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HOLISTIC CARE IN COMMUNITY DISASTER MANAGEMENT

Psycho-social Healthcare in Disaster Management

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Contents

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ABSTRACT

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Psychosocial Healthcare in Disaster management

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Recent global trends suggest an increase in natural and manmade disasters. The current pandemic is one such disaster that proves the need for heightened awareness on disaster and has highlighted the need for effective disaster management systems. Such disasters often result in a breakdown in social systems and infrastructure services and therefore affects human development and the economy. In order to minimize impact of disasters it is vital that a context specific multi-sectoral and multidisciplinary – holistic disaster management interventions approach is adapted. Furthermore, using principles of disaster management minimizes the risk of hazards turning into a disaster and therefore reduces vulnerability and the cost involved.

The healthcare system of a country plays a pivotal role at times of disaster. Thus, integrating disaster management within the primary health care can be proved instrumental in the provision of optimal assistance through the existing primary healthcare network. Furthermore, an integrated approach would insist on psychosocial wellbeing of those affected and can be administered through the primary health care workers themselves.

Considering psychosocial interventions as an essential aspect of recovery, the author proposes incorporating a holistic approach in policy and praxis of broader domain of disaster management. Further, the paper provides an insight into early interventions and best practices based on past learnings of the author. Identifying Post traumatic stress as a possible outcome of those affected could minimize psychological impact in victims, survivors and responders in the context of a disaster. Moreover, the paper provides interventions based on John Hopkins' R-A-P-I-D method[1] which can be administered by primary health care workers. In addition to providing psychosocial interventions for those affected, the importance of self-care has been identified towards minimizing possible signs of burnout. The paper concludes with recommendations aimed at strengthening the primary health care system towards effective disaster management within the sector.

Key words: Disaster, Disaster management, Healthcare, Holistic, Psychosocial

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[1] https://issuu.com/samaalmaqbali/docs/johns_hopkins_rapid_model-2

Overview

The paper presents a brief overview of the disaster scenario and explores the role of healthcare services in relief and disaster contexts. It proposes a critical review of current perspectives and practices, that de-prioritise psychosocial healthcare and interventions, and advocates for the inclusion of this important aspect as an integral component of Holistic Disaster Management. The paper lays a foundation for psycho-social healthcare in Holistic Disaster Management including both research and praxis for fieldworkers.

Introduction

Today in the context of a global pandemic more and more people and nations are aware of disaster. Not just the sudden onset or slow onset disaster but also global health disasters that affect entire populations not just the victims. No news is complete without mention of a hazard or disaster that has struck some corner of the globe. Almost every news channel, every daily newspaper features desperate faces of disaster of people struck by cyclones, earthquakes, floods, tidal waves, fires, building collapses, motor traffic collisions, etc. The difference lies only in location, nature and impact of the disaster.

Natural and manmade disasters often result in the breakdown of social system and infrastructure services with pronounced effects on human development and economy. We are told that the impacts of COVID19 that social development could be retarded by almost twenty – thirty years in some nations. They also cause health risks, disease and deaths either directly or through the disruption of health systems, leaving the affected communities without access to healthcare in times of emergency. A study done in 2012 shows empirical evidence shows that these negative effects are disproportionally concentrated in the developing countries which accounts for 68.2% of globally reported disaster mortalities[2]. A multiplicity of causes and risks - geophysical, urbanization, population growth and climate changes further increase the vulnerability to natural disasters, particularly, in developing countries.

Therefore, it becomes all the more critical that in order to meet the increased impact, incidence, and scale of natural and manmade disasters, there is an urgent need for adaptation of context-specific, multi-sectoral and multidisciplinary – holistic disaster management interventions and plans. Oftentimes we think of frontliners in a disaster as the rescue teams, the military, the NGO workers and health is often a support service. Furthermore, disaster response until very recently was understood and viewed in terms of physical loss, infrastructure and economic terms. However, more and more there is a growing body of learning that has brought to the fore the psychosocial impact of a hazard or disaster. In fact, the incorporation of psycho-social services into disaster management and response is still an ongoing debate and a service gap, even among health professionals that view health services as primarily emergency services in a disaster, attending to those injured physically, ignoring the mental and emotional wounds as almost a secondary priority. It almost highlights the sad divide existent between health professionals of primary/preventive health and curative care, psychiatrists & psychotherapists.

[2] Guha-Sapir D, Hoyois P, Below R. Annual disaster statistical review 2012 the numbers and trends. Centre for Research on the Epidemiology of Disasters (CRED) Institute of Health and Society (IRSS). Brussels, Belgium: Université catholique de Louvain; August 2013.

Hazard or Disaster?

The term disaster may be commonly understood to represent a sudden change in situation or condition which alter normal life of human beings. Disasters can be natural and/or man-made. Most often and in common usage the term disaster is used with reference to mean a situation triggered by natural causes, but many a times man-made disasters maybe more catastrophic. The COVID19 is one such that adds to the evidence of a catastrophic event. Disasters, regardless of natural or created, impact the life of everyone oftentimes with no respect or demarcation of haves or have-nots. However, it is also a fact that the most vulnerable and impacted, are often unable to fully recover from the plight they have fallen into. The most vulnerable are those in poorer economic strata of society, due to choice of geographic location, livelihood, housing, access to services, education and other social factors. Moreover, literal scarcity of water, food, shelter, medicines, fuels, electricity, communication etc., badly affect the have nots rather than the haves.

All disasters are hazards, but all hazards are not disasters. To explain further, if for instance, an earthquake was to hit a barren mountain with no human community, it would simply be a natural phenomenon. A hazard become a disaster only when it causes harm and destruction to life and property *of humans*.

When we look at Disaster Management (DM) scientists have come up with a risk equation to quantify this;

Risk= Threat x Vulnerability x Cost

- **Threat-** this is the frequency with which a hazard can hit the area. For example, the threat of an earthquake in the Himalayas is extremely high.
- **Vulnerability-** this is the weakness of an area towards an identified and particular hazard. For example, the Himalayas is extremely vulnerable to earthquakes, but not a tsunami.
- **Cost-** this is the human factor of the hazard. More the number of humans and property, greater is the cost involved and therefore, greater is the risk.

When the risk is high enough, there is a greater chance for a hazard to turn into a disaster.

In general, an incident is considered a *threat when the situation is mostly beyond our control*. Although when we think of the current COVID19 that maybe changing and have some exception. 'Disaster preparedness is about managing the unknown, it is not a science but a social behaviour that's responsive, predictive and imaginative'[3]. It's been said that, the time we spent on prevention today may be the life we save tomorrow.

So, what then is Disaster Management (DM)? **The basic principle of disaster management is to reduce the risk of a hazard turning into a disaster**. We do this by trying to minimize any of the above three variables in the risk equation.

Therefore, the focus in most DM projects, based on the risk equation above, is to *reduce the vulnerability and the costs* involved in an area of interest. Generally, in most incidents, it is the vulnerability that is almost completely under human control. Reducing vulnerability reduces the impact of a disaster as well as aids and enhances the recovery process of such a disaster. The focus of this paper is to address not the cost factors but mainly the mitigation of vulnerability.

[3] https://files.eric.ed.gov/fulltext/ED495715.pdf

Global Context – Health in Disaster Management & Disaster Risk Reduction

Lessons from the West African Ebola outbreak and Hurricanes Katrina and Haiyan show how an emergency can deteriorate into a disaster in the face of a weak health system. In such contexts it is critical to have a robust and functional health information management systems which could provide the information required for timely detection and response to presence of biological hazards such as cholera, typhoid fever, watery diarrhea, measles, etc., which often occurs as aftermaths of disasters.

Research has shown, and even with the ongoing pandemic of COVID 19 it has become evident that, high-income countries that have established, efficient and effective emergency medical care systems are better placed to deal with a crisis. Of course, it must be stated that we have also seen that even in nations with high end, 'state of the art' health facilities when and where policy gaps have been present the ability to manage this crisis has been found wanting. However, where it is present, this system has played a crucial role in responding immediately and successfully managing medical emergencies such as injuries, trauma and other life-threatening conditions. However, the challenge for us in this part of the globe is that, establishing such a robust emergency medical care system in low-income countries, such as ours, is not possible due to substantial financial, human and material resources required to maintain and operate such services[4].

What is possible to do in such contexts then, is instead to utilize this as an opportunity to mainstream and integrate the primary health care that exists in low-income countries with disaster response services. The integration of the disaster management within the primary health care can be proved instrumental in the provision of optimal and low-cost emergency medical assistance by utilizing the existing primary healthcare network (physical infrastructure and human/financial capital)[5]. Additionally, primary healthcare can integrate disaster preparedness in capacitating households, communities and health systems in managing disaster related risks and hazards[6]. My proposal is that the broader domain of Disaster management must be holistic; incorporating policy and praxis in, physical, medical, economic, infra-structural and psychosocial despite being portrayed and perceived as two separate entities with arguments in favour for and against each[7]. These arguments revolve around the conceptual definitions whereas primary health care and emergency medical assistance are considered as developmental and emergency response intervention respectively. Creditably, the divide appears to be closing as more and more awareness of a holistic, multi-disciplinary approach is proving its effectivity in disaster response and management. For eg, more than 90% of the patients were enrolled and examined for non-surgical primary care in the trauma unit established by army medical core for provision of specialized surgical care, in the advent of earthquake in Pakistan[8]. The evidence from implementation also shows that the provision of such an integrated healthcare services from primary health care facilities during disasters has drastically reduced the associated mortalities and morbidities[9]. The learnings from the implementation of the emergency response highlight the need for sustaining all the essential components of primary health care

[4] Dries DJ. Guidelines for essential trauma Care. Shock. 2005;23(1):97-8.
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5768434/
[6] The World Health Report 2008 - primary Health Care (Now More Than Ever), https://www.who.int/whr/2008/en/
[7] Redwood-Campbell L, Abrahams J. Primary health care and disasters-the current state of the literature: what we know, gaps and next steps. Prehosp Disaster Med. 2011;26:184–191. doi: 10.1017/S1049023X11006388. [PubMed] [CrossRef] [Google Scholar]
[8] Fernald JP, Clawson EA. The mobile army surgical hospital humanitarian assistance mission in Pakistan: the primary care experience. Mil Med. 2007;172:471–477. doi: 10.7205/MILMED.172.5.471. [PubMed] [CrossRef] [Google Scholar]
[9] https://www.who.int/whr/2008/en/

during disasters and adapting a holistic approach by mainstreaming and integrating emergency medical assistance and disaster response into primary health care policies, strategies, and services[10] [11] [12].

Globally, the two most recent landmark agreements adopted by the UN in 2015 are the Sendai Framework for Disaster Risk Reduction (SFDRR) and the Sustainable Development Goals (SDGs). The SFDRR in contrast to its predecessor, the Hyogo Framework for Action, puts a lot of emphasis on health proposing resilient health systems as the way forward in effective DRR [13]. In fact, the World Health Assembly, through resolution 64.10, urged countries to strengthen disaster risk management (DRM) programs by incorporating them into national health systems[14]

The Health System

The health system (see **Figure 1**[15]) consist of "*all organizations, people and actions whose primary intent is to promote, restore, or maintain health*"[16] and DRM is defined as the use of administrative and

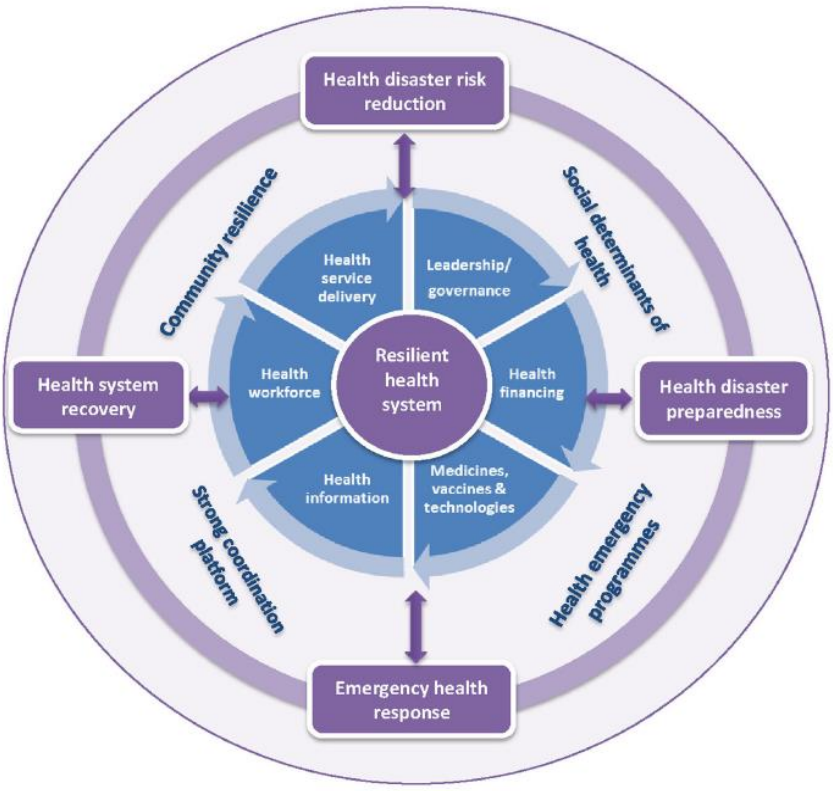


FIGURE 1 | The health system building blocks as a conceptual framework for public health disaster risk management.

[10] Gardemann J. Primary health care in complex humanitarian emergencies: Rwanda and Kosovo experiences and their implications for public health training. Croat Med J. 2002;43:148–155. [PubMed] [Google Scholar]

[11] Calderon-Abbo J. The long road home: rebuilding public inpatient psychiatric services in post-Katrina New Orleans. Psychiatr Serv. 2008;59:304–309. doi: 10.1176/appi.ps.59.3.304. [PubMed] [CrossRef] [Google Scholar]

[12] Sartore GM, Kelly B, Stain HJ. Drought and its effect on mental health--how GPs can help. Aust Fam Physician. 2007;36:990–993. [PubMed] [Google Scholar]

[13] http://www.frontiersin.org/Journal/10.3389/fpubh.2017.00263/abstract

[14] https://apps.who.int/iris/handle/10665/3566

[15] Olu Olushayo, Resilient Health System As Conceptual Framework for Strengthening Public Health Disaster Risk Management: An African Viewpoint - https://www.frontiersin.org/articles/10.3389/fpubh.2017.00263/full

[16] https://www.who.int/healthsystems/strategy/everybodys_business.pdf

operational procedures to implement interventions aimed at reducing the adverse impact of disaster hazards[17]. The health system encompasses all direct health-improving activities implemented either at home, in the community, both in the formal health sector level and the informal health sector levels which contribute to the social determinants of health, which are the conditions under which people are born, live, and grow.

A Resilient Health System[18]

What are the characteristics of a resilient health system? A study done post the Ebola crisis by a group of scholars and practitioners arrived at these conclusions;

- It is one which can effectively prepare for, withstand the stress of, and respond to the public health consequences of disasters.
- Resilient health systems can protect themselves and human lives from the public health impact of disasters and
- are critical to achieving good health outcomes before, during, and after disasters.

They also defined five characteristics or elements of such a health system.

1. Resilient health systems should be aware of the strengths and vulnerability of its building blocks and the spectrum of hazards and risks to which it is exposed.
2. They should be able to respond to a wide range of public health issues before or during a disaster.
3. Health systems should be able to quickly and effectively adapt to changing situations.
4. Should use integrated approaches for responding to public health events such as disasters.
5. Should be able to regulate itself.

Psychosocial care in a post disaster setting

Today the buzz word in the Disaster sector is 'build back better'. Almost universally, international agencies respond to disasters with a 'build back better' approach, which the UN office for the Coordination of Humanitarian Affairs (UNOCHA) defines as 'helping people rebuild their infrastructure so that they are safer than they were before the natural disaster struck'.

In such definitions we see the rather blinkered perspective of what 'build back better' might mean, in that it ignores some of the complexities of factors that impact and intersect in the life of a survivor of a disaster. It is important to bear in mind that in such contexts just as much as development practitioners one may reference Maslow's hierarchy of needs, in DM too this is a useful guide against which Disaster response and DM is referenced. There is an opportunity here for all programmes to take an approach that not only 'minds the relief-reconstruction gap' but addresses what are often viewed as competing priorities, together.

'Building back better', then, must not only rebuild disaster-resilient infrastructure, but must also build disaster-resilient societies in a multi-sectoral way. Holistic Disaster Management I believe is a step in that

[17] UNISDR Terminology on Disaster Reduction. *United Nations Office for Disaster Risk Reduction (UNISDR)*. (2009) - https://www.unisdr.org/files/7817_UNISDRTerminologyEnglish.pdf

[18] Ibid

direction and for me therefore Psychosocial healthcare in DM is a further step in the right direction towards a truly integrated healthcare response within Holistic DM.

I recall post the South Asian Tsunami of 2004, meeting with people that were dazed and numbed by shock and trying to plan relief interventions and realizing that it was so hard! None of our partners even considered that in our response planning except for a tiny part that allowed us to focus on some very basic psychosocial care for child survivors. The South Asian Tsunami I believe was one incident that awakened the consciousness of the humanitarian sector of the need for psychosocial care, to some degree. For me after several years in the field, involved in conflict response, this was the first ever time. Thereafter, we saw this being acknowledged and included in post-conflict response in 2009, most recently, after the deadly Easter Sunday bombings of 2019 in Colombo and now with the pandemic of COVID19 that has resulted in a significant majority of the global population suffering the impacts of lockdowns in their nations, many have realised the need for psychosocial interventions in their efforts. However, I note that despite this, specific mention of psychosocial intervention in the UN Global Humanitarian Plan in its three priorities is sadly lacking.

Disaster mental health is based on the principles of 'preventive medicine' This principle has necessitated a paradigm shift from relief centered post-disaster management to a holistic, multi-dimensional integrated community approach of health promotion, disaster prevention, preparedness and mitigation. This has ignited the paradigm shift from curative to preventive aspects of disaster management. This can be understood on the basis of six 'R's such as Readiness (Preparedness), Response (Immediate action), Relief (Sustained rescue work), Rehabilitation (Long term remedial measures using community resources), Recovery (Returning to normalcy) and Resilience (Fostering).[19]

Humanitarian and social assistance is an important part of the work to improve mental health of populations affected by disasters but should be complemented with other specific interventions[20].

"There can be no transforming of darkness into light and of apathy into movement without emotion"- CARL G. JUNG

Understanding the incident

So, humanitarian disasters are inevitable. The impact of a humanitarian disaster impacts people on different levels. There would be **victims, survivors and responders** who are generally affected directly and indirectly.
There are also **Cataclysmic events**[21] - Strong stressors that occur suddenly and typically affect many people at once (e.g., natural disasters)

Victims: Refers to those who were directly affected by the crisis and faced death or injury. Victims are subjected to Physiological and psychological trauma.

[19] https://pubmed.ncbi.nlm.nih.gov/26664073/
[20] http://www.saludydesastres.info/index.php?option=com_docman&task=doc_download&gid=436&Itemid=
[21] Feldman, R., 2010. *Understanding Psychology*. 10th ed. McGraw-Hill Publishing, p.474

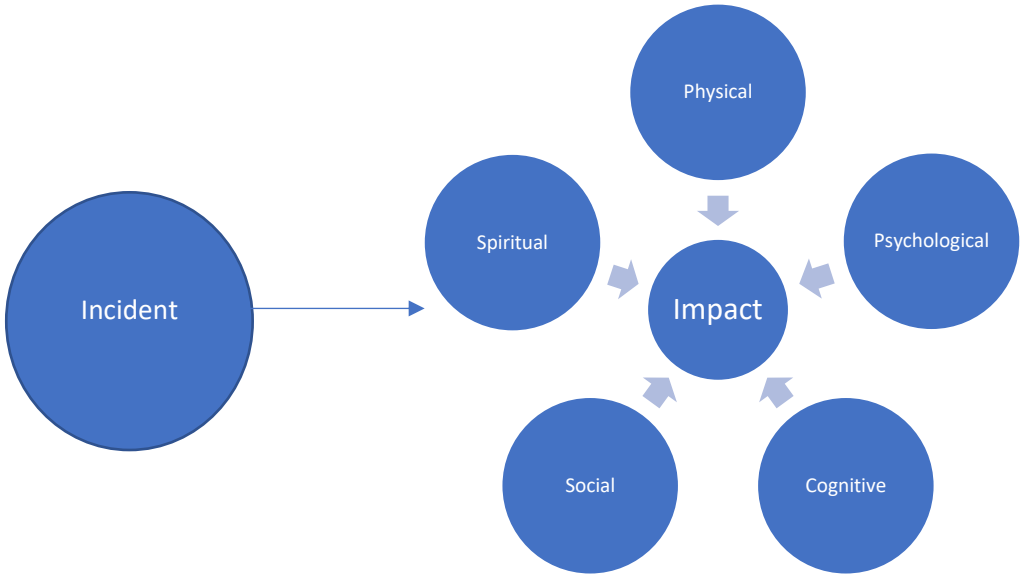
Survivors: Refers to those who witnessed the event, escaped the event, families or friends left behind of the victims. Survivors are subjected to more psychological trauma.

- **Survivor reactions at the three stages of response**
  - Reactions during emergency relief
  - Reactions during recovery
  - Reactions during long-term rebuild

Responders: Refers to those who responded to the crisis and may have witnessed the crisis. Humanitarian aid workers, fire fighters, medical front line workers, rescue operation workers, military, therapists, social workers. Responders may also be survivors of the crisis but are more subjected to secondary trauma.

Phases of emotions in a disaster relief response (see annexure 1 and 2)

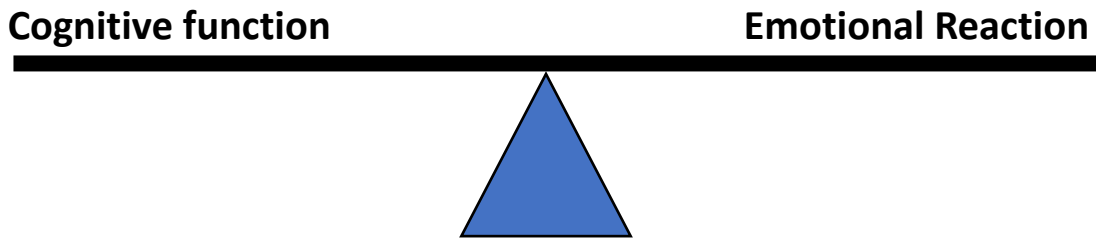
- Heroic
- Honeymoon
- Disillusionment
- Reconstruction



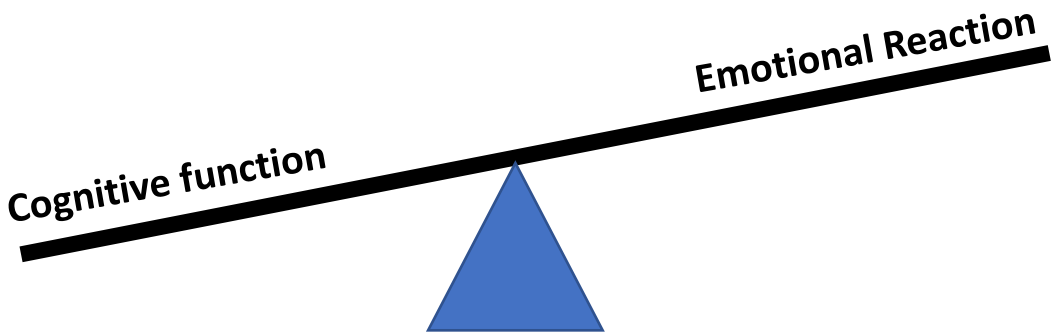
The impact of a traumatic incident can affect a person's Physiological/biological, Psychological/emotional, social, spiritual, cognitive wellbeing. The human biological system is connected to all other functions of the system such as the neurological, endocrinological and psychological system. Thus, with the impact of a traumatic event, which may or may not contain physical injury will eventually affect the cognition, hormones, emotions and behaviour of an individual. It is essential to consider all aspects when interventions are administered to victims or survivors of disaster.

Understanding the person affected

During 'normal' circumstances mind and body are balanced



During "Trauma" circumstances, mind and body are out of balance....



Psychological and emotional impacts of a crisis

A normal stressful incident in our day to day life would cause a certain amount of emotions like sadness, worry, anxiety or anger. After a couple of hours to a few days the emotions will settle, and we are able to cope with the stressful incident and move on. In the same manner, a humanitarian emergency or crisis can cause an impact which is more long term.

Stress is the body's response to external circumstances. In situations where there is real or perceived danger, the body goes through physical and psychological changes to prepare for "***fight, flight, flow or freeze or flow***". There is no right or wrong way to respond and typically a response is natural and depends on the experience and past triggers of the person. In such a context, those affected by a traumatic event would either **fight** – rescue others affected/face the crisis, **flight –** escape from the situation, **freeze** – unresponsive and a state of shock, **flow –** go with the flow of the event and others at the time of crisis. Thus, victims/survivors would have responded in one of the ways as mentioned above[22].

How people experience Trauma

- Direct: Immediate danger and life-threatening situations. May include physical injury and death of family/friends.
- Indirect: Second-hand knowledge of events. May have survivor guilt and associated negative emotions.
- Family and Loved ones: Involved with helping the above try and recover. Survivor guilt.

[22] Gold, S. N. (2017). *APA handbook of trauma psychology* (Vol. 2) p 533.

- First Responders: Experiencing negative emotions with failed rescue attempts or failed attempts to assist.

Age Specific response to Trauma

In keeping with accepted child safeguarding protocols, if you are you are unknown to the child survivor, or not a primary caregiver consent for physical touch should always have been sought.

Age	Reaction	Need	Intervention
Birth – 2 years	**Fear and disorientation**	**Trust and physical contact**	**Carry or hold and return to caregiver**
2 – 6 years old	**Fear and abandonment**	**Trust, care and stability**	**Sit beside and hold hand. Return to caregiver**
6-12 years old	**Doubt and inadequacy**	**Trust, Friends and stability**	**Establish routines and order**
12-18 years old	**Denial, anger and fear**	**Trust, identity, and friends**	**Restore peer attachments. Provide for privacy**
19-35 years old	**Isolation, denial and anger**	**Trust, control and normalcy**	**Empower with choices. Provide information**
35-65 years old	**Anger, fear**	**Normalcy and Privacy**	**Restore order and assure privacy**
65+ years	**Fear, disorientation**	**Routine, trust, control**	**Listen to stories. Restore order**

Acute stress disorder ASD (3 days – 1 Month)

The response to a major catastrophes or strong personal stressors that have effects from 3 days to 1 month of the incident. If symptoms persist beyond 1 month, it would be categorized as PTSD which would require intense interventions.

Post-traumatic stress disorder - PTSD (1 month – 3months)

A phenomenon in which victims of major catastrophes or strong personal stressors feel long-lasting effects that may include re-experiencing the event in vivid flashbacks or dreams[23].

[23] Feldman, op cit,p 474

Signs/Symptoms displayed by victim or survivor

(Extracted from DSM – 5 *Diagnostic and statistical manual of mental disorders: DSM-5*. (2017). Arlington, VA: American Psychiatric Association)

If below symptoms persist from 3 days to 1 month – ASD
If below symptoms persist form 1 month – 3 months – PTSD

- Flashback of the event
- Distressing dreams of the event
- Disassociation
- Loss of memory related to the event; avoidance of thoughts related to the event
- Avoidance of objects, situations or reminders related to the event
- Inability to recall details of the event
- Negative thoughts (I am bad, this world is bad)
- Fear, horror, anger, guilt, shame
- Self-blame
- Detachment and disengagement from others
- Irritable, reckless and self-destructive
- Hyper vigilance
- Exaggerated startle response
- Sleep disturbances
- Lack of concentration

Responding and caring for a victim/survivor – Psychological First Aid

In general life, during any physical injury the immediate response would be to provide the person with first aid. In the context of a humanitarian crisis, in addition to ensuring medical aid, it is vital that psychological first aid is also given priority.

In the context of COVID 19, it has created a sense of uncertainly and an increase in anxiety among those affected and those vulnerable. It is generally accepted that stress and emotional weight adds to the lowering of immunity of a person. While providing medical assistance to those affected, looking into the psychological aspect of the pandemic will also contribute towards the wellbeing of the patient. While recovery, may be uncertain for the patient under care, the caregiver must be aware that it also creates a sense of 'hopelessness' within oneself. Such situations are not only challenging for a patient but a caregiver as well. It is imperative to keep in mind that those affected have been separated from family and friends and thus will feel that they are 'suffering alone'. It is helpful as frontline workers or caregivers to focus on helping the patient to cope through the present day by imparting care and compassion through listening to them and acknowledging their emotions towards the situation. In addition, relating with the patient's spiritual belief would add meaning to the state of helplessness.

Psychological first aid can be provided by a lay person or a professional who is aware of the basic method. John Hopkins outlines this in what is called the R-A-P-I-D method[24]. The acronym includes what I have highlighted in brief below.

[24] https://issuu.com/samaalmaqbali/docs/johns_hopkins_rapid_model-2

1. **Reflective listening** to establish rapport and trust
2. **Assessment** of Cognitive, Emotional, Behavioural and Spiritual reactions.
3. **Prioritise** who receives attention based on risk and vulnerability.
4. **Intervention** to stabilise the individual and mitigate the impact of the incident.
5. **Disposition / Disperse** – determining ability to self-care or referral required.

Psychological first aid can be provided to a victim or survivor who is in a state of consciousness. The below mentioned can be followed by the responder.

a) Make a Connection with the Person

- Introduce yourself if you are unknown to the person
- Greet the person warmly and offer condolences if this is the first time to make a connection
- Be fully present – physically, emotionally, spiritually
- Be aware of cultural implications and act accordingly
- Build trust and rapport

b) Listen to the person – Listen more than talk!

As human when dealing with a stressful event it is most likely that we would want to talk about the stressful incident with family, a friend or a therapist. In the same manner, upon a traumatic incident, one's emotions and cognition would be shaken and affected. They may be confused, grieving, in shock or any of the above symptoms. At such a time, reasoning and decision making would be impaired. They would be in dysfunctional state and their emotions would be complex. (Similar to spaghetti).

In order to minimize the impact of such complexity or chances of PTSD, the responder may listen to the story, incident or narration of event of the victim/survivor. While the victim/survivor narrates the incident, he/she may repeat the same 'story' over and over again, cry in between, freeze in between conversation or the story may not make sense. At this point, it is important to simply listen to the person rather than trying to rationalize and make sense of the event or incident. Sometimes listening is all what a person requires

Tips for effective listening:

- Give your full attention to the victim or survivor
- Give eye contact while the person is talking
- Do not interrupt the conversation to ask questions in between
- Let the person talk more than you respond
- Listening without judging
- Provide clarification – keep your responses simple

c) Empathy

In simple terms, empathy means getting into another person's shoes. Thus, when listening to a person narrating the event, it will be helpful for the responder to understand the emotions of the person. In order to understand, the person the responder will have to ask oneself the question 'If I was the victim/survivor how would I feel?'. It is important that the responder refrains from showing sympathy towards the person, as it may make the victim/survivor feel even more helpless and powerless. Empathy is an approach that empowers and strengthens the victim/survivor further and give a sense of control. The affected person may have questions as to why the incident happened to me? Why did God allow this? Why me? In such

instances the responder does not have to provide an answer, but be honest to say, “I do not have answers” rather than providing solutions.

How to empathize?

Use phrases such as …

- Would you like to talk?
- I can imagine
- It must be difficult/tough/painful
- I am sorry about your loss
- I do not have an answer as to why this had to happen to you/ or to your loss

A good open source resource for Psychological First Aid is the WHO publication Psychological First Aid a guide for field workers.
https://apps.who.int/iris/bitstream/handle/10665/44615/9789241548205_eng.pdf;jsessionid=20E9A4A0D7853F0D384C2BD077DD92E0?sequence=1
It is downloadable in other languages too;
https://www.who.int/mental_health/publications/guide_field_workers/en/

Self- Care for frontliners

(extracted from - COMPASSION FATIGUE AND BURNOUT IN NURSING Enhancing Professional Quality of Life- Vidette Todaro-Franceschi, springer publishing,2013)

In terms of survivors who survived or witnessed the event, the impact would be greater, more evident and would range from immediate to delayed onset. Furthermore, responders would also have a similar impact which may be a rather delayed impact than immediate as burnout is known to develop gradually (Maslach, 1982). Generally, the survivors of an impact are given immediate medical and psychological attention as they are identified as outright survivors. Although responders at times may also be a survivor of the crisis, they are forced to respond to the crisis which may cause a combination of PTSD and compassion fatigue (p 157). Therefore, the impact is usually not identified by the responder themselves (p4) and lessor attention is given to such responders until awareness is heightened.

Responders to a crisis can be classified as humanitarian aid workers, fire fighters, medical front line workers, rescue operation workers, military, therapists, social workers etc. The general impact of a traumatic even causes a person to fight, flight, freeze or flow with the crisis. Responders to the crisis are known to be those who fight the crisis. Thus, this leads to them be on a survival mentality for days when responding to the crisis. They would keep going until the crisis is under control or over. This in turns leads to a delayed impact and when the crisis is over, there would be evident signs of distress in emotions and behaviour. This can be classified as compassion fatigue, burnout or secondary stress (p76). Compassion fatigue is the costly result of providing care to those suffering from the consequences of traumatic events.

Typical Causes of Secondary Trauma / Compassion fatigue

- Non compartmentalized compassionate care
- Owning other people’s problems/issues/concerns
- Over identifying with other people’s distress
- An empathetic connection to a trauma survivor / a feeling of responsibility
- Experiencing the traumatic event as if it were a personal experience
- Lack of rest and time to debrief

Identifying compassion fatigue/burnout

Behaviour Changes	Chronic fatigue
Exhaustion (physical, emotional, or both)	Depression
Anger, Blaming, Irritability	Exaggerated startle response
Apathy	Overworking / Reduced productivity
Substance abuse / Eating disturbances	Disrupted sleep patterns
Procrastination / Chronic lateness	Difficulty focusing or concentrating
Avoiding or dreading work	Calling out sick more often
Decreased sense of purpose	Diminished sense of personal accomplishment
Anxiety	Less able to feel joy or happiness
Low self-esteem / over personalisation	High self-expectations
Helplessness and hopelessness	Numbness, empty hearted
Disinterested and detached	Disillusioned
Reduced emotions of compassion/ numbness	Inability to maintain balance of empathy and objectivity
Frequent headaches	Frequent or lingering illness
Gastrointestinal complaints	Hypertension Cardiac symptoms such as chest pain or tachycardia
Muscle tension, aches, and pains	Questioning one's faith
Intrusive memories	

Self-Care & Interventions

- Delegate
- Set Personal boundaries / create margin
- Self-awareness / Clarify options
- Redefine what success means
- Intentional breaks / rest
- Debriefing – Critical incident debriefing
- Practical self-care methods – rest, eat, relax
- Social support

"Self-compassion is simply giving the same kindness to ourselves that we would give to others." - Christopher Germer. In the Bible it says, "The Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God" (2 Corinthians 1:3-4) ***So Take care of yourself, your wellbeing, as you cannot give to others what you don't have within yourself…***

Best practices

The best practices suggested below are based on the 'do no harm' principle and those collated from lessons learnt in responding to disasters and work with survivors. **It is essential to note that victims/survivors are already affected and thus it is imperative that responders do not cause further harm.**

DO…

- Remember every individual is resilient and a responder needs to help a survivor remember their own strengths and how they coped in difficult times before
- Let the person talk when he/she is ready or wants to talk about the incident. Do not force the person to talk about the incident.
- Help people to feel less anxious or worried by letting them know that what they are feeling, or thinking is understandable
- Acknowledge the loss
- Give permission to grieve
- Maintain confidentiality of what the person shares unless it involves medical assistance.
- Do not give false promises/hope or promises that you cannot keep which are connected to the incident. (Example: I will surely locate your family)
- Be honest with the person and tell the truth about the situation. If there is any loss involved it is important not to hide it for too long and it is to be disclosed in a professional manner.
- If appropriate, ensure basic physical needs are met
- Provide practical help such as assisting with phone calls
- Assist in finding or reuniting loved ones if displaced due to the disaster
- If / When requested, provide spiritual care such as prayer
- Do instil hope and connectedness in whatever realistic way that increases an individual's ability to cope.
- The help offered, must protect their dignity and protect their rights to ensure wellbeing and recovery.
- Help must be contextually relevant and culturally appropriate

DO NOTS…

- Do not expose the person to further triggers of the event (Avoid television news or any media repeating the incident)
- Do not assume you know the need of the survivor the individual's priorities may differ from yours; hence ask them.
- Do not further endanger, harm the dignity or deny the rights of the affected by the help offered.
- Do not try to fix the situation. Help the person accept the loss and grieve
- Do not change the subject
- Do not share your own experience or emotions regarding the event
- Do not say, "I know how you feel"
- Do not provide advise other than for medical reasons
- Do not minimise their loss
- Do not blame the person/assign guilt upon them
- Do not comment on the political/religious perceptions related to the event

- Do not begin counselling or psychological therapy if you are not trained to do so
- Do not ask questions for curiosity
- Do not take photographs of the person affected or any related for publishing on social media, unless for medical reasons

Recommendations

- Understand that Healthcare is a vital component of DM and its absence can turn a hazard into a disaster.
- Understand that Primary and community healthcare can play a crucial role in building the local capacity, responding immediately when a disaster or public health emergency struck and making the communities more resilient to disasters.
- Integrate and include Psychological First Aid in DM and emergency response mechanisms and systems as part of build back better policies.
- Arranging training courses for the faculty members to better equip them in transferring these newly acquired skills to the health profession students,
- Give attention to and invest in self-care of healthcare workers
- Provide for self-care within service policies and make it accessible as an essential and mandatory support for frontliners.
- Impart pre-and-in-service training on these and standardized competencies to adequately equip and prepare the first level healthcare providers in managing disaster affected patients and address associated ramifications/consequences of any catastrophic event.
- The recovery work should begin immediately after the critical phase of the emergency. The psychosocial impact of a disaster is the outcome of several factors which need to be dealt with appropriately; they include the nature of the event, the extent to which an individual is affected, and the nature of the losses. It will also be necessary to ensure continual monitoring to determine the medium- and long-term repercussions. [25]
- A good strategy of information and guidance for the community is essential to promote calm and to reduce fear and suffering

For Policy makers –

- Further strengthen the Primary Healthcare system within the sphere of disaster management, particularly in low-income countries as a strategy for resilience and recovery within build back better philosophy.
- Further the adaptation of holistic and integrated approaches, by developing capacities of first level healthcare providers, managers, trainers and health profession students on disaster management related competencies and skills - This signifies the need for medical educators to
- Adapt a tailored contextual strategy for transferring the competencies, to the healthcare providers during their pre-service and in-service training
- Map these competencies against the existing curriculum in the health professional schools and
- Updating these and developing tailored modules for teacher and faculty members on different aspects of disaster management,

[25] file:///C:/Users/HP/Downloads/16_MentalHealthPsychosocialSupport-7.pdf

- Developing and offering relevant continued medical education courses for all associated with DM.
- Specialized care should be reserved for cases with more complex mental disorders. The mental health services should be linked to primary health care

Conclusion

In an analysis of over 160 empirical studies involving over 60,000 survivors of disasters, conducted by Fran Norris and her colleagues. 41% of studies revealed evidence of severe to very severe impairment. By 'severe impairment' here is meant that there is interference with one's ability to function as one needs to, and this was significant among disaster survivors. This may be said the increased demand for mental health services may range from 15 to 25% of the directly affected population. So, for example, if we are looking at a catch area of roughly ten million people that are affected by some widespread adversity, (which could be a hurricane, a bombing, a terrorist attack), public health planners should estimate that in that scenario, somewhere between 1.5 million and 2.5 million people will require direct mental health services of some form[26].

Beverley Raphael, in her book, When Disaster Strikes says, "In the hours after a disaster, at least 25% of the population may be stunned, dazed, apathetic, and wandering, suffering from the disaster syndrome, especially if impact has been sudden and totally devastating[27]". At this point, she recommends psychological first aid and triage are necessary. If this be true, the need for people with these skills is immense and critical for recovery, to build back better and for resilience.

Disasters are inevitable and at times beyond human control. One can only minimize the risks and vulnerability to disaster through effective disaster management. With recent trends of an increase in disasters and catastrophic events affecting humankind in various unexpected forms, it has only made the general population more anxious than prepared. Such has led to an increase in mental health and psycho-social related issues. Thus, it is imperative to focus on accepting the inevitable and cultivating a resilience mindset which would prepare one to face disasters and cope in a much healthier manner. As frontline workers, while it is essential to cultivate resilience within oneself, one can also be an instrument of healing to those affected to grow through the crisis rather than decline and reach a helpless state. The psychosocial care provided to victims or survivors can turn a post-traumatic stress situation into post traumatic growth situation. In addition to focusing on physical and medical healing, being an instrument of emotional and spiritual healing adds towards the holistic restoration of a person.

When we care for others, we become not just people who talk of helping others, but people who put our words into deeds. We become true followers of the tenets of our faith. In both the Islamic & Christian traditions of faith we see that compassion is at the heart of belief. Jehovah is seen often to act with compassion towards the widow, the orphan and the alien, and requires his people to do so too. 'This is what the Lord Almighty said: 'Administer true justice; show mercy and compassion to one another. Do not oppress the widow or the fatherless, the foreigner or the poor. Do not plot evil against each other.'

[26] Norris FH, Friedman MJ, Watson PJ, Byrne CM, Diaz E, Kaniasty K. 60,000 disaster victims speak: part I. An empirical review of the empirical literature, 1981-2001. Psychiatry: Interpersonal and Biological Processes. 2002; 65:207–239. [PubMed] [Google Scholar]

[27] Raphael, Beverley. *When Disaster Strikes: A Handbook for the Caring Professions,* Hutchinson 1986. p.257

(Holy Bible - Zechariah 7:9-10). Similarly, the first verse of the Quran breathes the spirit of peace, it reads: "In the name of God, the Most Merciful, the Most Compassionate." This verse is repeated in the Quran no less than 114 times. It shows the great importance Islam attaches to such values as mercy and compassion. Goodness, the Holy Quran says, does not consist in turning your face towards East or West. The truly good are those who believe in God and the Last Day, in the angels, the Scripture, and the prophets; who give away some of their wealth, however much they cherish it, to their relatives, to orphans, the needy, travelers and beggars and to liberate those in debt and bondage; … These are the ones who are true, and it is they who are aware of God. (Al Quran 2:178) Jesus in His teaching said, 'You shall love your neighbor as yourself. There is no other commandment greater than these'. (Holy Bible – Gospel of Mark 12:31). And in another teaching, it says, Bear one another's burdens, and so fulfill the law... (Galatians 6:2).

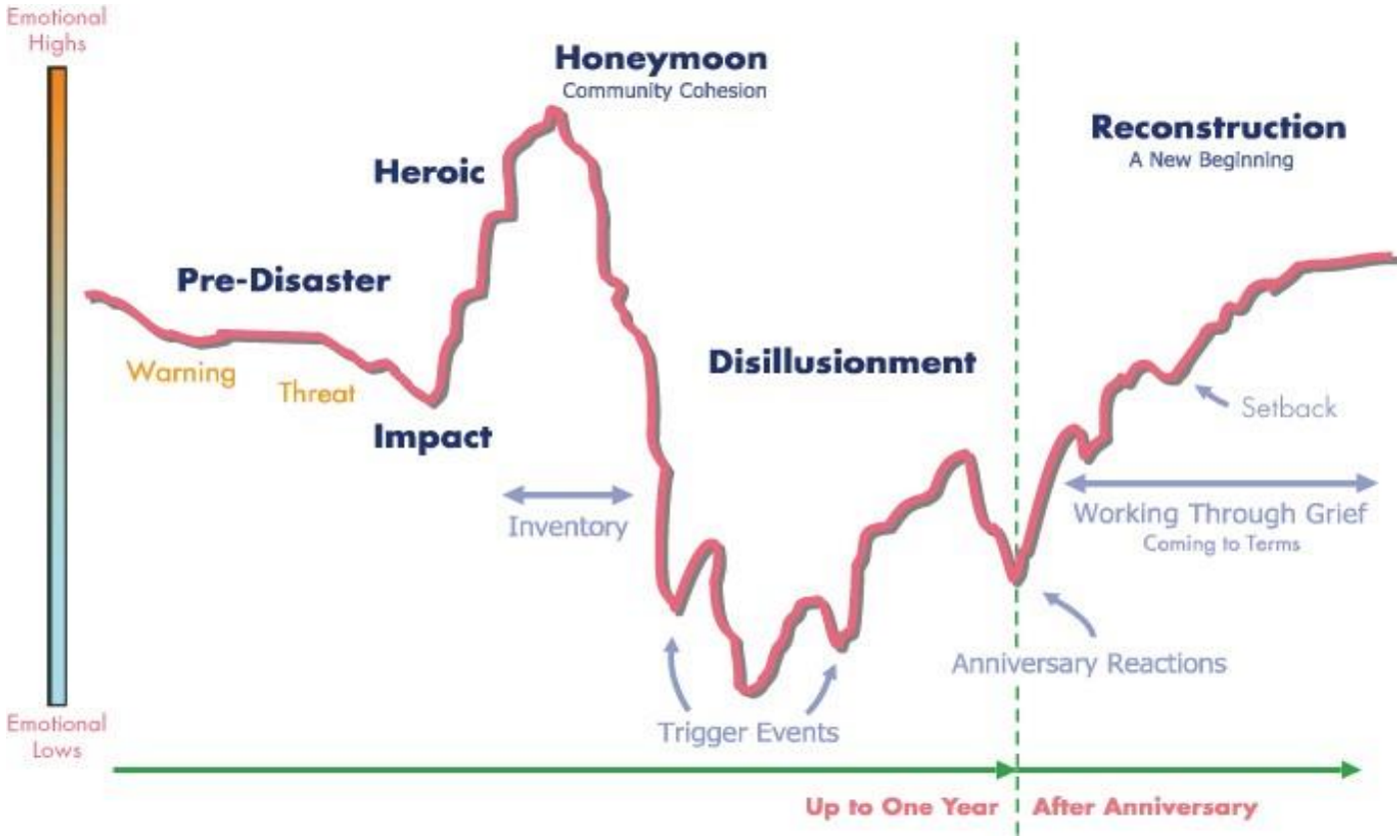
"It is a beautiful and mysterious power that one human being can have on another through the mere act of caring ...A great truth, the act of caring is the first step in the power to heal". – Phillip Moffitt

ANNEXURE 1


Phases of Disaster
1 Pre-disaster Phase
Disasters with no warning can cause feelings of vulnerability, fear of the future, lack of security, and loss of control. Disasters with warning can cause guilt or self-blame for failure to heed warnings.
2 Impact Phase
Reactions can range from shock to overt panic. Initial confusion and disbelief are followed by a focus on self-preservation and family protection. Emotions range from shock to panic.
3 Heroic Phase
Many survivors exhibit adrenaline-induced rescue behavior, high activity, and low productivity. Risk assessment may be impaired. There is a sense of altruism.
4 Honeymoon Phase
Community bonding occurs. Disaster assistance is readily available. Many are optimistic that all will return to normal. CCP staff can establish a program to identify, assess, and help those affected.
5 Disillusionment Phase
Stress and fatigue take a toll. Optimism turns into discouragement. Need for substance abuse services may increase. Larger community returns to business as usual. Demand for CCP services may increase.
6 Reconstruction: A New Beginning
Individuals and communities begin to assume responsibility for rebuilding their lives. People begin adjusting to new circumstances. There is a recognition of growth and opportunity.
Source: U.S. Department of Health and Human Service

ANNEXURE 2

EMOTIONAL PHASES OF A DISASTER: COLLECTIVE REACTIONS[28]



The graphic above illustrates the general progression of the disaster effects and reactions on communities from the pre-disaster or warning phase through the reconstruction phase. You can read more about each phase by clicking on the phase titles.

Phases of Disaster - Description

Starting from left to right, this graph illustrates the general progression of the disaster effects and reactions on communities.

- The first is the **Pre-Disaster Phase** where the amount of warning a community receives varies by the type of disaster. Perceived threat varies depending on many factors.
- Next is the **Impact Phase**. The greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychosocial effects.

[28] **U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2000). Training manual for mental health and human services workers in major disasters, second edition. Washington, DC.**

- Next is the **Heroic Phase** which is characterized by high altruism among both survivors and emergency responders.
- In the following weeks and months is the **Honeymoon Phase** where survivors feel a short-lived sense of optimism.
- Over time, survivors go through an inventory process where they recognize the limits of available disaster assistance. This leads into the **Disillusionment Phase** where survivors are coming to grips with reality of their situation. Certain trigger events, such as the anniversary of the disaster, can prompt survivors to re-experience negative emotions related to the disaster.
- Lastly, during the Reconstruction Phase, survivors experience setbacks and work through their grief, eventually readjusting to their new surrounding and situations.

Pre-Disaster Phase

Disasters vary in the amount of warning communities receive before they occur. For example, earthquakes typically hit with no warning; whereas, hurricanes and floods typically arrive within hours to days of warning. When there is no warning, survivors may feel more vulnerable, unsafe, and fearful of future unpredicted tragedies. The perception that they had no control over protecting themselves or their loved ones can be deeply distressing.

When people do not heed warnings and suffer losses as a result, they may experience guilt and self-blame. While they may have specific plans for how they might protect themselves in the future, they can be left with a sense of guilt or responsibility for what has occurred.

Impact Phase

The impact phase of a disaster can varies from the slow, low-threat buildup associated with some types of floods to the violent, dangerous, and destructive outcomes associated with tornadoes and explosions. The greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychosocial effects.

Depending on the characteristics of the incident, people's reactions range from constricted, stunned, shock-like responses to the less common overt expressions of panic or hysteria. Most typically, people respond initially with confusion and disbelief, and focus on the survival and physical wellbeing of themselves and their loved ones. When families are in different geographic locations during the impact of a disaster (e.g., children at school, adults at work), survivors will experience considerable anxiety until they are reunited.

Heroic Phase

In the immediate aftermath of a disaster event, survival, rescuing others, and promoting safety are priorities. Evacuation to shelters, motels, or other homes may be necessary. For some, post-impact disorientation gives way to adrenaline-induced rescue behavior to save lives and protect property. While activity level may be high, actual productivity is often low. The capacity to assess risk may be impaired and injuries can result. Altruism is prominent among both survivors and emergency responders.

The conditions associated with evacuation and relocation have psychological significance. When there are physical hazards or family separations during the evacuation process, survivors often experience post-trauma reactions. When the family unit is not together due to shelter requirements or other factors, an

anxious focus on the welfare of those not present may detract from the attention necessary for immediate problem solving.

Honeymoon Phase

During the week to months following a disaster, formal governmental and volunteer assistance may be readily available. Community bonding occurs as a result of sharing the catastrophic experience and the giving and receiving of community support. Survivors may experience a short-lived sense of optimism that the help they will receive will make them whole again. When disaster mental health workers, are visible and perceived as helpful during this phase, they are more readily accepted and have a foundation from which assistance can be provided in the difficult phases ahead.

Disillusionment Phase

Over time, survivors go through an inventory process during which they begin to recognize the limits of available disaster assistance. They become physically exhausted due to enormous multiple demands, financial pressures, and the stress of relocation or living in a damaged home. The unrealistic optimism initially experienced can give way to discouragement and fatigue. As disaster assistance agencies and volunteer groups begin to pull out, survivors may feel abandoned and resentful. Survivors calculate the gap between the assistance they have received and what they will require to regain their former living conditions and lifestyle. Stressors abound—family discord, financial losses, bureaucratic hassles, time constraints, home reconstruction, relocation, and lack of recreation or leisure time. Health problems and exacerbations of pre-existing conditions emerge due to ongoing, unrelenting stress and fatigue. The larger community less impacted by the disaster has often returned to business as usual, which typically is discouraging and alienating for survivors. Ill will and resentment may surface in neighborhoods as survivors receive unequal monetary amounts for what they perceive to be equal or similar damage. Divisiveness and hostility among neighbors undermine community cohesion and support.

Reconstruction Phase

The reconstruction of physical property and recovery of emotional well-being may continue for years following the disaster. Survivors have realized that they will need to solve the problems of rebuilding their own homes, businesses, and lives largely by themselves and have gradually assumed the responsibility for doing so. With the construction of new residences, buildings, and roads comes another level of recognition of losses. Survivors are faced with the need to readjust to and integrate new surroundings as they continue to grieve losses. Emotional resources within the family may be exhausted, and social support from friends and family may be worn thin. When people come to see meaning, personal growth, and opportunity from their disaster experience despite their losses and pain, they are well on the road to recovery. While disasters may bring profound life-changing losses, they also bring the opportunity to recognize personal strengths and to reexamine life priorities. Individuals and communities progress through these phases at different rates, depending on the type of disaster and the degree and nature of disaster exposure. This progression may not be linear or sequential, as each person and community bring unique elements into the recovery process. Individual variables, such as psychological resilience, social support, and financial resources, influence a survivor's capacity to move through the phases. While there is always a risk of aligning expectations too rigidly with a developmental sequence, having an appreciation of the unfolding of psychosocial reactions to disaster is valuable.