ADVANCES IN DISASTER MENTAL HEALTH AND PSYCHOLOGICAL SUPPORT

Edited by

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Preface

Since the psychology of disasters was introduced in 1948, many have struggled with the concept of disasters and mental health. The last 30 years have seen a major shift of perspective from the treatment of "mental illness" to "mental health care." This has meant that mental health care providers have moved closer to the community in there interventions and have, thereby, become psychosocial in their approach, using community resources and personnel. Although there has been an increasing acknowledgement of the need for mental health interventions, the actual translation of this sentiment into action is far from adequate. Lessons learned to date suggests that although this community approach is effective, programs suffer from not being able to receive a commitment to long-term rehabilitation of survivors. There seem to be many challenges in strengthening disaster mental health policy at all levels of disaster management and in providing psychosocial support at all stages of disaster response. Meeting these challenges would ensure that psychosocial support following disaster would be a norm and not an exception in the affected country.

Mental disorders are stigmatizing and walled off from the public health mainstream. Mental health needs to be accepted as integral to almost every aspect of health and development. The greatest obstacle to promoting mental health in developing countries is that it remains largely ignored by global health policies.

Disaster Mental Health programs and the Disaster Psychiatry special interest group of the American Psychiatric Association have developed a body of literature, response protocols, and capacity building mechanism to prepare a group of professionals that will respond during a disaster and alleviate the distress caused by such events. Resource rich countries have identified teams of responders from with the Mental Health system to provide assistance in longer term recovery while resource poor countries are struggling to increase the numbers of mental health professionals. Providing Mental Health and psychosocial support during long term reconstruction and development is still an emergent field. In part because of a lack of professionals trained in disasters and mental health, lack of evidence based literature, and lack of integrated disaster mental health and psychosocial support plans. This book attempts to contribute to the body of knowledge on the topic.

Much can change in a decade and half. It is hoped that the misconceptions that are surfacing among the institutions and the practitioners, specialists, and policy makers regarding the terminology and the core concepts of psychosocial support will be clarified over time. The recent MHPSS working draft also states clearly the fundamental guidelines for all people serving in the disaster scenario. This may be the opportunity for the humanitarian world to rethink its conventional modus operandi and to systematically view human beings holistically, in their physical, psychological, and emotional entirety.

We cannot afford to stand on the sidelines and be uninvolved and detached observers, no matter how encouraging and respectful our approach. The extent of human suffering and the politics of trauma call for professionals to become active advocates for the victims. We need to do more than to speak for them we must speak with them.

About the Book

This book is divided into four sections. Section I presents the theoretical bases for mental health and psychosocial support activities following a major disaster. Section II provides the reader with six specific examples of how mental health and psychosocial needs of affected populations have been addressed in Sri Lanka, Lebanon, Iraq, the Philippines, Afghanistan, and Palestine. Section III moves from mental health and psychiatry into a community model of psychosocial support. These sections present a transition from psychiatry to psychosocial support in India and are followed by two case studies; one from Kumbakonam, Tamil Nadu, India, and the other addressing the tsunami response during the acute to early reconstruction phases of the disaster cycle in the south and western provinces of Sri Lanka. Section IV proposes tools for monitoring and evaluation of community-based psychosocial support needs and interventions.

Section I comprises three chapters, which present an overview of the development of psychological support in emergencies, disaster mental health from the World Health Organization (WHO) perspective, and psychological support within disaster management in Asian countries.

The initial chapter begins with an overview of the development of psychological support in emergencies and describes various models of interventions used to deal with disaster, stressors, traumatic stress, and other manifestations of bereavements. A discussion of traumatic bereavement is presented and the chapter concludes with suggestions for addressing post-disaster stress manifestations.

The second chapter focuses on the WHO response to emergencies and presents the general principles that guide the response mechanism from the acute emergency phase to the reconstruction phase of a disaster. The chapter utilizes the 2004 South Asia tsunami as a backdrop to illustrate the capacity of WHO to respond to disasters.

The third chapter e addresses the disaster mental health response strategies. The author recognizes that mental health and psychosocial support are essential components in disaster response, because each of such events is capable of causing overwhelming traumatic stress to the survivors or the community. Some of the issues related to delivery of disaster mental health services at disaster sites and over the long term, to provide a continuum of care for recovering survivors and their communities over the course of days, months, and years are also addressed. The chapter concludes by describing some recent initiatives taken in some South Asian countries to include mental health and pscyhosocial support as a part of the response to disasters.

Section II presents six cases of psychological response in the Middle East, Asia, and the Pacific (Chapters 4-7). The interventions described in this section focus on mental health of populations impacted by disasters. The fourth chapter in this section addresses mental health and psychosocial support in Sri Lanka. The island nation has been plagued by civil insurgencies and natural disasters in the past ten years. The chapter addresses the mental health dimensions of both war and natural disaster, and recommends remedial measures. The author reports that, in his experience, the mental health consequences encompass depression, anxiety, stress disorders and somatization. The chapter reviews the mental health impact of the war, and the tsunami, at

the individual, family, and community levels. The impact of war on children and women is detailed, basing it on the dislocation of people, disruption of networks, relationships, structures, and institutions. The chapter concludes with an outline of various mental health and psychosocial support interventions that will the negative psychosocial results.

The fifth chapter focuses on mental health and pschosocial support in Lebanon. The chapter outlines the last 20 years of conflict and disturbance between the Muslim and Christian factions, as well as the Palestine–Israel clashes in Lebanon. The research for the chapter was conducted in Lebanon, to provide the reader with an assessment of the impact of the conflict on the mental health of the Lebanese population. The chapter concludes with suggestions for future action.

In the sixth chapter, a description of the Ministry of Health response after the Bam earthquake is presented. Iran is highly vulnerable to natural disasters, especially earthquakes and floods. The government's mental health response to the disasters formulated after the Rudbar earthquake was tested and lessons were learned. The chapter describes the mental health and psychosocial interventions following the major earthquakes. Finally, the chapter summarizes the lessons from the implementation experience and suggests a strategy for mental health responses for the future.

Chapter seven takes the reader to the Philippines, where great effort has been put into the organization of the Mental Health Task Force in Disaster Management (MHTFDM), a government initiative following the massive scale of devastation due to natural disasters and its psychosocial impact on the community. This Task Force frames mental health and psychosocial interventions within the overall management of the outcome of a disaster. The framework presented in the Chapter identifies the range of psychosocial intervention strategies that have been implemented after disasters in the Philippines.

Chapter eight discusses the ongoing humanitarian crisis in Afghanistan and the complexities of rebuilding the mental health care system in a nation with limited resources. The chapter provides the reader a historical overview of the political factors that have impacted the Afghan people. It describes the external forces and the strong politico-religious internal forces which have impacted the mental health well-being of the Afghan population. It presents a review of the mental health care system in the country and the relation between the frequency of traumatic events and the likelihood of developing psychopathology. The chapter presents two successful models of mental health care in Afghanistan.

The dynamics of forces impacting the psychological well-being of the population in the Gaza strip is the topic of Chapter nine. The chapter presents external factors that affect the population: economic, social, political, and legal dynamics. Substantial incidents have occurred in the country which have caused social and psychological suffering of the population. This chapter provides the historical con¬text of Gaza, and describes how the study of traumatic stress is relevant to the discipline of psychiatry and mental health.

Section III provides a transition from clinical psychiatry to disaster psychiatry. Chapter ten presents a theoretical overview of the evolution of mental health programs during disasters in the last 30 years. The discussion leads the reader to an understanding of how clinical approaches shifted in India using as a baseline disaster the Bangalore Circus Fire and follows up the impact of the 2004 tsunami on the population. This chapter frames the changing paradigms of service from a focus on mental illness to a focus on mental health care, and on to community-based psychosocial support programs. The chapter concludes that disaster psychiatry should be a part of the repertoire of emergency responses to any disaster in India.

Chapter eleven provides a case study of psychosocial support during the Kumbakonam Fire in Tamil Nadu, India, in which 92 children died. The chapter describes the conditions antecedent to the psychosocial response.

The qualitative data presented in the chapter proposes a series of community-based interventions that alleviated the distress caused by the fire and ways that the communities began to move forward and reframe their lives. This intervention provided two lessons of importance to the Indian Red Cross Society: the movement of volunteers from different parts of the country and building the capacity of local Red Cross and community volunteers to provide psychological first aid; and community and school interventions that helped the process of emotional reconstruction.

Chapter twelve describes the initiation of community-based psychosocial support interventions in the Republic of Maldives and Sri Lanka. The lessons learned permitted the response to be based in the target countries where the responders were organizing long-term psychosocial support response, and provided insights into the planning required by long-term planners to develop psychosocial support programs in communities and schools. The chapter recognizes that one of the greatest challenges in developing long-term psychosocial support programs is related to contextualizing the response and the use of the local languages and idioms of distress. The Chapter concludes with a description of a case of long-term development of psychosocial support in Sri Lanka

Section IV contains three chapters. Chapter 13 focuses on Ethnography, a widely received qualitative method of recording history as it is taking place. One way in which a systematic record can be documented is through ethnography. The use of qualitative research tools is proposed and examples on participatory methods to identify the idioms of distress, intensity, and resolution is presented. Chapter 14 discusses the development of a tool to measure resilience in India. The article presents and discusses the psychometric values of the tool. Chapter 15 reports on a tool developed to measure school readiness for psychosocial support in Indonesia. The chapter presents the method of contextualizing a tool originally developed by the World Health Organization.

The final chapter of the book presents a model of psychosocial support. The chapter describes the components of the American Red Cross Psychosocial Support Program for disaster impacted communities. This chapter describes the several components of the long-term development of psychosocial programs. It concludes that ultimately, communities are the orchestrators of their own recontruction and ultimately they have within them the capacity and the tools to achieve psychosocial competence as they move forward after a disaster.

Contents

Section III: Practice in Disaster Mental Health and Psychosocial Support

Section IV: Planning, Implementing, Monitoring & Evaluation of Psychosocial Support Programs

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Introduction

The contributions in the book will make the case that improving global mental health is the gateway for achieving many of the millennium development goals. In spite of many controversies, disaster mental health and psychosocial support have penetrated into the cycle of disaster response and have gained ground in being established as a stand-alone component.

This book is divided into four sections. The first section is presents the theoretical bases for mental health and psychosocial support activities after a major disaster. The second section provides the reader with six specific examples of how mental health and psychosocial needs of affected populations have been addressed in Sri Lanka, Lebanon, Iraq, the Philippines, Afghanistan, and Palestine. The third section moves from mental health and psychiatry into a community model of psychosocial support. The section presents a transition from psychiatry to psychosocial support in India. It is followed by two case studies one from Kumbakonam, Tamil Nadu, India and the other addressing the tsunami response during the acute to early reconstruction phases of the disaster cycle in the south and western provinces of Sri Lanka. The fourth section proposes tools for monitoring and evaluation of community based psychosocial support needs, and interventions.

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Section II presents six cases of psychological response in the Middle East, Asia, and the Pacific (Chapters 4-7).

The interventions described in this section focus mental health of populations impacted by disasters. The fourth chapter in this section addresses mental health and psychosocial support in Sri Lanka. The island nation has been plagued by civil insurgencies and natural disasters in the past ten years. The chapter addresses the mental health dimensions of both, war and natural disaster, and recommends remedial measures. The author reports that, in his experience, the mental health consequences encompass depression, anxiety, stress disorders and somatization. The chapter reviews the mental health impact of the war, and the tsunami, at the individual, family and community levels. The impact of war on children and women is detailed, basing it on the dislocation of people, disruption of networks, of relationships, structures and institutions. The chapter concludes with an outline of various mental health and psychosocial support interventions that validate psychosocial results.

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Section I

Theoretical Perspectives

Overview of the Development of Psychological Support in Emergencies

by Prof. Beverly Raphael, Center for Mental Health, NSW, Australia

Introduction

Psychological support for people affected by emergencies and disasters has arisen from the universal human response to reach out and comfort those who are shocked or suffering and to protect and to help them. Although people have offered comfort to others in many different ways in different societies and cultures, formal psychological support programs have only been instituted and given priority in relatively recent decades.

Inhabitants of different countries in Asia, as well as across the world, have suffered due to many major disasters, wars and conflicts, but the extent of psychological and psychiatric morbidity that may have been a consequence, has been studied only to a limited extent. Research on the effectiveness of psychological interventions to prevent or address such morbidity is even more limited. Nevertheless, there is a growing body of information that can contribute to developing a good practice and the consensus of experts that can contribute to supporting the rationale for interventions.

A further issue facing Asian countries as well as nations globally is the threat and impact of terrorism, which may have a profound psychological impact. Research studies following the Sarin Gas attack in Tokyo (Asukai, Maekawa 2002) have highlighted the impact of this type of threat psychologically as it has the potential of complex morbidity related to biological effects.

In situations of emergency or disaster, different levels of psychological support may be provided. Firstly, there is a general psychological support reflecting the human response to those who have been affected. This has often been identified as a part of Psychological First Aid (PFA), which will be discussed in detail later. Secondly, there are strategies that can be adopted in the initial days and weeks to assist those at the high risk of developing mental health problems, in reaction to what has happened. Here the intent may be prevention or early intervention. Thirdly, there are strategies to identify and treat those who would develop or present with psychiatric disorders in the aftermath. These disorders may be an exacerbation of a presenting condition, or may arise anew, as a consequence of the disaster experience.

The stressor exposures and the context of disaster

Psychological support needs to be based on an understanding of the potential psychological impacts, the stressors that the disaster brought and their impacts on individuals, families, and communities. Psychological support strategies need to delivered in ways that will take into account different levels of need, different patterns of impact, and the feasibility and cultural appropriateness of the response.

Natural disasters

Natural disasters such as earthquakes, volcanic eruptions, typhoons and cyclones affect many counties in Asia. A recent review of the natural disasters and mental health in Asia highlighted the extensive, frequent and damaging nature of such events. Three billion people were affected by such disasters worldwide between 1967 and 1991 and it was estimated that 85 percent of these lived in Asia (Kokai M, Fujii S, Shinfuku N, Edwards G 2004).

Man-made disasters

These include transport and industrial accidents, such as air and train crashes, chemical spills, and building collapses. More recently there have been terrorist attacks such as the Sarin Gas attack in the Tokyo subway (1995), and the Bali bombing (October 2002). Additional major threats include epidemics, which contribute to vulnerabilities, such as HIV/AIDS, or more recently severe acute respiratory syndrome (SARS) and Asian avian influenza.

Natural Disasters: Some natural disasters are known and anticipated by communities, particularly cyclical floods and storms. A culture of expectation and belief may influence how they affect people. Others are totally unanticipated either in their timings or in their nature. It is important to suggest that sudden onset and unanticipated occurrences of natural disasters, for example floods, major storms, earthquakes (see Odaira T, Iwadate T, & Raphael B 1993), forest fires, tsunami, and volcanic eruptions may have greater mental health impact, even when there has been a longstanding recognition that these events are likely to occur.

A disaster "culture" or belief system surrounding such episodes may see them as fate, which cannot be altered; or that protection from their impact can be achieved by the actions taken by leaders or by individuals. The impact may also be associated with high-intensity, unexpected physical forces such as wind, water, fire, explosives, volcanoes; inadequate preparation and mitigation; and a lack of resources with which to address such unpredictable outcomes. These may co-exist with the political or personal sense that prevention could not be effective or be too costly or that the disaster is not likely to occur.

Man-made disasters have been shown to have a greater psychological impact. They are frequently unanticipated and associated with human or social failure or neglect, or active malevolence and threat. While there are key stressors that will have an impact that can lead to psychological reactions and possibly psychiatric morbidity, the risk of adverse outcomes will be heightened if they are sudden, unexpected, or if they result from either the negligence or malice of others.

Interventions have evolved to deal with the key disaster stressors and their consequences, building on available evidence of what is likely to be effective. Interventions are offered at different points in the post-impact period. Their focus and aims are not always clear (Raphael 1986). Nevertheless there is a very powerful drive to deal with the human suffering that ensues, and often a strong need to be active and structured, in the face of post- disaster chaos.

Interventions will be described in terms of their types and effects over the immediate and longer periods in line with current views of the recovery process. The key stressors related to man-made disasters that may have a major psychological impact and that may thus influence mental health outcomes are as follows:

- *Deaths:* The number and nature of the deaths, the deaths of children, and the degree of severity (whether they were gruesome or mutilating) will result in traumatic stress impacts. Such deaths constitute a stressor exposure, which may contribute to the development of post-traumatic stress disorder' (PTSD). The intensity of grief may increase tremendously if the event causes the death of the loved ones and reconciling with the loss will be more difficult because of the unexpected and often horrific circumstances.

- *Life threat and injury* may lead to both profound psychological impact and difficult psychological adjustments over a longer term, especially injuries such as burns and mutilating blast injuries.

- Destruction of home, shelter, and community and the subsequent dislocation produces stressors related to survival, shelter, and loss of resources, destruction of neighborhoods and social networks, loss, or necessities of work and employment (Cao H, McFarlane A, Klimidis S 2003). Such ongoing stressors requiring prolonged adjustments may lead to grief, anger, and despair, unless the community re-gathers its strengths for recovery.

- Terrorist Attacks, conflicts, and war or other sources of human destruction lead to stressors as a result of being the intended or the non-specific victim of human malevolence.

Many other stressors are evoked by disaster, both acute and chronic. It is not surprising that such events would have a major impact on the mental health and well-being of the populations that survive them. This is a key issue when the extent of disasters in the Asian region has been overwhelming. Nevertheless, it is also well established that even in severe and overwhelming circumstances, many individuals and communities do adapt successfully in the aftermath (Silove, 1999).

But ongoing conflicts and chronic (or 'slow') disasters, such as those of famine, may destroy the substance and infrastructure of societies with a loss of social capital and an adverse impact on development (Coletta, Cullen 2000). Dealing with the impact of the trauma may be an essential component of facilitating personal recovery. However, as Colette and Cullen report, when larger numbers of people are adversely affected by post-traumatic psychological morbidity, they may be unable to utilize the aid or to use it for tasks that would assist further community development.

Many of the interventions have evolved in different cultural settings, particularly, western. They may or may not be appropriate in the Asian context. This highlights the need to ensure that there is a **research and evaluation framework** to support the development of sound evidence- based model for culturally appropriate and effective psychological interventions in Asia. This is also highlighted in research by Kokai M, Fujii S, Shinfuku N, Edwards G that there has only very recently been acceptance and recognition of the psychiatric impacts with the diagnosis of PTSD.

Although other forms of morbidity including depression, anxiety, and somatization disorders have recognized consequences, the authors consider that acceptance of the concept of PTSD has provided greater opportunities for "involvement of mental health professionals in providing ongoing support to survivors of natural disasters…and for further research" (Kokai M, Fujii S, Shinfuku N, Edwards G 2004, p110).

Emergency and Early Intervention

There are two major issues. Firstly, ensuring survival and safety are primary, and require the first priority. People may be triaged to shelter, treated for injury, provided with food and other essentials for survival, but initially they are in a state of shock, particularly in unexpected and severe life-threatening circumstances. In this state, a significant proportion of the affected population may be bewildered, stunned, manifest dissociative symptoms, be unable to cope, and be at a risk of placing themselves in danger. Others may be desperate to search for missing family members and loved ones, whom they fear may be dead. People may also be in distress, anxious, and may fear ongoing threats to their existence. It is clear that they need psychological support through this period. (US Consensus Conference on Mass Violence and Early Intervention, NIHM, 2001.)

Secondly, it is critical that whatever is provided does not cause harm. This is again a primary requirement. Psychological interventions provided during the emergency phase should support survival strategies, provide information, comfort those affected and protect those affected both physically and psychologically.

Psychological First Aid

Psychological first aid (PFA) has been the term used to describe the intervention that is considered appropriate for this emergency phase and its immediate aftermath (Raphael 1977a; Raphael 1986, NIHM, 2001).

PFA has been seen to encompass general psychological support, protecting from harm, comforting, allowing those who wish to talk of their experience to do so, providing information, assisting with the whereabouts of loved ones and dealing with knowledge of what may have happened to them. When disaster survivors are gathered together in shelters they may not only comfort and support each other, but also share knowledge and experiences of what has happened. This mutual sharing and the affiliative behavior may lead to strong bonds, which can assist survival and recovery, especially when there is sharing with those who have been through 'the same thing'. This spontaneous or natural grouping and 'debriefing,' as it may be called, is not a formal process, but may be perceived to be of value in supporting those involved to deal with the aftermath of disaster. (Ursano, Fullerton, Vance & Wang, 2000.)

This model of PFA has had renewed support following the Consensus Conference on Early Intervention after Mass Violence (NIMH 2001). The comparison with physical first aid, which also aims to assist survival, has been strengthened by a triage framework using the same ABC nomenclature (Airway, Breathing, Circulation).

In PSF, the triage process deals with the ABC of Arousal, Behavior and Cognition. Extreme levels of Arousal; Behavioral disturbance threatening the survival of the self or others; Cognitive impairment, for example through dissociative or organic processes altering mental functioning, may require immediate intervention or triage by further mental health assessment and management by specialists.

Psychological debriefing

This has been another form of intervention introduced in the immediate post-disaster period. It is built on a model that aims to help emergency workers to deal with the stress of their work. Dunning (1988) summarized some of the underlying conceptual frameworks from an educational approach to a more specific psychotherapeutic modality. The concept was applied when dealing with emergency workers after a number of major disasters. There was no evaluation of its effectiveness, but it was usually perceived as helpful.

The critical incident stress debriefing (CISD; Mitchell 1983) has been the most widely issued debriefing model. Although its proponents identify it as a technique for emergency workers, it has been extended to disaster affected populations in general and to the bereaved in specific cases. Recent evidence does not support the use of this technique for large populations and further suggests that it may be potentially associated with more adverse outcomes (Raphael & Wilson 2000; Litz BT, Gray MJ, Bryan RA & Adler AB, 2002.)

The US Consensus Conference supported the view that it was ineffective for such populations, especially as a single episode (NIMH 2001). However, various adaptations of the model have been widely used after disasters, such as in the psychosocial program in the Philippines, and multiple stressor debriefing after a disaster in the United States of America (Armstrong 2000), but they represent a broad approach of group support in the aftermath. Use of the model in later stages (Chemtob, 2000) suggested it may be associated with improved outcomes, but there was no control population studied to validate these assumptions.

As various workers have pointed out, those who need it might perceive debriefing as most helpful. It may also be that it heightens arousal for some of those affected in the immediate aftermath, altering the trajectory of resolution. It is often focused specifically on a view that talking about the experience may be of therapeutic value, which fails to take into account cultural factors, prescriptions for dealing with such

experiences, or individual psychological differences in coping patterns and adaptation.

Although debriefing is a term in common use, where people gather together or tell about their experience which may be seen as 'getting debriefed', there is no evidence this will prevent them from developing PTSD or other post disaster morbidity.

Thus, formal psychological debriefing programs are not recommended as an emergency psychological intervention for disaster-affected populations (Litz BT, Gray MJ, Bryant RA & Adler AB 2002; McNally RJ, Bryan RA & Ehlers A 2003).

Psychological tasks in the immediate aftermath

1.Identifying and dealing with the dead:

Those who have lost a family member or members may face difficulty in finding out if the person has died, if there is a body, if it is identifiable, if it can be released for the practices of burial relevant to their cultural or religious requirements. All these processes place enormous psychological demands on those who may already be traumatized. If there are mass deaths, it may be impossible to find loved ones, little opportunity for farewells, or appropriate burials. Empathetic, honest information; dignity for the deceased and bereaved; and whenever possible, an opportunity for farewell and a respect for cultural requirements is needed. Group memorialization may be spontaneous in the immediate aftermath and structured at later stages, as after the Bali bombing (Raphael, Wooding, Dunsmore, 2004).

This requires processes that are psychologically, socially, and culturally sensitive and which can be incorporated into formal protocols in pre-planning and preparation. However, in many circumstances, such levels of preparation will not be possible, and affected communities will handle these processes as best they can, often while still under some ongoing threat.

> Improving outcomes in relation to final rites require recognition that, when poorly managed, they can lead to further psychological traumatization, increasing the risk of adverse outcomes such as traumatic grief and PTSD.

> Group support, information about what is happening, and, compassionate understanding of family distress and shock are the key aspects of meeting psychological needs. Broad, bereavement-focused support can be provided if necessary. If there are indicators of risk or emerging pathology, those affected can be referred for grief counseling, provided either in individual or group settings.

2. Dealing with ongoing threat:

Fears such as further death and destruction through a return of the natural hazard, ongoing conflict, or struggle for survival, will continue to place people at risk. There is clear social and psychological evidence that direct engagement of those affected in the processes of their own response and recovery is vital for both community and individual recovery. The provision of protection, humanitarian aid from outside agencies, and provision of psychological support programs, should be balanced in a consultative, respectful agreement about what is appropriate for both the emergency and rehabilitation phases. These themes reflect those endorsed by the Sphere project's charter and minimum standards (Sphere Handbook, 2004).

Of particular relevance is the recognition of both vulnerabilities and capacities. Provision should be made to address the needs of those who are at risk as vulnerable populations, such as women, children, older people, people living with mental illnesses, HIV/AIDS, or disabilities.

It is also important to note that such provisions should be made in a non-discriminating way.

The Sphere Handbook emphasizes this point :"…it should also be remembered that disaster affected populations possess and acquire skills and capacities of their own to cope" (Sphere Handbook 2004). These vulnerabilities and capacities need to be taken into account. This is particularly relevant, since many models of psychological support focus only on vulnerabilities, often with expectancies that adverse outcomes will be inevitable, rather than recognizing individuals' strengths and capacities so as to engage and facilitate positive adaptations, which will add a sense of mastery to those affected. This is particularly relevant in the face of ongoing threat as it mitigates the helplessness that may otherwise prevent recovery.

Thus, providing psychological support will involve dealing with the acute and ongoing stressors, recognizing particular vulnerabilities, and assisting and strengthening existing coping capacities. It should be noted that the need for external support might vary over time, as may the required type of support. Resources that are depleted are both physical and psychological. Designers of psychological and social support interventions may need to respond to these changing patterns, and should always be cognizant of the need to engage those affected in terms of their own strengths and opportunities for adaptation (Sphere Handbook, 2004).

3.Health & Mental Health:
The capacity to meet health requirements in an emergency, and to sustain these subsequently, will depend on the health infrastructure; priorities of health care provision for the severely injured or affected; public health and knowledge infrastructure (particularly for communicable disease control); the present health status of the affected community; primary health care; and mental health care systems. Staff of mental health care systems need to be trained and prepared to deal with the mental health aspects of disaster, including understanding social components. This is dealt with in Sphere Health Care Standard 3 in terms of control of non communicable diseases in this instance the mental and social aspects of health (Sphere Handbook 2004, p 291 – 293).

The importance of information; recognition of needs related to the dead; psychological first aid; treatment of urgent psychiatric complaints; and community-based psychological interventions are all recognized (Sphere Handbook, 2004). As Kokai M, Fujii S, Shinfuku N, Edwards G (2004) highlight in their research, this may require a further development linked to understanding acute and longer term traumatic impacts. It is also the case that in less-developed settings, particularly rural, there may be a lack of basic mental health care components, including mental health professionals and psychotropic drugs.

Primary care resources need to be mobilized to meet mental health needs in most disasters, and there may also be a need to educate and utilize non-government organizations (NGOs), community workers, teachers and social systems to deliver such care. Specialists in mental health systems can provide consultation and backup for primary care providers such as general practitioners.

Transition from the acute emergency

The initial months after the impact is a period where the extent of risk and potential psychiatric morbidity related to the disaster will start to appear, although in some cases this may be delayed. Preventive interventions, where there is likely to be evidence of benefit, are usually begun in this period.If specific disorders have appeared, these may need to be treated as early as possible, so that the problem does not become chronic. Preventive interventions should be targeted for those at high risk, as evidence suggests that most other affected persons will recover. Although some models of intervention have evolved from individually based interventions, the same principles can be usefully applied in primary care, schools, or community and group based programs.

Psychological Interventions for the Psychologically Traumatized

Vulnerability to PTSD: When psychological distress related to the reactive processes of exposure to stressors such as Criterion A of PTSD continue at a high level, there is likely to be heightened risk of developing post-traumatic stress disorder. Heightened arousal, high levels of re-experiencing phenomena and dissociation or numbness may predict subsequent PTSD. Bryant and Harvey (1997) have shown that if this reaches a level that might be diagnosed as acute stress disorder, the risk of PTSD is increased

In a controlled trial of Australian accident victims, focused cognitive behavioral interventions have been shown to prevent the development of PTSD (Bryant RA, Harvey AG, Dang ST, Sackville T & Basten C, 1988b). This and other works provide a basis for using these cognitive techniques more widely, often with elements of anxiety management, cognitive restructuring, and exposure (although this technique should be implemented by appropriately trained clinicians). Many other models of intervention have been applied including those using Eye Movement Desensitizsation and Reprocessing (Gibson L, & Watson P 2003).

As noted, some consensus has been reached for early intervention after mass violence and disaster (NSW Health Department 2000; National Institute of Mental Health 2001), and for treatment and early intervention for PTSD (Foa, Davidson, Frances 1999). A minority of intervention studies deal with disaster-affected populations but do not comprehensively focus on populations with PTSD resulting from other trauma such as road accidents. These studies and reviews provide valuable insights, but findings may not necessarily be transferable to survivors of disaster and terrorism (Rose, Wessely, and Bisson 1998).

In one of the few studies of cnitive-behavior therapy (CBT) interventions for trauma effects following a terrorist incident, Gillespie K, Duffy M, Hackmann A and Clark DM (2002), implemented a community-based CBT program with survivors (with chronic PTSD) of the Omagh bombing in Northern Ireland in 1998. The median interval between the bombing and treatment was 10 months. Treatment consisted of relieving the traumatic event via imagined and sometimes direct exposure, which was then closely integrated with cognitive restructuring techniques. The researchers report 'significant and substantial' improvement in PTSD symptoms.

Bereaved Families and Communities: The issue of traumatic grief

There are particular circumstances in a disaster that may place those bereaved at heightened risk of problems: the sudden, unexpected and frequently untimely nature of the deaths, multiple deaths; the violent and horrific circumstance of the loss; multiple other concurrent stressors; and in some instances prolonged uncertainty about the death or difficulties and identification of the deceased (Raphael 1977b; Rynerson, 2001).

Grieving may be tough while survival is still an issue or other circumstances are overwhelming. The traumatic circumstances of death both post-traumatic stress reactive processes and bereavement reactions can occur simultaneously, creating a picture of traumatic grief (Raphael , Martinek 1997).

Interventions for those bereaved in disaster were first described in Lindeman's classic study of acute grief after the Coconut Grove Night Club fire (Lindeman 1944). He recommended assisting the grief work to facilitate normal grieving and to change patterns from abnormal. Lindy JD, Green BL, Grace M, Tichener J (1983) also provided psychotherapeutic outreach to victims, including the bereaved after another such fire. While neither of these reports were controlled trials, they highlighted the complexities of the emergency and of working with those affected at such times.

Interventions may be provided to prevent adverse outcomes of such high-risk bereavements, as with the provision of bereavement counseling in the early weeks after the loss, for those considered to be at higher risk. This type of intervention was provided on the basis of an earlier controlled trial of preventive intervention for recently bereaved widows (Raphael 1977b), a proportion of whom had more traumatic bereavements. Other reports have highlighted the findings from studies of bereaved adults and children following a range of circumstances of death, including violent deaths (Rynearson 2001; Wooding & Raphael 2004).

Psychological interventions were provided in early outreach to bereaved survivors of a rail disaster in Sydney, Australia (Raphael 1977a). This was counseling that aimed to facilitate their grieving through reviewing their experience of loss, reviewing their relationship with their loved one, and gradually encouraging their expression of grief. An independent evaluation found that there was some benefit, particularly for those who perceived this support as helpful, and that an important correlate of outcome was the opportunity to view the body of the deceased, which gave an opportunity to bid farewell to the dead person (Singh & Raphael 1981).

The above study (Raphael 1977a) and many others since have emphasized the importance of the mode of delivery of services and particularly the effectiveness of outreach. Most survivors of disaster do not seek psychological support on their own accord and there is a need for policy and planning groups to develop effective outreach services as a component of disaster response (Raphael, Wooding and Dunsmore, in press).

In their study of a massive earthquake in Taiwan (1999), Kuo CJ, Tang HS, Tsay CJ, Lin SK, Hu WH & Chen CC (2003) also highlighted this issue. These authors found that PTSD (37 percent) and major depressive disorder (MDD) (16 percent) were the two most prevalent disorders following the earthquake, however only 25 percent of those with PTSD and 26 percent of those with MDD sought help in a primary care setting.

The study by Kuo and colleagues is important being one of the few that examines psychiatric disorders in bereaved survivors following disaster and focusing on issues of prevalence but also on crucial aspects of service delivery and outreach.

With the recognition of PTSD, after its introduction as a diagnostic category in DSM-III in 1980, there has been a growth in studies identifying this condition as an outcome of disaster-related traumatic exposures. However the issue of diagnostic usage and clarity in this area remains one for further discussion, as highlighted by Wang X, Gao L, Shinfuku N, Zhang H, Zhao C & Shen Y (2000) in a study of victims following an earthquake in Northern China. Rates of PTSD in a 9 months' follow-up survey were 24.2 percent according to DSM-IV criteria and 41.4 percent using DSM-III-R criteria (Wang X, Gao L, Shinfuku N, Zhang H, Zhao C & Shen Y 2000).

The complexity of assessing not only PTSD but also PTSD and traumatic bereavement is an area of ongoing research (Raphael, Martinek and Wooding 2004) in relation to appropriate treatment planning and intervention.

Psychological interventions have focused on addressing traumatic impact as the primary purpose of interventions. It has only been recently that traumatic bereavements have been dealt with in the psychosocial interventions provided.

Pynoos's work with children highlighted the differential impact of these different stressors in terms of reactive processes (for example, traumatic stress reactions and grief reactions) and the different outcomes that may occur (e.g., PTSD and depression) (Pynoos 1987a; 1987b). Later developments in this work concerning disaster interventions for children have continued to address these joint themes in the interventions provided for those exposed to these complex stressors as well as supporting the role of psychological first aid in the emergency (Pynoos & Nader 1993; Goenjian AK, Karayan I, Pynoos RS, Minassian D, Najarian LM,

Steinberg, AM & Fairbanks LA 1997; Pfefferbaum B, Seale TW, McDonald NB, Brandt EN Jr, Rainwater SM, Maynard BT, Meierhkoefer B & Miller PD 2000; Laor 2002; Wooding & Raphael 2004).

Translation of this knowledge of psychological interventions for trauma and grief into more broadly based community programs has also occurred, making these models more available to use for larger populations affected by disaster. These range from the formation of bereavement support groups after such traumatic deaths to participation in community rituals. These interventions may focus on overcoming the trauma, defeating the threat, demonstrating mastery, or providing rituals, monuments, and other ways of acknowledging the dead giving the bereaved an opportunity to pay tribute to and mourn the loss of their loved ones.

Some examples or programs dealing with trauma and grief in large populations include the trauma programs developed to deal with trauma and loss after the genocide in Rwanda (Gupta 1999). This involved teaching community workers the key principles of trauma and grief interventions and supporting these workers to provide these in their communities.

School-based programs have also been shown to be of value in post-disaster settings, using books for children to tell their disaster story, school-based group sessions promoting mastery, and putting on plays such as a community play that deals with the fire dragon after a forest fire destroyed a community (Saltzman WR, Pynoos RS, Layne CM, Steinberg AM & Ainsenberg E 2001).

These themes of trauma and grief are relevant for many of those who have experienced a major disaster. The horrific circumstances and the multiple losses, including loved ones, houses, and entire communities, make these common themes, which may require psychological support, the current issue. These losses also merge with the chronic stressors of the recovery period. When communities, homes, places of work have been destroyed and when the stressors are ongoing, as they are after mass destruction, depression and post traumatic morbidity may hamper the community members' capacity to rebuild and recover, as may the lack of adequate resources.

Psychological Support in Primary Care: Although specific interventions as part of a formal disaster response program have been described above, in large-scale emergencies many people will either care for themselves or rely on primary care or community/indigenous healers. Education and training programs need to build capacity in these providers to recognize and manage post-disaster psychological morbidity, including PTSD, somatization, anxiety disorders, depression, and other outcomes. Brief psychological interventions using cognitive behavioral techniques (such as anxiety management and problem-focused coping) can be made available, as can education, self-help skills resources and, when appropriate, medication if disorders become significant.

Some presentations may be delayed, others will present with an exacerbation of earlier problems, or even an awakening of previously unresolved trauma (for example child abuse) and loss. The key elements of an assessment to determine other needed psychological support include a review of the experience; determining the patterns of distress; identifying the coping strategies used effectively; checking the ongoing stressors and issues; and assessing the level of distress and functional change as to whether it means that the person needs specialized psychological support. Such support should be provided while taking into account the distress levels, allowing counseling and dealing with the happening in "doses" that the person can tolerate. This allows building a sense of achievement with forward goals for the future, beyond the disaster experience.

Self-Help Groups: People come together spontaneously in the aftermath of disaster, with heightened affinitive behaviors. This positive reinforcement of life and survival builds strong social bonds, which may continue through the recovery period. Such self-help groups may not only provide the support for those who have shared the experience, but may become a forum for advocacy of those affected or an organization to address the renewal of the community. These psychologically supportive developments can enhance recovery and can also be supported by psychological or psychiatric consultations to provide guidance for the adaptations that may be required.

Psychiatric Disorders

People may present with significant psychiatric disorders in the aftermath of the disaster. These may represent an exacerbation of a pre-existing condition or a new problem. Each presentation requires careful assessment, taking into account the degree to which there is a pre-existing problem; how the disaster stressor experiences may have interacted with this; and thus the psychological and other interventions that will be required to treat it.

There may be presentations such as anxiety and depressive disorders or somatic symptoms (see Odaira T, Iwadate T, & Raphael B 1993) that are often related to perceived threat or toxic exposures or psychotic illnesses that incorporate elements of the disaster into delusional systems. Although disorders should be managed according to established guidelines for these clinical conditions, there is also the need to deal with the anxieties, distress, grief, and trauma that the disaster may have entailed.

Such conditions that are precipitated by the disaster exposure are likely to benefit from an early intervention with a strong emphasis on effective rehabilitation and return to functioning whenever possible. This means that the mental health care staff and referring agencies such as primary care providers have to be well prepared, with systems in place to ensure the delivery of effective interventions, such as cognitive behavioral therapies, medications as indicated, and social frameworks for disability support as well as active programs to support people to return to work. As discussed, treating those affected should also take into account their strengths. While recognizing the likelihood that much distress will be attributed to the disaster stressors, it is essential to ensure that other vulnerabilities contributing to the disorder are also dealt with.

Current evidence-based guidelines

The research base supporting psychosocial intervention is expanding, with extensive research focusing on post-traumatic stress impacts and extensive interventions provided for these. A summary of this evidence is provided in a manual for training mental health staff in preparation for any disaster occurence during the 2000 Olympic Games in Sydney (NSW Health Department 2000) and the NIMH US Consensus Conference for Early Intervention after Mass Violence (National Institute of Mental Health 2001).
These documents refer to the most up-to-date evidence regarding interventions and are further supported by a number of more recent publications in this field (Gibson & Watson 2003; Litz & Gray 2004; Raphael and Wooding 2004; Raphael & Wooding, in press).

The World Health Organization has also actively addressed the need for guidelines with its series of publications and particularly the mental health guidelines for emergencies (WHO 2003).

Challenges in Provision of Mental Health Services and Psychological Support

Mental health and psychological services have often been seen as either unnecessary or as unattainable in the face of the chaos when the population's physical needs are so great in the emergency and aftermath. There is growing recognition that psychological services are an essential component of the emergency health response as well as in the management of the longer term recovery period.

Stigma and lack of understanding may make outreach difficult, although there is growing acceptance by the public that such aid makes sense. It can also strengthen the image of mental health, and particularly positive mental health, in the public mind. Nevertheless, research to support interventions and evaluation of the provided interventions, based on what is known from other studies, is greatly needed yet ethically and practically difficult. Many studies focus on the disorders that may arise, and more recently on the affected individuals' personal growth, but fail to evaluate what has been done.

New challenges have also arisen with new type of disasters. These include terrorist attacks with causalities from fear related to the exposure as well as the exposure itself. Management of the pressure on health care emergency systems in terms of triaging those needing physical care and those needing anxiety management or both is a complex challenge. More prolonged toxic exposures from toxic spills or nuclear waste may also lead to this complex mixture of physical, somatic, and anxiety/depressive symptoms where organic and psychological problems coexist over time, often leading to management difficulties and requiring mental and physical health interventions.

Severe acute respiratory syndrome (SARS) has been an epidemic that has challenged health care systems with potentially disastrous results. Fears of pandemics such as influenza are exacerbated by such outbreaks as are fears of dealing effectively with biological terrorism, epidemics, quarantine controls, deaths, and the danger to health care workers. These may all constitute a disaster where it is crucial that psychosocial support is integrated to competent management of the outbreak.

Challenges also arise in relation to bombings, violent urban actions, and the ongoing nature of such threats. Psychological support for those traumatized by such injuries is essential through the recovery period. Effective programs have been provided for motor vehicle accident victims (Bryant RA, Harvey AG, Dang ST, Sackville T, & Basten C 1988a; 1988b), but the translation of these for people with major burn or blast injuries to ensure optimal outcomes (psychologically as well as physically) is not well-developed.

Education and training for mental health disaster preparedness is gaining momentum, supported now by guidelines for international training, mental health, and psychosocial interventions for trauma-exposed populations (Weine S, Danieli Y, Silove D, Van Ommeren M, Fairbank JA, Saul J 2002).

Such programs will be critically important in supporting the management of those exposed to the multiple stresses of trauma, grief, dislocation, human malevolence, and uncertainty. These programs will be of value as well to help build on the growing body of work in Asia that is responding to mental health aspects of disaster (Odaira T, Iwadate T, & Raphael B 1993; Wang X, Gao L, Shinfuku N, Zhang H, Zhao C & Shen Y 2000; Cao H, McFarlane A, & Klimidis S 2003; Kuo CJ, Tang HS, Tsay CJ, Lin SK, Hu WH, & Chen CC 2003; Kokai M, Fujii S, Shinfuku N, Edwards G 2004).

Finally, further research and evaluations are critical in this field, so that the complexities of human response in terms of fear and courage, pathology, and resilience can be better understood and responded to with effective, culturally appropriate psychological support that serves as an integral part of emergency health, aid, and social reaction and recovery.

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Disaster Mental Health: The World Health Organization Response

by Dr. R. Srinivasa Murthy

Introduction

Mental health response to emergencies is entering a new era with the new initiative of WHO in collaboration with other international agencies and voluntary organizations in 2005. I am referring to the formation of the Interagency Standing Committee (IASC) Working Group composed of UN agencies, International Organization of Migration (IOM), three consortia of major international NGOs, and the Red Cross and Red Crescent movement. They created an IASC Task Force with a one-year mandate to develop inter-agency guidance on minimum responses in mental health and psychosocial support in emergency settings (described in detail in the latter part of the chapter).

I have had the opportunity to witness the development of WHO responses during the last five years. This is my personal understanding of the response.

World Health Organization (WHO) has been in the forefront of response to emergencies, and mental health care is an important part of this response (Van Ommeren et al, 2005).

The importance that WHO attributes to dealing with the psychological traumas of war was highlighted by the resolution of the World Health Assembly in May 2005, when it urged member states "to strengthen action to protect children from and in armed conflict." The resolution of the WHO Executive Board in January 2005 urged "support for implementation of programs to repair the psychological damage of war, conflict and natural disasters." Similarly, WHO's Eastern Mediterranean Regional office, which covers a number of countries in conflict situation and disasters, adopted the following resolution at its 2002 annual Regional Committee meeting (WHO-EMRO, 2002).

'The Regional Committee, expressing grave concern at the deterioration of the health status of a number of vulnerable populations living in the Eastern Mediterranean Region, as a result of exposure to protracted social conflict and violence, imposition of sanctions and frequent natural disasters, affecting overall livelihood and human security, condemns denial of access to health workers and humanitarian assistance attempting to reach the needy in situations of conflict…and...urges Member States to:

1.1 Build up national capacity for emergency preparedness and disaster reduction/mitigation and response, in order to reduce avoidable mortality and disability;

1.2 Base policy and advocacy activities on the WHO core commitments in emergencies, in order to promote health as the leading concern in emergencies.

1.3 Implement interventions and activities based on credible operational research, taking into account lessons learned from previous emergencies'

The World Health Report 2001 focused on mental health. It estimated that, in the situations of armed conflicts throughout the world, "10 percent of the people who experience traumatic events will have serious mental

health problems and another 10 percent will develop behavior that will hinder their ability to function effectively. The most common conditions are depression, anxiety and psychosomatic problems such as insomnia, back or stomach aches." (WHO, 2001).

The current review of the WHO response is based on the published documents on the initiatives taken in the last few years. A landmark publication on disaster mental health care was the document Mental Health in Emergencies (WHO, 2003). This document summarizes the present position of the Department of Mental Health and Substance Dependence on assisting populations who have been exposed to extreme stressors, such as refugees; internally displaced persons; disaster survivors; and terrorism, war, or genocide-exposed populations. It recognizes that a large number of persons are exposed to extreme stressors, which are a risk factor in developing mental health and social problems. Principles and strategies described here are primarily for application in resource-poor countries, where a majority of the population who are exposed to disasters and war live. The mental health and well-being of humanitarian aid workers warrant attention too, but their needs are not addressed in this document.

In the document, the term social intervention is used for interventions that primarily aim to have social effects, and the term psychological intervention is used for interventions that primarily aim to have psychological effects. It is acknowledged that social interventions have secondary psychological effects and that psychological interventions have secondary social effects, as the term psychosocial suggests.

WHO in its constitution defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Using this definition of health as an anchor point, this statement covers the organization's current position regarding the mental and social aspects of dealing with the health of populations exposed to extreme stressors.

The document covers the following psychosocial objectives:

1. To be a resource point in terms of technical advice for field activities by governmental, nongovernmental and intergovernmental organizations in coordination with the WHO Department of Emergency Humanitarian Action.

2. To provide leadership and guidance to improve quality of interventions in the field.

3. To facilitate the generation of an evidence base for field activities and policy at the community and health system level.

The document outlines the stragegies for working with populations exposed to extreme stressors and presents clear guidelines for the necessary psychosocial interventions under the following major areas: Preparation before the emergency, assessment, collaboration, integration into primary health care, access to services for all, training and supervision, long-term perspective, and monitoring indicators. This is based on a literature review and the experience of experts with the aim to inform current requests from the field.

The choice of intervention varies with the phase of the emergency. The acute emergency phase is here defined as the period where the crude mortality rate (CMR) is substantially elevated because of deprivation of basic needs (e.g., food, shelter, security, water and sanitation, access to primary health care, management of communicable diseases), due to the emergency. This period is followed by a reconsolidation phase when basic needs are again at a level comparable to that before the emergency or, in case of displacement, are at the level of the surrounding population. In a complex emergency, different parts of a country may be in different recovery phases, or a particular location may oscillate between the two phases over a period of time.

The activities that can be undertaken for different phases of emergencies is presented in clear and practical terms both in the acute emergency phase and in the reconsolidation phase. In both the phases, the interventions are social interventions and psychological interventions. There is emphasis on rebuilding the mental health system for long-term care. One of the examples of the specific guidelines is the brief guidance to national leaders (Appendix 1).

WHO Response to Tsunami, 2004

The above approach to disaster mental health care was put into practice following the Asian tsunami in December 2004. A number of measures were put in place recognizing that the WHO's essential roles in emergencies include advising and assisting the Ministry of Health (MOH) on mental health policy, in planning and coordinating a response, in monitoring the quality of outside technical assistance, and assisting with reconstruction to build a sustainable national mental health services capacity. Existence of WHO regional and country offices made it possible for WHO to begin providing assistance from the first day of the emergency.

Basic WHO documents on mental health in emergencies were made available in the field within a few days of the disaster. Senior WHO staff and consultants were on site within 2 weeks and continued to stay for many months. WHO provided immediate support to the MoH in estimating the mental health needs and preparing strategies/action plans to respond to these. It also provided technical assistance in the form of documents, training manuals, and advice on the mental health interventions. WHO headquarters produced a manual on tsunami-affected children and a briefing note on the projected extent of mental health problems with recommended responses.

One of the key needs in the post-disaster period is coordination to match offers of assistance with the needs. WHO was part of the affected countries' coordination committees to ensure an effective and consistent approach for all psychosocial and mental health activities. This role has included screening all offers of assistance, selecting those that are likely to serve the populations best, directing them to the areas with maximum needs, twinning with local institutions and professionals and saying no to offers that are unlikely to be of any value (e.g., short visits by experts and professional counselors who do not speak local languages). Given the massive international response to the disaster, coordination tasks were substantial.

WHO assisted in training health and other sector professionals and workers in providing basic mental health care. A phased plan for systematic training was put in place in all countries, using WHO material adapted to the local situations. Almost all areas affected by the tsunami had poor mental health services before the disaster. WHO is working with the MOH, local institutions, and professionals and with international agencies to strengthen mental health services to respond to the pre-existing as well as newly emerging needs. These services are based on community mental health model and are designed with a clear view of maintaining long-term sustainability. The basic principles of mental health in emergencies are presented in Table 1.

WHO mobilized adequate financial and human resources to respond to the needs for the initial six months of mental health activities. Since donor interest often wanes quickly after disasters, WHO is making serious efforts to mobilize large resources to implement the long-term plans that it has developed.

Table 1. Mental Health in Emergencies: Basic principles
1. Contingency planning: Before the emergency, national level contingency planning should include (a) developing interagency coordination systems, (b) designing detailed plans for a mental health response, and (c) training general health personnel in basic, general, mental health care psychological first aid.
2. Assessment: Assessment should cover the sociocultural context (setting, culture, history, and nature of problems, local perceptions of illness, and ways of coping), available services, resources and needs. In assessment of individuals, a focus on disability or daily functioning is recommended.
3. Long-term perspective: Even though impetus for mental health programs is highest during or immediately after acute emergencies, the population is best helped by a focus on the medium –and long-term development of services;
4. Collaboration: Strong collaboration with other agencies will avoid wastage of resources. Continuous involvement of the government, local universities, or established local organizations is essential for sustainability.
5. Integration into primary health care: Led by the health sector, mental health treatment should be made available within primary health care to ensure (low-stigma) access to services for the largest number of people.
6. Access to service for all: Setting up separate, vertical mental health services for special populations is discouraged. Nevertheless, outreach and awareness programs are important to ensure the treatment of vulnerable groups within general health services and other community services.
7. Thorough training and supervision: Training and supervision should be carried out by mental health specialists (or under their guidance) for a substantial amount of time to ensure lasting effects of training and responsible care.
8. Monitoring indicators: Activities should be monitored and evaluated through key indicators that need to be determined, if possible, before starting the activity. Indicators should focus on inputs (available resources, including pre-existing services), processes (aspects of program implementation) and outcomes(eg.daily functioning of beneficiaries).
(adapted from Van Ommeran et al,2005)

Experience of different Regions

The Regional office of Americas (Pan American Health Organization-PAHO) has rich experience of working with disasters and mental health has been an important part of the disaster response (WHO-PAHO, 2000).

The WHO Regional office of South East Asia (SEARO) document "Mental Health and Psychosocial Relief Efforts after the Tsunami in South East Asia" describes in detail the activities in India, Indonesia, The Maldives, Sri Lanka, and Thailand (WHO-SEARO,2005). It is a rich source of information on what was done during the emergency and intermediate phases,and discusses the transition strategy and long-term plans for mental health and psychosocial services.

The Southeast Asia Regional office also published manuals for community level workers; trainers of community level workers; physicians, and for relief workers (Caring for Your Own Emotional Wellbeing - Guidelines for Relief Workers).

The WHO Eastern Mediterranean Regional office (EMRO) has a number of countries in conflict situation (Afghanistan, Iraq, Palestine, Sudan, Somalia), and two of the recent severe earthquakes have been in Iran (2003) and Pakistan (2005). A large number of initiatives have occurred in the mental health and psychosocial care in these countries (WHO, 2001, WHO-EMRO, 2002, Ghosh et al, 2004).

New Initiatives

An important leadership 2005 initiative of the World Health Organization,, proposed the formation of an IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings to the Interagency Standing Committee (IASC) Working Group, composed of directors of emergency programs of UN agencies, International Organization of Migration (IOM), three consortia of major international NGOs, and the Red Cross and Red Crescent movement.

The WHO proposal was accepted and an IASC Task Force was created with a 1-year mandate to develop inter-agency guidance on minimum responses on mental health and psychosocial support in emergency settings. The task force is co-chaired by WHO and InterAction, a Consortium of 160 NGOs.

The main task of the IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings is to develop inter-agency guidance for field-testing along the lines of the IASC Guidelines for HIV/AIDS Interventions in Emergency Settings). This Task Force will practical handbook with a matrix and action sheets. The matrix summarizes key actions for three areas: emergency preparedness, minimum response to be conducted even in the midst of emergency, and comprehensive response.

Action sheets, describing how each intervention in the minimum response column should be operationally implemented, focus on the practical activities to be conducted even in the midst of emergency. Each action sheet is short (about 750 words), describing key actions and listing key resources.

Much like the IASC Guidelines for HIV/AIDS Interventions in Emergency Settings, the Task Force's guidelines will include a preamble outlining its purpose, general principles for intervention, and potentially harmful practices to be avoided in emergencies. Currently, the Task Force is engaged in consultations with a wide range of stakeholders on different drafts of the guidance.

The following is the list of recommended steps described in the action sheets:
   -Establish coordination of inter sectoral mental health and psychosocial support.
   -Conduct coordinated assessments.
   -Initiate participatory systems and processes for monitoring and evaluation.
   -Identify, monitor, prevent, and respond to protection threats and failures through social protection.
   -Apply a human rights framework through mental health and psychosocial assistance.
   -Identify and recruit suitable staff and engage volunteers who have a deep understanding of local
    culture.
   -Enforce staff codes of conduct and ethical guidelines.
   -Organize orientation and training of aid workers in mental health and psychosocial support.
   -Prevent and manage mental health and psychosocial problems in staff and volunteers.
   -Facilitate conditions for community mobilization, ownership and control of emergency response in
    all sectors.

-Facilitate community social support and self-help.
-Facilitate conditions for appropriate cultural and religious healing practices.
-Facilitate support for young children (0-8 years) and their care-givers.
-Include specific social considerations (safe and culturally appropriate access for all) in the provision of water and sanitation.
-Include specific social and psychological considerations (safe aid for all that take into consideration cultural practices and household roles) in the provision of food and nutritional support.
-Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision in a coordinated manner.
-Include specific social and psychological considerations in the provision of general health care.
-Provide access to care for people with severe mental health problems.
-Protect and care for people with mental disorders living in custodial settings.
-Learn about and, where appropriate, collaborate with local, indigenous, and traditional healing systems.
-Minimize harmful use of alcohol and other substances.
-Provide access to formal and non-formal education.
-Organize psychosocial support in educational settings.
-Provide information to the affected population on the emergency, relief efforts and their legal rights.
-Provide access to information about constructive coping methods.

It is important to note that there are four groups of action sheets; organizational actions including assessment of needs; psychosocial interventions; care for the mentally ill persons in the community and in institutional settings and inclusion of social and psychological considerations in provision of water and sanitation, food, shelter, and general health care.

The final guidelines are expected to be available by the end of 2006. This will go a long way to minimize conflicting approaches being adopted by the humanitarian organizations and also encourage the inclusion of mental health and psychosocial interventions in the overall disaster response.

Conclusions

In summary, the WHO vision for a better emergency and post-emergency response includes general mental health care available in general health services including primary care; advocacy with other sectors for the implementation of relevant social interventions; facilitation of access to acute psychiatric care, and follow-up care in the community. It also emphasizes the importance of the integration of trauma-focused mental health care into general mental health care and an end to vertical trauma-focused programs and the separation of psychosocial programs from mental health programs.

(The ideas expressed are that of the author in his personal capacity and based on published documents of WHO and in no way represent the official position of WHO.)

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Appendix 1: Guidance to National Leaders in disaster mental health care

What happens in an emergency in terms of mental health?

Services for patients with severe mental disorders collapse. The incidence of common mental problems (e.g., mood and anxiety disorders, including problems induced by trauma) increases.

What parts of the mental health system should be kept running during a humanitarian emergency?

Basic needs of patients in custodial psychiatric hospitals should continue to be addressed. Care for urgent psychiatric complaints continues to be available through the health care systzem (assuming it was available before the emergency). Individuals with pre-existing psychiatric disorders continue to receive relevant treatment. Essential psychiatric medications, consistent with the Essential Drug List, continue to be available at primary care facilities (assuming they were available before the emergency)

What mental health activities should be initiated during a crisis/emergency?

A coordination mechanism for activities in the mental health (incl. psychosocial) sector to avoid fragmentation and wastage of resources should be established. There should also be: advocacy with other sectors to ensure that a number of social interventions are implemented; provision of information on the crisis; maintenance or re-establishment of normal cultural and religious events; access of children to formal or informal schooling and to normal recreational activities; participation of adolescents and adults in concrete, purposeful, common interest activities; social activities to include isolated persons in social networks; family tracing organization of camps/shelter in such way that surviving members of the same family and community stay together.

Ensure that individuals experiencing acute mental distress after exposure to traumatic stressors have access to psychological first aid at health services and in the community. Psychological first aid is not a formal clinical/counseling intervention. Rather, it entails basic, non-intrusive pragmatic support with a focus on: listening but not forcing, talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing, company with significant others; and protecting from further harm. If the emergency becomes protracted, ensure that plans are initiated to provide a more comprehensive range of community-based mental health interventions for the post-emergency phase.

Chapter 3

Psychological Support within Disaster Management in Asian Countries

By Dr. Vinod K. Sharma

Introduction

A majority of the natural disasters occurring in the world are taking place in Asian countries. Each day a disasters occurs, and each year millions of people are affected. During the last decade (1990-2000), about 43 per cent of world disasters happened in Asia, with 70 per cent of world casualties happening in the region.

The World Disaster Report's figures are mind-boggling. During 2002 alone, 583 million people reported affected in Asia, of which 60 per cent were from India. It is also known that about 97 per cent deaths related to natural disasters occur in developing countries. Whether natural or man-made, the extreme and overwhelming forces of disaster can have far-reaching effects on individuals, local communities, and national economies. Although disastrous events may last from seconds to a few days, effects on communities and individuals can continue from months to years during the extended process of recovery, reconstruction, and rehabilitation. Sometimes long-term recovery takes significant time due to the complex interaction of psychological, social, cultural, political, and economic factors. Some of the recent examples are the Orissa super cyclone (1999) and the Gujarat earthquake (2001) in India.

In most of the developing countries, even disasters of low magnitude with relatively few deaths or injuries, disruptions of food supply, utilities, transportation, social, and educational services, together with property damage and survivor rehabilitation often place intense demands on health services.

Mental health care is an essential component in response as each of such events is capable of causing traumatic stress to the survivors or community. However, no authentic data on cases of mental health is available for any of the past natural or man-made disasters.

The present paper deals mainly with disaster mental health response Strategies for providing timely and appropriate mental health services to disaster survivors, families, workers, and organizations in Asian countries. Some of the issues related to the delivery of disaster mental health services at disaster sites and over the long term to provide a continuum of care for recovering survivors and their communities over the course of the days, months, and years following disaster, will also be addressed. Some recent initiatives taken in some of the Asian countries are also presented.

Disasters and Mental Health Problems

Asia is a theater of a large variety of disasters. Among natural disasters, earthquakes, cyclones, and frequent floods are most frequent, causing death, injury, economic loss and mental health problems. Communal riots, terrorist attacks, urban fires, rail and road accidents are among the most frequent man-made disasters. 'Disaster Mental Health in India' published by Indian Red Cross (ed. Lakshminarayana et al, 2004) gave a good description of psychological/mental health-related issues of a variety of disasters from natural to man-made.

The case studies in the book, including the Bangalore circus tragedy, Bhopal gas disaster, Latur and the Gujarat earthquakes and the Gujarat communal riots have clearly presented the lack of clear policy about mental health--not only in India but in the whole region, where the Government response policy has no place for mental health.

Although individual reactions vary, clinical researchers have identified a common pattern of behavioral, biological, psychological, and social responses among individuals exposed to life-threatening events. This response pattern is known as post-traumatic stress syndrome. It is important to help survivors recognize the normalcy of most stress reactions to disaster.

Mild to moderate stress reactions in the emergency and early post-impact phases of disaster are highly prevalent because survivors (and their families, community members, and rescue workers) accurately recognize the grave danger involved in disaster. Although stress reactions may seem extreme and cause distress, they generally do not become chronic problems. Most people recover fully from moderate stress reactions within six to sixteen months.

Each disaster is unique and each victim is different and it is possible to learn many things from each individual situation. Stress reactions result from a variety of shocking events before, during, or after a disaster. Some survivors may experience additional traumas such as life-threatening accidents, sexual or physical abuse, or the witnessing of such things happening to other people. It is important to avoid assuming that a disaster involves the same type and intensity of experience for all survivors, and that all survivors bring a similar personal history of trauma into the disaster.

In addition to involving terrifying close encounters with death and severe physical harm, disasters often cause significant losses that may vary greatly from survivor to survivor (e.g., loss of loved ones, friends, and/or property).

Persons who were physically in the same place throughout much of a disaster may have been exposed to different specific traumatic events during and after the disaster. The same disaster may involve multiple elements ranging from accidental trauma (e.g., car, train, boat, or plane accidents, fires, explosions), to natural environmental cataclysm (e.g., floods, tornadoes, hurricanes, earthquakes), to deliberately caused devastation (e.g., lootings, riots, bombings, shootings, torture, rape, assault, and battery). Survivors may experience significant stress reactions among survivors the type and intensity of these reactions vary greatly within the same disaster.

In the wake of a disaster, survivors may experience financial difficulties related to vocational problems, unemployment, or problems associated with relocation, rebuilding, or repairing a home. Other long-term stressors may include resulting marital and family discord, medical illness, or chronic health problems. Seeking and receiving help for these various issues can result in additional stress for survivors.

Each survivor's personal history and unique psychological and relational strengths and deficits influence his or her response to disaster. Individual, family, and community beliefs, values, and resources also shape the meaning of the experience and have a role in the process of recovery.

Personal and cultural differences in disaster experience are vital in understanding why survivors may show different patterns of stress reactions to what seems to be the same disaster. Even in the briefest and most informal contact with disaster survivors, it is important to make a rapid, sensitive, and no intrusive assessment of the possible mitigating factors that may be shaping each survivor's specific stress reaction. Specifically, before judging or classifying a particular pattern of stress response, consider what is observable, what is disclosed, and what remains to be known about each survivor's unique background or experience in the following areas:

- Ethno cultural traditions, beliefs, and values
- Community practices, norms, and resources
- Family heritage and dynamics
- Individual socio-vocational resources and limitations
- Individual bio-psychosocial resources and vulnerabilities
- Prior exposure to traumatic experiences
- Specific stressful or potentially traumatic experiences during or since disaster

Factors Associated with Disaster Stress

People directly exposed to danger and life threat are at risk for the greatest impact. The literature examining the role of traumatic exposure is definitive. Regardless of the traumatic stressor, be it combat, physical abuse, sexual assault, or natural disaster, close-response is a strong predictor of who will likely be most affected.

The greater the perceived life threat and the greater the sensory exposure--that is the more one sees distressing sights, smells distressing odors, hears distressing sounds, or is physically injured--the more likely post-traumatic stress will manifest. Victims are not the only ones at risk. Helpers, including medical, morgue, and security personnel, rescue, fire, and safety workers, may also experience either direct or indirect trauma. Family members of victims too are at risk for what has been referred to as vicarious traumatization e.g., relationships with traumatized individuals can create much distress for others.

Listed below are factors associated with disaster stress to take into consideration when having to make informal rapid assessments of survivors.
- Personal injury
- Injury or fatality of loved ones, friends, associates
- Property loss/relocation
- Pre-existing stress
- Level of personal and professional preparedness
- Stress reactions of significant others
- Previous traumatization
- Self-expectations
- Prior disaster experience
- Perception/interpretation of causal factors
- Level of social support
- Primary victims: people directly exposed to the elements of the disaster
- Secondary victims: people with close family and personal ties to primary victims
- Tertiary victims: people whose occupations require them to respond to the disaster
- Quaternary victims: concerned and caring members of communities beyond the impact area

Following a disaster, administrators are faced with the challenge of having to quickly become familiar with disaster protocols (grant applications) and resources (mutual and other aid), while meeting rapidly emerging and changing disaster-precipitated needs. This work requires a good deal of ability to work within and effectively influence the institutional arrangements that define the overall disaster response and the community being served.

Disaster mental health response efforts are continuously subject to powerful real-world contingencies. All disasters become political events. Previously established networks and relationships, as well as political pressures, shape the disaster response. Consensus among agencies and organizations about matching resources with survivors is rare. The disaster setting is in constant flux as information and resources change rapidly.

Hourly updates on community needs, political pressures, and the convergence of resources result in frequent reappraisal of how best to respond to the diverse groups of people affected.

Immediately following a disaster, administrators are beset by offers of mental health services from around the country (if not the world) inquiries from the media, and requests for needs assessments and logistical plans for how, where, and by whom mental health services will be delivered. Administrators also must begin preparation to shift services from crisis intervention to ongoing aid and assistance.

Administrative collaboration should occur with mental health team leaders in order to sustain an effective overall intervention, including:

- Communicating with other health and social services.
- Coordinating planning and decisions with the community's overall Incident Command System.
- Monitoring the delivery and effectiveness of mental health services in several sites.
- Converting ongoing assessments into timely reports, applications for funding, and guidelines for deployment of mental health programs and personnel.

Peritraumatic Stress Reactions

Extreme "peritraumatic" stress symptoms (i.e., those symptoms which occur during or immediately after the traumatic disaster experience) include any of the following reactions if they are of sufficient intensity to cause significant impairment in reality orientation, communication, relationships, recreation and self-care, or work and education:

- Dissociation - depersonalization, derealization, fugue states, amnesia.
- Intrusive re-experiencing - flashbacks, terrifying memories or nightmares, repetitive automatic re-enactment.
- Avoidance - agoraphobic-like social withdrawal.
- Hyper arousals - panic episodes, startle reactions, fighting or temper problems.
- Anxiety - debilitating worry, nervousness, vulnerability or powerlessness.
- Depression - anhedonia, worthlessness, loss of interest in most activities, awakening early, persistent fatigue, and lack of motivation.
- Problematic substance use - abuse or dependency, self-medication.
- Psychotic symptoms - delusions, hallucinations, bizarre thoughts or images, catatonia.

A minority of disaster survivors experience sufficiently persistent and debilitating stress and dissociative symptoms to warrant a diagnosis of acute stress disorder (Koopman, Classen, Cardena & Spiegel, 1995; Johnson et al., 1997).

The defining feature of acute stress disorder is the development of anxiety, dissociation, and other symptoms that occur within one month of exposure to a traumatic stressor. Acute stress disorder is characterized by five major response patterns: (1)dissociation or a subjective sense of emotional numbing, (2) a re-experiencing of the event, (3) behavioral avoidance, (4) increased physiologic arousal, and (5) social-occupational impairment.

Post-traumatic stress disorder (PTSD) is a prolonged post-traumatic stress response. In addition, there may be much greater personality and social impairment than evidenced in the common stress reactions that survivor's experience following a disaster.

Disaster Mental Health Work

Disaster mental health work requires a personal orientation toward adventuresome ness, sociability, and calmness. Equally important is having the ability to exhibit empathy, genuineness, positive regard for others, and the ability to provide therapeutic structure. Generally speaking, therapeutic acumen transcends theoretical orientation and is applicable across various disaster response settings. Moreover, it is essential to communicating with survivors and rescue workers whether informally or while providing practical help, defusing, debriefing, or information. Key qualities required for such work are:

> a.Empathy:
> Ability to help the survivor feel that he or she is understood.
> b.Genuineness:
> Ability to reduce the emotional distance or alienation between the survivor and oneself.
> c.Positiveregardforsurvivor:
> Ability to convey respect for the survivor.
> d.Listening:
> Ability to utilize array of listening skills

Even with these qualities, the task of disaster mental health interventions is very complex and needs certain protocols and procedures to be followed.

The Way Forward

There have been extensive deliberations on the issue of disaster mental health in the recent years, particularly since the International Decade for Natural Disaster Reduction. In India, as part of the work of the High-Powered Committee on Disaster Preparedness Plans, a sub-committee was set up on trauma management, which issued its recommendations in 2002. Some of the key areas covered, and other felt needs based on experiences from the region, can provide a basis for charting a future course of action. Such a plan may include the following aspects:

a. Preparedness
> 1.Concrete action plans should be worked out on disaster mental health with achievable targets at national and local levels.
> 2.A team preparing such action plans should comprise psychologists, psychiatrists, doctors, government officials, paramedics, and NGOs working in the area of psychosocial rehabilitation.
> 3.Greater coordination and planning should be taken up between government and NGOs working indisaster situations.
> 4.More Trauma Care Centers should be established at all levels, particularly local levels.

b. Research
> 1. More in-depth research and preparation of case studies should be done in the area of disaster mental health.
> 2. Research-based disaster mental health manuals should be prepared.

c. Training
> 1. There is a need to have an adequate number of psychologists, psychiatrists, and mental health nursing staff who can act as disaster mental health counselors.
> 2. Doctors, nursing staff, NGOs, and community leaders working in the area of disaster should be given special training in disaster mental health.

3. Special disaster mental health training modules should be designed.
4. More institutional facilities for training should be provided in urban and rural areas.
5. Public education programs with disaster health components should be strengthened in disaster management.
6. All disaster training programs should include disaster mental health components.

d. Administration

1. National health policies should include disaster mental health management.
2. Trauma care standards and triage protocols should be established.
3. Mobile trauma care centers should be established.
4. Child guidance clinics should be activated and should have multidisciplinary teams comprising social workers, clinical psychologists, and psychiatrists to provide diagnostic and counseling services to children.
5. Ready lists of psychologists, psychiatrists, referral agencies, NGOS, social workers and development workers etc. should be prepared.

Section II

Evidenced Based Case Studies- Regional Perspectives

Chapter 4

Disaster Mental Health Care in Sri Lanka

By Daya Somasundaram,

Introduction

Sri Lanka is a small island that lies just off the southern tip of India. Over the centuries, the majority Sinhalese and the minority Tamil-speaking communities, who now inhabit the country, have migrated from neighboring India. The original autochthonous races, such as the Veddahs, are now facing extinction. The Sinhalese are mostly Buddhists while the Hindus and Muslims are Tamil speaking. The Christians come from both the Sinhala and Tamil communities. The country gained independence from the British in 1948. With the gradual development of political domination of the majority population and a series of anti-Tamil racial riots, culminating in 1983, a chronic ethnic war set in. India intervened unsuccessfully in 1987 to settle the conflict. From 2002 there has been an uneasy cessation of hostilities with frequent flare ups in individual incidents.

Historical development of disaster mental health care in the country

Sri Lanka has periodically experienced natural disasters such as flooding, landslides, cyclones, and exceptionally a tsunami. Although a disaster management unit was set up under the Ministry of Social Services, it did not function in a coordinated or effective manner. There was no disaster preparedness or planning. Mental health consequences were not considered. Despite the pioneering survey of the mental health consequences of the 1977 cyclone (Patrick & Patrick, 1981), there wasn't much development in the field of disaster mental health care in the country until the ethnic war.

The psychological consequences of the worsening civil war in northern Sri Lanka was only slowly realized by mental health workers, who did not really possess the appropriate knowledge, training, or facilities to tackle posttraumatic problems on such a large scale. In fact it was the insistent inquiries and demand for relief and information that first sounded the alarm and brought to notice the extent of the developing problems.

The Valikamam North Citizen's Committee organized the first public seminar on the subject in 1987 during the brief peace accord. The public interest and the increasing number of patients seeking treatment for war-induced mental disorders prompted the acquisition of the necessary knowledge, the recording of case histories, and the development, through experience, of methods for treating trauma victims. A recent summary of this development of treatment methods is given in the Advances in Psychiatric Treatment (Somasundaram, 1997).

In recognition of the psychological consequences of the conflict, the state finally appointed a Presidential Task Force in 1998 with the mandate to study the human dimensions of the disaster affecting the nation and to recommend remedial measures. The task force, under the leadership of Professor David Ratnavale, came up with an Action Plan, which saw to the setting up of the National Human Disaster Management Council to implement the recommendations. However, nothing much was achieved by the council.

Major disasters and how mental health care was provided

The first major disaster in the island where mental health was recognized and assessed was after the cyclone that hit Eastern Sri Lanka in 1977 (Patrick & Patrick, 1981). It was found that 77 percent of the directly affected population developed significant psychological dysfunction such as anxiety (84 percent), phobia (68 percent) depression (41 percent) and 'disaster syndrome' (23 percent). They identified early and delayed reactions and reported that only 15 percent had begun to lead a normal life at the end of one year. Mental health care was not provided.

The psychological consequence of the civil war for both the civilian population and the combatants was only tardily recognized. Psycho-dynamically, war is a form of severe and prolonged environmental stress. However, unlike natural disasters which are usually acute and of short duration, war tends to be chronic, causing continuing stress or repeated and multiple trauma. In addition, war is a man-made disaster and the attribution to human causality has adverse psychological consequences for the victim. On December 26, 2004, a tsunami hit the eastern and southwestern coastline of Sri Lanka, causing more than 30,000 deaths.

The victims of war in the two decades of an ethnic conflict in Sri Lanka have been profoundly affected psychologically and socially. Arbitrary detention, torture, massacres, extrajudicial killings, disappearances, rape, forced displacements, and bombing and shelling became common. The Tamil community, especially in the north and east of Sri Lanka, experienced the brunt of the war's impact.

Epidemiological surveys of the general population in war-affected areas of Sri Lanka (Somasundaram & Sivayokan, 1994; Somasundaram, 2001) showed widespread exposure to traumatic events.

Table 1: Distribution of War Stress in the Community and Outpatient Department (OPD)

Stress factors. Direct stress	Community (n = 98)	OPD (n=65)
Death of friend/relation	50 percent	46 percent
Loss to property	46 percent	55 percent
Injury to friend/relation	39 percent	48 percent
Experience of bombing/shelling/gunfire	37 percent	29 percent
Witness violence	26 percent	36 percent
Detention	15 percent	26 percent
Injury to body	10 percent	9 percent
Assault	10 percent	23 percent
Torture	1 percent	8 percent
Indirect stress		
Economic difficulties	78 percent	85 percent
Displacement [a]	70 percent	69 percent
Lack of food	56 percent	68 percent
Unemployment	45 percent	55 percent
Ill health [b]	14 percent	29 percent

a. After the 1995 mass displacement when the figure would have reached almost 100 percent
b. Ill health due to war-related injuries, including amputations caused by landmine blasts, epidemics such as malaria, reduced resistance to infections (due to stress and malnutrition), and septicemia had debilitating mental effects.

A more recent epidemiological survey (Vivo, 2003) carried out in Vanni, found that 92 percent of the primary school children had been exposed to potentially terrorizing experiences such as combat, shelling, and witnessing the death of loved ones.

Mental Health impact

According to Bracken, Petty, and Summerfield, in a Save the Children (1998) publication on current conflicts, "Civilians are no longer 'incidental' casualties but the direct targets of violence." Thus, not only the combatants but also the civilian are affected by modern warfare. As for the natural disaster such as the recent tsunami, it had a devastating effect on the fishing community living along the seacoast. But just as devastating as the physical effects of disasters are mental health consequences. The mental health impact of the war and tsunami was seen at the individual, family, and community levels, as discussed in the following sections.

Individual
At the individual level, considerable psychosocial problems were found in studies done in the community and at the outpatient department of a general hospital (Fig. 1) (Somasundaram & Sivayokan, 1994; Somasundaram, 2001).

Fig. 1- Psychosocial and Psychiatric problems in the OPD compared to the
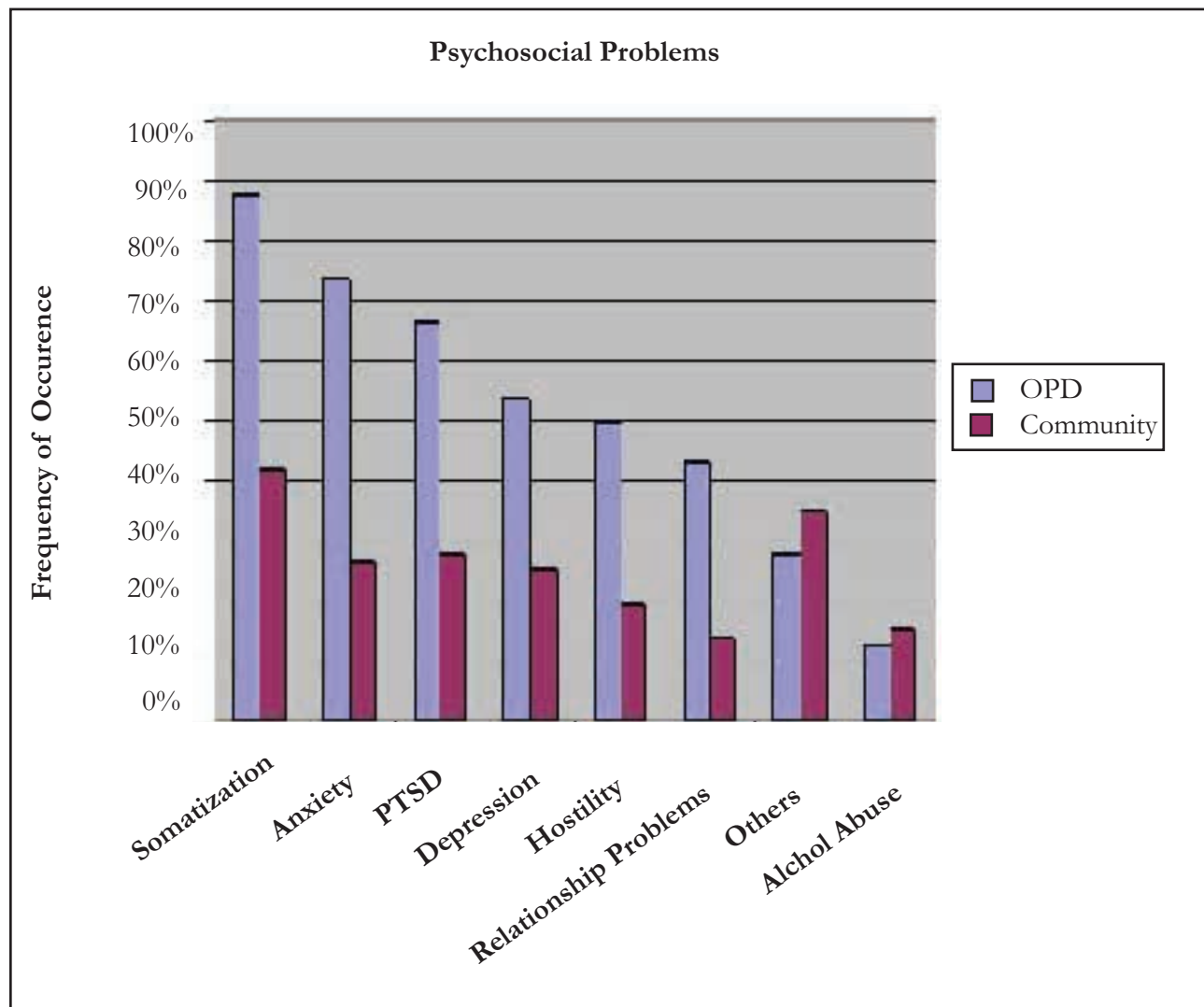
Community

In the above study the noteworthy finding was of 1 percent of the population having been tortured, the figure reaching 8 percent in the OPD patients. Torture was used as a routine procedure in all those detained. A study of 168 ex-detainees found that all had been subjected to torture (Doney, 1998). Eighty-six of the ex-detainees were found to suffer from post-traumatic stress disorder.

Notably, different and opposed parties use the very same methods of torture, even on their own cadre members, employing such practices as beating people with plastic pipes filled with sand, putting chilly powder into eyes, nostrils or genitalia, or suffocating individuals by putting a 'shopping' bag with petrol over their heads. Many individuals do not survive torture, but those who do, are released in a broken condition or, when dead, their maimed bodies are conspicuously exhibited to act as a warning to others. Torture is developed into a physical and psychosocial tool to break the individual personalities of those who try to resist as well as an encompassing method to coerce a community into submission by terror.

Torture became one aspect of institutionalized violence. Various laws were passed, such as the Prevention of Terrorism Act and Emergency Regulations, which facilitated prolonged incommunicado detention without charges or trial, in locations and conditions entirely at the discretion of the security forces, and allowed for the disposal of bodies of victims without judicial inquiry, legitimizing torture and death in custody (Amnesty International, 1986).

Children

The trauma of war appears to have caused considerable problems in children. Studies of the student population show that psychological problems are widely prevalent in the schools, including the university (Arunakirinathan, Sasikanthan, Sivashankar & Somasundaram, 1993; Sivashanmugarajah, Kalaivany & Somasundaram, 1994; Geevathasan, Somasundaram & Parameshwaran, 1993). It is significant that the Health Reach Program at McMaster University (1996) did a detailed study of children in the Eastern Province of Sri Lanka, in addition to their studies in Yugoslavia, Palestine and Iraq, and found significant more war trauma and psychological problems in Tamil (including Muslim) children compared to Sinhalese children.

In the above-mentioned study of children in the Vanni (Vivo, 2003), the effects of war experiences were interfering considerably with the daily life of 52 percent of the children (e.g., social withdrawal and weakening school performance). About 25 percent were found to suffer from PTSD, as defined in Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). A recent survey of tsunami-affected children showed that 41 percent had developed PTSD symptomatology (Vivo, 2005).

Women

In Northern Sri Lanka, the yearly statistics show that more females are seeking psychiatric treatment compared to males. The absence of young males in the age group where mental illness is common (70 percent of the seriously mentally ill are from the 20 to 44-year age group) and the higher female preponderance in the local population is due to the fact that some males in this age group left seeking jobs and other opportunities abroad. It is also that the males in this age group joined the militants, were killed, migrated, or left the area out of fear and sought asylum in foreign countries. It is significant that the army routinely arrests Tamil men in this age group. Often they are detained for long periods on mere suspicion, without judicial processing, and are tortured and often disappear. It is also noteworthy that it was the same age group that swelled the ranks of the militants; a vicious cycle where the increasing repressive policies aimed at this age group forced them either to join the militants or to flee abroad.

For all these reasons, the women were left behind to shoulder the responsibilities of family and home while keeping the society functioning during this critical period (Sivachandran, 1994). While men left their wives and children behind, women did not leave their children or husband to emigrate or flee the area. They were left to face the trauma of war all alone. They looked after their families single-handedly, filling in for the absent male in traditional male roles. They rode bicycles in great numbers, went to the shops, met and argued with authorities, took their children to schools and temples, and generally kept the home fire burning, during this crisis in the society. They were thus under considerable stress and more vulnerable to breakdown. The sex ratio of admission tilted even further towards female preponderance as the war continued, due to accentuation of this process (for example by 1991 the ratio of female to male was 1.2:1). In the final analysis this may have been the price women had to pay to save the society from collapse.

In contrast, the tsunami killed more women and children, making more men widowers.

Family

Due to close and strong bonds and cohesiveness in nuclear and extended families in the Tamil culture, the families tend to function and respond to external threats or terror as a unit rather than as individual members. The family tends to think, feel, experience, and respond together in a particular way. Thus, in the Tamil culture it may be more appropriate to talk in terms of family dynamics rather than of individual personalities.

During times of terrifying experiences, the family comes together to face the threat as a unit and provide mutual support and protection. It will act to define and interpret the terrifying event, give structure and assign a common meaning, as well as evolve strategies to cope with the trauma. Due to the ongoing war, the extended and nuclear family systems have been weakened or shattered by displacement, separation, migration, death, detention, and disappearance of family members. The traditional family unit as the basic social institution has barely survived, and its function has been irrevocably changed by the chronic conflict. The cohesiveness and traditional relationships are no longer the same. Children are now socialized in a war milieu with direct experiences of violence, emotions of terror, grief and hatred, and militant role models. The role of the mother has undergone momentous change with increasing non-traditional responsibilities, activities and "liberation."

Absence of members of the family due to death, disappearance, injury, or displacement creates unfaultable gaps in the functioning of the family unit. The uncertainty and grief about the missing member add to the ensuing maladaptive family dynamics. The loss of the essential unifying role of a missing member may cause disruption and disharmony. From the loss of one or both parents, separations and traumatization, pathological family dynamics can adversely affect each remaining member, particularly the children. A common situation is where the father has been detained, 'disappeared' or killed, but the family members are not sure of his fate. They are caught in a `conspiracy of silence' where further inquiries may lead to more problems for the father, were he still alive, and the mother may not be able to share the truth with the child. The family itself often becomes ostracized by society. The child then presents with behavioral problems. Having the mother share her fears and feelings with the child can be helpful. This is particularly difficult for a family where the male went missing due to the Tamil militants, where the social situation compels the remaining members to keep silent and makes it extremely difficult for them to receive social support. They often have to suppress the memory of the person altogether. In addition, the mother has to adapt to all the negative implications of being a widow in Tamil society.

In the Jaffna peninsula, there are close to 20,000 female-headed households. The effect on the family, the widow (Kumerandran, Pavani, Kalpana, Nagapraba, Kalamagal, Thayanithi, Sivashankar & Somasundaram, 1998) and the children has been immense. Jeyanthy, Loshani & Sivarajini (1993) assessed the impact of displacement in the north on the functioning of the family system. Psychological disturbances, particularly depressive symptoms, were much more common in the displaced families than in those living in their own homes.

Separation anxiety, cognitive impairment, conducts disorders and sleep disturbances were common in displaced children. Disturbances in family dynamics, particularly disputes and quarreling between father and mother, were attributed to economic stress, lack of privacy, and interference of others in overly crowded camps.

In contrast, the higher number of deaths of females due to the tsunami, left many men as widowers. They found it difficult to look after the few children who may have survived and do the domestic duties to run the family. Some were found to use alcohol as a coping mechanism, while other became depressed and suicidal.

Community

The war has had a tremendous impact on the community or village. During the current war, whole communities or villages have been targeted for total destruction, including their way of life and their environment. The village traditions, structures, and institutions that were the foundation and framework for their daily life have been irrevocably changed (Council of NGOs, 1998; National Peace Council & Marga, 2001).

In the various rural communities, the village and its people provided a sustaining support system, organics bond, nourishing environment, and a network of relationships. The village traditions, structures, and institutions were the foundation and framework for their daily life. In the Tamil tradition, a person's identity was defined to a large extent by their village or uur of origin (Daniel, 1984). All this has been destroyed by the war. Some villages have ceased to exist. Due to dislocation, people have been separated so that the network of relationships, structures, and institutions have been lost. Kai Eriksson (1976) described it as a "loss of communality". A very good example of the collective effect of displacement was the mass exodus from Valikamam in 1995 (UTHR-J, 1995). Even when people returned to their villages, as happened in Jaffna in 1996, the villages were not the same. They were newcomers. The old structures and institutions were no longer functioning. The protective environment provided by the uur was no longer there.

Similarly, in the life of Tamils, their house (veedu) and its history are very important. The dead ancestral relations continue to have connections with the house. They are remembered and considered as if they were present in the house, especially when rituals are performed. When people leave the house for long periods (e.g., displacement, going abroad), a biological link breaks. This affects the mental condition in several ways. People believe that ghosts or demons will occupy those houses, which are left empty for a long time. People who returned to their houses after displacement felt a change in the organic bond; they could not re-establish the relationship with their houses.

The ubiquitous presence of landmines buried in the land creates an unconscious apprehension in the back of the minds of people, making them ever vigilant, cautious about walking freely on the land, afraid of putting a wrong foot somewhere. They may develop nightmares of being caught up in a landmine explosion. The once-beloved land becomes a source of terror (Gunaratnam, Sinothaya & Somasundaram, 2003).

Collective Trauma

The cumulative effect of terror on the community can be described as collective trauma, which goes beyond the individual. In fact, given the widespread nature of the traumatization due to war, the individual's psychosocial reactions may have come to be accepted as a normal part of life. But at the community level, manifestations of the terror can be seen in its social processes and structures. This can be seen in the prevailing cultural coping strategies. People have learned to survive under extraordinarily stressful conditions.

However, some coping strategies that may have had survival value during intense conflict may become maladaptive during reconstruction and peace. For example, the Tamils have developed *deep suspicion and mistrust*. People have learned to simply attend to their immediate needs and survive to the next day. Any involvement or participation carried considerable risk, particularly because the frequent changes in those in power that entailed recriminations

false accusations, revenge, and killings. These happened, for example, in 1985 (Liberation Tigers of Tamil Elam- LTTE), 1987 (Indian Peace Keeping Force- IPKF), 1990 (LTTE), 1996 (Sri Lanka Army- SLA) and again in 2002-2003, as the LTTE took over the society in Tamil areas after the peace accord.

Gradually with time, those with leadership qualities, those willing to challenge and argue, the intellectuals, the dissenters and those with social motivation were weeded out, either intimidated into leaving, made to fall silent, or killed. Gradually people became very passive and submissive. These qualities have become part of the socialization process, where children are now taught to keep quiet, not to question or challenge, and to accept the situation.

The repeated displacements and disruption of livelihood have made people dependent on external relief. People have lost their self-reliance, earlier the hallmark of the Tamil. They have lost their motivation for advancement and progress. There is a general sense of resignation to fate. They have developed dependence on help from outside sources, on relief, or on handouts. Further, they have lost their trust in their fellow human beings as well as the world order. They no longer trust the security forces, including the police, because their experiences have taught them otherwise. Instead of trust in and respect for law and order, and belief in their legitimacy, there is terror.

Social deterioration

The signs of the effects of a chronic war can be seen in all social institutions, structures, and organizations in present day Jaffna. There is a general ennui. Most have left their houses and property, not taking the effort to do repairs. Once a hard-working society dominated by a strong work ethic, its output had declined considerably, since most people are not inclined to work. There is a crisis of leadership. There is a complete lack of quality in all aspects of society, partly due to crippling brain drain, but also the devastating effect of the war. As with adolescents (Geevathasan, Somasundaram & Parameshwaran, 1993; Sivashanmugarajah, Kalaivany & Somasundaram, 1994), marked impairment in cognitive functioning can be discerned in adults too.

There is a marked deterioration in social values demonstrated both with regard to sexual morals (for example, medical personnel report increased unwanted pregnancies, teenage abortions, and child sexual abuse in the refugee camps in Vavuniya and society in general) and to social ethics (robberies of the houses and property of those displaced, now claimed as a right, increase in crime rates). There is currently a dramatic increase in the number of incidents of child abuse, including sexual abuse, being reported in Jaffna to the District Child Protection Committee at General Hospital, Jaffna (Senthuran & Somasundaram, 2003).

Mental health interventions

Training
In view of the widespread mental health and psychosocial effects of the disasters in northern Sri Lanka, both war and the natural disaster as the tsunami, training of grass root community-level workers in basic mental health knowledge and skills was the easiest way of reaching a large population. They in turn would increase general awareness and disseminate the knowledge as well as do preventive and promotional work. The majority of the minor mental health problems would be managed by the community-level workers and others referred to the appropriate level. Primary health workers including doctors, medical assistants, nurses, family health workers; school teachers; village resources like the village headman (G.S.), elders, traditional healer, priests, monks, and nuns; governmental, non-governmental organizations (NGOs), volunteer relief, and refugee camp workers were given training using a manual based on the WHO/UNHCR (1996) booklet, *"Mental Health of Refugees,"* adapted to the Tamil cultural context (*Mental Health in the Tamil Community*). A group of trainers were trained in community mental health to use this manual and training was completed with UNICEF support.

They in turn trained the variety of community-level workers mentioned above. In this way the necessary knowledge and skill was spread to a wide population. A referral system where more severe problems can be referred for more specialized treatment was established at each district level as shown in Fig. 2.

Fig. 2 Referral structure for Management of Post Disaster Mental Health problems (at District Level)

- Multi disciplinary team - Psychiatric social worker, Clinical Psychologist, Counselor, Child therapist
  (*Includes art, play, 00drama*), Relaxation therapist and Occupational therapist.

Referral
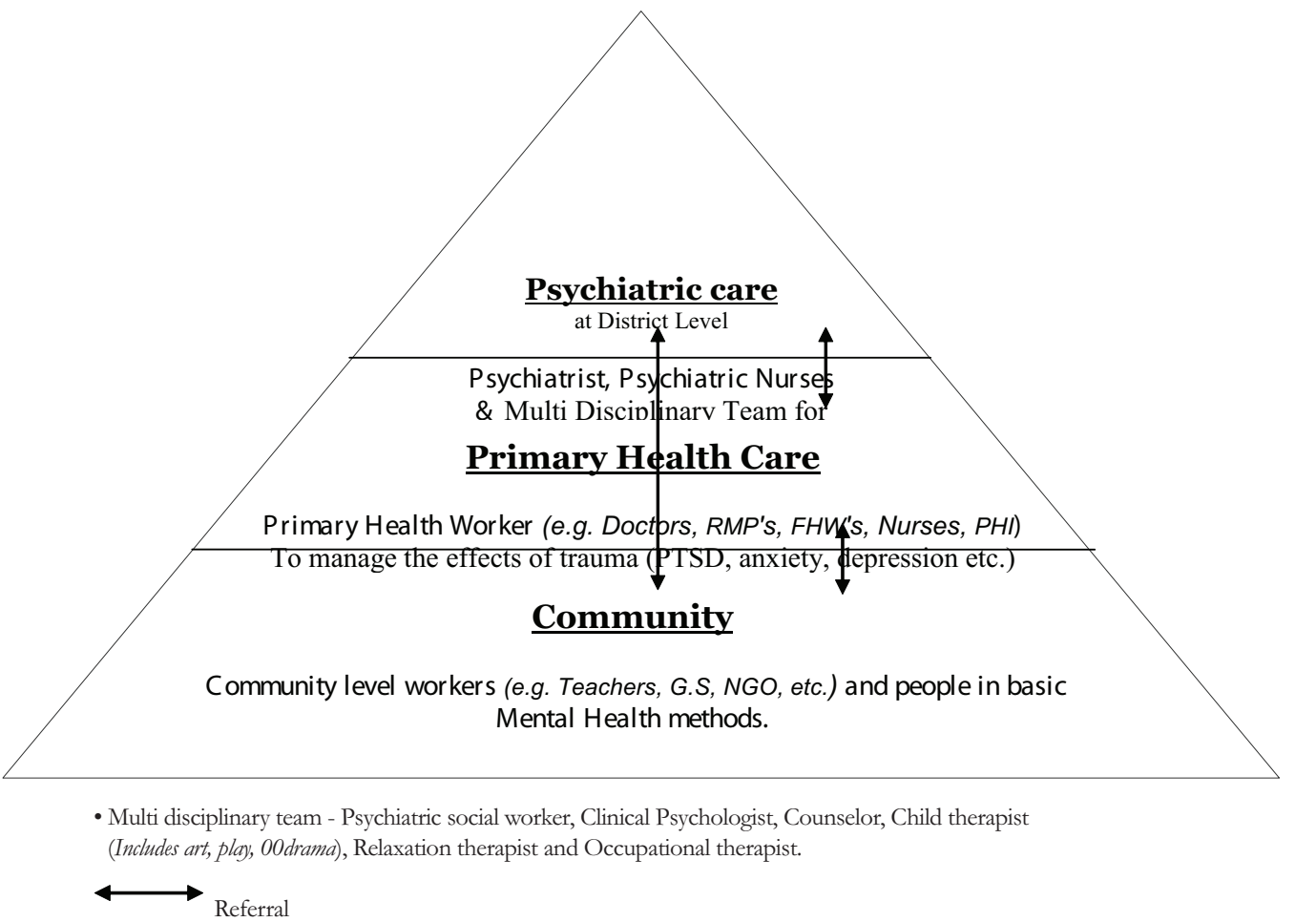
Selected primary school teachers (more than 125) in the Northeast have been trained for six months in basic mental health care of children and simple psychosocial intervention including narrative exposure therapy (NET), through the German GTZ program. Further, a large number of teachers (more than 1000) have been given brief training as befrienders to identify, help, and refer affected children and undertake mental health promotional activities. Manuals, Child Mental Health and Joyful Living, have been prepared in Tamil for this purpose. The Danish Red Cross in conjunction with the Sri Lankan Red Cross and Shantiam is undertaking a psychosocial program for school children through organized play activities using the manual, Muthathil sinthia muthukal, to train teachers.

Teaching of the culturally appropriate relaxation exercises or yoga to large groups in the community and as part of the curriculum in schools that can be both preventive and promotive of mental health was undertaken in a limited way. Similarly, structured play activity for children in refugee camps and community settings was done to promote mental health.

Indigenous coping strategies that have helped the local population to survive were encouraged. Culturally mediated protective factors such as rituals and ceremonies were strengthened. For example after the tsunami, funerals, and observance of anniversaries were very powerful ways to help people who were grieving devastating losses to find comfort. These rituals were a source of strength, support, and meaning.

Immediately following a disastrous event, either in war or after the tsunami, the community-level workers were trained to carry out psychological first aid and crisis intervention. Following a major disaster in the immediate post-impact period, at least 25 percent to 75 percent of the population may be stunned, dazed, apathetic, and wandering. Other symptoms of an Acute Stress Reaction could be overwhelming distress or disoriented behavior. At this point, psychological first aid could provide basic support and care, while preventing future psychological problems from developing.

Many survivors after disasters needed basic medical care. They were referred to medical services and the appropriate specialty (such as surgery, orthopedics, dentistry, pediatrics, gynecology etc.) after an initial history and assessment.

Psycho-education

Basic information for the general population about trauma and normal responses, suggestions on what to do, what not to do and coping techniques were provided through pamphlets, media (TV, radio, newspapers), public lectures, seminars, discussion, and street drama.

Individual Therapy

A wide range of interventions was used for traumatized individuals depending on their needs (see box). A multi-disciplinary Team (MDT) consisting of counselors (for adults, family, children), psychiatric social workers, relaxation therapists, and occupational therapists were trained to carry out these interventions with support from the Canadian High Commission.

Table 2: Therapeutic Interventions for Disaster Survivors with Severe Psychosocial Problems:

1. Psycho-education
2. Crisis Intervention
3. Psychotherapy
4. Behavioral-Cognitive methods
5. Relaxation Techniques
6. Pharmacotherapy
7. Group therapy
8. Family therapy
9. Expressive methods
10. Rehabilitation

Psychotherapy
Various forms of psychotherapeutic techniques ranging from listening and counseling to brief dynamic psychotherapy were used for traumatized individuals. The basic principles included building a trusting relationship, listening to the story, helping to ventilate emotions, and coming to terms with what had happened.

Using supportive techniques, symptomatic relief and problem solving within the counseling process were useful. Grappling with issues such as guilt, loss of control and powerlessness, so important in the West, were not that imperative in the local cultural context. However, shame, loss of face, trust, fate and blame were more important. (The loss of control described as fundamental squeal to traumatization in the West, may be based on the cultural belief in control that the individual is said to possess and the emphasis on individual responsibility often results in the guilt that flows from these beliefs.)

In contrast, in the East, the belief in karma, fate, and the links to family and ancestors make the world view very different. As such, a western-trained psychotherapist will find it difficult to understand the socio-cultural context and belief systems in developing countries, making it more difficult to handle these issues with their client. Indeed, misunderstandings and pursuit of Western preoccupations with guilt can make psychotherapy a perilous journey in more Eastern settings. Hence, clients were encouraged to consult the local priest, monk, or traditional healer who would better understand the belief systems of the local population and thus may be in a better position to remedy the situation.

A much more ambitious aim, termed logo therapy (Frankl, 1959), was used to find meaning in what happened. Once the meaning was found, most clients appeared to recover quickly. Again the cultural and religious beliefs, for example the doctrines concerning karma and suffering that are central both to Buddhist and Hindu belief systems were important. Clients were referred to traditional resources such as priests, monks, and healers whenever possible.

Behavioral Cognitive Methods

Essentially this amounted to trauma desensitization by exposure, by having the client confront the traumatic event using imagery. Several groups of teachers underwent training in Narrative Exposure Therapy (NET), which is a very effective treatment for PTSD.

Relaxation Techniques

Similar to Jacobson's Progressive Muscular Relaxation, culturally acceptable methods were effective for several of the consequences of traumatization, namely states of arousal, anxiety and somatization (Somasundaram, 2002). Traditional methods adapted to the client's culture and religions were developed to be practiced twice daily.

Breathing Exercises

The goal in therapy was to bring breathing under conscious control and make it deep, smooth, and regular. This usually entailed teaching abdominal, diaphragmatic breathing in contrast to the usual thoracic type of breathing. In Hindu settings, the yogic method of Pranayama and for Buddhist clients, mindful breathing or Ana Pana Sati could be taught. A mantra or word (OM) can be recited while breathing in and out.

Progressive Muscular Relaxation

Hindu clients were taught yogic exercises; Shanti or Shava Asanas. Buddhists were encouraged to practice mindful body awareness. Jacobson's progressive muscular relaxation was taught to other clients.

Repetition of Words

A meaningful word, phrase or verse was repeated over and over to oneself. For Hindus the mantra given to them during initiation or the Pranava mantra, OM, was selected. For Buddhists Buddhang Saranang Gachchami, Muslims Subhanallah and for Catholic Christians, the Jesus prayer ("Jesus Christ have mercy on m"e) or prayer beads were used.

Meditation

Various meditation practices, for example, for Buddhists Vipassana meditation and for Christians, contemplation, were chosen. Traditional methods of massage were also used to produce profound relaxation. Aurvedic or Siddha oil massages were both culturally familiar and effective.

Defining these cultural techniques as relaxation exercises may be a misnomer leading to an underestimation of their value. When methods are culturally familiar, they tap into past childhood, community, and religious roots and thus release a rich source of associations that can be helpful in therapy and the healing process. Further, mindfulness and meditation draw upon hidden resources within the individual and open into dimensions that can create spiritual well-being and give meaning to what has happened. Although these techniques do no formal psychotherapy, they may accomplish what psychotherapy attempts to do by releasing cultural and spiritual processes.

Pharmacotherapy

When there was severe PTSD or depression, drugs such as anti-depressants were used.

Expressive (Emotive) Methods

Artistic expression of emotions and trauma were cathartic for individuals and the community as a whole. Art, drama, story telling, writing poetry or novels (testimony), singing, dancing, clay modeling, sculpturing etc. were very useful emotive methods in trauma therapy. The traumatized individual was able to externalize the traumatic experience through a medium and thereby handle and manipulate work through outside activities without the associated internal distress. Children in particular, who were usually unable to express their thoughts or emotions verbally, benefited from the above-mentioned expressive methods and play therapy.

Group therapy
The formation of separate groups for ex-detainees, widows groups, torture survivors, landmine victims, and other groups of affected individuals were encouraged. Support groups for those involved in helping the clients can prevent burn-out.

Family therapy
Efforts were taken to keep the family together and united, strengthening family cohesion. The principles of family dynamics were used to facilitate supportive and healing relationships while counteracting damaging and maladaptive interactions.

Problems in providing care

The state has still not accepted the responsibility for the mental health consequences for the war. Thus it has been left to International and local NGOs to provide limited and urgent help. Without the involvement of the state, the long-term sustainability of these programs cannot be maintained. An important constraint is the lack of human resources. Trained individuals tend to leave the area of conflict.

Impact of Interventions

The impact of the interventions is difficult to quantify. General public and community-level workers trainings were conducted during various crises, such as the mass displacement of 1995. Trained personnel were able to take leadership roles and organize psychosocial activities in refugee camps and schools.

Evaluation of the Interventions

There has been limited evaluation of the interventions. A study of the outcome of relaxation exercises (Somasundaram, 2002), NET therapy (Vivo, 2005) and the teacher-counselor training program (GTZ, 2003) has been done.

Publications/reports
'Scarred Minds' by Sage (Somasundaram, 1998), New Delhi was an important publication, which described the psychological impact of war on the affected population. Several publications have appeared internationally, alongside many chapters in books and medical journals.

Discussion of issues

In view of the widespread traumatization and psychosocial problems described above, the most useful approach would be a *holistic, integrated,* community-based program. Any program should seek to promote the physical, psychological, familial, social, and spiritual health of the people who have been affected by ongoing war.

The psychosocial interventions should be a part of this overall approach. Grass-root workers should have an integrated training in all aspects, so that they could attend to any of these problems as part of their routine work. They should have simple, basic knowledge and skills that would allow them to help in most of the common problems, psychosocial included. But they should also be able to identify the more complicated problems needing specialized help and provide appropriate referral to them. A functioning and accessible referral should be in place. For the psychosocial problems of a severe nature, the multidisciplinary team is suggested.

Thus, the training of the grass-root workers has to include psychosocial aspects as part of their regular curriculum. We have adapted the WHO/UNHCR manual, *Mental Health of Refugees,* to the local cultural context for this purpose. A psychosocial component should form a natural part of all relief, rehabilitation, development programs.

As already mentioned, unless individuals and their families regain their mental health and functioning, the relief, rehabilitation and development programs will not work in many cases. Further, the programs' actual target population should become real participants, planning, implementing, and deciding on the future course. Decentralization in the planning, implementation, and funding of programs has to be brought about.

A real devolution of functioning with encouragement for the local leadership will be needed. A restructuring of the whole relief, rehabilitation, and development process will have to be undertaken. The idea of bringing in peace building and reconciliation as part of the rehabilitation activity is a good one. However, in this very authoritarian social setting, more power and will has to found for the ordinary people if this is to have any effect. They would also need to break out of the shackles that have bound them to think that all decisions will be taken at the top and their role is to follow. The climate of fear, terror, and silence will have to be broken. Space will have to be found for activities that will not be tolerated by those in power.

Ethical principles in protecting victims, particularly in cases where international personnel want to do research, administer questionnaires etc have to be laid out. Questions will have to be asked as to the benefits, if any, to the victims. What help and support will they be given after the questions expose their trauma and emotional problems? Will there be any follow-up programs? For what purpose is the research being done? Some professional standards will need to be established for psychosocial programs. For example the capacities of counseling can vary tremendously. Some programs claim to train people to be counselors in one week or less. Will the counselors be subsequently supervised?

Perhaps most important for the local community is the long-term sustainability of the psychosocial programs. Efforts should be directed at capacity building, so that local people become skilled in giving psychosocial help. In these training and skill building activities, importance needs to be given to local resources, particularly from the traditional sectors. Helpful traditional familiar methods may need to be identified and encouraged rather than importing western methods that may not be effective in the local cultural context. Practitioners already experienced in these methods may need to be found, encouraged, and coaxed to take part in psychosocial programs.

Conclusions

Disasters occur frequently. Sri Lanka needs to prepare a disaster plan with clear guidelines on what needs to be done from a mental health perspective. While man- made disasters such as war can be prevented and adverse consequences of natural disasters mitigated by early warning and organized responses; the widespread effects necessitate a community-based approach. The most effective means of achieving good coverage would be to train community-level workers in basic mental health. A referral system whereby they can refer more severe cases for mental health professional care should be in place.

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Chapter 5

Disaster Mental Health Care in Lebanon

by Neill Ghosh and R.Srinivasa Murthy

Introduction

Following the collapse of the Ottoman Empire in the wake of World War I, the League of Nations mandated the five provinces that comprise present-day Lebanon to France. Modern Lebanon's constitution, drawn up in 1926, specified a balance of political power between the various religious groups. The country gained independence in 1943. Lebanon is characterized by a mosaic of many religions and cultures that have continued, over the past 6000 years, to shape the country's politics, economy, and culture. The Lebanese terrain is a mixture of coast, mountain, and inland plain.

The population immediately after the beginning of the civil war in 1976 was 3.2 million, but the exodus of a large number of people due to war conditions, resulted in an estimated population of 2.7 million in 1990. In 1996, the Population and Housing Survey, conducted by the Lebanese Ministry of Social Affairs, estimated the total population at 3,111,828 inhabitants. The ethnicity of the population is: Arab 95 percent, Armenian 4 percent, and others 1 percent.

The religious makeup of the population is broken down as follows: Islam 70 percent (five legally recognized Islamic groups exist, comprising Alawite or Nusayri, Druze, Isma'ilite, Shi'a and Sunni), Christian 30 percent (eleven legally recognized Christian groups are made up of four Orthodox Christian, six Catholic and one Protestant). In 1997, the percentage populations of those below 15 years and above 65 years of age were 28 percent and 4 percent respectively. Also in 1997, 84 percent of females above the age of 15 years were literate, and the total adult literacy rate was 88 percent.

Overview of the Conflict

The Lebanon war that decimated the country for the best part of the last two decades was the most complex, long-lasting and destructive conflict to have taken place since the end of World War II. After 15 years of bloodshed, from 1975 to 1990, an estimated 150,000 people were killed, with a further 900,000 uprooted from their homes.

The internal struggle between different factions, Lebanon's geographic position, the presence of the Palestine Liberation Organization (PLO), and more than 300,000 Palestinian refugees have made the country a major battleground in the Arab-Israeli conflict. At the root of the conflict lay the issues of national identity, religious tolerance, power sharing, national sovereignty, and the future of Palestine. Though the war may be over, Lebanon remains vulnerable to its own fissures and the ongoing Arab-Israeli conflict.

Throughout the late 1960s and early 1970s, prior to the outbreak of full-scale conflict in Lebanon, there were frequent clashes between Palestine and Israel, and Palestinian and Lebanese forces in the south of the country. At the same time (and from the very creation of the state of Lebanon), animosity was brewing between Muslims and Christians in the country with the Muslims dissatisfied with what they considered an inequitable distribution of political power and social benefits.

On April 13, 1975, gunmen attacked and killed four Phalangists. In retaliation, a busload of Palestinians was ambushed in the Christian sector of Beirut. This sparked the beginning of full-scale war in Lebanon. Palestinian forces joined predominantly leftist-Muslim factions as the fighting persisted, eventually spreading to most parts of the country.

In October 1976, Arab summits were held in Riyadh and Cairo. In late 1977 and early 1978 there were intense clashes between the PLO and Lebanese leftists on one hand, and the pro-Israeli South Lebanon Army (SLA) on the other. In March 1978, Israel invaded Lebanon, occupying much of the south. The involvement of yet another actor only served to heighten the complexity of the conflict. By this time, the international community realized that it must get involved.

The United Nations Security Council passed Resolution 425 that called for the withdrawal of Israeli forces from Lebanese territory and created the UN Interim Force in Lebanon (UNIFIL). However, this force was largely seen as ineffective as it did little to abate the conflict, and by mid-1978 there were renewed clashes between the ADF and Christian militias. The Israeli-Palestinian fighting halted in a ceasefire that was brokered in July 1981. This was to hold for ten months until incidents such as PLO rocket attacks on Northern Israel led to a return of Israeli ground forces on June 6 1982.

In mid-June of the same year, Israeli forces laid siege to Palestinian and Lebanese forces in Beirut. In August 1982, US president Ronald Reagan's special Ambassador Habib brought about an agreement to facilitate the evacuation of Syrian troops and PLO fighters from Beirut. It was also agreed that a multi-national Force (MNF) consisting of US, French, and Italian troops, should be deployed to Lebanon to aid the security situation. In the same month, Bashir Gemayel was elected President of Lebanon, but was assassinated on September 14th. The following day, Israeli forces entered West Beirut and hundreds of Palestinian refugees were massacred in the Sabra and Shahila refugee camps.

On September 23rd, Bashir Gemayel's brother Amin was unanimously elected President. The MNF were recalled to Beirut and were joined by a British contingent at the end of September. In terms of full-scale fighting, late 1982 and the first half of 1983 were calm. However, there were a series of terrorist attacks on US interests such as the bombing, on April 18, 1983, of the US embassy in West Beirut in which 63 people were killed and on October 23 of the same year, the US and French headquarters of the MNF were bombed leaving 298 dead.

On May 17, 1983, an agreement was signed by Lebanon, Israel, and the US to facilitate Israeli withdrawal but Syria was not willing to discuss it and effectively stalemated the proceedings.

In September 1983, a full-scale battle broke out between the Druze Muslims, supported by Syria, and the Christian Lebanese Forces (LF). This involved intense fighting, and immense effort was put into brokering a ceasefire, which was eventually achieved by the US and Saudi authorities on September 26.

It is already clear from the nature of the conflict that the Lebanese authorities were not able to exert a large amount of control over the situation. This became even more apparent in February of 1984 when the Lebanese army suffered a mass defection of its Muslim and Druze units to opposition militias. May 1985 saw the beginning of the "Camps War," which was between the Palestinians in the refugee camps of Beirut, Tyre, and Sidon against the Shi'ite Amal Militia. This conflict was to flare up twice more in 1986.

By 1987, the Lebanese economy was worsening rapidly with the pound beginning to slide precipitously. On June 1st of the same year Prime Minister Karami was assassinated. Salim Al-Huss was appointed as the new prime minister . On September 23, 1988, Amin Gemayel's presidential term expired. Before leaving office,

he appointed Commander General Michel Aoun as interim PM to oversee the first free elections in the country for 20 years. Salim Al-Huss continued to act as de facto PM essentially splitting Lebanon between the Muslim government in West Beirut and the Christian government in East Beirut.

In March 1989, General Aoun attempted to close the illegal militia ports in Muslim parts of the country, which led to six months of shelling of East Beirut by Muslim and Syrian forces, and shelling of West Beirut and Shuf by Christian units and the army. This shelling was indiscriminate and often the civilian areas were specifically targeted. This resulted in nearly 1,000 deaths and further economic decline. The government was forced to focus all its energy on trying to bring an end to the war, and thus it was not able to pay focused attention to the ailing economy.

On November 4, 1989 the Taif Agreement was signed. This was a Charter of National Reconciliation. Under this agreement, Rene Moawad, a Maronite Christian deputy was made President but was assassinated almost immediately on November 22. Another Maronite, Elian Hraoui, was elected who named Salim Al-Huss as the prime minister. General Aoun was not willing to ratify the Taif agreement or accept Hraoui as president. Aoun's forces attacked the LF in East Beirut, which resulted in heavy fighting in which over 900 people were killed and 3,000 were wounded.

In August 1990, the National Assembly was approved and the president signed the constitutional amendments embodying the reform aspects of the Taif agreement. One important element of this was that the National Assembly was expanded from 99 to 108 seats and these seats were divided equally between Christians and Muslims in an attempt to try to foster some kind of balance and harmony between both the factions.

In October 1990, a joint Lebanese and Syrian military operation forced General Aoun to capitulate ending another bloody chapter of the Lebanese conflict. He was eventually granted a special pardon and allowed to leave the country.

On December 24, 1990, Omar Karami was appointed as the new prime minister and over the next two years, under his leadership; the Lebanese authorities began to reassert control over their territory. In May 1991, the remaining militias (with the important exception of Hezbollah) were dissolved and in July the armed forces moved against armed Palestinian elements.

The physical damage inflicted on the state of Lebanon by the sustained and bloody nature of this conflict was immense. The sheer number of killed and injured was astronomical with more than a third of the prewar population being killed, handicapped, or displaced. Massive damage was done to basic infrastructure and government services.

The economy before the onset of war was thriving with Beirut being an international finance and banking center. In the wake of nearly two decades of war, the country is heavily in debt and financially is a mere shadow of its former self.

Impact of the Conflict on Mental Health

The mental health impact of the war on the general population, on special groups such as women and children, and on specific issues such as substance abuse has been studied by a number of investigators.

One of the first studies (LB12), involving 9 epidemiological surveys (39,000 subjects) and 3 family studies (4000 subjects), was conducted worldwide in the 1980s in North America, Puerto Rico, Western Europe, the Middle East, Asia, and the Pacific Rim.

The Lebanon part of the study was conducted in Beirut in 1988-1989 with a sample of 521 people. The investigators determined cumulative rates of depression based on either research diagnostic criteria (RDC) or Diagnostic and Statistical Manual of Mental Disorders (DSM-III) criteria by de ned birth cohort, sex, and age of onset. Seven birth cohorts were de ned: earlier than 1905; 1905 through 1914; 1915 through 1924; 1925 through 1934; 1935 through 1944; 1945 through 1954, and 1955 or later. Age of onset for major depression was divided into 10-year intervals beginning at the age of 5 years, up to 74 years.

The Beirut sample shows that cumulative rates of onset were highest for the cohort born in 1955 or later. There were also dramatic variations in the rates of major depression between successive periods. The rate dropped sharply between 1940 and 1950; increased sharply between 1950 and 1960; dropped again, although less sharply, between 1960 and 1970; and increased again between 1970 and 1980.

In another worldwide study conducted in 1996 (LB11), on population-based epidemiological studies, using similar methods in 10 countries, with approximately 38,000 community subjects. It was found that the lifetime rates for major depression varied widely across countries, from 1.5 cases per 100 adults in the sample in Taiwan to 19.0 cases per 100 adults in Beirut.

In a general population, the study of 658 subjects aged 18-65 years, randomly selected from four Lebanese communities differentially exposed to the Lebanon Wars were interviewed using the DSM-III.

The individual levels of exposure to war events were assessed through a War Events Questionnaire (LB13). The four Lebanese communities that were selected for the study were deliberately chosen to represent increasing degrees of exposure to the Lebanon Wars: Bejjeh (BJ), a village 65km northeast of Beirut, which witnessed only 1 hour of shelling from the onset of the Lebanon Wars (1975) to the date of data collection (14 years later); Kornet Shehwan (KS) a village 15km northeast of Beirut, which was the target of sporadic shelling during most rounds of the Lebanon Wars; Ashra eh (ASH), a county within Beirut that was heavily bombarded during most outbreaks of the wars; and Ain Remmaneh (AR), a county on the demarcation line in Beirut where the rst battles were fought at the onset of the wars in 1975, and remained one of the most dangerous areas in Lebanon for 15 years. The lifetime prevalence of major depression differed signi cantly between the regions: 26.1 percent for BJ, 24.8 percent for KS, 16.3 percent for ASH and 41.9 percent for AR. The risk of developing a major depressive episode during war was found to increase by 1.96.

Generally, suicide rates have been low in Muslim countries. In a 1999 study (LB16), suicide ideation and attempts were assessed on the Diagnostic and Statistical Manual of Mental Disorders in more than 40, 000 subjects drawn from the United States, Canada, Puerto Rico, France, West Germany, Lebanon, Taiwan, Korea, and New Zealand. Results show that the lifetime prevalence rates per 100 persons for suicide ideation ranged from 2.09 in Beirut, Lebanon, to 18.51 in Christchurch, New Zealand. Lifetime prevalence rates per 100 persons for suicide attempts ranged from 0.72 in Beirut to 5.93 in Puerto Rico.

The data collected here clearly displays that there is a direct link between the trauma suffered during times of con ict and the onset of major depression. It can be seen that the severity and longevity of the Lebanon Wars have led to a signi cant occurrence of post-traumatic stress disorder in the general population of the country. A robust relationship was also established between exposure to con ict and the development of co-morbidity.

A conclusion drawn could be that the duration and the nature of the event that people are exposed to has a direct correlative effect on the development of co-morbidity of PTSD and depression. These disorders are most commonly found in those who have been forced to endure conflict. It should also be noted that the prevalence of PTSD seems to decrease spontaneously with time. These findings indicate that the majority of civilians who are exposed to war stress will not develop long-term mental health problems.

Impact of war on the mental health of children

Three hundred and eight-six children and adolescents, who had been exposed to the 'Grapes of Wrath' military campaign in South Lebanon in 1996, were randomly selected from 25 schools throughout the region (LB17). Subjects ranged from 6 to 19 years.

Using the War Events Questionnaire (Karam et al., 1999) to measure exposure, 15.8 percent of the sample reported the house damage of a very close person and 18.9 percent of their own homes. Injury of a very close person was reported by 7.8 percent of the subjects. The prevalence of PTSD among the sample was 24.1 percent with substantial levels of co-morbidity between PTSD, major depressive disorder, separation anxiety disorder, and overanxious disorder.

A sub sample (N=143) was prospectively followed and reevaluated one year later. Results showed that the prevalence of PTSD had dropped from 24.1 percent at Phase I to 1.2 percent at Phase II. Children who were orphaned by the war were also assessed for PTSD at Phase II and results showed a rate of 20.7 percent, considerably higher than the rate displayed by non-orphans. Only after 4 years did the rates of PTSD in orphans drop to a similar level of non-orphans, which was around 1 percent.

A sample of 224 Lebanese children, aged 10 to 16 years were interviewed (LB18) using measures of war exposure, mental health symptoms, ability to adapt, and PTSD.

The number and type of children's war traumas varied meaningfully in number and type by their age, gender, father's occupational status, and mother's educational level. As predicted, the number of war traumas experienced by a child was positively related to PTSD symptoms; and various types of war traumas were differentially related to PTSD, mental health symptoms, and ability to adapt. For example, children who were exposed to multiple war traumas, were bereaved, became victims of violent acts, witnessed violent acts, or were exposed to shelling or combat, exhibited more PTSD symptoms. Children who were separated from parents reported more depressive symptoms than children who experienced bereavement and were not displaced. Lastly, children who were separated from parents and who witnessed violent acts reported more pro-social behavior.

An investigation (LB19) used the Metropolitan Achievement Test (MAT) as well as a measure of intelligence and administered them to three groups of Lebanese children. The first group met the diagnostic criteria for PTSD. The second group had been exposed to qualitatively similar stressors, but did not meet the PTSD diagnostic criteria, and the third group consisted of non-traumatized controls. Data analysis using IQ as a covariate determined that the MAT scores of the PTSD children were significantly lower than the scores of the stress-exposed PTSD negatives and controls. No significant differences were observed when the MAT scores of the stress exposed PTSD negatives and the controls were compared.

Armed conflict affects all aspects of child development--physical, mental, and emotional. The disruption of food supplies, the destruction of crops and agricultural infrastructures, the disintegration of families and communities, the displacement of populations, the destruction of educational and health services and of water and sanitation systems, all take a heavy toll on the child.

We see that children in Lebanon were heavily exposed to war events. Results suggest that the most common disorder to be detected in children in Lebanon is PTSD. However, we see that this does not necessarily lead to a long-term personality change in the child as after cessation of conflict. In fact, it is possible to conclude that PTSD, whether measured categorically or on a continuum, decreases spontaneously in at least half of the subjects. Time is shown to be a natural healer. The exception was in the case of children who were orphaned by war. There is general consensus that children who are orphaned during conflict are at high risk of developing psychopathology. Results also suggest that children who develop PTSD suffer from scholastic impairment.

Impact of war on mental health of women

A sample of 152 women living in Beirut, Lebanon was studied to determine the relationship between life experiences, mothers' depression, and children's health and behavior (LB22).

Measures of the perceived negative impact of war and non-war related events, measures of available social support, socio-demographic variables, coping or response strategies and displacement were used to predict mothers' depressive symptoms and the impact on children's health. The level of perceived negative impact of war-related events was found to be strongly associated with higher levels of depressive symptoms among mothers. More surprising was the relative importance of experiences unrelated to the war in predicting higher levels of depressive symptoms.

Among the most noteworthy of the findings was the association between the use of an emotional response style and the measure of psychological dysfunction. Finally, the level of a mother's depressive symptoms was found to be the best predictor of her child's reported morbidity, with higher levels of symptoms associated with higher levels of morbidity.

Three hundred women in four different regions of Lebanon were studied (LB20). The results of this study showed that the cumulative rates of onset for major depression were highest in females as compared to males for those born between 1945 and 1954; these individuals would have been between 20 and 30 years of age when the Lebanese wars began in 1975. 28 percent of the females in the cohort born after 1954 had an onset of depression by age 25 compared to 17 percent of the males.

Women are made vulnerable in war through the suffering they are forced to endure. They are often targeted for having transgressed the traditional roles set for them by the society. War also brings an increased risk of sexual violence towards women, taken as the bearers of the family, community, ethnicity, and national identities.

It is not only men who are exposed to deprivation, wounding, and death during war: "Everyone suffers but women suffer more because they lose their husbands, sons, property and, in addition, they have to earn a living for the remaining children and relatives…most men die in war, and women bear this weight on their shoulders.". It is accepted today that the incidence of psychiatric disorders is approximately twice as high in women, in absolute terms, as in men. This has only been exacerbated by the Lebanon Wars.

A survey was conducted using 8 focus groups, 19 in-depth interviews with individuals, and a nationwide quantitative opinion survey of 1,000 persons (LB7). The study reported that 3 out of 10 Lebanese survived had a family member killed during the conflicts, 14 percent were wounded; 12 percent were tortured; 7 percent report the sexual assault of an acquaintance and 6 percent were kidnapped or taken hostage. Presented with a list of 12 physical and psychological effects of war, ranging from imprisonment to property damage, 44 percent of those survived say they had personally been subject to 4 or more of these effects. A total of 60 percent say the war took place where they lived; 22 percent say they lived under enemy control; 43 percent reported being forced to leave

home and live elsewhere; 60 percent reported losing contact with close relatives; and 62 percent say they were humiliated during the war. This report gives some idea of the far-reaching physical and psychological trauma that was, and is, suffered by the people of Lebanon.

Impact of war on the drug use patterns

As with much of the world, drugs made their appearance on a large scale in Lebanon in the mid 1960s when it became fashionable to experiment (LB9). The war resulted in greatly increased production of opium and derivatives such as heroin (LB9). This was due to the fact that society was busy planning for fighting and survival, and practically no control was exerted over the production, circulation, and sale of drugs.

A study (LB9) was conducted in 1991, among a sample of 1991 students from the American University, Beirut, and St Joseph's University, using the Diagnostic Interview Schedule. It was found that females were more likely to have tried tranquilizers and barbiturates than males (13.3 percent vs.6 percent for tranquilizers and 10.6 percent vs. 6.3 percent for barbiturates). For other "soft" illicit drugs, such as codeine and cannabis, the trend was reversed: 3.7 percent of males having tried cannabis vs. 0.7 percent of females, and 3.8 percent of males having tried codeine vs. 2.6 percent of females. "Hard" illicit drugs, such as cocaine and heroin, were found to have very low trial rates (0.5 percent for males and 0.4 percent for females). Of the total number of students, 0.2 percent were found to be abusers of any illicit drugs (cannabis, cocaine, heroin, codeine) according to ICD-10 and Feighner criteria, and 0.3 percent were found to be abusers of any of the illicit substances (tranquilizers, barbiturates, opiate derivatives, and stimulants).

One thousand eight hundred and fifty one students in Lebanon were studied through administering of the Diagnostic Interview Schedule (LB8). The prevalence of nicotine users in the sample was 18.3 percent and of the "ever consuming alcohol" was 49.4 percent. According to DSM-III criteria, 2.1 percent of the sample was alcohol abusers and 2.4 percent alcohol dependents. For the remaining substances, tranquilizers were found to have the highest rate of "ever" use (10.2 percent) whereas heroin had the lowest rate (0.4 percent); the rates of abuse in these categories (other than alcohol and nicotine) following DSM-III criteria ranged from 0.1 percent to 0.8 percent. When compared with a report done by the National Institution on Drug Abuse (NIDA) in 1991 detailing drug use among US full-time college students, Lebanese "ever trying" rates of substances were low in most categories. The exception to this is in the category of tranquilizers and barbiturates.

The study of treatment utilizers (LB10) deals with the co-morbidity of substance abuse with other psychiatric disorders. All inpatients with substance abuse/dependence (present or past) admitted to the psychiatry unit at St. George Hospital (Lebanon) between 1979 and 1992 totaled 222 (N = 222). Of these, 64.9 percent were found to have co-morbid psychiatric disorders with specific relations between individual substances and psychiatric diagnoses identified such as cocaine and bipolar disorder (42.1 percent), and cannabis and schizophrenia (44.8 percent). Patients with no axis I disorder were predominantly heroin users, most of them having an antisocial personality disorder. Polydrug abuse was found among 44.9 percent of patients, and most of the benzodiazepine abusers belonged to this category.

In Lebanon, with regard to the association of substance abuse and war, it can be summarized that the pain and suffering associated with war grew more acute as the war progressed, while resources to alleviate it became scarce. The increased stress, the rise of some psychiatric disorders, the virtual absence of official control, and the easy availability and local production of illicit drugs paved the way for increased use among the Lebanese.

Indeed many experts predicted that during and following the war, there would be a massive increase in substance abuse, especially among the traditionally at-risk group of university students. The data provided by the above studies suggests that this is not the case. In spite of the wide availability of drugs, the enormous stressors that

the Lebanese population had to face, the daily atrocities of war, severe educational and economic hardships, an ever-growing list of personal losses, and the virtual loss of hope by adolescents throughout the country, young college students seem not to abuse drugs to a great extent.

When compared with internationally reported statistics, substance abuse and dependence among university students in Lebanon in 1991 seems to have been relatively low (LB8). It is argued (LB9) that the "Lebanon wars have kept Lebanese youth away from the lifestyle (of drug abuse) of their peers in other countries of the world." This may be because during the wars, the young and adult family members were forced to coexist in close proximity (shelter time), which could be a strong source of parental control. Now that the wars are over, and the Lebanese youth is granted greater independence and freedom to roam, it is possible that drug use and abuse could increase. However, the data here suggests that war in Lebanon actually served to lower levels of substance abuse. The only exception to this rule was seen to be in the barbiturate and tranquilizer category. This could be explained by (1) the high demand of these substances by the Lebanese public due to self-prescription, most of the time, of these medicines for anxiety, insomnia, and other war-related psychosocial disturbances; and (2) the ease of availability of these substances on the Lebanese market over the counter and without prescription (LB8).

Interventions and Lessons Learned

It is well-recognized that the community should always be the base for dealing with the mental health needs of the population during, and after conflict situations. It is often the case during times of war that communities become fragmented through the massive loss of life and large-scale displacement that takes place. The rebuilding of community support networks is in reality the only way in which a sustainable recovery in the sphere of mental health can be achieved. This has been highlighted by many studies (Laor et al, 2001, Schwarzwald et al, 1994, Thabet & Vostanis 2000), which showed that in samples of refugees, PTSD seems to persist for many years, whereas in community samples, the instance of the disorder diminishes rapidly with time.

In the case of dealing with psychological stress of combatants, lessons in mental health that had been learned from the previous October 1973 war in Lebanon were applied during the Lebanon Wars (LB27).A three-echelon system of management was followed according to the practices of Western armies. The clinical pictures were essentially similar to those observed in other wars. Combat stress reactions (CSR) comprised 15 to 20 percent of the total casualties during the active phase of the war; the rate of late reactions was between 30 percent and 40 percent of the total CSR. Treatment on the battlefield was more effective than treatment following airlift to the soldiers returning to their units.

The role of stress in causing CSR and important lessons learned from the Lebanon Wars include: the need for a broad definition of CSR; the importance of forward unit intervention; the necessity of mobility and divisibility of mental health treatment units; fighting units should not be dispersed immediately after combat; and the management of stress reactions should be the responsibility not only of the mental health services, but of all sections of the medical corps, both in treatment and prevention. Community support is vital in the rehabilitation of mental disorders in children. The use of local knowledge and people is what makes community care so much more effective than help from outside forces such as NGOs.

While international organizations have a role to play, this should be largely in a training or advisory capacity as well as providing vital resources when needed. Throughout conflict, it is vital to the well-being of the child that the environment in which they live should be kept as normal as possible. One of the most important ways in which this can be achieved is through education.

Education provides a sense of stability to the children and encourages communication, which in turn helps children to avoid internalizing their experiences of war, which can only lead to prolonged stress. Interventions designed at promoting education during times of conflict have proven to be successful in the past. For example, the development by the United Nations Educational, Scientific and Cultural Organization (UNESCO) and UNICEF, of the teacher's emergency pack (TEP), containing basic materials such as brushes and paints, chalk, paper, pens, and pencils. These packs are distributed to local professionals in refugee camps and areas of conflict.

In Lebanon, the Education for Peace Programme, jointly undertaken in 1989 by the Lebanese government, NGOs, youth volunteers, and UNICEF, now benefits thousands of children and has been of immense value in relieving the psychological scars of war. Such programs do not focus on the child's emotional wounds, but seek to re-establish a sense of normalcy and foster an environment in which such wounds will heal naturally.

The fact that the research supports the idea that there is a spontaneous remission of PSD after the war raises interesting questions pertaining to interventions.

In the case of women and war, it must be recognized and reinforced that sexual violence is preventable. Therefore, prohibitions of rape and other forms of sexual violence must be included in the national law, in the military codes, and the training manuals of arms bearers and the peacekeeping forces. Victims of sexual violence need rapid access to appropriate and adequate mental health care. Their situation needs to be handled by trained female staff with confidentiality and sensitivity, respecting their cultural environment. This again reinforces the importance of community and local knowledge.

It is imperative that all phases of emergency and reconstruction assistance programs should take psychosocial considerations into account, while avoiding the development of separate mental health programs. Mental healthcare should be incorporated into primary health care. This is particularly important in areas of conflict where the burden of mental health problems is going to be significantly higher.

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Disaster Mental Health Care in Iran: Responses Based on Needs

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Introduction

Iran is one of the top ten countries most frequently stricken by natural disasters. Iranian disaster mental health activities started seven years ago with a needs assessment of the survivors of two earthquakes in Birjand and Ardabil, including five studies: an epidemiological survey, a direct needs assessment on the survivors, a needs assessment on relief workers, an assessment of objective losses and a qualitative study. All of these highlighted the need for psychosocial intervention in natural disasters.

Based on these studies, a national plan was developed. Human resource development was started, and integration of the new plan with the ongoing national mental health infrastructure was initiated. Psychologists and psychiatrists from all disaster-prone provinces were trained in training for trainers (TOT) workshops. On December 26th 2003 a devastating earthquake destroyed the city of Bam. About 30,000 people died and psychosocial intervention was started for more than 80,000 survivors. During the immediate phase (the first 2 weeks), information dissemination and tracing was done. During the intermediate phase, which lasted for more than 6 months, tent visits, initial psychosocial support and screening was completed. For the time being (more than 1 year post disaster), more than 84,000 survivors in more than 21,000 tents or temporary settlements have received initial psychosocial support, and more than 42,000 have received professional group trauma counseling.

There are also activities in schools, recreation centers for children, public meetings, and activities aimed at special groups. Health volunteers have been trained for psychosocial empowerment of the people. As the rebuilding of the health system is proceeding, the mental health component is being integrated within it. Evaluation has been undertaken systematically and results will be available in the near future. However, qualitative evaluations indicate positive results, especially for children.

The Islamic Republic of Iran is a large country with an area of more than 1. 6 million square kilometers and a population approaching 67 million. It comprises 30 provinces, 889 cities, and 2305 villages. The population is young with more than 31 million being under 18. Mainly due to increasing immigration from rural areas, a suburban sprawl is taking place around major cities and 65 percent of the population is now urbanized compared to 40 percent just 15 years ago. Large cities have been swelling and Tehran, the capital, is home to over 11 million people. The official language is Persian (Farsi), and 99.6 percent of the population is Muslim .The health system is unique in terms of the role of "medical universities" being responsible for health delivery to their territories and the health network expanding across the whole country especially the rural areas. In the rural locations, primary care is delivered by "behvarzes" who are local people trained to function as multipurpose health workers (Shadpour, 2000).

Iran is highly vulnerable to natural disasters especially earthquakes. Most of the earthquakes occur as the result of the motion of the Arabian plate northward against the Eurasian plate. Deformation of the earth's crust takes place in a broad zone that spans the entire width of Iran and extends into Turkmenistan. Floods are also common in some parts of Iran and most types of other disasters happen with lower frequencies too.

According to available data (Behju, Aghazade, Kianpour 1997) and after adding the recent casualties in Bam, about 150,000 people have died from natural disasters in Iran during the last century. About one third happened during the last 15 years.

Historical development of mental health care in major disasters

Following the declaration of the 1990 as the *International decade of Disaster Reduction* by the United Nations, a new law was ratified in the Islamic Republic of Iran in 1991 to organize the *National Committee for Disaster Reduction*. The deadly Rudbar earthquake, which happened in 1990, was highly influential in this initiative. One of the subcommittees was designated for health, to be headed by the Minister of Health. The subcommittee decided to plan a proposal on mental health service delivery to survivors of natural disasters.

Shahid Beheshti Medical University started a series of needs assessments commissioned by the said subcommittee in the Ministry of Health (MOH).

Five parallel research projects were accomplished; the full report is available in Persian (Yasamy et al, 1997) and a very brief summary of results will be presented later in this review. Based on the findings of this comprehensive needs assessment and after reviewing international findings, a national program was drafted by a large team of experts including the contributors to the studies. The program included executive, educational, and research strategies. Preparation of a series of manuals for the public, relief workers, professionals and executive officers was immediately started (Yasamy et al, 2000 a,b,c) followed by relevant human resource development.

Experts from the Shahid Beheshti Medical University and Mental Health Office in the Ministry of Health expanded their inter-sectoral activities. A series of training of trainers (TOT) workshops were held for the Red Crescent trainers, who in turn started training the relief workers on basic skills for psychosocial support. A new series of training for professionals was also started with the support of UNICEF.

In June 2002, an earthquake measuring 6 on the Richter scale struck Abgarm and Avaj Counties, where 235 people lost their lives and thousands were injured. The mental health office of the Ministry of Health immediately started a pilot project based on the national program with the collaboration of Red Crescent and the Qazvin University of Medical Sciences. One year later the Bam disaster happened, which will be discussed in detail later.

Table 1 summarizes the most recent disasters occurring during the last 7 years and related mental health-interventions.

Table 1: Most Recent Major Disasters (Earthquakes) and Psychosocial Interventions

Name	Date	Severity (Richter)	Mortality	interventions
Ardabil	28 Feb 1997	5.5	850	Needs assessment
Birjand	10 May 1997	7.1	1617	Needs assessment
Qazvin (Avaj-bgarm)	22 June 2002	6	235	Trauma counseling (Pilot)
Bam	26 Dec 2003	6.7	30,000	Comprehensive program

Epidemiological Needs Assessment

A historical cohort study was conducted one year after the two small-scale earthquakes with casualties counting 1617 in Ghaen - Birjand and 850 in Ardabil. An overall random sample of n= 1387, consisting of 703 survivors and 684 paired matched controls from adjacent villages not exposed to disaster, were interviewed. The tools used were the General Health Questionnaire-28 (GHQ-28, Goldberg &, Williams 1991; Goldberg & Hillier 1979), Rutter children's behavior questionnaire for completion by parents (Rutter, 1967), PTSD interview (Watson 1991, a, b) and Children's PTSD scale validated in Iran (Karami, 1994). Table 2 shows that general psychopathology is significantly severe both in adults and children about one year after the disaster.

Table 2: Comparison of General Psychopathology Between Exposed and Unexposed Groups

Test	Score (traumatized)		Score (control)		Significance
	Mean	SD	Mean	SD	
GHQ-28	34.10	17.14	15.85	10.04	P<0.001
Rutter 13.08	13.08	11.44	8.19	06.88	P<0.001

For adults, relative risk (RR) was 3.39 (95 percent CI= 2.86-4.03) and for children it was shown to be RR = 2.05 (95 percent CI = 1.45-2.91). Based on data gathered through PTSD scales, a considerable proportion of the adults (77 percent) and children (47 percent) were found to be suffering from PTSD, severe enough to require intervention.

Direct Needs Assessment

A 57-item questionnaire, covering areas such as personal exposure to trauma, losses, need for information and counseling and type of psychosocial support received were used. Some of the most important findings were as follows: 37 percent of the population were exposed to dead bodies, 94 percent expressed they were in need of more information, mostly about the health of their relatives (75.3 percent) compared with only 10.2 percent in need of information about the relief services during the immediate post disaster days. A total of 93 percent declared a need for emotional support but only 22 percent received it from relief workers. They had frequently received inappropriate advice; for example 63.7 percent had been told not to cry, 43.3 percent of the children were told not to play after the disaster; however 96.6 percent had restarted school within 3 months.

Educational Needs Assessment for Red Crescent Relief Workers

A 27-item questionnaire was shown to the survey sample relief workers when they were in need of training for basic psychosocial skills. As an example regarding risk communication: 20.5 percent admitted they had misinformed survivors about the fatal happening to their close relatives so as not to disturb themselves.

Qualitative Needs Assessment

In both disaster-affected counties the event was perceived as "the most traumatic experience of my life." Worries about children were prevalent. Depression was the dominant feature. Re-experience was still common one year after the disaster. Having an appropriate shelter was still a concern and a serious need for privacy was felt. Praying and religious beliefs were the only things that were helping the survivors and psychosocial needs had not been addressed. During needs assessment, most of the survivors said "it was the first time professionals were really talking to them."

Drafting a National Program for Mental Health in Disasters

The next phase was the preparation of the national program for mental health in natural disasters. One of the major strategies was the human resource development. MOH prepared a series of manuals and started TOTs for the Red Crescent trainers who, in turn, trained the relief workers. UNICEF joined in the MOH activities about 2 years ago, and a training workshop was conducted for the professionals just before the Qazvin earthquake.

Pilot study in Qazvin earthquake

The earthquake in Avaj and Abgarm regions in Qazvin brought forth a need for the pilot implementation of the national program. A regional psychosocial team was established on the second day according to the national program. The main activity was trauma counseling for at least four sessions for approximately 960 children and 742 adults. This included modified debriefing and relieving the intrusive thoughts and images, hyper-arousal, and avoidance symptoms in consecutive sessions. In cooperation with the Red Crescent, some parallel activities were done, covering 2800 students at schools and including 108 psychosocial play sessions, distribution of toys for children, and, pamphlets and brochures for adults. Three training workshops for local relief workers were also undertaken according to the national program. It was not possible to do a controlled trial. However a partial evaluation of the program was done and a before-and-after assessment was conducted on a random sample of survivors (n=389), using the previously mentioned instruments.

Table 3: Comparing the Before and After Assessments in Qazvin Earthquake Survivors (n=389)

	Before		After		
Scale	Mean	SD	Mean	SD	Significance
GHQ-28	6.8	4.6	5.2	3.8	<0.001
Rutter	11.0	8.0	7.0	6.7	<0.001
Children's PTSD	16.0	9.9	12.2	4.9	<0.001
Watson	64.4	6.7	56.1	10.7	<0.001

Using cut scores in the GHQ-28, general psychopathology in adults was 45.0 percent before and 35.5 percent after intervention (RR=1.4) An independent study on the non-traumatized children showed it to be 31.6 percent before and 30.6 percent after the intervention period, which was not significant.

Using cut scores in the Rutter scale, general psychopathology in children was 34.2 percent before and 23.1 percent after intervention (RR=1.5). An independent study on the non-traumatized children showed it to be 20.3 percent before and 20.3 percent after the intervention period, which was not significant. It also came out that the program was feasible, but sustainability of the program was highly dependant on motivating the helpers with different incentives.

Bam disaster

In the early morning of Friday, 26 December 2003, an earthquake measuring 6.7 on the Richter scale hit the city of Bam. The earthquake not only took about 30,000 lives, but approximately 30,000 people were injured and 85 percent of houses were destroyed. In addition to their houses and possessions, people lost their capacity to cope with the new situation. It was clear from the beginning that survivors would need strong support to deal with the psychological consequences and tracking back into normal lives.

Following the devastating earthquake in Bam, psychosocial interventions were among the earliest responses to the event. The Ministry of Health was prepared and psychosocial interventions started from the first day. The interventions have been diverse and extensive. Therefore, only a concise review would be possible.

Immediate intervention (0-2 weeks)

Main activities of MOH at this stage were:
    1. Erecting the psychosocial post.
    2. Rapid psychosocial assessment.
    3. Information dissemination and coordination of tracing activities. Injured survivors transferred to other cities were connected to their families. The MOH organized this activity from the second day following the disaster. For the first time, the internet was widely used to connect people with their families, and more than 5,000 messages were sent via emails, radios, billboards.
    4. Mental health workers participated in the funerals and mourning ceremonies. Due to the very high death toll, this activity was unable to meet the needs of all those affected.
    5. Inter-sectoral meetings to coordinate the activities were organized by the MOH from the first week onwards. The coordination of the activities with mental health workers in the Red Crescent and Social Welfare Organization was taken as more important.
    6. Mobilization of manpower both from the local and other areas of the country was another major activity. For instance, more than 430 psychologists and psychiatrists have been active during the post-disaster period. The state welfare organization undertook some tracing activities and offered support for orphans.

Mid term interventions (3 weeks - 6 months)

The outreach activities and tent visits by trained psychologists and psychiatrists (mostly psychiatric residents) formed the main activity. First, they gathered together the survivors in groups and started initial psychosocial support and screening of the most traumatized. They then started a professional group intervention for those screened. The package was developed in the United Kingdom and Norway and used in disaster situations in other regions. A pilot was done using the same package following the Qazvin earthquake in Iran. Traumatized people attended four sessions of group intervention with weekly intervals, and did homework in between.

UNICEF has started supporting this program and WHO has shown interest in launching a long-term program for rebuilding the mental health network and services in the region. Within the first year post-disaster, a total of 84,143 survivors in 21,540 tents or temporary settlements were covered and the program approached total coverage. Professional group trauma counseling has been carried out for 42,502 of the screened survivors (Figure 1).

Figure 1. Cumulative coverage of various interventions for the first 7 months

Cumulative trend of psychosocial support in Bam in as 1 Feb 2005
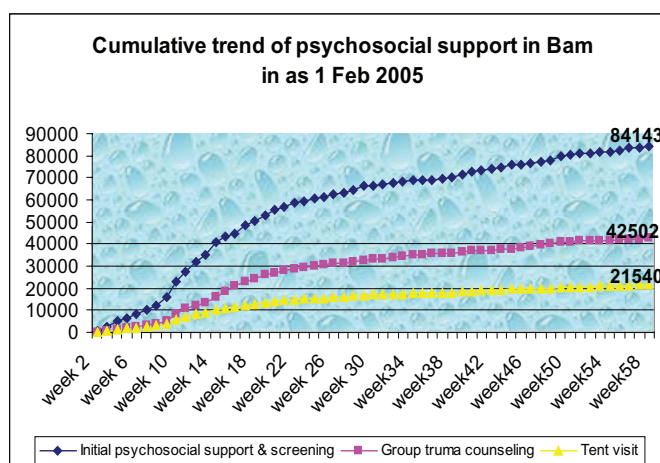
School interventions

Since about one-third of the teachers had died during the disaster and the others were severely traumatized, MOH initially worked with the 1,380 teachers to overcome their trauma.. Following this they were trained and persuaded to start the modified school activities. Trauma counseling of teachers was done directly by MOH professionals, or indirectly through trained school counselors. Most of the counselors were from the Bam public schools and only a small number of them came from Kerman, a neighboring city.

Community interventions

The community-based psychosocial interventions were initiated with the help of trained local health volunteers "Rabeteen". They provided initial psychological support and helped the survivors build up social networks and rebuild their community. Public meetings with the people led by the psychosocial teams were held to help empower the people to rebuild their lives. Community participation has been an important underlying principle, and local key persons and NGOs have been involved in all phases of the program--from planning to implementation.

Training activities

Although human resource development started long before the disaster, more trained manpower was needed especially from the local people. About 430 psychologists and psychiatrists, 105 school counselors, 1380 teachers, and hundreds of other health workers were trained by the ministry of health.

Evaluation and monitoring

Monitoring is being done on a regular basis by the supervisors, and feedback is given to the fieldworkers during the regular night meetings. Scientific evaluation is underway. These include cohort studies to determine the risk and protective factors, and the clinical trials to evaluate the interventions. Since the evaluations are still continuing, we have been collecting clinical data from the field workers, and most of them believe that the interventions have been effective for most of the survivors, especially the children.

Lessons learned

Repeated disasters in Iran have provided the grounds for formulation of the professional experience and translating them into national program improvements. The Bam earthquake, as a large-scale disaster, called for a program reformulation. Some of the lessons learned in our experience are as follows:

• For disaster responses, having a vertical organization helps to implement psychosocial interventions more efficiently. Most health systems in developing countries do not consider mental health as a serious component, leaving mental health workers in a horizontal organization make them just as an auxiliary component with limited efficiency. In Bam, the local mental health network was directly linked to the mental health office in Tehran. At the same time, at both levels, coordination's with the public health sector was underway. Human resource development should be in place before the program and in every area there should be a focal point prepared to start interventions as quickly as possible.

• Experiences from the small-scale disasters are not applicable to large-scale disasters, though some components of the experience can be used. In small-scale disasters, the social structure of the community is preserved, and you can thus expect more input from the local community. The integration of the mental health activities within the available health system is more feasible, schools can be reopened earlier, and a major part of the interventions for children can be implemented through schools. However in large-scale disasters, independent community outreach activities will be of more importance and integration of the mental health activities within the public health sector should wait until the latter is rebuilt.

• Some logistic and financial allocation should be available in stock before the disasters. For example, keeping toys for the children. Manuals and brochures for different levels should be prepared from before. Most clinicians who are not trained for trauma counseling will only add to the problems. Research should be done only if seriously needed. There should be a coordinating team lead by those involved in the major part of service delivery, who can supervise this.

• Expatriate psychologists and psychiatrists will not be helpful if they intend to fill clinical jobs. They can be more effective functioning as mental health specialists within a well-defined program imple mented through local organizations. It would be more realistic for expatriate organizations to hire unemployed local or national mental health workers who share the same language and culture than to hire local interpreters and pay for expatriate psychologists. Hiring local staff, who are already working with local organizations, should be banned.

• Men are more reluctant to receive interventions during the early phase and later on, they become less available as they head out for jobs. We need to formulate definite plans for them. Not only single parent mothers but also single parent fathers should be considered as special groups, deserving attention. Social empowerment and rebuilding the social networks with the help of community health volun teers in Iran may be applicable to similar conditions in developing countries.

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Institutionalizing Psychosocial Care in Disaster Management- the Philippine Experience

Chapter 7

by Lourdes Ladrido-Ignacio

Introduction

The Philippines, a founding member of the Association of Southeast Asian Nations (ASEAN) has been referred to as the pearl of the Orient. It is bounded by the China Sea in the west and the Pacific Ocean in the east.

Fig 1: Asia

It is an archipelago composed of 7,107 islands sprawled over a land area of 298,170 square kilometers. The climate is tropical with the weather shifting only between a wet and dry season due to the regular occurrence of monsoon rains between June and October. It has an extensive coastline and approximately 46 percent of its land consists of forests and woodland.

The natural topography renders the country vulnerable to natural disasters. This fact makes one question the old cliché that "lightening never strikes twice in the same place'" if lightening can be seen as analogous to the disasters. In the last decade, there has been a continuity of catastrophes, each, seemingly more devastating than the preceding one. These catastrophes have greatly affected the structure and organization of communities, sources of livelihood, and the general well-being of Filipinos. The continuing occurrence of these catastrophic events has reached disastrous proportions because of their tremendous impact on the people.

The Philippines strides the typhoon belt in the Pacific, and an average of 10 to 20 strong typhoons and 5 cyclones hit the country every year. There is an earthquake fault, which runs through the entire length of the country from its northernmost to its southernmost tip. There seems to be a continuing destabilization of this fault and the earthquakes strike regularly in many parts of the country.

On July 30, 1990 a massive earthquake measuring intensity 8 on the Rossi-Forel Scale rocked the northern and central parts of Luzon, the biggest island of the country. The earthquake was the strongest ever to hit the Philippines. It took its toll on human lives. Many were entrapped or killed as buildings toppled. Young students in two colleges were trapped as walls of their institution fell. Those who survived were caught in mass panic and hysteria and many were killed in ensuing stampedes as they rushed to building exits in the hope of reaching safer and more open spaces. Others, though outside the trembling structures, were killed by falling debris. The earthquake's effects were also felt in landslides from the mountains and collapsed bridges. As wide fissures appeared on the ground, the roads became inaccessible. Floods from the rivers submerged many of the affected areas and the over-all effect isolated many of the communities for a prolonged period.

The Philippines is also within the volcanic ring of fire. The eruption of many active volcanoes is another regular occurrence in the country. The most destructive one occurred on June 15, 1991, when Mount Pinatubo, which has been dormant for 600 years, erupted, causing a major disaster that had national and international impact. The ashes from the volcano were emitted beyond the country. The subsequent mud flow of lahar and other volcanic debris from the Mount Pinatubo eruption aggravated the destruction caused from the earthquake a year before since both these disasters struck practically the same regions in the country. Although the death toll was not as much as the earthquake, there was widespread devastation and displacement of people. There were entire communities that were buried and erased from the face of the earth. Since then, the annual strong typhoons have continued to release the volcanic lahar causing massive flooding to the outlying low areas. The clogged riverbeds caused the mudslides and volcanic debris to simply settle, harden, and, bury more villages along its path.

In addition, the rapid urbanization and industrialization that have been the mark of recent modernization have caused massive denudation of mountains and forests. Killer floods that have been caused by the loss of forest cover have aggravated the continuing destruction of communities and the victimization of the people from these disasters. While the country coped in 1991 with the massive devastation from the Mount Pinatubo eruption, a strong typhoon struck one of the southern islands resulting in the release of mudflow from the denuded mountains. The low-lying communities around it were struck by heavy flooding that drowned at least 3000 adults and children overnight. Striking with equal magnitude was the flood of released logs and mudflow from the mountain in the western part of the Philippines from November 29 to December 4, 2004. At least three towns were destroyed, and thousands of people were buried alive, killed, or injured through the weeklong destruction by the strong winds and typhoon.

The recurring disasters have made Filipinos realize that disasters are an integral part of their lives a realization reinforced by the continuing occurrence of such catastrophic events experienced regularly at yearly intervals such as massive flooding, killer earthquakes, and devastating volcanic eruptions.

Disasters cause rapid destructive change, widespread damage to infrastructure in their communities, physical injuries, and the shared experience in everyone affected of intense human suffering. Such traumatic experiences mean that the particular state of being a human is severely affected due to experiencing tremendous loss through the death of loved ones, loss of body parts, loss of homes, markers of heritage, and sources of livelihood.

The impact of these catastrophes have made people's disaster experience much more intense in the face of other social conditions characterized by social deprivation and a sense of social disadvantage prevailing among the majority of the people. Philippines as a developing country continues to be plagued by political and economic instability making poverty a serious concern. These factors often pose severe limitations in responding adequately to the demands of those who survive the disasters that strike regularly. The demands stretch the country's resources to its limit of endurance, aggravating further the human suffering that prevails among the victims of the disaster.

The Mental Health Task Force in Disaster Management (MHTFDM)

Following her visits to the earthquake affected areas, in July 16, 1990, and struck by the devastation that caused acute stress reactions, intense grief, and bereavement, the president of the Philippines called on psychiatrists and psychologists from the University of the Philippines to respond to the psychosocial needs of the disaster victims. It was agreed that a Mental Health Task Force in Disaster Management (MHTFDM) would be organized. The task force was to be an integral part of the Presidential Task Force on Disaster, which was responsible for the development of a disaster psychosocial program.

It was indeed fortunate that the leaders of the country at that time were keenly aware of the psychosocial consequences of the disaster and the need to provide the necessary psychosocial care for its victims. The MHTFDM proceeded to: 1.) assess the disaster's impact on the Filipino victims and document its psychosocial consequences, 2.) design the framework for psychosocial intervention in the disaster, 3.) implement various strategies of such interventions at different phases of the disaster when found relevant, and 4.) identify the "lessons learned" and make the necessary recommendations on the integration and institutionalization of a psychosocial intervention program in disaster.

Since there was recognition that the country's topography makes the Philippines vulnerable to the regular and continuing occurrence of disasters, it was immediately recognized that the very nature of the MHTFDM itself could lend to a demonstration of the process of integrating a psychosocial intervention program in the overall disaster response. It was also reasonable to expect that the necessary elements needed to institutionalize psychosocial care in disaster could be identified. Since a psychosocial program is vital to the success of the rehabilitation program after a disaster, such institutionalization is crucial in sustaining such a program. Long-term sustainability is expected either because rehabilitation can only be completed over a prolonged period of time or the continuing occurrence of the disaster necessitates a sustained and continuing response.

The Psychosocial Consequences of Disaster

Among the 1990 Filipino earthquake victims, the most common acute distress symptoms that showed up in a self-report questionnaire were as follows:

Physical/Behavioral	Emotional	Cognitive
-headache -fatigue -stomach pain -poor appetite/ poor digestion -trembling -sleeping problems	-nervousness -fearfulness -unhappiness/difficulty in being interested in anything -frequent crying -feeling that somebody is trying to harm him/her -difficulty in resuming ordinary activities in school, at home, or work	-difficulty in making decisions -trouble in thinking clearly -fear that thoughts will become blank

During the immediate impact of the disaster, these reactions may still be considered as normal reactions to an abnormal event. However, the unpleasantness of these reactions as well as the feelings of loss of control and general experience of disequilibrium and instability would make disaster-affected people vulnerable to psychological disorders, a condition that must be prevented. It is critical that disaster workers understand the distress symptoms and how to attend to them.

There has been documentation of the chronic reactions to stress of those victims of the volcanic eruption in 1991, who had lost their homes, were able to go home within 2 months, or had to stay longer in evacuation centers or resettlement sites. A self-report questionnaire was administered in affected areas in three provinces, one month, two months, and nine-months after the eruption as shown in Table 2

Table 2: Self-Report Questionnaire among Victims of the Volcanic Eruption:

Area affected by volcanic eruption	Number	Range of Positive Scores		
		One month later	Two months later	Nine months later
Tarlac	219	97.7 percent	18.8 percent	92.3 percent
Zambales	54	74.1 percent	23.3 percent	76.1 percent
Pampanga	110	83.1 percent	36.4 percent	----

The high positive scores for psychosocial symptoms, initially shown one month after the eruption, were significantly reduced when the victims from the three affected provinces were able to return home after two months.

In the provinces of Tarlac and Zambales, the disaster victims who were evacuated and had to stay in a tent city for nine months after the eruption, were found to have high positive stress scores to a degree equal to their scores one month after the eruption. Hence, psychosocial symptoms lingered and rendered the victims highly vulnerable for psychological morbidity

Table 3 shows the most frequently selected items in the self-report questionnaire among the victims of the Mount Pinatubo eruption nine months after the eruption, while still living in the tent city.

Table 3: SRQ Items identified as Chronic Stress Reactions among Victims of Volcanic Eruption, nine months later (n=.326)

Items 1-20	
Feels tired all the time	74.5 percent
Often have headaches	73.3 percent
Feel nervous tense and worried	73.0 percent
Feel unhappy	72.1 percent
Daily work suffering/ cant go back to work	71.2 percent
Items 21-25 Noticed interference in thinking	49.4 percent
Had fits/outbursts of anger/violence	44.5 percent
Items 26-30 Have flashbacks of what happened	77.6 percent
Feel bad in situation that reminds them of the disaster	68.1 percent

Victims of Disaster

It is generally understood that the entire population and their communities are victims of the disasters. However, many authors would classify these victims as: a) individuals/groups of individuals or, b) the community in general. Individual victims are identified as direct, indirect, and hidden victims but attention and concern is usually directed at the direct victims because they have suffered from the devastating loss. Equal concern is directed towards the hidden victims, the disaster workers, who are at risk for immediate burnout, rendering them ineffective for the much-needed care of the various physical and psychosocial needs of the direct victims.

The community itself can be considered a victim of the disaster. The devastation following a disaster extends to cause the destruction of the community structures and, displaces the sources of leadership and authority. A general state of community disorganization would right away prevail. The leaders of the community themselves would most likely be direct victims of the disaster and would suffer from its physical and psychological consequences. The community therefore would not be able to provide the necessary social support to the people. Often, external assistance from organized groups in the government and non-government agencies is necessary to put back the sense of order in the community to start the recovery process.

The physical and psychosocial consequences of the disaster and the recovery from them need to be seen from the viewpoint that the individual is in a continual interaction with his environment and the world around him.

Thus the psychosocial consequences of the disaster on individuals will affect their recovery and that of the community because the individual's recovery is necessary for the community's recovery and rehabilitation from the destruction. On the other hand, the return of community organization is necessary for the provision of the necessary social support system for affected individual community members. This is crucial for the re-establishment of the individual's sense of equilibrium, stability, and eventual recovery from the disaster.

Psychosocial stressors among these victims have been documented in the MHTFDM studies undertaken through focus groups discussions and informal conversations with the victims in the different disaster areas, as follows:

Table 4: Stressors among the disaster victims:

Individual/Groups (direct victims)	Service Providers/disaster workers (hidden victims)	The Community in general
Loss of loved ones Destruction/loss of property Loss of livelihood/jobs Loss of heritage Poor living conditions in evacuation centers Lack or delay of relief assistance especially of food Repeated evacuations/ persistent lahar flow Cessation of normal daily activity/school Uncertainty of future	Physical exhaustion Role Conflict Organizational conflicts/ disorganization within/ among agencies providing disaster management programs	Loss of community social structure Loss of social support system Unavailable community leaders Lack or delay in provision of relief assistance Uncertainty of political/economic support from national government.

Coping Among Disaster Victims

An important aspect in considering the psychosocial consequences of the disaster given all the stressors and psychosocial distress that the victims of the disaster have experienced, helping disaster victims cope or re-establish psychological equilibrium. Group discussions especially during the critical incident stress debriefing sessions, individual formal and informal interviews, and general observations during field visits have resulted in a list of coping mechanisms among the Filipino disaster victims.

Table 5: Some identified coping mechanisms among Filipino victims of disaster

1. Spirituality/ praying/singing religious songs
2. "Bayanihan"/ cooperative behavior/neighborliness
3. Concern for the welfare of others, especially the family members
4. Humor/laughter
5. Trying to get information by listening to the radio
6. Appointment of natural leader
7. Overactivity or overextension of one's capacity/keeping busy/purposeless action
8. Passivity/dependency/relying on relief distribution or others for daily needs
9. Anger/blaming others/suspiciousness
10. Denial of gravity of the situation
11. Increased smoking/drinking
12. Crying

The Framework for Psychosocial Intervention in Disaster

Psychosocial intervention in disaster aims at the transformation of those affected by the disaster from being a victim to being a survivor. This transformation is in fact the primary concern common to all disaster intervention programs, putting into focus the fact that the basic issue in overall disaster management is a psychosocial issue. This highlights the need to integrate psychosocial intervention in the over-all disaster management program.

The significance of this transformation cannot be emphasized enough. The sense of loss of control pervades all disaster victims. Yet it is this that differentiates a victim from a survivor. A victim feels that he has simply been the recipient of a catastrophic event and has no control over himself and his environment. He is passive and succumbs to being dependent on others and their resources to supply his daily needs and relies on others' power and influence to effect changes necessary for his recovery. The persistence of this concept of self as victim hinders his recovery and ability to adapt to the necessary changes. This also limits his participation in his community's recovery and rehabilitation after the disaster. Most of the victims demonstrate negative psychosocial symptoms such as heavy alcohol drinking and refusal to work to earn a livelihood.

A survivor exerts efforts to overcome the physical and psychosocial consequences of the disaster and regains a sense of control in his life. He is able to take a more active role in the activities that concern his personal (and his community's) recovery from the disaster. He has acquired a sense of empowerment in himself so that he feels he has a role and participation in whatever happens to him, his family and his community.

Throughout the different phases of a disaster, the main focus of interventions therefore is on those who survived the disaster. Immediately upon impact, every effort is directed at ensuring that people in affected areas survive the disaster. Rescue and emergency care are provided. Relief work provides the victims their basic needs of food clothing and shelter, ensuring that they will be able to live through the day even in the harshest living conditions. The heroism and human spirit required to sustain community mobilization for these activities are often at times immeasurable and indescribable. The spirit of community fills in the gap of helplessness and loss of control. The truism of the Biblical story of the Good Samaritan extended by almost everyone somehow diminishes the intense feelings of loss and uncertainty.

Table 6: Framework for Psychosocial Intervention in Disaster

1. Psychosocial Processing (PSP) For Direct Psychological Intervention At Individual And Community Level:

    1.1   Critical Incident Stress Debriefing
    1.2   Multiple Group Intervention
    1.3   Action-Oriented PSP
    1.4   Team Building
    1.5   Community Organization
    1.6   Psychosocial Rehabilitation/Activity-Based for Children And Adults

2. Education And Information Dissemination

    2.1   Disaster Orientation with Focus on Psychosocial Issues
    2.2   Disaster Preparedness
    2.3   Information Dissemination on When and How To Seek Psychosocial Care When Necessary

3. Training of Local Manpower in Psychosocial Intervention

4. Identification and Management of Psychological Morbidity

    4.1   By Non-Psychiatrists/ Development of System Of Referral
    4.2   Mental Health Care in Primary Health Care
    4.3   Psychiatric Treatment (Adults And Children

This framework identifies the range of psychosocial intervention strategies that have been implemented by the MHTFDM. Specific psychosocial needs that have been identified during each phase of the disaster can be addressed by any of these psychosocial intervention strategies. The prompt identification of psychosocial needs is therefore crucial.

a.Impact phase of the disaster

Crisis intervention aims at modulating the impact of the disaster and reducing the distress experienced by the victims during the initial impact phase. Rescue, emergency medical care, and relief assistance are immediately put into place by disaster management groups from the government and non-government agencies. In the Philippines, this is the responsibility of a national disaster coordinating council (NDCC) composed of representatives from the departments of health, social welfare, education, defense, agriculture and local government.

The acute stress reactions, especially the feelings of shock, helplessness, and mourning, after the disaster struck would generally be reduced with these activities, and the victims are able to start to regain their ordinary lifestyle. For those whose experiences of grief and stress are intense, a critical incident stress debriefing or grief counseling by trained personnel should be given, but caution must be exercised in recognizing that these may still be normal reactions to an abnormal event and follow-up session should be provided.

WHO has recently stated that single-session psychological debriefing is generally not recommended *(Ommeren)*.

To regain a sense of community right away in the three areas affected by volcanic eruption, the MHTFDM, worked with local government officials, to conduct several sessions of the critical incident stress debriefing and planned for the early resumption of community activities. These officials were able to gain a personal sense of equilibrium after these sessions and were able to appreciate the contribution of a psychosocial orientation to their programs. Among the activities that were immediately put in place was the opening of the schools in the towns and barrios. The sound of the flag ceremony in the morning and the children playing were agreed upon by almost everyone as helping them regain a sense of normality.

The MHTFDM has been able to provide the NDCC and its component agencies vital assistance in facilitating communication and information about the disaster through leaflets that could be used by media agencies, both broadcast and print, to disseminate facts and to minimize excessive fear, confusion, and panic. Timely communication is also necessary so that victims may know here and how they may obtain relief assistance, emergency care, and even psychological debriefing sessions for acute stress reactions.

During the impact phase, an important concern for the hidden victims of disaster comprising all disaster workers, including local government officials and staff, is their burnout. Many of them, as residents of the affected area, are direct victims of the disaster, but the nature of their work leads them to deny or ignore their own stress reactions. Within 48 to 72 hours after the impact of the disaster, they often experience physical exhaustion because of the extraordinary demands of their current work and the assistance expected of them. This and the disorganization inherent in the catastrophe can cause their burnout.

The MHTFDM not only documented these burnout experiences among disaster workers (Ignacio, et al 1994, DSWD "From Victims to Victors" 1996) during the crisis following the volcanic eruption, but worked with the appropriate government departments in rotating assignments of health and social workers so that those in the affected areas could be given a official time-out for rest, recreation and return to their homes. Their duties were taken care of by other workers from the non-affected areas. The MHTFDM has since advocated that every disaster program adopt a psychosocial orientation and integrate the management of burnout among their personnel. Training of facilitators for debriefing sessions was conducted so that these workers could participate in critical incident debriefing sessions when they came back from the field.

b. Inventory Phase

An inventory of the consequences of the disaster characterizes the aftermath of the disaster, generally about a month later. As victims assess the consequences of the disaster in their lives and salvage what is left of their homes and properties, intense feelings of loss, bereavement, and anxiety are experienced. At this time the rescue, emergency care and relief assistance have already been provided and have started to slow down. The victims now start to become more aware of the disaster's effects on them and their experiences of physical, psychological, and behavioral symptoms of stress.

In addition to the information given to the general public, especially through mass media, it is important for people to understand that these are expected and normal reactions and, as they resume their ordinary domestic and work activities, these reactions will decrease. This type of psychosocial processing is a crucial psychological intervention at this time.

The MHTFDM has identified at least six different strategies, which include the critical incident stress debriefing, multiple group sessions, action- oriented activities for special groups especially children and community team building and organization. Details of these are described by Ignacio et al in "From Victims to Survivors- Psychosocial Intervention in Disaster Management", 1994.

Psychosocial processing aims at helping the victims regain a sense of equilibrium and control through emotional catharsis and the identification of their strengths and coping behavior that helped them through the impact and aftermath of the disaster. This is done using the techniques of a critical incident stress debriefing (CISD) or a more specific grief counseling. These sessions would also allow for the identification of symptoms of psychological morbidity so that more specific and appropriate treatment could be provided immediately. This clinical approach underscores the need that mental health care be an integral part of the primary health care program.

At this time there are simultaneous activities provided by other disaster workers in the affected areas. These activities contribute to the victim's coping, as he goes through the inventory of his losses. Community rituals for the dead are particularly comforting for those who mourn the death of loved ones.

School activities, such as sports, musical, and theatrical programs as well as informal classroom programs, help students recover from the aftermath of experiencing a collapsed or buried school building and to resume normal academic activities. Teachers undergo training to integrate these activities in their curriculum. Returning to work, be it resumption of previous livelihood activities or the acceptance of alternative livelihood activities, allows men and women in the community to have a sense or normalcy. More importantly these activities are the means by which they acquire or regain a sense of power in themselves because they are actually able to experience the ability to function again and regain self-confidence. Local leaders also start to take control of their communities and reestablish community spirit and cooperation. They are able to put together the elements of local governance and community organization, which are vital in initiating and sustaining the community mobilization needed in the reconstruction and rehabilitation of their devastated community.

c) Reconstruction and Rehabilitation phase

This third phase is generally participated in by a majority of the population. Understandably, without this participation, recovery will be incomplete. Although the disaster has caused everyone to suffer from physical psychosocial and environmental disruptions in their lives, a majority of individuals recover and are eventually able to participate in the rehabilitation of their communities, at individual and community levels. Business establishments, farms, and markets resume normal activities, schools reopen and hold regular classes, and homes are rebuilt along with roads and bridges. There may still be problems in the provision of resources and assistance for these activities, because donor fatigue happens, but the general atmosphere is that a sense of normalcy has started to return.

Generally, however, this may be true only to a certain degree. The trauma felt by almost everyone lingers and throughout the different phases of the disaster, the pervasive feelings of grief and bereavement uncertainty and anxiety are important psychosocial concerns. The disaster is an experience of loss and, as such, it generates intense stress. There are equally strong demands on everyone to cope effectively, and disaster victims, because of the magnitude of the devastation, may find hard to respond appropriately.

Psychosocial intervention strategies must address these stressful feelings. If these stresses are not resolved throughout the different phases of the disaster, what may originally begin as signs of distress may become more severe psychological symptoms and possibly psychiatric illness. This progression would not only hinder the expected recovery from the disaster but would add to the burden experienced by the victims, their families, and the community.

The development of a referral network to provide for the necessary psychiatric treatment within the rehabilitation plan of the affected area is possible with the training of local health workers in primary mental health care.

The Development of Local Manpower in Disaster Management

Because of the continuity in the occurrence of disasters, government and non-government groups have been impressive in their responses when disaster strikes. Despite the country's limited resources, many efforts in various forms have been exerted to ease the plight of disaster victims all over the country. Disaster workers from other agencies generate and distribute resources within 24 hours for distributing the necessary food and clothing. Medical teams from the government and the private sector mobilize to attend to the injured or those with physical illnesses; others conduct health education programs and immunization to prevent the outbreak of diseases. Many others go to the affected areas to help reconstruct houses and markets, roads, and bridges as well as build community structures to protect victims from further trauma from the environment. Examples of these are building anti-lahar dams following the volcanic eruption and constructing evacuation centers.

While admittedly it is essential to provide victims with these kinds of assistance, it should be remembered that the focus is the human being and the importance of his transformation from being a victim to being a survivor, empowered to participate in his own recovery and rehabilitation as well as that of his community. As one addresses this issue, one recognizes that, indeed, psychosocial intervention is an essential component of disaster management.

A reorientation of all disaster workers and their training to this issue so that they can extend relevant psychosocial intervention within their daily activities is necessary. The transfer of knowledge and skills regarding psychosocial care from specialized mental health professionals to community workers seems to be the only way so that a majority of the survivors can be reached. Hence training is a major psychosocial intervention strategy.

As part of the framework of psychosocial intervention in disaster, this strategy includes a reorientation of disaster workers so that they can acquire a more holistic view to their work and therefore recognize that the human person has physical, psychological, and social needs. In helping the disaster victims, they must be aware that all these needs are integral to man.

In addition to the acquisition of a psychosocial orientation to their work, the magnitude of the stress experienced by disaster victims necessitates the training and development of local manpower to provide direct psychosocial intervention. This cannot adequately be taken care of by the mental health specialists alone.

The MHTFDM has conducted this kind of trainings and has documented training materials for primary and other community health workers as a part of its work in integrating psychosocial care in primary health care. This training has included their acquisition of the skills to facilitate debriefing sessions when necessary.

Multi-sectoral Collaboration: The Integrating Pathway to Effective Utilization of Psychosocial Intervention in Disaster Management

The MHTFDM has been the nucleus of the psychosocial intervention program since its organization by the President of the Philippines, in response to the perceived needs of the victims of the killer earthquake in 1990.

As part of the Presidential Task Force in Disaster, mandated to address the psychosocial needs of these victims, it had the advantage of having access to the national government's resources. Administratively it functioned under the Department of Health, which had the advantage of utilizing the department's resources from the national to the local levels. These resources included the existing infrastructure and manpower, which facilitated the entry and the conduct of the activities of the MHTFDM in the affected areas where disorganization prevailed. Through this structure, the MHTFDM took the initiative in introducing the concepts and framework of psychosocial intervention to planners and implementers of disaster management programs from the national down to the 'barangay' (village) levels and engaging them to participate in training programs and in implementing psychosocial intervention activities.

Aware of the government's shortage of technical expertise in mental health care in general, especially in disaster mental health programs, the president called on psychiatrists and psychologists from a university to lead the MHTFDM. These professionals were officers of a non-government organization that conducts programs in mental health training, research and consultancy for the development of mental health services. These professionals were able to organize and involve their other colleagues, both from the other government institutions and other private organizations, to participate in the agreed tasks of conceptualizing the objectives and implementing the MHTFDM's program of activities. They also participated in generating the financial resources of the Task Force because government resources were not sufficient to cover all the costs.

Hence, the MHTFDM has been able to establish a synergy between government agencies and non-government groups, each involving various professionals from the fields of health, social service, education, and the local government. The ease with which this multi-sectoral collaboration has been able to facilitate the work of the MHTFDM from the national to the local village levels has been recognized as the integrating pathway for the integration of psychosocial intervention in overall disaster management.

Among the major psychosocial intervention strategies that facilitated this are the training of local manpower and the reorientation of disaster policy makers at the national level and the disaster workers who actually carried out various activities at the local level.

The Institutionalization of Psychosocial Care

The MHTFDM experiences in managing the psychosocial consequences of disaster point to an urgent need to institutionalize a program that can implement psychosocial interventions quickly and effectively. This implies the necessity for a permanent structure composed of people who have acquired a psychosocial orientation to disaster work or who have been trained in psychosocial processing within a system that will ensure appropriate and immediate response to the different disaster phases. It is also important to emphasize that a way must be found to preserve the values and motivation of these disaster workers so that they do not lose their interest and skills.

In establishing this organization, the following elements have been identified.

1. The organization must be broad based, which can be achieved if the vowed aim of making it multi-sectoral at all levels is accomplished. Skill is required to harness the resources of these different sectors into an

integrated unit. The synergy among government organizations and NGOs must be maximized and the distrust that is often known to exist among them, overcome.

2. The organization should have a leadership structure that is highly credible in the mental health field and which can continuously motivate and inspire the members of the organization. This is especially critical since there may be times when there is no disaster and focus is on the maintenance activities.

3. To achieve permanence, the core of this organization must be lodged in a government agency such as the Department of Health. This ensures its sustainability and the reach of a nationwide organization.

4. The system that is created should be viable and have the capacity to respond and take the initiative in providing psychosocial interventions at different levels of the organization. It should also be self-renewing and self-sustaining, characterized by a system of continuous recruitment and training of practitioners; of continuing efforts at maintaining the quality of skills and high motivation of the manpower from various sectors; and a constant upgrading and refinement of knowledge and skills necessary for the effective provision of psychosocially oriented intervention in disaster.

5. The intervention methods should be relevant to the needs of the beneficiaries, the disaster victims. These intervention skills can be transferred even to those disaster workers who are not sophisticated or highly educated so that they can feel confident in their response to different distress symptoms. These skills should be such that they can be applied in similar crisis or stressful situations other than disaster.

6. The people in this organization, the caregivers, should be dedicated and committed to shared values, which is that the human being is the most important focus of intervention in any disaster situation and that the emotional and psychosocial well-being of a person is paramount in any effort in the rehabilitation of disaster victims.

7. The organization must be assured of access to funds to ensure continued viability. In the Philippines, the decision to endorse the functions of the MHTFDM to the Department of Health was based on the fact that all the activities of the Task Force were adopted by the National Program for Mental Health and included in its budget.

Institutionalization is expected to allow easier access to psychosocial care in the community. By collaborating and coordinating with the local community agencies that undertake disaster work and have been reoriented or trained to implement the psychosocial program, the envisioned organization will be able to promote mental health among the people who, otherwise, would be unable to avail themselves of mental health care.

To maintain the institutionalization of psychosocial care for disaster victims, care and attention must be given to the kind of technology to be used. The psychosocial field can be highly technical, one that requires some degree of sophistication. The treatment and intervention that will be implemented in the institution being developed should be specific, transferable, and responsive. The MHTFDM in planning its training activities has given this utmost consideration. It has also impressed on every program participant the crucial importance of sensitivity to an unfolding process and an ability to anticipate even adverse responses to action taken, so that caution will be observed or remedial action will be made in a timely fashion.

The process of institutionalizing the psychosocial intervention program will necessarily take time. To develop the required skills, training is necessary for a considerable length of time. Since the delivery and spread of psychosocial services is dependent upon people, it will take a long time for the system to replicate itself in local communities, throughout the Philippines.

In the long run, institutionalization will rise or fall depending on the maintenance activities that are undertaken. The main sustainability concern is how to keep the organization going in the absence of disaster and, in most cases, in the light of dwindling interest.

In addressing this issue, it was decided to endorse the transfer of function of the MHTFDM to the Department of Health's National Program for Mental Health. This way, those trained can continue to use their skills in other related programs in mental health care and in their daily work and to be in touch with the other previously trained workers from the community sectors. What must also be instituted is the funding for these maintenance activities and a regular process of informing the relevant personnel on field and research developments in disaster mental health.

Finally, it is imperative that the efforts at institutionalization immediately identify the critical persons and allies within agencies in the multi-sectoral collaborating group, and in the local areas, who will then help advocate for broader programs in the promotion of mental health in general and the integration of psychosocial care in disaster management in particular.

Viewed in this way, participating in disaster response has become a positive challenge especially for the mental health field. It has become an opportunity for growth and solidarity as the Philippines faces its vulnerability to natural disasters. The MHTFDM experience proves that an active program of psychosocial interventions can be organized, put in place, and possibly be institutionalized so that the enormous amount of human suffering, which may occur anytime from any disaster, can be responded to promptly and appropriately.

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Mental health in the aftermath of a complex emergency: the case of Afghanistan

by Peter Ventevogel, Martine van Huuksloot, Frank Kortmann

Introduction

Afghanistan did not face "a disaster," but a series of long-term disasters deeply affecting the population's coping mechanisms and the capacity of the health care system to respond to the country's mental health needs. In this context of an ongoing complex humanitarian crisis, the issue at stake is not how to respond to a single disaster, but how to rebuild the whole health care system and strengthen the coping mechanisms of a whole population affected by decades of violence and destruction.

The effects of 25 years of violence in Afghanistan on the physical and human infrastructure have been enormous. At the height of the crisis, the total number of refugees reached 3.7 million with 2 million in Pakistan and 1.5 million in Iran (CESR 2001). This amounts to 15 percent of the total population, which is estimated between 21 and 28 million people. Afghanistan is one of the most severely mine- and UXO-affected countries in the world. Most of the mines were laid during the Soviet occupation and the subsequent communist regime between 1980-1992. Mines were also used in internal fighting among various armed groups from 1992 to 1996, particularly in the city of Kabul and surroundings. The current known contaminated area is estimated to total an approximately 724 million square meters (ICBL 2001). In the last years, the effects of man made disaster are intensified by a severe drought affecting more than half of the population. The drought increased internal displacement and caused massive damage of livelihood. Livestock losses were reported at approximately 50 percent. Crop loss in many areas averaged 75 percent (State Department 2003).

The impact of decades of war and violence is reflected in Afghanistan's health statistics, which are among the poorest in the world. Life expectancy at birth is 43 years (World Development Report 2004); the under-5 mortality rate is 257/1000 (fourth highest in the world); and the maternal mortality rate is 1900/100000 (second highest in the world) (UNICEF 2004).

Afghanistan: A History of War and Violence

Violence is engrained in the history of Afghanistan. Its strategic position between the great civilizations of India, Persia, and Central Asia has made it from the very beginning, both a crossroad for trade and cultural exchange and an almost incessant battlefield. The list of conquests is impressive. From the Persian empire, the Macedonian Greeks under the leadership of Alexander the Great, to the Maurians, the Huns, Genghis Khan and his Mongol hordes, the disastrous Anglo-Afghan wars in the nineteenth century to more recently the long-term struggle against Soviet occupation (Tanner 2002).

Since the Soviet invasion of the country in 1979, Afghanistan has become the stage of an ongoing, complex humanitarian emergency. The period of Soviet occupation was characterized by massive human rights violations. The Soviet army and allies were involved in massive bombardments and targeted executions, while the mujahedeen, supplied and trained by the US, Pakistan, and Saudi Arabia, were involved in guerrilla warfare. The war generated an estimated 1 million deaths (HRW 2001).

The USSR was forced to withdraw in 1989 and the remnants of the communist regime were defeated in 1992. Rivalry among the mujahedeen groups in the early nineties led to the destruction of most parts of the capital Kabul. Fighting continued among the various mujahedeen until the fundamentalist Islamic Taliban movement emerged and within a few years controlled most of the country. The Taliban installed a harsh rule based on the Sharia law and Pashtun tribal culture, which they took far beyond existing cultural norms. During Taliban rule any law violation would be punished heavily, giving some stability and security in the country. On the other hand, individual freedom was curtailed and the rights of women were severely restricted. Girls older than 10 years were banned from education and women were not allowed to work or to leave their homes without the company of the husband or a male relative (PHR 2001).

In November 2001, the Taliban were ousted from power by the former mujahedeen supported by a US-led multinational coalition. The new government tried to rebuild the country's devastated infrastructure, but was accused of human rights violations (HRW 2003). The situation has stabilized, but violence is not over yet, and the coalition troops in the country face considerable troubles by former Taliban and Al Qaida fighters and renegade warlords.

Impact on Mental Health Status of Afghan Population

The few publications from the pre-war period about mental health and mental health care in Afghanistan give the impression that Afghanistan was not very different from any other developing country in the region (Gobar 1970, Waziri 1973).

The start of the violence in the late 1970 led to the exile of many mental health professionals, and little is known about the early effects of the war on the mental health status of the Afghans during the Russian occupation and the armed resistance of the mujahedeen. In the refugee camps in Pakistan, clinicians reported that they saw many patients with anxiety and depressive symptoms (Mufti 1986, Dadfar 1994).

The Taliban policy of extreme gender segregation and the denial of basic human rights to women led to increased rates of depression and anxiety. In a survey of 160 Afghan women in Kabul and Pakistan during the Taliban regime, 42 percent had symptoms diagnostic of posttraumatic stress disorder, 97 percent had major depression, and 86 percent had severe anxiety. The vast majority (84 percent) of the women reported that one or more family members were killed during the war (Rasekh et al. 1998). (See table 1).

A study conducted in 2000 by the Physicians for Human Rights compared the mental health status of women living in Taliban-controlled areas versus that in a non-Taliban controlled area. Major depression was far more prevalent among women exposed to Taliban policies (78 percent) than among women living in a non-Taliban controlled area (28 percent) (Amowitz et al. 2003). Possibly even more alarming were the high rates of suicidal incidences (65 percent in Taliban controlled area versus 18 percent in the non-Taliban controlled area) and actual suicidal attempts (16 percent in the Taliban controlled area and 9 percent in the non-Taliban controlled area). High rates of depression and anxiety among women were also found in a qualitative study in Taliban controlled villages near Herat in Western Afghanistan (de Jong 1999).

The fall of the Taliban regime has not resulted in dramatic improvements of the mental health status of the population. A nationwide survey (Lopes Cardozo et al. 2004) and an in-depth provincewide survey in Nangarhar Province (Scholte et al. 2004) found persistently high figures of depression and anxiety, particularly among women, with elevated scores on depression questionnaires in two-third of all women (58.4 percent-73.4 percent) and anxiety symptoms in four-fifth of all women (78.2 -83.5 percent). The studies found a clear relation between the number of traumatic events and the likelihood of developing psychopathology. Respondents with physical disabilities had a higher chance of developing psychopathology.

Among refugees in Pakistan (Amowitz et al. 2003), Iran (Kalafi et al. 2002), and the Netherlands (Gernaat et al. 2003), high rates of psychopathology were found (see table 1).

With the exception of the study among the refugees in the Netherlands, the previously mentioned are based upon scales measuring self-reported symptoms. Mental health symptoms, which are signs of emotional distress, need to be distinguished from psychiatric disorders. The prevalence figures must therefore be interpreted with caution since there are several possible sources for bias (Ventevogel 2005). Firstly, the respondents might have aggravated their symptoms in the expectation that this would increase the likelihood that they would be "rewarded" with materials, benefits, or assistance.

Secondly, the instruments might have tapped into "cultural idioms of distress.". Cultures vary considerably in the way unwell-being is expressed. An ethnographic study among Pashtun women in Pakistan indicated that cultural norms encourage women to publicly express sorrow and grief. (Grima 1993).

Thirdly, the instruments were not clinically validated. The use of psychiatric instruments in a setting for which they were not developed can lead to outcomes that do not reflect clinical reality. In a comment on the Afghanistan studies, concerns have been raised about the assessment instruments used and whether generalizations about clinical disorders and specific medical treatment can be made (Bolton and Betancourt 2004). In contrast to a self-reporting instrument, a clinical psychiatric diagnosis takes the severity of the reported symptoms and the associated disability into account and organizes the symptoms into clinically meaningful constellations.

Mental health and psychosocial initiatives in complex emergencies

In this article we distinguish between "mental health care" and "psychosocial care." Both mental health care and psychosocial care strive to prevent psychological problems and to provide aid to people who live in situations that threaten their mental balance.

Mental health care provides treatment of possible pathological reactions (Aarts 2001). Possible reactions include depression, posttraumatic stress disorder, and other anxiety disorders (De Jong et al. 2003). Regular local care systems are usually not equipped to provide adequate care for these people. In the case of complex disasters, with continuing conflict, population displacement, and food scarcity, the health services usually collapse (Van Ommeren et al. 2005). Therefore, it is necessary to support and rebuild the local health care system so that it can provide basic mental health care services. This can be done by training local health practitioners in mental health care skills and integrating the mental health care activities in the regular primary health care activities (Mollica et al. 2004, Van Ommeren et al 2005).

Psychosocial care deals with a broad range of psychosocial problems and promotes the restoration of social cohesion and infrastructure and stimulates culturally suitable coping strategies and skills. Stress can be reduced and social stability enhanced by normalizing daily life through the support of various social activities, education, and recreation. Adequate psychosocial care cannot be limited to trauma treatment (Aarts 2001).

The consequences of conflict and social uprooting are massive and cannot solely be understood in medical terms. Reframing distress into a mental illness could lead to the medicalization of social problems. The mental health care approach as described above needs to be complemented by the development of community-based psychosocial services. These activities should foster the active involvement of the communities in the recovery process (Prewitt Diaz 2004).

The local communities are actively involved in the design of interventions that aim to strengthen social networks and to revitalize culture-specific support mechanisms. Specific attention can be given to the vulnerable groups such as children, returnees, and IDPs, juvenile ex combatants, widows and orphans. Psychosocial programs often use multiple perspectives, and aim both at primary, secondary and tertiary prevention on national (macro) level, local communities (meso level), and individuals (micro level). The interventions can be massive public education, income-generating activities, self-help groups, teams for crisis intervention, or activities aimed at reconciliation and peace (De Jong 2002).

In the following part of the article we will describe two case studies of NGO projects. The first case study describes a project to integrate mental health care in the primary health care system. The second case study describes a community-based psychosocial project for children.

Integrating Mental Health into Primary Health Care

According to WHO Mental Health Policy Atlas, Afghanistan presently should have 8 psychiatrists, 16 psychiatric nurses and 20 psychologists for a population of about 25 million (WHO 2003). It is doubtful whether these professionals are indeed still in the country. The existence of mental health problems is widely recognized by both health care personnel and the general population. People with mental disorders seek refuge in traditional shrines or self medicate with psychopharmacological drugs.

The Mental Health Hospital in Kabul, with fifty beds, is the only psychiatric institution in the country and suffered severely during the subsequent fighting in the capital and the building was eventually destroyed. Some provincial capitals have asylums ("marastoom") whose main function is to provide shelter and food for drug-addicts and severe mentally disturbed patients without family support. Attempts in the 1980s to decentralize the mental health care and develop community mental health services were halted by the rising civil war. Outside Kabul, a mental health care system hardly exists. In the 1990s WHO had developed a 3-month residential training for primary care physicians in Northern Afghanistan (Mohit et al. 1999). Due to the ongoing violence this initiative could not be followed up.

The government, backed by major international donors, has decided to contact NGOs for health service delivery in the most underserved parts of the country.

The Afghan Ministry of Public Health developed a basic package of health services (BPHS) defining the medical interventions to be made available in all districts of the country (Government of Afghanistan 2003). The BPHS gave the necessary interventions in seven priority areas: maternal and newborn health, child health and immunization, public nutrition, communicable diseases, disability, essential drugs, and mental health.

It is a novelty for a low-income country to give mental health such a high priority. The Afghan government justifies this step by pointing at the clearly felt need by its population after decades of war and internal conflicts. Besides, it mirrors developments in international health policy to increasingly pay attention to mental health. The creation of available, accessible, affordable and acceptable mental health facilities in Afghanistan can only be accomplished through a major policy shift, breaking away from hospital-based psychiatry towards integration of mental health into primary health care services (Ventevogel et al. 2002).

WHO advocates the strategy to give priority to the mental health care services within the primary health care system (Eisenberg et al. 1999, WHO 2003b). The majority of the patients visit the primary care facilities anyway, but often the psychological origins of their complaints are not identified (Afana et al. 2002). Early recognition of mental problems prevents medicalization and over consumption of drugs and health care.

Case 1: Mental health in primary health care in Eastern Afghanistan

In 2002, the Dutch NGO HealthNet International started a mental health program in Eastern Afghanistan aimed at the integration of mental health services within existing primary health care structures. The program was carried out in the context of a basic health care program, aimed at supporting the governmental health care system. The project area consisted of eight districts, with a population of nearly 400,000. All districts were inhabited by Pashtuns of the Shinwari and Mohmand tribes, the main ethnic group in Eastern Afghanistan.

During the 25 years of war, this part of Afghanistan has suffered considerably. Many district inhabitants have been refugees in one of these periods. During the 1980s and early 1990s most tribal groups in this area supported one of the Mujaheddeen factions in their struggle against the Russian occupation. Many of the houses were damaged due to the war. The period of Taliban rule was relatively peaceful, but the restrictions on womens social and educational rights were significant.

During the American attacks on the Taliban and Al Qaida strongholds, some villages in Nangarhar suffered considerably due to raids by American allies. A research sample of nearly 800 patients in basic health centres in Nangargar revealed a high prevalence of experiences of shocking events: 50 percent had to flee and more than 20 percent reported the violent death of a family member or close friend (Ventevogel 2003). There was the potential for many traumatic experiences, yet the clinical impression of the project staff was that the prevalence of posttraumatic stress disorders was not as high as could be expected. This finding contrasted with the figures of epidemiological research based on lay administered symptom checklist (Scholte et al. 2004, Lopez Cardozo et al. 2004), but were corroborated by impressions from other clinicians.

The program consists of three pillars:

        -Training for health workers : Two-week training modules for primary health care doctors, nurses, and midwives were developed. The midwives were included because in this part of Afghanistan there are very few female nurses. The curriculum included essential information about the diagnosis and treatment of mental disorders. The course was limited to priority conditions, among which were common mental disorders (depression, anxiety disorders, and substance abuse) and severe neuropsychiatry disorders (schizophrenia, epilepsy, mental retardation), that tended to be neglected in post-conflict situations (Silove et al. 2000). The teaching methodology consisted of participatory lectures, and additional group-discussions, role-plays, interviews with patients, and excursions (to a traditional shrine where mental patients were treated). The bio-psycho-social approach was central to the modules, with a special emphasis on non-pharmacological treatment methods such as relaxation exercises, physical exercises, and mobilizing social support. The modules included presentations and handouts in English and Pashto and videos of patient interviews.

        -Raising community awareness: Bridging the gap between the local communities and the newly introduced services was essential for successful implementation of a mental health scheme. Therefore, 2-day training courses were organized for village health volunteers and traditional birth attendants. This enabled them to identify and refer typical cases of mental disorders to the health centers. HealthNet International also organized 1-day awareness raising workshops for community leaders and female influential figures.

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[2] This section is based on earlier published materials: Kortmann & Ventevogel 2003, Ventevogel & Kortmann 2004a and b.

[3] For example the American psychotherapist Gustavson, on a consultancy for the International Medical Corps, notes that "neither the Afghan population in general, nor patients in the clinics, appear to manifest an unusual high number of trauma related symptoms" (Gustavson 2004).

[4] The development of the training modules is described in Ventevogel and Kortmann 2004.

-Integration of activities in the health support structures: After the health workers in a health facility were trained, essential WHO-recommended psychiatric drugs were included in the monthly kits to the clinic. The existing health information system was adapted to accurately include mental disorders. The mental health activities were included in the general supervision system. When the health workers were trained, one of the district health supervisors was designated as a focal person for mental health. He was responsible for establishing training needs, refresher courses, and keeping mental health on the agenda of the general health workers.

This developed model of mental health services can be introduced to other parts of the country also and be adapted to local circumstances (available resources, culture, language). Currently plans are underway to extend the training activities to other areas of the country. The Afghan Ministry of Health has adopted the strategy of mental health in primary health care, and HealthNet International is planning to support other NGOs to organize similar courses in other parts of the country. In 2005 HealthNet International, with support of Caritas Austria, started to strengthen the psychosocial components by training psychosocial workers.

Psychosocial interventions

In Afghanistan, no large-scale psychosocial programs, as described by De Jong (2002), have been implemented yet, though the need for starting them is obvious (Baingana 2003, Bolton & Betancourt 2004, Van de Put 2002). Several NGOs have developed more focused psychosocial programs for children, such as Save the Children USA (De Berry 2004) and War Child Netherlands.

Case 2: Community Action Planning to improve children's psychosocial well-being in Western Afghanistan.

In 2004 the NGO, War Child Netherlands, started a pilot psychosocial program in Herat province in Western Afghanistan, consisting of several phases.

1.Pre-project Assessment
A field mission in 2003 identified factors that had an impact on the social and emotional condition of children and youth:

- Caregiver Support
Caregiver support is a critical protective factor for the psychosocial well-being of children. If caregiver support is weak or absent, the negative effect of a conflict on children is bound to be higher. Cultural factors and the dominance of Islam in the society have resulted in a surprisingly high quality of caregiver support, despite the challenging conditions for child care. Still, with the main focus of families and the educational system on survival, the support fails to meet children's elevated needs. Often children lack a safe social space to give their opinions and to share their problems and feelings with adults. This can affect their psychosocial development. The main focus of families and the educational system is and has been on survival and as a result, emotional support of children has been neglected. Cultural values discourage children to share their feelings with adults and this hampers healthy psychosocial development.

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[5] At the time of writing (April 2005) several new psychosocial project initiatives have started, such as the training of counselors of v

[6] This section is based on Van Huuksloot et al. 2004.

- Promoting constructive coping

Play is important for the development of children's constructive coping mechanisms. Through play, the children are encouraged to build relationships, to develop a wide range of skills and a healthy lifestyle. The poor economic environment in Afghanistan forces many children to make an active contribution to the household economy at an early age. Consequently, play is seen as a waste of productive time. Conflict has resulted in a whole generation missing a joyful childhood (60 percent of the current population is under age 18). Sometimes the parents or other close relatives were killed, which forced the children to become the primary family caregivers The growing phase passed while moving from place to place or working in foreign countries to feed the family. Additionally, the loss of traditional games and cultural practices limited the possibilities for children to develop constructive coping mechanisms.

2. Participatory needs assessment

Based on this assessment, War Child Netherlands designed a pilot project in four villages in Herat Province. This project started with a three-day participatory needs assessment in each community. The assessment was based on play in relation to other relevant protective factors such as children rights, caregiver support, daily activities, the existence of a peaceful child environment and child and community coping mechanisms. The needs assessment showed that Afghan families consider play important for child development and the well-being of children. The communities were able to give examples of play as an integral tool for physical, emotional, social, and cognitive child development. During focus group discussions in the villages, the community members expressed their ideas about the interferences with children's playing in the current situation of the community. In addition, they discussed ideas to improve children's play opportunities such as creation of a special place in the community to play, meetings to raise awareness of parents who do not allow their children to play, and the use of volunteers to set up sport and play groups.

3. Child Action Plans in Each Rural Community.

• Following the needs assessment, each community selected a male and female working group with adult and youth participants to develop a plan for the community to improve children's play that focused on play and related protective factors. War Child facilitated the actual implementation of the activities proposed by the communities. Examples are: Providing knowledge and skills-based training to working groups relevant to improving the children's play, as a tool for child development in the community.

• Completion of a Child Action Plan for the community
• Implementation and monitoring of the activities benefiting children in the community.

4. Community evaluations

Within the stage of community action planning, communities developed indicators to measure the success of their child-focused activities to improve a playful environment for children. The community-relevant indicators related to social changes such as more chances - especially for girls - to meet each other and to escape from the isolated and monotonous daily activities in the houses; improved balance between work-related responsibilities and moments to relax, play, and meet peers; less violent games, which often trigger memories of conflict; more moments of positive interaction between children; understanding and acceptance of adults for children's right to play and the importance of play for children's development and well-being.

Conclusion

This article described two pioneering projects to address respectively the mental health needs of the general population and the psychosocial needs of children.

The international humanitarian world is slowly recognizing the importance of addressing the psychosocial and mental health consequences in complex humanitarian emergencies (Srinivasa Murthy 2004). In a country like Afghanistan, the needs are huge and the initiatives are few. A united effort of the government, NGOs, and UN bodies is needed to expand the coverage of primary mental health care and psychosocial services to the whole population of Afghanistan.

Table 1: **Psychiatric epidemiological data of Afghanistan**

Authors	Study-population	Year of study	Instruments	Depression symptoms	Anxiety Symptoms	PTSD symptoms	All psychopathology
population based studies in Afghanistan							
Rasekh et al 1998	160 women in living in Kabul or recently arrived in Pakistan	1998 (Taliban)	HSCL-25 DSM-IV checklist	Female: 97 percent	Female: 86 percent	Female: 42 percent	Female: 98 percent
Amowitz et al. 2003	Women in Taliban controlled area (Jalalabad) (n= 223); Women in non-Taliban controlled area (Faizabad) (n=194)	2000 (Taliban)	PRIME MD	Taliban controlled area: 78 percent; Non-Taliban controlled area: 28 percent	-	-	-
Lopes Cardozo et al. (2004) Scholte et al. (2004)	Population based multi cluster sample (n= 799)	2002	HSCL-25 (depression and anxiety) HTQ (PTSD)	Male: 59.1 percent Female: 73.4 percent	Male: 59.3 percent Female: 83.5 percent	Male: 32.1 percent Female: 48.3 percent	-
Scholte et al. (2004)	Population based multi cluster sample in Nagarhar Province (n= 1011)	2003	HSCL-25 HTQ	Male: 16.1 percent Female: 58.4 percent	Male: 21.9 percent Female: 78.2 percent	Male: 7.5 percent Female: 31.9 percent	–_
Refugee Studies							
Amowitz et al. 2003	Afghan women arrived in Pakistan < 2 yrs ago (n= 201)	2000	PRIME MD	Female: 73 percent	-	-	-
Gernaat et. al (2002)	Cross-sectional prevalence study among Afghan refugees in the Netherlands (n= 51)	2001	CIDI	57 percent	-	35 Percent	65 percent
Kalafi et al.(2002)	Cross-sectional prevalence study among randomly selected Afghan refugees stteld in Iran (n=81)		General Health Questionnaire (GHQ-28).	-	-	-	34.5 percent

CIDI = 'Composite international diagnostic interview', GHQ = General Health Questionnaire, HSCL 25 = Hopkins Symptom Checklist 25, HTQ = Harvard Trauma Questionnaire, PRIME MD = a screening instrument for depression in primary care.

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Chapter 9

Psychological Support in Palestine: Review of Palestinian Mental Health in Gaza Strip during Al-Aqsa Intifada
By Dr. Iyad Zaqout

Introduction

Palestinian Occupied Territories comprises two areas separated geographically: the West Bank and the Gaza Strip. West Bank lies within an area of 5,800 sq. kilometers west of the river Jordan. It has been under Israeli Military Occupation, together with East Jerusalem, since June 1967 (Ministry of Health Report 2002).

The Gaza Strip is a slim rectangular coastal area on the eastern Mediterranean, 45 kilometers long, 7.9 kilometers wide at its northern end, 12.5 kilometers wide at its southern end, and 5.5 kilometers wide at its narrowest point encompassing a total area of approximately 362.5 squared kilometers (Efraini Orni and Elisha Efra, 1980). It became an internationally recognized entity in 1948 and has been called "The forgotten man of the middle east" and "The black hole of the Arab world." The Gaza Strip is the only part of Mandatory Palestine that was never incorporated into a sovereign state¬ (S. Roy, 1995). It is described as an area of extreme, impenetrable complexity; geographic, demographic, economic, social, political, and legal.

Prior to 1948, the Gaza Strip had no territorial demarcations but was a part of the Southern District of the Mandatory Palestine. The declaration of Israeli statehood in May 1948 precipitated not only the birth of the Gaza Strip, but also its defining social and economic feature, the Palestinian refugee problem. Within days after its geographic delineation, 250,000 refugees fled the war in Palestine. The strip's population tripled almost overnight, and the internal dynamics of the territory were altered forever (S. Roy, 1995).

Demography of Gaza Strip

The Gaza Strip is one of the most densely populated areas in the world. By 1993, before the Oslo Agreement, it was home to about 830,000 people, the overwhelming majority of whom (99 percent) were Sunni Arab Muslims. There is also a tiny minority of Arab Christians, mostly Greek Orthodox. About 75 percent of Gazans are refugees of the 1948 war and their descendents. More than half of the refugees still live in camps; the remainder resides in local villages and towns. More than half of the population is younger than fourteen years of age (UNRWA, 1992).

The 1997 census of the Palestinian Central Bureau of Statistics showed that the total number of residents in Gaza Strip was 1001569, 50.2 percent of them were children, 65 percent of them were refugees (PCBS, 1997).

Population density in the Gaza Strip is very high compared with the density in the West Bank and the neighboring countries. Density rate is about 3,278 inhabitants per one squared kilometer in Gaza Strip given that a sizable area of the Gaza Strip is still occupied by Israeli settlers. Therefore, the actual density rates are higher than the estimated figures (MOH 2002).

Economically Gaza Strip remains weak and underdeveloped and at present has virtually no economic base. Although unemployment rate was 24.1 percent (PCBS, 1998) before the uprising, a United Nations report puts the unemployment rate at closer to 65 percent within the last year.

Socially the residents of Gaza strip consist of three historic groups: Urban, Peasant, and the Bedouin. In 1948, the influx of 250,000 refugees irrevocably altered the social structure of the Area.

Politically and Legally the territory was under Israeli military occupation since 1967 and was under Egyptian administration before that. After Oslo Agreement, it was ruled over by the Palestinian National Authority (PNA).

Trans-Generational Trauma

In the earliest available reference to Gaza, it is described as a Canaanite city dating from 3200B.C, making it one of the oldest cities in the world. The city of Gaza and its environs experienced a continuous succession of conquerors and occupiers beginning with Egyptian pharaohs and ending with Israeli Army (S. Roy, 1995).

In the course of the last century, the Palestinian community has been confronted with a series of overwhelming changes in the conditions affecting their lives and their existence. The changes have been extremely stressful. The Palestinians have been arbitrarily and forcibly removed from their homeland, and resettled in different places. They have been ceaselessly exposed to oppressive conditions; some of which differ from locale to locale, some of which are similar.

The most well known milestones of their exhausting life journey in the past period are the following:

1948 catastrophe and the declaration of Israeli Statehood

Hours after the British government pulled out, Zionist leaders declared independence (May 14, 1948) and the US and the Soviet Union recognized the new state of Israel immediately. This resulted in the destruction of Palestinian society with the expulsion of 68 percent of its native people, of whom 4.5 million remain refugees today (S, Edward 2001). The following events had a major impact on the Palestinian war: the June 1967 war; the Intifada in 1987; the Gulf War in 1991; the 1993 Oslo Agreement and lastly, since September 2000, the ongoing Al-Aqsa Intifada.

The First Intifada

On December 9, 1987 the Palestinian uprising, the Intifada, erupted in the West Bank and Gaza Strip as a mass movement of civil disobedience and rebellion against the continuous Israeli occupation (Paige, J, 1991).

Before the outbreak of the Palestinian uprising, the Gaza had no elected mayor, no election process, no right of public awareness or public assembly. Palestinians had no flag and no sovereignty. Channels for political expression and legal protection did not exist and seemed increasingly importable in light of the 1985 reinstatement of preventive detentions and deportations. Heightened civilian settlement brought with it contested demands on vastly limited natural resources, especially land and water.

The outbreak occurred when an Israeli vehicle killed four Gazans from Jabalia Camp. Initial protests rapidly escalated into mass demonstrations and thousands of Gazans took to the street to erect barricades and begin their stone-throwing struggles. Within a week, the protest had spread to all areas of the Gaza Strip and the West Bank, and was being referred to as Intifada- the Uprising.

The Israeli army's response to the Intifada was to increase brutal and oppressive measures. There were numerous killings, detentions without trial, demolition of homes, torture, deportation, and curfews. The Palestinian Human Rights Information Centre estimates that during the period of the first Intifada from December 9, 1987, to December 31, 1993, Palestinians suffered 130,472 injuries and 1,282 deaths, of which 332 were deaths of children. Among these victims were those who were shot, beaten, tear gassed, or burned to the extent that they suffered permanent disability.

Approximately 57,000 Palestinians were arrested, many of whom were subjected to systematic physical and psychological torture. In contrast, the Israeli losses were minor: six Israeli settlers and 11 soldiers were killed (Marsella, A. etc.1994, Nixon, A., 1990). Records show that more than 481 people were deported, and 2,532 had their houses demolished during the first Intifada. The psychosocial and financial costs for the affected families in terms of medical and psychosocial care, loss of productive time, chronic disability, loss of function, and loss of life and property were enormous (Khamis, V., 1995a).

The Peace Process

In August 1993, the Palestinians were shocked to learn that for three years there had been continuous meetings between PLO leaders and politicians from Israel. So a political betrayal became a national plan.

Incidents progressed rapidly in a month after the announcement of the signing of Oslo Agreement in September 1993. On October 1994, the Cairo accord was signed, giving rise to the formation of the Palestinian Authority (PA). As a response, the Israeli army pulled out partially of the Palestinian areas. A total of 17.2 percent of the land was put under the direct autonomous control of PA (area A), 23.8 percent of the Palestinian land was under PA control with Israel responsible for security (area B), and 59 percent remained under Israeli control (area C).

Era after Oslo Agreement

The partial transferal of authority from the Israeli military government and its civil administration in the occupied territories has been a tremendous challenge to the Palestinian Authority in area A.

After transferal, the governmental, judiciary, and administrative structures, public services (such as health, infrastructure, and education) and organizations suffered from years of developmental neglect under Israeli administration. Since then, a Palestinian administration has been established both in the Gaza Strip and on the West Bank. In addition, the Palestinians' everyday life, even under normal circumstances, was marked by severe movement restrictions. Movement between two Palestinian areas meant crossing checkpoints. Treatment at checkpoints through the Israeli soldiers was often "cruel and degrading."

During the first nine months of 2000, before the outbreak of Al Aqsa Intifada, the Israeli army continued to attack Palestinian land and civilian facilities, preventing Palestinians from cultivating their land and building their houses on their own land. They opened fire on Palestinian civilians even when there was no threat imposed on their lives. For example, in May 2000 Israeli occupying forces opened fire on demonstrating Palestinian civilians on the 52ndanniversary of Al Nakba (1948 catastrophe), the anniversary of the uprooting and dispersal of the Palestinian people. As a result 6 Palestinian civilians were killed and about 1000 were wounded; 4 Palestinians were killed in a separate incident after landmines left by Israeli Occupying Forces exploded in the West Bank. The Israeli occupying forces killed 24 Palestinians in the first nine months of the year 2000.

In addition, the detention of Palestinians continued. By the end of September 2000, 1,610 Palestinians from West Bank and Gaza Strip were detained in Israeli prisons and, despite the landmark decision in 1999, certain forms of physical punishment were still used in Israeli prisons. During the entire year there was a "significant escalation in the use of lethal force by the Israeli Occupying Forces against Palestinian Civilians." Israeli settlements were expanded during the period when Barak became the prime minister in July 1999.

Until September 2000, 3499 new units were built and new bypass roads were constructed, meaning that there was an escalation of tension in that critical period before the outbreak of Al Aqsa Intifada.

The Second Intifada (Al Aqsa Intifada)

During September 2000, a new Palestinian uprising began against the Israeli military occupation. The immediate cause of the uprising was Israeli Knesset Member Ariel Sharon's visit accompanied by more than 1000 armed Israeli riot police in full riot gear to what Jews call "Temple Mount'" and Muslims "Noble Sanctuary" (El-Haram A-Sharif) on which sits Al-Aqsa Mosque.

Following Friday prayers, the Palestinians protested the violation of their holy place, which resulted in Israeli police fatally shooting several unarmed protesters. This event provided the immediate spark for Palestinian protests throughout the West Bank and Gaza Strip as well as the name for an uprising that continues at this writing - the Al-Aqsa Intifada.

The more distant cause for this second and more violent Intifada was the increasingly evident failure of the Oslo peace process, whose impetus, ironically, came from the first, mainly non-violent uprising of 1987-1993. Instead of a lasting peace between Israelis and Palestinians, Oslo brought economic underdevelopment including high unemployment, a 50-percent increase in Israeli settlement, building and land confiscation, and a decrease in Palestine freedom of movement and lack of civil liberties. As in all modern wars, the victims were mainly civilians.

As the Al-Aqsa Intifada continues into its fourth year, the Israeli army frequently shells the Palestinian Gaza Strip and West Bank. The Israeli army uses a variety of methods to shell or destroy homes. These methods include tank shells, bulldozers, helicopter gunships, and fighter aircraft (e.g., American-made F- 16s).

Homes have been bombarded and destroyed or made uninhabitable. Many families have found themselves living in tents. When families witness the destruction of their own homes by enemy soldiers, the psychological effects are immense, as the Palestinian home is not only a shelter, but also the heart of family life. There are memories of joy and pain as well as the attachment to the families' objects. Home is associated with feelings of security and consolation.

"Home" is highly significant to all human beings, and seeing one's home bombed is traumatic for anyone. For Palestinians refugees, the demolition of their homes is more horrifying as it reawakens the trauma of uprooting in 1948.

State of Mental Health

The overall state of mental health in Gaza is the outcome of many factors so interlinked that it is difficult to consider their effects separately. These factors therefore remain indivisible when their impacts on the human psyche, on individual lives and on the community as a whole are considered. Behind the specific traumatic upheavals of the past decades lies the amalgamation of the stressors, frustrations, and humiliations present in everyday life in Gaza, and the effect that this constant tension and pressure has had on the mental health of its population.

For this reason it is important, when exploring the impact of specific types of stressful events on victims and on society in Gaza, always to take into consideration the global context in which they are occurring and to which they are adding yet another element of suffering. It follows, naturally, that any intervention designed to improve mental health, and to prevent further human rights abuses, must acknowledge and address the intertwining elements of past and present experiences, as well as attitudes towards the future. The impact of the peace process and its stagnation on the Palestinians can not be comprehended without understanding the initial meaning of the Oslo Agreement itself and what it represented. In turn, this cannot be understood without a clear picture of what the new Intifada uprising means to this society.

The new Intifada, sprang into being as a result of years of frustration and humiliation to which the Palestinians were subjected to first during the occupation then during the first Intifada. A sense of sheer desperation led Palestinians to risk and undergo detention, beatings, killings, house demolitions, night raids, expulsions, and a number of other abuses at the hands of the Israelis in their attempts to struggle against their occupiers. During this period, it is estimated that 3,216 Palestinians were killed (570 of whom were children) in addition to 27,451 injured. More than 2000 homes were demolished and between 175,000 and 200,000 were arrested and detained, many of whom were subjected to systematic physical and psychological torture (PRCS 2004). Having suffered greatly and undergone a high degree of hardship throughout their struggle, the mood was obviously one of jubilation when, with the signing of the Oslo agreement, the Palestinians perceived that their long ordeal had had a purpose and that, through it, they had managed to take control of and change their communal fate. Then the frustration with the total deadlock in the peace process and the disappointing conditions in which the Palestinian Authority was immersed led to a mood of despair, frustration, disappointment and hopelessness, which dominated the atmosphere in the Palestinian society. The outbreak of the second Intifada was met with more desperation but less hope than ever.

The Psychological Consequences

An exact quantification of the need for treatment and support related to torture and organized violence committed by Israeli and Palestinian Authorities is very difficult to conduct. However, an estimation made by the Gaza Community Mental Health Program of the mental well-being of adults in Gaza (16-60 years), suggested that one-third of the random sample suffered from stress- related psychiatric disorders related to direct exposure to violence (including torture 15.4 percent and imprisonment 16.1 percent), and witnessing traumatic events (including clashes with the Israeli army 35.1 percent, killing of a friend 21.0 percent, or a family member 20.1 percent) (1998).

Such an atmosphere of unrest has had tremendous impact on vulnerable sectors in the society.

Vulnerable Sectors

Ex-Political Prisoners

During the occupation, and particularly during the first and second Intifada, these individuals sacrificed chunks of their lives and underwent intense physical and psychological suffering in the name of the cause in which they believed deeply.

During the period from 1987-1993, within the course of the first Intifada, approximately 175,000 Palestinians were detained by Israel, and 535,000 since the occupation began in 1967 up to the time of Oslo Agreement (Khamis, V., 1995a). Among these prisoners, 95.8 percent had been tortured by beatings, as well as many other methods: exposure to extreme cold (92.9 percent), or extreme heat (76.7 percent); forced to stand for a long period (77.4 percent); threats against personal safety (90.6 percent); solitary confinement (86 percent);

sleep deprivation (71.5 percent); food deprivation(77.4 percent); pressure applied to the neck (68.1 percent); witnessing the torture of others (70.2 percent); electric shock (5.9 percent); and having an instrument inserted into the penis or rectum (1.1 percent).

These victims have experienced psychological complications. The same study showed that 41.9 percent of the subjects found it difficult to adapt to family life; 44.7 percent found it hard to socialize; and 21.1 percent had sexual and marital problems (Qoota, Punamaki, and El-Saraj, 1997).

The Gaza Community Mental Health Program estimated that among survivors of torture committed by Israeli authorities, the most common mental and physical sufferings were major depression (17 percent), anxiety disorders (12 percent) and post-traumatic stress disorder (30 percent) which, among others things, manifests itself in difficulties concentrating, apathy, sleep disorders, and recurrent and intrusive distressing recollections of the events related to the trauma (Qoota , Punamaki, and El-Saraj, 1996).

In addition, the families of ex-political prisoners have suffered many different types of traumatic experiences. These included night raids and witnessing the brutal arrest of the father (or brother or son), long separation from the loved one, absence of a father figure, incessant worry for the welfare of the imprisoned person, etc. All these incidents naturally affected all individual family members as well as the dynamics of the family unit as a whole.

Another striking phenomenon is that the ex-political prisoners' feelings of alienation can lead to outbursts of anger directed at their loved ones. All these factors place at risk the harmony of the family, communication channels, and the structure and support traditionally found inside the family system.

Children

Childhood is considered as a period of special protection and rights. Violence puts young children in jeopardy. It threatens the very core of their existence. (Dubrow et al 1992).

Children under 18 years of age make up 53 percent of the Gaza Strip's population and remain the most vulnerable segment of the Palestinian population. They suffered from the harsh life conditions of the Gaza Strip, but their suffering escalated during Al-Aqsa Intifada. They were shot, arrested, and exposed to tear gases; they had their homes shelled and demolished; their friends and relatives were injured and even killed.

Children's responses to danger and life-threat include anxiety, somatization, and withdrawal symptoms and, especially among younger children, regression to the earlier stages of development and clinging to parents.

Recently children's symptom-related behaviors have been observed. The general focus has been to determine rates of symptoms and behaviors of Palestinian children such as nightmares, fighting, bed wetting, fear, and anxiety, to list a few. Attempts were made to relate these symptoms to various traumatic events or participation in the Intifada. For instance, Sarraj and Punamaki (1993) studied the psychological effects of collective punishment and home demolition on Gaza children and found a positive correlation between exposure and neurotic symptoms, fighting, and fears.

In a separate study, they investigated 108 children in Gaza to assess the relation between traumatic experiences and cognitive and emotional responses (Qoota, Punamaki, and El-Saraj, 1995).

Among their findings they concluded that children exposed to a higher frequency of traumatic incidents showed increased psychological distress in the form of neurotic symptoms and greater risk taking. Formal diagnostic psychiatric outcomes such as PTSD was screened by Vostanis (1999) who found that between 35-40 percent of children ages 6 to 11 in Gaza were suffering from moderate to severe levels of PTSD. Also the same researcher showed that PTSD and depression rates were increased in Gazan children (Vostanis P, 2003).

It was also clearly stated that children in Gaza who were more exposed to extensive forms of violence had more significant symptoms. A total of 59 percent of these children had post-traumatic reactions compared to 25 percent who had lower levels of exposure, proving that all of the children's sufferings were attributable to political violence (Vostanis P, 2002). According to the same researchers, the most common type of traumatic events was seeing the victims' pictures on TV (92.3 percent) followed by witnessing bombardment and shelling (83.6 percent) (Vostanis P, 2001).

Interventions Used for Handling Trauma

A traumatic event is recognized by the nature of the events, by the effects of the trauma on individuals and groups, and by the responses of individuals and groups to the event. In general, traumatic events are dangerous, overwhelming, and sudden (Figley, 1985). They are marked by their extreme or sudden force, typically causing fear, anxiety, withdrawal, and avoidance. Traumatic events are described as having high intensity, unexpectedness, and infrequency, (WHO 1992).

Although PTSD is among the most prevalent psychiatric disorders in Palestine (GCMHP 2001, 2003), systematic investigation of what constitutes effective treatment is still nonexistent. Until more comprehensive treatment outcome studies are available, we continue to be critically dependent on clinical wisdom in treating these patients.

Interventions used in the management of trauma should be directed at fostering the victims' natural coping mechanisms and mobilizing the community resources by enhancing positive social responses. They should encompass a wide range of activities directed both at the community and the individual levels.

Accordingly there are interventions for short-term and immediate responses and there are others managing long-term consequences. Generally speaking, large-scale interventions are directed at the preventive and promotive level while individual or family-based interventions provide curative responses. In this respect it sounds more practical to implement a public health approach in managing country-level disasters. Therefore, in presenting the Palestinian experience with management of disaster survivors, I will use the public health model in sorting the activities albeit that was not the original intended purpose.

Community-based Interventions

The primary task of community interventions is to help victims regain a sense of safety and of mastery. For young children, the family is usually a very effective source of protection against traumatization, and most children are amazingly resilient as long as they have caregivers who are emotionally and physically available (Van derKolk et al., 1991; McFarlane, 1988).

The Israeli army policy of mass destruction and global collective punishment has given rise to disintegration of the primary shelter for children, homes, and families. Even mature people rely on their families, colleagues, and friends to a function as a "trauma membrane."

In recognition of this need for affiliation as a protection against trauma, it has become widely accepted that the central issue in acute crisis intervention is the provision and restoration of social support (Lystad, 1988; Raphael, 1986).

Therefore it is highly important to involve the community in the intervention and use the community resources as a tool for healing when possible.

Pre-disaster Intervention (Primary Prevention)

One imperative aspect of the Palestinian experience of trauma is that it is continuous and it can be broadcasted that one region is more likely to experience attacks and bombardment than others. Thus, even before the traumatizing incident; people are prepared how to react in case of attack. This sense of readiness has been observed to influence the outcome of trauma once it happens. One of the most important characteristic of the trauma is un-expectancy and hence victims have an overwhelming feeling of helplessness once they are exposed. If this unpredictability is minimized and people are educated about how to react at the time of disaster, this might help decrease the level of stress at the time of the disaster. In addition, it must be stated that teaching and training the public about first aid and appropriate civil defense measures, not only help in decreasing the number of causalities among civilians during a disastrous event, but also helps people in coping with the incident and promoting their psychological healing.

Immediate Post-disaster Intervention (Secondary Prevention)

In Palestine as well as in all areas inflicted by man-made disasters and wars, the work of health professionals, including mental health professionals, can expose them to great dangers, being targeted by Israeli occupying forces. Therefore the intervention should be postponed until the situation is stable and there is no threat to the therapist's own life. It is difficult to calm down people when the mental health professional is also anxious or threatened.

Moreover, specific psychological interventions cannot begin until various other issues, often of a very practical nature, have been addressed (Van der Kolk, B. A., Mc Farlane A, Weisa L1996). For example, victims of home demolition may have to secure a place to sleep and a way of protecting their possessions.

After a disaster occurs, the emphasis needs to be on self regulation and on rebuilding. This means the re-establishment of security and predictability. It also means active involvement in adaptive action, such as the rebuilding of damaged property, engagement with other victims, and active engagement in the physical care of oneself and other survivors.

Once the situation permits an opportunity for intervention, the therapists or trained community mental health workers should begin their activities at the wrecked area. Basically, crisis intervention and screening of potential cases is carried out. The following risk factors are considered when the visits are assigned:

- Bereaved families
- Individuals who suffered injury
- Persons who witnessed horrendous images
- Those with preexisting psychiatric problems
- Persons with prior trauma
- Victims of home demolition
- Those with extended exposure to danger

- Individuals (especially children) with a lack of social supports or whose social support figures were also traumatized and are unable to be adequately, emotionally available

Among these individuals, victims having the following signs are considered for further intervention:

- Persons who had dissociation at the time of the event.
- Those who experienced serious depressive symptoms within a week and lasting for a month or more.
- Individuals with numbing, depersonalization, sense of reliving the trauma, and motor restlessness after the event.
- The survivors overwhelmed by emotion most of the time.
- Those whose emotions cannot be modulated when necessary.
- Survivors who inappropriately blames himself or herself
- Survivors who are isolated and avoid the company of others.

These cases are considered for follow-up visits. If short-term counseling does not help them they are referred for the long-term intervention. For children, it is highly imperative to put them in groups once they are identified as in need of intervention. The intervention can be carried out in their place of living or school. This should be well-coordinated with the teachers and school counselors (if present).

Brief School Intervention is carried out (intervention lasts 1-1.5 hours and uses 2 therapists per class. Teacher or school counselor is present, and parents should be informed).

- The therapists should introduce themselves and ask the children to speculate why they have come to the classroom.
- Explain that they have come to talk about the disaster; encourage students to share what they know for 10-30 minutes; validate correct information; be calm.
- Have children draw while therapists circulate and ask students to tell them about their drawings.
- Ask a volunteer child to share with the other students his drawings and give the story of that drawing. Then ask other children to volunteer.
- Reassure students that their symptoms are normal and will ease, that different people have different symptoms, and that teachers, parents, and counselors are available to help them.
- Thank the students and teachers and redirect their attention to learning.

Drama Therapy, Psychodrama

If appropriate settings are present, the drama therapy can be used by the well-trained professionals. Essentially the children must be well-prepared and individual interviews should be carried out for them, making them ready for the session. Then on the day of the session, 7 to 10 children are placed in groups and 2 therapists explain to them the reason for their presence and assign them roles. Then the children are encouraged to create more dramas or roles.

The therapist then starts to ask the children about their emotions and feelings while in the role. What did they expect in real life; what made them choose that role; what does it mean for them to play that role; and what other roles he would they like to have?

As a result of that discussion, each child is reassigned to the new role. The educational point is when the therapist intervenes in a timely manner and asks the child how he feels both at the time of and after the role-play.

This technique is especially used to re-channel children's revenge and aggression constructively so that the child's craving for becoming a fighter while he is 10 years old, for instance, is subsided and he will try other opportunities e.g., when he plays the role of a physician and feels how helpful he was to his injured colleagues. Releasing emotions through role playing and participation in relevant dramas can help the child to have peace of mind and may redirect his drives constructively.

Clinical Intervention: Long-term Psychotherapy (Tertiary Prevention)

The aim of this intervention is to minimize handicaps and disabilities and thus prevents many of the associated sequelae of chronic trauma. Here we deal with cases that have already developed a disorder and are in need of prolonged therapy. Mostly these cases are referred to the clinic after community outreach and as an outcome of screening.

Psycho-educative Psychotherapy
Patients are often confused by their symptoms and believe that they are "going crazy." Their families, colleagues, and friends may be equally confused about what to do, and may withdraw in the face of the patients' intense emo¬tionality, anger, grief, and withdrawal.

It is important to develop a cognitive frame that helps patients understand their intrusions and avoidance, helps them gain some emo¬tional distance from the experience, and begins to put the event into the larger context of their lives. Treat¬ment in these cases consists of translating the nonverbal, dissociated realm of traumatic memory into secondary mental processes in which words can provide meaning and form, thereby facilitating the transformation of traumatic memory into narrative memory. In other words, what is currently implicit memory needs to be made into explicit, autobiographical memory.

Again, talking about the trauma is rarely, if ever, enough. Trauma survivors need to take some action that symbolizes triumph over helplessness and despair. Most of all, they serve to remind survivors of the ongoing potential for communality and sharing. This also applies to survi¬vors of other types of traumas, who may have to build less visible memorials and common symbols, to help them mourn and express their shame about their own vulnerability. This may take the form of writing a book, taking political action, helping other victims, or any of the myriad of creative solutions that human beings can find to defy even the most desperate plight.

Cognitive behavioral therapy
Severe and relatively common destructive cognitions may arise after a traumatic event and need to be addressed. On the left side of the Table 1 are malignant schemata that an individual may have after a traumatic event. On the right side are more constructive schemata that a clinician can suggest.

Table 1: Cognitive Interventions

Malignant Schema	Constructive Schema
Life has no meaning.	Right now it is hard to make sense of what happened.
I can't go on.	What happened is very painful. It is hard but will get easier in time.
I behaved terribly.	I was frightened and unsure what to do and made some bad choices.
The world is unsafe.	Disasters are rare. Many things can be done to protect my safety.
I'm losing my mind.	Feeling confused and overwhelmed after a traumatic experience is common.
It was my fault it happened.	What was done to me was a crime.

Exposure Therapy
Exposure therapy techniques are designed to activate the trauma memories in order to modify pathological association and to gener¬ate new, non-pathological associations. The best example for that is systematic desensitization (SD)by gradual exposure of the patient to reminder of the trauma starting with imagined and ending up with concrete reminders, while the patient undergoes anxiety management training (AMT).

The successful outcome of SD in which cli¬ents are exposed to fearful imagery in a state of relaxation, has been reported in two studies with war veterans (Peniston, 1986; Bowen & Lambert, 1986). The treatment was effective compared to a no-treatment control condition, but required a large number of sessions, over an extended period of time. The magnitude of the effects of this treatment on the PTSD symptom patterns and on general functioning cannot be ascertained, however, because the severity of PTSD and related pathology was not assessed.

 The stages for the cognitive behavioral management can be as follows:

- •Seeing that people are concerned about them;
- •Learning about the range of normal responses to trauma and hearing; that their emotional reactions are normal responses to an abnormal event (rather than a sign of weakness or pathology);
- •Being reminded to take care of concrete needs (food, fluids, and rest).
- •Undergoing cognitive restructuring (changing destructive schema, such as "having fun is a betrayal of the injured;" "The world is totally unsafe," "'I am responsible for the disaster," or "Life is without meaning," to more constructive ones.)
- •Learning relaxation techniques;
- •Undergoing exposure to avoided situations either through guided imagery and imagination or in vivo.

Conclusions and Future Directions

In contemporary culture, the link between stress and illness has almost become a cliché. However, the complex ways in which organism and culture interact make it extremely difficult to define the exact nature of this relationship.

In this chapter, I tried to summarize the accumulated body of knowledge in the area of traumatic stress in the Gaza Strip that is the result of decades of suffering. During this period, substantial incidents have occurred making the Palestinian population one of the most worlds' long-suffering populations.

This chapter has provided the historical con¬text of Gaza and has described how the study of traumatic stress is relevant to the discipline of psychiatry and mental health. The historical antecedents and contemporary studies demonstrated how the tenacity and strength of the Palestinian community.

Today, the same forces that have historically stood in the way of healing of the Palestinian community con¬tinue to exist. The challenge is not only to identify the extent to which the stressors have affected our community, but also to provide adequate interventions to promote the healing of the society. This challenge is compounded by the dearth of the resources, and given the paucity of controlled studies, we are left with the clinical impression that the initial response to trauma needs to con¬sist of reconnecting individuals with their ordinary supportive networks and having them engage in activities that re-establish a sense of mastery. Research in this area remains weak and inadequate besides it is only descriptive without clear monitor for impact.

Through this review, it is strongly recommended that new techniques should be introduced and implemented with high quality ensured through research.

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Section
III

From Psychiatry to Psychosocial Support

Chapter 10

Psychiatry to Psychosocial: Lessons from Disaster Mental Health in India

by Dr. Rashmi Lakshminarayana

Introduction:

India has often been described as a "Theatre of a variety of disasters" (Parasuraman, Unnikrishnan, 2000). A look at the numerous natural disasters that have struck the country suggests this is, in fact, true (Table 1). In addition, the various technological and man-made disasters add to the ever-increasing number of people who need post-disaster assistance.

Despite repeated occurrences of disasters, the response to help affected communities has been long delayed. Specific areas of response within disaster response have had particular difficulties in being integrated to disaster response due to various causes. Disaster mental health in India is one such area. This chapter will attempt to chart the changing paradigms of providing care for affected populations.

Table 1: Table of natural Disasters in India from 1900 to 2006

	Number of events	Killed	Affected	Total affected
Drought	21	4,250,430	1,391,841,000	1,391,841,000
Average per event		202,401	66,278,143	66,278,143
Earthquake	25	61,705	24,966,300	27,265,183
Average per event		2,468	998,652	1,090,607
Epidemic	66	4,543,531	419,685	419,685
Average per event		68,841	6,359	6,359
Flood	177	52,386	712,492,850	721,784,935
Average per event		296	4,025,383	4,077,881
Wind Storm	138	163,128	78,415,340	87,515,997
Average per event		1,182	568,227	634,174

Source: CRED EM-DAT: The OFDA/CRED International Disaster Database

The early years--the 1980s

Although the first reference to the psychological effects of disasters is a descriptive account of the severe cyclone in the state of Andhra Pradesh in the late 1970s, the first systematic and prospective study of the psychological impact of a disaster was done following the Bangalore circus fire (1981) (Narayan et al 1987; 2004).

A total of 70 people from 58 families, mostly children, died. The study group consisted of 137 bereaved adult relatives of which nearly two-thirds were parents of the deceased victims. The contacts started at six months following the tragedy.

Contact was made at the homes from the National Institute of Mental Health and Neuro Sciences (NIMHANS) using a proforma devised to collect data for the study. Numerous grief reactions (e.g., worrying excessively, having preoccupying thoughts of those who died in the disasters, suffering feelings of guilt) were present among the bereaved relatives after 6 months had passed. Most had behavior phenomena related to the grief. A total of 74 percent of relatives reported worrying, crying, and disturbances in biological function.

Interviews had suggested that nearly 74 percent still had depressed feelings and about a third of the bereaved wanted to be left alone. An overall assessment by a psychiatrist indicated that 49 of those affected could benefit from psychiatric intervention. Of these, one who had a psychotic breakdown was treated as an in-patient. Sixteen others with severe problems (such as feeling of sadness, sleeplessness, preoccupation with the thoughts of the deceased) agreed to receive psychiatric help. Of these, four attended the psychiatric outpatient facility while the remaining twelve were treated at their respective residences as they were unwilling to visit NIMHANS for treatment. All were put on antidepressants and minor tranquillizers. In addition, a therapist provided brief "re-grief therapy" at their residences. Three home visits were made for each of these cases. With these treatments, 15 subjects made sufficient recovery and had taken up their regular day-to-day activities. Five of them were followed up for periods ranging from 1½ months to 18 months.

This study indicated that majority of the disaster survivors had multiple psychosocial needs which lasted for many months. Many of them were reluctant to seek professional help in psychiatric settings. Home-based assistance utilizing the community resources was feasible and effective.

The Bhopal Gas tragedy of 1984 represents a milestone in disaster mental health in India. Mental health effects were studied prospectively and systematically in the absence of a formal mental health infrastructure.

On the night of December 2, 1984, about 40 tons of methyl iso cyanate (MIC), an extremely dangerous chemical used in the Union Carbide factory in Bhopal, leaked into the surrounding environment. The chemical is lighter than water and very hygroscopic. The initial estimate of the number of persons who died immediately was around 2000, but in the following years that estimate has been revised to more than 10,000 people.

There was no direct involvement of the psychiatrists and neurologists until eight weeks after the disaster, despite recognition of the importance of treating disaster mental health effects within the first fortnight of the disaster. This lack of action is attributed to the shortage of mental health professionals in the state of Madhya Pradesh and the city of Bhopal (Srinivasamurthy 1990, 2004). None of the five medical colleges had a psychiatrist in their faculty.

A summary of some of the important studies is described in Table 2.

Table 2: Summary of important studies with implications for mental health done following the Bhopal Gas Tragedy (Murthy, 2004)

Studies	Findings
General health studies:	
Misra et al 1988: 3 month follow-up study of 33 adult patients, treated during the acute phase at hospital	Depression and irritability commonly reported
Gupta et al (1988): - 687 affected persons examined 2 months post disaster with a control population - Another 592 affected persons examined at 4 months post disaster with a control population	Behavioral tests showed memory, mainly visual perceptual and attention/ response speed along with attention/vigilance, was severely affected in the gas-exposed population. All these changes were associated with subjective complaints of lack of concentration and poor attention. Women were more affected than men and this difference was statistically significant.
Cullinan et al (1996): Epidemiological study of a representative gas-exposed population, 9 years post-disaster (n=474). A subset of 76 subjects underwent detailed neurological examination. Results compared with a control population.	Psychological symptoms in this subset were fatigue (88 percent), anxiety (65 percent), and difficulty in concentration (64 percent). Difficulty in decision making was reported in 80 percent as compared to 35 percent in the control population. Irritability was reported by 33 percent as compared to nil in the control group. Approximately 25 percent reported symptoms of depression.
Mental health studies: S**rinivasamurthy,1990:** One week observational study based on clinical and unstructured interviews at 2 months post-disaster	Estimate of the magnitude of mental health needs of population: - in communities 50 percent - those attending medical facilities 20 percent
Sethi et al , 1987: - 3 month study starting at 2 months following the disaster - 855 patients screened at the 10 general medical clinic, on the basis of their Self Reporting Questionnaire (SRQ) scores - Of 259 identified 215 assessed using the Present Status Examination (PSE)	- 259 were identified as having a potential mental disorder - 193 identified as having a psychiatric disorder (prevalence rate 22.6 percent) - Most patients were female under 45 - Main diagnostic categories: - Anxiety neurosis (25 percent),
Sethi et al 1987 - Detailed community-level epidemiological study examining mental health effects along with other health effects -Sampling frame drawn with populations variously exposed to the disaster being included along with a control group from the city, located away from the gas-exposed area. - Methodology for screening: Interview with head of household for presence of symptoms using standardized checklist - Those with symptoms further examined by a qualified psychiatrist who used the PSE-9th version and arrived at the ICD- 9th Version diagnosis - Annual surveys repeated for next 3 years	-Depressive neurosis (37 percent), - Adjustment reaction with prolonged depression (20 percent) - Adjustment reaction with predominant disturbance of emotions (16 percent). First-year survey: 4,098 adults from 1,201 households. -387 patients diagnosed to be suffering mental disorders (Prevalence rate of 94/1,000) -Majority female (71 percent);83 percent in age group 16-45 years -94 percent patients received a diagnosis of neurosis (neurotic depression, 51 percent; anxiety state, 41 percent and hysteria, 2 percent) with temporal correlation with the disaster.

General population psychiatric epidemiological studies show that the gas- exposed populations were having significantly higher prevalence rates for psychiatric disorders in comparison to the general population. The gradient relationship of higher rates of psychiatric morbidity with severity of exposure to the poisonous gas was maintained throughout the five years of the survey period. At the end of the five-year period, the number who recovered fully was small. Many continued to experience the symptoms along with significant disability in functioning (Srinivasamurthy, 2004).

Interventions were predominantly hospital and clinic-based with focus on training general medical officers in the essentials of mental health care. This was the first time where the onus of being primary responders to mental health needs of disaster populations was shifted from psychiatrists to general medical officers. The basic aim of the training was enhancing the medical officers' sensitivity to the emotional needs of individuals and to provide them with skills to recognize, diagnose, treat (and refer when required) the mental health problems (Srinivasamurthy and Isaac, 1987).

The period of initial training was six working days and was conducted by two consultant psychiatrists. Each group did not exceed 20 persons. The methodology was sensitive to the principles of "adult learning" with greater stress on interactive learning. These included case studies and group discussions facilitated by audiovisual and taped material of the affected population.

Moving closer to the community: The 1990s

A major earthquake of magnitude 6.4 on the Richter scale struck Marathwada, in western India in 1993. Approximately, 8000 people died and 14,000 were injured.

For the first time in the history of disasters in India, mental health professionals reached the affected area within the first week of the disaster. The local government recognized that the fragile mental health of affected women and children needed to be strengthened through a program of psychological rehabilitation. This was put as a need in the local government's proposal for funding for the earthquake rehabilitation program.

The Advisory committee appointed by the Government of India (December 8, 1993) proposed two rural hospitals with psychiatric care units. For the first time the Government proposed to earmark 7.5 million rupees to provide psychosocial services for the time frame of 3 years for 30,000 survivors.

Interventions included counseling of groups and individuals at hospitals that were housing the injured during the immediate post-impact phase. Counseling was carried out at the district level by psychiatrists attached to Government. hospitals and the Maharashtra Institute of Mental Health, Pune. Psychiatrists from the government and the voluntary sectors trained health personnel and NGO workers. The ICMR set up a center for Advanced Research on Mental Health Consequences of Earthquake for a period of five years at the MIMH, Pune. The study's findings are summarized in Table 3.

Table 3: Mental Health Studies Conducted After Marathwada Earthquake

Studies	Findings
Agashe , 2004: -Assessing the pattern and course, and, quantifying mental health problems along with identifying 'at risk' individuals who would develop psychiatric morbidity - Community-based study, modified cohort design with defined exposed and unexposed groups - Total of 8,557 individuals from 1,661 families (4,487 individuals from 910 families from the exposed group and 4,070 individuals from 751 families from the control group) -Sample recruitment carried out in multistage random manner with Proportionate Population Sampling (PPS) - Two-stage method of assessment employed - **Instruments used :** For screening – SRQ, Confirmatory assessment- Schedule for Clinical Assessment in Neuropsychiatry (SCAN); Marathi versions developed - First phase of assessment (April 1995 -July 1996) and Second phase (April 1998- August 1998	- At follow up, attrition of 21 families (1.26 percent) from the sample due to migration - 793 deaths in families in exposed group; proportion of female deaths higher (n=461- 58.13 percent), seen across all age groups - **Prevalence** of psychiatric morbidity in disaster-affected group was 570 (139/1000) as against 243 (68/1000) in the control group (Z=10.28; p<0.0001) - Alcohol-related problems accounted for the excessive prevalence of psychiatric disorders in males in both groups - Most common diagnosis disaster affected population: 'other reactions to severe stress' (n=305). equivalent to adjustment disorder Other disorders: major depressive disorders (n=47); PTSD (n=37) - **Children:** Sleep disturbances predominant - **The risk factors for developing psychiatric disorders:** physical injury, occurrence of disaster death in family, trapping experience, and dissatisfaction with social support in the case of adults, and occurrence of disaster deaths in the family in the case of children

A five-year follow-up study showed that there was a significant remission in psychiatric morbidity. A total of 68.5 percent of males and 70.76 percent of females no longer had a psychiatric diagnosis. Satisfaction with social support, occurrence of desirable life events, and absence or minimal severity of disaster injury emerged as significant protective factors. At follow-up, variables promoting remission included participation in a greater number of desirable life events such as cultural and religious activities and other traditional festivals.

These findings indicated that for the majority of those affected by the disaster, recovery lay in strengthening the community. However, lack of transparency between agencies, poor coordination, inadequate institutional experience, and hesitancy in committing to a long-term endeavor to understand these factors had led to the premature withdrawal of psychiatrists from the area. No document or information about long-term assessment of needs, vulnerability, morbidity, and the role of family systems among the survivors have been put forth till to date.

The Bombay riots followed by the Bombay blasts raised the issue of providing care in man-made disasters. Following the demolition of the disrupted structure at Ayodhya on the December 6, 1992, the city of Bombay witnessed riots between Hindus and Muslims. This was followed by bomb blasts in various parts of the city in March 1993. Approximately, 1500 people died in both the riots and the blasts. Motivated social workers, both lay and professionals, working in research institutes (TISS), and NGOs carried out psychosocial counseling individually and in groups (Joseph, 2000). Apart from these efforts, the role of mental health professionals among those affected by the riots was limited.

The super cyclone in Orissa in October 29, 1999 was among the most destructive natural calamities in India in this century. Winds with velocity of nearly 300 kilometers per hour and incessant rains lasted for about 48 hours and bought tidal waves as high as 10 meters to nearly 15 kilometers inland. More than 15 million people in the 12 districts were affected. Almost 20 000 persons were killed. (Source: Government of Orissa).

In response to the super cyclone, both the Government of India and NGOs came forward to provide rescue, relief, and rehabilitation of the affected in a concerted way. Action Aid India was among the few NGOs who identified the inadequate importance being given to the psychosocial stressors following the disaster. The focus consequently was strengthened on the prevention and management of the psychosocial consequences of disasters. This led to the development of the concept of "Sneha Abhiyan" ("Campaign of Love").

This was a response to ensure rehabilitation of the most vulnerable among the survivors of the Orissa cyclone: the children, women and old people, who were left without the care of families and also those people who were under severe psychological shock and depression (Kishore Kumar et al, 2000; Bharath et al , 2000). It aimed at their long-term community based rehabilitation (CBR), through support from Government of India and the Government of Orissa. The psychological support was provided as a part of the overall care. The unique feature was the care provided by the lay volunteers with limited professional involvement.

Action Aid undertook an evaluation of the program after two years (Srinivasamuthy et al, 2003). The evaluation provided an understanding of the processes involved in psychological support to disaster-affected population, the level of care that could be achieved by lay volunteers, the limits of care by this approach, and most importantly the impact of the interventions on the total functioning of the individuals and communities.

Assessments for individuals included psychological morbidity, quality of life and community life, and, the current level of disability. Children were screened for their psychological morbidity. The group-level experiences and the impact were assessed using focused group discussions. Another method used to understand the intervention's impact was using community-level indicators available from other records (e.g., health status, marriage/divorce, work status, suicides, alcohol use, school attendance for adolescents, participation in community activities etc). Based on the evaluation, the psychosocial needs of the survivors at different points of time were identified.

The most commonly used methods for psychosocial care by the Snehakarmis (community level workers) were: listening, emotional support (being together), collective grieving, externalization of interests such as recreation, guidance, practical help in housing, and assertiveness skills. The interventions' impact was seen in the form of: decreased emotional distress, higher levels of self confidence, more awareness of rights, increase in school attendance and better understanding of the needs of single women by the general community.

Among the important lessons learned in providing mental health care in this disaster was the importance of the proactive community intervention to protect the vulnerable and the effectiveness of using community-level helpers to provide care in the community and providing professional support when needed.

The Indian Red Cross Society (IRCS), with technical assistance from the American Red Cross (ARC), had planned a program to address the long-term mental health needs of the community. A total of 30 villages from 4 affected districts, with an approximate population of 16,000 were part of the program. The program worked in 45 schools in the selected communities and supported the people using the family counseling center at the IRCS Orissa state branch headquarters (Prewitt- Diaz et al 2004).

Another study examining the effects of a disaster in an urban scenario was following the fire that broke out in the Yamuna Pusta slum in New Delhi (1999). The slum had a population of approximately 20,000 living in about 4000 temporary shelter accommodations. The fire killed 32 people and many more were injured. Mental health care reached the affected population within a day when a team constituted by Institute of Human Behaviour and Allied Sciences (IHBAS) consisting of psychiatrists, psychologists, and social workers, reached the site.

During the initial three months of service delivery, it was felt that the long-term mental health consequences, service needs, and other related aspects of disasters needed to be studied systematically.

In the period from July 1999 to December 2000, an assessment of long-term mental health morbidity, relief work, and other community activities were continued with the regular cadre staff and student volunteers of psychology and social work on their field posting at IHBAS. The study found that the affected population experienced a higher prevalence of mental health morbidity than the unaffected population (Desai, 2004). Certain population subgroups (e.g., families with the complete loss of belongings in fire) were at higher risk of developing psychiatric disorders and mental ill health after disasters.

Community based to community involvement: The 2000s

Providing care at the community level has become a norm in recent years. The emphasis is shifting to encompass the best ways that the community members can be involved to plan interventions using their own resources.

The Gujarat earthquake measuring approximately 7.7 on the Richter scale hit the state on the morning of January 26, 2001. According to the Government of India, the earthquake and its aftershocks affected nearly 15.9 million people, resulting in more than 20,000 deaths, 167,000 injuries, and the destruction of more than one million homes. A number of studies were conducted to understand the psychosocial impact of the disaster. A summary of some of the important studies are listed in Table 4.

Table 4: Studies examining the Mental Health Impact of The Gujarat Earthquake

Studies	Findings
Parikh 2001: Quoted in Vankar, Mehta 2004 - Patients (n=151) hospitalized with earthquake related physical injuries. -Psychological distress assessed using General Health Questionnaire 28 (GHQ-28).	131 of the 151 patients had scored 4 or more.
Ramappa Bhadra 2004 **1)** - Patients attending a primary health care center. - Psychological distress assessed using Self Reporting Questionnaire (SRQ) and the WHO Disability Assessment Schedule. 2) - 104 paraplegics and 270 amputees were present in the 100 villages on Kutch. - Study on their mental health status using SRQ, WHO-DAS -2 and the Family Burden Schedule.	- 45.5 percent of patients attending Primary health center were having probable psychological distress (SRQ score > 6; mean score among this group was 8.9). - Score obtained on SRQ correlated well with WHO DAS. Higher SRQ scores were associated with more disability. - 80 percent had mental health problems. - The WHO-DAS -2 showed disability is higher among those who had a higher SRQ score. - Family burden higher in all domains for those having permanent disabilities.
Vankar ,Mehta 2004 **PTSD among teachers:** - Frequency , clinical manifestations and risk factors associated with post-traumatic stress among teachers in affected area (Kutch) , 6-8 months following the disaster (n=507). - 17 item PTSD Checklist (PCL-Civilian Version) to screen for PTSD used. **PTSD among adolescents** - Prevalence and clinical manifestations of PTSD in high school adolescent boys exposed to earthquake (n= 126). - The 20 item Posttraumatic Stress Disorder Reaction Index used in classroom settings.	- Age range of teachers: 20-58 years; Mean 34.2 (SD 10.2). - 51.6 percent men, 83.6 percent currently married. - Of 507 teachers screened, 171 (33.6 percent) met criteria for PTSD. - Significant risk factors: Female (40 percent women compared to 27.8 percent men (p=0.0031) , presence of pre-disaster stress, death of a child in school. - 25(19.8 percent) adolescents had features of clinically significant PTSD - 1 in 5 experienced PTSD symptoms. - Common manifestations: impaired concentration, easy startle, avoidance of trauma reminders, survivor guilt.
Desai et al 2001 - Study done jointly by IHBAS and ICMR. - Rapid assessment lasting 2 weeks of a broad range of psychological experiences, emotional states and behavioural patterns and of mental health service needs of different individuals and groups, done 4-5 weeks following the disaster.	- Transient psychological disturbance occurs in 70 percent-80 percent of the population. - Moderate to severe disturbances, subsyndromal psychiatric problems and acute stress-related disorders occur in 30 percent-50 percent of population and can benefit from intervention by the general health care providers and relief workers. - Diagnosable psychiatric disorders, mostly related to stress, which may begin to occur any time after 2-3 months of disaster and require specialized mental health care (5 percent to 15 percent).

Following these studies, it was felt that the mental health service needs of the majority of the population could be served by the community-level workers, teachers, and primary health care personnel. The importance of strengthening and supporting the socio-cultural coping mechanisms of the local communities was also recognized.

In an attempt to address the long-term mental health needs of the population, the Indian Red Cross Society, with technical assistance from the American Red Cross, worked with 10,000 individuals from the affected communities in Bhuj, which was among the worst affected cities. Specific focus was given to 340 orphaned children, widowed women, 200 adolescents, and about 200 elderly of both sexes. The targeted 10 schools in Bhuj city, children in the age group of 5–12 years and teachers, were also part of the program (Prewitt-Diaz et al 2004).

The Gujarat riots in early 2002 were among the worst episodes in the internal conflicts of the country since independence. About 97,162 people were said to be affected, out of which 1,243 lost their lives, 3,583 were injured, and 179 were documented as missing. Houses and commercial establishments were destroyed resulting in mass destruction of livelihoods and displacement of people. In the immediate aftermath of the violence, there were at least 100,000 women, children, and men in the 103 relief camps in the capital city of Ahmadabad. The challenges in providing psychosocial care to prevent and minimize the negative impact of the violence experiences were unique. The unsettled living conditions and the lack of trained professionals were chief among the challenges.

This led to the development of a model to provide psychosocial care based on the resources of the community itself. Action Aid's relief and rehabilitation program with the riot survivors in Ahmadabad, known as "Aman Samudaya" (AS), had a component of providing psychosocial support and counseling to deal with loss, betrayal, and anger (Chachra, 2004). The backbones of AS were the Aman Pathiks (peace volunteers) or the community-level workers (CLW), who were drawn mainly from the affected communities.

The CLWs were a vital link between the affected population and other agencies outside the community. Volunteers from the community were recruited and trained for a short period in the essentials of psychosocial care. Following the initial training, the CLWs were supervised once a week to both help them to understand their experiences and to support them in their work.

CLWs provided psychosocial care to about 50 families each. Such visits were utilized for talking about the survivor's feelings and experiences, imparting health education, discussing health problems, engaging in paralegal work, motivating individuals to hold group meetings, and organizing educational activities. The three goals of the CLWs were to help people understand the changes that they were experiencing in their bodies and minds; to decrease the physical and emotional effects by listening, relaxation, externalization of interests and activities; and to support the rebuilding of their shattered lives in the areas of housing, work, health, and community. Specific training was given to deal with the psychosocial needs of individuals, children, and women who had been victims of violence as well (Chachra, 2004).

The Asian tsunami of 2004 had its impact on the eastern coast of India affecting the Andaman and Nicobar Islands and Tamil Nadu. It was reported that in 41 districts, nearly 10,000 people lost their lives and more than 600,000 were displaced.

Children were the most affected with many losing both parents to the disaster (Davidson, 2006). A team from NIMHANS went to the Andaman and Nicobar Islands during the early phase in January and February 2005. The activities comprised mental health consultation at camps, community sensitization, mental health services to the students and children, and the training of teachers and NGO personnel.

An initial assessment revealed that 5 to 8 percent of the disaster-affected people were suffering from significant mental health problems following the early phase of the disaster. The team cautioned that it expected psychiatric morbidity to rise to 25 to 30 percent after the early phase had passed. It also reported high resilience in the joint family system of tribal Nicobarese during the early phase of disaster (Math et al 2006).

Describing the response by two NGOs in Tamil Nadu, Vijaykumar et al (2006) reported that normalization was seen as an important first step following the disaster. Using a number of training materials, volunteers were trained to deal with the survivors' mental health needs. Regular follow up was conducted with the assistance of NGOs. Psychiatric clinics were held in severely affected areas and bolstered by permanent field staff that conducted house visits (Davidson 2006, Vijaykumar, 2006). It was been reported that following the acute phase of the disaster, the incidence of PTSD were slowly rising among those living in the coastal areas (Davidson , 2006).

Conclusions

The above-described events show India to be a disaster-prone country thus providing consistent opportunities for mental health professionals to redefine their paradigms of providing effective mental health care to disaster-affected populations.

The last 30 years have seen a shift of perspective from "mental illness" to "mental health care." This has meant that all those involved in providing mental health care have been more involved with the community. Interventions have thereby become psychosocial in their approach, using community resources and personnel. Although there has been an increasing acknowledgement of the need for mental health interventions, the actual translation of this sentiment is far from adequate. With scarce human resources to provide skilled care, training, community-level workers seems to be indicated as one of the most efficient ways of implementing psychosocial interventions.

Lessons learned to date suggest that though this approach is effective, however, programs suffer from not being able to commit for long term rehabilitation of survivors. There seem to be many challenges in strengthening disaster mental health policy at all levels of disaster management and in providing psychosocial support at all stages of disaster response. Dealing with these challenges would ensure that psychosocial support, following disasters, would be a norm and not an exception in the country.

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The Kumbakonam School Fire Tragedy: A Disaster Mental Health Response by the Indian Red Cross Society and American Red Cross

Chapter 11

by Anjana Dayal

Introduction

The Kumbakonam school fire tragedy of July 2003 was one of the worst human-caused disasters of the decade. Ninety-three children died as a result of a fire in an elementary school in Kumbakonam, which is in the Tanjabur District of Tamil Nadu. The cause of the fire was accidental, but the children's deaths were a result of teachers' actions and a lack of disaster preparedness.

Responding to the Fire

At the time of the fire, the American Red Cross (ARC) was conducting a retreat in Nimrana Fort. Among the participants were members of a rapid response team from ARC and the Indian Red Cross (IRCS) personnel from Gujarat and Orissa. ARC offered to send the team to Kumbakonam as well as consider the possibility of a long-term program to alleviate the disaster-related stress as well as to train a cadre of volunteers and paid staff in disaster mental health techniques.

At the beginning of August, the Honorary Secretary of the Indian Red Cross made a personal visit to assess the damage, and on August 20, 2003 a combined team of ARC/IRCS personnel was deployed. The team was composed of an American Red Cross senior responder and IRCS members from Bhuj who were in training to become crisis intervention specialists. While the American Red Cross lead remained in Kumbakonam for a period five months, the IRCS crisis intervention staff rotated every three weeks to provide maximum exposure to a disaster response to these personnel.

By the end of November, a group of 21 local volunteers were trained in assessment, psychological first aid, and community and school-based psychological interventions. The Kumbakonam sub-branch of the IRCS had been developed and a group of 30 educators had been trained to continue teacher training on methods of recognizing and addressing the children's psychological and social needs. In addition, the communities had organized themselves and began to develop a disaster response plan.

This paper addresses the techniques utilized to engage the survivors, communities, Red Cross volunteers, schools and teachers in an organized response to the fire that would alleviate the community members' stress and emotional feelings.

Assessment Process

The rapid assessment process consisted of a community visit to gather basic demographic data from the surviving families. In addition, three quantitative techniques were utilized during the four months of the intervention (Dalton, Elias, and Wandersman, 2001): (1) participant observation, (2) interviewing, and (3) focused groups.

Participant observation involves careful, detailed observation, with written notes and conceptual and contextual interpretation. The PSP volunteers became part of the community, gained the community members' trust, and were able to learn insider knowledge of the survivors, their families, and communal networks. By minimizing the distance from the community, the volunteers hoped to understand the complexity of the recovery from the traumatic event of the fire and the coping mechanism used by the survivors to move ahead. In many ways this method is similar to a clinical case study (et al. p. 92).

Interviewing was open ended and unstructured, permitting the survivors to share their distress in their own words. This process allowed both the volunteer and the family to establish a strong personal relationship and provided contextual understanding of the distress caused by the fire and gave insight into the ways the family and community cope with surviving the fire (et al. p. 95).

Focus groups were held one week after the individual interventions have been initiated. The purpose of this technique was to begin to generate a series of psychosocial interventions for all the community groups. Multiple focus group discussions were held in each community and with teachers and children in the target schools. These groups generated information that was rich in understanding of the needs, wants, and strategies necessary for the community to recover and move ahead

Results

The following sections presents the comments of a random sample of survivors who participated in the Department of Mental Health's program after the school fire.

First child: (M Kartika is 10 years old and studying in the fifth standard.)

I was in the classroom at the second floor when I see fire from the window. I told teacher about that and tried to run away, the teacher didn't allow me at first, then after a minute she allowed me, and I ran out of the stair case at ground floor. Suddenly I realized that my younger brother, Vijay, was not with me, so I went back to third floor. I saw the door was locked and I came back down and I saw my second younger brother, I took him out of the school. I saw my uncle on the road and asked him to save Vijay. He (my uncle) came with me, we tried to search him (Vijay) all around. We also search in the water tank where some children had jumped in to escape, but he was nowhere. Then my uncle send me home, where I met my other uncle and explained the about the fire. He ran with me to school, and we tried again to search Vijay. My uncle took many burnt children, out from the school but we did not see Vijay. We went to the hospital two times, but Vijay was not there At 3.30 pm we identified his dead body in the hospital. Every Friday I dreams fire, I can see the whole school is burning again. I am so scared; I do not eat my food now regularly I do not like eating food.

First Family: (The family lost their daughter, Divya, who was 8 years old and was studying in the third standard.)

The father first welcomed us into house. He said that he had one and only child. He was at farm when he got a telephone call about the school fire. He got on his bike and ran to the school. He could not find out Divya, so he went to the Hospital, where he identified her body from her ornaments and school belt at 2.30pm. He got her body from hospital authority at 7.00pm. While talking about her age, he suddenly cried, and said that today is her birthday. After two three minutes he was able to talk again. When asked about the plan her birthday, he said, "She is not with us, how can we celebrate?" When asked how they celebrated last year, he said that he had a party "where all children from neighborhood came to the house; we cut a chocolate cake, and everyone danced."

His wife was weeping but was not able to cry. She said that her child was very brilliant in school. The girl was send to the school because the village school was in the Tamil language; they wanted their child to study in English medium.

Divya's grand father was sitting on a side to Divya's mother. The old man started to cry very heavily and expressing how he cared for Divya. Daily he was going to drop and pick up her from the school. She used to play with him every day; she liked to drink VIVA (a chocolate powder) with milk. "I used to buy that regularly," he said. "Last month I bought a different powder for her and she refused to take that with milk; she was not happy with me, but I have bought a new packet and I am preparing for her every day. On the day of fire she put on her socks and shoes first time by her self without her mother's help and asked her mother to put only two pieces of Idly (local food) in the tiffin because today was a half day and she would come back earlier".

2nd family: (Three children were studying in the school; one had escaped from the fire and two had died.}

Father said, "I thought about and tried to commit suicide, but neighbors explained me that my one daughter is still alive and I should live for her." Still he is not going to work and not eating regularly. "I had identified my dead children from their clothes and jewels. My children were lying down on the floor and got burnt because their front was not burnt more. My daughter has to sleep alone and feared for fire and couldn't sleep all night."

The mother had lost her son. She had a dream that the son was asking for bread as per daily routine, and she had not given it to him. "Then he was angry on me so I prepared and in anger had thrown it to him. I don't know why I have done like this to him." Both parents are remembering past experiences.

Third family: (The daughter, Kaushalya, was burnt and was shifted to hospital).

At that time my parents thought that I am also at home because two sisters are safe. In the afternoon they came to know that I was in hospital and they came to be with me. She can't move her fingers freely because of burn. She is going to doctor regularly. She is not fit to go to school but wants to go to school with her two sisters are going to school now.

Fourth Family: (Several volunteers went to Sarinya's house to see the family after she died in the school fire.)

We met her father and her grandmother. Her father said that she had been studying on the ground floor and was safe, but the teacher sent her upstairs and locked the door. Her bag and books are intact as her class was downstairs. They told us that Sarinya had beautiful handwriting and was good dancer. They showed photos of her and the prizes she had won. They had collected all her toys, books, dresses and her ornaments at one place under her picture; they have a kept a cup full of water there, if she would feel thirsty. The father was showing all her photographs and was very interesting getting it all shot in the camera. He was not letting his mother talk about her feelings; He was again and again interfering her when she was talking.

Saraniya used to go to the temple everyday and, because she was killed in the tragedy, now nobody in her house believes in God anymore. Grandmother was crying and at times she was talking to Saraniya's photograph.

Sarvan, a school child who survived.

I was in the classroom, seen the fire and every student was running around to get out from the school but the door was locked I was very confused what to do so I went back to my class room and set under a bench. Everyone was shouting and crying then I fainted and someone took me out of that place. I don't know who was that. He said that my mom and dad are in Singapore and I am staying with my aunty and she do not allow me to go out and play with other children so I do not have any friends after school in evening time. Still I am getting the dreams at the night and I'm scared to be alone."

The following table categorizes the comments made by respondents--teachers, parents, and children during the assessment phase.

Table 1: Table for belief systems, organizational pattern and communication processes

Belief Systems	Organizational Pattern	Communication Processes
Making meaning of adversity	Flexibility	Clarity
Positive Outlook	Connectedness	Open emotional expression
Transcendence and spirituality	Social and economic resources	Collaborative problem solving

The responses offered by the community during the focus groups' assessment activities informed the development of the psychosocial program. The American Red Cross PSP personnel provided the following technical assistance during the four-month intervention period:

1. They sensitized all segments of the community about the need for psychological support for the survivors of the Sri Krishana school fire accident.

2. They provided 18 volunteers with capacity building activities and assisted the communities of Kurrupur, Asoor, Prumbandi, and Old Pallakarai in organizing themselves for a period of the four months' Intervention.

3. Three schools (1)Saraswati Primary Patsala, (2) Banadurai Primary School, and (3) Nattham School's teachers and volunteers were given capacity building training, and each classroom received a school chest with sufficient materials for one year.

Community and School Interventions

In the immediate aftermath of the fire, the basic response was to identify the bodies, proceed with funeral rites, and then begin to deal with the issues of loss. For many families, they suffered not only the loss of a child or children but also material losses from expenses incurred in medical treatment and burials. Gurwhich, Sitterle, Young, and Pfefferbaum (2002) suggest that the initial psychosocial response to an emergency is to focus on meeting the basic needs of the survivors which, in this case, was shelter, food, and physical health.

The ARC psychosocial support team proposed simple practices for families coping with loss. One example was encouraging Divya's mother to resume her daily routine. In following up on this recommendation, the team members talked to the mother again and inquired about the food she was preparing. Her father-in-law said "She don't cook after the event; her mother cooks for us every day." The PSP volunteer asked the mother what Divya's favorite food was, and the mother said, "She used to like 'Maggie-noodles' so frequently. I used to prepare Maggie for her."

The PSP team wanted to help the mother start cooking again and told her that if she and the family approved, they wanted to celebrate Divya's birthday with them. If she would arrange for preparing and eating Maggie noodles in the afternoon, the whole PSP team would come to their house and celebrate Divya's birthday with the family. The mother was happy and said, "I will cook for you." All relatives came to help prepare for the celebration. The team met with Divya's mother's mom and dad who had a very close relationship with their daughter. The team talked with both of them for a long time while Divya's mother was preparing Maggie noodles, assisted by some of the PSP volunteers. Everyone had lunch together.

The family reminisced about Divya, and her grandfather said, "On Divya's last birthday I had presented her this cycle and she was driving it every evening in front of me." Divya's father showed Divya's dance video and everyone prayed for Divya's soul together. The team members left the home calmly without talking further, respecting the traditions of the culture.

Moving Forward with Community Support

It is important as the survivors begin to move on that activities are planned that will permit the survivors to recover their inner resources (Parsons, 2002) and enhance the strengths of their community networks (Kaniasty and Norris, 1995). Recovery after a disaster takes the form of many little steps, including interacting with others who at times cry with the individual and at other times give support.. Survivors should be encouraged to perform daily activities as they recover from their sorrow. It is very difficult for a father or mother to get over the death of a child but by talking and crying with supportive listeners, they can begin to cope with this tragic loss. Supporting the survivors by listening to them and letting them cry is a part of having their feelings accepted as a normal reaction to an abnormal situation.

Community Actions

Activities generated by the community itself are very valuable in helping the community with its recovery from the devastating fire. Divya's grandfather said that in their part of the village only Divya had died whereas in the other two partsof the village, five more children had died. He was considering organizing some program for them also. Amin,,one of the PSP volunteers, had explained to them that it is very good to organize such programs for affected families and community members. He also suggested some possible cultural and entertainment activities and told them, "It is your choice to organize any program in community's favor. If you need any help from us, we can support you to organize some community-based psychological support program."

Divya's grandfather is a council member on a three-village committee. The committee president and he subsequently organized a program for all affected families and all the community members. They encouraged all affected families to try to continue their daily activities as a way of gradually releasing their sorrow. They gave the affected famlies an example of Rajiv Gandhi, the past prime minister of India, who died in a bomb blast, devastating his family. His wife, after a period of deep mourning, emerged to become involved in politics and is leading the ruling party. This example was meant to show people that recovery, with effort, was possible. The council members requested that all community members support all affected families.

Supporting Community Networks

One of the most important natural networks in the community is the school. The PSP program attempted to mobilize social support networks as well as develop networks in the new school settings for the children.

Maintaining support for the children in the school and facilitating the establishment and strengthening of community networks is the kind of intervention that will protect the surviving children, their families, and other community members (McNally, Bryant, and Ehlers, 2003). The PSP program adapted the suggested activities set forth by SPHERE Project (2004), such as engaging adolescents and adults in re-organizing their community with cash-for-work activities, engaging traditional healers and respected community leaders in the community grieving activities, and using the language of distress expressed by the community to elicit participation in the development of their own PSP program (Raphael, 1996).

Information Dissemination

One of the challenges faced by the PSP team was to share timely, appropriate, and understandable information. To disseminate information, the team used flexible, mobile, and creative interventions. Some of these interventions include putting on talent shows with community members and using poetry, expressive writing, and story telling to help community members in dealing with the disaster's impact and in resuming normal activities.. Other activities included one-day health camps, which began with health screenings and ended with a community dinner and talent show. The PSP team's most important task was to assist survivors understand their feelings of distress and to cope with their losses. (Hanlon, 2003)

Summary

The Indian Red Cross Society PSP intervention has become a classic response utilized as a case study by the National Disaster Management Institute. This intervention provided many new lessons: (1) Moving ISRC PSP volunteers from other states for three weeks to assist the survivors with the community and school programs was challenging, but worthwhile; (2) Capacity building can effectively take place with the assistance of a wide variety of participants including Red Cross volunteers, teachers, and crisis intervention technicians, and (3) the IRCS enhanced its own capacity by using its own human resources to begin to go forward in the process of emotional reconstruction. Most importantly, this program helped people to move from victims to victors.

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A case study of Psychosocial Support programs in response to the 2004 Asia Tsunami

by Anjana Dayal

Introduction

This paper is divided into two parts. The first part discusses the American Red Cross (ARC) psychosocial response to the tsunami during the emergency phase. The second part presents a general overview of the development of the long-term intervention in Sri Lanka. The Sri Lanka psychosocial response is the largest and most complex of the three programs currently in operations as part of the tsunami response.

Background

One of the most powerful earthquakes in the planet hit the Asian continent with its epicenter at Ache Indonesia. Some of the tsunamis reached as far as 1,600 kilometers (91,000 miles) from the epicenter of the 9.0 magnitude quake, which was located about 160 kilometers (100 miles) off the coast of Indonesia's Sumatra Island at a depth of about 10 kilometers (6.2 miles). (www.lk.undp.org).

The Indian Ocean tsunami disaster resulted in one of the largest relief and rehabilitation operations ever launched by the Red Cross Red Crescent Movement. For the American Red Cross International Services, psychosocial support programs (PSP), a relatively new addition to its emergency response repertoire, became a program of great importance and assistance to the survivors of this terrible disaster. This paper presents and discusses the immediate response and the plans of long-term reconstruction of the PSP program. This applied intervention will change the nature of emergency responses in years to come.

Steps in formulating the PSP response to the tsunami

The American Red Cross PSP response was driven by a request from the International-Federation of Red Cross and Red Crescent Societies' (Federation) field assessment and coordination team (FACT) in the Republic of Maldives. The Federation realized that there were many people experiencing disaster-related distress and that the country did not have the human resources needed to alleviate this stress in schools or communities. In many of the islands the helpers were also survivors themselves. After consulting with the FACT members in the Maldives, ARC personnel in New Delhi wrote a concept paper that described the proposed PSP intervention as providing first-order capacity building activities to some 57 counselors and to equipping 328 teachers with the necessary tools to alleviate disaster-related stress of children as well implementing self-care activities.

The emergency phase in the Republic of Maldives

A two-person team consisting of a psychiatrist and a social worker went to the Republic of Maldives on January 3, 2005. The objective was to conduct a two-day psychological first aid course and to prepare personnel to go out to the affected atolls and give assistance. The ARC team helped build the counselors' skills to provide knowledge and also helped build the capacity of the Department of Mental Health (DMH) to implement community-based interventions. The Federation, the ARC PSP team, and the Ministry of Health of the Republic of Maldives studied the needs of DMH programs--focusing on community-based intervention models. They identified the urgent needs to train teachers, nurses, and representatives from health and education sectors. The first priority was to build the psychosocial capacity of the teachers; a second PSP team was requested from the ARC.

Table 1: Primary and secondary responsibilities for the Maldivian personnel trained in psychosocial first aid and sent to the affected atolls

Primary Responsibilities	Secondary Responsibilities
•Give support, care, and understanding to person exhiting signs of distress.	•Mobilize and advocate staying together by Strengthening community networks.
•Accept information and feelings of the persons.	•Keep the family groups together.
•Give information: •Determine what has happened and what will happen.	•Make sure that children are supported and kept active
•Provide the telephone for the counseling center.	•Help to facilitate and perform rituals.
•Help facilitate contact to other relatives.	•Support an on-the-scene visit later.
•Give clear information about the normal reactions to this abnormal situation.	•Support memorial time.
	•Ensure follow-up over time.

The second team, consisting of one psychologist and one community developer, departed New Delhi on January 10, 2005 with the objective of modifying a teacher manual and training six teachers in the Maldives to share the manual's contents with their peers. The team met for three days with the Maldivian teachers and developed three chapters that included some theory and a lot of practical experiences. Three teams of three persons, two Maldivian teachers, and a PSP staff member participated in a massive campaign to disseminate this information and build the psychosocial capacity of all teachers in the Republic of Maldives. During the reminder of January and for three weeks in February, the teams traveled to all the islands from the Indian Ocean to the Arabian Sea. At the end of this period, 328 teachers had participated in the capacity building sections. Each school received a school chest from ARC, consisting of school materials and games. When the schools opened, the teachers were able to respond effectively to the children's disaster-related stress.

By the third week of February a "Training of Trainers" workshop prepared a group of Maldivian professionals to take over the implementation of the psychosocial program and this aspect of the disaster response was handed over to the Republic of Maldives.

To date, the American Red Cross has provided funds for a PSP program to increase the Maldivans' capacity to attend to the psychosocial needs of the population in the event of future disasters. Psychosocial support, today, is a joint venture between the people of the Maldives and the ARC/PSP program.

The Emergency Phase in the Democratic Socialist Republic of Sri Lanka

Early conversations in the third week of January between ARC, SLRCS, the Federation, and other stakeholders opened the doors to the ARC PSP program to initiate operations in the southern and western provinces. It was agreed that the Danish Red Cross would continue to operate under the umbrella of the International Committee of the Red Cross (ICRC) in the north and east. In the third week of February, a team composed of a social worker and a psychologist came to Sri Lanka to conduct a detailed needs assessment in the southern and western provinces.

The team, based in Galle, began to analyze secondary sources from the region, train Sri Lankan Red Cross volunteers in psychological first aid and rapid needs assessment skills, visit schools and communities, and assist the Federation's emergency relief unit (ERU) to attend to the manifestations of distress during relief distributions. The team soon realized that many more persons were needed to conduct an in-depth assessment of the population's psychosocial needs.

By mid-March, a team of four PSP personnel was assigned to the Federation as staff-on-loan for a period of three months. The team's objective was to utilize a participatory approach to assess community and school needs, prioritize the psychosocial needs, and develop with the primary stakeholders a basic intervention that would be agreed upon by the target community or school. Once the assessment was completed, the staff developed concept papers and began to write a PSP proposal with the assistance of the Technical Assistance Unit of the International Services of the American Red Cross.

All ARC/PSP personnel were pulled from their assigned branches in the southern and western provinces for a period of two months until the proposal was evaluated and funding secured. This gap in service had detrimental effects on the primary stakeholders. When the long-term personnel returned to the branches in August, they were met with frustration, despair, and disbelief. It would take approximately the next three months to build the trust and support of the community to continue to organize them to take care of others psychologically. It was not until a year after the tsunami had passed that the SLRCS/ARC PSP were able to hire their first staff members in Sri Lanka.

Lessons Learned during the Emergency Phase

A lesson learned from this early weeks of the response was the inefficiency of placing the base of operations for the PSP tsunami response in New Delhi, when the actual work was taking place in the Republic of Maldives. All logistics were handled from New Delhi including recruitment, briefing, and communications, funding, assembling of school chests and transporting them via air to the Maldives. There were challenges in this cumbersome setup: (1) The government of India had not given ARC permission to operate outside of India; (2) The Indian Red Cross Society (IRCS) denied ARC permission to send goods and personnel outside of India; and (3) The ARC Delegation, with a focus on long-term programming, was not prepared to run disaster operations at the regional level. In the future, more attention should be given to modifying a country office into a Disaster Operations Center.

A second lesson learned was the response of the primary stakeholders once the ARC/PSP staff members were pulled out to develop concept papers and proposals. The transition between the rehabilitation phase and the early reconstruction phase resulted in a "second disaster" for the primary stakeholders. Mechanisms have to be developed that ensures the continuity of services from one phase of the disaster response to the next.

Onward to Long-term Development Programs: The Case of Sri Lanka

The tsunami of December 26, 2004, displaced almost one million people and killed more than 30,000 people in Sri Lanka. This was an unprecedented disaster in recent Sri Lankan history and posed many challenges for the reconstruction and rebuilding of people's lives. The social and psychological loss cannot be measured: the loss of loved ones, the shattered lives and lifestyles, and people left without identity, autonomy, and what psychologists term a "sense of place." The tsunami's impact was seen as far-reaching for the survivors' psychosocial health and well-being, and steps had to be taken to address the situation both immediately and over the long term.

The American Red Cross' PSP long-term psychosocial response was informed by a set of guidelines proposed by the Ministry of Health of Sri Lanka (January 10, 2005), the Consortium for Humanitarian Agencies (2005), the SPHERE Project (2004) as well as the Centre for National Operations (CNO) (2005). The CNO articulated three objectives for long-term reconstruction activities in psychosocial support: (1) Continue to support trainings and other psychosocial activities, (2) Develop further infrastructure for psychosocial support in Sri Lanka, and (3) Help to procure funding for suitable organizations to carry out their work on health and well-being. Most recently the emergence of the Inter-Agency Standing Committee/Mental Health and Psychological Support (IASC/MHPSS) guidelines (2006) not only continue to inform the program but are providing a road map for long-term development.

The PSP proposal was submitted to the American Red Cross, the International Federation, and the Sri Lanka Red Cross. The Psychosocial Technical Committee approved the proposal. Positions were advertised, and hiring was completed by mid December 2005, almost one year after the tsunami. The first group of Sri Lanka Red Cross personnel participated in capacity-building activities at the beginning of January.

The psychosocial support program is based on five strategies: (1) using a community-based approach, (2) making sure that interventions are contextual and culturally and linguistically appropriate, (3) empowering affected people, (4) encouraging community participation, and (5) encouraging active involvement.

Community-based approach

Past experience has shown that when implementing psychological support programs, community-based approaches are best. Building on local resources, providing training, and upgrading local structures and institutions are critical to the success of a psychological support program. This approach allows trained volunteers to share their knowledge with fellow community members. Because the majority of emotions (e.g., distress and sorrow) do not require professional treatment, these local resources often become instrumental in providing successful relief. A much larger number of people can be helped by working with groups rather than individuals and focusing on strengthening networks in the community. In addition, involving the community with its knowledge, values, and practices makes a culturally appropriate response more likely.

Interventions are contextual, culturally, and linguistically appropriate

The international arena where most ARC/PSP programs are implemented presents the challenge of diverse languages, cultures, and religious beliefs that are not frequently understood by thee outsider and is more of a hindrance than help during the immediate aftermath of an adverse event. Culture exercises a great influence the way in which people view the world. Building the capacity of community volunteers ensures inside knowledge of the local culture and utilizes their ability to provide culturally appropriate assistance to the affected population. Trained personnel from the disaster-affected community can react immediately in times of crisis and can assist with the provision of longer-term support to the survivors. They have easy access to, and the confidence of, the disaster survivors.

Empowerment

Accepting help may be the beginning step as part of the positive process and may solve a crisis for the affected individual. However, to the survivor, it may also emphasize inability and dependency, leading to bitterness or anger about being a victim in the eyes of others. The ARC PSP program is aware of the fact that high-quality psychosocial assistance is based on helping others to regain self-respect and autonomy. It puts the emphasis on the abilities and strengths of recipients more than on their problems and weaknesses. A high degree of community participation is generally accepted as an effective way to encourage empowerment of the people (International Federation of Red Cross and Red Crescent Societies, 2003).

Community Participation

Basing projects on ideas developed by concerned people themselves will promote empowerment and local ownership and help facilitate and consolidate a long-term capacity for problem solving. Through participation, people gain an increase in control over their lives as well as over the life of the community. Participation in collective decision making about their needs, as well as in the development and implementation of strategies, is based on their collective strength to meet those needs.

Active Involvement

The ARC PSP focuses on individual strengths and provides spaces so that community members can enhance their resilience by building on existing resources, coping mechanisms and resiliencies. The objectives of the interventions then becomes: (1) identifying and strengthening internal coping mechanisms, (2) fostering active involvement of people in community mapping and identifying problems, and resources, and (3) recognizing people's skills and competence

Self-help actions and strategies adopted by the affected populations themselves are a key to their successful recovery. Crucial in the planning of interventions is to listen to the communities' language of distress and to identify the community activities to help alleviate such distress. In major adverse events, community and family support structures may have broken, and they will have to be rebuilt. The focus of the PSP program is on people's positive efforts to deal with and come to terms with their experiences.

At this writing, six months have passed since the beginning of the program. There is more than one hundred SLRCS psychosocial staff in seven sites, supported by four delegates in all major communities in the southern and western provinces. To date, the PSP program has provided direct services to 46,751 persons in the service area.

The program is currently focusing on four programmatic areas. First, there are capacity- building activities at several levels. All SLRCS project staff received capacity building at the outset of their contracts. To date there are 76 SLRCS personnel trained as crisis intervention specialists. Teachers and community facilitators are participating in staff development activities. To date 91 teachers and 290 community facilitators have completed their basic 36-hour capacity building. Thirty one pre-service teachers are receiving a one-week course at the Ruhenu Teacher Training College, which brings the total of pre-service teachers trained to 152. Operational training on PSP and psychological first aid for volunteers and Chapter personnel has taken place in all seven districts. Seventeen master trainers received instruction in a one-week course on community based psychosocial support by an external expert.

In addition, the PSP program has two materials development centers, one in Kalutara and the other in Matara. Both Material Development Centers are working to produce trifolds, posters, manuals and story books that are culturally, linguistically, and contextually appropriate. These centers are filling a gap by providing appropriate psychosocial materials in the Sinhalese language and culture.

The PSP program is actively engaged in 58 communities in the geographical area for which the programs is responsible. Sixty seven resilience activities (including sport activities, cultural events, and network-enhancing activities and community cleanups) have been implemented, and six community centers have been re-established. In the six months of the program, four resilience projects have been developed. These activities are somewhat complicated in that they require the community to engage in mapping exercises, identification of existing risks factors, planning, developing, and evaluating a community project.

There are 51 schools that form part of the PSP activities in the seven districts. To date, activities such as school mapping, painting of chairs, creative and expressive activities, school kits distribution, mural and wall painting, and sport events have taken place. A total of 28,556 children, teachers and parents have been directly exposed to and positively affected by the PSP program.

The PSP program has established formal relations with the Ministry of Education and the Ministry of Social Services and Welfare. These relationships have led to participating in committees, conducting capacity building activities, planning joint activities, and preparing a crisis intervention professional program of study. These interactions with the Government of Sri Lanka will help ensure the program's long-term sustainability.

Challenges and lessons learned

Psychosocial support is a relatively new concept in the repertoire of immediate disaster response for the Movement partners. The initial reaction from the Federation and others is an acceptance that PSP should be part of the immediate response. The evidence and best practices are inconclusive about the effectiveness of PSP during the reconstruction phase.

Language becomes the way in which survivors express distress and assign an emotional value to the communication. PSP personnel must understand the context of the overall community's mode of expression. Materials development must be contextual. It is not sufficient that the materials are translated to the target language. A local person must then be asked to assess the materials and to make the content (language and pictures) fit into the local society and culture.

Many people utilize traditional healers and other respected members of the community. It is important to develop the capacity of the traditional healers and others so that they can provide psychological first aid and refer the affected member of the community to other sources as needed.

Evaluation PSP programs during the Immediate Tsunami Response

The Federation commissioned a study on the effectiveness of its interventions and those of the local Red Cross and participating national societies (PNSs) during the immediate response and rehabilitation phase. Many findings by this study suggested that the response of the Red Cross Movement had been less than effective. However, one of the key findings was the valuable role of psychosocial support during the emergency phase as well as the reconstruction phase of the tsunami. In Sri Lanka, Indonesia, and the Maldives, psychosocial work carried out by the PNSs is playing a crucial role in the recovery process, addressing the massive psychosocial impact of the disaster-affected people living in shelters and temporary accommodations (p. 21). The report further indicates "in Maldives, a PNS-run psychosocial program (American Red Cross) continues to play a critical role in providing support to the communities" (p. 22).

The report suggests that the Red Cross partners exhibited an "obsessive preoccupation in Sri Lanka with adherence to bureaucratic procedures that has led to near-total disengagement with the affected communities." The report once again commends the PSP interventions. "Only in sectors like psychosocial support, [is]there a continuing engagement with the communities." (p. 36). In Sri Lanka, the American Red Cross PSP program seems to be experiencing success in achieving community ownership of the projects resulting from community-based planning, design, and implementation.

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Section
IV

Planning, Implementing, Monitoring & Evaluation of Psychological Support Programs

Ethnography: A Tool for identifying community protective factors and activities that foster psychosocial competence

By Dr. Joseph O. Prewitt Diaz

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Chapter 13

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Introduction

During the last ten years more than 100 Red Cross National Societies have taken on the challenge of developing a psychosocial support program to prepare communities to face a crisis, emergency, or a disaster and maintain a sense of psychological balance among survivors. The program is oriented to provide psychosocial support during the acute phase of a crisis, emergency, or disaster during the rehabilitation and reconstruction phases of a stressful life event.

To determine the effectiveness of the program, funding agencies have requested that the Red Cross National Societies develop ways in which to identify the protective factors in the target communities and determine the activities that the community deems proper to achieve psychosocial well-being. The societies then develop programs, monitor the ongoing progress of the program, and conduct an evaluation process to draw lessons from the interventions.

The tool that will be used to seek information from the target communities will be qualitative in nature and will report the stories shared by the survivors about achieving psychosocial well-being.

The American Red Cross has developed a tool that provides for qualitative quarterly reporting, based on detailed implementation plans. This tool provides a way to utilize the community in identifying lessons to be learned or the possibility of identifying activities that we should learn. One way in which a systematic record can be documented is through ethnography. Ethnography is a widely received qualitative method of recording history as it is taking place.

Ethnography as a Scientific Method

Ethnography is a scientific method of recording people's beliefs, behavior, and culture directly from life. It is a highly intimate process. Werner and Schoepfle (1987) describe ethnography as a full or partial description of the activities of a group. In disasters, ethnography is used as a tool to study the cultural patterns of survivors and examine how resilience behaviors have helped the survivor to bounce back. By identifying activities that enhance the psychosocial well-being of the community members, this tool helps communities to prepare for the future in planning disaster response and preparedness programs.

Ethnographers become a part of the communities they study. They spend weeks getting to know people and months observing behavior, asking questions, and obtaining in-depth information about various subjects. Ethnographers spend time recording direct naturalistic observations of people's behavior. They spend even more time interviewing "key informants," people in the community who are knowledgeable about the group's customs, habits and work. They learn what the community members consider to be appropriate behavior and the proper way to do important tasks.

Ethnographers ask in-depth questions over a significant length of time to be confident that the answers they are receiving are true and not merely what those being interviewed think they want to hear. One of the objectives of ethnographic research is to learn so much about the lifestyles of the people under study that ethnographers can participate in community events without making mistakes (Goodenough, 1980). In India the American Red Cross has received approval from the Ethics and Research Board of the Government of India to conduct ethnographic field studies in Gujarat and Orissa.

The Structure of the American Red Cross Mental Health and Psychosocial Support (MHPSS) Program Systematic Assessment

The purpose of the psychosocial support program is to promote positive adaptation post-disaster and to assist target communities to identify protective factors and activities that will increase the psychosocial well-being.

The Mental health and Psychosocial Support (MHPSS) program has developed structured activities in target schools and communities that are conducted by trained teachers, Red Cross volunteers, and trained community facilitators. These activities consist of general psycho-educational and support-oriented activities designed to increase the understanding of the long-term consequences of loss, to normalize and validate stress-related experiences and reactions, and to provide skills that will enhance psychosocial well-being. These activities can take place in varied settings and are immediate, experiential, and simple.

The activities involve children, teachers, Red Cross volunteers, parents, community members, and government administrators. The interventions follow the SPHERE 2004, INEE and the latest IASC-MHPSS standards, 2005.

The Focused Ethnographies

The ethnographic data supporting the psychosocial support program was obtained through focused ethnography. The purpose of the focused ethnographic study is to identify protective factors and key variables that either support or impede the efforts to survive and foster psychosocial well-being. After providing the programmatic data on training materials and methods of service delivery by the local Red Cross, the ethnographers began a focused ethnography of the beliefs, behaviors, and attitudes in the target communities and schools.

This part of the ethnographic research included direct observation, interviews, and analysis of the behavior of Red Cross volunteers, community volunteers, teachers and crisis intervention specialists in the communities and schools during and after a crisis intervention activity.

After learning what the Red Cross volunteers did during their capacity building activities, the ethnographers participated in simulations and actual responses and thus they actually served as assistants to the crisis intervention teams. The ethnographer became knowledgeable about Red Cross volunteers and crisis intervention personnel's lifestyles due to the number of questions they asked and the number of recorded observations they made.

The PSS field-focused ethnography, for the first time, conducted the necessary form of research to identify the community perceptions about their own well- being. The focused ethnography specifically looked at the (1) general conditions of the community, (2) parents and their relationship to children and to each other, (3) children and adolescents and how they see their world. They also determined what services were available to the community members. (See Appendix A.)

The ethnographic data provided the program planners and the IRCS with a view of key Red Cross volunteer issues from the perspective of the service providers and of the persons that received the services. This balanced approach was critical for a realistic view of the MHPSS program and for rational program development and implementation.

Location of the Ethnographies

The programmatic ethnography was conducted in nine villages and nine schools in Gujarat and Orissa. The IRCS- NHQ selected the participant villages and schools after consultation with the State Branches.

Field Work: Data-gathering Process

The three step data-gathering process included selection of location, subjects, and methods.

Step 1-Selection of Locations

FIELD WORK DATA GATHERING PROCEDURES

	WHEN	WHAT	HOW
STEP 1		Selection of Locations	Consultation with NHQ / Consultation with State Branch
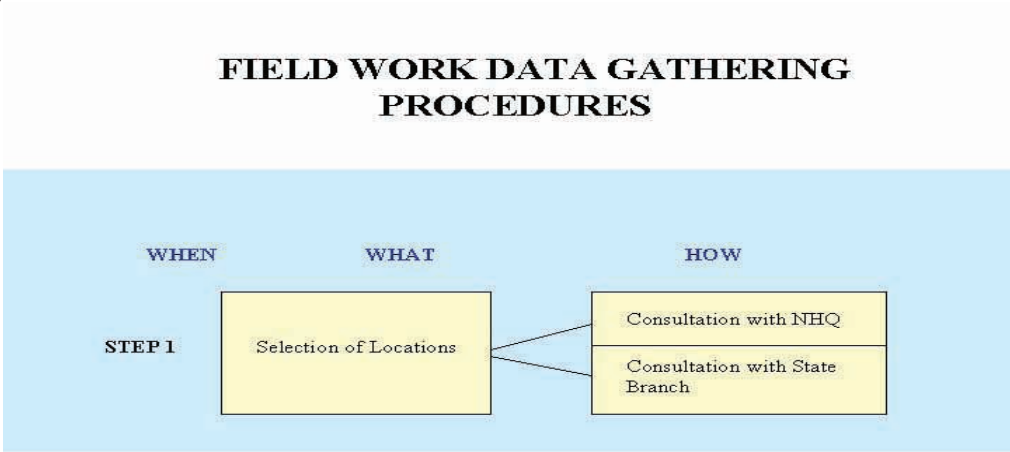
The ethnographers observed the interactions of Red Cross volunteers with the state officials, local school district personnel, and community volunteers, beneficiaries as well as teachers and students in their areas.
This phase of the project lasted for approximately one month in each target area and produced essential data on the types of community activities and resilience projects that existed, the models used for administrative organization, ideal profiles of administrators, norms or profiles of rules and regulations critical to the psychosocial support program, as well as an ideal profile of a Red Cross volunteer involved in psychosocial support programs in communities and schools.

Step 2-Selection of subjects

FIELD WORK DATA GATHERING PROCEDURES

STEP 2	Selection of subjects: -Gender -Age -Survivors status	Program Staff / Survivors / Red Cross Volunteers / Community Volunteers / Teachers
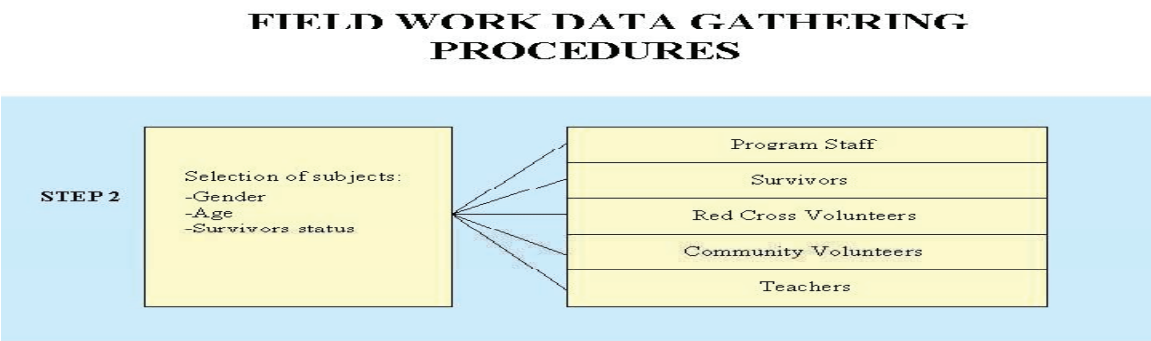
Following the review of existing records, the ethnographers spent six months of focused field experience with teachers, community facilitators, Red Cross volunteers and their families. These in-depth studies depended on the establishment of a high level of trust between the ethnographers and their informants.

Significant time was spent in Gujarat and Orissa. The first field sites for the focused ethnography were target schools and villages. These villages had substantial numbers of survivors who had to be relocated and a decision had to be made on the location of their new home. The ethnographers spent 12 weeks in Bhuj and Puri, and then shifted their studies to the villages along the coast, south of Puri.

In Gujarat the ethnographers went to villages and schools in Anjar, one of the worst affected area by the Gujarat earthquake, 2001.
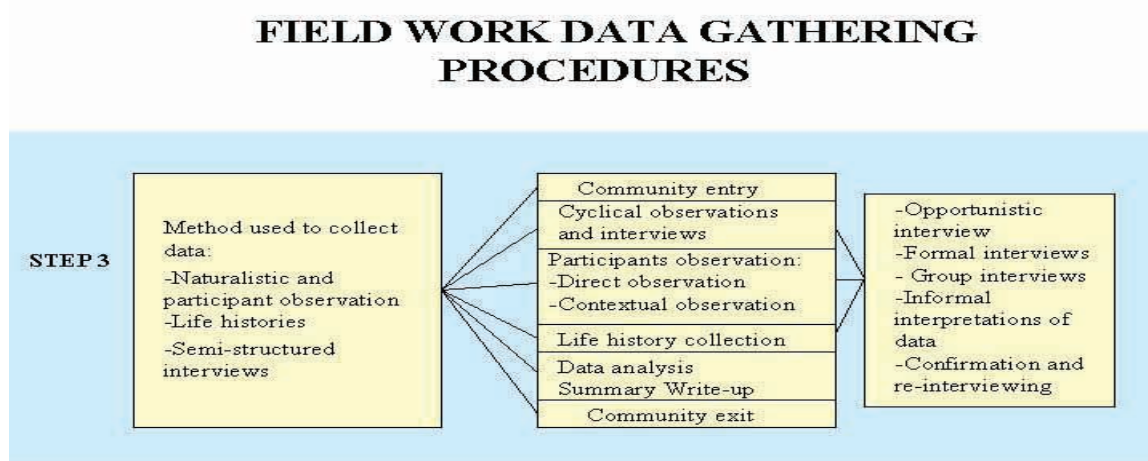
Step 3- Methods used to collect data

FIELD WORK DATA GATHERING PROCEDURES

Three classic ethnographic methods were used during the ethnographic fieldwork conducted for the MHPSS program: 1) ensuring naturalistic and participant observation, 2) conducting semi-structured/ opportunistic interviews, and 3) collecting life histories (Agar, 1987).

The *naturalistic and participant* observation phase included such diverse activities as spending days with Red Cross volunteers, community facilitators and teachers; living in community facilitators' households; participating in community training sessions; and attending meetings and resilience activities in all the villages in each participating state.

During and after each of these activities, more than 3,000 hours of observations of peoples' lives were recorded. This form of participant observation provided the environmental framework for understanding the relationships between community facilitators, communities, and the government institutions while developing the crisis response plans.

In semi-structured interviews a specific set of open-ended questions are asked, but the interviewer also uses volunteered information to ask additional questions that are generated by the interview itself. The semi-structured interview phase was interwoven with the participant observation. During the semi-structured interview phase of the project, formal, prearranged interviews with and about family members were recorded and transcribed. These semi-structured interviews with Red Cross volunteers and community facilitators in their homes, on the road, and at work produced hundreds of hours of answers to important questions.

The opportunistic interviews that were not pre-arranged but focused on one of the topics under study were also recorded. The opportunistic interview not only provides answers to the questions that ethnographers believe to be important, it also uncovers issues that the informants believe to be important. Since the purpose of the current evaluation was to discover how the protective factors and resilience markers have had an impact on the target villages and schools, semi-structured interviews avoided the problem typical of social science survey research: getting accurate answers to the wrong questions. Ethnographers were still able to get the answers to questions that the psychosocial delegate felt were important.

Collecting life histories was the third major component of the research effort. Life histories are descriptions, in the key informants' own words, of the everyday processes and major events in the lives of people in a community. The numerous life histories collected by the psychosocial support program provided a critical framework for understanding the lifestyles and the life events that are important to different groups in the community.

The total ethnographic data obtained was the result of more than 3,000 hours of participant observation, semi-structured interviews, and life histories. The ethnographers lived with families for weeks at a time observing family interactions and recording most of what they saw and heard. They set up interviews, conducted training sessions, and participated in community assessments. They also attended meetings with emergency management personnel as they conducted the risk assessment and prepared their school crisis response plan, in the schools, the villages, and at home.

Stages of the Ethnographic Research

Typically, ethnographic research has five stages: (1) entry into the community; (2) initial observations and interviews; (3) information review and confirmation; (4) increasingly intensive and focused interviews on selected topics; and (5) exit from the community

In all cases these are cyclical, not linear processes. At any given time, the ethnographer is not only collecting new information but also reviewing field notes and going back to key informants to confirm, modify, or reject the interpretations. Even the process of entering and leaving is not a linear one. Ethnographers continually meet potential informants, and for each new person there is a repetitive process of explaining who you are, what you are doing, and what will happen to the information you are collecting. Leaving a community is not simple either.

The very nature of ethnography causes the researchers to bond with the people they are studying. These bonds, like all friendships, are not easily severed. Most ethnographers develop life-long relationships with key informants.

The following summarizes the processes used by the ethnographers to collect data for the program.

1. Community Entry

One challenge that ethnographers were trained to solve is explaining to people what he or she is doing in the community, why he or she is collecting information, and what he or she is going to do with the information. In this psychosocial support program activity, the ethnographers identified a community facilitator who could introduce the ethnographer to a small circle of friends and acquaintances. Since the psychosocial support program had already established contacts with individuals in the communities, these networks were used for initial interviews, and for observation.

Since everyone knew many other people, the ethnographers worked their way through social groups, finding more and more people to talk to and being allowed into more and more homes and work sites. This process took considerable time since virtually no one was willing to talk in depth about his or her disaster reactions and subsequent experiences on the first visit. Time, familiarity, and "going with the flow" were needed until enough rapport was established and the people were comfortable and at ease enough so that the ethnographer could take out a notebook, turn on a tape recorder, or videotape the interview.

Once the primary barriers were down, the ethnographer was able to return and gather much more information from the informants. The ethnographer was trusted, and people were excited that their views were recorded and heard by the people who support, create, and run the psychosocial support programs. This is a common reaction to ethnography. People are often pleased that an ethnographer cares enough to ask them about their lives. This reaction often changes their reaction from indifference or hostility to openness and cooperation. Once trust is established, information pours out.

When community leaders were convinced that the ethnography could be beneficial, they would often take on the role of explaining why the researcher was present and why it would be a good idea for people to cooperate. While it often took time for people to become comfortable enough to talk honestly, the general reception of the ethnographers was positive.

2. Cyclical Observations and Interviews

After contacts had been established and confidence in the ethnographers was developed, the data rapidly expanded. The most intense cyclical part of the evaluation had begun. The ethnographers gathered initial data, asked for confirmation, discovered areas that needed to be visited in depth, and began the intensive data review process.

a.Naturalistic participant observation
Participant observation is the foundation of ethnographic research (Bernard, 1988). In this project, each ethnographer spent hundreds of hours directly observing what the community members did and said during their daily lives, while they worked, and when they interacted with other members of society. These observations were recorded in detail as a part of the ethnographer's field notes the raw data recorded directly during the research process. The notes were then reviewed and analyzed for regular patterns as a part of the total ethnographic assessment.

Ethnographers record two types of observations in their field notes. One is contextual observation. The other is direct observation and recording of key behavior. Contextual observations explain either the physical or the social context of any conversation or interview. Without this type of anchoring observation, it would be much easier to take what the Red Cross volunteers and community facilitators say out of context. The second form of observation was a recording of either physical surroundings (such as the vivid description of housing) the community, and people at risk, or recording observations of people's behavior.

b.Interviews

Ethnographic researchers spend much time "hanging out" in situations where they are able to observe important behavior and interview people doing the things about which the ethnographer is interested in learning. They also set up formal interview sessions with people whom they know well enough to be confident that rich, accurate information will be provided. Two types of interviewing, opportunistic interviews and formal interviews, form the basis for the data collected in the ethnography.

c.Opportunistic interviews

In some types of research, accidental encounters with people who could provide vital information are not considered part of the data collection process. However, in ethnographic research, these encounters are recorded. The purpose is to build up as broad and deep a base of descriptive information as possible, to make sure that no leads to important areas of information are lost, and to help confirm that the themes that the ethnographer describes are as accurate and representative as possible.

3.Formal interviews and key informants

In-depth interviews are the core of ethnographic research. Project ethnographers arrived at their first field site with questions and areas for recorded observations that had been created by the project advisory board members, project staff and the ethnography group. They pursue these questions while remaining open to issues of importance to their informants, issues that might have been overlooked by the experts.

It is common for ethnographers to record dozens of conversations with the same informants. Some are broad explorations of the areas of culture under study. Others are confirmations or re-examinations of earlier statements. The latter serve to clarify or check accuracy and validity of information. Interviews with key informants span months as more and more information is collected, recorded, and confirmed.

Ethnographers commonly conduct semi-structured rather than unstructured or fully structured interviews. Although the ethnographer has a series of pre-written questions to be asked, the questions are open-ended. Open-ended questions allow informants maximum leeway in the topic of discussion. Moreover, the ethnographer has the option of asking additional questions during the interview that help clarify answers.

Under certain circumstances, project ethnographers allowed the interviews to go off in unexpected directions to explore interesting or promising answers to their questions. The answers ethnographers received from initial questions sometimes indicated they were asking the wrong question, or asking the right question in the wrong way. In some cases, informants simply could not answer the question as it was asked; and in other cases, they provided the interviewers with a better question.

Many interviews were recorded verbatim using a tape recorder. Others were recorded by jotting down notes during the interview. Still others were written by the ethnographer after the interview. The reasons for these different approaches are simple. People willing to give information are sometimes unwilling to do so with a tape recorder running or when someone is taking notes. In such cases, notes jotted down after the fact are better than losing the information altogether. The ideal way is to get the most accurate verbatim recording possible, but other forms of data collection provide useful information as well. Both types of interviews may occur with the same informant and are useful for double-checking information collected from others or for capturing additional details.

Comparison of these types of interviews reveals differences in informants. Some provide wonderful detail. Others must be guided. Some informants require probing questions for the ethnographer to find out what they are really saying and what the information means.

Ethnographic interviews allow people to make their own uninterrupted statements; they also allow active intervention on the part of the interviewer to extract the basic information needed.

4. Group Interviews

Ethnographers often use a variation of the semiformal interview, the group interview. Many ethnographic interviews are conducted in natural settings (people's homes, the neighborhood, and at school). The ethnographer is rarely alone with an informant; so many interviews turn into group interviews, whether or not they start out that way. Group interviews allow informants to express themselves in a comfortable setting. They also enable ethnographers to explore diversity of opinion, as well as consensus. People interject their views into the interview, even though they are not the primary informant. If they agree with the informant, they provide additional confirmation about the subject. If they disagree, they provide important information about the intercultural diversity surrounding that subject.

The answers show the complexity and depth of issues that villages, schools, and Red Cross volunteers face, as well as the assumptions that they take into account in making key life decisions. Sometimes, it takes several interviews to clarify a simple subject.

5. Information interpretations of the data

One important interview technique ethnographer's use is to have informants interpret their own behavior, ideals, and beliefs, or the behavior of other people.

6.Confirmations and re-interviewing

Another crucial interview technique is to return to informants to re-ask important questions to confirm earlier statements. A characteristic of ethnographic interviews is the ability of the ethnographer to follow up on questions over a long period of time. Sometimes in the midst of the interview, the ethnographer misses something important, or later discovers that he or she should have asked for clarification.

Ethnographic interviewing is designed to overcome the weaknesses of one-time interviews. Field notes are read daily, and notes are made to return to an informant for further information as soon as possible (Goodenough, 1980).

a.Life History Collection

A life history is a record, in the informant's own words that recounts an important part of his or her life story. A complete life history is rare, because it takes many interviews and recounting of events on the part of informants as well as intensive analysis on the part of the ethnographer to ensure that all the key events in the informant's life have been recorded. Instead, most ethnographers collect focused life histories or histories of special events or narrowly defined areas of an informant's life.

Focused life history accounts are very valuable for two reasons: they reveal what events an informant thinks are crucial to his or her personal development, and they provide a context that helps in the interpretation of beliefs, attitudes, and current behavior. For example, the ethnographers collect life histories that give important insights into why migrants joined the migrant lifestyle and what events structured their migrations.

Life histories have historical events, but informants tend to jump forward and backward in time with confusing results if there are no follow-up interviews. Life histories often have many themes and information based on beliefs and attitudes interspersed in the historical account. This juxtaposition is very useful. During the analysis stage of the research, these data can be related to key events, themes, and processes in migrants' lives. These provide information that is especially useful in matching policy analysis and policy development to the reality of migrant life.

b.Data Analysis, Summary, and Write Up

One of the greatest strengths of ethnography is the identification of repetitive information that best describes the way most people think, believe, and behave. Once sufficient field data are collected, ethnographers search the data for themes, commonly held beliefs, similarities of behavior, and common ways of expressing ideas.

In ethnography, multiple examples of all-important findings from the study were scattered throughout the data. The process of data analysis required the ethnographers to identify themes and patterns as well as variations on them. When a theme became apparent, it was presented back to key informants for confirmation.

Ethnography offers the opportunity to discover shared cultural beliefs and ideas expressed in the words of a representative individual. A particular quote is a composite of dozens--even hundreds--of similar quotes.

Summary

The observations and interviews collected by the ethnographic field study covered a wide variety of topics.

After studying the answers and piecing together the observations from all of the States, three areas emerge that are critical to understanding the process of providing psychosocial support services to community facilitators, teachers, and Red Cross volunteers in the target communities and schools.(1)The recognition of protective behaviors that facilitated survival and positive adjustment, (2) the role of disseminating knowledge about psychological responses to a crisis and about helpful practices that facilitate behavior and attitude change (3) the benefits in engaging in preparedness activities in the community and schools to foster emotional growth and a sense of security.

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APPENDIX A

Psychosocial Checklist

Descriptor	Stimulus Question	Notes
General Conditions in the community		
	Families are living together.	
	Privacy in the shelter for the family and family members is available.	
	Community conducts activities to help children with difficulties.	
	The community can identify three strategies to deal with psychological distress.	
	The community has identified resilience factors that have helped them survive.	
	The community has a strategy to recover from the tsunami.	
	Social organization promotes social well-being through information, cultural and recreational activities.	
	Measures have been taken to improve the living conditions of children and their families.	
	There are persons in the community that provide regular activities for children (informal education, play and recreation).	

Parents		
	Parents are facing stress that is affecting their well-being and how they care for the children.	
	Parents want to participate in self-care activities.	
	Parents seek support for stressing difficulties.	
	Parents learn how to reduce the stress level in their children	
	Parents and children participate in stress reducing creative and expressive activities.	
Children		
	Children are provided with adequate nurture and care at home.	
	Children are provided with adequate nurture and care in school.	
	Culturally appropriate ways are used to promote expressive activities and play.	
	Culturally appropriate ways are used to promote creative activities.	
	Children who are alone are cared for in the community and school.	
Service		
	Children participate in development enhancing activities to re-establish a sense of place.	
	Social services are available for internally displaced persons.	
	Children experiencing psychological distress are identified and supported in formal and informal schooling.	
	Training and support to provide psychosocial support is provided to teachers and other school personnel.	
	Children and adolescents are taught methods of self-care.	

Measuring Resiliency in Two States in India: The Development of a Valid and Reliable Instrument

By Satyabrata Dash, Anjana Dayal, Rashmi N. Lakshminarayana

Introduction

Resiliency has been defined as the ability to spring back from and successfully adapt to adversity. Resilience is not a characteristic that happens by chance, it emerges in people who have worked hard to regain social and psychological competence and who have the cognitive skills and strengths to overcome challenges. Psychological resilience (Rutter, 1987) is the person's capacity to avoid a psychopathologic state despite difficult circumstances and to withstand stressors without manifesting psychological dysfunction such as persistent negative moods or mental illness.

Tedeshi, Park, Calhoun (1998) suggest that knowledge of an individual's and community's resilience and vulnerability before a disaster, as well as understanding the social and psychological responses to such events, enables the psychosocial personnel to promote resilient and healthy behaviors that sustain the social fabric of the community and facilitate recovery. The resilience theory explains the process by which some people are more likely to engage in health promoting activities in the schools that enhance psychological competence. Much of the research examines the interaction among factors in a young person's life that protect and nurture including conditions in the family, school, and community, which help young people make a positive adaptation after experiencing a disaster.

Understanding the community as a psychosocial entity permits the planners of long-term rehabilitation and sustainability programs to assist the community in identifying the factors that will enhance resilience and promote well being. It will allow the people to move beyond the loss and grief and resume normal activities.

There are interacting psychological and social factors that assist people to overcome adversity. Psychological factors include self-esteem and self-confidence, internal locus of control, and a sense of life purpose. Social factors include social supports from family, friends, teachers, and community.

These include a caring family that sets clear rules and standards, strong bonds with and attachment to the school community, and relationships with peers (Luthar, 2000; Kass, 1998; Blum & Reinhard, 1997; Luthar & Ziegler, 1991; Rutter, 1987). Bernard (1991) suggests the characteristics that are consistently exhibited by resilient young people are social competence, problem-solving skills, autonomy, and a sense of purpose.

In the final analysis, emotional maturity is the one factor that is most likely to characterize resilience in the face of disaster (Valliant, 2003). Situations of major loss demand the ability to give up previous certainties and to make the survival of others more important than the discomforts and suffering of one's immediate situation, which is essential to embody a sense of hope.

There has been an increase in post-disaster studies that attempt to measure why some people bounce back faster than others. The studies have identified three constructs that explain the capacity to bounce back: (1) A person has the support of parents, friends, and other adults; (2) A person has spiritual and psychological resources that will help her/him move ahead; and (3) A person has the desire to move ahead and improve his or her condition.

The theoretical base for the initial activity was the resiliency paradigm. The three paradigm components are the individual's feeling that: (1) I have the support of someone in my immediate environment. (2) I am responsible and respectful of myself, and (3) I can figure out ways to solve problems (Artz, Nicholson, Halsall, Larke 2001). Scholarly and popular literature alike suggests that encouraging and cultivating community resiliency is a positive or healthy approach to reduce risk factors prior to a crisis, an emergency, or a disaster.

Psychological support as a response to a disaster or a traumatic life event has been plagued by diverse approaches The purpose of this study is to determine a valid and reliable way to measure resiliency in communities affected by natural disasters in India. An increasing body of research from the fields of psychology, psychiatry, and sociology gives evidence that most people can bounce back from risks, stress, crises, and trauma and experience life success (Resiliency in Action, 2002).

The construct of resiliency has its origins in the self-efficacy theory proposed by Bandura (1989) that described a person's internal belief that one could accomplish a specific task. People who believe that they can master a given task because they feel they have the internal fortitude to change undesired behaviors usually succeed. These people can see themselves succeed in spite of great challenges or great adversity such as the result of a disaster. Bandura theorized that setbacks and difficulties in person's lives taught them that success usually takes sustained effort. The factors identified by Bandura are best identified as protective factors. Protective factors are individual or environmental safeguards that enhance a person's ability to resist risks and foster adaptation and competence.

Resiliency can be described on an individual, family, and community level, each interdependent and complementary of the other levels. This usage implies a track record of successful adaptation in the individual who has been exposed to biological risk factors or stressful life events, and it also implies an expectation of continued low susceptibility to future stressors (Werner & Smith, 1992, p. 4). Family resiliency: is composed of characteristics, dimensions, and properties that help families to be resistant to disruption when major changes or crises occur.(McCubbin & McCubbin, 1988, p. 247).

Within the context of this study, self efficacy and psychological hardiness are what is referred to as resiliency. Grotberg (1995) has conducted an international study to determine the elements of resiliency. She defines resilience as a "universal capacity which allows a person, group or community to prevent, minimize, or overcome the damaging effects of adversity."

Emotional resiliency comes from developing (1) curiosity about the future, (2) flexibility, resiliency, and adaptability., (3) a pattern of learning from unpleasant experiences and seeing victims become victors, (4) strong self-esteem, and (5) an expectancy of good outcomes. Bandura (1989) suggested that once a person realized that they had within them the capacity to succeed, they proceed to tackle even the most difficult situations and to persevere in the face of great adversity and rebound back after great adversity. By persevering, people are able to emerge from difficult situations with a stronger sense of efficacy. Ultimately the most positive thing psychosocial staff can do after a disaster is to assist people to realize their psychological hardiness and to help them define the degree of control and commitment that they still possess.

After a two- year period of gathering data in 14 countries from 589 children and their families or caretakers, Grotberg's" research grouped the main factors that influence the behaviors of survivors into three categories. "I have," "I can," and "I am."   The instrument reported herein used the three categories suggested by Grotberg to develop a 25-item instrument that will assist the program staff to identify resiliency makers in selected villages and communities in two States in India.

Method

Study # 1: One hundred and twenty persons participated in this survey in Bhuj, Kutch, Gujarat. Villagers from two villages, a Hindu village and and a Muslim village, were selected. The participants were divided into 48 females and 72 males with an age range of 15 to 45 years old. All the responders had experienced the earthquake. Most of the responders could not read or write.

The instrument consisted of three open-ended questions:

1. Who is the most supportive person in your family and in the community for you? What makes this person important to you?
2. What are the characteristic that you have that helped you to survive such a major disaster?
3. When something difficult happens to you, can you express yourself to others and find ways to solve the difficulties that arise?

The recorders of the questionnaire had written questions that they asked the subjects. The recorders read the questions to the responder and made a verbatim notation of the answer. All the interviewers brought back the responses and handed them over to the experimenter.

A panel composed of three persons (one psychologist and two teachers) evaluated the answers to every question. The judges were briefed about the meaning of resiliency as presented by Bandura (1989) in terms of self efficacy and as defined by Grotberg (1995). The judges generated a total of 155 potential stems in six different categories related to resilience: (1) Ability to be happy and contented and have sense of direction and purpose; (2) Capacity for productive work and a sense of competence and environmental mastery; (3) Emotional security and self-acceptance, self-knowledge and a realistic and undisturbed perception of one self, others, and one's surrounding; (4) Interpersonal adequacy and a capacity for warmth and caring relating to others and for intimacy and respect; (5) Desire to serve others; and (6) Religious, culture, spiritual affiliations.

Study # 2: Ten mental health professionals, utilizing the Brislin method, were asked to translate from English to Urya the 155 items obtained from the Gujarat questionnaire (Prewitt Diaz, Laksminarayana, and Bordoloi, 2003). First, the items in English were translated into Urya and then a back translation into English was done. A content analysis of the original translation and the back translation were compared to determine contextual applicability. A panel of four judges evaluated the stems and made the necessary changes to accurately represent context, meaning and technical adequacy intended in the original items.

A second panel composed of five mental health workers were given a definition of resiliency provided by Grotberg (1995) and asked to determine whether the items represented a part of the definition of resiliency. Each stem was ranked on a 5 point scale from (1) not related, (2) poorly related, (3) related, (4) very related, (5) represents the definition of resiliency. Seventy-six items were retained and ranked. A rater reliability analysis was performed with the rater reliability determined by a KR-21. The reliability was .944. Items with an inter item correlation of .40 and higher were retained and included in the preliminary version of the Resiliency Scale. A total of 52 items were retained.

Study # 3: A final version of the resilience questionnaire that consisted of 52 items was administered to 900 subjects in Orissa, who were survivors of the Orissa super cyclone. The Lickert scale consisted of five choices. The scores are coded from 0 to 4 and are mentioned below each question number.

The sample for this study was selected utilizing the random cluster method. A total of 188 villages were affected by the Orissa super cyclone. The sample consisted of men and women between 18 to 50 years of age.

The criteria for participation in this study were that the respondents had lost an immediate relative during the super cyclone and were now experiencing success.

Thirty clusters were identified utilizing a table of random sampling. Each examiner identified the center of the cluster, spun a pencil on a map, and walked to the limit of the village and then began to zigzag through the village picking every third house until 30 subjects had been interviewed.

The rest of the participants were inhabitants of the villages served by the Orissa State Branch of the Indian Red Cross Society Cyclone Shelter Program. The instrument was administered orally by community mobilizers, who wrote down the response given by the participant.

In the initial resiliency instrument trials, when the instrument was administered in its totality and the questions were not divided into subscales, the interviewers faced difficulty in achieving survivors' cooperation. There were criticism and reluctance from the survivors because they already had been a part of methodical surveys by various government and non-government organizations.

In addition to the above constraint, the survivors were confused about the content of the questions and complained of repetition when different questions on the same topic were asked at intervals. It was difficult for them to appreciate the different aspects of the same area of inquiry.

Sensitivity to the survivors' emotional and cultural context was given paramount importance to achieve cooperation of the individuals assessed. The questionnaire was administered in a way to make the assessment procedure a more supportive and continuous conversation rather than a methodical survey. Also measures were taken to keep the survivor focused on the context of the questions asked so that they could understand the different aspects that each question intended to cover.

To achieve the survivors' cooperation, psychosocial staff took the questionnaire of 52 questions and divided it into 8 subscales that assessed different areas of functioning and support. The questions in the subscale cover the individual's dynamics of interaction at self, family, social system, and occupational environment levels. The subscales were:
1. Qualities of the individual;
2. Feelings;
3. Use of humor;
4. Spiritual belief;
5. Social support system;
6. Involvement with the community;
7. Capacity to work, and
8. Pattern of working

The answer sheets were collected and revised. Those answer sheets with incomplete answers or that lacked the basic demographic information were deleted from the statistical analysis. The total number of subjects finally used for this analysis was 668.

Statistical Analysis

An SPSS statistical package was used to analyze the data. The statistics were determined for the 52 items. An inter correlation analysis was performed. The items were grouped into three factors "I am,, "I have, and "I can." The items with an inter-item correlation of less that .40 were rejected. The final instrument was composed of three subscales and a total of 25 items. Appendix A below presents the statistics for the resilience scale.

Results

An instrument was developed to measure resiliency in a group of subjects in the states of Gujarat and Orissa in India. The original instrument was developed in the Gujarati and Urya languages. A translation into English has been prepared for purposes of reporting the data. The instrument was administered to a group of 668 subjects between the ages of 18 to 27. Initially 52 questions were developed. The stimuli questions were translated by utilizing the translation and back translation methodology (Brislin, 1981). The final questionnaire consisted of 25 items divided into three categories (I am, I can, I have). The Alpha coefficient of reliability was (25) .94. This instrument, in its preliminary form, may be used by planners of community-based psychosocial support programs to establish baseline data and to measure the degree of whether the interventions increase the level of self-reported resilience.

Appendix A

Table 1: Category, Mean, Standard Deviation for items of Resilience Scale
N=668

Category	ID	Item	Mean	Standard Deviation
I can	1	When I make plans, I can follow through with them.	1.9222	.6409
I have	2	I have been successful all of my life.	1.5389	.7468
I can	3	I can do many things at a time.	1.5225	.7673
I can	4	I can succeed because I have experienced difficulties before.	1.6662	.7352
I can	5	I can look at a situation in more than one way.	1.5674	.7407
I can	6	I can take things one day at a time.	1.3757	.6998
I can	7	I can find something to laugh about.	1.7171	.7197
I have	8	I have people in my community who love me.	1.9461	.6049
I have	9	I have several who listen to me.	1.9805	.5932
I have	10	I have someone to help me when I am in trouble.	1.9865	.6084
I am	11	I am part of at least two community groups	2.1332	.7297
I have	12	I have a network of people that believe that I can succeed.	1.8353	.6838
I can	13	I can excel in creative activities.	1.6811	.6674
I have	14	I have the capacity to achieve my goals.	1.8428	.6599
I am	15	I am listened and respected in my community	1.8847	.6618
I am	16	I am valued by my friends, and neighbors	1.9820	.6659
I have	17	I have clear expectations about what my community can achieve	1.6602	.6750
I can	18	I take the necessary steps to achieve my objectives.	1.6287	.6501
I can	19	I can use humor as a way to cope	1.7919	.7569
I am	20	I am good at my work	1.8982	.6111
I am	21	I am proud of myself, my family, and my community	1.5853	.7648
I can	22	I can see several sides of a situation.	1.7650	.6595
I can	23	I can take care of myself, and my family.	1.8009	.6462
I am	24	I am considerate of the view points of others in difficult situations	2.1826	.6988
I have	25	I have people in the community who listen to my worries	2.0314	.6390

Reliability Coefficients (25 Items) Alpha= .9365

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Development Of A Psychosocial Questionnaire And A Worksheet For Teachers, Parents, Students And Other School Personnel To Assess Educational Needs Of Survivors Of The Tsunami In Calang, Indonesia

Chapter 15

By Sujata Bordoloi, Amin Khoja

Introduction

The earthquake and accompanying tsunami of 2004 devastated the coastal towns of Sumatra. In Aceh Gaya, Calang the main city and the six sub district were impacted. In Calang with a population of 20,000 persons pre-tsunami lost 80% of all its inhabitants. All physical structures were destroyed, and the natural resources disappeared. The economic well being of the community which consisted mostly of fishing and the exportation of fruits and other crops is no longer available. The school lost over 85% of all children and teachers. Currently the community has three elementary schools, two Junior High School, and one High School. There is also one Islamic elementary school.

The Psychosocial program of the American Red Cross has begun to plan with administrators, teachers, parents and children a long-term program that will enhance the educational environment through child friendly schools.

The program will be developed based on the WHO (2005) definition of psychosocial support , and the IASC/ Mental Health and Psychosocial support guidelines (In press) . The World Health Organization (WHO) (2005) define a psychosocial support intervention is an intervention using primarily psychological or social methods for the substantial reduction of psychosocial distress. The interventions suggested by the WHO guidance include counseling, activities with families, psycho educational activities, the provision of social support, rehabilitation activities (example leisure and socializing activities, interpersonal and social skill training, occupational activities, vocational training, and sheltered employment activities). (WHO (2005).

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[7] WHO (2005). WHO Assessment instrument for mental health systems. Geneva: WHO

[8] IASC/MHPSS (2006).Guidance on Mental Health and Psychosocial Support in emergency settings (4th Draft). Geneva. Interagency Standing Committee

[9] The areas proposed by the ARC PSP team were the result of review of secondary data, current models, and interviews with school personnel in Calang.

[10] Promoting equal opportunities and participation in decision-making is a cross cutting activity in both the psychological and social methods suggested by WHO

Table for suggested activities found in the WHO guidance and indicators identified by respondents and the ARC PSP team

Psychological methods	Social methods	Area proposed by the ARC team	Indicators identified by respondents
Psychological First Aid, Guidance and Counseling		Promoting an environment of trust where the children can express their feelings and receive constructive feedback.	Caring, happy, and safe environment. Effective and sensitive communication exists between teachers and students. There is a procedure that enables all students to openly talk about schoolwork and school life. Students who are different are treated with respect and equality.
Activities with families		Teachers, students and parents plan and develop curricular and co-curricular activities that enhance the psychological competence of children	Teachers, students and parents identify common problems in the school and community. Teachers, students and parents participate in executing school and community projects School/community projects and team projects are be implemented. Parents are interested, supportive, and believe in the role of the schools in their child's' psychosocial well-being.
Psycho-educational activities		Activities that engage children in individual, small, and large groups to share their feelings, Activities that engage children in individual, small, and large groups to share their feelings, and to learn the reasons why the feelings are present on them are encouraged.	Promoting small group work in the school environment. School actively involved students in decisions about how the school is organized. The school promotes students and teacher interaction and common activities.
Creative and expressive activities		Creative and expressive activities enhance the capacity of children to participate in team activities while at the same time they develop fine and gross motor skills.	Facilitate the availability of places to play. Provide facilities and equipment for physical and recreational activities. Insure that the students have opportunities for extra curricular activities such as drama, music, crafts, calligraphy, and writing.

	Leisure and social activities	Providing a friendly, rewarding and supportive atmosphere for children.	Teachers and students define problems and look for solutions together.
	Social skills training	Connecting school and home life through involving parents.	Parents and teachers participate in integrating the children into community cultural and social activities. Teachers enable parents to share questions or worries about their child. Opportunities for parents to be involved in activities linked with school life and work.
	Life skills training	Supporting cooperation and active learning.	Teachers emphasize life skills as part of the psychosocial development of children.
	Occupational activities	Assist the school in identifying community human capital and organizing occupational activities.	Parents and teachers recognize the benefits of occupational activities. The community engages in informal schools to provide occupational training.

Development of the Psychosocial Questionnaire

The instrument utilized for the pre-assessment visit by American Red Cross staff is an adaptation of "The Psycho-Social Questionnaire developed by WHO as part of the Health Promoting and Child Friendly School Program developed in 2003 (WHO/NPH, 2003). The items and information contained in this PSE Profile were derived in large part from a systematic review of evidence from more than 650 research articles in the international literature and the original Profile that was reviewed by schools in 20 countries worldwide.

The instrument was modified in the following way:

1. Three psychologists from the Crisis Center, University of Jakarta, reviewed the English version. On the basis of the review, 17 items were eliminated because they were not applicable to the Indonesian reality.

2. The instrument was translated by the staff of the PSP program in Banda Aceh, and back translated by a psychologist into English. This procedure assured linguistic compatibility.

3.Two teachers, two parents from Banda Aceh, and one PMI psychologist reviewed the instrument. The first suggestion was that two scales be eliminated: "Forbidding physical punishment and violence, and "Not tolerating bullying and harassment" because these scales or areas were sensitive due to the religious views and because they may be biased due to the conflict in the area. The five areas included in the questionnaire are:

•Providing a friendly, rewarding and supportive atmosphere for children
• Supporting cooperation and active learning
• Valuing the development of creative and expressive activities.
• Connecting school and home life through involving parents
• Promoting equal opportunities and participation in decision-making.

4. The committee suggested that the stimuli questions be reduced to no more than five items per scale (area). The committee then proceeded to discuss each item and to reduce the scale to five items each. (Attachment A below presents a copy of the revised questionnaire).

5. The instrument was prepared and field-tested with a group of teachers in Calang. The psychometric qualities will be obtained and reported.

III. Development of a Worksheet to lead individual and small group information and focused groups.

Descriptors of the five areas were adapted from the WHO PDE document (WHO/NPH, 2003). A description for each area is provided and a sample worksheet is provides to ascertain that the information in each group follows the same guidelines.

Area 1. Providing a friendly, rewarding and supportive atmosphere in the classroom and the school

The schools where the PMI/PSP program will be developed in Calang, is a place where teachers and pupils feel valued, teachers and children feel confident that they are doing a good job. Parents are interested and supportive, believe that they have a role in the school, and see reasons to give their support. Schools will be a caring, happy and safe environment in which to work and play. The role of the teacher includes taking care of his/her students' psychological competence and practice self care.

The indicators of a child friendly school are: (1) new people to the school feel confident and safe from the beginning of the school year. (2) It is about effective and sensitive communication, about pupils giving positive feedback to other pupils and to the teachers themselves. (3) Through a greater attachment and sense of belonging a school sense of place is developed by teachers and students.

Area 2. Supporting collaboration and active learning

The Indonesia Red Cross Psychosocial Support school program will emphasize collaboration as an important characteristic of schools by promoting small group work in class and ongoing collaborative contact between pupils. Solution focused activities will be the rule.

The program will facilitate student and teacher participation in projects, problem solving, collaborative learning which is stimulating, educational and fun.

The indicators for this area are 1) active learning which allow students to develop problem-solving skills and use of active learning techniques, such as role playing, school/community projects, team-based research projects (solution focuded activities); 2) facilitating collaborative behaviour among students in situations and places outside the school setting, such as the family and community; 3) teachers enhance their skills to facilitate collaboration, problem solving and finding solutions together.

Area 3. Promoting the development of creative and expressive activities

One of the key features of the PMI/PSP child-friendly school is the availability of places and opportunities for pupils to play, socialize and participate in creative, expressive, and recreational activities. These activities will provide opportunities for students to practice the skills learned in the classroom and to exchange new skills with their peers, and at home with their parents.

The indicators in this area will be 1) Facilities, equipment, as well as opportunities for physical activitities using simple, low-cost and easy ideas, such as using stones, logs, or paint to mark out popular games on the playground. 2) Ensure that students have opportunities, facilities, and time to learn crafts, play in drama, music, art, and calligraphy. 3) Encourage learning of life skills such as independence, organization, negotiation and arbitration through play; and 4) facilitate activities outside school time have the additional benefit of enabling staff and students to get to know each other better.

Area 4. Connecting school and home life through involving parents

The engagement of parents in school activities and decisions is an essential element of a Indonesia Red Cross psychosocial support child-friendly school. The family and school are two of the most important institutions that influence children. An important function of schooling is to assist families to help their young become emotionally and socially secure and productive members of the community. Contact between home and school promotes good teaching. Teachers are better able to understand the child and tailor their teaching to the child's needs if they are aware of their background.

The indicators in this area are 1) teachers are approachable and parents feel welcome at school, are involved in its life, and advocate for the school's values, policies and practices at home; 2) Sharing and information exchange takes place between the school and the community from students to their parents and caregivers; 3) activities are facilitated by the school which promote participation of parents and the larger community.

Area 5. Promoting equal opportunities and participation in decision-making

A child-friendly school facilitates children emotional and social support and helps them acquire the confidence they need to speak freely about the school and their life within it.

The schools participating in the PMI/PSP program will provide children the opportunity to be informed about the issues that affect them and to actively participate in the decision-making process together with staff and parents.

The indicators in this are include 1) opportunity for students to say if they believe that something is wrong or unfair and to influence the timing where change is necessary 2) students are provided with the opportunity and facilities to choose their leaders; 3) children are encouraged to take responsibility for themselves and their community by mapping challenges and identifying protective factors, 4) encourage students to participate in decision making about solution focused activities in the school and in creating their own learning environment.

Psychosocial Questionnaire

You are invited to fill out the following questionnaire by answering questions about this school that are grouped into five "areas". The answers to the questionnaire will assist the Psychosocial Support Program to develop activities in the Calang schools. Your response is very valuable, thank you in advance for your assistance with this task.

Please begin by providing the following information about yourself:

What is your role at the school?
☐ Principal or head teacher   ☐teacher   ☐support staff   ☐parent   ☐other

What is your sex?
☐male   ☐female

Instructions

Please answer each question by circling ONE of the four possible answers. Choose the answer that you feel best describes your school. Do not spend a lot of time thinking about the answer — usually your first reaction is the best. There are no right or wrong answers; we just want to know what you think about your school.

Please make sure that you have answered all the questions

1.1.   **The school is seen as an appealing place to work by those who work there. How much is this like your school?**

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

1.2.   **Teachers support students who are in distress. How much is this like your school?**

For male students:
Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

For female students:
Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

1.3.   **There is a trusted person who the students know they can approach if they have a problem or need confidential advice. How much is this like your school?**

For male students:
Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

For female students:
Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

1.4.   **Students are confident that they will get help and support when they need it. How much is this like your school?**

For male students:
Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

For female students:
Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

2.1   **Students spend time working together to solve problems.**
       How much is this like your school?

       For male students:

       Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

       For female students:

       Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

2.2   **Students are encouraged to ask questions in the classroom.**
       How much is this like yo school?

       For male students:

       Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

       For female students:

       Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

2.3   **Teachers organize students for group activities so that they can work together.**
       How much is this like your school?

       Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

2.4   **Teachers are seen to be co-operating with each other.**
       How much is this like your school?

       Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

2.5   **The students' work is regularly put on display.**
       How much is this like your school?

       Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

3.1 **There are regular times available for recreation and play throughout the school day. How much is this like your school?**

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

3.2 **All students have opportunities to experience creative learning experiences that are free from the stress of competition and examinations, e.g. music, art, drama. How much is this like your school?**

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

3.**3** **All students have opportunities to experience creative learning experiences that provide rewards for effort as well as achievement. How much is this like your school?**

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

3.4 **All students are provided with opportunities to engage in physical activity as a recreational choice. How much is this like your school?**

For male students:

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

For female students:

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

3.5 **There are activities outside the school hours that students can join. How much is this like your school?**

For male students:

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

For female students:

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

4.1   The school invites parents to discuss the child's work with the teachers. How much is this like your school?

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

4.2   Parents have the opportunity to discuss the school's policies and codes of conduct and to contribute to decision-making by the school. How much is this like your school?

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

4.3   Parents feel able to go to the school to ask questions or discuss worries they have about their child. How much is this like your school?

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

4.4   There are opportunities for parents to be involved in activities linked to the school life and work, e.g., outings, sport events. How much is this like your school?

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

4.5   The school regularly communicates news to parents about the school and its activities. How much is this like your school?

Not at all (1) A little (2) Quite a lot (3) Very much (4)

5.1 **Students have the opportunity to speak, and be listened to, in class. How much is this like your school?**

For male students:

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

For female students:

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

5.2 **Students who are 'different' in any way are treated with respect and equality. How much is this like your school?**

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

5.3 **There is a procedure that enables all students to openly express their feelings and thoughts about schoolwork and school life. How much is this like your school?**

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

5.4 **Girls and boys are treated as equals. How much is this like your school?**

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

5.5 **Girls and boys have the same opportunities to reach their potential. How much is this like your school?**

Not at all (1)   A little (2)   Quite a lot (3)   Very much (4)

Scoring the Profile

For each quality area, calculate the sum of all respondent's scores and place the sum in the Respondents' score column. Divide the Respondents' score by the Total # items to determine the Respondents' average score.

Areas	Schools		
	Respondents' Score	Total number of items	Respondents Average (A/B)
Providing a friendly, rewarding and supportive atmosphere		5	
Supporting collaboration and active learning		5	
Valuing the development of creative and expressive activities		5	
Connecting school and home life		5	
Promoting equal opportunities and participation		5	
TOTAL			

Looking at the results for different groups

To calculate the average scores for a specific group, such as persons serving in certain roles, assemble the responses of all persons in the groups and calculate an average score for that group using the same procedure used to calculate an average score for all respondents.

Areas	Average by Sex		Average Score by role			
	Male	Female	Principal	Teachers	Parents	Voiunteers
Providing a friendly, rewarding and supportive atmosphere						
Supporting collaboration and active learning						
Valuing the development of creative and expressive activities						
Connecting school and home life						
Promoting equal opportunities and participation						
TOTAL						

Psychosocial Support Programs in Disasters: The American Red Cross Perspective

<div style="float:right">**Chapter 16**</div>

by Dr. Joseph O. Prewitt Diaz

Introduction

Human beings are a part of the natural world and, as such, are the products of their nature, circumstances, and experiences. Tyler (2001) suggests that human beings use their individual experiences to construct their lives, identities, and relationships to their context. A person's private experiences occur in a context with a meaning that is somewhat socially constituted, so they also have a social as well as an individual character. Psychosocial competence is contextual in the sense that communities have an active part in defining their needs and determining when those needs are met. Thus, broadly, all human experiences are psychosocial.

Based on my field experience in developing, implementing, and evaluating disaster mental health and psychosocial support for the last seven years in Central America and South and Southeast Asia, I offer a retrospective discussion on the context of the American Red Cross-supported psychosocial support program.

The nature of psychosocial support

The definition of the psychosocial support program (PSP) has been a long-discussed issue between academics and practitioners alike. Psychosocial is a term used to refer to interventions that consider a person's view of self and the influences that a society, the environment, economy, biological make-up and a host of other external factors that influence the development of the way they see the world and react to everyday occurrences.

The World Health Organization (WHO) defines a psychosocial support intervention as an intervention using primarily psychological or social methods for the substantial reduction of psychosocial distress. The interventions suggested by the WHO guidance include counseling, activities with families, psycho educational activities, the provision of social support, rehabilitation activities (example leisure and socializing activities, interpersonal and social skill training, occupational activities, vocational training, and sheltered employment activities) (WHO, 2005).

- Psychosocial support is an internationally used term that involves any program that helps to rebuild the individual's, families' and communities' capacities to function normally. It first recognizes and validates the losses and then builds on peoples' innate strengths to guide them to self-motivating actions.

- Both the psychosocial workers and the beneficiaries do not focus on losses but on the actions and resources that can be utilized in rebuilding communities. It recognizes that recovery and resilience comes from within the affected groups; it cannot be imposed from outside.

- Non-professionals can be educated about stress and the impact of grief and loss. They can be trained to give psychosocial support to disaster-affected individuals and families and to build on the individual's and communities' resources.

- Finally, the role of psychosocial support is to study, understand, conceptualize and carefully intervene in the process by which communities enhance the community members' psychological well-being.

The American Red Cross psychosocial support program was formulated based on existing standards such as the SPHERE Project (2004), Interagency Network for Education in Emergencies (INEE) Standards (2004) and the emerging standards of IASC Task Force MHPSS (in progress). With the development of the SPHERE guidelines to engage communities in planning, developing, and evaluating psychosocial support activities, humanitarian organizations have been challenged to develop an integrated participatory model in PSP. The INEE Standards emphasize emergency formal and non-formal education and the Interagency Standing Committee on Mental health and Psychosocial Support (IASC/MHPSS) Standards suggest the inclusion of both qualitative and quantitative measures to monitor and evaluate signs of distress, community planning, program implementation, and to define the language of psychosocial well-being.

The effect of adverse events on individual and community psychosocial competence

Adverse events such as crisis, emergencies, and disasters affect communities and can produce such human and material losses that the resources of the community are overwhelmed and, therefore, the usual social mechanisms to cope with emergencies are insufficient (Lopez Ibor, 2005). Green (1982) reports that a disaster causes a total breakdown of everyday functioning; normal social functioning disappears; there is loss of the trusted elderly; and the community leadership, the health and emergency systems are overwhelmed in a way that survivors do not know how to receive help. Emergencies are situations that threaten the lives and well-being of large numbers of a population and extraordinary actions are required to ensure the survival, care, and protection of those affected. Emergencies include natural crises such as hurricanes, droughts, earthquakes, and floods as well as the situations of armed conflict. Crises are individual events that tax the capacity of individuals to respond.

One way to explain the social and psychological disruption is to see loss of place as a by-product of the reaction to a disaster. A disaster causes the survivors to lose their sense of place, which is the actual or perceived loss of social networks, governmental systems, and individual indicators of control that lead to individual and community psychosocial competence. It may take months before the persons affected by an adverse event can re-establish their sense of place and for the individual to feel comfortable in a new environment when the systems begin to work once more; health and welfare is re-established; schools are back in session; livelihood activities have been initiated; and the social networks become functional once more. Once the person begins to function normally within a community, it is said that resilience is enhanced and the survivors become stronger and realize that they have the capacity to survive.

Psychosocial Competence

Psychosocial competence provides a guide for understanding and contributing in a variety of ways to the well-being of individuals, communities, and their interactions. It suggests that there may be ways for attaining particularly facilitative psychosocial attributes that can be developed for psychological well-being and that there may also be a range beyond which psychosocial attributes cannot vary without producing detrimental personal and social effects. Identification of these limits and possibilities can benefit individuals and communities experiencing disaster-related stressors, and help them to realize their inner strengths and to establish supportive environments. Two types of psychological competence are identified in the study of stressful life events: individual and community psychosocial competence.

Individual psychosocial competence refers to levels by which survivors are able to guide and take charge of their lives, moving beyond the trauma. It consists of a number of factors, which include a sense of control and a sense of being an active part of family and community networks, of engaging in active planning, and a sense of being able to manage the physical and psychological support and threat. Each individual becomes a product as well as a contributor to the culture and its relationships to other cultures (Tyler, 2002).

Operationally defined, community psychosocial competence is the integration and transformation of knowledge about persons and community networks, about patterns of behaviors, relationships, values, practices, and attitudes within a specific context that allows planning, implementation, and evaluation of community activities and projects that foster a sense of place and psychosocial well-being.

Implementing a Psychosocial Support Program

The psychological support of the American Red Cross is predicated on industry-approved guiding principles (SPHERE, INEE, IASC/MHPSS, and WHO). Evaluation of these programs will depend entirely on the critical event for which psychosocial support is needed. The impact evaluation should reflect that PSP embraces the five following strategies:

- •Uses a community-based approach
- •Implements interventions that are contextually and culturally and linguistically appropriate.
- •Empowers affected people
- •Encourages community participation
- •Encourages active involvement

Community-based Approach

Past experience has shown that community-based approaches are best when implementing psychological support programs. Building on local resources, providing training, and upgrading local structures and institutions are critical to the programs' success. This approach allows trained volunteers to share their knowledge with fellow community members. Since the majority of emotions experienced (e.g., distress and sorrow) do not require professional treatment, local volunteers often become instrumental in providing successful emotional relief. A larger number of people are reached by working in groups through which community networks are strengthened, making it more likely to bring forth a culturally appropriate response.

The international arena where most ARC/PSP programs are implemented presents the challenge of encountering language, culture, and religious beliefs that are not frequently understood by the outsider. Culture exercises a great influence on the way in which people view the world. Building the capacity of community volunteers ensures that they may be able to provide culturally appropriate assistance to the affected population. Trained personnel from the community affected by the disaster can react immediately in times of crisis and can assist with the provision of long-term support to the survivors. They have easy access to and the confidence of the disaster survivors.

Empowerment

The American Red Cross PSP program operates under the premise that high-quality psychosocial assistance is based on helping others to regain self-respect and autonomy. It focuses as much attention on the abilities and strengths of the recipients as on their problems and weaknesses. A high degree of community participation is generally accepted as one way to encourage empowerment of the people (International Federation of Red Cross and Red Crescent Societies, 2003).

Community Participation

Basing projects on ideas developed by concerned people themselves will promote empowerment and local ownership and help facilitate and consolidate a long-term capacity for problem solving. Through participation, people gain an increase in control over their lives as well as the life of the community. Participation in collective decision making about their needs, as well as in the development and implementation of strategies, is based on acknowledging their collective strengths to meet those needs.

Active Involvement

The American Red Cross PSP focuses on individual strengths and provides a space for community members to enhance their resilience. The program is built on existing resources, coping mechanisms, and resiliencies. The objectives of the interventions then become: (1) identifying and strengthening internal coping mechanisms, (2) actively involving people in the community in mapping and identifying problems and resources, and (3) recognizing people's skills and competence.

Activities in a psychosocial support program

The focus of the PSP program is on people's positive efforts to deal with and come to terms with their disaster-related experiences.

A. Psychological First Aid- a first-order intervention

During an adverse event and up to the reconstruction phase, one of the most common and effective informal health community interventions is called Psychological First Aid or PFA. PFA is a first-order intervention after a crisis, an emergency or a disaster, designed to reduce the distress caused by exposure to a traumatic event, and to enhance the knowledge of the protective factors that helped the person to survive the event (SPHERE, 2004). In the longer term, PFA helps the survivor to identify and enhance resilience and prepares the survivor for long-term recovery.

Psychological first aid is natural and familiar to everyone. When someone is hurt as a child, the understanding attitude of his or her parents did as much to alleviate discomfort as the application of a bandage or a disinfectant to ease the pain. Taking a walk and talking things out with a friend are familiar ways of dealing with an emotional crisis. The same natural feelings that makes people want to help a friend motivates them to give a helping hand and support to a person who is injured or is a survivor of a disaster. The American Red Cross PFA model was developed in 2001 after the El Salvador earthquake (Prewitt Diaz, 2001; Rajesh and Das, 2003). The approach consists of five steps of PFA, taught by all persons that participate in the psychosocial program:

1. **Intervene immediately** close to where the event took place with experiential and simple activities. Take care of the basic needs expressed by the beneficiary.

2. **Listen, Listen, Listen.** Provide some sense of hope and expectation that the person will ultimately overcome the crisis. However, let the survivor know that things may never be the same as they were before the crisis.

3. **Validate the person's feelings.** Do not give false assurances. Always remain truthful and realistic. Emphasize how the survivor has coped with the situation so far and how the survivor has already begun to use the strategies for moving forward. Encourage the survivor to implement solutions or strategies that have a high probability of success.

4. Plan next steps. Every PFA intervention should have an ultimate outcome or some action that the individual is actually able to take. Restoring the person to the position of active participant rather than victim is critical to success. Provide constructive activities that the survivor can do to assist with the situation, such as helping to put up tents or distributing food and water in the camp. Reinforce whatever problem-solving skills the individual has demonstrated to this point.

5. Refer to existing networks in the community. Find a group of peers, family members, community members, or church members who can provide both support and temporary assistance during the crisis. Implement a buddy system so that the survivor is not left alone.

B. Assessment

Assessment is a process to determine the impact of a disaster and the community's needs and strengths and the available services. This section explains the use of both quantitative and qualitative tools in moving from a definition of language of distress in a community to defining and developing a road map to psychosocial competence. Quantitative methods provide objective and measurable data whereas qualitative methods give information about the subjective perceptions of individuals in a population, giving range, depth, and meaning to people's experiences. Both methods complement one another.

There are three specific sets of needs that survivors generally experience:
- Medical needs immediately after the disaster;
- Practical needs (such as housing, water, livelihood, schools for children, contacting family and friends) that continue well into the early reconstruction process; and
- Psychosocial needs that change over time.

The common strategies for measurement are rapid assessment, quantitative assessment to determine the survivor's level of distress, and qualitative assessments to determine feelings, actions, stressors, and strategies to move forward and achieve psychosocial competence.

1. Rapid Needs Assessment
The rapid needs assessment seeks to obtain demographic data from the survivors, identify factors that may be causing stress, determine the agencies that are currently providing services, identify any gaps in services, and determine what is it that community members want and what they are willing to do to achieve community psychosocial competence.

2. Paper and Pencil Tools
Another tool that the ARC PSP program has used with some degree of success is the Psychosocial Competence Scale. This paper and pencil test consists of 30 items that measure how the individual sees themselves in light of the disaster, the internal forces that protect him/her, and the willingness to move ahead.

3. Non-verbal tools
The third set of tools used is qualitative in nature and aims to collect data pertaining to the language of distress, how the community defines distress, and the steps taken by the community to achieve psychosocial competence. This instrument is a set of 30 cards divided into three scales: somatic, psychological, and sociological. The set of 30 stimuli cards (non-verbal tools) specify overt behavior in the form of a caricature, based entirely on the information obtained from the target communities. These cards have been categorized into social behaviors (fighting with neighbors, playing a group game, talking with a group of peers), psychological behaviors (intrusive thoughts, hopelessness), and somatic behaviors (sleeping with lights on, urinating in bed, thumb sucking).

Up to six community members are invited to meet and the cards are set on the floor in front of them. The process consists of six steps to elicit first-hand information from the community members to determine their language of distress. Each member picks a card and explains what the individual sees happening before, during, and after the disaster. Once all members have completed the round, the facilitator attempts to find out:

- •If there is a local name for this distressful event;
- •How it manifests itself;
- •The severity of suffering and dysfunction;
- •What causes it and who gets it;
- •How is it treated and how effective is the treatment; and
- •How the problem could be avoided.

This process is repeated with the representatives of all community segments. We have found the non-verbal tools to be a very effective instrument as a means for the community members to verbalize their language of distress. In Indonesia, feedback from teachers, students, and volunteers have indicated the need to develop a tool specifically for schools that incorporated signs of distress exhibited by children in the classroom (such as restlessness, fear of rain, becoming clingy). They felt that the non-verbal tool could be used to identify causes of stress for teachers and to develop helpful self-care activities for teachers and students.

4. Ethnographic Field Studies

An approach frequently used in the field is a qualitative approach called 'ethnography', which is a scientific method of recording people's beliefs, behavior, and culture directly from life (Prewitt Diaz, Trotter, Rivera and Jr. 1989). Cultural anthropologists and cross cultural psychologists have used ethnographic study for at least last 50 years. Most recently ethnographic studies are reported in the psychosocial support and mental health programs for the developing countries (Bolton and Tang, 2004). The method consists of participant observation, key informant interviews, and life history collections.

Ethnography is an informal and fast way to assess concerns, to survey results, and to become familiar with the local ways of thinking, opinions, perceptions and suggested interventions. It allows for the mapping of current resources, services, and practices. The mapping process helps to identify local resources, people, and community members, including vulnerable groups, and to develop mechanisms for social empowerment and strengthen community networks. It enables ethnographers to explore a diversity of opinions as well as to reach consensus.

The key informants give insight into how psychosocial distress manifests itself and what the social networks in the community can do. Life histories provide a collection of valuable accounts as they reveal events that the informant thinks are crucial to his or her personal development and provide a context that helps in the interpretation of beliefs, attitudes, and current behavior.

5. Focus Group Discussions

A meeting is held with many members of the community and the results are prioritized through the method of free listing. This process provides the program staff with an indication of the things that block elements of psychosocial competence and allow planning for preventive and self-care activities. The focus group discussions allow a participatory solution-searching process with the community that can assist in identifying the strategies that enable the community to achieve psychosocial competence after the disaster.

Focus groups provide a conduit to the target community to express emotional distress; to identify coping mechanisms and sources of psychosocial relief; to project the expected outcome of the interventions; to identify self-help techniques and activities accepted by the community; and to talk with the survivors on ways to move on to reconstruction.

The free listing of issues and ranking the responses through the use of stimuli cards, focus group discussions, and the key informant interviews give an insight into the existence and extent of stress in the community. Focus groups are very useful when there are a range of experiences and opinions among the community members in divulging information to the outsiders. Planning built on the community inputs provides the survivors with an opportunity to present their perspectives on the psychosocial distress and allows them to define ways to achieve psychosocial competence.

6. Outcome of the Assessment Process

The last five years have been very rich in the development of a participatory assessment mechanism that allows for community participation in ascertaining physical and emotional threats. The qualitative and quantitative assessment process generates information, which is vital for understanding the psychosocial problems, resources, and the methods by which the community will cope with stress and survive. Multidisciplinary, rapid, participatory, and coordinated assessments are conducted to utilize the generated information. The overall focus of any community-based psychosocial support program must be to assist the community in transforming its distress into a sense of competence, where the survivors are able to define their needs and list the tools necessary to address those needs.

C. Capacity-Building Activities

One of the objectives of the American Red Cross strategy in providing technical and financial support to the National Red Cross Society is to conduct staff development activities in all society sectors: national headquarters, state branches, and local branches. In the selected local branches, villages and schools have been targeted for direct services. Teachers and community facilitators are trained through thematic units focusing on group development, community-based disaster mental health preparation, mental health and psychosocial support programs publicity, and skills development.

Another aspect of capacity building is providing technical assistance in developing PSP curricula that can be used by the national society for its national level non-tsunami programs. The American Red Cross Module for Community Facilitators and Teachers has been adapted by Indonesian Red Cross Society into its national curriculum for PSP volunteers. In some cases, national societies working on PSP have also adopted the American Red Cross curriculum to implement PSP programs in other areas.

A continuum of capacity building has been formulated to guarantee participants a progression from participating in operational training sessions to becoming a crisis intervention professional. The operational trainings are provided to volunteers immediately upon responding to the disaster. They learn about common responses to disaster-related stress, how to conduct a rapid assessment, give psychological first aid, conduct self-care activities and, if teachers, a core of stress-releasing activities to conduct with children. All the described activities of assessment, material development center, and capacity-building activities are a step towards transforming the community in distress to the one that has achieved psychosocial well-being.

D. Enhancing Psychosocial Competence through schools

A willingness to prepare for a disaster and practice emergency procedures is a measure of personality that predicts survival in a practical and psychological sense. The ARC experience in disaster-affected areas showed the potential of the schools to be a hub for the rehabilitation and support activities in the communities. This formed the basis of ARC's school-based psychosocial support program. This program is informed by the disaster preparedness literature from the American Red Cross and the "Child Friendly Schools" concept proposed by WHO (2003).

A Child Friendly School (WHO, 2003) covers a very wide range of activities. It is about (1) effective and sensitive communication, (2) teachers who provide appropriate, constructive feedback about the child's work and giving encouragement, (3) pupils who give positive feedback to other pupils and to the teachers themselves and (4) a greater attachment and sense of belonging where the school becomes a place where boys and girls want to be.

1. Developing a healthy psychosocial environment in the schools

The core of school interventions - whether disaster preparedness or friendly schools - is to develop a healthy environment where girls and boys can experience a safe environment where they can express themselves freely. There are at least four steps in developing a healthy psychosocial environment: (1) participation, (2) threat identification, (3) designing of school psychosocial response plans, and (4) implementation of plans and evaluation of progress.

Participation: It is important to organize broad participation in the design and implementation of plans to create healthy school environments. Participants could include school administrators; managers of facilities, transportation and grounds, parents; and students. It is essential to work closely with the teachers and volunteers so that they fully understand:
  - •The role of the teachers and the school in promoting the physical and emotional development of children;
  - •Classroom management that promote positive behavior changes and a safe and secure environment is vital;
  - •The learning environment is a safe place for children to express themselves and learn ways to communicate in positive ways.

The American Red Cross PSP program uses participatory methods with all school groups (children, teachers, volunteers, and other adults in school) to identify psychosocial needs, provide staff development for teachers and other adults, and assist the school community to establish a psychosocial crisis response plan.

Teachers and other school staff and volunteers receive relevant and structured capacity-building activities, teaching aids, and tools to develop their skills. Using these activities and tools enables them to give psychosocial support to students and their families when needed and to promote students' development of psychosocial competence according to the needs and circumstances during emergencies.

Teachers are encouraged to share their adaptations and experiences with other adults in the school that can be included in the teacher training curriculum. Teachers and other school personnel are provided with regular supervision and capacity building activities on topics related to psychosocial competence and support for their own psychosocial needs.

Threat identification: It is helpful to conduct a campus mapping activity to identify the magnitude and relative importance of significant threats to psychosocial well-being within the school environment. Threats may be associated with the following: water quality, sanitation, food safety and nutrition, waste management, transportation, adjacent land uses, structural integrity, renovation, purchasing, and grounds management.

Once the definition of crisis is made operational and the teachers understand the concept of vulnerability and protective factors, they then learn to conduct a situational analysis of their school. The situation analysis is recorded by doing a three-dimensional map of the school grounds.

The two questions that are answered in this exercise are: (1) Where is the particular exposure to the threats identified, and who is at risk as a result? and (2) How and why are we vulnerable? Usually the teachers spend a lot of time discussing external sources of the problems. Once they get back to their map, the discussion turns inward to the reality of their school situation and challenges in the grounds around it. The teachers identify the vulnerable population sectors that may be at risk (kindergarten classes, children with exceptional needs, those that are physically handicapped etc.). School mapping helps to understand the risks to achieving psychosocial competence of teachers and students.

Teachers and students are exposed to capacity building activities that prepare them to handle a crisis or an emergency. Exercises and simulations are conducted every two months to make sure that all members of the school community are able to perform their assigned tasks. Since schools do not have the resources for the equipment needed for this activity, the program provides a resilient school grant to purchase the equipment (more under the section on resiliency projects). The teachers also identify the available school resources that can support the activities to reduce the crisis-related distress.

Design of intervention plans: Specific intervention plans should be designed to improve psychosocial well-being practices in the following areas: building the capacity of children and teachers in first aid and psychological first aid, identify evacuation routes, and engage parents and other adults in developing search-and-rescue mechanisms.

Teachers and other adults start the process of developing a plan by identifying what constitutes a crisis in their respective schools. The final part of the capacity building activities for the Safe School Program is the appointment of the coordinating committee and five operational committees. The coordinating committee basically manages the training, simulations, and response. The five operational committees are:

  • Evacuation,
  • Fire fighting,
  • Rescue and first aid,
  • Psychological first aid, and
  • Other support committees.

These five committees are composed of teachers, students, and other adults in the school. Ultimately, the purpose of appointing these committees is to be able to return the children safely to the local authorities and the parents.

Implementation of plans and evaluation of progress: The next steps are to:

  • Implement the intervention plans;
  • Define timetables to meet objectives;
  • Assign clear responsibility and accountability.

Twice a year progress should be evaluated in goal attainment and the effectiveness of interventions in order to adjust policies, intervention plans, and methods of implementation in response to evaluations, changing conditions, and availability of resources. The program's impact will be measured by the permanence of these committees, once Red Cross funding is no longer available.

2. Facilitating an inclusive school environment that leads to feeling of positive psychosocial competence

Once the school has developed the Safe School Program and the children and teachers are capable of conducting the activities in the plan, the projects turns its focus on preparing teachers to facilitate education for the children in an environment that nurtures learning and provides understanding to all the students. Usually this activity begins in the early reconstruction phase of the disaster (the guidance for this activity is taken from the INEE Standards). The "Friendly School" provides an opportunity for children to express themselves in a safe environment.

Most classrooms have received school chests (the school chest project was borrowed from a domestic ARC program) from the American Red Cross or other non-government organizations. The chest contains drawing books, pencils, crayons, colored clay, skipping ropes etc. that are useful in engaging children and provides a window for sharing feelings and experiences. (However, the experience has been that the chests in the past have been given to the teachers with no clear instructions on how to use the contents. Thus the chests, instead of being a helpful tool, have become a hindrance for schools that often do not have a secure storage space.)

Organizing expressive and creative activities in schools

To alleviate the disaster-related stress, the counselors and other school personnel could use one of the three cultural appropriate approaches: (1) talking (2) drawing (3) writing.

The *talking approach* allows the children to talk about their feelings and experiences related to the disaster. The sequence to follow while using this approach is to speak about disaster in general; discuss this specific disaster; and talk about each person's experience during the disaster.

In the *drawing approach* the child expresses his/ her feelings by using a non-verbal medium. The stimulus could be asking: "Where were you when the disaster happened?" Collages have proven to be one of the most powerful ways for children to express themselves.

The *writing approach* can be used with older children and adolescents. Utilizing drawing, pictures, or paper clippings as a stimulus allows the students to write about their disaster-related experiences.

Under the program, expressive and creative activities (drama, drawing, writing, singing, dancing, group discussions, arts and crafts, collages, story telling, plays, and community theater) were organized in the schools. These activities enabled the children in the target schools and communities to communicate their feelings.

1. Children develop skits, poems and songs to present to their peers and parents

Community-based skits and story telling also prove to be a powerful and effective way of venting feelings. These types of activities are used in both the school and community to facilitate the expression of feelings, to reduce distress, and to enhance a sense of belonging to the whole community including the elderly, physically handicapped, widows, and children and hastens their recovery process.

2. Children develop and paint school murals and collages

Once the students have attended to the task of making their school and campus safe and secure, they can assume responsibility of educating the community. One such activity could be to paint murals on the exterior walls of the community with messages encouraging actions that foster psychosocial competence. The messages are part of an attempt to reduce disaster-related emotional distress and to facilitate community healing.

Resilience projects in school

Resilience projects for increasing the psychosocial competency of the school community are paid for from the small grants from students, teachers, and parents. For example, if there are animals entering the ground of the school, a resilience project may be to put up a fence. If there is a need to pay overtime to a teacher who is conducting some adult education activities, this is again a resilience-enhancing project. The important factor in developing the proposal is ensuring that the school committee is able to clearly articulate the manner in which the project will enhance the psychosocial well-being of the school community.

Preparing pre-service teachers

Pre-service teachers are an untapped resource for carrying the message of psychosocial competence into disaster-affected areas as well as unaffected areas. The strategy is to include the topics related to psychosocial competence, resiliency, and development of a learning environment that fosters positive growth in children, self-care activities, and psychological first aid into the national teacher training curriculum.

Under the program, the pre-service teachers receive approximately 36 hours of training immediately preceding their student teaching semester. The pre-service teachers are supported with school chests and psychosocial activities-related material. Project staff provides supervision, once every month. The American Red Cross experience has been that pre-service teachers were enthused about organizing school psychosocial crisis response plan-related activities.

The program's objective is to assist pre-service teachers in developing mental immunity. By mental immunity we mean that the individual can: (1) recognize the threat and its characteristics; (2) use psychological capacities to cope with threatening situations, and (3) take preventive and objective measures in case the threat of disaster becomes a reality (Benyakar, 2003).

Preparing and Supporting the In-Service Teachers

Teachers and school personnel can provide children with an environment that is conducive to participatory learning, long after the disaster. Under the program, the teachers and school personnel are supported for up to three years with timely supervision. Six major areas are addressed in follow-up activities:

1. Sense of psychosocial well-being in school;
2. Signs of distress in children and how to address them;
3. Self-care activities;
4. Psychological first aid;
5. Use of school chests; and
6. Creating an inclusive environment.

Re-establishing the Community's Psychosocial Competence

The objective of engaging the community members in a systematic process of looking at themselves and determining their strengths and human capital, is called "Re-establishing the Sense of Place." Community interventions that are planned and developed for augmenting resilience and assisting the community to use their own resources for re-establishing their sense of place are found to be proactive, preventive, and positive in minimizing psychological dysfunction.

The programs' objectives are to:
- Conduct participatory assessment and context analysis of local community's resources, services, and practices, including identifying local resource people and community members;

- Provide capacity building and supervise community-based psychosocial workers on how to administer emergency support to alleviate disaster-related distress; and

- Address pre-emergency psychological or social symptoms and assist the community members to identify potential resilience activities that will contribute to the community psychosocial competence.

The program identifies community volunteers and provides capacity building to them so that they can become community facilitators (non-paid volunteers). The community facilitators assist in the development of community-owned and managed psychosocial support activities by promoting positive coping, individual, and group behaviors and strengthening networks that lead to psychosocial competence.

In every community the effort is to identify one out of fifty people to become a community facilitator. There are three distinct sets of activities that have to be developed by the community facilitator: (1) informal schooling, (2) informal health, and (3) community organization. Thus the challenge in developing community programs is to recognize that by enhancing resilience and assisting community in attaining its "sense of place" will lead to psychosocial competence - the focus of community-based psychosocial support programs.

A. Informal schooling

The informal school program works with children below five and out-of-school youth and marginalized groups of handicapped individuals, elderly, and widows. Each informal school is provided with recreation kits and other psychosocial support materials.

Education within these schools is facilitated by the community facilitators and led by the school teachers. In the morning sessions the focus is on education for children under five. The community facilitator, informal school teacher, and adults and adolescents from various marginalized group's assist in educating this group. In the afternoon session the activities focus on education for out-of-school youth and tutoring for children who need extra attention. These informal schools also serve as a venue where community elders come together to educate children about their history and culture and enhance their vocational skills.

Informal schooling includes creative and expressive activities to facilitate the involvement of the whole community including the elderly, physically handicapped, widows, and children in its recovery process. Not everyone feels comfortable expressing themselves verbally. Creative and expressive activities such as drawing, story telling, art and crafts, can provide creative ways for these individuals to communicate their feelings. Community-based skits and story telling has also proven to be a powerful and effective way of venting feelings; it is a simple healing process promoting a feeling of enjoyment and togetherness.

B. Informal health activities

Community health is divided into two sectors:1) trained medical personnel in the community health clinic or the local hospital who conduct the formal health activities, and 2) community members who carry out the informal health activities. These interventions usually rely on the traditional community resources, belief systems, and the definition of psychological well-being before the disaster. This level is broad and covers the:

1.Strengthening of the support provided by pre-existing community resources;

2.Community participatory activities that include getting members of the community together to identify and plan community activities to reduce the mental and social distress and to promote self care;

3.Activities that address important social factors to reduce social suffering;

4.Structured social services outside the health sector; and

5.Strengthening of community networks through community activities that ensure that isolated per sons come in contact with one other and generate mutual support.

C. Community Cohesion and Resilience Projects

The community facilitator is in charge of mobilizing the community and has responsibilities that are similar to someone working in disaster preparedness or response. But the exception is that the community facilitator is tasked with bringing the representatives of all segments of the community together for generating an understanding of the community and in planning a project jointly. Within the American Red Cross, psychosocial program resilience projects are defined as micro planning activities initiated in communities to assist the development of a long-term plan for reconstruction of the community's psychological and social networks.

PSP Long-term Development and Resilience Projects

The long-term development psychosocial support program is predicated on participatory planning by community members. The process proposes a set of community activities that will lead to community ownership, the development of human resources, and the sustainability of a representative community planning mechanism. The psychosocial project's role is to enhance the community's capacity for micro planning. Micro planning is the process that builds the capacity of the community to analyze its current situation and to develop strategies to work toward a better future. The common objective is to gain an understanding of the meaning of development to the community and to determine the currently available human and material resources and the common priorities to all community sectors.

Planning of resilience projects is an activity that is proactive rather than reactive and is sequential and collaborative. In emergency settings, the surrounding chaos, suffering, and time pressures push humanitarian agencies to act too quickly without learning about local beliefs and practices. Important opportunities thus are lost, and it becomes more likely that culturally inappropriate programming will be imposed. The meaningful participation of project beneficiaries in the assessment, planning, and implementation stages is essential in generating appropriate activities, a sense of ownership, and increased likelihood of sustainability.

To ensure that programming is inclusive, contextual, culturally sensitive, and appropriate, it is valuable to consider the four key questions that determine an effective disaster response and assist in developing a comprehensive, community-based psychosocial support program:

- *What do we want?* All community members get together and identify their psychosocial support needs. They rank the needs on the list and prioritize with the help of the community facilitator. This is the basis of the community-based psychosocial support intervention.

- *What do we have?* Knowledge about the community's capacity, its resources, strengths, and liabilities by analyzing the outcome of assessment process gives the community an insight into its actual rather than felt needs.

- *How do we use what we have to get what we want?* The community identifies the resources it has in terms of manpower, tools, land, etc. and, in a participatory process, assesses its utilization to achieve desired results.

- *What will happen when we do?* The outcomes of the community effort are compared with the program objectives, whether achieved or not.

Before implementing a community-based psychosocial support program, the planners, implementers, and beneficiaries should set up clear goals. The support organizations function as facilitators, providing structure and stimulation. Community members are usually willing to engage in the process and learn the skills in the process. The assessment's outcome acts as a baseline for problem identification and for measuring progress and is, therefore, an important element of community-based monitoring and evaluation.

Summary

This chapter presented the psychosocial program that is being implemented by the American Red Cross as part of the International response in disasters and long-term recovery. The program focuses on capacity building of local professionals and planning programs with beneficiaries using participatory techniques to identify the language of distress and to determine the community's psychosocial needs and wants. The two major programming areas are the community and schools. To date, the impact evaluation performed in existing programs suggest that non-professional personnel who learn first-order interventions, such as psychological first aid, and trained community volunteers can conduct timely interventions that will alleviate disaster-related stress.

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Lessons learned: Route map for future mental health and psychosocial support program planning, and development

1. Every program has a gestation period.
The expectation that a mental health or psychosocial support program is going to begin immediately is not appropriate. Every disaster brings different groups of responders in the acute ad rehabilitation phases. For GO's and INGO's who are prepared to serve for a short period of time (three months to one year), it is best to plan interventions with the existing government structures. For organizations planning to have psychosocial support programs during reconstruction to development, there is a need for careful planning interventions with the primary stakeholders. This gestation period (often as long as six months) allows for the careful planning, building the capacity of personnel on the ground, identifying the language of distress, severity, duration and what the community does to feel better and develop materials that are contextualized, are linguistically and culturally appropriate. All aspects of program from planning to evluation is conducted by local resources.

2.Establish network that will reach the most impacted within the community.
People mourn the losses, Begin to bond with the new place. Rituals from the old place and rituals from the new place are essential to the process of psychological rebuilding. Paradigm shift from formal mental health interventions in the health post or clinic to formal interventions by outreach teams or non-formal interventions by community volunteers may be the best way to reach the unreachable. Canvassing the neighborhood and engaging the survivors in community mapping may lead to more inclusive of persons that would otherwise not be counted.

3. Coordination and communication with other stakeholders prior to a disaster facilitate reaching the survivors quickly.
Coordination needs to take place with the other partners, non-health related organizations, and emergency management. Where possible protocols should exist in the country's emergency response plan outlining the roles of different partners in mental health and psychosocial support activities as part of the preparedness phase of disaster management. Well articulated response protocols and long term planners imbedded in the immediate response teams will guarantee uninterrupted services between the different phases of disaster reconstruction to development

4. Utilize a combination of measures to assure that a community has participated in identifying their emotional, psychological and social needs.
Use quantitative and qualitative methods of recording language of distress. Using the language of pathologies to identify the language of distress during the acute and early rehabilitation phases of a disaster is not an appropriate course of action. Most people will be distressed because they are experiencing loss of place, familiarity, and attachments (individual and collective). The signs of distress are related to disorientation, alienation and nostalgia. The community should be involved in defining its language of distress, and devising the potential interventions it needs to resolve the disaster related stress.

5. Accurate and timely information reduces disaster induced distress.
Information dissemination to the primary stakeholders has to be clear, simple, and easy to visualize. All information must be contextualized. To simply translate a handout to the target language does not guarantee that the primary beneficiaries will understand the messages. The amount of clear information that address basic needs, security and belonging needs, the faster people take charge of their own recovery.

6. Interventions must be simple, immediate, experiential and simple.
Medication may not the most prudent course of action in the aftermath of a major disaster. Community based interventions by health promoters and volunteers may be more effective. One recently accepted method is psychological first aid.

7. Assist local governments to institutionalize psychosocial support programs.
Psychosocial support is a simple program that can be easily institutionalized by the communities and local agencies. The ultimate goal should be to provide a sense of stability. Stability allows people to develop an intimate knowledge of their settings and to develop trusting relations with place and with each other, reintegration of the physical and psychological community, and recovery of home, family, friends and church.