's sense of identity or taking on a new identity, amnesia, feeling numb
- Disabling anxiety :ruminative worry, severe phobias, unshakeable obsessions, paralyzing nervousness, fear of losing control/going crazy
- Severe depression
- lack of pleasure in life, feelings of worthlessness, self-blame, dependency, sleep disruptions
- Problematic substance use: abuse or dependency, self-medication
- Psychotic symptoms :bizarre thoughts or images BUT be careful in your judgment

These people need some basic psychosocial intervention preferably close to their families and friends (**psychological First Aid**)

PSYCHOLOGICAL FIRST AID:
(Refer to basic Skills module for required skills)

The essential principles of the Psychological First Aid are:

1. To console distress and offer comfort
2. To offer practical help
3. To recognize the abnormality of the experience of the trauma
4. To recognize and respect the normality of the post trauma reaction, whatever that might be.
5. Not to medicalise or pathologise the reaction
6. Not to overwhelm with information
7. To offer a narrative or narratives matched to the individual's experience
8. To provide support that seamlessly merges into existing or professional support networks

STAGES OF PSYCHOLOGICAL FIRST AID

INITIAL STAGE – this could be carried out by the General Practitioner, medical, surgical specialist, Nurse or anyone involved in care

Comfort and console distress

Practical help-- Help provide for physical needs

Support for real world based tasks

Facilitate reunion with loves ones

Protect from further threat and distress

Education on normal responses to trauma – This involves two essential elements:

Recognizing the range of reactions

Respecting and validating the normality of the reaction

MIDDLE STAGE

- (a) Facilitate some telling of the trauma story
- (b) Ventilation of feelings as appropriate
- (c) Link people to systems of support
- (d) Promoting a sense of competence and control

FINAL STAGE

- (a) Identify needs for future intervention

- ***The basic human response is of comforting and consoling a distressed person.***

Offering human comfort and support is the most important component of psychological first aid. Being with those affected, protecting them from further harm, ensuring basic needs are met, conveying compassion and recognition for what they have been through are all very important tasks. Where appropriate do point out that how well they are and have handled themselves in this difficult situation. Do not give simple reassurances to people such as “it is God’s punishment” or “at least you have your children” or “look how others have suffered”. Be sensitive about what you say and what kind of language you use . Remember empathy!!

- ***Providing support for specific, practical tasks.***

Activity during the acute trauma stage can be productive or non-productive. Productive activity is oriented to the reality of the situation and involves the survivor taking an increasing and active role in his or her own return to functioning. As soon as possible disaster survivors should be encouraged to participate in simple but useful tasks. Tasks can become more complex or demanding as time passes ***Assess practical needs. Ask “What do you need?” provide practical help when required Ensure basic physical needs are met***

- ***Protecting the person from further threat or distress as far as is possible.***

Providing a safe environment is critical. Many survivors may have experienced an overwhelming loss of safety and this needs to be restored. Reuniting individuals with family and friends is important to regaining feelings of safety. When reunion is not possible, information about family and friends should be made available, particularly if the family and friends were also in danger or affected by the earthquake. Furthermore protect from curious and intrusive media attention by educating the community and the media.

- ***Provide opportunity to ventilate and Sharing the experience.***

People may wish to share their experience with others, particularly those who have ‘been through it’ with them and also those responding. Such natural talking through of what has happened is often the beginning of a healing process. If it occurs in such natural groups or settings, e.g. a shelter, it should be supported. However, it should not be expected or forced. Do not force people to talk. Listen to what they want to share with you.

- **For those unwilling to talk:**

- Some people may be very angry or remain mute and silent.
- Do not get anxious or feel rejected that they are not communicating. Remain calm; tell them you are here to help them in the best possible way.
- Maintain regular contact and greet them. Ask them about their welfare.
- Try and Share their grief and console them that losing someone dear is terrible and unfortunate.
- Make them understand they are not to blame for the tragedy and need not feel guilty
- Tell them you will return the next day or in a couple of days
- Tell them you are not upset or angry because he/she did not talk

- **Once the person starts talking, maintain a conversation using the following queries:**

- How are you and how are your other family members?
- Tell me about all the losses experienced by you and your family.
- How do you feel about the loss? – What is the personal meaning of loss to you?
- What is the support you received after the event from relatives, friends, relief workers, etc.?
- How have you been recovering? – How are you handling this situation?
- What are the effects of the event on health, like physical problems or problems like aches/pains, decreased sleep, decreased appetite, fear, and loss of interest?

- How do you visualize the future?
- What other help do you require?

- ***Facilitate social support.***

Provide or obtain company for people, preferably family or known people. Pay careful attention to the elderly, people who have lost family members, and orphans. Encourage social support but do not force.

- ***Help the people to regain and increase their sense of dignity and Facilitating the development of feelings of control and mastery***

One of the most important issues throughout all work conducted is human dignity. The loss of family members, personal possessions, contribute to the dehumanization of the disaster experience, the subsequent dependence on others for even the simple basics of everyday life may all be threats to the individual's personal dignity. Trauma survivors frequently experience a sense of helplessness and powerlessness. It is critical to provide an opportunity for the survivor to regain a sense of self-esteem and control over their life. *The survivors must be provided with opportunities to become involved in the relief, and reconstruction activities in order to overcome passivity and prevent the development of dependence on others.*

- **Support people in solving or handling problems.** Use problem-solving techniques. (see basic skills module)

- **Plan for the future:**

Screening people while we are talking to them
Need to identify people having more severe responses or vulnerable individuals. ***Connect the person to systems of support and sources of help that will be ongoing.*** It will be important to link survivors to organizations and services that will take over after the acute phase has passed and provide follow-up and assistance to those in need.

Psychological first aid can be summarized by the Acronym

- **P-D-C-A/P**

Protect

Direct

Connect

Assess/Prioritize

- **Educate & Consult**

Protect

- Help in Making sure survivors are safe and not exposed to more trauma
- Provide psychological Support
- Help Protect survivors from curious onlookers and from media exploitation

Direct

- Help survivors get accurate information about available resources and what to do next .
- Provide practical assistance in trying to restore normal routine Help with practical, everyday needs.

Focus is on helping meet basic needs: Safety, security, and basic needs (food, shelter, medical care, money, work, stability) are the essential foundation for emotional stability and recovery. ***Helping people achieve these needs is a psychological intervention!***

- Help Access to resources (medical, social, financial, work, etc)

Connect

- Help people start to reconnect to family, friends, resources (Effectively use services like provided by telephone companies, transport coming or going from your area, helicopter services etc)
- Provide supportive contact
- Help rebuild damaged social networks through helping communities identify and execute shared goals e.g. caring for parentless children , starting schools for children by teachers from among the survivors, taking care of needs of the disabled etc

Assess/ Prioritize

- Identify individuals & prioritize
Identify people at **increased risk** of developing psychiatric problems
- Link these people with appropriate resources for management and support. e.g. through referring them to mental health professionals for **screening ,clinical review and comprehensive mental health assessment .**

Educate & Consult

Focus on education and providing useful information

- Share accurate information about human responses to disaster with survivors, professionals, and administrators
- Educate your colleagues

General Psychosocial support Measures For ALL Members Of The Community

- Participate in relief and recovery efforts in your area as much as possible
- Discuss and decide about your needs as a group
- Help each other get what they need by sharing / pooling of resources available in your area like tents, blankets, food etc.
- Arrange social and religious gathering in your locality including offering prayers collectively for the dead, collaborate and work closely with area leaders / elders
- Discuss and share your feelings and thoughts of the experience with your friends, neighbors and family members
- Act with tolerance and forbearance with each others.
- Keep your families together as much as possible.
- Spend time with your children.
- Arrange for children's education to restart .
- Try and get back to rebuilding your locality and infrastructure to generate work for locals and development of a daily routines as soon as possible
- Avoid smoking, drugs and excessive intake of Tea etc

ALL the above activities promote natural resilience and would help people to take control of their lives rather than being dependant on outside help only.

Section III: Identification and referral of cases requiring specialist care

Some individuals will require evaluation and treatment by a mental health professional

(Psychiatrist or clinical psychologist) as the simple counseling skill described in the previous section will not be enough to help these individuals. It is important to learn to identify the common signs and symptoms of mental disorders so that they can be referred to specialist available in the area.

- (1) Previously known cases of mental disorders:** As mentioned in the beginning of this module, some disaster-affected people are likely to be suffering from mental disorder prior to the disaster. You may find exacerbation/relapse in symptoms of known cases of mental illnesses (e.g. psychoses, depression). Similarly, you may find a relapse in patients suffering from epilepsy due to discontinuation of antiepileptic medication during this period. Ask all the families in your area if there are any known cases of epilepsy or psychoses and ensure the continuation/restarting of the treatment of these cases through proper referral.

- (2) Individuals who continue to report/develop significant psychological symptoms after three weeks and which do not reduce after intervention by care providers:** As mentioned above some individuals may develop mental disorders after a disaster and may have significant ongoing distressing and disabling symptoms, which do not remit over time and do not improve despite intervention by you. Such people should be referred to a doctor or a mental health professional.

- (3) Individuals who are grossly dysfunctional** in activities of daily living based on the following observation:
 - Remaining isolated and inactive
 - Extremely poor self-care
 - Loss of sense of responsibility for self and other

- (4) Suicidal ideation/intent**

People who talk about committing suicide or have attempted suicide should be immediately identified and referred to a mental health professional. Community members should be able to identify such persons. Such persons should never be left alone.

(5) Withdrawal symptoms or increased consumption of Drugs including Sedatives: whenever you come across somebody complaining of severe body aches, restlessness, insomnia, muscle cramps, running nose and excessive watering of eyes or tremors, restlessness, insomnia, anxiety, and craving for drugs ask him to see a mental health specialist

if you find excessive drowsiness, slurring speech, unstable gait or disorientation in somebody, ask if he has increased his consumption of drugs. If yes, ask him to see mental health specialist.

(6) Physical violence in the family

Violence within the family usually perpetuated by the man against women and children or by the women against children may be an indirect indicator of a mental disorder. Sometime this physical violence may be related to drug abuse.

Such persons also need referral to the specialist for evaluation and treatment.

Psychological Disorders That Can Result From Traumatic Stress

Some people who experience disaster and trauma will develop psychological disorders. It is difficult to predict how many. This will be a minority of the affected population, not the majority.

Remember that during the emergency and post-impact phases, many people will show resiliency and recover naturally with social support. During this period, mental health professionals must use caution in diagnosis.

One informal rule is that, for most people, the impact of resiliency or natural healing should be seen within the first three months following the disaster. However as mentioned earlier a proportion of survivors will develop psychological disorders. The most commonly seen ones are :

- Acute Stress Disorder (ASD)
- Traumatic Grief
- Post Traumatic Stress Disorder (PTSD)
- Substance Abuse or Substance Dependence
- Major Depression
- Panic Disorder
- Generalized Anxiety Disorder
- Psychosomatic illness
- Brief Psychotic Episode
- Emotional or Behavioural Disorder (in children)

Acute stress reaction

A reaction that develops in an individual without any other apparent mental disorder solely in response to the disaster and that, in most cases, subsides within hours or days. The symptoms show a typically mixed and changing picture and include an initial state of “daze” with some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli, and disorientation. This state may be followed either by further withdrawal from the surrounding situation (to the extent of a stupor), or by agitation and over- reactivity.

Bereavement and grief

Grief refers to “the feelings and behaviors such as sadness, distress, anger, crying, etc., accompanying the awareness of irrevocable loss (not necessarily but including loss through death)”. The term bereavement is used when the loss is because of death. Following disasters there maybe grief for loss of loved one, home, valued possessions, livelihood, etc. Factors influencing the manifestation of grief include the individual’s personality, previous life experiences, past history of psychological problems, the significance of the loss, the existing social network and presence of other stressors. Usually grief reactions diminish in their intensity, gradually over a period of 4 to 6 weeks after the disaster. But, for some persons, grief may become complicated or chronic and may lead to severe depression. There may be recurrences at the time of anniversaries of these events.

Depression and Anxiety

Some mental disorders may occur following exposure to disaster. These include anxiety and depressive disorders. These are the most common disorders but others like adjustment disorders (with anxiety and/or depressive symptoms), somatoform disorders (physical symptoms due to stress) can also be seen. Depressive disorders are characterized by continuous sadness, lack of interest in work, socialization and leisure time activities, pessimistic thoughts, easy fatigability, crying, lower self esteem and decreased sleep.

Anxiety disorders are characterized by undue anxiety over trivial matters, restlessness, irritability, inability to concentrate, body-aches, palpitation, dryness of mouth and disturbed sleep. You may notice that some of the psychological responses listed at the beginning of this module can persist or appear as symptoms of depressive disorders and anxiety disorders as mentioned here. It is important to note that a group of symptoms is considered a mental disorder only when the symptoms are severe enough to cause significant distress and/or impairment in social, occupational, and other important areas of functioning.

Drug abuse

There may be increased use of sedatives/ tranquilizers and/or other addictive substances resulting in substance use related problems.

Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) is characterized by symptoms similar to acute stress disorder but lasting for more than one month. PTSD may begin several weeks or months after exposure to the disaster and if untreated, may run a protracted course, although many people recover over time without any intervention. The symptoms of PTSD can be characterized in three dimensions: (i) re-experiencing the trauma (ii) avoiding stimuli associated with the trauma and (iii) experiencing the symptoms of increased autonomic such as difficulty in falling or staying asleep, irritability or outbursts of anger, difficulty in concentrating, hyper vigilance and exaggerated startle response. It should be noted that persons experiencing minor symptoms of anxiety, nervousness or sadness should not be labeled as suffering from post-traumatic stress disorder. Because a disorder requires treatment by a doctor often with medication: for minor symptoms. Treating large numbers of patients for minor symptoms is inappropriate.

Psychosomatic illness

Some people undergoing psychosocial trauma may complain of physical symptoms such as headaches, tiredness and palpitations, loss of appetite, pain in abdomen, nausea or unidentifiable pain all over the body. It is important to recognize the psychological nature of these symptoms and manage these as a sign of emotional distress. However since it is not necessary that physical symptoms are due to psychological trauma, refer the individual to a physician whenever you think there is a possibility of symptoms being caused by physical illness, or if the symptoms are not responding to psychosocial intervention.

Section IV-Community Interventions- Promoting Community Self Help

Interventions with Communities

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

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

Helping the community heal is a foundation for mental health prevention and promotion

Community Interventions

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

❖ Identify leaders who:

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

o With their help organize Collective grieving to express unity and collective action.

Rituals and Commemorations

Memorial Services(Jumarat, chaliswan)

O Help Keep people in their natural groups if they must be relocated.
(education of administrators and maintaining liaison with them)

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

Help Provide social activities for new communities that form because of displacement. These can be identified following Group meetings in which participants brainstorm about various themes for rebuilding the community, help survivors to recognize the reality of loss, to identify and discuss local problems, and to work together toward an achievable, specific goal.

In Camps or Temporary Shelter

- Encourage people working in the affected areas to involve survivors in the relief and rescue efforts where possible, especially adolescents, orphans, widows, widowers and those without families. **Do not treat people as passive and helpless victims.** This is one of the most disturbing experiences for people who have been displaced or otherwise affected by disasters. **Instead, involve the survivors in concrete, purposeful and common activities**
- 1. Older children can help look after younger siblings and children, or help in the preparation of food for cooking
- 2. Adults can help in preparing, cooking and distributing food, organizing and constructing shelter, documenting information, organizing family tracing, clearing and cleaning spaces for living, providing security for the camp, organizing or supporting health services and healthcare, caring for the sick or teaching children
- 3. Provide opportunities for adults and adolescents with special skills to use their skills as much as possible for the wellbeing and functioning of the camp community and for earning their living, if possible.

Masons, carpenters, teachers, and others should be helped in starting to utilize their areas of expertise.

4. Promote psychological well-being:

Educate about the factors which can help like staying and participating in the activities promoting the welfare of all members rather than individuals, maintaining a strong religious belief .For children having a caring adult to look after them and provide for them.

On-Site Groups

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

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

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

Tips:

- Allow people to speak as they wish- do not force anyone to speak
- Listen to stories without probing
- Allow people to speak to each other, respond to each other, like a normal group discussion
- Support: normalize and validate their experiences
- Educate about normal responses to disasters and extreme stress
- Provide coping suggestions and encourage self care
- Validate feelings of helplessness while encouraging activity
- Highlight universality:
 - When people describe similar experiences, point this out
- Help people to see the shared parts of the experience (at the same time, do not isolate someone with different experience)

- Use the opportunity to identify:
 - People who require more services
 - People who may need follow up
 - People who may be “opinion leaders”

Section V. Special Groups:

Children in the family need special attention

Children do not have the mental or emotional maturity to understand adverse situations like adults. Often they cannot comprehend what has happened to them.

The impact of events like loud noises, shouting, running, panic and anxiety, separation from loved ones, loss of the comfortable environment, etc., affects them more than an adult.

Children Look At Adults

- ☐ After a disaster, children will look to adults as models for guidance and as role models
 - If parents are alarmed and distraught, children may also be alarmed and distraught
 - “If adults are upset, the danger is still REAL!”
 - Adult can reassure children by being:
 - Calm
 - Confident
 - Caring

Children Need Structure and Play

- ☐ Children depend on daily routines
 - Wake up
 - Eat meals
 - Go to school
 - Play with friends
 - Interact with family
 - Go to bed
 -

Children tend to show reactions to stress in the form of :

Pre-school children

- (1) Irritable, crying excessively.
- (2) Clinging behavior.
- (3) Expressing intense fear and insecurity repeatedly, excessively dependent behavior.
- (5) Excessive quietness and withdrawn behavior, avoidance or passive behavior.
- (6) Thumb-sucking, **bedwetting**, excessive temper tantrums etc., (even if the child was not doing so before the disaster).
- (7) Play activities may spontaneously involve aspects of the disaster event.
- (8) Reporting frightening dreams (nightmares and night terrors) waking up frequently from sleep and refusal to go to bed at times.

School going age group

- (1) **Withdrawal**.
- (2) Guilt.
- (3) Feelings of failure.
- (4) Anger, rage and aggressive behaviour.
- (5) **Fearfulness**, anxiety or **suspiciousness**.
- (6) Feeling low, decreased activity and interaction level.
- (7) Feeling nervous, unable to concentrate.
- (8) Recurrent memories or fantasies of the event.
- (9) Fantasies of playing 'rescuer'.
- (10) Intensely preoccupied with details of the event.
- (11) Dangerous, risk-taking behavior, rejecting social rules showing aggressive behavior, (in adolescents only).

(12) Loss of interest in studies, refusal to go to school, significant drop in academic performance.

(13) Psycho-somatic symptoms like stomachache, headache, giddiness, vomiting, heavy breathing and fainting attacks.

You have to take measures to increase feelings of security and bonding. You need to understand that these changes are 'normal' for the situation and take measures to help the child get over his/her stress. Some things you can Advise the family to do are:

- Re-establishing routines like eating, sleeping, going to school
- Giving security by actions like touching, hugging, reassuring them verbally
- Allowing them to talk about the event and listen to them without giving any advice
- Encouraging them to play or offering opportunities for painting and drawing where they can express their emotions. This is very healing
- Story telling, singing songs and games involving physical movement are other things that will help them feel better
- Giving lots of praise and love to them
- Pay more attention and spend time on their studies once they return to school.

When ever you come across children in the field,

- talk to them, reassuring them verbally, using culturally acceptable physical gestures, like patting on the head , ***but be careful about physical contact that it should be misinterpreted***
- ***ask them what they would like and if they wish to talk , Listen attentively***

Honest communication about situation, and real challenges in the future, as well as communication about hope
Activities that are constructive: play or other
Network of supportive people who will help the children
Developmentally-appropriate information and education about the disaster and its effects
Skill development to calm distress by improving coping skills, calming skills, and communications skills

Old people

Old people are often not totally in control of situations. They can take a longer time to recover from the **earthquake**.

- When confronted with the death of many young people in front of them they can become very depressed, they might withdraw and cry.
- They may find it difficult to sleep and lose their appetite and also fall ill.
- At times you may find them agitated
- At other times they would be feeling hopeless and having suicidal tendencies

It is important to take special care of them.

- They need to be near their loved ones and people who can spend time with them. Touching them and allowing them to cry when they feel like it is really beneficial because quite often they talk of their past life.
- Ensure that their physical needs including health needs are being looked after properly

- Keep them informed of the news, developments and activities taking place related to the disaster
- Re-establishing their daily routines, giving them responsibility that they can carry out without too much difficulty and
- enabling them to pray are some things that can help them to feel better.

WORK WITH FAMILIES

In addition to individual specific interventions, the family as a whole can also be helped simultaneously. This depends on the number of individuals surviving in the family. If some family members are present, encourage them to adopt the following activities:

- Share their experience of loss as a family.
- Contact relatives to mobilize support and facilitate recovery.
- Participate in rituals like prayers, keeping the dead persons photographs and preserving his/her belongings of the dead person.
- Make time for recreation using what is available like the radio, television, visiting religious places, playing with children and engaging in activities like sewing.
- Resume normal activities of the pre-disaster days with the family.
- Try and do things together as a unit and support one another.
- Be together as family members. Do not send women, children and the aged to far off places for the sake of safety; separation in this case can cause a lot of anxiety to them and to you.
- Restart activities that are special to your family, like having meals together, praying, playing games, etc.
- Keep touching and comforting your parents, children, spouse and the aged in your family. This will not only make you feel good but also make the other person feel the same.
- Keep in constant touch in case of a member of the family having to be shifted to a far off hospital or residence. Update him/her about yourself as well as find out about him/herself. This gives a feeling of being cared for.

DOs & DON'Ts

DOs

- * Do listen to people who share their stories, if necessary again and again.

- * Do expect and accept intense emotional reactions- these are normal reactions

- * Do be friendly, compassionate and caring, even if people are angry or demanding.

- * Do give practical help or assistance to people as and when required.

- * Do help people to contact others either by mail or by making telephone calls on their behalf.

- * Do engage people in meeting their own needs.

- * Do find out where the government and non-government services are located and direct people to the appropriate services available in the area (Systems-Savvy).

- * Do understand the emotions of people who have suffered losses, and take them seriously. There is no right or wrong way for people to feel, given the horrific situation.

- * Do give reliable information about what tsunamis are and how they occur. This will help people understand the situation.

- * Do protect people from further harm, as they may be vulnerable to assault and abuse by those who are taking advantage of the chaotic situation.

- * Do pay attention to the language you use. Be careful what you say to people. Use empathy NOT assumption.

DON'Ts

- * Don't force people to share their stories with you, especially very personal details. If they don't want to talk much, do not disturb them.
- * Don't tell people what you think they should be feeling, thinking or doing.
- * Don't make promises about what you will do for them, if you are not sure about this.
- * Don't give simple reassurances to people, saying 'everything will be ok', or 'at least you have survived' or 'others have suffered more than you'.
- * Don't tell people why you think they have suffered, especially giving reasons about their personal behaviors or beliefs.
- * Don't tell people what you think they should have or could have done, whilst in the critical situation, especially to save loved ones.
- * Don't criticize existing services and activities being carried out in these areas, especially in front of people who are in need of these services.
- * Support the service providers to make the services better.
- * Don't separate surviving family members and relatives from one another, if possible, especially children.
- * Don't label people as traumatized.
- * Don't say dismissive things like:
 - “I understand what happened to you”
 - “Calm down”
 - “Relax”
 - “Forget about it”
 - “You are really lucky”
 - “It could have been worse”

Module 3: Secondary Trauma & Self Care

As a result of their work, helpers/volunteers can enter a state of crisis
Often, there is a feeling of not having done enough or feeling overwhelmed by the needs

Workers & volunteers need to cope with:

- Their own fears of death
- Their own feelings of helplessness and sadness

This is called “Secondary Trauma”

Sources of Stress For Helpers

- Being part of the crisis
- Repeated exposure to grim experiences and strong emotions
- Carrying out physically difficult or exhausting tasks
- Lacking sleep and feeling fatigued
- Facing the perceived inability ever to do enough
- Feeling guilt over access to food, shelter, etc.
- Facing moral and ethical dilemmas
- Being exposed to anger and lack of gratitude
- Being detached from personal support system
- Feeling frustrated by policies and decisions of superiors

Anyone who works in the relief effort Can be effected:

- Rescue workers, relief workers, police, soldiers
- Doctors, nurses, , psychologists, social workers/Volunteers
- Government officials, administrators, clerks, drivers

Stress reactions in workers are normal and to be expected.

Common Stress Reactions of Disaster Workers:

Emotional

shock
anger
disbelief
terror
guilt
grief
irritability
helplessness
despair
loss of pleasure from regular activities

Cognitive

impaired concentration
confusion
distortion
intrusive thoughts
decreased self-esteem
decreased self-efficacy
self-blame

Biological

fatigue
can't sleep
disturbed sleep
hyperarousal
somatic complaints
impaired immune response
headaches
gastrointestinal problems
decreased appetite
decreased libido
startle response

Psychosocial

alienation
social withdrawal
disturbance increased stress within
relationships
substance abuse
vocational impairment

Warning Signs:

- Cynicism or ‘wounded’ ideals
- Feeling unappreciated or betrayed by the organization
- Loss of spirit
- Grandiose beliefs about own importance
- Heroic but reckless behavior
- Neglecting personal safety and physical needs
- Mistrusting colleagues and supervisors

Coping Techniques

- Reactions are normal and unavoidable
- Consciously try to relax
- Talk to someone with whom you feel at ease
- Express your feelings in ways other than talking: draw, paint, play music
- Listen to what people close to you say and think about the event
- Take care of yourself
- Work on routine tasks
- Discuss fears with someone you can trust
- Do not self-medicate
- Go easy on yourself
- Avoid inflated or perfectionist expectations
- Seek professional advice if reactions continue

On the Scene: 10 Self-Care Tips

1. Get enough sleep
2. Get enough to eat and drink (drink water, juice, soda; Avoid drugs)
3. Vary your work task
4. Do some light exercise
5. Do something pleasurable
6. Focus on what you did well
7. Take some time to think about what you learned today
8. Share a private joke
9. Pray, meditate or relax
10. Support a coworker

- **With other colleagues**

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

Make a 'Tree of Sustenance' for yourself.

In the leaves of the tree put down three negative and three positive qualities that you have. These are the qualities with which you reach out to people. In the boxes representing the roots of the tree, put the names of people whom you can turn to for care and support when you need comfort. In the clouds above the tree list out things that give you a sense of peace and happiness.

This tree is symbolic of you. If the roots are strong and supportive and the tree has clouds for water, the tree remains healthy and happy and is able to give more shade and fruits to people for a longer time.

Similarly have things and people around to care and support you. Since you are working in a field that draws on a lot of your emotional and physical strength, these people and things can provide nourishment and rejuvenation.

Self-help groups for managing stress

Care providers and relief workers should form strong bonds with their own colleagues and openly discuss the nature of their work and the possibility that it can be stressful. Small groups should be formed and the possibility of any of them getting "burnout" should be openly discussed.

These discussions should start even before there is evidence of the workers being affected by stress. The group must realize that each person can have a different response to the stressful situation. Nobody should be termed as "weak", or be "chastised" for "breaking

down".

These groups can have three kinds of sessions to provide **psychosocial** support to members.

- (1) Informal interaction and socialization during and after work.
- (2) Formal sessions held periodically to discuss the work plan and other activities.
- (3) Specific group exercises aimed to discuss and find ways of coping with the stressful experiences of relief workers.

Peer support groups

Peer support groups is a process of initiating semi-structured group discussion which involves discussing the problems different group members face in their life and work.

These may be problems that existed before the disaster, these may be problems of memories related to the disaster, or these may be problems faced after the disaster. Activities of the peer support group are carried out as follows:

It is done in small groups (approximately 6-8) of relief workers.

A person with experience in leading groups can act as moderator

It is done once or twice a week, and ideally with the same group members.

It begins with each worker reporting turn by turn a problem he or she feels comfortable discussing. This should be followed by other people asking questions to understand the situation better and to find out how the person has been feeling and coping.

Group members brainstorm together on how to find better ways to cope with the problem. In this manner a problem of each group member is discussed for about 15 minutes.

The group leader (and other participants) should show their appreciation of the work that the relief workers are doing and for being able to cope with the situation and its stresses. The positive gains made during relief work should be stressed here.

Groups should advise and support relief worker(s) who have shared their difficulties in coping with the situation they encounter in the field. All discussions should be kept confidential and group leaders should facilitate an atmosphere of interpersonal respect and encouragement.

The group leader should be able to identify any relief worker in need of more specific and individual attention and help.

OTHER SUPPORTIVE MEASURES FOR PSYCHOSOCIAL CARE OF RELIEF WORKERS

Some of the measures which a distressed relief worker may need at an individual level for his/her emotional care are as follows:

Consultation: A relief worker should consider approaching his or her supervisor/ leader or a mental health professional, if available, to seek consultation (advice, guidance, treatment, whatever may apply) if he is unable to cope effectively with his stressful experiences.

Crisis Intervention: This may be required in rare instances where a relief worker is in a crisis situation due to any reasons - personal, family or **fieldwork** related. The supervisor or the group leader has the responsibility for organizing appropriate support in these cases.

SEEK HELP IF

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

REMEMBER

- The work is going to be taxing on the mind and the body.

- It is important to build support systems to take care of one's personal well-being.

When You Return Home

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

Secondary Trauma Prevention

Creating a Supportive Environment By:

- Supervisors and peers providing support and guidance . Supervisor must understand that workers are human, too and Identify limitations on how far helpers should be pushed or stretched
- Seniors Acting as source of advice and help with problems, personal as well as professional while Respecting confidentiality
- Promoting Open and sharing organizational culture through Regular and frequent staff meetings and Sharing the information about self help and self care. Communication flow can be maintained by use of formal agenda, with an agreement on lack of interruption and discussion moderated by facilitator

**DISASTER AFFECTS EVERYONE.
YOU CAN MAKE A DIFFERENCE TO REBUILD THE COMMUNITY.**

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Appendix
Phases of Morale

There are also four phases for survivor, worker, and community morale. These four phases have been observed in many disasters all over the world.

<u>Morale Phase</u>	<u>Features</u>
<u>Heroic Phase</u>	This phase is characterized by individuals and the community directing very high levels of energy and attention into rescuing, helping, sheltering, emergency repair, and cleaning up. This increased activity lasts from a few days to a few weeks.
<u>Honeymoon Phase</u>	Despite the recent losses incurred during the disaster, this phase is characterized feelings of optimism. Survivors see the resources coming in, national or worldwide media attention, and visiting VIPs who reassure them their community will be restored, and their lives will return to normal. Survivors begin to believe that their home, community, and life as they knew it will be restored quickly and without complications. Less experienced disaster mental health professionals may form a similar expectation, and make false promises of restoration or have personal expectations which will be disappointed. Generally, at some point, resources begin to diminish, the media coverage lessens, VIPs are no longer visiting, and the complexity of rebuilding and restoration becomes increasingly apparent. At this same time, the increased energy that survivors and the community initially experienced begins to diminish and fatigue sets in, setting the stage for the next phase
<u>Disillusionment Phase</u>	Fatigue, irritating experiences, and the realization of all the work that is required to restore their lives combine to produce disillusionment. Survivors discover that promised financial benefits are not coming or are smaller than expected; they realize that politics, rather than need, shape decisions; that some people are receiving more assistance than other people. There will be many complaints about betrayal, abandonment, lack of justice, bureaucratic red tape and incompetence. Symptoms related to post-traumatic stress intensify and hope diminishes. Many workers lose their energy and feed disappointed.
<u>Morale Renewal Phase</u>	The groundwork laid during the previous months begins to produce observable changes. Large reconstruction projects begin. "Long-term" disaster-related programs have been established (e.g., medical, financial, mental health programs). Many individuals regain their level of functioning as before the disaster. Again, significant individual variance occurs within this phase. Generally speaking, some individuals are able to regain equilibrium within 6 months. For others it may well take between 18 and 36 months. For some individuals, the first year anniversary of the disaster precipitates or exacerbates post-traumatic stress symptoms. A majority of survivors attribute their increased appreciation of relationships and life and their confidence to manage difficult circumstances to the lessons learned from the disaster.

Module 2: Basic Skills of working with populations effected by disasters

Building A Helping Relationship

The quality of the relationship between the care provider and the population he is working with is an important component.

. A care provider who is regarded as trustworthy, interested, helpful and understanding is more likely to engage the population in ongoing and beneficial relationship. The following hints may be helpful for the development of a helping relationship.

- Maintain the **attitude** that the people have goodness, dignity and strength, worthy of courtesy, respect, acceptance, and expenditure of time.
- Maintain the **belief that** the people will benefit from the relationship. Even if a particular individual cannot be 'cured', a joint effort may at least lead to improvement of functioning, enjoyment, or physical health of the community.
- Remember that the relationship may take **time** to develop and that the importance of the relationship may not be acknowledged by all the individuals in a community.
- **Listen** to the people of the community in an understanding manner without feeling the need to 'label' or explain everything that has been said.
- Use people's **names**.

Ensure that the people understand what is your objective and plan

In your interaction with individuals :

- Do not use technical language without explaining the meaning of the words in simple terms.
- Do not patronise or 'talk down' to the individuals.
- Leave space for individuals to talk and express any problems being experienced. Do not crowd the individual by asking too many unimportant questions.
- **Watch and listen for clues** such as: lack of eye contact; curled up body posture; unspoken clues such as what is left out of conversation; or spoken clues such as, "*I'm mostly OK*", (which may be a purposeful hint that the individual has a specific problem that he or she would like to talk about).
- **Reassure** the individual and family members that what is said will not be laughed at or used in judgement.
- **If the individual is angry**, acknowledge the anger (e.g., "*I can understand you're feeling quite angry*") but do not take the anger personally. Give the individual time alone to calm down if necessary.

- **If the individual is demanding**, care providers need to make sure they: state clearly what they will and will not do; are **empathic** about the individual's feelings (e.g., disappointment or anger); provide the individual with alternatives to choose from so the individual has some sense of control over what is happening.

ENCOURAGING ADHERENCE TO TREATMENT

There are numerous reasons why people may not adhere to their medication or treatment programs.

Some people are *reluctant* to accept treatment (for example, those who experience unpleasant side effects from treatment or who do not understand the need for treatment), while others simply have difficulty sticking to their programme (for example, when illnesses make people forgetful or confused). The following guidelines deal with encouraging adherence to treatment. These guidelines are relevant to medical treatments as well as psychological and social treatments.

ENCOURAGING ADHERENCE

The information below covers some of the most common reasons for non-adherence and provides some effective strategies for encouraging adherence.

Problem

Individual does not believe he/she needs treatment

Provide education about the illness and treatment.

Listen to the individual's fears and beliefs about treatment and correct any false beliefs or irrational fears.

Check that the individual understands what has been said about the illness and treatment by asking the individual to *explain* his or her understanding of the situation.

Individual does not understand the instructions

Encourage the individual to ask questions.

Explain information clearly a number of times and ask the individual to *repeat* the information back to you.

Keep the treatment regime as simple as possible (e.g., take pills once per day)

Individual is reluctant to attend for treatment

Find out why the individual is reluctant (e.g., long waiting times, threatening atmosphere, transport or fear of stigma).

Build a positive therapeutic relationship.

Reward the individual with praise

Individual forgets to attend for treatment or forgets to take medication as prescribed

Provide reminders via family and friends.

Link treatment with daily routines (e.g., eat breakfast and take pills).

Explore the possibility of changing to a longer acting medication (e.g., a drug with a longer half-life).

Medical treatment causes unpleasant side effects

Non-adherence is a result of staff/service problems

(e.g., some doctors dislike the individual, etc.)

Check the appropriateness of the treatment or medication

Build a positive relationship with the individual or, if unsuccessful, refer the individual to another doctor (where possible).

Maintain a welcoming, non-threatening environment.

Maintain a flexible attitude and respect for the individual's rights and needs.

Individual has social/personal reasons for non-adherence

(e.g., feels stigmatised, family disapproves of treatment, treatment reminds of illness, suspiciousness, working and cannot come)

Educate the individual *and* family about the importance and effects of treatment.

Assist the individual to weigh the pros and cons of continuing treatment.

Consider other forms of treatment.

Peer support may encourage co-operation.

STRUCTURED PROBLEM SOLVING

There are rarely perfect or ideal solutions to problems, however, the structured problem solving approach aims to identify the most effective plan of action available at the time.

You can help the people find a solution to their problems in a systematic manner which can be because of the problem being :

- Too severe and novel in intensity e.g. Loss of number of family members, Loss of all the belongings during the earth quake.
- Too many crisis with compromised stress coping capabilities e.g. theft, child going missing / physical illness / disability can impose additional stress.

You can help the person by being a concerned individual rather than by being an expert.

- Approach the person in a gentle and reassuring manner creating an atmosphere of facilitating communication .

THE SIX STEP METHOD OF STRUCTURED PROBLEM SOLVING

Step 1: What is the problem?

Think about and discuss the problem or goal carefully then write down exactly what you believe to be the main problem or goal.

Step 2: List all possible solutions

Brainstorm and put down *all* ideas, even bad ones. List all possible solutions without any evaluation of them at this stage.

Step 3: Discuss each possible solution

Quickly go down the list of possible solutions and assess the main advantages and disadvantages of each one.

Step 4: Choose the best or most practical solution

Choose the solution that can be carried out most easily with your present resources (time, money, skills, etc.)

Step 5: Plan how to carry out the best solution

List the resources needed and the main problems that need to be overcome. Practise difficult steps

Step 6 :. Review how well the solution was carried out and praise all efforts.

Continue the problem solving process until you have resolved your or achieved your goal.

BASIC COMMUNICATION SKILLS;

The aim of communication skills training is to help you talk about very important and complicated issues without causing major arguments and hostility. Not everyone will need communication skills training.

HOW TO COMMUNICATE CLEARLY'

The following guidelines provide simple strategies that will help you to improve your communication skills. The basic rule is to keep messages *simple, clear, and positive*.

When Listening:

Be a good listener by

Attentive listening

- Establish eye contact with the person while talking to him/her
- Listen attentively to everything a person says convey this by maintaining eye contact in a culturally acceptable manner, bending forward ,nodding, etc.
- Respond by gestures and words (Hmmm...) to indicate that you are listening attentively
- Do not interrupt as far as possible
- Reassure the person at the end

Reflective Listening (also known as active listening)

- Establish eye contact with the person while talking to him/her
- Listen attentively
- Use short phrases (along with gestures) to indicate that you are listening, but do not interrupt frequently
- Try to encourage the person to talk more by repeating his/her words/phrases
- Reflect upon the contents and clarify wherever necessary
- Reflect upon your own feelings and emotions while listening to other's experience
- Summarize the contents in between and at the end of the talk
- Empathize with the person by sharing the experience of others
- Reassure the person but do not make false promises

When Talking:

- Look at the person (make eye contact)
- Be specific (e.g. Instead of saying, *"I'd like you to try and help me"* say, *"I'd like you to help me with keeping record of people needing psychosocial support"*)
- Express your thought or request simply and positively
- If necessary, suggest alternative behaviour for the future
- Show appreciation for positive behaviours or for changes that are to be made
- Use an appropriate tone of voice and body posture Remember that your tone of voice and your body language also give very strong messages. There is no point in asking someone to do something if you are standing with your hands on your hips and speaking in an angry or sarcastic manner.
- Use short statements or questions
- Ask one question or make one request at a time•
- Avoid strong emotional statements (e.g. *"I can't stand this disgusting mess!"*)

- Give praise for even small accomplishments - do not wait for major change
- Praise people immediately after they do something pleasing
- Avoid 'back-hand' compliments (e.g. "*That was a really nice thing to do, but...* ")
- Remember also that sometimes even clear and pleasant requests will be ignored. Perhaps the request was unreasonable. Or maybe the other person was feeling too troubled or too inconsiderate to help.

RELAXATION TRAINING:

Relaxation is useful for reducing physical and mental tension. Relaxation helps people to: reduce worry and anxiety, improve sleep, and relieve physical symptoms caused by stress (e.g., headaches, stomach pains, diarrhoea or constipation).

If you follow the steps below you will be well on your way to learning how to relax. This exercise should take about 15-20 minutes. However, if you only have 5 minutes to spare, 5 minutes is certainly better than nothing!

Practice the slow breathing method for one minute

See below.

Relax your muscles

For each of the muscle groups in your body, tense the muscles for 7-10 seconds, then relax for

about 10 seconds. Only tense your muscles moderately (not to the point of inducing pain). Tense

and relax your muscles in the following order:

Hands - curl hands into fists, then *relax*.

Lower arms - bend your hand down at the wrist, as though you were trying to touch the underside of your arm, then *relax*.

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

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

Neck - stretch your neck gently to the left, then forward, then to the right, then to the back in a slow rolling motion, then *relax*.

Forehead and scalp - raise your eyebrows, then *relax*.

Eyes - screw up your eyes, then *relax*.

Jaw - clench your teeth (just to tighten the muscles), then *relax*.

Tongue - press your tongue against the roof of your mouth, then *relax*.

Chest - breathe in deeply to inflate your lungs, then breath out and *relax*.

Stomach - push your tummy out to tighten the muscle, then *relax*.

Upper back - pull your shoulders forward with your arms at your side, then *relax*.

Lower back - while sitting, lean your head and upper back forward, rolling your back into a smooth arc thus tensing the lower back, then *relax*.

Buttocks - tighten your buttocks, then *relax*.

Thighs - while sitting, push your feet firmly into the floor, then *relax*.

Calves - lift your toes off the ground towards your shins, then *relax*.

Feet - gently curl your toes down so that they are pressing into the floor, then *relax*.

Enjoy the feeling of relaxation

Sit still for a few minutes enjoying the feeling of relaxation.

Practice once or twice every day for at least 8 weeks.

During the day, try relaxing specific muscles whenever you notice that they are tense.

Slow Breathing Exercise

(To be practiced regularly and at the first signs of anxiety or panic).

1. Hold your breath and count to 5 (do not take a deep breath).
2. When you get to 5, breathe out and say the word *relax* to yourself in a calm, soothing manner.
3. Breathe in and out slowly through your nose in a six second cycle. Breathe in for three seconds and out for three seconds. This will produce a breathing rate of 10 breaths per minute. Say the word *relax* to yourself every time you breathe out.
4. At the end of each minute (after 10 breaths) hold your breath again for 5 seconds and then continue breathing using the six second cycle.
5. Continue breathing in this way until all the symptoms of over breathing have gone.

It is important for you to practice this exercise so that it becomes easy to use any time you feel anxious.

Other relaxation methods

Although progressive muscle relaxation is the most recognised and documented method of relaxation, there are other methods that can achieve similar results. It is preferable for individuals to regularly use an effective method that they feel comfortable with and which has been successful in the past rather than use no method at all. Other methods include: Praying ,

meditation; exercise; These methods can be useful if they reduce tension for that individual and are used daily.

Psycho education

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

All survivors should be given educational information to

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

Such information can be delivered in many ways, including through public media, community education activities, and written materials. More intensive follow-up services should target subgroups of survivors who are at heightened risk for chronic or severe post-trauma problems.

First, survivors and families should be reassured about common reactions to traumatic experiences and be advised regarding positive and problematic forms of coping. Information about social support and stress management is particularly important.

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

Third, education regarding indicators that initial acute reactions are failing to resolve will be important, as will education about signs and symptoms of PTSD, anxiety, depression, substance use disorders, and other difficulties.

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

BASIC COUNSELLING SKILLS:

Empathy:

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

The Difference Between Empathy and Sympathy

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

Genuineness/Sincerity:

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

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

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

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

Positive Regard for survivor;

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

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

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

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

Active Listening Skills: (see Communication skills)

Collaborative problem solving (see problem solving section)

Grief counseling:

This is a technique which utilizes the above mentioned skills but modified to help bereaved survivors (i.e. those who have lost their close ones). The person is gently encouraged to talk about his relatives. This will hasten the process of mourning and its resolution. The following are to be done as a part of Grief Counseling:

- Approach the person in a gentle assuring manner; ask him about the overall welfare of his family members and then talk about the deceased person.
- Encourage him to share maximum information about the deceased family member. (e.g. to show and discuss the photo of a family member).
- Focus on pre-disaster relationship network, with the dead person and the personal meaning of the loss.
- Enquire about survivor guilt in this context and reassure survivors that it is a natural human reaction to feel guilty about being unable to save loved ones.
- Try to ensure that the bereaved person performs various mourning rituals.
- Ensure that survivor gets an opportunity to meet other survivors who know something more about the dead person.
- An opportunity to meet other people like nurses, doctors, or persons who extricated the body is also useful.
- One can use group approaches such as the group viewing the site of death and holding a public memorial service (Example) to make the process of grieving easier.

Source for this manual and associated training:

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APPENDIX –I

Understanding Regular Stress Responses

Fight or Flight Response

Humans, and almost all animals, have a set of natural stress responses. The stress response is called "fight or flight."

1. A threat or potential threat is perceived
 - ✓ There is some perception of a threat to safety or potential threat. For example:
 - Driving in traffic
 - Conflict at work or home
 - Exam or test
 - Job interview
2. Body responds by mobilizing energy and resources so we can respond quickly.

Adrenalin released in central nervous system (CNS), which creates a state of CNS arousal.

 - ✓ Hearts beats faster and stronger
 - ✓ Breathing is fast and shallow
 - ✓ Blood directed to the arms and legs
 - ✓ Many other effects
3. Threat is dealt with or avoided (coping)
 - ✓ Once we have this "emergency" boost, we can deal with the threat. We might fight the threat or we might run away (flight) or we might find some other way to cope. We usually can not run away from the stressors of modern life! That is why 'stress management' is so important in modern life.
4. Body returns to relaxed condition

Once the threat has been removed, the body returns to its relaxed condition (CNS arousal decrease)

❖ **In a disaster, steps 3 and 4 may not occur!** There may still be some threat or fear. What do you think happens when people stay in step 1 and 2 for a long time?

APPENDIX –II

Phases of Disaster Response

	Emergency Phase	Early Post Impact	Restoration
Time Line (varies with severity of the disaster)	Usually 1-2 days, in this disaster 5-7 days	Weeks to months	Months to years (in case likely to be 18-36 months)
Situation	The situation is chaotic and disorganized. Many people are involved. The community is completely focused on this event. Resources and help arrive in great amounts	The situation starts to become more organized. Resources and help continue to arrive. People are working together. There is a feeling of optimism (“We will succeed”).	Phase of rebuilding. Can have periods of very low individual and community morale. Finally, life starts returning to normal. People can return home and resume work.
Individual Psychological Responses	-Resiliency -Peri-traumatic Stress Responses	-Resiliency -Peri-traumatic Stress Responses -Development and identification of psychological disorder	-Resiliency -Psychological disorders in some people
Who may needs mental health services?	Any survivor Rescue workers Volunteers	Some survivors Community Rescue workers and volunteers	People who have developed psychological disorders; community as a partner in healing
Where MH services are provided	Where survivors are located (we go to them).	Where survivors are located (we go to them)	Combination: services in the community and at the clinic/hospital

