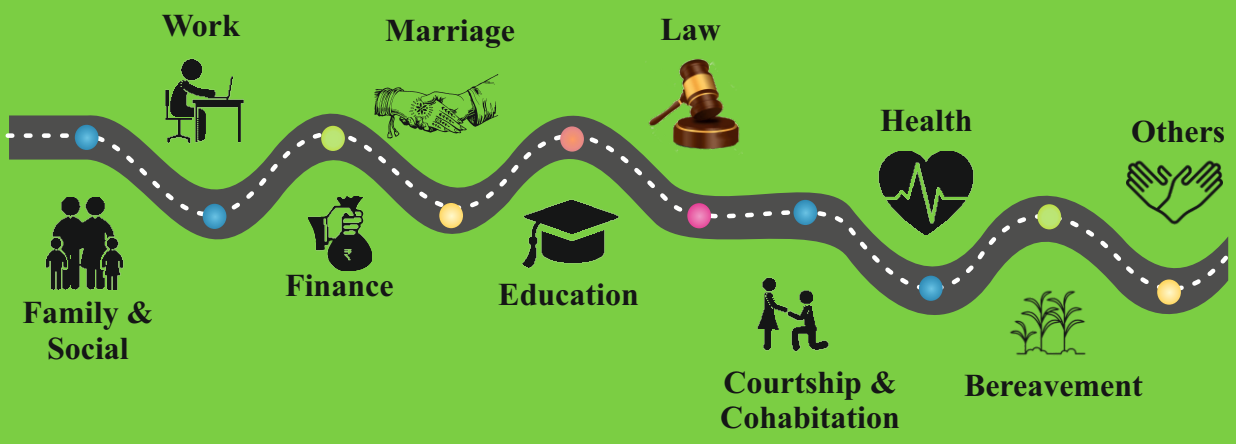
Module-2

National Disaster Management Training Module

Psychosocial Care in Disasters



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(NDMA)

National Institute of Mental Health and Neuro Sciences
(NIMHANS)

National Disaster Management Training

Module-2

Psychosocial Care in Disasters

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National Disaster Management Training Module-2
Psychosocial Care in Disasters

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FOREWORD

Disaster will have a long-lasting impact on different areas of life of the affected community. Psychological reactions of the disaster survivors determined by social factors like homelessness, loss of employment, destruction of the surrounding, loss of dear ones etc. Unlike physical health issues, mental health problems remain unnoticed most often. Early identification of psychosocial concerns of the disaster survivors and providing timely Psychosocial Support Services (PSS) plays a significant role in speedy recovery.

In our country there is a huge gap between the number of people who are in need for PSS services and available number of trained human resources. India being one of the disaster-prone countries, it is important to bridge this gap by increasing the number of trained human resources. This module aimed to bridge this gap by providing the information on PSS in disasters that can be used by the community level workers, across the country. Through this information and training material people with minimum education can be trained to be psychosocial caregivers.

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PREFACE

Disasters harm both people and the environment in numerous ways, Disaster-related psychological and social problems frequently overwhelm the ability of the afflicted population to cope. The effects are physiological, psychological and socio economic. These risks are a combination of both hazard and vulnerability. The mental health sequelae of disaster have been observed to include Post-traumatic stress Disorder(PTSD), anxiety, depression, sleep disturbances and emotional distress and these may persist even in the aftermath of the disaster. Studies have proven that distressing emotional reactions are followed by every disaster. It is thus necessary to offer and arrange appropriate psychosocial interventions, both in order to prevent normal responses developing into abnormal reactions. In the context of disasters, psychosocial support (PSS) refers to comprehensive interventions designed to address a variety of psychosocial issues that arise in the wake of a disaster. NIMHANS has a long history of providing psychosocial care to the disaster-affected communities by helping them deal and cope effectively. NIMHANS has observed in the past that during disasters, the distribution of material aid and attention to physical reconstruction (of the individual and surroundings) take precedence, whereas psychosocial care tends to be ignored. Communities affected by disasters are more resilient when PSS is integrated with other relief efforts. Early detection and treatment of mental health issues are made possible with the aid of prompt and organised psychosocial support services. NIMHANS, the nodal center for Psychosocial Care has worked, in association with NDMA through the project, 'Preparation of Psychosocial Care and Preparedness Modules and IEC Materials'.

The manual takes into account the need for psychosocial support and care in disasters along with strategies and techniques for the same. It has been curated with illustrations, case studies and includes evidence-based practice. There are 4 sections and each section describes working in disasters, with vulnerable groups and caring for carers. My hearty congratulations to the team. I wish them the best for implementation of the same

Dr. Pratima Murthy
Director,
NIMHANS,
Bengaluru.

AUTHORS NOTE

This 'Psychosocial Support in Disasters' module is the second module developed as a part of larger project titled 'Development of Psychosocial Care and Preparedness Module and IEC Materials' funded by National Disaster Management Authority (NDMA), New Delhi. Aim of this module is to enable the people from community in providing PSS services in disaster.

This module is divided into three parts. Part-1 is the information module, part-2 is the facilitators guide and part-3 have the workbook. Part-1 has 3 sections. 'PSS in Disaster' is elaborated under 9 chapters in section-1. This section begins with the brief overview to disaster and psychosocial first aid (PSFA), ways to establish psychosocial triage, significance PSS in disaster, assessment of psychosocial needs, stress and mental health issues among disaster survivors, impact of life events caused by disaster on family life cycle, PSS techniques and steps in facilitation of referrals/follow-up. Section-2 has 3 chapters focusing on working with vulnerable groups in disasters and section-3 discusses on caring for the care givers under 3 chapters.

In the facilitators guide (part-2), sessions have been designed in accordance to the information module. This module has 25:30 hours (section-1 14:30 hours; section-2: 6 hours; and section-3: 5 hours) of training programme. Each session consists of an activity (can be adopted both at onsite/offsite session) to facilitate the better participation of the participants. In the last part (part-3) 'workbook' is given along with the assessment materials. Participants can use it as take-home exercise.

This module is an essence of the field experience of the authors. Culture specific illustrations have been given throughout the information module considering different types of disasters. It is recommended to use the information module along with the facilitators guide while training the psychosocial caregivers.

Across the districts and states, wide range of target population such as, community level workers/community level health workers (CLW/CLH), NGO functionaries, GO grass root personnel, panchayat raj members, spiritual institutions, schools of social work, NSS volunteers, and community volunteers etc., can be trained to provide PSS services during disasters using this module.

We are extremely pleased to acknowledge the immense support obtained from everyone in successfully developing and bringing out this module.

We sincerely acknowledge, the National Disaster Management Authority (NDMA), New Delhi for the funding support and percipient periodical review in originating this module. Special gratitude to Shri Sanjeeva Kumar, IAS, Member Secretary, Shri Krishna S. Vatsa, Member, Shri Kamal Kishore, Member, Shri Rajendra Singh, PTM, TM, Former Director General, Indian Coast Guard, ShriRavinesh Kumar, Financial Advisor, and Ms Maithreyee Mukherjee, Senior Consultant, Psychosocial Care and Social Vulnerability Reduction for their immense support.

We are thankful to the honourable Director of National Institute of Health and Neuro Sciences (NIMHANS), Bengaluru Dr. Prathima Murthy and Former Directors Dr G Gururaj and Dr B N Gangadhar for their administrative support. We would also like to extend heartfelt thanks to

Dr.Vivek Bengal, Prof. and Head, Department of Psychosocial Support in Disaster Management (DPSSDM) for his continuous support and guidance. Special thanks to Dr. D. Dinakaran, Assistant Professor, DPSSDM for his valuable inputs in shaping this manual.

The consultation meeting held with SDMAs, DDMAs, first responders, and other volunteers substantially facilitated in plotting the content for this module. We greatly appreciate each and every member took part in the insightful discussion.

Mr. Rinse Thomas has done a wonderful job in grounding the language for the great cognizance of the target population. Exceptional illustrations have been developed by Mr. Govindaraju and Ms Christella Sowmya.

We would like to acknowledge all the direct and indirect support received from all the team members of DPSSDM, NIMHANS, Bengaluru.We thank Ms Christella Sowmya for representing different illustration in this module. We would like to appreciate the support rendered by Dr. Balashanthi Nikketha, Dr. Rajamanikandan Savarimalai, Ms. Sandhya P.D, Mr. Allen Daniel Christopher, Ms. Jane Maria, Mr. Kannan .M, Mr. Sathish and Ms. Sharmila.

LIST OF ABBREVIATIONS

Abbreviation	Explanation
DM	Disaster Management
DDMA	District Disaster Management Authority
DMHP	District Mental Health Programmes
MoHA	Ministry of Home Affairs
NDMA	National Disaster Management Authority
NGO	Non-Government Organizations
NMHP	National Mental Health Programmes
NPDM	National Policy on Disaster Management
NDMTM	National Disaster Management Training Module
PFA	Psychological First Aid
PSFA	Psychosocial First Aid
PSS	Psychosocial Support
PSSMHS	Psycho-Social Support and Mental Health Services
SDMA	State Disaster Management Authority
WHO	World Health Organization

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Section - 1

PSYCHOSOCIAL SUPPORT IN DISASTERS

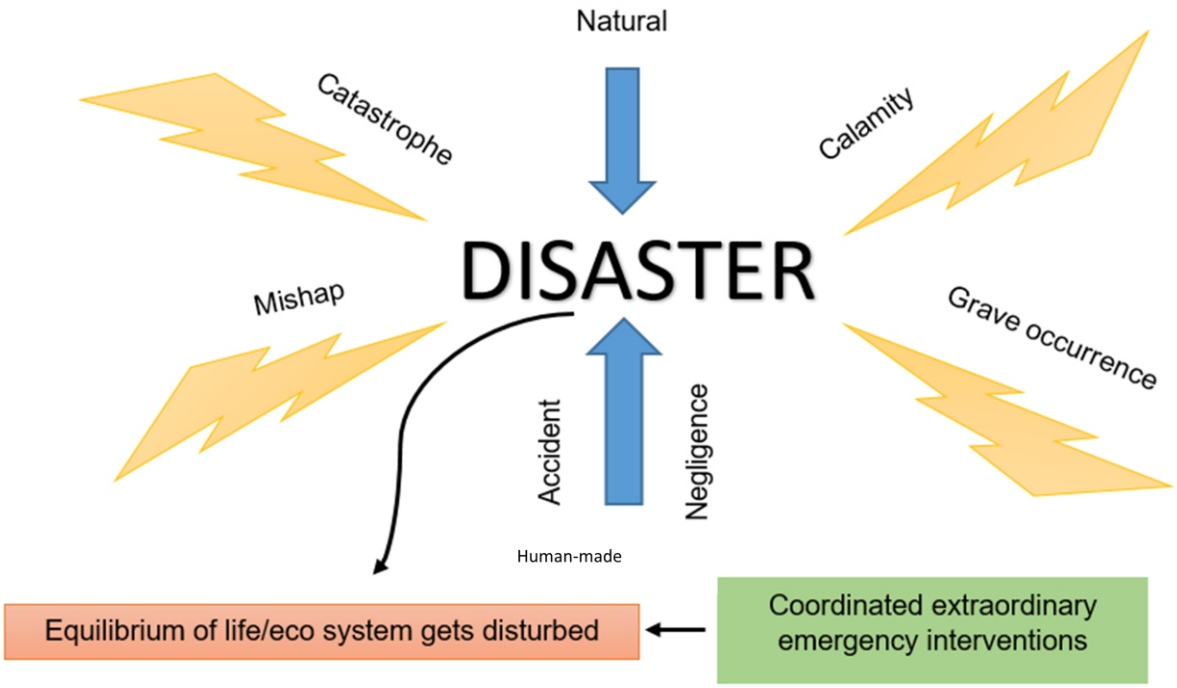
CHAPTER 1 INTRODUCTION TO DISASTER AND PSYCHOSOCIAL FIRST AID

Introduction to disaster

Disaster is a natural or human-made event. It causes severe damage to both human beings and the environment. The psychological and social issues caused by disasters generally go beyond the coping capacity of the affected community.

The intensity of the impact, damage created, and assistance required are the indicators that suggest whether any impact (natural or human-made) is a disaster. For example, an earthquake with large magnitude that happens in a desert cannot be termed as a disaster. If it occurs in a place where people live, it is said to be a disaster.

Figure 1.1: Nature of disaster



Disaster experiences vary from individual to individual. The severity is influenced by the type of loss and exposure, emotional or physical closeness of the individual with the disaster, pre-existing vulnerabilities, his/her coping strategies and community resources. The interaction between the individual and environmental factors over the timespan shape experiences of the survivors who are directly affected or the care providers who involve in the rescue/relief operations.

Impact of disaster

The impact caused by any disaster can be broadly classified into following domains;

Physical: Damage caused to body/physical structures or worsening of pre-existing physical condition. E.g., injuries, rashes, fracture, maternity complications etc.

Psychological: The psychological, emotional or behavioural responses to a disaster. E.g., shock, denial, fear, anger, sadness, flashbacks, increased use of substance etc.

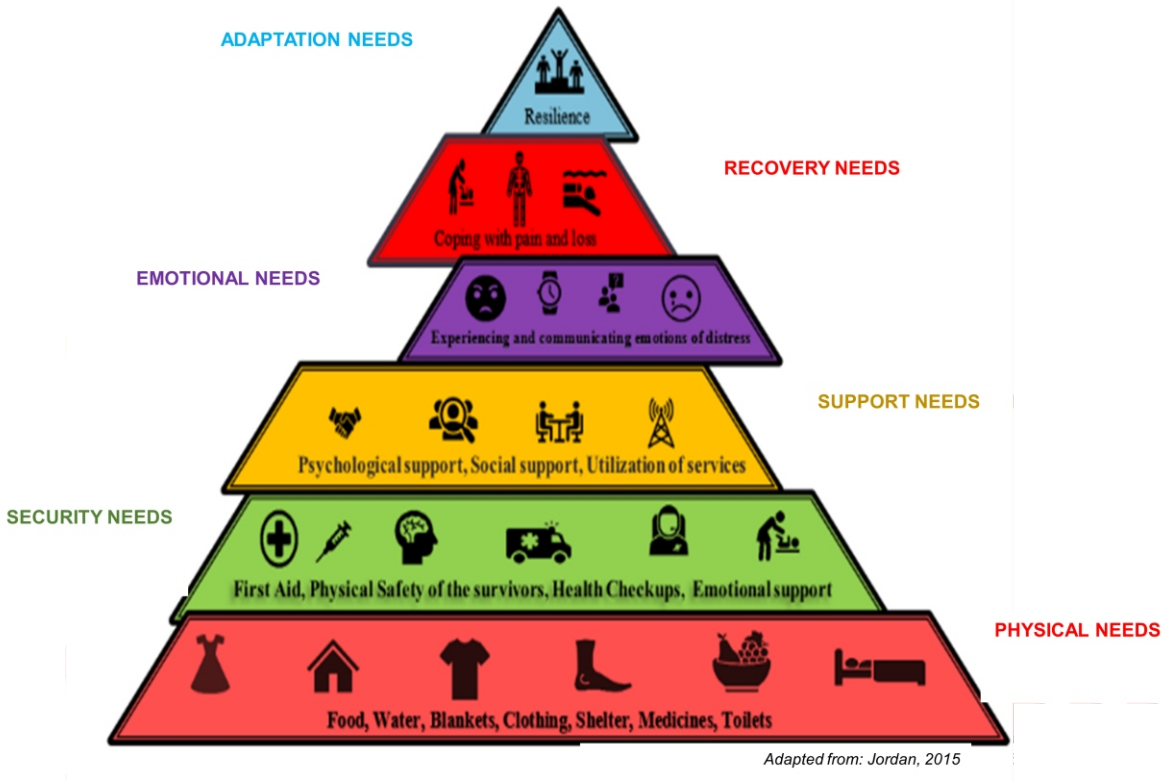
Social: Hardship created in the family or society due to the disaster. E.g., emergence of single parent families, migration, displacement, increase in crime rate etc.

Economic: Financial, property and livelihood losses incurred. E.g., financial loss, loss of property, debt traps etc.

These impacts are interconnected. Therefore, caregivers need to understand the connection between these impacts and to normalise it through psychosocial support.

Needs of the disaster survivors

Figure 1.2: Pyramid of disaster survivors needs



Adapted from: Jordan, 2015

PSYCHOSOCIAL FIRST AID (PSFA)

PSFA is a humane, supportive and practical assistance provided to a person immediately after a disaster. It involves providing support, assessing needs and concerns, helping people to meet basic needs, listening, comforting people and helping them to feel calm, helping people connect to information, services and social support and protecting people from further harm.

Who needs PSFA?
People who are in distress and need support following a crisis event.

When is it provided?
During or immediately after a crisis event. It may last for days or weeks depending upon the severity.

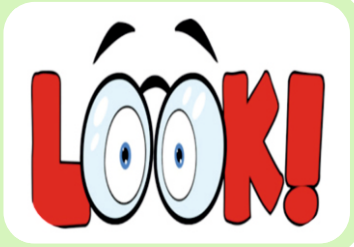
Where is it provided?
In any safe place/settings where privacy/confidentiality can be ensured.

World Health Organization (WHO) has given following four first aid strategies to guide the caregivers to deliver their service effectively.

PREPARE

- Understand people and situation specific to a disaster
- Understand the biopsychosocial factors that make people vulnerable to a disaster
- Locate the survivors in the disaster area
- Identify resources within the community

- Immediate emotional reactions
- Physical health issues
- Psychosocial needs and concerns
- Availability of support within the family
- Availability of local/community resources
- Strengths of the survivors, their family and the community



- Listen to their needs and concerns
- Acknowledge their strengths
- Normalize the feelings and thoughts
- Give reassurance
- Ensure their safety
- Provide basic needs

- Connect survivors to their primary caregivers or loved ones
- Connect them to a safe place for shelter and fulfil their basic needs
- Connect them to a care facility based on their bio-psycho-social concerns (persons with mental illness to respective district mental health programs; unaccompanied child with the child protection agency; and hearing aid for persons with hearing impairment).

Remember

- Disaster generally goes beyond the coping ability of the survivors
- Disasters can be broadly classified into natural and human-made
- Impact of disaster is inter-connected
- Primary needs of the survivors have to be addressed before focusing on the higher needs
- PSFA is a humane, supportive and practical assistance provided to a person immediately after a disaster
- Prepare, look, listen and link are the four strategies of PSFA

CHAPTER 2 PSYCHOSOCIAL TRIAGE

Triaging is a systematic assessment and classification of survivors to optimise and prioritise care based on their condition. It facilitates early identification and prompt mental health treatment for disaster-affected communities. Planning and arrangement of appropriate psychosocial support and mental health services can be done through psychosocial triage. This would not only reduce the consequences generated by disaster impact, but also ensure quality of psychosocial and mental health services. Psychological trauma is caused or worsened by the persons' closeness (physical or psychological) to the disaster, personal and environmental vulnerabilities, immediate and post disaster reactions and coping strategies/resources. Knowledge about these factors help frontline workers/community level workers/helpers to systematically code individuals affected by disasters as persons with low/medium/high risks and help them to decide upon what services to be given.

The psychosocial triage helps the caregiver to identify who requires immediate mental health attention, who has to be assigned for psychosocial care or PSFA and who has to be monitored by local health surveillance bodies. Psychosocial triage matrix (table 2.1) and figure (2.2) give the clearer picture of the same.

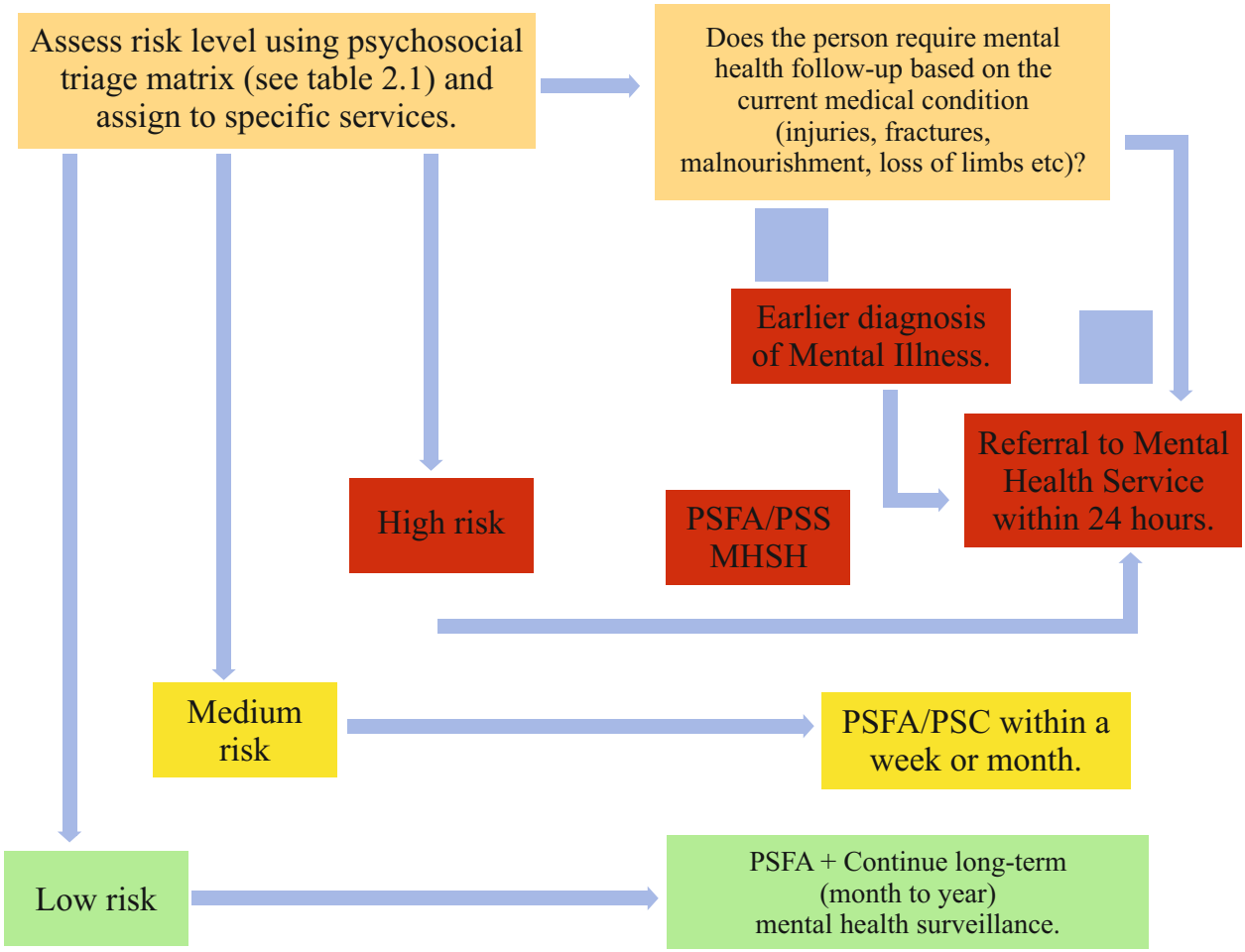
Table 2.1: Psychosocial triage matrix

Indicators	Low Risk	Moderate Risk	High Risk
Physical closeness	Greater distance from the epicentre (disaster affected site).	Closer to the epicentre but not in the epicentre.	Present in the epicentre.
Expressive closeness	Does not know the survivor/s	Knows/friend to the survivor /s	Closely related or best friend of the survivor/s
Individual vulnerabilities	1. No history of chronic physical or mental illness. 2. Able to regulate emotions. 3. Connected with social ties. 4. No significant life events in the past. 5. Not a person in the vulnerable group (children, women, PwD, migrant, farmer, third gender, etc.). 6. Optimistic.	1. Not certain about pre-existing physical/mental illness. 2. Certain problems with emotional regulation. 3. Partial social withdrawal. 4. Past life events present but not very significant. 5. Partially fitting in to a vulnerable group. 6. Partial Pessimism.	1. History of chronic physical or mental illness. 2. Poor emotional self-regulation. 3. Active social withdrawal. 4. Presence of significant life events in the past. 5. Absolutely fitting into a vulnerable group. 6. Extreme Pessimism.

Environmental vulnerabilities	1. Living with all family members. 2. Adequate parent-child relationship. 3. Adequate family functioning. 4. Absence of significant traumatic stress among parents. 5. No history of mental illness in the family. 6. Adequate family or community resources. 7. Not a victim of stigma or discrimination.	1. Living with some family members. 2. Tenuous parent-child relationship. 3. Inconsistent family functioning. 4. Presence of minimal traumatic stress among parents. 5. Not sure about mental illness in the family. 6. Erratic family / community resources. 7. Partial victim of stigma or discrimination.	1. Not living with family members. 2. Strained parent-child relationship. 3. Poor family functioning. 4. Presence of significant traumatic parental stress. 5. History of mental illness in the family. 6. Inadequate family or community resources. 7. Dire victim of stigma or discrimination.
Instant reactions during the disaster	Appeared relaxed during the impact.	Expressed mild to moderate distress.	Expressed acute distress.
Ongoing reactions	Expressed few common crisis reactions.	Expressed many common crisis reactions.	Florid manifestation indicating mental health treatment (self-harm or causing harm to others, hyper vigilance, depression, acute dissociation, psychotic features, elated mood, etc.).
Coping	Active or adaptive coping (Able to deal with the impact effectively).	Uncertain coping (Unaware of how to deal with the impact).	Avoidant or Maladaptive coping (Harming self/others, use of substances).

Source: Richter & Flowers 2008

Figure 2.1 Psychosocial Triage

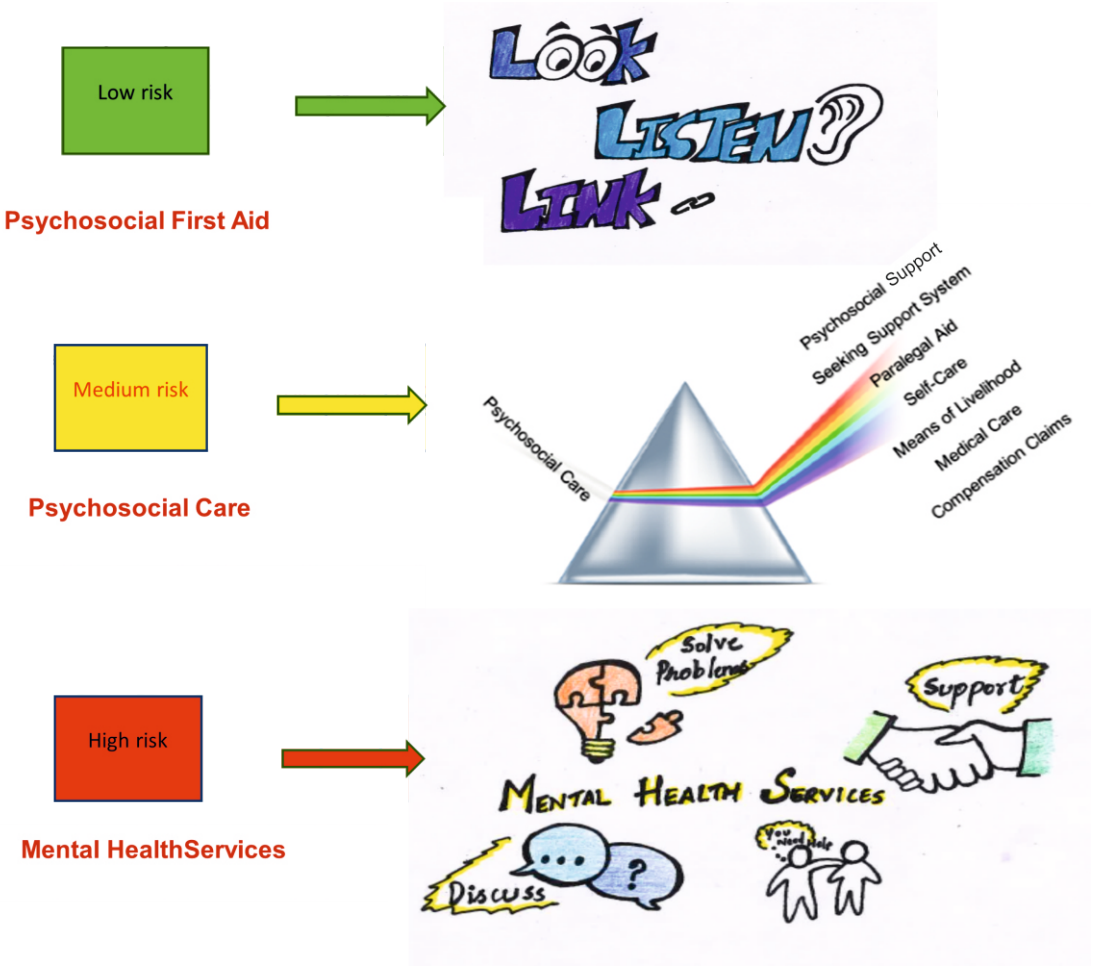


Adapted from Brannen et al., 2013

To identify the persons who need psychosocial support, they need to be assessed based on their post-disaster reactions (excessive worry, fear, prolonged sadness, increased anger, sleep disturbance, disturbance in appetite etc.) and functioning (inability to perform everyday routine, lack of concentration in work, decreased quality of work, lack of interest in taking care of self, inability to socialise, interpersonal relationship issues, etc.).

Based on the intensity of risk, the psychosocial support services need to be planned. For instance, persons who are at high risk, have to be referred to appropriate Mental Health Services within 24 hours. PSFA and PSS have to be provided within a week or month for the people who are at medium risk. For the low-risk people PSFA alone is sufficient. However, they have to be kept under mental health surveillance for a long-term (month to year).

Figure 2.2: Nature of psychosocial services provided based on the risk level



Case Illustrations in varied disasters

(1) "It was raining heavily for weeks. Houses, livelihoods and lives got swept away. The flood situation made me feel the lowest that I have ever felt in my life. I was afraid that I might lose my son". A 42 years old mother affected by flood.

(2) "My family was traveling to our hometown for a wedding. I was busy with my work and could not join them. They left home by midnight. I woke up to hear the news of a bus crashing against a container. The news channels flashed saying 40 persons died including '4 members of a family'. I was praying hard that it was not mine. My life shattered in a flash". A 35 years old husband.

(3) One day B, a nine years old girl woke up early in the morning hearing a crash and was told that a terrorist attack had taken place in the market. She took her teddy and rushed to check if Farina, her cook's daughter who loved her teddy was fine. She saw a tiny human drenched in blood. She kept the teddy next to her dead body. It has been two weeks already and she has not got out of her room even once. Whenever she hears a noise, she cries, shouting Farina.

(4) "There was a heavy pouring and forecast of landslide vulnerability, most people were evacuated from the danger. The next day, the landslide hit the small-town causing loss of property and causalities. I could not reach my people as the telecommunication services in that area was affected.". A 44 years old woman.

(5) C, a 22 years old visually challenged boy lost his entire family in the cyclone. He started questioning his existence asking himself whether he was a curse. He experienced feelings of grief, guilt and sadness. He wanted to kill himself, as he felt left out without any support. The only comfort was the dog that he adopted after the disaster.

(6) D, 34 years old police men worked in the frontline evacuation process during the Mangalore Air crash. He was staying away from his family and friends. After the first response with passengers, he felt traumatized seeing many lifeless passengers who lost their lives. He started losing interest in his daily activities, experienced disturbances in sleep and appeared to be moody and irritable. He complained of stress because of heightened societal pressure to aid the needy.

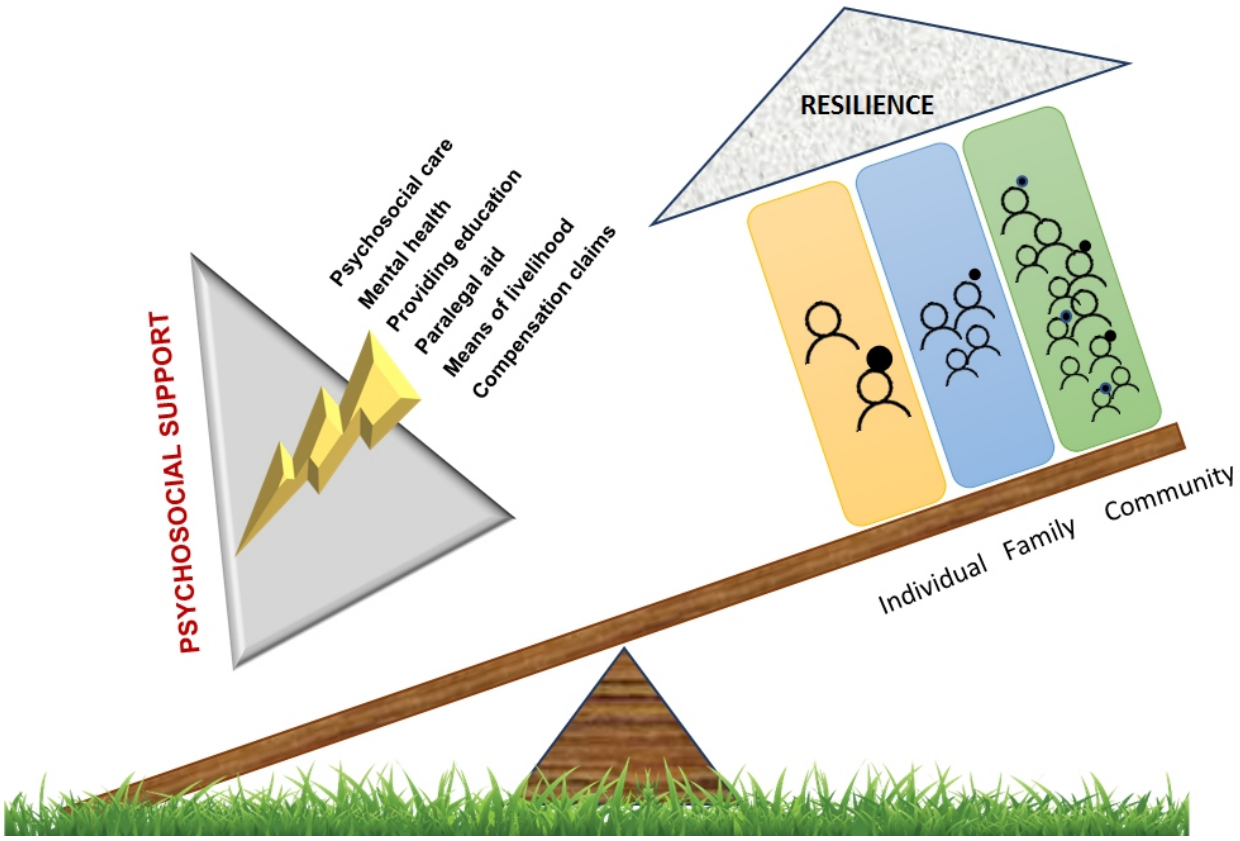
Remember

- The psychosocial triage helps the caregiver to identify persons at risk and provide them necessary psychosocial interventions.
- Persons with pre-existing mental health conditions warrant quick mental health evaluation.
- Higher the psychosocial vulnerability – higher the psychosocial impact.
- Persons with adaptive coping strategies are more resilient.

CHAPTER 3 PSYCHOSOCIAL SUPPORT IN DISASTERS

Disaster-affected communities experience various psychological reactions which are often determined by social factors, such as; homelessness, loss of employment, destruction of the surrounding environment, loss of dear ones etc. These psychological problems remain unnoticed unlike physical symptoms. PSFA is the entry point for psychosocial care interventions. Providing opportunities for people to express their concerns and connecting people with spectrum of psychosocial services enable speedy recovery. Psychosocial Support (PSS), in the context of disasters refers to comprehensive interventions aimed at addressing a wide range of psychosocial problems arising in the aftermath of a disaster. In the past, we see that distributing material relief and focus on physical reconstruction (body and environment) take priority during disasters. Integration of PSS along with other relief services enhance resilience among disaster-affected communities. Prompt and systematic psychosocial support services help in early identification and treatment of mental health problems.

PSYCHOSOCIAL SUPPORT PRISM



Evolution of Psychosocial Support in India

Psychosocial support is an integral part of Indian culture and religion. It gives dominance to rendering care for the weaker sections of the society, customs and practices that facilitate ventilation after loss and values that build community resilience. Many stakeholders have involved in the administration of psychosocial care services in the past. Large volume of work done in the area remain undocumented. The first documentation of psychosocial support appeared in 1981 after the Venus Circus Tragedy in Bengaluru. The initial phases were more individual centric and rendered by mental health professionals. There is shortage of work force in the field of mental health service delivery in India. Considering the Indian population and the magnitude of the psychosocial needs of disaster affected communities, training of non-professionals especially the local community in psychosocial care service delivery has become a time-tested effective model. The constitution of National Disaster Management Authority (NDMA), State Disaster Management Authority (SDMA) and District Disaster Management Authority (DDMA) constituted to plan, execute and monitor disaster management policies and its implementation. This helps in instrumentation of psychosocial support and mental health services in the country. Major psychosocial services are carried out during the relief and restoration phase. The preparedness and mitigation efforts in PSSMHS is in progress and need to be further expanded.

Figure 3.1: Implementation of psychosocial services in the past four decades in India

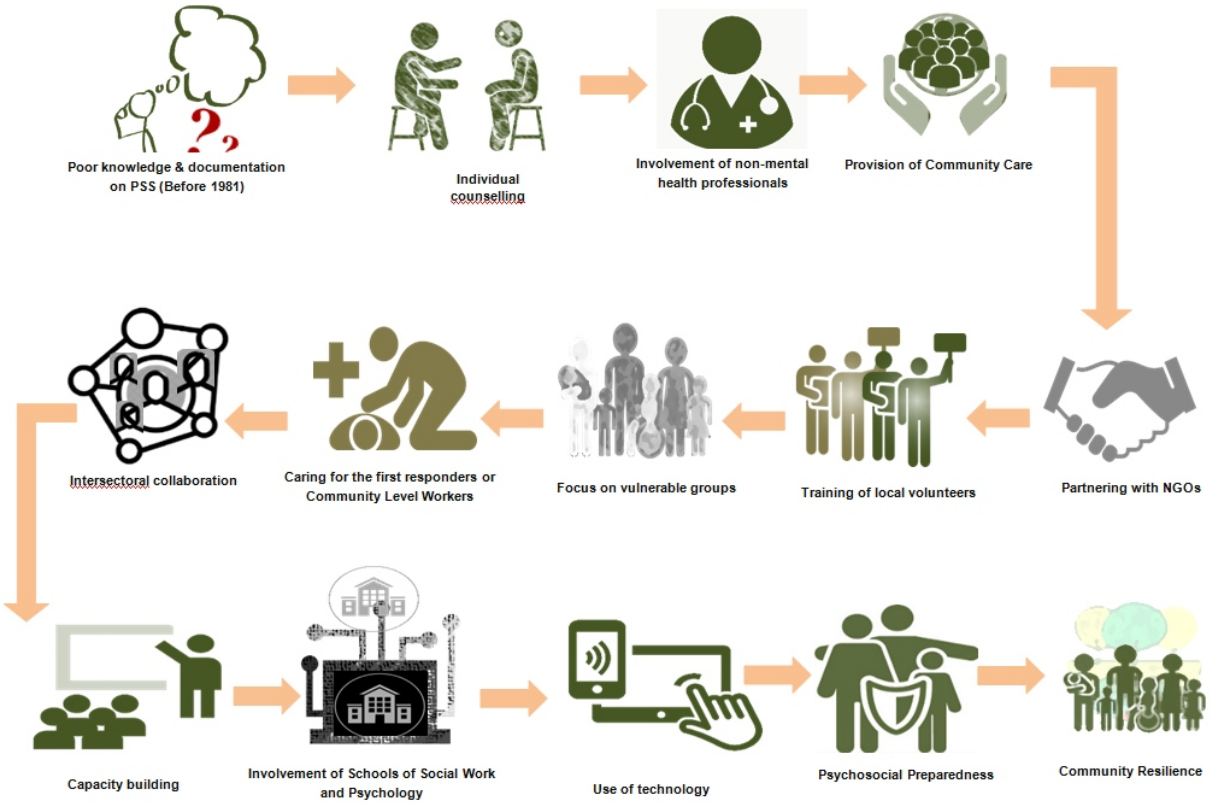


Figure 3.1.1: Psychosocial factors impacting the mental health of disaster affected communities

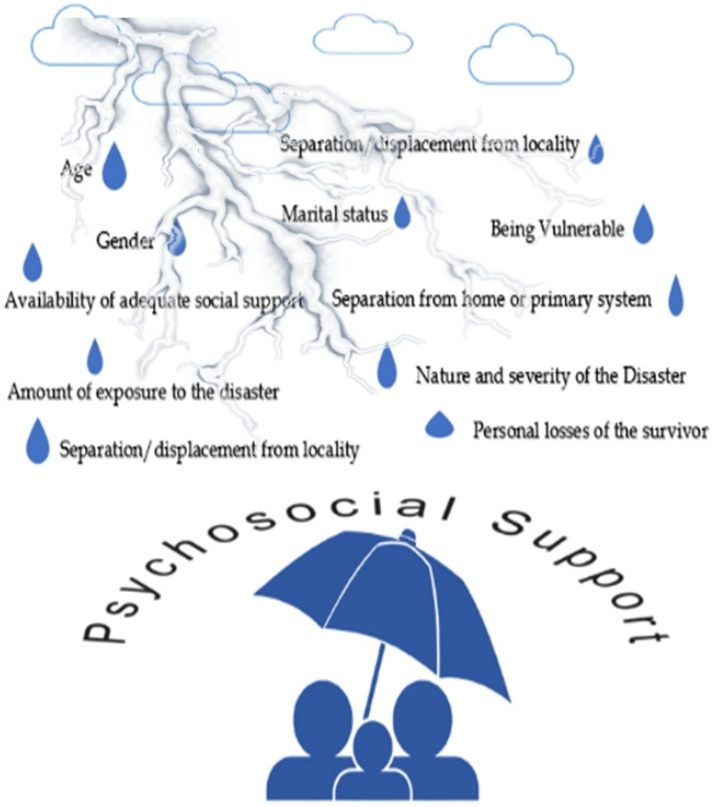


Figure3.1.2: PSS activities – CAREFUL

Creating capacity (professional and non-professional bodies including the community) on Psychosocial Care activities in the affected communities.

Awareness generation on psychosocial and mental health issues and services available.

Recreation and group activities- facilitating group mourning by ensuring religious or culture specific services to cope with the loss of the loved ones, initiating community kitchens, encouraging recreation and group sharing.

Empowering communities through multi-sectoral collaboration involving governmental, non-governmental and voluntary bodies.

Facilitating individual centric care for disaster survivors (listening to the individual, providing reassurances, being available and assessing their needs and resources).

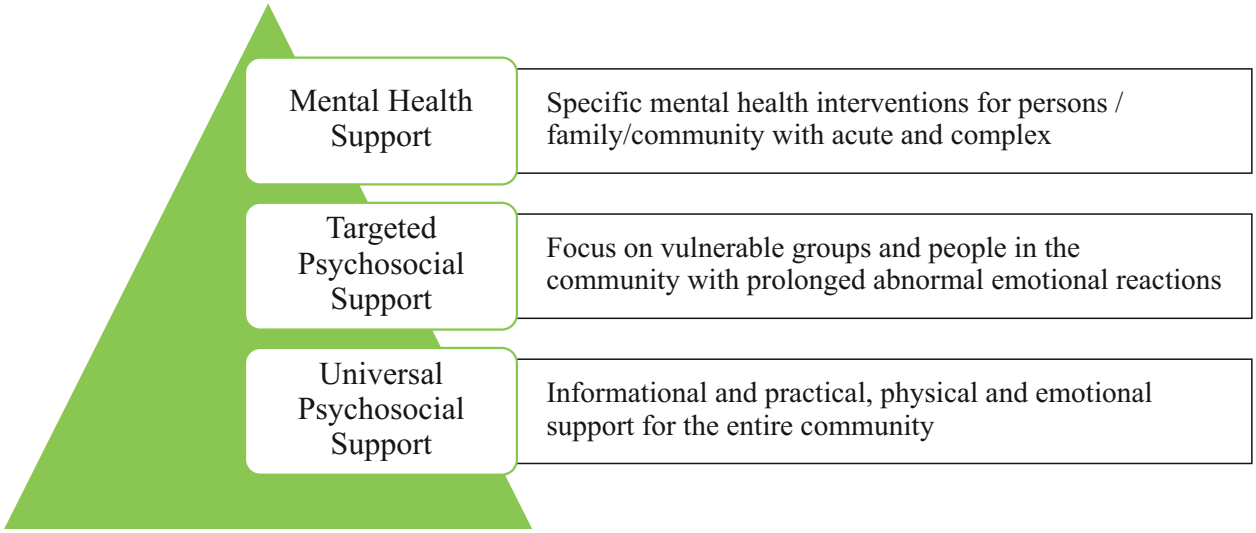
Updating and supporting the careivers with information, resources and self-care strategies.

Linking community to services to enhance livelihood options, reconstruction of homes, getting compensation, etc.

(Adapted from Seto et al., 2019)

Psychosocial support 'IS'	Psychosocial support 'IS NOT'
• Supportive services that ensure practical needs focusing on enhancing the well-being of disaster survivors/communities • Holistic service that helps survivors / families overcome physical, psychological social and economic impact of disaster • Care and reconstruction services that run for a longer duration • A coordinated and systematic resilience building activity that aims at early identification of mental health problems in individual/community and facilitates prompt treatment back to the community	• Individual specific • A relief service that focuses only on the immediate needs • A programme that goes for a shorter duration • One-time activity • A stigmatising or labelling activity • A service that focuses on obtaining solution for a single problem

Figure 3.2: Levels of psychosocial support



Remember

- Psychosocial support involves a spectrum of psychosocial services (providing psychosocial support and linking to services)
- Psychosocial support services ensure early identification and prompt mental health treatment
- The goal of psychosocial care is achieving optimal individual/ family/ community resilience
- First documented work on PSSMHS in India is Bengaluru Venus Circus Tragedy Incident
- The present focus is on promoting the community resilience in all the phases of disaster

CHAPTER 4 PSYCHOSOCIAL NEEDS ASSESSMENT

Psychosocial needs are the psychological and social requirements that communities, families or individuals have just after the disasters. Knowledge on the psychosocial needs of the individuals, families or communities help in planning better intervention strategies. Any psychosocial assessment should provide information regarding the following:

Individual Assessment	Family Assessment	Community Assessment
• Demographic information. • Biopsychosocial aspects and vulnerabilities. • Socio-vocational aspects and its limitations. • Coping (Adaptive and maladaptive). • Daily functioning. • Prior/present trauma experiences and perception.	• Family Composition. • Family Dynamics: Roles and responsibilities, leadership, adaptive patterns, problem solving abilities, decision making capabilities, rituals. • Family rules. • Changes in family structure. • Resources available in the family. • Trauma in the family.	• Hazard, risks and vulnerability in the community. • The nature and intensity of the disaster (physical, psychological, economic and social consequences). • Nature and types of services required (needs of vulnerable groups). • Available manpower and infrastructure (opportunities, community adaptations). • Gap between needs and resources (challenges in accessing healthcare).

Rapid need assessment in first two weeks after the disaster would reduce recall bias (not remembering the accurate information). The need assessment should also maintain conformity with the socio-cultural context of the community (traditions, beliefs, values, practices, norms and local perceptions and cultural/religious coping).

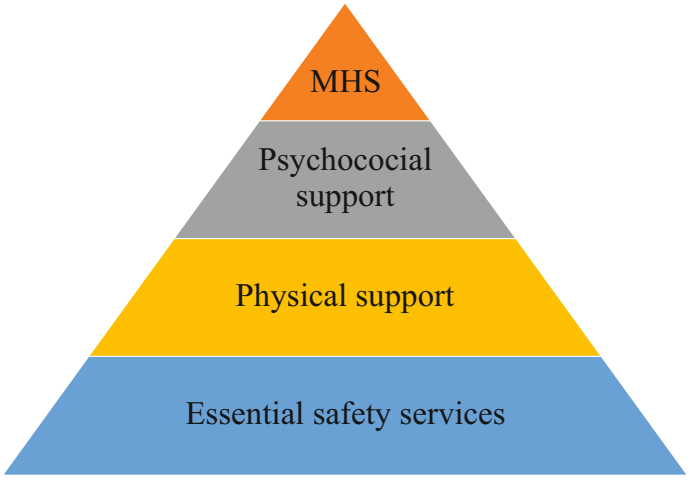
Figure 4.1: Psychosocial Needs Assessment Techniques, ICRC & IFRC, 2008

SWOD analysis: Assessment of the Strengths, Weaknesses, Opportunities and Difficulties

Community Assessment Tools

- **Routine change mapping:** It shows how the community members used to spend their whole day and how it has changed after the disaster.
- **Disaster timeline:** A chronological account of disaster events that has happened in the past and how people reacted to it.
- **Resource claim:** It is a method used to quantify or know the number of people receiving a particular service or belonging to a particular group.
- **Calendar of seasons:** This is used especially in rural environments to know about the local seasons, climate, patterns of rainfall, livestock management, agriculture/livestock production, sales, workforce involved and common problems experienced (drought, famine, over production, etc.). It can also talk about the seasonal outbreaks, health condition, and hazards.
- **Ranking of issues:** This method helps in understanding the local preferences and order of ranking by the community.
- **Stakeholder exploration:** Identifying individuals, groups, local authorities affected by the disaster, their interests, power relations, roles, existing strengths and resources.
- **Root cause identification:** It is a debate that is organised in the community to unveil the core causes for a specific problem and explains cause/effect relationship.
- **Understanding community organisations:** It helps in understanding the nature and type of support provided or available in an organisation.

Figure 4.2: Pyramid of Psychosocial needs



The need assessment should bridge between the needs and the services. Almost all the people affected by disaster would require basic facilities and services that ensure safety and security. If there are 100 people in the community, 95 persons will have different reactions to the event; around 50 to 70 people would suffer from mild, moderate to severe psychological distress. The distress created after any disasters can be minimised by strategies aiming at promotion of family or community support. Of the 100 affected people, 15 to 30 people might develop mild to moderate mental disorder. It is essential to focus on those people using appropriate psychosocial support services to prevent further worsening. Only 3 to 4 might suffer severe mental disorder and such individuals need to be identified earlier and have to be referred for mental health treatment. Along with the details discussed above, the needs assessment should also help in providing answers to the following questions: NGOs working in the community, availability of trained manpower for PSSMHS, assessment of additional manpower required for future work, who would require PSFA, PSS and MHS and vulnerable groups in the community.

Assessment of needs should involve all the stakeholders in the community like local leaders, community groups, government (health, education, WCD, youth development, SJD, revenue) and nongovernment organisations, faith-based institutions, etc. Methods like observation, field surveys, individual interviews, group discussions would help in assessing the psychosocial needs of the disaster-affected communities. Diverse populations including all the genders, age groups, cultural, linguistic, religious groups need to be included. Care should be taken that assessment fatigue (same community being assessed repeatedly by different stakeholders) does not happen. Structured and scientific need assessment helps in developing accurate intervention measures and enhances the quality of the intervention.

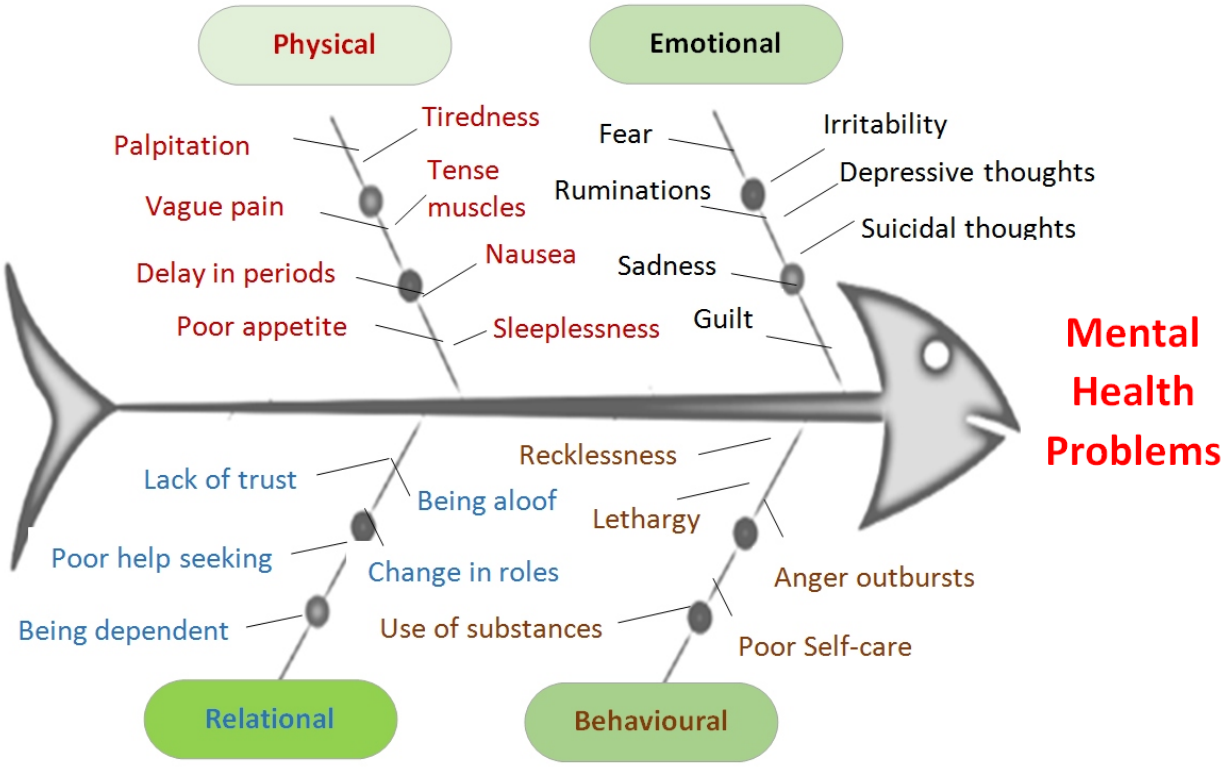
Remember

- Need assessment after two weeks would invite recall bias.
- Care needs to be taken to avoid assessment fatigue.
- Proper need assessment results in better planning and outcomes.

CHAPTER 5 STRESS DURING DISASTERS

One of the salient features of psychosocial care is enabling disaster survivors to understand stress and its reactions. The unpredictable environment, unexpected living conditions and unpleasant experiences cause excessive distress. Traumatic experiences yield anxiety and stress when it exceeds the coping capacity and resources of the individual, family and community. If people understand the reactions caused by the disaster, it is easy for them to deal with the changes caused by it. Numerous reactions are generated by stress and its manifestations. This varies from person to person during different phases of disaster. Prior knowledge about the stressful reactions and its consequences helps both the disaster survivor and the caregiver to identify the body's response to stress. This also facilitates early identification and quick treatment during the response, relief and rehabilitation phases.

Figure 5.1: Reactions during disasters



Physical Reactions

Physical reactions are easily noticeable. One of the most common physical symptoms, experienced by disaster survivors is body pain/aches. For relief from pain, people visit doctors or take self-prescribed medicines. Mostly, psychological reactions experienced by disaster survivors are portrayed as physiological reactions such as tension, fatigue, restlessness, disturbances in sleep and appetite, body pain/ache, muscle cramps, variations in blood sugar/pressure levels and rapid startle reactions. Some examples of physical reactions are given below:

Stomach ache and change in appetite

"Nowadays I feel severe stomach ache. I don't even feel like eating anything". (22 years old female)

Headache

"Its been 6 months, I have a terrible headache. I am not able to sleep or focus on my work. Medicines are also not helping me". (43 years old male)

Behavioural Reactions

Stress caused due to traumatic experiences, when goes beyond the coping capacity of a person lead to adaptive and maladaptive behaviours. Some of the common maladaptive behaviours are: lack of interest in life, reduced energy/activity level, excessive consumption of substances (alcohol, tobacco etc), isolating self from persons, places or environment.

Change in behaviour

"My wife and I generally don't fight. After the disaster, we argue even for petty things. I lost peace of mind". (32-year-old male)

School refusal

"My close friend died in the disaster. We used to play together but now I am all alone.I don't feel like going to school". (10-year-old child)

Psychological/Emotional Reactions

Psychological or emotional reactions are subjective experiences. There may be change in the person's behaviour, emotional expressions, and thinking patterns. For instance; trouble in concentrating, confusion, issues with memory, difficulty in making decisions and problem solving, anger, irritability, fear, anxiety, repetitive thoughts, suicidal thoughts/attempts, forgetfulness, grief, guilt, lack of interest, hopelessness, worthlessness and helplessness etc. Like physical or behavioural reactions, psychological reactions might not be visible. All the other reactions would eventually lead to a psychological reaction and vice versa.

Despair about losses

"My children are busy in their own life. I have nobody to listen to me. My husband went early leaving me alone". (52-year-old female)

Helplessness, sadness and guilt

"My engagement was fixed. My father had started preparing for the ceremony, but now I am left alone. We lost all the gold and money that my grandparents had saved by selling the land. It is all my fate. I am a bad sign for the family". (21-year-old female)

Nightmares

"I have had sleepless nights thinking about not being around my family and wonder if I would ever see them for one last time".(23-year-old male)

Relational Reactions

Stress can have significant impact on the relationships. It makes the person avoid or increase interactions with others. This would affect the person's social support and help-seeking behaviour. Change in roles and responsibilities post disaster would impact the family or community interaction patterns. Interpersonal reactions include trust issues, increased conflicts, feeling of rejection or abandonment, not accepting/judging others and exercising control over others.

Change in interaction "Because of lockdown, I am attending online classes. My parents don't understand my difficulties and are blaming me for holding laptop. I feel like running away from home". (17-year-old female child)

Being aloof
"I do not want to meet or talk to anyone. I want to be left alone". (24 -year - old male)

Multiple reactions experienced by different age groups in the post-disaster phase (Adapted from NSW Health, 2000)

Reactions among Children

- Physical: Poor bowel or bladder control, difficulties in speech (stuttering, baby talk), poor or increased appetite, physical complaints (headache, stomach pain).
- Behavioural: Inactiveness, thumb sucking, throwing temper tantrum, aggression, school refusal/avoidance.
- Psychological: Fear (new circumstances, being separated, dark, animals, weather, safety), irritability, nightmares, poor attention, poor concentration, lack of interest, preoccupation and thinking about the events related to the disaster.
- Relational: Not leaving parents, seeking parental attention, not mingling with peers.

Reactions among Adolescents

- Physical: Problems with sleep and food intake, pain/ache in the body.
- Behavioural: Rebelliousness, issues at school (quarrelling, picking up fights, poor interest in studies), increased or decreased activity/energy, engaging in unlawful/criminal behaviour, using drugs/alcohol.
- Psychological: Non-responsiveness, mood swings.
- Relational: Seeking attention, poor prosocial behaviour, displaying avoidant behaviour, change in peer groups.

Reactions among adults

- **Physical:** Sleep disturbances, poor/increased appetite, feeling tired or exhausted, somatic problems (gastrointestinal, multiple body pain, worsening of existing medical/psychiatric conditions).
- **Behavioural:** Avoiding (person/place), increased/decreased activity, anger outbursts, using substances.
- **Psychological:** Sadness, continuous crying, feeling sad, anxious, guilty, being irritable, fearful, having depressive thoughts (hopelessness, worthlessness, helplessness), having mood swings, self-blame/doubt.
- **Relational:** Frequent family conflicts, self- isolation from others.

Reactions among older adult

- **Physical:** Worsening of chronic medical/psychiatric conditions, change in sleep and eating patterns, decline in physical health.
- **Behavioural:** Agitation/irritability.
- **Psychological:** Feeling depressed, disoriented, having confusion, memory problems, poor interest, being suspicious, feeling of despair, being anxious about unfamiliar environment, feeling of embarrassment.
- **Relational:** Withdrawn behaviour, adjustment issues.

All of these reactions are normal reactions to a disaster. Survivors experience different emotional reactions during different phases of disaster. Understanding the variations in the psychological reactions over different time intervals and differentiating between normal and abnormal reactions help in developing appropriate psychosocial or mental health interventions. The figure below helps in understanding the distinction between normal and abnormal reactions during the disaster cycle.

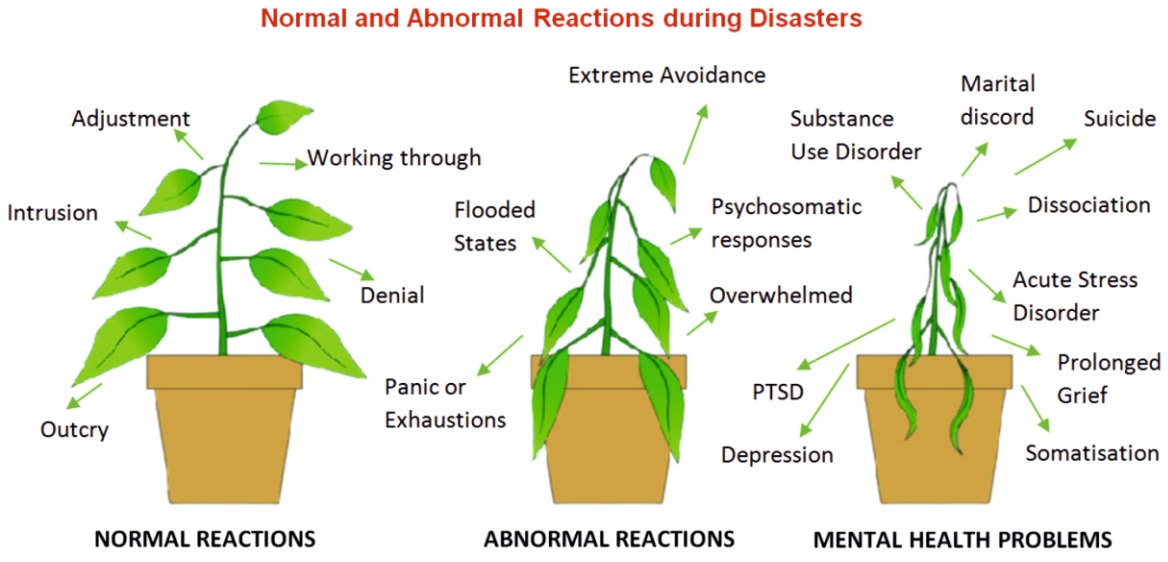
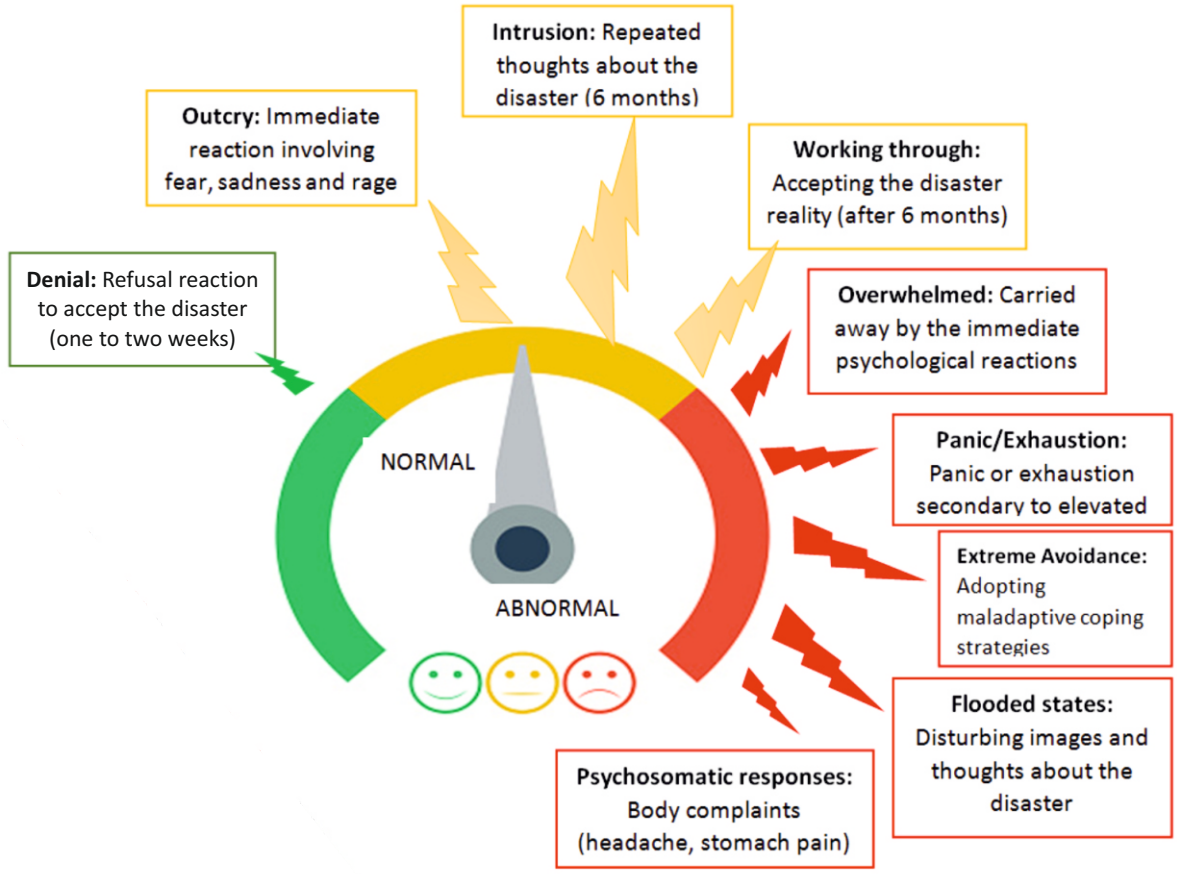
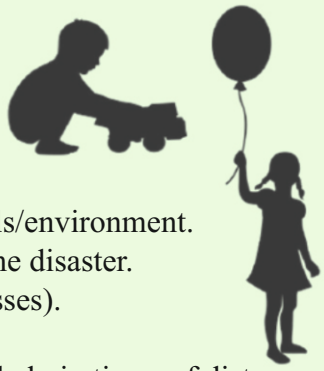


Figure 5.2: Stressful Reactions during Disasters



Dealing with the Psychological Reactions among Different Age Groups

Children (1 to 5 years)



- Provide simple and direct messages.
- Provide verbal reassurance and appropriate physical touch.
- Help in restarting and following the daily routine.
- Make the child to name the emotions she/he is experiencing.
- Facilitate living with family or with familiar and safe individuals/environment.
- Reduce or eliminate images/news/sounds/persons that remind the disaster.
- Encourage the child to talk about the feelings (especially the losses).
- Create opportunities for active play or group activities.
- Make sure that the child knows that you can be approached for help in times of distress.

Children (6 to 11 years)

- Reduce home/school expectations from the child.
- Enable structured but flexible activities at home/relief camp.
- Encourage the child to talk about his/her traumatic feelings.
- Actively listen to the child with warmth and care.
- Provide authentic information and correct misconceptions.
- Create peer activities using expressive arts.
- Have an eye on the needs of special children.
- Educate on safe/unsafe touch.
- Make the child know that there is help always.
- Monitor the child's screen time.

Adolescents

- Set the realistic home/school expectations.
- Facilitate sharing traumatic experiences.
- Ensure confidentiality.
- Do not force to talk.
- Create routine involving physical activities, self-care activities, group meeting and other social activities.
- Do not confront behaviour/feelings.
- Connect the adolescents' impulsivity or reckless behaviour to the disaster event.
- Educate on staying away from psychoactive substances. (alcohol, tobacco or other drugs), risky sexual behaviour, abuse and other social evils.
- Regulate the adolescent's screen time.
- Provide information of healthy coping, whom to approach in times of distress/crisis.
- Take care of adolescents with special needs (persons with disability, history of child sexual abuse, abandoned, orphaned, etc.).

Adults

- Enable access to essential resources.
- Create channels for the adult to talk about the disaster experiences.
- Provide authentic information on services, systems and aid.
- Correct false information.
- Help them to improve their problem-solving abilities.
- Encourage direct and frequent communication between family members.
- Provide information on strategies to follow while being with their spouses, children or older adults in the family.
- Empower the adults on the adaptive coping strategies and discourage maladaptive patterns.
- The community is the first responder in any disaster so empower the adult to take care of themselves and the community.
- Assess for abnormal reactions and facilitate appropriate mental health services.

Elderly

- Provide verbal and physical reassurance.
- Ensure access to essentials.
- Help in sustaining or rebuilding the support systems.
- Enable easy access to medical and financial resources.
- Create avenues to express their traumatic experiences.
- Educate on elderly abuse.
- Provide legal options available in case of elderly abuse.

Remember

- Stress is the body's response to external stimuli.
- Stress reactions can be physical, emotional, behavioral and relational.
- It is normal for survivors to experience negative psychological reactions after disaster.
- Awareness on stress reactions aid in early recovery.
- Appropriate and immediate psychosocial services curtail manifestation of mental disorders.

CHAPTER 6 MENTAL HEALTH ISSUES AMONG DISASTER SURVIVORS

Mental health problems can affect anyone. Disaster might cause the mental health problems among certain individuals. All the disaster survivors need not necessarily develop mental health problems. Persons who have suffered significant loss (poor social support), victims of abuse and persons with inadequate coping resources or maladaptive coping strategies and vulnerable groups are more susceptible to mental health problems. Persons with underlying mental health conditions, persons who have stopped psychiatric medications due to non-availability or difficulty in accessing medicines during disaster phases are also more prone to develop mental health problems.

Knowing about the mental health complications post-disaster would help in early identification and prompt treatment. Ongoing assessments, periodic visits by the caregiver, sensitising the community on mental illness, help in early identification of persons with mental health problems, and facilitation of appropriate mental health services.

After any disaster, the mental health issues among disaster survivors can be viewed as one of these four ways.

Blossomy flower: Survivors who experience psychosocial distress but are able to cope with it and do not develop any mental health problems.

Withering floret: Persons who display elaborate mental health problems (chronic symptoms) during mental health assessments that happen at multiple time intervals.

Slow bloomer: The survivor initially manifests the symptoms but gets better even without any intervention as time advances.

Bud blast: The survivor does not display mental health problems for a long time and has delayed manifestation of symptoms (more than 6 months to one year).

The most common mental health problems post-disasters are shown below;

Adjustment Problems: Disasters warrant significant adjustment and adaptation among survivors. Failure to adjust or adapt yields to adjustment disorders. They generally commence from three months to not more than six months of the disaster. It includes a group of emotional or behavioural symptoms that cause significant impairment in the survivors work or home functioning. The survivor experiences constant sadness, depressive thoughts (hopelessness, helplessness and worthlessness), reduced interest in work or other activities.

For instance, *Mrs. S, 32-year-old female, lost her house in Tsunami. She was feeling low and did not talk to anyone, not even to her close friends. She felt helpless and hopeless. Even after 6 months of disaster, she had slowness in doing all her daily activities. She was not able to adjust and get along with the family members. The family members got back to their usual routine, but she was not able to resume normal life.*

Along with referral to nearby mental health care facility, the caregiver can allow the individual to express freely on his/her difficulties. The focus of the intervention should be on creating adaptive coping strategies, problem-solving abilities, looking at the opportunities and solutions in spite of the threats, creating or rebuilding social support and building interpersonal skills.

Post-Traumatic Stress Disorder (PTSD): PTSD is characterised by repetitive disturbing thoughts or images of the disaster (intrusion), avoiding persons/place/things related to the impact (avoidance), being hypervigilant and having low emotional alertness. The onset of the symptoms range between one month to three months. In rare circumstances, the survivor can also experience the symptoms more than three months and at times six months after the impact. The symptoms affect the daily functioning of the individual. The survivor may also experience nightmares or flashbacks, refrain from coming in contact with people/place/things related to the impact, being aloof and significant sleep disturbance. The survivor may also have anger outbursts, worry, fear, guilt and despair.

Mr. R, a 17-year-old male, after the air crash incident in Calicut lost his parents and sibling. After the loss, his paternal uncle took him into custody. Since then, he was getting repetitive disturbing thoughts and images of crash. He had nightmares often and was not able to sleep most of the times. Whenever he heard the sound of a flight, he would get disturbed. At times, he would shout and yell at the uncle without reason. The symptoms lasted for more than 4 months.

After referral to nearby mental health care facility, the caregiver can educate the person that the reactions s/he is experiencing is a product of the stress triggered by disaster, should strengthen support from family/friends/other social units, teach

anxiety management techniques (relaxation techniques, yoga, breathing exercises, diversion techniques) and restart healthy routine (sleep, food, exercise) and curb unhealthy lifestyle.

Anxiety related problems: The symptoms include increased worry and fear that last for six months or more. The survivors experience restlessness, difficulty in breathing, irritability, sleep problems, increased heartbeat, profuse sweating, and feeling dizzy. The individual experiences fear of forthcoming danger may be because of vulnerability or uncertainty.

Mr. K, 38-year-old adult was evacuated with his family during the Chennai flood. After reaching his home, he was sweating profusely. He experienced increased heartbeat, restlessness and was irritable in doing activities. At times, he had disturbances in sleep and breathing difficulties. He is afraid that rains may come again and had constant worry and preoccupation about the same.

The caregiver has to refer the person with the above-mentioned difficulties to the nearby mental health care centre. The care provider can do the following to help in the person's recovery: Help the person to create a healthy routine and follow it, teach relaxation techniques (yoga, breathing exercises), provide reassurances and instil hope and support.

Depression: The survivor who is depressed shows persistent sadness, low energy levels, depressive cognitions, negative thinking, lack of interest in pleasurable activities, alteration in sleep and eating patterns and suicidal ideation or suicide attempt. They also might have low self-esteem. These individuals avoid social activities and have significant impairment in activities of daily functioning.

Ms. S, a 32-year-old female lost her husband who was working abroad, due to COVID. She got this news only two days after his death. It was very difficult for her to get the body. She was not even able to believe that her husband was dead. She does not have children and had no other support. She attempted suicide twice. She had feelings of hopelessness, helplessness and felt unworthy to live. She lost her appetite and could not sleep. She was not able to do any of her activities. She was weeping continuously and was thinking that life is miserable.

After facilitating mental health referral, the caregiver can make the person feel that s/he is available for the person to talk about his/her feelings, teach on adaptive coping strategies, establish routine, monitor for suicidal thoughts/ideation. The care provider also can encourage the participant to engage in constructive hobbies like listening to music, weaving, etc.

Panic Disorder: This disorder is characterised by recurring panic attacks that spans between few minutes (rarely hours). The person experiences extreme anxiety and unreasonable fear. Some of the symptoms during the panic attacks are racing heartbeat, pain in the chest region, shortness of breath, shivering, giddiness, profuse sweating, vomiting sensation and abdominal pain.

Mr. R, a 35-year-old male, escaped miraculously from the Avalanche in Kashmir. Since then, he was feeling restless, anxious and had unreasonable fear. This attack used to last for few minutes. He would experience increased heartbeat, ache in chest region, breathing difficulty and pain in abdomen.

Along with referral to mental health care facility, the care provider can ensure safety and security, teach anxiety reduction strategies and provide reassurances.

Dissociative reactions: After disaster, few people may have jerky movements in the body that might appear like fits (seizures). These episodes might occur when they meet specific persons or during specific situations. Here the person might not hurt himself/herself, does not lose consciousness and would express the views in an unusual voice. These indicate that the person is experiencing excessive distress and has certain unfinished desired goals. To achieve these secondary gains, the person might display such abnormal behaviour. It should not be considered that the person is acting.

During Latur earthquake, Mrs. L, a 50-year-old female, escaped from the collapsing building along with the family members. After the calamity, she had unusual jerky movements in the body. This happens whenever she meets her son or daughter. During such episodes, she falls and appears unconscious. She would speak in an unusual voice. During those times, family members give more attention to her.

Psychosocial Interventions would include interventions targeted towards the individual as well as the family members. The person needs to be oriented on the body-mind relationship saying how the repressed unconscious needs are manifested through bodily symptoms. Helping the person to talk about the feelings would help the person feel better. The family members need to be told to minimise giving attention to the person's symptoms without compromising the quality time.

Other Mental health Implications

Loss of productivity

People, after losing everything feel empty and lack interest to work. When people lose their families in disaster, they feel meaningless in living and do not take efforts to make their lives better.

"I don't feel like doing anything". (32-year-old woman)

Increase in substance use

Alcohol consumption is increasing day by day and many cultures encourage alcohol use. Disaster survivors, after the huge loss tend to increase the intake of alcohol, tobacco and other substances to cope with the loss. It acts as a temporary relief with lot of negative physical, psychological and social impact. The caregiver needs to sensitise the population on the ill-effects of harmful substance use.

"When I drink, I feel less for the loss of my loved ones". (45-year-old man)

Suicidal thoughts, attempts and suicides

After losing the dear ones and all the property, some might have suicidal thoughts, tend to harm themselves or even attempt suicide. Repetitive thoughts to end life are most common in the rebuilding phase. The care provider needs to orient community in general on help available when individuals think of committing suicide, should give information about suicide help-lines and other suicide prevention strategies. As suicide is a cry for help, the caregiver should also develop crisis intervention plans for persons who wish to end their lives and hasten appropriate physical and mental health interventions in case of an attempt.

"I don't feel like living. God has taken all my dear ones. I feel lonely and I want to end my life soon". (39-year-old female)

Marital discord and family problems

Emotional reactions that are subjective mostly shown as behavioural or relational reactions. Subjective distress is usually vented over the family. It leads to strained interpersonal relationship resulting in significant marital issues or issues with children or parents. The balance of the family system gets disturbed after the calamity.

"My mother and father are always fighting. I do not want to go home at all. I used to play with my sister. The waves took my sister. I am all alone now. My parents don't talk to me properly". (9-year-old boy)

Somatisation

Subsequent to disaster, physical symptoms are common. At times even after a year of the disaster, few may experience continuous bodily symptoms such as headache, stomach pain, vomiting sensation due to ongoing stressors.

"My entire body aches. I feel weak and numb. I feel dizzy. I have consulted many doctors but the symptoms are not improving". (37-year-old female)

Difficulties in restarting and managing livelihood

Disasters shatter the livelihood of the disaster-affected communities. Enormous work needs to be done to rebuild the lives of disaster affected communities. Survivors have trouble in restarting their jobs or business from the base, collecting monetary benefits or compensation, etc. If the survivor is not multi-skilled and has only one work profile, it limits him/her from getting a job. Limited vocational opportunities around the disaster neighbourhood or losses incurred discourage restarting of livelihood.

"I lost my certificates and other important documents during the flood. It is very difficult to start a new life here. It would take months to get duplicate ones. I don't know what to do. I am now doing petty jobs which do not even match my education".

(24 years old male).

Reactions to post-disaster can be delayed and manifested even after six months or one year. Researches provide evidence that almost 30% of the population affected during disaster are prone to one or more mental health condition. The caregiver needs to be watchful of the abnormal reactions and should educate the community to look for the reactions among the neighbours. As there is still stigma with respect to mental health treatment, it is essential to sensitise the community on the importance of mental health treatment and minimise or remove stigma with respect to seeking mental health intervention. The care provider needs to undertake ongoing assessments. This would help the care provider to know whether the person needs primary, secondary or tertiary mental health interventions.

Remember

- Mental health reactions can be immediate or delayed.
- Common mental health problems are Acute Stress Disorders, Post Traumatic Stress Disorder, Anxiety, Depression, etc.

CHAPTER 7 LIFE EVENTS, FAMILY LIFE CYCLE AND DISASTER

Stressful life events

Life events are significant events in a persons' life. They can be normative and non-normative in nature. Normative life events are foreseeable or predictable and take place in every individual's life, e.g., joining or leaving school, entering career or family life etc. Non-normative events are mostly unexpected (disasters, accidents, operation).

Life events can be;

- ***Desirable*** (Getting compensation promptly, moving to another place due to job) or ***undesirable*** (Loss of life or house or being shifted to a temporary shelter)
- ***Expected*** (Getting relief materials or welfare measures) or ***unexpected*** (Losing job, being a victim of accident, death)
- ***Entry*** (Birth, getting a new job, marriage) or ***exit*** (Death, getting terminated, facing destruction)
- ***Personal*** (Loss of family members, loss of personal property) or ***impersonal*** (Destruction to environment, damage to public property)

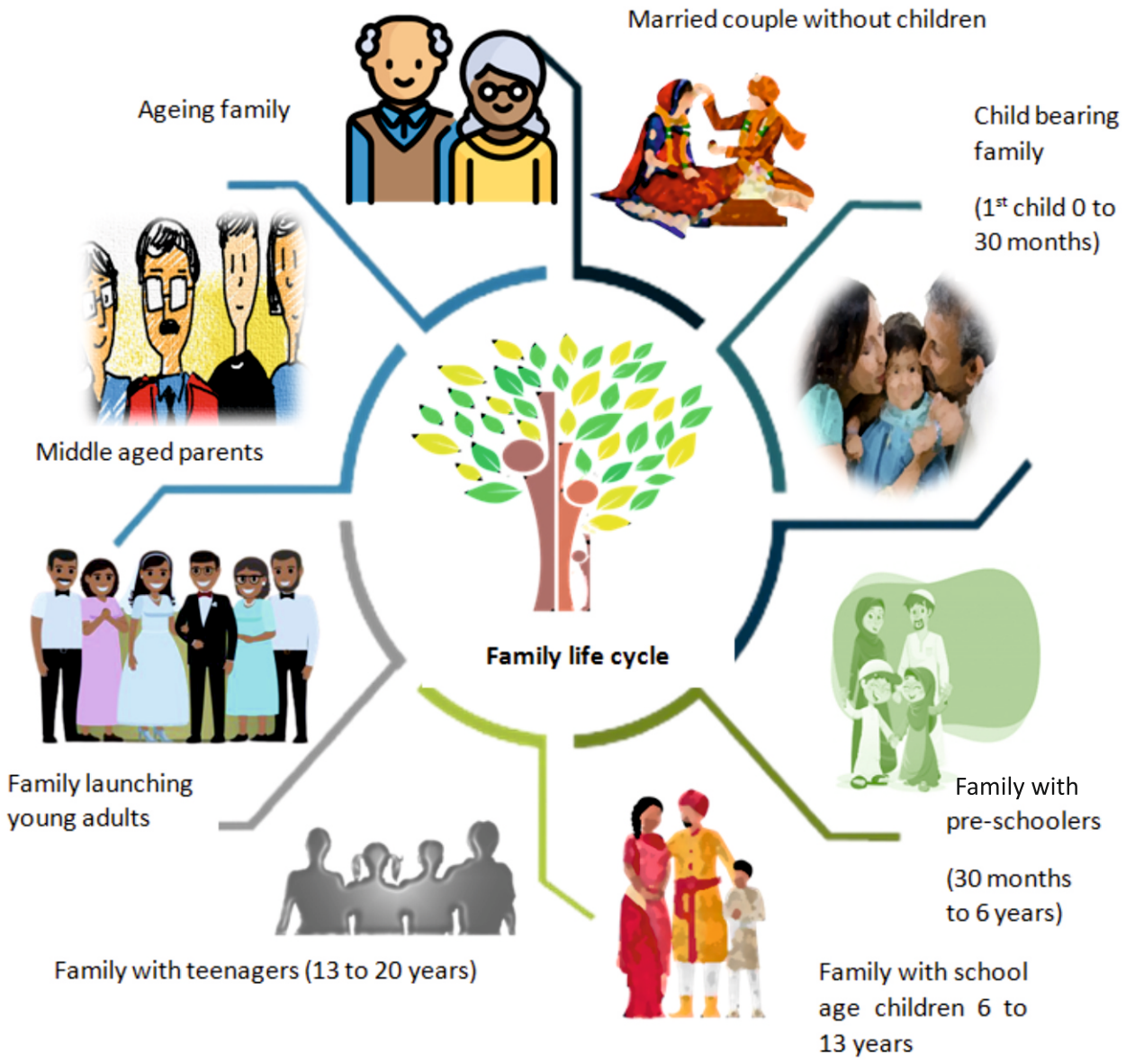
Stressful life events can impact the physical and mental health of individuals. Negative life events that happen before or after a disaster can be an indicator for predicting mental health problems. Understanding the life events help in establishing mental health monitory systems wherein persons with significant life events can be followed up closely. This would ease early identification and prompt treatment. Bereavement followed by loss of loved ones due to disaster is one of the most significant contributors to distress out of all the life events.

All individuals have significant events in their lives and the individual's coping abilities and resources help in reducing the effect of the life event. Disaster situations being unprecedented, increases the severity of life events in the individual. People loss their loved ones and property. Disaster situations create changes in the persons' roles and responsibilities. Moreover, the individuals suffer serious loss of support systems and resources. The support systems and resources that acted as buffering units prior to disaster from developing adverse mental health outcomes are now absent or diminished. This disturbs the individual's coping and eventually, his/her well-being gets affected. Hence, it is essential to look after the psychosocial and mental health needs of such individuals who have significant life events with the walk of disaster. Disaster makes people vulnerable and multiplies vulnerability among people who are already vulnerable. Lack of support and resources, subsequent to disaster impacts the coping of survivors resulting in higher distress. The life events also influence the life cycle, roles, responsibilities and rituals of the family. Disaster situations disrupt the family life cycle that induces distress among disaster survivors. The change in the family environment subjected by disaster affects the functioning of the individual, family and the community.

Family life cycle

Family is a recognized social group that nourishes emotional connection within the members and serves as one of the fundamental units of society. As individuals in the family grow, at every stage (a period in the life of a family) of development there is a set of roles and responsibilities (developmental tasks) expected from every member in the family. Each stage of family life involves natural changes, challenges and demands. Typical family life cycle of an individual is shown in the figure below;

Figure 7.1: Family life cycle



Impact of Disaster in the Family Cycle

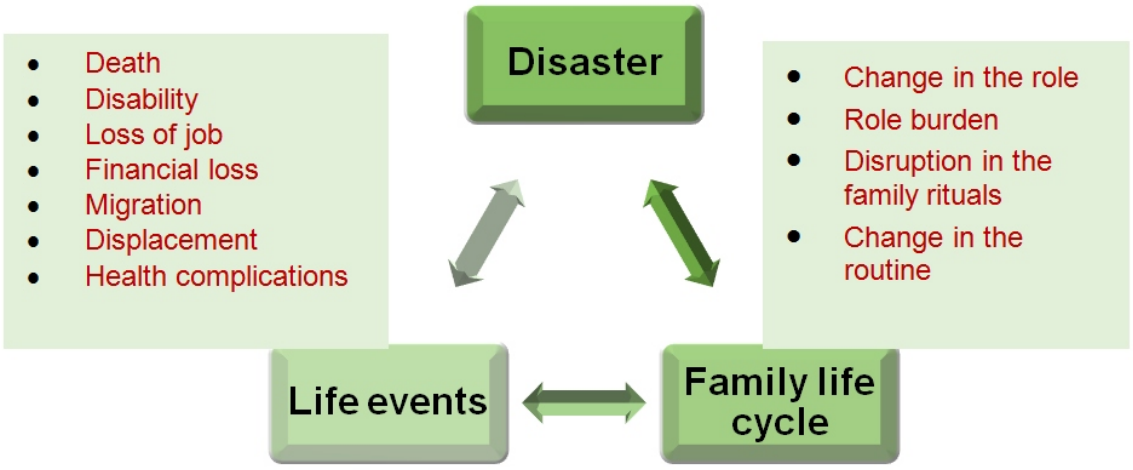
As already mentioned, every stage in the family life cycle has its own expectations and concerns. When expectations and concerns in one stage is not fulfilled, it gets carried over to the further stages. Failure to deal with the stressors and demands of one stage would add stressors to the following stages. Disaster situation adds stress to the family life cycle and impacts the family balance.

Disaster brings major impact to family life in terms of the person losing his/her spouse, children, parents or at times the entire family. Loss of livelihood, loss of employment opportunities and loss of habitat bring immense distress to the survivor. Loss of family members drives incomparable distress. Family systems get disturbed and the role expectation gets increased. When nominal or functional leaders of the family die in disasters, change in leadership takes place. Calamity results in poor adaptive patterns in the family especially poor problem solving and coping strategies.

Disaster uproots the family from the familiar neighborhood and the primary social support gets affected. Role change, multiplicity of roles, role reversals take place in the structure of the family when there is a death in the family. For instance, if the father and mother of the family are dead in a disaster, the grandparents need to take up the parent's role, if the father is dead, mother has to become the functional leader in dispensing both the instrumental (money, food, other essentials) and expressive (love, care, affection) roles leading to excessive burden due to multiplicity of roles. All these difficulties, change the routine of the family life and members in the family become vulnerable to multiple psychosocial issues.

Mental health complications are high when the family is left without any resources, adaptive coping capacities and inadequate support. It is essential for caregivers to look in to the needs of disaster survivors who lost balance in their family life cycle. Appropriate individual, family and community based psychosocial interventions would help in minimizing mental health problems among survivors whose family life cycle flow is disrupted.

Figure 7.2: Influence of Life Events on Family Life Cycle Post-disaster



Remember

- Disaster disrupts the equilibrium and flow of the family life cycle.
- Life events are common for all individuals.
- Negative life events that happen before or after a disaster can be an indicator for predicting mental health problems.
- Disaster situations disturb the family life cycle and cause distress among disaster survivors.

CHAPTER 8 PSYCHOSOCIAL SUPPORT TECHNIQUES

Disaster creates imbalance among individuals, families and communities. People will be in a state of confusion and look for support. Therefore, it is essential to render appropriate help for disaster survivors. This chapter talks about ten psychosocial techniques that are essential in the helping process. These techniques can be practiced by anyone who wants to assist the people hit by disasters and facilitates recovery. While applying these psychosocial support techniques, the caregivers should bear flowing points in minds;

- Disaster affects every individual in the community
- Reactions following a disaster are normal response
- Disaster contributes to both individual and collective trauma
- Even the survivors with good coping ability will have difficulties in sustaining the earlier level of functioning for the initial days after disaster
- Problems with daily living results in psychosocial issues among disaster survivors
- Cultural, religious and linguistic sensitivity is essential while developing community based psychosocial programmes
- Survivors need to be motivated to express about their disaster experiences
- Phase specific interventions need to be developed
- Rebuilding and maintenance of support systems is essential
- The caregivers should be open minded while engaging themselves in the caring process

PSYCHOSOCIAL SUPPORT TECHNIQUES

Ventilation

Disaster minimises individuals' coping abilities and resources. Individuals generally suppress their strong negative emotions. These pent-up emotions and feelings get bottled up and affect the well-being of the individual. Channels need to be created for individuals to ventilate their emotional distress that would help in preventing emotional explosion. Creating space for the disaster survivor to talk about his/her negative emotions is like a whistle in a pressure cooker. The whistle regulates the pressure and if a whistle is absent, the pressure cooker might explode. The ventilation process facilitated by the caregiver would act as a safety valve for the survivor to release his/her negative emotions.

Timely expression of traumatic experiences, through talking, facilitate faster recovery and prevent development of mental health complications. Sharing of disaster specific experiences can happen individually or in groups. Individuals should not be forced to talk but s/he should know that there are people or facilities available for individuals to talk about their trauma. During the catharsis (venting of negative emotions) through crying or talking or other acceptable ways of expressing crisis, the caregiver should not interrupt or ask the person to stop crying or talking. Strict confidentiality has to be ensured and the information shared by the survivor should not be shared with others unless threat to self/others is observed. The caregivers should not interrupt the survivor while s/he is talking until and unless it is vital. The caregivers should not interrogate and should accept him/her as s/he is.

Active listening

People affected by disasters want to be heard and opportunities need to be created for disaster survivors to vocalise their feelings and emotions. Some of the barriers to active communication are lack of privacy, noisy environment, preoccupation of the care provider, poor help seeking behaviour among the survivor, negative attitude of the care provider and lack of training in the helping process.

The **SLOWER** technique helps in motivating the survivor to talk about the negative experiences.

S – Sitting squarely
L – Leaning forward
O – Openness
W – Withhold your judgement
E – Eye-to-eye contact
R – Relaxed posture

To make the individual know that s/he is being listened, the caregiver can paraphrase periodically, can ask whether s/he has understood the individuals' expression as the individual felt and use adequate non-verbal communication (nods, mirroring of emotions, etc.). When disaster survivors feel that they are listened to, they feel comforted and safe. Active listening helps in providing warmth and positive regard for the survivor.

Empathy

Empathy is one of the basic and crucial psychosocial care techniques that help in building rapport and trust with the disaster survivors. Here, the caregiver understands the subjective experience of the survivor and communicates it to the survivor. E.g., *'I understand it must be very difficult for you to witness the pain and suffering', 'I can't imagine being in that situation', 'I know you have tried your best to support your family', etc*.

Expression of empathy can be practiced by these four basic elements;

- Viewing from the other person's perspective.
- Understanding their feelings and emotions.
- Non-judgmental acceptance.
- Communicating that the care provider has understood the other person's situation.

Empathy also means experiencing the circumstances, feelings and emotions of the other person despite not having the real traumatic experience. It is difficult to experience from the other person's point of view and it is an art which develops out of patient practice. Being empathetic towards the other person during the helping process will help in understanding the pain of the survivor and in initiating responsive psychosocial care activities for the survivor. Appropriate gender specific touch or gestures, adequate reassurances, mirroring of the other person's facial expressions/feelings and disclosure stories (when needed) aid in expressing empathy towards the disaster survivors.

Maintaining Routine

Disaster breaks one's routine. Restarting one's daily activities is essential to bring functionality among disaster survivors. Daily routine might involve healthy eating habits, proper sleep, engagement in household chores, resuming occupation, taking usual medicines, physical activity, following family rituals and other social activities. Restarting routine would be difficult initially because of factors like loss, confusion and personal vulnerabilities. The caregiver has to motivate the survivors to start doing their activities of daily living and can help those who have significant difficulty in resuming earlier life. The caregiver should also monitor closely such individuals and provide opportunities to ventilate and express their difficulties.

Avoiding maladaptive patterns

The techniques 1 to 9 foster positive coping strategies. During disaster situations, availability of resources will be limited or become scarce, exceeding the individual's coping abilities. The negative consequences of disaster make people adapt negative coping strategies. Along with encouraging disaster survivors to practice adaptive coping strategies (active problem solving, talking or writing about the feelings, giving and taking help), the caregivers should also discourage maladaptive coping strategies. Some of the commonly used maladaptive patterns are; using drugs or psychoactive substances, over or under eating, fighting/beating/quarrelling, avoiding or escaping from thoughts/people/place, gambling etc.

All the above psychosocial techniques help in speedy recovery of the survivors. Though all the techniques are important, the individuals can choose a particular or combination of techniques based on their need. Care to be taken to align these psychosocial techniques to the cultural and religious sentiments of the community.

Social Support

Social support makes people feel safe and assured. Social Support can be classified into three orders:

(1) Primary Social Support: Family,
(2) Secondary Social Support: Friends, Neighbours, Colleagues, and
(3) Tertiary Social Support: Government, Legal bodies, Non - Governmental Organisations, Religious Institutions.

All these three sources of support are important as they safeguard when individuals face distress. Social support also enhances a person's well-being and coping. Disaster situations disturb, uproot or wipe out social support units, especially the primary and secondary support. For example, an individual can lose his/her family members or friends in the disaster. It is essential for caregivers to develop strategies to recreate social support units, create opportunities for survivors to gather in groups and encourage individuals in family rituals and community engagement activities.

Yoga and relaxation

The unexpected confusion and uncertainty following any disaster, result in anxiety and fear. It would be difficult for individuals to relax because of the tremendous loss, continuous apprehension and fear of future. It is essential to train the survivors with anxiety or panic management strategies. Yoga and relaxation techniques can serve as such self-management strategies. Some of the yoga/relaxation techniques that can be practiced on a daily basis even in a restricted environment are given below:

Victorious Breathing (Ujjayi): This technique helps in calming the mind and body. The participants are asked to fill the lungs with air and breathe through nose making a snoring/hissing sound.

Bellows Breathing (Bhastrika): It involves rapid inhalation and exhalation creating a yogic fire within oneself. The participants have to sit in a cross-legged position. Then they need to make a fist and place the folded arms near the shoulders. While the participant inhales, s/he has to raise the hands up and open the fists. Then exhale forcibly bringing the arms down and closing the fist. The process can be repeated for 20 rounds.

Chanting: The participants are asked to create slow and progressive resonating vibration using the sounds aaa… uuu…. mmm….

Purifying Breathing (SudharshanaKriya): This is a cyclical breathing exercise in slow, medium and fast rates combining the victorious breathing, bellows breathing and chanting.

Mindfulness: Imagining a peaceful and serene environment or natural ambience and focusing on breathing or looking at serene objects like illuminated candle, images of God, nature or meditating on religious texts with undivided attention.

Jacobson's Progressive Muscular Relaxation (JPMR): It's progressively tightening and loosening muscles in the multiple parts of the body starting from head to toe. It is proved that stress gets accumulated in multiple parts of the body and manifested as pain. Systematic tightening and loosening of body muscles helps in releasing supressed emotions. The individual has to breathe in while tightening and gently release the tightening muscles while breathing out slowly.

Recreation

Recreation helps in shifting one's focus from the negative emotions triggered by the disaster. People can be encouraged to participate in recreational activities like singing songs, dancing, playing and other culture specific activities. These recreational activities help in fast improvement of the normalization process. Recreation options can be made available in the community through folk lore, puppet shows and other cultural media. This also can be made use to provide disaster specific information and awareness. Humour can also be a part of recreation. Providing channels for people to laugh and cherish would drive faster recovery.

Spirituality

Spirituality refers to the positive inner experiences that provide optimistic outlook towards life. It aims at establishing the connection between inner self of an individual and outer world. Spirituality also involves caring for self, others and the environment. It believes that there are things that are outside one's control and testing times offer platform for bettering oneself. It is a movement towards self-fulfilment. India, being a country of multiple faiths and religions, belief in God/nature/ offers support and peacefulness during difficult times. Questioning the supreme power is a part of the grieving process. This might get extended during the acceptance phase. The caregiver should not force anyone to perform specific spiritual rituals, but encourage survivors to practice their spiritual practices.

Externalisation of interests

Individual's roles get disturbed during disaster. Hence, positive rearrangement of roles based on the demands of the current situation is important. This ensures adjustment among the survivors. Shifting the focus to other constructive activities keeps the person engaged. It enhances the person's functionality as well. The caregiver should look for the interests and skills among the individuals or groups and encourage practicing the same on a daily basis. Activities constructed to remember the interests and skills of the individuals would make the survivors feel that their skills match with the need of the emerging situation. This would make them feel that they are not a burden for others, but a useful resource in community restoration.

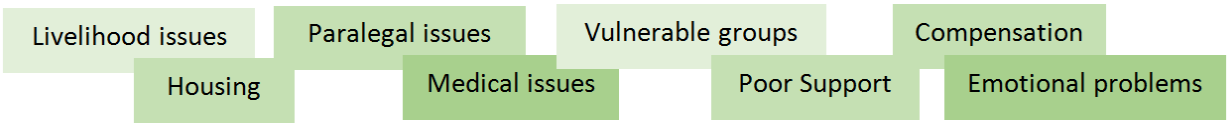
Remember

- Psychosocial techniques help in enabling faster recovery of the disaster survivors.
- Disaster survivors have to be encouraged to practice the psychosocial techniques.
- Cultural sensitivity needs to be maintained while practicing psychosocial techniques.

CHAPTER 9 REFERRALS AND FOLLOW-UP

Individuals, families and communities affected by disasters have different needs. Understanding the needs of disaster survivors and linking them to appropriate services is essential to promote resilience among individuals who have experienced the disaster. Referral is a linking process in which the caregiver initiates care management for a specific identified problem. While initiating a referral, the caregiver does not transfer care for the disaster survivor completely, but links the person to an advanced/appropriate facility or person and follows it up to see whether timely service is achieved. Though psychosocial support focuses on providing psychological and social support for the disaster survivors, the holistic care is achieved only through coordination of multiple service providers based on the needs of the disaster survivors.

Referral is required while survivors experience following psychosocial issues;



Ethical practices to be followed while facilitating referrals:

- Do not force the survivor to talk about the issues.
- Do not break confidentiality.
- Do not flood the survivor with information.
- Verify the authenticity of the agency to which the survivor is being referred.
- Do not just stop with referral but periodically review progress.
- Be a bridge between the agency and the survivor.
- Not all the needs of the survivor can be fulfilled and it has to be communicated clearly.

Follow-up

Follow-up is a process in which the caregiver understands whether the agenda for referral has been achieved or not. Though the process might be time consuming, rigorous and exhaustive, adequate follow-up ensures continuity of care and instils hope among disaster survivors. The follow-up should be done in a mild way without down scaling the relationship between the survivor and the service provider. During follow-up, the caregiver has to assess the quality of work done by the referral agency, satisfaction of the survivor, further assistance required, future plan of action, difficulties in reaching the goal, changes that the referral has facilitated in the survivor/family or society.

Figure 9.1: Steps in the Facilitation of Referral

Establishing Rapport
Using psychosocial care techniques (Active listening & empathy).

↓

Assessment of Needs
Biological, Psychological and Social.

↓

Deciding the need for referral
Why? What? Whom? When? How?(Psychosocial care, Strengthening Social Support, Paralegal Aid, Means of livelihood, Medical and Psychiatric Care, Compensation Claims).

↓

Preparing the objectives for referral
- To link the needs of the disaster survivors to the resources.
- To reduce distress among survivors.
- To facilitate the normalisation process.

↓

Exploring referral options
- Assessing whether the needs of the survivors' match with the services of the service providers.
- Having a list of service providers and their services will facilitate this process.

↓

Communicating to the survivor and the agency
- Talking to the agency about the survivor's needs.
- Selection of appropriate agency for referral.
- Discussing referral plan with the survivor and finalising the referral plan.
- Communicating the referral agenda to the survivor.

↓

Actual referral
- The survivor meets the agency and the actual referral.

↓

Receiving feedback
- The caregiver talks to the service provider and the survivor to know how the referral is progressing.

↓

Review and termination
- When the needs are met or the sessions are progressing as expected, the caregiver calls for termination (termination does not mean that the care provider stops providing PSS for the survivor).
- If the outcome of the referral is not happening as expected, the caregiver revisits the referral plan, reorients both the agency and the survivor and identifies other stakeholders for appropriate referral.

Remember

- Structured needs assessment precedes referrals.
- The care provider should have a directory of agencies to which survivors can be referred and should update it periodically.
- The care provider should act as a bridge between the survivor and the service providers.

Section - 2
WORKING WITH VULNERABLE GROUPS

CHAPTER 1 VULNERABLE GROUPS IN DISASTERS

When there is a threat of disaster, the vulnerable sections such as pregnant women, orphan children, persons with disability and uncared older adult population need special attention. There is a wide range of biological (sex, health conditions, disability), social (poverty, gender, age, education), and environmental (place of stay) factors that make a person vulnerable specific to different types of disaster. Following questions would help in providing better clarity on understanding vulnerability:

1. What are the threats or hazards that make people vulnerable?
2. What are the factors that influence them to be vulnerable to a specific threat or hazard?

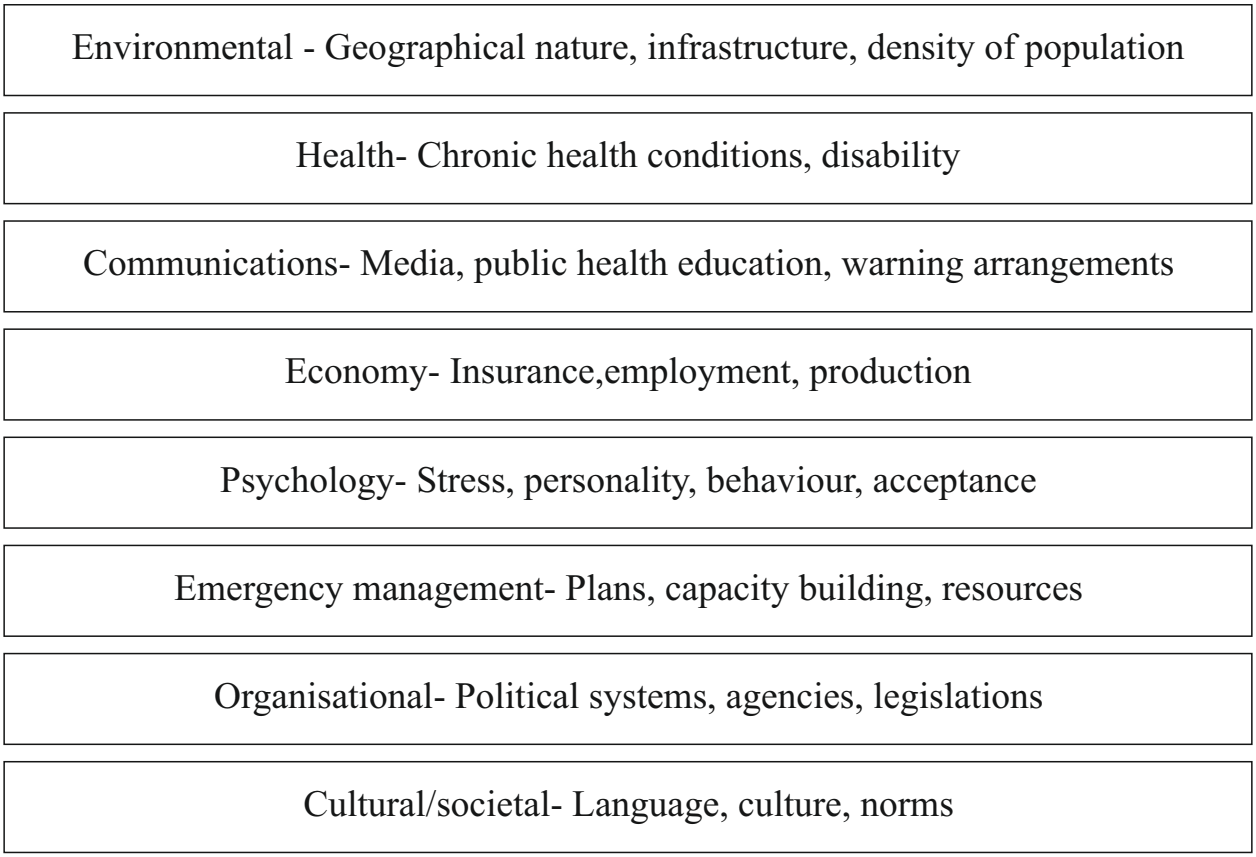
Often vulnerable population is overlooked. Hence, understanding their needs help in providing psychosocial support services effectively.

Table 1.1: Vulnerable groups, during different types of disasters

Factors	Vulnerable Groups
Age	Children and adolescents (unaccompanied children, orphans, child labourers and children in conflict with law)
	Older adult (older adults not cared for in families,older adults in older adult homes and older adult living alone)
Gender	Women (pregnant women, single women, widow and divorced women)
	LGBTQIA+ (lesbian, gay, bisexual, transgender, questioning, queer, intersex, pansexual, two-spirit (2S), androgynous and asexual)
Occupation	Farmers, fisherman, daily wagers, bonded labour, first responders, mine workers, commercial sex workers
Family	Single parents, families with younger children, families with large dependents
Ethnicity	Indigenous groups, cultural, linguistic and religious minorities, nomads
Status	Socio-economically disadvantaged, homeless, slumdwellers, unemployed
Health	Long-term medical condition, addiction, immune compromised state, persons with limited life span, persons in palliative care
Trauma	Intimate partner violence, previous experiences of trauma, violence in the family/community, victims of sexual/physical violence and abuse, bereavement
Displacement	Immigrants, migrants, environmentally displaced, internally displaced, refugees
Disability	Low vision, locomotor disability, dwarfism, intellectual disability, mental illness, cerebral palsy, specific learning disability, autism spectrum disorders, speech and language impairment, hearing impairment, muscular dystrophy, multiple disability
	Others (thalassemia, haemophilia, sickle cell disease, chronic neurological disorders)
Others	Tourists, prisoners, homeless people, unorganised workers, retired people

Vulnerability changes based on the pre-existing conditions, environment, political scenario, etc. For example, a drought or heavy rainfall in the field areas make farmers vulnerable; whereas, cyclone makes fishermen and people living in the coastal areas vulnerable. It is essential that all the vulnerable groups need to be identified and equipped with skills and resources to anticipate, cope better, resist and recover from the impact of disasters. Though different factors contribute to vulnerability among individuals, the major vulnerable groups are: ***Children, Women, Older adult and Persons with Disabilities***. It does not mean that other groups do not require attention. Vulnerable groups change based on the nature and intensity of the hazard, pre-existing risks and prevailing socio-political conditions. It is, hence essential to identify persons based on their vulnerability and plan measures to reach them promptly using assistive and easily accessible services. Type of vulnerable groups and the factors leading to it keep changing. Therefore, care need to be taken to constantly update information on 'persons at risk' and plan programmes that enhance the psychosocial competencies of vulnerable groups.

Figure 1.1: Indicators of vulnerability



Principles of working with vulnerable groups

Vulnerable groups being physically, psychologically or socially disadvantaged, need more attention, while providing PSS. As vulnerability refers to the compromised capacity of an individual to foresee, handle, resist to and recover from the impact of disaster, principles of working with vulnerable groups should focus on building resilience in them.

1. Principle of human rights promotion (promotion of equality, respect, dignity and autonomy)
2. Principle of non-discrimination (providing services without any discrimination)
3. Principle of accessibility (easy accessibility to information, resources and services)
4. Principle of protection from violence and exploitation (promoting awareness on legal framework that protects vulnerable populations from any form of violence or exploitation and exercising the same)
5. Principle of priority of services (offering rescue, relief and reconstruction services first to persons belonging to vulnerable population and then to the universal community)
6. Principle of preserving family unity (not separating vulnerable groups from their family or neighbourhood)
7. Principle of confidentiality (ensuring confidentiality to personal information of vulnerable groups and enabling anonymity while discussing their issues and concerns)
8. Principle of inclusion (including in decision-making, planning, execution and evaluation)
9. Principle of acceptance (accepting individuals with his/her strengths and limitations)
10. Principle of resourcefulness (acknowledging the inherent strengths, knowledge and abilities of persons belonging to vulnerable groups)

Steps in identifying and empowering vulnerable groups before/during/after disasters

STEP 1: Identify vulnerable groups: The first step to identify vulnerable population is to define vulnerable groups and their vulnerabilities. Understanding the socio-demographic characteristics (age, gender, economic status, occupation etc.) of the community helps in identification of people at risk in the community. The process should aim at listing out the criteria for vulnerable groups and categorise individuals based on the vulnerabilities.

STEP 2: Mapping of vulnerable groups: After identifying the vulnerable groups, they should be traced by mapping. The mapping should include details on the name of the person, type of vulnerability, contact details (personal as well as family/caregiver), nearest resource centre and so on. This can be done through local organisations, health centres and other stakeholders.

STEP 3: Identifying existing resources: Persons with vulnerability have internal and external strengths/resources. Internal resources include adaptive coping abilities, education, employment, family support, skills and awareness about disaster related preparedness. External resources include availability of organisations working for the respective vulnerable groups, existing plans, policies, legislations, services and programmes.

STEP 4: Connecting persons with services: If individuals in the vulnerable group are already receiving services, it is essential to evaluate whether the available services improving their psychosocial competencies, preparedness and disaster risk reduction. If individuals have not yet received the services, they need to be encouraged to register and avail services.

STEP 5: Disaster risk reduction strategies for vulnerable groups: Existing services on preparedness and psychosocial support has to be enhanced, ensure its reachability to the vulnerable groups. Participation of the vulnerable groups in the planning and implementation of services also has to be encouraged.

Remember

- Vulnerable groups are those groups whose biopsychosocial conditions affect their capacity to anticipate, cope, resist and recover subsequent to disasters.
- Children, Women, Elderly and Persons with Disability are commonly known vulnerable groups.

CHAPTER 2 IMPACT OF DISASTERS ON VULNERABLE GROUPS

As already discussed in Chapter 1, impact created by disaster can be grouped into physical, psychological, social and economic domains. Though disaster affects all groups of people, the impact caused by disasters on vulnerable groups are more. This chapter talks about the impact caused by disasters on vulnerable groups.

Impact of disasters on Children

Unpleasant experiences such as; loss of family, friends, home, pets, belongings (toys, clothes, other belongings), place of study (day care/preschool/school), teachers and place of recreation (parks, sports centres, library) etc., subsequent to disaster will have a severe impact on children. This affects the different areas of their life- physical, psychological and social, as shown in the table below;

Table 2.1: Impact of disaster on children

Age group	Physical impact	Psychological impact	Social impact
0 to 5 years	• Delay in developmental milestones • Headache • Vomiting • Multiple body ache • Change in appetite • Sleep disturbances	• Temper tantrums • Excessive crying and clinging behaviour • Regressive patterns (thumb sucking, bed wetting) • Delay in bowel or bladder control • Fear (darkness, being alone, strangers) • Night mares • High sensitivity (noise, light)	• Increase in the number of orphans • Child trafficking • Child abuse (physical, psychological & sexual)
6 to 12 years	• Headache • Stomach pain • Giddiness • Poor/increased appetite • Decreased sleep • Change in sleep and appetite	• Aggression • Regressive behaviours • Nightmares • Low mood • Lack of interest • Not obeying • Being disruptive • Increased anxiety and fear • Poor attention and concentration • Withdrawal	• School dropout • Easy exposure to negative elements of the society (substance abuse) • Runaway tendency • Increased risk-taking behaviour
13 to 18 years	• Change insleep and appetite	• Withdrawn behaviour	• Increased risk - taking behavior

	• Easily getting tired • Multiple body pain • Changes in menstrual cycle (for girls)	• Feeling guilty • Excessive irritability and aggression • Negative cognitions (helplessness, worthlessness, helplessness) • Disobedience • Poor concentration and interest • Suicidal thoughts • Poor problem solving and decision-making skills	• Increased antisocial behaviour (engaging in criminal activities) • Change in family structure, class and roles • Avoiding social interaction • Avoiding places/people/things associated with disaster event

"My grandmother would buy me a lot of toys. She died six months ago. Those toys used to make me feel her presence. I lost my toy box when our house got collapsed. I want those toys back and don't want to play with new toys". (7-year-old girl)

"The landslide killed my father and sister. My mother and I are left alone. We have no one to help. I wish we also were dead". (12-year-old boy)

How the forest caught fire, I don't know. It was in the night; we were all asleep… I feel scared to close my eyes. Even if I sleep, I get dreams of the fire, scream of the people, and dead bodies" (16-year-old girl)

"When I grow up, I want to kill them all and take revenge. They killed my father in front me. I don't want to go to the same house again.... I am not able to remove that incident from my mind" (8-year-old boy)

"We had two cows. They were my friends. I used to play with them every day. I saw them getting washed away but couldn't save them. I miss them very much and want them back". (6-year-old child)

Impact of disasters on Women

Disaster situations change the status of women from married to being widowed or from men headed families to women headed families. Even when there is no loss of life, when individuals are asked to shift to relief camps, women lack privacy. Disaster also makes women vulnerable to exploitation. The common impact of disasters on women are:

Table 2.2: Impact of disaster on women			
Physical impact	**Psychological impact**	**Economic impact**	**Social impact**
• Multiple body pain • Palpitation • Chest pain • Diabetes & hypertension • Infections • Respiratory diseases • Changes in sleep and appetite • Vomiting • Skin diseases • Allergy • Urinary tract infection • Excessive tiredness • Giddiness • Complications in pregnancy • Miscarriage	• Fear • Anger • Anxiety • Hatred • Guilt • Sadness • Rage • Disgust • Symptoms of PTSD (Avoidance, hypervigilance, intrusion) • Chronic stress • Preferring to stay alone • Self-neglect • Negative thoughts	• Financial difficulties • Unemployment • Loss of economic independence • Livelihood challenges	• Domestic violence • Sexual violence • Abuse • Women trafficking • Change in family roles, structures • Increase in crimes against women • Increased substance abuse

"I lost my husband in the train accident. Now I need to take care of my children alone. I am afraid. I don't know how I can survive without my husband. I don't want to take anyone's help. They might exploit me".(43-year-old female)

"During Tsunami, I lost both my children. The caregiver was talking to my husband and me about recanalization process. I am still apprehensive about the process. I am still not out of my children's loss". (29-year-old female)

"Before seeing the world, my child left me. I dreamt so much of my baby. Why God has punished us like this. I want my child back". (23-year-old female)

The people who attacked us were people we knew. They were not even considerate towards women, they pulled us and hit. We used to go to their weddings and we even celebrated festivals together. I don't think that will happen again. I lost trust on people." (34-year-old woman)

"Earlier I used to be very patient with my children. But now I lose my temper very soon. At times, even the sound of children playing irritates me. What is wrong with me, I don't understand?" (26-year-old woman)

Impact of disaster on Older adult

Deteriorating sensory abilities, pre-existing physical health conditions and decreased ability to concentrate, judge what is right and wrong, decision making etc., affect the physical and mental well-being of older adults and make them more vulnerable than the general population. The difficulties faced by older adult subsequent to disasters are listed below:

Table 2.3: Impact of disaster on Older adult

Physical impact	Psychological impact	Economic impact	Social impact
• Increase in physical health problems • Decline in performing daily routine • Injury • Disturbances in sleep and appetite • Increased chance of infection • Higher risk of life threat • Excessive tiredness	• Adjustment difficulties • Emotional coldness • Anxiety • Fear • Inability to take decision • Poor concentration • Excessive cribbing • Forgetfulness	• Increased cost of living • Livelihood challenges	• Threat to life and property • Poor accessibility to services • Increase in crimes • Loss of support • Older adult abuse • Neglect/abandonment

"My grandson died in the school building collapse. I used to take him every day to school. On the day of collapse also, I dropped him. Now, whenever I pass by the site, I remember him. Why did such a thing happen? He was the treasure of our family". (68-year-old male)

"I lost my son and daughter-in-law due to flood. They had long way to go in their life. I wish instead of them God would have taken me. I don't find any point in living". (74-year-old female)

"*Here at this relief camp, I don't have my people. My family members have been put in a different place. Even if I want some help, I don't feel like asking anyone. I am not able sleep at all. I am waiting to go back home". (81-year-old male)*

"I have BP, diabetes, and asthma. Looking at the news I feel scared of what if I get corona. I have been telling everyone to be careful. Nobody is listening to me. They don't even take a bath soon after coming. I am fed up of telling. If I happen to get corona, I am sure I am going to die like an orphan". (86-year-old female)

Impact of disaster on Persons with Disability (PwD)

Persons with disability require more attention from the family, community and government. The already existing difficulties such as poor mobility, dependence on others, societal stigma or discrimination, lack of services or poor accessibility to services, etc., make them suffer more post-disasters. Common issues faced by PwDs are listed below:

Table 2.4: Impact of disaster on persons with disability

Physical impact	Psychological impact	Economic impact	Social impact
• Worsening of the existing condition • Being bed-ridden • Easy exposure to infection and diseases • Reproductive issues	• Negative thoughts about self and others • Death wishes • Negative emotions (fear, guilt, sadness, hatred) • Mental health problems	• Loss of livelihood • Deprivation from basic facilities • No or underpaid job • Delay in social welfare benefits	• Social exclusion • Lack of access to resources • Communication barriers • Loss of existing support • Poor support • Violence against PwDs

"My father died in the recent earthquake. He was the only bread winner of our family. I, being a person with visual impairment, need to be supported by my parents. My mother and I are now left alone. I don't know what to do". (22-year-old male with *visual impairment*)

"When everybody was running to save their lives from the flood, I was helpless. With the help of rescuers somehow my life was saved, but I got severely injured. Thinking of my condition, I feel helpless. If I had been a normal person, my situation would not have been like this". (26-year-old male with locomotor disability)

- The groups mentioned above are the major vulnerable groups that are severely impacted subsequent to disasters.

- Along with these, the caregiver should also look for groups that would have disaster specific impact. For example, during droughts or heavy rainfall, farmers need to be focused and during cyclones fisher folk living near the coastal areas might get affected the most.

- Irrespective of disasters, people belonging to lower socioeconomic condition and socially disadvantaged groups (scheduled castes, scheduled tribes, other backward classes and minorities) get highly affected by disasters due to increased vulnerability in the form of poverty, lack of resources and poor support.

- Other groups that might warrant increased attention are people living in houses with poor quality construction and older construction sites.

- Homeless people and people with lower income also constitute groups that require increased attention.

- Institutionalised persons like prisoners, children, women, older adults in shelter homes, hospitalised persons, personnel working in hospitals also suffer greater loss as well as decreased attention during emergencies. These groups might face increased physical injuries and adverse physical effects. They experience significant loss of life and property that disrupts their existing support and resources leading to decreased social support and increased financial difficulties. These make these individuals more vulnerable to stress related disorders and other mental health problems (depression, anxiety, PTSD, etc.).

Remember

- Children, women, elderly and persons with disability suffer physical, psychological, economic and social damages post disaster.
- Along with the above-mentioned persons in need of increased assistance, disasters create new vulnerable groups.
- Lower socioeconomic condition and disadvantages faced by people in the society make people more vulnerable.

CHAPTER 3 STRATEGIES FOR WORKING WITH VULNERABLE GROUPS

Vulnerable groups have diverse needs. The caregivers need to make sure that services reach these groups. Adopting certain unique strategies while working with vulnerable groups help in enhancing their coping. This chapter elaborates strategies which caregivers need to incorporate while working with vulnerable population.

CHILDREN

Response of the children vary depending upon their age. Therefore, age of the children has to be considered while working with them in disasters. Age-appropriate activities need to be planned while providing PSS for the children. Along with focusing on the child, the caregiver needs to focus on their family as well. Parents are role models for the children. Therefore, parental coping influences the child. Parents need to be informed in advance about adaptive coping strategies, so that they can be the model for their children.

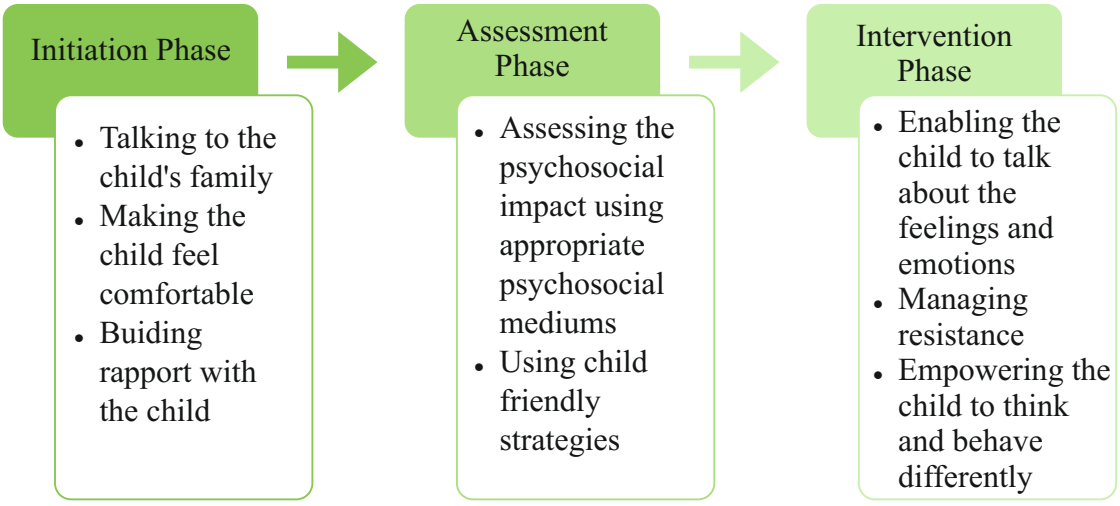
Some of the key measures to be adopted while working with children are:

- Help the child to be connected with significant people (parents, friends, teachers, relatives, neighbours).
- Engage the child in intervention (PSS) process using psychosocial mediums.
- Instil a helping spirit in the child.
- Monitor the child's routine.
- Limit exposure to disaster related media.
- Teach child to name the emotions and express them.
- Help child to learn self-care and adaptive coping strategies.
- Foster goal setting skills (short and long term).
- Encourage the child to be hopeful about the future.
- Enable child to understand better about self.
- Facilitate acceptance to change.

Mediums for working with children

Strategies that work with adults do not work with children. Children require expressive mediums that enable them to unconsciously express their feelings and inner experiences. Psychosocial caregiver need to assess the psychosocial impact of disaster and plan tailor-made intervention strategies. Mostly these mediums are done in groups and the group experience facilitate the healing process. The psychosocial mediums tap the emotional disturbances that children experience and facilitate positive thinking and behaviour.

Figure 3.1: Framework for using the psychosocial mediums



Common psychosocial mediums that can be used while working with children

1. Facial expression cards: Facial expressions help in naming the emotions. It is essential for children to understand the emotions that they are undergoing. Facial expressions help them to identify the emotions they are experiencing and talk it out freely. Through the facial expression card child's present feelings, disturbing events in the past and its impact on the child and his/her family and future plans will be explored.

2. Thematic story cards: The thematic story cards help in tapping the child's feelings, thoughts and emotions in the present, after the impact and helps in developing positive future goals. The children are made to relate themselves with the illustrations given in the thematic cards and asked to make meaningful stories of their past, present and future. It also reveals the child's current needs, coping abilities and available support.

3. Family portrait: Family portrait is another psychosocial medium through which the caregiver can understand the environment of child's family. This technique helps to minimize the resistance among children to talk about their families and enables communication, understanding and emotional relatedness. It can also be used as an assessment tool where the psychosocial caregiver can understand about the family's structure, roles of different individuals in the family and their closeness to the child. It also aid in understanding the communication patterns, roles, leadership patterns, and conflicts in the family. The caregiver needs to look into the colour, elements added in the portrait, distance between the members and emotions depicted to understand the child in the family.

4. Drawing: Drawing helps to express the repressed emotions, unspoken thoughts and improve the thinking abilities of the child. The child's drawing represents the child, his/her inner feelings, confined emotions, needs and concerns. It also acts as an assessment tool, where the caregiver can understand the child's emotional state and create strategies to foster adaptation and effective coping skills in the child. Drawing reduces anxiety among children. It also enhances relationship with the caregiver.

5. Writing: Writing can be used as an expressive medium for children who have difficulty in communicating their subjective feelings and emotions. Writing about distressing events also help children to decrease anxiety levels. While other creative activities help children cope with trauma, writing medium is more helpful to communicate his/her thoughts and feelings with words. It fosters self-understanding, acceptance and decreases tension. It is a healing way of releasing negative emotions, helps to imagine future positively and enhances reconciliation and reframing.

6. Family dolls: Story telling using dolls is fun and enjoyable. Children like playing with dolls. Dolls act as an encouraging medium for children while talking about their life stories. The doll characters make expression of the child's inner self easy. The inhibitions children have in communicating can be broken by using puppets and dolls for sharing personal experiences. This medium helps the child talk about the life experiences freely. Since the medium uses family dolls, it would help the caregivers to understand environment of the child's family. The child's expectations from the other family members, unity in the family and issues that are affecting the family functioning can be easily taped. The activity also helps in loosening the association the child has with the issues as the issues can be displaced to the doll while talking about them.

7. Clay modelling: Clay modelling can be used to reduce negative mood and anxiety, awaken creativity, foster socialization and aid healing from trauma. Clay is primarily a physical medium that has a soothing effect on both adults and children. It enables safe outlet for feelings while the child involves in reshaping of the clay. During the activity, the end product is not important but the process is more important. The child need not focus on making creative things but the child's expression associated to the things should be emphasised. Clay is a powerful tool for expression of emotions/thoughts, reshape, and mould the nonliving object into whatever thing s/he wishes.

Table 3.1: Mediums that suit children based on their age

Highly preferred		Can be preferred		Least preferred	

Medium	2-5 years	6-10 years	11-14 years	15-18 years
Telling Stories				
Talking				
Painting/Drawing				
Puppets				
Clay				
Activities/worksheets				
Roleplay				
Writing				
Physical activity				
Group games				
Imagining				

Adapted from Geldard et al., 2013

Advantages of using psychosocial mediums

- Empowers children to understand their emotions and name them
- Helps in expressing negative beliefs and emotions
- Builds psychosocial competencies
- Enables identification with peers
- Creates cohesion and team spirit
- Models' positive self-concept and boosts esteem
- Improves communication and understanding
- Mediums help in fostering communication among children who are resistant, less vocal and defensive
- Helps the caregiver to understand the inner feelings, thoughts and emotions of the child

WOMEN

Women in many Indian societies are restricted to do the household chores. Mostly they are economically dependent on men, poorly educated and culturally deprived of rights. These pre-existing social vulnerabilities along with physical and mental susceptibilities make women vulnerable during emergencies. The multiple losses especially loss of husbands or male households make women more vulnerable and make their livelihood and safety harder. There is increased chance of being abused (physically, sexually and emotionally) during or after emergencies. Women also face significant reproductive health and privacy issues during or after disasters. These vulnerabilities make them deprived of support services or resources in relation to disasters.

The caregiver needs to remember the following while working with women in disasters:

- Opportunities need to be created for women to express the impact of disaster and their needs.
- Services should focus on empowerment of women in making decision for their lives.
- Safety of women need to be ensured at all times.
- Engage women in planning, implementation and evaluation of services related to disaster risk reduction, relief and rehabilitation.
- Services need to be provided to assess domestic violence and sexual abuse of women.
- Privacy of women get largely affected especially when they are made to stay at relief camps. Hence, measures need to be taken to preserve the privacy of women.
- The reproductive health of women needs to be given due attention.
- Recanalization option needs to be suggested for those women who have lost their children in disasters.
- Special attention needs to be given to pregnant women, young women and women who have lost their husbands/children/other households.

Table 3.2: Measures to help women in disasters

Pre-disasters	Post-disasters
• Educate local leaders on the importance of including women in disaster risk reduction planning and preparedness activities. • Enable gender perspectives in vulnerability, risk and resource mapping. • Include gender roles, inequalities and disaster specific impact on women as a part of psychosocial assessment. • Incorporate gender dimensions in DRR planning and community resilience building activities. • Establish coordination with agencies that work towards the empowerment of women. • Build psychosocial competencies (coping with distress, identifying strengths/resources, seeking help, involving in decision making etc) of women.	• Care needs to be taken to include women headed households while providing the relief and reconstructive services. • Relief packages should be gender specific and aim at meeting the needs of women. • Services aiming at addressing the specific needs of women (dealing with domestic violence, substance abuse, abuse of children/women, high risk pregnancy etc) need to be created and informed in advance. • Vulnerable groups among women (single woman, widows, pregnant etc) need to be closely monitored and supported adequately. • Security and safety needs of need to be given priority.

PERSONS WITH DISABILITY

Disasters can worsen the condition of persons with disability or can create new persons with disability. Persons with disability have physical, communication and attitudinal barriers due to their condition. Our society still remains unaware about the needs of persons with disability. The vulnerabilities can worsen the condition of a person during disaster who is already disabled. PSS should focus on minimising the limitations of persons with disabilities and create accessibility for disaster related services.

The following are the barriers to include the PWDs in Disaster Management Cycle:

- Poor awareness on available schemes, programmes and policies.
- Poor access to disaster related information.
- Difficulty in accessing escape routes.
- Extreme reliance on caregivers.
- Poor visibility in the society.
- Stigma and discrimination.
- Non availability of data pertaining to PWDs.
- Lack of funding for programme planning and implementation.

It is hence essential to eliminate the barriers and enhance inclusion of persons with disability in planning and implementation strategies aiming at disaster risk reduction and relief or rehabilitation services. The following framework helps in enhancing coping, adaptation and resilience among persons with disability:

- Include in decision making: Persons with disability are resourceful. They know their issues better than any other persons. It is vital to create positions in decision making bodies for persons with disability such that they would be able to express their issues and make decisions to deal with them adequately.
- Eliminate barriers: Persons with disability have physical, information, social and economical barriers that act as a hurdle in receiving services. The barriers to social, professional and personal lives need to be identified and eliminated.
- Enhance sensitivity: Community and other stakeholders are unaware of the needs and concerns of persons with disability. It is hence essential to sensitise these stakeholders on the same.
- Identify the persons with disabilty: It is essential to identify persons with disability in advance so that preparedness, rescue, relief and rehabilitation efforts focused on PWDs can be faster.
- Set up preparedness strategies: Preparing PWDs and their caregivers in advance on disaster risk reduction and psychosocial competencies to minimise the impact of disaster.

Some of the strategies to be followed while helping persons with disability are:

- Make the person with disability know that help is available in a way s/he understands.
- Provide easy access to necessities (food, clothing, shelter, health, assistive devices).
- Ensure personal safety.
- Communicate with the person in a modality in which s/he is able to access information (e.g., sign language, brail).
- Respect the person and accept him/her with the limitations.
- Work from a rights perspective.
- Create easy accessibility to disaster related services.
- Assess the needs of persons with disability (physical, psychological, social and economic) and plan services accordingly.
- Understand the strengths and skills of persons with disability.
- Assess support available and the individuals' support needs (activities of daily living, livelihood, etc.).
- Along with the person with disability, the caregiver who predominantly takes care of him/her needs to be given attention. Many a time these caregivers will be more responsible than the individual himself/herself.

While designing any strategy for PwDs, their right to be included in planning, implementation and monitoring of DRR activities and PSS services need to be respected. Understanding their strengths along with their limitations make them feel respected and accepted.

PERSONS WITH MENTAL ILLNESS

Though persons with mental illness come under persons with disability, strategies can slightly differ while working with persons having mental illness. These persons might have difficulty in expressing their needs due to the symptoms. Poor awareness and stigma/discrimination towards mental illness, make people in the community difficult to reach out this population to provide support. Because of their mental illness, these individuals might have deficits in self-care and daily activities. Their family/social/occupational functioning may also get affected because of their condition. Emergencies can increase the symptoms due to the non-accessibility to medication/hospital services, loss of support systems, distress precipitated by disaster and non-availability of rehabilitative measures. Hence, while working with persons having mental illness, the caregiver needs to remember the following:

- Ensure safety and dignity.
- Be patient while providing services.
- Understand that they are not harmful.
- Try to elicit treatment details from available record or caregivers.

- Make a prompt link to the local DMHP team.
- Restart medication and facilitate regular treatment with help from local DMHP team.
- Provide basic facilities.
- Give precise instructions and do not overload them with information.
- If the person is withdrawn, initiate a conversation but do not force the person to talk.
- Do not try to argue with the person or debate on the symptoms.
- Give importance to the rights of person with mental illness.
- Include their primary caregivers or significant family members in planning and providing services.

OLDER ADULT

Pre-existing health complications, easy vulnerability to infections, poor responsiveness in the sense organs (hearing, vision, touch, smell etc), problem in thoughts (difficulty in understanding, hopelessness, helplessness, worthlessness, death wishes etc), poor accessibility to resources and support increase the vulnerability of older adults during disasters. These factors decrease the ability of older adults to recognise disaster related early warning signs, respond promptly during emergencies and access post-disaster specific information. While working with older adult the caregivers need to remember the following:

- Providing reassurance help them feel safe and comfortable.
- The rights of older adults need to be prioritised and respected.
- The caregiver needs to make a detailedassessment of the needs of older adults such as physical (medicines, assistive devices), psychological (problems in thoughts, mental health issues etc), social (family, religion, community, groups) and economic needs.
- Older adults without primary support must be assisted by some volunteers from the community.
- Some individuals might be reluctant to seek support. They should not be forced to take support. Caregiver should understand the reason for reluctance and formulate strategies to deal with it.
- While planning materials/services aiming at DRR, relief or rehabilitation, limitations (physical and sensory) of older adults should be considered.
- Older adult people are also resourceful. They might have past experiences of losses and have traditional knowledge related to disaster management. Therefore, while planning for disaster management related services, such knowledge and experiences need to be considered.
- Along with participation in planning, the skills and strengths of older adults can be utilised in taking care of themselves and other people who are in need.
- There is increased risk for abuse/exploitation of older adult. They need to be informed on the legal options available during such instances.

All the above strategies help in identifying the risks among vulnerable groups, help them to communicate with the caregivers and, strengthen PSS strategies for enhancing resilience among these groups.

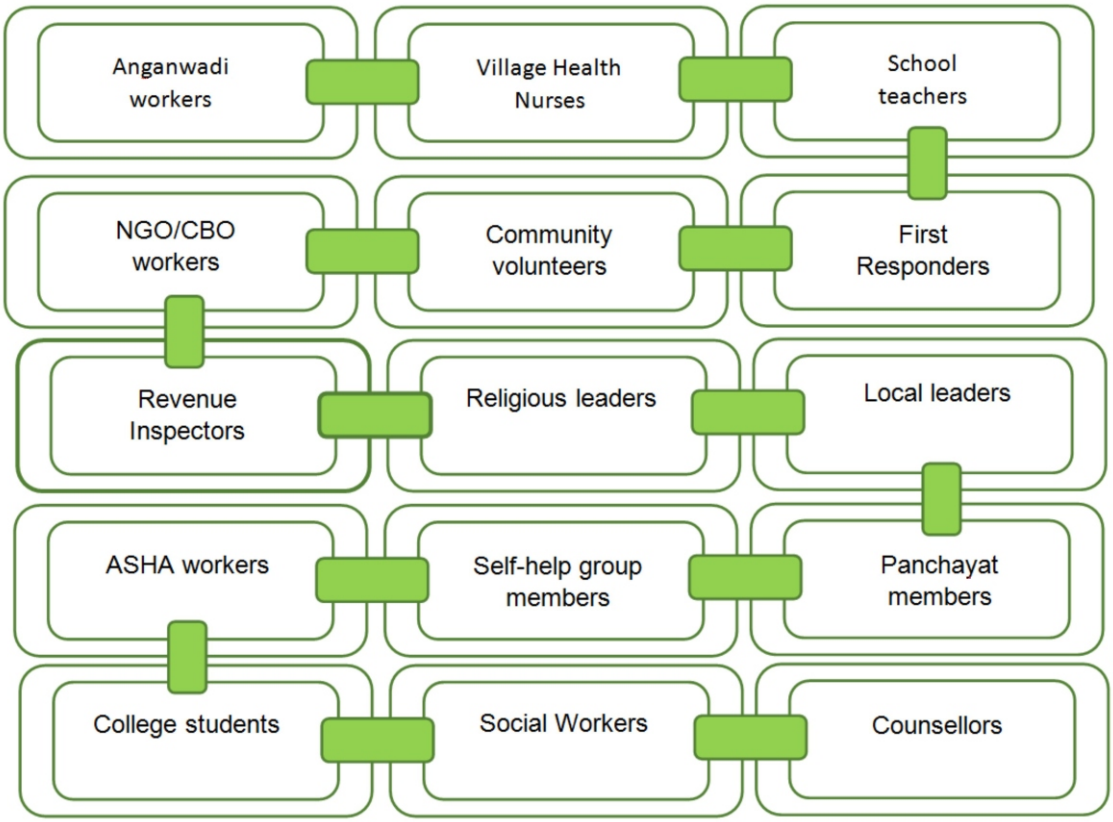
Remember

- Vulnerable groups need to be given first preference in disaster related services.
- The rights of persons in need of extra support during disasters need to be respected.
- Assessing the needs of vulnerable population and tailoring appropriate strategies enhance resilience among them.
- Psychosocial mediums help in tapping the unexpressed thoughts and feelings of the child.
- Children feel at ease to talk about the issues while using psychosocial mediums.
- Disasters create new persons with disability and can worsen the condition of persons who are already disabled.
- Though persons with disability have pre-existing vulnerabilities, identifying their personal strengths help in restructuring disaster management activities.

Section - 3
CARING FOR CARERS

CHAPTER 1 ROLES OF PSYCHOSOCIAL CAREGIVERS

Psychosocial support (PSS) in disasters mandates involvement of different stakeholders. In India, there is a huge disparity between the distribution of mental health professionals and the population density. This disparity makes mental health services hard to reach to all people. Therefore, it is essential to increase the number of trained human resources to reach out the persons in need for PSS. Any individuals with adequate capacity building and handholding, can deliver psychosocial services. Those individuals who are trained on implementing PSS services are called psychosocial caregivers. Their role is vital as they are volunteers from the same community and know the culture, sentiments, beliefs, attitudes and practices of the community members. The figure below enlists the different individuals who can be trained as psychosocial caregivers:

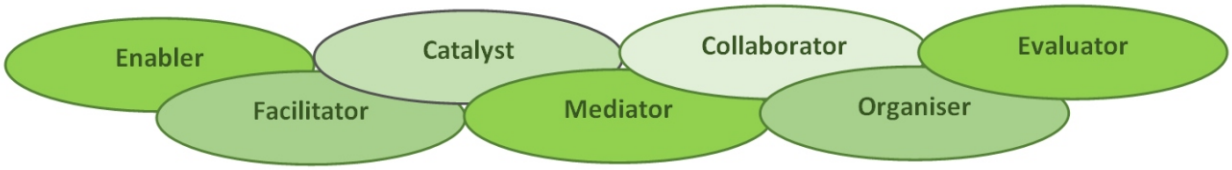


Importance of Psychosocial Caregivers

They act as a bridge between the survivors and the services.
They help in early identification, facilitation of referrals and follow-up.
They foster community participation, planning, implementation and continuity of services
They enhance spectrum of care services (rights and justice, compensation, health care, housing, psychosocial concerns, livelihood, self-help, legal and educational services).
Psychosocial caregivers, most often, belong to the local community. Hence, sustainability of the psychosocial services can be attained.

Role of Psychosocial Caregivers

The role of psychosocial caregivers is not restricted to providing emotional support. They also act as enablers in providing complete support. The roles of the psychosocial caregivers can be categorized as those prior to disasters and subsequent to disasters.



Some of the major roles and responsibilities are highlighted below:

PRE-DISASTER

- **Creating psychosocial response team:** Community members are the first responders in any disasters. For the prompt response to limit the negative consequences of disasters the psychosocial caregiver cannot function alone. It is essential to form teams who will be responsible for different activities and to work in **collaboration**. The psychosocial caregiver needs to be an **enabler** in creation of psychosocial response teams. Along with being a **facilitator**, it is necessary to be a **catalyst** in identifying short-term and long-term goals related to provision of preparedness and PSS services in the community. Working as a **mediator** between the existing services and people in need for support also forms the role of caregivers. Along with playing the role of an **organizer** of preparedness, mitigation and DRR activities, caregivers also need to **evaluate** such activities periodically.

- **Doing Hazard, Risk and Vulnerability (HRV) analysis and resource mapping:** Disasters cannot be prevented but the negative impact of the disasters can be reduced through effective preparedness measures. A well planned HRV analysis and resource mapping help in installing proper preparedness measures. The psychosocial caregiver needs to enable community participation in planning and implementation of HRV analysis and resource mapping.

- **Formulating psychosocial response plan:** The understanding gained through analysis of community hazards, risks, vulnerabilities and resources help in formulating preparedness and psychosocial response plans. Psychosocial response plans act as blueprints to preparedness and PSS services.

- **Conducting psychosocial mock drills:** The plans that evolved through community participation need to be communicated to the community through mock drills. Psychosocial mock drills help in sensitising the community on the psychosocial services, understanding community responses, knowledge and skill building. It helps in identifying the gaps in knowledge, attitudes, beliefs and practices. It also strengthens the community-based culturally sensitive preparedness and PSS services.

- **Promoting the psychosocial competencies of disaster-prone communities:** Psychosocial competencies help in dealing with the daily stressors that people experience in life. These skills help in enhancing the community's coping abilities, adaptation and resilience. The psychosocial caregivers can conduct group meetings that aim at nurturing psychosocial competencies among community members especially vulnerable groups.

- **Mobilising resources for better preparedness:** Skills related to mapping of resources, preservation of resources, creation of new resources and utilisation of existing resources during emergencies important to promote resilient communities. Each community and its members are resourceful. This resourcefulness can be internal as well as external. Internal resources can be traditional knowledge in anticipating emergencies, adaptive coping skills, etc. External resources can be availability of support from family, neighbourhood, non-governmental and governmental agencies.

- **Networking with local agencies:** Disaster impact is large and stress inducing. The needs of survivors are diverse. To meet the needs of disaster-prone communities, better preparedness initiatives need to be positioned through the involvement of multiple stakeholders. Local agencies who are already working with the community will have close ties with the community. If the community has trust on the local agencies, reaching out to them will be easier. The psychosocial caregiver needs to liaison with local agencies and instill spirit among them to work on creating disaster resilient communities.

POST-DISASTER

- **Assessing the post-disaster psychosocial needs of the community:** Disaster shatters individuals, families and communities. The psychosocial needs of communities, subsequent to disasters, can be grouped into physical, psychological, economic and social needs. The caregiver might be able to provide active PSS services during the search and rescue operations. During this time, the caregiver can engage in assessing the psychosocial needs of the community while helping in the search/rescue operation.

- **Psychosocial triaging:** Large number of people might require only psychosocial first aid. Certain individuals may require PSS and some people may require mental health referral and treatment. The psychosocial triaging would enable caregivers to categorise people based on their needs. Certain individuals might not develop mental health complications initially, but they need to be monitored closely. This facilitates prompt identification and early treatment. Triaging also helps in regulating the utilization of resources.

- **Providing multidimensional care:** PSS does not mean providing only emotional support. PSS services should also include a collection of services ranging from linking survivors with resources related to provision of rights and justice, compensation, health care, housing, livelihood, self-help and legal aid. It should not stop with referral. Its focus needs to be also on whether the survivor was able to access the resource, what change the link brought in the lives of the survivors and how the spectrum of care services helped in the road to recovery. The individuals need to be followed up periodically. Dependency issues need to be tackled. Self-sufficiency and ownership need to be promoted.

- **Focusing on people at risk:** Though all individuals in disasters need to be focused, special attention need to be given to vulnerable populations (children, women, older adult, persons with disability, etc). Sensitivity has to be ensured that priority is given to these groups while providing services.

- **Dealing with the barriers in accessing psychosocial care services:** There might be individual (survivor's attitudes, vulnerabilities, inadequate support), organisational (lack of professionals, services, professional attitudes) and environmental (culture, societal stigma) barriers that prevent the accessibility of PSC services. Psychosocial caregivers need to constantly assess the barriers and improvise with strategies that ascertain accessibility.

- **Facilitating coordination and communication:** The psychosocial caregiver should foster better communication and coordinate with stakeholders. Direct and meaningful communication between the survivors and services is necessary and it would enhance the quality of service.

- **Promoting psychosocial resilience:** The aim of psychosocial services is promoting prompt recovery. The psychosocial caregiver visits survivors periodically, provides emotional support, links with services and talks to them on adaptation skills, better coping abilities and creates opportunities to widen community support and resources. These individual and group psychosocial services act as roadmap for psychosocial resilience among individuals, families and communities.

Remember

- Psychosocial caregivers aid in preparing the community to anticipate, cope, resist and recover during disasters and in provision of holistic care subsequent to disaster.
- Psychosocial caregivers play a vital role in promoting resilience in the community.

CHAPTER 2 DISASTER RELATED WORK & MENTAL HEALTH COMPLICATIONS

Working in harsh disaster situations, exposure to negative life experiences, death, trauma of victims, staying away from families and dealing with extremities might trigger significant distress among caregivers. Prolonged distress while working in disasters might lead to burnout and secondary traumatic stress among caregivers. This would affect their well-being and curtail the efficiency of service. The caregivers need to distinguish between normal and abnormal reactions subsequent to disaster.

Table 2.1: Reactions post-disasters and necessary actions

Most first responders may experience mild distress, disturbances in sleep, fear, anxiety, sadness, increased use of substances	Normal reactions during disaster
Some first respondents may have prolonged sleep deprivation, moderate anxiety, changes in workplace behaviour	Need to be monitored to avoid worsening of symptoms
Few responders develop mental health problems like post-traumatic stress disorder (PTSD), major depression, etc.	Need prompt professional mental health treatment

Source: Benedek, Fullerton, & Ursano, 2007

Working in emergencies propels multiple stressors for the caregivers. Stress that experienced by the carers can be attributed by the work or the trauma caused by disaster. Timely identification and management of stress experienced by carers prevent them from having mental health adversities.

Pre-disaster stressors

Local response: Any individual will have strong bonding with the community in which s/he lives. When caregivers work in their local areas, they might have personal grievances about the family, friends and the neighbourhood.

Unprecedented call: Disasters can strike at any moment and caregivers may not be always prepared to respond promptly. When they are summoned for relief and rescue operations, they need to change their prior commitments and report.

Unfamiliar expedition: The caregivers need to travel long distances and work in unfamiliar communities during disasters. Traveling long distance and working in unacquainted environment would trigger stress among individuals.

Anticipating unknowns: Until and unless caregivers start disaster related operations, they might be completely unaware of the impact. The caregivers will have many questions for which s/he might not have immediate answers.

Stress during Disasters

Most of the caregivers working in disaster experience short-lived stress reactions and few among them develop severe mental health complications. It is a known fact that disaster carers experience shock, exhaustion, anger, despair, poor sleep, and change in routine. They have complaints about the work environment as well.

Table 2.2: Common reactions experienced by caregivers	
Psychological	Shock, fear, despair, guilt, shame, depressive cognitions, lack of interest, being emotionally cold, confusion, excessive worry, poor attention and memory, problems in decision making and problem solving, hatred.
Physical	Fatigue, multiple body pain, palpitation, perspiration, vomiting sensation, change in sleep and appetite, tension.
Interpersonal	Preferring to be alone, disturbed relationship with family / friends / colleagues, distrust, higher conflict.

Contributors to distress among caregivers

Work related

- Extreme working conditions
- Uncomfortable resting environment
- Poor Interpersonal relationship with colleagues, subordinates or higher ups
- Working in unfamiliar environment
- Inability to reach family or connect to social ties
- Difficulty in completing the assigned task
- Problems with planning and prioritisation

Trauma related

- Hearing the grievances of disaster affected people
- Witnessing fatalities
- Experiencing danger to self
- Having a disaster related physical impact (injury, illness, exposure to harmful radioactive substances)

Burnout

The unattended work-related prolonged distress causes burnout. Physical and psychological exhaustion along with decreased interest in work are the key characteristics of burnout.

Table 2.3: Common reactions among caregivers experiencing burnout	
Work	Work productivity (quality/quantity) decreases, work disengagement, shifting of work priorities, escapism.
Relational	Poor sensitivity to the needs of others, being aloof, undue complaining and blaming, scapegoating.
Psychological	Pessimism, irritability, mood fluctuations, persistent sadness, feeling trapped, memory and concentration problems, emotional exhaustion, poor decision making/problem solving and ruminating about negative events.
Physical	Changes in sleep and appetite, fatigue, multiple body pain, easily getting sick or being prone to accidents.
Behavioural	Increased use of psychotropic drugs, resorting to risky behaviours.

Secondary Traumatic Stress

Repeated exposure to disaster related negative events/trauma might make caregivers to mirror negative emotions (fear, anxiety, pain) experienced by survivors. Following are the indicators of secondary traumatic stress;

- Extreme anxiety about uncertainties
- Occurrences in the present or future
- Being hyper vigilant
- Physical reactions to stress (pounding heart, palpitation, perspiration, etc.)
- Repetitive thoughts/imagery about disturbing events in the past
- Perceiving other's trauma as one's own
- Experiencing compassion fatigue (decreased sympathy towards the disaster victims due to prolonged work in disaster settings)

Other mental health complications caregivers might develop are Depression, PTSD, Substance Use Disorder and Anxiety Disorders.

Thought for the mind

- Working in disaster settings affect the mental health of caregivers.
- Caregivers experience stress due to disaster related work and trauma witnessed/experienced in disasters.

CHAPTER 3 MENTAL HEALTH PRESERVATION STRATEGIES

Initially, caregivers involve in disaster related work with a heroic spirit. As days pass by, the spirit weans away and caregivers become susceptible to mental health complications. Being in a disaster situation, seeing the turmoil of the disaster victims/survivors, vigilant and risky work environment, erratic and intense work schedules, staying away from family and involving in live saving decisions make caregivers vulnerable to stress. Certain strategies need to be adopted by the caregivers during different stages of disaster management to preserve their mental health and avoid psychological problems.

1. SELF-CARE STRATEGIES FOR CAREGIVERS

Before

- Following a healthy lifestyle.
- Being informed about one's personal stressors and coping strategies.
- Taking part in different training programmes to acquire knowledge and skills related to rendering care during emergencies.
- Being clear about one's roles and responsibilities during the impact.
- Being aware of the stressors that can be precipitated during disasters and having a rough plan to deal with the stressors.
- Being prepared with a kit that contains the essential amenities for survival during disaster situations. An ever-ready survival kit can help in eliminating last minute hassles.

After

- Continuing healthy lifestyle.
- Evaluating one's physical and mental health.
- Focusing attention on reknitting with social and spiritual connections.
- Spending time for self.
- Seeking professional help when things are beyond one's coping abilities.

During

- Planning ahead and prioritising one's work.
- Working in teams.
- Having a 'dear comrade' and talking to him/her frequently.
- Following healthy lifestyle (food, sleep, exercise, etc.).
- Taking adequate breaks.
- Following one's routine.
- Adhering to safety precautions.
- Having debriefing sessions periodically.
- Maintaining a well-being journal.
- Talking to family and friends.
- Practicing yoga or relaxation techniques.
- Being assertive and setting limits.
- Avoiding the use of substances.
- Not over-identifying oneself with the trauma survivors or victims.
- Carers with pre-existing physical or mental health complications should resume their treatment regimen and be vigilant to avoid fresh surge of symptoms.
- Appreciate self and others

2. DEAR BUDDY

'Dear BUDDY' is a peer support system where the first responders are grouped together in pairs of two. The pairs need to monitor one another's work, stress and well-being. The system aims at promoting personal safety and resilience amidst disasters.

Steps to initiate buddyship

- Building rapport: Make the pairs understand one another. Facilitate a talk on their origin, family, interests, experiences, achievements and plans. This should capacitate the peers to develop awareness on either person's strengths or weaknesses.
- Observe one another during the work.
- Have daily or frequent debriefing sessions. The debriefing sessions facilitate ventilation and catharsis. The peers listen carefully to the feelings and emotions of one another and provide reassurances and support.
- Share basic needs during disaster situations
- Monitor work load, check the stress levels and direct appropriate management strategies

Do's

- Understand the needs of the co-buddy before s/he vocalises it
- Be an empathetic and active listener
- Communicate frequently
- Provide reassurances adequately
- Provide appropriate help or support when the co-buddy is in distress
- Motivate the co-buddy to seek professional treatment when needed

Don'ts

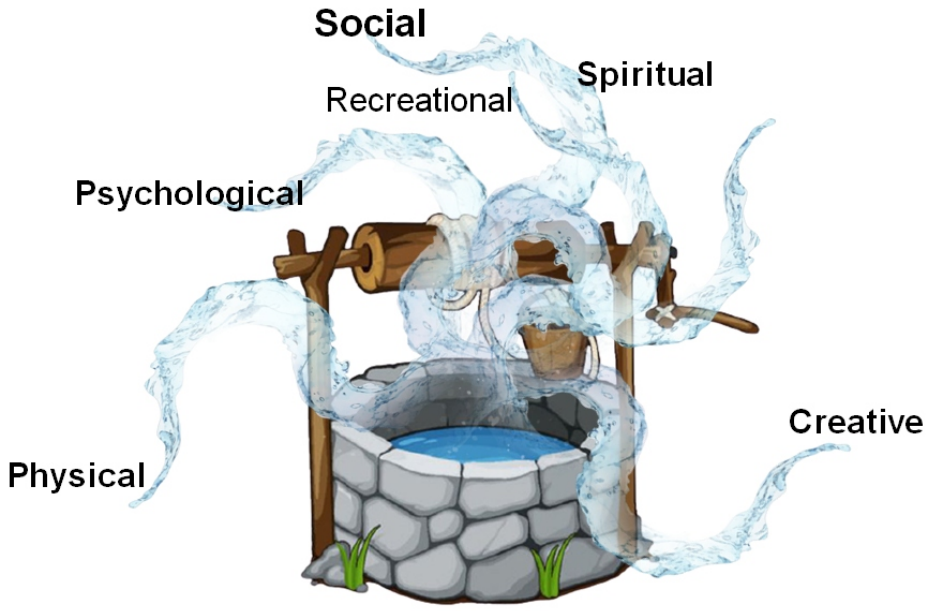
- Do not label or diagnose the co-comrade
- Do not try to counsel or give advice
- Do not be judgemental
- Do not demand the co-buddy to discuss about his/her problems
- Do not force the co-buddy to follow the given directions/ solutions/ alternatives

3. ENHANCING RESILIENCE AMONG CAREGIVERS

Distress experienced by most caregivers is temporary. The bouncing back ability fosters posttraumatic growth. Knowledge of risk factors that trigger distress and protective factors that favour resilience would enhance resiliency among caregivers.

	Risk Factors	Protective Factors
Pre-Disaster	• Pre-existing medical or psychological conditions • Lack of experience or training • Poor leadership and decision-making abilities • Unhealthy lifestyle • Significant negative life events in the past	• Longer experience working in disaster situations • Proper induction through capacity building activities • Enhanced professional skills • Team cooperation and support • Personal resilience and satisfaction with life/work
During Disaster	• Closeness to the disaster epicenter • Hazardous use of substances • Longer working hours in unfamiliar and unprecedented environment • Working in spite of severe injuries • Long exposure to dead bodies • Identifying oneself with survivors/victims or becoming emotionally involved • Having poor information • Poor coordination and support	• Adequate Social support • Good interpersonal relationship with superiors and co-workers
Post-Disaster	• Post disaster life events • Increased use of technological devices • Media Reporting of the disaster • Use of avoidance coping • Poor reinforcement	• Debriefing sessions • Psychological counseling services • Support from co-workers

4. WELLS OF COPING



PHYSICAL

- Cycling
- Walking
- Trekking
- Jogging
- Dancing
- Aerobics
- Playing sports

PSYCHOLOGICAL

- Imagining the past positive events
- Journaling
- Planning
- Singing
- Drawing

SOCIAL

- Meeting friends and relatives
- Making new friends
- Talking to friends over phone

CREATIVE

- Doing something different
- Breaking the monotony

RECREATIONAL

- Cooking
- Embroidery
- Designing
- Watching humour
- Going for a picnic/movie
- Taking a break

SPIRITUAL

- Praying
- Reading religious texts
- Chanting
- Pilgrimage
- Singing religious hymns
- Participation in religious ceremonies

Using the same adaptive coping strategies repeatedly might result in boredom. The caregivers need to try different portals of adaptive patterns like physical, psychological, social, creative, recreational and spiritual strategies to achieve holistic well-being. Care needs to be taken that the carers are able to differentiate between adaptive and maladaptive coping behaviours and practice the adaptive ones.

5. MAKING A TREE OF SUSTENANCE

Mitigation strategies for caregivers

- Positive and clear communication with colleagues
- Following routine
- Be connected with close ones
- Plan in advance
- Understand personal coping & follow adaptive coping strategies
- Be updated
- Monitor self-stress levels
- Seek professional help when distress escalates
- Update the tree of sustenance

Remember

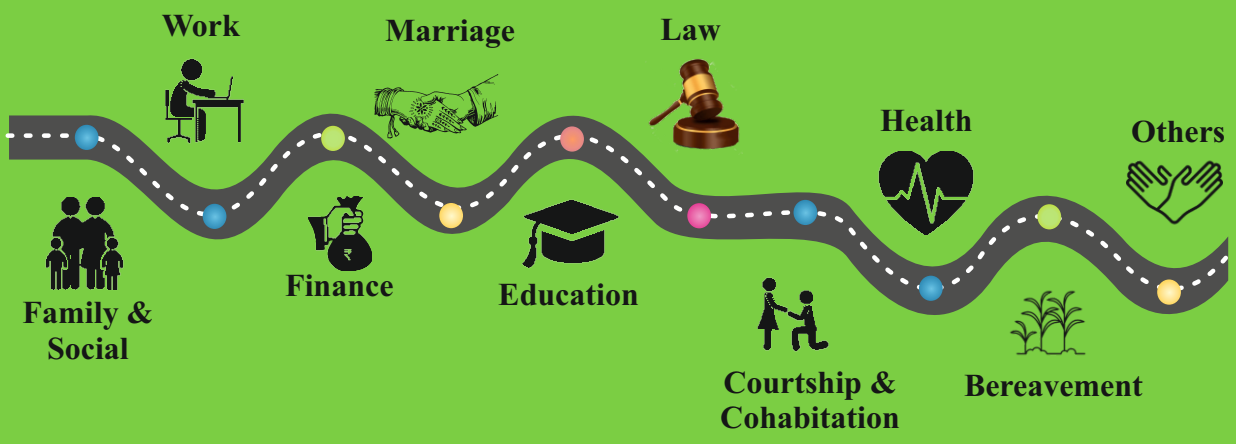
- Adaptive coping strategies and coping resources are essential to preserve the mental health of caregivers.
- Buddy system (dear comrade) will help in forming social ties in times of distress.
- Risk factors deter the process of resilience and protective factors favor resiliency.

Level-2: Certificate Course on Psychosocial Care in Disasters

The psychosocial care in disasters module can be provided as a certificate course. This would aim at provision of psychosocial care in disasters for survivors of disaster and vulnerable groups. CLWs can be proportionate trained persons from level-1, representatives from NGOs and CSO with Bachelor's Degree. The virtual training will be for three months and the participants will be provided with psychosocial care in disasters manual cum facilitation guide and workbook. The participants will be capacitated on psychosocial care in disasters services, PSS for vulnerable groups and caring for self. On completion of the course curriculum of 12 online sessions of two hours each and 20 resource material provided and completion of assignments, case studies and other requirements they will be provided a Certificate from NIMHANS and endorsed by NDMA/ SDMA.

National Disaster Management Training Module - 2
Facilitators Guide

Psychosocial Care in Disasters



March 2023

Jointly Developed by

National Disaster Management Authority
(NDMA)

National Institute of Mental Health and Neuro Sciences
(NIMHANS)

CONTENT

PROGRAMME SCHEDULE

No	Name of Session	Methodology	Duration
1	Introduction to disaster and psychosocial first aid	Recap, Role plays and Individual work	90 min
2	Psychosocial Triage	Case discussion and presentation	90 min
3	Psychosocial support (PSS) in disasters	Presentation & Discussion	90 min
4	Psychosocial needs assessment	Free listing and discussion	90 min
5	Stress during disasters	Role play and discussion	90 min
6	Mental health issues among disaster survivors	Case discussion	90 min
7	Life events, family life cycle and disaster	Sharing of experience	90 min
8	Psychosocial support (PSS) techniques	Group activity	180 min
9	Referrals and follow ups	Groups discussion	90 min
10	Vulnerable groups in disasters	Brain storming and Discussion	90 min
11	Impact of disasters on vulnerable groups	Role play	90 min
12	Strategies for working with vulnerable groups	Group activity and discussion	90 min
13	Roles of psychosocial caregivers	Brain storming and discussion	90 min
14	Disaster related work & mental health complications	Group activity and Discussion	90 min
15	Mental health preservation strategies	Group activity and discussion	90 min

Section - 1

FACILITATORS GUIDE

Session 1: Introduction to disaster and psychosocial first aid.

Aim: To give an overview of disaster and Psychosocial First Aid (PSFA).

Methodology: Recap, Role plays and Individual work.

Duration: 90 min.

Process: Facilitator will give an introduction to disasters, various types of disaster and its impact. Activity 1 given below will be conducted focusing on needs of disaster survivors. Followed by the activity the facilitator discusses about the PSFA and its strategies. The session will be concluded with activity 2..

Outcome of the session: Participants will understand the concept of disaster and PSFA.

Activity 1

Description of the activity: Needs Pyramid (Brainstorming).

Aim: To sensitize the participants on the needs of disaster survivors.

Duration: 30 min.

Materials Required: A4 sheets and pens.

The facilitator describes that the disaster survivors would have varied physical and psychosocial needs and asks the participants to list out the various needs the survivors experience after a disaster. The facilitator then helps the participants collate the needs in the needs pyramid.

Activity 2

Description of the activity: Psychosocial First Aid (Roleplay).

Aim: To help participants understand about Psychosocial First Aid.

Duration: 60 min

Materials Required: Role play cards.

Eight individuals will be asked to volunteer and will be paired into groups of two. In each group, one individual has to act like a caregiver and the other as survivor of a recent disaster as listed below.

Group 1: An 8 years old child who is alone (looking afraid and crying).
Group 2: A wounded transgender (not a very severe wound).
Group 3: A person who is wheelchair bound placed in a relief camp.
Group 4: A 30-year-old male looking for his family members who are missing.

After each roleplay, the facilitator asks how comforted the survivor felt, what are the various PSFA techniques that were used by the caregiver and summarizes the components of PSFA that can be integrated while dealing with the disaster affected individuals/communities.

FACILITATORS GUIDE

Session 2: Psychosocial Triage.

Aim: To help participants understand psychosocial training.

Methodology: Case discussion and presentation.

Duration: 90 min.

Process: Facilitators will give an introduction to psychosocial triage. An activity given below will be conducted and the session will be concluded.

Outcome of the session: Participants will understand the concept of psychosocial training.

Activity 3

Description of the activity: Psychosocial Triage.

Aim: To help participants understand psychosocial training matrix and facilitate psychosocial training using the psychosocial triage flowchart.

Duration: 90 min.

Materials required: Case vignettes (Given in Module 2 - chapter 2)

The facilitator initially orients the participants on the indicators listed in the psychosocial matrix and explains the participants about the psychosocial triage process using the psychosocial triage flowchart. Then the participants will be divided into 6 teams and each team will be given a case vignette. The teams need to read the case vignettes carefully and look for vulnerabilities. Based on the presence or absence of the indicators, the teams need to specify whether the person mentioned in the case belongs to high/moderate/low risk category. After assessing, the groups need to use the flowchart and specify the appropriate service for the person based on his/her level of psychosocial risk. In case of online instead of group activity the case vignettes will be displayed on the slide and participants will be encouraged take part in the discussion.

FACILITATORS GUIDE

Session 3: Psychosocial support (PSS) in disasters.

Aim: To help participants understand PSS, its evolution and levels of PSS.

Methodology: Presentation & Discussion

Duration: 90 min.

Process: Facilitator will give an introduction to PSS in disaster and its evolution in India. An activity given below will be conducted, then the facilitator will discuss about PSS activities, what is PSS and what is not PSS. The session will be concluded after discussing about the levels of PSS.

Outcome of the session: Participants will understand the concept of PSS.

Activity 4

Description of the activity: What is PSS? (Brainstorming).

Aim: To enhance the understanding of the participants on PSS.

Duration: 90 minutes.

Materials Required: Nil.

The facilitator asks the participants on what do they think of PSS. Once the participants respond on their thoughts about PSS, the facilitator discusses if the response given by the participant is part of PSS or not.

FACILITATORS GUIDE

Session 4: Psychosocial needs assessment.

Aim: To facilitate understanding of the participants on psychosocial needs assessment.

Methodology: Free listing and discussion.

Duration: 90 min.

Process: The session begins with the activity 5. Followed by the activity facilitator discusses about the psychosocial needs assessment at individual, family and community level and SWOT analysis. Brief overview of the community assessment tools will be given. The session will be concluded with the discussion on pyramid of psychosocial needs.

Outcome of the session: Participants will be able to do the psychosocial needs assessment.

Activity 5

Description of the activity: Individual, family and community needs.

Aim: To help participants to understand psychosocial needs assessment at different levels.

Duration: 90 min.

Materials Required: Three chart papers and markers.

The facilitator divides the participants into three groups and will be ask them to discuss on assessing the needs of individuals, families and communities. The discussion should cover pre-existing conditions, impact, requirements, resources and gap between the needs and resources pertaining to individuals/families and communities. Once all the groups finish their discussion, the nominated person from each group will be asked to present the points to the entire group. The facilitator summarizes the points after each presentation.

FACILITATORS GUIDE

Session 5: Stress during disasters.

Aim: To help participants understand the stress during disasters.

Methodology: Role play and discussion.

Duration: 90 min.

Process: Facilitators will give an introduction to stress during disasters and various stress full reactions. An activity given below will be conducted and then the facilitator will explain the ways to deal the psychological reactions among different age groups and the session will be concluded.

Outcome of the session: Participants will understand the stress during disasters.

Activity 6

Description of the activity: Role Play.

Aim: To understand the different stress reactions during disaster.

Duration: 90 min.

Materials Required: Nil.

The participants are divided into 4 groups and each group is asked to perform a roleplay that would express stressful reactions during disaster namely (1) physical, (2) psychological, (3) behavioral and (4) relational reactions. Ten minutes is given for the groups to plan for the roleplay. Facilitator goes around and clears the doubts of the participants. After planning, each group is asked to perform the roleplay for 5 minutes. After each roleplay, the facilitator brainstorms on the reactions expressed by each group and adds reactions pertaining to the topic. Once all the groups finish their act, the facilitator summarises the key points and talks about the importance of knowing the different reactions of stress reactions during disasters.

FACILITATORS GUIDE

Session 6: Mental health issues among disaster survivors.

Aim: To facilitate understanding about the mental health issues among disaster survivors.

Methodology: Case discussion.

Duration: 90 min.

Process: Facilitator discusses about the common mental health conditions that occur in the survivors' post disasters. Once the participants get oriented about the mental health conditions the session will be concluded followed by conducting activity 7.

Outcome of the session: Participants will be able to understand the common mental health conditions among the disaster survivors.

Activity 7

Description of the activity: Case based discussion.

Aim: To orient the participants on mental health conditions that might arise post disasters.

Duration: 90 min.

Materials Required: Case vignettes.

The participants will be divided into six groups. Each group will be given a case vignette (refer chapter 6) that explains about a mental health problem. The participants need to identify the symptoms and the condition. Each of the group will be given time to share their observations and other participants will be asked if they agree upon the same.

FACILITATORS GUIDE

Session 7: Life events, family life cycle and disaster.

Aim: To orient participants about the life evens and its impact on family life cycle post disaster.

Methodology: Sharing of experience .

Duration: 90 min.

Process: The session will begin with activity 8. Followed by the activity the facilitator orients the participants on stressful life events, family life cycle stages and impact of stressful events family life cycle.

Outcome of the session: Participants will understand various stressful life events caused by disaster and its impact on family life cycle.

Activity 8

Description of the activity: Paper pencil test.

Aim: To make the participants to understand the stressful life events in disaster.

Duration: 90 min.

Materials Required: Presumptive Stressful Life Events Scale (PSLES).

The facilitator distributes the PSLES Questionnaire (given in the annexure) to the participants and gives the instructions to fill it. Once the participants have filled, the facilitator encourages volunteers to share their personal experiences of stressful life events. The facilitator needs ensure confidentiality and provide reassurances as and when required.

FACILITATORS GUIDE

Session 8: Psychosocial support (PSS) techniques.

Aim: To introduce PSS techniques to the participants while working with disaster survivors.

Methodology: Group activity.

Duration: 180 mins.

Process: Facilitators will give an introduction to different PSS techniques and discusses 10 different PSS techniques one after the other. After 1st technique (Empathy), the activity 9 will be conducted. After participants' share their observations, the facilitator introduces the importance of ventilation and steps to be taken to facilitate ventilation of emotions and feelings among disaster survivors.

Outcome of the session: Participants will understand the PSS techniques.

Activity 9

Description of the activity: Breaking the balloon.

Aim: To teach the participants on the importance of ventilation and steps to follow to motivate disaster survivors to talk.

Duration: 180 mins.

Materials Required: Balloons.

The facilitator calls 10 to 12 volunteers. All the volunteers will be given one balloon. Of the 10 or 12 volunteers, 5 to 6 are informed in advance (secretly) that they should act like blowing the balloon and should not burst it. The facilitator calls all the volunteers and asks them to burst the balloons saying, "let us see who breaks the balloon first". Once all the volunteers (who did not receive secret communication in advance) have broken their balloons, the facilitator asks the overall group to talk about their observations.

FACILITATORS GUIDE

Session 9: Referrals and follow ups.

Aim: To make participants understand the significance of referrals and follow ups while providing PSS.

Methodology: Groups discussion.

Duration: 90 mins.

Process: Facilitator introduces the session and discusses about who needs referral in the process of providing PSS, steps in facilitation of referrals, ethics to be followed while referring and follow up. The session will be concluded with the following activity.

Outcome of the session: Participants will understand the ways of initiating referrals and doing follow ups.

Activity 10

Description of the activity: Connecting people with services.

Aim: To help the participants understand the spectrum of care, how to initiate referrals and do follow-ups.

Duration: 90 mins.

Materials Required: Case studies.

The facilitator divides the participants into three groups and gives one case vignette to each group. The groups have to discuss on the needs of the survivor presented in each case and the suitable referrals based on their needs. Once discussion is done, each group will be invited to present their points. Facilitator will generate the discussion and add on the points.

Case study 1: A 46-year-old woman who was a housewife with a 23 years old daughter lost her husband in the air crash. She was completely in a denial. The husband was the only bread winner of the family. Her daughter's marriage also got cancelled because of this. Both the mother and daughter were completely shattered and did not know what to do as they had no one to support.

Case study 2: A 16 years old female child lost both her parents in a bomb blast. She was staying in her maternal uncle's house since then. She was been crying for many months even after the incident. There were vivid scars on her face. When asked to speak about it, she was continuously crying and did not open up about it. Her uncle doesn't let her talk to others. She also seemed malnourished and poorly kempt and was not going to school.

Case study 3: A 60 years old man was found lying on the road. He was highly intoxicated. The neighbors told that he lost everyone in his family during the earthquake. The neighbors told that he is from an affluent family and had addiction issues even before the earthquake. The drinking has increased after the earthquake. He lost his house during the earthquake. His relatives cheated him recently and took most of his money. Because of it he mostly stays by the road and begs to manage in necessities.

Section - 2

FACILITATORS GUIDE

Session 1: Vulnerable groups in disasters.

Aim: To help participants understand the different vulnerable groups in disasters and factors leading to vulnerability.

Methodology: Brain storming and Discussion.

Duration: 90 mins.

Process: Facilitators will give an introduction to vulnerable groups in disaster and the activity given below will be conducted. In continuation to the activity, the discussion will be carried out on different factors leading to vulnerability, indicators of vulnerability, principles to be followed while working with vulnerable groups, and steps in identifying and working with vulnerable groups.

Outcome of the session: Participants will be able to identify different vulnerable groups, factors leading to vulnerability and steps to be followed while working with this group.

Activity 1

Description of the activity: Identifying vulnerable groups.

Materials Required: Table 1.1 (Module 2b).

Aim: To orient participants on different vulnerable groups in disasters.

Duration: 90 mins.

The participants will be shown table 1.1 (Module 2b) and will be asked to identify people who are vulnerable to disasters based on the vulnerability factors displayed in the table.

FACILITATORS GUIDE

Session 2: Impact of disasters on vulnerable groups.

Aim: To enhance participants understanding on the impact of disasters on vulnerable groups.

Methodology: Role play.

Duration: 90 mins.

Process: Facilitator discusses about the impact of disaster on vulnerable groups with special focus on children, women, older adult and persons with disability (PwD). The session will be concluded with the activity given below.

Outcome of the session: Participants will understand the impact of disaster on vulnerable groups.

Activity 2

Description of the activity: Impact of disasters on vulnerable groups.

Aim: To help participants understand the impact of disasters on vulnerable populations.

Duration: 90 mins.

Materials Required: Role play cards.

8 volunteers will be called and they will paired into four groups. Following topics will be given (one each) and the volunteers will be instructed to think of a case scenario depicting the impact. One member will be asked to play the role of a survivor and other as caregiver. Others will have to observe the role play and give their feedback.

Group 1: Impact of disaster on children
Group 2: Impact of disaster on women
Group 3: Impact of disaster on elderly
Group 4: Impact of disaster on persons with disability

FACILITATORS GUIDE

Session 3: Strategies for working with vulnerable groups.

Aim: To help participants understand the impact of disasters on vulnerable groups.

Methodology: Group activity and discussion.

Duration: 90 mins.

Process: Facilitators will give an introduction about strategies to work with women, children, older adult and person with disability. An activity will be conducted as given below and the session will be concluded.

Outcome of the session: Participants will understand various strategies to work with vulnerable groups.

Activity 3

Description of the activity: Planning strategies.

Aim: To orient the participants on the strategies for working with vulnerable groups.

Duration: 90 mins.

Materials Required: Four chart papers and markers.

The facilitator divides the participants into four groups and asks them to discuss on strategies for working with vulnerable groups (children, women, persons with disability and elderly). Then the facilitator adds on strategies to the discussion points.

Section - 3

FACILITATORS GUIDE

Session 1: Roles of psychosocial caregivers.

Aim: To make the participants understand about the roles of psychosocial caregivers.

Methodology: Brain storming and discussion.

Duration: 90 mins.

Process: The session begins with the activity given below. After the activity the facilitator will discuss about the roles of psychosocial caregivers in pre-disasters and post- disasters phases and also the importance of psychosocial givers in providing PSS.

Outcome of the session: Participants will understand the roles of psychosocial caregivers in disaster.

Activity 1

Description of the activity: Car and driver.

Aim: To orient participants about the roles of psychosocial care providers.

Duration: 90 mins.

Materials Required: Nil.

The participants will be asked to pair with each other. One of the persons (car) in the pair has to stand in front of the other (the posterior side facing the person). The person in the back (driver) has to lay both the hands on the other person's shoulder. The person in the front has to close his/her eyes and the person at the back has to direct movement without speaking and only with touch. All the pairs walk and after sometime, the pairs exchange their roles. After the exercise, the facilitator asks the group to share the experiences as a car and a driver. The facilitator explains that the experiences shared by the driver are those of the caregiver and that shared by the car are those experienced by the survivors.

FACILITATORS GUIDE

Session 2: Disaster related work & mental health complications.

Aim: To help participants understand stressors and mental health complications of psychosocial caregivers.

Methodology: Group activity and Discussion.

Duration: 90 mins.

Process: Facilitator introduces the topic and conducts the following activity. Once the activity is done the facilitator discusses about the common reactions experienced by caregivers, factors contributing to their distress, burnout and secondary traumatic stress in caregivers.

Outcome of the session: Participants will understand the common stressors and mental health complications among psychosocial caregivers.

Activity 2

Description of the activity: "I am getting burdened".

Aim: To sensitize participants on the mental health adversities experienced by caregivers due to disaster related work.

Duration: 90 mins.

Materials Required: Nil.

One volunteer will be asked to come and sit in the center on a chair. Other participants will be instructed to pile up things (books, files, other stationary in the training hall) one by one. Initially the volunteer will be able to hold the objects but when they get exhausted, s/he will not be able to hold it and they should stop taking the more of it. The facilitator then asks the volunteer to share his/her experiences.

FACILITATORS GUIDE

Session 3: Mental health preservation strategies.

Aim: To teach mental health preservation strategies to the participants.

Methodology: Group activity and discussion.

Duration: 90 mins.

Process: The session begins with activity 3. Followed by the activity the facilitator discusses different strategies that can be used by the psychosocial caregivers before, during and post-disasters.

Outcome of the session: Participants will understand various mental health preservation strategies.

Activity 3

Description of the activity: Group discussion.

Aim: To generate discussion among the participants about the strategies that can be adapted before, during and after disaster.

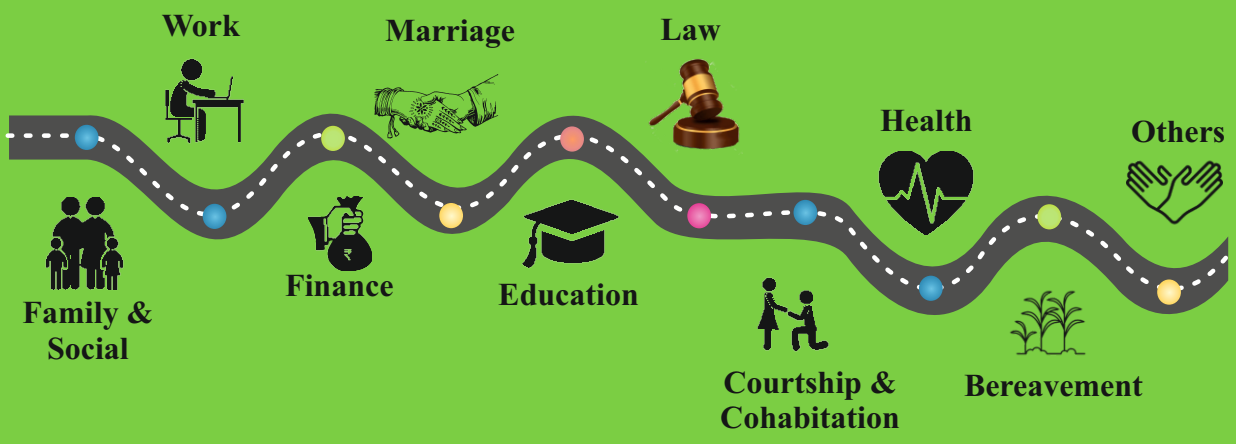
Duration: 90 mins.

Materials required: 3 papers and pens.

The participants will be divided into three groups and each group will be given the following topics: (1) Strategies to be adopted before disaster, (2) Strategies to be adopted during disaster and (3) Strategies to be adopted after disaster. Each of the group will be invited to present their points to all the participants.

National Disaster Management Training Module - 2
Workbook

Psychosocial Care in Disasters



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CONTENTS

Section - 1
PSYCHOSOCIAL SUPPORT IN DISASTERS

SOCIO-DEMOGRAPHIC PROFILE

1. Name(Initials):

2. Contact Details: Email:

   Phone Number (Optional):

3. Age:

4. Sex: Male☐ Female ☐ Others☐

5. Marital Status: Married☐
   Unmarried ☐
   Divorced / separated / widow / widower ☐

6. Education: Schooling1-10th std☐ Graduate☐
   Post Graduate ☐ Others (specify)☐

7. Place of residence: Urban☐ Rural☐ Semiurban☐

8. Current Address:

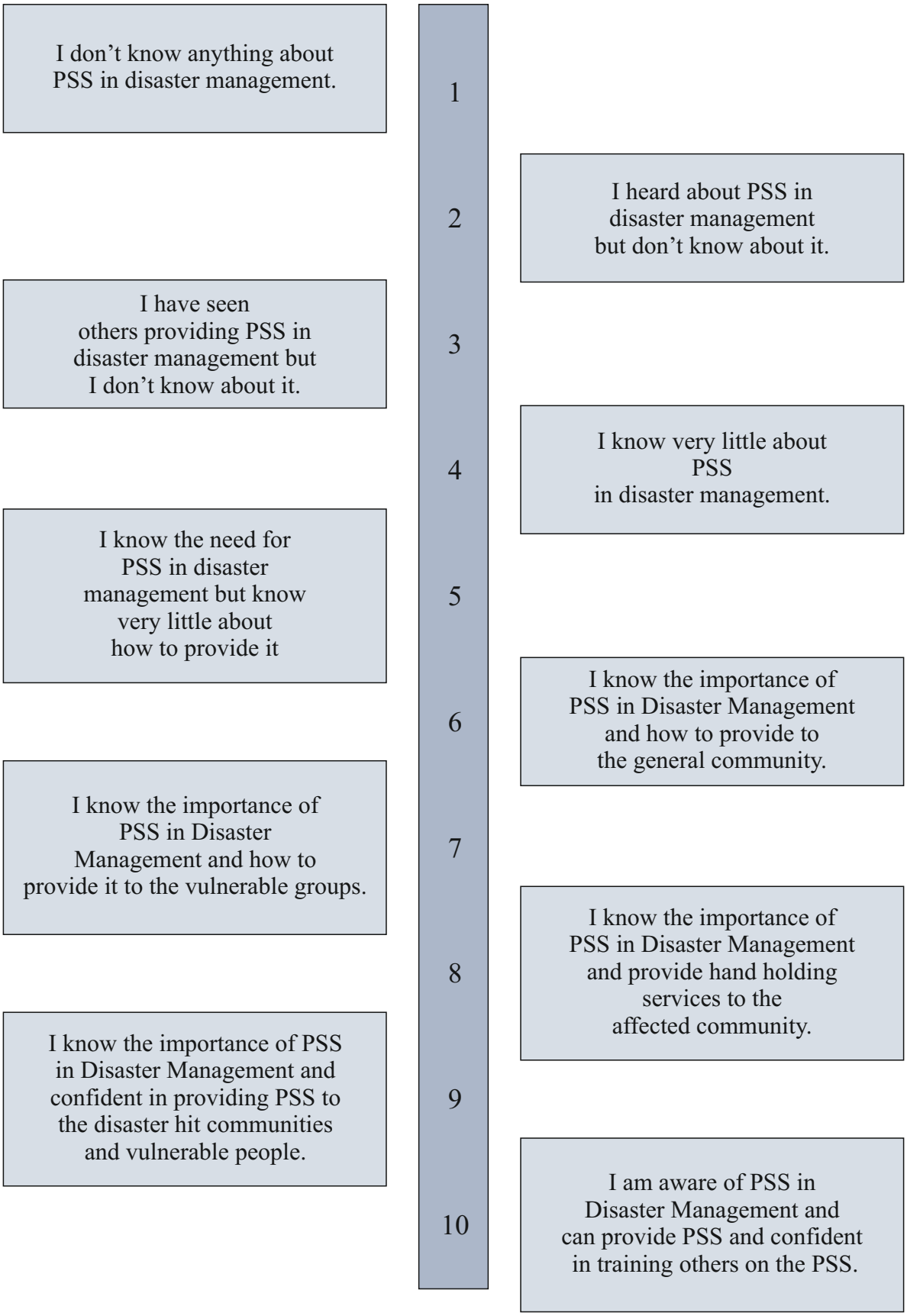
9. Occupation:

10. Monthly Income:

11. Years of Experience:

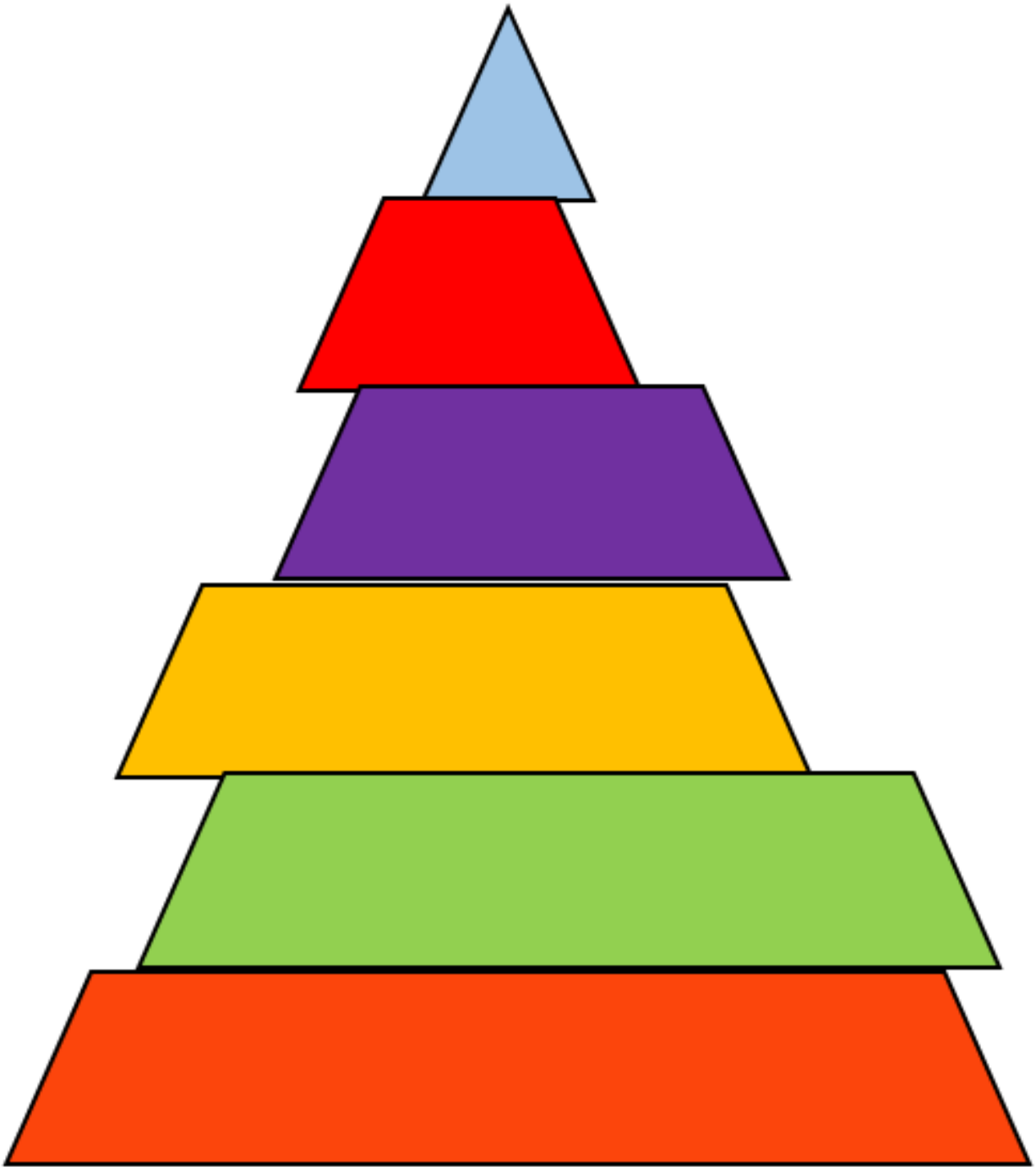
12. What are your expectations from the training?

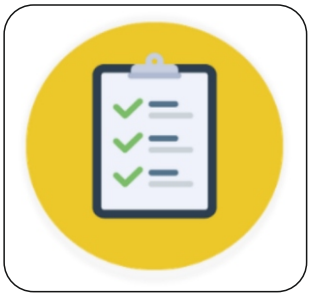
KNOWLEDGE ON PSYCHOSOCIAL SUPPORT (PSS) IN DISASTERMANAGEMENT



Impact of Disaster

Needs of the Disaster Survivors






LISTEN!

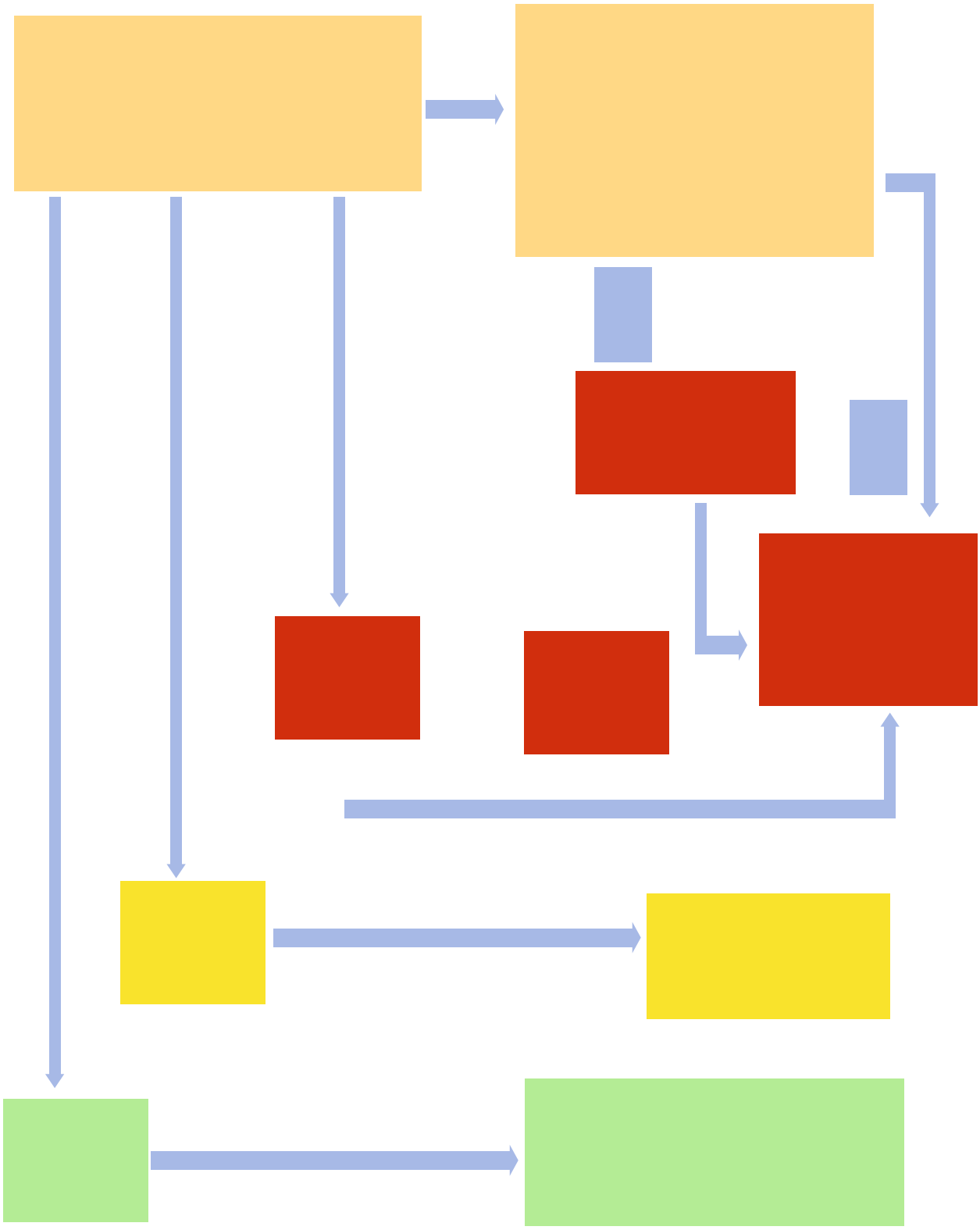

LOOK!

CHAPTER 2 PSYCHOSOCIAL TRIAGE

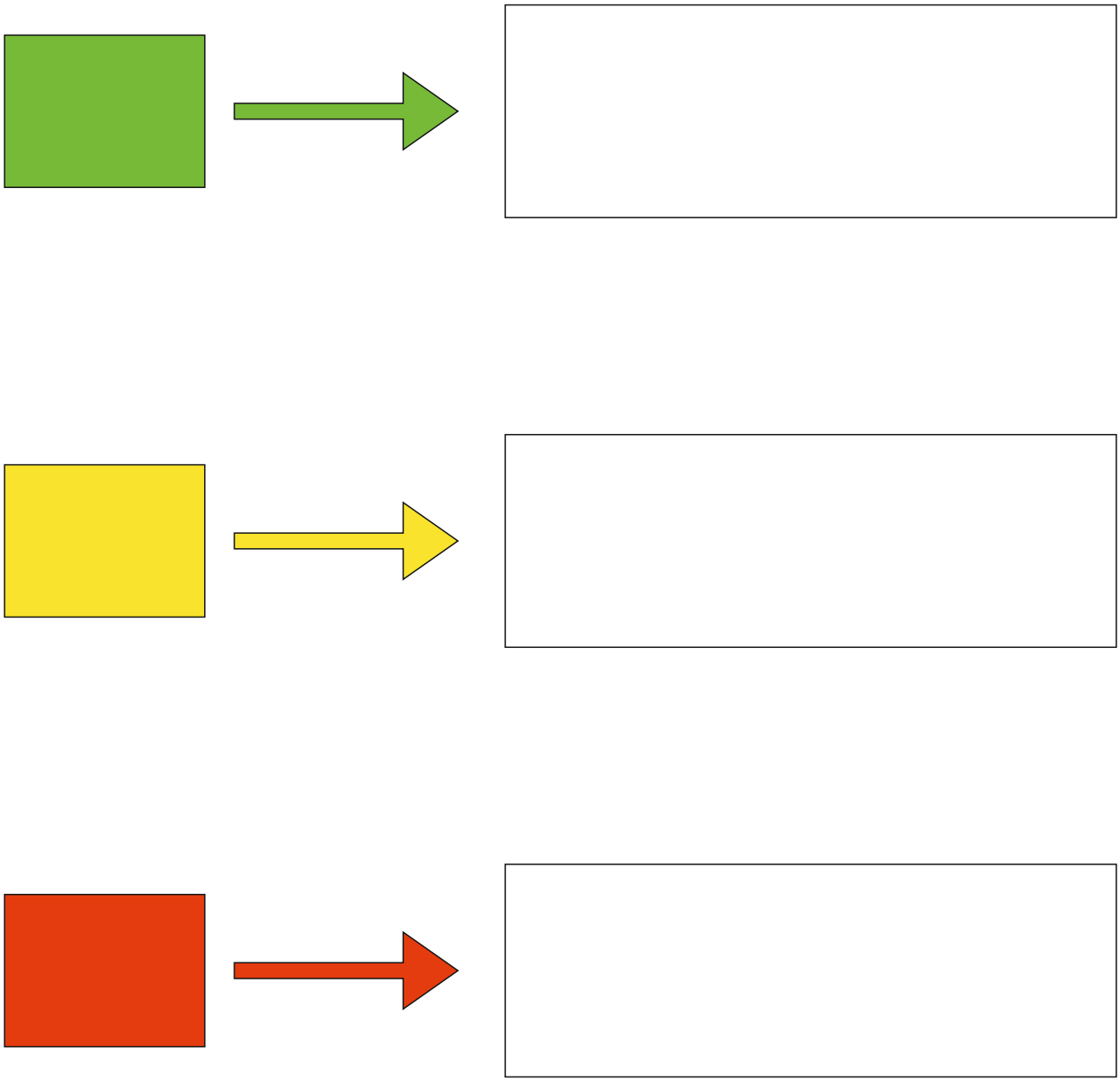
Psychosocial triage matrix

Indicators	Low Risk	Moderate Risk	High Risk
Physical closeness			
Expressive closeness			
Individual vulnerabilities			
Environmental vulnerabilities			
Instant reactions during the disaster			
Ongoing reactions			
Coping			

Psychosocial Triage

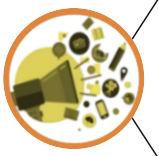


Nature of psychosocial services provided based on the risk level



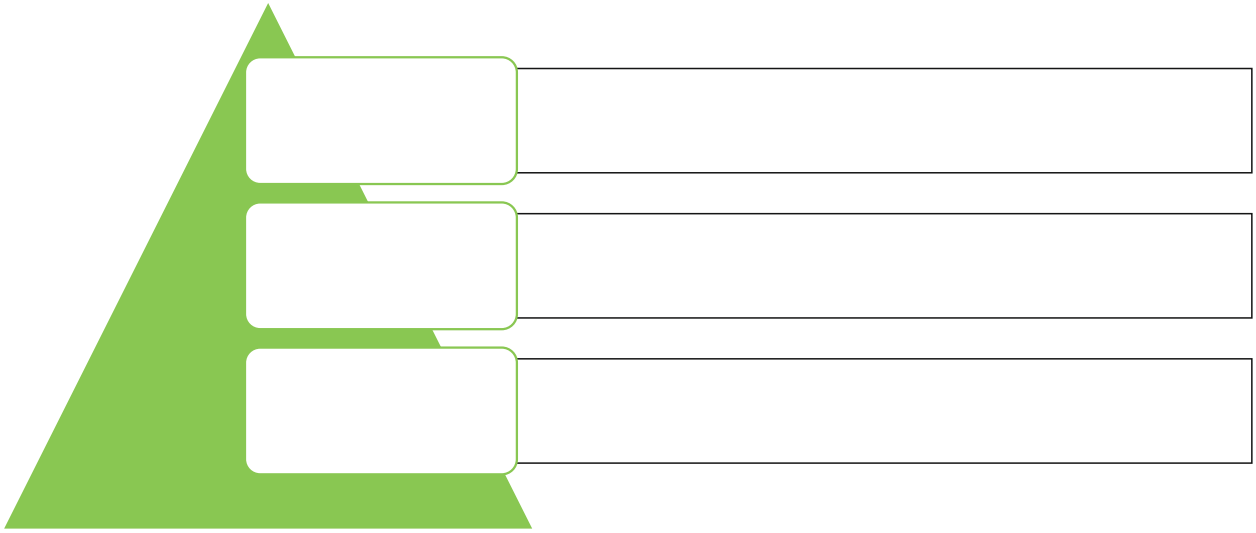
CHAPTER 3 PSYCHOSOCIAL SUPPORT IN DISASTERS

Psychosocial support (PSS) activities



✓ Psychosocial support 'IS'	✘ Psychosocial support 'IS NOT'

Levels of psychosocial support



CHAPTER 4 PSYCHOSOCIAL NEEDS ASSESSMENT

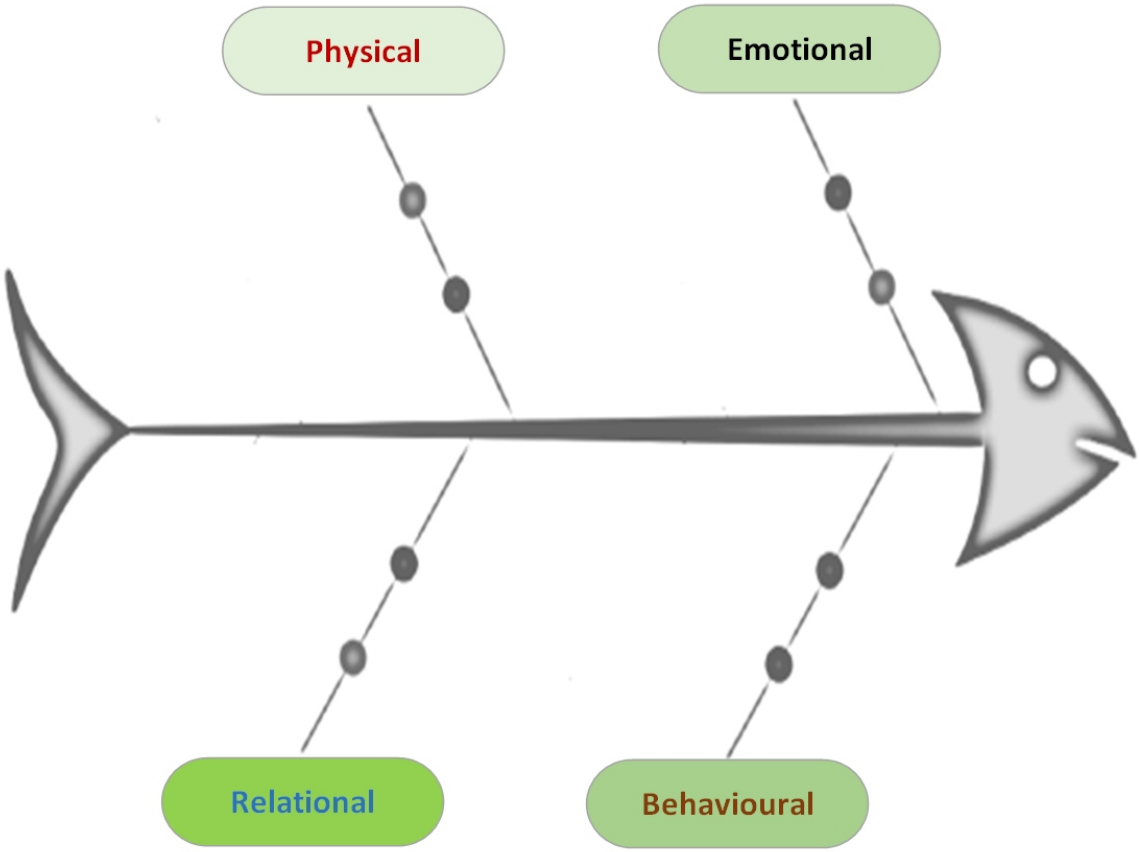
Different levels of psychosocial needs assessment

Individual Assessment	Family Assessment	Community Assessment
		

Psychosocial Needs Assessment Techniques, ICRC & IFRC, 2008

CHAPTER 5 STRESS DURING DISASTERS

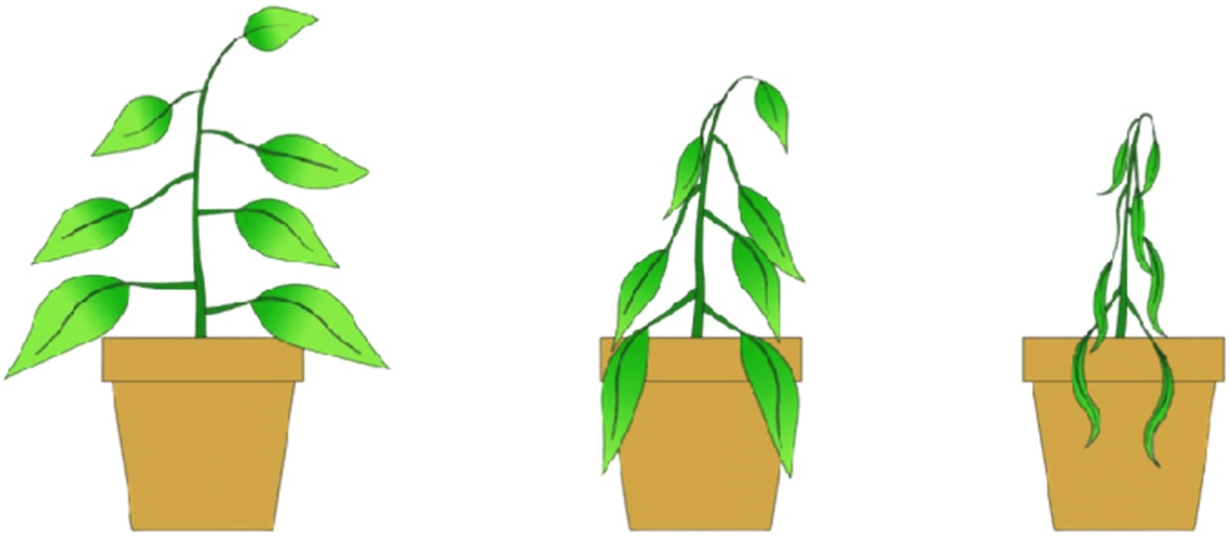
Stressful reactions during disasters



Multiple reactions experienced by different age groups in the post-disaster phase

Reactions among Children
Reactions among Adolescents
Reactions among adults
Reactions among older adult

Normal and abnormal reactions during disasters



NORMAL REACTIONS

ABNORMAL REACTIONS

MENTAL HEALTH PROBLEMS

Normal and abnormal reactions post-disasters

CHAPTER 6 MENTAL HEALTH ISSUES AMONG DISASTER SURVIVORS

THE MOST COMMON MENTAL HEALTH PROBLEMS POST-DISASTERS

Adjustment Problems:

Post-Traumatic Stress Disorder (PTSD):

Anxiety related problems:

Depression:

Panic Disorder:

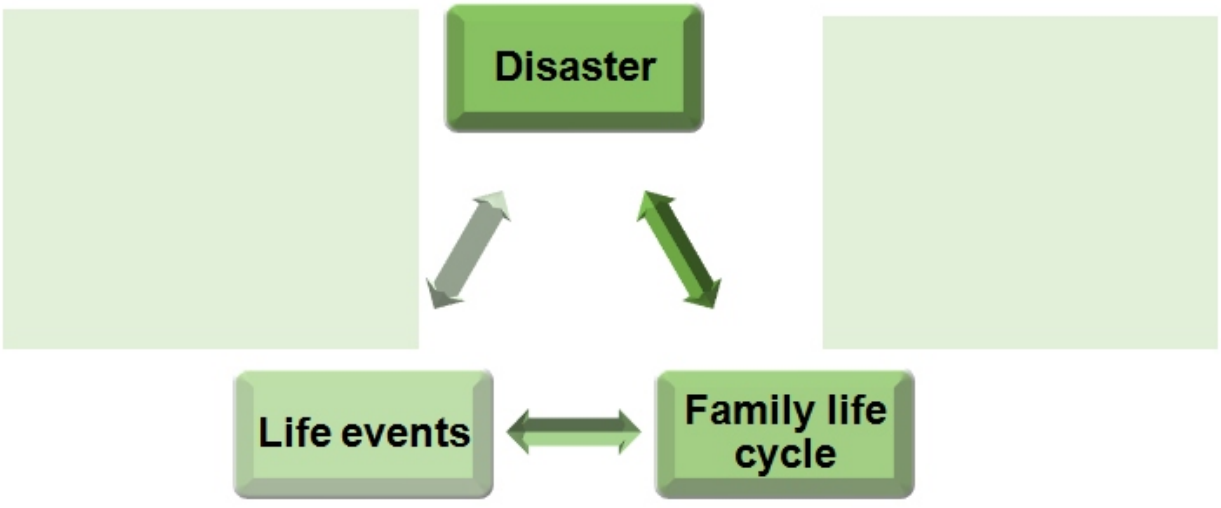
Dissociative reactions:

Other mental health problems:

CHAPTER 7 LIFE EVENTS, FAMILY LIFE CYCLE AND DISASTER

Family life cycle

Influence of life events on family life cycle post-disaster

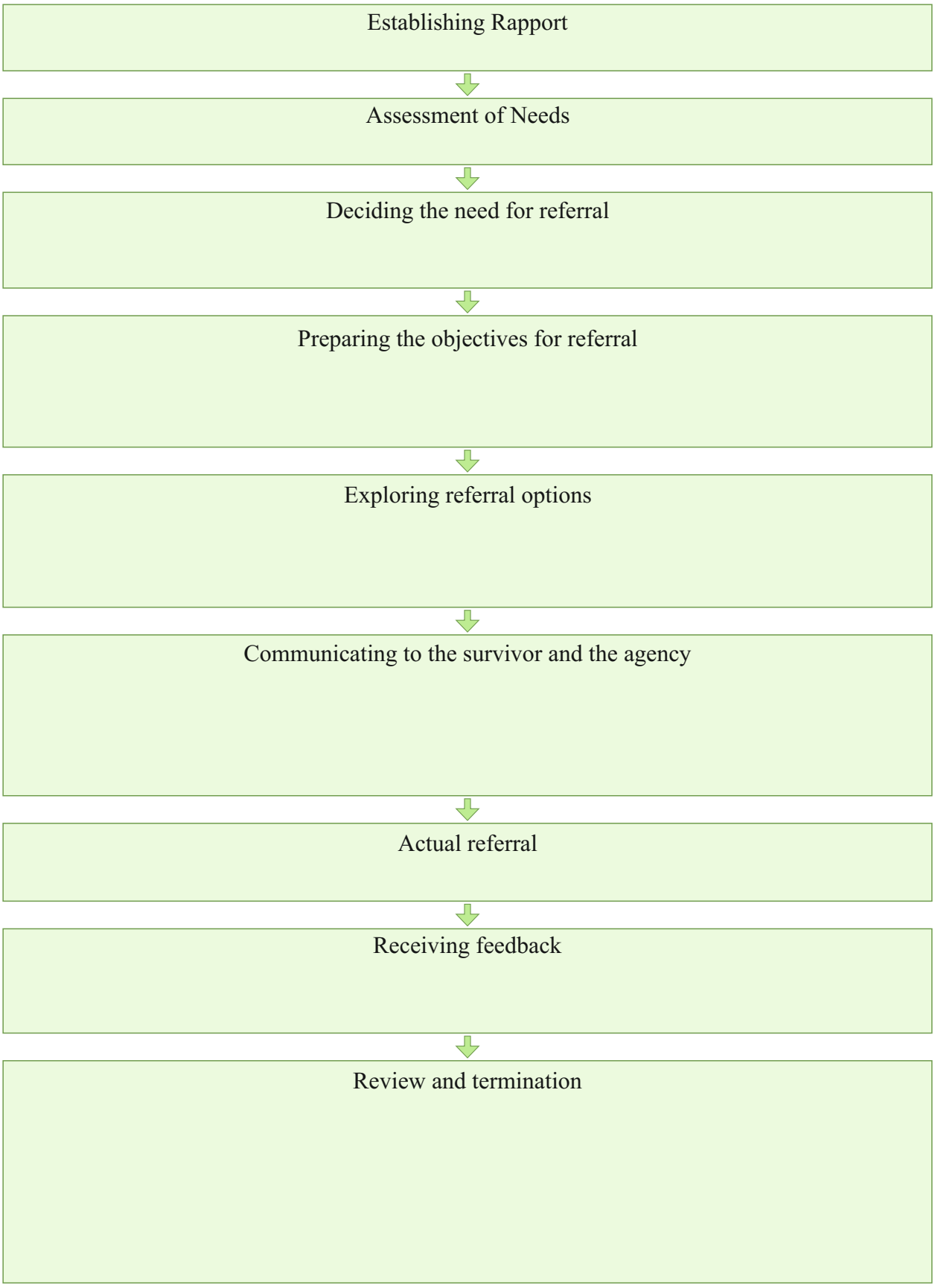


CHAPTER 8 PSYCHOSOCIAL SUPPORT TECHNIQUES

Psychosocial support techniques

CHAPTER 9 REFERRALS AND FOLLOW-UP

Steps in the facilitation of referral



Ethical practices to be followed while facilitating referrals

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Section - 2
WORKING WITH VULNERABLE GROUPS

CHAPTER 1 VULNERABLE GROUPS IN DISASTERS

Table 1.1: Vulnerable groups, during different types of disasters	
Factors	**Vulnerable Groups**
Age	
Gender	
Occupation	
Family	
Ethnicity	
Status	
Health	
Trauma	
Displacement	
Disability	
Others	

Indicators of vulnerability

Environmental:
Health:
Communications:
Economy:
Psychology:
Emergency management:
Organisational:
Cultural/societal:

Steps in identifying and empowering vulnerable groups before/during/after disasters

Steps 1:_____

Steps 2:_____

Steps 3:_____

Steps 4:_____

Steps 5:_____

CHAPTER 2 IMPACT OF DISASTERS ON VULNERABLE GROUPS

Impact of disaster on children

Age group	Physical impact	Psychological impact	Social impact
0 to 5 years			
6 to 12 years			
13 to 18 years			

Impact of disaster on women

Physical impact	Psychological impact	Economic impact	Social impact

Impact of disaster on older adult

Physical impact	Psychological impact	Economic impact	Social impact

Impact of disaster on persons with disability (PWD)

Physical impact	Psychological impact	Economic impact	Social impact

CHAPTER 3 STRATEGIES FOR WORKING WITH VULNERABLE GROUPS

Some of the key measures to be adopted while working with children

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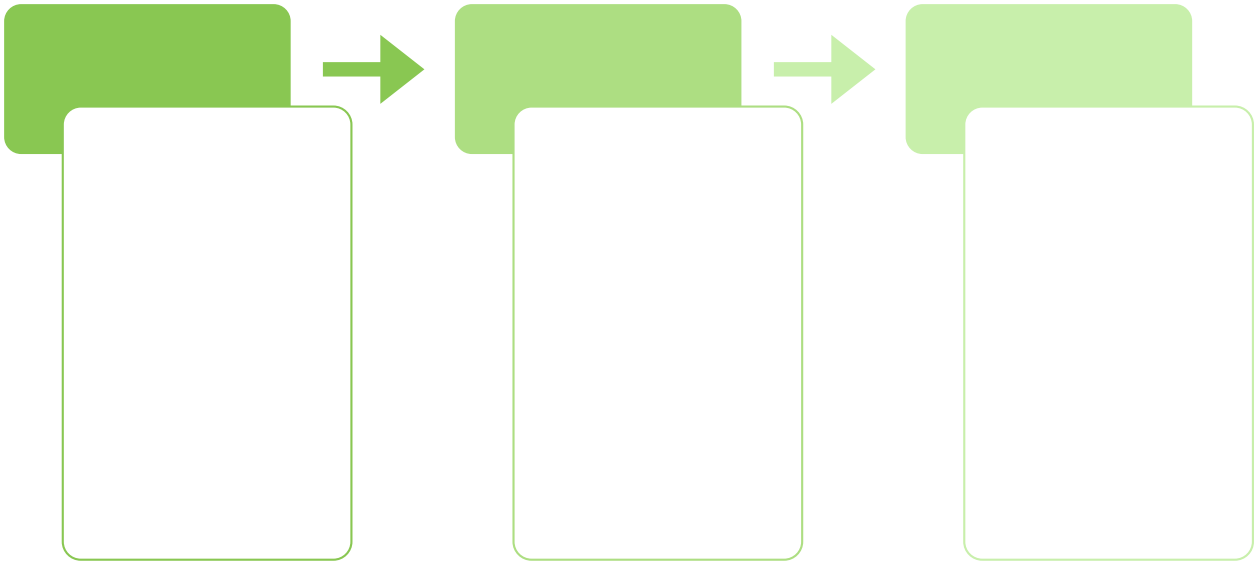

Common psychosocial mediums that can be used while working with children

The caregiver needs to remember the following while working with women in disasters:

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Measures to help women in disasters

Pre-disasters	Post-disasters

The barriers to include the PWDs in Disaster Management Cycle

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While working with persons having mental illness, the caregiver needs to remember the following:

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While working with elderly the caregivers need to remember the following:

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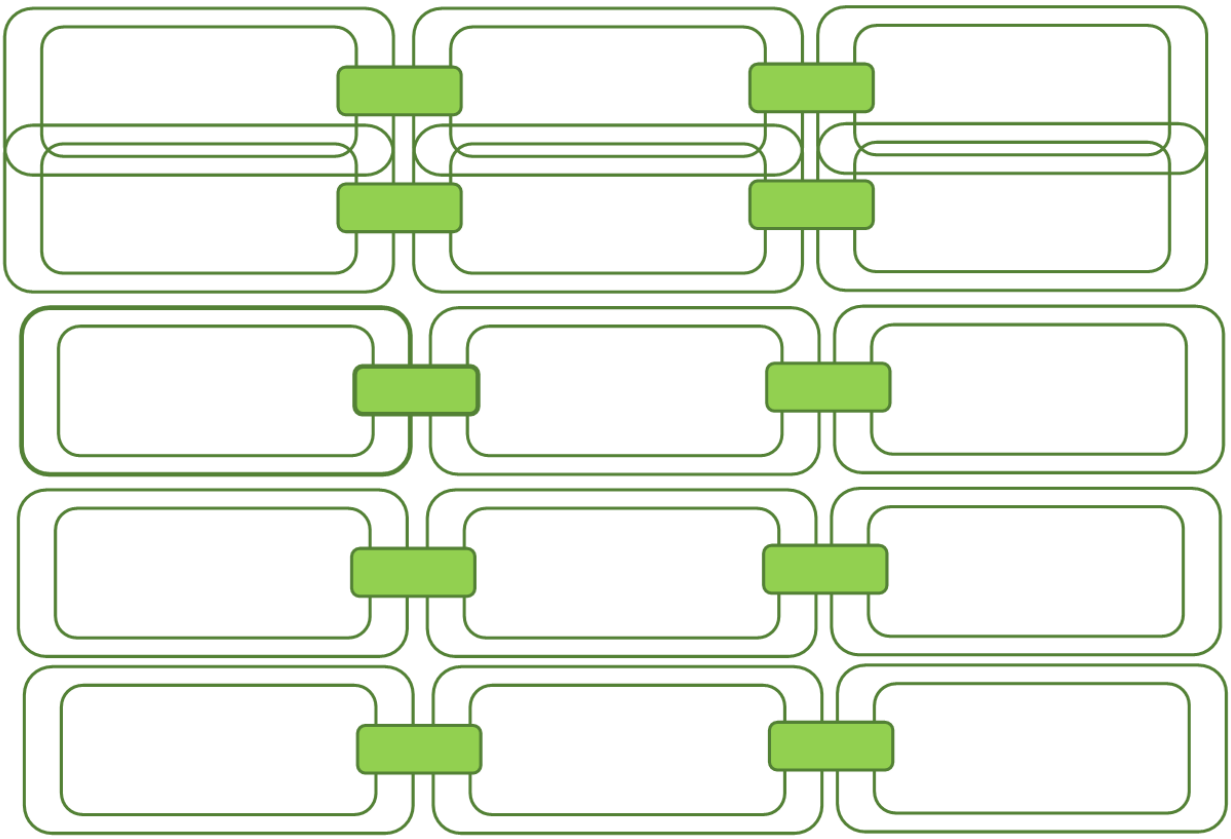
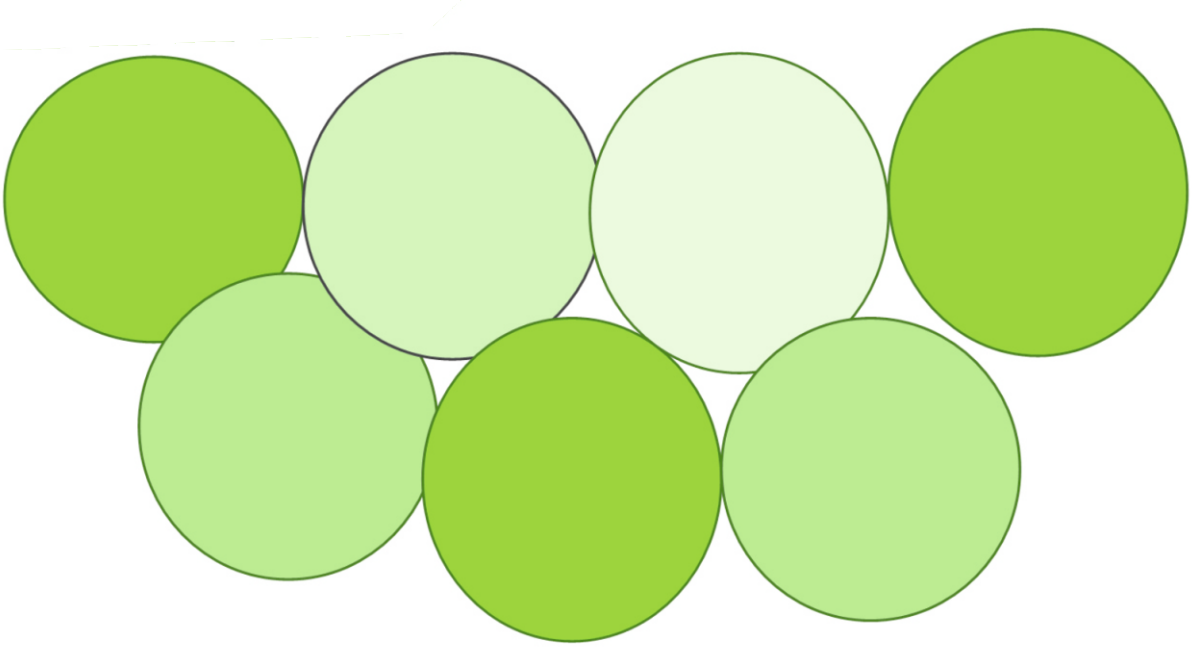
Section - 3
CARING FOR CARERS

CHAPTER 1 STRATEGIES FOR WORKING WITH VULNERABLE GROUPS

Who can be trained as psychosocial caregivers



Role of psychosocial caregivers



Role of psychosocial caregivers pre-disaster

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Role of psychosocial caregivers post-disaster

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CHAPTER 2 MENTAL HEALTH AMONG CAREGIVERS IN DISASTER

Reactions post-disasters and necessary actions	

Stress during disasters

Common reactions experienced by caregivers	
Psychological	
Physical	
Interpersonal	

Contributors to distress among caregivers

Work related

Trauma related

Common reactions among caregivers experiencing burnout	
Work	
Relational	
Psychological	
Physical	
Behavioural	

Secondary traumatic stress

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CHAPTER 3 MENTAL HEALTH PRESERVATION STRATEGIES

Before

After

During

Dear Buddy

Steps to initiate Buddyship

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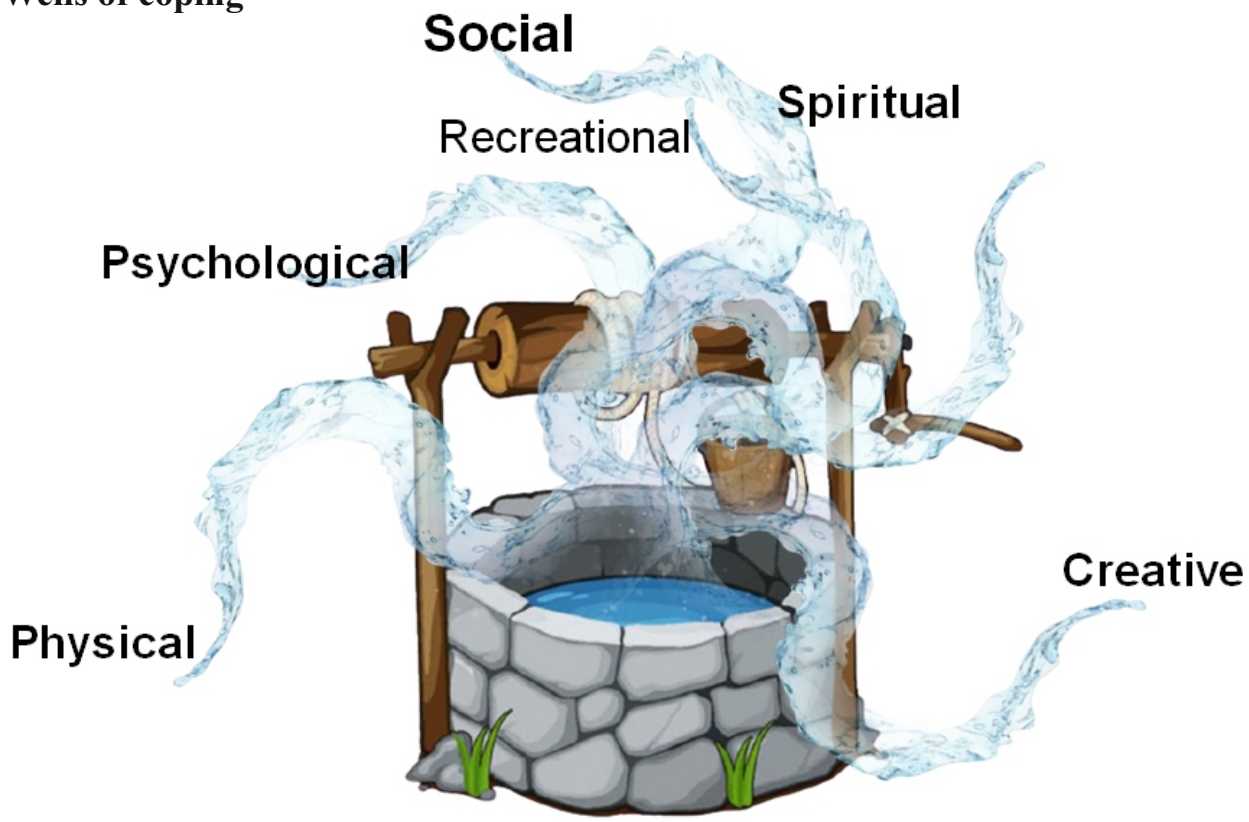
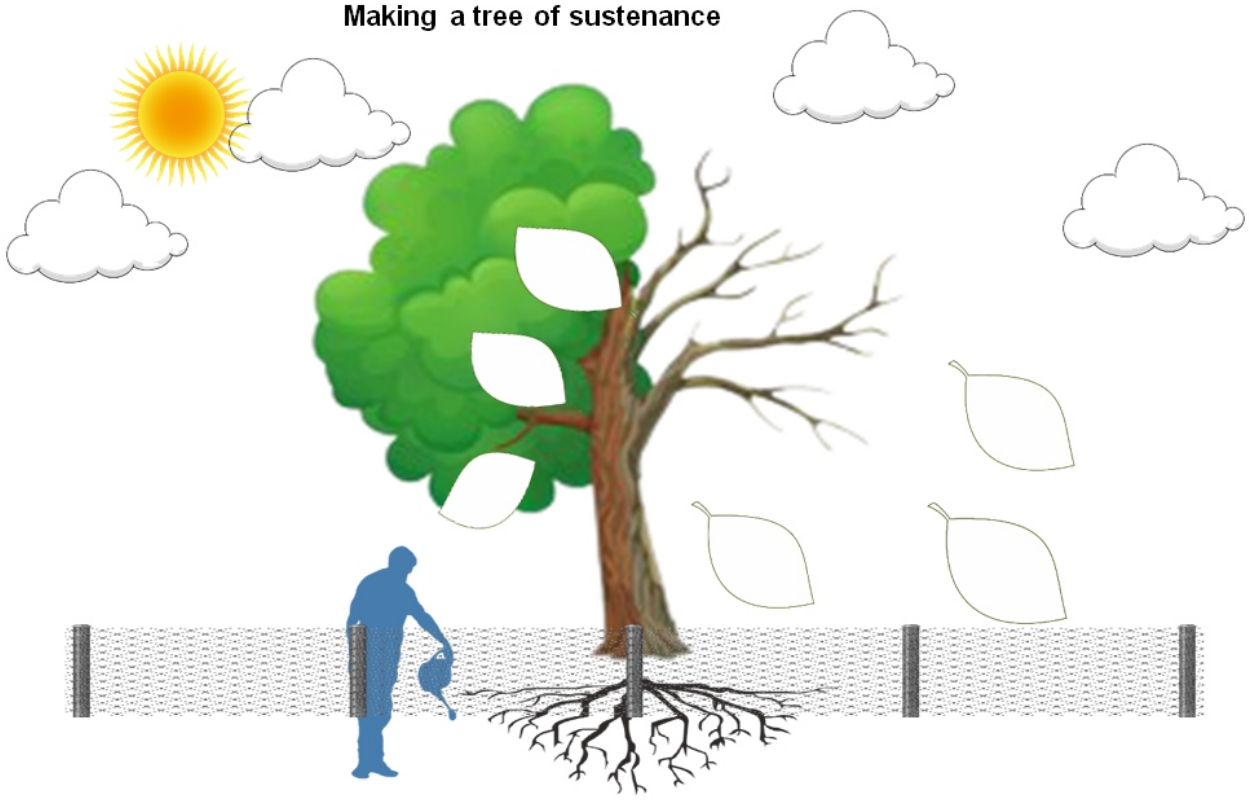
Enhancing resilience among caregivers

	Risk Factors	Protective Factors
Pre-Disaster		
During Disaster		
Post-Disaster		

Wells of coping





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