

SEA-EHA-7 (Rev.1)
SEA-Ment.-135
Distribution: General

Psychosocial Care of Tsunami-Affected Populations

Manual for Community Level Workers



World Health Organization
Regional Office for South-East Asia
New Delhi
April 2005

Acknowledgements:

This document is one in a series produced through collaborative efforts between the Mental Health Unit of the WHO Regional Office for South-East Asia and the Department of Mental Health and Substance Abuse, WHO Headquarters, to help affected communities cope with the Tsunami disaster.

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Comments from Drs. Mark van Ommeren, Benedetto Saraceno, Shekhar Saxena (who tested the first draft of this document in Sri Lanka and Maldives), Satish Mallik, Bela Shah, Anne Germain, Myron Belfar and Sridhar Sharma are highly appreciated.

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MESSAGE FROM THE REGIONAL DIRECTOR

December 26, 2004 will, forever, be a date that haunts our memory. It will always be associated with the massive earthquake in the Indian Ocean which generated the destructive Tsunami waves that battered the shores of many countries. Unfortunately, the WHO South-East Asia Region bore the brunt of the devastation. Among our Member States, Indonesia, Sri Lanka, Thailand, India and Maldives were affected the most. Myanmar and Bangladesh were also affected, but to a lesser degree.

WHO immediately responded to the disaster. During the early phase of the crisis, our priority was the provision of technical advice to governments of affected countries to help them take care of the immediate threats to human health.

Given its sheer magnitude and scope, no single organization can adequately cope with the disaster alone. WHO is supporting national health authorities of the affected countries in close coordination and cooperation with other agencies. Never before have organizations of the UN system demonstrated such an ability to respond to the immediate needs during a crisis with unity, professionalism and speed.

In addition to providing technical support on health issues, we were very cognizant of the psychosocial needs of those affected by the Tsunami disaster. Technical guidelines were immediately made available to governments and disseminated widely to agencies working in the field. It was widely recognized that impairment in psychosocial rehabilitation can affect efforts in physical rehabilitation.

Providing psychosocial support to communities affected by the Tsunami disaster is a key component of the Organization's long-term strategy to rehabilitate the damaged public health infrastructure.

I am confident these manuals will be found useful by community-based workers who will ultimately provide the psychosocial support to those affected by this unprecedented tragedy.

Samlee Plianbangchang, M.D., Dr.P.H.
Regional Director

PREFACE

The Tsunami disaster has imposed a huge burden on communities, not only physically but also in terms of the psychological trauma inflicted on them. It should be noted that EACH AND EVERY PERSON in the population is psychologically affected to some extent. Thus, in terms of numbers, the magnitude of the problem of psychological trauma of the disaster affected population is as large as the size of the population. It is imperative that psychosocial interventions be made accessible to each person in the community, because psychological distress can hamper rehabilitation and resumption of normal life.

WHO's policy on mental health/psychosocial support to disaster victims is that it should be community-based and culturally appropriate and take into account the needs of special groups such as children, women, the elderly, etc. WHO recommends that psychosocial support be provided to affected communities by community-based workers who understand the needs of disaster victims and are trained by experts in psychosocial support methodologies.

The role of the WHO lies in defining the psychosocial needs of the community, establishing technical guidelines to be used, providing technical support to governments, NGOs and other stakeholders involved in psychosocial support, as well as training people for the implementation of psychosocial support strategies, and monitoring and evaluation of programmes. Actual implementation in the field can be done by community-level workers, NGOs, self-help groups and other UN groups, etc., using WHO guidelines. All activities should be in collaboration with the Ministry of Health and the WHO Representative office.

This set of manuals, prepared by a group of experts has been developed for use by community-level workers entrusted with the responsibility of providing psychosocial support to the community. The manuals recommend increased community outreach, taking into account the needs of special groups such as children, women and the elderly, while offering a culturally appropriate approach to support.

It is hoped that the training these workers receive will enable them to reach each and every member of the community and provide them with the appropriate level of psychosocial support needed. In addition, relief workers can learn how to care for their own emotional well-being, so that they can handle the stress of relief work and serve the community better.

1. INTRODUCTION

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

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

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

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

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

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

The present manual is meant exclusively for *Community Level Workers (CLWs)*, to help them in providing psychosocial care to the Tsunami disaster victims in South-East Asia Region of WHO.

2. RESPECT FOR LOCAL CULTURE IN IMPLEMENTING PSYCHOSOCIAL INTERVENTIONS

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

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

Important considerations include:

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

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

3. SOCIAL SUPPORT

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

- Providing uncomplicated and accessible information on location of corpses.
- Discourage unceremonious disposal of corpses.
- Helping to trace the families of unaccompanied minors, the elderly and other vulnerable people.
- Encourage members of field teams to actively participate in grieving.
- Encourage recreational activities for children including opening schools.
- Widely disseminating uncomplicated, reassuring, empathic information on normal stress/trauma reaction to the community at large (religious leaders, teachers and other social leaders should be involved actively).

- Encourage the re-establishment of normal cultural and religious activities
- Involve adults and adolescents in concrete purposeful activities (e.g., repair of housing, distributing food, sanitation measures, etc.)
- Assist illiterate people to deal with official documentation required in order to obtain aid.
- Occupational rehabilitation for those who may have lost their means of livelihood.
- Please keep in mind that the local communities may be sensitive to the dress and demeanor of the workers especially if they happen to be from outside the community.

4. NEED FOR EXTERNAL PSYCHOSOCIAL SUPPORT SYSTEMS

Under normal circumstances, there are social support systems built into community life, like prayers, rituals, a role for each family member, neighbours sitting with the family members and providing support, etc. However in the unique circumstances of the present disaster, we must address the need of people who have not only lost loved ones, homes, means of livelihood, but their entire neighbourhoods and, with it, their life's context which essentially defines every individual. The best method in such a situation would be to find people in neighbouring villages or communities, people of similar cultural background, who understand the cultural norms to help them.

5. INTER-AGENCY COLLABORATION

In the community there may be many other people, NGOs or agencies, working with the community to provide psychosocial support. It is very important to coordinate activities between different groups to avoid duplication and even conflicting information being given to the community. Generally all activities should be coordinated by the Ministry of Health but in some countries the Ministry of Social Welfare may have a prominent role.

It should be noted that even though many psychosocial interventions are non-medical in nature, these still remain a health subject. Thus the role of health ministries is important.

6. WHO CAN USE THIS MANUAL?

Community Level Workers can be drawn from any or all of the following categories:

- (1) All types of health workers
- (2) Relief and rescue workers
- (3) School teachers, youth leaders and volunteers

Essentially all those who are in immediate and direct contact with the disaster-affected communities and are willing to be trained to provide psychosocial care can use this manual after appropriate training.

7. AIM OF THIS MANUAL

- (1) To sensitize the CLWs to the psychosocial aspects of disaster in the affected population,
- (2) To train them in delivery of psychosocial care to the survivors, and
- (3) To train them in identification and referral of individuals requiring specialist mental healthcare.

8. LEARNING OBJECTIVES

After going through the training provided in this manual, CLWs should be able to:

- (1) Identify the various psychological responses to the disaster among the affected population.
- (2) Learn the minimal counselling skills needed to provide psychosocial care to the disaster-affected population.
- (3) Identify people who may need referral for specialist care.
- (4) Learn the methods to help special groups like children, women and elderly.
- (5) Understand ways to take care of their own emotional well-being.

9. GETTING STARTED IN THE COMMUNITY

After appropriate training, when CLWs arrive in the community they should do the following:

- (1) Establish contact with community leaders of the area where they will work and introduce themselves and explain the work they will be doing.
- (2) Integrate the psychosocial support activities with other ongoing relief, rehabilitation and rebuilding efforts.
- (3) Form special groups for group counselling such as women's groups, groups of elderly, etc.
- (4) Locate and establish contact with the backup medical/mental health services of the region where they are working.

10. MODULE I: PSYCHOLOGICAL RESPONSES OF DISASTER-AFFECTED POPULATION

Disasters leave a psychological impact on affected peoples varying from transient reactions to the incident among the survivors, to lifelong emotional problems. The need for emotional support is crucial in order to enable people to begin the process of recovery, and to help them cope with the hardships imposed upon them due to the disaster.

Depending on the time that has elapsed since the disaster, psychological reactions seen among the victims vary. The emotional reactions generally observed in the affected population after a disaster include:

Immediate reactions (within 24 hours)

- (1) Tension, anxiety, panic
- (2) Stunned, dazed, shocked, disbelief
- (3) Elation or euphoria among survivors / or people suffering lesser losses
- (4) Restlessness, confusion
- (5) Agitation, crying and withdrawal
- (6) Survivor's guilt

These reactions are seen in nearly everybody in the affected region and can be considered 'NORMAL REACTIONS TO AN ABNORMAL SITUATION', and need not necessarily require specific psychological interventions.

Within days to weeks after the disaster

- (1) Being fearful, vigilant, hyper-alert (irritable, angry, unable to sleep)
- (2) Worried, despondent
- (3) Repeated 'flashbacks'
- (4) Weeping, guilt feeling (including survivor's guilt)
- (5) Sadness
- (6) Positive reactions including: hoping / thinking of future, getting involved in relief and rescue work
- (7) Acceptance of disaster as nature's doing

All these are normal responses and may need minimal psychosocial intervention. Not all emotional consequences of the disaster among the survivors are maladaptive. A

majority of people demonstrate healthy and mature coping responses to the situation. Common coping skills adopted by individuals and communities are listed in the box below:

Common coping skills of the disaster-affected population (healthy and unhealthy patterns – these may vary with culture)

Healthy coping skills

- Participation in relief and recovery efforts
- Ability to orient oneself rapidly
- Planning and execution of decisive action
- Appropriate use of assistance resources
- Appropriate expression of painful emotions
- Tolerance of uncertainty without resorting to impulsive action
- Use of will power and modes of tension relief to cope with anxiety
- Active life style

Unhealthy coping skills

- Excessive denial and avoidance
- Impulsive behaviour
- Over-dependence
- Violent behaviour
- Withdrawal from society
- Alcohol or substance abuse
- Use of tranquilizers

After about three weeks of disaster

The previously noted reactions may persist and manifest as:

- (1) Restlessness
- (2) Feeling panicky
- (3) Continued intense sadness, unrealistic pessimistic thoughts
- (4) Outward inactivity, isolated and withdrawn behavior
- (5) Anxiety manifested as physical symptoms such as palpitations, dizziness, restlessness, nausea, headache, etc.

These responses usually do not necessarily amount to a mental disorder. Individuals reporting these symptoms are likely to be helped by relief workers trained in providing some of the basic psychological intervention skills described in Module-II.

Frequently observed mental disorders after a disaster

Some disaster survivors may develop full blown mental disorders which become apparent usually a few weeks to months after the disaster. These are briefly described below.

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-activity.

Bereavement and grief

Grief refers to "the feelings and behaviours 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 may be grief for the loss of loved ones, home, valued possessions, livelihood, etc. Factors influencing the manifestations 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.

Diagnosable mental disorders

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, lowered self-esteem and decreased sleep. Anxiety disorders are characterized by undue anxiety for 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 as 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.

Alcohol and drug abuse

There may be increased use of alcohol 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 1 month. PTSD may begin several weeks or months after the exposure to disaster and if untreated, may run a protracted course, although many people recover over time without any intervention. The symptoms of PTSD can be categorized in three dimensions: (i) re-experiencing the trauma, (ii) avoiding stimuli associated with the trauma and (iii) experiencing symptoms of increased autonomic arousal 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.

Exacerbation/relapse of pre-existing mental disorders

Persons who are suffering from established mental disorders, may be more vulnerable to developing psychosocial problems following disasters. Their existing condition (especially epilepsy, depression and psychoses), may get exacerbated as a result, or they may suffer from relapse of episode or recurrence of previous symptoms.

Psychosomatic illness

Some people undergoing psychosocial trauma may complain of physical symptoms such as headache, tiredness, palpitations, loss of appetite, pain in the abdomen, nausea or unidentifiable pain all over the body. It is important to recognize the psychological nature of these symptoms, and manage these as signs of emotional distress. However, since it is not always necessary that physical symptoms are due to psychosocial 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.

11. MODULE II: PSYCHOSOCIAL INTERVENTIONS FOR DISASTER-AFFECTED PEOPLE

Intervention during the acute emergency phase (first three weeks)

In the acute emergency phase, although the grief is overwhelming, the most urgent tasks are to attend to the injured and perform the last rites for the dead. In the first few days after the disaster, mental health concerns should complement humanitarian work so as

not to unduly burden relief operations. Thus, it is advisable to conduct as few psychosocial interventions as critically needed, so there will be little interference with responses to vital needs such as food, shelter and control of communicable diseases. The CLWs can help people to cope with the disaster situation more effectively during this phase so as to minimize the adverse psychosocial consequences of disaster. This help can be in the form of general measures aimed to reduce the emotional turmoil immediately after the disaster. The crucial component in this phase is the complete breakdown of service delivery to known cases of serious mental and neurological disorders, such as, schizophrenia and epilepsy. Efforts should be made to ensure that these patients continue to receive and take their medication.

General psychosocial measures to enhance the emotional well-being of disaster-affected people during the acute emergency phase

- Provide uncomplicated and accessible information on location of corpses.
- Discourage unceremonious disposal of corpses.
- Provide family tracing for unaccompanied minors, the elderly and other vulnerable people.
- Encourage people to organize group activities like prayers, collective performance of rituals and other socio-religious activities.
- Encourage members of field teams to actively participate in grieving.
- Encourage recreational activities for children.
- Inform the people about the normal psychological reactions that occur after disaster and assuring them that these are NORMAL, TRANSIENT, SELF-LIMITING and UNIVERSAL (all the people in all the disasters have these kinds of reactions).
- Disseminate simple, reassuring but accurate information on normal stress/trauma reaction to the community at large (religious leaders, teachers and other social leaders should be involved actively).
- Encourage people to work together in looking after their needs like organizing community kitchen, having meals together, doing sanitation activities.
- Involve healthy survivors in relief work.
- Motivate community leaders and other key persons like teachers etc., to participate in group discussion / and encourage people to share their feelings
- Ensure the dissemination of accurate information to people.
- Ensure equitable distribution of relief aid.
- Deliver services in a 'healing manner' empathizing with people and showing no callousness towards any section (e.g. weaker or minority) of the community.

General suggestions that can be made to individuals for psychosocial well-being

- Stay away from danger but remain in familiar surroundings with close family members.
- Begin reconstruction of physical infrastructure as soon as possible.
- Avail of all possible government and other bonafide assistance
- Listen only to authentic and reliable information.
- Get back to your daily routine as soon as possible.
- Share your feelings and experiences; do not try to suppress your emotions.
- Try to help others by participating in relief and rehabilitation operations.
- Take time to relax and engage in some pleasurable activities such as meditation, prayers, music or movies.
- Do not consume excessive amounts of alcohol or sedative medications.
- Eat right and sleep well.

Important Do's and Don'ts for CLWs:

Do's

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

Don'ts

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

Try to show Empathy rather than Sympathy

Empathy	Sympathy
(1) "I can understand what you are going through."	(5) "Poor you, it is really bad that this happened to you."
(2) "I can understand that you are feeling angry at what has happened to you."	(6) "I am also angry and we will deal with it together."
(3) "I accept that you are very scared, almost anyone can feel scared."	(7) "Don't be scared, I am here to help you, whatever it takes."
(4) "I understand how you are feeling about what has happened to you."	(8) "How could it have happened to you. I will make sure it does not happen again."

Effective communication with disaster-affected people:**Active listening**

- Establish eye contact with the person while talking to him/her in a culturally appropriate manner
- Listen attentively to everything a person says
- Do not interrupt as far as possible
- Indicate your being attentive by verbal gestures, e.g. "Hmmm..., I see..., I understand...."
- Let your body posture and position convey your interest
- Reassure the person at the end of the meeting.

Reflective Listening

In addition to all aspects of Active Listening, the CLW, should try Reflective Listening using the techniques noted below. This essentially involves reflecting back on what one has heard and understood by summarizing or rephrasing whatever was said:.

- "Let me clarify if I have understood correctly, what you have shared with me. You have said that....., have I understood you correctly?"
- "Let me make sure that I have understood you correctly. You have said that.....Have I understood you correctly?"
- "Allow me to double check if I have been able to understand well enough what you have said so far, before we go any further. I understand that you have said....., is that correct?"
- Any one of the above or a suitable variation can be used for Reflective Listening. This increases the person's trust and confidence.

Intervention during the post-disaster reconsolidation phase (after 3 weeks)

Once the acute phase is over the CLWs should focus on providing psychosocial care along with general relief work. Disaster-affected people may experience different kinds of psychological reactions and may require different levels of psychosocial care, as follows:

- (1) **General psychosocial measures:** A majority of people are able to cope with psychological reactions with their own innate coping mechanisms with minimal support from others in the community. The CLWs can help these people by enhancing their emotional well-being by general psychosocial measures as given in the acute emergency phase.
- (2) **Specific psychosocial interventions:** Many victims suffer from psychological symptoms (but not necessarily mental disorders) and require psychosocial care from relief workers in the form of specific interventions like emotional first aid, grief counselling, etc. The methods by which these services can be provided are described below.
- (3) **Identification and referral:** Some people require treatment from a mental health professional because they suffer from either (a) an acute anxiety reaction that is so severe in that it limits basic functioning (such as being able to talk to people) or they suffer from (b) severely distressing or disabling psychological symptoms that do not improve over time and that do not improve through psychosocial intervention by CLWs.

Specific psychosocial interventions (basic counselling) by the CLWs

Many of the disaster survivors will have psychological and behavioural symptoms requiring psychosocial support. Most of them do not need treatment from a psychiatrist or any other mental health specialist. CLWs CAN HELP THEM AFTER TRAINING IN BASIC COUNSELLING SKILLS. Early identification and early intervention can help these people to cope better.

CLWs should learn these counselling skills during the training programme and whenever possible practice these skills initially in the presence of supervisors/trainers so that they can build up adequate confidence to implement them.

Who will require help?

- (1) Individuals reporting symptoms/problems like restlessness, panic, sleep problems, nightmares, frequent recollection of traumatic events, frequent bouts of crying and inability to think properly.
- (2) People who are seen to remain isolated/withdrawn most of the time and show no overt interest in the activities going on all around them (like distribution of food, blankets etc.).

- (3) Individuals who, on being approached, break into an irritated outburst or simply start weeping.
- (4) Individuals showing extreme reluctance to communicate when approached.
- (5) People who appear extremely distressed.
- (6) People who have significant losses (like death of family members).

How to help these people?

- (1) While delivering your routine services, pay special attention to identify such people.
- (2) Establish rapport with them by approaching them in a friendly and sympathetic manner.
- (3) Ask about their well-being and the help they need; offer the help.
- (4) Encourage them to talk about their problems and experiences.
- (5) Consider specific intervention techniques that can benefit them (such as Psychological/ Emotional First Aid, Trauma and Grief Counselling, Re-grieving and Anticipatory Guidance, Crisis counselling, Crisis intervention, Problem solving counselling etc.).
- (6) Deliver the chosen intervention.

It should be noted that some forms of counselling can be harmful to individuals whether they are attempted by non mental health professionals or by CLWs. Counsellors need to take great care not to push or force people into expressing feelings that they are not ready to express. The affected person needs to have a choice about whether or not to think about the disaster and whether or not to express feelings related to it. Although, it is true that thinking about the specifics of the trauma and getting in touch with feelings related to it can be helpful, forcing people to talk about it can be harmful. However, sometimes counsellors make the mistake to push trauma-survivors into focusing more on the trauma than they are able to bear. Harm should be avoided (the first rule in medicine is: do no harm). Indeed, one of the aims of trauma counselling is to create a safe environment in which the trauma survivor from his or her own choice decides to talk about the trauma and about ways of coping with it.

Counselling techniques to be used by CLWs

I. Psychosocial first aid:

The most frequent psychological help which CLWs will need to provide is emotional first aid.

Technique of emotional first aid include:

- (1) Identify people who you think are not coping well with the disaster situation as evident from the psychological symptoms reported by them.
- (2) Establish rapport with them.
- (3) Take care of their immediate physical needs:
- (4) Mobilize social support for them (but do not force it).
- (5) Protect them from further harm (like dangerous behaviour or impulsive life-altering decisions).
- (6) Convey that everybody in the disaster-affected area is having distress.
- (7) Start communicating with them; listen to their problems, convey compassion and assure them of help (but never in a forceful manner as it may insult their self respect).
- (8) Keep them under supervised care till the reaction passes off.

II. Trauma Counselling

This basically means creating safe opportunities for people to focus their thoughts, talk about them and express associated feelings. You have to facilitate this by the following actions:

- Listen attentively.
- Ask questions and clarifications to bring more details of the experiences (but never do this in a forceful/intruding manner). Some people need time before they are ready to share their experiences. Other people may not want to share their experiences and should not be forced to do so.
- Try to understand and share the pain and distress felt by the survivors and affected people.
- Communicate to them that you are with them i.e., you do understand what they went through (assuming that you do understand).
- Convey that anybody who undergoes similar situations will have feelings and distress. Share the experiences of other people.
- Talk about the ways in which the person has been trying to cope and brainstorm together for better ways to cope.
- Reassure the person that over time he will be able to cope better and better with the new situations and problems in the aftermath of the disaster.

III. Grief Counselling:

This is a technique similar to **'trauma counselling'**: 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 Counselling:

- 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 to make the process of grieving easier.

IV. Anticipatory Guidance:

- Such guidance helps the victims to accept their reactions as 'normal' and thus reduces feelings of uncertainty and helplessness.
- Provide information about the natural stress reactions that may be expected and that over time the intensity of feelings will very likely reduce.
- You can do it by holding information meetings.
- Focus not only on information about reactions, but also on what survivors themselves and their close network can do to deal with these reactions.

V. Crisis Counselling:

Often the disaster survivors may be in the middle of an ongoing personal or family crisis or stressful situation. For example, someone in the family may have a severe illness, or there may be a theft, or a child may be suddenly found missing, etc. These situations impose additional trauma and stress on the affected person who will need help and sensitive handling to deal with the crisis. You may help by providing crisis counselling consisting of the following components.

- Help the survivor to understand the problems and difficulty generated by the crisis.
- Help the survivor to enlist various alternatives and strategies for handling the situation.
- Help the survivor to assess the support network available to him.
- Help the survivor to take appropriate decisions.
- Help the survivor to develop steps for implementing the decisions.
- Try to restore a sense of capability in the survivor.

VI. Problem solving counselling

You can help the survivors by providing counselling to them in finding solution to their problems in a systematic way rather than avoiding the problem or reacting to the problem inappropriately and unproductively. You can help persons to solve specific problems by following these steps:

- Identify the problem
- Identify the alternative solutions through brainstorming
- Compare the pros and cons of each solution
- Identify the most suitable solution
- Implement the chosen solution

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 counselling skills 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 specialists available in the area.

- (1) **Previously known cases of mental disorders:** As mentioned in the beginning of this sub-module, some disaster-affected people are likely to suffering from mental disorders 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 CLWs:** As mentioned in Module-I 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 to not improve despite interventions by CLWs. 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 observations:
 - Remaining isolated and inactive
 - Extremely poor self-care
 - Loss of sense of responsibility for self and others

(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 alcohol and substance abuse:** Whenever you come across somebody complaining of severe body aches, restlessness, insomnia, muscle cramps, running nose and excessive watering of eyes or tremors, restlessness, irritability, insomnia, anxiety and craving for alcohol/drugs, enquire if the person is a habitual user of alcohol or drugs. If yes, refer the patient to a specialist.

If you find excessive drowsiness, slurring speech, unstable gait or disorientation in somebody, ask if he has increased his consumption of alcohol/drugs. If yes, ask him to see a 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. Sometimes this physical violence may be related to alcohol abuse.

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

12. MODULE III: PSYCHOSOCIAL INTERVENTION FOR SPECIAL GROUPS

Certain groups of people are more vulnerable to the psychosocial effects of a disaster. These include children, women, elderly, disabled people and persons suffering from mental or severe/chronic physical problems. In addition, bereaved people who have lost their family members or close relatives are also more vulnerable to psychosocial problems. You need to specifically attend to these groups of people to take care of their psychosocial needs.

Box items in this module describe the usual problems of these special groups and also provide guidelines to CLWs for rendering psychosocial care to these groups.

Psychosocial needs of disaster-affected children

Age group	Emotional responses seen
Pre-school children	<ul style="list-style-type: none"> (1) Irritable, crying excessively. (2) Clinging behavior. (3) Expressing intense fear and insecurity repeatedly, excessively dependent behaviour. (4) Fearful of water – even of water used for domestic purposes. (5) Excessive quietness and withdrawn behaviour, 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	<ul style="list-style-type: none"> (1) Withdrawl. (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.

Age group	Emotional responses seen
School going age group (contd.)	<p>(7) Feeling nervous, unable to concentrate.</p> <p>(8) Recurrent memories or fantasies of the event.</p> <p>(9) Fantasies of playing 'rescuer'.</p> <p>(10) Intensely pre-occupied with details of the event.</p> <p>(11) Dangerous, risk-taking behavior, rejecting social rules showing aggressive behaviour, (in adolescents only).</p> <p>(12) Loss of interest in studies, refusal to go to school, significant drop in academic performance.</p> <p>(13) Psycho-somatic symptoms like stomachache, headache, giddiness, vomiting, heavy breathing and fainting attacks.</p>

Measures to be taken by CLWs for children

- (1) Ensure that the infant/child remains close to its mother/family.
- (2) Ensure adequate nutrition and meeting of all physical needs.
- (3) Encourage and help the families to re-establish child's previous routine of eating, playing, studying, sleeping and interacting with others.
- (4) Try engaging the children in activities like drawing, storytelling, drama, games, etc., (do not too strongly encourage children to express disaster-related feelings through these activities; allow children control over the decision whether or not to think about the trauma and to express feelings about it).
- (5) Encourage the families (in groups) to facilitate play time activities specially the group games of the children.
- (6) Advise families/community leaders to start some kind of teaching activities (even non-formal) for school going children till the children are able to go back to their usual schools. Mobilize the help of educated youth volunteers for this.
- (7) Advise parents and families not to discourage children when they verbalize their feelings (but at the same time do not too strongly encourage children to express their feelings; allow children control over the decision whether or not to think about the disaster and to express feelings about it).
- (8) Whenever you meet small children in the field re-assure them verbally. Offer to be supportive and ask what they wish. If they wish to talk - listen - but do not encourage the re-experiencing of the trauma. Offer physical contact, but only if sought and in a way that cannot be misinterpreted at a later time.

Ask parents/ teachers to report on children who continue to show the symptoms even after one month and despite the appropriate measures listed above. These children may require specialist mental healthcare.

Specific measures for adolescents (Age: 10 – 19 years)

- Ensure privacy and confidentiality while interviewing them about their problems.
- Be cautious about gender sensitivity issues.
- Help them in deciding their future course of action.
- Encourage continuation of formal education especially of secondary and higher-secondary students.
- Involve them in formation of community groups.
- Encourage participation of older adolescents in community humanitarian activities.

Psychosocial care of the elderly

Possible psychological reactions

Elderly people may show one or more of the following psychological reactions to disaster:

- Immediate fear response followed by anger and frustration.
- Feel agitated, feel lonely and hopeless with a feeling of multiple losses.
- Increased dependence on families and refusing assistance from authorities.
- Withdrawn behaviour, crying repeatedly, feeling depressed
- Sleep disturbances
- Suicidal tendency.
- Disoriented as routine is interrupted.
- Concentration and communication difficulties.
- They are especially vulnerable if they are :
 - a. Physically disabled.
 - b. Living alone.
 - c. Lacking help from other resources.
 - d. Having to face the shock of losing all that they had attained in life.

Helping elderly people

- Ensure that they are not isolated and try to place them with their families or relatives or someone to whom they want to be attached.
- Ensure their physical safety and day-to-day physical needs.
- Facilitate easy access to aid and support services including health facilities.
- Help them to re-establish their daily routine
- Help them maintain their sense of identity.
- Keep them informed of the happenings.
- Involved them in relief work by asking for their suggestions and guidance.
- Interact with them about the tragedy and gently encourage them to express their feelings (but do not do this too strongly). Allow them to cry.
- Provide opportunities to feel a sense of continuity, culture and history.
- If the symptoms are causing gross dysfunction almost on a daily basis for at least two weeks then consider referral to a mental health professional (if available), or a physician.

Psychosocial care of women

Women tend to be more vulnerable to the psychosocial effects of the disaster and are likely to have more severe psychological problems than their male counterparts. They are more prone to depressive and anxiety symptoms as well as to psychosomatic symptoms. Of course, they are also able to provide higher levels of strength and ability to support others.

Some strategies to help women

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

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