

# Psychosocial care for people affected by disasters

According to the World Health Organization (WHO), only around 5 to 10 percent of the population affected by a disaster will need long term psycho-social interventions. Psychological effects are felt by everyone who is exposed to a disaster. Although, everyone is affected psychologically, majority of a given population exposed to a disaster will be able to cope.

## **Mental health and effects of disasters**

Mental health is affected by a disaster due to following main reasons.

### **a) Grief and mourning**

This is a Psychological reaction which follows the death of family members, friends and loved ones.

### **b) Exposure to a horrific event**

Disasters usually occur suddenly and totally unexpectedly, coming out of the blue with no previous experience. Many had a near death experience where their lives were saved miraculously. Many of them also witnessed their friends and family members getting killed or injured and were helpless and powerless to intervene.

### **c) Illness and physical injury**

Exposure to disasters usually can result in physical injury, loss of limbs and vulnerability to various forms of illness due to the adverse environmental factors. Many Tsunami victims were partially drowned resulting in forms of lung and respiratory diseases.

### **d) Living in an environment with no community network**

Following a disaster many people have to move out of their homes. Some houses were completely destroyed, other partially affected. Some move out of their homes for fear and safety.



Sports is a very good treatment for poor mental health conditions

## **Challenge to the society**

The challenge is the delivery of adequate, effective, and appropriate psychosocial care. It should be adequate to cover all who need care. It should be effective so that it provide comfort and relief to those affected. It also needs to be culturally sensitive where religious and traditional beliefs, attitudes and norms are respected.

## **Psychosocial interventions**

The psycho-social interventions provided have to be multi-sectored. This means involvement of medical and non medical mental health

professionals, governmental and non-governmental professionals, community volunteers and involvement of the disaster affected population themselves. It should be a multi-disciplinary and a participatory approach.

Service delivery should take place at different levels. Policy and planning can be at central level. The training to be done at provincial and district level. The implementation to take place at the community level.

All psycho-social interventions need to be socially and culturally sensitive and appropriate.

The service providers too would need psycho-social support and provisions to this effect have to be made available.

## **Reactions to disaster**

Reactions to disaster are many and may vary according to the individual and the circumstances. Psychological response can be immediate, midterm or long term. Common reactions seen after a disaster are:

### **a) Shock, disbelief and denial**

This is a common reaction in the immediate aftermath of a disaster. The person is in a state of shock not knowing how to respond. Disbelief and denial where the individual refuses to accept what has happened is common. This is regarded as a form of a protective mechanism of the mind to shield the individual from the traumatic experience. In the short term this is beneficial but prolonged denial and refusal to accept the reality is harmful.

**b) Fear**

This is a common reaction. Fear can be felt due to repeated memories of the trauma when the person is awake. It can also occur during sleep as nightmares. Fear due to the possibility of the disaster happening again is common. Rumors and misinformation contribute towards it. People tend to avoid situations and events that remind them of the tragedy.

**c) Anger**

Anger can be directed outwards at family members, friends, neighbours or close associates. It can sometime be directed at the rescue workers and people coming to their assistance, such as the health care workers. Occasionally anger can be directed at the deceased. Anger can also be directed inwards resulting in self injurious and self destructive behaviour. Suicide may be a tragic outcome of this destructive behavior.

**d) Confusion**

Mental confusion results due to many reasons. Psychological effects of the trauma, physical exhaustion, inadequate hydration, poor nutrition, exposure to adverse environment, environment, inadequate rest and illness and injury can all contribute to this state.

**e) Guilt and shame**

This reaction is seen in the immediate and medium term period. Self blame for the tragic event, feeling responsible and accountable for what has happened. Some feel shamed for not doing enough to help other victims. Some even regret to be alive which is termed psychologically as "Survivor Guilt".

**f) Grief (bereavement)**

Grief is define as the psychological reaction to loss. Grief can be normal or abnormal'. Abnormal grief reaction is called "pathological grief."

**Normal Grief Reaction**

This consists of 3 stages:

**Stage one- " It cannot be true " - stage of denial**

In this stage there are two psychological processes. Denial - where the person refuses to accept the loss. There is also Numbness-where the person does not feel the emotional pain and distress. This enables the individual to function as needed in the immediate aftermath of a disaster, The first stage lasts between few hours to few days.

**Stage two - "I feel miserable" - stage of sadness**

In the second stage the person feels the loss of the loved one. The person might direct the anger towards family and friends or people who were with the deceased at the time of the tragedy. There is often sleeplessness. Other psychological symptoms include hearing of the dead person's voice and having visions of the deceased. The person may misidentify the deceased person among a crowd. All these phenomena are normal in grief reactions and the person needs to be reassured these are not signs of insanity. Usually these features come in waves of emotions. The second stage last from few weeks to few months.

**Stage three- "It's time to move on" - stage reorganization**

During this stage the person comes to term with the loss and starts to readjust his or her life. The individual now begin to think about the future and makes plans accordingly. The memories of the deceased no longer bring out intense emotions. The person is now able to think about the good times spent with the deceased and enjoy the pleasurable memories. The individual resumes his normal day to day activities. The third stage last from few weeks to few months.

**Abnormal grief (Pathological grief)**

Grief is to be abnormal when the symptoms are:

- \* more intense than usual
- \* prolonged beyond six months
- \* delayed in onset

Abnormal grief reactions are more likely in several circumstances:

- \* after a death that was sudden and unexpected
- \* when the bereaved person was very close and dependent on the deceased
- \* when the survivor is insecure, or has difficulty in expressing feelings, or has suffered a previous mental disorder
- \* when the survivor has to care for dependent children and so cannot show grief easily

All the above reactions except Abnormal grief (Pathological grief) are regarded as *normal reactions to an abnormal situation*.

**Grief counseling**

Principles of grief counseling include:

- \* listening to the person's concerns
- \* providing information, explanation, and advice regarding the features of grief reaction
- \* encouraging the expression of emotion
- \* helping to accept the loss and take part in religious and socio-cultural activities associated with death
- \* supporting to solve practical problems
- \* encourage resuming day to day activities and planning for the future

### *Understanding death*

How a person understand that death depends on his age, previous experience, and his religious cultural background is considered here. An adult's concept of death includes:

- \* separation
- \* permanence
- \* immobility
- \* irreversibility
- \* physical causes of death
- \* universality
- \* inevitability

### *Children's understanding of death*

Most children develop a "mature" concept of death by the age of 8 to 10 years.

### **Psychosocial interventions**

#### **Aims of psycho-social interventions**

##### **a) Normalization of life**

The interventions that will help to normalization life include:

- \* ensuring basic needs are made - water, food, sanitation, shelter, mobility and safety
- \* reestablishment routine social practices - schooling, recreational activities, household duties, child care, home industries, employment and income generating activities
- \* re-uniting family tracing
- \* involving affected communities in the decision making and implementation of relief and rehabilitation

##### **b) Identifying high risk groups**

When the whole population of an area is affected it is important to identify and target the psycho-social interventions to these groups. High risk groups include:

- \* people who have lost all or majority of there immediate family members
- \* children who have lost both parents
- \* families with small children, where mother or father has died
- \* pregnant and lactating women
- \* disabled people
- \* elderly
- \* people vulnerable to harm and exploitation
- \* people with chronic disorders - epilepsy, diabetes, high blood pressure and mental disorders

##### **c) Provision of specialist care**

The following list includes the common mental disorders seen after a disaster:

- \* Acute stress reaction
- \* Bereavement disorders
- \* Adjustment disorders
- \* Depression
- \* Anxiety disorders
- \* Smatoform disorders
- \* Alcohol and drug abuse
- \* Post-traumatic stress disorder
- \* Exacerbation and relapse of pre-existing mental disorders.

These mental disorders require specialist mental health interventions and referral.

##### **d) Capacity building**

Developing technical and operational capacities of the governmental and non-governmental personal is an important activity in implementing psycho-social interventions. The activities include:

- \* preparation of guidelines
- \* training of selected service providers

#### **Interventions that can be harmful to the victims**

When implementing psycho-social interventions it is important to remember there are some activities which can be harmful to victims. Harmful activities include:

- \* forcing victims to talk about there experiences
- \* being aggressive or dominant over the victims
- \* giving sedatives to large numbers of people
- \* forcing people to do what YOU think is good for them
- \* 'labeling' people with medical diagnosis
- \* Promises which cannot be kept

### **References**

- \* World Health Organization manual for community level workers
- \* Where there is no psychiatrist - Vikram Patel
- \* Psychiatry - Oxford Core Text
- \* Guidelines for health workers in psycho-social care - Ministry of Health

**Dr Neil Fernando**  
Consultant Psychiatrist,  
Health Education Bureau