PSYCHOSOCIAL REHABILITATION IN DISASTER

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OVERVIEW

STRESS
HANS SELYE

- THE RATE OF WEAR AND TEAR WITHIN THE BODY
- THE STATE MANIFESTED BY A SPECIFIC SYNDROME WHICH CONSISTS OF NON-SPECIFICALLY INDUCED CHANGES WITHIN A BIOLOGIC SYSTEM

EUSTRESS/NON-PATHOGENIC STRESS

TRAUMATIC STRESS/DISTRESS
THE PSYCHOPHYSIOLOGY OF STRESS

NON-PATHOGENIC STRESS

HEALTHENED FUNCTIONING AND PERFORMANCE

NON-PATHOGENIC STRESS

STRESS - TENSION MODEL

STRESS stimulus

TENSION effect

(cause the illness)
TRAUMATIC STRESSOR

任何形式非常令人痛苦及超出正常经验范围的事件
- RAPE
- DOMESTIC VIOLENCE
- NATURAL CATASTROPHES – NATURAL DISASTER
- MAN-MADE DISASTERS – FLOODING DUE TO DEFORESTATION
NORMALLY INVOLVE A PERCEIVED THREAT TO THE PHYSICAL INTEGRITY OF THE INDIVIDUAL OR OTHERS

EVOKE REACTION OF INTENSE FEAR, HORROR, &/OR HELPLESSNESS

PSYCHOLOGICAL EFFECTS OF DISASTER
(EHRENFREICH, COPING WITH DISASTER, 2001)

IMMEDIATE & SHORT-TERM EFFECTS
LONG-TERM EFFECTS
SECONDARY TRAUMATIZATION
“SECOND DISASTER”
DELAYED EFFECTS OF DISASTER
1. SHORT-TERM EFFECTS

- HEART POUNDING
- MOUTHS GO DRY
- MUSCLES TENSE
- NERVES GO ON ALERT
- INTENSE ANXIETY
- FEAR
- TERROR

- SHOCK
- A SENSE OF UNREALITY
2. LONG-TERM EFFECTS

- CHRONIC GRIEF
- DEPRESSION
- ANXIETY
- GUILT
- DIFFICULTIES CONTROLLING ANGER
- SUSPICIOUSNESS
- IRRITABILITY

- HOSTILITY
3. SECONDARY TRAUMATIZATION

- FAMILIES OF THOSE DIRECTLY AFFECTED
- ONLOOKERS & OBSERVERS
- RELIEF WORKERS

4. “SECOND DISASTER”

- THE EFFECTS OF THE RESPONSE TO THE DISASTER
- CONFUSION AND COMPETITION FOR THE SCARCE RESOURCES DUE TO INFLUX OF HELPERS
- REFUGEES – LOSS OF PRIVACY, COMMUNITY, FAMILIARITY & CERTAINTY WITH RESPECT TO THE FUTURE
5. DELAYED EFFECTS OF DISASTER

- Psychological responses appearing months or years after the disaster
- “Honeymoon stage” – Initial relief & optimism of having been rescued
- “Doing well” – Suppress or inhibit the processing of the impact of the disaster

MOST COMMON FINDINGS ACROSS CULTURES FOR THOSE AFFECTED BY DISASTER

- Symptoms associated with posttraumatic stress disorder (PTSD)
- Depression
- Anxiety disorders
- Developmental delays for children
PREVALENCE OF ADVERSE PSYCHOLOGICAL EFFECTS FOLLOWING DISASTER (EINICHREICH, 2001)

- 90% : IMMEDIATELY AFTER DISASTER
- 20% - 50% : 12 WEEKS AFTER DISASTER
- 25% : 1-2 YEARS POST-DISASTER, INCLUDING SURVIVORS WITHOUT INITIAL SYMPTOMS WHO DEVELOPED SYMPTOMS 1-2 YEARS LATER (DELAYED RESPONSES, RESPONSES TO LATER CONSEQUENCES OF DISASTER)

DECEMBER 26TH TSUNAMI

- WHO – PREDICTED 30-50% OF THE POPULATION TO EXPERIENCE MODERATE – SEVERE PSYCHOLOGICAL DISTRESS THAT MIGHT RESOLVE THROUGH TIME, OR MILD DISTRESS THAT COULD BECOME CHRONIC
JUNE 2005 – 50% OF THE POPULATION WERE STILL EXPERIENCING PSYCHOLOGICAL PROBLEMS, 5 - 10% REQUIRED TREATMENT

RESPONSES OF DISASTER VICTIMS IN OTHER CULTURES

1985 MEXICAN EARTHQUAKES, DE LA FUENTE (1990) – 32% PTSD, 19% GAD, 135 DEPRESSION

VOLCANIC ERUPTION IN COLOMBIA, EARTHQUAKES IN ECUADOR, LIMA ET AL (1990) – PREVALENCE OF EMOTIONAL DISORDERS AMONG SURVIVORS WAS 3 TO 4X HIGHER THAN IN ORDINARY CLINICAL SETTING; PTSD & DEPRESSION

1985 DISASTER IN PUERTO RICO, GUARNACCIA (1994) – ATAQUE DE NERVIOS (ATTACK OF NERVES) COMMON IN THE AFFECTED POPULATION

- SIGNS/SYMPTOMS OF ATAQUE DE NERVIOS – MEET CRITERIA FOR DEPRESSION, DYSTHYMIA, GAD, PANIC DISORDER, PTSD
FACTORS AFFECTING VULNERABILITY TO ADVERSE PSYCHOLOGICAL EFFECTS

- The more severe the disaster & the more terrifying or extreme the experiences of the individual, the greater the likelihood of widespread & lasting psychological effects.

- Some types of disaster may be more likely to produce adverse effects than others.
  - Intentionally inflicted by others
  - Non-intentional infliction
  - Purely
  - Natural disasters
WOMEN (ESPECIALLY MOTHERS OF YOUNG CHILDREN), CHILDREN 3-10 YEARS OLD, & PEOPLE WITH A PRIOR HISTORY OF MENTAL ILLNESS OR POOR SOCIAL ADJUSTMENTS APPEAR TO BE MORE VULNERABLE THAN OTHER GROUPS.

IN ADDITION TO THE “PSYCHOLOGICAL” EFFECTS, SOME OF THE PHYSICAL EFFECTS (CRUSH INJURIES, HEAD INJURIES, PROLONGED PAIN) CAN DIRECTLY PRODUCE, THROUGH PHYSIOLOGICAL PROCESS, ADVERSE PSYCHOLOGICAL EFFECTS SUCH AS
- DIFFICULTY CONCENTRATING
MEMORY DIFFICULTIES
DEPRESSION
EMOTIONAL INSTABILITY

REFUGEES FROM WAR, POLITICAL OPPRESSION, OR POLITICAL VIOLENCE ARE ALSO AT RISK OF ADVERSE EFFECTS.
MALNUTRITION
RAPE
PHYSICAL ASSAULT
INFECTIOUS DISEASES
“STIGMATIZATION” OF THE DISASTER VICTIMS MAKES HEALING MORE DIFFICULT

SEVERAL SPECIFIC KINDS OF DISASTER EXPERIENCE ARE ESPECIALLY TRAUMATIC.

■ WITNESSING DEATH OF A LOVED ONE, BEING ENTOMBED OR TRAPPED, SERIOUSLY INJURED

THE AVAILABILITY OF SOCIAL SUPPORT NETWORKS – SUPPORTIVE FAMILIES, FRIENDS, COMMUNITIES – REDUCED THE LIKELIHOOD OF LASTING ADVERSE EFFECTS

THE MORE SEVERE THE DISASTER, THE LESS CHARACTERISTIC OF INDIVIDUALS MATTER.
ASSESSING THE PSYCHOLOGICAL IMPACT OF DISASTERS

- BY CATEGORY
  - RELIEF WORKERS
  - VICTIMS WHO HAVE A FAMILY MEMBER DIE IN THE DISASTER
  - VICTIMS WHO WERE TRAPPED OR ENTOMED
  - VICTIMS SEVERELY INJURED
  - THOSE WHO CONTINUE TO HAVE PAIN OR PHYSICAL DISABILITY

- CHILDREN AGED 5 – 10 Y/O
- MOTHER OF YOUNG CHILDREN
- VICTIMS WITH PRIOR HISTORY OF POOR ADAPTATION TO SCHOOL OR WORK
- HISTORY OF POOR COPING IN PREVIOUS PERIODS OF HIGH STRESS.
- BY SPECIFIC BEHAVIOUR PATTERN
THOSE WHO ENGAGE IN MALADAPTIVE BEHAVIOURS – CHILDREN STAYING OUT OF SCHOOL OR ADULTS NOT GOING TO WORK
THOSE WITH “VAGUE” MEDICAL PROBLEMS
THOSE WHO EXPRESS SUICIDAL THOUGHTS OR MAKING SUICIDE ATTEMPTS OR OTHER ATTEMPTS AT SELF-HARM

BY USE OF SCREENING INSTRUMENTS
SYMPTOM CHECKLIST CAN BE DISTRIBUTED IN CHURCH, SCHOOLS, WORKPLACES, SHELTERS, REFUGEE CAMPS
SYMPTOM REPORT QUESTIONNAIRE (SRQ) – HAS BEEN USED IN MANY COUNTRIES; HAS PROVEN TO BE SUCCESSFUL IN IDENTIFYING ADULTS & ADOLESCENTS IN DISTRESS
BY CASE FINDING

- OUTREACH EFFORTS – DISTRIBUTION OF LEAFLETS, ANNOUNCEMENTS ON RADIO/TELEVISIONS, ARTICLES IN NEWSPAPERS, PUBLIC LECTURES, POSTERS
- ENLIST TEACHERS, RELIGIOUS LEADERS, MEDICAL WORKERS, WORKPLACE SUPERVISORS, & OTHER LOCAL RESIDENTS

SOME DIAGNOSTIC ISSUES

- VARIED REACTIONS TO TRAUMA – ANXIETY, DEPRESSION, SOMATIC REACTIONS, CULTURALLY SPECIFIC RESPONSES
- DO NOT FOCUS ON WHETHER PEOPLE MEET SPECIFIC DIAGNOSTIC CATEGORIES IN THE ICD 10 OR DSM 4.
DISTINGUISH INTENSE BUT UNDERSTANDABLE RESPONSES TO CONCRETE SITUATIONS FROM PATHOLOGICAL RESPONSES

- INTENSE GRIEF VS. DEPRESSION
- ACHES & PAINS FROM INJURIES VS. SOMATICS SYMPTOMS (DEPRESSION, ANXIETY)
- NON-CLINICAL PARANOIA VS. PSYCHOSIS

- "PARANOIA DUE TO LOSS OF FAMILIAR CULTURAL CUES, MISCOMMUNICATIONS, REAL OR FANCIED DISCRIMINATION"

BE AWARE THAT SOME PEOPLE MAY MINIMIZE THEIR SUFFERING

- FOR FEAR THAT THEIR STORY MIGHT NOT BE BELIEVED
- FEAR OF STIGMATIZATION
- WILL LEAD TO ADVERSE CONSEQUENCES
THERE ARE DIFFERENT WAYS OF COPING WITH TRAUMA

- ADAPTIVE
  - FATALISM; BELIEF IN FATE OR KARMA; BELIEF IT WAS “GOD’S WILL” OR “IT WAS MEANT TO BE”
  - BELIEFS THAT CATASTROPHE & SUFFERING ARE A NORMAL PART OF LIFE & SHOULD BE EXAMINED FOR THEIR MEANING
  - USE OF FAMILY, COMMUNITY, CHURCH SUPPORT

- FOCUSING ON NEW DREAMS OR PRIORITIES OR A SENSE OF MISSION
- HARD WORK (LEARNING NEW SKILLS, ACQUIRING A NEW LANGUAGE, HELPING OTHERS, WORKING HARD) AS A SOURCE OF RENEWED SELF-WORTH
- EXERTING SELF-CONTROL
LESS ADAPTIVE COPING & MAY INDICATE A NEED FOR INTERVENTION
- EXPRESSING STRESS IN SOMATIC FORM
- DENIAL & SILENCE
- AVOIDANCE
- PROJECTION; BLAMING; SCAPEGOATING
- DISSOCIATION, NUMBNESS

PSYCHOLOGICAL RESPONSES TO TRAUMA MAY BE CONFUSED WITH PHYSIOLOGICAL RESPONSES
- HEAD INJURIES – HEADACHES, DIZZINESS, MEMORY LOSS, DIFFICULTY ATTENDING OR CONTRATING, SUDDEN OUTBREAKS OF CRYING OR ANGER OR LAUGHTER, MAY EXPRESS WORRY THAT THEIR MIND IS BROKEN
METABOLIC DISTURBANCES DUE TO BURNS, EXPOSURE TO TOXINS, CRUSCHING INJURIES, INFECTION, OR NUTRITIONAL DEFICIENCIES

PAIN MAY MASK THE REPORTING OF PSYCHOLOGICAL SYMPTOMS

SUBSTANCE USE MAY ALSO MASK OR EXACERBATE EMOTIONAL RESPONSES TO TRAUMA

CONSIDERATIONS IN DOING THE ASSESSMENT

- PUSHING THE VICTIM TO REVEAL WHAT HAPPENED TO THEM TOO FAST OR TO INSISTENTLY MAY EXACERBATE THE VICTIM’S SYMPTOMS OR EVEN RE-TRAUMATIZE THE VICTIM
  - LET THE CLIENT CONTROL THE PACE.
  - ASK GENTLE QUESTIONS & LISTEN.
  - LET WHAT THE
LET WHAT THE CLIENT NEEDS TO TELL YOU TO TAKE PRECEDENCE OVER PRE-DETERMINED NOTIONS OF WHAT INFORMATION MUST BE GATHERED.

ASSURE THE VICTIM OF CONFIDENTIALITY

INTERVIEWS DONE IN A SAFE, QUIET, PRIVATE PLACE.

CLARIFY TO THE VICTIMS FOR THE ASSESSMENT OR OTHER INQUIRY & GIVE THE PERSON ASSESSED AS MUCH CONTROL AS POSSIBLE OVER THE PROCESS.
IN SOME CULTURES, FOCUSING ON THE NEGATIVE EXPERIENCES MAY BE SEEN AS DETRIMENTAL TO YOUR FUTURE WELL-BEING.

A TRAUMATIC EVENT MAY BE VIEWED AS DUT TO ONE’S ACTIONS. HENCE, THE VICTIM SHOULD ENDURE IT, NOT SEEK HELP.

A TRAUMATIC EVENT MAY BE UNDERSTOOD AS A RESULT OF FATE, & IT MAY BE SEEN AS INAPPROPRIATE TO CHALLENGE OR MODIFY THE EVENT THAT HAV HAPPENED TO YOU.

REVELATION OF VICTIMIZATION (ESPECIALLY RAPE) MAY BE STIGMATIZING & MAY HAVE SERIOUS CONSEQUENCES.
IN SOME CULTURE, CHILDREN ARE PROTECTED FROM THE KNOWLEDGE OF DEATH. TO “SEE” DEATH CAN LEAD THE SPIRIT OF THE DEAD ENTERING THE CHILD, & TALK OF DEATH WITH A CHILD IS TABOO.

THE MEANING OF DREAMS VARY ACROSS CULTURES.

WHAT IS A “RE-EXPERIENCING OF A Traumatic Event” IN THE EYES OF WESTERN PSYCHIATRY MAY BE A BRIDGE TO THE SPIRIT WORLD OR A POTENT OF THE FUTURE IN THE EYES OF OTHER CULTURES.
THE MEANING OF AN EVENT MAY NOT BE THE SAME TO A COUNSELOR & A VICTIM FROM ANOTHER CULTURE.

- A RAPE VICTIM – RESULTING BELIEF THAT SHE INFERTILE OR UNMARRIAGEABLE MAY BE OF CENTRAL SIGNIFICANCE
- STIGMATIZATION DUE TO DISCLOSURE OF RAPE – ISOLATION, LOSS OF SUPPORT

THE SYMPTOMS MIGHT BE PERCEIVED BY THE VICTIMS AS SOCIALLY INAPPROPRIATE, SOURCE OF GUILT, SHAME & FAILURE, EVIDENCE OF FAILURE.

CAREGIVERS & RELIEF WORKERS, IN TURN, MAY RESPOND WITH IRRITATION OR WITHDRAWAL FROM THE VICTIMS
WHY THE NEED FOR PSYCHOSOCIAL REHABILITATION?

⇒ SYMPTOMS MAY BE DISTRESSING TO THE PERSON EXPERIENCING THEM.
⇒ SYMPTOMS MAY INTERFERE WITH THE PERSON DOING THINGS WHICH ARE IMPORTANT FOR HIS/HER IMMEDIATE SAFETY OR WELL-BEING OR TAKING PART IN THE RECOVERY OF THEIR COMMUNITY

AIMS OF PSYCHOSOCIAL REHABILITATION IN DISASTER

⇒ RESTORE PSYCHOLOGICAL & SOCIAL FUNCTIONING OF INDIVIDUALS & THE COMMUNITY
⇒ TO LIMIT THE OCCURRENCE & SEVERITY OF ADVERSE IMPACTS OF DISASTER-RELATED MENTAL HEALTH PROBLEMS
CHARACTERISTICS OF PSYCHOSOCIAL REHABILITATION

- Aimed at normal people having normal responses reacting to an overwhelming stress.
- Occurs in “non-clinical settings” with religious leaders, teachers, local leaders, mental health & other health professionals.

- Identify persons who are at risk for severe psychological & social impairment due to the shock of the disaster.
CHALLENGES OF PSYCHOSOCIAL INTERVENTIONS DURING DISASTER

- PEOPLE ARE NOT SEEKING MENTAL HEALTH ASSISTANCE
- PEOPLE MAYBE AMBIVALENT ABOUT RECEIVING SUCH HELP
- PEOPLE MIGHT BE OUTRIGHT RESISTANT TO SUCH HELP

STAGES OF PSYCHOLOGICAL RESPONSE TO DISASTER (EHRENREICH, 2001)

- THE “RESCUE” STAGE
- THE “INVENTORY” STAGE
- THE “RECONSTRUCTION” STAGE
## 1. Rescue Stage

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<tr>
<th>Various Emotional Responses Seen</th>
<th>Relief Activities</th>
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<tr>
<td>Psychic Numbing</td>
<td>Are focused on rescuing victims &amp; stabilizing the situation</td>
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<tr>
<td>Heightened Arousal</td>
<td>Victims are housed, clothed, given medical attention, provided with food &amp; water</td>
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<td>Diffuse Anxiety</td>
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<td>Survivor guilt</td>
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<td>Conflicts over Nurturance</td>
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- Confusional State
- May engage in heroic or altruistic acts
- Ambivalence
- Affective & Cognitive Instability
- Provide “defusing” & crisis intervention services for relief workers
- Ensure safety, physical needs are met
2. INVENTORY STAGE

PSYCHOLOGICAL PRESENTS
- POST TRAUMATIC STRESS DISORDER
- GENERALIZED ANXIETY DISORDER

RELIEF ACTIVITIES
- OVER THE NEXT YEAR OR 18 MONTHS, HEROIC EFFORTS GIVE WAY TO BUREAUCRATIZED FORMS OF HELP

- SEEK TO RE-UNITE FAMILIES & COMMUNITIES
- PROVIDE INFORMATION, COMFORT, PRACTICAL ASSISTANCE, EMOTIONAL FIRST AID
- ABNORMAL BEREAVEMENT
- POST TRAUMATIC DEPRESSION
- CULTURE SPECIFIC DISORDERS
- ATTENTION TURNS TO LONGER-TERM SOLUTIONS
- EFFECTS OF “SECOND DISASTER” ARE FELT

- EARLY INVENTORY
  - IDENTIFY THOSE AT MOST RISK & BEGIN CRISIS INTERVENTION, “DEBRIEFING”, & SIMILAR EFFORTS
EARLY INVENTORY STAGE (1st Month)
- CONTINUE TASK OF RESCUE STAGE
- EDUCATE LOCAL PROFESSIONALS, VOLUNTEERS, &

COMMUNITY WITH RESPECT TO EFFECTS OF TRAUMA
- TRAIN ADDITIONAL DISASTER COUNSELORS
- PROVIDE SHORT-TERM PRACTICAL HELP & SUPPORT TO VICTIMS
LATE INVENTORY STAGE (>2\textsuperscript{ND} MONTH ONWARD)

- CONTINUE TASKS OF RESCUE & EARLY INVENTORY STAGES

- PROVIDE COMMUNITY EDUCATION
- DEVELOP OUTREACH SERVICES TO IDENTIFY THOSE IN NEED
- PROVIDE “DEBRIEFING” & OTHER SERVICES FOR SURVIVORS IN NEED
3. RECONSTRUCTION STAGE

- PSYCHOLOGICAL PROBLEMS
  - ANXIETY
  - DEPRESSION
  - SUICIDE
  - CHRONIC FATIGUE
- A YEAR OR MORE AFTER THE DISASTER
- A NEW, STABLE LIFE MAY HAVE EMERGED
- AIDS DIMINISH AND EVENTUALLY DISAPPEAR
CHRONIC GASTROINTESTINAL SYMPTOMS
INABILITY TO WORK
LOSS OF INTEREST IN DAILY ACTIVITIES

VICTIMS WHO WERE ASYMPTOMATIC BEFORE BECOME SYMPTOMATIC

CONTINUE TO PROVIDE DEFUSING & DEBRIEFING SERVICES FOR RELIEF WORKERS & SURVIVORS
MAINTAIN A “HOTLINE” OR OTHER MEANS BY WHICH SURVIVORS CAN CONTACT COUNSELLORS
FOLLOW-UP THOSE SURVIVORS TREATED EARLIER

- DIFFICULTY THINKING CLEARLY
- POSTTRAUMATIC STRESS DISORDER
DISASTER WORKERS ARE AT VERY HIGH RISK OF ADVERSE EMOTIONAL EFFECTS!

SYMPTOMS OF “BURN OUT” IN DISASTER WORKERS

- EXCESSIVE TIREDNESS
- “LOSS OF SPIRIT”
- INABILITY TO CONCENTRATE
- SOMATIC COMPLAINTS
- SLEEP DIFFICULTIES
- GRANDIOSE BELIEFS ABOUT OWN IMPORTANCE
- CYNICISM
INEFFICIENCY
MISTRUST OF CO-WORKERS OR SUPERVISORS
EXCESSIVE ALCOHOL USE, CAFFEINE CONSUMPTION AND SMOKING

FORMS OF PSYCHOSOCIAL REHABILITATION
STRESS MANAGEMENT REDUCTION
PROBLEM SOLVING
ADVOCACY
REFERRAL OF AT-RISK INDIVIDUALS
DEFUSING
DEBRIEFING
**PRINCIPLE 1: SAFETY AND SECURITY UNDERLIE EMOTIONAL STABILITY**

- basic needs – food, water, clothing, shelter
- physical safety & security
- safety & integrity of family
- need for stable jobs, adequate housing, functioning community

**PRINCIPLE 2: ASSUME EMOTIONAL RESPONSES TO DISASTER ARE NORMAL**

The task of PSI is to elicit, facilitate, & support the inherent & natural healing processes of the individual & community.
**PRINCIPLE 3: INTERVENTION PHASE**

**SHOULD BE MATCHED TO THE DISASTER**

*Rescue Stage* – the highest priority for PSI is rescue & relief workers, for victims the most urgent needs are for direct, concrete relief

“PSYCHOLGICAL FIRST AIDS” –

: address feelings of acute distress

: difficulties in functioning affecting their ability to provide safety for themselves, & sense of cooperation with the rescue workers
**Inventory Stage** – PSI services continue to be high priority to relief workers, for the victims the bulk of PSI occur in this period.

**Reconstruction Stage** – continue to provide PSI, maintain means of communication for the survivors to reach the counselors.

**PRINCIPLE 4**: INTEGRATE PSYCHOSOCIAL ASSISTANCE WITH OVERALL RELIEF PROGRAMS

**PRINCIPLE 5**: INTERVENTIONS MUST TAKE PEOPLE’S CULTURE INTO ACCOUNT
PRINCIPLE 6: DIRECT INTERVENTIONS HAVE AN UNDERLYING LOGIC

Talking – makes sense of a disaster

Communication of information – accurate & full information decreases victims' level of stress

Empowerment – giving back the sense of loss of control

Normalisation – unfamiliar emotional responses are normal

Social Support – restoring or creating networks of social support is essential in dealing with extreme stresses

Relief of Symptoms – symptoms are distressing & may lead to difficulties in adapting
Build on Community Strengths, Traditions, & Resources

- **PRINCIPLE 7**: CHILDREN HAVE SPECIAL NEEDS
- **PRINCIPLE 8**: WOMEN HAVE SPECIAL NEEDS
- **PRINCIPLE 9**: RESIDENTS OF REFUGEE CAMPS HAVE SPECIAL NEEDS
PRINCIPLE 10: RESCUE AND RELIEF
WORKERS HAVE SPECIAL NEEDS

SPECIFIC INTERVENTION TECHNIQUES

CRISIS INTERVENTION
DEFUSING
CRITICAL INCIDENT STRESS DEBRIEFING
STRESS REDUCTION TECHNIQUES
EXPRESSIVE TECHNIQUES
OTHER EXPRESSIVE TECHNIQUES – ART TECHNIQUES, DOLL PLAY, PUPPET PLAY, STORY TELLING, WRITING, RELAXATION TECHNIQUES

DEFUSING

WHAT: INFORMAL PROCEDURE TO HELP GROUPS OF RELIEF WORKERS DEAL WITH THEIR REACTIONS TO SPECIFIC INCIDENTS (focus on the problem, solutions to problems, cohesion in the group)

WHO: RELIEF WORKERS

WHEN: WITHIN 24 HOURS AFTER THE INCIDENT
CRISIS INTERVENTION

- **WHAT:** SET OF TECHNIQUES THAT (1) IDENTIFY & CLARIFY THE ELEMENTS OF THE CRISIS, (2) DEVELOP PROBLEM-SOLVING STRATEGIES, (3) MOBILISE THE PERSON TO ACT ON THE STRATEGIES
- **WHO:** AIMED AT DISASTER VICTIMS, INDIVIDUAL RELIEF WORKERS
- **WHEN:** ANYTIME AFTER DISASTER

CRITICAL INCIDENT STRESS

- **WHAT:** STRUCTURED TECHNIQUE TO HELP INDIVIDUALS & GROUPS PROCESS THEIR DISASTER EXPERIENCE & BRING CLOSURE TO IT.
- **WHO:** RELIEF WORKERS, DISASTER VICTIMS
- **WHEN:** RELIEF WORKERS – PERIODICALLY, BEFORE RETURNING TO NON-RELIEF ACTIVITIES; VICTIMS – SEVERAL DAYS TO A YEAR
**STRESS REDUCTION TECHNIQUES**

- **WHAT:** TECHNIQUE TO REDUCE STRESS & ANXIETY
- **WHO:** RELIEF WORKERS, VICTIMS
- **WHEN:** TIMES OF STRESS, ON REGULAR BASIS

**EXPRESSIVE TECHNIQUES**

- **WHAT:** TECHNIQUES WHICH DO NOT REQUIRE THE ABILITY TO EXPLICITLY LABEL EMOTIONAL STATES
- **WHO:** CHILDREN, ADULTS WHO HAVE TROUBLE RESPONDING TO QUESTIONS OR EXPRESSING THEIR FEELINGS
- **WHEN:** SEVERAL DAYS TO A YEAR AFTER DISASTER

RECENT DEVELOPMENTS IN DISASTER MENTAL HEALTH

- CULTURALLY-EMBEDDED TREATMENTS OR COMMUNITY BASED COPING METHODS SHOULD BE UTILIZED (SHAH, AJDTS, 2006)
- PREVAILING RELIGIOUS PHILOSOPHY AND WORLDVIEW HELPED PEOPLE OVERCOME THEIR LOSSES (FALLOT & HECKMAN, 2005)
COLLABORATION WITH TRADITIONAL RESOURCES SUCH AS FAITH HEALERS MAY BE AN OPPORTUNITY IN TERMS OF CARE, PROVISION OF MEANING, & GENERATION OF COMMUNITY SUPPORT (OMMEREN, SAXENA, SARRACENO, 2005)

PSYCHOSOCIAL SUPPORT PROGRAM (SRI LANKAN NGO)

MOST PEOPLE HAVE THEIR OWN COPING SYSTEMS & SUPPORT OF THEIR FAMILIES, NEIGHBORS & FRIENDS.

- ARE YOU READY TO RECOGNIZE, RESPECT, AND LEARN FROM THESE?

COUNSELING TRAINING MUST HELP PARTICIPANTS TO UNDERSTAND AND DEVELOP THEIR OWN ATTITUDES AND BELIEFS TO BE ABLE TO PROVIDE AN EFFECTIVE SERVICE.

- HAVE YOU CONSIDERED THIS IN YOUR TRAINING PROGRAM ON COUNSELLING?
FAILURE TO UTILIZE THESE NATURAL COPING RESOURCES MAY UNDERMINE FUTURE COMMUNITY RESILIENCE BY REDUCING THE CAPACITY OF INDIGENOUS POPULATIONS TO UTILIZE THEIR INTRINSIC RESOURCES TO CONFRONT & COPE WITH THE PROBLEMS THEY ENCOUNTER.

DEVELOP & IMPLEMENT A PLAN OF INTEGRATED SERVICES. EXPAND [PROGRAM EVALUATION TERMS & OUTCOME STUDIES SO THAT THE MEASURED PARAMETERS DO NOT MYOPICALLY FAVOR WESTERN TREATMENTS.
RE-DOUBLE EFFORTS TO PRACTICE CLIENT CENTERED EVALUATIONS & TREATMENTS.

BE MINDFUL OF NEOCOLONIALISM, THE WESTERN INSTITUTIONAL & CULTURAL POWER/PRIVILEGE TO INFLUENCE AUDIENCES. LEARN TO BALANCE CULTURAL POWER SO THAT ALL PARTIES COLLABORATE.

UTILIZE ANTHROPOLOGY & RELATED DISCIPLINES TO CRITIQUE CULTURAL COMPETENCIES APPROPRIATELY WITHIN GRADUATE EDUCATION OF PSYCHOLOGISTS, PSYCHIATRISTS, & OTHER FIELDWORKERS.
GUIDELINES FOR ETHNOMEDICAL COMPETENCE IN PSYCHOSOCIAL WORK (SHAH, AJDTS, 2006)

- NEGOTIATE MUTUALLY AGREABLE THERAPY GOALS & EXERCISE MAXIMUM FLEXIBILITY CONSISTENT WITH THOSE GOALS.
- LEARN ABOUT CULTURALLY-EMBEDDED SELF-CONCEPTS & HEALING PRACTICES.

- ASCERTAIN HOW & WHY CULTURALLY-EMBEDDED TREATMENTS ARE UTILIZED (OR NOT) BEING UTILIZED.
- DETERMINE THE ADVANTAGES &/OR FEASIBILITY OF INTEGRATING PSYCHOTHERAPY SERVICES WITH CURRENTLY AVAILABLE TREATMENTS.
A COUNTRY’S GENERAL MODEL FOR DISASTER MENTAL HEALTH SERVICES SHOULD HAVE EMPHASIS ON CROSS-CULTURAL FACTORS, ALONG WITH RESPONSES BASED ON THE NEEDS, BELIEFS, & DESIRES OF LOCAL COMMUNITY.

THANK YOU!
MANY OF THESE BEHAVIORS HAVE ADAPTIVE QUALITY ENSURING
- SHORT-TERM SURVIVAL
- PERMIT THE VICTIM TO TAKE IN INFORMATION AT A CONTROLLABLE RATE