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Innovation The Research Concept

Understanding Psycho-Social Rehabilitation

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Abstract

Disasters are as old as human history but the dramatic increase and the damage caused by them in the recent past have become a cause of national and international concern. Over the past decade, the number of natural and manmade disasters has climbed inevitably. During the period 1994 to 1998, reported disasters average was 428 per year but from 1999 to 2003, this figure went up to an average of 707 disaster events per year showing an increase of about 60 per cent over the previous years. The biggest rise was in countries of low human development, which suffered an increase of 142 per cent. In this paper an attempt has been made to understand the types and phases of Disaster and the Psycho social impact. The authors also tried to elaborate the concept of Rehabilitation and various stages of psychosocial responses.

Keywords: Disaster, Rehabilitation, Psychosocial impact, Psychological Intervention.

Introduction

"Disaster is a crisis situation that far exceeds the capabilities "
-Quarentelly, 1985.

Disasters are as old as human history but the dramatic increase and the damage caused by them in the recent past have become a cause of national and international concern. Thus, being one of the essential rationale behind this theoretical paper. The current paper aims to understand the types and phases of disaster, explore the psycho social impact of disasters on human beings, elaborate and understand the concept of rehabilitation, principles involved and stages of psychosocial responses.

The word 'Disaster' is also defined as a crisis situation causing wide spread damage which exceeds far beyond our ability to recover. Thus, by definition, there cannot be a perfect ideal system that prevents damage, because it would not be a disaster then. It has to suffocate our ability to recover. Only then it can be called as 'disaster'.

Over the past decade, the number of natural and manmade disasters has climbed inevitably. During the period 1994 to 1998, reported disasters average was 428 per year but from 1999 to 2003, this figure went up to an average of 707 disaster events per year showing an increase of about 60 per cent over the previous years. The biggest rise was in countries of low human development, which suffered an increase of 142 per cent.

Objectives of the Study

1. *To understand the types and phases of Disaster
2. To explore the Psycho social impact of Disasters on human beings
3. To elaborate and understand the concept of Rehabilitation and various stages of psychosocial responses.
4. *To explore the principles of Rehabilitation

Understanding Disaster & Types

The term "disaster" originated from the French word 'desastre', Italian word 'disastro' and Latin word 'Astrum'. The term *des* means bad and *aster* means star. Thus, the term disaster would mean bad or evil star. World Health Organisation (WHO) defines disaster as ' an occurrence that causes damage, economic destruction, loss of life or leading to deterioration in health and health services on a scale sufficient to warrant an extraordinary response from the affected community or area.'

There exist various definitions of disaster and having analyzed them, it is clear that for an event to be categorized as a disaster the following attributes should be there:

1. It has to be an unusual event of sufficient magnitude and severity.
2. It should develop suddenly and perhaps unexpectedly.

3. It should result in widespread damage to property and disrupt normal life and routine functioning of the affected community.
4. It could generally be accompanied by high casualty figures in the affected population.
5. It would require immediate coordinated & effective response by multiple government & private sector organizations.
6. The response mechanism must address immediate human needs and facilitate speedy recovery. (Gulia, S, K.2004. Geneses of Disasters: Ramifications and Ameliorations).

Types of Disasters

Disasters are mainly of 2 types as follows:

Natural Disasters

Earthquakes, Floods, Landslides, etc which are beyond our control.

Manmade Disasters

War, Bomb Blasts, Chemical Leaks, etc which can be controlled by human being.

Phases of Disaster

Irrespective of its types, there are five phases of disaster. The phases are outlined below:

Readiness

The first phase of Disaster is readiness. Being prepared is important key to an effective disaster response. Compassionate and skillful response requires planning and building relationships with community members before the disaster.

Rescue

This is the second phase. This phase occurs in the initial hours or a few days after a disaster. The focus is on saving human life by moving the victim to a safer place.

Relief

The third phase of the disaster is focused on providing survivors with their basic needs: water, food, shelter and clothing. Relief work also includes securing the disaster site so that recovery work may begin. damaged property for further repairs and reconstruction

Recovery

This is the fourth phase which is perhaps the longest because it can take several years, depending on the scope of the disaster. Survivors face huge number of challenges as they work toward restoring normalcy. Recovery includes helping survivors find long-term solutions to their needs. This can include reconstruction or relocation, support for livelihoods or securing employment, transportation and especially restoration of hope among the affected persons.

Review

This is the fifth and final phase of Disaster. Evaluation of disaster response is an important part of demonstrating accountability and preparing for the next disaster.

Psycho-Social Impact of Disaster

Disaster, natural or man-made always negatively affects the human beings, the social and service structure of the society or community and the environment. Over the last quarter of a century, more than 150 million people a year have been seriously affected by disasters .The physical effects of a disaster are usually obvious. Hundreds or thousands of people lose their lives. The survivors suffer pain, physical and mental disability. Homes, workplaces, livestock, and equipment are damaged or destroyed. Disasters invariably have an immediate as well as long lasting impact on those concerned and their families, permeating all the spheres of human activity, ranging from the physical, socio -economic and ecological state to the mental, political and cultural state of the affected population. Some of the emotional effects are direct responses to the trauma of disaster. Other effects are longer-term responses to the interpersonal, societal, and economic effects of the disaster.

Disasters affect communities and societies and many of the psychological effects of disaster are created or affected by the direct social and economic effects of disaster, we will conceptualize both the effects of disaster and appropriate responses to disaster not as purely psychological and not as purely social or economic, but as *psychosocial impact.*

When people experience any disaster, they exhibit the following physiological responses:

1. Immediate responses can be like response to sights and sounds: Hearts pound, mouth dry, muscles tense, nerves go on alert, feeling of intense anxiety, fear or terror. Sometimes there is little or no warning, one may not understand what is happening ,may be in shock, a sense of unreality & fear dominates.
2. Long term effects includes sights, sounds, smells & feelings of the event persist as indelible images in our memories even long after the event . These appear as the immediate shock & terror scatters in various directions.
3. Disaster challenges our basic assumption and beliefs: (these are cognitive, information processing aspects) that our personal world is predictable, controllable, manageable, benevolent & meaningful. To believe that we can trust in ourselves and others. To believe we can cope with adversity of life.
4. Disaster destroys these beliefs. We become aware of our vulnerability. We feel helpless & hopeless c. We despair in our inability to make decisions and to act in ways that would make any difference to our families and in ourselves
5. In the wake of the disaster: We grieve for the death of loved ones . We may feel unworthy or guilty for having survived. We grieve for our home, for treasured personal memorable belongings, for lost documents, lost familiar neighborhoods
6. If disaster has disrupted our community's traditional subsistence activities or our community itself: we may feel intense feelings of loss tied to our cultural and social identity (Ehrenreich, 2001)

Understanding Rehabilitation

Rehabilitation is defined as "the restoration of function or the acquisition of new skills required as a result of the changed circumstances of a victim arising from torture or ill-treatment. It seeks to enable the maximum possible self-sufficiency and function for the individual concerned, and may involve adjustments to the person's physical, psychological

and social environment. Rehabilitation for victims of any disaster should aim to restore their independence; physical, mental, social and vocational ability; and full inclusion and participation in society. Psychological intervention is a topmost priority in an emergency or a disaster for both individuals and communities.

Psychosocial Interventions

It may be described in terms of actions with the priority goal of creating, restoring and maintaining the social functioning of the population affected as well as the affective and emotional balance of individuals at the level of their social environment.

Clinical Interventions

It may be described in terms of actions focused on the most vulnerable individuals, specifically targeting psychological or psychiatric effects. (Josse, Dubois, 2009)

Psycho-Social Resilience

The term resilience comes from the Latin verb resilio, ire, which means literally 'to jump back', thus 'rebound, resist'. Resilience refers to the psychological capacity to rebounce after one or more potentially traumatic events and to function well despite stress, adversity and unfavorable situations (Josse, Dubois 2009). It is an individual and/or collective process which makes it possible to face up to intense stress levels by developing (and using) one's own social and psychological resources.

Psychosocial resilience is defined as the psychological capacity to rebound after one or more potentially traumatizing events and to function well despite stress, adversity and unfavorable situations. It depends on the risk factors and protection factors of the individual and the situation (internal and external resources) . The more significant risk factors are that very fewer people may pull through easily. Therefore Humanitarian interventions must have an emphasis on all protection factors at economic, social and psychological levels, by strengthening or creating resources.

In any case, in the absence of well-designed interventions, up to fifty percent or more of the victims of a disaster may develop lasting depression, omnipresent anxiety, post-traumatic stress disorder, and other emotional disturbances. Even more than the physical effects of disasters, the emotional effects cause long-lasting suffering, disability, and loss of income. There is no single, universally applicable recipe for responding to disasters. Disasters may be relatively short lived, although devastating, or, may last for years, like in the case of famine and war. Perhaps the greatest source of variability, both in the effects of disaster and in the most appropriate responses, stem from differences between the countries and cultures in which a disaster occurs. The two major components of this variability are in terms of :

1. Level and patterns of economic development : Wealthy countries face disasters with a wealth of human and material resources, a well-developed medical and mental health infrastructure, including highly structured emergency planning, and efficient transportation and communication systems. Although, these are no protection against the direct effects of a disaster but it greatly facilitates responses to disaster. In poor countries it is vice versa.
2. Many characteristics of poorer countries: This makes people more vulnerable to the effects of a disaster. Substandard housing is more easily destroyed by the high winds of hurricanes and cyclones. The dwellings of the poor, crowded onto flood plains and unstable hillsides, are especially vulnerable to floods. Inefficient, understaffed, and unprepared government bureaucracies mismanage relief efforts.

Stages of Psychological Response to Disasters

The aftermath of disaster can be conceptualized in terms of a series of stages or phases, each of which has its own characteristics. These phases are not rigid. There is much variation at each stage and the stages overlap.

Stages of Disaster	Description of Stages	Psychological Responses
Rescue	It is seen in the first few hours or few days after the disaster. It involves rescuing victims and seeking to stabilize the situation. For e.g. providing cloth, food, water, house, medical attention.	Emotional responses seen. For e.g. psychic numbing, heightened arousal, diffused anxiety, survivor guilt, ambivalence, cognitive and affective instability.
Inventory Stage	Occurs once the situation has been stabilized, attention turns to longer- term solutions. Heroic rescue efforts give way to bureaucratized forms of help. Over the next year or eighteen months, organized assistance from outside gradually diminishes and the reality of their losses dawn on victims.	Wide variety of post-traumatic symptoms appear. For e.g. PTSD (Post traumatic stress disorder), GAD (Generalized Anxiety Disorder), Abnormal Bereavement, Post traumatic Depression etc.
Reconstruction Stage	Occurs a year or more after the disaster. During this phase, although many victims may have recovered on their own, a substantial number continue to show symptoms much like those of the preceding ("inventory") stage. Victims become aware of the reality of their permanence of their losses.	More complex syndrome appear For e.g. chronic fatigue, chronic gastrointestinal symptoms, inability to work, loss of interest in daily activities, and difficulty thinking clearly.

Source: Ehrenreich, H, J. 2001)

Principles of Rehabilitation

There are two major aspects to intervention with the victims of disasters: rebuilding the community affected by the disaster and intervening with individual victims. In each case, the underlying principle is to encourage healing processes, in individuals, families, and communities. The major principles of rehabilitation involved are as follows:

Safety and Material Security Underlie Emotional Stability

It is difficult for people to maintain a stable mental state, after a disaster or in any other conditions unless certain basic needs are met. First, they must be assured access to food, water, clothing, and shelter. Second, their need for physical safety and security must be met. In the case of disasters, this includes not only freedom from fear for one's life, due to the disaster itself, but security from banditry, from the fear of looters, from fear of rape or other assault in shelters or refugee camps, and from the fear that the disaster will lead to the permanent loss of one's land or one's home. Third, the safety and integrity of their family must be ensured. Fourth, their long term need for stable jobs, adequate housing, and an implementation of community must be met.

Assume Emotional Responses To Disaster are Normal

A wide range of emotional responses to disaster are *normal* responses to irresistible stress. They are not, in themselves, signs of "mental illness." They do not signify that the person suffering from the symptoms is "weak" or is "going crazy." Many of the symptoms experienced by the victims can be understood as adaptive mechanisms, by which people seek to protect themselves against the irresistible physical and emotional impact of the disaster. Both individuals and communities have natural healing processes. Psychosocial assistance in the wake of disaster is best presented in a form that does not require people to see themselves as "ill" or "mentally ill."

1. Use non-mental health terms to describe services and those providing them. Present services as "extra help for difficulties anyone would have trouble with" after being affected by a disaster.
2. Aggressive outreach and case finding is necessary. Use local residents, primary care health workers, teachers, religious leaders, and community leaders as informants. Use door-to-door canvassing, mailings, television and radio announcements, leaflets distributed in schools and workplaces, and announcements in churches to alert people to the availability of services and the indications for using them. In shelters, actively look for signs of distress (sobbing, facial expressions, body language, aggressiveness, substance abuse, etc.).
3. Use existing, non-mental health institutions such as schools, churches, community centers, and medical facilities as bases for psychosocial services.
4. Train and use non-mental health personnel (e.g., teachers, health workers, social service workers, religious workers) to provide psychosocial services.
5. Educational sessions or debriefing sessions may provide an opportunity for providing information about trauma and its consequences and enlisting support for the provision of trauma services, while giving services at the same time.
6. For all those who participate in delivering services, discretion, respect for the confidentiality of those being helped, and ethical behavior are essential.

Interventions should be Matched to The Disaster Phase

The types of response that are offered should match the phase of emotional responses and the needs of disaster relief operations as follows:

The "Rescue" Phase

Immediately after the disaster, the highest priority for psychosocial services is rescue and relief workers, whose continued effective functioning is essential. This may involve crisis management, crisis intervention, conflict resolution, assisting with problem solving, or "defusing". Small concrete services may be emotionally useful as well as practically helpful; e.g. bringing coffee for the rescue workers, lending a hand in cleaning up, giving a hug, expressing interest. Immediately after the disaster, the most urgent needs of victims are for direct, concrete relief for e.g., rescuing lives, ensuring physical safety, providing medical care, providing victims with food, water, shelter, reuniting them with their families. In doing so, they contribute to longer-term mental health.

1. Provide "psychological first aid" for those whose acute distress and difficulties in functioning interfere with the victim's cooperation with rescue and relief efforts and ability to help provide for their own safety. Try to identify signs of intense anxiety or panic, continuous crying, depressive withdrawal, disorientation, incoherence, difficulty complying with requests by relief workers or with the rules of the shelter.
2. Provide short term interventions to reduce anxiety, assist the rescue and relief process, and help prevent later maladaptive responses. These include comforting and consoling victims by a word or a hug; helping people reunite with family members or getting information about loved ones; helping people reconnect with neighbors, work-mates, and others who make up their personal "community;" helping defuse conflicts with other victims or between victims and relief workers; supporting victims in such "reality tasks" as identifying the dead or making decisions about animals and other property.
3. Begin broad preventive activities and activities that set the stage for later interventions: Provide accurate information as to what is happening, using all available mechanisms (e.g., mass media, meetings, leaflets). Reassure victims that acute reactions are normal and should not be sources of fear or of feelings that one has lost control.
4. Interventions that are cognitively complex are premature when people are still in a stunned

state. However, helping to reduce anxiety may help prevent later distress, and making contact with survivors even at very early stages after the disaster may create positive feelings towards the counselor that can make later interventions more acceptable and effective.

5. One problem in the early stage of response may be a rapid influx of people seeking to help, seeking to exploit the situation, or seeking to satisfy curiosity. At the level of those organizing the response to the disaster, immediate efforts to control the potentially adverse effects of this influx is part of creating a sense of safety for victims.
6. People who are indirectly affected by the disaster like the families or friends of victims, onlookers, even those watching repeated reports of the disaster on television may also show signs of distress. However it is seen that what is helpful to one person may not be needed or appreciated by another. For example, one person may find that talking about the event reduces distress, while another needs to be quiet and introspective.

The "Inventory" Phase

Continuing to provide services to relief workers remains a high priority during this period. The first days or weeks following the disaster may be a "honeymoon" phase, in which people's feelings of relief and optimism about the future dominate. A spirit of generosity and mutuality may appear, and individuals may be in a state of denial about their losses and the problems of the future. During this stage many people will not be receptive to psychosocial interventions or will feel they do not need them. Others, however, may welcome the chance to talk through their reactions within a few days of the disaster or to find someone who can help them plan how to overcome the obstacles they are facing. The bulk of psychosocial interventions directed at victims themselves occur in this period. Discouragement and disappointment with relief and reconstruction efforts may set in. Anxiety, sadness, irritability, frustration, and discouragement now combine with disaster-produced losses and post-traumatic stress effects to produce a relatively high level of need. Focusing on identification of those at risk and on interventions to reduce the longer-term impact is essential.

1. Provide broad outreach services aimed at providing education about responses to disaster and information as to the availability of services and guidance as to when to seek support. This may include use of newspapers, radio, and television; arranging community meetings or sending speakers to churches or schools; distributing leaflets through shelters, schools, workplaces.
2. Seek to identify those who are at risk or those in need of services and focus services on these people.
3. Provide concrete support in specific situations. This may include helping those who have lost a family member identify the victim and make funeral arrangements; advocating for improvements in the organization of shelters or for provision of specific supplies or services; helping organize society rituals and memorial ceremonies; helping prevent or combating scapegoating in a shelter or in a community.
4. Advocating for rapid progress in rebuilding homes, recreating jobs, restoring community services (e.g., schools, churches) and involving victims in themselves advocating for these both helps ensure that the essential underpinnings of psychological recovery are realized and helps restore a sense of mastery and control in victims. Training of supplementary disaster counselors will, of necessity, be a high priority during this period. Primary care health workers, teachers, religious leaders, traditional healers, and others can be enlisted.

The "Reconstruction" Phase

Emotional consequences of the disaster may continue to appear for up to two years or more post-disaster. In part this represents delayed reactions, in part responses to a growing recognition of the irreversible consequences of the disaster. The experience of several disasters suggests that mental health assistance should remain available for about two years or more after the disaster. Such services also permit longer-term follow-up of those treated earlier. It may be helpful to establish and maintain a telephone "hot line" or other ways for people to contact counselors if the need arises, for the period after counselors leave the site of the disaster.

Integrate Psychosocial Assistance with Overall Relief Programs

It is difficult to provide effective psychosocial services without the cooperation and support of those directing and providing medical and material relief efforts, at the local as well as the regional or national level. Governmental officials (at local or national level) often do not recognize or give much priority to the psychosocial effects of disasters. Rescue and relief workers, who are necessarily focusing on the urgent and concrete tasks of saving lives, protecting property, ensuring the provision of food, clothing, and shelter, and rebuilding the material infrastructure like road and rail network of the community may see psychosocial services as unnecessary or even as getting in their way. Educating both of these groups about the impact of psychosocial processes on the relief effort itself and on the long run consequences of not responding to the mental health effects is indispensable

Interventions must take People's Culture into Account

People from different cultural groups (including different sub-cultural groups within a larger society) may express distress in different ways and may make different assumptions about the sources of suffering and how to respond to it. Techniques originally devised in industrialized countries must be applied sensitively, if they are to be used elsewhere. Fortunately, there is a body of evidence suggesting that these techniques can be successfully adapted to a wide variety of situations. Interventions need to be

sensitive to these differences and may effectively draw on them.

Conclusion

Thus, psycho-social rehabilitation services is of utmost importance during times of crisis aftermath disaster (natural/man-made). This will help the recovery and reconstruction process.

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