





Guidance Note on Recovery

PSYCHOSOCIAL



The Guidance Notes on Recovery: Psychosocial was developed as collaboration between the International Recovery Platform (IRP) and United Nations Development Programme India (UNDP-India). IRP acknowledges the leading work of George Haddow and Damon Coppola, the consultants who facilitated the development of this Guidance Note, Sanjaya Bhatia, Knowledge Management Officer of IRP (UNISDR), and Chihiro Wakamiya, the psychosocial focal person of IRP. In addition, many individuals and agencies contributed to the consultative process of workshops, peer reviews and the sharing of good practices and lessons learned from tools and country specific case studies. In particular, the guidance and expertise of Dr. Berthold P.R. Gersons (Emeritus Professor of Psychology AMC University of Amsterdam) and Prof. Peter G. Van Der Velden (Institute for Psychotrauma, the Netherlands) were instrumental. For a full list of acknowledgements please see Annex 6.

IRP was conceived at the World Conference on Disaster Reduction (WCDR) in Kobe, Hyogo, Japan in January 2005. As a thematic platform of the International Strategy for Disaster Reduction (ISDR) system, IRP is a key pillar for the implementation of the Hyogo Framework for Action (HFA) 2005-2015: Building the Resilience of Nations and Communities to Disasters, a global plan for disaster risk reduction for the decade adopted by 168 governments at the WCDR. The key role of IRP is to identify gaps and constraints experienced in post disaster recovery and to serve as a catalyst for the development of tools, resources, and capacity for resilient recovery. IRP aims to be an international source of knowledge on good recovery practice. IRP promotes "Build Back Better" approaches that not only restore what existed previously but also set communities on a better and safer development path and support development of enhanced recovery capacity at regional, national, and sub-national levels with particular focus on high-risk low-capacity countries.

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Introduction

Purpose

There is currently an abundance of documents, plans and policies that address common issues faced in the mitigation, preparedness and relief phases of natural disaster management. Yet for disaster recovery planners and policy makers, there is no cohesive documented body of knowledge. It is conceded that preventive measures are vital to reducing the more costly efforts of responding to disasters. Nevertheless, in the post disaster situation, the availability of knowledge products reflecting past practices and lessons learned is critical for effective and sustainable recovery. Unquestionably, a wealth of experience and expertise exists within governments and organizations; however the majority of this knowledge is never documented, compiled, nor shared. Filling this knowledge gap is a key objective of the International Recovery Platform and the Guidance Note on Recovery: Psychosocial, along with its companion booklets, is an initial step in documenting, collecting and sharing disaster recovery experiences and lessons. IRP hopes that this collection of the successes and failures of past experiences in disaster recovery will serve to inform the planning and implementation of future recovery initiatives. The aim is not to recommend actions, but to place before the reader a menu of options.

Audience

The Guidance Note on Recovery: Psychosocial is primarily intended for use by policymakers, planners, and implementers of local, regional and national government bodies interested or engaged in facilitating a more responsive, sustainable, and risk-reducing recovery process. Yet, IRP recognizes that governments are not the sole actors in disaster recovery and believes that the experiences collected in this document can benefit the many other partners working together to build back better.

Content

The Guidance Note on Recovery: Psychosocial draws from documented experiences of past and present recovery efforts, collected through a desk review and consultations with relevant experts. These experiences and lessons learned are classified into four major issues:

- Who May Need Psychosocial Programming
- Assessment
- Symptoms
- Psychosocial Programming
- Key Psychosocial Issues in Recovery
- Role of the Media

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The materials are presented in the form of cases. The document provides analysis of many of the cases, highlighting key lessons and noting points of caution and clarification. The case study format has been chosen in order to provide a richer description of recovery approaches, thus permitting the reader to draw other lessons or conclusions relative to a particular context.

It is recognized that, while certain activities or projects presented in this Guidance Note have met with success in a given context, there is no guarantee that the same activity will generate similar results across all contexts. Cultural norms, socioeconomic contexts, gender relations and myriad other factors will influence the process and outcome of any planned activity. Therefore, the following case studies are not intended as prescriptive solutions to be applied, but rather as experiences to inspire, to generate contextually relevant ideas, and where appropriate, to adapt and apply.

This guidance note draws on material from established publications in this field. No originality is claimed.

Introduction to Psychosocial Recovery



According to a Policy Brief entitled, "Guidelines on Management of Psychosocial Support and Mental Health Services in Disasters" authored by Dr. Jayakumar.C, Senior Specialist, National Disaster Management Authority and Lt Gen (Dr) J.R Bhardwaj, Member, National Disaster Management Authority, New Delhi:

India is vulnerable to natural, manmade disasters, prolonged conflicts and other complex situations that impede the country's overall development. Disasters are quite devastating and usually leave a trail of human agonies including loss of human life, livestock, property, and livelihood loss, physical injuries and damages to development works. Along with relief, rehabilitation and care of physical health and injuries, psychosocial and mental health issues are also important and they need to be addressed.

However, psychosocial and mental health issues are often not addressed in predisaster planning efforts.

The forecasting of a disaster occurring in a country is highly uncertain, but the level of risk involved can be ascertained especially when it is a matter of human lives. Risk is simply a product of the magnitude of vulnerabilities and the associated cost. Although, enough consideration is given to the social, economic and political consequences of a disaster, but little attention is paid to the risks and their psychological impact on citizens. (Source: Nidhi Maheshwari, V. Vineeth Kumar. "Psychological Risk-analysis of Terrorism).

The reality is that all individuals involved in a disaster are impacted by the disaster. This is especially true for children who suffer trauma in a disaster.

Box 1: Two Types of Trauma

There are two types of trauma – physical and mental. Physical trauma includes the body's response to serious injury and threat. Mental trauma includes frightening thoughts and painful feelings. They are the mind's response to serious injury. Mental trauma can produce strong feelings. It can also produce extreme behavior; such as intense fear or helplessness, withdrawal or detachment, lack of concentration,

irritability, sleep disturbance, aggression, hyper vigilance (intensely watching for more distressing events), or flashbacks (sense that event is reoccurring). A response could be fear. One could fear that a loved one will be hurt or killed. It is believed that more direct exposures to traumatic events causes greater harm. For instance, in a school shooting, an injured student will probably be more severely affected emotionally than a student who was in another part of the building. However, second-hand exposure to violence can also be traumatic. This includes witnessing violence such as seeing or hearing about death and destruction after a building is bombed or a plane crashes.

Source: Helping Children and Adolescents Cope with Violence and Disasters: What Parents Can Do. http://infocenter.nimh.nih.gov/pdf/helping-children-and-adolescents-cope-with-violence-and-disasters-what-parents-can-do.pdf

Case 1: Impact on children of NGO efforts, Indian Ocean Tsunami, 2004

Topic: Helping children

The psychological impact of a disaster is harder to see than the physical effect, yet recovery from it often takes far longer. Along with the unbearable feeling of loss, there is guilt at having survived, at not having been able to help more. The simplest of human gestures provide comfort- a hug, a listening ear, words of support. Yet, it is essentially difficult for children to understand what happened. They suffer nightmares, they react with tears. For these children, life will never be the same. The tsunami killed one or both of their parents and "home" is now the Anna Satya Orphanage in Nagappatanam. Run by the Indian government, the centre provides food and health care for 135 children. In Hambatota, many children lost their parents at the Sunday fair in the centre of town was swept away by the tsunami. The Sri Lanka and Danish Red Cross Societies provide psychosocial support to these new orphans. Most of them want to say something. Some try to. Some cannot. They are scared of the sea and of the dark. "These children will need time, understanding and a lot of love," says a Red Cross counselor.

Source: "Tsunami: A Tribute", 2005, IFRC and Red Crescent Societies, p.59-62.

Lessons:

- Children traumatized by a disaster have a difficult time explaining their fears and anxieties
- Time and personal attention are needed to help traumatized children cope with a disaster

Case 2: Integrating psychosocial programs into recovery; Healing the invisible scars of the Haiti earthquake, 2010

Topics: Work in Haiti post earthquake

Where to start? How do you describe crowds of suffering people; people who have lost family members, breadwinners, homes, livelihoods and all their belongings? How do you come to terms with the thought that within the collapsed building across the road, the bodies of 100 nursing students are buried?

Ea Akasha is a Red Cross Red Crescent psychosocial delegate in Port-au-Prince. Every night, she sits down and records her experiences in an attempt to make sense of what she has seen.

"I find it hard to describe what I see", she says.

Ea arrived in Haiti within days of the 12 January earthquake. "My days go by, working with our volunteers, planning psychosocial activities, and finding someone to take care of the children."

There is no shortage of doctors in the field hospitals that now dot post-earthquake Port-au-Prince. But neither is there a shortage of unaccompanied children. Some of them were orphaned in the quake, others separated from the parents or carers. Most – if not all of them – are severely distressed by the events of the past weeks.

So what is needed are people to care for them. That's where Ea and a team of trained Haitian Red Cross psychosocial volunteers come in.

"A two year old was brought to the hospital area yesterday," Ea explains. "She is handicapped and can't move but there is no one to feed her or talk to her except the Red Cross psychosocial volunteers and the mothers of the other children."

When she arrived, Ea's first task was to train these volunteers; most of them severely affected themselves. Their role is to give information and help survivors back upon their feet. "You can see that the psychosocial activities make a difference", Ea states.

For the first time ever, psychosocial support is integrated into the wider Red Cross Red Crescent relief operation. Psychosocial delegates and volunteers are working alongside doctors, nurses and paramedics. "I don't understand why this hasn't been done before," muses a paramedic.

Source: Hedinn Halldorsson, "Haiti: Healing the invisible scars of the earthquake", 1 February 2010, IFRC . http://www.ifrc.org/docs/news/10/10020101/index.asp

Lessons:

- In disasters, many doctors and nurses rush to the scene to treat physical injuries but few psychosocial staff are available at a disaster scene
- Need to train volunteers in psychosocial support
- Psychosocial support should be integrated into the overall medical treatment of disaster victims

Sub Issue 1: Why Psychosocial Issues are Important in Recovery

Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode normally protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality.

- Pre-existing social problems (e.g. extreme poverty; belonging to a group that is discriminated against or marginalized; political oppression)
- Emergency-induced social problems (e.g. family separation; disruption of social networks; destruction of community structures, resources and trust; increased gender-based violence)
- Humanitarian aid-induced social problems (e.g. undermining of community structures or traditional support mechanisms). Similarly, problems of a predominantly psychological nature include:
 - Pre-existing problems (e.g. severe mental disorder; alcohol abuse)
 - Emergency-induced problems (e.g. grief, non-pathological distress; depression and anxiety disorders, including post-traumatic stress disorder (PTSD))
 - ➤ Humanitarian aid-related problems (e.g. anxiety due to a lack of information about food distribution)

Thus, mental health and psychosocial problems in emergencies encompass far more than the experience of PTSD.

Case 3: Role of psychosocial programming in community recovery; Indian Red Cross Society tsunami recovery programme for the survivors of Kanyakymari District

Topic: Integrated Recovery Project

Psychosocial support activities for the recovery of the disaster survivors has gone a long way forward following the development of the specific guidelines on Mental Health and Psychosocial Support in Emergency Settings by IASC8 (2007). A tsunami recovery programme for the survivors of Kanyakymari District was developed by Indian Red Cross Society, supported by the American Red Cross considers an integrated approach of health and psychosocial support.

The Integrated Recovery Project covered 40 affected communities with 75,000 families and designed the maximum utilization of human resources, strengthening the capacities to build resiliency and improve psychosocial well-being. The community volunteers who are trained become the focal point to work with the communities and implement the Red Cross programme. Hence, community people participated in the assessment, monitoring and evaluation of the specific project activities so they could develop capacities of problem solving and decision making. To work with the schools, a representative body of the school community was formed.

This representative body, through participatory assessment, identified the needs for improving the psychosocial well-being and interventions that facilitated development of child friendly atmosphere, improving health and creating a culture of safety.

This intervention showed that using psychosocial support as a platform for integrated intervention to facilitate recovery is essential to ensure that the community assumes responsibility and makes initiatives and contributions for their development.

Source: Subhasis Bhadra, C.M. Patheepa. "Facilitating Recovery in the Communities through Psychosocial Support." Second India Disaster Management Congress. November 4-6, 2009. New Delhi, India. http://nidm.gov.in/idmc2/session_psycho_social.asp

Lessons:

- Red Cross created psychosocial guidelines for treatment of traumatized disaster victims
- Red Cross trained community volunteers to implement the program and to conduct assessment, monitoring and evaluation of the program activities

Sub Issue 2: Key Concepts

Key concepts of psychosocial and disaster mental health have been developed by several organizations. The following two case studies outline psychosocial concepts that place the goal and the role of psychosocial support after a disaster in perspective.

Box 2: Key Concepts of Psychosocial Support

The Inter-Agency Standing Committee, 2007, "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings" noted:

Human rights and equity

Humanitarian actors should promote the human rights of all affected persons and protect individuals and groups who are at heightened risk of human rights violations.

Participation

Humanitarian action should maximize the participation of local affected populations in the humanitarian response. Many key mental health and psychosocial supports come from affected communities themselves rather than from outside agencies. Affected communities include both displaced and host populations and typically consist of multiple groups, which may compete with one another. Participation should enable different sub-groups of local people to retain or resume control over decisions that affect their lives, and to build the sense of local ownership that is important for achieving programme quality, equity and sustainability.

Do no harm

Work on mental health and psychosocial support has the potential to cause harm because it deals with highly sensitive issues. Also, this work lacks the extensive scientific evidence that is available for some other disciplines. Humanitarian actors may reduce the risk of harm in various ways, such as:

- Participating in coordination groups to learn from others and to minimize duplication and gaps in response
- Designing interventions on the basis of sufficient information
- Committing to evaluation, openness to scrutiny and external review
- Developing cultural sensitivity and competence in the areas in which they intervene/work
- Staying updated on the evidence base regarding effective practices
- Developing an understanding of, and consistently reflecting on, universal human rights, power relations between outsiders and emergency-affected people, and the value of participatory approaches

Building on available resources and capacities

As described above, all affected groups have assets or resources that support mental health and psychosocial well-being. A key principle – even in the early stages of an emergency – is building local capacities, supporting self-help and strengthening the resources already present.

Integrated support systems

Activities and programming should be integrated as far as possible. The proliferation of stand-alone services, such as those dealing only with rape survivors or only with people with a specific diagnosis, such as PTSD, can create a highly fragmented care system. Activities that are integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc.) tend to reach more people, often are more sustainable, and tend to carry less stigma.

Multi-layered supports

In emergencies, people are affected in different ways and require different kinds of supports. A key to organizing mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. This may be illustrated by a pyramid. All layers of the pyramid are important and should ideally be implemented concurrently:

- Basic services and security
- Community and family supports
- Focused, non-specialized supports
- Specialized services

Source: Inter-Agency Standing Committee, 2007, "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings", p.9-13.

Box 3: Key Concepts of Disaster Mental Health

Topic: Key Concepts of Disaster Mental Health

The report "Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations" notes:

The following concepts should be adopted by all disaster mental health providers, including those serving culturally diverse survivors. The concepts can also help administrators and service providers set program priorities. The concepts deviate in some ways from those on which mental health work has traditionally been based. However, their validity has been confirmed again and again in disasters of various types that have affected a broad range of populations (DHHS, 2000a).

- No one who sees a disaster is untouched by it
- There are two types of disaster trauma—individual and community
- Most people pull together and function adequately during and after a disaster, but their effectiveness is diminished by the effects of the event
- Stress and grief in disasters are normal reactions to abnormal situations
- Many emotional reactions of disaster survivors stem from problems of daily living brought about by the disaster
- Disaster relief assistance may be confusing to some survivors. They may experience frustration, anger, and feelings of helplessness related to Federal, State, and private-sector disaster assistance programs
- Most people do not see themselves as needing mental health services following a disaster and will not seek such services
- Survivors may reject disaster assistance of all types
- Disaster mental health assistance is often more practical than psychological in nature
- Disaster mental health services must be tailored to the culture of communities where they are provided
- Mental health workers should set aside traditional methods, avoid mental health labels, and use an active outreach approach to intervene successfully in disaster
- Survivors respond to active, genuine interest, and concern
- Interventions must be appropriate to the phase of the disaster

Social support systems are crucial to recovery

Source: Box 3 - Jean Athey; Jean Moody-Williams. Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations. 2003. http://www.diversitypreparedness.org/Topic/Subtopic/Record-Detail/18/audienceld 15872/resourceld 16080/

Case 4: Role of government, building mental health infrastructure to provide disaster mental health services; California Center of Mental Health Services role in disasters

Topic: Pre-planning and action items

The State of California looks to the Center of Mental Health Services (CMHS) to provide national leadership and directions for policies, programs and activities designed to improve disaster mental health crisis counseling services following major disasters in California.

As response and recovery programs in California depend on federal support, when we begin to look at ways to enhance service delivery and how to facilitate a less burdensome response at the state and local level it is imperative that we communicate lessons learned to CMHS and FEMA to make way for changes in federal regulations and/or guidelines, technical assistance and training.

The experience of providing response and recovery programs following 317 major disasters since 1987 dictates that to meet future needs the Disaster Assistance Coordinator must continue to provide the following services:

- Encourage local mental health department to use the Standardized Emergency Management System
- Urge all counties to have a mental health plan in place and to participate in all countywide disaster drills
- Encourage county mental health departments to provide yearly in-service training on disaster mental health disaster principles, treatment modalities, and neighborhood disaster preparedness, offer training sessions to community emergency services works on the psychological impact of disaster; develop a volunteer roster; establish pre-disaster linkages with other agencies, such as law enforcement, fire department, Red Cross, schools, etc; have available for immediate dissemination outreach material including, but not limited to media releases, community flyers, hotline numbers; and be prepared to begin a needs assessment immediately following a disaster
- Provide consultation and technical assistance to local mental health agencies in the development and implementation of crisis counseling service programs for disaster victims
- Maintain a current roster of county designated coordination for emergency

mental health services

- Survey counties annually to ascertain preparedness, response and recovery capabilities
- Provide liaison with county mental health officials, and state and federal disaster agency staff
- Provide federal program application training to county mental health staff
- Participate on State Preliminary Damage Assessment Team
- Report to State/Regional Operations Centers and/or the Disaster Field Office (DFO) at the request of the Governor's Office of Emergency Services
- Assist counties in obtaining available disaster counseling funds
- Participate and assume mental health related responsibilities with federal, and local planning, response, recovery and mitigation workgroups/committees, i.e., Statewide the Emergency Planning Committee, Mass Care and Shelter Response Committee, Local Mental Health Coordinators Regional Workshops, FEMA Regional Interagency Steering Committee for California response Planning, CMHS/State Mental Counter-Terrorism Workgroup, etc.

Source: Fain, L., L., 'Emotional aftershocks/psychological effects', 1996 American Society of Civil Engineers (ASCE) International Conference and Exposition on Natural Disaster Reduction, 1996, p.319-320.

Lessons:

- It is important to support pre-disaster community mental health programs
- Conduct a survey pre-disaster to identify the preparedness status of community mental health programs
- Promote training for community mental health staff
- Include mental health issues and requirements in emergency planning at all levels

Case 5: Communicating with the community, Aceh, Indonesia, 2005

Topic: Communications tools and mechanisms

After reviewing existing self-care materials, national staffs from an international NGO were trained to conduct focus groups to identify what people were going through (common reactions) and what activities people used to cope with the stress.

An artist was contracted to draw pictures depicting people from Aceh in local dress, portraying concepts that the community had identified. Another set of pictures illustrated the deep breathing relaxation technique.

The brochures were explained and distributed during community gatherings, e.g. after evening prayers at the mosque. Brochures were also distributed to other organizations, which in turn distributed them through their intervention programs.

Through the psychosocial coordination group, agencies jointly continued producing newsletters with information that represented the concerns of tsunami affected communities and local civil society. A local NGO was funded and supervised to continue producing relevant newsletters.

Source: WHO, 2007.

 $http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_20$

07.pdf

Lessons:

- Identify mental health issues and coping mechanisms by talking to community members
- Create materials that help people cope with the impacts of a disaster
- Work together with local NGO(s) to implement mental health programs

Case 6: Developing a mental health monitoring and evaluation (M&E) system, El Salvador, 2001

Topic: Action items

Local authorities and a psychosocial community team from a local university and an international NGO set up an M&E system in a camp of 12,000 people affected by an earthquake.

The system gathered quantitative and qualitative data on mutual support, solidarity, security, leadership, decision-making processes, access to updated information, perception of authorities, employment, normalising activities, perception of community cohesion and perception of the future. The system involved a baseline survey with regular three-month follow-ups in a random sample of 75 tents. On each occasion, data was collected within a 24-hour period by five volunteers.

After three months, the M&E system detected a substantial decrease in perceived mutual support and solidarity. Appropriate measures were taken (e.g. rearrangement of the distribution of tents and cooking facilities, group activities). Three months later the survey showed an increase in confidence in leadership and decision making processes, indicating that the trend had been reversed.

Source: http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health psychosocial june 2007.pdf

Lessons:

Establish an effective Monitoring & Evaluation (M&E) system in the field in

order to detect problems and identify solutions

Use M&E system to measure results

Case 7: NGO recruiting and training psychosocial volunteers, Sri Lanka, 2005

Topic: Red Cross and Red Crescent Societies Program

After the December 2004 tsunami, national Red Cross and Red Crescent societies from numerous countries worked with the Sri Lankan Red Cross Society, making extensive use of local volunteers.

The national Red Cross/Red Crescent societies collaborated to develop a common psychosocial support framework for the Sri Lankan Red Cross Society.

All relevant staff and volunteers engaged by the movement were trained according to similar principles, including training in working with cultural resources to provide community support. Because resources were invested in hiring and training staff and volunteers, there is now an enhanced understanding in the country of the positive effects of community-based psychosocial work.

Source: WHO, 2007.

 $http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_20\\ 07.pdf$

Lessons:

- Use local volunteers to implement psychosocial program
- Develop and implement a common psychosocial support framework
- Train volunteers

It should be noted that not all psychosocial interventions are undertaken postdisaster by psychosocial workers. There are numerous means for identifying and reducing stress factors that result from the impact of a disaster on individual victims and mental health workers. Prof. Dr. Berthold P.R. Gersons and Prof. Dr. Peter G. van der Velden note that

One of the primary aims, in addition to medical help, of the total disaster response is reducing and eliminating (perceived) sources of stress as much as possible during the aftermath. By reducing these sources, stress-reactions can be reduced as much as possible. To give some small examples: providing medicines for people who lost their medicines due to the disaster, offering new housing for those who lost their homes, introducing working-shifts for rescue workers and medical personnel will help decrease related stress-reactions. They all can be seen as psychosocial interventions, but are not undertaken by psychosocial workers.

The Guidance Notes have more information in the following chapters:

- Chapter 2: Who May Need Psychosocial Programming Anyone involved in a disaster is susceptible to some degree of emotional and psychological impact. This chapter identifies the wide variety of individuals who may be impacted by a disaster and require some form of mental health assistance including: children, women, men, injured individuals, special needs populations, disaster workers and volunteers, community level workers, the elderly, etc.
- Chapter 3: Assessment This chapter details basic information concerning how individuals can be assessed to determine the emotional and psychological impacts of a disaster on them. Additional information on assessment can be found in Annex 1 and Annex 3.
- Chapter 4: Symptoms This chapter briefly examines the symptoms that can be expected when dealing with individuals who have been traumatized by an emergency event.
- Chapter 5: Psychosocial Programming This chapter examines the wide variety of programs employed in various locales to provide psychosocial programming to impacted populations. Basic data and case studies are provided for communities/individuals, families, youth volunteers, children, the elderly, special needs populations, crisis counseling for adults, and disaster workers and volunteers.
- Chapter 6: Key Psychosocial Issues in Recovery This chapter identifies a
 number of issues that influence psychosocial programming including cultural
 issues, training, reunifying families, and documenting and remembering
 what happened.
- Chapter 7: Role of the Media This chapter discusses the critical role the
 media plays in helping to disseminate information to disaster survivors and
 their recovery efforts. Case studies are provided that examine a variety of
 media-related issues including cultural issues in media, media impact, media
 multiple stories, and media outreach to special needs populations.
- Annexes There are seven annexes at the end of this document.

Who May Need Psychosocial Programming



Anyone involved in a disaster is susceptible to some degree of emotional and psychological impact. This section identifies the wide variety of individuals who may be impacted by a disaster and require some form of mental health assistance including: children, women, men, injured individuals, special needs populations, disaster workers and volunteers, community level workers, elderly, etc.

According to the "Psychological First Aid: Field Operations Guide, 2nd Edition" developed by the National Child Traumatic Stress Network and National Center for PTSD, in emergencies, not everyone has or develops significant psychological problems. Many people show resilience, that is the ability to cope relatively well in situations of adversity. There are numerous interacting social, psychological and biological factors that influence whether people develop psychological problems or exhibit resilience in the face of adversity. Depending on the emergency context, particular groups of people are at increased risk of experiencing social and/or psychological problems. Although many key forms of support should be available to the emergency-affected population in general, good programming specifically includes the provision of relevant supports to the people at greatest risk, who need to be identified for each specific crisis. All sub-groups of a population can potentially be at risk, depending on the nature of the crisis. The following are groups of people who frequently have been shown to be at increased risk of various problems in diverse emergencies:

Examples of at-risk people:

- Children (From newborn infants to young people 18 years of age)
 - Separated from parents/caregivers (separated or unaccompanied children (including orphans)
 - Whose parents/caregivers, family members, or friends have died
 - Whose parents/caregivers were significantly injured or are missing
 - Involved in the foster care system
 - Recruited or used by armed forces or groups

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- Trafficked children
- Children in conflict with the law
- Children engaged in dangerous labour
- Children who live or work on the streets and undernourished/under stimulated children;
- Those who have been injured
- Those who have had multiple relocations and displacements
- Medically frail children and adults
- Those with serious mental illness
- Those with physical disability, illness, or sensory deficit
- Adolescents who may be risk-takers
- Adolescents and adults with substance abuse problems
- Women
 - Pregnant women
 - Mothers with babies and small children
 - Single mothers
 - Widows
 - In some cultures, unmarried adult women and teenage girls
- Men
 - > Ex-combatants
 - > Idle men who have lost the means to take care of their families
 - Young men at risk of detention
 - Abduction or being targets of violence
- Elderly people (especially when they have lost family members who were care-givers)
- Disaster response personnel
- Those with significant loss of possessions (for example, home, pets, family memorabilia)
- Those exposed first hand to grotesque scenes or extreme life threat
- Extremely poor people
- Refugees, internally displaced persons (IDPs) and migrants in irregular

situations (especially trafficked women and children without identification papers)

- People who have been exposed to extremely stressful events/trauma (e.g. people who have lost close family members or their entire livelihoods, rape and torture survivors, witnesses of atrocities, etc.)
- People in the community with pre-existing, severe physical, neurological or mental disabilities or disorders
- People in institutions (orphans, elderly people, people with neurological/mental disabilities or disorders)
- People experiencing severe social stigma (e.g. untouchables/dalit, commercial sex workers, people with severe mental disorders, survivors of sexual violence)
- People at specific risk of human rights violations (e.g. political activists, ethnic
 or linguistic minorities, people in institutions or detention, people already
 exposed to human rights violations)

It is important to recognize that:

- There is large diversity of risks, problems and resources within and across each of the groups mentioned above
- Some individuals within an at-risk group may fare relatively well
- Some groups (e.g. combatants) may be simultaneously at increased risk of some problems (e.g. substance abuse) and at reduced risk of other problems (e.g. starvation)
- Some groups may be at risk in one emergency, while being relatively privileged in another emergency

Where one group is at risk, other groups are often at risk as well. To identify people as 'at risk' is not to suggest that they are passive victims. Although at-risk people need support, they often have capacities and social networks that enable them to contribute to their families and to be active in social, religious and political life. Especially in economically disadvantaged groups, a high percentage of survivors may have experienced prior traumatic events (for example, death of a loved one, assault, disaster). As a consequence, minority and marginalized communities may have higher rates of preexisting trauma-related mental health problems, and are at greater risk for developing problems following disaster. Mistrust, stigma, fear (for example, of deportation), and lack of knowledge about disaster relief services are important barriers to seeking, providing, and receiving services for these populations. Those living in disaster-prone regions are more likely to have had prior disaster experiences.

Source: National Child Traumatic Stress Network and National Center for PTSD, *Psychological First Aid: Field Operations Guide*, 2nd Edition, July 2006, p.9

A study conducted in Bahraich district, Uttar Pradesh "collected data from flood affected and non flood affected populations. There was a vast negative impact of the recurrent floods in Bahraich district on mental health outcomes. There were large to very large differences between the flood affected group and the control group on anxiety, depression and total distress. Further, compared to the control group, the flood affected group scored lower on functioning and especially low on domains of psychological functioning. The study reveals that the primary stressors were economic factors such as loss of land, crop, livelihood and assets leading to food and job insecurity. Furthermore, due to superficial state support, the families were forced to seek private loans which resulted in long term indebtedness

Source: Khattri P.1, Joshi P.C.2, Wind T.3, Komproe I.H.4 and Guha-Sapir D.5, *Melnat Health Impacts of Recurrent Flooding: Evidence from Bahraich District, Uttar* Pradesh, Abstract submitted to 2nd India Disaster Management Congress, New Delhi, 4-6 November, 2009

Case 8: Integrated, holistic care is required to heal individuals impacted by a disaster; Victims of the Great Hanshin-Awaji Earthquake, 1995

Topic: Team care for disaster victims at the Kobe Red Cross hospital

In 1996, the Kobe Red Cross Hospital established the Department of Psychosomatic Internal Medicine, in response to the health needs of the victims of the 1995 Great Hanshin-Awaji Earthquake who were experiencing psychosomatic symptoms.

Five years after the earthquake, 37% of our patient responses confirmed the link of stress with the earthquake by choosing "largely related" (13%) or "somewhat related" (24%). Ten years after the earthquake, the number had not been reduced, but had instead increased to 39% ("largely related," 9%, and "somewhat related," 30%). 65% of those who had suffered significant damage reported their illness as "largely related" to their experience of earthquake damage and similarly, 68% of those who experienced big changes in their lives reported the same. These results imply the possibility of an existing undiagnosed and unrecognized group of psychosomatically ill patients due to the Great Hanshin-Awaji Earthquake after so many years.

The victims experience continuous generalized or integrated pain: Physical pain from injuries and illness: Psychological pain such as fear, anxiety, anger or depression; Social pain from destruction or damage to their houses, job loss, worsening of the financial situation, or loss of their community; and also Spiritual pain such as confusion about the meaning of life or wondering whether or not there is a God. In order to care for patients with such bio-psycho-socio-spiritual pains, we must provide comprehensive team care by networking not only with medical and psychological specialists but also with various other professions. Resources from welfare, administration, education, nonprofit organizations, and mass media must be pooled to create a functional network to give appropriate support. One lesson we learned is the necessity of providing integrated long-term intervention. To prevent

psychosomatic disorders, holistic care should be continuously provided, not only during the emergency phase, but also for an extended period afterwards.

Source: N. Murakami, Y. Ozasa, S. Muramatsu, S. Nakayama, M, Fukunaga, and Y. Nakai, 2007, 'The Health of Victims of the Great Hanshin-Awaji Earthquake: A Psychosomatic Perspective', "Japanese Journal of Disaster Medicine", vol.12, No.2.

Lessons:

- Individuals who experienced significant property damage were also the most stressed by the disaster
- It is necessary to provide long-term integrated approach to psychosocial intervention

Case 9: Stress on individuals and family caused by relocation 3 years after the earthquake, Managua, 1972

Topic: Examination of impacts caused by social and physical changes

The 1972 earthquake completely destroyed this central core area of Managua and heavily damaged the surrounding residential areas. Eighty percent of the structures in the city were destroyed, including all the hospitals with their equipment. Loss of life was high, with the death toll reaching an estimated 10,000 individuals. Another 20 thousand residents were severely injured and required medical attention which was not immediately available. An estimated fifty percent of the capital population was dislocated by the earthquake resulting in extreme overcrowding in neighboring towns and villages.

In the following three years, following the earthquake, the post disaster impact could be characterized by severe changes in life style. These were associated with the destruction of the city, the knowledge, experience, and the memory left of this event; the loss of life of dear ones; and the painful relocation experiences and loss of employment.

Physical Changes as they Impact Psycho-Social Adaptation

The socio-physical Managua no longer exists. The citizens' concept of the city is rooted in the past, and, today, represents an unfamiliar, albeit, safer, area of residence. There is no central area today as Managua is a series of dispersed neighborhoods, each with its own commercial shopping area.

Managuans still use old reference points in giving directions, although these may no longer exist. Even though old reference points have been destroyed by the earthquake, they are commonly used, oftentimes creating confusion to the listener, if the original reference point, for instance, a church, has been rebuilt at a different location. Physical changes of the neighborhood get superimposed on the familiar internalized memory of the known places and remembered as buildings standing still

in the past.

The infrastructure of Managua, its parks, churches, clubs, bars, and schools were destroyed. Each of the social structures were the vehicle for citizens to participate in certain types of activity influencing behavior, customs and a continuation of tradition.

Three years later, there are many replacements of these structures, some rebuilt, others new and unfamiliar, but in many cases, they are located further away distance. Community supports have been altered and residents search for ways to adopt and accept new or renewed forms of finding expression for work and recreation. Children attend different schools, families go to brand new churches, and fathers frequent a remodeled bar. The rapidity and completeness of the new physical and geographical changes have had a deep impact on these families.

Many new neighborhoods have been built, providing housing but, these changes have produced a variety of added stresses. First, the economic increase in the cost of housing has risen rapidly so that families have had to downgrade some of the comforts that they used to enjoy. Secondly, new neighborhoods do not provide the social interaction among friends and neighbors which existed, presenting new needs to reshape emotional bonds. Thirdly, as there is lower social interaction in the new neighborhoods, there is little sharing and few experiences of mutual social support.

Residents who return to their former neighborhoods do not face all the stresses of residents in the new settings.

 $Source: Raquel\ E.\ Cohen,\ Frederick\ L.\ Ahearn,\ "Post-Disaster\ Impact:\ Socio-Psychological\ Consequences\ of\ the\ Managua,\ Nicaragua,\ Earthquake-1979"$

http://raquelcohendisaster.com/Materials/Postdisaster%20Managua.htm

Lessons:

- Losing geographical references in a community can cause stress among disaster victims
- More study is needed on the impact of changes in the geography of a community caused by a disaster on community members

Disaster workers often work beyond their physical and emotional capacities especially in the early days of a disaster. This can lead to mental health issues that these workers are likely to ignore and/or fail to report or recognize.

Box 4: Stress is a large factor in the workplace for nurses

Topic: Nurses prone to ignore impacts of stress

It is generally believed that many nurses are strenuous workers with a strong sense of responsibility. Even in a distressing situation such as a disaster, nurses try to help grieving victims and solve their problems. More often than not, nurses try to handle everything by themselves without seeking help. Nurses working at the shelters tend

to neglect their own lives and families. They often fail to recognize their physical and mental fatigue; or, even if they notice such a condition, sometimes they might not be able to take any time off. Many nurses feel guilty about taking a break from work or receiving assistance, out of professional conscience.

Source: Information Base for Disaster Nursing Knowledge and Skills to Protect Lives http://www.coecnas.jp/english/index.html

Lessons:

- Nurses working in disasters tend to ignore their own lives and families and this can affect their work
- Nurses feel guilty about taking breaks and getting proper rest and need help in taking care of themselves

Case 10: Disaster workers energy levels and relief worker's self-care

Topic: Workers tire after 1-2 weeks in disaster

Quotes from health workers:

I think the fatigue of staff was at its peak about one week after the earthquake. I thought we should not have felt "I have to be here" and "should have taken rest.

We felt that we had to act as a leader because we are the health workers in the impacted area. We were exhausted after two weeks. Once the counseling started we conferred with assistant health workers from outside. I said that we had no power to continue. Replies from assistants were encouraging. They said "How can we assist you to continue your work?"

Source: Documents from Emergency Workshop "Psychological relief in the disaster situation" from Shizuoka Prefectural Earthquake Preparedness Education Center, "Mental Health Care Manual in disaster or accident situation", 2003, Shizuoka Prefecture. P.30. http://www.equakes.pref.shizuoka.jp/hondana/pdf/e03-2003/index.htm

Lessons:

- Emergency workers work until they are exhausted
- Outside mental health staff needed to help identify and address relief worker fatigue issues

Case 11: Stressors for firefighters after the response to Hurricane Katrina, 2005

Topic: Physical symptoms related to mental health issues

In August and September 2005, hurricanes Katrina and Rita made landfall in the United States, passing within miles of New Orleans, LA. Heavy winds and rain

damaged and breached levees protecting the city. These levee breaches resulted in flooding of up to 80% of the city, with water reaching a depth of 20 ft in some areas. When the hurricanes made landfall in New Orleans, more than 600 career firefighters worked for the New Orleans Fire Department (NOFD). Because of the flooding in sections of New Orleans, a number of fire stations were closed and relocated to temporary headquarters until the floodwater receded. During and after the hurricanes, firefighters participated in rescue and recovery activities and continued normal fire suppression duties. Because of the vast devastation and limited personnel, firefighters worked long hours, and many were separated from their families.

Following the hurricanes, the NOFD received anecdotal reports from firefighters about health symptoms suggestive of depression and anxiety including physical health symptoms. Firefighters were dealing with work-related stressors, such as extended working hours, sleep deprivation, violent threats, and lack of communication with coworkers. Many also experienced personal stressors, such as displacement of family members, destruction of their homes, and lack of communication with families.

The prevalence of respiratory symptoms and skin rashes reported by NOFD firefighters are similar to those found among relief workers reported through the Centers for Disease Control and Prevention active surveillance system in the Greater New Orleans area after the hurricanes. Depressive symptoms were twice as likely among those with either lower respiratory symptoms or skin rash. Coexistence of depression and physical symptoms has been reported in several studies.

Source: Tak, Driscoll, Bernard, and West, 'Depressive Symptoms among Firefighters and Related Factors after the Response to Hurricane Katrina', "Journal of Urban Health", 2007 March; 84(2): 153–161. http://www.ncbi.nlm.nih.gov/pmc/articles/ PMC2231627/

Lessons:

- Community firefighters experienced stress from their job, responding to a disaster and from the impact of the disaster on them and their families
- Stressed firefighters exhibited respiratory symptoms and skin rashes that could be the sign of depression

Case 12: Post-traumatic stress among Marmara Earthquake survivors involved in disaster preparedness as volunteers, Turkey, 1999

Topic: Reaction of NGO workers to the scope of disasters

This study examined the impact of being a volunteer in a nongovernmental disaster preparedness organization, combined with pre-disaster, during disaster and post-disaster variables, on post-traumatic stress growth among the survivors of the 1999 Marmara earthquake.

The results showed that earthquake experience severity can be grouped by perceived severity of impact and perceived life threat, while coping consisted of problem-focused, fatalistic, helplessness and escape coping approaches. Possible factors that may be related to growth were examined with regression analyses. The results showed that, using problem solving/optimistic and fatalistic coping, and being a disaster preparedness volunteer are significant predictors of post-traumatic growth.

Source: Nuray A. Karanci, 2005, "Post-Traumatic Growth among Marmara Earthquake Survivors Involved in Disaster Preparedness as Volunteers", Traumatology, Vol. 11, No. 4, 307-323.

Lessons:

- There are a variety of coping mechanisms used by NGO workers in a disaster
- Problem solving, coping and being a disaster preparedness volunteer helped individuals deal with stress

Case 13: Disaster worker's feeling of inadequacy, Hanshin-Awaji Earthquake, 1995

Topic: Fireman's lament for failing to save more people

An exhibition of pictures taken by the Kobe city firemen recording the Hanshin-Awaji earthquake was held in Kobe city office. A fireman who visited said that he can never forget the disappointment of failing to save people during the rescue.

Source: Kobe news paper, January 20th. 2010. Kobe Shinbun January 20, 2010

Lesson:

Perceived failure in saving lives can cause stress among disaster workers

Individuals with special needs (i.e. the elderly, persons with physical disabilities, mental health disabilities, hearing impaired, vision problems, etc.) can be especially susceptible to emotional and physiological issues in a disaster.

Case 14: Social vulnerabilities and feeling left behind in Orissa, India

Topic: Counseling required for persons with disabilities

A counseling and guidance all for the PWDs (Persons with disabilities) in districts is to be set up to provide psychosocial support during disasters. This center needs to work in coordination with the district administration.

Most victims of cyclone/floods suffer from trauma, grief and worry about losses to their families and property. Some can cope, some totally breakdown. The disabled are under more stress as they may not able to see or hear but are aware that there is a disaster. The counseling team needs to identify such people and help them cope. Members of the group need to be trained in counseling techniques.

Psychological support to the affected persons could be done by NGOs in coordination with the district administration.

Policy Recommendations

Key Issue: Inclusion of persons with disabilities in disaster planning

Topic: Actions to be taken to include disabled issues in disaster planning

The PWD (Persons with Disabilities) Act 1995 requires for equal access to people with disabilities to all government programs. This includes inclusion in all disaster plans developed for a community.

- Disabled to be included in all Government activities
- Conduct more research and provide legal services: Disability related research and legal services on disaster issues are scarce, but if available can point the way to practical solutions
- Make it official: Disability issues are non-existent in the Orissa Relief Code, which is the main guideline for management of natural disasters. This needs change. There is no national guideline on disability and disaster management
- Lack of instruction for PWDs in emergency situations, in particular for preparedness and training in facing calamities. General instructions are available but lack a component for disabled persons
- A liaison group between the government and the community: To keep the local authorities informed about the preparedness of the disabled in the village and put forward the needs of disabled

Illicit Sexual Relations and Trafficking

Key Issue: Disabled individuals not equipped to deal with disaster impacts

Topic: Two stories of individuals impacted by disasters

Many young widows, unmarried destitute girls, adolescent girls either develop illicit sexual relations (as mark of gratitude willingly or forcedly) or are being trafficked. The possibilities of sexual exploitation are higher in categories of mentally challenged & deaf dumb girl because mentally challenged girls do not understand its consequences where as deaf-dumb girl can not protest orally.

(Example Story) Reena, a 23 year old blind girl lost her entire family in the disaster. She was left all alone to live her rest of life. She found herself helpless. She was surrounded by tension, anxiety, guilt, grief, depression, frustration, stress etc. A young man — Anil started catering for her psychological, social, emotional and economic needs. Later they developed a physical relationship and she became pregnant. After sometime Anil started avoiding Reena and one day left and never came back. Now Reena feels unhappy, sad and guilty. She does not believe/trust any man.

Somatoform Disorders

Somatoform disorders involve the expression of psychological conflict in physical symptoms that have no medical basis. Individual can show motor disturbances, sensory disturbances, symptoms that simulate physical illness or complicated physical illness. They are the product of conflict or stress, which, instead of being expressed through emotional outlets, takes a physical route of expression. A supportive therapeutic relationship is seen as the most effective method to deal with these symptoms.

Source: Hans, A, Ram Kishore Sharma, R.L., Mohanty, R, Mishra, P, 2005, "Training Manual for Inclusion of Disability in Disaster Response", Shanta Memorial Rehabilitation Center (SMRC), Bhubaneswar, Orissa, India. http://www.preventionweb.net/files/9707_trainingmanual.

Lessons:

- Elderly and disabled individuals are more likely to feel left behind during disaster recovery
- Do not forget to provide psychosocial support to disabled individuals postdisaster
- Trained staff are critical to helping those individuals who have difficulty communicating their distress
- Disabled females are more susceptible to exploitation post-disaster

Chapter 3

Assessment

This chapter details basic information concerning how individuals can be assessed to determine the emotional and psychological impacts of a disaster on them. Additional information on assessment can be found in Annex 1 and Annex 3.

A manual developed for the World Health Organization provides the following guidance for assessing the psychosocial needs of individuals and communities:

In most emergency situations attention first goes to "the body." How many have died? How many are injured? What about food, clothing and shelter? Most help addresses these aspects. In addition to all the well meaning and much required physical help, we must remember **what affects the body, affects the mind too.**

Providing psychosocial support in disaster situation aims at:

- Helping people deal with difficult feelings in difficult times.
- Helping people cope with loss.
- Assisting people in adjusting to their environment and to other survivors.

Sensitizing towards the disaster situation

Disasters are unforeseen situations which catch us off-guard. What we **CAN** do is to **MANAGE** a disaster situation in the best possible manner.

- Disasters are events on which we have little or no control
- Such situations bring with them an acute feeling of helplessness.
- We face small 'disasters' in our day to day lives, e.g. spilling tea on important papers, road accidents
- We employ available resources and our support system to deal with these everyday 'disaster' situations
- In a disaster like flood, tsunami, earthquake, etc., where a large community is involved the traditional coping resources are challenged
- Thus the need for providing external support, material, social and psychological

Disasters can be sudden and overwhelming. In addition to the often catastrophic toll on lives and property, a disaster like a tsunami, earthquake or fire, also brings a flood of emotional reactions. How people deal with these emotional reactions may affect their recovery afterwards.

What to expect?

It is common for people who have experienced traumatic situations to have **very strong emotional reactions.** Understanding normal responses to these abnormal events can aid in coping with feelings, thoughts, and behaviors, and help along the path to recovery.

Shock and denial are typical responses to large-scale natural disasters, especially shortly after the event. Both shock and denial are normal, protective reactions.

Shock is a sudden and often intense disturbance of the emotional state that may leave one feeling stunned and dazed. Denial involves not acknowledging that something very stressful has happened, or not experiencing fully the intensity of the event. The person may temporarily feel numb or disconnected.

As the initial shock subsides, reactions vary form one person to another. Many people survive disasters without developing significant psychological symptoms. Others, however, may have a difficult time "getting over it." Survivors of trauma have reported a wide range of psychological problems including:

- Feeling low
- Alcohol and drug abuse
- Lingering symptoms of fear and anxiety

All of these reactions make it hard to work or go to school, cause family stress, and marital conflicts.

The following are normal responses to a traumatic event:

- Feelings become intense and sometimes are unpredictable. Moods become
 more irritable than usual, and you're likely to see the mood change back and
 forth dramatically. You will come across people who are especially anxious or
 nervous or even depressed.
- Thoughts and behavior patterns are affected by the trauma. Repeated and
 vivid memories of the event are common. These flashbacks may occur for no
 apparent reason and led to physical reactions such as rapid heartbeat or
 sweating. People may find it difficult to concentrate or make decisions, or
 become more easily confused. Sleep and eating patterns may also be
 disrupted.
- Recurring emotional reactions are common. Anniversaries of the event, such as at one month or one year, as well as reminders such as aftershocks from earthquakes or the sound of sirens, can trigger upsetting memories of

the traumatic experience. These 'triggers' may be accompanied by fears that the stressful event will be repeated.

- Interpersonal relationships often become strained. Greater conflict, such as
 more frequent arguments with family members and coworkers, is common.
 On the other hand, there could be people who are withdrawn and isolated,
 and who avoid usual activities
- Physical symptoms may accompany the extreme stress. For example, headaches, nausea and chest pain may result and may require medical attention. Pre-existing medical conditions may worsen due to the stress.
- Survivors' Guilt. Many survivors question why they survived and someone
 else perished, particularly when their survival seems to have more to do with
 coincidence or luck than some conscious choice. This reaction is called
 "survivor guilt" and it is a very normal response to a traumatic event. It is
 difficult for human beings to feel grateful for being alive, while at the same
 time feeling intense sorrow for those who did not survive.

How do people respond differently overtime?

It is important for you to realize that there is not one standard pattern of reaction to the extreme stress of traumatic experiences. Some people respond immediately, while others have delayed reactions – sometimes months or even years later. Some have adverse effects for a long period of time, while others recover rather quickly. Remember that a disaster is an abnormal situation, warranting abnormal reactions and additionally our usual coping mechanisms and support systems have been adversely affected.

Reactions can change overtime. Some who suffer from trauma are energized initially by the event to help them with the challenge of coping, only to later become discouraged or depressed.

Source: Maheshwari, Surabhika, Dr. Cherian Varghese, Dr. Kavita Venkataraman. "Manual for Facilitators." World Health Organization.

Psychological service assessment may be defined as evaluation of the impact of a disaster at a particular time on individuals, families and communities, with the purpose of determining needs for psychological service interventions. Assessment is a continuing process from pre-impact to healing. It is a complex, dynamic multidimensional inquiry which takes into account adaptive and maladaptive biological, psychological and social responses to threats of survival and to what is cherished in life.

Have children recovered their expected developmental phases and their sense of security, belonging and future? Have they grieved their losses and readjusted to new relationships, homes, friends, schools and routines? Have they done so on a deep

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level, or only superficially to please adults? Have their earlier symptoms resolved, are they more chronic, or have new ones developed? What sense can be made of the symptoms, relating to which manner of survival in what context?

Ultimately, have the children absorbed the story and meaning of the disaster into their lives in a way which is no longer threatening? Or has it radiated fear into their lives? Having made assessments of disaster affected populations one can plan and execute interventions."

Source: Emergency Management Australia: Guidelines for Psychological Service Practice. MENTAL HEALTH PRACTITIONERS GUIDE. 2003.

 $http://www.ag.gov.au/www/emaweb/RWPAttach.nsf/VAP/(3273BD3F76A7A5DEDAE36942A54D7D90)^{\sim} Manual26-GuidelinesforPsychologicalServices-MentalHealthPractitionersGuide.pdf/$file/Manual26-GuidelinesforPsychologicalServices-MentalHealthPractitionersGuide.pdf$

Case 15: Assessing mental health of disaster survivors, Usu volcano, March 2000

Topic: Plan for mental health team assessment practices: Round team system

A "Round team" worked around the shelters. The role of this team was:

- to decide the method of consultation or care
- advice or guidance for volunteers
- assessment for mental health care needs
- mental health care education for IDPs

Various professionals joined the mental health team to cope with not only medical treatment but also everyday problems. The round team constituted of doctors, nurses, psychiatric social workers, etc. They partnered with the Red Cross Psychological care center and shared information from early stages of recovery.

Source: "Hokkaido: Handbook for Psychosocial care activity in disaster situation" 2005, Hokkaido, p.51-58. (In Japanese) http://www.pref.hokkaido.lg.jp/hf/sfc/saigai9.htm http://www.pref.hokkaido.lg.jp/hf/sfc/saigaimokuji.htm

Lesson:

 The team approach to consultation and assessment and working with volunteers is effective

Chapter

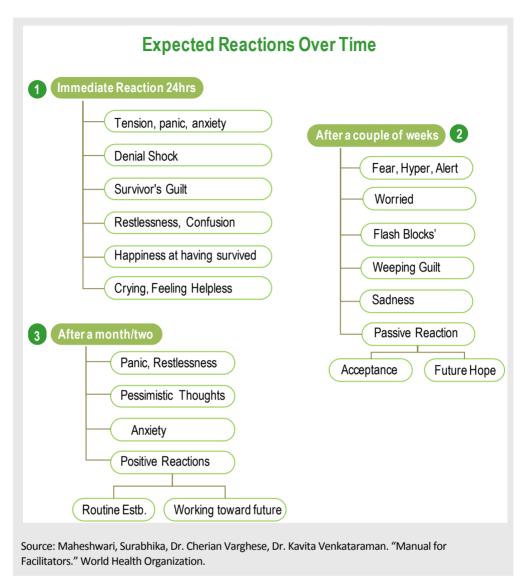
Symptoms

This chapter briefly examines the symptoms that can be expected when dealing with individuals who have been traumatized by an event.

The World Health Organizations provides the following guidance on recognizing symptoms of psychological stress.

No one who sees a disaster is untouched by it. All the people affected, need help to recover from the disaster. Helping people to come to terms with the disaster and normalizing the impact are the key aspects. Pay special attention to:

- People having symptoms/problems like restlessness, panic, sleep disturbances, nightmares, frequent recollection of traumatic events and frequent crying
- The ones who are seen to remain isolated/withdrawn most of the time and show no overt interest in the activities going on around them
- Individuals showing reluctance to communicate when approached
- People who have significant losses (like death of family members)



Case 16: Identifying individuals at risk and factors that can mediate that risk; Effects of Hurricane Mitch on mental health of the Honduran adult population, 1998.

Topic: Study of hurricane survivors

Hurricane Mitch ravaged Central America beginning on 25 October 1998. Honduras suffered the worst efforts of this natural disaster. The Pan American Health Organization (PAHO/WHO) and the Honduran government estimated that more than 1.5 million people were affected, 5,657 died, another 8,058 were missing, and 12,272 were injured. Some 285,000 were made homeless and had to seek housing in one of the 1,375 temporary shelters established. However, there has been little information about the effects of the disaster on the mental health of the population.

The impact of a disaster on mental health is the result of several factors that need to

be considered, such as the death and disappearance of family members, neighbors, and friends. Research has demonstrated that disaster can give rise to grief, post-traumatic stress, and other psychiatric disorders, a combination of these reactions, or no problems. Other disorders, such as violent behavior, may present as well. This can evolve toward chronic disorders or to resolution of the acute reaction. Change in conditions, biological and psychological predisposition, occupation and sociodemographic factors, cultural elements, the quality of relationship with the deceased, the nature of the intervention, confirmation of death versus presumed death, and social support causes results to vary.

The mental health of the Honduran population will require continuous surveillance in order to determine the long-term impacts of Hurricane Mitch. Recovery can be prevented by secondary stress can be more vulnerable and have higher indices of post-traumatic stress, greater depression, disability, and psychological discomfort. It is necessary to identify the individuals at risk and factors that can mediate that risk, so that services and appropriate interventions can be implemented.

Source: Rodriguez J, Bergonzoli G, Levav I, "Violencia politic y salud mental en Guatemala" *Acta Psiquiatrica y Psicologica de America Latina*, 2002; 48; 43-4.

Pan American Health Organization and World Health Organization, 2004, Management of Dead Bodies in Disaster Situations: Disaster Manuals and Guidelines, No.5, p. 117-119.

Lessons:

- Factors to be considered in measuring the impact of a disaster on mental health include death and disappearance of family members, neighbors and friends
- Grief, post-traumatic stress and other psychiatric disorders can arise from a disaster
- Greater depression, disability and psychosocial discomfort are additional symptoms of stress

Case 17: Alcohol Consumption in the aftermath of disaster, Tornadoes in Minnesota, U.S.A., 1998

Topic: Developing interventions to curb adolescent drinking in response to a disaster

On 29 March 1998, a series of category F-3 and F-4 tornadoes caused wide-spread destruction in four rural southern Minnesota counties in the United States. Extensive research has examined the impact of disaster exposure on adults' psychological functioning, including alcohol use. However, there has been little research on potential risk factors for adolescents' alcohol use following disaster exposure.

This study provides some preliminary data on alcohol use among disaster-exposed adolescents. Despite the widespread destruction and disruption posed by disaster to

this community, it is important to note that most adolescents refrained from drinking. However, a number of risk factors were identified that appear to contribute to adolescents' alcohol use. Specifically, we found that age, prior alcohol related negative consequences, and the extent of adolescents' prior trauma history significantly predicted binge drinking following this natural disaster. Adolescents who reported increased alcohol use following the tornado had a greater likelihood of having a more extensive prior trauma history and greater disaster-related post-traumatic symptomatology.

Developing interventions to curb adolescent drinking in response to disaster or other trauma exposure is important. The findings of the current study provide some suggestions for the development of post-disaster interventions that target post-traumatic symptomatology and alcohol use among adolescents. Based on risk factors identified in this study, interventions might be most effective if targeted at older adolescents who are already drinking or experiencing negative alcohol-related consequences. Moreover, it is important that prevention and intervention efforts target adolescents with previous trauma histories, since the results of this study suggest that recent disaster exposure may serve to exacerbate symptoms related to earlier traumatic experiences.

Source: Schroeder, J. M. and Polusny, M.A., 2004, "Risk Factors for Adolescent Alcohol Use Following a Natural Disaster", Prehospital and Disaster Medicine, Vol.19 (1), p.122-127. http://pdm.medicine.wisc.edu/Volume 19/issue 1/schroeder.pdf

Lessons:

- Binge drinking among adolescents can increase post-disaster
- Target adolescents with previous drinking issues and alcohol-related consequences for treatment for binge drinking post-disaster
- Also target adolescents with previous trauma because disasters can exacerbate previous traumas

Case 18: Stress symptoms and management for Community Level Workers (CLWs)

Topic: Stress Symptoms

Symptom of stress of the Community Level Workers

- CLWs had number of symptoms of stress due to disaster rehabilitation work

 change in routines, loss of interest in sex, catch colds and virus frequently,
 drink tea, coffee more than usual, feel depleted spiritually, emotionally and
 physically
- Frequent moodiness, irritability, impatience was reported more often and 'Little or no enthusiasm for job'

GUIDANCE NOTE ON RECOVERY: PSYCHOSOCIAL

- Higher age group reported lower symptoms of stress
- Regarding place of residence there is difference observed among the affected and non affected areas. In the item income of the respondents, respondents with lower income had more symptoms of stress and respondents with higher income reported less stress symptoms

Source: "Stress management for community level workers in disaster rehabilitation services." Jayakumar.C, Research Officer & Professor K. Sekar, Department of psychiatric social work. NIMHANS, Bangalore

Lessons:

- Stress symptoms include lack of interest in sex, catching colds and viruses and feeling spiritually, emotionally and physically depleted
- Older CLWs reported less stress symptoms
- Individuals with higher incomes reported less stress than those with lower incomes

Psychosocial Programming



This chapter examines the wide variety of programs employed in various locales to provide psychosocial programming to impacted populations. Basic data and case studies are provided for communities/individuals, families, youth volunteers, children, elderly, special needs populations, crisis counseling for adults, and, disaster workers and volunteers.

The World Health Organization provides the following guidance for providing psychosocial programming.

Offering psychological support to disaster affected individuals is not a onetime activity. Understand it as an emotional contract, a continuous and time taking activity. It can be understood as being friends with individuals to help them cope with their loss.

General Guidelines

- Provide practical help in dealing with the disaster. Help friend or family pack
 or clean up. Help with arranging the meals. Store belongings or provide a
 place to stay. Parents may be very busy, offer to spend some time with
 children to play and listen to their concerns. Offer specific types of help or
 ask how you can help.
- Listen. One of the best ways you can help is to listen. You don't have to come up with solutions or answers. It's okay if someone breaks down and cries. Others will ask "Why me?" They are not really looking for an answer but expressing their pain.
- Show by words and actions you care. Go ahead and act. Don't be afraid of saying or doing the wrong thing. A friendly arm around troubled shoulders or a few words of support and encouragement can help in a time of crisis.
 Small, kind deeds and sincere expressions of affection or admiration also will mean a lot.
- **Keep helping.** The disruptions caused by the disaster may continue for some time. Recovering may take even longer. Survivors will need regular, small acts of kindness to maintain their morale and to put their lives back together.

Source: Maheshwari, Surabhika, Dr. Cherian Varghese, Dr. Kavita Venkataraman. "Manual for Facilitators." World Health Organization.

According to the "Psychological First Aid: Field Operations Guide, 2nd Edition" developed by the National Child Traumatic Stress Network and National Center for PTSD, there are "Some Behaviors to Avoid as a Professional" when trying to help people impacted by a disaster.

- Do not make assumptions about what survivors are experiencing or what they have been through
- Do not assume that everyone exposed to a disaster will be traumatized
- Do not pathologize. Most acute reactions are understandable and expectable given what people exposed to the disaster have experienced. Do not label reactions as "symptoms," or speak in terms of "diagnoses," "conditions," "pathologies," or "disorders"
- Do not talk down to or patronize the survivor, or focus on his/her helplessness, weaknesses, mistakes, or disability. Focus instead on what the person has done that is effective or may have contributed to helping others in need, both during the disaster and in the present setting
- Do not assume that all survivors want to talk or need to talk to you. Often, being physically present in a supportive and calm way helps affected people feel safer and more able to cope
- Do not "debrief" by asking for details of what happened
- Do not speculate or offer possibly inaccurate information. If you cannot answer a survivor's question, do your best to learn the facts

Source: National Child Traumatic Stress Network and National Center for PTSD, "Psychological First Aid: Field Operations Guide, 2nd Edition". July, 2006, .6-7.

According to the National Child Traumatic Stress Network and National Center for PTSD's "Psychological First Aid: Field Operations Guide, 2nd Edition" psychosocial workers should engage in the following "core actions."

Core Actions:

- Contact and Engagement Goal: To respond to contacts initiated by survivors, or to initiate contacts in a non- intrusive, compassionate, and helpful manner
- 2. Safety and Comfort Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort
- 3. Stabilization (if needed) Goal: To calm and orient emotionally

overwhelmed or disoriented survivors

- 4. Information Gathering: Current Needs and Concerns Goal: To identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid interventions
- 5. Practical Assistance Goal: To offer practical help to survivors in addressing immediate needs and concerns
- 6. Connection with Social Supports Goal: To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community helping resources
- 7. Information on Coping Goal: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning
- 8. Linkage with Collaborative Services Goal: To link survivors with available services needed at the time or in the future

Source: National Child Traumatic Stress Network and National Center for PTSD, "Psychological First Aid: Field Operations Guide, 2nd Edition." July, 2006, p.10.

I. Psychosocial first aid:

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

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

II. Trauma Counseling

This basically means creating safe opportunities for people to focus their thoughts, talk about them and express associated feelings.

III. Grief Counseling:

This is a technique similar to 'trauma counseling': but modified to help bereaved survivors (i.e. those who have lost their close ones). The person is gently encouraged to talk about his lost relatives. This will hasten the process of mourning and its resolution.

IV. Anticipatory Guidance:

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

V. Crisis Counseling:

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

VI. Problem solving counseling

You can help survivors by providing counseling in finding solution to problems in a systematic way rather than avoiding the problem or reacting to the problem inappropriately.

Source: World Health Organization, 2005, "Psychosocial Care of Tsunami-Affected Populations: Manual for Community Level Workers", Regional Office for South-East Asia, New Delhi.

Sub Issue 1: Communities/Individuals

Social support networks are critical to providing effective psychosocial programming. The United State Federal Emergency Management Agency (FEMA) and the American Red Cross have noted that "Parents help their children when they take steps to understand and manage their own feelings and ways of coping. They can do this by building and using social support systems of family, friends, community organizations and agencies, faith-based institutions, or other resources that work for that family. Parents can build their own unique social support systems so that in an emergency situation or when a disaster strikes, they can be supported and helped to manage their reactions. As a result, parents will be more available to their children and better able to support them. Parents are almost always the best source of support for

children in difficult times. But to support their children, parents need to attend to their own needs and have a plan for their own support. Preparing for disaster helps everyone in the family accept the fact that disasters do happen, and provides an opportunity to identify and collect the resources needed to meet basic needs after disaster. Preparation helps; when people feel prepared, they cope better and so do children.

Source: FEMA, American Red Cross, "Helping Children Cope with Disaster", 2004, p. 6-7. http://www.fema.gov/pdf/library/children.pdf

The International Federation Reference Centre for Psychosocial Support created a "Community-based psychosocial support - A training kit" that builds on experiences of psychosocial work of the Red Cross Red Crescent Movement in the last decade from all over the world. It consists of a Trainer's book, a Participant's book and a CD-ROM with the Trainer's and Participant's books, PowerPoint slides and a template.

The training programme in psychosocial support seeks to:

- Heighten awareness regarding psychosocial reactions
- Improve preparedness and response to disasters
- Facilitate psychosocial support before, during and after disasters
- Promote resilience of individuals and communities
- Improve emotional assistance to staff and volunteers

The Trainer's book provides instructions on how to train workshop participants in the community-based psychosocial support modules located in the Participant's book. All seven modules in the Participant's book can be used as a complete training programme on basic psychosocial support skills. Alternatively single modules can be used for more specific training needs.

All guidance for trainers as well as the text in the participant's modules and power point slides is general and will need to be adapted to the particular cultural context the training is conducted in.

Source: "Community-based psychosocial support: Trainer's book", 2009, International Federation Reference Centre for Psychosocial Support. http://psp.drk.dk/graphics/2003referencecenter/Docman/Documents/docs/Trainers%20book.pdf

Case 19: Community activities support community resiliency, Cyclone Nargis, Myanmar,

Topic: Summary of community activities conducted

Community activities such as sport, singing, dancing and cooking-oriented competitions continue. The activities are aimed at developing self-reliance and resilience among affected communities. A total of 27 community activities were held between May and early August this year. The activities were conducted in eight to

ten townships every month, and benefited an estimated 11,300 people comprising both participants and onlookers. Activities are slowing down however due to the agricultural seasonal work and difficulties in finding appropriate venues to conduct activities during the monsoon season.

Integration with cash-for-work

Psychosocial support integration with the cash-for-work programme started in January this year and continued until the end of the programme in May. During this period, psychosocial support was integrated with various cash-for-work projects in seven townships on 21 occasions. Approximately 800 people as well as onlookers benefited from this approach. The integration took different forms – sometimes, staff and volunteers addressed the cash-for-work participants and other villagers at the end of the day, upon the conclusion of cash-for-work activities. Messages and knowledge on stress and coping were promoted during such sessions. On other occasions, hub staff and volunteers addressed villagers gathered near (but who were not participating in) cash-for-work activities, and sometimes played with the children of villagers working on the cash-for-work projects. Information, education and communication materials were also distributed and elaborated on during these occasions – they comprised posters on self-care and peer support, and brochures on how to address sleeping disorders following a disaster and how to take care of children affected by disasters.

Recreational kits

The tender process for 667 recreational kits is ongoing. The kits are scheduled for distribution to the field in September and will be sent to child-based institutions. The kits include story books, drawing books, board games and music instruments. The recreational kits were preceded by community kits - the distribution of a total of 668 kits to the 13 townships targeted under the Appeal, began in February and ended in June. They are meant for communities as a whole, to increase socialization and wellbeing. Contents include radios, batteries, and volleyball and badminton sets. In general, each village was presented with one kit – however, some large villages were presented with two kits. Since early July, the MRCS psychosocial support coordinator has increased travel to the field, meeting with health teams and affected communities to get updates on the progress of activities, as well as insights into needs.

Community preparedness for disasters

In response to the increased level of anxiety among communities due to the monsoon season (May to October), a mapping exercise (involving both health and disaster preparedness and disaster risk reduction activities) was conducted, with the aim of developing a community-based plan of action on 'dos and don'ts' in case of a disaster. The PSP team also provided support to the MRCS communications unit in the development of information for radio broadcasts. Discussions regarding broadcasting messages on disaster preparedness are ongoing with relevant

authorities and the media.

Community participation

The utilization of trained community volunteers such as village leaders, monks, nuns and teachers continues to be the strongest asset of the psychosocial support programme. Community participation, particularly in community activities such as competitions, is also substantial, owing to the culturally-acceptable interventions.

Capacity building

The psychosocial support programme's strong training component owes to the long-term commitment of the MRCS towards it. Furthermore, psychosocial support comes under the purview of the MRCS training unit – hence the strong emphasis on training and the availability of very experienced trainers. The final training-of-trainers (TOT) session for MRCS field staff (2 i-cs16 and health officers) and volunteers (Red Cross volunteers and community volunteers), was completed in May, bringing the total number of TOT-trained persons to 170. Multiplier training for community volunteers was also slowly phased out during this period and a total of 450 persons have received this training. A series of refresher training has been planned for 2009-2011. Training curriculum and facilitators notes have been drafted and are currently being tested before finalization.

Redirection of community-based activities

While the need to redirect community-based activities in order to address community resilience and self-reliance more efficiently and directly has been identified, an alternative to current activities has not yet been found. The expected change of direction has necessitated more field travel for the MRCS coordinator to monitor activities closely, and develop strategies for the future. In response to the MRCS decision to strengthen the Nargis psychosocial support programme, discussions are underway between the International Federation and the MRCS, on the type and numbers of personnel needed to meet this objective.

Source: IFRC, "Operations update" 9th October, 2009, 'Myanmar: Cyclone Nargis', Emergency Appeal, p. 14-16.

Lessons:

- Integrate psychosocial support with other recovery programs
- Include trained community volunteers in psychosocial support
- Build a cadre of trained volunteers
- Institutional support critical to long-term success

Topic: Critical steps in community mobilization

Recognition by community members that they have a common concern and

will be more effective if they work together (i.e. 'We need to support each other to deal with this')

- Development of the sense of responsibility and ownership that comes with this recognition ('This is happening to us and we can do something about it')
- Identification of internal community resources and knowledge, and individual skills and talents ('Who can do, or is already doing, what; what resources do we have; what else can we do?')
- Identification of priority issues ('What we're really concerned about is...')
- Community members plan and manage activities using their internal resources
- Growing capacity of community members to continue and increase the effectiveness of this action

Adapted from Donahue and Williamson (1999), Community Mobilization to Mitigate the Impacts of HIV/AIDS, Displaced Children and Orphans Fund; Inter-Agency Standing Committee, 2007, "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings", p. 95.

Case 20: Counseling for disaster survivors, Sri Lanka

Topic: NGO provision of trauma counseling and psychosocial programming

The Indian Ocean Tsunami devastated three quarters of the coastline of Sri Lanka. At its worst, in the early stages, there were nearly a million displaced persons whose homes were completely destroyed and washed away.

MERCY Malaysia began the response with their Psychosocial Support programs, which covered trauma counseling as well as psychosocial activities. MERCY Malaysia made conscientious efforts to deploy Tamil speaking mental health support volunteers in order that the help would fully benefit the beneficiaries. Five hundred out of the 2,000 survivors who were counseled by their volunteers were children. With the children, MERCY Malaysia volunteers provided counseling through art and play therapy. MERCY Malaysia's volunteers visited the communities living in IDP camps. Psychosocial intervention was given on an individual basis, in family groups as well as in the form of community counseling sessions. The volunteers also developed artwork and informative posters illustrating facts on tsunamis. Knowledge of tsunamis and lessons on preparedness has helped the communities tremendously in dealing with their experiences.

Source: "A Time to Heal: a Reflection of MERCY Malaysia's Response to the Indian Ocean Tsunami", 2005, MERCY Malaysia, p.197-198.

Lessons:

Deploy psychosocial volunteers who speak the local language

- Art and play therapy used with children
- Psychosocial intervention took place on individual, family and community levels
- Knowledge of the risk (tsunami) and lessons on preparedness help individuals and communities to deal with their experiences in a disaster

Case 21: Measures for psychosocial support and coping with trauma, Tsunami, Thailand, 2004

Topic: Actions of the Department of Mental Health

The tragedy of tsunami that struck Thailand on 26 December 2004 took a psychological toll on both adults and children. Post-disaster trauma made it difficult for affected people to get back to a normal life; disruption and lack of livelihoods and employment compounded the problem. The Department of Mental Health launched a sustained effort to support those who were affected in dealing with the trauma and stress of having lived though the disaster.

It mobilized staff response teams with psychiatrists, psychologists, social workers, nurses and pharmacists covering each affected district. These teams provided individual and group counseling as well as medication for those in need. Home visits are currently conducted on a weekly basis, and the programme is scheduled to continue with monthly visits for two years. Relatives of the missing or deceased who need follow up services, even in provinces not affected by the tsunami, are referred for follow-up in their home province.

A Mental Health Centre was opened near Khao Lak in March 2005. Response teams based at this centre deliver interventions and rehabilitation support and monitor tsunami survivors, particularly in the worst affected areas. DOMH also arranged outreach to schools to expand psychological education to assist in coping with trauma. Counseling, drugs and treatment have been provided to victims.

Source: "Tsunami Thailand: One Year Later, National Response and Contribution of International Partners", 2005, United Nations Country team in Thailand Office of the UN Resident Coordinator, p.30-31.

The Department of Mental Health, Ministry of Public Health, November 2005, www.dmh.go.th/english, Project of continuous provision of mental intervention and rehabilitation for tsunami victims, the Department of Mental Health, Ministry of Public Health, January 2005.

Lessons:

- Post-disaster trauma makes it difficult for individuals to return to normal life
- Team approach includes psychiatrists, psychologists, social workers, nurses and pharmacists
- Interventions include home visits, and individual and group counseling
- Opening a mental health center expanded the reach of the psychosocial

interventions

Case 22: Community recovery from earthquake, Great Hanshin-Awaji Earthquake, 1995

Topic: Community and social activities

Victims who had trouble facing drastic changes in their living environments and relationships increased, as did those who tended to confine themselves to their homes. In disaster stricken areas, initiatives were undertaken to help victims recover both physically and mentally through meaningful and fun activities. Social activities were conducted to prevent elderly residents living alone from becoming isolated from their communities. In addition, art and cultural activities were organized soon after the earthquake, and these touched the hearts of victims and provided them strength. In order to stabilize and revive normal day-to-day living after disaster, it is important to develop activities in which community members cooperate with one another and support the community.

Source: The Great Hanshin-Awaji Earthquake Memorial, Disaster Reduction and Human Renovation Institution "Lessons from the Great Hanshin-Awaji Earthquake", 2005, World Conference on Disaster Reduction, p. 16.

Lessons:

- Disasters add stress to existing stressful living environments and relationships
- Conduct activities that will prevent elderly residents from living in isolation post-disaster
- Important to develop activities in which community members cooperate with one another and support the community

Case 23: Engaging with other people and cultural activities is a source of strength, Great Hanshin-Awaji Earthquake, Kobe, Japan, 1995

Topic: Social and community activities

In the region affected by the Great Hanshin-Awaji Earthquake uplifting catch phrases "Cheer up, Kobe" and meet-and-greet activities intended to lend encouragement to the participants, along with participation in health, art, cultural and sporting activities, and establishment of Kobe Luminarie, an event initiated after the earthquake that is now held annually each winter, enabled all the people affected by the disaster to remain determined to continue with reconstruction and allowed them to face many difficulties. Engaging with people and cultural activities provides strength to victims. Restoring connections among people is an important key to rebuilding lives.

Source: The Great Hanshin-Awaji Earthquake Memorial, Disaster Reduction and Human Renovation Institution "Lessons from the Great Hanshin-Awaji Earthquake", 2005, World Conference on Disaster

Reduction, p.14.

Lesson:

 Cultural and community activities and celebrations can help raise the spirits of victims of disasters

Case 24: Alternative livelihoods, Andaman Islands, Tsunami

Topic: Training villagers to become Masons

The Andaman and Nicobar Islands are a remote archipelago in the Indian Ocean, lying some 1,200km from the Indian mainland. Many of the islands are populated by indigenous peoples. Over 3,500 people died when the tsunami struck and more than 5,000 are still missing. Some 40,000 people are living in transitional shelters.

With the logistical difficulties faced by all the agencies working there, it was soon realized that people would have to spend at least 18 months in transitional shelters. However, the early transitional shelters had been built with a much shorter timeframe in mind, and had floors made of earth.

Oxfam started a cash for work programme that provided better flooring in 162 transitional shelters. This was done through full community participation. The community suggested that some of its members should be trained as masons to do the flooring work. Fifteen masons were trained, including two women, one disabled person, and one blind person. These masons, and the laborers who work with them (a total of 45 laborers, 13 of whom are women), are all from the tsunami-affected communities. Although work on these shelters is complete, the masons are now being employed to do similar work by other NGOs and government agencies.

Source: "Back to work: How people are recovering their livelihoods 12 months after the tsunami", Oxfam Briefing Paper., p.1, 15. 2006.

Lesson:

 Training individuals and paying them to conduct recovery activities is one way to reduce stress

Case 25: Embroidery center assistance rooted in tradition and livelihood: Tokouen City Sichuan province, China

Topic: Victim's self-help

"Gathering the victims and alleviating their economic anxiety leads to psychosocial care" said one woman. She said folk dance class and music classes are also available.

Mr. Tominaga, JICA mission member, said that "the embroidery center is rooted in tradition-"Syokus embroidery" which has more than three thousand years' history

and "Chyan embroidery." It helps in psychosocial care"

Source: Kobe Newspaper (2010/02/10) http://www.kobe np.co.jp/ rentoku/shakai/201002kokoro/ 02. shtml

Lesson:

 Psychosocial care can take place in the form of traditional community activities

Case 26: Waiting for aid instead of organizing self-help, Earthquakes in El Salvador

Topic: Government guidance holds back community recovery

In 2001, there were two severe earthquakes in El Salvador within a few weeks. More than 26% of the population became homeless, and in many villages, the population had to move into tents. Schools were closed. On government instructions, the people waited for the army to arrive so that they could start clearing up and reconstructing houses. However, the rainy season was close and new dangers were foreseeable. Meanwhile, staff of aid organizations painted pictures with the children and played sports with them. Schools remained closed as it did not occur to teachers that biology and geography could possibly be better taught in the open air. The children naturally enjoyed all of this, but neither they nor their parents were really taken seriously. Instead of encouraging them to improve their situation, e.g. by digging water drains as a protective measure against flooding during the rainy season, they were left to wait. Instead of giving the children a chance to participate in self-help, they played games. Instead of addressing trauma and anxiety, this authoritarian support strategy confirmed the survivors' dependency and helplessness and thus degraded their psychosocial situation.

Source: Becker, D. & Weyermann, B., 2006, "Gender, Conflict Transformation & The Psychosocial Approach: Toolkit", Swiss Agency for Development and Cooperation (SDC) and Federal Department of Foreign Affairs (DFA). p.164.

Lessons:

- Do not wait for guidance from government to move forward in recovery and psychosocial support
- Government's lack of direction and community reluctance to act without government guidance exacerbated stress and anxiety levels in the community

Case 27: Migrant farm workers employed as outreach workers, El Nino, California, U.S.A., 1998

Topic: Helping migrants recover

In 1998, El Niño caused a series of storms that devastated many California

communities. The storms affected a large number of migrant farm workers, including many in Ventura County. The migrant workers were unwilling to seek help because of cultural proscriptions and language barriers. Some were illiterate. To improve its ability to assist the migrant workers, Ventura County's disaster crisis counseling project hired peer farm laborers. These workers, who had contacts and credibility within the migrant community, enabled the project to establish a unique communication model to reach farm laborers. The peer counselors went into labor camps and met with the victims of the rains and their indigenous leaders. Local residents noted that these were the first "government" workers in recent memory to be allowed in the farm workers' camp.

Source: "Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations", 2003, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Mental Health Services, p.26.

 $http://download.ncadi.samhsa.gov/ken/pdf/SMA03-3828/CulturalCompetence_FINAL with covers.pdf$

Lessons:

- Some individuals are unwilling to seek help because of cultural or language barriers
- Recruit and train psychosocial volunteers from the peer group because they have credibility and contacts within that peer group

Sub Issue 2: Families

Case 28: Assistance to parents, Hanshin-Awaji Earthquake

Topic: Programming for children

There were some ways to cope with the psychosocial care for children: child mental health doctors cared for suffering children via phone and case workers visited the school area and collected information about the children.

Pediatrics doctor also visited the school area. A place for psychosocial care for children was set up in the school area.

Sources: "The Great Hanshin-Awaji earthquake: Kobe City Child Heart Counseling 110" Report, Vol.2, 1996, Kobe City. P.13-14, 19, 23, 25, 28. (in Japanese).

Spenser, E. and Robert, S.P., 1985, *Post-Traumatic Stress Disorder in Children*, American Psychiatric Press. Moritani, Sugiura, Irie, and Tanaka, 1993, Introduction to Collage Treatment, Sogensha (in Japanese).

Lesson:

 Helping children cope included care from a mental health doctor, case worker who visited the school and a pediatric doctor

Case 29: Workshop for mother and child, Post Earthquake Kobe 1995-1996

Topic: Programming for mothers and children

Utilizing knowledge, skills and the personal network gained from the first workshop, the author participated in community-based debriefing group work project organized by the Kobe City Child Guidance Clinic from November 1995 to March 1996. The project aimed at mothers of preschool age children. A team consisting of a social worker, a clinical psychologist and psychiatrist instigated an out-reach program to local preschools.

The program started with a public lecture on stress and coping, followed by the participation of the audience in the "six piece story" technique. The six pieces of the story consist of 1) a main character, 2) a mission, 3) a thing or person that will assist in the accomplishing of the mission, 4) an obstacle, 5) a means to overcome the obstacle, and 6) and ending. This is a projective technique to identify individual coping styles is based on Lahad and Chohen's BASIC-Ph (Affect, Social, Imagination, Cognition, and Physical) model. Lehad and Cohen (1989) suggest that the most favored coping resources were projected to each individual's story writing. The story writing exercise and scoring of coping styles helped to reveal the strength and positive resources that each preschool mother mobilized in order to alleviate the impact of disaster related stressors. The debriefing group work followed in order to alleviate the impact of disaster debriefing session, information concerning the coping styles was explained as evidence of each participant's strength and healthy functioning. Thus, this debriefing group work not only ventilated the participants' affect and provided psychoeducation regarding stress responses, but also facilitated the positive reappraisal of the situation and the self.

Source: Lahad, M., & Cohen, A., 1989, 'BASIC-Ph: The Study of Coping Resources'. In M. Lehad (Ed.) "Community Stress Prevention, Col.2." Kiryat Shmona, Israel: Center For Emergency.

Tatsuki, S., 'A life-modeled social work practice with earthquake victims; phase specific responses during crisis and post-crisis periods', "The 5th United States/Japan Workshop on Urban Earthquake Hazard Reduction", p.339-341, 1997, Earthquake Engineering Research Institute.

Lessons:

- Outreach program developed by social worker, clinical psychologist and psychiatrist
- Activities included lecture on stress and coping and six piece story activity designed to allow participants to vent and reappraise their situation
- Stressed mothers cause stress for their children and they reduce this stress in order to help their children

Sub Issue 3: Youth Volunteers

Case 30: Youth helping families to recover, IFRC Youth Award - Together for humanity: Reducing the impact from disasters - Return of Happiness - Costa Rica Red Cross

Topic: Programming involving young people

"Return of Happiness", the programme presented by the youth of the Costa Rica Red Cross was winner of the Youth Award 2007. In the response to a disaster, youth volunteers are mobilized to ensure psycho-social support to the vulnerable groups, especially children, with particular focus on child protection. They also made efforts to ensure that members of the affected communities participate as social actors and that they made their voices heard in the reconstruction phase. The special attention given to the training of youth volunteers, close cooperation with UNICEF as well as with the Psychosocial Support Unit of the National Society, and the prompt mobilization of the youth volunteers in the local communities resulted in increased motivation of the youth volunteers. This makes the programme highly sustainable and contributes to rebuilding the local communities.

This youth programme complements the work of the Costa Rica Red Cross when responding to a disaster, and thanks to the approach of "with, for and by youth", the quality of the services to children increases whereas in the past they were often the "silent victims" and therefore particularly at risk.

Source: "IFRC Youth Award - Together for humanity: Reducing the impact from disasters: Return of Happiness - Costa Rica Red Cross" http://www.ifrc.org/youth/development/award/2007/disaster.asp

Lessons:

- Youth volunteers can be mobilized to help provide psychosocial support to vulnerable groups especially children
- Youth volunteers must be trained
- Support from UNICEF motivated youth volunteers and helped the community recover

Sub Issue 4: Children

The World Health Organization provides the following guidance for dealing with children in the aftermath of an emergency.

When helping a child

The intense anxiety and fear that often follows a disaster can be especially troubling for surviving children, especially if other children were victims of the disaster. Some may demonstrate younger behaviors such as thumb sucking or bed wetting. Children may be more prone to nightmares and fear of sleeping alone. Performance in school may suffer. Other changes in behavior patterns may include throwing tantrums more

frequently, or withdrawing.

After a disaster, children typically feel confusion and fear.

Confusion:

- What happened?
- How did it happen?

Fear:

- The event will happen again
- Someone will be injured or killed
- They will be separated from the family
- They will be left alone

There are several things parents, care givers, and you as a volunteer can do to help reduce the emotional consequences of trauma, including the following:

- Ensure the child is safe and is being looked after by a caring responsible adult
- Children cope best in their natural environment. As far as possible do not institutionalize or adopt the child out
- Be sensitive to knowing that a child often finds a toy/object/photograph comforting and that they may choose to wear or carry it around with them constantly
- Ensure regular monitoring of children who have been orphaned; check where they sleep; what their activities have been during the day and whether they feel safe
- Provide resources for children to play with, to occupy themselves or to express themselves through
- Arrange informal gatherings for children at places close to their families or new home-bases so that children have an opportunity to play and talk together
- Listen to children's stories. Often children are more comfortable expressing their feelings and experiences through make-believe stories or by using objects
- Encourage young people to take up a useful role of their choice, to help in the healing process

ACTIVITY SUGGESTIONS WITH CHILDREN Facilitate expression: Children can find it difficult to express emotions and difficult feelings. Various mediums can be used to help children feel less vulnerable and safer Drawing Writing Group Discussions Use puppets and stories Goal oriented activity: such activities help foster confidence and directed behavior Collage making Small repairs

Source: Maheshwari, Surabhika, Dr. Cherian Varghese, Dr. Kavita Venkataraman. "Manual for Facilitators." World Health Organization.

The National Child Traumatic Stress Network and National Center for PTSD's, "Psychological First Aid: Field Operations Guide, 2nd Edition" on "Working with Children and Adolescents" includes some key tips for working with children.

- For young children, sit or crouch at the child's eye level
- Help school-age children verbalize their feelings, concerns and questions; provide simple labels for common emotional reactions (for example, mad, sad, scared, and worried)
- Do not use extreme words like "terrified" or "horrified" because this may increase their distress
- Listen carefully and check in with the child to make sure you understand him/her
- Be aware that children may show developmental regression in their behavior

and use of language

- Match your language to the child's developmental level. Younger children typically have less understanding of abstract concepts like "death." Use direct and simple language as much as possible
- Talk to adolescents "adult-to-adult," so you give the message that you
 respect their feelings, concerns, and questions
- Reinforce these techniques with the child's parents/caregivers to help them provide appropriate emotional support to their child

Source: National Child Traumatic Stress Network and National Center for PTSD, "Psychological First Aid: Field Operations Guide, 2nd Edition". July, 2006, p.6-7.

Case 31: Play areas for children in IDP camps, Angola, 1999-2000

Topic: Children coping with disasters

Young children in IDP camps had few activities available, and parents spent little time interacting with young children.

Having identified adults whom local people sought out for advice and help with young children, an international NGO provided training on how to organize age and gender-appropriate activities that provided stimulation and promoted positive social interaction.

Although there were no schools or other centers, local participants conducted activities under the shade of trees, engaged mothers in the activities and made referrals for children needing special assistance. These activities benefited several thousand mothers and children.

Source: National Child Traumatic Stress Network and National Center for PTSD, "Psychological First Aid: Field Operations Guide, 2nd Edition". July, 2006. p.115.

Lessons:

- Children in IDP camps do not receive enough attention from adults
- NGO recruits and trains IDP camp residents to work with children
- No need for a structure to engage children in activities can happen outdoors

Children living temporarily in an emergency shelter need a space where they can just be children. Setting-up a "Child-Friendly Space" involves the following.

- Help to create a designated child-friendly space, such as a corner or a room that is safe, out of high traffic areas, and away from rescue activities
- Arrange for this space to be staffed by caregivers with experience and skill in

working with children of different ages

- Monitor who comes in and out of the child area to ensure that children do not leave with an unauthorized person
- Stock the child-friendly space with materials for all age ranges. This can include kits with toys, playing cards, board games, balls, paper, crayons, markers, books, safety scissors, tape, and glue
- Activities that are calming include playing with Legos, wooden building blocks, or play dough, doing cut-outs, working on coloring books (containing neutral scenes of flowers, rainbows, trees, or cute animals) and playing team games
- Invite older children or adolescents to serve as mentors/role models for younger children, as appropriate. They can do this by helping you conduct group play activities with younger children, or by reading a book to them or playing with them
- Set aside a special time for adolescents to get together to talk about their concerns, and to engage in age-appropriate activities like listening to music, playing games, making up and telling stories, or making a scrapbook

Source: Brymer M, Jacobs A, Layne C, Pynoos R, Ruzek J, Steinberg A, Vernberg E, Watson P, (National Child Traumatic Stress Network and National Center for PTSD). Psychological First Aid. Field Operations Guide 2nd Edition, National Child Traumatic Stress Network National Center for PTSD. 2006. http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA 2ndEditionwithappendices.pdf

Case 32: Helping children cope with an earthquake: 1 Year After China Sichuan Earthquake. 2008

Topic: Child Friendly Spaces

Field missions by UNICEF and counterparts in the days following the Wenchuan earthquake found an urgent need for professional psychosocial support and community-based protection services for children affected by the earthquake. Many children had been displaced by the earthquake and were living in makeshift camps with limited supervision, thereby exposing them to a high risk of abuse, neglect and danger. While there was keen interest in providing psychosocial support to children, services were being provided in a sporadic and uncoordinated manner, often by unqualified volunteers or by professionals who had little or no experience in emergencies. Based on these findings, UNICEF and the National Working Committee on Children and Women decided to establish 34 Child Friendly Spaces in camps and temporary shelters to provide children with integrated psychosocial support and protection services in a safe and healing environment. When the Panzhihua earthquake struck in August 2008, the decision was made to establish an additional 6 Child Friendly Spaces in the new earthquake zone, resulting in a total of 40 Child Friendly Spaces in 21 counties in Sichuan Province. The Child Friendly Spaces are located within the most affected communities where the needs and risks are the greatest. UNICEF has provided the Child Friendly Spaces with toys, library books, sports equipment, furniture, and prefabricated structures. UNICEF has also worked with counterparts to provide extensive capacity building to the staff of the Child Friendly Spaces, helping them to deliver psychosocial support and implement structured play and recreation activities for earthquake-affected children. The security and continuity that Child Friendly Spaces provide are critical to the long-term psychosocial recovery and well-being of children. As of the end of 2008, 42,000 children have received services at the Child Friendly Spaces, which offer daycare for pre-school-aged children, non-formal education for school-aged children, life-skills training for adolescents, and support for parents and caretakers. Through the Child Friendly Spaces, UNICEF is also reaching parents and communities on core issues such as health, immunization, injury prevention, and child protection.

Source: "UNICEF China Sichuan Earthquake One Year Report", May 2009, UNICEF, p.25. http://www.unicef.org/media/files/China Earthquake Report 2009ENG Part 1.pdf

Lessons:

- Children displaced by a disaster and with little supervision are exposed to high risk of abuse, neglect and danger
- Child friendly spaces provide children with integrated psychosocial support and protection services in a safe and healing environment
- The security and continuity that Child Friendly Spaces provide are critical to the long-term psychosocial recovery and well-being of children

Case 33: Psychosocial health education in affected area schools, Menchiku City, China

Topic: Role of a psychosocial teacher

They trained a "psychosocial teacher" and they had a class of "psychosocial education" for an hour a week to provide psychosocial care to children. There is a temporary "psychosocial visiting room" in the school. In the room, a full-time "psychosocial teacher" is available. He was a teacher of morality class and took the training programme and started the class of "psychosocial education". In the psychosocial class the children talk of painful memories.

Source: Tominaga, 2008, "Sichuan Earthquake JICA Psychosocial Care Assistant Project Survey" (in Japanese) www.ajcp.info/news20081202/20081201_Shisen-Report.pdf

Lessons:

- Trained psychosocial teacher to teach a class on psychosocial education once a week
- Provide a safe place for children to cope with stress and receive assistance in their recovery

Case 34: Help children to recover post-earthquake, Takarazuka, Japan

Topic: Puppet show for children to ease their minds

The puppet show "Kurarute" was held in Takarazuka city. Five hundred families attended the theater. It was full of laughter and shouts of joy. One of the mothers said "it has been the first time I laughed since the earthquake occurred." The show was held about 70 times. Both children as well as adults enjoyed the show.

Source: Women's net Kobe, 1996, "Women's Talk of Hanshin Earthquake", Mokuba shokan. From Shizuoka Prefectural Earthquake Preparedness Education Center, "Mental Health Care Manual in disaster or accident situation", 2003, Shizuoka Prefecture. p. 43.

http://www.equakes.pref.shizuoka.jp/hondana/pdf/e03-2003/index.htm

Lesson:

Puppet show is a good means for helping children cope with a disaster

Case 35: Psychological recovery of children; social protection measures for children, Tsunami, Thailand

Topic: Government program to help orphans

The tsunami resulted in the temporary erosion of a protective environment for an estimated 50,000 children. The weakening or break down of normal child protection mechanisms increased their vulnerability. The immediate national response to ensure adequate protection for these children was strong and effective. Almost all children who lost parents were cared for by their extended families; a strong psychological recovery programme for 150,000 children was quickly put into place. Crucial to children's psychological well being was their return to school. The school buildings that were damaged by the disaster were urgently repaired and temporary classrooms were erected. In some cases, arrangements were made for children attended school at their teacher's house. As a result more than 75 percent of school children in tsunami-affected areas were able to return to school two weeks after the disaster.

Expansion of the psychosocial and the involvement of teachers, helped children cope with fear and stress, promoting full attendance by the second month. This was a major success for the RTG and its partners particularly UNICEF, and Thai and international NGOs which supported this effort.

There was a great deal of concern also for orphans. Those not cared for by families were put under the care of state-run orphanages or at boarding schools where they received free meals and education until transferred to two special boarding schools being built for the children orphaned by the tsunami disaster.

Following the disaster, the Mental Health Department (DOMH) mapped out a strategic plan focusing on four different types of affected children: those orphaned by the tsunami; those who witnessed the catastrophe; those whose parents lost their jobs and homes; and those who had poor living standards even before the tsunami struck. These children are supported by a two year mental relief programme. In

Takua Pa District, a mental health care center was established to support their psychological conditions after the tsunami. A team of 500 psychologists was mobilized in the affected areas to provide advice to teachers and relatives in caring for the affected children.

The Ministry of Social Development and Human Security continues to provide assistance for the rehabilitation of tsunami orphans and children affected by the tsunami, by talking care and supporting the education of 2,182 children.

Source: "Tsunami Thailand: One year Later – National Response and Contribution of International Partners", 2005, United Nations Country Team in Thailand Office of UN Resident Coordinator. P.29-30. UNICEF tsunami report for UNCT, November 2005. Ministry of Social Development and Human Security report, 28 November 2005.

Lessons:

- Returning children to school was identified as crucial to their well being post disaster
- Involvement of teachers and psychosocial programming helped promote attendance among students
- A mental health care center helped 500 psychologists to deliver advice to teachers and parents on how to help children
- Support of the national government health ministry helped establish additional mental health centers and to expand assistance to childhood care and development

Case 36: Programming to help children recover, Sichuan Earthquake, China, 2008

Topic: Promoting children's mental health through photography

The effects of the earthquake on young children have unique, acute ramifications on these children's mental health as they grow older. Therefore, the Institute of Psychology, Chinese Academy of Sciences is providing psychological aid and recovery to 24 earthquake-affected children aged 10 to 12 through a Photography Psychological Activity program. The purpose of this project is to assist children with recovery and to rebuild their confidence. Through the program, photography activities are being used to help children understand concepts of the self, the disaster, their environment, their relationship to their community, and to articulate their dreams and aspirations. Two groups of students have been formed from the Ren Jia Ping School in Beichuan County. Six students each have been selected from the 4th and 6th grade, who will attend 10 two-hour sessions at their school over a six-month period. With the permission of the participants and their parents, an exhibition will be held at the end of the project, which will document the children's development and the area's overall reconstruction efforts through the eyes of children.

Source: Sichuan Earthquake: Relief & Recovery following the May 12, 2008 Disaster Interim Report, May 2009, Give2Asia, p.26.

Lesson:

Helping children through a photography psychosocial activity program

Case 37: Group work for children: Great Hanshin-Awaji earthquake

Topic: Classroom programming

In elementary schools after the earthquake, group work using drawing was put into effect. It was held in the classroom and it was for all students. One facilitator took care of each group of four to five students. They used A4 sized papers, pens and crayons. Students drew pictures freely.

To understand every student through this activity is important. Students who draw pictures of violence showed the effect of the earthquake on their mental state.

Source: Shigeyuki Mori, "Effectiveness of group work for children: psychosocial care for victims", 1996. Shinundo. .129-137. (In Japanese).

Lesson:

 Program allows children to express themselves through drawing and help others to understand their feelings

Case 38: Using a toy animal to help children recover, Sichuan Earthquake

Topic: Qiugiu the panda lends to psychosocial support

The urgent noise of a pair of chopsticks drumming on a large enamel food basin stops and a teenage girl, muffled up against the winter chill in a yellow anorak, stands up. Holding the furry toy panda in her hands, she begins the narrative session.

"After his parents died in the earthquake, Qiuqiu (the panda's name) wandered around for a while, before deciding to rebuild the family's house with his own two hands," she says. Then it is time for the next student, here at Minzhu Hongda Middle School in the heart of Sichuan's earthquake zone, to take up their own narrative of Qiuqiu.

The name means Little Ball, "which is significant in itself, giving the idea of rolling on with life," says IFRC Health and Psychosocial Support Delegate Dr Jeya Kulasingam, who's brought the activity to the school today. "The panda is an animal with which the community here identifies, especially as pandas were themselves caught up in the disaster – they're survivors too," he adds.

This method of second party story telling can still play a useful role in allowing the children to move forward with their narratives without having to revisit their pain and

grief. "It's all about their recovery process; how they recovered from the pain and grief," says Dr Jeya, a veteran of seven post-earthquake relief and recovery operations.

Qiuqiu's help

It's interesting to observe that the children hold the panda in very different ways, some very tight, some upside down, some looking at it as they talk – giving a window into different psychological states. A couple of them appear completely choked up and unable to continue at certain points.

"It is not unusual to see this in an exercise of this kind after a disaster, but what is unusual is for this to happen at such an early stage," says Dr Jeya. "Normally you would see that at a later stage, while at the beginning, it would be pandas riding around on bicycles and other fun, lightweight things like that, but not here."

For her part, teacher Luo Yumei, who has participated in several psychosocial trainings, including some from the Red Cross Society of China programme, Sunshine in Your Heart, is clear that the children's state of mind has greatly improved in the last few months. Ms Luo says the students' state of mind has made steady progress since the last time we visited the school in early November.

Sunshine in Your Heart

Less than an hour's drive away, in the hills outside the town of Shifang, is the middle school in the township of Yinghua. This is where Sunshine in Your Heart conducted a three-day psychosocial training for teachers and children in November last year.

The first sight which greets us is a lively game of ping pong in progress. One of the two boys playing is among the several children who have lost legs as a result of their earthquake injuries. His crutches are propped up against the ping pong table. Not only is he able to hold his own in the game, but also shows great agility in hopping off to retrieve the ball each time it is hit off the table.

Once we find a classroom and get underway with the panda narrative, it's noticeable that even though on the surface, this community would appear to have been more severely impacted, the children's psychological reactions show a greater degree of recovery. When we ask them to address Qiuqiu the panda and introduce themselves and their families' hopes for them, they become more serious and sombre, in contrast with the rest of the session, when they express themselves through the intermediary of the panda. But there is no choking up.

Children as barometer

Dr. Wang Wenzhong, director of the Crisis Intervention Centre in Sichuan, one of the psychologists conducting the November training, confirms that "there are very big differences in the way various communities are affected." Children may not at this stage necessarily be those worst impacted, he says, "but they are very easily influenced by the adults," who shoulder the burden of worry about the family's

economic losses.

"Kids are a good indicator of what's going on in a whole community," says Dr Jeya, "and with people restricted to having only one or sometimes two kids, the children's welfare and development becomes the communities' main concern, so we need to use this to continue and broaden our work."

Seeing clear evidence in the kids' behaviour that the activity demonstrated therapeutic value, Dr Jeya plans to develop a toolkit of narrative methods for teachers, including Qiuqiu and further techniques using puppets and further materials adapted from those used by the Psychosocial Reference Centre. The IFRC plans to offer help with training psychosocial support volunteers and funding for a dedicated psychosocial professional in the disaster area. That work will form a part of the IFRC's integrated programming in support of the Red Cross Society of China.

Source: By Francis Markus, IFRC, in Shifang, Sichuan, December 30th, 2009, http://www.reliefweb.int/rw/rwb.nsf/db900SID/EDIS-7QMM5N?OpenDocument, Website: http://www.ifrc.org/

Lessons:

- Second party story telling can help children to recover
- Using animals such as pandas to help children to communicate their feelings
- The rate of recovery among children is a good measure of community recovery as the community invests a great deal in the childrens' recovery

Sub Issue 5: Elderly Survivors

The World Health Organization provides the following guidance for working with elderly individuals.

When helping the old-age population

Do not neglect the aging survivors. They too are in a very vulnerable position, both physically and emotionally. Try to bring them together with the community and help ease out their fears.

- Ensure medical aid and physical well-being
- Guard against extreme feelings of hopelessness and helplessness
- Encourage healthy grief reactions, such as crying, or talking about losses.
- Allow elders to talk about their fears, anxieties and guilt
- Encourage group meetings with elderly survivors
- Encourage participation in community decision making

Source: Maheshwari, Surabhika, Dr. Cherian Varghese, Dr. Kavita Venkataraman. "Manual for Facilitators." World Health Organization.

The College for Nursing Art and Science at the University of Hyogo provides comprehensive guidance on their Disaster Nursing website.

Seniors living in an emergency shelter:

It is difficult for the elderly to secure a living place by themselves within a shelter. While they repeatedly move within the shelter and endure poor living environment, psychological stress sometimes manifests as physical symptoms. In addition, if elderly evacuees are inactive during the day, their ADL level tends to decrease, which can aggravate chronic disorders. PTSD (post-traumatic stress disorder) sometime develops in the elderly without being noticed and elderly evacuees may suffer from continuous psychological disturbances such as a sense of helplessness and anxiety about their future without prospects for restoring their lives.

Therefore, it is very important to assess the mental state of elderly evacuees and attempt to maintain and improve their mental health.

Assessment of psychological stress and anxiety about the future:

- 1. Mental state (anxiety/fretting, irritation, anger, depressive tendency, etc.)
- 2. Sleep patterns (insomnia, feeling of sound sleep, difficulty in falling asleep and waking after the onset of sleep)
- 3. Physical symptoms (increase in blood pressure, increase in glucose, and gastrointestinal symptoms such as nausea, vomiting, stomachache, hematemesis, and bloody feces due to acute gastric ulcer)
- 4. Living state (such as living environment in the shelter and personal relationships with surrounding people) and anxiety about the future)

Coping methods for psychological stress and anxiety:

- 1. Arrange assessment by health care practitioner and clarify the mental state of elderly evacuees.
- 2. Secure places that enable the elderly evacuee to be listened to without any time constraints, and listen attentively
- 3. In elderly with an unstable mental state, arrange a visit to or by a psychiatrist. If a prescription is required ensure that the physician's instructions for medication are noted and medication is properly managed
- 4. Identify factors associated with aggravation of the mental state, and adjust or intervene with these factors
- 5. Evaluate the area occupied by the elderly evacuee within the shelter, and consider setting up a private space or a change in place when necessary

6. Plan regular visits by mental health specialists and carry out mental support programs

Assessment of sense of helplessness and symptoms of PTSD (more assessment should be performed in addition to assessment of psychological stress and anxiety about the future).

Assess the elderly evacuees for:

- 1. Mental activity and ADL in shelter life
- 2. Symptoms of PTSD (such as continuous crying when remembering the time of the disaster, insomnia and despondency)
- 3. Troubles and stress in personal relationships within the shelter

Coping methods for sense of helplessness and symptoms of PTSD

- 1. When there are symptoms of PTSD, arrange for immediate visits to or by a psychiatrist or mental care specialist (such as a clinical psychologist, mental health nurse and counselor
- 2. Communicate as much as possible, and strive to build up a feeling of mutual trust
- 3. Plan for group discussions where the elderly can talk to one another about life in the shelter in the presence of mental care specialists.
- 4. Arrange for the establishment of a place of counseling by mental care specialists in the shelter

Seniors living in temporary housing:

For elderly people, transferring from a shelter to temporary housing and prolonged evacuation may induce stress-associated symptoms such as insomnia, shoulder stiffness, malaise and headache, and aggravate chronic diseases. In addition, elderly residents tend to lose hope for a new life, feeling left behind by others or finding no purpose or no pleasure in daily life.

Sometime after the disaster, and following relocation to a new home, some elderly residents develop prodromal symptoms of PTSD (post-traumatic stress disorder) or PTSD itself, stating such things as "I cannot remember the time of the disaster" or "I want to have as few contacts as possible with others". Adequate observation of these symptoms and nursing support are important during life in the shelter when the future is unclear.

Assessment of psychological stress and loss of hope:

- 1. Mental condition (anxiety/fret, irritation, anger, depressive tendency
- 2. Sleep state (insomnia, depth of sleep, difficulty in falling asleep and waking after sleep onset

- 3. Physical symptoms (increase in blood pressure, increase in glucose, digestive symptoms, shoulder stiffness, malaise and headache
- 4. Living state (environment in the temporary housing and personal relationships with surrounding people

Coping methods for psychological stress and loss of hope

- Carry out the above assessment at regular health consultations including during rounds, and evaluate mental condition, sleep state and physical symptoms
- 2. Listen to elderly residents carefully allowing as much time as they need, in a place they feel relaxed, and paying close attention
- 3. Make arrangements for visits to or by mental health specialists to elderly residents with psychosomatic problems
- 4. Where there are sleep disorders, evaluate and eliminate factors affecting sleep, introduce sound sleep measures (such as earplugs) and make arrangements for visits to medical institutions

Assessment of developing PTSD and its prodromal symptoms - in addition to the above assessment (for psychological stress and loss of hope), the following assessment should be performed:

- 1. Assess for PTSD and its prodromal symptoms (such as continuous crying when remembering the time of the disaster, being unable to remember the time of the disaster and reluctance to have contact with others
- Perform regular health consultations by making rounds of temporary housing, and evaluate the general physical and mental conditions of elderly residents
- 3. Evaluate stress associated with personal relationships and exchange with others in temporary housing

Coping methods for developing PTSD and its prodromal symptoms

- 1. When there are symptoms of PTSD make arrangements for visits to or by psychiatrists or mental care specialists (such as clinical psychologists, mental health nurses and counselors)
- 2. Communicate as much as possible, and establish mutual trust
- 3. Perform regular mental health consultations and recommend regular counseling, where necessary
- 4. Plan group recreations such as lunch/dinner parties and tea parties
- 5. Ensure that nurses who perform rounds of temporary housing are continuously involved in the same cases whenever possible

Source: University of Hyogo, Graduate School of Nursing. Information Base for Disaster Nursing Knowledge and Skills to Protect Lives. Mental Health: Elderly. Accessed 2010. http://www.coecnas.jp/english/group_senior/manual/manual02/08.html

Case 39: Programming for elderly victims during recovery, Hanshin-Awaji Earthquake, Japan, 1995

Topic: Support for elderly victims

Issues that emerged during the recovery phase included helping elderly residents of temporary emergency housing to stay healthy and positive, and dealing with psychological problems stemming from the shock and confusion of the disaster.

The Health Advisor project, which grew out of health management for disaster victims, was later developed being further expanded as a project covering the entire prefecture, not just the areas that suffered most under the earthquake.

Psychiatric first-aid stations, based mainly in local welfare offices, and emotional support centres set up by the Hyogo Psychiatric Health Association carried out a large number of visits and telephone consultations to support people's mental and emotional health. The results thus amassed were the subject of survey research by the Research Institute for Mental Health Care and led to the establishment of the Hyogo Institute for Traumatic Stress.

The utility of home visits by nurses in very aged communities such as temporary emergency housing and disaster reconstruction housing was investigated by nursing universities in the prefecture. This led to the establishment of the Health Advisor Project, which contributed greatly to both the health care and mental health care/emotional support of victims. Thanks to the work of volunteer nurses, the Mobile Health Care Rooms set up by this project not only promoted residents' health but also provided a venue for social interaction between local residents, leading to a degree of effectiveness in the promotion of positive living and community creation. It has been pointed out, however, that there are limits to the ability of volunteer nurses alone to take forward the promotion of positive living and community creation.

Projects to Support Independent Living by Elderly Victims, which were originally intended for elderly residents of disaster reconstruction housing, are aiding the formation of a sound community among residents via the promotion of positive living among the elderly.

Source: Hyogo Prefectural Government, Japan, "The Great Hanshin-Awaji Earthquake: The Report of the 10-Year Reconstruction Overall Verification and Recommendations", 2005, The Office of the 10th Year Restoration Committee, p.117-119.

Lessons:

- Activities include office visits and telephone consultations
- Used volunteer nurses to implement program but difficult to sustain the

program using volunteer nurses alone

Sub Issue 6: Special Needs Populations

Case 40: Helping hearing impaired individuals, Hurricane Floyd, U.S.A., 1999

Topic: Counseling services for hearing impaired

In September 1999, Hurricane Floyd arrived in North Carolina, causing the most devastating flooding the State had ever experienced. Outreach efforts organized through the "Hope After Floyd" program helped thousands of residents to deal with the hurricane's aftermath.

Outreach workers reported particular success in providing crisis counseling services to individuals who were deaf and hard of hearing, many of whom experienced fear and stress associated with the lack of access to information provided through television or radio. Following the disaster, project staff provided in-service training and consultation to emergency management agency officials on the needs of the deaf and hard-of-hearing populations, and worked to ensure that the Federal Communications Commission required broadcast stations to provide closed captioned emergency information.

Source: North Carolina Site Visit Report, 2000. Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations

Lessons:

- Program created to deal with psychosocial needs of the hearing impaired
- Hearing impaired individuals fear and stress over lack of access to information
- Program staff trained emergency workers and worked with FCC to provide captions for disaster information

Sub Issue 7: Crisis Counseling for Adults

The World Health Organization provides the following guidance for providing help to adults.

When helping an adult

- Allow crying and sharing of grief
- Crying, feeling helpless, vulnerable and sad are normal responses to loss.
 Being able to mourn losses and sharing the feeling of loss helps ease out the grief reaction
- Encourage the establishment of social support groups (religious groups, work

communities). Get people to interact with groups and communities with which they feel safe and understood

- Facilitate going back to the normal daily routine activities. Even if it is difficult to re-establish routines as before try to structure some daily activities. Start with simple activities such as time of sleep and waking up, meal times, etc.
- Educate (information about the disaster, caring for oneself and the community, health practices. Reconstruction)
- Encourage gainful employment in reconstructive tasks. This fosters a feeling of control and hope
- Discourage the spreading of any rumors
- Facilitate sharing of community responsibilities by adults



Source: Maheshwari, Surabhika, Dr. Cherian Varghese, Dr. Kavita Venkataraman. "Manual for Facilitators." World Health Organization.

Case 41: Helping family members work through painful issues, Crisis Counseling for Adults

Topic: Counseling parents

A husband, 49, wife, 47, and five children had recently immigrated to the United States from Honduras when a tornado damaged their home. The woman contacted

the crisis team located in a church near the disaster site to ask for help to find out "if she was crazy." She met with the crisis counselor and reported that her feelings and behavior were changing. She had heard from neighbors that behavior changes were to be expected after the trauma of a tornado. In spite of this knowledge, she thought that her experiences went beyond the normal "post-traumatic reaction." She described feelings of depression, crying spells, and inability to make up her mind about household routines. She had no interest in anything, and found it difficult to manage her children. Her drinking, normally limited to social situations, had increased, and her friends had expressed concern about it.

The family's home had been damaged, but they had already received monetary assistance from government agencies, and workers were ready to begin repairs. Although the response to this component of the upheaval was proceeding in a satisfactory manner, the family was still experiencing serious troubles. Most of the wife's complaints and expressions of difficulties centered around her husband, who suffered from multiple sclerosis that resulted in difficulty of movement and mood swings. Despite his disability, the husband wanted to control all aspects of the home's repair and the distribution of the funds received from government agencies. The woman felt her husband's attitude was adding to the complications associated with the repairs and wanted him to live with relatives while the workers were in the house. Her marital situation, already shaky, had worsened and she felt trapped. While previously she had been able to function with strong, realistic defenses and with support from her friends and relatives; she now felt that everything was falling apart because her nearest family members had also suffered in the disaster and had been forced to move to other parts of the state.

The crisis intervention counselor interviewed the husband, the couple, and the entire family to assess their psychological condition and hear their perceptions of the family's problems. The counselor was able to ascertain that the wife was using excessive control to deal with her feelings about the trauma, felt responsible for the family, and was unable to relinquish responsibility for the complex array of activities needed to deal with the bureaucracy of the disaster assistance agencies. Her inability to cope effectively with the reality of her life and process the emotions resulting from the tornado and its effects had precipitated a crisis.

The counselor also learned that the family's cultural traditions regarded the husband as the head and controlling force in the family - a role he did not want to relinquish. The counselor, sensitive to this traditional value system, helped the wife reassess and reevaluate her situation, showing her how the mix of traumatic events, traditional values, and her need for extended family ties were exacerbating the post-disaster crisis resolution process. By enabling the wife to experience relief through verbal expression of her feelings, and then guiding her into collaboration with her husband, rather than attempting to control his dealings with the repair workers, the counselor helped her gain control of her emotions. The counselor also helped the woman to recognize her own internal feelings.

As the woman became aware of her increased efficiency, she began to feel more positive about her family. The counselor supported her in the difficult situation and commended her for the way in which she had managed the bureaucratic requirements necessary to get her home repaired, despite her unfamiliarity with the procedures.

Like many disaster survivors, this family needed more than basic assistance. They were grappling with many problems before the tornado struck; the disaster unleashed latent problems in family relations that were aggravated by the unresolved family crisis. The crisis counselor needed to identify the boundaries of post-disaster crisis assistance and then put the family in contact with a community agency that could provide additional resources to help them resolve chronic marital problems.

Such an example highlights the types of crisis counseling for victims after the basic, concrete post-disaster assistance is rendered to normalize living conditions.

Source: Mental Health Services in Disasters: Manual for Humanitarian Workers (PAHO; 2000) http://www.helid.desastres.net/?e=d-0who-000--1-0--010--4----0-10l--11en-5000---50-packa-0---01131-001-7rC8QU8%5D42f9419900000004b13d126-0-0-0&a=d&cl=CL2.1.4&d=Jh0681e.4.2

Lessons:

- Existing family problems can be exacerbated by a disaster
- Crisis counselor identified problems and makes referral to community agency that can assist the family

Sub Issue 8: Disaster Workers and Volunteers

The World Health Organization provides the following guidance to disaster workers on how they can take care of themselves in disaster events.

Along with all the work in the field it is important to know when you need to refer and consult professionals to handle certain particularly difficult situations. Also, it is very essential to maintain personal physical and psychological well-being.

Seek professional help

We cannot take care of all that comes our way. Don't bite off more than you can chew. Also remember that you are dealing with human beings caught in a very difficult and vulnerable position in their lives. You need to be very patient and sensitive. There will be times when you will need to refer the person to someone else in the best interest of both you and the one(s) affected by the disaster.

Here's when to refer a person to a professional or supportive group:

• When you believe that improvement is "impossible: or the situation is "hopeless;"

- When the person says, "nothing is helping" or what you provide the person isn't helping;
- There are obvious and unusual changes in speech, appearance or behavior, including memory confusion, hallucinations and delusions;
- The person continues to be so emotional he or she cannot communicate;
- There is ongoing deterioration of life (social and physical);
- All that person reports are physical complaints;
- Increased substance abuse like alcohol and drugs;
- Threats of self harm of threats to others:
- Aggression and abuse (verbal and physical);
- If the situation seems horrible or unbearable; most importantly,
- If you're unsure, then refer.

Helping yourself

It is a difficult and traumatic situation for you too. Do not neglect yourself. It is important to ensure your health, both physical and psychological.

- Participate in group activities.
- Allow yourself to mourn personal loss if any.
- Peer supervision: discuss issues and difficulties regularly with others like you working in the field.
- Do not deny your emotional reactions and tensions.
- Keep some time everyday just for yourself.
- Continue to work on routine tasks if it is difficult to concentrate on demanding duties. Ask your colleagues/supervisors to reschedule your duties.
- Engage yourself in some de-stressing activity (hobbies and/or activities that relieve you e.g. going for a walk, listening to music, etc.) on a regular basis.
- Ensure your physical well being. Take care of your health and nutrition.

Source: Maheshwari, Surabhika, Dr. Cherian Varghese, Dr. Kavita Venkataraman. "Manual for Facilitators." World Health Organization.

According to the Inter-Agency Standing Committee's "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings"

Staff members working in emergency settings tend to work many hours under pressure and within difficult security constraints. Many aid workers

experience insufficient managerial and organizational support, and they tend to report this as their biggest stressor. Moreover, confrontations with horror, danger and human misery are emotionally demanding and potentially affect the mental health and well-being of both paid and volunteer aid workers, whether they come from the country concerned or from abroad.

The provision of support to mitigate the possible psychosocial consequences of work in crisis situations is a moral obligation and a responsibility of organizations exposing staff to extremes. For organizations to be effective, managers need to keep their staff healthy.

A systemic and integrated approach to staff care is required at all phases of employment – including in emergencies – and at all levels of the organization to maintain staff well-being and organizational efficiency. The word 'staff' in this action sheet refers to paid and volunteer, national and international workers, including drivers and translators, affiliated with an aid organization. Support measures should in principle be equal for national and international staff. However, some structural differences exist between the two.

For example, national staff is often recruited from the crisis area and are more likely to have been exposed to extremely stressful events or conditions. In addition, they and their families are often unable to leave the crisis area if the security situation worsens, in contrast with international aid workers, who tend to have good access to evacuation operations. For international workers, on the other hand, particular stressors include separation from their support base, culture shock and adjustment to difficult living conditions. These and other differences are often forgotten or left unaddressed in staff support systems. Humanitarian organizations should work to improve their performance in staff support and to reduce differential support practices for national and international staff.

Key actions for Staff:

- 1. Ensure the availability of a concrete plan to protect and promote staff wellbeing for the specific emergency
 - a. While most agencies have a general policy on staff welfare in emergencies, for each specific emergency they should also have a concrete plan for proactive staff support. The activities within the plan should be part of the overall emergency budget
- 2. Prepare staff for their jobs and for the emergency context
 - a. Ensure that national and international staffs receive information on (a) their jobs and (b) the prevailing environmental and security conditions and possible future changes in these conditions. Provide to international staff (and, when appropriate, to national staff) information on the local socio-cultural and historical context,

including:

- Basic knowledge of the crisis and the world view(s) of the affected population
- ii. Basic information on local cultural attitudes and practices and systems of social organization
- iii. Basic information on staff behaviors that may cause offence in the local socio-cultural context
- b. Ensure that all staffs receive adequate training on safety and security
- c. Ensure that all staff are briefed on a spectrum of stress identification (including but not restricted to traumatic stress) and stress management techniques and on any existing organizational policy for psychosocial support to staff
- d. Ensure that experienced field management staffs are available
- 3. Facilitate a healthy working environment
 - a. Implement the organization's staff support policy, including a rest and recuperation (R&R) provision. When the environment provides no opportunities for non-work related activities, consider organizing a higher frequency of R&R opportunities
 - b. Ensure appropriate food and hygiene for staff, taking into account their religion and culture
 - c. Address excessive, unhealthy living practices, such as heavy alcohol use by workers
 - d. Facilitate some privacy in accommodation (e.g. if possible, provide separate work and living places)
 - e. Define working hours and monitor overtime. Aim to divide the workload among staff. If a 24-hour, seven-days-a-week work pattern is essential in the first weeks of an emergency, then consider rotating staff in shifts. Eight-hour shifts are preferable, but if that is not possible, shifts should be no longer than 12 hours. Twelve hours on and 12 hours off is tolerable for a week or two during emergency situations, but it would be helpful to have an extra half-day added to rest schedules about every five days. The hotter or colder an environment, or the more intense the stress, the more breaks are required
 - f. Facilitate communication between staff and their families and other pre-existing support mechanisms

- 4. Address potential work-related stressors.
 - a. Ensure clear and updated job descriptions:
 - i. Define objectives and activities
 - ii. Confirm with staff that their roles and tasks are clear
 - iii. Ensure clear lines of management and communication
 - b. Evaluate daily the security context and other potential sources of stress arising from the situation
 - c. Ensure sufficient supplies for staff security (bullet-proof vests, communication equipment, etc.)
 - d. Ensure equality between staff (national, international, lower and higher management) in the personal decision to accept security risks. Do not force national staff to take risks that international staffs are not allowed or not willing to take
 - e. Organize regular staff or team meeting and briefings
 - f. Ensure adequate and culturally sensitive technical supervision (e.g. clinical supervision) for mental health and psychosocial support staff
 - g. Build teams, facilitate integration between national and international staff and address intra-team conflict and other negative team dynamics
 - h. Ensure appropriate logistical back-up and supply lines of materials
 - i. Ensure that members of senior management visit field projects regularly
- 5. Ensure access to health care and psychosocial support for staff
 - a. Train some staff in providing peer support, including general stress management and basic psychological first aid (PFA) for national staff who may be unable to leave the emergency area, organize access to culturally appropriate mental health (including psychiatric) and psychosocial support and physical health care
 - b. Ensure stand-by, specialist back-up for urgent psychiatric complaints in staff (such as suicidal feelings, psychoses, severe depression and acute anxiety reactions affecting daily functioning, significant loss of emotional control, etc.). Consider the impact of stigma on the willingness of staff to access mental health assistance and adjust back-up support accordingly (e.g. international staff may be fearful that they will be sent home if they seek assistance)
 - c. Ensure that staff are provided with prophylactics such as vaccinations and anti-malarial measures, condoms and (when

- appropriate) access to post-exposure prophylactics, and ensure adequate availability of medicines for common physical diseases amongst staff
- d. Ensure that medical (including mental health) evacuation or referral procedures are in place, including appropriate medically trained staff to accompany evacuees
- 6. Provide support to staff that have experienced or witnessed extreme events (critical incidents, potentially traumatic events)
 - a. For all critical incident survivors, make basic psychological first aid (PFA) immediately available. As part of PFA, assess and address the basic needs and concerns of survivors. Although natural opportunities should be provided for sharing among survivors, they should not be pushed to describe events in detail nor should they be pushed to share or listen to details of other survivors' experiences. Existing (positive and negative) coping methods should be discussed, and use of alcohol and drugs as a way of coping should be explicitly discouraged, as survivors are often at increased risk of developing addiction
 - Make available appropriate self-care materials. The materials should include contact information for a staff welfare officer/mental health professional in case survivors wish to seek help for any level of distress
 - c. When survivors' acute distress is so severe that it limits their basic functioning (or that they are judged to be a risk to themselves or others), they must stop working and receive immediate care by a mental health professional trained in evidence based treatment of acute traumatic stress. An accompanied medical evacuation may be necessary
 - d. Ensure that a mental health professional contacts all national and international staff members (including translators, drivers, volunteers, etc.) who have survived a critical incident one to three months following the event. The professional should assess how the survivor is functioning and feeling and make referral to clinical treatment for those with substantial problems that have not healed over time
- 7. Make support available after the mission/employment
 - a. Staff members should receive a technical debriefing and job evaluation from senior office staff.
 - b. Staff members should obtain an overall health check-up, including a

stress review and assessment

- c. Staff support mechanisms should be made available upon request
- d. Brief informational materials should be provided to help people understand and manage stress. This material should include an updated referral list of mental health professionals as well as opportunities for peer support

Source: Inter-Agency Standing Committee, 2007, "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings"

Box 5: Stress reactions by nurses in disaster events

Topic: Stress reactions and stress checks

Nurses working at the shelter are subject to considerable stress from taking care of disaster victims in an unfamiliar environment. Common stress reactions are shown below

- Lethargy
- Fatigability
- Lack of motivation
- Depression
- Feeling of guilt
- Irritation
- Nervousness
- Sense of fear
- Insomnia
- Exaltation/ego boost
- Resentment/distrust in human relationships
- Excessive eating
- Increased alcohol consumption
- Weight gain
- Constipation/diarrhea

The above listed are stress reactions that may occur when an individual encounters a traumatic situation, and are often observed among frontline nurses at the shelter.

When in an extremely stressful situation, nurses can develop burnout syndrome, PTSD (post-traumatic stress disorder), or depression.

Why do these stress reactions occur, then? The following section considers what causes these stress reactions.

1. Nurses' stress in disasters

Disasters occur without warning. Anybody can encounter a distressing situation unexpectedly, and nurses are no exception. Under any circumstances, nurses try to support disaster victims who suffer from anxiety, sadness or distress and to share their feelings and experiences. Such efforts require enormous energy and can traumatize nurses. Therefore, nurses struck by a disaster are at greater risk of developing PTSD because they suffer dual traumas of the direct disaster experience and victim support activities. It is believed that even if nurses are not primary victims of the disaster, they suffer from the disaster secondarily, by sharing victims' experiences and anguish under abnormal conditions.

In disasters, it often becomes difficult to provide sufficient support services due to a shortage of manpower, water and commodities caused by paralyzed lifelines and transportation systems. In such a situation, you might be frustrated because you cannot do what you could do without difficulty in normal situations. Consequently, conflicts with other nurses or relief workers and others tend to arise. Moreover, in the abnormal situation following a disaster, you may feel powerless when you are burdened with unreasonable expectations and demands without your efforts being recognized.

It is generally believed that many nurses are serious and strenuous workers with a strong sense of responsibility. Even in a distressing situation such as a disaster, nurses try to help grieving victims and solve their problems at any cost. More often than not, nurses try to handle everything by themselves without seeking help.

Nurses working at the shelters tend to neglect their own lives and families. They often fail to recognize their physical and mental fatigue; or, even if they notice such a condition, sometimes they might not be able to take any time off. Many nurses feel guilty about taking a break from work or receiving assistance, out of professional conscience. As mentioned above, nurses carry out their duties under various stresses, such as nursing activities themselves, the environment and the personal affairs of individual nurses.

2. Stress check

As stated in the previous sections, nurses engaged in support activities at the shelters are under considerable stress. Stress reactions and their impacts differ among individuals; even in the same situation, some nurses feel stress or are affected by stress more acutely than others. When working in an unusual situation or environment, it is often difficult to make an objective evaluation of your own stress condition. However, if you carry out your duties without recognizing your stress, your feelings and experiences will be left unexpressed, placing yourself at great risk of developing various physical and psychological stress reactions, such as listlessness,

helplessness, anxiety and sadness. If these stress reactions are intense or persistent, there is a possibility of developing burnout syndrome or PTSD. It is extremely important to know your own stress condition and stress reactions occurring in your body. It is also important to identify activities that cause stress in your daily activities. Knowing stress-causing activities is essential for continuing activities in a healthy condition.

IES-R (Impact of Event Scale-Revised) is a measure for evaluating the presence of signs and symptoms of PTSD. It is recommended that from time to time you evaluate your own mental state using this scale.

Source: Information Base for Disaster Nursing Knowledge and Skills to Protect Lives. Accessed 2010. http://www.coe-cnas.jp/english/index.html.

Lessons:

- Working is an emergency shelter can cause numerous types of stresses in nurses
- Nurse impacted by a disaster are at greater risk for PTSD
- Conflicts can arise between nurses and emergency workers which can be another source of stress
- Nurses are not good at getting help for themselves

Case 42: Helping hostage victims to cope, unspecified country, 1999

Topic: Actions taken to help hostage victims

After a violent hostage situation involving staff of an international NGO, all national and international staff received an operational debriefing and information on how and where to receive support from a national or foreign doctor or mental health worker at any time it was needed.

In the days following the incident, a staff counselor organized two meetings to discuss with staff how they were doing. Care (and medical evacuation) was organized for a person with severe anxiety problems.

One month later, a trained volunteer contacted all national and international staff individually to check their well-being and organized support as necessary.

Source: Inter-Agency Standing Committee, 2007, "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings."

Lessons:

- Psychosocial support was provided to staff after violent incident
- Staff counselor held two meetings and follow-up was conducted by a trained

volunteer

A paper entitled "Impact of events on community level workers in disaster rehabilitation services" enumerates the role of Community Level Workers (CLWs) in disaster.

The role of community level workers (CLWs) in an event of any natural or human made disasters is very decisive as they are one significant group of the first responders to the disaster. Generally, in disaster relief and rehabilitation work, the survivor's sufferings take the centre stage. Rarely, do the difficulties faced by community level workers get noticed or given importance.

Assisting the traumatized is always stressful and often traumatic where the human suffering reaches a level where local systems and resources can no longer contain the situation and often large numbers of care givers (CLWs) are required to alleviate the trauma among the survivors. These CLWs generally perform multiple functions beginning with rescuing the survivors from their life-threatening situation to distribution of various relief materials, transporting the survivors to safe destinations, managing safe living spaces, delivering psychosocial and mental health care. These carers in the context of this study the community level workers have to face innumerable problems while performing their work and this can result in a decrease in their efficiency and the effectiveness of their services, and an adverse impact on their psychological health. The study aimed at assessing the impact of events among the community level workers in disaster rehabilitation services. It adopted a descriptive research design and 200 community level workers from nongovernmental organizations who worked in post disaster rehabilitation were assessed for impact of events (intrusion, avoidance and hyper arousal). Results: Large numbers of CLWs were found to have suffered from the impact of the events at moderate or severe level. CLWs with the lowest education, income reported significant level on the Impact of events Scale.

Source: "Impact of events on community level workers in disaster rehabilitation services." Jayakumar.C, Research Scholar, Department of Psychiatric Social Work, NIMHANS, and Dr. K. Sekar, Professor and Head, Department of Psychiatric Social Work. NIMHANS, Bangalore.

Key Psychosocial Issues in Recovery



This chapter identifies a number of issues that influence psychosocial programming including cultural issues, training, reunifying families, and documenting and remembering what happened.

Sub Issue 1: Cultural Issues

The National Child Traumatic Stress Network and National Center for PTSD's "Psychological First Aid: Field Operations Guide, 2nd Edition" highlights the issue of cultural sensitivity.

Providers of Psychological First Aid must be sensitive to culture, ethnic, religious, racial, and language diversity. Whether providing outreach or services, you should be aware of your own values and prejudices, and how these may agree with or differ from those of the community being served. Training in cultural competence can facilitate this awareness. Helping to maintain or reestablish customs, traditions, rituals, family structure, gender roles, and social bonds is important in helping survivors cope with the impact of a disaster. Information about the community being served, including how emotions and other psychological reactions are expressed, attitudes toward government agencies, and receptivity to counseling, should be gathered with the assistance of community cultural leaders who represent and best understand local cultural groups.

The type of physical or personal contact considered appropriate may vary from person to person and across cultures and social groups, for example, how close to stand to someone, how much eye contact to make or whether or not to touch someone, especially someone of the opposite sex. Unless you are familiar with the culture of the survivor, you should not approach too closely, make prolonged eye contact, or touch. You should look for clues to a survivor's need for "personal space," and seek guidance about cultural norms from community cultural leaders who best understand local customs. In working with family members, find out who is the spokesperson for the family and initially address this person.

Source: National Child Traumatic Stress Network and National Center for PTSD, "Psychological First Aid: Field Operations Guide, 2nd Edition". July, 2006. p.9, p.11.

Case 43: Designed to be culturally competent, Hurricane Response in Puerto Rico 1996

Topic: Recognizing cultural issues

Hurricane Hortense struck Puerto Rico in 1996 with devastating impact. The disaster crisis counseling program was designed to be particularly sensitive to the Puerto Rican culture. For example, recognizing that this culture encourages strong ties with friends and neighbors, the program provided group debriefing sessions. The project also used cultural celebrations to advance its goals. For example, the festival of the Three Kings Day, which occurs in early January, was used as an opportunity for special outreach in which project staff went door to door "giving as altos"—a tradition of singing Christmas carols and giving donated gifts—as a way to identify needs and provide information and social support. The project also used dramatization to inform persons in the community about disaster phases and disaster planning.

Source: Puerto Rico Final Report, 1997. "Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations", 2003, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Mental Health Services, p.29. http://download.ncadi.samhsa.gov/ken/pdf/SMA03-3828/CulturalCompetence FINALwithcovers.pdf

Lessons:

- Design psychosocial program that is sensitive to local culture
- Use local celebrations to identify needs and provide information and social support

Case 44: Disaster Strikes a Highly Diverse Community, Northridge Earthquake, USA

Topic: Language barriers

On January 17, 1994, a major earthquake struck Los Angeles and Ventura Counties. The Northridge earthquake was the largest and most violent to hit an urban area in the United States since the 1906 San Francisco quake. The post-disaster recovery effort provided mental health services to 1.9 million persons, representing myriad ethnic groups, special populations, and lifestyles. The size and scope of the two affected counties, as well as the ethnic diversity of their residents, constituted a challenge to disaster mental health providers. For example, Ventura County is home to many undocumented migrant farm workers, the majority of whom do not speak English and are mistrustful of government at any level. Language and cultural barriers had to be overcome for persons from several Asian cultures as well. The diverse population in the affected areas also included other special populations, such as physically challenged persons and runaway youth, two groups that required special outreach strategies. The disaster mental health program staff recognized from the beginning of the project the need to develop and provide culturally relevant and linguistically appropriate services, covering a multitude of cultures and languages.

Source: California Final Report, 1995. "Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations", 2003, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Mental Health Services, p.20. http://download.ncadi.samhsa.gov/ken/pdf/SMA03-3828/CulturalCompetence FINALwithcovers.pdf

Lessons:

- Cultural diversity can be a challenge for an effective psychosocial program
- Important to develop and provide culturally relevant and linguistically appropriate services, covering a multitude of cultures and languages

Case 45: Disaster Projects Confront Distrust, Northridge (CA) earthquake, 1994

Topic: Working with new immigrants

Several disaster crisis counseling projects supported by the Federal Government have had to address the distrust of ethnic minority groups and their reluctance to use available resources. For example, following the 1994 California earthquake, the disaster crisis counseling project found that many immigrants' distrust of government posed a barrier to their use of disaster services. Likewise, some of the survivors of a hurricane in Alabama were immigrants from Asian Communist countries who did not trust any government and were not accustomed to receiving Government assistance.

Source: California Final Report, 1995, Alabama Final Report, 1999.

Lesson:

 Distrust of government can be a barrier for migrants receiving psychosocial support

Case 46: Disaster Resurface Emotional Reaction to Prior Stressors, Flooding in California, 1995

Topic: Displacement adds stress to past stressors

Flooding occurred in Clovis, California, in 1995, when a canal overflowed. Many families, mostly Hmong, who lived near the canal were displaced The Hmong population is a low-income community with immigrants from Southeast Asia who have a history of war and severe losses. Many were suffering from Post-Traumatic Stress Syndrome prior to the flood. The flood increased financial stress and anxiety, and exacerbated their existing symptoms.

Source: California Final Report, 1995 "Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations", 2003, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Mental Health Services, p.15-17. http://download.ncadi.samhsa.gov/ken/pdf/SMA03-3828/CulturalCompetence FINALwithcovers.pdf

Lesson:

Disaster can aggravate existing Post-Traumatic Stress Syndrome conditions

Sub Issue 2: Training

Lin, S., Shaw, D., and Ho, M.C., in their 2008 paper entitled, "Why are flood and landslide victims less willing to take mitigation measures than the public?" explain factors of disaster preparedness and hazard mitigation behavior.

Almost annually, natural hazards such as floods and landslides cause a great deal of financial loss and human suffering in Taiwan. In order to gain a better understanding of disaster preparedness, this paper examines several factors in relation to hazard mitigation behavior: social economic status (education, income), psychological vulnerability (sense of powerless and helpless), risk perception (perceived impact and control) and social trust. The statistical analysis reported here is based on the "2004 National Risk Perception Survey of Floods and Landslides in Taiwan". The main findings include: (1) in comparison with general public, victims are less willing to adopt risk mitigation measures than the public, even though they perceive larger impacts, worry more about the hazard, and pay more attention to hazard information; (2) trust, risk perception and social economic status are positive predictors for mitigation intentions, whereas psychological vulnerability is a negative predictor; and (3) psychological variables are stronger predictors for mitigation intentions than that of socio-economic variables. In light of these findings, the policy implications and intervention strategy are also discussed.

Source: Lin, S., Shaw, D., and Ho, M.C., 2008, "Why are flood and landslide victims less willing to take mitigation measures than the public?" Nat Hazards (2008) 44:305–314.

Case 47: Organize orientation and training of aid workers in mental health and psychosocial support, Sri Lanka, 2005

Topic: Pre-planning

A local NGO with a long history of providing psychosocial support to war-affected populations temporarily refocused its work to support tsunami survivors.

The NGO organized short action-oriented seminars to teach existing psychosocial field staff essential skills to better support people with specific tsunami-induced mental health and psychosocial problems, together with practical methods of intervention.

After the seminars, follow-up was provided through the NGO's existing system of weekly supervision.

Source: Inter-Agency Standing Committee, 2007, "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings", p.86.

Lesson:

 Refocus existing psychosocial programs concerning ongoing conflicts to meet disaster-related needs

Case 48: Preparing children for disasters, Turkish Red Crescent and government agencies

Topic: Psycho-social interventions in drills in Turkey

In Turkey, Turkish Red Crescent, the Directorate General of Civil Defense, Turkish Armed Forces and similar institutions often make drills or become a part of the drills made. For psycho-social interventions in drills, the conditions in the drill area should be studied beforehand and the necessary preparations should be made before going to the area.

- All the materials (forms, brochures, ropes necessary for activities, balls, papers, etc.) should be taken to the area as if it was a real intervention.
- The drill scenario should be studied beforehand and which psychosocial interventions will be implemented according to the scenario should be planned. Considering that drills last maximum one week, it is recommended that interventions should entail the psychological first aid and need identification work on the first days, then the actions towards the mobilization of community should follow this and lastly normalizing and social project development work should come. Also, either individual or group works can be done within the scope of support to relief workers.
- Those works to be done in the drill area should be discussed with the team leader beforehand and a regular reporting of the works done should be in place. The demands/instructions of other stakeholders should be fulfilled if the team leader and psycho-social support worker approve them.
- The presence of a psycho-social support worker in the drill area from the time it is established is very important for both arranging relations with other workers and building psycho-social intervention infrastructure (where and how tents and notice boards for psychosocial intervention will be built).
- It should be ensured that the stakeholders participating in the drill clearly
 understand psycho-social support services. When the importance of psychosocial support services and their limitations are shown, works will be done in
 a more orderly and efficient manner.
- A rehearsal of a psycho-social intervention by volunteers in the drill area draws the participants' attention to the psycho-social concept and gives it a concrete basis and thus makes interventions more understandable.

Source: Turkish Red Crescent, 2008, "Implementation Guidelines for Psycho-Social Support in Disasters: Towards relieving sufferings"

Lessons:

- Include psychosocial support in disaster drills
- Include psychosocial workers in disaster drills
- Presence of psychosocial workers in disaster drills will inform all participants in the drills on psychosocial programs and their value in recovery

Sub Issue 3: Reunifying Families

The National Child Traumatic Stress Network and National Center for PTSD in its publication entitled, "Psychological First Aid Field Operations Guide, 2nd Edition," offers notes about how to deal with children who are separated from parents/caregivers.

Attending to children who are separated from their parents/caregivers

Parents and caregivers play a crucial role in children's sense of safety and security. If children are separated from their caregivers, helping them reconnect quickly is a high priority. If you encounter an unaccompanied child, ask for information (such as their name, parent/caregiver and sibling names, address, and school), and notify the appropriate authorities. Provide children accurate information in easy-to-understand terms about who will be supervising them and what to expect next. Do not make any promises that you may not be able to keep, such as promising that they will see their caregiver soon. You may also need to support children while their caregivers are being located or during periods when caregivers may be overwhelmed and not emotionally accessible to their children. This support can include setting up a child-friendly space.

Source: National Child Traumatic Stress Network. National Center for PTSD . Psychological First Aid Field Operations Guide, 2nd Edition. http://dmh.mo.gov/diroffice/disaster/PsychologicalFirstAid--FieldOperationsGuide2ndedition.pdf

Case 49: Reuniting families and missing persons after Hurricane Katrina, U.S.A., 2005

Topic: Identifying lost children and reuniting them with their families

September through December: 0 to 3 months after landfall

The Katrina Missing Persons Hotline went live on September 5, 2005 (Labor Day). Through noon, December 7, 32 716 calls were handled, with 4909 reports of children missing or dislocated as a result of Hurricane Katrina and 102 children missing or dislocated as a result of Hurricane Rita (5011 total). By Christmas, 4371 children had been found and reunited with their families (87% of the total). This still left 740 children who had not been reunited with their searching relatives. Fortunately, NCMEC since has been able to identify and reunite every unaccompanied child in the shelters. Thus, there are no more lone children for whom there are searches for

parents or guardians. It seems likely that the remainder of those who still are not accounted for is not the usual "missing child" for whom the whereabouts are truly not known. They are better described as examples of "fractured families" in which the children are with one parent or other close relatives but there still is a parent or guardian who has not been reunited with his or her family. It also is suspected that a small number of these children did not survive the storm. The Justice Department also asked NCMEC to assist with their forensic imaging technology and specialists to help identify unidentified bodies at the appropriate time. Forensic artists routinely do facial reconstructions from skeletal remains or morgue photographs of unidentified deceased children.

March 17, 2006: 6 months after landfall

This article was written in December 2005. Since that time, the search for the 5192 missing and dislocated children from Hurricanes Katrina and Rita has continued. On March 17, 2006, the final child was reunited with her family, meaning that all 5192 cases have been resolved.

Source: Daniel D. Broughton, Ernest E. Allen, Robert E. Hannemann and Joshua E. Petrikin, 'Reuniting Fractured Families After a Disaster: The Role of the National Center for Missing & Exploited Children', "Getting 5000 Families Back Together: Reuniting Fractured Families After a Disaster: The Role of the National Center for Missing & Exploited Children", 2006, *Pediatrics*.

Sub Issue 4: Documenting and Remembering What Happened

According to the National Child Traumatic Stress Network and National Center for PTSD's "Psychological First Aid: Field Operations Guide, 2nd Edition," requirements like autopsies can be handled in a culturally sensitive way.

Sometimes exceptions are made for members of particular religious groups. In many jurisdictions, the law requires autopsies for any victim of a traumatic death or when the cause of death is not clear. This requirement may be upsetting, especially to members of religious groups that normally prohibit autopsies. In some jurisdictions, autopsy requirements can be waived by a Medical Examiner. Families who do not want an autopsy should be helped to find out about local laws. When a body has been significantly disfigured, you may suggest that—if it is in keeping with the religious tradition of the family—survivors place a photograph of the deceased on the casket in order to allow mourners to remember the person as he/she was alive and pay their respects.

Source: National Child Traumatic Stress Network and National Center for PTSD, "Psychological First Aid: Field Operations Guide, 2nd Edition". July, 2006. http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_2ndEditionwithappendices.pdf

Case 50: Mourning the dead, Armero Volcano, Colombia, 1985

Topic: recovering dead bodies

The town of Armero, in the Colombian Andes, was destroyed on 13 November 1985 by a volcanic eruption that caused an avalanche of ash, boiling mud, rocks, and trees. The landslide was almost 2 km wide and reached speeds of 90 km/h. It killed 80 percent of the 30,000 inhabitants of Armero, and left almost 100,000 inhabitants homeless in the surrounding region.

It was impossible to recover the corpses of the dead since the vast majority were dragged a great distance and buried under tons of sand and rubble. This situation prevented traditional ceremonies from being carried out, and many months after the disaster, family members were excited by rumors that the dead had been seen nearby or in far-off places, or wandering like a lost madman. Each of these false reports revised new hopes that were always followed by new disappointments. Two years after the tragedy corpses were found that were able to be identified; this motivated the families to seek the remains of their relatives in order to carry out conventional religious and cultural rites.

In the places where the houses stood, and which could more easily be identified later rather than in the immediate months after the disaster, headstones were placed with the names of the dead, and relatives now place flowers and say prayers there. They have become symbolic graves where families can conduct memorial activities, albeit belatedly.

Source: Pan American Health Organization and World Health Organization, 2004, "Management of Dead Bodies in disaster situations: Disaster Manuals and Guidelines, No.5", Chapter 4, p.113-115. Desjarlais R. et al., World Mental Health: Problems in Low-income countries (New York: Oxford University Press, 1995): Proframa de Cooperation International en Salud Mental "Simon Bolivar", Desasters, consecuencias psicosociales, Laexperiencia latinoamemricana (Serie de Monografias Clinicas No.2. Illinois (U.S.): Centro de la Familia Hispanica: 1989).

Lessons:

- Corpses are often lost in a disaster before relatives can claim them and bury them as their culture dictates
- Symbolic sites are identified where relatives can place headstones and to pay their respects to their dead relatives

According to the National Child Traumatic Stress Network and National Center for PTSD's "Psychological First Aid: Field Operations Guide, 2nd Edition," there are some key points to consider when thinking about how children mourn or experience memorial or funeral events.

In responding to questions children may have concerning a memorial service or gravesite, keep the following in mind:

- It can be helpful for a child to attend a funeral. Although emotionally challenging, funerals help children accept the physical reality of the death which is part of grieving. If not included, children can feel left out of something important to the family
- Parents/caregivers should give children a choice whether or not to attend a funeral or other ritual. They may be encouraged, but should not be pressured
- Before asking children to choose, tell them what to expect if they attend, including letting them know that adults may be upset and crying. Explain that there will be a special area for the family to sit together (if that is to be arranged). Let them know what will happen during the service
- Give them an opportunity to choose the person that they will sit next to at the service. Make sure that this person can pay appropriate attention to them
- Always provide a way for children to leave the service with that person, even temporarily, if they become overwhelmed
- Tell children about alternative arrangements if they do not wish to attend, such as staying with a neighbor or friend of the family
- If they choose not to attend, offer to say something or read something on their behalf, and explain how they can participate in memorial activities at a later time, including memorials of their own making
- If possible, bring younger children to the location early so that they can explore the space. Describe the casket and, if they wish, join them in approaching it. Caution should be exercised in regard to allowing young children to view or touch the body. A young child can use a photograph of the person to help say goodbye
- For younger children, reinforce that the deceased family member is not in distress

Source: National Child Traumatic Stress Network and National Center for PTSD, "Psychological First Aid: Field Operations Guide, 2nd Edition". July, 2006. http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_2ndEditionwithappendices.pdf

According to the National Child Traumatic Stress Network and National Center for PTSD's "Psychological First Aid: Field Operations Guide, 2nd Edition," "After traumatic death, some survivors may stay focused on the circumstances of the death, including being preoccupied with how the death could have been prevented, what the last moments were like, and who was at fault. These reactions may interfere with grieving, making it more difficult for survivors to adjust to the death.

These reactions include:

- Intrusive, disturbing images of the death that interfere with positive remembering and reminiscing
- Retreat from close relationships with family and friends
- Avoidance of usual activities because they are reminders of the traumatic death
- For children, repetitive play that includes themes involving the traumatic circumstances of the death

These reactions can change mourning, often putting individuals on a different time course than may be experienced by other family members. You may want to speak privately to a family member who was present at the time of the death in order to advise him/her about the extra burden of witnessing the death. Let him/her know that talking to a mental health professional or clergy member may be very helpful.

Some criteria for determining whether an emotional expression is becoming symptomatic are:

- Prolongation
- Intense suffering
- Associated complications (for example, suicidal behavior)
- Significant affects on the social and routine functioning of the individual

There have also been reports of an increase in the number of suicides in period's after-massive fatalities as a consequence of natural disasters.

Source: National Child Traumatic Stress Network and National Center for PTSD, "Psychological First Aid: Field Operations Guide, 2nd Edition". July, 2006. http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA 2ndEditionwithappendices.pdf

Case 51: Suicidal behavior, Colombia and Guatemala disasters

Topic: Delayed reactions to a disaster

Reports suggest that in recent years there has been a significant increase in the number of suicides in areas where massacres took place. Although there are no exact studies, and other factors can be an influence, an analysis of death records from the city of Rabinal (Guatemala) showed an evident increase of death by suicide which had been very rare in most indigenous cultures prior to the 1980s.

Among the most significant delayed effects noted as a result of the Armero disaster (Colombia) was the high number of suicides occurring among survivors in the first year after the tragedy. It is possible that the figures were even higher than reported, since suicide tends to be concealed or disguised as accidental death.

Source: Oficiana de Derechos Humanos del Arzobispado, Guatemala, op cit. Rodriguez J., 2002, op cit.

Lessons:

- Suicides increase post disaster
- Not all suicides that occur post disaster are reported as suicides

The National Child Traumatic Stress Network and National Center for PTSD's "Psychological First Aid: Field Operations Guide, 2nd Edition," provides the following guidance concerning:

- 1. Supporting survivors who receive a death notification;
- 2. Supporting survivors involved in body identification; and,
- 3. Helping caregivers confirm body identification to a child or adolescent.

Support Survivors Who Receive Death Notification

After learning of the death of a family member or close friend, people may have psychological and physiological reactions that vary from agitation to numbness. At the same time, they must cope with the continuing stress of still being in the disaster environment. In providing support, keep the following in mind:

- Don't rush. Family members need time to process the news and ask questions
- Allow for initial strong reactions: these will likely improve over time.
- When talking about a person who is a confirmed fatality, use the word "died," not "lost" or "passed away"
- Remember that family members do not want to know how YOU feel (sympathy); they want to know you are trying to understand how THEY feel (empathy)

Children may have a range of responses to being told of the death of a loved one. They may act as if they did not hear, they may cry or protest the news, or they may not speak for an extended period. They may be angry with the person who told them.

For adolescents, you can advise parents to caution teens about doing something risky, like storming off, driving while overwhelmed with such news, staying out late, engaging in high-risk sexual behavior, using alcohol or other drugs, or acting in some other reckless way. Parents/caretakers should also understand that an adolescent's anger can turn to rage over the loss, and they should be prepared to tolerate some expressions of rage. However, they should also be firm in addressing any behavioral risks. Expression of any suicidal thought should be taken seriously, and appropriate

additional assistance should be immediately sought. Expressions of revenge should also be taken seriously. Adolescents should be cautioned to think about the consequences of revenge, and be encouraged to consider constructive ways to respond to their feelings.

Family members should address immediate questions from children and adolescents about their living circumstances and who will take care of them. You may suggest that separation of siblings be avoided, if at all possible.

Support Survivors Involved in Body Identification

Where identifiable bodies have been recovered and family members have been asked to assist in the identification process, authorities may take family members to the morgue or an alternative location to view and identify the body. The Psychological First Aid provider will typically not participate in these activities, but may be of assistance prior to and after body identification. Some individuals may feel that they must see the body before they can accept that the person is dead. Adolescents and older children might ask to be present when the body is identified; however, in most cases, children should be discouraged from participating in the process. Children may not understand the extent to which the body has deteriorated or changed, and may find seeing the body extremely disturbing.

Help Caregivers Confirm Body Identification to a Child or Adolescent

After a family member has identified the body of a loved one, a caregiver should convey this to children. You may sit in to provide support and assistance. Since young children do not understand that death is final, a family member should make it very clear that the lost loved one's body has been found, and that he/she is dead. If the identification was made through forensic methods, it is important to explain the certainty of the identification in simple direct language. Parents should reassure children that the loved one is not suffering, that they were very loved by him/her, and that they will be taken care of. Allow children to ask questions, and—if an answer is not readily available—let they know that the parent or you will try to get additional information. You should caution parents/caretakers about giving disturbing details of the physical appearance of the body.

Source: National Child Traumatic Stress Network and National Center for PTSD, "Psychological First Aid: Field Operations Guide, 2nd Edition". July, 2006. http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA 2ndEditionwithappendices.pdf)

Case 52: Closure after a disaster, Great Hanshin-Awaji Earthquake, Kobe, Japan, 1995

Topic: "Photo Survey Study" Project

The book, "Telling Live Lessons from Disasters/Preciousness of Life: Hanshin Earthquake Note" was taken as a basic information tool by the students who learned about the Great Hanshin-Awaji Earthquake through class or school trips to study disaster management. They were extremely shocked by the pictures in this book. This

book has in total 47 photos from 6 newspaper companies, a news agency, a broadcasting corporation, student newspaper, public organization, and those offered by bereaved family or others.

The students wanted to know a lot about the photos and videos in those days such as "Why do not they run away in spite of coming close to fire" or "Why railways are left destroyed".

Source: http://home.kobe-u.com/sinsai/ The Great Hanshin-Awaji Earthquake - "Photo Survey Study" Project *Representative: Prof.Inagaki, Kobe University *"Our Hanshin Earthquake - Earthquake Photo "Survey Study" Project"

Lesson:

 Newspaper photos can be used to give students a true depiction of the damage and destruction caused by a disaster

Box 6: Cultural differences concerning death and respect for people's beliefs

Topic: Survivors when a family member or close friend has died

Culture Alert: Beliefs and attitudes about death, funerals, and expressions of grief are strongly influenced by family, culture, religious beliefs, and rituals related to mourning.

Learn about cultural norms with the assistance of community cultural leaders who best understand local customs. Even within cultural and religious groups, belief and practices can vary widely. Do not assume that all members of a given group will believe or behave the same way. It is important for families to engage in their own traditions, practices, and rituals to provide mutual support, seek meaning, manage a range of emotional responses and death-related adversities, and honor the dead person.

Source: National Child Traumatic Stress Network and National Center for PTSD, "Psychological First Aid: Field Operations Guide, 2nd Edition". July, 2006. http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA 2ndEditionwithappendices.pdf

Lessons:

- Beliefs and attitudes about death, funerals, and expressions of grief are strongly influenced by family, culture, religious beliefs, and rituals related to mourning.
- Rituals and traditions help individuals to cope with disasters

The Role of Media

This chapter discusses the critical role the media plays in helping to disseminate information to disaster survivors and their recovery efforts. Case studies are provided that examine a variety of media-related issues including cultural issues in media; media impact; media multiple stories; and, media outreach to special needs populations.

Role of Media & Information

A number of reports and studies were reviewed to develop the following summary of the role of media and information in recovery.

In addition to lives and health, truth and justice often become casualties in emergency situations. Emergencies tend to destabilize conventional channels of information and communication. Communications infrastructure may be destroyed, and existing communication channels may be abused by those with specific agendas e.g. the spreading of rumors or hate messages, or the fabrication of stories to cover neglect of duties. Rumors and the absence of credible and accurate information tend to be major sources of anxiety for those affected by an emergency and can create confusion and insecurity. Moreover, a lack of knowledge about rights can lead to exploitation.

Appropriate information received at an appropriate time may counter this. A responsible mechanism should proactively disseminate such useful information. Information and communication systems can be designed to help community members play a part in recovery processes and thus be active survivors rather than passive victims. Information and communication technology (ICT) and traditional methods of communication and entertainment – such as sketches, songs and plays – can play a crucial role in disseminating information on survivors' rights and entitlements, while appropriate information about relief and the whereabouts of displaced people can help to reunite families. In addition to the specific actions described below, ensuring good governance during emergencies through transparency, accountability and participation will help to improve access to information.

Key actions:

- 1) Facilitate the formation of an information and communication team.
 - If regular communication systems (in terms of people and infrastructure) are not fully functional, help to constitute a team of communicators to provide information on the emergency, relief efforts and legal rights and to strengthen the voices of marginalized or forgotten groups. The team may be drawn from local media organizations, community leaders, relief agencies, the government or other parties involved in the emergency response. Members of the affected community themselves may play a key role in disseminating information about services
- 2) Assess the situation regularly and identify key information gaps and key information for dissemination.
 - Study available assessments and the challenges they highlight
 - Analyze who controls channels of communication, asking whether particular groups are disseminating information in ways that advance specific agendas.
 - Conduct, when necessary, further assessments that address the following questions:
 - Which communities/groups of people are on the move and which have settled?
 - Who are the people at risk: are they the commonly recognized vulnerable groups or are they new ones?
 - Are there reports of survivors who have lost mobility? If so, identify where they are located and the existing response.
 - Where can people locate themselves safely and which places are dangerous?
 - If mental health and psychosocial supports are available, who is providing these supports? Which agencies are active in this area? Are they covering all affected communities and segments of the population? Are there sections of the community that have been left out?
 - What opportunities exist to integrate information and communication campaigns with other, ongoing relief efforts?
 - What is the level of literacy among men, women, children and adolescents in the population?
 - Which pre-existing communication channels are functional? Which channels would be the most effective in the current situation to carry messages related to the emergency, relief efforts and legal rights?
 - Which are the population groups that do not have access to media?

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- Which are the groups that have no access to media due to disability (e.g. people with visual or hearing impairments)? What methods may need to be developed for dissemination of information to reach out to such people?
- Collect and collate relevant information on a daily basis. This may include information relating to:
 - Availability and safety of relief materials
 - Ceasefire agreements, safe zones and other peace initiatives
 - Recurrence of emergency-related events (e.g. violence or earthquake aftershocks);
 - > The location and nature of different humanitarian services
 - > The location of safe spaces and the services available
 - ➤ Key results of assessments and aid monitoring exercises
 - Major decisions taken by political leaders and humanitarian coordination bodies
 - Rights and entitlements (e.g. quantity of rice that a displaced person is entitled to, land rights, etc.)
- Monitor relevant information issued by governments or local authorities, in particular information relating to relief packages
- Ask different stakeholders in the population, as well as relief workers, about
 the key information gaps that should be addressed (e.g. lack of knowledge
 about services, entitlements, location of family members, etc.). Work with
 survivors to identify the kind of messages they would like to disseminate and
 the appropriate way of doing this, anticipating the public impact it can have.
- Identify on an ongoing basis harmful media practices or abuses of information that should be addressed. Such practices include:
 - Dissemination of prejudicial/hate messages
 - Aggressive questioning of people about their emotional experiences
 - Failure to organize access to psychosocial support for people who have been asked about their emotional experiences in the disaster
 - Stigmatizing people by interviewing them in inappropriate ways
 - Use of images, names or other personally identifying information without informed consent or in ways that endanger survivors
 - Identify on an ongoing basis good media practices, such as:
 - Inviting experienced humanitarian workers (in the area of MHPSS) to give advise through media

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- Providing specific advice through news briefings.
- 3) Develop a communication and campaign plan
 - Maximize community participation in the process of developing a communication and campaign plan
 - Develop a system to disseminate useful information that addresses gaps identified
 - Educate local media organizations about potentially helpful and potentially harmful practices, and how to avoid the latter
 - Respect principles of confidentiality and informed consent
- 4) Create channels to access and disseminate credible information to the affected population.
 - Identify people in the affected population who are influential in disseminating information within communities
 - Generate a media and communications directory, including:
 - ➤ A list of local media with the names and contact details of key journalists covering stories relating to health, children and human interest
 - ➤ A list of names and contact details of journalists who are covering the emergency
 - A directory of personnel in different humanitarian agencies working in communications
 - Communication teams may create channels to disseminate information using local languages. This may include negotiating airtime on local radio stations or space on billboards at main road junctions and in other public places, or at schools, relief camps or toilet sites
 - In the absence of any media, consider innovative mechanisms such as distributing radios
 - Engage local people at every stage of the communication process, and make sure that messages are empathetic (showing understanding of the situation of disaster survivors) and uncomplicated (i.e. understandable by local 12-year-olds)
 - Organize press briefings to give information about specific humanitarian activities planned to happen in the next few days i.e. what, when, where, who is organizing the activity, etc.
 - Ensure that there is no unnecessary repetition of past horrific events in local media (e.g. avoid frequently repeating video clips of the worst moments of

the disaster) by organizing media briefings and field visits. Encourage media organizations and journalists to avoid unnecessary use of images that are likely to cause extreme distress among viewers. In addition, encourage media outlets to carry not only images and stories of people in despair, but also to print or broadcast images and stories of resilience and the engagement of survivors in recovery efforts.

- Sustain local media interest by highlighting different angles, such as the various dimensions of mental health and psychosocial well-being, survivors' recovery stories, the involvement of at-risk groups in recovery efforts and model response initiatives
- Disseminate messages on the rights and entitlements of survivors, such as disability laws, public health laws, entitlements related to land for reconstruction, relief packages, etc.
- Consider preparing messages on international standards for humanitarian aid, such as the Sphere Minimum Standards
- Consider distribution methods that help people to access information (e.g. batteries for radios, setting up billboards for street newspapers)
- 5) Ensure coordination between communication personnel working in different agencies

Coordination is important to:

- Ensure the consistency of information disseminated to the affected population
- Facilitate the development of inter-agency information platforms (e.g. bulletin boards) where survivors can go to receive all essential information, including information on positive ways of coping

Assessments are conducted to identify whether the affected population is receiving key information on the emergency, relief efforts and their legal rights.

 When there are gaps in key information, the relevant information is disseminated in a manner that is easily accessible and understandable by different sub-groups in the population

Sources and additional references on media issues in psychosocial recovery:

Action Aid International (forthcoming) Mind Matters: Psychosocial Response in Emergencies (video).

IASC (2003). Guidelines for HIV/AIDS Interventions in Emergency Settings.

Action Sheet 9.1: Provide information on HIV/AIDS prevention and care, pp.91-94. Geneva: IASC.

GUIDANCE NOTE ON RECOVERY: PSYCHOSOCIAL

- http://www.humanitarianinfo.org/iasc/content/products/docs/FinalGuidelines17Nov 2003.pdf
- OCHA (forthcoming). Developing a Humanitarian Advocacy Strategy and Action Plan: A Step-by-Step Manual.
- Office of the United Nations Secretary-General Special Envoy for Tsunami Recovery (2006).
- The Right to Know: The Challenge of Public Information and Accountability in Aceh and Sri Lanka

New York: United Nations.

http://www.tsunamispecialenvoy.org/pdf/The_Right_to_Know.pdf

Sphere Project (2004). Humanitarian Charter and Minimum Standards in Disaster Response.

Geneva: Sphere Project. http://www.sphereproject.org/handbook/index.htm

UNICEF (2005). Ethical Guidelines for Journalists: Principles for Ethical Reporting on Children.

http://www.unicef.org/ceecis/media 1482.html

UNICEF (2005). The Media and Children's Rights (Second Edition). New York: UNICEF.

http://www.unicef.org/ceecis/The Media and Children Rights 2005.pdf

Case 53: Sending messages concerning the recovery to the public, Hanshin-Awaji Earthquake, Japan, 1995

Topic: Earthquake Message Project

NHK (Japanese national broadcasting corporation) Kobe has broadcasted "News from Kobe" every 6pm since 2002 for Hyogo prefecture area. The main theme was "Hanshin-Awaji earthquake."

Characteristics of "Earthquake Message Project" are the following five points.

- Tell continuously: to remind about the earthquake, by broadcasting every Monday
- 2. Tell in a diversified way: hear each view point
- 3. Tell clearly: to make one message in five or six minutes to let listener focus
- 4. Tell from the heart: collect messages from bereaved families

Source: Institute for Fire Safety and Disaster Preparedness, 2005, "9th Disaster Management Grand Prize: Case collection," Ministry of Internal Affairs and Communications Fire and Disaster Management Agency. P.24-45. (in Japanese).

Sub Issue 1: Cultural Issues in Media

Case 54: Language barriers to communications, Northridge Earthquake, U.S.A., 1994

Topic: Disaster Strikes a Highly Diverse Community

On January 17, 1994, a major earthquake struck Los Angeles and Ventura Counties. The Northridge earthquake was the largest and most violent to hit an urban area in the United States since the 1906 San Francisco quake.

The post-disaster recovery effort provided mental health services to 1.9 million persons, representing myriad ethnic groups, special populations, and lifestyles. The size and scope of the two affected counties, as well as the ethnic diversity of their residents, constituted a challenge to disaster mental health providers. For example, Ventura County is home to many undocumented migrant farm workers, the majority of whom do not speak English and are mistrustful of government at any level. Language and cultural barriers had to be overcome for persons from several Asian cultures as well.

The diverse population in the affected areas also included other special populations, such as physically challenged persons and runaway youth, two groups that required special outreach strategies.

The disaster mental health program staff recognized from the beginning of the project the need to develop and provide culturally relevant and linguistically appropriate services, covering a multitude of cultures and languages.

Source: California Final Report, 1995. Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations

Case 55: Cultural barriers to communications, Hurricane Georges, Alabama, U.S.A, 1998

Topic: Multiple Methods Employed to Communication with Asian Groups

Hurricane George caused extensive damage in Alabama in 1998, leaving many people homeless and others with major losses to their homes and businesses. Included among the disaster survivors was an Asian population. The disaster crisis counseling program used several methods to reach and serve them. For example, it developed leaflets in the Cambodian, Laotian, and Vietnamese languages and distributed them to churches serving large numbers of Asian immigrants. The crisis counseling project also employed interpreters, a strategy that was viewed as highly effective in disseminating information to these groups. Finally, the project provided screening and information services to Asian adolescents in a church group.

Source: Alabama Final Report, 1999 Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations

Lesson:

 Interpreter and translated materials used to effectively reach non-English speaking populations

Case 56: Language barriers, Winter Storms, Fresno County, California, U.S. 1995

Topic: Bilingual and Bicultural Staff Assist Assuring Cultural Competence

Late winter storms in California in 1995 affected several ethnic groups in Fresno County. The county crisis counseling project sought to deliver services in a bilingual, bicultural manner. Staff members were assigned to match the ethnic and cultural attributes of each community; for example, Spanish-English speakers primarily concentrated in one area of the county, while Hmong-English speakers were deployed to another area.

Brochures and other forms of written information were translated into both Hmong and Spanish. Interpreters were used to reach persons who spoke Punjabi, Armenian, and Chinese. The project also arranged to provide oral translations of handouts for those who were illiterate.

Source: Jean Athey; Jean Moody-Williams. Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations. 2003. http://www.diversitypreparedness.org/Topic/Subtopic/Record-

Detail/18/audienceld__15872/resourceld__16080/

Lesson:

Non-English speakers and materials used to promote disaster info

Case 57: Communicating during the recovery, Aceh, Indonesia, 2005

Topic: Activities by NGOs

After reviewing existing self-care materials, national staffs from an international NGO were trained to conduct focus groups to identify what people were going through (common reactions) and what activities people used to cope with the stress.

An artist was contracted to draw pictures depicting people from Aceh in local dress, portraying concepts that the community had identified. Another set of pictures illustrated the deep breathing relaxation technique.

The brochures were explained and distributed during community gatherings, e.g. after evening prayers at the mosque. Brochures were also distributed to other organizations, which in turn distributed them through their intervention programmes.

Through the psychosocial coordination group, agencies jointly continued producing newsletters with information that represented the concerns of tsunami affected communities and local civil society. A local NGO was funded and supervised to continue producing relevant newsletters.

Sources:

- 1. American Red Cross (2004). From Crisis to Recovery, the Road to Resiliency: A Small Pocket Manual. American Red Cross Psychosocial Group, New Delhi. http://www.who.int/mental_health/emergencies/mh_key_res/en/index.html
- 2. International Catholic Migration Commission (ICMC) (2005). Setelah Musibah (After Disaster). ICMC, Indonesia. http://www.who.int/mental_health/emergencies/mh_key_res/en/index.html
- 3. World Health Organization (2005). Some Strategies to Help Families Cope with Stress. WHO, Pakistan. http://www.who.int/mental health/emergencies/mh key res/en/index.html

Lessons:

- Use focus groups to identify issues
- Use newsletters and brochures to communicate disaster information

Sub Issue 2: Media Impact

Case 58: Rumor and stigma: Who do you trust?

Topic: What news sources do people trust?

The correlation between the loss and the social trust for government. This result shows that the correlation between the loss and the social trust for government is significant. They received the message about the debris flows from TV news most frequently (92.0%), and from neighborhood magistrates as the second source (63.6%). Moreover, the third source is Newspaper/magazine (36.4%). The most frequent source is about triple than the third one. Otherwise, 16.9% participants very trust the neighborhood magistrates, and 14.1% participants very trust the TV news, both they are the most frequent information sources. On the other hand, this paper found that people received the information about the debris flow from two primary sources: TV news and neighborhood magistrates. Also, people trust these two sources more than others. As a result, risk managers have to focus on TV news and neighborhood magistrates when they deliver the messages of the debris flow and teach knowledge about the disaster management.

Source: Kai-Min Liao, Sue-Huei Chen and Hsin-Chi Li

Lessons:

- Trust in government as source of information can be low
- TV news and neighborhood magistrates found to be more trusted by people

ANNEXES

Annex 1: Check List of situation and roles of governance and specialist by stage

Early stage activity (from one week to one month after disaster)

- Follow of same as high risk group
- Awareness activity for preventing deterioration
- Phase to tackle mental health improvement of all regions

In this phase, stress response is coming to head

- Enforcement the oral explanation about stress response and health education through poster or brochure distribution
- Publicity the contact of consultation because the information itself that "there is the contact" connect to victim's peace of mind in case of emergency
- Assistant stress is increasing because of overwork
- Staffs in the suffered area are forced to tackle huge disaster measure although
 they are also victims. We try to think the cooperation system for avoiding too
 much burden on particular staff. Health education for assistant workers is also
 needed

Middle stage (from one month to three month after disaster) and Integration period activity (more than three month after disaster)

- Health education for depression, PTSD, suicide
- Health canceling
- Assistance for reconstruction

Middle stage (from one month to three month after disaster)

Forecasted situation or state	Main policy of city, town, or village public health center	Role of Mental health welfare center		
 ✓ Anxiety for reconstruction ✓ New formation of community ✓ Recovery gap between the residents ✓ Concerns of PTSD, depression, and maladjustment ✓ Problems related with alcohol 	living ✓ To continue health counseling ✓ Watch the support required	✓ Consulting mental health care • at clinics • counseling by phone • visiting shelters etc ✓ Advise for case meeting ✓ Support screening ✓ Support dissemination activity ✓ Psychosocial support for		

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Forecasted situation or state	Main policy of city, town, or village public health center	Role of Mental health welfare center
	and early intervention✓ Support activities in the facilities	supporters
	✓ Plan for psychosocial support for supporters	

Integration period activity (more than three month after disaster)

Forecasted situation or state	Main policy of city, town, or village public health center	Role of Mental health welfare center
 ✓ New regional development such as closing shelters or moving into temporally housing ✓ Showed the feeling left behind because of difficulty to fit new life ✓ Withdrawal, alcohol problem, and suicide, ✓ Prolong PTSD 	 ✓ Arrangement of continuous supporters and observers ✓ Support for normal activity in facilities ✓ Support for visiting support and exchange meeting for elderly ✓ Closing psychosocial support and shifting to normal mental health activity 	 ✓ Advise for case examination ✓ Advise for counterplan to withdrawal ✓ Presentation regional analysis of new community or technology for support ✓ Backup for shift from anti-disaster policy to normal affairs

Source: "Iwate prefecture mental health manual in disaster situation," 2006, Iwate prefecture mental health welfare center. (in Japanese)

 $http://www.pref.iwate.jp/^{\sim}hp1005/seisin/saigai/Mental\%20 health\%20 for\%20 disaster.htm$

Annex 2: Analyzing Disrupted Health Sectors: A Modular Manual

Generic model for providing Psychosocial Support (PSS) in disaster situations Disaster preparedness (to include PSS in all programmes of preparedness)

Phase I (first 6 weeks)

- Mental Health Professionals to be part of medical teams and provide care for acute events
- Manuals and modules for care in the community will have to be adapted and translated by an academic agency and made ready for use in the community.
- Department of Health, Department of Social Welfare and Department of Education of the State Government should identify nodal officers for PSS in the State
- This apex coordinating group (NGOs, academic institutions, and development partners) along with responsible persons in the affected districts from the corresponding departments
- To develop an action plan for training, identification of service delivery mechanisms and monitoring

Phase 2 (6 weeks to 6 months)

- Selection of CLWs
- Training of CLWs
- Field work initiated
- CLWs closely monitored
- Referral system initiated
- Frequent visits by monitoring teams

Phase 3 (6 months to 1 year)

- Full fledged field work with linkage to other social support systems and Governmental rehabilitation schemes
- Periodic monitoring
- From 1 year the activities can be scaled down and active interventions can be withdrawn formally by the end of 2 years
- The scheduling will vary depending on the type of disaster and the populations affected

Source: Psycho-social Support for Tsunami Affected Populations in India. Dr. Cherian Varghese MD, DNB, M Phil., PhD, WHO India Country Office, New Delhi. UN team for recovery support (UNICEF, UNFPA, UNDP, UNODC & Partners)

Annex 3: Intervention of Primary and Secondary Prevention, Psychological First-Aid, Family and Community Support, and Community Support Functioning

Public Health Measures	Individual/Group Measures
Principle: Safety	
 As much as possible, bring people to a safe place and make it clear that it is safe Provide an accurate, organized voice to help circumscribe threat and thereby increase the perception of safety where there is no serious extant threat Inform the media that enhancing safety perceptions in a community can be achieved by media coverage that strategically conveys safety and resilience rather than imminent threat Encourage individuals to limit exposure to news media overall, and to avoid media that contain graphic film or photos if they are experiencing increased distress following viewing Recommend limiting the amount of talking about the trauma if doing so makes one more anxious or depressed Teach people how to discriminate between political propaganda and more realistic information regarding threat in the context of war and terrorism. Educate parents regarding limiting and monitoring news exposure for children 	 Engage in imaginal exposure and real-world, in-vivo exposure which: Interrupt the post-traumatic stimulus generalization that links harmless images, people, and things to dangerous simuli associated with the original traumatic threat Re-link those images, people, and events with safety (The Bridge that collapsed was threatening, but all bridges are not." "That night was unsafe, but all nights are not unsafe.") Utilize "grounding techniques," such as reality reminders, to bring individuals to the relative safety of the present time Teach contextual discrimination in the face of trauma and loss triggers Assist in developing more adaptive cognitions and coping skills With children, include methods that aid in the reversal of regression in the ability to discriminate among indications of danger
Principle: Calming	
 First and foremost, engage in actions that help people directly solve concerns. (e.g., bolstering initial resources and preventing resource loss) Give information on whether family and friends are safe, and if further danger is impending Provide large-scale community outreach and psycho education via media presentation, interactive websites and computer programs about the following topics: Post-disaster reactions to help individuals see their reactions as understandable 	 Offer direct approaches in anxiety management to help those with severe agitation, "racing" emotions, or extreme numbing reactions attain a state of mastery or calming, such as: Therapeutic grounding (For those with re-experiencing symptoms) Breathing retraining Deep muscle relaxation Stress inoculation training, including: coping skills

Public Health Measures

and expectable

- Anxiety management techniques for common post-trauma problems (e.g., sleep problems, reactivity to reminders, startle reactions, incident-specific new fears)
- Signs of more severe dysfunction, so that people also do not underpathologize their symptoms and know where to turn for professional assessment and treatment
- > Limiting media exposure for those with minor to mid-level problems of anxiety
- Receiving news reports from a friend or family member that give the facts without the images and hyperbole, for those with more severe emotionality

Not Recommended:

> The use of lies, or "spinning" information, in order to calm a population or a group of rescued individuals, which ultimately undermines credibility and is counter-productive

Individual/Group Measures

- deep muscle relaxation
- breathing control
- assertiveness
- role playingcovert modeling
- thought stopping, positive thinking and self-talk
- Yoga
- Mindfulness treatments
- Imagery and music paired with relaxed states
- Medications such as anti-adrenergic agents, antidepressants, and conventional anxiolytics
- Interventions with a combination of anxiety management skills, cognitive restructuring, and exposure
- > Training in problem-focused coping, which assists individuals in breaking down the problem into small, manageable units. This will:
 - increase sense of control
 - provide opportunities for small wins
 - decrease the real problems people are facing
- "Normalization" of stress reactions to reduce anxiety associated with reactions (e.g., "I'm going crazy," "There's something wrong with me," "I must be weak.")
- Involvement with uplifting activities not associated with the trauma
 - Purpose:
 - To distract from distressing preoccupation with the trauma and its aftermath, (for individuals who are not in extreme distress)
 - To promote a sense of predictability, normalcy, and control (in both the outer world and inner world of cognition and emotions)
 - To foster positive emotions that include joy, humor, interest, contentment, and love and have a functional capacity to broaden a "thought-action" repertoire that leads to effective coping
- Examples:
 - > Being with friends
 - Listening to calming music
 - Going to a movie

Public Health Measures	Individual/Group Measures
	 Watching a situation comedy Exercise (also has a depression-reducing and an anxiety-reducing effect) Not Recommended: Benzodiazapene tranquilizers, which have been shown to increase the likelihood of PTSD among symptomatic trauma survivors, despite an immediate calming effect Psychological debriefing, which may enhance arousal in the immediate aftermath of trauma exposure Alcohol, which can lead to potential misuse and other alcohol-related behaviours
Principle: Self- and Collective Efficacy	
 Provide people with outside resources that can be used to help reverse the loss cycle, which leads to empowerment and restored dignity among citizens Create a way to manage and orchestrate people's personal and environmental resources As much as possible, involve victims in decision-making policy and efforts (e.g., targeting of need), to rebuild self- and collective efficacy. Promote activities that are conceptualized and implemented by the community, such as: religious activities meetings rallies collaboration with local healers collective healing and mourning rituals Foster "competent communities" that: encourage the well-being of their citizens provide safety make material resources available for rebuilding and restoring order share hope for the future support families, who are often the main provider of mental health care after disasters foster the perception that others are available to provide support, which: 	 Individual and group-administered cognitive behavioral therapy (CBT) should: Remind individuals of their efficacy Encourage active coping and good judgment about when and how to cope Enhance sense of control over traumatic stressors Help to "recalibrate" expectations and goals that were formed under "normal" circumstances Translate intervention within the socio-cultural ecologies of the target countries Foster behavioral repertoires and skills that are the basis of the efficacy beliefs, wit practice involving increasingly difficult situations Teach individuals to set achievable goals, so they may: reverse the downward spiral toward feelings of failure and inability to cope have repeated success experiences reestablish a sense of environmental control necessary for successful disaster recovery With children and adolescents: Address developmental interruptions Promote normal and adaptive developmental progression Teach emotional regulation skills when faced by trauma reminders Enhance problem-solving skills in regard to post-disaster adversities

Public Health Measures

Individual/Group Measures

- mitigates the perception of vulnerability
- emboldens individuals to engage in adaptive activities they might otherwise see as risky
- Collaborate with rural development and vocational skills training initiatives to:
 - > help local populations to enhance their survival capacities
 - > increase resilience and quality of life
 - prevent exacerbation of psychological disturbances by instilling hope and helping survivors to acquire a sense of control and mastery
- For children and adolescents:
 - > Be cognizant of the dangers of over-protectiveness
 - > Include them in community recovery
 - > Facilitate restoration of the school community, which fosters:
 - renewed learning opportunities
 - engagement in age-appropriate, adult-guided memorial rituals
 - school-initiated pro-social activity (learned helplessness into learned helpfulness)

Principle: Connectedness

- Help individuals to identify and link with loved ones
- Facilitate reconnection of children with parents and parental figures
- Increase the quantity, quality, and frequency of supportive transactions between trauma survivors and their social supporters
- Treat temporary housing and assistance sites as villages, whichhave:
 - > village councils
 - > welcoming committees
 - > churches
 - places to go for services
 - meeting places
 - entertainment
 - sports fields
 - recreational activities
 - > places for teens to congregate under supervision
 - > religion-school-community partnership networks

- Identify and assist those who lack strong support, who are likely to be more socially isolated, or whose support system might provide undermining messages (e.g., blaming, minimalization).
- In cases of evacuation and destruction of homes and neighborhoods, or where informal social support fails, make it a priority to:
 - > keep individuals connected
 - train people how to access support
 - provide formalized support
- Target social support via psychoeducation and skills-building, including:
 - > Enhancing knowledge of specific types of social support, such as:
 - emotional closeness
 - social connections
 - feeling needed
 - reassurance of self-worth
 - reliable alliance
 - advice

Public Health Measures

- mentoring services
- community solidarity activities
- citizens who fill social roles within their natural cultural traditions and practices
- As much as possible, address potential negative social influences (e.g., mistrust, ingroup/out-group dynamics, impatience with recovery, exhaustion, etc.) when designing interventions

Individual/Group Measures

- physical assistance
- material support
- Identifying potential sources of such support
 Learning how to appropriately recruit support
- Teach individuals to ignore attachment bonds in evacuation procedures
- With families, include specific strategies to address discordance amongfamily members that may stem from:
 - differences in the type and magnitude of exposure to trauma, loss, and subsequent adversities
 - differences between family members' personal reactions to trauma and loss reminders

Principle: Hope

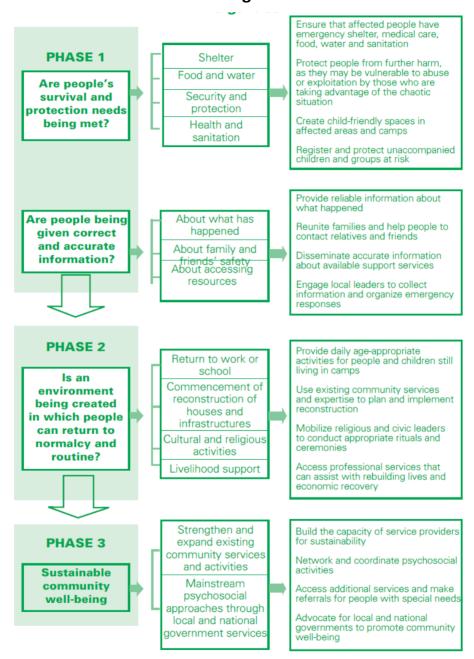
- Provide services to individuals that help them get their lives back in place, such as:
 - housing
 - employment
 - relocation
 - replacement of household goods
 - clean-up and rebuilding
 - > payment of insurance reimbursements
- Develop advocacy programs to help victims work through red tape and the complex processes involved in the tasks that emerge following mass disaster.
- Support rebuilding of local economies that allow individuals to resume their daily vocational activity, to prevent ongoing resource loss cycles
- The media, schools and universities, and natural community leaders (e.g., churches, community centers) should help people with:
 - Linking with resources
 - > Establishing systems that enable those in recovery from similar traumas to share their experience and hope with those struggling with recovery
 - Memorializing and making meaning
 - Accepting that their lives and their environment may have changed
 - Making more accurate risk assessment
 - Reducing self-blame

- Cognitive behavioral therapy (CBT) that:
 - Reduces exaggeration of personal responsibility and counteracts cognitive schemas, such as catastrophizing and the belief that problems are due to an internal, stable trait
 - Identifies, amplifies, and concentrates on building strengths
 - Normalizes responses
 - Indicates that most people recover spontaneously
 - Highlights already exhibited strengths and benefit-finding, rather than promoting benefit-finding prior to an individual's readiness.
 - Includes guided self-dialogue to:
 - envision a realistic, yet challenging, even difficult outcome (e.g., accepting
 that one's home will take months to rebuild vs. the assertion that "I will
 never have a home again")
 - underscore and restructure irrational fears
 - manage extreme avoidance behavior
 - control self-defeating self statements
 - encourage positive coping behaviors
- With children and adolescents, CBT that:
 - > Addresses ongoing trauma-generated expectations, beyond symptom response
 - > Includes forward-looking exercises that promote developmental progression to

Public Health Measures	Individual/Group Measures
➤ Problem-solving	instill hope and renewed motivation for learning and future planning
Setting positive goals	
 Building strengths that they have as individuals and communities 	

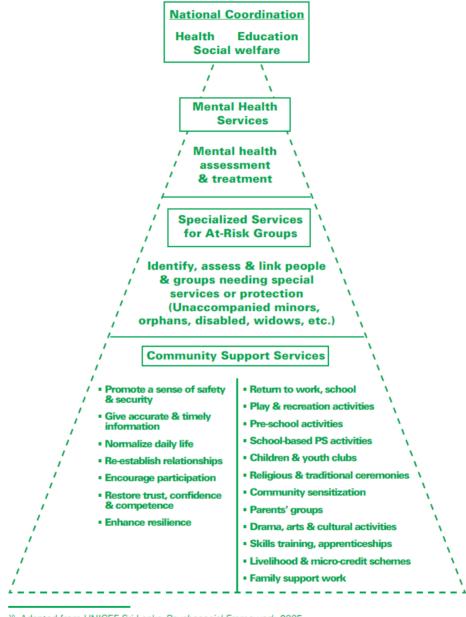
Source: Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence, the Journal of Lifelong in Psychiatry, Vol VII, No. 2, Spring 2009, p.235-237

Annex 4: Phases in Assessing and Supporting Psychosocial Well being in Emergencies



⁸ Adapted from the Framework of the Psychosocial Well-Being Working Group of the Consortium of Humanitarian Agencies in Sri Lanka

Annex 5: National Coordination Framework



¹⁰ Adapted from UNICEF Sri Lanka Psychosocial Framework, 2005

Source: Handbook on psychosocial assessment of children and communities in emergencies (from IRP Access hub) For further information: www.psychosocialnetwork.org

Annex 6: Acknowledgements

IRP and UNDP India would like to acknowledge the input and expertise of the following individuals who participated in consultative workshops, served as resource person and technical experts, contributed case studies and/or peer reviewed the Guidance Note on Recovery: Psychosocial

Abdulkhaeq Yahia Al-Ghaberi, Head of the Unit, External Coordination Unit Ministry of Water & Environment Yemen; Atsushi Koresawa, Asian Disaster Reduction Center (ADRC); Benjamin McGehee Billings, Majority Staff Director Subcommittee on Disaster Recovery, U.S. Senate Homeland Security Committee; David Stevens, United Nations Office for Outer Space Affairs (UNOOSA); Dr. Abdul Matine "Adrak", Afghanistan National Disaster Management Authority; Dr. Ehsan Mahmoud Kalayeh, Housing Foundation of Iran; Dr. Jayakumar, NDMA;

Dr. Kumar Rajan, WHO, India; Dr. Neil Britton, Asian Development Bank(ADB); Dr. Prachi, UN (India); Dr. R. Sekar, NIMHANS; Dr. R.P. Sinha, UNOPS; Dr. Sudibyakto Senior Researcher, Professional Directive of BNPB National Agency for Disaster Management(BNPB) Indonesia: Dr. Sujata Satapathy, NIDM, Delhi; Dr. T. Yoyok Wahyu Subroto, Department of Architecture and Planning Gadjah Mada University, Indonesia; Engr. Majid Joodi, Director-General for Recovery Iran; H.E. Abdulla Shahid, Minister of State for Housing, Transport and Environment, National Disaster Management Centre (NDMC) Maldives; Helena Molin Valdes, Deputy Director, United Nations International Strategy for Disaster Reduction (UNISDR); Ibraheem Hosein Khan, Deputy Secretary, Ministry of Food And Disaster Management Bangladesh; Hemanshee Pradhan, WHO, India; J. Radhakrishnan, UNDP; Jennifer Nyberg, Emergency Operations and Rehabilitation Division, Food and Agriculture Organization of the United Nations (FAO); Marqueza Cathalina Lepana-Reves, ASEAN Secretariat (ASEAN-UNISDR Technical Cooperation on HFA Implementation in ASEAN); Mohammad Abdul Wazed, Joint Secretary Ministry of Food & Management Bangladesh; Mr. Sugeng Triutomo, Deputy Chief Prevention and Preparedness Division, National Agency for Disaster Management (BNPB) Indonesia; Myint Thein, Ministry of Social Welfare, Relief and Resettlement, Myanmar; P.K. Dash, MCD; Prabodh Gopal Dhar Chakrabarti, SAARC Disaster Management Centre (SAARC DMC); Rudra Prasad Khadka, Under Secretary Disaster Management Ministry of Home Affairs Nepal; Saiful Mohammad, UNDP; Sally McKay, Disaster Management Unit Asia Pacific Zone Office, International Federation of Red Cross and Red Crescent Societies(IFRC); Shaukat N. Tahir, Senior Member of National Disaster Management Authority, Prime Minister's Secretariat of Pakistan; Thir Bahadur, Under Secretary Disaster Management Ministry of Home Affairs Nepal; Thomas Eldon Anderson, State Director, Office of U.S. Senator Mary Landrieu, USA; Unupitiya Wijesekera Liyanage Chandrasa, Director, Mitigation and Technology Disaster Management Centre, Sri Lanka; Yoshimitsu Shiozaki, Kobe University, Japan.

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Special thanks to the partners who support IRP: Asian Disaster Reduction Center(ADRC); Hyogo Prefectural Government, Japan; International Federation of Red Cross and Red Cresent Societies(IRFC); International Labour Organization (ILO); Ministry of Foreign Affairs Government of Italy; Cabinet Office Government of Japan; Swiss Agency for Development and Cooperation (SDC); Government of Switzerland; United Nations Development Programme (UNDP); United Nation Environment Programmes (UNEP); United Nations Human Settlements Programme (UN Habitat); United Nations International Strategy for Disaster Reduction (UNISDR), United Nations Office for the Coordination of Humanitarian Affairs (UN-OCHA), and The World Bank

























