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Manual for Community Level Workers to Provide Psychosocial Care to Communities Affected by the Tsunami Disaster

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CONTENTS

	<i>Page</i>
1. INTRODUCTION.....	1
2. RESPECT FOR LOCAL CULTURE IN IMPLEMENTING PSYCHOSOCIAL INTERVENTIONS.....	2
3. SOCIAL SUPPORT.....	3
4. NEED FOR EXTERNAL PSYCHOSOCIAL SUPPORT SYSTEMS.....	4
5. INTERAGENCY COLLABORATION.....	4
6. WHO CAN USE THIS MANUAL?.....	4
7. AIM OF THIS MANUAL.....	5
8. LEARNING OBJECTIVES.....	5
9. GETTING STARTED IN THE COMMUNITY.....	5
Part-I	
10. MODULE I: PSYCHOLOGICAL RESPONSES OF THE DISASTER-AFFECTED POPULATION.....	9
11. MODULE II: PSYCHOSOCIAL INTERVENTIONS FOR DISASTER-AFFECTED PEOPLE.....	14
12. MODULE III: PSYCHOSOCIAL INTERVENTION FOR SPECIAL GROUPS.....	24
Part-II	
13. MODULE IV: CARING FOR YOUR OWN EMOTIONAL WELL-BEING DURING RELIEF WORK.....	31

1. INTRODUCTION

Disasters place affected people and communities under enormous pressure. To cope with adverse physical and psychological conditions effectively is a major challenge that faces communities and their governments. Although these individuals do need and benefit from the material assistance and physical healthcare provided during the relief work, they also need appropriate psychosocial care to help them cope better with the psychological trauma they undergo during and after the disaster.

The Tsunami disaster has imposed a huge burden on the community not only in physically terms but also in the psychological trauma they have suffered. Every effort should be made to provide psychosocial support to the community, starting from the acute phase immediately after the disaster, and extending for several months and beyond till the community is rehabilitated both physically and psychologically.

It should be noted that EACH AND EVERY PERSON in the population is psychologically affected. Thus, 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 reach 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.

The international community has witnessed several major disasters in recent decades and their response is getting more streamlined. 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 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 to do so.

The present manual is meant exclusively for *Community Level Workers (CLW's)*, to help them in providing psychosocial care to the Tsunami disaster victims in SEAR.

2. RESPECT FOR LOCAL CULTURE IN IMPLEMENTING PSYCHOSOCIAL INTERVENTIONS

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

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

Important considerations include:

- Help-seeking expectations (e.g., persons used to dealing with traditional healers may expect almost immediate relief);
- Duration of treatment (which may need to be short because of limited access to care);
- Attitudes toward intervention (e.g., preference for or dislike of medication);

- Cost-effectiveness of the intervention; and
- Family attitudes and involvement (many cultures emphasize the family over the individual).

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

3. SOCIAL SUPPORT

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

- Providing uncomplicated and accessible information on location of corpses.
- Discourage unceremonious disposal of corpses.
- Helping to trace the families of unaccompanied minors, the elderly and other vulnerable people.
- Encourage members of field teams to actively participate in grieving.
- Encourage recreational activities for children including opening schools
- Widely disseminating uncomplicated, reassuring, empathic information on normal stress/trauma reaction to the community at large (religious leaders, teachers and other social leaders should be involved actively).
- Encourage the reestablishment of normal cultural and religious activities
- Involve adults and adolescents in concrete purposeful activities (eg. repair of housing, distributing food, sanitation measures, etc.)
- Assist illiterate people to deal with completing official documentation required in order to obtain aid.
- Occupational rehabilitation for those who may have lost their means of livelihood.

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. INTERAGENCY 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.

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 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 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 counseling 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 counseling 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.

Part-I

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

Disasters leave a psychological impact varying from transient reactions to the incident among the survivors, to lifelong emotional scars. 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) Denial of the situation
- (5) Restlessness, confusion
- (6) Extreme forms of reactions with agitation, aimless wondering, crying and withdrawal.
- (7) 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 no specific psychological intervention.

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 survivors 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 need only 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 populations (positive and negative patterns)

Positive coping skills

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

Negative coping skills

- Excessive denial and avoidance
- Impulsive behaviour
- Over-dependence
- Inability to evoke caring feeling in others
- Emotional suppression
- Substance abuse
- Inability to use support systems

After about three weeks of disaster

The previously noted reactions may persist or give way to other symptoms such as:

- (1) Restlessness, panic
- (2) Sadness, pessimistic thoughts
- (3) Outward inactivity, isolated and withdrawn behavior
- (4) Anxiety manifested as physical symptoms as palpitations, dizziness, restlessness, nausea, headache, etc.

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

Neuropsychiatric problems after disaster

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

Acute stress disorder

Immediately after a disaster, people often may experience symptoms such as shock, disbelief and numbness, sleeplessness, intense anxiety and fear, irritability, anger, various bodily complaints, restlessness, anticipatory anxiety, frightening 'flashbacks' of the traumatic experience, nightmares, vivid memories of the terrifying moment of trauma, despair and grief. In some people, these symptoms may be more intense and significantly disabling. The condition is then referred to as 'acute stress disorder'. The disorder usually occurs within a few days of the disaster and causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

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, valuable 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 traumatic events.

Diagnosable psychiatric disorders

Some psychiatric 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 enlisted in the beginning of this module can persist or appear as symptoms of Depressive disorders and Anxiety disorders as mentioned here. You should be careful that a group of symptoms is considered as a psychiatric disorder only when the symptoms persist beyond three weeks after disaster and 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. The symptoms of PTSD usually occur in 3 dimensions namely, (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.

Pre-existing neuropsychiatric disorders

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

Physical symptoms

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, be careful that it is not always necessary that physical symptoms are due to psychosocial trauma. Hence refer the individual to a physician whenever you think 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 concern 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 for 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.

Important Do's and Don'ts for CLWs:

Do's

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

Don'ts

- Do not force your help/ support
- Do not interrupt people when they share their emotions
- Do not pity on them
- Do not be judgmental
- Don't allow rumours to spread
- Do not label people with psychiatric diagnoses easily (avoid over psychiatrization)

Try to show Empathy rather than Sympathy

Empathy	Sympathy
(1) I can understand what you are going through.	(1) 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.	(2) It is horrible that this has happened to you
(3) I accept that you are very scared	(3) Don't be scared, I am here to help you however I can.
(4) Simply sitting in silence while the survivor expresses his/ her feelings or weeps.	(4) I am so sorry for you, don't worry everything will be all right.

Intervention during 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 the 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:** Some victims suffer from psychological symptoms (but not disorders) and require psychosocial care from relief workers in the form of specific interventions like emotional first aid, grief counseling, etc. The methods by which these services can be provided are described below.
- (3) **Identification and referral:** Some people who suffer from syndromal psychiatric disorders will need to be identified by the relief workers and be referred to specialist mental health services available in the area.

Specific psychosocial interventions (basic counseling) 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 COUNSELING SKILLS. Early identification and early intervention can help these people to cope better and prevent the perpetuation or culmination of these symptoms into a full blown psychiatric illness.

CLWs should learn these counseling 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 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, Ventilation/ Catharsis, Re-grieving and Anticipatory Guidance, Crisis counseling, Crisis intervention, Problem solving counseling etc.).
- (6) Deliver the chosen counseling

Effective communication with disaster-affected people:

Attentive listening

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

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

Try to practice Reflective Listening as much as possible

It should be noted that psychotherapy or intensive counseling on a one to one basis (eg. intrusive cognitive debriefing) can be harmful to individuals specially if attempted by non mental health professionals like CLWs.

Counseling techniques to be used by CLWs

I. Emotional first aid:

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

Technique of emotional first aid include:

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

II. Ventilation/ Catharsis: Talking out their emotions

This is a very important technique which can be implemented for many weeks following the disaster. This basically means making people focus their thoughts, talk about them, express associated feelings and to ventilate their emotions. It is helpful if people are able to work through their traumatic experiences again and again during the post-disaster relief work. You have to facilitate such 're-living' and active 're-experiencing' of the painful events by following actions:

- Listen attentively,
- Ask questions and clarifications to bring more details of the experiences (but never do this in a forcing/intruding manner)
- 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.
- Convey that anybody who undergoes similar situations will have the same feelings and distress. Share the experiences of other people.
- Reassure the person that he will be able to cope well with the new situations and problems in the aftermath of the disaster.

III. Grief Counseling:

This is a technique similar to **'talking out their emotions'**: but modified to help bereaved survivors (i.e. those, who have lost their close ones). The person is made to talk about his relatives who have died and also 're-live' his disaster experiences. 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.
- 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 this is a natural human reaction to think that why they could not save their family members.
- 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 the reactions as 'normal' and thus reduces feelings of uncertainty and helplessness.
- Provide information about the natural post-traumatic stress reactions that may be expected.
- 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 Counseling:

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 situation. You may help by providing crisis counseling consisting of the following components.

- Help the survivor to understand the problems and difficulty generated by the crisis situation.
- 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 and optimism in the survivor.

VI. Problem solving counseling

You can help the survivors by providing counseling 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
- Compare the pros and cons of each solution
- Identify the most suitable solution
- Implement the chosen solution

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.
- Do not consume excessive amounts of alcohol or sedative medications.
- Eat right and sleep well.

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 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 these disorders and should be able to refer these cases to the specialists available in the area.

1. Previously known cases of neuropsychiatric disorders: As mentioned in the beginning of this sub-module, some disaster-affected people are likely to suffer from diagnosable psychiatric disorders. Usually the psychiatric disorders do not become apparent until 4 to 6 weeks after the disaster and many times they develop only months or even years after the disaster. However even during the initial 4 to 6 weeks you may find exacerbation/relapse in symptoms of known cases of mental illnesses (e.g. psychoses). Similarly, you may find the relapse in the 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: As mentioned in Module-I some of the individuals may develop neuropsychiatric disorders after disaster and may have significantly distressing and disabling symptoms even three weeks after disaster.

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.

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. Excessive 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 severe psychiatric disturbance. 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	<ol 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 involve aspects of the disaster event. (8) Re-enactment of the event over and over again. (9) Reporting frightening dreams (nightmares and night terrors) waking up frequently in between the sleep, refusal to go to bed at times.
School going age group	<ol style="list-style-type: none"> (1) Guilt. (2) Feelings of failure. (3) Anger, rage and aggressive behaviour. (4) Fearfulness, anxiety or suspiciousness. (5) Feeling low, decreased activity and interaction level. (6) Feeling nervous, unable to concentrate. (7) Recurrent memories or fantasies of the event (8) Fantasies of playing 'rescuer'. (9) Intensely pre-occupied with details of the event. (10) Dangerous, risk-taking behavior, rejecting social rules showing aggressive behaviour, (in adolescents only). (11) Loss of interest in studies, refusal to go to school, significant drop in academic performance. (12) Psycho-somatic symptoms like stomachache, headache, giddiness, vomiting, heavy breathing and fainting attacks.

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 it yourself if possible, otherwise encourage family members/ volunteers to do this). Encourage if the themes are related to sea, water waves or other aspects of Tsunami. These activities facilitate the expression of feelings and thus aid ventilation/catharsis.
- (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.
- (8) Whenever you meet small children in the field touch them, hold them, re-assure them verbally and encourage them to talk about what they witnessed

Ask mothers/ 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: 11 – 18 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
- Ensure continuation of formal education especially of secondary and higher-secondary students
- Involve them in formation of community groups.

Psychosocial care of the elderly

Common psychological reactions

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

- Immediate fear response followed by anger and frustration.
- Denial as a normal defensive reaction to the trauma
- 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

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

Helping elderly people

- 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 reestablish 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 encourage them to ventilate their feelings. Allow them to cry
- Provide opportunities to feel a sense of continuity, culture and history.
- If the symptoms are causing gross dysfunction persisting beyond 4 weeks then consider referral to a mental health professional (if available), or a physician.

Psychosocial care of women

Women are 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

- Ensure that they stay close to their families.
- Involve them in community level activities like in community kitchen, sanitation, group religious activities.
- Involve them in ongoing relief activities like arranging group game play or teaching activities for the children, identifying physically ill people in the community etc.
- Encourage them to form self help groups for sharing of traumatic experiences.
- Specific intervention techniques described in previous module may be more frequently required in women.
- Extend special care to pregnant and nursing mothers by ensuring adequate nutrition, appropriate medical care, physical safety and privacy

Part-II

13. MODULE IV: CARING FOR YOUR OWN EMOTIONAL WELL-BEING DURING RELIEF WORK

Introduction

Workers participating in rescue and relief work after a disaster are exposed to traumatic stress which may affect their own emotional well-being. It has been observed and documented that relief workers develop stress-related problems during relief work and even after relief work is over.

Supervisors must make sure that field workers are promptly briefed about what to expect where they are going. Many community level workers will never have seen mutilated bodies or misery in such a large scale as in disasters. They must be properly counseled on these matters before they start their work.

You have been (will be) doing a very noble job by providing relief services to the disaster-affected communities. You might be working overtime, over exerting yourself, witnessing the plight and trauma of the people very closely and frequently realizing your limitations in helping them. These are likely to put you under severe stress and lead to what is often called "burnout". It is your responsibility to manage this stress and control its untoward effect on your emotional well-being and psycho-physical functioning. This is important not only for your own well-being but it can also affect your ability to serve disaster-affected people. This module provides information about the possible factors causing stress to relief workers and also provides guidelines to ensure your emotional well-being.

Before venturing out into the community make sure you are properly prepared in terms of living arrangements, food arrangements and communication needs. It is very important to keep in touch with your family and friends.

Stress in relief workers: why does it occur?

You are constantly exposed to stress during relief work due to the following reasons:

- You are repeatedly exposed to grim experiences such as handling bodies, dealing with multiple casualties, powerful emotions and tormenting stories of people affected.
- You frequently carry out physically difficult, exhausting, or dangerous tasks.
- You are exposed to unusual personal demands to help meet the needs of survivors.
- Frequently, you put your own physical and emotional needs at low priority to ensure maximum service to disaster-affected people.
- You neglect your sleep, food, and at times, even personal hygiene in your excessive concern for survivors.
- At times you perceive that you are not able to do enough good to the people and therefore you feel frustrated and helpless.
- At times you feel guilty that you have better access to food, shelter, and other resources than the survivors.
- Frequently, you face moral and ethical dilemmas.
- You are exposed to the anger and apparent lack of gratitude of some affected people
- You may be away from your home and family which deprives you of a very effective psychosocial support system.
- You may feel frustrated by the policies and decisions of your superiors.

Warning signs of unmanageable stress

You should be aware of some warning signs of unmanageable stress either in yourself or in your colleagues.

- Mental confusion, inability to make judgments and decisions, inability to concentrate and to prioritize tasks
- Inability to express verbally or in writing

- Anxiety, irritability, depression, excessive rage reactions
- Neglecting one's own safety and physical needs
- Sleep difficulties
- Appetite disturbances
- Excessive tiredness
- Progressive decline in efficiency
- Loss of spirit
- Self-blame
- Decreased self-esteem
- Heroic but reckless behaviour
- Grandiose beliefs about self importance
- Increased stress within relationships
- Mistrusting colleagues and supervisors
- Excessive use of alcohol, tobacco or drugs
- Feeling unappreciated or betrayed by the organization/ agencies one is working with

What you can do for yourself?

Self-help tips to reduce stress during relief work

- Try not to be emotionally involved, i.e. transfer the grief of others on to yourself. Be very kind and humane but a little detached.
- Be proud of yourself for volunteering your services. Realise that your work is very important even if at times people do not appreciate this.
- Remember that your reactions are normal and unavoidable.
- Be aware of your tension and consciously try to relax. You may also do deep breathing exercises for 10 to 15 minutes once or twice a day.
- Try to find time to do something you enjoy. e.g. listen to music, read a book, go for a jog etc.

- If you cannot sleep or feel too anxious, discuss this with someone you can trust. Don't take sleeping pills, or alcohol and other drugs.
- Talk to someone with whom you feel at ease; describe to him/her what you were thinking or feeling during the critical event.
- Listen to what people close to you say and think about the event. It has affected them too, and they may share insights that will benefit you.
- Continue to work on routine tasks if it is difficult to concentrate on demanding duties. Ask your colleagues/ supervisor to reschedule your duties.
- Tell your peers and team leader/supervisor about how the distressing event has affected you, so that they can understand.
- Avoid inflated or perfectionist expectations, either about yourself or others, lest you feel frustrated.
- Participate in group exercises like debriefing and defusing.
- After a few weeks if you still feel uneasy about your reactions, you should seek professional advice.
- Do not self-medicate in any circumstance.
- If at all possible communicate with your family on a daily basis.

Self-help groups for managing stress

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 "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 work through the stressful experiences of the relief worker. The most commonly used exercise is “debriefing”.

Debriefing

Debriefing is a process of semi-structured group discussion which involves going through, in detail, the sequence of events as experienced by each participant (relief worker). The discussion focuses on the cognitive and emotional reactions of relief workers who are trying to cope with the distressing situations that accumulate from their work experiences. The debriefing is carried out as follows.

- It is done in small groups (8-10) of relief workers working from the same agency / organization.
- The supervisor or the senior-most worker acts as the formal leader of the debriefing group.
- Usually, the debriefing exercise is done in a supportive and confiding environment.
- Usually, the debriefing should be carried out every evening.
- Each debriefing session usually lasts for about 2 hours.
- In the beginning, each worker gives factual information on the day's activities.
- This should be followed by a detailed description of the professional activities carried out by each relief worker.
- Workers should share the emotional and psychological reactions experienced by them while performing these activities.
- Both negative and positive experiences should be shared. The group leader as well as relief workers should encourage the expression of these experiences.
- The group should be able to highlight the normality and similarity (universality) of experiences of all the relief workers and the range of coping methods used by them.

- The group leader (and other participants) should appreciate the relief workers for their successful coping and the positive gains during relief work.
- Groups should advise and support relief worker(s) who have shared their difficulties in coping well in the field.

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 emotional care of relief workers:

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

- (1) **Defusing intervention:** A supervisor or a senior relief worker can help a colleague to express his thoughts and feelings about a task at hand.
- (2) **Consultation:** A relief worker should approach his 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.
- (3) **Crisis Intervention:** This may be required in rare instances where a relief worker is in a crisis situation due to any reasons – personal, familial or fieldwork related. The supervisor or the group leader has the responsibility for providing appropriate crisis intervention services in these cases.

Conclusion

Stress among relief workers is an important issue and should be addressed directly. Accepting the fact that it may occur, openly discussing it and supporting those who may be affected is crucial to the well-being of relief workers. It is the responsibility of the relief worker themselves, the supervisors and the organization for which they work to take care of the well-being of all workers.

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