

# Psychological Support in Events of Mass Destruction

## Challenges and Lessons

*The 1990s saw the introduction and implementation of psychosocial support as an important component of disaster management programmes. This article presents a community-based psychosocial programme that seeks to address three challenges identified in India when providing psychosocial support services. These challenges included assessment of the impact of a disaster on survivors, participatory planning to involve the community in support programmes and lastly the development and preparation of material to help the community help itself.*

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The last 25 years have witnessed the emergence of a new field within the rubric of mental health care. Psychological support has become an important component of the disaster preparation and response repertoire. The beginning of the 1990s witnessed the birth and evolution of psychosocial support [Jacobs 1995; Morgan 1994; Weaver 1995]. Research has been progressively increasing [Norris, Friedman, Watson, Byrne, Diaz, Kaniasty 2002]. Psychological support in disaster has been defined in many ways: disaster mental health [Jacobs 1995; Morgan 1994], psychological support [Simonsen 2001], trauma counselling [Kishore Kumar, Chandrashekar, Chowdhury, Parthasarathy, Girimaji, Sekar and Srinivasa Murthy 2000] and psychological first aid [Slaikeu 1990; Prewitt Diaz 2001].

The purpose of this paper is to present the three challenges raised in the development of a community-based psychosocial programme in India. The challenges were, (i) assessment, (ii) participatory planning, (iii) material development and translations.

Events of mass destruction in the last five years around the world: Terrorist Attacks on September 11, 2001 in the US, El Salvador Earthquake (January 13 and February 13, 2001), Gujarat Earthquake (January 26, 2001), the Bali Bombing (October 12, 2002) have served as stimuli to many academic practitioners to seek knowledge about human behaviour before, during and after an event of mass destruction [Seynaeve 2001; Australian Emergency Manuals 2002; Butler, Pazer and Goldfrank 2003; Pan American Health Organisation (PAHO) 2002].

Most recently two major organisations have proposed guidelines for psychological support as a part of the preparation and response services to events of destruction [World Health Organisation 2003; International Federation of the Red Cross-IFRC 2003].

Informed by a range of documents by acknowledged experts on guidelines, principles and projects, the Department of Mental Health and Substance Dependence draws attention to the following general principles: (1) Preparation before the emergency (2) Assessment (3) Collaboration (4) Integration into primary health care (5) Access to services for all (6) Training and supervision (7) Long-term perspective (8) Monitoring indicators'.

– World Health Organisation, 2003

The Policy for Psychological Support (International Federation of the Red Cross and Red Crescent [IFRC 2003] states that (i) it is the responsibility of national societies to include psychological perspective in every area of intervention, (ii) design psychological support as a component in other programmes like disaster preparedness, disaster response, first aid, health, social welfare, youth and organisational development, (iii) provide psychological support as a long-term and reliable commitment to ensure that the psychological aspects of relief work are professionally implemented and make a crucial difference to the population, volunteers and staff affected by the disaster. The IFRC (2003) policy refers to the design of psychological support according to basic principles.

The basic principles defined by the IFRC and adopted by the Indian Red Cross Society are:

(i) A community-based approach as opposed to a clinical and/or individual approach. The majority of reactions following a disaster, for example, distress and suffering, are not psychiatric illnesses (and do not therefore require professional treatment), but are reactions that can be prevented from developing into something more severe if services such as information, psychological education and support groups are provided. Working with people on an individual basis should be the exception, as this only responds to the needs of a few, and might lead to stigmatisation. To tackle problems in isolation is expensive and is not sustainable.

Any organised activity should relate to everyday realities and priorities that have been identified by the communities. It is important to make use of institutionalised social infrastructure already in existence. Target beneficiaries of PSP should be considered active survivors rather than passive victims.

(ii) Using community volunteer technicians and specialists forms an important response of the Indian Red Cross Society. With training and support from mental health professionals, community volunteers can work in an independent, efficient and effective manner. These community volunteers have access to, and have confidence of the beneficiaries. And, equally importantly, they are equipped with the necessary cultural sensitivity to provide adequate assistance to the affected population.

(iii) The programme will be technically appropriate and sensitive to the cultural and linguistic diversity of India. Programmes should be designed and implemented through a continuous community dialogue. The goal is to reintegrate individuals and families within the community, and identify and restore existing networks and coping mechanisms. Emphasis is placed on being aware of the level of heterogeneity in the community, communicating with local partners and beneficiaries, to create mutual trust and respect for linguistic diversity and cultural beliefs. Staff and local professional resources should be used to assure appropriateness of programme delivery.

(iv) Identifying and strengthening problem-solving resources in the community. The IRCS recognises it is important that communities have the capacity to help themselves through their own support networks and coping mechanisms that existed prior to the disaster. One of the important tasks pre-disaster is to find out about communities' previous and existing coping mechanisms and strategies, and support or build on these. In some situations, support structures may have disintegrated as a consequence of the disaster, and an alternative structure has to be introduced. This new structure should be adapted to the community's pre-disaster traditions. Facilitating access to communication with family and relatives and to family reunion, because these are very effective methods in promoting psychological well-being, and in reassuring people, especially children. The focus is on people's positive efforts to deal with and come to terms with their experiences, without minimising their concerns.

### Psychological Support in India

In India the National Institute of Mental Health and Neurosciences (NIMHANS) [Srinivasa Murthy 2002] has been at the forefront in studying the psychological consequences of disasters and interventions systematically since the Bangalore circus fire (1981) to the Gujarat riots of 2002 [Sekar, Sen Dave, Bhadra, Rajashekar, Kishore Kumar, Srinivasa Murthy 2002; Sen Dave, Sekar, Bhadra, Rajashekar, Kishore Kumar, Srinivasa Murthy 2002].

A review of existing literature in India [Srinivasa Murthy, Isaac 1987; Suri 2000; Mukherjee 2002; Kishore Kumar, Chandrashekar, Chowdhury, Parthasarathy, Girimaji, Sekar and Srinivasa Murthy 2000; Bharat, Chandrashekar, Kishore Kumar, Chowdhury, Parthasarathy, Girimaji, Sekar, and Srinivasa Murthy 2000; Sen Dave, Sekar, Bhadra, Rajashekar., Kishore Kumar and Srinivasa Murthy 2002; and Sekar, Sen Dave, Bhadra, Rajashekar, Kishore Kumar and Srinivasa Murthy 2002] present in-depth discussions on the need for psychosocial care after disasters such as the Orissa super cyclone, the Gujarat riots, and the Bhopal gas tragedy.

Lakshminarayana (2003, Table 1) has compiled all the studies documenting psychological response offered by institutions in India. All studies are in agreement that immediate response requires that great needs in the population need to be that and that many government and non-government organisations provide support to the surviving population. There is concurrence that psychological support is a long-term proposition that should be addressed by government organisations in the case of individual needs and non-government organisations in terms on community level work.

Organisations such as the National Institute for Mental Health (NIMHANS), OXFAM India, ACTION AID India, and CARE,

**Table 1: Disaster Mental Health in India – Overview**

Event	Casualties	Interventions
Bangalore Circus fire Tragedy (1981)	70 dead; mainly children	<ul style="list-style-type: none"> <li>– First systematic study of the psychosocial needs of the bereaved family</li> <li>– Majority of the survivors reluctant to seek professional help in psychiatric settings</li> <li>– Home based help, utilising community resources is feasible and effective</li> </ul>
Bhopal Gas Tragedy (1984)	More than 2,000 dead; 7,00,000 affected	<ul style="list-style-type: none"> <li>– Teams of psychiatrists, clinical psychologists, psychiatric social workers located in the city for periods of 2-4 weeks to provide psychiatric care to affected population</li> <li>– 50 medical officers were working in the various health facilities in the gas-affected area were trained to enhance their sensitivity to the emotional needs of survivors and to provide the skills to recognise, diagnose, treat and refer (when required) the mental health problems. Initial training was six days and it was conducted by senior psychiatrists, training manual was prepared.</li> </ul>
Bombay Riots (December 1992-January 1993)	500 dead; 67,000 affected	<ul style="list-style-type: none"> <li>– Study conducted of 192 hospitalised patients revealed that 33 per cent expressed anger and were in a state of shock, fear and helplessness; 2 per cent of those had attempted suicide; 21 per cent of those interviewed suffered from severe anxiety; 41 per cent had paranoid thinking and obsessional symptoms and majority had loss of libido</li> </ul>
Marathwada Earthquake (1993)	8,000 dead; 14,000 injured 1,70,000 affected	<ul style="list-style-type: none"> <li>– Core team consisted of psychiatrists, psychiatric social workers, clinical psychologists, psychiatric residents and nursing counsellors</li> <li>– The services were taken at the doorstep of the survivors and presented as stress, crisis and counselling services</li> <li>– Delivery of services was in the immediate intervention (first month post disaster) and outreach counselling services (second to six month post disaster)</li> </ul>
Baripada Fire (1997)	277 dead; 30,000 affected 1,500 injured	<ul style="list-style-type: none"> <li>– Survivors reported psychological distress.</li> <li>– Anxiety, depression, and Post-Traumatic Stress Disorder reported</li> </ul>
Gujarat Cyclone (1997)	10,000 dead; 1,000 affected	<ul style="list-style-type: none"> <li>– Trained Community Level Workers (CLW) provided psychosocial care</li> <li>– CLW were able to provide the essential care which was effective in decreasing distress, disability and improving the quality of life of survivors</li> </ul>
Yamuna Pusta Fire (1999)	32 killed; many injured	<ul style="list-style-type: none"> <li>– Team consisted of psychiatrists, social workers, psychologists</li> <li>– Short-term and long-term (up to 10 months) interventions planned</li> <li>– Certain groups at higher risk of developing psychiatric disorders than others</li> </ul>
Orissa Super Cyclone (1999)	9,885 killed; 15 million affected	<ul style="list-style-type: none"> <li>– Team consisted of a psychiatrist and a psychiatrist social worker who trained a group of 20 trainers (CLW) for a week in general principles; specific training to handle children including principles of play therapy given for a month; two day training to deal with specific problems relating to women imparted. Training included theoretical and practical applications of skills delivery, with clear defined roles for the CLW</li> <li>– Implementation of psychosocial support was done in an organised manner</li> <li>– Systematic evaluations of survivors reveal that those intervened with psychosocial support do show significant benefits of reduction in psychological morbidity, disability and better Quality of life</li> <li>– Manuals for CLW and teachers produced</li> </ul>
Gujarat Earthquake (2001)	More than 20,000 killed; 1,67,000 injured; 15.9 million affected	<ul style="list-style-type: none"> <li>– Team consisted of psychiatric social workers with regular inputs by psychiatrists</li> <li>– Patients attending primary health care centres found to have psychological distress</li> <li>– 80 per cent of people with paraplegia and amputation had psychological morbidity</li> </ul>
Gujarat Riots (2002)	2,000 killed; 1,50,000 displaced	<ul style="list-style-type: none"> <li>– Team consisted of psychiatrists and psychiatric social workers</li> <li>– Psychosocial intervention provided through Community Level Helpers (CLV)</li> <li>– Manuals for CLW, survivors, children and women produced</li> <li>– Regular monitoring and evaluation done</li> </ul>

have developed community-based mental health programmes in affected communities in Orissa and Gujarat. Recent studies [NSW 2000; Saynaeve 2002; Srinivasa Murthy, Kar, Sekar, Swain, Mishra and Daniel 2003; Butler Panzer and Goldfrank 2003] report that psychosocial care is an important part of the long-term rehabilitation of the survivors. They found in their studies that (i) proactive community interventions are important, (ii) community level helpers are an important link to provide service, (iii) care should be provided to the total community, (iv) practical assistance is as important as emotional support, and (v) psychosocial care should be a long term proposition.

### Response of the India Red Cross Society

The Indian Red Cross Society (IRCS) has 32 branches in the country with 650 district and sub-district branches. The IRCS is conscious of the exceptional emotional needs of survivors of events of mass destruction. As a result of the Gujarat earthquake in 2001, the IRCS requested the American Red Cross to provide technical assistance in the development of a community-based programme that would provide immediate assistance to survivors for disaster and first responders, and provide assistance after a disaster in the form of disaster preparedness in schools and villages in selected states.

The Indian Red Cross Society began to provide psychological support to survivors after the Gujarat earthquake of 2001 and the Gujarat riots of 2002. Some lessons have been learned by the experiences: (i) preparation is essential, in the form of education and assessment (ii) psychological support programme will become sustainable if they are long-term interventions, and a need to develop (iii) community-based psychological support programmes.

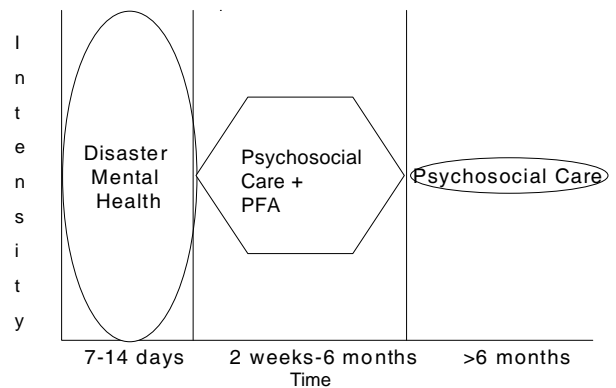
The India Red Cross Society [Ramalingam 2003] has developed a model psychological support programme (disaster mental health/psychosocial care programme-DMH/PC), which is grounded on the 'Continuum of Disasters' [Quarantelli 1985] (Figure 1).

During the preparation, warning and immediate response phases of the disaster, disaster mental health [Jacobs 1995] is the predominant tool. The disaster mental health model proposed by Jacobs (1995) and Mascelli (1988) is operationally defined as: "A service that focuses on the mental health needs of those directly affected by disaster, of disaster relief personnel, and of those indirectly affected by disaster (secondary victims). The field can be broadly divided into three areas: preparation, direct services and research" [Jacobs 1995: 545]. Specifically, the model proposes to inform the public about the emotional responses to a disaster, and to conduct rapid needs assessment and also provides defusing and debriefing services to first responders and survivors during the disaster.

A model for India should include education about possible disaster experiences and how to deal with them, training through disaster exercises, awareness of likely psychological reactions in the self and others is helpful, and psychological first aid as the immediate intervention. The mental health interventions proposed herein will increase a person's capacity to respond appropriately, to recognise and deal with the effects of stress and will lessen the likelihood for adverse emotional outcomes.

Psychological first aid is defined as an intervention that is given to a person in crisis, by a peer, community member, or a Red Cross volunteer with the purpose of alleviating the tensions,

**Figure 1: Continuum of Emotional Response to Disasters**



assuring that basic needs are met, and that the person feels supported and validated [Slaikeu 1990; Prewitt Diaz 2001; Pan American Health Organisation-PAHO 2001; Butler, Panzer and Goldfrank 2003] define psychological first aid as a group of skills identified to limit distress and the negative health behaviours that can increase fear, arousal, and subsequent health care utilisation. This intervention will enhance and promote individual and community resilience. This methodology requires that large numbers of schools, villages and Red Cross volunteers be trained in psychological first aid.

During the rehabilitation and reconstruction period, a multidisciplinary model best described as psychosocial care is recommended [Murthy, Kar, Sekar, Swain, Mishra and Daniel 2003]. Aarts (2000) defines psychosocial care as a broad range of community-based interventions that promote the restoration of social cohesion and infrastructure, as well as the independence and dignity of individuals and groups. Psychosocial care fosters resilience in the survivors and the community and serves to prevent pathological developments and further social dislocation.

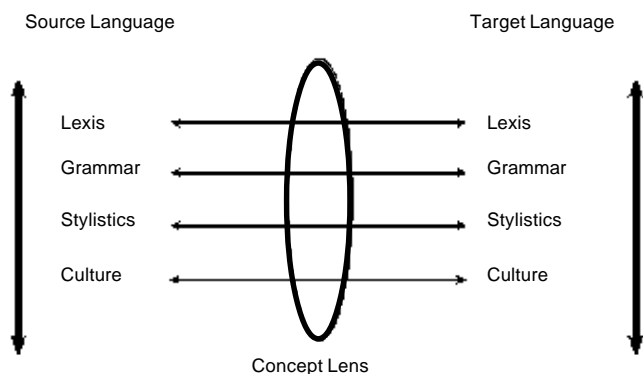
### Assessment

Several assessment tools [Petevi, Revel and Jacobs 2001; Centre for Disease Control and Prevention (CDC) 2003], and the adapted Haddon Matrix [Butler, Panzer and Goldfrank 2003] appear in the literature. These tools are very appropriate for assessment of immediate response to an event of mass destruction. That is, these tools measure emotional effects after an event based on clinical behaviours. This is not suitable for a community-based assessment. The International Centre, Netherlands Institute for Care and Welfare [Aarts 2000], the John Hopkins School of Public Health, and the International Federation of Red Cross and Red Crescent Societies [Abdallah and Burnham 2001] have proposed guidelines for community assessment.

The IRCS has set forth in the development of a typology of human behaviours in the community during the pre-impact, impact, and post-impact behaviours [Prewitt Diaz and Bordoloi 2003] utilising the Australian typologies [Australian Emergency Manuals Series 2002]. The use of ethnographic field study has been found to be applicable in the Indian context with its multiple languages, cultures, and castes.

Ethnography is a scientific method of recording people's beliefs, behaviour, and culture directly from life [Prewitt Diaz, Trotter, Rivera 1990]. It is a full or partial description of the activities of a group. In this case it would be the community that has been

**Figure 2: Process of Translation**



Source: Adapted from A Darwish (1999). The translation process: A view of the mind ([www.surf.net.au/writerscope/translation/mindview.html](http://www.surf.net.au/writerscope/translation/mindview.html)).

affected by the event of mass destruction. Ethnography is a five step cyclical process: (i) entry into the affected area, where primary and secondary survivors have settled, (ii) initial observations and interviews, (iii) information review and confirmation, (iv) increasingly intensive focused interviews on selected topics pertaining to rehabilitation and reconstruction, and (v) exit from the affected area. This procedure takes approximately 12 weeks to complete and will provide the survivors with an opportunity to provide inputs into the community-based psychosocial care programmes.

The type of information obtained consists of: (i) data on daily routine of the survivors currently and pre-disaster, (ii) observation of the emergency responders and the reaction of the survivors to the interventions, (iii) observation of the survivor's interaction with the IRCS and with government and non-governmental agencies, (iv) participant observation on the transition from the emergency phase to rehabilitation, (v) detailed description of different target groups in the community (children, elderly, women, members of lower castes, and others as needed), (vi) participant observation on the community recovery process, and (vii) observation of behaviours, habits and attitudes toward reconstruction.

The information gathered will be crucial in the planning of community-based psychosocial care programmes. In addition, behaviours that provide a community thermometer about how the community moves from being a survivor to achieving community resilience can be identified.

### Participatory Planning

A manual entitled 'Communities in Disasters: From Crisis to Recovery' outlines participatory planning process the community needs to engage in immediately after an event of mass destruction. The manual proposes that the communities develop the capacity to plan and implement community-based psychological support programmes by engaging members from different community groups specifically women, religious minorities, and members of lower castes.

Initially, the district branches of the IRCS conducted a needs assessment. This exercise provides an opportunity to identify the population and identify specific target groups such as religious minorities, specific cultural groups, and lower castes. Other assessments included psychological support services provided

to date, identified psychological and social problems and the projected needs. The next step involved a visit to the community or village. A meeting was held with the leaders of the community and with representatives of the population to be served. A final proposal was drafted and submitted to the state branch and to the national headquarters of the IRCS for approval, and assignment of funds to operate the project.

There is currently one long-term; community-based psychological support projects in the state of Gujarat, and two in the state of Orissa (Table 2). At the national level there will be a project to provide psychological first aid (PFA) training to 24,000 members of the St John's ambulance who serve as first responders together with the India Red Cross society during an event of mass destruction.

### Material Development

During the preparation phase of an event of mass destruction, dissemination of materials to the public in the villages and the schools is essential. The IRCS prepared one manual for the training of community facilitators. This manual prepares community volunteers to organise small groups in the villages, define the community needs by preparing a community risk map, conduct disaster mental health promotion activities in the community and the principles of psychological first aid.

A second manual was prepared for teachers in the target schools. The manual provides information to teachers about the importance of emotional preparedness prior to an event of mass destruction. It is divided into five modules (i) risk reduction, (ii) preparation of a school crisis response plan, (iii) role of participative teaching in crisis response, (iv) role of the teacher in stress reduction, and (v) stress management and self-care.

The material development effort of the psychological support programme of the IRCS is to prepare the target villages and schools to recognise potential psychological risks among members (for example, anxiety, fear, and situational stress). It helps teachers and community facilitators to identify strategies that need to be developed to cope effectively with an event of mass destruction.

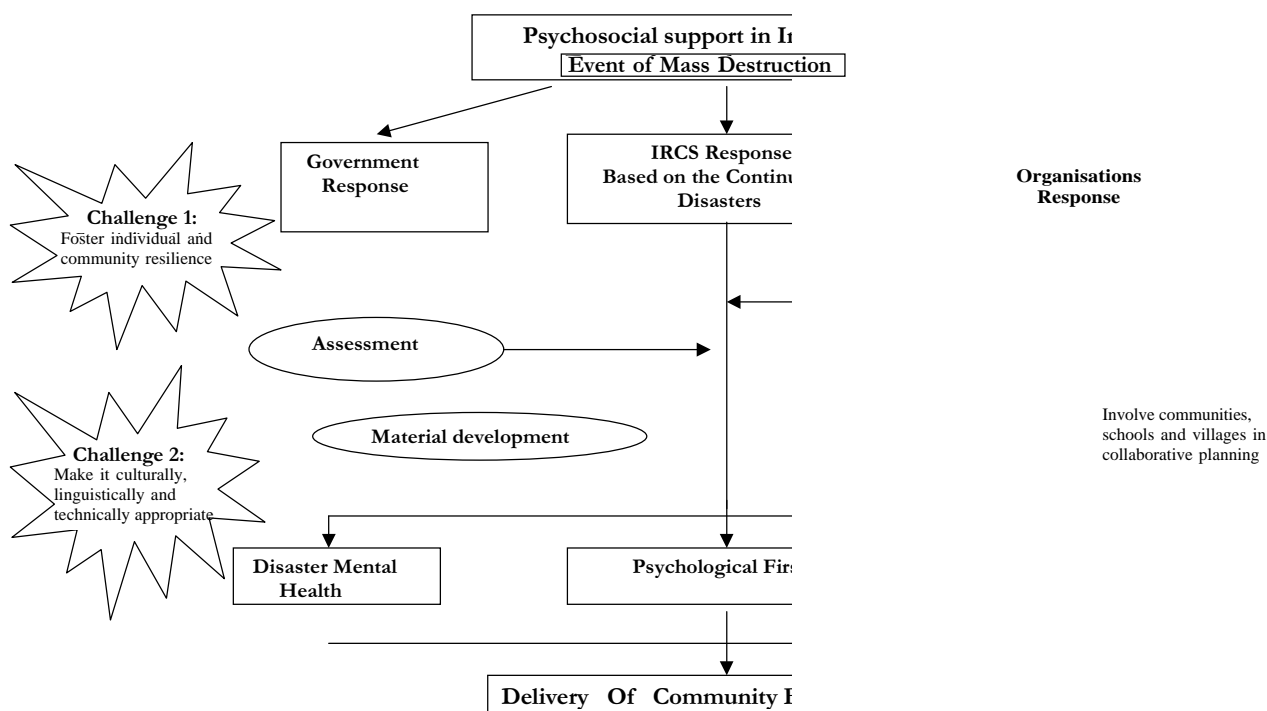
One of the challenges, experienced by the IRCS staff was to identify the methodology to develop materials for the communities. Attempts were made to find out the kind of materials that would most appropriately represent the community-accepted behaviours during the pre-impact, impact, and immediate post impact.

Initially the development of trifolds and posters was guided by the assumption that the behavioural responses to an event of

**Table 2: Current IRCS DMH/Psychosocial Care Programmes**

Location	Beneficiaries
Bhuj, Gujarat	(a) 2,000 families, i.e., 10,000 individuals – Specific focus on 340 orphaned children, widowed women, 200 adolescent and about 200 elderly of both sexes (b) 10 schools in Bhuj city – Children in age group of 5-12 years – 4,500 children and 9000 parents – 20 teachers to be trained in psychological first aid and stress management skills
Orissa (Sanapatna, Jaganathapatna, Sipakuda, Gabakunda)	(a) 30 villages with an approximate population of 16,000 (b) 45 schools in the chosen communities (c) Clientele using the Family Counselling Centre at the Orissa State Branch

**Figure 3: Model for Steps in Delivery of Care and Challenges in Developing a Psychosocial Support Programme in India**



mass destruction were universal (for example, confusion, anger, negotiation and resolution). The technical component of the materials was appropriate, however, the visuals did not represent the realities of all the target communities. This resulted in community members focusing more on ‘that visual is not like us’ rather than the information provided by the trifolds.

The second lesson learned was that materials generated in English had to be translated into the four target languages (Hindi, Gujarati, Telugu, and Oriya). There have been concrete efforts to translate questionnaires [Saxena, Chandiramani, Bhargava 1998; Sharan, Kulhara, Verma, Mohanty 2002] and manuals [Sen Dave, Sekar, Bhadra, Rajashekar, Kishore Kumar, Srinivasa Murthy 2002; Sekar, Sen Dave, Bhadra, Rajashekar, Kishore Kumar, Srinivasa Murthy 2002] related to mental health into local languages. However in our experience it was found that the translation of our materials often distorted the meaning. Further more, there are sufficient linguistic differences in dialects within the four language groups to render the written material unusable.

To address the translation of materials the methodology of translation and back-translation [Brislin 1980] was utilised. It involves looking for equivalence through (i) translation of text from the source language to the target language, (ii) independent translation of these back into the source language, and (iii) comparison of the two versions of the text in the source language until ambiguities or discrepancies in meaning are clarified and removed.

Darwish (1999) explains the process of translation. Translation is a complex dichotomous and cumulative process, which involves a host of activities drawing upon other disciplines related to language, writing, linguistics and culture. This multi-disciplinary process suggests that the transfer of data from the source to target language, synchroanalysis of text, translation and research of the matter, and continuous self-development and learning run simultaneously.

In the translation process, the translator possesses two sets of parallel linguistic and cultural repertoires. Each repertoire has a subset of components and units. When the translation analysis begins, the two parallel repertoires move constantly to match and replace elements in lexis, grammar, phonology, and cultural and situational equivalents. While transferring text from the source language to the target language, most attributes of text and discourse travel from one linguistic repertoire to the other linguistic repertoire through ‘concept lens’, that actually focuses on converting concepts invoked by identified attributes in the cultural context of the source language through activation of matching attributes in the target language. This binary action-reflex mechanism results in the translation product. The model in Figure 2 can further illustrate the process.

In the IRCS model, the written materials were prepared in English. They were sent out for translation to the target language to the concerned state (for example: materials sent to Gujarat for Gujarati translations). Once the materials were translated into the target language, a back translation into the source language was done. A content analysis of the original translation and the

**Table 3: List of Manuals**

1	Psychosocial manual for children
2	Psychosocial manual for adolescents
3	Psychosocial manual for families
4	Manual for Community Facilitators
5	Manual for Teachers
6	Crisis to Recovery: Communities in disaster
7	Colouring books for children
8	Disaster Mental Health In India – An Environmental and Organisational Assessment
9	Disaster Mental Health and Psychosocial Care: The Indian Red Cross Society Response
10	Trifolds and posters on ‘Share your feelings’ and Psychological First Aid
11	Manual on Psychological First Aid
12	Flip chart: A tool for trainer of trainers

back-translation were compared. A committee composed of two native language speakers and two technical experts evaluated the materials and made the necessary changes to represent the context, meaning and technical adequacy intended in the original document.

Twelve (Table 3) manuals have been produced in the last year that addresses the psychosocial needs of children, adolescent, families, communities and schools.

A flip chart that contains visuals that are applicable to the population of the target states has been prepared in English. It has 62 stimuli cards. Each card represents behaviours expected in the pre-impact, and the post-impact. Community metaphors [Ouellette and Rodriguez 2002] have been utilised to write stories for each stimuli card. The backs of the stimuli cards include a brief description of the intended content of the card. A space has been included on the back of the stimuli card so that the trainer may write text in the local language and utilise the local community metaphors to explain the context of the intended message.

The visual stimuli were developed by participants in the validation studies of the written materials in the villages of both Gujarat and Orissa. A group of field workers were asked to participate in the field test of the written materials. After exposure to the written content the participants were divided into small groups and asked to develop a lesson plan to teach Red Cross volunteers in the villages. The psychological support technical staff evaluated the sketches prepared by the participants.

The drawings were submitted to an illustrator who prepared a draft of the illustrations. For example, the materials used in Gujarat reflect the earthquake or the riots and the materials used in Orissa reflect the cyclone or the tsunami. The illustrations were shared with community-groups in villages in Orissa and Gujarat. The participants were asked to look at the illustration and to tell what is happening in the illustration. Based on the content generated by the illustration, modifications were made. The final draft was again, shared with the community-group. The illustrations approved by the community are currently used as visuals for all the material developed.

Children studying in elementary schools in Gujarat and Orissa were asked to draw their disaster experiences. The illustrations were judged for content, context and message by the technical staff as well as teachers and peers in the upper grades. These drawings were modified by the illustrator and presented to the children. The children were asked to look at the stimulus and to explain what was happening in the illustration. Based on the content generated from the stimulus card, the technical staff included the illustration, or a modified version.

## Conclusion

This article proposed to share one model (Figure 3) of psychological support for events of mass destruction with the community of practitioners and academics. This has been articulated in the background of (i) an existing base of DMH response to various disasters in the country since 1981, and, (ii) a growing awareness of the need for including DMH/PC, among various organisations both at a policy and action level. The Indian Red Cross Society, with its wide network, is currently integrating DMH/PC into its response protocols. This response is based in the community and focuses on helping communities from being mere survivors of a disaster to becoming resilient communities.

The article has addressed three challenges identified in India when providing psychological support services. The first challenge was the development of culturally, linguistically and technically appropriate tools to measure the effect of an event of mass destruction on the survivors and to identify the next step for rehabilitation and reconstruction. The second challenge was to involve the target villages and schools in development of their psychological support programmes. The third challenge was in preparing materials that could be used to prepare the community to help themselves and foster individual and community resilience.

This is a long-term programme that will certainly need careful monitoring and evaluation and changes as the development process goes on. The preliminary results of the three areas covered herein suggest that the programme is well on its way to provide psychological support information and to prepare the community members to respond, by using psychological first aid in a timely fashion in events of mass destruction. [17]

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[The views expressed in this article are the sole responsibility of the authors and not of the organisation.]

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