(213)

Mental Health services during Natural Disasters.

Dr.K.R.Antony*

My friend Albert, a social activist was visiting a coastal village in Orissa post Super-cyclone in 1999.He saw a man staring at a human body floating in the paddy field, right in front of his house. He was supporting his chin with his arm, with a blank distant stare and had no visible expression of any emotions or body response to the greetings of an approaching visitor to his house. He had a tired look on his face and apparently not eaten or drunk anything for the last couple of days. No tears in his eyes. Only upon repeated questioning about whose body it was, he gave a terse answer-"my wife" For the previous two days he could not get over the shock of losing everything in life, including his dear wife in the fast approaching high waves of sea water. And that dear wife's body is decomposing right in front of him and he has not got up to give a decent burial and perform the last rites due to her.

Well, that is the level of depression any victim of Natural disaster can go into. Often it is unrecognized and not acted upon by the relief workers in many natural disasters due to low priority and due to lack of technical experts to intervene. During the same post Super-cyclone period I have heard of children attending schools from relief camps having symptoms of deafness and blindness who have these manifestations as a psychological reaction to the shock of a deep trauma. These children were repeatedly experiencing the howling and whistling of high velocity wind and the sight of approaching deadly high waves swallowing their siblings and parents. These hysterical blindness and deafness can be considered an escape mechanism for a traumatised mind.

Similar anecdotes were heard during post-tsunami period from coastal Andhra, Tamil Nadu and Andaman islands from my colleagues in UNICEF.

Acute Post Traumatic Stress Syndrome is a clinical entity well recognized in the aftermath of Natural disasters. Justifiably, during any natural disaster the first concern of relief workers is to save lives and rescue all those who are still alive and limit further loss of lives and physical damage.

Relief Commissioners and their government staff as well as voluntary organizations get busy with setting up relief camps, telecommunication networks, power supply, approach roads, shelter camps, community kitchen and toilets. Provision of drinking water, food, medical aid and prevention of communicable diseases all get priority, but not mental health needs of the survivors and victims of disaster.

Many of the states do not have even absolute minimum number of Psychiatrists and clinical psychologists in their government service. The nearest medical colleges also do not have enough persons on pay roll to satisfy even the MCI Inspection teams. No wonder mental health needs of displaced communities in relief camps are ignored or kept as last item in the priority needs.

When there is such a severe shortage of required health staff with clinical expertise, managers of disaster relief operations are compelled to provide immediate Psychological First Aid (PFA) through volunteers and paramedical staff. They may be coached to use simple psychological techniques to relieve mental anguish or panic and possibly prevent any need of psychiatric intervention for majority of trauma victims.

The fundamental Principles of PFA that need to be adhered to, as described in the "Handbook of International Disaster Psychology-Practices and Programmes-Gilbert Reyes and Gerard Jacobs 2006" are as follows:

1. **Protection**-Damage control or stabilization to prevent worsening further from existing level. Gain survivors attention and cooperation to move to safer places. Despondent and persons not cooperating to move can endanger themselves and others who may benefit from moving location.

2. Social support-Boosting the inherent coping mechanism-Every individual or community has some endurance for hardships without external assistance. There are 3 categories of Social support-1.) Tangible(material) support-Food, shelter, financial aid etc 2.)Emotional support-anything someone says or does that helps another person to bear up. Even a caring and attentive companionship is an emotional support. 3.) Informational support-sharing some valuable bit of knowledge or information that solves their problem or gain access to resources that can reduce their misery or hardship.

Volunteers for PFA require good interpersonal skills-with active yet calming, comforting, confident presence, listening more than talking, offering unreserved compassion without judgement or prejudice.

3. Arousal reduction

Any life threatening situation like disasters can arouse fear and self protective emotions and stimulate nervous system response for survival- the "flight /fight response". The consequent thinking abilities and emotional functioning of victims during disaster may be altered and is a 'necessity' for a short period but debilitating in the long run. PFA volunteer should soothe and reduce this "arousal phenomena" so that the survivor is calm and mentally at rest; able to function at a higher level and even sleep well. Loss of or separation from near and dear ones also stimulates "arousal". Hope of reunion and frantic search for the loved ones also increase mental anguish. PFA provider can help in this search and effort for re-union of the survivor.

4. Assisted Coping

Coping is anything that people do to improve their lives or avoid losses in an adverse scenario like natural disasters. Victims often find it difficult to function in a systematic and organized fashion.PFA volunteers should assist in coping mechanism they display on their own and further empower them. Survivors should be treated with respect and encouragement for their resilience, competence and dignity. They must not be clinging on to the aid workers with a dependency feeling. People tend to cope by either 1. *Confronting directly or 2.enduring a problem or 3.managing their thoughts in minimising the emotional impact of the problem.*

Assisted coping is facilitating the selection of best option among the above three to solve their problem.

5. Supervision

There is a limit to the resourcefulness or abilities of a PFA volunteer. At times they become helpless and timid in confronting the field level issues. Supportive supervision by experienced PFA experts or mentors can solve this limitation.

6. Helping the Helper

Often humanitarian and philanthropic workers are very good, sensitive and idealistic personalities. They are particularly vulnerable to daily exposure to traumatic experiences of fellow human beings who for no fault of theirs have had to undergo such misery and hardships. Occupational hazards they face may include a sense of helplessness, obsessive thoughts coming up repeatedly of suffering of your clients and difficulty managing the level of involvement in the lives of others. In their enthusiasm they may feel they are not getting enough back up and the organization they represent is inefficient, inadequate, insensitive and even corrupt. Practitioners need themselves compassionate 'self care' to withstand 'burn out' syndrome. They must be encouraged to avoid long shifts, take mandatory breaks during duty hours and compulsory home leave after continuous working weeks for recuperation.

Screening and detection of those who need Psychiatric help.

Once the relief camps are established, certain group therapy and counselling services could be undertaken by the deputed Clinical Psychologists or the paramedical workers trained specifically in management of grief. If

families are already disbursed from the camps and they are back at home or children are attending schools, then paramedical workers can be trained to screen at home or neighbourhood, those requiring referral for psychiatric treatment.

Psychiatric help through Primary Physicians.

If the ground reality is such that no psychiatrist is deputed or available for daily duty in relief camps or in the vicinity of affected villages, a team of MBBS doctors can be trained on how to treat acute post trauma stress syndrome. Algorithms of management of locally prevalent most common diagnosis, based on situation specific signs and symptoms can be taught to those MBBS doctors. The options of medications like anxiolytics (Diazepam, Alprazolam, Lorazepam) antidepressants (Imipramine, Fluoxetine) should be limited to absolute minimum for common disorders. Those with severe breakdown may be psychotic and need antipsychotic medication. The medications prescribed must be made available in full at each camp site. Those prescribing and dispensing the medicines must emphasize the need for correct and regular dosing, and it should be underlined that many medicines take time, even upto two weeks to start producing the desired psychological improvement. The psychiatrist who volunteers or is deputed to train these group of primary care physicians should take "vicarious responsibility" and must be available for clarifications or consultation over phone or internet; better still for videoconferencing if broadband connectivity is established at camp site. "Ready-reckoners" and handbooks for case management should be prepared, duplicated and distributed adequately for medical and paramedical staff.

Conclusion

Psychological needs of displaced communities in transient shelters and victims and survivors of natural calamities living in their homes are seldom addressed systematically by government or international donors. Often it gets low priority and last attention by relief workers and civil society organizations. This also reflects the extremely inadequate training in mental health given to undergraduates in the Indian medical curriculum. Professional organizations of Psychologists and Psychiatrists must come forward to design protocols and handbooks for management and training modules for health staff in addition to drafting policy guidelines. One such manual was created after the Bhopal Gas Leak disaster in the early 1980s but this may need updating. National Disaster Management Agency must show stewardship to issue clear-cut directions to states to include this aspect in their Disaster Preparedness plans.

*Acknowledge inputs from my classmate Dr.Ajit Bhide, Psychiatrist St.Martha's Hospital, Bangalore.